

medicaid
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**Children's Medicaid and SCHIP in Texas:
Tracking the Impact of Budget Cuts**

Prepared by

*Anne Dunkelberg of the Center for Public Policy Priorities and
Molly O'Malley of the Kaiser Commission on Medicaid and the Uninsured*

July 2004

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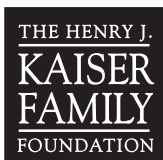
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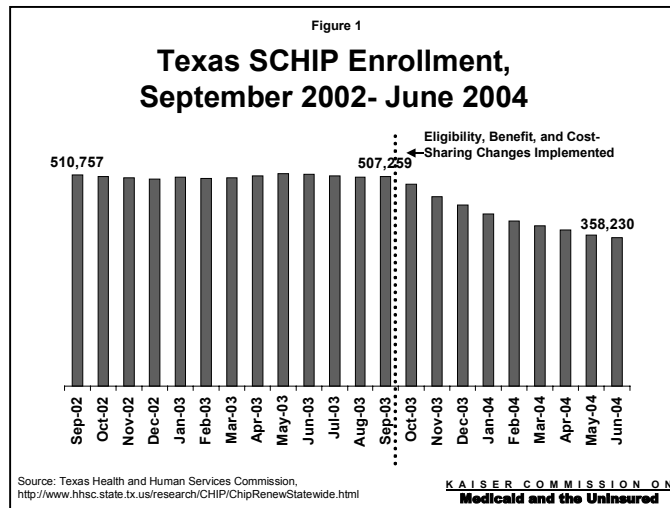
Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts

EXECUTIVE SUMMARY

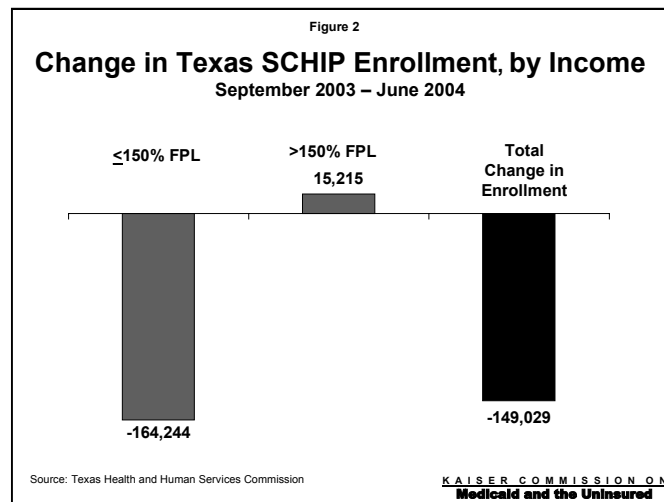
Enrollment in the Texas State Children's Health Insurance Program (SCHIP) has declined steeply over the past year on account of recent policy changes that have significantly impacted children. Cuts to Medicaid and SCHIP were deep, and even after several incremental restorations, are projected by state officials to reduce total spending for the FY2004-2005 biennium budget by more than \$1.6 billion. Savings were achieved by making changes to Medicaid and SCHIP eligibility and benefits. Policy changes in these programs have reduced the role of public health insurance coverage for low-income children in Texas who rely on Medicaid and SCHIP for comprehensive preventive and primary care health services. The state of Texas has one of the nation's lowest rates of employer-sponsored coverage and the highest rate of uninsured in the nation. Over 1.4 million children were uninsured in Texas in 2002. Health insurance programs such as Medicaid and SCHIP are vital to the health of many low-income children who otherwise would be unable to afford or obtain health insurance coverage. This policy brief provides a summary of recent Medicaid and SCHIP policy changes and their impact on coverage for children.

Many of the policy changes to Medicaid and SCHIP, earmarked for FY 2004 and FY 2005, affected the health coverage of children. Most of the cuts to Medicaid and SCHIP were targeted toward eligibility and benefit reductions in order to reduce overall Medicaid and SCHIP spending. The SCHIP eligibility changes were designed to reduce continued or new coverage through a reduction in continuous coverage from 12 months to 6 months, establishment of a 90-day waiting period, higher premiums particularly for families with incomes between 101-150% FPL, and higher co-payments. SCHIP benefit reductions included eliminating a number of previously covered services such as dental, hospice, skilled nursing, tobacco cessation, vision care and eyeglasses, and a reduction of about 50% in coverage of mental health and substance abuse services. The budget also reduced payment rates for a number of Medicaid and SCHIP providers.

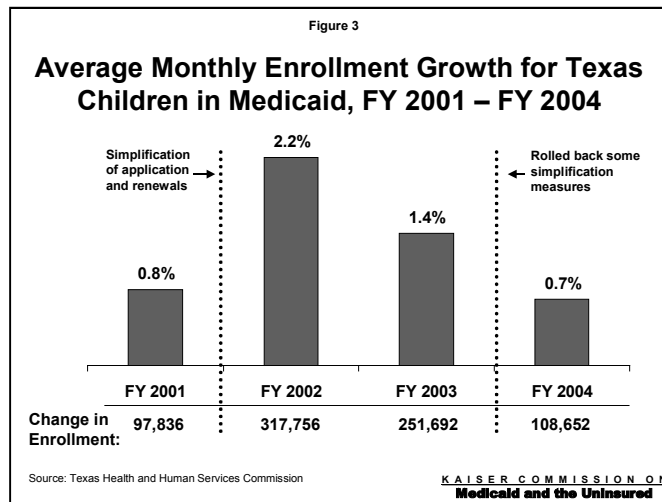
SCHIP enrollment has dropped by more than 149,000 children (a 29 percent decline) since the beginning of FY 2004 in response to numerous program changes (Figure 1). Data show that fewer children are being enrolled in SCHIP and more enrolled children are being disenrolled. The decline to date is related to failure to renew, reduced rates of new applications, and to some extent the exclusion of income disregards. Once the state ends the moratorium on terminations for nonpayment of premiums and applies the new asset limit in August 2004, the downward decline in enrollment could intensify in the months to come.



Lower income families are disproportionately affected by the changes in SCHIP. Data show that virtually all the net reduction in SCHIP enrollment has been among children in families with incomes below 150% FPL (Figure 2). The number of below-poverty children has dropped by more than 68 percent and the number of children between 101-150% FPL has dropped by more than one-third since September 2003. These numbers point to a need for a better understanding of how cost-sharing changes and benefit reductions have affected enrollment and parents' perceptions of the affordability and ability to secure SCHIP coverage. Although cost containment actions can produce short-term savings for the state, increased procedural complexities in the application and renewal process can result in large coverage losses for children enrolled in public health insurance programs.



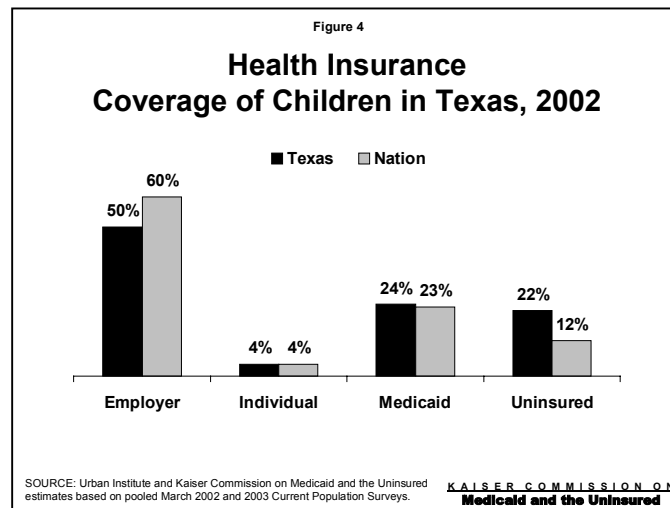
Recent enrollment numbers show the growth rate for children in Medicaid has slowed over the past two years. Previously, the Texas Medicaid program experienced robust growth in children’s enrollment largely due to outreach and simplification measures aimed at aligning children’s Medicaid enrollment and renewal processes with those of SCHIP. More recently however, slowing monthly enrollment growth has occurred, with the average increase for FY 2004 year-to-date down to just 0.7 percent (an increase of 108,652 children), lower than in the period just prior to implementation of simplified application and renewals (Figure 3). Growth in enrollment is slowing, likely due to both natural slowing that occurs as enrollment reaches increasingly higher percentages of those who are eligible and to the impact of increased procedural complexities in the application and renewal process that took effect in September 2003. Total combined child coverage in May 2004 (the most recent month for which both Medicaid and SCHIP data are available) was over 39,000 below the August 2003 level – the last month before the new SCHIP and Medicaid cost containment policies took effect.



I. STATE BUDGET BACKGROUND

Like many other states, Texas began its 2003 legislative session facing a budget shortfall of unprecedented magnitude. The drop in state tax revenue was alarming and contributed to an estimated shortfall of between \$9.9 billion - \$16 billion for FY2004-2005.¹ However, unlike other states, Texas entered this fiscal crisis already near the bottom nationally in both revenue and spending. In 2002, Texas ranked 49th in state spending per capita, with average state government spending nationwide 43 percent higher than in Texas. Texas also ranked near the bottom in taxes. According to the Census Bureau, Texas ranked 49th among the states in per resident state taxes. Meanwhile as Texas state legislators were trying close the budget shortfall, the Governor along with the Lieutenant Governor and Speaker of the House reiterated their commitment to not raise taxes as a means of addressing the state budget crisis. In the end, legislators balanced the budget without raising taxes through a combination of program cuts, use of rainy day funds, increases in fees and tuition, and last-minute federal fiscal relief provided by Congress.

Program cuts to Medicaid and SCHIP were deep, and even after several incremental restorations, are projected by state officials to reduce total spending for the FY2004-2005 budget by more than \$1.6 billion. Policy changes in these programs have reduced the role of public health insurance coverage for low-income children in Texas who rely on Medicaid and SCHIP for comprehensive preventive and primary care health services. The state of Texas has one of the nation's lowest rates of employer-sponsored coverage and the highest rate of uninsured in the nation (Figure 4). Over 1.4 million children were uninsured in Texas in 2002. Health insurance programs such as Medicaid and SCHIP are vital to the health of many low-income children who otherwise would be unable to afford or obtain health insurance coverage.



¹ The Texas Legislature meets every other year and adopts a biennial budget.

II. SUMMARY OF SCHIP AND MEDICAID POLICY CHANGES

Benefit and Eligibility Changes Affecting Children

In Texas, both the Medicaid and SCHIP programs experienced significant cutbacks in the final FY2004-2005 biennium budget and many of these cuts affected the health coverage of children. Most of the cuts were targeted toward eligibility and benefit reductions in order to reduce overall Medicaid and SCHIP spending. SCHIP benefit reductions included eliminating a number of previously covered services such as dental, hospice, skilled nursing, tobacco cessation, vision care and eyeglasses, and a reduction of about 50% in coverage of mental health and substance abuse services. Budget officials assumed a lower per capita SCHIP cost based on eliminating these previously covered services. Although SCHIP eligibility levels were maintained covering children with family incomes up to 200% FPL (\$31,340 annually for a family of three), the FY2004-2005 budget assumed major changes to the SCHIP eligibility process. The Health and Human Services Commission (HHSC) projected that changes to the SCHIP eligibility process will reduce SCHIP enrollment in FY 2005 by 32 percent below the number of children enrolled in 2003. Two of these policy changes lead to disenrollment for some children previously enrolled in SCHIP by imposing an asset limit and eliminating all deductions from income. The other eligibility changes were designed to reduce continued or new coverage through more frequent renewals, waiting periods, higher premiums and co-payments. Further detail of the SCHIP eligibility changes are summarized below and in Table 1.

- 1) **Elimination of deductions:** This policy change eliminated income deductions (e.g. for child support paid out, child care costs, earned income) so that gross, rather than net, income now determines SCHIP eligibility. This change terminated coverage in November 2003 for about 16,800 previously enrolled children in the upper income range for SCHIP.
- 2) **New asset test:** This policy will impose an “asset limit” as part of the eligibility rules for children in families with incomes at or above 150 percent of the federal poverty level (\$23,505 annually for a family of three). This limit, modeled on Texas Food Stamp policy, will be \$5,000 and will include funds in checking or savings, plus the “countable” value of vehicles. This vehicle policy is actually more restrictive than for children’s Medicaid. Because little data exists on the assets possessed by Texas families at this income level, it is impossible to predict with any accuracy the enrollment impact of this change.² This policy is scheduled for implementation in August 2004.
- 3) **90-day waiting period:** With this change children who are certified for SCHIP now have to wait 90 days before their coverage takes effect. This change reduces SCHIP spending primarily through a one-time shift of costs into the future. For example, new enrollees in September 2003 did not actually get their benefits until December 2003. The delay may also reduce SCHIP premiums over time, because parents who do not enroll their children until they are ill or injured will not have coverage for the first several months of medical bills. However, health care providers predict that other policy

² See “CPPP Comments on Proposed SCHIP State Plan,” <http://www.cppp.org/products/policyanalysis/com8-04-03.html>, or “Comments on SCHIP-Related Proposed Rules and Policy Changes,” <http://www.cppp.org/products/policyanalysis/com7-22-03b.html>, for a more detailed explanation.

changes (dropping to 6-month continuous eligibility, or cost-sharing increases) will result in higher per capita costs due to delayed access to care during months before coverage begins, which could offset any savings from the delay and potentially lead to higher premiums.

- 4) **Shorter, 6-month, coverage period:** Until fiscal year 2004, children were eligible for SCHIP for 12 months before their families were required to renew their benefits. This change reduces SCHIP enrollment by speeding up the transfer of children to the Medicaid program when their family income falls low enough (which will cost the state more), or dropping children completely (removing them to the ranks of the uninsured or to private coverage) should their family income rise above 200 percent of poverty. Enrollment is also expected to fall as a result of the inevitable percentage of parents not renewing even though their children remain eligible, an effect that is compounded by requiring renewal more often.

- 5) **Increased premiums and cost-sharing:** Changes in SCHIP premiums were targeted to families above 100% FPL. Families between 101-150% FPL now have a \$15 monthly premium, which replaces a \$15 annual enrollment fee. Families between 151-185% FPL had their monthly premium increased to \$20, and families 186-200% FPL are charged a \$25 monthly premium. This change reduces SCHIP enrollment because some parents will not or cannot pay the higher premiums. Of particular concern is how this policy affects families between 101-150% FPL, whose premium costs have increased from \$15 per year to \$180 per year. Texas also increased co-payments for certain services and selected populations. Families below 100% FPL now have a \$3 office visit co-pay, a \$10 hospital inpatient co-pay, and 1.25% of income annual cap on co-pays (previously was \$100). Families between 101-150% FPL had their office visit co-pay increased to \$5, and 1.25% of income annual cap on co-pays (previously was \$100). Families between 151-185% FPL had their office visit co-pay increased to \$7.

Table 1: Recent Changes in SCHIP Eligibility, Premiums, and Cost-Sharing

	Populations Affected	Policy Before Budget Cuts	Policy After Budget Cuts
Eligibility	All kids	Eligibility based on net income	Eligibility based upon gross income (i.e. no income deductions)
Asset Test*	Families \geq 150% FPL	None	\$5,000 asset limit, including funds in checking and savings accounts plus countable value of vehicles
Waiting Period	All kids	No waiting period	90-day waiting period
Coverage Period	All kids	12-months continuous	6-months
Premiums	Families 101-150% FPL	\$15 annual enrollment fee	\$15/month/family
	Families 151-185% FPL	\$15/month/family	\$20/month/family
	Families 186-200% FPL	\$18/month/family	\$25/month/family
Copayments	Families \leq 100% FPL	No office visit co-pay; No inpatient hospital visit co-pay; \$100 annual cap on co-pays	\$3/office visit; \$10/inpatient hospital visit; 1.25% of income annual cap on co-pays
	Families 101-150% FPL	\$2/office visit; \$100 annual cap on co-pays	\$5/office visit; 1.25% of income annual cap on co-pays
	Families 151-185% FPL	\$5/office visit	\$7/office visit

NOTE: Additional premiums and co-payments that apply to SCHIP beneficiaries were not changed and therefore are not listed in this table. *The change in asset test is scheduled for implementation in August 2004.

Other Medicaid and SCHIP Changes

Texas implemented a number of other Medicaid and SCHIP cost containment actions affecting low-income populations. For example, Medicaid eligibility for pregnant women was reduced from 185% FPL to 158% FPL (\$19,730 annually for a family of two) (Table 2). HHSC estimated this eligibility change would reduce enrollment by about 8,144 women per month in 2005. In May 2004, HHSC officials announced a proposal, that is expected to be formally approved by state budget officials, to restore maternity coverage to 185 percent of the FPL in FY 2005, allocating \$20.3 million in state General Revenue for that purpose.

In addition, the budget eliminated the medically needy program for adults with dependent children resulting in no coverage in 2005 for a projected monthly average of 9,328 “Medically Needy” adults. The Medically Needy “spend-down” program gives full Medicaid benefits on a month-to-month basis to certain families with large medical bills. Prior to FY2004, Texas’ program included individuals in certain families with dependent children—families which had large medical bills that, when subtracted from earnings, reduced their income to between 22 - 31 percent of the poverty level (\$395 per month for a working parent with two children, or \$275 per month for a non-working parent of two).³ This program cut is projected to reduce Medicaid payments by over \$115 million in FY2004-05.

Table 2: Medicaid Eligibility Changes		
	Eligibility Before Budget Cuts	Eligibility After Budget Cuts
Pregnant Women	185% FPL	158% FPL
Medically Needy Adults	22% - 31% FPL	Eliminated coverage for adults

The budget reduced provider rates for a number of Medicaid and SCHIP providers.⁴ Rate reductions were not as deep as originally proposed because state leaders announced in August 2003 that \$130.5 million in federal fiscal relief funds would be used to reduce the size of the planned cuts by 50 percent for FY 2004. In the end, hospitals and doctors’ rates were cut by 2.5 percent; nursing home provider rates were cut by 1.75 percent and community care providers were cut by 1.1 percent. These cuts apply to fiscal year 2004 only, as no decision was made for the second year of the biennium budget. In total dollars, the rate cuts in Medicaid and SCHIP were projected to save \$739 million (state and federal) over the biennium. In May 2004, HHSC announced that about \$60 million in general revenue would be allocated to avoid making deeper cuts in FY 2005 reducing the projected biennial savings from provider rate cuts to \$599 million.

Texas also froze enrollment in all of the state’s Medicaid Community and Long-Term Care waivers that help elderly and disabled Texans remain in their homes. The budget will reduce through attrition the number of enrollees in the largest of these, the Community Based

³ Prior to the 2003 cut, Texas was the only state with a Medically Needy option that did not include aged and disabled clients.

⁴ Medicaid providers who receive “cost-based” reimbursement (e.g. children’s hospitals, federally qualified health center) were exempted from the cuts.

Alternative Medicaid waiver to a specified cap, reducing the number of persons served by 3,452 (from 2003 enrollment of 33,756, to FY2005 enrollment of 30,304).

Texas began imposing Medicaid termination sanctions on TANF parents and caretakers in September 2003. The direct reduction in Medicaid caseloads from these sanctions is compounded by downward pressure on overall TANF participation related to new TANF sanction policies, and more restrictive TANF asset limits. As a result, the combined average monthly enrollment of TANF parents, parents in transition from TANF (Transitional Medicaid Assistance: TMA), and Section 1931 coverage (parents poor enough for TANF but not receiving cash assistance) in FY 2004 is more than 25,000 below 2003 levels.

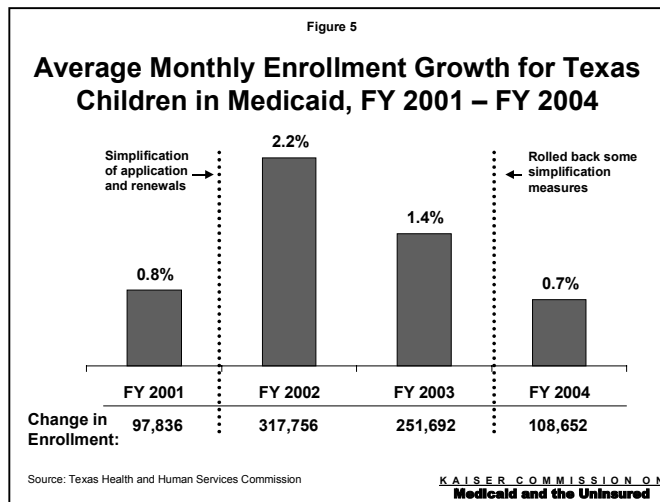
State budget officials chose to eliminate coverage of several optional benefits for adult Medicaid beneficiaries. As of September 1, 2003, services of licensed professional counselors, social workers, psychologists, licensed marriage and family therapists, podiatrists, chiropractors, and eyeglasses or hearing aids are not covered. HHSC has estimated the cuts would reduce spending over the entire biennium by \$42.8 million in general revenue. In addition, Texas assumed \$150 million in savings from the implementation of the following cost containment initiatives related to pharmacy: supplemental rebates, preferred drug list, and prior authorization. The state also reduced the personal needs allowance of Medicaid nursing home residents from \$60 to \$45, saving the state an estimated \$13 million in general revenue.

III. RECENT TRENDS IN MEDICAID AND SCHIP COVERAGE FOR CHILDREN

Recent Medicaid Enrollment Trends

The Texas Medicaid program has experienced robust growth in children's enrollment since 2000; however, recent enrollment numbers show the growth rate has slowed. Children's enrollment began increasing slowly when outreach for Texas SCHIP began in 2000, despite Medicaid eligibility procedures that were considerably more onerous than for SCHIP. In the state Legislature's 2001 session, in response to evidence that children were remaining uninsured due to procedural barriers to Medicaid enrollment, lawmakers adopted a new law aimed at aligning children's Medicaid enrollment and renewal processes with those of SCHIP.

Implementation of the new policies in January 2002 resulted in rapid enrollment growth, with average monthly enrollment growth jumping from 0.8 percent in FY 2001 to 2.2 percent in FY 2002, with new FY 2002 enrollment of 317,756—more than three times the enrollment growth in FY 2001 (Figure 5). Enrollment over FY 2003, while robust, slowed to an average of 1.4% monthly, with overall growth of 251,692. Slowing monthly enrollment growth has continued into the current fiscal year, with the average increase for FY 2004 year to date down to 0.7 percent (over 108,652 additional children), lower than in the period just prior to implementation of simplified application and renewals.



Application and Renewal. Growth in enrollment is slowing, likely due to both natural slowing that occurs as enrollment reaches increasingly higher percentages of those who are eligible, and to the impact of increased procedural complexities in the application and renewal process that took effect in September 2003. For example, the Texas Department of Human Services began running “data broker” checks⁵ on child Medicaid applications and renewals in August. In the case of renewals of child coverage, the information being compared to the data brokers’ at the outset was quite dated, because the program had been using a streamlined renewal process (common among SCHIP programs) in which parents are simply asked to report any changes in status. In cases where information is inconsistent, parents are asked for additional information and/or documents, and a child’s eligibility can be terminated if the parent does not respond quickly enough. The combination of dated information and the new data broker procedures resulted in some renewals being delayed, and in lapses in coverage (later restored) for some children.

In October 2003, DHS began issuing new child Medicaid renewal packets, which require parents to complete the entire 4-page application again, and to provide new income documentation. This change improved the accuracy of the information subject to the data broker checks. However, it also increased the time it takes for parents to complete and return the renewal packet. Renewal packets continued to be mailed in the fourth month of coverage, just as they were prior to initiation of the data broker checks and while the streamlined renewal processes were in place. No additional time was built into the renewal timeline to allow for either slower return by parents, or for the time needed by eligibility caseworkers to perform the data broker check, contact parents, and address any inconsistencies.

The additional work required of both parents and caseworkers had an unanticipated interaction with computer system changes made in 2002 as part of the implementation of legislation to simplify children’s Medicaid processes. In the past, an affirmative action by a caseworker was required to close a Medicaid case. Under an automation change designed to

⁵ DHS uses a variety of third party computer databases to verify financial and other information on applications and renewals for Food Stamps, Medicaid, and TANF benefits. Databases used include credit, residence, driver's license, vehicle ownership, employment, criminal convictions, marriage and divorce, real property ownership, telephone number, and death records.

facilitate the start-up of six-month continuous eligibility⁶ for children, children's Medicaid cases now are assigned an "end date" at the end of the sixth month. Now, unless an affirmative action is taken by a caseworker to renew the coverage, the case automatically closes on that end date, the opposite of the old system. With staffing levels in the state's eligibility system at an all-time low (workers were reduced by about 1,600 from 2001 to 2003), any backlog in processing renewals now entails a risk of improper termination of children's Medicaid. Not surprisingly, several instances of such terminations have occurred in FY 2004. Children in Houston and Dallas experienced lapses in coverage—subsequently restored—as the result of these workload, system, timing, and staffing mismatches. These disruptions of coverage are reflected in program application and renewal data, discussed below. While state officials maintain that the various problems have been identified and solutions put in place, local community based advocates report that full recovery from these mishaps often takes several months.

Early analysis of data after implementation of children's Medicaid simplification policies in 2002 found that approval of initial applications increased from about 58% in the 16 months prior to implementation to 70% in the first 9 months after implementation (January through September of 2002). Renewal rates (for the same periods) increased from 73% to 78%, and cases denied for failure to return requested information dropped from almost 13% to fewer than 2%.⁷ Of course, the most persuasive evidence of the effectiveness of the simplified policies has been the number of children enrolled since implementation in January 2002, growing from 1.1 to 1.7 million children.

Program data from the period since September 2002 suggest that the early improvements described above have eroded over time. The average monthly renewal rate for the period from October 2002 through April 2004⁸ dropped to 64%, and in the first eight months of FY 2004 (i.e., since new policies adopted by of the 78th Legislature have taken effect), the average dropped to 60%. The primary culprit in this reduced renewal rate is the automatic closure of cases, which has accounted for 82% of denials at renewal since the automated closure was launched in June 2002. Essentially, automatic closure has created an automatic record of non-renewals, and to some extent the apparent lower renewal rate may result from the program statistics now more completely capturing the cohort of children's cases that are due for renewal in a given month than was the case for months prior to the June 2002 automation of the end date.

Unfortunately, the automatic closure counts do not distinguish children whose family did not return their renewal packets on time from those who did respond, but who were terminated due to DHS backlogs in processing renewals. Since September 2004 there has been an increase in automatic closures as a percentage of total reviews (that is, of the total number of cases subject to renewal: the sum of denials and approved renewals). From June 2002 through August 2003, automatic closures averaged about 28% of all reviews, but that average crept up to 34% for the period from September 2003 to January 2004, consistent with the time period in which renewal processing backlogs were reported. The rate of automatic closures moderated somewhat in March and April of 2004. Closer examination of the children's cases denied at renewal for

⁶ Before January 2002, children in Texas Medicaid were eligible on a month-to-month basis.

⁷ Op. Cit.: *Simplified Eligibility for Children's Medicaid in Texas: A Status Report at Nine Months*, <http://www.kff.org/medicaid/4092-index.cfm?RenderForPrint=1>

⁸ Latest month for which program data were available. Source data provided in Appendix A.

reasons other than automatic closure reveals that denials for excess income and assets have increased in FY 2004, with income and asset denials more than doubling to almost 5% of all reviews. The most recent months' data also reveal a doubling of denials for missing information and non-compliance.

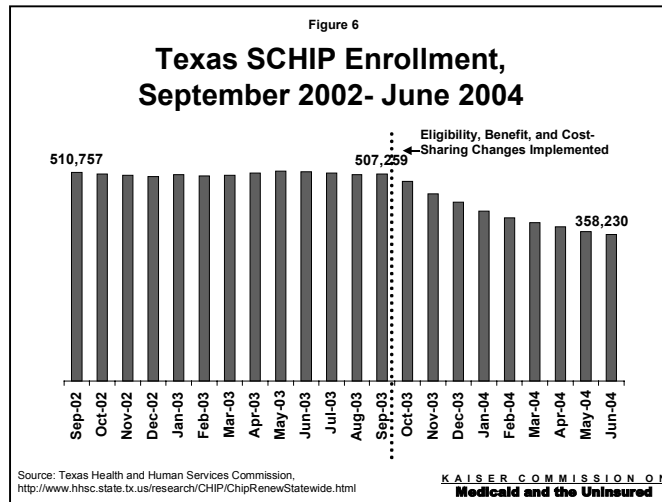
Approval rates for new child Medicaid applications remain high compared to pre-simplification statistics. For the entire period from January 2002 to April 2004, 78% of applications were approved, and the approval rate for the first eight months of fiscal year 2004 was over 79%. Application statistics are not a true measure of initial children's Medicaid enrollment; children whose coverage has been interrupted either due to a parent's not renewing, a DHS renewal processing backlog, or a spell of private or SCHIP coverage also will appear as an "application." As a result, total application numbers spike in months following renewal processing backlogs that have resulted in automatic case closures. Regional application and renewal data illustrate months in FY2004 in which renewal rates dropped sharply, and were followed by months with unusually large numbers of "applications," as children's renewals were eventually processed.

Recent SCHIP Enrollment Trends

SCHIP enrollment has declined steeply and steadily during FY2004 in response to numerous program changes, with June 2004 enrollment down more than 149,000 children (a 29 percent decline) since September 2004 (Figure 6). SCHIP program data are supported by more contemporary data systems than children's Medicaid, and program officials have routinely made web-based state and county-level application and renewal data available since implementation of the program in 2000. As a result, changes in the enrolled population are in some respects better documented than in Medicaid.

Still, the Texas experience with SCHIP disenrollment raises questions that cannot yet be fully answered. This significant drop has occurred despite the fact that the state has maintained a partial moratorium on "mid-term" terminations for non-payment of premiums for much of FY 2004,⁹ and will not impose a new asset limit on higher-income SCHIP children until August 2004. Thus, the decline to date is related to failure to renew, reduced rates of new applications, and to some extent the exclusion of children along the upper income limits of the program due to the elimination of income disregards. Because the state intends to reinstate terminations for premium payment arrears (families of about 130,000 children were mailed arrears notices in June 2004) and to apply the asset limit in August 2004, the downward decline in enrollment could intensify in the months to come.

⁹ According to community-based advocates, many families in arrears in FY 2004 failed to renew, assuming their children's coverage had already been terminated.



Application and Renewal. Agency reports for SCHIP do not currently include total numbers of applications received or the proportions approved and denied. However, routine reports do provide numbers of new enrollees, total children subject to renewal, approved renewals, denied at renewal, failed to renew, and total disenrolled for all reasons. These data make clear what is happening: fewer new children are being enrolled, and more enrolled children are being disenrolled.

The percentage of children due to renew who actually undergo the renewal process has not dropped, nor has the rate of successful renewals. However, because children now renew every six months (rather than 12 months), twice as many children are reviewed each month than was true before fiscal 2004, and thus larger numbers are also denied each month in the process. Non-renewals (those who do not complete the renewal process) as a percentage of children due for renewal have not increased, but their numbers are much larger, also contributing to growing monthly disenrollment totals.

Information about SCHIP applications processed, rates of approval, and reasons for denial are needed in order to begin to assess the reason for declining numbers of new enrollees. One factor leading to the lower average new monthly enrollment in FY2004 was the implementation of a 90-day delay in new coverage taking effect.¹⁰ This resulted in a three month period in which new enrollment was depressed. New enrollment rates have climbed for the last six months, but remain below averages in earlier years (Table 3).

	Average Monthly New Enrollment	Average Monthly Disenrollment
FY 2002	30,486	20,773
FY 2003	25,603	26,313
FY 2004 YTD	18,569	35,045

¹⁰ A number of statutory exceptions to this delay exist.

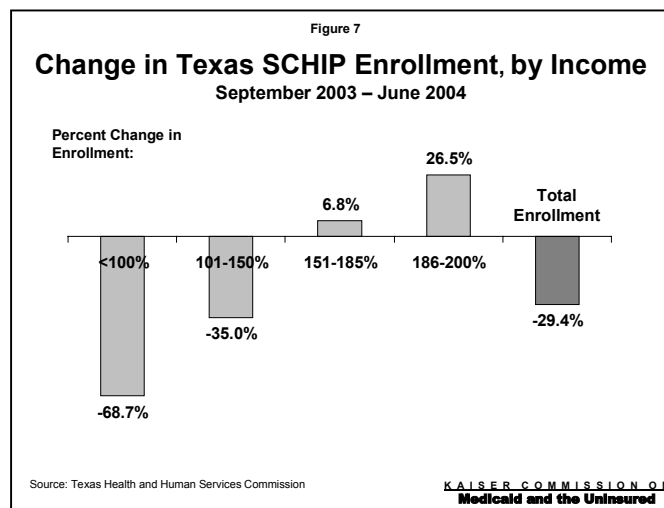
IV. IMPACT OF CHILDREN’S HEALTH CARE PROGRAM CHANGES

Lower Income Groups Disproportionately Affected by SCHIP Policy Changes

Program statistics show that virtually all the net reduction in SCHIP enrollment has been among families below poverty and those between 101-150% of poverty (Table 4 and Figure 7).¹¹ This is of special note, because the only direct change in Texas SCHIP eligibility standards implemented to date affected children just above 200% of poverty. A modest portion of the redistribution of enrollees across income groups is the result of the re-classification of clients into higher income groups due to the elimination of income disregards (about 17,000 children lost coverage because their family incomes were above 200% of poverty without the income disregards). As the table below indicates, the number of below-poverty children has dropped by more than 68%, and the number between 101-150% of poverty has dropped by more than one-third. These numbers point to a need for a better understanding of how cost sharing changes and benefit cuts have affected enrollment and parents’ perceptions of the affordability and ability to secure SCHIP coverage.

	<100%	101%-150%	151%-185%	186%-200%	Enrollment
September 2003	107,211	258,780	112,887	28,381	507,259
June 2004	33,601	168,146	120,568	35,915	358,230
Change in Enrollment	-73,610	-90,634	7,681	7,534	-149,029
Percent Change in Enrollment	-68.7%	-35.0%	6.8%	26.5%	-29.4%

Source: Texas Health and Human Services Commission



¹¹ The Texas Medicaid program has an asset limit of \$2,000 for children and therefore some families with incomes below poverty are denied Medicaid eligibility because of their assets and thus qualify for SCHIP coverage.

Texas contracts with the Institute for Child Health Policy (ICHP) of the University of Florida for evaluation of its SCHIP program, and state officials report that ICHP has been conducting field surveys of SCHIP “disenrollees” throughout the spring of 2004. Texas SCHIP officials had ICHP survey parents in arrears on their premiums early in 2004. While formal results have not been published, state officials have reported some general survey findings, which indicate some of the complexities of the interactions between benefit reductions and cost increases implemented concurrently in FY 2004. Surveyors report that the great majority of parents in the 100-150% poverty income group correctly understood that their cost-sharing obligation had increased from an annual \$15 fee to a monthly \$15 premium. While most parents agreed that their \$15 family premium¹² was a reasonable price for the coverage, an even greater percentage nevertheless said they could not personally afford the new higher premiums. Significant numbers expressed some reluctance to make monthly health care payments, given that their children do not use that care every month. Despite this, many ranked children’s health insurance high among priorities for family spending.

Apart from these preliminary survey findings, community-based advocates add that they have observed that some lower-income parents who used and valued the dental and vision benefits that were cut have dropped coverage. Some have related that by saving \$180 in premiums, they can afford the routine dental care or eyeglasses that their children need, calculating that they are better off saving for a certain expense instead of paying premiums for children who may remain healthy.

The dramatic drop in SCHIP coverage of children below poverty is more perplexing, since this group is not required to make monthly premium payments. New cost-sharing obligations for these families include a \$3 office visit co-payment, and a \$10 co-payment per inpatient hospital admission. An annual cap on co-payments, previously set at \$100, has been increased to 1.25% of family income (\$236 for a family of four; \$156 for a family of 2). SCHIP officials report that renewal rates for this income group have always been lower than for the higher income populations, and that renewal rates for this lowest-income group have dropped in FY 2004. Given that most of these families are not faced with substantial new out-of-pocket costs, their rationales for reduced SCHIP participation are not as easily understood as for the group paying new monthly premiums.

Community-based advocates report that parents have rapidly become aware of the reduced value of SCHIP, and that a generally strong preference for SCHIP in the past has been replaced in recent months with a new appreciation for Medicaid’s more comprehensive coverage. Families on the edge of Medicaid and SCHIP eligibility are reportedly considering whether to work less in order to preserve their children’s Medicaid benefits. If true, this would represent a significant loss for Texas, as one of the great societal benefits of creating a robust SCHIP program was the elimination of disincentives for working poor families to improve their financial situations. Advocates are hopeful that the findings of ICHP disenrollment surveys as well as research by other groups will better equip their organizations to improve SCHIP participation, and better inform lawmakers about unintended and negative consequences of recent SCHIP cuts.

¹² Premium is fixed, regardless of the number of children in the family.

Transitions between SCHIP and Medicaid Can Be Difficult for Families

Transitions from SCHIP to Medicaid, or vice-versa, continue to generate a significant stream of complaints, despite state efforts to improve this area of operations. Naturally, complaints about interruptions in coverage often come from families whose children have special or chronic health care needs, so that a temporary lapse in coverage can create a real barrier to needed care. DHS reports on children's Medicaid-SCHIP interactions show that their Medicaid eligibility system has "deemed" to SCHIP from 21,000-40,000 children leaving Medicaid due to increased family income or assets each month in fiscal 2004.¹³ In the same period, between 1,800 and 5,500 children per month were referred from the SCHIP eligibility contractor to DHS and enrolled in Medicaid.

Problems are reported with transitions in either direction. DHS has maintained that one-third to one-half of children referred to Medicaid monthly by the SCHIP contractor were not actually Medicaid eligible (though it appears that the contractor does not agree). In an attempt to improve these transitions, HHSC co-located a group of DHS eligibility workers at the contractor's SCHIP centralized eligibility center in February 2004. It is not yet clear to what extent this experiment will reduce errors, speed enrollment in Medicaid, and eliminate gaps in coverage. However, some recent complaints are related to the fact that, co-location notwithstanding, the two programs still have separate computer systems, and no means has yet been devised to allow the SCHIP contractor to track and report on the status of applications referred to the in-house Medicaid unit.

Children leaving Medicaid for SCHIP can encounter problems because the latter, using a strictly prospective insurance model, does not offer retroactive coverage of any kind. Under Texas law, DHS must assist a family whose child loses Medicaid eligibility in making a transition to SCHIP without an interruption in coverage.¹⁴ Medicaid eligibility officials say their policy allows them to extend Medicaid coverage for one month if an "agency error" delays prompt enrollment in SCHIP. However, they have never tracked how often this option is used. When processes work properly, a child determined to be ineligible for Medicaid at renewal and "deemed" eligible for SCHIP should be able to enroll in SCHIP without delay. However, some such families have reported that because of problems with DHS data systems, the SCHIP contractor believed that these children were subject to a 90-day delay in coverage. It appears that some disruptions of this kind may be related to problems in the piloting of the new Medicaid data system, and thus may be resolved as a part of the rollout of that system.

Actual combined Medicaid-SCHIP enrollment to date falls in between the higher "pre-cut" projections and the low "post-cut" budget assumptions.

An April 2004 HHSC report summarizing the impact of SCHIP caseload changes has noted that, despite the sharp declines in SCHIP enrollment, the annual monthly average combined children's Medicaid and SCHIP coverage for FY 2004 is anticipated to exceed the annual monthly average for FY 2003 (based on HHSC projections for the four months remaining in FY 2004). This will prove accurate if enrollment in the last months of FY 2004 is consistent with trends of recent months.

¹³ Texas Department of Human Services, TDHS CHIP Status Reports, 9/2003 through 3/2004.

¹⁴ Human Resources Code, § 32.0262(d).

Of course, looking at annual averages in this way obscures the upward trend underway in both children’s Medicaid and SCHIP prior to FY 2004. Total combined child coverage in May 2004 (the most recent month for which both Medicaid and SCHIP data are available) was over 39,000 below the August 2003 level—the last month before the new SCHIP and Medicaid policies of the 78th Legislature took effect. Before policy changes were made, combined children’s Medicaid-SCHIP coverage for FY 2004 and 2005 was projected to be much greater than current caseloads. In February 2003 HHSC projected that combined caseloads for children’s Medicaid and SCHIP would average 2,441,902 for FY 2004, and 2,611,610 in FY 2005.¹⁵ In contrast, the state budget passed in May 2003 assumed combined totals would average 393,000 fewer children in 2004 and 578,000 fewer in 2005 (Table 5). The lower budgeted caseloads have not materialized, because revised policies have slowed but not eliminated growth in children’s Medicaid. As a result, actual combined Medicaid-SCHIP enrollment to date falls in between the higher “pre-cut” projections and the low “post-cut” budget assumptions (e.g., in February 2004, the comparable combined enrollment figure was 2,254,812).

Table 5: Reductions in Children’s Medicaid and SCHIP Enrollment Assumed in 2004-2005 Texas Budget			
	Children’s Medicaid	SCHIP	Total
Prior to Budget HHSC Projections (Feb. 2003)			
2004	1,933,534	508,368	2,441,902
2005	2,095,497	516,113	2,611,610
Projections Based on State Budget Assumptions (May 2003)			
2004	1,668,479	380,603	2,049,082
2005	1,686,811	346,818	2,033,629
Reduction Assumed in State Budget			FY 2004: 392,820 FY 2005: 577,981

Source: Texas Health and Human Services Medicaid recipient-month reports, SCHIP enrollment reports, presentations to 78th Texas Legislature.

¹⁵ Medicaid data in this paragraph (and in most budget-related caseload documents) are stated in terms of “recipient-months”, and are not directly comparable to the “point-in-time” enrollment figures provided in other tables in this report. Because Texas Medicaid provides up to 3 months of retroactive coverage to new enrollees, point-in-time enrollment figures can never reflect the individuals who will apply for Medicaid at a later date, and who receive benefits for medical services provided in months prior to their application. Generally, the number of children’s recipient-months for child-only eligibility categories in Texas Medicaid is about 110% of the point-in-time enrollment of persons under age 19. Because Texas SCHIP offers prospective coverage only, there is no such statistical issue with SCHIP enrollment reports.

V. CONCLUSION

Texas' public health and human services sector has undergone a substantial retraction, with FY 2004-2005 state budget cuts to Medicaid and SCHIP still totaling more than \$1.6 billion for the biennium, even after selected restorations by state leaders. Benefits and eligibility for Medicaid services and SCHIP have been restricted, with SCHIP enrollment dropping by over 149,000 children (a 29 percent drop) in the first ten months of fiscal year 2004. Virtually all of the SCHIP attrition appears to be among children in families with incomes under 150% of poverty. Despite continued slow growth in children's Medicaid enrollment, combined child Medicaid and SCHIP coverage in May 2004 was well below August 2003 enrollment. The cost containment actions outlined in this brief raise potential new procedural and financial barriers for many low-income children in Texas.

The coverage of children under employer-sponsored insurance (ESI) has continued to decline for the last two years according to U.S. Census reports.¹⁶ If combined children's Medicaid and SCHIP numbers remain static (or drop), the percentage of uninsured Texas children will increase, as the number of Texans under age 19 grows by 115-150,000 children and youth each year. As of 2001, the Census was still showing improvements in reducing the proportion of uninsured children in the state.¹⁷ Absent improved rates of ESI coverage, maintaining children's Medicaid and SCHIP growth rates that at least track child population growth will be necessary to prevent a significant increase in the percentage of uninsured Texas children.

¹⁶ U.S. Census Bureau, "Health Insurance Coverage in the United States: 2002," September 2003; Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey," December 2003.

¹⁷ U.S. Census Bureau, "Children With Health Insurance: 2001," August 2003.

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