THE POLICY PAGE
An Update on State and Federal Action

Center for Public Policy Priorities
900 Lydia Street, Austin, Texas, 78702 PH: 512.320.0222 FAX: 512.320-0227 www.cppp.org

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Children's Health Insurance Program Signed Into Law

Will serve uninsured children to 200% of poverty level, including legal immigrant children

In This Issue: On May 28, the Governor signed SB 445, Texas' new law enacting the Children's Health Insurance Program (CHIP). The new program will be available to uninsured children from families up to twice the poverty level, if they are not already eligible for Medicaid. Texas' program will also be available to all legal immigrant children in the CHIP income group. Under separate legislation, children of low-income state employees — excluded under federal law from CHIP — will be eligible for dependent health benefits at a significantly reduced cost. A detailed summary of the new CHIP law and the related state employee coverage is provided below.

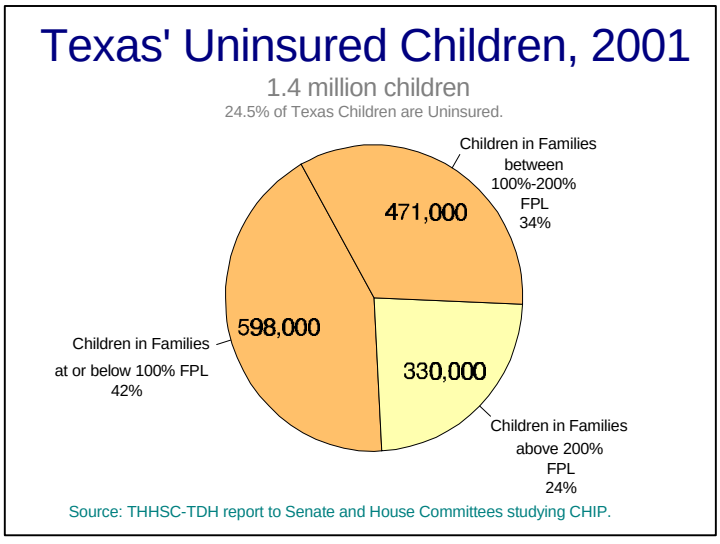
Who is Eligible Texas CHIP will be available to uninsured children from families with net incomes at or below 200% of (twice) the federal poverty income level (FPL) for that family size (see table below). Children who are eligible for Medicaid cannot be enrolled in CHIP. The law specifies that the deductions allowed from gross family income are those used by Medicaid for child care and work-related expenses: $90 per month per worker for work expenses, and for child care a maximum of $200 per month per child under age 2, and $175 per month per child age 2 or older. The law allows the Texas Health and Human Services Commission to adopt a 12-month continuous eligibility policy, so that once a child is enrolled he or she remains eligible for 12 months regardless of any change in family income.

Income Cap for CHIP: 200% of FPL (1999)		
family size	annual	monthly
1	$16,480	$1,373
2	$22,120	$1,843
3	$27,760	$2,313
4	$33,400	$2,783

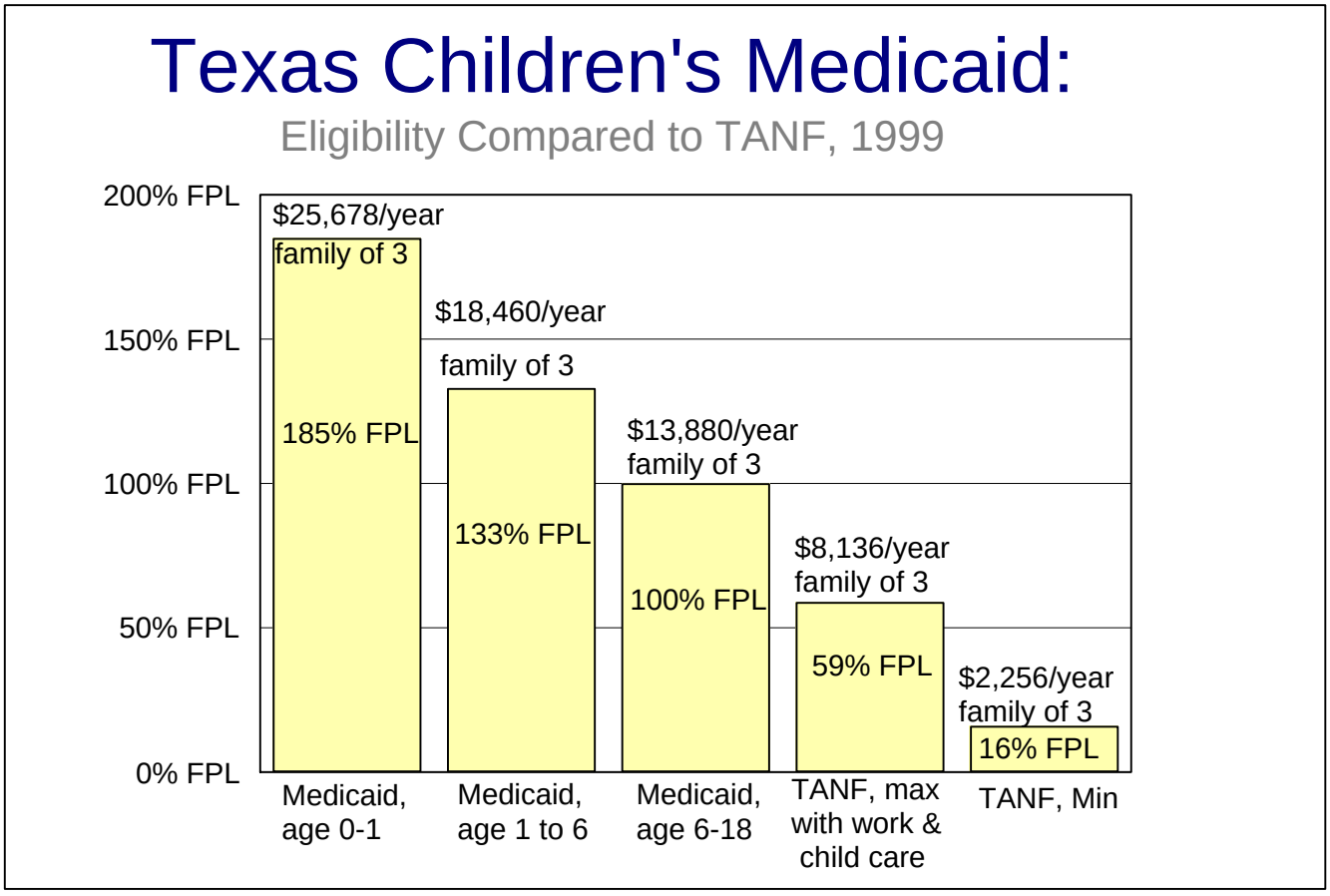
How Many Children Will This Cover? CHIP will target a large portion of Texas' uninsured children, those in families with incomes above the limit allowed for Medicaid, but not exceeding twice the poverty income. Official state estimates put this population in 2001 at roughly 471,000 out of a projected 1.4 million uninsured Texas children (see pie chart). However, the state projects that no more than 65 to 67% of eligible children will enroll in the program. Considering also the time needed for enrollment to build in the new program, the state projects a maximum enrollment of about 281,000 in 2001, growing to 448,000 by 2004.

However, states that are further along in CHIP development have not experienced CHIP enrollment growth as rapid as these projections. California, the only state with more uninsured children than Texas, began distributing applications May 1998 for July 1st coverage, and as of May 1999 had enrolled over 107,000 children. Texas hopes to enjoy a more rapid enrollment response by avoiding some of the pitfalls California and other states have encountered. Still, early enrollment experience in other states should underscore the critical importance of strong outreach and public education if Texas is to achieve enrollment close to the targeted levels.

CHIP/Medicaid Dividing Line Is Irregular The pie chart below illustrates one of Texas' greatest challenges in reducing the number of uninsured children; namely, that the largest number of such children are in families at or below the poverty line. The great majority of these children are currently eligible for Medicaid, but not enrolled in the program. The "dividing line" between CHIP and Medicaid eligibility is actually murkier than the chart would suggest.



One reason is that Texas still looks not only at the income of families, but also their resources (e.g., money in the bank or savings may not exceed $2,000, value of some automobiles may be considered), some small percentage of children below 100% FPL are actually ineligible for Medicaid due to the value of their resources. These children will, however, be eligible for CHIP. Also, Texas Medicaid eligibility still has a stair-step quality, with infants eligible to 185% FPL until their first birthday, and young children covered to 133% FPL until they reach age 6. Thus some uninsured children above the poverty line are actually eligible for Medicaid, rather than CHIP (see chart below).



Medicaid Enrollment Remains Far More Complicated Than CHIP Families just below poverty face considerably greater hassles getting their kids enrolled in Medicaid than will parents just above poverty who can enroll their children in CHIP. The CHIP family will be able to fill out an application to mail in, or even apply by phone or Internet, and once a child is found eligible, there will be no need to reapply for an entire year. Also, CHIP will have no resource or assets tests. In contrast, the Medicaid parent must attend a one to two hour long face-to-face interview with a Texas Department of Human Services eligibility worker, document both income and assets, and return to repeat the entire procedure every 6 months. *Thirty-nine states have already dropped the assets test, and 36 states have dropped the face-to-face interview requirement and accept mail-in applications for children's Medicaid. Texas could drop both of these barriers to children's coverage at any time.* Though technically these could be made at the administrative level, most agree that the Texas Legislature will have to authorize simplification of children's Medicaid eligibility policies, largely due to the state budget impact if participation by children in working poor families is improved.

Screening CHIP Applicants for Medicaid Eligibility Federal CHIP law requires states to review CHIP applications carefully, and ensure that children who are actually eligible for Medicaid are enrolled in Medicaid. (This provision was included to prevent states from diverting kids from Medicaid to CHIP in order to get the more favorable federal match rate.) Federal guidance clearly notes that simply referring these families to Medicaid will not be sufficient to meet the requirements under the law; the children must actually be enrolled in Medicaid.

Texas CHIP law states that families whose children appear to be Medicaid-eligible will be assisted in applying for Medicaid coverage. Though not spelled out in the law, this is likely to mean that the state (or its contractors) will contact the parents, notify them that their income and resources indicate that the child is eligible for Medicaid, provide the parents with information about where they can go for a face-to-face eligibility interview, and tell them just what information and documents they will need to complete that interview. The state hopes to collect enough information in Texas' CHIP application to keep unnecessary referrals to Medicaid to a minimum.

The new Texas CHIP law requires that CHIP applicant children who are denied Medicaid after such a referral must be automatically enrolled in CHIP without any additional paperwork. In addition, the state must track all children who are required to undergo a review for Medicaid eligibility, and report every six months to the legislature how many were enrolled in Medicaid as a result, and how many were neither enrolled in Medicaid or CHIP because the family failed to complete the Medicaid application process. This information should help identify whether the previously-described optional Medicaid eligibility policies are discouraging families from completing the application, and resulting in children remaining uninsured.

"Crowd-Out" Prevention As noted above, a child must be uninsured in order to be eligible for CHIP. Federal law requires states to design their CHIP in a way that will discourage employers and families from dropping existing health coverage in order to enroll in CHIP. Texas' law now requires that a child who applies for CHIP may not be enrolled in CHIP until 90 days after the last day the child was insured under another health plan. However, certain common-sense exceptions are allowed under federal law, and Texas CHIP law now defines a number of such exceptions. First, THHSC can allow children whose health coverage does not provide "adequate" benefits (as defined by the Commission) to enroll in CHIP. This provision could help the families of children with special health care needs, who often can only purchase health insurance that "excludes" (will not pay for) any coverage of the child's chronic condition.
Children who are losing Medicaid due to an increase in family income or reaching an age limit for Medicaid coverage will not be subject to the waiting period. Children enrolled in Texas Healthy Kids Corporation plans will likewise be exempt from a waiting period. Kids who are uninsured due to involuntary losses of health coverage — a parent's job loss due to layoff or business closure, termination of COBRA coverage, divorce — are exempt from the 90-day waiting period as well. A child who is uninsured at the time of application, but whose family terminated his coverage within the last 90 days, may be exempted from the waiting period if the family's out-of-pocket cost for the dropped coverage exceeded 10% of the family's income. Finally, THHSC can authorize good cause exceptions on other grounds at agency discretion. All of the exceptions noted above will also be treated as exceptions to any limited "open enrollment period" policies that may be used for CHIP after the first year of program operation.

Other Application Provisions Texas CHIP law directs THHSC to develop an application form and procedure for CHIP that is coordinated as closely as possible with Medicaid and Texas Healthy Kids Corporation (THKC) procedures, so that a single application could be used to enroll a child in either Medicaid, CHIP, or THKC. The application must be available in languages other than English, and permits the Commission to accept applications via mail, telephone, or Internet. THHSC must ensure that a child's eligibility for CHIP is determined and his family provided information on choice of CHIP health plans no later than 30 days from when the family submits a complete CHIP application (that is, one containing all necessary information) to the program. This requirement will not apply in cases where the child appears to be Medicaid-eligible and must undergo a full Medicaid eligibility interview appointment. *It will be important for child health advocates to monitor how quickly and easily these Medicaid applications are being completed. Conspicuous delays for significant numbers of CHIP applicants could hurt the public perception of CHIP and discourage families from applying.*

Inclusion of Legal Immigrant Children Federal law requires that CHIP coverage be available to legal immigrant children who arrived in the U.S. prior to 8/22/96 (the date the PRWORA was signed) on the same terms as citizen children. Children who arrived after that date are subject to a 5-year bar or freeze-out from CHIP, after which federal law once again requires states to include them. As such, only legal immigrant children who are in the 5-year bar period are excluded from federally-funded CHIP. Under Texas' new law, the state will offer CHIP-style coverage (paid for with state tobacco settlement funds) to legal immigrant children who are in the 5-year bar period from either Medicaid or CHIP. Cost-sharing will be the same for these children as for actual CHIP enrollees, except that children who would be income-eligible for Medicaid if not for their immigration status will have no enrollment fees or premiums. The law also states that if Congress gives states the option to lift the 5-year bar on Medicaid and CHIP, Texas will exercise that option and draw down the usual federal matching funds for these children. (Several bills currently pending in Congress would create that option.) New federal guidance issued May 26th guarantees immigrant families that their children's use of health benefits — like CHIP, Medicaid, and this new Texas program — will not create problems for them when they attempt to get a green card or become a citizen (a *Policy Page* on this guidance is upcoming).

How CHIP Will Be Administered Readers of earlier *Policy Page* discussions of CHIP will recall that a question under negotiation throughout the legislative session was what would be the relative roles of the Texas Health and Human Services Commission (THHSC) and the Texas Healthy Kids Corporation (THKC) in CHIP operations (see *Policy Page* #82). The CHIP bill finally adopted clearly defines the authority of THHSC over all policy decisions, and even states that the Commission may not delegate general CHIP policy oversight to any other entity. THHSC is directed to perform "readiness reviews" of contractors for CHIP administrative functions (e.g., a contractor hired to perform eligibility and enrollment functions), and of CHIP insurance plans themselves. All administrative and health plan contract procurements for CHIP are also subject to competitive procurement processes in compliance with state and federal laws and rules.

THKC Role The bill leaves the possibility of a major role for THKC as an option for THHSC. Like other contractors, THKC would be subject to a mandatory readiness review, and the bill mandates specific criteria for evaluating THKC's capacity: staffing levels at THKC and of their own subcontractors, properly documented policies and procedures, fiscal soundness, compliance with federal and state standards, accommodations for children with special health care needs, partnerships with other children's health programs, information systems, electronic interfaces, and business processes. Insiders expect that THKC's role will be limited to begin with, and will grow over time as the Corporation builds the capacity to take on a project of CHIP's scale.

TDH and TDHS The bill also discusses potential roles of the Texas Department of Health (TDH) and the Texas Department of Human Services (TDHS) in CHIP. These provisions can best be interpreted as functions that THHSC is likely to, but not required to, delegate to the agencies. Duties that THHSC "may" delegate to TDH include procuring and monitoring contracts with health insurance plans, and paying those health plans. TDH may also monitor program outcomes such as hospitalization rates for "ambulatory sensitive" conditions: conditions for which research has shown that sound preventive care can substantially reduce hospitalization. TDHS "may" be delegated certain functions related to the processing of applications, or the day-to-day oversight of a THHSC contract with a third party to perform eligibility and enrollment functions for CHIP.

Benefits Covered The CHIP bill does not include a detailed listing of covered benefits. The law directs THHSC to consider the health care needs of healthy children and children with special health care needs. It states that the covered benefits will provide at least the benefits recommended by the Senate and House Interim Committees in their reports of December 1998. It also defines the benchmark for the value of the CHIP benefit package (a requirement under federal CHIP law) to be the "actuarial equivalent" (i.e., equal to or greater in cash value than) of the state employee's basic HMO plan. Because it is assumed that CHIP will rely on managed care to the greatest degree possible, the law requires that children with chronic, life-threatening or disabling conditions must be allowed to use a specialist as their primary care doctor.

Minimum CHIP Benefits Recommended in Legislative Interim Reports

BENEFIT	CHIP Coverage
Hospital (inpatient)	Unlimited, including physician care. No blood or blood products.
Nursing Facility or Rehabilitation Hospital	60 days per year
Outpatient hospital services	Unlimited.
Physician care	Unlimited, except no infertility, mammography, prostate screens.
Surgery	Unlimited.
Mental Health: Outpatient	60 visits per year, 20 days crisis stabilization/evaluation. Conversion possible on basis of financial equivalence.
Mental Health: Inpatient	45 days annual inpatient; plus 60 days annual rehab day treatment or equivalent for children who meet state-defined criteria. Conversion possible on basis of financial equivalence.
Chemical Dependency	Prevention & intervention services. Inpatient or residential treatment limited to 14 days annual for detox and/or crisis stabilization. 60 days annual limit residential rehabilitation (or equivalent); 60 days annual limit partial hospitalization (or equiv.). Up to 12 weeks *intensive* outpatient rehabilitation; Up to 6 months outpatient rehab limited to 3 episodes per child.
Outpatient Rehabilitation	Unlimited habilitation and rehab (physical, occupational , and speech therapy), also includes developmental therapy.
Home Health	Unlimited, includes private duty nursing, skilled nursing visits, in-home therapies.
Durable Medical Equipment * (DME), Devices, Expendable Supplies, Prosthetic Devices	DME, Devices, & Expendable Supplies: $10,000 annual cap Prostheses: $10,000 annual cap.
Emergency Services and Ambulance	Covered; based on "prudent layperson" criterion.
Vision Care	One eye exam and pair of glasses per year; unlimited glasses or contact lenses if medically necessary.
Transplants	Covered with Medical Director's approval; no donor expense coverage.
Preventive and Therapeutic Dental*	Preventive coverage ONLY, one exam per year. NO therapeutic coverage (e.g., no fillings, etc.) unless part of another medical condition.

Emergency Dental	Limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.
Orthodontia	No cosmetic orthodontia; coverage only for orthodontia related to certain health care conditions.
Hospice	Covered without time limit for terminal illness, services should be designed for children.
Prescription Drugs	May be limited to a formulary, with provisions for additional coverage with medical necessity.
Case Management	Covered, including outreach, informing, care coordination, and intensive case management.
Non-emergency transportation*	Covered if family cannot provide transportation.
Respite	Not covered.
Smoking Cessation	$100 annual limit

Proposed coverage of the benefits marked with an asterisk (*) was modified when THHSC held a public hearing February 4, 1999 to receive comments on a Texas CHIP "State Plan" document to be submitted to federal authorities. At that time THHSC officials announced that they intended to increase the DME and prosthesis annual caps to $20,000, and add an annual therapeutic dental benefit of $300. The non-emergency transportation benefit would not be required, but health plans would be encouraged to offer the benefit in areas where public transportation is not accessible. While the new CHIP law does not mandate THHSC to adopt these February changes, it is likely that the Commission will do so.

Reproductive Care A controversial provision affecting Texas CHIP benefits states that the primary and preventive benefits may not include "reproductive services" other than prenatal care and care related to diseases or abnormalities of the reproductive system. This means that CHIP health plans will not provide family planning benefits, nor will abortion be covered under any circumstance (not even in cases of rape, incest, or to save the life of the mother). It is not 100% clear whether delivery of a baby is covered, since the restriction is limited to "primary and preventive" benefits only; presumably this point will be clarified soon. If delivery is excluded from CHIP, a pregnant teen would have to be transferred temporarily from CHIP to Medicaid to pay for the birth of her child. This would result in additional administrative costs for the state, unnecessary hassle for the teen and her physicians, and a less favorable federal match rate during the period of time she is enrolled in Medicaid.

Requirements for CHIP Health Plans Insurance plans available to CHIP enrollees will be selected by THHSC (or TDH or THKC under THHSC direction) through a competitive procurement process. Though the bill does not specifically direct the state to use managed care plans to provide CHIP coverage, federal law caps on family out-of-pocket spending in CHIP make managed care plans a much more practical choice for CHIP. It is assumed, however, that in certain parts of Texas, it will not be immediately possible to offer HMO coverage, and other models will have to be used. With the exception of state contracts with state-administered "primary care case management" networks (a model used in some Medicaid Managed Care areas), all CHIP health plan providers must be appropriately licensed by the Texas Department of Insurance (TDI). All CHIP health plans will be required to "seek participation of significant traditional providers, as defined by commission rule"; a parallel requirement is currently applied to Medicaid Managed Care plan providers. THHSC may give preference in the procurement process to health plans that contract with Medicaid Managed Care or THKC. Families must be offered a choice of at least two health plans in every metropolitan area, unless THHSC is unable to get 2 bids that meet state minimum standards for CHIP health plans.

Outreach Most parties involved in the CHIP discussion agree that a strong outreach and public education campaign will be critical to the success of the program. At the same time, there is ambivalence among elected officials about strong outreach, because it is assumed that CHIP outreach will also raise the level of awareness about Medicaid among working poor families. In the wake of changing welfare policies, Texas has lost about 230,000 children from the Medicaid rolls in the last 3 years, contributing to the high number of Medicaid-eligible-but-not-enrolled children described earlier. While improving children's participation in Medicaid is an important goal of advocates for children, some state leaders are wary of the price tag for funding the state's share of Medicaid if outreach brings in substantial numbers of additional children. As such, the nature and scope of CHIP outreach efforts is a topic of ongoing special concern.

Texas' new CHIP law directs THHSC to conduct a community outreach and education campaign that will promote enrollment in, and minimize duplication of effort among, all state-administered child health programs (as well as THKC if the Corporation board approves such coordination). The statute requires the outreach campaign to include school-based health clinics, and a toll-free telephone line from which families can get information about children's health coverage options. THHSC is directed both to contract with community-based organizations (CBOs - or coalitions of such groups) to implement the outreach campaign, and to draw on available voluntary efforts to get

the word out. The process for procuring contracts with CBOs must participation by a broad ranger of organizations, particularly those that target population groups with high levels of uninsured children. The precise particulars of how Texas' CHIP outreach campaign will be structured are under development, and CPPP will report on developments as the plans evolve.

Cost-Sharing Federal law limits the amount of family out-of-pocket cost states can build into their CHIP design. For families at or below 150% of FPL, cost-sharing is held to current Medicaid limits, and families from 150-200% FPL may not be required to pay costs in excess of 5% of family annual income. In the Texas CHIP bill, THHSC is directed to use co-payments, enrollment fees, and premium contributions, with higher-income families having higher contribution responsibilities. Cost-sharing by parents of children in CHIP must not exceed caps set under federal law. At this time, it seems likely that THHSC will propose a cost-sharing schedule similar to that proposed in the Senate and House interim committee reports on CHIP. Changes are possible, and may be most likely to affect the premiums in the highest income category. The interim committee reports recommended:

Families 100-150% FPL: $15 annual enrollment fee per family; $2 co-pay for office visits, $5 co-pay for Emergency Room; $1-2$ co-pays for prescriptions; maximum annual cap on co-payments of $100.

Families 150%-185% FPL: $15 monthly premium share per family; $5 co-pay for office visit; $25 Emergency Room co-pay; $5-$10 co-pay for prescriptions. Maximum annual out-of-pocket is 5% of family income.

Families 185%-200% FPL: $18 monthly premium per family; same co-payments and annual cap as 150-185% group.

Public Input. Though advocates had hoped for the statewide CHIP advisory committee included in the House version of CHIP legislation, the final compromise bill opted instead for a number of regional advisory committees. The committees are to provide recommendations on the implementation and operations of CHIP, and must meet at least quarterly. They must be established at least 6 months before CHIP coverage becomes effective, and must include a wide range of participants ranging from parents, child advocates, and CBOs to health insurers and health care providers. These committees may be created by adding additional members to existing Medicaid Managed Care regional advisory committees. At the same time, another new state law creates a statewide Medicaid Managed Care Advisory Committee which includes representatives from the regional Medicaid Managed Care Advisory Committees. Perhaps the new statewide Medicaid Managed Care Advisory Committee will eventually provide a way for the CHIP-related concerns of the regional committees to make their way up to a statewide forum.

Senate and House Committees with jurisdiction over THHSC are directed under Texas CHIP law to monitor implementation of the program, and perform any other oversight activities required by the Lieutenant Governor or Speaker.

Funding Issues The bill specifically provides that CHIP is not an entitlement, and that the Texas program must be re-authorized if either federal matching funds or tobacco settlement funds cease to be available in the future. If state-appropriated funding should ever prove inadequate to sustain additional enrollment, THHSC is directed to freeze enrollment and begin a waiting list for applicants. An explicit process for adding new enrollees as funds became available would be adopted. The bill also stipulates that CHIP will have "first call" on tobacco settlement funds in all future fiscal years, thus protecting the program from any minor fluctuations in that funding stream. Some $1.8 Billion in tobacco funds were allocated in the 2000-2001 budget, of which CHIP was allocated $179.6 million, or just under 10%.

Under federal law, states may not draw federal matching funds for CHIP administrative spending (including outreach) that exceeds 10% of the amount spent on actual health coverage. This is a problem in start-up years, when enrollment (and thus coverage spending) is very small, but the need for spending on start-up systems and outreach is at a high level. Texas' CHIP law requires the state to keep administrative spending under federal caps, but creates an exception for the first 24 months in which CHIP is operational. Because federal law allows states to carry excess administrative costs forward, to be matched in out years when total coverage amounts are much higher, Texas will eventually be able to get federal match for the costs that exceed 10% during those first 24 months.

When Will CHIP Be Available? The Commission is required under the new state law to submit required CHIP State Plan documents to federal authorities by September 1, 1999. Though operation of the program is not mandated until September 1, 2000, THHSC officials have announced that they are hoping to start up by May 2000. The state will attempt to implement as quickly as possible, but procuring health plans statewide and setting up eligibility and enrollment systems will take some time.

Children of State Employees: Federal CHIP law forbids expenditure of federal CHIP funds on children of state employees in any state that has historically funded part or all of the cost of health coverage for state employees' dependents (as distinguished from spouses). This was intended to prevent states from shifting their employee benefit costs onto the federal government. Texas has funded 50% of the cost of health coverage for employees' children, while the U.T and A & M systems funded 80% of that cost. Under SB 1351 by Barrientos (House sponsor Greenberg), state employees with

families at or below 200% FPL will be able to apply for a higher (80%) state subsidy of the children's coverage. State employees' children who are eligible for Medicaid would not be eligible for the enhanced state contribution, and would have to apply for Medicaid in order to access more affordable children's coverage. The new state contribution would not be available until FY 2001 (i.e., September 2000), while the CHIP timetable projects start-up no sooner than May 2000.

On the Horizon: What to Watch State employees and state contractors will be working hard over the next 12 months to build the new CHIP structure. State agency officials indicate a willingness to solicit input from the CHIP Coalition and other interested parties as they develop the program. Listed below are some key issues which CPPP and other advocates will be monitoring in the months to come. Readers are encouraged to be active in local CHIP Coalitions and CHIP Regional Advisory Committees, and to track evolving Texas CHIP policy via those groups, CPPP publications and web site, and the Texas CHIP Coalition web site (http://www.main.org/txCHIP).

How "family-friendly" will the CHIP application and enrollment processes be? Will a majority of families be able to complete the application without help from community groups? Will the requirements to verify family income be easy for families to fulfill?

What percentage of CHIP applicants will have to complete a Medicaid application process? Children who appear to be within Medicaid income and resource limits must complete a Medicaid application. Will families get the help they need to complete the Medicaid application process? How quickly will they learn whether their children will be enrolled in Medicaid or CHIP? Will the requirement for long, on-site eligibility interviews every 6 months discourage families from enrolling in or staying enrolled in Medicaid?

What kind of public education and outreach campaign will the state build? Will funds appropriated be adequate to get the word out? Will ethnic communities find messages and materials designed to meet their needs?

How well will state contractors who are hired to review CHIP applications and help families to enroll in a health plan perform? Will families be able to get children enrolled in health plans promptly, or will application backlogs occur?

How successful will the program be in reaching out to families with mixed immigration statuses? Citizen children of undocumented parents have the same eligibility for CHIP as any other citizen child. Will application processes and outreach materials be designed to calm undocumented parents' fears of deportation and of barriers to gaining legal status? Will they address legal immigrant's fears about immigration and naturalization hassles? Will income verification policies be flexible enough for the parent whose employer will not document his job, who gets paid only in cash, or whose income varies significantly from month to month?

Will cost-sharing practices be designed to prevent interruptions in coverage? The state will have to develop policies for families over 150% FPL who fall behind in premiums. Other states are using or developing grace periods, warning notices, emergency funds for covering arrears, etc. Also important will be finding ways to help families track their out of pocket costs, to ensure that they do not exceed the caps on those costs.
