

Chapter 5. Background on Medicaid and SCHIP in Texas

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In Texas, two programs that are jointly funded by the federal and state governments provide public health insurance for the state's low-income populations. Medicaid provides coverage to specific low-income populations of all ages, while the State Children's Health Insurance Program (SCHIP) provides public health insurance to children 18 years of age and below with family incomes under 200 percent of the Federal Poverty Level (FPL) who do not qualify for the Texas Medicaid program. This chapter serves as an introduction to both of these programs. The first section concentrates on the Texas Medicaid program, followed by a second section that focuses on SCHIP in Texas.

Medicaid

The History of Medicaid in Texas

Medicaid is a jointly administered state and federal entitlement program that provides health insurance for eligible low-income children, pregnant women, disabled individuals, and elderly individuals. The program, which was part of President Lyndon B. Johnson's Great Society agenda, was established by Congress under Title XIX of the Social Security Act of 1965. Every state offers Medicaid benefits, but variations exist among each state's Medicaid programs. Texas began offering Medicaid in September 1967.

Medicaid has evolved from programs narrowly targeted to people eligible for federal/state programs providing matches for cash assistance, known at that time as Aid to Families with Dependent Children (AFDC) and Aid to the Aged, Blind, and Disabled (AABD), into a much larger and more complex program. In 1972, federal law established the Supplemental Security Income (SSI) program. This program provides cash assistance to elderly and disabled poor. Health care coverage to this population was mandatory for states with established Medicaid programs.¹

Several federal mandates enacted in the 1980s required certain individuals not receiving assistance from AFDC or SSI to be eligible for Medicaid and increased the scope of the services offered by Medicaid. These expansions covered uninsured low-income pregnant women and their newborn infants, children in low-income families not receiving cash assistance, and low-income disabled poor and elderly individuals with more comprehensive health care coverage. These mandates also opened a wide range of services to children on Medicaid. As a result, both the number of individuals eligible and the costs for the Medicaid program expanded greatly.

In 1996, major welfare reform legislation was passed at the federal level. The AFDC program was eliminated, and a new program called Temporary Assistance to Needy Families (TANF) was created. At this point, Medicaid and welfare became delinked. This means that those eligible for Medicaid no longer have to be eligible for or receiving

cash assistance to receive Medicaid services, although those who are receiving TANF in Texas are automatically eligible for Medicaid (according to federal law). In Texas, the changes to the welfare system decreased the number of individuals and families who qualified for cash assistance. As an unintended result, the number of individuals in the Medicaid program decreased, because many eligible recipients were not fully aware that they could still receive Medicaid benefits even if they were not participating in the TANF program.

Another reason for the decrease in the number of Medicaid enrollees can possibly be attributed to the changes that welfare reform had upon immigrant populations. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the federal welfare reform act of 1996, gave states the option to decide whether or not to continue providing Medicaid to most legal immigrants. However, most immigrants entering the United States after August 22, 1996, would be subject to a five-year “bar” period, during which no federal Medicaid funds could be accessed for their care. Every state but Wyoming decided to continue treating so-called “qualified aliens” who were in the United States prior to August 22, 1996, the same as U.S. citizens for purposes of Medicaid eligibility. States can make a separate decision regarding post-1996 legal immigrants, and the 77th Texas Legislature is considering a bill that would activate coverage for this group when the first affected immigrants complete their five-year bar and become eligible in September 2001.

As originally drafted, PWORA would have revoked SSI coverage of legal immigrants (legal residents who are not citizens) who were in the United States before the bill was signed; the Balanced Budget Act (BBA) of 1997 restored SSI benefits, however, for legal immigrants who arrived in the United States prior to August 22, 1996. Those arriving after this date are still banned from the SSI program, and because Texas limits Medicaid coverage of the elderly and disabled largely to SSI beneficiaries, post-1996 entrants qualifying for Medicaid will be fewer in number. In July 1996, about 101,000 out of 2 million Texas Medicaid enrollees were recorded as legal immigrants, and 60 percent of these were SSI beneficiaries (later analysis by the Texas Department of Human Services revealed that many of these enrollees had in fact become U.S. citizens, so the actual number of legal immigrants was somewhat lower). These policy changes especially affect Texas with its large Hispanic population. The primary immigration-related impact on Texas Medicaid enrollment resulted not from actual changes in eligibility, but from fear and uncertainty among mixed-immigration status families about the impact that a family member’s use might have on another family member’s ability to get a green card or eventually naturalize. Federal guidance issued by the Immigration and Naturalization Service (INS) in May 1999 clarified that Medicaid use by an immigrant or his family member would not, except in rare cases, affect immigration status, but some immigration lawyers and immigrants remain reluctant to access Medicaid, even for U.S. citizen children of non-citizen parents.²

Medicaid Eligibility

Individuals now do not have to qualify for cash assistance to qualify for Medicaid. Specific income levels based on a family's or individual's income define who is eligible for Medicaid in many cases. An assets test is also used in Texas. To qualify for Medicaid in Texas, adults must have a "countable" income of less than 34 percent of the FPL. The income eligibility level is based on a three-person family with only one wage earner. It is also assumed that the family's only source of income is from earnings. The income level takes into account Texas' treatment of earnings, but not other income deductions such as child care expenses.³

Pregnant women who earn less than 185 percent of the FPL qualify for Medicaid. This coverage lapses two months after the birth and only covers services related to the pregnancy and birth. Low-income elderly and disabled Texans also are eligible for Medicaid; they must be at or below the required income level to qualify for SSI or the low-income nursing home benefit. To qualify for SSI, an individual must have an income of less than 74 percent of the FPL; to qualify for the nursing home benefit, the individual's income cannot exceed 223 percent of the FPL.⁴ Texas also offers a frail elderly program that is available to those with incomes up to three times the SSI level, which offers home care. Texas is the only state to have a home-care waiver with Medicaid funding. There are also programs that provide partial Medicaid coverage available to the elderly and the disabled with Medicare coverage.

Medicaid eligibility for children is a bit more complicated. In Texas, Medicaid covers infants less than one year old, if they are living in families who earn less than 185 percent of the FPL. Children age one until their sixth birthday are eligible for Medicaid in Texas if their family income is at or below 133 percent of the FPL. Children from age six through 18 are eligible for coverage if they are living in families with incomes that are 100 percent of the FPL or less. Finally, if families make 200 percent of the FPL or less and do not qualify for Medicaid because of their income or assets, they are eligible for the SCHIP program in Texas.⁵

In Texas, as mentioned, those eligible for Medicaid must also have limited assets to be eligible for Medicaid. Individuals and families who qualify for Medicaid are allowed to have up to \$2,000. In addition, families are permitted to have other limited assets, such as a house and limited equity in a car. Table 5.1 lists the federal Medicaid population guidelines in relation to Texas.

Table 5.1. Federal Medicaid Population Guidelines in Relation to Texas

Federally Mandated Medicaid Eligible Populations	Optional Medicaid Eligible Populations served in Texas	Optional Medicaid Eligible Populations NOT served in Texas and Populations covered by 1115 waivers in other states
Section 1931 Recipients	TANF Recipients ¹	Childless adults (1115 waiver) Parents of children over 34% of the Federal Poverty Level not receiving TANF
SSI Recipients	Pregnant women with family incomes less than 185% of the FPL ²	Elderly not receiving SSI but below 100% of the Federal Poverty Level
Children under 1 year old with family incomes at or below 185% of the FPL; children 1 to 6 years old with family incomes at or below 133% of the FPL; and all other children under 19 years old with family incomes less than 100% of the FPL	Medically needy: 133 1/3% of the 1996 AFDC level; this means in Texas, this benefit covers those who spend-down to 24% of the FPL ³	Breast and Cervical Cancer Patients through The Breast and Cervical Cancer Treatment Act of 2000
		Beneficiary groups of Ticket to Work and Work Incentives Improvement of 1999
		Medically Needy for the Aged and the Disabled ³

Adapted from: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, Third Edition* (Austin, Texas: Texas Health and Human Services Commission, February, 1999), pp. 49-50; Families USA Foundation, *Expanding Medicaid State Options: Could Your State Do More?* (Washington, D.C.: Families USA, 1999), pp. 4-5.

¹ In Texas, individuals receiving TANF are automatically eligible for Medicaid. Federal law requires six months of Transitional Medicaid for those leaving 1931 eligibility due to increased earnings, Texas currently provides 12 months under terms of its AFDC waiver, which expires in 2002.

² Covering pregnant women up to 133 percent of the FPL is mandatory.

³ See chapter 8 of this book, section entitled “A Federal Problem with Medicaid for the Elderly and the Disabled.”

The Number of Texans Covered by Medicaid

The size of the Texas Medicaid population may be expressed in two ways, the monthly average count and the unduplicated count. In 2000, the average monthly count was approximately 1,767,800 Texans.⁶ Of those covered by Medicaid, 60 percent were under age 20, 30 percent were adults, and 10 percent were aged 65 or over; 23 percent were SSI recipients. This number reflects the total number of Medicaid recipients, some of whom may have enrolled, unenrolled, and then reenrolled for services within the same year due to changes in their incomes.⁷

While there is a large Medicaid population in Texas, almost one of every eight Texans is enrolled at some point during the year. Although Medicaid rolls declined significantly from 1996 to 1999, they stabilized in 1999 and began to increase in 2000. Approximately 1.77 million people were enrolled in 2000, compared to the high of 2.1 million in 1996. This reduction is attributed to confusion concerning federal and state welfare reforms.⁸ It is important to note that approximately 50 percent of the Medicaid-eligible population in Texas is not enrolled in the program and Texas has the second largest uninsured rate in the nation.⁹

The Administration of Medicaid in Texas

The Texas Health and Human Services Commission (HHSC) is the single state agency administering Medicaid from the perspective of the federal government. However, the Texas Department of Human Services, Texas Department of Health, Texas Department of Mental Health and Mental Retardation, and the Texas Department of Protective and Regulatory Services all provide key administrative services to specific populations. Other state agencies that receive Medicaid funding include the Texas Commission for the Blind, Interagency Council on Childhood Intervention, Texas School for the Blind, Texas School for the Deaf, Texas Rehabilitation Commission., and the Texas Commission on Alcohol and Drug Abuse. The Texas Attorney General's Medicaid Fraud and Control Unit is responsible for fraud investigation and enforcement activities. In addition, the federal government provides oversight through the Health Care Financing Administration of the U.S. Department of Health and Human Services.¹⁰

The Cost of Medicaid

The states and the federal government jointly fund the Medicaid program. In 2001, Texas is receiving a 60.6 percent federal match for each state dollar spent providing Medicaid services. States are allowed to use funding from a variety of sources, including local government funding, provider taxes and fees, and general revenues. In 2000, the Texas Medicaid program cost approximately \$11.3 billion.¹¹

Services Covered by Medicaid in Texas

Federal law requires that states cover specific services within their Medicaid programs. Listed in the first column of Table 5.2 are the federally mandated Medicaid services. These services are available to Medicaid recipients if the service is medically necessary. Texas also chooses to cover some services that the federal government has deemed as optional to state Medicaid programs (see Table 5.2, second column). States are allowed to implement optional services so long as they are adequate in amount, duration, and scope (all optional services are required to be provided to individuals under age 21 if the service is medically necessary). States are not allowed to limit the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, types of illness, or condition."¹² For example, a state would not be allowed to exclude AIDS patients from the Medicaid prescription drug benefit. States are also required to offer the same Medicaid services throughout the state. There are some optional Medicaid services

that are not offered in Texas (see Table 5.2, third column). There currently is no copayment required to receive Medicaid benefits in Texas.

Table 5.2. Federal Medicaid Service Guidelines in Relation to Texas

Federally Mandated Medicaid Services	Optional Medicaid Services offered in Texas	Optional Medicaid Services NOT offered in Texas for adults
Early Periodic Screening, Diagnosis and Treatment for minors (EPSDT)	Limited Birthing Center	Christian Science Nurses
Ambulance	Case Management for certain Groups	Clinic Services (except for maternity and family planning)
Family Planning	Certified Registered Nurse Anesthetists	Routine Dental Care
Federally Qualified Health Centers	Chiropractic (limited)	Dentures
Home Health Care	Christian Science Sanitarium	Diagnostics, Screening, Preventive, and Rehabilitative Services
Inpatient and Outpatient Hospital	Day Activity and Health Service	Durable Medical Equipment such as Wheelchairs, Walkers and Crutches except when provided by a Medicaid Home Health Agency
Renal Dialysis	Emergency Medical	Institutions for Mental Disease, Persons over 65
Lab and X-ray services	Licensed Professional Counselor	Occupational, Hearing, or Speech Therapy
Medical Transportation (non-emergency) to Medicaid-Covered Health Care Services	Licensed Master of Social Work/Advanced Clinical Practitioner	Diagnostic services: Assessment of Persons with Mental Retardation
Nursing Facility Care	Hearing Instruments and other related Audiology	
Rural Health Clinics	Hospice Care	
Services of Certified Midwives, Family and Pediatric Nurse Practitioners	Intermediate Care Facilities for people with Mental Retardation/Developmental Disabilities	
Physicians	Maternity Care Clinic (limited)	
ICF-MR Dental	Medically necessary Surgery and Dentistry	
Dentists (when providing physician services)	Optometry and Eyeglasses	
Certified Family Practitioner	Personal Care Services in the Home	
	Physical Therapy	
	Podiatry	
	Prescription Drugs	

Adapted from: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, Third Edition* (Austin, Texas: Texas Health and Human Services Commission, February 1999), pp. 70-71.

The State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) was created by Congress as part of the Balanced Budget Act of 1997 and enacted as Title XXI of the Social Security Act. The purpose of SCHIP is to insure children in low-income working families whose incomes are too high to qualify for Medicaid but too low to be able to afford private health insurance. As of July 1, 2000, 50 states, the District of Columbia, and five U.S. territories have implemented SCHIP.¹³ According to the most recent data available, 3.3 million children have been enrolled in SCHIP nationally.¹⁴ The following section offers a brief history of the implementation of the SCHIP program in Texas, followed by specific information pertaining to the state SCHIP program, including type of plan and benefits, eligibility requirements, application process, cost sharing and copayments, the reenrollment process, financing, and outreach efforts.

The History of SCHIP in Texas

In the state of Texas the SCHIP program has been given the name TexCare Partnership to represent the partnership between the federal and state governments and the private sector. As mentioned, the BBA established the SCHIP program in 1997; however, it took the State of Texas three years to fully implement the TexCare Partnership program.

The Texas SCHIP program was developed in two phases. Phase I began on July 1, 1998, and expanded Medicaid to children ages 15 to 18 in families with incomes below 100 percent of FPL. Texas used SCHIP funds to implement this expansion, which was federally mandated by 2001. Then, in 1999, the Texas Legislature passed Senate Bill 445, which created Phase II of the Texas Children's Health Insurance Program. The bill assigned the statutory authority to oversee SCHIP in Texas to the Health and Human Services Commission. Birch & Davis was selected to be the SCHIP program administrator. The state also contracted with several other private sector entities, including Sherry Mathews Advertising and Public Relations as the media services contractor, and approximately 50 community-based organizations as community-based outreach contractors.

Enrollment in Texas began on April 3, 2000, and SCHIP coverage began May 1, 2000. As of March 5, 2001, the state had enrolled an estimated 273,525 children in the SCHIP program.¹⁵ Within the first seven months, the State of Texas enrolled an estimated 44.74 percent of its eligible population; the next best state, Arizona, enrolled 23.75 percent of its population during the first seven months of its program.¹⁶ The State of Texas has a goal of 428,000 children enrolled by the fall of 2001.¹⁷

The Texas SCHIP Plan

As an incentive to get states to participate in the SCHIP program, they are given some flexibility in the type of program they choose to make available to low-income uninsured children. Specifically, states have three options available for expanding coverage to uninsured low-income children: expand Medicaid, create a new separate child health program, or create a program that both expands Medicaid and designs a new and separate

child health insurance program. Given these three options, 23 states have expanded Medicaid, 15 states have created a separate child health program, and 18 states have chosen to create a combination of the two. In addition, many states have chosen to amend their state plans so that they can expand the numbers of children eligible for the program.¹⁸ Texas technically has implemented a combination plan because it both expanded Medicaid and created the separate TexCare Partnership program.

Phase I: Medicaid Expansion

As mentioned, Phase I of the Texas plan expanded Medicaid to children ages 15-18 below 100 percent of poverty. As noted, however, this expansion was federally mandated, and Texas only took advantage of SCHIP funds to accelerate the implementation of this mandate. States that chose to expand Medicaid had the advantage of being able to build upon the current infrastructure of the Medicaid programs they already had in place. By expanding Medicaid, eligible children would still be eligible for coverage if the economy were to take a downturn. Under this option, however, states would be expanding an entitlement program and be required to follow the regulations of the Medicaid program, including offering the full Medicaid benefits package, which, given that enrollment can be hard to control, could be costly if the program were to grow. Additionally, for some states this would mean expanding a system and set of rules with which they disagree.

Phase II: A New Separate Program

Phase II created a new and separate SCHIP Program. It serves both healthy children and those with chronic health conditions. Covered services include doctor visits, hospitalization, and prescription medication. The program also provides some vision, dental, and hearing services, as well as a full range of behavioral health, durable medical equipment, habilitative and rehabilitative services, and speech, physical, and occupational therapies. Once enrolled, children receive 12 months of continuous coverage, unlike state Medicaid, which in Texas has a six-month renewal policy.

In Texas, urban areas are typically served by HMOs while rural areas are served by exclusive provider organizations. All states that chose to offer a separate SCHIP program had several options. They could offer a benchmark plan equivalent to the standard Blue Cross/Blue Shield Preferred Provider Option offered under the federal employees benefit program, a health benefit plan offered by the state to its employees, or the HMO benefit plan with the largest commercial enrollment in the state.

Many states, like Texas, chose to design their own programs because this option had the advantage of allowing them to develop new systems, which they believed would better suit their needs. For example, such states could have the ability to create programs with more limited benefits packages than Medicaid expansion would require them to offer. They also could charge program participants a premium, although the amount of such cost-sharing would be limited. In addition, the stigma that many associate with Medicaid would be ameliorated. These states, however, are also likely to face costly and time-consuming operational problems in implementing their new programs. Furthermore,

states that create new programs must conduct an evaluation of the quality of care they are providing to children enrolled in them, which again is costly and time-consuming.

SCHIP Eligibility

Eligibility for the Texas SCHIP program is based on several factors, including net income, the age of the applicant, citizenship or residency requirements, and period of uninsurance. In particular, the Texas SCHIP program targets children in families who earn more than the poverty threshold but less than 200 percent of poverty, or families whose net incomes are between \$17,650 (the year 2001 federal poverty threshold for a family of four) and \$35,300.¹⁹ Net income is defined as pretax gross income minus deductions for child support, child care, disabled adult care, alimony, and work-related expenses. For the purposes of defining a family’s size, which contributes to the measure of qualified net income, the household is defined as all children who live in the home, including biological, adopted, and stepchildren, as well as all parents who live in the family’s home, including biological, adopted, and stepparents.

In addition to income, age is another factor used to determine whether children are qualified to receive public health insurance and what type of insurance they are eligible to receive, SCHIP or Medicaid. Table 5.3 presents the type of public health insurance coverage for which children are eligible according to the family’s income threshold and the age of the child. Families with more than one child may have children enrolled in different programs.

Table 5.3. Children’s Public Health Insurance Status According to Income and Age

Age	0-100% FPL	100-133% FPL	134-150% FPL	151-185% FPL	186-200% FPL
<1	Medicaid	Medicaid	Medicaid	Medicaid	SCHIP
1-5	Medicaid	Medicaid	SCHIP	SCHIP	SCHIP
6-18	Medicaid	SCHIP	SCHIP	SCHIP	SCHIP

Adapted from: Anne Dunkelberg, and Cathy Schechter, *Every Child Equal: What Texas Parents Want from Children’s Medicaid*, Center for Public Policy Priorities, Austin, Texas, September 2000, p. 14.

In Texas, legal immigrants as well as citizens are eligible for SCHIP. In order to apply for SCHIP, parents do not have to provide a social security number for their citizen children, nor must they provide proof of citizenship; instead, they only need to make a declaration of U.S. citizenship. Parents of legal residents must provide the immigration status of their child, which may be verified through INS documentation, I94 card, passport, or alien resident card. Eligibility is based on the child’s, not the parent’s, INS status, and therefore parents do not have to provide this information for any other family member.²⁰ In addition, a child enrolled in Medicaid or SCHIP is not considered to be a public charge, and thus enrollment will not negatively affect a family’s application for

citizenship. It is important to note that federal money cannot be used to provide health care coverage to immigrants who arrived after August 22, 1996, regardless of whether they are here legally, unless the legal immigrant has been in the country for at least five years. Therefore, states like Texas who have chosen to provide health insurance to legal immigrant children must finance the entire cost of providing this service with state dollars.

Yet another condition of children's eligibility in the state of Texas is the requirement that children be uninsured for at least 90 days before they can be enrolled in SCHIP. There are several "good cause" exceptions to this waiting period, which, in Texas, include termination of parent's employment, loss of Medicaid coverage, change in parent's marital status, the end of COBRA coverage, coverage through Texas Healthy Kids Corp, kids currently covered by a SCHIP program in another state or covered by the Texas Laredo Pilot Project, and, finally, whether the cost of children's health insurance coverage is more than 10 percent of the family's SCHIP net income. In order to deter crowdout, federal regulations stipulate that children must have been without insurance for six months before they can be enrolled in the SCHIP program. States were allowed to formulate exceptions to this six-month requirement of uninsurance, however, which, as indicated, Texas has done.

The Texas SCHIP Application Process

The Texas SCHIP application is short, easy to read, and offered in both English and Spanish. The application is a total of two pages, which families tear out and put into a postage-paid return envelope. There are approximately 50 community-based organizations, as well as numerous volunteers, across the state that help families obtain and complete the application. Additionally, there is a call center that is staffed to answer parents' questions and assist them in beginning the application process over the phone. The call center is operational past regular business hours and for a few hours on Saturday. There is also an AT&T language service for both the CBOs and call center employees if a translator is needed to communicate with families that speak another language. The application itself has been refined to include more information, clarify documents needed, and assure families that the information is completely private and will not be shared with the INS or IRS. Parents applying for SCHIP need only mail in proof of their income and there is no assets test for SCHIP. Sometimes, depending on their income, however, families may be asked assets questions to determine if they are Medicaid-eligible.

Federal regulations require that states screen SCHIP applicants for Medicaid. If children do in fact qualify for Medicaid, states must then enroll them in Medicaid rather than SCHIP. The applications of children who may qualify for Medicaid are automatically sent to DHS for review. However, if DHS determines children are not qualified for Medicaid, they are deemed eligible for SCHIP and the application is sent back to Birch & Davis for immediate enrollment into SCHIP. Unfortunately, the application process for Medicaid is much more cumbersome than that for SCHIP. For example, to become eligible for Medicaid, families must participate in a face-to-face interview, fill out up to

14 forms and provide up to 20 verifications, pass an assets test, reapply every six months, and report any change in income within ten days. Furthermore, transferring children from Medicaid to SCHIP, or vice versa, can cause confusion and frustration for parents. A large number of children have thus been lost during this process, which has led to lapses in coverage. In fact, as of March 2, 2001, out of the 100,733 children referred to DHS by CHIP, only about 24,985, or 25 percent, have been enrolled in Medicaid.²¹

Cost-Sharing and Copayments

Once children are enrolled in the SCHIP program, parents contribute to the costs of coverage on a sliding scale based on income. Families with incomes between 100 and 150 percent of FPL pay a \$15 annual enrollment fee, but no monthly premiums. Families between 150 and 185 percent FPL pay a \$15 monthly premium, but no enrollment fee. The remainder of families, those between 185 percent and 200 percent of FPL, pay an \$18 monthly premium and no enrollment fee. Total cost-sharing for families above 150 percent of FPL cannot exceed 5 percent of their annual gross income.²²

Families are also required to pay copayments, which again are based on a sliding scale. The copayments are paid to the provider or pharmacist at the time of service, and families do not pay any copayments for well-child or well-baby visits or immunizations. Additionally, families whose income is below 150 FPL may not pay more than \$100 in copays annually. Costs to families range from \$2 to \$10 for office visits, \$5 to \$35 for emergency room visits, and \$1 to \$10 for prescriptions (see Table 5.4).²³

Table 5.4. Texas SCHIP Copayments

Federal Poverty Levels	Office Visits	Cost per Emergency Room Visit	Prescriptions	Annual Reporting Caps
100-150 % FPL	\$2	\$5	\$1 for prescriptions valued over \$15	An annual self declared co-payment cap of \$90 per family
151-185 % FPL	\$5	\$25	\$10 brand name	4.5 % cap of gross income during a calendar year
186-200 % FPL	\$10	\$35	\$10 brand name	4.5 % cap of gross income during a calendar year

Adapted from: TexCare Partnership, *CHIP Copayment Levels*. Online. Available: <http://www.texcarepartnership.com/CHIP-CHIP-Copay-Page.htm>. Accessed: February 28, 2001.

Reenrollment Process

Soon, children in Texas who have been enrolled in the SCHIP program since its inception will be faced with having to reenroll in the program. The re-enrollment process has been designed to be a simple process. The annual reenrollment process starts at the beginning of the tenth month before a family reaches its year anniversary of coverage. Each family is sent a printout of its original application, which they are asked to review. If any of the

information has changed in the course of the year, they are asked to provide the new information on the form. If their information has remained the same they are asked to sign the form and return it. If the reenrollment form is not received by the end of twelfth month, the child will be disenrolled from the program.

Financing SCHIP

SCHIP is a partnership between the federal and state governments. Congress allotted a total of \$48 billion to be spent over a 10-year period, and each state receives a proportion of that total allotment based upon the number of its uninsured and low-income children.²⁴ SCHIP law requires states that do not use their SCHIP allotments within three years to return their unused funds to the federal government so that the funds can be redistributed to those states who have used all of their allotments.

For example, states had three years, beginning October 1, 1997, and ending September 30, 2000, to spend the first installment, the FY 1998 allotment, which amounted to a total of \$4.2 billion nationally and \$561.3 million in Texas.^{25,26} However, only 10 states spent their entire allotment and Texas was not one of them. In fact, Texas did not spend \$471.6 million of its FY 1998 allotment.²⁷ As a result, Congress fully reimbursed those states that had spent all of their funds and then put the remainder of the funds into one account from which they proportionately redistributed the SCHIP funds to states who were not able to spend their funds. States now have until FY 2002 to spend these allotments. Under this new arrangement, Texas received \$295.5 million and forfeited \$176.1 million.²⁸ In addition, states can use up to 10 percent of what they retained for outreach activities, which means that Texas can use \$29.5 million to continue to expand its current outreach efforts.²⁹

Outreach

Many states have launched aggressive statewide campaigns aimed at enrolling uninsured low-income children in SCHIP. States can spend up to 10 percent of their SCHIP allotment on program administration, direct child health services, and outreach.³⁰ In order to receive the federal funds for outreach, the state must first spend money on outreach activities. Once they have done this, they then can submit a claim to the federal government and be reimbursed for a proportion of that amount. In FY 2000 Texas spent a total of \$9,293,852 on outreach (see chapter 7).

Outreach in Texas has included multiple methods and approaches. For example, the state has designed fliers, as well as produced television and radio commercials in both English and Spanish. Public health workers disseminate outreach materials to providers who then offer this information to families with potentially eligible children. The CBOs have trained staff to perform outreach by conducting home visits as well as face-to-face and telephone interviews. Additionally, TexCare has teamed up with companies such as HEB, Randall's, Reliant Energy, Diamond Shamrock, and Kmart, among others, to reach the public in the stores that they trust.

Conclusions

The new SCHIP program appears to be working in Texas. As of March 5, 2001, the state had enrolled an estimated 273,525 children in the SCHIP program.³¹ Within the first seven months, the state of Texas enrolled an estimated 44.74 percent of its eligible population.³² It is estimated that 428,000 children will be enrolled by the fall of 2001.³³

Like any new system, the new SCHIP program has not run as smoothly as some would have liked. First, it took three years to implement the program. While Congress created the new program in 1997, the bill that enacted the Texas SCHIP program was not introduced to the state legislature until 1999 because of the biennial legislative system. Even then it still took over a year to get the program up and running. Second, while the Medicaid and SCHIP programs offer essentially the same services, only a small proportion of children applying for SCHIP who are deemed eligible for Medicaid actually enroll in the Medicaid program when they are referred to DHS. Third, the same application process is not used for both programs, although federal requirements make this possible. As a result, parents get shuffled between the two programs, which often causes confusion, frustration, and lapses in coverage. Furthermore, some parents may have one child in SCHIP and another child in Medicaid. Thus, parents of Medicaid children must provide numerous forms of documentation and verification, take off work to go to the DHS office, and then do it all over again every six months.

Despite the delay in the implementation of the program and some of the difficulties parents face during the SCHIP eligibility process, the TexCare Partnership is continuously working to make improvements in the enrollment process. And, while it is still premature to declare the SCHIP program in Texas a success, it has been responsible for insuring new populations of children who previously lacked health insurance, and it has been instrumental in highlighting the barriers to Medicaid. In fact, the Texas Blue Ribbon Task Force on the Uninsured (an interim committee created during the 76th Texas Legislature to study the problem of the uninsured in Texas) has recommended that the Medicaid and SCHIP programs be simplified to create a seamless system.³⁴ Furthermore, several bills have been introduced in the 77th Texas Legislature addressing the barriers to Medicaid. Specifically, Representative Patricia Gray, along with bipartisan authors, have proposed HB 825, and Representative Garnet Coleman proposed HB 1604. These bills concern the issue of Medicaid simplification. Concurrently, in the Senate, Senators Judith Zaffirini and Mike Moncrief have authored separate bills that address continuous eligibility, SB 43 and SB 374, respectively.

Notes

- ¹ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, Third Edition* (Austin, Texas: February 1999), pp. 19-21.
- ² Interview by Michelle Harper and Leah Kegler with Anne Dunkelberg, Senior Policy Analyst, Center for Public Policy Priorities, Austin, Texas, March 5, 2001.
- ³ Families USA, *Uninsured Parents and Medicaid Information, State-by-State* (Washington, D.C.: Families USA Health Action Annual Conference, January 2001), p. 1.
- ⁴ Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, p. 61.
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