SUBJECT: Children's Health Insurance Program (CHIP)

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Gray, Coleman, Capelo, Delisi, Glaze, Hilderbran, Maxey, McClendon, Uresti

0 nays

SENATE VOTE: On final passage, March 11 — 31-0

WITNESSES: For — Maurine Dickey, Parkland Hospital and Texas Hospital Association; Marilyn Donnellan, United Way of Texas; Anne Dunkelberg, Center for Public Policy Priorities; Susanne Elrod, Texas Disability Policy Consortium; Melanie Gantt, Mental Health Association of Texas; Frank Genco, Texas Planning Council for Developmental Disabilities; Colleen Horton, Texas Advocates Supporting Kids with Disabilities; Anthony Kimbrough, M.D., Texas Medical Association, Texas Pediatric Society and Texas Academy of Family Physicians; Clarissa Martinez, National Council of La Raza; Lisa McGiffert, Consumers Union; Susan Murphree, Advocacy Inc.; Otto Melange, Joint City/County Commission on Children; Jonas Schwartz, United Cerebral Palsy of Texas; Diana Klein

Against — None

On — Tyrette Hamilton, Texas Healthy Kids Corp.; Shirley Hutzler, Texas Association of Health Underwriters

BACKGROUND: **CHIP.** The Children's Health Insurance Plan (CHIP) is a federal initiative (Title 21 of the Social Security Act), enacted in the Balanced Budget Act of 1997, under which Texas is eligible to receive an average of about $423 million per year over the next 10 years if the state establishes a health insurance program that meets federal criteria and contributes matching funds averaging about $151 million per year.

During the interim between the 75th and 76th legislatures, lawmakers directed the Health and Human Services Commission (HHSC) and the Texas Department of Health to implement an initial phase of the CHIP plan that

expanded Medicaid and to develop strategies to create a "phase two" comprehensive program to be implemented in fiscal 2000. On February 4, 1999, HHSC heard public testimony on its proposal for the phase two plan.

States may provide CHIP coverage to infants in families with incomes up to 235 percent of the federal poverty level (FPL) and to children aged 1 to 18 in families with incomes up to 200 percent of poverty. To deliver health-care services under CHIP, states either may expand their Medicaid programs or use a benefits package that is the same as or actuarially equivalent to either the Federal Employee Health Benefit Plan, a state employee health-benefit plan (in Texas, Health Select), or the state's largest commercial health-maintenance organization plan (in Texas, NYLCare). The state also may use a combination of approaches, such as expanding Medicaid to include certain segments of the population while using a separate plan for other low-income Texans.

States were required to submit an implementation plan to the federal government by July 1, 1998, to draw down their allotment for federal fiscal year 1998. HHSC submitted a phase one implementation plan that expanded Medicaid coverage to include teenagers aged 15 to 18 in families with incomes below 100 percent of the FPL — a category of children who already were to be phased into the Medicaid program by 2001 under previous federal Medicaid requirements. Previously, the Texas Medicaid program was available to teens aged 15 to 18 if their family income was less than 25 percent of poverty.

For fiscal 1999, the FPL for a family of four is about $16,800. A family of four would be at 150 percent of the FPL if their income was about $25,200 or at 200 percent of the FPL if their income was $33,600.

Appropriations act. Article 12 of the House and Senate engrossed versions of the general appropriations bill for fiscal 2000-01 contains $179.6 million to implement phase one and two of the CHIP program and to pay for any additional Medicaid costs associated with increased Medicaid enrollment (Medicaid "spillover") resulting from outreach efforts to enroll children in the CHIP program.

Texas Healthy Kids Corp. Last session, the Legislature enacted HB 3 by Berlanga, which established the Texas Healthy Kids Corp. (THKC), a

nonprofit corporation that contracts with health-benefit plan providers to make affordable health insurance available to children in families of any income. The state provided $3 million in start-up funding. The corporation's initial benefit offerings began in August 1998 in two counties and had expanded statewide by February 1999.

Tobacco funds. In March 1996, Attorney General Dan Morales filed a lawsuit on behalf of Texas against five major tobacco companies. In July 1998, Texas finalized the lawsuit's settlement, which awarded the state $17.3 billion over the next 25 years. On average, the state can expect to receive about $1 billion per biennium. However, the future of tobacco settlement revenues is clouded by federal efforts to recoup a portion of states' settlement funds and by possible changes in the structure of the tobacco industry.

DIGEST:

CSSB 445 would create a children's health insurance program that would be developed and overseen by HHSC. Children under age 19 from families whose income was at or below 200 percent of poverty would be eligible under the plan.

CSSB 445 would amend statutes relating to THKC to allow the commission to buy CHIP-plan coverage through THKC, to subcontract with THKC for other services, and to add reporting and other requirements. The bill also would create an advisory committee for CHIP program implementation and operation and would enact other plan and administrative requirements.

CSSB 445 would specify that the CHIP program was not an entitlement program and that it would end when federal funding ended. HHSC would have to monitor federal legislation affecting CHIP, notify the governor, the lieutenant governor, and the House speaker of changes that would conflict with the state plan, and suggest recommendations. CSSB 445 also would require HHSC to provide a health-benefit plan for qualified alien children and to provide Medicaid and CHIP coverage to those children if the federal government authorized that coverage.

CSSB 445 would obligate toward the CHIP plan the first amount of money available to Texas each fiscal year as a result of the state's settlement with the tobacco industry. The bill also would require standing or other legislative

committees that have jurisdiction over HHSC to monitor implementation of the plan.

HHSC would have to submit a CHIP plan for federal approval by September 1, 1999, and implement plan coverage by September 1, 2000, unless delayed by additional federal authorization.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house.

Plan administration. HHSC would be the sole agency responsible for making CHIP policy, but it could delegate certain duties for monitoring contracting and provider performance to the Texas Department of Health (TDH) and could delegate eligibility determination-related duties to the Department of Human Services (DHS). HHSC would have to review each entity that contracted to implement any part of the CHIP plan to ensure that the entity could fulfill its contractual obligations. The commission also would have to implement rules for fraud detection and prevention. The Texas Department of Insurance would have to provide, upon request from HHSC, any necessary assistance and to monitor service quality and resolve grievances relating to plan providers.

TDH quality-of-services monitoring could include:

- monitoring rates of hospitalization for injuries and for ambulatory sensitive conditions such as asthma, diabetes, and epilepsy;
- measuring the percentage of enrolled adolescents reporting risky behavior such as use of tobacco, alcohol, and drugs; and
- measuring the percentage of adolescents reporting attempted suicide.

HHSC also could contract with THKC to obtain health-benefit plan coverage or with third-party administrators to provide eligibility screening, enrollment procedures, or other services, including those otherwise performed by TDH or DHS. In these situations, the state would retain all policymaking authority and would have to procure all contracts through a qualified competitive process.

Advisory committee. HHSC would have to appoint an advisory committee of unspecified size and duration to provide recommendations on CHIP program implementation and operation. The advisory committee would have to include

representatives of hospitals, health-benefit plans, primary care providers, state agencies, consumers, parents of children enrolled in the plan, rural health-care providers, advocates of children with special needs, specialty health-care providers, and community-based organizations that provide CHIP outreach.

Community outreach campaign. HHSC would have to conduct an outreach campaign to provide information about CHIP health benefits in a manner that promoted the goals of all child health programs and minimized duplication of effort. The campaign would have to include efforts involving school-based health clinics, a toll-free telephone number, and broad participation of community-based organizations, especially those with high levels of uninsured children. TDH and DHS also could conduct part of the campaign.

Reporting requirements. HHSC would have to report quarterly to the Health Care Information Council and to relevant legislative committees the number of children referred for Medicaid application who were enrolled in the Medicaid program and the number of children denied Medicaid coverage because they failed to complete the application process.

Eligibility and application. A child under age 19 would be eligible if a member of a family whose net income was at 200 percent of poverty or below. The child could not be eligible for Medicaid nor covered by another health-benefit plan unless the other plan was inadequate or cost more than 10 percent of the family's income. A child's eligibility would last up to 12 months after the date of the eligibility determination or until the child's 19th birthday.

Application forms and procedures would have to be coordinated with forms and procedures under the Medicaid program and THKC and, to the extent possible, be made available in languages other than English. Application could be made by mail, over the telephone, or through the Internet. The Texas Integrated Enrollment Services system could be used to screen and enroll children. Children who appeared to be Medicaid-eligible would have to receive assistance in applying for Medicaid coverage.

Eligibility determination and plan enrollment would have to occur by the 30th day after submission of a completed application on behalf of the child. Enrollment would be open for the first year of CHIP implementation.

Thereafter, HHSC could establish enrollment periods.

Plan coverage. Plan coverage would have to comply with federal law and state requirements and would have to be in substantial compliance with the recommended benefits package described by the House and Senate interim reports on CHIP. Primary and preventive services could not include reproductive services. The commission also would have to consider the health-care needs of children with special needs, and the plan would have to allow an enrolled child with chronic, disabling, or life-threatening illness to select an appropriate specialist as a primary care physician. The health commissioner would have to evaluate all covered benefits annually and modify them as appropriate.

The CHIP plan would be exempt from state laws mandating benefits or services provided by a particular provider or requiring the use of a particular form.

Cost sharing. Enrollees would have to share the cost of the health plan to the extent allowed by federal law, including copayments, enrollment fees, and a portion of the plan's premium. Families with higher incomes would have to pay progressively higher percentages of the cost of the plan. The commission would have to specify how and to which agency or provider the premium was paid.

Crowd-out. The health plan would have to have a waiting period and could include copayments and other provisions to discourage employers and other persons from discontinuing their coverage because of the availability of CHIP coverage. The waiting period would have to extend for at least 90 days after the date of application and would apply to a child who was covered by a health plan, other than a THKC plan, at any time during the 90 days before the date of application.

A child would not be subject to a waiting period and could enroll at any time if the family lost coverage as a result of job termination, change in marital status, or other involuntary or good-cause reasons.

Medical savings account. The plan would have to include an option for the child's parent to participate in a medical savings account (MSA) insurance

program qualified under Title 21 of the Social Security Act and to allow a parent's employer to contribute to the account. HHSC would have to inform each eligible child's parent about the existence of the MSA option and give the parent an opportunity to choose or refuse it.

Providers. The commission would have to select health-plan providers through open enrollment or a competitive bid. Providers would have to hold a certificate of authority or other appropriate license from the Department of Insurance and to satisfy any other applicable requirement. The commission would have to give preference to a managed care organization that provided similar coverage through the Medicaid program or THKC. The commission also would have to provide for a choice of at least two health-plan providers in each metropolitan area.

Plan for qualified alien children. HHSC would have to implement health-benefit plan coverage for children who:

- were defined in federal code as qualified aliens and were younger than 19 years of age;
- had entered the U.S. after August 22, 1996, and resided in the U.S. for less than five years; and
- met income eligibility requirements of the CHIP or Medicaid program but were not otherwise eligible for coverage under these plans.

This plan would have provide, to the extent possible, comparable benefits to the CHIP health-benefit plan. Health-benefits providers would have to meet similar requirements and could include cost-sharing provisions comparable to those in the CHIP health benefit plan.

Plan expenditures could not be included in determining the state's contribution toward federal CHIP funding. However, the state would have to provide Medicaid or CHIP coverage to qualified alien children if the federal government authorized that coverage.

SUPPORTERS SAY:

CSSB 445 would take advantage of the recent availability of hundreds of millions of federal dollars to help thousands of Texas children receive the health services they need to grow to be healthy, productive adults. Texas has at least 471,000 children who might qualify because they are in families with incomes above the current Medicaid limit but below 200 percent of poverty.

Eligibility. With federal CHIP funds and the availability of new state revenues through the tobacco settlement, there is no time like the present to address the long-standing problem of sick and uninsured children in Texas. The state should enroll as many children as federally allowed — those in families up to 200 percent of poverty. This bill, by implementing CHIP for families up to 200 percent of poverty and by implementing a comparable benefit plan for legal immigrant children, would help complete a continuum of coverage options for families of all incomes and health risks, which would include Medicaid, THKC, the high-risk pool, and employer-sponsored health benefit coverage.

Texas has a disproportionate number of uninsured children whose families have too many resources to qualify for Medicaid but who cannot afford insurance for the whole family or who work for employers that do not offer health insurance or insurance for dependents. One out of every four Texas children — or about 1.4 million — is uninsured. Surveys show that Texas ranks either first or second among states in terms of both the percentage and the total number of uninsured children.

CSSB 445 would help improve the lives, education, and potential of uninsured children. A healthy childhood is the foundation for a healthy, productive adulthood. Unhealthy children have difficulty concentrating on school work and participating in school activities, and they miss opportunities to develop mental, emotional, and work skills. Because uninsured children are less likely to receive preventive or therapeutic care in the early stages of an illness, they are more likely to miss school than are insured children, and their absences cost local school districts state funding. Productivity and often family income are reduced when a working parent must take time off to care for a sick child.

Save local tax dollars. CSSB 445 would save money for local taxpayers and for individuals with health coverage, who subsidize the cost of treating uninsured children. Such children are five times more likely to use costly hospital emergency rooms as their chief source of medical care and are four times more likely to require hospitalization because of delayed treatment. The price of care for uninsured individuals also is passed on to covered individuals in the form of higher hospital and medical charges and higher premium payments.

No entitlement. CSSB 445 would *not* create an entitlement program that would continually drain state dollars, because the bill would require the termination of the program should federal funding cease. Instead, CSSB 445 would promote parental responsibility by its cost-sharing structure, which would educate and move families toward the purchase of nonsubsidized health benefits when family income increased.

Good benefit package. By requiring the commission to develop a CHIP health-benefit package as proposed in the House and Senate interim reports, the bill would direct HHSC to include comprehensive benefits needed by children, while leaving the commission flexibility to develop a package that met funding and other constraints. Also, the House Public Health Committee expressed its intent that the CHIP plan include the durable medical equipment and therapeutic dental benefits needed by special-needs children, as discussed at the February 4 CHIP public hearing, even though the interim reports did not address these needs specifically.

By allowing the commission to contract with THKC for health-benefit coverage, the bill would allow the state to take advantage of the corporation's experience, network, and resources in making health-benefit coverage available to children. Also, having THKC contract with health insurers would give the CHIP program a more "private sector" character, in keeping with Texas' nonentitlement approach to CHIP.

Enrollment and crowd-out. CSSB 445 would establish an open enrollment period in the first year to get as many eligible children as possible in health-benefit plans. An extended first enrollment period is needed because parents across the state not only have to learn about the program, but many have to learn how insurance works and what the parent's role is. Because of the extensive first-year outreach and education effort and the waiting period requirements, "gaming the system" probably would not occur — that is, parents would not sign up children only when they were sick or drop private insurance to receive CHIP coverage (the "crowd-out" effect). In subsequent years, however, health-care and plan costs could be contained as needed because CSSB 445 would allow the commissioner to implement limited enrollment periods.

The waiting period should not be increased from 90 days because that would create undue hardship on families and children. The goal is to provide health care to children while they need it, not to penalize them excessively. A 90-day waiting period would be enough time to inhibit parents from dropping any coverage they may have had in order to obtain CHIP benefits.

Health-benefit plan providers might be able to participate in outreach and enrollment efforts because, to the general public, they are a highly recognizable source of health-benefit information, and their experienced agents could help consumers find the program or coverage that best fit their family's needs and income.

School-based outreach. CSSB 445 would take advantage of local schools as a natural meeting ground for parents, children, and public health. However, the role of school-based health clinics would be limited to an informational role, such as the prominent display of a poster informing children and their families about the CHIP program, similar to posters now used for THKC. Discussions of sexual activities and birth-control options would not be fostered by the presence of CHIP outreach and informational efforts, because CSSB 445 specifically would prohibit CHIP benefits from providing reproductive services.

Qualified alien health plan. Most legal immigrant children are already eligible for CHIP and Medicaid. By requiring HHSC to develop a health-benefit plan for other qualified alien (legal immigrant) children, this bill would help about 7,000 uninsured children who have immigrated legally to Texas since August 22, 1996, and who are barred for five years by federal law from receiving Medicaid or CHIP benefits. Because bills are pending in Congress to allow these children to be covered under CHIP, these provisions simply would update Texas' CHIP plan to conform with federal changes and to draw the full federal match for CHIP and Medicaid without having to wait for authority from the next legislative session.

Medical savings accounts. The bill's MSA provisions would help families who want to set aside savings for medical conditions not covered under the CHIP plan, such as orthodontia and eyeglasses, and could be a useful tool for parents who later were able to receive insurance through employers.

OPPONENTS SAY:

Texas should not yield to the enticement of federal dollars and set up another public program. The number of uninsured children is exaggerated because there is no indication whether the 1.4 million children said to be uninsured have been uninsured for one week or 10 years. Texas should not expand government bureaucracy to pay for something that families and the private market could handle on their own.

Through regulation and taxation, government has distorted the health-care market, thereby contributing to the increase in the number of individuals who cannot afford health care or health-care coverage. This bill would continue that distortion. The benefit package offered under CHIP would cause health-benefit providers to stop offering their plans with more limited benefits for children, reducing the availability of coverage for many families or raising the cost of health coverage for families who did not participate in government-sponsored programs.

Also, CHIP enrollment in other states has not been as high as often expected. Texas would be setting aside a substantial sum of money for CHIP that could be better used to meet other state priorities.

Creating an entitlement demand. An entitlement program must pay for services for all who are eligible. Even though CHIP program enrollment would be limited to appropriated funding, constituents would come to expect and demand that such benefits and services always be available. In other words, this bill would create new dependence on government subsidies. Once this program was implemented, it would be hard to reduce benefits or eligibility to meet federal or state funding cutbacks and shortages.

OTHER OPPONENTS SAY:

Eligibility. The state should take a more conservative step in implementing such a new, comprehensive program. Proposed funding levels for fiscal 2000-01 in HB 1, about $179.6 million for the biennium, might not cover adequately the expected enrollments in CHIP and "spillover" in the Medicaid program. Currently, as many as 600,000 children may be eligible for Medicaid but not enrolled, and these children could sign up for Medicaid if CHIP outreach efforts were highly successful. Eligibility should be revised to a lower level, such as 150 percent of poverty, to ensure that the state could meet program enrollment within current budget levels. The program also could be amended to authorize HHSC to raise eligibility levels if experience

with program implementation showed that sufficient funding would be available.

Health benefit coverage. CSSB 445 specifically should address health-benefit coverage and direct HHSC to use the coverage negotiated with all stakeholders and decided upon at the February 4 meeting. The reference to the House and Senate interim reports is too vague and could be interpreted to endorse different levels of coverage. CHIP coverage should include services to meet children's needs, especially those with disabilities and multiple severe medical conditions, often called "special-needs" children. The bill explicitly should instruct the commissioner to provide benefits such as coverage for pediatricians, pediatric subspecialists, and children's hospitals, improve substance abuse and mental health treatment coverage, match durable medical equipment benefits to those in the Medicaid program, and add therapeutic dental services. Advocates for the disabled say they would prefer a rich benefit package with a waiting list to a plan that did not provide enough benefits for the disabled and very sick.

The CHIP health-benefit package should be more limited than that proposed by HHSC in February, a good example of a "Cadillac" benefit package that would go beyond meeting children's general health-care needs and federal requirements and would make it hard to contain state expenses. Also, many health-benefit plan providers say it would be difficult to provide such a comprehensive health-benefit package within the modest premium costs projected by HHSC.

THKC involvement in the CHIP plan should be approached cautiously. The corporation is relatively new, and CHIP could force the organization to grow at almost an unmanageable rate and create enrollment backlogs. THKC involvement would not increase the "private sector" feel of the CHIP program because the same private health-benefit plan companies would be competing for CHIP contracts regardless of what entity managed the contract process. TDH, which administers the Medicaid managed care program, also could be a good candidate for procuring and administering contracts.

Terminating or reauthorizing the program. The CHIP program should be terminated if tobacco settlement funds are no longer available or substantially scaled back. Texas' contribution toward CHIP funding is estimated to average about $151 million each year to obtain the full amount of federal funds

allocated. Such participation would not be affordable without the tobacco settlement funds, which may be reduced to Texas because of federal recoupment efforts or changes in the structure of the tobacco industry. If federal requirements or funding change, the entire CHIP program should be reevaluated and reauthorized, if desired, by the Legislature. CHIP should not be allowed to continue in perpetuity despite changes in federal involvement.

Enrollment and crowd-out. The open enrollment provisions would limit the number of participating health-benefit plan providers and increase the cost of health benefits. Without limited enrollment periods, people would tend to seek and pay for health coverage when they were sick or injured and would drop coverage once they no longer were worried. Such behavior would counter the financing model that makes managed care possible and affordable — a reasonable monthly payment for a comprehensive array of services, regardless of use. The combined financial experience of enrollees receiving services with those not needing services maintains service availability for all enrollees. Also, the benefits of preventive and primary care services would not be realized by families whose health benefit coverage was sporadic and fragmented.

The CHIP waiting period should be extended to six months to prevent families from dropping their private coverage to gain CHIP benefits. The availability of health benefits through CHIP would cause the "crowd-out" effect if some employers dropped benefits knowing that employees could seek coverage through CHIP and if some parents refused employer-based health coverage so they could obtain CHIP coverage.

Health-benefit plan providers should be prohibited explicitly from enrolling children because of the potential for conflict of interest and the abuse that some states witnessed during their conversion to a Medicaid managed care system. In those states, some managed care organizations enrolled children under a plan and received monthly capitated payments for each enrollee without informing the parents that their children were able to obtain health services.

Medical savings accounts. The MSA provisions are unnecessary because they would not be used by families in this income range, who do not have the financial resources to establish such savings. Also, MSAs normally are used in conjunction with catastrophic plans that provide coverage after a high

deductible is met, as opposed to coverage by the more comprehensive CHIP plan. Finally, it is not clear whether an MSA option actually can be designed without violating federal caps on CHIP recipients' out-of-pocket spending.

Qualified alien plan. This plan should be a lower priority of the state and not implemented until CHIP costs are evaluated. It would be totally state-funded and would further expand state government's role in health care.

NOTES:

Major changes made by the House committee substitute to the Senate engrossed version of the bill include:

- expanding eligibility to include children in families with incomes at or below 200 percent of poverty (from the Senate eligibility proposal of children up to age 10 in families up to 200 percent of poverty and children aged 11 through 18 in families up to 150 percent of poverty);
- adding a provision that would end the CHIP program when federal funding ended;
- requiring the state to use for CHIP the first money available through the tobacco settlement receipts;
- specifically referring to benefits described by the House and Senate in their interim reports on CHIP and specifically requiring the exclusion of reproductive services;
- adding MSA provisions;
- adding provisions establishing the HHSC as chief policymaking authority and adjusting TDH, DHS, and TDI responsibilities
- adding the establishment of an advisory committee;
- adding requirements related to fraud prevention and control, outreach in school-based clinics, a toll-free number, and making application forms available in languages other than English;
- adding coverage for qualified alien children;
- specifying the implementation date of September 1, 2000; and
- substituting the specified legislative oversight committee with oversight by standing legislative committees.

The fiscal note for the Senate engrossed version of the bill was $120 million of anticipated expenditures in general revenue-related funds. The fiscal note for the House committee substitute is $127 million.