Chapter 9: Children's Health Insurance Program

What is the Children's Health Insurance Program? Who does this program serve, what benefits does it provide, and how does it operate in Texas?

History and Background

The Balanced Budget Act of 1997 (P.L. 105-33) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act and appropriated nearly $40 billion for the program for federal fiscal years (FFYs) 1998-2007. Like Medicaid, SCHIP is administered by the Centers for Medicare & Medicaid Services (CMS) and is jointly funded by the federal government and the states. Also like Medicaid, each state receives a different federal match for SCHIP. For federal fiscal year (FFY) 2014, the federal government funded 71.08 percent of Texas' SCHIP program, while the state funded the remaining 28.92 percent. Through SCHIP, states can provide health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid.

SCHIP offers states three options when designing a program. States can:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program;
- Design a separate state children's health insurance program; or
- Combine both the Medicaid and separate program options.

States that choose to expand their Medicaid programs are required to provide all mandatory benefits and all optional services covered under their Medicaid state plan, and they must follow the Medicaid cost-sharing rules. States that choose to implement a separate program have more flexibility. Within broad federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children ages 15 to 18 whose family income was under 100 percent of the federal poverty level (FPL). Phase I

of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

Enacting legislation for Phase II of SCHIP, a separate children's health insurance program, was passed by the 76th Legislature. This program is referred to simply as the Children's Health Insurance Program (CHIP). S.B. 445, 76th Legislature, Regular Session, 1999, specified that coverage under CHIP be available to children in families with incomes up to 200 percent FPL. Coverage under Phase II of the program began on May 1, 2000. The Health and Human Services Commission (HHSC) was given overall authority for the program. By February 2002, 516,000 children were enrolled. As of June 2014, 593,619 children were enrolled in CHIP.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized CHIP by appropriating nearly $69 billion in federal CHIP funding for states for FFYs 2009-2013.[1] The Act simplified the original name of the program from "SCHIP" to "CHIP." CHIPRA made numerous policy changes to state CHIP programs, which include the following:

- States must verify a CHIP applicant's citizenship;
- States may cover pregnant women above 185 percent FPL up to the income eligibility level for children in CHIP; and
- States may provide Medicaid and CHIP coverage to qualified immigrant children and/or pregnant women without the previously required 5-year delay. (See Chapter 2, Medicaid History and Organization, Children's Health Insurance Program Reauthorization Act of 2009.)

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). The ACA makes the following changes to CHIP:

- Extends federal funding for CHIP through FFY 2015. Prior to the ACA, CHIP was authorized through FFY 2013.
- Prohibits states from restricting CHIP eligibility standards, methodologies, or procedures through September 30, 2019. Medicaid payments are contingent upon meeting this CHIP maintenance of effort (MOE) requirement.
- As of January 1, 2014, shifts from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent FPL.
- Applies new federal rules for determining financial eligibility for CHIP (known as modified adjusted gross income (MAGI) rules). The ACA eliminates assets tests and most income disregards for CHIP.
- Increases the federal CHIP match rate for FFYs 2016 through 2019.

Who Is Covered in Texas

CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance.

To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident;
- A Texas resident;
- Under age 19;
- Uninsured for at least 90 days;[2] and
- Living in a family whose income is at or below 201 percent FPL.

Until the passage of CHIPRA, children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Since the program's inception, Texas covered certain qualified immigrant children under CHIP with 100 percent state funds if they met all other Medicaid or CHIP eligibility requirements.

In the past, Texas opted not to provide Medicaid coverage to qualified immigrant children with some exceptions, so qualified immigrant children at Medicaid income levels were covered in CHIP through 100 percent state funds. CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

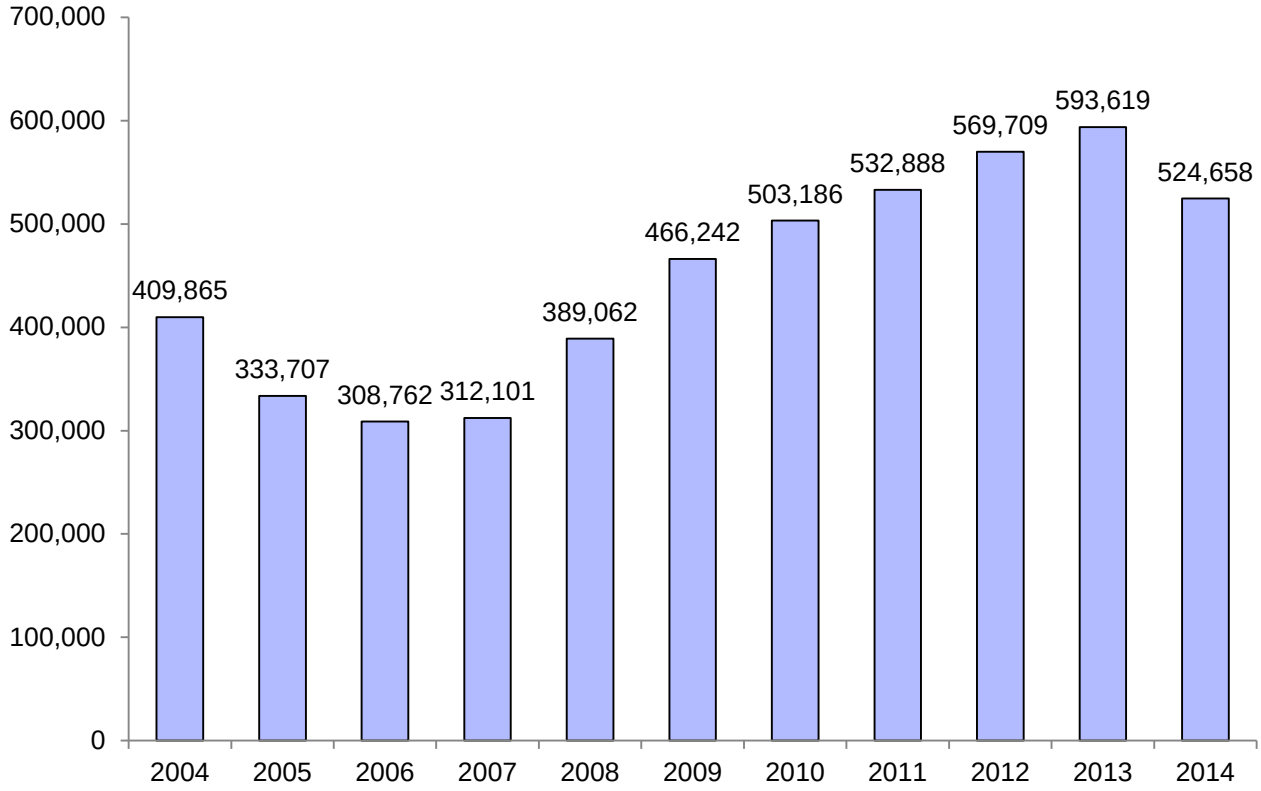
Federal policy formerly excluded a child from participating in federally-matched CHIP if the child's family was eligible for state health benefits plan due to employment with a public agency (even if the family declined the coverage). The ACA provides an exception to this exclusion and allows states to provide federally-matched CHIP to the children of public employees effective March 23, 2010, if the state health benefits plan meets the MOE requirements or the child qualifies for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Texas Retirement System school-employee children as of September 1, 2010 and to other eligible public employee children as of September 1, 2011.

Size of CHIP Population

Figure 9.1 shows the average monthly caseload for the CHIP population since state fiscal year (SFY) 2004. Earlier CHIP caseloads had peaked in May 2002 at 529,211,

declining through 308,762 in 2006. Since that time, CHIP caseload gradually increased to a new high enrollment of 607,057 in August 2013. Caseloads have subsequently decreased in CHIP under the ACA, which shifted from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent FPL.

Figure 9.1: Average Monthly CHIP Clients
SFYs 2004-2014



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

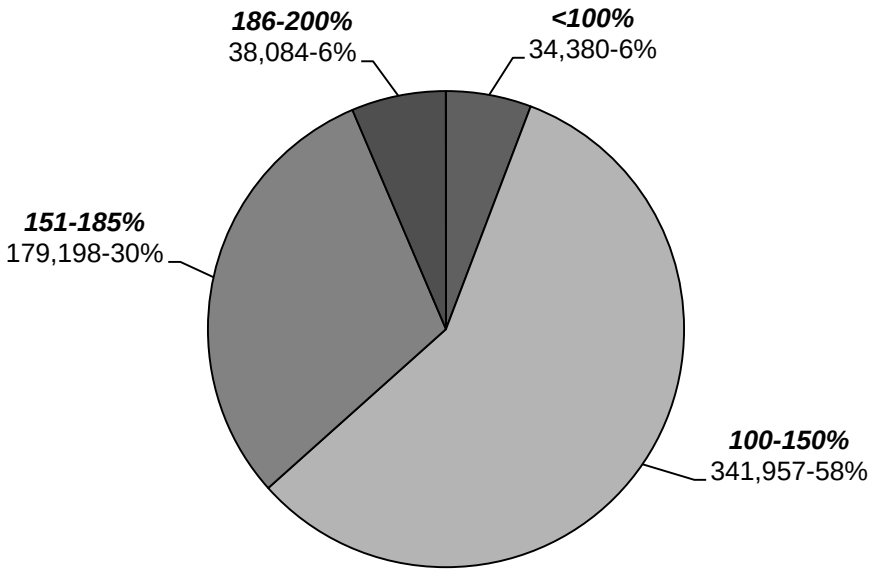
CHIP Demographics

Federal Poverty Level

During the most recent year for which full enrollment data is available, SFY 2013, the majority of CHIP enrollees (approximately 58 percent) were between 101 and 150 percent FPL. Approximately 30 percent were between 151 and 185 percent of FPL, and 6 percent were between 186 and 200 percent of FPL. Approximately 6 percent of enrollees were below 100 percent of FPL. **Figure 9.2** shows the percent distribution of CHIP enrollees by FPL category in SFY 2013. Under the new ACA eligibility criteria,

children who meet all other eligibility criteria and have incomes at or below 133 percent FPL qualify for Medicaid, not CHIP.

Figure 9.2: Distribution of CHIP Enrollment in SFY 2013 by Percent of FPL Category-Monthly Average
(Number and Percent by FPL)



Total Enrollment - 593,619

Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

Effective January 1, 2014, the ACA required states to use modified adjusted gross income (MAGI) for household income for CHIP income determinations (including for cost sharing determinations). In addition, the ACA eliminated income disregards and assets tests for CHIP, in the same manner that these changes apply to Medicaid.

Prior to January 1, 2014, Texas applied an income disregard in CHIP for child care expenses. The income disregard was $200 per month for each child under age two or $175 per month for each child age two or older. Texas also applied an assets test to children in CHIP with incomes above 150 percent FPL. The asset limit was $10,000 in countable liquid resources combined with excess vehicle value.

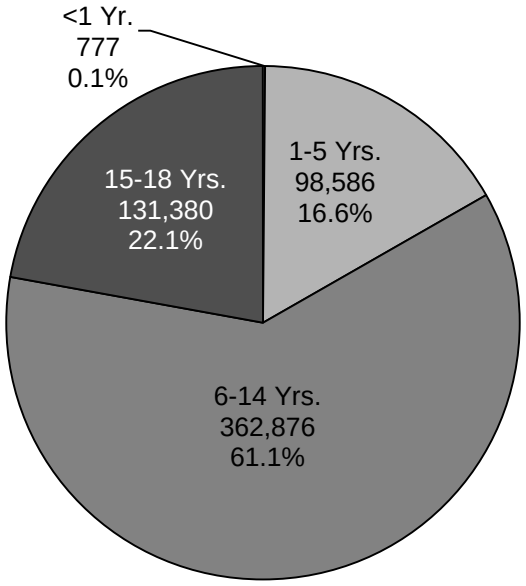
Age

Figure 9.3 shows the percentage of CHIP clients by age in SFY 2013. That year, the majority of CHIP clients were over age 5. Sixty-one percent of clients were between ages 6 and 14, and 22 percent of clients were between ages 15 and 18. Slightly under 17 percent were between ages 1 and 5, while less than 1 percent of clients enrolled in CHIP in SFY 2013 were under 1 year of age.

The higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid. CHIP serves children through age 18 up to 201 percent of FPL. Medicaid serves infants (12 months of age and younger) up to 198 percent of FPL, children ages 1 through 5 up to 144 percent of FPL, and children ages 6 through 18 up to 133 percent of FPL.

Figure 9.3 does not include CHIP Perinatal clients, who are all under 1 year of age. More detail on CHIP Perinatal is provided at the end of this chapter.

Figure 9.3: Average Monthly CHIP Enrollment by Age SFY 2013
(Number and Percent by Age Group)



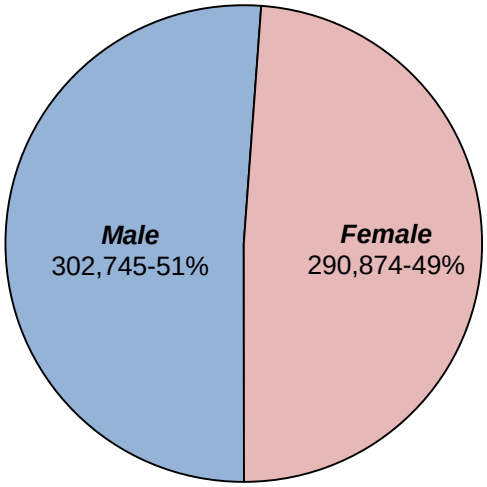
Total Enrollment - 593,619

Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

Gender

Figure 9.4 shows the proportions of CHIP enrollees by gender. Approximately 51 percent of enrollees are male, and 49 percent are female.

Figure 9.4: Average Monthly CHIP Enrollment by Gender SFY 2013



Gender Total - 593,619

Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

CHIP Benefits

States like Texas that operate a separate child health program have three options for determining coverage.[3]

- Benchmark coverage: Coverage that is substantially equal to one of the following: (1) The Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; (2) A health benefits plan offered by the state and made generally available to state employees; or (3) A plan offered by a managed care organization (MCO) that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
- Benchmark-equivalent coverage: Coverage that has the same aggregate actuarial value as one of the benchmark plans. States that choose to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." These include inpatient and outpatient hospital services, physician services, surgical and medical services, laboratory and X-ray services,

and well-baby and well-child care, including age-appropriate immunizations. States must also provide coverage that is at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional services category." These services include prescription drugs, mental health services, vision services, and hearing services.

- Any other health benefits plan that the U.S. Secretary of Health and Human Services determines will provide appropriate coverage.

Texas selected the third option for determining CHIP coverage - i.e., Secretary approved coverage. The state's benefit package is cost-effective, including a basic set of health care benefits that focus on primary health care needs. **Table 9.1** displays the current benefits covered by Texas CHIP. These benefits are subject to certain limitations and exclusions.

Texas most recently modified behavioral health and dental benefits pursuant to CHIPRA.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were signed into federal law on October 3, 2008. MHPAEA requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at parity with medical and surgical benefits. CHIPRA applied MHPAEA requirements to all state CHIP programs.

CMS approved a CHIP state plan amendment to remove the treatment limitations from existing CHIP behavioral health benefits, effective March 1, 2011, bringing CHIP into compliance with the mental health parity requirements in CHIPRA. To offset increased costs in the CHIP program, HHSC increased certain co-payments for CHIP members above 150 percent of FPL, effective March 1, 2011.

CHIP Dental

Prior to March 1, 2012, the Texas CHIP dental benefits package consisted of three tiers that covered certain preventive and therapeutic services up to capped dollar amounts per 12-month coverage period. CHIPRA required all state CHIP programs to cover dental services "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." To comply with this requirement, Texas CHIP was required to cover certain services that were not previously covered, including periodontic and prosthodontic services.

Effective March 1, 2012, Texas eliminated the three-tier benefit package. Now all CHIP members receive up to $564 in dental benefits per enrollment period. Emergency dental

services are not included under this cap. Members also can receive certain preventive and medically necessary services beyond the $564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC raised CHIP cost-sharing amounts.

Table 9.1: Services Covered by Texas CHIP, 2014

The following services are covered under CHIP in Texas:

- Inpatient general acute and inpatient rehabilitation hospital services.
- Surgical services.
- Transplants.
- Skilled nursing facilities (including rehabilitation hospitals).
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services.
- Physician/physician extender professional services (including well-child exams and preventive health services, such as immunizations).
- Laboratory and radiological services.
- Durable medical equipment, prosthetic devices, and disposable medical supplies.
- Home and community-based health services.
- Nursing care services.
- Inpatient mental health services.
- Outpatient mental health services.
- Inpatient and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Rehabilitation and habilitation services (including physical, occupational, and speech therapy, and developmental assessments).
- Hospice care services.
- Emergency services (including emergency hospitals, physicians, and ambulance services).
- Emergency medical transportation (ground, air, or water).
- Care coordination.
- Case management.
- Prescription drugs.
- Dental services.
- Vision.
- Chiropractic services.
- Tobacco cessation.

CHIP Cost-Sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP

annual enrollment fee amounts and co-payments vary based on family income. In addition, the total amount that a family is required to contribute out-of-pocket toward the cost of health care services is capped at five percent of family income. **Table 9.2** shows the current cost-sharing requirements and cost-sharing caps for that became effective on March 1, 2012.

Table 9.2: CHIP Cost-Sharing Requirements

Enrollment Fees (for 12-month enrollment period):	**Charges**
At or below 151% of FPL	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50

CHIP members up to and including 151% of FPL	**Charges**
Office visit	$5
Non-emergency ER	$5
Generic drug	$0
Brand drug	$5
Inpatient hospital	$35
Cost-sharing limit	5% (of family income, per enrollment period)

CHIP members above 151% up to and including 186% of FPL	**Charges**
Office visit	$20
Non-Emergency ER	$75
Generic drug	$10
Brand drug	$35
Inpatient hospital	$75
Cost-sharing limit	5% (of family income, per enrollment period)

CHIP members above 186% up to and including 201% of FPL	**Charges**
Office visit	$25
Non-emergency ER	$75
Generic drug	$10
Brand drug	$35
Inpatient hospital	$125
Cost-sharing limit	5% (of family income, per enrollment period)

CHIP Delivery Network

CHIP services are delivered by MCOs selected by the state through a competitive procurement. As of September 1, 2014, there were 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide.

Enrollees residing in a CHIP service area have a choice of at least two or more MCOs. (See http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/Managed-Care-Service-Areas-Map.pdf for a list of CHIP service areas by county.)

In order to provide CHIP members with a choice of dental plans, HHSC expanded the number of dental managed care plans from one to two.

CHIP Rates

The rate setting process for CHIP is essentially the same as for the STAR managed care programs. CHIP MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. Then, a provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an “adjusted premium rate” for each service area. A separate lump sum payment, called the “Delivery Supplemental Payment,” is computed for expenses related to each newborn delivery. While the Delivery Supplemental Payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump sum payment in the amount of $3,100 for each birth.

The resulting underlying base rates vary by service area and age group. A final adjustment is made to reflect the health status or acuity, of the population, enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium that is paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

Pharmacy costs associated with all CHIP clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the CHIP medical rates above.

CHIP dental benefits are reimbursed through a separate set of premium rates. The rate setting process for the CHIP dental plans is similarly derived from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward as with other programs. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental plans. A provision for possible fluctuation in claims cost is made through the addition of a risk margin.

CHIP Financing

Like Medicaid, CHIP is jointly funded by the federal government and states. However, unlike Medicaid, the total amount of federal funds allotted to the program each year is capped, as is the amount of funds allotted to each state. In the federal legislation that created CHIP, annual federal appropriations for the program totaled nearly $40 billion for the ten-year period that the program was originally authorized. Each state is allotted a portion of this amount based on a formula set in federal statute and receives federal matching payments up to the allotment. Each year's allotment has historically been available to states for three years, and any funds allotted to states that are not spent by the end of the three-year period are redistributed to states that have exhausted their allotment, with some exceptions. Under CHIPRA, this has changed to a two-year period to spend the annual allotment beginning with the FFY 2009 allotment.

The FFY 2013 and 2014 allocation are estimated to be fully expended. The federal allocation for Texas in FFY 2014 is $955,760,207.

Another difference between financing for Medicaid and CHIP is that CHIP offers a more favorable federal matching rate than Medicaid. The amount of federal CHIP funds that states receive is based on the Enhanced Federal Medical Assistance Percentage (EFMAP). Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The CHIP EFMAP for Texas was 71.51 percent in FFY 2013 and 71.08 percent for FFY 2014.

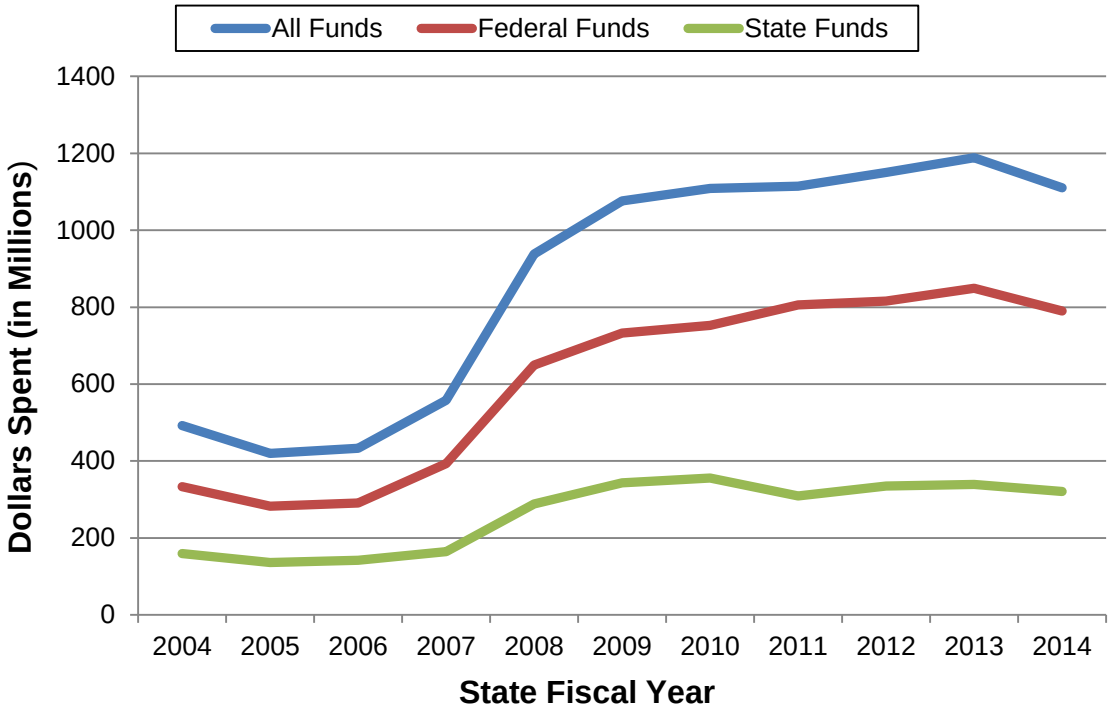
The ACA increases the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015, until September 30, 2019. The increase does not apply to:

- Certain administrative expenditures;
- Citizenship documentation requirements; and
- Administration of Payment Error Rate Measurement (PERM) requirements.

CHIP Spending

Texas CHIP spending has experienced sporadic growth in recent years. **Figure 9.5** shows state and federal expenditures for CHIP between SFYs 2004 and 2014. Current estimates project that total CHIP expenditures for SFY 2014 will be over $1.11 billion. Approximately 70 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services; 15 percent on prescription drugs; and the remaining 15 percent on administration.

Figure 9.5: Texas CHIP Expenditures
SFYs 2004-2014



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

CHIP Perinatal Program

The 2006-07 GAA (Article II, HHSC, Rider 70, S.B. 1, 79th Legislature, Regular Session, 2005) authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was the CHIP Perinatal program, which began in January 2007. CHIP perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status. The expecting mother must meet certain income requirements (income up to and including 202 percent FPL). Services include prenatal visits, prescription prenatal vitamins, labor with delivery, and post-partum care. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

Upon delivery, CHIP Perinatal newborns in families with incomes at or below 198 percent of FPL are eligible to receive 12 months of continuous Medicaid coverage from date of birth. Most CHIP perinatal clients fall into this income range. For CHIP Perinatal clients at or below 198 percent of FPL, the mother must apply for Emergency Medicaid to cover her labor with delivery by submitting a completed CHIP Perinatal - Emergency Medical Services Certification (form H3038P). This form is mailed to the mother, and she is instructed to bring it with her to the hospital at delivery. This form must be returned to establish Emergency Medicaid for the mother and to enable the child to receive 12 months of Medicaid coverage from the date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of FPL up to and including 202 percent of FPL remain in the CHIP Perinatal Program and receive CHIP benefits for the remainder of the 12-month coverage period.

Size and Demographics of the CHIP Perinatal Population

Table 9.3 shows the average monthly caseload for the CHIP Perinatal population since the program began in January 2007. Beginning September 2010, newborns under 185 percent of FPL began moving out of CHIP Perinatal and into Medicaid due to changes in eligibility. The monthly caseload has begun to stabilize around 37,000 members. Approximately 99 percent of clients are perinates and only 0.8 percent of clients are newborns.

All children in the CHIP Perinatal program are under the age of one because a woman can only enroll her child in the program prior to delivery. The majority of clients are at or

under 185 percent of FPL, with approximately 2.5 percent of all clients above this amount.

Table 9.3: CHIP Perinatal Caseload Summary, SFYs 2007-2014

Fiscal Year	Total Caseload	Perinates under 185% FPL	Perinates over 185% FPL	Newborns under 185% FPL	Newborns over 185% FPL
2007*	20,465	16,602	351	3,440	72
2008	58,589	31,631	586	25,854	519
2009	67,849	36,186	511	30,694	458
2010	67,148	36,158	433	30,215	342
2011	44,214	36,775	546	6,582	310
2012	37,190	36,238	652	-	300
2013	37,064	36,081	652	-	331
2014	37,718	36,841	573	2	302

* Averages are for Jan - Aug 2007 only, the first eight months of program implementation.

CHIP Perinatal Rates

Premium rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP, with the differences being the absence of acuity adjustment and the more focused scope of benefits and membership in CHIP Perinatal. MCO historical claims experience is totaled and trended forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits, and other miscellaneous costs. Final rates vary by risk group and service area. However due to low caseload among risk groups with income over 198 percent up to and including 202 percent of FPL, premium rates for these risk groups are calculated on a statewide basis.

Endnotes

[1] Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, "CHIP Financing Structure," June 2009, http://www.kff.org/medicaid/upload/7910.pdf (November 2014).

[2] There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom premiums exceed 9.5 percent of the family's net income. A complete list of the exemptions can be found at http://chipmedicaid.org/en/Previous-Coverage (November 2014).

[3] Herz, E. J., Fernandez, B., & Peterson, C.L., "State Children's Health Insurance Program: A Brief Overview," Congressional Research Service, Washington D.C., March 23, 2005, http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3047303232005.pdf (November 2014).