

Chapter 2: Medicaid and CHIP in Context

The Health Insurance Landscape

Who Are the Uninsured?

An estimated 5.0 million Texans, or 19.1 percent of the state population, had no health insurance in 2014.¹ Texas has the highest rate in the nation for people without insurance.² In 2014, approximately 800,000, or 11.0 percent, of Texas children under age 18 had no insurance (down from 15.6 percent in 2012).³ The national average uninsured rate for children was 6.0 percent.⁴

Most of the uninsured in Texas are adults under age 65. Most adults over age 65 have Medicare. **Figure 2.1** depicts the uninsured population in Texas by age group in 2014.

Data indicates 62 percent of uninsured, non-retired Texans age 18 and older have a job. Uninsured adults may work in jobs that do not

¹ U.S. Census Bureau, 2014 American Community Survey (ACS) for Texas.

² Ibid.

³ Ibid.

⁴ Ibid.

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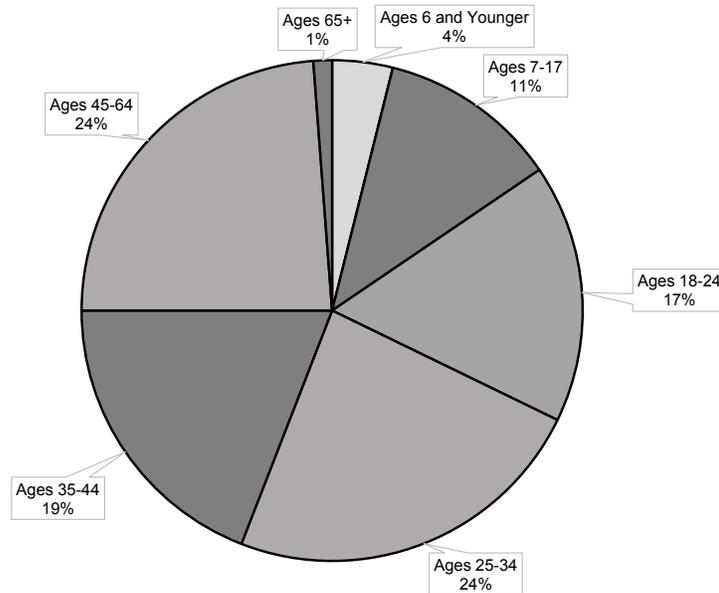
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offer employer-sponsored coverage, or they may not be able to afford the coverage offered. Unless they are caretakers of children eligible for Medicaid, are pregnant, or have

disabilities that qualify them for Supplemental Security Income (SSI), most of these adults are ineligible for Medicaid.

Figure 2.1: Total Uninsured Population in Texas by Age Group, CY 2014



Source: U.S. Census Bureau. 2014 ACS for Texas.

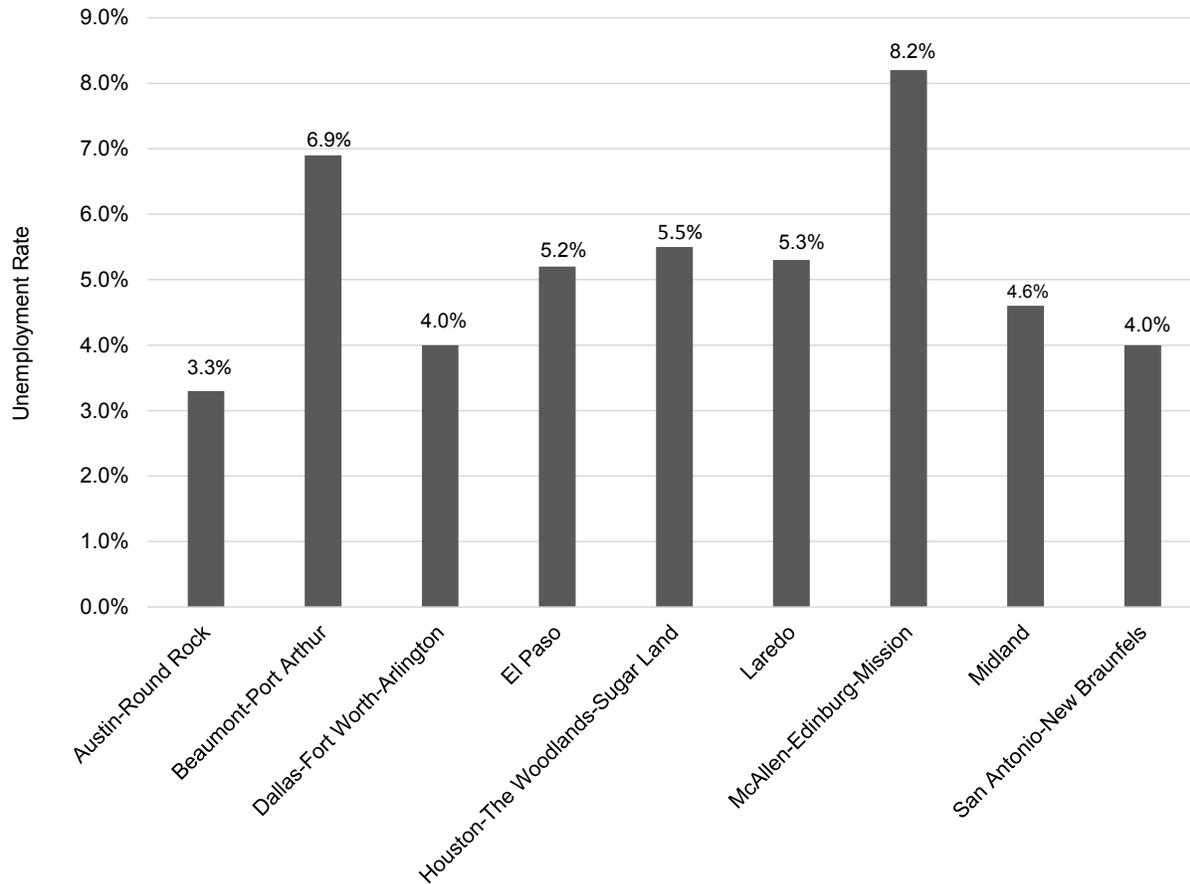
Unemployment

Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid due to their income level.

In June 2016, Texas’ seasonally adjusted unemployment rate was 4.5 percent, which was lower than the national rate of 4.9 percent. The percentage of working-age persons (ages 16 through 64) in Texas who had a job in June 2016 was 69 percent.

The unemployment rate varies among regions of the state, as shown in **Figure 2.2**. In June 2016, the Metropolitan Statistical Area (MSA) with the lowest unemployment rate was Austin-Round Rock, with a rate of 3.3 percent. The highest unemployment rate was in the McAllen-Edinburg-Mission MSA, with a rate of 8.2 percent.⁵

⁵ Texas Workforce Commission, <http://www.twc.state.tx.us/> (July 2016).

Figure 2.2: Unemployment Rates in Selected Texas Metropolitan Areas, June 2016

Source: Texas Workforce Commission

Poverty

Since Medicaid primarily serves low-income individuals, poverty in the state affects the number of people eligible for the Medicaid program. In 2014, about 4.5 million Texans (17.2 percent of the state's population) lived at or below the federal poverty level (FPL), and approximately 38 percent of these were children under age 18. Approximately 24.6 percent of all Texas children under age 18 were

living at or below the FPL in 2014.⁶ Approximately 24.9 percent of Hispanics and 23.2 percent of African Americans in Texas were living at or below the FPL in 2014, along with 9.3 percent of White Non-Hispanics.

Table 2.1 lists the Federal Poverty Guidelines by family size for 2014-2016.

⁶ U.S. Census Bureau, 2014 ACS for Texas.

Table 2.1: Federal Poverty Guidelines, 2014-2016

Size of Family Unit	2014 Annual Income	2015 Annual Income	2016 Annual Income
1	\$11,670	\$11,770	\$11,880
2	15,730	15,930	16,020
3	19,790	20,090	20,160
4	23,850	24,250	24,300
5	27,910	28,410	28,440
6	31,970	32,570	32,580
7	36,030	36,730	36,730
8	40,090	40,890	40,890
For each additional person, add	\$4,060	\$4,160	\$4,160

Source: U.S. Department of Health and Human Services, Health and Human Services Poverty Guidelines, 2014-2016 <http://aspe.hhs.gov/poverty/> (July 2016).

Note: Federal poverty guidelines are applicable to the 48 contiguous states and are effective March 1st of each year.

Health Insurance Mandate

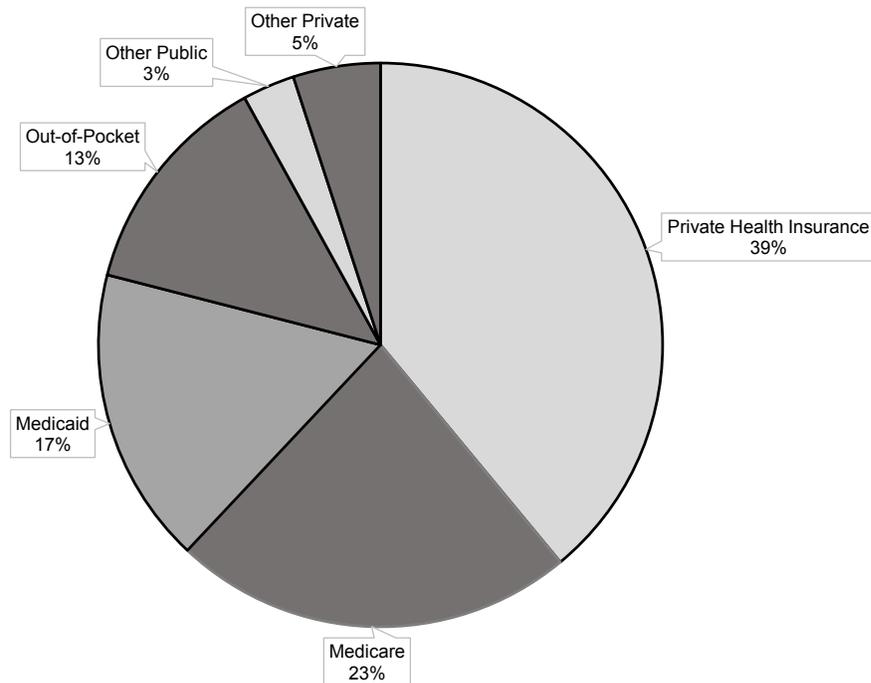
As required by the Affordable Care Act (ACA), beginning in 2014, most people must have health insurance that meets minimum federal coverage standards or pay a tax penalty. Health benefit plans provided by employers and most state or federal government health plans satisfy the requirement.

Persons who do not have access to employer or government-sponsored health coverage can buy an individual plan to cover themselves and their families. Also as a result

of the ACA, insurance companies cannot deny coverage or charge more for those who have a pre-existing condition.

Individual plans can be purchased directly from insurance companies and insurance agents or brokers. The Texas Department of Insurance's website, www.texashealthoptions.com, is a resource to help understand how to find and use health insurance. Coverage can also be purchased online through the federally-operated insurance marketplace at www.HealthCare.gov.

Figure 2.3: U.S. Personal Health Care Expenditures by Source of Funding, 2014



Source: Centers for Medicare & Medicaid Services (CMS) Office of the Actuary, National Health Expenditures Accounts.

Private Coverage

The limits of private insurance affect Medicaid. In 2014, 66 percent of the non-elderly U.S. population had private health insurance coverage, most often in the form of employer-sponsored coverage.⁷ That same year, private insurance paid for 39 percent of total national personal health care expenditures.⁸ **Figure 2.3** and **Figure 2.4** show national health care spending by

source of coverage and type of service, respectively.

In Texas, the proportion of the population covered by employer-sponsored health insurance is lower than the national average. Fifty-four percent of Americans under age 65 were covered by employer-sponsored health coverage in 2014, compared with 50 percent of Texans.⁹ In 2014, 16 percent of working adults age 18 to 64 in the U.S. were uninsured, compared with 26 percent in Texas.¹⁰ Certain working uninsured individuals with low incomes may turn to

⁷ U.S. Census Bureau, 2014 ACS for Texas.

⁸ CMS, Historical National Health Expenditures By Type of Service and Source of Funds. National Health Statistics Expenditures Accounts.

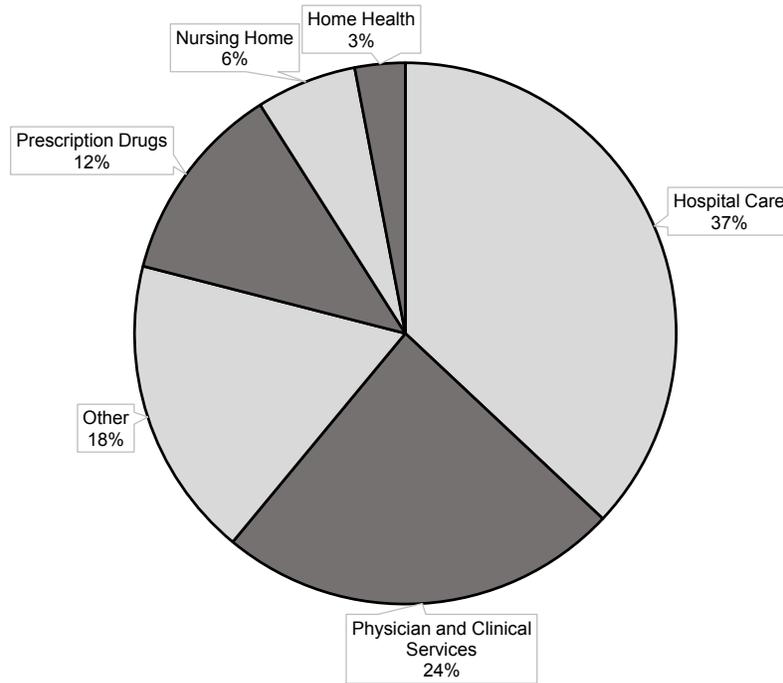
⁹ U.S. Census Bureau, 2014 ACS for Texas.

¹⁰ Ibid.

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Medicaid to meet their health care needs or those of their dependents when employer-sponsored coverage, or health coverage through a health insurance marketplace is not available or affordable.

Figure 2.4: U.S. Personal Health Care Expenditures by Category, 2014



Source: CMS Office of the Actuary, National Health Statistics Expenditures Accounts.

The passage of the ACA prohibited health plans from denying or limiting coverage for pre-existing conditions for children under age 19 effective September 23, 2010, and for adults starting January 1, 2014.

Medicare

The Social Security Act of 1965 created both Medicaid and Medicare. Medicare is a federally-paid and administered health insurance

program. As of September 2016, it covered 57.2 million Americans.¹¹

Medicare Parts A-D

Most Americans age 65 and over automatically qualify for Medicare Part A (hospital insurance for inpatient hospital services) in the same way they qualify for Social Security based on their work history and their payroll deductions while they were working. Qualifying

¹¹CMS, "Medicare Enrollment Dashboard," <http://www.cms.hhs.gov/MedicareEnRpts/> (December 2016).

individuals receive Part A coverage with no premium payment, but some cost-sharing through coinsurance and deductibles is required. People who do not qualify may purchase the hospital coverage. The federal government finances the hospital insurance program primarily through a payroll tax on employers and employees.

Medicare Part B is a voluntary program covering physician and related health services. Medicare Part A beneficiaries may choose to enroll in Part B. In addition, individuals age 65 and over may enroll in Part B, even if not eligible for Part A. Part B requires payment of a monthly premium. For low-income seniors who qualify, Medicaid pays the monthly premium. In addition to enrollee premiums, federal revenue finances the cost of the Medicare program. Both Part A and Part B have cost-sharing requirements where enrollees must pay coinsurance and deductibles. The Texas Medicaid program covers these costs for eligible low-income beneficiaries.

Part C establishes a managed care delivery option in Medicare called Medicare Advantage. Part C combines Part A and Part B coverage. Beneficiaries who live in an area in which Medicare managed care plans operate may choose to receive their Medicare services through such a plan. These plans

may offer additional benefits not available in the traditional Medicare program, or charge lower premiums.

Part D, the Medicare prescription drug benefit, was implemented in 2006. Previously, Medicare did not cover any outpatient prescription drugs, except for a few drugs covered under Part B. For those Medicare beneficiaries who qualified for Medicaid (called dual eligibles), Texas and other states offered prescription drugs through Medicaid.

The major impact of Part D on the Texas Medicaid program was that, as of early 2006, dual eligibles began receiving prescription drugs from Medicare, rather than Medicaid. In state fiscal year 2015, approximately 374,000 dual eligibles in Texas received prescription drug coverage through Medicare Part D.¹² Once determined eligible for Medicare, CMS requires dual eligible clients to enroll in a Medicare prescription drug plan for all their prescription drugs. However, Texas Medicaid continues to provide some limited drug coverage to dual eligibles for a few categories of drugs not covered under Medicare Part D.

Although the new benefit shifted prescription drug coverage from Medicaid to Medicare, it did not provide full fiscal relief to states. As

¹²Health and Human Services Commission (HHSC), Monthly Medicare Modernization Act Dual Eligible Counts.

described below, a significant share of the cost of providing the Part D benefit to dually eligible clients is financed through monthly payments made by states to the federal government.

State Role in Medicare

Medicare is financed and administered wholly at the federal level. Historically, states played no role in Medicare administration. However, since 1988, federal law has required state Medicaid programs to pay Medicare deductibles, premiums, and coinsurance for some low-income Medicare beneficiaries. Medicare also impacts Medicaid because of its coverage scope and limitations. For instance, Medicare does not currently cover some categories of medications covered by Medicaid, including some cough and cold products, vitamins and minerals, and over-the-counter medications. The Texas Medicaid program pays all of the cost of these drugs for dual eligibles.

The Texas Medicaid program also pays the federal government to provide Medicare drug coverage for individuals who are dually eligible through what is commonly known as “clawback” payments. It is estimated that in state fiscal year 2015, Texas Medicaid paid approximately \$1.13 billion for Medicare premiums and deductibles (Part A and Part B), and another \$375 million (all general revenue funds) for Medicare Part

D “clawback.” Taken together, this accounts for approximately six percent of the Texas Medicaid program budget, excluding disproportionate share hospital and upper payment limit funds.

Medicare only covers skilled nursing care required following a hospitalization. Coverage is limited to 100 days per “spell of illness” following a three-night stay in the hospital. Admission to the nursing facility (NF) must occur not more than 30 days after the hospital discharge date. Medicare covers payment at 100 percent for the first 20 days only and pays 80 percent for days 21-100. Medicaid covers the 20 percent coinsurance for dual eligibles. The Medicare NF benefit does not cover long-term institutional services and supports. Medicaid, however, covers long-term institutional services and supports and thus covers the cost of NF care for dually eligible clients not paid by Medicare. Medicaid also covers a broad range of community-based long-term services and supports not covered under Medicare.

TRICARE/Veterans Administration

TRICARE is a health care plan available through the Department of Defense for those in the uniformed services and their families, as well as for retired members of the military. The plan contracts with both military

health care providers and a civilian network of providers and facilities. The Veterans Health Administration offers a wide range of health care services for U.S. military veterans through a health care system consisting of Veterans Administration medical centers and outpatient clinics.

Medicaid and CHIP History

Medicaid Enrollment Over Time

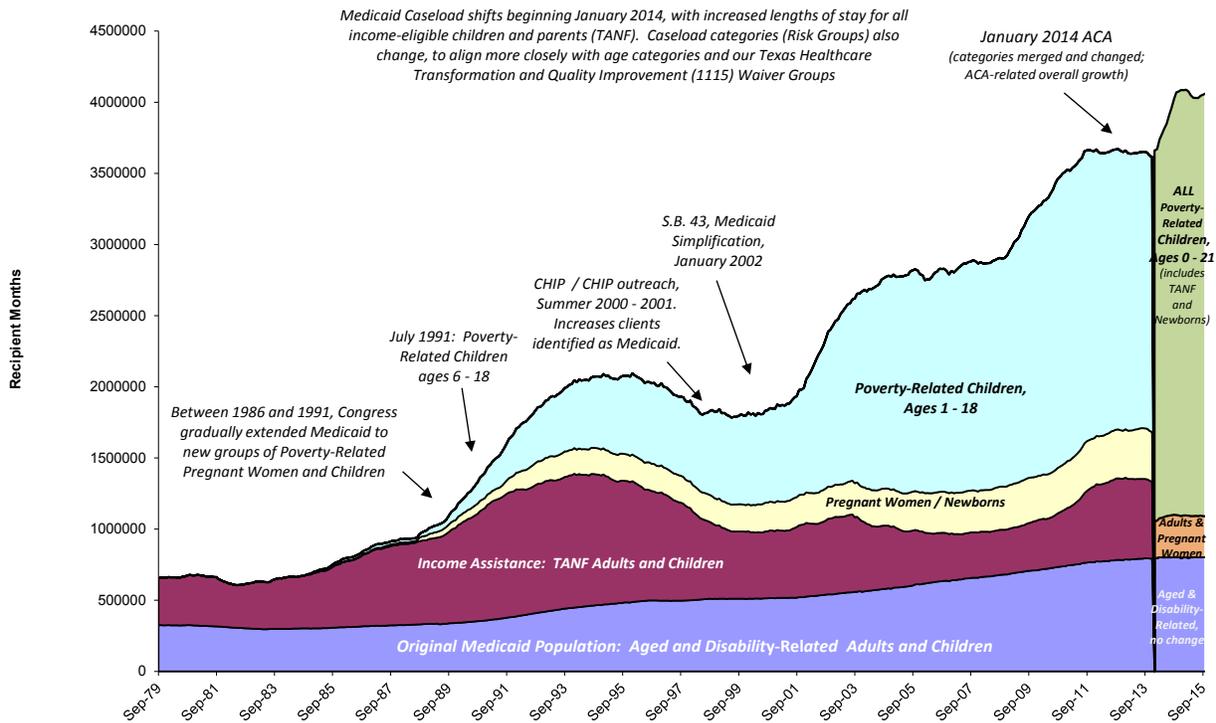
Congress established the Medicaid program under Title XIX of the Social Security Act of 1965 to pay medical bills for low-income persons who have no other way to pay for care. Texas began participating in the Medicaid program in September 1967.

During the late 1980s and early 1990s, Congress expanded Medicaid eligibility to include a greater number of people with disabilities, children, pregnant women, and older persons. These changes helped fuel the growth of the Medicaid program, and the Texas Medicaid population tripled in just a decade, adding more than one million people between 1990-1995 alone. In the mid- to late-1990s, caseloads declined in part due to the de-linking of Medicaid from cash assistance and stricter eligibility requirements for Temporary Assistance for Needy Families

(TANF). In 2002, the number of children enrolled in Medicaid grew sharply due to Medicaid application simplification and six-month continuous eligibility as required by S.B. 43, 77th Legislature, Regular Session, 2001. In 2003, Texas Medicaid's TANF populations began declining due to sanctions against adults not complying with the Personal Responsibility Agreement (PRA). The PRA is a document a child's parent or relative who is also approved for TANF must sign and follow.

In state fiscal year 2015, an average of 4.06 million Texans were served each month by Medicaid. **Figure 2.5** illustrates Texas Medicaid enrollment trends by category for September 1979 through September 2015.

Figure 2.5: Medicaid Caseload by Group, 1979–2015



Source: HHSC, Financial Services, HHS System Forecasting.

Linked to Financial Assistance Programs

As originally enacted, Medicaid coverage was available only to persons eligible for Aid to Families with Dependent Children, now referred to as TANF. TANF is the federal-state cash assistance program for low-income families, usually headed by a single parent. To be able to receive Medicaid, individuals were required to be receiving cash assistance (or welfare). In this sense, Medicaid was “linked” to welfare. Historically, Medicaid coverage has also been available to persons eligible for SSI in Texas. SSI is a federal cash

assistance program for low-income people age 65 and older or those who have disabilities. In Texas, SSI recipients are automatically eligible for Medicaid. For this reason, Medicaid has also been “linked” to SSI in Texas.

Temporary Assistance for Needy Families

Prior to the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), children under age 19 and their related caretakers who qualified for TANF cash assistance automatically qualified for Medicaid. With the passage of PRWORA, cash assistance and Medicaid are no

longer “linked.” If households need both TANF cash assistance and Medicaid, they must apply for both. Otherwise, they may only apply for TANF cash assistance or Medicaid.

Each state sets its income eligibility guidelines for TANF cash assistance. Texas has historically maintained lower TANF income caps compared to other states. In 2016, the TANF income cap for a parent with two children was \$188 per month. The TANF monthly cap is based on a set dollar amount and is not determined by the FPL.

Supplemental Security Income

In 1972, federal law established the SSI program, which provides federally-funded cash assistance to low-income people age 65 and older and those with disabilities. The Social Security Administration determines the eligibility criteria and cash benefit amounts for SSI. States may supplement SSI payments with state funds, and many states choose to do so. Texas does not, but does allow for a slightly higher personal needs allowance (PNA) for SSI clients in long-term care facilities. The PNA is the amount of the SSI check clients may keep for personal use while living in a long-term care facility.

To be eligible for SSI, an individual must be at least 65 years old or have a disability, and have limited assets and income. A child may be

eligible for SSI beginning as early as the date of birth – there is no age requirement. The individual’s income must be below the federal benefit rate (FBR). In 2017, the limit for an individual is \$735 a month in countable income and no more than \$2,000 in countable resources. The limit for couples is \$1,103 a month with no more than \$3,000 in countable resources. The amount of the SSI payment is the difference between the person’s countable income and the FBR.

De-Linking Medicaid and Financial Assistance

Historically, all Medicaid enrollees were either on SSI or welfare. Federal laws passed in the late 1980s mandated Medicaid coverage for groups of people ineligible for TANF or SSI. This resulted in a major expansion of the eligible population. Members of working families and others with low incomes were now also eligible to receive Medicaid.

The following program expansions resulted from federal mandates:

- Coverage of prenatal and delivery services for certain pregnant women and their infants;
- Expansion of services to low-income families who do not receive TANF cash assistance;
- Expansion of Medicaid to fill gaps in Medicare services for low-income

people age 65 and older and those with disabilities; and

- Coverage of the full array of federally-allowable Medicaid services as medically necessary and appropriate for all children on Medicaid.

Affordable Care Act

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 was enacted on March 30, 2010. Together they are called the ACA and make significant changes to state health care programs and to the health insurance market.

Among a number of other changes, the ACA mandates all individuals to have health insurance coverage. It also gives states the option to expand Medicaid eligibility up to and including 133 percent of the FPL for individuals under age 65.

The ACA also required the establishment of health insurance marketplaces by January 1, 2014, to assist individuals and small employers in accessing health insurance. The marketplace must be operated by a governmental entity or non-profit organization.

States had the option to establish a state-based marketplace, partner with the federal government to establish a marketplace, or have the federal government run the state's

marketplace. States that initially opted for a federally-run marketplace may request to move to a state-based marketplace over time. Texas currently utilizes the Federally-Facilitated Marketplace.

As of January 1, 2014, qualified individuals and employees of participating small employers can purchase health insurance coverage from qualified health plans on the Marketplace. Individuals above 100 percent up to and including 400 percent of the FPL may be eligible for premium subsidies and cost-sharing reductions for coverage purchased through the Marketplace.

History of CHIP and CHIP Perinatal

The Balanced Budget Act of 1997 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 1998-2007. Like Medicaid, SCHIP is administered by 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 2016, the federal match for Texas' SCHIP program was 69.99 percent, while the state funded the remaining 30.01 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 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 FPL. Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

S.B. 445, 76th Legislature, Regular Session, 1999, enacted Phase II

of SCHIP, which created Texas' Children's Health Insurance Program (CHIP). S.B. 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the 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 2016, 374,280 children were enrolled in CHIP.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP by appropriating nearly \$69 billion in federal CHIP funding for states for federal fiscal years 2009-2013.¹³ CHIPRA simplified the original name of the program from "SCHIP" to "CHIP," and made numerous policy changes to state CHIP programs, including:

- States must verify a CHIP applicant's citizenship.
- States may cover pregnant women above 185 percent of the FPL up to the income eligibility level for children in CHIP.
- States may provide Medicaid and CHIP coverage to qualified

¹³Kaiser 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).

immigrant children and/or pregnant women without the previously required five-year delay.

In 2010, the passage of the ACA made the following changes to CHIP:

- Extends federal funding for CHIP through federal fiscal year 2015. Prior to the ACA, CHIP was authorized through federal fiscal year 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 requirement.
- As of January 1, 2014, shifts from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent of the FPL.
- Applies new federal rules for determining financial eligibility for CHIP (known as modified adjusted gross income rules). The ACA eliminates assets tests and most income disregards for CHIP.
- Increases the federal CHIP match rate for federal fiscal years 2016-2019.

The Medicare Access and CHIP Reauthorization Act of 2015 extended federal funding for CHIP through federal fiscal year 2017.

The 2006-07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II,

HHSC, Rider 70), authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, 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.