

[ CHAPTER FOUR ]

MEDICAID AND THE STATE CHILDREN'S  
HEALTH INSURANCE PROGRAM IN TEXAS

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Medicaid and the State Children's Health Insurance Program (SCHIP) are key programs for providing health insurance and health care to low-income people in the United States. This chapter reviews the current state of Medicaid and SCHIP in the United States and Texas. Contents of this chapter summarize and update a white paper submitted to the Task Force by Warner, et. al. (see Appendix B).

### **MEDICAID**

Medicaid is a federal-state matching program established by Congress under Title XIX of the Social Security Act (SSA) of 1965 and administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). It is an entitlement program created to pay the medical bills of low-income people and increase access to health care. All people who meet the eligibility requirements are entitled to services. Every state (plus Washington, D.C., and five U.S. territories) has a Medicaid program, but since implementation is left to each state, there are variations in the eligibility, benefits, reimbursements and other details of the program among states.

Medicaid pays for basic health services such as inpatient and outpatient hospital care, physician visits, pharmacy, laboratory, X-ray services and long-term care for elderly and disabled beneficiaries. The people eligible for these services are mainly low-income families, children, related caretakers, pregnant women, the elderly and people with disabilities. For additional information on mandatory

and optional covered populations and benefits, please refer to Appendix B of this Report.

Cost for the program is divided between the federal government and state governments. The federal share of Medicaid spending was \$147.5 billion in the federal fiscal year (FFY) 2002 and \$160.7 in FFY 2003. Federal Medicaid expenditures are projected to increase to \$177.3 billion in FFY 2004, \$182.1 billion in FFY 2005, and \$192.2 billion in FFY 2006 (OMB, 2004).

### ***TEXAS MEDICAID PROGRAM***

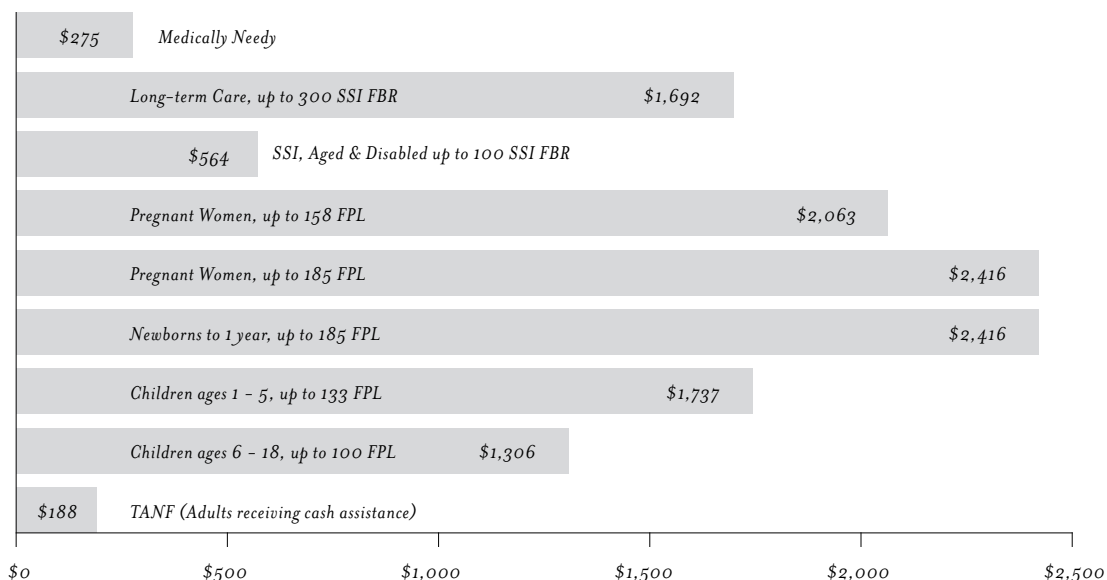
Texas joined the Medicaid program in September 1967. Each year, the federal government usually pays a little more than 60 percent of the cost of the Medicaid program in Texas (the exact percentage varies from year to year). For FFY 2004, the federal share in Texas was effectively 62.7 percent, based on basic rate of 60.22 percent with several federal enhancements. Combined federal and state spending for Medicaid in Texas was projected to be \$15.5 billion in the state fiscal year (SFY) 2004, not including the disproportional share hospital program (DSH) payments (which add another \$1.5 billion as detailed below). This has almost doubled from a budget of \$8.2 billion in 1996. The Medicaid budget (excluding DSH) has gone from being 20.5 percent of the state budget in 1996 to 26.1 percent of the budget in 2004. Of the total state Medicaid budget of \$17 billion estimated for SFY 2004, 87 percent is for payment of health services, 9 percent is for DSH payments, and 4 percent is for administration (THHSC, 2004a).

As of April 2005, there were 2.9 million people enrolled in Medicaid in Texas (THHSC, 2005a). Beneficiaries must be recertified every six months, at which time adults must renew in person and most children can renew by mail. Continuous eligibility varies: children have it for six months, newborns for one year, and pregnant women until two months post-partum, but all other adults in the program are eligible month by month and must report any income or status changes within 10 days. See Figure 1 for a chart showing various eligibility groups and the monthly income cut-offs to qualify for Medicaid in 2004. Texas Medicaid provides all of the mandatory services (as listed in Appendix B) per federal law, and also provides 36 optional services, 21 of these to all enrollees, and the rest to only children

or the elderly. Medicaid beneficiaries in Texas are enrolled in either traditional fee-for-service (FFS) Medicaid or a Medicaid managed care program, depending on their location and other factors.

Texas uses two different models for managed care delivery, health maintenance organizations (HMO) and primary care case management (PCCM). HMOs are licensed by the Texas Department of Insurance and receive a monthly capitation payment for each enrollee based on an estimate of average medical expenses. PCCM is a non-capitated model where each enrollee is assigned a primary care provider (PCP), who must authorize most of the specialty services for the person before they will be paid by Medicaid. The state hires a contractor

**Figure 1. Medicaid Eligibility in Texas, 2004  
Maximum Monthly Countable Income Limit (Family of Three)**



Source: Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, 5th ed. (2004, p. 4-5), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed March 22, 2005.

Notes: "Countable income" is gross income adjusted for allowable deductions, typically work-related. SSI does not certify families of three, SSI certifies only individuals and couples. SSI is not tied to the Federal Poverty Level, but is based on the FBR, as indicated above.

who sets up the provider networks and contracts directly with them. Reimbursement is fee-for-service, plus a small monthly case management fee for PCPs. Over one-third of Texas Medicaid clients have been enrolled in managed care, and nationally, over half of enrollees are in managed care (THHSC, 2004a). In September 2005, PCCM was expanded to the 197 counties that had not been covered by managed care, so Texas enrollment rates in managed care should begin to equal or exceed national rates.

#### ***DISPROPORTIONATE SHARE HOSPITAL PROGRAM***

States also get federal Medicaid money for the Disproportionate Share Hospital Program (DSH). DSH provides reimbursement to hospitals that serve a disproportionately large number of Medicaid patients or other low-income people to help compensate them for lost revenues (GAO, 1993). DSH funds are subject to the same federal matching rate as other Medicaid funding. However, unlike regular Medicaid funds, which are open-ended, DSH funds have a ceiling on the total amount for each state. The amount of DSH payments received and their percentage of states' total Medicaid budgets varies widely from state to state (Kaiser, 2002).

DSH payments are an important source of revenue for many hospitals, helping them to defray costs of uncompensated care to indigent, uninsured and underinsured patients. The DSH program is the only Medicaid program where reimbursement does not have to be solely for the treatment of Medicaid patients; it can help reimburse the uncompensated costs of treating uninsured and underinsured patients as well. In SFY 2003, 181 hospitals in Texas received \$1.3 billion in DSH payments (federal and state dollars combined). Of these

hospitals, 14 were state hospitals, 80 were public, 50 were non-profit and 37 were private for-profit hospitals. The state's matching funds for DSH come from intergovernmental transfers from nine local hospital districts, and state funds from 14 state hospitals (THHSC, 2004a; HSCSHCE, 2004).

#### ***UPPER PAYMENT LIMITS***

The Upper Payment Limit (UPL) is a program that reimburses hospitals for the difference between what Medicaid pays for a service and what Medicare would have paid for it. While Medicaid cannot pay more than Medicare would have paid for a service, Medicare rates are generally higher, so this difference is called the "Medicaid upper payment limit." The program is separate from DSH and is financed with both state and local funds like the rest of Medicaid. Texas has had a limited UPL plan that makes payments to public hospitals in rural counties under 100,000 population, as well as to the nine large urban public hospital districts (TLC, 2003).

The state gets the state portion of the matching funds through intergovernmental transfers from the nine largest hospital districts that are in the UPL plan. These districts received \$24.9 million in additional federal funds in FY 2001 and \$105 million in FY 2002. Texas' UPL plan complied with recent federal regulations intended to stop perceived abuses in the program (such as federal matching funds being retained by states for non-health purposes), and went one step further by requiring that all UPL funds received by the state to be used only for higher payments to hospitals or to support medical teaching facilities (TLC, 2003).

#### **STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

The State Children's Health Insurance Program (SCHIP) was created as part of the Balanced Budget

Act of 1997 and codified into Title XXI of the SSA. It is administered by CMS. It was established to offer health insurance to the large number of uninsured children with family incomes too high to qualify for Medicaid, but who cannot afford private insurance. Every state (plus Washington, D.C., and the five U.S. territories) has implemented SCHIP plans. SCHIP is a grant program with limited funds and not an entitlement program like Medicaid, so states such as Texas that have chosen to create a separate SCHIP program rather than expand children's Medicaid can place caps on the number of children enrolled or enact other restrictions that are not legal in Medicaid.

To qualify for SCHIP, children must be younger than 19, a U.S. citizens or legal residents, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of the federal poverty level (FPL) or below 50 percentage points above the state's Medicaid eligibility (CMS, 2000). Families pay premiums, deductibles and co-payments that vary according to their income levels.

SCHIP was appropriated approximately \$40 billion by Congress over 10 years. The minimum allocation to each state from these funds is \$2 million per fiscal year. SCHIP funds to a state remain available for the state to spend for three years (the fiscal year of the award and the next two fiscal years). Any funds that have not been spent during this period are subject to reallocation by the federal government and possible redistribution to other states that have exhausted their funds (CMS, 2004a). However, Congress has modified and extended these reallocation provisions on several occasions.

#### ***TEXAS SCHIP PROGRAM***

The current Texas Children's Health Insurance Program began in May 2000. There was a previous program in place from 1998-2002 that was phased out as Medicaid took over coverage of the enrollees, who were aged 15-18 under 100 percent FPL (THHSC, 2004a).

SCHIP is a federal-state matching program with a higher federal share than Medicaid. The federal share for SCHIP is 72.15 percent in Texas for FFY 2004, meaning the federal government gives Texas \$2.59 for every state dollar spent (THHSC, 2004a). Texas spent almost \$330 million on SCHIP in FY 2004, including both federal and state funds. There has been unspent money left over each year in Texas since the SCHIP program started, and that money has been returned or is projected to be returned to the federal government for redistribution each year since 2000.

Texas cannot use federal funds, provider taxes or beneficiaries' cost-sharing to make up the state share for SCHIP, and states also cannot use SCHIP funds to finance the state match for Medicaid.

Texas also has to show a maintenance of effort to receive federal funds: they cannot lower their Medicaid eligibility levels for children from what they had in place on June 1, 1997, and they must maintain at least the same level of spending on children's health programs that they had in 1996 (AAP, 1997). These provisions seek to ensure that SCHIP funds cover the intended target population of uninsured children without states trying to transfer additional children to the program in order to reap the higher federal matching funds.

As of December 2005, there were 322,898 children enrolled in SCHIP in Texas (THHSC, 2005b).

This is down from 507,259 children in September 2003, before cuts by the 78th Legislature took effect (Dunkelberg & O'Malley, 2004). Please see the white paper in Appendix B for the services that SCHIP beneficiaries in Texas can receive. SCHIP benefits last for six months, at which time parents need to send in a renewal form for their children if they remain eligible (THHSC, 2004b). Parents can mail in an application for SCHIP for their children or apply over the phone, and most newly enrolled children must wait 90 days before their benefits can begin (Texcare, 2004).

Beneficiaries pay from \$3 to \$10 per office visit and \$3 to \$20 per prescription, though some may be eligible to pay no co-payments (THHSC, 2004b). Monthly premiums for SCHIP were suspended from August 2004 to December 2005. A Governor's Directive was issued on Aug. 11, 2004, to the Texas Health and Human Services Commission (THHSC) to request that it delay the implementation of a plan to disenroll families who had missed three or more premium payments, and to study effective alternatives for cost-sharing. Since it would not be fair for some families to not pay their premiums and still be eligible for services, while others with the same income levels continued to pay, HHSC suspended premium payments (not co-payments for services) for all enrollees (THHSC, 2004c). New enrollment fees effective January 2006 are paid every six months and vary from \$25 to \$50 (families under 133 percent of the federal poverty level pay nothing) (TexCare).

## THE FUTURE OF MEDICAID AND SCHIP

### **FEDERAL**

In looking for ways to save money in Medicaid and other programs, the George W. Bush Administration has considered implementing block grants.

President Bush's FFY 2005 budget proposed converting various federal programs into block grants, which are fixed amounts of funds that give the recipients (state and local governments) more flexibility in carrying out the programs that are funded. These proposals were not completely new, as a Medicaid block grant, among others, was proposed in President Bush's FFY 2004 budget as well (Finegold, et al., 2004). In these proposals for Medicaid and SCHIP block grants, states would have the option of consolidating Medicaid and SCHIP funds into acute care and long-term care allotments. The amounts would be based on historical Medicaid and SCHIP spending. The amounts would increase annually over current funding by a certain rate in the first years of the block grant, but would decrease in later years to make the block grant budget-neutral over 10 years. The proposal contained certain requirements, such as that not more than 15 percent of funds could be used for program administration, up to 10 percent of funds could be transferred between allotments, and states would still have to provide benefits to currently mandated beneficiaries (Finegold, et al., 2004).

One criticism of the block grants is that the government is overestimating the amount that can be saved with increased flexibility. In addition, block grants do not address the underlying reasons that Medicaid costs are growing, such as the increase in enrollment and rising health care costs. The proposed increase in flexibility includes letting states tailor benefits packages to different populations, increase cost-sharing and cap enrollments. However, the most-used benefits are unlikely to be eliminated, and more cost-sharing and caps on enrollment create inequities for low-income people who may delay getting care if they cannot afford the co-pays. Capping enrollment and getting rid of the entitlement aspect means

that people who would otherwise qualify and may be worse off financially or health-wise than people already in the program could be denied benefits or put on waiting lists just because they register later. Another criticism is that block grants give states an incentive to reduce coverage, because they can keep any savings. Furthermore, block grants take away the monetary incentive to be innovative, because there are no federal matching funds for expansions. They set in stone the spending inequalities of high-income and low-income states and states, such as Texas, with a low base in expenditures that may be faster-growing are disadvantaged (Holahan & Weil, 2003; Families USA, 2003).

#### **MEDICAID AND SCHIP WAIVERS AND OTHER OPTIONS FOR CHANGE**

Waivers allow HHS to relinquish certain Medicaid and SCHIP laws and regulations, giving states more flexibility in these programs and encouraging experimentation with new approaches to delivering services. There are two broad waiver types, which refer to different sections of the SSA. Section 1115 waivers are called “research and demonstration waivers” and usually involve comprehensive reform projects, while Section 1915 waivers are called “program waivers” and involve waiving specific requirements to allow more innovative programs such as managed care and community-based care. Every state and territory has applied for and implemented at least one Medicaid waiver (HHS, 2001).

#### ***SECTION 1115 WAIVERS***

Section 1115 of the SSA allows HHS to authorize pilot projects in states that want to test new ways to promote the objectives of Medicaid and SCHIP. States can obtain federal matching funds for demonstration projects to pay for more services or extend coverage to more people. Applications

must show how projects will help further the goals of Medicaid or SCHIP, and include an evaluation component. Projects are usually approved for five years and may be renewed, and they must be budget-neutral, meaning they do not cost the federal government any additional money (HHS, 2001). Although called “demonstration” projects these arrangements often become permanent. The Arizona Medicaid program (called Arizona Health Care Cost Containment System, or AHCCCS) was introduced under an 1115 waiver in 1982 and through repeated renewals and amendments continues to operate today (CMS, 2004b).

Texas does not have an 1115 waiver. The state applied for an 1115 waiver in August 1995 after studying the options for controlling the state’s rapidly escalating Medicaid costs. This waiver would have expanded Medicaid coverage, eligibility and managed care. The waiver was not approved by the HHS for a variety of reasons, and a subsequent smaller 1115 waiver submitted in October 1996 addressing children’s health care was later abandoned due to the coming of SCHIP (Kegler, 2002).

#### ***Women’s Health Waiver***

Senate Bill 747 authorizing a demonstration project for women’s health care services was passed by the 79th Texas Legislature in May 2005, and the Texas Health and Human Services Commission and the Texas Department of State Health Services developed an 1115 waiver that was submitted to CMS. The waiver states four key elements of the demonstration project, which are to increase eligibility for Medicaid family planning services to women aged 18 and older with a net family income at or below 185 percent of the federal poverty level, to minimize obstacles to enrollment in family planning services, to identify women at risk of cardiovascular

disease and diabetes, and to pilot culturally appropriate outreach efforts to Hispanics. Services to be provided include health evaluation and physical examination, family planning services including education about all FDA-approved methods of contraception except emergency contraception, screening for various diseases and conditions, and referral to an appropriate specialist if needed. Abortions and emergency contraception are not covered. The women's health waiver concludes that the waiver would provide Medicaid family planning services to approximately 1.5 million more women in Texas and that it would result in savings of over \$430 million to Texas and the federal government over the five-year waiver period (THHSC, 2005c).

A women's health waiver would take advantage of the 90 percent federal Medicaid match as well as the "cost-beneficial nature of family planning services" to expand women's health and family planning services to millions of low-income and uninsured women at or below 185 percent FPL (Romberg, 2004). Waiver proponents point out that less than 25 percent of the over 4 million eligible women in Texas (at or below 185 percent FPL) receive care because of the lack of affordable care and/or affordable insurance. This is because the Medicaid income eligibility level for non-pregnant women is currently much lower. The waiver is expected to meet budget-neutrality requirements, and to produce significant cost savings, as the costs for services would be offset by savings from otherwise Medicaid-paid prenatal care, deliveries and newborn care.

#### *HIFA Waiver*

A new type of 1115 waiver is the Health Insurance Flexibility and Accountability demonstration initiative, or HIFA waiver, announced by the Bush Administration in August 2001. This waiver,

applicable to both Medicaid and SCHIP, is mainly intended to encourage new statewide approaches to increasing health insurance coverage, and proposals that meet HIFA guidelines will receive expedited review. Programs should be budget-neutral and maximize private insurance options using Medicaid and SCHIP funds for people below 200 percent FPL (CMS, 2004c).

HHSC submitted an 1115 HIFA waiver to CMS for an SCHIP premium assistance program in December 2004, and if approved, the program could begin in 2006 (THHSC, 2004d). This SCHIP buy-in program, authorized by House Bill 3038 of the 77th Texas Legislature and Senate Bill 240 of the 78th Legislature, would allow state and federal SCHIP funds to be used to pay part of the premiums to enroll eligible individuals into private health insurance plans. Texas already has a premium assistance program in place for Medicaid, called HIPP, or the Health Insurance Premium Payment program (THHSC, 2004a).

#### *Other Waivers*

There are three 1115 waivers for city-level demonstration projects authorized by House Bill 3122 of the 78th Legislature that have not been formally submitted to CMS yet. The HB 3122 Task Force was created through this bill to explore the feasibility of the development of local expansion waivers that would seek to use local funds for the state Medicaid match to draw additional federal Medicaid matching funds to their areas. General outlines of these waivers were submitted for preliminary review, and CMS responded that more discussion would be needed on the proposals, especially on the subject of limited enrollment options (Fenz, 2003). Currently the El Paso County Hospital District, Austin/Travis County,

and Bexar County Hospital District local waivers are under review by this task force. These waivers propose to use the additional federal dollars that the local match would obtain to fund local programs to cover uninsured low-income parents not currently eligible for other programs.

### **1915 WAIVERS**

There are two types of waivers allowed under Section 1915 of the SSA, 1915(b) and 1915(c) waivers. Section 1915(b) waivers are generally granted for two years at a time and permit states to waive Medicaid's freedom-of-choice requirement regarding providers, thus letting states require enrollment in managed care plans or create local programs not available statewide. The savings from managed care often allows states to provide additional services to Medicaid beneficiaries (such as non-medical support services that are not otherwise covered by Medicaid).

Section 1915(c) waivers let states develop innovative alternatives to institutionalization, and are approved initially for three years, with five-year renewal periods. The waivers allow states to provide home- and community-based services that help keep Medicaid beneficiaries out of nursing homes, hospitals and other institutions in order to maintain their independence and family ties as well as save money. The waivers cover elderly people or people with physical or mental problems who would qualify for Medicaid if they were institutionalized, and the programs must be budget-neutral (HHS, 2001).

Texas currently has five 1915(b) waivers for Medicaid managed care and hospital contracting and seven 1915(c) waivers for home- and community-based services (THHSC, 2004a).

### **SECTION 1931**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) added Section 1931 to the SSA, which allows states to end Medicaid eligibility to low-income parents who are not receiving cash assistance. States must cover, at a minimum, those parents with incomes below those required in 1996 for welfare, whether or not they receive welfare now, ensuring that those eligible before PRWORA was passed remain eligible. States may also cover those with higher incomes, which a majority of states do. Section 1931 gives states more flexibility to cover low-income people by increasing income and assets disregards and limits. Changes can be made by amending the state's Medicaid State Plan instead of applying for a federal waiver. Enrollments can effectively be capped by changing eligibility criteria and certain benefits for new recipients in case of budgetary pressures, so expansion through Section 1931 does not create an entitlement program. Section 1931 expansions also do not have to be budget-neutral like waivers do (Birnbaum, 2000). Texas has not implemented Section 1931 expansions.

### **MEDICAID AND SCHIP EXPANSION**

#### **OPTIONS FOR TEXAS**

Besides the current waivers being proposed to expand coverage, there are several other ideas Texas is pursuing or could pursue to expand coverage.

#### **ELIMINATION OF INCOME DISREGARDS/ASSETS TESTS FOR SCHIP**

The 78th Texas Legislature implemented a number of policy changes that led to a decline in the number of SCHIP-covered children in Texas. Among these changes were the elimination of income disregards and the implementation of asset testing. In order to expand coverage Texas could reverse these changes.

### ***PRENATAL CARE UNDER SCHIP***

The definition of “child” for SCHIP purposes was revised by CMS effective Nov. 1, 2002, to include children from conception (instead of birth) to age 19, allowing for an opportunity to extend prenatal care to more women (CMS, 2002; HHS, 2002).

Rider 70 of Article II of the state budget passed by the 79th Legislature authorizes the state to expand SCHIP eligibility to unborn children who meet certain criteria, regardless of the eligibility status of the mother, including unborn children of low-income undocumented pregnant women. The benefit and eligibility belong to the unborn child and not the mother, so additional women and unborn children can receive prenatal care and other related services. This will cover women with incomes of 186 to 200 percent FPL who make too much to qualify for Medicaid, plus women at zero to 200 percent FPL who are not otherwise eligible due to immigration status. Medicaid-eligible children will be switched from SCHIP to Medicaid by their first birthdays.

Safety-net hospitals throughout the state already provide prenatal care to some of this population using local dollars, so having SCHIP cover them allows federal matching funds to be obtained to cover a majority of these expenses. This new SCHIP program is projected to cover about 48,000 perinates in FY 2007; about 8,300 would not have had coverage otherwise, and over 39,000 would have been eligible for Medicaid under current rules (Dunkelberg, 2006).

### ***OTHER SCHIP/MEDICAID PREMIUM ASSISTANCE PROGRAMS***

Texas could develop a new public-private partnership model in which a health plan is developed specifically for small businesses. Such plans use either a state-designated board or a private insurer to administer the plan, and the state subsidizes

premiums for low-income workers. This model is similar to Maine’s Dirigo Health. These plans can, using a waiver, reduce the benefit package, and take advantage of Medicaid or SCHIP funds (Silow-Carroll & Alteras, 2004).

### ***SECTIONS 1931 AND 1902(r)(2)***

One of the easiest mechanisms Texas could use to expand coverage is to take advantage of Section 1931 and Section 1902(r)(2) of the SSA. As described previously, Section 1931 of the SSA allows states to extend Medicaid coverage to low-income parents with children (above the TANF limits) by income and asset disregards. To expand coverage to these parents, all that is needed is an amendment to the State Medicaid Plan. This method allows the state to later tighten eligibility criteria to scale back expansion if needed and to alter benefits. Similarly, Section 1902(r)(2) allows a state to use less restrictive income and resource methodologies when determining eligibility for Medicaid. This can also be done through a state plan amendment. Both of these options require additional state general revenue (GR) match dollars.

### ***HYPOTHETICAL 1931/HIFA***

Another expansion option for Texas takes advantage of the flexibility afforded in HIFA waivers to expand to both the 1931 (optional) population and to an additional (expansion) population of non-disabled, childless adults. Basing the HIFA cost savings on a hypothetical 1931 expansion to the full Medicaid package of benefits (that would be more costly to the federal government for less coverage), the state could offer a reduced benefit package to the 1931 population and with the “savings” cover additional childless adults (LBJ, 2003). See Appendix B for more details and estimated costs and impacts of possible alternatives. Also, note that if this waiver

option were implemented, the medically needy spend-down eligibility could be extended to adults not living with dependent children, which could help reduce uncompensated care in hospital emergency rooms and help fund trauma care.

#### ***MEDICALLY NEEDED SPEND-DOWN PROGRAM***

Funding for the Medically Needy spend-down program for parents with dependent children was discontinued in House Bill 2292 of the 78th Legislature (2003). It is inactive with the option of continuing it if sufficient funds are available. Spend-down for pregnant women and children is still in place, which is mandatory for states choosing to have a Medically Needy program. The spend-down part of the program allows temporary Medicaid coverage for pregnant women and children (and before 2003 also included non-aged, non-disabled parents or caregivers with dependent children) with high medical bills who make too much to qualify for Medicaid but whose earnings after medical bills are subtracted would be reduced to qualifying levels. The qualifying level for a family of three is currently \$275 in income per month or less, as well as \$2,000 or less in assets. Texas' program did not include the blind, disabled or elderly before 2003, so parents/guardians of dependent children were the only group that was discontinued. Non-disabled non-elderly childless adults are not eligible to receive Medicaid under any program, so covering them under the Medically Needy program would require a waiver (THHSC, 2004).

HHSC projects that re-establishing the Medically Needy program would cost \$241.3 million in All Funds (\$94.9 million GR) in 2006 and \$276.4 million in All Funds (\$109.2 million GR) in 2007, with costs increasing in subsequent years. HHSC projects that the increase in average monthly

recipient months (clients) would be 10,118 in 2006, 10,918 in 2007, 11,796 in 2008, 12,745 in 2009, and 13,769 in 2010 (THHSC, 2004).

#### ***TICKET TO WORK AND MEDICAID BUY-IN***

The Ticket to Work Program, established in 1999 through the Ticket to Work and Work Incentives Improvement Act, was designed to support individuals with disabilities in their employment and help with employment retention efforts using infrastructure and demonstration grants to provide Medicaid and other services to eligible individuals. Under this authorization, House Bill 3484 was passed by the 78th Legislature to study the establishment of a Medicaid buy-in program to allow certain beneficiaries in Texas to work without losing their Medicaid benefits. Senate Bill 566 of the 79th Legislature directs HHSC to develop and implement a Medicaid buy-in program for certain disabled people who earn too much to qualify for Medicaid to pay sliding-scale premiums to obtain Medicaid coverage. Working disabled people would have to earn less than 250 percent of the federal poverty level to be eligible. The program could be implemented as soon as September 2006, and is projected to serve about 2,300 people in 2007 (Dunkelberg, 2006).

#### ***COVERING LEGAL PERMANENT RESIDENTS***

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) required states to implement a five-year wait period for legal permanent residents arriving after August 1996 to receive Medicaid or SCHIP. The act left it to the states' discretion whether or not to allow coverage after the five years. To date, Texas has not taken advantage of this coverage expansion option. This option requires only a state plan amendment.

## OTHER OPTIONS

Several states including Florida have proposed a fundamental restructuring of their Medicaid programs to control growing costs. The State of Florida submitted a Section 1115 waiver to change its Medicaid program to reduce spending growth, increase predictability of costs, and increase market competition, and CMS approved the waiver in October 2005. The waiver will be implemented as a pilot program in two counties, and will eventually be expanded to cover all beneficiaries and services statewide within five years, subject to legislative approval. Florida Medicaid is currently a defined benefit program, but under the waiver it will become a defined contribution program, where the state will pay risk-adjusted premiums for the coverage option chosen by the beneficiary, including several managed care plans and individual or employer-sponsored insurance, if available. This means that the program is moving away from the concept of shared risk as people will be in different plans and their premiums will be based on estimated individual risk. Managed care plans will now be able to determine benefits for adults, subject to minimum requirements and state approval. A maximum annual benefit limit will be implemented for adults, and if a beneficiary's expenditures reach this amount, the state and insurance plan will not be responsible for additional costs (the amount has not been determined, and pregnant women and children are excluded). Changes such as these could have national implications if more states follow this approach (Kaiser, 2005).

## SUMMARY

The federal government has two key programs to address low-income individuals without health insurance under the age of 65: Medicaid and SCHIP. Although both programs have mandated

coverage, states are allowed to expand coverage and benefits, often by using one of the waivers provided for by the SSA. In order to address the increasing uninsured population in Texas, the state needs to consider broader use of these waivers, as well as other strategies, to increase enrollment and expand coverage for low-income individuals.

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