REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE *(DD-MM-YYYY)*	2. REPORT TYPE	3. DATES COVERED *(From - To)*
15-04-2009	FINAL REPORT	JULY 2008 to JULY 2009

4. TITLE AND SUBTITLE
Proposed Solutions for the Continuance of the Texas State Children's Health Insurance Program

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

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5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Greater San Antonio Hospital Council
7500 US Hwy 90 West, Suite 210
San Antonio, TX 78227

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
US Army Medical Department Center and School
BLDG 2841 MCCS-HE-HA (Army-Baylor Program in Health and Business Administration)
3151 Scott Road, Suite 1411
Fort Sam Houston, TX 78234-6135

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSORING/MONITORING AGENCY REPORT NUMBER
34-09

12. DISTRIBUTION AVAILABILITY STATEMENT
Approved for public release; distribution is unlimited.

13. SUPPLEMENTARY NOTES

20100401052

14. ABSTRACT
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15. SUBJECT TERMS
Greater San Antonio Hospital Council, Texas CHIP, SCHIP, CHIP

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			Education Technician
U	U	U	UU	52	19b. TELEPONE NUMBER *(Include area code)* (210) 221-6443

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Running Head: TEXAS STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Proposed Solutions for the Continuance of the Texas State Children's Health Insurance Program

Graduate Management Project

Capt Dawn Rose

U.S. Army-Baylor University Graduate Program

in Health Administration

Preceptor: Bill Rasco, Col (ret), USAF, MSC

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April 2009

Acknowledgements

There are several individuals deserving much credit for their mentorship, guidance, and support through the completion of this project. To my husband Marty, without you and your undying support, I would not have survived the last two years. This project is as much yours as it is mine. My children, Megan and Dallas, I hope I have given you as much inspiration as you give me everyday. You motivate me to do my best in all that I attempt. Because of you, I take challenges I normally would not. I thank you both and I love you all with all my heart and soul.

Mom, Dad, Trudy, and Jim; I cannot thank you enough for your loving support to help make our family who we are today. I strongly believe Marty and I would have lost our sanity a few times had it not been for the four of you. We thank you for all you have done. Know your deeds have not gone unnoticed. We love you more than I can express in this brief acknowledgement.

Thank you, Maj Brezinski, my reader, for amazing support and belief in me. You never doubted my ability to make something of this topic and have supported my pursuit of a resolution wholeheartedly. I appreciate your taking the time to go over my work repeatedly and for being honest with me about necessary edits, updates, and focus. Thank you.

I absolutely have to thank MAJ Kimberly Brenda (Kim) for putting up with me during our residency year. You listened to my incessant whining when I was ill and helped me out when I could not find the words. You are a fantastic word smith and a fantastic friend. For that, I thank you. I am so glad that we had the opportunity to complete our residency together.

I extend humble thanks to Mr. Bill Rasco for providing me with a once in a lifetime opportunity. Your mentorship and guidance have proven invaluable. The opportunities to excel have been infinite and I will forever be grateful for the time spent at the Greater San Antonio Hospital Council. It is a year that will not be soon forgotten.

Abstract

Although healthcare is not a right specified in the Constitution of the United States, many feel a social obligation to provide healthcare to the elderly, disabled, and children. The elderly and disabled receive health coverage benefits through Medicare and Medicaid. Established in 1997, the State Children's Health Insurance Program (SCHIP) is one of the mechanisms to provide uninsured children with health. The State Children's Health Insurance Program was up for renewal in August/September of 2007. President Bush twice vetoed renewal legislation; however, he did grant an extension of the program through March 2009. SCHIP has since been extended under the new Presidential administration; however, millions of children are still without insurance. Now that SCHIP renewal has been passed, the state of Texas will need to determine a level of support and a course of action to account for approximately 1.5 million uninsured children in Texas (Texas Health Care Primer, 2007).

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Introduction

Health coverage and insurance are currently hot button topics. While medical care is not a right defined by the Constitution of the United States, it is a concern our society has had for decades. In 1945, President Harry Truman sent a message to Congress requesting legislation to establish a national health insurance plan. A two-decade debate developed, with opponents advising the hazards of "socialized medicine" (http://www.seniorjournal.com, retrieved January 12, 2009). In 1965, President Lyndon Johnson was in office and had a vision for a "Great Society." He was no stranger to rural poverty. President Johnson learned empathy for the dearth of others when teaching students of Mexican descent at what is now Texas State University in San Marcos, Texas (http://whitehouse.gov, retrieved January 12 2009).

Amendments to the Social Security Act, commonly known as the Social Security Act of 1965, were borne from President Johnson's ideals of a great society and were signed into law in July. The act consists of amendments to the original Social Security Act passed over two decades earlier in the late 1930's. Established within the amendments were Medicare and Medicaid; health insurance programs for the elderly and the poor. These programs are funded by income taxes of employed individuals. According to www.ourdocuments.gov, almost 20 million beneficiaries enrolled in Medicare inside the first three years (retrieved January 12, 2009).

Medicare, as Title XVIII of the Social Security Act of 1965, focused primarily on providing medical care to the elderly. Due to the burgeoning elderly population and increases in healthcare costs, it became apparent that something must be done to assist individuals over the age of 65 (http://www.ourdocuments.gov, retrieved January 12, 2009). Over the years, disabled persons and children have been added to that focus as they are unable to care for themselves. They fall into a category that some of society accepts as deserving a right to healthcare. While all of these

groups are important, and healthcare is an issue for all of them, the focus of this paper is children's health coverage.

Millions of children are currently without healthcare because their families either choose to pay for their own medical care, which does not fall into the insured category, or cannot afford insurance coverage. To remedy the issues of access and affordability, Congress passed the State Children's Health Insurance Program (SCHIP) in 1997. Reauthorization of SCHIP is a controversial political topic in our federal government. There are many valid arguments for and against the program. The purpose of this paper is to review SCHIP legislation at the national level as well as in the state of Texas. The paper will illustrate the debate over the legislation, the current status of the legislation, as well as provide possible solutions for success of the program in Texas. For the purpose of this paper, SCHIP refers to the national program and CHIP refers specifically to Texas's program.

Background

Children's health insurance is important because uninsured children are more likely to have unmet medical needs than insured children (Takvorian, 2007). State Children's Health Insurance Program provides a healthcare safety net, along with Medicaid, for low-income children. State Children's Health Insurance Program is an effort to fill the coverage gap between Medicaid and those children whose parents can afford health insurance. Medicaid typically covers families whose wages are at or below 100 percent of the federal poverty level (FPL). The FPL is standard within the 48 contiguous states and varies for Alaska and Hawaii; it is determined based on the number of individuals within a family unit. According to the HHS, the FPL for a family of three in 2008 was $17,600 (retrieved January 6, 2009).

In general, those considered able to afford health insurance are families with an income above 200 percent of the FPL. When the program began in 1997, the FPL was approximately $16,602, for a family of three ("SCHIP at a Glance", 2007). State Children's Health Insurance Program is meant to capture those families with incomes between 100 percent and 200 percent of the FPL, which is currently $17,600 - $35,200 for a family of three.

In Texas, Medicaid extends eligibility to cover pregnant women under age 19 and infants whose family incomes are up to 185 percent of the FPL ($32,560). Pregnant women over the age of 19 are eligible if there income is up to 158 percent of the FPL ($27,808). Texas also offers Medicaid coverage to individuals in the "medically needy" group. This group consists of people whose income surpasses the Medicaid eligibility limits but do not have the necessary resources, such as money, to meet their medical costs (Texas Health and Human Services Commission, http://www.hhsc.state.tx.us/medicaid/index.html, retrieved January 6, 2009).

Federal guidelines assert that states can use SCHIP funds to create a separate SCHIP program, expand their Medicaid program, or adopt a combined approach (Takvorian, 2007). Benefits under each differ and funds are appropriated within the state budget according to which option is implemented. An explanation of each option, according to the American Academy of Pediatrics and Isong, PhD, follows below (http://www.aap.org/advocacy/schipcom.htm, retrieved January 6, 2009; Isong, 2006).

- **Separate SCHIP program, independent of Medicaid:** Subsidized health insurance is available for children. The insurance is accessible to eligible families on a sliding scale. The state has great flexibility under this option. Implementation is more difficult as a separate administrative organization would have to be created. Funds are not combined with Medicaid funds therefore the purchasing power of this type of

program is less effective. The state also chooses whether or not to offer dental benefits.

- **Expansion of current Medicaid program:** Income and asset guidelines for the current Medicaid program will be changed to include children under 19 years of age whose family incomes are up to 200 percent of the FPL. The state will be entitled to an enhanced Federal Medical Assistance Percentage (FMAP) for any child covered within the Medicaid expansion. Administratively, Medicaid expansion allows for quick implementation as the Medicaid program is already in place. All monies go into the Medicaid fund. The state must provide dental services that are mandated under the Early and Periodic Screening, Diagnosis and Treatment program to both current and newly eligible beneficiaries.
- **Combined approach:** The combined approached allows a state to operate both Medicaid and SCHIP programs at the same time. Both programs are federally matched with FMAP funds. The state is required to provide dental coverage to Medicaid beneficiaries but has the option of not providing dental coverage for SCHIP beneficiaries.

Texas chose the combined approach but did not implement its CHIP program right away. In fact, there were two phases of implementation. Phase I was the expansion of Texas's Medicaid program. Phase II was the implementation of the separate CHIP program (Hawkes & Hill, 2002). According to the Texas Health and Human Services Commission (THHSC), the original plan was to expand Medicaid. The state bill for CHIP execution was not passed until 1999 and it was not until the year 2000 that any children were enrolled in the program (THHSC, retrieved October 5, 2008). In the state of Texas, Medicaid covers children age birth to one year in

families whose annual income is within 0 – 185 percent of the FPL. Children ages one to five are eligible for Medicaid if their family's income is 133 percent of the FPL or below. Children ages six to nineteen are eligible if their family's income is 100 percent of the FPL or less (http://ccf.georgetown.edu/index/tx-programfacts, retrieved April 22, 2009). CHIP covers those not eligible for Medicaid whose incomes fall within the 0 – 200 percent bracket of the FPL (J. Banda & J. Berta, personal communication, September 24, 2008).

As of February 12, 2009, eligibility for CHIP is determined using household income. If a family's household income is at or below 150 percent of the FPL, they are not subject to what is called an asset test. An asset test is used to figure out the level of countable assets within a household. Families whose income exceeds 150 percent of the FPL are subject to an assets test. Countable assets include those that can be easily converted to cash, such as bank accounts and savings certificates, and vehicles. The countable asset limit for a family with income greater than 150 percent of the FPL is $10,000. If a family's assets exceed this limit, they will have to fill out a CHIP asset questionnaire and may not be eligible to receive CHIP benefits (www.chipmedicaid.org, retrieved February 12, 2009).

Other CHIP eligibility requirements include residency and lack of third party insurance. Children cannot have private insurance and be covered by CHIP at the same time. In fact, if a family has private insurance that costs less than 10 percent of its gross income, that family is not eligible for CHIP. If the insurance costs more than 10 percent of the family's gross income, the family must discontinue the insurance before CHIP coverage can commence. U.S. citizens, Legal Permanent Residents, and non-citizens who meet Alien Status requirements and are ineligible for Medicaid may apply for CHIP. The residency requirement is met if a child lives in Texas or

intends to make Texas his/her home. Inclusion of a Texas residence on the application is considered intent to make Texas their home.

Once eligibility and qualification are determined, there is a matter of cost. The State Children's Health Insurance Program is not an entitlement program like Medicaid. While Medicaid health coverage is supplied at no cost to qualified families, the Texas CHIP program has costs associated with it. Costs to qualified applicants are based on the family's income. To prevent an inability to afford premiums and co-pays, a cap of no more than 5 percent of a family's income is in place for families whose earnings are greater than 150 percent of the FPL. According to the Texas CHIP website, enrollment fees will not exceed $50 per family for a 12 month term of coverage, and most co-payments for both doctor visits and medicine average anywhere from $3 to $10 (http://www.chipmedicaid.org, retrieved February 12, 2009). More information can be found at www.chipmedicaid.org.

Literature Review

While Medicaid covers many of the uninsured, an identified need to provide healthcare coverage for children not eligible for Medicaid exists. Children rely on their parents or guardians to provide many things, the ability to receive healthcare being one of them. Not all guardians can or do provide healthcare treatment for their children. While children's health coverage was a concern voiced by some, the issue became more prominent in the 1980's and 1990's. In fact, the Omnibus Reconciliation Act (OBRA) of 1986 allowed for the increase of the Medicaid income eligibility threshold for children, age five and under, to 100 percent of FPL. Before this, the eligibility was reserved for families who met the Aid to Families with Dependent Children income requirements (http://www.kff.org/medicaid/, retrieved April 20, 2009). According to http://www.senate.gov (retrieved February 6, 2009), a reconciliation bill is:

> A bill containing changes in law recommended pursuant to reconciliation instructions in a budget resolution. If the instructions pertain to only one committee in a chamber, that committee reports the reconciliation bill. If the instructions pertain to more than one committee, the Budget Committee reports an omnibus reconciliation bill, but it may not make substantive changes in the recommendations of the other committees.

The purpose of the OBRA 1986 was to permit considerable policy making through the Congressional budget development process while providing a quick legislative path around the Senate filibuster (Lindblom, 2008). This method allows for easy amendments to existing policies and laws, such as those affecting Medicaid, Medicare, and SCHIP.

SCHIP is Title XXI of the Social Security Act of 1965 and is an integral part of the Balanced Budget Act of 1997 (BBA 97). The purpose of BBA 97 was to meet the spending cutback requirements of the reconciliation instructions of House Continuing Resolution 84, which passed the Senate on June 5, 1997, by a 76-22 vote. The reduction was approximately $137 billion over five years (http://www.senate.gov/~rpc/releases/1997/ RECON.htm, retrieved May 29, 2008). According to the June 20, 1997 Senate Budget Committee report,

> BBA 97 provides for an enormous expansion in the federal effort to extend health insurance to those children currently uninsured. This legislation contains an additional $16 billion specifically designed to provide health insurance to 5 million additional children (http://www.senate.gov/~rpc/releases/1997/ RECON.htm, retrieved May 29, 2008).

As with any legislation, SCHIP was developed through the policymaking process. The process includes three phases – formulation, implementation, and modification as seen in Figure 1 (Longest, 2006).

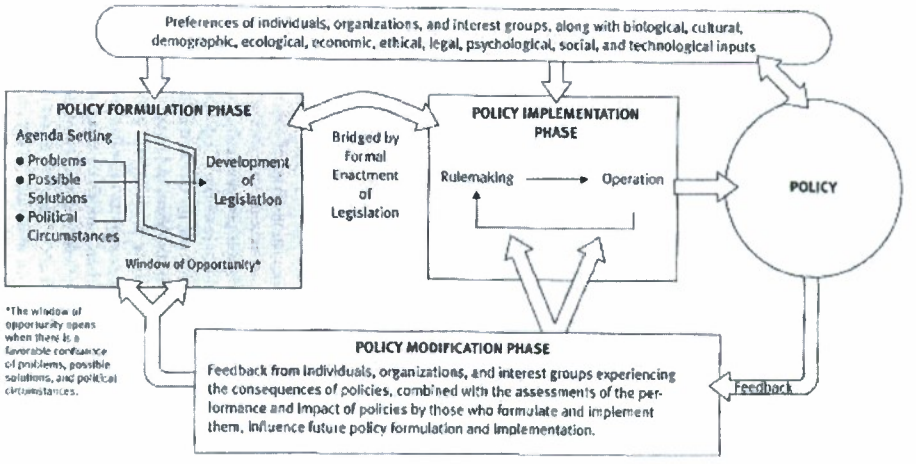

Figure 1. A Model of the Public Policymaking Process in the United States: Agenda Setting in the Policy Formulation Phase.

[1] From Longest, B.B., Jr. (2006). Health policymaking in the United States. (4th ed.). Illinois: Health Administration Press.

Policy formulation has two interrelated parts; agenda setting and legislation development. Policy formulation often leads to new civic laws or improvements to existing laws. According to Longest, health related laws or amendments to laws begin through diverse interactions of health-related problems, potential solutions to said problems, and ever-changing political circumstances (2006). The political situations relate to the problem and its possible resolution. In the case of SCHIP, one of the problems presented during agenda setting was that 1995 census data showed approximately 13.8 percent (10 million) of children under the age of 18 were uninsured. Once this problem was presented, possible solutions and political implications were evaluated before developing legislation.

Once a policy is formed and made into law, the policy enters the implementation phase. This stage involves two correlated sets of activities; rulemaking and operation. In rulemaking, formal rules and regulations essential to carry out the intent of the public laws are established.

Operationalization entails determining what actions are required to measure and fulfill the purpose of the law. For example, if the objective of a policy is to protect individuals from exposure to lethal substances, its operation activities involve supplying such protection. The State Children's Health Insurance Program was no exception. Congress determined and set forth baseline rules that each state must follow prior to implementing the policy. Included in the guidelines were specific options for providing children's healthcare, standards of benefits provided, and annual federal funding limits (Lambrew, 2007).

Although extended, SCHIP is currently in the modification phase of policymaking. After 10 years of existence, it is now time to determine what has worked, what has not worked and the effectiveness, or need, for the program. Efficiencies are also being examined, the extent of which have yet to be realized. The modification phase is highly significant, as the future destiny of the program will be determined, including continuation or dissolution. Inarguably, it has been determined that children's healthcare coverage is necessary; however, many ongoing issues such as funding could lead to dissolution.

Problem Statement

Although Texas has a combined program, with both Medicaid and SCHIP, thousands of children in Texas rely specifically on CHIP for healthcare. There are millions more who are still without insurance. Recent data estimate that nearly nine million children are uninsured in the U.S with over 1.4 million of those in Texas (Takvorian, 2007; Children's Defense Fund Texas [CDF], 2007; Dunkelberg, 2007). The number of uninsured children in Texas, whose family income falls below 200 percent of the FPL, is around 919,000 according to census estimates. Nearly 230,000 of these children are undocumented. This equates to about 689,000 documented children who are eligible for coverage that still need to be insured (Dunkelberg, 2007).

The problem is two-fold. First, SCHIP is extended for a period of 4.5 years, but there are still hundreds of thousands of children in Texas currently without medical coverage and are still in need of coverage. The need for a program such as SCHIP increases during an economic downturn, like the one the U.S. is currently experiencing. The second problem is that even though the program has been extended future funding is questionable as there is no guarantee that Texas will have or spend the state funds necessary to draw down the matching federal funds in order to insure more children. The funding of the Texas CHIP program is vital to both the children who are current beneficiaries of the program and those who remain uninsured. Because CHIP covers those not eligible for Medicaid, their chances of receiving healthcare coverage decrease considerably without a program such as CHIP.

Studies have shown that children who receive healthcare are more likely to be healthier adults. The purpose of the report, Overcoming Obstacles to Health, from the Robert Wood Johnson Foundation (RWJF) to the Commission to Build a Healthier America, is to observe the function of personal and societal responsibilities regarding health (Braveman & Egerter, 2008). The focus areas are those in which people tend to be influenced such as where an individual lives, works, and learns. The belief is that these focus areas influence both the choices afforded to people and the individual's capacity to formulate healthy choices. Common sense allows us to believe that higher income families can afford healthcare more easily than lower income families.

The data in the RWJF report show that children in impoverished families are seven times more likely to be in poor health as children in higher income families. Underprivileged adults are five times more likely to be in poor health than adults with higher incomes. Analyses of this data reflect a striking pattern between lower income and poor health. Based on the results of this

report, it is not too far of a stretch to see that consistent healthcare results in better health decisions made by an individual. Providing access to services is one step towards giving individuals more opportunity to receive health care and make better decisions based on the education they receive when getting said health care. Behavior is just one aspect of a complex model; however, knowledge tends to lead to action (Jette, Cummings, Brock, Phelps, & Naessens, 1981). If access is provided, lack of access is no longer a barrier to care. According to the Health Beliefs Model, described in The Structure and Reliability of Health Belief Indices, a prompt must happen in order to cause an appropriate health action (Jette, et al, 1981). While access to health care does not ensure a healthy individual, it does increase one's chances of being diagnosed with an illness earlier, therefore possibly preventing a greater health care burden and cost should he/she not be diagnosed until later. One can posit that if a person is diagnosed and educated in the early stages of illness, that person has the knowledge to make better decisions regarding their health. A pictorial depiction of the affects of better health decisions on both the individual and society is located in Appendix A. Not only will better decisions lead to less expenditure on health services in the future, but they also provide an opportunity to live longer, healthier lives, therefore prolonging one's ability to be a productive member of society (2008).

Indicators show that healthy children have better school attendance, learn better and are more likely to grow up as more productive members of society than they would have been had they not been healthy ("Growing up Healthy", 2005). The HHSC, National Institute of Health, Centers for Disease Control and Prevention (CDC), as well as the US Environmental Protection Agency are in the process of conducting a longitudinal cohort study tracking 100,000 children from before birth to age 21. The purpose of the study is to determine the effect of environmental factors on health and development. The goal of the study is to improve the well-being of children

(http://www.nationalchildrensstudy.gov/Pages/default.aspx, retrieved April 6, 2009). Similar to the RWJF study, the National Children's Study seeks to explain the roles of environmental factors on an individual's health. Each subject participating in the study will be tracked over time for growth and development. The fundamental principle of both studies is that a healthy child generally results in a healthy adult. State Children's Health Insurance Program provides an opportunity for children to receive healthcare, increasing their chances of becoming healthy adults as well as prolific members of society. While not a comprehensive solution, the two studies mentioned seek to determine the correlation between an opportunity in access to health care and health status as an adult.

The RWJF study alludes to the notion that the health of a child often predicts his or her health as and adult. For example if a child does not receive dental care, and has poor dental health, he or she is more likely to have greater dental problems as an adult (2008). Turner states that it costs less to provide health coverage for a child than an adult, and a healthy child has a great chance of becoming a healthy adult (2009). The premise of this notion is that it will cost society a lot less money if children have adequate health care coverage and access and will not be as much of a burden on the health care system as adults. To put this in perspective, uncompensated care given to adults who were uninsured for a full year, in 2004, totaled $26.3 billion. The cost for uninsured children who received uncompensated care that year was $3.6 billion (Hadley & Holahan, 2004).

Federal Funding

At inception, Congress appropriated almost $40B for SCHIP, covering a 10-year period through block grant funds. Block grant funds are monies that the federal government appropriates to state governments. States have autonomy to use the funds as deemed necessary

with minimal executive oversight from the federal level. States administer the program under broad federal guidelines. Executive oversight for the program's funding is minimal. If states follow the guidelines of the SCHIP policy, they have autonomy to use funds as deemed necessary. Currently, 18 states operate SCHIP programs, 11 expanded their Medicaid programs, and 21 took the combined approach (Ryan, 2007). Texas currently has a SCHIP-funded Medicaid expansion program as well as a stand alone SCHIP program called CHIP (Kaiser State Health Facts [KSHF], http://www.statehealthfacts.org/chfs.jsp?rgn=45&rgn=1, retrieved October 6, 2008).

States receive annual allocations for SCHIP. The funds are capped "on a matching basis for federal fiscal years 1998 through 2007" (Ryan, 2007). In other words, federal monies match a state's expenses up to its allotment amount. SCHIP matching rates differ by state because they are based on the Medicaid FMAP rates that also differ by state. SCHIP matching rates range from a low of 65 percent in Virginia and other states to a high of 84 percent in Mississippi (Bergman, Pernice, & Williams, 2004). It is important to note that SCHIP federal allocations are fixed which means new costs associated beyond a certain level of enrollment must be completely borne by the state (Garrett & Holahan, 2009). The SCHIP enrollment report for all states can be found in Appendix B. Texas has a reported average match rate of 72 percent since 2003 (KSHF, retrieved October 6, 2008). In essence, for every .28 cents the state of Texas spends towards its CHIP program, the federal government will provide .72 cents. States receive these allotments annually and each state has a three-year period in which to spend its allotment (Owcharenko, 2007). The federal government reallocates unspent funds to states that have already spent their allotments. For example, if Texas does not spend its federal allotment, the monies will be reallocated to another state that has depleted its allotment. States that receive the redistributed

funds have one year to spend the monies (Ryan, 2007). States can cap their beneficiary enrollment in order to control SCHIP spending.

For the most part, block grants are intended to supply federal funds to states for a limited amount of time. According to Finegold, Wherry, and Schardin, block grants became an integral part of the American federal system in 1966 (2004). Democratic initiatives led to the enactment of the first block grants. The Partnership for Health program and the Safe Streets program were the first two block grants passed during President Johnson's administration. Together, these two block grants represented less than one percent of all federal aid given to state and local governments at the time. In 1960, federal spending on children was approximately 1.9 percent of the Gross Domestic Product (GDP); by 2006, this percentage increased to 2.6 percent (http://urbaninstitute.org/UploadedPDF/411432_Kids_Share_2007.pdf, retrieved March 10, 2009).

The popularity of block grants grew under a Republican controlled Congress. Originally, the purpose of block grants was to replace existing categorical grants or provide federal funding in innovative policy areas (Finegold, et. al., 2004). More recent block grant initiatives, such as those of the 1990s and 2000s, symbolize a redirection of fiscal policy. The most recent block grants eradicate individual entitlements to services and substitute them with predetermined grants to each state and SCHIP is no different. The original block grant was for a 10-year period and funding was capped every year.

State Funding

According to Ryan, states finance SCHIP in a number of ways (2007). In addition to the federal allotments received, general revenue funds, cost sharing, and special revenue funds are a few avenues states can take to finance their respective program. Cost sharing alleviates the

overall cost borne by the state and happens through either a co-payment at each medical visit or a monthly premium. A family whose income is less than 150 percent of the FPL generally pays no more than $5 per visit. A cap of no more than 5 percent of a family's income is in place for families whose earnings are greater than 150 percent of the FPL. Initial CHIP cost sharing was put into practice in the second implementation phase of the program. For families under 100 percent of the FPL, no enrollment fees, premiums, deductibles, or copayments are mandated. For eligible families above 100 percent of the FPL, cost sharing is required and the amount payable depends on the percentage category the family falls within. For example, a family with an income between 100 percent and 185 percent of the FPL would pay a $15 enrollment fee and a $15 monthly premium; whereas a family whose income falls between 186 percent and 200 percent of the FPL would pay an $18 enrollment fee and an $18 monthly premium (Cooke, 1998). The cost sharing feature has fluctuated throughout the years and, along with other policy changes, has had an impact on enrollment numbers. Many policy changes, such as cost sharing, result from attempts to maintain the state budget.

Generally states are reluctant to pass laws that create increases in budget spending and Texas is one of those states (J. Banda & J. Berta, personal communication, September 24, 2008). In fact, the Texas Legislature enacted changes to its CHIP eligibility requirements and instituted benefit reductions in an effort to prevent an increase in the state budget. Proposed changes included increasing the waiting period for eligibility to 90 days, higher premiums for families with earnings between 101-150 percent of the FPL, as well as a cutback in uninterrupted coverage from 12 months to 6 months (Dunkelberg & O'Malley, 2004). The small shifts in eligibility requirements caused a significant decrease in CHIP enrollment (Dunkelberg, 2006). Table 1 below shows the correlation between these policy changes and decrease in enrollment

for years 2003 – 2006. Enrollment numbers have declined over the years due to different eligibility requirements and policy changes (THHSC, retrieved October 5, 2008). Comprehensive enrollment figures can be found in Appendixes C, D, and E.

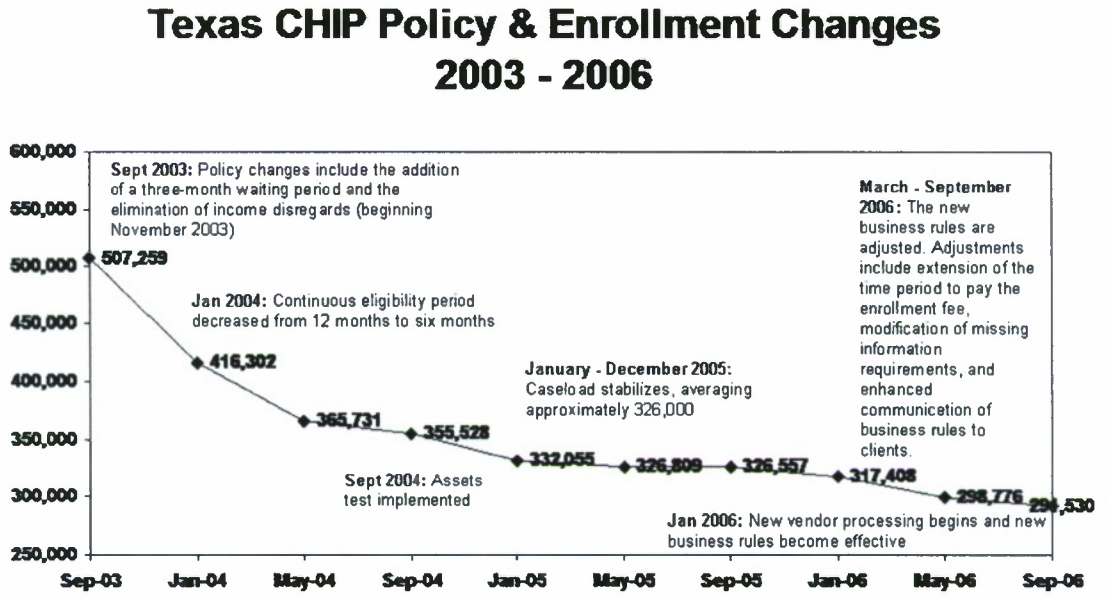

Table 1. The correlation of Texas CHIP Policy Changes and Enrollment; 2003 – 2006.

[2] From Texas Department of Health and Human Services, retrieved October 5, 2008.

Most states use special revenue funds in order to finance SCHIP. Texas State funding for its CHIP program is derived from the state's tobacco settlement pool. The program holds the top funding priority from tobacco monies. Tobacco settlement revenue is unstable as it does not afford the state the equivalent security as other states' committed funding streams. The Texas legislature and the governor possess the ability to adjust the amounts dispersed to an assortment of health-related programs (Bergman et al., 2004). In addition to adjusting the amounts allotted for programs, the actual tobacco settlement payments vary as they are based on tobacco sales, inflation, and industry profitability (http://www.dshs.state.tx.us/tobacco/settlement.shtm,

retrieved February 2, 2009). Under the settlement terms for Texas, settlement payments increase and decrease in proportion to U.S. consumption of cigarettes each year as compared to consumption in 1997 when the tobacco settlement was awarded. In addition to the use of tobacco settlement funds, Texas implemented cost sharing in its CHIP program.

The current economic downturn may be the final ingredient in a recipe for disaster when it comes to healthcare policy. During a recession the unemployment rate increases due to job losses. Families who depend on employer sponsored health coverage lose that coverage and may turn to Medicaid or SCHIP. According to Dorn, Garrett, Holahan, and Williams, an increase of one percentage in the unemployment rate leads to a 3 to 4 percent reduction in state revenues (2008). The decrease in revenue could prove harmful to the fate of CHIP as reductions in state revenue lead to budget cuts for all state programs. Such cutbacks are likely to have negative effects on tax revenue, employment income and state level economic output (Garrett & Holahan, 2009). Traditionally, states must balance their budgets. All state expenditures could be cut proportionately; therefore CHIP theoretically faces a 3 to 4 percent fiscal cut (Dorn, et al. 2008). In other words, at a time when enrollment is increasing due to the poor economy, revenue to support the program is decreasing. If state spending for CHIP is cut, the economic downturn is only exacerbated as this action magnifies economic fluctuations.

Benefits

Although benefits through Medicaid are more substantial, SCHIP allows states to have more flexibility than they have with Medicaid (Weil, Wiener, & Holahan, 1998). SCHIP is not an entitlement program; therefore, states can cap enrollment (Maley, 2005). The program is modeled on private insurance (states' employees' coverage). Because it is not an entitlement program, children are not entitled to a defined set of benefits. Benefits generally include, but are

not limited to, primary care, emergency care, immunizations, well-baby checks and preventive screenings (Ryan, 2007).

When determining appropriate benefits offered under SCHIP, states have two main options. They can base benefits on benchmark coverage or benchmark-equivalent coverage. Benchmark coverage is coverage equal to that of a benchmark benefits plan, such as the State's Employee plan. Benchmark-equivalent coverage is coverage that is not identical to a benchmark plan but is deemed appropriate by the Secretary of Health and Human Services. Texas chose benchmark-equivalent coverage. Currently, some of the services covered under the state's CHIP plan are outpatient primary care services, pharmaceuticals, x-rays, lab services, vaccines, vision, and dental services (http://www.chipmedicaid.org, retrieved January 29, 2009). A comprehensive list can be found in Appendix F (THHSC, retrieved October 5, 2008).

Beneficiaries

Nationwide, around 6.6 million children were beneficiaries of SCHIP in 2005 (Iglehart, 2007). Appendix B reflects 2007 nationwide child enrollment numbers, which do not greatly differ from 2005 (www.cms.hhs.gov, retrieved April 24, 2008). State Children's Health Insurance Program targets low-income children whose families cannot afford private or employer based health coverage but do not qualify for Medicaid. At the time, the eligibility threshold for income was 200 percent of the FPL. According to Iglehart, when SCHIP began, roughly 6 percent of children, whose family incomes were above 200 percent of the FPL, were uninsured and approximately 23 percent of children whose family incomes were below 200 percent of the FPL were uninsured (2007). From Figure 2, one can infer that those with incomes at less than 200 percent of the poverty level gain the most from SCHIP, as the number of uninsured children whose families had incomes below 200 percent of the FPL decreased

dramatically with the implementation of SCHIP; however, the number of uninsured children whose family income was above 200 percent of the FPL remained consistent.

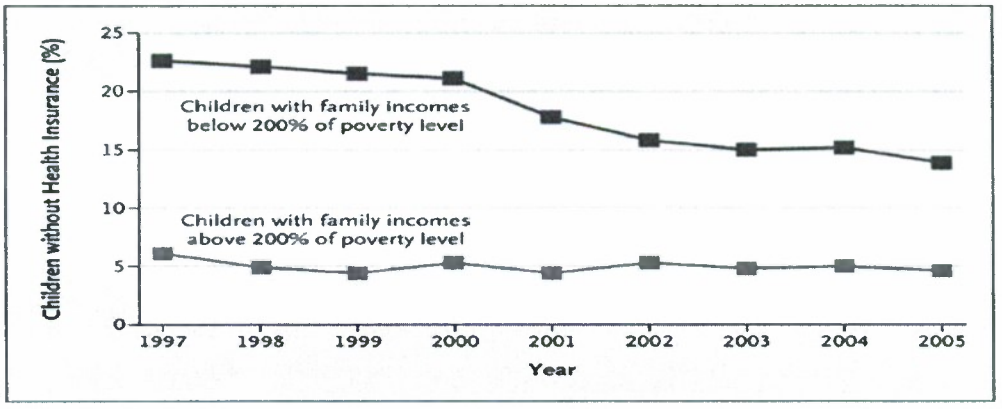

Figure 2. Percentage of Children without Health Insurance.

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[3] Data are from Ku, L. Medicaid: improving health, saving lives. Center on Budget and Policy Priorities analysis of National Health Interview Survey Data, August 2005.

According to the Texas CHIP website, http://www.chipmedicaid.com/english/index.htm, qualified beneficiaries of the Texas CHIP program include children age 18 or younger who are Texas residents, a U.S. citizen or legal permanent resident. Neither the parent's citizenship or immigration status are reported on the application form and do not affect the child's eligibility. Texas State employees may qualify for an insurance supplement for their dependent children under the age of 19 through CHIP. Texas also provides a CHIP Perinatal program in which Texas residents who are pregnant may benefit if qualified. Aside from pregnancy, prerequisites for the perinatal program include uninsured status, and inability to qualify for Medicaid. As recently as March 2009, more than 456,000 beneficiaries were documented in the statewide CHIP program (retrieved March 10, 2009).

Waivers

Section Demonstration 1115 waivers, allowable in the original SCHIP legislation, permitted unconventional uses of SCHIP monies ("SCHIP at a Glance", 2007). Under these waivers adults, to include parents of SCHIP beneficiaries, pregnant women and childless adults could benefit from SCHIP resources. It is estimated that over 670,000 adults in the U.S. receive coverage through SCHIP (www.cbsnews.com, retrieved April 24, 2008). Approval of waivers that allow for adult healthcare coverage diverges from the original intent of the policy, which was to provide healthcare coverage for children. In essence, the adults that are covered are taking coverage away from children which hurts the advocacy for this policy as the original intention of covering children is not being met.

Legislation Reauthorization

In September 2007, SCHIP legislation came up for reauthorization. During the policy modification phase, Congress reviewed feedback and conducted assessments to determine the implications of SCHIP. From this review, Congress cultivated new legislation for the continuation of the program. According to Iglehart (2007):

> The measure authorizes new expenditures of $35 billion over the next 5 years, which when added to the current annual expenditure of $5 billion makes for a total of $60 billion, enabling states to cover an estimated 3.2 million additional children and reducing by a third the number of uninsured children. … The bill would be funded through an increase of 61 cents in the federal excise tax on cigarettes, raising that tax to $1 per pack.

President Bush did not approve the modified policy. According to Iglehart, the President has reservations regarding the reauthorization of SCHIP, which at current spending levels might result in a 'crowd out' of private insurance (2007). Crowd out, in this instance, is when families

who can afford private coverage but qualify for SCHIP use SCHIP because it is available to them (at the expense of private plans). Iglehart surmises that the root of President Bush's resistance to the legislation is borne out of a fear of socialized medicine (2007). Former President Bush may view SCHIP as another step toward socialization. President Bush's 2008 budget did call for an addition of $4.8 billion for a period of 5 years but this falls far short of the amount needed to maintain current caseloads. It is unclear whether the proposed $4.8 billion includes current adult beneficiaries.

The House of Representatives, in a vote of 265-142, approved a second bill, which was amended to reflect President Bush's concerns. Although a second veto did not occur, the final vote for the second bill did not prove enough to override a second veto promised by President Bush ("SCHIP is Back", 2007). According to the Kaiser Commission, President Bush has approved an extension of the program through March 2009 ("President Bush Signs", retrieved April 25, 2008).

President Bush's actions allude to an underlying issue concerning SCHIP; the role of government in the control of healthcare. Reinhardt quotes Bush as saying "I believe in private medicine, not the federal government running the healthcare system (2007)." This statement indicates that President Bush believes the federal government should not have exclusive power over the nation's healthcare industry. Although unable to be proven with empirical data, it appears Congress believes the government should dictate what occurs within the healthcare arena. Through incremental policy enactment, such as SCHIP, the federal government is indeed gaining more influence over the nation's healthcare system.

In the midst of the debate over SCHIP legislation, the citizens of the United States of America voted in a new President. President Barack Obama holds a different perspective on

healthcare reform than President Bush did. President Obama's healthcare plan includes healthcare coverage for all children. The intention of his plan is to expand eligibility for the Medicaid and SCHIP programs. President Obama's plan will also ensure that the critical safety net function of these programs is continued (http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf, retrieved February 2, 2009).

On February 4, 2009 President Obama signed a bill reauthorizing SCHIP at $32.8 billion over the next 4.5 years. The new law will offer healthcare coverage to an additional 4.1 million children throughout the U.S. (Lubell, 2009). To pay for the $32.8 billion, a 62-cent federal tax increase will be imposed on cigarettes. While the initial proposal in 2007 stated an estimated increase of a $1 per pack tax, the actual increase brings the tax per pack of cigarettes to $1.41. Proportional tax adjustments will be implemented for other tobacco products. President Obama also addressed a memo to the United States Department of Health & Human Services (HHS) that opens doors for states to expand their SCHIP programs in ways previously unavailable to them. President Obama stated "No child should be receiving his care in the emergency room in the middle of the night" (Lubell, 2009).

It is apparent by the original bipartisan vote, which enabled the program to come to life, that the majority of our political leaders feel as though children should have healthcare regardless of their family's income. However, the actions of the state of Texas do not reflect this support. In the year 2000 Texas had a population of 20,851,820. As of 2007, the population had increased to 23,904,380, over 6.6 million of which are children (http://quickfacts.census.gov/qfd/states/48000.html, retrieved April 22, 2009). In an effort to maintain a consistent state budget, despite the increasing population, policy changes have resulted in thousands of qualified Texas children who are unable to enroll in its CHIP program.

As it stands, the federal standard for enrollment is 95 percent of SCHIP eligible children to be covered (Trapp, 2008). In Texas, approximately 71 percent of eligible children are enrolled in Medicaid or CHIP. There are roughly 29 percent of eligible children who remain uninsured. As stated earlier, the multiple policy changes tied to maintaining a steady budget make it increasingly difficult for new applicants to be accepted and for current beneficiaries to re-enroll. That being said, Texas has reasons for its actions.

There are many other industries and programs that require funding and attention in Texas. While healthcare is an important issue, it is difficult to decree healthcare related programs more important than education, transportation, commerce, agriculture, etc. A balance must be maintained, not only in the state's budget but in support of the many trades and businesses that keep Texas alive and well. Texas has a "rainy day" fund worth approximately $9.1 billion (J. Banda & J. Berta, personal communication, September 24, 2008). This, along with the stimulus package monies granted to Texas should keep Texas from having a major deficit in the current troubled economic times. Arguably, the "rainy day" fund monies could have been used to insure the children of Texas; however, there are trade-offs that will occur and, unfortunately, some individuals will miss out in an effort to improve state-wide sustainability.

Recommendations

Now that SCHIP has been extended nationwide, it is essential to continue and improve Texas's CHIP program. Many solutions exist for achieving a successful CHIP program in Texas, including retrenchment, researching and implementing best practices, increasing the state sales tax, and continuing/realizing/increasing cost sharing. Integration of numerous solutions, or hybrids of these options, will provide a best-fit compromise. A discussion of each proposed solution follows.

Retrenchment

Retrenchment must take place first. According to Swayne, Duncan, and Ginter, "retrenchment typically involves a redefinition of the target market" (2007, p.246). Due to the current economic conditions, more individuals are in need of a program such as CHIP. Outreach is imperative in order to educate new eligible beneficiaries. In addition to this, adequate funding must be provided. Revisiting the original purpose of CHIP is imperative for its continuance and success. Retrenchment may be complicated, as some currently benefitting from CHIP may lose healthcare coverage. Even so, a combination of retrenchment and any of the following solutions will most likely result in the best outcome.

In conjunction with a retrenchment initiative, an audit of Texas' current spending must be undertaken. According to the Kaiser Health Facts website, Texas spent $386M in 2007 towards the CHIP program (retrieved 6 Oct 08). However, in speaking with representatives from the Texas Hospital Association, there is an understanding that Texas still has 100 percent of its fixed federal contribution funds from the past three years (J. Banda & J. Berta, personal communication, September 24, 2008). The purpose of this may be to provide roll-over funding, within the three year window, to support its current program ("SCHIP at a Glance", 2007).

States are allowed to hold onto the federal funds for a period of three years; however, if the funds are not spent by the three year time limit, the state loses those funds. If Texas is truly not spending the allocation, this means that the state of Texas is missing out on federal funding for its CHIP program. In support of this line of thought, Methodist Health Ministries declares that, although Texas spent $386M toward the CHIP program, "Texas has forfeited at least $856 million in SCHIP federal funding" (Methodist Health Ministries [MHM], 2008). Basically,

Texas is spending some monies towards its CHIP program but not enough to receive the full benefit of matching federal funds.

The THHSC reports that historically, Texas has not spent its allotment. In fact, from 1998 – 2005 Texas' federal spending was a meager 54 percent of its federal allotment (THHSC, retrieved October 5, 2008). The federal funds that Texas does not receive are then re-allocated to other states that spend their required portion of state funds. In essence, Texas is contributing to the success of other states' CHIP programs and the children of this state miss out on healthcare coverage. Unfortunately uninsured individuals do not have the resources needed to advocate for themselves in an effort to prevent the reallocation of funds from happening. Texas may have taken this approach to maintain state independence, preserve as much autonomy from the federal government as they can, or simply to sustain a budget that is positive every year.

Best Practices

Researching and implementing best practices could prove beneficial for the program. One suggested best practice is Massachusetts's healthcare program. As Governor of Massachusetts, Mitt Romney put healthcare reform into action. According to Hart, Romney's health reform requires employers to provide health insurance to their employees (2006). Under this initiative, individuals are held accountable. They must purchase insurance for themselves as well as their family. The laws enacted by Romney are the first of their kind for any state within the U.S. Under Massachusetts' healthcare reform plan, a stand alone SCHIP program does not exist; however, an expansion of the state's Medicaid program has been implemented. Children up to 300 percent of the FPL are covered (http://www.kff.org/uninsured/upload/7494-02.pdf, retrieved March 10, 2009).

"Best" practices may be difficult to determine as this reform is in its infancy. Another concern regarding the best practice solution is that it may be a paradigm shift for many Texans and difficult to implement. A plan similar to that of Massachusetts requires mandating payment by employers and employees as well as the state. In theory, implementing best practices from another state is a positive action; however, to quote Dr. Dan Stultz, the President of THA, "what works for [Massachusetts] doesn't necessarily work for Texas" (D. Stultz, personal communication, January 22, 2009). In fact, Massachusetts' fiscal situation is not necessarily a favorable one as it is one of the 29 states facing a total budget shortfall of approximately $48 billion this year. Texas is not included in the 29 states mentioned (McNichol & Lav, 2008).

Pennsylvania's CHIP program is another model to consider. Pennsylvania's CHIP program is a separate program. According to Public Citizens for Children and Youth (PCCY), SCHIP was actually modeled after Pennsylvania's successful health coverage program for children (2009). Approximately 184,000 beneficiaries are enrolled in the Pennsylvania CHIP. Not only does Pennsylvania have a strong federal-state affiliation, but a sturdy public-private relationship exists that enables CHIP to work effectively throughout the state. The state's Department of Insurance administers the program and private contractors handle the coverage (PCCY, 2009).

There are three options of coverage under Pennsylvania's CHIP. 157,000 children are beneficiaries of the state's Free CHIP, approximately 25,000 children participate in the Low-Cost CHIP, and almost 2,000 are registered in the At-Cost CHIP. Families of qualifying children in the Free CHIP program pay nothing. The Low-Cost program requires payment of portions of premiums and payment of co-payments. The At-Cost program requires full payment at the state's cost. While many children in Pennsylvania still need insurance, the state's CHIP program is

successful in that 95 percent of children in the Commonwealth have healthcare coverage (PCCY, 2009).

For another state's best practices to work in Texas, an in depth analysis must be accomplished in an effort to proactively determine any unintended consequences. Successful implementation of best practices depends on the recognition of outcomes that are not initially anticipated. If Texas were to blindly put another state's procedures into practice, there could be negative repercussions on a statewide level. Modification of the practice in question can help eliminate negative results. Unintended consequences can have both positive and negative effects, the latter of which should be avoided, if at all possible, in order to have a successful CHIP program in Texas.

Sales Tax

An increase of the statewide sales tax might also prove favorable to the funding of CHIP. Increased sales tax will place the burden on every individual. A positive adjustment can make a great impact on the state's revenue. Revenue provided by the increase can quite possibly fund Texas' current CHIP program. However, pushback is already an issue when it comes to increasing taxes. Texas is a good example of this resistance. Before 2003, Texas had a "no new tax" pledge (Maley, 2005). Taxpayers did not want any more increases in taxes and the government was willing to appease the taxpayer at the time. In fact, tax cuts have been implemented in years past, to the disadvantage of the state budget. The state has to make up the difference of monies lost due to tax cuts. Plans to make up the funds lost due to tax cuts are done through the state budgeting process.

When a state budget is proposed, it is usually based on assumptions. If one of the assumptions was that although taxes are cut, productivity is increasing, it may very well be

proposed that there will be an increase in revenue regardless of the tax cuts. Typically, increased productivity can lead to increased revenue; however, if productivity goes down, so do revenues. Consumer behavior should also be factored into the assumptions. If taxes are raised, consumers may reduce their spending and possibly change their habits. If consumers reduce spending, tax revenue would then be less and the state will have to determine another way of recapturing revenue.

For this proposal to work, property taxes must be maintained in addition to an increase of the state sales tax. In the event property taxes were cut and the state relied on sales tax only, not only would the sales tax have to be increased, but homeowners would have no say-so in how funds are spent for their children's education. A negative outcome could prevail and would garner little support. More than a 5 percent sales tax increase across the board would be needed to cover Texas' CHIP costs without any matching federal funds. The total expenditures for CHIP, both federal and state, in fiscal year 2007 (FY07) were $531,567,222. In order to afford this amount without any federal funding, keeping the spending on other areas of commerce consistent, an increase of the state sales tax must occur. The downfall to only trying to achieve revenue equal to $531,567,222 is that the revenue does not include all of the 1.5 million children in Texas who are still in need of healthcare coverage; however it should cover more children than are covered at this time (Texas Health Care Primer, 2007).

Monthly state sales tax collections from retail establishments within Texas are shown in Table 2 below. The establishments include eating and drinking businesses. Table 2 shows Texas sales tax collections for each month over a 13 month period. The data in this table can be utilized to determine how much state revenue is currently collected from sales tax and how much revenue can be realized by implementing a sales tax increase. Additional monies from a sales tax

increase can be used to fund CHIP within the state of Texas, possibly independent of any federal funding.

Month	State Sales Tax Collections (in millions), Retail Establishments
February 2009	$855.88
January 2009	$868.14
December 2008	$986.06
November 2008	$950.47
October 2008	$747.73
September 2008	$776.75
August 2008	$925.80
July 2008	$828.92
June 2008	$858.46
May 2008	$909.40
April 2008	$806.39
March 2008	$812.57
February 2008	$855.78

Table 2. State Sales Tax Collections, Retail Establishments

[4] From http://www.texasahead.org/economy/tracking/tables.html#salestax, retrieved April 6, 2009.

The average sales tax per month, over the last 13 month period, is $860,180,769.23. By taking $1.00 and dividing it by the current tax rate, 8.125 percent, the tax base is established. The full tax base is $10,586,846,853.40. By multiplying the full tax base by the current sales tax rate, our average sales tax per month is verified at $860,180,769.23. By multiplying the full tax base by an increased sales tax of 5 percent (13.125 percent) higher sales tax revenue for the state is realized. In fact, it is $1,389,523,649.50. The difference between the current state sales tax

revenue and the proposed increased sales tax revenue is $529,342,880.27. This is added revenue to the state's budget that could be utilized for CHIP spending. Adding this additional revenue to the most recently reported state share of $145,910,547 for CHIP would mean Texas not only will not have to rely on federal funding but more Texas children have the potential of receiving healthcare coverage through CHIP. An increase of this magnitude would put Texas at the top of the sales tax chart nationally and will most likely not be supported by voters or legislative constituents.

Cost Sharing

Continuation of co-payments or an increase of the current caps might place a burden on beneficiaries but will greatly ease the state's funding obligation. Under cost sharing, an increase of a $5 co-payment to $10 would potentially double the amount of monies collected through the cost share plan and could facilitate the ease of financial support from the state to providers. The more money collected by a provider would directly translate into less money the state would have to pay providers who accept CHIP beneficiaries as patients. However, while cost sharing will assist the state in funding its CHIP program, research has shown that cost sharing can significantly reduce utilization rates which ultimately may bring in less funds ("Medicaid, SCHIP and Homelessness" 2007). Appropriate utilization is positive, but severely reduced utilization would create a negative outcome for this option, as less income would be realized.

Generally people who have health insurance tend to consume healthcare services more than they normally would if they had to pay for it themselves; this phenomenon is known as moral hazard (Shi & Singh, 2004). Moral hazard results from little or no co-payments, which translates to higher utilization rates. The moral hazard trend is prominent when no co-pays or premiums are required to receive care. To help assuage Texas's funding responsibility, proposed legislation

offers a cost sharing solution, as well as a buy-in option. The cost sharing solution and buy-in option can be viewed as a deterrent to moral hazard but a balance must be achieved in order to attain the revenues necessary for CHIP to remain a viable program.

Under the proposed Senate Bill No. 841 by Texas Senator Averitt, courtesy of his staffer Elizabeth Hadley and Senator Van De Putte's staffer Jamila Patten, families with incomes between 200 and 300 percent of the FPL must pay a portion of the cost of CHIP (personal communication, February 24, 2009). Payments will be made in the form of copayments, fees, and a fraction of the plan's premium. The cost shares paid by these particular enrollees must exceed the cost share required of families whose incomes fall below 200 percent of the FPL, but cannot exceed five percent of the family's net income. Costs will increase gradually as net family income increases and number of children covered within the family increases. The waiting period for this group of eligible beneficiaries is 180 days after the last date the applicant had healthcare coverage. In addition to the projected cost share, a buy-in option is proposed for families whose net income exceeds 300 percent of the FPL.

The proposed buy-in option allows families whose incomes are greater than 300 percent of the FPL to procure health coverage available through CHIP. Families within this category would be required to pay 100 percent of the premiums, fees, and any other costs as determined by the executive commissioner. The costs paid by this category of eligible beneficiaries must exceed the costs of those beneficiaries whose family income is at or below 300 percent. The waiting period for the buy-in option will be comparable to that of the families whose income falls between 200 and 300 percent of the FPL. In addition to these requirements, provisions under the buy-in option are designed to prevent crowd-out.

Each solution mentioned has its pros and cons. Retrenchment, along with a Texas State budget audit, can prove positive in refocusing on the intended beneficiaries; however, some individuals currently benefitting from CHIP may in fact no longer be eligible for CHIP enrollment and benefits. Implementing best practices can be useful in making CHIP both more viable and successful since someone else has already determined whether the practice works well. The downside to implementing best practices from another state is that not all states are alike and what works for a smaller state may not work for Texas. A sales tax increase can generate more revenue to put toward the program, but resistance from Texas citizens and voters might actually cause a decline in revenue as they may reduce spending. Cost sharing and buy-in options can create more revenue, in turn creating less burden on the state, but actually place more fiscal burdens on the eligible beneficiaries as they will have to pay more out of their own pocket.

A true fit for Texas may prove to be a combination of two or more of the above recommendations. While it is true that what works for one state will not always work for another, there are lessons to be learned, efficiencies that are realized, and portions of a program that may work very well anywhere. By analyzing possible solutions, sections may be taken from multiple recommendations and pieced together to create a successful program in Texas. To establish the best solution for the state of Texas, further research of each proposed solution is necessary.

Discussion

Healthcare in America is constantly under scrutiny. The debate of right or privilege has existed for decades. Without question the elderly, disabled, and children are a focus of those who advocate healthcare as a right. Of the three, the most recent policy concerns children. The implementation of SCHIP legislation helped alleviate the growing number of uninsured children in our country. Nationwide, SCHIP covers about 6.6 million children; however, almost 9 million

more children are still without insurance. Even with the continuance of the program, the almost 9 million uninsured children are still in need of adequate healthcare coverage. Those currently covered will likely maintain their coverage, as they are currently enrolled, but there is not adequate funding to insure each and every uninsured child.

Many politicians, as well as ordinary citizens, debate the validity of SCHIP on a daily basis. Some of the general public feel it is an individual's responsibility to provide health insurance for their children, while others feel it is society's/government's obligation to care for those who cannot care for themselves. Many questions arise from the debates. Is SCHIP truly another incremental step toward socialist healthcare? If the level at which eligibility occurs continues to increase (250 percent, 300 percent of FPL) how soon until everyone is eligible? If a person supports the program, does that mean they support socialist healthcare for our country? The U.S. currently spends 16 percent of its GDP on health care. The cost implications of expanding the SCHIP program, especially within an environment of scarce resources, may prove to be unaffordable. If retrenchment occurs and those who truly need this program benefit, is it worth it? Will each SCHIP beneficiary, or at least a majority of them, become productive members of society? Some of these questions can be answered with empirical data and some cannot. Some of these questions, if not all, are left unanswered even as SCHIP has been extended for two and a half more years.

Although SCHIP has been extended and Texas's CHIP program continues, over 1.5 million Texas children need to be insured (Texas Health Care Primer, 2007). In order to alleviate that number, Texas must develop a firm stance regarding its support for the programs and follow policy through to fruition. Whichever solution is deemed best, favorable outcomes must outweigh the negative. The future of Texas and the U.S. depends on the children of today. If they

are not afforded healthcare, there is a possibility that some will not contribute to society and, as a whole, everyone will pay a greater price in the upcoming decades.

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Appendix A

Affects of Better Health Decisions

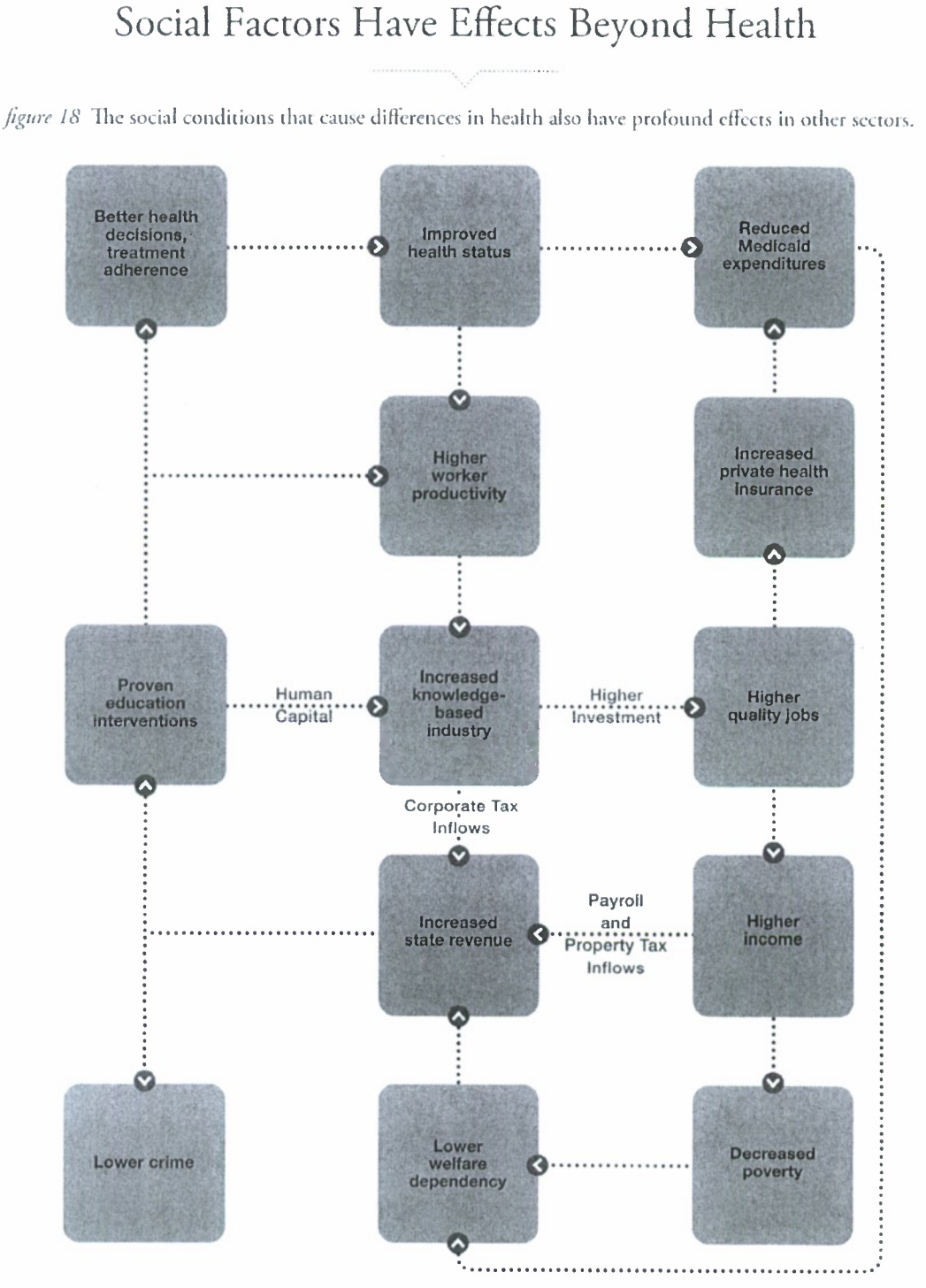

Figure 3. From Braveman, P. and Egerter, S.; Overcoming Obstacles to Health, 2008

Appendix B

SCHIP Enrollment Report

February 7, 2008	Number o f Children Ever En rolled Year b y Program T ype					
State (Program T ype)	M-SCHIP		S-SCHIP		SCHIP Total YEAR	
	FY 2006	FY 2007	FY 2006	FY 2007	FY 2006	FY 2007
Alabama (S)	NA	NA	84257	106691	84257	106691
Alaska (M)	20432	17558	NA	NA	20432	17558
Arizona (S)	NA	NA	96669	104209	96669	104209
Arkansas (C)	85798	85863	3440	3779	89238	89642
Califomia (C)	214216	265057	1177189	1273359	1391405	1538416
Colorado (S)	NA	NA	69997	84649	69997	84649
Connecticut (S)	NA	NA	23301	23632	23301	23632
Delaware (C)	172	145	10579	10998	10751	11143
District of Columbia (M)	6332	6566	NA	NA	6332	6566
Florida (C)	1877	1594	301718	321935	303595	323529
Georgia (S)	NA	NA	343690	356285	343690	356285
Hawaii (M)	22031	23958	NA	NA	22031	23958
Idaho (C)	17858	19019	6869	14041	24727	33060
Iliinois (C)	139565	157120	177216	188456	316781	345576
Indiana (C)	97213	95836	36483	34532	133696	130368
Iowa (C)	17756	17926	31819	32312	49575	50238
Kansas (S)	NA	NA	48934	49536	48934	49536
Kentucky (C)	42156	43470	23134	25306	65290	68776
Louisiana (C)	142389	151953	NA	1710	142389	153663
Maine (C)	22167	21966	8947	9071	31114	31037
Maryland (M)	112123	120357	23911	12530	136034	132887
Massachusetts (C)	129387	93922	71650	90561	201037	184483
Michigan (C)	61214	60508	57287	53517	118501	114025
Minnesota (C)	97	62	5246	5346	5343	5408
Mississippi (S)	NA	NA	83359	81565	83359	81565
Missouri (C)	106577	81764	NA	NA	106577	81764
Montana (S)	NA	NA	17304	20115	17304	20115
Nebraska (M)	44981	46199	NA	NA	44981	46199
Nevada (S)	NA	NA	39317	41862	39317	41862
New Hampshire (C)	671	621	11722	11467	12393	12088
New Jersey (C)	49994	49286	92811	100991	142805	150277
New Mexico (M)	25155	16525	NA	NA	25155	16525
New York (S)	51576	NA	636786	651853	636786	651853
North Carolina (C)	53180	67197	195186	172955	248366	240152
North Dakota (C)	1889	1808	4429	3661	6318	5469
Ohio (M)	221643	231538	NA	NA	221643	231538
Oklahoma (M)	116012	117084	NA	NA	116012	117084
Oregon (S)	NA	NA	59039	63090	59039	63090
Pennsylvania (S)	NA	NA	188765	227367	188765	227367
Rhode Island (C)	24028	24234	1464	1833	25492	26067
South Carolina (M)	68870	59920	NA	NA	68870	59920
South Dakota (C)	11254	11561	3330	3421	14584	14982
Tennessee (C)	NA	35589	NA	5774	NA	41363
Texas (S)	NA	NA	585461	710690	585461	710690
Utah (S)	NA	NA	51967	44785	51967	44785
Vermont (S)	NA	NA	6519	6132	6519	6132
Virginia (C)	65536	68075	71646	76088	137182	144163
Washington (S)	NA	NA	15000	14734	15000	14734
West Virginia (S)	NA	NA	39855	38582	39855	38582
Wisconsin (C)	57034	56904	NA	5619	57034	62523
Wyoming (S)	NA	NA	7715	8570	7715	8570
TOTALS	**2031183**	**2051185**	**4714011**	**5093609**	**6745194**	**7144794**

(S) = Separate child health programs. (M) = Medicaid expansion programs. (C) = Combination programs. NA = Not Applicable. Notes: Maryland changed to (M) 6/1/07; Missouri changed to (C) 10/1/07; New York phased to (S) 4/1/05 to 3/31/06. Data Source: SCHIP

Table 3. (Retrieved from www.cms.hhs.gov, April 7, 2008)

Appendix C

Texas CHIP Enrollment by Month (November 2006 – December 2008)

CHIP Enrollment, Renewal and Disenrollment by Month

Month	Total Enrollment	New Enrollment	Renewals	Completed Renewal - Deemed Ineligible	Total Disenrollment	Non-Renewals	Actual Renewal Rate	Attempted Renewal Rate	Total Disenrollment Rate
Dec-08	454,596	25,537	27,466	7,178	29,066	13,117	67.7 percent	72.5 percent	6.4 percent
Nov-08	458,125	27,759	32,286	8,761	34,728	14,335	69.3 percent	74.1 percent	7.6 percent
Oct-08	465,094	31,041	27,607	6,762	29,146	12,370	69.1 percent	73.5 percent	6.3 percent
Sept-08	463,199	24,773	28,363	6,724	38,210	19,477	59.3 percent	64.3 percent	8.2 percent
Aug-08	476,636	23,399	563	145	10,702	240	70.1 percent	74.7 percent	2.2 percent
July-08	463,939	30,476	1,312	273	11,410	759	63.4 percent	67.6 percent	2.5 percent
June-08	444,873	26,429	155	38	8,943	204	43.2 percent	48.6 percent	2.0 percent
May-08	427,387	26,412	147	25	8,201	174	45.8 percent	49.7 percent	1.9 percent
Apr-08	409,176	35,189	3	2	8,166	2	60.0 percent	71.4 percent	2.0 percent
Mar-08	382,153	29,447	52	16	5,406	4	92.9 percent	+4.4 percent	1.4 percent
Feb-08	358,112	32,964	29,242	7,474	27,743	15,019	66.1 percent	71.0 percent	7.7 percent
Jan-08	352,891	30,573	28,079	7,227	26,817	14,438	66.0 percent	71.0 percent	7.6 percent
Dec-07	349,135	33,109	27,069	6,262	24,959	12,434	68.5 percent	72.8 percent	7.1 percent
Nov-07	340,985	34,054	32,440	7,258	29,145	14,031	69.8 percent	73.9 percent	8.5 percent
Oct-07	336,076	34,946	25,516	6,772	26,249	12,874	66.5 percent	71.5 percent	7.8 percent
Sep-07	327,379	50,529	21,423	5,735	23,413	11,227	65.6 percent	70.8 percent	7.2 percent
Aug-07	300,262	27,997	29,391	7,270	30,120	14,038	67.7 percent	72.3 percent	10.0 percent
Jul-07	302,386	30,231	23,756	7,127	28,642	13,399	63.9 percent	69.7 percent	9.5 percent
June-07	300,798	26,465	24,615	6,670	32,187	15,848	60.8 percent	66.4 percent	10.7 percent
May-07	306,521	26,565	30,106	8,310	43,113	22,683	57.0 percent	62.9 percent	14.1 percent
Apr-07	323,069	28,751	23,051	8,364	30,771	14,384	61.6 percent	68.6 percent	9.5 percent
Mar-07	325,090	27,216	18,703	2,878	27,605	11,908	61.1 percent	64.4 percent	8.5 percent
Feb-07	325,479	28,545	27,642	3,178	24,881	9,648	74.1 percent	76.2 percent	7.6 percent
Jan-07	321,815	26,827	29,599	3,554	31,243	12,258	70.7 percent	73.0 percent	9.7 percent
Dec-06	326,231	28,892	30,383	3,418	24,002	9,061	77.0 percent	78.9 percent	7.4 percent
Nov-06	321,341	40,010	32,847	2,833	19,353	9,690	77.2 percent	78.6 percent	6.0 percent

Table 4. (Retrieved from http://www.hhsc.state.tx.us/research/CHIP/, January 9, 2009)

Appendix D

Texas Medicaid, CHIP, and Perinatal Coverage Enrollment Report

Children Enrolled in Medicaid, CHIP and CHIP Perinatal Coverage by Month

Month	Children Enrolled in Medicaid[1]	Children Enrolled in CHIP[2]	Children Enrolled in CHIP Perinatal Coverage[3]	Total Children Enrolled
Dec-08	1,860,644	454,596	---	2,315,240
Nov-08	1,851,473	458,125	26526	2,309,598
Oct-08	1,806,416	465,094	25,956	2,297,466
Sept-08	1,841,385	463,199	26,476	2,331,060
Aug-08	1,850,747	476,636	24,709	2,352,092
July-08	1,863,058	463,939	24,600	2,351,597
Jun-08	1,840,480	444,873	25,679	2,311,032
May-08	1,823,331	427,387	25,015	2,275,733
Apr-08	1,830,409	409,176	26,528	2,266,113
Mar-08	1,800,563	382,153	27,449	2,210,165
Feb-08	1,813,185	358,112	26,715	2,198,012
Jan-08	1,827,956	352,891	25,158	2,206,005
Dec-07	1,849,577	349,135	21,535	2,220,247
Nov-07	1,840,268	340,985	18,222	2,199,475
Oct-07	1,799,952	336,076	14,420	2,150,448
Sep-07	1,836,498	327,379	10,511	2,174,388
Aug-07	1,850,714	300,262	6,768	2,157,744
Jul-07	1,840,409	302,386	3,832	2,146,627
Jun-07	1,857,114	300,798	2,228	2,160,140
May-07	1,838,898	306,521	1,179	2,146,598
Apr-07	1,775,979	323,069	612	2,099,660
Mar-07	1,763,507	325,090	324	2,088,921
Feb-07	1,766,377	325,479	10	2,091,866
Jan-07	1,761,486	321,815	4	2,083,305
Dec-06	1,761,407	326,231	---	2,087,638
Nov-06	1,756,237	321,341	---	2,077,578
Oct-06	1,716,684	300,685	---	2,017,369
Sep-06	1,745,203	291,530	---	2,036,733
Aug-06	1,780,881	295,331	---	2,076,212
Jul-06	1,762,068	298,731	---	2,060,799
Jun-06	1,756,089	293,342	---	2,049,431
May-06	1,752,481	298,776	---	2,051,257
Apr-06	1,727,279	294,189	---	2,021,468

Mar-06	1,739,015	302,020	---	2,041,035
Feb-06	1,763,912	310,981	---	2,074,893
Jan-06	1,786,447	317,408	---	2,103,855
Dec-05	1,821,406	322,898	---	2,144,304
Nov-05	1,827,965	321,562	---	2,149,527
Oct-05	1,800,181	323,343	---	2,123,524
Sep-05	1,816,357	326,557	---	2,142,914

[1]Total number of Medicaid clients under the age of 19. These points in time counts offer a preliminary look at enrollment for any given month. The numbers are not final because Medicaid offers up to three months of retroactive coverage for eligible individuals. It takes about eight months to determine the final count for Medicaid enrollment.

[2]Total number of children enrolled in the traditional Children's Health Insurance Program (CHIP).

[3]CHIP perinatal coverage began in January 2007. Enrollment numbers are in addition to the numbers of children enrolled in traditional CHIP and are not included in other CHIP enrollment reports. Individuals are enrolled retrospectively (coverage begins the month the person is certified). This causes data available for reporting to be delayed at least one month.

Table 5. (Retrieved from http://www.hhsc.state.tx.us/research/, January 6, 2009)

Appendix E

Texas CHIP Enrollment by Income Group (August 2006 – December 2008)

CHIP Enrollment by Income Group

Number and Percent by Federal Poverty Level

Month	Number by FPL				Total Enrollment	Percent by FPL			
	<101 percent	101 percent-150 percent	151 percent-185 percent	186-200 percent		<101 percent	101 percent-150 percent	151 percent-185 percent	186-200 percent
Dec-08	29,100	250,539	148,042	26,915	454,596	6.4 percent	55.1 percent	32.6 percent	5.9 percent
Nov-08	29,703	252,807	150,476	25,139	458,125	6.5 percent	55.2 percent	32.8 percent	5.5 percent
Oct-08	30,579	257,129	154,111	23,275	465,094	6.6 percent	55.3 percent	33.1 percent	5.0 percent
Sept-08	30,947	254,903	155,613	21,736	463,199	6.7 percent	55.0 percent	33.6 percent	4.7 percent
Aug-08	32,951	264,443	157,155	22,087	476,636	6.9 percent	55.5 percent	33.0 percent	4.6 percent
July-08	31,828	256,237	152,208	23,666	463,939	6.9 percent	55.2 percent	32.8 percent	5.1 percent
June-08	29,949	244,018	145,474	25,432	444,873	6.7 percent	54.9 percent	32.7 percent	5.7 percent
May-08	27,932	232,999	138,792	27,664	427,387	6.5 percent	54.5 percent	32.5 percent	6.5 percent
Apr-08	24,860	221,216	130,674	32,426	409,176	6.1 percent	54.1 percent	31.9 percent	7.9 percent
March-08	23,275	205,814	122,096	30,968	382,153	6.1 percent	53.9 percent	31.9 percent	8.1 percent
Feb-08	21,278	191,493	115,306	30,035	358,112	5.9 percent	53.5 percent	32.2 percent	8.4 percent
Jan-08	21,258	189,155	113,474	29,004	352,891	6.0 percent	53.6 percent	32.2 percent	8.2 percent
Dec-07	21,832	187,083	111,859	28,361	349,135	6.3 percent	53.6 percent	32.0 percent	8.1 percent
Nov-07	21,706	182,094	109,494	27,691	340,985	6.4 percent	53.4 percent	32.1 percent	8.1 percent
Oct-07	21,618	177,890	108,920	27,648	336,076	6.4 percent	52.9 percent	32.4 percent	8.2 percent
Sep-07	21,166	172,617	106,216	27,380	327,379	6.5 percent	52.7 percent	32.4 percent	8.4 percent
Aug-07	19,118	152,280	102,094	26,770	300,262	6.4 percent	50.7 percent	34.0 percent	8.9 percent
Jul-07	19,448	154,018	101,694	27,226	302,386	6.4 percent	50.9 percent	33.6 percent	9.0 percent
June-07	19,004	152,064	101,654	28,076	300,798	6.3 percent	50.6 percent	33.8 percent	9.3 percent
May-07	19,511	155,266	102,660	29,084	306,521	6.4 percent	50.7 percent	33.5 percent	9.5 percent
April-07	21,163	166,469	105,419	30,018	323,069	6.6 percent	51.5 percent	32.6 percent	9.3 percent
March-07	21,986	167,725	105,334	30,045	325,090	6.8 percent	51.6 percent	32.4 percent	9.2 percent
Feb-07	22,139	167,925	105,509	29,906	325,479	6.8 percent	51.6 percent	32.4 percent	9.2 percent

Jan-07	22,240	165,986	104,106	29,483	321,815	6.9 percent	51.6 percent	32.3 percent	9.2 percent
Dec-06	25,928	167,233	103,885	29,185	326,231	7.9 percent	51.3 percent	31.8 percent	8.9 percent
Nov-06	23,735	164,337	104,277	28,992	321,341	7.4 percent	51.1 percent	32.5 percent	9.0 percent
Oct-06	20,152	150,725	101,712	28,096	300,685	6.7 percent	50.1 percent	33.8 percent	9.3 percent
Sept-06	14,000	148,808	100,752	27,970	291,530	4.8 percent	51.0 percent	34.6 percent	9.6 percent
Aug-06	14,059	151,404	101,637	28,231	295,331	4.8 percent	51.3 percent	34.4 percent	9.6 percent
*Note: Sum of income level groups does not equal total enrollment because of enrollees with unknown income level									

Table 6. (Retrieved from http://www.hhsc.state.tx.us/research/CHIP/, January 9, 2009)

Appendix F

Comprehensive List of Services Covered Under SCHIP

Services Covered by Texas CHIP, 2006
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 healthcare 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 health services; • Nursing care services; • Inpatient mental health services; • Outpatient mental health services; • Inpatient substance abuse treatment services; • Outpatient substance abuse treatment services; • Rehabilitation 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; • Care coordination; • Case management; • Prescription drugs; • Dental services; • Vision; • Chiropractic services; and • Tobacco cessation.

Figure 4. Texas Health and Human Services Commission Report, Chapter 7 Children's Health Insurance Program, 2006, retrieved from http://www.hhsc.state.tx.us/Medicaid/reports/PB6/PDF/Chapter07.pdf