



TWELVE-MONTH CHILDREN'S MEDICAID: THE RIGHT STEP FOR TEXAS' NEEDIEST CHILDREN

Long-Term Costs Due to Leaving Kids Uninsured Outweigh Short-Term Savings

The House Human Services Committee will hear seven bills Thursday, March 19, that would extend the coverage period for Texas Children's Medicaid from the current six months to 12 months. This change would benefit Texans from every practical angle:

- reducing the number of uninsured Texas children by 25 percent; reducing avoidable hospitalizations to cut costs-per-child by about the same amount;
- improving access to well-child care to improve health and comply with federal court requirements;
- reducing real taxpayer costs by bringing back federal tax dollars to Texas; and
- dramatically reducing workloads for Texas' crisis-ridden eligibility system.

Legislators concerned about the cost of 12-month coverage must look past the state budget bill to consider the huge price paid by Texas taxpayers for costs passed on to local jurisdictions when the state leaves needs unmet and federal dollars on the table. This *Policy Page* reviews the history of and arguments for 12-month enrollment for children.

History

Before 2002, children on Texas Medicaid were covered month-to-month only: parents had to report income changes within 10 days or face fraud charges. Children fell off the program in months with five Fridays, and the average child got only four months of enrollment at a time. Congress gave states the 12-month coverage option for children's Medicaid in 1997 when they created CHIP (the Children's Health Insurance Program). The Texas Legislature voted in 2001 (Senate Bill 43, Zaffirini) to extend 12-month coverage to children's Medicaid by phasing in six-month continuous enrollment in January 2002, with 12-month coverage set to begin in September 2003. In 2003, with a multibillion-dollar state revenue drop projected, the legislature postponed the phase-in of 12-month coverage until 2005, and in 2005 legislators voted to set both CHIP and children's Medicaid at six months (i.e., eliminating the planned phase-in). In 2007,

the legislature restored 12-month coverage for CHIP, but not for children's Medicaid.

Enrollment Impact and Numbers

Twelve-month coverage has a powerful effect on total enrollment. Cutting Texas CHIP coverage from 12 months to six months in 2003 primarily caused a 40 percent drop—more than 200,000 children—in CHIP enrollment. When the 2007 legislature eliminated that twice-yearly renewal requirement for CHIP, more than 118,000 additional children received coverage from March 2008 to August 2008—an average of more than 19,000 children every month—showing just how powerful a tool 12-month coverage is in covering eligible children.

The Texas Health and Human Services Commission (HHSC, the agency in charge of Medicaid and CHIP) projects 12-month coverage will add 376,000 children to Medicaid by 2011, which would cut the number of

uninsured Texas children (about 1.5 million today) by one-fourth. The Legislative Budget Board (LBB), which sets the official “score” and costs of proposed laws, projects a lower number: more than 258,000 children added by 2011. To put this in perspective: Medicaid covers just less than 1.9 million Texas children on any given day, and CHIP covers about 456,000. An estimated 1.5 million children in Texas lacked insurance in 2007—more than 20 percent of Texas’ children—and of these uninsured Texas kids, 700,000 to 800,000 could be enrolled in Medicaid or CHIP—but are not. An estimated two-thirds to three-fourths of these children qualify for Medicaid, and not CHIP.

12-Month Coverage in Texas Medicaid and Other States

As of January 2009, 18 states provided 12-month continuous eligibility for all children in Medicaid, and two more states provide it for younger children. Because the 12-month enrollment model is the most efficient way to administer eligibility for a program, Texas Medicaid uses it in several programs:

- Medicaid newborn coverage,
- Medicaid maternity coverage,
- the CHIP perinatal program,
- traditional Texas CHIP, and
- the Women’s Health Medicaid Waiver.

HHSC also proposed 12-month coverage in the agency’s recent SB 10 Medicaid 1115 waiver request.

The Benefits for Children’s Health—and Taxpayers’ Wallets

Twelve continuous months of eligibility would promote continuity of care and stable medical homes for children, easing recruitment and retention of doctors and other health care providers for Children’s Medicaid. Stably insured children are more likely to have a regular health care provider, to have preventive care visits, and to receive needed care without delays.ⁱ A recent study reported in the *New England Journal of Medicine* found that children covered for only part of a year—even those who experience only short gaps—

delay getting needed care ten times more often than children with full-year coverage, and report an unmet medical need as often as children uninsured all year.ⁱⁱ

Frew Lawsuit. The *Frew* lawsuit is a 15-year old federal class action lawsuit over Texas Children’s Medicaid. The *Frew* settlement agreement requires (among other things) the state to improve children’s rates of medical and dental check-ups and immunizations—but when the average child is only covered for 7.5 months, access to care is difficult to improve, especially for young children who need frequent well-child visits. Texas Medicaid can meet the *Frew* lawsuit settlement goals for check-ups, immunizations, and access to care much more easily with 12-month coverage.

Reduced Hospitalization Costs. Texas and California studies found that 12-month coverage reduces hospitalizations and the annual cost per child. According to an analysis by the Texas CHIP HMO run by Texas Children’s Hospital in Houston, medical costs per child decrease about 25 percent when a child has consistent access to a doctor provided by 12-month coverage. Keeping children out of the hospital and the emergency room makes good financial sense.

A 2007 report from the University of California studied hospitalizations of millions of California Medicaid enrollees from 1998 to 2002, and presented two key findings. First, children with interruptions in Medicaid coverage were far more likely to be hospitalized for “ambulatory-sensitive conditions”—hospital stays that could be avoided with proper ongoing care. Second, when California children’s Medicaid enrollment was increased from six to 12 months in 2001, avoidable hospitalizations fell by 25 percent, enrollment of children increased, and eligible children had fewer gaps in coverage.ⁱⁱⁱ

Loss of Federal Funds. Texas and national research indicate that uninsured children on average use about \$500 a year in care,^{iv} so “savings” to the state budget from leaving more eligible children unenrolled

in Medicaid translate directly into increased costs for local communities. According to the Texas economist Dr. Ray Perryman, for each state dollar “saved” by choosing not to fund health care through Medicaid, local taxes must rise 51 cents, private health insurance premiums increase by \$1.34, and retail sales decline by almost \$2.00. The size of this “negative multiplier effect” largely results from the substantial federal Medicaid match left on the table when uninsured children eligible for Medicaid get care funded through local governments and charities, without benefit of the \$1.47 in federal matching funds for each state Medicaid dollar.

Health Plan Costs and Accountability.

Twelve-month continuous eligibility for Children’s Medicaid would reduce Medicaid Managed Care health plan administrative costs. Health plans report substantial costs of continuous disenrollment and re-enrollment of eligible children because of temporary disruptions in their coverage. These costs pass through to taxpayers in the premiums charged by health plans to Medicaid, which would shrink with 12-month eligibility. Continuous coverage will also improve accountability of the health plans. Medicaid Managed Care health plan “HEDIS” standards hold HMOs accountable only for children enrolled for at least one full year, because less than one year is generally considered not enough time to show improvement. Since plans must only report on children enrolled for a year or more, and most children receive only 7.5 months of coverage, Medicaid Managed Care cannot reach its potential for improving care until Texas implements 12-month coverage.

Relieve the Strain on an Eligibility System in Crisis. Federal law “timeliness” standards require processing of 95 percent of all applications within a certain number of days: 30 days for Food Stamps, and 45 days for Medicaid. HHSC failed to meet federal standards for the past three-to-four years. Applications processed using the state’s newer eligibility system, TIERS, suffer the most severe delays. In many regions

of the state, common processing delays of more than three months prompted creation of formal policies to deal with the severe application backlog. Children renewing coverage or moving between Medicaid and CHIP routinely get dropped from coverage, even though they qualify and should move directly between the programs without any gap. The rate of improper denials in the Food Stamp program (known as the “negative error rate”) soared over the last five years, increasing from 2.8 percent in fiscal 2004 to 18.9 percent in the first quarter of fiscal 2008. Federal regulations state that a negative error rate exceeding 1 percent indicates poor customer service and requires corrective action.

Severe staffing shortages cause much of this problem, with HHSC eligibility staffing levels at less than two-thirds of what they were a decade ago, with dramatically higher client caseloads per worker. Twelve-month eligibility for Children’s Medicaid would dramatically reduce HHSC’s workload. With 1.9 million children enrolled, once-a-year renewal means cutting from 3.8 million renewals per year to 1.9 million. As noted above, Texas has been out of compliance with the federal law requiring 45-day Medicaid application processing since 2006, and 12-month coverage would reduce the number of state workers needed to bring Texas back into compliance with federal law. By relieving pressure on the eligibility system, 12-month children’s coverage will benefit not only children, but also seniors, adults with disabilities, and pregnant women who need Medicaid, as well as hungry Texans seeking food benefits in this economic downturn.

The Price Tag for the State Budget

Overwhelming evidence favors of 12-month coverage, but the Texas Legislature avoids taking the same steps for Children’s Medicaid that it took for CHIP because of the short-term costs to the state of providing care to these uninsured children. In the crudest sense, it is simply cheaper for the state budget’s bottom line to leave eligible children unenrolled and uninsured—

even though the total cost is higher once we consider local taxes and private insurance premiums.

As noted above, HHSC and the LBB currently have very different estimates of the enrollment impact of 12-month Children's Medicaid, and their costs estimates also vary. The LBB fiscal note (which determines the official cost to the state budget bill) estimates the state's two-year cost of 12-month eligibility in Children's Medicaid at \$296.7 million in General Revenue (GR, or state dollars). This amount assumes projected enrollment of more than 258,000 additional children by 2011. HHSC's estimate for the same two-year period is a much higher \$476.9 million GR to cover more than 376,000 additional children, a net of an estimated \$8.9 million in staffing cost savings.

Federal Economic Recovery Funds. Neither the HHSC nor the LBB cost estimates take into account the much more generous federal Medicaid match rate that Texas will get in 2010 and 2011 as the result of federal economic recovery funding. Texas is expected to get an additional \$5.45 billion in federal funds from 2009-2011, according to the U.S. Government Accountability Office (GAO). The recovery law does not require the Legislature to invest any of the state dollars "freed up" as a result back into the Medicaid program, the recovery assistance for Medicaid will provide Texas with far more than ten times the funds needed to pay for 12-month coverage. Of course, increased enrollment would itself result in increased recovery-act Medicaid funding for Texas, because the assistance ties directly to Medicaid spending.

Additional Bonuses for Enrolling Children in Medicaid. The cost of 12-month coverage would also be offset somewhat by bonuses from the federal CHIP reauthorization act, which Texas could earn for enrolling significant numbers of eligible children in Medicaid. A conservative estimate indicates that if enrollment under 12-month children's coverage meets

HHSC projections, Texas would earn \$25.6 million in 2011 and \$54 million in 2012-13.

Dropping the Ball: Eligible Children Roll on and off of Texas CHIP and Medicaid

Official HHSC data indicate that most kids who lose Medicaid at renewal time either remain qualified for Medicaid or move to CHIP. HHSC reports that 76 percent of children who lost Medicaid in 2006—more than three-of-four—lacked another source of insurance after they left Medicaid. In 2007, 45 percent of children losing Medicaid coverage came back on the program within the year, suggesting that eligible children experienced these gaps in coverage, caused by excessive red tape and eligibility system problems.^v

HHSC data show that during 2002, when CHIP covered children for 12 months and Medicaid for six months, the average length of coverage (ALOC) for children on Medicaid was only about six weeks less per year than kids on CHIP. This is mostly because children who come into Medicaid with unpaid bills can get up to 3 months of retroactive coverage, a policy that CHIP does not share. This means the Medicaid system already picks up much of the largest costs that might otherwise go along with a shift from 6 to 12 months in Medicaid.

The average length of coverage dropped for children in both programs in 2006 and 2007, when eligibility systems for both programs experienced a variety of severe disruptions resulting in long enrollment delays and steep declines in the number of children covered. Enrollment in 2008, which includes six months of higher CHIP enrollment from 12-month coverage for children in that program, still remained significantly below the average length of coverage in 2002 and 2003, and was no better than children's Medicaid ALOC. These data underscore the troubled performance of the eligibility system overall, and the need for Texas leaders to take serious action to remove the artificial barriers that leave hundreds of thousands of Medicaid-eligible children uninsured.

Average Months Children are Covered per Year: Texas CHIP and Medicaid

Fiscal Year	CHIP	Children's Medicaid (age 1-18)*
2002 (CHIP, 12 month; *Medicaid, month-to-month for 4 months and 6-month for remaining 8 months)	8.4	6.8
2003 (CHIP 12-month.; Medicaid 6-month)	8.3	7.4
2004 (Both 6-month)	7.4	7.4
2005 (Both 6-month)	7.5	7.7
2006 (Both 6-month)	7.1	7.5
2007 (Both 6-month)	6.8	7.4
2008 (CHIP 12-month reflected in final 6 months of fiscal 2008; Medicaid 6-month)	7.5	7.6

**Most Medicaid infants under age one have 12-month enrollment and are excluded from count.*

Postscript

Twelve-month continuous coverage in Children's Medicaid—equality with CHIP policy—would be the single most effective way:

- to demonstrate Texans' commitment to the bipartisan goal of insuring the poorest uninsured children first,
- to increase enrollment of Texas' eligible uninsured children, and

- to dramatically cut the costs and workload of our state eligibility workers and boost their performance.

Twelve-month coverage is the right thing to do for our neediest children, and for all Texans who must rely on our troubled eligibility system. The federal Economic Recovery Medicaid funds due Texas will provide the resources Texas needs to take this step in 2010 and 2011.

To learn more, sign up for e-mails, or make a donation, go to www.cppp.org.

The Center for Public Policy Priorities is a nonpartisan, nonprofit policy institute committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans.

ⁱ The National Academies Institute of Medicine, *Health Insurance is a Family Matter*, 2002. National Academy Press: Washington, D.C.

ⁱⁱ Olsen, et. al., "Children in the U.S. with Discontinuous Health Insurance Coverage," *New England Journal of Medicine*, 353:382-391, July 2005.

ⁱⁱⁱ Andrew Bindman, Arpita Chattopadhyay and Glenna Auerback, "Do Interruptions of Medicaid Coverage Increase the Risk of Avoidable Hospitalizations," presented at the Annual Research Meeting of AcademyHealth, Orlando, Florida, June 4, 2007.

^{iv} Jack Hadley and John Holahan, "Covering The Uninsured: How Much Will it Cost?" *Health Affairs*, June 4, 2003.

^v Texas External Quality Review Organization, Institute for Child Health Policy, University of Florida, *Survey Report of STAR and CHIP Renewals and Non-Renewals, Texas*, September 22, 2006; www.hhsc.state.tx.us/CHIP/reports/Report_MedicaidCHIP_Renewal_Survey_092906.pdf