TEXAS PUBLIC POLICY FOUNDATION

The Children's Health Insurance Program in Texas

A Look at CHIP Policy and Program Trends

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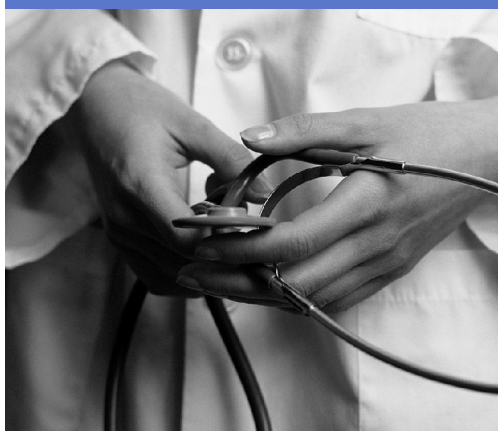

By Mary Katherine Stout
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The Foundation's mission is to improve Texas government by generating academically sound research and data on state issues, and by recommending the findings to opinion leaders, policy makers, the media and general public. The work of the Foundation is conducted by academics across Texas and the nation, and is funded by hundreds of individuals, corporations, and charitable institutions.

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Executive Summary

When the CHIP program was established by the Texas Legislature in 1999, it was billed as a program giving the state budget certainty and flexibility to design a program to reduce the number of uninsured children in the state. Yet in the program's short history, it has never proven to be as budget certain or flexible as it was once sold. Indeed total spending on CHIP has increased, and the Health and Human Services Commission has often warned of projected budget "shortfalls" in the program that require additional revenue to fill the holes. Efforts to target assistance to the most needy Texans have been met with resistance, and the program's benefits package—more generous even than the state's benefit package for state employees—still comes at low or no cost for eligible families. Attempts to exercise flexibility and control spending have been sharply criticized, despite earlier promises.

While the program was intended to be the solution to the number of uninsured children in the state, Texas' number of uninsured children has remained virtually unchanged. Across the nation, growth in CHIP and Medicaid enrollment has changed the number of uninsured children very little; however, enrollment in private health plans has declined significantly as otherwise insured children enrolled in government programs instead. In its roughly six years operating the CHIP program, the state has invested significant resources in addressing the problem of the uninsured through government programs, yet the state has made little progress in reducing the estimated number of uninsured.

Recent declines in the CHIP caseload have resulted in increased scrutiny of policy changes made in 2003 and the implementation of a call center model to facilitate the application process for a number of the state's health and human services programs, including CHIP. These criticisms fail to fully examine the reasons for the change in enrollment. Data suggests that a number of factors are at work, including: a choice not to reenroll, determination of ineligibility, and an improved economy, among others. Indeed, total enrollment in CHIP has been in almost constant decline since its peak in 2002, though new enrollment has been at recent highs, suggesting that many families continue to make use of the program as a temporary means of assistance, rather than a long term alternative to private health insurance. Importantly, the declines in CHIP enrollment are the result of a confluence of events and factors not attributable to one thing alone.

Texas must recognize the policy differences between Medicaid and CHIP and make use of the state flexibility available under the CHIP program to control cost, manage the caseload, and protect the integrity of the system by guarding against fraud and abuse. Indeed if the program is to exist at all, it must direct assistance to only those who are truly eligible. As the state continues to implement the call center model across programs, assess the impact of policy changes to the CHIP program in the last two years, and prepare to write a budget for the 2008-2009 biennium, there are five findings and policy recommendations to be considered:

- CHIP continuous eligibility should remain the same as the continuous eligibility period in Medicaid, and should not exceed six months.
- The state must take seriously the issue of "crowd out," by preserving the 90-day waiting period and providing for health insurance premium payment assistance for certain CHIP-eligible children with access to private health insurance.
- Maintain the CHIP assets test to ensure the eligibility of enrollees.
- Continue the implementation of call centers to facilitate applications for CHIP and other health and human services benefits.
- CHIP is not an entitlement and policymakers must exercise fiscal discipline to control spending.

Both Congress and state legislatures should ask critical questions about the performance of the CHIP program and whether it has accomplished the goals it was created to meet.

Introduction

When the State Children's Health Insurance Program (SCHIP or CHIP) was created by Congress in 1997 it was billed as the country's plan for reducing the number of uninsured children across the nation. The program was designed to provide insurance coverage to children whose families made too much to qualify for Medicaid, but who were considered to be making too little to afford private health insurance. At the time, it was said that the program would cover 5 million children by 2000—half of the estimated 10 million uninsured children across the country.

By the time President Clinton signed the CHIP program into law in August 1997, the Texas Legislature had already adjourned and would not take up consideration of the new program until the next regular session two years later. In 1999, Texas passed the CHIP program and the state began enrolling children in the new program in the first half of 2000. Since then, the Texas Legislature has made a number of program and policy changes to CHIP, as well as some associated changes to Medicaid. Following its enrollment growth in the early years, CHIP caseloads have fluctuated, trending downward since the program's enrollment peak in mid-2002. Recent caseload declines have been the subject of significant media attention, along with changes in the application and enrollment process in CHIP, though most of these reports deal superficially with the caseload declines.

In both Washington and in the states, CHIP has become a political favorite for providing health insurance to children—a combination of two untouchable issues that get a pass on intellectual rigor. It has generally escaped scrutiny and important questions about its performance, instead enjoying political favor and drawing fierce criticism when legislators undertake any effort to control the cost or the caseload. Furthermore, the persistent myths that surround the politically popular program do little to serve the interest of good public policy.

Both Congress and state legislatures should ask critical questions about the performance of the CHIP program and whether it has accomplished the goals it was created to meet. Looking at the program's history and structure, lawmakers must realize that CHIP is not an entitlement program (unlike Medicaid) and that the legislation creating the program was designed to give states significant flexibility. In addition, since CHIP was created to reduce the number of children without health insurance, the program's performance in this regard must be scrutinized.

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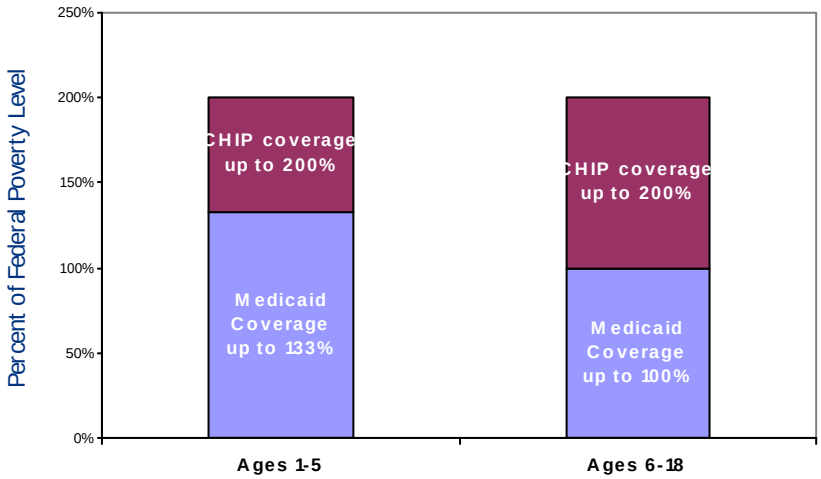
CHIP and Medicaid

In principle, the CHIP program was little more than an expansion of the Medicaid program. For years, Congress had incrementally expanded Medicaid coverage for children by slowly raising the age and income level for Medicaid eligibility. The impetus behind CHIP was to provide health insurance coverage for children in families with incomes too high for Medicaid, but still considered by the government as making too little to afford private health insurance.

Today, federal law requires states participating in the Medicaid program to provide Medicaid coverage to infants and children through age five with a family income up to 133 percent of the federal poverty level (FPL),[i] and to children ages six through eighteen with a family income up to 100 percent FPL. CHIP provides coverage for children in families making up to 200 percent FPL; however, states may extend CHIP eligibility to 50 percentage points above the Medicaid eligibility level in place in 1997, which allows some states to extend coverage to families with incomes up to as much as 300 percent of FPL, or even higher in some cases. In addition, some states use their CHIP program to extend coverage to families, not just children. Figure 1 illustrates the relationship and eligibility levels for the CHIP and Medicaid programs.

[i]For 2006, the federal poverty level for the 48 contiguous states for a family of three is $16,000 and $20,000 for a family of four. At 200% FPL, a family of three would have an annual income of $33,200 and a family of four would have an annual income of $40,000.

Figure 1: Income Eligibility Levels for Medicaid and CHIP



There are two critical differences between CHIP and Medicaid and both are to the credit of Congressional leaders who sought to control the size , scope, and cost of the program, as well as give states a measure of flexibility.

Federal law also allowed states to choose whether to create a new program, expand their existing Medicaid program, or use a combination of Medicaid and CHIP: Texas chose to establish CHIP as a separate program from Medicaid. A Mathematica Policy Research study submitted to the U.S. Department of Health and Human Services attributes states' decisions whether or not to create a separate program as a political calculation based on whether there was a positive or negative view of Medicaid within each state. Mathematica's survey of state administrators found half of the surveyed states with separate programs reported that Medicaid "was not viewed positively in their states."[1] Other factors surveyed included ease of implementation, ability to control the program (cost and enrollment included), and flexibility to try new ideas. Although expanding coverage for children could have been achieved by raising the income eligibility levels for Medicaid, the administrators' responses in the Mathematica survey point to the CHIP program's appeal because it gave states greater flexibility and control. Arguably, the flexibility and control available to the states for the CHIP program would not have been likely had Congress merely expanded Medicaid to include more children.

In fact, the structure of CHIP represents an important policy shift away from the entitlement of the Medicaid program. In particular, there are two critical differences between CHIP and Medicaid and both are to the credit of Congressional leaders who sought to control the size, scope, and cost of the program, as well as give states a measure of flexibility despite the pressure to create a new and generous government program.

First, CHIP is not an entitlement program for eligible individuals. Entitlement programs guarantee enrollment and services to anyone who is eligible, regardless of the cost. As a result, entitlement programs may exceed their appropriated amount of funding and require budget writers to find additional funds to pay the balance, highlighting the often unpredictable cost of the program. Medicaid is an entitlement program, but CHIP is not. In CHIP, states have the ability to control spending by capping enrollment and capping spending when funds run out. This is an important distinction between the programs, but one that is rarely discussed.

Indeed, when the CHIP program was created in Texas, the legislation's author laid out this distinction very clearly, assuring the members of the Texas House that the program would be controlled. Laying out the bill before the Texas House, then-State Representative Patricia Gray said:

> My next point is very important. The CHIP program has absolute budget certainty. Whatever our Appropriations Committee allocates for the CHIP program is the most that we will spend. The truth of the matter is we don't really know how much it will cost, and we won't know until we gain some experience in the program, but I can assure you that we have used very, very conservative projections in developing the CHIP budget. The worst case scenario, the absolute worst case scenario is that we enroll so many children that we hit the appropriations cap, and that is okay because this is not an entitlement program. So, when the funding runs out, the State will start a waiting list as we do with other health and human services programs.[2]

The worst case scenario, the absolute worst case scenario is that we enroll so many children that we hit the appropriations cap, and that is okay because this is not an entitlement program.

-Former State Rep. Patricia Gray

As evidenced by Representative Gray's assurances on the floor of the House, CHIP was sold to the Texas Legislature as a program that offered them greater control over the budget because CHIP is not an entitlement for services.

Second, total federal spending on the CHIP program is capped, as is the amount of federal funding a state can receive. The capped federal funds are allotted to the states using a formula that considers the number of low income uninsured and insured children in each state, along with a geographic cost factor.[3] States then draw down their federal grant through a matching arrangement that is similar, but more generous than, the match used for Medicaid. By law, states have access to their allotment for three years, at which time any unspent funds are redistributed to states that used their entire allotment.

This financing mechanism for CHIP gives both the state and the federal government considerably more certainty in budgeting than it does for Medicaid. Since federal Medicaid funds match state spending on Medicaid and there is no ceiling on expenditures, neither states nor the federal government have incentives to control spending. As a consequence, total Medicaid spending has soared and states have adopted an aggressive practice of drawing down as much federal money as possible. Although the same interest in "drawing down" federal funds applies to CHIP, the program's fixed grant establishes some degree of budget certainty and an effective limit on spending, though the constant quest for federal funds continues.

Furthermore, while federal funds only flow to the state as a match on state spending for CHIP, the amount of the entire federal allotment is based largely on a calculation using a standard of need. By contrast, in Medicaid, federal funding has no relation to need, only to state spending on the program. Calculating the amount of federal funds available based on state need better ties the funds with the program's stated goal of reaching the uninsured.

Because CHIP is not an entitlement and because the federal funds are tied to a need-based calculation with a ceiling on available funds, the program can offer better control over the program's cost and size. In addition, compared with Medicaid, the federal law creating CHIP also allows states more flexibility when establishing the benefits package, as well as options for increased cost sharing. The ability to have a meaningful cost sharing arrangement and vary the benefits package are the trickle down effects of a program that does not stand on entitlement.

Calculating the Caseload: A Look at CHIP Enrollment

In 1997, CHIP's goal was to cover five million of the nation's uninsured children, about half of the estimated number of uninsured children nationwide at that time. Yet for years after CHIP's creation, CHIP proponents all the way from President Clinton to the advocacy organizations that lobbied for the program's creation bemoaned the seeming lack of interest in the program.

A look at historical enrollment in CHIP reveals questions about whether the program has even met its goal of enrolling 5 million children nationwide, much less 5 million previously uninsured children.

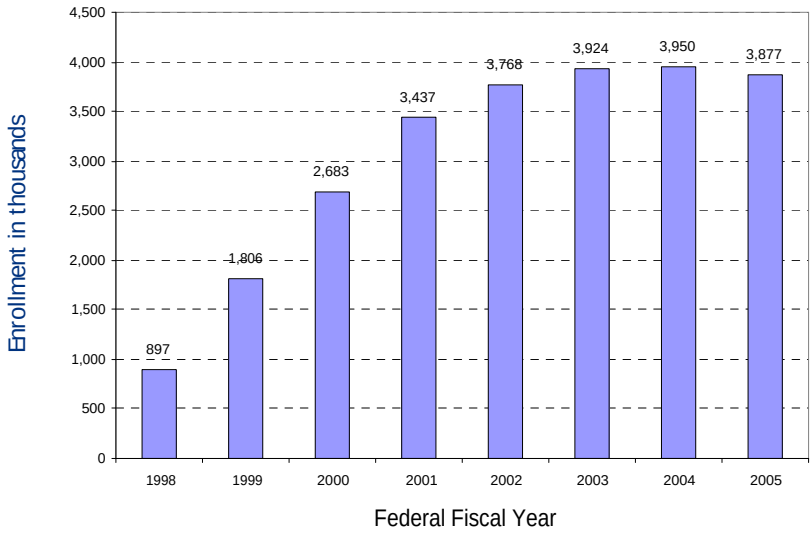
Frustrated by the low number of enrollees in 1999, President Clinton unveiled a plan to emphasize school outreach programs in an effort to enroll more children in the CHIP program, calling it "inexcusable" that federal funding was intended to insure 5 million children, while only 1 million children were enrolled at the time.[4] In September of 2000, President Clinton lauded the increase in CHIP enrollment, which had climbed to about 2.5 million children in June 2005, though still only half of the 5 million the program was intended to cover.[5] While heralding the increase in CHIP enrollment, President Clinton announced $700,000 in grants to give states additional assistance in identifying and enrolling children.[6]

Despite the $24 billion originally appropriated by Congress for CHIP and the highest expectations of conquering the problem of uninsured children, federal and state governments were time and again forced to create new strategies for outreach and enrollment in an effort to meet the targeted enrollment. Yet the success of those efforts is questionable at best, and a look at historical enrollment in CHIP reveals questions about whether the program has even met its goal of enrolling 5 million children nationwide, much less 5 million previously uninsured children.

There are two ways to count the caseload, each giving a different perspective on program enrollment. Point in time enrollment estimates the number of children on the program at any given time, while the ever enrolled count reports the number of children enrolled over the course of a year. The ever enrolled number—or an unduplicated count—is almost always higher, as would be expected as recipients move on and off the program over the course of a year.

Figure 2 shows point-in-time CHIP enrollment in the United States according to the number of children enrolled on the last day of the year.[7] As illustrated by the graph, enrollment climbed from slightly under 900,000 children in 1998 to just under 4 million children in 2004, yet still short of the goal of covering 5 million children.[8]

Figure 2: Point In Time CHIP Enrollment Nationwide 1998-2005



Sources: The Kaiser Commission on Medicaid and the Uninsured, "SCHIP Enrollment in 50 States: December 2004 Data Update," and the U.S. Centers for Medicare and Medicaid Services, "FY 2005 Fourth Quarter—Program Enrollment Last Day of Quarter by State—Total SCHIP."

Figure 3 shows the number of children ever enrolled across the country in the program by year from 1998 through 2004.[9] Not until 2002 did the number of children ever enrolled nationwide exceed 5 million, despite steady increases in enrollment almost every year.

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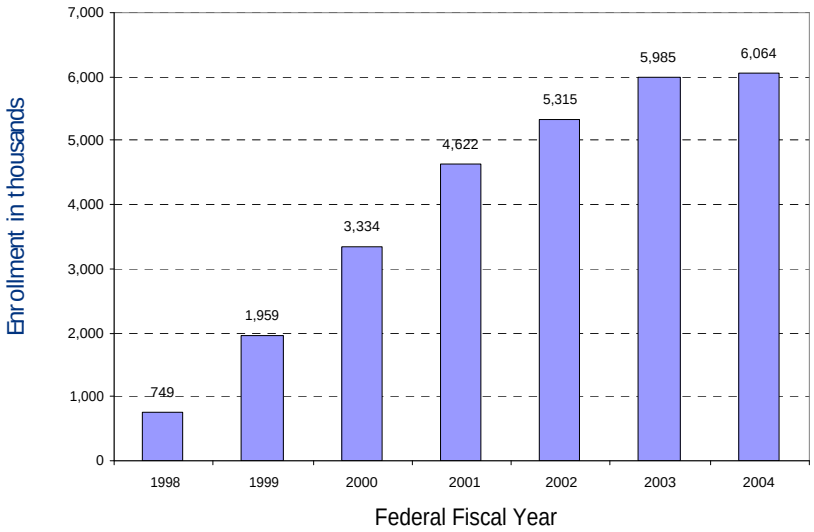
Figure 3: Nationwide CHIP Enrollment Ever Enrolled 1998-2004



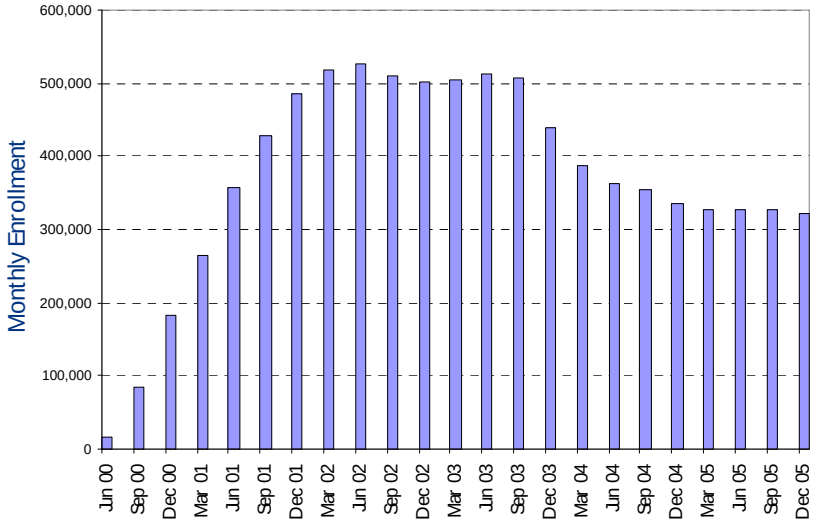
Source: Marilyn Ellwood, Angela Merrill, Wendy Conroy, "SCHIP's Steady Enrollment Growth Continues," Mathematica Policy Research, Inc. (May 2003): 3.

Note that neither the ever-enrolled nor the point-in-time data reflect fluctuations in enrollment over the course of the year as the monthly history would. For instance, national CHIP enrollment peaked in June of 2003 with 3,951,000, chil-

dren enrolled nationwide.[10] CHIP enrollment in December of 2004, as reflected in the point-in-time data in Figure 2, was just 1,600 children shy of the June 2003 peak, but still higher than the point-in-time data for 2003.[11]

Figure 4 reflects the monthly point-in-time enrollment in select months from June 2000 through December 2005 for Texas' CHIP program.[12] Texas CHIP enrollment peaked in May 2002 (date not shown on bar graph) at 529,211 children, showing a generally steady decline in monthly enrollment since that period.

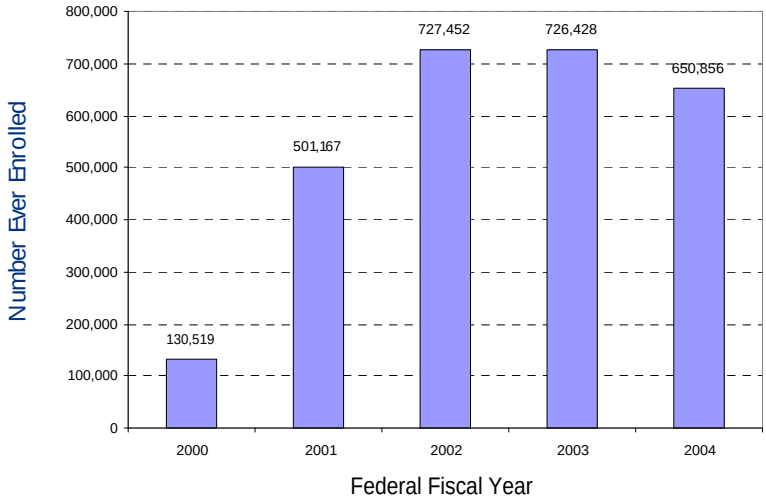
Figure 4: Monthly Texas CHIP Enrollment June 2000-December 2005



Source: Texas Health and Human Services Commission, "CHIP Enrollment, Renewal and Disenrollment Rates (December 2005)," 23 Feb 2005.

The number of children ever enrolled in the state's CHIP program is shown in Figure 5.[13] The data reflects high numbers of children ever enrolled in 2002 and 2003, which coincides with the peak in enrollment in May 2002.

Figure 5: Annual Texas CHIP Enrollment Ever Enrolled 2000-2004



Source: U.S. Center for Medicare and Medicaid Services, Enrollment Reports.

As the data indicates, enrollment in CHIP has failed to meet its proponents highest hopes, despite continued efforts in outreach to help boost enrollment. By the time the nation hit its peak in enrollment, Texas caseloads had already begun to decline—a trend that has continued and is discussed at length in the pages ahead.

CHIP, the Uninsured and "Crowd Out"

Despite the overall growth in caseloads and efforts to boost enrollment through aggressive outreach, there has been no meaningful reduction in the number of uninsured children in the U.S. or in Texas. Whether looking at the percentage of the uninsured as a whole, or at the percentage of uninsured children in particular, the percentage of the population without insurance remains relatively unchanged—even with massive growth in Medicaid, Medicare, and CHIP.

Historical data on the uninsured, and on the population at large by health insurance status, show increased participation in government health programs, a steady decline in the proportion of people in the private health insurance market, and little or no change in the percentage of the uninsured. Accordingly, the data presents evidence of government programs—primarily Medicaid and CHIP—crowding out private health insurance, rather than reducing the number of uninsured.

Despite the overall growth in caseloads and efforts to boost enrollment through aggressive outreach, there has been no meaningful reduction in the number of uninsured children in the U.S. or in Texas.

"Crowd out" was neither an unintended nor an unpredictable consequence of CHIP's creation. Lawmakers were fully aware that the creation of the CHIP program might encourage families to leave private coverage and join the CHIP program instead. In response to this concern Congress provided states the option to establish a waiting period for CHIP eligibility that might discourage families from pulling out of the private market by using the gap in coverage as a deterrent. Additionally, the states' ability to apply some measure of cost sharing through premiums, enrollment fees and copayments made CHIP more like private health insurance, rather than a no-cost benefits package that would be more likely to encourage families to forego the cost of private health insurance.

Of course, the federal government also knew that states would be eager to trade their lower Medicaid matching rate for the higher, "enhanced" matching rate available for CHIP expenditures. Accordingly, lawmakers feared that states would look for ways to shift Medicaid children into the CHIP program and receive a better match for state expenditures. In response, the CHIP program also employed a maintenance-of-effort requirement, requiring states to continue covering children under eligibility levels in place before the CHIP program was passed. Although termed differently, the maintenance-of-effort provisions are a tool used against states to prevent CHIP from crowding out existing government programs for the state's financial benefit. Arguably, these measures did a better job of keeping states from shifting children from Medicaid into CHIP than they did in preventing otherwise insured children from enrolling in CHIP.

Looking at the results of the CHIP program, it is clear that the concerns about crowd out were not unfounded. A February 1998 study from the Congressional Budget Office gave an early analysis of the CHIP crowd out phenomenon, and its impact on private heath insurance, saying:

> Despite provisions in the legislation requiring that insurance programs established under S-CHIP not displace private insurance, some displacement is inevitable. That outcome does not necessarily mean that low-income families or their employers will immediately drop coverage of dependents. But over time, labor markets will adapt to the existence of federal subsidies, with low-income workers receiving more compensation in the form of cash wages and less in the form of health insurance.[14]

The Congressional Budget Office went on to state that an estimated "60 percent of the participants in S-CHIP would otherwise have been uninsured. The remaining 40 percent would have had some other form of coverage."[15]

Whether crowd out occurs as a result of individuals making the choice to forego private health insurance and enroll in CHIP, or as a result of labor markets adapting to the existence of such programs and reducing benefits, there has been an undeniable shift away from private health insurance. Taken in combination with the relatively insignificant changes in the percentage of the uninsured and climbing government rolls overall, there is strong evidence that gains in CHIP enrollment (along with increased enrollment in Medicaid) have actually come at the expense of private health insurance.

There was less than a 2 percent reduction in the number of uninsured children nationwide from 1987 to 2004, despite 17 years of massive expansions of the Medicaid program and the creation of CHIP.

The Census Bureau estimates that in 1987 almost 13 percent of people in the U.S. were uninsured, compared to 15.7 percent of the population in 2004,[16] and that 12.9 percent of U.S. children under age 18 were uninsured in 1987, versus 11.2 percent in 2004.[17] That makes for a less than 2 percent reduction in the number of uninsured children nationwide from 1987 to 2004, despite 17 years of massive expansions of the Medicaid program and the creation of CHIP.

Figure 6 shows the health insurance status for U.S. children under age 18 between 2000 and 2004.[18] Each year, the proportion of uninsured children declines by fractions of a percentage point, while the proportion of children on government health plans increases, and the proportion on private plans decreases.

Figure 6: U.S. Health Insurance Status by Category of Coverage Under 18 Years

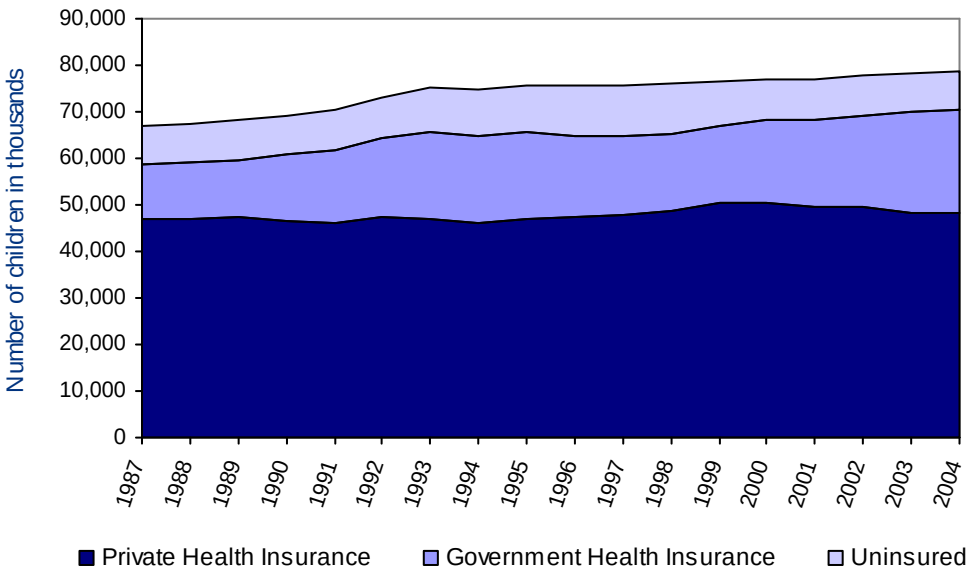
Year	Percent Private Health Insurance Coverage	Percent Government Health Insurance Coverage	Percent Uninsured
2000	69.8	24.4	11.9
2001	68.4	25.9	11.7
2002	67.5	26.8	11.6
2003	65.9	29.1	11.4
2004	65.6	29.7	11.2

Source: US Census Bureau, "Income, Poverty, and Health Insurance Coverage: 2004," Table C-2.

From 2000 to 2004 the proportion of uninsured children declined by less than one percentage point. This marginal reduction in the number of uninsured children, however, was dwarfed by the roughly four percentage point reduction among children receiving health insurance through a private plan. At the same time, the number of children receiving government health insurance grew by roughly 20 percent. It is improbable that a 20 percent increase in enrollment in government health insurance from 2000 to 2004 could have been achieved without also drawing children out of the private market when the change in the uninsured is so small.

Figure 7 compares the sources of health insurance coverage for children in the U.S. from 1987-2004.[19] Note that the graph uses actual numbers and illustrates the overall increase in population for this age group. The number of children in private health insurance has generally stayed the same throughout the period with some fluctuations and a slight decline in recent years, while the number of children on government insurance has grown substantially since 1987. The top band of the graph represents the number of uninsured children, which increased during the 1990s, but has remained relatively unchanged from 2000 through 2004, and was roughly the same in 2004 as it was in 1987. In actual numbers, there were roughly 8.2 million uninsured children in 1987 and 8.3 million uninsured children in 2004.

Figure 7: U.S. Health Insurance Coverage 1987-2004
Children Under Age 18



Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," Washington, GPO (Aug 2005): 69.

In fact, the graph clearly shows that the growth of the U.S population under age 18 has disproportionately received its health insurance coverage through the government. According to the Census Bureau, the under 18 population grew by roughly 10.4 million people, with an almost 9.9 million person increase in government health insurance.[20] As a percentage of the population those on private health insurance decreased by 8 percent, those on government health insurance increased by almost 11 percent, and the percentage of uninsured children declined by 1.7 percent. The dramatic increase in the number and percent of children on government insurance programs is not a result of dramatically declining uninsured children, but of the government programs crowding out participation in private health insurance.

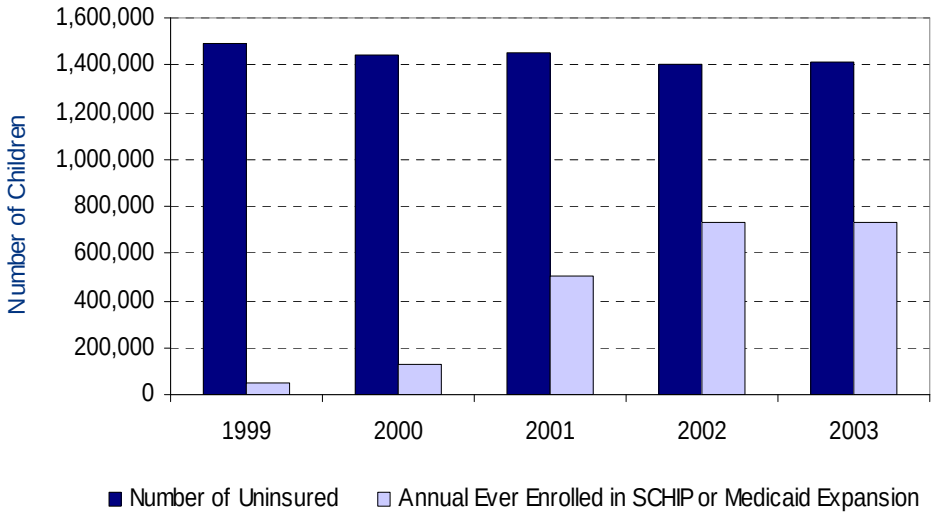
The graph also indicates that the creation of the CHIP program in 1998 did coincide with a decrease in the number of uninsured children across the country. However, those early gains in 1998 through 2000 have not continued and, even when CHIP enrollment peaked nationally in June 2003, the number of uninsured children has remained relatively unchanged.

The dramatic increase in the number and percent of children on government insurance programs is not a result of dramatically declining uninsured children, but of the government programs crowding out participation in private health insurance.

In Texas every year since 1990, estimates suggest that between 22 percent and 25 percent of children under age 18 in the state are uninsured.[21] Similarly, newspaper articles from around the state routinely highlight Texas' unchanged rate of uninsured children, despite state government efforts to reduce the number of uninsured. Neither increases in Medicaid coverage for children—nor the creation and enrollment of children in Texas' CHIP program—have been able to reverse the percentage of uninsured children in the state.

Figure 8 compares the number of uninsured children in Texas with the CHIP caseload from 1999 through 2003, years where data is consistently available and includes the state's 2002 peak in CHIP enrollment.[22] As the graph illustrates, the number of uninsured children has declined slightly, but less than the increases in CHIP enrollment. For instance between 2000 and 2001, Texas CHIP enrollment increased dramatically, but the number of uninsured stayed roughly the same. Between 2001 and 2002, the CHIP caseload increased again, and the number of uninsured dropped by less than the CHIP caseload increased. Between 2002 and 2003 CHIP enrollment was at its peak (also see Figure 4, page 12), yet the number of uninsured *increased* nonetheless.

Figure 8: Comparison of Texas Uninsured and CHIP Enrollment 1999-2003



Source: Annie E. Casey Foundation, "Kids Count State Level Data, Children 18 and below without health insurance, by Age Group," and the Centers for Medicare and Medicaid Services.

By any measure, the number of children enrolled in CHIP has never been accompanied by a commensurate reduction in the uninsured.

Once again, even as the number of children enrolled in CHIP increases, the number of uninsured children in the state—even across the country—remains relatively unchanged. As illustrated by Figures 7 and 8, enrollment in CHIP and Medicaid seems to have little impact on the number of uninsured, but coincides with declines in private coverage that signal the presence of crowd out.

Furthermore, the gains in enrollment and the relatively minor changes in the uninsured suggest that the market may be approaching saturation. Despite years of effort to reduce the number of uninsured children, the question that remains unanswered is whether it is even possible to significantly reduce the number of uninsured. A growing body of work points to the varying characteristics of the uninsured, suggesting that many people do not have insurance by choice. While organizations devoted to the cause of the uninsured insist that increased outreach will bring more people into the CHIP program, it has been erroneously assumed that those increases will drive down the number of uninsured children.

Since CHIP's primary goal was to reduce the number of uninsured, it is difficult to see how the program can be considered a success when it has failed to achieve the stated objective. The state has done a poor job identifying the eligible uninsured, and, by any measure, the number of children enrolled in CHIP has never been accompanied by a commensurate reduction in the uninsured. Accordingly, it not only fails to achieve its stated objective, but has a deleterious effect on the private health insurance market as well.

CHIP Policy in Texas

When President Clinton signed the CHIP program into law in August 1997, the Texas Legislature had already adjourned for the year and would not return until 1999. Although the program was not passed by the Texas Legislature until 1999, the first phase of the CHIP program really began in July of 1998 by expanding Medicaid coverage to include children ages 15-18 in families at less than 100 percent FPL. At the time, children ages one through five in families up to 133 percent FPL were covered under Medicaid, and children ages six through 18 in families up to 100 percent FPL were being gradually phased into Medicaid one year at a time through 2002. In 1998, only children ages 15-18 in families at less than 100 percent FPL were ineligible for the program by virtue of their age and birth date. The first phase of CHIP merely sped up the expansion to include children ages 15-18 sooner.

In 1999, the 76th Texas Legislature passed CHIP into law.

Just as congressional Republicans were generally uninterested in creating a new government program during the 1997 debate in Washington, some Texas Republicans were equally unenthusiastic about undertaking the new program in Texas. However, grassroots and advocacy organizations in the state were successful at building pressure for the program, and in 1999 the 76th Texas Legislature passed CHIP into law.

During the debate on the House floor, CHIP proponents stressed that the CHIP program was not an entitlement, that it needed no General Revenue appropriations because it would be funded through the state's tobacco settlement, and that the state could use waiting lists as a way to control growth in spending. In laying out the legislation, then-State Representative Patricia Gray insisted that the worst case scenario was that the state would enroll so many children in the program that the state would reach the appropriations cap, forcing the state to start a waiting list. Then-State Representative Glen Maxey echoed the plan to use a waiting list, engaging State Representative Oliveira in the debate on the House floor, asking:

> **Maxey:** And the money that we have appropriated is not even from General Revenue, it's from the tobacco settlement, is that not true?
>
> **Oliveira:** Exactly…we're not taking one General Revenue dollar…
>
> **Maxey:** And the bottom line is, the worst thing that could happen is that a waiting list forms, correct?
>
> **Oliveira:** Absolutely…
>
> **Maxey:** Did you know that at the Public Health committee meeting, that I made a pledge to Representative Delisi that if the state of Texas gets to have a waiting list on this program, the first time in history that I know of that we have done such a good job of enrolling kids

> that we have a waiting list, that I would do a jig out there on the star of the state Capitol and she said she would do it with me?[23]

This exchange was emblematic of the sales pitch for the program. Legislators made statements about the program being on a "funds available basis" and that the program would be financed through tobacco money and federal dollars only. There was no question that the 76th Legislature enacted CHIP with a clear understanding and seeming acceptance of the constraints that the state could—and would—put on the program. However, as time has shown, the state has balked at employing any of the promised protections.

Despite imminent passage, many legislators attempted to put more clear constraints on the program. Those legislators offered amendments hoping to specify that the income eligibility level would be based on gross income in comparison to the poverty level and not on net income (a measure that allowed families to deduct certain expenses such as child care and work expenses), to cover younger children up to 200 percent FPL and older children to 150 percent FPL, to specify that CHIP benefits be equivalent to the health benefit for state employees, to prevent coverage for legal immigrants (receives no federal match), to state the objective of the program, and to require legislative approval to continue the program with another revenue source in the event of future loss of tobacco funds.[24] Of the amendments listed above, only the last two made it onto the bill.[25]

There was no question that the 76th Legislature enacted CHIP with a clear understanding and seeming acceptance of the constraints that the state could—and would—put on the program. Yet, as time would show, the state balked at employing any of the protections.

When the 77th Texas Legislature gaveled in, CHIP enrollment in Texas had just passed 200,000 children and the program enjoyed political popularity, despite frustrations over slow enrollment. Backed by a well-orchestrated campaign through grassroots and advocacy organizations, the legislature passed a simplified eligibility process for Medicaid that would more closely mirror CHIP. The simplified eligibility changes included elimination of the face-to-face application and recertification process, and dramatically reduced verification of assets.[26]

Also included, and among the most significant of the eligibility changes, was the extended period of twelve months of continuous eligibility for both CHIP and Medicaid. Indeed, many families may have one child enrolled in CHIP and another in Medicaid by virtue only of the child's age, and different application processes between the two programs are undoubtedly hard to negotiate. Arguments that families would have difficulty managing enrollment in two different programs, and criticism that the poorer Medicaid eligible families were saddled with more rigorous application and recertification requirements, supported the efforts for simplified eligibility.

In the press release issued upon the bill's passage, its author, Texas Senator Judith Zaffirini, heralded the passage of the legislation by promising that "the number of uninsured children will be reduced."[27] In the end, the 77th Legislature appropriated $122.6 million in tobacco settlement receipts to fund Medicaid simplified eligibility, in addition to the $419.2 million in tobacco receipts for the CHIP "family of programs," which includes enrolling eligible children in Medicaid when they apply for CHIP, immigrant health insurance, and coverage

for state and school employees' children who would otherwise be CHIP eligible.[28] The total budget for CHIP (phases one and two) in the 2002-2003 biennium was almost $950 million.[29]

With a budget shortfall looming and CHIP caseloads increasing, lawmakers, advocates, and state agencies began warning that the CHIP program would experience a budget "shortfall" of its own. Early in 2002 the CHIP shortfall was estimated at $29.4 million, jumping to more than a $100 million shortfall when the federal funds are included.[30] By June, the Health and Human Services Commission briefed members of the Legislative Budget Board and estimated a $40-50 million General Revenue shortfall for the CHIP program.[31] Newspaper reports on the shortfall quote advocacy organizations and some health care providers in opposition to the Commission's consideration to implement a cap on enrollment and begin a waiting list.[32]

Ultimately faced with an almost $10 billion budget shortfall overall, the 78th Texas Legislature undertook major reforms to the state's health and human services agencies and programs. Through House Bill 2292, authored by then-State Representative Arlene Wohlgemuth, and through additional savings in the appropriations bill, the state was able to slow the growth in health and human services spending. To be more accurate, the budget measures in 2003 merely reduced the rate at which government spending would increase, limiting the increase in health and human services spending to $1.3 billion in All Funds, and $232.2 million in General Revenue.[33]

The elimination of dental or vision benefits in the CHIP program in the 78th Legislature actually better aligned the CHIP benefits with those received by state employees, whose dental and vision benefits are an optional service paid for by state employees—not part of the health benefits package provided by the state.

In order to achieve the needed savings, the Legislature made a number of policy changes in the CHIP program, including: calculating eligibility on gross income by eliminating deductions that allowed for child care and certain work expenses that were excluded from income; implementing a 90-day waiting period for coverage; requiring applicants to reapply for benefits every six months, rather than every twelve months; and implementing an assets test for children in families above 150 percent FPL. In addition, the legislature eliminated or scaled back some CHIP services, such as dental, vision, and mental health services, and instituted a more aggressive cost sharing program with new or higher premiums, co-payments, and enrollment fees, set on a sliding scale according to the recipient's income. Notably, during the original debate on the CHIP program, Representative Wohlgemuth had offered an amendment to ensure that CHIP benefits were no more generous than the state employee benefits, but the amendment failed. However, the elimination of dental or vision benefits in the CHIP program in the 78th Legislature actually better aligned the CHIP benefits with those received by state employees, whose dental benefits are an optional service paid for by state employees individually—not as part of the health benefits package provided by the state.

With these reductions came an outcry aided by the state's major newspapers and advocacy organizations. The monthly premiums were portrayed as draconian barriers to participation, despite surveys showing that recipients felt good about paying a portion of the cost and found the cost sharing reasonable.[34] In 2004, the Governor asked the Health and Human Services Commission to delay disenrolling

families for failure to pay monthly premiums, suggesting a longer review to assess the impact of the higher premiums and possible incentives for paying the premiums, such as tying them to additional services.[35] In addition, reductions in mental health services drew significant criticism, also prompting the Governor to direct additional funding to mental health services in the Fall of 2003.[36]

The CHIP assets test was labeled as equally draconian, though it was designed to ensure that assistance went only to CHIP-eligible children. The assets test, which only applies to families with incomes above 150 percent FPL, allows the state to count the cash on hand, the value of checking and savings accounts, the value of investments, as well as the value of the family vehicle(s).[37] At the same time, the assets test excluded the value of retirement accounts with penalties for early withdrawals; educational grants, scholarships, and certain education savings accounts; as well as modifications to vehicles that are used for a household member with a disability.[38] According to the 2004 Biennial Report from the Transition Legislative Oversight Committee, implementation of the assets test did identify both new and renewing applicants with assets that exceeded the limitations, including: an adult and one child with three vehicles totaling almost $50,000 in value after the allowable deductions, a family of four with a monthly income of more than $5,000 and three IRA accounts totaling almost $160,000, and a number of cases where recent model Lexus, Pathfinder, Cadillac, and Suburban vehicles exceeded the allowable asset value.[39]

By the time the Legislature would return in 2005, the reductions in CHIP services were well chronicled and the push to restore the services was strong. The 79th Texas Legislature faced an improved financial picture, though the Health and Human Services Commission reported a $68 million CHIP "shortfall" in its presentation to the House Appropriations Committee. The legislature ultimately restored dental, vision, and mental health coverage to 2003 levels. The push to allow continuous eligibility for CHIP to extend to twelve months was unsuccessful,[i] though it became a major point of deliberation as some legislators tried to negotiate down the amount of funding necessary for the lengthened continuous eligibility.

Interestingly, the push for 12 months continuous eligibility was initially for both Medicaid and CHIP, but because the cost for 12 months of continuous eligibility was lower for CHIP (due in large part to the state's ability to control the caseload), many focused their efforts on 12 months eligibility in CHIP alone. Taking a lesson from history, however, it could be assumed that had the push for 12 months of continuous eligibility in CHIP been successful, it would have been soon followed by a push to again make Medicaid more like CHIP, as was the case in 2001 with simplified eligibility for Medicaid. Indeed, lawmakers were wise to keep the CHIP and Medicaid eligibility periods consistent between the programs for this reason.

Had the push for 12 months of continuous eligibility in CHIP been successful, it would have been soon followed by a push to again make Medicaid more like CHIP, as was the case in 2001 with simplified eligibility for Medicaid. Indeed, lawmakers were wise to keep the CHIP and Medicaid eligibility periods consistent with one another for this reason.

[i]Note that the six month period of continuous eligibility was set to return to 12 months of continuous eligibility on September 1, 2005, a return to the continuous eligibility period in place prior to the changes from the 78th Legislature. To maintain a period of 6 months continuous eligibility required legislative action.

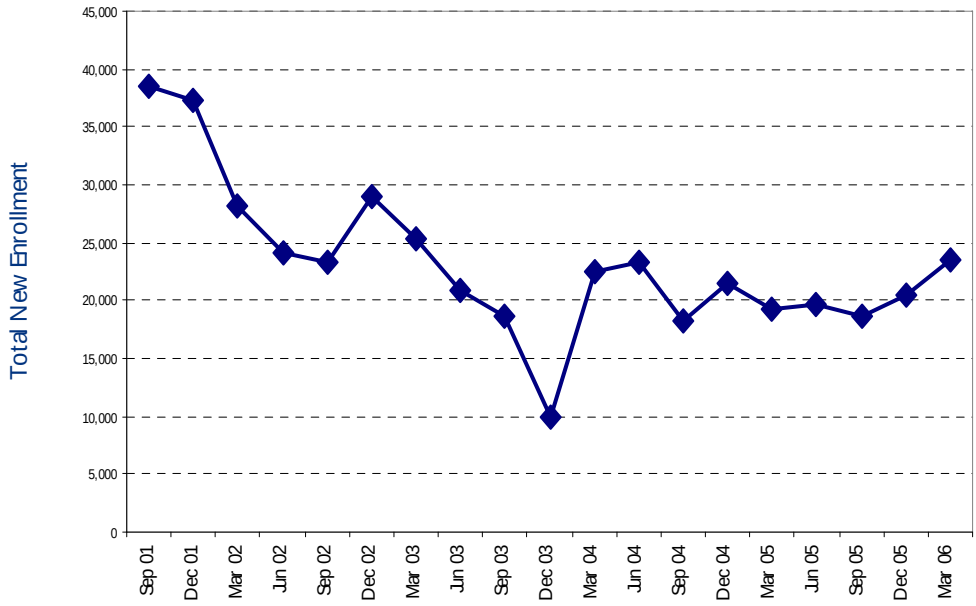
Finally, the 79th Legislature also included a rider in the Appropriations Act, directing HHSC to pursue additional funds with the Legislative Budget Board before taking steps to freeze enrollment in response to an anticipated shortfall. Although the direction itself may be fully appropriate, such provisions illustrate the seeming disinterest in controlling the program as it was first characterized. In fact, in an apparent bait and switch, the program that was said to have budget certainty would experience biennial "shortfalls" were it not for additional funding in supplemental appropriations, and the program has never relied on a waiting list despite projected cost overruns.

Counting Kids: A Look at the Changing CHIP Caseloads

Although there have been undeniable declines in the state's total CHIP enrollment, a superficial glance at the total caseload does not give the full picture. HHSC data on CHIP enrollment, renewals, and disenrollment offers a more detailed look at the state's monthly CHIP caseload.

While the total CHIP caseload is down from its May 2002 peak, the number of new enrollees for April 2006 was higher than it had been at any time since January 2003. April 2006 new enrollment in CHIP totaled almost 29,500, the highest it has been in any month since January 2003 when HHSC reported 32,095 new enrollees.[42] Figure 9 below illustrates the changes in new enrollment in CHIP in selected months since September 2001. In the graph below, March 2006 new enrollment data is slightly higher than new enrollment data for June 2004 (April 2006 new enrollment not pictured).

Figure 9: New Enrollment in Texas CHIP September 2001-March 2006



Source: Texas Health and Human Services Commission, "CHIP Enrollment, Renewal and Disenrollment Rates (March 2006)," 27 Feb 2006.

The generally downward trend in new enrollment from September 2001 through December 2003 can be attributed to several factors. First, in the early days of the CHIP program, Texas provided coverage to a number of children in homes with incomes of less than 100 percent of the Federal Poverty Level (FPL) who were not otherwise eligible for Medicaid coverage at the time; however, as Medicaid coverage expanded to cover children ages 6-18 under 100 percent FPL, CHIP coverage for that income level declined. From July 2000 to April 2006, the percentage of children covered in CHIP with a family income of less than 100 percent FPL declined from 27 percent to under 6 percent.[43] The decline in coverage among those with an income of less than 100 percent FPL was gradual in the earlier years, and did not drop below 20 percent until January 2004.[44] By contrast, enrollment among those with incomes 100 percent to 185 percent FPL has increased fairly steadily as a proportion of enrollment since the program began.[45]

Second, the period of twelve months of continuous eligibility for both Medicaid and CHIP became effective in September 2001, which likely minimized the movement between the programs and resulted in fewer applications for new enrollment. Accordingly, it is likely that the six months of continuous eligibility passed in 2003 could have accelerated the turnover in the program, as families may have been ineligible for a month or more, and then reenrolled when they became eligible again.

A look at CHIP disenrollment by reason shows that through 2005 an average of 32 percent of disenrollments were due to a determination that the family was no longer eligible for the program, despite completing the necessary renewal.

The disenrollment data also shows that disenrollments play a large part in both the declining caseload and may fuel some of the new enrollment. A look at CHIP disenrollment by reason shows that through 2005 an average of 32 percent of disenrollments were due to a determination that the family was no longer eligible for the program, despite completing the necessary renewal.[46] Additionally, an average of almost 36 percent of disenrollments in 2005 were due to the family's failure to reenroll, with the majority of the remaining disenrollees attributable to becoming eligible for and enrolling in Medicaid.[47] Data from the first quarter of calendar year 2006 continues to show that failure to reenroll and ineligibility (following a completed renewal) remain the two most common reasons for disenrollment.

This data supports the notion of CHIP as a safety-net that provides temporary assistance to families, rather than a long-term program: ineligible families are disenrolled from CHIP and, if eligible, children are enrolled in Medicaid. Furthermore, the large percentage of disenrollees who simply fail to reenroll is entirely expected and appropriate, as families obtain other coverage or choose not to reenroll in the program. It should also be noted that some portion of disenrollment due to non-renewal or incomplete information in the submitted renewal form, may be due to an applicant knowing that their family no longer qualifies for the program. While calculating the number of disenrollments under this scenario with confidence may be difficult, anecdotal stories suggest that this may be a factor for some disenrollees who fail to reapply.

Indeed there may be families that cycle on and off of the CHIP rolls, but the overall decline in enrollment indicates that other factors must also be at work as there are not new enrollees to take the place of every child who disenrolls from the program.

The recent decline in total enrollment has been publicly attributed to program and policy changes in the CHIP program. Caseload declines after the 78th Legislative Session in 2003 were immediately chalked up to the new assets test and verification, and to the loss of certain benefits. A December 2004 report from the Transition Legislative Oversight Committee highlighted the assets test as a measure to guard against fraud and abuse in the system, and a responsible step to ensure services go to only the most needy. The committee, which oversaw the change in programs and the consolidation of health and human services agencies, likened the impact of the assets test on the declining CHIP caseload to the 1995 decline in the food stamp caseload when the Lone Star Card was introduced. According to the Transition Legislative Oversight Committee's report, enrollment in the food stamp program declined by 32 percent in the two years following the introduction of the Lone Star Card, which was attributed to the card's success in reducing fraudulent use of the program.[48] This comparison captures the likelihood that some portion of the caseload decline in CHIP is also attributable to the use of the assets test to identify fraud and ensure eligibility for only the most needy.

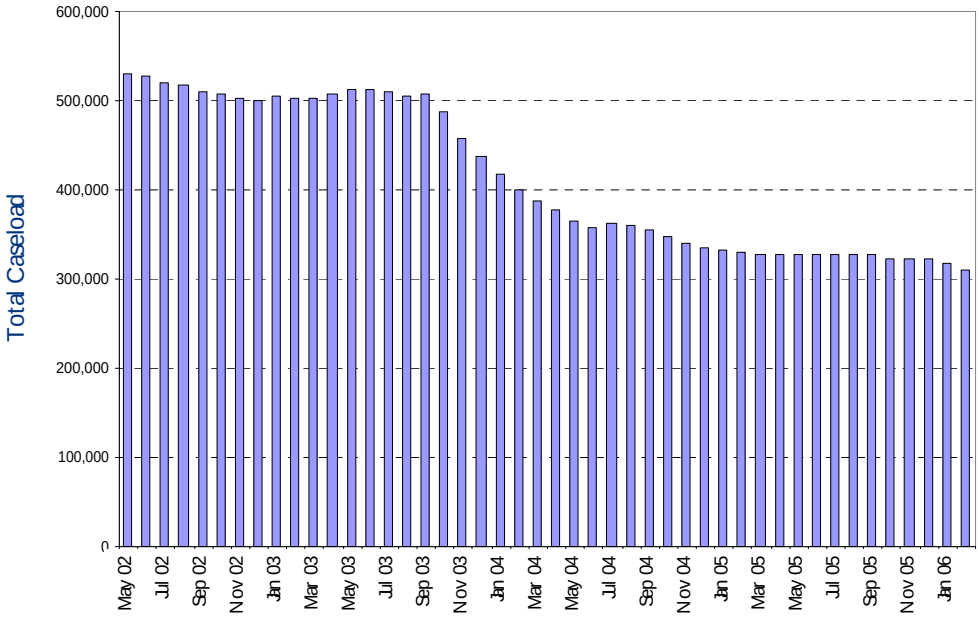
Enrollment in the food stamp program declined by 32 percent in the two years following the introduction of the Lone Star Card, which was attributed to the card's success in reducing fraudulent use of the program. This comparison captures the likelihood that some portion of the caseload decline in CHIP is also attributable to the use of the assets test to identify fraud and ensure eligibility for only the most needy.

Similarly, there is a real probability that the peak in CHIP enrollment included a number of ineligible children enrolled in the program due to more relaxed eligibility and verification processes. Prior to the legislative changes in 2003, eligibility was largely self-declared and the state made little meaningful effort to ensure enrollees were truly eligible. In addition, the relaxed standards, and lack of coordination between programs also resulted in the dual-enrollment of children in Medicaid and CHIP. By contrast, the 2003 policies have improved the integrity of the program, simultaneously targeting the assistance to those determined to be most in need and better ensuring that those children enrolled in the program are truly eligible. As a result, some portion of the decline can likely be attributed to the loss of ineligible enrollees who at one time effectively inflated program enrollment.

Continued declines in the total caseload have come under more intense scrutiny since the implementation of call centers to facilitate applications for government assistance programs, including CHIP. In reality, the CHIP caseload has been in almost continuous decline since its peak in May 2002 (shown in Figure 10), with the notable exception of March 2003 through September 2003 when the caseload fluctuated month-to-month, but showed a dip in the caseload overall.[49]

While the first quarter of calendar year 2006 may have seen more dramatic declines, it would be inappropriate to suggest that one thing alone—namely the roll out of call centers—could be responsible when CHIP caseloads were already declining. Much of the decline in the CHIP caseload has also coincided with the strengthening economy. Two March press releases from the Texas Workforce Commission tout the creation of new jobs in Texas and the reduction in the unemployment rate in the first two months of 2006. In January, season-

Figure 10: Texas Monthly CHIP Caseload



Source: Texas Health and Human Services Commission, "CHIP Enrollment, Renewal and Disenrollment Rates (March 2006)," 27 Feb 2006.

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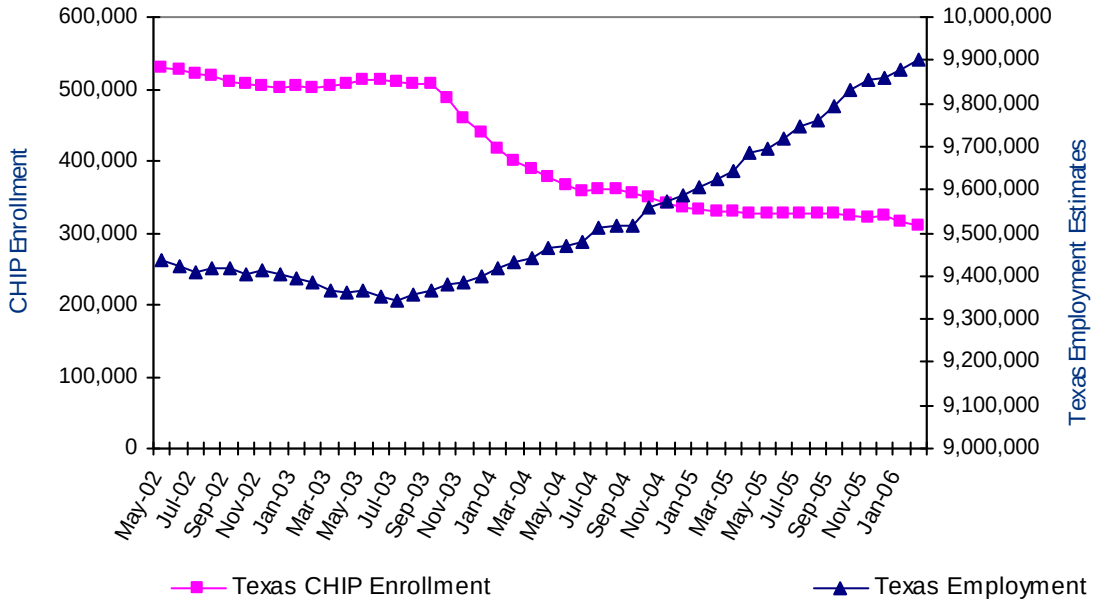
ally adjusted nonagricultural employment in the state grew by 13,200 jobs, and by 25,400 jobs in February, for an increase of almost 280,000 jobs on the year.[50] According to the Workforce Commission, the January and February increases represent the 16th and 17th consecutive months of job growth, reducing unemployment by .2 percent from December 2005, and by a full half point since January 2005.[51]

Figure 11 compares the declining CHIP caseload with the growth in Texas' seasonally adjusted nonagricultural employment. As the graph illustrates, the lowest period of employment occurred in 2003 and coincided with a slight increase in CHIP enrollment in the summer months of 2003, which was already in a slow decline. As employment began increasing in the last quarter of 2003 and policy changes passed in the 78th Session began to take effect, however, the decline in CHIP enrollment grew more pronounced. In the 17 months leading up to February 2006, the state's tremendous growth in employment has overlapped with continued, but slowed declines in CHIP enrollment.

The more likely explanation for the changing caseloads is the confluence of events that has contributed to the overall decline. If CHIP is truly to be considered a safety-net program and directed to serve the needs only of truly eligible Texas children, then there ought to be little distress when the program serves a temporary purpose. It is important to point out that despite the decline in total monthly enrollment, recent new enrollment data shows that new families con-

Figure 11: Comparison of Texas CHIP Enrollment & Employment By Month May 2002-February 2006



Sources: Texas Health and Human Services Commission, "CHIP Enrollment, Renewal and Disenrollment Rates (March 2006)," 27 Feb 2006, and Texas Workforce Commission, Labor Market Information, Employment Estimates (CES): Seasonally Adjusted Non-Agricultural Employment.

A slowed economy is almost always blamed for higher caseloads, but an improved economy rarely gets credited when caseloads decline.

tinue to make use of the program. In addition, a slowed economy is almost always blamed for higher caseloads, but an improved economy rarely gets credited when caseloads decline. A superficial glance at overall caseload trends fails to identify the variety of factors that could contribute to the recent declines.

Conclusion and Recommendations

State flexibility and budget certainty served as selling points of the CHIP program, both when it was created in Congress and when the Texas Legislature passed the program into state law. In this regard, CHIP's structure represents a significant and important departure from the entitlement nature and limitless spending that characterize the Medicaid program, but states must exercise the flexibility and control available to them under the CHIP program. States simply cannot treat the CHIP program as if it were an uncontrolled entitlement program. Maintaining these distinctions in future years will be critically important and may serve as an example of how Medicaid might best be reformed as well.

As yet, the CHIP program has delivered poorly on its promise of budget certainty and state flexibility. Sweeping promises from state lawmakers about the willingness of the state to employ caseload freezes have gone unenforced, despite so-called "shortfalls" in the CHIP budget and increasing appropriations for the program. The quest for maximizing federal funds pushes lawmakers to ignore the fiscal discipline that the program was said to encourage. In addition, policies designed to ensure that CHIP dollars are managed responsibly, targeting assistance to only those CHIP enrollees truly eligible for the program, have

been roundly criticized in the press and by lawmakers who have no intention of holding CHIP to its original purpose.

As a result, it is imperative that Texas lawmakers and leaders hold firm to the fiscally responsible and sound policies implemented in recent years. In particular, there are four areas of CHIP policy that lawmakers should seek to strengthen and maintain.

CHIP continuous eligibility must be the same as the continuous eligibility period in Medicaid, and should not exceed six months in duration. Given the advances in technology and the transition to a more seamless application process, there is no reason why eligibility should not be verified frequently. Advances in technology will increasingly allow for even more rapid eligibility verification and enrollment, and the state should be willing to verify eligibility as often as possible and cost effective to ensure that enrollees remain eligible for services.

The state should take seriously the issue of "crowd out," by preserving the 90-day waiting period and providing for health insurance premium payment assistance for certain children who have access to private health insurance. The current 90-day waiting period for CHIP enrollment provides a deterrent to families that might jettison private health insurance in favor of CHIP benefits that may come to them at either low or no cost. Establishing that CHIP benefits are not immediately available, helps guard against individuals migrating to the government program at the expense of obtaining insurance in the private market. In addition, employers frequently make use of the 90-day waiting period for new hires, which makes the government program more reflective of, and no more generous than, the benefits in the private market. This arrangement minimizes an individual's interest in skirting the employer's waiting period by immediately enrolling in CHIP.

The CHIP program has delivered poorly on its promise of budget certainty and state flexibility.

The state currently makes use of a premium payment assistance program for individuals who are Medicaid eligible, but have other access to private health insurance. A waiver to allow Texas to implement a premium payment program is currently under consideration at the federal level. In cases where it is cost effective, assistance with the private insurance premium for CHIP-eligible children could both minimize "crowd out" and result in some budget savings for the state.

The CHIP assets tests should remain in place to ensure the eligibility of enrollees. Since Texas created the Office of the Inspector General to step up efforts to guard against and prosecute fraud, the state has become a recognized leader in this area. Part of this anti-fraud focus is the state's effort to establish standards for determining eligibility which ensures that the program best meets the spirit of its existence as a program for individuals in need. Families who are not eligible for CHIP, or whose income and assets would allow them other options, but receive benefits anyway defraud the state and potentially prevent other eligible children from enrolling. The assets test best allows the state to target assistance to children and must be preserved to ensure the program's benefits are going to children for whom the program was designed to assist.

The state should continue the implementation of call centers to facilitate applications for CHIP and other health and human services benefits. Opponents of the state's plan to use call centers to facilitate applications for health and human services programs have seized upon declining CHIP caseloads in an effort to stall the continued roll out of the call center model. Importantly, the CHIP application process has always made use of a call center format, reinforcing the fact that recent declines in CHIP cannot be the result of the expanded use of call centers themselves, or the policy to use the model across programs. Part of the recent caseload decline may be attributable to process issues surrounding the expanded call centers, but that cannot entirely explain the overall decline. In fact, there are a number of factors that may help explain the reduction in the CHIP caseload, which has been on the decline since well before the new call center model roll out began.

Ultimately, these objections continue to center on the loss of state jobs and neglect to recognize the benefits of streamlining and modernizing the application process across programs. Issues arising from the call center roll out should be addressed expeditiously, but should not be used as the sole explanation for declining CHIP caseloads or as a reason to reverse course on the roll out already in progress.

The state must take seriously the opportunity to exercise control over the program, rather than treat the program as an entitlement and use supplemental appropriations to fill any projected "shortfalls."

CHIP is not an entitlement and policymakers must exercise fiscal discipline to control spending. When the CHIP program runs budget shortfalls and requires supplemental appropriations to fill the holes, the program fails to fulfill the promise of budget certainty and state control. The legislature should set the level of spending and the anticipated caseload, and the state should not exceed either number. The state must be willing to exercise a waiting list when funding runs out, creating an environment where fiscal diligence is required and generously extending coverage to people without assurances of eligibility is rejected outright. From the earliest debates on the CHIP program it was said to offer the state flexibility and budget certainty, but experience has proven those to be empty promises. The state must take seriously the opportunity to exercise control over the program, rather than treat the program as an entitlement and use supplemental appropriations to fill any projected "shortfalls" that arise in the future.

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About This Report

When the Children's Health Insurance Program (CHIP) was passed by Congress in 1997 and passed by the Texas Legislature in 1999, the program was touted as the way to reduce the number of uninsured. In Texas, legislators leading the push for CHIP sold it as a program that gave the state flexibility in running the program and budget certainty since it is not an entitlement, in contrast to the more rigid requirements and exploding costs resulting from Medicaid's structure as an entitlement.

In reality, proponents of CHIP have opposed any efforts to exercise the program's so-called flexibility, as well as efforts to control spending. Furthermore, there are real questions about CHIP's impact on the uninsured, which remains relatively unchanged despite CHIP's existence. In addition, policy changes passed by the Texas Legislature in 2003 and the implementation of an integrated eligibility model that uses call centers as the cornerstone of a simplified application process have drawn criticism in the face of declining caseloads in the CHIP program.

This report looks at the design of the CHIP program, whether CHIP is meeting the goal of covering uninsured children, and the impact of policy changes coupled with an improving economy as they relate to the decline in CHIP enrollment.