ISSUE BRIEF

Medicare/Medicaid Technical Assistance #59

AN OVERVIEW OF PROPOSED IMPLEMENTING REGULATIONS FOR THE STATE CHILD HEALTH INSURANCE PROGRAM (CHIP)

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for more information, please contact

Heather Mizeur
National Association of Community Health Centers, Inc.
1330 New Hampshire Avenue, N.W. Suite 122
Washington, DC 20036
202/659-8008 •  202/659-8519 fax

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Introduction

On November 8th, 1999 the United States Department of Health and Human Services (HHS) issued proposed regulations implementing the State Children’s Health Insurance Program (CHIP).\(^1\) This Issue Brief, prepared for the National Association of Community Health Centers, examines the Notice of Proposed Rule Making (NPRM). It begins with an overview of CHIP and then summarizes the regulations and identifies key issues for health centers and state and regional primary care associations (PCAs).

Persons who wish to submit comments may do so by mailing them to the United States Department of Health and Human Services, Health Care Financing Administration, Attention: HCFA-2006-P, P.O. Box 8010, Baltimore, MD 21244-8010. To be considered, comments must be received by January 7, 2000.

These proposed rules chiefly focus on standards for freestanding CHIP programs, since states that implement CHIP as a Medicaid expansion must follow all Medicaid rules. However, these proposed rules are important, regardless of whether your state does or does not have a freestanding program. Even in states that have implemented CHIP as a Medicaid expansion only, the outreach and enrollment assistance regulations remain critical – not to mention that such states also have the option to submit plan amendments that would create a freestanding CHIP program in the future. In states with freestanding programs, all aspects of the rules bear close examination, since they set the standards for the freestanding programs.

Another issue to bear in mind as you review the rules is that the regulations give enormous discretion over the way in which the program runs to states that elect to implement CHIP as a freestanding program. States make the program decisions regarding whether to:

- Set generous or limited eligibility standards
- Use lengthy or short applications
- Provide many or few enrollment sites
- Provide extensive or limited application assistance
- Require no, or extensive, documentation of family income and assets, evidence of other health coverage, or other factors related to eligibility

\(^1\) 64 Fed. Reg. 60882 (Nov. 8th, 1999)
Provide long or only short periods of enrollment
Require high or nominal premiums and cost sharing
Provide generous or limited benefits
Set the standards and payment levels for participating providers
Restrict families to managed care enrollment or offer a variety of plans and health care arrangements

Regardless of whether the final regulations are modified to include more detailed administration standards, the very nature of CHIP means that states will have near complete authority to design their freestanding programs. Thus, much of the work relating to CHIP implementation will be done through state based policy advocacy.

Background and Overview

CHIP was added to the Social Security Act as part of the Balanced Budget Act of 1997. CHIP is a grant-in-aid program which entitles participating states with approved state plans to annual federal funding allotments (in capped amounts on a matched basis for fiscal years 1998 through 2007) to establish and operate programs for “targeted low income children.” Targeted low income children are children who are ineligible for insurance (including Medicaid) but who have family incomes at or below 200 percent of the federal poverty level or a level that does not exceed the state’s “Medicaid applicable income level” by more than 50 percentage points. States have the option under CHIP to use their allotments to expand Medicaid, establish a freestanding CHIP program, or implement a combination of the two. As of November 1999, 30 states had used some or all of their CHIP allotments to operate freestanding programs. Table 1 displays state CHIP programs by program type (i.e., Medicaid expansion, freestanding program, or combination).

3 Proposed 42 C.F.R. §457.310(b)(1). The Medicaid applicable income level is the income level that establishes eligibility for “poverty level” coverage of children who were born after September 30, 1983, and are under age 19. For infants and children up to age 6, the minimum applicable Medicaid income level is 133% of the federal poverty level. For children ages 6-19, the minimum Medicaid applicable income level is 100% of the federal poverty level. The Medicaid statute gives states the additional option to set poverty level eligibility for children at whatever level they choose. Thus, for example, a state could set Medicaid eligibility for children under its basic program at 250% of the federal poverty level by creating generous earned income disregards for working families. In such a situation, a state would have the option to set its CHIP standard at up to 300% of the federal poverty level.
To date, HHS has approved 52 state CHIP plans. More than half of all approved plans provided coverage to families with incomes at or above 200% of the federal poverty level.

In the case of freestanding programs, the CHIP statute gives states far more flexibility over the design of the program than is the case for Medicaid. Within certain federal limits, states have broad discretion to design enrollment procedures, eligibility standards, benefit packages and cost-sharing requirements and have considerable flexibility over the manner in which child health assistance will be furnished to eligible children. The proposed regulations reflect this broad discretion. At the same time, however, the proposed rules do deal with certain issues that were either not addressed in the statute or were addressed elsewhere only ambiguously. This is particularly true in the case of state program compliance with the Presidential directive known as the Consumer Bill of Rights and Responsibilities (which orders Medicaid and CHIP plans, among others, to comply with fundamental beneficiary protections outlined in the directive) and due process requirements for children who apply for or receive CHIP benefits.

States that implement CHIP in whole or in part as a Medicaid expansion must adhere to all Medicaid requirements.

Summary of the Proposed Regulations

The NPRM would add a new Part 457 to 42 C.F.R.; this new Part contains the CHIP rules. (Medicaid regulations are found at Parts 431 through 450). Part 457 contains the following subparts:

- Subpart A: Introduction, State plans, and Outreach Strategies
- Subpart B: [Reserved]
- Subpart C: State Plan Requirements: Eligibility, Screening, Applications and Enrollment
- Subpart D: Coverage and Benefits: General Provisions
- Subpart E: State Plan Requirements: Beneficiary Financial Responsibilities
- Subpart F: [Reserved]

4 64 Fed. Reg. 60883
5 Id.
Subpart G: Strategic Planning, Reporting, and Evaluation

Subpart H: Substitution of Coverage

Subpart I: Program Integrity and Beneficiary Protections


The following discussion highlights the key provisions of each subpart and identifies important issues for health centers and S/R PCAs.

Subpart A – State Plans for Child Health Insurance Programs and Outreach Strategies

Subpart A contains general definitions and proposed rules regarding state program administration.

Current State Child Health Coverage and Coordination

Proposed 457.80 (b) requires state plans to include a description of current State efforts to provide or obtain creditable health coverage for uncovered children, including efforts to identify and enroll eligible children into existing public health insurance programs.

The Preamble suggests that to do this --

* * * the State must provide an overview of current efforts made by the State through child related programs (such as Medicaid, * * * community and migrant health centers, * * *) to provide health care services or obtain creditable health coverage for uncovered children by identifying and enrolling all uncovered children.6

Outreach

Proposed 457.90 (a) provides that the state plan --

must include a description of procedures used to inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs

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6 64 Fed. Reg. 60891
and to assist them in enrolling their children in one of the programs.

State plans thus must describe their informing and enrollment procedures but the proposed rule does not specify any particular procedure.

Relevant issues for health centers and PCAs: The proposed rule does not require any specific outreach or enrollment method. Although the Preamble encourages states with freestanding CHIP plans to "consider outstationing eligibility workers at sites that are frequented by families with children," the rule does not require states to address how they will incorporate their Medicaid outstationed enrollment programs at health centers and disproportionate share hospitals into their overall CHIP outreach and enrollment plans. Since screening for Medicaid eligibility is a condition of CHIP coverage, integration of these two activities would appear to be necessary and an issue that should be addressed in state CHIP plans, even if no specific integration method is required. In addition, health centers and PCAs who have tried to partner with or engage states to implement the outstationing regulations to little or no avail, may wish to use this as an opportunity to again raise the question of the adequacy of a state's compliance with the outstationing requirements and HCFA's enforcement of the current law and its regulations.

Enrollment Assistance

Proposed 457.110(a) provides that states --

must make accurate, easily understood information available to families of targeted low income children and provide assistance to these families in making informed health care decisions about their health plans, professionals, and facilities.

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7 64 Fed. Reg. 60892
8 All state Medicaid programs must maintain outstationed enrollment programs at federally qualified health centers and disproportionate share hospitals. 42 U.S.C. §1396a(a)(55); 42 C.F.R. A 1998 evaluation of state outstationed enrollment programs at FQHCs found that nationally less than half of all FQHCs operated outstationed programs. Those that did not do so cited the lack of state resources as the major reason for their failure to maintain such a program. Sara Rosenbaum et. al., Interim Findings from a Nationwide Study of Outstationed Medicaid Enrollment at Federally Qualified Health Centers (The George Washington University Medical Center, School of Public Health and Health Services, Center for Health Services Research and Policy, Washington D.C.)
Proposed 457.110(b) provides that states --

Must have a mechanism in place to ensure that the following information is made available to applicants and recipients in a timely manner: (1) types of benefits, and amount, duration and scope of benefits available under the program. (2) Names and locations of current participating providers.

Issues for health centers and PCAs: The proposed rule does not provide detailed standards regarding what constitutes effective informing, the timely provision of assistance, or the format or manner in which the names and addresses of current providers must be furnished. While the proposed rule requires states to comply with Title VI of the 1964 Civil Rights Act (prohibiting discrimination on the basis of race, ethnicity or national origin)9 as well as with the Americans with Disabilities Act and §504 of the Rehabilitation Act of 1973 (prohibiting discrimination on the basis of disability), states are not required to specify how they will comply with these laws. Proposed 457.130. The proposed rule gives only the broadest guidance to states on these matters.

For example, the Preamble suggests that --

A State may overcome language barriers by establishing a methodology for determining the prevalent language or languages in a geographic area and making information available in the languages that prevail * * * 10

Nothing in the proposed rules appears to require states to set forth in their state plans the procedures they will use to identify population needs for specialized informing techniques, nor does the proposed rule require states to develop effective informing procedures for persons whose primary language is not English or who have physical or mental disabilities that require the use of informing techniques that are reasonably adapted to meet such needs. Presumably, a state plan would have to address both issues in order for the plan to be in compliance with either Title VI or the ADA. Indeed, without addressing these issues, HCFA would have no way to measure whether the information is “accurate” or “easily understood.”

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9 Title VI also has been interpreted to prohibit language discrimination as well.
10 64 Fed. Reg. 60893.
Public Involvement

Proposed 457.120 requires state plans to include a description of the method the state will use to “involve the public in both the design and initial implementation of the plan” and “ensure ongoing public involvement once the state plan has been implemented.”

Issues for health centers and PCAs: While the Preamble proposes that “states should provide for participation from organizations and groups such as hospitals, community health centers, and other providers, beneficiaries, and advocacy groups,” in developing its CHIP program, the proposed rule itself only requires that states “involve the public” in such efforts, without specifically distinguishing among classes of “public” for input purposes. Key public subgroups would be eligible families, providers of services to low income and uninsured children, agencies involved in the provision of related services to targeted low income children, and managed care organizations in states that furnish CHIP through managed care arrangements. In addition, the proposed rule does not require states to involve the public in all aspects of the plan, including eligibility, benefits, program design, provider qualifications and payment, outreach and enrollment procedures, and family cost sharing.

Subpart C: State Plan Requirements: Eligibility, Screening, Applications and Enrollment

Proposed 457.305 requires state plans to “include a description of standards * * * used to determine eligibility.” Unlike Medicaid, states that maintain freestanding programs have broad latitude in establishing the eligibility standards under their freestanding programs. For example, the statute permits states to decide who is a family member for purposes of determining the child’s “family income.” States also may calculate eligibility based on either gross or net income. 12

The proposed rule clarifies that a targeted low income child eligible for CHIP must meet the state’s income eligibility rules. The child also

11 64 Fed. Reg. 60893
12 Medicaid, on the other hand, contains stringent definitions of “family” and requires that eligibility be based on net rather than gross income, including deductions – or “disregards” – for certain work expenses, child care, and a proportion of earned income, and excluding some income altogether (e.g., SSI payments received by siblings). As a result, families whose gross income is within – or even above – a state’s freestanding CHIP income eligibility level may actually qualify for Medicaid once family adjustments are made and non-countable income is excluded. For this reason, screening for Medicaid prior to CHIP enrollment is exceedingly important.
must not be “found eligible for Medicaid” either through the Medicaid application or screening process or “covered under a group health plan or health insurance coverage.” Proposed 457.305(b)(1) and (2). The rule also specifies that a child is not considered ineligible as a “targeted low income child” because she is covered by another plan as long as the child does not have “reasonable access to care under that plan.” Proposed 457 (b)(2)(ii). This provision is designed to permit enrollment in freestanding CHIP programs of children who may be covered through an absent parent living in another state and who may have no real access to their coverage if the absent parent has network-style coverage that effectively eliminates access to care. However, states must provide CHIP to American Indians and Alaskan Natives and cannot consider HIS benefits to be “coverage.” Proposed 457.125.

The proposed rule clarifies that in addition to these basic eligibility standards for targeted low income children, states may adopt “additional standards” for “one or more groups” of children related to (1) geographic area, (2) age, (3) income, (4) resources, (5) spenddowns, (6) disposition of resources, (7) residency, (8) disability status, (9) access to or coverage under other health coverage, or (10) duration of eligibility (as long as eligibility is reevaluated at least once every 12 months. Proposed 457.320.

In discussing state flexibility to target eligibility, the Preamble notes that --

*** in establishing residency requirements we urge states to be particularly attentive to meeting the health needs of migrant targeted low income children. We encourage states to allow migrants to maintain residency in the state in which they reside most often if they choose or to establish residency in the state in which they

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13 It is important to remember that the absence of other coverage is not a bar to Medicaid eligibility. Therefore, a low income child with limited coverage through a parent can still enroll in Medicaid, if eligible. States that implement CHIP as Medicaid expansions would not have to comply with this “no other coverage” limit on eligibility.

14 64 Fed. Reg. 60898.

15 The proposed rules would permit states to allow children to gain eligibility for CHIP coverage through a spend-down process similar to that used in the Medicaid medically needy program. This would assist families whose incomes exceed CHIP but who have high medical bills for special needs.

16 A state that uses a resource test (most do not) could permit a family to obtain CHIP once it disposes of “excess” resources. This, too, is similar to Medicaid.

17 The preamble notes that states are prohibited from establishing minimum residency time periods (durational residency), since such requirements are considered unconstitutional. 64 Fed. Reg. 60901.
are working. We also strongly recommend that states establish written inter-state agreements setting forth rules and procedures for resolving cases of disputed residency as States do under Medicaid.\textsuperscript{18}

The proposed rule also prohibits certain restrictions on eligibility, as follows:

- Standards that cover children with higher family income without covering children with lower family income within any defined group;
- Denial of coverage based on a pre-existing medical condition;
- Restricting eligibility based on disability status;
- Requiring social security numbers as a condition of eligibility;
- Excluding American Indian or Alaskan Native children;
- Standards that violate other federal laws;
- Exclusions based on citizenship or nationality\textsuperscript{19}

Proposed 457.320 (b).

\textbf{Issues for health centers and PCAs:} The eligibility latitude given to states under freestanding CHIP programs is wide. States cannot establish durational residency standards that require minimum residency periods. Although the Preamble encourages otherwise, states would be permitted, for example, to exclude coverage of migrant children by considering them to be domiciled in another state. Conversely, domicile states could exclude coverage of migrant children on the ground that the family is working out of state. Because all Medicaid rules apply to states that use CHIP funds to expand Medicaid eligibility, PCAs and health centers in those states that serve large numbers of migrant or seasonal farmworkers and their families may want to use this as an opportunity to comment on the state’s current compliance with Medicaid regulations regarding state residency requirements.\textsuperscript{20}

\textsuperscript{18} 64 Fed. Reg. 60901.
\textsuperscript{19} Children who entered the U.S. on or after August 22, 1996 would be excluded from CHIP because it is a means tested public benefit.
\textsuperscript{20} 45 CFR 435.403(i). The Medicaid regulation states that for any individual, “the State of residence is the State where the individual is living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).”
The rule's prohibitions against certain restrictions on eligibility are particularly important to health centers and certain special populations they serve. Under Proposed 457.320 (b)(4), a state may not require that a social security number (SSN) of an applicant child or family member be provided as a condition of eligibility.

The Preamble states –

We wish to clarify that * * * a SSN must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate child health program, States are prohibited from making the provision of a SSN by another family member a condition of the child's eligibility. This rule also applies to other members of the household whose income might be used in making the child's eligibility determination.21

Applications

Proposed 457.340 requires that every individual who wishes to do so must be given the opportunity to apply for child health assistance without delay. The proposed rule permits states to use either joint Medicaid/CHIP or separate application forms.

Issues for health centers and PCAs: Although the Preamble suggests that "materials be made available to applicants and beneficiaries in easily understood language and format,"22 the language of the proposed rule itself does not require that applications be made available in prevailing languages in the community nor that translation assistance be provided. States are not required to adapt their application procedures for persons with physical or mental disabilities or who are unable to read.

Eligibility Screening

Proposed 457.350(a) requires state plans to describe --

21 64 Fed. Reg. 60902
22 64 Fed. Reg. 60893
* * * the screening procedures that the state will use at intake and any follow-up eligibility determination, including any periodic redetermination, to ensure that only targeted low income children are furnished child health assistance.

The proposed rule notes that the objective of screening is to identify "any child" who is "potentially eligible for Medicaid" as a poverty-related child. Proposed 457.350(c)(1). Thus, a state need not screen the child for potential Medicaid eligibility under all possible Medicaid eligibility categories covered under the state plan (which may number in the dozens); the screening need only be calculated to identify poverty level children.

The proposed rule also specifies that the screening must examine the child's potential Medicaid eligibility not only on the basis of gross income but also on the basis of the child's adjusted (i.e., net) income, after the disregards and deductions available for families with children are applied. Proposed 457.350(d).

Issues for health centers and PCAs: Health centers that are involved in CHIP and Medicaid enrollment efforts should note that the Medicaid screening requirement is a two-phased activity under these proposed rules in order to ensure that children who qualify for Medicaid based on net income do not lose the opportunity to enroll in Medicaid.

Facilitating Medicaid Enrollment

Proposed 457.360 requires that states facilitate enrollment in Medicaid so that children whose screening reveals potential Medicaid eligibility actually are given the opportunity to enroll and apply. The state must establish procedures --

Through which the state initiates the Medicaid enrollment process for children found through eligibility screening to be potentially Medicaid eligible. Proposed 457.360 (b).

The rule requires states to either provide the Medicaid application assistance at the CHIP office or send the information to the Medicaid staff or use other reasonable procedures to ensure application and enrollment. Id.
Issues for health centers and PCAs: This section underscores the importance of coordinating the Medicaid screening and enrollment process with CHIP at outstationed enrollment sites, since these sites can be modified to permit immediate and on-site enrollment in either program.

Application for and Enrollment in CHIP

Proposed 457.361 requires states with freestanding programs to provide families a “reasonable opportunity to complete the application process” and must offer assistance to families “in understanding and completing applications and obtaining any required documentation.” Proposed 457.361(a). States also must send applicants a written notice of the decision and, if eligibility is denied or terminated, the specific reasons for the adverse decision. Proposed 457.361(c).

The proposed rule requires states to establish time standards for determining eligibility and must inform applicants of the standards. The standard under the proposed rule cannot exceed 45 days. Proposed 457.361(d). States have discretion to set the effective date of eligibility under the proposed rule, which can be the date of application or any other date (e.g., the first day of the month following the notice of eligibility date, or a retroactive date). Proposed 457.361(e).

Issues for health centers and PCAs: The proposed rule gives states broad discretion to design their application assistance systems and procedures and does not require that they build on existing application assistance efforts of community providers or outstationed enrollment providers. In addition, health centers serving migrant and seasonal farmworkers and their families may wish to encourage states to use their discretion under the rule to provide for expedited review of applications and enrollment of migrant children, as they are likely to reside in the state for only a few months.

Grievances and Appeals

The proposed rules require that states with freestanding programs provide families an opportunity to file “grievances and appeals for denial, suspension or termination of eligibility”. Proposed 457.365. Proposed regulation 457.985(b) gives states the discretion to design grievance and appeals procedures that are less rigorous than those used in the Medicaid fair hearing process. Most importantly, even though CHIP benefits are targeted at low income children who like Medicaid children
have very limited resources, the proposed rules do not require states to continue assistance at pre-termination levels until an impartial review of the child's case is carried out. 23

Issues for health centers and PCAs: In light of the fact that children receiving freestanding CHIP benefits may be as poor as those who receive Medicaid in other states, the absence of more rigorous protections against the erroneous denial or termination of coverage is significant.

Subpart D – Coverage and Benefits

Child Health Assistance

Freestanding CHIP programs provide “child health assistance” to enrolled children. Child health assistance would be defined as payment for part or all of the cost of “health benefits coverage” provided to targeted low income children. Proposed 457.402(a).

Proposed 457.402 describes the permissible categories of child health assistance. These categories essentially parallel the Medicaid statute, except that they do not include FQHC or RHC services. However, coverage of “clinic” services is an option. Proposed 457.402(a)(4). The proposed rules also permit the coverage of “enabling services” as child health assistance (rather than as administrative services). Enabling services are defined as --

* * * transportation, translation and outreach services only if designed to increase the accessibility of primary and preventive health care services for eligible low income individuals. Proposed 457.402(a)(26).

23 In many states, children who receive freestanding CHIP benefits may in fact be poorer than children who have Medicaid coverage in states with more generous Medicaid eligibility levels. Courts have held that constitutional due process considerations require that before Medicaid benefits can be denied, reduced or terminated, recipients must be afforded the opportunity for a fair hearing that meets minimum standards for fairness and impartiality. In addition, where benefits are terminated or reduced, assistance must be continued until the fair hearing is conducted. While freestanding CHIP coverage is not legally the same as Medicaid (i.e., CHIP does not create any federal entitlements), the issue of whether due process considerations require comparable protections before CHIP can be denied or taken away may raise a different set of questions.
The proposed rules would also adopt the Medicaid prudent layperson standard of emergency coverage and would clarify that a condition can be an emergency if it necessitates emergency "outpatient" care (i.e., coverage of emergencies is not permissible for inpatient emergencies only). Proposed 457.402(b).

The proposed rule would prohibit coverage for abortion services unless the abortion is necessary to save the life of the mother or the pregnancy is the result of rape or incest. The rule also proposes that managed care entities that wish to provide abortions outside of such limitations must do so under a separate contract using non-Federal funds. Proposed 457.475.

Issues for health centers and PCAs. The phrase "outreach * * * for eligible low income individuals" in proposed 457.402(a)(26) is ambiguous. Conceivably it could permit a state to pay primary health providers such as health centers to conduct outreach activities to find eligible children as part of their overall child health assistance services (rather than or in addition to outreach costs that are reimbursed as administrative expenses). This is important because the CHIP statute caps states' overall administrative costs and thus has been viewed as providing insufficient funds to support the types of outreach efforts that experts say are necessary to find eligible children. To the extent that the phrase "outreach * * * to eligible low income individuals" is interpreted as the identification of eligible children, then this represents an important option for states and health centers. States could build outreach funds into their payments to CHIP primary care providers, along with funding for other forms of enabling services, such as translation and transportation costs.

Health Benefits Coverage

Freestanding CHIP programs have a variety of ways to make health benefits coverage available to enrolled children. They can offer direct, fee-for-service coverage under a self-administered program (i.e., just like the traditional Medicaid program works). CHIP programs also can operate as PCCMs, with limited managed care contracts with primary care case managers and overall management performed by the state (like the Medicaid PCCM program). Freestanding state CHIP programs also can buy the equivalent of MCO coverage using "benchmark" or "benchmark equivalent" coverage. Benchmark equivalents include the Federal Employee Health Benefit Plan, the State employee plan, or the plan offered by the HMO with the largest commercial, non-Medicaid enrollment in the state. Proposed 457.410-420. Benchmark coverage must include inpatient and outpatient hospital services, physicians
services and medical supplies, laboratory and x-ray services, well baby and well child care, and age appropriate immunizations that meet ACIP standards. Proposed 457.430.

Therefore, what is listed as a class of covered benefits in the state plan may not be precisely what is covered if the state chooses to offer coverage solely through a benchmark or benchmark equivalent package that is purchased from a participating insurer or HMO. Furthermore, the insurer or HMO may apply limits to coverage that would not apply if the coverage were obtained directly through the state based plan. Finally, the proposed rules on coverage do not require any particular standard for the measurement of medical necessity for children, either by the state or by benchmark insurers.

*Issues for health centers and PCAs:* Because the benchmark plans may differ from the state comprehensive package and no specific medical necessity standard is required for freestanding programs, the issue of disclosure of coverage and coverage limitations becomes particularly important. Both providers and families will need to have clear, understandable materials and information regarding what is – and is not – covered, as well as the limitations that apply to covered benefits. A word of caution about benchmark plans: benefits included under the plan may not be appropriately designed for children. For example, a standard benchmark plan might include coverage for speech therapy after a stroke, but not provide coverage of speech therapy for developmental delays. Nothing in the proposed rule specifically requires benchmark plans to be designed to meet the specific health needs of children.

**Pre-existing condition exclusions**

Health insurers selling benchmark coverage may include pre-existing condition exclusions in their plan design. Proposed 457.480 prohibits state programs from including these exclusions in their plans except to the extent that such preexisting condition exclusion clauses are lawful under ERISA or the Health Insurance Portability and Accountability Act of 1996.

HIPAA in fact does prohibit the imposition of preexisting condition exclusions in the individual insurance market in the case of “eligible individuals”. However, the law defines “eligible individuals” as persons who once were members of a group, lost their group membership, and then obtained and paid for COBRA continuation coverage for the full period of COBRA eligibility (typically 18 months). Since CHIP children generally will not meet the requirements of “eligible individuals” under HIPAA, the level of protection afforded by this proposed rule against
preexisting condition exclusion clauses in a CHIP benchmark package offered by a private insurer is unclear. The proposed rule does state that CHIP benefits are considered creditable coverage; however, the prohibition against preexisting condition exclusions is triggered only if creditable coverage was followed by COBRA coverage.

Issues for health centers and PCAs: Clarification of the pre-existing condition exclusion provisions will be important for health providers caring for children with disabilities.

Grievance and appeals

State CHIP plans must include a grievance and appeals process that meets certain standards. As noted earlier, it is not a requirement to continue assistance at pre-termination levels while a hearing on benefit reduction is pending. Proposed 457.495

Subpart E – State Plan Requirements: Beneficiary Financial Responsibilities

Premiums, deductibles and cost sharing

Freestanding CHIP programs may impose premiums, deductibles and coinsurance. The proposed regulations set forth the conditions under which such cost sharing is permissible. The state plan must set forth the requirements relating to premiums, deductibles and coinsurance and such charges must be available through a “public schedule.” Proposed 457.505. The state plan must describe --

The methods, including the public schedule, the state uses to inform beneficiaries, applicants, providers and the general public of the cost sharing charges, the cumulative cost sharing maximum, and any charges relating to these amounts. Proposed 457.505 (b).

In addition, when states obtain CHIP coverage through premium assistance programs for children whose families have access to employer coverage, the plan must set out --

*** the procedures the state uses to ensure that beneficiaries are not charged copayments, coinsurance, deductibles or similar fees on well baby and well child care ***. A procedure that
primarily relies on a refund given by the state for an overpayment by a beneficiary is not acceptable. Proposed 457.505(c)

State plans also must set forth the procedures used to ensure that American Indian and Alaskan Native children are not charged any form of cost sharing (i.e., no premiums, deductibles or coinsurance). Proposed 457.505(c)(2).

**Cumulative maximum cost sharing limits**

State freestanding CHIP plans must establish cumulative cost sharing maximums. Proposed 457.560. These maximums apply to all cost sharing that families are “legally obligated to pay.” Proposed 457.560. Therefore, cost sharing on a sliding fee scale that is “forgiven” or not actually charged would not appear to count toward the cumulative maximum, since the family has no legal obligation to pay the fee. However, the cost sharing that is actually billed does appear to count toward the maximum regardless of whether the family actually makes the payment. Proposed 457.560. As a result, a family that incurs cost sharing obligations (either premiums or costs for covered services) must have the benefit of the cumulative maximum.

The proposed rule establishes 5% of total family income for one year as the cumulative maximum limit for families with incomes above 150% of the federal poverty level, as defined by the state. In the case of families with incomes below this level, the cumulative maximum is proposed at 2.5% Proposed 457.560 (c) and (d).

*Issues for health centers and PCAs:* The proposed rule does give states the option to set the cumulative maximum cost sharing levels lower than the maximum levels provided for under the rule. Proposed 457.560 (b).

**Premiums and cost sharing**

The state plan must set out the premiums or enrollment fees that are required; the time periods for which they are required; the groups of enrollees that are subject to premiums; the consequences of failing to pay a premium; and the method used to ensure that total cost sharing liability does not exceed the 5% cumulative maximum. Proposed 457.510 (a)-(e). Similar disclosure requirements are specified for cost sharing. Proposed 457.515. In addition, the proposed rules would prohibit copayments or cost sharing for well baby and well child services or for immunizations. The terms “well baby” and “well child” are defined as including: (1) all healthy newborn inpatient visits including routine
inpatient and outpatient screening services; (2) routine physical examinations; (3) laboratory tests; (4) immunizations and related office visits as recommended and updated by the AAP and by Bright Futures (guidelines for preventive health care developed by HHS in 1992); (5) routine preventive and diagnostic dental care as described in guidelines issued by the American Academy of Pediatric Dentistry. Proposed 457.520.

Cost sharing protections for lower income children

State freestanding programs may vary cost sharing requirements only in a manner that does not favor children from families with higher income over children from families with lower income. Proposed 457.530.

Level of cost sharing

Copayments and cost sharing: In the case of children with family incomes between 101% and 150% of the federal poverty level, the state cannot use more than one type of copayment per service. The permissible copayments for this group range as follows:

<table>
<thead>
<tr>
<th>Payment for service</th>
<th>Maximum allowable copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15.00 or less</td>
<td>$1.00</td>
</tr>
<tr>
<td>$15.01-$40.00</td>
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<td>$80.01 or more</td>
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Proposed 457.555.

In states where CHIP is administered through enrollment in managed care organizations, the rule proposes to limit cost sharing to $5.00 per visit. Proposed 457.555

Children with family incomes below 100 percent of the federal poverty level cannot be charged cost sharing that exceeds Medicaid allowable levels (copayments ranging from fifty cents for services for which the state pays $10 or less to $3.00 for services for which the state pays $50.01 or more). Proposed 457.540(b).

24 There may be children who are ineligible for Medicaid as poverty level children but who are eligible for freestanding CHIP because of a Medicaid eligibility rule that does not apply to CHIP. An example would be a child in a family whose income is below poverty but whose assets exceed Medicaid levels for poverty level children, in states whose freestanding CHIP programs do not include an asset test.
Children with incomes in excess of 150% of the FPL can be charged according to a different scale, as long as the cumulative maximum requirements are honored. Proposed 457.545.

**Deductibles:** The proposed rules provide that deductibles cannot exceed $3.00 per month per family during each period of eligibility in the case of children with family incomes between 101 and 150% of the FPL. Proposed 447.555(a)(4). This provision would appear to prohibit states from using lump sum, annually based deductibles (e.g., an annual $250 deductible). These types of deductibles, which are common in private insurance, could not only quickly result in a family’s hitting the applicable cumulative maximum cap but also could lead to an effective total lack of coverage for CHIP benefits. The proposed rules do not appear to adopt similar deductible cost protections for children in families with incomes over 150% of the FPL.

**Issues for health centers and PCAs:** Much has been written about the problem of cost sharing for low income children. The proposed regulations appear to be an effort to limit cost sharing exposure as much as possible within the limits of the law. Of particular importance to health center patients, however, will be the lack of cost sharing credit for copayments that are waived under a sliding fee schedule, as well as the lack of deductible protections for families with incomes over 150% of the FPL.

**Subpart F [Reserved]**

**Subpart G: Strategic Planning, Reporting, and Evaluation**

The proposed rules set forth strategic planning requirements that would require state plans to set out objective goals and performance measurements under which plan performance is measured through objective, independently verifiable means, compared against performance goals. Proposed 457.710.

States are required to submit quarterly and annual reports (comparable to Medicaid reporting) on program expenditures, the number of children who are enrolled in Medicaid (as CHIP children) or a separate CHIP program. Enrollment must be reported by age (under 1, 1-6, 6-12, and 13-18). Children must also be reported by type of system in which they are enrolled (e.g., managed care, fee for service, or primary care case management). Family income levels as a percentage of the federal poverty level also must be reported (however, the standards and methods used to evaluate family income do not have to be reported in the
quarterly report, nor is it clear that they need to be described with detail in the state plan.) Proposed 457.740 The state plan requirements relating to eligibility specify merely that the standards must be “described.” Proposed 457.305.

The proposed rules would require states to report annually by fiscal year regarding the results of its CHIP assessment of overall plan operations. Proposed 457.750. Specific in this report is an evaluation of how successful the state was in “discouraging the substitution of public coverage for private coverage.” Proposed 457.750(b)(2). How a state accomplishes this is not clear, other than through the use of waiting periods for coverage in the case of children with prior private coverage (e.g., 3 months without any coverage).

State Evaluations

The proposed regulations would require extensive evaluations of state plans by March 31, 2000 and propose numerous evaluation requirements including the characteristics of families assisted, the “quality of health coverage,” the amount of assistance, cost sharing, limits on coverage and service areas, the extent of substitution, the extent to which states used various coverage formats (e.g., fee for service, MCO enrollment, PCCMs) and other matters. Proposed 457.760.

Issues for health centers and PCAs: Health centers and PCAs may wish to examine state quarterly reports and seek involvement in a state’s overall evaluation efforts.

Subpart H: Substitution of Coverage

Proposed rules set forth the circumstances under which states may provide premium assistance for coverage under an employer sponsored health plan rather than provide basic CHIP coverage. The proposed rules would prohibit payment of premiums for any child without the imposition of a waiting period of between 6 and 12 months. Proposed 457.810(a). In addition, a state contribution is not permitted unless the employer contributes at least 60 percent of the monthly family premium.

Issues for health centers and PCAs: Under the proposed rule, a working family with initial access to employer-sponsored family coverage would apparently have to wait between 6 and 12 months before its child could qualify for the subsidy. This standard is not found in the statute. In addition, employers would have to contribute at least 60% of the coverage. Since employer contributions for family premiums for working
families are declining, this limitation could effectively foreclose CHIP’s utility as a means for supplementing employer sponsored plan premium requirements. The barriers to the use of CHIP as an employer subsidy are essentially statutory; their irony is apparent at a time when work is encouraged and employer contributions to family coverage are declining. The law effectively punishes families who find jobs with employers that contribute less than 60% of the premium and effectively encourage jobs with employers that offer no family coverage at all.

**Subpart I: Program Integrity and Beneficiary Protections**

The proposed rules would require states to maintain fraud detection systems. The rules also require the use of grievance and appeals systems as well as contracts that include provisions found in the Patients’ Bill of Rights, including information to enrollees regarding coverage, choice of providers and plans, access to emergency services, protections against excess financial liability, the right to file grievances and appeals, the right to confidentiality, and the right to non-discrimination and respect. Proposed 457.995.

**Subpart J: Allowable Waivers**

The statute permits states to seek certain waivers (the Department has placed a moratorium on applications for §1115 CHIP waivers for at least the first several years of operations). Among the waivers states may seek is a waiver that would permit cost-effective coverage through a community based health delivery system. Proposed 457.1005. This waiver specifically permits states to obtain waivers of the 10% upper limit on CHIP administrative costs to permit the development of coverage arrangements that involve contracts with health centers and DSH hospitals. Waivers must meet the coverage requirements of the law and cannot lead to costs higher than regular coverage. Proposed 457.1005.

States also may obtain waivers in order to support the purchase of family, rather than individual, coverage. Proposed 457.1010.

**Issues for health centers and PCAs:** Health centers and PCAs may wish to explore collaborations with DSH hospitals in the community to offer alternative coverage arrangements. Health centers serving large numbers of migrant or homeless families may wish to encourage their states to seek a waiver in order to provide targeted child health coverage to these special populations through health centers.
The Vaccines for Children Program

The Preamble contains a discussion of HCFA's interpretation that "children served by a separate State child health program are not Federally vaccine eligible because they are neither entitled to Medicaid nor uninsured * * *"\(^{25}\). Under this interpretation, the proposed rule effectively ratifies HCFA's determination that states with freestanding CHIP programs will have to use CHIP funding to separately purchase vaccines for enrolled children rather than securing the vaccines through the VFC program. The resulting additional costs, averaging more than $130 annually per child, will necessarily mean that fewer children will receive CHIP assistance with the same resources.

**Issues for health centers and PCAs:** Under the Vaccines for Children (VFC) law, a child is only "insured" when that child is entitled to benefits under a health insurance policy or plan. The CHIP statute provides that "Nothing in this title shall be construed as providing any individual with an entitlement to child health assistance under a State child health plan." Since the CHIP statute states absolutely that the legislation creates no entitlement, and since the VFC program defines insurance as benefits to which an individual is entitled, it would appear to be clear that, despite their eligibility for CHIP assistance, children in freestanding state CHIP plans are not entitled to insurance and thus should be considered VFC-eligible.

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\(^{25}\) 64 Fed. Reg. 60938
Table 1

HHS-Approved State Child Health Insurance Program Plans
As of November 1999

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