

State Children's Health Insurance Program

By Manjusha P. Kulkarni

The Balanced Budget Act of 1997 established Title XXI of the Social Security Act.¹ The State Children's Health Insurance Program (SCHIP), as Title XXI is called, was created to provide health care coverage to millions of uninsured, low-income children in the United States. Congress authorized \$40 billion in federal matching funds for states to provide health care coverage to children whose families have incomes above Medicaid levels but below 200 percent of the federal poverty level.² To encourage states to participate in SCHIP, Congress assured states an "enhanced federal match," that is, they would be paid a greater share of costs for SCHIP-funded expansions than for their existing Medicaid programs.³ Approximately 4.6 million children are currently enrolled in the SCHIP program.⁴

This article covers the following topics:

- Administration of the SCHIP program.
- Eligibility.
- Scope of covered benefits.
- Key issues confronting legal services programs and resources for dealing with them.

Administration

SCHIP, like the Medicaid program, is administered by the Centers for Medicare and Medicaid Services (CMS) and by the states.⁵ To participate in SCHIP, a state must develop a state plan outlining how the program will be administered, who will be eligible, and what benefits will be covered.⁶ State plans must be approved

¹ See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 552 (codified as amended at 42 U.S.C. § 1397aa-1397jj (1997)).

² The upper income eligibility levels in some states exceed 200 percent of the federal poverty level. NAT'L CONFERENCE OF STATE LEGISLATURES, 2000 STATE CHILDREN'S HEALTH INSURANCE PROGRAM CHARTBOOK 14 (2001).

³ 42 U.S.C. § 1397ee(b) (Supp. 2001).

⁴ CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES), THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM ANNUAL ENROLLMENT REPORT FEDERAL FISCAL YEAR 2001: OCTOBER 1, 2000-SEPTEMBER 30, 2001, at 1 (2002), available at www.hcfa.gov/init/schip01.pdf.

⁵ CMS establishes federal policies on the state Children's Health Insurance Program (SCHIP) through regulations and "Dear State Official" letters. CMS was known as the Health Care Financing Administration until June 2001.

⁶ 42 U.S.C. § 1397bb(a) (Supp. 2001); 42 C.F.R. § 457.305 (2002).

Manjusha P. Kulkarni is a staff attorney, National Health Law Program, 2639 S. La Cienega Blvd., Los Angeles, CA 90034; 310.204.6010; kulkarni@healthlaw.org.

Sources of Information on the State Children's Health Insurance Program

- Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-jj.
- State Children's Health Insurance Program Regulations, 42 C.F.R. §§ 457 *et seq.*
- Centers for Medicare and Medicaid Services, Dear State Official Letters, *at* www.hcfa.gov/Medicaid/letters
- Centers for Medicare and Medicaid Services transmittals and documents, *at* www.healthlaw.org/publications.shtml.
- Federal and state court cases.
- State statutes and regulations, contracts, and policy letters.

by the federal government.⁷ In order to participate in SCHIP and receive federal funding, a state must also abide by federal mandates.⁸

Title XXI gives states a great deal of flexibility in how they develop their programs; it allows them to create a separate program, expand their Medicaid program, or develop a combined program.⁹ If a state expands its Medicaid program, the Medicaid rules govern.¹⁰ These rules protect beneficiaries with, among others, equal access to medical services, a right to apply with reasonable promptness, and a right to notice and hearing. One of the most important Medicaid protections for

beneficiaries is the right to have payments to their providers covered for medically necessary services so long as they qualify for the program; this is called an "entitlement." If a state chooses to create a separate SCHIP program, the program is not an entitlement and applicants may not enroll in the program if funding is not available and the state caps enrollment.¹¹ Neither do other Medicaid benefits and protections apply to beneficiaries of a separate program.¹²

Eligibility

As in Medicaid, not all low-income individuals are eligible for SCHIP. The program is aimed primarily at uninsured, low-income children. To qualify for SCHIP, an individual must

- satisfy the financial need standard;¹³
- be a U.S. citizen or qualified legal immigrant;¹⁴
- be a resident of the state in which she is applying;¹⁵
- not be eligible for Medicaid;¹⁶ and
- not be covered under a group health plan or under health insurance coverage.¹⁷

Title XXI allows states to cover low-income parents of children enrolled in Medicaid or SCHIP.¹⁸ Before offering cov-

⁷ 42 U.S.C. § 1397aa(b), 1397ff (Supp. 2001); 42 C.F.R. § 457.150 (2002).

⁸ 42 U.S.C. § 1397cc(f)(2) (Supp. 2001); 42 C.F.R. § 457.130, 457.135 (2002).

⁹ 42 U.S.C. § 1397aa(a) (Supp. 2001); 42 C.F.R. § 457.70 (2002).

¹⁰ *See* 42 U.S.C. § 1397cc(e)(4) (Supp. 2001).

¹¹ *See id.* § 1397bb(b)(4).

¹² One of the most important Medicaid benefits is the right to access the Early and Periodic, Screening, Diagnosis, and Treatment program, which offers comprehensive health benefits to children.

¹³ 42 C.F.R. § 457.310(b)(1) (2002).

¹⁴ Qualified legal immigrants include, but are not limited to, permanent legal residents, asylees, refugees, Cuban or Haitian entrants, and battered individuals under the Violence Against Women Act. Immigrants who arrived in the United States after August 22, 1996, are barred from receiving SCHIP benefits and many other public benefits for five years. *See* 8 U.S.C. §§ 1601 *et seq.*; 42 U.S.C. §§ 1320b-7, 1396b(v) (Supp. 2001).

¹⁵ *See* 42 C.F.R. § 457.320(d) (2002).

¹⁶ *Id.* § 457.310(b)(2)(i).

¹⁷ *Id.* § 457.310(b)(2)(ii). Note that children enrolled in a Medicaid-expanded SCHIP program simultaneously may be enrolled in a group health plan. *See* 42 U.S.C. § 1396a(a)(25), 1396e(c)(2).

¹⁸ 42 U.S.C. § 1397ee(c)(3) (Supp. 2001); 42 C.F.R. § 457.1010 (2002).

erage to parents, however, states must establish that they are not covering parents in lieu of covering targeted low-income children.¹⁹

To enable families to apply for SCHIP without delay, states that develop separate or combined programs are required to inform applicants at the time of their application about the application and eligibility requirements, the time frame for determining eligibility, and the right to review of eligibility determinations.²⁰ States must establish time standards for determining eligibility, not to exceed forty-five calendar days, and must give applicants or enrollees a written notice of any decision on the application or other determination concerning eligibility.²¹

States must ensure that applicants who are potentially eligible for Medicaid are identified and enrolled in that program if they are determined to be eligible.²² This procedure is called "screen and enroll."²³ When a child is identified as potentially Medicaid eligible, the state must establish procedures in coordination with the Medicaid agency to facilitate enrollment in Medicaid.²⁴

States may confer presumptive eligibility on children in the separate child health program as well as those potentially eligible for Medicaid pending a final determination of eligibility.²⁵ The presumptive eligibility period begins on the date that a qualified entity determines that

the child has family income below the applicable income level and ends on the day a Medicaid or separate child health program eligibility determination is made or, if an application is not filed, the last day of the month following the date that presumptive eligibility begins.²⁶

Scope of Covered Benefits

In the SCHIP regulations, "child health assistance" is defined as payment for part or all of the cost of health benefits coverage provided to targeted low-income children; those benefits are listed below.²⁷ While the list of potential services is extensive, only coverage of basic services such as inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and radiological services, and well-baby and well-child care, including age-appropriate immunizations, is mandated upon states.²⁸ States have the discretion to offer optional benefits on a more limited basis or not at all.²⁹ Unlike in the Medicaid program, states establishing a separate SCHIP program do not have to offer the Early and Periodic, Screening, Diagnosis, and Treatment program, which covers any medically necessary service to children. In determining how to make mandated as well as optional services available to SCHIP beneficiaries, states may choose whether to offer SCHIP benefits through contracting with a managed care entity or on a fee-for-service basis.

¹⁹ 42 C.F.R. § 457.1010(b) (2002).

²⁰ *Id.* § 457.340(a)–(b).

²¹ *Id.* § 457.340(c).

²² 42 U.S.C. § 1397bb(b)(3)(B) (Supp. 2001); 42 C.F.R. § 457.350(b) (2002).

²³ See 42 C.F.R. § 60(b)(7) (2002). See also CMS, DEAR STATE HEALTH OFFICIAL LETTER (Nov. 23, 1998), at www.hcfa.gov/init/shscreen.htm.

²⁴ 42 C.F.R. § 457.350(f) (2002). See also *id.* § 431.636(b).

²⁵ *Id.* § 457.355.

²⁶ *Id.* § 457.301. Qualified entities include, but are not limited to, entities that provide health care services, elementary or secondary schools, state or tribal child support enforcement agencies, and entities that determine eligibility for public or assisted housing and receive federal funds. *Id.*

²⁷ *Id.* 42 U.S.C. § 1397jj(a) (Supp. 2001); 42 C.F.R. § 457.402 (2002).

²⁸ 42 U.S.C. § 1397cc(c) (Supp. 2001); 42 C.F.R. § 457.495 (2002). See also GAO (U.S. GENERAL ACCOUNTING OFFICE), MEDICAID AND SCHIP: COMPARISONS OF OUTREACH, ENROLLMENT PRACTICES, AND BENEFITS 6 (2000).

²⁹ GAO, *supra* note 28.

Scope of State Children's Health Insurance Program Benefits

Mandatory Benefits

- Inpatient hospital services.
- Outpatient hospital services.
- Physician services.
- Surgical services.
- Laboratory and radiological services.

Optional Benefits

- Clinic services (including health center services) and other ambulatory health care services.
- Prescription drugs.
- Over-the-counter medications.
- Prenatal care and pre-pregnancy family planning services and supplies.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment and other medically related or remedial devices (such as prosthetic devices and implants).
- Disposable medical supplies.
- Home and community-based health care services and related supportive services.
- Nursing care services.
- Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Case management services.
- Care coordination services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services if provided by a physician or other licensed or registered practitioner within the scope of practice, performed under the general supervision or at the direction of a physician, or offered by a licensed or state-operated health care facility.
- Premiums for private health care insurance coverage.
- Medical transportation.
- Enabling services (e.g., transportation, translation, outreach).
- Any other health care services or items specified by the secretary of health and human services and not excluded under 42 C.F.R. § 457.¹

¹ 42 U.S.C. § 1397jj(a) (Supp. 2001); 42 C.F.R. § 457.402 (2002).

Unlike the Medicaid program, SCHIP allows states substantial flexibility in designing the benefits package for their separate SCHIP program. In developing for SCHIP recipients a package of benefits from the list above, a state may choose among four options:

- “Benchmark coverage,”
- “Benchmark-equivalent coverage,”
- “Existing state-based coverage” in New York, Florida, or Pennsylvania as it was offered in August 1997, or
- “Secretary [of health and human services]–approved coverage.”³⁰

This means that the state's separate SCHIP program must be tailored to look like one of these models and contain essentially the same package of benefits. The “benchmark coverage” model consists of health benefits substantially equal to coverage in one of the following private insurance models: federal employees' health benefit plan, a state employee plan, or the health maintenance organization plan with the largest insured, commercial, non-Medicaid enrollment in the state.³¹ “Benchmark-equivalent coverage” is health benefits coverage that includes basic services, has an aggregate, actuarial value equivalent to the benchmark package, and has a substantial actuarial value for additional services included in the benchmark package.³² The “existing comprehensive, state-based health coverage” option includes a range of benefits, is administered by the state, and receives funds from the state; this option is limited to benefits offered in New York, Pennsylvania, and Florida as

of August 5, 1997.³³ “Secretary-approved coverage” consists of benefits deemed appropriate for targeted low-income children in the program by the secretary of health and human services.³⁴

States may institute cost sharing, which includes premiums, deductibles, coinsurance, and copayments, on children enrolled in a separate SCHIP program. However, states may vary cost sharing based upon the family income of enrollees only in a way that does not favor children from families with higher incomes over children from families with lower incomes.³⁵ More important, states may not impose cost sharing on preventive services, such as immunizations, well-baby visits, and well-child care.³⁶ Aggregate cost sharing for families with children enrolled in SCHIP may not exceed a cap of 5 percent of the family's total income for the length of a child's eligibility period.³⁷

Key Issues Confronting Legal Services Programs and Applicable Resources

Based upon a review of technical assistance requests that the National Health Law Program has received regarding SCHIP, the following problems have been identified as most likely for legal services practitioners to confront:

- Lack of coordination in Medicaid and SCHIP eligibility.
- Failure to give adequate notice and hearing rights when eligibility is denied.
- Termination due to lack of premium payment.

³⁰ 42 U.S.C. § 1397cc(a) (Supp. 2001); 42 C.F.R. § 457.410(a) (2002).

³¹ 42 U.S.C. § 1397cc(b) (Supp. 2001); 42 C.F.R. § 457.420 (2002).

³² 42 U.S.C. § 1397cc(c) (Supp. 2001); 42 C.F.R. § 457.430 (2002).

³³ 42 U.S.C. § 1397cc(d) (Supp. 2001); 42 C.F.R. § 457.440 (2002).

³⁴ 42 C.F.R. § 457.450 (2002). Coverage approved by the secretary of health and human services may include coverage provided to children under the Medicaid state plan, coverage offered under a section 1115 Medicaid demonstration waiver project, benchmark coverage, or benchmark-equivalent coverage. *Id.*

³⁵ 42 U.S.C. § 1397cc(e)(1)(B).

³⁶ *Id.* § 1397cc(e)(2) (Supp. 2001); 42 C.F.R. § 457.520 (2002). See also CMS, DEAR STATE OFFICIAL LETTER (Feb. 12, 1998), available at <http://hcfa.gov/init/chst213.htm>.

³⁷ 42 C.F.R. § 457.560(a) (2002).

- Gap in coverage because of waiting period.

Lack of Coordination in Medicaid and SCHIP Eligibility. A common problem in states with separate SCHIP programs is lack of coordination between Medicaid and SCHIP. This results in loss of applications, delays in obtaining an eligibility determination, or denials in eligibility.

SCHIP and Medicaid laws offer some protection for beneficiaries. As mentioned above, SCHIP regulations mandate that states create screening procedures that ensure facilitation of Medicaid enrollment as well as timely determination of SCHIP eligibility.³⁸ Medicaid statutes and regulations require that states must provide that all individuals seeking Medicaid eligibility can apply without delay and ensure reasonably prompt application assistance.³⁹ Both programs specifically require states to determine eligibility within forty-five days for nondisability-based populations.⁴⁰

Failure to Give Adequate Notice and Review When Eligibility Is Denied.

Another issue that legal services attorneys and advocates are likely to confront is lack of adequate notice and right to review. As in the Medicaid context, this problem can take many forms, including a failure to give proper notice regarding eligibility determinations and the right to review those determinations. To some degree, the SCHIP regulations do protect beneficiaries seeking to appeal actions affecting eligibility or services. As discussed above, states must give applicants or enrollees written notice of eligibility determinations.⁴¹ If eligibility is approved, the notice must inform the enrollee about rights and responsibilities under the program.⁴² If eligibility is denied, suspend-

ed, or terminated, the notice must contain the following:

- reasons for the determination;
- an explanation of the right to review;
- the standard and expedited time frames for review;
- the manner in which a review can be requested; and
- circumstances under which enrollment may continue pending review.⁴³

Applicants and enrollees experiencing denial, suspension, or termination as well as those not receiving a timely eligibility determination may have the adverse decision reviewed by an impartial person or entity and are entitled to receive a written decision within a reasonable period of time.⁴⁴ Unlike Medicaid, the SCHIP program does not mandate the right to an administrative hearing. However, in addition to the federal SCHIP regulations, the state SCHIP statute and regulations may offer notice and review procedures.

Termination Due to Lack of Premium Payment. A common problem for legal services clients is termination from SCHIP because of a failure to pay premiums. This often results from loss of a job or reduction in family income.

The SCHIP regulations require states to give enrollees reasonable notice of and an opportunity to pay past-due premiums, copayments, coinsurance, deductibles, or similar fees before termination.⁴⁵ A number of states allow enrollees thirty to sixty days to pay old premiums.⁴⁶ The states' termination processes must give enrollees a chance to show the decline in their family's income before termination for non-payment of cost-sharing charges.⁴⁷ Further-

³⁸ See *id.* § 457.340, 457.350.

³⁹ 42 U.S.C. § 1396a(a)(8) (Supp. 2001); 42 C.F.R. § 435.906 (2002).

⁴⁰ 42 C.F.R. § 435.911 (2002). See also *id.* § 457.340(c)(2).

⁴¹ 42 C.F.R. § 457.340(d) (2002).

⁴² *Id.* § 457.340(d)(1).

⁴³ *Id.* § 457.340(d)(2), 457.1180.

⁴⁴ *Id.* § 457.1130(a), 457.1140, 457.1150(a), 457.1160(a).

⁴⁵ *Id.* § 457.570(a).

⁴⁶ GAO, MEDICAID AND SCHIP: STATES' ENROLLMENT AND PAYMENT POLICIES CAN AFFECT CHILDREN'S ACCESS TO CARE 22 (2001).

⁴⁷ 42 C.F.R. § 457.570(b) (2002).

more, states must facilitate Medicaid enrollment for the child or adjust the child's cost-sharing category if any evidence indicates a decrease in family income.⁴⁸ If the child's enrollment is terminated, the family must be given an opportunity for an impartial review to address it.⁴⁹

Gap in Coverage Because of Waiting Period. Legal services practitioners are likely to see clients who qualify but may not enroll in SCHIP because they were recently enrolled in a group health plan. Overtly the SCHIP regulations do not seem to offer any beneficiary protection; the regulations simply specify that, in their state plans, states must describe reasonable procedures to ensure that SCHIP benefits do not substitute for group health plan coverage.⁵⁰ However, the discussion of public comments on the final SCHIP regulations explains that the problem of "crowd-out," or substitution of SCHIP benefits for employer-sponsored or group health plan coverage, was not as significant as initially imagined.⁵¹ In fact, the discussion explicitly invites states to propose alternatives to a period of uninsurance and to consider amending their state plans to modify their current policies.⁵² Furthermore, it indicates that CMS plans to work with states to develop alternative strategies.⁵³ Legal services practitioners can use this language in the preamble to encourage their state SCHIP agencies to abandon waiting periods or periods of uninsurance.⁵⁴

For further assistance in dealing with their clients' problems with the SCHIP program, legal aid practitioners can access the resources listed below. These Web sites offer a great deal of information on

SCHIP Resources on the World Wide Web

1. National Health Law Program, www.healthlaw.org, updates and analyzes federal legislation and policy developments, federal and state case law, major state activities, and academic research; offers access to model pleadings and extensive links to other organizations working on State Children's Health Insurance Program (SCHIP) issues.
2. Kaiser Commission on Medicaid and the Uninsured, www.kff.org, has extensive facts and figures on the SCHIP program, nationally and by state; publishes analyses on various aspects of SCHIP, including administration, eligibility, enrollment, outreach, and managed care contracting; and reports on national and state trends.
3. Center on Budget and Policy Priorities, www.cbpp.org, has information on federal and state budgetary issues and how they affect the SCHIP program.
4. National Conference of State Legislatures, www.ncsl.org, publishes an annual chart book with extensive facts on the national SCHIP program and state implementation, including eligibility and enrollment levels, benefit packages, cost sharing, and crowd-out provisions.

state and federal law and policy and also explain SCHIP issues involving administration, outreach, eligibility, and scope of benefits as well as others.

THIS ARTICLE CITES INTRODUCTORY MATERIALS about SCHIP for the new legal aid attorney, who will certainly face some of the challenges outlined above as well as many others. Equipped with this background information, the attorney can assist clients needing help in obtaining SCHIP eligibility and services and start down the path to a successful practice in public interest health law.

⁴⁸ *Id.*

⁴⁹ *Id.* § 457.570(c), .1130(a)(3).

⁵⁰ *Id.* § 457.805.

⁵¹ Discussion of Public Comments, 66 Fed. Reg. 2490, 2603 (Jan. 11, 2001).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ In undertaking administrative advocacy, legal services practitioners should be cognizant of pertinent Legal Services Corporation restrictions on such activities. See Alan W. Houseman & Linda E. Perle, *What You May and May Not Do Under the Legal Services Corporation Restrictions*, in this manual.