

Understanding SCHIP: The State Children's Health Insurance Program

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Introduction

For many individuals with disabilities contemplating a return to work, the question of continued medical coverage is a pressing issue. While SSI recipients returning to work are able to continue receiving Medicaid coverage for themselves in most states, what about their children? What if they find a job, which pays too much for their children to continue on Medicaid, but which does not itself provide health insurance? For these individuals, the State Child Health Insurance Program (SCHIP) may provide a critically important option for health care coverage.

The Balanced Budget Act of 1997 created SCHIP, by adding a new Title 21 to the Social Security Act. Initially, many had referred to it as the Child Health Insurance Program, or CHIP. However, pursuant to Section 704 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, the Federal government is prohibited from using the terms Child Health Insurance Program or CHIP. Therefore, we will use the term SCHIP. Final regulations implementing SCHIP became effective on June 23, 2000. The regulations add very little to the Title 21 requirements and are designed primarily to guide the States in obtaining reimbursement under the program.

The Centers for Medicare and Medicaid Services (CMS), which administers SCHIP, has a very helpful website on this program. To access this website go to: <http://www.cms.hhs.gov/home/schip.asp>. This website contains all information on SCHIP developed by CMS that summarizes interpretive guidance about the program, contains copies of informational letters sent to the States about the program, information about State implementation of SCHIP, and links to other helpful web sites.

Program Overview: The Basics of SCHIP

The purpose of SCHIP is "to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."

The statute authorizes \$40 billion over 10 years to be distributed to all 50 states and all U.S. territories. It commenced with the 1998 fiscal year, which began on October 1, 1997. Like Medicaid, the program is optional for each state, but as of the 2000 fiscal year (October 1, 1999), every state and territory is participating. Funds are allocated to each state based on a ratio, which includes the number of uninsured low-income children and the total number of low-income children in the state.

To receive funding, a state must have an approved plan, describing how the state will implement the program. However, "to provide states with the flexibility and time needed to develop their programs and to submit their child health plans," HCFA (now CMS) published "reserved" rates for the 1998 and 1999 fiscal years, which became final once each state's plan was approved.

The statute gives states an incredible amount of flexibility in implementing their program. States may simply extend Medicaid coverage to children who are eligible for SCHIP, create a separate program, or use a combination of both. Therefore, to fully understand how SCHIP is being implemented, it is critical to obtain your state's plan to determine the basic program structure, who is eligible, and what services are covered. A link is provided to each state's SCHIP program from the federal governments SCHIP website at www.insurekidsnow.gov.

Despite SCHIP's flexibility, the law provides some basic guidelines that will apply to all states. Each state's plan must include a description of the following:

1. The actual child health assistance to be provided under the plan;
2. Eligibility standards, including those relating to the geographic areas to be served, age, income and resources (including any standards relating to spend downs and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis;
3. Eligibility screening to ensure that only eligible children receive services under the program, that children found to be eligible for Medicaid are referred to the Medicaid program, and that eligible American Indians are provided services;
4. Outreach to families of children likely to be eligible under the program or under other public or private insurance programs to inform them of available coverage and to assist them in enrolling their children in programs for which they are eligible; and
5. Procedures for coordinating SCHIP with other public and private health insurance programs.

In an effort to improve outreach to children who may be eligible but who have not yet enrolled in the program, the Agricultural Risk Protection Act of 2000 "established a critical link between the National School Lunch Program, Medicaid and [SCHIP]." States may now share information with SCHIP and Medicaid "agencies about families who participate in the school lunch program in an effort to help identify eligible children." Almost every state has taken advantage of this

opportunity to "enlist the support of schools in its outreach and enrollment strategies." Sign Them Up: A Quarterly Newsletter about the Children's Health Insurance Program (CHIP), p. 5 (Fall 2001, Children's Defense Fund).

SCHIP Eligibility Criteria

As noted above, states are given a wide degree of latitude in establishing eligibility criteria, including ages, geographic areas, income and resource rules, and duration of eligibility. Again, however, there are certain mandatory guidelines. Generally, coverage must be limited to children who are:

- under 19 years of age,
- not eligible for Medicaid or other health insurance, and
- whose family income is below 200 percent of the federal poverty level (FPL) for their size of family. NOTE: to find the current FPLs, go to <http://aspe.hhs.gov/POVERTY/08poverty.shtml>

Eligibility for SCHIP is targeted towards uninsured low-income children. As a result, certain groups of children cannot be covered under SCHIP. These ineligible groups include:

- children who are covered under a group health plan or under health insurance coverage;
- children who are members of a family that is eligible for state employee insurance based on employment with a public agency;
- children who are residing in an Institution for Mental Diseases; and,
- children who are eligible for Medicaid coverage.

However, children enrolled in a state-created insurance program, which was in place prior to July 1, 1997, and did not utilize any federal funds, will still be eligible for SCHIP. Effective November 1, 2002, the definition of child has been amended to include "the period from conception to birth." This will allow a state, if it chooses, to cover prenatal care and delivery.

If a state has raised its Medicaid eligibility level above 150 percent of the poverty level before June 1, 1997, the state may raise the eligibility standards for SCHIP to 50 percent above the current Medicaid income level. However, the state cannot lower its Medicaid income and resource limits in an effort to make children ineligible for Medicaid and thereby eligible for SCHIP.

Any financial eligibility criteria must not operate to cover children in families with higher incomes without covering children in families with lower incomes. Nor can the eligibility criteria deny coverage to children with pre-existing medical conditions. Finally, children who are inmates in a public institution or who are patients in an institution for "mental diseases" are not eligible for coverage.

Available SCHIP Services

As noted above, states may choose to deliver services in one of three basic ways. They may simply choose to extend basic Medicaid coverage to those children determined to be eligible for SCHIP. In those cases, the state must apply, to SCHIP-eligible children, the full range of Medicaid services available to all other Medicaid eligible children in the state. This would include all the services available under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program mandates that states provide all medically necessary mandatory and optional Medicaid services. See English, Abigail and Madlyn Morreale, *The New Children's Health Insurance Program: Major Provisions and Early Lessons*, ABA Center on Children and the Law, www.abanet.org/child/chipfinal.html.

If a state chooses to create its own separate SCHIP program, it has a large degree of flexibility in choosing the scope of services to cover. There are four basic options available to states: benchmark coverage, benchmark-equivalent coverage, the preexisting state-based program in New York, Florida or Pennsylvania, or any other coverage package which is approved by CMS (formerly HCFA) as "appropriate." Benchmark coverage must be equivalent to the coverage available to federal employees, state employees, or members of the largest commercial, non-Medicaid health maintenance organization in the state.

Benchmark-equivalent coverage must be the "actuarial equivalent" of one of the benchmark packages. They must include, at a minimum, the following categories of services:

- Inpatient and outpatient hospital services;
- Physicians' surgical and medical services;
- Laboratory and x-ray services;
- Well-baby and well-child care, including age-appropriate immunizations.

The state must also include the following optional services, if the benchmark package used by the state to determine "actuarial equivalence" includes them:

- Coverage of prescription drugs;
- Mental health services;
- Vision services;
- Hearing services.

States are free to provide coverage for benefits that are not listed in either of these categories. In fact, the scope of permissive services is extremely comprehensive. Covered services may include the following:

- Inpatient hospital services;
- Outpatient hospital services;
- Physician services;
- Surgical services;

- Clinic services (including health center services) and other ambulatory health care services;
- Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person;
- Over-the-counter medications;
- Laboratory and radiological services;
- Prenatal care and pre-pregnancy family planning services and supplies;
- Inpatient mental health services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structured services;
- Outpatient mental health services, including services furnished in a state-operated mental hospital and including community-based services;
- Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices);
- Disposable medical supplies;
- Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home);
- Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting;
- Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act 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 (whether in a facility, home, school, or other setting) if recognized by state law and only if the service is:
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by state law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license.
- Premiums for private health care insurance coverage;

- Medical transportation;
- Enabling services (such 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;
- Any other health care services or items specified by the Secretary and not otherwise excluded.

Cost Sharing in the SCHIP Program

Cost sharing refers to out-of-pocket payment - such as premiums, deductibles, coinsurance, copayments, or other fees - charged by health insurance enrollees. Federal law permits states to require some SCHIP beneficiaries to share costs. Any cost-sharing income received by the state will reduce the state's appropriation under the program. Cost-sharing may not be required for preventive services such as well-child services, routine physical examinations, associated laboratory tests, immunizations, and routine preventive and diagnostic dental services. Furthermore, any cost-sharing requirements must not favor children of higher income families over lower income families.

States may not impose cost sharing that exceeds 5% of a family's gross or net income. Moreover, American Indian/Alaska Native children who are members of a federally recognized Tribe must not be charged any cost sharing. At their option, states may allow for self-declaration of Tribal membership to exempt families from cost-sharing provisions. Each SCHIP enrollee's family must be told of the maximum yearly cost-sharing limit for each child. States must allow eligible families to pay any past due cost-sharing charges before the disenrollment process begins. States must allow families an opportunity to show that their family income has declined before being disenrolled for failure to meet cost-sharing obligations.

The state plan must describe the methodology used to determine cost-sharing amounts, the consequences of not paying cost-sharing charges and the disenrollment protections that are provided for families that do not pay cost-sharing obligations. The CMS website provides links to all the SCHIP State Plans at:

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp#TopOfPage>

Other cost-sharing rules for children at or below 150% FPL include:

- States may not impose more than one type of cost sharing for a service;
- States may only impose one cost-sharing charge for all services delivered during a single office visit; and,
- Cost sharing for these children is limited to nominal amounts as set forth in the SCHIP regulation.

Finally, if the state is operating a Medicaid expansion program, the Medicaid rules for any cost sharing will apply.

Appealing SCHIP Decisions

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing any time a decision is made which affects his or her right to Medicaid or to any service for which Medicaid funding is sought. This is known as a "fair hearing" and will be available in all states.

A person whose Medicaid benefits or right to services funded by Medicaid are either denied or terminated is entitled to a written notice of that decision. The notice must explain: the action that is being taken, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a Legal Services, Legal Aid or similar program (such as a Protection & Advocacy program). States are permitted to establish their own time limits for requesting hearings. Typically, the Medicaid recipient will be permitted a time limit (30 - 60 days) for requesting the hearing. However, if the notice indicates that an ongoing benefit, such as funding for home health care services, is to be terminated on a certain date, the recipient will need to request the hearing before the termination date if continued services are going to be requested pending the appeal. Federal Medicaid law provides that benefits are to be continued pending the appeal (a concept often referred to as "aid continuing") if the hearing is requested before the effective termination date and the recipient (or advocate working on his or her behalf) specifically requests the continuation of benefits.

Conclusion

When CWICs are counseling SSA disability beneficiaries, they are cautioned to be mindful that there may be children in the family who are receiving critical Medicaid coverage through SCHIP. Work incentives planning and assistance services provided to beneficiaries must include an analysis of how achieving the beneficiary's employment goal will affect continuing eligibility for SCHIP. WIPA projects cannot deal with beneficiaries in a vacuum since employment or self-employment may affect multiple family members.

CWICs also must be knowledgeable about how their home state implements the SCHIP program and states vary widely in this area. To find your state's current SCHIP plan, refer to the CMS website at:

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp#TopOfPage>. CWICs are also encouraged to locate the specific SCHIP regulations for their home state which will most likely be available at the website of the State Medicaid agency, or the agency which is responsible for making Medicaid eligibility determinations.

Conducting Independent Research

Centers for Medicare and Medicaid Services (CMS) webpage on SCHIP - <http://www.cms.hhs.gov/home/schip.asp>

This CMS webpage provides links to all the SCHIP State Plans.:

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp#TopOfPage>

National Conference of State Legislatures' webpage on SCHIP -

<http://www.ncsl.org/programs/health/chiphome.htm>

SCHIP Information Center - <http://www.schip-info.org/>

The Henry Kaiser Family Foundation - <http://www.statehealthfacts.org/comparecat.jsp?cat=4>

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