January 8, 2001

Dear State Health Officials:

I am writing to announce the publication of the final rules for the State Children's Health Insurance Program, as authorized by the Balanced Budget Act of 1997. The SCHIP final rules (HCFA 2006-F) will be published this week in the *Federal Register* and will be available on the HCFA web site (www.hcfa.gov) today.

Background

As you know, the policy guidelines for the State Children's Health Insurance Program (SCHIP) have been evolving since SCHIP was enacted into law in August 1997. In order to provide States and other interested parties with guidance as quickly as possible, the Health Care Financing Administration (HCFA) worked closely with States to develop a system of providing information through a series of Questions and Answers and letters to State Health Officials. Based on this guidance, ongoing technical assistance and discussions with States to date, every State and Territory has an approved SCHIP plan, and 38 States have received approval for a total of 71 plan amendments. These State initiatives have resulted in more than 3.3 million children having received coverage through SCHIP in the twelve-month period ending September 30, 2000, an increase of nearly 1.4 million children as compared to the prior twelve-month period.

On November 8, 1999, HCFA released proposed regulations which largely incorporated the policy that had been previously issued and our experience in reviewing States' SCHIP plans and amendments. We received more than 1,000 pages of comments to these proposed rules and after consideration of these comments, we have issued the final SCHIP regulations, which are accompanied an extensive "preamble" discussion summarizing and responding to the comments.

Impact on States

Since the final rules largely maintain existing policy and, therefore, reflect current State practice, we do not anticipate that States will need to make major changes to their programs in response to the final rules. However, we expect that some States will need to adopt program changes to comply with the new rules, and, in some cases, the new rules require information about States' programs that will need to be added to the State SCHIP plan. The final rules also provide States with additional flexibility in certain areas, which may prompt States to consider program modifications and expansions, either now or in the future. States have 90 days from the date of publication to come into compliance with the regulations, although more time is allowed if the changes would require modifications to existing State contracts.

Information Sharing and Technical Assistance

Over the next several weeks and months, in collaboration with the SCHIP Technical Advisory Group and the Alliance of State SCHIP Directors, the National Governors Association, the American Public Human Services Association, the National Academy of State Health Policy, and the National Conference of State Legislators, we will provide more information about the new regulations, issue timely responses to

questions about the new regulations that might arise, and work closely with States as they consider their SCHIP programs in light of the final rules.

We have scheduled a series of conference calls to serve as a forum for briefing States on the various parts of the final rules. A member of the SCHIP Technical Advisory Group will facilitate the discussion to follow HCFA's presentation of the policies included in the final rules. The calls with States will take place on Tuesdays in January (January 9th, 16th, and 23rd) from 2:00 until 3:30 p.m. Eastern Standard Time. In addition, the National Governors' Association (through support provided by the David and Lucille Packard Foundation) will be holding a meeting for representatives from all States to discuss the implementation of the SCHIP regulations on January 25th and 26th, 2001. The meeting will take place at the Watergate Hotel in Washington, DC. For further information, please contact Joan Henneberry at NGA at (202) 624-3644.

We have also scheduled briefings with other interested organizations and welcome the opportunity to share information about the regulations with other groups. Such briefings should be scheduled through HCFA's Office of Intergovernmental and Tribal Affairs.

HCFA also will be reactivating the "Frequently Asked Questions and Answers" process that was used at the outset of the program. States and other interested parties may submit questions about the final rules via email and HCFA will respond to the inquiries and post the questions and answers on our web site, at "www.hcfa.gov/init/children.htm" on an ongoing basis. We hope this process will be a useful means of disseminating further guidance quickly as States consider program modifications.

Finally, we have developed and will continue to develop a series of materials to help States and interested parties review and analyze these new regulations. Attached is the first in a series of documents we will refer to as Informational Transmittals. This first Transmittal (#1-0101) considers some key policy areas that were the subject of a substantial number of comments. Informational Transmittal #2-0101 provides a section-by-section summary of the final regulations. These Informational Transmittals will be available on the HCFA SCHIP web site.

I hope you will find this information useful as you begin your review of the final regulations. We look forward to our continuing work together toward the success of this important program.

Sincerely,

Timothy M. Westmoreland
Director

Attachments

CC:
All HHS Regional Directors
All HCFA Regional Administrators
All HCFA Associate Regional Administrators For Medicaid and State Operations

Lee Partridge, American Public Human Services Association
Brett Ewig, Association of State and Territorial Health Officials
Joy Wilson, National Conference of State Legislatures
Matt Salo, National Governors' Association
Joan Henneberry, National Governors' Association
Joanne Chase, National Congress of American Indians
Yvette Joseph-Fox, National Indian Health Board

Attachment

State Children's Health Insurance Program
Informational Transmittal #1-0101
SCHIP Final Rules - HCFA 2006-F

Following is a brief discussion of some of the policy changes included in the SCHIP final rules that either were significant issues for States during the State plan development process or that generated a large number of comments on the proposed rules. This document is intended to highlight for States and other interested parties particular areas of new flexibility or further clarification. The document first notes the policy included in the Notice of Proposed Rule-Making (NPRM) and then describes the policy in the final rules.

Premium Assistance Programs (Employer-Sponsored Insurance) (457.810)

NPRM: In order to ensure that SCHIP funds would be used to expand coverage for children and not simply substitute for employer contributions, the proposed rules included three specific requirements States must meet in order to purchase employer-sponsored coverage with SCHIP funds. The child must not have been covered by employer-sponsored insurance for at least 6 months prior to enrolling in the premium assistance program (however, the State could cover the child during this period in the direct coverage portion of its SCHIP program); the employer must contribute at least 60 percent of the cost of coverage; and the premium assisted coverage must be cost-effective, that is, the cost of coverage through an employer-based plan must not be greater than the cost of direct coverage under SCHIP.

Final Rule: While the concern about substitution remains, the rules provide more flexibility for States wishing to adopt premium assistance programs in SCHIP.

The cost-effectiveness requirement is statutory and has been retained, but we have removed the requirement for a 60 percent minimum employer contribution, since a substantial employer contribution must be made in order for coverage subsidized through employer plans to be cost-effective. States will need to identify a reasonable minimum employer contribution level, based on data demonstrating that such a level is representative of the employer-sponsored insurance market in their State; monitor employer contribution levels over time to determine whether substitution is occurring; and report the findings in their State annual reports.

The minimum 6-month period without group health coverage has been retained, but States may establish reasonable exceptions to the waiting period. In addition, the regulations make clear that the waiting period requirement does not apply to children who have received coverage under a group health plan through Medicaid under section 1906 of the Act.

The rules also acknowledge the lack of a direct relationship between States and the employer-based insurance through which premium assistance may be provided. Children covered through premium assistance programs must be assured the minimum benefits and cost-sharing protections established by the SCHIP statute, either through the employer plan or as a supplement to the employer plan. States, however, are not precluded from relying on employer-based insurance that does not comply with the rule relating to reviews of health services decisions established elsewhere in the regulations, as long as families are provided the option to enroll in the direct coverage portion of the SCHIP program. States that determine that the employer plan's review process falls within the rules established under SCHIP need not offer the opt out protection. (See discussion of 457.1100 - 457.1190)

Substitution Prevention (457.805)

NPRM: The proposed rules incorporated the statutory provision that States must indicate in their State plans what procedures they will follow to ensure that health benefits coverage provided under SCHIP will not substitute for private coverage under a group health plan. The regulation text did not specify what those procedures must be, but the preamble discussed a "three-tiered" policy that required monitoring of substitution below 150 percent of the Federal Poverty Level (FPL), and a specific strategy for preventing substitution of coverage offered at higher income levels. In practice, we have generally required States to adopt periods of uninsurance (waiting periods) when expanding coverage to children with incomes above 200 percent of the FPL.

Final rule: The language of the final regulation text remains unchanged; however, in the preamble, we announced that we will change the way we have implemented this policy to allow more flexibility to States, in light of their experience with substitution to date and currently available research on this topic.

All States should continue to monitor substitution and report on the results of these monitoring efforts in their annual reports.

No specific strategy will be required for coverage of children with family incomes at or below 200 percent of the FPL. States offering coverage to children in families over 200 percent of FPL must identify in their State plans a specific trigger point (i.e., level of substitution) at which a substitution prevention mechanism would be instituted and the strategies the State will implement if monitoring shows unacceptable levels of substitution. For coverage above 250 percent of the FPL, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance (i.e., a waiting period) is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States that do adopt waiting periods may adopt reasonable exceptions

and should consider the impact waiting periods may have on children's access to services.

States may submit amendments to their State plans if they would like to modify their current policies in light of the policies discussed in these final rules.

Employment with a Public Agency (457.301)

NPRM: The SCHIP statute prohibits States from covering in SCHIP children of public employees who have access to coverage under a State health benefits plan. The proposed rules included definitions of the terms "employment with a public agency" and "State health benefits plan."

Final rule: To provide some additional flexibility, we have removed the definition of "employment with a public agency", as this is a term traditionally defined by States. Further, we have modified the definition of "State health benefits plan" to clarify that the term does not include plans in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or a plan that provides coverage only for a specific type of care, such as dental or vision care. We hope this added flexibility will provide States the needed vehicle for extending coverage to children who do not actually have access to State employee dependent coverage.

American Indians/Alaska Natives (457.120, 457.125 and 457.535)

NPRM: The proposed rules tracked the statutory requirement that States must assure that children who are American Indians/Alaska Natives (AI/ANs) have access to child health assistance under SCHIP. In addition the proposed rules included the previously-stated policy that AI/AN children must be exempted from cost sharing.

Final Rule: The final rules retain the cost-sharing exemption but clarify, in the preamble, that States may accept self-identification of membership in a Federally-recognized Tribe to facilitate this process. The preamble also provides that States should provide an inconspicuous method of identifying these children, so that providers know who is exempt from cost sharing at the point of service. The final rules also include a provision underscoring the importance of States and Indian Tribes and Tribal organizations working together in the development and implementation of SCHIP programs to ensure access for AI/AN children.

Coordination with Medicaid (457.340 and 457.350)

NPRM: The proposed rules required that the State plan include a description of the screening procedures States will use, at intake as well as at renewal, to ensure that only targeted low-income children are enrolled in SCHIP. They discussed several elements of the screening process and laid out processes for treatment of children found to be potentially eligible (as well as potentially ineligible) for Medicaid.

Final rule: We have clarified the steps required to ensure that an effective screen and enroll process is in place by reorganizing the sections into a more logical format and providing options for States.

In general, States must devise a system by which children are effectively screened and through which enrollment in the appropriate program (Medicaid or a separate child health program) is facilitated.

Information collected by one program, which is needed to make an eligibility determination by the other program, must be transmitted to the other program in a timely manner so that coverage is not delayed and families do not have to submit the same information twice. Families must be provided the information they need to complete the application process and be given appropriate notice of any determinations made on their application(s) for coverage.

In response to comments that the Medicaid agencies must also participate in the coordination activities between SCHIP and Medicaid, the final rules include provisions directing Medicaid agencies to coordinate with SCHIP.

The rules also make it clear that coordination procedures between Medicaid and SCHIP must be established when a child's eligibility for either program is renewed or redetermined, as well as when children first apply for coverage.

States continue to have broad flexibility to devise their coordination strategies in light of the particular needs and administrative structures operating in each State. All States are required to monitor and evaluate the effectiveness of the process they devise.

Gender, Race, Ethnicity, and Primary Language Reporting (457.740 and 457.750)

NPRM: The proposed rules did not require reporting of data on the gender, race, ethnicity or primary language of SCHIP enrollees.

Final Rule: We received a number of comments requesting that this decision be reconsidered because of the critical need to address language barriers, and to enable States and the Federal government to target outreach strategies in underserved areas and assess how well SCHIP is addressing racial and ethnic disparities. We considered current State practice and found that at least 42 States already collect this information through the application process.

The final rules require States to collect data on gender, race, and ethnicity of SCHIP enrollees and report these data in their quarterly statistical enrollment reports. Data on primary language must be collected and included as part of a State's annual report. The information must be collected in such a way that it is clear to the applicant or enrollee that failure to provide the information will not affect the child's eligibility, nor will the information be shared with other entities (e.g., the INS) for purposes of identifying immigration status.

Cost-Sharing (457.560 and 457.570)

NPRM: The proposed rules included policies on cost sharing that had largely been announced in previous guidance. However, the NPRM also included two new policies. First, it limited the total amount of cost sharing for families with incomes below 150

percent of the FPL to 2.5 percent of family income, consistent with the 5 percent cap on cost sharing for families with incomes above 150 percent of the FPL. Second, the proposed rules required States to have a process in place to give enrollees reasonable notice and an opportunity to pay past due cost sharing, prior to disenrollment for failure to pay.

Final Rule: We received a significant number of comments opposing and supporting the 2.5 percent limit. We reviewed current State cost-sharing policies and found that the cap on cost-sharing for families with incomes below 150 percent of FPL is not likely have much impact on current State practice; given current cost-sharing levels, it would only constrain State policies in cases where a child has an extraordinary need for health care services. The cost-sharing protection for these particularly vulnerable low-income children has been retained in the final rules.

Each State must include in its State plan a description of the consequences for not paying a charge (e.g., a grace period, a penalty period), in part, to allow for public input and comment. In addition, to help prevent children from unnecessarily or inappropriately losing coverage as a result of cost sharing, prior to disenrolling a child from coverage due to nonpayment of a premium, families must be afforded an opportunity to show that their circumstances have changed and that they are no longer required to pay the premium charged under the State's cost-sharing rules.

The State must also provide families with an opportunity for an impartial review of a decision to disenroll a child if the family believes it has made the required payment or otherwise disagrees with the termination of coverage.

Although we received a number of comments urging that the rules prescribe a particular method by which States should implement the cap on cost sharing, the rules continue to afford States the flexibility to design procedures that protect children and their families from unaffordable out-of-pocket costs. Such procedures must be described in the State plan.

Access to Services (457.495)

NPRM: The proposed rule at 457.735 required States to assure access to covered services, including emergency services as defined by the "prudent layperson standard"; and appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions, including access to specialists.

Final Rule: The final rules confirm that States must assure access to all services covered under the State plan, as well as to emergency services under the prudent layperson standard. In addition, the rule clarifies that States must ensure access to specialists that have experience in treating the child's particular medical condition and afford children access to an out-of-network specialist for a covered service if one is not available within their managed care network.

These protections are common elements of most States' consumer protection rules.

Reviews of Eligibility, Enrollment and Health Services Decisions (457.1100 - 457.1190)

NPRM: The proposed rules required States to allow grievances and appeals in the event of an adverse eligibility, enrollment or health services decision.

Final Rule: The proposed provision did not give a clear sense of what was expected and was sufficiently broad as to possibly require reviews of matters for which reviews are not required under Medicare and Medicaid. In addition, some commenters misunderstood that the NPRM required the Medicaid hearing procedures be used for SCHIP. At the same time, other commenters were concerned that the proposed rules did not ensure that all families would have access to an impartial process for resolving disputes with respect to a plan denial of a needed health service or a denial or termination of coverage. In response to these comments, we have reorganized and revised these sections of the regulations into a new subpart. The rules do not require a specific review procedure; they set parameters within which States must work to ensure basic protections for their SCHIP enrollees.

States must provide families an opportunity to request a review of a decision to deny or terminate coverage (eligibility and enrollment); deny health services; or to fail to make a timely decision with respect to coverage or health services. Reviews are not required when the decision results from a policy that applies to all children or to a broad group of children. For example, if a State closes off enrollment to all children due to fiscal constraints, the State is not required to provide the children denied coverage an opportunity for a review.

States have broad flexibility to design their review processes as long as their procedures are described in their State plan (to allow for public comment) and address the core elements set forth in the rules.

Reviews must be impartial and conducted by a person (or contractor) who has not been directly involved in the matter under review. Health services decisions must be subject to an external review (i.e., by an entity - the State or a contractor - other than the plan that made the decision under review).

Reviews may be conducted in person, by phone, or based on relevant documents.

Decisions on eligibility and enrollment must be made in a timely manner, in accordance with the medical needs of the child. No specific time standard is established for issuing decisions relating to eligibility and enrollment; however in setting time frames, the State must consider the need for expedited review when there is an immediate need for health services.

To prevent children from inappropriately experiencing a gap in coverage, families must have an opportunity for a review of a termination or suspension of enrollment before the child's coverage is actually terminated or suspended.

External reviews of health service decisions must generally be completed within 90 calendar days of the request. States are not required to have an internal review process, but if a State chooses to offer an internal and an external review, both parts of the review must be completed within 90 days. In those instances where a child's provider determines that an expedited review is necessary due to an urgent need for care, the review must be completed within 72 hours of the request (an additional 72 hours are available if the State has both an internal and external review process.)

These rules provide States with flexibility to design their review procedures, while ensuring children and their families a fair review process. Although some States do not now have review procedures in place, the review procedures that have been adopted in many States are likely to comply with these guidelines. On this and other areas where an amendment to the State plan may be needed, we will work with States to answer questions about implementation and provide technical assistance to facilitate program development.