# The State Children's Health Insurance Program: Guidance on Frequently Asked Questions

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## Abstract

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) includes provisions establishing the State Children's Health Insurance Program (S-CHIP) under a new Title XXI of the Social Security Act. The new federal-state program provides states with federal matching funds to expand health insurance coverage of uninsured low-income children. The program is authorized to spend a total of $20.3 billion in federal matching funds between fiscal years 1998 and 2002. This report is designed to provide background and guidance on the most frequently asked provisions of S-CHIP. These include questions on eligibility, benefits, cost sharing, state and federal funding, coordination with other health programs, and quality and accountability measures. This report will be updated periodically and is intended for a general audience.

# The State Children's Health Insurance Program: Guidance on Frequently Asked Questions

## Summary

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) includes provisions establishing the State Children's Health Insurance Program (S-CHIP) under a new Title XXI of the Social Security Act. The new state-federal partnership is intended to expand health insurance coverage of low-income children by providing states with federal matching funds. The program is authorized to spend a total of $20.27 billion for federal matching funds for child health insurance initiatives for the 1998 to 2002 period.

The S-CHIP is targeted at uninsured children who live in families with income below twice the poverty line. Generally, states will be able to use the child health initiative funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs or through a combination of both. A state will also be able to purchase a health benefits plan that is provided by community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost effective to do so.

Each state will be allotted funds from the total appropriated amounts based on a combination of the number of low-income children and low-income, uninsured children in the state. Federal matching funds will be disbursed quarterly to each state with an approved child health assistance plan. Each state will receive, from the federal government, a certain percentage (the enhanced federal matching percentage) of the total amounts paid for child health assistance equal to the Medicaid matching percentage (FMAP) for each state increased by about 30%.

This document is designed to provide guidance on the most frequently asked questions about the provisions of S-CHIP. Some questions cannot be answered definitively at present. The answers will depend on the rules implementing the program that will be issued by the Secretary of Health and Human Services. Also, the answer to many questions about the particular characteristics of the state programs will depend upon how a particular state responds to the Act. One of the biggest questions states must answer is whether to use child health initiative funds to expand coverage through their existing Medicaid programs, through a separate program, or through a combination of the two. At this time, it is not entirely known which states will elect to establish S-CHIP programs, whom they will elect to cover, and how they will provide access to coverage for eligible children. As of March 20, 22 states had submitted state plans to Health Care Financing Administration (HCFA): Alabama, California, Colorado, Connecticut, Florida, Idaho, Illinois, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, and Wisconsin. Of these states, 11 intend to expand Medicaid, 5 intend to create or expand separate state programs, and 6 intend to use a combination of Medicaid expansion and separate state program. Four states, Alabama, Colorado, Florida, and South Carolina have had plans approved.

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# The State Children's Health Insurance Program: Guidance on Frequently Asked Questions

## Overview

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33), as amended by technical amendments (P.L. 105-100, signed into law on November 19, 1997) includes provisions establishing the State Children's Health Insurance Program (S-CHIP) under a new Title XXI of the Social Security Act. The new state-federal partnership is intended to expand health insurance coverage of low-income children by providing states with federal matching funds. The program is authorized to match state spending for child health insurance initiatives up to a total of $20.27 billion for the 1998 to 2002 period.

The S-CHIP is targeted at those uninsured children who live in families with income below twice the poverty line.[1] Generally, states will be able to use the child health initiative funds to provide coverage through health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs or through a combination of both.

Each state will be allotted funds from total appropriated amounts based on a combination of the number of low-income children and low-income, uninsured children in the state. Each state's allotment would first be reduced by the federal share of increased Medicaid spending on a new Medicaid option allowing states to provide short-term Medicaid coverage to children based on preliminary income information (presumptive eligibility) and the enhanced federal matching payments for states choosing to expand Medicaid with Title XXI funds. The remaining payments will be disbursed quarterly by the Secretary of Health and Human Services (HHS) to each state with an approved child health assistance plan. Each state will receive, from the federal government, a certain percentage (the enhanced federal matching percentage) of the total amounts paid for child health assistance. The enhanced federal matching percentage for state child health programs would be equal to the Medicaid matching percentage (FMAP) for each state increased by about 30%.

Title XXI also includes provisions that are not directly a part of the S-CHIP. The second chapter of the title includes provisions that establish optional

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[1] States in which Medicaid covered children in families with income over 200% of the federal poverty level on June 1, 1997 may use an alternate definition of targeted low-income children defined as those with family income below 50 percentage points above the Medicaid applicable income level. As of May 1, 1997, six states provided Medicaid coverage for at least some children in families with income at or above 200% of the federal poverty level: California, Hawaii, Minnesota, Rhode Island, Vermont, and Washington.

presumptive eligibility for children under the Medicaid program. Under presumptive eligibility, states can choose to provide Medicaid coverage to children for a period up to 60 days based on preliminary income information. Once a final income determination has been made, the presumptive eligibility period would end. Other provisions included in this title are continued Medicaid coverage of certain disabled children who would have lost benefits under the federal welfare changes of 1996 and the establishment of grant programs for services for the prevention and treatment of type I diabetes in children and type I and II diabetes in Native Americans/Alaskan Natives.

This report is designed to provide guidance on the most frequently asked questions about the provisions of S-CHIP. Some questions cannot be answered definitively at present. The answers will depend on the rules implementing the program that will be issued by the Secretary of HHS. Also, the answer to many questions about the particular characteristics of the state programs will depend upon how a person's particular state responds to the Act. It is not entirely known which states will elect to establish S-CHIP programs, whom they will elect to cover, and how they will provide access to coverage for eligible children. As of March 20, 22 states had submitted state plans to Health Care Financing Administration (HCFA): Alabama, California, Colorado, Connecticut, Florida, Idaho, Illinois, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, and Wisconsin. Of these states, 11 intend to expand Medicaid, 5 intend to create or expand separate state programs, and 6 intend to use a combination of Medicaid expansion and separate state program.

**Table 1. S-CHIP Implementation, Type of Program Chosen by States**

| Medicaid expansion | | Separate state program | Combination |
|---|---|---|---|
| Alabama | Oregon | Colorado | California |
| Illinois | Rhode | Michigan | Connecticut |
| Idaho | South | New York | Florida |
| Missouri | Tennessee | Nevada | Massachusett |
| Ohio | Vermont | Pennsylvania | New Jersey |
| Oklahoma | | | Wisconsin |

**Source:** Congressional Research Service (CRS) analysis of submitted state plans.

HCFA has approved four state plans to date: Alabama, Colorado, Florida, and South Carolina. Alabama will expand coverage to some 20,000 uninsured children by expanding its existing Medicaid program to children up to age 19 whose family incomes are at or below the federal poverty rate (currently $16,050 per year for a family of four). Colorado hopes to insure 23,000 children by the third year of its program by extending its separate state program to children with family incomes up to 185% of the federal poverty level. Florida will expand Medicaid coverage for

children age 15-19 with family incomes up to 100% of the federal poverty level. Florida will also use S-CHIP funds to provide subsidized premiums for children in families at or below 185% of poverty through its Healthy Kids Program. The state currently serves 49,000 children under the program (which is capped at 60,000 this year because of budget constraints). State officials hope to enroll a maximum of 118,725 each year with the new S-CHIP funds. South Carolina will extend coverage to as many as 75,000 uninsured children in the state by expanding eligibility for its existing Medicaid program to children in families with income up to 150% of poverty.

## Background

Many policymakers have long had an interest in the subject of expanding health insurance coverage of individuals, and particularly of children. In the past, however, most proposals failed to garner sufficient political support. President Clinton's Health Security Act (H.R. 1600, S. 1757), for example, considered during the 103rd Congress, would have guaranteed health insurance coverage to most Americans through a combination of mandated employer contributions and government subsidies. When it became apparent that majority support could not be achieved for the proposal, some in Congress backed alternative measures to expand access to health insurance solely for children. Varying in specifics, these proposals would have provided some type of income-related federal subsidy to families to assist them in purchasing coverage for their children. They also would have required changes to the private health insurance market to ensure that plans were available to children, regardless of their health status or medical history. While none of these efforts succeeded, they helped initiate a debate about "putting children first" in future congressional efforts to expand access to health insurance.

Efforts to expand Medicaid, the federal-state program providing medical assistance for specified groups of low-income persons who are aged, blind, disabled or members of families with children, have, on the other hand, been more successful. Beginning in 1986, Medicaid was expanded to require coverage of new categories of children or pregnant women or to add optional coverage groups of children and pregnant women. To date, states have responded enthusiastically to new coverage options for children and, in many cases, have expanded their programs to cover more children than required.[2]

One other access initiative that succeeded, albeit briefly, was the enactment in 1990, as part of the Omnibus Budget Reconciliation Act (P.L. 101-508), of a modest tax credit for the purchase of health insurance for recipients of the Earned Income Tax Credit (EITC). The credit was intended to assist working families with the cost

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[2] All states are required to provide Medicaid benefits to children under age 6 in families with income below 133% of the federal poverty level and children under age 15 in families with income below the poverty level; older children under age 19 will be covered as the poverty-level expansion is phased-in. In addition, states have the ability to cover other groups of children under a Medicaid provision 1902(r)(2) that allows for certain types of income to be disregarded in determining the income eligibility of the family involved.

of private health insurance for their children. The credit was repealed in 1993 because of widespread concern about its failure to achieve its objectives.[3]

Interest in the subject of children's health insurance has remained strong, despite the broad reach of Medicaid and private insurance, because surveys indicate that many children still do not have health insurance. **Table 2** shows that about 62% of all children, or about 44 million, had private group health insurance as their primary source of coverage in 1996. Privately insured children are usually covered under the employer-sponsored plans of their working parents. Medicaid covered another nearly 16 million children with a comprehensive set of benefits. Nevertheless, 14.8% of all children, 10.6 million, were uninsured in 1996.[4]

**Table 2. Sources of Children's Health Insurance Coverage, 1996**

| | | Sources of health insurance[a] | | | |
|---|---|---|---|---|---|
| | Number (millions) | Employment-based[b] | Medicaid | Other[c] | Uninsured |
| Total under age 18 | 71.2 | 61.9% | 22.0% | 10.6% | 14.8% |

**Source:** CRS analysis of data from the March 1997 Current Population Survey.

[a] Some children have more than one kind of insurance; total percentage may exceed 100.
[b] Group health insurance through parent's employer or union.
[c] Private nongroup insurance, Medicare, or military health care (CHAMPUS/VA).

In 1997, expansion of health insurance again became a hotly debated subject. Almost 20 bills were introduced in the early days of the first session of 105th Congress to expand health insurance coverage of children. Among the proposed bills, most would have approached the problem by establishing grant programs providing states with funds to expand or implement programs to increase health insurance for uninsured children. The President's budget proposal for 1998 included a similarly flexible grant program for states. A few bills would have expanded Medicaid and several others would have used a tax based approach to provide incentives for families to purchase health insurance. CRS Report 97-385, *Children's Health Insurance: Issues for the 105th Congress* includes descriptions of these introduced bills.

The S-CHIP in the BBA 97 combined the approaches in the House and Senate passed budget bills. The House version was primarily a program of block grants to states for health care for children with very few strings attached. The Senate bill, on the other hand, provided for a federal matching program with more restrictions on the use of funds. The compromise was crafted in late July of 1997, and was passed by the House and Senate at the end of the month. The President signed the BBA 97 into

[3] See CRS Report 97-385, *Health Insurance for Children: Legislation in the 105th Congress*, by Beth Fuchs, Jean Hearne, Bob Lyke, and Patrick Purcell.

[4] See CRS Report 97-975, *Health Insurance Coverage of Children*, by Patrick Purcell.

law on August 5, 1997 (P.L. 105-33). The District of Columbia Appropriations Act, 1998 (P.L. 105-100), signed into law on November 19, 1997, included several technical corrections to the S-CHIP program.

## Child Health Assistance

**What Exactly Is Child Health Assistance?** Child health assistance, as described in Title XXI, is to consist *primarily* of health insurance coverage for targeted low-income uninsured children. Coverage that is purchased or provided by the state must meet specific standards for benefits and cost-sharing described in the law (see questions below for more description). Coverage can also be provided under the state's Medicaid program. If a state chooses to establish a program to purchase or provide health benefits for children other than under Medicaid, it will have the flexibility to choose whether to have the program administered privately or by the state or local governments, whether to use a new or existing program, which delivery method (e.g., managed care or fee-for-service) to use, and how to coordinate with Medicaid and other efforts to increase health insurance coverage of children. A state will also be able to purchase a health benefits plan that is provided by community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost effective to do so.

**Must All S-CHIP Funds Be Used To Purchase Health Benefits Coverage?** A state can use child health initiative funds to purchase or provide health insurance coverage for targeted low-income children that meets the requirements of Title XXI, to finance other initiatives for improving child health among low-income children, and to pay for outreach and administration of the plan. ("Other initiatives" is not defined but could include such activities as the direct purchase of services from providers on behalf of low-income uninsured children, health education programs, or other public health activities.) No more than 10% of a state's total Title XXI expenditures for a fiscal year can be used for other initiatives, outreach and administration.[5] The 10% limitation on payments for child health assistance that does not meet the coverage requirements may be waived if a state establishes to the satisfaction of the Secretary that (1) the coverage provided to targeted low-income children meets the benefits and cost sharing requirements of Title XXI, (2) the cost of such coverage is no more than it would otherwise be, and (3) such coverage is provided through the use of a community-based health delivery system or hospital.

## Eligibility

**Who Will Be Eligible for Coverage?** Title XXI defines children targeted by the legislation as those who are not eligible for Medicaid or covered under a group

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[5] The conference report (H.Rept. 105-217, p. 907) on the Balance Budget Act of 1997 states that the 10% limit is equal to 10% of state and federal Title XXI spending for the state involved. The legislation, however, defined the limitation to be equal to 10% of the federal share of Title XXI spending for the state. A technical correction included in P.L. 105-100 fixes this provision, allowing states to count state and federal Title XXI spending, not just federal spending, toward the 10% cap.

health plan or other health insurance,[6, 7] and reside in families with income below 200% of the federal poverty level (or, in states with Medicaid income levels for children already at or above 200% of poverty, below the Medicaid income level increased by no more than 50 percentage points).

Not all targeted low-income children will receive health coverage. Each state will have the flexibility to define the group of targeted low-income children who will become eligible for that state's program. Title XXI allows states to use the following characteristics in determining eligibility: geography, age, income and resources, residency, disability status, access to other health insurance and duration of eligibility for other health insurance. In other words, states can choose to limit eligibility to children in certain geographic, age, income, residency and disability categories or to children who do not have access to other health insurance. The statute includes several limitations on a state's eligibility standards. States could not cover children with higher family incomes before covering children with lower family incomes or deny eligibility to a child based on a preexisting medical condition.[8] States must establish procedures to ensure that only targeted low-income children receive benefits and that children found through screening to be eligible for Medicaid are enrolled in Medicaid. Eligibility procedures must also ensure that the new insurance does not substitute for coverage under group health plans and there is coordination with other public and private programs providing health benefits coverage for low-income children.

**Are Eligible Children Entitled To Benefits?** No, a provision of Title XXI specifically states that the law does not establish an individual's entitlement to the benefits of state child health programs funded under the child health initiative.

**How Many Children Will Be Covered?** The program is targeted at currently uninsured children who have income below 200% of poverty. There are about 5 million children in that category. The Congressional Budget Office (CBO) estimates that about 2.78 million children will actually receive coverage under the provisions of Title XXI. CBO also estimates that about 1.38 million of those children will have been previously insured assuming that states will not be 100% effective in

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[6] Other health insurance is defined by Section 2791 of the Public Health Service Act as medical care (provided directly, through insurance or reimbursement or otherwise including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical services contract, or health maintenance organization (HMO) contract offered by a health insurance issuer.

[7] Under new Section 2110(b) of the Social Security Act (as added by P.L. 105-33), targeted low-income children may include children covered under a health insurance program offered by a state and in operation since before July 2, 1997, and which receives no federal funds. Children who are inmates of a public institution, patients in institutions for mental disease, or eligible for health benefits under a state plan on the basis of a family member's employment with the state are not considered targeted low-income children.

[8] A preexisting condition is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

prohibiting the enrollment of children who had other insurance coverage and who either dropped it or whose employers discontinued offering such coverage. The phenomenon, called "crowd out," occurs when people who are themselves eligible for public insurance such as Medicaid, or whose dependents are eligible for public insurance, elect not to enroll in an employer-sponsored group health insurance plan because its premiums or cost-sharing expenses are higher than those in the public insurance program.[9]

**Table 3. Children Covered Under Title XXI: State Child Health Insurance Program**
(in thousands)

| | |
|---|---|
| Children covered by S-CHIP programs | 2,780 |
| Children identified by S-CHIP programs as Medicaid eligible and enrolled in Medicaid | 460 |
| Children covered by Medicaid under 12-month continuous eligibility | 70 |
| Children covered by Medicaid under presumptive eligibility provisions | 70 |
| Total | 3,440 |
| Previously uninsured | 2,060 |
| Previously insured | 1,380 |

**Source**: CBO.

**Note:** Section 4731 in the Medicaid title of BBA 1997, allows states to provide for a 12-month period of eligibility for children under age 19 who qualify for the program.

**Will a Preexisting Condition Keep a Child From Being Covered under S-CHIP Programs?** A state cannot deny eligibility under its S-CHIP program to a child on the basis of a preexisting medical condition. If the S-CHIP program covers children by purchasing group health insurance or a plan on behalf of a child, preexisting exclusions may be imposed as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA a plan can impose no more than a 12-month preexisting condition limitation period (a period during which that plan can restrict or even exclude coverage of the medical

[9] Both the extent and the implications for public health costs of the "crowd out" effect of expanded eligibility for Medicaid have been a recent topic of debate among health economists. Some researchers (Cutler and Gruber, 1996) have found relatively large crowd-out effects from expanded eligibility for children in the Medicaid program. Others (Dubay and Kenney, 1996) have found much smaller crowd-out effects. Although crowding out clearly shifts health costs from the private sector to the public sector, expanding eligibility for Medicaid or other public insurance reduces out-of-pocket costs for health care among near-poor families and allows them to spend more income on other necessities.

condition). HIPAA further restricts the preexisting limitation period for people moving from one health plan to another or from individual to group coverage. For those individuals, the maximum period for which coverage for preexisting conditions can be limited must be reduced by 1 month for every month that the individual had creditable coverage under a previous plan provided that he enrolled when first eligible and has no break in previous coverage.[10]

**Are Immigrant Children Eligible for S-CHIP?** The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), banned certain immigrants who entered the United States *after* August 22, 1996 from receiving federal means-tested public benefits for their first 5 years in the country. According to guidance documents that HCFA has provided the states, Title XXI health insurance coverage meets the definition of a federal, means-tested public benefit. Therefore, its health insurance coverage cannot be made available to these immigrant children. Further, states may not segregate their S-CHIP expenditures to convert a portion of the program into a fully state-funded, means-tested program in order to skirt the restrictions established by PRWORA. However, several groups of legal immigrant children *are* eligible for the full range of benefits provided under S-CHIP. These include: all legal immigrant children who were in the United States before August 22, 1996; refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants; and unmarried, dependent children of veterans and active duty service members of the Armed Forces.

In addition to providing insurance coverage to eligible immigrant children, states may use a limited amount of S-CHIP funds for expenditures other than health insurance assistance to conduct targeted outreach and health services initiatives in communities that include substantial numbers of immigrant children. These initiatives may benefit the health of all low income children, including but not limited to children eligible to receive services under Title XXI.[11]

**Are American Indian/Alaskan Native Children Eligible for S-CHIP?** American Indian/Alaskan Native (AI/AN) children are eligible for S-CHIP on the same basis as other children in their state, regardless of whether or not they may be eligible for or served by the Indian Health Service (IHS). Title XXI requires states to include a description of the procedures to be used to ensure the provision of S-CHIP assistance to eligible AI/AN children in their state plans. Further, HCFA has requested that state officials responsible for S-CHIP consult with federally recognized Tribes and other Indian Tribes and organizations in the state on development and implementation of the state plan.[12]

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[10] HIPAA defines a break in coverage as one that last 63 or more days.

[11] U.S. Health Care Financing Administration. *Letter to State Official: Immigrant Children.* January 18, 1998. (Available at http://www.hcfa.gov/init/chipimms.htm.)

[12] U.S. Health Care Financing Administration. *Letter to State Official: Tribal Consultation.* February 24, 1998. (Available at http://www.hcfa.gov/init/ch022498.htm.)

**Are States Required To Provide Public Notification of Eligibility?** States are required to include a description in their child health plan of the process used to obtain public involvement in the design and implementation of the plan. If the state intends to make changes to the plan that will result in restricting or limiting eligibility or benefits, those changes could not take effect until there had been public notice. In addition, states can choose to use a portion of their child health initiative funds for outreach activities that may include public notification as long as the state does not exceed the 10% limit on spending for services that are not benefits.

## Benefits

**What Benefits Will Be Covered?** The statute defines three minimum benefits options for states choosing to provide child health assistance coverage under Title XXI instead of under the Medicaid program. The options include (1) a *benchmark benefit package*, (2) *benchmark equivalent coverage*, (3) or any other health benefits plan that the Secretary determines, upon application by a state, provides appropriate coverage for the targeted population of low-income children.[13]

**What Is a Benchmark Benefit Package?** A benchmark benefit package is one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, (3) the health coverage that is offered by an HMO with the largest commercial (non-Medicaid) enrollment in the state involved.

**What Is Benchmark Equivalent Coverage?** Benchmark equivalent coverage is defined as a package of benefits that has the same actuarial value, as certified in an actuarial memorandum, as one of the benchmark benefit packages. A state choosing to provide benchmark equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services and well-baby and well-child care, including age-appropriate immunizations. Benchmark equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services.

States are encouraged to cover other categories of services such as mental health services. Abortions, except in the case of a pregnancy resulting from rape or incest, or unless the mother is in danger of death unless an abortion is performed, may not be covered.

**What Is the "Actuarial Value" of a Set of Benefits and Who Will Determine It?** The actuarial value of a set of benefits is the dollar value of those benefits. The calculation of the actuarial value of a set of benefits usually takes account of the services and providers covered, the cost sharing charged, and the way the care is

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[13] Three existing state programs, in Florida, New York, and Pennsylvania, were grandfathered in as meeting the minimum benefits requirements under S-CHIP.

managed. Two different packages of benefits may have the same actuarial value. For example, a plan that covers extensive hospital care but no dental or vision coverage may have the same actuarial value as a plan that offers limited hospital care coverage and high value dental and vision coverage.

S-CHIP requires that the actuarial value of "benchmark equivalent plans" be established by an individual who is a member of the American Academy of Actuaries. Actuaries must use generally accepted actuarial principles and methods, and meet certain standards in the calculation of the actuarial value of child health plans.[14]

**Does a State Child Health Insurance Program Have To Cover Childhood Vaccines?** Childhood vaccines are included as a basic benefit along with hospital, physician, laboratory and x-ray, and other well-child care for *benchmark equivalent plans*. If a state chooses to provide a benchmark equivalent plan (coverage at the same actuarial value as one of the benchmark plans) then childhood vaccines must be covered because all basic benefits must be covered under this option. If the state chooses to provide a *benchmark plan*, on the other hand, then childhood vaccines are only required if they are covered by the chosen benchmark plan. For example, if a state chooses to offer the standard Blue Cross/Blue Shield preferred provider benchmark plan as offered under FEHBP, then childhood vaccines must be covered because such benefits are currently a part of that plan. If a state chooses to offer the state employee coverage benchmark, then vaccines must be covered if they are covered by the state employee plan for that state. Alternatively, if they are not covered then the state would not be required to include coverage of vaccines.

**Is Mental Health Parity Required?** Mental health parity refers to the requirement that mental health benefits be offered and provided in a manner equal to similar services for physical benefits. The Mental Health Parity Act of 1996 (P.L. 104-204) requires limited parity for mental health coverage under group plans.[15] The S-CHIP statute does not include new requirements for mental health parity for participating plans. To the extent that group plans participating in S-CHIP would be subject to the mental health parity provisions of P.L. 104-204, they would remain subject to those rules. The statute does, on the other hand, include mental health services as a category of additional services for benchmark equivalent plans, and at least 75% of the actuarial value of such services must be covered in states choosing to provide a benchmark equivalent plan. For example, states offering a *benchmark equivalent plan* for which the benchmark plan covers unlimited inpatient mental hospital care may choose to provide 75% of the value of such inpatient care or may

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[14] Actuaries calculating the value of child health plans must use standardized utilization and price factors and a standardized population consisting of children of the age to be covered under the state child health plan. They must apply the same principles and factors in comparing the value of different coverage, and cannot take into account any differences in coverage based on the method of delivery, means of cost control, or utilization used. Coverage of abortions in the benchmark benefits packages should not be considered in determining equivalent coverage or actuarial equivalent coverage.

[15] The Act required insurers to establish the same annual and aggregate lifetime dollar limits for mental health coverage as for physical health coverage.

choose to limit inpatient care further, and provide higher value residential treatment or intensive outpatient treatment. States offering *benchmark coverage* are required to offer the same mental health benefits as are offered in the benchmark plan. For example, a state offering the state employee benchmark that covers 30 days of inpatient mental hospital care would be required to offer 30 days of inpatient mental hospital care.[16]

**Can Programs Impose Limits on the Amount, Duration, and Scope of Services?** S-CHIP provides states with broad authority to determine the amount, duration, and scope of services unless the state chooses to provide a benchmark plan. In that case, the amount, duration, and scope of the benefits must be the same as the chosen benchmark plan. States offering a *benchmark equivalent plan*, on the other hand, could provide a benefits package that includes unlimited inpatient hospital care or more limited inpatient care as long as the total package is certified to be the actuarial equivalent of the benchmark plan. If offering limited hospital days, other benefits would need to be more generous to compensate for the limited hospital care. On the other hand, if a state chooses to provide a *benchmark plan* and the chosen benchmark plan covers 45 days of hospital care, then the state CHIP plan must also cover 45 days of hospital care.

**Must the Same Benefits Be Provided Statewide?** There is nothing in the S-CHIP law requiring benefits provided under a state's CHIP program to be offered statewide. The Secretary may provide further guidance on this issue in regulations.

## Cost Sharing

**How Much Will Beneficiaries Have To Pay for S-CHIP Coverage?** Cost sharing is permitted under S-CHIP although there are a number of limitations, both general and specific. Generally, premiums, deductibles, coinsurance and other cost-sharing are allowed based on family income but only in a manner that does not favor children from higher-income families over those from families with lower incomes. Cost sharing will not be permitted for well baby and well child care, including immunizations. Schedules of cost sharing must be made public.

Specific limitations are as follows: for targeted low-income children in families with incomes below 150% of the poverty line, premiums may be imposed only insofar as they do not exceed the maximum monthly charges permitted under Medicaid. Under Medicaid, maximum monthly premium charges are set by regulation (42 CFR §447.52) and, for example, cannot exceed about $15 per month for a family of four earning $1,000 each month.

Other cost sharing for children may not exceed "nominal" amounts, as determined consistent with Medicaid regulations, indexed for health care inflation

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[16] A study produced by the HayGroup for the Coalition for Fairness in Mental Illness Coverage contains an analysis of the mental health benefits provided in the various benchmark plans for 16 states. For further information see: Hustead Edwin C. and Plazinski, Lori. *Value of Benefits Offered in Benchmark Plans for State Children's Health Insurance Program (S-CHIP)*. November 1997.

for the period since the date of such regulations. Medicaid defines "nominal" amounts in another regulation (42 CFR §447.54). Nominal deductibles (the amounts persons have to pay out-of-pocket before the program begins to pay for covered services) cannot exceed $2.00 per month per family per period of Medicaid eligibility. Nominal coinsurance is limited to 5% of the payment the agency makes for the service. Copayments for services cannot exceed the following amounts.

**Table 4. Medicaid "Nominal" Copayment Schedule**

| State payment for service | Maximum copayment allowed |
|---|---|
| $10 or less | $.50 |
| $10.01 to $25 | 1.00 |
| $25.01 to $50 | 2.00 |
| $50.01 or more | 3.00 |

**Source:** 42 CRF §447.54.

For targeted low-income children in families with income above 150% of the poverty line, premiums, deductibles, cost sharing or similar charges may be imposed on a sliding scale related to income only insofar as the total annual cost sharing for all targeted low-income children in a family does not exceed 5% of such family's income.

For states choosing to use S-CHIP funds to expand Medicaid eligibility, Medicaid cost sharing rules will apply.

**Will Beneficiaries (or Their Guardians) Be Free To Choose Their Own Providers?** There is no requirement that the S-CHIP programs provide individuals with a choice among health care providers. Accordingly, in some states, individuals may have to obtain non-emergency health care from a specific list of providers.

## Federal Funding under Title XXI

**Will All States Receive Federal Funds under Title XXI?** The S-CHIP is voluntary for states. A state that is interested in expanding health benefits coverage for children may receive federal matching payments up to its allotment under S-CHIP as long as the state submits and receives approval from the Secretary of HHS for its S-CHIP program outline and operates its program in accordance with the rules in Title XXI and the approved program outline. It is possible that some states will choose not to participate.

**When Do Federal Funds Become Available?** Funds will become available beginning in October of 1997. However, a state will not be eligible for federal funds until it receives approval of its plan from the Secretary of HHS.

**How Much Money Is Available?** A total of $4.295 billion was authorized by Congress for the S-CHIP program for FY1998, $4.275 for each of FY1999 through FY2001, $3.15 billion for each of FY2002 through FY2004, $4.05 billion for 2005 and 2006, and $5.0 billion for 2007. The 5-year total, for 1998 through 2002, is equal to $20.27 billion. The program will be subject to reauthorization for funding after 2007.[17]

**How Will Funds Be Divided among the States and Territories?** Generally funds will be divided among the states based on the number of low-income and uninsured children residing in each state.

- Total available funds are first to be reduced by .25% for the territories, then the remaining child health assistance funds will be distributed among the states and the District of Columbia based on the product of the number of low-income uninsured children for the state for the fiscal year and the state cost factor. The number of low-income uninsured children in families, for 1998 through 2000, is defined as the 3-year average of uninsured children in families with income below 200% of poverty. For FY2001, low-income uncovered children are defined as 75% of the 3-year average of the number of uninsured low-income children in the state for the fiscal year plus 25% of the number of low-income children in the state. After 2001, low-income uncovered children would be equal to 50% of the 3-year average of the number of uninsured low-income children in the state for the fiscal year plus 50% of the number of low-income children in the state. The state cost factor for a fiscal year is the sum of .85 multiplied by the ratio of the annual average wages per employee in the health services industry for such year to the national average wages per such employee for such year[18] and .15.

- Allotments for the states and the District of Columbia can be no lower than $2 million. After applying the $2 million floor, all states' allotments will be adjusted in a pro rata manner such that the total of all allotments does not exceed the total of allotment authorized and appropriated for that year.

- Of the .25% of total allotments available for the territories in any fiscal year, Puerto Rico will receive 91.6%, Guam, 3.5%, Virgin Islands, 2.6%, American Samoa, 1.2%, and Northern Mariana Islands, 1.1%.

The following **table** shows the allotments for each state for FY1998, as published by the HCFA in the *Federal Register*. In states implementing broad child health insurance programs, the percentage of low-income uninsured children is likely

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[17] BBA 97 provided $4.275 billion in federal funds for FY1998. P.L. 105-100 provided an additional $20 million for FY1998 federal allocations to the states. These funds were added to correct for a technical glitch which results in a "double counting" of the $60 million in diabetes grant funds that are taken from the children's health funds every year.

[18] The annual average wage per employee for each year would be calculated using the wages of employees in the health services industry as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

to go down over a period of years. Because the allocation formula uses the percentage of low-income uninsured children as an important part of the calculation, the proportion of funds allocated to each state will most likely change each year. In 2002, allotments will drop because of the drop in total funds available for the program in that year.

**Table 5. 1998 Allocations Under State Child Health Insurance Program**

($ in millions)

| States and Territories | 1998 | States and Territories | 1998 |
|---|---|---|---|
| Alabama | $ 86.4 | Montana | 9.8 |
| Alaska | 5.7 | Nebraska | 14.9 |
| Arizona | 113.7 | Nevada | 30.6 |
| Arkansas | 47.1 | New Hampshire | 11.5 |
| California | 858.9 | New Jersey | 88.9 |
| Colorado | 42.0 | New Mexico | 57.9 |
| Connecticut | 35.1 | New York | 256.9 |
| Delaware | 8.1 | North Carolina | 79.9 |
| District of Columbia | 12.1 | North Dakota | 5.1 |
| Florida | 271.6 | Ohio | 116.3 |
| Georgia | 125.3 | Oklahoma | 81.6 |
| Hawaii | 9.0 | Oregon | 39.3 |
| Idaho | 16.0 | Pennsylvania | 118.0 |
| Illinois | 123.1 | Rhode Island | 10.7 |
| Indiana | 70.9 | South Carolina | 63.9 |
| Iowa | 32.6 | South Dakota | 7.6 |
| Kansas | 30.8 | Tennessee | 66.5 |
| Kentucky | 50.2 | Texas | 564.1 |
| Louisiana | 102.2 | Utah | 24.4 |
| Maine | 12.5 | Vermont | 3.6 |
| Maryland | 61.9 | Virginia | 68.7 |
| Massachusetts | 43.1 | Washington | 46.9 |
| Michigan | 92.0 | West Virginia | 23.7 |

| States and Territories | 1998 | States and Territories | 1998 |
|---|---|---|---|
| Minnesota | 28.5 | Wisconsin | 38.7 |
| Mississippi | 56.3 | Wyoming | 7.8 |
| Missouri | 51.9 | Territories | 10.7 |

**Source**: HCFA.

**If a State Is Successful in Covering Uninsured Children Will its Allotment of Funds Be Reduced?** Initially, the formula for distributing funds among states relies on the number of low-income uninsured children in the state as a percentage of low-income uninsured children in the nation. (In the second 3 years of the program, this reliance is reduced since the formula becomes the *average* of low-income children **and** low-income uninsured children.) To the extent that a state's efforts to cover children are more successful than the national average, its number of uninsured children as a percentage of the national total will decline, resulting in a declining portion of the total S-CHIP allotment available to that state.

**Where Will the Funds for S-CHIP Come From?** The BBA 97 included provisions raising excise taxes on tobacco and tobacco products. Conferees agreed that about $8 billion of the allotment for S-CHIP for 1998-2002 is to be generated by the increase in the tobacco taxes although there is no dedication of those taxes to child health. The remaining funds will come from general revenues.

**How Much Is a State Required to Spend?** Like Medicaid the S-CHIP is a federal matching program. For each dollar of state spending, the federal government will make a matching payment. The state's share of program spending would be equal 100% minus the enhanced federal matching percentage (the enhanced FMAP) of spending for the state. The enhanced FMAP is equal to the state's Medicaid federal medical assistance percentage increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the federal medical assistance percentage is less than 100%. For example, state A has a Medicaid federal matching percentage of 50%. This means that under Medicaid the state must spend 50 cents for every 50 cents that the federal government contributes. The enhanced FMAP for the child health initiatives would be equal to the Medicaid federal matching percentage increased by 15 percentage points, (50%+(30% multiplied by 50%) = 65%.) The state share would be equal to 100%-65% = 35%.

Compared with Medicaid FMAPs, which range from 50% to 82%, the enhanced FMAP for the S-CHIP programs will range from 65% to 85%. All child health assistance for targeted low-income children , including child health coverage provided under the Medicaid program, will be subject to the same enhanced federal matching percentage. The enhanced FMAP is subject to a ceiling of 85%. Enhanced FMAPs for 1998 are shown in **Table 6**.

## Table 6. Enhanced Federal Matching Rate Under State Child Health Insurance Program and Medicaid for 1998

| States | Enhanced FMAP | Medicaid FMAP |
|---|---|---|
| Alabama | 79% | 69% |
| Alaska | 72% | 60% |
| Arizona | 76% | 65% |
| Arkansas | 81% | 73% |
| California | 66% | 51% |
| Colorado | 66% | 52% |
| Connecticut | 65% | 50% |
| Delaware | 65% | 50% |
| District of Columbia | 79% | 70% |
| Florida | 69% | 56% |
| Georgia | 73% | 61% |
| Hawaii | 65% | 50% |
| Idaho | 79% | 70% |
| Illinois | 65% | 50% |
| Indiana | 73% | 61% |
| Iowa | 75% | 64% |
| Kansas | 72% | 60% |
| Kentucky | 79% | 70% |
| Louisiana | 79% | 70% |
| Maine | 76% | 66% |
| Maryland | 65% | 50% |
| Massachusetts | 65% | 50% |
| Michigan | 68% | 54% |
| Minnesota | 67% | 52% |
| Mississippi | 84% | 77% |
| Missouri | 72% | 61% |

| States | Enhanced FMAP | Medicaid FMAP |
|---|---|---|
| Montana | 79% | 71% |
| Nebraska | 73% | 61% |
| Nevada | 65% | 50% |
| New Hampshire | 65% | 50% |
| New Jersey | 65% | 50% |
| New Mexico | 81% | 73% |
| New York | 65% | 50% |
| North Carolina | 74% | 63% |
| North Dakota | 79% | 70% |
| Ohio | 71% | 58% |
| Oklahoma | 79% | 71% |
| Oregon | 73% | 61% |
| Pennsylvania | 67% | 53% |
| Rhode Island | 67% | 53% |
| South Carolina | 79% | 70% |
| South Dakota | 77% | 68% |
| Tennessee | 74% | 63% |
| Texas | 74% | 62% |
| Utah | 81% | 73% |
| Vermont | 74% | 62% |
| Virginia | 66% | 51% |
| Washington | 67% | 52% |
| West Virginia | 82% | 74% |
| Wisconsin | 71% | 59% |
| Wyoming | 74% | 63% |

**Source**: HCFA.

**What Qualifies as a State Matching Payment?** The state matching payment may be shared by other levels of government, such as counties, but cannot be comprised of federal funds or program spending that is largely subsidized by federal

funds. Provisions in the Medicaid statute that limit the use of provider donations and provider-specific taxes as a state's share of program spending apply to the S-CHIP program as they apply to the Medicaid program. Generally, such provisions prohibit the use of donations from providers as a state's share of Medicaid spending unless the donations are unrelated to Medicaid payments. Provider-specific taxes are prohibited unless they are broadly applied to all providers in a provider type and are applied uniformly to the providers. Provider-specific taxes may not include provisions assuring that the providers who pay the tax will be repaid for the amount of taxes paid.[19]

Each state child health program outline must specify the sources of the non-federal share of plan spending.

**Is Cost-Sharing by Beneficiaries Considered Part of the State Match?** No. Beneficiary cost sharing revenue is not considered part of the state match for expenditures under S-CHIP. Beneficiary cost sharing revenues must be applied to offset (reduce) federally matchable S-CHIP expenditures. The result of this offset is to reduce both the state and federal shares of allowable S-CHIP expenditures. For example, if the total expenditure for a beneficiary is $1,000 and the state collects $50 in beneficiary cost sharing, the amount the state can claim against its federal allotment is $950. If the enhanced matching rate for that state is 73%, the federal government would provide $694 and the state would provide $256.[20]

**Will States Be Able To Use S-CHIP Funds on Programs That Already Exist?** As long as existing programs are able to meet the standards in Title XXI relating to enrollment, benefits, cost-sharing, and state-matching, then such programs will be able to qualify for federal matching payments under Title XXI. In addition, children covered by programs "offered by a state which receives no federal funds for the program's operation" are eligible for S-CHIP.

Three existing child health insurance programs in New York, Florida, and Pennsylvania, have been grandfathered in as meeting Title XXI benefits standards. The three programs are subject to a maintenance of effort provision that would, in any year, require the Secretary to reduce the states' allotments if spending on children's health insurance in the preceding fiscal year is less than the total of such spending in FY1996.[21]

**Can S-CHIP Funds Be Used To Replace Funds for Current State Health Programs?** The S-CHIP statute attempts to limit states' ability to replace funds being spent on child health insurance efforts with S-CHIP funds by including two separate "maintenance of effort" provisions. A Medicaid "eligibility standards"

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[19] See CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

[20] U.S. Health Care Financing Administration. *Frequently Asked Questions and Answers: State Children's Health Insurance Program*. September 11, 1997. (Available at www.hcfa.gov/init/qa/q&a10-03.htm.)

[21] The legislative language on this point may be subject to more than one interpretation. The Secretary of HHS has indicated that the provision will be interpreted to apply to only the three states.

maintenance of effort provision requires that no payments can be made from S-CHIP funds for assistance provided under a state plan if the state adopts more restrictive income and resource standards and methodologies for determining eligibility under the state's Medicaid program than those in effect as of June 1, 1997.

Beginning in 1999, a second maintenance of effort provision becomes effective but only for New York, Pennsylvania, and Florida. The provision requires that the state's allotment for any year be reduced by the amount by which the total of state spending for child health insurance in the previous fiscal year is less than the total of such spending in 1996.

**Can States Claim an Enhanced Federal Match if They Have Already Expanded Coverage for Children Under Their Medicaid Plans?** The Medicaid statute requires states to cover children under age 6 in families with income under 133% of the federal poverty level and children who were born after September 30, 1983 in families with income under 100% of the federal poverty level. Federal law includes several provisions that allow states to expand Medicaid eligibility for children beyond federally mandated levels, including Section 1115 waivers and Section 1902(r)(2) of the Medicaid statute. In general, states cannot receive an enhanced match under Title XXI for children already covered under a Medicaid state plan expansion. However, if a state expanded Medicaid eligibility for children after March 31, 1997, that state may amend its Medicaid state plan to include the expansion group as an optional group of targeted low-income children and receive an enhanced match for their coverage under S-CHIP.

**What If a State Is Unable to Set up an S-CHIP Program in 1997?** Except for funds that have been redistributed by the Secretary, allotments for each state with an approved child health plan will remain available for that state for a period of 3 years. For example, a state's FY1998 allotment would continue to be available to that state, if unused, through the end of FY2000 as long as the state has a child health plan submitted and approved by the Secretary before the end of FY1998. The Secretary is directed to establish a procedure for distributing any funds that are still unused after the 3-year period of availability has expired. Those funds will expire in the fiscal year for which they are redirected.

**What Must a State Do To Receive its Allotment?** A state participating in Title XXI will be required to submit a plan to the Secretary specifying how the state intends to use the child health assistance funds and the nature of the child health assistance to be provided including cost-sharing requirements, the method of health care delivery (e.g., managed care, fee-for-service, direct provision of services, or vouchers) and utilization control, eligibility standards, outreach activities, and the methods to be used to assure quality and appropriateness of care. The plan will be required to include a description of the current insurance status of children in the state, current state efforts to provide or obtain health insurance for uncovered children, and how the S-CHIP plan will coordinate with such efforts.

The Secretary is required to promptly review state plans and amendments to the plans to determine compliance with the S-CHIP requirements. Unless the state is notified in writing within 90 days of receipt that a plan or amendment is disapproved and the reasons for disapproval or that additional information is needed, the plan or

amendment will be deemed approved. In the case of a disapproval, the Secretary will provide a state with a reasonable opportunity for correction. An approved state plan for child health insurance becomes effective beginning in a specified calendar quarter that is at least 60 days after the plan is submitted. Plan amendments must be approved for the purposes of this title and take effect on the dates specified in the amendment.

**What Happens When a State's Allotment Runs Out?** Once a state's allotment for a year runs out, no additional federal matching funds will be available to that state for S-CHIP programs for that year. If a state has established a new program or is using an existing program, the state will not receive federal matching funds above the allotment amount for program spending for that year. If a state has expanded Medicaid and is using S-CHIP funds for enhanced federal matching under Medicaid, the federal matching rate for any additional spending on children will revert to the traditional Medicaid FMAP.

## S-CHIP and Other Programs or Insurers

**How Will S-CHIP Programs Interact with Other Health Insurance Programs?** No federal payments will be made in cases where a private insurer would have been obligated to pay for the same service except for a provision of the private insurance plan that denies payment on the basis of the child's eligibility under the Child Health Insurance Plan. In order to prevent duplicative federal payments, no federal matching payments will be made under the Child Health Insurance plan if the same services are eligible for reimbursement under any other federally operated or financed health insurance program **except** for a health insurance program operated or financed by the IHS. Furthermore, each state plan is required to include a description of how services are to be provided to targeted low-income children who are Indians.

In general, children eligible for Medicaid, using the income and resources rules in effect in the spring of 1997, will not be eligible for coverage under S-CHIP. States that choose to use S-CHIP funds for enhanced Medicaid matching payments for expanded Medicaid eligibility will not be able to make payments on behalf of children meeting the Medicaid income and resource standards and methodologies used on March 31, 1997. States are required to establish procedures to ensure that children found through screening to be eligible for Medicaid are enrolled in Medicaid.

**Can S-CHIP Funds Be Used on Programs Like Women, Infant, and Children (WIC) or Food Stamps?** It is not clear. S-CHIP requires that 90% of funds allotted to states be spent on health benefits coverage that meets specific standards for benefits and cost sharing. The remaining 10% may be used on such activities as administration of the plans, outreach, and "other child health assistance." "Other child health assistance" is not defined in the statute although S-CHIP does prohibit amounts provided by the federal government, or *services assisted or subsidized to any significant extent by the federal government* from being used as the required nonfederal share of S-CHIP spending.

**What About States Operating Medicaid Under Comprehensive Demonstration Waivers?** Although the law is not clear, it appears that Medicaid programs operating under comprehensive demonstration waivers will be treated, for purposes of the S-CHIP program as Medicaid. In other words, states will not receive S-CHIP funds for children eligible for Medicaid or a Medicaid waiver program as of March 31, 1997.

**How Will S-CHIP Programs Interact with Other Private Health Insurance Such as Employer Sponsored Insurance?** States can deny eligibility to children who have access to other health coverage but are not required to do so. However, states must deny eligibility to children who have coverage under other health insurance. So, for example, some states may cover children who have no *access to* employer sponsored insurance while others may limit coverage to children who are not *covered by* employer sponsored insurance. The statute does not define what *access to* employer-sponsored insurance means. The definition of the term may be left to the state, or the Secretary of HHS may define the term in federal regulations.

States would have the flexibility to use S-CHIP funds to contribute to the cost of employer-sponsored insurance as long as the child's coverage meets the standards for benefits and cost-sharing in the Title XXI. State plans must provide methods for assuring that health care provided under the plan does not substitute for (crowd-out) coverage under group health plans.

**Can States Use S-CHIP Funds To Purchase a Family Plan?** A provision of Title XXI gives the Secretary the authority to approve waivers allowing child health initiative funding for the purchase of family coverage when cost effective. A state may cover families that include targeted low-income children if the state establishes to the satisfaction of the Secretary that the purchase of such coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved and will not substitute for other health insurance coverage.

**Are Other Waiver Authorities Included in Title XXI?** In addition to the family coverage waiver, two other waiver options are included in Title XXI. States may waive the 10% limitation on spending for purposes other than the purchase or provision of health insurance as long as the following qualifications are met: coverage provided to targeted low income children under the waiver meets the benefits and cost sharing standards of Title XXI, the average cost of coverage under the waiver is not greater than the coverage that otherwise would have been provided, and coverage is provided through the use of a community based health care delivery systems such as community health centers or disproportionate share hospitals.[22]

Title XXI allows states to use the waiver authority of Title XI of the Social Security Act, Section 1115 for the purpose of conducting comprehensive demonstrations. In a question and answer document posted on the HCFA's

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[22] Disproportionate share hospitals under Title XIX are those designated by the state to provide a disproportionate share of care to Medicaid and uninsured individuals.

homepage,[23] the agency indicates that Section 1115 waivers will not generally be approved before regular Title XXI programs are operating. HCFA officials state:

> Title XXI was written to provide a broad range of options to allow states maximum flexibility in designing the program that best meets the needs of their children. While the law provides that Section 1115 ... applies to Title XXI, we believe it would be reasonable for states to have experience in operating their new Title XXI programs before designing and submitting demonstration proposals.

## Quality and Accountability

**How Will Quality of Care Be Ensured?** A state child health plan must include strategic objectives, performance goals, and performance measures for providing child health assistance to targeted low-income children. Strategic objectives must be specific and relate to increasing creditable health coverage among targeted low-income children and other low-income children. For each strategic objective, performance goals must be identified along with performance measures that are objective and independently verifiable.

Plans must also include assurances that the state will collect data, maintain records, and furnish reports as required by the Secretary as well as provide the required annual assessments and evaluations. The Secretary shall have access to any records or information for reviews or audits as deemed necessary.

**How Will the Federal Requirements on S-CHIP Be Enforced?** S-CHIP programs will have to be conducted in accordance with the state plan and any approved amendments. The Secretary will establish a process for enforcing requirements under this title. Approved plans will continue in effect unless amended or unless the Secretary finds the plan out of compliance with the federal requirements.

The S-CHIP statute includes provisions authorizing the Secretary to establish a process for enforcing the requirements of Title XXI. The Secretary is directly to include in the process the withholding of funds in cases of substantial noncompliance as long as the state is provided a reasonable opportunity for correction before such financial sanctions are taken.

**Are There Program Integrity or Fraud and Abuse Protections in Title XXI?** Certain administrative, program integrity and fraud and abuse penalties in Title XI of the Social Security Act have been made specifically applicable to the child health programs under Title XXI. They include provisions relating to administrative and judicial review, disclosure of information about ownership and convicted individuals, criminal penalties, and periods within which claims must be filed, conflict of interest standards, limitations on payments, contracts with managed care entities, state licensure, and sanctions for managed care entities.

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[23] U.S. Health Care Financing Administration.
http://www.hcfa.gov/init/children.htm.

**Will There Be Data To Help Members of Congress Assess the Success of the Program in the Coming Years?** Each state child health plan will have to include an assurance that the state will collect data, maintain records, and furnish reports to the Secretary as needed and will have to provide an annual report to the Secretary by January 1 following the end of each fiscal year assessing the operation of the plan and the progress made in reducing the number of uncovered low-income children during the prior fiscal year. States will also be required to provide an evaluation by March 31, 2000, assessing (a) the effectiveness of the state plan in increasing the number of children with health coverage, (b) the effectiveness of specific elements of the plan, such as characteristics of families and children assisted and quality of coverage provided, (c) the effectiveness of other public and private programs in the state in increasing health coverage for children, (d) state activities to coordinate the plan with other public and private programs providing health care coverage, (e) trends in the state affecting the provision of health care to children, (f) plans for improving the availability of health insurance and health care for children, and (g) recommendations for improving the program, among other matters the state and Secretary consider appropriate. The Secretary will be required to submit to Congress a report based on the state evaluations by December 31, 2001. The report must also be made available to the public.