

# **State Plan Amendment**

## **Utah Children's Health Insurance Program**

Submitted February 27, 2002

The following changes are requested to Utah's State Child Health Plan for the earliest effective date possible.

- 1) The word "recertification" will change to "renewal" and "recertify" will change to "renew" wherever they are used in this State Plan.
- 2) Section 2, Add a new section 2.4 that reads: " The Department accepts applications for enrollment at times when sufficient funding is available to justify enrolling more individuals. The Department limits the number it enrolls according to the funds available for the program."
- 3) Section 4.1.3, under "Income," change #10 to read: " The income of a child, earned or unearned, who is under the age of 19 is not counted when determining CHIP eligibility, unless the child is the head of household." Under subheading "Budgeting," change paragraph 3 to read "Farm and self-employment income is determined by using the most recent period of time for which an individual has records. Expenses will be deducted from the gross income to determine the countable income of the individual. An individual may elect to have 40% of the gross self-employment or farm income deducted for business expenses or they may choose to verify actual expenses. If an individual chooses to verify actual expenses, CHIP will allow any expenses that are allowed by the Internal Revenue Service."
- 4) Section 4.1.7, under "Access to or coverage under other health coverage," change 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> paragraphs to read: " To qualify for enrollment in CHIP, a child must not be enrolled under a group health plan or other health insurance coverage, this includes coverage under a group health plan or other health insurance coverage as defined by HIPAA, through which they have not exhausted their maximum lifetime benefits; have access to health insurance coverage available through an employer where the cost to enroll the child in the plan is less than 5% of the household's countable gross annual income, or be eligible to enroll under a state employee's group health insurance plan.

If a child, custodial parent or legal guardian voluntarily terminates health insurance coverage for the child, the child is not eligible for CHIP enrollment for 90 days after such coverage was terminated. The child may be eligible beginning the 91<sup>st</sup> day after the date the prior insurance coverage ended if all other elements of eligibility are met.

Exceptions to 90-day ineligibility period:

1. Voluntary termination of COBRA coverage

2. Voluntary termination of coverage by a non-custodial parent
3. Involuntary termination from a group health plan

If a non-custodial parent who lives in another state has enrolled a child in his or her insurance plan, but the plan does not provide coverage or provides only limited coverage in Utah, the child may be enrolled in CHIP.

If an absent parent is court-ordered to provide health insurance for a child and the child has reasonable access to a health insurance plan, the child is not eligible for CHIP enrollment."

5) Section 4.1.9, under "Other standards (identify and describe): Household Composition:" change Paragraph 1, a-d to read, "

- a. A child, under the age of 19 who does not have access and is not covered by a group health plan, other health insurance, or Medicaid, and will be included in the CHIP coverage.
- b. The child's spouse
- c. The child's siblings, half-siblings, adopted siblings and stepsiblings if they are also under the age of 19.
- d. The parents and stepparents of any child who is counted in the household size.
- e. The children of any child counted in the household size.
- f. The unborn children of any person counted in the household size.
- g. The father of any unborn child who is not married to the pregnant woman and has acknowledged paternity."

Change paragraph #4 in this section to read, "If an individual is caring for a child of his or her former spouse and a divorce has been finalized, the household can choose whether or not to count that child in the household size."

6) Section 4.3, under "Describe the methods of establishing eligibility an continuing enrollment," subheading "Enrollment Procedures", change 1<sup>st</sup> paragraph to read:

" To apply for CHIP benefits, individuals may file an application through the postal mail, or online at a central location, if available. Applicants may apply with a CHIP application, a Medicaid application or a DWS form 61A. The date of the application shall be the day the signed application form is postmarked or received online.

When an emergency or some other circumstance beyond the control of the applicant prevents them from filing a CHIP application, a grace enrollment period beginning no earlier than four days prior to the date an applicant submits a completed and signed application may be allowed. To receive the coverage, the applicant must inform the eligibility staff that medical services were received during those four days and request the coverage."

Under "Re-certification/Termination of Coverage" subheading change subheading to read:

"Eligibility Renewal/Termination of Coverage" and change the first two paragraphs to read: " A renewal is a re-evaluation of the CHIP eligibility factors to determine if a child is still eligible. A renewal must be completed every 12 months. Renewal forms are computer-mailed and are due within 10 days following the mail date. If the child continues to be eligible, coverage will continue for an additional 12 months. Enrollees are sent a pre-printed enrollment form where changes and updates can be made."

Under "CHIP coverage will terminate for the following reasons:" change language in "e" to read: "the child has coverage or access to coverage under a group health plan or other health insurance coverage except as provided in Section 4.1.7."

- 7) Section 6.2.1, under subheading "Level of Coverage, for enrollees at 100% through 150%" delete "No co-payment or co-insurance due for inpatient and outpatient hospital services" and insert "\$5.00 co-payment for inpatient hospital services." For enrollees 151% through 200% delete "Inpatient and outpatient hospital service require co-insurance of 10% of the allowed amount. The allowed amount is the billed charge less 25%." and insert "Inpatient hospital services require co-insurance of 10% of the allowed amount."
- 8) Section 6.2.2, under subheading "Level of Coverage, for enrollees at 100% through 150%" delete "\$5 co-payment for each emergency room visit for emergent reasons." and insert "\$5.00 co-payment due for outpatient hospital services and emergency room visits." For enrollees 151% through 200% delete "\$30.00 co-payment for each emergency room visit." and insert "\$35.00 co-payment for each emergency room visit."
- 9) Section 6.2.3, under subheading "Level of Coverage, for enrollees at 100% through 150%" delete "\$5.00 co-payment per medical visit." and insert "\$5.00 co-payment per medical visit, including hospital inpatient and outpatient physician visits." For enrollees 151% through 200% delete "\$10.00 co-payment per medical visit." and insert "\$15.00 co-payment per medical visit, including hospital inpatient and outpatient physician visits."
- 10) Section 6.2.6, under subheading "Level of Coverage, for enrollees at 100% through 150%" delete "\$2 co-pay for brand name drugs not on approved list." and insert "\$5.00 co-payment for brand name drugs not on the approved list." For enrollees 151% through 200% delete "\$4 co-pay for generics and brand name drugs on the approved list." and insert "\$5.00 co-payment for generics and brand name drugs on the approved list."
- 11) Section 6.2.8, under subheading "Level of Coverage Laboratory, for enrollees at 100% through 150%" delete "No co-payment or co-insurance is required for laboratory services." and insert "\$2.00 co-payment for laboratory services under \$50.00. \$3.00 co-payment for laboratory services over \$50.00." For enrollees

151% through 200% delete "No co-pay or co-insurance for laboratory services under \$50." and insert "\$5.00 co-payment for laboratory services under \$50.00." Under subheading "Level of Coverage, X-Ray, for enrollees at 100% through 150%" delete "No co-payment or co-insurance is required for x-ray services." and insert "\$2.00 co-payment for x-ray services under \$100.00. \$5.00 co-payment for x-ray services over \$100.00." For enrollees 151% through 200% delete "No co-pay or co-insurance for X-ray services under \$100." and insert "\$5.00 co-payment for x-ray services under \$100.00."

- 12) Section 6.2.17, under subheading "Scope of Coverage" delete covered dental codes "00110-00130, 00274, 01120 (cleaning), 01201 & 01203 (fluoride), 01351 (sealants), 01510-01550, and 02110-02161 (fillings)." and insert "0120-limit two exams every 12 months, 0140 (exams); 0220, 0230, 0270, 0272, 0274 (x-rays); 1110, 1120 (cleanings); 7110, 7120, 7110-D, 7120-D (extractions); 3220, 3230, 3240 (pulpotomy); 9110 (palliative/emergency). Under subheading, "Level of coverage for enrollees at 100% through 150%" delete "no co-insurance" and insert "Plan pays 100% for cleanings, exams, and x-rays. \$3.00 co-payment for emergency services including extractions and pulpomies." For enrollees 151% through 200% delete "100% coverage for cleaning, oral exam and fluoride. 20% co-insurance for dental fillings." and insert "Plan pays 100% for cleanings, exams, and x-rays. 20% co-payment for emergency services including extractions and pulpomies."
- 13) Section 6.2.22 add "chiropractic services". Under subheading "Level of Coverage," delete "No co-insurance or co-payments." Insert "For enrollees at 100% through 150% of the federal poverty level: \$5.00 co-payment per visit." "For enrollees at 151% through 200% of the federal poverty level: \$15.00 co-payment per visit."
- 14) Section 6.2.24 under subheading "Vision Care, Levels of Coverage," delete "1 exam every 24 months" and insert "1 exam every 12 months." Under subheading "Hearing Services, Levels of Service," delete "1 examination every 24 months" and insert "1 exam every 12 months"
- 15) Section 8.2.1 delete "There will be no premiums required for participation in CHIP." and insert, "No premium will be collected for CHIP enrollees at or below 100% of the federal poverty level, 101% through 150% of the federal poverty level will be charged a monthly premium of \$5.00 per child, 151% through 200% of the federal poverty level will be charged a monthly premium of \$10.00 per child."
- 16) Section 8.2.3 delete section and add the following: "The following are the co-payment and co-insurance requirements for participation in CHIP. Levels of co-payments will be limited to the income groups identified in the federal enabling legislation 2103(e)(3)(A) & (B). Notwithstanding any inconsistent references within this State Plan, the Plan is hereby modified to conform to this federal language.

Co-payment requirements for CHIP clients/enrollees at 100% through 150% of the federal poverty level.

Hospital Services (inpatient, outpatient, and emergency department):

- \$5 co-payment for inpatient, outpatient and emergency department visits.
- \$10 co-payment for each emergency room visit for non-emergent reasons.

Outpatient Office Visits:

- \$5 co-payment per visit. This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.
- No co-payment for well-baby care, well-child care and immunizations.

Prescription Drugs:

- \$2 co-payment for generics and brand name drugs on the approved list.
- \$5 co-payment for generics and brand name drugs not on the approved list.

Note: A prior authorization will be required to use brand name drugs not on the approved list.

Laboratory:

- \$2 co-payment for laboratory services under \$50.
- \$3 co-payment for laboratory services over \$50.

X-ray:

- \$2 co-payment for x-ray services under \$100.
- \$5 co-payment for x-ray services over \$100.

Vision Screening Services:

- 100% coverage of allowed amount up to \$30, limit of one exam every 12 months.

Hearing Screening Services:

- 100% coverage of allowed amount up to \$30, limit of one exam every 12 months.

Dental Services:

- Plan pays 100% for cleanings, exams, and x-rays.
- \$3.00 co-payment for emergency services including extractions and pulpotomies.

Mental Health Services, In-Patient Care:

- \$5 co-payment for each visit
- 30 days per plan year, per child limit

Mental Health Services, Out-Patient Care:

- \$5 co-payment for each visit
- 30 visits per child, per plan year limit

Out-of-Pocket Maximum:

- The out of pocket expense is 5% of a family's annual gross income. The state database will track the out of pocket expense.

Co-Insurance and Co-payment requirements for CHIP clients/enrollees at 151% through 200% of the federal poverty level:

Hospital Services (inpatient, outpatient, and emergency department):

- Co-insurance, 10% of allowed amount.
- \$35 co-payment for each emergency department visit.

Inpatient/Outpatient office visits:

- \$15 co-payment per visit. This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry visits.
- No co-payment for well-baby care, well-child care and immunization.

Prescription Drugs:

- \$5 co-payment for generics and brand name drugs on the approved list.
- 50% co-insurance for prescriptions not on the approved list.

Laboratory:

- \$5 co-payment for laboratory services under \$50.
- 10% co-insurance for laboratory services over \$50.

X-rays:

- \$5 co-payment for x-ray services under \$100.
- 10% co-insurance for x-ray services over \$100.

Vision Screening Services:

- 100% coverage for allowed amount up to \$30, limit to one exam every 12 months.

Hearing Screening Services:

- 100% coverage for allowed amount up to \$30, limit to one exam every 12 months.

Dental Services:

- Play pays 100% for cleanings, exams, and x-rays.
- 20% co-insurance for emergency services including extractions and pulpotomies.

Durable Medical Equipment and Supplies:

- 20% co-insurance of allowed amount.

Mental Health Services, In-Patient Care:

- Co-insurance, 10% of allowed amount for first 10 days; 50% of allowed amount for next 20 days.
- Residential treatment in lieu of inpatient care may be substituted at same co-insurance.
- 30 days per child, per plan year limit.

Mental Health Services, Out-Patient Care:

- Co-insurance, 50% of allowed amount.
- 30 visits per child, per plan year limit.

Out-of-Pocket Maximum:

- The out of pocket expense is 5% of a family's annual gross income. The state database will track the out of pocket expense.

Co-Insurance and Co-payment requirements for CHIP clients/enrollees who are Native American.

- No co-payments or premiums are charged for the CHIP Native American policy.”