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Subpart H—Substitution of Coverage

SOURCE: 66 FR 2684, Jan. 11, 2001, unless otherwise noted.

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) *Scope.* This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

(a) *State plan requirements.* The state plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

(b) *Limitations.* (1) A state may not, under this section, impose a period of uninsurance which exceeds 90 days from the date a child otherwise eligible for CHIP is disenrolled from coverage under a group health plan.

(2) A waiting period may not be applied to a child following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program.

(3) If a state elects to impose a period of uninsurance following the loss of coverage under a group health plan under this section, such period may not be imposed in the case of any child if:

(i) The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;

(ii) The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v).

(iii) The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

(iv) The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;

(v) A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);

(vi) The child has special health care needs; and

(vii) The child lost coverage due to the death or divorce of a parent.

[78 FR 42313, July 15, 2013]

§ 457.810 Premium assistance programs: Required protections against substitution.

A State that operates a premium assistance program, as defined at § 457.10, must provide the protections against substitution of CHIP coverage for coverage under group health plans specified in this section. The State must describe these protections in the State plan; and report on results of monitoring of substitution in its annual reports.

(a) *Period without coverage under a group health plan.* For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) Any waiting period imposed under the state child health plan prior to the provision of child health assistance to a targeted low-income child under the state plan shall apply to the same extent to the provision of a premium assistance subsidy for the child and shall not exceed 90 days.

(2) States must permit the same exemptions to the required waiting period for premium assistance as specified under the state plan at § 457.805(a)(2), and § 457.805(a)(3) for the provision of child health assistance to a targeted low-income child.

(b) *Employer contribution*. For health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

(c) *Cost effectiveness*. In establishing cost effectiveness—

(1) The State's cost for coverage for children under premium assistance programs must not be greater than the cost of other CHIP coverage for these children; and

(2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other CHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

(d) *State evaluation*. The State must evaluate and report in the annual report (in accordance with § 457.750(b)(2)) the amount of substitution that occurs as a result of premium assistance programs and the effect of those programs on access to coverage.

[66 FR 2684, Jan. 11, 2001, as amended at 78 FR 42313, July 15, 2013]

Subpart I—Program Integrity

SOURCE: 66 FR 2685, Jan. 11, 2001, unless otherwise noted.

§ 457.900 Basis, scope and applicability.

(a) *Statutory basis*. This subpart implements—

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions, including the following, apply to States under title XXI in the same manner as they apply to a State under title XIX:

(i) Section 1902(a)(4)(C) of the Act, relating to conflict of interest standards.

(ii) Paragraphs (2), (16), and (17), of section 1903(i) of the Act, relating to limitations on payment.

(iii) Section 1903(w) of the Act, relating to limitations on provider taxes and donations.

(iv) Section 1124 of the Act, relating to disclosure of ownership and related information.

(v) Section 1126 of the Act, relating to disclosure of information about certain convicted individuals.

(vi) Section 1128 of the Act, relating to exclusions.

(vii) Section 1128A of the Act, relating to civil monetary penalties.

(viii) Section 1128B(d) of the Act, relating to criminal penalties for certain additional charges.

(ix) Section 1132 of the Act, relating to periods within which claims must be filed.

(x) Sections 1902(a)(77) and 1902(kk) of the Act relating to provider and supplier screening, oversight, and reporting requirements.

(b) *Scope*. This subpart sets forth requirements, options, and standards for program integrity assurances that must be included in the approved State plan.

(c) *Applicability*. This subpart applies to separate child health programs. Medicaid expansion programs are subject to the program integrity rules and requirements specified under title XIX.

[66 FR 2685, Jan. 11, 2001, as amended at 76 FR 5970, Feb. 2, 2011]

§ 457.902 Definitions

As used in this subpart—

Actuarially sound principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

Fee-for-service entity means any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services.