

July 25, 2001

Tommy Thompson
Secretary
c/o Center for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

**RE: HCFA-2006-IFC
Revisions to the Regulations Implementing SCHIP**

To Whom It May Concern:

The National Health Law Program (NHeLP) is a non-profit, civil rights organization that advocates for justice in health care for low-income people including children, immigrants, and people of color. We submit these comments in response to the Notice "State Child Health; Revisions to the Regulations Implementing the State Children's Health Insurance Program," published in the Federal Register on June 25, 2001.

As a health care advocacy organization, and one involved with the design and early implementation of SCHIP, we hope you will afford our recommendations the same attention as CMS has given states and other organizations with a stake in SCHIP. We know you share our commitment to providing health coverage to children and we look forward to working with you on these issues throughout your tenure.

We are pleased that CMS contemplates no further delays in implementing the regulations. Although we believe the interim final regulations propose some improvements, such as strengthening the presumptive eligibility option in SCHIP, we are concerned that many of the changes proposed in the interim final regulation could weaken important child health protections. We have signed on to the comments submitted by Families USA but believe our technical expertise should prove helpful to CMS on three particular issues which we have outlined below:

- **Social Security Numbers:** The interim final rule allows states to require children applying

for separate state child health insurance programs to provide their social security number as a condition of eligibility. This proposed change is inconsistent with the Privacy Act, which, contrary to the conclusion announced by CMS, was not amended by § 205 of the Social Security Act to allow states to require that those numbers be provided.

- **Primary Language Reporting:** The interim final rule eliminates the requirement that states collect the primary language of families using SCHIP, creating a potentially major barrier to assuring that the program reaches eligible children in families in which English is not the primary language.

- **Review Processes:** The interim final rule allows states to utilize state-specific grievance and appeal requirements enacted to regulate the resolution of disputes in the commercial insurance arena. If these general statutes do not meet the procedural requirements for the termination or reduction of eligibility or services in need-based assistance programs, then they will not adhere to constitutional requirements for due process.

Our specific comments on these issues are attached. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

Mara Youdelman
Staff Attorney
National Health Law Program

***Comments on the June 25, 2001 Revisions to the Regulations
Implementing the State Children's Health Insurance Program***

A. Allowing States to Require Social Security Numbers of Applicants, § 457.340(b)

The interim final SCHIP rule published on June 25, 2001, reiterates provisions from the final rule (published January 11, 2001) that states cannot require SSNs from non-applicants, such as parents or other family members who are not applying for health insurance benefits. The interim

rules also reference Medicaid rules regarding protections regarding the use of SSNs. We support both of these provisions.

The interim final rule also provides a new interpretation of the Privacy Act, concluding that states may require SSNs of applicants to separate state child health programs. In issuing this proposed change to the regulations, CMS specifically solicited comments on the impact that this provision may have on immigrant populations. Much evidence attests to the fact that requiring SSNs negatively impacts the enrollment of eligible immigrants, causing many eligible people to forego benefits. This phenomenon is well documented in other comments submitted in response to the proposed changes to the regulations.

The interim final rule attempts to alleviate this problem by applying to SCHIP a requirement from the Medicaid regulations that a state must not deny or delay services pending issuance or verification of an individual's SSN (42 C.F.R. § 435.910(f)). Yet we have heard from countless state advocates of ongoing failures to implement this provision. Neither applicants nor state eligibility workers appear to know about it. Applicants without SSNs do not complete applications because they do not know they can receive benefits pending receipt of an SSN and state eligibility workers refuse to process applications if an SSN is not provided. Further, incorrect implementation of the Social Security Administration's Enumeration at Birth (EAB) process -- by which newborns can be issued SSNs at the hospital at time of birth -- has exacerbated problems for immigrant parents seeking SSNs for their children. Some hospitals have refused to issue an SSN to a newborn without the SSNs of one or both parents, despite clear guidance from SSA that a parent's SSN is not required. And if EAB does not occur, a parent has to apply for an SSN for the child at an SSA office, where the parent must provide evidence of the child's identity, parent's identity and relationship of parent and child. Counter to SSA policy, some SSA offices have refused to process the child's SSN application if the parent does not provide an SSN or translated versions of foreign-language identity documents. Thus, the policy to provide SCHIP benefits pending issuance or verification of an SSN does not adequately address the problems that arise by allowing states to require SSNs of all applicants.

Our concern, however, is somewhat broader. The preamble to the proposed regulations states that the change in policy regarding the ability to require SSNs from applicants for SCHIP is based on a closer reading of legislative history generated when the term "general public assistance" was added to 42 U.S.C. § 405(c)(2)(C)(i), Social Security Act (SSA) § 205(c)(2)(C)(i). CMS concluded from this history, which it did not identify, that "general public assistance" includes federal-state programs like SCHIP, and that it therefore acts as an exception to the Privacy Act provision that otherwise prohibits the provision of one's SSN as an eligibility requirement for such programs. While we were unable to locate any legislative history that shed light on the intended meaning of "general public assistance", [\(1\)](#) we believe that CMS has overlooked language in § 205 itself that demonstrates unequivocally that the term does not

include programs like SCHIP, which are funded jointly by the federal and state governments. Consequently, while states may request that an applicant voluntarily provide an SSN, if she has one, they cannot deny eligibility if an SSN is not provided. And any request for an SSN must clearly identify the reason for the request and the voluntary nature of any compliance.

According to the Privacy Act:

(a)(1) It shall be unlawful for any Federal, State or local government agency to deny to any individual any right, benefit, or privilege provided by law because of such individual's refusal to disclose his social security account number.

(2) [The] provisions of paragraph (1) of this subsection shall not apply with respect to-(A) any disclosure which is required by Federal statute. . .

Pub.L. 93-579 § 7, 88 Stat. 1896. Thus, for a state to make the provision of an SSN an eligibility requirement, a federal statute must *require*, not merely *permit*, that result. Title XXI of the Social Security Act, which authorizes the SCHIP program, does not do so.

CMS does not argue that Title XXI contains the mandate required by the Privacy Act. Instead, the interim final rule relies upon another provision of federal law, enacted in 1976, which allows a state to require SSNs for the administration of certain "law[s] within its jurisdiction." SSA § 205(c)(2)(C)(i). [\(2\)](#) The laws covered by this section are limited to "any tax, *general public assistanc* e, driver's license, or motor vehicle registration law". The interim final rule concludes that SCHIP, a federal-state cost sharing program, is a program of general public assistance and that § 205 therefore demonstrates Congress' intent to override the Privacy Act and allow SSNs to be used as an eligibility requirement in programs such as SCHIP.

While such an interpretation would perhaps be reasonable in a vacuum, the statutory text of § 205 itself conclusively demonstrates that the "general public assistance" exemption does not cover SCHIP or any other program that is funded in whole or in part with federal dollars.

That the phrase "general public assistance" does not include programs like SCHIP is demonstrated by reference to three subsections of §205. The first of these is §205(c)(2)(B)(i)(II), which instructs the Commissioner of Social Security to issue an SSN "to any individual who is an applicant for or recipient of benefits *under any program financed in whole or in part from Federal funds*. . . " The SCHIP program, funded in part by federal funds, is certainly encompassed by this term. The very next subparagraph, § 205(c)(2)(C)(i), is the one that CMS is now attempting to interpret. Congress there provided States with the ability to use SSNs "in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction. . ." This section was enacted two years after § 205(c)(2)(B)(i)(II) and uses a term that is different from that utilized one paragraph earlier when Congress wanted to refer to programs like SCHIP that are funded with federal dollars. Basic rules of statutory construction dictate that the use of different terms, especially in the same section of a statute, be construed to indicate different meanings. Consequently, the two terms "any program funded in whole or in part from Federal funds" and "general public assistance" cannot be deemed equivalent.

It is nonetheless possible that the term "general public assistance" was meant to be the broader term -- one that encompassed both programs financed in whole or part by Federal funds and the wholly state or locally funded programs that traditionally have been recognized as general public assistance. But this possibility is belied by the history and language of another subsection of § 205. Subsection 205(c)(2)(C)(vi) was enacted in 1976 contemporaneously with subsection (C)(i). In it, Congress authorized state agencies to require disclosure of an individual's SSN in the administration of any general public assistance, driver's license or motor vehicle registration law referred to in (c)(2)(C)(i), but also "for the purpose of responding to requests for information from an agency operating pursuant to part A of title IV". Part A of Title IV was at the time AFDC, a program funded in whole or in part by federal funds. This section illustrates that Congress never intended the term "general public assistance" to encompass programs funded in whole or in part with federal dollars, for if it did, then the provision just quoted in § 205(c)(2)(C)(vi) would be redundant. Again, basic rules of statutory construction prohibit the assumption of redundancy in a statute.

In fact, Congress specifically amended § 205(c)(2)(C)(vi) in 1996 to acknowledge the change in administrative structure created when it replaced AFDC with TANF. The original language enacted in 1976 was changed from "an agency operating pursuant to part A of title IV" to "an agency administering a program *funded under part A of Title IV*. . ." This amendment demonstrates that Congress continues to recognize that the "general public assistance" language in § 205 does not encompass programs such as TANF, and SCHIP, that are funded in whole or in part with federal funds. As such, that language cannot act as an exception to the specific prohibition found in the Privacy Act against requiring SSNs from applicants or recipients of such federally funded programs.

Other provisions of both federal and state law recognize the distinction between "general public assistance" and "programs funded in whole or in part with federal funds" and therefore reinforce the conclusion that the former term does not include the latter. These provisions include:

- 7 C.F.R. § 674.34 (Department of Education regulations for Perkins loan recipients) - recipients do not have to repay loans if ". . . receiving payment under a federal or state public assistance program, such as Aid to Families with Dependent Children, Supplemental Security Income, Food Stamps, or state general public assistance".
- D.C. Code § 3-205.49 - distinguishing SSI from general public assistance.
- Rhode Island, RI St. § 40-6-3.1 - distinguishing general public assistance from SSI and Medicaid; RI St. § 39-2-5 - distinguishing general public assistance from SSI, AFDC, Food Stamps, and the Rhode Island medical assistance program.
- Pennsylvania, 51 Pa.C.S.A. § 7902 - Agent Orange judgments shall not be income or compensation for "determining the eligibility for State or local government benefit programs, including, but not limited to, general public assistance and vocational rehabilitation".

Consequently, we believe that when CMS reviews the provisions discussed here it will realize that the "general public assistance" language contained in § 205(c)(2)(C)(i) does not create an exception to the Privacy Act that covers SCHIP, and that requiring the provision of SSNs for purposes of qualifying for SCHIP is therefore prohibited.

While the statutory text of the Privacy Act and § 205 prohibit requiring SSNs from applicants, CMS can still achieve the goal of aiding in administration of the program. States retain at least three alternatives regarding SSNs, which are not mutually exclusive: (1) requesting SSNs on a voluntary basis, as the Privacy Act contemplates; [\(3\)](#) (2) seeking to collect SSNs - separately - for children who appear to be eligible under Medicaid, but not the separate state program; or (3) serving children who do not provide SSNs under the separate state program (provided they are otherwise eligible), since a child-applicant who fails to provide an SSN could be considered automatically ineligible for Medicaid, satisfying any concerns about screen and enroll requirements. This final option is comparable to the practice in some states where, for example, a child whose income falls below the Medicaid standard but who has high assets would be eligible for a separate state program, if that program has no assets test.

To summarize, states may not require SSNs from applicants for SCHIP, but they may request them as long as they also make known the fact the providing one's SSN is totally voluntary and will not affect one's eligibility for the benefit.

RECOMMENDATION:

Delete § 457.340(b) and relevant language in the preamble at 66 Fed. Reg. at 33811, col. 2 and 3. Add to Preamble the text from the discussion of the final rule, 66 Fed. Reg. at 2541, col. 3, last two paragraphs (January 11, 2001).

B. Reporting of Primary Language of Enrollees, § 457.750

The collection of reliable data is essential to identifying the need for specific research, education and prevention projects in the SCHIP program. We applaud the retention of requirements that states report quarterly data on the race, ethnicity and gender of SCHIP enrollees, but are dismayed that the interim final rule deletes the final rule's requirement that states report, on an annual basis, the primary language of enrollees.

According to the National Conference of State Legislatures, twenty percent of the nation's children under the age of 18 are immigrants or members of immigrant families. See Anne Morse, SCHIP and Access for Children in Immigrant Families, NCSL, 2000. Immigrant children are three times more likely to be uninsured and four to five times as likely to lack a regular source of medical care as are children in U.S.-born families. Despite being eligible for SCHIP, many of these individuals have limited English proficiency and are either not enrolled or not using services because of language barriers. Recently, researchers at the University of Pittsburgh compared the populations of children who are enrolled in Medicaid with those who are eligible but not enrolled and found the most significant difference was language-related. See University of Pittsburgh (2000). If the President's stated concern for the immigrant community is to be converted into a meaningful commitment, the number of LEP individuals being served, and the nature of the SCHIP services they utilize, must be captured.

As Secretary Thompson recognized during his confirmation hearing, we must strive to bring greater focus and resources to reduce the health disparities that persist in this country for minority and other under-served communities. In his testimony to the Senate Finance Committee, he stated "[a]ll too often, these disparities can be dramatically reduced through targeted research, education, and prevention efforts." Yet without a coordinated effort to collect primary language data on SCHIP enrollees, we will not have a great deal of the information essential to mounting these efforts.

The most recent Census data publicly available identifies over 32 million individuals who speak a language other than English at home. It is expected by all that this number will increase once the 2000 Census data is tabulated. LEP individuals may have difficulty not only enrolling in SCHIP, but also in accessing care. According to the University of California, Institute for Health Policy Studies, 25% of all Spanish-speaking Latinos had difficulty understanding the Medi-Cal (CA's Medicaid program) and Healthy Families (CA's SCHIP program) applications. And once children are enrolled, obtaining services often continues to be a problem. Language barriers are a primary reason why non-English speaking populations disproportionately underutilize cost-effective preventive care.

We recognize CMS' concern that states may find it more useful to record the primary language of the head of the household rather than the child enrollee. See Interim Final Regs, 66 Fed. Reg. at 33816. This may be appropriate where a non-English speaking parent/guardian will be responsible for scheduling appointments, implementing treatment plans, and/or conducting follow-up. If the parent/guardian's primary language is not English, the state should have this information to ensure language access for the parent/guardian as well as the child. This was recognized in the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, issued by HHS' Office of Minority Health. See 65 Fed. Reg. 80877, Standard No. 10 (Dec. 22, 2000). The CLAS standards state:

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g. when the patient/consumer is a minor or severely disabled), the management information system record and the chart should document the language not only of the patient/consumer but also for the accompanying adult(s).

CMS' recognition that it may be more useful at times to collect the primary language of the head of the household rather than the child cannot logically support its decision to require the states to collect such data from neither the child nor the adults. For example, the Agency for Healthcare Research and Quality (AHRQ) concluded that the disadvantage that some Hispanic children experience in their access to health care may be related to their parents' inability to speak English well enough to interact fully with the health care system. They found that Black and Hispanic children are at a substantial disadvantage compared with White children, even when accounting for health insurance and socioeconomic status. When their parents' ability to speak English is comparable, the differences between Hispanic and White children become negligible. These results suggest that the Hispanic disadvantage in children's access to care is related to language ability and characteristics associated with having parents with limited English skills, including differing knowledge about the health care system. Weinick and Krauss, AHRQ (2000).

CMS has already recognized the importance of providing linguistically appropriate information through the requirement of 42 C.F.R. § 457.110. ⁽⁴⁾ The omission of a requirement for states to report enrollees' primary language will not only hinder states in ensuring linguistically accessible services but also impede CMS' ability to monitor compliance with the regulation. Indeed, it is difficult to discern how CMS could have any idea of whether materials are being provided in appropriate languages if the languages that applicants and recipients speak are not being reported. Rather than deleting the reporting requirement, CMS should adhere to the CLAS guidelines issued by its own department and require states to collect and report the primary language of both the head of household (as appropriate) and child. At a minimum, states should be required to collect primary language data about either the head of household or the enrollee. This solution would recognize both the need for state flexibility and the value of collection.

The interim final rule recognizes the value of collection of primary language data, identifying a number of potential uses: targeting outreach, retention, enrollment, and service efforts to under-represented groups; achieving the goals of Healthy People 2010 and recently enacted legislation requiring the Secretary of Commerce to produce statistically reliable annual state data on the number of uninsured low-income children; and assessing compliance with civil rights requirements. See 66 Fed. Reg. at 33816. While any one of these reasons is sufficient in and of itself, the collected data will be invaluable in helping HHS meet its goal of eradicating disparities in health care by the year 2010. Absent a commitment to require the consistent reporting and collection of data, HHS and CMS will lack the tools to measure their own progress and, ultimately, to ascertain whether they have met their stated goals.

We recognize that there may be resistance in some quarters to requiring states and/or federally-assisted health providers to report and collect primary language data. However, the vast majority of states, in recognition of the importance of ensuring culturally and linguistically appropriate services and eliminating health disparities, already collect, or require the collection of, primary language data in their Medicaid managed care or SCHIP programs. Currently, forty states acquire such data, and 13 of them collect it on their SCHIP applications. ⁽⁵⁾ Thus, it is difficult to discern the impetus for CMS' proposed change in policy. It certainly sends the wrong message with regard to the importance of culturally and linguistically appropriate services. Moreover, it permits the small percentage of states that are not collecting this data to drag down the efforts of the vast majority that are, for the resulting information will be incomplete and therefore more likely to be statistically unreliable. Given the large number of states already doing the right thing, and the amount of data that CMS requires health providers to collect and report (and that health providers collect for their own marketing and management purposes), we do not believe that the reporting of data regarding primary language would impose significant, additional costs or administrative burdens on those few states not already doing so.

We urge you to take this opportunity to reaffirm the commitment CMS and HHS to reducing

health disparities by reconsidering the deletion of the primary language reporting requirement in the SCHIP rule. The information acquired will have a profound positive impact on our ability to ensure that all income-eligible children, regardless of language spoken, are linked to health insurance, and that ethnic disparities in health care access and outcomes are being addressed not only in word but in deed.

RECOMMENDATION: Amend § 457.750 to add (7)

(7) Collect and provide data regarding the primary language of SCHIP enrollees and heads of households.

C. Grievance and Appeal Procedures, Subpart K, §§ 457.1120-1190

In the revised regulations, CMS has reduced the enrollee protections provided by the January 11th final rule's grievance and appeal procedures. We note that, in every instance where comments were considered, an alternation was made at the expense of enrollee protection. We are concerned that this creates an imbalance when it comes to ensuring timely services for individuals who are enrolled in SCHIP programs. By contrast, the previous regulations issued by the agency allowed states flexibility to establish grievance and appeal procedures and, at the same time, ensured minimum protections upon which all SCHIP enrollees could rely. We urge you to return to the previous minimums. Our comments, below, focus on two issues, first, clarity of the June 25th regulations, and, second, serious constitutional questions raised by these new rules.

The preamble to the June 25th rules says "States that elect to use State-specific grievance and appeal requirements still must provide an opportunity for review of all matters listed in section 437.1130." 66 Fed. Reg. at 33818. Yet the regulation itself fails to specify that a state-specific process must provide enrollees an opportunity for review of all matters - eligibility and enrollment as well as health services. Since existing state processes generally are designed to respond only to reviews of health services matters, this statement should be included in the regulations themselves because it is an essential consumer protection and an important notice to the states that their grievance and appeal procedures must address enrollment and eligibility

matters, as well as health services matters.

This needed change does not, however, address more serious concerns we have with the rules. We are concerned that the revised regulations introduce constitutionality questions that were not raised by the final rules, and for this reason, urge CMS to return to the final rule's standards. In particular, the interim final rule raises serious constitutional issues for SCHIP recipients whose services are reduced or terminated. This is because these rules allow states to apply their general health insurance issuer grievance and appeal provisions to SCHIP programs. If these general statutes, which were designed to operate in the market place of commercial insurance, do not meet the requirements for the termination or reduction of eligibility or services in a need-based program such as SCHIP, then they will not adhere to constitutional requirements for due process.

The due process clause to the U.S. Constitution guarantees that a state or its agents cannot take actions to deprive an individual of a property interest without affording him or her an opportunity to be heard about that denial. Receipt of a federal benefit has been recognized as a property interest. The standards that guide constitutional due process for public benefit recipients were first set forth by the U.S. Supreme Court over 30 years ago in *Goldberg v. Kelly*, 397 U.S. 254 (1970). The Goldberg Court noted individuals' "brutal need" for public assistance benefits, writing that "termination of aid pending resolution of a controversy ... may deprive an eligible recipient of the very means by which to live while he waits. Since he lacks independent resources, his situation becomes immediately desperate." *Id.* at 264. In *Goldberg*, the Court laid out the constitutional requirements that states must meet in order to assure due process. Before a state takes an action that would deny, reduce, or terminate benefits, it must provide:

- prior written notice, "tailored to the capacities and circumstances" of the beneficiary, explaining a decision to deny or terminate benefits;
- continued benefits pending a final decision on termination; a fair hearing "at a meaningful time and in a meaningful manner" before an impartial decision maker; and
- a timely decision. *Id.* at 245, 267-71.

Since *Goldberg*, the Court has held that due process applies in those situations where there is a "legitimate claim of entitlement." E.g., *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972). In making this determination, courts have focused on the degree of discretion afforded the agency granting the benefits. While Title XXI grants a state flexibility in the manner in which it establishes its program and in how it structures its benefits, it sets clear rules regarding how beneficiaries are to receive the benefits once they are determined eligible for them. Thus, they are entitled to a review process that meets constitutional due process standards. Compare *Davis v. Ball Memorial Hosp.*, 640 F.2d 30 (7th Cir. 1980) (finding Hill-Burton patients had a

property interest entitling them to due process regarding the availability of free hospital care benefits available on a first-come-first-served basis). See *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1 (1975) (holding available state remedies did not meet constitutional due process requirements in case involving termination of utility service). Even where there is no apparent "brutal need," courts have granted procedural protections to plaintiffs. See, e.g., *Caramico v. Secretary of the Dep't of HUD*, 509 F.2d 694 (2nd Cir. 1974) (citing occupant's substantial period of past residence to hold that even housing occupants not entitled to relocation assistance had a due process right to notice and to submit opposing considerations in the Federal Housing Authority's decision not to waive a requirement that foreclosed buildings must be delivered unoccupied).

Based on cases such as these, we are concerned that if the state's general health insurance issuer laws do not meet the Goldberg requirements for due process, states will violate the due process rights of SCHIP recipients whose services or eligibility are reduced or terminated. The fact that Title XXI states that SCHIP is not to be construed as an entitlement is not dispositive -- courts have viewed these types of statements as evidence of whether there is a protected interest rather than a foregone conclusion. See, e.g., *Movers Warehouse, Inc. v. City of Little Canada*, 71 F.3d 716 (8th Cir. 1995). While, due to its limited funding, SCHIP may not be an entitlement in the same sense as Medicaid because it will not necessarily be available for all who meet its eligibility criteria, it is an entitlement in the same sense as public or subsidized housing, which is also not always available but which nonetheless requires adequate processes to protect the interests of those actually receiving the benefit as well as those with a legitimate claim of entitlement to it based on the program's articulated eligibility criteria. See *Escalera v. New York City Housing Authority*, 425 F.2d 853, 861 (2nd Cir. 1970).

RECOMMENDATION:

Delete amendments made to Subpart K by the interim final rule and restore Subpart K as provided in final rule of January 11, 2001.

Neither the statute nor the conference reports define "general public assistance". See e.g. House Conf. Rpt. 94-1515 at 490, Sen. Conf. Rpt. 94-1236 at 490-1, (accompanying P.L. 94-455, 1976).

The relevant text of § 205(c)(2)(C)(i) states: "It is the policy of the United States that a State (or political subdivision thereof) may, in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction, utilize the social security account numbers issued by the Commissioner of Social Security for the purpose of establishing the identification of individuals affected by such law, and may require any individual who is or appears to be so affected to furnish to such State . . . the social security account number. . . ."

"Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it." Pub.L. 93-579 § 7(b), 88 Stat. 1896.

This section, addressing enrollment assistance and information requirements, states:
"(a)Information disclosure. The State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals, and facilities." 42 C.F.R. § 457.110, 66 Fed. Reg. 2673 (Jan. 11, 2000).

The states now collecting or requiring enrollment brokers or managed care organizations to collect this data, starting with the 13 that collect it on their SCHIP applications, are: FL, GA, HI, IL, MO, MT, NE, NV, NH, OH, OK, OR, WA, AZ, CA, CO, IN, IA, KY, LA, ME, MD, MA, MI, MN, NJ, NM, NY, NC, ND, PA, RI, SC, TN, TX, UT, VT, VA, DC, and WI.