Idaho Department of Health and Welfare
Policy Option Research for
Premium Assistance Programs

Final Report
June 26, 2007

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Results Summary

Introduction

As requested by the State of Idaho, Department of Health and Welfare, this is the final report on the premium assistance programs in the six states of Oregon, Michigan, Utah, Maine, Illinois, and Pennsylvania.

Each state section contains a state-specific discussion of the following components requested in the project proposal.

1. A brief description of the program selected for review.
2. Insight provided by discussion with key program officials when available (Maine was the only state we were unable to reach).
3. An analysis of how the program would fit within Idaho, including advantages and disadvantages of implementing such a model in Idaho from a fiscal, health policy and political standpoint.
4. A Subsidy Model which not only projects enrollment for implementation of each state's program in Idaho but also the estimated subsidy cost based upon the program structure and characteristics.
5. An Operational Model which includes the staffing implications as well as start-up costs, development costs, and automation requirements. The estimates from the operational model are dependent on the enrollment projections for some of the variable costs.
6. Each state section concludes with a comment on the state statute and administrative rule governing each state's program and the statute changes which might be considered for the implementation of each program in Idaho. Appendix 4 contains detailed examples of state-specific statutes and rules from the states reviewed in this report.

Program Descriptions

The six programs represent a variety of designs, but all have the common goal of helping eligible persons purchase health insurance. Only three of the six coverage programs discussed—those in Oregon, Utah and Illinois—fit a strict definition of premium assistance and are directly comparable to Idaho's Access Card programs. The other three states' programs support coverage through slightly different mechanisms: Maine's DirigoChoice is a subsidized, reduced-cost program, Pennsylvania pays participants' premiums with wraparound Medicaid benefits, and Michigan's Muskegon County has a defined-benefit, limited-price health co-operative. These latter three states' programs may serve as sources for potentially significant changes to the Access Card programs or for programs additional to the Access Card.

Premium assistance programs typically focus on one or more policy objectives. This review of premium assistance and similar programs in six states identified their major policy objectives as cost savings, coverage expansion, and/or informed choice.

A cost savings program aims to reduce the state-funded cost of Medicaid enrollees by utilizing employer-offered insurance programs as a replacement of traditional Medicaid benefits and full state funding. The state subsidizes employee premiums and the point-of-service cost sharing of

the employer sponsored coverage, which results in savings when compared to the cost of funding the client in the Medicaid program.

The objective of a coverage expansion program is to reduce the number of uninsured by creating or expanding the subsidy-eligible population. These programs increase the number of individuals receiving Medicaid benefits primarily through direct subsidies (sometimes fixed) of commercial health insurance premiums. These programs are offered to low-income individuals, often at higher thresholds of poverty than those required to be eligible for Medicaid, with the goal to make private health insurance more affordable.

An informed choice program provides a Medicaid enrollee the opportunity to select a commercial health insurance program over traditional benefits while ensuring coverage without benefit restrictions. Programs of this nature require administrative flexibility to accommodate a beneficiary moving between traditional direct Medicaid and commercial employer-provided health insurance.

These policy objectives are not mutually exclusive but should be considered throughout the evaluation of advantages and disadvantages of each program that follows. It should also be noted that the objective(s) for any one state can also evolve over time. Pennsylvania, for example, historically focused almost exclusively on its cost savings program with one of the longest-running and successful Health Insurance Premium Assistance Program (HIPP) operations. This state just recently passed but is still implementing a major coverage expansion through its State Children's Health Insurance Program (SCHIP) called Cover All Kids. In April 2007, the Pennsylvania governor presented a Prescription for Pennsylvania program which outlines one component called Covering all Pennsylvanians (CAP). CAP drives a small business health insurance mandate with the penalty of an additional 3 percent payroll tax to fund uninsured coverage.

The following table summarizes the significant program features for each of the six states.

Results Summary

Summary of Program Features			
State	***Oregon***	***Michigan***	***Utah***
Program Name	Family Health Insurance Assistance Program (FHIAP)	Access Health	Utah's Premium Partnership for Health Insurance (UPP)
Choice Available? (Direct Coverage or Premium Assistance)	Choice depending on eligibility for direct coverage programs	Subsidized single-source coverage only Aimed to help the working uninsured Not available to Medicaid/Medicare eligibles	Premium assistance only Aimed to cover the working uninsured as alternative to Medicaid coverage
Eligibility Individual/Family	Individual	Both	Both
Eligibility Top FPL Level	185%	Employer's median wage must be $12/hour or less	Children: 200% Family: 150%
Enrollment	15,776 (May 2006)	1,500 (Dec 2006)	142 adults & 138 children (May 2007)
Asset Test?	Yes	No	No
Adult Coverage?	Yes	Yes	Yes
Employer or State Sponsored?	Both	Employer	Employer
Employer Size Restriction	None; includes small and large groups	Small to mid-sized companies	None; includes small and large groups
Minimum Employer Contribution	0%	30% of Total Cost	≥50%
State Share of Premium	50% - 95%	Community Share is usually set at 40% of Total Cost	Up to $100/child per month Up to $20/child (for dental) per month Up to $150/adult per month
Individual Share of Premium	5% - 45%	30%of Total Cost	Total remaining after subsidy
Who Gets Payment? (Insurance Company or Individual)	Individual	Non-Profit Administrator	Individual

Results Summary

Summary of Program Features			
State	***Maine***	***Illinois***	***Pennsylvania***
Program Name	Dirigo Choice	Family Care/All Kids Rebate	Health Insurance Premium Payment (HIPP) Program
Choice Available? (Direct Coverage or Premium Assistance)	This is a health coverage plan available to small business employees, the self-employed, & individuals above Medicaid eligibility guidelines	Choice available	No choice for working Medicaid enrollees
Eligibility Individual/Family	Both	Family	Family
Eligibility Top FPL Level	300%	Children: 200% Family: 185%	PA Medicaid FPL Level
Enrollment	15,000 (Dec 2006)	6,200 (May 2007)	21,000 (April 2003)
Asset Test?	No	No	No
Adult Coverage?	Yes	Yes	Yes
Employer or State Sponsored?	Both	Employer	Employer
Employer Size Restriction	50 or fewer employees	None; includes small and large groups	None; includes small and large groups
Minimum Employer Contribution	0%	0%	0%
State Share of Premium	8% - 40%	Up to $75/person per month	100% of employee portion of premium
Individual Share of Premium	<40%	Total remaining after subsidy	0%
Who Gets Payment? (Insurance Company or Individual)	Individual (when employee) Insurance company (when not employee)	Individual	Insurance company

Subsidy Model Summary

In the table below, we have summarized projected program enrollees and costs for a five-year period. In each program shown, we assumed that enrollment would grow linearly to an ultimate "mature" level by the end of the 5th year. Enrollment levels and costs vary significantly among the programs, depending on:

- Eligibility rules.
- Actual take-up rates in the program's state of origin (e.g., in Oregon, Utah, or Illinois).
- Enrollment caps.
- Subsidy levels per person.
- Other variables, such as the presence of other programs, and education and advertising efforts.

Projected Enrollees and Subsidy Costs in Idaho

	Year 1	Year 2	Year 3	Year 4	Year 5
Oregon: FHIAP					
Average Number of Enrollees	836	2,380	3,924	5,468	7,012
Enrollees at End of Year	1,544	3,088	4,632	6,176	7,720
Subsidy Cost per Enrollee per Month	$200	$218	$238	$259	$282
Total Subsidy Cost per Year	$2,006,400	$6,226,080	$11,206,944	$16,994,544	$23,728,608
Michigan: Access Health					
Average Number of Enrollees					
Enrollees at End of Year	262	612	997	997	997
Subsidy Cost per Enrollee per Month	$80	$64	$60	$66	$73
Total Subsidy Cost per Year	$251,520	$470,016	$717,840	$789,624	$868,586
Utah: UPP					
Average Number of Enrollees	202	575	949	1,322	1,695
Enrollees at End of Year	373	746	1,120	1,493	1,866
Subsidy Cost per Enrollee per Month	$80	$87	$95	$104	$113
Total Subsidy Cost per Year	$193,920	$600,300	$1,081,860	$1,649,856	$2,298,420
Maine:DirigoChoice					
Average Number of Enrollees	2,531	7,205	11,878	16,551	21,224
Enrollees at End of Year	4,673	9,346	14,020	18,693	23,366
Subsidy Cost per Enrollee per Month	$174	$190	$207	$226	$246
Total Subsidy Cost per Year	$5,284,728	$16,427,400	$29,504,952	$44,886,312	$62,653,248
Illinois: FamilyCare/ All Kids Rebate					
Average Number of Enrollees	90	256	423	589	755
Enrollees at End of Year	166	332	499	665	831
Subsidy Cost per Enrollee per Month	$68	$74	$75	$75	$75
Total Subsidy Cost per Year	$72,900	$227,328	$380,700	$530,100	$679,500
Pennsylvania: HIPP					
Average Number of Enrollees	234	667	1,100	1,533	1,965
Enrollees at End of Year	433	865	1,298	1,731	2,164
Subsidy Cost per Enrollee per Month	$117	$128	$140	$153	$167
Total Subsidy Cost per Year	$328,536	$1,024,512	$1,848,000	$2,814,588	$3,937,860

Oregon: Family Health Insurance Assistance Program (FHIAP)
The Oregon program produced relatively high total costs due to high expected enrollment and high subsidy costs per enrollee. Among the reasons for higher enrollment is the ability to enroll in either group or individual coverage. Oregon has also done a good job marketing the program and maintaining a stable environment, allowing consistent enrollment growth year over year. We also expected greater enrollment rates in the lower income ranges, where the percent covered by FHIAP is higher. Maintaining this higher level of subsidy for the lowest income eligibles will be an important consideration in order for Idaho to achieve these results.

Michigan: Access Health
The Michigan estimates reflect conversations with Karen Cotton, the Region One Director for Idaho's Department of Health and Welfare. Karen has assembled a leadership team to explore the option of implementing a Muskegon County-like three-share model in the five northern counties of Idaho. Involved in this leadership team are individuals from Northern Idaho Health Network and other independent consultants. The preliminary results of this feasibility study done for these five northern counties are the estimates presented in the table above. These estimates have been provided at the request of the State of Idaho, and are not subject to any of the assumptions or limitations of the other information presented in this report. Any discussion of the underlying basis for these estimates of the Michigan model in Idaho's five northern counties should be directed to the Region One team.

Utah: Premium Partnership (UPP)
The Utah program resulted in a lower number of potential eligible enrollees, since the program requires that an individual be eligible for their employer coverage, but not enrolled. UPP also has a flat dollar subsidy maximum, which constrains total spending. Per person costs increase with inflation, but are limited by the subsidy maximum.

Maine: DirigoChoice
Like Oregon, subsidy costs are quite high per enrollee, particularly for enrollees in the lower income ranges. Overall enrollment is projected to be significantly higher than other programs due to much less restrictive eligibility requirements. Since the DirigoChoice program was designed to work in conjunction with the Dirigo Medicaid entitlement redesign, it was extremely difficult to isolate the cost of the premium assistance program. Unfortunately, the researchers were unable to contact a representative from the State of Maine to help define the exact amount of the subsidy.

Illinois: FamilyCare/All Kids Rebate
Enrollment under the Illinois program is projected to be relatively small compared to other programs due in part to the smaller subsidy and more restrictive enrollment criteria. For example, adults may enroll only if they are parents of eligible children. Similar to Utah's UPP program, this rebate has a flat dollar subsidy maximum. Per person costs increase with inflation but are limited by the subsidy maximum.

Pennsylvania: Health Insurance Premium Payment (HIPP)
The HIPP program enrollment is only open to Medicaid-eligible individuals, so it is difficult to draw comparisons between this program and the others. The generous subsidy is mitigated by

the requirement that the employer coverage be more cost-effective than Medicaid. Note that our projections do not reflect any offsetting savings in direct Medicaid benefit costs.

Subsidy Modeling Methodology

We projected program eligibles, enrollment, and costs using the following steps. The State where the program is currently operating will be referred to as the "Program State".

1. Start with the statewide population in Idaho and in the Program State.

2. In each state, approximate the percentage of the population that meets the program eligibility requirements using available census data.

3. For programs that had been in operation for less than five years, we extrapolated the Program State's current enrollment rate out to a steady state enrollment period. Based on current enrollee counts in the Program State, we calculated an enrollment rate (i.e., enrollees as a percentage of approximate eligibles), and applied that rate to the Idaho approximate eligibles to project enrollment in Idaho.

4. We estimated the subsidy cost per enrollee, making adjustments in Idaho as appropriate.

5. With the steady state of enrollment projected, and costs estimated over a five-year period, our enrollment projection was then assumed to have a linear growth pattern from Year 0 until program maturity and steady state enrollment is reached (five years). For the subsidy costs, we assumed an annual health cost inflation rate of 9% across the five-year estimation horizon.

Operational Model Summary

In the table below we have summarized the results of the Total Operating Costs for a five-year period. For every state but Michigan, these estimates are based upon the projected enrollment from above. For Michigan, actual expenses for Muskegon County were estimated. As discussed in the state specific modeling for Michigan, this information is based upon the information gathered for this particular implementation and for purposes of operational cost modeling could not be adjusted for the differences between the Michigan and Idaho populations.

In order to reflect these different assumptions, the end of year enrollment figure assumed for the administrative or operational cost has been displayed for each year and each program being implemented in Idaho.

Results Summary

Operational Costs in Idaho

Oregon: FHIAP	Year 1	Year 2	Year 3	Year 4	Year 5
End of Year Enrollment	1,544	3,088	4,632	6,176	7,720
Total Cost	$1,342,556.80	$1,452,354.38	$1,636,317.17	$1,807,660.69	$2,007,494.58
Average Cost Per Enrollee	$133.78	$50.85	$34.75	$27.55	$23.86
Michigan: Access Health					
End of Year Enrollment	240	480	720	960	1,200
Total Cost	$609,918.40	$628,215.95	$686,120.52	$746,933.98	$769,342.00
Average Cost Per Enrollee	$390.97	$141.49	$93.73	$73.23	$58.82
Utah: UPP					
End of Year Enrollment	373	746	1,120	1,493	1,866
Total Cost	$463,881.60	$477,798.05	$492,131.99	$506,895.95	$522,102.83
Average Cost Per Enrollee	$191.20	$69.21	$43.23	$31.96	$25.67
Maine: DirigoChoice					
End of Year Enrollment	4,673	9,346	14,020	18,693	23,366
Total Cost	$463,881.60	$561,223.10	$663,987.60	$772,412.87	$879,149.34
Average Cost Per Enrollee	$15.27	$6.49	$4.66	$3.89	$3.45
Illinois:Family Care/All Kids Rebate					
End of Year Enrollment	166	332	499	665	831
Total Cost	$148,118.91	$171,017.41	$193,879.94	$217,988.02	$243,299.03
Average Cost Per Enrollee	$137.04	$55.62	$38.24	$30.86	$26.86
Pennsylvania: HIPP					
End of Year Enrollment	433	865	1,298	1,731	2,164
Total Cost	$1,908,296.00	$1,965,544.88	$2,024,511.23	$2,085,246.56	$2,147,803.96
Average Cost Per Enrollee	$678.61	$245.57	$153.37	$113.38	$91.07

Cost per participant per year is shown for each state (total cost for the year, divided by total number of participants served during the year). That the administrative costs per participant vary widely is not surprising given the variety of implementations. For example, costs for implementation of the Maine program are relatively low because most of the administrative cost is assumed to have been delegated to the carrier and integrated with the overall Dirigo redesign. On the other hand, costs for the Pennsylvania model are very high, as the decentralized Health Insurance Premium Payment model creates high fixed costs, which are spread over a low enrollment.

We would expect to see cost per participant per year for those programs with high fixed costs to decrease over time as membership grows and these fixed costs are distributed over an increasing membership base.

Operational Modeling Methodology

In developing the staffing and cost estimates for implementation of each program in the State, we used the following high-level methodology:

1. Gathered information regarding the current administrative functions performed.
2. Identified specific tasks to be performed for each major function.
3. Estimated the labor resources required to conduct the tasks based on each program's current staffing, organizational structure, enrollment, and use of information technology.
4. Projected labor requirements using the projected enrollment by month.

5. Calculated labor costs based on job title, the responsibilities of each position, education and experience requirements, and the average wages observed in the marketplace.
6. Calculated labor-driven variable costs based on historical experience.
7. Estimated direct costs specific to the program, in addition to the variable costs.
8. Calculated total cost as the sum of labor costs plus variable costs plus direct costs.
9. For start-up costs we identified the various infrastructure costs that would likely be necessary during implementation. We estimated the costs of these investments based on historical experience.

More detailed information regarding the specific staffing and cost development methodologies we used are described in the paragraphs below.

Information Gathering

We gathered specific information about each program's current operations from multiple data sources. First, we conducted informational interviews with personnel at each program (except Maine). One purpose of these interviews was to obtain information regarding the administrative activities performed by the program personnel, and to identify the current organizational structure and staffing levels associated with each program. The depth of information obtained through these interviews varied widely.

Second, we supplemented information obtained through the aforementioned interviews with research conducted using publicly available resources such as State websites. For example, we reviewed the enrollment forms for every state, and reviewed organizational charts and policy documents when available. Through this review of information, we were able to develop a general understanding of the relative complexity and nuances of each program, for use in estimating expected staffing levels for implementation of these programs in the State.

Staffing Models and Assumptions

We developed a separate staffing model for each program. As previously stated, we first identified the major functions and tasks to be performed. For transaction or "production" activities, we estimated the resources required to complete the tasks on a per transaction basis. For example, we estimated the amount of time required to process an enrollment application based on our understanding of the enrollment process. Using the enrollment projections, we estimated the total resource requirement on a full time equivalent (FTE) basis. For activities not related to transactions, we estimated the number of FTEs required based on the size of the program and the assumed duties of the staff. Also, if the comparison program had a specific position, we assumed that position would be implemented if the program was implemented in the State and the enrollment projection was similar in size to that of the existing state program.

For some of the programs, interviewees identified the various positions on their staff and their job responsibilities. For other programs, we lacked position information and therefore assumed the types of positions that would be necessary to perform the required activities (i.e., if the reimbursement function is required, then a reimbursement position is included).

Fixed vs. Variable Staffing

It is important to note that we identified both "variable" and "fixed" positions. Variable positions are those directly related to the number of enrollees in the program. These tend to be production positions related to specific transactions such as processing of enrollment applications or production of reimbursement checks. Fixed positions tend to be related to management or other functions that are not directly related to enrollment levels, but rather are related to the completion of specific tasks such as establishing the minimum benefits level for an acceptable policy, or providing a marketing/outreach function. Given the low total staffing for each program, we did not adjust the management staffing levels for span-of-control. Of course, if the implemented program grows significantly necessitating a very large staff, it may be appropriate to add additional management personnel. On the other hand, given the low total membership in each program, some of the management staffing needs may be overstated. For example, in most cases, we included a full-time director, except when we knew for sure that the director led more than one program. For very small programs, it may be practical to assign the director's responsibilities to an existing state employee rather than have a stand-alone position.

Shared Infrastructure Functions

Many of the premium assistance programs we surveyed receive significant infrastructure support from other State agencies. The level of infrastructure support provided by these "sister" agencies varies by state. The most common areas of centralized support were Information Systems, Fiscal and Accounting, and Human Resources. In addition to these overhead functions, some states centralized the eligibility function at regionally distributed eligibility offices or a centralized eligibility operation for all Medicaid programs. In some cases, program personnel were able to indicate the number of personnel in the other departments that support the program, and in other cases they were not. In those states where we know that services are provided by sister agencies, we indicated this in the assumptions. However, in most cases we did not have adequate information to estimate the staffing support from that sister agency.

Dedicated vs. Shared Personnel

In addition to support from other agencies, some of these programs operate within an agency that is responsible for multiple programs. In these cases, personnel responsible for functions such as outreach or enrollment processing are responsible for multiple programs. For shared staff, we tried to estimate the proportion of staff time dedicated to the premium assistance program; however, in several cases the apportioning was done based on very simple assumptions.

Efficiencies

In developing the staffing models we assumed that the programs would be implemented with the same organizational structure, level of information systems, and complexity as they are currently implemented. We did not assume any benefit from changes to the organizational structure, enhancement of information systems capabilities, or changes in complexity. Of course, these issues should be considered by the State when implementing a specific program, and may result in lower staffing needs and/or lower

administrative costs. Nonetheless, we did not have adequate information to estimate the impact of modifications to the programs during implementation in the State.

Typical Functions

Despite variances in approach among the six programs studied, the following administrative functions were consistent across all programs considered in this study:

- Eligibility verification (initial and ongoing);
- Review of insurance plans for financial viability or compliance;
- Reimbursement (payments to members, employers, or insurance carriers); and
- Marketing and/or outreach (to eligible members, employers, or brokers).

Despite the consistency of functions, the activities performed by the programs in support of these activities varied in complexity. For example, the complexity of enrollment forms varied, some programs were aggressive at marketing while others were not, and the approaches to ongoing eligibility verification also varied widely. To the extent possible, we took these variances into account in developing the staffing estimates.

Enrollment Projections

The projection of enrollees for each program was used in estimates of the operational costs. The methodology and assumptions for these projections is described in the section above pertaining to the subsidy modeling.

Administrative Cost Modeling

We estimated the administrative costs associated with steady-state operation of each program using a traditional cost build-up methodology. The major components of the administrative cost are:

- Wages and salaries;
- Benefits and taxes;
- Variable costs; and
- Start-up costs.

Our methodology for estimating each major cost component is described below.

Wages and Salaries

For each position identified in the staffing model, we estimated the wage and salary costs. We used publicly available salary and wage survey information to estimate the national wage level on an hourly basis for the current year. For each required position, we identified a similar position and wage rate in the commercial environment. We used a 3.0% inflation rate applied to the hourly rate to estimate the wage cost in Years 2-5.

Two issues may cause the administrative cost estimates provided herein to be overstated. First, we expect that wages in the State of Idaho may be slightly lower than the national wage rates that were used for these estimates. Second, wages for state government positions may also be slightly lower than the wage rates used herein. Both of these factors should be considered when evaluating the administrative cost estimates provided in this report.

Benefits and Taxes

We used a labor-driven factor to estimate the value of benefits and taxes. Based on our experience with commercial organizations, a reasonable factor for estimating these costs is 36%. We used this amount (as a percent of salary) for our administrative cost estimates. In evaluating the administrative cost estimates provided in this report, it is important to consider the actual benefit/tax load that should be expected in Idaho.

Variable Costs

Variable costs represent the final cost component for consideration in the steady-state administrative costs. Variable costs represent those indirect costs that are generated by day-to-day operations. Based on our experience with commercial entities, a reasonable factor estimating these costs is 100%. We used this amount (as a percent of salary) for our administrative cost estimates. In evaluating the administrative cost estimates provided in this report, it is important to consider the actual variable cost loads that are observed for State operations, especially in light of how some administrative costs may be borne or absorbed by the budgets of other state agencies.

Start-up Costs

The aforementioned cost components represent administrative costs on an ongoing basis for steady-state operation of the program. There are additional costs associated with start-up or "implementation" of the program. These costs are typically related to acquisition of assets such as furniture and computers, as well as development costs for infrastructure systems. For this report, we have attempted to estimate the start-up costs for implementation of each state program in Idaho. It is, however, very difficult to accurately estimate start-up costs without detailed information regarding the State's implementation strategy and costs for capital acquisitions. For example, the State may be able to use existing furniture and equipment for the premium assistance program, rather than acquire new assets. Or the State may be able to use existing information systems programmers for the development of a database rather than use outside consultants, which would significantly reduce the costs of system development. Without more information regarding the State's costs and implementation strategy, it is only possible to offer a rough estimate of these start-up costs.

Our start-up cost assumptions for each implementation of each program are described in the state discussion sections below.

Waivers

Medicaid waivers related to premium assistance programs are included as separate attachments to this report (in PDF form). These documents are also available on www.cms.gov (see in particular http://www.cms.hhs.gov/MedicaidStWaivProg_DemoPGI/MWDL/list.asp to browse all states' waivers). Relevant waiver documents for Oregon, Utah, and Illinois are included as attachments (Oregon Health Plan 2 Proposal.pdf, Utah Primary Care Network PCN 2006 ESI HIFA Amendment Application.pdf, and Illinois KidCare Parent Coverage Proposal.pdf).

Note that Michigan has no waivers associated with Access Health in Muskegon County, Pennsylvania requires no waivers for its HIPP program since the program is authorized under Section 1906 of the Social Security Act, and Maine does not have a waiver for DirigoChoice per se, although it does have a waiver to allow the same insurance plan offered by Anthem that serves DirigoChoice participants to be the health plan for Medicaid-eligible participants in the Dirigo Health Plan. This is a program component of the overall Dirigo initiative that is separate from but related to DirigoChoice.

The attached waiver documents for Oregon, Utah and Illinois each take the form of Health Insurance Flexibility and Accountability (HIFA) demonstration proposals under Section 1115 waiver authority. Each of these documents uses the standard Centers for Medicare and Medicaid Services (CMS) HIFA proposal template, and therefore facilitates comparison with each other and with Idaho's HIFA proposal documentation. Within the template format, these proposals allow the state to describe the characteristics of the demonstration program and eligible population. The proposals also reflect the results of negotiations between each state and CMS that are unique to each demonstration program.

Due to the unique development process for each HIFA waiver, it is difficult to draw broad conclusions from the three attached proposals about the best way to amend Idaho's existing HIFA proposal, should Idaho Medicaid choose to do so. In addition, amendments to Idaho's existing HIFA demonstration would undoubtedly be proposed in the context of the ongoing administration of Idaho's demonstration and in the context of existing partnerships between Idaho Medicaid and CMS.

Therefore, these documents are likely of greater utility for Idaho Medicaid as examples of program description and negotiated program elements for these three states' premium assistance programs that Idaho may use as whole or partial models should Idaho Medicaid choose to adopt program elements from one or more of these states' programs. These documents also serve as examples of the way three different states choose to describe their programs within the template format; therefore, a comparison of the program description sections in this paper with the corresponding waiver proposals for these three states may also be instructive for Idaho.

Funding

The Health Insurance Flexibility and Accountability (HIFA) demonstration proposal serves as the recommended process for accessing federal funds. A review of the current Section 1115 waiver can be performed to see if there is any capacity for gaining a greater authorization of Federal matching funds. Each of the three programs mentioned above using HIFA proposals, Oregon, Illinois, and Utah, filed amendments to existing section 1115 funding requests. The

other potential sources of state funds identified in this report are the state and county indigent funds, Disproportionate Share Hospital (DSH) payments, tobacco settlement funds, and other general revenue.

Overall Assumptions

In all of our projections, we have ignored the effects of overall state population growth. Where appropriate, we have reflected the potential impact of health care cost inflation on the premium assistance program costs.

All of our projections assume total replacement of the existing Idaho premium assistance programs. If a new program is implemented side-by-side with the existing Idaho programs, then our projections would need to be adjusted. From an operational cost modeling perspective, no additional savings were assumed to be derived from the replacement of the current programs. Furthermore, an assessment of the cost of the current premium assistance programs in the State of Idaho was beyond the scope of this report.

Our enrollment growth projections assume simple linear growth over five years. If the State chooses to replace existing premium assistance programs with a new program, and aggressively acts to move current enrollees into the new program, then enrollment might grow much more quickly than we have projected.

The modeling of an Idaho implementation of several programs currently operating at a certain level of maturity in other states requires a set of reasonable assumptions and a core methodology that is consistent across the analysis of each state. The state-specific analysis sections describe the methodology employed in the estimates and the assumptions required to calculate the requested results.

Overall Limitations

The purpose of this report is to help the State evaluate the feasibility of implementing various premium assistance programs in Idaho. It is our expectation that the State will use this report to understand the approximate magnitudes of enrollees and program costs. The report may not be suitable for other purposes. If the State ultimately decides to implement a new premium assistance program, then a more refined study may be needed which considers then-current market conditions and the specific requirements of any enabling legislation.

The projections described in this report are not predictions. Rather, they are projections of consequences that will occur if the underlying assumptions are realized precisely. Actual experience will deviate from these projections due to a variety of influences. If a premium assistance program is implemented, program experience data should be collected, studied, and if appropriate, any program projections should be modified to reflect that experience.

In performing this study, Milliman and Boise State University (BSU) have relied on data and information from many sources, such as the U.S. Census Bureau. We have not audited the data sources for accuracy, although we have reviewed them for reasonableness. If data or information provided to us were inaccurate or incomplete, the values and conclusions in this report will need to be revised for consistency.

Results Summary

This report was prepared by Milliman and Boise State University (BSU) for the State. Although Milliman and BSU understand that this report may be distributed to third parties, Milliman and BSU do not intend to benefit any such third parties. If this report is distributed to third parties, it should be distributed only in its entirety.

The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon this report without a thorough understanding of those assumptions and methods.

Oregon: Family Health Insurance Assistance Program (FHIAP)

1. Program Description

The Family Health Insurance Assistance Program (FHIAP) is a premium assistance program that enables participants to purchase private health insurance in the group market through their employer or in the individual market if employer-sponsored insurance is not available.[1] Initially funded only through state dollars, in 2003 this program was integrated with the Section 1115 waiver for the Oregon Health Plan and became qualified for federal match. At that point, traditional Medicaid groups, such as pregnant women and children, became eligible to participate in FHIAP. FHIAP is a Medicaid savings program as well as an expansion initiative. Traditional enrollees in Medicaid are ensured standard benefits, while higher-income beneficiaries are still eligible for a partial subsidy.

FHIAP pays from 50% to 95% of premiums, depending on participants' income. FHIAP includes both child and adult participants, and all dependent children must be enrolled in some type of health insurance before the adults in the family are eligible for FHIAP. Applicants must have had no insurance for the preceding six months, although there is a substantial grace period for employees who enroll in employer-sponsored insurance and subsequently learn about FHIAP. (FHIAP officials are currently awaiting federal approval of a change in the no-insurance period from six months to two months for both adults and children.[2]) FHIAP also subsidizes dental coverage in the group market.

FHIAP applicants who have access to employer-sponsored insurance must enroll in that insurance if it meets a minimum benefits threshold established by the state and if the employer contributes to the premium. Employees in businesses of any size may participate, and the business is allowed to currently offer insurance. If FHIAP participants are enrolled in group insurance, the employee participant pays his or her share of the premium to the employer, and FHIAP reimburses the employee. If FHIAP participants do not have access to employer-sponsored insurance or are not workers, they may enroll in an individual plan offered by FHIAP-participating carriers. Individual plans must also meet a minimum benefit threshold. FHIAP pays the carrier directly for the full cost of the individual premium, and the participant pays FHIAP for his or her share; premium recovery rates are generally high. FHIAP also subsidizes enrollment in the state's high risk pool.

The proportion of FHIAP funds used for group coverage and for individual coverage is based on a complex budget allocation. FHIAP has legislative direction to focus on the group market and there is no wait time or reservation list for groups, although group enrollment typically grows slowly. The majority of FHIAP participants are enrolled in individual plans, and there is typically a long waiting list for this part of the program. When a spot on the individual reservation list opens, the next person in line is sent an application. Individuals therefore invest little time in the application process until there is an open spot. Individuals must be uninsured at the time of their initial inquiry but are not forced to remain uninsured while on the reservation

[1] Institute for Health Policy Solutions: An Overview of the Oregon Family Health Insurance Assistance Program by Jennifer Sexton (December 1998)
[2] Kelly Harms (Office of Private Health Partnerships) and Craig Kuhn (FHIAP program manager), phone call, 5/18/07.

list; often they can be enrolled in the regular Oregon Health Plan, the state's Medicaid program, while they are waiting.[3]

2. Program Staff Comments on FHIAP[4]

FHIAP managers consider the program to be very successful, as evidenced by its nearly 10-year existence and long reservation list. One critical success factor cited by program officials has been productive relationships with stakeholders, including community groups, insurance agents, carriers, employers, and other state agencies. Positive relationships with carriers have proven particularly important because carriers have had to create new plans solely to meet the FHIAP benchmark. Another critical success factor has been the investment in electronic transaction systems. FHIAP has a proprietary database that helps to manage bill payments and eligibility determination. In the past, the program had found that Medicaid and FHIAP both occasionally enrolled the same person, but over time this issue has been resolved.

A third success factor emphasized by program managers is that state health insurance programs have similar eligibility guidelines and that there are few "artificial gaps" between different programs and among eligibility categories. For example, officials consider consistency of eligibility guidelines among adults and children to be important. This reduces confusion among target populations as well as administrative complexity.

Challenges that the program has encountered have included the administration structure and strategy. FHIAP started out with a third-party administrator but found that the TPA could not adjust quickly enough to evolutions in program policy. FHIAP officials strongly recommend state administration of similar programs.

Enrollment of group plans has also proven to be challenging. Although FHIAP has legislative direction to focus on the enrollment of employer groups, managers recognize that there are barriers to group coverage for the eligible population. For example, many individuals with low incomes work in part-time jobs or in industries that do not typically provide coverage. It has also been difficult to encourage employers to offer insurance if they do not already do so; carriers' percent-of-group participation requirements often present an obstacle to employers considering new plans. FHIAP has invested a great deal of time in outreach to employers and, although group enrollment has not grown as quickly as hoped, there has been a slow and steady increase. Coordination of open enrollment periods and eligibility determination has also presented a timing issue for FHIAP-assisted group enrollment.

3. Would the Family Health Insurance Assistance Program Work in Idaho?

FHIAP and Idaho's current premium assistance program have certain philosophical and mechanical similarities, notably in that both states strive to support employer-sponsored insurance through premium assistance; both states require enrollees to be uninsured at the time of application; neither state provides wrap-around Medicaid coverage; and both states cover adults up to 185% of poverty. The two states' programs are alike enough that it is not necessary to discuss wholesale replacement of Idaho's program with Oregon's; rather, it may be useful to examine which elements of difference in Oregon's program might have utility in Idaho.

[3] Kelly Harms (Office of Private Health Partnerships) and Craig Kuhn (FHIAP program manager), phone call, 5/18/07.
[4] Kelly Harms (Office of Private Health Partnerships) and Craig Kuhn (FHIAP program manager), phone call, 5/18/07, and Jeanene A. Smith (Office for Oregon Health Policy and Research administrator), phone call, 5/14/07.

Marked differences between the two states' programs include the following: 1) FHIAP adjusts the amount of premium assistance it pays according to the participant's income, while there is no upper limit on the amount of the premium paid by the participant; 2) FHIAP gives assistance to adults enrolled in individual coverage, which is how most FHIAP participants are covered; 3) FHIAP does not require that employers have not previously offered coverage, only that eligible individual employees be uninsured; 4) group coverage can be in businesses of any size; 5) Oregon uses a benchmark to determine coverage adequacy before assisting enrollees with premium costs; and 6) FHIAP handles its subsidy flows differently from Idaho.

The first four differences between FHIAP and Idaho's Access Card programs listed above might present possible policy opportunities for Idaho's programs. Establishing a sliding scale of subsidy amounts with higher levels of assistance for lower-income participants might increase affordability and enrollment. Establishing a sliding scale of subsidy *percentages*, as in Oregon, might go even further toward this goal. In terms of making premium assistance available to individuals, Oregon's experience both highlights strong demand for individual assistance and recognizes fundamental barriers to group coverage for low-income populations. If Idaho chose to emulate this program element, the state could potentially make significant progress toward reducing the number of uninsured Idahoans without access to employer-sponsored insurance. In terms of allowing uninsured individuals to enroll in currently offered employment-based coverage, this approach may present certain advantages over Idaho's current program in that it does not require employers to purchase a plan for the first time in order that employees become eligible for the subsidy.[5] The size of the population served by the Access Card programs could be expanded if Idaho also allowed group coverage in businesses of any size.

In terms of differences in the flow of subsidies in the two states' premium assistance programs, Idaho depends on agreements with carriers to discount premiums by the subsidy amounts for individual participants and then bill the Idaho Department of Health and Welfare for aggregated subsidies. Conversely, FHIAP sends premium assistance to participants in group plans as reimbursements after the full premiums are withheld from paychecks by employers. This approach avoids burdensome requirements of employers, but may present affordability issues for employees, depending on the timing of the reimbursements. FHIAP takes an altogether different approach for its individual coverage program, by paying the entire premium amount for participants in individual plans directly to the carriers and billing participants separately for their share. The way FHIAP handles individual subsidy flows might be a potential model if Idaho ever considers adding an individual element to its existing premium assistance program.

4. Subsidy Modeling

The Oregon Family Insurance Assistance Program (FHIAP) offers premium subsidies to uninsured low-income people so that they can purchase insurance through their employer plans or through the individual insurance market. To be eligible, individuals must have not had insurance for at least 6 months (requirement is waived for people coming off Medicaid), must not be Medicare eligible, and must meet all of the following income and asset requirements:

- Family income must be no more than 185% of FPL.
- Investments and savings must be less than $10,000.

[5] See discussion of Utah's premium assistance program on page 11.

To qualify with employer coverage, the employer plan must offer benefits that are at least as rich as Medicaid. There is no minimum requirement for employer contribution to the premium. In Oregon, most enrollees have been individuals.

We projected program eligibles, enrollment, and subsidy costs using the following steps, which are detailed in Appendix 3-A:

1. Start with the statewide population in Idaho and in Oregon.

2. In each state, estimate the percentage of the population that meets the program eligibility requirements. We used census data to estimate the number of uninsured individuals who were less than age 65, uninsured, and who met the income thresholds. We did not have population data that was split by income levels and by asset level, so we assumed that the people who meet both the income and asset requirement, expressed as a percentage of people who meet the income requirement, is the same in Oregon and Idaho.

3. Based on current enrollee counts in Oregon, we calculated an enrollment rate (i.e., enrollees as a percentage of eligibles), and applied that rate to the Idaho eligibles to project enrollment in Idaho. The Oregon program is relatively mature, having been implemented in 2003. Enrollment in the Oregon program has been limited by a waiting list. When projecting Idaho enrollment, we assumed that a similar waiting list would be used to limit enrollment to the same percentage of eligibles as in Oregon. Whether Idaho would ultimately use such a waiting list could have a material affect on the enrollment.

4. The subsidy varies by income level, and depending on whether the insurance is through an employer or purchased on the individual market. We allocated the number of Idaho enrollees by FPL category based on the distribution of enrollees by FPL and product type in Oregon, and on differences between the total numbers of uninsured people by FPL in Oregon versus Idaho.

5. We estimated the subsidy cost per enrollee. The subsidy is expressed as a percentage of premium, and it varies by income level. For people with employer group insurance the subsidy percentage applies only to the portion of the premium that is paid by the employee. For people with individual insurance, the subsidy percentage applies to their entire premium. We estimated the premium rates for group and individual insurance by starting with the Oregon rates that are published by FHIAP, and then adjusting them to reflect expected differences between Oregon and Idaho using area factors published in Milliman's 2007 Commercial Health Cost Guidelines (HCGs). The HCGs area factors reflect differences in utilization rates and average costs per service. The HCGs suggest that Idaho health insurance costs per person are approximately 1.2% lower than Oregon costs.

6. We projected enrollment and costs over a 5-year period, assuming increases due to inflation and increasing enrollment. Since FHIAP has been in existence in Oregon since 2003, we assumed Idaho would reach Oregon's current enrollment rate in four years. Our enrollment projection assumes linear growth. For the subsidy costs, we assumed an annual health cost inflation rate of 9%. Actual growth patterns will be a function of

many variables, including funding limitations, public awareness, competing programs and outreach.

5. Operational Modeling

Through the interview process and review of publicly available information, the researchers obtained a detailed understanding of Oregon's FHIAP. From this information, we were able to make a few basic observations about this program that were considered in our staffing plan. First, the Oregon program conducts most of the major activities typically associated with premium assistance programs including:

- Program management;
- Policy administration;
- Initial and ongoing verification of eligibility;
- Review of employers' plans to determine eligibility;
- Review and approval of participant documentation, and
- Production of reimbursement checks.

Second, Oregon staffs for its own infrastructure services such as information systems and human resources rather than using centralized State resources. Finally, the program does delegate responsibility for certain activities, such as check writing, to other State agencies.

Staffing

Using the information provided by Oregon personnel and information gathered by the researchers, we developed a staffing model to estimate the required staffing for implementation of the Oregon model in Idaho. The assumptions we made regarding each type of position are shown in the table below:

Oregon Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Director	Assumed 1.00 FTE to provide general oversight and direction for the program. Supervisory and management personnel will report to this individual.
Policy Analyst	Assumed 1.00 FTE to provide assistance to the director in developing and interpreting program policy.
Marketing/Outreach Coordinator	Assumed 1.0 FTE to provide training for employers and brokers, and outreach to the community and eligible participants.
Administrative Clerk	Assumed 1.0 FTE to handle incoming mail, provide general office support, and prepare reimbursement requests for data entry, verification, and authorization by the Accounts Payable Clerk.
Supervisor, Fiscal	Assumed 1.0 FTE when quantity of Accounts Payable Clerk and Administrative Clerk exceed a total of 3.0 FTEs, otherwise staff to be managed by the Director.
Accounts Payable Clerk	Assumed 5 minutes per check. Responsible for reviewing reimbursement requests and authorizing payment. Minimum 1.0 FTE.

Oregon Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Supervisor, Eligibility	Assumed 1.0 FTE for every 3.0 FTE Enrollment Specialist and Member Services Representative. Will supervise enrollment specialists and Member Services Representatives (when staffing volume does not necessitate a Supervisor of Customer Service).
Enrollment Specialist	Assumed 20 minutes per new enrollment application. Processes applications to determine eligibility, notifies applicant of decision, and enters enrollment data into enrollment system. Minimum 1.0 FTE.
Supervisor, Customer Service	Assumed 1.0 FTE for every 3.0 FTE member services representative if less than 1.0 FTE Supervisor, Eligibility. Will supervise Member Service Representatives.
Member Services Representative	Assumed 15% of active members call each month, and that calls last 10 minutes on average from receipt to final disposition and documentation. Will answer telephone and written inquiries from participants, general public, employers, and others. Minimum 1.0 FTE.
Data Analyst	Assumed 1.0 FTE. Will generate ad-hoc reports, assist with actuarial calculations, etc.
Human Resources Specialist	Assumed 1.0 FTE. Responsible for interface with state human resources department and providing human resources function.
System Engineer	Assumed 1.0 FTE. Responsible for information system development and maintenance, including web-site programming. Interfaces with State information technology area when additional resources are needed.
Benchmark Analyst	Assumed 1.0 FTE. Responsible for development of annual plan benchmark.

Using these assumptions and the enrollment projections, we estimated the year-end staffing levels for the Oregon program as shown in the table below.

State of Oregon Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	1.00	1.00	1.00	1.00	1.00
Policy Analyst	1.00	1.00	1.00	1.00	1.00
Marketing/Outreach Coordinator	1.00	1.00	1.00	1.00	1.00
Administrative Clerk	1.00	1.00	1.00	1.00	1.00
Supervisor, Fiscal	-	-	1.00	1.00	1.00
Accounts Payable Clerk	1.00	2.00	3.00	4.00	5.00
Supervisor, Eligibility	1.00	1.00	1.00	1.00	1.00
Enrollment Specialist	3.00	3.00	3.00	3.00	3.00
Supervisor, Customer Service	-	-	-	-	-
Member Services Representative	1.00	1.00	1.00	1.00	2.00
Data Analyst	1.00	1.00	1.00	1.00	1.00
Human Resources Specialist	1.00	1.00	1.00	1.00	1.00
System Engineer	1.00	1.00	1.00	1.00	1.00
Benchmark Analyst	1.00	1.00	1.00	1.00	1.00
Total Staffing	**14.00**	**15.00**	**17.00**	**18.00**	**20.00**

The staffing estimates shown in the table above represent the application of current staffing for the Oregon program adjusted for projected membership if implemented in Idaho. The Oregon program has a significant number of dedicated employees. It is, nonetheless, a large program, with more than 18,000 enrollees at any given time. It may be possible to reduce the staffing need by delegating certain responsibilities (i.e., information systems and human resources) to other existing state agencies/departments.

Administrative Cost

Using the administrative cost build-up methodology described in the methodology/assumptions section above, we estimated the annual administrative costs associated with steady-state operation of the Oregon program in Idaho. These values are shown in the table below.

State of Oregon Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 568,880	$ 615,404	$ 693,355	$ 765,958	$ 850,633
Benefit Cost	$ 204,797	$ 221,546	$ 249,608	$ 275,745	$ 306,228
Other Variable Cost	$ 568,880	$ 615,404	$ 693,355	$ 765,958	$ 850,633
Total Cost	**$ 1,342,557**	**$ 1,452,354**	**$ 1,636,317**	**$ 1,807,661**	**$ 2,007,495**

The cost estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section.

Start-up Cost

Implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. In the case of the Oregon model, we would anticipate a need for infrastructure to support the estimated 14 FTEs required to handle Year 1 workload, and additional investment as additional staff are needed to support growth of the program. The researcher estimates the start-up cost of $40,000 to $60,000 for infrastructure is needed to support the Year 1 staffing. This estimate assumes acquisition of computer terminals, a photocopier and facsimile machine, furniture, and network printers to support the

operation. Additional investment would be needed as additional personnel are added to support growth in the program.

In addition to these infrastructure costs, Idaho should expect to make investments in information systems to support this program. The Oregon program is highly dependent on information systems, and Oregon personnel stressed the value of good information systems as integral to the success of the program. Based on Oregon's use of information systems, the researchers believe that a system is needed to support processing of applications, storage of enrollment data, and authorization of reimbursements. In addition, Oregon personnel stated that interfaces were developed to support information exchange with the various insurance carriers in the State of Oregon, and that these interfaces have significantly improved operational efficiency. Such a system could be developed using a vendor for $250,000 to $400,000 depending on the complexity of the system. Alternatively, it may be possible to develop a system for relatively low cost using existing state information systems resources.

Marketing and outreach is the final component of the implementation cost. The cost estimate for marketing is highly dependent on the marketing strategy and intensity employed by Idaho. A two-prong approach that includes marketing to eligible beneficiaries and employers would be reasonable. For eligible beneficiaries, we would assume an initial mailing to all eligible beneficiaries at an approximate cost of $0.66 plus labor cost per eligible. A brochure explaining enrollment procedures would cost approximately $0.50 to $1.50 per eligible depending on complexity, size, and quantity. Marketing to employers requires additional labor, through one-on-one meetings, briefings, and participation in organized gathering such as trade shows. The Marketing/Outreach Coordinator would participate in these educational seminars and meet one-on-one with major employers. It may be appropriate to develop marketing collateral for these meetings, at additional cost.

6. Process Recommendations

6.1 State Statute

As mentioned in the FHIAP description and discussion of FHIAP's possible "fit" in Idaho, FHIAP and Idaho's premium assistance programs are alike enough that Idaho could reasonably plan to incorporate certain elements of FHIAP into its existing programs. Using the existing Access Card statute as a base, Idaho could add language similar to Oregon's to authorize these design changes.

The FHIAP statute is included in the Appendix in its entirety. The scope of the Oregon statute authorizing FHIAP is roughly comparable to Idaho's premium assistance statute, although Oregon includes fewer absolute figures such as subsidy amounts. Instead, the FHIAP statute gives authority to the Office of Private Health Partnerships to administer the program, and further authorizes the Office for Oregon Health Policy and Research and the Oregon Health Policy Commission to "make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation." Such an approach to state authority may allow for more flexible program design and/or responses to changes in the policy environment that help to ensure the success of the program.

Selected elements of the FHIAP statute could provide model authorizing language should Idaho decide to adopt design elements of FHIAP. Design changes that would close parts of the gap between the Access Card and FHIAP include: 1) Adjusting the amount of premium assistance according to the participant's income (see 735.726, level of assistance determinations), 2) Giving assistance to adults enrolled in individual coverage (see 735.720, definitions for ORS 735.720 to 735.740), 3) Not requiring that employers not offer coverage, only that eligible individual employees be uninsured (see 735.724, application to participate in program; issuance of subsidies; restrictions; employment group health benefit plan enrollment), and 4) Using a benchmark to determine coverage adequacy before assisting enrollees with premium costs (see 735.730, establishment of minimum benefit requirements for plan subsidy).

Oregon's administrative rules for FHIAP speak to each of these design elements in comprehensive detail (FHIAP rule is also included in its entirety in the Appendix). In addition, FHIAP rules also outline the subsidy flows, which are different from Idaho's. In particular, see sections 442-005-0130 (Member Invoicing - Individual Market), 442-005-0140 (Member Payments - Individual Market), 442-005-0150 (Carrier Payments - Individual Market), 442-005-0200 (Vendor Set-up/State Accounting System - Group Market), and 442-005-0220 (Subsidy Payments - Group Market).

Michigan: Access Health

1. Program Description

Access Health was created to help small and mid-size businesses provide health care benefits to low-income employees and their dependents.[6] The Muskegon County Health Project spearheaded the initiative, beginning with surveys of businesses and uninsured individuals to identify the target market and appropriate cost thresholds. Businesses, providers and consumers worked together to develop a basic benefit package. The State of Michigan and Muskegon's two hospitals agreed to allow the use of Disproportionate Share Hospital (DSH) funds to help finance the program, and Muskegon County set up an independent 501(c)(3) corporation to accept DSH community match donations. After a five-year planning process, Access Health was implemented in Muskegon County in 1999.[7] Recently, Access Health has begun an expansion to neighboring Ottawa County. There are also plans to expand into Oceana County in the near future, although there is no set start date.

The Access Health model is unique among the models discussed in this paper because 1) it is a reduced-price benefit plan with a capped premium for participants and employers (rather than a subsidized commercial insurance product); 2) eligibility criteria are based on groups rather than individual characteristics; 3) the public funding source is disproportionate share hospital (DSH) funds voluntarily redirected to the coverage model by the local hospitals; and 4) the program is county-based rather than state-based.

The Access Health benefit plan is predicated on premium affordability for employers and employees and therefore limits both the total amount of the premium and the proportion of that premium paid by the employer and employee participants. Businesses and their employees may participate if the business is located in Muskegon County, has a median wage of $12 or less per hour, and has not offered health benefits in the previous 12 months. There are no individual eligibility criteria. Use of group factors for eligibility makes this model fundamentally different than Medicaid, which uses individual income and other individual characteristics for eligibility determination. Since Access Health is also not a traditional commercial insurance product, there are no percent participation requirements and frequently only a minority of employees in a given group enroll in the program. Access Health has enrolled approximately 525 businesses over the life of the program and has averaged approximately 1,500 enrollees.[8]

Access Health contracts directly with providers. It maintains its own sales staff and also works through local insurance agents who donate their time to identify and enroll eligible businesses and members. Claims and payments are managed through two third-party administrators.[9]

Voluntary DSH funding is an investment in the coverage program by local hospitals, which would otherwise care for more uninsured patients and be exposed to higher levels of bad debt.

[6] http://www.access-health.org/pages/eligibility/
[7] Employee Benefit Research Institute Issue Brief No. 282, June 2005, by Paul Fronstin and Jason Lee (gives a comprehensive history of the creation of the program).
[8] Phone call with Vondie Woodbury 5/16/07.
[9] http://www.cjaonline.net/Communities/MI_Muskegon.htm

2. Program Staff Comments on Access Health[10]

Access Health is considered a success mainly because it still exists, exceeding expectations despite many obstacles. Take-up rates and financial solvency are both credited to foundational work conducted to gather community and stakeholder input into benefit design, price points, and the program framework. Program success is also attributed to positioning the program as a "health co-op" rather than as a traditional insurance product. It is also acknowledged that Muskegon County residents in part-time jobs and in non-profit organizations, in particular, would be largely uninsured in the absence of Access Health.

Examples of challenges encountered by the program are the issue of sole proprietorship eligibility and ensuring the sustainability of the public funding source. When Access Health was first implemented, sole proprietorships flooded the program and are now disallowed in favor of focusing resources on small groups. In terms of public funding, the sustainability of using DSH has been in question throughout the life of the program. On the one hand, confidence about the ongoing use of DSH is high since Access Health is a well known program and the way it uses DSH has been unofficially sanctioned by federal officials as appropriate. On the other hand, there are frequent efforts at the state level to re-direct DSH funds for other uses and Access Health is currently involved in requesting an exemption from the latest statewide DSH plan.

3. Would Access Health Work in Idaho?

Implementation of a state-wide coverage model similar to Muskegon County's Access Health has been proposed in Idaho in the past. In 2001-2002, during the first year of Idaho's federally funded State Planning Grant on the Uninsured[11], Planning Grant leaders considered Muskegon County's model an ideal model for replication in Idaho. At that time, the model was commonly referred to as the "small business model." The model is also sometimes called the "three-share model," referring to the way premium costs are shared by employers, employees, and public funding. This model was never implemented in Idaho on a state-wide basis, though discussions eventually led to the design and implementation of Idaho's Access Card program.

Recently all five counties in the Idaho Department of Health and Welfare Region One have begun planning efforts to implement the Access Health model, and North Idaho has engaged Access Health consultants through Community Health Ventures to assist these efforts. In North Idaho, Region One's Healthy Communities Access Program (HCAP) grant project generated interest in the Muskegon model and a delegation visited Muskegon County several years ago. At present, the project coalition, led by the North Idaho Health Network (NIHN), is midway through a feasibility study to determine whether implementation of a three-share model would be appropriate and beneficial to the Region. In contrast with Muskegon County, NIHN is not pursuing use of DSH funds, but rather is investigating the feasibility of several alternate public funding sources including county indigent dollars. Detailed design of a North Idaho three-share model is pending the completion of the feasibility study and a subsequent plan to gather stakeholder input. Initial design ideas include using a similar average wage to that used in Michigan, extending eligibility to employee groups of two to 20, and excluding sole proprietorships.

[10] Vondie Woodbury, Access Health [title], phone call 5/16/07

[11] The State Planning Grant program is a coverage development and planning program funded by the Health Resources and Services Administration, U.S. Department of Health and Human Services.

The current efforts in North Idaho, if successful, would implement this program in a five-county area. Nevertheless, the Muskegon model is fundamentally a county or community model. If Idaho were to revisit implementation of the Access Health model on a state-wide basis, the state would need to consider making design changes to the original Muskegon model in two major areas: funding/statewideness and product design.

Funding/Statewide Options and Feasibility Considerations

One of the reasons that this model was not implemented state-wide in Idaho in 2001-2002 was that it would have required either commitments from Idaho hospitals to divert DSH or upper payment limit (UPL) funds or identification of other non-Medicaid state funding. It might be possible for the entire State of Idaho to implement the existing model as a state-wide program, although that would require the participation of all 44 Idaho counties, as well as the hospitals in those counties. The state could consider several options for the implementation framework, including: 1) legislate diversion of DSH in all counties to provide public funding in each county; 2) offer assistance to individual counties with model design and implementation as a county option; 3) change the program eligibility to use individual criteria so that the state can use traditional Medicaid funds, thereby avoiding use of those Medicaid funds traditionally routed to hospitals as reimbursement and enabling state-wide, non-county-based implementation.

Feasibility issues involved in each of these approaches include, but are not limited to, the following:

> **Option 1**: Mandating county and hospital participation would require significant county and hospital buy-in and/or significant legislative support. Replicating a coverage model 44 times in 44 counties may require significant communications and design efforts.
>
> **Option 2**: Encouraging optional county participation would present fewer legislative challenges, but would be unlikely to result in significant implementation or enrollment. A county option program could consider county-based DSH or county indigent funds as possible funding sources. If some amount of indigent fund expenditure is diverted to a coverage program, this new spending could theoretically offset the need for the current level of incident-based care. Obtaining the necessary county buy-in would be challenging due to the counties' current budget pressures. There has been support for using this funding mechanism on a very limited basis among a small group of counties in the past. These counties also discussed the possibility of obtaining federal Medicaid match for the new coverage/preventive care, although this would present an additional challenge.
>
> **Option 3**: If the state is more interested in a state-wide program than a county-based program for reasons of efficiency of scale, then use of individual eligibility criteria and state-wide funding may be more desirable than group eligibility factors and county-based funding. Changes to the Muskegon model on this level may mean that a different state's premium assistance model would provide a better basis for design. For example, New Mexico has a state-wide three-share model that supports employer-sponsored insurance but relies on individual eligibility criteria and reduced-price insurance plans offered by the state's managed care organizations.

Product Design Options and Feasibility Considerations

In terms of the insurance product used in the model, the state could consider two options: 1) commissioning the design of a new commercial insurance product; or 2) changing the model so that it uses existing commercial products.

Feasibility issues involved in each of these approaches include, but are not limited to, the following:

> **Option 1**: If the state prefers to use the existing Muskegon County model as its program design basis (or potentially a New Mexico–like model if Idaho prefers to look at options for state-wide implementation), it would need to solicit a new, dedicated health plan with a limited premium (and therefore limited benefits). This approach would not only serve to limit the premium shares paid by employer and employee, but would also control the public share and would therefore facilitate public budgeting. This approach would also potentially remove the uncertainty, time investment, and labor costs involved in making group (or individual) purchase decisions in the open market. Based on the experience in Muskegon County, stakeholder input into this design is an important indicator of success.
>
> **Option 2**: Alternatively, Idaho could forego the creation of a new commercial insurance product. If, as in Muskegon County, the state seeks to limit the premium amounts paid by employers and employees for reasons of affordability, using existing commercial products would require greater amounts of public funding per premium paid, as well as more flexibility in public budgeting. If the state prefers not to limit the amounts paid by enrollees, then the resulting approach would be similar to Idaho's Access Card program in that it would rely on current employer-sponsored commercial coverage and their attending costs. This type of implementation might make public budgeting easier but is likely to result in very low take-up, similar to the Access Card experience.

Other Design Considerations and Potential Challenges

If Idaho were to implement a model similar to Access Health, the most important issue to consider is whether the state should somehow support implementation on a county basis or whether design changes should be made to facilitate state-wide implementation. In addition, regardless of the scale of implementation, project leaders would need to decide whether to open the model to sole proprietorships, which can cause adverse selection and funding issues, and whether to offer any coverage options for employed individuals whose employers do not offer coverage through the model or through traditional insurance. Experience with the Idaho Access Card has shown that reliance on employers' coverage decisions can either cover entire groups at a time but perhaps more often leaves entire groups uncovered if employers are not willing to participate. Limiting the employer share of the premium may increase employers' willingness to cover their employees, but would not guarantee employee access to the program.

4. Subsidy Modeling

As discussed with the State of Idaho, the unique nature of a three-share model did not fit with the consistent subsidy modeling framework developed for the other premium assistance programs. While the full subsidy modeling was excluded, summarized analysis as reported by the Region One team can be found in the Subsidy Modeling Summary section above.

5. Operational Modeling

As with Maine and Illinois, The researcher's access to detailed information regarding the administrative activities conducted to support the Michigan program was relatively limited. However, in our interview with Michigan personnel, we did obtain some staffing information that could be used to estimate staffing needs for implementation of the Michigan program in Idaho. Note, however, that these estimates are based solely on Michigan's stated estimate of staffing needs, rather than a true understanding of the administrative activities performed in Michigan. For the purpose of modeling staffing needs, we estimated Idaho enrollment in the Michigan program assuming linear growth over the five years, without adjustment for differences between the Michigan population and the Idaho population.

Staffing

Based on the limited information gathered during our informational interview with Michigan, we developed the following assumptions regarding staffing levels for the program.

Michigan Premium Assistance Program Staffing Workload Assumptions	
Function	**Staffing Assumption**
Director	Assumed 1.00 FTE. Provides oversight, advises on policy decisions, advocates for the program, provides legislative testimony, etc.
Member Services Representative	Assumed 1.00 FTE. Handles inquiries from participants of the program.
Sales Representative	Assumed 1.00 FTE. Conducts marketing and outreach activities to increase the number of employers participating in the program.
Data Analyst	Assumed 1.00 FTE. Performs data analysis, assists with ad-hoc reporting.
Office Manager	Assumed 1.00 FTE. Performs administrative support tasks, filing, answers the telephone, etc.
Claim Processor	Assumed 1.00 FTE per 600 members. Processes claims.

Using these assumptions we estimated the staffing for implementation of the Michigan program in Idaho. Year-end staffing estimates for each position are shown in the table below.

State of Michigan Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	1.00	1.00	1.00	1.00	1.00
Member Services Representative	1.00	1.00	1.00	1.00	1.00
Sales Representative	1.00	1.00	1.00	1.00	1.00
Data Analyst	1.00	1.00	1.00	1.00	1.00
Office Manager	1.00	1.00	1.00	1.00	1.00
Claim Processor	1.00	1.00	2.00	2.00	2.00
Total Staffing	**6.00**	**6.00**	**7.00**	**7.00**	**7.00**

The staffing estimates shown in the table above represent the application of current staffing for the Michigan program adjusted for projected membership if implemented in Idaho. Note that the

Michigan program also offers a disease management program. For the purpose of this illustration, we excluded this functionality from the staffing estimate, as we believe it is unrelated to the core premium assistance program.

Administrative Cost

Using the same administrative cost build-up methodology as described in previous paragraphs, we estimated the annual administrative costs associated with this program. These values are shown in the table below.

State of Michigan Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 258,440	$ 266,193	$ 290,729	$ 316,497	$ 325,992
Benefit Cost	$ 93,038	$ 95,830	$ 104,662	$ 113,939	$ 117,357
Other Variable Cost	$ 258,440	$ 266,193	$ 290,729	$ 316,497	$ 325,992
Total Cost	**$ 609,918**	**$ 628,216**	**$ 686,121**	**$ 746,934**	**$ 769,342**

The cost estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section.

Start-up Cost

As stated in previous sections of this report, implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. For implementation of the Michigan model in Idaho, we would anticipate a need for infrastructure costs ranging from $20,000 to $40,000. This estimate assumes acquisition of computer terminals, a photocopier and facsimile machine, furniture, and a network printer to support the operation. Additional investment will be needed as additional personnel are added to support growth in the program.

Given the low projected enrollment for implementation of the Michigan program in Idaho, we recommend minimal investment in information systems capabilities. It may be appropriate to develop a database for tracking enrollment information and reimbursement transactions; however, we do not anticipate that additional development work would be cost effective. We would expect that a database could be developed by a vendor for less than $10,000, or for little cost using existing state information technology resources.

Marketing and outreach is the final component of the implementation cost. The cost estimate for marketing is highly dependent on the marketing strategy and intensity employed by Idaho. Unlike other state programs, however, Michigan markets mainly to employers, rather than eligibles. The Sales Representative is responsible for conducting marketing and outreach activities to increase program awareness within the employer community. An effective marketing and outreach strategy would include face-to-face visits with employers, direct mail, and participation in employer trade shows and other formal meetings. We estimate the additional cost for the marketing/outreach program to be $25,000 to $40,000 for the first year.

6. Process Recommendations

6.1 State Statute

Muskegon County's Access Health program (and now Ottawa County's similar program) is a county option and there is no state statute or rule authorizing or governing the program.[12] If Idaho chose to pursue implementation of a similar program on a state-wide basis, it would have several basic options (see the discussion of "fit"; options are listed here with additional comment on probable statute requirements).

Option 1: Mandating county and hospital participation would require significant county and hospital buy-in and/or significant legislative support. Regardless of whether Idaho implemented such a mandatory county program as a replacement for the Access Card or a supplement to it, the program would need significant new statute to ensure consistency among counties. At a minimum, use and flow of disproportionate share (DSH) funds and the basic program outline, including eligibility and benefits, would need to be described in the statute. Any mandatory use of indigent funds for a new coverage program would also require new statute language.

Option 2: Encouraging optional county participation would require less statute modification, but would be unlikely to result in significant county participation. A legislative resolution supporting use of DSH for indigent funds for the new coverage program on a county-by-county basis would be a minimum level of legislative direction.

Option 3: If Idaho is more interested in a state-wide program than a county-based program for economies of scale, then the use of individual eligibility criteria and state-wide funding may be more desirable than group eligibility factors and county-based funding. Changes to the Muskegon model on this level may mean that a different state's premium assistance model would provide a better basis for design. Regardless of the method of designing and procuring authority for such a program, Idaho would need significant new statute language (and corresponding administrative rule) that would potentially be created in the absence of available model language.

[12] Verified by Access Health administrator in a phone call, April 19, 2007.

Utah: Utah's Premium Partnership for Health Insurance (UPP)

1. Program Description

Utah has implemented a new premium assistance program called Utah's Premium Partnership for Health Insurance[13] (UPP) which, in November 2006, replaced an existing premium assistance program called Covered at Work. Covered at Work was the premium assistance component of Utah's Primary Care Network; it experienced extremely low take-up, largely attributed to the modest premium subsidy amount of $50 per person per month. UPP participants receive assistance in the amount of $150 per employee per month and $100 per child per month. If dental services are covered in the employer-sponsored plan, children may be eligible for an additional $20 per child per month in assistance.

The program is currently capped at an enrollment of 1,000 individuals due to funding capacity; however, the number of enrollees has yet to reach this enrollment cap.[14] Eligible individuals must work in businesses that currently offer health insurance but may not be currently enrolled in that insurance. Eligible individuals may work in a business of any size. There is a 90-day waiting period if an employee drops their insurance. Employers must contribute 50% of the cost of the employee's coverage, but there are no requirements for dependent coverage contribution.

Income eligibility for UPP is based on whether the lowest-cost employer-sponsored insurance option exceeds 5% of the potential participant's income, as well as federal poverty level (FPL) limits of 150% for adults and 200% for children. Eligible children have a choice of enrolling in CHIP, UPP, or switching between the two. Eligible adults may choose between Utah's Primary Care Network program and UPP. However, the timing of enrolling in or switching to UPP from direct public coverage is dependent on employers' open enrollment periods.

2. Program Staff Comments on UPP[15]

UPP was designed to improve on the low subsidy and low take-up of its predecessor program. The amount of the subsidy has been raised and children are now eligible; therefore, the possible total subsidy amount per family is significantly higher. Eligibility levels for coverage programs have not been raised—adult Primary Care Network and CHIP eligibility stayed the same—but now these groups can choose to get support for enrolling in employer-sponsored insurance if that is available to them. (Note: CHIP children are subject to a quarterly premium of $13 or $15, depending on family income.) It was expected that these changes would dramatically increase take-up, but there is no evidence of that happening yet.

Marketing and outreach have been challenges and remain so. It's difficult to find and reach out to those uninsured people who have an offer of employer-sponsored insurance but who are not enrolled. There was enthusiastic support from brokers and other stakeholders about the change from Covered at Work to UPP, but enrollment continues to be slower than expected. Utah employs an outreach worker for UPP, but that person also works on other programs.

[13] http://health.utah.gov/upp/index.htm
[14] Current enrollment is 142 adults and 138 children (UPP manager Heidi Weaver, phone call 5/10/07).
[15] Heidi Weaver, UPP Program Manager, May 10, 2007

The administrative effort of determining premiums as a percent of income in addition to federal income eligibility is not considered to be unduly large. This was a design element of Covered at Work before UPP.

3. Would Utah's Premium Partnership for Health Insurance Work in Idaho?

The similarity of the social and political values held by Utah and Idaho is reflected in the two states' premium assistance programs. Like Idaho's Access Card and Access to Health Insurance programs, Utah's new premium assistance program (and, formerly, Utah's Covered at Work program) limits the subsidy amount to beneficiaries, regardless of the premium amount. In both states, adult premium assistance focuses on enrollment in employer-sponsored coverage. In both states, requirements for employer contribution to employee and dependent premiums are the same, and there are minimal requirements for the coverage provided through employer-sponsored plans. In addition, both states depend heavily on the broker/agent community to stimulate enrollment.

The similarity of several of the major design elements of the two states' programs might mean that the salient question is not whether UPP would "fit" in Idaho, but whether there are aspects of UPP that could or should be incorporated into Idaho's premium assistance programs.

Key differences in program design fall mainly into the areas of subsidy amount and eligibility criteria. These differences include: 1) the larger fixed subsidy amount in Utah; 2) extra subsidies for dental services for children; 3) the fact that eligible adults may work in businesses of any size that already offer employer-sponsored coverage; and 4) slightly different income eligibility criteria.

In terms of subsidy amount differences, Utah's experience with the low take-up of Covered at Work and the state's subsequent decision to raise the subsidy amount available through UPP may highlight an opportunity for Idaho to increase enrollment in its programs. Similarly, Utah's subsidy of $150 for adults is based on decision-making in 2006, and Idaho's subsidy amount is based on the health insurance environment in 2002, when costs were lower. If Idaho is concerned with issues of insurance affordability, then the state may need to update its premium assistance amount for adult coverage. (Although past examination of the adult premium amounts purchased with the assistance of Access to Health Insurance has shown them to be fairly low, which may be partly due to the fact that Access to Health Insurance currently requires employers to start new plans, giving them a strong incentive to purchase limited plans with lower premiums.) Increasing the subsidy amount would be technically simple but would require significant legislative support.

In terms of eligibility criteria, allowing enrollment of uninsured adults who work in businesses that currently offer insurance has garnered some support in Idaho; this program change might entail a marginal enrollment boost if it could extend to those employees in small groups that are eligible but not enrolled. This is not likely to be a large enrollment gain due to carriers' requirements for high percentage enrollment among small groups (leaving relatively few uninsured per group to target with premium assistance). However, if Idaho removed the "currently uninsured" requirement of businesses and included large businesses in its program, as Utah does, it could enroll many more eligible-but-not-insured employees in large groups. These changes would also enable the updated premium assistance program to cover uninsured adults in businesses whose employers have already made time-consuming purchase decisions. This might

provide an improvement on the current necessity of convincing those employers who do not offer insurance to purchase new plans.

Utah's use of the premium-as-percent-of-income eligibility criterion in addition to federal poverty level limits may help the state focus its program dollars where affordability issues are most acute; however, this eligibility element is unlikely to foster enrollment in general and may add significant administrative complexity to eligibility determination.

4. Subsidy Modeling

The Utah Premium Partnership for Health Insurance (UPP) offers premium subsidies to help uninsured low-income workers afford coverage offered by their employers. To be eligible, individuals must meet all of the following income requirements:

- Employee premium contribution of the least expensive health insurance option offered by the employer plan is more than 5% of employee's total household income before taxes.
- Family income must be no more than:
  - 150% of FPL for adults.
  - 200% of FPL for children.

We projected program eligibles, enrollment, and subsidy costs using the following steps, which are detailed in Appendix 3-B:

1. Start with the statewide population in Idaho and in Utah.

2. In each state, estimate the percentage of the population that meets the program eligibility requirements. We used census data to estimate the number of uninsured individuals who were less than age 65 and who met the income thresholds. Of these individuals, we estimated the number who worked for employers offering health care, but were not enrolled. Since the subsidy varies for adults and children, we modeled eligible children and eligible adults separately. Due to limitations in the details on the data, we had to make certain implicit assumptions, such as:

   - Of people who satisfy the FPL limits, the percentage who also satisfy the minimum employee contribution rate requirement (as a percentage of income) is the same in Utah and Idaho.
   - Of the low income uninsured, the percentage of people who have some family connection to an employed person is the same in Utah and Idaho.

3. Based on current enrollee counts in Utah, we calculated an enrollment rate (i.e., enrollees as a percentage of eligibles), and applied that rate to the Idaho eligibles to project enrollment in Idaho. Because the Utah program is relatively new (it replaced a previous program, starting November 2006), we assumed that the enrollment level had not reached maturity. Current enrollment is approximately 280 people. We assumed that Utah enrollment would reach maturity after 5 years, with a total of approximately 3,000 people. This ultimate enrollment level appeared to be somewhat consistent with the program's growth pattern between November 2006 and May 2007.

4. Based on actual per-enrollee subsidy costs in Utah, estimate subsidy costs per enrollee and in total in Idaho. Monthly enrollee benefits are limited to the lesser of their contribution to the employee health plan, or the following limits: $150 per adult, and $100 per child (plus $20 for dental). We were not able to collect information from Utah on actual per-participant subsidy costs. Therefore, we assumed that 60% of the maximum possible monthly benefit would be paid per enrollee. We assumed that 40% of participating children would also utilize the $20 per month dental subsidy, available only to children. Finally, we assumed the subsidy costs per participant would increase with health inflation at an annual rate of 9%.

5. Project enrollees and costs over a 5-year period. We assumed that enrollee growth would be linear. Actual growth patterns will be a function of many variables, including funding limitations, public awareness, competing programs, and outreach.

5. Operational Modeling

Through the interview process and review of publicly available information, we determined that the Utah program is relatively simple and operates in a manner similar to other premium assistance programs described herein. However, with less than 300 participants (adults and children), enrollment in the Utah program is very low.

It is important to consider in the staffing model that Utah delegates responsibility for the eligibility function to the Utah Bureau of Eligibility. This delegation significantly reduces the staff required to operate the program. However, without information on the existing staffing levels or operational efficiency, it is difficult to estimate the staffing or financial impact of the enrollment activity. Assuming approximately 30 minutes processing time per new enrollment application each month, it would be reasonable to assume that a fractional FTE could handle this responsibility; or if decentralized into existing enrollment offices in Idaho, the function could be absorbed by existing staff. Whether or not a 30-minute assumption is reasonable depends on the complexity of the application process when implemented in Idaho, and the use of information systems to support efficient processing of the applications.

Staffing

Using the information provided by Utah personnel and information gathered by the researchers, we developed a staffing model to estimate the required staffing for implementation of the Utah model in Idaho. The assumptions we made regarding each type of position are shown in the table below:

Utah Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Director	Assumed 1.00 FTE to provide general oversight and direction for the program. The program manager will report to this position.
Program Manager	Assumed 1.00 FTE to provide assistance to the director in developing and interpreting program policy and managing day-to-day operational issues.
Marketing/Outreach Coordinator	Assumed 1.0 FTE to provide training for employers and brokers, and outreach to the community and eligible participants.

Utah Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Accounts Payable Clerk	Assumed an average of 2 minutes per reimbursement transaction; plus 30 minutes per case for verification on a rolling six months. Minimum of 1.0 FTE rounded up to nearest 1.0 FTE.

Using these assumptions and the projected enrollment, we estimated year-end staffing by position for five years as shown in the table below.

State of Utah Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	1.00	1.00	1.00	1.00	1.00
Program Manager	1.00	1.00	1.00	1.00	1.00
Marketing/Outreach Coordinator	1.00	1.00	1.00	1.00	1.00
Accounts Payable Clerk	1.00	1.00	1.00	1.00	1.00
Total Staffing	**4.00**	**4.00**	**4.00**	**4.00**	**4.00**

* Does not include eligibility staffing requirement for Bureau of Eligibility Services

The staffing estimates shown in the table above represent the application of current staffing for the Utah program adjusted for projected membership if implemented in Idaho. As previously stated, the Utah program delegates the eligibility and enrollment function to the State Department of Eligibility. We do not have adequate information to estimate the staffing needed to complete this function, although based on a reasonable assumption of 30 minutes per enrollment application, we believe this work can be performed with minimal additional staff.

Administrative Cost

Using the same administrative cost build-up methodology as described in previous paragraphs, we estimated the annual administrative costs associated with this program. These values are shown in the table below.

State of Utah Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 196,560	$ 202,457	$ 208,531	$ 214,786	$ 221,230
Benefit Cost	$ 70,762	$ 72,884	$ 75,071	$ 77,323	$ 79,643
Other Variable Cost	$ 196,560	$ 202,457	$ 208,531	$ 214,786	$ 221,230
Total Cost	**$ 463,882**	**$ 477,798**	**$ 492,132**	**$ 506,896**	**$ 522,103**

* Does not include eligibility function expenses incurred by other state agency.

The cost estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section.

Start-up Cost

As stated in previous sections of this report, implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. For implementation of the Utah model in Idaho, we would anticipate a need for

infrastructure costs ranging from $20,000 to $30,000. This estimate assumes acquisition of computer terminals, a photocopier and facsimile machine, furniture, and a network printer to support the operation. Additional investment will be needed as additional personnel are added to support growth in the program.

Given the low projected enrollment for implementation of the Utah program in Idaho, we recommend minimal investment in information systems capabilities. It may be appropriate to develop a database for tracking enrollment information and reimbursement transactions; however, we do not anticipate that additional development work would be cost effective. We would expect that a database could be developed by a vendor for less than $10,000, or for little cost using existing state information technology resources.

Marketing and outreach is the final component of the implementation cost. The cost estimate for marketing is highly dependent on the marketing strategy and intensity employed by Idaho. Utah focuses its marketing efforts on the employer and broker communities rather than on eligibles. As with Michigan, an effective marketing and outreach strategy would include face-to-face visits with employers, direct mail, and participation in employer trade shows and other formal meetings. We estimate the additional cost for the marketing/outreach program to be $25,000 to $40,000 for the first year.

6. Process Recommendations

6.1 State Statute

As with consideration of Oregon's FHIAP as a source of ideas for possible design changes to Idaho's premium assistance programs, consideration of Utah's UPP is probably of greater utility as a source of ideas for design changes rather than as a model that would serve as a wholesale replacement for the Access Card. Therefore, if Idaho pursued programmatic design changes to make the Access Card more similar to UPP, the existing Access Card statute could be used as a base and could be amended to incorporate UPP-like design elements. However, it must be noted that the Utah statute authorizing UPP is very general and contains very few specifics on program design (see Utah statute in Appendix 4). Rather, the statute gives the Utah Department of Health broad authority to make design changes to encourage enrollment in employer-sponsored insurance, and design specifics are outlined entirely in rule. This represents a much different balance between statute and rule than is the case in Idaho for Access Card design and operational authority.

Utah administrative rule, then, may provide model language for design changes to Idaho's premium assistance programs should Idaho decide to pursue incorporation of UPP-like design elements (see discussion of UPP's "fit"), including: 1) the larger fixed subsidy amount in Utah; 2) extra subsidies for dental services for children; 3) the fact that eligible adults may work in businesses of any size that already offer employer-sponsored coverage; and 4) slightly different income eligibility criteria. Considering the current level of detail in Idaho's premium assistance statute, these changes would likely need to be made to both statute and rule in Idaho, instead of only to rule as in Utah. Utah's recent changes to rule to implement UPP and repeal the previous Covered at Work program are included in their entirety in the Appendix 4; see in particular R414-320-19 (benefits for discussion of subsidy amounts) and R414-320-7 (creditable health coverage).

Maine: DirigoChoice

1. Program Description

DirigoChoice is a health insurance plan commissioned by the State of Maine and carried by Anthem as the centerpiece of a comprehensive, "system-wide" health reform effort called Dirigo.[16,17,18] Maine's Dirigo Health Reform Act was enacted in 2003 in an effort to control heath costs, improve quality, and expand coverage. DirigoChoice is unique among the programs described in this paper both because of its place within Maine's other health system reforms and because it is a special-purpose discounted plan rather than an existing commercial plan that low-income Mainers can buy with individual subsidies. In other words, DirigoChoice is a tiered-price plan rather than a target of cash subsidies granted by the state.

DirigoChoice is also unusual in that it is administered by the Dirigo Health Agency, a new public agency in Maine, and is operated separately from Maine's Medicaid program. The Dirigo Health Agency has purchased a group health insurance plan from Anthem. Participants in DirigoChoice make contributions to the Dirigo Health Agency and are enrolled in the Anthem plan. Maine's Medicaid agency (the Department of Health and Human Services) has also has created its own separate Medicaid contract with Anthem, as well as operating agreements with the Dirigo Health Agency. This means that Anthem provides the coverage for both MaineCare (Maine Medicaid) and DirigoChoice, and that that Medicaid-eligible workers enrolled in DirigoChoice experience relatively seamless transitions between the two programs (Medicaid-eligible enrollees in DirigoChoice pay only the cost-sharing allowed by Medicaid and have wrap-around services provided by Medicaid if not included in the Anthem plan). Maine has Section 1115 waiver authority for the Anthem Medicaid plan but not for DirigoChoice itself.

The chief target populations for DirigoChoice are non-Medicaid-eligible employees in small businesses, the self-employed, individuals without access to employer-sponsored insurance, and the dependents of each group. Enrollees receive discounts on monthly payments and deductibles and out-of-pocket expenses19 based on their income and family size, up to 300% of federal poverty. Employers must pay a minimum of 60% of the single employee-only share of the premium (i.e., employers are not required to cover any premium costs for dependents). The plan is available to employers whether or not they previously offered insurance.

2. Program Staff Comments on DirigoChoice

We attempted to contact the managers of Dirigo and DirigoChoice both with and without assistance from State Coverage Initiatives (Academy Health) program staff. Maine officials did not respond to multiple requests for information.

3. Would DirigoChoice Work in Idaho?

Establishing health reform on the scale of Maine's Dirigo requires an enormous amount of political will. It would certainly be possible to implement a Dirigo-like plan in a small state like Idaho, though Idaho might consider creating its own program elements in order to avoid some of the pitfalls experienced in Maine. For example, there is early evidence that implementing certain aspects of Dirigo have proved to be very problematic for stakeholders, such as the proposed mechanisms meant to capture savings from hospitals and insurance plans and re-direct them to

new coverage. In any case, Dirigo and DirigoChoice are very comprehensive system changes far beyond the scale of Idaho's current premium assistance programs.

Setting aside the larger context of Dirigo, the major distinction between DirigoChoice and Idaho's programs is that DirigoChoice is a special-purpose insurance plan designed and commissioned by the state. The advantage of this approach is that DirigoChoice incorporates certain benefit and pricing/affordability considerations into one comprehensive plan targeted at the uninsured. Instead of increasing coverage among one type of uninsured group (e.g., employees of small businesses), DirigoChoice acts as a de-facto purchasing pool to include several different uninsured populations. This approach helps the state cover uninsured populations that may have been previously difficult to reach, and it also removes a measure of uncertainty in making purchase decisions for employers and individuals.

Creating such a comprehensive product in Idaho seems possible, though the effort would require significant political will, design investment, and long-term commitment. If Idaho were to create a tiered-price plan, it would likely act as a replacement to Idaho's existing premium assistance programs. If, on the other hand, Idaho created a plan similar to DirigoChoice but without its tiered discounts, there might be elements of Idaho's current premium assistance programs that would be sensible to retain. For example, it might make sense to offer Access Card-like targeted subsidies to certain groups that they could use to purchase the new state-commissioned plan. As in Maine, the most difficult element of such an undertaking is likely to be the identification of funding.

4. Subsidy Modeling

DirigoChoice is an insurance plan that low-income individuals can purchase with subsidies from 20%-100%, depending on income. Individuals with FPL level up to 300% are eligible for a subsidy. The subsidy is available both to employees enrolling through their employer plan, as well as those enrolling as individuals.

DirigoChoice has a significant portion of enrollees coming from traditional Medicaid, even though this is not a stated target population. They are also successfully enrolling individuals eligible for other insured plans. Therefore, in modeling this program in Idaho, we assumed all individuals with income less than an FPL of 300% and under the age of 65 to be eligible for the state subsidy.

We projected program eligibles, enrollment, and subsidy costs using the following steps, which are detailed in Appendix 3-C:

1. Start with the statewide population in Idaho and in Maine.

2. In each state, estimate the percentage of the population that meets the program eligibility requirements. We used census data to estimate the number of individuals under age 65 who met the income threshold for subsidy eligibility.

3. Based on current enrollee counts in Maine, we calculated an enrollment rate (i.e., enrollees as a percentage of eligibles), and applied that rate to the Idaho eligibles to project enrollment in Idaho. The Maine program is relatively mature, having been implemented in 2003.

4. The subsidy varies by income level, and depending on whether the insurance is through an employer or purchased on the individual market. We were not able to get data on enrollment distribution in Maine. Therefore, we allocated the number of Idaho enrollees by FPL category based on the distribution of enrollees by FPL and product type in the Oregon model, since the Oregon and Maine programs have similar features in this regard.

5. We estimated the subsidy cost per enrollee. The subsidy is expressed as a percentage of premium, and it varies by income level. For people with employer group insurance, the subsidy percentage applies only to the portion of the premium that is paid by the employee. For people with individual insurance, the subsidy percentage applies to their entire premium. Actual per-person subsidy costs in Maine were not available. Therefore, we estimated the premium rates for group and individual insurance by starting with the rates developed in the Oregon model. We then applied relative cost factors to determine market rates for the different DirigoChoice plans.

6. We projected enrollment and costs over a 5-year period, assuming increases due to inflation and increasing enrollment. Since DirigoChoice has been in existence in Maine since 2003, we assumed Idaho would reach Maine's current enrollment rate in four years. Our enrollment projection assumes linear growth. For the subsidy costs, we assumed an annual health cost inflation rate of 9%. Actual growth patterns will be a function of many variables, including funding limitations, public awareness, competing programs and outreach.

5. Operational Modeling

As previously stated, the researchers were unable to conduct interviews with personnel regarding the Maine DirigoChoice program. As such, it was necessary to estimate staffing needs based on assumptions and information obtained through public sources such as the program website. In developing the staffing assumptions for implementation of this program in Idaho we made the following assumptions:

1. Employers will contact their insurance agent or carrier to register as a participating employer.
2. Employees will enroll in the program through their employer.
3. The employer will inform the insurance carrier of their participants.
4. Employers will deduct the premium amount from the employee's payroll check.
5. Insurance carrier will notify the Agency of enrollment.
6. Agency will establish an account for each enrollee and deposit the reimbursement in that account.

We developed the staffing and cost estimates described below based on the assumptions above.

Staffing

Based on our understanding of the Maine DirigoChoice program, it appears that the insurance carrier (currently Anthem) is responsible for most of the administrative activities related to this program, such as the labor intensive eligibility/enrollment function. Nonetheless, the State would likely be responsible for auditing or verifying the determinations made by Anthem to ensure that they are consistent with regulatory requirements. In developing our staffing model

for implementation of this program in Idaho, we assumed that the State would be responsible for the following activities:

- Program management, including audit of the carrier, and policy development;
- Outreach and marketing; and
- Processing reimbursements.

The assumptions we used to estimate required staffing levels for each of these functions are shown in the table below.

Maine Premium Assistance Program Staffing Workload Assumptions	
Function	**Staffing Assumption**
Director	Assumed 1.00 FTEs to provide oversight, advise on policy decisions, advocate for the program, provide legislative testimony, etc.
Program Manager	Assumed 1.00 FTE to manage the carrier(s), supervise and manage staff, interface with employers, attend industry meetings, etc.
Marketing/Outreach Coordinator	Assumed 1.00 FTEs to provide outreach and marketing to employers, brokers, and eligible participants.
Accounts Payable Clerk	Assumed 2 minutes per reimbursement transaction, and one transaction per participant per month. Minimum staffing of 1.0 FTE; estimate rounded up to nearest 1.0 FTE.

Using these assumptions we estimated the staffing for implementation of the Maine program in Idaho. Year-end staffing estimates for each position are shown in the table below.

State of Maine Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	1.00	1.00	1.00	1.00	1.00
Program Manager	1.00	1.00	1.00	1.00	1.00
Marketing/Outreach Coordinator	1.00	1.00	1.00	1.00	1.00
Accounts Payable Clerk	1.00	2.00	3.00	4.00	5.00
Total Staffing	**4.00**	**5.00**	**6.00**	**7.00**	**8.00**

The staffing estimates shown in the table above represent the application of current staffing for the Maine program adjusted for projected membership if implemented in Idaho. As previously stated, the Maine program delegates many functions to the insurance carrier and the employer. The major responsibility of the agency is to provide oversight and management of the program and verification of reimbursement payments. Within this context, overall staffing levels should be very low for this program.

Administrative Cost

Using the same administrative cost build-up methodology as described in previous paragraphs, we estimated the annual administrative costs associated with this program. These values are shown in the table below.

State of Maine Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 196,560	$ 237,806	$ 281,351	$ 327,294	$ 372,521
Benefit Cost	$ 70,762	$ 85,610	$ 101,286	$ 117,826	$ 134,108
Other Variable Cost	$ 196,560	$ 237,806	$ 281,351	$ 327,294	$ 372,521
Total Cost	**$ 463,882**	**$ 561,223**	**$ 663,988**	**$ 772,413**	**$ 879,149**

The cost estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section.

Start-up Cost

As stated in previous sections of this report, implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. For implementation of the Maine_model in Idaho, we would anticipate a need for infrastructure costs ranging from $20,000 to $30,000. This estimate assumes acquisition of computer terminals, a photocopier and facsimile machine, furniture, and a network printer to support the operation. Additional investment will be needed as additional personnel are added to support growth in the program.

For information systems and marketing/outreach we would expect the start-up costs of implementation of a program similar to the DirigoChoice program to be very limited. We would anticipate that the carrier would bear most of the initial marketing and outreach costs. There may be some start-up costs associated with development of an information system to track enrollment and financial transaction data, however we anticipate this cost to be higher.

6. Process Recommendations

6.1 State Statute

Maine's system-wide health reform, Dirigo, and the subsidized health plan that is a part of it, DirigoChoice, are complex, highly designed programs, and authorizing statute reflects that complexity. The Appendix includes only those sections of the Dirigo statute related to DirigoChoice. These sections outline the income eligibility limit for DirigoChoice and the broad framework for the subsidized health plan subject to discounted premiums for those eligible for DirigoChoice.

Because Dirigo and DirigoChoice are such unique programs and because they are arguably products of Maine's unique health care market, regulatory environment, and state culture, the statute related to Dirigo may be more useful as information that clarifies program design than as a source of model statute language for Idaho. If Idaho decided to emulate Maine by creating one subcontracted, privately sourced health insurance plan to serve individuals and employees up to 300% of poverty, with tiered pricing depending on employer contributions and individual income (as well as potentially using this plan design as the benefit package for Idaho Medicaid participants to create a seamless boundary between Medicaid and subsidized commercial insurance), then Idaho would likely create authorizing statute for these programs entirely from scratch in order to ensure appropriateness of design and stakeholder buy-in. This program and

any authorizing Idaho statute, depending on design, would probably serve as replacements for the existing Idaho premium assistance programs and related statute.

Illinois: FamilyCare/All Kids Rebate

1. Program Description

Illinois operated a children-only premium assistance program called KidCare Rebate[16] on a state-only basis (i.e., without federal financial participation) until 2002. The state then obtained authority under a Health Insurance Flexibility and Accountability (HIFA) waiver to incorporate KidCare Rebate into the state's Medicaid program and to establish a program component for parents of eligible children. More recently, all of Illinois' programs for children, including the KidCare Rebate, have been incorporated into a new comprehensive program for children called All Kids. The rebate program has subsequently been renamed the All Kids Rebate; the adult premium assistance remains the "FamilyCare Rebate."

Low-income families with private health insurance may qualify for the FamilyCare/All Kids Rebate programs. Eligible individuals may use the Rebate to purchase employer-sponsored insurance in businesses of any size, or individual plans.[17] Eligible employees may work in businesses in which insurance is already offered and eligible individuals may already be covered with private insurance.[18] Illinois uses Title XXI funds for Rebate participants other than those who are already insured; currently insured individuals are covered with Title XIX funds.

Families that are eligible for both the premium assistance and direct coverage programs (i.e., children with family incomes between 133% and 200% of FPL and adults between 133% and 185% of FPL) may choose which program they would prefer to use; this element of program design is called "informed choice." These premium assistance programs provide a capped monthly subsidy of up to $75 per person. Insurance plans purchased with the aid of these programs must cover physician and inpatient hospital services, but there is no specific coverage benchmark because participants have "informed choice" between premium assistance and direct coverage.[19] There is also no required level of employer contribution. Families are responsible for premium costs after the subsidy and for all other cost-sharing.

2. Program Staff Comments on the FamilyCare/All Kids Rebate[20]

The Rebate programs are generally considered to be successful because they are simple in design. Important elements of this simplicity include the lack of benefit benchmark, the lack of employer contribution requirement, direct payments to employees/participants so the program is not considered to be burdensome to employers, and a one-page Rebate application.

In addition, current enrollment is considered satisfactory (approximately 6,200 individuals, 1,000 of whom are parents); there were no stated take-up expectations that are not being met. The existing take-up is attributed primarily to the fact that the majority of Rebate participants are already insured and the program does not depend on new purchase decisions.

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[16] http://www.allkidscovered.com/choice.html#rebate

[17] Individual plans do not comprise a large proportion of the plans purchased with the Rebate (Matt Warner and Lynn Thomas, Illinois Department of Health and Family Services, phone call 5/17/07.)

[18] The majority of Rebate participants already have insurance at the time of application (ibid.).

[19] Illinois' and Idaho's programs both make use of informed choice, but in Idaho only child participants have a choice between premium assistance and direct coverage, whereas in Illinois adults eligible for the Rebate also have the option of FamilyCare.

[20] Matt Warner and Lynn Thomas, Illinois Department of Health and Family Services, phone call 5/17/07

3. Would the FamilyCare/All Kids Rebate Work in Idaho?

Illinois' premium assistance program provided considerable design inspiration for Idaho's Access Card and Access to Health Insurance programs. The two states' programs are similar in that they both are built on the concept of beneficiaries having informed choice between premium assistance and direct coverage (Medicaid). This design element enables both states to avoid making detailed requirements of the coverage purchased with public assistance (i.e., there is no actuarial "benchmark" for coverage purchased through premium assistance), since eligible children always have the option of switching from premium assistance to comprehensive direct coverage. In addition, both states limit premium subsidy amounts to beneficiaries, neither state subsidizes employers' premium costs, and in both states, adults with incomes up to 185% of poverty are eligible.

The fundamental likeness between premium assistance programs in Illinois and Idaho means that Illinois' programs would be fairly compatible with Idaho's policy environment. In fact, Idaho Medicaid has been endeavoring to change an element of its premium assistance program that would make it even more like the Illinois program: Illinois allows currently insured families to enroll in premium assistance (the state uses Title XIX funds to pay for these enrollees) instead of only those who have no insurance. There is some state-based support for this change in Idaho but obtaining federal approval has been a challenge.

There are additional elements of Illinois' premium assistance program that Idaho has not yet seriously considered but which could be incorporated into Idaho's programs as program expansions. These include: 1) raising the income limit for children's eligibility to 200% of poverty; and 2) allowing adult beneficiaries to use premium assistance within employer groups of any size or individual plans instead of only in small businesses. Although using premium assistance to encourage small businesses coverage is a valid goal, there may be many low-income workers in large businesses who cannot afford their share of employer-sponsored premiums and who might become covered with the aid of premium assistance.

Finally, there are also elements of the FamilyCare/All Kids Rebate that Idaho could consider adopting in order to limit or shrink the Access Card and Access to Health Insurance programs, including: 1) limiting adult eligibility to parents of eligible children; 2) lowering the beneficiary subsidy from $100 to $75 per person per month; and 3) removing the requirement that employers contribute to premiums.

4. Subsidy Modeling

The FamilyCare/All Kids Rebate pays a monthly subsidy of up to $75 per person for eligible parents and children who enroll in individual or employer insurance plans. A person does not have to be previously uninsured to enroll in the rebate program. To be eligible, individuals must have income levels meeting the following requirements:

- 133-185% of FPL for adults.
- 133-200% of FPL for children.

We projected program eligibles, enrollment, and subsidy costs using the following steps, which are detailed in Appendix 3-D:

1. Start with the statewide population in Idaho and in Illinois.

2. In each state, estimate the percentage of the population that meets the program eligibility requirements. We used census data to estimate the number of uninsured people who were less than age 65 and who met the income thresholds. Of these individuals, we estimated the number who worked for employers offering health care. We recognized that people who purchase individual insurance will also be eligible. We are implicitly assuming that the ratio of eligible people who do not have employer coverage to total eligible people is the same in Illinois and Idaho.

3. Based on current enrollee counts in Illinois, we calculated an enrollment rate (i.e., enrollees as a percentage of eligibles), and applied that rate to the Idaho eligibles to project enrollment in Idaho. Because the Illinois program has operated since 2002, we assumed that its enrollment had reached a mature level. Current enrollment is approximately 6,300 people. We assumed that Idaho enrollment would reach maturity after 5 years.

4. Based on actual per-enrollee subsidy costs in Illinois, we estimated subsidy costs per enrollee and in total in Idaho. Monthly enrollee benefits are limited to the lesser of their contribution to the employee health plan, or $75 per person. We were not able to collect information from Illinois on actual per-participant subsidy costs. Therefore, we assumed that 90% of the maximum possible monthly benefit would be paid per enrollee. We assumed that the average subsidy paid per person would increase with health care at an annual rate of 9%, but would never exceed $75.

5. Project enrollees and costs over a 5-year period. We assumed that enrollee growth would be linear. Actual growth patterns will be a function of many variables, including funding limitations, public awareness, competing programs, and outreach.

5. Operational Modeling

In developing the staffing estimate for the Illinois FamilyCare/AllKids Rebate program, we relied heavily on assumptions and information available from public sources. Our interviews with program personnel revealed that Illinois has delegated responsibility for most administrative activities required to support this program to other state agencies and departments. There is no single stand-alone department serving this program; and therefore program personnel were unable to estimate the number of FTEs currently serving the program or the current administrative costs incurred by the program.

Staffing

Due to the lack of available information regarding current staffing levels to support the Illinois program, the researchers relied on various assumptions regarding the functions to be performed, the complexity of those functions, and the labor resources required to perform the associated tasks. Based on our understanding of the Illinois program, the major functions conducted in support of the program are:

- Program management and policy development;
- Outreach and marketing;
- Initial review of applications for eligibility;

- Processing of reimbursement request forms and evidence;
- Reimbursement check production; and
- Ongoing verification of participant eligibility.

In addition to these major functions, we assumed a minimal level of oversight would be necessary to support the program. The assumptions we used to estimate required staffing levels for each of these functions are shown in the table below.

Illinois Premium Assistance Program Staffing Workload Assumptions	
Function	**Staffing Assumption**
Director	Assumed 0.25 FTEs to provide oversight, advise on policy decisions, and advocate for the program, etc.
Marketing/Outreach Coordinator	Assumed 1.00 FTE to provide outreach and marketing to employers, brokers, and eligible participants.
Enrollment Specialist	Assumed an average of 10 minutes per new application; plus 30 minutes per case for verification on a rolling 6-month basis.
Accounts Payable Clerk	Assumed an average of 2 minutes per check for accounts payable processing, and 1 check per participant per month.
Reimbursement Verification Clerk	Assumed an average of 10 minutes per reimbursement request to process the form, review the evidence, and follow-up if necessary

Based on these assumptions, and the enrollment projections provided above, we calculated the total staffing in FTEs. Note that staffing estimates were calculated on a monthly basis to take into account the growth of the program over time. Year-end staffing levels by position are shown in the table below.

State of Illinois Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	0.25	0.25	0.25	0.25	0.25
Marketing/Outreach Coordinator	1.00	1.00	1.00	1.00	1.00
Enrollment Specialist	0.06	0.06	0.06	0.06	0.06
Accounts Payable Clerk	0.04	0.07	0.10	0.14	0.17
Reimbursement Verification Clerk	0.17	0.35	0.52	0.69	0.87
Total Staffing	**1.52**	**1.73**	**1.93**	**2.15**	**2.35**

* Represents only marginal staffing requirements. Assumes that workload is distributed among existing state agencies/departments.

In developing the staffing estimates for implementation of the Illinois program in Idaho, we assumed a similar decentralized model, whereby all functions are delegated to other departments/units within state government, and that no stand-alone unit is created to support this program. The staffing estimates provided in the table above and the cost estimates provided in the table below illustrate only the marginal "workload driven" requirements. This is an important distinction, as the other models developed for this report reflect full-time staff dedication to the premium assistance program except where noted.

Given the relatively small enrollment anticipated for the Illinois program, it is highly likely that existing personnel in other State agencies could accommodate the additional work generated by

the program. It would be reasonable that the oversight and advocacy responsibilities could be performed by an existing director within the Medicaid program or other department. We believe that one additional FTE would be needed to provide the marketing/outreach function. For purposes of management and supervision, that FTE could be located in the same department/agency as the director. The remaining functions (enrollment verification, accounts payable, and reimbursement verification) are transaction based, and could likely be absorbed in other state agencies/departments.

Administrative Cost

Using the staffing estimates developed as described in the previous section, we estimated the fully-loaded administrative costs for implementation of this program in the State. Again, we used a traditional cost build-up methodology, first calculating salary costs, and then adding benefits/taxes, and variable costs both as a percentage of salary.

To estimate wage costs, we used wage data from the Bureau of Labor Statistics, and various state and commercial job postings. We selected wage rates for positions we determined to be similar to those required for performance of the administrative functions. Note that the wage rates used herein are not adjusted to reflect wage rates in Boise, Idaho, and in some cases are based on wage rates from the commercial environment rather than the state government environment. A formal position grading and wage determination activity would be necessary to determine the actual wage rates that could be achieved for this program. Nonetheless, we believe the methodology used herein is reasonable for the purposes of comparisons among programs.

We calculated total wage cost by month by multiplying the estimated number of hours required for each administrative function by the appropriate hourly wage rate. We then added estimated benefits and taxes as a percentage of wages using a factor of 0.36. We chose this factor based on our experience with other organizations. Note that the employee benefits/tax load for state employees in Idaho may be different. Finally, we added estimated variable costs using a factor. We assumed a variable cost factor of 1.00 times wage cost. Again, actual variable costs for State government operations in Idaho may be different.

A summary of the estimated five-year administrative cost associated with the Illinois model in Idaho is shown in the table below.

State of Illinois Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 62,762	$ 72,465	$ 82,153	$ 92,368	$ 103,093
Benefit Cost	$ 22,594	$ 26,087	$ 29,575	$ 33,252	$ 37,113
Other Variable Cost	$ 62,762	$ 72,465	$ 82,153	$ 92,368	$ 103,093
Total Cost	**$ 148,119**	**$ 171,017**	**$ 193,880**	**$ 217,988**	**$ 243,299**

* Represents only marginal costs. Assumes that workload is distributed among existing state agencies/departments.

Note that the costs estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section.

Start-up Cost

Implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. In the case of the Illinois model, we would anticipate that infrastructure acquisition would be minimal because no additional hiring is expected (except for the Marketing/Outreach Specialist). It may be possible to obtain idle assets (i.e., furniture, computer equipment, etc.) for use by this FTE, from other agencies. If not, we would not expect infrastructure acquisition for this position to exceed $5,000, assuming that access to shared infrastructure (i.e., photocopier, facsimile, network printer, etc.) could be arranged.

Given the low projected enrollment for implementation of the Illinois program in Idaho, we recommend minimal investment in information systems capabilities. It may be appropriate to develop some rudimentary database for tracking enrollment information and reimbursement transactions; however, we do not anticipate that additional development work would be cost effective. We would expect that a database could be developed by a vendor for less than $10,000, or for little cost using existing state information technology resources.

We anticipate that the most significant start-up cost associated with implementation of the Illinois program would be related to initial marketing and outreach activities. The start-up costs of such a program will, of course, be dependent on the intensity of the marketing effort. We would expect the state to undertake an initial and ongoing direct mail effort aimed at eligible beneficiaries, as well as a focused effort to recruit employers and brokers for participation. Start-up costs would include development of print materials (i.e., a brochure, stationary, etc.), and postage. Additional costs for marketing/outreach to brokers and employers could include development of an employer brochure, mailings to employers, participation in employer fairs, and/or other activities. The costs of these activities will be dependent on the intensity of the activities ultimately undertaken by the state.

6. Process Recommendations

6.1 State Statute

Illinois statute and rule related to the Rebate programs are included in the Appendix in their entirety. Like the premium assistance programs in Oregon and Utah, Illinois' Rebate programs are similar enough to Idaho's Access Card programs that the Rebate and related statute and rule language might serve as example language for relatively contained amendments to existing Idaho premium assistance statute. However, most of the differences between Idaho's and Illinois' premium assistance programs are simple enough that model language may not be necessary if Idaho decides to emulate certain elements of Illinois' program; rather, it might be easier to draft original language for amendments in the context of existing Idaho statute.

Paragraph 25 (of section 106 (Children's Health Insurance Program Act) of Chapter 215 (Insurance) of Illinois code) in particular discusses premium assistance, explicitly prohibits the use of a coverage benchmark, and directs the Department of Health and Family Services to set a premium subsidy amount (as in Oregon, Utah, and Maine statute, a dollar figure for the subsidy is not listed in code and setting the amount is an authorized administrative decision). In contrast with Idaho, Illinois also describes other design specifics in rule rather than statute, such as family income guidelines for eligible children and parents (see 215 ILCS 106/20 and related rule text).

Pennsylvania: Health Insurance Premium Payment (HIPP) Program

1. Program Description

Pennsylvania's Health Insurance Premium Payment Program (HIPP) is widely considered the most successful implementation of HIPP. This Medicaid savings initiative was established in federal Medicaid statute in 1990 and implemented in Pennsylvania in 1994 (a 1997 amendment to federal law made the program voluntary, in response to the failure of many states to implement it). HIPP pays the worker's share of the premium for those eligible for Medicaid with access to employer-sponsored health coverage when the employer coverage is demonstrated to be more cost-effective than Medicaid. Enrollment in HIPP is mandatory if it is shown to be cost-effective. Pennsylvania attributes tens of millions of dollars (2003 savings: $76.3 million) in annual Medicaid savings to its HIPP program.

Outreach programs, employer referrals, and targeted questions on Pennsylvania's application for medical assistance all help to identify potential HIPP enrollees. The Department of Public Welfare collects most information directly from employers, so that potential HIPP enrollees do not have to submit employment information to the state.[21] An automated referral system sends a notice to Medicaid participants who obtain employment and who may be eligible for HIPP, although the system does not distinguish in advance between employment with or without an offer of insurance.[22] Automated systems also determine the cost-effectiveness of using Medicaid funds to pay the premiums of employer-sponsored insurance. If an employer offers more than one type of plan and more than one plan is shown to be cost-effective for Medicaid by at least $1, then the employee/HIPP participant may choose among the cost-effective plans.

Coverage is comprehensive because Medicaid wraps around coverage purchased through HIPP. Further, HIPP covers the payment of employee premium contributions, benefit co-payments and deductibles. In most cases, the state sends payments for the employee's portion of the premium to the employer and the employer agrees not to take the employee portion out of the employee's paycheck. If this is not possible, the state's second-choice subsidy flow is to send payment to the employee in care of the employer. The state's third choice is to send the payment directly to the employee.

2. Program Staff Comments on HIPP[23]

Consistent with the literature on Pennsylvania's HIPP program, program managers attribute the success of the program to its high degree of automation, including both the automated referral process and the automated cost-effectiveness determination. Communication and partnerships with Pennsylvania employers are also cited as important factors in the program's success. The HIPP program makes an effort to be accommodating to employers since the program relies on their participation. For example, HIPP has approximately 700 participants who work at Wal-Mart and HIPP managers work separately with individual store branches so that no one location is required to bear the entire administrative burden for all 700 employees' participation.

[21] http://www.cmwf.org/tools/tools_show.htm?doc_id=235063
[22] Darin Morrill, Manager, Policy Unit, HIPP, phone call 5/16/07.
[23] Ibid.

Because partnerships with employers are important for HIPP operations, outreach and marketing are important programmatic functions. However, there is room for improvement in outreach efforts; for example, in outreach to new employers.

The stated priority of the HIPP program is to save Medicaid funds, but the state attributes possible marginal coverage increases to the program as well. Coverage through HIPP may be desirable in mandatory managed care counties, because all HIPP participants automatically have fee-for-service care. It may also be possible for employees to place dependents on their coverage without increasing premiums, in which case HIPP actually funds coverage of dependents as well, although this is not likely to be a large effect.

3. Would Pennsylvania's Health Insurance Premium Payment (HIPP) Program Work in Idaho?

Implementing a HIPP program in Idaho on the scale of the Pennsylvania program would be a significant shift in policy because Idaho's main premium assistance programs have had a very different focus. HIPP is a fundamentally different approach to premium assistance than Idaho's Access Card and Access to Health Insurance programs in that achieving cost savings is the primary goal and expanding coverage is a distant second. HIPP may assist in maintaining continuity of coverage (or help the state to avoid re-enrollment problems) if participants prefer private-sector coverage to Medicaid; HIPP may also indirectly bolster private coverage by helping employers meet percent-participation requirements for their employee groups, thereby maintaining the coverage of entire groups. However, evidence of these dynamics in Pennsylvania seems to be anecdotal.

Whether HIPP should be implemented on a large scale in Idaho depends on the state's goals. Because HIPP is so different from Idaho's current premium assistance program, Idaho could consider a Pennsylvania-like implementation of HIPP as one option and replacing the Access Card with HIPP as a second option. There are not many aspects of Pennsylvania's HIPP that could easily be added to Idaho's Access Card program without making major changes. Consideration of HIPP in Idaho should probably be conducted in the context of a savings initiative rather than an expansion of coverage.

Implementing HIPP on a large scale in Idaho in order to achieve cost goals would require significant investment in both information technology and staff. States' reluctance to implement HIPP programs has been largely due to the view that cost-effectiveness analysis for each individual enrollee is a prohibitively resource-intensive undertaking. However, Pennsylvania has made the necessary resource investments, and attributes much of the success of its programs to its excellent software and information systems as well as to regionally distributed staff that conduct outreach to participants and employers. These investments are possible in Idaho, but they would present challenges given the state's existing information technology investment plans and the potential difficulty of major staff requests.

Using HIPP as a replacement for the current Access Card program would entail the same investment challenges and would also present a realignment of savings versus expansion goals. HIPP does have a potential advantage over the current format of the Access Card program in that it would be available to children eligible for Title XIX in addition to children eligible for Title XXI. HIPP might offer another advantage to the current Access Card population in that it wraps Medicaid services around private coverage, and it also pays the entire participant premium.

However, the wrap-around element is somewhat contrary to the philosophy behind informed choice between premium assistance and direct coverage, and child premiums tend to be low enough that the current premium assistance amount available to children is likely to make children's coverage affordable in most cases.

Implementing HIPP as a replacement for the adult Access to Health Insurance program would be less feasible still, since it would require support for the idea of paying for the entire employee portion of employer-sponsored insurance premiums and since the adult Idahoans currently eligible for the Access Card are not Medicaid-eligible (which renders moot any cost savings achievable by using HIPP as an alternative to direct coverage).

One element of Pennsylvania's program that may hold a useful lesson for Idaho is its emphasis on outreach. According to a 2004 report, Pennsylvania had 53 HIPP outreach staff who were credited with building relationships with the private sector and broad program awareness. If it is possible for Idaho to consider this element of HIPP's success in Pennsylvania and to increase its own outreach staff, enrollment in the Access Card may increase.

4. Subsidy Modeling

The HIPP program is a cost savings program for Medicaid. For Medicaid-eligible workers, HIPP pays the employee's share of the premium and provides Medicaid wraparound coverage for those with access to employer-sponsored health coverage when the employer coverage is demonstrated to be more cost-effective than Medicaid. If these conditions are met, enrollment is mandatory. In implementing this program, Pennsylvania has made a significant investment in infrastructure, in terms of both staffing and systems, to identify potential HIPP enrollees.

We projected program eligibles, enrollment, and subsidy costs using the following steps, which are detailed in Appendix 3-E:

1. Start with the statewide population in Idaho and in Pennsylvania.

2. Estimate the number of Medicaid-eligible individuals who have coverage at work.

3. Based on current enrollee counts in Pennsylvania, we calculated an enrollment rate (i.e., enrollees as a percentage of eligibles), and applied that rate to the Idaho eligibles to project enrollment in Idaho.

4. Estimate the subsidy costs per participant per month, based on the average group market rate for premiums in Idaho. From that we estimated the employee premium contribution and out-of-pocket costs (e.g., for deductibles and coinsurance), both of which would be subsidized by HIPP. Note that our projections do not reflect any offsetting savings in direct Medicaid benefit costs.

5. We projected enrollment and subsidy costs over a 5-year period, anticipating increases due to inflation and increasing enrollment. Since HIPP is a relatively mature plan, in existence in Pennsylvania since 1994, we assumed Idaho would reach Pennsylvania's current enrollment rate in 5 years. Our enrollment projection assumes linear growth. We assumed a health care cost inflation rate of 9%. Actual growth patterns will be a function

of many variables, including funding limitations, public awareness, competing programs, and outreach.

5. Operational Modeling

Through our interviews with personnel from the Pennsylvania program and information gathered from other sources, we determined that the Pennsylvania program performs many of the typical activities that we would expect to see in a premium assistance program. There are three major differences that we took into account when building our models:

- The Pennsylvania model combines both centralized and decentralized staff. The Director, policy analysts, and fiscal services are centralized as a single unit. The program operates five regional offices through which participants can receive service, submit applications, and obtain information. It is not clear if these regional offices are collocated with other state Medicaid facilities.
- As a normal course of business, the Pennsylvania program reviews every health plan by entering the plan summary information into a computer system that calculates whether that plan is acceptable for the program. Although the computer system significantly streamlines the process, it also generates a data entry burden.
- The Pennsylvania program proactively contacts eligible beneficiaries each month. Personnel estimated that approximately 7,000 notices are sent to eligible beneficiaries each month. Although this process is automated, this proactive approach generates additional cost that must be taken into account as direct costs.

Our methodology and results for the staffing, administrative cost, and start-up cost modeling is provided below.

Staffing

To develop the staffing model for Pennsylvania, we assumed the same centralized and decentralized model as currently exists in Pennsylvania. We assumed that Idaho would have five regional offices. We estimated staffing volumes by position as shown in the table below.

Pennsylvania Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Director	Assumed 1.00 FTE to provide general oversight and direction for the program.
Policy Analyst	Assumed 1.00 FTE to provide assistance to the director in developing and interpreting program policy.
Program Manager	Assumed 1.0 FTE to manage personnel in the central office, and provide oversight for the five regional offices.
Administrative Clerk	Assumed 1.0 FTE per each of five regional offices. Responsible for intake of application forms and provides general office support.
Supervisor, Eligibility	Assumed 1.0 FTE per each of five regional offices. Responsible for management of staff in regional offices, and prioritization and allocation of production work among enrollment specialists.

Pennsylvania Premium Assistance Program Staffing Workload Assumptions	
Position	**Staffing Assumption**
Enrollment Specialist	Assumed 30 minutes per application, with a minimum of 1.0 FTEs for each of 5 regional offices. Will process enrollment applications.
Accounts Payable Clerk	Assumed 1.0 FTE. Will approve disbursements and perform financial reporting.
System Engineer	Assumed 1.0 FTE. Will perform computer programming and web development. Will also interface with State information technology area when necessary.

Using these assumptions and the projected enrollment, we estimated year-end staffing by position for five years as shown in the table below.

State of Pennsylvania Premium Assistance Program Idaho Implementation
Five-Year Administrative Staffing Estimate (FTEs) (Month 12)

Position	Year 1	Year 2	Year 3	Year 4	Year 5
Director	1.00	1.00	1.00	1.00	1.00
Policy Analyst	1.00	1.00	1.00	1.00	1.00
Program Manager	1.00	1.00	1.00	1.00	1.00
Administrative Clerk	5.00	5.00	5.00	5.00	5.00
Accounts Payable Clerk	1.00	1.00	1.00	1.00	1.00
System Engineer	1.00	1.00	1.00	1.00	1.00
Supervisor, Eligibility	5.00	5.00	5.00	5.00	5.00
Enrollment Specialist	5.00	5.00	5.00	5.00	5.00
Total Staffing	**20.00**	**20.00**	**20.00**	**20.00**	**20.00**

It is important to note that the decentralized staffing model, which distributes staff among multiple regional offices, significantly increases staffing needs. While the decentralized model may make sense for the Pennsylvania model, which has more than 11,000 current enrollees, this model may be inefficient for implementation of the Pennsylvania model in Idaho.

Administrative Cost

Using the administrative cost build-up methodology described in other sections, we estimated the annual administrative costs associated with this program. These values are shown in the table below.

State of Pennsylvania Premium Assistance Program Idaho Implementation
Five-Year Administrative Cost Estimate

Cost Component	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Cost	$ 808,600	$ 832,858	$ 857,844	$ 883,579	$ 910,086
Benefit Cost	$ 291,096	$ 299,829	$ 308,824	$ 318,088	$ 327,631
Other Variable Cost	$ 808,600	$ 832,858	$ 857,844	$ 883,579	$ 910,086
Total Cost	**$ 1,908,296**	**$ 1,965,545**	**$ 2,024,511**	**$ 2,085,247**	**$ 2,147,804**

Note that the costs estimates shown in the table above represent the steady-state administrative costs based on the staffing estimates described in the previous section; and rough wage, benefit/tax, and variable cost estimates. This cost estimate does not include specific direct costs that will be dependent on the implementation strategy used by the State, or start-up costs, which are described in the next section. Furthermore, significant cost reductions may be achievable

through consolidation of operations rather than the decentralized model currently employed in Pennsylvania.

Start-up Cost

Implementation costs typically involve expenditures for infrastructure (i.e., computers, furniture, office equipment, etc.), marketing, and information systems. In the case of the Pennsylvania model, we would anticipate infrastructure start-up costs ranging from $55,000 to $70,000. Note that we have assumed acquisition costs for computer terminals and furniture for all staff, and acquisition of a photocopier and facsimile machine for the central office. For staff located in decentralized (regional) offices, we assumed use of existing photocopier and facsimile resources (although acquisition of furniture and computer terminals for these staff.

According to information provided in the interview, the use of information systems is integral to success of the Pennsylvania program. In the current model, decentralized enrollment specialists enter enrollment and plan data into an enrollment system, which produces an eligibility determination. The system appears to be relatively sophisticated and requires ongoing maintenance. We would expect that a database could be developed by a vendor for less than $100,000, or for little cost using existing state information technology resources. Note that the staffing model reflects one system engineer (programmer) FTE.

The Pennsylvania plan is not currently actively marketed. As such, the researchers did not include staffing or costs for the marketing of the plan.

6. Process Recommendations

6.1 State Statute

There is neither state statute authorizing HIPP nor rules governing the program.[24] Federal statute authorizing HIPP and Pennsylvania's State Plan for Medical Assistance provide authority and guidance for program operations. Included in the Appendix, for reference, is Section 1906 of the Social Security Act (the relevant federal statute).

[24] Confirmed with Darin Morrill, Manager, Policy Unit, HIPP, phone call 5/16/07.

Appendix 1: Program Outlines

Oregon: Family Health Insurance Assistance Program (FHIAP)

Eligibility

- *Population:*
  - Not have had group health insurance within the last six months
  - Be uninsured for the previous 6 months
    - Except for those leaving the OHP/Medicaid program
  - Oregon resident
  - U.S. citizen or a qualified non-citizen
  - Not be eligible for or receiving Medicare
  - Employer's insurance plan must meet a minimum benchmark that is actuarially equivalent to federally required Medicaid benefits
- *FPL Level:* Available to families and individuals with up to 185% of FPL
- *Income Definition:*
  - Asset Test: Have investments or savings less than $10,000
- *Employer Requirements:*
  - Employer contribution not required
  - Employer's offered insurance must meet a minimum benchmark

Assistance Program

- *Payments Cover:*
  - Pays 50% to 95% of members' monthly premium[25]
    - 0% to 125% of FPL: 95% subsidy
    - 125% up to 150% of FPL: 90% subsidy
    - 150% up to 170% of FPL: 70% subsidy
    - 170% up to 185% of FPL: 50% subsidy
  - Does not subsidize deductibles, co-pays, or other coinsurance
- *Payment Process:*
  - Reimbursements sent directly to employee
  - No Medicaid wrap-around coverage; equivalence is set at time of enrollment
- *System Infrastructure:*
  - Request that applicants obtain health plan information directly from their employers
- *Managing Department:* Family Health Insurance Assistance Program
- *Source of Federal Funds:* HIFA Section 1115

Additional Information

- *Facts & Figures:*
  - 5,000 or fewer enrolled
  - 10,000 on waiting list
- *Recent Changes*:
  - Initially funded only through state dollars. In 2003, integrated with the 1115 waiver for the Oregon Health Plan and became qualified for federal match.

[25] http://12.109.133.237/Files/2_-_OR_coverage_options.pdf

Michigan: Access Health

Eligibility

- *Population:*
  - Available to employees of small businesses (one or more W-2 employees)
  - Employer did not offer health coverage during the previous 12 months
  - Employee must not be eligible to receive health benefits under other health insurance plans or programs
- *FPL Level:*
  - Uninsured individuals because of DSH funding
  - Company must have a median wage of $12 or less per hour
- *Income Definition:* Not used
- *Employer Requirements:*
  - Required to 50% of premium which is equal 30% of program total cost
  - Assistance Program
- *Payments Cover:* Part of Employee contribution to premium
- *Payment Process:*
  - Employee premium contribution: 50%
    - $300 out of pocket maximum
  - Co-pays are typically $5 per primary care visit
  - Federal money covers 40% of plan costs
- *System Infrastructure:*
  - Pregnancy is only a covered benefit on the Access Health plan if the member is not eligible for Medicaid[26]
- *Managing Department:* Muskegon Community Health Project
- *Source of Federal Funds:*
  - Community raised funds also subsidize total program cost
  - Each $1 of the community's contribution is matched by $1.29 in federal DSH funds

Additional Information

- *Facts & Figures:*
  - Individuals with pre-existing conditions are not excluded from coverage, nor do they pay a different rate
  - Members can choose their own primary care provider
- *Recent Changes:*
  - Outcomes(March 2000–June 2001):
    - Over 525 businesses currently enrolled with 1,500 individuals served. Over 300 SCHIP and Medicaid eligible children were also identified and enrolled.
    - Important economic development incentive for small business development/expansion.
    - 97% of local providers (over 200 physicians) and both county hospitals participate.
    - Every $1 of public money leverages $2 of private funds.

[26] http://www.cmwf.org/tools/tools_show.htm?doc_id=235093 and http://www.cjaonline.net/Communities/MI_Muskegon.htm

- Generates $2.0 million annually in new revenue to pay for local health services for previously uninsured (slow pay/no pay population).
- State of Michigan encouraging replication of program through new planning grants and $10 million appropriation of tobacco settlement funds

Utah: Utah's Premium Partnership for Health Insurance (UPP)

Eligibility

- *Population:*
  - Available to adults (ages 19 to 64) & children (18 & under) who do not currently have health insurance
  - Eligible to get health insurance through employee's job (or spouse's job)
  - Must be a U.S. citizen or legal resident
  - Eligibility is based on family size and income
  - Income includes the following: wages that enrollee or spouse earns, child support, alimony, Social Security, etc.
- *FPL Level:*
  - Adults with income up to 150% of FPL
  - Children with family income up to 200% of FPL, including both Title XIX and Title XXI–eligible children
- *Other Eligibility Requirements:*
  - Employee premium contribution to the least expensive health insurance option must be more than 5% of total household income (before taxes)
- *Employer Requirements:*
  - Employer offered health insurance plan must meet basic guidelines
  - Required 50% employer contribution

Assistance Program

- *Payments Cover:* Reimbursement for premium expenses only
- *Payment Process:*
  - Reimbursements sent directly to employee
    - Up to $150 per adult per month
    - Up to $100 per child per month
    - An additional $20 per child if he/she is enrolled in dental coverage
- *Managing Department:* Utah Department of Health
- *Source of Federal Funds:* Medicaid Section 1115

Additional Information

- *Facts & Figures:*
  - Funded with federal and state money
  - As of May 2007, 142 adult and 138 child enrollees.
- *Recent Changes:* Utah's program underwent several changes in late 2006. See narrative description of program.

Maine: DirigoChoice

Eligibility

- *Population:*
  - Uninsured individuals
  - Employees in small businesses
  - The self-employed
- *FPL Level:* Available to those up to 300% of FPL
- *Income Definition:* Monthly income and assets
- *Employer Requirements:*
  - Employers required to pay 60% of employee costs

Assistance Program

- *Payments Cover:* Up to 100% of employee costs, percentage is based on income and assets
- *Payment Process:*
  - Prevention services covered 100%
    - i.e., physicals, blood testing, flu shots, mammograms, well-baby care
  - Healthy ME incentive program
    - Receive cash rewards for meeting health goals like smoking cessation
  - 20% to 100% employee subsidies for:
    - Monthly payments
    - Annual deductibles
    - Annual out of pocket expenses
    - Fitness club membership
- *Managing Department:* Dirigo Health Agency and the Governor's Office for Health Policy and Finance
- *Source of Federal Funds:* Medicaid Section 1906

Additional Information

- *Facts & Figures:*
  - Participation is voluntary
  - Began January 2005
  - Cash incentives for employers who have not offered health insurance in the past 12 months
  - Over 15,000 enrollees in 2006
- *Recent Changes:*
  - In year one only, state funds help finance the program
  - Under the Dirigo Health Plan, Maine expanded Medicaid eligibility from 100% to 125% for PFL for single and married adults without dependent children

Illinois: FamilyCare/All Kids Rebate

Eligibility

- *Population:*
  - Low income parents
  - Low income children up to 18 years old
- *FPL Level:*
  - Parents with income up to 185% of FPL
  - Children with household income between 133-200% of FPL
- *Employer Requirements:*
  - Employer health insurance must cover doctor and inpatient hospital care

Assistance Program

- *Payments Cover:* Reimbursement for premium expenses only
- *Payment Process:*
  - Enrollee pays for all co-pays, coinsurance and deductibles
  - Reimbursement for up to $75 per person per month premium subsidy
    - Rebate amount must be less than enrollee's contribution
- *System Infrastructure:*
  - Health benefits are limited to the private or employer insurance plan coverage
  - Capped subsidy amounts
  - Participation is not mandatory
- *Managing Department:* Medicaid, Governor
- *Source of Federal Funds:* Section 1115 Waiver

Additional Information

- *Facts & Figures:*
  - Approximately 6,200 enrollees as of May 2007[27]
  - Eligible individuals can choose between receiving premium assistance or direct state-provided coverage
- *Recent Changes:*
  - Funded with state-only dollars prior to state's Section 1115 waiver approval
  - In the past, families participating in this program were not eligible for the state's regular direct SCHIP coverage, KidCare, because their children were insured.

[27] Matt Warner and Lynn Thomas, Illinois Department of Health and Family Services, phone call 5/17/2007

Pennsylvania: Health Insurance Premium Payment (HIPP) Program

Eligibility

- *Population:*
  - Low-income working adults
    - Must be actively eligible for Pennsylvania's Medicaid program using standard eligibility criteria
    - Enrollee maintains Medicaid eligibility
    - Mandatory enrollment under available employer plan
- *FPL Level:* Varies according to Medicaid beneficiary class
- *Income Definition:* Income includes: wages, interest, dividends, social security, Veterans' Benefits, Pensions, and Spouse's income if living with him/her
- *Employer Requirements:*
  - No employer contribution required

Assistance Program

- *Payments Cover:*
  - Employee Premium Contribution
    - Including continuation of benefit premiums under COBRA
  - Health Insurance Co-Payments
  - Health Insurance Deductibles
- *Payment Process:*
  - Premium reimbursements usually sent directly to the employers
    - If necessary, payment can be made to enrollee
  - Standard Medicaid Wraparound Coverage to supplement Employer Health Insurance
  - Enrollees are advised to use Medicaid providers to ensure payment of additional benefits
- *System Infrastructure:*
  - HIPP Automated Database
    - Comprehensive database linked to other state agencies and departments
    - Computerized matrix containing information on benefits programs of employers in the state
    - Performs all analyses and calculations
    - Generates payments, reports, tracks cases, and automated correspondence
- *Managing Department:* Department of Public Welfare
  - 5 regional offices collect information pertaining to enrollees and employers in each geographic area
- *Source of Federal Funds:* Medicaid Section 1906

Additional Information

- *Facts & Figures:*
  - More than 21,000 members enrolled as of April 2004
  - Achieved a savings goal of $76.3 million in FY 2003
- *Recent Changes:* HSA available 12/2006

Appendix 2: References

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Appendix 3: Subsidy Model Details

Appendix 3-A

Oregon: Family Health Insurance Assistance Program (FHIAP)

Projected Enrollment and Subsidy Costs in Idaho

Eligibility: **Program began in 2003**

Not eligible for Medicare
No insurance in past 6 months, or on Medicaid
Up to 185% Federal Poverty Level (FPL)
State resident
US citizen or other eligible
Working
Assets/Savings<$10,000

	Oregon	Idaho - Estimated
(1) **State Population**	3,700,758	1,466,465
(2) **Percent of State who are uninsured, and in income range** < age 65, < 185% FPL	17.8%	16.0%
(3) **Estimated Population in State meeting criteria in (2)** = (1) x (2)	658,958	235,286
(4) **Percent of (3) meeting FHIAP requirements, and enrolling**	2.6%	2.6%
(5) **Enrollment after 4 Years of Operation**	17,297	6,176

(6) **Estimated Per Person Cost of Subsidy in Idaho Per Month**

Group Enrollment	Subsidy	Market Rate	FHIAP Portion	Employee Portion	Employer Portion	Estimated Enrollees
0-125% of FPL	95%	$251	$141	$7	$103	994
125-150% of FPL	90%	$251	$133	$15	$103	1,045
150-170% of FPL	70%	$251	$104	$44	$103	194
170-185% of FPL	50%	$251	$74	$74	$103	183
						2,416
Average FHIAP Subsidy Per Person for Group Enrollment			$129			

Individual Enrollment	Subsidy	Market Rate	FHIAP Portion	Member Portion	Estimated Enrollees
0-125% of FPL	95%	$269	$256	$13	2,471
125-150% of FPL	90%	$269	$242	$27	1,039
150-170% of FPL	70%	$269	$188	$81	144
170-185% of FPL	50%	$269	$135	$134	106
					3,760
Average FHIAP Subsidy Per Person for Individual Enrollment			$246		
Average FHIAP Subsidy Per Person, blending Group and Individual			$200		
Projected Enrollment after 4 Years of Operation					6,176

(7) **Projected Total Enrollment after 5 Years of Operation, by Medicaid Eligibility (Under 100% FPL)**

Under 100% FPL	2,867
Over 100% FPL	4,853
Total	7,720

Notes:

(1) Current Population Survey data, www.census.gov

(2) Current Population Survey data, www.census.gov
This is to reflect differences in income distribution and insurance coverage between Oregon and Idaho.

(4) Calculated value for Oregon (5) / (3). We assumed the same value for Idaho.

(5) Actual enrollment for Oregon. Idaho enrollment calculated as (3) x (4). FHIAP has been in existence since 2003, so assume Idaho will reach this State's current enrollment rate in 4 years.

(6) Average Portion Paid by Employer in FHIAP in Oregon is 42%. Area adjustment to reflect expected differences between Oregon and Idaho gave an Average Portion Paid by Employer in Idaho of 41%. (2004 Medical Expenditure Panel Survey) Market Rates used are based on Oregon rates published by FHIAP (4/30/07), adjusted to reflect differences in costs in Idaho. 41% is lower than would be expected as the average employer contribution. We believe that is due to Oregon's inclusion of self-employed and COBRA people.

(7) Assume linear growth until maturity at 5 years. Break-out by Medicaid eligibility is based on population in Idaho under 100% FPL.

Appendix 3-B
Utah: Utah's Premium Partnership for Health Insurance (UPP)
Projected Enrollment and Subsidy Costs in Idaho

Eligibility: **Program began in 2006**

Uninsured or on Medicaid
US citizen or legal resident
Eligible for health insurance through employer
150% Federal Poverty Level (FPL) for adults
200% FPL for children

	Utah	Idaho - Estimated
(1) **State Population**	2,550,063	1,466,465
(2) **Percent of State who are uninsured or on Medicaid, and in income range**		
Adults < age 65, <150% FPL	5.2%	8.0%
Children, <200% FPL	6.4%	7.0%
(3) **Percent with coverage at work, but not enrolled**	23.8%	19.5%
(4) **Estimated Population in State meeting criteria in (2) and (3)** = (1) x (2) x (3)		
Adults, < age 65	31,555	22,841
Children	38,782	20,060
(5) **Percent of (4) meeting UPP requirements, and enrolling**		
Adults, < age 65	0.5%	0.5%
Children	0.4%	0.4%
(6) **Enrollment after 6 months of Operation**		
Adults, < age 65	142	103
Children	138	71
Total enrollment (6-month maturity)	280	174
(7) **Projected Enrollment after 5 Years of Operation**	3,000	1,866
By Medicaid Eligibility (Under 100% FPL)		
Under 100% FPL		781
Over 100% FPL		1,085
Total		1,866
(8) **Estimated Cost of Subsidy**		
Estimated Per Adult Subsidy Per Month		$90
Estimated Per Child Subsidy Per Month		$65
Estimated Per Person Subsidy Per Month		$80

Notes:

(1) Current Population Survey data, www.census.gov

(2) Current Population Survey data, www.census.gov
This is to reflect differences in income distribution and insurance coverage between Utah and Idaho.

(3) Medical Expenditure Panel Survey data, http://www.meps.ahrq.gov
Percent of employees in low-wage firms which offer employer coverage (Table VII.B.2(2004))
adjusted for % of employees who do not enroll (Table VII.B.2.a.(1)(2004)).
This is to reflect differences in employer coverage availability and employee enrollment
between Utah and Idaho.

(5) Calculated value for Utah = (6) / (4). We assumed the same value for Idaho.

(6) Actual enrollment for Utah. Idaho enrollment calculated as (4) x (5).

(7) UPP is a new program. We assumed enrollment in Utah would reach 3,000 in 5 years (here, ignoring UPP's cap
on enrollment of 1,000). We projected Idaho enrollment based on the relationship determined above, and
assuming linear growth until maturity at 5 years. Break-out by Medicaid eligibility is based on population in Idaho under 100% FPL.

(8) Assumed that Participants used 60% of maximum medical subsidy.
Assumed 40% of children had dental coverage, and of those, 60% of maximum dental subsidy was used (not available for adults).

Appendix 3-C
Maine: DirigoChoice
Projected Enrollment and Subsidy Costs in Idaho

Eligibility: **Program began in 2003**
< 300% Federal Poverty Level (FPL)

	Maine	Idaho - Estimated
(1) **State Population**	1,321,574	1,466,465
(2) **Percent of State who are in income range**		
< age 65, <300% FPL	41.4%	46.5%
(3) **Estimated Population in State meeting criteria in (2)**		
= (1) x (2)	547,136	681,840
(4) **Percent of (3) meeting DirigoChoice requirements, and enrolling**	2.7%	2.7%
(5) **Enrollment after 4 Years of Operation**	15,000	18,693

(6) **Estimated Per Person Cost of Subsidy in Idaho Per Month**

Group Enrollment	Subsidy	Estimated Market Rate	DirigoChoice Portion	Employee Portion	Employer Portion	Estimated Enrollees
<100% FPL	100%	$270	$108	$0	$162	3,140
100-150% of FPL	80%	$264	$85	$21	$158	2,841
150-200% of FPL	60%	$251	$60	$40	$150	748
200-250% of FPL	40%	$241	$38	$58	$144	449
250-300% of FPL	20%	$233	$18	$75	$140	299
						7,477
Estimated Average Subsidy Per Person for Group Enrollment			$86			

Individual Enrollment	Subsidy	Estimated Market Rate	DirigoChoice Portion	Member Portion	Estimated Enrollees
<100% FPL	100%	$289	$289	$0	4,711
100-150% of FPL	80%	$283	$226	$57	4,262
150-200% of FPL	60%	$269	$161	$108	1,121
200-250% of FPL	40%	$258	$103	$155	673
250-300% of FPL	20%	$250	$50	$200	449
					11,216
Estimated Average Subsidy Per Person for Individual Enrollment			$232		

Estimated Average Subsidy Per Person, blending Group and Individual	$174
Projected Enrollment after 4 Years of Operation	18,693
(7) **Enrollment after 5 Years of Operation**	23,366
By Medicaid Eligibility (Under 100% FPL)	
Under 100% FPL	4,603
Over 100% FPL	18,763
Total	23,366

Notes:

(1) Current Population Survey data, www.census.gov

(2) Current Population Survey data, www.census.gov
This is to reflect differences in income distribution and insurance coverage between Maine and Idaho.

(4) Calculated value for Maine (5) / (3). We assumed the same value for Idaho.

(5) Actual enrollment for Maine. Idaho enrollment calculated as (3) x (4). DirigoChoice has been in existence since 2003, so assume Idaho will reach this State's current enrollment rate in 4 years.

(6) Employer portion assumed to be 60% of total premium, the required minimum for participation in DirigoChoice. The distribution of enrollees for different income types is approximated based on Idaho distribution developed in the Oregon model. Premium rates are based on Idaho rates developed in the Oregon model, adjusted for differences in plan cost-sharing features. In DirigoChoice, cost-sharing varies by income level.

(7) Assume linear growth until maturity at 5 years. Break-out by Medicaid eligibility is based on population in Idaho under 100% FPL.

Appendix 3-D
Illinois: FamiliyCare/All Kids Rebate
Projected Enrollment and Subsidy Costs in Idaho

Eligibility: **Program began in 2002**
Parents: 133-185% Federal Povery Level (FPL)
Children: 133-200% FPL

	Illinois	Idaho - Estimated
(1) **State Population**	12,831,970	1,466,465
(2) **Percent of State who are in income range**		
Adults < age 65, 133-185% FPL	4.7%	6.4%
Children, 133-200% FPL	3.5%	4.9%
(3) **Percent with coverage available at work**	76.6%	64.2%
(4) **Estimated Population in State meeting criteria in (2) and (3)** = (1) x (2) x (3)		
Adults, < age 65	457,944	60,173
Children	347,321	46,048
Total	805,265	106,221
(5) **Percent of (4) meeting Rebate requirements, and enrolling**	0.8%	0.8%
(6) **Projected Enrollment after 5 Years of Operation**	6,300	831
(7) **Estimated Cost of Subsidy**		
Estimated Subsidy Per Person Per Month		$68

Notes:

(1) Current Population Survey data, www.census.gov

(2) Current Population Survey data, www.census.gov
This is to reflect differences in income distribution between Illinois and Idaho.

(3) Medical Expenditure Panel Survey data, http://www.meps.ahrq.gov
Percent of employees in low-wage firms which offer employer coverage (Table VII.B.2(2004)).
This is to reflect differences in employer coverage availability between Illinois and Idaho.

(5) Calculated value for Illinois =(6) / (4). We assumed the same value for Idaho.

(6) Actual enrollment for Illinois. Idaho enrollment calculated as (4) x (5).
The program has been in existence since 2002, so assume Idaho will reach Illinois's current enrollment rate in 5 years. Assume linear growth until maturity at 5 years.

(7) The Illinois rebate is $75 per month per person. We assumed 90% of the maximum possible monthly benefit would be paid per enrollee, or 90% x $75 = $68.

Appendix 3-E
Pennsylvania: Health Insurance Premium Payment (HIPP) Program
Projected Enrollment and Subsidy Costs in Idaho

Eligibility: **Program Began 1994**

Medicaid Eligible adults and children

Coverage available at work, deemed to be more cost-effective than Medicaid

	Pennsylvania	Idaho - Estimated
(1) **State Population**	12,440,621	1,466,465
(2) **Percent of State who are eligible for Medicaid**		
Adults, < age 65	5.1%	5.2%
Children	5.7%	6.3%
(3) **Percent with coverage available at work**	80.0%	64.2%
(4) **Estimated Population in State meeting criteria in (2) and (3)** = (1) x (2) x (3)		
Adults, < age 65	509,133	49,001
Children	567,692	59,454
(5) **Percent of (4) meeting HIPP requirements, and enrolling**		
Adults, < age 65	0.8%	0.8%
Children	3.0%	3.0%
(6) **Projected Enrollment after 5 Years of Operation**		
adults (20% of total enrollment)	4,200	404
children (80% of total enrollment)	16,800	1,759
Total Enrollment	21,000	2,163

(7) **Estimated Cost of Subsidy in Idaho Per Person Per Month**

		HIPP Subsidy		
Estimated Market Rate for Group Premium	Employer Portion of Premium	Employee Portion of Premium	Employee Out of Pocket Costs	Total HIPP Subsidy
$251	$185	$66	$51	$117

Notes

(1) Current Population Survey data, www.census.gov

(2) Current Population Survey data, www.census.gov
This is to reflect differences in Medicaid participant populations between Pennsylvania and Idaho.

(3) Medical Expenditure Panel Survey data, http://www.meps.ahrq.gov
Percent of employees in low-wage firms which offer employer coverage (Table VII.B.2(2004)).
This is to reflect differences in employer coverage availability between Pennsylvania and Idaho.

(5) Calculated value for Pennsylvania =(6) / (4). We assumed the same value for Idaho.

(6) Actual enrollment for Pennsylvania. Idaho enrollment calculated as (4) x (5).
HIPP has been in existence since 1994, so assume Idaho will reach Pennsylvania's current enrollment rate in 5 years. Assume linear growth until maturity at 5 years.

(7) Employer Portion of premium is estimated to be 73.9%, based on Medical Expenditure Panel Survey data in Idaho.
Out of Pocket Costs are estimated to be 17% of total medical expenditure (premium + out-of-pocket costs), based on the Milliman Medical Index 2007.
Market Rate for Group Insurance is based on group rates developed in analysis of the Oregon model.

Appendix 4: Statute and Rules Examples

Oregon: Family Health Insurance Assistance Program (FHIAP)

Statute

http://www.leg.state.or.us/ors/735.html
(Family Health Insurance Assistance Program)

735.720 Definitions for ORS 735.720 to 735.740. For purposes of ORS 735.720 to 735.740:

(1) "Carrier" has the meaning given that term in ORS 735.700.

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(3)(a) "Family" means:

(A) A single individual;

(B) An adult and the adult's spouse;

(C) An adult and the adult's spouse, all unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult or the adult's spouse, and all dependent children of a dependent child; or

(D) An adult and the adult's unmarried, dependent children under 23 years of age, including adopted children, children placed for adoption and children under the legal guardianship of the adult, and all dependent children of a dependent child.

(b) A family includes a dependent elderly relative or a dependent adult disabled child who meets the criteria established by the office and who lives in the home of the adult described in paragraph (a) of this subsection.

(4)(a) "Health benefit plan" means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement for hospital, medical and surgical expenses. "Health benefit plan" includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability

insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.

(5) "Income" means gross income in cash or kind available to the applicant or the applicant's family. Income does not include earned income of the applicant's children or income earned by a spouse if there is a legal separation.

(6) "Investment and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the office may establish that are available to the applicant or the applicant's family to contribute toward meeting the needs of an applicant or eligible individual.

(7) "Medicaid" means medical assistance provided under 42 U.S.C. section 1396a (section 1902 of the Social Security Act).

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

(9) "Subsidy" means payment or reimbursement to an eligible individual toward the purchase of a health benefit plan, and may include a net billing arrangement with carriers or a prospective or retrospective payment for health benefit plan premiums and eligible copayments or deductible expenses directly related to the eligible individual.

(10) "Third-party administrator" means any insurance company or other entity licensed under the Insurance Code to administer health insurance benefit programs. [Formerly 653.800; 2003 c.684 §8; 2005 c.727 §§5,5a; 2005 c.744 §§23d,23e,23g]

Note: 735.720 to 735.740 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 735 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

735.722 Family Health Insurance Assistance Program; eligibility for participation; selection of administrator. (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the office, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health Policy Commission, shall make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner. [Formerly 653.805; 2003 c.128 §1; 2003 c.683 §4; 2003 c.784 §12; 2005 c.238 §6; 2005 c.262 §6; 2005 c.727 §6; 2005 c.744 §24a]

Note: See note under 735.720.

735.724 Application to participate in program; issuance of subsidies; restrictions; employment group health benefit plan enrollment. (1) To enroll in the Family Health Insurance Assistance Program established in ORS 735.720 to 735.740, an applicant shall submit a written application to the Office of Private Health Partnerships or to the third-party administrator contracted by the office to administer the program pursuant to ORS 735.722 in the form and manner prescribed by the office. Except as provided in ORS 735.728, if the applicant qualifies as an eligible individual, the applicant shall either be enrolled in the program or placed on a waiting list for enrollment.

(2) After an eligible individual has enrolled in the program, the individual shall remain eligible for enrollment for the period of time established by the office.

(3) After an eligible individual has enrolled in the program, the office or third-party administrator shall issue subsidies in an amount determined pursuant to ORS 735.726 to either the eligible individual or to the carrier designated by the eligible individual, subject to the following restrictions:

(a) Subsidies may not be issued to an eligible individual unless all eligible children, if any, in the eligible individual's family are covered under a health benefit plan or Medicaid.

(b) Subsidies may not be used to subsidize premiums on a health benefit plan whose premiums are wholly paid by the eligible individual's employer without contribution from the employee.

(c) Such other restrictions as the office may adopt.

(4) The office may issue subsidies to an eligible individual in advance of a purchase of a health benefit plan.

(5) To remain eligible for a subsidy, an eligible individual must enroll in a group health benefit plan if a plan is available to the eligible individual through the individual's employment and the employer makes a monetary contribution toward the cost of the plan, unless the office implements specific cost or benefit structure criteria that make enrollment in an individual health insurance plan more advantageous for the eligible individual.

(6) Notwithstanding ORS 735.720 (4)(b), if an eligible individual is enrolled in a group health benefit plan available to the eligible individual through the individual's employment and the employer requires enrollment in both a health benefit plan and a dental plan, the individual is

eligible for a subsidy for both the health benefit plan and the dental plan. [Formerly 653.810; 2003 c.128 §2; 2003 c.683 §1; 2005 c.238 §7; 2005 c.262 §7; 2005 c.727 §7; 2005 c.744 §25]

Note: See note under 735.720.

735.726 Level of assistance determinations. (1) The Office of Private Health Partnerships shall determine the level of assistance to be granted under ORS 735.724 based on a sliding scale that considers:

(a) Family size;

(b) Family income;

(c) The number of members of a family who will receive health benefit plan coverage subsidized through the Family Health Insurance Assistance Program; and

(d) Such other factors as the office may establish.

(2) Notwithstanding the sliding scale established in subsection (1) of this section, the office may establish different assistance levels for otherwise similarly situated eligible individuals based on factors including but not limited to whether the individual is enrolled in an employer-sponsored group health benefit plan or an individual health benefit plan. [Formerly 653.815; 2005 c.744 §26]

Note: See note under 735.720.

735.728 Subsidies limited to funds appropriated; enrollment restrictions. (1) Notwithstanding eligibility criteria and subsidy amounts established pursuant to ORS 735.720 to 735.740, subsidies shall be provided only to the extent the Legislative Assembly specifically appropriates funds to provide such assistance.

(2) The Office of Private Health Partnerships shall prohibit or limit enrollment in the Family Health Insurance Assistance Program to ensure that program expenditures are within legislatively appropriated amounts. Prohibitions or limitations allowed under this section may include but are not limited to:

(a) Lowering the allowable income level necessary to qualify as an eligible individual; and

(b) Establishing a waiting list of eligible individuals who shall receive subsidies only when sufficient funds are available. [Formerly 653.820; 2005 c.744 §27]

Note: See note under 735.720.

735.730 Establishment of minimum benefit requirements for plan subsidy. The Office of Private Health Partnerships may, based on the recommendation of the Administrator of the Office for Oregon Health Policy and Research, establish minimum benefit requirements for individual health benefit plans subject to subsidy pursuant to the Family Health Insurance Assistance Program, including but not limited to the type of services covered and the amount of cost-sharing to be allowed. [Formerly 653.825; 2005 c.744 §28]

Note: See note under 735.720.

735.731 Coverage of immunizations; rules. (1) The Family Health Insurance Assistance Program shall provide coverage of age-appropriate immunizations or other health care services

when an eligible individual is enrolled in a health benefit plan that does not provide coverage of age-appropriate immunizations or other health care services required by the state medical assistance program and the eligible individual is receiving a subsidy described in ORS 414.839.

(2) The Office of Private Health Partnerships shall adopt rules implementing subsection (1) of this section. [2003 c.683 §3; 2003 c.735 §12; 2005 c.744 §29]

Note: See note under 735.720.

735.732 Confidentiality of information in enrollment applications; exchange of information with governmental agencies; use of Social Security numbers. (1) Except as otherwise provided in this section and ORS 735.710, the Office of Private Health Partnerships may not disclose information provided to the office as part of an application for enrollment in the Family Health Insurance Assistance Program.

(2) The office may exchange information provided to the office with other state and federal agencies for the purposes of verifying eligibility for the program, improving provision of services and identifying economic trends relevant to administration of the program.

(3) In accordance with applicable state and federal law, the office may require applicants to provide their Social Security numbers and use those numbers in the administration of the program. [Formerly 653.830; 2005 c.744 §30]

Note: See note under 735.720.

735.733 Basic benchmark health benefit plan eligible for subsidy. The Office of Private Health Partnerships shall establish at least one basic benchmark health benefit plan that qualifies for a subsidy described by ORS 414.839. In establishing a basic benchmark plan, the office shall consider employer-sponsored health benefit plans offered to employees and dependents of employees in Oregon. [2003 c.684 §11; 2005 c.744 §31]

Note: See note under 735.720.

735.734 Rules. The Office of Private Health Partnerships, in consultation with the Administrator of the Office for Oregon Health Policy and Research and the Department of Human Services, shall adopt all rules necessary for the implementation and operation of the Family Health Insurance Assistance Program. [Formerly 653.835; 2005 c.744 §32]

Note: See note under 735.720.

735.736 Family Health Insurance Assistance Program Account. There is established in the State Treasury the Family Health Insurance Assistance Program Account, which shall consist of moneys appropriated to the account by the Legislative Assembly and interest earnings from the investment of moneys in the account. All moneys in the Family Health Insurance Assistance Program Account are continuously appropriated to the Office of Private Health Partnerships to carry out the provisions of ORS 735.720 to 735.740. [Formerly 653.840; 2005 c.744 §33]

Note: See note under 735.720.

735.738 Reports of program operation. The Administrator of the Office for Oregon Health Policy and Research shall report biennially to the appropriate interim human resources committee and to the Legislative Assembly on the effectiveness and efficiency of the Family Health Insurance Assistance Program, including services and benefits covered under the purchased health insurance plans, consumer satisfaction and other program operational issues. [Formerly 653.845; 2005 c.238 §8; 2005 c.727 §8]

Note: See note under 735.720.

735.740 Sanctions for violation of program requirements; civil penalties. (1) The Office of Private Health Partnerships may impose sanctions against an individual who violates any provision of ORS 735.720 to 735.740 or rules adopted thereto, including but not limited to suspension or termination from the Family Health Insurance Assistance Program and repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled individual. Sanctions allowed under this subsection shall be imposed in the manner prescribed in ORS chapter 183.

(2) In addition to the sanctions available pursuant to subsection (1) of this section, the office may impose a civil penalty not to exceed $1,000 against any individual who violates any provision of ORS 735.720 to 735.740 or rules adopted pursuant thereto. Civil penalties imposed pursuant to this section shall be imposed pursuant to ORS 183.745. [Formerly 653.850; 2003 c.684 §9; 2005 c.744 §34]

Note: See note under 735.720.

735.750 Definitions for ORS 735.750 to 735.756. As used in ORS 735.750 to 735.756:

(1) “Benefits plan” has the meaning given that term in ORS 735.605.

(2) “Other costs” means costs incurred by the Oregon Medical Insurance Pool that are not covered by the premiums received by the pool for a subsidized member.

(3) “Premium” has the meaning given that term in ORS 735.700.

(4) “Subsidized member” means a medical assistance program client who is enrolled in a benefits plan and who is receiving a subsidy from the Family Health Insurance Assistance Program established in ORS 735.720 to 735.740.

(5) “Subsidy” has the meaning given that term in ORS 735.720. [2003 c.684 §1; 2005 c.744 §35]

Note: 735.750 to 735.756 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 735 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

735.752 Eligibility for coverage for certain members. Notwithstanding ORS 735.615 (3)(a) and (f), a subsidized member is eligible for coverage under ORS 735.600 to 735.650. [2003 c.684 §2]

Note: See note under 735.750.

735.754 System for payment or reimbursement of subsidies and costs. (1) In order to

increase public subsidies for the purchase of health insurance coverage provided by public programs or private insurance described by ORS 414.839, the Office of Private Health Partnerships, the Oregon Medical Insurance Pool Board and the Department of Human Services shall work cooperatively to obtain federal matching dollars. The office, the Oregon Medical Insurance Pool Board and the department shall develop a system for payment or reimbursement of other costs and subsidies provided to subsidized members.

(2) For each subsidized member, the Oregon Medical Insurance Pool Board shall determine:

(a) The full cost of administering the benefits plan of the subsidized member; and

(b) The amount of other costs.

(3) The Oregon Medical Insurance Pool Board shall bill the Family Health Insurance Assistance Program for the total amount of the premium received by the Oregon Medical Insurance Pool Board and for the amount of other costs. The program shall forward the bill to the department.

(4) The department shall pay the program an amount equal to the portion of the premium that is a subsidy and for other costs. The program shall forward the payment to the Oregon Medical Insurance Pool Board. [2003 c.684 §3; 2005 c.744 §36]

Note: See note under 735.750.

735.756 Determination of subsidies and costs. (1) Of payments made to the Family Health Insurance Assistance Program by the Department of Human Services under ORS 735.754 (4), the department shall determine:

(a) The portion of a subsidy of a subsidized member that is from the General Fund; and

(b) The portion of other costs that is from the General Fund.

(2) The department shall bill the program for the amounts determined under subsection (1) of this section. The program shall forward the bill for the amount determined under subsection (1)(b) of this section to the Oregon Medical Insurance Pool Board.

(3) The board shall:

(a) Determine the amount of funds needed for the payment of other costs under subsection (1)(b) of this section; and

(b) Impose and collect assessments in that amount against insurers, using the methodology described in ORS 735.614 (2), (6) and (9).

(4) The board shall pay the program for the amounts determined under subsection (1)(b) of this section.

(5) The program shall forward to the department the amounts determined under subsection (1) of this section.

(6) ORS 735.614 (3), (4), (5), (7) and (8) applies to assessments collected under this section. [2003 c.684 §4]

http://www.leg.state.or.us/ors/414.html

414.831 Family Health Insurance Assistance Program. The Office of Private Health Partnerships shall focus on expanding group coverage provided by the Family Health Insurance Assistance Program. [2001 c.898 §5a; 2003 c.14 §201; 2003 c.684 §6; 2005 c.744 §37]

Administrative Rules

http://arcweb.sos.state.or.us/rules/OARS_400/OAR_442/442_005.html

The Oregon Administrative Rules contain OARs filed through March 15, 2007
OFFICE OF PRIVATE HEALTH PARTNERSHIPS
DIVISION 5
THE FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM

442-005-0000
Purpose and Statutory Authority
(1) OAR 442-005-0000 to 442-005-0350 are adopted to carry out the purpose of ORS 735.720 to 735.740, establishing within the Office of Private Health Partnerships a Family Health Insurance Assistance Program for Oregon residents who earn up to 185 percent of the federal poverty level.
(2) OAR 442-005-0000 to 442-005-0350 are adopted pursuant to the general authority of the Office of Private Health Partnerships under ORS 735.734 and the specific authority in ORS 735.720 to 735.740.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06
442-005-0010
Definitions
(1) "Alien Status Requirement." A qualified non-citizen meets the alien status requirement for FHIAP if the individual is one of the following:
(a) A person who was admitted as a qualified non-citizen on or before August 22, 1996.
(b) A person who entered the U.S. on or after August 22, 1996 and it has been five years since he or she became a qualified non-citizen.
(c) A person who has obtained their qualified non-citizen status less than five years ago, but entered the U.S. prior to August 22, 1996. The non-citizen must show that he or she has been living in the U.S. continuously for five years from a date prior to August 22, 1996 to the date the non-citizen obtained their qualified status and did not leave during that five year period. If the non-citizen cannot establish the five-year continuous residence before he or she obtained their qualified status, the person is not considered to have entered the U.S. prior to August 22, 1996.
(d) Regardless when they were admitted, a person with one of the following designated statuses:
(A) A person who is admitted as a refugee under section 207 of the INA;
(B) A person who is granted asylum under section 208 of the INA;
(C) A person whose deportation is being withheld under section 243 (h) of the INA;
(D) A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;
(E) A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988;
(F) A person who is a victim of a severe form of trafficking.
(e) Regardless of when they were admitted, a qualified non-citizen who is:
(A) A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or
(B) On active duty in the U.S. Armed Forces (other than active duty for training).
(C) The spouse or unmarried dependent child of the veteran or person on active duty described in (e) (A) and (B).
(f) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or
(g) A member of an Indian tribe (as described in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).
(h) Any legal non-citizen who was approved for a FHIAP subsidy prior to November 1, 2004.

(2) "Appeal" means the opportunity for an applicant to request and receive administrative review by Office staff of a decision made or action taken by the Third Party Administrator (TPA) or state office regarding program eligibility, subsidy level, termination, re-enrollment, overpayments, misrepresentation, or any other decision adverse to the applicant (ref. 442-005-0320).
(3) "Applicant" means a person who has initially applied or a member who is applying for continuation of FHIAP subsidy payments, but who has not yet been determined to be eligible to receive such subsidy or continued subsidy. "Applicant" also includes dependents as defined in OAR 442-005-0010(7).
(4) "Benchmark" means an identified minimum level of health insurance benefits qualifying for subsidy eligibility. The benchmark is established by the Office in consultation with the Health Insurance Reform Advisory Committee and is submitted to and approved by the federal government.
(5) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services that authorizes the transaction of health insurance. Carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.
(6) "Certified carrier" means a carrier that has been certified by the Office to participate in FHIAP. Certified carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.
(7) "Citizen" for the purposes of FHIAP means a native or naturalized member of the United States who can show proof of identity and citizenship as required in the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171).
(8) "Dependent" for the purposes of FHIAP may include:
(a) An applicant's spouse, but not when deemed separated pursuant to OAR 442-005-0050(4) or 442-005-0070(5)(c).
(b) All of the applicant's and applicant's spouse's unmarried children, step children,-legally adopted children or children placed under the legal guardianship of the applicant or applicant's spouse who are under the age of 23 and reside with the applicant, and all dependent children of a dependent child.
(c) An unborn child of any applicant or applicant's dependent as verified by written correspondence from a licensed medical practitioner.
(d) An elderly relative or an adult disabled child, regardless of age, who lives in the home of the applicant, may be included as a dependent.
(A) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b), dependent elderly relative means any person 55 and older.
(B) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b) adult disabled child means:
(i) A child of the applicant of applicant's spouse who is unmarried, a step child, a legally adopted child, or a child placed under the legal guardianship of the applicant of applicant's spouse who is over the age of 18 and resides with the applicant; and
(ii) A child who is disabled with a physical or mental impairment that :
(I) Is likely to continue without substantial improvement for no less than 12 months or to result in death; and
(II) Prevents performance of substantially all the ordinary duties of occupations in which a person not having the physical or mental impairment is capable of engaging, having due regard to the training, experience and circumstances of the individual with the physical or mental impairment.
(9) "Federal poverty level" means the poverty income guidelines as defined by the United States Department of Health and Human Services. These guidelines will be adopted by FHIAP no later than May 1 each year.
(10) "FHIAP" means the Family Health Insurance Assistance Program established by ORS 735.720 to 735.740.
(11) "Group" means insurance offered through an employer or an association.
(12) "Health insurance producer" means a person who holds a current, valid license pursuant to ORS 774.052 to 774.089 as an insurance producer, where such producer is authorized to transact health insurance.

(13) "Incarcerated" means a person living in a correctional facility, such as:
(a) Individuals who are legally confined to a correctional facility such as jail, prison, penitentiary, or juvenile detention center; or
(b) Individuals temporarily released from a correctional facility to perform court-imposed community service work; or
(c) Individuals on leave of less than 30 days from a correctional facility; or
(d) Individuals released from a correctional facility for the sole purpose of obtaining medical care.
(14) "Income" includes, but is not limited to, earned and unearned gross income received by adults and unearned income received by children. Income includes bartering, or working in exchange for goods and services, discounts on goods and services, working in exchange for rent, and payments made for personal living expenses from business funds.
(a) For purposes of determining average monthly income, an applicant may deduct child or spousal support payments made by the applicant for a child or spouse that FHIAP does not consider a dependent. No deduction is allowed for support that is owed but not paid and collected through an offset against the applicant's state income tax refund.
(b) Income does not include educational grants or scholarships.
(15) "Investments and savings" include, but are not limited to: cash, checking accounts, savings accounts, time certificates, stocks, bonds, non-retirement qualified annuities, other securities easily converted to cash, and the tax-assessed value, as indicated by the county assessor, of any real property. Any of the above investments and savings that are owned by or in which a beneficial interest is held by the applicant or any member of the applicant's family will be considered investments and savings of the applicant.
(a) "Investments and savings" does not include one piece of real property maintained by the applicant or the applicant's family as a primary residence. If the applicant or applicant's family maintain multiple residences or own real property as residential rentals, those properties (other than one single primary residence) are included within the definition of "investments and savings."
(b) "Investments and savings" excludes 529 Educational Savings Plans and qualified retirement accounts, including but not limited to IRAs and 401(k) plans.
(16) "Medicaid," see OHP.
(17) "Medicare" means coverage under either parts A or B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et. seq., as amended.
(18) "Member" means a person approved for FHIAP and enrolled in a health insurance plan using the subsidy.
(19) "Misrepresentation" means making an inaccurate or deliberately false statement of material fact, by word, action, or omission.
(20) "OHP" means the Oregon Health Plan Medicaid program and all programs that include medical assistance provided under 42 U.S.C. section 396a (section 1902 of the Social Security Act).
(21) "Overpayment" means any subsidy payment made that exceeds the amount a member is eligible for, and has been received by, or on behalf of, that member, as well as any civil penalty assessed by the Office.
(22) "Qualified non-citizen" for the purposes of FHIAP. A person is a "qualified non-citizen" if he or she is any of the following:
(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq).
(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157).
(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158).
(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1523(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996)).

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year.
(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980.
(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980).
(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the United States Immigration and Naturalization Service.
(i) American Indians born in Canada to whom the provision of section 289 of the INA (8 U.S.C. 1359) apply.
(j) Members of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).
(k) A veteran of the U.S. Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty requirements described in 38 U.S.C. ¶ 5303A(d).
(l) A member of the U.S. Armed Forces on active duty (other than active duty for training).
(m) The spouse or dependent child of a person described in either (k) or (l) above.
(n) A legal non-citizen approved for FHIAP subsidy prior to November 1, 2004.
(23) "Reapplication" means the periodic review and determination of a member's continued eligibility or subsidy level.
(24) "Reservation list" means a list of potential applicants for FHIAP, entered onto a register maintained by the TPA or state office as authorized by ORS 735.724.
(25) "Resident" means a citizen or qualified non-citizen who resides in Oregon or a full-time college student who is a citizen or qualified non-citizen and has a parent who lives in Oregon.
(26) "Self-employment" means gross receipts received from a business owned, in whole or in part, by a FHIAP applicant or dependent if the gross receipts are reported on an Internal Revenue Servcie (IRS) Schedule C or 1099. Self employed income also includes income received for providing adult foster care if the recipient of the care lives in the applicant's home. Self-employment does not include income received from a partnership, S-corporation, C-corporation, or adult foster care if the care is not provided in the caregiver's home. Self-employment does not include income received from a Limited Liability Company except in the following situations:
(a) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule C for said income, that income will be treated as self-employment and subject to business deductions.
(b) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule F or J for said income, that income will be treated as Farming, Fishing or Ranching and subject to business deductions.
(27) "Support" means any court-ordered monetary payment for a child or former spouse or domestic partner whom FHIAP does not count in the applicant's family.
(28) "Voluntary payroll deduction" means an amount the employee has authorized the employer to deduct from the employee's income to pay expenses not required by law.
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0020

Reservation Lists

(1) To manage enrollment and ensure that funds are available to cover subsidy payments for those enrolled, two reservation lists will be established and maintained for FHIAP. One list will be for prospective applicants who have or will have access to group health benefit coverage. One list will be for prospective applicants who do not have access to group health benefit coverage.

(2) The Office will establish procedures to manage the reservation lists with the goal of equal distribution of funds between the group health benefit market and the individual health benefit market. This may require FHIAP to release applications from one reservation list ahead of the other.
(3) An applicant may obtain an individual or group application by first getting on the reservation list; or may access a group application via FHIAP's website; or from an employer or insurance producer.
(4) Prospective applicants will be added to the appropriate reservation list or assigned a reservation number in order of the date FHIAP receives a completed reservation request either in writing or over the telephone. A completed application form may be deemed a reservation request if no prior request was made.
(5) Each request will be assigned a reservation number, which will also function as confirmation of placement on the appropriate reservation list.
(6) Prospective applicants on the reservation list will be notified of their right to apply for FHIAP, as program funds are available.
(7) When enrollment in FHIAP reaches the maximum that funding will allow, additional enrollment may occur as current members terminate or if additional program funding becomes available.
(8) A prospective applicant has 75 calendar days from the date the Office mails the application form, or notifies the prospective applicant that they may apply for a FHIAP subsidy, to return a completed application form to the Office. If the Office does not receive a completed application form postmarked within 60 calendar days from the date it mails the application form, or notifies the applicant, the Office will mail a notice to the prospective applicant reminding them to complete and submit the application form.
(9) If a prospective applicant does not return an application form within 75 calendar days from the original date of mailing or notification, the Office will remove the prospective applicant's name from the reservation list.
(10) A prospective applicant may enroll in a health benefit plan while on the reservation list as long as they have met the six-month period of uninsurance requirement or exceptions to the period of uninsurance requirement prior to enrolling in the plan.
(11) FHIAP applicants may add new dependents to an existing insurance plan or their FHIAP application without adding them to the reservation list first.
(12) Members who have terminated from FHIAP cannot re-enroll in the program without first being placed on the appropriate reservation list unless they have a family member who is still enrolled in FHIAP.
Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0030

Application Process

(1) An application form developed by the Office, and any documentation required on the form, will be used to determine eligibility and subsidy level.
(2) The Office will establish procedures for the application process with the goal of more equally distributing funds between the group health benefit market and the individual health benefit market. This may require the Office to release applications from one reservation list ahead of the other.
(3) The application process is the only time when applicants may submit information proving their program eligibility. Information not submitted during this process will not be accepted for purposes of audit, appeal or contested case hearing except as provided in OARs 442-005-0310, 442-005-0320, 442-005-0330 and 442-005-0340.
(4) As program funds are available, prospective applicants on a reservation list are notified in writing of their eligibility to apply for FHIAP. An application form is included with the notice.
(5) Once the completed application is received, FHIAP will take action on it. Action may be approval, denial or a request for further information from the applicant.

(6) FHIAP may screen applications for FHIAP for potential eligibility for OHP. If FHIAP discovers that such potential eligibility exists, FHIAP will advise the applicant in writing of this possibility.
(7) Documents that verify required information requested on the application must be provided with the application if FHIAP is not able to verify the information electronically. Required documentation includes but is not limited to:
(a) A copy of a current Oregon identification or other proof of Oregon residency for all adult applicants;
(b) For non-United States citizens, a copy of documentation from INS showing their status and when they arrived in the United States.
(c) Documents verifying all adult applicant's and spouse's earned and unearned income and children's unearned income for the three months prior to the month in which the application is signed. Documentation may include, but is not limited to, pay stubs, award letters, support printouts and unemployment benefit stubs or printouts;
(d) A completed Self-Employment Income Worksheet and documents verifying income from self-employment for the six months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;
(e) A completed Farming, Ranching and Fishing Income Worksheet and documents verifying income from farming, fishing and ranching for the 12 months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;
(f) The most recently filed federal tax return and all schedules for applicants who have income from self-employment or farming, fishing or ranching.
(g) A copy of any group insurance handbook, summary, or contract that is available to any applicant.
(h) A completed Group Insurance Information (GII) form, if the applicant has group insurance available to them.
(i) For applicants with no income, the completed No Income form or other signed statement explaining how the applicant is meeting their basic needs, such as food, clothing and shelter.
(8) Additional verification must be provided when FHIAP requests it.
(9) FHIAP may verify any factors affecting eligibility, benefit levels or any information reported, such as:
(a) Data received by FHIAP that is inconsistent with information on the FHIAP application.
(b) Information provided on the application is inconsistent;
(c) Other information received by FHIAP is inconsistent with information on the FHIAP application;
(d) Information reported on previous applications is inconsistent with a current FHIAP application.
(10) FHIAP may decide at any time during the application process that additional eligibility factors must be verified.
(11) FHIAP may deny an application or end ongoing subsidy when acceptable verification or required documentation is not provided.
Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0040
Pending Applications

(1) Whenever additional information is requested by FHIAP during the application process the application will be placed in a "pend" status.
(2) Whenever further information is requested by FHIAP during the application process, the applicant has 45 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not rpostmarked within 30 calendar days from the date on the request, the Office will mail a "15-day notice" to the applicant advising that only 15 days remain in which to provide the additional information.
(3) If an applicant does not provide all requested information within 45 days of the initial request, the application will be denied.

(4) Once an applicant has been denied because the applicant failed to respond to the request for further information, the applicant must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0050

Eligibility

In order for an applicant to qualify for a FHIAP subsidy, applicants must:
(1) Be a resident of Oregon or a full-time college student with a parent who is a resident of Oregon;
(2) Be a United States citizen or a qualified non-citizen who meets the alien status requirement;
(3) Not be eligible for or receiving Medicare benefits;
(4) Have investments and savings that are available of no more than $10,000 on the last day of the month prior to the month the application is signed. Investments and Savings are not available if owned by or a beneficial interest in them is held by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for the purposes of this subsection (4);
(5) Have income of less than 185% of the Federal Poverty Level in effect at the time of determination. Income determination is outlined in OAR 442-005-0070;
(6) Meet one of the statutory definitions of family in ORS 735.720(2) at the time of eligibility determination. To be included in the family size for FHIAP eligibility determination, the applicant's family members must meet the definition of dependent under OAR 442-005-0010 (8):
(a) A dependent may be counted in two separate households for the purposes of determining eligibility for FHIAP and any other assistance program;
(b) A dependent may be counted in two separate households for the purpose of determining eligibility for both families in FHIAP;
(c) A dependent may not be enrolled in two premium/medical assistance programs at the same time;
(d) A dependent may be enrolled in FHIAP and any non-premium/medical assistance program at the same time;
(e) If a dependent is counted in two separate households for the purpose of determining eligibility in two premium/medical assistance programs, enrollment will be determined by criteria established in procedure;
(7) Meet either a period of uninsurance requirement or exceptions listed in OAR 442-005-0060;
(8) Not be incarcerated for more than 30 days or be a ward of the State;
(9) Provide necessary materials in order to allow for eligibility determination. If information submitted is inconsistent, and applicant may be denied;
(10) If applying for subsidy in the group market, must be able to enroll in an group insurance plan that meets the benchmark standard established by the Office within twelve months of eligibility determination. If an applicant to the group market does not have access to a group plan, the group plan they have access to does not meet the benchmark standard, or they cannot enroll into their group plan within twelve months of eligibility determination, the applicant will be denied and placed on the reservation list for an individual subsidy using the same date they were placed on the group reservation list.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; IPGB 3-2006(Temp), f. & cert. ef. 11-27-06 thru 5-25-07

442-005-0060

Period of Uninsurance Requirement

In order for an applicant to be eligible for a FHIAP subsidy, an applicant must have been without any health insurance coverage for six months immediately prior to either the signature date on the application, the date of eligibility determination, or any reservation entry date. This requirement does not apply if any applicant:
(1) Is currently enrolled in the OHP.
(2) Was enrolled in the OHP within the last 120 days.

(3) Is a former FHIAP member.
(4) Has enrolled in an insurance plan while on the reservation list as long as they have met the six-month period of uninsurance immediately prior to enrolling in the insurance plan.
(5) Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 - 735.714.
(6) Has a military insurance plan.
(7) Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list, as long as the applicant had been without any insurance coverage for six consecutive months immediately prior to becoming insured under the group plan.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0070

Income Determination

In order to qualify for FHIAP, an applicant must have average monthly gross income, from all sources, of up to 185 percent of the federal poverty level in effect at the time of determination. Subsidies will be approved on a sliding scale determined by income and family size.
(1) Average income from all sources, except income received from farming, fishing, ranching, or self-employment, will be determined using income received in the three-calendar months prior to the month in which the application was signed.
(2) FHIAP will determine if income received is considered farming, fishing or ranching by whether the income is reported on an IRS schedule F or J form. FHIAP will determine average income from farming, fishing or ranching by using gross receipts for the 12 months prior to the month the application was signed less deductions by either method (a or b) below. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Farming, Ranching and Fishing Income Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year's eligibility determination, including appeal and contested case hearing processes.
(3) FHIAP will determine if the applicant or applicant's spouse meets the definition of self-employment. Upon meeting the definition of self-employment, the average monthly gross receipts from self-employment and prior to FHIAP deductions will be determined using gross receipts received from the self-employed business during the six months prior to the month in which the application was signed. If the average gross monthly self-employment income during the six months prior to the month the application was signed exceeds $10,000.00, the applicant will be ineligible for FHIAP. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Self-Employment Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year's eligibility determination, including appeal and contested case hearing processes.
(a) Income received from farming, fishing, ranching and self-employment will be reduced by 50 percent for business expenses; or
(b) Income received from farming, fishing, ranching and self-employment will be reduced by the actual allowable expenses incurred during the six or twelve months prior to the date the application was signed.
(A) The following are considered allowable expenses:
(i) Labor (wages paid to an employee or work contracted out) except when paid to the applicant, anyone in the applicant's family, or a business partner.
(ii) Raw materials, equipment, machinery or other durable goods used to make a product or provide a service, excluding personal vehicles and real property. FHIAP will determine whether a vehicle is considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.
(iii) Interest paid to purchase income-producing property, such as equipment or capital assets.
(iv) Insurance premiums, taxes, assessments, and utilities paid on income-producing property.
(v) Service, repair, and rental of business equipment (including motor vehicles) and property that is owned, leased or rented, excluding personal vehicles. FHIAP will determine whether a vehicle is

considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.
(vi) Advertisements and business supplies.
(vii) Licenses, permits, legal, or professional fees.
(viii) Transportation costs at 20 cents per mile, if the cost is part of the business expense. Commuting expenses to and from the worksite are not considered part of the business expense. If applicant is able to prove actual expenses for fuel and maintenance on business vehicles, those amounts can be deducted in lieu of the mileage calculation. In no instance will both deductions be allowed.
(ix) Charges for telephone services that can be verified as a necessary expense for self-employment.
(x) One-third (33.3%) of utility costs when the business shares a physical address with the applicant's residence.
(xi Costs related to traveling to another area only when there is a reasonable possibility of deriving income from the trip, except for the cost of meals.
(xii) Business related bank and credit card fees.
(xiii) Bad debt.
(B) The following are not allowed as costs of producing self-employment income:
(i) Meals for the applicant or their family.
(ii) Payments on the principal of the purchase price of income-producing real estate.
(iii) Federal, state, and local income taxes, draws, or salaries paid to any family member, money set aside for personal retirement, and other work-related personal expenses (such as transportation, personal business, and entertainment expenses).
(iv) Depreciation.
(v) Costs related to traveling to another area when there is no reasonable possibility of deriving income from the trip.
(vi) Interest paid on credit card accounts.
(vii) Personal telephone charges.
(viii) Interest or principal payments on a mortgage when the business shares an address with the applicant's residence.
(ix) Rental payments for real property when the business shares a physical address with the applicant's residence.
(x) Losses incurred by another business.
(4) Income is available immediately upon receipt, or when the applicant has a legal interest in the income and the legal ability to make the income available, except in the following situations when it is considered available as indicated:
(a) For earned and unearned income:
(A) Income available prior to any deductions such as garnishments, taxes, payroll deductions, or voluntary payroll deductions will be considered as available; however, support payments as defined in OAR 442-005-0010(34) may be deducted from gross income if the applicant is able to prove the payments were made.
(B) Income usually paid monthly or on some other regular schedule, but paid early or late is treated as available on the regular payday.
(C) Payments made in a "lump-sum" will be divided out over the number of months the payment is for. "Lump sum" payments will only be divided if the applicant can provide proof of the period for which the payment was made.
(b) Earned income is available as follows:
(A) Income withheld or diverted at the request of an employee is considered available in the month the wages would have been paid;
(B) An advance or draw that will be subtracted from later wages is available when received.
(c) Payments that should legally be made directly to an applicant, but are paid to a third party on behalf of an applicant, are considered available the date that is on the check or stub.
(5) Income is not available if:

(a) The wages are withheld by an employer, with the exception of garnishment, even if in violation of the law;
(b) The income is paid jointly to the applicant and other individuals and the other individuals do not pay the applicant his/her share.
(c) It is received by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for purposes of this subsection (5)(c).
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0080

Additional Eligibility Requirements in the Group Market

(1) Applicants on the group reservation list will be approved for a FHIAP subsidy only if a group plan that meets the benchmark standard is available to them or someone in their family at the time of application, even if enrollment in the plan is not immediate.
(2) If an applicant is sent an application based on availability of group insurance and does not have a group plan available to them or anyone in their family within 12 months of application, the application will be denied. The applicant will automatically be placed on the individual reservation list using the same date they were placed on the group reservation list.
(3) If an applicant on the group reservation list has access to a group insurance plan, but it does not meet the benchmark, the application will be denied and the applicant will be placed on the individual reservation list using the same date they were placed on the group reservation list.
(4) In the instance when FHIAP is not allowed as a qualifying event, the applicant must enroll during the employer's open enrollment period. The applicant will remain eligible for subsidy through their group insurance for 12 months.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0090

Determination - Approvals and Denials

(1) If the applicant is denied subsidy during the application process, FHIAP will send a letter advising the applicant of the decision. The letter will include information regarding the applicant of the decision. The letter will include information regarding the applicant's right to appeal or request a contested case hearing and the steps necessary to do so (ref. 442-005-0330). Applicants whose entire family are denied and wish to reapply must first get on the appropriate reservation list.
(2) If the applicant is approved for subsidy, FHIAP will send a letter advising the applicant of the decision. The letter will include information about who has been approved for subsidy and the level of subsidy to be paid.
(3) The subsidy eligibility period will be based on the subsidy approval date, not the effective date of enrolment in the insurance plan.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0100

Subsidy Levels

(1) When a family has average gross monthly income up to 125 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:
(a) 95 percent of the member's monthly premium amount in the individual health benefit plan market; or
(b) 95 percent of the member's share of the monthly premium amount in the group health benefit plan market.
(2) When a family has average gross monthly income from 125 up to 150 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 90 percent of the member's monthly premium amount in the individual health benefit plan market; or
(b) 90 percent of the member's share of the monthly premium amount in the group health benefit plan market.
(3) When a family has average gross monthly income from 150 up to 170 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:
(a) 70 percent of the member's monthly premium amount in the individual health benefit plan market; or
(b) 70 percent of the member's share of the monthly premium amount in the group health benefit plan market.
(4) When a family has average gross monthly income from 170 up to 185 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:
(a) 50 percent of the member's monthly premium amount in the individual health benefit plan market; or
(b) 50 percent of the member's share of the monthly premium amount in the group health benefit plan market.
(5) The subsidy amounts will never exceed 50 percent, 70 percent, 90 percent, or 95 percent of the total premium based on percentage of federal poverty level in effect at the time of eligibility determination.
(6) With the exception of administrative error or audit, subsidy percentage levels will only be re-evaluated at reapplication. Subsidy dollar amounts may change, however, if the actual premium being subsidized changes.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0110

Applicant Referral to Health Insurance Producers

(1) FHIAP will provide assistance to FHIAP applicants requesting help with health benefit plan decisions.
(2) Applicants who wish to purchase an individual health benefit plan will be referred, upon their request, to participating producers.
(3) To qualify for referrals from FHIAP, health insurance producers must:
(a) Have a current Oregon resident health insurance, general lines producer license, or a nonresident health insurance or general lines producer license, if the nonresident licensee can service the member face to face;
(b) Complete training as required by FHIAP;
(c) Have Errors and Omissions Insurance, with limits of at least $500,000 per occurrence and $1,000,000 aggregate annually, in force during their participation in the Producer Referral Program and agree to notify FHIAP if Errors and Omissions coverage is no longer in force;
(d) Agree to provide the same level of client contact and service to customers receiving a FHIAP subsidy as is provided to other customers;
(e) Agree to help customers fill out an entire Oregon Medical Insurance Pool application if necessary;
(f) Agree to advise FHIAP when the sale of a health benefit plan to FHIAP applicants is completed, whether or not the coverage is a certified plan, or the prospective purchaser decides not to purchase any health benefit plan if requested by the Office; and
(g) Agree to inform customers if they or their dependents may be eligible for OHP.
(4) FHIAP reserves the right to remove any agent from the referral program at any time.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0120

Enrollment In Health Benefit Plans - Individual Market

(1) To remain eligible for subsidy assistance, an applicant must apply for coverage with an insurance plan within the timeframes outlined by FHIAP on the Certificate of Eligibility. The following rule (previously 442-004-0090(2) has been incorporated in section 442-005-0190, Enrollment in FHIAP - Group Market

(2) Approved applicants will no longer be eligible for a FHIAP subsidy if they fail to enroll into an insurance plan as outlined by FHIAP on the Certificate of Eligibility. Approved applicants who fail to enroll must get on a reservation list in order to receive an application to reapply for a FHIAP subsidy. The following rule (previously 442-004-0090(3) has been incorporated in section 442-005-0190, Enrollment in FHIAP - Group Market
(3) Applicants approved for a subsidy in the individual market must use the subsidy to purchase a plan offered by a FHIAP-certified carrier that meets the benchmark standard. The following rule (previously 442-004-0090(4)(a) through (d) has been incorporated in section 442-005-0200, Vendor Set-up/State Accounting System - Group Market
(4) A family approved for a FHIAP subsidy may choose to enroll family members into different plans, including enrolling some family members in a group plan, some family members in an individual plan and some family members in the OHP as long as no family member is enrolled in OHP and FHIAP at the same time.
(5) If a person is enrolled in two insurance plans, FHIAP will subsidize only one plan.
(a) If one of the plans is a group plan that meets the benchmark, FHIAP will subsidize the group plan. If both plans are group plans that meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.
(b) If both of the plans are individual, FHIAP will subsidize only a plan offered by a FHIAP-certified carrier that meets the benchmark standard. If both plans meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.
(6) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.
(7) If the applicant is approved for individual insurance subsidy and has not yet enrolled in an individual insurance plan, FHIAP will begin to subsidize premiums no earlier than the first of the month following the date of the approval letter.
(8) If the applicant is approved for individual insurance subsidy and is already enrolled in the insurance plan, FHIAP may begin subsidizing premiums from the first of the month in which they are approved for subsidy. The subsidy eligibility period will be based on the subsidy approval date
(9) If a carrier elects to discontinue participation in the program, members served by that carrier will have to reapply for insurance coverage with another FHIAP-certified carrier and maintain continuous coverage in order to remain eligible for the subsidy. For the purposes of this section, continuous coverage may include a 120 calendar-day break in coverage.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0130

Member Invoicing - Individual Market

(1) Except for the first billing period, FHIAP will not pay the carrier until the member's portion of the premium has been received.
(2) Invoices are mailed to members one month in advance of the carrier due date to ensure timely payment to the carrier.
(3) Member payments are due to FHIAP by the date provided on the monthly invoice.
(4) Unpaid balances greater than $3.00 are mailed a reminder and given an extension on the original due date.
(5) If the payment is not postmarked by the due date on the reminder, FHIAP subsidy may be cancelled.
(6) If FHIAP fails to send a reminder, the member will be billed for two months during the next billing cycle. In these instances:
(a) FHIAP will not pay the carrier until the amount due has been paid.
(b) FHIAP will not be responsible for carrier non-payment terminations.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0140

Member Payments - Individual Market

(1) Member payments will be processed no less than each business day.
(2) Members will be notified of payments returned by the bank for Non-Sufficient Funds (NSF).
(a) A check that is returned for Non-Sufficient Funds is considered the same as non-payment.
(b) Replacement funds must be sent within 10 days of the date on the notification letter.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0150

Carrier Payments - Individual Market

(1) Member payments must be received before payment to the carrier will be made, except for the first billing period.
(2) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0160

Carrier Refunds - Individual Market

(1) FHIAP will resolve member overpayments by requesting a refund from the carrier; except for overpayments older than three months and overpayments resulting from member misrepresentation.
(2) FHIAP will seek carrier refunds within 30 days of overpayment determination.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0170

Member Refunds - Individual Market

(1) Member refunds will be processed no less than weekly.
(2) Member refunds will not be processed for amounts under $25.00 unless it is the final payment on a termed account.
(3) Members will receive refunds for their portion of any overpaid premium.
(4) Member refunds of premiums paid to a carrier will be processed upon receipt of the refund from the carrier.
(5) Current members billed incorrectly may request a refund or take a credit on their active account for refunds over $25.00.
(6) Member refunds for premium not yet sent to the carrier will be paid weekly even if an additional refund is due from the carrier as long as both refunds are over $25.00.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0180

Selection of Certified Carriers in the Individual Health Benefit Plan Market

Carriers may request to go through the certification process at any time. Selection criteria used to determine which carriers may be certified includes but is not limited to:
(1) Agree to a three-year commitment to be a FHIAP-certified carrier.
(2) Agree to electronic transferring of invoices and payments.
(3) Accept the Certificate of Eligibility in lieu of a first month's payment.

(4) Be an Oregon licensed health insurance company or health care service contractor holding a valid certificate of authority from the Department of Consumer and Business Services authorizing the transaction of health insurance.
(5) Be in the Oregon small employer-sponsored health benefit plan market (2-50 employees) and Oregon individual health benefit plan market.
(6) Have been in the individual or portability market for at least the last three consecutive years.
(7) Agree to accept FHIAP payment grace periods.
(8) The carrier shall remain responsible for notifying its FHIAP membership of premium rate increases.
(9) Offer one or more health benefit plans that meet FHIAP's benchmark requirements.
(10) Agree to give the Office of Private Health Partnerships a written 180-day notice of intent to withdraw from being a certified carrier.
(11) Agree that the -- Office of Private Health Partnerships may cancel partnership with cause by giving 180-day written notice.
(12) If the Office determines at any time that an insufficient number of individual health benefit plan options are available, it may request additional Individual Health Benefit Plan carriers to be certified.
(13) The carrier discontinuing participation must notify each insured FHIAP member 90 calendar days before their coverage will be discontinued and inform each insured to contact FHIAP for assistance in obtaining new coverage.
(14) May give preference to carriers with statewide coverage.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0190

Enrollment in FHIAP - Group Market

(1) Any applicant approved for a subsidy in the group market must enroll in a group plan that meets the benchmark standard within 12 months of being approved for FHIAP. Applicants that do not enroll in a group plan within 12 months will have to get back on the reservation list in order to reapply for a subsidy.
(2) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.
(3) If the applicant is approved for a group insurance subsidy, FHIAP will subsidize premiums that pay for the full approval month, no matter what day in the approval month the decision is made. The subsidy eligibility period will be based on the subsidy approval date.
(4) Once enrolled, if a member loses their group coverage due to loss of employment, or the employer discontinues the group plan, FHIAP will subsidize a COBRA, portability plan, or individual plan.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0200

Vendor Set-up/State Accounting System - Group Market

Subsidy payments may be payable to:
(1) The member or member's employed spouse from whose pay check the premium is being deducted.
(2) Parents of member children.
(3) Carriers.
(a) Member payments must be received before payment to the carrier will be made, except for the first billing period.
(b) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0210

Employer Verification - Group Market

(1) Employer contribution changes - Members must report changes in circumstances to FHIAP as provided in 442-005-0260.
(2) Subsidy changes - FHIAP will request a new employer verification form if plan changes become evident through payroll deduction changes, member notification, etc. FHIAP will continue to subsidize the member at the documented rate until new rates are received. Underpayments will be paid to members when new rates are documented.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0220

Subsidy Payments - Group Market

(1) The amount FHIAP will subsidize is based on the monthly insurance premium less the employer's contribution.
(2) FHIAP will reimburse the eligible members' portion of the premium in the group market using submitted payment verification. Verification can include, but is not limited to payroll records, pay check stubs, employer letters, carrier invoices, receipts, and cancelled check copies.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0230

COBRA/Portability

(1) Potential applicants with a COBRA or Portability plan are placed on FHIAP's reservation list.
(2) Members receiving group subsidy who lose their insurance coverage may opt for COBRA, Portability, or an Individual insurance plan and FHIAP will continue to provide premium subsidy.
(3) Members approved for group subsidy who lose their insurance coverage prior to using the FHIAP subsidy may opt to use their FHIAP subsidy toward COBRA, state continuation, or portability.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0240

Reapplication for Health Insurance Subsidy

(1) Eligibility for subsidy lasts for a maximum of twelve months.
(2) Members must reapply for subsidy once every 12 months after receiving their initial approval.
(3) FHIAP will send members an application at least 60 calendar days before their subsidy eligibility ends. The application will be mailed to the last known address of the member. The information provided by the member on this application will be used to determine the family's eligibility for the next 12 months.
(4) FHIAP will review eligibility during the reapplication process using the same requirements as outlined in OAR 442-005-0020.
(5) The application is mailed with a letter, outlining the review process and the due date for return of the reapplication materials.
(6) The member will have at least 45 calendar days from the date the application is mailed to return the reapplication materials. If the reapplication materials are not postmarked within 30 calendar days, the Office will mail a notice to the member Reminding them to return their application to FHIAP by the due date.

(7) If the reapplication materials are not postmarked by the due date, the application is denied and the applicant must make a new reservation in order to receive an application as space permits.
(8) Once the completed application materials are received FHIAP will take action on it. The action may be approval, denial, or a request for further information from the applicant.
(a) Reapplications that require more information to determine FHIAP eligibility will be placed in a "pend" status.
(b) Whenever further information is requested by FHIAP during the reapplication process, the applicant has 45 calendar days following the date of the request to provide the additional information. If the information requested by FHIAP is not postmarked within 30 calendar days from the date on the request, the Office will mail a notice to the member advising that only 15 days remain in which to provide the additional information.
(c) If a member does not provide all requested information within 45 calendar days of the initial request, the reapplication will be denied.
(d) Once a member has been denied because they failed to respond to the request for further information, the member must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.
(9) If a member is denied continued eligibility during the reapplication process, FHIAP will notify the member in writing of the reason for the denial, the effective date of the action, a phone number and resource for questions, and appeal and contested case hearing rights.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0250

Adding Dependents

(1) Members may add dependents to their FHIAP enrollment at any time throughout the 12-month eligibility period as long as the dependent meets the period of uninsurance requirement or exceptions outlined in OAR 442-005-0060.
(2) Premium rates and the member's portion of the premium could change as a result of adding dependents.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0260

Member Reporting

(1) Members must report changes in circumstance to FHIAP within 30 calendar days of their occurrence by phone or in writing. These circumstances include the following:
(a) Change of Name;
(b) Change in Employers;
(c) Changes to family composition including death, divorce, any family member becoming a ward of the state or being incarcerated for more than 30 continuous days;
(d) Change of home or mailing address, even if temporarily away (more than 30 days):
(e) If any FHIAP member drops health benefit coverage;
(f) Obtaining different or additional health benefit coverage;
(g) Any family member becomes ineligible for health benefit plan;
(h) Change in employer contribution for FHIAP members receiving subsidy in the group market;
(i) If group insurance becomes available to a member enrolled in the individual market as stipulated in OAR 442-005-0190(2).
(2) Failure to report any of the above changes may result in termination from the program, subsidy suspension, loss of insurance coverage or an overpayment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0270

Termination of Subsidy

Termination from the FHIAP program occurs when:
(1) Payment of the member's share of the insurance premium is not postmarked by the date stipulated in correspondence from FHIAP;
(2) The member is no longer a resident of Oregon;
(3) The member terminates or is terminated from the member's health benefit plan and fails to notify FHIAP;
(4) The insurance plan that covers an eligible child of any member terminates or is terminated, and the member does not replace the eligible child's health insurance within 120 calendar days from the date FHIAP notifies the member to replace the child's coverage.
(5) The member is determined to be ineligible at reapplication or any time during the subsidy year. Ineligibility results if:
(a) A member is eligible for or receiving Medicare on or before the date the application was signed. Subsidy may remain in force for the remainder of the applicant's 12-month eligibility period if the applicant became eligible for Medicare after signing the application.
(b) A member is incarcerated beyond 30 continuous calendar days.
(c) Any member is enrolled in OHP and FHIAP simultaneously and fails to timely terminate from one program after being notified by FHIAP that they must do so.
(d) Any information submitted is inconsistent and does not allow for eligibility determination.
(e) FHIAP staff makes an administrative error when determining eligibility and the applicant should have been denied and the error is identified during an audit of the member's file.
(f) An applicant or member in the individual market becomes eligible for a benchmark-approved group plan with an employer contribution and doesn't enroll within 30 days of the first opportunity of enrollment in the group plan.
(g) The member failed to submit required or requested information or submitted inadequate or unclear information such that FHIAP cannot make an eligibility determination.
(6) In the group market, the member fails to provide monthly verification of coverage, premiums, and employer contribution within 30 days from the date FHIAP requests such documentation.
(7) The member fails to pay an overpayment amount as per OAR 442-005-0280.
(8) The member fails to return their reapplication within 45 days from the date it was mailed to them.
(9) A member is found to have committed misrepresentation on their FHIAP application. If a civil penalty is imposed, the member is ineligible to enroll or re-enroll in FHIAP.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0275

Misrepresentation/Civil Penalty

(1) FHIAP may investigate any applicant, member or former member for misrepresentation in obtaining subsidy benefits. Such investigations may be through random file audits or by management request.
(2) FHIAP may ask appropriate legal authorities to initiate civil or criminal action under Oregon laws when, in FHIAP's judgment, available evidence warrants such action.
(3) FHIAP may issue an intent to take disciplinary action against a member by giving notice of the opportunity for a contested case hearing.
(4) When a finding is made that an applicant or member has committed misrepresentation:
(a) The member is terminated from FHIAP and ineligible to re-enroll in FHIAP;
(b) The member is liable for repayment to FHIAP the full amount of overpayment FHIAP has established, regardless of any restitution amount ordered by a court;

(c) The applicant or member is liable for any civil penalty set by FHIAP up to a statutory limit of $1,000. The civil penalty amount will be set by using a sliding scale based on the amount of subsidy paid on the member's behalf.
Stat. Auth.: ORS 735.734, 735.740, & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0280

Overpayments

(1) Any overpayment amount is a debt owed to the State of Oregon and may be subject to collection. An overpayment may result from administrative error, member error, misrepresentation, or civil penalty.
(2) An overpayment is considered to be member error if it is caused by the member's misunderstanding or error. Examples include, but are not limited to, instances where the member intentionally or unintentionally:
(a) Did not provide correct or complete information to FHIAP;
(b) Did not report changes in circumstances to FHIAP;
(c) Claimed and was reimbursed for an ineligible subsidy period.
(3) An administrative error overpayment may be caused by any of the following circumstances:
(a) FHIAP committed a calculation, procedural, or typing error that was no fault of the member;
(b) FHIAP failed to compute or process a subsidy payment correctly.
(4) A misrepresentation error includes but is not limited to the member giving an inaccurate or deliberately false statement of fact that results in an inappropriate eligibility determination or an incorrect subsidy level calculation. Misrepresentation may result in a civil penalty.
(5) The FHIAP member is having the health insurance premium subsidized by another state government program, such as, but not limited to OHP, and such subsidy results in a double payment for the same health insurance premium.
(6) FHIAP will mail notification of overpayments to the member. This written notice shall:
(a) Inform the member of the amount of and the reason for the overpayment;
(b) Inform members of their appeal and contested case hearing rights.
(7) FHIAP will collect overpayment amounts in one lump sum if the member is financially able to repay the overpayment amount in that manner.
(8) If the member is financially unable to pay the amount due in one lump sum, FHIAP will accept regular installment payments as outlined in 442-005-0290 - Payment Plans.
(9) If FHIAP is unable to recover the overpayment amount from the member within overpayment guidelines:
(a) FHIAP may renegotiate the payment plan agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.
(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.
(10) If the member submits an appeal or contested case hearing request, FHIAP will discontinue any attempts at collection until the conclusion of the appeal or hearing.
(11) If the appeal decision is in the member's favor, FHIAP will refund any money collected as overpayment recovery as outlined in OAR 442-005-0280, 442-005-0290 and 442-005-0300.
(12) Any former FHIAP member with an outstanding overpayment balance who is reapplying for FHIAP subsidy must meet the regular eligibility criteria and be repaying their outstanding overpayment as follows:
(a) A minimum of $10 per month or the amount necessary to collect the overpayment amount in one year, whichever is greater, or

(b) An offset against any future monthly subsidy payment in the amount necessary to collect the overpayment amount in one year.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0290

Payment Plans

Subsidy overpayments that are paid on the member's behalf are the member's responsibility. Members may be eligible to establish a payment plan to reimburse FHIAP.
(1) Payment plans for Individual members who are currently enrolled:
(a) Members who have been billed at an incorrect subsidy level or premium rate will be responsible for repayment of their portion of the amount FHIAP overpaid the insurance carrier on their behalf.
(b) Members will have an option to either repay the overpayment amount in full or establish a payment arrangement.
(c) Payments established under a payment arrangement will consist of no less than the regular monthly member portion plus an amount sufficient to reduce the overpayment to zero within 120 days.
(d) If the overpayment cannot be paid within 120 days, special payment arrangements may be coordinated. Consideration for the payment plan will be the time remaining before the next reapplication period. The overpayment must be paid in full to FHIAP within 12 months unless an exception is negotiated.
(e) Once a payment plan is approved FHIAP sends the member a letter. The letter:
(A) Outlines the payment arrangement and informs members that they are responsible for making timely payments according to the established payment plan.
(B) Informs the member of what action FHIAP will take to collect the overpayment.
(f) If the member fails to follow the payment plan, the member may be terminated for non-payment. The unpaid balance will then be transferred to collections.
(2) Payment plans for group members who are currently enrolled:
(a) Members have an option to either repay the overpayment amount in full or establish a payment arrangement.
(b) Group member overpayments will be collected by reducing subsidy reimbursements on active accounts until the full overpayment is repaid,
(c) Group overpayments must be repaid within 120 days unless alternate timeframes are negotiated.
(d) Consideration for the payment plan will be the time remaining before the next reapplication period.
(e) The overpayment must be repaid within 12 months unless an exception is negotiated.
(3) Payment plans for inactive members: See Collections Section 442-005-0300.
(4) Terminated members with an outstanding unpaid balance, who are reapplying to the program, must establish payment arrangements in order to be eligible for re-enrollment.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0300

Collections

(1) FHIAP staff will reconcile terminated accounts with unpaid balances.
(2) FHIAP staff will notify the member in writing of the collection amount. The terminated member will have 21 days to appeal before further collection action is taken, unless appeal rights were already extended in other FHIAP correspondence.
(3) Terminated members may be eligible to establish a payment plan as outlined in OAR 442-005-0290.
(4) If FHIAP is unable to recover the unpaid balance from the terminated member or no payment is made within 90 days:

(a) FHIAP may renegotiate the collection agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.
(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0310

Audits

(1) Quality assurance audits will be performed to verify:
(a) FHIAP statutes, rules, policies and procedures are followed correctly.
(b) FHIAP procedures are effective.
(c) Eligibility is determined correctly.
(2) Audits may be performed on a directed or random basis.
(3) As a result of an audit:
(a) A member or former member may be determined ineligible for a FHIAP subsidy.
(b) A member or former member may be determined ineligible retroactively for a prior subsidy eligibility period.
(c) A subsidy level adjustment may be necessary for a current or previous determination period.
(4) An audit determination could result in an overpayment or underpayment to a member or former member.
(5) The member or former member must submit additional verification when FHIAP requests it.
(a) FHIAP may verify any factors affecting eligibility, benefit levels or any reported information. Such information includes, but is not limited to:
(A) Any information submitted by the member that is inconsistent.
(B) Information provided on the application that is inconsistent.
(C) Other information that is used as verification but is inconsistent with the information on the application.
(D) Information reported on previous application that is inconsistent with the current FHIAP application.
(b) FHIAP may decide at any time that additional eligibility factors must be verified.
(c) FHIAP may deny an application or end ongoing subsidy when requested verification is not provided.
(6) Requested verification includes the same information as listed in OAR 442-005-0030 as well as any other information that will verify information already submitted.
(7) If additional information is requested during a directed or random audit, the member has 30 days from the date of the Request for Information letter to submit the information. FHIAP will use the postmark date to determine timeliness. If a FHIAP member fails to cooperate with a FHIAP audit, the member may be disenrolled.
(8) If a decision differs from the original eligibility determination, FHIAP will notify the member in writing of the reason for the denial or change in determination, the effective date of the action, and the member's appeal and contested case hearing rights.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0320

Appeals

(1) All FHIAP correspondence that notifies applicants or members of decisions and determinations will include appeal language and outline the steps necessary to file an appeal.
(2) An applicant or member may appeal any decision made or action taken by FHIAP.

(3) To appeal a decision or action, the applicant or member must advise FHIAP in writing of their desire to appeal. The written appeal request must be postmarked within 21 calendar days of the date on the notice or action.
(4) The appeal request must include the reasons for the appeal, which shall be limited to the issue(s) cited in the decision or determination.
(5) On its own or if asked by an applicant or member, FHIAP may consider additional information during the appeal process. If further information is requested by FHIAP, the applicant or member has 15 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not postmarked within 15 calendar days from the date on the request, the original decision will be upheld.
(6) Once FHIAP has made a decision on appeal, the applicant or member will be notified of the appeal decision.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0330

Contested Case Hearings

(1) An applicant or member may request a hearing on FHIAP's appeal decision.
(2) To receive a hearing, the hearing request must be in writing, signed by either the applicant, member, or their attorney and be postmarked no later than 21 calendar days following the date of the appeal decision notice.
(3) The hearing request must include the reasons for the hearing, which shall be limited to the issue(s) cited in the appeal decision notice.
(4) FHIAP will conduct a contested case hearing pursuant to ORS 183.413 to 183.470.
(5) Once a hearing is requested, FHIAP will not pursue collection of any alleged overpayment until FHIAP has issued a final order affirming the overpayment.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0340

Extenuating Circumstances

The Agency Administrator or designee will appoint a case management panel to review extenuating circumstance requests that may result in exceptions to application of the administrative rules. Requests relating to life circumstances beyond the applicant's control will be considered.
(1) Exceptions will not be granted for any eligibility requirements except the extension of timeframes associated with submitting information, including, but not limited to the application, income verification, appeal or hearing request and information specifically requested by FHIAP staff.
(2) Exceptions will also be considered for non-payment of the member's portion of the insurance premium.
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0350

Rule Authorizing Agency Representative

(1) Subject to the approval of the Attorney General, a FHIAP officer or employee is authorized to appear on behalf of the agency in a hearing that may result in the change or termination of program benefits as well as in some cases imposing civil penalties.
(2) The agency representative may not make legal argument on behalf of the agency.
(a) "Legal argument" includes arguments on:
(A) The jurisdiction of the agency to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency; and
(C) The application of court precedent to the facts of the particular contested case proceeding.
(b) "Legal argument" does not include presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:
(A) The application of the facts to the statutes or rules directly applicable to the issues in the contested case;
(B) Comparison of prior actions of the agency in handling similar situations;
(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case; and
(D) The admissibility of evidence or the correctness of procedures being followed.
(3) When an agency officer or employee represents the agency, the presiding officer shall advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer shall provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after conclusion of the hearing.
(4) The presiding officer may limit an authorized representative's presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments to insure the orderly and timely development of the hearing record, and shall not allow an authorized representative to present legal argument as defined in subsection (2)(a).
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

Michigan: Access Health

Statute

Not applicable. Since Access Health is a county-based program, there is no state statute that authorizes or describes the program.

Administrative Rules

Same.

Utah: Utah's Premium Partnership for Health Insurance (UPP)

Statute

http://le.utah.gov/~code/TITLE26/htm/26_0F010.htm

26-18-3.5. Copayments by recipients -- Employer sponsored plans.

(1) The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

(2) (a) The department shall seek approval under the department's Section 1115 Medicaid waiver to cap enrollment fees for the Primary Care Network Demonstration Project in accordance with Subsection (2)(b).

(b) Pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at $15 per year for those persons who, after July 1, 2003, are eligible to begin receiving General Assistance under Section **35A-3-401**.

(c) Beginning July 1, 2004, and pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at $25 per year for those persons who have an income level that is below 50% of the federal poverty level.

(3) Beginning May 1, 2006, within appropriations by the Legislature and as a means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:

(a) maximizing the health insurance premium subsidy provided under the state's Primary Care Network Demonstration Project by:

(i) ensuring that state funds are matched by federal funds to the greatest extent allowable; and

(ii) as the department determines appropriate, seeking federal approval to do one or more of the following:

(A) eliminate or otherwise modify the annual enrollment fee;

(B) eliminate or otherwise modify the schedule used to determine the level of subsidy provided to an enrollee each year;

(C) reduce the maximum number of participants allowable under the subsidy program; or

(D) otherwise modify the program in a manner that promotes enrollment in employer sponsored health insurance; and

(b) exploring the use of other options, including the development of a waiver under the Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

Amended by Chapter 148, 2006 General Session

Download Code Section Zipped WP 6/7/8 26_0F010.ZIP 2,859 Bytes

Administrative Rules

http://www.rules.utah.gov/publicat/bulletin/2007/20070115/29380.htm

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-320
Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver

NOTICE OF PROPOSED RULE

DAR File No.: 29380
Filed: 01/02/2007, 12:54
Received by: NL

RULE ANALYSIS

Purpose of the rule or reason for the change:
This rule complies with the Standard Terms and Conditions of the Section 1115 Demonstration Waiver program approved by the Centers for Medicare and Medicaid Services. In addition, this rule is necessary to change the name of the Department's waiver program to Utah's Premium Partnership for Health Insurance (UPP). It also clarifies other sections that describe program eligibility.

Summary of the rule or change:
This amendment removes language that allows an individual enrolled in employer-sponsored health insurance for less than 60 days to be eligible for the Section 1115 Demonstration Waiver program. Throughout the text, this amendment changes all "HIFA" references to "UPP." It also adds a new premium change requirement, clarifies UPP enrollment eligibility criteria, specifies income requirements, allows an individual 45 days to provide eligibility information or verifications, clarifies eligibility criteria for a Primary Care Network or Children's Health Insurance Program recipient, clarifies the effective date of enrollment for faxed or online applications, deletes the new enrollment fee requirement for reenrollment, removes the requirement that an alien's sponsor is responsible to repay benefits, clarifies reimbursement criteria for dental coverage, and makes other minor clarifications.

State statutory or constitutional authorization for this rule:
Sections 26-18-3 and 26-1-5

Anticipated cost or savings to:

the state budget:
There are minimal savings in state and federal dollars because this rule limits enrollment in the demonstration waiver program. Nevertheless, there is insufficient data to quantify dollar amounts.

local governments:
There is no budget impact because local governments do not fund demonstration waiver programs.

other persons:
There is a minimal loss of revenue to providers and an out-of-pocket expense to Medicaid clients who do not qualify for the demonstration waiver program. Nevertheless, there is insufficient data to quantify dollar amounts.

Compliance costs for affected persons:
There is a minimal loss of revenue to a single provider and an out-of-pocket expense to a single Medicaid client who does not qualify for the demonstration waiver program. Nevertheless, there is insufficient data to quantify dollar amounts.

Comments by the department head on the fiscal impact the rule may have on businesses:
This rule follows an emergency rule published to assure compliance with federal law to implement the Standard Terms and Conditions of the Section 1115 Demonstration Waiver program approved by the Centers for Medicare and Medicaid Services for employer-sponsored health insurance. Moving Medicaid clients to privately-provided insurance will have a positive impact on business. David N. Sundwall, MD, Executive Director (DAR NOTE: The 120-day (emergency) rule filing is under DAR No. 29250 in the December 15, 2006, issue of the Bulletin, and was effective 11/28/2006.)

The full text of this rule may be inspected, during regular business hours, at the Division of Administrative Rules, or at:
Health
Health Care Financing, Coverage and Reimbursement Policy
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231

Direct questions regarding this rule to:
Craig Devashrayee at the above address, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

Interested persons may present their views on this rule by submitting written comments to the address above no later than 5:00 p.m. on:
02/14/2007

This rule may become effective on:
02/22/2007

Authorized by:

David N. Sundwall, Executive Director

RULE TEXT

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-320. Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver.

R414-320-1. Authority.

This rule is authorized by [~~Utah Code~~]Title 26, Chapter 18 [~~The Health Insurance Flexibility and Accountability (HIFA) Demonstration is authorized by a waiver of federal Medicaid and SCHIP requirements approved by the federal Center for Medicare and Medicaid Services~~]and allowed under Section 1115 of the Social Security Act. This rule establishes the eligibility requirements for enrollment and the benefits enrollees receive under the [~~HIFA Demonstration~~] Health Insurance Flexibility and Accountability Demonstration Waiver (HIFA), which is Utah's Premium Partnership for Health Insurance (UPP).

R414-320-2. Definitions.

The following definitions apply throughout this rule:

(1) "Adult" means an individual who is at least 19 and not yet 65 years of age.

(2) "Applicant" means an individual who applies for benefits under the [~~HIFA~~] UPP program, but who is not an enrollee.

(3) "Best estimate" means the Department's determination of a household's income for the upcoming certification period based on past and current circumstances and anticipated future changes.

(4) "Child" means an individual who is younger than 19 years of age.

(5) "Children's Health Insurance Program" or "CHIP" provides medical services for children under age 19 who do not otherwise qualify for Medicaid.

(6) "Department" means the Utah Department of Health.

(7) "Enrollee" means an individual who [~~has~~]applie[~~d~~]s for and [~~been~~]is found eligible for the [HIFA]UPP program.

(8) "Employer-sponsored health plan" means a health insurance plan offered through an employer where:

(a) the employer contributes at least 50 percent of the cost of the health insurance premium of the employee;

(b) coverage includes at least physician visits, hospital inpatient services, pharmacy, well child visits, and children's immunizations;

(c) lifetime maximum benefits are at least $1,000,000;

(d) the deductible is no more than $1,000 per individual; and

(e) the plan pays at least 70% of an inpatient stay after the deductible.

(9) [~~"HIFA" Health Insurance Flexibility and Accountability~~]"Utah's Premium Partnership for Health Insurance" (UPP) program provides cash reimbursement for all or part of the insurance premium paid by an employee for health insurance coverage through an employer-sponsored health insurance plan that covers either the eligible employee, the eligible spouse of the employee, dependent children, or the family.

(10) "Income averaging" means a process of using a history of past and current income and averaging it over a determined period of time that is representative of future income.

(11) "Income anticipating" means a process of using current facts regarding rate of pay, number of working hours, and expected changes to anticipate future income.

(12) "Income annualizing" means a process of determining the average annual income of a household, based on the past history of income and expected changes.

(13) "Local office" means any Bureau of Eligibility Services office location, outreach location, or telephone location where an individual may apply for medical assistance.

(14) "Open enrollment means a time period during which the Department accepts applications for the [~~HIFA~~]UPP program.

(15) "Public Ins<u>t</u>itution" means an institution that is the responsibility of a governmental unit or that is under the administrative control of a governmental unit.

(16) "Primary Care Network" or "PCN" program provides primary care medical services to uninsured adults who do not otherwise qualify for Medicaid.

(17) "Recertification month" means the last month of the eligibility period for an enrollee.

(18) "Spouse" means any individual who has been married to an applicant or enrollee and has not legally terminated the marriage.

(19) "Verifications" means the proofs needed to decide if an individual meets the eligibility criteria to be enrolled in the program. Verifications may include hard copy documents such as a birth certificate, computer match records such as Social Security benefits match records, and collateral contacts with third parties who have information needed to determine the eligibility of the individual.

R414-320-3. Applicant and Enrollee Rights and Responsibilities.

(1) Any person who meets the limitations set by the Department may apply during an open enrollment period. The open enrollment period may be limited to:

(a) Adults with children [~~under age 19~~]living in the home;

(b) Adults without children [~~under age 19~~]living in the home;

(c) Adults enrolled in the PCN program;

(d) Children enrolled in the CHIP program;

(e) Adults or children who were enrolled in the Medicaid program within the last thirty days prior to the beginning of the open enrollment period; or

(f) Other groups designated in advance by the Department consistent with efficient administration of the program.

(2) If a person needs help to apply, he may have a friend or family member help, or he may request help from the local office or outreach staff.

(3) Applicants and enrollees must provide requested information and verifications within the time limits given. The Department will allow the client at least 10 calendar days from the date of a request to provide information and may grant additional time to provide information and verifications upon request of the applicant or enrollee.

(4) Applicants and enrollees have a right to be notified about the decision made on an application, or other action taken that affects their eligibility for benefits.

(5) Applicants and enrollees may look at information in their case file that was used to make an eligibility determination.

(6) Anyone may look at the eligibility policy manuals located at any Department local office.

(7) An individual must repay any benefits received under the [~~HIFA~~]UPP program if the Department determines that the individual was not eligible to receive such benefits.

(8) Applicants and enrollees must report certain changes to the local office within ten calendar days of the day the change becomes known. The local office shall notify the applicant at the time of application of the changes that the enrollee must report. Some examples of reportable changes include:

(a) An enrollee stops paying for coverage under an employer-sponsored health plan.

(b) An enrollee changes health insurance plans.

(c) An enrollee has a change in the amount of the premium they are paying for an employer-sponsored health insurance plan.

(d) An enrollee begins to receive coverage under, or begins to have access to Medicare or the Veteran's Administration Health Care System.

(e) An enrollee [~~has a change in the amount the enrollee pays for coverage under an employer-sponsored health plan~~]leaves the household or dies.

(f) An enrollee[~~leaves the household or dies~~] or the household moves out of state.

(g) [~~An enrollee or household moves out of state~~]Change of address of an enrollee or the household.

(h) [~~Change of address of an enrollee or the household~~]An enrollee enters a public institution or an institution for mental diseases.

~~[(i) An enrollee enters a public institution or an institution for mental diseases.]~~

(9) An applicant or enrollee has a right to request an agency conference or a fair hearing as described in R414-301-5 and R414-301-6.

(10) An enrollee must continue to pay premiums and remain enrolled in an employer-sponsored health plan to be eligible for benefits.

(11) Eligible children may choose to enroll in their employer-sponsored health insurance plan and receive [~~HIFA~~]UPP benefits, or they may choose direct coverage through the Children's Health Insurance Program.

R414-320-4. General Eligibility Requirements.

(1) The provisions of R414-302-1, R414-302-2, R414-302-3, R414-302-5, and R414-302-6 apply to adult applicants and enrollees.

(2) The provisions of R382-10-6, R382-10-7, and R382-10-9 apply to child applicants and enrollees.

(3) An individual who is not a U.S. citizen and does not meet the alien status requirements of R414-302-1 or R382-10-6 is not eligible for any services or benefits under the [~~HIFA~~]UPP program.

(4) Applicants and enrollees for the [~~HIFA~~]UPP program are not required to provide Duty of Support information. An adult who would be eligible for Medicaid but fails to cooperate with Duty of Support requirements required by the Medicaid program cannot enroll in the [~~HIFA~~]UPP program.

(5) Individuals who must pay a spenddown or premium to receive Medicaid can enroll in the [~~HIFA~~]UPP program if they meet the program eligibility criteria in any month they do not receive Medicaid as long as the Department has not stopped enrollment under the provisions of R414-320-15. If the Department has stopped enrollment, the individual must wait for an applicable open enrollment period to enroll in the [~~HIFA~~]UPP program.

R414-320-6. Residents of Institutions.

(1) Residents of public institutions are not eligible for the [~~HIFA~~]UPP program.

(2) A child under the age of 18 is not a resident of an institution if [~~he~~]the child is living

temporarily in the institution while arrangements are being made for other placement.

(3) A child who resides in a temporary shelter for a limited period of time is not a resident of an institution.

R414-320-7. Creditable Health Coverage.

(1) The Department adopts 42 CFR 433.138(b), 2005 ed., which [~~are~~]is incorporated by reference.

(2) An individual who is covered under a group health plan or other creditable health insurance coverage, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), [~~at the time of application~~]is not eligible for enrollment[~~if they have been enrolled for less than 60 days at the time of application~~].

(3) Eligibility for an individual who has access to but has not yet enrolled in employer-sponsored health insurance coverage will be determined as follows:

(a) If the cost of the employer-sponsored coverage [~~does not exceed~~]is less than 5% of the household's gross income, the individual is not eligible for the [~~HIFA~~]UPP program.

(b) For adults, if the cost of the employer-sponsored coverage exceeds 15% of the household's gross income the adult may choose to enroll in the [~~HIFA~~]UPP program or may choose direct coverage through the Primary Care Network program if enrollment has not been stopped under the provisions of R414-310-16.

(c) A child may choose enrollment in [~~HIFA~~]UPP or direct coverage under the CHIP program if the cost of the employer sponsored coverage is equal to or more than 5% of the household's gross income.

(d) An individual is considered to have access to coverage even if the employer offers coverage only during an employer's open enrollment period.

(4) An individual who is covered under Medicare Part A or Part B, or who could enroll in Medicare Part B coverage, is not eligible for enrollment, even if the individual must wait for a Medicare open enrollment period to apply for Medicare benefits.

(5) An individual who is enrolled in the Veteran's Administration (VA) Health Care System is not eligible for enrollment. An individual who is eligible to enroll in the VA Health Care System, but who has not yet enrolled, may be eligible for the [~~HIFA~~]UPP program while waiting for enrollment in the VA Health Care System to become effective. To be eligible during this waiting period, the individual must initiate the process to enroll in the VA Health Care System. Eligibility for the [~~HIFA~~]UPP program ends once the individual becomes enrolled in the VA Health Care System.

(6) The Department shall deny eligibility if the applicant, spouse, or dependent child has voluntarily terminated health insurance coverage within the 90 days immediately prior to the application date for enrollment under the [~~HIFA~~]UPP program.

(a) An applicant, applicant's spouse, or dependent child can be eligible for the [~~HIFA~~]UPP program if their prior insurance ended more than 90 days before the application date.

(b) An applicant, applicant's spouse, or dependent child who voluntarily discontinues health insurance coverage under a COBRA plan, or under the [~~state~~]Utah Comprehensive Health Insurance Pool, or who is involuntarily terminated from an employer's plan may be eligible for the [~~HIFA~~]UPP program without a 90 day waiting period.

(7) An individual with creditable health coverage operated or financed by [~~the~~]Indian Health Services may enroll in the [~~HIFA~~]UPP program.

(8) Individuals must report at application and recertification whether each individual for whom enrollment is being requested has access to or is covered by a group health plan or other creditable health insurance coverage. This includes coverage that may be available through an employer or a spouse's employer, Medicare Part A or B, or the VA Health Care System.

(9) The Department shall deny an application or recertification if the applicant or enrollee fails to respond to questions about health insurance coverage for any individual the household seeks to enroll or recertify.

R414-320-8. Household Composition.

(1) The following individuals are included in the household when determining household size for the purpose of computing financial eligibility for the [~~HIFA~~]UPP program:

(a) The individual;

(b) The individual's spouse living with the individual;

(c) All children of the individual or the individual's spouse who are under age 19 and living with the individual; and

(d) An unborn child if the individual is pregnant, or if the applicant's legal spouse who lives in the home is pregnant.

(2) A household member who is temporarily absent for schooling, training, employment, medical treatment or military service, or who will return home to live within 30 days from the date of application is considered part of the household.

R414-320-9. Age Requirement.

(1) An individual must be younger than 65 years of age to enroll in the [~~HIFA~~]UPP program.

(2) The individual's 65th birthday month is the last month the person can be eligible for enrollment in the [~~HIFA~~]UPP program.

R414-320-10. Income Provisions.

(1) For an adult to be eligible to enroll, gross countable household income must be equal to or less than 150% of the federal non-farm poverty guideline for a household of the same size.

(2) For children to be eligible to enroll, gross countable household income must be equal to or less than 200% of the federal non-farm poverty guideline for a household of the same size.

(3) All gross income, earned and unearned, received by the individual and the individual's spouse is counted toward household income, unless this section specifically describes a different treatment of the income.

(4) Any income in a trust that is available to, or is received by a household member, is countable income.

(5) Payments received from the Family Employment Program, Working Toward Employment program, refugee cash assistance or adoption support services as authorized under Title 35A, Chapter 3 are countable income.

(6) Rental income is countable income. The following expenses can be deducted:

(a) Taxes and attorney fees needed to make the income available;

(b) Upkeep and repair costs necessary to maintain the current value of the property;

(c) Utility costs only if they are paid by the owner; and

(d) Interest only on a loan or mortgage secured by the rental property.

(7) Cash contributions made by non-household members are counted as income unless the parties have a signed written agreement for repayment of the funds.

(8) The interest earned from payments made under a sales contract or a loan agreement is countable income to the extent that these payments will continue to be received during the certification period.

(9) Needs-based Veteran's pensions are counted as income. Only the portion of a Veteran's Administration check to which the individual is legally entitled is countable income.

(10) Child support payments received for a dependent child living in the home are counted as that child's income.

(11) In-kind income, which is goods or services provided to the individual from a non-household member and which is not in the form of cash, for which the individual performed a service or which is provided as part of the individual's wages is counted as income. In-kind income for which the individual did not perform a service, or did not work to receive, is not counted as income.

(12) Supplemental Security Income and State Supplemental payments are countable income.

(13) Income that is defined in 20 CFR 416 Subpart K, Appendix, 2004 edition, which is incorporated by reference, is not countable.

(14) Payments that are prohibited under other federal laws from being counted as income to determine eligibility for federally-funded medical assistance programs are not countable.

(15) Death benefits are not countable income to the extent that the funds are spent on the deceased person's burial or last illness.

(16) A bona fide loan that an individual must repay and that the individual has contracted in good faith without fraud or deceit, and genuinely endorsed in writing for repayment is not countable income.

(17) Child Care Assistance under Title XX is not countable income.

(18) Reimbursements of Medicare premiums received by an individual from Social Security Administration or the [~~State~~]Department [~~of Health~~]are not countable income.

(19) Earned and unearned income of a child is not countable income if the child is not the head of a household.

(20) Educational income, such as educational loans, grants, scholarships, and work-study programs are not countable income. The individual must verify enrollment in an educational program.

(21) Reimbursements for employee work expenses incurred by an individual are not countable income.

(22) The value of food stamp assistance is not countable income.

R414-320-12. Assets.

There is no asset test for eligibility in the [~~HIFA~~]UPP program.

R414-320-13. Application Procedure.

(1) The application is the initial request from an applicant for [~~HIFA~~]UPP enrollment. The application process includes gathering information and verifications to determine the individual's eligibility for enrollment.

(2) The applicant must complete and sign a written application or complete an application

on-line via the Internet to enroll in the [~~HIFA~~]UPP program.

(a) The Department accepts any Department-approved application form for medical assistance programs offered by the state as an application for the [~~HIFA~~]UPP program. The local office eligibility worker may require the applicant to provide additional information that was not asked for on the form the applicant completed, and may require the applicant to sign a signature page from a hardcopy medical application form.

(b) If an applicant cannot write, he must make his mark on the application form and have at least one witness to the signature. A legal guardian or a person with power of attorney may sign the application form for the applicant.

(c) An authorized representative may apply for the applicant if unusual circumstances prevent the individual from completing the application process himself. The applicant must sign the application form if possible.

(3) The date of application will be decided as follows:

(a) The date the Department receives a completed, signed application is the application date when the application is delivered to a local office.

(b) The date postmarked on the envelope is the application date when a completed, signed application is mailed to the agency.

(c) The date the Department receives a completed, signed application via facsimile transfer is the application day. The agency accepts the signed application sent via facsimile as a valid application and does not require it to be signed again.

(d) The transaction date is the application date when the application is submitted online.

(4) If an applicant has a legal guardian, a person with a power of attorney, or an authorized representative, the local office shall send decision notices, requests for information, and forms that must be completed to both the individual and the individual's representative, or to just the representative if requested or if determined appropriate.

(5) The Department shall reinstate a [~~HIFA~~]UPP case without requiring a new application if the case was closed in error.

(6) The Department shall continue enrollment without requiring a new application if the case was closed for failure to complete a recertification or comply with a request for information or verification:

(a) If the enrollee complies before the effective date of the case closure or by the end of the month immediately following the month the case was closed; and

(b) The individual continues to meet all eligibility requirements.

(7) An applicant may withdraw an application any time before the Department completes an eligibility decision on the application.

(8) If an eligible household requests enrollment for a new household member, the application date for the new household member is the date of the request. A new application form is not required. However, the household shall provide the information necessary to determine eligibility for the new member, including information about access to creditable health insurance.

(a) Benefits for the new household member will be allowed from the date of request or the date an application is received through the end of the current certification period.

(b) A new income test is not required to add the new household member for the months remaining in the current certification period.

(c) A new household member may be added only if the Department has not stopped enrollment under [~~s~~]Section R414-320-15.

(d) Income of the new member will be considered at the next scheduled recertification.

(9) A child who loses Medicaid coverage because he or she has reached the maximum age limit and does not qualify for any other Medicaid program without paying a spenddown, may enroll in [~~HIFA~~]UPP without waiting for the next open enrollment period.

(10) A child who loses Medicaid coverage because he or she is no longer deprived of parental support and does not qualify for any other Medicaid program without paying a spenddown, may enroll in [~~HIFA~~]UPP without waiting for the next open enrollment period.

(11) A new child born to or adopted by an enrollee may be enrolled in [~~HIFA~~]UPP without waiting for the next open enrollment period.

R414-320-14. Eligibility Decisions and Recertification.

(1) The Department adopts 42 CFR 435.911 and 435.912, 2004 ed., which are incorporated by reference.

(2) When an individual applies for [~~HIFA~~]UPP, the local office shall determine if the individual is eligible for Medicaid. An individual who qualifies for Medicaid without paying a spenddown or a premium cannot enroll in the [~~HIFA~~]UPP program. If the individual appears to qualify for Medicaid, but additional information is required to determine eligibility for Medicaid, the applicant must provide additional

information requested by the eligibility worker. Failure to provide the requested information shall result in the application being denied.

(a) If the individual must pay a spenddown or premium to qualify for Medicaid, the individual may choose to enroll in the [~~HIFA~~]UPP program if it is an open enrollment period and the individual meets all the applicable criteria for eligibility. If the [~~HIFA~~]UPP program is not in an enrollment period, the individual must wait for an open enrollment period.

(b) At recertification, the local office shall first review eligibility for Medicaid. If the individual qualifies for Medicaid without a spenddown or premium, the individual cannot be reenrolled in the [~~HIFA~~]UPP program. If the individual appears to qualify for Medicaid, the applicant must provide additional information requested by the eligibility worker. Failure to provide the requested information shall result in the application being denied.

(3) To enroll, the individual must meet [~~the~~]enrollment eligibility criteria [~~for enrollment and it must be~~]at a time when the Department has not already stopped enrollment under provisions of [~~s~~]Section R414-320-15. An applicant [~~must be able to enroll in his or her employer-sponsored health insurance by the end of the month following the application month to be eligible~~]may apply for UPP anytime between the month before the applicant signs up for the employer's health insurance plan and before coverage begins. Otherwise, eligibility will be denied, and the individual may reapply during another open enrollment period.

(4) The local office shall complete a determination of eligibility or ineligibility for each application unless:

(a) The applicant voluntarily withdraws the application and the local office sends a notice to the applicant to confirm the withdrawal;

(b) The applicant died; or

(c) The applicant cannot be located; or

(d) The applicant has not responded to requests for information within the [~~30~~]45 day application period or by the date the eligibility worker asked the information or verifications to be returned, if that date is later.

(5) The enrollee must recertify eligibility at least every 12 months.

(6) The local office eligibility worker may require the applicant, the applicant's spouse, or the applicant's authorized representative to attend an interview as part of the application and recertification process. Interviews may be conducted in person or over the telephone, at the local office eligibility worker's discretion.

(7) The enrollee must complete the recertification process and provide the required verifications by the end of the recertification month.

(a) If the enrollee completes the recertification and continues to meet all eligibility criteria, coverage will be continued without interruption.

(b) The case will be closed at the end of the recertification month if the enrollee does not complete the recertification process and provide required verifications by the end of the recertification month.

(c) If an enrollee does not complete the recertification by the end of the recertification month, but completes the process and provides required verifications by the end of the month immediately following the recertification month, coverage will be reinstated as of the first of that month if the individual continues to be eligible.

(8) The eligibility worker may extend the recertification due date if the enrollee demonstrates that a medical emergency, death of an immediate family member, natural disaster or other similar cause prevented the enrollee from completing the recertification process on time.

R414-320-15. Effective Date of Enrollment and Enrollment Period.

(1) The effective date of enrollment is the day that a completed and signed application or an on-line application is received by the local office and the applicant meets all eligibility criteria. The effective date for applications submitted by fax and online is the date of the electronic transmission. The Department shall not provide any benefits before the effective enrollment date.

(2) The effective date of enrollment cannot be before the month in which the applicant pays a premium for the employer-sponsored health insurance and is determined as follows:

(a) The effective date of enrollment is the date an application is received and the person is found eligible, if the applicant enrolls in and pays the first premium for the employer-sponsored health insurance in the application month.

(b) If the applicant will not pay a premium for the employer-sponsored health insurance in the application month, the effective date of enrollment is the first day of the month in which the applicant pays a premium for the employer-sponsored health insurance. The applicant must enroll in the employer-sponsored health insurance no later than the end of the month following the month the application is received.

(c) If the applicant cannot enroll in the employer-sponsored health insurance by the end of the month immediately following the

application month, the application shall be denied and the individual will have to reapply during another open enrollment period.

(3) The effective date of enrollment for a newborn or newly adopted child is the date the newborn or newly adopted child is enrolled in the employer-sponsored health insurance if the family requests the coverage within 30 days of the birth or adoption. If the request is more than 30 days after the birth or adoption, enrollment is effective the date of report.

(4) The effective date of re-enrollment for a recertification is the first day of the month after the recertification month, if the recertification is completed as described in R414-320-13.

(5) If the enrollee does not complete the recertification as described in R414-320-13, and the enrollee does not have good cause for missing the deadline, the case will remain closed and the individual may reapply during another open enrollment period.

(6) An individual found eligible shall be eligible from the effective date through the end of the first month of eligibility and for the following 12 months. If the enrollee completes the redetermination process in accordance with R414-320-13 and continues to be eligible, the recertification period will be for an additional 12 months beginning the month following the recertification month. Eligibility could end before the end of a 12-month certification period for any of the following reasons:

(a) The individual turns age 65;

(b) The individual becomes entitled to receive Medicare, or becomes covered by Veterans Administration Health Insurance;

(c) The individual dies;

(d) The individual moves out of state or cannot be located;

(e) The individual enters a public institution or an Institute for Mental Disease.

(7) If an adult enrollee discontinues enrollment in employer-sponsored insurance coverage, eligibility ends. If the enrollment in employer-sponsored insurance is discontinued involuntarily and the individual notifies the local office within 10 calendar days of when the insurance ends, the individual may switch to the PCN program for the remainder of the certification period.

(8) A child enrollee may discontinue employer-sponsoreed health insurance and move to direct coverage under the Children's Health Insurance Program at any time during the certification period without any waiting period.

(9) An individual enrolled in the Primary Care Network or the Children's Health Insurance Program who enrolls in an employer-sponsored plan may switch to the [~~HIFA~~]UPP program if the individual reports to the local office within 10 calendar days of enrolling in an employer-sponsored plan and before coverage on the employer-sponsored plan begins.

(10) If a [~~HIFA~~]UPP case closes for any reason, other than to become covered by another Medicaid program or the Children's Health Insurance Program, and remains closed for one or more calendar months, the individual must submit a new application to the local office during an open enrollment period to reapply. The individual must meet all the requirements of a new applicant.

(11) If a [~~HIFA~~]UPP case closes because the enrollee is eligible for another Medicaid program or the Children's Health Insurance Program, the individual may reenroll if there is no break in coverage between the programs, even if the State has stopped enrollment under R414-320-15.

(a) If the individual's 12-month certification period has not ended, the individual may reenroll for the remainder of that certification period. The individual is not required to complete a new application or have a new income eligibility determination.

(b) If the 12-month certification period from the prior enrollment has ended, the individual may still reenroll. However, the individual must complete a new application[~~,~~] and meet eligibility and income guidelines[~~, and pay a new enrollment fee~~] for the new certification period.

(c) If there is a break in coverage of one or more calendar months between programs, the individual must reapply during an open enrollment period.

R414-320-18. Improper Medical Coverage.

(1) An individual who receives benefits under the [HIFA]UPP program for which he is not eligible is responsible to repay the Department for the cost of the benefits received.

(2) [~~An alien and the alien's sponsor are jointly liable for benefits received for which the individual was not eligible.(3)~~]An overpayment of benefits includes all amounts paid by the Department for medical services or other benefits on behalf of an enrollee or for the benefit of the enrollee during a time period that the enrollee was not actually eligible to receive such benefits.

R414-320-19. Benefits.

(1) The [~~HIFA~~]UPP program provides cash reimbursement to enrollees as described in this section.

(2) The reimbursement shall not exceed the amount the employee pays toward the cost of the employer-sponsored coverage.

(3) The amount of reimbursement for an adult will be up to $150 per month per individual.

(4) The amount of reimbursement for children will be up to $100 per month per child for medical and an additional $20 if they choose to enroll in employer-sponsored dental coverage.

(a) When the employer-sponsored insurance does not include dental benefits, the children may receive cash reimbursement up to $100 for the medical insurance cost and enroll in direct dental coverage under the CHIP Program.

(b) When the employer-sponsored insurance includes dental, the applicant will be given the choice of enrolling the children in the employer-sponsored dental and receiving an additional reimbursement up to $20, or enrolling in direct dental coverage through the CHIP Program.

http://www.rules.utah.gov/publicat/bull_pdf/2007/b20070415.pdf

Health, Children's Health Insurance Program

R382-10

Eligibility

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 29732

FILED: 03/26/2007, 10:27

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule implements Utah's Premium Partnership for Health Insurance (UPP) program. The UPP program is a Section 1115 Demonstration Waiver that allows the Department of Health to pool personal and employer funds from the Children's Health Insurance Program (CHIP) and Primary Care Network (PCN), and enables individuals and families to purchase health insurance through their employer. This rule also clarifies how the agency determines the due date for verifications and the effective date of CHIP enrollment.

SUMMARY OF THE RULE OR CHANGE: This rule defines an "employer-sponsored health plan" and outlines UPP service coverage. The rule also clarifies CHIP and UPP program enrollment options, CHIP program criteria, and parent and stepparent income requirements that determine CHIP program eligibility. This rule explains the CHIP enrollment option to not wait for the next open enrollment period when a child discontinues an employer-sponsored health insurance plan, clarifies how the agency determines the effective date of CHIP enrollment, and the due date for verifications. This rule also clarifies CHIP eligibility termination when a child enrolls in other health insurance coverage, and includes numbering changes, and other minor clarifications.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 26-18-3 and 26-1-5

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: 20 CFR 416(K) Appendix, 2006 ed.

ANTICIPATED COST OR SAVINGS TO:

- THE STATE BUDGET: There is no budget impact because the rule allows CHIP to reimburse eligible children under the UPP program at the same amount as the current CHIP per member per month cost.
- LOCAL GOVERNMENTS: There is no budget impact because local governments do not fund the CHIP or UPP programs.
- OTHER PERSONS: There is no budget impact because though the CHIP client mix changes, the total number of recipients and payments remains the same.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because though the CHIP client mix changes, payments for a single client remain the same.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule to implement the UPP program should have a positive fiscal impact on business. Employer sponsored health plans will be supported. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH, CHILDREN'S HEALTH INSURANCE PROGRAM
CANNON HEALTH BLDG, 288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Gayleen Henderson or Craig Devashrayee at the above address, by phone at 801-538-6135 or 801-538-6641, by FAX

at 801-538-6860 or 801-538-6099, or by Internet E-mail at ghenderson@utah.gov or cdevashrayee@utah.gov
INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY
SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER
THAN 5:00 PM on 05/15/2007.
THIS RULE MAY BECOME EFFECTIVE ON: 05/23/2007
AUTHORIZED BY: David N. Sundwall, Executive Director

R382. Health, Children's Health Insurance Program.
R382-10. Eligibility.
R382-10-1. Authority.
This rule sets forth the eligibility requirements for coverage under
the Children's Health Insurance Program (CHIP). It is authorized by
Title 26, Chapter 40.

R382-10-2. Definitions.
(1) The Department adopts the definitions found in Sections 2110(b) and (c) of the Social Security Act as enacted by Pub. L. No.
105-33 which [~~are~~]is incorporated by reference in this rule.
(2) [~~The following additional definitions also apply:~~]"Agency" means any local office or outreach location of either the Department of
Health or Department of Workforce Services that accepts and processes
applications for CHIP.
([~~a~~]3) "Applicant[~~,~~]" means a child on whose behalf an application has been made for benefits under the Children's Health
Insurance Program, but who is not an enrollee.
([~~b~~]4) "Best estimate" means the Department's determination of a
household's income for the upcoming eligibility period, based on past
and current circumstances and anticipated future changes.
([~~c~~]5) "Children's Health Insurance Program" or "CHIP" means the program for benefits under the Utah Children's Health Insurance
Act, Title 26, Chapter 40.
([~~d~~]6) "Department" means the Utah [~~State~~]Department of Health.
(7) "Employer-sponsored health plan" means health insurance that meets the requirements of R414-320-2(8) (a) (b) (c) (d) and (e).
([e]8) "Income averaging" means a process of using a history of past or current income and averaging it over a determined period of
time that is representative of future income.
([f]9) "Income anticipating" means a process of using current facts regarding rate of pay, number of working hours, and expected
changes to anticipate future income.
([~~g~~]10) "Income annualizing" means a process of determining the
average annual income of a household, based on the past history of
income and expected changes.
([~~h~~]11) "Local office" means any Bureau of Eligibility Services office location, outreach location, or telephone location where an
individual may apply for medical assistance.
([~~i~~]12) "Quarterly Premium" means a payment that enrollees must
pay every [~~3~~]three months to receive coverage under CHIP.
([~~j~~]13) "Renewal month" means the last month of the eligibility
period for an enrollee.
(14) "Utah's Premium Partnership for Health Insurance" or "UPP"
means the program described in R414-320.
([~~k~~]15) "Verifications" means the proofs needed to decide if a
child meets the eligibility criteria to be enrolled in the program.
Verifications may include hard copy documents such as a birth
certificate, computer match records such as Social Security benefits
match records, and collateral contacts with third parties who have
information needed to determine the eligibility of a child.

R382-10-3. Actions on Behalf of a Minor.
(1) A parent or an adult who has assumed responsibility for the
care or supervision of a child may apply for CHIP enrollment, provide
information required by this rule, or otherwise act on behalf of a child
in all respects under the statutes and rules governing the CHIP program.
(a) The child, if 18 years old or an emancipated minor, the child's
parent or legal guardian must indicate in writing to the Department who
is authorized as the child's representative.
(b) The [~~executive director of the~~]Department [~~or his designee~~
]may designate an authorized representative if the child needs a
representative but is unable to make a choice either in writing or orally in the presence of a witness.
(2) Where the statutes or rules governing the CHIP program
require a child to take an action, the parent or adult who has assumed responsibility for the care or supervision of the child is
responsible to take the action on behalf of the child. If the parent or
adult who has assumed responsibility for the care or supervision of
the child fails to take an action, the failure is attributable as the
child's failure to take the action.
(3) Notice to the parent or adult who has assumed responsibility
for the care or supervision of the child is notice to the child.

R382-10-5. Verification and Information Exchange.
(1) The applicant and enrollee upon renewal must provide

verification of eligibility factors as requested by the [~~Department~~]agency.
(a) The agency will provide the enrollee a written request of the needed verifications.
(b) The enrollee has at least 10 calendar days from the date the agency gives or mails the verification request to the enrollee to provide verifications.
(c) The due date for returning verifications, forms or information requested by the agency is 5:00 p.m. on the date the agency sets as the due date in a written request to the enrollee, but not less than 10 calendar days from the date such request is given to or mailed to the enrollee.
(d) The agency allows additional time to provide verifications if the enrollee requests additional time by the due date. The agency will set a new due date that is at least 10 days from the date the enrollee asks for more time to provide the verifications or forms.
(e) If an enrollee has not provided required verifications by the due date, and has not contacted the agency to ask for more time to provide verifications, agency denies the application, renewal, or ends eligibility.
(2) The Department may release information concerning applicants and enrollees and their households to other state and federal agencies to determine eligibility for other public assistance programs.
(3) The Department must release information to the Title IV-D agency and Social Security Administration to determine benefits.
(4) The Department may verify information by exchanging information with other public agencies as described in 42 CFR 435.945, 435.948, 435.952, 435.955, and 435.960[~~, 1997 edition~~].

R382-10-10. Creditable Health Coverage.
(1) To be eligible for enrollment in the program, a child must meet the requirements of Sections 2110(b)(1)(C) and (2)(B) of the Social Security Act as enacted by Pub. L. No. 105-33.
(2) A child who is covered under a group health plan or other health insurance coverage including coverage under a parent's or legal guardian's employer, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is not eligible for CHIP assistance.
(3) A child who is covered under an absent parent's insurance coverage that does not provide coverage in the State of Utah is eligible for enrollment.
(4) A child who is covered under a group health plan or other health coverage but has reached the lifetime maximum coverage under that plan is eligible for enrollment.
(5) A child who has access to health insurance coverage,[~~through an employer~~] where the cost to enroll the child in the least expensive plan offered by the employer is less than 5% of the household's gross annual income, is not eligible for CHIP[~~-assistance~~]. The child is considered to have access to coverage even if the employer offers coverage only during an open enrollment period.
(6) A child who has access to an employer-sponsored health plan where the least expensive plan is equal to or greater than 5% of the household's gross annual income, and the employer offers an employer-sponsored health plan that meets the requirements of R414-320-2 (8) (a), (b), (c), (d) and (e), may choose to enroll in the employer-sponsored health plan and receive reimbursement through the UPP program or may choose to enroll in the CHIP program.
(a) If the employer-sponsored health plan does not include dental benefits, the child may enroll in CHIP dental benefits.
(b) A child who chooses to enroll in the UPP program may switch to CHIP coverage at any time.
([~~6~~]7) The Department shall deny eligibility if the applicant or a custodial parent has voluntarily terminated health insurance coverage in the 90 days prior to the application date for enrollment under CHIP.
(a) An applicant or applicant's parent(s) who voluntarily terminates coverage under a COBRA plan or under the Health Insurance Pool (HIP), or who is involuntarily terminated from an employer's plan is eligible for CHIP without a 90 day waiting period.
(b) An applicant who voluntarily terminates health insurance coverage purchased after the previous CHIP open enrollment period ended but before the beginning of the current open enrollment period and who met CHIP eligibility requirements at the time of purchase, is eligible for CHIP without a 90 day waiting period.
([~~7~~]8) A child with creditable health coverage operated or financed by the Indian Health Services is not excluded from enrolling in the program.
([~~8~~]9) An applicant must report at application and renewal whether any of the children in the household for whom enrollment is being requested has access to or is covered by a group health plan, other health insurance coverage, or a state employee's health benefits plan.
([~~9~~]10) The Department shall deny an application or renewal if the enrollee fails to respond to questions about health insurance coverage for children the household seeks to enroll or renew in the program.

R382-10-13. Income Provisions.

To be eligible to enroll in the Children's Health Insurance Program, gross household income must be equal to or less than 200%
of the federal non-farm poverty guideline for a household of equal size.
All gross income, earned and unearned, received by the parents and
step[-]parents of any child who is included in the household size, is
counted toward household income, unless this section specifically
describes a different treatment of the income.
(1) The Department does not count income that is defined in 20 CFR 416(K) Appendix, [~~1997~~]2006 edition, which is adopted and
incorporated by reference.
(2) Any income in a trust that is available to, or is received by a household member, is countable income.
(3) Payments received from the Family Employment Program, General Assistance, or refugee cash assistance or adoption support
services as authorized under Title 35A, Chapter 3 is countable income.
(4) Rental income is countable income. The following expenses can be deducted:
(a) taxes and attorney fees needed to make the income available;
(b) upkeep and repair costs necessary to maintain the current value of the property;
(c) utility costs only if they are paid by the owner; and
(d) interest only on a loan or mortgage secured by the rental property.
(5) Deposits to joint checking or savings accounts are countable income, even if the deposits are made by a non-household member. An applicant or enrollee who disputes household ownership of deposits to joint checking or savings accounts shall be given an opportunity to prove that the deposits do not represent income to the household. Funds that are successfully disputed are not countable income.
(6) Cash contributions made by non-household members are counted as income unless the parties have a signed written agreement for repayment of the funds.
(7) The interest earned from payments made under a sales contract or a loan agreement is countable income to the extent that these payments will continue to be received during the eligibility period.
(8) In-kind income, which is goods or services provided to the individual from a non-household member and which is not in the form of cash, for which the individual performed a service or is provided as part of the individual's wages is counted as income. In-kind income for which the individual did not perform a service or did not work to receive is not counted as income.
(9) SSI and State Supplemental Payments are countable income.
(10) Death benefits are not countable income to the extent that the
funds are spent on the deceased person's burial or last illness.
(11) A bona fide loan that an individual must repay and that the individual has contracted in good faith without fraud or deceit, and
genuinely endorsed in writing for repayment is not countable income.
(12) Child Care Assistance under Title XX is not countable income.
(13) Reimbursements of Medicare premiums received by an
individual from Social Security Administration or the [~~State~~] Department [~~of Health~~]are not countable income.
(14) Needs-based Veteran's pensions are not counted as income. If the income is not needs-based, only the portion of a Veteran's
Administration check to which the individual is legally entitled is
countable income.
(15) Income of a child is excluded if the child is not the head of a
household.
(16) Educational income such as educational loans, grants, scholarships, and work-study programs are not countable income. The individual must verify enrollment in an educational program.
(17) Reimbursements for expenses incurred by an individual are
not countable income.
(18) Any payments made to an individual because of his status as
a victim of Nazi persecution as defined in Pub. L. No. 103-286 are not countable income, including payments made by the Federal Republic of Germany, Austrian Social Insurance payments, and Netherlands WUV payments.
(19) Victim's Compensation payments as defined in Pub. L. No.
101-508 are not countable income.
(20) Disaster relief funds received if a catastrophe has been declared a major disaster by the President of the United States as
defined in Pub. L. No. 103-286 are not countable income.
(21) Income of an alien's sponsor or the sponsor's spouse, is not
countable income.

R382-10-14. Budgeting.
The following section describes methods that the Department will
use to determine the household's countable monthly or annual income.
(1) The gross income [~~of all household members~~]for parents and
stepparents of any child included in the household size is counted [~~in~~]to determin[~~ing~~]e a child's eligibility[~~the eligibility of a child~~], unless the income is excluded under this rule. Only expenses that are required to make an income available to the individual are deducted from the gross income. No other deductions are allowed.
(2) The Department shall determine monthly income by taking
into account the months of pay where an individual receives a fifth
paycheck when paid weekly, or a third paycheck when paid every other
week. The Department shall multiply the weekly amount by 4.3 to
obtain a monthly amount. The Department shall multiply income paid
bi-weekly by 2.15 to obtain a monthly amount.

(3) The Department shall determine a child's eligibility and costsharing
requirements prospectively for the upcoming eligibility period at the time of application and at each renewal for continuing eligibility.
The Department shall determine prospective eligibility by using the
best estimate of the household's average monthly income that is expected to be received or made available to the household during the
upcoming eligibility period. The Department shall prorate income that
is received less often than monthly over the eligibility period to determine an average monthly income. The Department may request
prior years' tax returns as well as current income information to determine a household's income.
(4) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The Department may use a combination of methods to obtain the most
accurate best estimate. The best estimate may be a monthly amount
that is expected to be received each month of the eligibility period, or
an annual amount that is prorated over the eligibility period. Different
methods may be used for different types of income received in the
same household.
(5) The Department shall determine farm and self-employment income by using the individual's recent tax return forms. If tax returns
are not available, or are not reflective of the individual's current farm or
self-employment income, the Department shall request income information from a recent time period during which the individual had
farm or self-employment income. The Department shall deduct 40% of
the gross income as a deduction for business expenses to determine the
countable income of the individual. For individuals who have business
expenses greater than 40%, the Department shall request expense
information and deduct the expenses from the gross income. The Department shall deduct the same expenses from gross income that the
Internal Revenue Service allows as self-employment expenses.
(6) The Department may annualize income for any household and
in particular for households that have self-employment income, receive
income sporadically under contract or commission agreements, or
receive income at irregular intervals throughout the year.

R382-10-16. Application and Renewal.
The application is the initial request from an applicant for CHIP enrollment for a child. The application process includes gathering
information and verifications to determine the child's eligibility for
enrollment in the program. Renewal is the process of gathering
information and verifications on a periodic basis to determine
continued eligibility of an enrollee.
(1) The applicant must complete and sign a written application to
become enrolled in the program.
(2) The Department accepts any Department-approved application form for medical assistance programs offered by the state as
an application for CHIP enrollment.
(3) Individuals may apply for enrollment during open enrollment
periods in person, through the mail, by fax, or online.
(4) A family who has a child enrolled in CHIP, may enroll a new
child born to or adopted by a household member without waiting for
the next open enrollment period.
(5) A child who loses Medicaid coverage because he or she has
reached the maximum age limit and does not qualify for any other
Medicaid program without paying a spenddown, may enroll in CHIP
without waiting for the next open enrollment period.
(6) A child who loses Medicaid coverage because he or she is no
longer deprived of parental support and does not qualify for any other
Medicaid program without paying a spenddown, may enroll in CHIP
without waiting for the next open enrollment period.
(7) A child enrolled in the UPP program who discontinues his or
her coverage under an employer-sponsored health plan, may enroll in
CHIP without waiting for the next open enrollment period.
([~~7~~]8) The Department may interview applicants, the applicant's
parents, and any adult who has assumed responsibility for the care or
supervision of the child to assist in determining eligibility.
([~~8~~]9) If eligibility for CHIP enrollment ends, the Department
shall review the case for eligibility under any other medical assistance program without requiring a new application.
The Department may request additional verification from the household if there is insufficient information to make a determination.

R382-10-18. Effective Date of Enrollment and Renewal.
(1) The effective date of CHIP enrollment is the date a completed
and signed application is received [~~by the Department~~]at a local office by 5:00 p.m. on a business day. This applies to paper applications delivered in person or by mail, paper applications sent via facsimile transmission, and electronic applications sent via the internet. If a local office receives

an application after 5:00 p.m. of a business day, the effective date of CHIP enrollment is the next business day.
(2) The effective date of CHIP enrollment for applications delivered to an outreach location is as follows:
(a) If the application is delivered at a time when the outreach staff
is working at that location, the effective date of enrollment is the date
the outreach staff receives the application.
(b) If the application is delivered at a time when the outreach office is closed, including being closed for weekends or holidays, the
effective date of enrollment is the last business day that a staff person
from the state agency was available to receive or pick up applications
from the location.
(3) The Department may allow a grace enrollment period beginning no earlier than four days before the date a completed and signed application is received by the Department. The Department shall not pay for any services received before the effective enrollment date.
([~~2~~]4) For a family who has a child enrolled in CHIP and who adds a newborn or adopted child, the effective date of enrollment is the
date of birth or adoption if the family requests the coverage within 30
days of the birth or adoption. If the request is made more than 30 days after the birth or adoption, enrollment in CHIP will be effective
beginning the date of report, except as otherwise provided in R382-10-18(1).
([~~3~~]5) The effective date of enrollment for a renewal is the first day of the month after the renewal month, if the renewal process is
completed by the end of the renewal month, or by the last day of the
month immediately following the renewal month, and the child continues to be eligible.
([~~4~~]6) If the renewal process is not completed by the end of the renewal month, the case will be closed unless the enrollee has good
cause for not completing the renewal process on time. Good cause
includes a medical emergency, death of an immediate family member, or natural disaster, or other similar occurrence.
([~~5~~]7) The Department may require an interview with the parent, child, or adult who has assumed responsibility for the care or supervision of a child, or other authorized representative as part of the
renewal process.

R382-10-19. Open Enrollment Period.
(1) 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.
(a) The Department shall notify the public of the open enrollment
period 10 days in advance through a newspaper of general circulation.
(b) During an open enrollment period, the Department accepts
applications in person, through the mail, by fax, or online. The
Department sorts applications according to the date received.[~~When~~
~~an application is received through the mail, the date of receipt is the~~
~~date of the postmark. When an application is submitted online, the date~~
~~of receipt is the date of electronic transmission.~~] If the applications
received on a day exceed the number of openings available, the
Department shall randomize all applications for that day and select the
number needed to fill the openings.
(c) The Department will not accept applications prior to the open
enrollment date, except as provided in R382-10-16.

R382-10-21. Quarterly Premiums.
(1) Each family with children enrolled in the CHIP program must
pay a quarterly premium based on the countable income of the family
during the first month of the quarter.
(a) A family whose countable income is equal to or less than
100% of the federal poverty level or who are American Indian pays no premium.
(b) A family with countable income greater than 100% and up to
150% of the federal poverty level must pay a quarterly premium of
$13[~~.00~~].
(c) A family with countable income greater than 150% and up to
200% of the federal poverty level must pay a quarterly premium of
$25[~~.00~~].
(2) A family who does not pay its quarterly premium by the premium due date will be terminated from CHIP. Coverage may be
reinstated when any of the following events occur:
(a) The family pays the premium by the last day of the month
immediately following the termination;
(b) The family's countable income decreased to below 100% of
the federal poverty level prior to the first month of the quarter.
(c) The family's countable income decreases prior to the first
month of the quarter and the family owes a lower premium amount.
The new premium must be paid within 30 days.
(3) A family who was terminated from CHIP who reapplies within one year of the termination date, must pay any outstanding
premiums before the children can be re-enrolled.

R382-10-22. Termination and Notice.
(1) The Department shall notify an applicant or enrollee in writing of the eligibility decision made on the application or at renewal. (2) The Department shall notify an enrollee in writing ten days before taking a proposed action adversely affecting the enrollee's eligibility.
(3) Notices under this section shall provide the following information:
(a) the action to be taken;
(b) the reason for the action;
(c) the regulations or policy that support the action;
(d) the applicant's or enrollee's right to a hearing;
(e) how an applicant or enrollee may request a hearing; and
(f) the applicant's or enrollee's right to represent himself, or use legal counsel, a friend, relative, or other spokesperson.
(4) The Department need not give ten-day notice of termination if:
(a) the child is deceased;
(b) the child has moved out of state and is not expected to return;
(c) the child has entered a public institution; or
(d) the child has enrolled in other health insurance coverage, in which case eligibility [~~may cease immediately and~~]ends the day before the new coverage begins[~~without prior notice~~].

R382-10-23. Case Closure or Withdrawal.
The [~~d~~]Department shall terminate a child's enrollment upon enrollee request or upon discovery that the child is no longer eligible.
An applicant may withdraw an application for CHIP benefits any time prior to approval of the application.

KEY: children's health benefits
Date of Enactment or Last Substantive Amendment: [~~June 1, 2004~~]2007
Notice of Continuation: June 10, 2003
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-300

Primary Care Network, Covered-at-Work Demonstration Waiver

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 29730
FILED: 03/26/2007, 09:40
RULE ANALYSIS
PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The repeal of this rule is necessary because the Covered-at-Work Demonstration Waiver program no longer exists. The program is replaced by Utah's Premium Partnership for Health Insurance (UPP) program, which is a Section 1115 demonstration waiver. This repealed rule describes the authority of the covered-at-work program and its program benefits.
SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety. The replacement program under the 1115 demonstration waiver is implemented in a separate, companion rule filing, Rule R414-310. (DAR NOTE: The proposed amendment to Rule R414-310 is under DAR No. 29731 in this issue, April 15, 2007, of the Bulletin.)
STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 26-18-3 and 26-1-5
ANTICIPATED COST OR SAVINGS TO:
THE STATE BUDGET: There is no budget impact because of the repeal of this rule. The costs of the Covered-at-Work Demonstration Waiver program are being replaced by the UPP program.
LOCAL GOVERNMENTS: There is no budget impact because local governments do not fund waiver programs.
OTHER PERSONS: There is no budget impact because of the repeal of this rule. The costs of the Covered-at-Work Demonstration Waiver program are being replaced by the UPP program.
COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no budget impact because of the repeal of this rule. The costs of the Covered-at-Work Demonstration Waiver program are being replaced by the UPP program.
COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This repeals obsolete language and will have no fiscal impact on business. David N. Sundwall, MD, Executive Director
THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.
DIRECT QUESTIONS REGARDING THIS RULE TO:
Craig Devashrayee or Gayleen Henderson at the above address, by phone at 801-538-6641 or 801-538-6135, by FAX at 801-538-6099 or 801-538-6860, or by Internet E-mail at
cdevashrayee@utah.gov or ghenderson@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY
SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER
THAN 5:00 PM on 05/15/2007.
THIS RULE MAY BECOME EFFECTIVE ON: 05/23/2007
AUTHORIZED BY: David N. Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

~~**[R414-300. Primary Care Network, Covered-at-Work Demonstration Waiver.**~~

~~**R414-300-1. Introduction and Authority.**~~

~~This rule describes the benefits under the Primary Care Network (PCN)Covered-at-Work Program. The PCN Covered-at-Work Program is authorized by an amendment to a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter 18.~~

~~**R414-300-2. Definitions.**~~

~~"Spouse" means an individual who is married to an applicant or enrollee and has not legally terminated the marriage.~~

~~**R414-300-3. Nature of Program and Benefits.**~~

~~(1) The Covered-at-Work Program provides cash reimbursement to an enrollee who meets the eligibility requirements and application requirements of R414-310. The Covered-at-Work Program provides benefits as described in this section.~~
~~(2) The reimbursement shall not exceed the amount the employee pays toward the cost of the employee's employer-sponsored coverage for the employee and the employee's spouse if covered under the employee's plan. The employer must pay at least 50 percent of the employee's health insurance premium.~~
~~(3) The amount of reimbursement for a single person or for a married couple when only one spouse is eligible for the reimbursement, will be provided on the following schedule, in the designated amounts:~~
~~(a) Up to $50 per month for the first 24 months of eligibility.~~
~~(b) Up to $40 per month for the next 12 months (third year)of eligibility.~~
~~(c) Up to $30 per month for the next 12 months (fourth year)of eligibility.~~
~~(d) Up to $20 per month for the last 12 months (fifth year)of eligibility.~~
~~(4) The amount of reimbursement for a married couple when both spouses are eligible for the reimbursement and both are covered under the same employer sponsored plan, will be provided on the following schedule, in the designated amounts:~~
~~(a) Up to $100 per month for the first 24 months of eligibility.~~
~~(b) Up to $80 per month for the next 12 months (third year)of eligibility.~~
~~(c) Up to $60 per month for the next 12 months (fourth year)of eligibility.~~
~~(d) Up to $40 per month for the last 12 months (fifth year) of eligibility.~~
~~(5) The amount of reimbursement for a married couple when both spouses are eligible for the reimbursement but are covered under their own separate employer-sponsored plans, will be provided as described in subsection (3) for each spouse.~~
~~(6) Benefits provided to a Covered-at-Work enrollee are limited to a lifetime maximum of 60 months.~~

~~**KEY: Medicaid, primary care network, covered-at-work benefits**~~
~~**Date of Enactment or Last Substantive Amendment: February 10, 2004 Authorizing, and Implemented or Interpreted Law: 26-18-3]**~~

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-310

Medicaid Primary Care Network Demonstration Waiver

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 29731
FILED: 03/26/2007, 10:12

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to remove references to and the rule (Rule R414-300) for the Covered-at-Work program, which is being discontinued and replaced by a new program, Utah's Premium Partnership for Health Insurance (UPP). The UPP program is a Section 1115 demonstration program awarded to the Utah Department of Health and is described in Rule R414-320 which was effective 11/01/2006. This rule also clarifies how the agency determines the due date for verifications and the effective date of Children's Health Insurance Program (CHIP) enrollment. (DAR NOTE: The proposed repeal of Rule R414-300 is under DAR No. 29730 in this issue, April 15, 2007, of the Bulletin.)
SUMMARY OF THE RULE OR CHANGE: This rule is being modified

throughout to delete all references to and the rules for the Covered-at-Work program. This rule defines an "employersponsored
health plan" and outlines UPP service coverage.
This rule clarifies that an individual may choose to enroll in either the UPP program or the PCN program when the cost of
the least expensive employer-sponsored health insurance plan exceeds 15% of the household's gross income. This rule
clarifies that all child support payments, including those for repayment of past due child support, is counted as income of
a child, and describes how the agency determines the due date for verifications and the effective date of Primary Care
Network (PCN) enrollment.
STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS
RULE: Sections 26-18-3 and 26-1-5
ANTICIPATED COST OR SAVINGS TO:
THE STATE BUDGET: This rule change will not affect the state
budget because it is removing references to the Covered-at-
Work program, which is being discontinued. State budget costs for the replacement program, Utah's Premium Partnership for Health Insurance, are described in Rule R414-
320 which was adopted on 11/01/2006.
LOCAL GOVERNMENTS: This rule change will not affect local
government because it is removing references to the Covered-at-Work program which is being discontinued.
OTHER PERSONS: This rule change will not affect other persons because it is removing references to the Covered-at-
Work program which is being discontinued. Costs to other persons for the replacement program are described in Rule
R414-320 which was adopted on 11/01/2006.
COMPLIANCE COSTS FOR AFFECTED PERSONS: This rule change
does not involve compliance costs to any persons because it
is removing references to the Covered-at-Work program which
is being discontinued. Costs to other persons for the replacement program are described in Rule R414-320 which
was adopted on 11/01/2006.
COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE
RULE MAY HAVE ON BUSINESSES: This rule assists with the implementation of the UPP program and should not have a
negative fiscal impact. David N. Sundwall, MD, Executive Director
THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR
BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.
DIRECT QUESTIONS REGARDING THIS RULE TO:
Gayleen Henderson or Craig Devashrayee at the above
address, by phone at 801-538-6135 or 801-538-6641, by FAX
at 801-538-6860 or 801-538-6099, or by Internet E-mail at
ghenderson@utah.gov or cdevashrayee@utah.gov
INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY
SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER
THAN 5:00 PM on 05/15/2007.
THIS RULE MAY BECOME EFFECTIVE ON: 05/23/2007
AUTHORIZED BY: David N. Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-310. Medicaid Primary Care Network Demonstration Waiver.

R414-310-2. Definitions.
The following definitions apply throughout this rule:
(1) "Applicant" means an individual who applies for benefits
under the Primary Care Network program[~~or the Primary Care~~
~~Network - Covered-at-Work program~~], but who is not an enrollee.
(2) "Best estimate" means the Department's determination of a
household's income for the upcoming certification period based on
past and current circumstances and anticipated future changes.
(3) "Co-payment and co-insurance" means a portion of the cost
for a medical service for which the enrollee is responsible to pay for
services received under the Primary Care Network.
(4) "Deeming" or "deemed" means a process of counting income from a spouse or an alien's sponsor to decide what amount of
income after certain allowable deductions, if any, must be considered income to an applicant or enrollee.
(5) "Department" means the Utah Department of Health.
(6) "Enrollee" means an individual who has applied for and been found eligible for the Primary Care Network program[~~or the~~
~~Primary Care Network - Covered-at-Work Program~~] and has paid
the enrollment fee.
(7) "Enrollment fee" means a payment that an applicant or an
enrollee must pay to the Department to enroll in and receive
coverage under the Primary Care Network[~~or the Primary Care~~

~~Network - Covered-at-Work~~] program.
(8) "Employer-sponsored health plan" means health insurance that meets the requirements of R414-320-2 (8) (a) (b) (c) (d) and (e).
~~[(8)]~~(9) "Income averaging" means a process of using a history of past and current income and averaging it over a determined period
of time that is representative of future income.
~~[(9)]~~(10) "Income anticipating" means a process of using current facts regarding rate of pay, number of working hours, and
expected changes to anticipate future income.
~~[(10)]~~(11) "Income annualizing" means a process of determining the average annual income of a household, based on the
past history of income and expected changes.
~~[(11)]~~(12) "Local office" means any Bureau of Eligibility Services or Department of Workforce Services office location, outreach location, or telephone location where an individual may
apply for medical assistance.
~~[(12)]~~(13) "Open enrollment means a time period during which the Department accepts applications for the Primary Care Network
[~~or the Covered-at-Work~~]program[~~s~~].
~~[(13)]~~(14) "Primary Care Network" or "PCN" [~~includes two programs under a federal waiver of Medicaid regulations. The two~~
~~programs are:~~
~~(a) The Primary Care Network Program. This program provides primary care medical services to uninsured adults who do~~
~~not otherwise qualify for Medicaid~~]means the program for benefits
under the Medicaid Primary Care Network Demonstration Waiver.[~~,~~
~~and;~~
~~(b) The Covered-at-Work Program. This program provides cash reimbursement for all or part of the insurance premium paid by~~
~~an employee for health insurance coverage through an employersponsored health insurance plan that covers either the eligible employee, the eligible spouse of the employee, or both.~~]
~~[(14)]~~(15) "Recertification month" means the last month of the eligibility period for an enrollee.
~~[(15)]~~(16) "Spouse" means any individual who has been married to an applicant or enrollee and has not legally terminated the
marriage.
~~[(16)]~~(17) "Verifications" means the proofs needed to decide if an individual meets the eligibility criteria to be enrolled in the program. Verifications may include hard copy documents such as a
birth certificate, computer match records such as Social Security benefits match records, and collateral contacts with third parties who
have information needed to determine the eligibility of the individual.
~~[(17)]~~(18) "Student health insurance plan" means a health insurance plan that is offered to students directly through a university or other educational facility or through a private health
insurance company that offers coverage plans specifically for
students.
(19) "Utah's Premium Partnership for Health Insurance" or "UPP" means the program described in R414-320.

R414-310-3. Applicant and Enrollee Rights and Responsibilities.
(1) Any person may apply during an open enrollment period
who meets the limitations set by the Department. The open enrollment period may be limited to:
(a) individuals with children under age 19 in the home;
(b) individuals without children under age 19 in the home;
(c) those enrolled in the PCN program;
(d) those enrolled in the [~~Covered-at-Work~~]UPP program;
(e) those enrolled in the General Assistance program;
(f) those that were enrolled in the Medicaid program within the
last thirty days prior to the beginning of the open enrollment period;
or
(g) such other group designated in advance by the Department
consistent with efficient administration of the program.
(2) If a person needs help to apply, he may have a friend or family member help, or he may request help from the local office or
outreach staff.
(3) Applicants and enrollees must provide requested information and verifications within the time limits given. The
Department will allow the client at least 10 calendar days from the
date of a request to provide information and may grant additional
time to provide information and verifications upon request of the
applicant or enrollee.
(4) Applicants and enrollees have a right to be notified about
the decision made on an application, or other action taken that
affects their eligibility for benefits.
(5) Applicants and enrollees may look at information in their
case file that was used to make an eligibility determination.
(6) Anyone may look at the eligibility policy manuals located
at any Department local office.
(7) An individual must repay any benefits received under the
Primary Care Network program [~~or the Covered-at-Work program~~
]if the Department determines that the individual was not eligible to
receive such benefits.
(8) Applicants and enrollees must report certain changes to the
local office within ten calendar days of the day the change becomes

known. The local office shall notify the applicant at the time of application of the changes that the enrollee must report. Some examples of reportable changes include:
(a) An enrollee in the Primary Care Network program begins to receive coverage under a group health plan or other health insurance coverage.
(b) An enrollee in the Primary Care Network program begins to have access to coverage under a group health plan or other health
insurance coverage.
(c)[~~An enrollee in the Covered-at-Work program no longer pays for coverage under an employer-sponsored health plan.~~
~~(d)~~] An enrollee in the Primary Care Network program[~~or the Covered-at-Work program~~] begins to receive coverage under, or begins to have access to student health insurance, Medicare Part A
or B, or the Veteran's Administration Health Care System.
~~[(e) An enrollee in the Covered-at-Work program has a change in the amount the enrollee pays for coverage under an employersponsored health plan.~~
~~(f)~~](d) An enrollee leaves the household or dies.
~~[(g)~~](e) An enrollee or the household moves out of state.
~~[(h)~~](f) Change of address of an enrollee or the household.
~~[(i)~~](g) An enrollee enters a public institution or an institution for mental diseases.
(9) An applicant or enrollee has a right to request an agency conference or a fair hearing as described in R414-301-5 and R414-
301-6.
(10) An enrollee in the Primary Care Network program is responsible for paying any required co-payments or co-insurance
amounts to providers for medical services the enrollee receives that
are covered under the Primary Care Network program.[
(11) ~~An enrollee in the Covered-at-Work program must continue to pay premiums and remain enrolled in the employersponsored
health plan to be eligible for benefits.~~]

R414-310-4. General Eligibility Requirements.
(1) The provisions of R414-302-1, R414-302-2, R414-302-3, R414-302-5, and R414-302-6 apply to applicants and enrollees of
the Primary Care Network program[~~and the Covered-at-Work program~~].
(2) An individual who is not a U.S. citizen and does not meet the alien status requirements of R414-302-1 is not eligible for any
services or benefits under the Primary Care Network program[or the
Covered-at-Work program].
(3) Applicants and enrollees are not required to provide Duty of Support information to enroll in the Primary Care Network program[~~or the Covered-at-Work program~~]. An individual who would be eligible for Medicaid but fails to cooperate with Duty of
Support requirements required by the Medicaid program cannot enroll in the Primary Care Network program[~~or the Covered-at-Work program~~].
(4) Individuals who must pay a spenddown or premium to receive Medicaid can enroll in the Primary Care Network program[
or the Covered-at-Work program] if they meet the program eligibility criteria in any month they do not receive Medicaid as long
as the Department has not stopped enrollment under the provisions
of R414-310-16(2). If the Department has stopped enrollment, the
individual must wait for an applicable open enrollment period to
enroll in the PCN[~~or the Covered-at-Work~~] program.

R414-310-5. Verification and Information Exchange.
(1) The provisions of [~~R414-307-4~~]R414-308-4 apply to applicants and enrollees of the Primary Care Network program[~~ and
the Covered-at-Work program~~].
(2) The Department safeguards information about applicants
and enrollees according to the provisions found in R414-301-4.

R414-310-6. Residents of Institutions.
The provisions of R414-302-4(1), (3) and (4) apply to applicants and enrollees of the Primary Care Network program[~~ and
the Covered-at-Work program~~].

R414-310-7. Creditable Health Coverage.
(1) The Department adopts 42 CFR 433.138(b) and 435.610,
2004 ed., and Section 1915(b) of the Compilation of the Social Security
Laws, in effect January 1, 2004, which are incorporated by reference.
(2) An individual who is covered under a group health plan or
other creditable health insurance coverage, as defined by the Health
Insurance Portability and Accountability Act of 1996 (HIPAA), at the
time of application is not eligible for enrollment in the Primary Care
Network program[or the Covered-at-Work program]. This includes
coverage under Medicare Part A or B, student health insurance, and the
Veteran's Administration Health Care System. However, an individual
who is enrolled in the Utah Health Insurance Pool [~~(H.I.P.)~~]may enroll
in the Primary Care Network[~~or the Covered-at-Work~~] program.
(3) Eligibility for the Primary Care Network program [~~or the
Covered-at-Work program~~]for an individual who has access to but has
not yet enrolled in health insurance coverage through an employer or a
spouse's employer will be determined as follows:
(a) If the cost of the [~~employer-sponsored coverage~~]least

expensive health insurance plan offered by the employer does not exceed [~~5%~~]15% of the household's gross income, the individual is not eligible for the Primary Care Network program[~~ or the Covered-at-Work program~~].

[~~(b) If the cost of the employer-sponsored coverage exceeds 5% but does not exceed 15% of the household's gross income, the individual is not eligible for the Primary Care Network program. These individuals may be eligible for the Covered-at-Work program if they choose to enroll in the employer-sponsored coverage, by the end of the month following the month in which they apply for the Covered-at-Work program~~.

] [~~(c)~~](b) If the cost of the [~~employer-sponsored coverage~~]least expensive health insurance plan offered by the employer exceeds 15% of the household's gross income, and the employer offers a health plan that meets the requirements of R414-320-2 (8) (a) (b) (c) (d) and (e), the individual may choose to enroll in either the Primary Care Network program or the [~~Covered-at-Work~~]UPP program unless enrollment for one of these programs has been stopped under the provisions of R414-310-16(2).[~~To enroll in the Covered-at-Work program, the individual must enroll in the employer-sponsored coverage, by the end of the month following the month in which they apply for the Covered-at-Work program.~~]

(c) If the cost of the least expensive health insurance plan offered by the employer exceeds 15% of the household's gross income, but the employer does not offer a health plan that meets the requirements in R414-320-2 (8) (a) (b) (c) (d) and (e), the individual may only enroll in the PCN program.

(d) The individual is considered to have access to coverage even if the employer offers coverage only during an open enrollment period.

(4) An individual who is covered under Medicare Part A or Part B, or who could enroll in Medicare Part B coverage, is not eligible for enrollment in the Primary Care Network [~~or the Covered-at-Work~~]program, even if the individual must wait for a Medicare open enrollment period to apply for Medicare benefits.

(5) An individual who is enrolled in the Veteran's Administration (VA) Health Care System is not eligible for enrollment in the Primary Care Network program[~~or the Coveredat-Work program~~]. An individual who is eligible to enroll in the VA Health Care System, but who has not yet enrolled, may be eligible for the Primary Care Network program [~~or the Covered-at-Work program~~]while waiting for enrollment in the VA Health Care System to become effective. To be eligible during this waiting period, the individual must initiate the process to enroll in the VA Health Care System. Eligibility for the Primary Care Network program [~~or the Covered-at-Work program~~]ends once the individual becomes enrolled in the VA Health Care System.

(6) Individuals who are full-time students and who can enroll in student health insurance coverage are not eligible to enroll in the Primary Care Network program[~~or the Covered-at-Work program~~].

(7) The Department shall deny eligibility if the applicant or spouse has voluntarily terminated health insurance coverage within the six months immediately prior to the application date for enrollment under the Primary Care Network program[~~or the Covered-at-Work program~~]. An applicant or an applicant's spouse can be eligible for the Primary Care Network [~~or the Covered-at-Work program~~]if their prior insurance ended more than six months before the application date. An applicant or applicant's spouse who voluntarily discontinues health insurance coverage under a COBRA plan or under the state Health Insurance Pool, or who is involuntarily terminated from an employer's plan may be eligible for the Primary Care Network[~~or the Covered-at-Work~~] program without a six month waiting period.

(8) Notwithstanding the limitations in this section, an individual with creditable health coverage operated or financed by the Indian Health Services may enroll in the Primary Care Network program[~~or the Covered-at-Work program~~].

(9) Individuals must report at application and recertification whether each individual for whom enrollment is being requested has access to or is covered by a group health plan or other creditable health insurance coverage. This includes coverage that may be available through an employer or a spouse's employer, a student health insurance plan, Medicare Part A or B, or the VA Health Care System.

(10) The Department shall deny an application or recertification if the applicant or enrollee fails to respond to

questions about health insurance coverage for any individual the household seeks to enroll or recertify in the program.

R414-310-8. Household Composition.
(1) The following individuals are included in the household when determining household size for the purpose of computing financial eligibility for the Primary Care Network Program[~~or the Covered-at-Work program~~]:
(a) the individual;
(b) the individual's spouse living with the individual;
(c) any children of the individual or the individual's spouse who are under age 19 and living with the individual; and
(d) an unborn child if the individual is pregnant, or if the applicant's legal spouse who lives in the home is pregnant.
(2) A household member who is temporarily absent for schooling, training, employment, medical treatment or military service, or who will return home to live within 30 days from the date of application is considered part of the household.

R414-310-9. Age Requirement.
(1) An individual must be at least 19 and not yet 65 years of age to enroll in the Primary Care Network program[~~or the Covered-at-Work program~~].
(2) The month in which an individual's 19th birthday occurs is the first month the person can be eligible for enrollment in the Primary Care Network program[~~or the Covered-at-Work program~~].
(a) If the individual could qualify for Medicaid in that month without paying a spenddown or premium, the individual cannot enroll in the Primary Care Network [~~or Covered-at-Work~~]program until the following month.
(b) the individual could enroll in the Children's Health Insurance Program and it is an open enrollment period for CHIP for that month, the individual cannot enroll in the Primary Care Network program[~~or the Covered-at-Work program~~] until the following month.
(3) The benefit effective date for the Primary Care Network program[~~or the Covered-at-Work program~~] cannot be earlier than the date of the 19th birthday.
(4) The individual's 65th birthday month is the last month the person can be eligible for enrollment in the Primary Care Network program[~~or the Covered-at-Work program~~].

R414-310-10. Income Provisions.
(1) To be eligible to enroll in the Primary Care Network program[~~or the Covered-at-Work program~~], a household's countable gross income must be equal to or less than 150% of the federal nonfarm poverty guideline for a household of the same size. An individual with income above 150% of the federal poverty guideline is not allowed to spend down income to be eligible under the Primary Care Network program[~~or the Covered-at-Work program~~].
All gross income, earned and unearned, received by the individual and the individual's spouse is counted toward household income, unless this section specifically describes a different treatment of the income.
(2) Any income in a trust that is available to, or is received by a household member, is countable income.
(3) Payments received from the Family Employment Program, Working Toward Employment program, refugee cash assistance or adoption support services as authorized under Title 35A, Chapter 3 are countable income.
(4) Rental income is countable income. The following expenses can be deducted:
(a) taxes and attorney fees needed to make the income available;
(b) upkeep and repair costs necessary to maintain the current value of the property;
(c) utility costs only if they are paid by the owner; and
(d) interest only on a loan or mortgage secured by the rental property.
(5) Cash contributions made by non-household members are counted as income unless the parties have a signed written agreement for repayment of the funds.
(6) The interest earned from payments made under a sales contract or a loan agreement is countable income to the extent that these payments will continue to be received during the certification period.
(7) Needs-based Veteran's pensions are counted as income. Only the portion of a Veteran's Administration check to which the individual is legally entitled is countable income.
(8) Child support[~~payments received by a parent in the household which is in repayment of past due child support is counted as income for the parent. Current child support~~] payments received for a dependent child living in the home are counted as that child's income.
(9) In-kind income, which is goods or services provided to the individual from a non-household member and which is not in the form of cash, for which the individual performed a service or which is provided as part of the individual's wages is counted as income.
In-kind income for which the individual did not perform a service, or did not work to receive, is not counted as income.
(10) Supplemental Security Income and State Supplemental payments are countable income.

(11) Income, unearned and earned, shall be deemed from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997. Sponsor deeming will end when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public assistance.
(12) Income that is defined in 20 CFR 416 Subpart K, Appendix, 2004 edition, which is incorporated by reference, is not countable.
(13) Payments that are prohibited under other federal laws from being counted as income to determine eligibility for federally funded medical assistance programs are not countable.
(14) Death benefits are not countable income to the extent that the funds are spent on the deceased person's burial or last illness.
(15) A bona fide loan that an individual must repay and that the individual has contracted in good faith without fraud or deceit, and genuinely endorsed in writing for repayment is not countable income.
(16) Child Care Assistance under Title XX is not countable income.
(17) Reimbursements of Medicare premiums received by an individual from Social Security Administration or the State Department of Health are not countable income.
(18) Earned and unearned income of a child who is under age 19 is not counted if the child is not the head of a household.
(19) Educational income, such as educational loans, grants, scholarships, and work-study programs are not countable income. The individual must verify enrollment in an educational program.
(20) Reimbursements for employee work expenses incurred by an individual are not countable income.
(21) The value of food stamp assistance is not countable income.

R414-310-11. Budgeting.
This section describes methods that the Department uses to determine the household's countable monthly or annual income.
(1) The gross income of all household members is counted in determining the eligibility of the applicant or enrollee, unless the income is excluded under this rule. Only expenses that are required to make an income available to the individual are deducted from the gross income. No other deductions are allowed.
(2) The Department determines monthly income by taking into account the months of pay where an individual receives a fifth paycheck when paid weekly, or a third paycheck when paid every other week. The Department multiplies the weekly amount by 4.3 to obtain a monthly amount. The Department multiplies income paid biweekly by 2.15 to obtain a monthly amount.
(3) The Department shall determine an individual's eligibility prospectively for the upcoming certification period at the time of application and at each recertification for continuing eligibility. The Department determines prospective eligibility by using the best estimate of the household's average monthly income that is expected to be received or made available to the household during the upcoming certification period. The Department prorates income that is received less often than monthly over the certification period to determine an average monthly income. The Department may request prior years' tax returns as well as current income information to determine a household's income.
(4) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The Department may use a combination of methods to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the certification period, or an annual amount that is prorated over the certification period. The Department may use different methods for different types of income received in the same household.
(5) The Department determines farm and self-employment income by using the individual's most recent tax return forms. If tax returns are not available, or are not reflective of the individual's current farm or self-employment income, the Department may request income information from the most recent time period during which the individual had farm or self-employment income. The Department deducts 40% of the gross income as a deduction for business expenses to determine the countable income of the individual. For individuals who have business expenses greater than 40%, the Department may exclude more than 40% if the individual can demonstrate that the actual expenses were greater than 40%.
The Department deducts the same expenses from gross income that the Internal Revenue Service allows as self-employment expenses.

(6) The Department may annualize income for any household and specifically for households that have self-employment income,
receive income sporadically under contract or commission agreements, or receive income at irregular intervals throughout the
year.
(7) The Department may request additional information and verification about how a household is meeting expenses if the average household income appears to be insufficient to meet the household's living expenses.

R414-310-12. Assets.
There is no asset test for eligibility in the Primary Care Network program[or the Covered-at-Work program].

R414-310-13. Application Procedure.
(1) The Department adopts 42 CFR 435.907 and 435.908, 2004 ed., which are incorporated by reference. The Department shall maintain case records as defined in R414-308-8[~~01~~].
(2) The applicant must complete and sign a written application or complete an application on-line via the Internet to enroll in the
Primary Care Network program[~~or the Covered-at-Work program~~].
(a) The Department accepts any Department-approved application form for medical assistance programs offered by the state as an application for the Primary Care Network program[~~or the~~
~~Covered-at-Work program~~]. The local office eligibility worker may
require the applicant to provide additional information that was not
asked for on the form the applicant completed, and may require the
applicant to sign a signature page from a hardcopy medical application form.
(b) If an applicant cannot write, he must make his mark on the application form and have at least one witness to the signature. A
legal guardian or a person with power of attorney may sign the application form for the applicant.
(c) An authorized representative may apply for the applicant if unusual circumstances prevent the individual from completing the
application process himself. The applicant must sign the application
form if possible.
(3) The [~~date of~~]application date is the [~~day~~]date the agency receives a signed application form [~~is received by the~~]at a local office by 5:00 p.m. on a business day. This applies to paper applications delivered in person or by mail, paper applications sent via
facsimile transmission, and electronic applications sent via the internet.
If a local office receives an application after 5:00 p.m. on a business
day, the date of application is the next business day.
(4) The application date for applications delivered to an outreach location is as follows:
(a) If the application is delivered at a time when the outreach staff
is working at that location, the date of application is the date the
outreach staff receives the application.
(b) If the application is delivered at a time when the outreach
office is closed, including being closed for weekends or holidays, the
date of application is the last business day that a staff person from the
state agency was available to receive or pick up applications from the
location.
(5) The due date for verifications needed to complete an application and determine eligibility is 5:00 p.m. on the last day of the application period.
([~~4~~]6) If an applicant has a legal guardian, a person with a power
of attorney, or an authorized representative, the local office shall send
decision notices, requests for information, and forms that must be
completed to both the individual and the individual's representative, or
to just the representative if requested or if determined appropriate.
([~~5~~]7) The Department shall reinstate a medical case without
requiring a new application if the case was closed in error.
([~~6~~]8) The Department shall continue enrollment without requiring a new application if the case was closed for failure to
complete a recertification or comply with a request for information or
verification:
(a) if the enrollee complies before the effective date of the case
closure or by the end of the month immediately following the month
the case was closed; and
(b) the individual continues to meet all eligibility requirements.
([~~7~~]9) An applicant may withdraw an application for the Primary
Care Network program[~~or the Covered-at-Work program~~] any time
before the Department completes an eligibility decision on the
application.
([~~8~~]10) The applicant shall pay an annual enrollment fee to enroll
in the Primary Care Network Program[~~or Primary Care Network -~~
~~Covered-at-Work Program~~] once the local office has determined that
the individual meets the eligibility criteria for enrollment.
(a) Coverage does not begin until the Department receives the
enrollment fee.
(b) The enrollment fee covers both the individual and the individual's spouse if the spouse is also eligible for enrollment in the

Primary Care Network [~~or the Primary Care Network - Covered-at-Work~~]Program.
(c) The enrollment fee is required at application and at each recertification.
(d) The enrollment fee must be paid to the local office in cash, or by check or money order made out to the Department of Health or to the Department of Workforce Services.
(e) The enrollment fee for an individual or married couple receiving General Assistance from the Department of Workforce Services is $15. The enrollment fee for an individual or couple who does not receive General Assistance but whose countable income is less that 50 percent of the federal poverty guideline applicable their household size is $25. The enrollment fee for any other individual or married couple is $50.
(f) The Department may refund the enrollment fee if it decides the person was ineligible for the program; however, the Department may retain the enrollment fee to the extent that the individual owes any overpayment of benefits that were paid in error on behalf of the individual by the Department.
([~~9~~]11) If an eligible household requests enrollment for a spouse, the application date for the spouse is the date of the request. A new application form is not required; however, the household shall provide the information necessary to determine eligibility for the spouse, including information about access to creditable health insurance, including Medicare Part A or B, student health insurance, and the VA Health Care System.
(a) Coverage or benefits for the spouse will be allowed from the date of request or the date an application is received through the end of the current certification period.
(b) A new enrollment fee is not required to add a spouse during the current certification period.
(c) A new income test is not required to add the spouse for the months remaining in the current certification period.
(d) A spouse may be added only if the Department has not stopped enrollment under section R414-310-16.
(e) Income of the spouse will be considered and payment of the enrollment fee will be required at the next scheduled recertification.

R414-310-14. Eligibility Decisions and Recertification.
(1) The Department adopts 42 CFR 435.911 and 435.912, 2004 ed., which are incorporated by reference.
(2) When an individual applies for PCN[~~or the Covered-at-Work program~~], the local office shall determine if the individual is eligible for Medicaid. An individual who qualifies for Medicaid without paying a spenddown or a premium cannot enroll in the Primary Care Network[~~or the Covered-at-Work~~] program. If the individual appears to qualify for Medicaid, but additional information is required to determine eligibility for Medicaid, the applicant must provide additional information requested by the eligibility worker. Failure to provide the requested information shall result in the application being denied.
(a) If the individual must pay a spenddown or premium to qualify for Medicaid, the individual may choose to enroll in the PCN[~~ or the Covered-at-Work~~]program if it is an open enrollment period[~~for those programs~~], and the individual meets all the applicable criteria for eligibility. If the PCN [~~or the Covered-at-Work programs~~]program [are]is not in an enrollment period, the individual must wait for an open enrollment period.
(b) At recertification for PCN[~~or the Covered-at-Work program~~], the local office shall first review eligibility for Medicaid. If the individual qualifies for Medicaid without a spenddown or premium, the individual cannot be reenrolled in the PCN[~~or Covered-at-Work~~] program. If the individual appears to qualify for Medicaid, the applicant must provide additional information requested by the eligibility worker. Failure to provide the requested information shall result in the application being denied.
(3) To enroll, the individual must meet the eligibility criteria for enrollment in the Primary Care Network program[~~or the Covered-at-Work program~~], pay the enrollment fee, and it must be a time when the Department has not stopped enrollment under section R414-310-16.[~~An applicant for the Covered-at-Work program must be able to enroll in his or her employer-sponsored health insurance by the end of the month following the application month to be eligible for the Coveredat-Work program. Otherwise, eligibility will be denied, and the individual may reapply during another open enrollment period.~~]
(4) The local office shall complete a determination of eligibility or ineligibility for each application unless:

(a) the applicant voluntarily withdraws the application and the local office sends a notice to the applicant to confirm the withdrawal;
(b) the applicant died; or
(c) the applicant cannot be located; or
(d) the applicant has not responded to requests for information within the [~~30~~]45 day application period or by the date the eligibility worker asked the information or verifications to be returned, if that date is later.
(5) The enrollee must recertify eligibility at least every 12 months.
(6) The local office eligibility worker may require the applicant, the applicant's spouse, or the applicant's authorized representative to attend an interview as part of the application and recertification process. Interviews may be conducted in person or over the telephone, at the local office eligibility worker's discretion.
(7) The enrollee must complete the recertification process and provide the required verifications by the end of the recertification month.
(a) If the enrollee completes the recertification, continues to meet all eligibility criteria and pays the enrollment fee, coverage will be continued without interruption.
(b) The case will be closed at the end of the recertification month if the enrollee does not complete the recertification process and provide required verifications by the end of the recertification month.
(c) If an enrollee does not complete the recertification by the end of the recertification month, but completes the process and provides required verifications by the end of the month immediately following the recertification month, coverage will be reinstated as of the first of that month if the individual continues to be eligible and pays the enrollment fee.
(8) The eligibility worker may extend the recertification due date if the enrollee demonstrates that a medical emergency, death of an immediate family member, natural disaster or other similar cause prevented the enrollee from completing the recertification process on time.

R414-310-15. Effective Date of Enrollment and Enrollment Period.
(1) The effective date of enrollment in the Primary Care Network program is the day that a completed and signed application[~~or an on-line application~~] is received by the local office as defined in R414-310-13(3) and R414-310-13(4)(a) and (b) and the applicant meets all eligibility criteria, including payment of the enrollment fee. The Department shall not provide any benefits or pay for any services received before the effective enrollment date.
(2) [~~The effective date of enrollment in the Covered-at-Work program cannot be before the month in which the applicant pays a premium for the employer-sponsored health insurance and is determined as follows:~~
~~(a) The effective date of enrollment is the date an application is received and the person is found eligible, including payment of the enrollment fee, if the applicant enrolls in and pays the first premium for the employer-sponsored health insurance in the application month.~~
~~(b) If the applicant will not pay a premium for the employer sponsored health insurance in the application month, the effective date of enrollment is the first day of the month in which the applicant pays a premium for the employer-sponsored health insurance. The applicant must enroll in the employer-sponsored health insurance no later than the end of the month following the month the application is received. The applicant must be determined eligible and pay the enrollment fee for the Covered-at-Work program.~~
~~(c) If the applicant cannot enroll in the employer-sponsored health insurance by the end of the month immediately following the application month, the application shall be denied and the individual will have to reapply during another open enrollment period.~~
~~(3)~~]The effective date of re-enrollment for a recertification in the Primary Care Network program [~~or the Covered-at-Work program~~]is the first day of the month after the recertification month, if the recertification is completed as described in R414-310-14(7).
[~~(4)~~](3) If the enrollee does not complete the recertification as described in R414-310-14(7), and the enrollee does not have good cause for missing the deadline, the case will remain closed and the individual may reapply during another open enrollment period.
[~~(5)~~](4) An individual found eligible for the Primary Care Network program [~~or the Covered-at-Work program~~]shall be eligible from the effective date through the end of the first month of

eligibility and for the following 12 months. If the enrollee completes the [~~redetermination~~]recertification process in accordance
with R414-310-14(7) and continues to be eligible, the recertification
period will be for an additional 12 months beginning the month following the recertification month. Eligibility could end before the
end of a 12-month certification period for any of the following reasons:
(a) the individual turns age 65;
(b) the individual becomes entitled to receive student health insurance, Medicare, or becomes covered by Veterans Administration Health Insurance;
(c) the individual dies;
(d) the individual moves out of state or cannot be located;
(e) the individual enters a public institution or an Institute for Mental Disease.
~~[(6) If an individual on the Covered-at-Work program voluntarily discontinues enrollment in employer-sponsored insurance coverage, eligibility for the Covered-at-Work program ends. If the enrollment in employer-sponsored insurance is discontinued involuntarily and the individual notifies the local office~~
~~within 10 calendar days of when the insurance ends, the individual~~
~~may switch to the PCN program for the remainder of the certification period.~~
~~(7)~~](5) An individual enrolled in the Primary Care Network program loses eligibility when the individual enrolls in any type of
group health plan or other creditable health insurance coverage including an employer-sponsored [~~coverage~~]health plan, except under the following circumstances:
(a) An individual who gains access to or enrolls in an employer-sponsored health plan may switch to the [~~Covered-atwork~~]
UPP program if the individual [reports to]notifies the local office [~~within 10 calendar days of enrolling in an employersponsored~~
~~plan,~~]before the coverage in the employer-sponsored health plan begins, and if the requirements defined in R414-310-7(3)(b)[~~or (c)~~] are met.
(b) An individual who enrolls in the Utah Health Insurance Pool (H.I.P.) does not lose eligibility in the Primary Care Network.
~~[(8) An enrollee in the Primary Care Network who reports within 10 days that he or she has gained access to enroll in employer-sponsored coverage may either switch to the Covered-at-~~
~~Work program. To switch to Covered-at-Work, the following requirements must be met:~~
~~(a) The requirements of R414-310-7(3) must be met.~~
~~(b) The individual must enroll in the employer-sponsored coverage and begin paying premiums for the insurance.~~
~~(9)~~](6) If a Primary Care Network[~~or Covered-at-Work~~] case closes for any reason, other than to become covered by another Medicaid program, and remains closed for one or more calendar months, the individual must submit a new application to the local
office during an enrollment period to reapply. The individual must meet all the requirements of a new applicant including paying a new
enrollment fee.
~~[(10)~~](7) If a Primary Care Network [~~or Covered-at-Work~~]case closes because the enrollee is eligible for another Medicaid
program, the individual may reenroll in the Primary Care Network[
or the Covered-at-Work] program if there is no break in coverage
between the programs, even if the State has stopped enrollment
under R414-310-16(2).
(a) If the individual's 12-month certification period has not ended, the individual may reenroll for the remainder of that certification period. The individual is not required to complete a
new application or have a new income eligibility determination. The
individual must continue to meet the criteria defined in R414-310-7.
The individual is not required to pay a new enrollment fee for the
months remaining in the current certification period.
(b) If the 12-month certification period from the prior enrollment has ended, the individual may still reenroll in the Primary
Care Network[~~or the Covered-at-Work~~] program. However, the
individual must complete a new application, meet eligibility and
income guidelines, and pay a new enrollment fee for the new
certification period.
(c) If there is a break in coverage of one or more calendar months between programs, the individual must reapply during an
open enrollment period for the Primary Care Network[~~or the~~
~~Covered-at-Work~~] program.[
~~(11) Lifetime eligibility for benefits under the Covered-at-Work program is limited to 60 months for each enrollee.~~]

R414-310-16. Enrollment Limitation.
(1) The Department shall limit enrollment in the Primary Care
Network program[~~and the Covered-at-Work program~~].
(2) The Department may stop enrollment of new individuals at
any time based on availability of funds.
(3) The Department and local offices shall not accept applications nor maintain waiting lists during a time period that
enrollment of new individuals is stopped.
(4) If enrollment has not been stopped, individuals may apply
for the Primary Care Network program[~~or the Covered-at-Work~~
~~program~~].
(5) An individual who becomes ineligible for Medicaid, or who must pay a spenddown or premium for Medicaid, but who was

not previously enrolled in the Primary Care Network[~~or Covered-at-Work~~] program, may apply to enroll in the Primary Care Network[~~or the Covered-at-Work~~] program if the State has not stopped enrollment under R414-310-16(2). If enrollment has been stopped, the individual must wait for an open enrollment period to apply.

R414-310-18. Improper Medical Coverage.
(1) An individual who receives benefits under the Primary Care Network program [~~or the Covered-at-Work program~~] for which he is not eligible is responsible to repay the Department for the cost of the benefits received.
(2) An alien and the alien's sponsor are jointly liable for benefits received for which the individual was not eligible.
(3) An overpayment of benefits includes all amounts paid by the Department for medical services or other benefits on behalf of an enrollee or for the benefit of the enrollee during a time period that the enrollee was not actually eligible to receive such benefits.

KEY: Medicaid, primary care, covered-at-work, demonstration
Date of Enactment or Last Substantive Amendment: [~~December 16, 2004~~]2007
Authorizing, and Implemented or Interpreted Law: 26-18-1; 26-1-5; 26-18-3

Maine: DirigoChoice

Statute

Note: Section 6912 below outlines DirigoChoice and also makes reference to the larger Dirigo Health Program ("Dirigo") statute in section 6910. Section 6910 follows, in its entirety.

Title 24-A, §6912, Subsidies

Source: http://janus.state.me.us/legis/statutes/24-A/title24-Asec6912.rtf

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Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees whose income is under 300% of the federal poverty level. Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees, whose income is under 300% of the federal poverty level. [2005, c. 400, Pt. A, §7 (amd).]

1. Administration. Dirigo Health shall, by rule, establish procedures to administer this section.

[2003, c. 469, Pt. A, §8 (new).]

2. Eligibility for subsidy. To be eligible for a subsidy an individual or employee must:

A. Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level and be a resident of the State; or [2005, c. 400, Pt. A, §8 (amd).]

B. Be enrolled in a health plan of an employer with more than 50 employees and have an income under 300% of the federal poverty level. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health. [2005, c. 400, Pt. A, §8 (amd).]

[2005, c. 400, Pt. A, §8 (amd).]

3. Limitation of subsidies. Dirigo Health shall limit the availability of subsidies to reflect limitations of available funds.

[2003, c. 469, Pt. A, §8 (new).]

4. Limitation on amount subsidized. Dirigo Health may limit the amount subsidized of the payment made by individual plan enrollees under section 6910, subsection 4, paragraph C to 40% of the payment to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals in accordance with subsection 2, paragraph A exceed the maximum subsidy level available to other eligible individuals.

[2003, c. 469, Pt. A, §8 (new).]

5. Notification of subsidy. Dirigo Health shall notify applicants and their employers in writing of their eligibility and approved level of subsidy.

[2003, c. 469, Pt. A, §8 (new).]

6. Report. Within 30 days after any subsidies are established pursuant to this section, the board shall report on the amount of the subsidies, the funding required for the subsidies and the estimated number of Dirigo Health Program enrollees eligible for the subsidies and submit the report to the joint

standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

[2005, c. 400, Pt. A, §9 (amd).]
PL 2003, Ch. 469, §A8 (NEW).
PL 2005, Ch. 400, §A7-9 (AMD).

Title 24-A, §6910, Dirigo Health Program

Source: http://janus.state.me.us/legis/statutes/24-A/title24-Asec6910.rtf

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1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health Program not later than October 1, 2004. The Dirigo Health Program must comply with all relevant requirements of this Title. Dirigo Health Program coverage may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board.

[2005, c. 400, Pt. C, §8 (amd).]

2. Legislative approval of nonprofit health care plan or expansion of public plan. If health insurance carriers do not apply to offer and deliver Dirigo Health Program coverage, the board may have Dirigo Health provide access to health insurance by proposing the establishment of a nonprofit health care plan organized under Title 13-B and authorized pursuant to Title 24, chapter 19 or by proposing the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit its proposal, including, but not limited to, a funding mechanism to capitalize a nonprofit health care plan and any recommended legislation to the joint standing committee of the Legislature having jurisdiction over health insurance matters. Dirigo Health may not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

[2005, c. 400, Pt. C, §8 (amd).]

3. Carrier participation requirements. To qualify as a carrier of Dirigo Health Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and [2003, c. 469, Pt. A, §8 (new).]

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not

refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

[RR 2003, c. 1, §22 (cor).]

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage must also qualify as health plans in Medicaid.

[2005, c. 400, Pt. C, §8 (amd).]

4. Contracting authority. Dirigo Health has contracting authority and powers to administer Dirigo Health Insurance as set out in this subsection.

A. Dirigo Health may contract with health insurance carriers licensed to sell health insurance in this State or other private or public third-party administrators to provide Dirigo Health Program coverage. In addition:

(1) Dirigo Health shall issue requests for proposals from health insurance carriers;

(2) Dirigo Health may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities;

(3) Dirigo Health shall require participating health insurance carriers to offer a benefit plan identical to the Dirigo Health Program, for which no Dirigo Health subsidies are available, in the general small group market;

(4) Dirigo Health shall make payments to participating health insurance carriers under a Dirigo Health Program contract to provide Dirigo Health Program benefits to plan enrollees not enrolled in MaineCare;

(5) Dirigo Health may set allowable rates for administration and underwriting gains for the Dirigo Health Program;

(6) Dirigo Health may administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health insurance coverage through Dirigo Health for the duration of their eligibility periods for continuation benefits pursuant to the federal Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003; and

(7) Dirigo Health may administer or contract to administer the United States Internal Revenue Code of 1986, Section 125 plans for employers and employees participating in Dirigo Health, including medical expense reimbursement accounts and dependent care reimbursement accounts.

[2005, c. 400, Pt. C, §8 (amd).]

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program and that the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

[2005, c. 400, Pt. C, §8 (amd).]

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health Program coverage for themselves and their dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health may collect payments from eligible individuals participating in the Dirigo Health Program to cover the cost of:

(a) Enrollment in the Dirigo Health Program for eligible individuals and dependents;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall reduce the payment amounts for individuals eligible for a subsidy under section 6912 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in the Dirigo Health Program or are covered by another creditable plan.

(5) Dirigo Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) Dirigo Health may limit the number of plan enrollees.

(7) Dirigo Health may establish other criteria for participation.

[2005, c. 400, Pt. C, §8 (amd).]

[2005, c. 400, Pt. C, §8 (amd).]

5. Enrollment in Dirigo Health Program. Dirigo Health shall perform, at a minimum, the following functions to facilitate enrollment in the Dirigo Health Program.

A. Dirigo Health shall publicize the availability of the Dirigo Health Program to businesses, self-employed individuals and others eligible to enroll in the Dirigo Health Program. [2005, c. 400, Pt. C, §8 (amd).]

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6912 and eligibility for MaineCare. To facilitate the screening and referral process, Dirigo Health shall provide a single application form for Dirigo Health and MaineCare. The application materials must inform applicants of subsidies available through Dirigo Health and of the additional coverage available through MaineCare. It must allow an applicant to choose on the application form to apply or not to apply for MaineCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for MaineCare or a subsidy. Except when the applicant has declined to apply for MaineCare or a subsidy, an application must be treated as an application for Dirigo Health, for a subsidy and for MaineCare. MaineCare must make the final determination of eligibility for MaineCare. [2003, c. 469, Pt. A, §8 (new).]

C. Except as provided in this paragraph, the effective date of coverage for a new enrollee in the Dirigo Health Program is the first day of the month following receipt of the fully completed application for that enrollee by the carrier contracting with Dirigo Health or the first day of the next month if the fully completed application is received by the carrier within 10 calendar days of the end of the month. If a new enrollee in the Dirigo Health Program had prior coverage through an individual or small group policy, coverage under the Dirigo Health Program must take effect the day following termination of that enrollee's prior coverage. [2005, c. 400, Pt. C, §8 (amd).]

[2005, c. 400, Pt. C, §8 (amd).]

6. Quality improvement, disease management and cost containment. Dirigo Health shall promote quality improvement, disease prevention, disease management and cost-containment programs as part of its administration of the Dirigo Health Program.

[2005, c. 400, Pt. C, §8 (amd).]
PL 2003, Ch. 469, §A8 (NEW).
RR 2003, Ch. 1, §22 (COR).
PL 2005, Ch. 400, §C8 (AMD).

Administrative Rules

Note: Several attempts were made to locate administrative rules specific to DirigoChoice but these attempts were unsuccessful.

Illinois: FamilyCare/All Kids Rebate

Statute

Source:
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1255&ChapAct=215%26nbsp%3BILCS%26nbsp%3B106%2F&ChapterID=22&ChapterName=INSURANCE&ActName=Children%92s+Health+Insurance+Program+Act%2E

INSURANCE
(215 ILCS 106/) Children's Health Insurance Program Act.

(215 ILCS 106/1)
Sec. 1. Short title. This Act may be cited as the Children's Health Insurance Program Act.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/5)
Sec. 5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all citizens of the State, it is important to enable low-income children of this State, to the extent funding permits, to access health benefits coverage, especially preventive health care. The General Assembly recognizes that assistance to help families purchase health benefits for low-income children must be provided in a fair and equitable fashion and must treat all children at the same income level in a similar fashion. The State of Illinois should help low-income families transition from a health care system where government partners with families to provide health benefits to low-income children to a system where families with higher incomes eventually transition into private or employer based health plans. This Act is not intended to create an entitlement.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/10)
Sec. 10. Definitions. As used in this Act:
"Benchmarking" means health benefits coverage as defined in Section 2103 of the Social Security Act.
"Child" means a person under the age of 19.
"Department" means the Department of Public Aid.
"Medical assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.
"Medical visit" means a hospital, dental, physician, optical, or other health care visit where services are provided pursuant to this Act.
"Program" means the Children's Health Insurance Program, which includes subsidizing the cost of privately sponsored health insurance and purchasing or providing health care benefits for eligible children.
"Resident" means a person who meets the residency requirements as defined in Section 5-3 of the Illinois Public Aid Code.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/15)
Sec. 15. Operation of the Program. There is hereby created a Children's Health Insurance Program. The Program shall operate subject to appropriation and shall be administered by the Department of Public Aid. The Department shall have the powers and authority granted to the Department under the Illinois Public Aid Code. The Department may contract with a Third Party Administrator or other entities to administer

and oversee any portion of this Program.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/20)
Sec. 20. Eligibility.
(a) To be eligible for this Program, a person must be a person who has a child eligible under this Act and who is eligible under a waiver of federal requirements pursuant to an application made pursuant to subdivision (a)(1) of Section 40 of this Act or who is a child who:
(1) is a child who is not eligible for medical assistance;
(2) is a child whose annual household income, as determined by the Department, is above 133% of the federal poverty level and at or below 200% of the federal poverty level;
(3) is a resident of the State of Illinois; and
(4) is a child who is either a United States citizen or included in one of the following categories of non-citizens:
(A) unmarried dependent children of either a United States Veteran honorably discharged or a person on active military duty;
(B) refugees under Section 207 of the Immigration and Nationality Act;
(C) asylees under Section 208 of the Immigration and Nationality Act;
(D) persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act;
(E) persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980;
(F) persons lawfully admitted for permanent residence under the Immigration and Nationality Act; and
(G) parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.
Those children who are in the categories set forth in subdivisions (4)(F) and (4)(G) of this subsection, who enter the United States on or after August 22, 1996, shall not be eligible for 5 years beginning on the date the child entered the United States.
(b) A child who is determined to be eligible for assistance may remain eligible for 12 months, provided the child maintains his or her residence in the State, has not yet attained 19 years of age, and is not excluded pursuant to subsection (c). A child who has been determined to be eligible for assistance must reapply or otherwise establish eligibility at least annually. An eligible child shall be required, as determined by the Department by rule, to report promptly those changes in income and other circumstances that affect eligibility. The eligibility of a child may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A child's responsible relative or caretaker may also be held liable to the Department for any payments made by the Department on such child's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.
(c) A child shall not be eligible for coverage under this Program if:
(1) the premium required pursuant to Section 30 of this Act has not been paid. If the required premiums are not paid the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums had been paid. If the required monthly premium is not paid, the child shall be ineligible for re-enrollment for a minimum period of 3 months. Re-enrollment shall be completed prior to the next covered medical visit and the first month's required premium shall be paid in advance of the next covered medical visit. The Department shall promulgate rules regarding grace periods, notice requirements, and hearing procedures pursuant to this subsection; (2) the child is an inmate of a public institution or a patient in an institution for mental diseases; or

(3) the child is a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency. (Source: P.A. 92-597, eff. 6-28-02; 93-63, eff. 6-30-03.)

(215 ILCS 106/22)

Sec. 22. Enrollment in program. The Department shall develop procedures to allow community providers, schools, youth service agencies, employers, labor unions, local chambers of commerce, and religious organizations to assist in enrolling children in the Program.
(Source: P.A. 91-470, eff. 8-10-99; 91-471, eff. 8-10-99; 92-16, eff. 6-28-01.)

(215 ILCS 106/25)

Sec. 25. Health benefits for children.

(a) The Department shall, subject to appropriation, provide health benefits coverage to eligible children by:

(1) Subsidizing the cost of privately sponsored health insurance, including employer based health insurance, to assist families to take advantage of available privately sponsored health insurance for their eligible children; and

(2) Purchasing or providing health care benefits for eligible children. The health benefits provided under this subdivision (a)(2) shall, subject to appropriation and without regard to any applicable cost sharing under Section 30, be identical to the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act. Providers under this subdivision (a)(2) shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code and shall be reimbursed at the same rate as providers under the State's approved plan under Title XIX of the Social Security Act. In addition, providers may retain co-payments when determined appropriate by the Department.

(b) The subsidization provided pursuant to subdivision (a)(1) shall be credited to the family of the eligible child.

(c) The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan does not meet federal benchmarking standards or cost sharing and contribution requirements. To be eligible for inclusion in the Program, the plan shall contain comprehensive major medical coverage which shall consist of physician and hospital inpatient services. The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan offers benefits in addition to physician and hospital inpatient services.

(d) The total dollar amount of subsidizing coverage per child per month pursuant to subdivision (a)(1) shall be equal to the average dollar payments, less premiums incurred, per child per month pursuant to subdivision (a)(2). The Department shall set this amount prospectively based upon the prior fiscal year's experience adjusted for incurred but not reported claims and estimated increases or decreases in the cost of medical care. Payments obligated before July 1, 1999, will be computed using State Fiscal Year 1996 payments for children eligible for Medical Assistance and income assistance under the Aid to Families with Dependent Children Program, with appropriate adjustments for cost and utilization changes through January 1, 1999. The Department is prohibited from providing a subsidy pursuant to subdivision (a)(1) that is more than the individual's monthly portion of the premium.

(e) An eligible child may obtain immediate coverage under this Program only once during a medical visit. If coverage lapses, re-enrollment shall be completed in advance of the next covered medical visit and the first month's required premium shall be paid in advance of any covered medical visit.

(f) In order to accelerate and facilitate the development of networks to deliver services to children in areas outside counties with populations in excess of 3,000,000, in the event less than 25% of the eligible children in a county or contiguous counties has enrolled with a Health Maintenance Organization pursuant to Section 5-11 of the Illinois Public Aid Code, the Department may develop and implement demonstration projects to create alternative networks designed to enhance enrollment and participation in

the program. The Department shall prescribe by rule the criteria, standards, and procedures for effecting demonstration projects under this Section.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/30)
Sec. 30. Cost sharing.
(a) Children enrolled in a health benefits program pursuant to subdivision (a)(2) of Section 25 and persons enrolled in a health benefits waiver program pursuant to Section 40 shall be subject to the following cost sharing requirements:
(1) There shall be no co-payment required for well-baby or well-child care, including age-appropriate immunizations as required under federal law.
(2) Health insurance premiums for family members, either children or adults, in families whose household income is above 150% of the federal poverty level shall be payable monthly, subject to rules promulgated by the Department for grace periods and advance payments, and shall be as follows:
(A) $15 per month for one family member.
(B) $25 per month for 2 family members.
(C) $30 per month for 3 family members.
(D) $35 per month for 4 family members.
(E) $40 per month for 5 or more family members.
(3) Co-payments for children or adults in families whose income is at or below 150% of the federal poverty level, at a minimum and to the extent permitted under federal law, shall be $2 for all medical visits and prescriptions provided under this Act.
(4) Co-payments for children or adults in families whose income is above 150% of the federal poverty level, at a minimum and to the extent permitted under federal law shall be as follows:
(A) $5 for medical visits.
(B) $3 for generic prescriptions and $5 for brand name prescriptions.
(C) $25 for emergency room use for a non-emergency situation as defined by the Department by rule.
(5) The maximum amount of out-of-pocket expenses for co-payments shall be $100 per family per year.
(b) Individuals enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) of Section 25 shall be subject to the cost sharing provisions as stated in the privately sponsored health insurance plan.
(Source: P.A. 94-48, eff. 7-1-05.)

(215 ILCS 106/35)
Sec. 35. Funding.
(a) This Program is not an entitlement and shall not be construed to create an entitlement. Eligibility for the Program is subject to appropriation of funds by the State and federal governments. Subdivision (a)(2) of Section 25 shall operate and be funded only if subdivision (a)(1) of Section 25 is operational and funded. The estimated net State share of appropriated funds for subdivision (a)(2) of Section 25 shall be equal to the estimated net State share of appropriated funds for subdivision (a)(1) of Section 25.
(b) Any requirement imposed under this Act and any implementation of this Act by the Department shall cease in the event (1) continued receipt of federal funds for implementation of this Act requires an amendment to this Act, or (2) federal funds for implementation of the Act are not otherwise available.
(c) Payments under this Act shall be appropriated from the General Revenue Fund and other funds that are authorized to be used to reimburse or make medical payments for health care benefits under this Act or Title XXI of the Social Security Act.
(d) Benefits under this Act shall be available only as long as the intergovernmental agreements made pursuant to Section 12-4.7 and Article XV of the Illinois Public Aid Code and entered into between the

Department and the Cook County Board of Commissioners continue to exist.
(Source: P.A. 90-736, eff. 8-12-98; 91-24, eff. 7-1-99.)

(215 ILCS 106/40)

Sec. 40. Waivers.

(a) The Department shall request any necessary waivers of federal requirements in order to allow receipt of federal funding for:

(1) the coverage of families with eligible children under this Act; and

(2) for the coverage of children who would otherwise be eligible under this Act, but who have health insurance.

(b) The failure of the responsible federal agency to approve a waiver for children who would otherwise be eligible under this Act but who have health insurance shall not prevent the implementation of any Section of this Act provided that there are sufficient appropriated funds.

(c) Eligibility of a person under an approved waiver due to the relationship with a child pursuant to Article V of the Illinois Public Aid Code or this Act shall be limited to such a person whose countable income is determined by the Department to be at or below such income eligibility standard as the Department by rule shall establish. The income level established by the Department shall not be below 90% of the federal poverty level. Such persons who are determined to be eligible must reapply, or otherwise establish eligibility, at least annually. An eligible person shall be required, as determined by the Department by rule, to report promptly those changes in income and other circumstances that affect eligibility. The eligibility of a person may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A person may also be held liable to the Department for any payments made by the Department on such person's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.
(Source: P.A. 92-597, eff. 6-28-02; 93-63, eff. 6-30-03.)

(215 ILCS 106/45)

Sec. 45. Study.

(a) The Department shall conduct a study which includes, but is not limited to, the following:

(1) Establishes estimates, broken down by regions of the State, of the number of children with health insurance coverage and without health insurance coverage; the number of children who are eligible for Medicaid, and of that number, the number who are enrolled in Medicaid; the number of children with access to dependent coverage through an employer, and of that number, the number who are enrolled in dependent coverage through an employer.

(2) Ascertains, for the population of children potentially eligible for coverage under any component of the Program, the extent of access to dependent coverage, how many children are enrolled in dependent coverage, the comprehensiveness of dependent coverage benefit packages available, and the amount of cost sharing currently paid by the employees.

(b) The Department shall submit the preliminary results of the study to the Governor and the General Assembly by December 1, 1998 and shall submit the final results to the Governor and the General Assembly by May 1, 1999.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/50)

Sec. 50. Program evaluation. The Department shall conduct 2 evaluations of the effectiveness of the program implemented under this Act. The first evaluation shall be for the first 6 full months of implementation, and the evaluation shall be completed within 90 days after that period. The second evaluation shall be for the first 12 full months of implementation and shall be completed within 90 days after that period.
(Source: P.A. 90-736, eff. 8-12-98.)

(215 ILCS 106/55)
Sec. 55. Contracts with non-governmental bodies. All contracts with non-governmental bodies that are determined by the Department to be necessary for the implementation of this Act are deemed to be purchase of care as defined in the Illinois Procurement Code.
(Source: P.A. 90-736, eff. 8-12-98; 91-266, eff. 7-23-99.)

(215 ILCS 106/60)
Sec. 60. Emergency rulemaking. Prior to June 30, 1999, the Department may adopt rules necessary to establish and implement this Act through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this Act is deemed an emergency and necessary for the public interest, safety, and welfare.
(Source: P.A. 90-736, eff. 8-12-98; 91-266, eff. 7-23-99.)

(215 ILCS 106/96)
Sec. 96. Inseverability. The provisions of this Act are mutually dependent and inseverable. If any provision or its application to any person or circumstance is held invalid, then this entire Act is invalid.
(Source: P.A. 90-736, eff. 8-12-98.)
(215 ILCS 106/97)
Sec. 97. (Repealed).
(Source: P.A. 92-597, eff. 6-28-02. Repealed by P.A. 93-63, eff. 6-30-03.)

(215 ILCS 106/98)
Sec. 98. (Amendatory provisions; text omitted).
(Source: P.A. 90-736, eff. 8-12-98; text omitted.)

(215 ILCS 106/99)
Sec. 99. Effective Date. This Act takes effect upon becoming law.
(Source: P.A. 90-736, eff. 8-12-98.)

Administrative Rules

Note: 89 Ill. Adm. Code 125 (Illinois Code Title 89, Chapter 1, Subchapter b, Part 125) outlines Illinois' Children's Health Insurance Program, which includes the Rebate program. In the following rule, the Rebate program is referred to as the Family Care/ KidCare Rebate, although since the implementation of All Kids, the term "All Kids" has generally replaced the term "KidCare." Part 125 is copied here in its entirety.
Source: http://www.hfs.illinois.gov/lawsrules/125.html

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 125
CHILDREN'S HEALTH INSURANCE PROGRAM

SUBPART A: GENERAL PROVISIONS

Section
125.100 General Description
125.110 Definitions

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section
125.200 Eligibility for Children's Health Insurance Program
125.205 Eligibility Exclusions and Terminations
125.220 Application Process
125.225 Presumptive Eligibility for Children
125.230 Determination of Monthly Countable Income
125.240 Eligibility Determination and Enrollment Process
125.245 Appeals
125.250 Annual Renewals
125.260 Adding Children to and Removing Children from the Program and Changes in Participation
125.265 Adding Eligible Adults to the Program and Changes in Participation

SUBPART C: KIDCARE HEALTH PLAN

Section
125.300 Covered Services
125.305 Service Exclusions
125.310 Copayments
125.320 Premium Requirements
125.330 Non-payment of Premium
125.340 Provider Reimbursement

SUBPART D: KIDCARE REBATE

Section
125.400 Minimum Coverage Requirements
125.420 Coverage Verification Process
125.430 Provision of Policyholder's Social Security Number
125.440 KidCare Insurance Rebate
125.445 Rebate Overpayments

AUTHORITY: Implementing and authorized by the Children's Health Insurance Program Act [215 ILCS 106] and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].

SOURCE: Adopted by emergency rulemaking at 22 Ill. Reg. 15706, effective August 12, 1998, for a maximum of 150 days; adopted at 23 Ill. Reg. 543, effective December 24, 1998; emergency amendment at 24 Ill. Reg. 4217, effective March 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11822, effective July 28, 2000; amended at 26 Ill. Reg. 12313, effective July 26, 2002; emergency amendment at 26 Ill. Reg. 15066, effective October 1, 2002, for a maximum of 150 days; amended at 27 Ill. Reg. 4723, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10807, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18623, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 7163, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13632, effective September 28, 2004; emergency amendment at 30 Ill. Reg. 535, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. _____, effective May 26, 2006.

SUBPART A: GENERAL PROVISIONS

Section 125.100 General Description

This Part implements the Children's Health Insurance Program Act [215 ILCS 106] that authorizes the Department to administer an insurance program to assist families in purchasing health insurance benefits. The Program is not an entitlement. The Program will enable eligible residents of Illinois, to the extent funding permits, access to health benefits coverage. The Department shall provide health benefits coverage to eligible individuals through purchasing or providing health care benefits or by subsidizing the cost of privately sponsored health insurance, including employer-based health insurance.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.110 Definitions

For the purpose of this Part, the following terms shall be defined as follows:

"Act" means the Children's Health Insurance Program Act [215 ILCS 106].

"Caretaker Relative" means a relative as specified in this definition, with whom the child lives, who is providing care, supervision and a home for the child. Caretaker relatives include:

Blood or adoptive relatives within the fifth degree of kinship:
father and mother
brother and sister
grandmother and grandfather (including up to great-great-great)
uncle and aunt (including up to great-great)
nephew and niece (including up to great-great)
first cousin
first cousin once removed (child of first cousin)
second cousin (child of great-aunt/uncle)
Step relatives:
step-father and step-mother
step-brother and step-sister
A person who is or has been married to one of the above relatives.

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"Eligible Adult" means an individual 19 years of age or older who is a parent or other caretaker relative and that individual's spouse if they reside together.

"Family" means the child applying for the Program and the following individuals who live with the child:

The child's parents
The spouse of the child's parent
Children under 19 years of age of the parents or the parent's spouse
The spouse of the child
The children of the child
If any of the above is pregnant, the unborn children.

"FamilyCare" means expansion of coverage to include Eligible Adults as permitted by the KidCare Parent Coverage Waiver.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

"KidCare/FamilyCare Health Plan" means the health benefits coverage containing cost sharing features that is available to eligible families under the Children's Health Insurance Program or the KidCare Parent Coverage Waiver, and includes KidCare/FamilyCare Share (no premium required) and KidCare/FamilyCare Premium (premium required).

"KidCare/FamilyCare Rebate" means the program under which the Department, on behalf of an eligible individual, makes rebate payments to offset a family's cost of insuring an individual under privately sponsored or employer-based health insurance.

"Medical Assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

"Program" means the program created under the Children's Health Insurance Program Act and this Part.

"Rebate" means the payment made by the Department under KidCare Rebate.

"REV" means the Recipient Eligibility Verification system through which medical providers can obtain eligibility and claim status information electronically.

"Significant Health Insurance" means coverage that includes physician services and inpatient hospital services that would qualify for coverage under KidCare Rebate.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 125.200 Eligibility for Children's Health Insurance Program and FamilyCare

A child or eligible adult may be eligible under the Program provided that all of the following eligibility criteria are met:

a) The child or eligible adult is not eligible for Medical Assistance including Section 120.32.

b) The child is under 19 years of age.

c) Countable Income

1) A child is a member of a family whose monthly countable income is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level.

2) An eligible adult is a member of a Family whose monthly income is above 133 percent of the Federal Poverty Level and at or below 185 percent of the Federal Poverty Level.

d) The individual is a resident of the State of Illinois.

e) The individual is either a United States citizen or included in one of the following categories of non-citizens:

1) United States veterans honorably discharged or individuals on active military duty, or the spouse or unmarried dependent children of such persons.

2) Refugees under Section 207 of the Immigration and Nationality Act.

3) Asylees under Section 208 of the Immigration and Nationality Act.

4) Individuals for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act.

5) Individuals granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

6) Individuals lawfully admitted for permanent residence under the Immigration and Nationality Act.

7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

8) Nationals of Cuba or Haiti.

9) Individuals identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking.

10) Amerasians from Vietnam.

11) Members of the Hmong or Highland Laotian tribe when the tribe helped United States personnel by taking part in military or rescue operations.

12) American Indians born in Canada.

13) Individuals who are a spouse, widow or child of a United States citizen or a spouse or a child or a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the United States citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month after assistance and whose need for assistance is due, at least in part, to the abuse.

f) The individual's Social Security Number (SSN) is provided to the Department, or if it has not been issued or is not known, proof that application has been made for an SSN is provided.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.205 Eligibility Exclusions and Terminations

a) An individual shall not be determined eligible for coverage under the Program if:

1) The individual is an inmate of a public institution.

2) The individual is a patient in an institution for mental diseases.

3) The individual is a member of a family that is eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency.

4) The individual is in categories described in Section 125.200(e)(6) or (e)(7), and the individual entered the United States on or after August 22, 1996; he or she shall not be eligible for five years beginning on the date the individual entered the United States.

b) An individual with significant health insurance can choose between KidCare/Family Care Health Plan and KidCare/FamilyCare Rebate.

c) Termination of an individual's coverage under the Program shall be initiated upon the occurrence of any of the following events:

1) A child becomes ineligible due to:

A) Losing his or her Illinois residency.

B) Attaining 19 years of age.

C) Becoming enrolled in Medical Assistance.

D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.

2) An eligible adult becomes ineligible due to:

A) Losing his or her Illinois residency.

B) No child under 19 years of age remaining in the family.

C) Becoming enrolled in Medical Assistance.

D) Meeting the provisions of subsection (a)(1) or (a)(3) of this Section.

E) Income exceeding the range established in Section 125.200(b)(2).

3) A child or an eligible adult becomes ineligible due to:

A) The required premiums under the KidCare/FamilyCare Health Plan are not paid as specified in Sections 125.320 and 125.330.

B) An individual enrolled in KidCare Rebate is no longer being covered under a private or employer-based health insurance plan, except that an individual may change enrollment from KidCare/FamilyCare Rebate to the KidCare/FamilyCare Health Plan pursuant to Section 125.260(c).

C) The individual fails to report to the Department changes in information that impacts upon the individual's eligibility for the Program.

D) The individual makes a request to the Department to terminate the coverage.

E) The Department determines that the individual is no longer eligible based on any other applicable State or federal law or regulation.

F) The Department determines that the individual failed to provide eligibility information that was truthful and accurate to the best of the applicant's knowledge and belief and that affected the eligibility determination.

G) There has been a Rebate overpayment and it has not been repaid to the Department according to terms established by the Department, which may include recoupment out of future Rebate payments or a payment plan.

H) The Department determines that the individual's eligibility was incorrectly determined.

I) The application was approved pending receipt of the individual's Social Security Number and it is not provided later when requested.

d) Following termination of coverage under the Program, the following action is required before the individual can be re-enrolled:

1) A new application must be completed and the individual must be determined otherwise eligible;

2) There must be full payment of premiums under the KidCare Health Plan, for periods in which a premium was owed and not paid for the individual, including premiums owed when the individual was, for purposes of this Part, a member of another family;

3) Any overpayment of Rebates paid on behalf of the individual must be repaid to the Department. A Rebate overpayment shall be considered repaid if the Department can recoup the overpayment out of future Rebate payments;

4) If the termination was the result of non-payment of premiums, the individual must be out of the Program for three months before re-enrollment; and

5) The first month's premium must be paid if the individual is eligible for KidCare/FamilyCare Premium and the individual's family chose to have coverage under subsection (g) of this Section when the individual was initially enrolled in the Program or if there was an unpaid premium on the date the individual's previous case was canceled.

e) An application will be denied if any of the eligible adults in the family was responsible as a caretaker relative or eligible adult during a period for which a premium under the Program was due to the Department and the premium remains unpaid at the time of application. Such an application shall be denied regardless of whether the individual for whom the premium remains unpaid is included in the application.

f) An application will be denied if any of the eligible adults received benefits or was a caretaker relative of a child during a period for which a Rebate overpayment was received or was the payee of a Rebate overpayment and the overpayment has not been repaid to the Department. Such an application shall be denied regardless of whether the individual for whom the Rebate overpayment remains unpaid is included in the application.

g) A certificate of prior creditable coverage will be issued when the individual's coverage is terminated under the KidCare/FamilyCare Health Plan.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.220 Application Process

a) Families will be able to apply for the Program using any of the following methods:

1) Submit the Department's application to an address specified by the Department.

2) Apply at a Department of Human Services (DHS) local office.

3) Apply through a KidCare Application Agent that has an agreement in place with the Department.

4) Apply online at www.kidcareillinois.com.

5) Additional methods that the Department establishes.

b) The application will meet all requirements found at 89 Ill. Adm. Code 110.10.

c) Families are obligated to provide truthful and accurate information for determining eligibility and to report promptly to the Department any change in non-financial information provided on the application or financial information for eligible adults.

d) The Department may cease accepting or processing applications if enrollment in the Program is closed due to limited appropriations.

e) The Department shall send a notification of its determination within 45 calendar days after the date the application was received.

f) The 45 calendar days may be extended when a decision cannot be reached because:

1) information necessary for a determination is available only from a third party and the party fails to respond or delays his or her response to the request for such information, or

2) additional information is needed from the applicant.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.225 Presumptive Eligibility for Children

a) A child younger than 19 years of age may be presumed eligible for a KidCare Health Plan under this Part if all of the following apply:

1) an application for medical benefits has been made on behalf of the child;

2) the child is a resident of Illinois;

3) the child is not an inmate of a public institution as described in Section 125.205(a)(1);

4) the child is a member of a Family whose monthly countable income, as stated on the application, is above 133 percent of the Federal Poverty Level and at or below 200 percent of the Federal Poverty Level;

5) the State employee who registers the application has no information that the child is not a U.S. citizen or a qualified non-citizen as described in 89 Ill. Adm. Code 125.200(e) or 89 Ill. Adm. Code 118.500; and

6) the child has not been presumed eligible under this Part 125 or 89 Ill. Adm. Code 118 or 120 within the past 12 months.

b) Entities qualified to make a determination of presumptive eligibility include State employees involved in enrolling children in programs under this Part 125 or 89 Ill. Adm. Code 118 or 120.

c) The presumptive eligibility period begins on the date of application.

d) The presumptive eligibility period ends on the date the State's determination of the child's eligibility under this Part 125 or 89 Ill. Adm. Code 118 or 120 is updated in the data system.

e) No copayment or premium requirements apply during the period of presumptive eligibility.

(Source: Added at 28 Ill. Reg. 13632, effective September 28, 2004)

Section 125.230 Determination of Monthly Countable Income

a) Monthly countable income for applications processed for the Program is determined by taking the total gross monthly income of the family and subtracting allowable deductions and exemptions as described in 89 Ill. Adm. Code 120, Subpart H.

b) For the purpose of subsection (a) of this Section, the number of individuals in the family determines the applicable income standard.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.240 Eligibility Determination and Enrollment Process

a) If the monthly countable income is at or below 133 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in Medical Assistance, if otherwise determined eligible pursuant to 89 Ill. Adm. Code 120, Subpart H.

b) If the monthly countable income is above 133 percent and at or below 200 percent of the Federal Poverty Level for a child, or at or below 185 percent of the Federal Poverty Level for an adult, for the number of individuals in the family, and all other eligibility requirements of this Part are met and enrollment is open, the individual will be enrolled in the Program.

c) For purposes of cost sharing, families in the KidCare/FamilyCare Health Plan will be enrolled into either KidCare/FamilyCare Share or KidCare/FamilyCare Premium as follows:

1) If monthly countable income is above 133 percent and at or below 150 percent of the Federal Poverty Level for the number of individuals in the family, the individual will be enrolled in KidCare/FamilyCare Share.

2) If monthly countable income is above 150 percent and at or below 200 percent of the Federal Poverty Level for the number of individuals in the family, a child will be enrolled in KidCare Premium or, if monthly countable income is above 150 percent and at or below 185 percent of the Federal Poverty Level for the number of individuals in the family, an eligible adult will be enrolled in FamilyCare Premium.

d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

e) Eligibility determinations for the Program made by the fifteenth day of the month will be effective the first day of the following month. Eligibility determinations for the Program made after the fifteenth day of the month will be effective no later than the first day of the second month following that determination. The duration of eligibility for the Program for children will be 12 months unless one of the events described in Section 125.205 (c)(1) or (c)(3) occurs. The 12 months of eligibility will commence when the first child in a family is covered under the Program. Children added to the Program after the eligibility period begins will be eligible for the balance of the 12-month eligibility period.

f) Individuals determined to be eligible for the KidCare/FamilyCare Health Plan may obtain coverage for a period prior to the date of application for the Program. This coverage shall be subject to the following:

1) The family must request the prior coverage for the individual within six months following the initial date of coverage under the KidCare/FamilyCare Health Plan.

2) The prior coverage will be individual specific and will only be available the first time the individual child is enrolled in the Program.

3) The prior coverage will begin with services rendered during the two weeks prior to the date the individual's application for the KidCare/FamilyCare Health Plan was filed and will continue until the individual's coverage under the KidCare/FamilyCare Health Plan is effective pursuant to subsection.

Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.245 Appeals

a) Any person who applies for or receives assistance under the Program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the annual renewal including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been

approved. However, if the individual is eligible for KidCare/FamilyCare Premium, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to the retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, if an individual is eligible for KidCare/FamilyCare Premium, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and copayment requirements shall apply to any retroactive period.

4) Determination of the amount of the premium, Rebate, or copayments required. Coverage, Rebate amount and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

b) In addition to the actions that are appealable under subsection (a) of this Section, individuals covered under the KidCare/FamilyCare Health Plan shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) The Department's decision to deny an application due to closing of enrollment for the Program shall not be appealable.

d) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;

2) Calling a toll free telephone number (800/435-0774, or as designated by the Department).

e) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

f) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

g) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

h) If an appeal is initiated within ten calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations including premiums must be met during the period.

i) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.

j) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.250 Annual Renewals

a) Eligibility shall be reviewed by the Department, or its authorized agent, at least annually.
b) Prior to the 12-month eligibility period ending, and in sufficient time for the Family to respond

to the Department=s request for information, the Department or its designee will send an annual renewal notice to the Family.
c) Annual renewals shall be subject to all eligibility requirements set forth in Sections 125.200 and 125.205.

(Source: Amended at 24 Ill. Reg. 11822, effective July 28, 2000)

Section 125.260 Adding Children to the Program and Changes in Participation

a) Families may add eligible children to the Program during the 12-month eligibility period, without eligibility being reviewed by the Department. Coverage for children added shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the family's original 12-month eligibility period and may also include any prior coverage established pursuant to Section 125.240(f).

b) Premium amounts under the KidCare Health Plan and Rebates under KidCare Rebate will be adjusted to reflect adding or removing a child from the Program.

c) A child who would otherwise be terminated from KidCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the KidCare Health Plan without eligibility being reviewed by the Department if there is no unpaid Rebate overpayment. Coverage under the KidCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e) and shall continue for the remainder of the existing 12-month eligibility period. However, at the time of the change in coverage, a family may choose to have the KidCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds within 30 days after the Department's notice that the child's coverage has been changed to KidCare Health Plan any Rebate payment received for a month in which there was no private or employer based insurance coverage, notwithstanding Section 125.445(c).

d) A child with significant health insurance may choose to change coverage from the KidCare Health Plan to KidCare Rebate without eligibility being reviewed by the Department if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under KidCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form and shall continue for the remainder of the existing 12-month eligibility period.

Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006

Section 125.265 Adding Eligible Adults to the Program and Changes in Participation

a) Families may add Eligible Adults to the Program during the 12-month eligibility period if the family income meets the income levels as stated in Section 125.240. Coverage for the added eligible adult shall be prospective from the effective date determined according to Section 125.240(e) and may also include any prior coverage established pursuant to Section 125.240(f).

b) Premium amounts under the FamilyCare Health Plan and Rebates under FamilyCare Rebate will be adjusted to reflect adding or removing an eligible adult from the Program.

c) An eligible adult who would otherwise be terminated from FamilyCare Rebate because of losing private or employer-sponsored health insurance may change coverage to the FamilyCare Health Plan if there is no unpaid Rebate overpayment. Coverage under the FamilyCare Health Plan shall be prospective from the effective date determined according to Section 125.240(e). However, at the time of the change in coverage, a Family may choose to have the FamilyCare Share or Premium coverage retroactive to the first day of the first month following the last month of coverage under the private or employer sponsored insurance if the family refunds, within 30 days after the Department's notice that the person's coverage has been changed to FamilyCare Health Plan, any Rebate payment received for a month in which there was no private or employer based insurance coverage, except as described in Section 125.445(c).

d) An eligible adult with significant health insurance may change coverage to FamilyCare Rebate if the family returns a Rebate form and there are no unpaid premiums owed to the Department. Coverage under FamilyCare Rebate shall be prospective from the effective date determined according to Section 125.240(e), following receipt by the Department of a completed Rebate Form.

(Source: Added at 30 Ill. Reg. _____, effective May 26, 2006)

SUBPART C: KIDCARE/FAMILYCARE HEALTH PLAN

Section 125.300 Covered Services

a) For children covered under the KidCare Health Plan, covered health care services shall be the same covered services for children as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided in Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

b) For eligible adults covered under the FamilyCare Health Plan, covered health care services shall be the same covered services for adults as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided at Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.305 Service Exclusions

The following health care services will not be covered under the KidCare/FamilyCare Health Plan:

a) Services provided only through a waiver approved under Section 1915(c) of the Social Security Act.

b) Abortion services.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.310 Copayments

a) Copayments may be charged to the family by a health care professional whenever the service is performed in an office or home setting, except for visits scheduled for well-baby care, well-child care or age-appropriate immunizations. Copayments may also be charged to the family by hospitals, once per inpatient admission or outpatient encounter (including the emergency room). No copayment is permitted for visits to health care professionals or hospitals made solely for speech, occupational or physical therapy, audiology, radiology or laboratory services (including APL Group 2 procedures). Families with an enrolled individual who is an American Indian or Alaska Native shall not be charged copayments.

b) Copayment requirements are as follows:

1) Practitioner office visit:

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

2) Home health care visit:

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

3) Inpatient hospitalization:

A) KidCare/FamilyCare Share copayment: $2 per admission.

B) KidCare/FamilyCare Premium copayment: $5 per admission.

4) Outpatient encounter (including the emergency room):

A) KidCare/FamilyCare Share copayment: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $5 per visit.

5) Prescription drugs:

A) KidCare/FamilyCare Share copayment: $2 for a 1- to 30-day supply on both generic and brand name drugs.

B) KidCare/FamilyCare Premium copayments: $3 for a 1- to 30-day supply on generic drugs or $5 for 1 to 30-day supply on brand name drugs.

6) Nonemergency visit to an emergency room:

A) KidCare/FamilyCare Share copayments: $2 per visit.

B) KidCare/FamilyCare Premium copayment: $25 per visit.

c) The maximum out-of-pocket expense a family will incur for copayments during a 12-month eligibility period is $100.

d) Once the family has satisfied the copayment cap, the family is responsible for submitting receipts, to the Department, documenting the payment of copayments. The Department may return partial documentation received on copayments to the family.

e) Upon the Department determining that the copayment cap has been satisfied, the following will occur:

1) A notice stating that the copayment cap has been satisfied, and the date satisfied, will be sent to the family.

2) A message that the copayment cap has been satisfied, and the date satisfied, will be available through the family identification card.

3) REV will be updated to reflect that the copayment cap has been reached.

f) Providers will be responsible for collecting copayments under the KidCare/FamilyCare Health Plan.

g) Providers may elect not to charge copayments. If copayments are charged, the copayment must comply with the requirements in this Section.

h) Providers shall be responsible for refunding to the family copayments they collect after the family has reached the copayment cap.

i) The Department will not require providers to deliver services when copayments properly charged under the KidCare/FamilyCare Health Plan are not paid.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.320 Premium Requirements

a) Families with individuals enrolled in KidCare/FamilyCare Premium pursuant to Section 125.240(c) must pay the premiums established by this Section.

b) The premium amounts are $15 for one individual, $25 for two individuals, $30 for three individuals, $35 for four individuals, and $40 for five or more individuals.

c) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

d) The premium due date will be 26 days after the fifth day of the calendar month preceding the month of coverage.

e) The premium will not change during the eligibility period, unless the family adds or removes individuals from the coverage.

f) No premiums shall be charged to families with an enrolled individual who is an American Indian or Alaska Native.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.330 Non-payment of Premium

a) KidCare/FamilyCare Health Plan participants will have a grace period through the end of the month following the coverage month to pay the premium.

b) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

c) Partial premium payments will not be refunded.

d) Collection action will be initiated by the Department to collect unpaid premiums.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.340 Provider Reimbursement

a) Providers under this Part shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code.

b) Provider participation under this Part shall be voluntary.

c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency.

d) In addition to reimbursements received from the Department, providers may retain copayments defined in Section 125.310.

e) Providers under this Part shall be prohibited from billing families covered under the KidCare/FamilyCare Health Plan any difference between the charge amount and the amount paid by the Department, except for copayments as specified in Section 125.310.

f) Providers shall be responsible for refunding to the family copayments collected in excess of the amounts permitted by this Part.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

SUBPART D: KIDCARE/FAMILYCARE REBATE

Section 125.400 Minimum Coverage Requirements

For an eligible individual to participate in KidCare/FamilyCare Rebate, the eligible individual must be covered by an insurance plan that offers comprehensive major medical coverage providing benefits for physician services and hospital inpatient services.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.420 Coverage Verification Process

a) All applications for participation in KidCare/FamilyCare Rebate must be accompanied by the Department=s Insurance Rebate Form.

b) Verification of insurance coverage for the previous coverage period will be required at the annual renewal of KidCare/FamilyCare Rebate.

c) The Department, or its authorized agent, may verify insurance coverage for participants under KidCare/FamilyCare Rebate.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.430 Provision of Policyholder=s Social Security Number

For an eligible individual to participate in KidCare/FamilyCare Rebate, the policyholder=s valid Social Security Number must be provided.

(Source: Added at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.440 KidCare/FamilyCare Insurance Rebate

a) The Rebate will be paid to the individual policyholder insuring the individual.

b) The Department will issue Rebates on a monthly basis.

c) The total dollar amount of the Rebate paid by the Department per individual per month shall be the lesser of:

1) The maximum monthly amount set by the Department calculated in accordance with the restrictions in 215 ILCS 106/25 and available appropriations, or

2) The policyholder=s monthly portion of the premium paid for coverage of individuals enrolled under KidCare/FamilyCare Rebate.

d) The Department shall set the amount of the Rebate, described in subsection (c) of this Section, prospectively.

e) To be eligible for payment, a Rebate must equal at least one dollar.

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Section 125.445 Rebate Overpayments

a) For purposes of this Part, a Rebate overpayment occurs in any of the following circumstances:

1) the monthly Rebate paid was higher than the policyholder=s portion of the premium for the individuals enrolled in KidCare/FamilyCare Rebate;

2) the monthly Rebate paid per individual was higher than the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1);

3) the Rebate was paid for an individual who was incorrectly enrolled in KidCare/FamilyCare Rebate due to inaccurate or untruthful information provided on the application;

4) the Rebate was paid for a period during which the individual was not covered by private or employer-based insurance meeting the requirements of Section 125.400; or

5) the Rebate was paid for an eligible adult for whom an increase in income was not reported within ten days after the change and the Family's income exceeded the upper limit set at Section 125.200(c)(2).

b) Collection action will be initiated by the Department to collect Rebate overpayments.

c) In cases where the Family notified the Department of the loss of insurance of any enrolled individual or the increase of income with respect to an eligible adult within ten days after the change but past the date when the Department was able to stop issuance or adjust the amount of the next Rebate, the relevant portion of the Rebate is not an overpayment.

d) In cases where an individual is covered by private or employer-based insurance (regardless of whether the coverage meets the requirements of Section 125.400) and, due to Department error, Department of Human Services error or inaccurate information from an employer or other third party, an individual is enrolled in Rebate that should not have been or a Rebate payment is higher than it would have been if properly calculated based on accurate information, no overpayment occurs, provided the amount sent in any month does not exceed the maximum monthly amount set by the Department pursuant to Section 125.440(c)(1).

(Source: Amended at 30 Ill. Reg. _____, effective May 26, 2006)

Pennsylvania: Health Insurance Premium Payment (HIPP) Program

Statute/Administrative Rule

There is neither state statute authorizing HIPP nor rules governing the program.[1] Federal statute authorizing HIPP and Pennsylvania's State Plan for Medical Assistance provide authority and guidance for program operations. Included below for reference is the relevant federal statute: Section 1906 of the Social Security Act.

ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS

SEC. 1906. *[42 U.S.C. 1396e]* (a) Each State plan—

> (1) may implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));
> (2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and
> (3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)).

(b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

> (2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this title.

(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

[1] Confirmed with Darin Morrill, Manager, Policy Unit, HIPP, phone call 5/16/07.

(B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—
(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but
(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.
(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan.

(d) [Stricken.[101]]

(e) In this section:

(1) The term “group health plan” has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986[102], and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974[103] .
(2) The term “cost-effective” means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.

[101] P.L. 105-33, §4741(b)(2); 111 Stat. 523.

[102] See Vol. II, P.L. 83-591.

[103] P.L. 78-410, Title XXII, P.L. 83-591, §4980B, and P.L. 93-406, Title VI.

Appendix 5: Program Officials Interview Contacts

Idaho Department of Health and Welfare
Policy Option Research for Premium Assistance Programs
Program Contacts

State	Program	Contact
Oregon	FHIAP	Kelly Harms *Office of Private Health Partnerships* Craig Kuhn *Office of Private Health Partnerships* Jeanene Smith *Office of Oregon Health Policy & Research* Tina Huntley *Office of Oregon Health Policy & Research*
Michigan	Access Health	Vondie Woodbury *Muskegon Community Health Project* Tracy Host *Muskegon Community Health Project* Gary Packingham *Vice President Community Health Ventures* Rick McMaster *North Idaho Health Network* Karen Cotton *Idaho Regional Director - Region 1* Linda LaMott *LaMott Agency Consultant to Idaho Region 1*
Utah	Utah Premium Partnership	Heidi Weaver *Program Manager Utah PCN*
Maine	DirigoChoice	Trish Reilly *Office of Policy* Karynlee Harrington *Executive Director*
Illinois	FamilyCare/All Kids	Theresa Egelston *Medicaid Director* Christina McCutchan Matt Warner *Medicaid Director* Lynn Thomas
Pennsylvania	HIPP	Daron Morrill *Health Policy*