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An Overview of the Oregon Family Health Insurance Assistance Program

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On July 1, 1998, the state of Oregon began enrolling people into its new Family Health Insurance Assistance Program (FHIAP). The program is designed both to build on the private insurance sector and to aid uninsured families and individuals in obtaining health insurance coverage. A $23.4 million dollar state-funded program, FHIAP does not yet meet the standards required by the federal Child Health Insurance Program (CHIP). However, it is a useful model to which other states that are developing employer subsidy programs in coordination with CHIP may refer. (Oregon is in the process of developing a FHIAP pilot project which will enroll children into Title XXI-qualified employer coverage through the consumer-choice health purchasing group, Health Choice.)

This document will describe the development and implementation of this innovative program, from its conception in August 1997 to the present. In addition to a basic portrait of the uninsured in Oregon, an account of the policy decision-making process that was undertaken to determine the principles behind the program will be given. A detailed description of the program is provided, including basic operations — such as eligibility and administrative rules and why it was decided that the program would work the way that it does. Finally, the document will examine FHIAP in operation — with particular emphasis on how the day-to-day activities of the program are managed.[1]

According to a 1996 Oregon Population Survey, an estimated 340,500 Oregonians do not have health insurance. Of these, approximately 42% (144,100) earn more than 200% FPL; 19% (64, 500) earn less than 100% FPL; and 39% (131, 800) earn between 100 and 200% FPL.[2] It is the last group that the FHIAP program is specifically designed to serve. Available funding is projected to cover 15,000 to 17,000 people. A separate Medicaid look-alike CHIP program is budgeted to cover 17,000 additional uninsured children in this income range. Statewide, roughly 11% of the population are uninsured. The percentage of people who do not have health insurance varies highly within the state by region. In the counties in the Portland metro area, less than 10% of the population lacks health insurance while in most other counties, which are largely rural, 14% or more of the population is uninsured. In recent years, an increasing percentage of Oregon employers are offering health insurance coverage to their employees. Both the Governor and the Legislature are committed to building upon this employer-sponsored insurance base. This goal is clearly outlined in the authorizing legislation which states that the purpose of FHIAP "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…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

[1] The staff at FHIAP and others involved in developing the program provided much of the information for this document.
[2] FHIAP Staff

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benefit coverage."[3]

Policy Design: How and Why Choices were Made

The legislature designated three state agencies as responsible for the formation of the principles and policies of the Family Health Insurance Assistance Program. These agencies are: the Office for Oregon Health Plan Policy and Research, which is responsible for policy recommendations and counsel to the Governor and Legislature, as well as program oversight and monitoring; the Oregon Health Council, which is responsible for program concept and policy recommendations to the Governor; and the Insurance Pool Governing Board, which is responsible for policy formulation, program design, program implementation and management, marketing and outreach, fiscal systems, and program evaluation. Most of the FHIAP staff was hired from other agencies within State government including the three agencies mentioned above. In addition, FHIAP staff members were "borrowed" from agencies, such as Medicaid, to assist during the start-up process. Together, these groups made up the implementation team for FHIAP.

Upon passage of the FHIAP legislation, the first priority of the implementation team was to outline the mission and the principles of the new program that would serve to guide subsequent policy decisions. The legislation defined the mission of the program: to remove economic barriers to health insurance coverage by providing a subsidy to low-income individuals and families earning too much to qualify for Medicaid. The program is also intended to build on the private sector and encourage self-reliance through participation in and access to the health benefit system. In addition to this underlying mission, the advisory board developed and agreed upon the basic principles of FHIAP. (See Appendix 1) It was these basic principles to which the board referred when making policy decisions and when designing the program's structure and rules. The FHIAP staff felt that establishing the principles underlying the new program was crucial to the program development process that followed.

The principles of FHIAP are to:

- Foster independence and self-reliance
- Build on strengths of the current system
- Encourage cost consciousness, comparison shopping, and consumer choice
- Respect confidentiality and maintain personal dignity
- Assure administrative simplicity and efficiency
- Not an entitlement
- Respond to "real life" issues of maintaining a household budget on a modest income
- Extend health coverage to the uninsured
- Emphasize health insurance for children
- Promote equity in health care financing

Once the mission and principles of the program were agreed upon, the FHIAP implementation team set about determining program policies.[4] Reaching consensus among stakeholders was a priority despite the additional time and effort required to achieve it. The team made a concerted effort to include the most outspoken critics of the program in order to incorporate a multitude of views and opinions. Because the basic principles of the program were already established, the team was able to refer back to them in justifying particular decisions. The team used several methods to obtain public input: surveys of potential clients; focus group sessions with clients, employers, and agents; and public hearings throughout the state.

[3] HB 2894, Oregon Legislative Assembly
[4] A timeline of implementation team activities is listed in Appendix 2.

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The implementation team developed issue briefs for each policy area, based on public input. These briefs gave background on each issue, described various policy options, recommended a policy and provided rationale for that recommendation. Among the many issues considered were: eligibility criteria, period of time uninsured, benefits standards, federal poverty level threshold, subsidy levels, whether and how to administer a reservation list, and prospective vs. retrospective subsidy payments. From this input, preliminary administrative rules were developed and public hearings were held to obtain public comment on these proposed rules. Comments from individuals and groups attending the public hearings (as well as written comments submitted by constituencies) were taken into consideration and used to refine the administrative rules of the program. Pursuant to the legislation, the Administrator of the Office for Oregon Health Plan Policy and Research was ultimately responsible for policy decisions regarding FHIAP. The Insurance Pool Governing Board was responsible for carrying out those decisions through program implementation.[5]

Program Design: The Choices Made

The Family Health Insurance Assistance Program is a subsidy program to help chronically uninsured people obtain health coverage. Private health insurance is purchased in the group market through an employer or in the individual market through an insurance agent. To qualify for a subsidy an applicant must:

- be a resident of Oregon
- be a qualified resident of the United States
- have average monthly income for the past three months below 170% of FPL
- have liquid assets less than $10,000
- not be eligible for or receiving Medicare
- not have had health insurance for at least six months *(does not apply to those on Medicaid during the past six months.)*

Under FHIAP rules, before an adult can receive a subsidy payment, all children in the family must be covered under some form of health insurance. Furthermore, individuals who are eligible for Medicaid are not required to enroll in the Medicaid program. They may opt to participate in FHIAP instead.[6]

Reservation List

A reservation list is used to manage enrollment in FHIAP. The legislature has authorized funding, through a tobacco tax, for the 1997-99 biennium. It is estimated that the $23.4 million dollars budgeted for this program will serve approximately 15,000 to 17,000 Oregonians. An applicant must place his/her name on the reservation list before an application to the program can be completed. Applicants to the program must fill out and mail a reservation card to the FHIAP office or call a toll-free number in order to obtain a place on the reservation list. The list is maintained on a first-come, first-served basis. There are no exceptions to this rule. However, FHIAP will continue to accept reservation requests after the program is full. When the program is full, the reservation list will serve as a waiting list. Names will be removed from the list in the order that they were received. If an applicant has been without coverage for at least six months prior to placement on the reservation list, she may purchase coverage in either the individual or group market while awaiting space in the program without jeopardizing her eligibility status. However, the individual will not be reimbursed for coverage obtained while waiting to enroll in the program.

[5] HB 2894, sec. 3(2)
[6] This eligibility rule will be modified for FHIAP inclusion under CHIP.

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Reservation cards can be obtained from the FHIAP office, employers, and other outreach groups, such as Medicaid offices, community health centers, etc. The card requests basic information from the applicant, such as name, address, phone, and the number and ages of family members wishing to be covered. Eligibility determination occurs later in the application process. If a person loses eligibility or is denied enrollment to the program and wishes to reapply, she must start the process again placing her name on the reservation list. Reservation processing began on May 1, 1998, two months prior to the opening of program enrollment.

The Application Process

Once a space in the program is available, the applicant is sent an application which is completed and returned to the FHIAP office. An applicant must provide photocopies of: proof of income, photo identification, Immigration and Naturalization Service (INS) card (for non-citizens), and most recent federal tax return (for self-employed applicants). If it is determined that the applicant is eligible for the program, she can receive the subsidy in one of two ways. If the applicant has access to employer-based health insurance and the employer makes *any* contribution towards employee or dependent coverage, the applicant and dependents, unless eligible for Medicaid or Medicaid look-alike CHIP, must enroll in the employer's plan. If the applicant does not have access to health insurance coverage through her employer or has missed her employer's open enrollment period, she may use the subsidy to purchase coverage through an individual plan.[7] Insurance carriers are certified by the state to participate in this program and applicants choose from among their offering of health benefit plans. Applicants may enroll in one of the plans offered by the certified carriers with the assistance of their own insurance agent or with the assistance of a FHIAP approved insurance agent to which they have been referred. However, they are not required to use an agent. If an applicant is denied enrollment in a plan because of health status, she may use her subsidy to purchase coverage through the Oregon Medical Insurance Pool (OMIP). OMIP offers coverage to anyone in Oregon who has been denied coverage because of his/her health status and is not eligible for Medicare. Premium costs in OMIP are set at not more than 125% of the individual market.[8]

An enrollee is determined to be eligible for the program for 12 months. However, she must report any changes affecting eligibility status to the FHIAP office. Changes that are required to be reported include: new name or address, dropping or changing health insurance coverage, loss or addition of family member(s), a change of employer, change in employer contribution amount, or if a child is no longer eligible to be covered under the health insurance plan.[9] It is only during the redetermination process that the subsidy percentage will be recalculated. The subsidy amount may be recalculated to respond to premium increases and changes in health insurance coverage. As long as an enrollee continues to meet eligibility requirements, there is no limit to the length of time that she may participate in the program.

Payment of Subsidy

The subsidy an enrollee receives is a percentage of the enrollee's share of the premium, based on income and family size (Table 1). The subsidy percentage that enrollees receive is not based on the total cost of the health plan in which the applicant enrolls. Applicants may enroll in any of the plans offered by the FHIAP-certified carriers in the individual market or by their employer. Therefore, there is no limit on the subsidy dollar amount that FHIAP will pay. In the group market, subsidy payments are made prospectively to enrollees on a monthly basis. Enrollees must provide verification of enrollment each month to FHIAP, in the form of a paycheck stub, if enrolled in an employer-based plan. If enrolled in an

[7] Some insurance carriers are voluntarily allowing applicants to enroll in their employer's plan without having to wait for the next open enrollment period.
[8] FHIAP Insurance Agent Training Seminar, April & May 1998, pg. 11.
[9] FHIAP Member Handbook

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individual plan, enrollees are not paid prospectively but billed for only their share of the premium, which is combined with the subsidy and sent directly to the carrier. Enrollees must remain current in their payments to the carrier. Despite the risk of misused program dollars, it was decided to implement a prospective payment system in the group market in order to remove cash-flow barriers to FHIAP coverage that many low-income families may face.[10] Subsidy amounts are set at 95%, 90% or 70% of the enrollee's share of premium, depending on income and family size. By offering substantial subsidy amounts and certifying carriers, FHIAP intends to provide an incentive for people to purchase a plan with adequate benefits.[11]

Table 1: Income Guidelines and Subsidy Levels

Family Size	Average Monthly Income (Column A*)	Average Monthly Income (Column B)	Average Monthly Income (Column C)
1	**$671-$845**	**$846-$1,102**	**$1,103-$1,140**
2	**$904-$1,138**	**$1,139-$1,364**	**$1,365-$1,537**
3	**$1,138-$1,432**	**$1,433-$1,716**	**$1,717-$1,934**
4	**$1,371-$1,726**	**$1,727-$2,069**	**$2,070-$2,330**
5	**$1,604-$2,020**	**$2,021-$2,421**	**$2,422-$2,727**
6	**$1,838-$2,313**	**$2,314-$2,773**	**$2,774-$3,124**
7	**$2,071-$2,607**	**$2,608-$3,125**	**$3,126-$3,520**
8	**$2,304-$2,901**	**$2,902-$3,477**	**$3,478-$3,917**
For each additional family member add:	**$233-$292**	**$293-$350**	**$351-$397**
FHIAP will pay:	**95%**	**90%**	**70%**

*Applicants who earn less than the lowest amount in Column A may still be eligible for FHIAP at the 95% subsidy rate.
Source: FHIAP application.

Start-Up Activities

The FHIAP legislation was signed by the Governor on July 28, 1997 and the development of the program design had begun by the end of the next month. In addition to determining the program's rules and procedures, the implementation team needed to complete four main tasks in order to move towards the actual enrollment of applicants. These four tasks were: certification of carriers for participation in the program, marketing of the program to stakeholders and potential customers, training of insurance agents for participation in the referral program, and the selection of a third-party administrator to run the day-to-day operations of FHIAP.

[10] The FHIAP staff anticipates that a small percentage of subsidy payments will be made to enrollees who are no longer eligible for the program or who are no longer enrolled in an insurance plan. An effort will be made to collect these overpayments. However, it is assumed that some payments made will not be retrievable and a five-percent loss is built into the FHIAP budget for the 1997-99 biennium. Program expenditures will be reviewed in 1999 to determine whether the 5% estimate was accurate.
[11] Communication with FHIAP staff

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Certification of Carriers[12]

In the group market, FHIAP will subsidize any employer's coverage. In the individual market,however, health insurance *carriers* are certified for participation in the Family Health Insurance Assistance Program. Health plans and benefits are not certified by FHIAP staff. A request for proposals for participation as a Certified Health Insurance Carrier for FHIAP was sent to all carriers operating in the state.

The criteria to participate in FHIAP are:[13]

- Must be an Oregon licensed health insurance carrier or health care service contractor.
- Must be in the group, small group and individual health insurance markets in Oregon.
- Must have been in the individual health insurance market for at least three years in Oregon. Exceptions include: a carrier that is a participant in the Insurance Pool Governing Board or a carrier that is a participant in the Oregon Health Plan Medicaid expansion.
- Must offer one or more health benefit plans that include (as part of the plan or as an optional benefit): prescription drug, preventive services, maternity benefits, mental health and chemical dependency, hospice and palliative care.
- Must agree to provide 180 day notice of withdraw from FHIAP.
- Must agree to net balance/list billing arrangements with the third party administrator.
- Must demonstrate and maintain an individual market rejection rate not to exceed 20%.
- Must agree to assist in the development of a common health benefit plan and subsidy application for the individual market for FHIAP applicants.
- Must agree that the certificate of eligibility for FHIAP subsidy will serve as the initial premium deposit when a FHIAP eligible applicant is making application for a health benefit plan.
- Must document corrective action taken to comply with market conduct examination findings.
- Must meet the minimum financial requirements by the Insurance Division, Department of Consumer and Business Services.

All carriers that submitted a proposal were accepted into the program and awarded a two-year contract. The FHIAP certified carriers for the individual market are: Kaiser Permanente for the Northwest Region, KMSB Health Plans, ODS Health Plans, PacifiCare of Oregon Health Plans, QualMed Health Plans, Regence Blue Cross Blue Shield of Oregon, Regence HMO Oregon, and Oregon Medical Insurance Pool.

Marketing and Outreach

The marketing of FHIAP began early in the program design process. Over the months that followed the signing of the legislation, the implementation team had discussions with and gave informal presentations about the program to: insurance agents and associations, employer groups, community action programs, state agencies, and other stakeholder groups. In addition, surveys and focus groups were conducted with employers, agents, and potential applicants.[14] The feedback from these meetings and surveys was used to design the program, to raise general awareness of the program among the agencies and organizations who have contact with potential customers, and to develop the next phases of the FHIAP marketing plan.

Once the program was developed, the implementation team focused on raising general awareness of the program in the state and targeting the populations groups and regions within the state with the highest percentage of uninsured people. During the weeks immediately prior to the opening of the reservation list (May 1) and the actual enrollment of individuals in FHIAP (July 1), more than 70 training sessions for

[12] Carriers participating in the individual market
[13] FHIAP Carrier RFP, 1/26/98
[14] FHIAP Marketing Plan

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"stakeholder organizations," both public and private, were held in 28 locations throughout the state. Posters, reservation cards, table tents, and other marketing materials were distributed for display to AFS offices, Employment offices, Community Action Program offices, County Health Departments and other organizations. Training and marketing efforts were first undertaken in regions with the highest rates of uninsurance. In these regions, partnerships were created with Latino, Russian and African-American communities. Spanish language marketing materials were made available.

The FHIAP staff will continue to aggressively market the program as they strive to reach budgeted program capacity. In September of 1998,the first enrollment figures were reported. At that time, the majority of enrollees were obtaining coverage through the individual market.[15] Subsidizing members who are enrolled in individual plans is more costly for the state than subsidizing the employee's premium share of an employer-based plan. In order to reverse this trend, which will limit the total number of people who can be covered, the FHIAP staff plans to intensify marketing efforts directed at employers. These efforts will include: designing a group application process and directly assisting agents in working with employers, a continuation of presentations to Chambers of Commerce and other employer groups, the writing and distribution of articles for business-oriented newsletters an publications, and, with the assistance of business and industry associations, a direct mail campaign to employers.[16] Other methods of increasing enrollment which were and will continue to be used include: the development and distribution of radio reports, assisting news reporters in finding a local angle to the story, the creation of public service announcements, targeted mailings to food stamp recipients and those denied by Medicaid, and the placing of posters, table tents, and reservations cards in schools, churches, community centers, community colleges, chambers of commerce, libraries, and city and county government offices.

Training of Insurance Agents

Insurance agents are used by FHIAP both to market the program to potential customers and, for those applicants enrolling in an individual plan, to help applicants complete applications and choose health insurance plans. Through its voluntary agent referral program, FHIAP matches agents with applicants who request help with the enrollment process. Agents who speak a language other than English are matched with customers who may need brochures and application materials interpreted for them. All agents in the state are able to assist applicants with enrollment in the program but only those agents who have undergone training and are part of the referral program will receive referrals. Agents who have been in contact with a prospective member prior to the submission of a reservation card are able to identify themselves on the card so that when space is available, and the person is ready to be enrolled, the agent can assist in the application completion process. The carrier pays commissions to the agent at a rate agreed upon between them. FHIAP expects to have 230-260 agents throughout the state working with the program.

The agent participant requirements are:

- An Oregon resident health insurance or general lines agent license
- Complete FHIAP training program
- Have Errors and Omissions Insurance
- Have an appointment with one FHIAP-certified carrier
- Provide FHIAP members with information on Children's Health Insurance Program and Oregon

- Assist FHIAP members in enrolling in the state's high-risk pool if they are turned down for insurance in the individual market.
- Agree to provide the same level of contact or service to FHIAP members as is provided to other

[15] This imbalance may be due to the lag time involved in enrolling in an employer's health insurance plan.
[16] FHIAP Marketing Plan

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clients.

Agents must schedule a meeting with the FHIAP member within one-week of the referral. Agents are also responsible for preparing reports to FHIAP which indicate when the agent met with the client, the options that were discussed, and the action taken. The purpose of the follow-up report is to verify a level of customer service and to track those perspective members who do not purchase health insurance coverage. FHIAP is also exploring ways to more extensively use agents who work with employers.

Selection of Third Party Administrator

The selection of the third party administrator (TPA) for FHIAP was of critical importance to the implementation team. Because the TPA has the most direct contact with enrollees, the team wanted to ensure that the administrator chosen would provide excellent customer service. Meetings were conducted with potential bidders to explore ideas for program administration and match FHIAP needs and expectations against what TPAs are capable of providing.

The implementation team based their review of the proposals on the following criteria:

- Licensed TPA
- Proven ability to administer a program the scope and size of FHIAP
- Efficiency of payment procedures
- Ability to operate the program cost-effectively
- Demonstrated commitment to customer service

A three-year contract subject to legislative authorization was awarded.

FHIAP in Operation

The FHIAP staff is responsible for administration of program policy, quality assurance, data analysis, program evaluation, eligibility appeals, and marketing and outreach activities conducted for the program. In addition, the staff handles the development and updating of marketing and application materials. The TPA is responsible for the day-to-day operations of FHIAP. Its responsibilities include:

- Management of the reservation list
- Management of the agent referral program
- Sending applications to prospective applicants
- Determination and redetermination of eligibility and subsidy amount
- Premium collection and billing
- Data collection and reporting
- Front-line customer service and initial complaint resolution

The TPA has thirty employees, nine of which serve as full-time FHIAP member specialists. Its customer service hotline is in operation every weekday from 9 a.m. to 9 p.m. The TPA is responsible for responding to inquiries within 24 hours, excluding weekends and holidays. There is both an automated voice response and a live operator. Spanish and Russian speaking staff members are also employed by the TPA in order to assist non-English speaking customers.

Reservation List

The reservation list is maintained by the TPA. FHIAP staff is responsible for the marketing materials and public awareness campaign that is necessary to build the list. Potential customers can place their name on the list by either mailing a reservation card to the FHIAP office (staffed by the TPA) or calling the office using a toll-free number. The TPA, at the direction of the FHIAP staff, is responsible for sending

reservation list information as well as program applications to individuals on the reservation list. Individuals on the reservation list can obtain information about where they are on the list and the approximate waiting time for the program by calling a toll-free number.

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The Application Process

When directed to do so by the FHIAP staff, the TPA will take names from the reservation list, in the order that they were received, and mail an application packet to the appropriate people. The application packet includes: the application; a member handbook, which explains FHIAP; and a health insurance guide, which explains health insurance terms and options. Applications are mailed on a monthly allotment basis in order to manage growth in program enrollment. Completed applications with supporting documents[17] must be returned by applicants to the FHIAP office within 30 days in order to remain valid. The applicant must indicate whether or not she has access to coverage through her employer and whether or not she would like to be referred to a health insurance agent. The TPA is responsible for providing application materials in alternative formats, such as audio, Braille, or large print, if necessary. If required, the TPA also assists applicants in completing the application. The TPA must objectively explain the health insurance coverage options available to the applicant, while encouraging the customer to seek or retain coverage. Once completed applications are received, the TPA must respond within 10 days. If an application is complete, the TPA determines whether or not the applicant is eligible and the subsidy amount she should receive. If an application is incomplete, the TPA must notify the applicant as to what information is missing. The applicant has 30 days to send the missing information to the TPA or the applicant may have to return to the reservation list.

The TPA is also responsible for maintaining a record of each application received and a complete record of every verbal or written transaction with an individual. Records will be retained for three years after contract expiration.

Enrollment

Once applications are deemed complete, the TPA, using the information provided by the applicant, determines whether or not the applicant is eligible. If the applicant is eligible, the subsidy percentage amount that she is eligible for is also determined. Letters indicating either acceptance into the program or denial are sent. If an applicant is denied, she is informed of the reason for the rejection of the application and is given a telephone number to call if she has further questions. If upon second review, the applicant is still deemed ineligible and wishes to dispute the ruling, she has 30 days in which to file an appeal with the Insurance Pool Governing Board (IPGB). IPGB has 60 days to respond to the appeal. If the applicant does not agree with IPGB's ruling, she may request a contested case hearing.

If an applicant is accepted into the program, she receives a letter of acceptance, indicating the subsidy percentage that she will receive. If she has indicated on her form that employer-based insurance is available, an employer verification form will also be sent. If not, she will receive a Certificate of Eligibility for FHIAP which she will forward to a carrier with her application for an individual health plan. The employer verification form must be completed before subsidy payment can begin. The enrollee has 60 days to return the form. The verification form asks for information from the employer on the health insurance plan that is offered, the total premium for the plan, and the percentage of premium for both employee and dependent coverage that the employer pays. There has been some difficulty in the employer verification form completion process. Information provided by applicants has been sporadic. FHIAP staff revised the verification form by making the questions more specific. Accurate employer information is needed for FHIAP to run smoothly and it was realized that this might necessitate the involvement of employers in filling out the form. However, some applicants have expressed the concern that they would prefer their employer need not know that they are applying to the program. Confidentiality is a basic principle of the program and this is a dilemma that has not yet been resolved. If

[17] Supporting documents include: paycheck stubs from the previous three months, photo identification, INS card (for non-citizens only), and most recent federal tax return (for self-employed applicants only.)

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applicable, the acceptance letter will also indicate whether the applicant may also be eligible for either Medicaid or CHIP. Even if eligible, the applicant is not required to participate in these programs. She may opt to participate in FHIAP instead.

The enrollee is responsible for enrolling herself and her family into a health insurance plan. If coverage is being obtained through an employer, the enrollee, after completing and returning the employer verification form to the FHIAP office, enrolls in the employer plan just as any other employee would. In some cases, enrollees will need to wait for their employer's next open enrollment period in order to enroll [18] While waiting, the enrollee can use her subsidy to purchase coverage in the individual market. If an enrollee does not have access to employer-based health insurance and is going to purchase coverage in the individual market, she must do so from among the FHIAP certified carriers. If she indicated on her application that she would like to be referred to a health insurance agent, the TPA forwards her name to an agent in her area. The enrollee is informed that an agent will be calling. The TPA is responsible for maintaining a tracking system to monitor referrals. When the enrollee selects a plan, she submits to the carrier a Certificate of Eligibility, which she receives from the TPA, along with the health insurance application form. The Certificate serves to notify the carrier that the applicant is a FHIAP enrollee and that a premium deposit is not required. The enrollee has 90 days to enroll in a health insurance plan or her eligibility will be lost.

Subsidy/Premium Collection and Payment

When a FHIAP enrollee receives coverage through her employer's plan, the TPA administers a prospective subsidy payment.[19] The payment is normally made to the individual.[20] The payment is paid via check. Direct deposit of the funds into the enrollee's bank account is not done. The enrollee is then responsible for providing to the FHIAP office a copy of her paycheck stub in order to verify that coverage was in effect during the past month. The TPA scans and files the record and discards the hardcopy. The verification of coverage must be received by the TPA by the 20th of month for the subsidy payment to be received by the enrollee by the first of the next month. If verification is not received, a grace period of one month will be given.

In the individual market, the TPA bills the enrollee for his/her portion of the health insurance premium. The TPA then combines the FHIAP subsidy with the enrollee's contribution and pays the total premium to the FHIAP certified carrier. The TPA bills the enrollee for premium payment by the 20th of the month. The enrollee must return payment within 10 days. If payment is not received, two follow-up notices are sent before the subsidy is cancelled.[21] The TPA transfers payments electronically to the carriers through electronic fund transfer from bank accounts managed by the TPA. The TPA receives wire transfers of subsidy amounts from the Oregon State Treasury. The TPA is also responsible for identifying and collecting overpayments made by the state, as required.

[18] Again, some insurance carriers are voluntarily allowing applicants to enroll in their employer's plan without having to wait for the next open enrollment period.

[19] Prospective means that the check is to arrive to the member 3-5 days prior to the payroll deduction.

[20] Under an employer arrangement, instead of the state prospectively paying the subsidy amount to the employee, the employer pays the entire premium to the carrier. The employer is reimbursed for the subsidy amount by the state and collects the employee contribution through payroll. While the FHIAP program allows employers to participate in this capacity, no employers, at this time, have volunteered to perform this function.

[21] In most cases, the individual would have insurance coverage cancelled by the carrier for non-payment of premium.

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Disenrollment/Redetermination

In order to disenroll from the program, the enrollee must notify the TPA in writing that she wishes to do so. Redetermination of eligibility for FHIAP is done after 12 months of enrollment. It is only during the redetermination period that the subsidy percentage will be re-figured. The TPA is responsible for reevaluating an applicant's eligibility for enrollment and notifying the enrollee whether or not she is eligible to continue in the program. The monthly subsidy amount that the enrollee receives can change due to a premium increase, change in income or a change in coverage.

Enrollee Services

In addition to answering inquiries about the program and assisting applicants in completing the application form, the TPA is responsible for handling changes in enrollment status. Changes in status include: change of address, name, employer, health insurance coverage, or the addition or loss of family members. The TPA is also responsible for answering complaints and grievances that arise in relation to application, enrollment, redetermination and subsidy levels. When necessary, the TPA will forward the complaint or refer the complainant to the correct party. If a complaint or grievance is still unresolved, the TPA will work with the FHIAP staff to resolve the matter at the agency level.

Data Reports

The TPA is responsible for collecting data and reporting information to the FHIAP staff on a regular basis. The performance of administrative services is tracked. Reports include: application turnaround time; percentage of member issues resolved on the first call; percentage of reimbursements issued within one day from the date of request to the date of mailing; and billing error rate. The TPA also tracks telephone calls to the FHIAP office and provides monthly reports on the telephone statistics. These reports indicate the number of attempted calls, number of completed calls, average seconds of holding time, average speed to answer phone calls (in seconds), number of abandoned calls and longest abandon time, for developing enrollment reports to ensure successful program operation.

Financial reports are also prepared by the TPA. The following information must be reported monthly and quarterly:

- FHIAP fund transfers for administration and subsidy payments
- a listing of members' non-sufficient funds checks
- payments to overage
- subsidy checks that were used for purposes other than subsidizing the price of health benefit premiums[22]

The TPA is responsible for annual financial statements for FHIAP for every fiscal year end. In addition, the TPA is also responsible for timely filing of 1099 reports and other federal and state reports, with review and approval by FHIAP staff.

Program Evaluation

In order to evaluate the overall effectiveness of FHIAP, the program staff will use the performance data obtained from the TPA and will conduct surveys of enrollees. In the short-term, drop-off surveys, surveys of members and focus group discussions with agents and employers will be used by the FHIAP staff to improve the day-to-day operation of the program. Membership data will be collected and tabulated, program costs will be compiled and the eligibility determination and subsidy payment process will be

[22] IPGB and BestChoice Administrators administration agreement, May 15, 1998

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reviewed for accuracy.

In the long term, customer satisfaction with the program and agent referral system will be measured using the short-term feedback and an annual survey. Ultimately, the program's success will be measured in terms of the impact it has on Oregon's rate of uninsurance, its impact on enrollment in employer-based coverage, and its impact on long-term insurance status of program participants.

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Appendix 1

FHIAP's Mission

- Remove economic barriers to health insurance coverage for uninsured, low-income Oregonians.
- Build on the private sector and encourage self-reliance through participation in and access to the health benefit system.

Program Principles

In designing the concept for FHIAP, the Legislature wanted to develop a model program that not only protects the well-being of economically disadvantaged Oregonians, but helps them to become self-reliant. Toward that goal, the program is designed based on the following principles:

- **Fosters independence and self-reliance** – The subsidy amount will decrease as family income increases, so the affordability of health coverage will not end when families work their way off of welfare or increase their income through job advancement.
- **Encourages cost consciousness, comparison shopping, and consumer choice** – Eligible families without employer-sponsored coverage may apply the subsidy to their choice from among a variety of health benefit plans.
- **Respects confidentiality and maintains personal dignity** – Oregonians using the subsidy are not stigmatized in any way.
- **Assures administrative simplicity and efficiency** – Program administration will not require the development of a new government agency and the program design encourages participation and is easily accessible to the customer.
- **Not an entitlement** – Program expenditures are limited to the funding allocated and the expenditures authorized by the Legislature. Being eligible for the program doesn't guarantee that a person or family will receive the subsidy.
- **Responds to "real life" issues of maintaining a household budget on a modest income** – Subsidies will be adequate to make health insurance more affordable, as well as recognize a family's cash flow needs.
- **Builds on strengths of the current system** – Encourages and builds upon employer-based coverage, and recognizes that providing access to health care to all Oregonians requires collaboration between the private and public sectors.
- **Extends health coverage to the uninsured –** The goal of the program is to remove economic barriers and increase the number of Oregonians with access to health care.
- **Emphasizes health insurance for children –** Adults are eligible for the subsidy only if all children in the family are covered by a health benefit plan.
- **Promotes equity in health care financing –** The program targets those working Oregonians who through their tax dollars help pay for both Medicaid and Medicare, yet cannot afford health coverage themselves.

Source: Family Health Insurance Assistance Program

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Appendix 2
Timeline of Implementation Team Activities

August – December 1997

- Recruitment of Implementation Team
- Conducted analysis of program policy issues for consideration by policy makers
- Presented policy recommendations to the Oregon Health Council and Office for Oregon Health Plan Policy and Research
- Introduced 900 insurance agents to the program
- Conducted surveys of potential applicants and focus groups with employers
- Established working group of health insurance agents to assist in the development of employer marketing strategies
- Developed partnerships with groups that will help market the program
- Developed administrative rules for program operation
- Began developing publications and marketing materials

January – April 1998

- Conducted public hearings to gain broad input on the proposed program policies and administrative rules
- Released RFPs and awarded contracts to a Third Party Administrator and insurance carriers participating in the individual market
- Developed a marketing and outreach strategy
- Filed program administrative rules
- Field tested and printed publications and marketing materials
- Developed a training curriculum and began delivering training to insurance agents and community organizations serving low income citizens
- Began development of program evaluation plan

May – August 1998

- Continued program training throughout the state
- Began program "ramp up"
    - Opened reservation list on May 1
    - Began sending applications to those on the reservation list on June 1
    - Made first subsidy payment on July 1

September – December 1998

- Continue program marketing and outreach
- Complete reservation list "drop off" survey
- Begin conducting monthly customer service surveys
- Develop program data reports
- Complete program evaluation plan
- Complete program ramp-up
- Apply for amendment to state CHIP plan to integrate Title XXI into FHIAP

Source: FHIAP Staff

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