Questions	Massachusetts	Wisconsin	Mississippi	Oregon
For more information:	Division of Medical Assistance Massachusetts Executive Office of Health and Human Services 600 Washington Street 5th Floor Boston, MA 02111 http://www.state.ma.us/dma/businesses/ipIDX.htm	Division of Health Care Financing Wisconsin Department of Health and Family Services One West Wilson Street Madison, WI 53702 http://www.dhfs.state.wi.us/badgercare/html/HIPP.htm	Mississippi Department of Finance and Administration Office of Insurance 455 North Lamar Street Jackson, MS 39201 http://www.dom.state.ms.us/chip.html	Oregon Insurance Pool Governing Board 625 Marion Street NE, Suite 2 Salem, OR 97301-3749 http://www.ipgb.state.or.us/Docs/fhiaphome.htm
1. Under your SCHIP program, do you provide coverage through employer-sponsored insurance (ESI)?	Yes. MassHealth's Family Assistance Program uses Title XXI (SCHIP) funds for coverage through ESI.	Yes, under BadgerCare. WI focuses on family coverage and uses both Title XXI and Title XIX (Medicaid) funding to provide coverage through ESI. WI uses a seamless approach to coverage for families, but uses two streams of funding (Title XXI and Title XIX). Section 1115 demonstration is used to cover parents under Title XXI. BadgerCare uses the infrastructure of CARES intake system to process all public programs. Title XXI ESI under BadgerCare is used if cost-effective criteria and benchmark are met; otherwise, WI tests cost-effectiveness under Title XIX Health Insurance Payment Program (HIPP).	We do not currently provide coverage through ESI. **Implementation is on hold for an indefinite period of time.**	Not under SCHIP, but through a state program that mirrors some of the requirements under Title XXI. OR uses a state-funded Family Health Insurance Assistance Program (FHIAP) that has a premium assistance component. Private health insurance is purchased in the group market through an employer or in the individual market through an insurance agent or health insurance company. FHIAP has 1,327 children enrolled in coverage; 372 are in group health insurance coverage.
2. How long did it take HCFA to review and approve the application/amendment to provide coverage through ESI?	Four months. The Title XXI Plan was submitted in January 1998; questions were received and sent to HCFA and approval was obtained on 5/31/98.	One year and three months. A Section 1115 waiver was requested on 10/14/97 and approved on 1/22/99.	Roughly six months. MS received federal approval to implement its premium assistance plan on 2/10/99.	MS submitted an amendment application for ESI in August 1999. HCFA questions were received in August 1999, and the answers are still in development.
2.1. What were the major hurdles in obtaining HCFA approval?	We had to clarify the buy-in under SCHIP and HIPP. The requirements under HCFA (employer contribution, benchmark, look-back, cost-effectiveness and crowd-out) were difficult to explain in the Title XXI plan and ended up just referencing the Section 1115 waiver and including documents in the Title XXI plan.	Meeting the HCFA requirements and implementing a plan that worked well for WI. ESI is a small portion of BadgerCare and very difficult to access because of stringent requirements. The main difficulty in receiving HCFA approval for BadgerCare was allowing coverage of families/adults and children within the context of the SCHIP law. Eventually, that is why WI needed a Medicaid 1115 waiver and made BadgerCare a Medicaid expansion.	The two biggest hurdles were: the look back period (MS wanted it to be three months while HCFA insisted on six months); and the employer contribution minimum (HCFA sought 60% but conceded to 50% for MS).	HCFA noted that most of the target population would have dependent coverage under Medicaid or SCHIP, thus questioning the need for ESI. In addition, they were afraid that enrollees would be subject to increased cost-sharing under employer-based plans. Finally, HCFA expressed concerns about how the "Medicaid screen and enrollment" requirement would be addressed.

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2.2. Do you have letters that describe HCFA's concerns?	Yes. Q&A are included as part of the Title XXI SCHIP plan even though not specifically referenced in documents. Major issues were: 1) Employer contribution - 50% in MA was granted under Section 1115 with a description sent to HCFA in lieu of a detailed analysis for approval under SCHIP; 2) Crowd-out - There is no look-back period in MA, but HCFA has the option to cancel SCHIP funds for ESI if substitution is too great based on quarterly crowd-out reports sent to HCFA; and 3) Benchmarking - MA did not use one of the HCFA prescribed benchmarks, but received approval for the side-by-side benefit analysis used under Section 1115 that compares employer plans to that of a large HMO in the state (Harvard-Pilgrim) instead of actuarial approach to benefit reviews.	Yes. Questions pertaining to: Cost-effectiveness test; enrollment threshold; eligibility; systems; and cost-sharing. Questions and answers are in the WI draft BadgerCare revised waiver application after page 57 (dated December 18, 1998); cover letter to HCFA from WI DHFS dated January 15, 1999.	Yes. Copies can be requested in writing, but they might not be very helpful. Most of the relevant information was communicated through phone conversations with HCFA personnel.	Yes. Contact the Office for Oregon Health Plan Policy and Research.
3. In obtaining HCFA approval, what other waiver, plan amendment, policy and regulations, studies, or other materials were essential to your decision making and program design?	MA Section 1115 Waiver was used and the unique features contained therein.	We used a Section 1115 demonstration waiver. WI wanted to tap into ESI for two reasons: 1) to cover families in hopes of getting children more medical care; and 2) to enjoy cost-savings to the state. ESI was also included in the Medicaid and SCHIP state plan amendment.	MS researched OR's non-SCHIP plan because we thought it would be a good model for their own. MS proceeded despite the fact the OR is still non-SCHIP.	N/A
4. When designing how to furnish coverage through ESI, was there an estimate done of the eligible population?	Yes, but only of uninsured children and not specific numbers pertaining to eligible children with access to ESI. Total children covered under some form of employer-related health insurance (0-400% FPL) is 555,869. Uninsured children (0-400% FPL) is 122,023. The Title XXI state plan has further details (pp. 2-3).	Yes, but only for overall SCHIP population. WI DHFS estimated 61,000 households with uninsured children at any point between 1995 and 1997. For the '97-'98 combined sample of WI Family Health Survey, there were 54,000 uninsured children <200% FPL, and 90,000 uninsured adults <200% FPL.	Yes, but only for overall SCHIP-eligible population. SCHIP (phase II) as a whole was made eligible for an estimated 85,000 children. Once the plan is operational, statistics will be gathered by the state/program actuary.	Yes, but not specific to the eligible population with access to ESI. In 1996 the target population was 131,800 people who were uninsured and had incomes between 100%-200% FPL.

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5. How many families and children are covered through the employer buy-in program?	Approximate number of children insured through ESI as of May 2000 is 79 under Title XXI. An additional 700 are receiving premium assistance through Section 1115 program. At the end of 1998, 619 children were enrolled in premium assistance (both Title XXI and Section 1115 Waiver). (1998 Annual Report)	As of 6/5/00 there were seven families (11 parents and 16 children) enrolled in BadgerCare that are being covered through ESI, and 209 applicants (families, not individuals) in the "pipeline" awaiting eligibility determinations. As of 6/5/00, 28,830 EVIC forms were sent to employers; 18,404 forms have been returned with 5,561 of them stating the applicant was no longer employed with the company, and 7,432 of the forms showing no access to family coverage. Only 1,048 of the 18,404 forms returned had employer plans meeting the Health Insurance Portability and Accountability Act (HIPAA) requirements along with family coverage, but only 209 of the 1,048 met the 60%-80% employer contribution. One goal of WI is to enroll as many uninsured kids as possible under BadgerCare. Utilizing the ESI component is just one of the mechanisms we can employ. ESI never had solid goals, but was part of the overall BadgerCare focus.	Unavailable. Providing coverage through ESI will not be operational for an indefinite amount of time. Statistics will be gathered once the program is operational.	As of 9/11/00, 4,119 individuals were receiving either employer- or individual based subsidies in the FHIAP program. There is a waiting list ("reservation list") of 26,308 individuals, but again this includes those who also will get non-employer plan subsidies. The reservation list is necessary to manage enrollment because of the limited funds available for this program. As of 9/11/00, 711 people are enrolled in ESI, or 17.3% of FHIAP members. Of these, 372 are children in group insurance, and 955 children were enrolled in individual insurance.
		WI established the ESI component in part to position itself to use this potentially useful tool once HCFA makes it easier to enroll children through ESI.		
6. How many employers are participating in the employer buy-in program?	Not many. Database maintained on employers and employer plans, but this is time consuming and not very useful, because calls are made - and are necessary - to each employer for every new applicant to program. Having a database with only contact name and phone number would be less time consuming and more helpful.	No firm count, but because of the limited enrollment by enrollees, limited numbers of employers participate.	N/A	There are about 200 in the FHIAP program. Further verification and participation in ESI is done on case-by-case basis. The database is updated and grows as applications are received.

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7. Did your agency encounter any resistance from employers, employer groups, insurance associations or children/family advocacy groups upon expanding coverage through ESI?	No. MA worked with interested parties in the developing program. Through meetings and outreach efforts, it was decided to make the program as "invisible" to the employer as possible. When participating, the employer treats the enrollee the same way as all other employees. This helps the enrollee avoid any stigma that might be associated with government assistance. Very few employers are reluctant to provide information, some are slow, but that is normal.	No. Some employers questioned if any new requirements would be imposed upon them, but when they found out it would be invisible to employers and seamless to enrollees, they bought in. Some policy people questioned the reason for providing coverage through ESI if only a few people would be eligible (WI wants to be positioned if HCFA requirements change). Employers provide information in a timely fashion during reviews.	Yes. Employers were worried in the beginning about administrative costs that were going to be imposed upon them. Employers expressed concerns regarding the SCHIP requirement that children receiving assistance currently be uninsured; this could result in eligibility disparities between employees of the same income and salary level, (e.g., one employee presently insuring dependents and therefore ineligible for a subsidy with the other employee with uninsured dependents and therefore eligible). These concerns helped MS craft an appropriate program for the state. The program will be invisible to employers from the administrative end, but there still could be the case where two employees have the same income and salary, but one employee receives benefits and one does not.	Resistance for FHIAP was minimal. The OR Associated Industries, an employer group, was behind the program and presently supports its expansion.
8. What incentives does your program offer to small employers that encourage them to offer insurance to low-income employees?	MA has a special program, Insurance Partnership Program (IPP), to provide incentives (payments) to small employers to keep eligibles covered through ESI. MA Title XXI state plan outlines IPP.	DHFS notifies employers of federal and state prohibitions on dropping coverage. New state pool statutes for small employers in 99-01 biennium.	There will be no direct incentives.	There are no direct incentives in the FHIAP program.

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9. Describe your organizational chart with specific references to the number of employees working on the program that furnishes coverage through ESI and their functions ?	In the Division of Medical Assistance (DMA) there is a Director of Benefits and Recovery (1). Two people manage the daily operations of the Family Assistance program (2). There are four FTEs working on Family Assistance and one part-time employee (4.5). In addition, there are several people managing the Family Assistance Program, which includes ESI and non-ESI components. MA made a concerted effort to use existing DMA staff when expanding into ESI. Public Consulting Group - PCG (vendor) has six-to-eight employees working on the DMA Family Assistance Program (ESI and non-ESI). MA has found it challenging using existing DMA staff as it expands into providing coverage through ESI. Existing staff have other obligations and the extra work for ESI has made the process time consuming. A full-time manager of the program is essential.	WI uses the existing Medicaid infrastructure as much as possible and therefore it is difficult to define those working only on ESI. There is a single point of entry into BadgerCare and then it is determined how to provide coverage (ESI or other). WI highly recommends using as much of the existing infrastructure as possible. WI saw problems when they analyzed creating an entirely new administrative layer. State employees in WI primarily provide oversight for contractors doing eligibility reviews and database maintenance. Deloitte and Touche (enrollment) and EDS (eligibility reviews) are vendors that work in part on ESI. Seven FTEs are located at enrollment centers throughout WI administering BadgerCare at the state level.	The Third Party Administrator (TPA) is working on an organizational structure in preparation for the start of the program.	In the FHIAP program, OR uses existing state employees and does not use vendors. (All internal).
Outreach associated with providing coverage through ESI:				
10. What kind of outreach and marketing does your program prescribe in order to enroll children through ESI?	DMA combines the ESI outreach with MassHealth. TV, radio, and print media campaigns target employees that might be eligible. Targeting employers is secondary. We also use targeted mailings to low- and moderate-income people across MA. In the fall of every school year, informational and promotional items are sent to every school-aged child in the state. Community organizations and health centers receive promotional items and "rolodex" cards for easy access and contact information.	WI has launched statewide campaigns on radio, TV, and in newspapers. Brochures, posters, and direct mailings are also used. Local health care providers and agencies are brought into outreach activities via training and informational materials. There is also ongoing Web site information describing various aspects of BadgerCare including ESI. (http://www.dhfs.state.wi.us/BadgerCare) We are also working with school systems and are expanding "Covering Kids."	We will advertise on TV, radio, billboards, and in newspapers. MS will ask businesses and schools to display/include items in offices/mailings. When a family applies for SCHIP, there will be a letter that explains the ESI aspect. MS also will hold forums with economic development organizations/employers associations.	FHIAP used focus groups including potential recipients and employers when developing the program. OR gives presentations to insurance agents, employer groups, community action groups, and state agencies. Mailings and general media outlets are used to some extent.

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11. What kind of outreach and marketing does your buy-in program prescribe in order to inform employers and insurers?	Promotional pieces are sent to employers, but our target is the employees; employer marketing is secondary.	Wisconsin employs statewide campaigns on radio, TV, and in newspapers. Brochures, posters, and direct mailings are used for employers. WI has hotline that employers or employees can call. WI also hosts direct communications/meetings with employer associations.	MS will advertise on TV, radio, billboards, and in newspapers to hopefully interest employers. MS will ask businesses and schools to display/include items in their offices/mailings.	FHIAP used presentations, focus groups, direct mailings to employers, and articles in business journals and newspapers.
12. Is there an "enrollment broker" involved with your state describing coverage and premiums?	Yes. MA uses state enrollment centers and state employees to describe coverage. The enrollment broker function is handled in part by a vendor doing eligibility review and in part by DMA staff that receive the applications and make calls to applicants to complete forms.	Yes. A contractor aids in the enrollment process before sending the application to employer review. Deloitte and Touche acts as an enrollment broker in WI. Automated Health Systems Inc. (AHSI) is the BadgerCare HMO enrollment broker.	MS DHS will be responsible for all eligibility determinations and enrollment for SCHIP. The TPA will assist in enrolling a SCHIP child in the parent's employer plan if the plan is determined eligible for a premium subsidy.	Yes. While the FHIAP staff answer general questions about the program and the premium payment process, insurance agents explain the employers coverage and help enroll members.
13. During which hours does your program accept applications to provide coverage through ESI?	Enrollment centers are open during regular business hours. A customer service telephone is operational into the evening. Enrollment packets are mailed to applicants.	Applications are accepted during regular business hours for walk-up enrollment (7a.m. - 6p.m. depending on center). Our hotline number can be accessed after regular business hours to request forms.	MS will hold regular business hours for enrollment. Enrollment packet mailings will be conducted.	OR holds regular business hours for processing with a customer service line answered from 9a.m. to 5p.m., Monday - Friday. The application is sent via mail to applicant.
Overview of policies for providing coverage through ESI:				
14. What are the income thresholds associated with providing coverage through ESI?	1) Premium Assistance is available to children under 19 who have access to insurance and certain employed adults aged 19-64 who have insurance and eligible children, provided the employer plan meets cost-effectiveness and benchmark requirements. If enrolled in ESI, a child is ineligible for MassHealth Standard and CommonHealth programs. 2) Families of eligible children with gross monthly income below 150% FPL will not be required to pay a portion of the monthly premium.	Applicant families not exceeding 185% FPL of countable income are eligible and may remain in the program (if they wish) until their income exceeds 200% FPL (if enrollment is capped, then only stay in the program until their income exceeds original eligibility level). WI covers custodial parents and their spouses living with children under age 19. They must have no coverage for six months prior to the application (three months for HIPP/Medicaid) or must not have had access to 80% + coverage by their employer 18 months prior to application.	To cover dependent children under age 19, family income will have to be no greater than 200% of the FPL. Co-pays and out-of-pocket maximums will apply only to those with income between 150%-200% FPL. The out-of-pocket maximum will be $800 for families between 151%-175% FPL and $950 for those between 176%-200% FPL.	To qualify for the FHIAP program: 1) Applicant's average monthly income for the past three months must be below 170% FPL. 2) Applicants must have liquid assets less than $10,000. 3) Applicants cannot be eligible for or receiving Medicare. 4) Applicants must not have had health insurance for a least six months (does not apply to those on Medicaid during the past six months). There are three monthly income thresholds for the subsidy.

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	3) Families with gross income in excess of 150% FPL will be required to contribute a family share (up to 200% FPL). Family share is a flat amount based on the number of children in the family and cannot exceed 5% of family income. 4) The premium assistance amount will be calculated based on information collected from the program application and during eligibility review.	No premium required if individual is at or below 150% FPL; the premium maximum is 3% of income for those above 150% FPL. DHFS determines if HMO/Medicaid plan is more cost-effective; if so, the family is enrolled. New premium requirements go into effect for every $500 increase in family income.	When the family reaches the out-of-pocket maximum, MS will provide the family with documentation that no co-payments apply for the remainder of the year.	For a family of four making less than $1,176 per month, a 95% premium subsidy of the employee contribution will be received; between $1,777-$2,131, a 90% subsidy, between $2,132-$2,415, a 70% subsidy. Before an adult can receive a subsidy payment, all children in the family must be covered under some form of health insurance. If a person is eligible for both Medicaid and FHIAP, the person may choose which plan to enroll in.
	Other eligibility standards must be met as required by the SCHIP program as a whole - detailed in section 4 of the Title XXI state plan. Unless the family share is greater than 5% of income, families offered subsidies will not have the choice of accepting the subsidy or enrolling in MassHealth - they must enroll in ESI.	If family share exceeds 3% FPL, the BadgerCare provider will be instructed (via mail or letter for enrollee to present at time of service) to bill BadgerCare directly. If enrollee pays bill, BadgerCare will reimburse and remind enrollee to present letter.		
	Once the family has incurred out-of-pocket expenses totaling 5% of the family income, they will be required to submit proof of payment to MA, which will review the submitted bills in a timely fashion. Once review is complete, the family will be notified of procedures for submitting future bills to MA. MA will provide MassHealth documentation for the member to submit to the health care provider at the point of service.			
	The documentation would request the provider to bill any further co-payment and deductibles directly to MA. If the provider required the family to pay the bill up-front, DMA would reimburse the family for the expense. The enrollee could also take the bill and submit it to DMA for payment. This process lasts until the end of the eligibility year. There is no cost-sharing for well-baby and well-child visits.			

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15. Does your SCHIP plan have a "family waiver" or family component if it is cheaper to cover the entire family through ESI than through the default plan?	Yes. MA will cover families if it is cost-effective and the employer plan meets the benchmark requirements. (Received HCFA approval under Section 1115 waiver program). Families with gross monthly income below 150% FPL are not required to pay a portion of monthly premium. Families with gross income in excess of 150% FPL are required to contribute a family share (up to 200% FPL). The family share is a flat amount based on the number of children in the family. Family share cannot exceed 5% of family income. Premium assistance subsidy is calculated based on information gathered during application review and eligibility determination. MA purchases family coverage but the family share calculation is based on the number of children, so it is in effect only covering the children.	Yes. If the cost of the whole family in ESI is less than the cost of children only in BadgerCare HMO, both adults and children will be funded through Title XXI.	No. MS did not ask for a "family waiver" or family component from HCFA. Program participants will either enroll in the "regular" SCHIP plan (fully insured plan purchased by state) or in the premium assistance program.	No, because FHIAP is a state-funded program. OR covers families based on family size and average monthly income. Applicants are required to enroll in their employer's health plan if dependent coverage is offered and the employer makes a contribution. If there is no employer contribution, the employee may choose to enroll in that coverage or go into the individual market.
16. What is the minimum percentage an employer must contribute to meet the premium requirements?	There is a 50% minimum (demonstrated that the majority of employers cover that much in Section 1115 waiver).	There is a 60% minimum and an 80% maximum. There is a 60% HCFA requirement and an 80% state legislative requirement. If employer contributes more than 80%, then employee is not eligible for subsidy.	There will be a 50% minimum.	There is no minimum percentage.
17. Does your buy-in program require employees to select the least expensive employer plan?	No. Employer plans are investigated and reviewed against the benchmark and for cost-effectiveness and an employee may choose any employer plan that is deemed eligible.	No. Employee has the choice of any plan the employer offers that meets the standard plan requirements of HIPAA and is cost-effective.	No. The employee can select any employer plan that is eligible.	In FHIAP an applicant can select any employer plan that has dependent coverage as long as the employer contributes something.
Application processing for providing coverage through ESI:				

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18. In processing an applicant, what are the screening processes to determine eligibility?	MassHealth screens all applicants between 150-200% of FPL for the availability of employer-based coverage. An "insurance investigator" contracted by MassHealth asks screening questions then sends information on Family Assistance Program that simultaneously gathers information and requests release of information on employee. The application (Medical Benefit Request - MBR) is received along with a pay stub for verification by DMA and the data is entered into a computer. Calls to applicants to complete information request is done by DMA. Once the application is complete, the information is sent electronically to the contractor (PCG) doing the employer investigation. PCG uses an electronic data form and contacts employer and obtains information on plans.	During the application process, the applicant is asked whether they are employed and whether they have access to ESI. When eligibility for BadgerCare is established, the employer information is forwarded to the fiscal agent contractor (EDS). The fiscal agent contractor sends the Employer Verification of Insurance Coverage (EVIC) to the employer. EVIC asks questions about health plans offered, cost of the plans, and the employer share of premium. The family is eligible for FFS benefits throughout the enrollment process. The fiscal agent contractor follows up with a phone call if there is no response from the employer. If there is no response from the employer within 56 days, the family is enrolled in an HMO or left in FFS. Enrollment takes place at the earliest available open enrollment period of the employer plan.	Screening will be done by DHHS. If an employee is eligible for SCHIP, they are eligible for the ESI component. A program actuary at the state insurance administration will undertake the cost-effectiveness evaluation. When determined eligible for SCHIP, a family will receive information on the availability of the ESI premium subsidy and will be requested to submit information about the employer plan on a form provided for that purpose. Missing information on the employer plan will be obtained by the TPA or program actuary. TPA will help with the information gathering, and if the employer plan is determined eligible for a subsidy, the applicant will be notified by the TPA whether or not they can enroll.	In FHIAP, an application packet is mailed to the applicant and includes a handbook which explains insurance terms and conditions. Applications are mailed (by FHIAP staff) on a monthly allotment basis in order to manage growth in program enrollment. Completed applications with supporting documents (proof of residency, three previous months of pay stubs to verify income, and an asset test) must be returned by applicants to the FHIAP office within 60 days in order to remain valid. The applicant must indicate whether or not there is access to ESI.
	It takes 60 days to make a determination of eligibility from time of completed MBR. It takes 45 days if the applicant has insurance and is looking to enroll a child. If employer-based coverage meets requirements, the applicant is instructed to enroll. FFS is available during enrollment determination.			Agency must respond within 30 days from time the completed application is received. If the application is incomplete, the applicant has 30 days to send the missing information to FHIAP or the applicant may have to return to the reservation list. After they receive the completed application, the agency determines eligibility and the subsidy amount.
	Eligibility standards must be met - SCHIP program as a whole - which is detailed in Section 4 of the state plan, Chapter 2. Applicants above 200% FPL applicants are sent to the Children's Medical Security Plan. Specific to providing coverage through ESI (pp. 2-15 of Section 1115 waiver), DMA will claim federal reimbursement under Title XXI for children.			

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19. Does your buy-in program prescribe asking applicants if they have access to ESI or is there an independent check with the employer (or both)?	Both. The question is asked on the application (MBR) and then an independent check is conducted. The review will determine if the employee has access to health insurance as well as if the employer plan is eligible.	Both. The applicant is asked during the application process, and then the fiscal agent conducts an independent check after the application is deemed eligible for BadgerCare.	MS will ask applicants first. Participation in the ESI component is voluntary, so there will be no check unless the employee wants their employer's health plan. If they want their employer's plan, they will have to submit information to the plan/program actuary.	Both for FHIAP. They give the applicant forms to be verified by the employer/spouse's employer. Oregon's current SCHIP program screens for third party resources, including ESI.
20. Who gathers information from families about access to employer benefits and how is the information gathered?	An insurance investigator contracted by DMA (PCG), gathers the information.	Generally, Deloitte and Touche handles the enrollment process from the applicant along with some assistance from DHFS, and EDS handles the employer side of things. The state sends the EVIC to the employer and EDS follows up with a phone call if necessary.	A program actuary of the State & School Employee Health plan will be required to evaluate this information. Required forms will have to be completed by the employer to document plan information.	This was formerly done by the TPA; it is now conducted in-house by FHIAP staff.
20.1. Do states that ask for information from applicants about the availability of employer-based insurance think it is reliable?	Yes, but it is verified. Information is gathered from employers on: plans, total cost, employer contribution, and summary of benefits.	Yes, but it is verified. WI relies heavily on employer verification through the use of EVIC forms and conducts follow-up if necessary.	Yes, but it will be verified. The program actuary will require applicants to get information on the employer's plan, which the employer has verified.	Yes, but the employer must verify insurance coverage information on a plan form.
20.2. How does your buy-in program collect the specific information on an employer plan in order to make a determination based on the cost-effective requirement? (i.e., are there questions on a form, does someone call the family, is further research done with the actual employer to confirm what the applicant said about the availability of employer-based insurance?)	Employer plan information is compiled by a vendor (PCG) through telephone conversations and analysis is conducted on a benefit-by-benefit basis. Once it is determined that the employer plan is eligible on a benefit-by-benefit basis, calculations are made to determine if it would be cheaper to subsidize the employee for the employer plan or to cover the applicant under the default plan.	The EVIC is the first step and it is sent via mail to the applicant's employer. Further research is performed directly with actual employer by EDS to confirm the information on EVIC if necessary. If the employer fails to return the EVIC form, the applicant is permanently enrolled in Medicaid HMO or FFS. Once the employer plan is deemed eligible, then a cost-effective analysis is done to determine if it is cheaper to provide coverage through ESI than it would be under the default plan. WI runs a simple analysis of a subsidy under ESI and a subsidy under other eligible BadgerCare program. If ESI is cheaper, then they go with ESI.	It will be the responsibility of the program actuary to determine if the employer's plan is cost-effective versus enrolling dependents in regular SCHIP. Information about the employer plan will be supplied on a form. At this time the actual procedures are not finalized. MS will be looking at the cost to cover the child through ESI versus the cost of providing the child coverage under the state's default plan. MS will also look at the ESI subsidy to the child and compare that to the cost of enrolling the child in the default program.	FHIAP uses an employer verification sheet and collects data. Regulations require the applicant to take employer insurance if dependent coverage is available, if there is an employer contribution to that coverage, and if they are eligible under program. No cost-effective requirement, per se because if the family meets eligibility standards and the employer plan is eligible, then they will be enrolled as long as state funds are available. Each month the member must submit pay stubs showing health insurance deducted from the pay check.
21. Does your buy-in program contract the information gathering, application processing and eligibility determinations when providing coverage through ESI?	Yes. These processes are contracted to PCG.	Yes. WI uses Deloitte and Touche for the eligibility of employee component and EDS for database and employer reviews.	Mississippi will contract the information gathering for the ESI component out to the TPA and the program actuary. DHS will be responsible for enrollment in SCHIP, but not ESI.	No. Initially this was done by the TPA. It is now being done by FHIAP staff. No new TPA will be hired until after the next legislative session.

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22. What information does your buy-in program prescribe obtaining from an applicant's employer specific to the employer's insurance plan (e.g., exact benefits, employee contribution required and employer contribution percentage)?	The contractor (PCG) completes the verification form by contacting the employer and asking questions pertaining to: self insurance, ERISA employer, number of employees, FT or PT insurance coverage, number of plans available, if employee is enrolled in any of the plans, the level of coverage (family or individual), effective date on the policy, if employee is not enrolled - do they have access, total monthly premium, employer contribution, employee contribution, group number and open enrollment dates. Determination can be made on eligibility of employer plan as soon as the form is complete.	The employer is sent an Employer Verification of Insurance Form (EVIC). EVIC asks questions about health plans offered, the cost of the plans, and the employer share of premium. The family is eligible for FFS benefits at the beginning of the enrollment process. Review is lengthy; it takes roughly 56 days to review the applicant and employer (Deloitte and Touche - applicant eligibility and EDS - data system and employer verification). Enrollment takes place at the earliest available open enrollment period of the employer plan.	A form must be completed by the employer that documents the type of benefits the employer offers, and the cost of the premium to both employer and employee. It will be the employee's responsibility to get this information to the program actuary.	In FHIAP, premium and benefit information on the employer plan the applicant chooses must be documented from the employer and submitted to the agency by the applicant/employee. This would include: the employer contribution; the employee share of the contribution; the type of plan (HMO, PPO, indemnity); the form also asks if dental is part of the coverage and requires the plan identification number and company name.
23. When evaluating an employer's plan based on the benchmarking requirement, does your buy-in program prescribe a side-by-side, actuarial, or some other comparison?	The SCHIP benefit benchmark must be met on a benefit-by-benefit basis. (It must meet or exceed every benefit in order to qualify for the SCHIP program.)	An actuarial equivalence test, of sorts, is performed. The actuarial equivalence looks at the employer plan versus the minimum HIPAA requirements in providing major medical coverage. An eligible employer plan must meet the minimum requirements established in HIPAA. If it does not meet these requirements, then a benefit-by-benefit comparison could be done, but it is not the norm. If it meets the HIPAA requirements then the employer contribution and cost-effectiveness tests are performed.	Employer plans will have to be equal to or greater than the State & School Employee Health Plan (which will be the benchmark plan). The actuary will review the benefits in the plan on a benefit-by-benefit basis. If the employer plan is equivalent or better on this basis, no further evaluation will be necessary. If the employer plan does not meet the benchmark on all benefits, but may meet the overall equivalency test ($), the actuary may conduct a full actuarial analysis.	No benchmarking is done because FHIAP is a non-SCHIP/non-Medicaid program. If the employer contributes financially and the employee is eligible, then any employer plan may be deemed eligible.
23.1. Does your SCHIP agency do the evaluation or is it contracted?	At this time, the service is contracted service to PCG.	The employer evaluation is done through the EDS.	MS regulations state that this will be performed by the program actuary of the State & School Employee Health Plan.	FHIAP does the limited review that is necessary. Since FHIAP is not SCHIP, federal requirements do not apply.
23.2. What are the standards/minimum requirements?	If employer-based coverage meets SCHIP requirements on a benefit-by-benefit basis, the applicant is instructed to enroll.	The employer plan must meet or exceed the standard plan requirements set forth in HIPAA.	The State & School Employee Health Plan will be used as the benchmark plan.	N/A. See above.
24. Does your buy-in program prescribe keeping files/database on employer plans so subsequent employees from the same employer can be added without re-evaluating the employer?	Yes. This is done by the PCG.	Yes. The EDS maintains a database.	Yes. The program actuary will keep such documentation.	At present this is done in-house by FHIAP staff.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
24.1. How often do you do re-evaluations of employer plans?	Re-evaluations are performed at least on a yearly basis.	Employer plans are reviewed on the anniversary of the open enrollment period.	Re-evaluations will be performed every 12 months, based on the enrollment period of the employee's plan.	Redeterminations are done every 12 months.
25. Who maintains the data on employer plans?	Contractor	Contractor (EDS)	The program actuary will maintain this data.	Currently the staff at FHIAP are maintaining the data on employer plans.
26. What are the procedures in your buy-in program to determine the amount of the premium paid by an enrollee covered through ESI?	Individuals with incomes below 150% FPL will not be required to pay a portion of the monthly premium; those over 150% FPL share the cost of the premium (a flat amount based on the number of kids, not to exceed 5% of family income). The formula used in calculating the premium assistance payment will take into consideration the total health insurance premium, employer contribution, and MA's required family cost-share amount (between $0-$30/family). First MA estimates the premium assistance payment through ESI by subtracting the employer contribution and MA cost-share from the total health insurance premium. Second, the estimated premium assistance payment will be compared to the cost of covering the eligible children on MassHealth direct coverage.	The applicant fills out a form used for all BadgerCare programs. One of the questions on the form asks if they have access to ESI and if it is okay to contact their employer. Families not exceeding 185% FPL of countable income are eligible and can remain in the program (if they wish) until their income exceeds more than 200% FPL. (If enrollment is capped, then they can only stay in the program until their income exceeds the original eligibility level). No premium is required at or below 150%FPL; there is a premium maximum of 3% of income for those above 150% FPL. DHFS determines if the HMO/Medicaid plan is more cost-effective; if so, the family is enrolled. There are new premium requirements for every $500 increase in family income. Family premium calculations exclude self-identified American Indian/Alaska Native children.	Each employee premium will be paid by the state plan, where the employer pays at least 50%. Co-pays will be required by people between 150%-200% FPL. This includes $5 co-pays for outpatient care, and $15 co-pays for emergency room care. As the program's only out-of-pocket expense, co-pays must total no more than 5% of the employee's income in a calendar year.	In FHIAP, either 95%, 90%, or 70% of the employee portion is paid by the program, depending on income and assets. The remaining portion is paid by the recipient.
	If the estimated payment amount through ESI is less than the cost-effective amount (MassHealth coverage), then the actual premium assistance payment amount is the same as the estimated amount; otherwise the direct MassHealth coverage option is chosen.	Premiums range from $30 - $105 (for a family of six, 200% FPL) per month depending on family size and income. A premium table is listed in Attachment #1 of the December 18, 1998, BadgerCare Amended Waiver Request (1/11/99 answers to HCFA questions); cover letter to HCFA dated 1/15/99.		
27. Has your buy-in program evaluated the impact of the premiums in discouraging people from enrolling in coverage through ESI or the default plans?	No formal study has been conducted. Premiums range from $0 - $30 per month.	No formal study has been conducted. Premiums range from $30 - $105 per month (for a family of six, 200% FPL).	No formal study has been conducted. No premiums will be paid by the employee; however, the out-of-pocket maximum will be: $800 for families at 151%-175% FPL; and $950 for 176%-200%. Co-pays will be $5 for out-patient care and $15 for emergency care.	No formal study has been conducted for FHIAP. Due to high concentration of managed care, OR expected premiums and deductions to be low for families.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
27.1. Does your program inform people on the initial application that they may be subject to a premium?	Yes, but the information is not on the application; it is only in a handbook that is sent with the application. The handbook outlines the premium payments. Once the applicant is eligible, then the premium discussions begin with staff.	Yes. There is a 3% maximum premium for those over 150% FPL. It is clearly stated.	Yes. Program staff will inform them that their premium will be paid, but that they are responsible for co-pays.	Yes. It is in the FHIAP application packet.
27.2. Does your program ask if the families would be willing to pay a premium?	Yes.	Yes, they must agree as a part of the process.	No. According to the regulations governing MS's SCHIP, no premiums will be paid by the employee; only the co-pays will be required.	Yes. If the employer offers dependent coverage and the employer makes a contribution, the applicant is required to pay it.
28. How does your employer buy-in program determine when a family (utilizing ESI coverage) has enrolled in the employer's insurance plan and when does your program begin sending checks to the family to subsidize the cost?	Through a review process it is determined if the employer plan is eligible. If it is, the employee is enrolled (if cost-effective, etc.). Before payments are made, the employee must provide one of the following: 1) an enrollment form; 2) a letter from the employer stating that they are enrolled; or 3) a pay stub showing withholding for insurance (this is a last resort, and if this is the case, DMA will send a check with the reimbursement and an advance payment). Coverage begins once the determination is made and monthly audits track the enrollment in the employer plan.	Coverage begins at the earliest open enrollment period if it is less than six months away. (FFS is available until the period starts. If it is more than six months, they get HMO coverage until then.) A pay stub is required as proof of initial and ongoing enrollment. The WI program pays employees that have premiums withheld from their paycheck as a reimbursement. The initial check is sent to the employee after they provide proof (pay stub) that the premium was deducted from the paycheck.	The program staff will ensure the child is enrolled once they learn of the employer's open enrollment period. The TPA will send checks starting in the same month that enrollment in the employer plan begins. It is up to the employee to enroll the child and advise program staff. The program will have a component to remind the employee to enroll their child, prior to the enrollment period.	In FHIAP, members must enroll in an employer plan within 90 days of being accepted. They also must notify state staff by sending pay stubs. A subsidy is sent for the next month.
28.1. Does your buy-in program send the money in advance or only after receiving some confirmation?	They are sent in advance so the employee does not see a reduction in income.	Reimbursement is made depending on the arrangement with the employer. Three options are given to the employer: 1) WI sends the check to the employee for the cost of the premium deducted by the employer (overwhelming favorite). A pay stub is required on a monthly basis in order for the enrollee to receive the reimbursement. The first month of coverage is covered by BadgerCare; the check sent to the employee will be for month two; 2) WI sends the check to the employer for the cost of the employee's premium (seldom used); or 3) WI pays the insurance company directly (not used at all, maybe one or two cases).	The program anticipates that they will send the checks in advance of the premium deduction being taken.	Only after receiving some confirmation (e.g., pay stubs) from the prior month does the program send out a subsidy check in advance of the premium deduction being taken.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
29. How does your program verify continued enrollment under ESI?	It is verified through monthly audits and quarterly reviews. The audits match program eligibility files against the enrollment files of several of the largest commercial carriers. They require the participant to report changes in income, employment status, or insurance status. Full reviews are conducted at least every 12 months. Eligibility is reviewed by: 1) information matching with other agencies and health carriers; or 2) a written update of the member circumstances on a prescribed form. As a result of this review, DMA will determine if the member continues to be eligible or if the member needs a change in coverage.	The employer is contacted by WI DHFS prior to the anniversary enrollment period. Any change in the status of the employee must be sent to DHFS from the employee. The pay stub is also used to determine if the employee continues to be enrolled. An annual review of all ESI program participants is performed.	A random audit of recipients every few months is anticipated, as are annual reviews.	Copies of pay stubs that show the employee contribution has been taken out must be submitted every month. Random audits are also made.
30. How long does it take to determine if an employer's plan meets the requirements of your program?	Once the completed Medical Benefit Request (MBR) is received by the investigations contractor, there is a maximum determination time of 60 days for applicants that are not covered under insurance, but have "potential access" to insurance. Maximum of 45 days for applicants that are "self-declared" - stating they have insurance. The investigations rarely take this long. Potential access investigations take approximately 5-6 days with 2-3 actual hours spent on the investigation. Self-declared investigations take approximately 3-4 days with one actual hour of time spent on the investigation. DMA will request all corroborative information from applicant within 5 business days of the initial receipt of MBR. The applicant has 60 calendar days to provide information and complete the MBR. If 60 days expires, MBR becomes deactivated.	It depends primarily upon how prompt the employer is with providing plan information. BadgerCare families are covered by FFS as soon as they are determined eligible for BadgerCare. If the family cannot be enrolled into the ESI within 56 days, the family is left in FFS or enrolled into Medicaid HMO.	This has yet to be determined.	It takes no more than 30 days, or the time it takes to determine eligibility. If further information about the employer plan is needed, the recipient has 30 days from the point of notification to get it.
Payments associated with providing insurance through ESI:				

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
31. To whom does your buy-in program make the premium assistance payment?	Payments are made to two entities: 1) Families - DMA pays families, and families make payments to insurance carriers (through employer payroll deduction); and 2) Billing and Enrollment Intermediaries (BEI).	It depends on the arrangement with the employer. There are three methods of payment: 1) WI sends check to the employee for the cost of the premium deducted by the employer (overwhelming favorite); 2) WI sends the check to the employer for the cost of the employee's premium (seldom used); or 3) WI pays the insurance company (hardly used at all, maybe one or two cases).	MS originally wanted to give subsidies to employers, but employers did not like the idea because of the inequity in the program (uninsured requirement, etc.) and the administrative burden. MS is now planning to make payments to families.	In FHIAP the subsidy is made to the employee.
32. What advantages does your buy-in program see with the method of payment you use for those covered through ESI?	A direct payment to the family reduces stigma because they receive coverage like everyone else. It also reduces the burden on the employers as the enrollee is "invisible" to the employer.	It reduces the stigma of public assistance since employees are contributing. It also encourages the employee to begin looking to employer for health benefits.	Employee payments will be the easiest method administratively and is the only viable option from the state's point of view because of employer resistance.	FHIAP believes it reduces the burden on employers, and reduces the stigma of public assistance. It is also easy to administer.
33. How does your buy-in program handle co-pays covered through ESI?	SCHIP pays for co-pays, coinsurance, and deductibles for children eligible for premium assistance provided: 1) the member was uninsured at the time of the eligibility determination, had access to ESI and MA required the enrollment in the insurance plan; and 2) the co-pay, coinsurance, or deductible was incurred as the result of a well-child visit or exceeds the 5% rule.	The only co-pays, if any, that would be required, are the ones that are required for Medicaid. SCHIP pays for all co-pays on ESI-covered services up to the Medicaid amount (i.e., as though Medicaid is the secondary payer).	Recipients will make co-pays of $5 for out-patient care and $15 for emergency care for non-HCFA required services. Total calendar year out-of-pocket expenses (including co-pays) cannot exceed 5% of income. In the event an enrollee is charged more than $5 or $15, that total amount will be charged against the out-of-pocket maximum. All co-pay amounts are counted against out-of-pocket expenses.	In FHIAP all out-of-pocket expenses are paid by the employee.
	Once families exceed 5% they will cease to be responsible for additional co-payments or deductibles relative to their children's health care for that eligibility year. MA will notify these families of the 5% cap and provide procedures for receiving reimbursement for expenses above the cap. Once the family has incurred out-of-pocket expenses totaling 5% of the family income, they will be required to submit proof of payment to MA who will review the submitted bills in a timely fashion.	In the event an employer plan stipulates co-pays exceeding the Medicaid amount, that employer plan may be disqualified because it may not meet the minimum HIPAA requirements. If the employer plan stipulates co-pays higher than the Medicaid amount and the plan is approved by WI (has not happened yet), the co-pay and the additional amount paid by the enrollee would go toward the out-of-pocket expenses cap that cannot exceed 5% of income.	The out-of-pocket maximum will be $800 for families between 150%-175% FPL, and $950 for families between 176%-200% FPL. The state will implement wrap-around coverage for higher co-pays.	

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
	Once the review is complete, the family will be notified of procedures for submitting future bills to MA. MA will provide MassHealth documentation for the member to provide to the health care provider at the point of service. The documentation would request the provider to bill any further co-payment or deductible directly to MA. If the provider required the family to pay the bill upfront, MA would reimburse the family for the expense. The family could also take the bill and submit it to DMA for processing and payment to provider. This process lasts until the end of the employer enrollment year.			
33.1. Do you provide insurance cards and then require providers to submit bills?	The enrollee will be established as eligible under the Medicaid system prior to enrollment in ESI and issued a MassHealth card in order to receive FFS. The MassHealth card would not be used again until the enrollee reaches the out-of-pocket threshold. A card would also be issued from the employer plan.	Yes. A BadgerCare card is given to all enrollees. Enrollees must go to a Medicaid provider and the bill process is handled just like Medicaid.	Yes. Recipients will receive a card for the plan in which they enroll.	No. Employees receive a card from the employer plan, but all out-of-pocket expenses are paid by the employee, including co-pays.
33.2. Are providers willing to bill in small amounts for co-pays?	Yes. If the enrollee goes to a Medicaid provider, then there is no problem. There may be more problems with non-Medicaid providers, but MA has encountered few problems so far.	Yes. Providers already bill in small amounts for Medicaid and will do it for those receiving coverage through ESI.	Yes. Providers currently bill Medicare secondary coverage carriers for small amounts, so MS does not anticipate this will be problematic. MS anticipates several providers may complain about the administrative costs of doing this. Co-pays cannot exceed the 5% rule.	N/A

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
34. What relationship does your buy-in program have with pharmacies specifically relating to co-pays covered under ESI?	MA SCHIP Family Assistance Program covers pharmacy benefits. Using Harvard-Pilgrim HMO as benchmark (which covers pharmacy) makes it a mandatory benefit under an employer plan for large companies if they want to participate. Co-pays are paid using the same method as Medicaid services. Drug co-pays are made by the enrollee up to the 5% rule. If small companies under IPP do not have pharmacy, they can still qualify with the pharmacy benefit excluded from the package.	Pharmacy coverage is included and is processed just like Medicaid. All co-pays are covered unless there is a small fee associated with Medicaid. SCHIP pays for co-pays up to the Medicaid amount.	If pharmacy benefits are paid by a secondary carrier which is BCBS, MS anticipates they will have no problem billing them for co-pays. Most pharmacies have an automated billing system through insurance carriers that limits the administrative costs of billing in small amounts.	In the FHIAP program, pharmacy expenses are covered only if the employer plan covers the benefit. The state will not pay for drug co-pays or any co-pays for that matter, because employees are required to pay all out-of-pocket expenses, including drug co-pays.
35. For network-based ESI, if an enrollee goes outside of the network for care, how does your program handle payments for these out-of-network services?	The employee is responsible for understanding all network and managed care aspects of the plan in which they are enrolled. Program policy states that it will not pay for out-of-network benefits, but this is difficult to enforce.	Prior to service (handled just like Medicaid) the enrollee will need a prior authorization. This process is the same as it would be under Medicaid. Out-of-network care is allowed, but subject to the Medicaid fee schedule cap.	The employee will be responsible for understanding all network and managed care aspects of the plan in which they enroll. The program will not pay for out-of-network benefits.	In FHIAP, the employee signs up for the employer plan and therefore must follow the rules of the specific plan.
Satisfying requirements as they relate to providing coverage through ESI:				
36. How does your buy-in program prevent, monitor, and evaluate crowd-out or substitution to ensure that providing coverage through ESI under SCHIP does not substitute for coverage under Medicaid or private group health plans?	MA does not have a look-back period (Section 1115 waiver), but the state reports all substitutions to HCFA on a quarterly basis. If HCFA sees too much substitution, they may cancel funding. To discourage families from dropping coverage prior to enrolling in the Family Assistance Program, extensive insurance investigations will be conducted that will include matching the applicant's data against the insurance carrier database.	EDS investigates all applicants (i.e., SCHIP, Title XIX, and HIPP). In cases where the applicant is employed, they rely on employer verification of plan information. A look-back period of six months helps prevent substitution. There is also a legislative requirement prohibiting employers from dropping employee coverage to take advantage of programs such as BadgerCare. (A substitution analysis will be included in the annual report.)	The state will monitor and evaluate statewide trends in ESI to measure the degree of crowd-out. A look-back period of six months will help with crowd-out. (A substitution analysis will be included in the annual report.)	In FHIAP if the employer offers a plan with any kind of dependent coverage, the employee must enroll in that plan to be eligible for any kind of subsidy. (OR's annual evaluation of the program contains a review of potential substitution effects.)

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
	(Database includes subscriber lists representing approximately 90% of the health insurance market in MA). DMA will randomly sample those members who applied for assistance without insurance and will assess how many had insurance within the six months prior to their application for MassHealth to help determine if crowd-out is occurring. MA has a requirement that if you do not utilize ESI as an applicant, but have access to it, you will not receive other MA benefits. (A substitution analysis is included in the annual report.)	Also, applicants are not eligible for BadgerCare if: 1) they are currently covered or were covered three months prior to applying; and 2) they currently have access to 80% employer-subsidized insurance or in 18 months prior to application. A long-term is study being planned.		
37. Does your program perform the evaluation and monitoring of crowd-out in-house, or is it contracted?	Both. PCG reviews applications for crowd-out and DMA produces quarterly reports for HCFA.	EDS for the most part makes sure crowd-out is not occurring. DHFS reviews reports for crowd-out.	This will be performed by the program actuary of the State & School Employee Health Plan.	The OR Office of Health Plan Policy and Research prepares the evaluation of FHIAP.
38. What is the time period your buy-in program uses for the look-back period when providing coverage through ESI?	There is no look-back period used in MA. The Section 1115 waiver did not have one and it would be confusing for those involved if had look-back for some programs and not for others.	WI uses a look-back period of six months for ESI through SCHIP and three months for default/Medicaid.	MS will use a six-month look-back period.	FHIAP also uses a six-month look-back period.
38.1. How did your program decide on this timeframe?	It made the most sense for the MA population being served.	The requirements were recommended by HCFA for SCHIP.	HCFA insisted that this be the standard.	In the FHIAP program, six months was selected prior to the HCFA requirement, and was chosen because it was long enough to discourage voluntary dropping of coverage and it wouldn't be burdensome to most of Oregon's chronically uninsured population.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
39. How does your buy-in program satisfy the HCFA cost-effectiveness requirements when subsidizing employer-based coverage?	It must be no more costly to buy into the employer-based plan than to cover under MassHealth. MA compares the cost of covering the eligible children through ESI to other MassHealth programs. If premium assistance through ESI is lower than other programs, then the family qualifies for a subsidy. If the premium assistance amount is higher than the cost-effective amount, then MA sets the subsidy at the cost-effective amount. Unless the family share exceeds 5% of income, families offered subsidies will not have a choice of accepting the subsidy for ESI or enrolling in MassHealth.	It must be no more costly to buy into ESI than to cover under Medicaid. If it is cost-effective to cover the family under BadgerCare Title XXI, then they enroll; otherwise, WI tests cost-effectiveness under Title XIX Health Insurance Payment Program (HIPP). If neither Title XXI or XIX are cost-effective, then the applicant is enrolled in regular BadgerCare.	Since dependents in the ESI program must be eligible for SCHIP, it simply must cost the state no more to have children ensured through ESI than through regular SCHIP.	Presently OR doesn't pursue this because FHIAP is state-funded and the program requires that an employee take their employer's plan if the employer offers dependent coverage. However, an evaluation from June 1999 acknowledged that in the prospective waiver to expand the program with SCHIP funds, a thorough cost-effectiveness test will need to be undertaken for each applicant.
40. How does your buy-in program handle the restriction for federal funding of abortions when providing coverage through ESI?	No SCHIP funds will cover abortions except if it is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. No SCHIP funds will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion except to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	No SCHIP funds will cover abortions except if it is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. No SCHIP funds will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion except to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	According to MS's SCHIP Rules & Regulations, Article 3.3N, abortions cannot be covered under the program unless they are medically necessary. The state will adopt the provisions under 8.4.8 and 8.4.9 of Title XXI state plans.	This program is completely state-funded so there would be no separate subsidy for this service. Coverage for voluntary pregnancy termination depends on the plan purchased by the employer.
Deadlines associated with providing coverage through ESI:				
41. Are there any deadlines associated with the enrollment process when providing coverage through ESI?	Yes. Eligibility deadlines: a determination is made within 60 days from the receipt of the complete MBR if the applicant is potentially eligible for MassHealth Family Assistance; a determination is made within 45 days from the date of receipt of the MBR for all other nondisabled applicants. Determinations are made within 90 days from the date of receipt of a complete MBR for the disabled. (See HCFA question #30 in MA Title XXI state plan.)	Yes. Contractors have to perform reviews within 60 days. (This is outlined in the state plan.)	No. The only relevant deadlines will be those related to the employer plan open enrollment period.	Yes. A prospective recipient has 90 days to enroll in their employer-sponsored plan once their application is accepted.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
42. How long does it take an applicant to complete the application process before becoming active with coverage provided through ESI?	1) The state requires the vendor conducting the insurance investigation to complete the process within 60 days; children at 150-200% FPL are presumed eligible during this period and can receive care on a fee-for-service basis. 2) During this period the child may not be enrolled in SCHIP Premium Assistance program, but may be eligible for either Medicaid Premium Assistance Program or regular SCHIP. Children can receive MassHealth Family Assistance benefits on a FFS basis for maximum of 60 days. During these 60 days the vendor determines if applicant is eligible for ESI subsidy. Self-declared investigation has a maximum of 45 days in which time the applicant or children are not eligible for MassHealth and must continue receiving benefits through their employer or another source.	It takes roughly 56 days for the review process and then it depends on the open enrollment period of employer plan. There is a 60-day maximum. The time depends on when the employer returns the verification forms. If an employer refuses to submit EVIC, there is not much WI can do the and applicant is covered under BadgerCare if they qualify.	MS cannot determine this until the program is implemented.	The prospective recipient is put on a waiting list (because of budgetary constraints) prior to having their application considered for the program. When there is room in the program, they are sent an application in the mail; they must return the application within 60 days. By statute they will be notified of eligibility within 30 days of the receipt of the completed application. They then have 90 days to enroll in coverage.
42.1. How many days does it take to enroll an applicant once eligibility has been determined?	This depends on the open enrollment period.	It depends on the open enrollment period of the employer plan.	N/A	The recipient has no more than 90 days from acceptance to enroll in employer insurance.
42.2. Is the applicant covered during the application process?	Yes and no. 1) For applicants with potential access to ESI, a child may not be enrolled in SCHIP Premium Assistance program (but may be eligible for either Medicaid Premium Assistance Program or regular SCHIP). Children can receive MassHealth Family Assistance benefits on a FFS basis for a maximum of 60 days. During these 60 days it is determined if ESI is eligible. 2) A self-declared applicant is not eligible for MassHealth and must continue receiving benefits through their employer or another source.	Yes. The applicant is placed in fee-for-service Medicaid coverage.	Yes. The children will be covered under regular SCHIP.	No. Subsidies begin once an applicant is determined eligible. They may purchase or enroll in a plan once they are on the reservation list, but only if they have been uninsured for six months prior to applying.
42.3. If the applicant is covered during the application process, what is the process they must undertake to receive medical care?	The applicant would use a MassHealth card, go to a MassHealth provider, and pay for services out-of-pocket.	They need to go to Medicaid provider, comply with the Medicaid BadgerCare rules, and show their card prior to services.	They will need to go through the regular SCHIP process to obtain service.	N/A

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
Problems associated with providing coverage through ESI:				
43. What happens when ESI does not meet SCHIP benefit standards?	MassHealth option for the applicant if they meet income thresholds. If the family's gross income is between 150-200% FPL and there is an uninsured child, they will be eligible for Family Assistance Program not covered under Title XXI funding.	If Title XXI ESI eligibility is not established, then an eligibility review is conducted through HIPP. If eligibility is not established under either Title XXI or HIPP, the applicant remains in the default program, either FFS or managed care.	The children will be covered under regular SCHIP.	Since FHIAP is completely state-funded, once an applicant is determined eligible and enrolls in ESI, a subsidy is paid.
44. What happens if an employer refuses to provide information about a plan or employee?	MA initiates follow-up calls and letters. If the employer refuses to provide information, the applicant is placed in MassHealth, provided they are eligible.	DHFS calls the employer four weeks after EVIC is sent. There is not much WI can do if the employer refuses to submit information other than enroll the applicant in the default plan.	It is the responsibility of the employee to pursue this information. Failure to do so might negate eligibility for the employee for the ESI premium subsidy. The applicant would remain enrolled in the state's regular SCHIP plan.	The program notifies the employee and it is their responsibility to remind the employer to provide the necessary information. If the employer won't fill out the form, OR program staff calls the employer. If the employer cooperates, the program helps the employee enroll in FHIAP. If the employer does not cooperate, the applicant, depending on their eligibility, is placed in another program or the individual program (FHIAP program for employees without access to employer plan - either temporarily or for extended periods - to purchase insurance coverage).

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
Compliance Issues associated with providing coverage through ESI:				
45. What policies are in your program to handle non-payment of premiums?	Enrollees found to be abusing the system in some way will have their benefits terminated. Any portion of the premium payment that is not made within 60 calendar days of the billing date will result in termination of coverage after an advance notice is given.	DHFS sends out two letters. The enrollee must pay by the end of the month of second letter. If nothing is paid, the enrollee is made ineligible for six months. To re-enroll, the employee must repay all premiums.	No premium payments will be required of the applicant.	Although FHIAP is not an SCHIP program, in FHIAP a member must submit verification of the premium payroll deduction each month. If they fail to do so, further reimbursements are withheld and the member is sent a warning notice. If the member doesn't respond, the member is terminated from the program.
	Another coverage period cannot begin unless DMA collects all outstanding premiums. Formal hearings are available for anyone wishing to appeal the case. If an overdue payment is made in full within 30 calendar days of the date of termination, coverage shall begin retroactive to the date of termination, if otherwise eligible.			If this happens they must be returned to the reservation list and are subject to a six-month period of no insurance.
	If an overdue payment is made in full later than 30 calendar days of the date of termination, coverage shall begin retroactive to the date of the premium payment, if otherwise eligible.			
46. What are your termination policies for enrollees who stopped their ESI coverage but continued receiving the state subsidy?	Employees found abusing the system in some way may have their benefits terminated. Employers that are abusing the system may no longer be eligible and may face prosecution. Formal hearings are available for anyone wishing to appeal the case. Payback of an inappropriate premium subsidy is required before re-enrolling and subject to general SCHIP rules.	If there is no "good cause" reason for dropping out of ESI, the enrollee will be terminated and may re-enroll after six months. Reimbursement of the state subsidy is expected.	There is no formal process in place for this condition as of yet, but MS will follow SCHIP guidelines. MS anticipates using a period where the abusing enrollee will not be eligible to re-enroll with the stipulation that all misused subsidies must be paid back.	Employees must mail copies of all pay stubs to show program staff that premium deductions are being taken by the employer so this should be revealed. The recipient must return to the reservation list if they wish to re-enroll.
47. What kind of monitoring does your program prescribe when making payments to families covered through ESI in order to eliminate the misuse of funds?	A quarterly audit determines whether families receiving subsidies have used them to enroll in the health plan. Monthly review matches program eligibility files against the enrollment files of several of the state's largest commercial carriers (approximately 90% coverage).	A copy of the pay stub must be submitted by the employee showing the premium was taken out of check, then WI sends the payment to the employee that is enrolled in the program.	MS anticipates a random review of the recipient will take place subsequent to the implementation period.	The FHIAP program relies on the employee to comply with submitting their pay stubs to show that their employer has deducted their contribution. If they don't comply, they are terminated from the subsidy program.
Assessing the outcomes of providing coverage through ESI:				

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
48. How does your buy-in program assess the effectiveness of providing coverage through ESI?	MA conducts an annual assessment of the effectiveness of the State Plan. MA measures the increase in the number of kids with employer-sponsored coverage. The Current Population Survey will be used to calculate a baseline number of uninsured low-income children at the start of the program and to measure changes from that baseline annually.	No firm goals have been established for ESI at this time because WI knew going in that this program would be a small portion of BadgerCare. An evaluation will be done on BadgerCare as a whole and will look at ESI from the cost-savings point of view.	An evaluation will be conducted during the annual assessment of the Title XXI plan.	FHIAP data is gathered by staff at the OR Insurance Pool Governing Board. The data has been evaluated in a formal report by the Office for Oregon Health Plan Policy & Research.
49. Does your program use the information from the enrollment process to assess the effectiveness of providing coverage through ESI?	Yes. The information is included in the annual assessment of the effectiveness of the State Plan.	Yes. EDS maintains a database for all BadgerCare and an annual assessment is done using that information.	Yes. MS is planning to use at least some of the information from the enrollment.	The program is just beginning to use the enrollment data in the analysis of ESI on an annual basis. Data is available in the form of monthly "snapshots" as well as an evaluation done in June 1999 of FHIAP. These snapshots show participation rates for both ESI and non-ESI programs together.
50. Does the state come close to the administrative cost limit in providing coverage through ESI?	No. Most of the administrative expenses associated with eligibility are charged to Title XIX. The biggest administrative costs with ESI are enrolling in and administering fee-for-service coverage costs associated with employer plan investigations.	No. WI has been providing coverage through ESI for less than a year, so no analysis done as of yet, but are sure the costs are not coming close to 10%.	N/A	N/A. Since the program is state-funded, it is not applicable.
Special provisions associated with providing coverage through ESI:				
51. What are some of the provisions under your buy-in program that are unique and/or you would recommend to other states as they contemplate providing coverage through ESI?	Unique aspects to MA include: 1) The ability to remit subsidies to the appropriate carrier without involving the family - BEI; 2) BEI: a small employer administrative insurance agent is working with MassHealth (partnership is outlined on p.16 of IHPS report);	WI recommends using: 1) As much of the available infrastructure as possible when administering the program; and 2) the single-entry system, which is working wonderfully for WI and is something other states should copy.	Unique aspects of the Blue Cross/Blue Shield relationship include: 1) BCBS of MS will administer regular SCHIP and Premium Assistance Program - provider will first bill the employer carrier, then BCBS for the allowable unpaid;	A unique situation in OR that might not be prevalent in other states is the high percentage of managed care plans in the state and the low number of small employees who make dependent coverage available.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
	3) Section 1115 waiver for Insurance Partnership Program - small employers are receiving incentive payments through BEI for offering coverage to low-income workers; and 4) MA foregoes enhanced matching payments for components that are not consistent with Title XXI (e.g., subsidies to families under 200% FPL whether they are already insured or not).	Providing coverage through ESI is difficult to do on a large scale right now, but WI wanted to be in the position to take advantage of HCFA changes (more lenient requirements) when they come.	2) BCBS will provide supplemental cost-sharing coverage to premium assistance program enrollees whose employer-based plans do not include the SCHIP cost-sharing provisions; 3) BCBS will cover certain required services such as immunization, which may not be covered under the employer plan and coverage for any pre-existing conditions subject to a waiting period under the employer plan; and 4) BCBS will track families' out-of-pocket expenses to ensure total spending does not exceed 5% of income.	
52. How does your buy-in program take advantage of both the regular match under Title XIX and the enhanced match under Title XXI?	MA forgoes enhanced matching payments for components of the program that are not consistent with rules of Title XXI: 1) MA provides subsidies to families under 200% of poverty whether they are already insured or not (Title XXI permits using enhanced funds only for currently uninsured children); and 2) IPP small employers will receive incentive payments (Title XXI does not allow this because funds can only be used for children).	WI receives enhanced FMAP of 71% for entire family under Title XXI if cost-effective. It also receives a 59% regular FMAP for adults and 71% for kids if it is cost-effective under Title XIX. It is a capped program, however, based on the dollar amount set by state.	MS plans on taking advantage of both matches once the program is operational.	There are no Title XXI funds available to the FHIAP program thus far.
53. If your program uses wrap-around benefits when providing coverage through ESI, how does it structure the benefit?		The wrap-around coverage covers the ESI and brings it up to the level of Medicaid. WI looks at employer plans on a case-by-case basis to determine if it is cost-effective to buy into that program under the wrap-around in order to meet the minimum benchmark requirements.	If the employer plan does not cover immunizations or well-child care, these will be covered under a wrap-around. Since employer plans will have to meet the benchmark on a benefit-by-benefit basis, there should not be any other major benefits not covered by an approved plan. Wrap-around coverage will be provided for deductibles, co-insurance, and co-pays higher than SCHIP.	N/A since FHIAP is not SCHIP and not subject to federal requirements.

Questions	Massachusetts	Wisconsin	Mississippi	Oregon
			MS does not plan to wrap-around for vision and dental benefits because the additional cost would likely preclude many employer plans from passing the cost-effectiveness test. Since enrollment in the employer plan will be voluntary, the family will have the option of staying in the state's SCHIP plan, which covers vision and dental. Co-pays for outpatient and emergency room visits will be paid by the recipient while deductibles and co-insurance higher than SCHIP co-pays will be paid by the program.	