



# HB 2934—Oregon Basic Health Program (BHP) Stakeholder Advisory Group: Recommendations

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November 2015

Prepared by  
The Oregon Health Authority

Prepared on behalf of  
BHP Stakeholder Advisory Group

Prepared for  
The Oregon State Legislature  
Per House Bill 2934

This report is available online at: <http://www.oregon.gov/oha/OHPR/Pages/Basic-Health-Program-Stakeholder-Group.aspx>



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November 12<sup>th</sup>, 2015

House Committee on Health Care  
Oregon Legislative Assembly

Dear Chair Greenlick and Members of the Committee,

In 2015, the Oregon Legislature passed House Bill 2934 tasking the Oregon Health Authority (OHA) with convening a stakeholder advisory group (SAG) to examine key policy issues related to the federal Basic Health Program (BHP) in the context of Oregon's health care system. The BHP is a health coverage option for individuals with incomes between 138 and 200 percent of the federal poverty level (FPL) and individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to immigration status.

From July through November 2015, the group met on six separate occasions to develop recommendations on the policy, operational and financial preferences for the design of a BHP. In developing recommendations, the group considered findings from an independent study conducted in 2014 that investigated the financial feasibility of operating a BHP in Oregon per HB 4109 (2014). The recommendations and companion report are based on available information shared with the group during the stakeholder process and input provided by participants.<sup>1</sup> The recommendations in this report are exclusively the product of the workgroup, do not convey any policy recommendations from the Oregon Health Authority, and seek to further the goals of reducing the cost of health care and ensuring all residents of this state equal access to health care.

### **Principles for Designing and Selecting a BHP in Oregon**

States have considerable flexibility in how to establish a BHP. The recommendations are thus designed to provide direction and guidance to the Oregon Legislature on key elements of a BHP, and overlap with the requirements outlined in the federal Blueprint,<sup>2</sup> the mechanism to officially request federal program approval. The stakeholder group proposes a development framework and program structure based on a set of design principles. The principles were used as decision-making criteria in selecting the preferred design and approach for a BHP in Oregon.

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<sup>1</sup> All meeting materials, presentations and supporting documents are available at:

<http://www.oregon.gov/oha/OHPR/Pages/Basic-Health-Program-Stakeholder-Group.aspx>

<sup>2</sup> See CMS federal BHP Blueprint: <http://www.medicaid.gov/basic-health-program/downloads/minnesota-bhp-blueprint-december.pdf>

The principles also outline the group’s rationale for its final recommendations and include:

- Increase access to coverage for uninsured, including those ineligible for Medicaid, and Oregon’s COFA population<sup>3</sup>
- Increase affordability of coverage for low-income Oregonians
- Reduce churn by minimizing and mitigating the frequency of and impact from coverage transitions, including the benefit cliff among federal insurance affordability programs (IAPs)
- Sponsor an accountable care model using a measurement framework to incentivize quality and population health improvements
- Promote a sustainable and predictable rate of growth (e.g. 3.4 percent in Medicaid, PEBB, and OEBC)
- Maintain a healthy and vital Marketplace and spread the coordinated care model (CCM)
- Exercise stewardship of State resources by maximizing federal resources available through the ACA

### **Recommended BHP Framework: Policy, Operational, and Financial Preferences**

Based on the principles outlined above, the stakeholder group decided upon the following framework and program design for a BHP.

<b>Hybrid Marketplace</b>	
<b>Delivery System</b>	CCOs and commercial QHPs plans compete for BHP enrollees using principles of Oregon’s coordinated care model (CCM)
<b>Benefit Coverage</b>	Full Medicaid benefit level without adult dental
<b>Provider Reimbursement</b>	Average of Medicaid and Commercial (~81% of Oregon’s commercial reimbursement rate)
<b>Premiums &amp; Cost-sharing</b>	<138% FPL, \$0; 138-200% FPL graduated premium structure; no cost-sharing
<b>Eligibility &amp; Enrollment</b>	Marketplace standards; 12-month continuous eligibility; FFM eligibility system (federal hub)*
<b>Consumer Choice</b>	Standard Health Plan (SHP) offerings via Marketplace
<b>Administrative Functions</b>	Marketplace and carriers (client services, grievances, premium billing)
<b>Sustainable Growth Rate</b>	Annualized sustainable fixed rate of growth; methodology and rate to be determined by Legislature

\*Please see paragraph on page II regarding use of federal hub as the FFM cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

<sup>3</sup> Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia. For more info, please see COFA Alliance National Network (CANN): [www.cann.us](http://www.cann.us)

The group also recommends that the Legislature consider updating the 2014 BHP financial feasibility model and to develop financial projections for future years beyond 2017 based on the design preferences outlined above. It is important to note that as of October 2015, the Federally-Facilitated Marketplace (FFM) cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations for states such as Oregon, which rely on a federally-supported State-based Marketplace (SBM).

Through careful consideration of the federal program in the context of Oregon, the group concluded that the BHP could serve as a potential policy tool to further expand coverage to the remaining uninsured and increase affordability for low-income Oregonians (138-200 percent of FPL) already insured through the Marketplace. The group identified a broader question for consideration by policy makers about whether the BHP could serve to help stabilize Oregon's individual market by potentially resetting rates in the Marketplace. The group also discussed the potential disruption a BHP could create to the Marketplace by removing BHP enrollees from current Marketplace risk pools. Lastly, the group observed that fees would continue to be assessed on plans for the population, maintaining the population's support of Marketplace administration.

Recommendations from the 2015 BHP Stakeholder group offer a comprehensive approach and rationale for pursuing a BHP for consideration by Oregon policy makers. The stakeholder group identified an approach to designing a BHP that may expand coverage to some of the remaining uninsured, offer more affordable coverage to Marketplace enrollees below 200 percent of FPL, leverage federal funding to help control long-term costs in Oregon's Marketplace, and further spread the coordinated care model (CCM) in the Marketplace.

The workgroup recommends that the Legislature carefully consider the important benefits of a BHP program and weigh those benefits against the implementation costs and technological barriers identified in the report. Although adult dental was not included in the preferred benefit package, the group strongly recommends that the Legislature determine if there's sufficient federal revenue to pay for this benefit. In closing, the BHP could be an opportunity to build on existing innovative state coverage and reform initiatives in Oregon. We hope the report offers a comprehensive assessment of the BHP for consideration by Oregon policy makers and stakeholders.

## **Roster: HB 2934 BHP Stakeholder Group (July-November 2015)**

### **Staff, Senator Chip Shields**

Senate Health Committee

### **Representative Alissa Keny-Guyer**

House Health Committee

### **Janet Bauer**

Policy Analyst

Oregon Center for Public Policy

### **Victoria Demchak**

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### **Jim Francesconi**

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### **D'Anne Gilmore**

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Department of Consumer and Business

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### **Robin J Moody**

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Health Systems

### **Hannah Rosenau**

Senior Policy & Access Coordinator

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### **Joseph Santos-Lyons**

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### **Martin Taylor**

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### **Danielle Sobel**

Associate Director of Health Policy

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### **Oliver Droppers V**

OHA, Division of Health Policy and

Analytics

## Background

In 2015, the Oregon Legislature passed House Bill 2934 tasking the Oregon Health Authority (OHA) with convening a stakeholder group to examine key policy issues related to the implementation of the federal Basic Health Program (BHP) in the context of Oregon's health care system. This work was to build on previous work of [House Bill 4109](#) (2014) that resulted in an independent [study](#) of the costs and impacts of a BHP in Oregon. The legislature required the group to submit their recommendations to the interim legislative committees by December 1, 2015.

A number of stakeholders were required to participate in this work (see roster):

- Advocates for low-income individuals and families;
- Advocates for consumers of health care;
- Representatives of health care provider groups;
- Representatives of the insurance industry; and
- Members from the House of Representatives and the Senate appointed by the chairs of the legislative committees related to health care.

## What is a BHP?

Beginning January 1, 2015, states have the option under the Affordable Care Act (ACA) to establish a Basic Health Program (BHP) to provide federally subsidized coverage to low-income individuals. The BHP serves as one of several insurance affordability programs (IAPs) offered through the ACA. In states that implement a BHP, BHP-eligible individuals cannot receive federal subsidies to purchase qualified health plans (QHPs) in the Marketplace. Rather, BHP consumers are enrolled in "standard health plans" (SHPs)<sup>4</sup> that cover the 10 essential health benefits (EHBs). The BHP effectively sits between Medicaid and Marketplace coverage.

A BHP program provides coverage to residents under age 65 who are:

- U.S. citizens with incomes between 138-200 percent of the FPL;
- Lawfully present immigrants<sup>5</sup> and COFA<sup>6</sup> individuals up to and including 138% FPL who are not eligible for Medicaid due to immigration status (i.e. have lived in the U.S. less than five years);<sup>7</sup>

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<sup>4</sup> Standard health plans may be sponsored by state-contracting HMOs, insurers, Medicaid or CHIP managed care organizations, provider networks, or other qualified entities.

<sup>5</sup> Lawful permanent residents (LPRs): people lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

<sup>6</sup> Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia.

- Ineligible for coverage under Medicaid, CHIP, or Military/CHAMPUS-TRICARE; and
- Lack access to employer-sponsored insurance (ESI) that meets ACA standards for comprehensiveness and affordability.

States can operate a BHP either as an extension of its Medicaid program or as an extension of the Marketplace. States that establish the program need to address a number of design elements for federal approval, ranging from benefits and cost sharing structure to the myriad of implementation options. Specifically, states implementing a BHP will:

- Receive federal funds equal to 95% of the premium tax credits and cost-sharing reductions a state's BHP enrolled population would have otherwise received to purchase a QHP coverage in the Marketplace;
- Provide federally mandated 10 essential health benefits (EHBs) through a managed care or similar system at a medical-loss ratio of no lower than 85%;
- Ensure consumer cost sharing is no greater than what enrollees would have paid in QHP coverage through the Marketplace;
- Offer standard health plans to BHP enrollees from at least two different offerors, with some exceptions; and
- Establish a competitive procurement process for selecting standard health plans.

### **HB 4109: BHP Study Results (2014)**

In the 2014, the Oregon Legislature passed HB [4109](#) requiring the Oregon Health Authority (OHA) to commission an independent study of the feasibility of operating a BHP in Oregon. Through a competitive bid process, the OHA contracted with national experts, Wakely Consulting Group and Urban Institute, to conduct the study and prepare a [comprehensive report](#). Key conclusions of the study were:

- An estimated 87,600 people would qualify for BHP in 2016; 61,400-66,300 individuals would enroll. This would result in a slight decline (5,400-9,900) in the overall number of uninsured in Oregon.
- Two different BHP scenarios were modeled. Neither scenario yielded a financial "break even" point for Oregon. Projections indicate deficits ranging from \$1.6-\$119.1 million in 2016.
- A BHP program would have a marginal impact on the individual market risk pool, carrier interest in the exchange Marketplace, and Marketplace stability.

The analysis in the 2014 report was dependent on a number of assumptions and limitations, some of which are highly variable. Several limitations identified were the analysis was limited to a single year, 2016, without projected costs for future years, did not

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<sup>7</sup> Five-year ban: under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.

incorporate annual changes to the 2<sup>nd</sup> lowest cost silver plan over a multiple-year period (used as the basis for determining federal BHP revenues), or assess whether providers would be willing to accept reimbursement rates similar to Medicaid levels. The report also did not address Oregon's transition to the FFM. For complete results including study limitation, please see the full report.<sup>8</sup>

### **HB 2934: Stakeholder Advisory Group Process (2015)**

From July through November 2015, the group met on six separate occasions to develop recommendations on the policy, operational and financial preferences for the design and operation of a BHP, in order to further the goals of reducing the cost of health care and ensuring all residents of this state equal access to health care. Staff with the Oregon Health Authority (OHA) and Department of Business and Consumer Services (DCBS) provided participants with an overview of the BHP, results from the 2014 BHP study, and shared data on Oregon's Marketplace including enrollment, premiums and federal subsidies available through the ACA. HB 2934 required the following:

- OHA to convene a stakeholder group to develop recommendations for the Legislative Assembly concerning the BHP.
  - Stakeholder advisory group to develop recommendations to address “*the policy, operational, and financial*” preferences of the group in the “design and operation” of a BHP.
  - Stakeholder advisory group's recommendations further the goals of the Legislative Assembly of “*reducing the cost of health care and ensuring all residents*” of Oregon have equal access to health care.
- OHA report recommendations to interim legislative committees no later than Dec. 1, 2015.

The advisory group carefully considered federal policy that governs the BHP including a requirement that states must offer at least two standard health plans (SHPs) that are selected through a competitive contracting process.<sup>9</sup> The group also considered issues around consumer affordability, provider reimbursement, several operational considerations, and different benefit designs (see next section). Towards the end of the process, participants reviewed several straw models that encapsulated preliminary design preferences expressed by the group. Based on the design principles and identified advantages and disadvantages, the group reached a consensus on the recommendations described in this report (see pg. 12).

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<sup>8</sup> Available: [http://www.oregon.gov/oha/OHPR/docs/OregonBasicHealthPlanReport\\_11.10.2014.pdf](http://www.oregon.gov/oha/OHPR/docs/OregonBasicHealthPlanReport_11.10.2014.pdf)

<sup>9</sup> Federal reqs ([42 CFR 600.420\(a\)\(1\)](#)) require states to have at least two carriers offer standard health plans in a BHP.

Outlined in Table 1 is the timeline and list of topics considered by the group.

<b>Table 1. Stakeholder Group Timeline – July-November 2015</b>	
<b>July 2<sup>nd</sup></b>	Initial convening of stakeholder group; outlined key findings from 2014 BHP study.
<b>July 29<sup>th</sup></b>	Reviewed federal guidance related to the BHP; considered consumer affordability, premium and cost-sharing options for BHP, and levels of benefit coverage.
<b>Aug. 13<sup>th</sup></b>	Reviewed delivery systems, contracting and provider networks, and provider reimbursement.
<b>Sept 16<sup>th</sup></b>	Assessed operational and financing considerations; identified initial design preferences.
<b>Oct 8<sup>th</sup></b>	Evaluated straw models and identified initial set of recommendations including guiding principles.
<b>Nov 5<sup>th</sup></b>	Reviewed draft report and adopted recommendations.

### **Principles for Designing and Selecting a BHP in Oregon**

The group opted to develop a set of principles used as decision-making criteria in selecting the preferred design and approach for a BHP in Oregon. These include:

- Increase access to coverage for uninsured, including those ineligible for Medicaid, and Oregon’s COFA population<sup>10</sup>
- Increase affordability of coverage for low-income Oregonians
- Reduce churn by minimizing and mitigating the frequency of and impact from coverage transitions, including the benefit cliff among federal insurance affordability programs (IAPs)
- Sponsor an accountable care model using a measurement framework to incentivize quality and population health improvements
- Promote a sustainable and predictable rate of growth (e.g. 3.4 percent in Medicaid, PEBB, and OEBB)
- Maintain a healthy and vital Marketplace and spread the coordinated care model (CCM)
- Exercise stewardship of State resources by maximizing federal resources available through the ACA

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<sup>10</sup> Compact of Free Association (COFA): refers to individuals from the Republic of Palau, the Republic of the Marshall Islands and the Federated States of Micronesia. For more info, please see COFA Alliance National Network (CANN): [www.cann.us](http://www.cann.us)

## Program Design and Operational Considerations

The stakeholder advisory group reviewed a number of policy considerations regarding preferences for designing a BHP including delivery system options. The key policy considerations, although not exhaustive, are summarized below.

### Delivery System Options for Offering a BHP

The group considered four potential options to offer standard health plans (SHPs) in Oregon based on the state's existing delivery system:

1. Marketplace: competitive contracting process for commercial health plans to offer BHP options.
2. Coordinated care organizations (CCOs): seek federal permission to waive the two plan offerings and competitive contracting requirement; contract directly w/ CCOs to offer BHP.
3. Stand-alone option: state contract directly with carriers to offer BHP (e.g. PEBB/OEBB).
4. Alternative hybrid model: competitive contracting among CCOs and QHP carriers through Marketplace (pending federal/state approval).

**Consumer affordability:** consider the fiscal impact to consumers in terms of out-of-pocket options including potential savings by selecting preferred premiums and cost-sharing levels for BHP enrollees in Oregon. A critical issue is how to improve affordability of coverage for individuals between 138-200% FPL as compared to the required federal contribution to premium and maximum out-of-pocket costs (OOP) in the Marketplace.

**Benefit coverage:** several different benefit packages were considered, Medicaid/OHP and the 10 essential health benefits (EHBs) package offered in the Marketplace.<sup>11</sup> A key difference between the two packages is adult dental, which is not an EHB in the Marketplace. In addition, Medicaid covers a range of services either not typically covered by commercial health insurers or covered with limitations such as non-emergency medical transportation (NEMT), hearing aids, and mental/behavioral health services without limitations.

**Eligibility and enrollment:** two different approaches were assessed: (1) Medicaid continuous, open enrollment, and (2) Marketplace's open enrollment period (OEP) and

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<sup>11</sup> See: [PacificSource Health Plans Preferred CoDeduct Value 300 plan](#).

special enrollment period (SEP). The group also considered whether enrollees should have 12-month, continuous eligibility.<sup>12</sup>

**Delivery system:** evaluated a BHP offered through “standard health plans” (SHPs) as a part of Medicaid, offered by coordinated care organizations (CCOs), or through the Marketplace. Federal regulations<sup>13</sup> require states to offer a choice of SHPs through a competitive contracting process. According to CMS, an exception to the requirement to implement a competitive contracting process was only available for program year 2015.<sup>14</sup> If offered through CCOs, Oregon would likely need the Centers for Medicare and Medicaid Services (CMS) approval to waive two federal requirements: (1) ensuring consumers have a choice of at least two carriers, and (2) competitive contracting in selecting SHP carriers.

**Provider reimbursement:** several different reimbursement levels were considered: Medicaid, commercial (100%), Medicare (77% of commercial), and an in between rate (~81% of commercial, higher than Medicaid and Medicare, but lower than commercial reimbursement). Provider reimbursement effect issues of participation and network adequacy, carrier interest, and overall financial viability of the program. A key concern raised by the group was provider willingness to accept reimbursement rates significantly lower (i.e. commercial) for individuals already enrolled in Marketplace coverage between 138-200% of FPL.

In addition to the policy considerations, several operational and financing considerations were also reviewed as part of the stakeholder process, summarized below.

**Enrollment and eligibility system:** as a federally-supported State-based Marketplace (SBM), setting aside critical questions around IT feasibility, Oregon currently has two options to manage eligibility determination and enrollment: (1) OHA’s new Medicaid eligibility system, or (2) the Federal Facilitated Marketplace (FFM). The critical IT feasibility issue the group considered is whether CMS will be able to accommodate BHP eligibility determination for states that are a federally-supported SBM in 2017 or 2018. As of October 2015, CMS has indicated they are not able to support BHP through the FFM as it cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

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<sup>12</sup> CMS federal [regs](#): States have the option of only redetermining eligibility every 12 months, regardless of any changes in income or other circumstances, as long as the enrollee is under age 65, is not otherwise enrolled in minimum essential coverage (MEC), and remains a residents of the state.

<sup>13</sup> See 42 [CFR](#) 600.420(a)(2)

<sup>14</sup> See 42 [CFR](#) 600.410(c)(1) and 600.410(c)(3).

**Financing:** federal funds cannot be used for development, start-up, or ongoing administration costs. Consequently, Oregon needs to determine what, if any, source(s) of funding would be available for BHP start-up (including eligibility system modifications, plan procurement, actuarial work, etc.) and ongoing administration (consumer outreach & assistance, premium billing if relevant, appeals, general program costs).

### **Stakeholder Constraints**

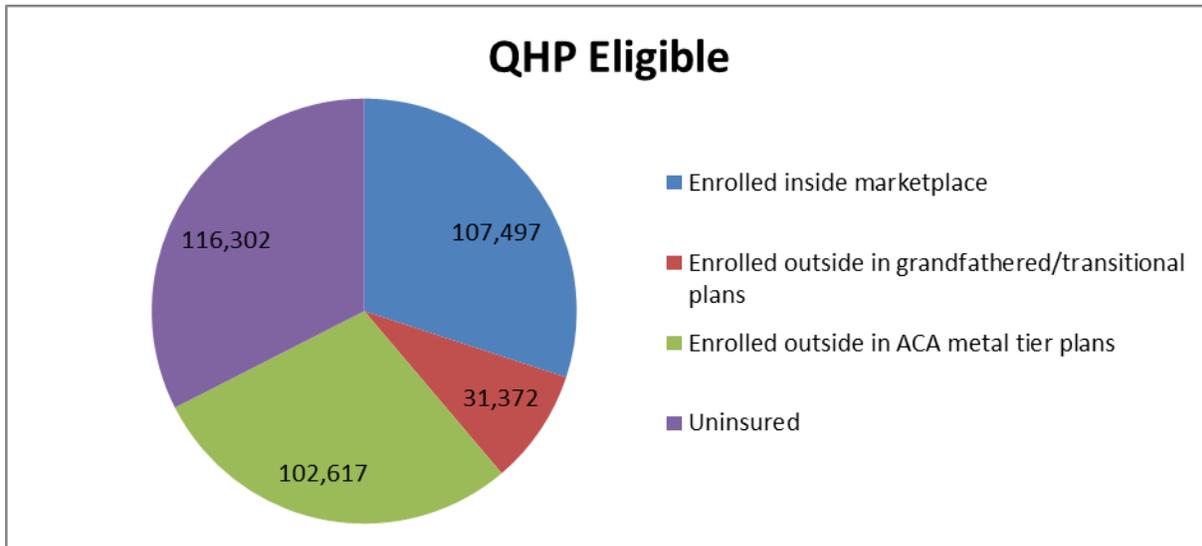
The group was directed to rely upon the study results from 2014. During the process, several members of group asked if OHA staff could update the study results based on the preferences expressed by the group. The legislature did not allocate any funding for HB 2934; thus, OHA was unable to update the 2014 study. As a result, the group did not have more recent actuarial data and current estimates of federal BHP funding (e.g. 2016/17) in making their recommendations.

### **Oregon's Marketplace**

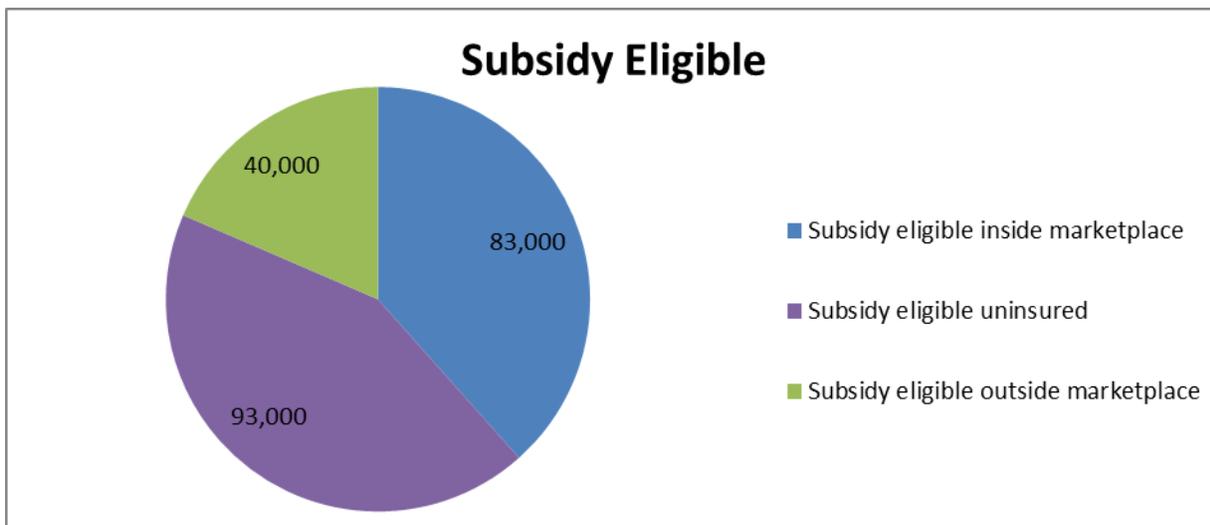
Using 2015 Marketplace enrollment data, the group examined the potential impact of a BHP on the Marketplace. The group assessed the number of individuals enrolled inside the Marketplace in 2014 and 2015, as well as the remaining uninsured below 200% of FPL (See Figures 1 and 2; Tables 1-3, and 5), including how many adults with Marketplace coverage opted to enroll in stand-alone dental (see Table 4).

Based on the information below, the group concluded that the BHP could potentially offer an opportunity to enroll a *sizable* portion of the remaining uninsured below 200% of FPL. Participants also acknowledged, that based on 2015 enrollment, approximately 42% of individuals currently enrolled in QHP coverage fall below 200% of FPL. Depending on how the BHP is setup (Medicaid vs. Marketplace), participants raised the question about the impact to Oregon's Marketplace (see Tables 3 and 5). However, DCBS maintained that the Marketplace was flexible and had the capacity to adapt, if policymakers decided to establish a BHP separate from the QHP-eligible population. Participants also considered consumer affordability based on the 2016 Marketplace premiums and advance premium tax credits (APTC) (See Table 6).

**Figure 1. Eligibility for Qualified health Plans (QHPs)<sup>15,16</sup>**



**Figure 2. Premium Subsidy Eligible Oregonians<sup>17, 18</sup>**



<sup>15</sup> Best estimates based on demographic and plan selection data on persons who selected a plan at HealthCare.gov, enrollment data reported by carriers to the Oregon Insurance Division, and a U.S. Department of Health and Humans Services (HHS) commissioned analysis of Oregon’s eligible population.

<sup>16</sup> Please Note: This graph has been corrected since first presented in September 2015. In September, the total enrolled outside in ACA metal tier plans was listed as 107,363 and the total enrolled outside in grandfathered/transitional plans was listed as 26,626. The total enrollment outside the marketplace is still the same (133,989), but the split is actually 102,617 in ACA metal tier plans and 31,372 in grandfathered/transitional plans.

<sup>17</sup> See above.

<sup>18</sup> The estimated 93,000 subsidy eligible uninsured does not include uninsured who are ineligible to purchase QHPs.

**Table 2. Marketplace Enrollment 2<sup>nd</sup> Quarter 2015**

Enrollment By Plan Types 2015 <sup>19</sup>								
Plan types	Cata-strophic	Bronze	Silver	Gold	Platinum	2015 Marketplace Total	2014 Marketplace Total	2014 to 2015 Marketplace Change +/-
<b>Total</b>	752	27,839	68,713	9,294	899	107,497	76,514	30,983

**Table 3. Marketplace Enrollment <200% FPL**

Marketplace Enrollment <200 % FPL (2 <sup>nd</sup> quarter, 2015) <sup>20</sup>		
0-200% FPL	2015 Marketplace Total	% Enrollment in QHP <200% FPL
46,116	107,497	42.9%

**Table 4. Dental Plan Enrollment**

Adult Dental Plan Enrollment <sup>21</sup>	
2015 Marketplace Total	% Enrollment in QHP <200% FPL
21,592	Unknown

**Table 5. Uninsured QHP Eligible below 200% FPL<sup>22</sup>**

Approximate QHP Eligible Uninsured Below 200% FPL	
FPL	Number of persons
138-150% FPL	2,938
150-200% FPL	22,108
<b>Total</b>	<b>25,046</b>

<sup>19</sup> Data Source: Oregon Insurance Division (OID) Quarterly Enrollment Report

<sup>20</sup> Information reported by Department of Human and Health Services (DHHS)

<sup>21</sup> Adults with dental-only plans: unknown what number/percentage of adults <200% FPL enrolled in QHPs purchased dental.

<sup>22</sup> Estimate made by HHS commissioned consultant during open enrollment in February 2015, when 99,000 persons of all incomes had selected a Marketplace plan.

**Table 6. 2016 Marketplace Premiums and APTC**

Individual Required to Pay				Total Premium with APTC			
1 Household 2016	Household Income (2015 FPL)	Percentage of income Individual will pay toward premium for 2 <sup>nd</sup> lowest silver <sup>23</sup>	Premium Cap (annual maximum contribution to premium paid by the individual)	Second Lowest Silver Plan Premium*	Number of Months Premiums Paid	Annual Premium	Total Covered by CMS with APTC <sup>24</sup>
133% FPL	\$15,654	2%	\$318	\$261	12	\$3,132	\$2,814
150% FPL	\$17,655	4%	\$719	\$261	12	\$3,132	\$2,413
200% FPL	\$23,540	6%	\$1,509	\$261	12	\$3,132	\$1,623
250% FPL	\$29,425	8%	\$2,407	\$261	12	\$3,132	\$775

<sup>23</sup> Based on 2<sup>nd</sup> lowest approved standard plan silver rate for age 40, single, non-tobacco users in Portland metro.

<sup>24</sup> Does not include savings for those who also qualify for cost share reduction, which may reduce their coinsurance, copays, deductibles and maximum out-of-pocket. A single person household at 300% of FPL could qualify for APTC in some areas of the state, such as Eastern Oregon, Deschutes Co., and some coastal counties where premiums exceed the affordability premium cap set for APTC.

## **Potential Advantages and Disadvantages: Recommended Framework**

The group's recommendations are based on a set of principles (see pg. 4), data from Oregon's Marketplace, identified advantages and disadvantages with offering the program, and federal regulations. At the group's first in-person meeting (July 29<sup>th</sup>), Representative Greenlick posed a fundamental question for the group: "*What's the issue that the BHP is attempting to address in Oregon?*" In response, at each meeting the group identified a set of potential advantages and disadvantages. It is important to note that several of the identified advantages and disadvantages are contingent on the design of the BHP. Summarized below are the advantages and disadvantages of a BHP in Oregon.

### ***Potential advantages:***

- Increase affordability with more low-income individuals able to afford coverage by reducing premiums and cost sharing for low-income individuals;
- Expand coverage and access to care for some of the remaining uninsured 0-200% FPL;
- Reduce churn below 200% by smoothing transitions as incomes fluctuate at 138% FPL, potentially reduce rate of pregnancy related churn between Medicaid and the Marketplace;
- Reduce potential net reduction in income for individuals moving from Medicaid to Marketplace coverage (i.e. the benefits cliff);
- Offer additional benefit coverage and encourage appropriate use of primary and preventive care (e.g. by removing copayments);
- Opportunity to expand the Oregon's coordinated care model to the Marketplace; and
- Incorporate a sustainable rate of growth, creating potential long-term savings by controlling annual costs.

### ***Potential Disadvantages:***

- Federal funding may not cover cost of plans leading to financial exposure for the State, and
- State funding for start-up and ongoing administrative costs.

## Recommended BHP Framework

The stakeholder group decided upon the following design framework and program structure.

Hybrid-Marketplace	
<b>Delivery System</b>	CCOs and commercial QHPs plans compete for BHP enrollees using principles of Oregon’s coordinated care model (CCM)
<b>Benefit Coverage</b>	Full Medicaid benefit level without adult dental
<b>Provider Reimbursement</b>	Average of Medicaid and Commercial (~81% of Oregon’s commercial reimbursement rate)
<b>Premiums &amp; Cost-sharing</b>	<138% FPL, \$0; 138-200% FPL graduated premium structure; no cost-sharing
<b>Eligibility &amp; Enrollment</b>	Marketplace standards; 12-month, continuous eligibility; FFM eligibility system (federal hub)*
<b>Consumer Choice</b>	Standard Health Plan (SHP) offerings via Marketplace
<b>Administrative Functions</b>	Marketplace and carriers (client services, grievances, premium billing)
<b>Sustainable Growth Rate</b>	Annualized sustainable fixed rate of growth; methodology and rate to be determined by Legislature

\*The FFM cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations.

Summarized below is the group’s rational for selecting their preferences in designing a BHP.

**Delivery system:** there are advantages and disadvantages with operating a BHP through the Marketplace or as a State Medicaid program. Several members of the group shared concerns with the potential impact on the Marketplace outside of the results provided in the 2014 BHP study report. Participants evaluated whether to offer BHP coverage through a traditional insurance product or incorporate a CCO like-design, specifically, adopting the principles for Oregon’s coordinated care model (CCM).<sup>25</sup> As demonstrated by CCOs, Oregon’s CCM is making progress by bending the cost curve and has demonstrated measurable improvement in quality and integration of services.<sup>26</sup> Another design consideration identified by participants was to incorporate a fixed and sustainable rate of growth. Specifically, establishing a sustainability rate of growth including a methodology that mirrors Oregon’s approach in CCOs, and is now also a requirement in PEBB and OEBC.

<sup>25</sup> For more info, see Oregon’s Coordinated Care Model Alignment [Work Group](#).

<sup>26</sup> See Oregon’s Health System Transformation 2014 [Final Report](#).

This approach aligns with the recommendations and strategies put forward by the Oregon Health Policy Board in 2013 to align implementation of the ACA in Oregon.<sup>27</sup>

**Benefit coverage:** the group identified that offering OHP as a single benefit package for all BHP enrollees would be more protective for this low-income population. It would also support administrative simplification of the program, potentially resulting in lower administrative costs, and create less confusion among providers serving both Medicaid and BHP enrollees. In terms of cost drivers with the BHP, offering dental benefits is the largest and most costly benefit when comparing benefit differences between Medicaid and the Marketplace. Census was not to include adult dental in benefit package unless the legislature decides there's sufficient federal revenue to pay for this benefit.

**Provider reimbursement:** the group recognized that there would likely be significant reservations among certain providers if a BHP were offered with rates considerably lower than currently offered by commercial plans (i.e. QHPs). It was acknowledged that offering a BHP based on Medicaid rates could limit provider and/or carrier participation, potentially creating an access issue for BHP enrollees, and thus limited in terms of statewide feasibility.

- The group ultimately recommended a reimbursement rate that would serve as a mid-point between Medicaid and commercial, but higher than Medicare. The rationale is providers may be supportive of expanding coverage but unwilling to accept Medicare level reimbursement or even lower, Medicaid (e.g. ~81% of commercial, ~18% higher the Oregon Medicaid rate). A concern expressed was that providers would receive a considerable decrease in reimbursement for those individuals already enrolled in the Marketplace, approximately a 19% reduction in reimbursement compared to Oregon's commercial reimbursement rate.

**Consumer cost-sharing:** the group agreed to increase affordability for individuals by removing deductibles and co-pays for direct services, costs which potentially create barriers to care. The group agreed to no-cost or premiums below 138% of FPL and a graduated premium tier structure for those between 139-200% FPL (similar to New York's BHP model). The focus should be on premiums rather than co-pays due to administrative complexities and encouraging access to care.

**Eligibility and enrollment:** the group preferred enrollment via the Marketplace's open enrollment period (OEP) and special enrollment period. The group also opted for 12-month, continuous eligibility once enrolled. The group did not decide on the issue of

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<sup>27</sup> See Oregon Health Policy Board (Dec. 2013). [Report](#) Recommendations for Aligning Affordable Care Act implementation with Oregon's health system reform.

disenrollment upon non-payment of premiums as this would require additional study to understand the potential impact.

To create savings to Oregon's budget, the group also considered transitioning Medicaid pregnancy coverage between 139-185% into a BHP that could potentially generate annual state savings of up to \$12 million.<sup>28</sup> Pregnancy-related CAWEM could be an additional population to consider. Any such changes would require consultation with CMS and legislative approval.<sup>29</sup>

Based on the recommendations, the group suggests the following next steps:

- 2016—Develop federal CMS Blueprint
- 2017—Introduce enabling legislation;
- 2018—Implement, contingent on federal approval and IT feasibility

## Federal Blueprint

States considering the BHP must make a number of policy and operational decisions prior to requesting federal approval. To date, two states currently offer the BHP, both of which support a state-based Marketplace (SBM) and provide state funding for the BHP. As of 2015, Oregon relies on the Federal Facilitated Marketplace (FFM) to determine eligibility for federal subsidies through the Marketplace. As previously stated, CMS informed Oregon they are currently unable to develop and modify the federal eligibility system (FFM) needed to implement the BHP in Oregon in 2016 or 2017.

**How the Blueprint Works:** The Blueprint is the official form states must use and is intended to collect the program design choices of the state while providing a full description of the operations and management of the program and its compliance with the federal rules. The Blueprint must also be accompanied by a funding plan that provides for any non-federal funding that will be used to pay for benefits or services not covered by federal funds available through the BHP. The Blueprint:

- Provides vehicle for CMS to grant BHP certification to states choosing to operate a BHP.
- Demonstrates compliance with program standards and show operational readiness.
- Incorporates funding plan for first 12-months of operations.
- Grants operational authority but does not obligate state to operate BHP.

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<sup>28</sup> See Oct. 8<sup>th</sup> 2015 HB 2934 Stakeholder Advisory Group presentation [materials](#).

<sup>29</sup> Citizen Alien Waived Emergent Medical ([CAWEM](#)): is Medicaid program in Oregon that covers provide health benefits for individuals not eligible for Medicaid services due to citizen/alien status.

## Conclusion

The BHP is an insurance affordability program (IAP) established by the ACA, that offers coverage in lieu of Marketplace coverage for individuals with incomes between 138-200% of the federal poverty level (FPL) and for individuals lawfully present up to 200% FPL but do not qualify for Medicaid due to their immigration status. Per HB 2934, the stakeholder advisory group recommends a number of financial, policy and operational preferences.

If the Oregon Legislature opts to pursue a BHP in Oregon based on the proposed design principles and framework, the BHP provides an opportunity to expand coverage to some of the remaining uninsured, offer more affordable premiums and cost-sharing for low-income residents, potential increase in federal funding to cover additional populations in combination with a federal 1332 waiver, and leverage control over health care costs in Oregon's Marketplace. The BHP also provides the State of Oregon an opportunity to spread the coordinated care model (CCM) beyond Medicaid, PEBB, and OEBB.

The workgroup recommends that the Legislature carefully consider the important benefits of a BHP program and weigh those benefits against the implementation costs and technological barriers as outlined in this report. In closing, the BHP could be an opportunity to build on existing innovative state coverage and reform initiatives in Oregon. We hope the report offers a comprehensive assessment of the BHP for consideration by Oregon policy makers and stakeholders.

## Attachments

1. HB 2934 (2015)

**Enrolled**  
**House Bill 2934**

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER .....

AN ACT

Relating to access to health care; and declaring an emergency.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** (1) **The Oregon Health Authority shall convene a stakeholder group consisting of:**

- (a) Advocates for low-income individuals and families;**
- (b) Advocates for consumers of health care;**
- (c) Representatives of health care provider groups;**
- (d) Representatives of the insurance industry; and**
- (e) Members from the House of Representatives and the Senate appointed by the chairs of the legislative committees related to health care.**

**(2) The first meeting of the group shall occur no later than 30 days after the effective date of this 2015 Act.**

**(3) The group shall provide recommendations to the Legislative Assembly regarding the policy, operational and financial preferences of the group in the design and operation of a basic health program, in accordance with 42 U.S.C. 18051 and 42 C.F.R. part 600, in order to further the goals of the Legislative Assembly of reducing the cost of health care and ensuring all residents of this state equal access to health care.**

**(4) The group shall, in its deliberations, consider the findings from the independent study commissioned under section 1, chapter 96, Oregon Laws 2014.**

**(5) The authority shall report the recommendations of the group to the interim legislative committees related to health care no later than December 1, 2015.**

**SECTION 2.** Section 1 of this 2015 Act is repealed December 31, 2015.

**SECTION 3.** This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.

**Passed by House April 20, 2015**

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

**Passed by Senate May 26, 2015**

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Peter Courtney, President of Senate

**Received by Governor:**

.....M,....., 2015

**Approved:**

.....M,....., 2015

.....  
Kate Brown, Governor

**Filed in Office of Secretary of State:**

.....M,....., 2015

.....  
Jeanne P. Atkins, Secretary of State