Basic Health Program
HB 4017 Advisory Group Meeting
October 14, 2016

Summary of Questions and Comments

Note: Some of the questions and comments are addressed more thoroughly in the October 20, 2016 draft of the DCBS Response to Wakely/Urban Oregon BHP Study.

Wakely Consulting Group & Urban Institute Oregon BHP Study

Provider Rates

Q. Did Wakely consider what will happen on the provider side? Everyone who would enroll in a BHP is or could be enrolled in a QHP, where all providers are currently paid current commercial rates, and a BHP would only pay providers 81%. Did the Wakely Study reflect the likely cost shift when providers take a rate cut such as this in order to serve the BHP population?

A. No adjustments were made to reflect any effect in the remaining exchange marketplace in terms of the lower BHP reimbursement rate pushing up the cost. Logically this makes sense, but it is not modeled. Wakely agreed that could be noted in their final report document.

Q. This population was underinsured pre ACA and suddenly these people were insured and the providers were getting paid commercial rates, did those increases in rates and payment have an effect on price? Did providers bring their costs down?

A. That is a complicated question. There are differing opinions regarding cost-shifting and it is difficult to quantify. Research on cost-shifting has come to very different conclusions, with different outcomes in different markets.

Consumer Savings

Q. Table ES3 on page 5 shows average out-of-pocket savings for uninsured individuals are higher for scenarios with 50% cost sharing and lower where there is no cost-sharing. That seems counter-intuitive.

A. The biggest driver is the people who come into each of these situations are different and have different comorbidities. Also the uninsured savings calculation assumes that the uninsured behaves in the same way as insured.

Possible QHP Enrollees
Q. Do the people in Tables 2.3 and 2.4 include undocumented immigrants?

A. No, they are not eligible for BHP or tax credits on the marketplace. (DCBS noted that estimates for unauthorized immigrants are included in the DCBS response, but the Wakely/Urban scope of work was to consider BHP-eligible population only.)

Q. Can there be a greater explanation of the difference between Table 2.3 and 2.4?

A. Table 2.3 estimates enrollees in nongroup (individual) market in Oregon inside and outside the Marketplace, without a BHP. Table 2.4 estimates total BHP enrollee uptake in different BHP subsidy options.

Q. What children would be covered under BHP? Would expect none.

A. It would be very few, but could include some. (e.g., A pregnant woman who chose to stay in BHP is counted as a two-person household. Most would go to Medicaid.)

Effect on Individual Market Premiums
Q. How did Wakely study arrive at the 1.5% increase in individual market rates as the result of a BHP? It seems like it should be higher.

A. The narrow explanation is that Wakely looked only at people who would move away from the exchange to BHP, and determined their average morbidity level considering age, sex, tobacco factors. Wakely found that those remaining in QHP would have slightly higher average morbidity. Wakely found that the average morbidity factor increased by more than the average age factor for those remaining in the Marketplace, which implied that carriers would need to increase rates by 1.5%.

DCBS Response to Wakely/Urban Oregon BHP Study

Policy Concerns

Affordability and Access
Q. How many people on bronze plans pay little to no premiums and may be adversely affected by a BHP because they would be paying a premium?

A. We know only how many people who qualify for CSR plans based on household income actually enroll in a CSR plan, but cannot distinguish between those who fail to enroll in CSR plans because they are confused by low/no premium bronze plans and those who deliberately choose a bronze plan. We will add the count to DCBS response. (Note: It was a little more than

16,000 persons below 200% FPL in 2016.) Agents commented that they sometimes work with people who insist on bronze plans, even when counseled about the advantages of the CSR plan, though bronze plans can be a good choice for some.

Q. If there is an opt-out for people to get out of the BHP, could those folks just participate on the exchange?

A. If a state does a 1331 waiver to operate a BHP, there is no opt out. Every adult below 200% FPL, who is ineligible for Medicaid, would be offered only BHP.

Q. What happens if the individual doesn't pay their premium?

A. They would be uninsured or at least not insured through the BHP. Like a QHP, there could be grace periods and reenrollment opportunities.

Comments:

- If we have a BHP, you take away the choice from the consumers to choose bronze or silver plans that works well when they are informed.
- There could be continuity of care complaints, because with a BHP we are removing the choice of keeping your silver level plan.
- How many insurers will actually participate in this and how will networks be built?
- An access issue not in the DCBS policy report is that it is unknown how providers will respond to reduced reimbursement. You are asking for them to take a rate cut and to build a network of providers who are willing to participate.
- At federally qualified health centers, we are interested in serving these people. We see underinsured patients now. They have insurance, but tell us they can't afford to go to the doctor because of the cost-sharing, so we provide them care.
- Regarding consumer choice, is there value in having a bronze plan to the individual and to the overall system cost? In Medicaid there are not many conversations around choice, with a defined benefit and people have only one plan. There is no anxiety because the public is paying and it provides a societal benefit. With BHP the government is paying for it and identifying the benefit structure.
- May be helpful to reflect more fully the savings for the out-of-pocket cost in the response, specifically savings to people who are previously uninsured.
- Fair to note in coverage gaps the support BHP could offer in terms of affordability for dental, if the State subsidized that coverage.
- A BHP would protect consumers from issues around premium tax credit reconciliation.

Equity and disparities

Q. Report says BHP would increase disparities for people who wouldn't get assistance from BHP. I find this a puzzling framework because it makes it seem the BHP is doing harm to people who are not being helped, i.e. people in the family glitch.

A. It isn't that BHP makes people worse off; in most instances it would exacerbate the existing disparity between those who are eligible and those who are ineligible for QHP subsidies because of the greater subsidy for BHP.

Q. Another population not being served by the BHP is undocumented individuals, if we are looking at the gaps and have an overview, the undocumented population must be included.

A. The Wakely/Urban analysis and the DCBS response looks at similarly situated households of lawfully present Oregon residents. However, DCBS recognizes this serious gap. Unauthorized immigrants health coverage is addressed in a footnote on page 8 of the draft, but we considered making this more prominent.

Comments consensus – make the unauthorized immigrants health coverage issues more prominent.

Uninsured Rate

No questions or comments.

Individual Market Stability

Comments:

- From the agents' perspective, we have seen a lot of changes in the individual market (i.e. lack of carriers in areas). Seems like there is potential by pulling people out of QHP into BHP may cause more market instability and also may impact market uninsured rate. The 1.5% impact on individual rates seems like a low number, especially due to what we have seen as a trend.
- Agree that 1.5% seems low and agree about the possible impact on QHP and market stability.
- In the individual market we've gone from a dozen carriers, to 6 or 7 and the same thing is occurring in the larger metro area.
- I feel the same way, market stability is important. The Wakely/Urban report states any increase would effect only people over 400% FPL, but believe it has a larger effect.
- Agents are seeing a lot of plans leaving the marketplace. The Medicaid market is stable, companies are making money. Question: how do we export the qualities making

Medicaid stable into the individual portion of the marketplace to help stabilize? The BHP may be a way to bring in other carriers who understand this market and the consumers. I expect a decrease in the Medicaid population because the economy is picking up.

- There are differences between Medicaid and commercial. Most major commercial insurers are engaged in serving Medicaid market. The fundamental differences why the Medicaid market is so stable versus the commercial market: 1) provider rates critical and 2) drug pricing. Achieving Medicaid rates for provider or drug pricing would be very difficult for the commercial population. The care coordination model would be beneficial to bring over, but some of the cost-savings cannot map over.
- Would commercial insurers be able to have a conversation regarding provider rates, and a conversation regarding drug costs?
- The DCBS response may need more explanation about the fact that separate risk pools are created with the BHP. You are creating different products in different risk pools. That is a real concern.

Churn and Simplicity

Comments:

- To simplify the message to the consumer would be a huge component to effectively pull this off. There is significant confusion helping consumers navigate the Medicaid system and the FFM system. Adding a third system can be extremely confusing. This needs to be presented as one of the challenges. Look at what systems can be created to help mitigate the confusion with the consumers. People will be lost all together and leave the system, because they get confused.
- This will be creating a trap for people if we cannot make this clear enough for people to know what they are even eligible for.
- There is already frustration now between the FFM and Medicaid. I have great concern over whether adding BHP could create another layer of complexity, particularly for those with chronic disease management issues. Issues from a care coordination and quality perspective. It's not enough to just make sure folks stay insured; need to maintain care coordination.
- In my experience when someone is no longer eligible for Medicaid, and the doctor they have been seeing is not in their QHP network and that individual must choose an entirely new provider group or doctor is very distressing.
- In the conclusions, DCBS should add a bullet that emphasizes the challenges between the existing two systems and that adding a BHP might add to that challenge. Should also add bullets for people going from one segment to another and unable to maintain their

provider and for the cost of creating an eligibility system – the cost for a third system cannot be overemphasized.

- There would need to be significant training on BHP and transition between the three programs.
- I participated last year on the BHP task force (Oregon Health Authority's BHP Stakeholder Group). Care coordination and churn were at the forefront of decision-making. BHP would have to conform with Oregon's CCO model and the task force envisioned that CCOs would be a natural contractor for BHP because they already do care coordination.
- BHP adds another layer of complexity, assuming that we are staying with our current IT infrastructure. This picture would look different if we had our own technology.

Q. Concerned about 3rd point in this section, saying that some plans would *"likely"* be different than plans in Medicaid.

A. We can change the term "likely" to "possibly" since any difference would depend upon design.

IT Infrastructure

Comments:

- If there was one portal, the three different programs would be invisible to the consumer. Without that, all of the messaging around go to HealthCare.gov could cause more confusion. It would be setting people up for an impractical solution to churn and simplicity.
- (Provided via email after the meeting.) I cannot over emphasize the fractured nature of our current enrollment system for OHP and QHP. The FFM platform has many shortcomings. It is really an information gathering system that sends data (poorly at that) to carriers and OHP. The shortcomings of having two systems and potentially three are beyond what I can describe. This needs to be stressed in conclusions, as well as the cost of a new system to handle a BHP or even OHP or QHP (like Cover Oregon's system originally was supposed to do). Legislators need to recognize the actual cost of these system changes.

General

Coordinated Care Model
Comments

- It might be helpful to have a section around what are the advantages of moving this model to the CCO. As we look to alternatives, we must consider the coordinated care model. In the conversation about 1332, we really need to be in touch with next federal administration.

- There are commercial products that cannot be turned into a CCO.

- The CCOs are independent entities and not tied exclusively to Medicaid contracting.

Possible Alternatives

Comments

- You can do a lot of premium and cost-sharing assistance for the cost of expanding COFA for all lawfully present immigrants. We should be looking at a robust premium and cost-sharing program subsidy for everyone below 200% FPL.

- If one intention of BHP is to help underserved populations, can we leverage something like FHIAP to fill in gaps. It was not part of tax code, it helped reach certain population segments?

- (Provided via email after the meeting) FHIAP is an interesting idea…it used an existing system on delivering plans. Is that something we could or should look at?

Public comment
John Mullin, Oregon Law Center, stated he wanted to underscore from advocacy perspective, the importance of inclusion, affordability and innovation and to encourage everyone to hold true to those ideas moving forward. Asked how can we get closer to 100% insured? He reminded the Subcommittee of HB 4017 requirements to produce a blueprint that considers all these concerns. Undocumented populations and low-income Medicare households are good populations to bring up; they may be outside the scope of HB 4017 but it underscores the context of what the challenges are.