

Progress Report to the 2017 Oregon Legislature

Consideration of Increasing Access to Affordable, High-Quality Health Care with Section 1332 Affordable Care Act Waiver or Alternative Strategies

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Executive Summary

Introduction

As directed by Section 2, Subsection (1) of House Bill 4017 (2016), the Department of Consumer and Business Services (DCBS) established a subcommittee of the Marketplace Advisory Committee to consider issues preventing Oregonians from receiving quality affordable health care, and to determine if a 1332 waiver would be useful in resolving those issues.

The subcommittee also considered — as instructed by House Bill 4017 — ways to meet objectives of the Basic Health Program. The Legislature’s instructions permitted the subcommittee to frame those recommendations either within or outside of the 1332 waiver structure.

1332 Waivers

Under Section 1332 of the Patient Protection and Affordable Care Act (ACA), a state may apply for a waiver for specific sections of the ACA to provide better insurance coverage or care to its residents. Waivers can modify the individual or employer mandates, benefits or subsidies, Qualified Health Plan (QHP) certification, or role of the exchange in eligibility determination and enrollment. A 1332 waiver must protect consumers by maintaining coverage levels at the same or greater benefit and affordability levels as those that existed before the waiver, must provide coverage to at least as many consumers, and cannot increase the federal deficit.

To apply for a waiver, states must submit an application to the Department of Health and Human Services (HHS) and the Department of the Treasury. States must ask for public comment before submitting an application and after HHS and Treasury deem the application complete. The application will be accepted or rejected within 180 days after application is deemed complete.

Issues Preventing Access to Affordable Health Care in Oregon

The subcommittee discussed a number of issues that may prevent Oregonians from receiving affordable, high-quality health care. Many of these issues affect consumers with incomes less than 200 percent of the federal poverty level (FPL), and include issues identified in DCBS’s [response](#) to the [Oregon Basic Health Program Study Findings](#) prepared by Wakely Consulting Group and the Urban Institute.

The subcommittee identified possible strategies to resolve these issues, such as expanding the subsidy model used for the Marketplace’s Compact of Free Association (COFA) program. Such a model would cover all lawfully present individuals with incomes of less than 138 percent FPL who are subject to the five-year ban on Medicaid eligibility. Other strategies included increasing the quality of QHPs by including coordinated care model characteristics, increasing outreach to

help individuals navigate the differences between bronze plans and silver plans with cost-sharing reductions, and helping families that are paying substantially more for employer-sponsored coverage than their counterparts in the individual market.

HB 4017 Subcommittee Recommendations

At this time, the subcommittee recommends that Oregon not pursue a 1332 waiver, due to the lengthy application process and uncertainty about future federal health care reforms. Many of the strategies suggested by the subcommittee can be implemented without a 1332 waiver. The usefulness of a 1332 waiver should be re-evaluated in the future when new federal guidance is available.

The subcommittee recommends the Marketplace begin working with insurance carriers to increase the use of the coordinated care model in QHPs. The subcommittee also recommends the Marketplace expand outreach and education to consumers who may be at risk for purchasing a bronze plan when they would be better served by a silver plan with cost-sharing reductions.

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Background

Section 1 of House Bill 4017 (2016) directed the Department of Consumer and Business Services (DCBS) to address a number of considerations necessary for the development of an Oregon Basic Health Program (BHP) blueprint, including updating the BHP analysis commissioned by the Oregon Health Authority in 2014. In December 2016, the Oregon Legislature was provided with the updated BHP analysis, Oregon Basic Health Program Study Findings prepared by Wakely Consulting Group and the Urban Institute, along with the DCBS response to the study's findings and recommendations from the Oregon Health Insurance Marketplace Advisory Committee. The Marketplace Advisory Committee recommended, and DCBS agreed, that Oregon should not proceed with a waiver request to establish a BHP (a 1331 waiver), but should consider alternatives to address BHP objectives and other needs identified during the BHP analysis.

Section 2, Subsection (1) of HB 4017 directed DCBS to “convene an advisory group to advise and assist the Department in identifying federal provisions subject to waiver that are expected to improve the delivery of quality health care to residents of this state including, but not limited to, alternative approaches for achieving the objectives of the Basic Health Program.”

This progress report describes the current status of meeting the directives in Section 2, Subsection (1) of HB 4017.

The waiver described in Section 2, Subsection (1) of HB 4017 is authorized by Section 1332 of the ACA, which allows states to apply for waivers to specific sections of the ACA to encourage state innovation in health system reform. Waivers may be used to:

- Alter the individual or employer mandates by modifying or eliminating tax penalties for individuals or employers
- Modify which benefits or subsidies must be provided
- Modify or eliminate Qualified Health Plan (QHP) certification
- Modify exchange responsibilities for eligibility and enrollment, or eliminate the exchange as the vehicle for eligibility determination and enrollment

A 1332 waiver must protect consumers by maintaining coverage levels at the same or greater benefit and affordability levels as those that existed before the waiver, must provide coverage to at least as many consumers, and cannot increase the federal deficit.

States wanting to waive applicable sections of the ACA under a 1332 waiver must submit an application to the Department of Health and Human Services (HHS) and the Department of the Treasury. Before submitting an application, the state must pass legislation granting authority to implement the waiver and solicit public comment on the application by conducting public hearings. States with federally recognized tribes must consult with the tribes through a separate process to ensure meaningful consultation.

The 1332 waiver application must include all of the following:

- Justification for the provisions the state wishes to waive
- Data to show the proposed waiver will not decrease coverage or affordability
- A 10-year budget showing the waiver will not increase the federal deficit
- Proof of the state's legal authority to implement the waiver
- An implementation plan and timeline

After an application is submitted, HHS and the Department of the Treasury will review it. An initial review will be conducted within 45 days to determine if the application is complete. After the application has been deemed complete, a public notice and comment period will occur. Acceptance or rejection of the application will occur no later than 180 days after the application is deemed complete.

The Marketplace Advisory Committee designated an HB 4017 subcommittee to determine the necessity for and desirability of applying for a 1332 waiver by considering the following:

- 1332 state innovation waiver requirements
- BHP objectives and what could be achieved through alternative strategies
- Obstacles to accessing affordable, high quality health care

Subcommittee Findings and Recommendations

The subcommittee identified a number of barriers, gaps, and other issues its members believe may contribute to preventing Oregonians from receiving affordable, high-quality health care, including:

- Existing subsidies for Qualified Health Plans (QHP) do not remove all financial barriers to access
- Provider incentives for providing high-quality health care and improving health outcomes are inconsistent or insufficient
- Bronze plans cover few medical services, except for certain preventive services, until the deductible is met
- Some consumers may be selecting bronze plans when silver plans would better fit their needs
- Unauthorized immigrants are ineligible for coverage through Medicaid or QHPs
- Those with household incomes over the eligibility levels for advance premium tax credit (APTC) assistance assume the entire cost of insurance with after-tax dollars
- Transition support for consumers who move back and forth (“churn”) between Medicaid and QHP could be improved
- Social determinants of health such as economic, cultural, and language barriers should be addressed in all health care delivery
- Adult dental and non-emergency medical transportation should be part of QHP coverage for those less than 200 percent of the federal poverty level (FPL)

The subcommittee focused on the needs of all non-Medicaid-eligible Oregonians in households with incomes less than 200 percent FPL. The subcommittee especially considered several groups of people, including:

- Families caught in the “family glitch.” Eligibility for premium tax credits depends on income and on whether a family has access to affordable employer-sponsored insurance. If an employer offers family coverage and the employee’s required contribution for only his or her own coverage is determined to be affordable, the entire family is ineligible for a premium tax credit or cost-sharing reductions. Their employer-sponsored coverage for the whole family may require them to pay far more for coverage than similar-income households that purchase on the Marketplace and do not have an offer of coverage at work.
- Legal permanent residents who are in households less than 138 percent FPL, who would otherwise be eligible for Medicaid, except they have been in the country for less than five years.
- Medicare beneficiaries between 135 percent FPL and 200 percent FPL pay substantially more for premiums and out-of-pocket costs than they would in QHP coverage.

Possible Strategies

The subcommittee identified 12 possible solutions to the identified barriers, gaps, and issues. The strategies were organized into four categories, based on the estimated time and work needed to operationalize them.

1. Strategies possible to implement within existing Marketplace authority and budget in the 2018 plan year
 - Increase insurers' use of the coordinated care model in QHPs
 - Expand education and outreach efforts to help consumers understand the differences between bronze and silver plans and identify when silver plans might better serve them
2. Strategies that might be achieved with a 1332 waiver or a state-funded wrap-around program
 - Provide some limited cost-sharing assistance, similar to federal cost-sharing assistance in silver plans, to bronze plan enrollees
 - Expand the COFA Premium Assistance Program to include non-COFA lawful permanent residents who have incomes of 138 percent FPL or less, but are ineligible for Medicaid because they have been in the United States for less than five years
 - Provide assistance to individuals and families affected by the "family glitch"
 - Provide a BHP-like wrap-around subsidy program to assist Oregonians who have household incomes of 200 percent FPL or less purchase coverage through the exchange
 - Provide subsidy or other assistance to individuals whose incomes are just over APTC eligibility limits
3. Concepts requiring more consideration and information before strategies can be drafted

The subcommittee recommends revisiting these ideas in the future:

 - Provide assistance to reduce the effects of the Medicare "cliff" – the sharp increase in costs that modest-income households confront when they move from Marketplace to Medicare eligibility
 - Create a smoother transition for individuals who move back and forth between Medicaid and QHPs
 - Address social determinants of health through QHP coverage and health care delivery
 - Expand QHP benefits to include dental and non-emergency medical transportation – similar to Medicaid benefits
4. Strategies with logistical HealthCare.gov barriers
 - Allow unauthorized immigrants to purchase health insurance through the exchange.

Although OAR 836-053-0431 already requires Oregon insurers outside the Marketplace to sell all individual health benefit plans "without regard to . . . immigration status or lawful presence in the United States," these plans are available for purchase only directly from insurers. Unauthorized immigrants do not qualify for APTC or other subsidies, but many Oregonians who

don't qualify for subsidies choose to use the Marketplace platform for ease of comparison shopping. The subcommittee recommends further consideration of this strategy if customization of HealthCare.gov becomes available or if Oregon uses a different exchange platform in the future.

Subcommittee Recommendations

The subcommittee recognized there is considerable uncertainty about whether the ACA will continue in its current form and the difficulty of predicting what changes may be made.

The subcommittee recommends that:

- Oregon not pursue a 1332 waiver at this time, given the expected two-year timeline for securing a 1332 waiver under existing rules, and ambiguity about future changes, limits, and opportunities in federal health reform. The feasibility of applying for a waiver should be reevaluated when new federal guidance is available.
- The Marketplace begin carrier discussions regarding increasing use of the coordinated care model in QHPs.
- The Marketplace expand outreach and education to help consumers who may choose bronze plans when a silver plan may better suit their needs.
- DCBS request permission to submit a second report to the legislature in late June when there may be more guidance on federal health reform changes.

At its Jan. 26, 2017, meeting, the Marketplace Advisory Committee accepted an overview of the subcommittee's report and recommendations, and agreed that a progress report would be submitted by DCBS to the Oregon Legislature by March 1, 2017. Pursuant to these recommendations, DCBS submits this report to the Legislature and expects to submit an additional report by June 30, 2017, when more federal guidance may be available.