**Medicaid OHP**

- Children 0-18
- Pregnant Women (including CAWEM)
- Adults 19-64 Not immigrants banned from Medicaid (except CAWEM emergency)

**QHP**

- Children 0-18
- Adults Ages 19-64 Including lawfully present immigrants banned from Medicaid

**BHP**

- Adults Ages 19-64 Including lawfully present immigrants banned from Medicaid

---

**Income Levels**

- 0% FPL: No subsidy
- 100% FPL: APTC and CSR
- 200% FPL: APTC
- 300% FPL: Directed to Medicaid CHIP
- 400% FPL: No subsidy

---

**Eligibility**

- Adults Ages 19-64 Including lawfully present immigrants banned from Medicaid
- 65+, no free Part A Medicare
- Pregnant Women (including CAWEM)
BHP Consideration in Oregon

- **HB 4109** OHA submitted Wakely/Urban 2014 BHP Study, with no proposal, to 2015 Legislature.

- **HB 2934** Stakeholder group convened July – Sept. 2015 to consider BHP design.
  - Stakeholder BHP recommendations submitted to 2015 Legislature, resulting in HB 4017

- **HB 4017** directed DCBS, with advisory groups, to:
  - Consider and report on BHP recommendations (1331 waiver).
  - Consider and report on state innovation 1332 waiver, including alternative approaches for achieving the BHP objectives.
Recommendations for Proposed BHP HB 2934 Stakeholder Group 2015

- No premium <138% FPL
- Graduated premiums (50% of QHP) >138% FPL
- No cost-sharing for everyone <200%
- 12-month continuous enrollment
- Medicaid equivalent medical benefits
- No adult dental (interested in/price out)
- Provider reimbursement 82% of commercial

This is Scenario 1, the Proposed BHP. Wakely/Urban also modeled 7 variations.
Recommendations (cont.)
HB 2934 Stakeholder Group 2015

- BHP participants to enroll through Internet portal

- CCOs & insurers to offer standard plans that cover the same medical services as OHP, using principles of Oregon’s coordinated care model (CCM).

- Annual sustainable fixed rate of growth; methodology and rate set by legislature
Affordability & Access

- 2016 52K enrollees in QHPs < 200% FPL
  - Enrollment <200% FPL would increase to 79K persons
  - Enrollment <200% FPL would increase to 66K persons, without 12-month continuous enrollment.
- Would increase affordability for most persons eligible to enroll.
  - Wakely/Urban - Consumer savings $1,085 average per capita compared to QHP enrollees
Affordability & Access (cont.)

• In a BHP, choice is eliminated; everyone enrolls in the same coverage.
  ▪ Some consumers who intentionally choose a bronze plan would see their total health care coverage costs increase.
Equity & Disparities

• A BHP would increase equity with $0 premium & no cost-sharing for Medicaid-ineligible lawfully present immigrants <138% FPL.

• Increases equity for low-income persons compared to those enrolled in very generous ESI offerings.

• BHP would increase the disparities that already exist between those categories of persons < 200% FPL who can enroll in a highly subsidized QHP and those who cannot (e.g., family glitch, 65+).
Uninsured Rate

• The proposed BHP predicted to reduce number of BHP eligible uninsured persons from 24,600 to 12,400.
Individual Market Stability

• BHP would have a separate risk pool from individual health plans (QHPs).
  ▪ Increased enrollment of younger, low health-risk persons in BHP would not improve individual health plan risk pool.

• BHP is predicted to result in contributing 1.5% to individual health plan rate increases.
  ▪ Wakely assumed that all carriers would estimate the same impact as this study did.
Churning & Simplicity

• BHP would add a third set of eligibility and enrollment standards.

• Annual estimated churning among 3 programs
  ▪ 44K persons eligible for OHP & BHP
  ▪ 39K persons eligible for QHP & BHP

• BHP enrollees are not required to reconcile their income and subsidy in annual tax return.
Additional Considerations

• Other state experiences
  - New York
  - Minnesota
  - Washington and other states that considered

• IT system options
  - Utilize and customize federal platform
  - Develop an Oregon-run eligibility system
BHP Cost Projections

- Projected annual deficit $62.8 M
  - Federal revenue for the BHP is 95% of APTC and CSR, calculated as if the BHP enrollee had been in a QHP.
  
  - States must also fund or offset additional reductions in premiums or cost-sharing.
  
  - BHP additional projected administrative costs for the state and for health plans to establish and maintain does not include IT development.
<table>
<thead>
<tr>
<th>BHP Proposed - Scenario 1</th>
<th>BHP-like Alternative State QHP Wrap-around Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% APTC &amp; CSR if enrollees were in QHP</td>
<td>100% APTC &amp; CSR (5% = $18.3 M savings)</td>
</tr>
<tr>
<td>Separate eligibility, enrollment &amp; administration ($20.3 M)</td>
<td>Integrated with QHP eligibility, enrollment &amp; administration (Expected savings TBD)</td>
</tr>
<tr>
<td>1331 Waiver</td>
<td>Expect no waiver is necessary</td>
</tr>
<tr>
<td>Stakeholder recommendations – could operationalize most. Single portal would require Oregon–run IT.</td>
<td>Stakeholder recommendations – could operationalize most, except 12-month continuous enrollment. Oregon wrap-around IT only for subsidy administration.</td>
</tr>
<tr>
<td>Must offer standard plan. Everyone &lt;200% FPL has no choice.</td>
<td>May give consumers &lt;200% FPL choice of any metal level QHP; narrow choice for state subsidy (e.g., certain silver plan(s)).</td>
</tr>
<tr>
<td>Ages 19-64 only</td>
<td>Ages 19-64; age 65+ pay Part A Medicare</td>
</tr>
<tr>
<td><strong>BHP</strong> Proposed - Scenario 1</td>
<td><strong>BHP-like Alternative</strong> State wrap-around Subsidy</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Eligibility churning among three programs OHP, BHP &amp; QHP</td>
<td>Eligibility churning between two programs OHP &amp; QHP</td>
</tr>
<tr>
<td>Creates a new risk pool for BHP enrollees; Predicted 1.5% rate increase in individual market</td>
<td>Retains enrollees in the single risk pool for individual health plans; expect modest improvement in risk pool demographics</td>
</tr>
</tbody>
</table>
| Must comply with federal regulations for BHP 1331 waiver; changes require federal approval. | State-run subsidy program may allow more flexible integration with other potential Oregon or national health reforms. e.g.,  
  - HB 2828 considerations  
  - Possible FHIAP-like program for family glitch |
MAC Potential Recommendations

- A 1331 waiver BHP
- A BHP-like alternative within QHP structure
- Add targeted subsidies for certain QHP enrollees (e.g., expand COFA model to everyone <138% FPL barred from Medicaid because of immigration status)
- Advocate federal changes to family glitch rule
- Reinstate FHIAP-like program for family glitch people
- Advocate federal changes to QMB to increase equity for Medicare beneficiaries < 200% FPL
- Maintain status quo
Next Steps

• Advisory Committee advises DCBS Director
• DCBS will present its BHP findings and recommendations and the Advisory Committee’s advice during December 2016 legislative days