

DEPARTMENT OF BUSINESS AND CONSUMER SERVICES

Response to

**Oregon Basic Health Program Study Findings**

Prepared by Wakely Consulting Group and the Urban Institute  
Report dated September 28, 2016

October 20, 2016

## Table of Contents

|  |    |
|--|----|
| Background and Problem Statement.....  | 3  |
| Oregon Basic Health Program (BHP) 2015 Stakeholder Advisory Group Recommendations... | 4  |
| Problems and Gaps that a BHP May Address.....  | 6  |
| Affordability and Access.....  | 6  |
| Equity and Disparities.....  | 10 |
| Uninsured Rate.....  | 16 |
| Individual Market Stability.....   | 18 |
| Churning and Simplicity.....   | 19 |
| BHP Experiences in Other States.....   | 21 |
| Information Technology and Administration for BHP.....                               | 23 |
| BHP Cost Projections.....  | 25 |
| BHP Alternatives.....  | 27 |
| BHP Subcommittee Comments and Recommendations.....                                   | 28 |
| Appendix   |    |

## Background and Problem Statement

Since the full implementation of the Affordable Care Act (ACA) in 2014, Oregon has experienced a dramatic drop in the uninsured as hundreds of thousands of Oregonians enrolled in expanded Oregon Health Plan Medicaid, qualified health plans (QHP) through the Oregon Health Insurance Marketplace, or in individual plans directly with insurers.<sup>1</sup> Since guaranteed issue went into effect, consumers can enroll through the Marketplace or directly with carriers without fearing rejection because of pre-existing conditions.

In addition to simply increasing the numbers of those covered, health care affordability and access have also improved for many. This is especially true for those enrolled in Medicaid. But is also true for those below 200 percent of the federal poverty level (FPL) enrolled with tax credit supported premiums in highly subsidized Marketplace cost-sharing reduction (CSR) plans with lower copayments, coinsurance, deductibles and/or maximum out-of-pocket costs.

The overarching goal of many financing health reforms is to provide access to care through some model of universal coverage. The ACA approached this goal in a fragmented way in response to the country's fragmented existing health care financing and delivery systems and the political compromises made to incorporate conflicting ideas. Despite tremendous progress in coverage, access and affordability, some problems and gaps persist and some new problems have arisen.

A Basic Health Program (BHP) has been proposed as a solution to some remaining problems and gaps. When evaluating any specific proposed solution, we want to consider what problems we are trying to solve or mitigate and the possible intended and unintended consequences of the proposed solutions.

---

<sup>1</sup> The Oregon Health Authority's Oregon Health Insurance Survey documents a drop in the uninsured rate for all ages from 15.5 percent in 2013 to 5 percent in 2015. The National Health Insurance Survey (NHIS), conducted by the Census Bureau on behalf of the Centers for Disease Control and Prevention documented a drop in the uninsured rate for all ages from 14.2 percent in 2013 to 8 percent in 2015. The Census Bureau's American Community Survey documented that Oregon's uninsured rate for all ages had dropped from 14.7 percent to 7.0 percent in 2015. These surveys use somewhat different methodologies, sample sizes and timing, but all confirm the same dramatic downward trend for the population in total and similar persistence of somewhat higher uninsured rates for young adults and some minority populations.

## **Oregon Basic Health Program (BHP) 2015 Stakeholder Advisory Group Recommendations**

The 2015 Legislature directed the Oregon Health Authority (OHA) to use a Stakeholder Advisory Group to further consider an Oregon BHP and report back to the 2016 legislative session. The stakeholders made recommendations that were incorporated into HB 4017 as items for DCBS to consider and address in reporting back to the 2017 legislature and for creating a blueprint that describes how Oregon could implement a BHP. A significant part of the blueprint is describing how a state would fund a BHP beyond the federal funds available for a BHP.

The Stakeholder Advisory Group recommendations for a BHP included:

- **Hybrid-Marketplace Delivery System**

CCOs and commercial QHPs should compete for BHP enrollees using principles of Oregon's coordinated care model (CCM).

- **Benefit Coverage**

Medical benefits should be the same as Medicaid without adult dental, though the group asked that any modeling also calculate what adding adult dental would cost. (In consultation with OHA actuaries, DCBS determined the only other material difference between essential health benefits offered through the Marketplace and the Medicaid medical benefits is non-emergency medical transportation.)

- **Provider Reimbursement**

Providers should be paid an average of Medicaid and commercial rates. (Described in the recommendations as approximately 81 percent of Oregon's commercial reimbursement rate, but recalculated during the Wakely/Urban 2016 BHP study to be approximately 82 percent of commercial in 2016 dollars.)

- **Reduced Premiums and Cost-sharing**

No cost-sharing (copayments, coinsurance, deductibles) for any BHP enrollee. Those at or below 138 percent FPL would pay \$0 premium; those from 138 to 200 percent FPL would pay on a graduated premium structure, which DCBS took from Stakeholder discussions to be at half the QHP sliding scale premiums for purposes of the Wakely Urban study.

- **Eligibility and Enrollment**

BHP enrollees should come through open enrollment or special enrollment periods with 12-month, continuous eligibility once enrolled. The stakeholders noted that the federal portal would be unable to operationalize a BHP. (The stakeholders were aware of the pending DCBS study and report to be made to the 2016 Legislature regarding Marketplace state-based information technology.)

- **Sustainable Growth Rate**

An annualized sustainable fixed rate of growth should be set by the Legislature.

The stakeholder recommendations for benefit coverage, provider reimbursement, premiums and cost-sharing provided direction for the Wakely/Urban 2016 Oregon BHP study. Scenario 1 in the Wakely/Urban study includes all the stakeholder recommendations. Scenario 2 is the same as Scenario 1, but adds dental benefits.

As discussed later in this response, Scenarios 1 and 2 have the highest program deficits of all scenarios; Scenario 2 is the most expensive with the addition of dental benefits. The other scenarios, 3 to 8, are variations showing the potential costs with and without 12-month continuous eligibility, 50 percent cost-sharing for those at or above 139 percent FPL, and with and without dental benefits. All scenarios consider only the recommended provider reimbursement (approximately 82 percent of commercial rates). DCBS asked Wakely/Urban to calculate these alternative scenarios to better inform advisory and policymaker considerations of the BHP and BHP-alternatives.

In this report references to the proposed BHP should be understood to be Scenario 1, with 12-month continuous eligibility, no cost-sharing for any BHP enrollee and sliding scale premiums only for those above 138 percent FPL.

## **Problems and Gaps that a BHP May Address**

In general, anyone whose household income is at or below 200 percent (federal poverty level) FPL and eligible for a BHP is currently eligible to enroll in a qualified health plan (QHP).<sup>2</sup> Section 1331 of the Affordable Care Act (ACA) provides the option for states to create a Basic Health Program for low-income residents “who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace.” A BHP does *not* expand who is eligible for coverage assistance. Once a BHP is established, however, all eligible persons may enroll only in the BHP.

The BHP option allows states flexibility to create a more highly subsidized option for consumers and to design plans that differ somewhat from a QHP. For example, a BHP may not require more financial participation from enrollees than is required in a QHP for premiums and cost-sharing, but it may require less. While the BHP financing and administrative requirements pose significant challenges – discussed later in this report – we begin with considering the effects of QHPs and potential effects of a BHP on some major policy concerns:

- Affordability and access.
- Equity and disparities.
- Uninsured rate.
- Individual market stability.
- Churning and Simplicity

### **Affordability and Access**

Two QHP subsidies – tax credits and cost-sharing reductions – have greatly increased coverage affordability for lower income persons. Enrollees pay a sliding scale percentage of household income toward premiums, with the federal government paying the balance through tax credits – usually in the form of advance premium tax credits (APTC) applied to the enrollee’s monthly premium. Cost-sharing reduction (CSR) versions of the silver plans, which reduce copayments, coinsurance, deductible limits and maximum out-of-pocket (MOOP) costs are the other important QHP subsidy offered to those in households below 250 percent FPL.

Persons with the lowest household incomes qualify for exceptional subsidies in CSR silver plans. Those with household incomes:

- Below 150 percent FPL qualify for 94 percent actuarial value CSR plans, which are equivalent to platinum-plus plans and exceed the value of all but the very richest of large group plans.<sup>3</sup>

---

<sup>2</sup> Persons over age 65 who are ineligible for free Part A Medicare may enroll in a QHP, but are prohibited from enrolling in a BHP.

<sup>3</sup> The most popular 94 percent actuarial value CSR plans in 2016 offered: \$5-10 primary care visits, RX \$5/10 generic – 10/25% specialty, \$0-100 in-network deductible, and maximum out-of-pocket \$750-\$2,250.

- From 150 percent to 200 percent FPL qualify for 87 percent actuarial value CSR plans, which are equivalent to gold-plus plans and are also richer than many large group plans.<sup>4</sup>

In 2016, more than 16,000 Oregonians with household incomes at or below 150 percent FPL and more than 36,000 Oregonians with incomes between 150 percent to 200 percent FPL enrolled in QHPs.<sup>5</sup> Despite big gains in our Marketplace QHP enrollment and efforts to ensure everyone understands their choices, not everyone who qualifies for a CSR plan enrolls in such a plan.<sup>6</sup>

- Of the more than 16,000 persons at or below 150 percent FPL who selected a plan during open enrollment, nearly two-thirds of the enrollees selected and effectuated a CSR platinum-plus equivalent plan.<sup>7</sup>
- Of the more than 36,000 persons from 150 percent to 200 percent FPL who selected a plan during open enrollment, about 70 percent of them selected and effectuated a CSR gold-plus equivalent plan.

It is likely that many of the more than 16,000 enrollees below 200 percent FPL who failed to enroll in a CSR plan instead chose bronze plans, where applying their full tax credit would result in free or near-free premiums.

For some people, a low premium bronze plan that insures them against large medical costs can be a good choice. But many in households below 200 percent FPL would have difficulty paying the bronze plan's higher cost-sharing and maximum-out-of-pocket (MOOP) costs. Some enrollees may not understand that bronze plans require enrollees to pay for much of their own care out-of-pocket before they hit high deductible limits and MOOP for the bronze plan.<sup>8</sup>

Plans are displayed at healthcare.gov based on the premium cost – making it more likely that a confused person might choose the low or no-cost premium bronze plan, rather than the CSR plan option. Anecdotally, DCBS has heard that some people enrolled in a QHP feel they cannot afford to access care, because of cost sharing. This may result when some lower income persons choose bronze plans, rather than a CSR plan.

The Marketplace actively works with agents and community partner agencies to ensure that consumers understand their health plan choices. Thanks to increased efforts by agents and community partners, it appears that the number of persons accidentally failing to select CSR plans continues to decline – a trend that is expected to continue.

---

<sup>4</sup> The most popular 87 percent actuarial value CSR plans in 2016 offered: \$10-15 primary care visits, RX \$10/15 generic – 25/50% specialty, \$0-850 in-network deductible, and maximum out-of-pocket \$1,500-\$2,250.

<sup>5</sup> The total enrollment number count from HHS, ASPE *Issue Brief*, March 11, 2016. *Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, Appendix Table C11, known household data income known for 124,753 of the 147,109 persons who selected a plan.

<sup>6</sup> For the Oregon BHP Study update, Urban Institute estimates in 2017 nearly 21,000 non-elderly persons below 150 percent FPL and nearly 70,000 non-elderly persons from 150 percent to 200 percent FPL would be eligible for Marketplace tax credits or enrollment in a BHP.

<sup>7</sup> Effectuated data from 2016 Q1 Marketplace assessment reports to DCBS from carriers. To effectuate means that the person has made a premium payment.

<sup>8</sup> Deductible limits for 2017 bronze plans range from \$5,000 to \$7,150 and most have a MOOP of \$7,150.

In Marketplace focus groups, participants have identified making premium payments and reaching deductibles as affordability issues. Even for those below 200 percent FPL, the annual contribution to premium is more than a token amount. A single adult with \$17,820 annual income in 2017 will be at 150 percent FPL and expected to contribute 4.07 percent of household income, which is \$725 annual premium to the second lowest silver plan. (See Table 1) The proposed BHP is projected to cut the premium in half when compared to the CSR plan.<sup>9</sup>

It is important to recognize that some persons now intentionally choose a low or no-cost premium bronze plan. They do so based on their own predicted health needs, a desire to have protection from catastrophic expenses and to avoid the tax penalty by having minimum essential coverage. If their only option was a BHP plan, with a premium set at half of the required contribution to a QHP premium, those who intentionally choose a bronze plan would see their premiums increase. It is also likely many young and healthy individuals now intentionally choosing a bronze plan would see their overall costs increase, as they will be correct in predicting that their own health risk will reflect the predicted low health risk for that population.

People who deliberately choose a bronze plan may object to being forced out of a free or near-free bronze plan and into a BHP where they would have to contribute more to premiums. At about half the cost of QHP, annual premiums would range from \$250 for someone at 139 percent FPL to \$760 for someone at 200 percent FPL. However, for those who required more health care than they predicted, a BHP would generally result in less cost for the consumers than would be the case in a low or no premium bronze plan, as is currently true for those selecting a CSR plan.

The ACA requires enrollee contributions to premiums to increase with increased income. The federal percentage of household income required to be contributed to QHP premium does not acknowledge the real cost-of-living differences in the country, especially for housing – usually the largest budget item in moderate and low-income households. One large rental database shows that Oregon is one of the more expensive housing states, with Portland median rents now tied with Chicago, Minneapolis, Long Beach and Anaheim, and about double the median rents in cities such as Lexington, Ken., or Cleveland.<sup>10</sup> Rural Oregon also struggles with insufficient supply of affordable rental housing. Housing expenses versus premium expenses are a real choice for a number of Oregonians.

The study projects saving just over \$1,000 in average annual per capita out-of-pocket costs for enrollees in a BHP as compared to enrollees in a QHP. Because of the deeply subsidized CSR plans for those below 200 percent FPL, with low cost-sharing and low sliding-scale premiums every BHP scenario compared to a QHP results in about the same average consumer savings. The actual amount of savings an individual would experience would vary widely, with those with more health expenses saving more and those with fewer health expenses saving less.<sup>11</sup>

---

<sup>9</sup> The proposed BHP model is based on the 2015 HB 2934 Stakeholder Advisory Group recommendations incorporated into HB 4017. Wakely modeled eight possible scenarios to fully inform DCBS, OHIM Advisory Committee and 2017 Legislature.

<sup>10</sup> <https://www.apartmentlist.com/rentonomics/national-rent-data/>

<sup>11</sup> Calculating the savings for the uninsured persons who could enroll in a BHP is somewhat more complex. The Wakely/Urban model – like most all actuarial and economic models would – predicts that the closer it gets to free, the more people enroll and the greater the take up by young and low health risk persons. This is consistent with our

Lawfully present immigrants who would be eligible for Medicaid, except for their immigration status can enroll in QHPs.<sup>12</sup> However, they must contribute to premiums and pay cost-sharing. All of the BHP scenarios modeled in the Wakely study assume that persons in households below 138 percent FPL would pay no premium and no cost-sharing, as will be the case for persons to be enrolled in Oregon's COFA premium assistance program beginning in January 2017.<sup>13</sup>

It is unclear what effect, if any, reduced provider rates in a BHP would have on network adequacy and access to care. The analysis assumes that providers will accept the reduced commercial rates and continue to participate as they currently do in QHPs with commercial rates for medical services. Some provider representatives were among the stakeholders making the recommendation to OHA that a BHP pay providers at approximately 81 percent of commercial rates. However, some stakeholders now question whether the broad community of providers would agree to this rate reduction.

#### Conclusions:

- A BHP would increase affordability for most persons who are eligible to enroll in the program and would otherwise enroll in a CSR plan, including lawfully present immigrants who are excluded from Medicaid because of their immigration status.

---

experience in ACA implementation, where young adults have been the largest cohort in Medicaid expansion and the smallest cohort in QHP implementation. People who do not expect to need something are reluctant to spend much on it, making a scenario with no cost-sharing more attractive to young and low health-risk population than a scenario with even half the cost-sharing of a QHP. The young and healthy will also have lower use of health care services, which would also reduce the average costs and therefore the average potential savings. Even when the costs increase, older and those with medium and high health risk have higher take up rates and higher use of health care services, which results in more per capita savings for them when compared to what it would cost them if they were uninsured.

Greater total enrollment and enrolling a higher ratio of young and healthy persons in the scenarios with no cost-sharing result in the finding that the most subsidized and expensive scenarios are the ones that deliver the least per-capita average savings for the previously uninsured.

This model also assumes that uninsured people access and use health care at the same rate as the insured, though there is evidence people without insurance tend to forego services. However, the calculated savings may be a good proxy of the toll taken on the health of uninsured people who may be going without medical services.

<sup>12</sup> Those barred by immigration status have typically been residents for less than five years or are citizens of one of the Compact of Free Association (COFA) nations Compact of Free Association (COFA) are international agreements between the U.S. and three Pacific island nations – the Federated States of Micronesia, the Marshall Island and Palau – along with the Commonwealth of the Northern Mariana Islands. Among other conditions, the agreements allow citizens of these countries to live and work in the U.S. and American citizens to live and work in COFA nations, but since 1996 COFA residents are permanently barred from eligibility for Medicaid benefits. Most other resident aliens can be eligible for Medicaid after five-years of U.S. residency.

<sup>13</sup> In 2017, Oregon will launch an additional state-funded subsidy program covering the entire contribution to premiums and cost-sharing for COFA people at or below 138 percent FPL enrolled in QHPs. The Oregon program, enacted by the 2016 Legislature, is administered by DCBS.

- In a BHP, everyone would enroll in the same coverage, eliminating the possibility of choosing a bronze plan – whether accidentally or intentionally. For those choosing a bronze plan accidentally, they would be assured of enrolling in coverage with affordable access.
- Some number of those with low health needs, who intentionally choose a bronze plan, would see their total health care coverage costs increase as their BHP premiums would be more than their QHP bronze plan premium contributions, without the offset of reduced cost-sharing for health care services.
- The Wakely/Urban analysis projected that a BHP would result in about a 1.5 percent increase in the individual market premiums, contributing in a small way to the number of factors driving premium increases in the individual market borne by those not eligible for premium subsidies.

### **Equity and Disparities**

The ACA attempted to address some of the country’s fragmented health care coverage inequities with a patchwork of fixes, including:

- Allowing states to expand Medicaid to 138 percent FPL.
- Establishing QHPs with tax credits and subsidies, increasing symmetry to those with employer-sponsored insurance who have significant pre-tax advantage and may also have relatively low employee premium contribution requirements and cost-sharing.
- Extending QHP coverage to virtually all immigrants who are “lawfully present” in the country, including those currently excluded from Medicaid by reason of their immigration status.
- Extending QHP coverage to those over age 65 who are ineligible for free Part A Medicare.<sup>14</sup>

The Wakely/Urban report does not address coverage for unauthorized immigrants, because the ACA prohibits both QHP and BHP coverage to persons who are not lawfully present in the country.<sup>15</sup> However, the department acknowledges this serious gap in affordable health coverage for some persons living in Oregon. We also understand that households may include both legally

---

<sup>14</sup> To qualify for free Part A Medicare, a person (or spouse) must have worked for 40 quarters in employment that paid payroll taxes (Social Security and Medicare). Those who have worked for 30-39 quarters in such employment qualify for a lower Part A premium (\$226/month in 2016). Those with fewer than 30 quarters pay the full Part A premium (\$411/month in 2016). Persons who are permanently disabled are eligible for free Part A after two years on SSDI; persons of any age with End Stage Renal Disease and Amyotrophic Lateral Sclerosis are eligible for free Part A with no waiting period; for ESRD usually 3 months after dialysis begins or transplant and ALS upon collecting SSDI.

<sup>15</sup> Unauthorized immigrants who are not legal residents include those who entered without authorization, those who have over-stayed a visa and those applying for asylum or who are in the country in some other temporary status.

present and unauthorized immigrants. As part of an analysis for DCBS in 2015, the State Health Access Data Assistance Center (SHADAC) estimated that about 103,000 non-elderly, unauthorized immigrants lived in Oregon.<sup>16</sup> SHADAC estimated that about 46,000 of these immigrants were below 138 percent FPL, with about 31,000 of those below 138 percent FPL being uninsured. Approximately 57,000 of the unauthorized immigrants were above 138 percent FPL and could buy insurance directly from insurers, but without any subsidy.<sup>17</sup>

In this response, DCBS considers the broader context of all similarly situated Oregon residents who are lawfully present in the country and living in households below 200 percent FPL. While the ACA mitigates a number of inequities, some remain. The following describes insurance eligibility and costs for four major categories of households and the ways in which a QHP does or a BHP may affect disparities among those persons.

- Lawfully present immigrants who are ineligible for Medicaid because of their immigration status.
- Persons over age 65 who are ineligible for free Part A Medicare.
- Households that are offered employer-sponsored coverage that is regarded as affordable by the federal definition (“Family Glitch”).
- Persons over age 65 or those with permanent disabilities who are eligible for free Part A Medicare.

#### *Lawfully present immigrants ineligible for Medicaid*

In Oregon, those who have been in the U.S. less than five years and the COFA people are the two largest groups of lawfully present immigrants ineligible for Medicaid coverage, regardless of their income. However, they may enroll in a QHP or a BHP. The Urban Institute estimates Oregon has approximately 5,500 immigrant adults barred from Medicaid coverage because of less than five years residency and that of those, about 4,000 are eligible for tax credits.<sup>18</sup> We are uncertain of the total number of COFA immigrants who would otherwise be eligible for Medicaid if not for their immigration status.<sup>19</sup>

In 2016, about 2,500 Oregonians below 100 percent FPL enrolled in a QHP.<sup>20</sup> It is likely that all of these current QHP enrollees are persons who would be eligible for Medicaid, except for their immigration status – either COFA or lacking five-year U.S. residency. The lowest premium

---

<sup>16</sup> In an October 2016 update from SHADAC, they now estimate a total of about 105,000 unauthorized nonelderly immigrants in Oregon with about 9,000 of those being children ages 0-18 and 96,000 being adults ages 19-64. SHADAC emphasizes that these are approximate and are not statistically different than the 2015 estimates.

<sup>17</sup> DCBS has no data about the insurance coverage of unauthorized immigrants above 138 percent FPL. However, OAR 836-053-0431 requires carriers to sell all individual health benefit plans “without regard to...immigration status or lawful presence in the United States.”

<sup>18</sup> Matthew Buettgens, Senior Research Analyst at The Urban Institute, provided this estimate as part of their consultation on BHP. This estimate is based on two years of pooled American Community Survey data. The approximately 1,500 who would not be eligible for tax credit assistance are assumed to be ineligible because they have employer-sponsored insurance offers.

<sup>19</sup> After 2017 open enrollment, with the launch of the COFA premium and cost-sharing assistance program, DCBS will have a better estimate of total COFA eligible below 138 percent FPL.

<sup>20</sup> Data are not available for the number of enrollees with incomes less than 138 percent FPL. HHS provides aggregated enrollment data for persons >100 to 150 percent FPL. It is likely that many enrollees with incomes below 138 percent FPL are lawfully present immigrants ineligible for Medicaid because of their immigration status. Others in households >100 to 150 percent FPL are likely persons ineligible for free Part A Medicare.

contribution anyone will pay is calculated at 100 percent FPL, regardless of their actual household income. In 2017, someone at 100 percent FPL or less would be required to pay \$241 and someone at 133 percent FPL would be required to pay \$321 in annual premium contribution. While extending QHP coverage with tax credits and CSR plans significantly reduces the disparity between these lawfully present immigrants and other residents, for these poorest immigrants, it is not equivalent to Medicaid coverage, which requires no premium or cost-sharing and provides dental coverage and transportation assistance.

The proposed BHP would increase equity for lawfully present immigrants by offering Medicaid-like \$0 premium and no cost-sharing coverage to those with incomes below 138 percent FPL, as the state's premium and cost-sharing assistance program for COFA people will begin to do in January 2017.

#### *Those Ineligible for Free Part A Medicare*

Older persons who are ineligible for free Part A Medicare are currently eligible to be covered by QHPs.<sup>21</sup> However, the ACA explicitly excludes them from coverage in a BHP.

People who are ineligible for free Part A include seasonal or domestic workers and others in the cash economy, as well as unpaid family caregivers and immigrants – who may have labored for years – but not at covered employment.

In 2015, almost 5,000 persons age 65 and older were uninsured in Oregon.<sup>22</sup> But that is not a complete picture of how many are likely to be ineligible for free Part A; an additional 1,500 persons were enrolled in QHPs through the Marketplace and in individual plans directly with carriers at the end of 2015. Others pay for Part A and, though they may be eligible to, are not enrolled in a QHP. It is reasonable to assume that at least 6,500 older Oregonians are ineligible for free Part A.

If Oregon established a BHP, the QHP enrollees could continue to be served through the Marketplace in a QHP, but those in households below 200 percent FPL could not enroll in BHP and would not see their premiums halved and cost-sharing eliminated. As people ineligible for free Part A turned 65 and were forced out of the proposed BHP into a QHP, their premiums would double and they would have to assume some cost sharing.<sup>23</sup>

#### *“Affordable” employer-sponsored insurance – the “Family Glitch”*

The family glitch, despite its nickname, was not an accident. The federal government set a different affordability standard for households in which one member is offered employer-sponsored coverage than the affordability considerations used to calculate the graduated premium contributions required for a QHP. In 2016, an offer of employer-sponsored insurance is considered unaffordable if the coverage *for the individual employee* exceeds 9.66 percent of

---

<sup>21</sup> Currently, more than 700 Marketplace enrollees are ages 65+. At the end of 2015, nearly 1,000 Marketplace enrollees were over age 65.

<sup>22</sup> According to the Oregon Health Insurance Survey, about .8 percent of persons over age 65 were uninsured in 2015. In 2014, the American Community Survey conducted by the Census Bureau estimated a total of 582,273 persons 65+ in Oregon.

<sup>23</sup> It appears that Minnesota may use only state funds to enroll elders in a BHP-equivalent, though that is not confirmed at this time. New York's BHP does not address over age 65 QHP eligible persons under 200 percent FPL.

household income.<sup>24</sup> By comparison, a household must be at 400 percent FPL to be expected to contribute 9.66 percent of household income to QHP premiums.<sup>25</sup>

People who are offered employer-sponsored coverage that is deemed affordable by federal standard are ineligible for QHP enrollment and subsidy; they would also be ineligible for BHP.

Some people currently covered by employer-sponsored insurance that meets the federal unaffordable definition do not enroll in a QHP. Wakely/Urban study predicts that a more highly subsidized offering in a BHP may prompt more of those who are in unaffordable coverage to opt-out of employment-based coverage.<sup>26</sup> It is possible that targeted outreach could also encourage some more of those in federally-defined unaffordable coverage to enroll in QHPs. However, enrolling those already eligible to enroll in a QHP or the proposed BHP would have no effect on people who are stuck in the family glitch.

A recent analysis by Urban Institute researchers found that more than 6 million people live in families where the cost of the employee share of premium does not exceed 9.66 of household income. However, the cost for the family can exceed 14 percent of household income for households below 200 percent FPL – even after factoring in the pretax advantage of the employee contribution. This is a disturbing difference when compared to the 3.24 percent to 4.07 percent of household income those families would be expected to contribute to a QHP.<sup>27</sup>

In Oregon as many as 69,000 persons may be affected by the family glitch, with about 36 percent or nearly 25,000 persons below 200 percent FPL, if the employee and the entire family could gain subsidy eligibility.<sup>28</sup> If each employee must accept the employer-offered coverage, then about 27,000 Oregonians would be affected by the family glitch, with about 7,560 persons under 200 percent FPL who could gain subsidy eligibility. The Urban Institute study concluded that fixing the family glitch alone would not have a substantial effect on the number of uninsured, but would contribute to improving affordability.

#### *Eligible for Free Part A Medicare*

Persons with Social Security permanent disability and those over age 65, who are eligible for free Part A Medicare (hospitalization), are excluded from QHP enrollment, despite a surprising disparity in costs and coverage between Medicare and QHP for those in lower income households. This disparity persists, even when factoring in other public assistance programs to help pay for Medicare premiums and out-of-pocket costs.<sup>29</sup> These persons would also be ineligible for BHP enrollment.

---

<sup>24</sup> Percentage of household income is scheduled to increase to 9.69 percent in 2017; up from 9.66 percent in 2016.

<sup>25</sup> In 2017, 400 percent FPL is nearly \$48,000 for one-person household and over \$97,000 for a household of four.

<sup>26</sup> Each scenario modeled by Wakely Consulting Group and the Urban Institute includes an estimate for this population. See Table 4.1 in the Oregon BHP Study.

<sup>27</sup> Matthew Buettgens, Lisa Dubay, Genevieve M. Kenney *Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending But Increases Government Costs* Health Affairs 35:71167-1175. doi: 10.1377/hlthaff.2015.1491

<sup>28</sup> Matthew Buettgens provided this estimate as part of the Wakely/Urban consultation on BHP. This is based on research for the “Family Glitch” journal article cited above.

<sup>29</sup> Up to 100 percent FPL the Qualified Medicare Beneficiaries (QMB) program (a Medicaid program) pays for Medicare Part B premiums, deductible and coinsurance costs; for those with free Part A this is essentially equivalent

In 2015, the Kaiser Family Foundation reports that 20 percent of Oregon Medicare beneficiaries – 138,100 persons – have incomes between 100 percent to 200 percent FPL.<sup>30</sup>

Unlike the graduated costs for coverage in a QHP, with significant subsidies for those below 200 percent FPL, all Medicare beneficiaries with incomes ranging from \$15,890 (135 percent FPL) to \$85,000 (more than 700 percent FPL) pay the same flat amount for Part B Medicare (physicians, outpatient, equipment).<sup>31</sup> Part D Medicare (pharmacy) premiums vary by the plan selected, with some graduated assistance available from the federal government for persons below 150 percent FPL.

For persons below 135 percent FPL – a lower threshold than expanded Medicaid – there are some Medicaid administered subsidies for Medicare coverage and out-of-pocket costs but, for those from 100 percent to 135 percent FPL, none are equal to the QHP subsidies or Medicaid coverage provided to those under age 65 or those without permanent disabilities.

See Table 1 for examples comparing premium payments in Medicare, employer-sponsored insurance, QHPs and the proposed BHP .

Conclusions:

- A BHP would increase equity for those lawfully present immigrants ineligible for Medicaid by allowing the state to establish increased subsidies, similar to the state's new COFA program, to approximate Medicaid-like coverage for those in households with incomes at or below 138 percent FPL.
- A BHP would increase equity for those low-income persons without access to generous employer-sponsored insurance by providing them coverage more similar to some very generous large group plans. However, when compared to typical plans offered to small group employers with fewer than 50 employees, or even most large groups, CSR plans are already more generous than plans offered those workers and the BHP would be even more substantial in comparison to most employer-sponsored insurance.

---

to OHP Medicaid coverage (but does not cover non-emergency medical transportation and dental). For those 100-120 percent FPL the program pays only for Medicare Part B premium; enrollees will qualify for some federal assistance with Part D pharmacy but are otherwise responsible for out-of-pocket costs for copays, coinsurance, deductible and uncovered pharmacy costs. The program will pay for Medicare Part B premium if funds are available for persons from 120 percent to 135 percent FPL, who are also eligible for some federal assistance for Part D. The Oregon program has never been out of funds to date. Limited federal assistance with Part D is the only subsidy for those 135 percent to 150 percent FPL, who are responsible for Part B and Part D premiums as well as cost-sharing. Until January 2016, Medicare beneficiaries were also subjected to an assets test, unlike QHP or OHP enrollees. Now eligibility is income-based. For a fuller discussion of the coverage gaps for Medicare beneficiaries, this Massachusetts analysis identifies all the gaps also present in Oregon and other states, with two exceptions: Oregon has eliminated the assets test and Massachusetts provides a state-funded pharmacy assistance program in addition to the federal assistance for drugs. Nancy Turnbull, Katherine Heflin [\*Minding the Gaps: The State of Coverage to Supplement Medicare in Massachusetts\*](#), September 2015 Blue Cross Blue Shield Foundation of Massachusetts.

<sup>30</sup> [Henry J. Kaiser Family Foundation State Health Data Facts, \*Distribution of Medicare Beneficiaries by Federal Poverty Level, 2015\*](#).

<sup>31</sup> These are for 2016 income levels. 2017 is not yet available.

Table 1

**Comparing Premiums in Medicare, Employer-Sponsored Insurance, Qualified Health Plans and Proposed BHP**

| Traditional Medicare* with Free Part A  |                | Medicare Advantage* with Free Part A   |                | ESI - consistent with ACA affordability test "Family Glitch"   |  |  | QHP   | Proposed BHP @ 50% QHP | QHP   | Proposed BHP @ 50% QHP |
|---|----------------|--|----------------|--|--|--|---|------------------------|---|------------------------|
| Enrollees from \$15,890/yr (135% FPL) to \$85,000/yr (>700% FPL) pay the same premiums, with some RX exception.                   |                | Enrollees from \$15,890/yr (135% FPL) to \$85,000/yr (>700% FPL) pay the same premiums                                       |                |  | 1 Adult<br>\$16,513/yr<br>2017<br>139% FPL | 1 Adult<br>\$17,820/yr<br>2017<br>150% FPL | 1 Adult<br>\$16,513/yr<br>2017<br>139% FPL<br>3.24% household income annual contribution to premium |                        | 1 Adult<br>\$17,820/yr<br>2017<br>150% FPL<br>4.07% household income annual contribution to premium |                        |
| Annual premium Part B   | \$1,872        | Annual Premium Part B  | \$1,872        |  |  |  |   |                        |   |                        |
| Annual Premium Part D pharmacy persons 135-150% FPL get small assist with RX costs from Federal Extra Help; above 150%FPL no help | \$ 408         | RX generally included in most popular Medicare Advantage plans   | \$ -           |  |  |  |   |                        |   |                        |
| Annual premium Medigap F low  | \$1,224        | Medicare Advantage Additional Premium low - A few carriers in Oregon offer a \$0 additional premium to Part B Advantage Plan | \$ -           |  |  |  |   |                        |   |                        |
| Annual premium Medigap F high   | \$2,532        | Medicare Advantage Additional Premium high   | \$1,428        |  |  |  |   |                        |   |                        |
| <b>Total Annual Premium Low</b>   | <b>\$3,504</b> | <b>Total Annual Premium Low</b>  | <b>\$1,872</b> | <b>9.69% income in 2017 Annual premium affordability limit</b>   | <b>\$1,600</b>                             | <b>\$1,727</b>                             |   |                        |   |                        |
| <b>Total Annual Premium High</b>  | <b>\$4,812</b> | <b>Total Annual Premium High</b>   | <b>\$3,300</b> | <b>14.1% income - Annual after ESI tax advantage mean premium for persons 138-199% FPL - per Urban Institute Family Glitch study</b> | <b>\$2,312</b>                             | <b>\$2,495</b>                             | <b>\$ 523</b>   | <b>\$ 262</b>          | <b>\$ 725</b>   | <b>\$ 363</b>          |

\*Medicare plan premiums are for 2016 plans offered in Oregon. Will update with 2017 premium costs, which just became available for open enrollment.

- A BHP would not change the existing coverage and costs for persons caught in the family glitch, disabled and elderly persons covered by Medicare or QHP enrollees who are age 65 and older. But the creation of a BHP would increase inequities that already exist among categories of persons who can and those who cannot enroll in a highly subsidized QHP – increasing the inequity gap when compared to QHP enrollees age 65 and older; low income persons snared in less generous employer-sponsored insurance by the “family glitch”; and low income Medicare beneficiaries with free Part A Medicare.

### **Uninsured Rate**

A primary goal of the ACA is to reduce the number of uninsured persons. Oregon’s uninsured rate has dropped dramatically since 2013. According to the Census Bureau’s American Community Survey (ACS), Oregon’s rate of uninsured for all ages was nearly 15 percent in 2013 and about 7 percent in 2015, while the ACS reported that Massachusetts – with the lowest uninsured rate in the country – had about 3 percent uninsured in 2015. Massachusetts achieved level during a decade of ACA-like reforms in the state. While the biennial Oregon Health Insurance survey documents an uninsured rate of 5 percent, it appears that our state could get somewhat closer to universal coverage – recognizing that a certain number of people will remain voluntarily or involuntarily uninsured, especially if they must complete applications or pay a portion of the costs.<sup>32</sup>

In 2017, Wakely/Urban predicts about 270,000 nonelderly persons at all income levels in Oregon would be uninsured without a BHP, with about 101,000 of the uninsured living in households with incomes less than 200 percent FPL. Of those uninsured persons below 200 percent FPL, Wakely/Urban predicts that only 24,600 would be eligible for a BHP in 2017.

The Wakely/Urban study predicts that with a Medicaid-like free BHP with \$0 premium and no cost-sharing for everyone below 200 percent FPL – an option that was modeled to give an upper range of what might be possible – the number of uninsured would be reduced by 16,600. With premiums at half the cost of QHP and no cost sharing for everyone, the study predicts reducing the number of uninsured by 8,600 persons.<sup>33</sup> And finally, with BHP premiums at half of QHP for everyone and cost-sharing set at half of QHP for those at or above 139 percent FPL, the number of uninsured is predicted to be reduced by only 4,200 persons. If BHP offered 12-month continuous enrollment, the drop in predicted uninsured would be expected to increase somewhat.<sup>34</sup> Following the recommendations of the 2015 BHP stakeholder group – with 12-month continuous enrollment, no cost-sharing for any BHP enrollee, no premiums for persons at or below 138 percent FPL and graduated premiums (set at half of QHP rate in the Wakely model) for persons with household incomes 139 percent to 200 percent FPL – results in a

---

<sup>32</sup> Examples of persons who are voluntarily uninsured, for whom affordability is not a barrier, include persons granted religious exemptions from the individual mandate and those who choose to be uninsured because they do find value in medical insurance and would rather pay the penalty than be insured.

<sup>33</sup> This proposed option also included \$0 premium and no cost-sharing for those below 138 percent FPL.

<sup>34</sup> With 12-month continuous eligibility: the Medicaid-like Option A, with \$0 premium and no cost-sharing, would result in the highest predicted uptake – reducing the number of uninsured by 20,600; Option B, with half the premium cost of a QHP and no cost-sharing for persons 139-200 percent FPL, is expected to reduce the number of uninsured by 12,200; and Option C, with half the premium cost and half the cost-sharing of a QHP for persons 139-200 percent FPL, is expected to reduce the number of uninsured by 7,200. Option C incorporates all the recommendations of the 2015 BHP Stakeholder Group.

predicted 12,200 drop in uninsured persons. These recommendations mirror Medicaid standards, with the exception of charging some premium to those over 139 percent FPL.

According to the Kaiser Family Foundation in 2015, many uninsured people cited the high cost of insurance as the main reason they lack coverage.<sup>35</sup> The Medicaid expansion and the highly subsidized QHPs for those below 200 percent have demonstrated the power of economic incentives to move people into coverage. The Wakely/Urban uptake projection is again based on further increasing the economic incentives to enroll by reducing the QHP premium and cost-sharing – not on any other program characteristic. If the BHP or a BHP alternative was implemented or the ACA was amended to increase the tax credit and level of subsidy in CSR plans, we would expect that additional eligible people would enroll as predicted by the Wakely/Urban update.

The 2015 Oregon Health Insurance Survey found that lower incomes corresponded with lower rates of insurance coverage, with the highest uninsured rate at 139-200 percent FPL. (See Table 2.)

Table 2 **Oregon Health Insurance Survey 2015**

| <b>Federal Poverty Level</b> | <b>Percent Uninsured</b> |
|------------------------------|--------------------------|
| 0-100%                       | 9.3%                     |
| 101-138%                     | 9.4%                     |
| 139-200%                     | 10.5%                    |
| 201-300%                     | 6.6%                     |
| 301-400%                     | 3.8%                     |
| 401%+                        | 1.7%                     |

The 2015 Oregon Health Insurance Survey also identified Hispanic/Latino residents and certain counties and regions as having the highest rates of uninsured.

Why wouldn't significantly increasing affordability – short of making it free – for eligible persons result in even greater expected uptake and bigger drops in the number of uninsured than predicted in the Wakely/Urban study? The success of Medicaid OHP and QHP enrollment, combined with BHP eligibility requirements, leaves only 24,600 BHP-eligible uninsured persons out of a projected total 100,900 uninsured non-elderly persons with household incomes below 200 percent FPL in the state. The characteristics of those who remain uninsured also influence the likely potential BHP enrollment.

The 2015 Oregon Health Insurance Survey found that persons in the age group 19-34 were the least likely in Oregon to have insurance, with 10.3 percent uninsured – about 87,000 uninsured young adults.<sup>36</sup> This corresponds with a recently published Urban Institute report – part of an on-going project tracking the ACA's effects on coverage – which found that nearly half of the QHP eligible uninsured in the country are ages 18-34 and said that “young adults are the most likely to

<sup>35</sup> <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

<sup>36</sup> Number calculated on Oregon's July 2015 population total and Kaiser Family Foundation Population Distribution by Age, analysis of Census Bureau's March 2015 Current Population Survey.

be uninsured.”<sup>37</sup> The report pointed to lack of awareness of financial assistance among those still uninsured and concluded that “affordability is also less likely to be the barrier to enrollment for those eligible for the largest marketplace tax credits and cost-sharing reductions (those with incomes below 200 percent of FPL) compared with those eligible for less assistance.” The Office of Health Analytics stated that the low rate of coverage for young adults is “likely driven by several factors” including that they “are less likely to have steady employment that provides health insurance. They may perceive that they don’t need health insurance, won’t use it, or that it is too expensive.”<sup>38</sup>

Wakely/Urban estimates that 40,400 young adults, ages 19-34, would be eligible for the BHP in 2017 out of a total of about 90,000 young adults with incomes below 400 percent FPL, who are potentially eligible for QHP tax credits and subsidies. In 2016, the Marketplace enrolled more than 30,000 young adults in QHPs, but does not have their household income data.

As the full tax penalty for not having minimum essential health coverage hits in 2016 it will apply more pressure on persons in higher incomes to have coverage. However, it is unclear whether increasing the penalty to \$175 for people with low predicted health risk at 150 percent FPL will induce them to spend \$725 in premium contribution or whether increasing the penalty to \$325 for people at 200 percent FPL will induce them to spend \$1,523 in premium contribution, if they do not see the value of such coverage. Cutting their premiums in half would certainly encourage some not currently insured to enroll, though the challenge of enrolling young adults remains.

#### Conclusions:

- A BHP is predicted to contribute in a small way to reducing the projected total remaining 101,000 uninsured Oregonians below 200 percent FPL. The proposed BHP, with no cost-sharing and half of QHP premiums for those over 138 percent FPL, is predicted to cut the number of BHP eligible uninsured persons from 24,600 to 12,400.
- Continuing and revising targeted strategies to inform eligible persons about currently available financial assistance and the value of coverage may also contribute somewhat to reducing the number of uninsured below 200 percent FPL.

#### **Individual Market Stability**

To be considered a single risk pool everyone in the pool must have equal access to enroll in every offering in the pool. BHP plans would be available only to persons below 200 percent FPL; by definition that excludes everyone else in the individual market. The BHP would have its own risk pool. In contrast QHP plans are individual health plans that can be purchased by anyone through the Marketplace or directly from the carriers. The federal subsidies make the QHP plans more affordable, but do not affect who can enroll in the individual health plans.

---

<sup>37</sup> Linda J. Blumberg, Michael Karpman, Matthew Buettgens and Patricia Solleveld *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?* Urban Institute March 2016 [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2016/rwjf427898](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf427898)

<sup>38</sup> Oregon Health Authority [Oregon Health Insurance Survey: Demographic Information Fact Sheet 2015](#)

Market stability is an issue across the individual market. The proposed BHP would draw a higher ratio of young adults to enroll in the BHP risk pool. Enticing young adults to enroll in individual plans at or near the same rate as their incidence in the QHP eligible population is a big challenge. But it is a challenge at all income levels with young adults.

Older adults enroll in QHPs through the Marketplace or individual plans directly with carriers at a much higher rate than younger adults. In 2016, about 44 percent of the estimated eligible persons ages 18-34 enrolled, while about 85 percent of the estimated eligible persons ages 55-64 enrolled in a QHP or ACA-compliant individual plan through the Marketplace or directly with carriers.<sup>39</sup>

While individual health status varies, taking populations as a group, the older the group the higher the health needs. The Urban Institute analysis of all APTC-eligible persons anticipates about 33 percent of older adults, ages 55-64, would have a predicted high health risk compared to only about 6 percent of the youngest adults, ages 18-24, with high health risk. Enrolling older persons at a higher rate than younger persons from the pool of eligible persons is a significant factor in individual risk pool stability.

The Wakely/Urban study predicts that a BHP would cause premiums in the individual market to increase by about 1.5 percent. Many factors contribute to premium increases, with claims experience, medical trend and the loss of reinsurance being among the most significant considerations in 2017 rate increases. The predicted loss of some additional younger, low-risk people to a BHP would be a small additional factor in rate increases and individual market stability.<sup>40</sup>

Conclusions:

- Any increase in enrolling younger, low health-risk persons in a BHP would not accrue to the individual health plan rates, as a BHP would have a separate risk pool from the pool or individual health plans/QHPs.<sup>41</sup>
- The predicted 1.5 percent individual health plan rate increase attributable to a BHP is modest, when compared to other factors affecting the individual market.

### **Churning and Simplicity**

As the Wakely/Urban report notes, the only two states to implement the BHP since the ACA passed – New York and Minnesota – were able to integrate their BHPs into existing Medicaid or

---

<sup>39</sup> All QHPs are offered both inside the Marketplace and by the carriers directly. There are six ACA-compliant high deductible/HSA compatible plans sold only by the carriers directly, which are not sold through the Marketplace. In 2016, about 8,000 persons remain enrolled outside the Marketplace in non-ACA compliant grandfathered plans.

<sup>40</sup> The Wakely model did not consider whether there would be any cost-shifting to the individual market as a result of paying providers 82 percent of the commercial rate, but in discussion Tim Courtney, Senior Consulting Actuary on this analysis from Wakely, acknowledged cost-shifting is a logical possibility.

<sup>41</sup> To be considered in the same risk pool all participants must have access to the same plans.

Marketplace functions in ways that are not currently feasible for Oregon. New York and Minnesota experiences are discussed below in the section *BHP Experiences in Other States*.

Oregon does not have a single integrated eligibility and enrollment portal for Medicaid and QHP coverage that would simplify the process for the consumer. But even with an integrated administration, these programs still have separate eligibility criteria, networks, plans and benefits.

Currently, some churning happens among Medicaid, QHP and employer-sponsored insurance. The introduction of a BHP would add another set of eligibility criteria, and – depending upon the design – possibly networks, plans and benefits that also differ from Medicaid, QHP and employer-sponsored insurance.

If QHP enrollees report household income increases or decreases, then their CSR benefit level for the plan they selected and amount of APTC eligibility will be recalculated. However, their plan, insurer, and network remain unchanged. If a state establishes a BHP, then everyone eligible to enroll in the BHP is ineligible to enroll in a QHP. During the plan year, if QHP enrollees report income changes that entitle them to Medicaid, then they are expected to enroll in Medicaid.<sup>42</sup> It would be similar with a BHP, though 12-month BHP continuous eligibility would help reduce churning from BHP to QHP. Continuous eligibility also adds considerably to the expense of such a program – even when additional federal revenue for 12-month eligibility is factored in.

If Oregon had a state-run information technology system supporting Medicaid, QHP and BHP plans that could help mitigate the complexity for a consumer. But some stakeholders warn that even state-run IT support would not be sufficient to overcome consumer confusion.

The Wakely/Urban report predicts that the groups most likely to churn between Medicaid and BHP are older adults (ages 55-64), young adults (ages 19-24) and generally those with a high school education. The report also predicts that older adults (ages 55-64), non-Hispanic blacks and American Indian/Alaska natives will be the groups most likely to churn between BHP and QHPs. Given our experience with very high health insurance enrollment rates for older adults, it is likely older enrollees would have a high rate of maintaining coverage, regardless of changing program eligibility and their own health challenges. Other groups may be more likely to lose coverage in the churning process.

Finally, the minimum income thresholds at which a household is required to file federal income tax returns are less than expanded Medicaid eligibility levels, so both a QHP and a BHP enrollee would be required to file tax returns. Both would check the box that they had minimum essential coverage. QHP enrollees must also complete a form when filing federal taxes to reconcile the assistance they received during the course of the year. BHP enrollees are not required to complete any form reconciling income or subsidy.

---

<sup>42</sup> Pregnant women at or below 185 percent FPL are allowed to choose whether to stay in a QHP or enroll in Medicaid. Medicaid provides richer pregnancy coverage than QHPs, but some women have personal reasons for retaining their QHP enrollment and may do so and continue to be enrolled in CSR plans and receive APTC.

Conclusions:

- With Oregon's Medicaid and Marketplace structure, the addition of a BHP would establish another eligibility threshold to be navigated by Oregon residents seeking assistance with coverage. The Marketplace could assist with that navigation, but it would not be seamless for consumers and some may lose coverage in shifting from eligibility for one program to another.
- Instituting a BHP with 12-month continuous eligibility could decrease some churning that would result from having this additional eligibility threshold.
- BHP enrollees would not be required to reconcile their income and BHP assistance in their annual tax return.

DRAFT

## BHP Experiences in Other States

Washington, the state responsible for the original BHP that inspired the BHP option in the ACA, ended its program. The Washington BHP went through a number of changes since it began in 1987. After the economic downturn in 2008, state funding for BHP was cut by 43 percent with ensuing program cuts. After the ACA, Washington was one of seven states in the country to get a “transitional bridge” waiver to cover nonelderly adults up to 133 percent FPL, beginning in 2011. That waiver was in effect until Washington’s 1115 Medicaid waiver went into effect January 2014, allowing the state to transfer transitional program enrollees to the expanded Medicaid program. Washington also opened a state-based exchange, which made the highly subsidized CSR plans available to adults above 138 percent FPL. Washington has repeatedly considered reinstating the BHP. But to-date has declined to do so.

While many states have considered implementing a BHP, only two – New York and Minnesota – have done so.<sup>43</sup> Each had unique circumstances that made the BHP a logical and attractive choice for the state.

### *New York*

In 2001 New York lost a state court decision that required the state to provide state-only funded Medicaid coverage for legally authorized immigrants who were barred from Medicaid eligibility because of their eligibility status – principally, if they had been in the U.S. for less than five years. New York has had a substantial number of immigrants that are eligible for this coverage over the last 15 years.

In 2015, when New York transferred 259,000 enrollees from its state-only funded Medicaid coverage to the Essential Plan (New York’s BHP), all of these enrollees were lawfully residing immigrants with incomes below 138 percent FPL. According to the state Department of Health, this transfer would save the state over \$1 billion in state FY 2015-2016. When the program extended to all New York residents below 200 percent FPL in January 2016, the state predicted annual savings would decrease to \$803 million – still a considerable savings when compared to the previous annual state expenditures for immigrants ineligible for federally-matched Medicaid.

In 2016, the Essential Plan charges an individual with household income from 150 percent to 200 percent FPL an annual premium of \$240 for a plan with \$2,000 MOOP. Persons below 150 percent FPL pay no premium and have limited to no cost sharing. (See Appendix 1 for Summary of Essential Plan Costs and Benefits)

---

<sup>43</sup> States that have, to-date, at some point considered and declined to go forward with developing a BHP include California, Connecticut, Maryland, Rhode Island and Washington. Inquiries made to national consultants involved in developing BHPs – including Manatt and the Wakely/Urban consultants for Oregon’s BHP analysis – did not turn up any states, other than Oregon, currently considering a BHP. Massachusetts has its own comprehensive reforms that predate the ACA and continue under an 1115 Medicaid waiver.

### *Minnesota*

The state had a long history of broad support for forging ahead with state-generated funding to extend health coverage to lower income persons. The state's MinnesotaCare program grew, since its launch in 1992 as Minnesota HealthRight, to a program that covered residents with incomes up to 275 percent FPL.<sup>44</sup> Provider and premium taxes provided, and continue to provide, the revenue stream for state support.

When Minnesota implemented its Marketplace (MNSure), the state did not cover people below 200 percent FPL, since the state intended to develop a BHP. Instead, Minnesota used a Medicaid transitional waiver to cover those enrollees and to give the state time to launch the BHP, which began in January 2015. For the BHP, Minnesota reduced income eligibility for MinnesotaCare to not exceed 200 percent FPL, transitioning those above that income to MNSure. In 2016, MinnesotaCare covers about 110,000 adults and state funding for the BHP is now \$162 million. This is a substantial savings from the state's costs for covering persons up to and exceeding 200 percent FPL entirely with state generated funds for more than two decades. Current BHP spending in Minnesota Care is even a savings over the Medicaid transitional waiver, which required state match that exceeded \$244 million in FY 2014.

---

<sup>44</sup> MinnesotaCare provided subsidized coverage for childless adults up to 250 percent FPL and parents up to 275 percent FPL.

## **Information Technology and Administration for BHP**

### **SBM-FP Technology Limitations**

The BHP requires an eligibility and enrollment IT infrastructure to support its implementation. A technology system is required to not only perform eligibility and enrollment functions but also support appeals, redeterminations, verification procedures, and disenrollment procedures to name only a few.

Oregon has two options for managing and operationalizing a BHP: 1) utilize and customize the federal platform or 2) develop our own eligibility system.

Oregon uses the federal platform for its QHP eligibility and enrollment technology system. HHS has improved this technology each year it has been in operation. However, HHS has made it clear that it has no plans to develop separate IT infrastructures for any state to offer BHP or any other state-specific healthcare reform efforts. HHS is unwilling to make the necessary IT investments to operationalize the state-specific rules needed to conduct BHP eligibility and enrollment determinations (among many other requirements). HHS has been unwilling to take on other IT projects requested by a number of states to improve administration of QHPs in the Marketplace. It is exceedingly unlikely that HHS will reconsider their position on BHP development. This means that the federal platform is not customizable for Oregon and the federal platform cannot support the BHP.

Second, Oregon could develop its own eligibility and enrollment system. Developing a system to support the functions required for a BHP would require significant state resources. Developing a system also has many operational unknowns and significant cost. A cost-benefit analysis was presented to the State Legislature last year after DCBS conducted a request for proposals process for an IT system for the Marketplace. At that time, the Legislature decided to forego a state-operated system after analyzing the costs, consumer impact, and operational risks associated with operating a technology system.

Without the ability to modify our existing use of the federal platform and the unknowns and significant expenses related to building our own technology to support the BHP, Oregon is constrained in its ability to operationalize a BHP.

### **Actuarial and other Administrative Responsibilities**

In addition to information technology requirements, a BHP requires separate actuarial expertise for activities such as rate setting and risk mitigation work such as reinsurance. This will be described in greater detail in the BHP blueprint.

## BHP Cost Projections

In a QHP, premiums and cost-sharing are paid for by a combination of the consumer's contributions to premium and cost-sharing and the Federal support through APTC and subsidies that reduce the member's copayments, coinsurance, deductible limit and MOOP.

If a state chooses to do a BHP, the Federal revenue for the BHP is calculated to be 95 percent of the APTC and CSR funding that would have subsidized the member's QHP. If a state reduces the consumer's required contribution to premium or cost-sharing from what it would have been in a QHP, the state must fund that difference – as well as make up the five percent loss in federal subsidy.<sup>45</sup> As the Wakely/Urban analysis of eight different scenarios demonstrates, this results in a substantial deficit to make up, even when states take innovative approaches.

One of the most important cost-reducing innovations in the Wakely/Urban analysis is an assumption that providers will be reimbursed at 82 percent of commercial rates. DCBS is uncertain whether providers would agree to this reduced reimbursement, but this assumption was built into all the scenarios – based on the 2015 Stakeholder report, which included input from provider organizations, and HB 4017 direction.<sup>46</sup> In addition, the Wakely/Urban study made the same assumption about reduced reimbursement for all services, including prescription drugs. However, insurers have regulatory and other barriers in negotiating prescription drug prices, which State Medicaid agencies do not, that may make achieving this level of discount outside of Medicaid more difficult.

Stakeholder recommendations and HB 4017 also directed that:

- All BHP participants should pay no cost-sharing.
- Only those above 138 percent FPL should pay premiums on a sliding scale.<sup>47</sup>
- Eligibility would be continuous for 12-months.
- Medical benefits should be the same as Medicaid without adult dental, though dental option should also be calculated.

The HB 4017 specifications are the assumptions in the report's scenarios 1 and 2, with projected annual BHP deficits of about \$63 million without dental coverage and \$99 million with dental coverage. Scenarios 1 and 2 are the most expensive of the scenarios modeled, but also come closest to the Medicaid equivalent no-cost coverage for enrolling the most people. Scenarios 1 and 2 also reduce the number of projected uninsured by an additional 3,600 persons over the two identical scenarios (5 and 6), which do not assume 12-months continuous enrollment.

---

<sup>45</sup> Table 1.1 *Consumer Premiums and Cost Sharing for Marketplace Benchmark Plan* in the Wakely/Urban report details the consumer's contribution to second lowest silver QHP premium and average out-of-pocket costs that, if reduced in a BHP, must be funded by the state.

<sup>46</sup> HB 4017 states that the rate would be an average of *Medicare* and commercial, which would result in a much higher payment of about 88.5 percent of commercial. However, the Stakeholder recommendation was an average of Medicaid and commercial rates, calculated to be about 82 percent of commercial. For purposes of the Wakely/Urban analysis, we assumed it to be the average of Medicaid and commercial rates.

<sup>47</sup> DCBS asked Wakely to calculate based on half of the QHP premiums, which increase with increasing income, to meet the requirement of a sliding scale for premiums. DCBS did not ask Wakely to model more generous premium approaches – such as New York's.

The total projected deficits in all scenarios include a projection for on-going administrative costs, but do not include one-time information technology expenses that would be incurred to build or modify a system. The Wakely/Urban study modeled alternative scenarios to those directed in HB 4017 to inform Oregon's consideration of different approaches to BHP and of BHP alternatives.

DRAFT

## **BHP Alternatives**

DCBS is also interested in alternative approaches to improving affordability and access, equity, and reducing Oregon's uninsured rate even further. The following is intended to prompt discussion by the BHP Subcommittee and the Marketplace Advisory Committee. It should not limit discussion and none should be regarded as a department proposal at this point.

The Oregon Health Authority has contracted with RAND Corporation to evaluate broader possibilities for covering and delivering care to all Oregon residents, as directed by HB 2828. The examples below are within the scope of HB 4017, directing consideration of the BHP, alternatives, and possible 1332 waivers.

### **Possible Alternatives within Marketplace QHP offerings**

- Expand the COFA state-funded program that funds the consumer's required contribution to premium and cost-sharing to include the estimated 4,000 lawfully present immigrants with household incomes at or below 138 percent FPL, now excluded from Medicaid eligibility because of the 5-year waiting period.
- Establish additional state-funded subsidies for everyone enrolled in a QHP, who is below 200 percent FPL.
- Develop targeted additional state tax credits for certain populations – e.g., those in family glitch households; those currently uninsured who enroll in a QHP; everyone below 175 percent FL.
- Encourage additional coordinated care model-like offerings in the Marketplace.

### **Other Possible Equity Solutions**

- Encourage Congress to authorize expansion of federal Medicaid subsidies, through the Qualified Medicare Beneficiaries (QMB) programs administered by the states, to make their coverage equivalent to expanded Medicaid for persons 100-138 percent FPL and equivalent to QHP subsidies for Medicare beneficiaries from 139 percent to 200 percent FPL.