

Basic Health Program (BHP) Stakeholder Group

AGENDA

August 13th, 2015

8:00 – 10:00 a.m.

Lincoln Building, 7th Floor Suite 775
421 SW Oak Street
Portland Oregon 97204

Call-in number: 888.398.2342

Participant code: 3732275

Webinar registration: <https://attendee.gotowebinar.com/register/7004342435701579777>

Time	Item	Presenter
8:00am	Welcome and introductions	OHA Staff
8:10am	Meeting Summary: 7/29 th	OHA Staff
8:15am	HB 2934: Revised Work plan <ul style="list-style-type: none">• Key topics, questions and revised timeline	OHA Staff
8:20am	HB 4109 BHP Feasibility Study (2014): Key results <ul style="list-style-type: none">• Market and delivery system, provider networks and provider reimbursement	OHA Staff
8:50am	Stakeholder group <ul style="list-style-type: none">• Input on program design considerations (cont.)	Advisory Group
9:50am	Wrap up, next steps	OHA staff

Materials

1. Agenda
2. HB 2934
3. Presentation

Next meeting:

Sept 16th, 2015, 3-5pm

Lincoln Building, 7th Floor Suite 775

421 SW Oak Street

Portland Oregon 97204

Enrolled
House Bill 2934

Sponsored by COMMITTEE ON HEALTH CARE

CHAPTER

AN ACT

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

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

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

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

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

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

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

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

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

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

Passed by House April 20, 2015

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate May 26, 2015

.....
Peter Courtney, President of Senate

Received by Governor:

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

Approved:

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

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

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

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

HB 2934: Basic Health Plan Stakeholder Group

**August 13th, 2015
Oregon Health Authority**

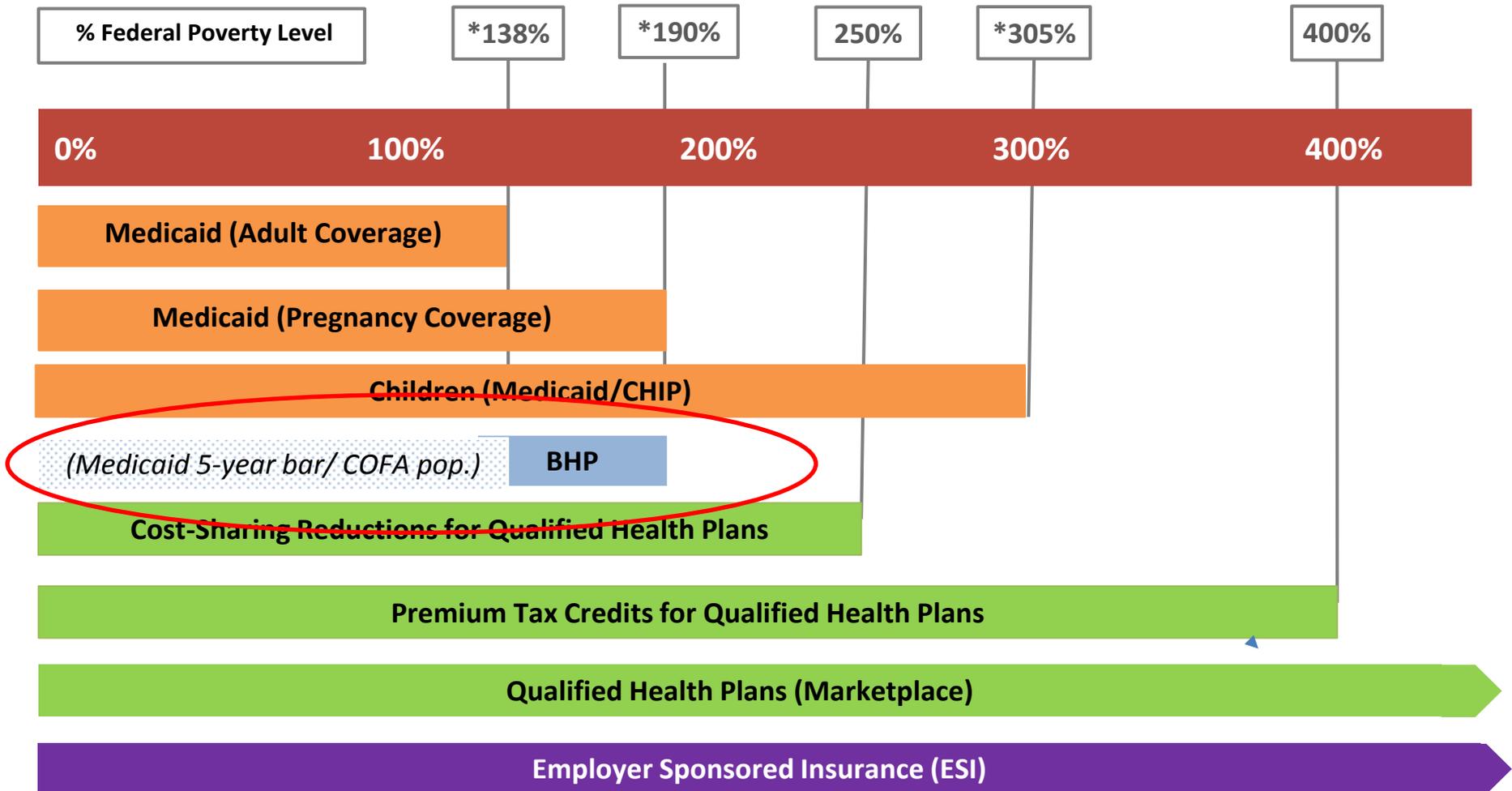
Presentation Overview

- Overview and background – revised work plan, timeline, and initial list of key considerations
- BHP Study (2014) – delivery system/carriers; provider reimbursement
- Input from stakeholder group: program design (cont.)

Basic Health Program (BHP) Overview

- The Affordable Care Act (ACA) gives states the option to establish a BHP for:
 - Individuals above 138% FPL up through 200% FPL who are ineligible for Medicaid or CHIP, and who do not have access to affordable employer coverage; and
 - Individuals at or below 138% of FPL who are ineligible for Medicaid due to immigration status.
- Federal government gives states 95% of what would have been spent on tax credits in the marketplace.
- Must offer two health plans; plans must include all essential 10 health benefits (EHB).
- Monthly premiums and cost sharing cannot exceed the amount the individual would have paid for coverage in the marketplace.

How BHP Could Fit into Oregon's Coverage Landscape

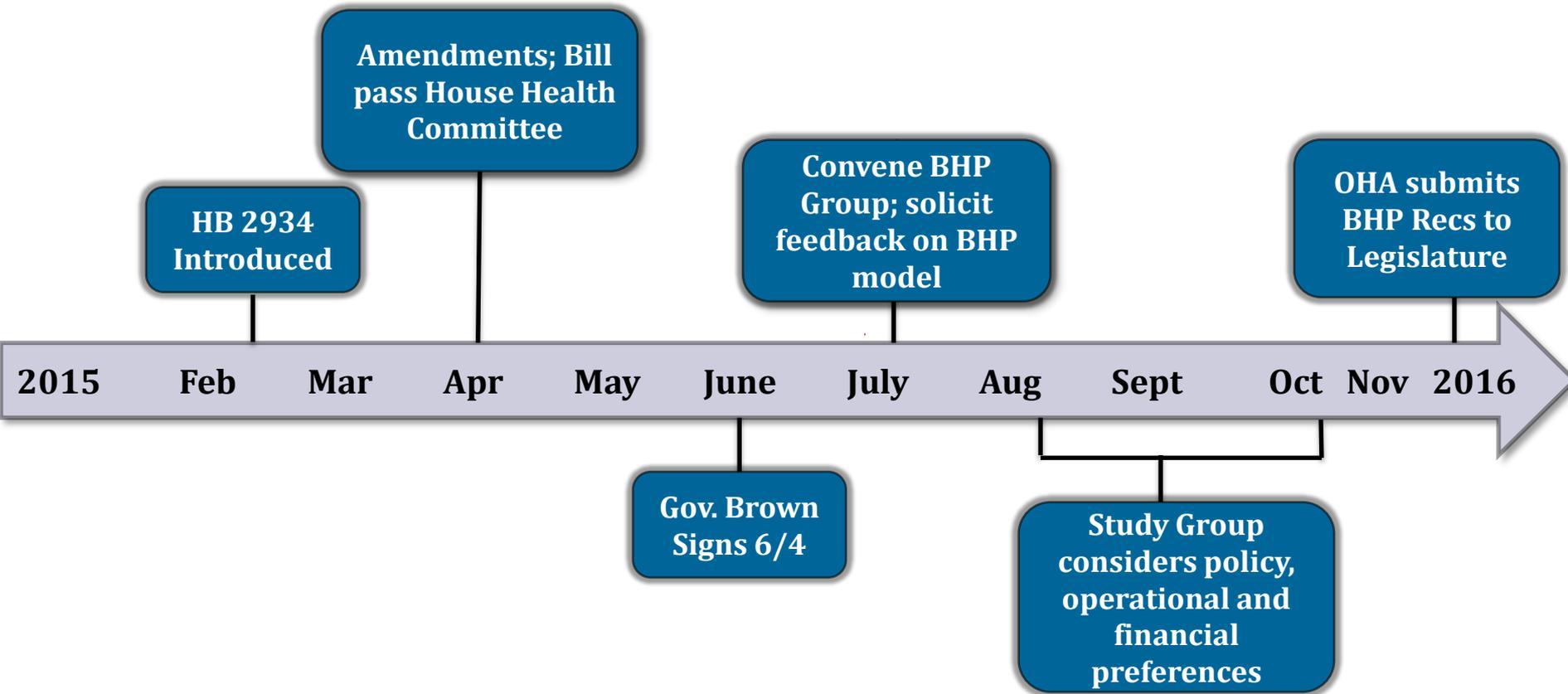


*Indicates the 5% across-the-board income disregard in Medicaid and CHIP. (Illustration adapted from the Washington State Health Care Authority.)

Requirements of HB 2934

- Requires OHA to convene a stakeholder group to provide recommendations to Legislative Assembly concerning the BHP.
- OHA must report recommendations to interim legislative committees no later than Dec. 1, 2015.
- Recommendations need to address “the policy, operational, and financial” preferences of the group in the “design and operation” of a BHP.
- Recommendations should further the goals of the Legislative Assembly of “reducing the cost of health care and ensuring all residents” of Oregon have equal access to health care.

Timeline: HB 2934 BHP Stakeholder Group



Revised Work plan/Timeline

Stakeholder group: four meetings

- **July 2nd** — initial convening of stakeholder group; outlined key findings from 2014 BHP study.
- **July 29th** — review federal guidance related to the BHP; consider consumer affordability, premium and cost-sharing options for BHP, and level of benefit coverage.
- **Aug. 13th** — review potential delivery systems, contracting and provider networks, and provider reimbursement.
- **September 16th** — review operational and financing considerations; review straw models and finalize recommendations for legislature.
- **Oct 8th**— finalize recommendations.

Revised Work plan/Timeline (cont.)

Report submission

- **October** — OHA staff finalize written recommendations for Legislature
- **November** — OHA submits recommendations to the Legislature
- **January (2016)** — presentation to House Committee on Health – Interim Legislative Days (**tentative*)

HB 4109 BHP Study (2014)

Per the requirements of House Bill 4109, the study estimated:

- Eligible BHP population including individuals likely to enroll
- Consumer affordability and continuity of coverage
- Impact to Oregon's Marketplace
- Potential federal funding for BHP
- State implementation and administrative costs

Consumer Preferences: Initial Reactions

Benefit coverage

- 2017 EHB benchmark plan via Marketplace)
 - 10 EHBs: PacificSource Preferred Codeduct value (2017)
 - Embed dental or offer as standalone option (?)

Consumer out-of-pocket option(s):

- Scenario b: Graduated cost-sharing
 - No cost-sharing \$0 <138% FPL
 - 2014 model: 50% cost-sharing for 139-200% FPL
 - Alternative tiered model: 138-150% FPL; 150-175% FPL; 175-200% FPL

BHP Oregon Evaluation Lens: Advantages and Disadvantages

○ Potential Advantages

- Reduced premiums and cost sharing for low-income individuals
- More low-income individuals able to afford coverage
- May smooth transitions as incomes fluctuate at 138% FPL

○ Potential Disadvantages

- Federal funding may not cover cost of plans; State will have financial exposure
- Identify funding source for start-up and ongoing administrative costs
- New transition point is created at 200% of the FPL.
- Exchange volume will decline; potential impact

○ Other Considerations

- Technological considerations (e.g. federally-facilitated marketplace or FFM)

Scope of Recommendations: HB 2934

○ Requirements for Program Design

Consumer Preferences

- Premiums and out-of-pocket costs
- Level of benefit coverage

Delivery System and Fiscal Preferences

- Plan offerings, procurement and contracting
- Provider reimbursement
- Network adequacy

Operations Considerations

- Enrollment period
- Disenrollment procedures for non-payment of premium
- Administrative financing (i.e. collection of premiums)
- Federally-facilitated Marketplace - feasibility
- Coordination of insurance affordability plans (IAPs)
(OHP/Marketplace)

Health Plans and Delivery System Considerations

SOURCE: Wakely BHP Model -- 2014 Report

HB 4109: BHP Study (2014)

Scenarios Modeled

	Scenario 1	Scenario 2
Covered Benefits	a. Commercial EHB b. OHP Plus	a. Commercial EHB b. OHP Plus
Provider Reimbursement level	Medicaid	Commercial
Member Premium	\$0	<138% FPL: \$0 138 – 200% FPL: 50% of QHP level
Member Cost Sharing	\$0	<138% FPL: \$0 138 – 200% FPL: 50% of QHP level

2016 Financial Impact to State

BHP Revenues and Expenses (\$000s)

		Scenario 1a	Scenario 1b	Scenario 2a	Scenario 2b
Revenue	Federal BHP Payment	\$207,498	\$207,498	\$191,573	\$191,573
	Member Premium	\$0	\$0	\$31,779	\$31,779
Claim and Carrier Expense	Claim Expense Liability	\$178,230	\$199,570	\$257,805	\$276,517
	Standard Health Plan Expenses [1]	\$15,498	\$17,354	\$45,495	\$48,797
Net	Surplus/(Deficit), Excluding State Admin	\$13,769	(\$9,426)	(\$79,948)	(\$101,962)
Admin Expenses	State Admin Expenses [2]	\$15,380	\$15,380	\$17,179	\$17,179
Net	Surplus/(Deficit)	(\$1,611)	(\$24,806)	(\$97,127)	(\$119,141)

[1] Standard Health Plan Expenses assume loss ratios of 92% for scenarios 1a /1b and 85% for scenarios 2a / 2b.

[2] State administrative expenses are estimated at \$19.32 PMPM/\$23.32 PMPM for Scenarios 1/2. The higher amount assumes that BHP, rather than plans, handle premium collection.

- Projected shortfalls in 2016, stated in dollars per year per enrollee, are \$24 for Scenario 1a; \$374 for Scenario 1b; \$1,582 for Scenario 2a; and \$1,941 for Scenario 2b.
- Scenario 1 assumes 66,000 enrollees and scenario 2 assumes 61,000 enrollees.

Financial Impact to State

- Wakely found a 2016 federal funding shortfall for each scenario:

Scenario :	1a	1b	2a	2b
Shortfall (millions):	\$1.6	\$24.8	\$97.1	\$119.1

- Major difference involves Scenarios 2a/2b vs. Scenarios 1a/1b. Why? Higher provider reimbursement with Scenarios 2a/2b.
- Could adjust scenarios to reduce or eliminate shortfall.
 - For example, adding \$10 monthly premium above 175% FPL to Scenario 1a would change it from shortfall to surplus.
- Other state budget effects need to be factored in.

Impact to the Individual Marketplace

- Fewer enrollees
 - 2014 BHP report estimated that BHP would reduce Marketplace size by 30%, from 187,000 to 131,000 covered lives
- Small increase in rates
 - 2014 report estimated that BHP would increase individual insurance rates by 1%, including in the Marketplace
 - Most Marketplace enrollees (62%) will have premium tax credits (PTCs) and be unaffected by 1% increase
 - 74,000 individually insured, inside and outside the Marketplace, will not get PTCs. They must pay the 1% increase. Most of them (50,000) earn > 400% FPL.

*Wakely/Urban Presentation to BHP Study Advisory Group, Sept. 22, 2014

Other Effects of a 30% Smaller Marketplace*

- Fewer covered lives = less carrier participation?
 - Will consumers have fewer QHP choices? Will less competition among carriers mean higher premiums?
 - No such problems emerged in 2014 in Minnesota, which implemented a BHP-like approach, limiting its marketplace to consumers over 200% FPL. Problems may occur there in the future, however.
- Fewer QHP surcharges = less ability to cover Marketplace administrative costs?
 - This problem could probably be prevented if BHP or BHP plans pay the Marketplace for services rendered

*Wakely/Urban Presentation to BHP Study Advisory Group, Sept. 22, 2014

Other Effects of Smaller Marketplace, cont'd*

- Fewer covered lives = possible Marketplace destabilization?
 - Highly unlikely under ACA insurance reforms
 - With BHP implementation, we estimate that 62% of Marketplace enrollees will have subsidies that can't be used to buy insurance elsewhere
 - Commonwealth Choice was an insurance exchange in MA that has been stable since its start in 2007, operating under insurance reforms like the ACA's. It had the following features:
 - It served only unsubsidized consumers >300% FPL
 - During its first several years, <20,000 people enrolled (<1/2 of 1% of the state's non-elderly adults)

*Wakely/Urban Presentation to BHP Study Advisory Group, Sept. 22, 2014

Coordinated Care*

- Longstanding state strategy: delivery system and payment reform via coordinated care
- Extending strategy to adults 138-200% FPL
 - BHP could use Coordinated Care Organizations (CCOs); likely to be more effective in promoting care coordination than QHPs (as currently configured)
- Federal BHP competitive bidding requirements
 - Must conduct a new RFA for BHP
 - Potential challenge: BHP consumers generally must be offered a choice between BHP plans from at least two sponsoring organizations. In some parts of Oregon, only one CCO is available.

*Wakely/Urban Presentation to BHP Study Advisory Group, Sept. 22, 2014

Table 3.3 – Summary of Expected BHP Claims Expense for Each Scenario

	Scenario 1a		Scenario 1b		Scenario 2a		Scenario 2b	
Covered Benefits	EHB		OHP <i>Plus</i>		EHB		OHP <i>Plus</i>	
Provider Reimbursement Level	Medicaid				Commercial			
Enrollee Premium / Cost Sharing (Relative to QHP Benchmark Coverage)	\$0				<138% FPL: \$0 138 – 200% FPL: 50%			
Expected BHP Enrollees	66,339				61,389			
Projected 2016 Claims Expense (\$000s)	\$178,230		\$199,570		\$257,805		\$276,517	
Projected 2016 Claims Expense Per Enrollee Per Year	\$2,687		\$3,008		\$4,200		\$4,504	

*Difference in provider rates b/w Scenarios 1 and 2 = ~ \$76 million

Table 3.4 – Total Projected BHP Cash Flows for 2016 (thousands)

		Scenario 1a	Scenario 1b	Scenario 2a	Scenario 2b
		Medicaid Reimb.		Commercial Reimb.	
Revenue	Federal BHP Payment	\$207,498	\$207,498	\$191,573	\$191,573
	Member Premium	\$0	\$0	\$31,779	\$31,779
Claim and Carrier Expense	Claim Expense Liability	\$178,230	\$199,570	\$257,805	\$276,517
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Net Per Enrollee Per Year	Surplus/(Deficit) [3]	(\$24)	(\$374)	(\$1,582)	(\$1,941)

[1] Standard Health Plan Expenses are based on assumed loss ratios of 92% for scenarios 1a /1b and 85% for scenarios 2a / 2b.

[2] State administrative expenses are assumed to be \$19.32 PMPM/\$23.32 PMPM for Scenarios 1/2. This assumption is based on the analysis described in Section 6, BHP operational considerations. Note that federal BHP payments cannot be used to directly offset state administrative expenses; however, the State can charge a fee to the standard health plan issuers that can be built into plan rates and thus offset by federal BHP payments.

[3] There may be other offsetting savings to the state resulting from the implementation of BHP. These are explored further in section 7 of this report.

BHP: Delivery System/Carrier Scenarios

Options in Oregon to offer Standard Health Plans:

1. Marketplace: competitive contracting process for commercial health plans to offer BHP options
2. CCOs: seek federal permission to waive the “competitive contracting process” and contract directly w/ CCOs to offer BHP
 - Would require federal permission to waive the “two plan” and “competitive contracting” requirements
 - Limit consumer choice compared with existing Marketplace
3. State contract directly with carriers to offer BHP (e.g. PEBB/OEBB); stand alone option
4. Hybrid-model: competitive contracting among CCOs and QHP carriers through Marketplace (pending federal/state approval)

BHP: Reimbursement Preferences

1. Medicaid level reimbursement to providers ~62-63% of commercial rates in Oregon
2. Commercial rates – significant cost implications for program
3. Medicaid rates ~ 81% of commercial rates in Oregon
4. Alternative approach: contract for negotiated rates...?

Delivery System Preferences

Delivery System Preferences: Initial Reactions?

Delivery System/Standard Health Plans:

1. Marketplace
2. CCOs
3. State contracts with health plans to offer BHP (stand alone option)
4. Hybrid approach

Provider reimbursement level:

1. Medicaid
2. Commercial
3. Medicare
4. Other (e.g. negotiated)

Next Steps

- **Sept. 16th** — review operational and financing considerations; eligibility and enrollment.

[Oregon Basic Health Program Study](#) report (2014) prepared by Wakely Consulting Group and the Urban Institute

Report available at:

http://www.oregon.gov/oha/OHPR/docs/OregonBasicHealthPlanReport_11.10.2014.pdf

HB 2934 Stakeholder Group (2015)

Upcoming Meetings

Dates & Times:

- September 16th, 3-5pm
- October 8th 8-10am (*final meeting)

Location:

OHA Transformation Center, 421 SW Oak St., PDX, Suite 775 (7th floor, Training Room)

HB 2934 report due to the Legislature by December 2015