Federal Health Reform in Oregon: Implications for Expanding Insurance Coverage and Access to Care

(Based on Oregon Health Policy and Research staff understanding as of April 1, 2010)

Policy/ program area	What federal reform does	Where there is state flexibility	Interactions with Oregon reforms and programs[1]	Details to be determined	Funding, pilots, and other opportunities
Medicaid/ CHIP	• All individuals under age 65 up to 133% of poverty and former foster children at all income levels up to age 26 are mandatory Medicaid populations (begins in 2014). • Federal funding established (100% for newly eligible in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and subsequent years). • Enhanced CHIP match for children by 23 percentage points which will raise Oregon's match to 96.7% from the current 73.7% (beginning in 2015). • Reduces federal aggregate disproportionate share hospital allotments gradually between 2014 and 2020 based on a state's uninsurance rate. Imposes smaller reductions for low-DSH states (which include Oregon with a FY 2009 DSH allotment of approximately $45.5 million). • States must maintain eligibility levels for adults until insurance exchange is fully operational and eligibility levels for children until 2019.	• Option to phase-in newly eligible population beginning in 2010. • Option to provide home and community-based services through state plan and not waiver for high-needs individuals up to 300% of the maximum SSI payment.	• Healthy KidsConnect will likely have interaction with an Oregon health insurance exchange. See Tax Credits for Purchasing Coverage and Health Insurance Exchange sections for further detail.	• Unclear as to whether Oregon would receive enhanced federal funding in 2014 for newly eligible individuals enrolled beginning in 2010. • Unclear as to how the community-based state plan option would affect Oregon.	Enhanced federal funding to implement coverage expansions.

[1] Oregon Health Authority and Department of Human Resources staff will provide support for analysis of these issues in coordination with statutory as well as informal advisory bodies including but not limited to the Health Services Commission, the Medicaid Advisory Committee, the Health Insurance Reform Advisory Committee, and the Cost-sharing Work Group.

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Health insurance exchange	• Annual grants for Exchange start-up costs (1 yr past bill passage through 2014). • States establish Exchanges for individuals and small groups (Jan. 2014). • Minimum Exchange functions specified in the bill. • Individuals are eligible for the Exchange if citizens or lawfully in the United States and not incarcerated; but individuals under 133% who are eligible for Medicaid must be enrolled in Medicaid. • Small employers with fewer than 100 employees are eligible. • HHS defines the benefits package that must be offered in Exchange plans with package to parallel benefits in employer-based plans. • HHS establishes additional criteria for qualified health plans that may be sold in the Exchange, sets open enrollment periods, reviews insurance rate increases. • Plans offered in the Exchange pay for a standardized percentage of the actuarial value of covered services (bronze to platinum). • Federal tax credits and cost-sharing reduction payments are available only in the Exchange. • There will be individual and small group markets outside the Exchange.	• States can choose to create two exchanges (individual and small business) or merge them • States can form regional exchanges. • States may allow employers with 100+ employees to participate in Exchange beginning 2017. • States may set additional criteria for plans selling in the Exchange (including but not limited to consideration of plan justifications for premium increases). • State may require Exchange plans to cover benefits not included in the benefits package established by HHS, but must pay additional cost of coverage for individuals receiving tax credits and reduced cost-sharing.	• Provides considerable definition to exchange business plan required by HB 2009. • More analysis required on how difficult the bill will make it to (1) require Exchange plans to use a value-based benefit package as specified in HB 2009 and (2) use a competitive bidding process to select plans to offer in the Exchange.	• HHS Secretary to establish criteria for qualified health plans. • Risk adjustment requirements unclear. • HHS guidance on benefits required.	• Annual grants for exchange start-up available until January 1, 2015; amounts to be determined by HHS Secretary.

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Tax credits for purchasing coverage	• Advanced refundable federal income tax credits to individuals lawfully in the US between 100% and 400% FPL on sliding scale (beginning 2014). • Tax credits and federal payments to reduce premiums and cost-sharing are not available to employees with access to an employer plan unless the plan's actuarial value is less than 60% of the cost of covered services or the employee share of premium for the employer plan exceeds 9.5% of income. • Tax credits and federal payments to reduce premiums and cost-sharing only available for purchase in the Exchange.	• States may further reduce premiums and cost-sharing to make coverage affordable at state expense. • Basic health plan option: States may use federal tax credit and cost-sharing reduction dollars (95%) to provide the essential benefits package to individuals from 133-200% FPL through standard contracted plans instead of the Exchange.	• Premiums may be higher than the 5% of household income standard recommended by the Health Fund Board's Eligibility & Enrollment Committee. • FHIAP and KidsConnect are income-based premium subsidy programs. State will need to decide how these program will fit into the structure of an Exchange.	• HHS will establish rules for basic health plans.	Increased affordability of health insurance for individuals under 400% FPL.
Cost-sharing reductions	• Federal payments reduce the out-of-pocket limit by specified amounts depending on income (2014). Silver plan is used as basis for calculation. • Additional federal payments will be made to plans to reduce cost-sharing as prescribed by HHS so the plan pays a specified percentage of total costs for covered services – from 94% to 70% depending on income (2014).	• See Tax Credits for Purchasing Coverage	• Cost-sharing levels and mechanisms will impact utilization incentives in the benefit plan.	• HHS will establish method of reducing cost sharing (by a date not specified)	
Public plan	• There will be no federal public plan. • However, created nonprofit Consumer Operated and Oriented Plan (CO-OP) program. • Office of Personnel Management to contract for at least 2 multi-state plans in Exchange.	• States can create own public plan and sell it under the Exchange provided it satisfies criteria for qualified plans.	• HB 2009 directs OHPB to do a feasibility study for a public plan. • CO-OP plan would be regulated by Ins. Division.	• Distribution formula for CO-OP appropriations.	• $6 billion available to finance CO-OP program.
High risk pool	• Temporary national high-risk pool program created. Effective within 90 days of enactment until Jan. 1, 2014.	• OMIP could apply to administer Oregon's program.	• OMIP statutes changed in 2010 special session to comply with federal requirements. • Eligibility criteria different and more restrictive than OMIP. • Additional federal funding will likely not cover costs for new eligibles.	• Application to be a high-risk pool entity not yet released.	• $5 billion appropriated, allocation methodology not established.

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Small business assistance	• Tax credits for small employers with low-wage employees to purchase employee coverage (credit amount varies but does not exceed 50% of cost) (2010-2013). • Tax credits for same employers available for maximum of two years for purchase through the Exchange (2014-forward).		• HB 2009 requires development of a small business product; impact of such a product unclear in context of federal reform		
Employer responsibilities	• Waiting periods for coverage may not exceed 90 days (Jan. 2014). • Non-offering employers with 50+ full-time equivalent employees pay an assessment if one or more full-time employees receives a premium tax credit. (Fee is $2,000 per full-time employee, excluding the first 30 employees.) Offering employers pay $3,000 per subsidized full-time employee per year. (Jan. 2014) • Employers with fewer than 50 full-time equivalent employees exempt from assessment. • Employer must provide a "free choice voucher" equal to the employer's contribution to an employer-sponsored plan to employees below 400% FPL whose premiums for the employer's plan are between 8-9.5% of income. Voucher allows employee to purchase non-subsidized coverage in the Exchange using employer dollars. • Employers with 200+ full-time employees must automatically enroll full-time employees in coverage offered by the employer. Employees may opt out of coverage.	• Federal law may preclude states from taxing employers based on whether or not they provide coverage for employees.	• HB 2009 directed HPB to assess feasibility of payroll tax to encourage employers to continue to provide coverage to their employees; should consider if needed given federal provisions.	• It is not clear whether each federal requirement creates a floor or whether it pre-empts greater state requirements.	
Individual responsibility	• Individuals required to maintain minimum essential coverage unless not affordable (Jan. 2014). • Penalty for non-compliance beginning in 2014 with amounts gradually increasing to the greater of $695 or 2.5% of taxable income in 2016. • Exemptions defined (including those for whom premiums cost more than 8% of income, those below tax filing threshold, those with less than 3-month gap, etc.) • Current coverage is treated as minimum essential coverage (on a grandfathered basis); new coverage must meet essential benefit requirements.	• No state flexibility on tax rules. • State could provide additional funds to eliminate the affordability gap (individuals for whom premium costs more than 8% of income) thereby tightening the mandate.	• "Minimum essential coverage" to satisfy the mandate need not meet the requirements of the HHS-defined "essential benefits package" for Exchange plans. In contrast, HB 2009 directed HPB to develop a baseline (essential) benefit plan to which all plans must conform. • Answers a question posed by HB 2009 re: advisability of a mandate.		

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			• Establishes what insurance benefit satisfies an individual insurance requirement.		
Insurance Regulation	• Guarantee Issue and renewability (Jan. 2014). • Rate Bands—allows variation based on age 3:1, rating area, family composition, tobacco use 1.5:1. • Pre-existing condition exclusions prohibited for children 6 months from enactment and for adults by 2014. • Eliminates waiting periods of more than 90 days for group coverage (Jan. 2014). • Prohibits lifetime limits, allows certain annual limits until 2014. • Dependent coverage up through age 26 for all plans 6 months from enactment.	• State could move to guarantee issue/renewability before 2014.	• HB 2009 directed the state to determine if such reforms were feasible and make recommendation for enabling legislation. • Oregon has different rating requirements so must come into compliance with new federal requirements by 2014. • FHIAP and PEBB/OEBB will need to allow dependent children to stay on plan longer.	• Intersection of federal review and state regulatory authority.	• Opportunity to apply for a 10-state demonstration to apply wellness incentives in individual market.
Insurance Oversight	• Plans must report expenses, spend minimum % of revenue on medical services or provide rebates. • Establishes federal process for annually reviewing premium increases, requiring plans to justify increases. • Establishes a federal consumer assistance or ombudsman program.	• States may collect additional information.	• Generally follows direction that Oregon has taken in making more insurance information more transparent. • Oregon law doesn't require annual review of "unreasonable" rate increases so federal review may be more exacting. • Insurance Division currently has regulatory authority for rate reviews. • Insurance Division also has a consumer protection unit and ombudsman.	• Intersection of federal review and state regulatory authority is not yet clear.	• $250 million in federal grants available to states to support premium review and approvals. • $30 million in federal grants to establish consumer assistance or ombudsman programs.
Reinsurance and risk adjustment	• Establishes a federal temporary reinsurance program for early retirees 90 days after enactment. • States must establish transitional reinsurance program for individual and small group markets 2014-2016. • Secretary establishes risk corridors for qualified health plans	• State can coordinate transitional program with state high-risk pool. • State can collect additional amounts on voluntary basis.	• HB 2755 requires DCBS to conduct reinsurance feasibility study and report by October 1, 2010. • Programs generally begin in	• Secretary establishes standards, formulas for payment and contributions from	• $5 billion appropriated to finance early retiree reinsurance program. • $25 billion over 3 years to fund transitional reinsurance program.

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	2014-2016. • States adjust risk in individual and small group markets, but not grandfathered plans.		2014 and last through 2016. Risk adjustment appears to be only mechanism to continue beyond that timeframe. • PEBB/OEBB could choose to be a participating employer in the early retiree program. • Further analysis needed on transitional reinsurance, risk corridors, risk adjustment.	insurers to the transitional program. • Coordination with state high-risk pool. • Risk corridor formula described in bill, but administration of assessments/ payments not clear. • HHS must set criteria/methods for risk adjustment with state input.	
Other Financing Mechanisms	• Excise tax on high-cost insurance plans of 40% of excess over a cap. Applies to self-insured plans and plans sold in group market but not plans sold in individual market. (Jan. 1, 2018) • Annual fee on health insurance, increasing gradually from $8 billion in 2014 to $14.3 billion in 2018. Fees for subsequent years are indexed. • Other taxes include annual fees on the pharmaceutical sector, Medicare related taxes, excise tax on medical devices, tanning tax, amongst others.	• States required to adhere to federal provisions.	• PEBB and OEBB may be considered high-cost plans and subject to excise tax. • Oregon's premium tax applies on insurers from October 1, 2009, through September 30, 2013. There is no overlap between Oregon's current premium tax and the federal annual health insurance fee.		