
Oregon Health Fund Board



Eligibility and Enrollment Committee

Affordability Recommendations to the Board

February 13, 2008

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Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

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Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program. In developing these recommendations, the Committee met six times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

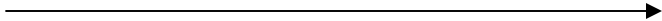
Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee’s task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

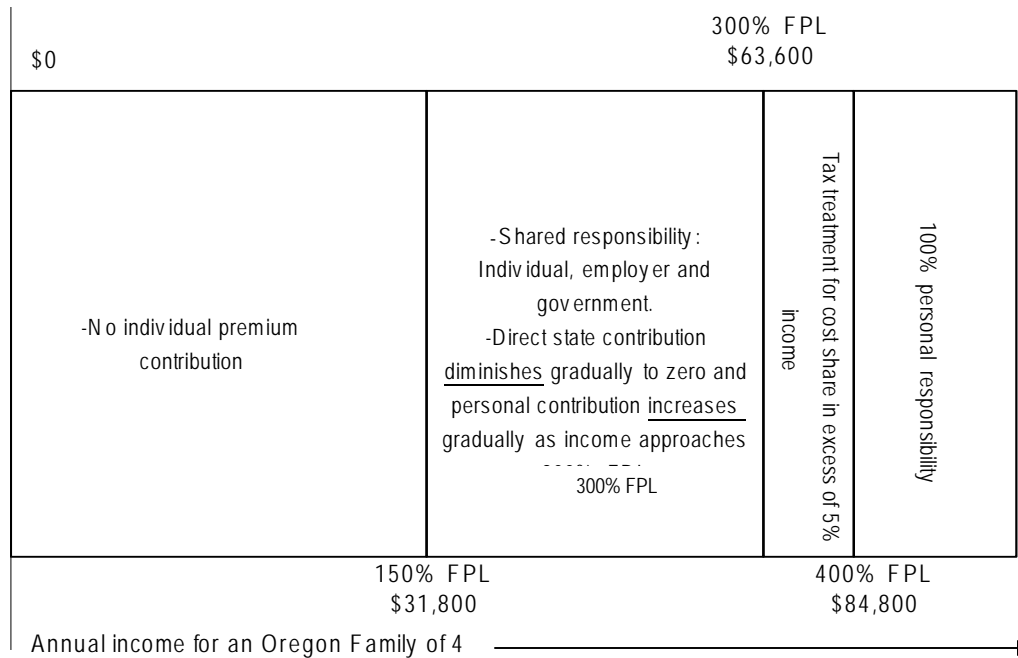
Increasing Annual Household Income 

<p>No Personal Cost Share For Premium Below x% FPL?</p>	<p>Shared State, Individual, and Employer Responsibility Between x% and x% FPL?</p>	<p>100% Personal Responsibility – No State Participation Above x% FPL?</p>
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Affordability Recommendations

- ❖ For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- ❖ Structure the personal cost share to emphasize premiums over other types of cost sharing.
 - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
 - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- ❖ Design state premium contribution as a gradual sliding scale to avoid a “notch effect” or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- ❖ Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability framework as recommended by the Eligibility and Enrollment Committee:



Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- ❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- ❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- ❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- ❖ Explore potential tax treatments for individuals between 300% and 400% FPL.
- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

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Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the six meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	208,000	42%	46,000	40%
150% to below 200%	67,000	13%	29,000	25%
200% to below 250%	60,000	12%	10,000	9%
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	499,000	100%	114,000	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [See www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance."¹
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of

¹ Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at <http://econ-www.mit.edu/files/128>.

Massachusetts Foundation, “Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.”²

- Drs. Matthew Carlson and Bill Wright’s presentation of data from a 3-year Medicaid cohort study, “Impact of Copays on a Medicaid Population.” www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf

Proposed Cost Sharing Structure Options

- A. The first question addressed by the committee was: At what income should a family reasonably be expected to share responsibility for premium cost?

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

- B. The second question addressed by the committee was: At what income level should premium cost be 100% personal responsibility?

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

² Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, “Setting A Standard Of Affordability For Health Insurance Coverage” *Health Affairs*, July/August 2007; 26(4): w463-w473.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit (\$15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty (\$26,000 annual income for one person), while a few others felt that the state contribution should not phase out until 400% of federal poverty (\$41,600 annual income for one person).

An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility

package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable.....Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option [150% FPL] increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning \$50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, “Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required.” Another member felt that sustainability included maximizing our federal leverage, “Still, in terms of maximizing federal contributions, I ... favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this.”

For the numbers of people potentially impacted by the Committee’s recommendations, see the attached chart, “Population Affected by Affordability Proposal.”

Recommendations

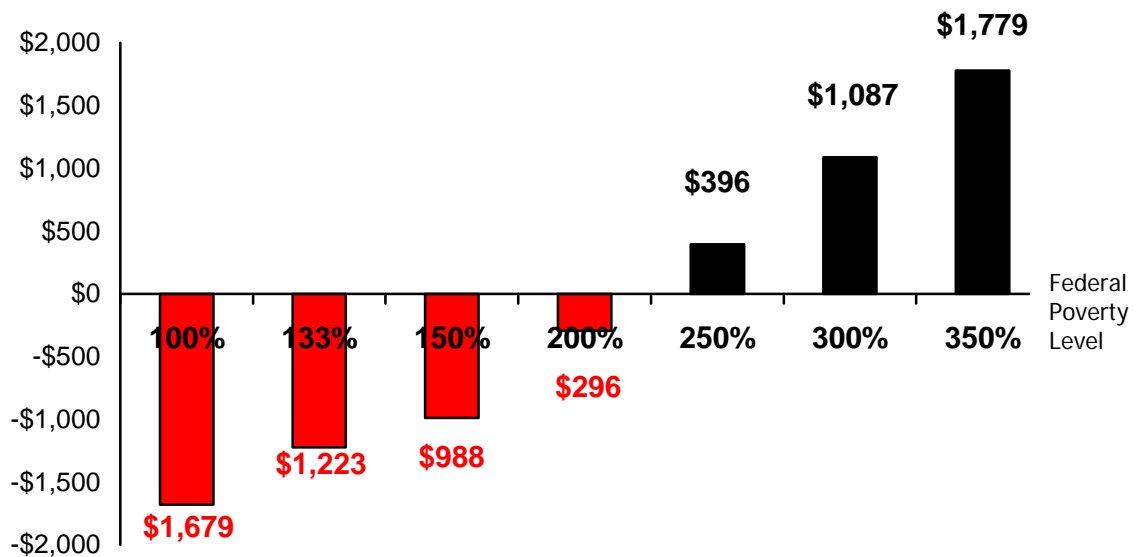
Recommendation #1: For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.

Proposal Overview

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute’s review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee’s recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee’s review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family’s income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



Source: Economic Policy Institute “Basic family budget calculator” Accessed online <12.05.06>
http://www.epi.org/content.cfm/datazone_fambud_budget

As one member noted, “A model that looks only at subsidies for ‘insurance premium’ costs when ... out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums...is unknown, cannot hope to succeed on the basis of ‘equity’ or ‘sustainability’. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring ‘affordability’.” Another

member echoed the “administrative simplicity” sentiment by suggesting potentially simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation #2: Structure individual cost sharing to emphasize premiums over other types of cost sharing.

- **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
- **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee’s approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee’s statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual’s payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family’s available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, “At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *unaffordable*?”

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of

the federal poverty level (FPL) or \$53,000 annually for the Portland area, 200% of FPL or \$42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL (\$42,000) in the Portland area, 250% FPL (\$35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level (\$15,600 for an individual or \$31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

Recommendation #3: Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them – Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #4: Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- ❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- ❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- ❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

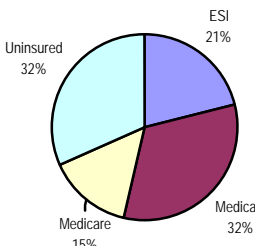
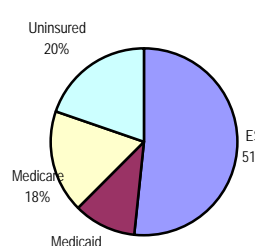
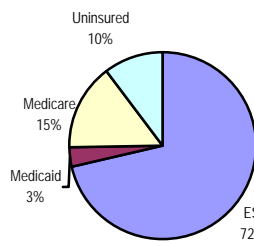
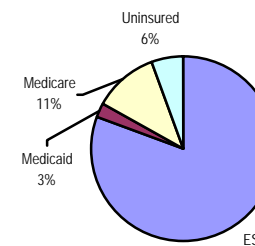
For the Finance Committee

- ❖ Explore potential tax treatments for individuals between 300% and 400% FPL.
- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
<p>806,000 Oregonians -550,000 insured (68%) -255,000 uninsured (32%)</p> <p>Insurance source for < 150% FPL:</p> 	<p>1,032,000 Oregonians -828,000 insured (80%) -204,000 uninsured (20%)</p> <p>Insurance source for 150% FPL to below 300% FPL:</p> 	<p>513,000 Oregonians -458,000 insured (89%) -55,000 uninsured (11%)</p> <p>Insurance source for 300% FPL to below 400% FPL:</p> 	<p>1,311,000 Oregonians -1,211,000 insured (93%) -99,000 uninsured (7%)</p> <p>Insurance source for 400% FPL and above:</p> 

Data from CPS 2-year average, Data collected in 2006 and 2007.

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	\$10,400	\$15,600	\$20,800	\$26,000	\$31,200	\$36,400	\$41,600
2	\$14,000	\$21,000	\$28,000	\$35,000	\$42,000	\$49,000	\$56,000
3	\$17,600	\$26,400	\$35,200	\$44,000	\$52,800	\$61,600	\$70,400
4	\$21,200	\$31,800	\$42,400	\$53,000	\$63,600	\$74,200	\$84,800
5	\$24,800	\$37,200	\$49,600	\$62,000	\$74,400	\$86,800	\$99,200
6	\$28,400	\$42,600	\$56,800	\$71,000	\$85,200	\$99,400	\$113,600
Each add'tl person, add	\$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.