

Basic Health Program (BHP) Stakeholder Group

AGENDA

September 16th, 2015

3:00 –5:00 p.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/6967362561122754050>

Time	Item	Presenter
3:00pm	Welcome and introductions	OHA Staff
3:10pm	HB 2934: Revised Stakeholder Process <ul style="list-style-type: none">Meeting Summary: 8/13thRevised process	OHA Staff
3:20pm	Oregon Marketplace <ul style="list-style-type: none">2014 and 2015 enrollment, premiums, and dental plans	D'Anne Gilmore, DCBS
3:40pm	BHP Program Design <ul style="list-style-type: none">Input on program design considerations-scenario 1AAddress identified constraintsReview advantages and disadvantages	Stakeholder Group
4:50pm	Wrap up, next steps	OHA staff

Materials

1. Agenda
2. HB 2934
3. August 13th meeting summary (*draft*)
4. BHP Learning Collaborative – State Experiences to Date, Sept. 2015
5. Presentation
6. Background info – federal immigration definitions (from ASPE [issue brief](#), March 2012)

Next meeting:

Oct. 8th, 2015, 8-10am

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 Program (BHP) Stakeholder Group

Meeting: August 13, 2015, 8:00am – 10:00am, 421 SW Oak Street, PDX 97201

Members in attendance: Rep. Keny-Guyer, J. Bauer, V. Demchak, A. Hess, Senator Shield's Staff; J. Francesconi, D. Gilmore, R. Moody, H. Rosenau, J. Santos-Lyons, D. Sobel, and M. Taylor.

Meeting Synopsis:

- Oregon legislative direction — Representative Greenlick asked the stakeholder group to come up with a \$0 General Fund recommendation, while Representative Keny-Guyer isn't operating under the same expectations.
- Several federal constraints around the competitive request for proposal (RFP) requirement for states interested in offering a Basic Health Program (BHP) and also the requirement to offer two standard health plans (SHP).
- Significant technological issues around eligibility and enrollment—the federal eligibility system cannot accommodate BHP programing requirements until at least 2018. Beyond 2018 is unknown.
- Stakeholder process—recommendation to OHA staff to create a model or framework to allow the stakeholder group to have a base program design (scenario 1A) and then provide options for the group to consider. Group will also periodically revisit potential advantages and disadvantages of a BHP in Oregon.
- Next steps—group would prefer to see the bigger picture of a BHP implementation in Oregon before confirming key operational design elements. Specifically, group would like to consider all available program design options “together” (collectively) rather than separately in terms of selecting program design preferences that impact overall costs of the BHP.

General Summary: OHA staff provided a summary overview of the federal BHP requirements and the timeline to report recommendations to interim legislative committees, no later than December 1, 2015.

OHA staff gave a brief overview of the workgroup preferences made in the previous BHP stakeholder group. During the July 29th meeting, the workgroup indicated initial preferences of utilizing the 2017 EHB benchmark plan, and having adult dental coverage be offered as a standalone option. The group also indicated initial preference of incorporating consumer out-of-pocket expenses, with some sort of a tiered cost sharing model based on federal poverty level (FPL).

The Stakeholder Group had a robust discussion on the previous meeting's recommendations, with at least one member of the group expressing concern with developing recommendations without all of the program design requirements being examined together.

OHA staff then led the group through a conversation about Health Plans and Delivery Systems considerations, drawing on the 2014 Oregon BHP Study. The group discussed the potential advantages and disadvantages of having the BHP operated through the Marketplace versus

coordinated care organizations (CCOs). Some members of the group shared concerns with potential impacts on the Marketplace. The group was not ready to make a recommendation on the overall delivery system design options.

Key Discussion Points and Considerations: Summarized below is a range of discussion points raised at the August 13th meeting including main decision points and preliminary recommendations put forth by the Stakeholder Group.

Administrative considerations: identified several potential complications if multiple benefit packages are offered basing this on historical experience in Oregon with having several benefit packages in Medicaid (OHP *Standard* and OHP *Plus*, pre-ACA). A single benefit package for all BHP enrollees would support administrative simplification of the program and likely result in lower administrative costs and less confusion among providers. The group requested additional information about administrative complexities and costs with offering multiple benefit packages in Medicaid, possibly historically data from OHP *Plus* and *Standard*.

Eligibility and enrollment systems: looking to the future, its unknown if or when CMS will be able to support states interested in pursuing a BHP that rely upon the federally-federally marketplace portal for enrollment? 2018, 2019, or later -- if at all?

- Currently, CMS is not able to develop and modify the federal eligibility system (FFM) required to support a BHP. What options, if any, are available for states that use the federally facilitated marketplace (FFM) to implement a BHP?
- New York and Minnesota operate state-based marketplaces (SBM) that use a single eligibility system for MAGI Medicaid, CHIP and Marketplace programs. Oregon, a Supported State Based Marketplace, uses the FFM for Marketplace eligibility and enrollment into qualified health plans (QHPs). For Medicaid, OHA is working to implement a new modified adjust gross income (MAGI) Medicaid eligibility and enrollment system called the ONE system.

Financing: federal funds cannot be used for development, start-up, or ongoing administration costs. Consequently, what source(s) of funding would be available for BHP start-up in Oregon (including eligibility system modifications, plan procurement, actuarial work, etc.) and ongoing administration costs (consumer outreach & assistance, premium billing if relevant, appeals, general program costs).

Benefit package: One potential option is to offer adult dental as a separate standalone package available for individuals to purchase rather than embedding dental into the standard health plan (SHP). In terms of cost drivers with the BHP, offering dental benefits is the largest and most costly benefit when comparing benefit differences between Medicaid and the Marketplace.

Consumer affordability: consensus that co-pays should not be included in the BHP due to administrative complexities and concerns with potentially creating a barrier to care. Group agreed to move forward with no-cost sharing below 138% and a graduated cost-sharing

structure for those between 139-200% FPL (similar to New York's BHP model). Focus should be on premiums rather than co-pays and use of cost-sharing to deter non-urgent utilization of emergency services.

Oregon Health Plan (OHP): several considerations summarized below.

- Pregnancy coverage: moving pregnant women b/w 138-185% FPL out of Medicaid into BHP. CMS requires states to maintain existing coverage for traditional Medicaid populations including any pre-ACA expansion populations post ACA implementation. Prior to 2014, Oregon covered pregnant women up to 185%. Whether CMS would allow a state to transition pregnancy related coverage category in Medicaid into BHP is unknown. Oregon would need to seek federal guidance about permissibility of this option including offering a compelling rationale for such a policy. Transitioning pregnancy related Medicaid coverage into BHP would likely increase "federal deficit."
- Question re: what percent of enrollees in the Citizen Alien Waived Emergent Medical (CAWEM) would be eligible for BHP and thus generate potential cost-savings in Oregon by ensuring coverage for these women through BHP rather than Medicaid CAWEM?
- Financial sustainability of Medicaid: projected \$500 million shortfall in the 2017-2019 biennium for Oregon's Medicaid program.

Oregon Marketplace: group asked staff to compare 2014 projections developed by Wakely and Urban with actual enrollment in Oregon's Marketplace in 2014 and 2015. Also, the group would like staff to assess whether the potential impact to the Marketplace is significantly different than estimated by Wakely in 2014 based on actual enrollment in QHPs in 2014 and 2015. Potential comparisons should cover:

- Estimated vs. actual monthly premium for those under 200% FPL?
- Size of Oregon's Marketplace in terms of enrollment below 200% FPL.
- Any estimates for the remaining uninsured below 200% FPL?
- Percentage of Marketplace enrollees that purchase dental coverage, including individuals below 200% of FPL.
- Impact to the Marketplace in terms of sustainability. Wakely estimated that 1/3 of the Marketplace would transition to a BHP in 2016. Based on actual 2014 and 2015 enrollment is the magnitude correct? Over estimate, underestimate?

Federal requirements: existing BHP federal regulations.

- Two carrier requirement. CMS requires states to offer BHP enrollees are least two standard health plans (SHPs) of which have to be offered by two different carriers.
- Selecting BHP health plans: states are required to conduct a competitive RFP process to select SHP carriers. There could be flexibility at the federal level through an exemption process by CMS. However, it's unclear whether CMS will allow states to request exemption for the entire state vs. certain geographic areas that have limited carrier/provider participation.

Bifurcated BHP: suggestion to offer the BHP in both Medicaid and the Marketplace, simultaneously. Specifically, individuals below 138% would be enrolled in a BHP in Medicaid through CCOs setting aside a number of significant federal exceptions that would be needed to adopt this approach. The remaining BHP eligible population would be offered a BHP in the Marketplace (139-200% FPL).

- This option could simplify administrative complexities, with some unknown set up costs to implement.
- Federal guidance would be needed around this, and whether this is even federally permissible as well as a number of substantial IT challenges.

Advantages and disadvantages of a BHP in Oregon: What's the issue that the BHP is attempting to address?

- Potential to offer additional services not otherwise currently offered in Oregon's standard benchmark plan.
- Design a BHP to encourage individuals to utilize primary and preventive care services by removing co-pays for covered services.
- Create state savings by transitioning Medicaid pregnancy related coverage between 139-185% into a BHP. CAWEM is an additional population to consider.
- BHP as a mechanism to further spread the coordinated care model (CCM) in Oregon.

HB 2934 stakeholder process: members expressed the need to take a different approach to develop recommendations from the approach laid out by OHA staff. Several group members suggested that the starting place for the discussion in September should be with scenario 1A and then adding to and taking away various program design elements in an effort to arrive at a scenario that is close to "break even" for the State.

Follow-up and next steps:

- Additional financial resources to rerun the BHP model. Oregon Legislature did not provide any funding in HB 2934 to support this work, specifically, additional econometric or actuarial modeling to update the 2014 model developed by Wakely and Urban.
- In September, share information on enrollment in QHPs in 2014 and 2015.
- Develop a list of "federal/policy constraints" for the group to consider as part of their recommendations.
- Next meeting, start the discussion using scenario 1A.
 - Review options/scenarios around costs (e.g. benefit package, premiums)
 - Consider list of constraints identified that the legislature would need to be aware of in terms of federal permissibility.
 - Revisit the "advantages & disadvantages" of a BHP.

Medicaid and CHIP

MAC

Learning Collaboratives

**Basic Health Program (BHP)
Learning Collaborative:**

**BHP Planning & Implementation –
State Experiences to Date**

September 2015

BHP Learning Collaborative (LC) Overview

- Established by CMS in 2013 as a forum for discussion among states and officials from the Center for Medicaid and CHIP Services (CMCS) for the purpose of shaping BHP guidance and supporting program implementation
- Led by CMS and supported by Manatt and Mathematica

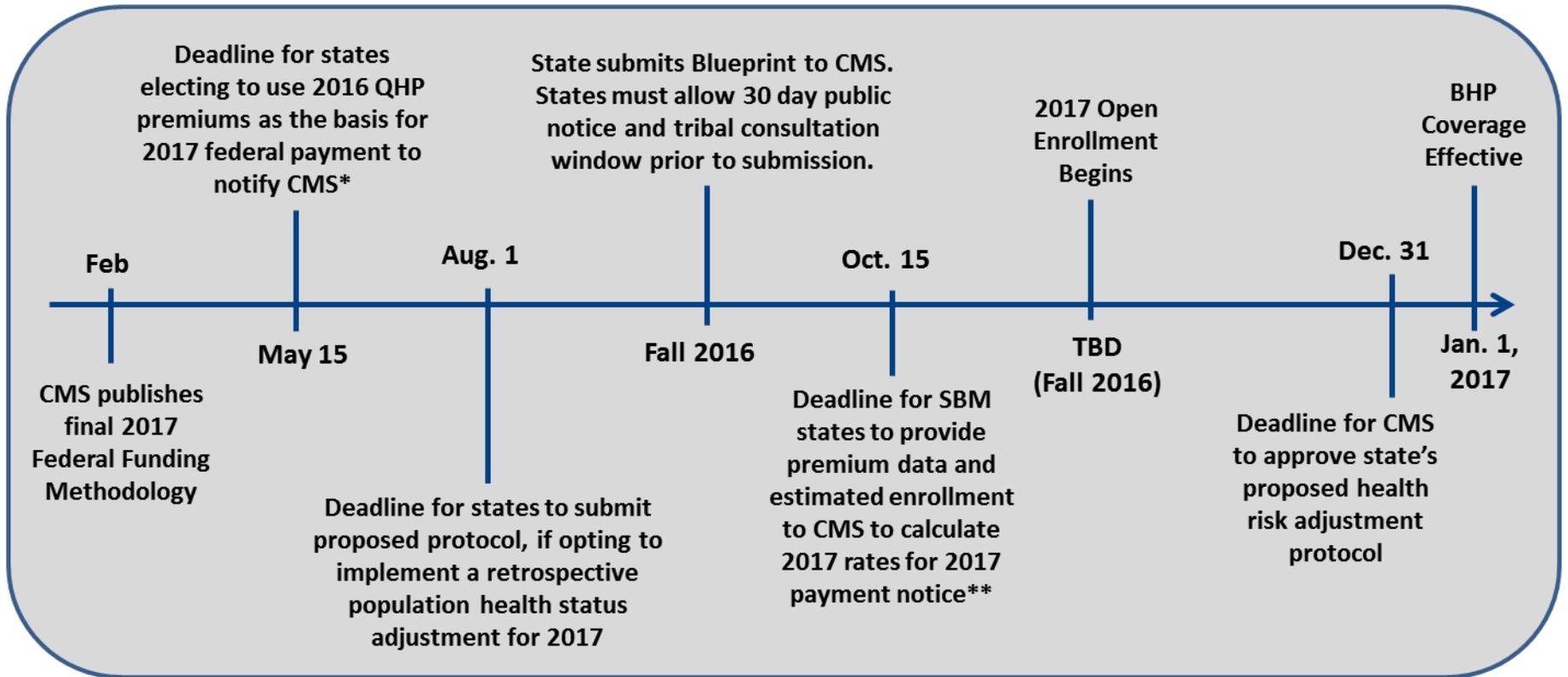
Basic Health Program Refresher

Basic Health Program Summary

- ACA gives states the option to establish a Basic Health Program (BHP) to provide subsidized coverage to low-income individuals who are ineligible for Medicaid, CHIP, other MEC, and do not have access to affordable employer coverage
- People with incomes 133-200% FPL and lawfully present non-citizens with incomes 0-200% FPL who are ineligible for Medicaid due to citizenship status are eligible for BHP
- Federal government gives states 95% of what would have been spent on APTC/CSR in the Marketplace
- Health plans must at a minimum include essential health benefits
- Monthly premiums and cost sharing cannot exceed the amount the individual would have been required to pay if the individual had received coverage in the Marketplace

ACA Section 1331; Full list of regulatory guidance at Appendix A

2016 BHP Planning Timeline for January 1, 2017 BHP Implementation



* To allow greater certainty regarding total BHP payments for 2017, states are provided the option to have final 2017 federal BHP payment rates calculated using the projected 2016 adjusted reference premium (i.e., to use 2016 premium data multiplied by a defined premium trend factor to calculate payment rates). States that elect to use 2016 premiums as the basis for the 2017 BHP federal payment must inform CMS no later than May 15, 2016.

** States implementing BHP must submit actual enrollment data to CMS each quarter.

Key Implementation Steps

Standard Health Plan Contracting & Management

- Define plan requirements (e.g., quality, local provider availability, actuarial value, premiums, innovative features etc.)
- Conduct plan procurement
- Protect against discrimination
- Establish infrastructure for on-going oversight

Eligibility & Enrollment Standards

- Determine whether to align the following with Marketplace or Medicaid standards:
- Authorized representatives and certified application counselors, if permitted
 - Enrollment period (open vs. continuous)
 - Effective date for eligibility
 - Redeterminations
 - Appeals
 - Verification procedures
 - Disenrollment procedures due to premium non-payment

Administration

- Configure IT systems
- Establish Trust Fund and appoint trustees
- Select administering agency and officials
- Submit required reports
- Develop, submit and oversee Blueprint
- Provide public access to premium and cost-sharing information

Financing

- Analyze program costs and available financing
- Evaluate affordability
- Submit premium data to CMS (for SBM states)
- Submit projected enrollment data to CMS
- Determine use of health risk adjustment

Federal Guidance on Health Risk Adjustment

- State option to propose and implement a retrospective adjustment to federal BHP payments to reflect the actual value that would be assigned to the population health factor based on 2016 program data
- States electing this option must develop proposed protocol, including description of how state will collect necessary data to determine adjustment
- Following 2016 program year, CMS will review state's findings and adjust state's BHP federal payment amount, as necessary
- Absent state election to pursue a retrospective adjustment, CMS assumes no health status differences between BHP and QHP enrollees

BHP Planning and Implementation: State Experiences to Date

State Approaches to BHP

	Minnesota	New York
Program Administration & Financing	<ul style="list-style-type: none"> Administered by MN Dept of Human Services (DHS) Funded via Health Care Access Fund 	<ul style="list-style-type: none"> Administered by NY Dept of Health (DOH) Funded via state budget appropriation based on state savings
Timing for Launch	<ul style="list-style-type: none"> Implemented BHP on January 1, 2015 	<ul style="list-style-type: none"> Phasing in BHP beginning on April 1, 2015; full implementation planned for January 1, 2016
BHP Population	<ul style="list-style-type: none"> Individuals with household incomes between 133 – 200% FPL Lawfully present non-citizens with household incomes 0-200% FPL 	<p>Transition Period:</p> <ul style="list-style-type: none"> Lawfully present non-citizens with household incomes 0-133% FPL <p>Full Launch:</p> <ul style="list-style-type: none"> Individuals with household incomes between 133 – 200% FPL Lawfully present non-citizens with household incomes 0-200% FPL
Avg. Enrollment	<ul style="list-style-type: none"> Approximately 100 – 117,000/month 	<ul style="list-style-type: none"> Projected annual enrollment following full implementation: 470,000+
Standard Health Plans	<ul style="list-style-type: none"> 2014 MinnesotaCare managed care plans providing coverage in 2015; full procurement for 2016 coverage year 	<ul style="list-style-type: none"> MMC plans providing coverage for 2015 transition population; completing full procurement for 2016 coverage year

State Reasons for Pursuing BHP

- Build on previous innovative state coverage initiatives
- Increase in federal funding flows to cover existing coverage populations
- More affordable premiums and cost-sharing for enrollees
- Administrative simplification/avoidance of churn in 2015



New York's Implementation Experience

New York's BHP Experience: Program Administration



Approach

- New York State Department of Health (DOH) administers its BHP (known as the “Essential Plan,” or “EP” in New York), as well as the state’s Medicaid and CHIP programs and NY State of Health (the State-based Marketplace)
- Commissioner of the DOH is the State Administrative Officer who is responsible for program oversight
- EP being implemented by interdisciplinary team pulled from Medicaid and Marketplace
 - Despite interdepartmental nature, team fully integrated



Key Insights

- NY’s fully integrated administrative structure has facilitated some administrative simplifications/efficiencies across coverage programs (e.g., EP procurement built off QHP procurement, EP rate development leveraged actuarial support for Medicaid rate development)
- Ability to leverage both Medicaid and Marketplace expertise very helpful to EP planning and implementation

New York's BHP Experience: Program Financing



Approach

- EP Cost Projections (April 2015 – March 2016)¹
 - Total EP Costs: \$1.7B
 - Federally Funded Trust Fund: \$1.57B
 - NYS Funds: \$155M
- Program administration costs are funded through state savings
- Between 2015 (transition period) and 2016 (full program launch):
 - Per enrollee costs expected to increase from \$445 to \$498 PMPM (about 12%), potentially due to general increases in health care costs and utilization
 - Federal per enrollee costs expected to decrease from \$430 to \$413 PMPM (about 4%) as new EP enrollees likely to have lower federal payments due to relatively higher incomes and smaller PTC/CSR amounts
- Estimated administrative costs to be revisited following full launch



Key Insights

- Ability to generate state savings by transitioning state-only financed populations to EP critical to securing state funds for program administration

New York's BHP Experience: BHP Population



Approach

- Phased implementation approach:¹
 - Transition Period (April 1 – December 31, 2015)
 - Lawfully present non-citizens with household incomes 0-133% FPL
 - Full Launch (January 1, 2016)
 - Individuals with household incomes between 133 – 200% FPL
 - Lawfully present non-citizens with household incomes 0-200% FPL
- Projected full annual enrollment following full implementation: 470,000+



Key Insights

- State was providing coverage to 250,000 lawfully present non-citizens with state-only dollars prior to transitioning this population to EP in April 2015

1) Lawfully present non-citizens who are children, pregnant women, or those in need of long-term care services remain in state-funded Medicaid coverage

New York's BHP Experience: BHP Launch



Approach

- Timing of full launch tied to Marketplace 2016 OEP due to large number of anticipated enrollees who will transition from QHP coverage
 - Using administrative renewal where possible for current QHP enrollees and their families
 - Those determined newly EP-eligible will be auto-enrolled into their QHP issuer's EP product if the EP network is comparable to the QHP network; otherwise, enrollee will be notified to select a new EP plan/product
 - State currently conducting review to compare EP and QHP networks
- Transition population will be converted from transition plans (MMC plans) to newly-procured EP products effective January 1, 2016
 - Enrollees will be auto-enrolled in MMC plan's EP product where available; if the MMC plan is not participating in newly-procured EP, consumer will be notified to select a new EP plan/product



Key Insights

- Phased-in approach to implementation allowed for:
 - near-term use of federal funding for existing coverage populations
 - alignment of full program launch with Marketplace OEP to smooth transitions for newly EP-eligible QHP enrollees and their families
 - additional time to ensure seamless conversion of transition population to EP
 - correlation of program launch with EP contracts

New York's BHP Experience: Standard Health Plans



Approach

- Contracted with MMC plans to provide EP coverage for 2015 transition population; completing new procurement for 2016 coverage
 - Targeted outreach to both MMC plans and QHP issuers to participate in 2016 EP procurement
- Waived requirements that each enrollee has a choice of at least 2 plans in 2015; will offer enrollee choice for 2016 coverage year
- DOH will oversee EPs
 - DOH MMC team overseeing 2015 transition plans
 - Marketplace team selecting and overseeing EPs from 2016 onward
- Rates are hybrid of Medicaid/Marketplace rate for 2016



Key Insights

- Rate setting required detailed analysis of differences in plan design/covered services across coverage programs

New York's BHP Experience: Standard Health Plans (cont.)



Approach

- EP modeled after standard Silver product on Marketplace with two premium and cost-sharing tiers:
 - At or below 150% FPL: No premium contribution, cost-sharing at Medicaid levels
 - 151 – 200% FPL: \$20 monthly premium contribution and higher cost-sharing (but lower than for standard Silver QHP)
- Individuals will have option to purchase an adult dental/vision add-on as part of EP
- Due to state law, transition population up to 133% FPL receives additional wrap-around benefits for which they would otherwise be eligible if enrolled in Medicaid (including adult vision/dental), as well as retroactive Medicaid eligibility, funded with state dollars



Key Insights

- Differences in plan design requirements added complexity to design process

New York's BHP Experience: Eligibility & Enrollment



Approach

- Integrated, automated eligibility system for Medicaid, CHIP and Marketplace programs
- Opting to implement continuous open enrollment and re-determine eligibility every 12 months
- In areas where states were granted flexibility, primarily follows Marketplace rules with some exceptions (e.g., Medicaid non-filer rules)
- Availability of multiple coverage options (wrap benefits for transition population, two-tiers of co-premiums/cost-sharing, availability of vision/dental wrap) adds complexity to the enrollment experience
- State not conducting outreach specific to EP – some targeted materials to Navigators/Assisters/Brokers, but most materials branded under New York State of Health and encompass whole suite of available coverage programs



Key Insights

- To guide planning and implementation and ensure seamlessness in enrollee transitions, New York developed tools for internal staff use that chart differences across coverage programs (e.g., across program rules, benefit design)

New York's BHP Experience: Key Policy Issues for Implementation



Approach

Non-Filer Households

- Because non-filers may be eligible for EP, state using Medicaid non-filer rules with retrospective sampling and CMS to evaluate potential payment adjustments

Risk Adjustment

- Urban Institute analysis estimated impact of EP in New York and projected:
 - marginally healthier EP population
 - minimal impact on premiums in the individual market with EP implementation
 - significant number of new EP enrollees who previously couldn't afford QHP coverage
- Accordingly, state did **not** opt for risk adjustment as part of payment methodology



Minnesota's Implementation Experience

Minnesota's BHP Experience: Program Administration



Approach

- Administered by the Minnesota Department of Human Services (DHS) in collaboration with other state agencies (the State Exchange, Commissioner of Health, Department of Commerce)
- State Medicaid Director is BHP State Administrative Officer who is responsible for program oversight
- Leveraged existing administrative structure of prior 1115 MinnesotaCare program



Key Insights

- State was able to leverage prior administrative and operational structure; however, required education of existing staff and acquisition of new, specialized expertise (e.g., risk adjustment)

Minnesota's BHP Experience: Program Financing



Approach

- Cost Projections for CY 2015²
 - Total Medical Payments = ~\$633M
 - Premium Revenue = ~\$34M
 - Federal BHP Funding = ~\$229M
 - State Health Care Access Funding = ~\$370M
- Program administration costs funded through the state's Health Care Access Fund
 - Dedicated state funding source (separate from general funds) funded via broad-based tax on providers and insurance premiums



Key Insights

- Strong commitment to existing 1115 MinnesotaCare program and an influential advocacy community enabled use of state funds for program administration

Minnesota's BHP Experience: BHP Population



Approach

- Approximate monthly enrollment: 100 – 117,000 enrollees
 - New enrollees (versus transition population) account for approximately 25% of total
 - Too soon to determine differences in utilization or population demographics, but new applicants appear somewhat younger than average



Key Insights

- State was providing coverage to approximately 80,000 individuals through an existing 1115 MinnesotaCare program prior to launching BHP in January 2015

Minnesota's BHP Experience: BHP Launch



Approach

- Implemented BHP on January 1, 2015
- Employed block renewal process to convert 2014 MinnesotaCare enrollees transition population into BHP
- New applicants are able to submit online, phone or paper applications on a rolling basis year-round
- Utilized Navigators for consumer outreach and education regarding MinnesotaCare and application assistance



Key Insights

- Phased-in approach to implementation may be preferable to allow more time for system build, staff training, and verification of enrollees' continued eligibility under new program rules
- Consistent messaging at all levels (contact center, state/county staff, Navigators) critical, particularly at launch when systems/processes change to accommodate early lessons learned
- Navigators critical to maximizing enrollment and providing as seamless an experience as possible to the enrollee

Minnesota's BHP Experience: Standard Health Plans



Approach

- DHS oversees standard health plans (SHPs)
- Contracted with 8 plans for the 2015 coverage year
 - Due to state procurement cycle and timing of federal rulemaking process, leveraged existing 2014 MinnesotaCare contracts with health plans in 2015 to provide BHP coverage
 - New, statewide procurement conducted for 2016 SHPs; state has extended notices of intent to contract to selected plans, currently working to finalize contracts
- Waived requirements that each enrollee has a choice of at least 2 plans in 2015, will offer enrollee choice for 2016 coverage year
- SHP rates are developed using same process as used for state's Medicaid program, but based on MinnesotaCare enrollees' utilization and experience



Key Insights

- Program alignment between Medicaid and MinnesotaCare programs taken into consideration when selecting SHPs to receive notice of state's intent to contract for 2016

Minnesota's BHP Experience: Eligibility & Enrollment



Approach

- Single, shared eligibility system to determine eligibility for Medicaid, CHIP, BHP and Marketplace programs
- Opted to implement continuous enrollment and re-determine eligibility up to every 12 months with second year of enrollment synched to the calendar year
- In areas where states were granted flexibility to choose between Medicaid and Marketplace standards, primarily follows Medicaid rules with some exceptions



Key Insights

- Flexibility between Medicaid/Marketplace standards a positive, but also resulted in creation of complex set of “hybrid” program rules
- Improving the eligibility and enrollment process for mixed coverage households a key priority

Minnesota's BHP Experience: Key Policy Issues for Implementation



Approach

1332 Waiver

- Considering 1332 waiver as potential vehicle for promoting coordination and streamlining across Insurance Affordability Programs

Non-Filer Households

- Because non-filers may be eligible for MinnesotaCare, state using Medicaid non-filer rules

Risk Adjustment

- Opted to develop and implement a risk adjustment protocol as part of payment methodology



Key Insights

- Risk adjustment viewed as critical to financing and sustainability of MinnesotaCare

Development of Minnesota's Proposed Risk Adjustment Protocol

- Minnesota submitted initial proposed protocol to CMS in July 2014 and revised protocol in December 2014

Protocol describes state's proposed approach to:



Data
Model
Calculation
Population Health Factor
Health and Adjustment Process

Minnesota's Approach to Health Risk Adjustment



- **Data**

- Aggregated risk score information from final 2015 EDGE server submission for Minnesota's metallic individual market single risk pool
- Encounter data collected from standard health plan offerors under the MinnesotaCare program

- **Risk Adjustment Model**

- Federal HHS-HCC risk adjustment model
- Because same model adopted by state for individual market, ensures consistent risk measurement for MinnesotaCare and individual market populations, thereby simplifying calculation of the Population Health Factor (PHF)

Minnesota's Approach to Health Risk Adjustment



- **Calculation**

- Retrospective PHF adjustment intended to measure relative risk level of individual market including MinnesotaCare enrollees versus excluding MinnesotaCare enrollees
- PHF calculated as ratio of average risk score for individual market and MinnesotaCare populations combined, to average risk score for individual market population
- PHF calculation includes adjustment for differing levels of turnover in MinnesotaCare and individual market populations (as partial year members may have lower risk scores than they would had they been enrolled for the whole year)

Discussion on BHP State Planning & Implementation Experiences

Comments?

Questions?



BHP LC Contacts

CMS Contacts:

Stephanie Kaminsky

Stephanie.Kaminsky@cms.hhs.gov

Manning Pellanda

Manning.Pellanda@cms.hhs.gov

Appendix

BHP Final Guidance

- **Basic Health Program Final Rule**, published March 12, 2014. <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05299.pdf>
- **Fact Sheet on Final Rule**, published March 2014. <http://medicaid.gov/Basic-Health-Program/Downloads/BHP-Final-Rule-Fact-Sheet.pdf>
- **Medicaid and CHIP FAQs: The Basic Health Program**, published May 8, 2014. <http://www.medicare.gov/basic-health-program/downloads/basic-health-program-faqs-5-7-14.pdf>
- **Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015**, published June 2014. <http://medicaid.gov/Basic-Health-Program/Downloads/Risk-Adjustment-and-BHP-White-Paper.pdf>
- **Basic Health Program Federal Funding Methodology for Program Year 2016**, published February 2015. <https://www.federalregister.gov/articles/2015/02/24/2015-03662/basic-health-program-federal-funding-methodology-for-program-year-2016>
- **State Report for Health Insurance Exchange Premiums**, published October 2014. <http://medicaid.gov/basic-health-program/downloads/premium-data-collection-tool.zip>
- **BHP Blueprint**, published October 2014. <http://medicaid.gov/basic-health-program/downloads/bhp-blueprint.zip>

HB 2934: Basic Health Plan Stakeholder Group

**September 16th, 2015
Oregon Health Authority**

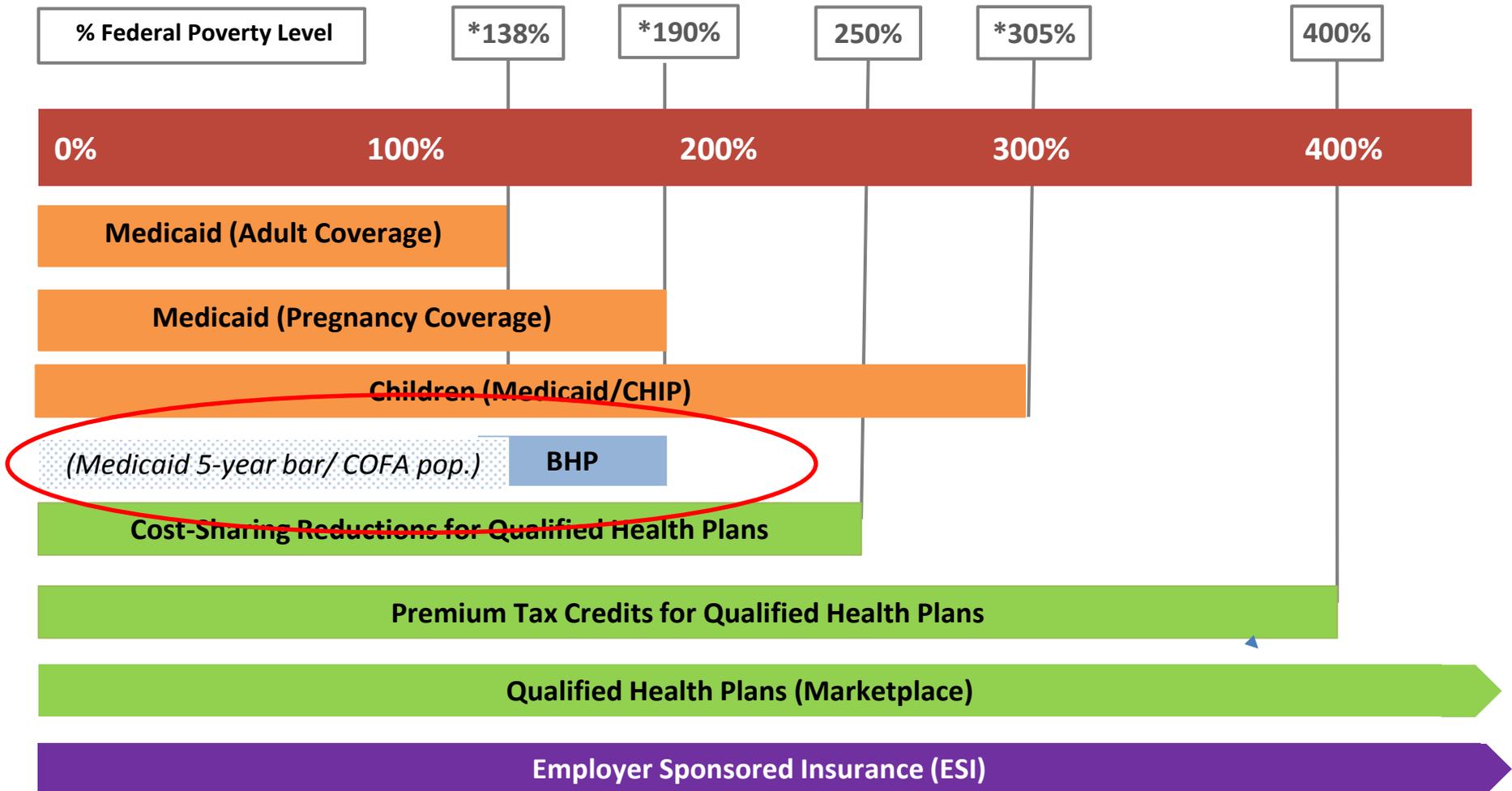
Presentation Overview

- Revised process: August 13th meeting recap
- Oregon Marketplace
- BHP Study (2014) – operational and financing considerations
- Input from stakeholder group on program design (cont.)
 - Scenario 1A

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

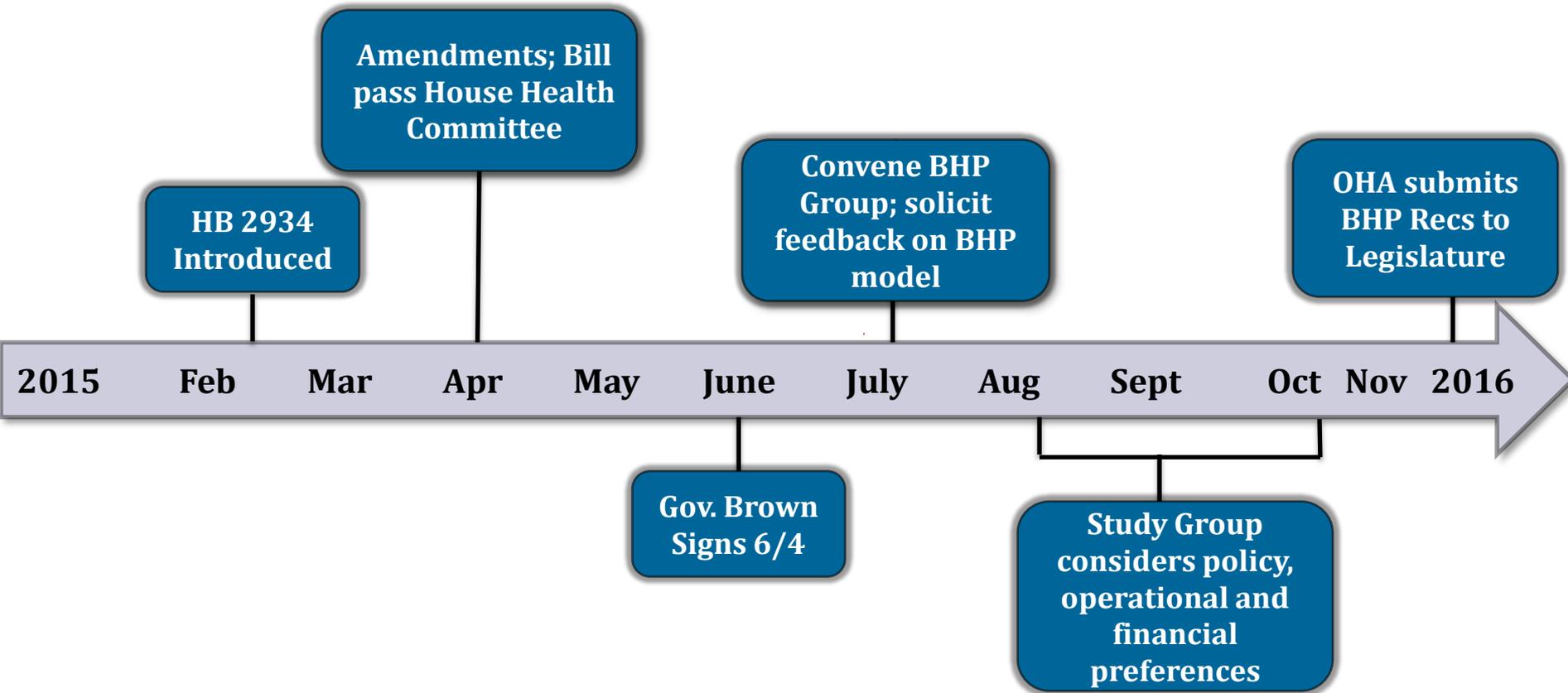


*Indicates the 5% across-the-board income disregard in Medicaid and CHIP. (Illustration adapted from the Washington State Health Care Authority.)

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 financing straw model and identify preliminary 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*)

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)

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
- BHP as a policy to spread coordinated care model (CCM)
- Offer additional benefit coverage; encourage appropriate use of primary and preventive care (e.g. removing copays)

○ 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

Policy and Operational Constraints

○ Federal requirements

- Ensure two standard health plans from at least two offerors (consumer choice)
- Competitive contracting process for selecting standard health plans

○ Financing

- Potential need for state general fund to support program
- Administrative expenditures
- Volatility in Marketplace (premiums)
- Carrier and provider participation

○ IT Systems – eligibility , enrollment and renewal

- Federally-facilitated Marketplace – federal feasibility
- Ability to monitor cost-sharing compliance

OREGON MARKETPLACE

2016 Marketplace Premiums and APTC

Individual Required to Pay				Total Premium with APTC			
Individual - 2016	Household Income (2015 FPL)	Percentage of income Individual will pay toward premium for 2 nd lowest silver*	Premium Cap (annual maximum contribution to premium paid by the individual)	Projected Second Lowest Silver Plan Premium*	Number of Months Premiums Paid	Projected Annual Premium	Total Covered by CMS with Advanced Payment Tax Credits (APTC)**
133% FPL	\$15,654	2%	\$318	\$274	12	\$3,288	\$2,970
150% FPL	\$17,655	4%	\$719	\$274	12	\$3,288	\$2,569
200% FPL	\$23,540	6%	\$1,509	\$274	12	\$3,288	\$1,779
250% FPL	\$29,425	8%	\$2,407	\$274	12	\$3,288	\$881
300% FPL	\$35,310	10%	\$ 3,411	\$274	12	\$3,288	\$ (123)
400% FPL	\$46,962	10%	\$4,537	\$274	12	\$3,288	\$ (1,249)

*Based on 2nd lowest approved standard plan silver rate for age 40, single, non-tobacco users in Portland metro. Actual second lowest silver for each area still to be determined by OID based on all health plans, not just standard plans.

**Does not include savings for those who also qualify for cost share reduction, reducing or eliminating their coinsurance or copays. Persons above 300%FPL would not pay more than the annual premium, but having exceeded the cap they would receive no tax credit. This helps to demonstrate the affordability of Oregon premiums, based on the federal definition of affordability.

Oregon Marketplace 2015

Marketplace Enrollment (2nd quarter, 2015)*

Plan types	Catastro phic	Bronze	Silver	Gold	Platinum	2015 Marketplace Total	2014 Marketplace Total	2014 to 2015 Marketplace Change +/-
Total	752	27,839	68,713	9,294	899	107,497	76,514	30,983

Marketplace Enrollment <200 % FPL (2nd quarter, 2015) **

0-200% FPL	2015 Marketplace Total	% Enrollment in QHP <200% FPL
47,380	107,497	42.3%

Adult Dental Plan Enrollment***

2015 Marketplace Total +	% Enrollment in QHP <200% FPL
21,592	-

*Data Source: OID Quarterly Enrollment Reports

** Information reported by Department of Human and Health Services (DHHS)

***Adults with dental-only plans: unknown what number/percentage of adults <200% FPL enrolled in QHPs purchased dental

+Enrollment is an average from 2nd quarter, 2015

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

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
	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)
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.

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.
- Other state budget effects need to be factored in.

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. Stand alone option: state contract directly with carriers to offer BHP (e.g. PEBB/OEBB)
4. Hybrid-model: competitive contracting among CCOs and QHP carriers through Marketplace (pending federal/state approval)

Table 1 – Program Design & Financing Input(s)(millions)*

BHP Program Elements	Design Options (Scenario 1) †	BHP Program (+/-)
1. Benefit Coverage: OHP Plus (*92% of cost difference b/w OHP and EHB is dental)	\$21.34	
2. Premiums (program revenue)		
\$10 monthly premiums with incomes >175% FPL	(\$2.6-\$3.5)	
\$10 monthly premiums with incomes > 150% FPL	(\$5.5-\$6.7)	
\$10 monthly premiums with incomes 138-150% FPL, \$20 premiums 151-175% FPL, and \$40 above 175% FPL	(\$17.3-19.1)	
3. Provider Reimbursement: commercial	\$76.95-\$79.57	
4. Standard Health Plans expense (8-15%) (92% and 85% MLR)		
8% (92% medical loss ratio MLR)	\$15.49-\$17.35	
15% (85% medical loss ratio MLR)	\$45.49-\$48.79	
5. Administrative Expenses (Premium billing)	\$15.38-\$17.19	
Net – Surplus/(Deficit)		

† (revenue)/program expense

*Listed in the table are potential design aspects of the BHP program identified as “modifiable” that could change the “bottom line” fiscal result as modeled by Wakely and Urban in the 2014. However, further analysis is needed to accurately and correctly determine the magnitude of these policy options.

Table 2: Approaches to Designing a BHP

BHP Program Elements	Design Preferences
1. Benefit Coverage (OHP/EHB)	
2. Premiums	
3. Provider Reimbursement <ul style="list-style-type: none"> • Medicaid, commercial, Medicare, other 	
4. Standard Health Plans expense (92% and 85% MLR)	
5. Administrative Considerations <ul style="list-style-type: none"> • Premium collection/billing • Consequences of non-payment (Disenrollment) • Funding 	
6. Eligibility Determinations/Enrollment Functions <ul style="list-style-type: none"> • Ongoing vs. open enrollment 	<i>Not modeled</i>
7. Enrollment and Eligibility <ul style="list-style-type: none"> • Enrollment criteria: ongoing, continuous vs. open enrollment periods • Eligibility criteria: Medicaid, current monthly income vs. Marketplace, projected annual income • Coverage limitations: retroactive coverage or prospective coverage 	<i>Not modeled</i>
8. Technological Considerations (Health.gov/FFM)	<i>Not modeled</i>



INCREASE



DECREASE



NO CHANGE/NO DIFFERENCE

Program Policy Considerations

Next Steps

- **Oct. 6th** — propose final draft recommendations.

[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:

- 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

Figure 5. Definitions

Foreign born: Someone born outside the United States and its territories, except those born abroad to U.S. citizen parents. The foreign born include those who have obtained U.S. citizenship through naturalization and other persons in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to U.S. citizen parents, are native born.

Immigrant: A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 et seq (similar to the statutory term “alien”). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this paper adheres to the legal definition of immigrant.

Lawful permanent residents (LPRs): People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

Naturalized citizens: LPRs who have become U.S. citizens through the naturalization process. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

Refugees and asylees: Persons granted legal status due to persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum application is approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants: Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants – The term “lawfully present” is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security (DHS) regulations at 8 CFR 103.12(a). The same definition is also used by the U.S. Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid (CMS) issued a guidance to states that further defined “lawfully present” for determining eligibility for Medicaid/CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009 (CMS, “Re: Medicaid and CHIP Coverage of ‘Lawfully Residing’ Children and Pregnant Women,” SHO # 10-006, CHIPRA #17, Center for Medicaid, CHIP, and Survey and Certification, July 1, 2010, <https://www.cms.gov/smdl/downloads/SHO10006.pdf>). Lawfully present immigrants broadly include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period, for work, as students, or because of political disruption or natural disasters in their home countries, and some may seek to adjust their status and may have a status that allows them to remain in the country but do not have the same rights as LPRs.

Qualified immigrants: The following foreign-born persons are considered for eligibility for federal benefits:

- LPRs
- refugees

- asylees
- persons paroled into the United States for at least one year
- persons granted withholding of deportation or removal
- persons granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees/asylees)

Nonqualified immigrants: Immigrants who do not fall under the qualified immigrant groups, including immigrants formerly considered permanently residing under color of law (PRUCOLs), persons with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban: Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States. Detailed immigrant eligibility criteria for these programs are provided in the discussion and tables of the report.

References

- Broder, Tanya. 2005. "Immigrant Eligibility for Public Benefits." In *Immigration and Nationality Law Handbook 2005–06*, edited by Gregory P. Adams (759–86). Washington, DC: American Immigration Lawyers Association. http://www.nilc.org/immspbs/special/imm_elig_for_pub_bens_aila_0305.pdf.
- Broder, Tanya, and Jonathan Blazer. 2010. "Overview of Immigrant Eligibility for Federal Programs." Washington, DC: National Immigration Law Center. <http://www.nilc.org/immspbs/special/overview-immeligfedprograms-2010-07.pdf>.
- Capps, Randy, and Karina Fortuny. 2006. "Immigration and Child and Family Policy." Washington, DC: The Urban Institute.
- Capps, Randy, Michael Fix, and Everett Henderson. 2009. "Trends in Immigrants' Use of Public Assistance after Welfare Reform." In *Immigrants and Welfare: The Impact of Welfare Reform on America's Newcomers*, edited by Michael Fix (93–122). New York: Russell Sage Foundation.
- Chilton, Mariana. 2007. "Well-Being of Citizen Children of Immigrants In Relation to Food Stamps and WIC, 1998–2005." Harris School Working Paper Series 07.10. Chicago, IL: University of Chicago. http://harrisschool.uchicago.edu/about/publications/working-papers/pdf/wp_07_10.pdf
- Crosnoe, Robert, Juan Pedroza, Kelly Purtell, Karina Fortuny, Krista Perreira, and Hirokazu Yoshikawa. Forthcoming. "Promising Practices for Increasing the Access of Immigrants to Health and Human Services." Washington, DC: Department of Health and Human Services.
- Cunyngham, Karen. 2004. "Trends in Food Stamp Program Participation Rates: 1999 to 2002." Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service.
- Dorn, Stan. 2011. "How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation." Washington, DC: The Urban Institute. <http://www.urban.org/UploadedPDF/412446-National-Health-Reform-Legislation.pdf>.
- Feld, Peter, and Britt Power. 2000. "Immigrants' Access to Healthcare after Welfare Reform: Findings from Focus Groups in Four Cities." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Fix, Michael E., and Jeffrey S. Passel. 2002. "The Scope and Impact of Welfare Reform's Immigrant Provisions." Assessing the New Federalism Discussion Paper 02-03. Washington, DC: The Urban Institute.