SB 1526: Program Design and Implementation Considerations for CHIP Premium Assistance in Oregon

INTRODUCTION

States have the flexibility to offer premium assistance programs using public funds through Medicaid and the Children's Health Insurance Program to subsidize private coverage.[i] Resulting from passage of Senate Bill 1526 (2014), the Oregon Health Authority (OHA) has been charged with examining the feasibility of offering premium assistance in Oregon's Children's Health Insurance Program (CHIP), for children in families with incomes between 200-300% of the federal poverty level (FPL).[ii]

With implementation of the Affordable Care Act (ACA), public and private health coverage options for children and families have changed, with implications for consumer access, benefit coverage, and affordability. The coverage landscape for low-income children includes Medicaid, the Children's Health Insurance Program (CHIP) and subsidized qualified health plans (QHPs) through the Marketplace. The latter potentially offer an alternative coverage source to children in families currently covered in CHIP between 138%-300% FPL. The ACA's individual mandate to obtain coverage may also lead to additional enrollment in employer-sponsored insurance (ESI) by families with children now enrolled in CHIP. This brief provides an overview of key policy and implementation issues in providing premium assistance to CHIP-eligible children.

Highlights

Key policy issues for premium assistance in CHIP for:

Consumers:

- Ensure voluntary participation and choice
- Foster whole family coverage
- Safeguard consumer out-of-pocket costs and affordability

Benefit Coverage and the Health System:

- Guarantee comparable CHIP benefit coverage
- Participation by health plans and overlap in provider networks
- Differences in provider reimbursement in Medicaid and commercial plans
- Impact on quality and accountability

Implementation:

- Requires federal and state authority
- Complexities with program administration
- Program cost-effectiveness and budget neutrality
- Outreach and education

As Oregon contemplates the feasibility of using federal CHIP funds to subsidize commercial insurance for children, there are two main commercial coverage options available[1]: QHPs and ESI. Either approach would shift children from public to private coverage. In enacted, approximately 17,000 children from 200%-300% FPL now enrolled in CHIP, approximately one-third of the state's CHIP population would have the option to enroll in to commercial coverage.

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[i] See Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, Final Rule. Federal Register/Vol. 78, No. 135 / Monday, July 15, 2013 (codified in title 45 of C.F.R.).

[ii] OHA is required to report its findings and any recommendations for legislation to the Senate Interim Committee on Health Care and Human Services no later than March 2015.

PROGRAM DESIGN CONSIDERATIONS

There are several issues and design parameters to consider regarding premium assistance for the CHIP population between 200%-300% FPL. In general, the structure of premium assistance programs creates a partnership between the government, commercial markets, health systems, and consumers to provide health care for beneficiaries. Several key issues affecting these groups are discussed below.

CONSUMERS

Voluntary Participation and Choice. Any premium assistance program must ensure that families with eligible children would have a choice to participate in premium assistance until they age out at 19, and be able to move back into direct CHIP coverage at any time.

Mixed Family Coverage. Under the ACA, a family may be eligible for different insurance programs—Medicaid, CHIP, Marketplace or ESI—referred to as "mixed" family coverage. Depending on carrier participation and provider network overlap in Medicaid and commercial markets, offering premium assistance to CHIP eligible children may help support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type.

*Cost-sharing and Affordability***.** Oregon families with children enrolled in CHIP do not pay premiums or cost sharing on behalf of their children. To ensure children in premium assistance do not have greater out-of-pocket costs than those with direct CHIP coverage, the state or carrier would have to wrap consumer out-of-pocket costs to the extent that they exceed CHIP levels. The state must also ensure that the total costs of premiums and cost sharing for a child does not exceed 5% of the family's income, per federal regulations.

Parents with children enrolled in CHIP may be eligible for subsidized QHP coverage through the Marketplace. While Oregon's CHIP does not impose premiums, it is important to examine the ramifications of doing so, if Oregon contemplates using consumer premiums as a mechanism to reduce state costs in a premium assistance program. In states with CHIP programs that have premiums, parents enrolled in QHPs would thus be required to pay premiums for their QHP coverage as well as premiums for children enrolled in CHIP. The could potentially result in an increase in the total percentage of family income required for insurance coverage, and exceed the maximum percentage of income allowed for Marketplace subsidized coverage, otherwise referred to as "premium stacking."

A 2014 study by Wakely Consulting Group [2] identified the most significant impact for CHIP enrollees transitioning to QHPs was a substantial increase in estimated out-of-pocket costs at the point of care (deductibles, copays, and/or coinsurance), which is similar with premium assistance through ESI coverage.[3] Annual cost sharing in QHPs is considerable higher relative to the $0 cost sharing in Oregon's CHIP program. Further, the financial impact to CHIP enrollees transitioning to QHPs is especially pronounced for children with special health care needs who would likely reach the out-of-pocket maximum for cost sharing in a year.[4]

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The following table compares the actuarial value[iii], average out-of-pocket costs (copayments, deductibles and coinsurance) and out-of-pocket maximums for children enrolled in CHIP compared to the coverage that would be available through the Marketplace in Oregon (with cost sharing reduction subsidies up to 250% FPL). The figures assume enrollment as an individual in the lowest cost silver plan. Member out-of-pocket costs are capped for coverage under both CHIP and plans offered on the Marketplace, limiting the financial exposure to families.[iv] Member out-of-pockets costs would also have to be capped for ESI offerings.

Table 1. Actuarial Value, Average Cost Sharing and Out-of-Pocket Maximum

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Average Annual Cost Sharing	$0	$411-$480	$0	$891-$960
Out-of-Pocket Maximum	$0	$1,250	$0	$5,000

Note: Wakely estimated the annual cost sharing for each state's CHIP plan using the actuarial value calculated for a standard population reflected in the 2015 Federal Actuarial Value Calculator. Their analysis assumed no difference in provider discounts negotiated by CHIP insurers or QHPs, which may be material. Estimates for the average annual cost sharing for QHPs used the national QHP premium averages for 2014 in states with a Federally-Facilitated Marketplace (FFM).

BENEFIT COVERAGE AND HEALTH SYSTEM

*Benefit Coverage***.** States have flexibility, within federal guidelines, to define the benefits covered by both CHIP and QHPs. Plans under both programs are generally required to provide basic services such as the core services described below. In general, state CHIP programs often provide more comprehensive benefit coverage than found in commercial health plans.[5,6] In Oregon, CHIP beneficiaries have access to full Medicaid benefits under the Oregon Health Plan (OHP) including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services mandated for children in Medicaid.

In the absence of a specific waiver, state premium assistance programs must provide "comparable coverage" to direct CHIP benefits, which often entails providing wraparound coverage to fill in gaps between commercial and CHIP benefits. Oregon's former CHIP premium assistance program, Healthy Kids Connect, phased out in 2013, found this requirement challenging over time as fewer and fewer plans met the benchmark[v] in order to participate in the program, i.e. individuals could only receive premium subsidies for plans that met the benchmark.

[iii] Actuarial value represents the share of health care expenses the plan covers for a typical group of enrollees.
[iv] Oregon's CHIP program does not require copays for its vision and dental services, whereas QHPs generally require 35% coinsurance after a deductible on routine vision exams (except for children age 3-5/6 depending on FPL) as well as on eyeglasses. Compared to CHIP, QHPs do not offer dental checkups as part of their EHBs.
[v] Per federal regulations, the benefit benchmark had to be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

The 2014 Wakely study[vi] also compared CHIP to QHP benefits (assuming enrollment as an individual in the lowest cost silver plan) across core and child-specific domains. Core benefits are those that are typically included in a major medical insurance policy. Child-specific benefits reflect additional services important when considering children's medical needs. See Table 2.

Table 2. Benefit Coverage Categories

Core Benefits	Child-Specific Benefits
1. Physician services	1. Dental – Preventive & Restorative Services
2. Clinic services & other ambulatory health care services	2. Dental Orthodontic
3. Laboratory & radiologic services	3. Vision – Exams
4. Durable medical equipment & other medically-related remedial devices	4. Vision – Corrective Lenses
5. Inpatient services	5. Audiology – Exams
6. Inpatient mental health services	6. Audiology – Hearing Aids
7. Surgical Services	7. ABA Therapy
8. Outpatient Services	8. Autism – General
9. Outpatient Mental Health Services	9. Physical, Occupational , and Speech Therapy
10. Prescription Drugs	10. Podiatry
11. Emergency Medical Transportation	11. Habilitation
	12. Enabling Services
	13. Non-emergency Medical Transportation
	14. Over-the-Counter Medications

Wakely found that benefits available through Oregon's CHIP program were considerably richer than those available through the QHPs in the Marketplace. Table 3 summarizes the coverage limits of core and child-specific benefits in Oregon's QHPs in 2014 compared to more robust coverage in CHIP.[vii]

Table 3. Benefit Coverage and Limits

	Total Benefits	CHIP			QHPs (Based on EHB)		
		Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	71%	29%	0%	29%	29%	43%

*Health Plans, Provider Networks and Reimbursement***.** The state would need to consider what kinds of private coverage it is willing to subsidize with CHIP funds (e.g. individual coverage in and out of the Marketplace, ESI small and large group). Oregon data from 2012 (prior to the ACA's coverage expansions, namely Medicaid and the Marketplace), indicate

[vi] Ibid.

[vii] Please refer to the full Wakely report for methodology, assumptions, and limitations for each comparison, and Appendix B, State-Specific Results for Oregon for more detail on benefit and consumer cost-sharing comparisons.

that 48% of children were covered through ESI, 5% were covered by non-group insurance, 39% were in Medicaid or CHIP, and 7% were uninsured.[7] In Oregon, health plan participation in Medicaid and the commercial markets varies regionally. Of the 21 carriers participating in either the individual or small group markets, eight of them are also partners in a Medicaid CCO.[8] In other words, provider participation and contracts between Medicaid/CHIP and the commercial markets may vary. Lastly, enrollment in Medicaid CCOs could decline if CHIP children enroll in private coverage through premium assistance, potentially affecting the risk pool.

Provider reimbursement would be affected as commercial plans generally reimburse providers at higher levels than in Medicaid or CHIP. Offering premium assistance for QHP or ESI coverage to a segment of Oregon's existing CHIP eligible children could provide enhanced reimbursement to providers relative to CHIP payment rates. This could affect access to care, regionally, and to specialty services due to higher provider participation rates in commercial plans. [9,10] However, if that higher reimbursement leads to higher per member per month (PMPM) charges, that would increase costs to the state.

*Quality and Accountability***.** Quality and accountability are cornerstones of Oregon's health system transformation. The ability for Oregon to monitor quality and access for children's health care is well established in Medicaid. Quality measures are used by OHA to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations they serve. Oregon and CCOs are held accountable through 33 performance measures, 17 of which are incentive metrics; with approximately 1/3 assessing the quality of children's health in OHP. A similar accountability and quality infrastructure is not currently in place, statewide, in the commercial market.

*Commercial Market Trends***.** Recent national analyses on premium assistance programs indicate that commercial market trends are moving in the opposite direction for premium assistance to expand capacity.[11,12] States examined in these analyses were found to experience a general decline in availability of ESI and increase in employee cost sharing, challenging the cost effectiveness requirement of their premium assistance program. Also noted was the increase in high deductible health plans and similar products that are less comparable to Medicaid and CHIP coverage.[13,14]

IMPLEMENTATION CONSIDERATIONS

Timing and Authority. Implementation of a premium assistance program would likely not begin until 2016. OHA would need approval from CMS and the legislature to establish and administer the program. Premium assistance authority, whether achieved through the state plan option and/or a demonstration waiver, would depend on the program's design.[15] In other words, implementation timing for any premium assistance program is determined by its scope and complexity.

Program Administration. The state would need to ensure administrative capability and capacity for eligibility and enrollment determinations, as well as customer support for the population served. There may also be added administrative burden to the state and/or insurance carriers in tracking and monitoring children to ensure they receive comparable benefit coverage and pay no more than 5% cost sharing as a percent of family income.

Financing. Premiums assistance programs must be cost-effective.[viii] Historically, these programs have been funded by federal/state CHIP dollars, employer contributions, and premium contributions by families.[16] Per federal regulations the cost to the state of covering an individual through premium assistance, including administrative costs, must be the same or less than providing "comparable coverage" to the individual in the direct CHIP program.[17] Additionally, if premium assistance is implemented through a demonstration waiver, the program must be "budget neutral," meaning that the federal government's costs must not exceed what they would have been without the premium assistance demonstration.[18]

If premium assistance were to cost the state more than covering an individual in the direct CHIP program, the state may need to identify additional funding sources for the program. In 2013, Oregon's premium assistance program for CHIP eligible children from 200%-300% FPL, Healthy Kids Connect, was funded by approximately 21% state general fund, 6% other funds, and 73% federal CHIP matching funds.[19] The federal match rate for Oregon's CHIP program in 2015 will be 74.84%.

Outreach and Education: Outreach and education is also critical for creating program awareness and providing assistance to the target population, participating carriers, employers, community partners, and other stakeholders. Historically, the Information, Education, and Outreach (IEO) unit (closed as of Jan 2014) aided the premium subsidy programs by providing education, presentations, and trainings at enrollment events, employer job fairs, insurance producer continuing education courses, and by training the state staff. IEO also marketed program information through several mediums, including posters, flyers, brochures, radio and television, to create program awareness. Ultimately, the IEO unit helped eligible beneficiaries enroll and stat in the program and assisted employers in providing subsidized health insurance to their eligible employees and their families.

CONCLUSION

There is a range of issues that Oregon policy makers need to address as they consider options that could alter the mix of public and private coverage for low-income children. These include access to services, benefit coverage and comparability, consumer affordability, market dynamics and trends, and federal cost-effectiveness requirements.

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[1] Urban Institute and Kaiser Commission on Medicaid and the uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).

[2] Wakely Consulting Group. Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans. July 2014.

[viii] See P.L. 111-3 §301 and P.L. 111-148 §10203(b)(1).

[3] McMorrow, S., Kenney, G., Anderson, N. et. al. (2014). Trade-offs between public and private coverage for low-income children have implications for future policy debates. *Health Affairs,* 33(8), 1367-1374.
[4] Wakely Consulting Group. July 2014.
[5] Benefits and Cost Sharing in Separate CHIP Programs. May 2014.
[6] Wakely Consulting Group. July 2014.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).
[8] Overlap Among Carriers Participating in Oregon's Health Insurance Market. 9.26.2014 Materials, 2014 Coordinated Care Model Alignment Workgroup.
[9] Oregon 2012 Physician Workforce Survey. (Unpublished)
[10] McMorrow, S., Kenney, G., Anderson, N. et. al. (2014).
[11] Kaiser Commission on Medicaid and the Uninsured (2013, March). Fact Sheet Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act.
[12] Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., Kenward, K. (2014). Health benefits in 2014: Stability in premiums and coverage for employer-sponsored plans. *Health Affairs, 33(10), 1851-1860.*
[13] Kaiser Commission on Medicaid and the Uninsured (2013, March).
[14] Claxton, G., Rae, M., Panchal, N., et al.. (2014).
[15] Kaiser Commission on Medicaid and the Uninsured (2013, September). Medicaid Expansion through Marketplace Premium Assistance: Fact Sheet.. September 2013.
[16] Premium assistance programs: how are they financed and do states save money. The. Issue paper, October 2005.
[17] Kaiser Commission on Medicaid and the Uninsured (2013, March).
[18] Kaiser Commission on Medicaid and the Uninsured (2013, September).
[19] Office of Private Health Partnerships Governor's Balanced Budget 2013-2015. OHA Presentation to the Human Services Legislative Sub-committee on Ways and Means. February 13, 2013.

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