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November 10, 2014

House Committee on Health Care
Oregon Legislative Assembly

Dear Representatives Mitch Greenlick and Alissa Keny-Guyer,

In March 2014, the Oregon Legislature passed House Bill 4109, directing the Oregon Health Authority (OHA) to commission an independent study of the costs and impacts of operating the federal Basic Health Program (BHP) in Oregon. Through a competitive RFP process, OHA worked with national experts, Wakely Consulting Group (Wakely) and the Urban Institute (Urban), to analyze the Basic Health Program's potential effects on consumers, the Oregon Marketplace, and state-supported health care programs. Throughout the process, OHA also engaged a group of stakeholders to identify and solicit input on key assumptions, and review preliminary findings.

States exploring the BHP as a potential alternative coverage program for low- and moderate-income consumers need to consider a number of program design elements ranging from benefit design, out-of-pocket costs, plan and provider networks, reimbursement rates, and program administration and financing. Per the requirements of House Bill 4109, the study estimated:

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

Findings from the commissioned report offer a comprehensive assessment of the BHP in Oregon for consideration by Oregon policy makers and stakeholders.

Enclosed is the report.

Sincerely,

Suzanne Hoffman, MPH
Interim Director

Oregon Basic Health Program Study

October 29, 2014

Oregon Health Authority, Oregon Health Policy Research

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Table of Contents

EXECUTIVE SUMMARY **1**

Background 1

RESULTS **2**

BHP Eligibility and Enrollment 2

The Number of Uninsured 3

Consumer Effects 4

Churning 4

State Fiscal Effects 5

Oregon's Marketplace 8

Care Coordination 9

1) INTRODUCTION **10**

ACA Implementation in Oregon 10

BHP Background 10

Scope of Work 14

General Approach 14

Scenarios Modeled 14

2) BHP ELIGIBILITY, ENROLLMENT AND CHURN **16**

Background 16

Methodology 16

Results 17

3) PROJECTED BHP REVENUES AND COSTS 30

Background 30

Key Assumptions and Methodology 30

Results and Considerations 32

4) BHP ENROLLEE AFFORDABILITY 39

Background 39

Results 39

5) BHP IMPACT ON OREGON MARKETPLACE AND INDIVIDUAL MARKET 42

Background 42

Risk Pool Effects 42

Attractiveness to Carriers and Options for Consumers 48

Capacity to Cover Administrative Costs 50

Potential Instability 52

6) BHP OPERATIONAL CONSIDERATIONS 55

7) BHP STRATEGIC CONSIDERATIONS 59

Potential state budget savings 59

Coordinated Care 62

Longer-term transitions 65

8) MODEL UPDATES 66

Differences in Urban Estimates of BHP Eligibles 66

Differences in Urban Estimates of Churn 66

Differences from Oregon Medicaid Advisory Committee (MAC) Report 67

9) RELIANCE AND LIMITATIONS 70

APPENDIX A – DETAILED METHODOLOGY

APPENDIX B – FEDERAL BHP PAYMENT METHODOLOGY

APPENDIX C – URBAN INSTITUTE HEALTH INSURANCE POLICY SIMULATION MODEL

APPENDIX D – FISCAL EFFECTS OF VARIOUS ADJUSTMENTS TO SCENARIOS 1A AND 1B

APPENDIX E - IMPACT OF BHP ON INDIVIDUAL MARKET DETAILS

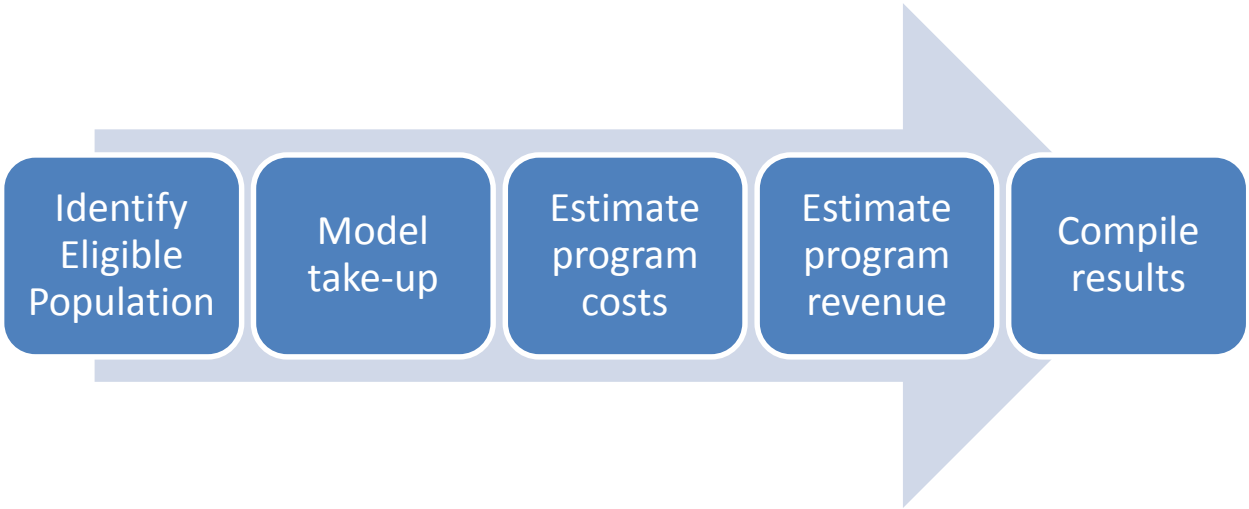
APPENDIX F – COMPARISON OF EHB AND OHP *PLUS* BENEFITS

EXECUTIVE SUMMARY

Background

Section 1331 of the Patient Protection and Affordable Care Act (ACA) gives states the option to operate a Basic Health Program (BHP) to cover certain consumers with incomes up to 200 percent of the federal poverty level (FPL) through state-contracting "standard health plans," rather than Qualified Health Plans (QHPs) offered through the Health Insurance Marketplace. BHP-eligible consumers include citizen and lawfully present immigrant adults between 138 and 200 percent FPL; and lawfully present immigrants under 138 percent FPL whose immigration status makes them ineligible for federally matched Medicaid (usually because of lawful residence for less than five years). BHP enrollees must receive coverage no less generous and affordable than what they could have obtained from subsidized QHPs. The federal government provides states with funding equal to 95 percent of the subsidies BHP enrollees would have received in the Marketplace, but that funding cannot be used for program administration or operations.

In March 2014, the Oregon Legislature passed House Bill 4109, which directed the Oregon Health Authority (OHA) to commission an independent study of the costs and impacts of operating BHP in Oregon. OHA contracted with Wakely Consulting Group (Wakely) and The Urban Institute (Urban) to produce this report, which analyzes BHP's potential effects on consumers, the Oregon Marketplace, state-funded health care costs, and other topics. The following illustrates our general method for identifying the most important financial impacts of the BHP on the State of Oregon in 2016:



We analyzed two basic approaches to BHP implementation (table ES 1):

- Scenario 1 involves BHP coverage like Medicaid, with provider reimbursement significantly below commercial levels, and without any premium charges or copayments.
- Scenario 2 has BHP furnishing "hybrid" coverage. Providers receive commercial reimbursement. Consumers at or below 138 percent FPL are not charged premiums or copays. Those between

138 and 200 percent FPL are charged half the premiums and copays that they would have paid for subsidized QHP coverage.

Each scenario has two variants that involve covered benefits:

- Variant a (Scenarios 1a and 2a) has BHP covering only essential health benefits (EHBs) that are offered in the Marketplace.
- Variant b (Scenarios 1b and 2b) also covers additional services provided by the Oregon Health Plan (OHP), including non-emergency medical transportation, chiropractic services, and adult dental care.

Table ES 1 – Summary of BHP Approaches that were Modeled

	Scenario 1a	Scenario 1b	Scenario 2a	Scenario 2b
Provider Reimbursement Level	Medicaid		Commercial	
Covered Benefits	EHB	OHP *Plus*	EHB	OHP *Plus*
Member Premium	$0		<138% FPL: $0 138 – 200% FPL: 50% of Premium for QHP Benchmark	
Member Cost Sharing	$0		<138% FPL: $0 138 – 200% FPL: 50% of Cost Sharing for Silver QHP	

Our estimates differ from those Wakely produced for the Oregon Medicaid Advisory Committee in April 2014 because this new report uses a different source of data with a much larger sample of Oregon residents; we use a methodology that takes into account unaccepted offers of employer-sponsored insurance (ESI), which significantly changes the income distribution of BHP-eligible consumers; our methodology incorporates information about morbidity and risk level, which enables a more accurate estimate of state BHP costs; and these estimates take into account 2015 QHP premiums and the final federal regulations and BHP federal payment methodology for 2015, which allow a more accurate estimate of federal BHP payments.

All estimates are for 2016, assuming that ACA's initial coverage transitions are then complete.

RESULTS

BHP Eligibility and Enrollment

Based on our analysis, 87,600 people will qualify for BHP in 2016. Enrollment will be affected by BHP affordability:

- Under Scenario 1, where premiums and cost sharing are not charged, we estimate that 66,300

would enroll in BHP in 2016.

- With Scenario 2, where most BHP consumers will be charged half of QHP premiums and out-of-pocket cost-sharing, 61,400 are projected to enroll.
- Without BHP, this population would be eligible for subsidized QHP coverage. We estimate that 55,600 would enroll, a smaller number receiving coverage than under either BHP Scenario.

The Number of Uninsured

Of Oregon's 87,600 citizens and lawfully present noncitizens with incomes at or below 200 percent FPL who do not qualify for Medicaid or the Children's Health Insurance Program (CHIP) and who are not offered employer-sponsored coverage,[1] 54,700—about 62 percent—would be uninsured without the ACA. The number of uninsured among this group will decline substantially under the ACA, whether or not the state implements BHP. However, by making coverage more affordable, BHP would further increase coverage levels among these low-income residents, who lack access to insurance subsidized by employers or pre-ACA public coverage:

- Under the ACA without BHP, these adults would be eligible for subsidized coverage in the Marketplace. Most would enroll. An estimated 15,000, or 17 percent, would remain uninsured.
- Under BHP Scenario 1, in which no cost-sharing is charged, the proportion lacking coverage within this low-income group would decline still further, to 5.8 percent. The projected number of uninsured would fall by approximately 9,900 to 5,100.
- Under BHP Scenario 2, with consumer costs generally at half of the amounts charged by subsidized QHPs, 11 percent of this group would be uninsured. Compared to the ACA without BHP, the number without coverage would fall by 5,400 to 9,600.

BHP might further reduce the number of uninsured, beyond the amounts estimated here. That is because BHP avoids the risks of tax reconciliation, which will face consumers who claim advance payment of tax credits (APTC) in the Marketplace. The extent to which such risks will deter future QHP enrollment is not yet known, so they are not reflected in our estimates.

[1] We defined this group to exclude consumers under 200 percent FPL who are either (a) eligible for Medicaid or CHIP or (b) ineligible for federally funded subsidies because of immigration status or offers of employer coverage. We are estimating here the impact of BHP on insurance coverage among low-income Oregon residents who lacked other sources of subsidized coverage before the AACA and, depending on the state's policy choices, could qualify either for BHP or QHP subsidies.

Consumer Effects

Without BHP, the average consumer at or below 200 percent FPL receiving subsidized QHP coverage would pay more than $1,070 in premiums and more than $510 in out-of-pocket costs in 2016. With BHP, those amounts would fall to:

- $0 under Scenario 1, resulting in average annual savings of $1,589 per adult; and
- $533 in premiums and $250 in out-of-pocket costs under Scenario 2, yielding average annual savings of about $800.

That said, moving consumers out of QHPs and into BHP plans could cause some consumers to experience interrupted courses of treatment or provider relationships, and some could have fewer choices of plans and providers. Many QHPs' provider networks are likely to be narrower than the networks that typified pre-ACA commercial insurers, and the Oregon Health Plan's Coordinated Care Organizations enjoy important advantages over traditional Medicaid provider networks. That said, Scenario 1 envisions provider payment rates 38 percent below those paid by QHPs—a differential that could limit provider participation. Moreover, a number of consumers could temporarily "fall between the cracks" and lose coverage for a time. Hands-on assistance might limit those risks, but some disruption is inevitable.

Churning

The impact of BHP on churning—transitions between health plans offered by different insurance affordability programs when incomes or other household circumstances change—depends on how BHP is structured. If BHP is operated as a free-standing program, with its own health plans that are distinct from both those in the Marketplace and those offered by Oregon Health Plan (OHP), then BHP implementation will increase churning among insurance affordability programs by 25 percent. However, if BHP is aligned with OHP so that the same health plans serve all eligible consumers up to 200 percent FPL, then such churning would decline by 29 percent, compared to ACA implementation without BHP.

That said, most churning takes place, not between insurance affordability programs, but between eligibility for assistance and ineligibility for assistance. For example, when a Medicaid beneficiary's income rises above 138 percent FPL, he or she will often become ineligible for both QHP subsidies and BHP. Such ineligibility results whenever a family member is offered single coverage through an employer for which the worker's share of the premium is 9.5 percent of family income or less. BHP does not greatly affect this form of churn because eligibility is the same for both BHP and QHP subsidies.

Two additional churning issues warrant separate mention. First, CMS's regulations for BHP make clear that BHP can offer 12-month, continuous eligibility, basing subsidies on household circumstances at the time of application. Such eligibility would reduce mid-year changes in coverage, an issue that our modeling did not examine..

Second, pregnant women with incomes between 138 and 185 percent FPL face a kind of churning that BHP could eliminate, depending on the state's approach to BHP. Without BHP, many women in this income range will enroll into subsidized QHP coverage before they became pregnant. But once they conceive, they can qualify for pregnancy-related OHP coverage of additional services, with an exemption from all cost-sharing, both for premiums and out-of-pocket costs. To obtain this additional help, however, they must change from a QHP to an OHP plan, which may require changing providers mid-pregnancy. By contrast, if BHP provides coverage through the same OHP plans that serve Medicaid consumers, women in this income range who become pregnant can access the additional benefits and cost-sharing protections offered by OHP without changing plan or provider.

State Fiscal Effects

Estimated state revenues and costs for 2016 vary by scenario, as shown by table ES 2. It is important to note that federal BHP payments are tied to changes in the second lowest cost silver plan available on the Marketplace, which can vary from year to year. Such changes may reflect market factors, such as carrier business strategy, that do not track with true medical cost trends. This reduces the overall predictability of state fiscal impacts. On the other hand, the state gains some predictability from CMS's plan to publish each year's federal payment amounts in February of the previous year as well as the option to base one year's federal BHP payments on the previous year's benchmark premiums, trended forward to reflect CMS national projections.

Notwithstanding the latter features of BHP that provide advance notice of any changes to federal payments that result from QHP market shifts, policymakers could consider retaining any modest BHP surpluses in the BHP trust fund to guard against future contingencies. More broadly, this feature of BHP financing reinforces the need for regular updating of budget projections, especially during the years before benchmark premiums in the Oregon Marketplace become more predictable.

Table ES 2 –Projected BHP Cash Flows for 2016 (thousands)

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

[1] Standard Health Plan Expenses assume loss ratios of 92% for scenarios 1a /1b and 85% for scenarios 2a / 2b.
[2] State administrative expenses are estimated at $19.32 PMPM/$23.32 PMPM for Scenarios 1/2. The higher amount assumes that BHP, rather than plans, handle premium collection.

Projected shortfalls in 2016, stated in dollars per enrollee, are $24 for Scenario 1a; $374 for Scenario 1b; $1,582 for Scenario 2a; and $1,941 for Scenario 2b.

Most state administrative costs shown here involve functions, like eligibility and enrollment, that the Marketplace or OHA would perform without BHP. Federal BHP funds cannot pay these costs directly, but they can finance them indirectly. Administrative costs could be paid by BHP plan surcharges, which increase BHP premiums, which in turn are paid by federal BHP funds.

Our results show the fiscal impact of provider reimbursement levels. Higher reimbursement levels make Scenario 2 much more expensive than Scenario 1, even though Scenario 1 has no consumer cost-sharing. Our results also show the cost effects of adding covered benefits, whether one moves from Scenario 1a to 1b or from Scenario 2a to 2b.

State administrative expenses were estimated based on experience for a similar program implemented in Massachusetts. Estimated state administrative expenses range from $15.45 to $23.18 per member per month for scenario 1, with a best estimate of $19.32 pmpm (as included in Table ES 2). State administrative expenses for scenario 2 are projected to be higher – ranging from $18.95 to $28.68 pmpm with a best estimate of $23.32 pmpm – with an assumption that the state would assume the premium billing function. Though the state could consider transferring this responsibility to the standard health plans offering BHP, the estimates above do not reflect this potential approach.

None of the four specific policy options we modeled yielded “break even” results or better, without considering the possibility of additional state budget savings, discussed below. However, the state

administrative costs estimated above show the middle of a broad estimated range. If the lower end rather than the mid-point of the range turns out to be correct, then Scenario 1a's modest net deficit, shown above, will become a modest net surplus. If the higher end turns out to be more accurate, that net deficit shown above will be an underestimate. If Oregon implements BHP as, in essence, a new category of OHP coverage, OHA may be able to refine this report's estimates of BHP administrative costs by starting with the estimated per capita administrative costs for OHP adults. To evaluate any additional administrative costs that would result from using a separate federal payment stream (and potentially a separate program office inside OHA) for BHP adults, policymakers could analyze the administrative arrangements that have been required for "Healthy Kids."

Looking more broadly than at administrative costs, modest adjustments to these four scenarios could change the "bottom line" fiscal result, albeit through making trade-offs. For example, by foregoing some of Scenario 1's gains that result from the absence of consumer costs—most notably, the increased enrollment that results from zero-cost coverage—policymakers willing to charge premiums to some or all BHP enrollees could improve on the fiscal results shown in table ES-2:

- Charging $10 monthly premiums to BHP consumers with incomes above 175 percent FPL would change Scenario 1a's one-year $1.6 million deficit into a surplus between $1.0 and $1.2 million. That surplus would rise to between $3.9 and $4.3 million if $10 monthly premiums were charged to all BHP enrollees with incomes over 150 percent FPL.
- Charging $10 monthly premiums to enrollees between 138 and 150 percent FPL, $20 between 151 and 175 percent FPL, and $40 above 175 percent FPL would lower Scenario 1b's estimated $24.8 million deficit to a one-year shortfall between $5.7 million and $5.9 million.

BHP implementation is likely to yield state budget savings in other areas, which could offset any losses or add to any gains experienced as a direct result of BHP. For example:

- From January to May 2014, approximately 4,400 pregnant women with incomes above 133 percent FPL received OHP coverage of maternity care services that is fully exempt from cost-sharing and includes benefits that go beyond subsidized QHP coverage. Oregon pays its standard share of Medicaid costs for these services. Depending on how the state implements BHP, these women could continue to receive current benefits and cost-sharing protections during pregnancy, but the federal government would pay a much larger share of their health care costs, saving state general fund dollars.
- For calendar year 2013, approximately 4,600 pregnant women with incomes below 133 percent FPL received coverage of maternity care services through Oregon's Citizen Alien Waived Emergent Medical Plus (CAWEM Plus) program. These women are non-citizens with an immigration status that disqualifies them from Medicaid. Some are lawfully present immigrants who could qualify for BHP. If the state implements BHP, those in the latter group could continue receiving current services and cost-sharing protections, but instead of paying its standard CHIP

share of their costs, the state could shift some or all of its current spending to the federal government's BHP payments.

Further analysis is needed to determine the magnitude of these and other state budget effects, including potential savings from federal BHP dollars substituting for general fund spending on mental health and substance use disorders .

Starting in 2017, Oregon could potentially benefit from a higher level of federal funding under ACA Section 1332, which permits major changes to the ACA's architecture that are cost-neutral to the federal government and do not increase consumer costs or reduce benefits, compared to standard ACA implementation. This section could potentially provide Oregon with 100 percent rather than 95 percent of the federal subsidies that BHP enrollees would have otherwise received in the Marketplace. However, the federal government has not promulgated any substantive standards for this provision, in draft or final form; even such fundamental issues as the approach to federal cost neutrality remain completely undefined. As a result, one cannot currently assess, even preliminarily, whether Section 1332 could feasibly provide a better funded vehicle into which BHP, or a similar program, might eventually transition.

Oregon's Marketplace

Implementing BHP is estimated to reduce the size of Oregon's qualified health plan Marketplace by nearly a third (30 percent), from 187,000 to 131,000. We assess the impact on the Marketplace in several dimensions.

Risk Pool. BHP implementation is estimated to modestly affect the individual market's overall risk pool, increasing premiums by 1.0 percent for 74,000 residents (both inside and outside the Marketplace) who are projected to pay full premiums, two-thirds of whom have incomes over 400 percent of FPL.

Carrier interest, with implications for consumer choice and premiums. Fewer covered lives could translate into less carrier interest, which in turn could mean fewer consumer choices and reduced competition, ultimately translating into higher premiums. These results have not yet been observed in Minnesota, however, which is implementing a BHP-like program by serving consumers under 200 percent FPL through a Medicaid waiver, outside the Marketplace. Five Minnesota carriers participated in the 2014 Marketplace, offering consumers in the median county 33 QHP choices. Competition was sufficiently robust that 2014 benchmark premiums were lower in Minnesota than in any other state. In 2015, the number of Minnesota's QHP options will increase, and officials believe that urban premiums will remain the country's lowest, despite an increase of between 4.5 and 12 percent above 2014 levels.

Stability. Even without enrollees under 200 percent FPL, 62 percent of the Oregon Marketplace's projected enrollees would have subsidies that cannot be used elsewhere, making the Marketplace highly unlikely to become unstable. Insurance reforms and coverage expansion policies like the ACA's have prevented instability at a Massachusetts exchange operating since 2007, even though the Massachusetts

exchange is limited to consumers over 300 percent FPL, serves only unsubsidized consumers who are free to purchase coverage elsewhere, and during its initial years had fewer than 20,000 members.

Administration. BHP can likely be implemented without preventing the Oregon Marketplace from covering its administrative costs. Whatever entity runs Oregon's Marketplace might charge BHP to cover the cost of Marketplace administrative services that benefit BHP.

Uncertainties around the future structure of Oregon's Marketplace make it impossible to definitively resolve BHP's administrative architecture at this time. However, many observers expect OHA to assume responsibility for OHP eligibility and enrollment functions, while a federally facilitated Marketplace (FFM) handles comparable functions for QHP enrollees. If so, and if BHP is implemented so that it functions essentially as a new category of OHP coverage, then OHA could cover administrative costs for BHP consumers just as it will for other OHP enrollees. OHA would then allot to BHP OHA's administrative costs incurred for BHP consumers. If approved by the Legislature, those costs could be covered by premium assessments that are ultimately paid by federal BHP dollars, as explained earlier.

Care Coordination

Oregon's ongoing effort at reforming health care delivery and payment to promote care coordination could be applied more rapidly and effectively to consumers with incomes between 138 and 200 percent FPL if they receive BHP than if they are enrolled in QHPs, as currently constituted. With BHP, such consumers could be covered through the same Coordinated Care Organizations (CCOs) that serve Medicaid consumers. Among other gains, this could lower long-term BHP costs by bringing BHP within CCO's cap on annual increases in capitated payments.

1) INTRODUCTION

This section provides background on ACA implementation in Oregon, the Basic Health Program, the scope of work for which OHA contracted with Wakely and Urban, and the general approach to the analysis.

ACA Implementation in Oregon

Working within the health insurance coverage framework provided by the Affordable Care Act (ACA), Oregon established its own health insurance Marketplace (Cover Oregon) for the individual and small-group markets, and expanded the Oregon Health Plan (OHP) Medicaid program for low-income individuals. As of May 2014, approximately 83,852 individuals have enrolled in private coverage through Cover Oregon's Qualified Health Plans (QHP) and 338,000 individuals have enrolled in Oregon's Medicaid program. The majority of Medicaid enrollees receive care through Oregon's 16 Coordinated Care Organizations (CCOs). CCOs are networks of all types of health care providers who have agreed to work together in their local communities to improve outcomes and reduce costs for people who receive health care coverage under the Oregon Health Plan (Medicaid).

Due to some computer portal issues with the Cover Oregon roll-out, Cover Oregon will be relying on the Federally-Facilitated Marketplace (FFM) for some of its IT functionality beginning with 2015 open enrollment. This model is referred to as a federally-supported state-based Marketplace.

BHP Background

Section 1331 of the Affordable Care Act (ACA) establishes the Basic Health Program (BHP), which gives states the option to provide coverage to eligible individuals, including those with household incomes between 138 percent and 200 percent of the federal poverty level (FPL), through state-contracted standard health plans that meet certain requirements, rather than through the Marketplace. The following provides some of the key BHP provisions based on federal regulations dated March 12, 2014. Note that this is not a comprehensive list of requirements.

Eligibility

BHP eligibility requirements are similar to those for subsidized coverage through state Marketplaces; however, the BHP is limited to the population with household incomes under 200% FPL. More specifically, BHP eligible individuals fall into one of the following categories:

- Residents of the State who:
  - Have incomes between 138% and 200% FPL
  - Are U.S. citizens or lawfully present immigrants

  - Are under age 65
  - Are not eligible for coverage under the State's Medicaid program, the Children's Health Insurance Program (CHIP) or Military/CHAMPUS-TRICARE (except for pregnancy-related coverage or eligibility categories that provide less than full services)
  - Do not have access to Employer-Sponsored Insurance (ESI) or other coverage that meets ACA affordability and minimum coverage standards
  - Meet all other eligibility criteria for subsidized coverage through the Marketplace
- Lawfully present immigrants with household income up to 138% of FPL and who are not eligible for Medicaid as a result of the five year residency requirement.

In a state that establishes a BHP, BHP-eligible individuals are not eligible to receive federal subsidies in the form of premium tax credits and cost-sharing reductions to offset the costs of qualified health plans in the Marketplace.

Coverage Requirements

Similar to Qualified Health Plans (QHPs) offered through state Marketplaces, standard health plans are required to provide Essential Health Benefits (EHB) as defined under 45 CFR Section 156. The EHB standards define the minimum required covered benefits and similar standards apply for Medicaid Alternative Benefit Plans (ABPs) that apply to adults who became eligible for Medicaid through ACA Medicaid expansion. In 2013, states had the option of selecting among up to 10 benchmark plans to define EHBs that were then required to be covered under all non-grandfathered health plans in the individual and small group insurance markets with effective dates on or after January 1, 2014. For standard health plans under the BHP, states can use the EHBs defined for commercial coverage, or they can choose one or more additional benchmark options to apply to standard health plans. States also have the flexibility to provide additional benefits through the BHP, for example, to be comparable to the Medicaid Alternative Benefit Plans (ABPs). Benefits offered in the Marketplace are a floor, not a ceiling, for BHP.

Consumer Premiums and Out-of-Pocket Cost Requirements

States cannot require BHP enrollees to pay more in premiums or out-of-pocket costs than they would have had they enrolled in subsidized second lowest cost silver QHP coverage (benchmark plan) through the Marketplace. States have the option to vary premiums and cost sharing for BHP coverage based on household income, so long as lower income enrollees do not pay more than higher income enrollees.

The following table summarizes the premiums and average out-of-pocket costs consumers with household incomes under 200% FPL pay for subsidized coverage through the Marketplace.

Table 1.1 - Consumer Premiums and Cost Sharing for Marketplace Benchmark Plan

Household Income	Estimated 2016 Income, 1 Person Household	Premium for Benchmark Plan as Percent of Household Income	Annual Premium Amount	Out of pocket Costs as Percent of Average Claims
< 133% FPL	<$16,411	2.00%	$328	6%
133% – 150% FPL	$16,411 - $17,838	3.02% - 4.02%	$496 - $717	6%
150% – 200% FPL	$17,838 - $23,783	4.02% - 6.34%	$717 - $1,508	13%

Contracting Requirements

The BHP regulations require that states employ a competitive contracting process for procuring standard health plans to provide BHP coverage. That process must meet standard federal requirements for state procurement as well as additional standards discussed below. States can contract with entities that include the following to offer standard health plans:

1. Licensed health maintenance organizations (HMOs)
2. Licensed health insurance insurers
3. Network of health care providers
4. Non-licensed health maintenance organizations participating in Medicaid and/or CHIP

Note that if the state contracts with a health insurance issuer, the contract must require that the medical loss ratio (MLR) be at least 85 percent. At a high level, this means that the health insurance issuer must use at least 85 cents of each dollar for medical claims expenses or other health-related services rather than administrative or other non-benefit expenses. In applying these requirements, assessments, taxes, and fees are treated differently from health plans' internal administrative costs; the former are subtracted from the premium before the MLR calculation is made.

Federal Funding

The federal government provides funding of roughly 95% of the expected premium tax credits and cost-sharing reduction subsidies BHP enrollees would have received had they enrolled in subsidized coverage through the Marketplace. To implement a BHP, states must establish a BHP trust fund either with an independent entity or in a segregated account within the State's fund structure. Federal funding can only be used to reduce premiums and cost-sharing for eligible individuals enrolled in BHP standard health plans

or to provide additional benefits to eligible BHP enrollees. Operational costs incurred by the State to administer the BHP cannot be directly funded with federal BHP payments. However, States can impose fees on carriers participating in the BHP program to fund state operations, and use federal BHP funds to pay the resulting increase in carrier premiums. Most Marketplaces use a similar approach to funding administrative costs by surcharging QHP premiums and using premium tax credits to cover most of the resulting increase in QHP premiums.

Federal payments are made to the BHP trust fund on a quarterly basis with prospective payments based on estimated enrollment segmented into different "federal payment cells" multiplied by the payment rate developed for each cell. Payments are then retrospectively adjusted at the end of each quarter based on actual enrollment for that quarter.

Operational Requirements

The federal regulations include the following BHP operational requirements that states must address:[2]

1. Eligibility determinations and appeals
2. Contracting with standard health plan offerors. States are expected to provide enrollees with a choice of at least two standard health plans unless an exception can be justified.
3. Oversight and financial integrity, which includes operation of the BHP Trust Fund and required federal reporting.
4. Consumer assistance, such as providing clear information to potential applicants and enrollees about their coverage options.
5. Extending protections to American Indian/Alaska Natives and compliance with Civil Rights and nondiscrimination requirements.
6. Data collection and reporting for efficient and effective operation of the BHP and as required to support program oversight.
7. Program termination procedures, as applicable.

Though not included in the regulations, to the extent premiums are imposed on BHP enrollees, the State or standard health plans would also need premium collection functionality. Section 6 of this report summarizes operational considerations for the state.

[2] 45 CFR Section 600.145

Scope of Work

The following provides a high level description of each of the components included in the scope of work for this study and indicates where the information can be found within the report. Note that all cost projections are for calendar year 2016 only and should not be assumed for future years. The Strategic Analysis discussion, in Section 7, explores future cost implications.

Table 1.2 – Summary of Scope of Work

Description	Location in Report
BHP Enrollment Estimates	Section 2
Churn Estimates	Section 2
Assessment of Available Funds	Section 3
Program Cost Estimates	Section 3
Impact of BHP on Marketplace Population and Risk	Section 5
Estimated Impact of BHP on Commercial Market Premiums	Section 5
Strategic Analysis	Section 7
Consumer Affordability Impacts	Section 4
Comparison of BHP Operating Costs and Revenues	Section 3
Analysis of State Cost Offsets	Section 7
Structuring BHP Implementation to Fit Oregon's Coordinated Care Model	Section 7
BHP Operational Assessment and Analysis of Administrative Costs	Section 6

General Approach

BHP eligibility and enrollment analysis performed by Urban provides the foundation for the other analyses in this report. Urban performed the first two pieces of the analysis described in Table 1.2. The results of these analyses can be found in section 2 of this report. These analyses provided the basis for estimating the BHP program costs and revenues (section 3), and identifying the impact of BHP implementation on the State's Health Insurance Marketplace (section 5), and the estimated impact to individuals who are expected to enroll in the BHP relative to the coverage (or lack thereof) they would have had in the absence of the BHP (section 4).

Scenarios Modeled

To determine the factors and assumptions on which the study was based, Wakely and Urban worked with OHA staff and the Oregon BHP Study Advisory Group, which was established in response to the authorizing legislation which required OHA to solicit input using a public process. Based on input received, four scenarios were used as the basis for BHP modeling. These scenarios fall into two main categories. Scenarios 1a and 1b assume provider reimbursements similar to those provided through the Oregon Health Plan (OHP *Plus*, Oregon's Medicaid Program) and BHP enrollees not subject to any premiums or out-of-pocket costs when they access services. Under scenario 1a, the BHP would cover benefits similar to those provided through QHPs offered in the Marketplace and under scenario 1b, the BHP would cover

benefits similar to those provided through OHP. Scenarios 2a and 2b assume BHP provider reimbursements at commercial insurance levels, no premiums or out-of-pocket cost sharing for individuals with incomes under 138% FPL, and premiums and cost sharing equal to half of what BHP enrollees would have received, after federal premium and cost sharing subsidies, had they been enrolled in the second lowest cost silver plan offered through Oregon's Marketplace and subsidized.

The following table summarizes the scenarios that were modeled at the request of OHA and the Oregon BHP Study Advisory Group.

Table 1.3 – Summary of Scenarios Modeled

	Scenario 1a	Scenario 1b	Scenario 2a	Scenario 2b
Provider Reimbursement Level	Medicaid		Commercial	
Covered Benefits	EHB	OHP *Plus*	EHB	OHP *Plus*
Member Premium	$0		<138% FPL: $0 138 – 200% FPL: 50% of Premium for QHP Benchmark	
Member Cost Sharing	$0		<138% FPL: $0 138 – 200% FPL: 50% of Cost Sharing for Silver QHP	

Note that benefits covered under OHP *Plus* include all of the EHBs, as well as the following additional benefits:

- Adult dental[3]
- Chiropractic[4]
- Non-emergency transportation
- Unlimited inpatient rehabilitation
- Unlimited physical, occupational and speech therapy
- Unlimited durable medical equipment

[3] Preventive, diagnostic and basic services.

[4] Limited to certain conditions only.

2) BHP ELIGIBILITY, ENROLLMENT AND CHURN

Background

As a first step in the BHP analysis, Urban estimated the number of Oregonians eligible for BHP in 2016 and their characteristics, particularly those relevant to health care costs or to outreach and enrollment. Urban then modeled enrollment in BHP under two different scenarios of premiums and cost sharing. Enrollment in qualified health plan (QHP) coverage through the Marketplace both with and without BHP was also modeled.[5] Finally, churning in eligibility for the Oregon Health Program (OHP), BHP, and subsidized qualified health plans both with and without BHP was estimated.

Methodology

The estimates are based on three years of Oregon households from the American Community Survey (ACS), the largest Census Department household survey (2009-2011). The data were aged to 2016, and we assessed eligibility for OHP, BHP, and Marketplace subsidies using the final ACA regulations issued by HHS and the Treasury Department. The HIPSM-ACS model was then used to simulate family health coverage decisions, taking into account all forms of health coverage for which family members were eligible. Coverage decisions were simulated under three scenarios: no BHP, BHP without cost sharing, and BHP with cost sharing. Finally, we estimated the annual churning in health coverage by combining the ACS data with data from the Survey of Income and Program Participation (SIPP). Additional methodological details are available in Appendix A.

[5] Urban and Wakely modeled the impact of BHP on Cover Oregon per the requirements in House Bill 4109 (2013). The bill passed prior to the April 25th 2014 announcement by the Cover Oregon Board of Directors, which stated that beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology or Marketplace. The report will refer to qualified health plans (QHPs) in lieu of referencing Cover Oregon as a coverage option.

Results

Characteristics of Those Eligible for BHP

We estimate that there would be 87,600 Oregonians eligible for BHP in 2016 (Table 2.1). The large majority, 54,700, were uninsured without the ACA. About 14,700 had private nongroup coverage before the ACA, and 18,100 had employer coverage deemed unaffordable under the ACA.[6]

More than nine in 10 BHP eligibles have family incomes between 138 and 200 percent FPL. However 6,500 people with incomes below 138 percent FPL are also eligible for BHP because they are lawfully resident non-citizen adults ineligible for federally-matched Medicaid, primarily because they have been resident less than five years. The latter population includes Compact of Free Association (COFA) migrants, though our survey data did not allow us to explicitly identify them as a separate category.

Comparing BHP eligibles with all non-elderly adults in Oregon, BHP eligibles would be:

- Younger (43.3 percent under 35 versus 35.8 percent).
- Less likely to be employed (56.3 percent versus 67.7 percent).
- Less likely to be Hispanic and more likely to be Asian/Pacific Islanders.
- Less likely to have a college degree (18.3 percent versus 27.2 percent).
- Slightly less likely to be native-born and to speak English at home.

Among BHP eligibles speaking a language other than English at home, 57.2 percent report that they do not speak English very well. Not surprisingly, Spanish is the most common language other than English spoken at home. Other common languages among BHP eligibles include Chinese, Vietnamese, Russian, Korean, and Hindi/related languages.

Comparing BHP eligibles that were uninsured pre-ACA with previously insured BHP eligibles, the pre-ACA uninsured would be younger, less likely to be employed, less likely to be white and non-Hispanic, less likely have a college degree, and less likely to have a college education.

[6] An offer of coverage is unaffordable if the worker's share of the single premium is more than 9.5 percent of family income.

Table 2.1. Characteristics of BHP Eligibles in Oregon, 2016

	Pre-ACA Coverage Group									
	ESI		Non Group		Uninsured		Total		All Nonelderly Adults	
	N	%	N	%	N	%	N	%	N	%
Total BHP Eligibles	18,100	100.0%	14,800	100.0%	54,700	100.0%	87,600	100.0%	2,413,700	100.0%
Age										
19 - 24 years	2,700	14.9%	2,600	17.6%	9,200	16.8%	14,500	16.6%	305,300	12.6%
25 - 34 years	4,500	24.9%	2,600	17.6%	16,500	30.2%	23,500	26.8%	560,100	23.2%
35 - 44 years	2,700	14.9%	2,500	16.9%	10,700	19.6%	15,800	18.0%	486,400	20.2%
45 - 54 years	2,500	13.8%	2,300	15.5%	9,400	17.2%	14,200	16.2%	499,000	20.7%
55 - 64 years	5,800	32.0%	4,800	32.4%	9,000	16.5%	19,600	22.4%	562,900	23.3%
Race/Ethnicity										
White, Non-Hispanic	14,800	81.8%	12,200	82.4%	42,400	77.5%	69,400	79.2%	1,894,500	78.5%
Black, Non-Hispanic	200	1.1%	-	0.0%	1,700	3.1%	2,000	2.3%	40,800	1.7%
Hispanic	1,000	5.5%	200	1.4%	4,900	9.0%	6,100	7.0%	265,500	11.0%
Asian/Pacific Islander, Non-Hispanic	1,400	7.7%	1,300	8.8%	3,300	6.0%	6,000	6.8%	115,700	4.8%
American Indian/Alaskan Native	400	2.2%	200	1.4%	1,700	3.1%	2,400	2.7%	68,400	2.8%
Other, Non-Hispanic	200	1.1%	800	5.4%	800	1.5%	1,800	2.1%	28,800	1.2%
Gender										
Male	8,400	46.4%	6,300	42.6%	29,200	53.4%	43,900	50.1%	1,196,700	49.6%
Female	9,700	53.6%	8,500	57.4%	25,500	46.6%	43,700	49.9%	1,216,900	50.4%
Education										
Less than High School	800	4.4%	500	3.4%	6,800	12.4%	8,100	9.2%	222,000	9.2%
High School	7,500	41.4%	4,800	32.4%	23,100	42.2%	35,300	40.3%	826,400	34.2%
Some College	5,800	32.0%	5,000	33.8%	17,400	31.8%	28,200	32.2%	709,300	29.4%
College Graduate	3,900	21.5%	4,600	31.1%	7,600	13.9%	16,000	18.3%	655,900	27.2%
Health Status										
Better than Fair	15,100	83.4%	12,500	84.5%	46,400	84.8%	74,000	84.5%	2,041,600	84.6%
Fair or Poor	3,000	16.6%	2,300	15.5%	8,300	15.2%	13,600	15.5%	372,100	15.4%
Function Limitation[1]										
No	16,700	92.3%	14,000	94.6%	50,600	92.5%	81,300	92.8%	2,194,200	90.9%
Yes	1,400	7.7%	800	5.4%	4,100	7.5%	6,300	7.2%	219,400	9.1%
Language										
English	15,500	85.6%	11,700	79.1%	44,600	81.5%	71,800	82.0%	2,028,400	84.0%
Spanish	700	3.9%	200	1.4%	4,600	8.4%	5,500	6.3%	228,800	9.5%
Chinese	200	1.1%	700	4.7%	600	1.1%	1,600	1.8%	22,100	0.9%
Haitian	-	0.0%	-	0.0%	-	0.0%	-	0.0%	300	0.0%
Korean	100	0.6%	100	0.7%	400	0.7%	500	0.6%	9,000	0.4%
Vietnamese	300	1.7%	300	2.0%	1,000	1.8%	1,500	1.7%	20,800	0.9%
Portuguese	-	0.0%	-	0.0%	-	0.0%	100	0.1%	1,000	0.0%
Polish	-	0.0%	100	0.7%	-	0.0%	100	0.1%	800	0.0%
Hindi and Related	200	1.1%	200	1.4%	-	0.0%	400	0.5%	8,000	0.3%
French	100	0.6%	-	0.0%	100	0.2%	100	0.1%	7,500	0.3%
Russian	200	1.1%	-	0.0%	500	0.9%	700	0.8%	13,500	0.6%
Other	900	5.0%	1,500	10.1%	3,000	5.5%	5,400	6.2%	73,400	3.0%
English Speaking Status[2]										
Speaks English Very Well	1,400	51.9%	1,400	45.2%	3,900	38.2%	6,700	42.1%	189,500	49.2%
Does Not Speak English Well	1,200	44.4%	1,700	54.8%	6,200	60.8%	9,100	57.2%	195,800	50.8%
Citizenship										
Born U.S. Citizen	16,100	89.0%	11,700	79.1%	46,100	84.3%	73,900	84.4%	2,090,000	86.6%
Naturalized U.S. Citizen	600	3.3%	1,100	7.4%	2,800	5.1%	4,500	5.1%	114,400	4.7%
Not a U.S. Citizen	1,400	7.7%	2,000	13.5%	5,900	10.8%	9,200	10.5%	209,200	8.7%
Employment Status										
Employed	8,400	46.4%	6,900	46.6%	33,900	62.0%	49,300	56.3%	1,633,000	67.7%
Not Employed	9,700	53.6%	7,800	52.7%	20,900	38.2%	38,400	43.8%	780,700	32.3%
MAGI										
<138% FPL	1,000	5.5%	1,600	10.8%	4,000	7.3%	6,500	7.4%	670,800	27.8%
138 - 150% FPL	3,300	18.2%	2,100	14.2%	10,100	18.5%	15,500	17.7%	41,800	1.7%
150 - 175% FPL	6,500	35.9%	5,200	35.1%	21,100	38.6%	32,800	37.4%	95,600	4.0%
175 - 200% FPL	7,400	40.9%	5,900	39.9%	19,500	35.6%	32,800	37.4%	94,700	3.9%

Source: UI Analysis of ACS Records

1: Includes cognitive, ambulatory, independent living, self-care, vision, or hearing difficultly.

2: For non-English speaking adults only.

BHP and QHP Enrollment

We simulated take-up under three scenarios:

- *BHP scenario 1*. Modeled on OHP. Beneficiaries do not pay premiums or cost sharing.
- BHP scenario 2. BHP eligibles up to 138 percent FPL pay no premiums or cost sharing. Higher-income BHP eligibles pay half of the premiums and cost sharing that they would have paid in a subsidized QHP coverage. Those between 138 and 150 percent FPL would pay 1.5 percent of income in premiums and would be covered at 97 percent actuarial value[7], while those between 150 and 200 percent FPL would pay 2 to 3.2 percent of income in premiums and would be covered at 94 percent actuarial value.
- *Without BHP*. BHP eligibles can purchase a subsidized QHP.

Different groups of BHP eligibles are assumed to enroll in coverage at different rates (Table 2.2). Under BHP scenario 1:

- Uninsured BHP eligibles above 138 percent FPL would enroll at a rate of 91 percent. Nearly all of these people would be subject to the individual coverage requirement, so they would enroll in coverage at a higher rate than OHP-eligible adults with incomes below 138 percent FPL.
- Nearly all BHP eligibles that were in the pre-ACA nongroup market would shift from unsubsidized nongroup coverage to subsidized QHP plans. As they transition to ACA-compliant plans, individuals can be expected to have been screened for QHP subsidy eligibility. Nearly all those in QHPs below 200% FPL are expected to take up BHP.
- Only about 15 percent of the 18,100 BHP eligibles enrolled in an employer's plan would switch to BHP. This low rate is consistent with our analysis of the literature on the crowd-out of employer coverage by public coverage.
- Lawfully resident non-citizens who have incomes up to 138 percent FPL would enroll at a rate of 73 percent. This is consistent with expected take-up of OHP among non-immigrants with similar incomes.

Under BHP scenario 2, higher beneficiary cost sharing would reduce take-up among the pre-ACA uninsured and pre-ACA employer groups. Legal immigrants with incomes up to 138 percent FPL would not pay any more than under scenario 1, so their behavior would be unchanged. BHP eligibles with higher

[7] Actuarial value refers to the percent of total medical claims covered on average by the plan rather than through member cost sharing.

incomes would pay half the premium and half the cost sharing that they would through the Marketplace without BHP. Those in the pre-ACA nongroup market were already paying much more for coverage than they would under scenario 2, so take-up would be little affected by the increase in cost sharing.

Without BHP, higher premiums and cost sharing would lower take-up rates for all except those in the pre-ACA nongroup market. Our QHP take-up rates are consistent with 2014 Marketplace enrollment data from the few states for which the income distribution of enrollees was available at the time of writing.

One factor could increase the impact of BHP on enrollment more than is shown in our estimates. It is possible that reconciliation of advance premium tax credits, which will occur for the first time in the 2014 tax season, could discourage QHP enrollment, as such reconciliation could lead to publicity about APTC claimants losing tax refunds or incurring tax debts. BHP enrollees would not be subject to tax reconciliation, so any drop in QHP enrollment due to reconciliation would increase the difference in enrollment between QHPs and BHP.

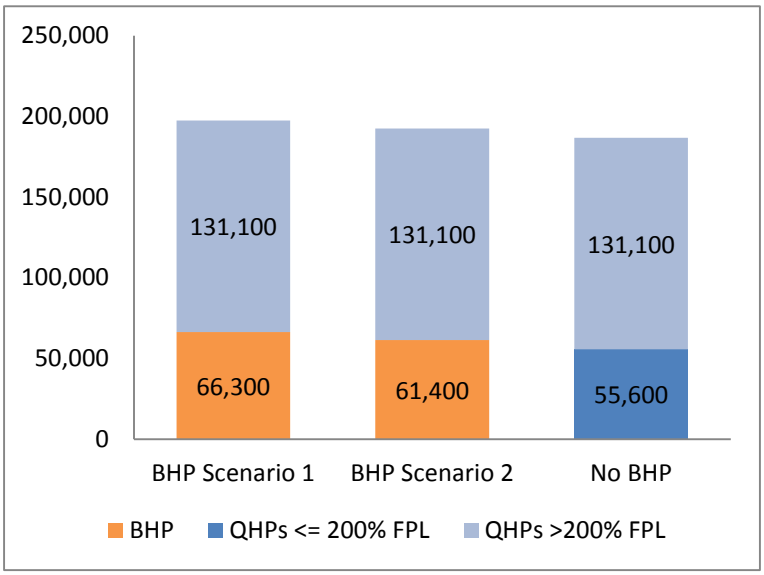
Table 2.2. Overall Take-Up Rates and Number of Enrollees

	BHP Scenario 1	BHP Scenario 2	QHPs < 200% FPL Without BHP
Lawfully resident non-citizens < 138% FPL	73% (4,700)	73% (4,700)	40% (2,600)
Pre-ACA uninsured*	91% (46,100)	82% (41,500)	75% (38,200)
Pre-ACA nongroup*	98% (12,900)	98% (12,900)	98% (12,900)
Pre-ACA employer*	15% (2,500)	13% (2,200)	11% (1,900)
Total	76% (66,300)	70% (61,400)	64% (55,600)

*Excluding lawfully resident non-citizens < 138% FPL.

Applying these differences in take-up, of the 87,300 Oregonians eligible for BHP, we project that 66,300 would enroll under BHP scenario 1, an overall take-up rate of about 76 percent (Table 2.2). Under BHP scenario 2, we project that 61,400 would enroll in BHP, a take-up rate of 70 percent. Without BHP, 55,600 people who would have been eligible for BHP would enroll in subsidized QHPs, a take-up rate of 64 percent.

Figure 2.1. Enrollment in BHP and QHPs, 2016



Across all income levels, we project that 121,100 adults above 200 percent FPL would enroll in QHPs in 2016 with BHP (Table 2.3). These enrollees are either eligible for subsidies with incomes at or above 200 percent FPL or not eligible for subsidies at all.[8] In addition to the adults shown in Table 2.3, 10,000 children with family income above 200 percent FPL would be covered through QHPs, leading to a total QHP enrollment of 131,000 people with BHP (Figure 2.1). Without BHP, QHPs would also enroll 55,600 people eligible for subsidies below 200 percent FPL, bringing the total enrollment in QHPs up to 187,000.

Age, health status, and functional limitation of average enrollees change little between BHP scenarios. In a completely voluntary, underwritten insurance market, we would expect lower premiums to result in somewhat healthier enrollees on average. However, under the ACA, take-up would be strongly influenced by factors such as the individual coverage requirement that are not correlated with health care needs. Under any scenario, a large majority of those subject to the requirement would enroll in coverage. Also, we are reducing cost-sharing as well as premiums, making coverage more attractive to those with higher health needs as well.

Comparing BHP enrollees with QHP enrollees, we find that BHP enrollees are generally younger. (In this and the following paragraph, we describe the characteristics of QHP enrollees with incomes over 200 percent FPL and compare them to BHP enrollees.) About 43 percent of BHP enrollees would be between 19 and 34, compared with 26 percent of QHP enrollees. However, BHP enrollees are generally in worse health. About 15 percent would be in fair or poor health, compared with 10 percent of QHP enrollees and 27 percent of adults enrolled in OHP. We produced detailed estimates of the expected health care costs

[8] We did not consider the Cover Oregon small group Marketplace in this report.

of BHP and QHP enrollees that were used to estimate BHP costs and the effect of BHP on QHP premiums as described later in this report.

Multilingual and multicultural outreach would be particularly important for BHP. BHP enrollees are less likely to be white, non-Hispanic than QHP enrollees (80 percent versus 89 percent). Also, BHP enrollees would be less likely to be native-born than QHP enrollees (41 percent in BHP option 1, versus 33 percent). And a higher share would speak a language other than English at home, and a lower share of those speaking other languages at home would speak English very well. Obviously, the same considerations would apply in designing strategies to enroll these low-income consumers in QHP coverage.

Table 2.3. Nonelderly Adult Enrollment in BHP and QHPs, 2016

	BHP, Scenario 1		BHP, Scenario 2		QHPs < 200% FPL, Without BHP		QHPs > 200% and Unsubsidized	
	N	%	N	%	N	%	N	%
Total Enrollees	66,300	100.0%	61,400	100.0%	55,600	100.0%	121,100	100.0%
Age								
19 - 24 years	11,400	17.2%	10,800	17.6%	9,700	17.4%	8,000	6.6%
25 - 34 years	17,500	26.4%	16,300	26.6%	14,600	26.2%	23,800	19.7%
35 - 44 years	12,400	18.7%	11,300	18.3%	10,100	18.1%	21,200	17.5%
45 - 54 years	10,900	16.4%	10,000	16.3%	9,000	16.2%	25,400	21.0%
55 - 64 years	14,100	21.3%	13,000	21.2%	12,200	22.0%	42,700	35.2%
Race/Ethnicity								
White, Non-Hispanic	52,400	78.9%	48,100	78.3%	44,700	80.3%	106,500	88.0%
Black, Non-Hispanic	1,700	2.6%	1,600	2.6%	1,400	2.5%	500	0.4%
Hispanic	4,700	7.0%	4,500	7.3%	3,600	6.4%	5,800	4.8%
Asian/Pacific Islander, Non-Hispani	4,200	6.3%	4,000	6.6%	3,000	5.4%	4,700	3.9%
American Indian/Alaskan Native	2,000	3.1%	1,800	3.0%	1,600	2.9%	2,100	1.7%
Other, Non-Hispanic	1,400	2.1%	1,400	2.2%	1,300	2.4%	1,400	1.2%
Gender								
Male	34,600	52.2%	31,700	51.7%	28,500	51.3%	61,100	50.5%
Female	31,700	47.8%	29,700	48.3%	27,100	48.7%	59,900	49.5%
Education								
Less than High School	6,000	9.0%	5,500	8.9%	4,100	7.4%	4,800	4.0%
High School	26,700	40.2%	24,800	40.3%	22,700	40.9%	39,300	32.4%
Some College	21,900	32.9%	19,900	32.4%	18,800	33.8%	37,300	30.8%
College Graduate	11,800	17.8%	11,200	18.3%	10,000	17.9%	39,600	32.7%
Health Status								
Better than Fair	56,300	84.9%	52,100	84.9%	47,400	85.2%	108,700	89.8%
Fair or Poor	10,000	15.1%	9,300	15.1%	8,200	14.8%	12,300	10.2%
Function Limitation[1]								
No	61,500	92.7%	56,900	92.7%	51,500	92.6%	115,500	95.4%
Yes	4,800	7.3%	4,500	7.3%	4,100	7.4%	5,600	4.6%
Language								
English	54,200	81.7%	49,800	81.1%	46,700	83.9%	108,200	89.3%
Spanish	4,300	6.5%	4,200	6.8%	3,100	5.5%	5,800	4.8%
Chinese	1,200	1.8%	1,200	1.9%	900	1.7%	1,400	1.1%
Korean	400	0.6%	400	0.7%	200	0.4%	900	0.8%
Vietnamese	1,300	1.9%	1,100	1.9%	900	1.5%	600	0.5%
Hindi and Related	300	0.4%	300	0.4%	200	0.4%	300	0.2%
Russian	500	0.7%	500	0.8%	400	0.8%	600	0.5%
English Speaking Status[2]								
Speaks English Very Well	4,900	40.7%	4,600	40.0%	4,000	45.2%	7,900	61.7%
Does Not Speak English Well	7,300	60.5%	7,000	61.3%	5,000	56.0%	5,100	39.7%
Citizenship								
Born U.S. Citizen	55,700	84.0%	51,300	83.5%	48,100	86.5%	111,200	91.8%
Naturalized U.S. Citizen	3,600	5.5%	3,400	5.5%	3,000	5.4%	7,300	6.0%
Not a U.S. Citizen	7,000	10.5%	6,800	11.0%	4,500	8.1%	2,600	2.1%
Employment Status								
Employed	39,200	59.1%	36,900	60.1%	34,400	61.9%	80,500	66.5%
Not Employed	27,100	40.9%	24,500	39.9%	21,200	38.1%	40,600	33.5%
MAGI								
<138% FPL	4,700	7.2%	4,700	7.7%	2,600	4.7%	-	0.0%
138 - 150% FPL	12,500	18.8%	11,700	19.0%	10,900	19.6%	-	0.0%
150 - 175% FPL	25,600	38.6%	23,900	39.0%	23,000	41.4%	-	0.0%
175 - 200% FPL	23,500	35.5%	21,000	34.3%	19,000	34.2%	-	0.0%

Source: HIPSM-ACS 2014.
BHP Scenario 1: Zero premiums and no cost sharing.
BHP Scenario 2: No premiums or cost sharing for those < 138% FPL, half of subsidized QHP premiums and cost sharing for those 138-200% FP
1: Includes cognitive, ambulatory, independent living, self-care, vision, or hearing difficultly.
2: For non-English speaking adults only.

Geographic Distribution of BHP Eligibles and Enrollees

We show the geographic distribution of those eligible for BHP in 2016 (Figure 2.2) and those projected to enroll under BHP option 1 (Figure 2.3). These areas are based on Public Use Microdata Areas (PUMAs) defined by the U.S. Census Bureau, which are the smallest geographic units for which the ACS is representative.

Figure 2.2 2016 BHP Eligibles

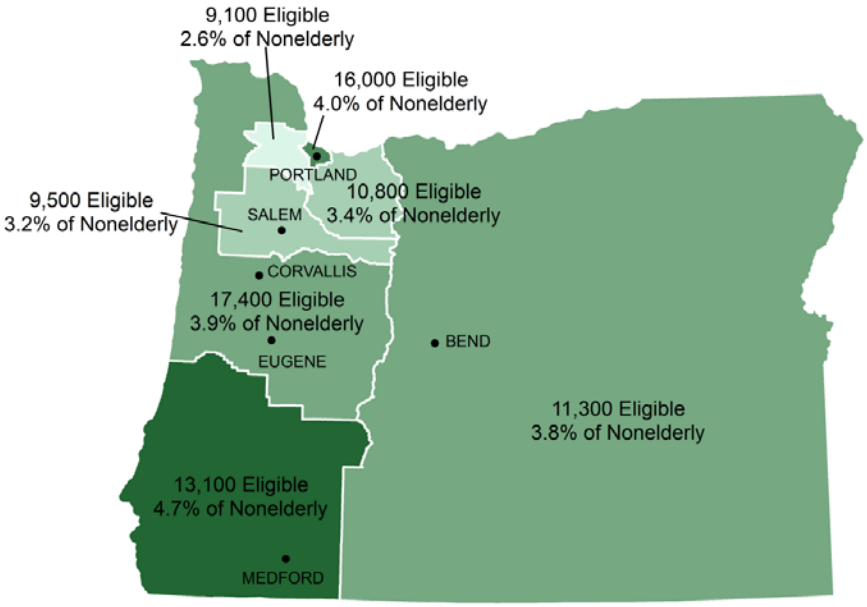
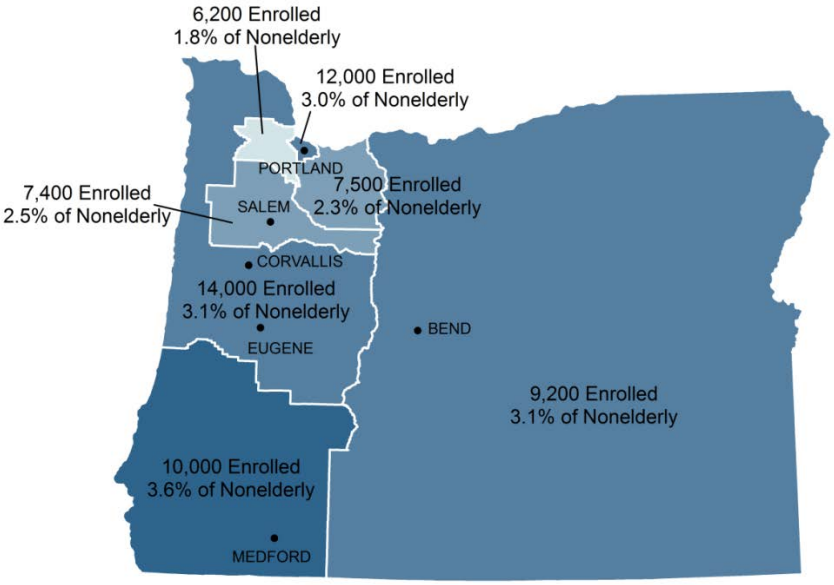


Figure 2.3 2016 BHP Enrollees



Impact of BHP on Health Insurance Coverage

We first take a look at health insurance coverage for those eligible for BHP. Without the ACA, 54,700 would be uninsured, or 62.4 percent of BHP eligibles—that is, all state residents with incomes at or below 200 percent of FPL who are citizens or lawfully present non-citizens, who are ineligible Medicaid and CHIP, and who are not offered employer-sponsored coverage that the ACA classifies as affordable (Table 2.4). We defined this group to exclude consumers under 200 percent FPL who are either (a) eligible for Medicaid or CHIP or (b) ineligible for federally funded subsidies because of immigration status or offers of employer coverage. We are estimating here the impact of BHP on insurance coverage among low-income consumers who, depending on the state's policy choices, could qualify either for BHP or QHP subsidies.

Under the ACA without BHP, the uninsured rate for this low-income group would fall to 17.1 percent as 55,600 people enroll in subsidized Marketplace plans. Under BHP without cost sharing (scenario 1), only 5.8 percent of this low-income group would be uninsured. Under BHP with cost sharing (scenario 2), 11.0 percent of these low-income consumers would be uninsured. Thus, compared with the ACA without BHP, BHP scenario 1 would reduce the number of uninsured by 9,900 and scenario 2 would reduce the number of uninsured by 5,400.

Table 2.4. Health Coverage of BHP Eligible Population, 2016

	Without ACA		ACA, BHP Scenario 1			ACA, BHP Scenario 2			ACA, No BHP		
					Δ			Δ			Δ
Insured	**32,900**	**37.6%**	**82,500**	**94.2%**	**49,600**	**78,000**	**89.0%**	**45,100**	**72,600**	**82.9%**	**39,700**
Employer	18,100	20.7%	15,200	17.4%	-2,900	15,500	17.7%	-2,600	15,900	18.2%	-2,200
Non-Group outside CO	14,800	16.9%	1,000	1.1%	-13,800	1,100	1.3%	-13,700	1,100	1.3%	-13,700
Cover Oregon	0	0.0%	0	0.0%	0	0	0.0%	0	55,600	63.5%	55,600
BHP	*0*	*0.0%*	*66,300*	*75.7%*	*66,300*	*61,400*	*70.1%*	*61,400*	*0*	*0.00%*	0
Uninsured	**54,700**	**62.4%**	**5,100**	**5.8%**	**-49,600**	**9,600**	**11.0%**	**-45,100**	**15,000**	**17.1%**	**-39,700**
Total	***87,600***	***100.0%***	***87,600***	***100.00%***	***0***	***87,600***	***100.0%***	***0***	***87,600***	***100.0%***	***0***

Note: This table includes a small number of residents offered employer-sponsored insurance that the ACA classifies as unaffordable and therefore does not preclude eligibility for BHP or QHP subsidies.

In Table 2.5, we show changes in health coverage under the ACA for the entire population below 200 percent FPL. The uninsured are heavily concentrated among those with low income, so the uninsured rate without the ACA, 27.9 percent, is much higher than the uninsured rate for the total population. Even without BHP, the ACA would reduce the number of uninsured below 200 percent FPL by more than two thirds, leading to an uninsured rate of 7.8 percent. Most of this reduction is due to Medicaid expansion, but the new enrollment in subsidized QHPs also increases health coverage. The differences between the BHP scenarios in Table 2.5 are driven by the differences among BHP eligibles that we saw in Table 2.4, but are set in the broader context of the total population below 200 percent FPL.

Table 2.5. Health Coverage of Oregonians Below 200% FPL, 2016

	Without ACA		ACA, BHP Scenario 1			ACA, BHP Scenario 2			ACA, No BHP		
					Δ			Δ			Δ
Insured	**1,025,500**	**72.1%**	**1,320,900**	**92.9%**	**295,400**	**1,316,500**	**92.6%**	**291,000**	**1,311,000**	**92.2%**	**285,500**
Medicaid	543,400	38.2%	838,100	58.9%	294,700	838,100	58.9%	294,700	838,100	58.9%	294,700
Medicare	25,700	1.8%	25,700	1.8%	0	25,700	1.8%	0	25,700	1.8%	0
Employer	375,200	26.4%	351,000	24.7%	-24,200	351,400	24.7%	-23,800	351,700	24.7%	-23,500
Other Public	23,800	1.7%	23,800	1.7%	0	23,800	1.7%	0	23,800	1.7%	0
Non-Group outside CO	57,300	4.0%	11,900	0.8%	-45,400	12,000	0.8%	-45,300	16,100	1.1%	-41,200
Cover Oregon	0	0.0%	4,100	0.3%	4,100	4,100	0.3%	4,100	55,600	3.9%	55,600
BHP	*0*	*0.0%*	*66,300*	*4.7%*	*66,300*	*61,400*	*4.3%*	*61,400*	*0*	*0.00%*	0
Uninsured	**396,500**	**27.9%**	**101,100**	**7.1%**	**-295,400**	**105,500**	**7.4%**	**105,500**	**111,000**	**7.8%**	**111,000**
Total	***1,422,000***	***100.0%***	***1,422,000***	***100.00%***	***0***	***1,422,000***	***100.0%***	***0***	***1,422,000***	***100.0%***	***0***

Churning in Health Coverage

Our final analysis related to eligibility was to estimate churning in eligibility for the three affordability assistance programs available under the ACA: OHP, BHP, and subsidized QHP plans. Considering these as three separate programs, 536,000 non-elderly adult Oregonians would change eligibility from 2016 to 2017 (Table 2.5, first panel). About 144,000 would churn between eligibility for the three different

assistance programs, while the remaining 392,000 would either lose eligibility for all three programs or go from being ineligible for any program to being eligible for one of the three assistance programs.

Changes between 2016 and 2017 in the overall number of people in each eligibility type should be taken with caution. The most recent available survey data that follow people's income and health coverage over time are from the recession years. They are driven by trends in employment that may not apply to 2016. Indeed, the 118,000 BHP eligibles in 2017 is close to earlier estimates of the number of BHP eligibles in Oregon that were based on 2008-2009 data. What we can conclude is that changes in employment can have a noticeable impact on BHP eligibility. The number of 2016 BHP eligibles is based on the latest available survey data, making it more reliable than the 2017 estimate given in Table 2.5. If employment changes little or improves somewhat from 2016 to 2017, the number of BHP eligibles is likely to be very similar between the two years.

BHP and QHPs would see particularly high rates of churning. Only about 33 percent of 2016 BHP eligibles and 51 percent of QHP subsidy eligibles would remain eligible for the same program in 2017. We find that employment is particularly volatile for people in or near the BHP income range. The most recent available data on income transitions were from 2009 to 2010, so they reflect economic and employment trends that will not necessary be present from 2016 to 2017. We reweighted the data to reflect the 2016 income distribution, but it is possible that the data still overstate the employment changes among low-income families that would occur in 2016. However, that is unlikely to change the basic conclusion that most BHP eligibles would experience churning.

In the second panel of Table 2.5, we show churning among non-elderly adults if either there was no BHP or if BHP plans were aligned with QHPs, so that enrollees changing eligibility would be able to continue their current plans. Compared with BHP as an entirely separate program, the number of adults experiencing changes in their eligibility for assistance would decline by 5 percent, and the number switching between plans in different assistance programs would decline by 20 percent.

In the third panel of Table 2.5, we show churning if BHP plans were aligned with OHP coordinated care organizations (CCOs). In that case, enrollees would not have to change plans if their eligibility changes from one program to another. This would result in a further reduction of 7 percent in churning overall, and a 29 percent reduction in churning between plans in different assistance programs.

Thus, compared with no BHP, introducing BHP would increase churning and decrease continuity of coverage if its plans were distinct from both OHP and QHPs. However, if BHP plans were aligned with OHP CCOs, BHP would increase continuity of coverage among adults in Oregon. Aligning BHP plans with QHPs would lead to churning at levels similar to churning without BHP.

Several final comments help place these results in perspective. First, the vast majority of churning does not take place between insurance affordability programs. Rather, most changes occur when people gain or lose eligibility. For example, if a Medicaid beneficiary's income rises above 138 percent FPL, he or she

will typically be offered Employer Sponsored Insurance (ESI) that makes the beneficiary ineligible for both QHP subsidies and BHP. Depending on how Oregon approaches BHP, the percentage of churning that involves movement between eligibility and ineligibility, rather than between programs, is:

- 73 percent, if BHP is administered as a separate program, with health plans distinct from both the Marketplace and OHP;
- 77 percent, if Oregon does not implement BHP or if BHP plans are the same as QHPs; and
- 83 percent, if BHP is aligned with OHP.

Second, the tables below make the baseline for comparison the scenario with the greatest possible amount of churning—namely, BHP plans administered separately from both the Marketplace and OHP. If one instead makes the baseline implementation of the ACA in Oregon without BHP and focuses exclusively on churning between programs, then this analysis shows that:

- Implementing BHP to operate as a separate delivery system, distinct from both the Marketplace and OHP, would increase churning between programs by 25 percent; but
- Implementing BHP to align with OHP would reduce churning between programs by 29 percent.

Finally, CMS's regulations for BHP make clear that BHP programs can offer continuous eligibility. In fact, federal BHP payments are calculated as if each BHP program provides continuous eligibility, where subsidies are based on household circumstances at the time of application, without mid-year changes. To the extent that Oregon implements continuous eligibility for some or all BHP enrollees, that would reduce mid-year changes in coverage, an issue that our modeling did not examine.

A very different kind of churning that BHP could potentially address involves pregnant women with incomes between 138 and 185 percent FPL. Without BHP, they may enroll into subsidized QHP coverage before they became pregnant. But once they conceive, they also qualify for the Oregon Health Plan, under a special eligibility category that applies to pregnant and post-partum women up to 185 percent FPL. Women with pregnancy-based OHP coverage receive additional services not covered by QHPs. They also are exempt from all cost-sharing, both for premiums and out-of-pocket costs.

Accordingly, women in this income range who enroll in QHPs must choose between continuity of care—that is, remaining with their Marketplace plan and provider—and shifting to OHA to obtain additional health care services, with the increased access to care that accompanies lower out-of-pocket costs. Women who access these additional benefits and cost-sharing protections will typically be required to change plans and providers mid-pregnancy. By contrast, if BHP is implemented in a way that provides coverage through the same OHP plans to residents up to 200 percent FPL, women in this income range who become pregnant can keep the same plan and provider as they access the additional benefits and cost-sharing protections offered by OHP.

Table 2.5. Churning Among Non-Elderly Adult Oregonians

BHP With Plans Distinct From Both OHP and QHPs

	2017 Eligibility				
2016 Eligibility	OHP	BHP	Cover Oregon	Ineligible	Total
OHP	522,000	40,000	36,000	110,000	707,000
BHP	23,000	29,000	18,000	18,000	88,000
QHP	17,000	12,000	75,000	43,000	146,000
Ineligible	102,000	37,000	81,000	1,252,000	1,472,000
Total	663,000	118,000	209,000	1,424,000	2,414,000
Total Number Churning	536,000				
OHP/BHP/QHP Churning	144,000				

No BHP or BHP Plans Aligned with QHPs

	2017 Eligibility			
2016 Eligibility	OHP	Cover Oregon/ BHP	Ineligible	Total
OHP	522,000	75,000	110,000	707,000
QHP/ BHP	40,000	133,000	61,000	234,000
Ineligible	102,000	118,000	1,252,000	1,472,000
Total	663,000	327,000	1,424,000	2,414,000
Total Number Churning	507,217		-5%	
OHP/BHP/QHP Churning	115,215		-20%	

BHP Plans Aligned with OHP

	2017 Eligibility			
2016 Eligibility	OHP	Cover Oregon	Ineligible	Total
OHP/BHP	613,000	53,000	129,000	795,000
QHP	29,000	75,000	43,000	146,000
Ineligible	139,000	81,000	1,252,000	1,472,000
Total	781,000	209,000	1,424,000	2,414,000
Number Churning	473,834		-7%	
OHP/BHP/QHP Churning	81,832		-29%	

3) PROJECTED BHP REVENUES AND COSTS

Background

This section summarizes the estimated federal BHP payments to the state, BHP program costs and the projected surplus or deficit to the state if a BHP is implemented. As noted in the introduction, states that implement the BHP receive a federal payment equal to approximately 95 percent of the amount of premium and cost sharing reduction subsidies BHP enrollees would have received had they been enrolled in QHPs through the Oregon Marketplace.

Administrative expenses incurred by the state such as eligibility and enrollment functions cannot be paid for directly with federal BHP funds. Administrative costs could be paid by BHP plan surcharges, which increase BHP premiums, which in turn are paid by federal BHP funds. Issues related to administrative costs are discussed in more detail in Section 6.

Additional factors that could affect the fiscal feasibility of BHP are discussed in Section 7, which analyzes strategic considerations.

States have flexibility to define program parameters, such as delivery system and managed care approaches and provider reimbursement levels. States can also define covered benefits (so long as they meet minimum standards for Essential Health Benefits), enrollee premiums (so long as they are no more than what the individual would have paid for the second lowest cost silver plan in the Marketplace), and enrollee cost sharing at the point of service (so long as it is no more than what the enrollee would have paid had they been enrolled in subsidized Marketplace coverage). Based on discussions with OHA staff and the BHP Study Advisory Group, four scenarios were defined to use in modeling BHP impacts. These scenarios are defined in Table 1.3.

Key Assumptions and Methodology

The analysis in this section is based on a detailed Wakely model that incorporates demographic, claim cost, and premium data at the household level. The primary data sources for this model are:

- Demographic information and relative health risk scores by household based on the analysis performed by Urban and summarized in Section 2 of this report.
- 2015 QHP rate filings with rates by age and region in Oregon were used as the basis for estimating projected claim costs for the individual market and BHP populations.
- The second lowest Silver rates for 2015 to be offered through the Oregon Marketplace as provided by the Oregon Insurance Division.
- Assumptions mutually agreed to by OHA and Wakely which are described later in this section.

In general, the financial impacts of the BHP were modeled within the following framework:

- All cash flows and demographic assumptions are projected to 2016. This projection inherently involves several factors including:
    - Take-up of enrollment into the BHP, which is based on the Urban analysis described in Section 2 of this report.
    - Premium and claim cost trends, which are defined later in this section.
    - Impact of induced (patient initiated) utilization on claim costs due to a change in the relative richness of coverage. Induced utilization is the expected increase in utilization of medical services as a result of reduced cost-sharing, thus decreasing financial barriers for individuals seeking care.
    - Estimated changes in the federal reinsurance program as it phases out from 2014 – 2016.
- To simplify the analysis, all enrollees in ACA-compliant plans in the individual market (both on and off the Marketplace) are assumed to choose the second lowest cost silver plan available through the Oregon Marketplace.
- Federal BHP payment estimates are based on the formulas and factors defined in 45 CFR Part 600 - Basic Health Program; Federal Funding Methodology for Program Year 2015, as published in the Federal Register on March 12, 2014. Details regarding these calculations are provided in Appendix B.
- The standard health plans that offer BHP coverage are assumed to pay providers at either commercial or Medicaid levels. For purposes of this analysis, Medicaid reimbursement levels were assumed to be 62% of commercial reimbursements. It is important to note that the claims expense estimates for Scenarios 1a and 1b are highly sensitive to this assumption.
- Estimated 2016 2nd lowest cost Silver rates for purposes of calculating BHP payments are based on 2015 second lowest cost Silver rates provided by the State and trended to 2016 using the 2015 federal BHP payment methodology (the 2016 payment methodology is not yet available).
- Claim cost estimates by household are derived using the 2015 2nd lowest cost Silver rates by region in Oregon as the starting point.
- We assumed the following BHP administrative costs per discussions with OHA staff and as described in section 6 of this report:
- Standard health plan administrative costs equal to 8% of program costs under scenarios 1a and 1b (Medicaid approach) and 15% of program costs under scenarios 2a and 2b (Commercial

approach). Note that the BHP regulations require that health insurance issuers offering a standard health plan use at least 85 cents for each dollar collected for medical and quality improvement expenses.

- State administrative expenses equal to $19.32 PMPM for scenarios 1a and 1b, and $22.32 PMPM for scenarios 2a and 2b, as described in Section 6 of this report.
- Though the ACA requires certain protections for American Indians/Alaska Natives in programs, including BHP, any special provisions for this population have not been considered in the analysis contained herein.

Additional details on the methodology and assumptions used can be found in Appendix A.

Results and Considerations

The following outlines the results of the 2016 projections used to develop the projected net surplus/deficit to the state of the BHP. Key considerations are also explored in each section.

Projected Federal BHP Payments

Our analysis shows that federal BHP payments available to the State of Oregon, based on Urban's enrollment estimates, are projected to be between $191.6 and $207.5 million for 2016.

Table 3.1 below summarizes the estimated federal payments under each scenario.

Table 3.1 – Projected 2016 Federal BHP Payments

	Scenarios 1a and 1b (No Enrollee Premium / Cost Sharing)	Scenarios 2a and 2b (Some Enrollee Premium / Cost Sharing)
BHP Covered Lives	66,339	61,389
Amounts in ($000s)		
95% of Premium Tax Credits	$152,918	$140,998
95% of Cost Sharing Reductions	$54,579	$50,575
Total	$207,498	$191,573
Per Enrollee Per Year Amounts		
95% of Premium Tax Credits	$2,305	$2,297
95% of Cost Sharing Reductions	$823	$824
Total	$3,128	$3,121

Scenarios 2a and 2b show lower federal BHP payments because fewer residents are expected to take up BHP enrollment (due to the higher enrollee premium and cost sharing amounts).

It is important to emphasize the importance of the projected 2016 second lowest cost Silver rates in our analysis. Because the second lowest cost silver plan may change from year to year, and because competitive dynamics in the state may change over time, there is potentially high levels of variation in the second lowest cost silver plan from year to year. Such year-to-year changes in QHP benchmark premiums may not track with changes in health care costs that drive program expenses.

Unexpected changes in the second lowest cost silver rates could have a significant impact on the federal BHP revenues Oregon will receive to support the BHP. Below is a comparison of the 2015 second lowest cost age 21 silver rates in each of Oregon's rating areas compared with the second lowest cost silver premium in 2014.

Table 3.2 – Comparison of 2014 and 2015 Second Lowest Cost Silver Rate for Age 21 Year Old*

Rating Area	2014 2nd Lowest Cost Silver Plan Carrier	2015 2nd Lowest Cost Silver Plan Carrier	2014 2nd Lowest Silver Cost Rate	2015 2nd Lowest Silver Cost Rate	% Change
BEND	Kaiser Foundation Health Plan of the Northwest	Moda Health Plan	$200	$167	-16.5%
COAST	Health Republic Insurance Company	LifeWise Health Plan of Oregon	$185	$178	-3.8%
EUGENE	PacificSource Health Plans	Moda Health Plan, Inc.	$188	$173	-8.0%
MEDFORD	Health Republic Insurance Company	Moda Health Plan, Inc.	$179	$184	2.8%
PENDLETON-HERMISTON	Health Republic Insurance Company	LifeWise Health Plan of Oregon	$181	$182	0.6%
PORTLAND	Moda Health Plan	LifeWise Health Plan of Oregon	$173	$182	5.2%
SALEM	Health Republic Insurance Company	LifeWise Health Plan of Oregon	$175	$178	1.7%

*Note that because all rates must be based on a standard age curve, the percent change column above will be consistent across all ages.

While premiums are typically expected to increase from year to year due to increases in the cost of medical services, the second lowest cost silver plan premium changes from year to year may not follow expected trends for a number of reasons, including:

- The identity of the 2nd lowest cost silver plan for any given region might change.
- Carriers may implement narrower provider networks, drug formularies, or other utilization management approaches that might result in lower expected increases.
- Change in the competitive environment or a particular carrier's business strategy may impact

changes in the second lowest cost premiums.

Also note that under the 2015 federal BHP payment rules, states have the option to either utilize the actual 2015 second lowest cost silver plan rates as the basis for the calculation, or they can utilize the 2014 second lowest cost silver plan rates projected to 2015. The option of having each year's benchmark premiums trended forward to the following year, based on CMS national projections, can ameliorate, to some degree, the effect of fluctuations in the state's benchmarks. That option, along with CMS's publication of each calendar year's federal BHP payment rates in February of the previous year, should delay the impact of any unexpected changes to Oregon's benchmark premiums and give the state time to plan and make adjustments.

States can also propose to HHS a methodology for developing a health risk factor to adjust the federal payment to account for differences between the health risk of the BHP population and that underlying the second lowest cost silver rates. Should Oregon proceed with the BHP, further analysis should be done with respect to these options to ensure that Oregon is able to maximize the available federal funding. The methodology for determining 2016 federal BHP payments is not yet available, so the methodology that will apply to 2015 BHP payments was used to project BHP payments to 2016.

Projected BHP Claims Expense

Wakely projected the claim costs of the estimated 2016 BHP population based on the assumed benefits, reimbursement levels, and cost sharing amounts for each scenario. Claim costs include the expected liability to the standard health plan offerors, and do not include consumer out-of-pocket expenses (e.g., copayments, deductibles and coinsurance). Overall, we estimate the BHP claim expense liability to be between $174.4 and $277.4 million for 2016. Table 3.3 summarizes the estimates for each scenario.

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

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

There is significant variation in claims expense between scenarios 1a/1b and scenarios 2a/2b because Medicaid fees are estimated to be about 38% lower than commercial fees (based on those underlying the

second lowest cost silver plan). Actual costs will depend heavily on the provider reimbursement rates achieved, as well as the effectiveness of medical management programs.

The claims expenses were estimated based on the following general process:

First, allowed claim costs derived from the 2015 Cover Oregon second lowest cost silver rates were used as the starting point. The term "allowed claims" means total costs before member cost sharing is subtracted, but after discounts from provider reimbursement arrangements are applied. See Appendix A for information on how these were derived.

Next, costs were projected to 2016 by applying adjustments for

- Assumed provider reimbursement levels of 62% of baseline costs for scenarios 1a and 1b and 100% of baseline costs for scenarios 2a and 2b.
- Utilization and unit costs trends of 3.4% annually for scenarios 1a /1b and 6.0% for scenarios 2a /2b.
- Member cost sharing levels as defined for each scenario.
- Induced utilization to reflect benefit richness.
- The relative morbidity factor for the expected BHP enrollees compared to individual market enrollees supplied by the Urban Institute.
- For scenarios 1b and 2b, we added costs for OHP Plus benefits that are not covered by the EHB benchmark plan. These were estimated to be about $27 PMPM, or $322 PMPY prior to any member cost sharing.

Projected BHP Cost to the State Oregon

This section summarizes the total estimated cash flows associated with a BHP for calendar year 2016 from the perspective of the State. This helps the state identify BHP costs that may not be covered by federal BHP payments. As discussed throughout this section, these results are highly sensitive to changes in the second lowest cost silver plan premium that is used to identify federal BHP payments. Because BHP revenues are somewhat disconnected from claim expenses, any conservatism or aggressiveness on the part of QHP issuers in setting QHP rates could produce unexpected positive or negative cash flows for the State.

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

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

Key takeaways and considerations include:

- Prior to accounting for state administrative costs, all Scenarios except 1a result in a net cost to the state. The state would need to consider its approach for handling the surplus projected under Scenario 1a (or any other scenario resulting in a surplus). For example, the state could retain that surplus in the BHP trust fund as a "hedge" against possible fluctuations in future federal payment levels that result from unforeseen changes to QHP benchmark premiums. Some of that surplus could also be used to raise provider reimbursement slightly above Medicaid levels.

- Scenarios 1a / 1b show very different results compared to Scenarios 2a / 2b due to the lower Medicaid fee levels assumed. The fee levels carriers are able to achieve will have a significant impact on the projected State surplus or deficit under a BHP. If BHP is implemented through using the Coordinated Care Organizations that currently serve OHP beneficiaries, it may be easier to maintain provider payment levels at or near Medicaid levels.

- Under scenarios 2a and 2b in which Commercial provider reimbursements are assumed and enrollees pay less than what they would have paid had they enrolled in QHPs, the plans do not generate enough of a savings to offset the 5% reduction in subsidy payments that otherwise would have been available had the BHP enrollees enrolled in QHP coverage.

- The scenarios modeled represent a range of possible results; however, the State could adjust consumer premium and cost sharing subsidies or provider payment levels in order to achieve expenses that are expected to better match revenues (i.e. a "break-even" or modest surplus goal). The State could also modify program details to encourage the disproportionate enrollment of the lowest-income BHP consumers, who will qualify for the highest federal BHP payments, potentially improving the overall balance of federal dollars relative to state BHP costs. For example, if no premiums are charged below 150 percent FPL, more consumers below that threshold will enroll, bringing with them higher federal payments.

- Based on the scenarios above, state incurred costs beyond federal BHP funding per enrollee per year range from $24 to $1,941.

It is important to understand that the standard health plan administrative expenses in these scenarios are high level estimates. Administrative expenses for standard health plan offerors are assumed to be 8% or 15% of calculated BHP capitation payments (excluding member premium). These expenses include consideration for ACA issuer taxes and reinsurance assessments. We believe these assumptions are reasonable and are consistent with what we have observed in other States and other BHP studies but it will be important to refine these estimates with more detailed studies in order to improve the predicted State surplus and deficit.

In addition to the sensitivity of results across the scenarios, there will also be variation in results from year to year as standard health plan offerors negotiate different provider reimbursement levels and BHP payments change according to the level of the second lowest cost Silver rate in the Marketplace.

BHP administrative costs play an important role in this fiscal analysis. It is important for the reader to keep in mind that the above estimates show the mid-range within several administrative cost estimates described in greater detail below. If the lower end rather than the mid-point of the range turns out to be correct, then Scenario 1a's modest net deficit, shown above, will become a modest net surplus. If the higher end turns out to be more accurate, that net deficit shown above will be an underestimate.

Modest adjustments to the policies modeled here can also affect the fiscal "bottom line." For example, charging premiums under Scenarios 1a and 1b would yield revenue. Depending on the details, higher premiums could also reduce participation levels, which would lower state costs and federal revenues.

Even without formal modeling, one can define the range of possible cost effects under policy adjustments that add to Scenario 1 premiums below the amounts in Scenario 2. Enrollment would fall somewhere between the amounts estimated here for Scenario 1, without any premiums, and for Scenario 2, with

higher premiums than those in the adjusted policies. Using enrollment estimates for Scenarios 1 and 2 to define the two ends of a range within which the actual cost effects would fall, the following summarizes the impact of several possible adjustments to Scenarios 1a and 1b (see Appendix D for additional details on these calculations):

- Charging $10 monthly premiums to BHP enrollees with incomes above 175 percent FPL would
  - yield between $2.6 million and $2.8 million in fiscal gains under Scenario 1a, changing what was a $1.6 million deficit into a surplus of between $1.0 and $1.2 million; and
  - produce between $2.8 million and $3.5 million in gains under Scenario 1b, changing a $24.8 million deficit into a deficit of between $21.4 million and $22.0 million.
- Charging $10 monthly premiums to BHP enrollees with incomes above 150 percent FPL would
  - yield between $5.5 million and $5.9 million in fiscal gains under Scenario 1a, changing what was a $1.6 million deficit into a surplus of between $3.9 and $4.3 million; and
  - produce between $5.9 million and $6.7 million in gains under Scenario 1b, changing a $24.8 million deficit into a deficit of between $17.8 million and $18.9 million.
- Charging $10 monthly premiums to enrollees between 138 and 150 percent FPL, $20 between 151 and 175 percent FPL, and $40 above 175 percent FPL would
  - yield between $17.3 million and $18.9 million in fiscal gains under Scenario 1a, changing what was a $1.6 million deficit into a surplus of between $15.7 and $17.3 million; and
  - produce between $18.9 million and $19.1 million in gains under Scenario 1b, changing a $24.8 million deficit into a deficit of between $5.7 million and $5.9 million.

While these adjustments would provide fiscal benefits, they would forfeit some of the policy advantages of Scenario 1. To the extent that higher premiums would reduce participation, the number of uninsured could increase as a result.

4) BHP ENROLLEE AFFORDABILITY

Background

This section illustrates the estimated financial impact of the program for potential BHP enrollees. This analysis is based on the estimated BHP enrollment developed by Urban and summarized in Section 2 of this report. Premium and out-of-pocket expenses for expected BHP enrollees are estimated under each BHP scenario and compared to that estimated based on the previous insurance status.

Results

Table 4.1 provides estimates of the previous insurance coverage status of projected BHP enrollees based on the Urban modeling and indicates that 84%-91% would previously have been insured through QHPs in the Marketplace, 9%-14% would previously have been uninsured, and the remainder would have been enrolled in other coverage.

Table 4.1 – Previous Coverage Status of BHP Enrollees

Population Type	Number of Enrollees		Distribution of Enrollees	
	Scenario 1a / 1b	Scenario 2a / 2b	Scenario 1a / 1b	Scenario 2a / 2b
Previous QHP Enrollee	55,635	55,633	83.9%	90.6%
Previous Other Individual Market (non-QHP)	104	0	0.2%	0.0%
Previous Uninsured	9,829	5,402	14.8%	8.8%
All Other	773	354	1.2%	0.6%
Total BHP	66,339	61,389	100%	100%

Table 4.2 illustrates the premiums that apply for subsidized coverage for the second lowest cost silver plan available on the Marketplace compared to the premiums that would apply for BHP under scenarios 2a and 2b for a sampling of household incomes and sizes. Note that there are no premiums for BHP enrollees under scenarios 1a and 1b.

Table 4.2 – Monthly Premiums for BHP Scenarios 2a and 2b Compared to Marketplace 2nd Lowest Cost Silver Plan for a Sampling of Households

	Premium as % of Income		Premium for Single Household		Premium for Household of 4	
FPL	Marketplace	BHP	Marketplace	BHP	Marketplace	BHP
100%	2.0%	0%	$19	$0	$40	$0
138%	3.3%	1.6%	$44	$22	$90	$45
150%	4.0%	2.0%	$58	$29	$119	$60
175%	5.2%	2.6%	$88	$44	$179	$90
200%	6.3%	3.2%	$123	$61	$250	$125

Out-of-pocket costs were calculated by applying the relative health risk factor to the average expected allowed claims cost for each individual in the Urban developed database and then multiplying by the average member cost sharing percentage applicable under each scenario as outlined in Table 4.3. Those assumed to be uninsured, were assumed to pay 100% of their average claim costs with no adjustments made for expected lower utilization or higher provider rates that are generally associated with uninsurance.

Table 4.3 – Average Percent of Total Claim Costs Paid by Member for Each Scenario

	No BHP		BHP	
FPL	Uninsured	Marketplace	Scenarios 1a/1b	Scenarios 2a/2b
<138%	100%	6%	0%	0%
138%-150%	100%	6%	0%	3%
150%-200%	100%	13%	0%	6.5%

Table 4.4 illustrates the average expected savings to BHP enrollees compared to what they would have paid in premiums and out-of-pocket costs (member cost sharing) in the absence of the BHP. In all scenarios, the BHP is estimated to reduce the out-of-pocket expenses for BHP enrollees. These savings are a result of BHP premium and cost sharing subsidies above and beyond what is available for coverage provided through the Marketplace. The extent of estimated consumer out-of-pocket savings under a BHP varies depending on the coverage (or lack thereof) in the absence of the BHP offering. Out-of-pocket savings are most dramatic for those who have remained uninsured in 2015 despite the availability of subsidized coverage through the Marketplace. For residents who would have enrolled in individual market coverage in the absence of the BHP, we estimate that annual out-of-pocket savings in the BHP would be $800 - $1,590. The savings are even higher for those who were previously uninsured. For this population, we estimate an annual savings of $3,120 - $3,955.

Table 4.4 – Comparison of Average Annual Out-of-Pocket Expense for Each Scenario

Previous Coverage	No BHP			BHP			Consumer Savings in BHP
	Member Premium	Cost Sharing	Total	Member Premium	Cost Sharing	Total	
Scenarios 1a / b							
Individual ACA	$1,076	$513	$1,589	$0	$0	$0	$1,589
Uninsured	$0	$3,955	$3,955	$0	$0	$0	$3,955
Scenarios 2a / b							
Individual ACA	$1,072	$510	$1,582	$533	$250	$783	$799
Uninsured	$0	$3,538	$3,538	$273	$145	$418	$3,120

Another potential advantage of the BHP is that enrollees will not be subject to the reconciliation of tax credits as required by enrollees receiving subsidized coverage through the Oregon Marketplace. If household income increases during the year or there is a reduction in household size, subsidized Marketplace enrollees may experience reductions in their tax refunds or increases in their tax liabilities if they don't report changes in circumstances throughout the year. This does not apply to BHP enrollees.

Despite the opportunity for consumer savings in the BHP relative to the options available through the Marketplace, there may be some actual or perceived disadvantages of BHP implementation to consumers, including:

- A different set of available plan options.
- Different provider networks, which may not include a consumer's specific provider. Provider access may be strained, especially if low Medicaid reimbursement rates are utilized.
- If BHP plans are distinct from both Marketplace and OHP plans, additional churn as demonstrated in Section 2 of this report, requiring consumers to change plans more frequently as income changes.

As a transitional effect, consumers would be moved out of QHPs into BHP standard health plans. While some consumer may be pleased at the resulting cost savings and, depending on the state's approach to BHP implementation, additional benefits, clinical relationships to QHP providers could be disrupted, and ongoing treatment could be interrupted. Moreover, unless affected consumers receive hands-on assistance, some may not successfully make the transition and could experience an interruption in coverage.

5) BHP IMPACT ON OREGON MARKETPLACE AND INDIVIDUAL MARKET

Background

When one adds children to the adults discussed in Urban's analysis summarized in Section 2, 187,000 individuals are projected to be enrolled in QHPs through the Oregon Marketplace in 2016 if the state does not implement BHP. With the introduction of the BHP, that number would fall by roughly 30 percent, to 131,000. In this section, we analyze several potential effects of this change on both the individual market as a whole and on the Oregon Marketplace in particular.

First, we analyze how the introduction of the BHP would impact the individual health insurance market risk pool. While the majority of this market consists of policies purchased through the Marketplace, the single risk pool requirements of the ACA mean that rates for individuals purchasing outside the Marketplace will also be affected. We accordingly estimate the impact of BHP on individual market premiums and analyze the effects of such premium changes on Oregon Marketplace enrollees as well as others in the nongroup market.

Second, we explore whether a smaller number of covered lives in the Marketplace is likely to make carriers substantially less interested in participating. If so, consumers could have fewer QHP options, and reduced competition could increase premiums.

Third, we analyze the impact of BHP implementation on the Oregon Marketplace's ability to cover its administrative costs. Such costs will likely be paid through surcharges on QHP premiums. Fewer QHP enrollees will mean fewer surcharge payments.

Finally, we assess whether a smaller Marketplace presents a serious risk of instability or even a potential "death spiral" because of increased vulnerability to adverse selection. In this context, we also examine other potential sources of instability introduced by BHP.

Risk Pool Effects

BHP's Estimated Impact on Individual Market Premiums

Table 5.1 below summarizes enrollment in individual market (inside and outside the Marketplace) plans before and after implementation of a BHP.

Table 5.1 – Comparison of Projected ACA-Compliant Individual Market Population with and without BHP

Population Type	Scenario 1a / b	Scenario 2a / b
Total Individual Market - Without BHP	210,700	210,700
BHP - Previous Individual Market	52,300	52,200
BHP - Previous Uninsured	7,600	3,200
BHP – Legal Immigrants <138% FPL	5,700	5,700
BHP - All Other	700	300
Total Individual Market - With BHP	155,000	155,100
Total BHP	66,300	61.400

All individuals enrolled in individual coverage outside of the Marketplace were assumed to be in non-grandfathered policies and part of the single risk pool.

The characteristics of the people who go from the Individual ACA market to BHP are also important since their absence from the individual market risk pool will have an impact on premium levels set in the Marketplace.

Using the federal rating factors by age and relative morbidity estimates provided by the Urban Institute, we estimate that implementation of a BHP will result in an average age factor increase of 1.9% in the Individual market along with an increase in the relative morbidity of 2.9%. In other words, those remaining in the Individual market will be somewhat older and have slightly higher morbidity as compared with a "No BHP" environment.

Implementation of a BHP is estimated to result in about a 1% increase in Individual ACA market premiums. The 1% increase is based on the assumption that managed care organizations make the same estimates of the age and morbidity change underlying the enrollment from the Urban analysis in Section 2. Using that analysis, the 1% increase is derived from the fact that morbidity (which includes the impact of age) in the remaining Individual ACA market increases 2.9% while the age factor increases only 1.9%. A 1% increase in premiums would be necessary in order to maintain the same expected loss ratios as in an environment without a BHP. In other words, a 1% increase in rates would be needed in order for insurers to cover administrative expenses and maintain target profit levels due to the expected changes in the Individual ACA population if a BHP were implemented. Appendix E shows the estimates in more detail.

As a practical matter, each managed care organization will make its own assessment of the impact of BHP implementation, so it is certainly possible that for any given plan, such as the second lowest Silver plan, the rate could change by more or less than our 1% estimate.

Impact of Changed Individual Market Premiums on Consumers

As noted earlier, BHP implementation is projected to raise the average risk level of the overall nongroup market. As a result, nongroup premiums would increase by approximately 1.0 percent above the levels that would otherwise be charged. This would apply both within and outside the Oregon Marketplace. Here, we analyze the effects on consumers of this slight premium increase.

Consumers would be affected based on their subsidy eligibility and plan choice, as follows:

- **Unsubsidized enrollees.** Nongroup enrollees without Premium Tax Credits (PTCs) are subjected to the full premium increase, since they pay full nongroup premiums.
- **PTC beneficiaries enrolled in "benchmark plans" are unaffected**. Such plans are the second-lowest-cost available silver-level QHPs. These consumers make income-based premium payments that depend entirely on FPL and household size. The gross premium amount charged before application of the PTC affects only the federal government's PTC costs, not the charges to such a consumer.
- **Costs rise slightly for PTC beneficiaries enrolled in plans more costly than the benchmark**. If a PTC beneficiary selects a plan more expensive than the benchmark premium, the beneficiary pays the income-based amount described above, plus the difference between the benchmark premium and the premium charged by the beneficiary's chosen plan. For example, if the benchmark plan charges $200 a month and the beneficiary chooses a $300 plan, the consumer payment will be the income-based amount plus $100. If premiums rise by 1.0 percent for both the benchmark plan and the beneficiary's chosen plan, that $100 difference will increase by $1.00, as will the beneficiary's monthly premium costs. Put more generally, *whatever additional payments PTC beneficiaries make for selecting more costly plans will change by the same percentage and in the same direction, up or down, as the percentage change that applies to all nongroup premiums*.
- **Costs fall slightly for PTC beneficiaries enrolled in plans less costly than the benchmark**. When a PTC beneficiary chooses a QHP less expensive than the second-lowest-cost silver plan, the consumer pays the applicable income-based charge, minus the difference between the benchmark plan and the consumer's chosen plan. If both the benchmark plan and the consumer's chosen plan experience a 1.0 percent premium increase, the gap between premiums rises by 1.0 percent, so the consumer's savings increase by 1.0 percent. Continuing with the earlier example, if the applicable benchmark plan charges $200 a month and a PTC beneficiary picks a $100 plan, he or she pays the applicable income-based amount, minus $100. If premiums rise by 1.0 percent, the benchmark plan and the beneficiary's chosen plan will charge $202 and $101, respectively. The beneficiary will then pay the applicable income-based charge, minus $101. *Whatever savings consumers achieve by selecting less costly plans will change by the same percentage <u>but in the opposite direction</u>, up or down, as the percentage*

change that applies to nongroup premiums generally.

Behavioral effects of the projected 1.0 percent premium increase are likely to be quite modest. Most consumers exposed to the full increase have incomes over 400 percent FPL. Even below that income threshold, few otherwise uninsured are likely to enroll or even change plans due to a small, market-wide premium increase. The same is true of PTC beneficiaries, given the even more limited cost exposure they face.

Table 5.3 shows the expected distribution of Oregon residents enrolled in individual market coverage, assuming BHP implementation, in terms of the categories described above:

- Within the Oregon Marketplace—
    - 81,000 out of 131,000 enrollees (62 percent) are projected to receive PTCs. The expected premium reduction in the nongroup market will have little or no effect on them.
    - The remaining 50,000 enrollees will pay the full premium increase. 38,000 of them have incomes above 400 percent FPL; the rest are ineligible for PTCs because of ESI offers the ACA classifies as affordable.
- Outside the Oregon Marketplace, approximately 24,000 consumers are expected to obtain nongroup coverage, all of whom will be subject to the full premium increase resulting from BHP implementation. This group is evenly split between those with incomes above and below 400 percent FPL.
- Putting together the entire nongroup market, both within and outside the Oregon Marketplace—
    - More than half (52 percent) of all recipients of nongroup coverage are expected to use PTCs and thus to be largely unaffected by the expected premium increase.
    - Among nongroup enrollees who do not receive PTCs—74,000 out of a total nongroup market of 155,000 consumers—two-thirds (68 percent) have incomes above 400 percent FPL.

Table 5.3 Projected nongroup enrollment in 2016, by inclusion within the Oregon Marketplace, income, and PTC eligibility (assuming BHP implementation)

	Number	Percentage of Oregon Marketplace enrollees	Percentage of combined nongroup market
Inside the Oregon Marketplace			
At or below 400% FPL			
Eligible for PTCs	81,000	62%	52%
Ineligible for PTCs	12,000	9%	8%
Above 400% FPL	38,000	29%	25%
All Oregon Marketplace enrollees	***131,000***	***100%***	***85%***
Outside the Oregon Marketplace			
At or below 400% FPL	12,000	n/a	8%
Above 400% FPL	12,000	n/a	8%
All nongroup enrollees outside the Oregon Marketplace	***24,000***	***n/a***	***15%***
Combined nongroup market		n/a	
At or below 400% FPL			
Eligible for PTCs	81,000	n/a	52%
Ineligible for PTCs	24,000	n/a	15%
Above 400% FPL	50,000	n/a	32%
All nongroup enrollees	***155,000***	***n/a***	***100%***

Source: HIPSM-ACS 2014. *Note*: Approximately 3,000 individuals are estimated to enroll in nongroup coverage outside the Oregon Marketplace and are therefore classified in this table as ineligible for PTCs, even though, had they enrolled in the Oregon Marketplace, they would have qualified for PTCs. Other people with incomes at or below 400 percent FPL shown as purchasing nongroup coverage outside the Oregon Marketplace would be ineligible for PTCs, regardless of where they purchased nongroup coverage, because of ESI offers the ACA characterizes as affordable. The same is true of the 12,000 individuals shown here as ineligible for PTCs and estimated to enroll in the Oregon Marketplace with income at or below 400 percent FPL. Totals may not sum because of rounding.

State Mitigation Options

State policymakers could prevent BHP implementation from increasing premiums in the nongroup market. The state mitigation measure could go beyond preventing a premium increase to yield a reduction in nongroup premiums. However, the required strategy would require administrative effort that, at this juncture, does not yet appear to be justified by the likely gains.

To be specific, Oregon could administer a risk-adjustment system that combines BHP enrollees with recipients of nongroup coverage. BHP regulations make clear that the federally administered risk-adjustment system will not include BHP's standard health plans, but nothing forbids a state from structuring its own risk-adjustment system to combine BHP with nongroup members.[9] If Oregon pursues

[9] As part of its authority to regulate insurance Oregon could also require individual carriers that cover BHP members to pool such members together with their individually insured customers.

this approach, it could use the federal methodology for calculating risk-adjustments and seek the same information from BHP standard health plans as QHPs must provide for risk-adjustment purposes. This strategy would seek to keep BHP consumers within the same overall risk pool as recipients of nongroup insurance, leaving nongroup risk levels and premiums essentially unchanged. Moving consumers with incomes below 200 percent FPL from QHPs into BHP would have the same effect as moving them from one set of nongroup plans to another.

Moreover, this strategy could lower nongroup premiums. To the extent that BHP implementation increases enrollment of healthy consumers who would not enroll in QHPs, a state-administered risk adjustment system would share the benefits of those low risk consumers with the rest of the nongroup market. The resulting premium reduction could make coverage more affordable to an estimated 74,000 Oregon residents, as shown by Table 1.

However, the extent of the premium reduction will depend on the number of healthy enrollees induced to enroll by BHP implementation. In turn, this depends on the extent to which BHP reduces premiums below QHP levels as well as the impact of tax reconciliation on QHP enrollment, which is as yet unknown. Accordingly, it is not yet clear to what extent nongroup premiums could be reduced by a state-based risk adjustment system.

A state-run risk-adjustment system would generate administrative costs. Even if Oregon uses the federally-developed methodology for determining amounts that plans must contribute and the payments that plans receive, effort would be required for Oregon to establish and administer such a system. CMS estimates that its cost to administer risk-adjustment on behalf of almost all states will be approximately $27.3 million in 2015, which CMS will fund by charging carriers approximately $1 per year per covered life.[10] Several factors would likely increase the per capita costs of Oregon's state-administered system above projected federal levels for 2015. Oregon would need to incur start-up cost already paid by CMS; Oregon would not benefit from CMS's nationwide economies of scale; operating a state-administered program, Oregon would need to meet federal reporting requirements that do not apply to CMS;[11] future administrative costs are likely to rise above 2015 levels, as error rates begin to be applied to risk adjustments in 2016, modifying payment transfers for 2017, with appeals of such modifications beginning in spring 2018;[12] and additional costs may be required if Oregon serves BHP consumers through Coordinated Care Organizations that do not provide commercial insurance. If so, such CCOs will not have

[10] CMS. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015," *Federal Register*, Vol. 79, No. 47, March 11, 2014, 13744- 13843, 13828 http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

[11] See 45 CFR 153.310(c) and (d).

[12] Op cit. at 13768.

an existing method of data reporting for risk-adjustment like QHPs use. Creating new reporting channels for CCOs and ensuring their effective and accurate operation would require time and effort from both CCOs and state officials.

To be clear, the state could likely cover its administrative costs by surcharging plans, in the same way that CMS is covering its costs, with enrollees paying the ultimate increase. To the extent that total administrative costs rise because Oregon cannot benefit from CMS's economies of scale, those higher administrative cost surcharges would probably be outweighed, for enrollees, by lower nongroup premiums. All of this would likely require state statutory change as well as hiring of additional state staff or the shift of staff time away from other purposes.

On balance, a state-administered risk-adjustment system that includes BHP along with nongroup insurers could prevent the projected 1 percent increase in nongroup premiums resulting from BHP implementation and yield reductions in nongroup premiums below what would be charged in the absence of BHP. The latter result could potentially benefit tens of thousands of residents. However, the extent of those premium reductions is not yet known. Until the state has reason to believe that BHP implementation would yield a significant influx of healthy enrollees who would not otherwise participate in the Marketplace, these gains are probably not worth the necessary administrative effort, given other pressing priorities facing the state.

Methodology and Assumptions Underlying Premium Estimate

The analysis of the impact of a BHP on the Oregon Marketplace relies primarily on the demographic characteristics in the Urban analysis of 2016 BHP enrollment. As noted above, we calculated the impact to rates assuming carriers would set rates using the same pricing assumptions with respect to administrative expenses and profit levels.

All individuals enrolled in individual coverage outside of the Marketplace were assumed to be in non-grandfathered policies and part of the single risk pool.

Each carrier will make its own assessment of the impact of a portion of its population leaving to join the BHP. We have inherently assumed that all carriers will estimate this impact to be the same as presented in this report.

Attractiveness to Carriers and Options for Consumers

Since implementing BHP would reduce the number of covered lives in Oregon's Marketplace, carriers would likely be less interested in participating. One result could be fewer choices for consumers. Another could be reduced competition between insurers, potentially leading to higher premiums.

These outcomes have not been observed as serious problems in Minnesota, which implemented a BHP-like program for 2014 to transition to BHP implementation starting in 2015, the earliest year permitted under federal BHP regulations. In 2014 Minnesota consumers with incomes at or below 200 percent FPL qualify, not for subsidized QHP coverage, but for the state's Medicaid waiver program, MinnesotaCare (MNCare). Before the ACA, a slightly different version of MNCare had covered childless adults up to 175 percent FPL and parents up to 215 percent FPL. Beginning in January 2014, the state's Marketplace, "MNSure," has been covering only consumers with incomes above 200 percent FPL, with federal subsidies ranging up to 400 percent FPL.

Despite a highly problematic initial MNSure roll-out, excluding consumers under 200 percent FPL has not appeared to create significant problems for the state's Marketplace. QHP enrollment was reduced but remained robust. As of April 13, 2014, 47,902 consumers had enrolled in QHPs, and 37,985 had joined MNCare.[13] By the end of open enrollment MNCare participants thus represented 44 percent of the roughly 86,000 people who enrolled in MNCare and QHPs combined.

Despite this reduction in the number of covered lives in Minnesota's Marketplace, insurers have not shied away. Five different carriers contracted with 10 different provider networks to sponsor 78 QHP options for 2014. In the median county, consumers could choose from among 33 QHPs, including 10 silver, 10 bronze, eight gold, two platinum, and three catastrophic plans.[14] While this range of choices was significant, it was somewhat narrower than in the average Marketplace rating area nationally, where five carriers offer 47 QHPs.[15] Moreover, competition was sufficiently robust that Minnesota's Marketplace had the country's lowest benchmark QHP premiums in 2014.[16] For 2015, the total number of QHP options

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[13] MNsure. *MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, April 16, 2014*, https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf. Since then, MNCare enrollment has remained unconstrained, but only those qualifying for special enrollment periods have been able to sign up for QHPs. Accordingly, as of July 10, 2014, 52,233 consumers were covered through QHPs, and 54,154 had joined MNCare. MNsure. *MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, July 16, 2014*, https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf.

[14] Authors' calculations, MNSure. *Provider Networks.* (undated) https://www.mnsure.org/images/Individual-ServiceAreas-ProviderLook-up.xls.

[15] Amy Burke, Arpit Misra, and Steven Sheingold. "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014." *ASPE Research Brief,* June 18, 2014, Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (ASPE/HHS).

[16] ASPE Office of Health Policy. "Table 4: Weighted Average Premiums, 48 States," *Health Insurance Marketplace Premiums for 2014.* September 25, 2013, http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

rose from 78 to 84, even as the carrier with the largest number of QHP enrollees was replaced by a new insurer.[17]

Capacity to Cover Administrative Costs

Some of the Oregon Marketplace's costs vary with the number of enrollees. The Marketplace charges QHPs a set monthly amount for each covered life. Accordingly, a change in size should not affect the Oregon Marketplace's ability to cover costs that vary directly with enrollment, since declining revenue would be matched by declining expenditures.

However, other Marketplace administrative costs are fixed, in whole or in part. If a reduction in the number of enrollees leads to fewer payments that are needed to cover such fixed costs, the Oregon Marketplace may need to raise its QHP assessments to avoid an operating deficit. Such increased assessments would result in higher premiums, which would place QHPs at a disadvantage in competing with plans outside the Marketplace.

The Oregon Marketplace may be able to prevent this result by charging the BHP program or BHP standard health plans for administrative services rendered. For example, the 2014-2015 business plan for Cover Oregon (the Oregon Marketplace), as presented to the State Legislature, proposes that the Oregon Health Plan should pay the same per member per month administrative fee to the Oregon Marketplace as is paid by QHPs.[18] When a consumer applies through the Oregon Marketplace, whatever program or plan winds up serving the consumer pays the administrative fee. Along similar lines, Minnesota's exchange receives per capita payments from Medicaid, including MNCare, when public programs, rather than QHPs furnish coverage for someone who originally enrolled through that state's marketplace.[19]

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[17] MNSure. "Health Care Coverage and Plan Rates for 2015." October 1, 2015, https://www.mnsure.org/images/2015-10-1-MNsure-healthcare-coverage-plan-rates.pdf. This insurer pulling out of the Marketplace, which had not previously been a major player in the state's insurance market, captured 59 percent of QHP enrollees in 2014 by offering plans that combined low premiums with broad provider networks. Such coverage, according to a company representative, ultimately did not prove financially or administratively sustainable. Kyle Potter and Steve Karnowski. "Lowest-cost insurer drops from Minnesota exchange," *Houston Chronicle* (Associated Press), September 16, 2014, http://www.chron.com/news/article/Lowest-cost-insurer-drops-from-Minnesota-exchange-5759776.php.

[18] Cover Oregon. *Update To Cover Oregon Business Plan 2014-2015. Presented To Oregon State Legislature On May 28, 2014*.

[19] The Minnesota Marketplace has proposed a balanced budget for 2015. Officials anticipate receiving $11 million from a 3.5 percent "withhold" of premium revenues from QHPs, along with $22 million from the Medicaid program, including MNCare, which contributes to MNSure's administrative costs in proportion to the benefits it receives. In effect, MNCare's implementation shifted some of funding of Marketplace administration from QHP assessments to Medicaid, which is the strategy discussed in the text for Oregon. However, another factor facilitating financial feasibility in Minnesota appears to be much less applicable in Oregon: the Minnesota Marketplace's annual

Regardless of how the Oregon Marketplace is ultimately administered, QHP premium surcharges are likely to play a central role providing administrative funding. That approach was endorsed by the Oregon Legislature for Cover Oregon, and it is used by HHS for federally-facilitated Marketplaces. In either case, if consumers below 200 percent FPL shift from QHPs to BHP, the Marketplace's administrative payments might likewise come from the BHP program or BHP plans, rather than from QHPs. If so, BHP's share of the Marketplace's administrative costs would be in proportion to the benefit received by BHP[20]—for example, if Oregon's Marketplace processes an initial application or renewal, and the consumer ultimately receives BHP, BHP or the BHP standard health plan could make a corresponding payment.

This approach might modestly strengthen the Marketplace's financial sustainability. BHP's greater affordability is projected to increase enrollment above QHP levels, as discussed earlier. Under the approach discussed here, BHP would increase the number of administrative payments provided to Oregon's Marketplace (albeit while adding some offsetting administrative costs). The precise details of such an arrangement cannot be defined with precision, and its feasibility cannot be conclusively assessed, until after state and federal officials finalize the architecture of the Marketplace that will serve Oregon residents.

At this juncture, however, many observers expect OHA to assume responsibility for OHP eligibility and enrollment functions, while the federally facilitated Marketplace (FFM) handles comparable functions for

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administrative costs are projected to fall by 69 percent in 2015 as the bulk of its work transitions away from initial infrastructure development and towards ongoing operations. MNsure. "Preliminary MNsure Budget for Calendar Year 15," March 12, 2014, http://www.lcc.leg.mn/mnsure/meetings/04092014/Bd-2014-03-12-Prelim2015Budget.pdf; Christopher Snowbeck, "MNsure board OKs 3.5 percent premium withholding," *TwinCities Pioneer Press.* May 14, 2014, http://www.twincities.com/politics/ci_25762410/mnsure-board-oks-3-5-percent-premium-withholding; James Nord. "MNsure enrolls 170,000 Minnesotans as insurance deadline passes." *Politics in Minnesota*. April 1, 2014, http://politicsinminnesota.com/2014/04/mnsure-enrolls-170000-minnesotans-as-insurance-deadline-passes/.

[20] The Office of Management and Budget has developed rules for cost-allocation when multiple programs benefit from the common provision of shared services, such as eligibility determination, call centers, and in-person consumer assistance, such as the help furnished by social services offices. See, e.g., See 2 CFR Part 225, http://www.whitehouse.gov/sites/default/files/omb/assets/omb/fedreg/2005/083105_a87.pdf.

A different approach to covering Marketplace administrative costs would surcharge BHP standard health plans, rather than the BHP program itself. This approach may seem, to some, more evenhanded; whatever plan winds up with the consumer pays the Marketplace for the administrative services that facilitated the enrollment, whether the plan is a QHP or a BHP standard health plan. BHP standard health plans would incorporate these surcharges into their premiums, and the resulting premium increases would be covered by federal BHP payments. This method of using federal BHP dollars to cover plan surcharges is discussed elsewhere in this report, in connection with administrative costs. The key point, for purposes of this discussion, is that the BHP program would be responsible for the Marketplace administrative costs from which BHP benefits, whether the BHP program makes a direct payment to the Marketplace or an indirect payment by reimbursing the BHP standard health plans for their payments to the Marketplace.

QHP enrollees. If so, and if BHP is implemented so that it functions essentially as a new category of OHP coverage, then payment arrangements for BHP administration could be arranged straightforwardly. OHA could cover administrative costs for BHP consumers just as it does for other OHP enrollees, either paying those expenses directly or reimbursing the FFM, depending on how arrangements are finalized in federal-state negotiations. OHA would then allot to BHP its administrative costs incurred for BHP consumers.

If the Legislature enacts statutory authorization, some or all of those costs could be covered by premium assessments that would nominally be charged to BHP plans. As a practical matter, however, those plans would immediately pass on those costs to the federal government by including them within higher premiums, which federal BHP dollars would pay.

Potential Instability

Before the ACA, small purchasing pools sometimes destabilized and even experienced "death spirals" because their size left them vulnerable to the effects of adverse selection. Even a few unhealthy enrollees could drive the average risk level within a small pool well above that in plans offered outside the pool. If this happened, a healthy person obtaining coverage through the pool would see premiums spike, while retaining the option to purchase identical coverage at a much cheaper price elsewhere. Some of the lowest-cost pool members would then depart, further increasing the average risk level within the pool, further increasing premiums charged within the pool, causing some of the healthiest remaining pool members to leave, etc.

Reforms to the individual market like those implemented in Massachusetts's 2006 legislation and the ACA disrupt this self-reinforcing cycle. Many mechanisms seek to ensure that the premium charged by a nongroup plan reflects the risk level of the nongroup market as a whole, rather than the risk level of the particular plan's enrollees or even the exchange's membership. Carriers operating in the nongroup market must pool all nongroup members together in setting rates; risk-adjustment seeks to combine risk pools between nongroup carriers; an insurer must charge the same premium for a plan offered both inside and outside the exchange; and the combination of significant subsidies and an individual coverage requirement encourages the enrollment of healthy consumers, improving risk pools across the board.

As a result, if an exchange's enrollees have risk levels higher than those outside the exchange, exchange enrollees will almost certainly not be able to find the identical coverage available outside the exchange for a substantially lower premium, as was typically the case in the past. Illustrating the stability of exchanges under the ACA's market reforms is the "Commonwealth Choice" program, a little-known component of the Massachusetts 2006 reforms. Like the ACA, the Massachusetts reforms changed individual market rules, added an individual coverage requirement, and provided subsidies that extended broadly up the income scale—in Massachusetts, to 300 percent FPL.

When Commonwealth Choice began in July 2007, it mainly offered private insurance options to unsubsidized individuals with incomes above 300 percent FPL.[21] By the end of 2007, slightly fewer than 15,000 individuals were covered through Commonwealth Choice.[22] Individual enrollment remained under 20,000 at the end of 2008.[23] By July 2010, overall enrollment was approximately 36,000-37,000, of which 75 percent was in the nongroup portion of the program; other parts of Commonwealth Choice involved small group coverage.[24] Total enrollment, in both small group and nongroup portions of the program combined, reached a steady state in 2012 slightly above 40,000 covered lives.[25] At no point did the program become unstable because of its very small size, including during its first several years, when it enrolled less than one-half of one percent of the state's estimated total population of 4.2 million non-elderly adults.[26]

Along similar lines, Minnesota limitation of Marketplace coverage to consumers above 200 percent FPL has not led to adverse selection that increased premiums and triggered a "death spiral." Instead, it had the country's lowest QHP benchmark premiums in 2014, at least 17 percent below the cost of QHP premiums in the second least-expensive state;[27] observers have noted no signs of Minnesota's

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[21] The program thus served as an exchange that, in many ways, became the template for ACA insurance Marketplaces. Commonwealth Choice also offered group coverage to small firms, but this aspect of the program remained little-known and rarely used until 2010, when the state put several new initiatives in place that increased participation.

[22] Massachusetts Commonwealth Connector (Connector). *Commonwealth Choice Progress Report.* December 13, 2007.

[23] Connector. *Connector Summary Report.* December 11, 2008. https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2008/2008-12-11/Connector%2520Summary%2520Report%2520-%252012%252011%252008.xls.

[24] Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2010*.

[25] Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2012*. December 2012.

[26] Author's calculations, 2010 population estimates. For 2013, the estimated population of non-elderly adults was slightly higher, at 4.3 million. U.S. Census Bureau, "Massachusetts," *State & County Quick Facts,* Last Revised: Thursday, 27-Mar-2014 09:55:43 EDT, http://quickfacts.census.gov/qfd/states/25000.html.

[27] According to HHS estimates of weighted average premiums by state, Minnesota's premiums for the lowest-cost silver plan, second-lowest cost silver plan, and lowest-cost bronze plan were $192, $192, and $144 a month, respectively, well below those in any other state among the 48 (including the District of Columbia) for which data were reported. The state in second place for silver plans was Tennessee, with $235 and $245 weighted average premiums for the lowest and second-lowest-cost silver plans, respectively, 18 percent and 22 percent above Minnesota's corresponding averages. The state with the second-least-expensive weighted-average lowest-cost bronze plan was Oklahoma, with $174 monthly premiums that exceeded Minnesota's levels by 17 percent. Authors'

Marketplace "imploding."[28] Average premiums in 2015 are estimated to increase between 4.5 percent and 12 percent.[29] State officials characterize 2015 benchmark premiums in Minnesota's urban areas as continuing to be the lowest in the country.[30]

Two final comments about Marketplace stability are important. First, even with BHP implementation, 62 percent of Oregon Marketplace members are expected to be PTC beneficiaries. All else equal, the availability of subsidies will lower the average risk level of these consumers, compared to others who must purchase nongroup insurance at full price. More important, these PTC beneficiaries will be tethered to the Oregon Marketplace by federal rules that forbid the use of QHP subsidies to purchase coverage elsewhere.

Second, BHP would create a very different kind of instability during its initial implementation, as numerous adults are shifted from the Marketplace to BHP. Consumers would pay lower costs, but their provider networks could change. Depending on the details of BHP implementation, some consumers could have fewer choices of plan and physician than were offered in the Marketplace. QHP networks are likely to be narrower than the networks that typified pre-ACA commercial insurers, and the Oregon Health Plan's Coordinated Care Organizations enjoy important advantages over traditional Medicaid provider networks. That said, Scenario 1 envisions provider payment rates 38 percent below those paid by QHPs. That differential could turn out to limit consumers' provider options. Moreover, as with any transition between coverage systems, some consumers could "fall between the cracks" and become temporarily uninsured. The state can provide hands-on assistance to limit those risks and help consumers successfully navigate the transition, but some disruption is inevitable.

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calculations. ASPE Office of Health Policy. "Table 4: Weighted Average Premiums, 48 States," *Health Insurance Marketplace Premiums for 2014.* September 25, 2013, http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

[28] James Nord. "MNsure claims success in first year sign-ups." *Politics in Minnesota*. April 4, 2014. http://politicsinminnesota.com/2014/04/mnsure-claims-success-in-first-year-sign-ups/.

[29] Christopher Snowbeck. "MNsure: Twin Cities' rates still look cheaper, but gap is shrinking in Minnesota," *Star Tribune,* October 4, 2014, http://www.startribune.com/business/278072961.html.

[30] Minnesota State Department of Commerce. "Commerce Announces Minnesota Health Insurance Rates – Lowest Rates in Nation for Second Year," October 1, 2014, http://mn.gov/commerce/insurance/media/newsdetail.jsp?id=209-143493.

6) BHP OPERATIONAL CONSIDERATIONS

This section presents Wakely's analysis intended to assist OHA in the identification and sizing of significant operational expenses in the implementation and administration of a Basic Health Program (BHP). The estimates in this section were utilized in Section 3, Projected BHP Revenues and Expenses.

The estimated operating expenses detailed at Table 6.1 were developed to assist OHA in the identification and sizing of significant operational expenses in the implementation and administration of a BHP. It is important to note that the range of expenses is directional only and is not intended to be definitive. Prior to making any decisions on whether or not to implement a BHP, OHA should develop a detailed analysis of the level of existing state resources that could be leveraged, as well as input from key system vendors regarding the range of pricing at various enrollment levels and program functionality.

The primary source of the expense estimates was the first full year of operations for the Commonwealth Care ("CommCare') Program in Massachusetts, which was a subsidized health insurance program for low-income adult residents between 100-300% of poverty and ineligible for Medicaid. The CommCare Program was required to develop much of the same functionality necessary to administer a BHP, so is considered a reasonable proxy for estimating a range of expenses applicable to a BHP. Wakely consultants subjectively adjusted the CommCare baseline data based on its business knowledge, prior experience in administering a subsidized health insurance program, and working with a number of state-based Marketplaces, health plans, and private vendors on implementation and operational issues related to subsidized health insurance programs. In addition, in order to reflect inherent differences between a potential BHP in Oregon, the level of uncertainty in existing capacity and resources which could be leveraged, and the number of undecided policy decisions which will impact implementation and operations, Wakely created a low and high range of expenses by decreasing and increasing the modified CommCare baseline estimates which are labeled "Best Guess". The estimates include start-up cost, which are generally isolated to eligibility & enrollment, call center and premium billing functions, and could vary significantly in Oregon depending on negotiated vendor terms, type of systems selected, and structure of the financial elements on the contract. Based on the CommCare experience, first year costs were not significantly different from ongoing costs, as the one-time start-up costs were offset by the first year ramp up of staffing and other functions. The amount of start-up versus ongoing maintenance and operations expenses is highly dependent on the structure of vendor contracts and the extent to which existing systems and resources will be leveraged.

The development of more refined expense estimates is recommended after key policy issues are finalized and the level of shared resources with other agencies are evaluated. This is especially important for technology-related expenses such as Eligibility & Enrollment, Call Center and Premium Billing. An additional conceptual question to assess and quantify for all functions, but is especially relevant to Eligibility & Enrollment and Call Center functions, is whether or not BHP expenses are incremental to the overall system. As a significant number of BHP enrollees would have been enrolled in the Marketplace in

the absence of a BHP, the cost to operate the systems would still be incurred but which entity records the expense is the open question.

Finally, while it is generally true that as the scale of a program increases applicable per unit cost decreases, without tight vendor management, control of change orders and scope creep, and ongoing competitive procurement dynamics employed by the administrators of the BHP, such savings may not be realized.

Table 6.1 - Estimated Operating Expense

	Basic Health Program - Oregon					
	Year One - Dollars			Year One - PMPM		
	Low	Best Guess	High	Low	Best Guess	High
Eligiblity & Enrollment	$ 4,720,000	$ 5,900,000	$ 7,080,000	$ 5.93	$ 7.41	$ 8.89
Call Center	$ 3,520,000	$ 4,400,000	$ 5,280,000	$ 4.42	$ 5.53	$ 6.63
Outreach & Communications	$ 2,000,000	$ 2,500,000	$ 3,000,000	$ 2.51	$ 3.14	$ 3.77
Actuarial & Legal	$ 560,000	$ 700,000	$ 840,000	$ 0.70	$ 0.88	$ 1.06
Appeals	$ 400,000	$ 500,000	$ 600,000	$ 0.50	$ 0.63	$ 0.75
Staffing	$ 621,600	$ 777,000	$ 932,400	$ 0.78	$ 0.98	$ 1.17
SG&A	$ 480,000	$ 600,000	$ 720,000	$ 0.60	$ 0.75	$ 0.90
Total Administrative Expenses - No Premium Billing	***$ 12,301,600***	***$ 15,377,000***	***$ 18,452,400***	***$ 15.45***	***$ 19.32***	***$ 23.18***
Premium Billing Functionality	$ 2,578,338	$ 2,946,672	$ 4,051,674	$ 3.50	$ 4.00	$ 5.50
Total Administrative Expenses - w/Premium Billing	***$ 14,879,938***	***$ 18,323,672***	***$ 22,504,074***	***$ 18.95***	***$ 23.32***	***$ 28.68***

Contextual Footnotes to Estimated Expense Table:

- As the state is considering a BHP options with and without a member premium component, total expense estimates include a version with and without expense estimates related to a member premium billing component.
- PMPM estimates assume enrollment take-up with no premium component for all expense lines, except the premium billing expense line.
- Eligibility & Enrollment leveraged an existing state-administered Medicaid Management Information System ("MMIS"). Business rule-logic for Commonwealth Care eligibility was incorporated onto existing business rules, and was administered by the state Medicaid program.
- Call Center was entirely outsourced to a third-party. Existing state contract was leveraged, but new terms negotiated.
- Outreach & Communications was sized to reflect a less robust spend reflecting potential economies with other programs such as Medicaid or QHP outreach.
- Baseline Actuarial & Legal expenses were adjusted downward to reflect a less intensive need for such services. Commonwealth Care Program required shorter time to go-live, and heavily

outsourced services due to time constraints. It is expected that with the planning lead-time for a BHP, the expenses for actuarial and legal services would be managed downward comparatively to CommCare.

- Appeals pmpm cost estimate based on approximately 80,000 covered lives and are not expected to be significantly different for a slightly smaller program.
- Staffing details are as follows:

Staff Title	Salary/FTE	Benefit Factor	Salary & Benefits	Est. FTEs	Total Cost
Procurement & Analytics	$75,000	0.40	$105,000	2.0	$210,000
Carrier Management	$60,000	0.40	$84,000	2.0	$168,000
Legal Support	$90,000	0.40	$126,000	0.5	$63,000
Operations Mgmt. / Oversight	$110,000	0.40	$154,000	1.0	$154,000
Finance / Reporting	$65,000	0.40	$91,000	2.0	$182,000
Total Staffing				7.5	$777,000

- SG&A assumes spending levels similar to Commonwealth Care Program. Includes expenses for products and services such as Rent & Utilities, Office Supplies & Equipment, Communications, Furniture & Fixtures, etc.
- Premium Billing Function. Reflects an average of expense levels derived from various market-based information. The Premium Billing estimate does not include certain pass-through cost such as postage, mailing, printing, lockbox services, and banking related fees and charges. Such expenses are generally negotiated by the premium billing vendor and not reflected in any of the expense lines noted above.

Several final comments are important to put these results in perspective. First, the vast majority of these administrative costs will be incurred, with or without BHP. If BHP-eligible consumers are in the Marketplace rather than BHP, someone will still need to determine their eligibility, enroll them into coverage, operate a call center that handles their questions, process their appeals, etc. BHP implementation merely shifts these costs from a different entity into the BHP program.

Second, premium billing costs will be incurred only if the state collects premium payments on behalf of BHP standard health plans. If plans bill instead, they will shoulder the relevant costs (albeit building them into premiums, which are ultimately reimbursed by BHP).

Third, Oregon may choose to implement BHP as, in essence, a new category of OHP coverage. If so, administrative costs would be largely subsumed within broader OHA operations. They would need to be

accounted for separately, given BHP's distinct federal reimbursement stream, but such distinct accounting is already done for other purposes, such as the federal CHIP program. If policymakers take this approach, OHA may be able to refine this report's estimates of BHP administrative costs by starting with the estimated per capita administrative costs for OHP adults. To evaluate any additional administrative costs (legal support, carrier relations, procurement and analytics, data and reporting, etc.) that would result from using a separate federal payment stream (and potentially a distinct program office inside OHA) for what would essentially be a new category of OHP coverage, policymakers could analyze the administrative arrangements that have been required for "Healthy Kids."

7) BHP STRATEGIC CONSIDERATIONS

Here, we focus on two issues: potential state budget savings resulting from BHP implementation; and the implications of BHP for Oregon's commitment to delivery system reforms that focus on care coordination.

Potential state budget savings

Future additional analysis of BHP's fiscal impact that involves an estimate of possible state budget savings could include the following areas:

- *Medicaid coverage of pregnant women with incomes between 138 and 185 percent FPL*. Currently, when women in this income range receive QHP coverage and become pregnant, they can transfer to the OHP. This lets them benefit from OHP's complete exemption from all cost-sharing and coverage of services that go beyond those available in QHPs, although such a shift may require changing providers mid-pregnancy**.** During January through May 2014, an average of approximately 4,400 such women per month have received OHP coverage.

  Oregon could implement BHP in a way that would allow these women to retain continuous relationships with their providers while retaining the cost-sharing limits and increased benefits currently provided by OHP. At the same time, BHP would provide a higher percentage of funding than is made available by the federal Medicaid program.

  Scenario 1b described above, in which BHP consumers receive all OHP-covered services, at zero cost, would preserve the current program configuration for pregnant women. The same result might also be achieved under a modified version of Scenario 1a, with EHBs supplemented by additional covered services as part of maternity care. However, for Scenarios 2a or 2b to furnish pregnant women with zero-cost coverage, additional measures may be needed. One possible approach begins with the little-known fact that Medicaid coverage of pregnancy-related services does not preclude eligibility for QHP subsidies. This means that pregnant women enrolled in QHPs, with Essential Health Benefits funded largely by federal subsidies, could also receive "wrap-around" Medicaid coverage of services, premium costs, and out-of-pocket costs that are outside what is paid for by federally subsidized QHP coverage.

  Using BHP to substitute for QHPs, this means that states should be able to implement BHP to provide pregnant women with the same services and cost-sharing protections that they would receive from subsidized QHPs, deploying Medicaid to furnish wrap-around coverage. If as many propose for Oregon, BHP provides cost-sharing protections and services to all of its members that go beyond those available in the Marketplace, such BHP coverage could be furnished to pregnant women as well, funded through federal BHP dollars. Additional "wrap-around" coverage needed to preserve benefits and cost-sharing limits currently furnished to pregnant women—services that go beyond what other BHP consumers receive—would be covered through a Medicaid "wrap-around," with Oregon receiving standard federal Medicaid match.

This arrangement may offer fiscal advantages as well as the capacity to retain pregnant women's current coverage arrangements outside the context of Scenario 1b. The state could achieve substantial savings on services furnished to pregnant women by shifting the bulk of their costs from Medicaid to BHP financing. At the same time, the expenditure of federal BHP dollars on pregnant women would be limited so that such dollars remain available to serve other eligible adults.

One important caveat attaches to this apparently promising approach, however. CMS has not yet released guidance explaining how such Medicaid "wrap-around" coverage will work in the Marketplace. Until that guidance issues, extrapolating the use of Medicaid "wrap-around" coverage to the BHP context necessarily involves some uncertainty about the applicable federal ground rules.

- Compared to the status quo, more pregnant women in this income band would likely receive OHP's services and cost sharing protections that go beyond QHP coverage, since those who begin coverage when they are not pregnant would receive this additional coverage automatically, without having to change plans (and perhaps provider networks). In turn, this might increase total maternity care expenses beyond the amount now paid by the OHP for pregnant women in this income range, even though the federal government would likely pay a higher percentage of such costs. The net impact on state expenditures would thus need to be estimated with care.

- *CHIP coverage of lawfully present immigrant women with incomes at or below 138 percent FPL*. Such women are not "qualified aliens" as defined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA),[31] but they currently qualify for CHIP coverage of maternity care. Altogether, approximately 4,600 pregnant immigrant women who are not "qualified aliens" receive maternity care coverage through Oregon's CHIP program. Some of these women are lawfully present immigrants, who could qualify for BHP. If Oregon implemented BHP under Scenario 1, the percentage of health care costs paid by the federal government would increase without changing the services these women receive or the amount they are charged for coverage or care; and if CMS consents to providing more generous and affordable coverage to pregnant BHP enrollees than to other BHP members, the same could also be true under Scenario 2, as explained earlier.

- *General fund spending on mental health and substance use disorders (M/SUD).* BHP implementation would increase the state's ability to define federally-subsidized services and provider networks for two groups of consumers who otherwise would be covered through QHPs: adults with incomes between 138 and 200 percent FPL; and lawfully present immigrants

[31] Public Law 104-193.

with incomes below 138 percent FPL whose immigration status makes them ineligible for federally matched Medicaid. This creates the possibility for more generous coverage of M/SUD services that includes the providers who currently receive state general fund dollars for such services. While QHP plans in the Marketplace are subject to mental health parity requirements, the amount, duration, and scope of benchmark benefits are based on commercial coverage. In Oregon, the applicable benchmark plan, issued by PacificSource Health Plans, contains limits on covered diagnoses, duration of inpatient services, and specific types and settings of treatment that could require QHP enrollees to access state-funded M/SUD services that fall outside QHP coverage.[32] By contrast, with BHP, the state could structure covered benefits and provider networks so that currently state-funded treatment of M/SUD qualifies for new federal funding.[33]

The state is currently restructuring its provision of these services, so estimating the precise amount of savings will not be easy. One starting point would be to identify the nature and cost of state-funded M/SUD services previously furnished to potentially BHP-eligible individuals.

- *Bulk purchasing*. BHP implementation would add covered lives to OHA's purchasing of services on behalf of the state's health programs. This may allow a small leveraging of reduced prices that benefit the Oregon Health Plan, Oregon Healthy Kids, and other OHA programs.

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[32] The plan does not cover the following services: "Treatment for the following diagnosis: Mental retardation; Paraphilias; Learning disorders; Gender Identity Disorders in Adults (GID); Urinary incontinence; Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger; Food dependencies; Nicotine-related disorders; Treatment programs, training, or therapy as follows: Residential mental health programs exceeding 45 days of treatment per year; Educational or correctional services or sheltered living provided by a school or halfway house; Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; Court-ordered sex offender treatment programs; Court-ordered screening interviews or drug or alcohol treatment programs; Marital/partner counseling; Support groups; Sensory integration training; Biofeedback (other than as specifically noted); Hypnotherapy; Academic skills training; Equine/animal therapy; Narcosynthesis; Aversion therapy; Social skill training; Recreation therapy outside an inpatient or residential treatment setting."

CCIIO, "Oregon EHB Benchmark Plan," https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/oregon-ehb-benchmark-plan.pdf. To the extent that such limits are not comparable to those imposed on the treatment of physical health care—for example, if residential physical health care services are covered for more than 45 days per year—they could run afoul of mental health parity requirements.

[33] This could potentially include services provided in the criminal justice context.

Coordinated Care

In 2010, Oregon's health care leaders articulated a bold strategy for change in the *Action Plan for Health,* envisioning a future system with characteristics like the following:[34]

- "A coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian."
- "A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and healthy lifestyles."
- "A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick. All the care a patient gets will be coordinated and the patient will be a part of all decisions concerning his or her health."

OHP's Coordinated Care Organizations (CCOs) comprise a linchpin of the state's effort to realize this vision. Adults with incomes between 138 and 200 percent FPL will benefit from Oregon's innovative approach more rapidly and thoroughly if BHP provides them with coverage through CCOs rather than QHPs, which are subject to less state oversight and control.

One advantage of CCO enrollment is that BHP costs can be limited by CCO's cap on annual increases in capitated payments—currently 3.4 percent per year—yielding potential savings outside the time frame of analysis for this report. That said, policymakers need to consider the trade-offs for imposing such a limitation, including possible health plan resistance to accepting BHP implementation and participating in BHP as well as the potential for narrower provider networks than would otherwise be offered to BHP enrollees.

To fold BHP enrollees into the state's CCOs, policymakers need to develop a strategy for meeting federal BHP requirements involving competitive bidding. Oregon must conduct a BHP Request for Applications (RFA) giving plans a chance to serve BHP consumers. CMS has made clear that the exception to competitive bidding requirements available in 2015 will not apply to BHP programs that begin in later years.[35] These requirements include the following:

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[34] Oregon Health Authority. "Oregon's Action Plan for Health." December 2010.

[35] The preamble to the final BHP rule includes the following analysis by CMS : "Comment: While we received several comments supporting the competitive contracting process exception for program year 2015, many commenters recommended that HHS extend this exception through 2016, or alternatively, provide this exception to states during their first year of implementation even if that occurs after 2015."

- The state must follow standard procurement procedures for federal grants.[36]
- The state must negotiate[37] premiums, cost-sharing, benefits, and innovative features, such as:
    - Care coordination and care management for enrollees (especially those with chronic conditions);
    - Incentives for using preventive care; and
    - Strategies to maximize patient involvement in health care decision-making, including through incentives for appropriate utilization and provider choices.

In its plan procurement process, the state must also consider criteria that ensure:

- Consideration of enrollees' health care needs;
- Provider networks that meet, at the state's option, either Medicaid or QHP standards;
- Managed care or similar processes to improve quality, accessibility, appropriate utilization, and efficiency of service provision;
- Performance measures and standards related to quality and improved outcomes; and
- Coordination with other insurance affordability programs to ensure continuity of care. To promote such continuity, states apparently may favor, in plan selection, bidders that participate in Medicaid (or the Marketplace).[38]

"Response: We are finalizing the proposed provisions providing an exception only for 2015. …. For states that elect to implement BHP after 2015, we believe that these states will have sufficient time between the issuance of these final rules and a post-2015 implementation to establish a competitive contracting process for the procurement of standard health plans. The statute requires such a process and we do not believe we have the authority to exempt states from the process beyond the startup year for the program."

[36] See 45 CFR 92.36 (b) through (i).

[37] In clarifying the meaning of "negotiation," CMS explained that "nothing precludes a state from establishing standards that will serve as the starting point for negotiations with standard health plans offerors." That approach leaves room for negotiation around such elements as "price [paid by the state], the provision of benefits in addition to those specified in the state's solicitation, lower premium and cost-sharing amounts than those specified in the state's solicitation, or any other aspects of the state's program…"

[38] In its preamble to the final BHP rule, CMS rejected commenters' proposal to require, as a matter of federal law, that BHP plans must participate in either Medicaid or the marketplace. In discussing that proposal, CMS left considerable room for state flexibility: "We share the commenters' interest in having strategies in place between states and standard health plan offerors to promote continuity of care for BHP enrollees transitioning into, or out

None of the above requirements appear inconsistent with the RFA procedures and requirements Oregon uses with CCOs. The state would need to prevent cross-subsidization between BHP and Medicaid; BHP enrollees thus probably need to be pooled separately. Moreover, OHA could choose to simplify some of the CCO requirements in applying them to BHP, since federal Medicaid requirements would not apply, other than in certain limited areas (such as for network adequacy).

One additional BHP requirement could pose a problem, however. As a general rule, states must ensure that each BHP enrollee will have a choice of standard health plans from at least two offerors. In some areas of Oregon, CCOs are not currently available from more than one sponsoring organization. The same is likely to be true with a separate BHP RFA.

However, a state may request an exception to this "two offeror" requirement by demonstrating that it has reviewed (1) whether it is insisting on contractual requirements beyond those needed under federal law; (2) whether additional negotiating flexibility would be consistent with statutory requirements and available BHP funding; and (3) whether potential bidders have received enough information to participate in BHP.[39]

In this case, Oregon's CCO requirements go beyond the minimum requirements of the BHP statute. However, they are consistent with the BHP statutory preference for a competitive negotiation process that focuses on health plan "innovation," "care coordination and care management," "incentives for use of preventive services," "the establishment of relationships between providers and patients that maximize patient involvement," and "incentives for appropriate utilization."[40] Moreover, the regulatory exception does not *substantively* forbid states from going beyond federally required contractual requirements for BHP plans. Rather, it requires states to go through the *process* of determining the impact of any state-imposed requirements on consumer choice. If OHA can demonstrate a rigorous and thoughtful process, it may be able to justify the absence of consumer choices in certain areas of the state as needed to advance the state's care coordination strategy.[41] Such arguments may or may not succeed,

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of, the program. States have the discretion to include standards and criteria in their competitive procurement process to further the goals of continuity of care that the commenters are expressing. We do not believe, however, that limiting competition to plan offerors who participate in other IAPs is the only method to assure continuity of care, and in fact, could prevent BHP enrollees from having access to a range of qualified standard health plan offerors and their networks of providers. The commenters' concerns are addressed in part by the requirement specified in § 600.425 that states must coordinate the continuity of care for enrollees across the insurance affordability programs, and describe in their Blueprints how they will do so."

[39] 42 CFR 600.420(a).

[40] ACA §1331(c)(2)(A).

[41] The absence of multiple, competing BHP options in particular parts of Oregon is likely to relate to limitations in the underlying health care provider infrastructure, particularly in rural areas. The BHP statute makes clear Congress's support for state flexibility in accommodating such local variations. Rather than insisting on rigid national standards,

given CMS's view that the availability of at least two BHP plans is an important safeguard for BHP consumers.

Longer-term transitions

Starting in 2017, states will have the ability, under ACA Section 1332, to make major changes to the ACA's architecture, including Marketplaces, tax credits, and cost-sharing reductions. This is the section under which Vermont is pursuing a state-based approach to single-payer coverage. Dubbed "state innovation waivers," changes under Section 1332 must be cost-neutral to the federal government and may not increase consumer costs or reduce benefits, compared to what they would have received under the ACA without a waiver.

This new option has a special potential application in the context of states considering BHP, which must already meet requirements related to federal cost-neutrality and preventing consumers from experiencing higher costs or reduced benefits. Most important, Section 1332 offers the potential to let a state use 100 percent, rather than 95 percent, of federal subsidies to provide funding for BHP-like, state-contracting health plans operating outside the Marketplace.

The potential this section offers for higher federal funding than BHP (as well as fewer restrictions, such as the absence of any requirement for competition among carriers) is tempered by the absence of CMS substantive standards. The federal government has promulgated final regulations concerning the *process* for obtaining such waivers.[42] However, neither regulations nor guidance have been issued to explain the *substantive* requirements that states must satisfy, including how federal cost-neutrality will be calculated. Only after such regulations or guidance issue, at least in proposed form, can Oregon officials and stakeholders make even a preliminary assessment of whether Section 1332 could feasibly serve as a better funded and more flexible vehicle into which BHP might eventually transition.

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the ACA requires the BHP procurement process to include: "Consideration of, and the making of suitable allowances for, … differences in local availability of, and access to, health care providers;" and "Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market." ACA §1331(c)(2)(C). Moreover, the statutory requirement for BHP plan choice is not absolute. Rather, it provides: "A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans." ACA §1331(c)(3)(A). Oregon may be excused from the statutory requirement to offer multiple plans if it is not feasible to offer more than one BHP plan in a particular geographic area that has the care innovation features required by Oregon's RFA, in the state's effort to implement the innovation goals identified by the BHP statute.

[42] CMS, Department of the Treasury. "Application, Review, and Reporting Process for Waivers for State Innovation." Federal Register. Vol. 77, No. 38, 11700- 11721, Monday, February 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf, promulgating 31 CFR 33.100 et seq., 45 CFR 155.1300, et seq.

8) COMPARISON TO PREVIOUS ESTIMATES

Prior to the release of this report, both Wakely and Urban had performed analyses related to the BHP in Oregon. The following summarizes differences between the assumptions, methodologies and results of those earlier reports compared to this report.

Differences in Urban Estimates of BHP Eligibles

Earlier Urban Institute estimates of BHP in Oregon found a larger number of eligibles than our latest work.[43] Earlier estimates were based on the CPS, rather than the ACS. However, the two biggest reasons for the difference were not directly related to the choice of surveys. First, the earlier estimates were based on 2008-2009 survey data. Health coverage in Oregon changed noticeably between those years and the more recent years used in our analysis. Second, the earlier estimates pre-dated HHS regulations on eligibility for Medicaid and QHP subsidies under the ACA. These regulations differed substantively from what we had assumed. The differences tended to increase Medicaid eligibility and decrease subsidy eligibility.

Differences in Urban Estimates of Churn

An earlier Urban Institute study of churning was national in scope, was based on earlier survey data, pre-dated final ACA eligibility rules, and tabulated churning among all nonelderly persons.[44] These estimates are based on the population of Oregon in 2016. Due to the focus on BHP, we tabulated churning among non-elderly adults, rather than all non-elderly.

In another relevant study on churning, Hwang, Rosenbaum, and Sommers found that BHP would reduce the number of people churning between Medicaid and the Marketplaces.[45] This study was national, based on earlier data, and predated final rules. Also, the authors did not model affordable offers of coverage among those not enrolled in employer offers.

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[43] Dorn, Buettgens, and Carroll, Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States.

[44] Buettgens, M., Nichols, A., and Dorn, S. (2012) *Churning under the ACA and State Policy Options for Mitigation*. Washington, DC. The Urban Institute. http://www.urban.org/health_policy/url.cfm?ID=412587

[45] Hwang, A., Rosenbaum, S. and Sommers, B.D. (2012) Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges, Health Affairs 31, No. 6: 1314-1320

Differences from Oregon Medicaid Advisory Committee (MAC) Report

Wakely performed similar analysis to that included in this report in an April 2014 study for the Oregon Medicaid Advisory Committee under a contract with the State Network, an initiative of the Robert Wood Johnson Foundation. While the analysis in this report and the earlier work both rely on the same model, there are numerous differences in assumptions and calculations that are important to be aware of when comparing results of these two studies. Table 8.1 provides a high level summary of the key differences.

Table 8.1 – Summary of Key Differences in Method and Assumptions

Assumption/Calculation	April 2014	October 2014
BHP Population/Take-Up	SHADAC Study	Urban Institute
Silver Rates	2014 OR Individual QHP Filings	2015 OR Individual QHP Filings
BHP Payment Regulation	December 2013 Proposed	March 2014 Final
Basis for Claim Costs	2014 OR Individual QHP Filings	2015 OR Individual QHP Filings
Commercial/Medicaid Annual Claim Cost Trends	7.0%/3.4%	6.0%/3.4%
Carrier Administrative Costs	Excluded	8% / 15% retention for scenarios 1 / 2
State Administrative Costs	3%-7% of BHP Revenue	$19.32/$23.32 PMPM

Below we provide additional details on some of the differences identified in Table 8.1.

BHP Population and Take-Up

Whereas this study relied on enrollment estimates provided by Urban, the April 2014 study used BHP enrollment estimates based on the State Health Access Data Assistance Center (SHADAC) Projection Model.[46] Table 8.2 summarizes the age, gender, and income distribution from both studies.

[46] Wakely Consulting Group (2014) Financial Implications of Alternative Coverage Programs in Oregon.

Table 8.2 – BHP Demographics, October 2014 Report versus April 2014 Study

October 2014 - Urban Institute (BHP Scenario 1)					
	<150% FPL		150%-200% FPL		
Age	Females	Males	Females	Males	Total
19-25	2,005	2,572	3,094	5,828	13,498
26-29	1,109	915	1,791	3,498	7,314
30-44	2,595	3,031	7,132	7,787	20,545
45-54	997	1,351	4,276	4,231	10,855
55-64	2,003	1,421	6,740	3,963	14,128
Total	8,709	9,291	23,033	25,306	66,339
April 2014 - SHADAC					
	<150% FPL		150%-200% FPL		
Age	Females	Males	Females	Males	Total
19-25	1,981	1,732	4,586	6,271	14,570
26-29	245	1,700	3,385	2,685	8,015
30-44	1,813	1,556	8,719	13,166	25,254
45-54	526	678	6,017	4,214	11,435
55-64	663	882	7,309	4,285	13,139
Total	5,228	6,548	30,016	30,621	72,413

Overall, the Urban Institute estimates of the BHP population are slightly older on average and project a higher percentage of enrollees in the 0%-150% FPL category.

The estimates from SHADAC were based on the Current Population Survey (CPS), which has a smaller sample size than the ACS data used by Urban. Also, SHADAC estimates assumed that those not actually enrolled in employer coverage did not have offers. Data from several sources, such as the SIPP, show that a significant share of the uninsured have employer offers that they have not taken up. These offers can disqualify them from eligibility for BHP or QHP subsidies. By including the effect of such offers, this new analysis provides a more accurate estimate of the income distribution of BHP-eligible adults, with fewer who have incomes towards the higher end of the BHP spectrum, where ESI offers are more common. As a result, we find average federal BHP payments that are higher, since low income is associated with greater QHP subsidy levels, hence higher federal BHP payments. We also find that if BHP is used to shift the threshold of transition between Medicaid plans and QHPs from 138 percent FPL to 200 percent FPL, churning declines substantially; with fewer BHP- and QHP-subsidy-eligible individuals estimated around 200 percent FPL, such a conclusion is more likely.

It is also important to note that the Urban Institute demographic profile included estimates of relative morbidity by person. This data was used in projecting claim costs for BHP enrollees. The SHADAC population estimate did not have this data, so age and gender cost relativities were applied when modeling BHP claim costs.

Silver Rates

The second lowest cost Silver rates are used as the basis for BHP payments, as specified in the March 2014 BHP Payment regulation. The April 2014 study was based on 2014 rates; whereas the federal BHP payment estimates in this report are based on the 2015 second lowest cost Silver rates by rating area. Table 3.3 shows the percentage change from 2014 to 2015 in second lowest cost Silver rates by region. The year over year change varies by region.

Overall, we estimate that using 2015 rates as the basis for 2016 BHP payments results in about $2 million in lower payments. It is important to note that claim costs are also affected by the updated Silver rates because we used these rates as a basis for claim cost estimates. This is addressed in the Claim Costs subsection, below.

BHP Payment Regulation

Although the March 2014 final BHP payment regulation was available at the time of the April 2014 Study, it was mutually decided by the State and Wakely that results would not be updated from the original usage of the December 2013 proposed regulation. The October 2014 report is based on the March 2014 final regulation.

The most important difference between the proposed and final regulations is a reduction to the "Income Reconciliation Factor", which is used in the formula for calculating BHP payments related to the federal premium tax credits. The proposed regulation used a factor of 0.98; whereas, the final regulation uses 0.9492. We estimate that the reduction in this factor results in a reduction of BHP payment revenue to the State of about $4.5 to $5.0 million, depending on the scenario.

Other differences between the two regulations include splitting the 21-44 age bracket into two (21-34 and 35-44) and the addition of CMS estimates of the 2014 and 2015 impact of the federal reinsurance program on Silver rates. These differences had minimal impact on results.

Basis for Claim Cost Estimates

Similar to the BHP payment estimates, we used 2015 second lowest cost Silver rates in this report as a basis for estimating claim costs versus 2014 rates. We also used retention and federal reinsurance estimates as reported in each carrier's Unified Rate Review Template (URRT) for the specific second lowest cost carriers in each rating region when estimating claim costs from premiums. In the April 2014 study, we used high level, industry-average assumptions in backing out retention and reinsurance.

We estimate that using the 2015 second lowest cost Silver rates and carrier-specific retention and reinsurance result in BHP claim cost estimates of $2.0 to $2.8 million lower than the April 2014 study.

9) RELIANCE AND LIMITATIONS

The following information is provided in conformance with Actuarial Standards of Practice.

Wakely relied on the following sources to inform this report:

- Oregon Health Authority –Medicaid experience, Oregon Health Plus Benefits, and anticipated future Medicaid claim trend.
- Oregon Insurance Division - CY2015 Second lowest cost Silver rates
- Urban Institute – BHP Population demographic characteristics and relative morbidity
- BHP Payment calculations and assumptions in the regulations published in the March 12, 2014 Basic Health Program Final Federal Funding Methodology for 2015.
- Publicly available 2014 and 2015 Health Insurance Rate Filings available at http://www.oregonhealthrates.org/

The BHP analysis in this report depends on a number of key assumptions, some of which are highly variable, thus limiting the scope of this analysis. Readers should be aware of the following limitations.

1. **Second Lowest Cost Silver Rates Can be Highly Volatile:** As demonstrated in the comparison of the 2014 second lowest cost silver rates to the 2015 second lowest cost rates, there is a potential for significant volatility in the rates used as a basis for determining federal BHP revenues.
2. **BHP Payment Formula:** The federal BHP payment formula for plan year 2015 was applied in developing the projected 2015 federal BHP payments. This formula is subject to change for plan year 2016 which could have an impact on the BHP payments provided in this report.
3. **Interaction between the Marketplace and the BHP beyond 2016:** If a BHP is implemented, Silver premium levels in the Marketplace will likely be affected, which will in turn impact the BHP FPTC and cost sharing subsidy payments since they both depend on the Silver rates. Since our analysis was for 2016 only, this effect is outside the scope of our analysis.
4. **Claims Expense Projections for 2016:** The analysis includes claims expense projections for calendar year 2016 based on the 2015 second lowest cost silver plan rates with adjustments made based on information contained in the rate filings. If these are not representative of the underlying claims expense for the covered population, actual costs may vary.
5. **Projections for future years:** Projections for 2016 are not representative of future year impacts. For example, in 2017, the federal transitional reinsurance program is expected to be completely phased out, which will likely increase the QHP premiums which are used as the basis for

developing federal payments to the BHP trust fund. We would estimate premiums would increase by 2%-5% due to the reinsurance program phase out in 2017, which would likely increase federal BHP payments.

6. **Induced utilization:** Though additional utilization of services resulting in the reduction of enrollee cost sharing from 30% (in the standard silver plan) to 6 – 13% (for subsidized QHP coverage) was factored into the projected claims expenses, Wakely did not assume any additional use of services as a result of reducing enrollee cost sharing from the 6 – 13% of average claims for QHP coverage down to no cost sharing for scenarios 1a and 1b.

7. **Assessment of carrier participation or achievability of assumed provider reimbursement:** Our modeling assumes that the State will be able to effectively contract with willing standard health plans. Also, we assumed under scenarios 1a and 1b that those plans would be able to negotiate provider reimbursement similar to Medicaid levels (62% of the commercial level underlying the 2015 second lowest cost silver plan). While we believe these assumptions are reasonable, it is possible that actual results could vary from those assumed.

Wakely reviewed data and assumptions for reasonableness, but did not audit any data used. Any errors in the data may cause material errors in our analysis. This report is developed for the Oregon Health Authority and the Oregon Legislature, for the purpose of estimating the expected impact of implementing a BHP for calendar year 2016. Other uses, including estimating costs for future years, may be inappropriate. Actual results will vary if experience differs from the assumptions made herein, or if significant changes are made to federal regulations defining federal BHP payment methodology or other program requirements. When shared, the report must be shared in its entirety. Many of the concepts in this report are actuarial in nature and should be reviewed and interpreted by individuals with the appropriate background.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Tim Courtney and Julia Lerche are both Fellows of the Society of Actuaries and members of the American Academy of Actuaries. Both meet the qualification standards for performing the actuarial analyses included in sections 3, 4 and 5 of this report.

Appendix A

Detailed Methodology

DETAILED METHODOLOGY

The following provides additional details on the assumptions and methodologies employed in the analyses summarized in this report.

Section 2: BHP eligibility, enrollment and churn

We began by modeling eligibility for OHP, BHP, and subsidized QHP coverage using three years of Oregon households from the American Community Survey (ACS), the largest Census Department household survey. We then modeled take-up of all forms of health coverage under the ACA under three scenarios: no BHP, BHP without cost sharing, and BHP with cost sharing. Finally, we estimated the annual churning in health coverage by combining the ACS data with data from the Survey of Income and Program Participation (SIPP).

Eligibility for OHP, BHP, and QHPs

Sample of households in each state. To obtain a large, representative population for Oregon, we pool together the Oregon observations on the 2009, 2010, and 2011 American Community Surveys (ACS).

Non-citizens. We impute documentation status for non-citizens based on an imputation methodology that was originally developed by Passel[47]. Undocumented immigrants and lawfully present immigrant adults who have been U.S. residents for less than five years are generally ineligible for Medicaid.

Tax units and filing. To model tax units and filing behavior, we use 2011 tax rules (including thresholds for tax filing requirements), Earned Income Tax Credit (EITC) eligibility guidelines, and poverty guidelines as defined by the U.S. Department of Health and Human Services. Baseline coverage and post-ACA eligibility are based on estimates from Urban Institute's ACS-Health Insurance Policy Simulation Model (ACS-HIPSM). A description of ACS-HIPSM is provided in Appendix C.

Tax units and filing status are determined based on the IRS guidelines set forth by the 2011 1040 Instructions and the 2011 Earned Income Credit eligibility guidelines. The primary tax filing unit for each family is defined as the head of the family, the spouse, and any qualifying children or qualifying relatives (as defined by the IRS). In multi-generational households, nuclear subfamilies are tested for their filing status. If they are not found to file as a unit themselves, they are tested to qualify as dependents of the head of the household.

[47] Passel, J. and D. Cohen. 2009. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center.

Tax filing status is determined based on characteristics of the head of the tax unit and pooled income within the tax unit. Married couples are assumed to be filing jointly to qualify for tax credits. As support within the household is not captured by the ACS, any unmarried tax unit head with dependents is considered filing as a head of household. Any other unmarried person without dependents is tested as single. To determine requirement to file, individual Adjusted Gross Income (AGI) is pooled for each person within the tax unit and compared to the 2011 minimum mandatory filing threshold.

Due to limitations of the income that is captured by the ACS, some taxable income categories could not be included in total income. Capital gains are not reported as investment income in the ACS, so it was not counted. Paid alimony was also excluded; however, internal analysis based on CPS alimony data suggests this exclusion would not affect our results. The ACS does not collect data on unemployment compensation, but because this was likely an important form of income for people at the margin of the Medicaid and subsidy eligibility thresholds, it was imputed based on reported unemployment compensation from the 2008 CPS.

None of the adjustments needed to calculate AGI are reported by the ACS, so we therefore take total income as a proxy for AGI. Total income is calculated as the sum of wages, business income, farm income, rents, most forms of positive investment income, retirement income, unemployment compensation, and the taxable portion of social security income.

EITC eligibility is calculated in a slightly different way. AGI is pooled only among the head of the tax unit, the spouse (if filing as a married couple), and qualifying children. Qualifying dependents are not tested to file for EITC individually because they are either childless dependents (ineligible for EITC) or are found not to file in subfamily analysis. However, because they are claimed on the tax unit head's return, they take on the EITC eligibility status of their tax unit.

Once it was determined which tax units were required to file and which were eligible for EITC, units were assigned filing decisions. A 2005 Treasury Report estimated that about 7.4 million taxpayers who were required to file did not in Tax Year 2003.[48] That year, approximately 131 million individual tax returns were filed,[49] meaning the filing rate among those required to file was about 95 percent. A study by the IRS of Tax Year 2005 filings estimated the following EITC participation rates, by number of qualifying children: 55.6% among those without qualifying children, 73.6% among those with one qualifying child, and 85.9%

[48] Treasury Inspector General for Tax Administration, "The Internal Revenue Service Needs a Coordinated National Strategy to Better Address an Estimated $30 Billion Tax Gap Due to Non-filers," November 2005, Reference Number 2006-30-006.
[49] "Internal Revenue Service Data Book 2003," Internal Revenue Service, 2003

among those with two or more qualifying children.[50] Based on these rates, tax units were randomly assigned their decision to file or not file.

Eligibility for Medicaid/CHIP, QHP subsidies and BHP. Medicaid and subsidy eligibility are determined using Modified Adjusted Gross Income (MAGI), which adds nontaxable social security income to AGI. Unit-level MAGI is pooled among the unit head, the spouse (if married), and any qualifying children with an individual AGI above the single tax filing threshold. The income of other qualifying children and qualifying relatives is not included. This is then used to calculate a ratio of MAGI to the applicable federal poverty level (FPL) of the unit. Special prorating of units that include undocumented parent(s) or childless spouses is used to scale the total AGI (including that of the undocumented family members) by a ratio of the FPLs including and excluding the undocumented family members.

Medicaid eligibility for some groups, particularly the blind and disabled, does not change under the ACA. We model their eligibility using pre-ACA rules. To determine Medicaid and CHIP eligibility for other groups, tax unit-level MAGI-as-a-percentage-of-FPL is assigned to the tax unit head, the spouse (if married), and qualifying children with individual AGI above the single tax filing threshold. Excluded qualifying children and qualifying relatives are automatically eligible for Medicaid under CMS regulations. Under the ACA, the children of non-filing qualifying dependents also automatically qualify for Medicaid. The remaining parents, childless adults, and children are then tested for Medicaid eligibility based on the corresponding eligibility threshold in their state of residence. Children who are found ineligible for Medicaid are tested for CHIP eligibility.

QHP subsidy eligibility is determined slightly differently. To be eligible for subsidies, one must have a MAGI-as-a-percentage-of-FPL between 100 and 400 percent.[51] Eligibility for any public coverage precludes eligibility for subsidies, so subsidy-eligible consumers cannot be eligible for Medicaid or CHIP under the ACA, as determined above, nor can they currently be eligible for Medicare. Finally, if any family member has of single coverage that costs 9.5 percent of family MAGI or less, the entire family is barred from eligibility. For this determination, we use the ACS-HIPSM imputation of employer offers and the affordability of those offers.

The BHP population consists of those eligible for subsidies up to 200 percent of FPL. This includes lawfully present immigrants below 138 percent of FPL who are ineligible for Medicaid because they have been

[50] Plueger, D, "Earned Income Tax Credit Participation Rate for Tax Year 2005," Internal Revenue Service, 2009.

[51] Legal immigrant adults resident less than five years may also be eligible even if their incomes are lower.

resident less than five years. The large sample size of the American Community Survey allows us to identify this population in Oregon.

Enrollment in BHP and Other Health Coverage

Health Insurance Policy Simulation Model (HIPSM). Once we have modeled eligibility status for Medicaid/CHIP and subsidized coverage in the Marketplaces, we use HIPSM to simulate the decisions of employers, families, and individuals to offer and enroll in health insurance coverage and then map those results to the ACS using regression modeling to assign probabilities of take-up. To calculate the impacts of reform options, HIPSM uses a micro-simulation approach based on the relative desirability of the health insurance options available to each individual and family under reform (Buettgens, 2011). The approach allows new coverage options to be assessed without simply extrapolating from historical data, by taking into account factors such as affordability (premiums and out-of-pocket health care costs for available insurance products), health care risk, whether the individual mandate would apply, and family disposable income.

Our utility model takes into account people's current choices as reported in the survey data. For example, if someone is currently eligible for Medicaid but not enrolled, they or their parents have shown a preference against Medicaid. They will be less likely to enroll in Medicaid under the ACA than a similar person who becomes newly eligible for Medicaid and thus has not had a chance to express a preference. We use such preferences to customize individual utility functions so that people's current choices score the highest among their current coverage choices, and these preferences affect their behavior under the ACA. The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and non-group coverage.

Changes in health insurance coverage under the ACA are computed in six main steps:

- *Changes in Medicaid and CHIP enrollment***.** We begin by estimating additional enrollment in Medicaid and CHIP, both by those gaining eligibility under the ACA and among those who are eligible under current Medicaid and CHIP eligibility rules, but not enrolled. Many characteristics are used to determine take-up, but the two most important are newly gaining eligibility and current insurance coverage, if any.
- *Changes in enrollment in BHP and the non-group Marketplace***.** We estimate enrollment in single and family policies in the non-group Marketplace, both by those eligible for subsidies and those ineligible. Undocumented immigrants are barred from the Marketplace. First, we estimate those who would be family policyholders based on the characteristics of their family and estimate enrollment for them and their family members who would be eligible for the same insurance plan. Then, for those not covered by family policies, we estimate enrollment in single plans.

- *Enrollment of the uninsured in Employer Sponsored Insurance (ESI)***.** Demand for ESI would increase because of the individual mandate, small-group market reforms, and small firm tax credits. We estimate additional ESI enrollment for those currently uninsured with an ESI offer in their family and who would not enroll in coverage in steps 1 and 2 above. As with step 2, we treat single and family policies separately. In a full HIPSM simulation, employers change their ESI offer decisions, and there is movement both into and out of ESI. We do not currently model employer behavior on the ACS, but our results are similar to results from the full simulation with the CPS for overall level of ESI after reform as well as the characteristics of the uninsured who gain ESI coverage.

- *Enrollment of the uninsured in non-group coverage***.** We complete the simulation by estimating additional enrollment in non-group coverage outside the Marketplace by those currently uninsured with no ESI offer in the family who would not enroll in steps 1 or 2. This would result largely from the effect of the mandate. There would be some additional coverage for the undocumented here as well, since non-group coverage would be their only option without an ESI offer.

- *Transition from single to family ESI***.** The individual mandate will provide incentives for families to obtain coverage for all members. In particular, the expected utility model in HIPSM predicts that a certain number of single ESI policyholders in families where other members are uninsured or taking non-group coverage would purchase family ESI to cover the entire family. We model such transitions on the ACS based on the behavior of single ESI policyholders in HIPSM with mixed coverage in other members. Such families are not common, but this transition captures a behavioral response to the individual mandate.

- *Transition from non-group to ESI***.** In addition to the transition from ESI to the non-group Marketplace, HIPSM predicts changes from non-group coverage to ESI. These cannot be fully modeled on the ACS because we do not model changes in ESI offers, but we can model such transitions in cases where an ESI offer was present both with and without the ACA. Single and family ESI policies are considered separately. The number of people changed by this step is much lower than the number affected by most of the earlier steps, but this movement into ESI is a notable result from HIPSM.

BHP Scenarios. We simulated health insurance decisions under three different scenarios:

1. *No BHP*. Federally subsidized coverage in QHPs was available to those who would have been eligible for BHP. Take-up of QHP coverage was based on the standard health insurance Marketplace take-up in HIPSM. Little data are available on the income distribution of 2014 Marketplace enrollees. New York is one of the few states which published that information. The resulting take-up rates by income closely match published data on Marketplace enrollees in New York. They were also consistent with preliminary data we were given by Oregon on the number of 2014 QHP enrollees through Cover Oregon above or below 200 percent FPL provided

by the state, though much less detail was available for Oregon enrollees.

2. *BHP Scenario 1*. In this scenario, no premiums or cost sharing were charged for BHP. BHP take-up was based on Medicaid take-up in HIPSM. However, a much higher share of BHP eligibles would be subject to the individual coverage requirement than OHP eligibles. Take-up rates for previously uninsured adults gaining eligibility but not subject to the individual coverage requirement was 73 percent. Higher-income eligibles subject to the individual coverage requirement had a take-up rate of about 90 percent.

3. *BHP Scenario 2*. In this scenario, there were no premiums or cost sharing for BHP eligibles up to 138 percent of poverty (legal immigrant resident less than five years). For BHP eligibles with higher incomes, premiums were set to half of the percent of income that they would have to pay for the second lowest cost silver QHP without BHP. Similarly, beneficiary cost sharing was set to half the federally allowable QHP level. Take-up for those up to 138 percent FPL was the same as in BHP Scenario 1, while take-up for higher-income BHP eligibles was between that of QHP and BHP Scenario 1.

Churning in Health Coverage

In order to estimate changes in program eligibility and coverage over time, it is essential to use panel data, which track a representative sample of people over time. We used the Survey of Income and Program Participation (SIPP) as our source of panel data. The latest available survey cycle began in 2008. Each SIPP wave lasts four months. Households are interviewed once per wave, when they provide information based on the current month as well as the preceding three months. Households enter the survey on a staggered basis, so that approximately one-fourth of the households in the panel are interviewed in each month.

The SIPP data will allow us to determine how eligibility for OHP, BHP, and the Marketplace would change for each observation one and two years after the initial data. But the SIPP is not state-representative. We address this limitation by using SIPP data to impute future income and employment for each observation on our Oregon HIPSM-ACS data used for determining BHP eligibility and enrollment. That method corrects for differences in demographic, economic, and employment characteristics between Oregon and the broader SIPP population. Using a statistical match, we imputed income and employment for each HIPSM-ACS observation one year later by matching HIPSM-ACS characteristics with characteristics in the first wave of SIPP data.

We chose to use income transitions between 2009 and 2010 rather than between 2008 and 2009 because the earlier data showed greater effects of the recession. The SIPP data needed to be adjusted in order to be compatible with the 2016 HIPSM-ACS records. Income and poverty thresholds were aged to 2016. Less straightforward, data of income changes from 2009 to 2010 are driven by economic conditions that are not expected to be present from 2016 to 2017. To adjust for this, we assumed that there would be little change in the income distribution in Oregon between 2016 and 2017. We reweighted the SIPP data

so that the income distributions in the first wave and fourth wave (i.e., one year later) would conform to the ACS income distribution for Oregon and used this weight in the statistical match.

Section 3: Projected BHP revenues and costs

Eligible Population and Demographic Characteristics

All demographic and BHP take-up assumptions are based on the Urban Institute's analysis. A database with details at the household level was provided to Wakely by the Urban Institute.

The detail from the Urban database that was used in Wakely's analysis was as follows:

- Income as a percentage of FPL
- Age
- Previous source of coverage (Uninsured, insured in Individual private market, or legal immigrant with income less than 138%).
- Geographic region within Oregon
- Relative morbidity level (similar to a concurrent risk score model).

The relative morbidity levels provided by Urban were based on a process of imputing self-reported health status. Below is a brief description of this process.

Health status is highly correlated with medical spending and so it affects whether individuals and household take-up health insurance and the type they choose. However, because ACS does not include a health status indicator, we developed a process for imputing it. We used a hot deck imputation, with the donor data being the Medical Expenditure Panel Survey – Household Component (MEPS-HC) for combined year 2005 - 2007. The hot deck method randomly selects the value to be imputed to a recipient record (from the ACS file) from a donor record (from the MEPS-HC data) in the same cell (defined by a set of classification characteristics). We imputed health status (which consists of this ranking: 1 - Excellent, 2 - Very good, 3 - Good, 4 - Fair, 5 - Poor) separately for children and adults. For adults, cells for the hot deck procedure were formed from these ACS variables:

- Physical Limitations
- Cognitive Limitations
- Receipt of Supplemental Security Income (SSI)
- Age Category (Less than 19, 19 – 34, 35 – 49, 50 – 59, 60 and greater)

- Sex
- Current Health Insurance Coverage Type (Medicaid, Medicare, Employee Sponsored, Other Government, Non-Group, Un-Insured)
- Health Insurance Unit Income to Poverty Threshold Ratio Category (.5 or less, 0.5 – 1, 1 – 1.5, 2.5 – 4, 4 or more)
- Education Attainment (No High School Diploma, High School Diploma, Bachelor's Degree or higher)

For children, cells for the hot deck procedure were formed from these characteristics:

- Physical Limitations
- Cognitive Limitations
- Receipt of Supplemental Security Income (SSI)
- Health Insurance Unit Income to Poverty Threshold Ratio Category (.5 or less, 0.5 – 1, 1 – 1.5, 2.5 – 4, 4 or more)

The software used to perform the imputation collapsed cells when required by dearth of sample in full crossing. Note that hot decking was performed independently for each ACS survey year according to an identical methodology, including the use of the same donor file from MEPS-HC.

Federal BHP Payments to the State

Appendix B provides a detailed description of these calculations; however, we note here that all calculations were based on the following sources of data:

- Distribution of age and income based on Urban demographic data, as described above.
- 2015 Second Lowest Cost Silver premiums by region as provided by the State.
- Formulas and factors described in the March 12, 2014 proposed BHP Payment regulation.

Calculation of Federal Premium Tax Credits (PTC) and Cost Sharing Reduction (CSR) Subsidies in the Individual Marketplace

Wakely calculated federal premium tax credits and cost sharing subsidies using a methodology similar to that employed by the Marketplaces based on federal regulations. When we make comparisons of out-of-pocket expenses for BHP eligible individuals under an assumption that no BHP is implemented, we calculate federal premium tax credits and cost sharing subsidies using the expected method used by CMS.

Ultimately, these subsidies are calculated on an individual/household basis, so that actual premiums, incomes, and cost sharing amounts are used rather than the averages by rate cell used for the BHP payments. This can create differences in APTC and cost sharing subsidy amounts for the same individual in the BHP versus in the Marketplace, in addition to the main difference that BHP payments apply a factor of 95%.

Projected 2016 Claims Expenses

Project 2016 claims expenses for each household in the Urban database were developed as follows:

1. Begin with allowed claim costs derived from the second lowest Silver rates filed in the CY2015 Oregon individual Marketplace. The term "allowed claims" means total costs before member cost sharing is subtracted, but after discounts from provider reimbursement arrangements are applied.
2. Project costs to 2016 by applying adjustments for utilization and unit costs trends, assumed provider reimbursement levels (e.g. Commercial versus Medicaid), member cost sharing levels, and induced utilization to reflect benefit richness.
3. Adjust costs based on the relative health risk of the individual compared to the average for the individual market.
4. If applicable for the given scenario, add costs for OHP *Plus* benefits that are not covered by the EHB benchmark plan.

Below we provide a more detailed description for each of the elements discussed above.

Starting CY2014 costs

We calculated starting allowed costs as follows:

A. Calculate the average second lowest Silver rate for each of the standard seven geographic regions in Oregon. The demographic data from the Urban Institute database was used to calculate averages across ages.

B. Multiply by an assumed medical expense ratio of 80%, consistent with the federal minimum medical loss ratio requirement for individual market business.

C. Divide by the assumed Silver actuarial value of 0.70 to derive allowed costs.

D. Remove the estimated reduction for the temporary federal reinsurance program in 2014. We removed the reinsurance reduction because federal reinsurance does not apply in the BHP. Based on the estimate provided in March 2014 Final BHP Federal Funding Regulation,

the reinsurance program is estimated to reduce premiums 10% on average. Therefore, we increased allowed costs in C. by 1/(1-0.10) = 1.111.

E. Divide by the average morbidity relativity factor individual market enrollees (without BHP) for each region using morbidity relativities from Urban.

F. Multiply by the actual morbidity relativity for the given household as provided by Urban.

Projection of CY2016 Net Costs

To project claim costs to 2016, we applied the following adjustments:

- Utilization and unit cost trend. The combined utilization and unit cost trend used depended on the reimbursement assumption being used. For commercial reimbursement, the trends were based on the average trends used in CY2014 Oregon Marketplace rate filings for carriers with existing business, but adjusted downward based on preliminary results from the Cy2015 rate filings. Our estimated average total cost trend (i.e. utilization and unit cost) from the CY2014 rate filings was 7.2%. Based on discussions with Oregon rate reviewers and OHA staff, we agreed that a lower trend of 6% would be appropriate given that 2015 rate filings were generally using lower trends.

For scenarios 1a and 1b we assumed an annual Medicaid trend rate of 3.4%, which was provided by the OHA staff and is based on Oregon's 2012 Section 1115 waiver filed with CMS.

We applied annual trend over two years, from 2014 to 2016.

- Difference in provider reimbursement levels. In our modeling, we tested scenarios with different reimbursement levels. We assumed that the costs derived from the 2014 second lowest silver rates represented 100% of average commercial fees. Using information from the Oregon All Payer All Claims database and average paid to billed ratios from State Medicaid experience, we developed an adjustment factor to approximate Medicaid fee levels. This Medicaid factor was calculated as the ratio of 39.5%/64.0% = 62%, where 39.5% was the paid to billed ratio from State Medicaid data, and 64.0% was the average allowed to billed ratio from the all payer database. The table below shows the factor we applied for the two reimbursement scenarios.

Scenario	Factor
Commercial Fees	1.00
Medicaid	0.62

- Member cost sharing. We multiplied adjusted allowed costs by the standard actuarial value established for the Silver cost sharing subsidy plans and those assumed under each BHP scenario. These actuarial values (which represent the average portion of total expected claims costs covered by the plan relative to the enrollee) vary by income level, and are summarized below.

Income as % of FPL	Marketplace Coverage	BHP Scenarios 1a and 1b	BHP Scenarios 2a and 2b
0%-138%	94%	100%	100%
138% - 150%	94%	100%	97%
150%-200%	87%	100%	93.5%

- Induced utilization. We adjusted utilization based on assumed changes in consumer behavior as benefit richness changes. We used the federal induced utilization factors as a basis. It was also necessary to estimate the inherent induced utilization (IU) built into the Silver rates filed in the Marketplace since the Silver rate applied for the standard Silver 70% plan and the cost sharing subsidy plans (73%, 87%, and 94%). Based on a review of the Oregon individual Marketplace rate filings, we estimate the average IU factor to be 1.03; although it is important to note that the factors varied by carrier.

The final IU factor was the ratio of the federal factor for the given benefit level being considered (as measured by actuarial value) to the 1.03 base IU assumed to be inherent in the Silver rates. Since all scenarios tested used an actuarial value of at least 0.87, the IU factor was constant at 1.12/1.03 = 1.09.

Note that no additional utilization was assumed for further reducing enrollee cost sharing from the levels in the cost-sharing reduction plans available through the Marketplace.

OHP Benefits not Covered by the EHB Benchmark Plan

In scenarios 1b and 2b, we estimated the impact of adding certain categories of service covered under the State Medicaid Plan (OHP) that were not covered in the Oregon EHB Benchmark plan. Appendix F provides a comparison of the OHP *Plus* and EHB Benchmark plans.

Using State Medicaid experience and capitation rates, we estimated the cost of the additional OHP benefits to be about $27.00 PMPM. The table below summarizes our estimate by benefit category. Note that we did not trend the experience since most of the benefits are subject to minimal or no inflation.

Benefit Category	Age Category 21-44	45-54	55-64
Adult Dental	$24.69	$24.69	$24.69
Chiropractic	$0.25	$0.30	$0.34
Non-Emerg. Transportation	$0.76	$0.76	$0.76
Unlimited IP Rehab	$0.24	$0.24	$0.24
Unlimited PT/OT/ST	$0.02	$0.02	$0.02
Unlimited DME	$0.82	$0.82	$0.82
Total	$26.78	$26.82	$26.87

Member Premium

Member premiums are calculated as the difference between the household premium and the federal premium tax credit (PTC). The PTC is calculated as the difference between the premium for the second lowest cost silver plan available to the covered family members and the maximum household payment, which is a percentage of income as defined in the ACA. The table below shows this percentage for selected income levels; however, it should be noted that we linearly interpolated for all income values.

Income as % of FPL	Percentage of Income
0%-132%	2.0%
133%	3.0%
150%	4.0%
175%	5.2%
200%	6.3%
250%	8.1%
300%	9.5%
399%	9.5%
400%+	0.0%

Member premiums were assumed to be $0 for scenarios 1a and 1b. For scenario 2a and 2b, member premiums were set to $0 for the population with household incomes below 138% FPL and were set to half of the maximum household payment that would apply to QHP coverage on the Marketplace.

Member Cost Sharing

In our scenarios, we varied the portion of this maximum allowed cost sharing that would be subsidized by the State. In the scenario where the State subsidy is 50%, this means the member will be responsible for half of the expected cost sharing (as a percent of total allowed claims costs) that would have applied had the member been enrolled in the second lowest Silver plan on the Marketplace. It is important to note

that in all scenarios, BHP enrollees with incomes below 138% FPL were assumed to be subject to no cost sharing requirements for all benefit types.

Out-of-pocket costs for the uninsured were derived from projected 2016 average allowed costs (based on the 2014 second lowest cost silver plan) adjusted for relative health risk as provided by Urban. No assumptions were made for the relative use of services for someone who is uninsured compared to someone with insurance. Additionally, provider reimbursement levels used to derive the out-of-pocket costs for the uninsured population were assumed to be consistent with 2014 2nd lowest cost silver plan trended to 2016.

Program Administration Costs

The State of Oregon will incur operational costs in order to facilitate a BHP. There will be start-up costs to cover the development of processes, systems and staff to manage BHP interactions with the federal government, contracted carriers, and enrollees.

Once the BHP is set up, there will be annual ongoing costs to maintain and run the program.

For annual costs, we assumed State administrative expenses would be $19.32 PMPM for scenarios 1a and 1b, and $22.32 PMPM for scenarios 2a and 2b (the higher amount reflects the addition of a premium collection function) . These assumptions were based on discussions with the State and the development is outlined in Section 6 of the report.

Finally, based on discussions with the state standard health plan administrative costs were estimated to be 8% for scenarios 1a and 1b (to align with CCO administrative costs) and 15% for scenarios 2a and 2b (to align with the maximum allowable administrative costs for BHP coverage offered by insurance companies).

Appendix B

BHP Payment Methodology

FEDERAL BASIC HEALTH PROGRAM PAYMENT METHODOLOGY

The Basic Health Program (BHP) funding calculation methodology used in the Wakely model is based on the March 2014 Basic Health Program Final Federal Funding Methodology for 2015. Under the section 1331 of the Patient Protection and Affordable Care Act, a federal funding payment amount will be made to the states with a Basic Health Program for low-income individuals.

The federal BHP payment include two components:

1. Federal premium tax credit (PTC), and
2. Federally-funded cost-sharing reductions (CSR).

The federal BHP payment is 95 percent of the PTC and CSR.

Rate Cells

The BHP funding methodology defines multiple federal BHP payment rate cells, which are combinations of five factors: Age, Income levels, geographic areas, coverage status and household size. (Note that the rule includes coverage status (individual or family coverage) as a factor, but we did not consider this in our study.)

Rather than calculating PTC and CSR on a person-by-person basis, BHP payments will be determined using averages within subcategories of the rate cell factors. Within each subcategory, a uniform average is determined in order to calculate payment. For example, for the age 21-34 rate cell, a straight average across ages is calculated.

We calculated subcategory averages for the four factors by using the analysis performed by the Urban Institute. This data provides information including age, poverty status (percentage of Federal Poverty Level FPL), Public Use Microdata Area (PUMA), Super Public Use Microdata Area (Super-PUMA), and household serial number.

Each factor within the BHP payment rate cells is developed based on the Urban Institute data at the household level, and the unique combination of all the four factors is used. Below are the detailed descriptions of each rate cell factor and how they are developed using the Urban analysis.

- *Age*: The Urban Institute data has the exact age information for each individual. We regrouped the ages to the age ranges that are defined in the March 2014 rule.
- Ages 0-20
- Ages 21-34

- Ages 35-44
- Ages 45-54
- Ages 55-64
- *Income levels*: Income levels are measured as a percentage of FPL. We calculated a straight average across FPL percentages within the following ranges defined as defined in the March 2014 rule.
- 0 to 50 percent of the FPL
- 51 to 100 percent of the FPL
- 101 to 138 percent of the FPL
- 139 to 150 percent of the FPL
- 151 to 175 percent of the FPL
- 176 to 200 percent of the FPL
- *Geographic areas*: The Urban Institute data includes PUMA and Super-PUMA area codes. The IPUMS website (https://usa.ipums.org/usa/volii/PUMA_composition_OR.shtml) provides the mapping between the combination of the two codes and each county in the state of Oregon. We then group counties by geographic rating area defined by the state and demonstrated at http://www.oregonhealthrates.org/?pg=approved_rates.html.

  Oregon has defined seven rating areas by county. Below is the definition of each area according to counties included. A complete mapping between PUMA, Super-PUMA code and County and rating areas can be found at the end of this Appendix.

  - **Bend**: Deschutes, Klamath, and Lake counties
  - **Coast**: Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook counties
  - **Eugene**: Benton, Lane, and Linn counties
  - **Medford**: Douglas, Jackson, and Josephine counties
  - **Pendleton-Hermiston**: Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler counties
  - **Portland**: Clackamas, Multnomah, Washington, and Yamhill counties
  - **Salem**: Marion and Polk counties

- *Household sizes*: We calculate household size by using household serial number to identify the members in the same household. The March 2014 rule defines household sizes from 1 to 5+ members.

Premium Tax Credit Formula

The formula for calculating the federal premium tax credit portion of the federal BHP payment amount is as follows:

Federal Premium Tax Credit = (Adjusted Reference Premium – Household Payment) * Income Reconciliation Factor

Below we further define each of these components.

Adjusted Reference Premium

Adjusted reference premium is calculated based on the LifeWise CY2015 Standard Silver rates by age and region and trended to 2016. The projection to 2016 includes adjustments for the change in the federal reinsurance program and a population health factor. Following this methodology, we projected 2016 Silver rates as follows:

2016 Adjusted Reference Premium = 2015 LifeWise Standard Silver rate (by age cell) * Premium trend factor * Reinsurance transition impact factor * Population health factor

The components of this formula were determined as follows:

- 2015 Second lowest silver rates

  LifeWise rates by age and region for the Standard Silver plan were used as a proxy for the second lowest cost silver rates at the direction of the Division of Insurance. Note that LifeWise had other Silver rates, but these were not used.

- Premium Trend factor

  Based on the March 2014 rule, the trend factor should approximate the change in health care costs per enrollee. We used the same trend factor source in the March 2014 rule to trend Silver rates to 2016. The source of the trend factor is the annual growth rates in private health insurance expenditures per enrollee from the National Health Expenditure projections developed by CMS. The trend factor from 2015 to 2016 is 1.038.

- Reinsurance transition impact factors

The federal reinsurance program reduces coverage over 2014, 2015, and 2016. As part of the projection of 2016 Silver rates, an adjustment is needed to reflect the reduced reinsurance protection in 2016. The adjustment to rates was calculated by applying expected changes in the parameters of the reinsurance program. An estimate of the impact on premiums from 2014 to 2015 was provided in the Final BHP federal funding regulation. The BHP regulation estimated rates would increase by 4.4% due to the changing reinsurance protection.

At the time of this writing, we do not know the reinsurance parameters for 2016; however, we do know the federal target amount of reinsurance contributions for 2016. Using the difference in expected premium impact due to the change in parameters from 2014 to 2015, we apply this difference to the relative change in expected federal reinsurance contribution collections to calculate a proxy impact for 2016. The table below shows our assumptions underlying this estimate.

Year	Threshold	Coinsurance	Expected Federal Collections	Estimated Impact on Marketplace Premiums
2014	$60k-$250k	80%	$10B	-10.0%
2015	$70k-$250k	50%	$6B	-6.0%
2016	TBD	TBD	$4B	-4.2%

The final factor for 2016 is (1-0.06)/(1-0.042) = 1.020, or in other words, the impact of the reduction in reinsurance protection from 2015 to 2016 is expected to have a +2.0% impact to rates.

- Population health factor

We used the same population health adjustment factor as the final rule for 2015 BHP program year, which is equal to 1.00. By applying a 1.00 adjustment factor, we assume that the health status for BHP enrollees in the state of Oregon would be the same level as the state's individual market so the Marketplace premiums would have been the same if the state did not implement the BHP program.

Household Payment

The household payment is the maximum amount a household can pay for the second lowest Silver plan in the Marketplace. It is calculated by applying the federally defined percentages of annual household income that defines the maximum amount households would pay for the second

lowest cost silver plan available through the Marketplace. The percentages range from 2% to 9.5%, and increase with income as a percent of FPL.

The household payment for each FPL is calculated based on the following formula:

2016 Monthly Household Payment = 2014 Federal Poverty Guideline Income*Trend factor * FPL percentage * Applicable percentage per ACA

The 2014 Federal Poverty Level income amount is based on the Federal Poverty Guidelines, which are summarized in the table below.

Household Size	2014 FPL Guideline (100%)
1	$11,670
2	$15,730
3	$19,790
4	$23,850
5	$27,910

PTC and CSRs for 2016 will be determined based on the 2015 FPLs. The trend factors from 2014 to 2015 was assumed to be 2.5% based on the intermediate inflation forecasts for non-labor CPI-U (table IV.a1) from the most recent Medicare Trustees Report. This is the basis described in examples shown in the March 2014 rule.

The applicable percentage is based on the values in the Affordable Care Act (ACA). The table below shows the values from the ACA. Though these amounts are indexed annually based on the excess of growth of medical premiums relative to household income, Wakely assumed the amounts below for purposes of this analysis.

Income Level	Initial Percentage	Final Percentage
Up to 133% FPL	2.00%	2.00%
133-150% FPL	3.00%	4.00%
150-200% FPL	4.00%	6.30%
200-250% FPL	6.30%	8.05%
250-300% FPL	8.05%	9.50%
300-400% FPL	9.50%	9.50%

We calculated applicable percentages for each FPL using a linear interpolation within each FPL range. For example, the applicable percentage for a household FPL level 140% is in the 133-150% category, with a range from 3% to 4%. The formula for calculating the percentage for 140% FPL would be:

$$3\% + \frac{140\%-133\%150\%-133\%}{} = 3.41\%$$

Finally, we take the straight average of the monthly household payment for each household size based on the FPL rate cells defined in the March 2014 rule.

The final average monthly household payment is summarized as below:

Maximum Household Payments by Income Level and Household Size

	Household Size				
Income	1	2	3	4	5
0-50	$4.98	$6.72	$8.45	$10.19	$11.92
51-100	$15.05	$20.29	$25.52	$30.76	$36.00
101-138	$26.27	$35.41	$44.55	$53.69	$62.83
139-150	$53.03	$71.47	$89.92	$108.37	$126.82
151-175	$74.95	$101.02	$127.10	$153.17	$179.24
176-200	$107.96	$145.51	$183.07	$220.63	$258.19

Income Reconciliation Factor (IRF)

The income reconciliation factor is defined to be 0.9492 in the final rule. This is a 3% decrease from the 0.98 level in the March 2014 payment regulation.

Cost-sharing Reduction

The formula for calculating the federal cost sharing reduction amount is as follow:

Cost-sharing Reduction = Adjusted Reference Premium * Factors for Removing Admin Cost * Standard AV Factor * Tobacco Factor * IU Factor * Increase in AV

The assumed adjusted reference premium is the same amount as the 2016 adjusted reference premium used for the Premium Tax Credit calculation.

Factors for Removing Admin Cost

The March 2014 rule uses a factor of 0.80 to derive claim costs by removing assumed administrative costs from the premium.

Standard AV Factor

The March 2014 rule defines the standard actuarial value (AV) factor as 1 over the standard actuarial value of 70% for Silver plans, or 1.43.

Tobacco Factors

The general formula for the final tobacco factor is equal to the weighted average of the tobacco rating adjustment factor with the tobacco rating utilization factor for the State of Oregon. The formula is:

Tobacco Rating Adjustment Factor for Tobacco Users * Tobacco Utilization Factor in Oregon + Tobacco Rating Adjustment Factor for Non-tobacco Users * (1 - Tobacco Utilization Factor in Oregon)

- Tobacco Rating Adjustment Factor

  The tobacco rating adjustment factor for non-tobacco users is 1.00 since there is no tobacco impact for non-tobacco users. The tobacco rating adjustment factor for tobacco users is based on the average tobacco factors from the eleven different 2015 individual plans rate filings from the state of Oregon. We took the average of all the tobacco factors by age and further average these into the age categories defined in the March 2014 rule. The average tobacco load was 1.11 for all age categories above age 21.

- Tobacco Rating Utilization Factors

  As prescribed in the March 2014 rule, we used the percentage of the cigarette use in the State of Oregon from the Center for Disease Control and Prevention, Tobacco Control Interactive Maps with State Tobacco Activities Tracking and Evaluation (STATE) System. The percentage of cigarette use in Oregon was 17.9% in year 2012.

  http://apps.nccd.cdc.gov/statesystem/InteractiveReport/InteractiveReports.aspx?MeasureID=4

Induced Utilization Factor

The induced utilization factor is 1.12 according to the March 2014 rule.

Increase in Actuarial Value

The increase in actuarial value varies by income range and is based on the actuarial value of the subsidized Silver cost sharing reduction plan variations as defined in the ACA. The factor is calculated as the difference in actuarial value between the cost sharing reduction level and the standard silver plan (70%). The table below shows the factors by FPL range.

FPL Category	AV with Cost Sharing Subsidy	Silver Plan AV	Increase in AV
0-50	0.94	0.70	0.24
51-100	0.94	0.70	0.24
101-138	0.94	0.70	0.24
139-150	0.94	0.70	0.24
151-175	0.87	0.70	0.17
176-200	0.87	0.70	0.17

Mapping of Puma, Super-Puma, County and Rating Area

Super-PUMA	Super-PUMA & PUMA	Counties	Rating Areas
41100	41100100	Baker County	PENDLETON-HERMISTON
41100	41100100	Umatilla County	PENDLETON-HERMISTON
41100	41100100	Union County	PENDLETON-HERMISTON
41100	41100100	Wallowa County	PENDLETON-HERMISTON
41100	41100200	Crook County	PENDLETON-HERMISTON
41100	41100200	Gilliam County	PENDLETON-HERMISTON
41100	41100200	Grant County	PENDLETON-HERMISTON
41100	41100200	Hood River County	PENDLETON-HERMISTON
41100	41100200	Jefferson County	PENDLETON-HERMISTON
41100	41100200	Morrow County	PENDLETON-HERMISTON
41100	41100200	Sherman County	PENDLETON-HERMISTON
41100	41100200	Wasco County	PENDLETON-HERMISTON
41100	41100200	Wheeler County	PENDLETON-HERMISTON
41100	41100300	Harney County	BEND
41100	41100300	Klamath County	BEND
41100	41100300	Lake County	BEND
41100	41100300	Malheur County	BEND
41100	41100400	Deschutes County	BEND
41200	41200500	Clatsop County	COAST
41200	41200500	Columbia County	COAST
41200	41200500	Lincoln County	COAST
41200	41200500	Tillamook County	COAST
41200	41200600	Benton County	EUGENE
41200	41200600	Linn County	EUGENE
41200	41200701	Lane County	EUGENE
41200	41200702	Lane County	EUGENE
41300	41300800	Coos County	COAST
41300	41300800	Curry County	COAST
41300	41300800	Josephine County	COAST
41300	41300900	Jackson County	MEDFORD
41300	413001000	Douglas County	MEDFORD
41400	414001101	Marion County	SALEM

Super-PUMA	Super-PUMA & PUMA	Counties	Rating Areas
41400	414001102	Marion County	SALEM
41400	414001200	Yamhill County	PORTLAND
41501	415011301	Multnomah County	PORTLAND
41501	415011302	Multnomah County	PORTLAND
41501	415011303	Multnomah County	PORTLAND
41501	415011304	Multnomah County	PORTLAND
41501	415011305	Multnomah County	PORTLAND
41502	415021306	Multnomah County	PORTLAND
41502	415021307	Clackamas County	PORTLAND
41502	415021308	Clackamas County	PORTLAND
41502	415021309	Clackamas County	PORTLAND
41503	415031310	Washington	PORTLAND
41503	415031311	Washington	PORTLAND
41503	415031312	Washington	PORTLAND
41503	415031313	Washington	PORTLAND

Appendix C

Urban Institute Health Insurance Policy Simulation Model

The Urban Institute's Health Policy Center has used micro simulation models to assist state and federal governments with health care reform decisions for a decade, beginning with the 'Roadmap to Universal Coverage' project funded by the Massachusetts Blue Cross Blue Shield Foundation which set the general outline for Massachusetts' health reform debate in 2005, and ultimately, that state's landmark health reform law. In 2009, we released a report for New York that estimated the impact of several health reform proposals—including a single payer system—on health coverage, health care utilization, health costs, and the overall economic impact to the state. More recently, we have used micro simulation to assist state agencies in New York, Virginia, Washington, Missouri, Massachusetts, Utah, and Oregon with many different aspects of Affordable Care Act implementation and have provided technical assistance to HHS/ASPE. A bibliography of research using HIPSM is available at http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.

The Urban Institute's latest micro simulation model, the Health Insurance Policy Simulation Model (HIPSM), estimates the cost and coverage effects of proposed health care policy options. HIPSM is designed for quick-turn around analysis of policy proposals. It can be rapidly adapted to analyze a wide variety of new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of policy options at a number of points in time.

HIPSM was developed by researchers in the Health Policy Center and Urban-Brookings Tax Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization. Funders of HIPSM's development include the Stoneman Family Foundation, the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and the Urban Institute.

Data Sources

HIPSM uses three years (2009-2011) of pooled data from the American Community Survey (ACS). The ACS is an annual survey fielded by the United States Census Bureau. We use an augmented version of the ACS prepared by the University of Minnesota Population Center, known as the Integrated Public Use Microdata Sample (IPUMS), which uses the public use sample of the ACS and contains edits for family relationships and other variables. The 2009 ACS has a reported household response rate of 98.0 percent, which ranges from 94.9 percent in the District of Columbia to 99.4 percent in Wisconsin (U.S. Census Bureau 2009). It is a mixed-mode survey that starts with a mail-back questionnaire – 52.7 percent of the civilian non-institutionalized sample was completed by mail in 2009 – and is followed by telephone interviews for initial non-responders, and further followed by in-person interviews for a sub-sample of remaining non-responders.

In preparing the HIPSM files, we impute the offer of employer-sponsored insurance (ESI) and worker eligibility for ESI to CPS/ACS observations, since it is not available on those surveys. The February 2005 CPS Contingent Work and Alternative Employment Supplement is the most recent CPS survey that asked questions about ESI offer and eligibility. Consequently, we developed a regression model to impute offer and eligibility status using a match of the February 2005 CPS and the March 2005 ASEC and the wealth of

socioeconomic data on both surveys. This regression captures the variation in offer and eligibility across workers of different characteristics. For example, most part-time workers are not eligible for ESI, even if other workers in their firm are offered coverage and are eligible for it. The probability of offer from the regression model is adjusted to give results matching the latest available ESI offer rates by firm characteristics from the Medical Expenditure Panel Survey-Insurance Component.

Heath expenditures by individuals and families are central pieces of information necessary for computing health insurance premiums, evaluating the health insurance options facing families, and assessing the costs of the components of the ACA. The ACS does not collect data on health care expenditures, so we statistically match health care expenditure data from individuals in the Medical Expenditure Panel Survey—Household Component (MEPS-HC) to individuals in the ACS. A number of adjustments to the MEPS data are made as well, and these are described below.

We then reconcile MEPS-HC spending with the National Health Accounts (NHA) Personal Healthcare Expenditures data, which are maintained by federal actuaries. According to Sing et al., compared to the NHA, MEPS routinely underestimates the aggregate insured costs associated with Medicaid and privately insured individuals.[52] To adjust for any MEPS underreporting of the high-cost tail of the health expenditure distribution, we looked to the Society of Actuaries (SOA) High-Cost Claims Database.

Determining Eligibility under the ACA

Eligibility for Medicaid, the Children's Health Insurance Program (CHIP), and Marketplace subsidies under the ACA follows the final HHS regulations. Medicaid eligibility for some groups, particularly the blind and disabled, does not change under the ACA. We model their eligibility using pre-ACA rules.

Otherwise, Medicaid, CHIP, and subsidy eligibility are determined using MAGI, which adds nontaxable social security income to AGI. Unit-level MAGI is pooled among the unit head, the spouse (if married), and any qualifying children with an individual AGI above the single tax filing threshold.[53] The income of other qualifying children and qualifying relatives is not included. This is then used to calculate a ratio of MAGI to the applicable federal poverty level (FPL) of the unit. Special prorating of units that include undocumented parent(s) or childless spouses is used to scale the total AGI (including that of the undocumented family members) by a ratio of the FPLs including and excluding the undocumented family

[52] M. Sing, J. S. Banthin, T. M. Selden, C. A. Cowan, and S. P. Keehan, "Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002," *Health Care Financing Review* 28(Fall 2006): 25–40. Also, T. M. Selden and M. Sing, "Aligning the Medical Expenditure Panel Survey to Aggregate U.S. Benchmarks," Agency for Healthcare Research and Quality, Working Paper No. 08006, July 2008, http://gold.ahrq.gov/projectsearch/staff_summary.jsp?project=IM05209, accessed June 28, 2010.

[53] There are some differences between Medicaid/CHIP and Marketplace premium tax credit eligibility in how the income of various family members is counted.

members.[54] People are then tested for Medicaid and CHIP eligibility based on the applicable eligibility threshold in their state of residence.

QHP subsidy eligibility is determined slightly differently. To be eligible for subsidies, one must have a MAGI-as-a-percentage-of-FPL between 100 and 400 percent. Eligibility for any public coverage precludes eligibility for subsidies, so subsidy-eligible consumers cannot be eligible for Medicaid or CHIP under the ACA, as determined above, nor can they currently be eligible for Medicare. Finally, no unit member can have an offer of single coverage that costs less than 9.5 percent of family MAGI.

Constructing Synthetic Firms

In order to compute firm level premiums for employer-sponsored coverage and to model firm decisions of whether to offer insurance or not, and if offering, the type of health insurance coverage they provide, workers were grouped into simulated, or "synthetic," firms. These groupings allow HIPSM to model firm decisions related to health insurance in response to policy changes, reflecting the combined preferences and characteristics of the workers in each firm as well as their dependents who might also obtain coverage through the employer. The distribution of synthetic firms mimics the known distribution of employers by size, industry, region, and baseline offer status, and workers matched into each are those reporting employment in the same type of firms. Our sources of data for firms and the health coverage they offer are the Statistics of U.S. Business, the MEPS-IC, and the Kaiser-HRET Employer Benefits Survey.

Utility and Elasticity

Unlike other micro simulation models, which use either expected utility or elasticity methods for decision-making, HIPSM uses both. Our basic framework is expected utility. Workers value different insurance options based on premiums, expected out-of-pocket payments, risk of high out-of-pocket expenditures, and how much they value health care. Workers convey their valuation to employers, who decide whether and what to offer their workers based on whether the sum of the workers' valuations for an option is greater than its cost.

Because our utility is dollar-valued, we can examine whether the valuations that families have for various insurance options are reasonable. We adjust the utility values for individuals by adding a latent preference term so that the baseline insurance coverage choice that they make in a HIPSM simulation is consistent with what they are observed to have chosen in the core data. This adjustment captures unobserved reasons why people might not choose the coverage type that appears to be their best option given what

[54] We impute immigration status following the methodology of Passel, J. and D. Cohen. 2009. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center.

we can observe. We calibrate the distribution of these unobserved preference terms so that the model reproduces price elasticity estimates from the literature. [55]

The Flow of a Policy Simulation

HIPSM coordinates behavior by iterating a sequence of steps. Each iteration involves a sequence of four stages. At the beginning of an iteration, the health insurance industry sets premiums for all available health insurance plans given information observed in the last period and any policy changes that become effective this period. In the second stage, based on these premiums and information about their employees, employers decide whether to offer an employer-sponsored health insurance plan, and if so, the plan to be offered and the employees' cash wages. In the third stage, individuals choose their optimal health insurance option given their available alternatives and associated premiums, income, and relevant tax incentives. Once the iteration is complete, the next period begins and the process repeats. Coverage decisions in the previous period are used to update premiums based on current risk pools, and so on. Iterations continue until coverage decision changes from the previous iteration fall below a specified level; in other words, until an equilibrium state has been reached.

Additional Information on Methodology

Buettgens, M. (2011) *HIPSM Methodology*. http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf

Buettgens, M., Dean Resnick, Victoria Lynch, Caitlin Carroll (2013) *Documentation on the Urban Institute's American Community Survey Health Insurance Policy Simulation Model (ACS-HIPSM).* http://www.urban.org/health_policy/url.cfm?ID=412841

[55] ESI price elasticity: Linda Blumberg, Len M. Nichols, and Jessica S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics* 1 (2001); L. Nichols, L. Blumberg, P. Cooper, and J. Vistnes, "Employer Decisions to Offer Health Insurance: Evidence from the MEPS-IC Data," Paper presented to American Economic Association meetings, New Orleans, LA, 2001; J. Gruber and M. Lettau, "How Elastic Is the Firm's Demand for Health Insurance?" *Journal of Public Economics* 88 (2004): 1273–93.

Nongroup price elasticity: Congressional Budget Office, *The Price Sensitivity of Demand for Nongroup Health Insurance*, Background paper (Washington, DC: Congressional Budget Office, August 2005).

Appendix D

Fiscal Effects of Various Adjustments to Scenarios 1a and 1b

The following table provides details for the calculation the impact on BHP net surplus or deficit of various adjustments to Scenarios 1a and 1b as outlined in Section 3 of this report.

Fiscal Effects of Various Adjustments to Scenarios 1a and 1b (thousands)

	Scenario 1a	Scenario 1b
Net deficit shown in table 3.4	***($1,611)***	***($24,806)***
Adjustment #1: charging $10 monthly premiums above 175% FPL		
High-enrollment end of range		
Total cost effect of adjustment (premiums raised)	***$2,820***	***$2,820***
Net Surplus/(Deficit)	***$1,210***	***($21,986)***
Low-enrollment end of range		
Premiums raised	$2,520	$2,520
Lost federal revenue	($7,824)	($7,824)
Reduced state expenditures	$7,885	$8,760
Total cost effect of adjustment	***$2,581***	***$3,455***
Net Surplus/(Deficit)	***$971***	***($21,351)***
Adjustment #2: charging $10 monthly premiums above 150% FPL		
High-enrollment end of range		
Total cost effect of adjustment (premiums raised)	***$5,892***	***$5,892***
Net Surplus/(Deficit)	***$4,282***	***($18,914)***
Low-enrollment end of range		
Premiums raised	$5,388	$5,388
Lost federal revenue	($13,145)	($13,145)
Reduced state expenditures	$13,246	$14,716
Total cost effect of adjustment	***$5,490***	***$6,959***
Net Surplus/(Deficit)	***$3,880***	***($17,847)***
Adjustment #3: charging $10 monthly premiums at 138-150% FPL, $20 at 151-175% FPL, and $40 above 175% FPL		
High-enrollment end of range		
Total cost effect of adjustment (premiums raised)	***$18,924***	***$18,924***
Net Surplus/(Deficit)	***$17,314***	***($5,882)***
Low-enrollment end of range		
Premiums raised	$17,220	$17,220
Lost federal revenue	($15,648)	($15,648)
Reduced state expenditures	$15,770	$17,519
Total cost effect of adjustment	***$17,341***	***$19,091***
Net Surplus/(Deficit)	***$15,731***	***($5,715)***

Appendix E

Impact of BHP on Individual Market Details

The following table provides details for the differences in the relative age and morbidity factors for Oregon's individual (non-group) health insurance market with and without BHP implementation. See Section 5 for additional details on the methodology utilized to develop the estimates below.

Age and Morbidity Factors for Individual Market with and without BHP

	Scenarios 1a and 1b			Scenarios 2a and 2b		
Income Level	Enrollees	Federal Age Factor	Relative Morbidity	Enrollees	Federal Age Factor	Relative Morbidity
Without BHP						
0-138	7,665	1.184	0.837	7,665	1.184	0.837
139-200	62,708	1.527	1.019	62,708	1.527	1.019
201+	140,372	1.713	1.140	140,372	1.713	1.140
Total	210,746	1.639	1.093	210,746	1.639	1.093
With BHP						
0-138	4,211	1.177	1.026	4,211	1.177	1.026
139-200	10,425	1.278	0.958	10,529	1.282	0.963
201+	140,372	1.713	1.140	140,372	1.713	1.140
Total	155,008	1.670	1.125	155,113	1.670	1.125
Change - With BHP vs. Without BHP						
0-138	(3,454)	-0.6%	22.6%	(3,454)	-0.6%	22.6%
139-200	(52,283)	-16.3%	-6.0%	(52,179)	-16.1%	-5.6%
201+	0	0.0%	0.0%	0	0.0%	0.0%
Total	(55,738)	1.9%	2.9%	(55,633)	1.9%	2.9%

Appendix F

Comparison of EHB and OHP *Plus* Benefits

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
1. Ambulatory patient services		
a. Primary care to treat illness/injury	√	√
b. Specialist visits	√	√
c. Outpatient surgery	√	√
d. Acupuncture	NC	√ chemical dependency, HIV, migraine, post-stroke depression, limited medical conditions during pregnancy
e. Chiropractic	NC	√ certain conditions only (including back pain with neurologic component, not muscular)
f. Naturopath	NC	√
g. Chemotherapy services	√	√
h. Radiation therapy	√	√
i. Infertility treatment services	NC	NC
j. Sterilization	√	√
k. Home health care	√	√
l. Telemedical services	√	√
m. Routine vision care	NC	NC for adults 21 and over
n. Care for disease of the eye	√	√
o. Foot care	√	√
p Medical contraceptives	√	√
q TMJ services	NC	NC
r Dental - diagnostic & preventive	NC	√ (for all ages)
s Dental - basic	NC	√ (for all ages)
t Dental - major	NC	NC for adults 21 and over
2. Emergency services		
a. Emergency room - facility	√	√
b. Emergency room - physician	√	√
c. Ambulance service - ground and air	√	√
3. Hospitalization		
a. Inpatient medical and surgical care	√	√
b. Organ & tissue transplants	√ limited to organs specified $5000 limit for travel expenses $8000 limit for donor expenses lodging for caregiver	√ limited to organs specified
c. Bariatric surgery	NC	√ limited to Type 2 diabetics
d. Anesthesia	√	√
e. Breast reconstruction (non-cosmetic)	√	√
f. Blood transfusions	√	√
g. Hospice / respite care	√ respite limit 5 consecutive days / 30 days	√
4. Maternity and newborn care		
a. Pre- & postnatal care	√	√
b. Delivery & inpatient maternity services	√	√
c. Newborn child coverage	√	√
5. Mental health and substance use disorder services, including behavioral health treatment		
a. Inpatient hospital - mental/behavioral health	√ limit 45 days / yr for residential treatment	√
b. Outpatient hospital - mental/behavioral health	√	√
c. Inpatient hospital - chemical dependency	√	√
d. Outpatient hospital - chemical dependency	√	√
e. Detoxification	√	√
f. Counseling or training in connection with family, sexual, marital, or occupational issues	NC	NC

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan
Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
6. Prescription drugs		
a. Retail	√	√
b. Mail order	√	√
c. Generic	√	√
d. Brand	√	√
e. Specialty	√	√
f. Insulin/needles for diabetics	√	√
g. Tobacco cessation drugs	√	√
h. Contraceptives	√	√
i. Fertility drugs	NC	NC
j. Growth hormone therapy	√	√
7. Rehabilitative and habilitative services and devices		
a. Inpatient rehabilitation	√ limit 30 days / yr additional 30 days for head/spinal cord injury	√ No limits when in skilled nursing, IP hospital or IP rehab
b. Physical, speech & occupational therapy (outpatient)	√ limit 30 visits / yr additional 30 visits / condition for specified conditions	√ Covered no limits for 3 months After 3 month stabilization, 2 visits per year (PT/OT/ST) Change of status triggers an additional 6 visits/year for ST/OT/PT
c. Massage therapy	NC	√ as part of PT
d. Durable medical equipment	√ limit $5000 for non-essential DME	√ Per Administrative Rules
e. Prosthetics	√	√
f. Orthotics	√	√
g. Vision hardware	NC	NC for adults 21 and over Covered for ages 19 and 20
h. Hearing aids - adults	√ $4,000 every 48 months for certain people under age 25	√ 1 hearing aid every 5 years
i. Cochlear Implants	√	√
j. Skilled nursing	√ limit 60 days / yr	√
k. Home based habilitative services per state plan	Not covered	√
8. Laboratory services		
a. Lab tests, x-ray services, & pathology	√	√
b. Imaging / diagnostics (e.g., MRI, CT scan, PET scan)	√	√
c. Genetic testing	√ medically necessary	√ medically necessary

State of Oregon

Medicaid Essential Health Benefits (EHB) Benchmark Plan

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
9. Preventive and wellness services and chronic disease management		
a. Preventive care	√	√ (Per USPSTF Grade A&B recommendations and HRSA Women's Preventive Services)
b. Immunizations	√	√ (Per ACIP recommendations)
c. Colorectal cancer screening	√	√
d. Screening mammography	√	√ Per HRSA Required Health Plan Coverage
e. Routine eye exams (separate office visit)	NC	√ for 19 and 20 year olds NC for adults 21 and over
f. Routine hearing exams (separate office visit)	√ medically necessary	√
g. Nutritional counseling	√ limit 5 visits / lifetime	√
h. Diabetes education	√	√
i. Smoking cessation program	√	√
j. Allergy testing & injections	√	√
k. Diabetes - medically necessary equip. & supplies	√	√
l. Screening pap tests	√	√
m. Prostate cancer screening	√	√
n. Low protein food for inborn errors of metabolism	√	√
10. Pediatric services, including oral and vision care (19-20 year olds)		
a. Preventive care - physician services	√	√ (Per USPSTF Grade A&B recommendations and HRSA Women's Preventive Services)
b. Immunizations	√	√ (Per ACIP recommendations)
d. Routine eye exams (separate office visit)	NC	√ for 19 and 20 year olds NC for adults 21 and over
e. Routine hearing exams (separate office visit)	√ medically necessary	√
f. Hearing aids	√ limit $4000+CPI / 4 yrs	√
g. Dental - diagnostic & preventive	NC	√
h. Dental - basic	NC	√
i. Dental - major	NC	√

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan
Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
11 Non-EHB services		
a EPSDT	NC	√
b Services provided in a Rural Health Clinic	NC	√
c Services provided in a Federally Qualified Health Center	NC	√
d Dental (for 21 and over)	NC	Routine and basic are covered
e. Nursing facility services	NC	√
f. Targeted case management	NC	√
g. Clinic Services	√	√
h. non-emergency medical transportation	NC	√
i. Private duty nursing services	NC	√
j. Intermediate care services	NC	√
k. Extended services for pregnant women	NC	√
l. Personal care services	NC	√

† The nonfunded region of the Prioritized List of Health Services serves as the list of underlying exclusions for OHP Plus. The list also has associated guidelines that may limit certain covered services.
√ Covered benefit. Any limits on the benefit are noted (see also † pertaining to OHP coverage).
NC Not a covered benefit
* Except for Pediatric oral and vision benefits, which are from other plans as specified.
** Currently under review by DMAP