

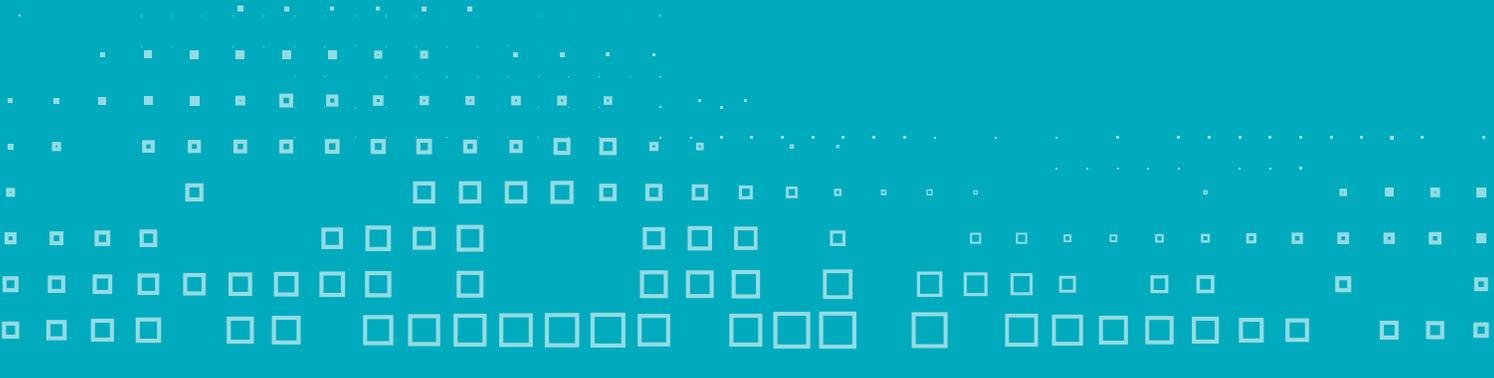
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Oregon Health Authority Public Option Implementation Report

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About Oregon Health Authority

The Oregon Health Authority is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. OHA is overseen by the nine-member citizen Oregon Health Policy Board working toward comprehensive health reform in our state.

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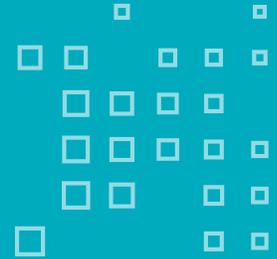


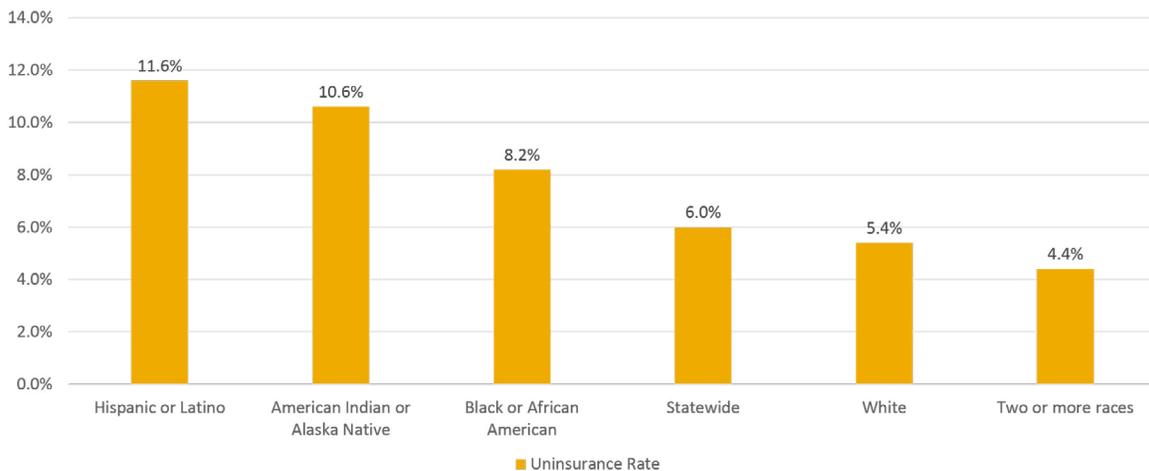
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Introduction

Oregon is committed to closing the remaining gap in health insurance coverage and doing so in a way that helps the State meet its goal of eliminating health inequities. According to the Oregon Health Insurance Survey, approximately 6% of the State’s population, or approximately 248,000 individuals, were uninsured in 2019.^{1,2} There are clear disparities in uninsurance rates by race and ethnicity in Oregon—while only 5.4% of white Oregonians were uninsured in 2019, the comparable numbers were 11.6% of the Hispanic or Latino population, 10.6% of American Indian or Alaska Natives, and 8.2% of Black or African Americans (see Figure I below).³

Figure I. Uninsurance Rates in Oregon by Race and Ethnicity (Combined), 2019



Source: Data from Oregon Health Insurance Survey (OHIS) Online Dashboard: The Uninsured. 2019 data. Available [here](#).

Additionally, Oregon continues to face sharply rising health care costs, with premiums and deductibles growing at rates that far exceed rates of growth in household income.⁴ Impacts of these rising health care costs affect all Oregonians but are especially challenging for the uninsured, who are twice as likely to report delaying care because of cost (35% of uninsured adults vs. 14% of insured adults).⁵ Because Oregon’s Hispanic, Latino, American Indian, Alaska Native, Black and African American populations are far more likely to be uninsured compared to the State’s white population, the rising cost burden of health care in Oregon—

¹ “Oregon Health Insurance Survey (OHIS), Early Release Results, 2019,” Oregon Health Authority (OHA). Available here: <https://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2019-OHIS-Early-Release-Results.pdf>.

² Early estimates from the 2020 Household Pulse Survey indicate the uninsured rate in Oregon may have risen to around 8.3% in 2020. 2020 OHIS data on Oregon’s uninsured rate in 2020 is not yet released. Early estimates are from “Data Brief: COVID-19 and Changes to Oregon Residents’ Health Insurance Coverage, January 2021,” Oregon Health Authority (OHA). Available here: <https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Coverage-stats-Jan2021-1-26-21-final.pdf>.

³ OHIS 2019 Data, by Types of Uninsurance. Available here: <https://visual-data.dhs.ohio.state.or.us/t/OHA/views/OregonUninsuranceRates/Uninsurance?%3Aiid=2&%3AisGuestRedirectFromVizportal=y&%3Aembed=y>

⁴ “The Burden of Health Care Costs for Working Families,” Penn LDI, April 2019. Available here: https://ldi.upenn.edu/wp-content/uploads/archive/Penn%20LDI%20and%20US%20of%20Care%20Cost%20Burden%20Summary_Final.pdf.

⁵ Health Equity and Cost Containment, Oregon Health Policy Board (OHPB). October 6, 2020. Available here: https://www.oregon.gov/oha/OHPB/MtgDocs/5.%20Health%20Equity%20and%20Cost%20Containment_updated.pdf.

and consequentially, the negative impacts on health care access—is not borne by all Oregonians equally and exacerbates existing health inequities. These inequities demand that advancing health equity must be the overarching goal across all efforts to effectively address the remaining uninsured in Oregon.

Legislative Direction for the Public Option

Oregon is considering a public option⁶ to increase the availability of affordable and comprehensive health insurance coverage for individuals with incomes above Medicaid eligibility levels pursuant to HB 2010, which Governor Kate Brown signed into law in July 2021. This bill charges the Oregon Health Authority (OHA), in collaboration with the Department of Consumer and Business Services (DCBS), with creating an Implementation Report for a public option that would be made available to those in the individual market and would seek to address rising health care costs in Oregon in an equitable way.⁷

Coordinated Care Model Is the Aspiration for the Public Option. The first critical decision in designing the public option was to select a starting point for the State’s implementation planning—in other words, the model with the most features that the State desires for the public option to reflect. The initial model shapes expectations and sets defaults on a range of issues upon which the State can continue to build. Importantly, the starting model does **not** dictate which entities would offer the coverage or define what role each regulator would play.

A previous Manatt study conducted for OHA outlined three potential public option models for the State’s consideration:⁸

- A Coordinated Care Model, in which the State would seek to mirror in a public option product features currently found in coordinated care organizations (CCOs) that currently provide Medicaid benefits;
- A carrier-based model, in which the State public option would draw from features currently offered by carriers in the Oregon Health Insurance Marketplace; and
- A State-run model in partnership with a third-party administrator (TPA), in which the State would design its own plan and hold the plan risk as the insurer and use a TPA to support claims processing and plan administration/implementation.

In evaluating the three potential public option models, a Coordinated Care Model emerged as being the best positioned to enable the State to begin designing a plan that can achieve the State’s five most important goals for the public option:

1. Advance health equity;
2. Improve affordability;
3. Maximize federal support, including federal tax credits and federal “pass-through” funding;
4. Reduce churn, and where that is not feasible, streamline coverage transitions; and

⁶ For the purposes of this report, “public option” refers to the “public health plan” as cited in HB 2010.

⁷ This Implementation Report does not address the small group market. As of this writing, no state has explored a public option for that market because market conditions are substantially different.

⁸ The three models selected for analysis were identified and refined based on preliminary recommendations from the Universal Access to Care (UAC) Workgroup and conversations within the OHA and were informed by models being pursued in other states at the time of analysis..

5. Find an optimal balance between enabling state control and minimizing risk to the State.

Manatt, working with OHA and DCBS, then drafted a Recommendation Memo endorsing a Coordinated Care Model as the starting point for building the public option. Starting with a Coordinated Care Model and aiming to incorporate many CCO-like features into a Marketplace product offered by licensed insurers affords a degree of flexibility for the State to further determine specific design parameters that best meet the needs of the remaining uninsured, while also advancing the State's health insurance affordability and cost containment goals. Further analysis can be found in the Recommendation Memo.

Following development of the Recommendation Memo, Manatt and OHA then convened three working sessions with stakeholders from OHA, including the Marketplace and DCBS, to further discuss key public option design parameters in detail and address specific implementation questions identified in HB 2010. These working sessions informed the development of the public option recommendations outlined in this Implementation Report.

HB 2010 specifically requires the Implementation Report to provide recommendations for ten specified public option design and implementation parameters:

6. The operating structure and governance of the public option, including which agency will administer the plan and how a delivery system will be procured;
7. How the State can leverage existing state-backed plans or networks, such as coordinated care organizations and plans offered by the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB), to offer a more affordable option;
8. Plan design options to reduce out-of-pocket costs for individuals in order to reduce barriers to care at the point of service;
9. How the plan can further the State goals of health system transformation, including but not limited to using value-based payment and global budgets, eliminating health disparities, aligning quality and access metrics, and meeting the State's Cost Growth Target;
10. Cost containment options and opportunities for the State to leverage purchasing power to ensure program affordability and ensure that per capita costs stay within the Cost Growth Target;
11. Plan and program design options aligned with the State's goal of eliminating health inequities in the next ten years;
12. Other structural and program changes the State could make to ensure successful implementation of any plans developed, including how a State-based technology platform could further the implementation and accessibility of a public option;
13. Enrollment infrastructure that may be needed by coordinated care organizations, if coordinated care organizations are the recommended delivery system, to enroll members in a separate program;
14. Outreach infrastructure and investments that would support educating people in this State, particularly communities of color and populations with above-average uninsured rates, about available options for subsidized coverage and newly available options under the American Rescue Plan Act (ARPA), and support increasing enrollment of eligible individuals in existing programs that provide affordable coverage; and
15. Statutory changes needed to implement the recommendations.⁹

⁹ A full list of HB 2010's specified issues for which OHA must provide a recommendation is provided in [Appendix II](#).

Recommendations for Oregon's Public Option

A Public Option for Oregon. OHA and DCBS seek to develop an affordable, comprehensive, on-Marketplace public option that has low cost-sharing and robust benefits, and that advances many of the State's broader health equity and cost containment goals. Recognizing that there may ultimately be tradeoffs between certain plan features and/or further priority setting needed in order for the State to move forward with implementation, OHA and DCBS envision a public option that:

- Is offered on-Marketplace¹⁰ and available to everyone who is eligible to purchase health insurance on the Marketplace;¹¹
- Offers low cost-sharing, ideally between 94% and 98% actuarial value (AV),¹² to address the needs of the target population;
- Offers comprehensive benefits, including all Essential Health Benefits (EHBs)¹³ and, if possible, dental coverage;
- Maximizes continuity of care across Medicaid and the Marketplace by aligning provider networks as much as possible;
- Is regulated by both OHA and DCBS, with OHA oversight over plan design, DCBS oversight over licensure, and coordinated oversight over other state and federal requirements for ACA-compliant health plans in the individual market;
- Is aligned with statewide efforts to advance health equity, by incorporating health equity principles and requirements into the public option's benefits, provider networks, and plan operating and governance structures;
- Is aligned with statewide efforts to contain costs without compromising on quality or access, by incorporating statewide value-based payment (VBP) targets and using the State's aligned set of quality and access measures, particularly measures around health equity; and

¹⁰ Groups of people purchasing health insurance together are called risk pools. The State can decide whether to offer the public option outside or inside the existing individual insurance market risk pool, and whether to place an individual market plan on the Oregon Health Insurance Marketplace. A plan offered "on-Marketplace" would be a plan that is within the individual market risk pool, is required to meet ACA requirements, is eligible for placement on the online Marketplace and is eligible to receive federal advanced premium tax credits. Source: <https://www.oregon.gov/oha/HPA/HP/docs/Manatt-Health-Oregon-Public-Option-Report-An-Evaluation-of-Proposed-Delivery-Models-December-16-2020.pdf>.

¹¹ To be eligible to enroll in health insurance coverage through the Marketplace, individuals must live in the United States; must be a U.S. citizen or national, or be lawfully present; and cannot be incarcerated. Additionally, under the ACA, individuals may also be eligible for advance premium tax credits (APTCs) if their income for the year is between 100% and 400% of the federal poverty level; they are not claimed as a dependent by another person; they are enrolled in coverage through a health Exchange and are not offered "affordable" coverage through an eligible employer-sponsored plan that provides minimum value; they are not eligible for coverage through a public program such as Medicaid, Medicare, CHIP or TRICARE; and they do not file a married-filing-separate tax return (with exceptions). Source: <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/APTC%20and%20CSRs%20Basics.pdf>.

¹² A health insurance plan's actuarial value (AV) is the percentage of total average costs for the covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, the beneficiary would be responsible for 30% of the costs of all covered benefits. However, the actual cost-sharing paid by each beneficiary will depend on their individual use of health care services, which typically will be a higher or lower percentage of the total costs than the average amount. Source: <https://www.healthcare.gov/glossary/actuarial-value/>.

¹³ Under the ACA, there is a set of ten categories of services health insurance plans must cover called the Essential Health Benefits. Source: <https://www.healthcare.gov/glossary/essential-health-benefits/>.

- Improves affordability through premium reductions that generate pass-through savings under a 1332 waiver and reset rates to subsequently hold the public option accountable to the statewide Cost Growth Target of 3.4%.

While the State’s goal is to develop an affordable, comprehensive public option that supports advancement of the State’s health equity and cost containment goals, certain features, such as ensuring low cost-sharing and comprehensive benefits, will require additional State dollars. Without additional State funds, the State may be unable to develop a plan that includes all of the above features without significantly compromising premium affordability or other core features of the public option. The State may also require statutory changes and a state-based marketplace (SBM)¹⁴ to implement certain features of the public option, depending on the plan’s ultimate design. Both the plan design considerations and potential funding sources are discussed in further detail below.

Aligning State Efforts to Advance Health Equity Across All Markets

The State is pursuing a multifaceted strategy to eliminate health inequities in Oregon, and the public option can be a key component of achieving that goal by implementing an affordable and equitable coverage option that can effectively close the remaining coverage gap.

Oregon has a bold vision for eliminating health inequities. As a central priority for the State, OHA has adopted the strategic goal of ending health inequities in Oregon by 2030. Specifically, as defined by the State’s Health Equity Committee (HEC), Oregon will have established a health system that creates health equity when “all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.”¹⁵

¹⁴ Under the ACA, states are provided the option to either use the federal Marketplace platform or to establish their own state-based marketplace. Today, there are three types of Marketplace models: (1) the federally facilitated marketplace, or FFM, in which the federal government is responsible for all core functions; (2) a state-based marketplace on the federal platform (SBM-FP), in which the State relies on the federal eligibility and enrollment platform for certain functions but maintains responsibility for other core functions; and (3) the SBM, in which the State operates all Marketplace functions, but the State may still use federal government services and data for operational activities. Oregon is currently an SBM-FP.

¹⁵ “Health Equity Definition,” Health Equity Committee, Oregon Health Authority and Oregon Office of Equity and Inclusion. N.d. Available here: https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition_October%202019%20HEC%20Presentation%20to%20OHPB.pdf.

Oregon Health Equity Committee's Framework for Health Equity

Oregon recognizes that achieving health equity requires the ongoing collaboration of all regions and sectors of the State, including tribal governments, to address the equitable distribution or redistribution of resources and power and to recognize, reconcile and rectify historical and contemporary injustices. To achieve this, the State has articulated a framework for identifying and implementing effective solutions to advance health equity, including recognizing the role of historical and contemporary oppression and structural barriers facing Oregon communities; engaging a range of partners representing diverse constituencies and perspectives; and directly involving affected communities as partners and leaders in change efforts.¹⁶

In recent years Oregon has taken several steps to address health inequities. Oregon has launched Cover All Kids (2017) and Cover All People (2021)¹⁷ to provide insurance coverage for individuals ineligible for Medicaid due to immigration status, and the State is streamlining its Medicaid enrollment processes to reduce barriers for Medicaid-eligible individuals. Additionally, the State established the HEC to support the development of policies that promote the elimination of health disparities and advance health equity for all people in Oregon.

At its fullest, this vision encompasses alignment on health equity across the entire health care market. The public option, then, would be just one of several products subject to these health equity initiatives. Achieving such an ambitious vision will necessarily take time, and the State may choose to adapt these requirements for the public option ahead of some or all other insurance products.

To achieve full alignment with the State's priorities in addressing health equity across all design parameters addressed in this Implementation Report, it is recommended that the State:

Expand health equity principles and requirements within the Medicaid Coordinated Care Model to all regulated insurance products in Oregon, including those within the PEBB and the OEPP, the Marketplace, and the public option. Achieving health equity is a core value of the State and is not limited to one set of programs. Where programs in Oregon demonstrate significant advancements in establishing principles and requirements that support the State's goal of eliminating health inequities by 2030, they should be expanded across all regulated insurance products in Oregon as expeditiously as possible, recognizing that the State may choose to apply health equity principles to the public option on a faster timeline than for other products.

The Coordinated Care Model is the aspiration for the public option because it incorporates requirements for a centralized, community-based governance structure that consistently prioritizes health equity within its service planning and delivery. For example, the State's Medicaid Coordinated Care Model articulates specific requirements for CCOs to demonstrate a commitment to advancing health equity. CCOs are expected to develop and annually update a Health Equity Plan, which outlines a framework for becoming an equity-

¹⁶ "Health Equity Definition," Health Equity Committee, Oregon Health Authority and Oregon Office of Equity and Inclusion. N.d. Available here: https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition_October%202019%20HEC%20Presentation%20to%20OHPB.pdf.

¹⁷ In 2017, Oregon passed **SB 558**, which significantly expanded eligibility for the State's Medicaid program (Oregon Health Plan) to include all kids under the age of 19, regardless of immigration status if they meet income and other criteria. Similarly, in 2021, Oregon passed **HB 3352**, which extends health care coverage to additional populations, including undocumented adults, Deferred Action for Childhood Arrivals recipients, legal permanent residents and young adults who age out of Cover All Kids.

focused organization that advances the specified health equity principles defined by the State. CCOs were also required to demonstrate plans for engaging Medicaid members, community partners, tribal liaisons and others in advancing social determinants of health (SDOH) spending. Additionally, the State has created mechanisms for CCOs to invest in health-related services, SDOH, and health equity to improve outcomes and reduce avoidable costs.

To the extent possible, all regulated insurance products in Oregon—including the public option—should be designed with similar principles and requirements in mind, as well as subject to the same (or similar) health equity standards that CCOs are currently measured against to ensure alignment across markets.

Align quality and access measures across markets. As part of its commitment to advancing health equity and ensuring health care quality at the State level, Oregon has long sought to better align and streamline regulatory standards across markets. For example, since 2015, Oregon has pursued a long-term, statewide vision of developing a set of aligned health outcome, quality and equity measures that may be applied across services provided by CCOs, Marketplace plans, and/or PEBB and OEBC. As of May 2021, the State’s “Aligned Measures Menu” includes 57 health care quality measures that span six domains of health care services: prevention/early detection; chronic disease and special health needs; acute, episodic and procedural care; system integration and transformation; patient access and experience; and cost/efficiency. The State continues to develop new health equity measures that may be applied across markets.¹⁸ The State should seek alignment across markets where feasible, especially as to equity measures, but also take into account other federal reporting requirements, such as quality reporting by Marketplace carriers.

Ensure the public option is accompanied with robust outreach, education and marketing efforts. Central to Oregon’s goal of eliminating health inequities by 2030 is a committed effort to advancing outreach and engagement with communities of color and populations with above-average uninsured rates. For example, nearly 9 in 10 uninsured Hispanic or Latino Oregonians born in the U.S. were eligible for the Oregon Health Plan (OHP) or financial assistance in 2019.¹⁹ The public option should be accompanied by robust outreach, education and marketing efforts that are culturally and linguistically appropriate to inform these communities and populations of the available options for affordable coverage—in particular, outreach and marketing efforts to emphasize availability of new coverage initiatives that provide additional opportunities for subsidized coverage and new coverage options under the ARPA, which may address the barriers faced by individuals who are eligible for coverage options in Oregon yet remain uninsured. Outreach efforts should also continue to support the enrollment of eligible individuals into existing programs that provide affordable coverage, such as OHP. The State could also incorporate requirements for the public option to affirmatively reach out to individuals being disenrolled from Medicaid to connect them with resources to either re-enroll in OHP or enroll in individual market coverage, potentially through the public option.

¹⁸ Oregon Health Plan Metrics Committee, Aligned Measure Menu Set. Reflects Committee decisions through May 25, 2021. Available here: <https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/Aligned-Measures-Menu.pdf>.

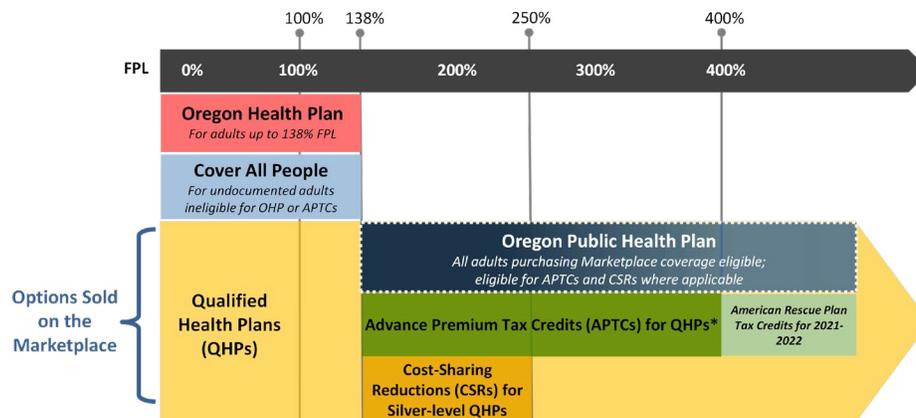
¹⁹ Oregon Health Insurance Survey (OHIS) 2019 Data, by Eligibility for OHP or Exchange Subsidy Among the Uninsured. Available here: <https://visualdata.dhsosha.state.or.us/t/OHA/views/OregonUninsuranceRates/Eligibility?%3Aiid=2&%3AisGuestRedirectFromVizportal=y&%3Aembed=y>.

Affordable and Comprehensive Coverage

Health care affordability and access remain critical issues for the public option to address, as health care costs in Oregon are projected to continue growing faster than both the State’s economy and Oregonians’ wages.²⁰ In 2019, 9.3% of Oregonians reported having high out-of-pocket health care costs relative to their annual income,²¹ and 19% of uninsured Oregonians reported having to use their savings to be able to pay off medical bills.²² Neither premiums nor cost-sharing should be a barrier to having and using coverage. The State, however, must balance affordability of cost-sharing and premiums with ensuring that the public option covers a robust set of benefits. The State is also looking to the public option to advance ongoing, statewide efforts to contain rising health care costs in a way that preserves health care quality, access and outcomes for all Oregonians.

Meeting the needs of the target population. Oregon is specifically seeking to create an affordable and comprehensive coverage option designed to be attractive to individuals above Medicaid eligibility levels—namely, individuals with incomes from 138% up to roughly 250% of the federal poverty level (FPL). While individuals with incomes just above Medicaid eligibility levels are provided federal cost-sharing reductions (CSRs), plus additional temporary premium subsidies that improve affordability under the ARPA, this population continues to face significant levels of cost-sharing that are barriers to accessing health care. Any Marketplace-eligible individuals would be permitted to enroll in the public option, regardless of income level, but the design and marketing of the plan would focus on the population with incomes just above Medicaid eligibility levels.

Figure II. The Oregon Public Option Within the Adult Coverage Continuum



* Lawfully present individuals not eligible for Medicaid due to immigration status may qualify for APTCs below 138% FPL.

²⁰ From 2013 to 2017, per-person health care spending in Oregon was growing at a rate of 6.5%, while Medical and Urban Consumer Price Indices (CPIs) grew at much slower rates year over year. Source: “The Oregon Health Care Landscape: how we got here and where we are going,” Oregon Health Authority. Presentation for the Task Force on Universal Health Care, August 21, 2020. Slide 20. Available here: <https://olis.oregonlegislature.gov/liz/201911/Downloads/CommitteeMeetingDocument/225798>.

²¹ “Health Equity and Cost Containment,” Oregon Health Policy Board. October 6, 2020. Available here: https://www.oregon.gov/oha/OHPB/MtgDocs/5.%20Health%20Equity%20and%20Cost%20Containment_updated.pdf.

²² “Cost Growth Target Program Updates,” Oregon Health Policy Board, June 2021. Available here: <https://www.oregon.gov/oha/OHPB/MtgDocs/4.0%20Cost%20Growth%20Target%20Program%20Updates.pdf>.

Enhancing premium affordability. A key component of ensuring coverage affordability is ensuring affordable health care costs and managing the rates of cost growth over time. Since 2012, Oregon has maintained a Cost Growth Target of 3.4% within its Medicaid program, and in 2017, the State extended its Cost Growth Target to the PEBB/OEBB programs. In 2019, the State expanded the statewide Cost Growth Target program to all health care spending through the passage of SB 889, which requires all payers and providers in the State be held accountable to the Cost Growth Target of 3.4%.²³ To ensure long-term affordability of the public option and to continue to advance the State’s efforts to advance cost containment, the State should first commit to a rate reset, followed by the public option’s continued adherence to the State’s Cost Growth Target of 3.4%.

The rate reset, which is necessary to adjust for excess cost growth in the past,²⁴ would require the State’s statutory commitment to achieving premium reduction targets, with rate-setting authority and mandatory participation requirements incorporated as necessary accountability measures to ensure the targets are met. Oregon has previously capped certain hospital payments for PEBB/OEBB programs as part of its broader affordability and cost containment goals.²⁵

Beyond this initial premium reset, Oregon should seek to demonstrate continued adherence to the statewide Cost Growth Target of 3.4% as an additional means of ensuring the program remains affordable in the long term, especially given that the Cost Growth Target is well below Oregon’s historic growth rate of 6.5% across all markets.²⁶ While federal ARPA subsidies substantially improve the premium affordability of plans offered on the individual market today, the State must have a mechanism for ensuring continued premium affordability of the public option beyond the expiration of federal ARPA subsidies, which are currently slated to continue only through 2022.

In addition to ensuring long-term affordability, legislatively mandated premium reductions followed by adherence to the State’s Cost Growth Target would also provide the State with a mechanism for generating pass-through savings under a 1332 waiver, to the extent those established premium reductions and the Cost Growth Target are met by the State and reduce federal costs. Those savings could then be reinvested by the State to provide additional benefits or reduce cost-sharing for the public option, as discussed below.

Addressing cost-sharing. In 2019, 45% of Oregon Marketplace enrollees enrolled in bronze plans. These plans feature very high levels of cost-sharing; deductibles and out-of-pocket maximum limits for most bronze plans in Oregon are \$8,700.^{27, 28} While primary care physician (PCP) and specialist visits are not subject to the deductible in most bronze plans, PCP visits commonly carry a \$50 co-pay and specialists a \$100 co-pay—a significant expense for many. Individuals with incomes below 150% of the FPL are eligible for lower cost-

²³ See Oregon Revised Statutes (ORS) 442.385 and 442.386. The remainder of SB 889 is reprinted following ORS 442.386.

²⁴ Oregon hospital payment reports illustrate the wide range of pricing variability year over year for specific services. For example, from 2018 to 2019, the cost of a CT scan of the abdomen with contrast demonstrated a 29% increase in median payments statewide; the median payment for a heart catheterization increased by 20.7%; and the median payment for a drug assay increased by 47.6%. More examples and the full data dashboard are available here: https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHospitalPaymentReport2019/Welcome?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link#1.

²⁵ Since 2017, under ORS 243.256 and 243.879, Oregon OEBB and PEBB health benefit plan claims payments for inpatient and outpatient hospital services are capped, with payment for in-network hospital services limited to 200% of Medicare rates and payments to out-of-network hospitals limited to 185% of Medicare rates.

²⁶ From 2010–2017, per-person health care costs in Oregon grew at a rate of 6.5% annually. Source: <https://olis.oregonlegislature.gov/liz/201911/Downloads/CommitteeMeetingDocument/225798>.

²⁷ “State Health Facts, Marketplace Plan Selections by Metal Level,” Kaiser Family Foundation (KFF). Available here: <https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-metal-level>.

²⁸ 2022 Marketplace QHP Benefit data provided by Oregon Health Insurance Marketplace.

sharing in the 94% actuarial value (AV) silver plan that most commonly features a \$100 deductible, a \$10 co-pay for PCP visits and a \$20 co-pay for specialist visits. This is in contrast to plans offered by CCOs under Oregon’s Medicaid program, which offer comprehensive benefits, no premiums and no cost-sharing (i.e., 100% AV). However, there are challenges in using Medicaid-like cost-sharing for a Marketplace product, as the ACA relies on higher cost-sharing to keep premiums affordable.²⁹

Recognizing that while OHA and DCBS remain committed to developing a public option with low cost-sharing (ideally, a plan with a 94–98% AV), reducing current cost-sharing would require additional state funds. Accordingly, the State may be limited in the degree to which it will be able to bring down cost-sharing levels for the public option, depending on whether the State pursues and gains approval for a 1332 waiver, and the degree to which federal savings are ultimately achieved under the waiver.

Ensuring comprehensive benefits. To ensure affordability and preserve access to premium tax credits for a public option offered on the Marketplace, the public option’s benefits must comply with Oregon’s EHB requirements. For equity and other reasons, the public option should also offer limited³⁰ pediatric and adult dental benefits, if possible, and should be aligned with State initiatives to improve coverage and access to primary care and behavioral health services, including more favorable cost-sharing for such services.

Oregon’s current EHB benchmark plan provides a solid starting point for the public option benefit package. The benchmark plan includes recently enhanced coverage of treatments for substance use disorders (SUDs) and greater access to non-opioid pain treatments³¹ as part of the ten categories of essential health benefits required of all Marketplace plans: ambulatory patient services; emergency services; hospitalization; laboratory services; mental health and SUD services; pediatric services (including oral and vision care); pregnancy, maternity and newborn care; prescription drugs; preventive/wellness services and chronic disease management; and rehabilitative and habilitative services and devices.³²

Marketplace coverage of dental benefits is more limited than in Medicaid. Adult dental is not a covered benefit under the EHB, and individuals can only obtain dental coverage either as part of a health plan that offers the additional dental benefit, or by itself through a separate, stand-alone dental plan. In either case, adults must pay a separate premium that is not eligible for premium tax credits. Pediatric dental benefits must be offered in the Marketplace either as part of the qualified health plan (QHP) or as a stand-alone dental plan, but individuals do not have to purchase that additional coverage. Under Oregon’s Medicaid program, dental coverage is a benefit covered under its Alternative Benefit Plan (ABP), and the program provides coverage for a range of dental services, including basic dental services such as cleaning, fluoride varnish, fillings and extractions; dentures;³³ certain types of crowns/sealants; and root canals (some services are

²⁹ Currently, the ACA offers plans at varying “metal tiers”: platinum, gold, silver and bronze plans, which carry a 90%, 80%, 70% and 60% AV, respectively. The ACA also provides additional cost-sharing reductions that offer silver plan variations for eligible populations at the 94%, 87% and 73% AV levels (e.g., individuals earning up to 150% FPL, between 151–200% FPL, or 201–250% FPL respectively).

³⁰ The intended benefit package would include preventive and restorative treatment but not orthodontia.

³¹ Oregon revised its EHB package to enhance SUD benefits following CMS’ 2019 Notice of Benefit and Payment Parameters (NBPP) rule permitting states more flexibility in developing their state-mandated benchmark plan. The approval letter is available here: <https://www.cms.gov/files/document/82820-or-ehb.pdf>. More information on Oregon’s Essential Health Benefits rulemaking is available here: <https://dfr.oregon.gov/help/committees-workgroups/Pages/EHB-rulemaking-committee.aspx>.

³² “What Marketplace health insurance plans cover,” HealthCare.gov. Available here: <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>.

³³ Prior authorization is required, and services are limited to one every five years for partial dentures, and one every ten years for full dentures, with exceptions for medical necessity. Source: Oregon Medicaid Alternative Benefit Plan.

limited to pregnant women and children under age 21). Given that 2019 survey data indicates Oregonians are more likely to report delaying dental care due to cost, compared to other services such as routine medical care or filling a prescription,³⁴ unless cost is prohibitive, the public option should include adult and pediatric dental services roughly comparable to the Medicaid benefit package as a covered benefit to ensure a robust and comprehensive benefits package that is equitable and meets the needs of many Oregonians.

However, because adult dental care remains a benefit category that is not included as one of the ten EHBs for which the ACA provides premium tax credits, should the State include dental benefits in the public option, the State would be responsible for paying any associated additional premium cost as a result of that benefit being included.³⁵ Accordingly, the State may be limited in the degree to which it will be able to offer a dental care benefit under the public option, depending on the availability of state funds or whether the State pursues and gains approval for a 1332 waiver, and the degree to which federal savings are ultimately achieved under the waiver to fund the additional benefit.

Pursuing a 1332 waiver to fund either cost-sharing subsidies or additional dental benefits. Offering additional benefits and/or lowering cost-sharing will require new sources of State funding. As discussed above, the State should commit to legislatively mandated premium reductions followed by adherence to the State's Cost Growth Target in order to provide the State with a mechanism for generating pass-through savings under a 1332 waiver, to the extent those established premium reductions and the Cost Growth Target are met by the State and reduce federal costs. In 2021, Colorado submitted a 1332 waiver amendment request to the Centers for Medicare & Medicaid Services (CMS) that proposes a similar strategy for achieving federal savings that would be directed toward new state subsidies (see callout box below). In particular, Colorado's waiver proposal, if approved, includes the State's statutory commitments to premium reductions of 5%, 10% and 15%, with accountability measures in place to ensure these premium reductions are met.

Colorado also chose to keep its existing reinsurance waiver in place and proposed to incorporate the new waiver proposal as an amendment, a strategy that Oregon could similarly pursue. This combined approach enhances state flexibility by providing two potential revenue streams from federal savings that can be reinvested as the State chooses, to enhance future federal savings, increase state subsidies or pursue other state priorities for improving the Marketplace.

Colorado's waiver amendment request is still under review by CMS. Should Colorado's request be approved, it would be the first 1332 waiver beyond a state reinsurance program to be approved by CMS, signaling the agency's openness to new waivers relating to a public option.³⁶ In pursuing this pathway for additional State funding, it would be imperative that Oregon communicate early and often with the Center for Consumer Information and Insurance Oversight (CCIIO) about the State's 1332 waiver plans.

³⁴ "Cost Growth Target Program Updates," Oregon Health Policy Board, June 2021. Available here: <https://www.oregon.gov/oha/OHPB/MtgDocs/4.0%20Cost%20Growth%20Target%20Program%20Updates.pdf>.

³⁵ Under the ACA, premium tax credits cannot be applied to the portion of an individual's premium attributable to covered benefits that are not essential health benefits (EHB). If the public option included benefits that are not included in the definition of EHB, the portion of the premium attributable to that benefit would not be applicable for financial assistance. Source: 42 U.S. Code § 18031 - Affordable choices of health benefit plans. Available here: <https://www.law.cornell.edu/uscode/text/42/18031>

³⁶ As of November 2021, CMS has not approved any 1332 waivers beyond 15 state reinsurance waivers (including one for Oregon) and an employer mandate waiver for Hawaii. The Trump Administration approved a reinsurance waiver for Georgia in 2020 that included a second phase in which Healthcare.gov was to be replaced by private enrollment channels in 2023, but that second phase is under reconsideration by the Biden Administration.

Recap: Colorado's Proposed 1332 Waiver Amendment Request

Colorado's current 1332 waiver funds the State's reinsurance program, which has reduced premiums by 20% and generated pass-through savings that fund a portion of the reinsurance program. Under Colorado's recent proposal, the State would amend its 1332 waiver to also implement the Colorado Option, which includes premium reductions of 5%, 10% and 15% from 2023–2025; standardized plan designs; and state subsidies. Starting in 2026, the annual percentage increase in the premium rate for the standardized plan in both the individual and small group markets will be capped at the rate of medical inflation, relative to the previous year. The pass-through funding obtained from the State's statutorily mandated premium reductions would fund state-based subsidies for advance premium tax credit (APTC)-eligible Coloradans, beginning with enhanced CSRs for individuals with an income of 151–200% of the FPL, as well as subsidies for Coloradans not eligible for APTCs under the ACA (e.g., family glitch³⁷ and undocumented populations). Under the waiver amendment request, initial pass-through estimates would start small (\$12 million in 2023) but grow over time as premium reductions increase under the Colorado Option (the proposal estimates \$122 million in pass-through funding by 2025, and \$137 million by 2027).

Quantifying the Options: Preliminary High-Level Analysis

Manatt worked with actuaries to generate a preliminary, high-level quantitative analysis of key elements of the Oregon proposal. Key findings from that analysis include:

- **Baseline assumptions.** Based on available Oregon individual market enrollment data for 2020 and 2021,³⁸ and assuming ARPA subsidies are extended through 2023,³⁹ the individual market enrollment is projected to grow by 9% from 2021 to 2023 because of ARPA subsidies, including a 20% gain in Marketplace enrollment and a reduction in off-Marketplace enrollment.
- **Adding state-financed cost-sharing subsidies.** State-financed cost-sharing subsidies are projected to cost from \$11.7 to \$31.7 million in 2023, depending on the how large the targeted reductions are and who is eligible to receive them; these state-financed cost-sharing subsidies could potentially drive 2–3% of additional enrollment growth in 2023, and could also result in up to 6,000 enrollees changing plans to reduce their cost-sharing obligations.

³⁷ Under the ACA, employees who are offered "affordable" employer-sponsored coverage options cannot receive premium assistance for plans purchased on the individual market. Employer-sponsored coverage is deemed "affordable" if the employee's share of the premium does not exceed 9.83% of the employee's household income. However, the IRS has determined that even if coverage for the employee's entire family (e.g., coverage for themselves and all their dependents) costs more than 9.83% of household income, the employee's entire family is not eligible for premium assistance on the individual market as long as the "self-only" coverage for the employee does not exceed this amount. This is known as the "family glitch" and is currently under review by the IRS. Source: <https://www.commonwealthfund.org/blog/2021/eliminating-family-glitch>.

³⁸ 2021 enrollment is estimated based on publicly available year-to-date enrollment summaries.

³⁹ Actuarial estimates above did not examine a scenario in which ARPA subsidies are not extended through 2023. If ARPA subsidies expire at the end of 2022, as current law requires, there would be consequences for the individual market that are beyond the scope of this report. For example, a September 2021 KFF report highlighted that if ARPA premium subsidies expire at the end of 2022, premium payments could increase for approximately 8 million marketplace enrollees, and 3.7 million middle-income individuals who gained premium subsidy eligibility under ARPA would not be eligible for any subsidy in 2023. Source: <https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/>.

- Under a 94% CSR Wrap Scenario, in which Marketplace enrollees with incomes in the 151–200% of FPL range who choose silver plans would receive an additional cost-sharing subsidy that would increase the AV of the plan from 87% to 94%, the cost of these increased subsidies is projected to range from \$11.7 to \$14.3 million in 2023, with an overall enrollment gain of 4,000 lives, or roughly 2%. Another 3,000 lives currently on bronze plans with a 60% AV are projected to substantially reduce their potential cost-sharing burdens by shifting to the new silver plans with a 94% AV.
- Under a 98% CSR Wrap Scenario, in which Marketplace enrollees with incomes in the 138–200% of FPL range who choose silver plans would receive an additional cost-sharing subsidy that would increase the AV of the plan from 94% to 98% for Marketplace enrollees in the 138–150% of FPL range and from 87% to 98% for those in the 151–200% of FPL range, the cost of these increased subsidies is projected to range from \$25.9 to \$31.7 million in 2023, with an overall enrollment gain of 6,000 lives, or roughly 3%. Another 6,000 lives currently on bronze plans with a 60% AV are projected to substantially reduce their potential cost-sharing burdens by shifting to the new silver plans with a 98% AV.
- **Adding state-financed adult dental coverage.** Adding state-financed adult dental coverage to the ACA benefit package is projected to cost from \$36.3 to \$78.5 million in 2023, depending on the level of coverage offered.
 - The cost of adding “basic” dental coverage as a fully subsidized benefit is estimated to range from \$36.3 to \$44.4 million. Basic dental coverage was defined as routine and basic benefits only (e.g., cleanings, fluoride treatment, fillings).
 - The cost of adding “major” dental coverage as a fully subsidized benefit is estimated to range from \$64.2 to \$78.5 million. Major dental coverage was defined as routine, basic and major benefits (e.g., routine and basic benefits plus crowns, bridges and periodontal surgery).
- **Generating pass-through funding through premium reductions.** Premium reductions driven by the implementation of an Oregon public option could generate incremental pass-through savings to pay for some or all of the state support options modeled, with projected pass-through savings ranging from \$32.8 million (5% premium reduction) to \$111.5 million (15% premium reduction) in 2023. The projections assume that each insurer would offer only one Marketplace silver plan with the specified premium reductions, and the results reflect the average projected impact that the public option plans would have on the benchmark plan. If the Oregon public option is successful in achieving a 15% premium reduction, it could potentially fully cover the costs of both major dental coverage for adults (\$78.5 million) and the near elimination of cost-sharing obligations (98% AV plan at a cost of \$31.7 million) for Marketplace enrollees up to 200% of the FPL who choose silver plans. Figure III also shows how other combinations of new subsidies and premium reductions could be incorporated into the public option.

Figure III: Summary of the Projected 2023 Results (excluding excess funding of reinsurance)

2023 Projections (in Millions)	Best Estimate	Low Estimate	High Estimate
State Cost of 94% CSR Wrap	\$13.0	\$11.7	\$14.3
State Cost of 98% CSR Wrap	\$28.8	\$25.9	\$31.7
State Cost of Adult Dental Coverage – Basic	\$40.3	\$36.3	\$44.4
State Cost of Adult Dental Coverage – Major	\$71.3	\$64.2	\$78.5
Add'l Federal Pass-Through Funding - 5% Public Option	\$38.6	\$32.8	\$44.4
Add'l Federal Pass-Through Funding - 10% Public Option	\$64.4	\$54.8	\$74.1
Add'l Federal Pass-Through Funding - 15% Public Option	\$97.0	\$82.4	\$111.5

Additional pass-through savings from reinsurance. In addition to the pass-through savings under the public option shown in Figure III the current reinsurance waiver could generate excess pass-through payments to the extent the ARPA-enhanced premium tax credits are extended to 2023 . Oregon’s reinsurance program (ORP) is estimated by DCBS to have decreased the second-lowest-cost silver (SLCS) plan Marketplace premium by 8.0% in 2021 with a reinsurance program of \$107.8 million. Assuming a similar premium reduction target and increased enrollment and/or claims subject to the reinsurance reimbursement (i.e., due to the extension of the ARPA-enhanced premium tax credits), the ORP would be estimated to grow from \$114.1 million to \$124.7 million in 2023. Should the ARPA-enhanced premium tax credits remain in place for 2023, federal pass-through funding for Oregon’s reinsurance program in 2023 is projected to increase from \$54.0 million to approximately \$80.0 million, reducing the State’s share of funding from \$60.1 million to \$44.7 million, and leaving \$15.4 million in excess funding that could either held in reserve or be reinvested into the reinsurance program to increase the program size and further reduce premiums.

Should Oregon choose to reinvest the excess funding generated, it is estimated the reinsurance program could reduce the cost of the SLCS plan by approximately 10.3–11.2%. However, the State would also need to take into consideration the possibility that the ARPA-enhanced premium tax credits will not be extended beyond 2023, in which case the State may then need to either reduce the reinsurance program’s targeted impact (which could lead to larger-than-average, market-wide premium rate increases), or identify an additional funding source to sustain the program at such a size.

See [Appendix III](#) for detailed tables from this analysis.⁴⁰

⁴⁰ All the actuarial analyses and projections presented in this report are preliminary and high level. Oregon could pursue additional steps to refine these projections in the future, with more detailed data and robust Oregon-specific micro-simulation modeling.

Build Back Better Act (2021): A Potential Opportunity for Additional Funds

As of this writing, nearly \$10 billion in additional federal funding for state reinsurance programs or reducing cost-sharing will be available as part of the Build Back Better Act (2021), should it pass Congress as currently designed. If the funds are to be allocated proportionately by state, Oregon may have an opportunity to use nearly \$100 million in annual federal funding from the act for reinsurance or for reducing cost-sharing. However, availability of this federal funding would be contingent on whether Congress passes the plan as currently designed, and whether the implementing guidance limits Oregon's planned uses for the funds.

Plan Design

To further advance the State's health equity goals, several plan design features beyond the benefit and cost-sharing changes discussed above should be incorporated into the public option. These include:

- **Incorporating health equity into the public option benefits design.** Benefits included in Oregon's CCO program were developed with health equity in mind, including incorporating coverage for SDOH services, culturally and linguistically appropriate services and supports, and traditional health care workers (e.g., doulas, peer support specialists, health navigators, community health workers). The public option should seek to incorporate similar health equity-oriented benefits and services to ensure it meets the unique needs of its target population, including individuals with incomes from 138% up to roughly 250% of the FPL, as well as communities of color. This may include, for example, ensuring provider networks include culturally appropriate providers to support the delivery of its covered benefits and services.
- **Leveraging existing CCO provider networks to advance health equity.** To preserve continuity of care for individuals across Medicaid and Marketplace plans, the public option should overlap with/leverage existing plan networks, such as those within the CCO program, which are tailored to the needs of lower-income enrollees. The State has options for how to promote continuity of care, such as having stringent standards to broaden which categories of community providers must be included in the networks such that the standards encompass all providers serving a set percentage of the Medicaid population in a region. Oregon currently has continuity of care requirements for patients in certain circumstances, and the State should consider opportunities for expanding continuity of care requirements for the public option.⁴¹

Additionally, Oregon should seek to incorporate requirements for plans to have provider networks that advance health equity. For example, under the Colorado Option, carriers are required to maintain networks that include a majority of the essential community providers in the service area. Networks are also required to be culturally responsive, and to the greatest extent possible, to "reflect the diversity of its enrollees in terms of race, ethnicity, gender identity, and sexual orientation in the area that the network exists." Networks are also not allowed to be any more restrictive than the narrowest existing network the carrier

⁴¹ ORS 743B.225. Available here: https://oregon.public.law/statutes/ors_743b.225.

is already offering for the nonstandardized plans it offers in the individual market for the metal tier for that rating area. Carriers are further required, as part of their network access plans, to provide a description of the carrier's efforts to establish "diverse, culturally responsive networks that are well-positioned to address health equity and reduce health disparities."⁴²

- **Incorporating health equity into plan governance.** One of the central features of Oregon's Medicaid program that seeks to advance health equity is the community-based governance structure required of all CCOs. In determining the governance requirements for the licensed insurers that will deliver the public option, the State should consider the requirements that currently apply to CCOs to advance health equity, starting with the community and public representation requirements that apply to CCOs and health care service contractors (HCSCs).

Under current law, CCOs are required to have a governing body that includes, among others, members "from the community at large" to ensure that the organization's decision making is "consistent with the values of the members and the community."⁴³ Insurer licensing requirements also include requirements for public members in some cases. For example, at least one-third of the managing group of HCSCs (the predominant health insurer type in the Marketplace) must be "representatives of the public."⁴⁴

Incorporating health equity considerations for these public representatives would further advance the State's health equity goals, and would complement insurance expertise by ensuring that health equity is a central feature of any entity that ultimately delivers the public option as represented in equity-based planning, goal setting and other similar requirements. Where specific representational requirements cannot be accommodated within the governance structures of licensed insurers, the State should ensure the active engagement of an advisory role or advisory board to function alongside the established governance structures to ensure both insurance expertise and equity-based governance are represented in leadership.

Beyond the specific plan requirements envisioned for the public option, Oregon has also long pursued ambitious, statewide health system transformation efforts that seek to advance health care equity, access and quality through the delivery of high-value, coordinated care. This effort is outlined in the State's VBP compact, in which over 40 health care organizations in Oregon have voluntarily signed on to demonstrate their shared commitment that 70% of all health care payments will be under advanced VBP models by 2024.⁴⁵ Therefore, it is recommended that the State continue to advance VBP requirements across all regulated products, including the public option.

Advancing VBP across markets. Oregon has already made significant strides in advancing VBP adoption across the State, especially within the Medicaid program. Where programs in Oregon demonstrate significant advancements in achieving high rates of VBP adoption to support the State's goal of having at least 70% of all health care payments in the State subject to shared savings arrangements with upside risk, they should be expanded across all regulated insurance products in Oregon as expeditiously as possible, again with the possibility that requirements apply to all Marketplace plans or to the public option before other products.

⁴² Colorado House Bill 21-1232. Available here: https://leg.colorado.gov/sites/default/files/2021a_1232_signed.pdf.

⁴³ OAR 410-141-3715. Available here: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=275054>.

⁴⁴ ORS 750.015: Management to include representatives of public. Available here: https://www.oregonlegislature.gov/bills_laws/ors/ors750.html.

⁴⁵ "Oregon Value-Based Payment Compact: A statewide collaborative partnership for bending the cost curve," Oregon Health leadership Council. October 15, 2021. Available here: <https://orhealthleadershipcouncil.org/wp-content/uploads/2021/10/Oregon-VBP-Compact.pdf>.

Aligning all regulated insurance products around the State's broader VBP goals is essential for advancing health equity, by coalescing providers and payers around a unified set of tools for reimagining and re-envisioning how the health care system delivers and pays for whole-person care.

In 2019, Oregon's Medicaid CCO market had the highest share of pay-for-performance VBP payments⁴⁶ at 47%, followed by PEBB/OEBB at 45%, the commercial market at 44% and Medicare Advantage at 35%. Much of this can be attributed to the specific annual targets required of CCOs for the percentage of VBP payments they make to providers that bear upside and/or downside risk. For example, in 2022, CCOs are required to have no less than 50% of their payments to providers be VBP payments that include pay-for-performance or higher levels of risk sharing. In 2023 and 2024, that target increases to 60% and 70%, respectively. Additionally, beginning in 2023, CCOs will also be required to have no less than 20% of their total payments made to providers be alternative payment models (APMs)⁴⁷ with shared savings and downside risk or higher levels of risk sharing, and this target increases to 25% by 2024. CCOs are further required to develop and implement VBPs in specified care delivery areas, including hospital care, maternity care, behavioral health care, children's health care and oral health care.⁴⁸ The State should seek to apply and align its established goals and requirements for VBP adoption across all regulated insurance products, and the public option should be no exception.

Plan Requirements and Oversight

Entities offering the public option would be required to be licensed as insurers, in addition to meeting all other plan design and governance features outlined in this Implementation Report. This maintains current insurer licensing requirements and ensures a level playing field between the entity offering the public option and other entities currently on the Marketplace.

While licensing requirements would remain under DCBS oversight, oversight of plan design, provider contracting, governance and other features of the public option could be coordinated between OHA and DCBS, using long-standing collaboration processes in place between the Division of Financial Regulation (DFR) and the Oregon Health Insurance Marketplace, which was recently moved from DCBS to OHA. In the State of Washington, for example, the Health Care Authority and the Marketplace have primary responsibility for designing key features of the Washington public option including standardization requirements, but the Office of Insurance Commissioner retains authority over licensing and QHP certification. Many other states have similar models of collaborative oversight between the Marketplace and the State insurance department. Therefore, with regard to Oregon's public option regulation and oversight, it is recommended that:

⁴⁶ CMS Learning Action Network (LAN) categories 2C or higher.

⁴⁷ An alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population. Source: [https://qpp.cms.gov/apms/overview#:~:text=An%20Alternative%20Payment%20Model%20\(APM,care%20episode%2C%20or%20a%20population](https://qpp.cms.gov/apms/overview#:~:text=An%20Alternative%20Payment%20Model%20(APM,care%20episode%2C%20or%20a%20population).

⁴⁸ Value-Based Payment Roadmap for Coordinated Care Organizations, Oregon Health Authority. September 2019. Available here: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf>.

- **OHA role in plan design.** Given OHA’s role in defining coverage standards for the Medicaid population, it is well positioned to develop a public option product that meets the needs of individuals just above Medicaid eligibility levels. Accordingly, OHA would have a primary role in developing and defining specific plan parameters, such as plan benefits and cost-sharing, as well as in setting requirements for the public option in order to support the plan in achieving broader affordability and health equity goals.
- **DCBS role in rate regulation.** Oregon would commit to reduced premiums in statute, as the Colorado Option does, in order to enable the State to potentially capture federal pass-through dollars under a 1332 waiver. Under such a model, Oregon would hold carriers and providers accountable for ensuring public option premiums meet established reduction targets, through a process that would be tied to rate review. For example, under the Colorado Option, in the event that a provider or carrier is unable to achieve the established premium reduction targets, carriers are permitted to engage in nonbinding arbitration prior to filing rates. If nonbinding arbitration does not resolve the issue, the Division of Insurance (DOI) then holds a public hearing, which engages “all affected parties,” including carriers, hospitals, health care providers, consumer advocacy organizations and individuals. Based on the evidence presented at the hearing and other available data/actuarial analysis, the insurance commissioner is then permitted to establish provider and/or hospital reimbursement rates as needed to meet the premium reduction targets, subject to statutory minimums that take into account the hospital or provider type.⁴⁹ Oregon may also seek to mandate provider participation in carefully targeted ways, as the Colorado Option does.

Colorado vests these powers in the State’s insurance regulator, and Oregon could do the same. Alternatively, the legislature could provide for OHA to have a joint role in the public hearing process and other aspects of ensuring that premium reduction targets are met in cases where licensed insurers are unable to achieve the required reductions through the provider contracting process.

Other Considerations

Marketplace considerations. In creating a new type of insurance product that will be offered on the Marketplace, the State must consider the potential impacts on the remaining market, and what structural changes may be needed to further implement the public option to ensure it achieves its affordability and health equity goals.

- **Advantages of an SBM platform.** It may not be possible for Oregon to implement a public option as described above without transitioning to a full state-based marketplace (SBM) from its current status as an SBM on the federal platform (SBM-FP). Currently, the federally facilitated marketplace, commonly known as Healthcare.gov, does not accommodate state-specific cost-sharing subsidies beyond those already offered under the ACA. Should Oregon pursue additional cost-sharing subsidies through a 1332 waiver, the State would either have to secure new flexibilities under the FFM or transition to a full SBM. In

⁴⁹ Under the Colorado Option, rates cannot be less than 155% of Medicare rates for hospitals, and 135% of Medicare rates for providers. The legislation incorporates various adjustments and exceptions for certain categories of hospitals, including small, rural and critical access hospitals, among others. Reimbursement rates for hospitals are required to take into account “the cost of adequate wages, benefits, staffing, and training for health care employees to provide continuous quality care.”

the last three years, six SBM-FP states have successfully transitioned from SBM-FP status. These states have used second-generation technology platforms that have proven effective and generated savings for the transitioning states that have been reinvested to improve their Marketplaces. While it is possible the FFM may offer additional flexibilities at some point in the future, having SBM status would further the implementation and accessibility of not only the public option, but all plans offered on the Marketplace in Oregon. Further, an SBM might present the State with an opportunity to generate some savings compared to current federal user fees.⁵⁰ The potential benefits of a full SBM include more robust data collection, the ability to customize the enrollment interface, enhanced consumer shopping tools and customer services, improved eligibility systems (likely enabling better continuity of coverage), the ability to extend open enrollment periods, and the ability to add special enrollment periods in response to state emergencies like the 2020 wildfires. All of these tools ultimately would give the State more autonomy and flexibility in enrollment, marketing and outreach than Healthcare.gov.

- **Potential impacts on market stability.** The State aspires for the public option to have lower cost-sharing and additional benefits. Offering such a plan would likely be very attractive to individuals seeking a more affordable Marketplace coverage option, and therefore, would also likely experience high levels of enrollment, which may have some impacts on the remaining market. For example, a 98–99% AV product might attract a less healthy population, which could be addressed by risk adjustment (additional actuarial modeling may be necessary).

Alternatively, if the State offers a public option with similar levels of cost-sharing and with similar provider reimbursement as other plans currently offered on the Marketplace, the State may preserve current Marketplace dynamics, but would also ultimately fall short of the State’s stated goals for pursuing a public option in the first place, which includes improving coverage affordability for Oregonians that are most in need. If the public option makes no advancements in the State’s desired goal of containing health care costs more broadly (i.e., cost-sharing and premiums essentially remain the same as they are on the Marketplace today), it will also limit any advancements in addressing existing health inequities in Oregon.

- **Potential impacts on the second-lowest-cost silver plan.** If the public option is a lower-premium silver plan offered on the Marketplace, it may impact the benchmark premium. Because premium tax credits are pinned to that benchmark premium, which is the premium of the second-lowest-cost silver plan by area, lowering that premium could reduce the amount of premium tax credits for consumers who do not purchase the benchmark plan. For individuals eligible for tax credits, the impact of this lowered premium tax credit would depend on what plan they purchase and its cost in relation to the benchmark plan. For consumers who purchase the benchmark plan, there would be no change; however, others could see a reduction in their purchasing power for other plans. An example is included in [Appendix IV](#).

Statutory Changes. Certain public option design recommendations/decisions may require statutory authorization and/or benefit from accompanying statutory changes to fully implement. These include:

⁵⁰ Under CMS’ 2022 [Notice of Benefit and Payment Parameters \(NBPP\) Final Rule](#), 2022 user fees for the FFM will be 2.75% of premiums, and user fees for state-based marketplaces on the federal platform will be 2.25%. The savings generated by the six transitioning states (NV, PA, NJ, NM, ME and KY) have been dependent on user fees at the time. An Oregon transition would similarly be dependent on a user fee analysis.

- **Implementing premium reduction targets followed by a cost growth cap.** In pursuing a 1332 waiver that relies on the State achieving premium reduction targets in the Marketplace, the State would need authority to pursue a 1332 waiver and additional authority to hold plans and providers accountable to the established premium targets. To achieve pass-through savings, such legislation would have to define the premium targets and establish the accountability and enforcement mechanisms necessary to ensure the premium reductions targets are met, such as the provider rate-setting authority and provider participation requirements incorporated into the Colorado Option.
- **Transitioning to a State-based Marketplace (SBM).** Should Oregon choose to pursue a transition from a state-based marketplace on the federal Marketplace (SBM-FP) to a full SBM, it could require statutory authorization to ensure a cost-effective transition.
- **Adding dental benefit.** Should Oregon choose to require that certain plans offer a dental benefit, this could be accomplished administratively through changes in the standard plan, though the fiscal consequences of adding a non-EHB benefit may require statutory authorization.
- **Incorporating health equity provisions into insurer licensing requirements.** Should Oregon choose to incorporate additional governance requirements under the insurer licensing processes, that could require a statutory change.

Conclusion

Designing and developing a comprehensive and affordable public option for Oregon is a critical step for the State as it seeks to achieve its broader goals of eliminating health inequities, containing health care costs and ultimately, achieving universal coverage. Advancing these efforts requires a public option that:

- Is offered on-Marketplace;
- Aims to offer low cost-sharing, ideally at 94–98% AV, to address the needs of the target population;
- Offers comprehensive benefits, including, if possible, dental coverage;
- Seeks to maximize continuity of care across Medicaid and the Marketplace by aligning provider networks as much as possible;
- Is regulated by both OHA and DCBS, with OHA oversight over the public option’s plan design, DCBS oversight over licensing, and a coordinated approach to other State and federal requirements for individual market plans;
- Is aligned with statewide efforts to advance health equity, by incorporating health equity principles and requirements into the public option’s benefits, provider networks, and plan operating and governance structures, to the extent possible; and
- Is aligned with statewide efforts to contain costs without compromising on quality or access, by incorporating statewide VBP targets; using the State’s quality, access and equity measures; and holding the public option accountable to the statewide Cost Growth Target of 3.4%.

Developing a public option that includes all of the above features may require several statutory changes and/or other program changes to implement, including imposing statutorily mandated premium reduction targets or cost growth cap requirements; transitioning to an SBM; and requiring an additional dental benefit to be included in benefit plans.

Several key decisions remain as the State seeks to implement the public option, including:

- Determining whether or not the State will commit to legislatively required premium reduction targets followed by cost growth limitations, with authority to ensure compliance that allows the State to pursue federal pass-through funding under a 1332 waiver, including:
 - If the State does commit to legislatively mandated premium reduction targets, what those premium reduction target amounts should be;
 - If the State does pursue pass-through funding, what level of cost-sharing subsidy should be offered to improve affordability of the public option; and
 - If the State does pursue pass-through funding, what, if any, level of dental benefit can be offered to improve comprehensiveness of the public option.
- Determining whether the State will seek to transition its SBM-FP to a full SBM to further enable implementation of the public option. Depending on a number of factors (when each project is started, federal response time, potential roadblocks, etc.), Oregon could potentially complete its transition to a full SBM on a similar timeline to securing approval for a 1332 waiver (see Figures IV and V below).

Each of the above decisions carries significant implications for the ability of the public option to be comprehensive and affordable and should be carefully considered by the legislature in the context of what the public option ultimately aims to achieve.

Figure IV. Timeline for Waiver Development, Approval and Implementation

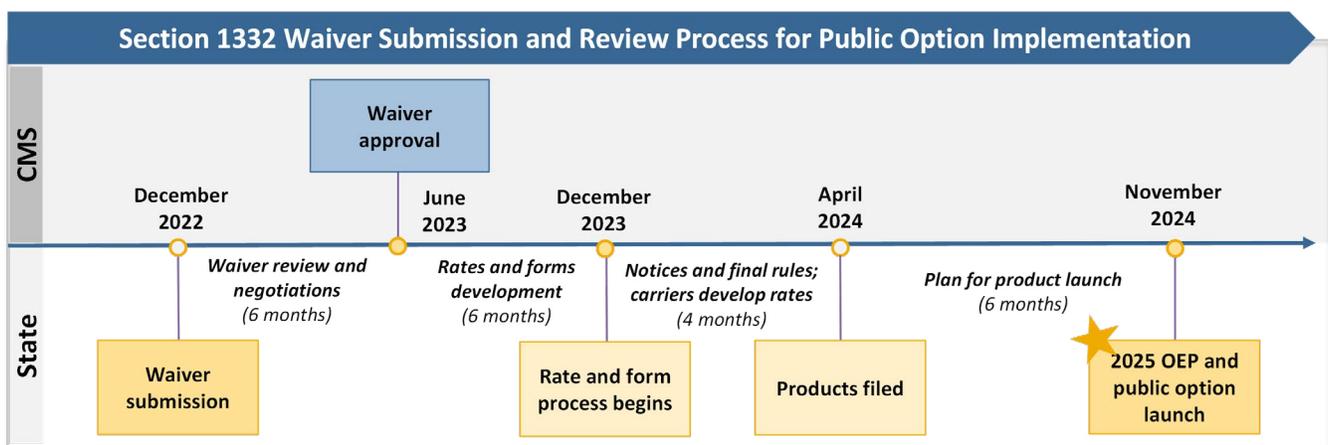
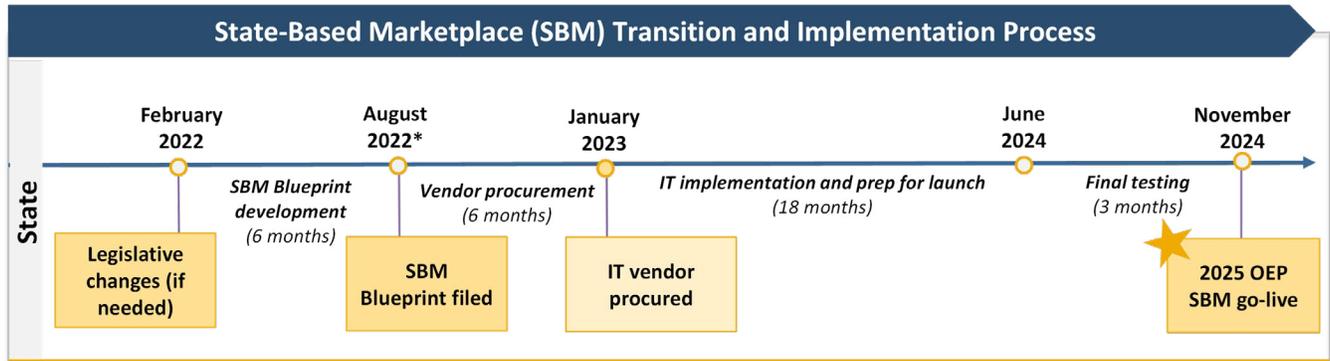


Figure V. Timeline for State-Based Marketplace Transition and Implementation



*States are required to submit an SBM Blueprint 15 months in advance of the State’s open enrollment period (OEP). While Oregon’s Blueprint could be filed as late as August 2023 in advance of a 2025 OEP, the illustrated timeline incorporates an additional year for IT implementation, which many states have taken in their transition.

Appendix I. Requirements from HB 2010 and Summary of Recommendations

Requirement from HB 2010	Recommendation for the Public Option
1. The operating structure and governance of the public option, including which agency will administer the plan and how a delivery system will be procured	OHA and DCBS should dually regulate the public option, with aligned but distinct oversight over plan design and rate regulation. Governance structures should incorporate similar health equity governance requirements expected of CCOs in a manner that complements existing insurer licensing requirements.
2. How the State can leverage existing state-backed plans or networks, such as coordinated care organizations and plans offered by the Public Employees' Benefit Board and the Oregon Educators Benefit Board, to offer a more affordable option	To preserve continuity of care for individuals across Medicaid and Marketplace plans, the public option should align with existing plan networks, such as those within the CCO program. The State has options for how to promote continuity of care, such as having stringent standards to broaden which essential community providers must be included in the networks such that the standards encompass all providers serving a set percentage of the Medicaid population in a region.
3. Plan design options to reduce out-of-pocket costs for individuals in order to reduce barriers to care at the point of service	The State would aim to improve cost-sharing affordability through additional state cost-sharing subsidies, and provide benefits based on Oregon's EHB benchmark plan. If possible, the State will seek to add dental benefits to the public option.
4. How the plan can further the State goals of health system transformation, including but not limited to the use of value-based payment and global budgets, eliminating health disparities, aligning quality and access metrics, and meeting the State's Cost Growth Target	As part of the State's broader efforts to advance health equity and cost containment goals across the entire market, the public option would be held to the same health equity, VBP, quality and access metrics and cost growth requirements as all regulated health insurance products.
5. Cost containment options and opportunities for the State to leverage state purchasing power to ensure program affordability and ensure that per capita costs stay within the Cost Growth Target	The State should hold the public option accountable to the State Cost Growth Target of 3.4% following a rate reset under established premium reduction targets.
6. Plan and program design options aligned with the State's goal of eliminating health inequities in the next ten years	The State should incorporate health equity principles and requirements into the public option's benefits, provider networks, and plan operating and governance structures to the fullest extent possible.
7. Other structural and program changes the State could make to ensure successful implementation of any plans developed, including how a state-based technology platform could further the implementation and accessibility of a public option	A full SBM would further the implementation and accessibility of not only the public option, but all plans offered on the Marketplace in Oregon and may present the State with an opportunity to generate additional cost savings. Should Oregon pursue a state cost-sharing subsidy to improve affordability of the public option, the State will need an SBM to implement it.
8. Enrollment infrastructure that may be needed by coordinated care organizations, if coordinated care organizations are the recommended delivery system, to enroll members in a separate program	Enrollment into the public option should be as easy as enrollment into any other product on the Marketplace. Entities offering the public option would be required to be licensed as insurers, and any CCOs seeking to offer the public option would need to comply with insurer licensing requirements.

Requirement from HB 2010	Recommendation for the Public Option
<p>9. Outreach infrastructure and investments that would support educating people in this state, particularly communities of color and populations with above-average uninsured rates, about available options for subsidized coverage and newly available options under ARPA, and support increasing enrollment of eligible individuals in existing programs that provide affordable coverage</p>	<p>The public option should be accompanied by robust outreach, education and marketing efforts to inform these communities and populations of the available options for affordable coverage. The State could also incorporate requirements for the public option to affirmatively reach out to individuals being disenrolled from Medicaid to connect them with resources to either re-enroll in the OHP or enroll in individual market coverage, likely through the public option.</p>
<p>10. Statutory changes needed to implement the recommendations</p>	<p>Certain recommendations may require statutory authorization and/or benefit from accompanying statutory changes to fully implement. For example, implementing premium reduction targets would require legislation. Requiring an additional dental benefit to be offered by certain plans on the Marketplace, transitioning to an SBM, and incorporating health equity provisions into insurer licensing and governance requirements could require statutory changes to implement.</p>

Appendix II. HB 2010 Factors for Implementation Report Analysis and Recommendations

HB 2010 requires OHA to analyze the following factors in developing the implementation plan:

- a) Federal opportunities to support a state-supported public option;
- b) State populations most in need of new coverage options;
- c) The effect of a new public option on market stability;
- d) How the American Rescue Plan Act of 2021 and other federal program changes inform state policy options related to new coverage;
- e) How a state-based technology platform could further the implementation and accessibility of a public option;
- f) Adverse consequences of certain design elements that the State may wish to avoid;
- g) What level of additional subsidies, such as premium assistance or cost-sharing subsidies, would improve affordability; and
- h) Coverage strategies being developed by the Task Force on Universal Health Care.

HB 2010 further requires OHA to make recommendations on the following issues, based on its analysis:

- a) The operating structure and governance of the public option, including which agency will administer the plan and how a delivery system will be procured;
- b) How the State can leverage existing state-backed plans or networks, such as coordinated care organizations and plans offered by the Public Employees' Benefit Board and the Oregon Educators Benefit Board, to offer a more affordable option;
- c) Plan design options to reduce out-of-pocket costs for individuals in order to reduce barriers to care at the point of service;
- d) How the plan can further the State's goals of health system transformation, including but not limited to using value-based payment and global budgets, eliminating health disparities, aligning quality and access metrics, and meeting the Cost Growth Target;
- e) Cost containment options and opportunities for the State to leverage state purchasing power to ensure program affordability and ensure that per capita costs stay within the Cost Growth Target;
- f) Plan and program design options aligned with the State's goal of eliminating health inequities in the next ten years;
- g) Other structural and program changes the State could make to ensure successful implementation of any plans developed, including how a state-based technology platform could further the implementation and accessibility of a public option;
- h) Enrollment infrastructure that may be needed by coordinated care organizations, if coordinated care organizations are the recommended delivery system, to enroll members in a separate program;

- i) Outreach infrastructure and investments that would support educating people in this state, particularly communities of color and populations with above-average uninsured rates, about available options for subsidized coverage and newly available options under the American Rescue Plan Act, and support increasing enrollment of eligible individuals in existing programs that provide affordable coverage; and
- j) Statutory changes needed to implement the recommendations.

Appendix III. Detailed Actuarial Analysis and Findings

Manatt worked with actuaries to generate a preliminary, high-level quantitative analysis of key elements of the Oregon proposal.

Table 1 presents an overview of the individual market without the public option (the baseline case). The table shows enrollment in Oregon’s individual market for 2020 and 2021¹ and projects that enrollment for 2022 and 2023 based on certain assumptions, including continuation of the ARPA enhanced premium tax credits through 2023.² These baseline projections show significant enrollment growth in the individual market (9% gain from 2021 to 2023), with a bigger gain in Marketplace enrollment (20% from 2021 to 2023) and a reduction in off-Marketplace enrollment.

Table 1: Oregon’s Individual Market Enrollment by Coverage Type—Baseline 2020–2023

	2020	2021	2022	2023
ACA Subsidized – Marketplace	93,949	98,646	128,240	132,088
ACA Non-Subsidized – Marketplace	33,499	31,489	25,191	24,436
ACA Off – Marketplace	48,009	45,128	36,102	35,019
Grandfathered Plans	117	105	94	85
Total Individual Market	175,574	175,369	189,628	191,627

Tables 2 and 3 present the projected cost and 2023 enrollment impact of two scenarios in which cost-sharing subsidies are increased for specified Marketplace populations. In Table 2 (the 94% CSR Wrap Scenario), Marketplace enrollees with incomes in the 151–200% of FPL range who choose silver plans would receive an additional cost-sharing subsidy that would increase the AV of the plan from 87% to 94%. Table 2 projects the cost of these increased subsidies to range from \$11.7 to \$14.3 million, with an overall enrollment gain of 4,000 lives, or roughly 2%. Another 3,000 lives currently receiving bronze plans with a 60% AV are projected to substantially reduce their potential cost-sharing burdens by shifting to the new silver plans with a 94% AV.

¹ 2021 enrollment is estimated based on publicly available year-to-date enrollment summaries.

² While it is possible ARPA tax credits will not be extended through 2023, which is not a scenario examined by the actuarial estimates above, several studies cite various consequences of ARPA not being extended that are beyond the scope of this report. For example, a September 2021 KFF report highlighted that if ARPA premium subsidies expire at the end of 2022 as currently slated, premium payments could double for approximately 8 million marketplace enrollees who signed up before the ARPA subsidies were enacted, with premiums and deductibles increasing most drastically for the lowest-income enrollees. Moreover, approximately 3.7 million middle-income individuals could lose premium subsidy eligibility gained under ARPA; these individuals would be required to not only make up the difference in the subsidy but also pay for any increase in the premium sticker price until January 1, 2023. Source: <https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/>.

Table 2: 94% CSR Wrap Scenario—Annual Cost Estimate to the State in 2023

	2023 Enrollment		Allowed PMPM		Paid/Allowed Ratio		Cost of 94% CSR Wrap in Millions ((2) * (4) * 12 * [(6) - (5)] /1,000,000)
	Baseline (1)	94% CSR Wrap (2)	Baseline (3)	94% CSR Wrap (4)	Baseline (5)	94% CSR Wrap (6)	
Catastrophic	646	646	\$142	\$142	64%	64%	\$0.0
Bronze	87,877	84,795	\$362	\$362	72%	72%	\$0.0
Silver 70% Non-CSR	28,480	28,480	\$607	\$607	80%	80%	\$0.0
Silver 73% CSR	9,566	9,566	\$630	\$630	82%	82%	\$0.0
Silver 87% CSR / 94% CSR	21,045	28,159	\$780	\$780	90%	95%	\$13.0
Silver 94% CSR	14,062	14,062	\$900	\$900	95%	95%	\$0.0
Gold	29,868	29,868	\$959	\$959	88%	88%	\$0.0
Total Individual Market (Best Estimate)	191,544	195,576	\$590	\$610	83%	84%	\$13.0
Low Estimate (-10%)							\$11.7
High Estimate (+10%)							\$14.3

In Table 3 (the 98% CSR Wrap Scenario), Marketplace enrollees with incomes in the 138–200% of FPL range who choose silver plans would receive an additional cost-sharing subsidy that would increase the AV of the plan from 94% to 98% for Marketplace enrollees in the 138–150% of FPL range, and from 87% to 98% for those in the 151–200% of FPL range. Table 3 projects the cost of these increased subsidies to range from \$25.9 to \$31.7 million, with an overall enrollment gain of 6,000 lives, or roughly 3%. Another 6,000 lives currently receiving bronze plans with a 60% AV are projected to substantially reduce their potential cost-sharing burdens by shifting to the new silver plans with a 98% AV.

Table 3: 98% CSR Wrap Scenario—Annual Cost Estimate to the State in 2023

	2023 Enrollment		Allowed PMPM		Paid/Allowed Ratio		Cost of 98% CSR Wrap in Millions ((2) * (4) * 12 * [(6) - (5)] /1,000,000)
	Baseline (1)	98% CSR Wrap (2)	Baseline (3)	98% CSR Wrap (4)	Baseline (5)	98% CSR Wrap (6)	
Catastrophic	646	646	\$142	\$142	64%	64%	\$0.0
Bronze	87,877	81,846	\$362	\$362	72%	72%	\$0.0
Silver 70% Non-CSR	28,480	28,480	\$607	\$607	80%	80%	\$0.0
Silver 73% CSR	9,566	9,566	\$630	\$630	82%	82%	\$0.0
Silver 87% CSR / New 98% CSR	21,045	31,795	\$780	\$780	90%	98%	\$23.7
Silver 94% CSR / New 98% CSR	14,062	15,766	\$900	\$900	95%	98%	\$5.2
Gold	29,868	29,868	\$959	\$959	88%	88%	\$0.0
Total Individual Market (Best Estimate)	191,544	197,967	\$590	\$610	83%	86%	\$28.8
Low Estimate (-10%)							\$25.9
High Estimate (+10%)							\$31.7

Table 4 presents the projected cost of adding “basic” or “major” adult dental coverage to the ACA benefit package as a fully subsidized benefit. Basic coverage was defined as routine and basic benefits only (e.g., cleanings, fluoride treatment, fillings); major was defined as routine, basic and major benefits (e.g., routine and basic benefits plus crowns, bridges, periodontal surgery). Table 4 projects the cost of basic dental coverage to range from \$36.3 to \$44.4 million, and the cost of major dental coverage to range from \$64.2 to \$78.5 million.

Table 4: Estimated Cost of Dental Coverage for Adults by Service Type in 2023

Service Type	Basic Coverage Level	Major Coverage Level
Routine Dental Services	Yes	Yes
Basic Dental Care	Yes	Yes
Major Dental Care	No	Yes
Orthodontia	No	No
1) Estimated Dental Cost PMPM in 2023	\$20	\$36
2) ACA Individual Market Enrollment (Adults aged 19 years and older)	164,805	164,805
3) Total Annual Premium Cost of Subsidy in Millions [Row (1) * 12 * Row (2) / 1,000,000] – Best Estimate	\$40.3	\$71.3
4) Low Estimate (-10%)	\$36.3	\$64.2
5) High Estimate (+10%)	\$44.4	\$78.5

Table 5 presents the projected additional pass-through savings (i.e., in addition to those that would be generated solely by the reinsurance program) that would be realized if Oregon’s public option were successful in reducing the lowest-cost silver plans offered on the Marketplace by each of the individual ACA carriers by 5%, 10% or 15%. The projections assume that each insurer would offer only one Marketplace silver plan with the specified premium reductions, and the results reflect the average projected impact that public option plans would have on the benchmark plan (the second-lowest-cost silver plan offered on the Marketplace in each rating area, which is used to determine federal premium tax credits). Table 5 projects the additional pass-through amounts to range from \$32.8 to \$44.4 million under the 5% scenario, \$54.8 to \$74.1 million under the 10% scenario, and \$82.4 to \$111.5 million under the 15% scenario.

Table 5: Estimated Change in Pass-Through Savings under 5%, 10% and 15% Public Option Scenarios in 2023

Service Type	Calculation Detail (1)	Baseline (2)	5% Reduction (3)	10% Reduction (4)	15% Reduction (5)
1) APTC under Waiver PMPM	N/A	\$473	\$447	\$429	\$406
2) Change from Baseline	Row (1) Change vs. Column (2)	N/A	-5.6%	-9.4%	-14.1%
3) Subsidized Enrollment	N/A	132,088	132,088	132,088	132,088
4) APTC under Waiver (in Millions)	Row (1) * Row (3) * 12 / 1,000,000	\$750.0	\$707.9	\$679.6	\$644.0
5) APTC Change from Baseline (in Millions)	Row (4) difference vs. Column (2)	-	\$42.2	\$70.4	\$106.0
6) Reconciliation Factor	N/A	-	0.92	0.92	0.92
7) Change in Pass-Through from Baseline (in Millions) – Best Estimate	Row (5) * Row (6)	N/A	\$38.6	\$64.4	\$97.0
8) Low Estimate (-15%)	Row (7) * [1-15%]	N/A	\$32.8	\$54.8	\$82.4
9) High Estimate (+15%)	Row (7) * [1+15%]	N/A	\$44.4	\$74.1	\$111.5

Table 6 combines the projections from the previous tables. Notably, it demonstrates that if the Oregon public option is successful in achieving a 15% premium reduction, it would generate \$111.5 million in pass-through savings (best estimate), which would fully cover the costs of both major dental coverage for adults (\$78.5 million) and the near elimination of cost-sharing obligations (98% AV plan at cost of \$31.7 million) for Marketplace enrollees at up to 200% of the FPL who choose silver plans. Table 6 also shows how other combinations of new subsidies and premium reductions could be incorporated into the public option.

Table 6: Summary of the Projected 2023 Results

2023 Projections (in Millions)	Best Estimate	Low Estimate	High Estimate
State Cost of 94% CSR Wrap	\$13.0	\$11.7	\$14.3
State Cost of 98% CSR Wrap	\$28.8	\$25.9	\$31.7
State Cost of Adult Dental Coverage – Basic	\$40.3	\$36.3	\$44.4
State Cost of Adult Dental Coverage – Major	\$71.3	\$64.2	\$78.5
Add'l Federal Pass-Through Funding - 5% Public option	\$38.6	\$32.8	\$44.4
Add'l Federal Pass-Through Funding - 10% Public option	\$64.4	\$54.8	\$74.1
Add'l Federal Pass-Through Funding - 15% Public option	\$97.0	\$82.4	\$111.5

Oregon’s reinsurance program (ORP) is estimated to have decreased the second-lowest-cost silver (SLCS) plan Marketplace premium by 8.0% in 2021 with a reinsurance program of \$107.8 million. Assuming a similar premium reduction target and increased enrollment and/or claims subject to the reinsurance reimbursement (i.e., due to the extension of the ARPA-enhanced premium tax credits), the ORP would be estimated to grow from \$114.1 million to \$124.7 million in 2023. As shown in Table 7, should ARPA enhanced premium tax credits remain in place for 2023, federal pass-through funding for Oregon’s reinsurance program in 2023 is projected to increase from \$54.0 million to approximately \$80.0 million, reducing the State’s share of funding from \$60.1 million to \$44.7 million, and leaving \$15.4 million in excess funding that could either be held in reserve or be reinvested into the reinsurance program to increase the program size and further reduce premiums.

Should Oregon choose to re-invest the excess funding generated, it is estimated the reinsurance program could reduce the cost of the SLCS plan by approximately 10.3% to 11.2%. However, the State would also need to take into consideration the possibility that the ARPA-enhanced premium tax credits will not be extended beyond 2023, in which case the State may then need to either reduce the reinsurance program’s targeted impact (which could lead to larger-than-average, market-wide premium rate increases), or identify an additional funding source to sustain the program at such a size.

Table 7: Oregon’s Reinsurance Program—Projected Excess State Funding Available in 2023

	CY2023
1) ORP – No ARPA-Enhanced Premium Tax Credits	
Reinsurance Payments (in Millions)	\$114.1
– Federal Portion	\$54.0
– State Portion	\$60.1
Assumed Impact on SLCS Premium Rate	-8.0%
2) ORP – w/ ARPA-Enhanced Premium Tax Credits	
Reinsurance Payments (in Millions)	\$124.7
– Federal Portion	\$80.0
– State Portion	\$44.7
Assumed Impact on SLCS Premium Rate	-8.0%
3) Excess State Funding Available	\$15.4
4) Low Estimate (-15%)	\$13.1
5) High Estimate (+15%)	\$17.7

Appendix IV. Premium Tax Credit Impacts Example

Illustrative Example of Premium Impacts on Premium Tax Credits

Calculating Premium Tax Credits (PTCs)

- PTCs are calculated by subtracting the individual expected contribution from the cost of the benchmark plan.

Expected Contributions

- Individual expected contributions are set on a sliding scale by income. Under ARPA, for an individual earning 250% of the FPL, or approximately \$32,200 a year, the individual contribution is limited to 4% of \$32,200, or \$1,288.³

Illustrative Example of Premium Costs by Plan Type

- The benchmark plan, or the second-lowest-cost silver plan, costs \$6,000 annually.
- The bronze plan costs \$4,000 annually.
- The gold plan costs \$8,000 annually.

How the Benchmark Premium can Impact Purchasing Power

Given a benchmark premium of \$6,000 and a maximum required contribution of \$1,288 for an individual earning 250% of the FPL, this individual will receive a PTC of \$4,712. Regardless of what plan this individual ultimately purchases, their eligible PTC amount will remain at \$4,712.

- To purchase the benchmark plan, it would cost \$1,288, which is equivalent to the individual's expected contribution.
- To purchase the bronze plan, it would cost \$0, because the PTC amount exceeds the cost of the bronze plan's premium.⁴
- To purchase the gold plan, it would cost \$3,288.

If the benchmark plan decreases in value to \$5,000, the amount of PTC this individual is eligible for is reduced (e.g., \$5,000 minus the maximum required contribution of \$1,288 means they will receive only \$3,712 in PTC). The intended result of the public option plan would be to incentivize insurers to lower premiums for their other plans to remain competitive, in which case an individual could have similar or better buying power than in the above example. However, if all other premiums remain the same, then the individual in the above example would pay more for plans other than the benchmark plan:

- To purchase the benchmark plan, the cost remains equivalent to their expected contribution of \$1,288.
- To purchase the bronze plan, it would now cost \$288.
- To purchase a gold plan, it would now cost \$4,288.

³ "Explaining Health Care Reform: Questions About Health Insurance Subsidies," KFF. October 29, 2021. Available here: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/>

⁴ When premium tax credit amounts exceed the cost of the plan's premium, the premium tax credit is adjusted to the cost of the premium, and the excess tax credit is not used.

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