SB 1526: Oregon's Children's Health Insurance Program and Premium Assistance

February 2015

Prepared by
The Oregon Health Authority

Prepared for
The Oregon State Legislature
Per Senate Bill 1526

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February 27th, 2015

Senate Committee on Health Care
and Human Services
Oregon Legislative Assembly

Dear Senators Monnes Anderson and Kruse,

In 2014, the Oregon Legislature passed Senate Bill 1526, charging the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families between 200-300% of the federal poverty level (FPL), commonly referred to as premium assistance. In response to the requirements of SB 1526, OHA has enclosed its report and recommendations to the Legislature.

In summary, creating a premium assistance program for a segment of Oregon's CHIP population is not recommended at this time. The following considerations support OHA's recommendation:

- Oregon's Medicaid/CHIP eligibility and enrollment systems and Marketplace are still stabilizing.
- Oregon Health Plan (OHP) provides children up to 300% FPL with access to high quality, no cost coverage, and richer benefits than generally available under commercial coverage.
- OHP enrollees are served by innovative care delivery systems through coordinated care organizations (CCOs) and patient centered primary care homes (PCPCHs).
- Offering premium assistance to a subset of OHP members poses an equity issue and may compromise Oregon's goals of achieving an integrated and coordinated health care delivery system.
- Implementation would result in significant administrative burden including startup costs for the state, and potentially for insurance carriers as well.
- Federal costs for premium assistance would be greater than direct CHIP coverage and the state would be responsible for the difference.

To preserve the gains achieved through Oregon's success in enrolling low- and moderate-income children in OHP coverage, the OHA does not recommend that the Legislature establish a CHIP premium assistance program for children served by the OHP at this time.

Sincerely,

Lynne Saxton

Lynne Saxton, Acting Director

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Executive Summary

Senate Bill 1526 (2014) charged the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families between 200-300% of the federal poverty level (FPL), referred to as premium assistance. Federal statute requires states' CHIP premium assistance programs to:

- Provide "comparable coverage" to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits;
- Ensure CHIP beneficiaries do not have greater out-of-pocket costs (OOP) than those with direct CHIP coverage, and wrap consumer costs to the extent they exceed CHIP levels; and
- Be cost effective from the federal perspective, meaning that the federal cost of covering an individual through premium assistance is the same or less than providing "comparable coverage" to the individual in the direct CHIP program.

Contemplating premium assistance within the new context of the Affordable Care Act (ACA) and the Oregon's health system transformation presents new and important considerations as public and private health coverage options for children and families have changed. These changes have implications for consumer access, benefit coverage, quality and affordability.

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP and several premium assistance programs for families up to 300% FPL through Healthy Kids. As a result of the ACA and state's own reforms, Oregon's insurance affordability programs for low- and moderate-income families now include Medicaid, CHIP and federally subsidized commercial coverage through Marketplace qualified health plans (QHPs). Starting in 2014, children below 300% FPL in premium assistance through CHIP were transitioned to comprehensive, no-cost coverage through the Oregon Health Plan (OHP). Unsubsidized coverage for families remains available through individual plans outside the Marketplace and through employer sponsored insurance (ESI).

States that offer premium assistance to CHIP eligible children may help to support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type. In Oregon, the earliest feasible implementation date for the premium subsidy program described in SB 1526 would be calendar year 2017, when approximately 16,000 children from 200-300% FPL are projected to be enrolled in CHIP.

To determine whether the program would be cost effective, OHA staff assessed the potential budget impacts of CHIP premium assistance through Marketplace QHPs or analogous individual plans outside the Marketplace. The cost of each coverage option was compared to the cost of the direct CHIP program, taking into account premiums, costs for any wraparound of benefits and consumer OOP costs (if applicable), and administrative expenses to operate the program. Due to the widespread variation found across ESI plans

in Oregon, only general program estimates for this coverage option were examined. Assumptions relating to program take-up were not made as the number of enrollees did not ultimately affect whether a premium assistance program is cost effective.

Results suggest that Oregon would have to allocate an additional $714-$818 per member, annually, in state funds to establish a CHIP premium assistance program for individual plan coverage in or outside the Marketplace. (Projected costs for direct CHIP coverage in CY 2017 is $2,109 per member per year.) In other words, the analysis finds that after taking into account total premium assistance program costs—additional federal and state share for premiums, wraparound and admin expenses—coverage for each option is not cost effective.

A final consideration is the status of future federal funding for CHIP. Currently, federal funds for CHIP are only appropriated through federal fiscal year (FFY) 2015 and a continuation requires Congressional action. If federal CHIP funding ends after FFY 2015, states are required to maintain income eligibility levels for CHIP children through FFY 2019 as a condition for receiving federal Medicaid payments. The current level of uncertainty makes it difficult for states interested in pursuing CHIP premium assistance to move forward.

Recommendation

The OHA advises that a premium assistance program for Oregon's CHIP population is not feasible at this time for the following reasons:

- Oregon's Medicaid/CHIP eligibility and enrollment systems and Marketplace are still stabilizing.
- OHP already provides children up to 300% FPL with access to high quality, no cost coverage, and richer benefits than generally available commercial coverage.
- CHIP enrollees are served by innovative care delivery systems through coordinated care organizations (CCOs) and patient centered primary care homes (PCPCHs).
- Offering premium assistance to only a subset of CHIP eligible children poses an equity issue and may compromise Oregon's goals of achieving an integrated and coordinated health care delivery system.
- Implementation would result in administrative burden for the state and insurance carriers due to tracking and monitoring children to ensure they receive comparable benefit coverage and pay no more in OOP costs than in CHIP.
- Oregon would be unable to meet federal cost effectiveness requirements for creating a CHIP premium assistance program in 2017 without additional state spending or significant changes to benefits and cost sharing in order to reduce overall program costs.

OHA does not recommend that Oregon create a CHIP premium assistance program at this time. Opportunities to improve Oregon's CHIP program should be reassessed after the status of the program's federal funding is addressed by Congress.

Background

Senate Bill 1526 (2014) charged the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families with between 200-300% of the federal poverty level (FPL). The use of public funds through Medicaid or CHIP to purchase commercial coverage is commonly referred to as premium assistance. States have flexibility to offer premium assistance programs using public funds through Medicaid and CHIP) to subsidize commercial coverage, including coverage through Marketplace Qualified Health Plans (QHPs).[1]

There are a few options under federal CHIP authority to do premium assistance. In general, federal statute requires states' CHIP premium assistance programs to:

- Provide "comparable coverage" to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits;
- Ensure families with children do not have greater out-of-pocket costs (OOP) than those with direct CHIP, and wrap consumer costs to the extent they exceed CHIP levels; and
- Assure the program is cost effective to the state, meaning that the cost of covering an individual through premium assistance is the same or less than providing "comparable coverage" to the individual in the direct CHIP program.[2]

Premium Assistance Programs

In general, the structure of premium assistance programs aims to create a partnership between the government, commercial markets, health systems, and employers to provide health care for beneficiaries. Contemplating premium assistance within the context of the Affordable Care Act (ACA) and the state's health system transformation efforts presents new and important considerations as public and private health coverage options for children and families have changed. These changes have implications for consumer access, benefit coverage, quality and affordability.

The insurance affordability landscape in Oregon for low-income children includes Medicaid, CHIP and subsidized commercial coverage through Marketplace qualified health plans (QHPs). Alternative coverage options for families remains available through individual plans outside the Marketplace and through employer sponsored insurance (ESI). In examining the feasibility of a voluntary CHIP premium assistance program, the state considered the main types of commercial coverage available: Marketplace QHPs, analogous individual plans outside the Marketplace and ESI.

The earliest feasible implementation date for the program would be calendar year 2017, when approximately 16,000 children from 200-300% FPL are projected to be enrolled in

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

[2] 42 U.S.C. 1397ee(c)(3)(A)

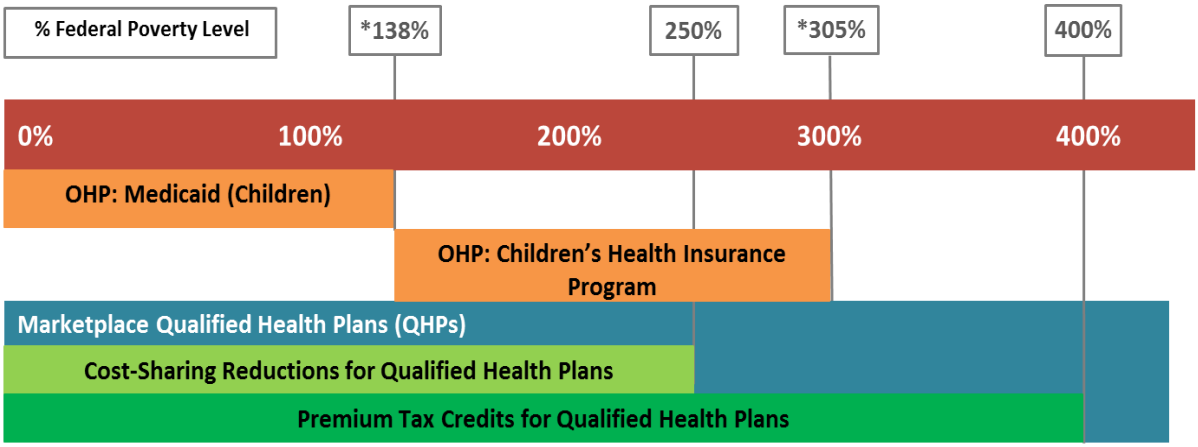
CHIP.[3] These children would have the option to enroll in to commercial coverage. In addition to providing families a choice between direct CHIP and commercial coverage, offering premium assistance to CHIP eligible children may help support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type. In 2013, an estimated 154,000 Oregon children were in families with incomes between 200-300% FPL. An estimated 72% (111,650) of these children were covered by ESI. It is unknown how many of these children could qualify for CHIP eligibility in 2017 and potentially enroll in premium assistance.[4]

History of Children's Public Insurance Coverage in Oregon

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP, and several premium assistance programs through Healthy Kids. Oregon's premium assistance programs were available in a variety of formats, but in general, they subsidized both ESI as well as certain individual plans for children in families up to 300% FPL.

Due to ACA coverage expansions, these programs ended December 31, 2013. Starting in 2014, Oregon children in families up to 300% FPL became eligible to receive comprehensive, no-cost coverage through the Oregon Health Plan (OHP). Subsidized commercial coverage for individuals not eligible for Medicaid or CHIP and without access to affordable ESI is also available through QHPs. Figure 1 illustrates the insurance affordability programs available to children after 2014.

Figure 1. Insurance Affordability Programs for Oregon Children in 2014 and Beyond



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

[3] Office of Forecasting, Research and Analysis (OFRA), OHA: CHIP enrollment and forecast, Dec. 2014.
[4] Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

Oregon continues to operate a separate CHIP program, offering coverage to children less than 19 years of age in families with incomes from above 138% through 300% FPL. Oregon's current CHIP enrollment for 2015 is estimated to be over 75,000. By 2017, Oregon's entire CHIP population is projected to be just below 60,000 beneficiaries, with 22% of those between 200-300% FPL.[5] For more information as to how Oregon's current CHIP program is governed, see Appendix A.

Future of Federal CHIP Funding

Under current law, federal fiscal year (FFY) 2015 (10/1/14—9/30/15) is the last year federal appropriations are provided for CHIP, even though the program is still authorized. Continued federal funding beyond 2015 is important, as the ACA requires states to maintain the CHIP eligibility standards that were in place as of enactment (March 2010) through FFY 2019, otherwise known as maintenance of effort (MOE).[6] If Congress extends CHIP funding, the existing enhanced federal match rate may increase by 23 percentage points, bringing the average CHIP federal matching rate to 93% and Oregon's rate to 97.25%. This enhanced federal matching rate continues until September 30, 2019.

Specifically, MOE requires:

- *Maintain eligibility standards*. States' "eligibility standards, methods and procedures" must be no more restrictive through September 30, 2019 than those in effect on March 23, 2010.
- *Ensure comparability of CHIP and QHP benefits.* The Secretary of Health and Human Services (HHS) must determine by April 1, 2015 whether the benefits and cost sharing under QHPs are at least comparable to CHIP. Beginning October 2015, states may meet their obligation to maintain eligibility standards for children by enrolling children eligible for CHIP into QHPs certified to be comparable to CHIP, if available. Federal guidance on how comparability will be assessed has not yet been issued.
- *Assure Marketplace coverage if CHIP funds exhausted.* States with separate CHIP programs, such as Oregon, may limit enrollment based on availability of federal CHIP funds, which effectively provides an exception to the MOE requirement in the absence of such funds. Such states would be required to have procedures to enroll eligible children in Medicaid or Marketplace plans certified as being comparable to CHIP. As a result, many children may be left uninsured or face significantly higher cost sharing.

Oregon's 1115 Demonstration further protects CHIP resources. Specifically, in the Special Terms and Conditions of the 2012 waiver approval (STC 18.f.), the State is required to maintain the funding line on the Prioritized List of Health Services at the level it was on the 2012-2013 list through the end of the Demonstration, June 30, 2017.

[5] OHA Office of Forecasting, Research and Analysis, 12/19/14.
[6] ACA §2101(b), creating SSA §2105(d)(3)(B)); 42 USC 1397ee(d)

Recommendation from the Medicaid Advisory Committee

In the fall of 2014, Oregon's Medicaid Advisory Committee (MAC) was asked by OHA to examine the issue of a voluntary premium assistance program, per SB 1526, and advise the Authority. The Committee reviewed federal regulations and guidance for CHIP and premium assistance, assessed Oregon's health coverage and reform landscape, and considered the state's historical experience with premium assistance programs. The committee assessed the benefits and challenges of a CHIP premium assistance program, viewed through the lens of CHIP beneficiaries and their families, the State, CCOs, the commercial market/Marketplace, and providers.

The Committee advises that, while premium assistance offers some benefits, such programs are complex and costly to implement and administer and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and the Marketplace are still stabilizing. Further, the post-2014 coverage environment is very different, as most Oregon children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market. OHP enrollees are also served by innovative care delivery models via CCOs. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim. Please see Appendix B (pg. 14) for the Committee's memo to OHA.

Implementation Considerations

A number of implementation considerations were identified if Oregon was to implement a premium assistance program in CHIP. Oregon would need to make system changes to ensure administrative capability and capacity for eligibility and enrollment determinations. Additional agency staff would be required to operate the program and provide customer support for the population served. Contractual arrangements with premium assistance plans would also have to be established. In addition, there may be an added administrative burden to the state and/or insurance carriers to ensure that participating children receive comparable benefit coverage and pay no more than 5% cost sharing as a percent of family income.

Further, OHA would need approval from CMS and the legislature to establish and administer the program. Federal premium assistance authority, whether achieved through the state plan option and/or a demonstration waiver, would depend on the program's design (see next section, technical assistance from CMS). In other words, implementation timing for any premium assistance program is determined by its scope and complexity.

CMS Guidance and Technical Assistance for Premium Assistance

OHA staff received technical assistance from the Centers for Medicare and Medicaid Services (CMS) regarding conditions CMS would likely require to approve a voluntary CHIP premium assistance program for children in families from 200-300% FPL. Preliminary feedback from CMS indicated:

- A premium assistance program for a subset of the CHIP population is permissible under federal authority.
- Under existing federal CHIP authority, the state is required to ensure that enrollees in premium assistance programs receive the same level of benefits and do not have greater OOP costs than the levels in the CHIP State Plan.
- If the program is implemented through a demonstration waiver, it must be "budget neutral," meaning that the federal government's costs must not exceed what they would have been without the premium assistance demonstration.
- The cost of providing coverage through premium assistance must be comparable to the cost of providing direct coverage under the State Plan.[7]
- There are several operational considerations that must be discussed and agreed upon between the state and CMS, subject to a more concrete proposal by the state. Examples include eligibility and enrollment system needs and processes for tracking and administering consumer OOP costs (if applied) to ensure they do not exceed federal limits.

As part of implementing the ACA, specifically, expansion of Medicaid, several states expressed interest in establishing Medicaid Marketplace Premium Assistance programs. In 2013, HHS issued guidance for states around offering premium assistance in the Marketplace through an 1115 waiver. In 2014, CMS approved two states'—Arkansas and Iowa—1115 waivers to establish a Medicaid Market Premium Assistance program by applying an alternative state-developed cost effectiveness test that considers, among other factors:

- Savings from reduced churn between Medicaid and the Marketplace
- Economic benefits of increased competition on the Marketplace
- Improved access
- Improved patient outcomes
- Benefits of family coverage under one product

OHA would need to engage in comprehensive research and analysis in order to determine whether an alternative cost effectiveness test would be approved by CMS.

Premium Assistance and Cost Effectiveness

To determine cost-effectiveness of the premium assistance program proposed in SB 1526, the cost of commercial coverage option was compared to the cost of the direct CHIP program, taking into account premiums, cost for any wraparound of benefits and consumer OOP costs (if applicable), and administrative expenses. Program costs were estimated for calendar year (CY) 2017, the earliest feasible implementation date for a premium assistance program in Oregon.

The Oregon Health Plan (direct CHIP) covers benefits not typically provided by Marketplace QHPs or employer sponsored insurance, including:

[7] Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

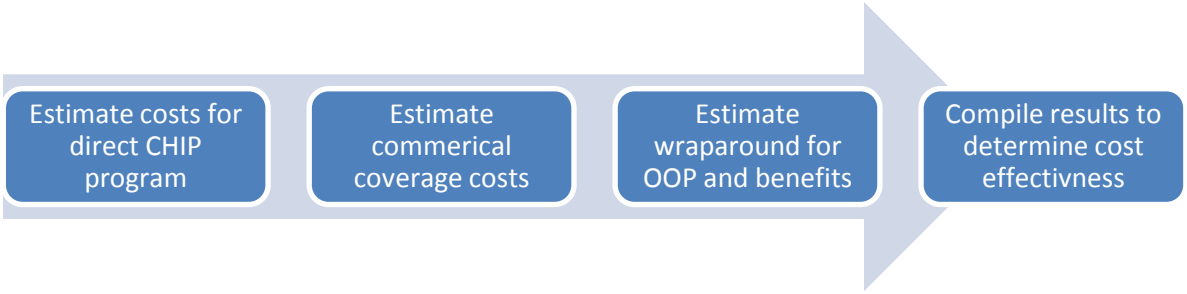
- Pediatric dental – QHPs are not required to provide this, so generally families must purchase a stand-alone dental plan incurring additional premiums and cost sharing.
- Vision services – Available in the Marketplace, but often with high deductibles, other cost sharing, and more limited benefits. These services are not limited by Oregon's CHIP program due to federally required Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.[8]
- Hearing exams, hearing aids.
- Physical and speech therapy and habilitative services – Commercial plans often have limitations and exclusions compared to benefits covered in Medicaid/CHIP.
- Non-emergent medical transportation – Typically not available through QHPs or ESI coverage; transportation is frequently a barrier to access for children in lower income households.
- Enabling services – Sign language and other translation/interpretation for individuals with Limited English Proficiency.

In addition, QHPs and ESI have higher cost sharing through premiums and co-pays/deductibles than in Oregon's CHIP program.[9]

Methodology for Estimating CHIP Premium Assistance Cost Effectiveness

Figure 2 illustrates the method used to determine cost effectiveness for a CHIP premium assistance program in Oregon. The analysis began by estimating premium and administrative costs for providing direct CHIP coverage in CY 2017, using available historical Medicaid data. To estimate the number of CHIP enrolled children that would be eligible for premium assistance between 200-300% FPL, OHA's Office for Forecasting, Research and Analysis used caseload data from fall 2014. An estimated 16,458 would be eligible. We then estimated premiums for Marketplace coverage in Oregon, projecting costs to 2017. Finally, we compared the estimated costs for offering premium assistance (i.e. the cost of subsidizing children's premiums, and wrapping benefits and OOP costs) through QHPs with direct CHIP coverage to determine cost effectiveness.

Figure 2. Method for Determining Cost Effectiveness (2017)



[8] EPSDT provide comprehensive services for serious conditions that affect growth and development. This is particularly important set of benefits are low-income, publicly insured children are more likely than privately insured children to have a range of special health care needs. See Commonwealth Fund Data Brief, September 2005.

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

Table 1 shows the projected costs and federal and state funds, with and without the 23% bump in federal match for CHIP in CY 2017,[10] CHIP premiums for CY 2017 are projected to cost $1,968 per member per year (PMPY). Program administration expenses were estimated as a percent of total program expenditures using Oregon's current CHIP admin rate of 6.7%. Prior to calculating the projected state funded portion of CHIP in 2017, we reviewed the 2015-17 Governor's Budget. The budget assumes that federal CHIP funding will be reauthorized and includes the 23% bump provided by the ACA, bringing Oregon's federal CHIP match rate to 97.25% in CY 2017. We estimated the total state and federal funds with and without the ACA bump. Total projected costs for direct CHIP coverage in CY 2017 is $2,109 PMPY.

Table 1. Projected CHIP Costs and Federal and State Funds, PMPY, CY 2017

CHIP Premium	**$1,968**	
Federal Match	97.25% (with 23% bump)	74.25% (without 23% bump)
Federal Funds	$1,914	$1,461
State General Funds	$54	$507
CHIP Admin (6.7% of Total Program Expenditures)	$141	
Total CHIP Program Cost (PMPY)	**$2,109**	

After determining the total projected cost for CHIP in CY 2017, which established the ceiling for funds available for any premium assistance program for it to be cost effective, we estimated the cost for a premium assistance option for individual coverage. For individual coverage, costs for individual plans both in and outside of the Marketplace were assumed to be the same.[11] The annual premium rate used for individual plans was the second lowest cost silver plan (SLCSP). To conservatively estimate program costs, the Medford region, with the highest SLCSP was selected.[12] It is necessary to estimate the premium of the second-lowest cost silver plan in the Marketplace to determine the amount of subsidy the state would have to cover in a CHIP premium assistance program.

To estimate costs for wraparound of non-covered services and OOP costs for physical and mental health costs for individual commercial plans, we assumed the state's expenses would be similar to what is currently paid for children in the Temporary Assistance for Needy Families-Medical (TANF) program and children eligible under the poverty level medical category (PLM),[13] who have major medical third party resources. Therefore, claims from TANF and PLM children with major medical third party resources were used.

[10] 2017 is the earliest feasible implementation date for the program

[11] ACA §1301(a)(1)(C) requires that QHPs "charge the same premium rate for QHP plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent."

[12] The projected 2017 SLCSP rates for Oregon range from a low of $1,428 PMPY (Bend) to a high of $1,572 PMPY (Medford); the median rate is $1,524.

[13] http://www.oregon.gov/oha/healthplan/tools/OHP%20Rate%20Group%20categories.pdf

The data period used to estimate physical and mental health costs was July 2012 through June 2014. Per member per year (PMPY) estimates were derived from the claims data, demographically adjusted to reflect less newborn-related costs in the CHIP population than in TANF and PLM, and trended forward to 2017 using a 3.4% Medicaid trend rate that aligns with the Oregon's 2012 Medicaid waiver. The OOP wraparound costs to the state were estimated by reimbursing the full value of cost sharing claims, at commercial rates, instead of limiting claims to Oregon's Medicaid reimbursement rate.

The estimated annual premium for an individual level plan was $1,572, which on average pays about 70% of the costs of all claims.[14] We further assumed that approximately 10% of the premiums are for administrative expenses, resulting in total estimated medical costs of $2,021 ($1,572 x 90% / 70%), and the plan would pay $1,415 ($1,572 x 90%). The difference in cost sharing, or the cost to the state to cover the child's OOP costs, is $606 PMPY.

The cost to wrap services (i.e. benefits) available in OHP that are not provided in the individual commercial plans is $456 PMPY. Currently, clients with major medical third-party resource (TPR) still enroll in a Medicaid dental care organization (DCO) as their TPR is unlikely to cover dental. The dental wraparound costs were estimated using CCO rates. The dental wraparound costs could be significantly more if a standalone commercial dental plan is purchased through the Marketplace. The total wraparound costs the state would have to pay for both services and OOP costs would be $1,062 PMPY.

Table 2 (see next page) lists the comparison of program costs between the direct CHIP program and premium assistance for individual plans both in and outside of the Marketplace. For premium assistance, two admin rates were used: the current CHIP admin rate of 6.7%, and 10%, which is the maximum allowable admin rate for CHIP. It is highly unlikely that a premium assistance program would be able to achieve Oregon's current direct CHIP admin rate of 6.7%, due to the added administrative complexity for operating such a program. This is supported by FHIAP's historical administrative costs for premium assistance, which fluctuated between 9-14% of total program costs.[15] Assumptions relating to program take-up were not made as they would require considerable modeling beyond what was needed to determine cost effectiveness for a premium assistance program.

[14] Refers to the actuarial value of 70% for Silver plan as specified by the ACA. A health plan will pay 70% of health care expenses, while the enrollee themselves will pay 30% through some combination of deductibles, copays, and coinsurance.
[15] Unpublished FHIAP program data from 2000-2009.

Table 2. Cost Comparison of Direct CHIP Program to Premium Assistance Program for Individual Plans, PMPY, Projected for CY 2017		
	Direct CHIP Program (Oregon Health Plan)	**Premium Assistance for Individual Plans In and Outside the Marketplace**[16]
Eligible Population	16,458	
Benefits	Oregon Health Plan	Essential Health Benefits
Premium	$1,968	$1,572[17]
Wraparound Cost	N/A	$1,062
Program Admin	$141	$189-$293*
Total Program Cost (PMPY)	**$2,109**	**$2,824-$2,927**
Program admin for premium assistance was calculated at 6.7% and 10%.		

Employer Sponsored Insurance Coverage Option

Due to variation in ESI plans and limited data availability of data, program estimates for this coverage option were not feasible. One of the main obstacles is that small employers or those with less than 50 employees[18] offering non-grandfathered plans, are required to offer the essential health benefits, while large employers (>50 employees) are not, making it difficult to compare ESI benefits to direct CHIP benefits. Based on an analysis of ESI in Oregon by the State Health Access and Data Assistance Center (SHADAC), the projected average annual premium for family ESI coverage in Oregon in CY 2016/2017 is $19,237, with families paying an average of 23% of the premium costs, or $5,140.[19,20] The average ESI deductible for an Oregon family for the same time period is projected to be $3,846.[21]

Taking into account the average premium costs and deductibles that a family in Oregon would have to pay for ESI coverage, it is unlikely ESI plans would be cost effective to the state under premium assistance. Recent national analyses[22,23] support this assessment, indicating there has been general decline in the availability of affordable ESI and an increase in employee cost sharing—further reducing a state's ability to meet the federal

[16] The individual plan rates for plans sold through Marketplace are same as the rates for the same plans outside of the Marketplace, by company.
[17] SLCSP rates for Oregon range from low of $1,428 PMPY (Bend) to high of $1,572 PMPY (Medford); the median rate is $1,524.
[18] ACA §1402
[19] SHADAC analysis of Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey - Insurance Component (MEPS – IC) 2004,2005,2008,2009,2012 & 2013.
[20] For the MEPS IC survey, "family coverage" is any coverage other than single and employee-plus-one. Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, survey respondents are asked to report costs for a family of four.
[21] SHADAC analysis of Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey - Insurance Component (MEPS – IC) 2004,2005,2008,2009,2012 & 2013.
22 Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act. Kaiser Commission on Medicaid and the Uninsured (March 2013).
[23] Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., Kenward, K. (2014). Health benefits in 2014: Stability in premiums and coverage for employer-sponsored plans. *Health Affairs, 33(10), 1851-1860.*

cost effectiveness requirement for a CHIP premium assistance program. For these reasons, there's likely to be considerable need for subsidization of enrollee costs in ESI. Further analysis of ESI as a viable option for premium assistance is necessary to make a conclusive determination.

Summary of Cost Effectiveness Analysis

After taking into account total premium assistance program costs—premiums, wraparound and admin expenses—this analysis finds that there would be a net cost to the state to offer this coverage option. Results in Table 3 suggest that Oregon would have to allocate additional state funds, approximately $714-$818 PMPY per enrollee, to establish a CHIP premium assistance program.

Table 3. Cost Effectiveness of Premium Assistance Compared to Direct CHIP Coverage, PMPY, Projected for CY 2017	
Direct CHIP Program Cost	$2,109
Premium Assistance Program Cost for Individual Plans In and Outside the Marketplace	$2,824-$2,927
Cost Effective (PMPY) Surplus/(Deficit)	**($714-$818)**

Alternatively, in order to generate savings in an effort to meet the federal cost effectiveness requirements, Oregon would have to restructure key features of its existing CHIP program by waiver (e.g. reduce benefits, and/or establish monthly premiums beyond the maximum OOP cost limit of 5%).

Conclusion

While CMS has indicated that offering a voluntary CHIP premium assistance program to a subset of the population is federally permissible, several factors led OHA to conclude that such a program not feasible at this time. In agreement with the MAC, the OHA finds that, while these programs offer some benefits, they are often complex and costly to administer, and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and Marketplace continue to stabilize.

Further, Oregon's post-ACA, 2015 coverage environment is very different than in previous years. Approximately 350,000 children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through OHP than what is generally available in the commercial market. The majority of children enrolled in Medicaid/CHIP are also served by innovative care delivery models via CCOs and patient-centered primary care homes. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim. Lastly, the coverage option(s) modeled for premium assistance were not found to be cost effective.

The Oregon Health Authority does not recommend establishing a CHIP premium assistance program for children served by OHP. If there is legislative interest in pursuing this option,

OHA recommends further research and analysis to ensure that coverage options, enrollment systems, child-specific benefits, issues of affordability, and provider network alignment are critically examined and that the important gains achieved through Oregon's success with enrolling low-income children in OHP coverage are protected.

Appendix A: Summary of CHIP in Oregon, 2014

Summary of CHIP in Oregon, 2014

Eligibility Levels	Ages 0-1: >185-300% FPL Ages 1-18: >138-300% FPL
Enhanced FMAP	74.84% in FY 2015[24]; projected 97.25% (with 23% ACA bump) in FY 2017, although funding beyond 2015 currently unknown.
Waiting Period	None (the period of uninsurance was reduced from two months to zero, effective 8/23/13).
Eligibility and Enrollment	Eligibility levels in Oregon for CHIP were revised based on 2014 federal poverty levels and reflect Modified Adjusted Gross Income (MAGI)[25] converted income standards that include a five-percentage point of the FPL disregard.
Five-Year Waiting Period for Lawfully Residing Children	Oregon does not have a waiting period for lawfully present children.
Benefits	OHP *Plus* (full Medicaid w/EPSDT coverage per Prioritized List), with specified enhanced dental and vision coverage.
Cost-sharing	No premiums and copays; 5% aggregate cap on cost-sharing as a percent of family income.
Delivery System	Coordinated Care Organizations (CCOs), Fee-for-service (FFS), Fully Capitated Health Plan (FCHP), or Indian Health Services (IHS).
Continuous Eligibility for 12months	Oregon allows children to retain coverage for 12 months, regardless of whether their family income changes during that time period.

[25] The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security; does not include income from gifts, inheritance, Survivors Benefits, some other income sources are partially excluded; does not consider property, savings accounts, etc. for eligibility determination.

MEMORANDUM

DATE: January 6, 2015

TO: Oregon Health Authority, Medical Assistance Programs

FROM: Oregon Medicaid Advisory Committee

RE: Senate Bill 1526: Options and Considerations for Premium Assistance in Oregon's Children's Health Insurance Program

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Senate Bill 1526 (2014) charges the Oregon Health Authority (OHA) with assessing the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance premiums for children in families with incomes between 200-300% of the federal poverty level (FPL), commonly referred to as premium assistance.

In the fall of 2014, Oregon's Medicaid Advisory Committee (MAC) was tasked by OHA to examine the issue of a voluntary premium assistance program, per SB 1526, and advise the Authority. The Committee reviewed federal regulations and guidance, assessed Oregon's health coverage and reform landscape, and considered the state's historical experience with premium assistance programs. The Committee then examined the benefits and challenges of a CHIP premium assistance program, viewed through the lens of CHIP beneficiaries and their families, the State, Coordinated Care Organizations (CCOs), the commercial market/Marketplace, and providers.

While the Committee identified some benefits, they recognize such programs are complex, costly to administer, and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and Marketplace are still stabilizing. Further, the post-2014 coverage environment is very different, as most Oregon children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market. OHP enrollees are also served by innovative care delivery models via CCOs. Lastly, per SB 1526, the option to enroll in premium assistance would only be available to a very small fraction of children in OHP. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim.

Based on the Committee's work, it advises OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time and that the state reassess future opportunities to improve Oregon's CHIP program after the status of the program's federal funding is resolved by Congress.

Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee

Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Background

Premium assistance programs aim to offer low- and moderate-income families access to affordable commercial health insurance coverage. These programs provide eligible beneficiaries additional coverage options, and may support whole family coverage, by allowing all members of a family to remain in a single commercial plan and be served by the same provider network, regardless of their coverage type.

States have varied experiences with implementing such programs through Medicaid and CHIP.[26] States that offer CHIP premium assistance programs are required to provide "comparable coverage" and ensure that children do not have greater out-of-pocket costs (premiums and cost sharing) than under direct CHIP coverage through Title XXI of the Social Security Act. States must fill benefit gaps that exist between commercial plans and CHIP benefits and wrap consumer out-of-pocket costs, to the extent that they exceed CHIP levels, if premium assistance if offered. States must also ensure that the program is cost effective, that is, the cost of covering an individual through premium assistance must be no more than providing "comparable coverage" than in the direct CHIP program.[27]

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP and several premium assistance programs through Healthy Kids. Oregon's premium assistance programs were available in a variety of formats, but in general, subsided both employed sponsored insurance (ESI) as well as certain individual plans for children in families up to 300% FPL. Due to ACA coverage expansions, these programs ended December 31, 2013. Starting in 2014, children in Oregon in families up to 300% FPL receive comprehensive, no-cost coverage through the Oregon Health Plan (OHP).

Program Design Considerations for CHIP Premium Assistance in Oregon

In order to assess issues relating to the design and implementation of a CHIP premium assistance program in Oregon, the Committee reviewed the general structure for the program based on current federal guidelines and taking into account the state's health coverage landscape. Table 1 provides an overview.

[26] Kaiser Commission on Medicaid and the uninsured. Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act. March 2013

[27] U.S.C. 1397ee(c)(3)(A)

Table 1. Program Design Considerations for CHIP Premium Assistance in Oregon

Program Element	Requirements and Options
Benefits	State must provide "comparable coverage" to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits
Premiums and Cost Sharing	State must ensure children in premium assistance do not have greater out-of-pocket costs than those with direct CHIP, and wrap consumer out-of-pocket costs to the extent they exceed CHIP levels
Carriers/ Delivery System	Commercial coverage options that may be subsidized include: – QHPs, including CCOs offering certified QHPs – Individual plans available outside the Marketplace – Commercial plans offered by employers * *Provider networks between OHP and the commercial markets vary*
Employer Contribution	Optional; historically, has been a requirement in past Oregon ESI premium assistance programs
Administering Entity	Oregon Health Authority
Program Administration	At a minimum, administrative capability would need to be developed for: – Eligibility determination and enrollment – Tracking of benefits and consumer out-of-pocket costs – Education and outreach, customer service, etc. – Coordination with plan administration
Financing	– FY 2015 federal match rate = 74.84%[28] – FY 2017 federal match rate = 74.25% (without ACA 23% bump); 97.25% (with 23% ACA bump)[29]
Cost Effectiveness[30]	The State's cost of covering an individual through premium assistance must be the same or less than providing "comparable coverage" to the individual in the direct CHIP program; must include the cost of providing wraparound coverage and administrative costs; can be applied on an individual or aggregate basis.
Federal Budget Neutrality	If the state seeks a federal waiver to implement the program, the program must be budget neutral to the federal government, meaning the costs must not exceed what they would have been without the premium assistance demonstration.
Federal Authority	Several options for states interested in offering premium assistance coverage for children currently eligible for CHIP: CHIP State Plan options; 1115 Demonstration Waiver; or Innovation Waivers (starting in 2017, ACA provides states the flexibility to apply for federal "Innovation Waivers).

[28] FY 2015: Federal Register, January 21, 2014 (Vol 79, No. 13), pp. 3385-3388.
[29] The ACA extends CHIP through most of 2015 and beginning October 1, 2015 the already enhanced CHIP federal matching rate will increase by 23 percentage points, not to exceed 100%. The enhanced federal matching rate continues until September 30, 2019.
[30] See P.L. 111-3 and P.L. 111-148 §10203(b)(1). An exception to this lies in the 1905(a) option, which does not include a statutory reference to cost effectiveness, however recent regulatory guidance mentioned above includes a cost effectiveness definition similar to the statutory definition described here.

CHIP Premium Assistance: Programmatic Benefits and Challenges

The Committee considered the potential structure for a CHIP premium assistance program in Oregon and identified benefits and challenges viewed through the lens of CHIP beneficiaries and their families, the State, CCOs, the commercial market/Marketplace, and providers. The table below is not an exhaustive list of benefits and challenges.

Table 2. Benefits and Challenges for CHIP Premium Assistance in Oregon

Stakeholder	Benefits	Challenges
Consumers	• Offers voluntary participation and choice of health plans • Safeguards benefits and consumer out-of-pocket costs and affordability • Fosters whole family coverage • Depending on design, may help consumers maintain continuity across plans and providers based on IAP eligibility	• Creates an additional coverage option which may add consumer confusion • Equity issue: Per terms of SB 1526 not all CHIP children would have access to premium assistance, only those from 200-300% FPL • Unknown impact on access to health care providers, including care coordination and continuity
State	• Prior experience in offering premium assistance programs	• Complexities with program administration; need to ensure comparable benefits and affordability to direct CHIP coverage • Increase in provider reimbursement may lead to higher PMPM charges; state could face increased costs • A performance and quality infrastructure similar to OHP's is not currently in place statewide in the commercial market • State responsible for start-up and ongoing administrative costs • Requires federal approval, and state legislative and budget approval • Federal cost effectiveness and budget neutrality are difficult to achieve
CCOs	• None identified unless certified as QHPs	• Enrollment in CCOs could decline, potentially affecting risk pool
Commercial Plans	• More covered lives • PA through Marketplace could encourage more CCOs to offer certified QHPs	• Oregon's Marketplace is still stabilizing • Complex plan administration if a separate CHIP look-alike plan is needed • Different enrollment periods between CHIP and the commercial market • Voluntary nature of program creates potential risk volatility for participating carriers as individuals could dis-enroll/reenroll at any time
Providers	• Enhanced provider reimbursement relative to OHP payment rates	• Encourage consumers to switch providers more frequently; providers' patient panels could be less stable

Although CHIP premium assistance programs may offer some advantages—consumer choice, while maintaining benefit coverage and consumer affordability comparable to CHIP—the Committee concluded that these programs are often complex in design, face considerable implementation barriers, including costly administration, and may add to consumer confusion.

A recent synthesis of research on the impact of the Medicaid and CHIP programs found that beneficiaries experience improved access to care, utilization, and financial protection. Research also indicates that these programs are positively associated with the quality of care children receive, and that parents value the programs.[31] In Oregon, the MAC acknowledges the success of Healthy Kids, which has brought affordable comprehensive coverage to over 100,000 children through Medicaid and CHIP.[32] The Committee also noted that the benefit coverage for children in the OHP is also more generous than the essential health benefits (EHBs) benchmark plan offered through the Marketplace.[33] Nearly 90% of OHP members are served through innovative care delivery models via CCOs, and as of March 2014, nearly 80% of CCO members were enrolled in a patient-centered primary care home.[34] Overall, it is unclear at this time whether or to what degree establishing a CHIP premium assistance program leverages current statewide health reform initiatives, advances spread of the coordinated care model and supports triple aim goals.

In addition to weighing the benefits and challenges of a premium assistance program, the Committee considered the program in the context of Oregon's existing coverage landscape and health care market trends. In Oregon and nationally, commercial market trends show a general decline in availability of ESI, increases in employee cost sharing, and expanding use of high deductible health plans. These trends make it increasingly difficult for states to meet the federal cost effectiveness requirement of a premium assistance program through ESI.[35,36]

Conclusion

The Committee advises that Oregon's Medicaid and CHIP eligibility and enrollment systems as well as its Marketplace are still stabilizing. It is unclear how offering premium assistance to a limited number of low-income families aligns with the Oregon's priorities. These include ensuring all children in Oregon are healthy and Kindergarten ready, and achieving

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[31] Paradise, J. The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us? Kaiser Family Foundation. July 2014.

[32] http://www.oregonhealthykids.gov/healthykids/history.html

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

[34] Oregon Health Plan Section 1115 Annual Report. Demonstration Year: 12, 7/1/2013–6/30/201[34] FY 2015: Federal Register, January 21, 2014 (Vol 79, No. 13), pp. 3385-3388.

[34] The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security; does not include income from gifts, inheritance, Survivors Benefits, some other income sources are partially excluded; does not consider property, savings accounts, etc. for eligibility determination.

an integrated and coordinated health care delivery system in support of the triple aim for all Oregonians. The Committee advises the OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time, and that future consideration may warrant further deliberation by interested stakeholders. The Committee recommends Oregon consider future opportunities to improve Oregon's CHIP program be reassessed after the status of the program's federal funding is resolved by Congress. Thank you for your consideration.

Medicaid Advisory Committee Members (*as of Jan. 2015)

Karen Gaffney, MS – Co-Chair, *Lane County health care executive, Trillium CCO Board Member*

Janet Patin, MD – Co-Chair, *physician, Columbia Pacific CCO Board Member*

Romnee Auerbach, MS, ANP, PMHNP-BC – *health care provider*

Rhonda Busek, MBA – *Interim Director, Medical Assistance Programs, OHA*

Carol Criswell, BA – *parent, patient advocate*

Kay Dickerson, BA – *OHP member, patient advocate*

Kristen Dillon, MD, FAAFP – *physician, Columbia Gorge CCO Board Member*

Alyssa Franzen, DMD – *dental provider; Dental Director, Care Oregon*

Leslie Sutton, JD – *children & disability advocate, Oregon Council on Developmental Disabilities*