HB 2009 STAFF MEASURE SUMMARY

House Committee On Health Care

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Sub-Referral To: Joint Committee On Ways and Means
Meeting Dates: 3/14

WHAT THE MEASURE DOES:

Allows an individual to enroll in a coordinated care organization (CCO) if not eligible for Medicaid or premium tax credits through the Affordable Care Act (ACA) and meets specified income requirements: (1) between 138-400 percent of the federal poverty level (FPL), or (2) between 400-600 percent of the FPL and is offered employer-sponsored health coverage but required to pay full cost of premiums. Eligible individuals are required to pay enrollment premiums. Authorizes the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to adopt rules to establish enrollment process, determine enrollment premiums, and collect premiums to reimburse CCOs for covered services. Establishes coverage mandate for individuals who are full-time residents to enroll in health coverage that meets the “minimum essential coverage” requirements created by the ACA for at least nine months in a calendar year. Specifies penalty amount for individuals. Specifies conditions for which an individual is not subject to the coverage mandate. Directs OHA to use collected penalties to fund premium assistance and conduct outreach.

REVENUE: May have revenue impact, but no statement yet issued.
FISCAL: May have fiscal impact, but no statement yet issued.

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

No amendment.

BACKGROUND:

Recently, policy proposals have been introduced at both the federal and state levels that would permit individuals above Medicaid eligibility levels to “buy in” to Medicaid or leverage the state Medicaid program to strengthen coverage across the individual market and Medicaid. States are exploring the concept of a Medicaid buy-in program (or public option) to establish a new coverage program targeting lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace. A state has flexibility in designing a Medicaid buy-in proposal, making policy decisions across a range of key program features such as provider networks, reimbursement rates and the role of public and private plans, to create a program that resembles a Medicaid benefit, a marketplace product or a hybrid of the two. States may choose to pursue federal waivers (e.g., Section 1332). As of 2019, seven states have introduced legislation to create Medicaid buy-in proposals seeking to address marketplace access and competition, insurance premium and cost-sharing affordability, and alignment across Medicaid and individual insurance market coverage.

In 2018, Congress eliminated the ACA’s financial penalty for individuals who do not have insurance starting in 2019, often referred to as the individual mandate or shared responsibility. In response, states are moving forward with state-level individual insurance mandates including New Jersey, Rhode Island, and Vermont, among others. States are considering a shared responsibility mandate and imposing penalties for those who do not maintain coverage. This policy approach may generate state revenue and incentivize currently uninsured adults to obtain coverage, if affordable. States are considering uses for potential revenue generated from the penalties including funding market stabilization and consumer affordability initiatives.

PRELIMINARY

House Bill 2009 establishes a targeted Medicaid-like buy-in program and state-based shared responsibility coverage requirement.

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