

The Oregon Bridge Plan: Potential Federal Pathways to Meet Oregon's Goals

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Joel Ario, Managing Director

Manatt Health

- **Overview of Three Federal Financing Options**
- **Comparing Options and Implementation Considerations**
- **Questions**

Overview of Three Federal Financing Options

House Bill 4035 requires the Oregon Health Authority (OHA) to pursue three potential options for federal authority and financing of Oregon's bridge plan.

Section 1115 Waiver

*Also known as **Medicaid Demonstration Waivers**, 1115 waivers offer states an avenue to test new approaches in Medicaid.*

Section 1331

*Section 1331 of the ACA enables states to establish a **Basic Health Program (BHP)** for individuals not eligible for Medicaid with household incomes under 200% FPL.*

Section 1332 Waiver

*Also known as a **State Innovation Waiver**, states can use 1332 waivers to waive certain ACA Marketplace requirements and capture federal savings, if any, for state purposes.*

1115 Option: Expand Medicaid

1115 Waivers: Medicaid Demonstration Waivers

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve State Medicaid demonstration projects. These demonstrations give states additional flexibility to design their programs and are intended to demonstrate and evaluate policy approaches not typically allowed under Medicaid rules such as:

- Expanding eligibility to populations not otherwise eligible for Medicaid;
- Providing services not typically covered by Medicaid; or
- Using innovative payment and delivery models.

Waivers are initially approved for a period of three or five years.

Waivers must:

- ✓ Be approved by the Secretary
- ✓ Be budget neutral to the federal government
- ✓ Promote the objectives of the Medicaid program
- ✓ Receive stakeholder input during development process

Section 1115 Financing

- **Federal share: 60%***
- **State Share: 40%***
- 90% match for expansion adults not available for bridge program

** For Oregon; other states' match rates vary*

Source: [Medicaid State Plan Amendments](#), Medicaid.

An 1115 waiver may be an ideal short-term option, but not a cost-effective, long-term option.

Considerations

- Simple and relatively quick to implement (~6 months)
- May be needed as a stop gap while options with better federal financing are pending
- Builds on Oregon's investment in CCOs
- Allows customized plan design
- Shifts some population away from Marketplace (impacts under study)
- Precludes optionality
- 40% state match is more expensive than 1331 or 1332 options
- Not a viable long-term path given 40% state match

1331 Option: Basic Health Program (BHP)

Overview: Section 1331 of the ACA, The Basic Health Program (BHP)

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Section 1331 allows states to implement a BHP for individuals up to 200% FPL who would otherwise be eligible to purchase coverage through the Marketplace.

- **Overview.** Statute establishes Medicaid-like parameters for BHP coverage (competitive bidding process, minimal or no premiums and cost sharing) that make the BHP a good fit for individuals transitioning out of Medicaid
- **Eligibility.** Custom-made for the 138-200% FPL population; also includes legal immigrants not otherwise eligible for Medicaid.
- **No Optionality.** Those eligible for the BHP are not eligible for tax credits to purchase Marketplace coverage.
- **Per-Capita Federal Funding Formula:** Oregon would get 95% of what the state would have received in tax credits and cost sharing reductions for the full BHP population. Funds must solely benefit BHP enrollees and cannot pay for administrative costs. Per-capita formula reduces risk to the state (state not financially responsible for increased enrollment).

Section 1331 Financing

- **Federal share: 95% of federal spend for Marketplace coverage**
- **State Share: Possibly \$0. Depends on state decisions on benefits and other program costs**
- Per capita funding formula
- State responsible for administrative expenses

The Basic Health Program removes enrollees below 200% FPL from the individual market risk pool.



Key Considerations:

- What is the risk profile of the lower income, more heavily subsidized 138-200% FPL population vs. the 200-400+% FPL population?
- What kind of strategies may be needed to ensure CCO and provider participation beyond paying enhanced rates?

State History with the Basic Health Plan (BHP)

Minnesota

- The first state to implement a BHP in 2015, building off its pre-existing MinnesotaCare program.
- The BHP program is administered by the Medicaid agency with joint procurement for Medicaid managed care and the BHP issuers; payments to issuers include BHP adjustment.
- The BHP reduces pass through for the state's reinsurance program; CMS is expected to fix this problem.

New York

- Adopted a BHP for low-income adults in 2016 building on a prior state program.
- The BHP program is administered jointly by the Medicaid agency and the Marketplace, capitation rates are set by the Medicaid agency at higher than Medicaid rates.
- The BHP covers nearly 970,000 enrollees, roughly double initial projections, and Trust Fund runs a surplus.
- New York pursuing BHP expansion above 200% FPL.

Oregon BHP History

- Oregon Legislature commissioned two BHP studies in 2014 and 2015; state did not implement advisory group recommendation.
- Oregon and other states shifted focus to 1332 waivers resulting in reinsurance waivers.
- BHP re-emerging alongside 1332 waivers as reform states consider ways to make coverage more affordable.
- Unlike Oregon's most recent public option study, BHP targets 138-200% FPL population.

How a 1331 Could Support Oregon's Bridge Plan

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1331 is the most straightforward long-term option and likely could be a short-term option for the group that is affected by the PHE unwinding if Oregon commits to adopting the long-term option within a set period of time.

Considerations

- Well-defined pathway for addressing churn in 138-200% FPL population
- 95% financing formula has worked well in NY and MN (except for reinsurance issue which is likely to get fixed)
- Per capita financing eliminates state financial risk for increased enrollment
- Statute sets out clear path to implementation, but also precludes optionality
- Shifts population away from Marketplace (impacts under study)
- Both MN and NY had BHP-like plans pre-ACA (setting precedent for payer and provider payment terms)
- Short-term 1331 likely will be conditioned on commitment to implement long-term 1331

1332 Option: Pursue Consumer Choice

Section 1332 of the ACA permits states to reshape individual market coverage by replacing key components of the ACA with alternative state solutions that meet the same coverage and affordability goals as the ACA.

- **Waivable provisions** include:
 - **Benefits and subsidies.** States may modify the rules governing covered benefits and subsidies. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies for alternative approaches.
 - **Marketplace and QHPs.** States can modify or eliminate QHP certification and the Marketplaces as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.
- **Market placement.** Alternative 1332 benefit plans can be offered on or off Marketplace, or as a separate state program.
- **Risk pool placement.** 1332 plans can be offered in same risk pool as Marketplace plans or in a separate risk pool in most circumstances.

Section 1332 Financing

- **Federal share: 100% with offsets**
- **State Share: Depends on offsets**
- Offsets (e.g., loss of federal user fees) make financing similar to 1331 financing, except state responsible for cost of increased enrollment under current pass through formula

1332 waivers must meet four guardrails that are stringently enforced by the Departments of Health and Human Service and Treasury.

Guardrails

1 *Scope of Coverage*

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver

2 *Comprehensive Coverage*

The waiver must provide coverage that is at least as “comprehensive” as coverage offered through the Marketplace

3 *Affordability*

The waiver must provide “coverage and cost-sharing protections against excessive out-of-pocket” spending that is at least as “affordable” as Marketplace coverage

4 *Federal Deficit*

The waiver must not increase the federal deficit including all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue

Deficit Neutrality

Section 1332 requires that waivers **“must not increase the federal deficit over the period of the waiver.”**

Increased enrollment counts as new spending that must be offset by reduced premiums or other savings to generate pass through payments.

Pass Through Funding Under a 1332 Waiver

Section 1332 allows the federal government to “pass through” funds it would have spent on premium tax credits, cost-sharing reductions, and small employer tax credits to the state.

To receive federal pass-through funding:

- States must submit actuarial analysis to CMS forecasting federal costs with & without waiver
 - Net federal savings = state revenue as pass through funds
- CMS has only approved funding for reinsurance waivers
- Oregon’s proposal for a bridge program would require CMS to address legal and operational questions beyond those addressed with reinsurance

Using federal pass-through funding

- States may use pass through funding to:
 - Fund reinsurance programs
 - Provide state subsidies
 - Expand benefits
 - Other state uses, including an off-Marketplace coverage plan

[1] Dept. of Treasury Overview of Methodology Used to Calculate State Reinsurance Waiver Pass-Through Amounts: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-OTA-Methodology-Pass-through-Amounts-Feb-2021.pdf> [2] Overview of 1332 Guidance for State Relief and Empowerment Waivers (Nov. 2018), CMS: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/State-Relief-Empowerment.PDF> [3] <https://www.healthaffairs.org/doi/10.1377/forefront.20210309.706522/full/>

Overview of 1332 Waivers

- **Hawaii** secured the first 1332 waiver to preserve its state employer mandate in 2016
- **15 states have been approved for reinsurance waivers** since 2017
- **Many states have considered broader affordability waivers** but none have been approved to date
- **Colorado and Maine** have pending waivers to combine reinsurance with broader affordability initiatives

Oregon's History with 1332

- Oregon was early adopter of reinsurance waiver in 2017 and has considered various other 1332 innovations
- 2021 report proposed public option to extend CCO model to Marketplace
- Potential to lose coverage gains in PHE unwinding gives new urgency to finding a federally-financed solution (1331 or 1332)

Next Steps on 1332

- Optionality would offer choice between BHP-like product and Marketplace products to meet needs of people churning in and out of coverage at different income levels
- 1332 waiver is only potential vehicle for that form of optionality
- But indications are that optionality cannot be accommodated in the FFM until 2026 and may require an SBM

How a 1332 Could Support Oregon's Bridge Plan

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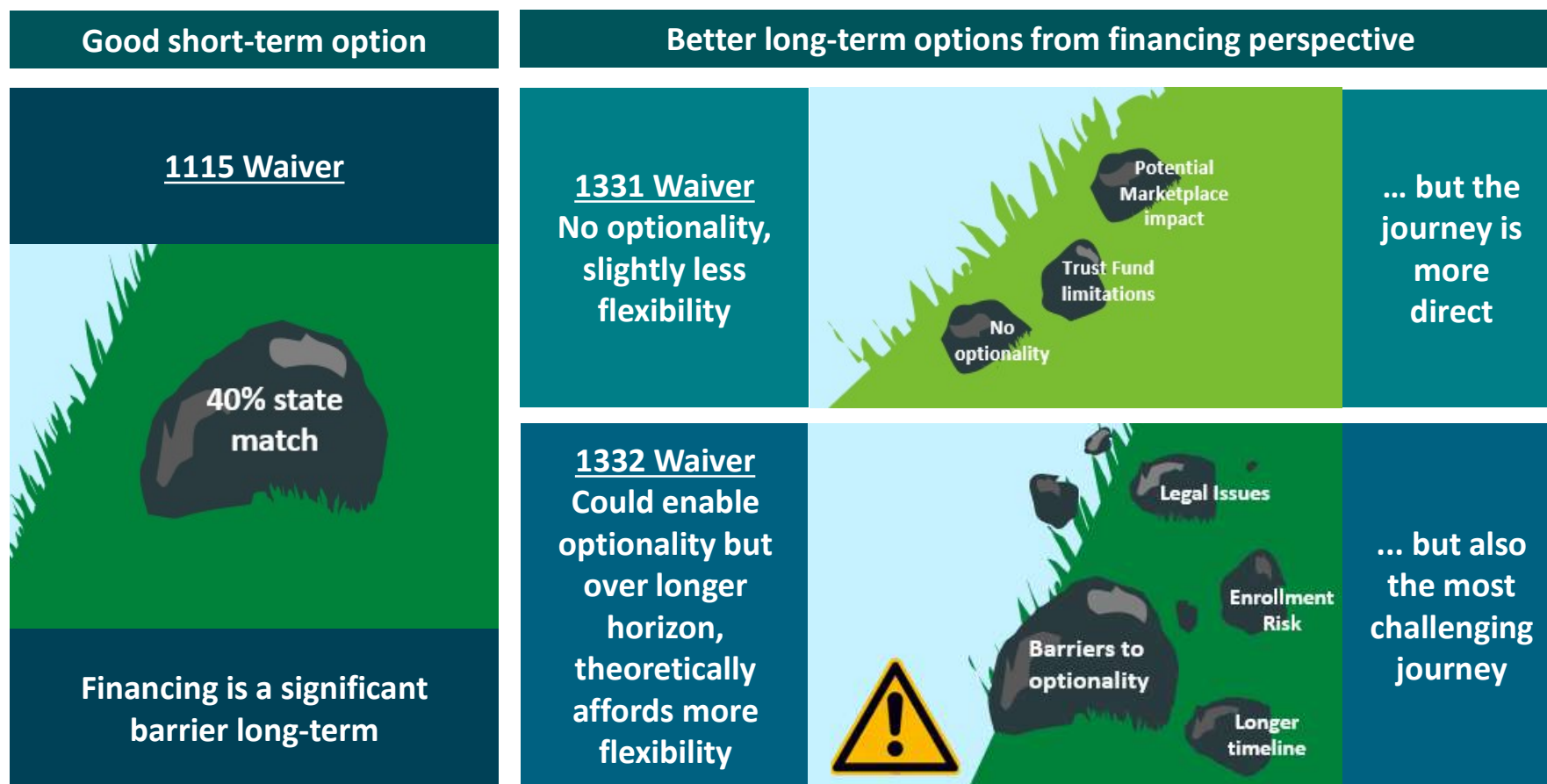
1332 has the potential to be the most flexible long-term option but comes with legal and operational challenges that are very likely to extend the timeline for approval and implementation.

Considerations

- Only pathway to optionality (if the legal and operational barriers can be overcome)
- Most flexible in terms of plan design and market placement (on or off Marketplace, Medicaid-regulated product, or state-defined hybrid product)
- More options to deal with potential disruption to the Marketplace
- Strong financing formula similar to 1331
- But potential for state to be at risk for increased enrollment (measure is aggregate spending not per capita spending)
- Multiple legal and operational challenges
- Optionality likely to require SBM, may be available on FFM in 2026

Comparing Options and Other Implementation Considerations

Each Waiver Pathway Faces Different Risks and Challenges



Key Considerations for the Task Force

Financing

An 1115 waiver is **the most costly to the state**, given the 40% match.

However:

- While a 1331 may provide the state with more dollars, the Trust Fund cannot be used for program administration
- While a 1332 waiver may also offer more dollars, it may carry an enrollment risk to the state and has other legal and operational uncertainties

Optionality

A 1332 waiver is the **only authority that permits optionality**.

However:

- Many legal issues with 1332
- FFM can not accommodate optionality until at least 2026, and CMS may well conclude that optionality requires SBM or at least some state build
- Very challenging to avoid consumer confusion and duplicate enrollments where consumer is eligible for two programs, one of which is operated by the federal government (FFM)

Timing and Pairing

The state may require an **immediate 1115 waiver** given likely timeline for either a 1331 or 1332

However:

- 1331 could be implemented more quickly than a 1332 (avoiding or reducing time in 1115 with a 40% match)
- But short-term 1331 may require commitment to long-term 1331
- Pairing an 1115 with a 1332 may offer more flexibility and more options for mitigating disruption if that proves an issue, but it is a less certain and likely longer path

The Task Force has flexibility to design a benefit plan with comprehensive benefits and no or minimal cost sharing under any of the three pathways.

1115 Waiver

Broad flexibility to design bridge plan with Medicaid-like features

1331 Waiver

Reasonable flexibility to design bridge plan that complies with statutory requirements for a Medicaid-like product

1332 Waiver

Flexibility to waive QHP certain requirements and design new product with Medicaid-like features

The Task Force has flexibility to address provider issues, including a capitation rate above Medicaid rates, under any of the three pathways, though the starting point will differ.

1115 Waiver

Medicaid as starting point; state can adapt provider rates for 1115 target populations

1331 Waiver

Medicaid as likely starting point; two states with BHPs have increased reimbursement from Medicaid levels

1332 Waiver

Marketplace as likely starting point; ACA Marketplace products typically have rates closer to group rates than Medicaid

The Task Force will have more information in June to determine what market disruptions there are, if any, under each pathway and then develop appropriate mitigation strategies

1115 Waiver

Depends primarily on whether target population is significantly more or less healthy than Marketplace population

1331 Waiver

Depends primarily on whether target population is significantly more or less healthy than Marketplace population

1332 Waiver

Depends primarily on whether the target population is in the individual market risk pool

Financing is a key distinguishing feature among the three models.

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Questions?