Building a Basic Health Program

Initial Plan Design Considerations

Bridge Program Task Force

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Oregon Health Authority

Todays goals

- Understand HB 4035 direction to the Task Force related to the plan design of the bridge program
- Discuss key plan design elements and their connectedness
- Lay groundwork for future decisions on plan design
- Introduce federal approval process – Basic Health Program Blueprint

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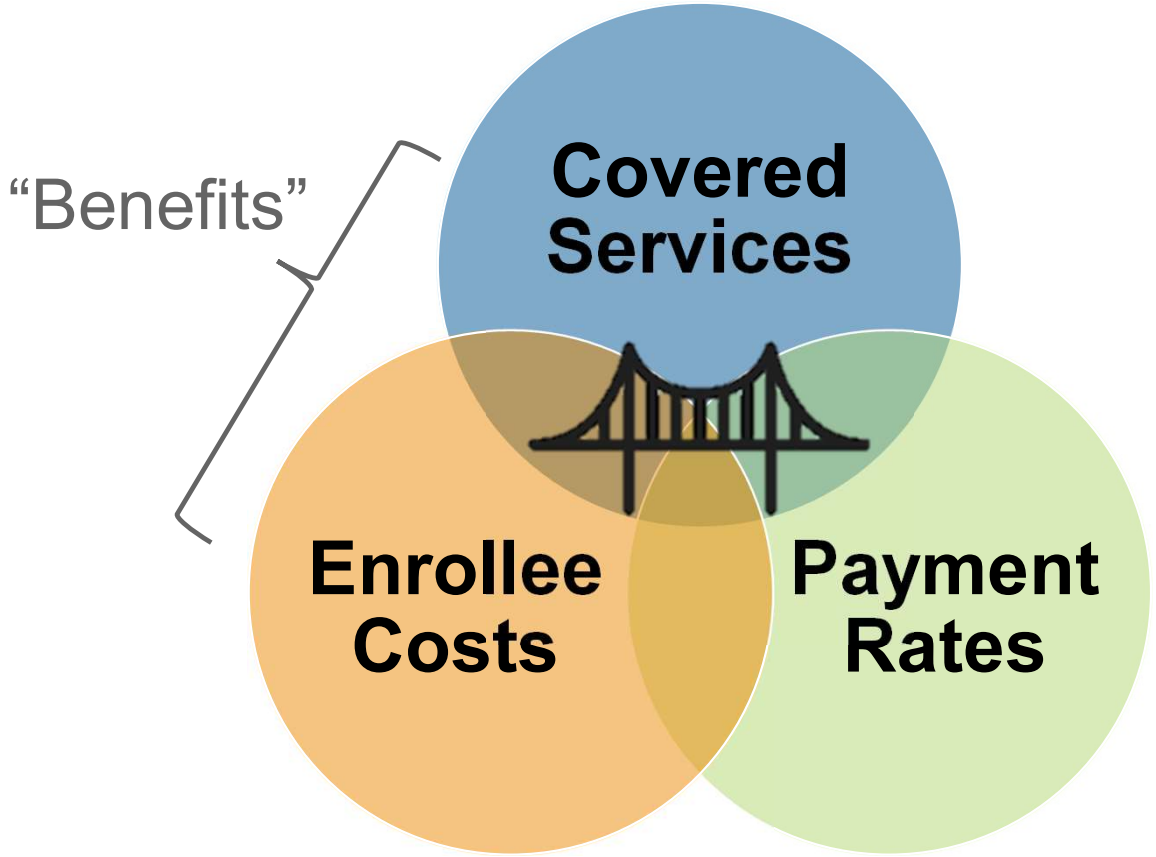
Key terms

- **Out-of-pocket costs / cost-sharing**
  - Costs members pay at the point of care, such as co-payments, coinsurance, and deductibles. Monthly premiums are not considered out-of-pocket costs.
- **Cost-Sharing Reductions (CSRs)**
  - Additional financial assistance available to Marketplace enrollees with income <250% FPL that reduce co-pays, deductibles, and out-of-pocket maximums. Only available if enrollees choose silver-tier plans
- **Advanced Premium Tax Credits (APTCs)**
  - Federal financial assistance toward the purchase of individual health insurance through the Marketplace

Key plan design components for consideration



HB 4035 direction on plan design

- Use and enhance the CCO delivery system
- Provide all Essential Health Benefits
  - *Underlying policy goal to align with OHP service package as possible*
- If practicable:
  - Cover dental services
  - Have lower out-of-pocket costs than current Marketplace plans, with goal of no out-of-pocket costs
  - Establish sufficient rates for plans and providers within available state and federal funding which are higher than current Medicaid rates

Covered Services

Essential Health Benefits

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
- Prescription Drugs
- Rehabilitative & Habilitative Services & Devices
- Laboratory Services
- Preventive & Wellness Services & Chronic Disease Management
- Pediatric Services, Including Oral & Vision Care

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Additional OHP covered services

OHP Covers services beyond the Essential Health Benefits

- Dental services
- Care coordination
- Behavioral health services beyond what commercial plans often cover including: substance use disorder treatment, peer-delivered services
- Non-emergency medical transportation services (ie, rides to appointments)
- Long-Term Services & Supports (not part of CCO benefits)

Consideration for covered services

- Existing CCO service package may offer most operationally efficient starting point for Bridge Program services
    - Are there services in the OHP services package that should be considered for removal?
- Is OHPs dental coverage package the appropriate starting point?

Enrollee Costs

Enrollee costs

There are multiple types of enrollee costs:

- Out-of-pocket costs/cost-sharing:
    - Co-payments
    - Deductibles
    - Co-insurance
- Monthly premiums

HB 4035 direction on enrollee costs

- Lower out-of-pocket costs than current marketplace options & consider plan with zero out-of-pocket costs
- HB 4035 does not provide specific direction regarding monthly premiums
  - Minimizing premiums would be consistent with broad legislative guidance for the program

Enrollee costs vary across marketplace plans

- Financial assistance comes in form of Premium Tax Credits
  - Value of subsidy based on enrollee income and cost of 2nd lowest silver plan in their service area
  - Additional cost-sharing reductions (CSR) available for 138-200% income group *if they choose a silver plan*
- Silver plan premiums could be $1 or even up to $100 / month
- Out-of-pocket costs vary across plans (with CSR):
  - <150% FPL: $100-400 deductibles, $5-10 co-payments
  - 150-200% FPL: higher deductibles & co-pays

OHP member costs

- Federal Medicaid rules limit use of premiums and cost-sharing
- Oregon has eliminated all cost-sharing & premiums from OHP
    - Historically, nominal Medicaid co-pays have shown to reduce access to care and generate little revenue

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Federal rules for BHP enrollee costs

- Premiums can be no higher than in the Marketplace
  - Current enhanced subsidy levels lower the federal limits compared to pre-ARPA ($0 premiums for <150% FPL)
- Cost-sharing can be no higher than for Marketplace plans (considering CSRs)
- No cost-sharing for preventive services

Highlights from BHP states

- **Minnesota:**
  - Sliding scale premiums for people with income from 160-200% FPL ranging from $4-$28 / month.
  - No deductibles, modest co-payments
- **New York:**
  - Recently eliminated all premiums (previously: $20/mo premiums for >150% FPL)
  - No deductibles or cost-sharing for dental/vision
  - Minimal co-pays <138, modest co-payments for 138-200% FPL

Bridge Program enrollee cost considerations

- HB 4035 does not mention monthly premiums – should monthly premiums be considered for some or all enrollees?
  - If so, how might premiums be structured?
  - How might the Task Force weigh revenue impact with potential impact on enrollees?
- A new set of rules or program structure may create operational challenges for CCOs
  - How do these challenges differ across different forms of enrollee costs?

Provider Payment Rates

Plan & provider reimbursement

- Task Force to make recommendations on reimbursement rate levels needed to operate Bridge Program within available funds
  - Payment rates potentially most significant variable determining overall Bridge Program costs
- Bill language implies a Medicaid-like rate development process
  - Bill calls for reimbursement rates above Medicaid levels, *if practicable*
- Operational Considerations: CCOs may have challenges if structure deviates significantly from OHP

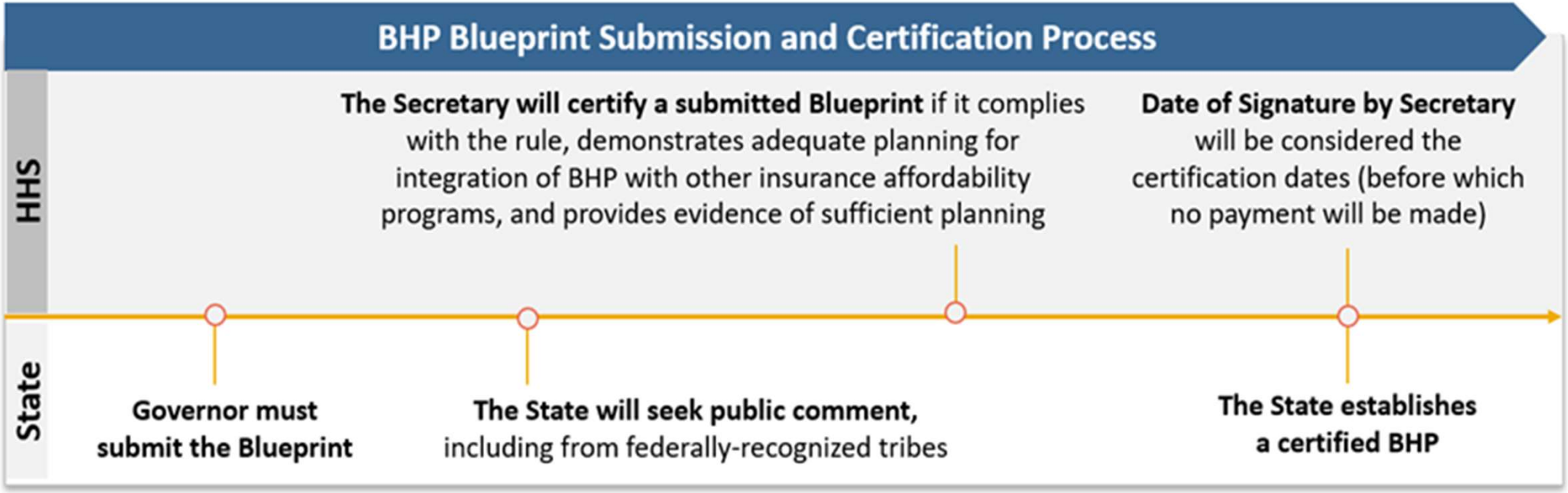
Big picture plan design considerations

- Federal (and state) funding availability will greatly inform Task Force decision-making on payment rates
- More complicated deviations from OHP policies and procedures could cause implementation challenges for CCOs
    - Varying commercial experience between CCOs may affect implementation, readiness, need for technical assistance
- Reimbursement rate setting may be further complicated by uncertainty related to redetermination process and population unknowns

Basic Health Program Blueprint

Basic Health Program: What is the blueprint?

- Blueprint provides a full description of the operations and management of the program and its compliance with federal rules



Blueprint includes plan design information

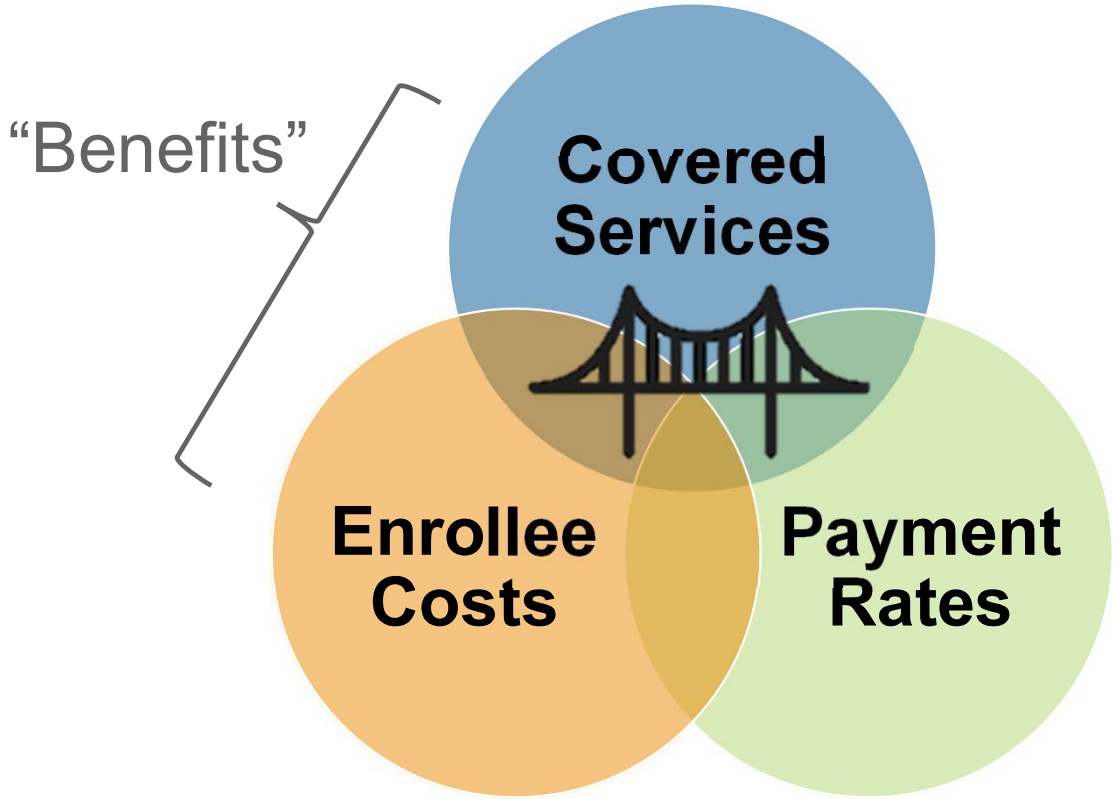
- Section 4: Eligibility and Enrollment
    - Records the state's choices in determining eligibility procedures for BHP and records assurances that demonstrate federal compliance
- Section 6: Premiums and Cost-sharing
    - Documents compliance with requirements for establishing premiums and cost-sharing.
- Section 8: Standard Health Plan
    - The final section of the BHP Blueprint is an attachment that allows a state to define the standard health plan(s) offered under the BHP.

Administrative information

- Section 1: State Background Information.
- Section 2: Public Input. Records the state's method for meeting the public comment process.
- Section 3: Trust Fund. Information on BHP Trust Fund (Institution, address, phone number).
- Section 5: Standard Health Plan Contracting. Collects information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.
- Section 7: Operational Assessment. State makes assurances that it will be able to meet operational requirements.

Recap & Next Steps

Key plan design components for consideration



Future meeting plan design decisions

- What services are covered?
    - Are there deviations from OHP benefit package?
- What is the enrollee cost structure?
    - Will monthly premiums and/or cost-sharing be included? If so, how should they be set and implemented?
- What reimbursement levels are used to set capitation rates?
    - What are the implications on participation, access, financing, and more?