Actuarial Analysis of Basic Health Program in Oregon

June 14, 2022

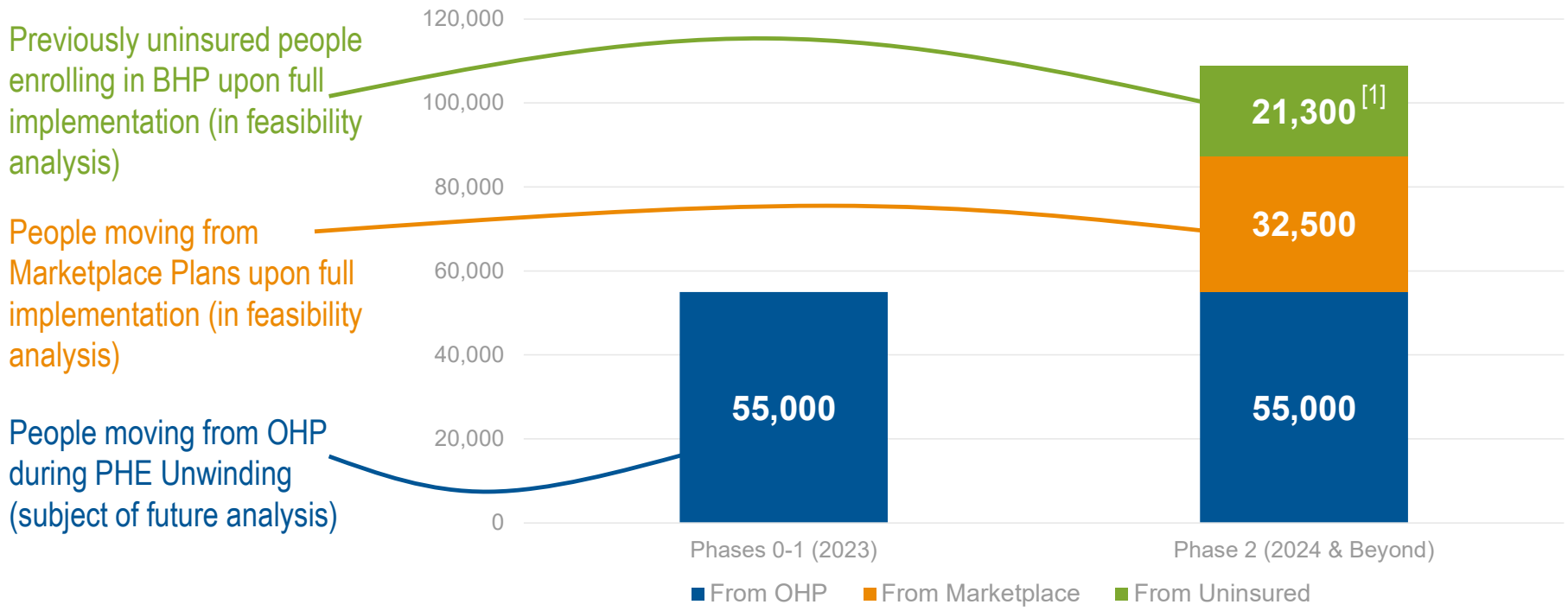
Manatt Health

Overview of High Level Feasibility Analysis

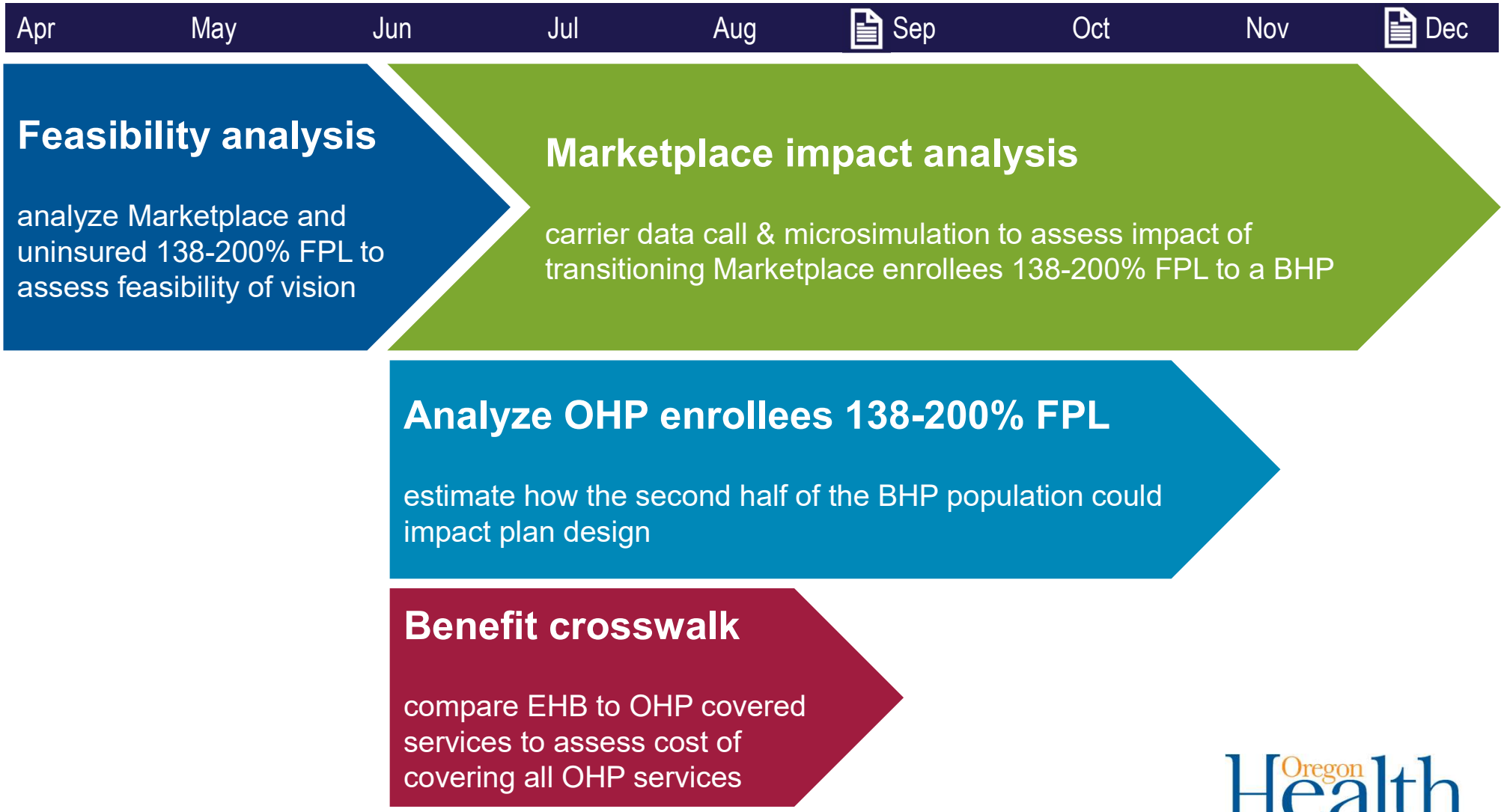
- **Goal.** To determine whether it would be financially feasible for CCOs to offer a BHP product to Oregonians in the 138-200% FPL category that covers a robust service package with low-to-no costs to enrollees and higher-than-Medicaid reimbursement rates.
- **Financial Parameters.** Fully federally funded with no cost to the state.
- **Findings.** This actuarial analysis found that offering a BHP product is financially feasible without cost to enrollees and could enable higher-than-Medicaid provider rates.
- **Improved Coverage.** This actuarial analysis is based on assumptions of the BHP covering 53,800 people coming from the Marketplace, including 21,200 previously uninsured people – reducing the state's uninsured rate. The analysis does not consider a second population who will lose Medicaid coverage and be eligible for the BHP.
- **Robust Benefits.** The BHP benefit plan would include the EHBs and a new adult dental benefit; changes in benefits would require adjustments to provider rates.

Analysis focused on subset of BHP population*

initial population estimates, subject to revision



[1] Some of the uninsured in this estimate may also be in the 55,000 moving over from Medicaid in the PHE unwinding.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Feasibility analysis
analyze Marketplace and uninsured 138-200% FPL to assess feasibility of vision
Marketplace impact analysis
carrier data call & microsimulation to assess impact of transitioning Marketplace enrollees 138-200% FPL to a BHP
Analyze OHP enrollees 138-200% FPL
estimate how the second half of the BHP population could impact plan design
Benefit crosswalk
compare EHB to OHP covered services to assess cost of covering all OHP services

Key Findings on Overall Cost

High level actuarial analysis indicates that CCOs could offer a BHP product with no premiums and no cost sharing that could reduce the uninsured rate at no net cost to the state.

- BHP enrollment of 53,000 includes 32,500 enrollees currently served in the Marketplace and 21,300 people currently uninsured.[1]
- Federal BHP funding for this population would range from $329 to $386 million depending on whether ARPA subsidies are renewed.[2]
- Analysis found federal funding could support higher-than-Medicaid reimbursement rates.[3,4]

CMS proposal to remove the reinsurance penalty from the BHP formula could add $32 million to BHP funding, potentially enabling higher provider reimbursement

Summary of the BHP (Including Major Dental) in Oregon in 2023

2023 Projections (Costs in Millions)	Best Estimate for BHP ARPA-level Subsidies	Best Estimate for BHP pre-ARPA-level Subsidies
BHP Enrollment	**53,800**	**53,800**
Total Cost – Estimated Medicaid Reimbursement Levels[4]	$317	$317
BHP Federal Funding [2]	$386	$329
BHP Premium and Cost Sharing – Members	$0	$0
Estimated Federal Funding Surplus	**$69**	**$12**

[1] This analysis modeled BHP enrollment for 2023, not including the PHE population; these estimates represent a snapshot of BHP enrollment in relation to the Marketplace.
[2] These estimates will change when an updated analysis is conducted to incorporate CMS' recent Proposed BHP rule, which incorporates a "fix" for the reinsurance impacts on BHP funding.
[3] The state would still be responsible for covering the administrative costs of the BHP and the BHP Trust Fund.
[4] Estimate based on OHA calculations using multiple data sources to reflect projected costs based on average reimbursements paid by Medicaid, separate from the actuarial analysis.

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Enrollment Impact With and Without ARPA

The BHP has a powerful impact on enrollment, reducing the uninsured rate even if ARPA subsidies expire.

- Adoption of a BHP reduces the uninsured rate by 0.5% in both ACA tax credit scenarios (ARPA and pre-ARPA).[1]
- Total enrollment is highest at 201,300 with a BHP and ARPA subsidies. Enrollment is reduced to 173,800 with no BHP and no ARPA subsidies.
- Marketplace enrollment varies from 142,000 with ARPA subsidies and no BHP. Enrollment is reduced to 93,800 with a BHP and no ARPA subsidies.[2]
- **Low-to-no cost sharing is critical for ensuring plan take-up.**

Summary of Market Enrollment Scenarios in Oregon in 2023

	With ARPA Subsidies			Without ARPA Subsidies		
2023 Enrollment Projections	**No BHP**	**BHP**	**Diff.**	**No BHP**	**BHP**	**Diff.**
Total Exchange	142,000	109,500	-32,500	126,300	93,800	-32,500
Total Individual	180,000	147,500	-32,500	173,800	141,300	-32,500
BHP	0	53,800	53,800	0	53,800	53,800
Individual + BHP	180,000	201,300	21,300	173,800	195,100	21,300
Uninsured	234,900	213,700	-21,200	241,100	219,900	-21,200
Uninsured Rate	5.4%	4.9%	-0.5%	5.5%	5.0%	-0.5%

In New York, the take up rate for their no cost sharing BHP program is 96%, compared to 51% for consumers determined to be eligible for On-Exchange plans that have higher cost sharing.[3]

[1] This analysis used 2019 American Community Survey (ACS) data for the uninsured population.
[2] This analysis did not adjust individual market enrollment estimates to account for the potential secondary impacts of Silver loading and higher costs.
[3] NY State of Health, Sept 2021 Update: https://info.nystateofhealth.ny.gov/health-insurance-coverage-update-september-2021

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The BHP Funding Formula

Federal funding for a BHP is based on the amount of premium tax credit (PTC) that would have been provided each fiscal year to eligible individuals enrolled in BHP if the individuals were allowed to enroll in a QHP, adjusted for the impacts of silver-loading.

BHP Federal Funding Amount = 95% (**PTC** *Estimated PTC that would have been paid if BHP enrollee enrolled in a QHP.* X **1.188** *Premium Adjustment Factor (PAF). Accounts for impacts of silver-loading.*) (**1.0063** *Income Recon Factor. Accounts for expected APTC to PTC ratio*) + ~~**95% of CSR** *Estimated CSR that would have been paid if BHP enrollee enrolled in a QHP*~~

CSRs were removed in 2017

Reinsurance and the BHP Federal Funding Formula

The BHP funding formula penalizes states that reduced their benchmark premium in the Marketplace through reinsurance, but CMS recently proposed to remove that penalty. This means that Oregon's reinsurance program could be maintained or adjusted up or down without any adverse impact on BHP funding.

Source: Federal Funding Methodology for Program Year 2023 and Proposed Changes to Basic Health Program Regulations, May 2022.

Estimated Cost of BHP Coverage

The BHP would cover 32, 500 people currently enrolled in Marketplace plans and 21,300 people currently uninsured for an average cost of $454 PMPM

- BHP enrollment from the Marketplace (32,500) assumes 100% take up rate, with more than 80% of enrollees in 87 or 94% AV plans and an average AV of 91%
- BHP enrollment from the uninsured population assumes 50% take up rate, with relatively younger population leading to lower costs
- Adjustment for uninsured population was 0.82, accounting for age, geography, and estimated pent-up demand

OHA estimates BHP will add another 55,000 enrollees losing Medicaid coverage

Cost of BHP Coverage at Estimated Medicaid Provider Rates, 2023

	BHP Cost From Individual ACA	BHP Cost From Uninsured	Total BHP Expenditure
BHP Enrollment	32,500	21,300	53,800
Estimated PMPM @ Medicaid Reimbursement Rates [1]	$489	$401	$454
Additional BHP Benefits PMPM	$36	$36	$36
Total BHP Expenditure PMPM	$525	$437	$490
Total BHP Expenditure in Millions	**$205**	**$112**	**$317**

[1] Estimate based on OHA calculations using multiple data sources to reflect projected costs based on average reimbursements paid by Medicaid, separate from the actuarial analysis

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Impacts on Marketplace: Morbidity

Morbidity is roughly equal between the BHP and remaining individual market risk pool, which means that separating the two pools should not have much positive or negative impact on Marketplace premiums

- **Average Morbidity.** The analysis looked at various data sources, including a study of risk scores for enrollees in 94% and 87% AV plans, to conclude that those in the BHP pool (138-200% FPL) appear to have similar average morbidity as the remaining individual market
- **Changes in Morbidity**. However, the analysis also found that Marketplace premiums and BHP funding will be quite sensitive to relatively small differences in morbidity
  - If, for example, morbidity changes that made the individual market risk pool less healthy were to increase benchmark premiums by 1%, this would increase BHP funding by $4 million
- **Further work.** Because this high-level analysis was based largely on publicly available information and did not have access to detailed carrier data, next steps could include a data call and a deeper look at carrier claims experience to confirm that morbidity impact is expected to be neutral

Impact on Marketplace: Silver Loading

Establishing a BHP will eliminate most silver loading, which will make bronze and gold plans more expensive relative to silver plans and the second-lowest cost silver plan (benchmark plan).

- **Basics of Silver Loading.** When federal government stopped paying cost-sharing reductions, plans began increasing silver premiums to build in the value of the no longer reimbursed cost-sharing (referred to as "silver loading"). By increasing the value of the benchmark silver plan, the value of tax credits increased for those not purchasing the benchmark plan. With the launch of the BHP, most silver loading would disappear.
- **Impact on Residual Individual Market.** Bronze and gold enrollees will see premiums rise and some may drop coverage as a result. Their decisions could have broader impact on the morbidity of the remaining Marketplace risk pool (if, for example, a significant percentage of relatively healthy bronze enrollees exit the market). This could increase premiums in individual market and potentially lead to further enrollment reductions.
- **Impact on BHP Funding.** BHP funding formula accounts for reduction in silver loading by adding an 18.8% funding increase to compensate for the aggregate loss. If premiums rise further because healthy bronze enrollees drop coverage, the consequence would be an increase in BHP funding; this BHP funding could not be redirected to the Marketplace, but the state could choose to use other state funds to add subsidies in the Marketplace.
- **Further Work Needed.** Analysis of these dynamics was beyond the scope of this high-level analysis.

Limitations

The high-level analysis did not take into account various issues that could be explored in future analyses.

- **Individual Market Impact.** Analysis did not model consumer behavior at a detailed level. Further analysis could explore second order market impacts from removal of silver loading.
- **PHE Unwinding Impact:** Analysis did not take into account that a second group of BHP enrollees will be moving to the BHP from Medicaid through the Bridge Plan. This group could double the BHP population and have implications for morbidity, provider rates, and other market dynamics.
- **Benefit Package:** Analysis did not consider benefits beyond the EHBs and dental and assumed no premiums or cost sharing. Further analysis could look at costs for a range of options for additional benefits and/or cost sharing within BHP parameters.

Next Steps

The Task Force will need additional actuarial analysis to inform its decision-making process.

- **Individual Market.** Carrier data call would increase understanding of morbidity issues, and microsimulation would increase understanding of the likely impact of loss of silver loading on consumer behavior and QHP premium rates.
- **Medicaid.** CCO data call would help evaluate the demographics and relative morbidity of the population coming to BHP through Bridge Plan.
- **Benefits.** Detailed crosswalk of EHBs v. CCO benefit package would identify additional benefit options to be priced. Microsimulation would increase understanding of how premium and cost sharing options could impact enrollment.