Joint Task Force on the Bridge Health Care Program
Post Meeting Summary

Attendees	Co-Chair Elizabeth Steiner Hayward (by video) Co-Chair Rachel Prusak (by video) Pat Allen (by video) Stefanny Caballero (by video) Adrienne Daniels (by video) Jonathan Frochtzwajg (by video) Antonio Germann (by video) Representative Cedric Hayden (by video) Kelsey Heilman (by video) Lindsey Hopper (by video) Eric Hunter (by video) John Hunter (by video) Kirsten Isaacson (by video) Heather Jefferis (by video) William Johnson (by video) Sharmaine Johnson Yarbrough (by video) Keara Rodela (by phone) Matthew Sinnott (by video) Andrew Stolfi (by video)
Absent	Senator Bill Kennemer Fariborz Pakseresht
Date/Time	November 1st, 2022, 8:30am-12pm **(**recording**)**.

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Meeting Topics	• Marketplace Mitigation Options • Preview of Basic Health Program Actuarial Analysis
Discussion of Key Issues	Marketplace Mitigation Options At earlier meetings (10/4 and 10/18) the Task Force heard results of an analysis exploring how creation of the Basic Health Program (BHP) could affect premiums and coverage decisions for people who are not eligible for the program and would continue to purchase plans in the Marketplace. That analysis found that when the BHP is created, people earning less than 200% FPL will transition to BHP coverage and exit the Marketplace, which would initially result in a smaller but slightly healthier population of people buying coverage in the Marketplace. This slight improvement in the average health of Marketplace consumers would initially be expected to lead to slightly lower premiums in the Marketplace. The creation of the BHP will have secondary effects on coverage and affordability for subsidized consumers in the Marketplace. The Affordable Care Act requires insurers to offer enhanced coverage toward out-of-pocket costs (“cost-sharing reduction (CSR) plans”) for consumers

earning less than 250% FPL. States allow insurers to recoup the cost of these subsidized plans by increasing premiums for silver tier plans. This "silver loading" practice increases the price of silver premiums, but also increases the value of consumers' advance premium tax credits (APTC) which are tied to the second lowest cost silver plan (SLCSP) in their region.

Insurers will discontinue most silver loading when consumers eligible for CSRs migrate to the BHP. This will result in a forecasted reduction in silver plan premiums of 10-12% and a related reduction in APTC for Marketplace consumers. While these changes would not significantly impact the number of consumers purchasing Marketplace coverage, it would lead some consumers to switch from gold to more affordable silver tier plans. These effects vary meaningfully by consumer age and income but are similar across rating regions.

At the Task Force's 11/1 meeting, Laurel Swerdlow (OHA) and Numi Rehfield-Griffith (DCBS) presented two policy options that have been explored to mitigate these effects:

- A subsidy program that would lower consumers' premiums through offsets applied to the cost of plans in the Marketplace. These offsets would be funded by recapturing federal dollars lost from silver loading and reinvesting them in the subsidy program; and
- Calculating consumers' APTC based on the price of a gold plan in their region rather than the second lowest cost silver plan.

OHA and DCBS researched the feasibility of both options through an amendment to the state's 1332 waiver for its reinsurance program. This work involved 1) meetings with carriers in October to explore the feasibility of implementing the options, and 2) discussions with CMS regarding the likelihood of federal approval of a waiver amendment for each approach. These discussions revealed that the subsidy program concept would be operationally challenging for carriers to implement on the timeline needed.

The gold benchmark, in contrast, was supported in concept by carriers. CMS provided additional feedback on the gold benchmark concept. To receive approval for a 1332 waiver amendment for the concept, Oregon would need to consider the four federal "guardrails" for Section 1332 waivers:

1) The proposal must provide coverage at least as **comprehensive** as would be available otherwise. The gold benchmark is compatible with this idea in concept.
2) The proposal must provide **coverage** to a comparable number of people as would be otherwise covered. The gold benchmark is compatible with this idea in concept.
3) The proposal must provide coverage that is at least as **affordable** as would otherwise be available. While the gold benchmark is compatible with this concept for Oregon overall, there are five

counties (Benton, Lane, Linn, Polk and Marion) in which some consumers could see a lower subsidy with a gold benchmark than they would if silver loading is continued.

4) The proposal must be **budget neutral to the federal government** over what would otherwise occur. The gold benchmark is not, by itself, compatible with this guardrail because tying consumers' APTC to the cost of a gold rather than silver plan results in more generous subsidies for consumers. However, if the gold benchmark was an amendment to the state's existing 1332 waiver for its reinsurance program, the savings currently generated by the reinsurance program could offset the cost of increased consumer APTC, potentially resulting in *overall* budget neutrality to the federal government.

OHA and DCBS were engaged in ongoing negotiation with CMS at the time of the Task Force presentation to clarify: 1) whether the federal Healthcare.gov platform would support Oregon's switch to a gold benchmark, 2) whether CMS would allow existing 1332 waiver savings to count as offset to an amendment that was not, by itself, budget neutral, and 3) whether CMS would allow a gold benchmark that resulted in more affordable coverage for consumers on average, but not necessarily for all individual consumers. More information was being gathered on these topics.

Consulting group Oliver Wyman was also conducting actuarial analysis to determine the cost of a shift to a gold benchmark, and whether savings from the state's reinsurance program would be sufficient to offset this cost without compromising reinsurance program goals and targets.

Members expressed general support for the gold benchmark concept, and requested additional information on:

1) The reinsurance program's ability to achieve its programmatic targets for premium reduction if some savings are redirected to offset the cost of a shift to a gold benchmark;
2) The age distribution of people in the five counties that could be negatively affected by a shift to the gold benchmark;
3) The estimated number of consumers in counties positively and negatively affected by a shift to a gold benchmark, disaggregated by age band.

Members also noted the need to be mindful of the new CCO contract cycle that will begin in 2025 and the number of operational changes that maybe occurring during this time.

<u>Preview of BHP Actuarial Analysis</u>

At its upcoming November 15th meeting, the Task Force will be presented with results of an actuarial analysis of projected federal revenues and total costs to operate a BHP. In preparation for that

meeting, the Task Force heard a foundational presentation on 11/1 reviewing:

1) the BHP funding formula and the analytic approach to modeling BHP revenue; and
2) the analytic approach to modeling BHP costs.

Revenues. Tammy Tomczyk from Oliver Wyman provided an overview of the federal funding formula for the BHP by individual consumer. The calculation considers the estimated premium tax credit (PTC) a consumer would be eligible for *if* purchasing coverage on the Marketplace. This value varies by regional premiums, consumer age, household size, household income, and various allowable factors such as tobacco use (note: the formula accounts for enhanced PTCs authorized by Congress through 2025 in the Inflation Reduction Act).

The formula then adjusts consumers' estimated PTC for:

- A *premium adjustment factor* that accounts for the loss of federal PTC for BHP consumers when a state does not "silver load" premiums for cost sharing reductions. This factor was 1.188 in 2022.
- A *population health adjustment* that adjusts for the loss of federal revenue that can occur if a BHP leads to lower Marketplace morbidity and, by extension, lower Marketplace premiums. This factor is optional, set to 1.0 by default, and may be requested by states.
- A *reinsurance adjustment* that offsets federal pass-through savings a state is generating from operating a reinsurance program under a Section 1332 waiver. This factor was part of a proposed rule not yet finalized at the time of this meeting.
- An *income reconciliation factor* that adjusts for differences between advance (estimated) premium tax credits and actual premium tax credits at year end, since there is typically slight variation at the population level between APTCs calculated at the point of enrollment and final PTC a consumer is eligible for based on actual income at year-end. This factor was 1.0063 in 2022.

The adjusted PTC is multiplied by .95 to determine the final BHP funding for that consumer. This amount is paid by the federal government to states operating a BHP.

Costs. Joel Ario of Manatt Health provided an overview of how costs will be projected for Oregon's BHP.

The analysis will first forecast the population who would enroll in the BHP. This population is estimated at approximately 111,600, including 1) 55,000 people currently enrolled in OHP, 2) 36,600 people purchasing coverage on the Marketplace, and 3) 10-20,000 people who are uninsured. This number will be further refined.

	The analysis assumes the BHP matches the covered service package provided by CCOs to OHP enrollees. The per member per month (PMPM) cost to provide this level of coverage must be calculated differently for the three populations. Specifically: 1. The cost to cover *enrollees transitioning from OHP* is calculated based on per member per month (PMPM) costs for OHP enrollees. This amount is adjusted for the estimated demographics, geography, and health status of the OHP-to-BHP population, as well as what is known about their likely service utilization from OHP claims data. 2. The cost to cover *enrollees transitioning from the Marketplace* starts from the OHP-to-BHP per member per month cost, adjusts for the estimated demographics, geography and health status of the Marketplace-to-BHP population, and considers what is known about their service utilization from Marketplace claims data. 3. The cost to cover *enrollees who were previously uninsured* uses the Marketplace-to-BHP per member per month cost, adjusts for the estimated demographics, geography and health status of the uninsured population, and considers what is known about their service utilization from Marketplace claims data. ***Implications.*** The Task Force will revisit its preliminary program design recommendations when revenue and cost estimates are presented on November 15th. While many of the preliminary recommendations are not contingent on the actuarial analysis, the following areas will need to be affirmed or revised depending on the analysis: • capitation rates paid to CCOs to provide coverage to BHP members; • covered services; and • enrollee costs.
Action Items and Follow-Up Requests	• Staff will begin preparing draft recommendations on mitigation strategies for further discussion at the November 15th and November 29th meetings. • Additional information was requested on how a shift to a gold benchmark may affect affordability for people of different ages. This analysis has been requested but the timeline for delivery is not yet available.
Meeting Materials (OLIS)	• Agenda for the Day | slides • Marketplace Mitigation Options | slides • Preview of BHP Actuarial Analysis | slides • Public Comment Outreach Flyers | English | Spanish

Upcoming meetings (at 8:30am unless otherwise noted):

- November 15th, 2022
- November 29th, 2022
- December 13th, 2022