
November 15, 2018

**LPRO**: LEGISLATIVE POLICY AND RESEARCH OFFICE

# UNIVERSAL ACCESS TO CARE WORK GROUP 2018

# AGENDA

I. **Welcome, Opening Remarks** .....8:00—8:05am
Representative Salinas, Chair, Work Group

II. **Public Comment**.....8:05—8:20am
Representative Salinas, Chair

III. **Medicaid Buy-in: Population Groups & Final Considerations** 8:20—9:00am
Tim Sweeney, OHA
Zachary Goldman, OHA
Jesse O'Brien, DCBS
Oliver Droppers, LPRO

IV. **Universal Access to Primary Care**.....9:00—9:45am
Glenn Rodriquez, Work Group Member
TBD

**BREAK 9:45-10am**

V. **Review & Discuss Draft Report & Policy Considerations**.....10:00—11:00am
Representative Salinas, Chair, Work Group

VI. **Work Group – Refine Proposals & Prioritization Exercise**...11:00—11:50am
Representative Salinas, Chair, Work Group

VII. **Adjourn**.....12:00 pm


# Today's Objectives

- Final Considerations for a Medicaid-like buy-in policy approach in Oregon
  - Review data and target populations
  - Summarize key considerations for policy makers
- Review list of policy approaches - identify advantages and disadvantages; member perspectives exercise
- Review DRAFT report and process to finalize and submit the report

# UNIVERSAL ACCESS TO PRIMARY CARE

# Universal Access to Primary Care: A Foundation for Health Care System Reform in Oregon

Glenn Rodriguez, MD

November 15, 2018

# A Brief History of Primary Care Transformation in Oregon

- HB 2009:  Transformation of Primary Care in Oregon

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians.

# A Brief History of Primary Care Transformation in Oregon (continued)

- 2015: SB 231

Establishes Primary Care Payment Reform Collaborative and annual primary care spending report

- 2016: PSU evaluation – "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings"
  - Cost trends for 1.2 million Oregonians
  - Decreased cost trend 4.2%
  - Estimated $240 million in savings 2011-2014
- 2017: SB 934
  - Increase investment in primary care
  - Improve reimbursement methods
  - Align primary care reimbursement
- 2018: PCPR Collaborative proposes a new model for primary care payment

# Goals for the next steps in primary care transformation:

1. Universal access to primary care services without financial barriers
2. Payment model which supports the PCPCH model of care
3. Payment standardization to decrease administrative costs and demands

# Policy options

- Incremental improvements on Oregon journey
  - Standardize definition of primary care to align with national consensus
  - Adopt recommendations of the Primary Care Payment Reform Collaborative to implement a single payment methodology

Or

- Establish a universally accessible, publicly funded, primary care system in Oregon
  - Vermont and Rhode Island examples


# MEDICAID BUY-IN: OREGON CONSIDERATIONS

# Medicaid Buy-in
# Oregon Design Considerations

Oct 18 meeting - members requested staff review available data on potential populations for a *Medicaid-like buy-in option*

- Brief provides estimates, when available, for targeted or potentially eligible populations – exception is small businesses
- Revised policy matrix oriented to priority populations

Multiple data sources: Oregon Health Insurance Survey, DCBS coverage data, Urban Institute

Limitations: point-in-time estimates, different years, modeling (HISPM), incomplete data sets

# Medicaid Buy-in
# Oregon Design Considerations

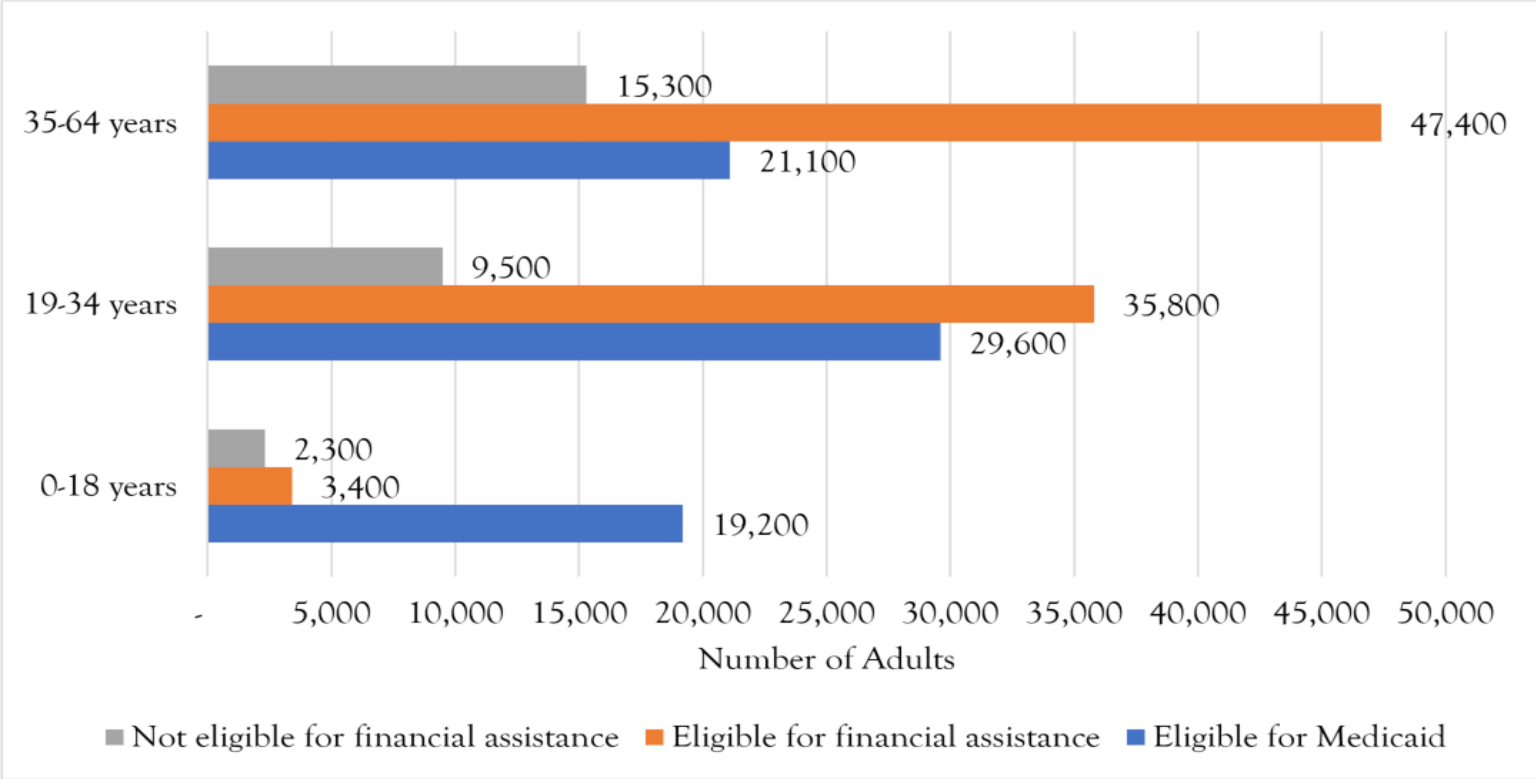
**UAC Work Group Preliminary Proposed Model Design Elements**

| Benefits | Enrollee Costs | Provider Network |
|---|---|---|
| Medicaid equivalent benefits (vision & adult dental) | Monthly premiums<br>No deductibles<br>Nominal co-pays (point of care) | Coordinated care organizations and affiliated partners/networks |

| Administration Options | Provider Reimbursement | Financing |
|---|---|---|
| State-sponsored plan<br>CCOs administer plan<br>TPA | Medicaid per-member, per-month (PMPM) payment | Member pays monthly premiums, entirely<br>Capitation model |

# Medicaid Buy-in
# Oregon Design Considerations

**Figure 2. Estimated Number of Uninsured, U.S. Born, Adults in Oregon Eligible for Medicaid or Federal Subsidies by Age Group (2017)**




Source: Oregon Health Authority 2018.

# Medicaid Buy-in
# Oregon Design Considerations

| Estimated Number of Uninsured, U.S. Born, Adults in Oregon Eligible for Medicaid of Federal Subsidies by Age Group (2017)* | | | | |
|---|---|---|---|---|
| Age | Eligible for Medicaid | Eligible for federal subsidies | Not eligible for Medicaid or Subsidies | **Total** |
| 0-18 years | 19,200 | 3,400 | 2,300 | 24,900 |
| 19-34 years | 29,600 | 35,800 | 9,500 | 74,900 |
| 35-64 years | 21,100 | 47,400 | 15,300 | 83,800 |
| Total | 69,900 | 86,600 | 27,100 | 183,600 |

Source: OHA Health Policy and Analytics Division (Nov. 2018). Uninsured Fact Sheet. *Excludes undocumented immigrants

# Medicaid Buy-in
# Oregon Design Considerations

**Table 2. Uninsured Population, Characteristics Reported by Healthcare.gov (2017)**

| Number of Individuals Not Eligible for Marketplace Tax Credits or Medicaid (*excludes children eligible for OHP in Oregon) | | | | | | |
|---|---|---|---|---|---|---|
| Income Level | Uninsured, No ESI Offer Pre-ACA | | Uninsured, with ESI Offer Pre-ACA | | Total | |
| <100 % FPL | 344 | 0.7% | 67 | 0.2% | 411 | 5.3% |
| 100 - 150 % FPL | 987 | 2.0% | 2,059 | 7.1% | 3,046 | 3.9% |
| 150 - 200 % FPL | 4,168 | 8.6% | 7,584 | 26.3% | 11,752 | 15.2% |
| 200 - 250 % FPL | 4,032 | 8.4% | 5,584 | 19.4% | 9,616 | 12.5% |
| 250 - 300 % FPL | 3,776 | 7.8% | 3,323 | 11.5% | 7,099 | 9.2% |
| 300 - 400 % FPL | 7,324 | 15.2% | 4,187 | 14.5% | 11,511 | 14.9% |
| 400 % + | 27,559 | 57.2% | 6,041 | 20.9% | 33,600 | 43.6% |
| Total | 48,189 | 100.0% | 28,846 | 100.0% | 77,035 | 100.0% |

*Source: Urban Institute 2016, unpublished.*

# Medicaid Buy-in
# Oregon Design Considerations

| | Individuals not eligible for Medicaid or federal marketplace subsidies based on immigration status. | Individuals not able to obtain affordable coverage in the individual market. | Small employers (<50 employees) affordable coverage options |
|---|---|---|---|
| **Eligible Populations and Estimates** | • **20,630** adults ages 19-64 between 0-400% Federal Poverty Level (FPL) <u>not</u> eligible for Medicaid or federal subsidies in the Marketplace<br>• ~**3,500-6,500** legal permanent residents who are in households less than 138 percent FPL who would otherwise be eligible for Medicaid except they have been in the country for less than five years (Oregon Center for Public Policy)<br>• ~**130,000** estimated unauthorized immigrants in Oregon (2014) | • **22,805** individuals and families between 138-400% FPL without offer of employer-sponsored coverage and NOT eligible for federal subsidies on the Marketplace (see pg. 7 for description of the ACA's "family glitch")<br>• **27, 559** individuals and families over 400% FPL <u>without</u> affordable employer-sponsored coverage<br>• **6,041** individuals and families over 400% FPL <u>with</u> affordable employer-sponsored coverage | • ~**101,381** firms <50 employees, accounting for 632,325 employees<br>• Representing 39.2 percent of covered employment and 31.1 percent of wages Q 1 2018)<br>• **174,170** enrolled in Small Group off-exchange (June 2018)<br>• **1,056** enrolled in small group on Exchange (DCBS 2018)<br>• <u>Unknown</u> - percentage of employees (632,325) that enroll in affordable coverage from their "small employer"<br>*Oregon Employment Department forthcoming report (Jan. 2019) on number of small employer that offer health coverage. |

| | | | |
|---|---|---|---|
| **State Considerations** | • Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange<br>• Network adequacy and solvency requirements<br>• Requires licensing CCOs as commercial insurers<br>• Potentially complicate transition to CCO 2.0<br>• Potentially establish separate state reinsurance program to attract CCOs and limit volatility (requires funding) | • Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange<br>• Ensure network adequacy requirements<br>• State legislation to allow CCOs to offer Medicaid Buy-in plans (i.e., licensing CCOs as commercial insurers)<br>• Potentially establish separate state reinsurance program to attract CCOs and limit volatility (requires funding) | • Potential for market destabilization: disruption to existing carriers and Marketplace enrollees; on and off the Exchange<br>• Network adequacy requirements<br>• Likely requires state legislation to establish requirements<br>• Potential disruption to CCOs and transition to CCO 2.0 |
| **Implementation Considerations** | • Required or voluntary participation by CCOs<br>• Program administrator (OHA, DCBS, other)<br>• Potential need for eligibility system<br>• Setting initial premiums will be complicated; risk-sharing solution may be needed<br>• Adverse selection; initial enrollees may have high-costs/health care needs<br>• Requires additional information, analysis, and financial modeling | • Required or voluntary participation by CCOs<br>• Potential eligibility system<br>• Protect Marketplace and commercial offerings available currently on and off Exchange<br>• Eligible individuals purchase coverage directly from CCOs<br>• Maintain risk pool for individual market<br>• Requires additional information, analysis, and financial modeling (particularly to assess potential impacts on the risk pool in the Marketplace) | • Required or voluntary participation by CCOs<br>• Disruption to current risk pool for small group market |

# UNIVERSAL ACCESS TO CARE WORK GROUP

# POLICY PROPOSALS AND REPORT

# Two Exercises

1. Members will be asked to jot down on sticky notes perceived "advantages" and "disadvantages" for each policy proposal
   - 5 minutes per proposal (i.e., fill out sticky notes, place on posters)
   - 5 minutes group reaction and discussion on individual proposals
   - 10 minutes total per individual proposal

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2. Next, members will be asked to indicate their perspectives on each policy proposal (dot exercise)
   - 5-10 minutes to post dots on all 8 policy proposals (*you can only use "one ●" per proposal – NO more than 8 dots total)
   - 15-20 minutes for group reaction and discussion

# LPRO: Legislative Policy and Research Office

| Policy Approach | | Potential Advantages | Potential Disadvantages |
|---|---|---|---|
| **Medicaid-like Buy-in** | Evaluate a coverage program that targets lower-income individuals and families not eligible for Medicaid or federal subsidies through the Marketplace | | |

| | | |
|---|---|---|
| Green | ● | Yes, this policy is an incremental step to increasing health coverage |
| Yellow | ● | I am neutral on this policy approach |
| Red | ● | No, this policy is not an incremental step to increasing health coverage |
| Blue | ● | I need more information before I can form an opinion |


# Draft Report – Member Input

Critical concepts that were discussed missing from the preliminary draft (Jan-Nov. 11 mtgs – ~30 hours of in-person meetings)?

Critical issues, perspectives, or key messages members would like shared with legislators about universal access to care in Oregon?

Top issues ***agreed upon*** by members that should be reflected in the final report (no more than 3)?


# Next Steps

**Nov. 20** – staff to email a revised draft report to the work group

**Nov. 21 – Nov. 29** – members to review, provide feedback, electronically

**Dec. 3-5** – staff will incorporate feedback; send revised report to Chair Salinas for final review

**Dec. 5** – submit report to the House Committee on Health Care

**Dec. 12** – presentation to House Health Care (12-3pm)