UNIVERSAL ACCESS TO HEALTH CARE WORK GROUP

Medicaid Buy-in Proposals

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LPRO: LEGISLATIVE POLICY AND RESEARCH OFFICE

DRAFT – FOR DISCUSSION PURPOSES ONLY

The table below outlines several Medicaid buy-in proposals for the Universal Access to Care Work Group to consider. The fourth proposal labeled as "Proposal D" is less a Medicaid buy-in proposal but has been identified through work group discussions. Rather this proposal is aimed at spreading key elements of the coordinated care model which serves as the foundation for Oregon's transformation of the state's Medicaid delivery and financing system including the 15 coordinated care organizations.

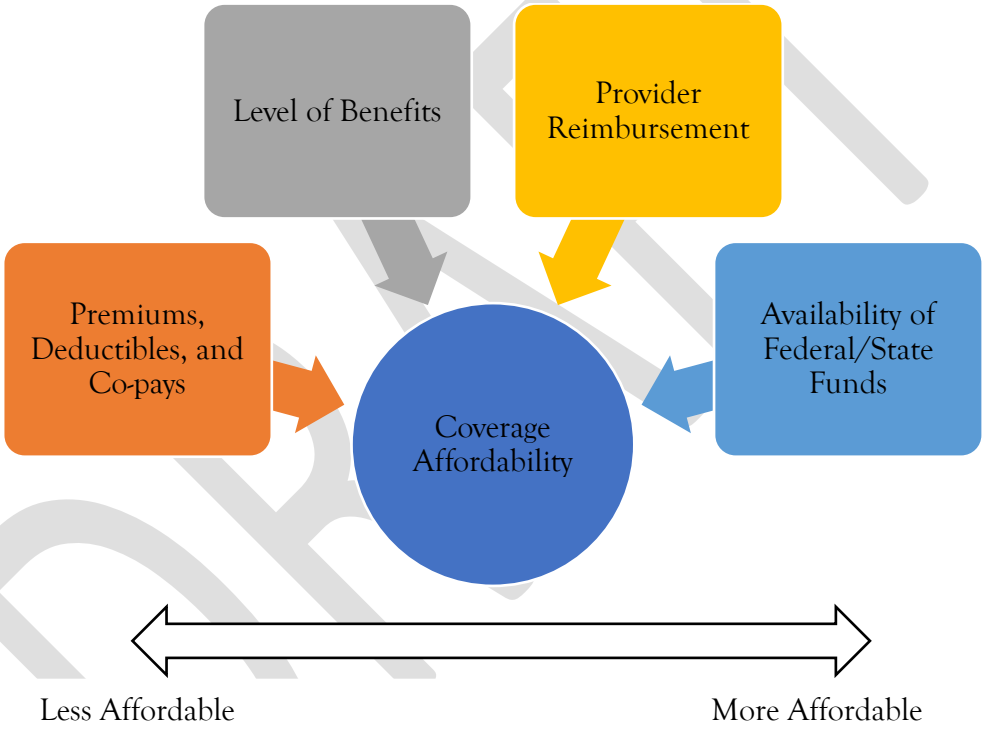
It is worth noting that for each proposal, there are a number of factors (inputs) that can be modified based on the preferences of work group members. The design considerations as outlined in each row are intended to serve as discussion items for the work group. The initial offerings are intended to reflect the discussion from the August 23rd meeting as well as prior discussions in March and April. As evident in the table, there are a number of design elements that can be modified based on the policy priorities around coverage and access as identified by members.

The sample of proposals provided is not complete and should not be considered an exhaustive list. As presented by the Oregon Health Authority and Department of Consumer and Business Services, there are many critical considerations to explore and assess in working to conceptualize a Medicaid buy-in model proposal(s) for Oregon. A number of these considerations have been included in the conceptual proposals.

- Population – available to all or parameters to population
- Access and competition within the insurance market
- Affordability – offer subsidies based on marketplace standards, premium assistance
- Market alignment
- Risk pool – in Medicaid risk pool versus separate from Medicaid
- Financing

In considering the Medicaid Buy-in proposals outlined in the table, there are four key factors that influence the overall costs for health coverage. For each factor, depending on the preferences of the work group, adjustments to one or more the factors can increase or decrease the potential "affordability" associated with each proposal. Such impacts, depending on their direction, may impact any potential uptake among individuals in Oregon. These factors also may also be further affected by an individual or family's insurance status including but not limited to reasons for being uninsured and/or underinsured, health status, and geographic location, among other factors that influence coverage and affordability. [1]

Figure 1. Key Factors that Influence Coverage Affordability



[1] Oregon Health Authority (2018). Oregon Health Insurance Survey – Early Release Results.

		Proposal A	Proposal B	Proposal C	Proposal D
Overview		***Improve Access and Affordability***: Contract with CCOs to provide consumers outside of Medicaid eligibility to purchase insurance product with similar design consideration to CCO plans.	***Increase Access and Competition***: CCOs offer commercial insurance product on Marketplace in counties with limited carriers (fewer than two carriers).	***Strengthen Alignment Between Medicaid and Marketplace:*** ensure the same provider networks are offered in Medicaid and Marketplace; enhance care continuity.	***Spread coordinated care model:*** establish quality reporting and incentive structures modeled after those in Medicaid and CCOs for QHP offerings in Marketplace.
Policy Goal & Priorities		Expand affordable coverage in Oregon • Reduce monthly premiums, or • Reduce out-of-pocket costs, or • Enhance benefits or value for given premium	Stabilize/Strengthen Individual Market • Carrier of last resort • More plans on the marketplace • Increased plan offerings (potentially)	Streamline transitions for consumers between Medicaid and commercial coverage • CCOs offer plans on the Marketplace (individual market) • CCOs offer plans to small group market • Accountability and quality (Triple Aim)	Spread Oregon's Health Care Transformation (coordinated care model) • CCO-type plans on the marketplace (individual market) • CCO-like financial incentives on the marketplace (individual market)
Key Design Considerations	Delivery Model	Managed care through CCO and existing provider network	Managed care through CCO and existing provider network	Managed care through CCO and existing provider network	No change
	Marketplace, Stand Alone, other	Offered outside of the Marketplace (Off-exchange)	Offered on Marketplace	Offered on Marketplace	No change
	Target population (s)	Individuals and families 0-400% Federal Poverty Level (FPL) not eligible for Medicaid or the Marketplace Individuals and families over 400% FPL without affordable employer-sponsored coverage	Mirror federal Marketplace requirements: eligible individuals and families between 138-400% FPL Individuals that already qualify for advance premium tax credits (APTCs)	Mirror federal Marketplace requirements: eligible individuals and families between 138-400% FPL Individuals that already qualify for APTCs	Population currently eligible for ACA Marketplace coverage Individuals that already qualify for APTCs
	Benefit Coverage	Full Medicaid benefits offered in Oregon Health Plan (OHP) tied to Prioritized List **-OR-** Limited OHP Benefits (e.g., no adult dental or vision)(e.g., see retired benefits for OHP Standard)	10 Essential Health Benefits offered in Qualified Health Plans (QHPs) (mirror federal requirements for plan offerings)	10 Essential Health Benefits offered in QHPs (mirror federal requirements for plan offerings)	10 Essential Health Benefits (mirror federal requirements for plan offerings)
	Cost-Sharing	• Premiums • Deductibles • No co-pays at point of care	Graduated out-of-pocket costs • Monthly premiums with progressive tax credits • Nominal co-pays (point of care)	Mirror existing marketplace cost-sharing structure	Mirror existing marketplace cost-sharing structure
	Provider Reimbursement	• Emphasis on value, not volume or fee-for-service • Tied to Medicaid	• Emphasis on value, not volume or fee-for-service • Mid-point between Medicaid and commercial	• Emphasis on value, not volume or fee-for-service • Mid-point between Medicaid and commercial	No change
	Scalability and Financial Model	• Statewide (potentially) • Fixed rate of growth • Financed by individual insurance premiums	• Limited offerings • Utilize existing DCBS rate review	• Statewide (potentially)	• Statewide • Fixed rate of growth
	Federal and State Considerations	• Potential for market destabilization • Requires licensing CCOs as commercial insurers • Network adequacy and solvency requirements	• May require 1332 waiver • Requires licensing CCOs as commercial insurers to offer QHPs on Marketplace • Ensure network adequacy requirements	• Likely requires 1332 waiver • Likely requires state legislation to establish requirements • Potential disruption to existing carriers and Marketplace • Requires licensing CCOs as commercial insurers • Network adequacy requirements	• May require 1332 waiver • Potential need for state legislation to establish requirements
	Feasibility and Implementation Considerations	• Voluntary opt-in approach for CCOs • Setting initial premiums will be complicated; risk-sharing solution may be needed • Initial enrollees may have high costs/health care needs	• Maintain risk pool for individual market • Voluntary opt-in approach for CCOs (?)	• Maintain risk pool for individual market • Voluntary opt-in approach for CCOs (?)	• Mandatory requirements for all carriers that offer QHPs in the Marketplace