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Oregon Public Option Report: An Evaluation and Comparison of Proposed Delivery Models

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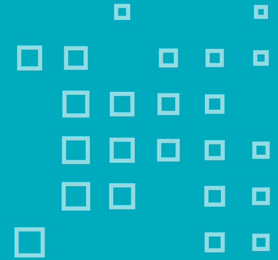

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Executive Summary

Section 9 of Senate Bill 770 (SB 770), signed into law in 2019, directed the state of Oregon to engage in an analysis to help policymakers develop policy around a public option or Medicaid buy-in model for Oregon. The goal of the public option is to improve affordability and increase access to healthcare to help the state continue to move toward universal coverage. The public option could be available to all state residents,[i] or could be more narrowly targeted to subsets of the overall population. In particular, uninsured and underinsured populations have been identified as having specific needs that may benefit from a public option. These populations will be explored in more detail in this report:

- Lower-income population, whose incomes fluctuate between Medicaid and Marketplace eligibility (the "churn population") and are susceptible to losing coverage
- Uninsured population, who are ineligible for tax credits and cannot afford coverage, including those with offers of employer insurance, people ineligible for federal assistance due to immigration status, and those with incomes above 400% of the federal poverty level (FPL)
- Tax-credit-eligible consumers, who struggle to afford existing coverage options

Models for Consideration

This report explores three proposed public option delivery models and how they may be designed to broadly benefit Oregonians and serve the unique needs of the above populations. The models were identified and refined based on preliminary recommendations from the Universal Access to Care (UAC) Workgroup[1] and conversations within the Oregon Health Authority (OHA), and were informed by models being pursued in other states. These models include:

- **A coordinated care organization (CCO)-led model**, in which the state utilizes existing CCOs—ideally serving the same geographic service area for which they deliver Oregon Health Plan (OHP) benefits—to offer a public option product to a broader population. Given the importance of CCOs in Oregon's healthcare system, a CCO-led public option delivery model has unique benefits for improving continuity of care for the Medicaid churn population and increasing state bargaining power. However, there are also distinct considerations around provider reimbursement, CCO administrative capacity, operational and regulatory issues (such as insurance licensure and federal approval of any contractual requirements of CCOs), and the impact of a CCO-led public option on other markets. These considerations would need to be addressed prior to implementation. For example, Oregon might need to adjust state legislative or regulatory requirements—such as by allowing or requiring CCOs to become licensed as insurers—in order for CCOs to be able to offer the public option. The report also considers specialized designs for offering a CCO-led model to distinct populations to mitigate some of the model's risk or CCO capacity issues. A targeted

[i] The public option could be available to all residents; however, we assume that Medicaid- and Medicare-eligible individuals are unlikely to enroll, based on access to subsidized coverage.

model may be particularly attractive for individuals in the churn population, just above Medicaid eligibility, or to populations ineligible for federal tax credits such as those in the "family glitch"[ii] or undocumented immigrants. An addendum to this report includes an analysis of a more narrowly targeted CCO-led model.

- **A carrier-led model**, in which the state utilizes commercial insurance carriers to deliver a public option product under a state contract with provisions that allow for design flexibility. The public option could be offered inside the individual insurance market broadly, including to the tax-credit-eligible population on the Marketplace, or could be offered more narrowly off the Marketplace. In this model, consideration should be given to potential cost-saving mechanisms—including provider reimbursement or value-based payment (VBP) arrangements—to differentiate the model from other carrier-led offerings. Consideration should also be given to ensuring participation by plans and providers. Notably, a carrier-led model on the Marketplace may not lower premium costs for some tax-credit-eligible consumers who are shielded from premium changes due to how federal tax credits are calculated. Instead, the savings from a lower-premium public option would be captured by the federal government. Under that scenario, this model would lend itself strongly to a Section 1332 waiver to capture premium tax credit savings as state pass-through funding that could be used to fund other elements of the program. Like the CCO-led model, the specialized carrier-led designs could also target specific populations, such as the tax-credit-eligible population or the currently unsubsidized population, particularly those over 400% of the FPL.
- **A state-led model in partnership with a third-party administrator (TPA)**, in which the state holds the plan risk as the insurer and uses a TPA for processing claims and plan implementation. This option could be modeled on the self-insured plan covering state employees. Depending on the benefit design and enrollee health status, the state-led model may be the lowest-cost model for consumers since the state has the opportunity to adjust requirements around tax liabilities and will have reduced administrative expenses compared to those in other options. This model also affords the state the most control, and therefore, the most flexibility in plan design. However, this option would also require the state to hold significant financial risk relative to the other options and may require a Section 1332 waiver depending on design.

[ii] Individuals impacted by the family glitch are ineligible for tax credits because of a family member's access to employer-sponsored coverage that is deemed "affordable" for both the individual and his or her family based solely on the cost of individual coverage, rather than the cost of the family plan.

Figure 1. Overview of Proposed Delivery Models

Strengths	Potential Weaknesses	Population Best Suited	Risk Pool	Waiver(s)	State Control
CCO-led Model The state utilizes existing CCOs—ideally serving the same service area for which they deliver OHP benefits—to offer a product available to a broader population.					
✓ Spreads the CCO model ✓ Tailorable to specific population needs ✓ Likely to offer a more affordable plan option	× Requires additional CCO administrative capacity and financial risk × May have limited access to tax credits, unless on the Marketplace × May require state financial support under some designs	Churn Population	Inside or Outside the Individual Market	1332 Waiver Needed, if Using Tax Credits	Moderate State Control
Carrier-led Model The state utilizes commercial insurance carriers to deliver a public option product under a contract with specific design provisions.					
✓ Limits state risk and utilizes existing infrastructure ✓ May improve premiums for current and new enrollees	× Limited affordability impact × Unknown carrier and/or provider participation without incentives/penalties × May fail to (or may negatively) impact subsidized enrollees, without a 1332 waiver to capture savings	Unsubsidized; Tax-Credit Eligible	Inside the Individual Market and/or on the Marketplace	No Federal Approval Needed	Low State Control
State/TPA-led Model The state holds the plan risk and uses a third-party administrator for implementation; the plan may be modeled on the self-insured plan covering state employees.					
✓ The state holds the plan risk and uses a third-party administrator for implementation, which allows the state flexibility and control in establishing parameters ✓ May be modeled on the self-insured plan covering state employees	× Increased state infrastructure needs and risk × Requires state-funded reserves × Risk pool issues, depending on enrollee health profile	Unsubsidized	Inside or Outside the Individual Market; may be on the Marketplace	QHP Certification/ 1332 Waiver Potentially Needed	High State Control

Key Considerations for Public Option Model Evaluation and Design

When evaluating these models, the state should consider how the model design aligns with the needs of the target populations outlined above, the associated premiums and cost-sharing to ensure affordability for consumers, risk pool placement to minimize negative impact on existing markets, interactions with federal funding and authority, and potential cost savings, as well as other considerations outlined in this report. However, it is important to acknowledge that no model can solve all policy goals or meet the needs of all Oregonians.

Notably, the models described in this report will continue to be developed against the backdrop of the COVID-19 pandemic, and considerations may evolve as the healthcare and economic landscapes change in response to the public health emergency.

Target Population. The target population will influence which delivery mechanism is selected, how the option is designed, the health status of those enrolling, and in turn, the projected premium. While the public option may be offered broadly with fairly open eligibility requirements, the plan design may benefit specific populations over others.

Premiums and Cost-Sharing. The premiums and cost-sharing of a public option will be closely linked and will be determined by a plan's actuarial value (AV),[iii] risk pool placement and available subsidies. Under Section 9 of SB 770, the state must "minimize cost-sharing" while weighing the potential impact on premiums.

Opportunities for Cost Savings. Ensuring affordable premiums and cost-sharing in the public option requires that the state find cost savings that may be passed to consumers. Ways to achieve potential savings include influencing provider reimbursement, making changes to administrative cost requirements (e.g., medical loss ratios [MLRs], taxes), and creating a new cost-sharing design.

Federal Waivers. Section 9 of SB 770 requires Oregon to develop a public option plan at "no net cost to the state." By design, the delivery models discussed in this report can be structured without state financial support or a federal waiver. However, a Section 1332 waiver—which allows states to make innovative, structural changes to Affordable Care Act (ACA) individual market provisions within legislative constraints—may be necessary to access and leverage federal tax credits outside the Marketplace or access pass-through funding that allows a state to recoup federal cost savings from state policies (discussed in more detail on pages 20–21). This new funding could be reinvested in the public option program to further reduce premiums and/or cost-sharing for Oregonians. Waivers can also be utilized to cover new populations.

[iii] Actuarial value is the percentage of total average costs for covered benefits that are paid by the insurance plan. The remainder is the responsibility of the consumer.

Risk Pool Placement. The price of health insurance is influenced by the health status of the people who purchase it. Groups of people purchasing together are called risk pools. The state can decide whether to offer the public option outside or inside the existing individual insurance market risk pool, and whether to place an individual market plan on the Oregon Health Insurance Marketplace. This decision involves numerous considerations, including for enrollees, such as whether the public option would include access to tax credits, what state and federal authorities are required, how much risk the implementing entity takes on, and the potential impact on other markets, including the value of federal tax credits.

Figure 2. Overview of Health Insurance Market Risk Pools

Estimated Impact

This report outlines initial program design recommendations for each model and features an analysis of enrollment for an illustrative public option in the individual market. The analysis utilizes Oregon-specific 2018 data from the state's All Payer All Claims (APAC) database to estimate the average reimbursement rate paid in Oregon across Medicaid, commercial and state-employee plans. This report estimates the premiums and enrollment of both a silver and a gold public option plan using this average, benchmark provider payment rate. According to the analysis, premiums under such a plan would be approximately 10% less than those of existing options. Estimated enrollment under the analysis ranges from 7,000 to 11,000, including between 3,400 and 4,600 uninsured Oregonians who would gain coverage. Note that this analysis relies on data collected before the COVID-19 pandemic and is meant to be illustrative and directional. An increase in the number of uninsured and in Medicaid enrollment due to the pandemic, for example, will likely impact public option pricing and take-up.

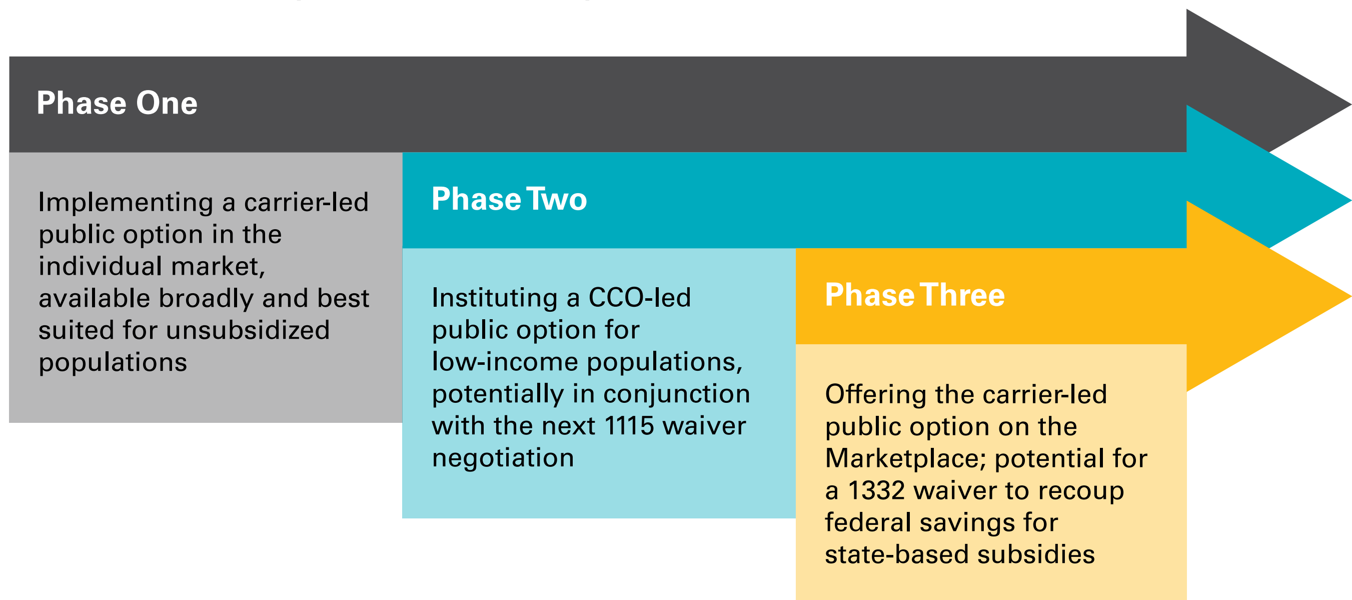
A supplemental analysis of the projected premiums and enrollment of a targeted CCO-led model was performed after the initial report was complete and can be found in the report addendum. The program would target undocumented immigrants and individuals who fall into the family glitch, who are ineligible for federal tax credits or other medical insurance assistance. Analytical results are included as an addendum.

Potential for Phased Approach

Understanding that each public option may be best suited to different populations, and recognizing the tandem goals of making the option available broadly and reducing the number of uninsured, there may be opportunities for a phased approach. Whichever public option is chosen as the starting model, there is opportunity to grow and evolve the program over time in response to changing state demographics and policy needs.

A dynamic, phased approach may also help the state adapt to relevant changes, such as policy changes at the federal level that make approval of a public option Section 1332 waiver more likely, and/or a decision by Oregon to transition from the federal Marketplace (Healthcare.gov) to a state-based Marketplace (SBM) with its own technology platform.

Figure 3: Illustrative Example of the Phased Public Option for Increased Enrollment



Next Steps

This report is meant to memorialize conversations to date on how to select a feasible and impactful public option for Oregon and to outline possible delivery models and program designs for further consideration by the public, stakeholders and state lawmakers. The legislature will have the opportunity to review the recommendations when it convenes for the 2021 legislative session.

Introduction

In July 2019, Oregon Governor Kate Brown (D) signed SB 770 into law, establishing the Task Force on Universal Coverage to spearhead the state's effort to achieve universal coverage for Oregonians and calling for an analysis of a potential public option or Medicaid buy-in plan for the state. The Task Force builds on previous work undertaken to evaluate opportunities to expand coverage in Oregon, including the 2017 RAND study of financing options[2] and the 2018 work conducted by the Universal Access to Care (UAC) Workgroup,[iv,3] which included a Marketplace-based public option, a Medicaid-like buy-in, and expansion of the CCO model.

Medicaid Buy-In vs. Public Option

The terminology of public option and Medicaid buy-in are evolving. While these terms are often used together, they define different program design approaches. A public option generally includes a state-sponsored plan that mirrors commercial insurance, which might be offered by a TPA or private insurance carrier. By contrast, a Medicaid buy-in describes a coverage option that in some way leverages the Medicaid program. Throughout this paper we will refer to the models under consideration in Oregon as public options.

The CCO model has been the state's vehicle for creating a more cost-effective Medicaid program since 2012 and has been successful in containing Medicaid costs within a 3.4% annual cost growth target. There are 15 CCOs approved to provide services from 2020–2024 (including some CCOs under a parent company) with regional service areas that serve the state's one million Medicaid recipients. CCOs are required to provide physical, behavioral, and oral healthcare services but also make community investments that improve health outcomes and seek to address health inequities. In 2017, the 3.4% cost growth target was extended to the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB), which provide health coverage to 300,000 state and school district employees.[4] Under Senate Bill 889, also passed in 2019, an implementation committee is currently meeting to establish a cost growth target for the entire state, building on the existing cost growth targets for CCOs and public employee health plans. As SB 770 guides Oregon's path toward universal coverage, Oregon's cost growth target work guides the state's path toward high-value, cost-effective care. In both cases, the CCOs offer important lessons for how state purchasing leverage can be used to achieve healthcare reform goals. These lessons can be translated to how Oregon can offer a state-sponsored health plan to improve affordability and access.

[iv] The UAC, in consultation with a range of Oregon healthcare stakeholders, previously produced preliminary policy recommendations around universal coverage related to a premium assistance program, enrollment assistance and outreach, consumer coverage simplification, administration simplification, plan uniformity, a primary care trust fund, a shared responsibility mandate, a Medicaid-like buy-in, and expansion of the CCO model.

The charter in SB 770 is to provide additional research and analysis to help policymakers form policy around a public option or Medicaid buy-in model for Oregon, referred to throughout this paper as a public option, that is available to all residents but offers value for specific populations. Policymakers have specifically expressed interest in building on the CCO model, either by using CCOs to deliver the public option or by requiring insurers or other entities to incorporate CCO practices into their public option products.

The Public Option and COVID-19

It is important to note that work to design the public option began before the beginning of the COVID-19 pandemic. At the time of this writing, the public health emergency is still underway, and the future healthcare and economic impacts of the crisis will be unknown for some time. However, it is clear that COVID-19 has and will continue to have a profound effect on Oregonians and the healthcare system nationwide. A few important themes are already beginning to emerge:

- **Governments are taking a leading role in ensuring access to COVID-19 testing and treatment.** Federal and state governments are instituting new policies to ensure commercially insured Americans are guaranteed access to COVID-19-related services regardless of ability to pay (at least in the short term). The increased role of government in healthcare is highlighting the need for public entities to ensure access to healthcare in times of crisis. A public option could offer a stable and accountable healthcare product.
- **Advancing health equity is an urgent priority.** The COVID-19 pandemic has highlighted significant racial and economic inequities in healthcare access and outcomes. Nationally, data show that Black/African American, American Indian/Alaska Native (AI/AN), Pacific Islander, and Latino/Latina/Latinx populations are bearing a disproportionate burden of COVID-19 in geographic locations reporting demographic data.[5] Age-adjusted COVID-19-related mortality compared to white populations is 3.4 times higher for Black/African Americans, 3.3 times higher for the AI/AN population, 2.5 times higher for Latino/Latina/Latinx, and 2.9 times higher for Pacific Islander communities. This means that, not only is COVID-19 infecting communities of color at higher rates than whites, but communities of color are also dying at higher rates than whites, even when holding infection rates constant.[6]

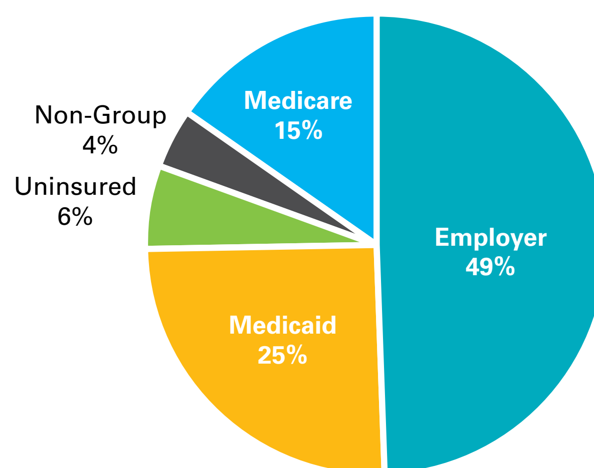
  The underlying inequities in our system require new strategies. To that end, OHA has outlined an ambitious 10-year strategic goal to eliminate health inequities,[7] and the CCO model has made strides toward addressing access challenges to counteract inequities. However, health equity should not only be a focus of public programs, but of the healthcare system as a whole. The healthcare system should seek to dismantle the structural nature of racism and oppression in the system. The public option is an opportunity to bring some of the provisions and expectations of the CCO program to a broader population.
- **Stabilizing and sustaining payments to critical providers requires flexibility and warrants creative approaches to generating revenue and structuring payments.** The state is in a position to institute new payment arrangements in Medicaid, such as prospective payments or loans, to providers to meet immediate needs. The public option also offers an opportunity to help stabilize the healthcare system following the pandemic, with accelerated movement toward value-based payments.

- **The economic impact of COVID-19 will shift how Oregonians receive healthcare coverage.** If unemployment continues to rise, the loss of employer-sponsored health insurance will cause more people to become eligible for Medicaid or tax credits in the Marketplace. This may strain CCO network capacity, or could significantly expand the number of people seeking coverage in the individual market, and highlights the need for a new, more affordable option for Oregonians purchasing healthcare coverage without employer support. This shift more broadly opens a window of opportunity to advance health equity, strengthen primary care, and ensure that Oregon's health system meets the needs of Oregonians.
- **The recession that is expected to follow the COVID-19 pandemic will put significant pressure on the state budget in the short term.** This is due to a loss in tax revenue and a simultaneous increase in the need for state services. Such pressure emphasizes the need to design a budget-neutral public option, with the possibility of an evolving program in the future as the economy improves.

Oregon's Current Healthcare System and Coverage Gaps

Oregon has made significant progress over the past decade in lowering the state's uninsured rate, which is down from about 15% in 2011 to about 6% in 2019, or 248,000 individuals.[8] While Oregon's 6% uninsured rate is lower than the national average (8.5%),[9] progress in recent years toward universal coverage has somewhat slowed. In 2019, mirroring national trends, nearly half of all Oregonians were covered by employer-based health plans, with an additional 40% covered by Medicare or Medicaid (see Figure 1). It remains to be seen how these coverage dynamics will shift in the aftermath of the COVID-19 pandemic, but the significant economic impact of social distancing is likely to cause at least a short-term reduction in employer-based coverage as individuals shift to Medicaid or individual market coverage or become uninsured.

Figure 4. Oregon Insurance Coverage Sources, 2019



Source: Oregon Health Insurance Survey, 2019.

Even before COVID-19, uninsured Oregonians faced a range of barriers to receiving health insurance coverage. Loss of Medicaid under the OHP is a significant factor in the rise of the uninsured rate in Oregon. According to the 2019 Oregon Health Insurance Survey, 35% of Oregon's uninsured say that losing OHP coverage is the primary reason for lack of insurance. About one in five of the uninsured (20%) cite premium affordability as the primary reason for lack of insurance, and about 22% lost a job and therefore lost coverage or the ability to pay for coverage. About 25%, however, are not interested in health insurance coverage and may not be likely to take up a public option plan without additional incentives such as an individual mandate penalty.[v,10]

[v] An individual mandate is a requirement that residents acquire health insurance for most of the year or pay a tax penalty (with exemptions based on a lack of affordable options or other hardships, for example). An individual mandate can incentivize people—particularly those who are relatively healthy and typically use less healthcare—to purchase

While CCOs offer a robust statewide coverage option for one million Oregonians, many Oregonians either are not enrolling in Medicaid or are losing Medicaid coverage due to eligibility changes. In the individual commercial health insurance market, Oregon's Marketplace is stable and competitive—with at least two insurance carriers in each county—allowing for consumer choice. During the 2020 open enrollment period, 145,264 Oregonians selected Marketplace coverage.[11]

In 2020, the average monthly second-lowest-cost silver, or "benchmark," plan premium on the Marketplace in Oregon is $446, with an average deductible of $4,027.[12] While consumer costs on the Marketplace depend on consumers' eligibility for tax credits and cost-sharing reductions, an individual's eligibility for tax credits may not mean coverage is always affordable. Twenty percent of the uninsured in Oregon cite affordability as their primary barrier to coverage. A significant portion of uninsured Oregonians are likely eligible for financial assistance and likely still find cost to be a barrier.[13]

Of those who are uninsured, approximately two-thirds are eligible for some form of financial assistance for health insurance, about one-third are eligible for OHP, and about one-third are eligible for Marketplace tax credits. The remaining third of the uninsured are not eligible for financial assistance because their income is too high, their immigration status makes them ineligible, or they have an offer of employer-sponsored coverage (see Figure 5).[14] Accordingly, those who are uninsured range across income groups, with 18% above 400% of the FPL; about 62% between 100% and 399% of the FPL (many of these individuals qualify for Marketplace subsidies, though some are not eligible for tax credits due to employer coverage offers, immigration status, or OHP eligibility for those between 100% and 138% of the FPL); and 20% below the poverty line and likely eligible for OHP coverage (see Figure 6).

Figure 5. Distribution of Oregon Non-elderly Uninsured Individuals by Eligibility for Coverage Programs, 2018

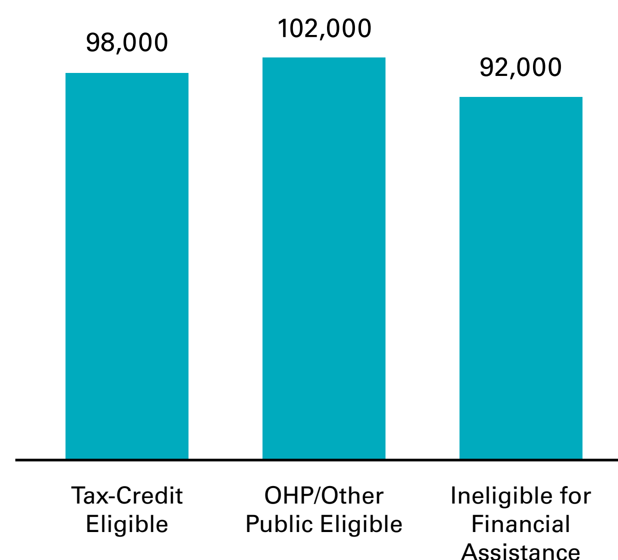
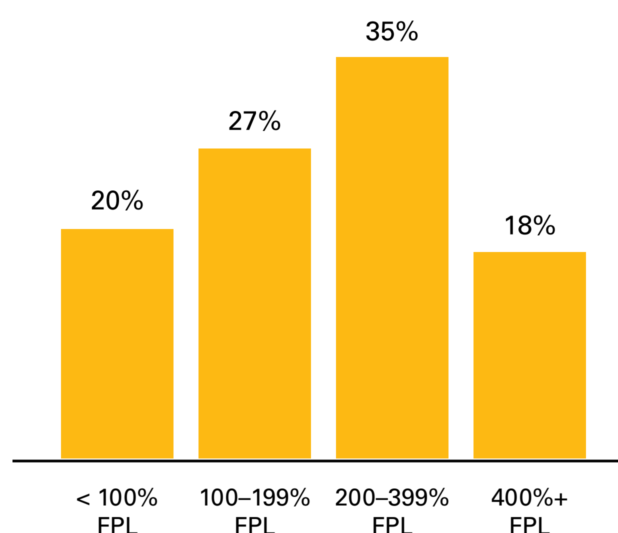


Figure 6. Distribution of Oregon Non-elderly Uninsured by Income Level, 2018



Note: **Non-elderly** includes those ages 0-64, in order to exclude those eligible for Medicare (ages 65+) and more accurately reflect potential state option enrollees.

Source: Kaiser Family Foundation (KFF) (2020). *State Health Facts: Oregon*. Retrieved Apr. 27, 2020.

health insurance, thereby improving the risk pool and the affordability of coverage in the individual market. Revenue collected from the individual mandate fee may be used to further subsidize coverage or advance other priorities.

The Uninsured in Oregon

Low-Income Populations. Even before COVID-19, a relatively high proportion of the uninsured in Oregon were either OHP eligible or tax-credit eligible, which highlights that many people are becoming ineligible for one program and not enrolling in alternative coverage. The population whose incomes fluctuate between Medicaid and Marketplace eligibility levels is often referred to as the "**churn population.**"

Tax-Credit Eligible. Approximately one-third of uninsured Oregonians are eligible for tax credits. Cost and lack of awareness of the availability of and criteria for subsidies likely remain barriers to coverage.

Tax-Credit Ineligible. Those who are uninsured and ineligible for tax credits and Medicaid largely fall into three categories: those with incomes above 400% of the FPL, those who are offered but do not enroll in employer-sponsored coverage (including those who fall into the family glitch),[vi] and those who are ineligible for subsidies due to immigration status.

Immigration Status. Undocumented residents over 19 years of age are ineligible for both Medicaid and Marketplace financial assistance; therefore, many likely face affordability barriers to health insurance coverage.

See the Appendix for an in-depth discussion of these populations.

Overview of Public Option Models for Oregon

Public option models are not one size fits all. Some models may be more effective than others in addressing specific goals and objectives, and an important first step for choosing an appropriate model is defining the state's policy priorities, goals, and objectives. The overall goal of a public option program for Oregon (as specified by SB 770) is to lower costs, to increase affordability for Oregon consumers, and to increase the number of Oregonians with health insurance coverage. In addition to these central goals, the public option can be designed to meet other policy priorities and objectives. OHA has identified the following objectives for the option:

[vi] The "family glitch" is a structural issue preventing some families from being eligible for tax credits; spouses in particular may consider coverage unaffordable and therefore be uninsured (children may be eligible for Medicaid or CHIP). Individuals impacted by the family glitch are ineligible for tax credits because of a family member's access to employer-sponsored coverage that is deemed "affordable" for both the individual and his or her family based solely on the cost of individual coverage, rather than the cost of the family plan. These family members fall into the family glitch, and because neither the employer nor the Marketplace coverage is truly affordable, they are at an increased risk of lacking health insurance altogether.

- **Ensuring affordability compared with current offerings**, by offering a product with lower premiums and reduced cost-sharing for high-value services.
- **Increasing state purchasing power and expanding current state programs**, by aligning the option with existing state programs, such as CCOs and state employee and school district coverage. Alignment with existing, successful programs can minimize administrative burden for carriers and providers and allows the state to incorporate VBP, health equity, and social service elements of existing programs into the public option to advance the state's healthcare policy and equity goals.
- **Maximizing federal funding support**, by considering options that have access to federal tax credits on the Marketplace or through a Section 1332 or Section 1115 waiver.
- **Minimizing disruption of existing markets**, by ensuring the option has a neutral or positive impact on the existing individual market and the current CCO program.

Informed by the 2017 RAND study and the work of the UAC Workgroup—as well as public option models developing in Washington and Colorado—staff within OHA and the Department of Consumer and Business Services (DCBS) began the work of evaluating the most impactful and feasible models that could address the stated goals of SB 770, fulfill its objectives, and meet the needs of Oregonians who remain uninsured. These efforts have led to the evaluation of three potential options for a public option model in Oregon:

Figure 7: Proposed Delivery Model

Model	Overview	Population Best Suited	Risk Pool	Waiver(s)	State Control
CCO-led Model	The state utilizes existing CCOs—ideally serving the same service area for which they deliver OHP benefits—to offer a product available to a broader population	Churn Population	Inside or Outside the Individual Market	1332 Waiver Needed, if Using Tax Credits	Moderate State Control
Carrier-led Model	The state utilizes commercial insurance carriers to deliver a public option product under a contract with specific design provisions	Unsubsidized; Tax-Credit Eligible	Inside the Individual Market and/or on the Marketplace	No Federal Approval Needed	Low State Control
State/TPA-led Model	The state holds the plan risk and uses a TPA for implementation; the plan may be modeled on the self-insured plan covering state employees	Unsubsidized	Inside or Outside the Individual Market; may be on the Marketplace	QHP Certification/ 1332 Waiver Potentially Needed	High State Control

In order to choose a public option delivery model, OHA will need to evaluate essential program considerations that are relevant across each model and that will impact how each delivery model is designed. Examining these considerations and how they fit with Oregon's overall policy goals will also help identify which delivery model is the best fit.

Key Program Design Considerations

Target Population. Determining target population(s) and eligibility requirements will influence which delivery mechanism is selected, how the option is designed, the health status of those enrolling and, in turn, the projected premium. If a central goal of the public option is increasing the number of Oregonians with healthcare coverage, understanding who remains uninsured and why will be central to selecting a model that offers value to select populations. All the models could be offered broadly and do not have to restrict enrollment to specific populations, but some models may be better suited to particular populations than others, as noted in Figure 7 above.

Providing a New Coverage Option for Unsubsidized Immigrant Populations

Under all models, providing a public option to populations that do not qualify for federal assistance because of immigration status will likely require additional state subsidies to make an insurance product affordable for individuals with lower incomes. According to 2016 data, about 2.6% of Oregon's residents are unauthorized immigrants, or 110,000 individuals.[15] Current restrictions preclude the use of federal funds for these populations, requiring state funding. There may be opportunities to use other revenue sources to make such a program budget-neutral to the state. Further, the state could consider a system-wide savings such as a reduction of uncompensated care to justify a state investment in these subsidy programs. Such an approach would require additional analysis.

Risk-Bearing Entity. Selecting which entity will administer the public option is a foundational decision in selecting the delivery model. Oregon needs to evaluate whether the state is in a position to implement the public option or whether the state will partner with existing entities, like existing insurance companies or CCOs. This decision will depend largely on the state's desire for control over the program, weighed against its ability or desire to accept fiscal risk or administrative obligations. State-run programs may allow for the most flexibility in program design and potential cost savings because the state has unique bargaining power unavailable to commercial plans; however, under a state-run program the state is more exposed to risks inherent in health insurance markets due to unknown enrollment and health status changes. (For more information on projected enrollment, see Appendix.)

Benefits. Depending on the chosen delivery model, the state may be able to tailor plan benefits. All insurance products offered in the individual market are required to provide ten essential health benefits (EHBs),[vii] which will likely serve as the base for all model designs. Depending on the target population and the state's policy goals, the public option could include additional benefits that mirror the Medicaid program (under a CCO-led model), or additional value-added, health-related, and equity centered services, such as addressing social

[vii] The ten essential health benefits (EHBs) include ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive services and chronic disease management; and pediatric services, including oral and vision care.

determinants of health or access to culturally responsive and linguistically responsive interventions such as the use of traditional health workers (THWs)[viii] within a commercial insurance context. Importantly, the benefit package will impact overall premiums, and decisions about which services to include should be weighed against increased cost.

Premiums and Cost-Sharing. Health insurance premiums are determined by covered benefits, the percentage of costs for covered benefits paid by the insurance plan (known as actuarial value), reimbursement levels for participating providers, and the overall health of the risk pool. Within these parameters, the state will have levers to influence the ultimate premium of the public option through provider reimbursement; changes to administrative cost requirements (e.g., increasing MLRs[ix] that limit spending on nonmedical claims, taxes); and cost-sharing design. Existing research suggests that consumers are more sensitive to premium costs when choosing healthcare coverage,[16] but both premiums and cost-sharing (e.g., deductibles, coinsurance, copayments) contribute to overall consumer affordability.[17] High cost-sharing remains a barrier for ensuring access to care even among individuals with insurance coverage, and cost-sharing requirements are often hard for consumers to understand. Premiums and cost-sharing are linked and must be carefully weighed in order for Oregon policymakers to design a public option with the highest value for Oregonians.

SB 770 requires that the public option have "minimal cost-sharing." The public option can take many approaches to cost-sharing: mirroring Medicaid, the Marketplace, or a different model entirely. Under Medicaid, the federal government imposes restrictions on the level of cost-sharing beneficiaries are required to contribute based on the fact that premiums, deductibles, and copayments often prove to be access barriers for lower-income individuals and families. However, a public option with Medicaid-like cost-sharing (without additional state investment or subsidies) will have a high AV, and therefore a high premium. It is unlikely the state could provide an option that meets the affordability needs of the existing uninsured under Medicaid-like cost-sharing without providing additional financial assistance to enrollees. Further, a product with significantly different cost-sharing would not compete on a level playing field with other existing healthcare plans in the individual market. A plan with comparatively low, Medicaid-like cost-sharing would influence the uptake and health profile of the individuals choosing the public option. These shifts in the risk profile of enrollees could undermine current offerings and have a destabilizing impact on the existing market.[x] For these reasons, this report assumes that Oregon would likely choose an option(s) with cost-sharing levels mirroring those of the individual market and with the possibility of offering products in metal tiers with lower cost-sharing (e.g., gold and platinum) for enrollees seeking a plan with a higher AV.

[viii] THW is an umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider, such as doulas, personal health navigators, peer support specialists, peer wellness specialists, and community health workers.
[ix] The MLR is the proportion of premium revenues spent on clinical services and quality improvement. The ACA requires insurance companies to spend at least 80% or 85% of premium dollars on medical care.
[x] This may be partially mitigated with participation in risk adjustment but should still be considered in the option design.

Understanding Metal Tiers

In the individual (and small group) market and Marketplace, health insurance plans are organized by metal tiers with specific AVs, ranging from 60% (bronze) to 90% (platinum). No platinum plans are currently offered in Oregon. The higher the AV, the lower the cost-sharing and the higher the premium. Federal law requires QHPs to follow specific cost-sharing design requirements—including AVs by metal tiers and access to preventive services pre-deductible—reducing flexibility for new cost-sharing design within a state option in the individual market, without a waiver. Having the state option offer coverage at multiple tiers, e.g., silver and gold plans, would allow consumers to choose a low cost-share plan with higher premiums to meet their needs. Additionally, if the state chooses to offer a plan in the individual market, there are tools to offer additional value and to "minimize" cost-sharing within the metal tier framework by building upon the state's existing standardized plan. Oregon currently requires standardized plans to offer primary and specialty office visits with a copayment and not subject to deductible. This may be continued and expanded for the state option.

In 2019, 10% of Oregonians that participate in the Marketplace selected gold plans, 51% chose silver plans, and 39% selected bronze plans.

Ensuring Participation. Attracting carrier or CCO participation will be critical for non-state/TPA-led models, and ensuring provider participation in the public option plan networks will be essential—particularly in rural areas—for success across all models. The state has several options for ensuring the participation of risk-bearing entities and providers, ranging from voluntary to mandatory participation. There will likely need to be a mechanism beyond simply encouraging voluntary provider participation, especially among providers who would receive lower reimbursement rates under a public option. This is discussed in more detail after the evaluation of the models on page 38.

Risk Pool Placement. Insurer flexibility to divide their insured populations into separate risk pools is strictly limited under the ACA to prevent "unfair discrimination" against certain populations, such as those with preexisting conditions. The ACA's "single risk pool" standard requires insurers to treat their total population of individual market enrollees as a single risk pool, with pricing differences for specific benefit plans limited to a handful of factors (age, family composition, smoking status, and geographical rating area). The state can decide whether to offer the public option outside or inside the existing individual market risk pool. Either choice has pros and cons, and has implications for who enrolls, who has access to tax credits, what regulations are required, how much risk the implementing entity takes on, and the potential impact on other markets. Separately, if the state decides to place the option inside the individual risk pool, it can also choose whether to offer the plan on or off the Marketplace. Because Oregon's Marketplace uses the federal technology platform, the state's ability to innovate is limited. Any plan offered through the Marketplace must satisfy state and federal requirements and be certified by the state for placement on Healthcare.gov.

Depending on the health risk of the individuals who enroll in the public option, offering a public option outside the individual market, in a new risk pool, could result in a low-cost product for healthy individuals. However, the migration of enrollees seeking lower premiums out of the individual market will alter the

existing risk pool and may raise premiums for enrollees who remain in the individual market. The opposite scenario is also true: If less-healthy individuals are attracted to an option with a new risk pool, the plan will bear more risk and the premium will be more expensive without the protection of risk adjustment in the individual market. The level of risk will depend on the program design and the target population.

Figure 8. Overview of Health Insurance Market Risk Pools

Offering a public option in the individual market, including through the Marketplace, could improve coverage and affordability for all individual market enrollees by attracting healthy risk and lowering cost if the new option attracts healthier enrollees. The biggest considerations for offering the option in the individual market are twofold—reduced flexibility in plan design because of individual market requirements (e.g., offering plans at specific metal tiers) and potential impact on the Marketplace's second-lowest-cost silver benchmark plan. Each year, the level of federal tax credits offered to individuals in the Marketplace is calculated using the second-lowest-cost silver plan available in each region.

Effect on the Second-Lowest-Cost Silver Plan. If a lower premium public option silver plan is offered in the Marketplace, it may impact which plan becomes the second-lowest-cost silver plan. This impact is greater in areas where more than one public option silver plan is available and when the public option is the lowest- and second-lowest-cost silver plans. Lowering the premium of the second-lowest-cost silver plan reduces the amount of premium tax credits available to Marketplace consumers, creating savings for the federal government, but not for the state of Oregon. For Oregonians eligible for tax credits, the net effect of a lower-cost public option may be cost neutral or may minimally impact plan choice in the Marketplace, depending on the level of fluctuation in the benchmark plan, leaving only the federal government benefiting.

There are at least two options to help capture savings for the state of Oregon and individual Oregonians. One option is to avoid loss of premium tax credits by initially implementing a public option in the individual market but outside of the Marketplace. This option expands the existing risk pool in the near term. Placement on the Marketplace would be postponed to when policies that mitigate the potential impact on the second-lowest-cost silver plan have been established or the state obtains its own technology platform, allowing for more

flexibility and control. This phased-in approach would have the effect of helping consumers ineligible for tax credits pay more affordable premiums in the short term and focusing on tax-credit-eligible individuals in the long term.

The second option would be to apply for a Section 1332 waiver to recoup federal savings from reduced premiums on the Marketplace. Those savings could then be reinvested to benefit tax-credit-eligible individuals.

Potential Benefits of Transitioning From the Federal Marketplace Technology Platform to a State-Based Marketplace Technology Platform

SBMs that control their own technology platforms have more autonomy over operations, the consumer experience, and customer service, and have significantly more influence over their insurance markets. Transitioning from an SBM on the federal platform, Healthcare.gov, to a full SBM could lead to:

- Increased flexibility for state-specific policy priorities, like Medicaid buy-in/public option, or state subsidy programs
- Ability to customize the enrollment interface
- Enhanced consumer tools and customer service
- Improved eligibility systems and continuity of coverage
- Improved performance (SBMs with their own technology have seen reduced premium growth, enrollment of younger populations, and reductions in the uninsured rate)
- Access to more enrollee data
- Savings of tens of millions of dollars in federal user fees
- Opportunity to revise the enrollment schedule by expanding open enrollment and opening special enrollment periods

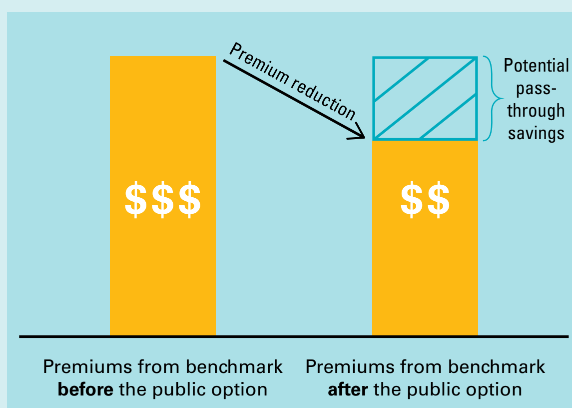
Necessary Authority and Federal Funding. While models can be designed that do not require federal approval—for example public options that meet all existing qualified health plan requirements and/or do not make structural changes to existing government programs, like Medicaid managed care—there may be opportunities to apply for a waiver to gain design flexibility or access federal funding. This funding could include tax credits for use outside the Marketplace or recoupment of federal savings that result from the public option.

Four Reasons to Consider a Section 1332 Waiver

Oregon should consider a Section 1332 waiver if it would be advantageous to:

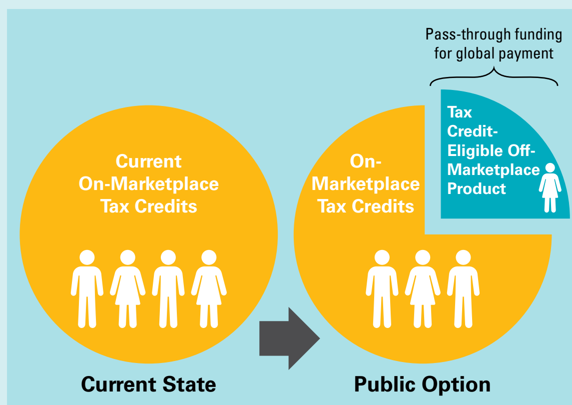
- **Access savings from lower rates or enhanced administrative efficiencies through a pass-through mechanism.** Funding from a pass-through waiver could be reinvested in the program to further reduce premiums and/or cost-sharing for Oregonians.

  An on-Marketplace buy-in product that has a lower premium than current plans is likely to reduce the cost of the second-lowest-cost silver plan used to set the level for tax credit subsidies, thus reducing aggregate federal costs. A state could apply to access those savings through a Section 1332 waiver as pass-through, under a mechanism similar to the Oregon reinsurance waiver.



- **Pursue an off-Marketplace option that utilizes federal tax credits** to subsidize costs for consumers.

  If the state chooses to offer a public option off the Marketplace, the state could apply receive a global payment equivalent to the projected amount of federal premium tax credits that would have been offered to enrollees on the Marketplace. This funding could be used to fund and further subsidize state option coverage outside of the Marketplace.



- **Alter current QHP or tax credit requirements** in the public option (authorizing, for example, a model that is restricted to a gold-level plan) for the public option.
- **Offer a public option to only a select subsidized population** in the Marketplace.

The decision to pursue a waiver will depend on the state's administrative capacity to apply for it, the total potential savings, and the likelihood of approval. The Trump Administration has expressed an interest in some of these ideas—for example, providing tax credits to off-Marketplace, non-QHP products—but no waivers have been approved for these mechanisms to date. The interpretation of Section 1332 waiver guidelines may change over time to give states increased flexibility. The timing of a waiver application for the Oregon public option will be an important factor for potential approval.

Notably, Oregon may design a public option that does not require a waiver in the short term, with plans to apply for a waiver as the public option evolves. This could mean a future Section 1332 waiver for federal pass-through, or coordinated Sections 1332 and Section 1115 waivers to help the public option better align with the state's evolving Medicaid program.

Potential Impact on Other Markets. Each model should take into consideration the impact of its introduction on other existing markets. Changes to the risk pool profile discussed above are just one example of potential impact. The mechanism used to increase participation could also influence the models' effect on other insurance markets and product implementation. Mandating participation between the public option and other state programs (such as Medicaid and the state employee health plans) for carriers or providers could impact provider access within those programs as providers absorb additional patients and both carriers and providers make participation decisions across programs. The public option could also have a positive impact across programs by diversifying existing risk pools and/or reducing uncompensated care across the health system, subsequently lowering costs for all.

Potential Companion Strategies to Achieve Key Policy Goals

It is important to acknowledge that no model can achieve all policy goals or meet the needs of all Oregonians. Other policy solutions, each with pros and cons, could be a better match for some target populations or could be used in tandem with the state option to maximize impact and expand coverage toward universal access. Oregon could, for example:

- **Invest in additional culturally and linguistically responsive outreach campaigns** to attract uninsured Oregonians who are eligible for Medicaid or subsidized Marketplace plans.
- **Institute an individual mandate fee** to encourage individuals who are uninterested in coverage to enroll.
- **Require insurers to meet higher standards** to participate in the Marketplace with an active purchaser model.
- **Introduce facilitated enrollment programs**, particularly for individuals experiencing churn.
- **Implement other affordability or cost-saving policies**, such as building on Oregon's prescription drug price transparency program and instituting policies to address the rising cost of prescription drugs as a proportion of clinical services.

Evaluating and Comparing Proposed Delivery Models

Each of the models selected by OHA for further evaluation can be tailored across the key design considerations discussed above to meet Oregonian-specific goals. No model is perfect; each has strengths and considerations based on who is most likely to enroll, potential premium impact, and how much influence the state decides to exert to produce an affordable option.

This section will evaluate each proposed delivery model and discuss key program design components for additional consideration.

Figure 9: Proposed Model Strengths and Potential Weaknesses

Model	Strengths	Potential Weaknesses	Potential Mitigation Strategies
CCO-led Model	✓ Spreads the CCO model ✓ Tailorable to specific population needs ✓ Likely to offer a more affordable plan option	× Requires additional CCO administrative capacity and financial risk × May have limited access to tax credits, unless on the Marketplace × May require state financial support under some designs	Offering the plan to select populations may limit potential risk and alleviate operational burden on existing CCOs, though a targeted option may require an SBM-controlled technology platform.
Carrier-led Model	✓ Limits state risk and utilizes existing infrastructure ✓ May improve premiums for current and new enrollees	× Limited affordability impact × Unknown carrier and/or provider participation without incentives/penalties × May fail to (or may negatively) impact subsidized enrollees, without a 1332 waiver to capture savings	The carrier-led model can be offered in a tiered fashion by first providing a more affordable off-Marketplace option to populations <400% of the FPL; later it can be offered on the Marketplace under a waiver to capture savings.
State/TPA-led Model	✓ The state holds the plan risk and uses a third-party administrator for implementation, which allows the state flexibility and control in establishing parameters ✓ May be modeled on the self-insured plan covering state employees	× Increased state infrastructure needs and risk × Requires state-funded reserves × Risk pool issues, depending on enrollee health profile	The state may need to wait for an SBM-controlled technology platform before implementing this kind of plan and fully taking advantage of its flexibilities.

Evaluation of a CCO-Led Model

Under the first model, the public option would be offered by the state in partnership with current CCOs. Oregon's Medicaid program has been delivered by CCOs since 2012. CCOs have been successful in controlling costs under a 3.4% cost growth target and also improving health outcomes.[18] CCOs have also expanded the use of VBP strategies (see page 39 for more detail) and have governing boards that work closely with the communities they serve to expand primary care and behavioral health and improve social equity through community investments. In the CCO 2.0 program, which began in 2020, the CCOs are required to meet a series of rigorous new requirements to further value-based care and increase health equity.[xi]

Key CCO 2.0 Components: Potential Requirements to Replicate in the State Option

- Increased focus on integrative primary and behavioral health services
- Additional spending to address social determinants of health (SDOH)
- Access to traditional healthcare workers (e.g., doulas, peer support specialist, health navigators, community health workers)
- Reinvestment in community-based activities
- Community interaction through Community Advisory Councils and health assessments
- Specific health equity and language access metrics to improve access for culturally and linguistically diverse and low-income populations
- Targets for value-based payment arrangements
- Address language and cultural barriers to care

Given the importance of the CCOs to the Oregon healthcare system and Oregon's desire to continue promoting the model, a CCO-led public option delivery model has unique benefits and risks, depending on its program structure. The chart below provides a brief overview of the structure of a CCO-led model, and additional design considerations are outlined below.

[xi] A key focus of the CCO 2.0 policy and procurement process was a focus on health equity. Health equity requirements of CCOs include designing and implementing a health equity plan, working with and integrating traditional health workers, designating a health equity administrator, conducting training and development activities, developing and reporting on a language access plan, and submitting data on interpreter services. The CCO 2.0 Recommendations of the Oregon Health Policy Board report is available at https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report.pdf.

Figure 10: CCO-Led Model Design Components

Design Components of a CCO-led Public Option Delivery Model	
Coverage offerer(s)/ risk-bearing entity	CCOs, with potential for state support or carrier partnerships for smaller CCOs
Premiums and cost-sharing	• Premiums primarily determined by benefits and cost-sharing • Cost-sharing could mirror Marketplace metal tiers, or different cost-sharing levels if offered outside individual market • Provider reimbursement will also impact the total cost of coverage
Benefits	EHBs or Medicaid benefits, depending on design
Risk pool placement	In or out of the individual-market risk pool; could be offered through the Marketplace if CCOs and plans meet requirements
Cost-saving measures	Provider reimbursement rates could be set by the state
Ensuring participation	CCOs and providers may be required to participate
VBP/SDOH provisions	Follow the same requirements as those of the current CCO 2.0 program
Health equity	CCOs currently have several requirements around advancing health equity, which could be applied to the public option plan

The CCO-led model could be a unique opportunity for an Oregon-specific public option, but any expansion of coverage by CCOs into the individual market involves many considerations with respect to the feasibility and viability of this expansion. Specifically, the option must factor in how to meet the needs of the uninsured, who range from low to high income and have different reasons for not purchasing coverage today.

Capacity. The various CCOs operate with a wide variety of enrollment volumes, business models, and geographic service areas.

Based on March 2020 enrollment, of the 11 non-PacificSource CCOs, the five smallest CCOs had fewer than 30,000 enrollees and another five had between 30,000 and 60,000. The CCO with the largest enrollment volume had more than 300,000 enrollees; additionally, the four PacificSource CCOs had more than 200,000 enrollees combined.[19]

With the exception of PacificSource, which operates four distinct CCOs covering three different regions, the remaining 11 CCOs operate in only one of the following four rating regions within the state: Eastern, Northwest, Southwest, or Tricounty. Some CCOs have de minimis enrollment in a second region, but in each instance these members make up less than 1% of the additional region, and therefore are not substantial. Furthermore, only one of the non-PacificSource CCOs currently has enrollment in more than four of Oregon's 36 counties.

For CCOs to cover more individuals under a public option plan, several capacity issues emerge for consideration. Notably, CCOs may need to increase provider networks in order to take on new enrollees. This will shift their negotiating capacity with providers but may also prove challenging for CCOs that are already facing provider capacity issues when serving Oregon's most vulnerable populations, and in rural areas,

depending on which providers decide to participate. If the public option launches without adequate provider networks, members may not be able to access the care they need. If only current CCO providers accept public option payments, the existing Medicaid network may become strained.

Depending on the program structure and level of state support, CCOs may also be required to set and accept premiums and copays from enrollees unless Oregon performs this role on a state platform. This will require new administrative and technical capacity since the current Medicaid program does not require copays or premium contributions from individuals. It may also lead to some CCOs bearing a degree of credit risk, as they are unlikely to be consistently paid in advance by churning members. The impact of this risk will depend upon the populations that ultimately enroll in this model and the associated tax credits these members are eligible to receive.

Offering a CCO-led plan in the individual market will require licensure as an insurer or an exemption from the state, which can have significant drawbacks. This will be a key operational consideration if this model is selected for further development and incorporated into implementing legislation.

CCOs may also be able to offer a plan through an existing commercial entity with which they have a relationship.

Financial Requirements. To operate as an individual market plan, CCOs would need to be able to meet the reserve requirements set by the Division of Financial Regulation (DFR) for health insurers offering individual or group health insurance in the state of Oregon. These requirements are in place to protect consumers from financial insolvency. Analysis performed by Optumas, an actuarial and health reform consulting firm, compared the reserve requirements for CCOs under the CCO 2.0 program with reserve requirements for health insurers to identify the financial capacity that a CCO-led model would require.

Under state law,[20] Oregon health insurers must meet the following reserve obligations:

1. Have a minimum of $3 million of capital and surplus to be licensed as an insurer (state licensure is required by the ACA) and maintain a minimum of $2.5 million of capital and surplus on an ongoing basis regardless of business volume.
2. Maintain total adjusted capital and surplus based on business volume that ensures a risk-based capital (RBC) ratio of at least 200% of the authorized control level.

The requirements above operate such that the initial $3 million acts as a floor of total adjusted capital and surplus to be held. If the total adjusted capital and surplus required for an insurer to meet the 200% RBC minimum is less than $3 million, the entity must hold at least $3 million. However, if the required amount of capital and surplus to maintain the 200% RBC minimum is above $3 million, then the minimum amount to hold would be only the amount required to meet 200% RBC, not 200% RBC plus $3 million.

Upon comparing the reserves required by the CCO 2.0 program and those required by the DFR, we note the ongoing maintenance of a minimum of 200% RBC ratio has been adopted by OHA for the CCOs, but the $3 million capitalization requirement minimum is not in place. To the extent a CCO had more than $3 million in capital and surplus for CCO purposes, that CCO would meet the $3 million capitalization requirement without needing to obtain additional up-front capital. At this time, all of the CCOs currently have more than $3 million in capital and surplus and therefore this requirement is not expected to be a barrier. However, there

are differences in how DCBS and OHA treat companies with RBC between 200% and 350%. OHA considers that range to be acceptable, while DCBS considers companies with 200–300% RBC to be “troubled” and requires additional reporting from them; companies with 300–350% RBC are also subject to more monitoring and encouraged to increase capital and surplus to at least the 350% RBC level. To the extent a CCO fell in that 200–350% RBC range for its full book of business, including any public option business, DCBS and OHA would have to develop a shared understanding of how such a CCO should be treated, taking into account that OHA and the state are ultimately responsible for Medicaid obligations, while neither DCBS nor the state has the same liability when a DCBS licensed insurer goes insolvent.

Note that the considerations and assessments cited above are largely based on information available prior to any impact of the COVID-19 pandemic on healthcare expenditures. Depending upon the severity and duration of this pandemic, it could have a material impact on the current level of reserves for the CCOs, which could create additional challenges in meeting the aforementioned requirements; conversely, this could result in additional short-term reserves being held by the CCOs, depending upon the duration of suppressed utilization due to the delay of elective services.

Effects on Other Markets. If the provider reimbursement rates used by the CCOs under this delivery model are significantly lower than rates paid by current Marketplace plans,[xii] there is the possibility that CCO premiums would also be substantially lower. In this case, allowing CCOs to fully compete with the current Marketplace and/or individual market carriers could have the unintended effect of reducing competition in the market if carriers were not able to compete on price or simply chose to withdraw from the market. Alternatively, CCOs may not be able to meet network adequacy requirements if they are required to offer lower provider reimbursement rates, and providers are not required to accept those rates. Finally, as described above, if the CCO public option were inside the Marketplace and were deemed the second-lowest-cost silver plan, tax credit levels may be lowered depending on the price differential between the lowest- and second-lowest-cost silver plans. Additionally, depending on the total enrollment, a new product line through the CCOs may strain the capacity of the CCO provider network, which may impact existing Medicaid beneficiaries.

A differential in the payment rates between Medicaid and non-Medicaid populations using the same provider network may put pressure on payment rates and provider behavior for the existing Medicaid population. Opportunities for the OHA to determine an appropriate rate—in relation to existing provider reimbursement rates by payers, including Medicaid, Medicare, state employee plans, and commercial plans—will be a central focus of the next report.

Finally, if CCO participation in the public option plan is mandatory and/or is likely to disrupt Medicaid managed care operations, the Centers for Medicare & Medicaid Services (CMS) will have to approve additional contracts, and may reject them if new requirements threaten the existing managed care system.

[xii] Note that the provider reimbursement could be set at current CCO rates or a new rate as determined for the program. As discussed above, these rates should balance cost savings and ensure adequate provider participation.

Potential Specialized Design: CCO-Led Model for Specific Populations

To mitigate the potential capacity and market impact concerns, Oregon may want to consider a specialized design that expands the CCO model only to certain populations, whether as a transition or in conjunction with other policies. However, balancing the size of the population in each service area with the potential burden of administering a new program and reimbursement design will be an important consideration for determining the target population and program viability.

Individuals With Incomes Right Above Medicaid Eligibility. The CCO model may be particularly attractive for lower-income Oregonians who are just above the Medicaid eligibility level, particularly for individuals shifting from Medicaid coverage eligibility to Marketplace coverage.[xiii] The CCO model has the advantage of offering a higher continuity of providers than other options. Additionally, the CCO requirements in Medicaid are conducive to meeting the clinical and social needs of the low-income population, such as access to health-related services to address SDOH and integrating traditional healthcare workers (e.g., doulas, peer support specialist, health navigators, community health workers) into care teams.

A tailored, specialized program could be accomplished via three potential pathways:

- **A bridge plan.** The U.S. Department of Health & Human Services and the Department of the Treasury have issued guidance describing a "bridge plan" model.[21] Under this model, a state could allow an issuer that contracts with a state Medicaid agency as a Medicaid managed care organization to offer QHPs in the Marketplace on a limited-enrollment basis to certain populations "allowing individuals transitioning from Medicaid or CHIP coverage to the Marketplace to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network." The guidance does not indicate that a waiver is required, but the state must ensure all applicable laws are met. However, the guidance advises that an SBM would be in the best position to implement such an option. No state has implemented a bridge plan. Limited enrollment is generally prohibited under the ACA's guaranteed issue requirement with a limited exception for network capacity considerations.
- **A Section 1332 waiver.** The state could apply for a waiver to use tax credits for a limited population and potentially waive some of the QHP requirements for a tailored plan.
- **A coordinated Section 1332 and Section 1115 waiver process.** The state may consider coordinating Sections 1332 and Section 1115 waivers that would permit individuals at risk of churning between Medicaid and Marketplace eligibility to stay in their Medicaid plan for a specific amount of time (e.g., one year or until the next open enrollment period) by using the equivalent of federal tax credits to fund the program. To date, no state has applied for, or received, such a waiver. Without a precedent, there is uncertainty about whether a combined waiver could meet both waiver requirements and whether it would be approved.

[xiii] According to the Kaiser Family Foundation, in 2018, 136,400 Oregonians below 200% FPL were uninsured. Further, 35% of Oregonians surveyed in 2019 indicated they had lost OHP coverage. Source: Kaiser Family Foundation, State Health Facts: Health Coverage & the Uninsured; internal OHA survey, available at https://www.kff.org/other/state-indicator/nonelderly-up-to-200-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Uninsured Due to Immigration Status. Immigrants who are undocumented, or who are unable to access federal subsidies, often find it challenging to access health insurance coverage in and outside of the workplace, since many are in low-wage jobs that may not offer insurance coverage and are ineligible for federal tax credits. This population contributes to the uninsured rate and to uncompensated care for providers.[22] If the state chooses to subsidize coverage for some individuals, extending and subsidizing CCO coverage for those who do not qualify for Medicaid or premium tax credits due to immigration status might be a good option. Federal approval would not be needed, and the CCOs likely provide coverage that would be comprehensive, focused on the needs of the lower-income population, and less costly for Oregon to subsidize than other options.

A supplemental analysis of this specialized program is provided as an addendum below. Using publicly available data on the estimated size of the undocumented population in Oregon, the analysis projected that 787 to 3,026 would enroll in a CCO-led model that is subsidized by the state under a structure that mirrors the ACA.

Evaluation of the Carrier-Led Model

Oregon may also consider a carrier-led model, where the state contracts with an existing carrier to offer a state-sponsored product. The state would have the flexibility to design the program using contract provisions similar to those used with CCOs, including adding requirements that carriers address health equity issues, similar to provisions in the CCO program that are not in conflict with QHP requirements (for more, see page 40). This option would be in the individual market and could be offered broadly, including to the tax-credit-eligible population, or more narrowly outside the Marketplace. Washington State is employing this model, which is open to multiple carriers, and Colorado has been considering a similar model. The chart below provides a brief overview of the structure of the carrier-led model.

Figure 11: Carrier-Led Model Design Components

Design Components of a Carrier-led Public Option Delivery Model	
Coverage offerer(s)/ risk-bearing entity	Existing insurance carrier
Premiums and cost-sharing	• Premiums primarily determined by benefits and cost-sharing • Cost-sharing at silver and gold plan levels • Provider reimbursement will also impact the total cost of coverage
Benefits	EHBs with the option to include value-added services used in the CCO program in the contract requirements
Risk pool placement	Offered in the individual market, with a choice of whether to offer it on and/or off the Marketplace
Cost-saving measures	Aggregate reimbursement cap or reference rate; other cost-sharing measures (e.g., increased MLR)
Ensuring participation	The state may want to require participation, tie it to other state programs, or incentivize participation on a voluntary basis
VBP/SDOH provisions	The carrier contract may provide for specific VBP targets and/or coverage of value-added services
Health equity	The state may require plans to meet health equity standards beyond existing QHP requirements, potentially aligning with the CCO program

The clear advantage of this model is ease of implementation. Carriers already compete to offer coverage in the Marketplace and individual market, and it would be relatively straightforward operationally for Oregon to issue a request for proposals asking a carrier or carriers to meet Marketplace requirements, along with state-specified program requirements. However, some challenges, as discussed below, would need to be addressed before implementation.

Differences Between Current Offerings and a Public Option. Oregon may wish to add new program features, such as requiring that a percentage of payments be value-based payments to providers or setting additional health equity requirements. However, Oregon would need to balance how new requirements, that mirror existing state programs, could hinder the public option's ability to compete with Marketplace plans that are not subject to the same requirements. Alternatively, new program elements only available in the public option may cause non-public option carriers to leave the market because of an uneven playing field. For example, under a carrier model, benefits and cost-sharing metal levels would need to be similar to Marketplace coverage; otherwise the public option might attract a very different risk profile than other QHPs.[xiv]

Cost Savings. For a carrier-led plan to be more affordable than current offerings, it must have a unique cost-saving mechanism. In the other two public option models, the state would likely require carriers to reimburse providers using one of two mechanisms—an aggregate rate cap or a reference rate (for more information, see page 36)—both of which are likely to be set to a percentage of Medicare to be determined based on the subsequent premium savings. Unlike the current market, under a public option administered in partnership with a commercial carrier, the state could influence provider reimbursement rates through legislation or contract provisions. Carriers are more likely to prefer a reference rate model, which alleviates the burden of renegotiating rates with their existing provider networks. Under SB 889, per-capita spending by carriers offering the public option would be measured against the healthcare cost growth target alongside the spending of all other carriers and plans.

Ensuring Participation. Incentives for both plan and provider participation in this option will be necessary. These incentives could be structured as benefits, penalties, or a combination of both. For example, to encourage carriers to participate, Oregon may tie participation in the public option to Medicaid or PEBB/OEBB, or even to offering commercial coverage. Provider participation may be more difficult than carrier participation because generally there is more carrier competition than provider competition in Oregon, particularly in rural areas, which enhances provider negotiating power. Ensuring participation could be addressed by simply mandating providers to participate in this option, by requiring participation in multiple state programs, or by making participation a condition of state licensure in order to secure both adequate networks and appropriate pricing.

Offering incentives could also secure voluntary participation. For example, Nevada gave insurers additional incentive points on their Medicaid managed care contracts for participating in the state's Marketplace.[23] Colorado and Washington also provide examples of both incentives and penalties that other states are considering, ranging from tax breaks to financial penalties (see page 38 for more).

[xiv] As noted above, the public option would also participate in risk adjustment alongside other plans in the individual market, potentially mitigating these issues. But carriers may still take the public option into consideration when deciding whether to offer coverage each year.

Potential Stakeholder Reaction. In all scenarios, current Marketplace insurers will be skeptical of their ability to be price-competitive with the public option and could precipitously reduce their Marketplace footprint absent assurances that some form of level playing field will be preserved. Provider response will be based in large part on whether they see this option, and the chosen reimbursement rates, as fair to them.

Potential Specialized Design: Carrier-Led Model for the Unsubsidized

Options for Individuals With Income Above 400% of the FPL.[xv] A carrier-led model could provide a new, lower-cost option to unsubsidized populations, with limited state financial and administrative risk. A product offered in the individual market, but off the Marketplace, would limit the potential impact on the second-lowest-cost silver plan, and therefore subsidies for existing Marketplace enrollees. This option would allow anyone who is paying the full cost of the premium to benefit from lower rates. A state-sponsored option would also provide protection from year-to-year carrier fluctuations. However, this model is not without costs to the state. A significant number of Marketplace enrollees in Oregon do not receive tax credits. Encouraging these individuals to move off-Marketplace will lower state assessments, impacting the Marketplace's operating budget.

Options for Individuals Without Subsidies Due to Immigration Status.[xvi] Despite cost-saving measures, a carrier-led public option with premiums and cost-sharing mirroring Marketplace plans is likely to remain unaffordable to those lower-income individuals under 250% of the FPL who do not qualify for Medicaid or premium tax credits due to immigration status. However, as under the CCO delivery model, Oregon could consider providing subsidies to increase affordability for this coverage. With its own technology platform, the Marketplace could administer a state premium and cost-sharing subsidy program for the subset of undocumented immigrants ineligible for federal subsidies.

[xv] In 2018, 52,600 uninsured Oregonians under the age of 65 had incomes over 400% of the FPL. Source: KFF, State Health Facts: Health Coverage & Uninsured, available at https://www.kff.org/uninsured/state-indicator/distribution-by-fpl-2/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22oregon%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xvi] In 2018, 30,000 people were ineligible for financial assistance due to citizenship status. Source: KFF, State Health Facts: Health Reform, available at https://www.kff.org/health-reform/state-indicator/distribution-of-nonelderly-uninsured-individuals-who-are-ineligible-for-financial-assistance-due-to-income-offer-of-employer-coverage-or-citizenship-status/.

Potential Specialized Design: Carrier-Led Model for Tax-Credit-Eligible Populations

A carrier-led model could be offered through the Marketplace to assist those who are already eligible for tax credits, but Oregon would need to take additional steps to ensure value for those enrollees. Since tax-credit-eligible populations are largely insulated from premium changes due to tax credit requirements based on percentage of income, the option would have to be designed to offer value outside of premium affordability, making the provider networks more attractive in some way, or employing value-based cost-sharing. Under this model, Oregon may also want to consider applying for a Section 1332 waiver to capture pass-through savings to repurpose for state use potential premium tax credit savings that would otherwise flow to the federal government without a waiver. If the savings are substantial enough, they could be used to fund additional subsidies for consumers.[xvii]

This population, in particular, could benefit from additional policies working in lieu of or in tandem with the state option—specifically, outreach and enrollment to seek out Oregonians who are currently uninsured and eligible for financial support. This may also be a requirement as part of the state option contract with insurers.

Evaluation of the State-Led Model in Partnership With a TPA

The final model under consideration is a state-led delivery model in partnership with a TPA. In many ways this option is similar to the state's role with PEBB and OEBB. Under this design, the state would serve in the role of insurer, in partnership with a TPA to perform all the standard insurance functions other than assuming risk.[xviii] Like the CCO-led model, the state/TPA-led model could be in the individual market or could operate in a separate risk pool. Depending on the benefit design (and enrollee risk pool), the state-led model is likely to result in lower consumer costs, compared to the other delivery models under consideration, because the state will have greater bargaining power and the flexibility to reduce its own tax liabilities, and will serve as a nonprofit entity with reduced administrative expenses. Like the other options, the state-led delivery model could be available broadly or be targeted to specific populations.

Notably, a state-led option also affords the opportunity to incorporate clinical and payment provisions that mirror CCO SDOH and access program requirements into the plan design, serving as another platform to advance the OHA's goal of eliminating health inequities (see page 40 for more on cross-model equity considerations).

[xvii] This will be an ongoing topic of consideration for the universal coverage workgroup.

[xviii] Please note that ORS 731.390 prohibits government insurers from receiving certificates of authority. However, the state may pass a statutory exemption for the state option plan. SAIF, which provides the state's workers' compensation insurance program, can serve as precedent for an exemption.

Figure 12: State/TPA-led Model Design Components

Design Components of a State/TPA-Led Public Option Delivery Model	
Coverage offerer(s)/ risk-bearing entity	The state would carry the risk
Premiums and cost-sharing	• Premiums primarily determined by benefits and cost-sharing • Cost-sharing designed based on target population needs • Provider reimbursement will also impact the total cost of coverage
Benefits	EHBs with the option to include value-added services used in the CCO program in the contract requirements
Risk pool placement	May be in or out of the individual risk pool (the former if plan meets or is deemed to meet requirements); could be offered through the Marketplace, depending on program design
Cost-saving measures	Provider reimbursement at rate determined/negotiated by the state
Ensuring participation	As with the carrier models, the state may wish to require provider participation, tie it to other state programs or incentivize participation on a voluntary basis
VBP/SDOH provisions	Likely the same as current CCO 2.0 requirements
Health equity	The state may require plans to meet health equity standards beyond existing PEBB/OEBB requirements, potentially aligning with the CCO program

This option offers considerable flexibility for the state but also includes some important considerations for implementation, as described below.

Unique Cost-Saving Features. A state insurer would enjoy unique advantages if approved as a non-taxpaying entity that could, depending on legislative preference, operate on a thin net margin with limited need to maintain a large surplus. A state insurer also could leverage existing state resources to save money on administrative costs and could negotiate reimbursement rates directly with providers rather than through intermediaries such as CCOs or commercial insurers. However, the state insurer will still have to set premiums, in partnership with an actuary, at a level that minimizes the risk of excessive losses.

Financial Risk. The biggest challenge with this model is the risk of premium collections falling short of costs because the health of the risk pool is worse than expected. In other proposed models, the state is not the risk-bearing entity, but under this model, the state would be responsible for the differential between premiums and claims. And unlike the PEBB or OEBB cases, where the risk pool is well known with predictable claims costs, the risk pool for the public option would be unknown in the first few years of operation, with considerable risk that premiums do not cover costs.

There would also be a risk of actual enrollment being greater or less than expected, causing unanticipated impact on costs. The larger the potential enrollee population, the larger the state risk and the harder it will be for the state to reasonably price the product based on predicted risk and subsequent claims. This

could be mitigated by scaling the program by tailoring the plan to a smaller population in the initial product offering. That would provide more information about potential enrollees and a better understanding of their potential risk profile. Additionally, depending on program/plan design, a 1332 waiver could be used to fund, with federal money, a reinsurance program specific to the state-led model, helping mitigate higher-than-expected claims.

Administration. Under this model, the state would serve in the role of insurer, meaning this model offers the most design flexibility. Most of the administrative risks could be managed—as they are by employer groups—using TPAs. Many TPAs are large insurers that are expert in managing administrative risk. The state also could take as much direct control over administration as it wanted to, or it could contract out those responsibilities to its TPA. As such, the state would need to institute a governance structure, including a board, to administer the program. If this were the chosen model, Oregon would need to determine the most appropriate board structure based on the finalized program design.

Even with an active TPA, however, the state would be the insurer and would bear ultimate responsibility for building service capacity and maintaining required reserves, which will require an up-front investment from the state depending on what financial requirements the Legislature applies to this new entity. As discussed on page 26, health insurers in Oregon are required to meet risk-based requirements and a $3 million surplus capital requirement.

While the state may be able to waive these requirements for a state-sponsored product, Wakely Consulting, a healthcare actuarial consulting firm, conducted an analysis of potential risk-based requirements using capital holdings from other insurers to ascertain best practices. Wakely estimated that current carriers with risk-based capital levels just above the required levels (approximately 250% and up to 600%) typically hold between 15% and 25% of annual collected premiums (with smaller insurers holding a higher percentage) as necessary capital to meet potential operational and risk needs.

Under an example scenario where the state offers silver and gold plans in the individual market with a 10% or 20% premium reduction as compared with a similar commercial product, the risk-based capital requirements range from $11.7 million to $41.6 million annually, assuming first-year enrollment of 7,000–28,000. As enrollment and premiums rise, so do capital requirements. As seen in Figure 13, higher annual premiums in the state-led plan lead to higher capital needs. These estimates are illustrative based on historical insurer levels, or 15% to 25% of annual premiums. If the state pursues this option, a more refined risk-based capital requirement calculation would be needed. The plan would also need to hold surplus as required by Oregon law (discussed in more detail above), but as is true for other tax liabilities described above, the state may be in a position to change the requirements and ensure consumer protection from insolvency by other means.

Figure 13: Reserve and Capital Requirements for an Individual Market State-Led Option

Scenario	10% Premium Reduction		20% Premium Reduction	
Reserves/Capital Needed for State-led Plan	Low End	High End	Low End	High End
Estimated Enrollment in the Public Option	7,171	12,786	14,321	27,683
Estimated 2021 Per Member, Per Month Market Premiums Across All Ages, Metal Tiers[xix]	$545	$545	$485	$486
Estimated 2021 Annual Market Premiums	$46.9M	$83.5M	$83.3M	$161.5M
Estimated Capital Needed	$7.0M	$20.9M	$12.5M	$40.4M

Risk pool placement and market impact. The state insurer would have more control over plan design if it were outside the individual market risk pool (and not subject to individual market plan requirements), but this approach would have a negative impact on individual market premiums if the public option attracted healthy risk out of the existing market (as it is likely to do if it leverages its cost-saving advantages to offer lower premiums). One option to mitigate this risk for a product outside the individual market is to keep premiums higher and focus instead on increased benefits or lower cost-sharing, but this could turn the public option into a high-risk pool and/or make the premiums unaffordable for most people.

The state insurer model would likely fit best inside the individual market, where a low-priced option could expand enrollment and improve the overall health of the risk pool. The public option would have less flexibility in plan design, but that may be appropriate to minimize disruption and to create more risk in pricing the product. The public option could be offered through the Marketplace but, like other models, could impact tax credits, and would be heavily constrained as long as Oregon is dependent on Healthcare.gov. Like the carrier-led model, the state/TPA-led model could begin with an off-Marketplace plan. Then, it could be migrated onto the Marketplace as more is learned about the impact of a public option on competition and the state has time to implement a state-based technology platform. It's important to note that a plan offered only outside of the Marketplace will still have an impact on Marketplace revenue and its operating budget.

Like the other options, the state/TPA-led plan could be targeted to a subset of individuals. This would help mitigate risk. However, the state's administrative responsibilities include fixed costs that would be the same regardless of the size, and the population size would need to be large enough to make the option viable and worth the effort. An SBM technology platform could administer the state/TPA-led model for little to no additional cost even if the plan were to be offered only off-Marketplace.

[xix] The market premiums vary slightly between the low and high scenarios due to minor differences in the metal level and demographic mix of enrollees in the plan.

Opportunities for Cost Savings

In order for Oregon to provide a more affordable product than is currently being offered, some cost-saving measures will be required under each of the proposed public option delivery models. There are a range of program design levers that a public option can utilize to reduce costs, and therefore premiums. These include changes to tax obligations or provider reimbursement rates, increased VBP or global budgeting mechanisms, and new MLR requirements. Additionally, the state can initiate policies or interventions that address underlying health costs, such as investment in population health or policies that reduce the cost of prescription drugs. The contribution of prescription drug spending to rising healthcare costs makes drug costs a particularly important issue for cost containment, but it may require interventions beyond public option plan design and likely would require system-wide policy intervention. Oregon has committed enormous resources to managing prescription drug prices,[xx] so there may be opportunities to leverage that work as part of Oregon's larger vision for building on its CCO accomplishments through system-wide cost containment.

Healthcare Cost Growth Target

One cost-containment policy that is unique to Oregon and a handful of similarly positioned states is the use of a cost growth target. Under SB 889, the state is developing a cost growth target that would apply to healthcare entities across the state beginning in 2021.

The cost growth target is an important longer-term and broad-based cost-containment tool that should be considered when designing Oregon's public option. However, the public option should include additional cost-saving requirements to offer immediate relief for consumers.

Changing provider reimbursement is the most foundational assumption for cost savings in a public option but also the most controversial. In order to reduce premiums, the public option presumes reduced provider payment rates compared with existing Marketplace reimbursement rates. Public options and other federal health reform proposals have relied on a percentage of Medicare as a benchmark for setting rates, largely because the methodology and rates are publicly available and Medicare rates are accepted by a majority of providers. Oregon may use a percentage of Medicare or Medicaid payment rates as a basis for provider payments depending on the needs of the program and available data. The differential between current rates and the public option rate will impact how much more affordable the plan is and, therefore, how much enrollment it can attract. While rates are an important tool to increase affordability for consumers, importantly, savings achieved by relying on sub-Marketplace or sub-commercial rates need to be balanced with ensuring adequate provider payment and program participation. Provider willingness to participate in

[xx] House Bill 4005 (2018), the Prescription Drug Price Transparency Act, directed the Oregon Department of Consumer and Business Services to establish Oregon's Drug Price Transparency program, through which it accepts reports and discloses certain information from prescription drug manufacturers, health insurance carriers, and consumers on drug prices. Implementation is ongoing as of April 28, 2020. Available at https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HB4005/Enrolled. HB 2658 (2019) requires 60-day advance notice to DCBS of large drug price increases. Available at https://olis.leg.state.or.us/liz/2019R1/Measures/Overview/HB2658.

the public option will depend on both current payment rates in the region and whom the program attracts—if the currently uninsured enroll in the program, it is likely that provider revenue would increase, but if the public option attracts individuals currently enrolled in commercial coverage, provider revenue could decrease.

There are two mechanisms to institute cost savings with provider rates in the public option: (1) Allow the implementing entity (an existing carrier or CCO, or the state) to negotiate rates with individual providers toward a preassigned aggregate target or cap; or (2) establish a set reference rate for all participating providers, which could vary for different categories of providers. Each has advantages and disadvantages, and choosing a mechanism may depend on how large a reimbursement differential is envisioned. The larger the differential, the harder it will be for non-state entities to achieve it through negotiations. As the Colorado example illustrates, it may also be advisable to consider differences among hospitals when setting target reimbursement rates.

Additional Information on Provider Rates

Determining the reference rate for a public option is also an opportunity for the state to consider a cross-market reference price that accounts for average rates across Medicaid, state-employee plans, and commercial plans. This could encourage provider participation by smoothing reimbursements across government-sponsored or regulated programs.

A high-level analysis of claims in the APAC database, adjusted to account for Oregon-specific service weights in national research, was performed to determine a cross-market "blended reimbursement rate" as a percentage of Medicare. The analysis estimates that a blended rate across payers in Oregon is between 145% and 165% of Medicare.

The analysis of a potential public option in this report utilizes the blended rate for illustrative purposes (see page 52 for more detail). However, a decision about whether to use a specific provider rate or other cost savings mechanism would be required in implementing legislation.

Figure 14: Considerations for Provider Reimbursement

Considerations for Provider Reimbursement	
Aggregate Rate Cap	**Reference Rate**
• The state sets an aggregate provider reimbursement cap, but allows carriers to negotiate within the cap • Preferred by providers, but puts negotiation onus on the carrier	• The state sets a reference rate for specific services for all participating providers • Preferred by carriers; likely to face provider opposition
Example	**Example**
Washington's Cascade Care: Plans will be subject to an **aggregate reimbursement cap of 160% of Medicare rates**, with reimbursement floors for: • Primary care physicians at 135% of Medicare allowable costs • Rural hospitals at 101% of Medicare allowable costs **Exceptions:** If the cap will raise premiums; if plans can achieve 10% premium reductions through other means; and/or if plans are unable to form adequate networks given the reimbursement restrictions	**PEBB and OEBB:** Payments for inpatient and outpatient hospital services are limited to 200% of the amount Medicare would pay for the services. **Colorado Health Insurance Option:** The state recommended a base rate of **155% of Medicare** for hospitals, with the opportunity for increases based on the hospital type: • 20% increase for independent or critical access hospitals • Up to 30% increase for having a high share of Medicaid/Medicare patients • Up to 40% increase for managing underlying costs of care

Further Discussion of Important Issues Across the Delivery Models

Provider Participation. Provider participation is an important consideration across all three proposed delivery models and will require careful consideration of the full range of strategies to achieve robust participation. Traditionally, providers have been opposed to public option proposals for fear of inadequate reimbursement rates. Without robust provider participation, public option enrollees may face barriers to care, which may exacerbate existing health inequities if providers serving communities of color are either not in the network or receive inadequate reimbursement. The state has a range of options for how to achieve adequate participation. On the most extreme end of the spectrum, Oregon could require insurers, CCOs, and/or providers to participate in the program through state regulations and licensure. While this would ensure adequate networks across the state, it is also likely to attract strong stakeholder opposition and may lead to market withdrawals. Alternatively, the state could require participation in the public option program as a condition of participating in other programs, also known as tying. For example, to be able to offer coverage or see patients in other state programs like Medicaid, PEBB, or OEBB, CCOs or providers could be required to also participate in the public option. Finally, participation in the public option can be voluntary and administered through traditional provider contract negotiations. Under each of these options, including

the voluntary model, there are opportunities to provide incentives for participation, such as additional points on other state-led procurements, exemptions from other state requirements (e.g., certain taxes), and/or streamlined administrative billing or quality reporting.

Examples of Carrier Participation Incentives in Other States

In **Nevada**, carriers that offer Marketplace plans are given additional points during Medicaid managed care procurement in order to encourage participation.

Washington is seeking voluntary participation and has released a request for proposals to offer Cascade Care, the state's new public option. However, the state may add requirements to compel participation in the future.

Examples of Provider Participation Incentives in Other States

The **Colorado** state option proposed in legislation released in March requires hospitals to participate in the plan, but not other provider types. Hospitals that refuse to participate in the plan's network (without an exemption) can face a financial penalty (of $10,000/day for the first 30 days and $40,000/day thereafter) and/or suspension or conditional loss of licensure.

Washington will start Cascade Care as a voluntary program for providers, but may add requirements, such as tying, in the future if the provider networks are inadequate.

Value-Based Care and Addressing Social Needs. A key assumption for public options is that the state will be a more stable purchaser and payer over time since the state has a long-term interest in keeping the product in the market and is less affected by fluctuating market and profitability decisions. If enrollees remain in coverage year over year, the option can offer a unique opportunity to invest in VBP programs, delivery system reforms, advance health equity, and improve population health in the medium and long terms. Oregon can also align and leverage these initiatives across all state-sponsored programs, including Medicaid, CHIP, and PEBB/OEBB.

Oregon has remained a leader in encouraging value-based care that addresses behavioral and social needs alongside clinical health and has the opportunity to continue this leadership under the public option, regardless of the chosen delivery model. The CCO 2.0 model includes VBP targets, incentivizing the use of primary and behavioral healthcare and community investment, and including access to value-added services. Regardless of the delivery model, OHA has expressed an interest in bringing these elements of the CCO program into the public option. This can be achieved through expansion of the CCO program, or through innovative contracting requirements in a carrier-led model under which public option participants must engage in value-based arrangements and/or provide access to value-added and health-related services such as traditional health workers as part of implementing the public option plan.

Health Equity. To achieve Oregon's goal of eliminating health inequities in 10 years, it is imperative that the public option integrate strategies to advance health equity. Currently, CCOs have several robust requirements designed to advance health equity. Oregon CCOs must, for example, participate in evaluation procedures to make progress toward documenting and eliminating health disparities; and must establish community advisory councils (CACs) that include Medicaid members and oversee community health improvement plans that address health disparities. If implementing a CCO-led option, the state could naturally carry these requirements into the public option. A state/TPA-led model could also require these program components. Under a carrier-led model, Oregon could include some of these requirements under contracting provisions (e.g., community investments, value-based payment targets, and access metrics) as long as they are not in conflict with existing QHP requirements. Ensuring CCO health equity and an SDOH program in state- or carrier-led models will continue to advance OHA's goal and begin bridging the gap in health equity requirements across markets.

Key CCO 2.0 Health Equity and SDOH Components: Potential to Replicate in the Public Option

- Increased focus on integrative primary and behavioral health services
- Additional spending to address SDOH
- Access to traditional healthcare workers
- Reinvestment in community-based activities
- Community interaction through Community Advisory Councils and health assessments
- Specific health equity and language-access metrics
- Targets for value-based payment arrangements (70% of CCOs' payments to providers by 2024)
- Address language and cultural barriers to care access

Potential for Phased Implementation

Understanding that each public option may be best suited to different populations, and recognizing the tandem goals of making the option available broadly and reducing the number of uninsured, there may be an opportunity to maximize gains while minimizing risks through a phased approach. A dynamic, phased approach may also help the state adapt to relevant policy changes—for example, policy change at the federal level that makes approval of a public option Section 1332 waiver more likely, and/or a transition from a State-based Marketplace-Federal Platform (SBM-FP) to an SBM with its own technology platform, which will offer the state more flexibility and control over an on-Marketplace public option plan and provide the state an affordable mechanism to administer other models and innovations.

A phased approach could take multiple forms, but one possibility is to initially implement a lower-risk carrier-led option in the individual market (tailored toward unsubsidized populations) and to expand on the state offering over time by moving it to the Marketplace or adding components that require a Section

1332 waiver. The state could start a complementary program utilizing the CCOs specifically for low-income and churn populations, timed with the next Section 1115 waiver negotiation.

It is important to note that whichever public option is chosen as the starting model, there is opportunity to grow and evolve the program over time in response to changing state demographics and policy needs.

Figure 15. Phased Approach Example

Conclusion

Each of the three proposed public option delivery models explored in this report has benefits and disadvantages for meeting the goals of improving affordability and striving toward universal access to healthcare in Oregon. However, it is important to acknowledge that no model can solve all policy goals or meet the needs of all Oregonians. When evaluating each model for possible implementation, the state should consider how the model design aligns with the needs of the target populations outlined above, the associated premiums and cost-sharing that will influence affordability for consumers, risk pool placement to minimize negative impact on existing markets, interactions with federal funding and authority, and potential cost savings, as well as other considerations outlined in this report.

- **A CCO-led model**, in which the state utilizes existing CCOs to offer a public option product to a broader population, has unique benefits for improving continuity of care for the Medicaid churn population and increasing state bargaining power. However, there are also distinct considerations around provider reimbursement, CCO administrative capacity, operational and regulatory issues, and the impact of a CCO-led public option on other markets that would need to be addressed prior to implementation. Additionally, the state may consider offering a CCO-led model to distinct populations, including lower-income Oregonians, to mitigate some of the model's risk or CCO capacity issues. An addendum to this report includes an analysis of a more narrowly targeted CCO-led model.
- **A carrier-led model**, in which the state uses commercial insurance carriers to deliver a public option product under a state contract with provisions that allow for design flexibility. The public option could be offered inside the individual insurance market broadly or more narrowly off the Marketplace. To differentiate the model from other carrier-led offerings, its design could include cost-saving mechanisms, like provider reimbursement or VBP arrangements. It would also require components to ensure participation by plans and providers. Notably, the carrier-led model may have limited impact for some

tax-credit-eligible consumers who are shielded from premium changes due to how federal tax credits are calculated. However, the state may be able to capture federal government savings under a Section 1332 waiver.

- **A state-led model in partnership with a TPA**, in which the state holds the plan risk as the insurer and uses a TPA for processing claims and plan implementation. This model may afford the state the most control, and, therefore, the most flexibility in plan design. Depending on the benefit design and enrollee health status, it could also be the lowest-cost model for consumers. However, this option would require the state to hold significant financial risk relative to the other options.

An initial analysis of an illustrative public option in the individual market compares two scenarios with premiums 10% or 20% lower than those of existing silver and gold plans. Under the analysis, estimated enrollment ranges from 7,000 to 28,000, including between 3,500 and 11,600 Oregonians who would gain coverage after being uninsured. For more information, see the appendix.

This report is meant to memorialize conversations to date on how to select a feasible, viable, and impactful public option for Oregon and to outline possible delivery models and program designs for further consideration by the public, state lawmakers, and other stakeholders.

An addendum to this report incorporates additional actuarial analysis on a more narrowly targeted CCO-led model. After the report and addendum are published, the legislature will have the opportunity to review the recommendations ahead of the 2021 legislative session.

Appendix

A Closer Look at the Key Uninsured Populations

The Uninsured: Low-Income Populations

Even before COVID-19, a relatively high proportion of the uninsured in Oregon were either OHP- or tax-credit-eligible, highlighting that many people who are becoming ineligible for one program are not enrolling in alternative coverage. Lower-income populations with incomes that fluctuate between Medicaid and Marketplace eligibility can be susceptible to losing coverage, in a process often referred to as “churn.” As people churn in and out of coverage, care is often disrupted. In a 2015 study of low-income individuals in Kentucky, Arkansas, and Texas, the authors found that 25% of respondents changed coverage types over the course of a year, which was in turn associated with care disruptions as well as worsening self-reported quality of care and health status. Nearby states, including Washington and California, also face churn. In these states, a higher proportion move from Marketplace to Medicaid coverage rather than the reverse,[24,25] potentially in part because of the increased costs of moving to a Marketplace plan. An analysis of Oregon-specific data is underway. Insight into the behavioral patterns of this population in the state may help inform future program design.

The Uninsured: Tax-Credit-Eligible

With approximately one-third of uninsured Oregonians eligible for tax credits, cost and lack of awareness of the availability of and criteria for subsidies are likely to remain barriers to coverage. Those who are eligible for tax credits fall between 100% and 400% of the FPL and would therefore be able to pay a reduced premium for Marketplace coverage. For those between 100% and 250% of the FPL, cost-sharing reductions are also available for consumers who select a silver plan. According to the state, one of the largest barriers to coverage for tax-credit-eligible populations is lack of awareness of the availability of subsidized coverage.

Only about 4% of Oregonians have individual market coverage, including the 145,264 enrollees in the Oregon Health Insurance Marketplace in January 2020.[26] Due to increased affordability of Marketplace plans for those eligible for premium tax credits and/or cost-sharing reductions, Marketplace enrollees mostly fall into the income category of 100%–400% of the FPL. Marketplace enrollment for the unsubsidized is approximately 21% (this includes individuals with unknown income or who did not request financial assistance). Of those who select a plan on the Marketplace, 39% select a bronze plan, 51% select a silver plan, and 10% select a gold plan.

The Uninsured: Tax-Credit-Ineligible

Those who are uninsured and ineligible for tax credits or Medicaid largely fall into three categories: those with incomes above 400% of the FPL; those who are offered but do not enroll in employer-sponsored coverage; and those who are ineligible for subsidies due to immigration status.

Those with incomes above 400% of the FPL are ineligible for tax credits and must pay the full premium when purchasing coverage in the individual market. While those who receive relatively generous tax credits are largely shielded from significant changes in premiums, those at the higher end of the income spectrum, especially those above 400% of the FPL, are vulnerable to premium increases, often rendering coverage unaffordable. The income range of 400%–600% of the FPL has garnered attention with respect to the uninsured and the underinsured because they fall just over this "subsidy cliff" but also often find full-priced individual market coverage unaffordable.

Many of the uninsured who are eligible for employer-based insurance find the premiums too expensive. One group that experiences significant attention is composed of those who fall into the "family glitch," resulting from a structural issue preventing some families from being eligible for tax credits; they also often find coverage unaffordable and therefore are uninsured. Individuals impacted by the family glitch are ineligible for tax credits because of a family member's access to employer-sponsored coverage that is deemed "affordable" for both the individual and his or her family based solely on the cost of individual coverage, rather than the cost of the family plan. These family members fall into the family glitch, and because neither the employer nor the Marketplace coverage is truly affordable, they are at an increased risk of lacking health insurance altogether.

The Uninsured: Immigration Status

Finally, those who are ineligible for federal assistance due to immigration status have a higher likelihood of being uninsured than citizens, regardless of their documentation status. Nationally, almost half (45%) of undocumented people were uninsured in 2018.[27] Estimates project that approximately 30,000 undocumented

people living in Oregon were uninsured in 2018.[28] These individuals are ineligible for both Medicaid and Marketplace financial assistance, and therefore many likely face affordability barriers to health insurance coverage.

Preliminary Premium and Enrollment Analysis

Any of the three models under discussion could be structured in a way to achieve cost savings, although (as discussed above) a big part of each model is which savings mechanisms are used and whether providers have the ability to absorb lower rates than are currently offered in the individual market. For this report, Wakely modeled an illustrative example of the potential impact of introducing a public option in the individual market at silver and gold levels in 2021. Importantly, premiums are only one affordability consideration and the public option plan's cost-sharing design (e.g., deductibles, coinsurance) will also contribute to the overall consumer affordability of the product.

Under this example model, the public option would not be available through the Marketplace to those with premium tax credits, and therefore the potential impact on the second-lowest-cost silver plan benchmark was not analyzed. Rather, the option was modeled by targeting those who are themselves paying premiums or are potentially subsidized by the state, such as those who do not qualify for assistance due to immigration status.

The premium modeling was based on a provider reimbursement analysis conducted by OHA using 2018 Oregon-specific data from the state's APAC database. Wakely modeled the average provider reimbursement rate paid in Oregon across Medicaid, commercial and state-employee plans to establish an average benchmark reimbursement rate relative to Medicare. A benchmark reimbursement rate of 145% of Medicare was applied to estimate the premiums of a public option plan.[xxi] Oregon individual market data from 2019 and 2020 was used to estimate enrollment in either a silver or gold public option plan.

The public option is assumed to pay enrollment brokers at a rate similar to that of private insurers in the current market and to pay applicable taxes, but not to pay the federal or Oregon Marketplace user fees for an individual market plan that is not offered on the Marketplace. If the plan is offered off-Marketplace, Oregon user fees may decrease due to lower premiums per member and lower Marketplace enrollment. The analysis reflects year one enrollment only, and enrollment would be expected to grow over time. Additional underlying assumptions are included in the appendix on page 46.

The charts below reflect the findings of the analysis of premium costs and estimated changes in enrollment for those currently enrolled in coverage and for the uninsured.

[xxi] The analysis was also performed using the average Medicaid provider reimbursement rate. Under this scenario, the silver-level premium is estimated at $314 per month and gold-level premium is estimated at $340 per month, a 27% decrease compared with the 2021 lowest-cost premium. Enrollment under this scenario will be higher than under the blended rate scenario, due to lower premiums.

Figure 16: Oregon Public Option Analysis With Market Average Provider Reimbursement (Silver and Gold Scenarios)

Starting Assumptions		
Starting Market Size in 2021		
On-Marketplace Enrollment	123,946	
Off-Marketplace Enrollment	48,587	
Total	**172,533**	
Starting Lowest-Cost Premium in 2021, Age 40		
Silver	$432	
Gold	$469	
Estimated Premiums in 2021, Age 40	**Premium**	**% Below Lowest**
Silver, Market Average Provider Reimbursement	$390	-10%
Gold, Market Average Provider Reimbursement	$422	-10%
Estimated Enrollment in Public Option	**Low End**	**High End**
From Uninsured Take-up (Ineligible for Subsidies)	3,435	4,580
From On-Marketplace Migration (Ineligible for Subsidies)	1,230	2,279
From Off-Marketplace Migration	2,435	3,947
Total	**7,100**	**10,805**
Market Size With Public Option Enrollment	**Low End**	**High End**
On-Marketplace Enrollment	122,716	121,125
Off-Marketplace Enrollment	53,252	55,445
Total	**175,968**	**176,570**

Notably, this analysis found the following:

- An average public option premium (between silver and gold plans) for a 40-year-old enrollee of $390 per month for silver and $422 for gold.
- A public option enrollment of between approximately 7,000 and 11,000. These figures will be impacted by the final option structure (who administers the plan, provider networks, etc.), premiums and marketing of the option.
- Under the modeled individual market plan, participation by an estimated 3,400 to 4,600 currently uninsured individuals in the first year of implementation.
- An estimated increase in overall market size by 2% in the first year. This impact will increase, depending on the number of enrollees the public option attracts.

This analysis is meant to serve as a baseline example, and the state can make additional design decisions to increase impact. It is also important to note that these results represent the first year of the program, and enrollment would likely increase after the first year as more consumers become aware of the product.

Additionally, if Oregon decides to offer a public option through the Marketplace that impacts the second-lowest-cost silver plan, Oregon could also consider applying for a Section 1332 waiver to capture the savings and repurpose them for lowering cost-sharing or other initiatives.

Data Analysis and Assumptions

Wakely has conducted preliminary analysis of the range of potential enrollment in a public option plan, if offered by the OHA in 2022. The earliest year the public option would be viable is 2022; however, for simplicity we are using 2021 estimated metrics and not explicitly projecting to 2022.

The analysis assumed that the public option plan offering would be available off-Exchange only. To estimate the enrollment, we have relied on reported or estimated enrollment in 2019 and 2020 in Oregon individual market on- and off-Exchange, metal level, and subsidy eligibility, as well as the estimated number of uninsured who would not be eligible for subsidies on Exchanges. We combined these estimates with estimated elasticities of demand in order to model the number of individuals who would be selecting to enroll in the public option plan offering off-Exchange if the public option plan is less expensive than the lowest-cost silver/gold plan currently available either on- or off-Exchange.

Public Option Premium Modeling

The public option premium modeling was based on the provider reimbursement analysis conducted by the OHA team using the APAC database. The OHA team has repriced 2018 claim data to determine the average reimbursement by market as a percentage of the Medicare fee schedule. The results for the outpatient facility reimbursement and Medicaid CCO rates were adjusted based on the additional provider payments information received from Optumas and OHA to more accurately reflect the overall provider reimbursement in Oregon Medicaid managed care via subcapitated and quality incentive payments not captured in APAC data.

The average reimbursement rates by market were then blended to develop a market average or "universal" provider reimbursement rate. The average included the individual ACA, Medicaid (CCO), PEBB and OEBB, and group markets. The relativity between the blended rate and the individual ACA market reimbursement rates was used to adjust nonprescription drug claim costs of the lowest-cost plan in the individual ACA market to estimate public option nonprescription claim costs. No changes were made to prescription drug costs or the costs of other ancillary benefits, such as durable medical equipment, in-office-administered injectable medications, home health and ambulance service. The resulting premium was 10% lower than that of the lowest-cost plan in the ACA market.

As an additional data point, we developed a public option premium assuming Medicaid CCO provider reimbursement levels, which resulted in a premium 27% below that of the lowest-cost plan in the ACA market.

Public Option Enrollment Modeling

We assumed that enrollment in the public option plan will likely be comprised of three segments of the population: (1) currently uninsured individuals who are not eligible for subsidies available to low-income individuals on-Exchange; (2) current on-Exchange enrollees (also not eligible for subsidies) in silver, gold and potentially bronze plans who may be willing to switch to a lower-cost plan (in the case of the bronze plan, we assumed that members would choose the public option plan only if the public option premium is lower than the lowest bronze plan premium available on-Exchange, adjusted for generosity in one scenario); and (3) current off-Exchange enrollees in silver, gold and potentially bronze plans who may be willing to switch to a lower-cost plan (in the case of the bronze plan, we assumed that members would choose the public option plan only if the public option premium is lower than the lowest bronze plan premium available off-Exchange, adjusted for generosity in one scenario). For silver and gold plans, the migration is based on the calculated public option premium reduction, even if a member is currently enrolled in a richer (higher-cost) plan. For the bronze plan, the migration is based on the premium difference (potentially adjusted for the difference in AV) compared with the public option silver plan.

Due to the uncertainty surrounding this type of analysis, Wakely modeled a range of potential enrollment in the public option plan (low and high), by varying the take-up dampening factors.

The current estimates do not account for the potential impact of COVID-19 on enrollment and coverage cost. Additionally, the analysis assumes that the state reinsurance program continues but does not include the impact of a public option on the reinsurance program.

Assumption Sources

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- [Data Request—Provider Payment Rates Final 20201016.xlsx] Provider reimbursement analysis data provided by OHA on October 16, 2020.
- Input from Optumas team on CCO provider reimbursement structure.

Disclosures and Caveats

Responsible Actuaries. Julie Peper and Ksenia Whittal are the actuaries responsible for this communication. They are members of the American Academy of Actuaries and fellows of the Society of Actuaries. They meet the qualification standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of OHA and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary. Wakely does not intend to create a reliance on these outside parties, and these materials may not be released to third parties without Wakely's prior written consent; when consent is granted, the materials should be provided in their entirety. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. Please note that these results are preliminary and are subject to change as we gather input and potentially refine the modeling methodology and assumptions. Users of the results should be qualified to use and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of OHA, the party receiving this output, to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent of OHA.

Data and Reliance. Wakely relied on information and data provided by OHA, Manatt Health Strategies, and other public data sources in the analysis. Wakely reviewed the data for reasonableness but has not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. This analysis is based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this analysis. Furthermore, changes in state or federal law (e.g., new Section 1332 waiver reinsurance parameters, health reimbursement arrangement regulation) were not included in the analysis. The potential impact of COVID-19 was not included in the analysis. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

Deviations From Actuarial Standards of Practice (ASOPs). Wakely completed this analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate ASOPs with no known deviations.

[1] For more information about the UAC, see the final recommendations and members available at https://www.oregonlegislature.gov/salinas/HealthCareDocuments/UAC%20Work%20Group%20Report%20%20FINAL%2012.10.18%20.pdf.

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Addendum

Analysis of a Targeted CCO-Led Model

This addendum to the Oregon Public Option Report presents the results of a supplemental actuarial analysis that was done after the initial report was completed. This analysis models the impact of a CCO-led offering outside of the individual market. Optumas and Wakely provided the analysis under the following parameters:

- Assumes one standard benefit design with Medicaid-like benefits and cost-sharing, leveraging the existing Medicaid payment structure.
- Eligible consumers would include two populations that are ineligible for ACA subsidies because of an employer offer (often referred to as the family glitch population[xxii]) or because of immigration status (undocumented immigrants).
- The state provides eligible enrollees subsidies using the ACA subsidy structure to cap the percentage of income an enrollee can contribute to healthcare coverage, ranging from 2.07% to 9.83% by income.

The analysis differs from the one presented in the initial report in three key respects:

- **Narrowly targeted unsubsidized populations.** The product is narrowly targeted at two populations that generally cannot afford coverage. To make coverage affordable, the state would have to provide state subsidies modeled on the ACA subsidy structure.
- **CCO-delivery of Medicaid-like product.** The "targeted public option"[xxiii] would be delivered exclusively by the CCOs outside the individual insurance market with minimal cost-sharing to improve affordability. The CCOs would not have new licensing, reserve or operational requirements of the sort that were discussed in the initial report for CCO-led models inside the individual market.
- **Medicaid rates.** Providers would be paid CCO rates, which are lower than the blended rates used in the earlier modeling. Those rates were blended across commercial markets and public programs so that they readily fit with any of the delivery options.

The analysis includes three enrollment scenarios: (1) healthier-than-average enrollees and higher take-up, (2) average health status and take-up, and (3) sicker-than-average enrollees and low up-take. These scenarios account for the premium and enrollment ranges below. Projected enrollment is based on the presence of state subsidies.

[xxii] Individuals impacted by the family glitch are ineligible for tax credits because of a family member's access to employer-sponsored coverage that is deemed "affordable" for both the individual and his or her family based solely on the cost of individual coverage, rather than the cost of the family plan. Because neither the employer nor the Marketplace coverage is truly affordable, these family members are at an increased risk of lacking health insurance altogether.
[xxiii] Based on its design, this could be referred to as a Medicaid buy-in.

Lower premium cost. The analysis shows the CCO-led model premium would be substantially lower than that of similar-value offerings in the individual market. Premiums, **before subsidies**, are estimated at between $361 and $403 per month for a plan above ACA platinum-level (90% actuarial value) coverage. For comparison, the lowest-cost 2022 bronze plan is projected at $317, silver at $432 and gold at $469. Even at these decreased premiums, the analysis assumes state subsidies are needed to incentivize enrollment.

State subsidies to increase affordability. The state costs of providing subsidies would be $62.3 million to $73.0 million annually depending on estimated take-up. Average monthly subsidies (per member, per month (PMPM)) are estimated to range from $221 to $261. Essentially, these subsidies would result in consumer premiums in the average scenario ranging from $11 to $250 per month for enrollees with income between under 133% FPL and 400% FPL. Put another way, the state would spend less than $3,000 per person on an annualized basis to extend affordable coverage to as many as 27,600 people currently unable to access subsidized coverage.

Targeted coverage expansion. The analysis suggests that the state could make important incremental progress in a targeted coverage expansion under these assumptions (and others presented below). Estimated enrollment gains range from 19,900 to 27,600, with less than a 1% drop in individual market coverage.

Most of the enrollment gains would be driven by the family glitch population; it is estimated that between 70% and 90% of this target population would enroll in the CCO-led public option. Coverage gains among the undocumented population that is currently uninsured could be as high as 10%. It is estimated that between 9% and 28% of undocumented immigrants currently enrolled in the individual market will migrate to the CCO-led model.

Due to data limitations and varying estimates on the undocumented population in Oregon, this analysis relies on self-reported data from the 2018 Census Bureau American Community Survey to estimate the baseline undocumented uninsured. Demographic change since 2018 and/or more accurate, state-specific data available on this population would impact the overall take-up analysis. Additionally, changes in national and state policy, such as the recent federal public change rule and Oregon's expansion of coverage to undocumented children will impact undocumented immigrants' desire for and/or comfort with enrolling in state-sponsored coverage.

The impact of the COVID-19 pandemic was not included in this analysis. The pandemic and subsequent recession are expected to increase the need for health insurance coverage. The largest coverage migration is expected to be individuals moving out of employer-based coverage and into the individual market or Medicaid, though the level of migration is highly uncertain and dependent on whether Congress provides more relief to employers and what business decisions employers make. To the extent there is a net loss in employer-based coverage, the number of individuals affected by the family glitch will be reduced as fewer individuals are locked out of subsidized coverage by an offer of employer coverage.

The charts below reflect the findings of the analysis on enrollment changes by population category, premium comparisons, estimated subsidies by income level and state costs.

Figure 17. Estimated CCO-Led Public Option Premiums, Before State Subsidies

	Scenario 1: Lower acuity, higher take-up	Scenario 2: Average acuity and take-up	Scenario 3: Higher acuity, lower take-up
Starting Lowest-Cost Premium in 2021, Age 40			
Bronze (On- and Off-Marketplace)	$317		
Silver (On- and Off-Marketplace)	$432		
Gold (On- and Off-Marketplace)	$469		
Pre-Subsidy Public Option Premium in 2021, Age 40			
CCO Equivalent Premium	**$361**	**$384**	**$403**

Figure 18. Estimated CCO-Led Public Option Enrollment by Population

	Scenario 1: Lower acuity, higher take-up		Scenario 2: Average acuity and take-up		Scenario 3: Higher acuity, lower take-up	
Starting Size of Eligible/Target Populations in 2021						
Family Glitch	27,258		27,258		27,258	
Undocumented (Uninsured)	30,000		30,000		30,000	
Undocumented (Insured Off-Marketplace)	1,320		1,320		1,320	
Total	**58,579**		**58,579**		**58,579**	
Estimated Average Enrollment in Public Option						
	Estimate	**Take-up**	**Estimate**	**Take-up**	**Estimate**	**Take-up**
Family Glitch	24,532	90%	21,807	80%	19,081	70%
Undocumented (Uninsured)	2,650	9%	1,325	4%	662	2%
Undocumented (Insured Off-Marketplace)	376	28%	251	19%	125	9%
Total	**27,558**	**47%**	**23,382**	**40%**	**19,869**	**34%**
Estimated Average Enrollment in Public Option by FPL Range						
	Estimate	**Take-up**	**Estimate**	**Take-up**	**Estimate**	**Take-up**
<133% FPL	2,061	90%	1,832	80%	1,603	70%
133-150% FPL	2,099	58%	1,793	50%	1,523	42%
151-200% FPL	5,831	42%	4,825	35%	4,035	29%
201-250% FPL	5,772	43%	4,843	37%	4,082	31%
251-300% FPL	5,532	46%	4,710	39%	4,015	33%
301-400% FPL	6,265	47%	5,379	40%	4,611	34%
Total	**27,558**	**47%**	**23,382**	**40%**	**19,869**	**34%**

Figure 19. Estimated Required State Subsidies by Target Population

	Scenario 1: Lower acuity, higher take-up		Scenario 2: Average acuity and take-up		Scenario 3: Higher acuity, lower take-up	
Estimated Subsidies by Target Populations in 2021						
	Total (millions)	**Avg. PMPM Subsidy**	**Total (millions)**	**Avg. PMPM Subsidy**	**Total (millions)**	**Avg. PMPM Subsidy**
Family Glitch	$64.2	$218	$63.2	$241	$59.6	$260
Undocumented (Uninsured)	$7.6	$239	$4.2	$262	$2.2	$281
Undocumented (Insured Off-Marketplace)	$1.2	$263	$0.9	$286	$0.5	$305
Total	**$73.0**	**$221**	**$68.2**	**$243**	**$62.3**	**$261**
Estimated Subsidies by FPL Range						
	Total (millions)	**Avg. PMPM Subsidy**	**Total (millions)**	**Avg. PMPM Subsidy**	**Total (millions)**	**Avg. PMPM Subsidy**
<133% FPL	$8.7	$350	$8.2	$373	$7.5	$392
133-150% FPL	$7.9	$316	$7.3	$338	$6.5	$357
151-200% FPL	$19.9	$284	$17.7	$306	$15.7	$324
201-250% FPL	$16.1	$233	$14.8	$255	$13.4	$274
251-300% FPL	$12.1	$182	$11.5	$204	$10.8	$223
301-400% FPL	$8.3	$111	$8.6	$133	$8.4	$151
Total	**$73.0**	**$221**	**$68.2**	**$243**	**$62.3**	**$261**

Key Assumptions and Limitations

Optumas and Wakely completed the analysis of the CCO-led model in partnership.

Optumas CCO-Led Premium Estimate Analysis

Background

Optumas has compiled preliminary scenario modeling for use within Wakely's public option model. The scenarios are developed for the CY2022 contract period and reflect various index rates that can be used to develop premiums for the Medicaid buy-in option for immigrant, family glitch and 400–600% FPL individuals. The scenarios are reliant on the CY2021 CCO capitation rates, trended forward to 2022.

This analysis has incorporated the following populations:

1. TANF
2. ACA 19–44, 45–54, 55–64
3. Maternity (used to incorporate an approximate impact of delivery events that would be covered under the construct of a buy-in premium, rather than a separate delivery case rate)

The following components of CCO capitation rates have been excluded from this analysis:

1. Quality Pool
2. Assertive Community Treatment and Supported Employment Services (ACT/SE)
3. Child and Adolescent Needs and Strength Assessment (CANS)
4. Mental Health Children's Wrap
5. Managed Care Organization (MCO) Tax
6. Qualified Directed Payments for Enhanced Hospital Reimbursement

Within the scenario modeling, components of the index rates that are itemized include non-essential medical transportation (NEMT) and dental services, as well as nonmedical load.

Adjustments

With the baseline being the CY2021 CCO capitation rates, trended forward to CY2022, this analysis incorporates estimates of acuity differentials between the current adult TANF and ACA populations, relative to the adult population that could enroll via the buy-in option. While enrollment expectations have not yet been provided to **Optumas** regarding the differences between the various subpopulations that are expected to enroll, the overarching assumption in this analysis is that the eligible population will primarily comprise higher-income parents.

Note that as a result of timing and data limitations prohibiting the use of Oregon's historical experience to develop these acuity adjustments at this time, **Optumas** has developed a lower and an upper bound scenario, which accounts for variation in trend projection factors and acuity assumptions based on a review of experience in other Medicaid programs:

1. **Lower Bound**
   a. Adjust non-expansion parents (TANF) for the estimated acuity differential observed in other states comparing expansion with non-expansion parents. Observations in other Medicaid programs suggest that the expansion parents are roughly 0–10% less costly on a PMPM basis than previously enrolled TANF parent populations. The lower bound scenario assumes the lower end of the range, using a 10% reduction in PMPM expenditures relative to the TANF population.
   b. Adjust expansion (ACA) population for an estimated acuity differential based on observations in other states comparing the combined parent and childless adult expansion population to a parent-only expansion population. Observations in other Medicaid programs suggest that the expansion parents are up to 30% less costly on a PMPM basis than the combined parent and childless adult expansion population. The lower bound scenario assumes a 30% reduction in PMPM expenditures relative to the ACA population.

   A 50/50 blend of the adjusted TANF and ACA experience described in 1.a–1.b above has been applied to form the lower bound scenario, which also reflects a trend projection from CY2021 to CY2022 on par with the lower bound trends developed within the CCO rate development.

   Additionally, a modest increase to the PMPM expenditures underlying this scenario has been included to account for an expectation that costs related to deliveries will be included within the premiums for the buy-in program; within the CCO program, separate delivery case rates are paid in the event of a delivery and therefore are not included within the TANF and ACA capitation rates that originally formed the basis of the analysis.

2. **Upper Bound**
   a. Adjust expansion (ACA) population for an estimated acuity differential that assumes a lesser reduction in PMPM expenditures than that described in 1.a and assumes that the acuity will be indicative of some level of the higher-cost childless adult population. This upper bound scenario assumes a 15% reduction in PMPM expenditures relative to the ACA population.
   b. The scenario noted in 2.a results in a PMPM expenditure that is within $1 of the comparable TANF upper bound projection with a 0% acuity differential assumption. As a result, no blend has been applied and the upper bound scenario reflects only the ACA-based scenario described in 2.a.

   The upper bound scenario includes a trend projection from CY2021 to CY2022 on par with the upper bound trends developed within the CCO rate development. Additionally, an adjustment to incorporate an estimate for delivery-related expenditures as noted in the description of the lower bound has also been incorporated within the upper bound scenario.

Caveats

Please note the following caveats that should be considered in the review and use of the index rate scenarios described in this narrative:

1. The accompanying analysis does not directly take into account the potential for selection bias, in that the buy-in program will be optional for individuals who qualify and choose to enroll. Therefore, it is likely that the population choosing to enroll in this program is predisposed to having higher PMPM expenditures than the entire eligible population.
2. This analysis does not directly consider the costs of children who could be eligible for this program. This analysis is predicated on an assumed PMPM expenditure for each covered individual and is currently developed to be on a per-adult basis. Consideration for children who could be eligible for the program would require the provided index rates to be scaled for a lower average age, as well as consideration for additional benefits offered through Early and Periodic Screening, Diagnostic and Treatment (EPSDT), including services such as Applied Behavioral Analysis (ABA) services.
    a. The CY2021 certification letter for the CCO program, along with Appendix I of the certification letter, has been provided along with this narrative. These provide additional information related to premium differences between populations, which can be used to inform relative cost differences between the CCO-enrolled adult and children populations: "Oregon CY21 Rate Certification - CCO Rates.pdf" and "Oregon CY21 Certification Appendix I - Payment Rate Summaries.xlsx."
3. The implied average age underlying the index rates is on par with a blend of a TANF and Medicaid expansion population. Based on review of TANF and expansion populations in other Medicaid programs, the assumed average age range inherent in the figures provided is 33 to 38.
4. The scenarios reflect the underlying reimbursement across all services that is currently present within the CCO program, as well as the underlying nominal member cost-sharing applicable to the CCO program.
5. The nonmedical load of 11% included within this scenario modeling is considered a reasonable statewide placeholder for nonmedical expenditures, and is slightly higher than the approximate 10.3% program-wide nonmedical load (net of MCO tax) applicable to the CY2021 CCO capitation rates. Note that the nonmedical load within the CCO program is developed on a tiered structure, in that it varies by CCO depending on factors such as regional differences and differences in enrollment size contributing to varying levels of economies of scale achievable by each CCO. Therefore, as enrollment projections are developed including differences in the mix of regional enrollment for the buy-in option, adjustments to this amount should be considered to better align with the nonmedical load specific to the CCOs operating in each region.

Wakely Enrollment, State Subsidy and Market Impact Analysis

- The earliest year the public option plan, if offered by the OHA, would be viable is 2022. As a simplifying assumption, Wakely is using 2021 estimated metrics such as lowest ACA premiums, market size enrollment and Medicaid CCO experience, without explicitly projecting to 2022. A number of market changes (from 2021 to 2022), such as issuer participation, plan offerings and premium changes, may impact the analysis.

- One of the key assumptions underlying the work is the CCO equivalent premium. Wakely relied on the analysis provided by Optumas in order to develop a 2021 premium for an age 40 individual used in the enrollment analysis. Wakely adjusted to account for the child population expected to enroll in this public option plan offering, and morbidity differences of the subset of individuals choosing to enroll in the public option plan. Finally, Wakely tested a range of morbidity adjustments in three modeled scenarios (low, average and high morbidity). Wakely also relied on CCO demographic distribution summary data (CY19) provided by OHA on November 5, 2020 [CCO Enrollment - CY19.xlsx].
- Wakely assumed CCO benefit richness of 100% actuarial value, with little to no cost-sharing. The lowest-cost bronze plan in the ACA market is assumed to have 60% actuarial value.
- For modeling of subsidies, Wakely relied on estimated average income by FPL range from Current Population Survey data (2018) trended to 2021 using 3% average wage growth rate. Wakely relied on average family size by FPL range from Current Population Survey data. The use of average values is a simplifying assumption as a result of data limitations, and the actual range of net premiums and the associated change from the lowest available bronze premium would be broader.
- Another key assumption and one that is difficult to assess is how the morbidity of the public option will compare to the current CCO Medicaid experience. The first morbidity assumption adjusts from a Medicaid population and moves to an individual ACA population. For this assumption, Wakely relied on Optumas, which provided a range. The second assumption adjusts for the members who are expected to enroll in the public option. In general, the family glitch members are expected to be slightly healthier than the average individual ACA market member. The noncitizen population is expected to have higher morbidity than the current individual ACA market population, but the amount varies depending on the take-up of the population. We expect this population to be less likely to enroll/receive subsidies given concerns over their citizenship status and the inherent challenges with proving income levels, etc. Thus, we expect a disproportionate number will have health conditions since they are more likely to overcome the barriers to enroll. Since the vast majority of public option enrollees are from the family glitch population, in all scenarios the public option is expected to have lower morbidity than the current individual market.
- There are several limitations to this analysis. Wakely did not include any startup or ongoing operational costs. Wakely also assumed that the state would be able to effectively verify eligible individuals. For both the family glitch and undocumented population, it may be difficult to appropriately verify eligibility. The extent to which the states' verification efforts differ from what is estimated here (i.e., looser or more stringent) could result in different estimates. The exact outreach efforts, such as incentivizing agents and brokers via commission, could also impact results.
- To estimate the number of individuals who will enroll in the CCO offering who are eligible because they are affected by the family glitch, Wakely used a previous national microsimulation analysis by the Urban Institute that estimated take-up of Marketplace subsidies. Wakely then adjusted those estimates to create Oregon-specific estimates and then further adjusted those take-up results for differences in networks, branding and other factors such as the first year of the program.

- To estimate the take-up of those ineligible for subsidies due to immigration status, Wakely assumed there would be two major groups that could transition to the CCO coverage: undocumented immigrants who are currently uninsured, and undocumented immigrants who currently have coverage in the individual market (off-Exchange). Wakely used Kaiser Family foundation estimates for the number of uninsured in this group and used Census data with additional adjustments to estimate the number of off-Exchange enrollees in this group. Wakely then applied take-up probabilities based on the premium difference using elasticity functions. Finally, Wakely added a muting factor to reduce take-up due to nonpremium reasons such as networks, revealed coverage propensities and current national environmental factors. Wakely notes small differences in the estimated income distribution of the undocumented population could result in non-material change take-up, and slight increase to the estimated subsidy amount.
- Wakely assumed no area rating for the public option plan and that the same CCO public option premium would be charged statewide. To the extent public option enrollment mix is significantly different by FPL and CCO region, this would impact the estimated take-up rates.
- These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this analysis. Furthermore, changes in state or federal law (e.g., new 1332 reinsurance parameters, health reimbursement arrangement (HRA) regulation) were not included in the analysis. The potential impact of COVID-19 was not included in the analysis.
- Additionally, the analysis assumes that the state reinsurance program continues but does not include the impact of a public option on the reinsurance program.

Disclosures and Caveats

Responsible Actuaries. Julie Peper and Ksenia Whittal are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of OHA and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary. Wakely does not intend to create a reliance to these outside parties, and these materials may not be released to third parties without Wakely’s prior written consent, and when consent is granted, the materials should be provided in their entirety. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. Please note that these results are preliminary and are subject to change as we gather input and potentially refine the modeling methodology and assumptions. Users of the results should be qualified to use them and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of the OHA receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of the OHA.

Data and Reliance. We have relied on information and data provided by OHA, Optumas, Manatt and other public data sources in the analysis. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this analysis. Furthermore, changes in state or federal law (e.g., new 1332 reinsurance parameters, HRA regulation) were not included in the analysis. The potential impact of COVID-19 was not included in the analysis. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

Deviations From ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs, with no known deviations. A summary of ASOP compliance is listed below:

- ASOP No. 23, Data Quality
- ASOP No. 41, Actuarial Communication
- ASOP No. 56, Modeling

Analysis Sources

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