Oregon
Medicaid Advisory Committee

Addressing Churn: Coverage Dynamics in Oregon's Insurance Affordability Programs

Full Report and Recommendations

August 2014

Oregon Health Authority

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Oregon Medicaid Advisory Committee

John A. Kitzhaber, MD, Governor

Oregon Health Authority

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August 5, 2014

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Bonetto, McKelvey, and members of the Board:

The Medicaid Advisory Committee (MAC) thanks the Oregon Health Policy Board for the opportunity to submit recommendations designed to minimize coverage disruptions and smooth transitions between the Oregon Health Plan (OHP) and Qualified Health Plans (QHPs) available in the health insurance Marketplace for low- and middle-income Oregonians.

The Affordable Care Act (ACA), offering new coverage opportunities for individuals and families, also creates new transition points. Coverage transitions for Oregonians are caused by several factors, including income shifts, changes in employment and family circumstances, and administrative issues. This phenomenon, known as churn, is not new, but its extent and scope are now more complex due to different coverage dynamics provided by the ACA. Some degree of churn is inevitable but its potentially adverse impacts such as disruptions in care, gaps or loss in coverage, and increased exposure to out-of-pocket costs can be mitigated.

In 2013, the Oregon Health Authority (OHA) charged the MAC with developing recommendations to reduce and mitigate churn and its effects. For seven months, the committee reviewed evidence on the historical impact of churn in the OHP (Medicaid), and assessed the characteristics of Oregonians most likely to churn in the new ACA coverage environment. The MAC also studied other states' experience implementing different "churn" or mitigation policies and heard from experts on strategies to address coverage transitions in Oregon.

The recommendations are designed around a set of principles to ensure consumer access to quality affordable health coverage that is streamlined across programs. They also seek to balance the financial viability and operational self-sufficiency of Oregon's health care system. Lastly, the recommendations align with the Board's 2013 charge from Governor Kitzhaber to:

- Create system-wide transparency and accountability through a robust measurement framework.
- Spread the foundation of Oregon's health system transformation, the coordinated care model, to the broader market by aligning coordinated model principles across payers and implementing organization alignment around those principles.

The committees' recommendations, recognize a level of urgency around churn, but also aim to address its effects long term. The recommendations below can be implemented starting in 2015.

- Simplify and streamline OHP eligibility, enrollment and redetermination processes.
- Align OHP income eligibility and QHP tax credits' income budget periods.
- Conduct a cost-benefit analysis of adopting 12-month continuous eligibility for OHP income-eligible adults.
- Adopt and publicly report transparent eligibility and enrollment performance indicator(s) to monitor churn in OHP.

The longer-term recommendations could be implemented in 2016:

- Implement contractual mechanisms to support and streamline care transitions between relinquishing and receiving Medicaid CCOs and QHPs.
- Develop a plan to ensure insurance and delivery system alignment between Medicaid CCOs and Oregon's commercial market.
- Offer wraparound of targeted consumer out-of-pocket costs and /or benefits.

In closing, we appreciate the opportunity to report on existing and future challenges related to transitions among ACA coverage options for individuals and families served by the Oregon Health Plan. It is critical that Oregon's officials monitor and work to ensure access to continuous, quality, affordable care and coverage for OHP members, now serving approximately one in four Oregonians. The committee seeks the Board's acumen, and support of the recommendations.

Sincerely,

Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Karen Gaffney, MS
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Medicaid Advisory Committee Report
Submitted to Oregon Health Policy Board in August 2014

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The committee and staff would like to acknowledge the support and expertise provided by Manatt Health Solutions and Wakely Consulting Group made available through the State Health Reform Assistance Network.

If you would like additional copies of this report, or if you need this material in an alternate format, please email: Mac.Info@state.or.us.

Executive Summary

The Medicaid Advisory Committee (MAC) was tasked by the Oregon Health Authority (OHA) to develop recommendations that ***optimize continuity of care and coverage*** for low- and middle-income Oregonians through the Oregon Health Plan (OHP) and Qualified Health Plans (QHPs) available through the state's Health Insurance Marketplace[1] (Marketplace), Cover Oregon.

Seamless continuity across all insurance affordability programs (IAPs)—Oregon Health Plan's Medicaid and Children's Health Insurance Program (CHIP) and subsidized private coverage in the Marketplace—"is a core principle of health reform."[2] In the new ACA coverage landscape, millions of individuals and families will transition (or churn) between coverage options on an annual basis, largely due to fluctuations in income and changes in household circumstances. [3,4] Experts estimate that:

- Nationally, 32-35% of adults with incomes below 200% FPL will experience a change in eligibility within *six months* of their Medicaid or Marketplace coverage,[5,6]; 31-51% of individuals will experience a change in eligibility within *one year*; and 24% of adults will experience at least *two* eligibility changes *within a year.*
- In Oregon, 27% of eligible Medicaid parents and childless adults will experience a change in eligibility due to income changes within *one year*.[7]

States cannot eliminate churn entirely but can take action to reduce its frequency and minimize its adverse impacts.[8] Through technical assistance funded by the Robert Wood Johnson Foundation available through the State Health Reform Assistance Network, the OHA and the MAC worked with Manatt Health Solutions (Manatt) to examine a range of policy options to both reduce and mitigate churn, including three alternative coverage options for individuals below 200% of the federal poverty level (FPL).

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[1] Health Insurance Marketplace (referred to Marketplace hereafter) refers to a resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. In some states, the Marketplace is run by the state. In others it is run by the federal government.

[2] Brooks, T. (2014). Open Enrollment, Take Two. *Health Affairs,* 33(6): 927.

[3] Sommers, B. & Rosenbaum, S. (2011).Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges*. Health Affairs*. 30 (2): 228-236.

[4] Urban Institute (2012, June). Churning Under the ACA and State Policy Options for Mitigation,

[5] Sommers, B., Graves, J., et al, (2014). Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact. *Health Affairs*, 33(4): 700-7.

[6] See Sommers, B. & Rosenbaum, S., (2011).

[7] SHADAC (2013, July). Medicaid Eligibility Churn as a Result of Income Shifts and Characteristics of Those Like to Churn: Oregon.

[8] Buettgens, M., Nichols, A., & Dorn. S. (2012). Churning under the ACA and state policy options for mitigation. Washington, DC: Urban Institute.

Additionally, Wakely Consulting Group (Wakely) analyzed the financial feasibility and impact of the three alternative coverage options or programs. These were examined for their potential to ease consumer affordability and maintain continuity of care, while balancing the financial impact to health care providers (when applicable), the State and the Marketplace.

The programs are:

- Basic Health Plan (BHP)
- Medicaid Bridge Plan
- Consumer Out-of-Pocket and/or Benefit Wraparound

After careful consideration, the committee prioritized administrative strategies to reduce churn by supporting and maintaining enrollment in Medicaid. These strategies should be implemented immediately to address existing, preventable churn and reduce the overall scope of the problem. To mitigate the effects of churn that result from changes in program eligibility, the committee preliminarily recommends several long-term strategies for implementation in 2016 and beyond. The committee also recommends continuous monitoring and assessment of existing coverage programs, and a re-evaluation of the long-term strategies in 12-18 months, after programs are more established and better data on churn patterns is available. The committee determined that the BHP and Medicaid Bridge Plan, due to their implementation costs and administrative complexity are not feasible for Oregon to pursue at this time.[9]

Recommendations

The committee requests the Health Policy Board endorse and advise the OHA to adopt the following recommendations to reduce and avoid churn for individuals and families served by the OHP.

Recommendations To Reduce And Avoid Churn:

- ***Simplify and Streamline OHP Eligibility, Enrollment and Redetermination Processes*.** As OHA re-assumes responsibility for OHP eligibility, enrollment and redetermination, the agency should take steps to reduce administrative barriers for consumers by making improvements and simplifications at every step of the process.[10,11,12]

[9] HB 4109 passed in 2014 requires OHA to examine the feasibility of operating a BHP in Oregon.
[10] Wright, B., and Carlson, M. (2012, September) The OHP Standard Disenrollment Study, Final Report.
[11] Wright, B., and Carlson, M. (2012, September) The Healthy Kids Disenrollment Study, Final Report.
[12] Ellwood M. (1999). The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist. The Washington, DC: Urban Institute.

- Potential action steps include, but are not limited to, using plain language and accessible application and renewal forms as well as consumer facing notices that clearly explain the basis of the eligibility determination and needed action steps by the consumer to ensure enrollment; eliminating communication barriers related to language, culture, age, vision, and hearing; eliminating eligibility criteria and verification procedures not required under federal law; continuing to use "Fast Track" or available Supplemental Nutrition Assistance Program (SNAP) data to automatically enroll individuals in Medicaid pending federal approval; complying with federal administrative renewal procedures that minimize consumer action and further ensure retention; and maximizing state and community partnerships to assist with outreach, enrollment, and redetermination processes.

❖ ***Align Medicaid and Tax Credit Income Budget Periods.*** By 2016, for individuals applying for new coverage, OHA should transition from a "current" monthly income budget period for eligibility determination to one that accounts for "reasonably predictable changes." For OHP income-eligible beneficiaries[13] renewing their coverage, OHA should adopt a projected annual budget period. The intent is to optimize consumer coverage and continuity in OHP by offering more stability in enrollment on an annual basis.

❖ ***Study 12-Month Continuous Eligibility for all OHP Beneficiaries.*** In 2015, OHA should conduct a study of the costs and benefits of adopting 12-month continuous eligibility for OHP income-eligible adults, contingent on additional guidance from CMS on the federal match rate (or FMAP) for the non-expansion Medicaid population. This cost-benefit analysis should include any available evidence about reduced administrative costs, improved health outcomes and service cost offsets resulting from better management of chronic conditions. A 12-month continuous eligibility policy is already in place for children in OHP.

❖ ***Adopt Transparent OHP Eligibility, Enrollment and Redetermination Performance Indicator(s).*** Starting in 2015, OHA should start publicly reporting on a regular basis the OHP eligibility, enrollment and redetermination performance indicators as specified by the Centers for Medicare and Medicaid Services (CMS).[14]
- OHP performance metrics should provide consistent, timely, and reliable program data to monitor Medicaid/CHIP monthly applications, number of determinations or renewals, and number of individuals determined ineligible for OHP by determination reason.

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[13] Modified Adjusted Gross Income (MAGI) is the calculation used for income eligibility determinations and is generally adjusted gross income plus any tax-exempt Social Security, interest, or foreign income.

[14] On September 16, 2013, CMS issued a letter to State Medicaid and CHIP Directors. Please see letter Letter to State Medicaid and CHIP Directors re Medicaid and CHIP Performance Indicators. Sept. 16, 2013.

Recommendations to Mitigate Disruptions from Coverage Transitions:

- ***Implement Contractual Mechanisms*.** By 2016, OHA and the Marketplace should adopt contractual mechanisms to streamline care transitions between Coordinated Care Organizations (CCOs) and QHPs, such as:
  - Require relinquishing and receiving entities to create transition plans, tailored to enrollees' specific health care needs, for a defined timeframe (e.g. 90-120 days). At a minimum, plans should be developed for pregnant women, adults and children with significant health care needs or complex medical conditions such as severe and persistent mental illness (SPMI), people receiving ongoing care management or health services, people who are hospitalized at time of transition, and individuals who received prior authorization for services from the relinquishing plan.
  - Encourage plan acceptance of prior authorizations and ongoing courses of treatment to avoid disruptions in care. This may require ongoing care for a specified timeframe (e.g. 90-120 days) from beneficiaries' previous provider(s) that may be out-of-network under the receiving plan.

- ***Align Markets*.** In 2016, OHA and Cover Oregon should promote alignment between Medicaid and the Marketplace by incentivizing CCOs' participation as QHPs. OHA and Cover Oregon should also explore ways to encourage CCOs and QHPs to maintain similar provider networks, including physical, mental and dental health care providers, to support uninterrupted care coordination.

- ***Wraparound of Consumer Out-of Pocket Costs and/or Benefits.*** OHA should seek funding to: 1) subsidize premiums and/or cost-sharing for former Medicaid beneficiaries enrolling in QHPs; and, if funding is available, 2) provide coverage for (or "wrap") a limited set of targeted Medicaid benefits that are not offered by QHPs (e.g., non-emergency medical transportation or adult dental). Both options would require the use of state-only dollars. Wraparound benefits would be provided to select populations under certain circumstances and for specific timeframes (e.g., pregnant women or hospitalized individuals until a transition plan is developed).

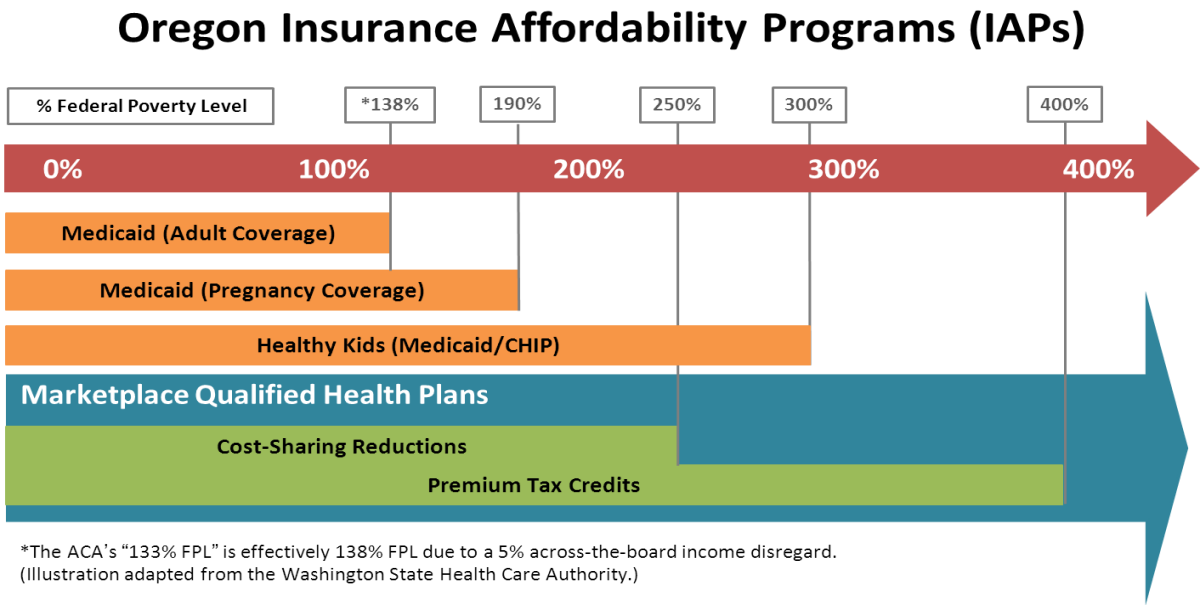
[FULL REPORT]

Table of Contents

Introduction

Equally important to expanding coverage is ensuring that those already insured retain coverage.

Implementation of the Affordable Care Act (ACA) is having a major impact on Oregon's health insurance marketplace dynamics. Specifically, the ACA establishes a continuum of subsidized coverage through insurance affordability programs (IAPs). These include Medicaid, the Children's Health Insurance Program, the Basic Health Program (state option), and premium tax credits and cost-sharing reductions for individuals with incomes up to 400% of the Federal Poverty Level (FPL) to purchase commercial coverage called qualified health plans (QHPs). The figure below shows the IAPs available in Oregon as of 2014.



A key success of ACA implementation in Oregon is the state's 2014 Medicaid expansion. Within less than six months, there were nearly 357,500 new enrollees in the Oregon Health Plan (OHP), for a total enrollment of 971,000[15]—covering nearly one in four Oregonians. Equally important to expanding coverage is ensuring that those already insured retain coverage. Coverage transitions are caused by several factors, including income shifts, changes in family circumstances, and administrative issues, such as difficulties meeting documentation requirements for continued eligibility. The phenomenon commonly referred to as "churn" is not new, but its extent and scope are more complex due to coverage dynamics created by the ACA. A key policy issue for states is managing churn in a way that preserves continuity of care and coverage and eases consumer affordability. It is also a cost-effective approach to improving quality of health care.

[15] Oregon Health Authority (2014) (*As of June 30, 2014)

Why Churn Is an Issue

"Churning makes Medicaid less efficient and less effective." *Lu & Steinmetz, 2013* [16]

The ACA promotes coverage and access to quality affordable care and provides numerous consumer protections. However, low- and moderate-income individuals remain vulnerable to the loss of insurance and churn because they experience more fluctuations in family structure, income, and employment status.[17] The potentially negative effects of churn include but are not limited to:

- Breaks in coverage that lead to increased use of emergency rooms and hospitalizations for ambulatory sensitive conditions, poorer management of chronic disease, and lower rates of preventive care.[18]
- Differences in benefit coverage and provider networks that lead to fragmented, lower quality of health care and increased costs, e.g., duplication of diagnostic tests and the need to coordinate or renew treatment plans.
- Increased costs particularly for individuals and families churning out of Medicaid into commercial coverage (e.g. higher out-of-pocket expenses including premiums, co-pays and deductibles).
- Less incentive for health plans and providers to invest in long-term health improvements, as enrollment turnover means health plans cannot expect to realize savings from such investments.
- Difficulty for states to measure and compare quality across health plans over time.
- Increased administrative expenses associated with enrollment turnover.

The magnitude and scope of churn's effects varying state to state are significant and avoidable, especially for low-income individuals and families enrolled in Medicaid.

History of Medicaid Churn: A Persistent Challenge

Historical reasons low-income families "churned" are still germane in today's coverage environment: income, changes in family status, inability to pay monthly premiums, and barriers to reenrolling due to complicated or burdensome renewal procedures. The reality for states is that even under ACA reform, individuals will continue to transition on and off Medicaid, to other coverage programs, or fall into periods of uninsurance. The challenge and opportunity is for

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[16] Ku, L., & Steinmetz, E. (2013). Bridging the gap: Continuity and quality of coverage in Medicaid. Association of Community Affiliated Plans: Washington DC. p. 14.

[17] Ku, L., & Ross, D. (2002, December). Staying covered: The importance of retaining health insurance for low-income families. The Commonwealth Fund: New York, NY.

[18] See Institute of Medicine (2002). *Care Without Coverage: Too Little, Too Late.* Washington, DC: National Academy Press. Banerjee, R., Ziegenfuss, J., & Shah, J. (2010). Impact of discontinuity in health insurance on resource utilization. *BMC Health Serv Res*, 10, 195. Ginde, A., Lowe, R., & Wilde, J. (2012). Health insurance status change and emergency department use among US adults. *Ann Intern Med*., 172(8): 642-647.

states to "rethink Medicaid in the new normal"[19] -- in other words, rethink how best to address historic factors that create churn in the new ACA landscape.

In reducing churn, states can address the issue of coverage continuity and better manage Medicaid expenditures as churn increases administrative costs. For example, a report on New York's Medicaid program found that the administrative costs of enrolling a child in Medicaid was approximately $280. Such costs, driven by reenrollment of individuals, when avoided, can reduce the overall state administrative costs among individuals that churn in out and out of Medicaid, annually. Improved continuity of coverage in Medicaid is efficient and can substantially lower average monthly costs per enrollee. A 2009 report found the average cost per month for an adult enrolled in Medicaid for six months and 12 months was 25% less and 47% less, respectively, compared to an adult enrolled for a single month.[20] Surprisingly, the average monthly Medicaid expenditure for an adult enrolled in Medicaid for 12 continuous months is approximately two-thirds the level of an individual enrolled for six-months.[21]

Churn in the Oregon Health Plan: Lessons Learned

Prior to ACA implementation, and Medicaid expansion in 2014, individuals and families covered in Oregon's Medicaid program experienced churn.[22] For example, in 2003, Oregon modified OHP *Standard*, Oregon's Medicaid expansion program for low-income adults and couples with no children up to 100% FPL. Enrollees in OHP *Standard* compared to OHP *Plus* (Oregon's traditional Medicaid program) were required to pay higher premiums and copays, received fewer benefits, and were disenrolled and "locked-out" of the program for six months if they failed to pay their premiums.

The impact of these changes was significant and well-studied.[23] Notable impacts were higher unmet need for health care among those that lost coverage, including individuals with chronic illness more likely to report unmet need and increased ED utilization among newly uninsured. Also, increased cost-sharing including premiums disproportionately affected the lower income groups, with a decline in enrollment in OHP *Standard* by approximately 45% after OHP 2 implementation; many that lost coverage remained uninsured.[24]

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[19] Rosenbaum, S., & Sommers, B. (2014). Rethinking Medicaid in the new normal. *Saint Louis University School of Law, 5*(127): 128-152.

[20] Ku L., MacTaggart P, Pervez F, & Rosenbaum S. (2009), Improving Medicaid's Continuity and Quality of Care. Association for Community Affiliated Plans: Washington DC.

[21] Ibid.

[22] Oberlander, J. (2007). Health Reform Interrupted: The Unraveling Of The Oregon Health Plan. *Health Affairs*, 26(1): w96-w105.

[23] Ibid.

[24] Wright, B., Carlson, M., Allen, H., Holmgrn, A., & Rustvold, D. (2014). Riasing premiums and other costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs,* 29(12): 2311-2316.

A 2012 study of the changes to OHP *Standard* measured the amount of disenrollment, assessed churn rates, and identified the key reasons or drivers behind disenrollment.[25]

- Approximately 17% of adults were disenrolled from the program during their annual redetermination window.
- Most disenrollment (64%) happened for one of two reasons: either people did not realize they needed to reapply, or they tried to reapply but were unable to provide all required documentation by the deadline, resulting in either denial (for partially completed applications) or a failure to turn in any redetermination materials at all.
- Just 6% of disenrollment from OHP *Standard* was attributable to individuals finding private coverage, and 18% represented people deliberately choosing not to reapply.

The researchers' findings indicate that administrative challenges, including difficulty with application and income documentation processes, were a significant factor to individuals 'churning' on and off OHP *Standard*. The authors noted that more individuals who disenrolled would likely have reenrolled in the program had it not been closed to new enrollment. A similar 2011 study by the same researchers found that approximately 15% of children enrolled in Healthy Kids, Oregon's health coverage program for children in low- to middle-income families, were also disenrolled due to administrative reasons.[26]

Other studies have found that, as Oregonians were disenrolled from Medicaid, there was an increased likelihood that these individuals had unmet health care and medication needs, and increased medical debt compared to their insured counterparts.[27,28] Future Oregon Medicaid policy should be designed in light of findings from these studies to ensure seamless coverage continuity, particularly in the new environment of federal health reform.

Estimates and Characteristics of Individuals Likely to Churn in Oregon

Prior to the 2014 Medicaid expansion and the success of the "Fast-Track" enrollment,[29] OHA sought to understand the potential magnitude and characteristics of individuals likely to churn. This exploration of the likely churn population was conducted by the State Health Access Data Assistance Center (SHADAC) and Providence's Center for Outcomes Research and Education (CORE).

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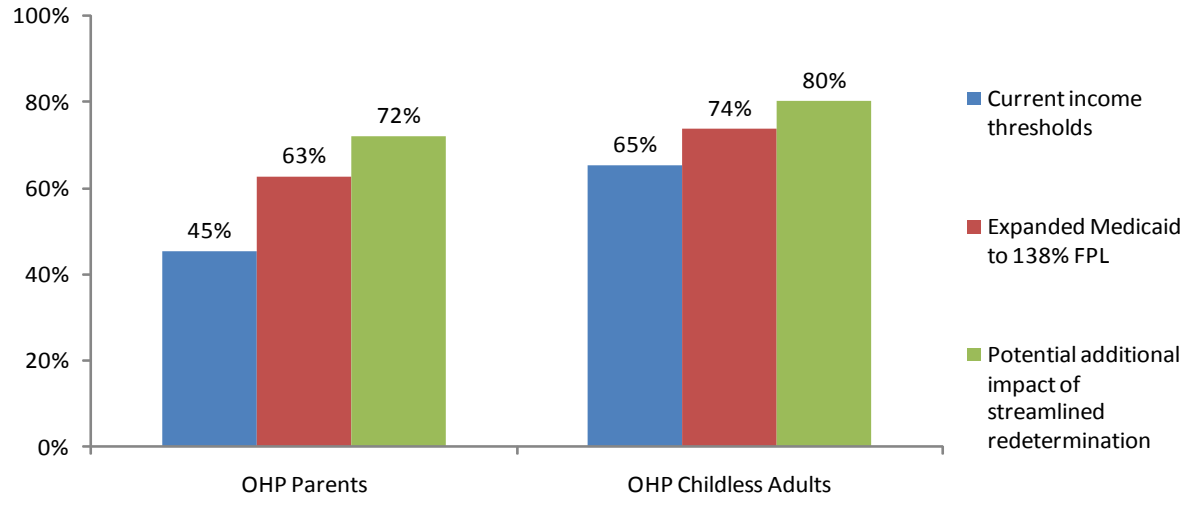
[25] Wright, B., and Carlson, M. (2012, September) The OHP Standard Disenrollment Study, Final Report.
[26] Wright, B., and Carlson, M. (2012, September) The Healthy Kids Disenrollment Study, Final Report.
[27] Wright BJ, Carlson MJ, Edlund T, et al. (2005). The impact of increased cost sharing on Medicaid enrollees. *Health Affairs*, 24(4): 1106–1116.
[28] Carlson, M., DeVoe, J., & Wright, B. (2006). Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results from a Prospective Cohort Study of the Oregon Health Plan. *Annual of Family Medicine*, 4(5); 391-398.
[29] Fast-track enrollment allows states to enroll eligible individuals into coverage using data already available from their Supplemental Nutrition Assistance programs (SNAP).

SHADAC used state administrative data, data from the Census Bureau's Survey of Income and Program Participation (SIPP), and the SHADAC Projection Model for Oregon to model enrollment dynamics between Medicaid, Oregon's health insurance Marketplace and other coverage options. The estimates were developed prior to the adoption of Fast-Track that helped Oregon far exceed initial estimates for OHP enrollment in 2014.

SHADAC estimated Medicaid retention rates for OHP parents and childless adults based on Medicaid expansion and the potential impact of streamlined redetermination in OHP (see Figure 1, next page). Key findings from this assessment include the following:

- Expanding Medicaid eligibility to adults with incomes up to 138% FPL was projected to substantially reduce churn. An estimated 50% of enrolled adults would lose eligibility after 12 months due to changes in their income; with the Medicaid expansion, SHADAC estimated that this rate would fall to about 30%.
- Streamlined renewal procedures could further reduce churn. Generally, about half of program terminations occurring at renewal are for process-related reasons; SHADAC estimated that this rate could be reduced by up to half.
- The combined effects of Medicaid expansion and streamlined renewal could result in continuous eligibility rates of 72% to 80%, varying by eligibility group.

Figure 1: Projected Medicaid Retention Rates for Adults



Source: SHADAC analysis of the Census Bureau's Survey of Income and Program Participation (SIPP) applied to Oregon Health Plan administrative data from November 2012 (percent of people who remain enrolled in the same eligibility category 12 months after initial enrollment or eligibility redetermination). March 2013.
Note: Additional impact of streamlined redetermination assumes that process-related terminations (currently around 50% of terminations) would be reduced by half.

Individuals and families who transition out of OHP may shift to various insurance options or become uninsured. While significant shifts are projected between the Medicaid and the Marketplace, SHADAC's findings suggest a number of individuals that move out of both OHP and the Marketplace will transition to employer-sponsored insurance (ESI) coverage (see Table 1).

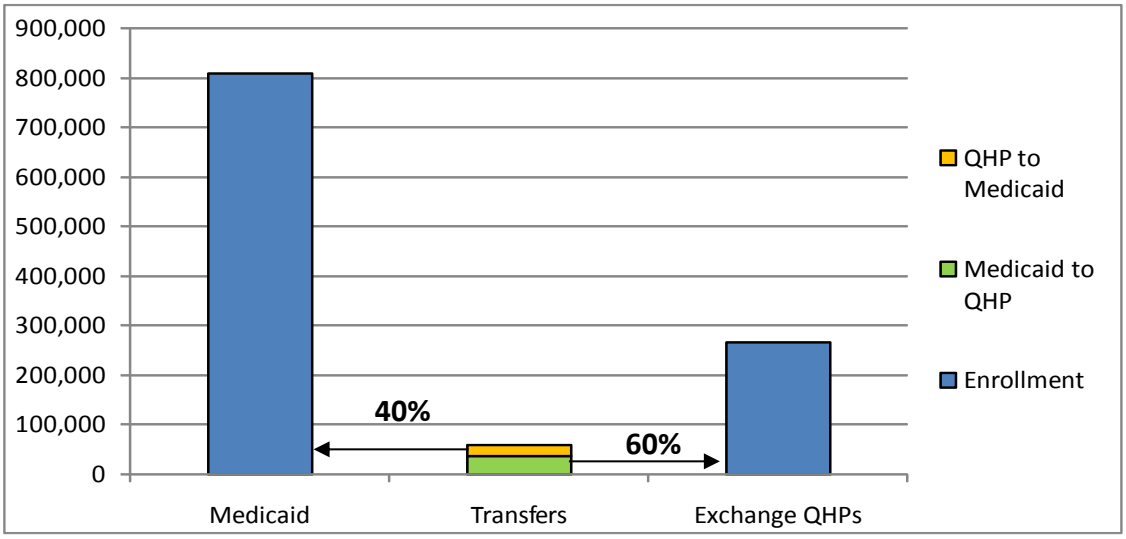
Table 1. Shifts From Medicaid and the Marketplace to Other Coverage Sources Associated With Income Shifts, 2016*

Shifts out of Medicaid to:				Shifts out of Marketplace to:			
ESI	**Marketplace**	**Other Nongroup**	**Uninsured**	**ESI**	**Other Nongroup**	**Uninsured**	**Medicaid**
157,000	36,000	5,000	21,000	77,000	-	9,000	24,000
72%	16%	2%	10%	70%	0%	8%	22%

**Source:* SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data.*
Source: SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data.

SHADAC estimated that, starting in 2016, approximately 60% of the movement between Medicaid and the Marketplace (approx. 36,000 individuals) will be individuals moving from Medicaid to QHPs ("churning upward"). Conversely, 40% are projected to churn downward from QHP coverage to Medicaid. The estimated number of individuals transferring between Medicaid and QHPs, however, would be a relatively small portion of total enrollment, as illustrated in Figure 2.

Figure 2: Transfers Between Markets*



**Estimates were developed in March 2013 prior to Fast-Track enrollment into OHP.*
Source: SHADAC analysis of SIPP data applied to Oregon Health Plan administrative data from November 2012-March 2013.

In addition to estimating the number of individuals likely to churn between IAPs, SHADAC's study also revealed the following characteristics about individuals expected to churn between Medicaid and QHPs:

- Approximately 38% are between the ages of 45 and 64 (the baby boomer generation)
- Approximately 47% are married
- Almost 49% have a household size of 3-5 individuals
- More than 70% are either not working or have only part-time employment
- Approximately 47% are uninsured
- Around 33% are likely to have a work-limiting or work-preventing physical or mental condition
- An estimated 40% have incomes between 101-138% FPL
- Over 68% show high school as their highest level of education

In 2013, Providence's Center for Outcomes Research and Education (CORE) assessed annual income variation and demographic and health characteristics in the probable 2014 Medicaid expansion population. Through the Oregon Health Insurance Experiment (OHIE), CORE had collected data from 17,000 low-income Oregonians who signed up for the OHP "lottery"[30] and who were therefore a reasonable representation of Oregon's likely Medicaid expansion population. Findings from this assessment revealed the following:

- Average annual variation in household income was ±41.5% of FPL, indicating a significant level of income volatility among this population.
- Approximately 17% of households were likely to churn across the 138% FPL threshold annually.
- Greater income variation was experienced by those with chronic conditions and living in urban households.
- Higher starting incomes were associated with increased churn rates between OHP and the Marketplace; specifically, estimated churn rates were 54% for households with starting incomes between 139-175%, 24% for households with starting incomes between 101-138% FPL, and 9% for households at 100% FPL.
- Poorer households were less likely to move "upward."[31] Churn estimates dropped to 16% when starting household incomes were 176% FPL or higher, meaning these households less likely to move "downward" and cross the 138% FPL eligibility threshold.

While these analyses were derived from different data sources, combined they provide a clear picture of the volatility of the likely churn population and help to inform policy options considered by the MAC.

[30] Oregon Health Insurance Experiment (OHIE) is a randomized study or "lottery" that began in April 2008 to examine the impact of providing public insurance coverage through the Oregon Health Plan to a low-income adult population in Oregon.

[31] Also supported by Sommers, B., Graves, J., Swartz, K., & Rosenbaum, S. (2014). Medicaid and Marketplace Eligibility changes will occur often in all states; Policy options can ease impact. *Health Affairs,* 33(4): 700-707.

Affordability Cliff: Financial Implications of Churn

As individuals' and families' incomes increase and they transition upward out of Medicaid, they are eligible to receive federally subsidized coverage to purchase QHPs. However, even nominal out-of-pockets expenses can act as a barrier to care for individuals with low incomes and/or significant health care needs, as these individuals are particularly sensitive to such costs.[32] Such barriers can result in unintentional consequences including unmet health care needs, and adverse, avoidable health outcomes. As individuals are unable to afford out-of-pocket costs, they forego care and often become sicker and eventually visit costly sites such as emergency rooms, increasing the state's overall health care expenses.[33] For individuals or families that transition coverage from Medicaid to QHPs, the affordability cliff can be significant, especially for those below 200% FPL.

The OHP currently does not impose premiums or deductibles on its members, but does require nominal copayments ($1-$3) for a range of covered services. In compliance with federal regulations, certain populations and services in OHP are exempt from cost sharing. These populations include children and pregnant women. Ultimately, states must ensure that the total out-of-pockets costs (premiums, deductibles, cost sharing, copayments, etc.) for all family members does not exceed five percent of a family's income on a quarterly or monthly basis. In contrast, individuals enrolled in QHPs in the Marketplace are responsible for a portion of premiums and cost sharing that increases at several key FPL thresholds. Out-of-pocket caps apply so that low-income individuals' costs are capped at lower levels than for higher income individuals. Table 2 identifies these cost differentials by FPL.

Table 2: Qualified Health Plan Member Premiums and Cost Sharing

FPL	Annual Income for Single Individual*	Max. Premium As % of Income**	Actuarial Values for Cost-Sharing***	Out-Of-Pocket Cap
Under 138%	<$15,856	2%	94%	$750/individual $1,500/family
138-150%	$15,856-$17,235	3 - 4%		
150-200%	$17,235- $22,980	4 - 6.3%	87%	$1,500/individual $3,000/family
200-250%	$22,980-$28,725	6.3 - 8.1%	73%	$4,250/individual $8,500/family
250-400%	$28,725-$45,960	8.1 - 9.5%	70%	Maximum $6,350/ individual $12,700/family

*Based on 2013 Poverty Guidelines.
ACA §1401*ACA §1402

[32] R. Kaiser Commission on Medicaid and the Uninsured (2013, February). Premiums and Cost sharing in Medicaid: A Review of Research Findings.
[33] Ibid.

Benefit Differences: OHP and QHP Coverage

Individuals who move from OHP to a commercial plan or QHP through the Marketplace may experience a more limited scope of benefits. As shown in Table 3 below, benefits covered in the commercial essential health benefits (EHB) benchmark are more limited than those covered in Medicaid through the Alternative Benefit Plan (ABP) offered in OHP *Plus*. Due to benefit differences, individuals who transition may experience unmet needs or exacerbation of various health conditions, including chronic diseases. Benefit alignment can reduce the potential for such consequences and should focus on benefit differences with higher cost implications (*), which include inpatient hospital mental/behavioral health, inpatient rehabilitation, outpatient therapies and adult dental.

Table 3. Differences in Commercial EHBs and Medicaid ABP

Benefit	Commercial/QHPs	Medicaid
Acupuncture	Not Covered	Limited to specific conditions (i.e., chemical dependency, HIV, migraine, post-stroke depression, and some conditions during pregnancy)
***Adult Dental**	Not Covered	Limited major dental services
Bariatric	Not Covered	Limited to Type 2 diabetics
Chiropractic	Not Covered	Limited to specific conditions (i.e., back pain with neurologic component)
Hearing Aids (Adults)	Not Covered	Covered
Hospice/Respite care	Limited respite care - 5 consecutive days or 30 days/yr.	Covered
***Inpatient Hospital Mental/Behavioral Health**	Limited to 45 days/yr. for residential treatment	Covered
***Inpatient Rehabilitation**	Limited to 30 days/yr. with add. 30 days for head/spinal cord injury	Covered
Massage Therapy	Not Covered	Covered
Naturopath	Not Covered	Covered
***Outpatient Therapies**	Limited to 30 days/yr. with add. 30 days for specific conditions	Covered

In addition to the 10 EHBs, states are required to cover certain "mandatory services" through their Medicaid program (see below for list). Consequently, individuals who move from Medicaid to a QHP may experience, at a minimum, a change in the scope of EHBs including certain mandatory benefits not necessarily in commercial plans.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Services provided in a Rural Health Clinic
- Services provided in a Federally Qualified Health Center
- Dental (routine and urgent for 21 and over)
- Nursing facility services
- Targeted case management
- Non-emergency medical transportation
- Private duty nursing services
- Intermediate care services
- Extended services for pregnant women
- Personal care services

Committee Process and Principles

In the fall of 2013, the MAC began working with Manatt Health Solutions (Manatt) and Wakely Consulting Group (Wakely) to explore churn. During this process, the committee examined a number of issues: Oregon's coverage and health insurance market dynamics in the context of state and federal reform, characteristics of individuals likely to churn, the experience and policy direction of other states, and strategies to mitigate churn's effects. As committee members considered options to reduce churn they adopted a set of principles to guide their work (see Table 4).

Table 4. Committee Principles for Evaluation of Churn Mitigation Strategies
Maximize affordability, benefit coverage, and continuity of care for individuals and families.
Consider the health and support needs of diverse racial and ethnic communities, parents, pregnant women, children, persons with disabilities, and residents in rural and frontier areas, among others served by OHP.
Balance consumer needs with the need for financial viability and operational self-sufficiency in the state Medicaid program, the health insurance Marketplace, and the health care delivery system.
Promote coverage options that ensure access and continuity to comprehensive health services and result in the lowest net level of churn.

Environmental Scan of State Churn Options

To learn from the experience of other states, committee staff prepared an environmental scan of other states' efforts to mitigate churn. The churn mitigation strategies identified included contractual mechanisms, the federal Basic Health Plan option, Medicaid Bridge Plan, benefit and/or consumer out-of-pocket wraparounds, and premium assistance programs. Please see Appendix A for the complete results of the environmental scan. Additionally, representatives from the Washington Health Care Authority presented to the MAC in March and reviewed their state assessment of churn, highlighted the coverage context in WA State, and identified their key policy goals to mitigate churn.[34] The committee concluded that states have a range of options to address churn. However, there is no single, comprehensive policy to alleviate and prevent churn for thousands of Oregonians that will transition among coverage options.

Strategies to Address Churn in Oregon

The committee, in consultation with Manatt and Wakely, identified strategies aimed at reducing or avoiding churn and mitigating disruptions for individuals that transition on and off Medicaid. A brief overview and list of key considerations for each strategy are highlighted on subsequent pages and in Appendix B. Implementation timing for the strategies depends on their scope and complexity, beginning in 2015 at the earliest. Furthermore, while several strategies are complementary and may be implemented in various combinations, the alternative coverage programs are mutually exclusive from a practical perspective. A state would choose the Basic Health Program, a Medicaid Bridge Plan, or Wrap, not a combination of these, due to the administrative complexity and resources required to operate each program.

Options for Reducing and Avoiding Churn

The intent of these policies is to reduce the number of times an individual moves from one coverage vehicle to another and/or to minimize insurance gaps as individuals transition. The two policy options are:

Aligning Medicaid and Tax Credits' Income Budget Periods: States have the option to determine Medicaid eligibility using reasonably predictable changes in income. In addition, for those renewing their MAGI-based coverage[35] (i.e. financial eligibility), the State may also assess eligibility using projected annual income without a waiver. This option serves as an incremental step in moving toward 12-month continuous enrollment (see next option). It

[34] Medicaid Advisory Committee meeting (March 2014), Manatt presentation. See slides 8-41.

[35] Modified adjusted gross income or MAGI refers to the definition of income for eligibility for certain Medicaid populations and premium credits in the Exchanges is based on modified adjusted gross income (MAGI). MAGI is the basis for determining Medicaid and CHIP eligibility for nondisabled, nonelderly individuals.

assists states in smoothing out mid-year income changes, ensuring eligibility is determined on an annual basis.

Twelve-Month Continuous Medicaid Eligibility: Implementing twelve-month continuous eligibility for Medicaid will reduce month-to-month disenrollments in Oregon. To date, no other state has implemented this option for adults, as it would increase enrollment and coverage costs. In other words, continuous eligibility will increase enrollment continuity and coverage, while also creating additional costs for a state.

Options for Mitigating Churn Disruptions

Beyond administrative improvements in the Medicaid program, the committee examined opportunities for market alignment between Medicaid and the Marketplace, as well as alternative coverage options to mitigate churn. These alternative programs cover specific populations in an effort to facilitate care and coverage continuity and reduce financial burden on individuals moving from Medicaid to subsidized coverage in the Marketplace.

Benefits and Provider Network Alignment: States can lessen the impact of churn on individuals moving between Medicaid and the Marketplace through a variety of mechanisms. Benefit alignment can be achieved by contractual mechanisms that require Medicaid coordinated care organizations (CCOs) and QHPs receiving enrollees to be responsible for care previously provided by a relinquishing payor for a limited period. CCOs/QHPs could cover on-going medical treatment and medications, out-of-network care, and/or honor prior authorization(s) during a transition.

To address provider network alignment, states can require or provide incentives for cross-market participation of plans and providers. New York has decided that plans participating in Medicaid and Child Health Plus must also offer Marketplace coverage. A cross-market mandate can help to smooth transitions by allowing individuals shifting between coverage options to stay with the same health plan.[36] Oregon could also require or incent CCOs and QHPs to maintain the same provider networks. Aligning network adequacy requirements across markets can help ensure adequate number and types of providers, especially in mental health and substance abuse services.[37]

Wraparound Program: Wraparound is a state-funded program designed to provide additional benefits and/or reduce costs (e.g. premiums or other out-of-pocket costs) for those who transition from Medicaid to Marketplace coverage. States can "wrap" one or more options

[36] Guerra, V., and McMahon, S. (2014, January). Minimizing Care Gaps for Individuals Churning between the Marketplace and Medicaid: Key State Considerations. Center for Health Care Strategies.
[37] Ibid.

for individuals transitioning between IAPs for a fixed period of time. Described below are options for states to consider.

- *Premium and cost sharing assistance*: Offer additional premium and cost sharing subsidies to former Medicaid enrollees selecting the lowest price QHPs, making plans more affordable for individuals.
- *Wraparound benefits*: Allow individuals whose incomes increase beyond the Medicaid limit to retain certain benefits and thus continue to receive medically necessary services[38] in their care plan for a fixed period of time when they move to a QHP.
- *Complete Wrap*: With federal approval, move individuals *near* the Medicaid income limit to a QHP (with financial support for premiums and cost sharing) to minimize disruptions if income does increase; would have to include wrap-around coverage for Medicaid benefits not included in QHP.

Medicaid Bridge Plan: The "Bridge" program, first proposed by Tennessee in 2011, is an option to provide former Medicaid enrollees with stable coverage as individuals' transition from Medicaid to QHPs. The intent of the program is to offer individuals and families a chance to stay in the same plan and provider network by offering a Medicaid plan in the Marketplace.[39] In Oregon, a Bridge program would likely entail CCOs offering certified QHPs with enrollment limited to previously eligible Medicaid individuals and/or parents of children covered in CHIP (up to 200% FPL). This would allow individuals to remain with the same carrier and provider network and help families split among different products to obtain coverage under one issuer and enroll in the same plan.

Basic Health Plan (BHP):[40] is an optional program available through the ACA. It allows states to establish coverage for residents with incomes above 138% and up through 200% of FPL and lawfully present non-citizens at or below 138% FPL, not eligible for Medicaid as they have not resided in the U.S. for five years. The federal government will pay states 95% of the premium tax credits and cost sharing subsidies that individuals would have otherwise received to purchase QHPs in the Marketplace. States in turn are responsible for providing coverage with benefits and out-of-pocket costs that are the same or better than what BHP eligible individuals would have received in QHPs. States also must establish a competitive process to contract with health plan offerors.

[38] CMS defines medically necessary services as health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

[39] In December 2012, CMS issued guidance for stated interested in Medicaid Bridge plans. Please see Guidance memo,

[40] Wakely estimated the financial impact of the three alternative coverage options to mitigate churn. See Appendix IV in full Wakely report.

Recommendations

The committee recommends the following strategies to promote access to quality, affordable health care and uninterrupted coverage for individuals and families served by OHP. The recommendations will reduce the number of times individuals will move from one coverage vehicle to another and/or minimize service gaps as individuals' transition. Strategies to address administrative-related churn, such as aligning Medicaid and tax credit income budget periods or implementing 12-month continuous eligibility can be adopted in Oregon under any coverage program configuration.

During the committee process, members extensively evaluated the issue of administrative related churn. The committee strongly felt that addressing the historical challenges and complexities related to enrollment and renewal/redetermination in OHP offers a critical opportunity for the OHA to reduce and avoid churn in the coming years. Several recommendations reflect the committee's interest in enhancing oversight and monitoring of OHP enrollment and renewal process starting in 2015, including a targeted, ongoing effort to simplify OHP enrollment process.

Recommendations To Reduce And Avoid Churn:

- ***Simplify and Streamline OHP Eligibility, Enrollment and Redetermination Processes*.** As OHA re-assumes responsibility for OHP eligibility, enrollment and redetermination, the agency should take steps to reduce administrative barriers for consumers by making improvements and simplifications at every step of the process.[41,42,43]
  - Potential action steps include, but are not limited to, using plain language and accessible application and renewal forms as well as consumer facing notices that clearly explain the basis of the eligibility determination and needed action steps by the consumer to ensure enrollment; eliminating communication barriers related to language, culture, age, vision, and hearing; eliminating eligibility criteria and verification procedures not required under federal law; continuing to use "Fast Track" or available Supplemental Nutrition Assistance Program (SNAP) data to automatically enroll individuals in Medicaid, pending federal approval; complying with federal administrative renewal procedures that minimize consumer action and further ensure retention; and maximizing state and community partnerships to assist with outreach, enrollment, and redetermination processes.

[41] Wright, B., and Carlson, M. (2012, September) The OHP Standard Disenrollment Study, Final Report.
[42] Wright, B., and Carlson, M. (2012, September) The Healthy Kids Disenrollment Study, Final Report.
[43] Ellwood M. (1999). The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist. The Washington, DC: Urban Institute.

- ***Align Medicaid and Tax Credit Income Budget Periods.*** By 2016, for individuals applying for new coverage, OHA should transition from a "current" monthly income budget period for eligibility determination to one that accounts for "reasonably predictable changes." For OHP income-eligible beneficiaries[44] renewing their coverage, OHA should adopt a projected annual budget period. The intent is to optimize consumer coverage and continuity in OHP by offering more stability in enrollment on an annual basis.

- ***Study 12-Month Continuous Eligibility for all OHP Beneficiaries.*** In 2015, OHA should conduct a study of the costs and benefits of adopting 12-month continuous eligibility for OHP income-eligible adults, contingent on additional guidance from CMS on the federal match rate (or FMAP) for the non-expansion Medicaid population. This cost-benefit analysis should include any available evidence about reduced administrative costs and improved health outcomes and service cost offsets resulting from better management of chronic conditions. A 12-month continuous eligibility policy is already in place for children in OHP.

- ***Adopt Transparent OHP Eligibility, Enrollment and Redetermination Performance Indicator(s).*** Starting in 2015, OHA should start publicly reporting on a regular basis the OHP eligibility, enrollment and redetermination performance indicators as specified by the Centers for Medicare and Medicaid Services (CMS).[45]
  - OHP performance metrics should provide consistent, timely, and reliable program data to monitor Medicaid/CHIP monthly applications, number of determinations or renewals, and number of individuals determined ineligible for OHP by determination reason.

[44] Modified Adjusted Gross Income (MAGI) is the calculation used for income eligibility determinations and is generally adjusted gross income plus any tax-exempt Social Security, interest, or foreign income.
[45] Letter to State Medicaid and CHIP Directors re Medicaid and CHIP Performance Indicators. Sept. 16, 2013.

Recommendations to Mitigate Disruptions That Result From Coverage Transitions:

After months of widespread discussion, the committee determined that the Basic Health Plan and Medicaid Bridge plan are not viable alternative coverage options for 2014 or 2015. Specifically, the committee concluded that any recommendation regarding BHP from the standpoint of churn should wait until the feasibility study required by House Bill 4109 (2014) is completed in the fall of 2014. The committee identified several issues for future BHP discussions that include: determining reasonable provider reimbursement rates, scope of benefit coverage (OHP vs. QHP), the feasibility of operating BHP through existing CCOs, consumer choice, and administrative complexity in establishing an entirely new program. In the future, the Medicaid Bridge Plan may serve as a potentially viable option. If Oregon opts to reevaluate the Medicaid Bridge Plan, the committee suggests considering the following factors: reasonable provider reimbursement rates, administrative feasibility, interest among CCOs in offering QHPs for a limited population, and federal flexibility to implement the program. In lieu of not *currently* supporting these two alterative coverage problems, the committee is recommending three strategies: use of contractual mechanisms, enhanced network alignment between OHP and QHPs, and a Wraparound program.

- ***Implement Contractual Mechanisms*.** By 2016, OHA and the Marketplace should adopt contractual mechanisms to streamline care transitions between Coordinated Care Organizations (CCOs) and QHPs, such as:
  - Require relinquishing and receiving entities to create transition plans, tailored to enrollees' specific health care needs, for a defined timeframe (e.g. 90-120 days). At a minimum, plans should be developed for pregnant women, adults and children with significant health care needs or complex medical conditions such as severe and persistent mental illness (SPMI), people receiving ongoing care management or health services, people who are hospitalized at time of transition, and individuals who received prior authorization for services from the relinquishing plan.
  - Encourage plan acceptance of prior authorizations and ongoing courses of treatment to avoid disruptions in care. This may require ongoing care for a specified timeframe (e.g. 90-120 days) from beneficiaries' previous provider(s) that may be out-of-network under the receiving plan.

- ***Align Markets*.** In 2016, OHA and Cover Oregon should promote alignment between Medicaid and the Marketplace by incentivizing CCOs' participation as QHPs. OHA and Cover Oregon should also explore ways to encourage CCOs and QHPs to maintain similar provider networks, including physical, mental and dental health care providers, to support uninterrupted care coordination.

- ***Wraparound of Consumer Out-of Pocket Costs and/or Benefits.*** OHA should seek funding to: 1) subsidize premiums and/or cost-sharing for former Medicaid beneficiaries

enrolling in QHPs; and, if funding is available, 2) provide coverage for (or "wrap") a limited set of targeted Medicaid benefits that are not offered by QHPs (e.g., non-emergency medical transportation or adult dental). Both options would require the use of state-only dollars. Wraparound benefits would be provided to select populations under certain circumstances and for specific timeframes (e.g., pregnant women or hospitalized individuals until a transition plan is developed).

Conclusion

In working to address churn, Oregon has a range of options that offer flexibility, align with the state's existing policies, and may enhance the current delivery system in Medicaid and Marketplace. The MAC's recommendations offer a set of comprehensive and practical strategies for policymakers and state officials to address churn. These recommendations will help Oregon achieve multiple, overlapping goals in terms of continuity of care and coverage, consumer affordability, and administrative simplification for those served in OHP.

Appendices

A. Glossary/Acronym List
B. Environmental Scan of State Options to Mitigate Churn
C. Summary of Churn Options

Appendix A: Glossary/ Acronym List[46]

Affordable Care Act (ACA): A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the Obama administration. Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions. ACA also refers to a set of specific conditions identified by the Oregon Legislation in which practices will get enhanced reimbursement.

Alternative Benefit Plan (ABP): a state's Medicaid plan must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the Affordable Care Act, whether the state uses an ABP for Medicaid expansion or coverage of any other groups of individuals. Individuals in the new Medicaid adult eligibility group receive benefits through an ABP.

Benefits: The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Centers for Medicare and Medicaid Services (CMS): A federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

Children's Health Insurance Program (CHIP): Insurance program jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Coordinated Care Organizations (CCO): Are community-based, risk-bearing organizations governed by a partnership among providers of care, community members and those taking financial risk who have agreed to work together for people who receive health care coverage under the Oregon Health Plan (Medicaid).

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing: The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network

[46] Definitions from http://www.healthcare.gov/glossary/W/index.html
and: http://www.samhsa.gov/healthreform/parity/

providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Division of Medical Assistance Programs (DMAP): The agency that administers Medicaid and the State Children's Health Insurance Program (CHIP) in Oregon.

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT): A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Essential Health Benefits (EHB): A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Exchange: Consumers and small businesses have access to new Health Insurance Marketplaces (or Exchanges). Consumers in every state (including the District of Columbia) are able to shop for and buy private insurance from qualified health plans (QHPs) available through a marketplace or "Exchange."

Family Health Insurance Assistance Program (FHIAP): The Office of Private Health Partnerships (OPHP), Oregon Health Authority (OHA) administers FHIAP. The premium assistance program provides subsidies to help families and individuals pay for health insurance offered either through employer-sponsored insurance (ESI) or private health insurance carriers. Coverage provided by the insurance plans must meet or exceed the FHIAP benchmark criteria, which is approved at a level actuarially equivalent to federally mandated Medicaid benefits.

Federal Financial Participation (FFP): That portion paid by the Federal government to states for their share of expenditures for providing Medicaid services, administering the Medicaid program, and certain other human service programs.

Federal Medical Assistance Percentages (FMAP): Are the percentage rates used to determine the matching funds rate allocated annually to certain medical and social service

programs in the United States of America. FMAP eligible programs are joint federal-state partnerships between the federal government of the United States and state governments, which are administered by the states. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Health Insurance Marketplace (or Marketplace): A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

Managed Care Organization (MCO): A health insurance plan that covers the services of a particular network of doctors and other providers for people enrolled in the plan.

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Modified Adjust Gross Income (MAGI): The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

Oregon Health Plan (OHP): Also known as Oregon's Medicaid program, OHP provides health care coverage to low-income Oregonians through programs administered by the Oregon Health Authority. OHP Plus covers comprehensive medical, dental, vision, prescription drug and behavioral health benefits. Non-pregnant adults have reduced dental and vision benefits. The State's benefit package is based on the OHP Prioritized List of Health Services, which is a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration for its entire Medicaid population. OHP Plus does not require a premium or a deductible, but does require co-pays for a range of covered services

Oregon Health Policy Board (OHPB): The nine-member board serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. OHPB was established through House Bill 2009, signed by the Governor in June 2009. Board members are nominated by the Governor and must be confirmed by the Senate. Board members serve a four-year term of office. The Board is responsible for implementing the health care reform provisions of HB 2009.

Out-of-Pocket Costs: Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Per Member/Per Month (PMPM): A capitation payment method where an insurance company pays an amount to a primary care physician based on the number of members on the physician's panel

Premium: The amount that must be paid for an individual's health insurance or plan usually paid monthly, quarterly or yearly.

Qualified Health Plan (QHP): Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

State Plan Amendment (SPA): A State Plan is a contract between a state and the Federal Government describing how that state administers its Medicaid program. It gives an assurance that a state abides by Federal rules and may claim Federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that States must meet to participate.

Waiver: The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid and the Children's Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects; each authority has a distinct purpose, and distinct requirements.

Appendix B: Environmental Scan of State Options to Mitigate Churn

State/ Organization	Description	Populations	Funding	Authority/ Requirements
Medicaid Managed Care States (Maryland, New Mexico, New York, Indiana)[47]	**Health Plan Contracting** • Several states' Medicaid Managed Care Organizations (MCOs) have coverage transition provisions in MCO contracts to protect populations receiving certain types of care. • For example in Maryland, receiving MCOs are responsible for continuing care previously provided by the relinquishing payer including accepting prior authorizations and covering out of network providers for a period of up to 90 days (or through the delivery and post-partum for a pregnant woman).[48] • Conversely, some *receiving* MCOs can allow transitioning beneficiaries to continue to obtain care from a previous provider for a specific timeframe. • Few states mandate that *relinquishing* MCOs be held financially responsible for provision of care to enrollees during the transition period. • Many states, such as New York, New Mexico and Indiana[49], require both *receiving* and *relinquishing* MCOs to coordinate coverage of individuals transitioning and jointly develop a transition plan to provide services within a defined timeframe, ranging anywhere from 90 to 120 days.	Populations needing transitional care for: • Pregnancy; • Certain dental care; • Hospitalizations; • Transplants; • Chemotherapy, radiation therapy, and dialysis; • Individuals with DME, home health services, medications; • Individuals with prior authorizations for procedures; and • Behavioral health and chemical dependency.	• N/A	• N/A

[47] Not an exhaustive list of states.
[48] Minimizing Care Gaps for Individuals Churning between the Marketplace and Medicaid: Key State Considerations, Prepared by Veronica Guerra and Shannon McMahon, Center for Health Care Strategies, January 2014.
[49] Ibid

Appendix B: Environmental Scan of State Options to Mitigate Churn

State/ Organization	Description	Populations	Funding	Authority/ Requirements
Mass.	**Extensive contract language to guide MCO coverage transitions between Medicaid and the state's exchange.** • The state performs readiness reviews of its MCO contractors prior to enrolling new beneficiaries; take steps to minimize disruptions in care and ensure uninterrupted access to medically necessary services. • Readiness reviews conducted on 11 elements that range from network access, care management capabilities, quality improvement strategies, and IT systems. • To minimize the disruption of care and ensure uninterrupted access to Medically Necessary Services, at a minimum, receiving MCO contractors must provide transition plans that is tailored for certain subsets of new enrollees (see column to the right).	• Readiness reviews benefit all MCO members • Transition plans required for a) Pregnant women; b) Those with high health care needs; c) Those receiving ongoing services or who are hospitalized at the time of transition; • Those with prior authorization for services such as scheduled surgeries, out-of-area specialty services, or nursing home admission from the relinquishing contractor	• N/A	• N/A
NCQA	**Managed Care Organization Accreditation** • NCQA accreditation requires transition of care standards for certain conditions for Medicaid and private market MCOs in order to receive accreditation, which is required for licensure in some states. • Members in their second or third trimester of pregnancy have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the post-partum period. • Enrollees undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the current active treatment period or for up to 90 calendar days, whichever is shorter.	• Women in second or third trimester of pregnancy • Individuals undergoing active treatment for a chronic or acute medical condition	• N/A	• N/A
Affordable Care Act (ACA) Basic Health Plan	BHP is an ACA optional coverage program for low-income consumers: • Allows states to use federal tax subsidy dollars • Covers individuals between 139% - 200% FPL and legal immigrants <138% FPL in US <5 years	Covers individuals between 139-200% FPL, and legal immigrants <138% FPL in US <5 years, not Medicaid/CHIP eligible.	State receives 95% of the Premium Tax Credits (PTC)	• Section 1331 of the ACA • CMS

Appendix B: Environmental Scan of State Options to Mitigate Churn

State/ Organization	Description	Populations	Funding	Authority/ Requirements
(BHP)	• Requires the "essential health benefits" at a minimum • Mandates a medical-loss ratio of at least 85% • Premiums/cost sharing no more than what enrollees would pay in QHP • State must offer a choice of at least two plans • Plan selection must use a competitive bidding process and consider such things as care coordination/management; incentives for use of preventive services; and patient engagement, incentives for appropriate utilization		and Cost Sharing Reductions (CSR) value BHP enrollees receive had they enrolled in a QHP	approval to operate a BHP
Minnesota BHP[50]	• MN already covers individuals above 138% FPL up to 200% FPL through MinnessotaCare, a jointly funded, federal-state program administered by the MN Dept. of Human Services that provides subsidized health coverage to eligible Minnesotans. • Currently, MinnesotaCare is funded mostly by a state tax on health care providers and health plans. By establishing a BHP, the federal government would pick up most of the cost for this population.	Same as above.	Same as above.	Existing Medicaid managed care contracting reqs.
Medicaid and CHIP Learning Collaborative States	• Eight states participate in the federal BHP Learning Collaborative with CMS: California, DC, Massachusetts, Minnesota, New York, Rhode Island, Oregon, and Washington. • Washington and Oregon have pending legislation to study feasibility of the BHP. • New York included a BHP proposal (only if financial analysis proved fruitful) in the proposed NYS Executive Budget. • Minnesota has expressed a desire to move forward with the implementation of a federal BHP in 2015 (see above). • Potential timing for implementation differs across states, though majority seems to believe 2015 is unrealistic & looking at 2016.	Same as above.	Same as above.	Varies by state

[50] Basic Health Plan Offers a Chance to Provide Comprehensive Health Care Coverage for Low-Income Minnesotans. Minnesota Budget Project. January 2012.

Appendix C: Policy Options and Considerations to Reduce, Avoid, or Mitigate Churn

Strategies to reduce and avoid churn. Goals include reducing the number of times an individual moves from one coverage vehicle to another and/or minimizing insurance gaps as individuals' transition. Policy options include:

- Aligning Medicaid and tax credits' income budget periods
- 12-month continuous Medicaid eligibility

Aligning Medicaid and Tax Credits' Income Budget Periods	
Overview:	Medicaid/CHIP eligibility is based on monthly income; tax credits/cost sharing reductions' eligibility is based on projected annual income. When individual is found ineligible for Medicaid based on monthly income and ineligible for tax credits/cost sharing reductions based on projected annual income, regulations require Medicaid eligibility to be based on projected annual income. As a result, the individual will be eligible for Medicaid.
Eligibility:	OHP eligibility up to 138%FPL
Enrollee Benefits and Costs:	No additional costs to State; potential savings by keeping individuals in same provider network.
Financing:	For new OHP applicants, state may take into account reasonably predictable changes in income. For Medicaid MAGI beneficiaries renewing their coverage, the state may use a projected annual budget period as well as take into account "reasonably predictable changes" in income
Financial Implications:	Undetermined
State Admin:	Minimal
Timing and Legislation:	OHA and Cover Oregon will begin exploring the legal parameters for this option. Need to consider OHP and QHP contracting timelines.
Advantages and Disadvantages	
Consumers	
Advantages: • Individual does not ping pong between Medicaid and tax credits/cost sharing reductions every time income fluctuates, so long as annual income remains below Medicaid eligibility levels • Addresses coverage black hole problem **Disadvantages:** None identified	
State	
Advantages: None identified **Disadvantages:** May require programming changes in eligibility systems and application questions to take into account reasonably predictable changes and projected annual income	
Cover Oregon	
No readily apparent effect to Cover Oregon	
Plans and Providers	
No readily apparent effect to plans or providers	
*Please see pages 11-12 of the report for committee recommendation.	

Appendix C: Policy Options and Considerations to Reduce, Avoid, or Mitigate Churn

12 Month Continuous Medicaid Eligibility	
Overview:	Regardless of change in income eligibility individuals remain eligible for 12 months. Option available for children and adults. 1115 Waiver required for adult 12-month continuous eligibility.
Eligibility:	Adults up to 138%FPL; Continuously eligibility already in CHIP.
Financing:	CMS assessed that 99 percent of the cost should be financed at the enhanced matching rate available for newly-eligible adults and the remaining 1 percent at a state's regular Medicaid matching rate through enhanced FMAP until 2017.
Financial Implications:	FMAP 99 percent of the cost of providing 12 month continuous coverage for Expansion. Non-expansion FMAP has not been determined by CMS.
Timing and Legislation:	Would require state dollars to fund. Would need legislatively approved budget authority.
Advantages and Disadvantages	
Consumers	
Advantages: Eliminates churn for adults during coverage year **Disadvantages:** None identified	
State	
Advantages: • Simplifies administrative processes for the state • May have potential for cost savings **Disadvantages:** • State fiscal obligation for the costs of 12 months continuous coverage for newly eligible • Matching rate for currently eligible adults is unknown	
Plans and Providers	
No readily apparent effect to plans or providers	
*Please see page 12 of the report for committee recommendation.	

Strategies to mitigate disruptions that result from churn. Goals include maintaining continuity of plan and providers; minimizing the consumer affordability cliff; and/or enrolling families in the same plan. Policy options include:

- Benefits and provider network alignment
- Wraparound of consumer benefits and/or out-of-pocket costs
- The Bridge Plan
- The Basic Health Plan program

Appendix C: Policy Options and Considerations to Reduce, Avoid, or Mitigate Churn

Medicaid Bridge Plan	
Overview:	Permit Medicaid CCOs certified as QHPs to offer plans to certain populations that would serve as a "bridge" between Medicaid/CHIP and Marketplace coverage.
Eligibility:	Limit enrollment to individuals previously enrolled in Medicaid and their family members, with incomes below 200% of the FPL, and parents of CHIP children up to 200% FPL. Limit enrollment to 12 months or less. (*California's Bridge plan under review by CMS does not limit to 12 months) *Estimated uptake in 2016: Previously OHP Eligible, 69,451; CHIP Parents, 40,444*
Benefits and Costs	Bridge Plans must meet QHP certification requirements. Enrollees would receive at least the same benefits and pay no more in premiums and cost sharing than they would for benchmark coverage in the Marketplace.
Financing	OHA/Cover Oregon would create a "new" second lowest cost silver plan (SLCSP) for Bridge Plan eligible. Bridge Plan is expected to be a lower cost alternative because it is built off the Plan's existing Medicaid provider network.
Financial Implications	Relative to QHP coverage, reduce consumer total annual out-of-pocket costs by $600-$1,725 (previously eligible/CHIP parents); Provider impact varies depending on reimbursement rate(s). Providers would receive lower reimbursement rates in BHP vs. QHP: either Medicaid or average b/w Medicaid/commercial reimbursement.
State Admin:	Estimated state admin costs $2.1-$5.7 million, annually.
Timing and Legislation:	Request for Application process for carriers for plan benefits year 2016 from Dec. 2014 – April 2015. June/July, 2015, CO certifies plans. Oct. 2015, 2016 plans become publicly available (open enrollment begins).
Advantages and Disadvantages	
Consumers	
Advantages: • Allows consumers to remain in their CCOs and maintain their providers as they transition to the Marketplace (during the one year transition) • Consumers would obtain the EHBs in the QHP but may lose some Medicaid covered benefits • Bridge eligibles will have lower premiums than individuals not in the Bridge Plan; reduces affordability cliff • Ensures whole family coverage (children and parents under 200% FPL are on the same plan) **Disadvantages:** • Bridge Plan is time limited; new transition occurs in one year • Equity issue for individuals who were never enrolled in Medicaid are not eligible to enroll in a Bridge Plan and will not benefit from the lower costs associated with Bridge Plans.	
State	
Advantages: None identified **Disadvantages:** • Administrative and systems complexity; eligibility and enrollment systems will have cost implications • Requires federal approval from CMS	
Cover Oregon	
Affect to Cover Oregon is unknown at this time.	
Plans and Providers	
Advantages: Medicaid CCOs are able to retain some of their members (with incomes from 139-200% FPL) as they transition to the Marketplace **Disadvantages:** • CCOs seeking to be Bridge Plans must meet QHP certification requirements • In order to reduce consumer costs, providers could be paid at a lower rate than what they would be paid in a QHP	
*Please see page 13 of the report for committee recommendation and Wakely Coverage options report.	

Appendix C: Policy Options and Considerations to Reduce, Avoid, or Mitigate Churn

Basic Health Plan (BHP)	
Overview:	Optional program for states to use federal tax credits and costs sharing reductions to subsidize coverage for individuals with incomes below 200% FPL who would otherwise be eligible to purchase coverage through the Marketplace. Depending on design, the BHP may also help consumers maintain continuity across plans and providers as their income fluctuates above and below Medicaid levels.
Eligibility:	Individuals with incomes between 139% and 200% FPL (and under 138% FPL for lawful immigrants subject to Medicaid 5 year bar), under age 65, and who meet all other eligibility requirements for QHPs. *Estimated uptake in 2016: 72,412.*
Benefits and Costs:	Enrollees must receive at least the same benefits and pay no more in premiums and cost sharing than they would in the Marketplace.
Financing:	The federal government pays the state 95% of value of the premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the applicable 2nd lowest cost silver Marketplace plan.
Financial Implications:	Potential to reduce annual consumer out-of-pocket costs from $460-$1,500 (break-even scenario); Provider impact varies depending on reimbursement rate(s).
State Admin:	Estimated state admin costs $6-$14 million, annually. OHA would need to set up a trust fund to receive federal funding for subsidies; administrative costs are not federally funded.
Timing and Legislation:	• BHP feasibility study due to the legislature in November 2014 per HB 4109 (2014). • Earliest implementation date for states is 2015; earliest feasible implementation date for Oregon would likely be 2016. • Would need legislatively approved budget authority, as federal funds are not available for state costs to establish and administer the program.
Advantages and Disadvantages	
Consumers	
Advantages: • Premiums and cost sharing lower than in QHPs • May result in more individuals securing coverage and complying with the individual mandate • Smoother transitions as incomes fluctuate at 138% FPL and smooths affordability cliff at 200% FPL **Disadvantages:** • BHP eligible consumers are ineligible for QHP subsidies and could only purchase QHP coverage at full price • New transition point and affordability cliff created at 200% FPL (depending on subsidy levels) • Marketplace eligible consumers may have higher premiums as a result of the decline in Marketplace participation; further financial modeling is needed	
State	
Advantages: • May help consumers maintain plan & provider continuity as income fluctuates above and below Medicaid levels • May provide FFM states greater control over the coverage options available for this population **Disadvantages:** • Federal funding may not cover cost of plans; State has financial exposure • State fiscal responsibility for start-up and ongoing administrative costs (eligibility and enrollment systems will be required with cost implications) • Administrative work required to compile rate cell data for payment rates	
Cover Oregon	
Advantages: None identified **Disadvantages:** • Fewer covered lives in the Marketplace may affect risk pool, increase QHP premiums, and affect financial sustainability and plan participation; further financial modeling needed • Reduced admin revenue from $9.38 PMPM admin fee for QHPs to $6.95 PMPM admin fee for state programs	
Plans and Providers	
Advantages: None identified **Disadvantages:** In order to reduce consumer costs, providers may receive lower reimbursement rates than in a QHP	
*Please see page 13 of the report for committee recommendation and Wakely Coverage options report.	

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Oregon Churn Mitigation Strategies

Medicaid Advisory Committee Meeting
March 26, 2014

Deborah Bachrach
Kinda Serafi

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Overview

- Overview of Program Churn
- Strategies to Mitigate Disruptions as a Result of Churn
- Strategies to Avoid or Reduce Churn
- Unique Pregnant Women Churn Considerations
- Discussion

Overview of Program Churn

What is Churn?

- Churn occurs when individuals experience a change in eligibility and, as a result, must **transition from one coverage vehicle to another**.

- The Urban Institute estimates **29.4 million individuals** under the age of 65 will change coverage vehicles from one year to the next:
  - An estimated 32 percent of individuals will experience a change in eligibility within six months of their Medicaid or Marketplace coverage
  - An estimated 51 percent of individuals will experience a change in eligibility within one year of their Medicaid or Marketplace coverage
  - An estimated 27 percent of Oregonians eligible for Medicaid will experience a change in eligibility due to income changes within twelve months

Source: Urban Institute, "Churning Under the ACA and State Policy Options for Mitigation," (June 2012); Sommers, B, Graves, John, et al, "Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact, " Health Affairs (April 2014).; SHADAC, "Medicaid Eligibility Churn as a Result of Income Shifts and Characteristics of Those Like to Churn: Oregon,"(July 2013).

What Are the Implications of Churn?

Changes include: cost-sharing, premiums, benefits provider network, and plan

Gaps in coverage

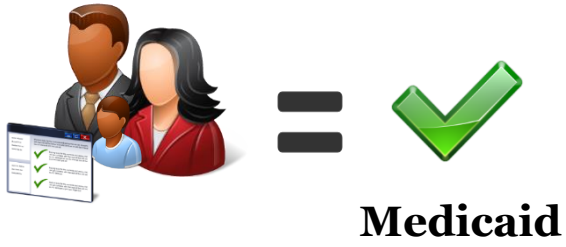
Different family members enrolled in **different coverage vehicles**

For example: husband, pregnant wife, 7 year old child with a family income of 150% FPL ($35,700 a year for a family of four):

- Pregnant mom is eligible for Medicaid until 60 days post partum;
- Husband is eligible for premium tax credits/cost sharing reductions;
- 7 year old child is eligible for CHIP; newborn will be eligible for Medicaid.

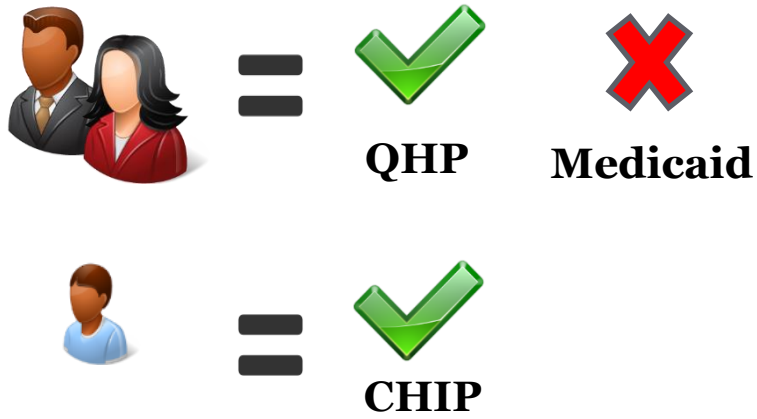
Meet the Smith Family

In December 2013, Mary (age 45), her husband Tom (age 42), and their son Bobby (age 7) applied for coverage. Their monthly income for a family of three was $2,000, making them eligible for Medicaid.



In March 2014, Tom gains part-time employment and their household monthly income increases to $2,500. Tom and Mary report the change in their income and their eligibility is re-evaluated.

Tom and Mary are ineligible for Medicaid but eligible for premium tax credits and cost sharing reductions when purchasing a Qualified Health Plan. Bobby is eligible for CHIP.



What Changes do the Smith Family Experience?

Cost-Sharing

- Mary and Tom went from having no cost sharing to having a maximum out of pocket obligation of $2,500/year*
- Bobby will have no cost sharing in CHIP.

Premiums

- Mary and Tom went from paying no monthly premiums to paying $103/month*
- Bobby will have no premiums in CHIP.

Plan Coverage

- Mary and Tom must change plans from a Coordinated Care Organization (CCO) to a Qualified Health Plan (QHP)
- Bobby stays in his CCO.

Provider Network

- Mary, Tom must change their doctors because the doctors who they were seeing under their CCO plan are not in network in their QHP.
- Bobby maintains his provider network.

Benefits

- Mary and Tom will experience a change in benefits including no coverage of vision, dental and non-emergency medical transportation.
- Bobby will not experience a change in benefits from Medicaid to CHIP.

Changes in cost-sharing, premiums, plan coverage and provider network will also occur if the Smith's family income changes from 250% of the FPL to 130% of the FPL

* This premium is the cost after receiving advanced tax credits for the second lowest cost silver plan in the Portland, OR area. The out of pocket maximum is based on the same second lowest cost silver plan.

Goals and Strategies to Address Churn

Mitigate Disruptions as a Result of Churn

Goals:

- Maintain access to the same plans and providers as family circumstances change
- Reduce the affordability cliff as a result of a transition from Medicaid to a QHP
- Enroll families in the same plan

Strategies:

- **Bridge Plan:** facilitates continuity of plans and providers; reduces affordability cliff; enables families with mixed coverage vehicles to enroll in the same plan; smooths change in benefits
- **Basic Health Plan:** reduces affordability cliff; may facilitate continuity of plans and providers
- **Tax Credits/Cost Sharing and Benefits Wrap:** reduces affordability cliff; smooths changes in benefits
- **Benefits and Provider Network Alignment:** enables continuity of benefits and providers during transition period

Goals and Strategies to Address Churn

Reduce or Avoid Churn

Goals:

- Reduce the number of times an individual moves from one coverage vehicle to another
- Minimize insurance gaps as individuals transition

Strategies:

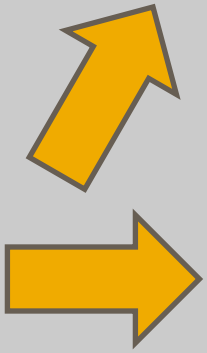
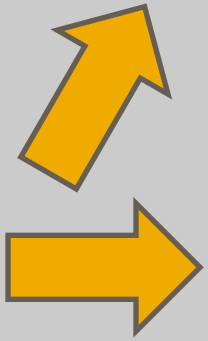
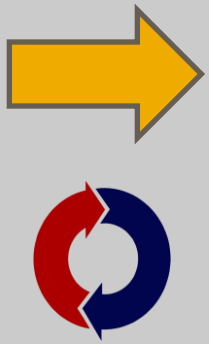
- Align income budget period rules
- Implement adult 12 month continuous eligibility for Medicaid
- Align coverage start and end dates by leveraging QHP enrollment rules

Strategies to Mitigate Disruptions as a Result of Churn

Basic Health Plan (BHP) Program Requirements

- **Overview**: States may use tax credits and costs sharing reductions to subsidize coverage for individuals with incomes below 200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through the Marketplace. States can use the BHP to reduce premiums and cost sharing for eligible consumers. Depending on design, the BHP may also help consumers maintain continuity across plans and providers as their income fluctuates above and below Medicaid levels.
- **Eligible Individuals:** Individuals with incomes between 138% - 200% FPL (and under 138% FPL for lawful immigrants subject to Medicaid 5 year bar), under age 65, and who meet all other eligibility requirements for QHPs.
- **Comparable, or Better, Costs and Benefits:** Enrollees must receive at least the same benefits and pay no more in premiums and cost sharing than they would in the Marketplace.
- **Financing Formula:** The federal government pays the state 95% of value of the premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the applicable 2nd lowest cost silver Marketplace plan.
- **Administration:** States must set up a trust fund to receive federal funding for subsidies; administrative costs are not federally funded.
- **State Activity:** Minnesota is pursuing a BHP; New York & Washington has pending state legislation to explore financial viability/implementation of a BHP; Oregon preparing to release RFP.

Basic Health Plan: Implications for Mary and Tom Smith

Transition Pathways	Cost Sharing	Premiums	Benefits	Plan	Provider Network
Mary and Tom transition from Medicaid to QHP. 				 Change	 Change
Mary and Tom transition from Medicaid to Basic Health Plan 	 Depending on the level of the subsidy	 Depending on the level of the subsidy		 Issuer will stay the same but the product will change	

Basic Health Plan: Advantages and Disadvantages

Advantages

- Premiums and cost sharing are lower than in QHPs
- May result in more individuals securing coverage and complying with the individual mandate
- Smoother transitions as incomes fluctuate at 138% FPL

Disadvantages

- Federal funding may not cover cost of plans; State has financial exposure
- Start-up and ongoing administrative costs not federally funded
- New transition point is created at 200% FPL
- Affordability cliff at 200% FPL (depending on subsidies of premium tax credits/cost sharing reductions)
- In order to reduce consumer costs, providers could be paid at a lower rate than what they would be paid in a QHP
- Exchange volume will decline; individuals eligible to enroll in a BHP are not eligible for a subsidized QHP
- Does not address whole family coverage issues

Bridge Plan Overview

- **Overview: A Coordinated Care Organization (CCO) that has been certified as a QHP and limits enrollment to consumers, and their family members, transitioning from Medicaid to the Marketplace**
- **Individual Eligibility:** Oregon could consider limiting enrollment to individuals previously enrolled in Medicaid, and their family members, with incomes below 200% of the FPL and also limiting enrollment to twelve months or less.
- **Bridge Plan Certification:** Bridge Plans must meet QHP certification requirements.
- **State Activity:** The Bridge Plan was originally developed by Tennessee but not implemented. California is awaiting approval from CMS to offer Bridge Plans to a projected 670,000 individuals with incomes below 200% FPL churning off of Medicaid.
- **Affordability**: The second lowest cost silver plan (SLCSP) will be different for Bridge Plan eligible individuals than non-Bridge Plan eligible individuals. As a result, the amount of the tax subsidy will differ even if the Bridge Plan eligible and Bridge Plan ineligible individuals have the same income. The Bridge Plan eligible individual will be able to use their tax subsidy to purchase a Bridge Plan which is expected to be a lower cost alternative because it is built off of the Plan's existing Medicaid provider network.

Bridge Plan Affordability

Bridge plan **eligible**

SLCSP = Plan Y

Peter is Bridge Plan eligible and therefore the SLCSP is **Plan Y.**

Peter is eligible for a tax credit of $68/mo ($125-$57).

Peter would pay **$22/month** if he enrolled in Plan X.

Bridge plan **ineligible**

SLCSP= Plan Z

George is not Bridge Plan eligible and his SLCSP is **Plan Z.**

George is eligible for a tax credit of $93/mo ($150-$57).

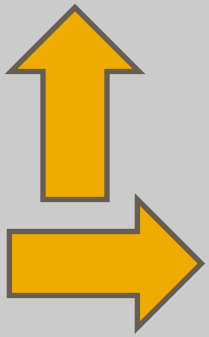
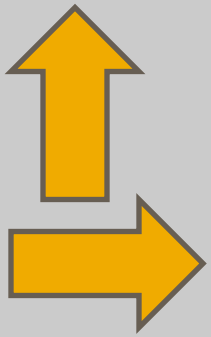
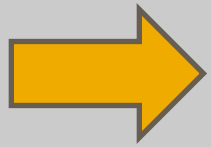
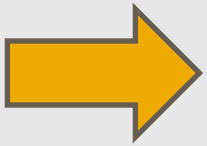
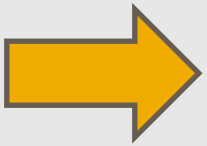
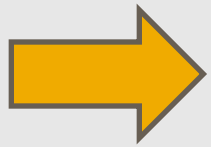
George would pay **$32/month** if he enrolled in Plan Y.

Two single-person households, Peter and George, with income at **150%** of FPL ($17,235), each have to pay **4%** of their income to buy the SLCSP ($689/year or $57/month).

Peter is eligible for a Bridge plan and George is not. Both are 35-year-old non-smokers.

Plan Selection Options	Plan's Monthly Premiums	Peter's Monthly Premiums (Bridge eligible)	George's Monthly Premiums (NOT Bridge eligible)
Plan X **(Bridge Plan only available to Peter)**	$90	$22	n/a
Plan Y (SLCSP for Peter; lowest cost silver plan for George)	$125	$57	$32
Plan Z (SLCSP for George)	$150	$82	$57

Bridge Plan: Implications for Mary and Tom Smith

Transition Pathways	Cost Sharing	Premiums	Benefits	Plan	Provider Network
Mary and Tom transition from Medicaid to QHP				 Change	 Change
Mary and Tom transition from Medicaid to non-subsidized Bridge Plan				 New coverage vehicle	
Mary and Tom transition from Medicaid to subsidized Bridge Plan				 New coverage vehicle	

Bridge Plan: Advantages and Disadvantages

Advantages

- Plans and provider network will stay the same during the one year transition (product changes)
- Reduces the affordability cliff
- Family members stay in the same plan

Disadvantages

- Bridge Plan is time limited; new transition occurs in one year
- Administrative and systems complexity
- Equity issue: individuals who were never enrolled in Medicaid are not eligible to enroll in a Bridge Plan and will not benefit from the lower costs associated with Bridge Plans.

State Subsidizes Premiums and Cost Sharing and Wraps Benefits

- **Overview:** State provides subsidies to reduce the cost of premiums and cost-sharing down to Medicaid levels using state-only dollars.

  State wraps additional Medicaid benefits not offered by a QHP using state-only dollars (e.g., non-emergency transportation, vision, dental).

- **Individual Eligibility:** Must meet QHP eligibility requirements; Oregon considering income eligibility of up to 200% of the FPL.
- **Financing:** No federal funding available; must use state only dollars.
- **State Activity**: Massachusetts subsidizes premiums and cost-sharing for individuals with incomes up to 300% of the FPL. (Received a waiver and uses federal Medicaid dollars for subsidies)

QHP Cost-Sharing, Premium and Benefits Wrap: Implications for Mary and Tom Smith

Transition Pathways	Cost Sharing	Premiums	Benefits	Plan	Provider Network
Mary and Tom transition from Medicaid to QHP 	↑	↑	↓	Change	Change
Mary and Tom transition from Medicaid to fully subsidized QHP with benefit wrap	→	→	→	Change	Change

QHP Cost Sharing, Premium and Benefit Wrap Advantages and Disadvantages

Advantages

- Premiums and cost sharing will not change as a result of transition
- Benefits will not change as an individual transitions from Medicaid to QHP

Disadvantages

- New transition occurs above 200% FPL
- Significant affordability cliff at 200% FPL
- Cost sharing, premium and benefit wrap must be paid for with state only dollars
- Administratively complex to wrap cost-sharing, premiums and benefits

Benefits and Provider Network Alignment Strategy

- **Overview:** Leverage QHP contracting process to mitigate disruptions in coverage and care during transition period.
- Maximize QHPs participating as CCOs and CCOs participating as QHPs; require or incent CCOs/QHPs to maintain same provider network in QHP and CCOs
- Require QHPs to cover on-going medical treatment and medications during transition period
- Require QHPs to cover out of network care during transition period
- Honor prior authorization during transition

Alignment in Benefits and Provider Networks: Implications for Mary and Tom Smith

Transition Pathways	Cost Sharing	Premiums	Benefits	Plan	Provider Network
Mary and Tom transition from Medicaid to QHP	↑	↑	↓	⟳	⟳
State contracts with QHPs participating as CCOs and CCOs to participate as QHPs and maintain same provider networks	↑	↑	↓	⟳ Same plan/different product	⟳ Same plan/different product
QHPs cover medical treatment and medications	↑	↑	→ For limited period	⟳	⟳
QHPs cover out-of-network care	↑	↑	→ For limited period	⟳	→ For limited period
QHPs honor prior authorization	↑	↑	→ For limited period	⟳	⟳

Strategies to Avoid or Reduce Churn

Aligning Medicaid and Tax Credits' Income Budget Periods

- **Background:** Medicaid/CHIP eligibility is based on monthly income; tax credits/cost sharing reductions' eligibility is based on projected annual income.

  Coverage black hole: When an individual is found ineligible for Medicaid based on monthly income and ineligible for tax credits/cost sharing reductions based on projected annual income, regulations require Medicaid eligibility to be based on projected annual income. As a result, the individual will be eligible for Medicaid.

- **Regulatory Budget Period Options for Medicaid:**
  - For new applicants, the state may take into account **reasonably predictable changes** in income
  - For Medicaid MAGI beneficiaries renewing their coverage, the state may use a **projected annual budget** period as well as take into account "reasonably predictable changes" in income

Aligning Medicaid and Tax Credits' Income Budget Periods

Advantages

- Individual does not ping pong between Medicaid and tax credits/cost sharing reductions every time income fluctuates, so long as annual income remains below Medicaid eligibility levels
- Addresses coverage black hole problem

Disadvantages

- May require programming changes in eligibility systems and application questions to take into account reasonably predictable changes and projected annual income

12 Month Continuous Medicaid Eligibility

- **Overview:** Regardless of change in income eligibility individuals remain eligible for 12 months. Option available for children and adults.
- **Authority:** State must seek 1115 Waiver approval for adult 12 month continuous eligibility.
- **Match Rate:** CMS assessed that 97.4 percent of the cost should be financed at the enhanced matching rate available for newly-eligible adults and the remaining 2.6 percent at a state's regular Medicaid matching rate.
- **Financing:** The federal government will finance **99 percent** of the cost of providing 12 month continuous coverage to adults newly eligible for Medicaid in Oregon.

12 Month Continuous Medicaid Eligibility

Advantages

- Eliminates churn for adults during coverage year
- Simplifies administrative processes for the state
- Offers health plan issuers and providers a more reliable source of revenue and greater certainty about the population they will be serving.

Disadvantages

- State fiscal obligation for the costs of 12 months continuous coverage for newly eligible
- Matching rate for currently eligible adults is unknown

Alignment of Start and End Dates

- If start date of a QHP doe snot align with Medicaid end dates, then there is a gap in coverage:

If QHP Selection Date . . .	***. . . Then Coverage Effective Date***
Between 1st and 18th of month	1st day of following month
Between 19th and last day of month	1st day of second following month

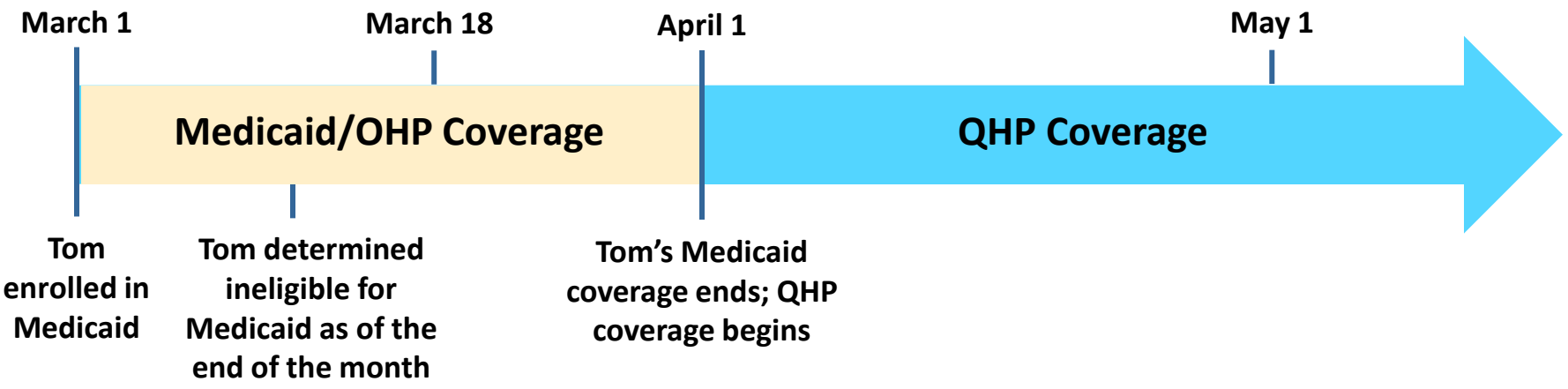
45 C.F.R. 155.410

- In Oregon, Medicaid coverage continues until last day of month that enrollee loses Medicaid eligibility.

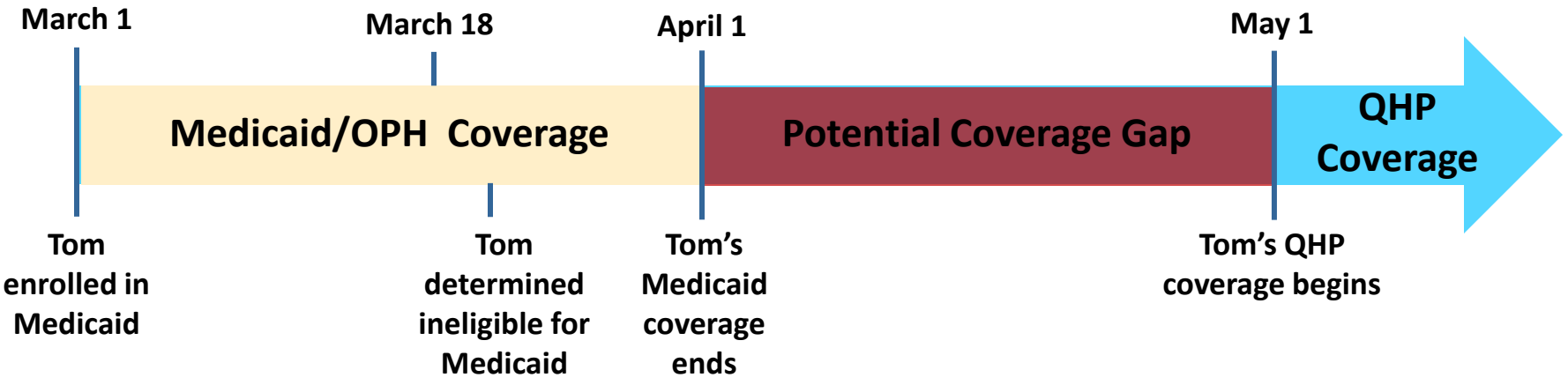
If QHP Selection Date . . .	***. . . Then There Is…***
Between 1st and 18th of month	**No** coverage gap
Between 19th and last day of month	**Coverage gap**

Potential Coverage Gaps When Transitioning from Medicaid to a QHP

Scenario 1: Tom determined ineligible for Medicaid and selects QHP between 1st - 18th of month



Scenario 2: Tom loses Medicaid eligibility and selects QHP between 19th - last day of month



Leveraging QHP Effective Date Rules

1

CCIIO allows states to establish earlier effective dates for QHP coverage

- Establish QHP coverage effective date as first day of month following loss of Medicaid eligibility, regardless of when the person selects a QHP
- E.g. Tom loses coverage March 29th and is permitted to enroll in a QHP effective April 1st

ACA 1321(d); 45 C.F.R. 155.120(b)

2

CCIIO allows for early QHP application submission if impending Medicaid ineligibility is known

- For example, pregnant woman with income 133%-190% FPL will lose Medicaid 60 days post-partum. Since final date is known, eligibility could be assessed and effective date established

CCIIO guidance; 26 C.F.R. 1.36B-2(a)(2)

Alignment of Start and End Dates

Advantages	Disadvantages
• Eliminates coverage gaps	• There does not appear to be any disadvantages

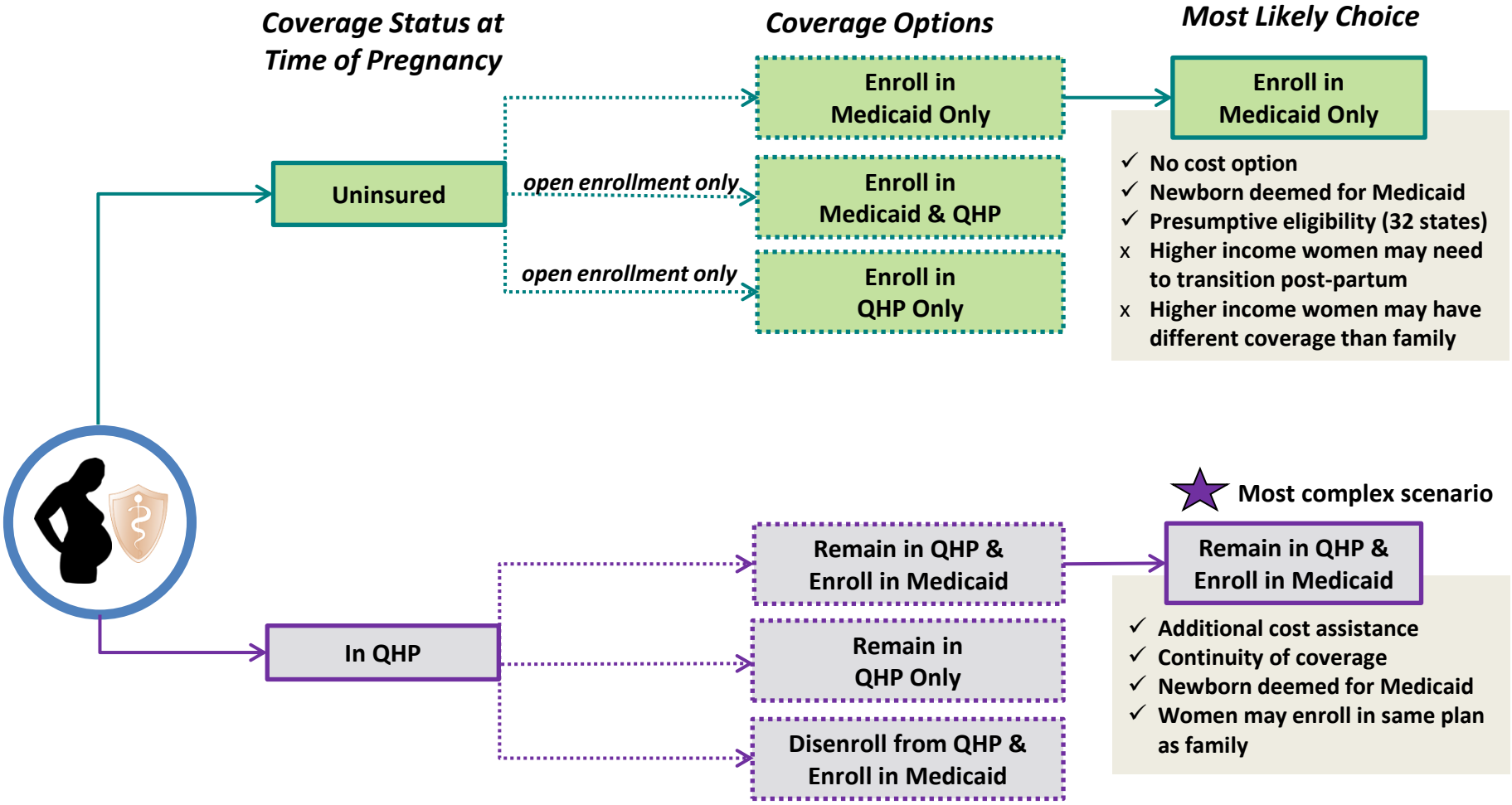
Special Churn Considerations for Pregnant Women

IRS Minimum Essential Coverage Final Rule

- **Pregnancy-related Medicaid coverage — provided under 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) – is not considered minimum essential coverage (MEC)**
- **Women enrolled in pregnancy-related services remain eligible for subsidized QHP**
- **Women who do not enroll in QHP would subject to a coverage penalty, however women covered with pregnancy-related Medicaid in 2014 will not be liable for the penalty**

78 FR 53646, § 1.5000A–2

Pregnant Women Coverage Scenarios



Oregon Churn Mitigation Strategies:

Stakeholder Considerations

Basic Health Program: Stakeholder Considerations

Consumer Considerations:

- BHP eligible consumers will have more affordable coverage than what they would have received if they were in a QHP
- BHP eligible consumers are ineligible for QHP subsidies; BHP eligible consumers will not have QHP consumer choice unless they purchase QHP at full price
- Marketplace eligible consumers may have higher premiums as a result of the decline in Marketplace participation; further financial modeling is needed
- Smooths affordability cliff for individuals with income below 200% of the FPL
- Creates new transition point at 200% of the FPL

Provider Considerations:

- Providers may receive lower reimbursement rates than what they would have received in a QHP

Basic Health Program: Stakeholder Considerations (cont'd)

State Considerations:

- Tax credits and cost-sharing subsidies may not cover the costs of the BHP
- State fiscal responsibility for start-up and ongoing administrative costs
- Eligibility and enrollment systems will be required with cost implications
- Administrative work required to compile rate cell data for payment rates
- Unmet costs to be borne by the state

Marketplace Considerations:

- QHP premiums may increase because there will be fewer covered lives in the Marketplace; further financial modeling needed
- Fewer covered lives in the Marketplace may affect risk pool, financial sustainability and plan participation; further financial modeling needed
- Reduced administrative revenue for the Marketplace—a decline from $9.38 PMPM admin fee for QHPs to $6.94 PMPM admin fee for state programs

Bridge Plan: Stakeholder Considerations

Consumer Considerations:

- Allows consumers to remain in their CCOs and maintain their providers as they transition to the Marketplace
- Consumers would obtain Essential Health Benefits in the QHP but may lose some Medicaid covered benefits
- Ensures whole family coverage where children and parents are in the same plan despite transition to the Marketplace
- Bridge eligible consumers will have lower premiums than individuals not in the Bridge Plan
- Consumers not eligible for the Bridge Plan because they were not enrolled in Medicaid will have higher premiums than individuals in the Bridge Plan

Plan Considerations:

- CCOs keep covered lives as consumers transition from Medicaid/CHIP to the Exchange
- CCOs seeking to be Bridge Plans must meet QHP certification requirements

Bridge Plan: Stakeholder Considerations (cont'd)

State Considerations:

- Eligibility and enrollment systems will be required with cost implications
- Requires federal approval from CMS

Marketplace Considerations:

- No readily apparent effect to the Marketplace

Benefits and Provider Network Alignment Strategy

- **Overview**
  - Leverage QHP contracting process to mitigate disruptions in coverage and care during transition period.
- **Same Providers**
  - Require or incent CCOs and QHPs to maintain same provider network in Medicaid and the Marketplace.
- **Same Benefits**
  - Require CCOs /QHPs receiving enrollees to be responsible for care previously provided by a relinquishing payor for a limited period of time.
  - Examples in state managed care contracts include:
    - pregnancy coverage;
    - certain dental care, such as orthodontia;
    - hospitalizations or transplants;
    - chemotherapy, radiation therapy, and dialysis;
    - individuals with ongoing needs such as durable medical equipment, home health services, or prescription medications;
    - individuals with prior authorizations for procedures; and
    - behavioral health and chemical dependency services.

Benefit and Network Alignment: Stakeholder Considerations

- **Consumers**
  - Enables continuity of providers as individual transitions between QHP and CCO
  - Enables on-going treatment during transition
- **Plans**
  - Imposes fiscal obligation to cover select services and treatment during transition
- **Providers**
  - Maintain patient relationship during course of treatment
- **State and Marketplace**
  - May require incentives for CCOs to participate as QHPs and vice versa
  - Will require regulation or contract provisions to ensure continuing treatment during transition

Aligning Income Budget Periods for Medicaid & Tax Credits

Income Budget Period Rules:

- Medicaid/CHIP eligibility is based on monthly income.
- Tax credits/cost sharing reductions' eligibility is based on projected annual income.

Implications of Misalignment of Budget Periods:

- When an individual is found ineligible for Medicaid based on monthly income and ineligible for tax credits/cost sharing reductions based on projected annual income, regulations require Medicaid eligibility to be based on projected annual income. As a result, the individual will be eligible for Medicaid.
- Individuals may ping back and forth from Medicaid to advance premium tax credits/cost sharing reductions each month, even though their annual income is below Medicaid eligibility levels.

Resolution:

- For new applicants, the state may take into account **reasonably predictable changes** in income.
- For Medicaid MAGI beneficiaries renewing their coverage, the state may use a **projected annual budget** period as well as take into account "reasonably predictable changes" in income.

Aligning Income Budget Periods: Stakeholder Considerations

Consumers

- By aligning income budget periods, the individual stays in Medicaid even if their monthly income fluctuates, so long as their annual income remains below Medicaid eligibility levels.

Plans

- CCOs will have a more reliable source of revenue and greater certainty about the population they will be serving.

Providers

- Providers will have a more reliable source of revenue and greater certainty about the population they will be serving.

State and Marketplace

- May require programming changes to eligibility systems to account for reasonably predictable changes at application and projected annual income at renewal; may also require changes to questions asked on single streamlined application and renewal form.
- May be a state fiscal obligation for Medicaid enrollees once enhanced FMAP begins to decrease.

12 Month Continuous Medicaid Eligibility

- **Overview:** Regardless of change in income eligibility individuals remain eligible for 12 months. Option available for children and adults.

- **Authority:** State must seek 1115 Waiver approval for adult 12 month continuous eligibility for adults; for children state may submit a State Plan Amendment

- **Match Rate:** The federal government will finance **99 percent** of the cost of providing 12 month continuous coverage to adults newly eligible for Medicaid in Oregon.

Continuous Eligibility: Stakeholder Considerations

- **Consumer:**
  - Children and adults will maintain Medicaid/CHIP coverage for 12 months regardless of a change in eligibility.
- **Plan:**
  - CCOs will have a more reliable source of revenue and greater certainty about the population they will be serving.
- **Provider:**
  - Providers will have a more reliable source of revenue and greater certainty about the population they will be serving.
- **State and Marketplace:**
  - Continuous eligibility simplifies administrative processes.
  - There will be a fiscal obligation for the costs of covering the newly eligible.
  - The matching rate for the costs of currently eligible individuals is unknown.

Alignment of Start and End Dates

- In Oregon, Medicaid coverage continues until last day of month that enrollee loses Medicaid eligibility.

If QHP Selection Date . . .	***. . . Then There Is…***
Between 1st and 18th of month	**No** coverage gap
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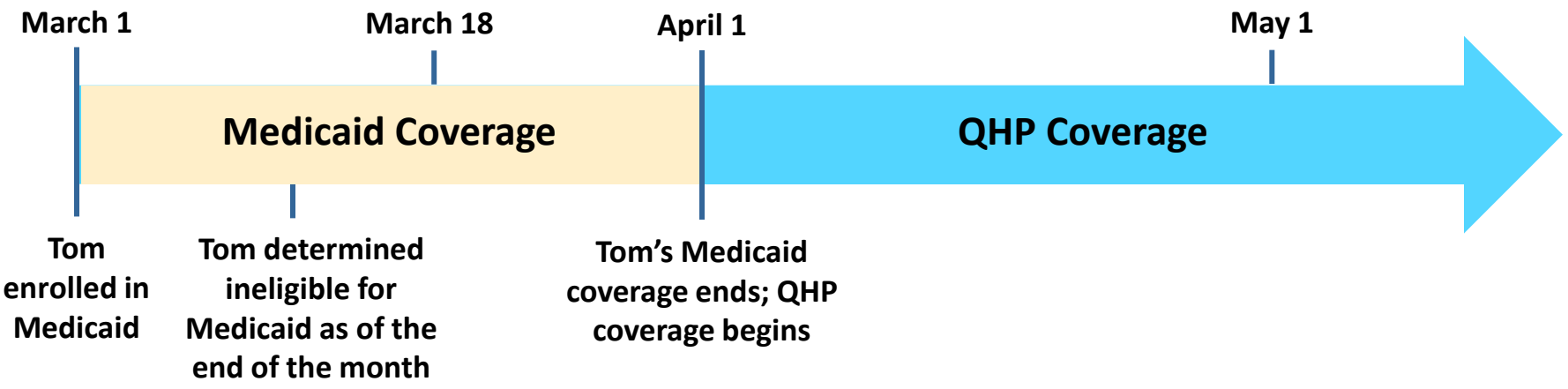

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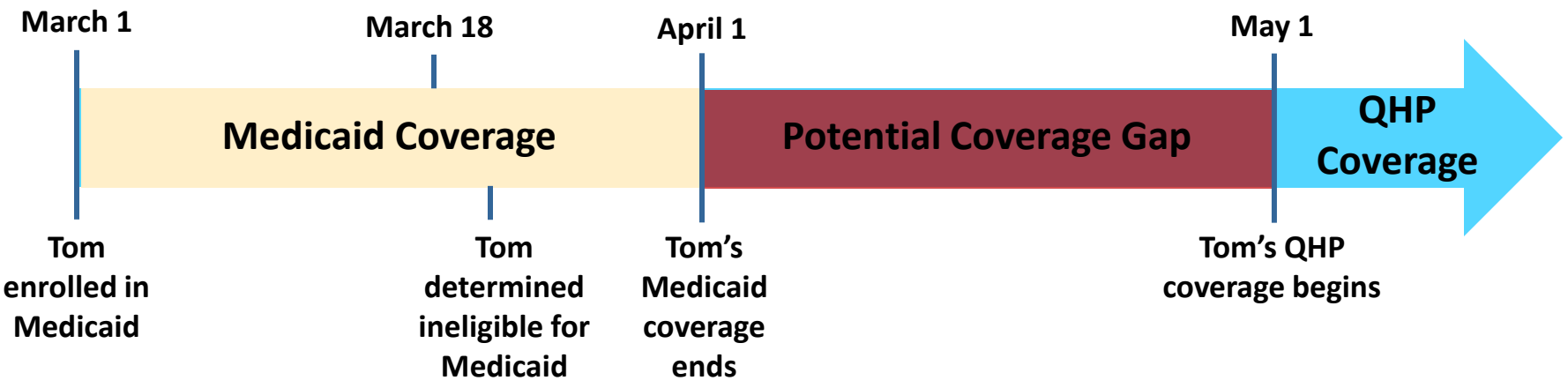

Wakely
Consulting Group

Financial Implications of Alternative Coverage Programs in Oregon

Tim Courtney, F.S.A., M.A.A.A.

April 24, 2014

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Table of Contents

Executive Summary

The Affordable Care Act (ACA) has introduced several reforms that have changed and will continue to change the health insurance market dynamics for states. In particular, the expansion of Medicaid eligibility and the introduction of the health insurance marketplace with its associated premium and cost sharing subsidies established a new continuum of coverage opportunities for individuals.

An emerging concern for states is the potential for individuals to lose eligibility for coverage under the different programs due to income fluctuations and other changes in family circumstances. As a result, individuals may involuntarily shift or churn in and out of programs. The Urban Institute estimates 29.4 million individuals under the age of 65 will change coverage vehicles from one year to the next:

- An estimated 32 percent of individuals will experience a change in eligibility within six months of their Medicaid or Marketplace coverage;[1]
- An estimated 51 percent of individuals will experience a change in eligibility within one year of their Medicaid or Marketplace coverage;[2]
- An estimated 27 percent of Oregonians eligible for Medicaid will experience a change in eligibility due to income changes within twelve months.[3]

There are several options available to states seeking to smooth coverage transitions for low-income residents. This report analyzes three alternative coverage options or programs for Oregon to consider:

1. The Basic Health Program (BHP): option under the Affordable Care Act (ACA) allows states to provide federally subsidized coverage to individuals with incomes between 138%-200% of the Federal Poverty Level (FPL), and lawfully present non-citizens below 138% FPL not eligible for Medicaid due to resident status.
2. Bridge Plan: program establishes a limited coverage option for individuals and their family member transitioning from Medicaid, to maintain the same Medicaid carrier that becomes a certified qualified health plans (QHPs) on the exchange.
3. Wraparound Plan: program where the State directly pays for additional benefits and/or a portion of consumer premiums and/or cost sharing above federal subsidy levels, for certain eligible persons.

[1] Urban Institute, "Churning Under the ACA and State Policy Options for Mitigation," (June 2012); Sommers, B, Graves, John, et al, "Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact, " Health Affairs (April 2014).
[2] Urban Institute, "Churning Under the ACA and State Policy Options for Mitigation," (June 2012); Sommers, B, Graves, John, et al, "Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact, " Health Affairs (April 2014).
[3] SHADAC, "Medicaid Eligibility Churn as a Result of Income Shifts and Characteristics of Those Like to Churn: Oregon,"(July 2013).

Wakely was asked by Oregon to evaluate these options from the perspective of assessing each program's potential impact on consumer affordability and coverage, and the financial impact to the State and Oregon's health insurance exchange, Cover Oregon.

Our preliminary findings include the following:

- The BHP offers the State an opportunity to provide annual out-of-pocket savings of about $460 to $1,500 per capita for consumers with no outlays required of the State other than to administer the program. We estimate these state administrative costs to be between $6 and $14 million, annually. The consumer savings increase as carriers are able to negotiate lower reimbursement with providers; however, we estimate that savings can be achieved even if carriers negotiate the same level of reimbursement currently used for qualified health plans (QHPs) in the Exchange.

- The Bridge Plan program has the potential to provide even higher per capita out-of-pocket savings, although for more limited population transitioning out of Medicaid, than the BHP. The consumer savings of the Bridge Plan program are highly dependent on the level of provider reimbursement that participating carriers are able to negotiate. , The Bridge could facilitate annual savings of $600 to $1,725 per person at an estimated cost of to the State of $2.1 to $5.7 million

- The Wraparound program could provide annual out-of-pocket savings of $11 to $24 per capita per $1 million of State expenditures. Additional benefits in the form of reduced out-of-pocket expenses or extra plan benefits could be provided to consumers at an added cost (i.e. beyond purely operational costs) to the State under either the BHP or Bridge Plan programs. Since the program is entirely State funded, our analysis merely represents an estimate of State expenses required to provide different levels of subsidy.

The analysis in this report is highly dependent on assumptions and has limitations. Any policy decisions based on this analysis should consider the reasonableness of our assumptions and caveats described. In particular, the following caveats should be understood:

- This report was developed prior to the April 25th 2014 announcement by the Cover Oregon Board of Directors, which stated that beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology. The Oregon Health Authority will take over Medicaid eligibility in 2014.

- Wakely's analysis is for 2016 only. The implementation of a BHP or Bridge Plan is likely to change the premium levels and demographic composition of the Qualified Health Plan (QHP) market offered through the Exchange. Projected alternative program results in 2017 and future years may not necessarily be similar to the 2016 projections in this report.

- The analysis is highly dependent on the 2014 premiums developed by Oregon insurance carriers. The BHP analysis assumes that claims costs used to develop premiums provide a good approximation of actual claims costs. The Bridge analysis assumes that the dynamics of the differences between the first and second lowest cost Silver plans do not change materially.

- The impact of an alternative coverage program on the individual QHP market is outside the scope of this report.

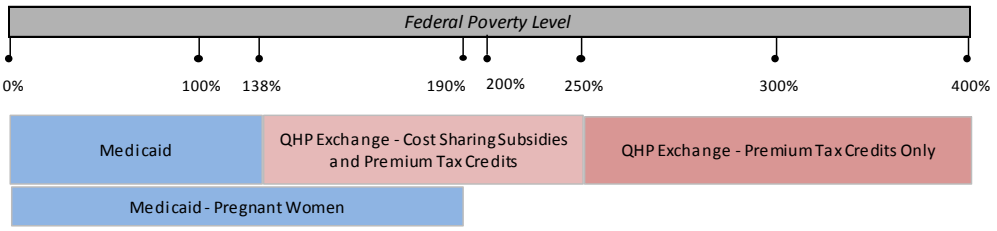
- This report focuses on the financial impact of different programs. There may be other non-financial advantages or disadvantages to these programs that that the State will want to consider. These other considerations are outside the scope of this report.

- Our results can be sensitive to assumptions. While we believe the assumptions used are reasonable, Wakely does not warrant that the results presented and underlying assumptions will be achieved.

Oregon Enrollment Dynamics Resulting from ACA

Beginning in 2014, the Affordable Care Act (ACA), together with decisions made by the State of Oregon, prompted an expansion of Medicaid eligibility to include all adults with incomes up to 138% of the Federal Poverty Level (FPL). For the individual market, the State elected to create its own health insurance exchange called Cover Oregon. Individuals who enroll in Cover Oregon will be eligible for federal premium tax credits and cost sharing subsidies according to income levels.

Below is a high level picture of Oregon's insurance affordability programs available to residents at different income levels.



The Medicaid expansion coupled with financial assistance for individuals with incomes up to 400% of the FPL created a new continuum of subsidized coverage. While these changes provide expanded coverage opportunities for Oregon residents, they create new transition points where residents will gain and lose eligibility for different health coverage programs, due to income fluctuations or other changes in family circumstances. As a result, individuals will experience changes in benefits, premiums and cost sharing levels. This issue, often called "churn," has the following potential effects for residents:

- ***Continuity of care***. As individuals gain or lose eligibility for Medicaid and change health coverage programs, there can be a discontinuity in provider relationships.
- ***Covered Benefits***. The Medicaid program in Oregon covers more services than the Qualified Health Plan (QHP) benchmark plan in Cover Oregon (most notable is adult dental). Appendix A is a summary of the differences in coverage between the OHP (Medicaid) program and the QHP benchmark plan.
- ***Affordability and Out of Pocket Expense***. As residents' incomes fluctuate, out-of-pocket expenses for health insurance premiums and cost sharing can vary significantly and abruptly at certain key points in the income continuum. Table 1 shows the maximum consumer premium and cost sharing subsidies for QHP eligible by income level as a percentage of FPL.

Table 1 Maximum Premium Payments and Cost Sharing by Household Income Level			
Income as % of FPL	Maximum Premium		Maximum Cost Sharing (AV)
	Low Threshold	High Threshold	
133%-150%	3.0%	4.0%	94%
150%-175%	4.0%	5.2%	87%
150%-200%	5.2%	6.3%	87%
200%-250%	6.3%	8.1%	73%
250%-300%	8.1%	9.5%	70%
300%-399%	9.5%	9.5%	70%

Churn can also create challenges for the State and carriers, including:

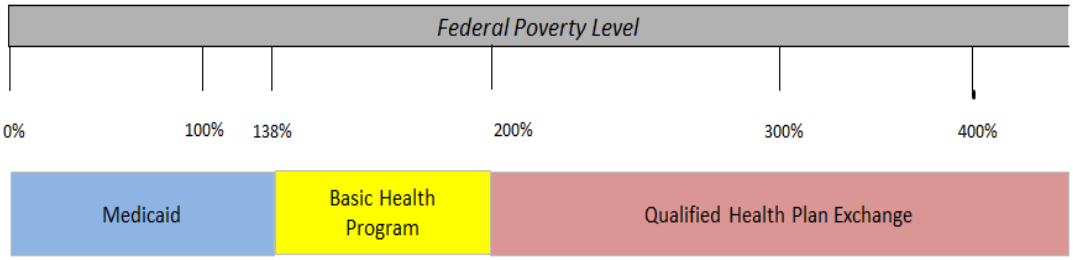
- Frequent turnover in enrollment, which increases administrative expenses for the Oregon Health Authority, Cover Oregon and health plans.
- Frequent enrollee switching among health plans, can compromise Medicaid's and Cover Oregon's efforts to measure and compare quality across contracted health plans over time.
- Undermining of incentives for health plans and providers to invest in longer-term health improvements, because enrollment turnover means health plans cannot be assured of benefitting from such investments.

In order to counteract some of these potential disruptions, Oregon is considering three alternative coverage options:

1. ***Basic Health Program***. The Basic Health Program (BHP) is a provision in the Affordable Care Act allowing states to establish coverage for residents with incomes between 138% and 200% of FPL[4] and lawfully present non-citizens below 138% FPL who are not yet eligible for Medicaid because they have not resided in the U.S. for 5 years. The federal government pays states about 95% of the premium tax credits and cost sharing subsidies that individuals would have otherwise received to purchase QHPs in the Exchange. The State in turn is responsible for providing coverage with benefits and out-of-pocket costs that are the same or better than what BHP eligible individuals would have received in QHPs. The State must establish a competitive process to contract with standard health plan offerors.

[4]The ACA sets the eligibility threshold at 133% FPL but provides for an additional 5% income disregard, creating an effective eligibility cut-off of 138% FPL. Data used in our analysis was based on a 138% FPL cutoff.

The graphic below shows how the BHP fits in between Medicaid program and QHPs in the Exchange.



2. ***Bridge Plan***. This program allows issuers that contract with the State for Medicaid to offer qualified health plans in the exchange to individuals at or below 200% FPL who were previously eligible for Medicaid or are adult parents of a CHIP-eligible child up to 200% FPL.

3. ***Wrap***. This is a state-funded program that provides additional benefits and/or, reduced premiums and/or cost sharing to individuals enrolled in a QHP on the Exchange. For purposes of this report, eligibility is the same as that for the Bridge Plan.

It is important to note that implementation of any of the above coverage alternatives will have an impact on enrollment in QHPs and residents who do not meet the eligibility requirements of these alternative programs. It is outside the scope of this report to analyze this impact; however, any decision to adopt an alternative coverage program should consider how it will affect premium and morbidity levels in the Marketplace.

Wakely Financial Impact Modeling

The Oregon Health Authority asked Wakely Consulting Group (Wakely) to assess the financial impact of the BHP, Bridge and Wrap coverage alternatives. For each coverage option, Wakely modeled estimated revenues and expenses (claims and administrative) from the perspective of the State, Cover Oregon, as well as the affordability impact to consumers (where appropriate).

In order to assess the financial impact, Wakey built a detailed model with demographic, claim cost, and premium data by household. The primary data sources for this model were the State Health Access Data Assistance Center (SHADAC) study to determine potential BHP enrollment, American Community Survey (ACS) demographic data, and CY2014 QHP rate filings by age and region in the State of Oregon. Appendix B provides a brief description of the SHADAC projection model.

In general, the financial impact for each coverage option was modeled within the following framework:

- All cash flows and demographic assumptions are projected to 2016. This inherently involves a projection of several factors, including:
  - Coverage decisions made by residents in 2014, 2015 and 2016 given the availability of qualified health plans on the exchange, expanded Medicaid and other elements of the ACA, first implemented in 2014.
  - Premium and claim cost trends.
  - Impact of induced utilization on claim costs due to a change in the relative richness of coverage (or versus no coverage at all). Induced utilization is the expected increase in utilization of medical services as a result of reduced cost-sharing, thus decreasing financial barriers to individuals' seeking care.
  - Estimated changes in the federal reinsurance program.
- Comparisons of cash flows and financial impact are made between the given program being considered and the absence of that program. When modeling cash flows in the absence of a coverage alternative, we assumed the coverage decision in 2016 would be no different than in 2015. For example, individuals who are projected to be uninsured in 2015 would also be uninsured in the "absence" of the program 2016.
- We assumed all enrollees in the exchange choose a Silver plan. Although this will not be the case in practice, it will produce the lowest estimate of out-of-pocket expenses for exchange enrollees since cost sharing subsidies are only available if the Silver plan is chosen.
- Certain scenarios in our models assume that managed care organizations are able to negotiate provider reimbursement levels that are lower than commercial levels. It is important to note that the results of our BHP and Bridge analyses are highly sensitive to this assumption.
- We assumed that alternative coverage options would produce operational and administrative costs for the State. For the BHP, the state administration costs are assumed to be three or seven percent of federal revenues (this estimate is based on BHP analysis

from Utah[5] and Washington[6]). State administration costs in the Bridge and Wrap scenarios are assumed to be 10% of estimated commercial carrier administration expenses in the exchange[7].

- For each coverage option, three different scenarios were modeled that ranged from a "nominal" consumer benefit scenario in terms of benefit coverage (commercial EHB vs. OHP) and affordability (limited subsidizing of premiums and cost sharing), to an "enhanced" benefit scenario (i.e. both OHP benefit levels and no member premium or cost-sharing).
- Start-up administrative expenses incurred by the State were not included in our analysis

The remainder of this report discusses Wakely analysis of the BHP, Bridge and Wrap program alternatives. Each section presents financial results, provides a detailed description of the program structure, describes the characteristics of the eligible population, and describes the assumptions and methods underlying our analysis.

Model Assumptions

Variables	Modeling Options	
Delivery System	Medicaid CCOs	Marketplace QHPs
Provider Reimbursement Levels	Average of Medicaid and Commercial	100% Commercial
Benefits Covered	Commercial EHB Benchmark	OHP *Plus*
Consumer Premiums and Cost Sharing	Level of subsidization beyond federal requirements (none → full)	
State Administrative Expenses	Low	High
Funding	*Funding mechanisms dependent on option.*	

[5]Buettgens M, Dorn S, Roth J, Carroll C (2012) The Basic Health Program in Utah. Washington, DC. The Urban Institute. http://www.urban.org/health_policy/url.cfm?ID=412695

[6]Buettgens M, Carroll C (2012) The ACA Basic Health Program in Washington State. Washington, DC. The Urban Institute. http://www.urban.org/health_policy/url.cfm?ID=412572

[7] QHP carriers are allowed to operate at an 80% medical loss ratio, thus 10% of their 20% admin costs equals the state's 2% program admin costs.

Basic Health Program

To better understand the benefits and risks of a Basic Health Program (BHP) in Oregon, Wakely assessed the financial impact of the BHP on the eligible populations as well as the State and the exchange. We used a detailed model to provide financial projections of the potential costs associated with a BHP.

1. Structure of the Basic Health Program

The BHP is an optional State-run program that offers a federally subsidized alternative for States to provide the essential health benefits to low- and moderate-income individuals between 138% and 200% of the federal poverty level (FPL). There are numerous details in the ACA language as well as implementing regulations. For purposes of this report, we highlight only key features of the law and federal guidance to date.

Eligibility

The following individuals are eligible to enroll in a BHP:

- Residents of the State who:
  - Have incomes between 138% and 200% FPL
  - Are U.S. citizens or lawfully present immigrants (in the U.S. for five or more years)
  - Under age 65
  - Are not eligible for coverage under the State's Medicaid program, the Children's Health Insurance Program (CHIP) or Military/CHAMPUS-TRICARE
  - Do not have access to Employer-Sponsored Insurance (ESI) that meets ACA standards
  - Meet all other eligibility criteria for a QHP(comprehensive and affordable) or other forms of minimum essential coverage (MEC)
- Lawfully present immigrants with income up to 138% of FPL and who are not eligible for Medicaid as a result of the five year waiting period.

In a state that establishes a BHP, BHP-eligible individuals are not eligible to receive federal subsidies in the form of premium tax credits and cost-sharing reductions, to purchase qualified health plans in the Exchange.

Delivery System and Provider Reimbursement Levels

States choosing to implement a BHP must establish a competitive process for entering into contracts with health plans that must provide at least the essential health benefits. Contracting plans are subject to a medical loss ratio requirement of 85%.

Our model assumes that the BHP in Oregon will likely be administered by the Medicaid agency and build on the state's Medicaid Coordinated Care Organizations (CCOs). This would allow states to cover low-income parents and children in the same or similar plans, and by the same provider

networks. Since residents eligible for the BHP will share many similar characteristics with individuals eligible for the Medicaid program, managed care plans wishing to contract with the State are likely to be those that have successful relationships with the State's Medicaid program. Several aspects of the State contracting process described in the ACA are likely to align well with items considered by the State in its process of selecting managed care plans or CCOs with which to contract for Medicaid-eligible residents.

There may be an incentive for Medicaid managed care plans or CCOs to also contract with the State for a BHP because it will preserve membership stability as members gain and lose Medicaid eligibility. This stability should in turn give plans leverage to negotiate provider reimbursement rates that are more favorable than Medicaid levels.

For purposes of the BHP modeling, we considered two scenarios:

1. Assume plans negotiate provider reimbursement rates halfway between estimated commercial levels and the Medicaid fee schedule.
2. 100% of estimated commercial fee levels. Commercial fee levels were estimated based on implied costs from the second lowest cost Silver plans by region.

It is important to note that results are highly sensitive to the assumed provider reimbursement levels that plans are assumed to achieve. While it is difficult to predict what the actual result will be, we believe the two scenarios modeled represent a reasonable range of likely results. It is possible that actual reimbursement could be higher or lower than the range presented in this report.

Benefit Levels

Health plans contracting with the State BHP must provide benefits at least equal to the essential health benefits benchmark plan in the State. States can elect to offer additional benefits not included in the essential health benefits plan.

For the modeling in this report, we assumed one of two benefit options:

1. The Oregon EHB benchmark plan (PacificSource Preferred CoDeduct)
2. The Oregon Medicaid Alternative Benefit Package (APB), the Oregon Health Plan Plus

Appendix A provides a detailed comparison of covered services under these two designs.

BHP Funding

The federal government will make prospective payments to States implementing a BHP. All federal BHP funds must be spent on BHP consumers and cannot be used to cover state program administrative expenses.

The trust fund may only be used to:

a. Reduce member premiums and cost sharing
b. Expand covered services
c. Increase provider reimbursement rates to encourage provider participation in the BHP network

In December 2013, CMS released proposed regulations to determine program requirements and prospective payments to States implementing a BHP. This was followed up with a final regulation released in mid-March 2014. This report is based on the provisions on the proposed regulation; however we believe the Final Regulation has only minimal differences that will not materially affect results.

Appendix C provides a detailed description of the BHP payment calculations and assumptions made in this report.

At a high level, the federal government will pay 95% of the federal premium tax credits and cost sharing subsidies that would have been paid on behalf of individuals who would have otherwise been enrolled in QHPs in the exchange.

The BHP funding regulation establishes a prospective payment scheme that is intended to be straightforward to administer while also preserving accuracy. The scheme divides BHP payments into rate cells based on the following factors:

- Age
- Income Level
- Geographic Area
- Household Size

Subcategories within each of the above categories are defined and payments are based on an assumed uniform average within each subcategory (e.g. a simple average of payments by age are calculated for the 45-54 age subcategory).

For detailed information on the methods, assumptions and data sources for modeling the BHP impact see Appendix D.

2. Results

The Wakely model for analyzing the financial impact of a BHP produces detailed projections for each person identified as eligible. Table 2 shows the final BHP enrolled population characteristics for selected measures.

Table 2 Assumed Demographic Characteristics of BHP Enrollees					
	<=150% FPL		150%-200% FPL		
	Females	Males	Females	Males	Total
Average Age	36.0	33.9	42.0	38.0	39.1
19-25	1,981	1,732	4,586	6,271	14,570
26-29	245	1,700	3,385	2,685	8,015
30-44	1,813	1,556	8,719	13,166	25,254
45-54	526	678	6,017	4,214	11,434
55-64	663	882	7,309	4,285	13,138
Total	**5,228**	**6,549**	**30,015**	**30,620**	**72,412**

Many analyses are possible; however, in this report, we focus on two main aspects of the BHP:

i. Financial impact to the consumer. We compare consumer out-of-pocket expenses in the BHP with the estimated out-of-pocket expenses in the absence of the BHP. For BHP enrollees who were previously uninsured, this means that out-of-pocket expenses in the absence of BHP consist of 100% of allowed costs and no member premium. Where applicable, we also include the value of OHP benefits that exceed the EHB benchmark plan as an additional value for the consumer.

ii. The financial impact for the State. Results are presented as the net cash flow of federal revenues less projected healthcare expenditures and State administrative expenses. While revenues and claim costs may be passed through to insurers or contracted carriers, we show these cash flows as being the responsibility of the State.

As noted earlier in this report, we tested results under three different levels of consumer benefit: nominal, middle, and enhanced. For the "middle" level of benefit, we calculate a "break-even" scenario where we set the State cost sharing subsidy at 50% and solve for the level of State member premium subsidy that produces claim liabilities that exactly offset federal BHP revenues.

Given that results can be sensitive to certain assumptions, we also varied provider reimbursement levels and the State administrative cost assumption.

The grid below summarizes the scenarios we tested.

	Nominal	Break-Even	Enhanced
Provider Reimbursement Basis	Average Commercial and Medicaid or 100% Commercial		
Benefits Covered	EHB	EHB	OHP+
Member Premium	Member Pays 100% of Max Premium in the Exchange	Member Pays 46% of Max Premium in the Exchange	Member Pays 0% of Max Premium in the Exchange
Member Cost Sharing	100% of maximum allowed cost sharing	50% of allowed cost sharing	None
State Administrative Expense	3% or 7% of Federal Revenue		

For the scenarios we tested, we found that the State would be able to provide significant benefits above and beyond those in the exchange. In particular, we found that the State would be able to provide the same marketplace EHB benefit levels and reduce the cost sharing by 50% through subsidized cost sharing (relative to what would have been paid through exchange coverage). In addition, the State would be able to reduce member premiums by either a 54% or 4% member premium subsidy (depending on provider reimbursement levels) with no additional costs beyond the State's own administrative expenses (which cannot be covered with federal funds).

Table 3 below summarizes the State's expected surplus or deficit and projected savings in out-of-pocket expenses for BHP enrollees under the different combinations of assumptions.

Table 3

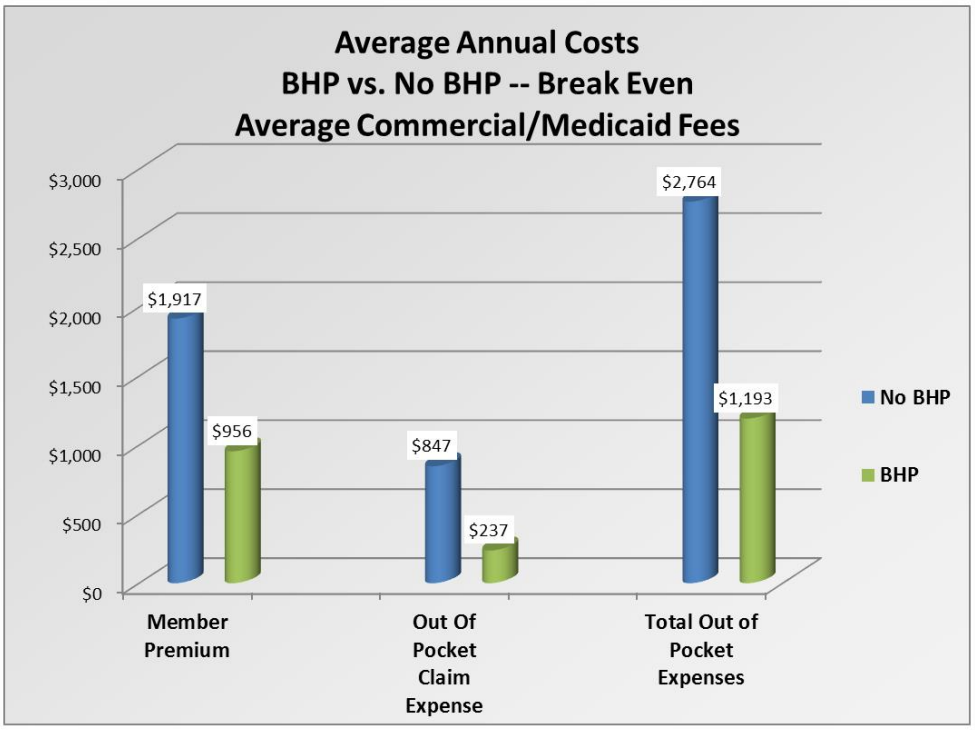
Basic Health Program
Summary Results

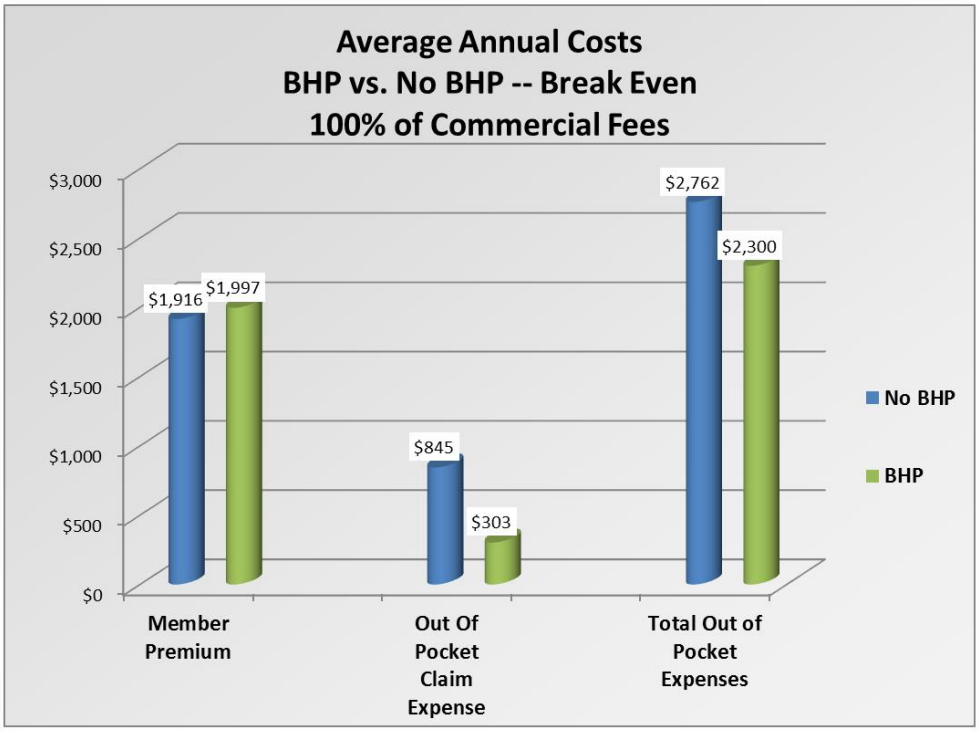
State Revenues less Claim and Administrative Expenses - Surplus/(Deficit) Amounts in ($000s)				
	Assumed Provider Fee Levels			
	Average of Commercial and Medicaid		**100% of Commercial**	
Scenario	**3% Admin**	**7% Admin**	**3% Admin**	**7% Admin**
Nominal	$92,560	$84,661	$21,948	$14,061
Break-Even [1]	($648)	($8,548)	($5,915)	($13,801)
Enhanced	($113,990)	($121,890)	($194,205)	($202,091)
Out-of-Pocket Savings and Additional Benefits for Enrollees in BHP vs. Same Enrollees without BHP -- Annual Amount Per Member				
	Assumed Provider Fee Levels			
	Average of Commercial and Medicaid		**100% of Commercial**	
Scenario	**3% Admin**	**7% Admin**	**3% Admin**	**7% Admin**
Nominal	$211	$211	$76	$76
Break-Even [1]	$1,499	$1,499	$461	$461
Enhanced	$3,064	$3,064	$3,061	$3,061

[1] The State is assumed to subsidize 50.5%/3.9% of member premium for the average commercial/Medicaid and 100% commercial reimbursement scenarios, respectively

Exhibit A provides details of the projected cash flows from the perspective of the State, the BHP enrollee, the federal government and managed care plans.

It is also helpful to consider a visual representation of projected out-of-pocket savings for enrollees. Below we show graphs comparing member premium, cost sharing, and total out-of-pocket expense for the break-even scenarios with reimbursement assumed to be the average of commercial and Medicaid and 100% commercial.





It may seem non-intuitive that the member premium is higher in the BHP for the graph based on 100% Commercial fees. The reason for this is that there is no member premium for persons who are

uninsured in the absence of a BHP. However these same people have high out-of-pocket expenses given their lack of any coverage.

3. Caveats and Limitations of the Analysis

The BHP analysis in this report depends on a number of key assumptions and is limited in scope. Readers should be aware of the following limitations:

- *Impact on the exchange*. We did not model how the individual Exchange will be affected by the presence of a BHP in terms of enrollment or morbidity.

- *Interaction between the exchange and the BHP beyond 2016*. If a BHP is implemented, Silver premium levels in the exchange will likely be affected, which will in turn impact the BHP FPTC and cost sharing subsidy payments since they both depend on the Silver rates. Since our analysis was for 2016 only, this affect is outside the scope of our analysis.

- *Impact of affordability on BHP take-up rates*. Although we tested different scenarios of benefits to BHP enrollees, we did not vary the take-up rates with affordability. It is possible that more eligible residents will join the BHP as benefits are enhanced and out-of-pocket expenses are reduced.

- *Churn effects with a BHP in place.* The BHP will help mitigate churn between Medicaid and the exchange; however, a new threshold of churn will be created between the BHP and exchange at 200% of the FPL. We did not address the impact of this issue on residents.

- *Assessment of carrier participation or achievability of assumed provider reimbursement.* Our modeling assumes that the State will be able to effectively contract with willing managed care plans. Also, we assumed those plans would be able to negotiate provider reimbursement somewhere between Medicaid and Commercial levels. While we believe these assumptions are reasonable, it is possible that actual results could vary from our range of assumptions.

- *Reliance on exchange premiums:* Second lowest cost Silver premiums in the exchange were relied upon to estimate expected claims costs. Results may differ if premiums do not accurately capture expected claims.

- *Estimates only for 2016:* Results for years beyond 2016 may be different as a result of the termination of the temporary reinsurance program. This would presumably increase the federal payments to the state for the BHP.

- *Relative costs of the uninsured are unknown:* Results will differ if the claims costs for the newly insured populations vary significantly from that assumed in this analysis.

Bridge Plan

A Bridge plan (sometimes called a "Medicaid bridge plan") is an alternative to the BHP with different features, but still has potential to provide residents out-of-pocket savings, additional covered benefits and continuity of providers.

Using the alternative coverage model used for the BHP analysis, Wakely modeled the financial impact of a Bridge plan on both the State and eligible residents. Many aspects of our analysis use data and assumptions used to model the BHP. In these cases, our descriptions below do not repeat what was already described in the BHP section above, but will only describe differences where applicable.

1. Structure of the Bridge Plan

The Bridge plan was formally addressed in a December 10, 2012 CMS memo regarding "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid." This memo states that an exchange may allow an issuer with a state Medicaid managed care organization contract to offer a Medicaid bridge plan as a QHP on the exchange under certain terms. Briefly, these terms are:

- The Bridge plan can generally be closed to other enrollment (i.e. besides those eligible for the Bridge plan), provided the issuer demonstrates that it has adequate network capacity only for the covered Medicaid/CHIP and eligible bridge plan population.
- The Bridge plan must meet qualified health plan requirements.
- The Exchange must ensure that the Bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance premium tax credits.
- The Exchange must identify eligible consumers and convey coverage options.
- Information on bridge plan eligible individuals must be provided to the federal government in order to support the calculation of premium tax credits.

The Bridge plan carries potential consumer savings because it is likely to result in lower premium rates as a result of the new exclusive market established within the exchange. Because carriers will be responsible to cover residents who were formerly eligible for Medicaid, they will likely be able to achieve provider reimbursement levels comparable to or somewhat higher than Medicaid levels (but significantly below commercial levels). These lower fee levels should translate into lower Bridge plan premiums.

Bridge eligible consumers will receive a premium tax credit based on the second lower Silver rate available to them, which will most likely be equal to the lowest Silver rate available in the State exchange. The Bridge plan rates are not counted in the determination of the second lowest Silver rate for any person in the exchange who is not eligible for the Bridge plan.

The second lowest cost silver plan (SLCSP) will be different for Bridge Plan eligible individuals than non-Bridge Plan eligible individuals. As a result, the amount of the tax subsidy will differ even if the Bridge Plan eligible and Bridge Plan ineligible individuals have the same income. The Bridge Plan

eligible individual will be able to use their tax subsidy to purchase a Bridge Plan which is expected to be a lower cost alternative because it is built off of the Plan's existing Medicaid provider network.

We expect that the difference between the exchange lowest Silver rate and the Bridge plan rate will produce premium tax credits that will cover a larger portion of the member premium than in the Standard exchange.

To illustrate how this works, the example below shows two hypothetical Bridge premium levels and the impact on an individual with income equal to 150% of FPL.

Pricing for a 40-year old single adult with income of 150% FPL (income of $17,705)

			Without Bridge		With Bridge	
		Premium	Federal Tax Credit	Member Cost	Federal Tax Credit	Member Cost
Example 1	Second Lowest Cost Silver	$325	$266	$59	$216	$109
	Lowest Cost Silver	$275	$266	$9	$216	$59
	Bronze*	$210	$266	$0	$216	$0
	Bridge	$225	$266	N/A	$216	$9
Example 2	Second Lowest Cost Silver	$325	$266	$59	$241	$84
	Lowest Cost Silver	$300	$266	$34	$241	$59
	Bronze*	$210	$266	$0	$241	$0
	Bridge	$225	$266	N/A	$241	$0

* Cost sharing reduction subsidies are not available for bronze plans

In Example 1, the member will pay $9 for the cheapest Silver plan whether the Bridge plan is in place or not. However, in Example 2, the member pays nothing for the Bridge plan, but would pay $34 for the lowest cost Silver if the Bridge plan were not in place.

Eligibility

In our modeling, we analyzed a Bridge plan by limiting enrollment to individuals previously enrolled in Medicaid, and their family members, with incomes at or below 200% of the FPL. In the model, we analyzed two groups of individuals eligible for the Bridge plan:

- Adults who were previously eligible for Medicaid, but whose income increases such that Medicaid eligibility is lost (up to 200% FPL).
- Parents of children eligible for the State CHIP program (138-200% FPL).

Delivery System and Provider Reimbursement Levels

Under a Bridge plan, we assume that the State will contract with managed care plans already contracted under the State Medicaid program to exclusively cover Bridge eligible persons. Members whose incomes increase to no more than 200% of FPL will continue to be enrolled with the same carrier they had under Medicaid. This will improve continuity in providers and care coordination for beneficiaries.

Similar to our BHP analysis, we assume that additional stability and volume of membership should give carriers leverage to negotiate provider reimbursement rates that are lower than commercial market levels.

For purposes of the Bridge modeling, we considered two scenarios:

1. Assume plans negotiate provider reimbursement rates halfway between estimated commercial levels and the Medicaid fee schedule.
2. 100% of estimated Medicaid fee levels.

It is important to note that results are highly sensitive to the assumed provider reimbursement levels that carriers are assumed to achieve. While it is difficult to predict what the actual result will be, we believe the two scenarios modeled represent a reasonable range of likely results. It is possible that actual reimbursement could be higher or lower than the range presented in this report.

Benefit Levels

The Bridge plan must provide benefits at least equal to the essential health benefits benchmark plan in the State. Additional benefits not included in the essential health benefits plan can also be added if desired.

For the Bridge modeling, we assumed one of two benefit options:

1. The Oregon EHB benchmark plan (PacificSource Preferred CoDeduct)
2. The Oregon Medicaid benefit package, OHP Plus

Appendix A provides a detailed comparison of covered services under these two designs.

Funding

The Bridge plan is considered a qualified health plan, and Bridge Plan eligible residents will continue to receive federal advance premium tax credits and cost sharing subsidies, but no additional federal funding is available.

As noted above, we expect that the premium tax credits will provide a significant benefit to Bridge individuals because of the large expected difference in premiums between the second lowest Silver rate (likely the lowest Silver rate in the standard exchange) and the Bridge rate. These extra tax credits can

be used by individuals to pay a higher portion of the Bridge premium than what they may have purchased in the standard exchange.

For detailed information on the methods, assumptions and data sources for modeling the Bridge Plan impact see Appendix E.

2. Results

The Wakely model for analyzing the financial impact of a Bridge plan produces detailed projections for each person identified as eligible. Many analyses are possible; however, in this report, we focus on two main aspects of the Bridge:

i. The projected expenses to the State to cover additional subsidies and operational costs.
ii. Out-of-pocket savings and additional benefits for the consumer. We compare consumer out-of-pocket expenses in the Bridge with the estimated out-of-pocket expenses in the absence of the BHP. For Bridge enrollees who were previously uninsured, this means that out-of-pocket expenses in the absence of Bridge consist of 100% of allowed costs and no member premium.

Bridge results were assessed for two potential eligible populations – residents previously eligible for Medicaid whose income increases above Medicaid eligibility but no higher than 200% FPL, and parents of CHIP-eligible children.

As noted earlier in this report, we modeled results under three different levels of consumer benefit. Given that results can be sensitive to provider reimbursement levels, we also scenarios with average commercial/Medicaid fees and 100% Medicaid fees.

The grid below summarizes the scenarios we tested.

	Nominal	**Middle**	**Enhanced**
Provider Reimbursement Basis	Average Commercial and Medicaid or 100% Medicaid		
Benefits Covered	EHB	EHB	OHP
Member Premium	Member Pays 100% of Max Premium in the Exchange	Member Pays 50% of Max Premium in the Exchange	Member Pays 0% of Max Premium in the Exchange
Member Cost Sharing	100% of Maximum Allowed Cost Sharing	50% of Maximum Allowed Cost Sharing	None
State Administrative Expense	10% of Carrier Admin (2% of Bridge Plan Revenue)		

Based on the assumptions we tested, we found that by implementing a Bridge plan, the State could facilitate annual savings of $600 to $1,725 per person at a cost of $2.1 to $5.7 million. Any subsidies the State chooses to add would incrementally increase State expenses, but consumers would see significant additional savings or improved benefit coverage.

Table 4 below summarizes the State's expected expenses and projected benefit to consumers (from out-of-pocket savings and additional benefits).

Table 4

Bridge Plan
Summary Results

State Subsidy and Administrative Expenses
Amounts in ($000s)

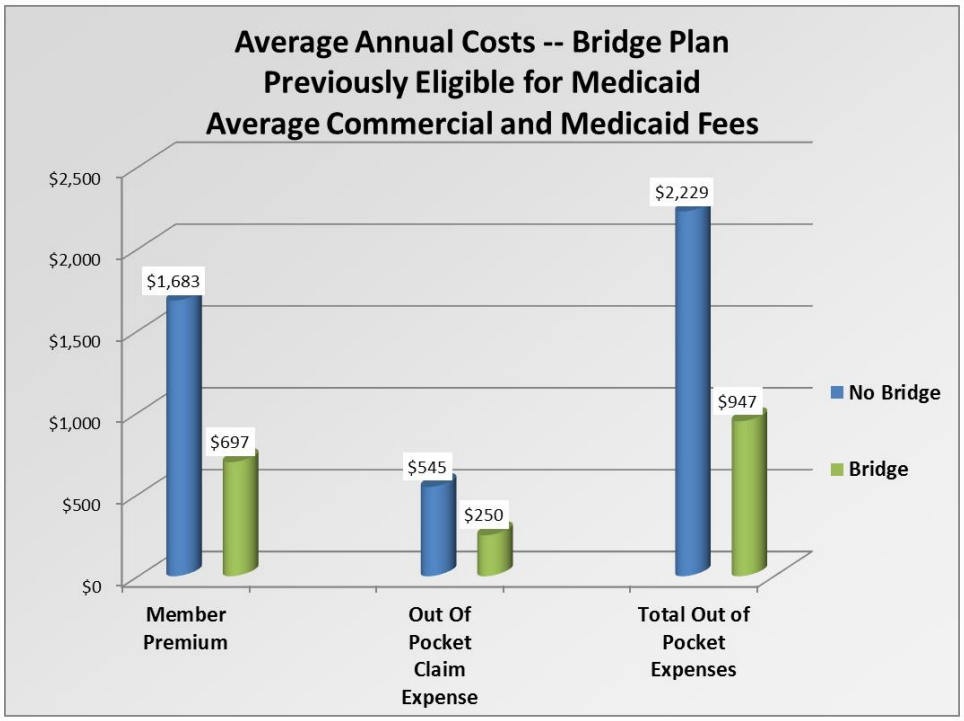
	Assumed Provider Fee Levels			
	Average of Commercial and Medicaid		100% of Medicaid	
Scenario	Prev. Medicaid	CHIP Parents	Prev. Medicaid	CHIP Parents
Covered Persons	*69,451*	*40,444*	*69,451*	*40,444*
Nominal	$5,280	$2,011	$5,286	$2,014
Middle	$68,427	$44,726	$43,835	$29,416
Enhanced	$153,912	$100,446	$104,721	$69,823

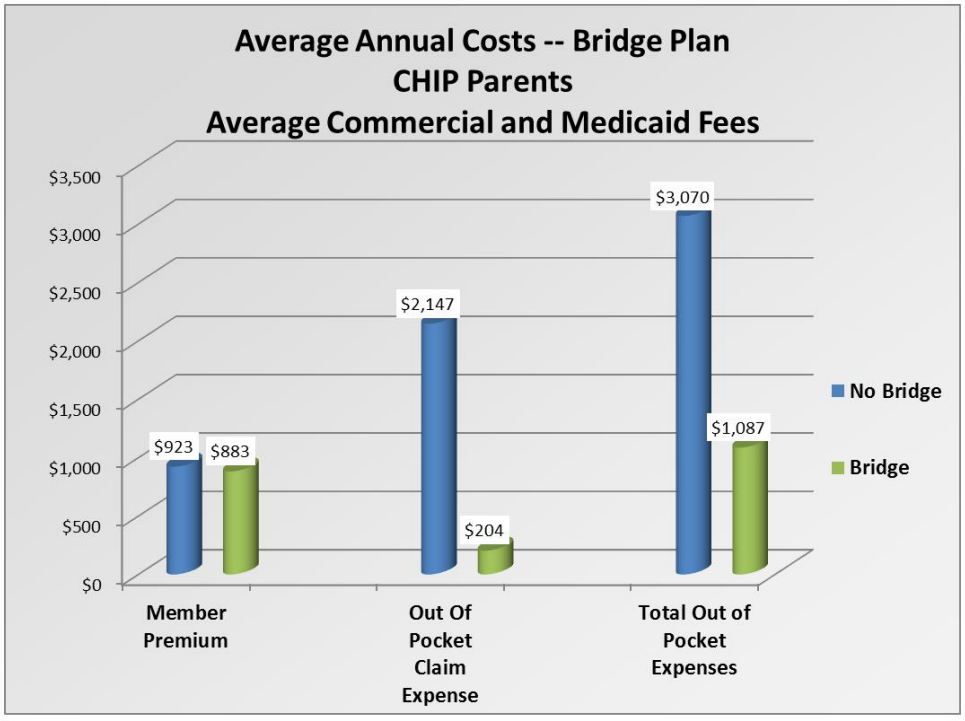
Out-of-Pocket Savings and Additional Benefits for Enrollees in Bridge vs. Same Enrollees without Bridge -- Annual Amount Per Member

	Assumed Provider Fee Levels			
	Average of Commercial and Medicaid		100% of Medicaid	
Scenario	Prev. Medicaid	CHIP Parents	Prev. Medicaid	CHIP Parents
Nominal	$335	$897	$1,001	$1,621
Middle	$1,282	$1,983	$1,615	$2,347
Enhanced	$2,550	$3,391	$2,551	$3,394

Exhibit B provides details of the projected cash flows from the perspective of the State, the Bridge plan enrollee, the federal government and managed care plans.

Similar to our BHP analysis, below we show a graphical representation of consumer out-of-pocket savings for the "Nominal" benefit scenario.


Average Annual Costs -- Bridge Plan
Previously Eligible for Medicaid
Average Commercial and Medicaid Fees
$2,500
$2,000
$1,500
$1,000
$500
$0
$1,683
$697
$545
$250
$2,229
$947
No Bridge
Bridge
Member Premium
Out Of Pocket Claim Expense
Total Out of Pocket Expenses


Average Annual Costs -- Bridge Plan
CHIP Parents
Average Commercial and Medicaid Fees
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$923
$883
$2,147
$204
$3,070
$1,087
No Bridge
Bridge
Member Premium
Out Of Pocket Claim Expense
Total Out of Pocket Expenses

Similar to the BHP analysis, it is important to note the apparently counter-intuitive result that the member premium for the Bridge plan can be close to or even higher than premiums in the case where no Bridge plan is assumed to be implemented. The reason for this is that there is no member premium for persons who are uninsured in the absence of a Bridge plan (this will only be true for scenarios modeling CHIP Parents since all previous Medicaid enrollees were assumed to have Medicaid as their last coverage). However these same people would see significant out-of-pocket savings since they will pay 100%without coverage.

3. Caveats and Limitations of the Analysis

The Bridge analysis in this report depends on a number of key assumptions and is limited in scope. Readers should be aware of the following limitations:

- *Impact on the exchange*. We did not model how the individual Exchange will be affected by the presence of a Bridge plan in terms of enrollment or morbidity.

- *Interaction between the exchange and the Bridge beyond 2016*. If a Bridge is implemented, Silver premium levels in the exchange could be affected, which will in turn impact the Bridge APTC and cost sharing subsidy payments since they both depend on the Silver rates. Since our analysis was for 2016 only, this affect is outside the scope of our analysis.

- *Impact of affordability on Bridge take-up rates*. Although we tested different scenarios of benefit to Bridge enrollees, we did not vary the take-up rates with affordability. It is likely that more eligible residents will join as benefits are enhanced and out-of-pocket expenses are reduced.

- *Churn effects with a Bridge plan in place.* The Bridge will help mitigate churn between Medicaid and the exchange; however, a new threshold of churn will be created between the Bridge and exchange as member experience income growth above 200% FPL. We did not address the impact of this issue on residents.

- *Assessment of carrier participation or achievability of assumed provider reimbursement.* Our modeling assumes that the State will be able to effectively contract with willing managed care plans. Also, we assumed those plans would be able to negotiate provider reimbursement at Medicaid or somewhere between Medicaid and Commercial levels. While we believe these assumptions are reasonable, it is possible that actual results could vary from our range of assumptions.

- *Impact of dynamics between first and second lowest cost Silver plan.* The difference in premium between the first and second lowest cost Silver plans plays a significant role in the benefit of the Bridge plan to consumers. These should be assessed on an annual basis to ensure that the addition of the Bridge plan is in fact benefiting the eligible population.

QHP Wraparound

A QHP Wraparound is a program that leaves the exchange unaltered, with the State subsidizing member premium or cost sharing or offering additional benefits for individuals who meet income eligibility requirements.

Using the model built for the BHP and Bridge analysis, Wakely modeled the financial impact of State subsidies that supplement the existing exchange marketplace in 2016. Many aspects of our analysis use the same data and assumptions used to model the BHP and Bridge options. In these cases, our descriptions below do not repeat what was already described in those sections, above, but will only describe differences where applicable.

1. Structure of the QHP Wraparound

A Wraparound program is at the discretion of the State. The structure of the Exchange Marketplace does not change, so federal advance premium tax credits and cost sharing subsidies are unaffected. The purpose of modeling the QHP Wrap in this report is to identify the expected expenses the State would incur to subsidize out-of-pocket expenses or additional covered benefits for certain eligible individuals.

Eligibility

In our modeling, we analyzed Wrap eligible populations based on the same two definitions of persons eligible for the Bridge plan:

1. Persons previously eligible for Medicaid whose incomes increased to level between 138% and 200% of FPL.
2. Parents of children eligible for the State CHIP program (138-200% FPL).

Delivery System and Provider Reimbursement Levels

The Wrap program supplements the QHP exchange, so no changes to the delivery system or provider reimbursement are expected. All modeling assumes providers are reimbursed at 100% of estimated commercial fee levels.

Benefit Levels

For the Wrap modeling, we assumed one of two benefit options:

1. The Oregon EHB benchmark plan (PacificSource Preferred CoDeduct)
2. The Oregon Medicaid benefit package, OHP Plus

Appendix A provides a detailed comparison of covered services under these two designs.

Funding

There is no federal funding for the Wrap program. All expenses are funded by the State.

For detailed information on the methods, assumptions and data sources for modeling the Wrap program impact see Appendix F.

2. Results

The Wakely model for analyzing the financial impact of a Wrap program produces detailed projections for each person identified as eligible. Many analyses are possible; however, in this report, we focus on two main aspects of the Wrap:

i. The projected expenses to the State to cover additional subsidies and operational costs.
ii. Out-of-pocket savings and additional benefits for the consumer. We compare consumer out-of-pocket expenses under a QHP Wrap with the estimated out-of-pocket expenses in the absence of a QHP Wrap. For eligible persons who were previously uninsured, this means that out-of-pocket expenses in the absence of the QHP Wrap consist of 100% of allowed costs and no member premium.

Wrap results were assessed for two potential eligible populations – residents previously eligible for Medicaid whose income increases, and parents of CHIP-eligible children. These two populations are mutually exclusive and are always presented separately.

As noted earlier in this report, we modeled results under three different levels of consumer benefit.

The grid below summarizes the scenarios we tested.

	Nominal	**Middle**	**Enhanced**
Provider Reimbursement Basis	100% of Commercial		
Benefits Covered	EHB	EHB	OHP
Member Premium	Member Pays 100% of Max Premium in the Exchange	Member Pays 50% of Max Premium in the Exchange	Member Pays 0% of Max Premium in the Exchange
Member Cost Sharing	50% of Maximum Allowed Cost Sharing	50% of Maximum Allowed Cost Sharing	None
State Administrative Expense	10% of Carrier Admin (2% of Exchange Plan Revenue)		

Based on our analysis, we estimate that the State can provide about $11 to $14 in annual savings per person for each $1 million spent for those previously eligible for Medicaid. For CHIP parents the annual savings is $22 to $24 per person for each $1 million. This value is higher for CHIP parents because we assume that individuals stay uninsured if no QHP Wrap is provided.

Table 5 below summarizes the State's expected expenses and projected benefit to consumers (from out-of-pocket savings and additional benefits).

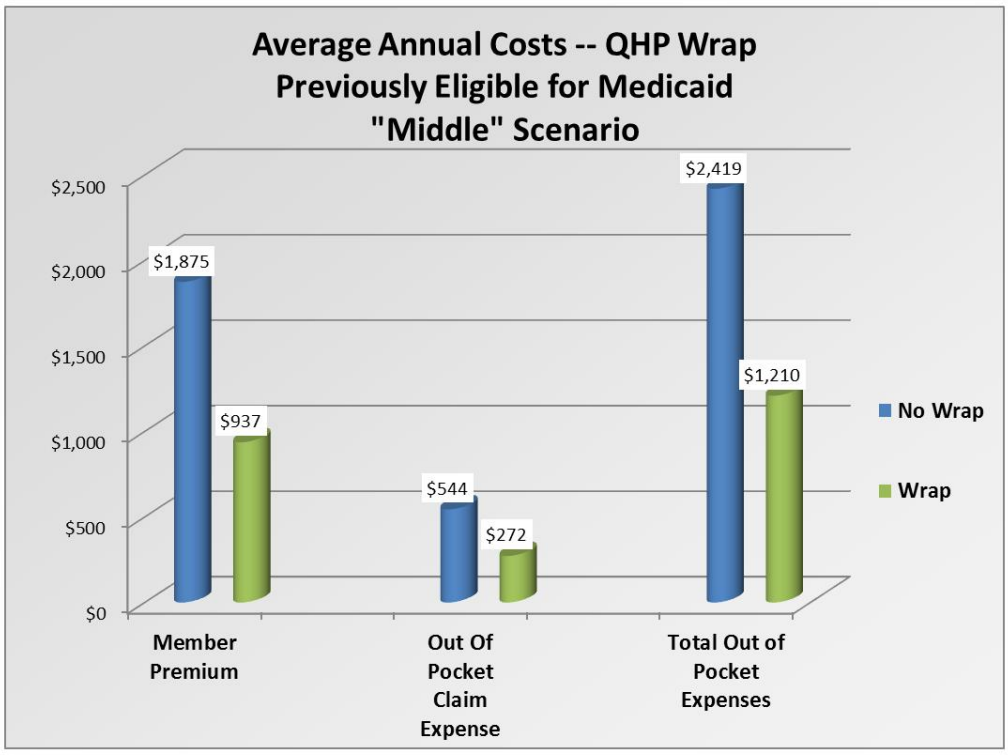
Table 5

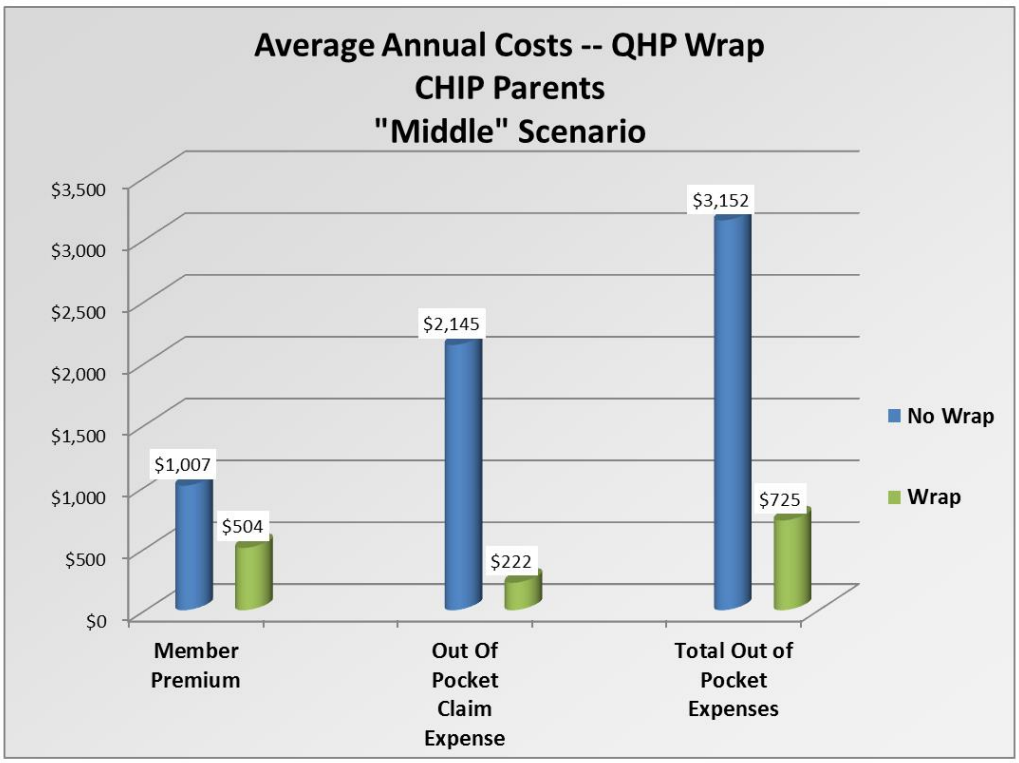
Wrap Program
Summary Results

Scenario	Assumed Provider Fee Levels: Average of Commercial and Medicaid — Prev. Medicaid	Assumed Provider Fee Levels: Average of Commercial and Medicaid — CHIP Parents
Covered Persons	*69,451*	*40,444*
State Subsidy and Administrative Expenses Amounts in ($000s)		
Nominal	$24,568	$79,877
Middle	$92,728	$100,969
Enhanced	$221,965	$144,038
Out-of-Pocket Savings and Additional Benefits for Enrollees in Bridge vs. Same Enrollees without Bridge -- Annual Amount Per Member		
Nominal	$272	$1,923
Middle	$1,254	$2,444
Enhanced	$2,534	$3,215
Consumer Benefit PMPY per $1M of State Expenditures		
Nominal	$11.08	$24.07
Middle	$13.52	$24.21
Enhanced	$11.42	$22.32

Exhibit C provides details of the projected cash flows from the perspective of the State, the exchange enrollee, the federal government and managed care plans.

Similar to our BHP and Bridge analyses, below we show a graphical representation of consumer out-of-pocket savings for the "Middle" benefit scenario.


Average Annual Costs -- QHP Wrap
Previously Eligible for Medicaid
"Middle" Scenario
$2,500
$2,000
$1,500
$1,000
$500
$0
$1,875
$937
$544
$272
$2,419
$1,210
Member Premium
Out Of Pocket Claim Expense
Total Out of Pocket Expenses
No Wrap
Wrap


Average Annual Costs -- QHP Wrap
CHIP Parents
"Middle" Scenario
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$1,007
$504
$2,145
$222
$3,152
$725
Member Premium
Out Of Pocket Claim Expense
Total Out of Pocket Expenses
No Wrap
Wrap

3. Caveats and Limitations of the Wraparound Analysis

The Wraparound analysis in this report depends on a number of key assumptions and is limited in scope. Readers should be aware of the following limitations:

- *Impact of affordability on exchange take-up rates*. Although we tested different scenarios of benefit to QHP Wrap enrollees, we did not vary the take-up rates with affordability. It is possible that more eligible residents will join the exchange as benefits are enhanced and out-of-pocket expenses are reduced.

- *Churn effects with a Wraparound plan in place.* The Wraparound subsidies will help mitigate churn between Medicaid and the exchange; however, a new threshold of churn will be created between the Wrap and exchange as member experience income growth above 200% FPL. We did not address the impact of this issue on residents.

Appendix A

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
1. Ambulatory patient services		
a. Primary care to treat illness/injury	√	√
b. Specialist visits	√	√
c. Outpatient surgery	√	√
d. Acupuncture	NC	√ chemical dependency, HIV, migraine, post-stroke depression, limited medical conditions during pregnancy
e. Chiropractic	NC	√ certain conditions only (including back pain with neurologic component, not muscular)
f. Naturopath	NC	√
g. Chemotherapy services	√	√
h. Radiation therapy	√	√
i. Infertility treatment services	NC	NC
j. Sterilization	√	√
k. Home health care	√	√
l. Telemedical services	√	√
m. Routine vision care	NC	NC for adults 21 and over
n. Care for disease of the eye	√	√
o. Foot care	√	√
p Medical contraceptives	√	√
q TMJ services	NC	NC
r Dental - diagnostic & preventive	NC	√ (for all ages)
s Dental - basic	NC	√ (for all ages)
t Dental - major	NC	NC for adults 21 and over
2. Emergency services		
a. Emergency room - facility	√	√
b. Emergency room - physician	√	√
c. Ambulance service - ground and air	√	√
3. Hospitalization		
a. Inpatient medical and surgical care	√	√
b. Organ & tissue transplants	√ limited to organs specified $5000 limit for travel expenses $8000 limit for donor expenses lodging for caregiver	√ limited to organs specified
c. Bariatric surgery	NC	√ limited to Type 2 diabetics
d. Anesthesia	√	√
e. Breast reconstruction (non-cosmetic)	√	√
f. Blood transfusions	√	√
g. Hospice / respite care	√ respite limit 5 consecutive days / 30 days	√
4. Maternity and newborn care		
a. Pre- & postnatal care	√	√
b. Delivery & inpatient maternity services	√	√
c. Newborn child coverage	√	√
5. Mental health and substance use disorder services, including behavioral health treatment		
a. Inpatient hospital - mental/behavioral health	√ limit 45 days / yr for residential treatment	√
b. Outpatient hospital - mental/behavioral health	√	√
c. Inpatient hospital - chemical dependency	√	√
d. Outpatient hospital - chemical dependency	√	√
e. Detoxification	√	√
f. Counseling or training in connection with family, sexual, marital, or occupational issues	NC	NC
6. Prescription drugs		
a. Retail	√	√
b. Mail order	√	√
c. Generic	√	√
d. Brand	√	√
e. Specialty	√	√
f. Insulin/needles for diabetics	√	√
g. Tobacco cessation drugs	√	√
h. Contraceptives	√	√
i. Fertility drugs	NC	NC
j. Growth hormone therapy	√	√

Appendix A

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
7. Rehabilitative and habilitative services and devices		
a. Inpatient rehabilitation	√ limit 30 days / yr additional 30 days for head/spinal cord injury	√ No limits when in skilled nursing, IP hospital or IP rehab
b. Physical, speech & occupational therapy (outpatient)	√ limit 30 visits / yr additional 30 visits / condition for specified conditions	√ Covered no limits for 3 months After 3 month stabilization, 2 visits per year (PT/OT/ST) Change of status triggers an additional 6 visits/year for ST/OT/PT
c. Massage therapy	NC	√ as part of PT
d. Durable medical equipment	√ limit $5000 for non-essential DME	√ Per Administrative Rules
e. Prosthetics	√	√
f. Orthotics	√	√
g. Vision hardware	NC	NC for adults 21 and over Covered for ages 19 and 20
h. Hearing aids - adults	√ $4,000 every 48 months for certain people under age 25	√ 1 hearing aid every 5 years
i. Cochlear Implants	√	√
j. Skilled nursing	√ limit 60 days / yr	√
k. Home based habilitative services per state plan	Not covered	√
8. Laboratory services		
a. Lab tests, x-ray services, & pathology	√	√
b. Imaging / diagnostics (e.g., MRI, CT scan, PET scan)	√	√
c. Genetic testing	√ medically necessary	√ medically necessary
9. Preventive and wellness services and chronic disease management		
a. Preventive care	√	√ (Per USPSTF Grade A&B recommendations and HRSA Women's Preventive Services)
b. Immunizations	√	√ (Per ACIP recommendations)
c. Colorectal cancer screening	√	√
d. Screening mammography	√	√ Per HRSA Required Health Plan Coverage
e. Routine eye exams (separate office visit)	NC	√ for 19 and 20 year olds NC for adults 21 and over
f. Routine hearing exams (separate office visit)	√ medically necessary	√
g. Nutritional counseling	√ limit 5 visits / lifetime	√
h. Diabetes education	√	√
i. Smoking cessation program	√	√
j. Allergy testing & injections	√	√
k. Diabetes - medically necessary equip. & supplies	√	√
l. Screening pap tests	√	√
m. Prostate cancer screening	√	√
n. Low protein food for inborn errors of metabolism	√	√
10. Pediatric services, including oral and vision care (19-20 year olds)		
a. Preventive care - physician services	√	√ (Per USPSTF Grade A&B recommendations and HRSA Women's Preventive Services)
b. Immunizations	√	√ (Per ACIP recommendations)
d. Routine eye exams (separate office visit)	NC	√ for 19 and 20 year olds NC for adults 21 and over
e. Routine hearing exams (separate office visit)	√ medically necessary	√
f. Hearing aids	√ limit $4000+CPI / 4 yrs	√
g. Dental - diagnostic & preventive	NC	√
h. Dental - basic	NC	√
i. Dental - major	NC	√

Appendix A

State of Oregon
Medicaid Essential Health Benefits (EHB) Benchmark Plan

Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Adopted EHB Benchmark: Commercial/Exchange Small Group - PacificSource Preferred CoDeduct	OHP+
11 Non-EHB services		
a EPSDT	NC	√
b Services provided in a Rural Health Clinic	NC	√
c Services provided in a Federally Qualified Health Center	NC	√
d Dental (for 21 and over)	NC	Routine and basic are covered
e. Nursing facility services	NC	√
f. Targeted case management	NC	√
g. Clinic Services	√	√
h. non-emergency medical transportation	NC	√
i. Private duty nursing services	NC	√
j. Intermediate care services	NC	√
k. Extended services for pregnant women	NC	√
l. Personal care services	NC	√

† The nonfunded region of the Prioritized List of Health Services serves as the list of underlying exclusions for OHP Plus. The list also has associated guidelines that may limit certain covered services.
√ Covered benefit. Any limits on the benefit are noted (see also † pertaining to OHP coverage).
NC Not a covered benefit
* Except for Pediatric oral and vision benefits, which are from other plans as specified.
** Currently under review by DMAP

Appendix B: BHP Payment Calculations

The Basic Health Program (BHP) funding calculation methodology used in the Wakely Financial Model is based on the December 2013 Basic Health Program Proposed Federal Funding Methodology for 2015 (BHP proposed rule). Under the section 1331 of the Patient Protection and Affordable Care Act, federal funding payment amount will be made to the states with a Basic Health Program for low-income individuals.

The funding methodology proposes that the federal BHP payment include two portions:

1. Federal premium tax credit (PTC), and
2. Federally-funded cost-sharing reductions (CSR).

The federal BHP payment is 95 percent of the PTC and CSR.

RATE CELLS

The proposed regulation defines multiple federal BHP payment rate cells, which are combinations of four factors: Age, Income levels, geographic areas and household size. (Note that the proposed rule also uses coverage status as a factor, but we did not consider this in our study.)

Rather than calculating PTC and CSR on a person-by-person basis, BHP payments will be paid prospectively using averages within subcategories of the rate cell factors. Within each subcategory, a uniform average is determined in order to calculate payment. For example, for the age 21-44 rate cell, a straight average across ages is calculated.

We calculated subcategory averages for the four factors by using the 2011 American Community Survey (ACS) data, which is a subset of the Integrated Public Use Microdata Series (IPUMS). The ACS data provides the demographic information including age, poverty status (percentage of Federal Poverty

Level FPL), Public Use Microdata Area (PUMA), Super Public Use Microdata Area (Super-PUMA), household serial number.

Each factor within the BHP payment rate cells is developed based on the information from ACS at the household level, and the unique combination of all the four factors are used. Below are the detailed descriptions of each rate cell factor and how they are developed using the ACS data.

- *Age*: The ACS data has the exact age information for each individual. We regrouped the ages to the age ranges that are defined in the proposed rule.
    - Ages 0-20
    - Ages 21-44 (note: the final rule splits this into 21-34 and 35-44)
    - Ages 45-54
    - Ages 55-64
- *Income levels*: Income levels are measured as a percentage of FPL in the ACS data. We calculated a straight average across FPL percentages within the following ranges defined in the proposed rule.
    - 0 to 50 percent of the FPL
    - 51 to 100 percent of the FPL
    - 101 to 138 percent of the FPL
    - 139 to 150 percent of the FPL
    - 151 to 175 percent of the FPL
    - 176 to 200 percent of the FPL
    - 201 to 250 percent of the FPL
    - 251 to 300 percent of the FPL

- *Geographic areas*: ACS data includes two area codes PUMA and Super-PUMA. The IPUMS website (https://usa.ipums.org/usa/volii/PUMA_composition_OR.shtml) provides the mapping between the combination of the two codes and each county in the state of Oregon. We apply the same grouping logic as defined by Cover Oregon, the Oregon Health Insurance Exchange (http://www.oregonhealthrates.org/?pg=approved_rates.html) in the approved exchange rates by area.

  Cover Oregon has defined seven rating areas by county. Below is the definition of each area according to counties included. A complete mapping between PUMA, Super-PUMA code and County and rating areas can be found at the end of this Appendix.

  - **Bend**: Deschutes, Klamath, and Lake counties
  - **Coast**: Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook counties
  - **Eugene**: Benton, Lane, and Linn counties
  - **Medford**: Douglas, Jackson, and Josephine counties
  - **Pendleton-Hermiston**: Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler counties
  - **Portland**: Clackamas, Multnomah, Washington, and Yamhill counties
  - **Salem**: Marion and Polk counties

- *Household sizes*: ACS data contains a household series number to identify the members in the same household. The proposed rule defines household sizes from 1 to 5+ members.

PREMIUM TAX CREDIT

The formula for calculating the federal premium tax credit amount is as follows:

Federal Premium Tax Credit = (Adjusted Reference Premium – Household Payment) * Income Reconciliation Factor

Below we further define each of these components.

Adjusted Reference Premium

Adjusted reference premium is calculated based on the approved second lowest silver monthly premium rates for 2014 individual plans released by the Cover Oregon, and trended to 2016, including adjustments for the change in the federal reinsurance program and a population health factor. Following this methodology, we projected 2016 Silver rates as follows:

2016 Adjusted Reference Premium = 2014 Second lowest silver rate (by age cell) * Premium trend factor * Reinsurance transition impact factor * Population health factor

The components of this formula were determined as follows:

- 2014 Second lowest silver rates

  The second lowest cost silver plan is based on the 2014 Individual Exchange rate filings. There is one set of second lowest Silver rates by age for each geographic region.

- Premium Trend factor

  Based on the proposed rule, the trend factor should approximate the change in health care costs per enrollee. We used the same trend factor source in the proposed rule to trend Silver rates to 2016. The source of the trend factor is the annual growth rates in private health insurance expenditures per enrollee from the National Health Expenditure projections developed by CMS. The trend factors are

The factor from 2014 to 2015 is 1.035 and while the trend from 2015 to 2016 is 1.038.

- Reinsurance transition impact factors

The federal reinsurance program reduces coverage over 2014, 2015, and 2016. As part of the projection of 2016 Silver rates, an adjustment is needed to reflect the the reduced reinsurance protection in 2016. The adjustment to rates was calculated by applying expected changes in the parameters of the reinsurance program. For 2014, We estimate that the 2014 federal reinsurance program will reduce premiums by 12.5%. This is based on Wakely data and client experience.

The 2015 reinsurance parameters have been announced, but we do not know the parameters for 2016; however, we do know the federal target amount of reinsurance contributions for 2016. Using the difference in expected premium impact due to the change parameters from 2014 to 2015, we apply this difference to the relative change in expected federal reinsurance contribution collections to calculate a proxy impact for 2016. The table below shows our assumptions underlying this estimate.

Year	Threshold	Coinsurance	Expected Federal Collections	Estimated Impact on Exchange Premiums
2014	$60k-$250k	80%	$10B	-12.50%
2015	$70k-$250k	50%	$6B	-7.20%
2016	?	?	$4B	-5.00%

The final factor for 2016 is (1-0.05)/(1-0.125) = 1.085.

- Population health factor

We used the same population health adjustment factor as the proposed rule for 2015 BHP program year, which is equal to 1.00. By applying a 1.00 adjustment

factor, we assume that the health status for BHP enrollees in the state of Oregon would be the same level as the state's individual market so the Exchange premiums would have been the same if the state did not implement BHP program.

Household Payment

The household payment is the maximum amount a household can pay for the second lowest Silver plan in the Exchange. It is calculated by applying federally defined percentages of annual income. The percentages range from 2% to 9.5%, and increase with income as a percent of FPL.

The household payment for each FPL is calculated based on the following formula:

2016 Monthly Household Payment = 2013 Federal Poverty Guideline Income*Trend factor * FPL percentage * Applicable percentage per ACA

The 2013 Federal Poverty Level income amount is based on the Federal Poverty Guidelines, which are summarized in the table below.

Household Size	2013 FPL Guideline (100%)
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570

Trend factors from 2013 to 2016 are based on the intermediate inflation forecasts for non-labor CPI-U (table IV.a1) from the most recent Medicare Trustees Report. This is the basis described in examples shown in the proposed rule. Below are the trends factors we used.

Trend Year	Trend Factors
2014	2.2%
2015	2.4%
2016	2.5%

The applicable percentage is based on the values in the Affordable Care Act (ACA). The table below shows the values from the ACA.

Income Level	Initial Percentage	Final Percentage
Up to 133% FPL	2.00%	2.00%
133-150% FPL	3.00%	4.00%
150-200% FPL	4.00%	6.30%
200-250% FPL	6.30%	8.05%
250-300% FPL	8.05%	9.50%
300-400% FPL	9.50%	9.50%

We calculated applicable percentages for each FPL using a linear interpolation within each FPL range. For example, the applicable percentage for a household FPL level 140% is in the 133-150% category, with a range from 3% to 4%. The formula for calculating the percentage for FPL 140% would be: $3\% + \frac{140\%-133\%}{150\%-133\%} = 3.41\%$

Finally, we take the straight average of the monthly household payment for each household size based on the FPL rate cells defined in the proposed rule.

The final average monthly household payment is summarized as below:

FPL	1	2	3	4	5
0-50	$5.14	$6.93	$8.73	$10.53	$12.32
51-100	15.51	20.94	26.36	31.79	37.21
101-138	27.07	36.54	46.01	55.49	64.96
139-150	54.64	73.75	92.87	111.98	131.10
151-175	77.22	104.24	131.26	158.28	185.30
176-200	111.24	150.16	189.07	227.99	266.91
201-250	167.34	225.88	284.43	342.97	401.52
251-300	249.33	336.57	423.80	511.04	598.27

Income Reconciliation Factor (IRF)

The income reconciliation factor is defined to be 0.98 in the proposed rule.

COST-SHARING REDUCTION

The formula for calculating the federal premium tax credit amount is as follow:

Cost-sharing Reduction = Adjusted Reference Premium * Factors for Removing Admin Cost * Standard AV Factor * Tobacco Factor * IU Factor * Increased in AV

The adjusted reference premium is the same amount as the 2016 adjustment reference premium used for Premium Tax Credit.

Factors for Removing Admin Cost

The proposed rule uses a factor of 0.80 to derive claim costs by removing assumed administrative costs from the premium.

Standard AV Factor

The proposed rule defines the standard actuarial value (AV) factor as 1 over the standard actuarial value of 70% for Silver plans, or 1.43.

Tobacco Factors

The general formula for the final tobacco factor is equal to the weighted average of the tobacco rating adjustment factor with the tobacco rating utilization factor for state of Oregon. The formula is:

> Tobacco Rating Adjustment Factor for Tobacco Users * Tobacco Utilization Factor in Oregon + Tobacco Rating Adjustment Factor for Non-tobacco Users * (1 - Tobacco Utilization Factor in Oregon)

- Tobacco Rating Adjustment Factor

  The tobacco rating adjustment factor for non-tobacco users is 1.00 since there is no tobacco impact for non-tobacco users. The tobacco rating adjustment factor for tobacco users is based on the approved tobacco factors for individual plans rate filings from the state of Oregon. We received total 13 rate filings for individual plans from the state with valid tobacco factors from age 0 to 65. We took the average of all the tobacco factors by age and further average these into the age categories defined in the Proposed rule. The following table shows the tobacco rating adjustment factor by age category.

Age	Average
0-20	1.06
21-44	1.12
45-54	1.13
55-64	1.12

- Tobacco Rating Utilization Factors

  We used the percentage of the cigarette use in the state of Oregon from the Center for Disease Control and Prevention, Tobacco Control Interactive Maps with State

Tobacco Activities Tracking and Evaluation (STATE) System. The percentage of cigarette use in Oregon is 17.9% in year 2012.

http://apps.nccd.cdc.gov/statesystem/InteractiveReport/InteractiveReports.aspx?MeasureID=4

Induced Utilization Factor

The induced utilization factor is 1.12 according to the proposed rule.

Increase in Actuarial Value

The increase in actuarial value varies according to income range and is based on the actuarial value of the Silver cost sharing subsidy plans in the ACA. The factor is calculated as the difference in actuarial value between the cost sharing subsidy level and the standard silver plan (70%). The table below shows the factors by FPL category..

FPL Category	AV with Cost Sharing Subsidy	Silver Plan AV	Increase in AV
0-50	0.94	0.70	0.24
51-100	0.94	0.70	0.24
101-138	0.94	0.70	0.24
139-150	0.94	0.70	0.24
151-175	0.87	0.70	0.17
176-200	0.87	0.70	0.17

Super-PUMA	Super-PUMA & PUMA	Counties	Rating Areas
41100	41100100	Baker County	PENDLETON-HERMISTON
41100	41100100	Umatilla County	PENDLETON-HERMISTON
41100	41100100	Union County	PENDLETON-HERMISTON
41100	41100100	Wallowa County	PENDLETON-HERMISTON
41100	41100200	Crook County	PENDLETON-HERMISTON
41100	41100200	Gilliam County	PENDLETON-HERMISTON
41100	41100200	Grant County	PENDLETON-HERMISTON
41100	41100200	Hood River County	PENDLETON-HERMISTON
41100	41100200	Jefferson County	PENDLETON-HERMISTON
41100	41100200	Morrow County	PENDLETON-HERMISTON
41100	41100200	Sherman County	PENDLETON-HERMISTON
41100	41100200	Wasco County	PENDLETON-HERMISTON
41100	41100200	Wheeler County	PENDLETON-HERMISTON
41100	41100300	Harney County	BEND
41100	41100300	Klamath County	BEND
41100	41100300	Lake County	BEND
41100	41100300	Malheur County	BEND
41100	41100400	Deschutes County	BEND
41200	41200500	Clatsop County	COAST
41200	41200500	Columbia County	COAST
41200	41200500	Lincoln County	COAST
41200	41200500	Tillamook County	COAST
41200	41200600	Benton County	EUGENE
41200	41200600	Linn County	EUGENE
41200	41200701	Lane County	EUGENE
41200	41200702	Lane County	EUGENE
41300	41300800	Coos County	COAST
41300	41300800	Curry County	COAST
41300	41300800	Josephine County	COAST
41300	41300900	Jackson County	MEDFORD
41300	413001000	Douglas County	MEDFORD
41400	414001101	Marion County	SALEM
41400	414001102	Marion County	SALEM
41400	414001200	Yamhill County	PORTLAND
41501	415011301	Multnomah County	PORTLAND
41501	415011302	Multnomah County	PORTLAND
41501	415011303	Multnomah County	PORTLAND
41501	415011304	Multnomah County	PORTLAND
41501	415011305	Multnomah County	PORTLAND
41502	415021306	Multnomah County	PORTLAND
41502	415021307	Clackamas County	PORTLAND
41502	415021308	Clackamas County	PORTLAND
41502	415021309	Clackamas County	PORTLAND

41503	415031310	Washington	PORTLAND
41503	415031311	Washington	PORTLAND
41503	415031312	Washington	PORTLAND
41503	415031313	Washington	PORTLAND

Appendix C: SHADAC Projection Model

Enrollment projections were developed using the State Health Access Data Assistance Center (SHADAC) Projection Model, a complex spreadsheet model that that predicts the coverage effects of the ACA at the state level. The model uses high-level assumptions about behavior changes and then translates these assumptions into effects on groups of individuals that have similar characteristics (e.g. age, insurance type, income, employer size). Specifically, the model analyzes how policy changes affect individual and employer behaviors, and how these behavior changes translate into shifts in health insurance coverage.

The SHADAC Projection Model for Oregon is based on data from three federal surveys: the 2010 American Community Survey (ACS), the 2009 Medical Expenditure Panel Survey Household Component (MEPS-HC), and the 2010 Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Data from the ACS and MEPS-IC are specific to Oregon; because state estimates are not available from MEPS-HC, the model uses national data matched to Oregon ACS data using statistical matching techniques. The baseline data were adjusted to match public coverage enrollment data from Oregon's Medicaid and CHIP enrollment files.

To the extent possible, the assumptions used in the model for Oregon are based on Oregon-specific data or developed in consultation with state officials. For example, the population and employment growth projections are based on the August 2012 Oregon Economic and Revenue Forecast.31 Public program participation rates among the newly and previously eligible are based on discussions with senior policy staff. Other assumptions are based on empirical evidence (e.g. peer reviewed literature) or other reputable sources (e.g. Congressional Budget Office).

For more information about the development of the baseline data and the model structure and assumptions, please see the July 2012 State Health Reform Assistance Network issue brief, "Predicting the Health Insurance Impacts of Complex Policy Changes: A New Tool for States."

Appendix D: BHP Program: Method, Assumptions and Data Sources

Method

Our overall approach to estimating the potential financial impact of implementing a BHP in Oregon involved the following elements:

- Estimate the size and demographic characteristics of the population eligible for the BHP in Oregon and the estimated enrollment in 2016.
- Calculate the federal premium and cost sharing subsidies that would be made available to fund the BHP in 2016 based on the projected second lowest cost Silver Level plan premiums offered in the exchange.[1]
- Estimate the financial impact to consumers and the State under three different scenarios that range from a "nominal" consumer benefit scenario in terms of benefit coverage (commercial EHB vs. OHP) and consumer affordability (varying subsidization of premiums and cost sharing), to an "enhanced" benefit scenario (i.e., OHP benefit package with no member premium or cost-sharing). We also modeled a "break-even" scenario where we varied the amount of premium subsidy BHP enrollees would receive such that State revenues and claim expenses would offset.
- Test results by varying values for a few key assumptions. In addition to the different consumer benefit scenarios, we also tested results assuming State administrative costs would be 3% of BHP payments versus 7%, and assuming health plan fee levels would be equal to the midpoint between commercial and Medicaid levels versus 100% of commercial fees.

Assumptions and Data Sources

In order to accomplish the steps discussed in the Method section above, numerous assumptions were needed. This section describes the assumptions and data sources underlying the different aspects of the BHP financial modeling.

Eligible Population and Demographic Characteristics

In order to model the projected State revenues and insured claim costs under a BHP, it was necessary to estimate detailed demographic characteristics of eligible residents. The demographic characteristics were age, sex, household income, household size, and source of insurance coverage (including no insurance) prior to the implementation of the BHP.

The State of Oregon had previously engaged SHADAC to estimate the potential size of the population likely to choose to enroll in a BHP. The SHADAC study did not have all necessary

[1] Basic Health Program: Proposed Federal Funding Methodology for Program Year 2015. December 12, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-12-23/pdf/2013-30435.pdf

detail for our financial model; however, our BHP population characteristics are tied to the level of detail that was available in the 2013 study. Appendix B provides a brief description of the SHADAC projection model.

In addition to the age and gender detail available from the SHADAC study, we also needed the following detail:

- Income as a percentage of FPL
- Age by year
- Previous source of coverage (Uninsured, insured in Individual private market, or legal immigrant with income less than 138%).
- Geographic region within Oregon

The additional detail needed for the BHP financial modeling came from 2011 American Community Survey Data, combined with take-up assumptions provided by the State.

Table 6 shows the final BHP enrolled population characteristics for selected measures.

Table 6

Assumed Demographic Characteristics of BHP Enrollees

	<=150% FPL		150%-200% FPL		
Average	Females	Males	Females	Males	Total
Age	36.0	33.9	42.0	38.0	39.1
19-25	1,981	1,732	4,586	6,271	14,570
26-29	245	1,700	3,385	2,685	8,015
30-44	1,813	1,556	8,719	13,166	25,254
45-54	526	678	6,017	4,214	11,434
55-64	663	882	7,309	4,285	13,138
Total	**5,228**	**6,549**	**30,015**	**30,620**	**72,412**

Appendix D: BHP Program: Method, Assumptions and Data Sources

Overall targets by previous source of insurance coverage were provided by the State, and were determined as follows:

Source of Prior Coverage	Value	Source
Previously Uninsured		
Total number of previously uninsured with income 139%-200% FPL	44,319	SHADAC
- Number of residents who are undocumented and uninsured with income 139%-200% FPL	31,910	SHADAC, Health Affairs, Pew
= Documented uninsured, 139%-200% FPL*	12,409	
x Assumed BHP take-up rate	67%	State Assumption
= Documented BHP enrollees	**8,314**	
Previous Individual Insurance		
Individual coverage in the exchange*	64,098	SHADAC
x Assumed BHP take-up rate	100%	State Assumption
= BHP enrollees previously enrolled in the exchange	**64,098**	
Total BHP Population	**72,412**	SHADAC
*A March 2013 brief by SHADAC estimated 7,000 uninsured recent legal immigrants <= 138% FPL in the State of Oregon. The state assumed that 50% of this population was previously enrolled in individual coverage through the exchange and the other 50% accounted for a portion of the documented uninsured between 139%-200% FPL.		

Projected Claim Costs

We estimated claim costs for each resident in the Wakely database. In general terms, we projected 2016 costs as follows:

1. Begin with allowed claim costs derived from the second lowest Silver rates filed in the CY2014 Oregon individual exchange. The term "allowed claims" means total costs before member cost sharing is subtracted, but after discounts from provider reimbursement arrangements are applied.
2. Adjust starting claim costs if the person was previously uninsured.
3. Project costs to 2016 by applying adjustments for utilization and unit costs trends, assumed provider reimbursement levels (e.g. Commercial versus Medicaid), member cost sharing levels, and induced utilization to reflect benefit richness.
4. If applicable for the given scenario, add costs for OHP benefits that are not covered by the EHB benchmark plan.

Below we provide a more detailed description for each of the elements discussed above.

Starting CY2014 costs. For persons previously insured under an individual insurance plan or who were legally present immigrants, we calculated starting allowed costs as follows:

A. Calculate the average second lowest Silver rate for each of the standard seven geographic regions in Oregon. American Community Survey (ACS) census data was used to calculate averages across ages.
B. Multiply by an assumed medical expense ratio of 80%, consistent with the federal minimum medical loss ratio requirement for individual business.
C. Divide by the assumed Silver actuarial value of 0.70 to derive allowed costs.
D. Remove the estimated reduction for the temporary federal reinsurance program in 2014. We removed the reinsurance reduction because federal reinsurance does not apply in the BHP. Based on rate filings we have reviewed and our own internal calculations, we estimated that the 2014 reinsurance program would reduce premiums 12.5% on average. Therefore, we increased allowed costs in C. by 1/(1-0.125) = 1.143.
E. Divide by the average age/sex factor for each region using ACS census data by age and cost relativities by age based on nationwide commercial group data from the TruVen MarketScan[2] database.
F. Multiply by the estimated actual cost relativity for the given person's age, again using cost relativities from the TruVen MarketScan data.

Adjustment for Uninsured Status. Since we are modeling the financial impact of a BHP in 2016, a portion of the population assumed to enroll will come from persons who remained uninsured in 2014 and 2015 despite the availability of guaranteed issue coverage in the exchange or through an employer. These people are likely to be relatively healthy given the ready availability of coverage.

On the other hand, as noted in the "Eligibility" section, above, we assume that only some of the individuals who remain uninsured in 2015 will enroll in the BHP. This will mean that uninsured persons who do enroll in the BHP are likely to be less healthy on average.

To account for these factors, we needed an adjustment to apply to starting costs derived from the Silver rates.

The uninsured cost adjustment factor was calculated as follows:

[2] The Truven MarketScan database is a robust, high-quality healthcare claim data set with patient level of detail from a diverse set of data sources including employers, health plans, and government agencies.

1. Start with estimated costs for Oregon uninsured persons in 2015 from the March 2013 Society of Actuaries (SOA) study "Cost of the Newly Insured under the Affordable Care Act (ACA)". This cost estimate was $96.68 per member per month (PMPM).
2. Adjust for an assumed increase in costs due to the presence of insurance coverage, using relativities in the SOA study. We calculated this adjustment as the ratio of costs after ACA versus before ACA for persons with incomes between 138% and 200% FPL who were uninsured but who purchased coverage in 2014 or 2015. This ratio was $231.32/$127.93 = 1.808.
3. Apply a selection adjustment of 1.33. This selection assumption was based on the William Bluhm paper "The Minnesota Antiselection Model" and assumed a participation rate of 67%.
4. Calculate the relativity of the adjusted uninsured cost to the overall estimated cost of the exchange. This calculation was ($96.68 x 1.808 x 1.33)/$374.18 = 0.62. Note that the costs in this calculation are Oregon-specific and are from the SOA study
5. Adjust the 0.62 factor in step 4 for the average age/sex factor of the uninsured population. Based on the ACS data, we estimated this factor to be 0.864 (i.e., the uninsured are on younger than exchange enrollees on average). Therefore, the final uninsured adjustment factor was 0.62 x 0.864 = 0.72.

Projection of CY2016 Net Costs. To project claim costs to 2016, we applied the following adjustments:

- Utilization and unit cost trend. The combined utilization and unit cost trend used depended on the reimbursement assumption being used. For commercial reimbursement, the trends were based on the average trends used in Oregon exchange rate filings for carriers with existing business, we used a combined utilization and unit cost annualized trend of 7.2%. For Medicaid trend, we assumed an annual rate of 3.4%, which was provided by the State. So, if a scenario was based on average commercial and Medicaid fees, then we used an average trend of (7.2% + 3.4%)/2 = 5.3%. We applied annual trend over two years, from 2014 to 2016.

- Difference in provider reimbursement levels. In our modeling, we tested scenarios with different reimbursement levels. We assumed that the costs derived from the Silver rates represented 100% of average commercial fees. Using information from the Oregon All Payer All Claims database and average paid to billed ratios from State Medicaid experience, we developed an adjustment factor to approximate Medicaid fee levels. This Medicaid factor was calculated as the ratio of 39.5%/64.0% = 62%, where 39.5% was the paid to billed ratio from State Medicaid data, and 64.0% was

the average allowed to billed ratio from the all payer database. The table below shows the factor we applied by scenario.

Scenario	Factor
Commercial Fees	1.00
Commercial/Medicaid Average	0.81
Medicaid	0.62

- Member cost sharing. By default, we multiplied adjusted allowed costs by the standard actuarial value established for the Silver cost sharing subsidy plans. These actuarial values vary by income level, and are summarized below.

Income as % of FPL	Actuarial Value
0%-150%	94%
150%-200%	87%

- Induced utilization. We adjusted utilization based on assumed changes in consumer behavior as benefit richness changes. We used the federal induced utilization factors as a basis. It was also necessary to estimate the inherent induced utilization (IU) built into the Silver rates filed in the exchange since the Silver rate applied for the standard Silver 70% plan and the cost sharing subsidy plans (73%, 87%, and 94%). Based on a review of the Oregon individual exchange rate filings, we estimate the average IU factor to be 1.03; although it is important to note that the factors varied by carrier.

  The final IU factor was the ratio of the federal factor for the given benefit level being considered (as measured by actuarial value) to the 1.03 base IU assumed to be inherent in the Silver rates. Since all scenarios tested used an actuarial value of at least 0.87, the IU factor was constant at 1.12/1.03 = 1.09.

OHP Benefits not Covered by the EHB Benchmark Plan. In some scenarios, we tested the impact of adding certain categories of service covered under the State Medicaid Plan (OHP) that were not covered in the Oregon EHB Benchmark plan. Appendix A provides a comparison of the OHP and EHB Benchmark plans.

Using State Medicaid experience and capitation rates, we estimated the cost of the additional OHP benefits to be about $27.00 PMPM. The table below summarizes our estimate by benefit category. Note that we did not trend the experience since most of the benefits are subject to minimal or no inflation.

Benefit Category	Age Category		
	21-44	45-54	55-64
Adult Dental	$24.69	$24.69	$24.69
Chiropractic	$0.25	$0.30	$0.34
Non-Emerg. Transportation	$0.76	$0.76	$0.76
Unlimited IP Rehab	$0.24	$0.24	$0.24
Unlimited PT/OT/ST	$0.02	$0.02	$0.02
Unlimited DME	$0.82	$0.82	$0.82
Total	**$26.78**	**$26.82**	**$26.87**

BHP Payments to the State

Appendix B provides a detailed description of these calculations; however, we note here that all calculations were based on the following sources of data:

- Distribution of age and income based on the SHADAC and ACS data, as described above.
- 2014 second-lowest cost Silver premium levels by region from the exchange filings.
- Formulas and factors described in the December 2013 proposed BHP Payment regulation.

Calculation of Federal Advance Premium Tax Credits (APTC) and Cost Sharing Reduction (CSR) Subsidies

Wakely calculated federal advance premium tax credits and cost sharing subsidies using the actual method used by CMS. When we make comparisons of out-of-pocket expenses for BHP eligible individuals under an assumption that no BHP is implemented, we calculate federal premium tax credits and cost sharing subsidies using the expected method used by CMS. Ultimately, these subsidies are calculated on an individual basis, so that actual premiums, incomes, and cost sharing amounts are used rather than the averages by rate cell used for the BHP payments. This can create differences in ATPC and cost sharing subsidy amounts for the same individual in the BHP versus in the exchange, in addition to the main difference that BHP payments apply a factor of 95%.

Member Premium

A State BHP can charge enrollees a member premium, but it can be no higher than the premium that would have been paid by that member selecting the second lowest cost Silver plan in the exchange. The eligibility requirements for the BHP dictate that enrollees have incomes no higher than 200% of FPL, so all BHP enrollees will be eligible for premium tax credits and cost-sharing subsidies.

Member premiums are calculated as the difference between the household premium and the federal advance premium tax credit (APTC). The APTC is calculated as the difference between the total premium and the maximum household payment, which is a percentage of income as defined in the ACA. The table below shows this percentage for selected income levels; however, it should be noted that we linearly interpolated for all income values.

Income as % of FPL	Percentage of Income
0%-132%	2.0%
133%	3.0%
150%	4.0%
175%	5.2%
200%	6.3%
250%	8.1%
300%	9.5%
399%	9.5%
400%+	0.0%

In our modeling, we tested different State subsidy levels for member premium net of the federal tax credit. In our scenarios, we present the State subsidy level as a percentage of the maximum allowed member premium. A value of 100% means the state pays the entire premium; whereas, a value of 50% means the member pays half of what would have otherwise been required to pay for the second lowest cost Silver plan on the exchange.

Member Cost Sharing

Similar to the member premium, the BHP benefit plan can have cost sharing no greater than the Silver subsidy level for which the member would have been eligible in the exchange.

In our scenarios, we varied the portion of this maximum allowed cost sharing that would be supplemented by the State. We present member cost sharing as a percentage of the maximum allowed level. A value of 100% means the member will pay the same relative cost sharing level as that paid in the exchange plan for which they would have been eligible. A value of 0% means the member will not be responsible for any cost sharing.

State Program Costs

The State of Oregon will incur operational costs in order to facilitate a BHP. There will be start-up costs to cover the development of processes, systems and staff to manage BHP interactions with the federal government, contracted carriers, and enrollees.

Once the BHP is set up, there will be annual ongoing costs to maintain and run the program.

While it is realistic to assume there will be start-up costs, we did not include these expenses in our analysis at the State's request since an estimate was not readily available.

For annual costs, we assumed State administrative expenses would be either 3% or 7% of federal BHP payments. These two assumptions are intended to represent a reasonable range of likely expenses and were based on discussions with the State and other publicly available BHP studies.

In addition to the State administrative expenses, we assumed that a fee similar to the Cover Oregon exchange fee will need to be collected from contracted plans. This fee was assumed to be $6.95 PMPM. It is shown as an administrative expense in Exhibit A and in our analysis.

Appendix E: Bridge Plan: Method, Assumptions and Data Sources

Method

Our overall approach to estimating the potential financial impact of implementing a Bridge in Oregon involved the following elements:

- Estimate the size and demographic characteristics of the population eligible for the Bridge plan in Oregon and the estimated take up and enrollment.
- Calculate the federal premium tax credit and cost sharing subsidies that will be paid by the federal government for Bridge eligible individuals. These calculations take into account the availability of an additional Silver plan (i.e. the Bridge plan) for purposes of determining the second lowest Silver rate.
- Estimate the financial impact to consumers and the State under three different scenarios that range from a "nominal" consumer benefit scenario in terms of benefit coverage (commercial EHB vs. OHP) and affordability (varying subsidization of premiums and cost sharing), to an "enhanced" benefit scenario (i.e., OHP benefit package with no premium or cost-sharing).
- Test results for different population types and for different provider reimbursement levels. In addition to the different consumer benefit scenarios, we also tested results assuming eligibility would depend on either previous Medicaid eligibility or being a parent of a CHIP-eligible child, and assuming health plan fee levels would be equal to the midpoint between commercial and Medicaid levels versus 100% of Medicaid fees.

Assumptions and Data Sources

In order to accomplish the steps discussed in the Method section, above, numerous assumptions are needed. This section describes the assumptions and data sources underlying the different aspects of the Bridge plan financial modeling.

Eligible Population and Demographic Characteristics

In our modeling, we analyzed the Bridge plan for two different population types:

i. Persons previously eligible for Medicaid whose incomes increased to level between 138% and 200% of FPL.
ii. Parents of children eligible for the State CHIP program (138-200% FPL).

In order to model the projected State revenues and insured claim costs under the Bridge plan, it was necessary to estimate detailed demographic characteristics of eligible residents who choose to enroll. The necessary characteristics were age, sex, household income, household size, and source of insurance coverage prior to the implementation of the Bridge.

Appendix E – Bridge Plan: Method, Assumptions and Data Sources

The demographic detail primarily came from 2011 American Community Survey Data, with a target number of CHIP parents provided by the State.

Table 7 shows the final assumed Bridge population enrollee characteristics in 2016 for the two categories of Bridge eligible individuals. The enrollment assumptions below assume that 100% of all eligible persons would choose the Bridge plan.

Table 7
Demographic Characteristics of Bridge Population Enrollees as of CY2016

Previously Eligible for Medicaid			CHIP Parents			
			Females		Males	
Age	Females	Males	Previously Covered	Uninsured	Previously Covered	Uninsured
19-25	6,364	3,490	634	1,516	114	480
26-29	5,374	2,764	1,188	2,430	1,047	1,776
30-44	16,803	10,210	3,665	5,918	4,307	5,724
45-54	7,716	6,513	1,726	2,748	1,505	2,525
55-64	6,119	4,097	995	713	1,125	309
Total	42,376	27,075	8,208	13,324	8,098	10,814

The Previous Medicaid population was estimated based on the following assumptions:

- Begin with all adults ages 21 to 64 identified as having Medicaid coverage as of 2011 in the ACS database.
- Apply an assumed percentage of people whose income would increase to a level between 138% and 200% of FPL. These percentages were based on an income churn study provided by the State. The resulting percentages were as follows:

Initial FPL	Nonelderly Adults	Number Churning to 139-200%	% Churn After one year
0-42%	9,997,136	1,055,368	10.6%
43-138%	22,222,687	3,513,640	15.8%

The same percentages were applied across all age and sex cohorts.

- Increase starting income to a level between 138% and 200% of FPL. No data was available on the level of income that would be attained by individuals whose income increases. For the purposes of our analysis, we assumed that incomes would increase in proportion to the starting income, with the additional stipulation that ending income must be between 138% and 200% FPL. The table below shows the new, higher income level for selected beginning income levels. We interpolated for other beginning income levels.

Initial FPL	FPL After Churn
0%-50%	138%
75%	158%
100%	185%
125%+	200%

The demographic characteristics of the CHIP Parent population were based on a subset of the 2011 ACS database, which was scaled to match an overall CY2016 target of 40,444 provided by the State.

The ACS subset data had the following characteristics:

- Income between 138% and 200% FPL.
- All sources of current insurance except Medicare, Dual eligibles and Veterans administration eligible individuals.
- Must be at least one child present in the household.

This subset yielded a total of 40,288 people, which was very close to the 40,444 target from the State.

The overall target of 40,444 was derived as follows:

Total CHIP children, FPL 139%-200% [1]	49,156
x Average Number of Children per Household [1]	1.73
= Number of CHIP households	28,407
x Average number of parents per household [2]	1.42
= Number of CHIP Parents	40,444

[1] July 2013 ICS data

[2] Sep 2013 data provided for Fast Track letters

Appendix E – Bridge Plan: Method, Assumptions and Data Sources

Projected Claim Costs

The development of projected claim costs for Bridge eligible individuals followed most of the same steps and assumptions described in the BHP section, above. The differences in the development of projected Bridge plan claim costs are as follows:

1. *Projection of costs to 2016*. In addition to the adjustments described in the BHP section, above, we also applied a reduction in costs for the expected federal reinsurance program[3] that would apply in 2016. Federal reinsurance does not apply for the BHP, but does apply to the Bridge plan since it's still considered a QHP plan in the exchange.

   The adjustment was calculated by applying expected changes in the parameters of the reinsurance program to our estimate that the program is expected to reduce exchange premiums by 12.5% in 2014. The table below shows our assumptions underlying this estimate.

Year	Threshold	Coinsurance	Expected Federal Collections	Estimated Impact on Exchange Premiums
2014	$60k-$250k*	80%	$10B	-12.50%
2015	$70k-$250k	50%	$6B	-7.20%
2016	?	?	$4B	-5.00%

   * The above parameters were used for 2014 rate setting; however, the final 2014 attachment point was changed to $45,000 in the 2015 Notice of Benefit and Payment Parameters.

Determination of Silver Rates for the Bridge Plan

Individuals who are eligible for the Bridge plan will receive federal premium tax credits based on the second lowest Silver premium available to them. In all scenarios tested in our analysis, the Bridge plan rates are below the projected 2016 lowest Silver rate in the exchange.

The Bridge rates for purposes of calculating the federal premium tax credit (FPTC) were developed as follows:

1. Begin with projected 2016 EHB allowed claim costs by region, which include adjustments for trend, federal reinsurance, and provider reimbursement levels.
2. Apply an assumed actuarial value of 70% to get net costs for a Silver plan.

[3] The federal reinsurance program is a temporary program established by the ACA that pays individual QHP carriers protection against large claims during 2014 through 2016.

3. Add administrative costs of 20% of premium, plus a $9.38 PMPM for the Oregon exchange fee.

It should be noted that the Bridge member will potentially pay a higher premium if they are a tobacco user.

The table below compares the second lowest Silver, lowest Silver, and two Bridge plan rates under different provider reimbursement assumptions for a 40 year-old.

PLAN TYPES	BEND	COAST	EUGENE	MEDFORD	PENDLETON - HERMISTON	PORTLAND	SALEM
Second Lowest Silver	$326	$302	$306	$292	$295	$282	$285
Lowest Silver	$276	$276	$276	$276	$276	$268	$276
Bridge Plan - Avg Comml/Mcaid	$260	$241	$245	$233	$236	$226	$228
Bridge Plan – Medicaid fees	$202	$187	$190	$181	$183	$175	$177

These premiums show that the Bridge plan rates have the potential to be significantly lower than the premiums upon which the FPTC will be calculated.

Calculation of Advance Premium Tax Credit and Cost Sharing Subsidies Bridge versus no Bridge

In general, the method for calculating federal APTC and cost sharing subsidies in the Bridge plan modeling follows the federal calculations. Subsidies are calculated on an individual basis, so that actual premiums, incomes, and cost sharing amounts are used.

If a Bridge plan is assumed to be in place, then the determination of the APTC will be calculated as the difference between the lowest Silver rate in the standard exchange (which will be the second lowest for Bridge eligible individuals) and the maximum household payment (see the Method, Assumptions and Data Sources - Member Premium section in the BHP description).

When we compare with APTC amounts under an assumption that no Bridge plan is in place, then the second lowest Silver rate is used.

Please note that the income used for the calculation of the household payment with or without a Bridge plan will be the higher income consistent with the churn assumptions.

The cost sharing subsidy calculation is the same regardless of whether a Bridge Plan is place; however, the lower provider reimbursement levels associated with the Bridge Plan scenarios reduce member cost sharing for benefits that charge members coinsurance. We do not know the extent to which Bridge plan benefits will include coinsurance, so we chose

a middle-ground assumption that 50% of member cost sharing would be affected by changes in provider reimbursement.

Member Premium

The maximum member premium in the Bridge plan is equal to the Bridge premium less the APTC (if the APTC exceeds the Bridge premium, then the member pays nothing). The State can also choose to further subsidize the member premium.

We modeled different State subsidy levels for member premium net of the APTC. In our scenarios, we present the State subsidy level as a percentage of the maximum allowed member premium. A value of 100% means the state pays the entire premium; whereas, a value of 50% means the state pays half of the difference between the Bridge premium and the APTC.

Member Cost Sharing

Similar to the member premium, the Bridge plan can have cost sharing no more than the Silver CSR level for which the member would have been eligible in the exchange. The State can also choose to further subsidize the member's cost sharing.

In our scenarios, we varied the portion of this maximum allowed cost sharing that would be subsidized by the State. We express the State member cost sharing subsidy as a percentage of the maximum allowed level. A value of 100% means the member will pay the same relative cost sharing level as that paid in the exchange plan for which they would have been eligible. A value of 0% means the State will pay the difference between the full allowed cost and the Bridge plan carrier liability.

State Administrative Costs

The State of Oregon will incur operational costs in order to facilitate a Bridge plan coverage alternative. We assumed no start-up costs; although some initial expenses may be needed. With respect to ongoing operational expenses, we assumed that the State would incur 10% of the administrative expenses that health plans incur to provide the Bridge plan.

We assumed that carriers would incur administrative expenses equal to 20% of revenues (this excludes the $9.38 PMPM exchange fee). This means that the State is assumed to incur expenses equal to 2% of the Bridge plan premiums

Appendix F: Wraparound Program: Method, Assumptions and Data Sources

Method

Our overall approach to estimating the potential financial impact of implementing a Wrap in Oregon involved the following elements:

- Estimate the size and demographic characteristics of the population eligible for the Wraparound plan in Oregon and the estimated take up and enrollment.
- Calculate the federal premium tax credit and cost sharing subsidies that will be paid by the federal government for eligible individuals.
- Estimate the financial impact to consumers and the State under three different scenarios that range from a "nominal" consumer benefit scenario in terms of benefit coverage (commercial EHB vs. OHP) and affordability (varying subsidization of premiums and cost sharing), to an "enhanced" benefit scenario (i.e., OHP benefit package with no premium or cost-sharing).
- Test results for different population types. We tested results assuming eligibility would depend on either previous Medicaid eligibility or being a parent of a CHIP-eligible child.

Assumptions and Data Sources

In order to accomplish the steps discussed in the Method section above, numerous assumptions are needed. This section describes the assumptions and data sources underlying the different aspects of the Wraparound program financial modeling.

<u>Eligible Population and Demographic Characteristics</u>

The Wraparound population uses the same eligibility rules and assumptions as the Bridge modeling. Those assumptions are repeated below.

We analyzed the Wraparound for two different population types:

i. Persons previously eligible for Medicaid whose incomes increased to level between 138% and 200% of FPL.
ii. Parents of children eligible for the State CHIP program.

As with the BHP and Bridge modeling, it was necessary to estimate detailed demographic characteristics of eligible residents who choose to enroll. The necessary characteristics were age, sex, household income, household size, and source of insurance coverage in 2015.

The demographic detail primarily came from 2011 American Community Survey Data, with a target number of CHIP parents provided by the State.

Appendix F – Wraparound Program: Method, Assumptions and Data Sources

Table 8 shows the final assumed enrolled population characteristics for the two categories of Wrap eligible individuals. This is the same as the Bridge population.

Table 8
Demographic Characteristics of Wrap Population

Previously Eligible for Medicaid			CHIP Parents			
			Females		Males	
Age	Females	Males	Previously Covered	Uninsured	Previously Covered	Uninsured
19-25	6,364	3,490	634	1,516	114	480
26-29	5,374	2,764	1,188	2,430	1,047	1,776
30-44	16,803	10,210	3,665	5,918	4,307	5,724
45-54	7,716	6,513	1,726	2,748	1,505	2,525
55-64	6,119	4,097	995	713	1,125	309
Total	42,376	27,075	8,208	13,324	8,098	10,814

For additional details on the development and assumptions underlying these populations, please see the same section in the description of the Bridge Plan, above.

Projected Claim Costs

The development of projected claim costs for Bridge eligible individuals followed the same steps and assumptions as the Bridge Plan.

Calculation of APTC and Cost Sharing Subsidies QHP Wrap versus no QHP Wrap

We calculated APTC and cost sharing subsidies in the Wrap program using the federal calculations. Subsidies are calculated on an individual basis, so that actual premiums, incomes, and cost sharing amounts are used.

We needed to calculate these values in order to determine the remaining obligations of the consumer. Once this is known, we then model how much of the remaining consumer expenses are subsidized by the State.

Appendix F – Wraparound Program: Method, Assumptions and Data Sources

Member Premium

The maximum member premium for the QHP Wrap is equal to the second lowest Silver premium less the APTC (if the APTC is higher than the premium, the member pays nothing) negative values are not allowed). The State can also choose to further subsidize the member premium.

In our modeling, we tested different State subsidy levels for member premium net of the APTC. In our scenarios, we present the State subsidy level as a percentage of the maximum allowed member premium. A value of 100% means the state pays the entire premium; whereas, a value of 50% means the state pays half of the difference between the exchange premium and the APTC.

Member Cost Sharing

For the QHP Wrap program, we model different levels of cost sharing subsidy provided by the State that is in addition to the cost sharing subsidy provided by the federal government.

In our scenarios, we varied the portion of the cost sharing that would be supplemented by the State. We express State member cost sharing subsidies as a percentage of the remaining consumer obligation after reflecting the federal subsidy. A value of 100% means the member will pay the same relative cost sharing level as that paid in the exchange plan. A value of 0% means the State will pay the difference between the full allowed cost and the exchange plan carrier liability.

State Program Costs

The State of Oregon will incur operational costs in order to facilitate the QHP Wraparound program. We assumed no start-up costs; although some initial expenses may be needed. With respect to ongoing operational expenses, we assumed that the State would incur 10% of the administrative expenses that health plans incur to provide the Silver plan in the exchange.

We assumed that carriers would incur administrative expenses equal to 20% of revenues (this excludes the $9.38 PMPM exchange fee). This means that the State is assumed to incur expenses equal to 2% of the Silver exchange plan premiums.

Exhibit A.1
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					($150,564)			$150,564
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		($150,564)	($197,496)		$348,060
Claim Expenses										
Medical Expense Liability	$224,681									$249,575
Member Cost Sharing		$61,337					$34,279			
Subtotal	$224,681	$61,337	$0		$0		$34,279	$0		$249,575
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$5,925
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,964
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**($184,844)**	**($197,496)**	**$6,039**	**$86,521**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	($2,079.27)			$2,079.27
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	($2,079.27)	($2,727.38)		$4,806.64
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$3,446.58
Member Cost Sharing		$847.05					$473.39			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$473.39	$0.00		$3,446.58
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$81.82
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.22
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	($2,552.66)	($2,727.38)	$83.40	$1,194.84

Exhibit A.2
Projected Revenue and Expenses
Basic Health Program
2016

Population:	BHP Eligible
Fee Basis:	Average Commercial and Medicaid
Benefits Covered:	EHB
Member Premium:	Member Pays 46.0% of Allowed Premium in the Exchange
Member Cost Sharing:	50% of allowed allowed cost sharing
State Administrative Expense:	3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					($69,219)			$69,219
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		($69,219)	($197,496)		$266,715
Claim Expenses										
Medical Expense Liability	$224,681									$266,715
Member Cost Sharing		$61,337					$17,140			
Subtotal	$224,681	$61,337	$0		$0		$17,140	$0		$266,715
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$5,925
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,964
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**($86,358)**	**($197,496)**	**$6,039**	**($11,964)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	($955.90)			$955.90
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	($955.90)	($2,727.38)		$3,683.28
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$3,683.28
Member Cost Sharing		$847.05					$236.70			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$236.70	$0.00		$3,683.28
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$81.82
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.22
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	($1,192.59)	($2,727.38)	$83.40	($165.22)

Exhibit A.3
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					$0			$0
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		$0	($197,496)		$197,496
Claim Expenses										
Medical Expense Liability	$224,681									$305,561
Member Cost Sharing		$61,337					$0			
Subtotal	$224,681	$61,337	$0		$0		$0	$0		$305,561
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$5,925
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,964
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**$0**	**($197,496)**	**$6,039**	**($120,030)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	$0.00			$0.00
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	$0.00	($2,727.38)		$2,727.38
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$4,219.74
Member Cost Sharing		$847.05					$0.00			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$0.00	$0.00		$4,219.74
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$81.82
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.22
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	$0.00	($2,727.38)	$83.40	($1,657.59)

Exhibit A.4
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					($150,564)			$150,564
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		($150,564)	($197,496)		$348,060
Claim Expenses										
Medical Expense Liability	$224,681									$249,575
Member Cost Sharing		$61,337					$34,279			
Subtotal	$224,681	$61,337	$0		$0		$34,279	$0		$249,575
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$13,825
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,864
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**($184,844)**	**($197,496)**	**$6,039**	**$78,621**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	($2,079.27)			$2,079.27
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	($2,079.27)	($2,727.38)		$4,806.64
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$3,446.58
Member Cost Sharing		$847.05					$473.39			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$473.39	$0.00		$3,446.58
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$190.92
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$274.32
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	($2,552.66)	($2,727.38)	$83.40	$1,085.75

Exhibit A.5
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 46.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					($69,219)			$69,219
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		($69,219)	($197,496)		$266,715
Claim Expenses										
Medical Expense Liability	$224,681									$266,715
Member Cost Sharing		$61,337					$17,140			
Subtotal	$224,681	$61,337	$0		$0		$17,140	$0		$266,715
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$13,825
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,864
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**($86,358)**	**($197,496)**	**$6,039**	**($19,864)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	($955.90)			$955.90
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	($955.90)	($2,727.38)		$3,683.28
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$3,683.28
Member Cost Sharing		$847.05					$236.70			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$236.70	$0.00		$3,683.28
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$190.92
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$274.32
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	($1,192.59)	($2,727.38)	$83.40	($274.32)

Exhibit A.6
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$150,072		($150,072)					($136,144)		$136,144
Member Premium	$138,815	($138,815)					$0			$0
Cost Sharing Reduction			($65,196)					($61,351)		$61,351
Subtotal	$288,887	($138,815)	($215,268)		$0		$0	($197,496)		$197,496
Claim Expenses										
Medical Expense Liability	$224,681									$305,561
Member Cost Sharing		$61,337					$0			
Subtotal	$224,681	$61,337	$0		$0		$0	$0		$305,561
Administrative Costs										
SG&A, Taxes, and Fees	$57,777									$13,825
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,928	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,864
Net Cash Flow	**($1,722)**	**($200,152)**	**($215,268)**	**$8,151**	**$0**	**$0**	**$0**	**($197,496)**	**$6,039**	**($127,929)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,072.46		($2,072.46)			$0.00		($1,880.13)		$1,880.13
Member Premium	$1,917.01	($1,917.01)				$0.00	$0.00			$0.00
Cost Sharing Reduction			($900.35)					($847.25)		$847.25
Subtotal	$3,989.47	($1,917.01)	($2,972.81)		$0.00	$0.00	$0.00	($2,727.38)		$2,727.38
Claim Expenses										
Medical Expense Liability	$3,102.80					$0.00				$4,219.74
Member Cost Sharing		$847.05					$0.00			
Subtotal	$3,102.80	$847.05	$0.00		$0.00	$0.00	$0.00	$0.00		$4,219.74
Administrative Costs										
SG&A, Taxes, and Fees	$797.89					$0.00				$190.92
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$910.45	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$274.32
Net Cash Flow	($23.78)	($2,764.06)	($2,972.81)	$112.56	$0.00	$0.00	$0.00	($2,727.38)	$83.40	($1,766.68)

Exhibit A.7
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					($150,518)			$150,518
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		($150,518)	($197,162)		$347,681
Claim Expenses										
Medical Expense Liability	$224,430									$319,818
Member Cost Sharing		$61,201					$43,927			
Subtotal	$224,430	$61,201	$0		$0		$43,927	$0		$319,818
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$5,915
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,954
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**($194,445)**	**($197,162)**	**$6,039**	**$15,908**

Annual Amount per Member

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	($2,078.63)			$2,078.63
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	($2,078.63)	($2,722.78)		$4,801.40
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$4,416.63
Member Cost Sharing		$845.18					$606.63			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$606.63	$0.00		$4,416.63
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$81.68
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.08
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	($2,685.25)	($2,722.78)	$83.40	$219.69

Exhibit A.8
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 96.1% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					($144,619)			$144,619
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		($144,619)	($197,162)		$341,782
Claim Expenses										
Medical Expense Liability	$224,430									$341,782
Member Cost Sharing		$61,201					$21,964			
Subtotal	$224,430	$61,201	$0		$0		$21,964	$0		$341,782
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$5,915
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,954
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**($166,583)**	**($197,162)**	**$6,039**	**($11,954)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	($1,997.16)			$1,997.16
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	($1,997.16)	($2,722.78)		$4,719.94
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$4,719.94
Member Cost Sharing		$845.18					$303.31			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$303.31	$0.00		$4,719.94
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$81.68
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.08
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	($2,300.48)	($2,722.78)	$83.40	($165.08)

Exhibit A.9
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 3.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					$0			$0
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		$0	($197,162)		$197,162
Claim Expenses										
Medical Expense Liability	$224,430									$385,452
Member Cost Sharing		$61,201					$0			
Subtotal	$224,430	$61,201	$0		$0		$0	$0		$385,452
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$5,915
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$11,954
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**$0**	**($197,162)**	**$6,039**	**($200,244)**

Annual Amount per Member

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	$0.00			$0.00
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	$0.00	($2,722.78)		$2,722.78
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$5,323.02
Member Cost Sharing		$845.18					$0.00			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$0.00	$0.00		$5,323.02
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$81.68
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$165.08
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	$0.00	($2,722.78)	$83.40	($2,765.33)

Exhibit A.10
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					($150,518)			$150,518
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		($150,518)	($197,162)		$347,681
Claim Expenses										
Medical Expense Liability	$224,430									$319,818
Member Cost Sharing		$61,201					$43,927			
Subtotal	$224,430	$61,201	$0		$0		$43,927	$0		$319,818
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$13,801
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,841
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**($194,445)**	**($197,162)**	**$6,039**	**$8,022**

Annual Amount per Member

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	($2,078.63)			$2,078.63
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	($2,078.63)	($2,722.78)		$4,801.40
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$4,416.63
Member Cost Sharing		$845.18					$606.63			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$606.63	$0.00		$4,416.63
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$190.59
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$273.99
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	($2,685.25)	($2,722.78)	$83.40	$110.78

Exhibit A.11
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 96.1% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					($144,619)			$144,619
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		($144,619)	($197,162)		$341,782
Claim Expenses										
Medical Expense Liability	$224,430									$341,782
Member Cost Sharing		$61,201					$21,964			
Subtotal	$224,430	$61,201	$0		$0		$21,964	$0		$341,782
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$13,801
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,841
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**($166,583)**	**($197,162)**	**$6,039**	**($19,841)**

PMPY

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	($1,997.16)			$1,997.16
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	($1,997.16)	($2,722.78)		$4,719.94
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$4,719.94
Member Cost Sharing		$845.18					$303.31			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$303.31	$0.00		$4,719.94
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$190.59
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$273.99
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	($2,300.48)	($2,722.78)	$83.40	($273.99)

Exhibit A.12
Projected Revenue and Expenses
Basic Health Program
2016

Population: BHP Eligible
Fee Basis: Commercial
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 7.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		868,947					868,947			
Enrollment - Members		72,412					72,412			
Revenue										
Federal Premium Tax Credit	$149,782		($149,782)					($135,880)		$135,880
Member Premium	$138,772	($138,772)					$0			$0
Cost Sharing Reduction			($65,196)					($61,283)		$61,283
Subtotal	$288,555	($138,772)	($214,979)		$0		$0	($197,162)		$197,162
Claim Expenses										
Medical Expense Liability	$224,430									$385,452
Member Cost Sharing		$61,201					$0			
Subtotal	$224,430	$61,201	$0		$0		$0	$0		$385,452
Administrative Costs										
SG&A, Taxes, and Fees	$57,711									$13,801
Cover OR Exchange Fee	$8,151			($8,151)					($6,039)	$6,039
Subtotal	$65,862	$0	$0	($8,151)	$0	$0	$0	$0	($6,039)	$19,841
Net Cash Flow	**($1,737)**	**($199,974)**	**($214,979)**	**$8,151**	**$0**	**$0**	**$0**	**($197,162)**	**$6,039**	**($208,130)**

Annual Amount per Member

	Individual Exchange - No BHP					Basic Health Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,068.47		($2,068.47)			$0.00		($1,876.47)		$1,876.47
Member Premium	$1,916.42	($1,916.42)				$0.00	$0.00			$0.00
Cost Sharing Reduction			($900.35)					($846.31)		$846.31
Subtotal	$3,984.88	($1,916.42)	($2,968.81)		$0.00	$0.00	$0.00	($2,722.78)		$2,722.78
Claim Expenses										
Medical Expense Liability	$3,099.33					$0.00				$5,323.02
Member Cost Sharing		$845.18					$0.00			
Subtotal	$3,099.33	$845.18	$0.00		$0.00	$0.00	$0.00	$0.00		$5,323.02
Administrative Costs										
SG&A, Taxes, and Fees	$796.98					$0.00				$190.59
Cover OR Exchange Fee	$112.56			($112.56)		$0.00			($83.40)	$83.40
Subtotal	$909.54	$0.00	$0.00	($112.56)	$0.00	$0.00	$0.00	$0.00	($83.40)	$273.99
Net Cash Flow	($23.98)	($2,761.60)	($2,968.81)	$112.56	$0.00	$0.00	$0.00	($2,722.78)	$83.40	($2,874.24)

Exhibit B.1
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,059		($147,059)			$135,102		($135,102)		
Member Premium	$116,920	($116,920)				$96,755	($96,755)			0
Cost Sharing Reduction			($62,468)					($48,748)		
Subtotal	$263,979	($116,920)	($209,527)		$0	$231,858	($96,755)	($183,850)		$0
Claim Expenses										
Claim Liability	$234,084					$177,468				$0
Member Cost Sharing		$37,854					$34,743			$0
Subtotal	$234,084	$37,854	$0		$0	$177,468	$34,743	$0		$0
Administrative Costs										
SG&A, Taxes, and Fees	$52,796					$46,372				$5,280
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,613	$0	$0	($7,817)	$0	$54,189	$0	$0	($7,817)	$5,280
Net Cash Flow	**($30,719)**	**($154,774)**	**($209,527)**	**$7,817**	**$0**	**$200**	**($131,498)**	**($183,850)**	**$7,817**	**($5,280)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,117.44		($2,117.44)			$1,945.28		($1,945.28)		
Member Premium	$1,683.48	($1,683.48)				$1,393.14	($1,393.14)			$0.00
Cost Sharing Reduction			($899.45)					($701.90)		
Subtotal	$3,800.92	($1,683.48)	($3,016.89)		$0.00	$3,338.42	($1,393.14)	($2,647.18)		$0.00
Expenses										
Claim Liability	$3,370.48					$2,555.29				$0.00
Member Cost Sharing		$545.04					$500.25			$0.00
Subtotal	$3,370.48	$545.04	$0.00		$0.00	$2,555.29	$500.25	$0.00		$0.00
Administrative Costs										
SG&A, Taxes, and Fees	$760.18					$667.68				$76.02
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$872.74	$0.00	$0.00	($112.56)	$0.00	$780.24	$0.00	$0.00	($112.56)	$76.02
Net Cash Flow	($442.31)	($2,228.52)	($3,016.89)	$112.56	$0.00	$2.88	($1,893.39)	($2,647.18)	$112.56	($76.02)

Exhibit B.2
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,059		($147,059)			$135,102		($135,102)		
Member Premium	$116,920	($116,920)				$48,378	($48,378)			($48,378)
Cost Sharing Reduction			($62,468)					($48,748)		
Subtotal	$263,979	($116,920)	($209,527)		$0	$183,480	($48,378)	($183,850)		($48,378)
Claim Expenses										
Claim Liability	$234,084					$180,070				$0
Member Cost Sharing		$37,854					$17,371			$14,770
Subtotal	$234,084	$37,854	$0		$0	$180,070	$17,371	$0		$14,770
Administrative Costs										
SG&A, Taxes, and Fees	$52,796					$36,696				$5,280
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,613	$0	$0	($7,817)	$0	$44,513	$0	$0	($7,817)	$5,280
Net Cash Flow	**($30,719)**	**($154,774)**	**($209,527)**	**$7,817**	**$0**	**($41,103)**	**($65,749)**	**($183,850)**	**$7,817**	**($68,427)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,117.44		($2,117.44)			$1,945.28		($1,945.28)		
Member Premium	$1,683.48	($1,683.48)				$696.57	($696.57)			($696.57)
Cost Sharing Reduction			($899.45)					($701.90)		
Subtotal	$3,800.92	($1,683.48)	($3,016.89)		$0.00	$2,641.85	($696.57)	($2,647.18)		($696.57)
Expenses										
Claim Liability	$3,370.48					$2,592.75				$0.00
Member Cost Sharing		$545.04					$250.12			$212.67
Subtotal	$3,370.48	$545.04	$0.00		$0.00	$2,592.75	$250.12	$0.00		$212.67
Administrative Costs										
SG&A, Taxes, and Fees	$760.18					$528.37				$76.02
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$872.74	$0.00	$0.00	($112.56)	$0.00	$640.93	$0.00	$0.00	($112.56)	$76.02
Net Cash Flow	($442.31)	($2,228.52)	($3,016.89)	$112.56	$0.00	($591.83)	($946.69)	($2,647.18)	$112.56	($985.25)

Exhibit B.3
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,059		($147,059)			$135,102		($135,102)		
Member Premium	$116,920	($116,920)				$0	$0			($96,755)
Cost Sharing Reduction			($62,468)					($48,748)		
Subtotal	$263,979	($116,920)	($209,527)		$0	$135,102	$0	($183,850)		($96,755)
Claim Expenses										
Claim Liability	$234,084					$182,671				$22,337
Member Cost Sharing		$37,854					$0			$29,540
Subtotal	$234,084	$37,854	$0		$0	$182,671	$0	$0		$51,877
Administrative Costs										
SG&A, Taxes, and Fees	$52,796					$27,020				$5,280
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,613	$0	$0	($7,817)	$0	$34,838	$0	$0	($7,817)	$5,280
Net Cash Flow	**($30,719)**	**($154,774)**	**($209,527)**	**$7,817**	**$0**	**($82,407)**	**$0**	**($183,850)**	**$7,817**	**($153,912)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,117.44		($2,117.44)			$1,945.28		($1,945.28)		
Member Premium	$1,683.48	($1,683.48)				$0.00	$0.00			($1,393.14)
Cost Sharing Reduction			($899.45)					($701.90)		
Subtotal	$3,800.92	($1,683.48)	($3,016.89)		$0.00	$1,945.28	$0.00	($2,647.18)		($1,393.14)
Expenses										
Claim Liability	$3,370.48					$2,630.21				$321.62
Member Cost Sharing		$545.04					$0.00			$425.33
Subtotal	$3,370.48	$545.04	$0.00		$0.00	$2,630.21	$0.00	$0.00		$746.95
Administrative Costs										
SG&A, Taxes, and Fees	$760.18					$389.06				$76.02
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$872.74	$0.00	$0.00	($112.56)	$0.00	$501.62	$0.00	$0.00	($112.56)	$76.02
Net Cash Flow	($442.31)	($2,228.52)	($3,016.89)	$112.56	$0.00	($1,186.54)	$0.00	($2,647.18)	$112.56	($2,216.11)

Exhibit B.4
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,232		($63,232)			$56,869		($56,869)		
Member Premium	$37,320	($37,320)				$71,412	($71,412)			0
Cost Sharing Reduction			($29,293)					($22,859)		
Subtotal	$100,552	($37,320)	($92,525)		$0	$128,281	($71,412)	($79,728)		$0
Claim Expenses										
Claim Liability	$56,141					$83,579				$0
Member Cost Sharing		$86,841					$16,488			$0
Subtotal	$56,141	$86,841	$0		$0	$83,579	$16,488	$0		$0
Administrative Costs										
SG&A, Taxes, and Fees	$20,110					$25,656				$2,011
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,663	$0	$0	($4,552)	$0	$30,209	$0	$0	($4,552)	$2,011
Net Cash Flow	**$19,749**	**($124,161)**	**($92,525)**	**$4,552**	**$0**	**$14,494**	**($87,900)**	**($79,728)**	**$4,552**	**($2,011)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,563.45		($1,563.45)			$1,406.12		($1,406.12)		
Member Premium	$922.76	($922.76)				$1,765.70	($1,765.70)			$0.00
Cost Sharing Reduction			($724.28)					($565.20)		
Subtotal	$2,486.21	($922.76)	($2,287.73)		$0.00	$3,171.82	($1,765.70)	($1,971.33)		$0.00
Expenses										
Claim Liability	$1,388.11					$2,066.54				$0.00
Member Cost Sharing		$2,147.18					$407.68			$0.00
Subtotal	$1,388.11	$2,147.18	$0.00		$0.00	$2,066.54	$407.68	$0.00		$0.00
Administrative Costs										
SG&A, Taxes, and Fees	$497.24					$634.36				$49.72
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$609.80	$0.00	$0.00	($112.56)	$0.00	$746.92	$0.00	$0.00	($112.56)	$49.72
Net Cash Flow	$488.30	($3,069.95)	($2,287.73)	$112.56	$0.00	$358.36	($2,173.37)	($1,971.33)	$112.56	($49.72)

Exhibit B.5
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,232		($63,232)			$56,869		($56,869)		
Member Premium	$37,320	($37,320)				$35,706	($35,706)			-35705.94003
Cost Sharing Reduction			($29,293)					($22,859)		
Subtotal	$100,552	($37,320)	($92,525)		$0	$92,575	($35,706)	($79,728)		($35,706)
Claim Expenses										
Claim Liability	$56,141					$84,814				$0
Member Cost Sharing		$86,841					$8,244			$7,009
Subtotal	$56,141	$86,841	$0		$0	$84,814	$8,244	$0		$7,009
Administrative Costs										
SG&A, Taxes, and Fees	$20,110					$18,515				$2,011
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,663	$0	$0	($4,552)	$0	$23,067	$0	$0	($4,552)	$2,011
Net Cash Flow	**$19,749**	**($124,161)**	**($92,525)**	**$4,552**	**$0**	**($15,306)**	**($43,950)**	**($79,728)**	**$4,552**	**($44,726)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,563.45		($1,563.45)			$1,406.12		($1,406.12)		
Member Premium	$922.76	($922.76)				$882.85	($882.85)			($882.85)
Cost Sharing Reduction			($724.28)					($565.20)		
Subtotal	$2,486.21	($922.76)	($2,287.73)		$0.00	$2,288.97	($882.85)	($1,971.33)		($882.85)
Expenses										
Claim Liability	$1,388.11					$2,097.06				$0.00
Member Cost Sharing		$2,147.18					$203.84			$173.31
Subtotal	$1,388.11	$2,147.18	$0.00		$0.00	$2,097.06	$203.84	$0.00		$173.31
Administrative Costs										
SG&A, Taxes, and Fees	$497.24					$457.79				$49.72
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$609.80	$0.00	$0.00	($112.56)	$0.00	$570.35	$0.00	$0.00	($112.56)	$49.72
Net Cash Flow	$488.30	($3,069.95)	($2,287.73)	$112.56	$0.00	($378.45)	($1,086.69)	($1,971.33)	$112.56	($1,105.88)

Exhibit B.6
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Average Commercial and Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,232		($63,232)			$56,869		($56,869)		
Member Premium	$37,320	($37,320)				$0	$0			-71411.88005
Cost Sharing Reduction			($29,293)					($22,859)		
Subtotal	$100,552	($37,320)	($92,525)		$0	$56,869	$0	($79,728)		($71,412)
Claim Expenses										
Claim Liability	$56,141					$86,048				$13,005
Member Cost Sharing		$86,841					$0			$14,019
Subtotal	$56,141	$86,841	$0		$0	$86,048	$0	$0		$27,024
Administrative Costs										
SG&A, Taxes, and Fees	$20,110					$11,374				$2,011
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,663	$0	$0	($4,552)	$0	$15,926	$0	$0	($4,552)	$2,011
Net Cash Flow	**$19,749**	**($124,161)**	**($92,525)**	**$4,552**	**$0**	**($45,105)**	**$0**	**($79,728)**	**$4,552**	**($100,446)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,563.45		($1,563.45)			$1,406.12		($1,406.12)		
Member Premium	$922.76	($922.76)				$0.00	$0.00			($1,765.70)
Cost Sharing Reduction			($724.28)					($565.20)		
Subtotal	$2,486.21	($922.76)	($2,287.73)		$0.00	$1,406.12	$0.00	($1,971.33)		($1,765.70)
Expenses										
Claim Liability	$1,388.11					$2,127.59				$321.55
Member Cost Sharing		$2,147.18					$0.00			$346.62
Subtotal	$1,388.11	$2,147.18	$0.00		$0.00	$2,127.59	$0.00	$0.00		$668.17
Administrative Costs										
SG&A, Taxes, and Fees	$497.24					$281.22				$49.72
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$609.80	$0.00	$0.00	($112.56)	$0.00	$393.78	$0.00	$0.00	($112.56)	$49.72
Net Cash Flow	$488.30	($3,069.95)	($2,287.73)	$112.56	$0.00	($1,115.25)	$0.00	($1,971.33)	$112.56	($2,483.59)

Exhibit B.7
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,347		($147,347)			$135,370		($135,370)		
Member Premium	$116,938	($116,938)				$55,324	($55,324)			$0
Cost Sharing Reduction			($62,541)					($35,933)		
Subtotal	$264,285	($116,938)	($209,888)		$0	$190,694	($55,324)	($171,302)		$0
Claim Expenses										
Claim Liability	$234,356					$126,465				$0
Member Cost Sharing		$37,898					$29,959			$0
Subtotal	$234,356	$37,898	$0		$0	$126,465	$29,959	$0		$0
Administrative Costs										
SG&A, Taxes, and Fees	$52,857					$38,139				$5,286
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,674	$0	$0	($7,817)	$0	$45,956	$0	$0	($7,817)	$5,286
Net Cash Flow	**($30,745)**	**($154,835)**	**($209,888)**	**$7,817**	**$0**	**$18,273**	**($85,283)**	**($171,302)**	**$7,817**	**($5,286)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,121.59		($2,121.59)			$1,949.13		($1,949.13)		
Member Premium	$1,683.73	($1,683.73)				$796.59	($796.59)			$0.00
Cost Sharing Reduction			($900.50)					($517.38)		
Subtotal	$3,805.33	($1,683.73)	($3,022.09)		$0.00	$2,745.72	($796.59)	($2,466.51)		$0.00
Expenses										
Claim Liability	$3,374.39					$1,820.92				$0.00
Member Cost Sharing		$545.67					$431.37			$0.00
Subtotal	$3,374.39	$545.67	$0.00		$0.00	$1,820.92	$431.37	$0.00		$0.00
Administrative Costs										
SG&A, Taxes, and Fees	$761.07					$549.14				$76.11
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$873.63	$0.00	$0.00	($112.56)	$0.00	$661.70	$0.00	$0.00	($112.56)	$76.11
Net Cash Flow	($442.69)	($2,229.41)	($3,022.09)	$112.56	$0.00	$263.10	($1,227.96)	($2,466.51)	$112.56	($76.11)

Exhibit B.8
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,347		($147,347)			$135,370		($135,370)		
Member Premium	$116,938	($116,938)				$27,662	($27,662)			($27,662)
Cost Sharing Reduction			($62,541)					($35,933)		
Subtotal	$264,285	($116,938)	($209,888)		$0	$163,032	($27,662)	($171,302)		($27,662)
Claim Expenses										
Claim Liability	$234,356					$130,557				$0
Member Cost Sharing		$37,898					$14,980			$10,887
Subtotal	$234,356	$37,898	$0		$0	$130,557	$14,980	$0		$10,887
Administrative Costs										
SG&A, Taxes, and Fees	$52,857					$32,606				$5,286
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,674	$0	$0	($7,817)	$0	$40,424	$0	$0	($7,817)	$5,286
Net Cash Flow	**($30,745)**	**($154,835)**	**($209,888)**	**$7,817**	**$0**	**($7,949)**	**($42,642)**	**($171,302)**	**$7,817**	**($43,835)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,121.59		($2,121.59)			$1,949.13		($1,949.13)		
Member Premium	$1,683.73	($1,683.73)				$398.29	($398.29)			($398.29)
Cost Sharing Reduction			($900.50)					($517.38)		
Subtotal	$3,805.33	($1,683.73)	($3,022.09)		$0.00	$2,347.43	($398.29)	($2,466.51)		($398.29)
Expenses										
Claim Liability	$3,374.39					$1,879.84				$0.00
Member Cost Sharing		$545.67					$215.68			$156.76
Subtotal	$3,374.39	$545.67	$0.00		$0.00	$1,879.84	$215.68	$0.00		$156.76
Administrative Costs										
SG&A, Taxes, and Fees	$761.07					$469.49				$76.11
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$873.63	$0.00	$0.00	($112.56)	$0.00	$582.05	$0.00	$0.00	($112.56)	$76.11
Net Cash Flow	($442.69)	($2,229.41)	($3,022.09)	$112.56	$0.00	($114.46)	($613.98)	($2,466.51)	$112.56	($631.16)

Exhibit B.9
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$147,347		($147,347)			$135,370		($135,370)		
Member Premium	$116,938	($116,938)				$0	$0			($55,324)
Cost Sharing Reduction			($62,541)					($35,933)		
Subtotal	$264,285	($116,938)	($209,888)		$0	$135,370	$0	($171,302)		($55,324)
Claim Expenses										
Claim Liability	$234,356					$134,650				$22,337
Member Cost Sharing		$37,898					$0			$21,774
Subtotal	$234,356	$37,898	$0		$0	$134,650	$0	$0		$44,111
Administrative Costs										
SG&A, Taxes, and Fees	$52,857					$27,074				$5,286
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$60,674	$0	$0	($7,817)	$0	$34,891	$0	$0	($7,817)	$5,286
Net Cash Flow	**($30,745)**	**($154,835)**	**($209,888)**	**$7,817**	**$0**	**($34,172)**	**$0**	**($171,302)**	**$7,817**	**($104,721)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,121.59		($2,121.59)			$1,949.13		($1,949.13)		
Member Premium	$1,683.73	($1,683.73)				$0.00	$0.00			($796.59)
Cost Sharing Reduction			($900.50)					($517.38)		
Subtotal	$3,805.33	($1,683.73)	($3,022.09)		$0.00	$1,949.13	$0.00	($2,466.51)		($796.59)
Expenses										
Claim Liability	$3,374.39					$1,938.77				$321.62
Member Cost Sharing		$545.67					$0.00			$313.52
Subtotal	$3,374.39	$545.67	$0.00		$0.00	$1,938.77	$0.00	$0.00		$635.14
Administrative Costs										
SG&A, Taxes, and Fees	$761.07					$389.83				$76.11
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$873.63	$0.00	$0.00	($112.56)	$0.00	$502.39	$0.00	$0.00	($112.56)	$76.11
Net Cash Flow	($442.69)	($2,229.41)	($3,022.09)	$112.56	$0.00	($492.02)	$0.00	($2,466.51)	$112.56	($1,507.84)

Exhibit B.10
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 100% of maximum allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,394		($63,394)			$57,019		($57,019)		
Member Premium	$37,326	($37,326)				$44,470	($44,470)			$0
Cost Sharing Reduction			($29,327)					($16,850)		
Subtotal	$100,720	($37,326)	($92,721)		$0	$101,489	($44,470)	($73,868)		$0
Claim Expenses										
Claim Liability	$56,206					$59,543				$0
Member Cost Sharing		$86,941					$14,218			$0
Subtotal	$56,206	$86,941	$0		$0	$59,543	$14,218	$0		$0
Administrative Costs										
SG&A, Taxes, and Fees	$20,144					$20,298				$2,014
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,696	$0	$0	($4,552)	$0	$24,850	$0	$0	($4,552)	$2,014
Net Cash Flow	**$19,818**	**($124,268)**	**($92,721)**	**$4,552**	**$0**	**$17,096**	**($58,688)**	**($73,868)**	**$4,552**	**($2,014)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,567.45		($1,567.45)			$1,409.82		($1,409.82)		
Member Premium	$922.92	($922.92)				$1,099.55	($1,099.55)			$0.00
Cost Sharing Reduction			($725.12)					($416.62)		
Subtotal	$2,490.37	($922.92)	($2,292.57)		$0.00	$2,509.37	($1,099.55)	($1,826.44)		$0.00
Expenses										
Claim Liability	$1,389.72					$1,472.24				$0.00
Member Cost Sharing		$2,149.67					$351.54			$0.00
Subtotal	$1,389.72	$2,149.67	$0.00		$0.00	$1,472.24	$351.54	$0.00		$0.00
Administrative Costs										
SG&A, Taxes, and Fees	$498.07					$501.87				$49.81
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$610.63	$0.00	$0.00	($112.56)	$0.00	$614.43	$0.00	$0.00	($112.56)	$49.81
Net Cash Flow	$490.01	($3,072.59)	($2,292.57)	$112.56	$0.00	$422.70	($1,451.09)	($1,826.44)	$112.56	($49.81)

Exhibit B.11
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Medicaid
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,394		($63,394)			$57,019		($57,019)		
Member Premium	$37,326	($37,326)				$22,235	($22,235)			($22,235)
Cost Sharing Reduction			($29,327)					($16,850)		
Subtotal	$100,720	($37,326)	($92,721)		$0	$79,254	($22,235)	($73,868)		($22,235)
Claim Expenses										
Claim Liability	$56,206					$61,485				$0
Member Cost Sharing		$86,941					$7,109			$5,167
Subtotal	$56,206	$86,941	$0		$0	$61,485	$7,109	$0		$5,167
Administrative Costs										
SG&A, Taxes, and Fees	$20,144					$15,851				$2,014
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,696	$0	$0	($4,552)	$0	$20,403	$0	$0	($4,552)	$2,014
Net Cash Flow	**$19,818**	**($124,268)**	**($92,721)**	**$4,552**	**$0**	**($2,635)**	**($29,344)**	**($73,868)**	**$4,552**	**($29,416)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,567.45		($1,567.45)			$1,409.82		($1,409.82)		
Member Premium	$922.92	($922.92)				$549.78	($549.78)			($549.78)
Cost Sharing Reduction			($725.12)					($416.62)		
Subtotal	$2,490.37	($922.92)	($2,292.57)		$0.00	$1,959.59	($549.78)	($1,826.44)		($549.78)
Expenses										
Claim Liability	$1,389.72					$1,520.26				$0.00
Member Cost Sharing		$2,149.67					$175.77			$127.75
Subtotal	$1,389.72	$2,149.67	$0.00		$0.00	$1,520.26	$175.77	$0.00		$127.75
Administrative Costs										
SG&A, Taxes, and Fees	$498.07					$391.92				$49.81
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$610.63	$0.00	$0.00	($112.56)	$0.00	$504.48	$0.00	$0.00	($112.56)	$49.81
Net Cash Flow	$490.01	($3,072.59)	($2,292.57)	$112.56	$0.00	($65.14)	($725.55)	($1,826.44)	$112.56	($727.33)

Exhibit B.12
Projected Revenue and Expenses
Bridge Plan
2016

Annual Dollar Amounts in (000s)

Population: CHIP Parents Eligible
Fee Basis: Medicaid
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,394		($63,394)			$57,019		($57,019)		
Member Premium	$37,326	($37,326)				$0	$0			($44,470)
Cost Sharing Reduction			($29,327)					($16,850)		
Subtotal	$100,720	($37,326)	($92,721)		$0	$57,019	$0	($73,868)		($44,470)
Claim Expenses										
Claim Liability	$56,206					$63,427				$13,005
Member Cost Sharing		$86,941					$0			$10,333
Subtotal	$56,206	$86,941	$0		$0	$63,427	$0	$0		$23,338
Administrative Costs										
SG&A, Taxes, and Fees	$20,144					$11,404				$2,014
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$24,696	$0	$0	($4,552)	$0	$15,956	$0	$0	($4,552)	$2,014
Net Cash Flow	**$19,818**	**($124,268)**	**($92,721)**	**$4,552**	**$0**	**($22,365)**	**$0**	**($73,868)**	**$4,552**	**($69,823)**

PMPY

	Individual Exchange - No Bridge					Bridge Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,567.45		($1,567.45)			$1,409.82		($1,409.82)		
Member Premium	$922.92	($922.92)				$0.00	$0.00			($1,099.55)
Cost Sharing Reduction			($725.12)					($416.62)		
Subtotal	$2,490.37	($922.92)	($2,292.57)		$0.00	$1,409.82	$0.00	($1,826.44)		($1,099.55)
Expenses										
Claim Liability	$1,389.72					$1,568.28				$321.55
Member Cost Sharing		$2,149.67					$0.00			$255.50
Subtotal	$1,389.72	$2,149.67	$0.00		$0.00	$1,568.28	$0.00	$0.00		$577.05
Administrative Costs										
SG&A, Taxes, and Fees	$498.07					$281.96				$49.81
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	$0.00
Subtotal	$610.63	$0.00	$0.00	($112.56)	$0.00	$394.52	$0.00	$0.00	($112.56)	$49.81
Net Cash Flow	$490.01	($3,072.59)	($2,292.57)	$112.56	$0.00	($552.98)	$0.00	($1,826.44)	$112.56	($1,726.41)

Exhibit C.1
Projected Revenue and Expenses
Wrap Plan
2016

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$146,781		($146,781)			$146,781		($146,781)		
Member Premium	$136,320	($136,320)				$136,320	($136,320)			0
Cost Sharing Reduction			($62,398)					($62,398)		
Subtotal	$283,101	($136,320)	($209,179)		$0	$283,101	($136,320)	($209,179)		$0
Claim Expenses										
Claim Liability	$233,823					$233,823				$18,906
Member Cost Sharing		$37,812			$0		$18,906			
Subtotal	$233,823	$37,812	$0		$0	$233,823	$18,906	$0		$18,906
Administrative Costs										
SG&A, Taxes, and Fees	$56,620					$56,620				$5,662
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$64,438	$0	$0	($7,817)	$0	$64,438	$0	$0	($7,817)	$5,662
Net Cash Flow	**($15,160)**	**($174,131)**	**($209,179)**	**$7,817**	**$0**	**($15,160)**	**($155,226)**	**($209,179)**	**$7,817**	**($24,568)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,113.43		($2,113.43)			$2,113.43		($2,113.43)		
Member Premium	$1,962.81	($1,962.81)				$1,962.81	($1,962.81)			$0.00
Cost Sharing Reduction			($898.45)					($898.45)		
Subtotal	$4,076.25	($1,962.81)	($3,011.88)		$0.00	$4,076.25	($1,962.81)	($3,011.88)		$0.00
Expenses										
Claim Liability	$3,366.72					$3,366.72				$272.22
Member Cost Sharing		$544.43					$272.22			
Subtotal	$3,366.72	$544.43	$0.00		$0.00	$3,366.72	$272.22	$0.00		$272.22
Administrative Costs										
SG&A, Taxes, and Fees	$815.25				$0.00	$815.25				$81.52
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	
Subtotal	$927.81	$0.00	$0.00	($112.56)	$0.00	$927.81	$0.00	$0.00	($112.56)	$81.52
Net Cash Flow	($218.28)	($2,507.24)	($3,011.88)	$112.56	$0.00	($218.28)	($2,235.03)	($3,011.88)	$112.56	($353.74)

Exhibit C.2
Projected Revenue and Expenses
Wrap Plan
2016

Population: PREVIOUS MEDICAID Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		833,415					833,415			
Enrollment - Members		69,451					69,451			
Revenue										
Federal Premium Tax Credit	$146,781		($146,781)			$146,781		($146,781)		
Member Premium	$136,320	($136,320)				$136,320	($68,160)			($68,160)
Cost Sharing Reduction			($62,398)					($62,398)		
Subtotal	$283,101	($136,320)	($209,179)		$0	$283,101	($68,160)	($209,179)		($68,160)
Claim Expenses										
Claim Liability	$233,823					$233,823				$18,906
Member Cost Sharing		$37,812			$0		$18,906			
Subtotal	$233,823	$37,812	$0		$0	$233,823	$18,906	$0		$18,906
Administrative Costs										
SG&A, Taxes, and Fees	$56,620					$56,620				$5,662
Cover OR Exchange Fee	$7,817			($7,817)		$7,817			($7,817)	
Subtotal	$64,438	$0	$0	($7,817)	$0	$64,438	$0	$0	($7,817)	$5,662
Net Cash Flow	**($15,160)**	**($174,131)**	**($209,179)**	**$7,817**	**$0**	**($15,160)**	**($87,066)**	**($209,179)**	**$7,817**	**($92,728)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$2,113.43		($2,113.43)			$2,113.43		($2,113.43)		
Member Premium	$1,962.81	($1,962.81)				$1,962.81	($981.41)			($981.41)
Cost Sharing Reduction			($898.45)					($898.45)		
Subtotal	$4,076.25	($1,962.81)	($3,011.88)		$0.00	$4,076.25	($981.41)	($3,011.88)		($981.41)
Expenses										
Claim Liability	$3,366.72					$3,366.72				$272.22
Member Cost Sharing		$544.43					$272.22			
Subtotal	$3,366.72	$544.43	$0.00		$0.00	$3,366.72	$272.22	$0.00		$272.22
Administrative Costs										
SG&A, Taxes, and Fees	$815.25				$0.00	$815.25				$81.52
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	
Subtotal	$927.81	$0.00	$0.00	($112.56)	$0.00	$927.81	$0.00	$0.00	($112.56)	$81.52
Net Cash Flow	($218.28)	($2,507.24)	($3,011.88)	$112.56	$0.00	($218.28)	($1,253.62)	($3,011.88)	$112.56	($1,335.15)

Exhibit C.3
Projected Revenue and Expenses
Wrap Plan
2016

Population: Bridge Eligible
Fee Basis: Commercial
Benefits Covered: OHP+
Member Premium: Member Pays 0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		1,318,743					1,318,743			
Enrollment - Members		109,895					109,895			
Revenue										
Federal Premium Tax Credit	$300,802		($300,802)			$300,802		($300,802)		
Member Premium	$139,137	($139,137)				$139,137	$0			($139,137)
Cost Sharing Reduction			($106,059)					($106,059)		
Subtotal	$439,939	($139,137)	($406,861)		$0	$439,939	$0	($406,861)		($139,137)
Claim Expenses										
Claim Liability	$337,741					$337,741				$74,029
Member Cost Sharing		$38,687			$0		$0			
Subtotal	$337,741	$38,687	$0		$0	$337,741	$0	$0		$74,029
Administrative Costs										
SG&A, Taxes, and Fees	$87,988					$87,988				$8,799
Cover OR Exchange Fee	$12,370			($12,370)		$12,370			($12,370)	
Subtotal	$100,358	$0	$0	($12,370)	$0	$100,358	$0	$0	($12,370)	$8,799
Net Cash Flow	**$1,841**	**($177,825)**	**($406,861)**	**$12,370**	**$0**	**$1,841**	**$0**	**($406,861)**	**$12,370**	**($221,965)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$228.10		($228.10)			$228.10		($228.10)		
Member Premium	$105.51	($105.51)				$105.51	$0.00			($105.51)
Cost Sharing Reduction			($80.42)					($80.42)		
Subtotal	$333.61	($105.51)	($308.52)		$0.00	$333.61	$0.00	($308.52)		($105.51)
Expenses										
Claim Liability	$256.11					$256.11				$56.14
Member Cost Sharing		$29.34					$0.00			
Subtotal	$256.11	$29.34	$0.00		$0.00	$256.11	$0.00	$0.00		$56.14
Administrative Costs										
SG&A, Taxes, and Fees	$66.72				$0.00	$66.72				$6.67
Cover OR Exchange Fee	$9.38			($9.38)		$9.38			($9.38)	
Subtotal	$76.10	$0.00	$0.00	($9.38)	$0.00	$76.10	$0.00	$0.00	($9.38)	$6.67
Net Cash Flow	$1.40	($134.84)	($308.52)	$9.38	$0.00	$1.40	$0.00	($308.52)	$9.38	($168.32)

Exhibit C.4
Projected Revenue and Expenses
Wrap Plan
2016

Population: CHIP Parents Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 100.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,077		($63,077)			$63,077		($63,077)		
Member Premium	$42,184	($42,184)				$42,184	($42,184)			$0
Cost Sharing Reduction			($29,260)					($29,260)		
Subtotal	$105,261	($42,184)	($92,337)		$0	$105,261	($42,184)	($92,337)		$0
Claim Expenses										
Claim Liability	$56,078					$56,078				$77,772
Member Cost Sharing		$86,744			$0		$8,972			
Subtotal	$56,078	$86,744	$0		$0	$56,078	$8,972	$0		$77,772
Administrative Costs										
SG&A, Taxes, and Fees	$21,052					$21,052				$2,105
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$25,605	$0	$0	($4,552)	$0	$25,605	$0	$0	($4,552)	$2,105
Net Cash Flow	**$23,578**	**($128,928)**	**($92,337)**	**$4,552**	**$0**	**$23,578**	**($51,156)**	**($92,337)**	**$4,552**	**($79,877)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,559.60		($1,559.60)			$1,559.60		($1,559.60)		
Member Premium	$1,043.03	($1,043.03)				$1,043.03	($1,043.03)			$0.00
Cost Sharing Reduction			($723.47)					($723.47)		
Subtotal	$2,602.63	($1,043.03)	($2,283.07)		$0.00	$2,602.63	($1,043.03)	($2,283.07)		$0.00
Expenses										
Claim Liability	$1,386.56					$1,386.56				$1,922.94
Member Cost Sharing		$2,144.79					$221.84			
Subtotal	$1,386.56	$2,144.79	$0.00		$0.00	$1,386.56	$221.84	$0.00		$1,922.94
Administrative Costs										
SG&A, Taxes, and Fees	$520.53				$0.00	$520.53				$52.05
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	
Subtotal	$633.09	$0.00	$0.00	($112.56)	$0.00	$633.09	$0.00	$0.00	($112.56)	$52.05
Net Cash Flow	$582.98	($3,187.81)	($2,283.07)	$112.56	$0.00	$582.98	($1,264.87)	($2,283.07)	$112.56	($1,975.00)

Exhibit C.5
Projected Revenue and Expenses
Wrap Plan
2016

Population: CHIP Parents Eligible
Fee Basis: Commercial
Benefits Covered: EHB
Member Premium: Member Pays 50.0% of Allowed Premium in the Exchange
Member Cost Sharing: 50% of allowed allowed cost sharing
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,077		($63,077)			$63,077		($63,077)		
Member Premium	$42,184	($42,184)				$42,184	($21,092)			($21,092)
Cost Sharing Reduction			($29,260)					($29,260)		
Subtotal	$105,261	($42,184)	($92,337)		$0	$105,261	($21,092)	($92,337)		($21,092)
Claim Expenses										
Claim Liability	$56,078					$56,078				$77,772
Member Cost Sharing		$86,744			$0		$8,972			
Subtotal	$56,078	$86,744	$0		$0	$56,078	$8,972	$0		$77,772
Administrative Costs										
SG&A, Taxes, and Fees	$21,052					$21,052				$2,105
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$25,605	$0	$0	($4,552)	$0	$25,605	$0	$0	($4,552)	$2,105
Net Cash Flow	**$23,578**	**($128,928)**	**($92,337)**	**$4,552**	**$0**	**$23,578**	**($30,064)**	**($92,337)**	**$4,552**	**($100,969)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,559.60		($1,559.60)			$1,559.60		($1,559.60)		
Member Premium	$1,043.03	($1,043.03)				$1,043.03	($521.51)			($521.51)
Cost Sharing Reduction			($723.47)					($723.47)		
Subtotal	$2,602.63	($1,043.03)	($2,283.07)		$0.00	$2,602.63	($521.51)	($2,283.07)		($521.51)
Expenses										
Claim Liability	$1,386.56					$1,386.56				$1,922.94
Member Cost Sharing		$2,144.79					$221.84			
Subtotal	$1,386.56	$2,144.79	$0.00		$0.00	$1,386.56	$221.84	$0.00		$1,922.94
Administrative Costs										
SG&A, Taxes, and Fees	$520.53				$0.00	$520.53				$52.05
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	
Subtotal	$633.09	$0.00	$0.00	($112.56)	$0.00	$633.09	$0.00	$0.00	($112.56)	$52.05
Net Cash Flow	$582.98	($3,187.81)	($2,283.07)	$112.56	$0.00	$582.98	($743.35)	($2,283.07)	$112.56	($2,496.51)

Exhibit C.6
Projected Revenue and Expenses
Wrap Plan
2016

Population: CHIP Parents Eligible
Fee Basis: Commercial
Benefits Covered: OHP+
Member Premium: Member Pays 0.0% of Allowed Premium in the Exchange
Member Cost Sharing: None
State Administrative Expense: 2.0%

Annual Dollar Amounts in (000s)

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Enrollment - Member Months		485,328					485,328			
Enrollment - Members		40,444					40,444			
Revenue										
Federal Premium Tax Credit	$63,077		($63,077)			$63,077		($63,077)		
Member Premium	$42,184	($42,184)				$42,184	$0			($42,184)
Cost Sharing Reduction			($29,260)					($29,260)		
Subtotal	$105,261	($42,184)	($92,337)		$0	$105,261	$0	($92,337)		($42,184)
Claim Expenses										
Claim Liability	$56,078					$56,078				$99,748
Member Cost Sharing		$86,744			$0		$0			
Subtotal	$56,078	$86,744	$0		$0	$56,078	$0	$0		$99,748
Administrative Costs										
SG&A, Taxes, and Fees	$21,052					$21,052				$2,105
Cover OR Exchange Fee	$4,552			($4,552)		$4,552			($4,552)	
Subtotal	$25,605	$0	$0	($4,552)	$0	$25,605	$0	$0	($4,552)	$2,105
Net Cash Flow	**$23,578**	**($128,928)**	**($92,337)**	**$4,552**	**$0**	**$23,578**	**$0**	**($92,337)**	**$4,552**	**($144,038)**

PMPY

	Individual Exchange - No Bridge					Wrap Program				
	Carrier	Beneficiary/ Member	Federal Government	Cover Oregon	State of Oregon	Carrier	Member	Federal Government	Cover Oregon	State of Oregon
Revenue										
Federal Premium Tax Credit	$1,559.60		($1,559.60)			$1,559.60		($1,559.60)		
Member Premium	$1,043.03	($1,043.03)				$1,043.03	$0.00			($1,043.03)
Cost Sharing Reduction			($723.47)					($723.47)		
Subtotal	$2,602.63	($1,043.03)	($2,283.07)		$0.00	$2,602.63	$0.00	($2,283.07)		($1,043.03)
Expenses										
Claim Liability	$1,386.56					$1,386.56				$2,466.34
Member Cost Sharing		$2,144.79					$0.00			
Subtotal	$1,386.56	$2,144.79	$0.00		$0.00	$1,386.56	$0.00	$0.00		$2,466.34
Administrative Costs										
SG&A, Taxes, and Fees	$520.53				$0.00	$520.53				$52.05
Cover OR Exchange Fee	$112.56			($112.56)		$112.56			($112.56)	
Subtotal	$633.09	$0.00	$0.00	($112.56)	$0.00	$633.09	$0.00	$0.00	($112.56)	$52.05
Net Cash Flow	$582.98	($3,187.81)	($2,283.07)	$112.56	$0.00	$582.98	$0.00	($2,283.07)	$112.56	($3,561.42)