

Memorandum

To: Co-Chair Steiner Hayward, Co-Chair Prusak, and Members of the Task Force

From: Marty Carty, Director of Government Affairs

Date: May 24, 2022

Re: Bridge Health Care Program: Plan Design, Part 1

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers, also known as federally qualified health centers (FQHCs), in leading the transformation of primary care to achieve health equity for all. Health centers deliver integrated primary, behavioral, and oral health care services to over **416,000 Oregonians**. 41% of health center patients identify as a racial or ethnic minority, 10% are experiencing homelessness and 3% are veterans. Community health centers provide care to some of Oregon's most vulnerable populations including **one in six Oregon Health Plan (OHP) members**.

We write to offer comment on the first part of the Plan Design for the Bridge Health Care Program, keeping in mind that an estimated **41,000 patients** served by Community Health Centers in Oregon **fall within the target demographic of 138%-200%** of the Federal Poverty Line (FPL). Community Health Center patients must be prioritized in this planning process.

Benefits and Coverage:

- At minimum, benefits must equal those offered within OHP Essential Health Benefits (EHB) to ensure continuity of care for those transitioning from OHP to a bridge health plan.
- Additionally, OPCA supports routine oral and behavioral health care, services for adults outside EHB coverage. Data show that many adults are not accessing preventative oral or behavioral health care due to prohibitive costs. In the interest of health equity, including these benefits is vital¹.

Enrollee Costs:

- OPCA believes the ideal model is no-cost for enrollees wherein there are no premiums, copays, coinsurance or deductibles.
- However, OPCA recognizes the Task Force may recommend consumers bear some cost burden. In that scenario, we would continue to advocate for **no coinsurance or deductible** and **no copays for preventative care**. Cost-sharing could apply to low copays for non-preventative services and low, sliding-scale premiums.
- Premiums, if implemented, should begin at a threshold above the 138% minimum and follow a sliding scale based on income. Minnesota implemented a cost-sharing plan with their MinnesotaCare basic health plan; enrollees pay no premiums up to 160% FPL, at which point a sliding scale is implemented starting at \$4 and ending at \$28 when enrollees are at 200% FPL. Oregon could implement a similar model, adjusted for potential population differences².
 - Reduced cost-sharing for MinnesotaCare did not result in significant fluctuation in private or marketplace plan enrollment; rather, the primary result was a substantial decrease in the uninsured population³.

¹ [OHA Public Option Implementation Report](#)

² [MNCare Premiums](#)

³ [MN Insurance Uptake Rates](#)

- Cost significantly inhibits access to health insurance and priority populations are disproportionately represented in the uninsured population¹. Reducing costs of health insurance is necessary to promote Oregon's health equity goals.

Reimbursement:

- Reimbursement should occur at a rate higher than OHP and should utilize a Value-Based Pay model that adjusts for race, ethnicity, and other social determinants of health.
 - Failure to adjust for race, ethnicity, and other social determinants of health disadvantages those populations and those who serve them.
- Community Health Centers are the primary, oral, and behavioral health care access point for the target demographic, as evidenced by the 41,000 patients between 138-200% FPL served by CHCs. To continue to provide equitable access to services and recognize the complex and unique needs of this population due to social determinants of health, OPCA supports an enhanced reimbursement rate valuation for Community Health Centers (CHC).