Joint Task Force on the Bridge Health Care Program

HB 4035 – 2022

Public Comment Log

- The members of the Joint Task Force on the Bridge Health Care Program should review all public comment submitted to inform its work related to HB 4035.
- LPRO staff will post all public comment to the Oregon Legislative Information System (OLIS) on a rolling basis as it is received.
- To streamline the process of reviewing public comment, LPRO staff will also maintain this log of public comment received and a link to materials on OLIS. Snapshots of the log will be provided to members with each meeting packet as a notice of any new comment received since the previous meeting.

Last updated 6/13/22

Date Added	Submitting Individual	Submitting Organization	Description	Available on OLIS at
4/26/22	Sean Kolmer, Senior Vice President of Policy and Strategy	Oregon Association of Hospitals and Health Systems	A letter from OAHHS stating that: • The bridge program should be a temporary solution, • Provider payments should be sufficient to ensure adequate access to care for enrollees in the bridge program, • Oversight and accountability over the state financial impact of the program are critical, and • The bridge program should not prevent individuals from enrolling in or continuing marketplace coverage.	Link
5/5/22	Richard Blackwell, Director, Oregon Government Relations	PacificSource	A letter from PacificSource containing: • Requests for specific data or information to inform Task Force discussions and decisions. • Recommended areas of focus for the Task Force during program design discussions.	Link
5/9/22	Dan Cushing	Coalition for a Healthy	A letter requesting that the Task Force incorporate three principles into its proposal: • Center the member experience; • Ensure provider participation; and	Link

		Oregon (COHO)	• Leverage the successful, local model	
5/9/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Organization (OPCA)	A letter supporting the utilization of coordinated care organization (CCO) provider networks and also emphasizing that there should be no wrong pathway to health insurance coverage. Also supporting pursuit of a Section 1332 waiver to support administration of the bridge program.	Link
5/10/22	Rachel Bonesteel, Policy Manager	United States of Care	A letter encouraging the Task Force to design the Bridge Program as a long-term coverage option through 1332 State Innovation Waiver authority. The letter: • Supports allowing Oregonians who purchase coverage in the marketplace to retain the option to do so through "optionality." • Urges caution that a 1331 Blueprint may result in less federal funding for the state than a 1332 waiver. • Notes that an 1115 Medicaid demonstration waiver does not offer sufficient flexibility for program design.	Link
5/10/22	Dr. Christine Bugas	N/A	A letter supporting the creation of a long-term Bridge Program that lowers the cost of health care coverage and maximizes the number of people covered. The letter draws on Dr. Bugas' personal perspective as an emergency medicine physician.	Link
5/10/22	Maribeth Guarino, Health Care Advocate	Oregon State Public Interest Research Group (OSPIRG)	A letter encouraging the Task Force to consider • How the Bridge Program can address Medicaid churn as a long-term solution beyond the pandemic-related redeterminations period. • How optionality offered through a 1332 waiver would provide more flexibility for Oregonians to choose plans that best meet their needs.	Link
5/23/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Organization (OPCA)	A letter encouraging the Task Force to: • Prioritize people who seek care at Community Health Centers (CHCs) in designing the Bridge Program. • Include dental and behavioral health services within the benefits package. • Where member costs are necessary, use sliding scale premiums and co-pays for non-preventive services and avoid use of co-insurance, deductibles, or co-pays for preventive services. • Tie provider reimbursement to value-based payment models that incorporate social risk adjustment and provide enhanced reimbursement rates for CHCs.	Link
5/23/22	Dr. Calie Roa, President	Oregon Dental Association	A letter encouraging the Task Force to include dental benefit that provides full coverage in the Bridge Program benefits. Also supporting a robust reimbursement structure to help encourage provider participation.	Link
5/24/22	*Maribeth Guarino,*	*Oregon State Public Interest Research*	A letter encouraging the Task Force to design the Bridge Program so that it aligns coverage with the Oregon Health Plan as much as possible. Also urging the minimization of member costs.	Link

	Health Care Advocate	*Group (OSPIRG)*		
5/24/22	*Rachel Bonesteel, Policy Manager*	*United States of Care*	A letter outlining recommendations in 5 areas: 1. Benefit design – should align with Oregon Health Plan coverage, including dental. 2. Beneficiary Costs – premiums and cost-sharing should be minimized or eliminated. 3. Provider Reimbursement – should be sufficient to support continued access to care. 4. Health Equity – same standards that apply to the Oregon Health Plan should apply to the Bridge Program 5. Federal Funding Pathway – should consider the statutory requirements and potential constraints related to benefit design and cost-sharing applicable to the pathways currently being explored.	Link
5/26/22	*Sean Kolmer, Senior Vice President of Policy and Strategy*	*Oregon Association of Hospitals and Health Systems*	A letter encouraging the Task Force to not rush its recommendations. Also requesting that hospitals and providers have the ability to negotiate their participation in the Bridge Program, including negotiating commercial-range rates as well as payment mechanisms.	Link
6/13/22	*Dr. Robert Lowe*	*N/A*	A letter supporting the establishment of a robust bridge plan. The letter draws on Dr. Lowe's experience as a retired emergency physician.	Link
6/13/22	*Marty Carty, Director of Government Affairs*	*Oregon Primary Care Organization (OPCA)*	A letter advocating for: • Extension of prospective payment system (PPS) wrap payments to the bridge plan population; • Reimbursement rates that adjust to the for the unique needs of the target demographic and associated costs of care; • Minimal enrollee out-of-pocket costs; • Elimination of unnecessary barriers to coverage, including a no-wrong-door approach to enrollment; and • Broad benefit coverage that builds off of coverage provided by the Oregon Health Plan.	Link

Oregon Association of Hospitals and Health Systems

April 25, 2022

Oregon State Legislature
Joint Task Force on the Bridge Health Care Program
900 Court St. NE
Salem, OR 97301

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

On behalf of Oregon's 62 community hospitals and the patients they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) appreciated the process for development of House Bill 4035, and we look forward to continuing that conversation as the Joint Task Force on the Bridge Health Care Program carries out its legislative directives. As we have stated previously, this policy discussion is ultimately about ensuring access to health care for those Oregonians who need it most during this transition out of the emergency phase of the pandemic. The discussion should be focused on how to help this group of people in the short term and how to create stability for them moving forward.

We encourage the Task Force to continue a collaborative approach with robust stakeholder input beyond the members of the Task Force as the recommendations for a new bridge program take shape. As a starting point, we highlight the following considerations:

1. **We maintain that the bridge program should be a temporary solution.** The immediate goal is to ease the transition for individuals who are no longer eligible for the Oregon Health Plan following redeterminations at the end of the federally declared Public Health Emergency. Longer term, the goal should be to transition those individuals to appropriate marketplace or employer-based plans or other currently existing and funded programs. We recognize the affordability challenges some individuals face even when eligible for marketplace subsidies and cost sharing reductions. These challenges are complex and call for a different conversation around understanding and addressing underlying cost drivers – such as in the health care cost growth target program. The recommendations regarding the bridge program must be developed within the context of these overarching policy goals.

2. **Provider payments must be sufficient to ensure adequate access to care for enrollees in the bridge program.** If the program is not financially sustainable for providers, provider networks could be disrupted, which could result in care gaps and health inequities for the bridge population at a minimum. Further, hospitals across Oregon remain financially and operationally fragile as the impact of the pandemic lingers, and the road to recovery will be long. Adding more cost burdens to the financial pressure hospitals are already facing puts their ability to care for their communities at even greater risk.

3. **Oversight and accountability over the state financial impact of the program are critical.** OHA stated in "Oregon's COVID-19 Plan – Resilience in Support of Equity (RISE)" that the bridge program will "Be fully funded by the federal government (if approved). The plan would come at no additional cost to Oregon's budget" (p. 23). Any potential need for additional state funds should be part of any proposals presented to the Task Force and stakeholders and should be monitored closely as negotiations with federal regulators unfold. Further, any

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assumed state budget savings should stay within the Oregon Health Plan and other programs that are designed to provide health insurance coverage for Oregonians.

4. **The bridge program should not prevent individuals from enrolling in or continuing marketplace coverage.** Again, we submit that the bridge program should minimize disruptions in coverage and care, serving as a safety net for those in need as the system then navigates them to a more permanent solution. We caution against creating a program that ultimately increases fragmentation in the health insurance continuum and makes navigating the system more complex for consumers.

We look forward to continuing this discussion as we all work together toward uninterrupted coverage and care for the 1.4 million Oregonians currently enrolled in the Oregon Health Plan.

Thank you,

Sean Kolmer
Senior Vice President of Policy and Strategy
Oregon Association of Hospitals and Health Systems

4000 Kruse Way Place, Bldg. 2, Suite 100
Lake Oswego, Oregon 97035
*Phone 503-636-2204 * Fax 503-636-8310*

PacificSource

May 5, 2022

Senator Elizabeth Steiner Hayward, Co-Chair
Representative Rachel Prusak, Co-Chair
Joint Task Force on the Bridge Health Care Program
Oregon Legislative Assembly
900 Court Street NE
Salem, OR 97301

Delivered electronically.

Co-Chairs Steiner Hayward and Prusak:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in four states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We appreciated the conversation beginning the work of the Task Force on April 26. It is clear that the Task Force shoulders a consequential responsibility impacting the health care of many Oregonians. The Task Force will need timely and useful data in order to inform the decisions it will need to decide in the coming weeks. To that end, we have prepared a non-exhaustive list of questions and data inquiries that the Task Force may need in order to proceed with its legislative charge:

1. More specific information on the number of Oregonians that could lose Oregon Health Plan coverage when the redetermination process begins in earnest, and within that population which Oregonians would be eligible to opt out of a basic health program. This number should reflect what happens if the Congress re-authorizes the enhanced advance premium tax credits enacted under the American Rescue Plan Act.[1]
2. If known, the number of Oregonians not covered by any insurance who would be prompted (or encouraged) to enroll in a basic health program.
3. Among Oregonians who purchase insurance through the Oregon Health Insurance Exchange, the numbers of eligible people that would be moved to a basic health

[1] Pub. L. 117-2, 135 Stat. 4.

program, who may elect to enroll in a basic health program, and when all eligible people could move to a basic health program.

4. Any data or information that indicates that among the commercially insured, who cannot reasonable utilize their benefits, and the predominant reasons why benefits go unused.
5. Any aggregated, anonymized statistics on consumer complaints related to premiums or cost sharing. *Note:* these do not need to be confirmed complaints.
6. Any data or information that estimates the costs of uncompensated care to providers and systems. In addition, if known any data or information that would indicate any broader economic losses that bae be connected to un-insurance or under-insurance.

In addition to data we believe would be beneficial in making recommendations, we would also ask the Task Force to focus on a few key areas of program design in the coming weeks:

1. Among the other states who operate or who are contemplating basic health programs, how is enrollment effectuated in the basic health program? Does enrollment proceed in a manner more familiar to Medicaid, or to commercial insurance? Would enrollment be completed on a continuous basis, or on a plan year? Are there any barriers Oregon would face in adopting another state model to be administered through coordinated care organizations?
2. The nature and extent of cost sharing under a BHP, and whether the other states that have implemented or who are contemplating a basic health plan also instituted cost sharing. Modest cost sharing appears to be a component of other state basic health plans, though cost sharing is wholly outside of the coordinated care organization model and not actionable within the given timeline.
3. To what extent plan design and implementation follows the Oregon Health Plan, or commercial health benefit plans. Each choice contains risks and opportunities.
4. A detailed implementation timeline – the level of plan complexity and deviation from the current models of health care coverage could complicate (or simplify) implementation of a basic health plan in the given timeline.

Thank you for taking our thoughts into consideration. We look forward to a more fulsome discussion concerning these ideas at future Task Force meetings.

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations

COALITION FOR A HEALTHY OREGON
COMMITTED TO LOCAL CARE

May 10, 2022

From: Coalition for a Healthy Oregon

To: Joint Task Force On the Bridge Health Care Program

Subject: CCO Principles for a Successful Bridge Health Care Program

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

House Bill 4035, enacted in the 2022 Legislative Session, raises the exciting possibility of improving health coverage and continuity of care for Oregonians with a focus on reducing the uninsured rate and achieving health equity. The language of HB 4035, the legislative record, and public statements from Oregon Health Authority clearly specify this new benefit ought to build upon the Oregon Integrated and Coordinated Health Care Delivery System, i.e., coordinated care organizations (CCOs). **The seven CCOs in Coalition for a Healthy Oregon (COHO) call your attention to following policy considerations.** We request these principles be incorporated in your proposal pursuant to Section 4 of the bill.

Center the Member Experience

1) Use current CCOs to maintain continuity of care—It is critically important to expand enrollment within existing CCOs rather than create a new layer/silo of health care delivery. Existing CCOs have relationships with members, providers, and community stakeholders; there are robust systems in place to ensure quality and accountability.

2) Benefit package should be as close to Oregon Health Plan as possible—Members will lose trust in the system if they do not understand why they can no longer access services they rely upon.

3) Movement from CCO to Bridge Program should not be disruptive for members or providers.

4) Maximize flexibilities for CCO outreach—This includes outreach to current CCO members, as well as providers and community-based organizations (CBOs) on the redetermination process and the move to the new Bridge Program.

COALITION FOR A HEALTHY OREGON

Ensure Provider Participation

5) Capitation based funding—Budgeting on a per-person (capitated) basis encourages the adoption of value-based payments, which aligns with state policy goals.

6) Provider rates should be high enough to sustain the network—A robust provider network is critical protect patient access and choice as well as to support providers from the BIPOC community and other marginalized communities.

7) Additional administrative burden should be minimized.

Leverage The Successful, Local Model

8) Use the CCO model as a basis for plan requirements—This includes local governance, care coordination, Social Determinants of Health and Equity programs, and quality measures, including incentive metrics.

9) Ensure budget neutrality to the state General Fund by maximizing federal funds and existing infrastructure.

10) Provide flexibility and assistance for existing CCOs to meet any new capital reserves or other requirements for offering the Bridge Health Care Program—This is especially needed for CCOs not currently enrolled as health plans on the exchange.

Thank you for your dedication to this important work. We offer our assistance if you have any questions or policy considerations for our experts to review.

Sincerely,

Advanced Health
AllCare Health
Cascade Health Alliance, LLC
InterCommunity Health Network CCO
Trillium Community Health Plan
Umpqua Health Alliance
Yamhill Community Care

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 10, 2022

Re: Bridge Health Care Program Goals and Pathways

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 OHP members**.

We write to offer comment on the Goals and Pathways for the Bridge Health Care Program, regarding the health care exchanges and choice of waiver for the establishment of a Bridge Program. OPCA believes that the Bridge Plan is not merely a temporary fix; rather, it is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity. Oregon's community health centers serve a large percentage of the target demographic for this plan; an estimated 41,542 people who accessed care at a health center in 2020 fell between 138% – 200% of FPL. Community health centers are for everybody. Their doors are open to anyone regardless of ability to pay, immigration status, or if a person has health insurance.

Exchanges:

- OPCA supports a Bridge Plan administered within the CCO network; approximately 29%[1] of Oregonians were insured through OHP in 2021, including a large percentage of the target demographic. While we look forward to the shift to a State-Based Marketplace in the future, housing the Bridge Plan in the CCO network will meet the urgent needs of the target population.
- Based on community health center patient population data, OPCA believes that a majority of the Bridge Plan target population is at risk for disenrollment from Medicaid due to redetermination – if the Bridge Plan were managed within the CCO network, this would enhance a smooth transition of coverage and allow for many to maintain continuity of care.
- There should be no wrong pathway to health insurance coverage – Oregonians must have access to information about their options no matter their point of entry, whether that is in the CCO network, the marketplace, or elsewhere.

Waiver Options:

- OPCA supports exploring the use of a 1332 waiver application process to establish a Bridge Plan. While the 1331 waiver option does provide a clear template for a potential plan and may allow for a faster approval process, it would limit enrollee choices in coverage and may prove inflexible to provide for the needs of Oregon's innovative health care system in the future.
- Pursuing the 1332 waiver would preserve Oregonians' autonomy of choice between the Bridge Plan and other marketplace options and would lessen destabilizing effects on the marketplace as fewer eligible Oregonian's may be siphoned from the marketplace.
- The 1332 waiver would be malleable to future needs in Oregon and OPCA strongly believes that it would create a short-term plan and pave the way to meet long-term needs in health insurance access.

[1] 255315 (oregonlegislature.gov)

May 10, 2022

Bridge Plan Task Force Members

RE: 5/10 Joint Task Force on the Bridge Health Care Program Meeting to Discuss Goals & Pathways

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments as the Bridge Plan Task Force (BPTF) discusses the goals and the possible waiver pathways for the Bridge Plan. We appreciate the opportunity to weigh in and share our perspective based on our experience in other states also working to ensure their residents have access to high-quality, affordable health care.

United States of Care is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We work in states across the country to develop pragmatic policy solutions that meet the needs of people and have been engaged in efforts to advance and implement public health insurance options, as well as other efforts to expand access to coverage and improve affordability. United States of Care is unique in its commitment to advancing policies that are designed to respond to the needs of people. We have seen through our research that the high cost of care is the biggest issue of concern to people, even when you consider varying demographics, geography, and ideologies. The high cost of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. In Oregon, that is no different, and the Bridge Plan provides people with an immediate solution while paving a path for other reforms down the road.

Building on Oregon's History as a Health Care Innovator

Oregon's efforts to address health equity, reduce disparities, and ensure every Oregonian has access to quality, affordable coverage are commendable. Now, Oregon has the opportunity to not only maintain the coverage and affordability gains made over the last few years but to build on those even further. We know that about one-third of individuals who leave Medicaid return within a year, and because that churn won't go away, the Bridge Plan provides a needed safeguard and coverage for populations that may otherwise fall through the cracks. However, the Bridge Plan should not be seen only as a temporary solution for people who churn between Medicaid, the Marketplace, and being uninsured. Instead, the Bridge Plan should be seen as a necessary step now and for promoting continuous coverage for all Oregonians long-term. While the focus of the Bridge Plan is to provide coverage for those with incomes between 138-200% of the federal poverty level (FPL), it is important for the BPTF to recognize

that this is also an important stepping stone for creating additional coverage programs, such as a public health insurance option, that help even more people.

Key Waiver Pathway Considerations

The Bridge Plan builds on Oregon's history as a pioneer in health care innovation through bold initiatives. The BPTF is charged with making a recommendation to state agencies on the best waiver pathway that maximizes federal funds and minimizes costs to the state and enrollees, and **we believe the 1332 state innovation waiver meets those goals while also creating a long-term solution that helps even more Oregonians.** The BPTF should seek a 1332 waiver to allow for further expansion to eventually meet the needs of all Oregonians struggling to afford high-quality, affordable health care.

The waiver pathway for Oregon's Bridge Plan should allow for the appropriate flexibility to create a coverage program that best fits the needs of the Bridge Plan population, while also providing a future allowing for a pathway to expand coverage to additional Oregonians through a public health insurance option in the future. The BPTF should consider the benefits and limitations of the different types of federal waivers on these other long-term needs as they are developing their proposal and related recommendations for the Bridge Plan. We also encourage the BPTF to consider whether to seek approval for multiple waivers in tandem, which can allow for flexibility to cover additional populations in the future and can better support streamlined enrollment across coverage programs.

Specific aspects of waivers the BPTF should take into account as they deliberate the appropriate waiver pathway are outlined below.

- **1332 State Innovation Waiver:** Leveraging a 1332 waiver would design the most flexible option for expanding eligibility for coverage for people with incomes beyond 200% FPL through a public health insurance option. A 1332 waiver would also present the state with more flexibility to leverage pass-through funding to invest in other state coverage programs, as 100% of the funding the state would receive for premium tax credits without a waiver is reinvested in funding programs that meet the needs of the state's population. We believe 1332 waivers bring great opportunity and potential, and that Oregon can learn from the experiences of Nevada and Colorado, who have used 1332 waivers to expand coverage and improve affordability for their residents.
    - In addition to preserving Oregonians' choices when it comes to their coverage and care, ensuring that Marketplace plans remain an option for the population eligible for the Bridge Plan will **lessen the destabilizing effects on the Marketplace**. Instead of separating all Oregonians up to 200% of the federal poverty level from the Marketplace, as would occur under a basic health program (1331 waiver), that population will have private Marketplace plan options available to them under a 1332 state innovation waiver.

- **1331 Basic Health Program:** Creating a Basic Health Program (BHP) under Section 1331 of the ACA may mean Oregon receives less federal funding or has federal limitations to cover future additional populations, beyond those with incomes between 138-200% FPL, through a public health insurance option. Under a BHP, states only receive 95% of the premium tax credit amount that the state would have gotten without a waiver. In addition, individuals deemed eligible to enroll in Basic Health Program coverage are not permitted to enroll in qualified health plans in the Marketplace, so the BHP creates a separate risk pool, which may have implications for the Marketplace risk pool.

- **1115 Medicaid Demonstration Waiver:** 1115 waivers primarily focus on providing additional flexibility for states to design and improve their Medicaid programs. Oregon currently operates its Medicaid program through an 1115 waiver, which implemented the Coordinated Care Organization (CCO) community-based infrastructure for the Oregon Health Plan. An 1115 waiver on its own would likely not provide the flexibility to align innovative waiver provisions to support expanded access to care across coverage programs and markets.

We strongly believe that the development of the Bridge Plan will continue making progress toward Oregon's goals of developing a low-cost, high-quality plan and will position Oregon to continue to be a national leader in health reform. Overall, we applaud the Task Force for its commitment to ensuring continuity of coverage and affordability for all Oregonians through the design of the Bridge Plan. As you continue to develop the policy in HB 4035 and weigh the various considerations, please consider the team at United States of Care a resource, and if you have any questions regarding these comments, please don't hesitate to reach out.

Sincerely,

Liz Hagan
Director of Policy Solutions
ehagan@usofcare.org

Caitlin Westerson
State External Affairs and Partnerships Director
cwesterson@usofcare.org

Rachel Bonesteel
Policy Manager
rbonesteel@usofcare.org

Dear Members of the Task Force and Policymakers,

Thank you for working hard every day to lower the cost of health care for Oregonians. I am here to support a long-term bridge plan for people in Oregon.

I live in Portland, Oregon and I have spent my career working in the emergency department as an Emergency Medicine doctor. I am here to support healthcare for the folks in Oregon who struggle to get and keep coverage.

Delayed treatment means worsening of outcomes and much more expensive treatments. We know how this works. This past Monday, I saw a patient with a pressure ulcer to bone. If he had come in three days earlier, he would have been able to take an antibiotic and use a topical ointment to control the infection. But he waited because he didn't have health insurance. The infection progressed so rapidly, he will now require a great deal of care. Unfortunately, this case is not an anomaly.

As a physician, I see every day how the high cost of unaffordable health care is the single most common barrier to medical care, individual well-being and public health. High health care costs force people to delay care and put their well-being, even their lives, at risk. So many people simply can't afford to get the early, sustained and coordinated care that can improve their health and even save their lives.

High insurance premiums that keep increasing every year, expensive prescription drugs that keep increasing every year, out-of-pocket costs that keep increasing every year all add up for Oregon families struggling simply to make ends meet. For these reasons, I urge policymakers to create a low-cost, high quality and long-term bridge plan that covers as many people as possible, improves health and helps save lives.

Thank you,

Chris Bugas,
Emergency Medicine Physician

May 10, 2022

TO: Bridge Plan Task Force
FR: Maribeth Guarino, Health Care Advocate, Oregon State Public Interest Research Group (OSPIRG)
RE: Goals & Pathways for a Bridge Plan

OSPIRG is a consumer advocacy group with members across the state working towards a healthier, safer world for all of us. We have been a proponent of health policy solutions that work to lower costs for Oregonians, including the Medicaid churn population, for years. We continue to support the creation of this bridge plan and urge the task force to think carefully about the decision in front of them in terms of where the bridge plan will be housed and which waiver or waivers will be most appropriate to make this plan successful.

The bridge plan is not just a program to help with redetermination; redetermination is the opportunity to implement a long-term solution that helps individuals and families with unsteady incomes that churn in and out of Medicaid to maintain insurance coverage throughout the year. As pointed out by OHA in the first task force meeting, about ⅓ of individuals who leave Medicaid will return within a year. As long as income restricts eligibility, that churn is not going to go away because income is not fixed for everyone, but this bridge plan can be there to make sure that those folks don't lose health insurance coverage every 6-12 months before they re-qualify for Medicaid.

To that end, the bridge plan needs to be a lasting program with a smooth transition of coverage. Keeping people with their CCOs will keep Oregonians with their providers and systems they are familiar with. It will also cut down on administrative costs in moving patients to private plans, and reduce confusion for consumers, so we're glad to see CCOs at the forefront of the conversation about where to house the bridge plan.

The waiver conversation also needs to be thought about in the long-term..

In discussions around HB 4035 which created this task force, a big concern for consumer advocates was the restrictions placed on consumer choice by a 1331 waiver. As has been discussed by the task force, optionality is limited except with a 1332 waiver. Limited eligibility would create a greater impact on the private market and restrict consumer choice by drawing individuals off of the Marketplace, which is not the goal for this bridge plan and could prevent individuals from choosing plans that work best for them and their families - including choosing coverage for prescription drugs, treatments, specialists, or other medical needs.

A 1332, on the other hand, will draw less people from the Marketplace and lessen any destabilizing effects on it by allowing those individuals to stay there. The target population for the bridge plan is not in the Marketplace - they are currently either uninsured or covered by Medicaid, and we should be aware of how the waiver options affect each of those populations.

The bridge plan is intended to provide an option for health insurance that smooths transitions and fills gaps. It is not intended to replace, exclude, or prevent access to other insurance options. Yes, we have to move quickly with redetermination timelines, but again, this is not a short-term program or a bandaid. We need to build a lasting program that fits in the bigger picture of the Oregon health care system. A 1332 provides more flexibility for consumer choice as well as more stability for the private Marketplace, its risk pool and its costs. It also provides the most flexibility in plan design and enrollment, which means it can fit in more easily with OHP as well as dovetail better with future health policy considerations, such as transitioning to a state-based marketplace, implementing an expanded public option plan, and the work of the universal health care task force which is considering single-payer options.

In our view, a 1332 waiver provides the best path forward to a successful bridge plan program in a way that lets us continue to rise to the challenge of health care innovation in Oregon. In my own experience, very little in health care policy and innovation has been easy, but this is a relatively unique situation we're in as a nation and as a state, so I urge you as task force members to be creative as you make these decisions, and I thank you all for your time and commitment, and the opportunity to speak with you today.

OPCA
Oregon Primary Care Association

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 vital[1].

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 differences[2].
    - 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 population[3].

[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 population[1]. 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).

To: **Co-Chairs Senator Steiner Hayward, Representative Prusak**
Vice Chairs Senator Kennemer and Representative Hayden
Members of the Bridge Health Care Program Task Force

From: **Oregon Dental Association**

Date: **May 24, 2022**

Re: **Inclusion of Dental Benefits in the Bridge Program**

The Oregon Dental Association (ODA) represents over 2,100 practicing dentists across all corners of the state. Our members are committed to improving access to dental care and were pleased that House Bill 4035 included language stating that dental benefits should be included in the Bridge Program, "to the extent practicable". We are pleased that the Task Force has dedicated meeting time to discussing the issue.

Further, ODA was very encouraged to hear Mr. Vandehey's, Oregon Health Authority, comments at the first meeting, stating that the intent is to include a dental package similar to what is available to adult participants in the Oregon Health Plan (OHP) today.

The Oregon Health Plan offers comprehensive dental coverage, from regular cleanings to fillings, extractions, dentures, crowns, and emergency care. The ODA agrees that the Bridge Program should seek to match this coverage at minimum to provide continuity of care for patients.

Good dental care is a critical piece of overall health. As this Task Force well knows, an untreated dental issue can quickly devolve into significant and costly health issues like, heart disease, cancer or diabetes. Untreated oral pain is also high driver of unnecessary emergency department visits.

ODA also appreciates Mr. Vandehey's comments during the first meeting related to provider reimbursement. Participation in OHP provider panels is often hampered due to low reimbursement rates. Dental offices are particularly vulnerable to low reimbursement rates due to high overhead and equipment costs, and we know that low Medicaid reimbursement directly causes dentists to limit the number of Medicaid patients they see. Ensuring a robust— higher than Medicaid—reimbursement structure will enable stronger provider participation and increase access to care to those most in need.

We are very concerned that the 2022 EHB "Oregon Benchmark Plan" included in meeting materials does not include full adult dental benefits. It is not yet clear how these materials will guide the discussion, or if they are meant to be used as a base for the Bridge Program. If that is the case, the ODA urges the committee to expand on the EHB and include dental benefits for all Bridge Program participants, regardless of age, and also include strong reimbursement rates for dental providers that participate in the Bridge Program. A person cannot live a healthy life if they cannot access basic adult oral healthcare.

Sincerely,

Dr. Calie Roa, ODA President

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May 24, 2022

TO: Bridge Plan Task Force
FR: Maribeth Guarino, Health Care Advocate, Oregon State Public Interest Research Group (OSPIRG)
RE: Plan Design for a Bridge Plan

OSPIRG is a consumer advocacy group with members across the state working towards a healthier, safer world for all of us. We have been a proponent of health policy solutions that work to lower costs for Oregonians, including the Medicaid churn population, for years. As a stepping stone between the Oregon Health Plan (OHP) and private insurance, the bridge plan must have a strong plan design that allows Oregonians to continue their treatments, get necessary procedures, and maintain the same quality of care that they received on their previous plan. It should not feel so drastically different in coverage levels or cost compared to OHP that consumers experience a lapse in care.

Though the bridge plan is intended to mostly benefit the Medicaid churn population, with a 1331 waiver in place there will be Oregonians who, due to changing income levels, will also join the bridge plan from the Health Insurance Marketplace. Therefore, the plan design must take into account the differences between private plans and OHP. The bridge plan should include at least the essential health benefits required of plans on the ACA marketplace, but we should strive to cover more. A plan that mirrors the OHP's level of services and coverage would be better, allowing for better continuity and access to care as Oregonians switch between these plans; at the same time, it leaves the door open for Oregon to adopt a public option in the private market that mirrors the bridge plan design there, and in the meantime may encourage private insurers to cover those services to accomplish the same goals for those switching to private plans.

In designing the bridge plan, the task force should carefully consider what services and type of care we are promoting. The plan should be designed to promote primary and preventative care, offer services like dental and behavioral health, and eliminate low-value care and redundant or unnecessary services. We have a unique opportunity to shape the system in creating this plan, and we should use it to improve the experience for Oregonians and the quality of care they receive.

The bridge plan should also minimize cost-sharing and premiums for consumers. One of the goals for this program is to reduce the impact of Oregonians going from paying little-to-nothing on Medicaid to paying large premiums and deductibles for private coverage. The cost-sharing for this plan should reflect the nature of the bridge plan as a stepping stone between public and private coverage. This task force should pursue all possibilities in reducing consumer costs,

including sliding scale fees, caps on cost-sharing based on a percentage of income, and any federal funds available through a waiver to provide subsidies to bridge plan enrollees.

The bridge plan is an opportunity to improve the health care system in Oregon by reducing costs and improving care. We should take every opportunity available to us to do so.

May 24, 2022

Bridge Plan Task Force Members

RE: 5/24 Joint Task Force on the Bridge Health Care Program Meeting - Plan Design Part 1: Benefits, Costs and Reimbursements

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments as the Bridge Plan Task Force (BPTF) discusses the plan design for the Bridge Plan, including considerations around benefits, costs, and provider reimbursements. We appreciate the opportunity to weigh in and share our perspective based on our experience in other states also working to ensure their residents have access to high-quality, affordable health care.

United States of Care is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We work in states across the country to develop pragmatic policy solutions that meet the needs of people and have been engaged in efforts to advance and implement public health insurance options, as well as other efforts to expand access to coverage and improve affordability. United States of Care is unique in its commitment to advancing policies that are designed to respond to the needs of people. We have seen through our research that the high cost of care is the biggest issue of concern to people, even when you consider varying demographics, geography, and ideologies. The high cost of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. In Oregon, that is no different, and the Bridge Plan provides people with an immediate solution while paving a path for other reforms down the road.

When we talk to people around the country about their health care, we learn that they often have trouble understanding their care and navigating the health care system. The specific population that the Bridge Plan will be supporting often "churns" between Medicaid and Marketplace coverage. Having consistency across coverage options, would create an easier to navigate system where beneficiaries don't have to question what services are available and how to access them.

Designing a Comprehensive Benefits Package

The Bridge Plan should be **at least as comprehensive as Marketplace plans** with essential health benefits (EHBs), but should aim higher and **include more services covered by the Oregon Health Plan (OHP), including dental**. Designing Bridge Plan benefits to be similar to OHP will allow for better continuity of care and provide the same or better level of access to services for Oregonians switching between these two sources of coverage. The Bridge Plan benefits package and coverage levels should not vary so significantly from the Medicaid benefit

package under OHP that individuals experience a lapse in the provision of necessary care if they were to transition from one program to the other. For example, because of the federal continuous coverage requirement brought on by the Public Health Emergency, the percentage of uninsured adults who delayed care because of cost or faced challenges paying medicaid bills decreased in 2021 across all income brackets. With thoughtful consideration to benefits, the Bridge Plan will be critical to providing continuity of coverage for vulnerable Oregonians.

The Task Force should pursue opportunities to prioritize dental, primary, behavioral, and preventive health care with this plan. All OHP beneficiaries have dental coverage that allows them annual cleanings, x-rays, fillings, and more, and the Bridge Plan should provide, at a minimum, the same dental coverage for its members. Research has connected oral and periodontal (gum) diseases to chronic conditions, such as heart disease and diabetes. Providing dental health care now can prevent and alleviate the burden of chronic diseases later on in life. Proper dental care is a cornerstone of healthy communities, as oral health coverage can improve health outcomes and reduce overall health spending. Opportunities to expand access to oral health care can also help address existing racial disparities in access for those underserved by the current health care system. Additionally, coverage of preventive, primary, and behavioral health care services in the Bridge Plan benefits package prioritizes investment in the long-term health and well-being of Oregonians. With these facts in mind, we urge the BPTF to include dental coverage in the benefits package of the Bridge Plan as well as develop a benefit structure that prioritizes primary, preventive, and behavioral health care.

Minimizing Cost to Beneficiaries

The Bridge Plan should **minimize or eliminate premiums and cost-sharing for individuals** covered under the plan. From a recent poll, we learned that overall cost, including expensive premiums, is a top concern for Oregonians. One of the goals for the Bridge Plan is to reduce the impact of Oregonians churning from one coverage source to another, and subsequently going from paying little to no cost-sharing on Medicaid to paying large premiums and deductibles for private coverage. As the name suggests, this program should be a"bridge" between OHP coverage, with no premiums and out-of-pocket costs, and Marketplace coverage, with higher premiums and out-of-pocket costs. The Bridge Plan should not feel so drastically different in coverage levels or cost compared to OHP that consumers experience a lapse in care and we ask the BPTF to limit the premium and cost-sharing requirements under the Bridge Plan. We encourage the BPTF to look to states like Minnesota and New York, that have prioritized the affordability of coverage for this population, which both states have found to be a historically healthy population. The increased cost burden of making the drastic transition to higher-cost Marketplace coverage may result in some Oregonians choosing to forgo coverage, and these coverage gaps can lead to missed doctor's appointments, higher costs for services, and thus can lead to poorer health outcomes because of delayed or neglected care.

We encourage the BPTF to prioritize coverage of certain high-value services, including preventive, primary, and behavioral health care services with little to no cost-sharing in the Bridge Plan design. The COVID-19 pandemic has exacerbated the existing mental health crisis, and Oregonians continue to report barriers to accessing mental health care, forcing many to forgo care due to high costs. Increasing access to affordable access to key health care services

can help reduce unnecessary hospital admissions and emergency room utilization, and improve overall health. And specifically focusing on providing coverage with no or minimal cost-sharing for preventive and primary care services where there are gaps in access and utilization for communities of color, such as chronic disease management services to address issues like heart disease, hypertension, and diabetes, can also improve racial and ethnic health disparities.

Provider Reimbursement to Support Continued Access to Care

As the BPTF identifies key plan design elements to promote the goals of the Bridge Plan, it is important to develop adequate provider reimbursement levels so this population continues to have access to necessary services as they transition to the Bridge Plan. We ask the BPTF to set provider reimbursement higher rates than OHP and to explore value-based payment model options that take into account social drivers of health and address unique patient needs. In particular, we ask the BPTF to support essential community providers that serve as critical care access points for this population.

Promoting Health Equity Across Coverage Options

As the BPTF develops the Bridge Plan framework, it will be important to consider how best to utilize the strengths of the Coordinated Care (CCO) infrastructure. To further support continuity of coverage, promote care coordination, and advance health equity, **the Bridge Plan should be required to adhere to the same health equity standards as OHP.** This was a recommendation from OHA's implementation plan for a public health insurance option, and since CCOs currently operate under those standards, it will minimize any disruptions in adopting the Bridge Plan while continuing to move Oregon towards eliminating health equities. Maintaining or improving these equity metrics will keep the Bridge Plan aligned with OHP.

Federal Funding Pathway

We appreciate the BPTF's focus on plan design as it relates to benefit structure and cost-sharing requirements for individuals covered under the Bridge Plan. As these continue to be deliberated, we encourage the BPTF to **consider the statutory requirements and potential constraints related to benefit design and cost-sharing under the federal pathways currently being explored**. We also encourage the BPTF to consider the long-term implications of whichever pathway is pursued to stand up the Bridge Plan. The BPTF should consider how leveraging multiple pathways, such as a 1331 and 1332, may work together over time to ensure all Oregonians continue to have access to high-quality, affordable health care. In the face of federal inaction, Oregonians face a 41% increase in their premium prices on the individual market at the end of the year when the enhanced subsidies from the American Rescue Plan Act go away. For this reason, we believe it is critical to be thinking about the impending affordability challenges in concert with mitigating churn, as the Bridge Plan is intended to do.

We appreciate the deliberations of the BPTF members on these important considerations in the Bridge Plan design. We strongly believe that the development of the Bridge Plan will continue making progress toward Oregon's goals of developing a low-cost, high-quality plan and will position Oregon to continue to be a national leader in health reform and health equity. Including comprehensive health benefits that match the benefits this population would receive through OHP, minimizing cost-sharing, and adhering to the health equity standards will enhance the Bridge Plan as a coverage option and lead to better health outcomes for Oregonians.

We applaud the Task Force for its commitment to ensuring continuity of coverage and affordability for all Oregonians through the design of the Bridge Plan. As you continue to develop the policy in HB 4035 and weigh the various considerations, please consider the team at United States of Care a resource, and if you have any questions regarding these comments, please don't hesitate to reach out.

Sincerely,

Rachel Bonesteel
Policy Manager
rbonesteel@usofcare.org

Allyson Horstman
Policy & External Affairs Coordinator
ahorstman@usofcare.org

Oregon Association of Hospitals and Health Systems

May 26, 2022

Oregon State Legislature
Joint Task Force on the Bridge Health Care Program
900 Court St. NE
Salem, OR 97301

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

On behalf of Oregon's 62 community hospitals and the patients they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) appreciates the Task Force's continued collaborative and thorough discussion about how to formulate the bridge program under HB 4035. Increased transparency and stakeholder engagement remain critical as the planning continues; this program will have effects far beyond the immediate population it seeks to enroll. As the Task Force weighs the options to identify the lower risk pathway and program design, we offer the following recommendations to help preserve access to health care for patients in our communities.

1. **Take time to find the right long-term solution.**

The health care system in Oregon is facing unprecedented strain. At the same time, several significant reform efforts are being considered or are already underway. With the likely extension of the federal Public Health Emergency, there is more time to prioritize planning and the coordination of resources to support the redeterminations process, and even less justification to develop a new program on a short timeline that carries significant risk of unintended consequences. We caution that the task force should not rush to a solution for this particular population that will create an adverse ripple effect and require us to spend valuable resources fixing more problems in the future.

For example, we share the concerns raised by some Task Force members and in other public comments about creating a new plan that restricts consumer choice. Allowing people to remain on, or choose to join, a marketplace plan will help mitigate the scenario where the "churn point" is just moved from 138% to 200% FPL. It also leverages the administrative efficiency of existing systems and provides much-needed reimbursement stability for providers serving this population. If the task force chooses to sacrifice optionality for a more straightforward path in the short term, Oregon may also be sacrificing important opportunities to innovate and provide better coverage and care for this and other populations in the future.

Taking the time needed to find the right solution for the population identified for this current challenge will also allow that solution to dovetail with other important policy goals. Initiatives like the one being discussed for this population are inseparable from broader cost containment and payment reform work. We need to be mindful of how this and other such programs may slow or interfere with those efforts. For instance, entities absorbing any additional costs associated with the options considered by the task force would face an additional barrier to reaching the Cost Growth Target. Similarly, restrictions on provider rates would further tie payment models to fee-for-service when health systems across the state are working together to move toward value-based care. The challenges in our health care system must be examined and addressed holistically if lasting change is to be made.

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2. **Hospitals and other providers must have the ability to negotiate their participation in the bridge plan. This includes negotiating commercial-range rates as well as payment mechanisms.**

As we have voiced elsewhere,[1,2] hospitals in Oregon are struggling to make ends meet and to provide the level of care that their communities need and expect. While each individual hospital and health system has its own unique story about how it has been impacted, patterns across the state show that many hospitals' expenses are outpacing revenue as they face high inflation, supply chain disruptions and shortages, lengthening hospital stays due to deferred care and a fragmented post-acute care system, and the need to increase employee wages.[3]

A bridge program that requires people currently enrolled on marketplace plans move to a separate plan with reduced reimbursement functions as yet another cut to hospitals' dwindling revenue. The same is true if the bridge program creates a plan that precludes current Medicaid enrollees from selecting a marketplace plan when they otherwise would have as part of the redeterminations process. Hospitals and health systems need to be able to negotiate rates and payment mechanisms and decide to participate in plan networks or not based on their individual financial and other circumstances.

Hospitals want their patients and communities to get well and stay well – especially people who face socioeconomic challenges that are often rooted in other forms of marginalization. As the task force considers plan design options, it must be realistic about what it costs to offer those benefits and whether our delivery system can meet those needs with the limited resources it has available. If hospitals and other providers are not able to obtain sustainable reimbursement for patient care, services may be reduced, access will become challenging, the burned-out health care workforce will face even more strain, and quality of care could be at risk. Everyone loses in that scenario – which defeats the purpose of what this program seeks to accomplish.

Thank you for the opportunity to provide comment. We look forward to reviewing the actuarial analysis planned for the next meeting on June 14, which will shed greater light on the financial realities of this potential program. We will remain engaged as the task force develops its proposal.

Thank you,

Sean Kolmer
Senior Vice President of Policy and Strategy
Oregon Association of Hospitals and Health Systems

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[1] https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/CGT_OAHHS-Comments-4-8-22.pdf
[2] https://oahhs.org/press-releases/hospitals-finish-2021-in-weakened-financial-position-as-omicron-wave-hit/#:~:text=Continued%20workforce%20shortages%2C%20higher%20expenses%20and%20flat%20revenue,a%20yearly%20data%20report%20from%20Apprise%20Health%20Insights.
[3] https://d1o0i0v5q5lp8h.cloudfront.net/oahhs/live/assets/documents/Apprise/HUFA/CY%202021%20HUFA%20Annual%20Report.pdf?_t=1649697044

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To the Bridge Program Task Force,

I'm writing in support of a robust bridge plan because expanding health care has the potential to transform and improve lives.

As a retired emergency physician, I can tell you that throughout my career i the emergency department, I saw many patients who benefit a great deal when they have health care, especially low-income individuals who may have gone without for many years before qualifying for coverage under the Affordable Care Act. Many of these individuals are among the hardest-working Oregonians around, doing some of the most difficult jobs while juggling many life challenges. And some years, they earn too much to qualify for health care yet don't have employer-provided coverage.

This churn in coverage hurts individuals' health, and puts our public health at risk, particularly as COVID-19 continues to spread and future public health crises loom. By expanding the threshold to qualify for health care for Oregonians who work as cashiers, grocery store clerks, transportation workers, daycare providers, ride-share drivers and those who work part-time, we can improve and save tens of thousands of lives. These are people who earn too much to qualify for health care yet may not be able to afford insurance on the marketplace.

A bridge plan for Oregon is a reasonable, common-sense step toward a more robust expansion of health care that will prevent many people from falling through coverage gaps and going without access to health care. Individuals, families and pregnant mothers who would otherwise be left without health care should not get left behind with Oregon's bridge plan.

Thank you for your efforts to implement Oregon's bridge plan and your work to help physicians better care for our patients.

Sincerely,

Robert Lowe, MD

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: June 14, 2022

Re: Bridge Health Care Program Plan Development

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers (CHCs), 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 OHP members**.

We write to offer comment on the Plan Development for the Bridge Health Care Program regarding enrollee costs, benefits and coverage, and reimbursement rates. OPCA believes that the Bridge Plan is not merely a temporary fix; rather, it is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health.

OPCA encourages the task force to prioritize health equity in all plan design decisions and appreciate this emphasis in the advance reading materials. We remind members that Oregon has hit landmark highs in insurance coverage because of extended eligibility during the Public Health Emergency (PHE), specifically for communities of color. Racial inequities are a fundamental root cause of health disparities, including unequal access to health insurance coverage – during the PHE, Black and African American Oregonians experienced an unprecedented increase in coverage[1]. These are upstream health equity gains Oregon cannot afford to lose – decisions must clearly address historically sidelined populations, who will be most impacted by task force decisions. Systemic disenfranchisement must not be perpetuated by the Bridge Health Program.

Community health centers provide comprehensive primary, behavioral, and oral health care to ~41,542 unique patients in the target demographic – accounting for about 10% of the total CHC patient population -- which are currently eligible for Medicaid PPS wrap payments. We are concerned that as this population transitions out of Medicaid yet remain CHC patients that any decrease in provider reimbursement will have unintended consequences not only for this population but on the CHC's larger patient population. CHCs provide uncompensated services such as expanded dental services, mobile community access points, and school-based health centers, as well as care for uninsured Oregonians. When preventative care is inaccessible, negative impacts are seen across the entire health system; this looks like increased emergency room visits, delayed care, unmanaged chronic conditions, reduced prescription adherence, and increased need for higher levels of care over time. CHCs depend on enhanced reimbursement to expand preventative services which reduce health inequities and disparities across their entire population.

[1] Unwinding Federal Public Health Emergency and OHP Continuous Coverage Policies

With these concerns in mind, OPCA advocates for:

- Extension of the PPS wrap payment model up to 200% FPL for Federally Qualified Health Centers to mirror the current Medicaid reimbursement and wrap payment model. Without such an extension, community health centers will experience incredible loss of revenue without a reciprocal decrease in patient touches.
- Reimbursement rates that adjust for the unique needs of the target demographic and associated costs of care. Insurance coverage does not automatically equal reduced costs. Providers must be reimbursed at a rate that ensures continued network adequacy.
- Minimal enrollee out-of-pocket costs and elimination of unnecessary barriers to health insurance coverage.
    - If changes to federal funding require greater cost-sharing, we continue to advocate for no premiums or copays for preventative care, with low copays for other services.
    - This includes a no-wrong-door approach to enrolling people in the Bridge Health Plan; robust and culturally appropriate education and outreach efforts are integral to the success of this program.
- Broad benefit coverage, building on OHP coverage, to promote continuity of care both for patients and for CCOs who will be responsible for administering the Bridge Health Plan.