Joint Task Force on the Bridge Health Care Program

Glossary of Key Terms and Acronyms

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Acronym	Term	Definition
AV	Actuarial Value	*Also see metal tiers.* In this context, actuarial value refers to the percent of overall health care costs covered by an insurance plan. For example, a health plan with an AV of 80% covers, on average, 80% of costs for enrollees in that plan (though costs for individual enrollees may be higher or lower).
APTC	Advance Premium Tax Credit	*Also see PTC.* Advance premium tax credits are federal financial assistance toward the purchase of individual health insurance on the marketplace. APTCs are based on an estimate of the PTC an individual will be eligible for in that plan year. Individuals applying for marketplace-based coverage can elect to have estimated PTCs applied in advance to reduce their monthly premiums.
ARPA	American Rescue Plan Act of 2021	Federal COVID-19 relief legislation signed into law on March 11, 2021. ARPA enhanced and expanded the subsidies available to people purchasing health insurance coverage on the marketplace through December 2023. These enhanced subsidies would increase funding available under ACA Sections 1331 and 1332 if extended, but will expire at the end of 2023 without additional congressional action.
BHP	Basic Health Program	Section 1331 of the Affordable Care Act (ACA) allows states to create a program that offers Medicaid-like coverage to people earning <200% of the Federal Poverty Level who are not eligible for Medicaid but are eligible for subsidies to purchase coverage on the marketplace.
	BHP-like	*Also see BHP.* A program with coverage that is similar to a Basic Health Program but is created through a mechanism other than a Section 1331 Blueprint.
	Bridge Program	Oregon House Bill 4035 (2022) authorized the state to create a bridge program to "provide affordable health insurance coverage and improve the continuity of coverage for individuals who regularly enroll and disenroll" in Medicaid or other health care coverage due to frequent fluctuations in income.[1]
	Capitation	*Also see Rates and Reimbursements.* A payment method that establishes a fixed per-person payment amount intended to cover all health care costs for that person within a defined set of services. The term capitation is sometimes used to refer to the amount Coordinated Care Organizations are paid to provide coverage to OHP enrollees ("CCO capitation rate"); the term capitation is also sometimes used to refer to per-member per-month (PMPM) amounts paid by health plans to health care providers under alternative payment arrangements (i.e.., not fee-for-service payment arrangements).

	Carrier	An entity that provides health benefit plans.
	Churn / Churn population	People who frequently gain and lose health insurance coverage (particularly Medicaid) or experience disruptions in coverage due to fluctuations in income.
CCO	Coordinated Care Organization	Locally governed organizations that administer coverage and provider networks for OHP members in geographically defined service areas of Oregon.
CGT	Cost growth target	Oregon has established a goal that overall health care costs will not increase by more than 3.4% per year.
	Cost sharing	*Also See OOP*. The portion of health care costs paid "out of pocket" by an individual, including deductibles and co-pays. Cost sharing typically does not refer to premiums.
CSR	Cost sharing reductions	*Also see cost sharing, Silver Loading.* Additional financial assistance available to individuals with incomes <250% FPL who purchase coverage on the marketplace. CSRs reduce co-pays, deductibles, and out-of-pocket maximums. CSRs are distinct from premium tax credits and only apply to "silver" tier plans. Carriers are required to provide CSRs to income eligible individuals enrolled in Silver tier plans, however, the federal government stopped paying CSR subsidies to carriers in 2017. Most states use "Silver Loading" to replace the lost revenue for carriers.
	Exchange	*Also see HIM.* An alternative term for the health insurance marketplace, a platform for purchasing health insurance.
FFM / FFE	Federally Facilitated Marketplace / Federally Facilitated Exchange	*Also see HIM.* A marketplace platform, Healthcare.gov, that is managed by the federal government.
HIM	Health insurance marketplace or marketplace	*Also see SBM, SBM-FP.* A service available in every state that helps people find and enroll in health insurance. Some states operate their own marketplace (or "exchange") while others like Oregon use the federal Healthcare.gov platform.
	Market disruptions / market stability	*Also see risk pool, Silver Load, CSR.* Changes in individual or small group health insurance markets that may occur following creation of a Bridge Program due to the removal of people eligible for the Bridge Program from the risk pool. Market disruption may also result from increased net premiums in the Marketplace due to reductions in PTC and "Silver Loading" to account for a smaller CSR eligible population.
	Medicaid-like	*Also see OHP.* A health insurance program that resembles the Oregon Health Plan in covered benefits and enrollee costs but is offered to people who are not eligible for Medicaid.
	Metal tier ("bronze", "silver", "gold")	A way of classifying health plans sold on the Marketplace according to the share of costs a member typically pays OOP. "Gold" tier plans have the highest monthly premiums and the lowest member OOP costs. "Bronze" tier plans have the lowest monthly premiums and highest OOP costs. "Silver" tier plans are midway between Gold and Bronze plan.

	Morbidity	*Also see risk pool.* The prevalence of poor health in a population. In the context of health insurance, morbidity refers to the average or aggregate disease burden of a group, with higher morbidity describing a population with poorer overall health.
OHP	Oregon Health Plan	Oregon's Medicaid program
	Optionality	The ability for consumers to choose between the Bridge Program or subsidized coverage purchased on the marketplace. *Note: optionality does not refer to having a choice of plans within the Bridge program or choice of plans on the Marketplace. It refers only to choice between Marketplace and Bridge coverage.*
OOP	Out of pocket costs	Any health care costs paid by members at the point of care, including cost sharing (deductibles, co-pays) and non-covered services. Premiums are not considered OOP costs.
	Pathways	Options to secure federal funding for a Bridge Program, including an 1115 demonstration waiver, a 1331 blueprint, and a 1332 state innovation waiver. Oregon refers to these options collectively as federal "pathways."
	Phases	Discrete periods of time when Oregon would design, apply for and implement a Bridge Program.
	Premium	A monthly amount paid by an enrollee who purchases health insurance coverage. Premiums are distinct from other costs such as deductibles or co-pays.
PAF	Premium Adjustment Factor	A component of the Section 1331 Basic Health Program federal funding formula. A state's BHP funding is based on the premium tax credits that individuals would have otherwise received to purchase subsidized coverage on the Marketplace. The PAF is an 18% increase to the base funding formula that was established when the federal government discontinued paying Cost Sharing Reductions *(also see CSRs above).* The PAF simulates silver loading that a 1331 state would otherwise need to use but for its implementation of a BHP.
PTC	Premium Tax Credit	The premium tax credit helps eligible individuals purchase health insurance through the marketplace. The federal tax credit is based on income, and those with lower incomes receive higher credits.
	Procurement cycle	The State of Oregon's process for contracting with Coordinated Care Organizations and establishing per member per month rates for Oregon Health Plan members.
PHE	Public Health Emergency	Federal determination that a public health emergency exists because of confirmed COVID-19 cases. Originally declared on January 31, 2020; last renewed for 90 days on April 12, 2022.
QHP	Qualified Health Plan	A health plan that meets Affordable Care Act requirements to be offered on the marketplace, including covering essential health benefits (EHB) and limiting enrollee cost sharing.
	Rate	In this context, "rate" refers to the amount a health plan receives to provide coverage to a member (such as a BHP or Medicaid

		enrollee). Often expressed as a per-member per-month (PMPM) amount.
	Redetermination	Federal requirement that Medicaid eligibility be regularly renewed (usually once every 12 months). Redetermination requirements have been suspended because of the federal Families First Coronavirus Response Act (FFCRA).
	Reimbursement	In this context, "reimbursement" refers to the amount a health plan pays a health care provider to deliver services to its members. Reimbursements can be structured many ways, such as fee-for-service (FFS), capitation, diagnosis or episode-based, etc.
	Reinsurance	Protects insurers from losses related to complex and high-cost medical claims. States can implement reinsurance programs to lower premiums for plans sold on the Marketplace. Some states, including Oregon, have Section 1332 waivers to receive pass-through dollars the federal government saves on the cost of PTCs because of a reinsurance program. The Oregon Reinsurance Program (operating since 2018) has on average lowered premiums by an aggerate 6.5%.[a]
	Risk pool	A group of individuals whose health status or costs of care are aggregated (pooled) to calculate average measures for the group.
SBM	State Based Marketplace	*Also see HIM.* A marketplace platform managed and operated by a state rather than the federal government.
SBM-FP	State Based Marketplace – Federal Platform	*Also see SBM, FFM / FFE.* A marketplace platform managed and operated by a state rather than the federal government, but which uses the federal Healthcare.gov platform for enrollment & eligibility determinations.
	Silver-loading	*Also see cost-sharing reductions.* An adjustment made by health plans to their silver-tier premiums to offset the loss of revenue the federal government used to pay for CSRs. Silver-loading replaces federal CSR payments by increasing premiums for silver plans, increasing revenue from PTCs. The creation of a BHP eliminates most silver-loading, due to the reduced population enrolled in CSR Silver Plan Variants.
	1115 Waiver	Section 1115 of the Social Security Act allows states to request approval to waive certain Medicaid program requirements to implement pilot projects to improve their programs.
	1331 Blueprint	The form that states use to request certification of a Basic Health Program from the federal government. The form contains a description of how the plan will be designed and operated.
	1332 Waiver	Section 1332 of the Affordable Care Act allows states to apply to waive certain provisions of the ACA to "pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."[b]