Questions and Answers

Last updated 7/7/2022

This document contains a running log of questions submitted or posed by members of the Joint Task Force on the Bridge Health Care Program. LPRO staff compiled the responses from information available as of the date of this document. Updated information will be provided as it becomes available. We thank Oregon Health Authority and Department of Consumer and Business Services staff for their assistance.

Contents

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Bridge Program Population

About the Bridge Program Population

Q: What is known about the population of people who lack insurance coverage in Oregon? How does this rate compare to other states?

A: LPRO staff compiled a slide deck on the uninsured population from the 2019 American Community Survey. Available here.

Q: What is known about the population of people who may be eligible for the Bridge Program, including their demographics?

A: The population that would be eligible for the Bridge Program are 1) adults ages 18 to 64, who 2) earn less than 200% of the federal poverty level (FPL), who 3) are not eligible for Medicaid or affordable group coverage, but 4) are eligible for premium tax credits. This population includes lawfully-present immigrants who earn less than 138% FPL but are ineligible for Medicaid because they have resided in the U.S. for fewer than five years. The slide deck here contains estimates of the demographic profile of the population 138-200% FPL who are not covered under other public insurance.

Q: How many people would be eligible for the Bridge Program?

A: OHA has estimated that 55,000 people currently enrolled in Oregon Health Plan (Medicaid) would be eligible for the Bridge Program. Manatt estimated 32,500 people currently covered through the Marketplace and 21,300 people currently uninsured may also be eligible. These are rough estimates. OHA is working to connect eligibility system data, actuarial and other CCO data, and survey data, to provide more precise estimates of eligible population size and demographics.

Q: Among the population who would be eligible for the Bridge Program, how are they geographically distributed across the state?

A: OHA is unable to provide this information at this time, as current estimates of the eligible population are not based on member-level enrollment data. The ACS slide deck here provides information on the geographic distribution of a population that is similar to those who would be eligible for the Bridge Program.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: Among the population of people currently enrolled in Medicaid who would transition to a Bridge Health Care Program, what percent are entering Medicaid via presumptive eligibility determinations in hospital versus other channels?

A: OHA is unable to provide this analysis at this time but a relatively small portion of OHP enrollees enter through hospital presumptive eligibility. The percentage of overall OHP enrollees who enter through this process may not be reflective of the subset of enrollees who could be eligible for the BHP.

Q: Among people currently insured through the Marketplace who would be eligible for the Bridge Program, which carriers provide their current coverage?

A: OHA is unable to provide this analysis at this time but this information may be available in late 2022 following completion of a carrier data call and further actuarial analysis.

Q: What do we know about the health status of the BHP-eligible population?

A: In a preliminary actuarial analysis that was limited to individuals currently covered through the Marketplace, Manatt estimated the "morbidity" or burden of poor health in the BHP-eligible population is similar to overall morbidity in the individual and small-group market. The morbidity of the BHP-eligible population currently enrolled in OHP is unknown. Additional analysis is underway and will be shared as it becomes available.

Q: What portion of the BHP-eligible population is offered employer sponsored insurance that is considered affordable under current ACA requirements?

A: OHA does not have access to data that would answer this question.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Enrollment, Marketplace Platforms, and Coverage Transitions

Q: Among states that operate Basic Health Programs, how is enrollment effectuated? Is it more similar to Medicaid or to commercial insurance? Does it occur on a continuous basis or during an open-enrollment period?

A: There is flexibility in the Basic Health Program Blueprint (federal application) to design enrollment procedures that are more Medicaid-like or Marketplace-like. The approaches used in Minnesota and New York are documented in their Basic Health Program blueprint applications, Section 4. The specific approach to be outlined in Oregon's BHP Blueprint has not yet been determined.

Q: Does one federal pathway* (e.g. a 1331 Blueprint versus a 1332 waiver) provide better options for managing the "churn point" or coverage transitions for people transitioning off OHP?

A: OHA discussed options with CMS to implement a Bridge Program under a Section 1331 blueprint and a Section 1332 waiver. Discussions about the 1332 waiver included exploration of "optionality," a scenario where eligible consumers would be able to choose between a BHP-like product and other subsidized coverage on the Marketplace. The idea behind optionality is to mitigate the coverage "cliff" at 138% FPL where Medicaid eligibility ends without creating a new coverage cliff at 200% FPL where BHP eligibility ends. While there is reason to believe people at 138% FPL experience more frequent income fluctuations than people at 200% FPL, and are less likely to be offered employer-sponsored insurance (ESI), OHA is not able to confirm these assumptions from existing data.

OHA's vision is to make Bridge Program coverage transitions as seamless as possible under either pathway. The ideal scenario results in an OHP member "transitioning in place." In other words, they would receive a letter from their Coordinated Care Organization (CCO) saying their coverage had switched from OHP to BHP, but they would experience no disruptions in access. This approach requires that a BHP is offered through CCOs; a Marketplace-based option would require different administrative procedures.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: Is one of the federal pathways* more easily implemented than the other?

A: OHA has indicated that, in general, the more closely a Bridge Program resembles the OHP, the easier it will be for the state and CCOs to implement. The choice of federal pathway is closely linked to how Oregon operates its individual Marketplace. Currently, Oregon operates a state-based Marketplace on the federally facilitated exchange (Healthcare.gov). CMS has indicated that the federal platform can accommodate Oregon's plan to establish a Basic Health Program under a 1331 BHP Blueprint, but the federal platform could not enable "optionality" (e.g. the ability of consumers to choose between BHP-like coverage and subsidized Marketplace coverage) as was proposed by the state under a 1332 waiver.

Q: How quickly could Oregon implement a state-based exchange?

A: OHA has indicated that if the Oregon Legislature opted to pursue a state-based exchange during the 2023 legislative session, the platform may be operational by 2026.

Q: Is it possible to offer a Basic Health Program with a 2-year eligibility period rather than one year?

A: CMS indicated that this is not an option.

Q: How would enrollees be assigned to CCOs? Would people be able to choose which CCO they enroll in? Could this process be designed with consideration for continuity in provider access?

A: This is still to be determined. OHA has procedures for auto-assignment and manual enrollment (member choice) depending on the members' residence, CCO capacity, and other contributing factors (e.g., whether the member is eligible for auto-assignment exceptions or exemptions), but has not yet considered whether an auto-assignment process for the BHP would differ.

Q: What needs to be done to communicate with enrollees about the redetermination process and PHE "unwinding," including ensuring digital access, language access, etc.?

A: OHA has convened a community and partner workgroup to advise on this process as required by HB 4035. This group will provide ongoing support and guidance to OHA on these topics; information about their work is available here. OHA provided a report to the Legislature on May 31, 2022 with an update on planning efforts related to the PHE unwinding.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: How would creation of a BHP impact revenues for county health departments?

A: This question has not been explored at this time.

Federal Pathways*

Q: Are the federal pathways* mutually exclusive? Can they be implemented sequentially?

A: The pathways are not mutually exclusive. A phased or sequential approach is possible. A short-term 1115 waiver could be followed by a more permanent 1331 Blueprint or 1332 waiver. House Bill 4035 directs the state to pursue a temporary, short-term 1115 waiver as part of its' redetermination of Medicaid enrollees' eligibility when the Public Health Emergency (PHE) ends. OHA and DCBS are preparing this federal 1115 waiver request for submission as soon as possible in 2022.

Oregon could pursue either a 1331 Blueprint or 1332 waiver as a longer-term vehicle for creating the Bridge Program; CMS has advised OHA that a 1331 Blueprint is the recommended federal pathway to achieve the goal of HB 4035. CMS clarified that Oregon could implement a BHP under a 1331 Blueprint prior to pursuing a 1332 waiver to create a BHP-like product. However, CMS clarified that the 1331 BHP would need to be fully implemented for a period of 1-2 years before a 1332 waiver should be requested.

Q: Are the federal pathways* different with respect to implementation timeframes? Is one pathway more likely to receive federal approval than the other?

A: The federal pathways differ in terms of implementation timeframes. The 1331 Blueprint is a relatively straightforward application process with well-defined parameters for program design decisions. The 1332 waiver has not previously been utilized for the creation of a BHP-like product and would present many unknowns and potential program design challenges. CMS has recommended Oregon pursue a 1331 Blueprint for creation of the Bridge Program.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: Oregon already has an 1115 waiver to deliver Oregon Health Plan coverage through Coordinated Care Organizations. Would a separate 1115 application for a Bridge Health Care Program affect the state's currently pending 1115 waiver application?

A: No. The use of a short-term, temporary 1115 waiver for creation of a Bridge Health Care program would be unlikely to impact anything related to the state's separate pending Medicaid waiver (aka "the waiver").

Q: Would pursuing a 1331 Blueprint for people earning <200% preclude the state from pursuing a separate 1332 waiver for people earning more than 200% FPL?

A: No. Implementing a Basic Health Program under a 1331 Blueprint does not prevent Oregon from applying for other waivers. New York is pursuing a 1332 waiver to cover people above BHP income eligibility levels in addition to their 1331 Blueprint.

Federal Financing and State Budget Implications

Q: What actuarial analyses are planned and when will they be available?

A: This question will be addressed as part of the overall timeline update to be presented to the Task Force at the 7/12 meeting.

OHA and DCBS are working to finalize the specific parameters for additional analysis over the next 4 months. A series of analyses are planned, as follows:

- Analysis of the impact of creating a HBP on the existing ACA individual market including the impact on premiums in the individual market and analysis of enrollee responses to premium changes. Results of this analysis is planned for the September Task Force meeting.
- More robust analysis to project potential enrollment in a BHP as well as the costs to provide coverage to the BHP population and the expected federal funding Oregon would receive. Results of this analysis are planned to be presented at a Task Force meeting in October.
- Additional analysis will be sought to project the potential implications of BHP design scenarios and/or specific strategies to mitigate

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

negative impact on the individual market. The timing and scope of these analysis will depend on future Task Force discussions.

Q: What are the state budget implications if the Bridge Program has higher than expected enrollment?

A: Increasing the level of coverage among the population is consistent with the goals of HB 4035, though the state budget implications of higher-than-expected enrollment are different under a 1331 Blueprint and a 1332 waiver. The federal funding formula for a 1331 BHP Blueprint is calculated on a per-person basis and the state would receive federal funds for the program that would be tied to the number of people enrolled. Under a 1332 State Innovation Waiver, the state would receive an aggregated (population-based) amount of federal funds rather than a per person amount. The state would be accountable for "deficit neutrality," meaning federal funds for the waiver could not exceed that aggregated amount if enrollment was higher than expected.

Q: Are there differences in program administration costs to implement either of the pathways*?

A: OHA is currently in the process of developing its budget for the 2023-25 biennium, which will include funding requests necessary to implement Bridge Program elements recommended by the Task Force.

OHA has not produced cost comparisons related to the difference in implementing a Bridge Program through either a 1331 or 1332 pathway. There are differences in how federal funds may be used under the two pathways. Under a Section 1331 Blueprint, federal funds are held in a BHP trust to cover enrollee benefits. Federal funds from the trust may not be used for program administration and these costs must be covered with state dollars. The section 1332 waiver offers more flexibility in how federal funds may be used (toward enrollee benefits versus program administration) but federal funds are subject to overall deficit neutrality rules that constitute additional financial risks to the state.

Q: Is one federal pathway more financially predictable or stable long-term than the others?

A: Generally, 1115 and 1332 waivers are approved by CMS for 3-5 years and must be reapproved at the discretion of the sitting federal administration. A Section 1331 Blueprint does not generally need to be renewed once approved. The federal funding formula for the 1331 Basic Health Program has historically been updated on an annual basis; in 2022,

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

CMS proposed to move away from annual formula updates to a formula that would be updated on an as-needed basis. This proposed change is currently open to public comment.

Q: Does one pathway* or the other support reduction of uninsurance rates for the 4.5% of Oregonians without coverage?

A: Nothing in the basic structure of the 1331 Blueprint and 1332 waiver automatically points toward differences in the likely effect on uninsurance rates. However, enrollment or "uptake" of the BHP by eligible consumers may be sensitive to whether and how cost sharing is incorporated into the benefits design. To the extent that 1331 funding is on a per-capita basis, scalable to varying levels of enrollment, and not subject to deficit neutrality rules, it may be easier for the state to promote higher levels of plan uptake *over time* under a 1331 Blueprint.

Q: What is the administrative cost of churn, which may not be well captured in analyses of either Medicaid or Marketplace enrollees?

A: A 2015 study[1] simulating Medicaid churn from pre-ACA data (2005-2010) estimated that the process of disenrolling and reenrolling one person in coverage within a year incurs administrative costs between $400 and $600, an amount which would be higher in today's dollars. A national study of Medicaid service utilization and costs estimated that churn resulted in a $650 per-member per-month increase in acute care costs (driven primarily by higher emergency department utilization and inpatient stays) and an overall $310 per-member per-month increase in total costs.[2]

Q: Does the cost of administering member cost sharing (such as premiums or co-pays) offset the revenue gained through these strategies?

A: OHA does not expect that the administrative costs of implementing cost sharing will exceed 1) the revenues gained from these strategies, and 2) reduced costs that result from lower service utilization. OHA has not yet made forecasts of the administrative costs of these strategies or the revenue impacts but aims to explore the operational and fiscal implications of these strategies.

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: Will actuarial analyses consider the future costs of deferred care that may result from the pandemic?

A: OHA will not be able to answer this question due to limited resources. It is outside the scope of their actuarial analysis.

Plan Design

Access, Covered Services and Enrollee Costs

Q: What are the differences between covered services under the Essential Health Benefits (EHB) package and OHP package (as delivered through CCOs)?

A: OHP covers all EHBs as required by federal law. At a high level, the covered services in OHP and marketplace plans are very similar, though with some nuanced differences such as in limits in the volume of some services allowed. OHP also includes some additional services such as non-emergency medical transport (NEMT), enhanced behavioral health care, bariatric surgery, and dental that are not required in marketplace plans. OHA is working to develop a comparison of these service packages with additional detail. OHA also plans to provide more detailed estimates of the cost of providing the OHP service package to BHP enrollees as part of upcoming actuarial analyses.

Q: Does the federal government have the ability to dictate non-covered services under one or both of these pathways?

A: Federal BHP funds can be used to pay for services that are not part of the EHB or traditionally covered by marketplace plans with the exception of abortion services subject to the Hyde Amendment. The Hyde Amendment prohibits the use of federal funds to pay for abortion except in very narrow circumstances. This amendment covers programs funded through the Department of Health and Human Services, such as Medicaid. The Affordable Care Act extends Hyde Amendment exclusions to programs federally funded under the Affordable Care Act, including Basic Health Programs and federal premium tax credits for the purchase of subsidized coverage on the Marketplace. States can cover these services using state revenues as they do with Medicaid.

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: How much overlap exists in provider networks for people earning 138-200% FPL who are covered through OHP and the Marketplace?

A: OHA is investigating this issue through its Medicaid to Marketplace Migration team and working to provide a more complete response to the Task Force.

Q: Does one federal pathway offer better ability than the other to increase members' access to providers?

A: Generally no, the differences between a 1331 Blueprint and 1332 waiver would not automatically lead to differences in provider access (though access may be indirectly affected by plan design decisions made under either pathway).

Q: Does the choice of federal pathway* have implications for enrollee cost sharing?

A: Generally, no. Oregon has broad flexibility to design enrollee cost sharing as part of a BHP under either pathway.

Q: What options exist for customizing how co-pays may apply to certain services?

A: Federal rules limit overall enrollee costs allowable in BHP programs. BHP premiums and cost-sharing cannot be higher than what an individual would have paid for a Marketplace plan. The ACA also generally prohibits cost-sharing for preventive services except in limited instances such as out-of-network care. States have some flexibility in setting co-payments, though more complicated co-payment designs can cause consumer confusion and increased administration costs.

Q: What research exists regarding the relationship between premiums and enrollment or plan uptake?

A: Research on health insurance premiums generally shows that premiums reduce the number of people covered. This can occur when 1) people decline to enroll due to cost barriers, 2) enroll in a plan that is never "effectuated" (activated as coverage) because they do not pay the first months' premium, or 3) enroll in a plan that is effectuated but later disenroll due to premium nonpayment. Higher premiums tend to create larger barriers to coverage, though specific estimates of the effect vary by population. Research suggests rates of coverage among lower-income enrollees are highly sensitive to premiums. A 2014 study of Medicaid

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

enrollees in Wisconsin[3] found that increasing the monthly premium from $0 to $10 reduced the average length of enrollment by 1.4 months and decreased the likelihood of remaining continuously enrolled for 12 months by 12 percent. A simulation study of lower income Marketplace enrollees estimated that eliminating Marketplace premiums would increase enrollment by 14.1 percent in 2019.[4]

Plan Administration and Provider Reimbursements

Q: How will success (i.e. performance) be measured in a BHP, and how will this relate to plan or provider payment?

A: This has not yet been determined. The BHP could build on the incentives and other provisions in CCO contracts. OHA is working with Manatt to understand how New York and Minnesota have integrated value-based purchasing into their BHP designs.

Q: How would the creation of a BHP impact federal funding for safety net providers or Federally Qualified Health Centers?

A: Federally Qualified Health Centers are those that receive Section 330 grant funding under the Public Health Service Act to provide care in communities underserved by the health system. KFF estimated that in 2017, Medicaid accounted for 44% of FQHC revenue while Section 330 grants accounted for 18%.[5] Federal law establishes a Prospective Payment System (PPS) for FQHCs to tie payments to the cost of providing care and ensure that provision of care for Medicaid enrollees does not reduce federal grant funds for care of people who are uninsured.[6] In Oregon, OHA makes quarterly "wraparound" payments to FQHCs based on the number of OHP members served. These payments are intended to make up the difference between CCO (and third party) payments a clinic received for care of OHP members and what clinics would have been paid at their PPS rate.[7]

---

[3] https://www.sciencedirect.com/science/article/abs/pii/S0167629614000642
[4] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00345
[5] https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/#:~:text=Section%20330%20of%20the%20Public%20Health%20Service%20Act,appropriation%20and%20the%20Community%20Health%20Center%20Fund%20%28CHCF%29.
[6] https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Pager-Update.pdf
[7] https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-FQHC-RHC.aspx

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Nationally, half of people served in FQHCs are Medicaid enrollees, and changes in Medicaid caseloads are an important factor in FQHC financial stability during the "unwinding" of the public health emergency.[8] Oregon Primary Care Association has estimated that FQHCs provide care to one in six OHP members.[9] When the PHE ends, people who maintained OHP coverage under the continuous eligibility (CE) provision may lose coverage and be disenrolled. When this occurs, FQHCs providing care to these individuals may no longer be able to bill OHA for wraparound payments for their care. This change is not directly related to the creation of a Basic Health Program though a BHP could be designed to replicate the wrap payment model used in OHP.

Q: What options exist for directing how CCOs invest funds toward provider reimbursements?

A: OHA does not set provider reimbursement rates paid by CCOs and would not likely consider doing so for a BHP. OHA would seek to develop a program with payment rates to CCOs that are sufficient to ensure members have access to high quality health care services when they are needed. OHA has not yet developed strategies to direct how CCOs should structure reimburse providers if capitation rates developed for the BHP assume higher payment rates than current OHP capitation rates. Furthermore, strategies to provide additional direction to CCOs would likely depend on funding available, which will become more clear after upcoming actuarial analysis.

[8] https://www.kff.org/policy-watch/community-health-centers-taking-actions-prepare-for-unwinding-public-health-emergency/

[9] https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/255963

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*