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 7/11/22

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
6/14/22	*Rachel Bonesteel, Policy Manager*	*United States of Care*	A letter outlining recommendations for plan design and federal pathway choice, including: • Setting provider reimbursement rates higher than OHP and exploring value-based payment models; • Requiring all CCOs to offer the Bridge Plan; • Eliminating premium and cost-sharing for Bridge Plan enrollees; • Including dental benefits that, at a minimum, aligns with OHP coverage; and • Considering using a combined approach to 1331 and 1332 pathways	Link
6/14/22	*Samantha Shepard,*	*CCO Oregon*	A letter from the CCO Oregon Oral Health Workgroup urging the inclusion of comprehensive dental coverage in the Bridge Program	Link

	Executive Director			
6/21/22	*Courtni Dresser, VP of Government Relations*	*Oregon Medical Association*	A letter submitted on behalf of the following provider organizations: • Oregon Medical Association • Oregon Society of Anesthesiologists • Oregon Chapter of the American College of Emergency Physicians • Oregon Academy of Opthalmology • Oregon Association of Orthopaedic Surgeons • Oregon Academy of Family Physicians • Oregon Psychiatric Physicians Association • Oregon Pediatric Society • Metropolitan Pediatrics • Douglas County Individual Practice Association • WVP Health Authority • North Bend Medical Center • The Portland Clinic • The Oregon Clinic • Urgent Care Northwest – Astoria • Oregon Council of Child & Adolescent Psychiatry • Oregon Society of Physician Assistants • Oregon Chapter of the American College of Physicians The letter encourages the Task Force to consider four key principles in designing the Basic Health Program: 1) A benefit plan that supports continuity of care as enrollees move between OHP and BHP 2) Minimizing administrative barriers to coverage transitions 3) Funding to support enrollee outreach and equitable enrollment 4) Rates higher than Medicaid to support a robust provider network	Link
7/11/22	*Jackie Fabrick, Program Manager, Government Relations*	*Providence Health Services*	A letter outlining the following requests to the Task Force: 1) Ensuring adequate data and time for decisions. 2) Considering how the elimination of "silver loading" in the Marketplace will impact premiums for people earning more than 200% FPL; 3) Considering how access to providers may be affected for people who transition from a Marketplace plan to the Basic Health Plan; and making information available to consumers to compare CCO and other plan provider networks; 4) Designing the program to operate within federal funding without state subsidy and considering plan designs that support provider reimbursements higher than OHP;	Link

			5) Use of navigators trained to help people transition from OHP to other coverage; 6) Identifying and providing assistance to close gaps in federal and state subsidies.	

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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Chapter

June 21, 2022

Co-Chairs Senator Steiner Hayward, Representative Prusak
Vice Chairs Senator Kennemer and Representative Hayden
Members of the Bridge Plan Task Force

The provider organizations supporting these comments represent many of the specialty physicians and physician assistants practicing in all corners of the state. Our members are committed to safe, accessible healthcare, and greatly appreciate the work of the Task Force, which we believe will further these goals. We also believe this opportunity to increase coverage fits squarely into critical health equity goals, and the implementation and details of the plan will be crucial to ensure that we all meet the stated goals.

We know that insurance coverage is not the same as access to healthcare, although it is a key piece of the puzzle. We look forward to working with the Task Force to ensure that the plan created allows for key principles to be met:

- Any plan must include broad robust benefit plan for enrollees that is similar to the Oregon Health Plan which would allow for continuity of care as enrollees move from OHP to the Bridge Plan.
- The plan must be administratively simple for both the patients and their providers, thus reducing a drop of a patient due to administrative hurdles.
- The plan and the administration of the sign-up process should be equitable and ensure that the state and its stakeholders have the funding needed to reach all patients to ensure that they are enrolled and continue to have access to care.
- The plan should have a robust network of providers to ensure access to quality care for all within the plan. To ensure an adequate network the plan should include a provider rate that is above the current Medicaid rate, and is not benchmarked to public payer rates.

We respectfully encourage the Task Force to move in the creation of a bridge plan that will include a solid benefit package, and sufficient provider reimbursement to ensure true access to care and robust provider panels, and investment in an equitable administrative process.

Thank you for your consideration, and for your work on this important effort,

CC:
Courtni Dresser
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July 12, 2022

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

Dear Co-Chair Steiner Hayward, Co-Chair Prusak and members of the joint task force:

Providence's advocacy priorities have long included health care access and coverage for everyone. This includes support for Medicaid expansion, Cover All Kids and Cover All People; along with complementary strategies including expanding income eligibility for hospital financial assistance and the HOPE amendment. To this end, we actively engaged in conversations about House Bill 4035 during the 2022 legislative session and advocated for policies that would ensure that the Medicaid redetermination population is able to maintain coverage with limited disruption.

As we have monitored the joint task force's discussions over the past couple of months, many of our initial concerns about the Basic Health Plan program have yet to be resolved. We understand the task force still has significant work ahead to define the scope of the program, analyze data and make recommendations. In outlining our guiding principles and priorities related to this policy decision, it is Providence's hope to inform aspects of the conversation as it moves forward.

- **Ensure the task force has adequate data to fully understand the impact of these decisions across markets.** When House Bill 4035 was passed the legislature was anticipating a restrictive timeline, based on the expiration of the federal public health emergency, and no opportunity to address these issues during the 2023 legislative session. Now that there is time for a broader, more thorough conversation, Providence urges this committee to take the time to be certain proposed solutions are not risking health insurance access for some while creating a new plan for others. Take advantage of the time to find a solution with the fewest impacts to other Oregonians.
- **Consider the impact on individuals and families over 200% FPL that may have their premiums increased when individuals leave the marketplace for the Basic Health Plan.** Providence appreciates work underway by the Division of Financial Regulation to understand the uncertainty the Basic Health Plan creates for the rest of the insurance market. Based on Providence's initial analysis, we found similar conclusions as those that were presented by Manatt at the June task force meeting. Both reviews finding that a very large portion of members enrolled on the individual marketplace in a silver cost-sharing reduction plan will leave the marketplace for the Basic Health Plan, thus eliminating CSR subsidies and reducing what is called the silver CSR load. Since the

Affordable Care Act Advanced Premium Tax Credits for all marketplace plans are tied to the second lowest silver plan premiums, the premiums for other metal levels, primarily bronze and gold plans, will see a dramatic premium increase. In some cases, premium increases could be as large as 19%. This means a family of four with a total income around $55,000 purchasing a bronze plan in the marketplace, will see a dramatic premium increase. We are concerned the ultimate result will be lower income individuals and families that do not qualify for the Basic Health Plan will leave the market entirely, thus reducing the number of insured in Oregon.

- **Consider the impact on 33,000 Oregonians under 200% FPL that will be required to transition from their current commercial insurance plan to the Basic Health Plan.** While we fully understand the benefit of a Basic Health Plan for those individuals who "churn" off Medicaid, individuals between 138-200% FPL chose to participate on the individual market today for a variety of reasons. For some, participation on the individual market provides access to primary care, specialty and behavioral health providers that may not be available in a Coordinated Care Organization network. Forcing a transition to a Basic Health Plan may result in loss of a patient-provider relationship. Oregon has done incredible work since the Affordable Care Act was passed to contain costs on the individual market, ensure carriers are available in all counties, maintain network adequacy and provide a robust benefit package.
- **Create a program that operates fully within the capitated budget provided by the federal government.** Legislative intent was clear that a Basic Health Plan would need to operate within the capitated global budget provided by the federal government, understanding that it is not financially viable to expand Medicaid to individuals up to 200% FPL. While we understand this leads to difficult decisions, it is important that we do not jeopardize the financial stability of the Oregon Health Plan by putting financial burdens on a system that we currently struggle to fully fund.
- **Consider the impact on health care providers.** There has been discussion within the task force about the three "levers" needing to be considered – reimbursement rates, enrollee costs and covered services. Medicaid reimbursement does not cover the cost of providing health care services; providers take losses to serve this important population. While providers understand that a Basic Health Plan will result in reimbursement less than full commercial reimbursement, the burden should not fall solely on providers.

Providence wants every Oregonian to have access to affordable health insurance coverage, especially those that will no longer be eligible for Medicaid once the federal public health emergency expires. By focusing some of the task force's conversation on how this impacts Oregonians across insurance markets (Oregon Health Plan, Basic Health Plan, individual marketplace and small group) we can ensure we do not perpetuate a dramatic cost-shift and shift the burden of Medicaid "churn" to low-income individuals and families over 200% FPL. Some of the strategies we have put forward previously and continue to support include:

- Specialized navigators – Trained to focus on individuals redetermined off Medicaid, able to provide detailed information about federal subsidies and provider networks that most closely align with current CCO plans (see mapping below). Navigators should proactively connect with individuals that are no longer eligible for Oregon Health Plan and qualify for subsidies.

- Network mapping – Require the OHA to develop consumer facing system that maps CCO and individual market provider networks to help consumers make decisions. It would be valuable to allow customers to see the plans that align most closely with their current network and the costs of those plans. The OHA has already requested and received data from Providence to accomplish this goal.
- Subsidy assistance - Identify gaps in existing federal and state subsidies and develop robust assistance plan that address these gaps.

Providence shares the legislature's goals to maintain affordable access and limit gaps in coverage when the federal public health emergency expires. We are committed to partnering as this work moves forward to ensure that while we meet these goals, Oregon also protects all customers on the individual market who deserve affordable access to care. Thank you for the opportunity to provide comment.

Respectfully,

William Olson
Chief Executive Officer
Providence Health & Services – Oregon

Don Antonucci
Chief Executive Officer
Providence Health Plan