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: July 12, 2022

Re: Bridge Health Care Program Marketplace Impact

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

We write to offer comment on the Bridge Health Care Program. OPCA believes that the Bridge Plan is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health. Racial inequities are a fundamental root cause of health disparities, including unequal access to health insurance coverage – during the Public Health Emergency (PHE), Black and African American Oregonians experienced an unprecedented increase in coverage[1]. These are upstream health equity gains Oregon cannot afford to lose – systemic disenfranchisement must not be perpetuated by the Bridge Health Program.

It is with these priorities in mind that OPCA advocates for the following:

- Zero out-of-pocket costs for enrollees, as premiums deter enrollment and even small increases in co-pays are correlated with reduced care. Increased cost-sharing of any kind puts a greater burden of cost on individuals with chronic needs who are unlikely to disenroll regardless of cost[2].
- If cost-sharing is the cost-saving lever chosen by the Task Force, we advocate for sliding scale premiums introduced at a percentage above 138% FPL, zero co-payments for preventative services with minimal co-payments for non-preventative care, and no coinsurance or deductibles.
    - We also encourage Task Force members to articulate protocols around these cost-sharing requirements, such as policies regarding missed premium payments. As cost-sharing would be a significant change for individuals accustomed to OHP, we also advocate for robust education for system navigators as they engage enrollees.
    - Using Minnesota's BHP as a case study, it is important to note that they followed a similar model of cost-sharing. While the BHP reduced uninsurance rates overall, it did not have an equitable impact in all communities – Hispanic and Indigenous Minnesotans experience disproportionately high rates of uninsurance compared to white Minnesotans[3]. This highlights potential unintended health equity consequences for communities of color if Oregon's Bridge Program includes even minimal cost-sharing.
- Regardless of reimbursement rate, CHCs should receive their PPS wrap payments for this population. As discussed in prior OPCA written and oral testimony as well as in advanced readings, the PHE unwinding will shift many CHC patients off Medicaid, making them PPS ineligible – as many as 10% of CHC patients state-wide[4]. CHCs receive PPS to support uncompensated yet lifesaving services and it is vital that considerations are made to keep CHC programs and services whole.

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[1] Unwinding Federal Public Health Emergency and OHP Continuous Coverage Policies
[2] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF
[3] MN Uninsurance Rates
[4] BPTF Questions and Answers