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July 12, 2022

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

Dear Co-Chairs Steiner Hayward and Prusak and Members of the Joint Task Force on the Bridge Health Care Program,

We thank the Task Force for its thoughtful work to date. We share the Task Force's goal of maintaining coverage gains made during the public health emergency. However, as more details become known and this group shifts into early actuarial analyses and plan design, we feel compelled to share our continued concerns about the implementation of a Basic Health Plan (BHP) and its impact on the individual market.

This process began with planning for the end of the federal public health emergency and a focus on the roughly 300,000 current enrollees that may fall off of the Oregon Health Plan (OHP) during the redetermination process for the current 1.4 million OHP members. The Basic Health Plan captures individuals with incomes between 139-200% of the Federal Poverty Level (FPL), which the state estimates is roughly 55,000 (or 18%) of the 300,000 who may lose coverage. Our issues are threefold: (1) the Basic Health Plan is a blunt policy tool that has the potential to do more harm than good, (2) these potential harms and a fully envisioned mitigation strategy must be understood before moving forward with any waiver request, and (3) Oregon is lagging in preparations for redeterminations and must quickly build a communications and outreach plan for current OHP enrollees and the estimated 245,000 (or 82%) people who may lose coverage and are ineligible for BHP.

By implementing a Basic Health Plan now, Oregon would enter into uncharted territory. The ACA established the Basic Health Plan as an alternative coverage option for low- and moderate-income populations at a time when the individual market had not yet stabilized. New York and Minnesota established BHPs in 2015 to *build upon existing state programs* established prior to the passage of the ACA. No other states have adopted a Basic Health Plan since 2015. We have significant concerns about a BHP's impact on mature exchange premiums and enrollment.

As a recent analysis from Brookings notes, "Creating a BHP shifts all enrollees who are eligible for generous [cost-sharing reductions (CSRs)] out of the Marketplace and into BHP. This all but eliminates the need for insurers to silver load, which in turn essentially eliminates the benefits of silver loading for the higher-income enrollees who remain in the Marketplace.[10] In light of this fact, it is doubtful that it currently makes sense for states that do not already have a BHP to adopt one."[1]

A Basic Health Plan not only captures 55,000 people potentially losing Oregon Health Plan coverage, but also removes 32,500 people from the Marketplace (an estimated 22-24% of current

[1] Matthew Fielder. *The case for replacing 'Silver Loading'*. Brookings and USC Schaeffer Center for Health Policy & Economics. May 20, 2021. https://www.brookings.edu/essay/the-case-for-replacing-silver-loading/.

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Oregon Exchange enrollees) and places them in the Basic Health Plan without choice. This removal and redirection of almost a quarter of the Marketplace to a Basic Health Plan has the potential to be significantly destabilizing, especially in light of silver loading and the impact on cost-sharing reductions (CSRs). The remaining 82,800 people with subsidized plans on the Marketplace will be impacted to varying degrees. For example, for the average 21-year-old in Multnomah county at 201% FPL on a subsidized bronze plan, we estimate their costs could go up over 50%, with steeper increases for the average 40- and 60-year-olds in the same plan, location and income. These cost increases will be further exacerbated if ARPA subsidies are not renewed by Congress by the end of the year.

Our healthcare system is complex and interwoven. Changes to one part of the system have the ability to cascade, shift costs, and impact many other parts of the system and lives. For this reason and the details included above, we strongly urge the Task Force to complete its Market Stabilization Report before committing itself to a final recommendation on a Basic Health Plan. This will give a full picture of the costs and benefits of any particular strategy. Presently, the state is proposing to build a new program for 55,000 people while also reassigning coverage for 32,500 people, increasing costs for a significant portion of 82,800 people, and lagging on a plan for 245,000 people. All of these moving pieces should be considered in context to each other before making bold steps.

Lastly, while we understand communication and outreach work is occurring in a separate conversation, we want to call out how crucial that planning is to the success of our collective ability to keep Oregonians covered. Oregon is currently behind other states like Virginia and California when it comes to establishing and implementing communication and outreach plans. We should be taking full advantage of the additional time granted as a result of the extended public health emergency. We should be reaching out to our Medicaid members now to encourage them to update their contact information to ensure that they receive all state communications, but we need clear direction from regulators. This nuts-and-bolts work is incredibly important to our shared goal of keeping as many Oregonians covered as possible through the redeterminations process.

Kaiser Permanente is committed to working to keep people covered once the PHE ends. We launched a national effort to prepare for the restart of the Medicaid eligibility redeterminations process and are leveraging our clinical settings to increase member awareness and how to access assistance. Please consider us a faithful partner in ensuring as many Oregonians maintain coverage as possible through this process. Thank you for this opportunity to participate in this important process and share our concerns.

Regards,

/s/ Elizabeth Edwards

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