Memorandum

To: Co-Chair Steiner Hayward, Co-Chair Prusak, and Members of the Task Force

From: Marty Carty, Director of Government Affairs

Date: July 26, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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 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. These are upstream health equity gains Oregon cannot afford to lose – systemic disenfranchisement must not be perpetuated by the Bridge Health Program. We appreciate the work that the Task Force and legislative staff have done to understand the needs of the target population and the scope of impact of the Bridge Plan and future Basic Health Plan.

Marketplace Impact

OPCA does not anticipate that many CHC patients are on metal tier plans which will be negatively impacted by reduced silver loading, as privately insured patients (irrespective of FPL) are approximately 14% of the CHC patient population and a smaller fraction of that are insured on the marketplace. However, we understand the potential impact on the broader community and how high costs across all insurance types deters accessing care. We appreciate the comprehensive overview provided at the previous Task Force meeting and encourage the Task Force to pursue the proposed mitigation strategies and continue building a Bridge Plan which is accessible to patients in the initial target demographic of adults 138-200% FPL. We look forward to hearing more about these strategies in upcoming meetings and support the work that the Oregon Health Authority (OHA) and Department of Consumer and Business Services (DCBS) are doing to recapture funding through a 1332 waiver. We support a mitigation strategy (or combined strategies) which will incur least burden to the consumer and minimal added implementation obstacles for the Bridge Plan.

Plan Development

We urge the Task Force to eschew designing the Bridge Plan from a scarcity perspective – while we know the actuarial analysis is preliminary and based on pre-COVID-19 data, it does indicate that a Bridge Plan with zero out-of-pocket costs, OHP-like benefits, and above Medicaid reimbursement is feasible. Additionally, based on revenue forecasting during the 2022 Legislative Session, Oregon is functioning at a significant surplus and the use of general funds to support the Bridge Plan, if necessary, is a viable option. We encourage Task Force members to consider this expanded funding option before cutting benefits, adding enrollee costs, or lowering provider reimbursement rates. **These cost-saving mechanisms** are all associated with greater barriers to entry, reduced access to care, and may **undermine the overall success of the Bridge Program.**

As stated in previous OPCA public comment, we advocate for a plan which:

- **Is at least as expansive as OHP in covered services, including routine oral care and behavioral health care.** Preventative oral care reduces emergency room visits and prevents periodontal diseases and chronic illnesses, resulting in cost saving for the entire health care system. Additionally, studies show that integrated behavioral health care reduces severity of depression in patients, provides patients with a better overall experience in health care, and reduces overall costs in health care due, in part, to reduced emergency care visits.
- **Reimburses at rates which are higher than Medicaid and use a cost-based model, such as value-based pay, that adjusts for patient demographics and needs.** As mentioned in previous OPCA public comment, we urge Task Force members to consider the complex health needs of certain historically underrepresented populations, including those who identify as BIPOC, LGBTQIA2S+, and/or have experience with other social determinants of health, and allow for reimbursement adjustment based on their unique health needs.
- **Prioritizes zero out-of-pocket costs to enrollees, which includes premiums, copays, deductibles, and coinsurance.** We emphasize that individuals moving from Medicaid will be accustomed to no out-of-pocket costs and an abrupt shift to any amount of enrollee cost -- even the smallest premium or copay -- could deter them from both enrolling in coverage and accessing covered services.
- **Provides enhanced reimbursement to safety net providers, specifically Federally Qualified Health Centers (FQHC's), who are now and will likely continue to care for this population.** As mentioned in previous OPCA testimony, the testimony of United States of Care, and OHA advanced readings, FQHCs currently receive Medicaid reimbursement (which is below cost) and PPS wrap payments (which is a cost-based payment) for the redetermination population. As individuals move off Medicaid and onto the Bridge Plan, CHCs will no longer receive adequate, cost-based payments for services as they lose PPS wrap – this will impair their entire service array, not limited to the population impacted by redetermination.
    - CHCs provide a number of otherwise unreimbursed services that PPS payments help offset, such as school-based health centers, dental services, mobile clinics, and many others. These programs will be threatened if CHC funding is not kept intact.
- **Clearly articulates a comprehensive engagement and outreach strategy** – this looks like consistent, culturally inclusive messaging about plan benefits, eligibility, costs, and enrollment pathway. We strongly advocate for a no-wrong-door approach, wherein all system navigators can support potential enrollees.