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House Bill 4035 Joint Interim Task Force on the Bridge Health Care Program

Preliminary Recommendations to the Oregon Legislative Assembly

8.5.22

CO-CHAIR COVER LETTER

[to be added after content finalization]

EXECUTIVE SUMMARY

[to be added after content finalization]

FRONT MATTER

About this report

This report was prepared on behalf of the Joint Task Force on the Bridge Health Care Program by the Oregon Legislative Policy and Research Office, which provides centralized, professional, and nonpartisan research, issue analysis and committee management services for the Legislative Assembly. The Legislative Policy and Research Office does not provide legal advice. This document contains general information that is current as of the date of publication. Subsequent action by the legislative, executive, or judicial branches may affect accuracy.

Acknowledgments

[tbd]

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SECTION I. BACKGROUND

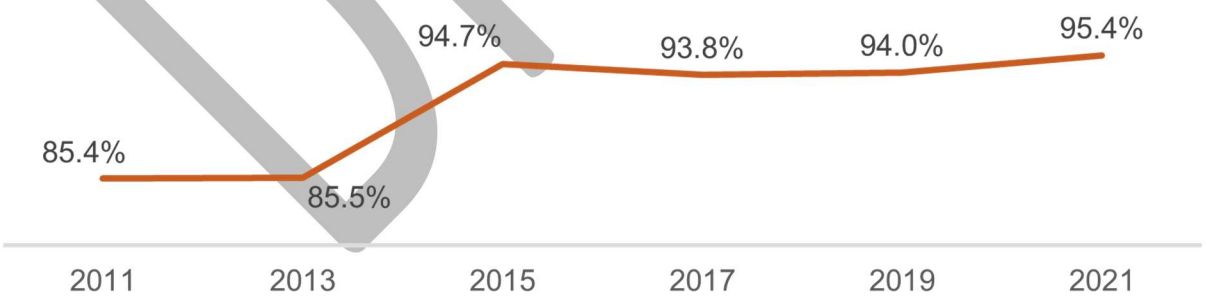
Heath insurance coverage is a critical driver of health outcomes. A broad body of research confirms that people with coverage are more likely to receive care on a timely basis, are more likely to receive preventive and screening services, and are better able to manage chronic conditions over time (Institute of Medicine Committee on the Consequences of Uninsurance, 2002) (Sommers, Gawande, & Baicker, 2017).

Oregonians access health insurance coverage through a range of publicly and privately funded health plans, including:

- **Medicaid:** coverage obtained through the Oregon Health Plan (OHP) and typically administered at the local level by Coordinated Care Organizations (CCOs). The Medicaid program is a state-federal partnership.
- **Medicare:** coverage offered primarily to those 65 and older; Original Medicare is administered by the U.S. Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage is an alternative option offered through private insurers.
- **Individual:** coverage purchased individually, including on the Marketplace (Healthcare.gov), with or without federal premium tax credits.
- **Group coverage:** coverage obtained through an organization such as an employer, union, etc.

The overall rate of health insurance coverage in Oregon has improved over the past decade (see Exhibit A), with notable gains in coverage occurring in 2014 after Oregon implemented Medicaid expansion and established its own health insurance Marketplace under the Affordable Care Act (KFF, 2022).

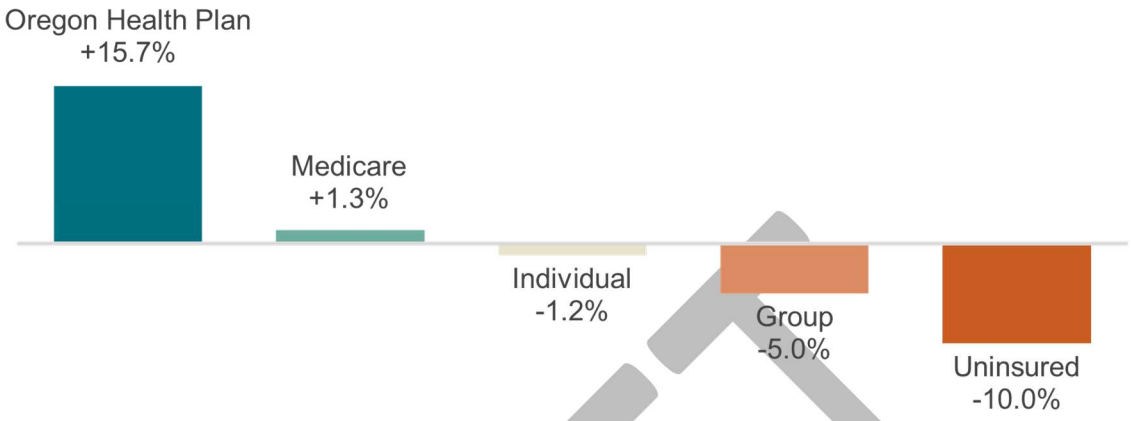
Exhibit A: Oregon's rate of insurance coverage has increased over time.



Source: Percent of Oregonians (all ages) with insurance coverage, by year. Oregon Health Insurance Survey

Oregon's increase in the rate of insurance coverage reflects increased enrollment in OHP over time and a decrease in the percent of people who were uninsured or covered through group insurance (see Exhibit B). The rates of coverage from Medicare and individual insurance have been relatively stable during this time.

Exhibit B: Over the past decade, more people gained coverage through Oregon Health Plan and fewer people were uninsured.



Source: Change in insurance source between 2011 and 2021, by type. Oregon Health Insurance Survey

Despite overall coverage gains, 6% of Oregonians remained uninsured and inequities in coverage persisted between some groups following Medicaid expansion (Oregon Health Authority, 2022). Data from the Oregon Health Insurance Survey reveals that in 2019:

- 96.3% of people with incomes above 400% of the Federal Poverty Level (FPL) had health insurance, compared with 92% of people at or below 400% FPL.
- The rate of coverage was substantially lower for Hispanic (88.4%), American Indian/Alaska Native (89.4%) and Black (91.8%) Oregonians than for White Oregonians (94.6%).
- Coverage varied by age; 99.3% of people aged 65 and over, and 97.2% of people 18 and younger were covered as compared to 92.3% of people ages 35-64 and 89% of people ages 19-34.

A substantial number of people who receive coverage through Medicaid also experience what is known as "churn," gaining and losing eligibility for the program due to frequent fluctuations in income. Adults whose incomes are near the Medicaid income cap for adults – typically 138% FPL - are particularly at risk of churn (Corallo, Garfield, Tolbert, & Rudowitz, 2021). Others are at risk churn if they experience barriers during the renewal process, such as missing deadlines to submit information or missing or inaccurate information submitted on renewal forms.

These disruptions in Medicaid enrollment persist despite state efforts to streamline enrollment processes and remove barriers to continuous enrollment (Corallo, Garfield, Tolbert, & Rudowitz, 2021). Nationally, roughly one in ten Medicaid enrollees (10.3%) experience churn over the course of a year, and rates are higher for children (11.2%). The Oregon Health Authority (OHA) estimates that as of September 2019, 34% of people enrolling in OHP were returning to the program after less than 12 months, and 25% were

returning within 6 months of having been previously enrolled (Vandehey, 2022). These figures mirror a 2014 study of churn in Oregon (Oregon Medicaid Advisory Committee, 2014) that estimated that following OHP expansion, and after additional state efforts to administratively streamline enrollment processes, between 72-80% of OHP enrollees would retain their coverage over a 12-month period, while the remainder would transition to other coverage or become uninsured.

Coverage Expansion Efforts and History in Oregon

Oregon engaged in several efforts in recent years to improve the rate of coverage and reduce coverage inequities.

Section 1331 of the Patient Protection and Affordable Care Act (ACA) offered the opportunity to create a Basic Health Program (BHP) for people earning between 138 and 200 percent of the federal poverty level (FPL) who would otherwise be eligible for federal premium tax credits to purchase coverage on the Marketplace. This federal option phased in under the ACA and first became available to states in 2015 (Centers for Medicare & Medicaid Services, 2015).

The Oregon Legislature explored the feasibility of a BHP in stages over several years, including:

- In 2014, the Oregon legislature passed House Bill 4109 directing OHA to study the financial feasibility of a BHP. OHA engaged Wakely Consulting Group and The Urban Institute to assess multiple scenarios for a BHP. A report issued in October 2014 found the program would increase overall rates of coverage and improve affordability for enrollees (Wakely Consulting Group and the Urban Institute, 2014).
- In 2015, the legislature passed House Bill 2934 that directed OHA to convene a stakeholder advisory group to develop recommendations for a BHP. The report, delivered November 2015, outlined a set of design principles including full Medicaid coverage without dental, a sliding scale premium, and no enrollee co-pays or deductibles; and alignment to Oregon health policy goals such as a sustainable rate of growth and the CCO model (BHP Stakeholder Advisory Group, 2015).
- In 2016, the legislature passed House Bill 4017 that directed the Department of Consumer and Business Services (DCBS) to convene an advisory group to explore options beyond a BHP for increasing coverage and access to care for Oregonians earning less than 200 percent of FPL. Among its recommendations, the advisory group explored the creation of a BHP-like wrap-around subsidy program under a Section 1332 State Innovation Waiver. The group ultimately determined there was insufficient federal guidance available at the time to recommend proceeding with a Section 1332 waiver to create a BHP-like wraparound program (Oregon Department of Consumer and Business Services, 2017).

In addition to this exploration of a BHP or BHP-like program, the Oregon legislature took other steps in recent years to improve coverage and affordability for Oregonians, including:

- In 2017, the legislature passed House Bill 2391 directing DCBS to pursue a Section 1332 waiver for the creation of the Oregon Reinsurance Program. The Oregon Reinsurance Program launched in January 2018. The program reimburses health insurers for certain high-cost claims for enrollees covered through the Marketplace to lower premiums for these members.
- In 2019, the legislature passed Senate Bill 770 establishing a Task Force on Universal Health Care to recommend the design of a universal health care system. The Task Force first convened in July 2020 with final recommendations planned to the legislature by September 2022.
- In 2021, the legislature passed House Bill 2010 directing OHA and DCBS to develop a plan for a public health insurance option (or "public option"). A report and recommendations were developed by Manatt and delivered in January 2022. The report outlined a series of design principles for a Section 1332 waiver to create the public option (Ario, Karl, & Zhan, 2022).

Coverage and Churn in the COVID-19 Era

The COVID-19 pandemic officially reached Oregon in early 2020 with the first presumptive case reported by the Oregon Health Authority on February 28, 2020 (Oregon Health Authority, 2020). The federal government issued a public health emergency (PHE) declaration related to the COVID-19 pandemic on January 31, 2020 (Azar, 2020) and Governor Kate Brown declared a state of emergency in Oregon on March 8 (Brown, 2020). The federal PHE has been renewed approximately every 90 days since its issuance. It remained in place at the time of this report.

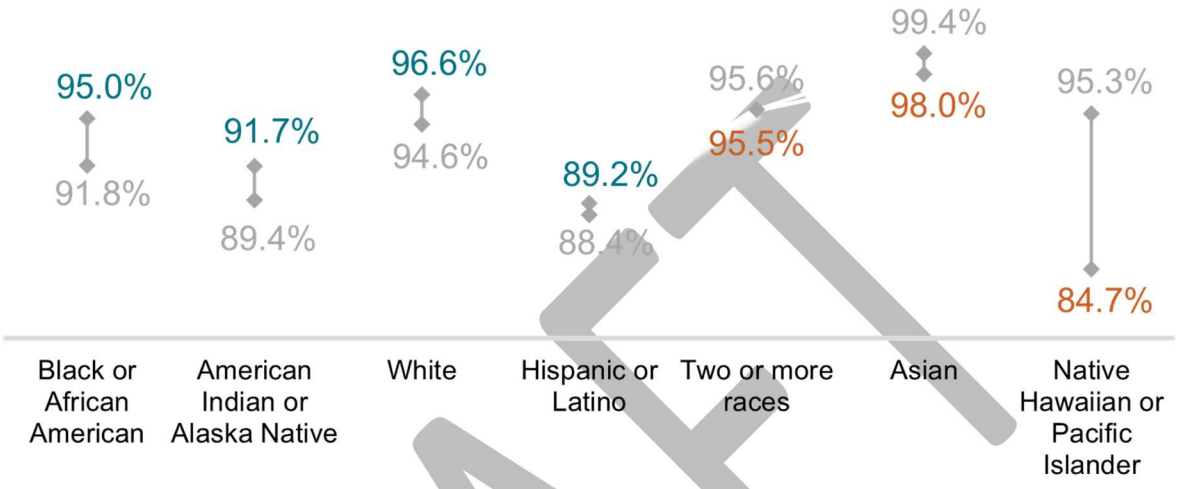
The COVID-19 pandemic drove dramatic changes in Oregon's health insurance landscape since 2020. The Families First Coronavirus Response Act of 2020 (FFCRA) provided states with enhanced federal funding in exchange for:

- Providing "continuous eligibility" (CE) for Medicaid and Children's Health Insurance Program (CHIP) enrollees until the end of the emergency declaration, regardless of income changes, unless the individual asked to be disenrolled or ceased to be a state resident.
- Agreeing not to implement higher premiums or more restrictive eligibility rules than those that were in place on January 1, 2020.
- Covering COVID-19 related testing, vaccines, and related treatments free of charge to enrollees.

Oregon, along with other states, accepted these conditions in exchange for the enhanced federal funding. Enrollment in OHP increased to 1,323,775 in December 2021, (Oregon Health Authority, 2022) up from 1,050,179 in December 2019 (Oregon Health Authority,

2020), as those who would have previously lost coverage remained enrolled under the CE provision. Oregon's overall uninsured rate fell from 6.0% to 4.6% between 2019 and 2021, reaching a historic low, with improvements for most racial and ethnic groups (see Exhibit C).

Exhibit C: During the pandemic, coverage rates increased for most groups.



Source: Change in coverage rate from 2019 to 2021, by race. Oregon Health Insurance Survey.

Unwinding from the Public Health Emergency

When the federal COVID-19 PHE declaration expires, states will return to routine eligibility determination processes for their Medicaid programs. This shift will include disenrolling people who maintained OHP coverage during the PHE under the CE provision.

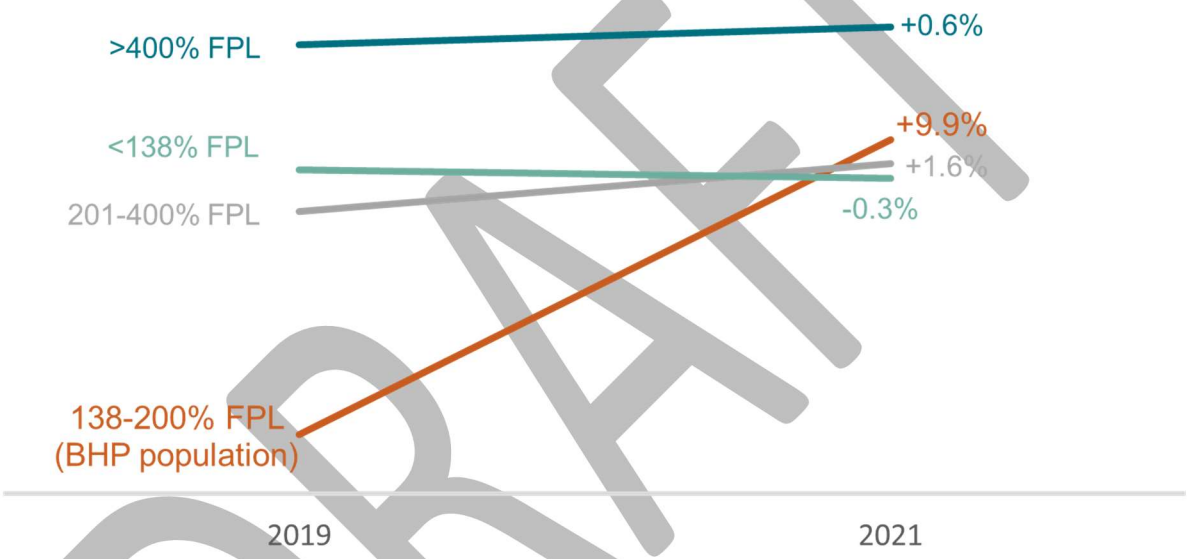
The end date for the PHE declaration was unknown at the time of this report, but CMS issued guidance to states on March 3, 2022 to begin planning for this transition or "unwinding" of the PHE (Centers for Medicare and Medicaid Services, 2022). Key elements of this guidance included:

- States must redetermine eligibility for *all Medicaid/CHIP enrollees* upon expiration of the PHE. CMS will provide 60-days advance notice to states prior to the PHE expiring.
- States will have twelve months to *initiate* redeterminations and must complete redeterminations by the end of the fourteenth month following PHE expiration.
- States are encouraged to distribute renewals across the twelve-month redetermination year to address workforce challenges associated with processing requests and minimize processing errors.
- States should take a risk-based approach to sequencing redeterminations that maximizes coverage continuity by processing renewals of people likely to be re-enrolled prior to redeterminations for people likely to lose eligibility.

This redeterminations effort nationally represents the most substantial shift in the national health insurance landscape since the passage of the Affordable Care Act in 2010.

OHA has estimated approximately 300,000 people may lose OHP coverage at post-PHE redetermination (Vandehey, 2022). People earning between 138-200% of the federal poverty level were anticipated to be disproportionately impacted by disenrollment, as this group had seen substantial coverage gains during the pandemic, relative to people in other income groups (see Exhibit D).

Exhibit D: During the pandemic, adults earning between 138-200% FPL have seen the largest coverage gains.



Source: Change in coverage for adults ages 19-64 between 2019 and 2021, by percent of the Federal Poverty Level (FPL). Oregon Health Insurance Survey.

The Oregon Health Insurance Survey also revealed that between 2019 and 2021:

- The percent of insured adults who delayed care because of cost fell the most among people earning between 138-200 percent FPL;
- The percent of adults who had trouble paying medical bills also decreased the most in this income bracket, relative to other income groups.

Oregon's 2022 Legislative Session and House Bill 4035

Without further action, Oregon, like other states, faces the prospect of returning to pre-pandemic rates of uninsured people, increasing disparities in coverage, and experiences of churn.

Recognizing these risks to Oregon's gains in coverage, the legislature passed House Bill 4035 (HB4035) to:

- Maintain or improve overall rates of insurance coverage and reductions in coverage inequities.
- Establish a Task Force to create a new affordable coverage option, the Bridge Health Care Program, for people who earn below 200 percent FPL and are at risk of churn.
- Direct the Oregon Health Authority to develop a redeterminations process that maximizes retention of OHP coverage and, for those losing coverage, streamlines the transition to other coverage.

The legislature charged the Joint Task Force on the Health Care Bridge Program ("the Task Force") with developing a proposal for a health insurance program that could achieve Oregon's goals for health coverage. Subsequent sections of this report document the work of the Task Force, information it considered, and its recommendations.

SECTION II. POLICY CONTEXT AND PATHWAYS

The Joint Task Force on the Bridge Health Care Program first convened on April 26, 2022. Members (see Exhibit E) were recruited from a diverse array of sectors and organizations and appointed by Governor Kate Brown.

Exhibit E: Task Force members, seats, and organizational affiliations

Member	Seat
Senator Elizabeth Steiner Hayward	Co-Chair
Representative Rachel Prusak	Co-Chair
Senator Bill Kennemer	Vice Chair
Representative Cedric Hayden	Vice Chair
Alicia Temple *Oregon Law Center*	Representative of low-income workers who are likely to be eligible for the Bridge Program
Jonathan Frochtzwajg *Cascade AIDS Project*	Expert in health equity
Keara Rodela *Coalition of Community Health Centers*	Expert in health equity
Sharmaine Johnson Yarbrough *Wallace Medical Concern*	Expert in navigation assistance for health insurance consumers
Kirsten Isaacson *Service Employees International Union, Local 49*	Representative from organized labor
William Johnson *Moda Partners*	Representative of an insurer that offers Qualified Health Plans on the Health Insurance Exchange
Eric Hunter *CareOregon*	Representative of a Coordinated Care Organization
John Hunter *Oregon Health & Science University*	Representative of a hospital or health system
Antonio Germann *Salud Medical Clinic / Pacific Pediatrics*	Other representative of health care providers
Heather Jefferis *Oregon Council for Behavioral Health*	Expert in behavioral health care
Matthew Sinnott *Willamette Dental Group*	Representative of oral health care provider that contracts with Oregon Health Authority
Adrienne Daniels *Multnomah County Health Department*	Representative of the Medicaid Advisory Committee
Lindsey Hopper *PacificSource Health Plans*	Representative of the Health Insurance Exchange Advisory Committee
Stefanny Caballero *Virginia Garcia Memorial Foundation*	Designee for the Oregon Health Policy Board chairperson
Patrick Allen	Director, Oregon Health Authority
Fariborz Pakseresht	Director, Oregon Department of Human Services
Andrew Stolfi	Director, Oregon Department of Consumer and Business Services

HB 4035 Vision for the Bridge Program

To achieve the goal of creating the Bridge Health Care Program, House Bill 4035 charged the Task Force with two tasks:

- By September 1, 2022,[1] developing a proposal for a Bridge Program, including recommendations for any federal waiver requests, and suggested timelines for program implementation.
- By December 31, 2022, identifying potential disruptions to the individual and small group insurance markets by the Bridge Program, and developing mitigation strategies to ensure market stability.

This report represents the first of these two deliverables: a proposal and preliminary recommendations to design the Bridge Program. The Task Force will revisit these recommendations in its second report, with consideration of additional information and analyses being prepared through the summer.

House Bill 4035 outlined a series of requirements for the Task Force to include in its program design decisions. These required design elements included:

- Prioritizing health equity, a reduction in the rate of uninsurance, and the promotion of continuous coverage for communities that have faced health inequities.
- Consistency with the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570, and enhancing the CCO delivery system.
- Ensuring that the bridge program is available to all individuals residing in the state with incomes at or below 200% FPL who do not qualify for Medicaid but do qualify for advance premium tax credits (APTC).
- Maximizing federal financial participation (FFP) in the program.
- Minimizing costs to enrollees.
- Minimizing costs to the state budget.
- Providing, at a minimum, all essential health benefits (ORS 731.097).
- Establishing a capitation rate to be paid to (health plan) providers that is sufficient to provide coverage.
- Offering coverage through CCOs and aligning procurements for service providers on the same cycle as the procurements cycle for CCOs.
- Providing a transition period for eligible individuals to enroll in the Bridge Program.

[1] House Bill 4035 required the Task Force to submit its recommendations for program design by July 31, 2022, unless the federal public health emergency declaration for COVID-19 was extended beyond April 16, 2022. On July 15, 2022, Health and Human Services Secretary Xavier Becerra extended the PHE declaration.

In addition to these requirements, the bill encouraged the Task Force to explore options for the following design elements to the extent practicable:

- Including an option or options for dental coverage.
- Including an option that has no cost-sharing, deductibles, or other out-of-pocket costs; and an option that has lesser cost-sharing, deductibles or out of pocket (OOP) costs, than qualified health plans on the health insurance exchange.
- Establishing a capitation rate that allows provider reimbursements to be higher than current OHP rates.
- Taking into account the health insurance exchange as an option for potential bridge program participants if the participants choose to opt out of the Bridge Program.
- Including an option for offering the Bridge Program on the health insurance exchange if the plans meet the criteria established by the OHA and DCBS.
- Requiring CCOs to accept enrollees in the Bridge Program, or requiring OHA to contract with a new entity to accept Bridge Program enrollees.

A summary of Task Force deliberations related to plan design elements is presented in Section III.

Federal Pathways to Create the Program

A key goal of House Bill 4035 was to design a Bridge Program that could maximize the use of federal funds to finance the program while minimizing reliance on state funds or enrollee costs. The measure referenced the multiple federal policy pathways that Oregon could pursue to achieve this goal. Federal pathway options included:

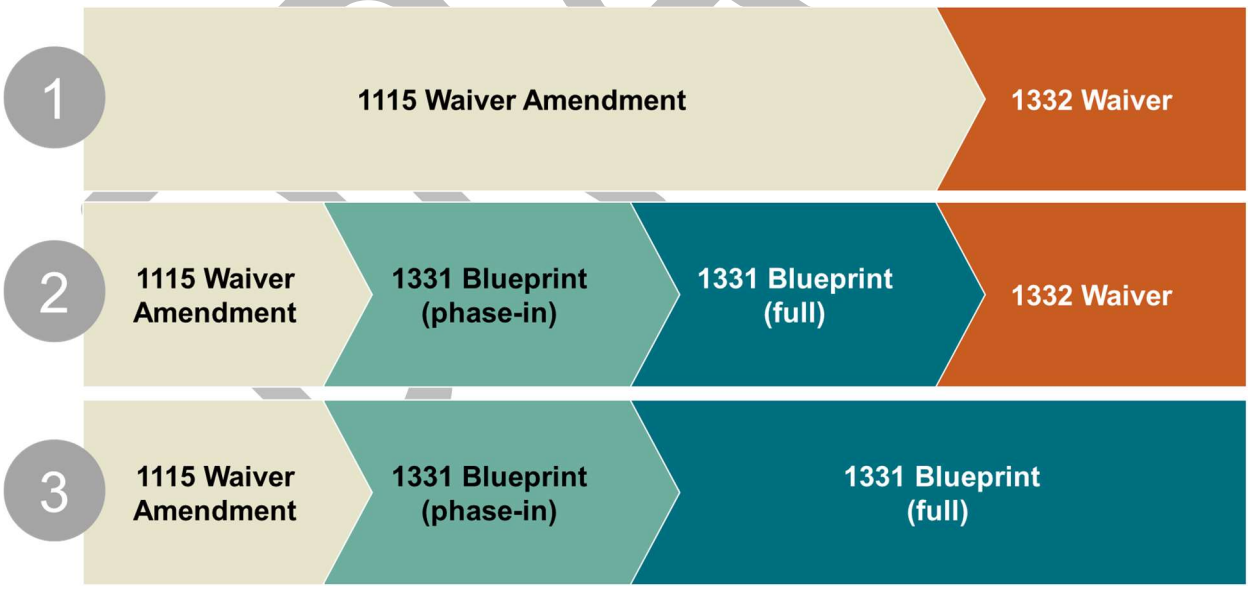
- An 1115 Medicaid Demonstration waiver. Section 1115 of the Social Security Act allows states to request approval to waive certain Medicaid program requirements to implement pilot projects to improve their programs (Centers for Medicare and Medicaid Services, n.d.).
- A Section 1331 Basic Health Program Blueprint. Section 1331 of the Affordable Care Act (ACA) allows states to create a program that offers Medicaid-like coverage to people earning <200% of the Federal Poverty Level who are not eligible for Medicaid but are eligible for subsidies to purchase coverage on the marketplace (Centers for Medicare and Medicaid Services, n.d.).
- A Section 1332 State Innovation waiver. Section 1332 of the Affordable Care Act allows states to apply to waive certain provisions of the ACA to "pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA" (Centers for Medicare and Medicaid Services, n.d.). These waivers are not limited to strategies focused on the population earning between 138 and 200% FPL and Oregon has considered a range of uses for 1332 waivers, including options to make coverage more affordable for people earning up to 400% FPL.

Each of the pathways posed a different strategy to secure federal funding, as well as different requirements for state infrastructure and contribution to program costs. The pathways also differed with respect to implementation timeline, impacts to the ACA individual marketplace, and degree of uncertainty of federal approval. Appendix XX contains further information about these differences.

The Task Force initially explored three options (see Exhibit F), including:

1. A longer-term amendment to the state's existing 1115 waiver for OHP to preserve OHP coverage for adults earning between 138-200 percent FPL while the state sought federal approval for a 1332 waiver to create the Bridge Program.
2. A short-term 1115 waiver amendment while the state sought federal approval to use a 1331 Blueprint as a temporary authority for Oregon's Bridge Program. The state would eventually request federal authority to transition to a BHP-lookalike program using a 1332 waiver to allow eligible people to choose between the Bridge Program and the Marketplace.
3. A short-term 1115 waiver amendment that would preserve OHP coverage for adults earning between 138-200 percent FPL while the state sought federal approval for a 1331 Blueprint to serve as the permanent federal authority for Oregon's Bridge Program.

Exhibit F: Federal Pathways to Create the Bridge Program



Relative to the 1331 and 1332 options, the use of an 1115 Medicaid Demonstration Waiver as a long-term vehicle for a Bridge Program was identified as likely to be inconsistent with the budget goals of House Bill 4035 due to much higher state matching fund requirements under this waiver authority. This approach was ruled out early in Task Force discussions.

A 1332 waiver was considered to provide the most flexibility in program design; however, no state had used a 1332 waiver in this way (Pitsor & Scotti, 2021) and there was substantial uncertainty about the feasibility and timing for securing federal approval.

A 1331 Basic Health Program Blueprint was, by comparison, a straightforward approach. One drawback to a 1331 Blueprint was that it would not provide an option for individuals at incomes between 138-200 percent FPL to opt out of Bridge Program coverage and instead receive Affordable Care Act subsidies to purchase coverage on the Marketplace.

The Marketplace infrastructure required to pursue each pathway was also a substantial consideration. Oregon operates a state-based Marketplace on the federally facilitated Healthcare.gov exchange (SBM-FFE). Discussions between OHA and CMS at the time sought to understand whether Oregon could offer a Bridge Program on its exchange.

Federal Guidance in May 2022

The exploration of these federal pathways initially was expected to be a primary focus of the Task Force in early 2022. However, in May 2022, CMS provided guidance to OHA on a recommended pathway.

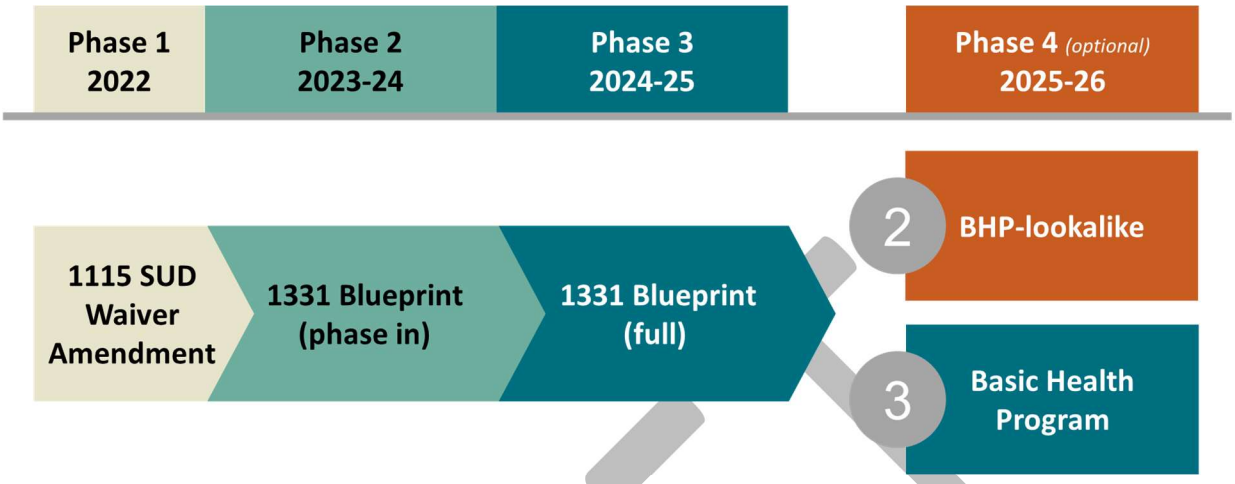
CMS recommended that Oregon pursue a phased approach to creating the Bridge Program using a 1331 Blueprint (see Exhibit G). In the immediate term ("Phase 1"), Oregon would request a Section 1115 waiver to maintain coverage for people at 138-200 percent FPL who enrolled in Medicaid and would lose coverage when the PHE expired.

In Phase 2, the state would implement a Section 1331 Blueprint for a Basic Health Program (BHP) and transition the existing "Phase 1" Medicaid population into the BHP.

In Phase 3, the state would transition to full implementation of the BHP, enrolling people between 138-200 percent FPL who were uninsured or currently enrolled in the Marketplace to the BHP.

The state could then further explore the use of a Section 1332 waiver for a "Phase 4" to give enrollees a choice of coverage through the BHP or Marketplace subsidies. This implementation of a Section 1332 waiver to offer this choice would require a state-based marketplace and thus was not an option available to Oregon until 2025, at the earliest.

Exhibit G. CMS Recommendation for Pathway and Phases of Bridge Program Implementation



The CMS phases provided a framework for the Task Force's remaining work. The Task Force narrowed its subsequent discussions and recommendations on program design for a 1331 Basic Health Program, as that was the only immediate-term pathway that offered a clear line to federal approval through Phase 3. The Task Force left open the possibility of a 1332 waiver in Phase 4.

Recommendations related to the 1331 Blueprint form the basis for this report on program design. The Task Force may make additional recommendations related to a 1332 waiver in its strategies to mitigate marketplace impacts of a BHP. Those recommendations would be submitted separately to the Legislative Assembly in December 2022.

SECTION III. CONSIDERATIONS FOR DESIGNING THE BRIDGE PROGRAM

Section 1331 of the Affordable Care Act allows states to request federal approval to create a Basic Health Program (BHP) to provide coverage similar to Medicaid for people who are lower income but do not qualify for Medicaid. States can use this option to create BHP coverage for people who:

- Are age 64 or younger.
- Are citizens or lawfully present non-citizens with incomes between 138 and 200 percent of FPL who do not qualify for Medicaid or CHIP.
- Are lawfully present non-citizens with incomes below 138 percent FPL who do not qualify for Medicaid.
- Are not eligible for other minimum essential coverage, such as affordable employer sponsored insurance.
- Are not incarcerated. (Centers for Medicare and Medicaid Services, 2014)

When states create a BHP, people in these categories who were previously eligible for advance premium tax credits (APTC) to purchase subsidized coverage on the exchange, instead become eligible for the BHP. States have the option to design enrollment procedures that align to the Marketplace, with an open enrollment period, or to offer continuous enrollment throughout the year, as with Medicaid.

Federal funding for the program is calculated on a per-enrollee basis and tied to the level of premium subsidies that eligible individuals would have otherwise received through the Marketplace. States are not required to contribute general funds or "match" to the program but are required to establish a trust into which federal funds are deposited. BHP trust funds must be used solely to provide coverage to enrollees and may not be used for program administration costs.

To receive federal approval for a BHP, states must submit a 1331 Blueprint application to the Centers for Medicare & Medicaid Services (CMS) outlining how they intend to design, implement, and operate the BHP (Centers for Medicare and Medicaid Services).

Key components of the BHP Blueprint include:

- Section I. Program administration and governance information
- Section II. A description of the public comment and Tribal consultation processes followed
- Section III. A description of the governance and administration of the BHP trust
- Section IV. Procedures for determining eligibility and processing enrollment
- Section V. Describing the care delivery system to be used and procedures for contracting
- Section VI. Requirements for enrollee premiums or cost-sharing

- Section VII. Attestation of the state's ability to implement and operate the program in accordance with federal law
- Section VIII. A description of the covered set of benefits and limitations on benefits

Although available as an option since 2015, only New York and Minnesota have opted to implement a BHP to date. Kentucky has also initiated planning efforts and aims to launch their BHP in 2024.

The Task Force's recommendations related to program design were intended to guide OHA's and DCBS' development of the federal Blueprint application.

Benefit Design

The Task Force considered two primary aspects of benefits design to address the requirements of House Bill 4035 and provide guidance on the federal Blueprint application. These include covered services, and enrollee cost sharing.

Covered Services

House Bill 4035 required that the Bridge Program must cover, at a minimum, the ten "essential health benefits" (EHBs) that are required to be covered under any health plan that is offered on the ACA Marketplace. To the extent practicable, the bill also encouraged the Task Force to include an option for dental coverage in its recommendations.

As defined in federal law (Centers for Medicare and Medicaid Services, n.d.), the minimum EHBs required for Marketplace plans broadly include the following service categories:

- Outpatient (ambulatory) patient services
- Emergency services
- Hospitalization, including surgeries
- Pregnancy, maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Prescription drugs
- Pediatric care, including oral and vision care

In Oregon, as in other states, EHBs are more specifically defined through a "benchmark plan" that outlines the covered services and restrictions within the EHB categories for a given plan year. Oregon's benchmark plan for plan years beginning on or after January 1, 2022 is available through the DCBS Division of Financial Regulation (OAR 836-053-0012).

A primary consideration for the Task Force was the difference between the EHB covered services package and the service package available to OHP members (Oregon Health Authority, n.d.). Differences in the OHP and BHP service packages were potentially problematic for continuity of care for people enrolling into the BHP from other coverage. House Bill 4035 also encourages enhancement of the existing CCO delivery model and requiring CCOs to offer different covered service packages for OHP and BHP was identified as a potential operational concern in early discussions.

The Task Force reviewed a comparison of the EHB and OHP covered service packages presented by OHA at a July 26th meeting. The detailed comparison is provided in Appendix XX. The comparison focused primarily on differences between EHBs and OHP-covered services provided by CCOs. It did not assess differences between EHBs and OHP-covered services accessed outside of the CCO delivery system, including long-term services and supports provided by Oregon Department of Human Services (ODHS) and Oregon Health Plan coverage offered on an "open card" or fee-for-service basis to non-CCO members. The analysis also did not explore differences in pharmacy coverage or health related services (HRS) that CCOs may provide.

The analysis broadly found alignment in EHB and OHP across 40 service groupings. Three service areas offered by CCOs are not included in the EHB benchmark plan. These include:

- Adult dental care
- Non-emergent medical transportation (NEMT)
- Bariatric surgery

Additionally, pharmacy services are broadly covered by OHP and the EHB benchmark, but there are four tiers of formularies within the Marketplace and a single formulary for OHP. This difference typically provides OHP enrollees broader prescription drug coverage than is covered in many Marketplace plans.

Task Force discussions generally supported the alignment of the Bridge Program's covered service package to the OHP package if possible, given the advantages this could provide for continuity of care. The group shared a preference that dental coverage be a priority for its' plan design recommendations.

Enrollee Cost Sharing

Health plans can be designed with various types of enrollee cost sharing, such as:

- Premiums, a monthly amount paid by an enrollee to obtain insurance coverage (e.g., a member may pay $100 per month to buy coverage, or may participate in a plan with a "sliding scale" premium tied to their income).

- Co-payments, fixed dollar amounts charged for certain services (e.g., a member may pay a $50 co-pay when visiting a specialty care provider).
- Deductibles, fixed annual amounts that must be 100% met before an insurer pays charges (e.g., a member may be required to pay 100% of a $500 annual deductible before their coverage pays claims).
- Co-insurance, a percent of the total cost of services that must be covered by the enrollee (e.g., a member may be required to pay 5% of the total cost of their care after meeting a deductible).

The ACA generally prohibits cost-sharing for most preventive services except in some limited instances such as out-of-network care.

Enrollee cost sharing can be expressed as the "actuarial value" (AV) of a health plan, or the percent of total average health care costs that are paid by its members rather than the plan. (Centers for Medicare and Medicaid Services, n.d.) For example, a health plan with an AV of 95% covers 95% of the average costs of its' members care, while the members pay, on average, the remaining 5% through premiums or "out of pocket" (OOP) costs. Qualified Health Plans (QHPs) sold on the Marketplace are classified into plan tiers according to their AV, including:

- Bronze plans, with an AV of at least 60%.
- Silver plans, with an AV of 70%.
- Gold plans, with an AV of 80% or higher.
- Catastrophic plans, available to people ages 30 and younger, and some low-income people.

In contrast, OHP coverage does not impose monthly premiums or other cost-sharing on members (see Exhibit H).

Federal law requires that states design a BHP so that enrollees do not pay higher monthly premiums or OOP costs than would be charged if they received coverage under a QHP from the Marketplace (Centers for Medicare and Medicaid Services, n.d.).

House Bill 4035 outlined requirements and recommendations for the Task Force to consider with respect to enrollee cost sharing. The plan must be designed to minimize costs to enrollees, and to the extent possible, include an option for no cost sharing or OOP costs and an option for lesser cost sharing or OOP costs than is available through QHPs on the Marketplace.

Exhibit H: Enrollee Cost Sharing by Coverage Type

Oregon Health Plan	Basic Health Plan	Qualified Health Plans (Marketplace)
No premiums or out-of-pocket (OOP) costs	Premiums and OOP costs cannot be higher than Qualified Health Plans	Premiums and OOP costs vary by plan tier and enrollee income

The states with BHPs (existing or planned) have varied in their approaches to enrollee cost sharing:

- Minnesota's BHP, "MinnesotaCare," originally launched as a state-funded program in 1992, transitioning to a BHP in 2015. Most MinnesotaCare enrollees pay a monthly premium that is based on family income. Most enrollees 21 years of age and older also have cost sharing for certain services:
  - $75 copay for ER visits (does not apply if visit leads to inpatient admission
  - $25 copay for nonpreventive visits (does not apply to substance use disorder and mental health visits)
  - $250 per inpatient hospital admission
  - $100 copay for ambulatory surgery
  - $25 copay for eyeglasses
  - $25 (brand) or $7 (generic and some brand) co-pay for prescription drugs up to $70 per month (some mental health drugs have no copay)
  - $40 per visit for radiology services
  - $15 per non-routine dental visit
  - 10% coinsurance for durable medical equipment (DME)
- New York's BHP, operating as the "Essential Plan," was established in 2015. The Essential Plan initially had both sliding scale premiums and cost sharing. New York has since eliminated premiums. Cost sharing requirements vary by income with enrollees between 138-150 percent FPL having only nominal cost-sharing for prescription drugs. Enrollees between 151-200 percent FPL have cost sharing on other services, though preventive care is covered with no cost sharing. Essential Plan enrollees do not have a deductible.
- Kentucky was at the time of this report planning to implement their BHP with premiums tiered by income, nominal co-payments, and no deductible.

Equity Implications of Benefit Design

House Bill 4035 required the Task Force to develop recommendations for the Bridge Program that prioritized health equity, a reduction in the rate of people without insurance, and promotion of continuous health coverage for communities that face health inequities. The American Academy of Actuaries has noted that:

> *"When considering the impact of benefit design on health outcomes and disparities, issues arise around two key areas: access to care and affordability of care. Access and affordability are affected by the services covered, sites of care, network structure (tiered, narrow, broad network), and the out-of-pocket costs, including both cost-sharing and premiums, for which the insureds are responsible."* (Health Equity Work Group, 2021)

Research on health insurance premiums generally shows that premiums reduce the number of people with health insurance coverage. This can occur when

1) people decline to enroll due to cost barriers (i.e., lower "uptake"),
2) people enroll in a plan that is never "effectuated" (activated as coverage) because they do not pay the first months' premium, or
3) people 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 Medicaid enrollees are highly sensitive to premiums (Sommers, Tomasi, Swartz, & Epstein, 2012). A 2014 study of Medicaid enrollees in Wisconsin found that increasing the monthly premium from \$0 to \$10[2] reduced the average length of enrollment by 1.4 months and decreased the likelihood of remaining continuously enrolled for 12 months by 12 percent (Dague, 2014). In 2003, the Oregon Health Plan implemented new premiums and coverage restrictions following premium-nonpayment due to state budget deficits; research on the impact of these changes found rates of coverage fell 13 percent for OHP Plus and 44 percent for OHP standard in the months following this change (Wright, Carlson, Smith, & Edlund, 2005).

Research on the relationship between premiums and BHP uptake is limited by the small number of states with these programs, but rising rates of enrollment following New York's elimination of its BHP monthly premium suggests premiums may pose similar barriers to enrollment for this population as is seen in Medicaid (New York State of Health, 2021).

[2] This research used administrative data on Medicaid enrollment from March 2008 to September 2009. Adjusting for inflation, a \$10 premium in March 2008 would be equivalent to \$14.83 in June 2022. *(Source: CPI Inflation Calculator, U.S. Bureau of Labor Statistics)*

In contrast to plan designs with premiums that can limit uptake, plans incorporating OOP costs such as copays or deductibles can drive unintended avoidance or underutilization of care. Researchers have examined the effect of temporarily introducing co-pays into OHP; they assessed enrollees' self-reported unmet care needs in the months before and after OHP co-pays were eliminated, finding that the percent of enrollees with unmet care needs fell from 28 to 19 percent following the elimination of co-pays (Wright, Carlson, Smith, & Edlund, 2005). These findings are consistent with a Kaiser Family Foundation (KFF) review of literature from 2000-2017 finding that co-pays in Medicaid and CHIP, even at relatively low levels ($1-5), are associated with adverse care utilization patterns including reductions in necessary services and increased emergency department utilization (Artiga, Ubri, & Zur, 2017). While high health care costs are a concern for lower-income Americans generally, Black and Latinx adults are disproportionately affected by high costs and are more likely to report deferring needed care (Montero, Kearney, Hamel, & Brodie, 2022).

Task Force discussions included consideration of how premiums or OOP costs in the BHP could lead to barriers to enrollment or continuous coverage as well as delaying or avoiding necessary care. Members noted difficult tradeoffs to be considered, such as the possibility that a BHP may only be able to offer certain services such as dental coverage or the full CCO service package with the addition of member premiums or co-pays. Actuarial analysis of the impact of cost sharing on uptake or affordability were not yet available at the time of this report.

Relying on literature to inform their discussions, Task Force members generally preferred that enrollee cost sharing be considered as a "last resort" plan design modification if necessary to ensure the program could be created and financially sustained at all. Generally, if cost sharing was determined to be necessary at a later date, Task Force members indicated that a sliding scale premium tied to enrollees' monthly income, paired with navigation support for enrollees during coverage transitions, may be the most equitable option. The Task Force wanted further analysis of projected BHP enrollee demographics and microsimulation of enrollee behavior under various cost sharing scenarios to inform this conclusion.

Plan Administration, Rates, and Provider Reimbursements

Section 1331 Blueprints provide broad flexibility in how states may administer Basic Health Programs, offering options to more closely resemble Medicaid or Marketplace plans from the consumer's perspective. Programs resembling the Marketplace may, for example, offer enrollment during a single "open enrollment" period during the year, with plans offered by commercial carriers that also offer Qualified Health Plans (QHPs) on the Marketplace. BHPs that more closely resemble Medicaid may, for example, offer continuous eligibility and rolling enrollment throughout the year and be offered by managed care organizations (MCOs) administering Medicaid coverage.

OHA met with representatives from other states in July 2022 to better understand variation in BHP administration in other states and implications for Oregon.

- New York's Essential Plan is administered by the New York State Department of Health, which also administers NY's Marketplace, Medicaid and CHIP programs. The state operates an integrated eligibility system across coverage programs, allowing enrollment on a rolling basis throughout the year. The state has aligned its BHP procurement process to the approach used for Qualified Health Plan providers (New York State Department of Health, 2015).
- MinnesotaCare is administered by the Minnesota Department of Human Services that also oversees its Medicaid program. Like NY, the state allows enrollment on a rolling basis through an integrated eligibility system spanning Medicaid, BHP and QHPs. The state's procurement for Medicaid and BHP is aligned through a single contracting process for managed care plans (Minnesota Department of Human Services, 2017).
- Kentucky was newly developing a BHP in 2022. At the time of this report, Kentucky was planning a BHP to be offered through its Medicaid Managed Care Organizations (MCOs).

House Bill 4035 requires that the Bridge Program be provided through Oregon's CCOs that provide OHP coverage to most Medicaid enrollees in Oregon. Task Force recommendations must be consistent with and generally enhance the CCO delivery system.

To achieve this, the bill required that the BHP align to the existing procurement cycle for CCOs and provide a transition period for people to enroll in the program. The bill encouraged that to the extent practicable, CCOs be required to accept BHP enrollees. The Task Force was asked to consider whether the Bridge Program could be offered through Oregon's exchange (the federally facilitated Healthcare.gov platform) and whether eligible consumers could be offered a choice between the BHP and existing APTCs.

Plan Administration

At the July 26th Task Force meeting, OHA presented a proposed approach to BHP plan administration (see Appendix XX). The program would be offered by CCOs and broadly align to OHA's existing procurement process and cycle for OHP, mirroring the approach previously used by the agency to phase in new coverage programs such as Cover All Kids and Healthier Oregon. Program implementation would occur according to phases recommended by CMS, including:

- Phase 1, beginning when the PHE expires and extending until federal approval is secured for the 1331 Blueprint. During this phase, existing OHP members earning between 138-200% FPL would remain enrolled in OHP under a temporary

amendment to one of the state's existing Medicaid 1115 waivers. During this phase, there would be no operational changes required for CCOs.

- Phase 2, beginning when federal approval of a Blueprint is secured and relevant infrastructure is operable, and ending no later than December 31, 2024 (if the PHE is not renewed). During this period, existing OHP enrollees who are eligible for BHP would transition coverage on a rolling basis as they undergo eligibility redeterminations.
- Phase 3, beginning as soon as January 1, 2024, would open the BHP to enrollment of eligible individuals without other coverage, and eventually to individuals in the Marketplace during the open enrollment period (for coverage beginning January 1, 2025). CMS confirmed that the federal Healthcare.gov platform could be used to offer Oregon's BHP to eligible consumers, but that eligible consumers could not, under Section 1331 authority, opt out of the Bridge Program and retain APTCs to buy coverage on the Marketplace.
- Phase 4 was proposed by CMS as an optional phase that could begin 1-2 years after the creation of Oregon's BHP if the state transitioned to a state-based marketplace platform. In Phase 4, Oregon could explore the use of a Section 1332 State Innovation Waiver to offer a "BHP-lookalike" product, enabling consumers to choose between BHP-like coverage and retention of APTCs to purchase other subsidized QHPs.

Oregon's Integrated and Coordinated Delivery System makes CCOs accountable for delivering health care services to OHP members (ORS 414.570). This system statutorily mandates that OHP members be enrolled in CCOs with exemptions for specified categories of individuals, including American Indians and Alaska Native beneficiaries (ORS 414.631). With House Bill 4035 establishing the requirement that the Bridge Program be "consistent with" Oregon's CCO delivery system, the application of these exemptions to enrollment in CCOs for the Bridge Program requires consideration. OHA has begun discussing the application of enrollment exemptions in a BHP with CMS, but the issue remains unresolved as of this report.

Plan Rates and Provider Reimbursements

Rates paid to plans are an important factor in health plans' ability to engage providers in their networks, and plans are generally required to maintain provider networks that can deliver the care needed by their members (Health Equity Work Group, 2021). The relationship between plan rates, provider reimbursements and adequacy of provider networks is influenced by a range of economic and workforce factors that can meaningfully vary across regions. Research on Medicaid provider networks suggests that within a contracted provider network, the provision of care to Medicaid enrollees is often concentrated among a small proportion of the network, which can create challenges for members seeking to access care (Ludomirsky, et al., 2022). Increasing reimbursement

rates to providers can result in increased access to services for Medicaid enrollees (McKnight, 2019).

CCOs are required to maintain provider networks with sufficient numbers, provider types and geographic distribution to ensure that members can receive timely, medically appropriate, and culturally responsive care (OAR 410.141.3515). Oregon establishes the rate paid to CCOs for OHP members but the state does not typically mandate the levels at which CCOs pay contracted providers (Oregon Health Authority, n.d.). Instead, CCOs negotiate provider reimbursements within their "global budgets." House Bill 4035 required that the Bridge Program pay a capitation rate (per member, per month amount) to CCOs that would be sufficient to provide coverage to people enrolling in the Bridge Program. To the extent possible, the bill encouraged the Task Force to develop program design recommendations that allowed for provider reimbursements to be at levels higher than OHP reimbursements.

At a July 26th meeting, OHA staff reviewed information from other states regarding their BHP rates and provider reimbursements.

- New York's Essential Plan has been able to pay BHP provider reimbursements at approximately 25% above Medicaid levels, with rates increasing over time; in 2021, the state also established a quality pool to incentivize BHP plan and provider performance.
- Kentucky, in an early planning stage for its BHP in mid-2022, was aiming for its plans to pay providers at reimbursements approximately 10% above Medicaid levels.
- In contrast, Minnesota requires that its Medicaid MCOs with MinnesotaCare (BHP) plans cannot reimburse providers at levels higher than they do for Medicaid.

The Task Force discussed plan rates and provider reimbursements over the course of several meetings. Discussions included how differences in provider networks across OHP, QHPs and a BHP could impact access to care for members transitioning coverage. Members noted the importance of ensuring that enrollees reassigned from OHP or the Marketplace to the BHP could retain existing care provider relationships to the extent possible. OHA was exploring options to better compare provider networks across plans and coverage programs at the time of this report.

Commercial health plans, including QHPs offered on the Marketplace, generally pay provider reimbursements at higher levels than Medicaid. One concern from members related to the possibility that providers could see reduced reimbursements for care of enrollees covered through the Marketplace who transitioned to the BHP, if the BHP reimbursed at a level closer to OHP. Actuarial analysis to estimate BHP capitation rates was not fully available at the time of this report (see "Feasibility Study Findings"), and Task Force discussions were preliminary and conceptual. Members noted the fragility of the

existing health care delivery system due to workforce and financial strains from the pandemic. There was a desire to "keep providers whole," minimizing these potential impacts on provider reimbursements.

The Task Force considered how the BHP may align to OHP with respect to other direct payments to providers beyond those made by CCOs. One issue of interest to Task Force members, and members of the public providing testimony, related to OHA payments to federally qualified health centers (FQHCs). FQHCs are those that receive Section 330 grant funding under the Public Health Service Act to provide care in communities underserved by the health system. 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 (National Association of Community Health Centers, 2018). OHA makes quarterly "wraparound" payments to FQHCs 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 (Oregon Health Authority, n.d.).

When the PHE ends, FQHCs may no longer be able to bill OHA for wraparound payments for the care of members who transition from OHP to BHP. This change is not directly related to the creation of a Basic Health Program, but the question of whether Oregon's BHP should retain the OHP approach to wraparound payments was noted as something to be considered in setting BHP plan rates and goals for provider reimbursement levels.

Finally, members also sought to understand how the BHP may align to Oregon's existing accountability and performance frameworks for CCOs, including the state's 3.4% cost growth target (Oregon Health Authority, n.d.), CCO quality incentive program (Oregon Health Authority, n.d.), and the state's requirements for CCOs to meet targets and milestones for the adoption of value-based payments by their providers (Oregon Health Authority, n.d.). OHA had not yet developed specific proposals for these implementation elements at the time of this report, but recommended Oregon's BHP program align as closely as possible to the existing OHP program design to minimize CCO operational burdens.

Feasibility Study Findings

OHA and DCBS engaged a consulting group, Manatt, to explore whether it would be financially feasible for coordinated care organizations (CCOs) to offer BHP coverage as envisioned in HB 4035. This feasibility analysis focused on a subset of the BHP-eligible population, including:

- Approximately 21,300 people who earn between 138-200% of the federal poverty level and are uninsured; and
- Approximately 32,500 people earning 138-200% FPL who purchase subsidized coverage in the Marketplace.

The analysis did not include consideration of people continuously enrolled in Medicaid during the public health emergency (PHE) who would be eligible for the BHP (estimated 55,000).

Results of the analysis were presented to the Task Force on June 14, 2022 (Ario, Presentation: Actuarial Analysis, 2022). Key findings included:

- Estimated federal funding *for the study population* would range from $329-386 million depending on whether temporary enhancements to premium tax credits under the American Rescue Plan Act (ARPA) are renewed beyond 2022. These estimates did not consider a proposed federal change that removes a penalty for states with 1332 waivers.
- Estimated costs to cover *the study population* were $317 million if providers were reimbursed for their care at OHP reimbursement levels.
- A projected surplus of $12-69 million *for the study population* suggested it would be possible for the BHP to support higher-than-OHP capitation rates paid to CCOs.
- A BHP could reduce Oregon's uninsured rate by 0.5%; the number of Oregonians gaining coverage would likely be smaller if the program included premiums or cost sharing.

Further analysis beyond the feasibility study was needed to support the Task Force's work, including a) analysis of revenues and costs for people enrolled in OHP who would be eligible for the BHP, and b) analysis of enrollment and premium impacts for those earning more than 200 percent FPL who would remain in the Marketplace (see "Market Impacts"). A request for carrier data was issued by DCBS to commercial insurers in early July to support further analysis.

Market Impacts of Creating a BHP

House Bill 4035 directs the Task Force to consider the stability of premiums for people remaining in the individual and small group insurance markets and how the creation of a BHP could drive instability in the marketplace. The Task Force has begun looking at two types of potential market impacts: how the creation of a BHP may impact the overall prevalence of poor health (or "morbidity") of people remaining in the marketplace, and the potential effects of carriers discontinuing a practice called "silver loading" following BHP creation (Aron-Dine, 2017).

Change in Marketplace Risk Pool Morbidity

A key concern in the creation of a BHP is whether removal of people earning between 138-200 percent FPL from the individual Marketplace would lead to shifts in the average morbidity of the population remaining in the individual and small group market. This could drive increases in their premiums or other costs.

The Manatt feasibility study assessed the projected average morbidity of people in the individual and small group market risk pool following the creation of a BHP. Their analysis found that transitioning the study population to a BHP was not projected to directly change the average morbidity of people who would continue to buy coverage in the Marketplace.

Discontinuation of Silver Loading

The second market stabilization issue the Task Force has started to discuss is "silver loading," a practice implemented in many states in 2017 to offset the loss of revenue when the federal government discontinued Cost Sharing Reduction (CSR) payments to carriers for plan subsidies required under the ACA (Aron-Dine, 2017). Silver loading increases the premium value of the silver-tier plan that serves as the benchmark for calculating individuals' advance premium tax credits (APTC) in the Marketplace. Silver loading boosts the value of APTC and makes coverage more affordable for people covered under all metal plan tiers.

The creation of a BHP is anticipated to eliminate the need for silver loading, leading to a reduction in the premium value of the benchmark plan. This change was anticipated to reduce advance premium tax credits and increase the net cost of coverage for people in Bronze and Gold tier plans who would remain in the Marketplace. In plan year 2022, 79% of people in bronze plans (n=48,665) and 80% of people in gold plans (n=20,127) reported incomes above 200% FPL and could be affected (see Exhibit I).

The BHP federal funding formula includes a "payment adjustment factor" to address states' loss of this federal revenue for the BHP-eligible population, but no such adjustment exists for people who receive APTCs for purchasing coverage in the Marketplace (Ario, Presentation: Actuarial Analysis, 2022).

Exhibit I: Marketplace Plan Selection by Tier and Federal Poverty Level, 2022

		Federal Poverty Level									
Metal Level	N	<100 %	≥100% to ≤138%	≥100% to ≤150%	>150% to ≤200%	>200% to ≤250%	>250% to ≤300%	>300% to ≤400%	>400% to ≤500%	>500%	Other or Unknown
Bronze	61,601	0%	0%	2%	6%	12%	15%	27%	11%	14%	13%
Silver	59,329	2%	4%	16%	33%	19%	9%	10%	4%	3%	3%
Gold	25,159	0%	0%	1%	5%	15%	16%	24%	10%	15%	15%

Source: State, Metal Level, and Enrollment Status Public Use File (2022), Centers for Medicare and Medicaid Services
https://www.cms.gov/files/zip/2022-oep-state-metal-level-and-enrollment-status-public-use-file.zip

Mitigation Options

These market impacts are the subject of further actuarial analysis planned for presentation to the Task Force in fall 2022 for its second report. OHA and DCBS had begun preliminary discussions with CMS to explore potential mitigation strategies including:

- A narrow amendment to the state's 1332 waiver for its reinsurance program. The amendment would allow Oregon to recapture the federal savings generated by the creation of the BHP and elimination of silver loading. These "pass through" savings would be reinvested in Oregon's marketplace to offset premium increases.
- A 1332 waiver to tie the value of APTC to a gold rather than silver tier benchmark plan in the marketplace. This approach would de-couple APTC from the value of the second lowest cost silver plan, thus minimizing the impact on APTC if silver loading ceased.

These approaches were being explored with CMS at the time of this report; no state had specifically received a 1332 waiver for these purposes, though Colorado had recently been the first state to secure CMS approval of a 1332 waiver to recapture federal savings through mechanisms other than a reinsurance program (Centers for Medicare and Medicaid Services, 2022).

Tribal Consultation

House Bill 4035 directs OHA and DCBS to consult with Oregon Indian tribes during the deliberations of the Task Force and incorporate tribal recommendations into the Task Force report and requests for federal approvals under subsections (7) and (9).

OHA staff engaged the OHA Tribal Affairs team in planning for required Tribal consultation. Per OHA's Tribal Consultation and Urban Indian Health Program Confer Policy ("Tribal Consultation Policy"), this process begins with formal notification to tribal leaders through a Dear Tribal Leader Letter (DTLL). The DTLL is a critical component of the formal tribal consultation and confer process with the nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP). These consultations and confers are required to be offered to the Tribes and UIHP on issues that may impact the Tribes and the health of their members. The Tribes choose to engage in further discussion and consultation at their discretion.

Based on the recommendation of OHA Tribal Affairs, OHA will send three DTLLs related to HB 4035:

- Notification of the temporary expansion of OHP coverage to include people in Oregon with income from 138 to 200 percent FPL. This is the key function of what is referred to as Phase 1 of the Bridge Program.
- Notification of the Bridge Program more broadly.

- Notification of the process and goals of the Community and Partner Workgroup – as a part of the larger redeterminations effort.

Once each DTLL is sent to the Tribes by Tribal Affairs, the Tribes and UIHP have 30 days to request a formal consultation or confer. If a request for consultation is received, OHA Tribal Affairs must schedule the consultation within 30 days of the date the request was made. Consultations may be collective (with more than one Tribe participating) or individual. This is determined at the request of the Tribes. Key decision-makers and subject matter experts from OHA must be present at the consultation/confer meeting(s). Per OHA's Tribal Consultation Policy, if a consultation/confer occurs, OHA must also communicate the outcomes of the consultation back to the Tribes/UIHP by letter or email within 30 days of the final consultation meeting.

Community Engagement

The Task Force has included time for public comment at every meeting beginning with the second meeting on May 10, 2022. Written comments have been accepted on an ongoing basis since the Task Force's first meeting on April 26, 2022. As of the meeting on July 26, the Task Force has heard from over 20 individuals, representing providers, insurers, CCOs, consumer advocates, and potential BHP enrollees (see Appendix XX).

A consumer listening session was scheduled for July 21st to invite community feedback and testimony on program design. However, due to low registration, the event was postponed to the fall to ensure adequate time for outreach and engagement. Existing registrants were encouraged to submit written comment or attend an alternate public testimony opportunity at Task Force meetings.

OHA staff joined a CCO Operations Collaborative meeting on July 12th to solicit input and answer questions about the Bridge Program. The meeting generated a wide range of questions about operational details of the BHP. OHA staff determined that follow-up and ongoing engagement would be beneficial for discussion and planned ongoing attendance at future meetings to ensure adequate feedback mechanisms between OHA, CCOs and the Task Force on BHP operations.

Additional CCO operational issues identified in Task Force meetings that required further exploration prior to program launch included:

- Consideration of CCOs' infrastructure and whether it supported their ability to collect premiums or other OOP cost sharing design elements, given that these are not elements of OHP.
- Questions regarding how member assignment to CCOs would occur in regions served by multiple CCOs.
- How BHP performance and reporting requirements may align or differ from OHP.

- How OHA may operationalize any recommendation that CCOs should reimburse providers at higher rates for BHP than OHP covered services, given that CCOs typically negotiate their own provider reimbursement rates.
- Whether CCOs would have sufficient time and advance notice of operational changes needed to launch or sustain the BHP.

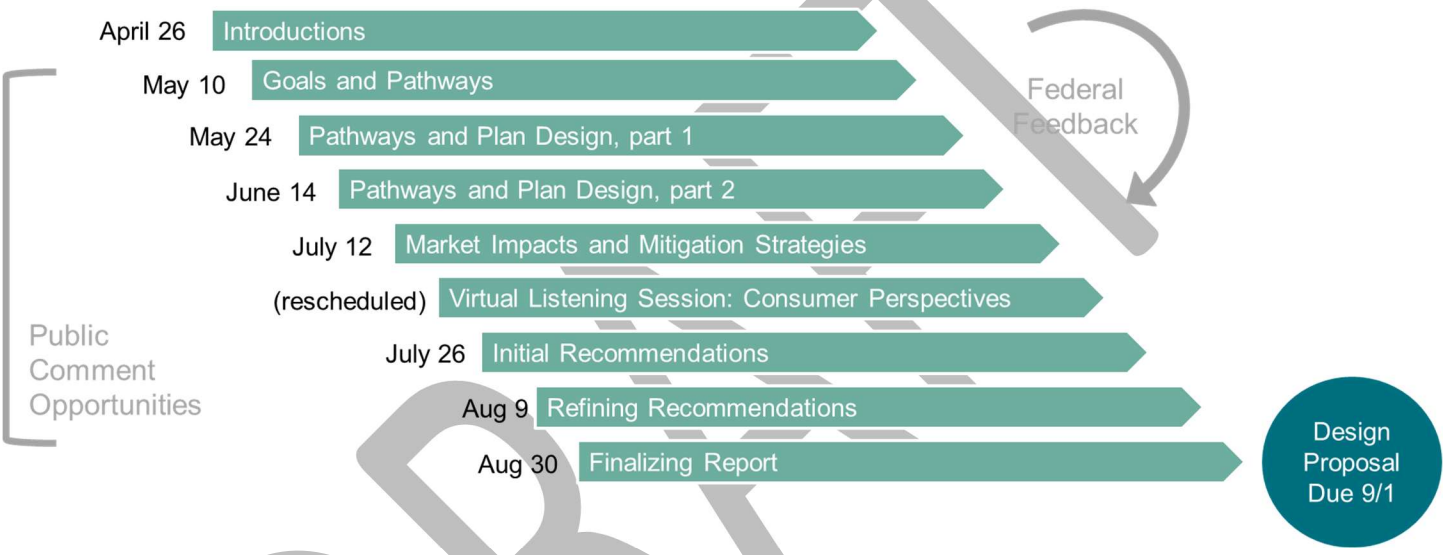
OHA staff and a representative from the Task Force also joined the Health Insurance Marketplace Advisory Committee meeting on July 21st to present an overview of the Task Force's work and invite input. The group supported the proposed phased approach to implementing the BHP. They requested additional information about silver loading, and further opportunities to discuss and provide input on mitigation strategies. A follow up presentation is scheduled for the group's meeting on October 13th.

SECTION IV. PRELIMINARY RECOMMENDATIONS

[Note to reviewers: this draft content is presented for Task Force preparation for the August 9th meeting with the understanding that recommendations have not yet been discussed or approved.]

Task Force discussions about plan design decisions took place over several meetings between late May and early August 2022 (see Exhibit J).

Exhibit J: Task Force Meetings and Topics, April to August 2022



Early in 2022, state officials had assumed that the federal PHE declaration may expire sometime in mid or late 2022. Under this original timeline, CMS would have required Oregon to complete all OHP eligibility redeterminations by late 2023. To ensure continuity of coverage for people who would lose eligibility for OHP, the state had sought to secure federal approval for the creation of a Bridge Program by late 2023. OHA and DCBS prepared a draft amendment request to the state's 1115 Medicaid waiver for substance use disorder to request temporary authority to maintain enrollees' OHP coverage under that waiver if the PHE expired prior to the launch of a BHP. This proposed waiver amendment was posted for public comment at the time of this report.

The federal PHE declaration was subsequently extended in April and July, and at the time of this report, CMS had not provided states with 60-days of notice of intent to allow the PHE declaration to expire. Thus the timeline for reinitiating OHP eligibility redeterminations was unknown.

At a July 12th meeting the Task Force discussed the timeline to develop its recommendations for designing the Bridge Program in light of the PHE extension. The feasibility analysis suggested Oregon could implement the Bridge Program with few or no deviations from the vision outlined in House Bill 4035. However, there were several important sources of information not yet available at that time, including:

- The BHP federal funding formula for 2023 and beyond. CMS had published a proposed rule for public comment (Centers for Medicare and Medicaid Services, 2022). This proposed rule included several updates to the BHP funding formula that had the potential to shift the revenues Oregon would be projected to receive for its BHP (Keith, 2022).
- Actuarial analysis of the cost to cover the subset of the BHP-eligible population enrolled in OHP under the continuous eligibility provision of the PHE declaration. This analysis was underway and slated for presentation later in August.
- Ongoing federal policy negotiations related to the enhanced APTC authorized in the American Rescue Plan Act of 2021. These APTC enhancements were set to expire at the end of 2022, but Congress was considering a three-year extension of the tax credits. Because the federal formula for BHP funding tied program revenue to the value of APTCs, the pending expiration and potential extension of the enhancements had implications for Oregon's potential BHP revenue.

This information will be critical for the development of specific program design recommendations and program budget estimates. The Task Force advanced preliminary recommendations based on the information available as of August 9, 2022 with the intent to revisit these recommendations in October 2022 when additional actuarial analysis, Tribal feedback, and federal regulatory information is available. The Task Force also held initial discussions regarding potential contingency scenarios (see Appendix XX) if projected federal funding or program costs in subsequent actuarial analyses were meaningfully different than what was known at the time preliminary recommendations were developed.

Program Design Recommendations

Preliminary information reviewed by the Task Force suggests a Bridge Program could achieve the goals of House Bill 4035. Specifically:

- The feasibility study estimated a Bridge Program would reduce Oregon's percent of people without insurance coverage by 0.5 percent, extending coverage to approximately 21,300 Oregonians.
- The recommended phased implementation promotes continuous coverage for people who will lose eligibility for OHP when the PHE expires and reduces the risk of churn for people transitioning between OHP and other coverage types.
- Offering the program with no enrollee costs minimizes cost barriers to enrollment and care that disproportionately impact communities that experience health

inequities. The Bridge Program would provide a new affordable coverage option for people earning less than 200 percent FPL who are ineligible for OHP and currently purchase coverage through the Marketplace.

The Joint Task Force on the Bridge Health Care Program advances the following preliminary recommendations for the creation of Oregon's Bridge Program. These preliminary recommendations may be expanded or revised by the Task Force in its December 2022 report.

Exhibit K: Recommendations to create Oregon's Bridge Program

Federal Pathway
• Oregon's Bridge Program should be established through a Section 1331 Basic Health Program Blueprint, as recommended by CMS. • The program should offer a transition period for enrollees by following the phased implementation approach suggested by CMS. The state should seek federal approval of the Blueprint on a timeline that will support Phase 3 implementation by 2025. • The program should be made available through Oregon's Marketplace, either by requesting modification of the federal Healthcare.gov platform or through a state-based marketplace, depending on the platform in use by phase 3. • OHA and DCBS should continue to explore with CMS the option to create a BHP-like product under Section 1332 waiver authority, which could enable Oregon to offer enrollees a choice between the Bridge Program and marketplace subsidies in phase 4.
Program and Plan Administration
• To promote continuous coverage for Oregonians, CCOs should be required to accept eligible enrollees to the program in the phased implementation manner outlined in this report. OHA should seek to develop enrollment procedures for each phase that emphasize continuity of care and provider access for enrollees transitioning to the Bridge Program from OHP and the Marketplace. • OHA should align procurement for the Bridge Program to existing OHP processes and timelines to minimize CCO administrative burden to launch the program. OHA should continue to engage CCOs through the Operations Collaborative to identify opportunities to operationally align the program to OHP.
Benefit Design
• Preliminary analysis suggests the Bridge Program could offer a covered service package that fully aligns to the CCO service package for OHP, including adult dental coverage. The CCO covered service package for OHP includes all essential health benefits.

- The program could be offered to enrollees at no cost, including no monthly premiums and no out-of-pocket costs to access services. To minimize administrative complexity and enhance the CCO delivery system, Oregon's 1331 Blueprint should request waiver of the federal requirement to offer at least two BHP plans to eligible consumers.
- If future actuarial analysis suggests the program can offer enrollees the full CCO covered service package at no enrollee costs and without reliance on state funding, OHA should establish capitation rates that enable CCOs to pay providers at levels higher than OHP.

Federal and State Funding

- The feasibility analysis suggests the proposed Bridge Program design maximizes federal financial participation under a Section 1331 Blueprint. This federal pathway relies on a per capita funding formula that affords flexibility for enrollment to fluctuate over time without subjecting the state to federal budget neutrality requirements.
- This approach does not depend on the extension of federal tax credit enhancements in the American Rescue Plan Act (2021) to minimize costs to the state budget.
- These assumptions require further actuarial analysis that is anticipated in late 2022.

Next Steps

At the time of this report, the federal public health emergency declaration remained in effect. The future end date of the PHE and the related timeline for Oregon's redeterminations process were unknown.

House Bill 4035 required the Task Force to submit a second report no later than December 31, 2022 with recommendations to alleviate disruptions to health care coverage for individuals and small employers. These recommendations will address in greater detail the market impacts and mitigation strategies described in section III of this report.

Additional meetings and analyses were planned through fall 2022 in support of the Task Force's remaining work (see Exhibit L).

Exhibit L: Task Force Meetings and Topics, September to December 2022

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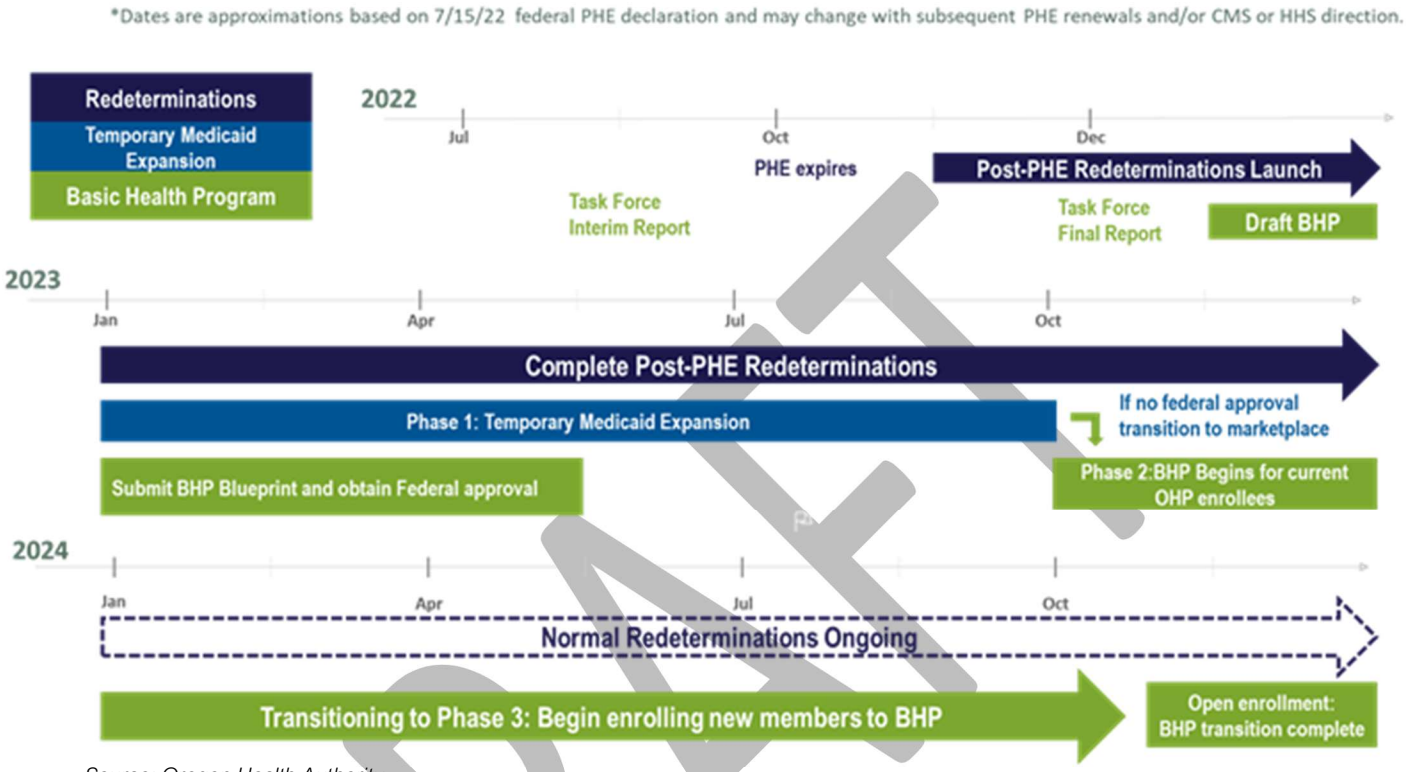
Appendix A: Covered Services Comparison

Covered Services Comparison - State EHB Benchmark and CCO	
Notes: - Focus of the analysis is the **CCO** covered services and not OHP more broadly, which includes fee-for-service covered services. - Unless noted, assume no quantitative limit on services. - Children's services not included in the analysis. - Not a covered service for either: Infertility services and adult orthodontia. - "PL" refers to Prioritized List - https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx	
Benefit Type	**Notes**
Services Covered by EHB Benchmark and CCOs **EHB = CCO**	
PRIMARY CARE	n/a
SPECIALIST/PHYSICIAN SERVICES	CCO: Agnostic to provider type. CCOs may limit specialist visits (e.g. require referrals)
OTHER PHYSICIAN SERVICES	CCO: Agnostic to provider type.
OUTPATIENT - HOSPITAL AND PHYSICIAN/SURGICAL	CCO: Agnostic to provider type* (if surgery pairs and is funded on the PL). Some surgeries/procedures often covered by commercial insurance may not be covered under OHP.
HOSPITAL SERVICES	EHB: Respite care provided in a nursing facility subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. CCO: 90 day period with subsequent 60 day periods.
URGENT CARE	CCO: Agnostic to provider type.
HOME HEALTH CARE	CCO: Generally covered, but subject to PL.
EMERGENCY SERVICES	CCO: Generally covered, but subject to PL.
EMERGENCY TRANSPORT	n/a
INPATIENT HOSPITAL SERVICES	n/a
INPATIENT PHYSICIAN AND SURGICAL	CCO: Generally covered, but some surgeries or diagnoses may not be covered due to PL.
SKILLED NURSING	EHB: Quantitative limit on services. CCO: Post-hospital extended care. CCOs are responsible for a SNF benefit that is more akin to commercial SNF coverage, does not include coverage for K plan and other services. CCOs responsible for post-hospital extended care benefits with up to 20-day stay to allow discharge from hospitals.
MATERNITY CARE - PHYSICIAN	CCO: PL - includes out of hospital birth for low risk pregnancies, including licensed direct entry midwives. There is a carveout for this (and a few other services).
MATERNITY CARE - INPATIENT	CCO: PL - includes out of hospital birth for low risk pregnancies, including licensed direct entry midwives.
BEHAVIORAL HEALTH OUTPATIENT	CCO: PL - generally covered but some conditions not covered.
SUBSTANCE USE DISORDER - OUTPATIENT	n/a
SUBSTANCE USE DISORDER - INPATIENT	n/a

PRESCRIPTION DRUGS	EHB: In accordance with 45 CFR 156.122 , EHB plans must cover the same number of prescription drugs in each United States Pharmacopeia (USP) category and class as the benchmark plan and, at a minimum, at least one drug in every USP category and class. CCO: Medicaid more generous because of open formulary. Some drugs not covered according to PL.
OUTPATIENT REHAB & HABILITATION	EHB: Quantitative limit on services. CCO: PL puts limits on OP Rehab and habilitation (similar to EHB). Can also include home health and DMEPOS which is also separately listed.
CHIROPRACTIC CARE	EHB: Quantitative limit on services. CCO: Plan uses the term "spinal manipulation." Subject to PL - some conditions not covered and quantity limits.
DURABLE MEDICAL EQUIPTMENT	CCO: Not covered for unfunded diagnoses, some common DME not covered as medically necessary.
HEARING AIDS	EHB: Quantitative limit on services. One hearing aid per hearing impaired ear if prescribed, fitted, and dispensed by a licensed audiologist with the approval of a licensed physician. Coverage will be provided every 36 months as medically necessary for the treatment of a member's hearing loss. Medicaid: Binaural every 5 years ages 21+, 3 years for children <21, limits on batteries.
IMAGING	n/a
PREVENTIVE CARE/SCREENING/IMMUNIZATION	n/a
ROUTINE FOOT CARE	EHB: Benefit is limited to persons being treated for diabetes mellitus. CCO: PL covers for several high risk conditions including diabetes.
ACUPUNCTURE	EHB: Quantitative limit on services. CCO: Quantitative limit may vary by condition. Listed as bundled services as a duplication of physician services and nurse practitioner services from existing state plan.
REHABILITATIVE SPEECH THERAPY, OCCUPATIONAL & REHAB PHYSICAL THERAPY	EHB: Quantitative limit on services. 30 visits per condition per calendar year. CCO: Medicaid more generous. Quantity limits for adults 21+. Physical, speech, & occupational therapy - rehab/hab.
LABORATORY OUTPATIENT & PATIENT SERVICES & X-RAYS	n/a
TRANSPLANT	n/a
ACCIDENTAL DENTAL	CCO: Limits on dentures, crown, and periodontal.
DIALYSIS	
ALLERGY TESTING	EHB: Described as "Other medically necessary diagnostic services provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition." CCO: only covered by PL if patient has a funded comorbidity such as asthma or for severe allergies.
CHEMOTHERAPY	n/a
RADIATION	n/a

DIABETES EDUCATION	EHB: Quantitative limit on services. Covers three hours of education per year if there is a significant change in condition or treatment; covers one diabetes self-management education program at the time of diagnosis. CCO: Medicaid likely more generous.
PROSTENTIC DEVICES	n/a
INFUSION THERAPY	n/a
NUTRITIONAL COUNSELING	EHB: Quantitative limit on services. CCO: Through diabetes prevention program, intensive behavioral counseling (home health).
RECONSTRUCTIVE SURGERY	EHB: Limited to one attempt at cosmetic or reconstructive surgery when necessary to correct a functional disorder; or when necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or when necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. CCO: Non-cosmetic. Subject to PL - may be more or less generous than commercial depending on condition.
COSMETIC SURGERY	EHB: Limited to one attempt at cosmetic or reconstructive surgery when necessary to correct a functional disorder; or when necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or when necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. CCO: OHP concept of cosmetic is different. Generally cosmetic services are in the unfunded region of the PL, but may be covered if there is comorbidity and must be considered medically necessary - then considered hospital services.
WEIGHT LOSS PROGRAMS	EHB/CCO: Intensive weight loss counseling, including diabetes prevention program is covered. (Intensive weight loss counseling is also in the EHB because it's a USPSTF preventive service).
Service is not in EHB Benchmark, but is a CCO Covered Service **CCO > EHB**	
DENTAL - ROUTINE	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous.
DENTAL - BASIC	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous, subject to PL and OAR.
DENTAL - MAJOR	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous, subject to PL and OAR.
BARIATRIC SURGERY	CCO: Limitations on types when it is considered medically necessary.
NON-EMERGENT MEDICAL TRANSPORTATION	CCO: Unique to CCO.

Appendix B: Proposed Timeline for Implementing a BHP



Source: Oregon Health Authority presentation to the Joint Task Force on the Bridge Health Care Program, July 26th, 2022. Available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256312

Appendix C: Plan Design Survey for Contingency Planning

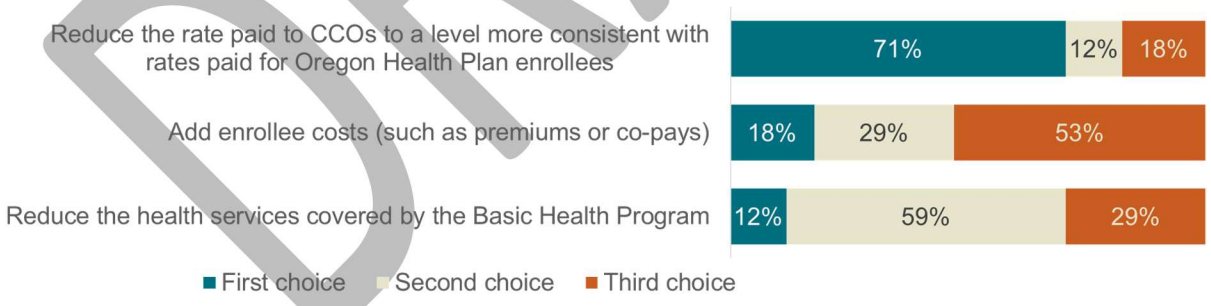
The Task Force developed its preliminary recommendations based on the program revenue and cost information available as of August 9th, 2022. Discussions included consideration of alternate scenarios if subsequent analysis indicates projected program funding or costs are different than estimates provided in the feasibility study.

These alternate scenarios were to guide additional actuarial analysis and planning and should not be interpreted as alternate recommendations for program design.

To develop alternate plan design scenarios for consideration at its fall meetings, Task Force members completed a survey of preferences and priorities for plan design.[3] The survey asked members to indicate their preferences for adjustments to the plan design if federal funding could not support the program design as envisioned in the bill.

Members were asked to indicate the order in which they would implement changes, including reducing CCO capitation rates to a level consistent with OHP, adding enrollee costs or reducing the range of services covered. A majority of members indicated that if it was necessary to reduce program costs, their preferred choice would be to first reduce the capitation rates paid to CCOs to a level consistent with OHP before adding enrollee costs or reducing services (see exhibit 1). At their July 26th meeting, members discussed these results, noting two caveats: a) this question does not consider whether Oregon may avoid reductions in program costs by investing state funding, and b) the question does not consider whether these steps would be taken in tandem, rather than sequentially.

Exhibit 1: Rank-ordered plan design changes if cost reduction was necessary

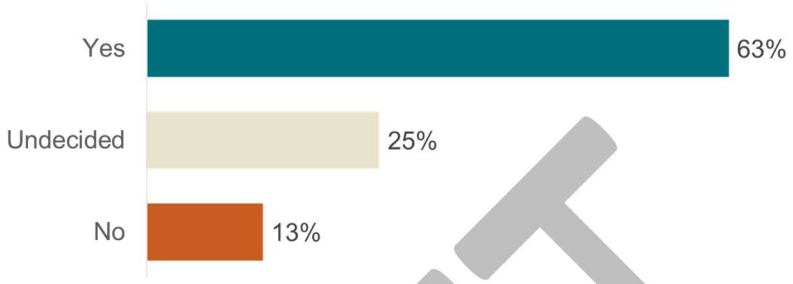


Members were asked to indicate if they would support the creation of the program if federal funding did not support capitation rates to CCOs that were higher than capitation rates paid for OHP members (see Exhibit 2). Roughly two thirds of Task Force members (65%)

[3] The Legislative Policy & Research Office conducted a confidential survey of the voting members of the Task Force in July 2022 (n=17). Non-voting members did not receive surveys (n=4). The web-based survey was administered using the Qualtrics Survey Platform. All invited members received an individual, one-time link, and 100% of members completed the short questionnaire (n=17). Results were analyzed by two members of the LPRO team.

indicated support for the program under this scenario, while one third were undecided (24%) or opposed (12%).

Exhibit 2: Support for creation of a Basic Health Program with capitation rates at levels similar to OHP

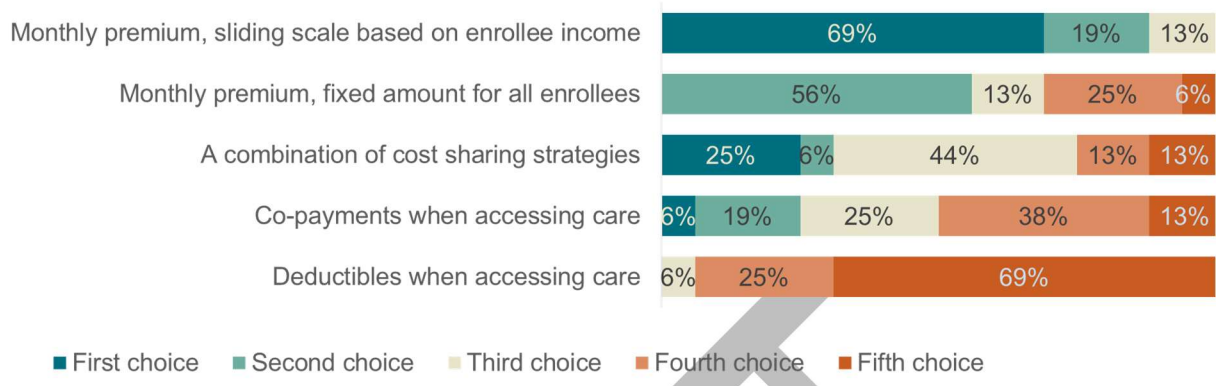


Members offered several comments along with these responses, including:

- A concern that OHP capitation may not support adequate provider networks; (n=4)
- That advantages of zero enrollee costs outweigh challenges of lower OHP rate; (n=4)
- Concern that OHP rates will reduce payments to providers; (n=3)
- That advantages of aligning to OHP design outweighs downside of lower OHP rate; (n=3)
- Concern that it is premature to discuss rates without actuarial analysis; (n=3)
- Workforce shortages / rising labor costs need consideration; (n=2)
- OHP rates are sufficient to provide access to care; (n=2)
- Importance of tying payments to quality and outcome measures; (n=1)
- New administrative costs for CCOs may need to be considered; (n=1)
- That an OHP capitation rate was preferable to unreimbursed or charity care for people without coverage. (n=1)

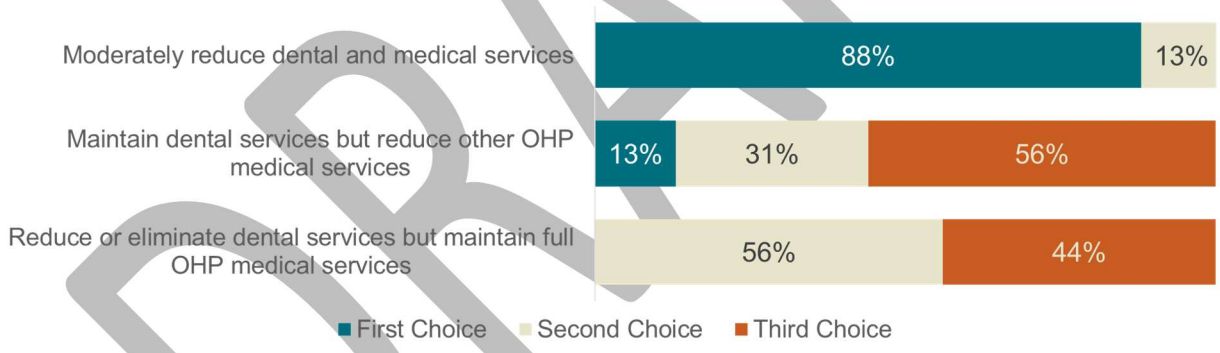
While the survey indicated a preference to avoid introduction of enrollee cost sharing or reduction in services, members were asked to indicate preferences if this design choice was necessary. Results indicated that if it was necessary to add enrollee cost sharing to the program design, the preferred choice was to introduce a sliding scale monthly premium or a combination of premium and other cost sharing strategies (see Exhibit 3). There was a strong preference to avoid deductibles, with smaller numbers of members indicating co-pays or fixed monthly premiums were least preferred choices.

Exhibit 3: Preferred mode if enrollee cost sharing was necessary



Members were asked to indicate how they would prioritize changes if reductions in the covered service package were necessary (see Exhibit 4). A majority of members (82%) indicated they would make moderate reductions across both medical and dental services while retaining some dental coverage. A smaller percent preferred to make reductions exclusively to medical services (12%) or dental services (6%) but not both.

Exhibit 4: Prioritization of covered services if reductions were necessary



Members met individually with Co-Chairs Steiner Hayward and Prusak to discuss plan design preferences. Members' input from the survey and Co-Chair meetings were used to iteratively update a planning framework to guide subsequent actuarial analysis for fall meetings (see exhibit 5).

Exhibit 5: Framework for Alternative Plan Design Modeling

Baseline Scenario

- If federal funding is sufficient, create the Bridge Program according to the House Bill 4035 vision with OHP covered services and no enrollee costs.

Alternate Scenario #1 (if necessary)

- Align capitation rates to Oregon Health Plan rates

Alternate Scenario #2 (if necessary)

- Modest reduction of medical and dental, preserving all Essential Health Benefits and basic dental coverage
- Add modest sliding scale premium administered by the state

Appendix D: Key Terms and Acronyms

Acronym	Term	Definition
AV	Actuarial Value	*Also see metal tiers.* In this context, actuarial value refers to the percent of overall health care costs covered by an insurance plan. For example, a health plan with an AV of 80% covers, on average, 80% of costs for enrollees in that plan (though costs for individual enrollees may be higher or lower).
APTC	Advance Premium Tax Credit	*Also see PTC.* Advance premium tax credits are federal financial assistance toward the purchase of individual health insurance on the marketplace. APTCs are based on an estimate of the PTC an individual will be eligible for in that plan year. Individuals applying for marketplace-based coverage can elect to have estimated PTCs applied in advance to reduce their monthly premiums.
ARPA	American Rescue Plan Act of 2021	Federal COVID-19 relief legislation signed into law on March 11, 2021. ARPA enhanced and expanded the subsidies available to people purchasing health insurance coverage on the marketplace through December 2023. These enhanced subsidies would increase funding available under ACA Sections 1331 and 1332 if extended, but will expire at the end of 2023 without additional congressional action.
BHP	Basic Health Program	Section 1331 of the Affordable Care Act (ACA) allows states to create a program that offers Medicaid-like coverage to people earning <200% of the Federal Poverty Level who are not eligible for Medicaid but are eligible for subsidies to purchase coverage on the marketplace.
	BHP-like	*Also see BHP.* A program with coverage that is similar to a Basic Health Program but is created through a mechanism other than a Section 1331 Blueprint.
	Bridge Program	Oregon House Bill 4035 (2022) authorized the state to create a bridge program to "provide affordable health insurance coverage and improve the continuity of coverage for individuals who regularly enroll and disenroll" in Medicaid or other health care coverage due to frequent fluctuations in income.[1]
	Capitation	*Also see Rates and Reimbursements.* A payment method that establishes a fixed per-person payment amount intended to cover all health care costs for that person within a defined set of services. The term capitation is sometimes used to refer to the amount Coordinated Care Organizations are paid to provide coverage to OHP enrollees ("CCO capitation rate"); the term capitation is also sometimes used to refer to per-member per-month (PMPM) amounts paid by health plans to health care providers under alternative payment arrangements (i.e.., not fee-for-service payment arrangements).
	Carrier	An entity that provides health benefit plans.

	Churn / Churn population	People who frequently gain and lose health insurance coverage (particularly Medicaid) or experience disruptions in coverage due to fluctuations in income.
CCO	Coordinated Care Organization	Locally governed organizations that administer coverage and provider networks for OHP members in geographically defined service areas of Oregon.
CGT	Cost growth target	Oregon has established a goal that overall health care costs will not increase by more than 3.4% per year.
	Cost sharing	*Also See OOP*. The portion of health care costs paid "out of pocket" by an individual, including deductibles and co-pays. Cost sharing typically does not refer to premiums.
CSR	Cost sharing reductions	*Also see cost sharing, Silver Loading.* Additional financial assistance available to individuals with incomes <250% FPL who purchase coverage on the marketplace. CSRs reduce co-pays, deductibles, and out-of-pocket maximums. CSRs are distinct from premium tax credits and only apply to "silver" tier plans. Carriers are required to provide CSRs to income eligible individuals enrolled in Silver tier plans, however, the federal government stopped paying CSR subsidies to carriers in 2017. Most states use "Silver Loading" to replace the lost revenue for carriers.
	Exchange	*Also see HIM.* An alternative term for the health insurance marketplace, a platform for purchasing health insurance.
FFM / FFE	Federally Facilitated Marketplace / Federally Facilitated Exchange	*Also see HIM.* A marketplace platform, Healthcare.gov, that is managed by the federal government.
HIM	Health insurance marketplace or marketplace	*Also see SBM, SBM-FP.* A service available in every state that helps people find and enroll in health insurance. Some states operate their own marketplace (or "exchange") while others like Oregon use the federal Healthcare.gov platform.
	Market disruptions / market stability	*Also see risk pool, Silver Load, CSR.* Changes in individual or small group health insurance markets that may occur following creation of a Bridge Program due to the removal of people eligible for the Bridge Program from the risk pool. Market disruption may also result from increased net premiums in the Marketplace due to reductions in PTC and "Silver Loading" to account for a smaller CSR eligible population.
	Medicaid-like	*Also see OHP.* A health insurance program that resembles the Oregon Health Plan in covered benefits and enrollee costs but is offered to people who are not eligible for Medicaid.
	Metal tier ("bronze", "silver", "gold")	A way of classifying health plans sold on the Marketplace according to the share of costs a member typically pays OOP. "Gold" tier plans have the highest monthly premiums and the lowest member OOP costs. "Bronze" tier plans have the lowest

		monthly premiums and highest OOP costs. "Silver" tier plans are midway between Gold and Bronze plan.
	Morbidity	*Also see risk pool.* The prevalence of poor health in a population. In the context of health insurance, morbidity refers to the average or aggregate disease burden of a group, with higher morbidity describing a population with poorer overall health.
OHP	Oregon Health Plan	Oregon's Medicaid program
	Optionality	The ability for consumers to choose between the Bridge Program or subsidized coverage purchased on the marketplace. *Note: optionality does not refer to having a choice of plans within the Bridge program or choice of plans on the Marketplace. It refers only to choice between Marketplace and Bridge coverage.*
OOP	Out of pocket costs	Any health care costs paid by members at the point of care, including cost sharing (deductibles, co-pays) and non-covered services. Premiums are not considered OOP costs.
	Pathways	Options to secure federal funding for a Bridge Program, including an 1115 demonstration waiver, a 1331 blueprint, and a 1332 state innovation waiver. Oregon refers to these options collectively as federal "pathways."
	Phases	Discrete periods of time when Oregon would design, apply for and implement a Bridge Program.
	Premium	A monthly amount paid by an enrollee who purchases health insurance coverage. Premiums are distinct from other costs such as deductibles or co-pays.
PAF	Premium Adjustment Factor	A component of the Section 1331 Basic Health Program federal funding formula. A state's BHP funding is based on the premium tax credits that individuals would have otherwise received to purchase subsidized coverage on the Marketplace. The PAF is an 18% increase to the base funding formula that was established when the federal government discontinued paying Cost Sharing Reductions *(also see CSRs above).* The PAF simulates silver loading that a 1331 state would otherwise need to use but for its implementation of a BHP.
PTC	Premium Tax Credit	The premium tax credit helps eligible individuals purchase health insurance through the marketplace. The federal tax credit is based on income, and those with lower incomes receive higher credits.
	Procurement cycle	The State of Oregon's process for contracting with Coordinated Care Organizations and establishing per member per month rates for Oregon Health Plan members.
PHE	Public Health Emergency	Federal determination that a public health emergency exists because of confirmed COVID-19 cases. Originally declared on January 31, 2020; last renewed for 90 days on April 12, 2022.

QHP	Qualified Health Plan	A health plan that meets Affordable Care Act requirements to be offered on the marketplace, including covering essential health benefits (EHB) and limiting enrollee cost sharing.
	Rate	In this context, "rate" refers to the amount a health plan receives to provide coverage to a member (such as a BHP or Medicaid enrollee). Often expressed as a per-member per-month (PMPM) amount.
	Redetermination	Federal requirement that Medicaid eligibility be regularly renewed (usually once every 12 months). Redetermination requirements have been suspended because of the federal Families First Coronavirus Response Act (FFCRA).
	Reimbursement	In this context, "reimbursement" refers to the amount a health plan pays a health care provider to deliver services to its members. Reimbursements can be structured many ways, such as fee-for-service (FFS), capitation, diagnosis or episode-based, etc.
	Reinsurance	Protects insurers from losses related to complex and high-cost medical claims. States can implement reinsurance programs to lower premiums for plans sold on the Marketplace. Some states, including Oregon, have Section 1332 waivers to receive pass-through dollars the federal government saves on the cost of PTCs because of a reinsurance program. The Oregon Reinsurance Program (operating since 2018) has on average lowered premiums by an aggerate 6.5%.[a]
	Risk pool	A group of individuals whose health status or costs of care are aggregated (pooled) to calculate average measures for the group.
SBM	State Based Marketplace	*Also see HIM.* A marketplace platform managed and operated by a state rather than the federal government.
SBM-FP	State Based Marketplace – Federal Platform	*Also see SBM, FFM / FFE.* A marketplace platform managed and operated by a state rather than the federal government, but which uses the federal Healthcare.gov platform for enrollment & eligibility determinations.
	Silver-loading	*Also see cost-sharing reductions.* An adjustment made by health plans to their silver-tier premiums to offset the loss of revenue the federal government used to pay for CSRs. Silver-loading replaces federal CSR payments by increasing premiums for silver plans, increasing revenue from PTCs. The creation of a BHP eliminates most silver-loading, due to the reduced population enrolled in CSR Silver Plan Variants.
	1115 Waiver	Section 1115 of the Social Security Act allows states to request approval to waive certain Medicaid program requirements to implement pilot projects to improve their programs.
	1331 Blueprint	The form that states use to request certification of a Basic Health Program from the federal government. The form contains a description of how the plan will be designed and operated.

1332 Waiver	Section 1332 of the Affordable Care Act allows states to apply to waive certain provisions of the ACA to "pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."[b]

Appendix E: Questions and Answers

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.

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.

Estimates using population survey data are currently the best available information regarding the demographic characteristics of the BHP population. Because the BHP population consists of people who are covered under OHP, commercial coverage, and uninsured, there is no administrative data source available that contains comprehensive demographic information about this population. Limited demographic information such as age and gender will be available in the fall when OHA and DCBS combine OHP and commercial carrier data. Insurers do not consistently collect enrollee-level race and ethnicity and this information would not be available until after a BHP is created.

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.

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 hospitals 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, what is the breakdown in plan enrollment by metal tier and FPL?

A: See table below for the number and percentage of people selecting plans in each tier, by income level. Note that these numbers reflect plan selection on the Marketplace; the number of people whose plan selections are effectuated (activated as coverage) is slightly lower due to nonpayment of premiums.

		Federal Poverty Level									
Metal Level	N	<100%	≥100% to ≤138%	≥100% to ≤150%	>150% to ≤200%	>200% to ≤250%	>250% to ≤300%	>300% to ≤400%	>400% to ≤500%	>500%	Other or Unknown
Bronze	61,601	0%	0%	2%	6%	12%	15%	27%	11%	14%	13%
Silver	59,329	2%	4%	16%	33%	19%	9%	10%	4%	3%	3%
Gold	25,159	0%	0%	1%	5%	15%	16%	24%	10%	15%	15%

Source: State, Metal Level, and Enrollment Status Public Use File (2022), Centers for Medicare and Medicaid Services https://www.cms.gov/files/zip/2022-oep-state-metal-level-and-enrollment-status-public-use-file.zip

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.

Q: How would the Bridge Program affect coverage options for adults who are non-citizens?

A: Coverage options for Oregon adults and children who are non-citizens vary by income, age, and immigration status.

- Full OHP coverage is generally available to adults who meet eligibility requirements, such as income, and have a qualifying immigration status. People who are Lawful Permanent Residents, (LPR) also known as "green card" holders, must generally wait five years to be eligible for full coverage.
- Adults who don't qualify for full OHP due to immigration status can still qualify for limited benefits. Citizen Waived Medical (CWM) covers emergency care, and CWM Plus covers full OHP benefits regardless of immigration status during pregnancy and for 60 days after a pregnancy ends.
- As of July 1, 2022, a new program called Healthier Oregon covers adults 19-25, or 55 and older, who would be eligible for full OHP if not for immigration status. This includes people in these age ranges who haven't met the 5-year LPR waiting period requirement. The Healthier Oregon program will also expand full OHP eligibility to adults ages 26 to 54 in the future as funding becomes available. This expansion may occur before Oregon's Bridge Program is available.
- Until Healthier Oregon expands, adults have not met the 5-year LPR waiting period requirement for full OHP coverage may still be eligible for tax credits and cost-sharing reductions on Marketplace plans.

- Oregon's Bridge Program would provide coverage to adults earning up to 200% FPL. Certain non-citizens who have not met the 5-year LPR waiting period requirement for OHP coverage may also qualify for the Bridge Program. However, the Bridge Program may not offer the same benefits available through Healthier Oregon. Further policy development may be needed to both maximize federal funding and consider equity between future OHP and Bridge Program enrollees.

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.

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 two-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 Public Health Emergency (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.

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 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.

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 less than 200% FPL 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 was addressed as part of the overall timeline update presented to the Task Force at the 7/12 meeting and can be found in the slide deck here.

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 BHP 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 are 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 negative impact on the individual market. The timing and scope of these analyses will depend on future Task Force discussions.
- These analyses and simulations *will not* be able to report results that are disaggregated by race and ethnicity. Enrollee-level data are being compiled from several sources including OHP, DSHS, and commercial carriers. These data sources do not contain standardized information about enrollee demographics that can be reported across the BHP population as a whole.

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 three to five 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, 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 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.

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.

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.

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 defined 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 provided a detailed comparison of these service packages at the July 26th Task Force meeting. 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.

Q: How much overlap exists in provider networks for people earning 139-200% 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 enrollee cost sharing, coverage, and utilization of health services?

A: Research on health insurance premiums generally shows that premiums reduce the number of people with health insurance coverage. 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 enrollees in Wisconsin 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.

In 2003, the Oregon Health Plan implemented new premiums and coverage restrictions following premium-nonpayment due to state budget deficits; research on the impact of these changes found rates of coverage fell 13 percent for OHP Plus and 44 percent for OHP standard in the months following this change. Oregon also temporarily introduced co-pays to the Oregon Health Plan, and later rescinded them. The study assessed enrollees' self-reported unmet care needs in the months before and after co-pays were eliminated, finding that the percent of enrollees with unmet care needs fell from 28 to 19 percent following the elimination of co-pays. These findings are consistent with a KFF review of literature from 2000-2017 finding that co-pays in Medicaid and CHIP, even at relatively low levels ($1-5), are associated with adverse care utilization patterns including reductions in necessary services and increased emergency department utilization.

Q: Do Minnesota and New York, the other two states with Basic Health Programs, include enrollee cost sharing in their plan designs?

A: The table below compares cost sharing in New York and Minnesota's BHPs in plan year 2022. Both states have made changes to enrollee cost sharing over time. OHA presented case studies of both state programs at a meeting on July 26th including details regarding how and why the programs have evolved over time.

	NY Essential Plan (135 – 150% FPL)	NY Essential Plan (151 – 200% FPL)	MinnesotaCare
Preventive Care	$0	$0	
Nonpreventive Care			$25 (substance use disorder /mental health visits excluded)
Primary Care Physician Visit	$0	$15	
Specialist Visit	$0	$25	
Inpatient Hospital Stay (per admission)	$0	$150	$250
Behavioral Health Outpatient Visit	$0	$15	
Emergency Room	$0	$75	$75
Urgent Care		$25	
Ambulatory Surgery			$100
Radiology			$25/visit
Physical Therapy, Speech Therapy, Occupational Therapy	$0	$15	
Durable Medical Equipment (DME)			10% co-insurance
Rx (generic)	$1	$6	$7
Rx (preferred)	$3	$15	$7
Rx (non-preferred)	$3	$30	$25
Dental	$0	$0	$15/non-routine visit
Vision	$0	$0	$25 copay for eyeglasses

Plan Administration and Provider Reimbursements

Q: How do provider reimbursements relate to enrollees' access to care? 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 reimbursements to 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.

The relationship between plan rates, provider reimbursements and adequacy of provider networks is influenced by a range of economic and workforce factors that can meaningfully vary across regions. Research on Medicaid provider networks suggests that within a contracted provider network, the provision of care to Medicaid enrollees is often concentrated among a small proportion of the network. Increasing reimbursement rates to providers can result in increased access to services for Medicaid enrollees.

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 (FQHCs) 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%. 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. 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.

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. Oregon Primary Care Association has estimated that FQHCs provide care to one in six OHP members. 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 wraparound payment model used in OHP.

Appendix F: Public Comment

- Public comment to be added when report is finalized