



*Prepared by
Legislative Policy and
Research Office*

**Joint Task Force on the
Bridge Health Care Program**

**Preliminary Program
Design Recommendations**

September 2022

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LETTER FROM THE CO-CHAIRS

The ongoing COVID-19 pandemic has posed an unprecedented public health emergency. Like other states, Oregon took steps to ensure people had access to health care coverage during the pandemic, including leveraging a federal option for Oregon Health Plan (OHP) enrollees to maintain continuous eligibility. The number of Oregonians with health care coverage has reached a historic high (95.4 percent of all Oregonians) and the state has seen meaningful reductions in disparities in coverage.

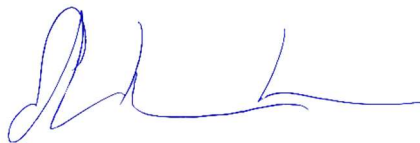
As the public health emergency comes to an end, Oregon faces a new challenge: ensuring maintenance of those gains in coverage and reductions in inequities. House Bill 4035 (HB 4035) took a critical step toward this goal by establishing a Joint Task Force to create a Bridge Health Care Program—a new program to offer affordable, high-quality coverage for lower-income Oregonians.

This report reflects the Task Force’s preliminary recommendations for designing the Bridge Health Care Program, including a process and timeline for federal approval, an approach to program and plan administration, and goals for the program’s benefit design. We faced an ambitious timeline to develop these recommendations for the Legislative Assembly. In our time together, the Task Force has explored a broad range of topics, from the equity implications of benefit design choices to the interdependencies of health insurance markets. As with most complex health policy challenges, we faced questions without simple answers.

We extend our gratitude to Task Force members for their hard work, collaboration, and respect for the multiple perspectives reflected among the group. We thank members of the community who invested time to provide public testimony that meaningfully informed Task Force discussions. We also thank the staff at the Legislative Policy and Research Office, Oregon Health Authority, and Department of Consumer and Business Services for their behind-the-scenes work in support of the Task Force.

Looking ahead, the Task Force will reconvene in October to take up its second charge: identifying potential disruptions to the individual and small group insurance markets following the creation of the Bridge Program. As we develop recommendations for mitigation strategies to ensure market stability, we also look forward to the opportunity to work with the Task Force to refine the preliminary recommendations in this report as additional information and analysis become available.

Sincerely,



Senator Elizabeth Steiner Hayward
Senate District 17



Representative Rachel Prusak
House District 37

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EXECUTIVE SUMMARY

Before the COVID-19 pandemic, six percent of Oregonians were uninsured, with inequities in coverage by income and race. The Oregon Health Plan (OHP) provides health insurance coverage to roughly a third of Oregonians. Many people covered through OHP also experience “churn,” gaining and losing coverage due to fluctuations in income and administrative barriers during renewal. In 2020, the federal government incentivized states to maintain coverage for Medicaid enrollees during the public health emergency (PHE) regardless of income changes. Since then, Oregon’s coverage rates increased and disparities in coverage by race and income levels decreased.

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

Oregon passed [House Bill 4035](#) (HB 4035) in 2022 to maintain increases in coverage and reductions in coverage inequities when the PHE ends, and the state is required to begin disenrolling people no longer eligible for OHP. The measure established a Joint Task Force on the Bridge Health Care Program to develop recommendations for a new affordable coverage option for people earning between 138–200 percent of the federal poverty level (FPL) who do not qualify for OHP. The Task Force developed preliminary recommendations between April and August 2022. Following the passage of HB 4035, the federal government twice extended the PHE, moving forward by at least six months the date by which a program needs to be in place to ensure no loss of coverage for OHP enrollees. This report reflects Task Force recommendations as of its August 30, 2022, meeting, with recognition that the end date for the PHE was unknown at that time.

Recommendations to Create the Program

The Task Force recommends the following approach to designing the Bridge Program based on preliminary information available through August 2022. **Recommendations** will be updated in the fall as more information is available.

- 1. Federal Pathway and Timeline.** Oregon’s Bridge Program should be established through phased implementation of a [Section 1331](#) Basic Health Program (BHP) Blueprint. The state should seek federal approval on a timeline that supports full implementation by 2025. The Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) should continue to explore a [Section 1332](#) State Innovation Waiver to offer a choice between the program and coverage purchased on the Marketplace.
- 2. Program and Plan Administration.** OHA should align Coordinated Care Organization (CCO) contracting and implementation processes for the BHP to existing OHP approaches, minimize operational burdens for CCOs, and create publicly posted opportunities for CCO engagement. CCOs should be required to accept eligible consumers transitioning from OHP in Phase Two, and from the Marketplace in Phase Three. Enrollment procedures should complement existing CCO infrastructures and navigation systems, emphasizing continuity of care.

OHA should establish capitation rates that enable CCOs to pay providers at levels higher than OHP. The program should provide adequate reimbursements to safety net providers such as Federally Qualified Health Centers (FQHCs) in a manner that considers the value of wraparound payments and is consistent with Oregon’s goals for value-based care.

- 3. Benefit Design.** The program should align benefits to the CCO-covered service package for OHP, including dental coverage and all essential health benefits. The program should be offered with no monthly premiums or out-of-pocket costs.

This program design achieves the **coverage goals of HB 4035**, including:

- Maintaining coverage for approximately 55,000 people expected to lose OHP and extending coverage to an estimated 21,300 uninsured Oregonians.
- Reducing the risk of churn for people transitioning from OHP to other coverage following the unwinding of the continuous eligibility provision of the PHE, or due to fluctuations in income over time.
- Providing a no-cost coverage option for people earning 138–200 percent FPL who currently purchase coverage in the Marketplace.

The recommendations are consistent with the **budget requirements of HB 4035**:

- The program design maximizes federal financial participation (FFP) through a per capita funding formula that is flexible to shifting enrollment levels and program costs and does not subject the state to federal budget neutrality requirements.
- The design minimizes reliance on state funding for costs that cannot be paid with federal funds, including BHP administration costs and services that are required to be covered under state law but prohibited from FFP under federal law.

Creating the Bridge Program would have consequences for Oregon’s Health Insurance Marketplace due to the discontinuation of an insurance carrier practice called “silver loading” that makes Marketplace plans more affordable. Mitigation strategies will be needed to understand effects to the exchange, address silver loading, and avoid premium increases for people earning more than 200 percent of the FPL.

Next Steps

These recommendations and assumptions are based on information available as of August 2022. The Task Force will revisit its preliminary recommendations in fall 2022 with updates based on Tribal consultation and additional actuarial analysis. The Task Force will submit a second report by December 31, 2022, including finalized recommendations on Bridge Program design and recommended mitigation strategies to address any secondary effects on Oregon’s Marketplace.

This report is available at:

<https://olis.oregonlegislature.gov/liz/202111/Committees/JTBHCP/2022-08-30-08-30/MeetingMaterials>

I. BACKGROUND

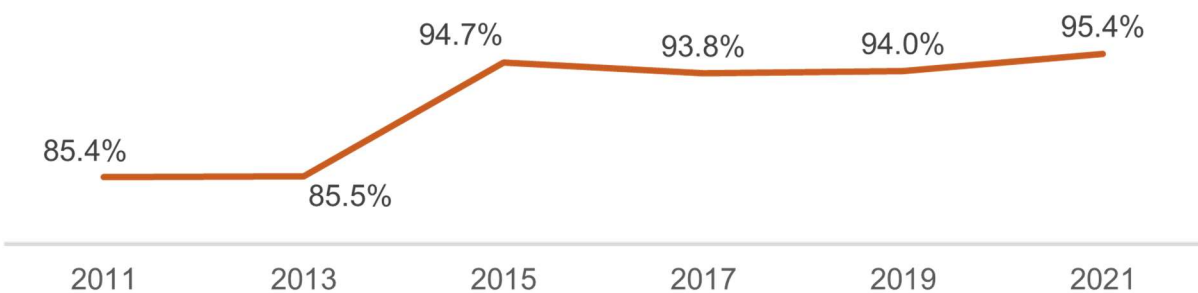
Health insurance coverage is a critical driver of health outcomes. A broad body of research confirms that people with coverage are (1) more likely to receive care on a timely basis (2), are more likely to receive preventive and screening services, and (3) are better able to manage chronic conditions over time (Institute of Medicine Committee on the Consequences of Uninsurance, 2002) (Sommers, Gawande, & Baicker, Health Insurance Coverage and Health — What the Recent Evidence Tells Us, 2017).

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

- **Medicaid:** coverage obtained through 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, e.g., an employer or union.

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 Patient Protection and Affordable Care Act (ACA) (KFF, 2022).

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

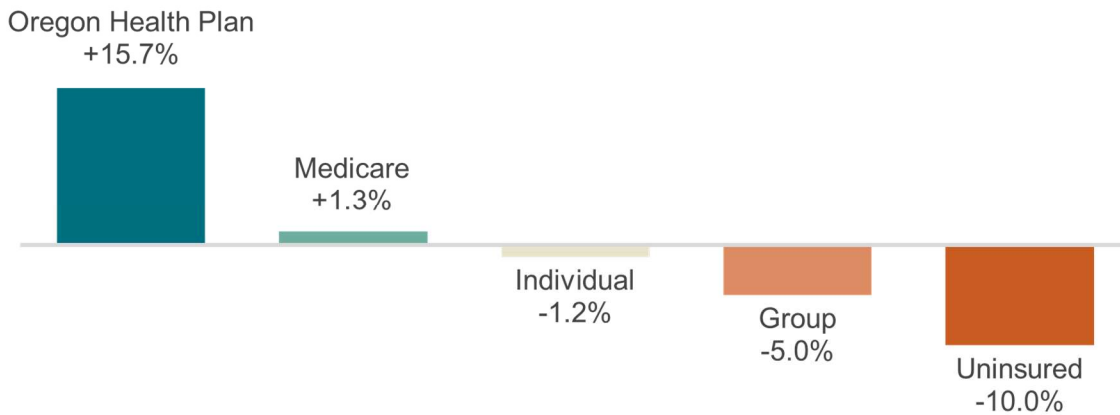


Source: Percent of Oregonians (all ages) with insurance coverage, by year. Oregon Health Insurance Survey

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

- 96.3 percent of people with incomes above 400 percent of the FPL had health insurance, compared with 92 percent of people at or below 400 percent FPL.
- The rate of coverage was substantially lower for Hispanic (88.4 percent), American Indian/Alaska Native (89.4 percent) and Black (91.8 percent) Oregonians than for White Oregonians (94.6 percent).
- Coverage varied by age; 99.3 percent of people aged 65 and over, and 97.2 percent of people 18 and younger were covered as compared to 92.3 percent of people ages 35–64 and 89 percent 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 percent FPL—are particularly at risk of churn (Corallo, Garfield, Tolbert, & Rudowitz, 2021). Others are at risk of churn if they experience barriers during the renewal process, such as not receiving paperwork they need to complete, missing deadlines to submit information, or missing or inaccurate information submitted on renewal forms.

Churn disrupts access to care, both for people losing coverage and for those transitioning between coverage types. A review of literature (Sugar, Peters, De Lew, & Sommers, 2021) notes **people experiencing Medicaid churn**:

- are less likely to receive preventive care or refill prescriptions;
- are more likely to visit emergency departments or be hospitalized; and
- report declines in overall health and harmful effects on the quality of their health care.

Churn is also disruptive to health plans and health care providers, increasing administrative costs and undermining the management and monitoring of members' care quality over time (Sugar, Peters, De Lew, & Sommers, 2021). A 2015 study simulating Medicaid churn from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling one person in coverage within a year incurred administrative costs between \$400 and \$600 (Swartz, Farley Short, Roempke Graefe, & Uberoi, 2015). 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, in the five months following coverage disruption (Ji, Wilk, Druss, Lally, & Cummings, 2017).

These disruptions in Medicaid enrollment persist despite state efforts to streamline enrollment processes and remove barriers to continuous enrollment. Nationally, roughly one in 10 Medicaid enrollees (10.3 percent) experience churn over the course of a year, and rates are higher for children (11.2 percent). (Corallo, Garfield, Tolbert, & Rudowitz, 2021). The Oregon Health Authority (OHA) estimates that as of September 2019, 34 percent of people enrolling in OHP were returning to the program after less than 12 months, and 25 percent were returning within six months of having been previously covered (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 and renewal processes, 72–80 percent 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 explore options to improve the rate of coverage and reduce coverage inequities.

Section 1331 of the ACA offered the opportunity to create a Basic Health Program (BHP) for people earning between 138 and 200 percent of the 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**, [House Bill 4109](#) directed 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**, [House Bill 2934](#) directed OHA to convene a stakeholder advisory group to develop recommendations for a BHP. The report, delivered in 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**, [House Bill 4017](#) directed the 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 to improve coverage and affordability** for Oregonians in recent years, including:

- **In 2017**, [House Bill 2391](#) directed 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**, [Senate Bill 770](#) established 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 and planned to submit final recommendations to the legislature by September 2022.
- **In 2021**, [House Bill 2010](#) directed OHA and DCBS to develop a plan for a public health insurance option (or “public option”). Manatt developed a report and recommendations 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, Oregon Health Authority Public Option Implementation Report, 2022).

Coverage and Churn in the COVID-19 Era

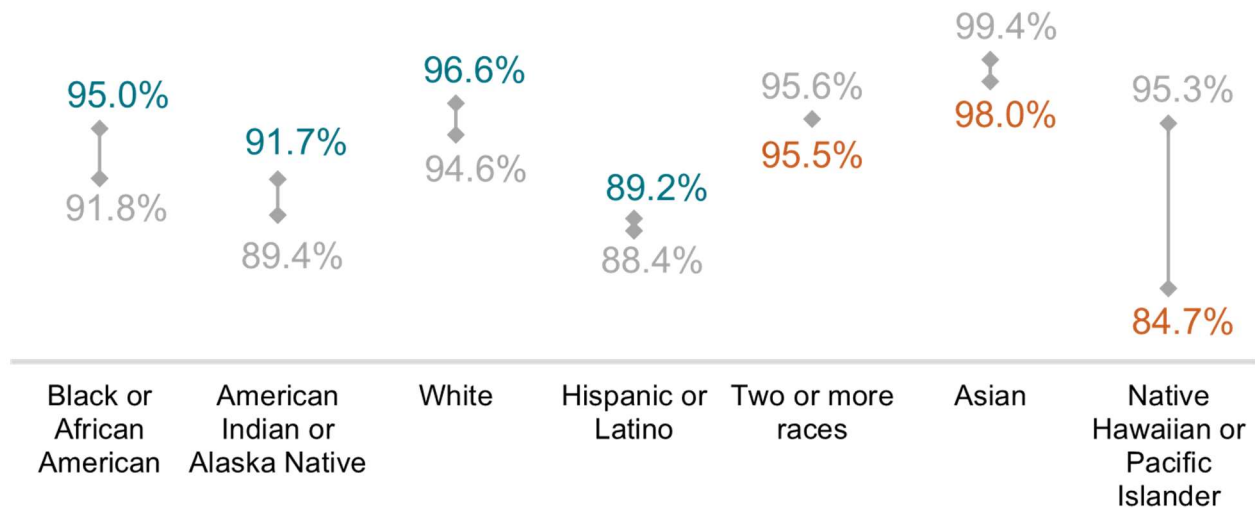
The COVID-19 pandemic officially reached Oregon in early 2020 with the first presumptive case reported by the Oregon Health Authority on February 28, 2020 (Oregon Health Authority, 2020). The federal government issued a public health emergency (PHE) declaration related to the COVID-19 pandemic on January 31, 2020, (Azar, 2020) and Governor Kate Brown declared a state of emergency in Oregon on March 8, 2020, (Brown, 2020). The federal PHE has been renewed approximately every 90 days since its issuance. It remains 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 to help them manage the costs of Medicaid during the pandemic. As a condition of receiving that funding, **states were required to:**

- provide "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;
- agree not to implement higher premiums or more restrictive eligibility rules than those that were in place on January 1, 2020; and
- cover COVID-19 related testing, vaccines, and related treatments free of charge to enrollees.

Oregon, along with every other state, accepted these conditions in exchange for enhanced federal funding. People enrolled in OHP have since retained coverage during the PHE and churning has stopped. 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. Since the PHE declaration, Oregon's overall uninsured rate fell from 6.0 percent to 4.6 percent 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 but who are no longer eligible for OHP.

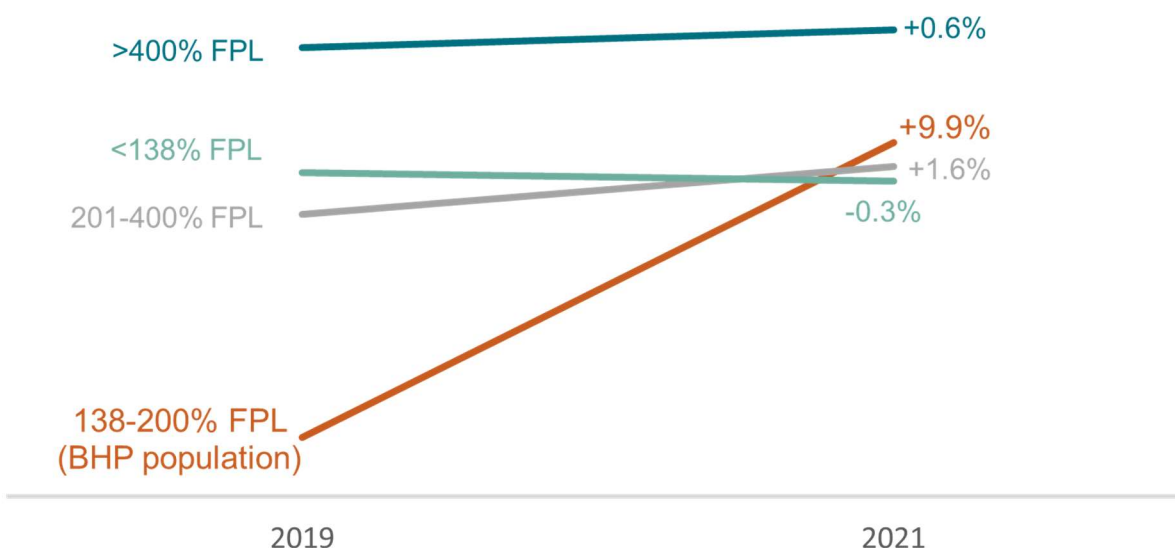
The end date for the PHE declaration is unknown at the time of this report, but CMS issued guidance to states in December 2020 and frequently since then to help states begin planning for this transition or “unwinding” of the continuous coverage requirement (Centers for Medicare and Medicaid Services, 2020). **Key elements** of this guidance include:

- States must redetermine eligibility for nearly all Medicaid/CHIP enrollees upon expiration of the PHE. The Biden Administration will provide 60 days advance notice to states prior to the PHE expiring.
- States will have 12 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 12-month redetermination year to address workforce challenges associated with processing requests, strengthen outreach to and support for beneficiaries, and minimize procedural closures among eligible people.
- 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 ACA in 2010.

OHA has estimated approximately 300,000 people may lose OHP coverage at post-PHE redetermination (Vandehey, 2022). People earning between 138–200 percent of the FPL are 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 percent 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 Legislative Assembly passed **House Bill 4035** (HB 4035) 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; and
- direct OHA 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 Bridge Health Care Program (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.

II. POLICY CONTEXT AND PATHWAYS

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

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 <i>Oregon Law Center</i>	Representative of low-income workers who are likely to be eligible for the Bridge Program
Jonathan Frochtzwaig <i>Cascade AIDS Project</i>	Expert in health equity
Keara Rodela <i>Coalition of Community Health Clinics</i>	Expert in health equity
Sharmaine Johnson Yarbrough <i>Wallace Medical Concern</i>	Expert in navigation assistance for health insurance consumers
Kirsten Isaacson <i>Service Employees International Union</i>	Representative from organized labor
William Johnson <i>Moda Partners</i>	Representative of an insurer that offers Qualified Health Plans on the Health Insurance Exchange
Eric Hunter <i>CareOregon</i>	Representative of a CCO
John Hunter <i>Oregon Health & Science University</i>	Representative of a hospital or health system
Antonio Germann <i>Salud Medical Clinic / Pacific Pediatrics</i>	Other representative of health care providers
Heather Jefferis <i>Oregon Council for Behavioral Health</i>	Expert in behavioral health care
Matthew Sinnott <i>Willamette Dental Group</i>	Representative of oral health care provider that contracts with OHA
Adrienne Daniels <i>Multnomah County Health Department</i>	Representative of the Medicaid Advisory Committee
Lindsey Hopper <i>PacificSource Health Plans</i>	Representative of the Health Insurance Exchange Advisory Committee
Stefanny Caballero <i>Virginia Garcia Memorial Foundation</i>	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

House Bill 4035 Vision for the Bridge Program

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

- **By September 1, 2022**,¹ develop a proposal for a Bridge Program, including recommendations for any federal waiver requests, and suggested timelines for program implementation.
- **By December 31, 2022**, identify potential disruptions to the individual and small group insurance markets by the Bridge Program, and develop 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 fall.

HB 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;
- achieving 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 program is available to all individuals residing in the state with incomes at or below 200 percent FPL who do not qualify for Medicaid but who 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; and
- providing a transition period for eligible individuals to enroll in the 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 (1) an option that has no cost sharing, deductibles, or other out-of-pocket costs; and (2) 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 if the participants choose to opt out of the program;
- including an option for offering the program on the health insurance exchange if the plans meet the criteria established by the OHA and DCBS; and
- requiring CCOs to accept enrollees in the program or requiring OHA to contract with a new entity to accept 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 HB 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:

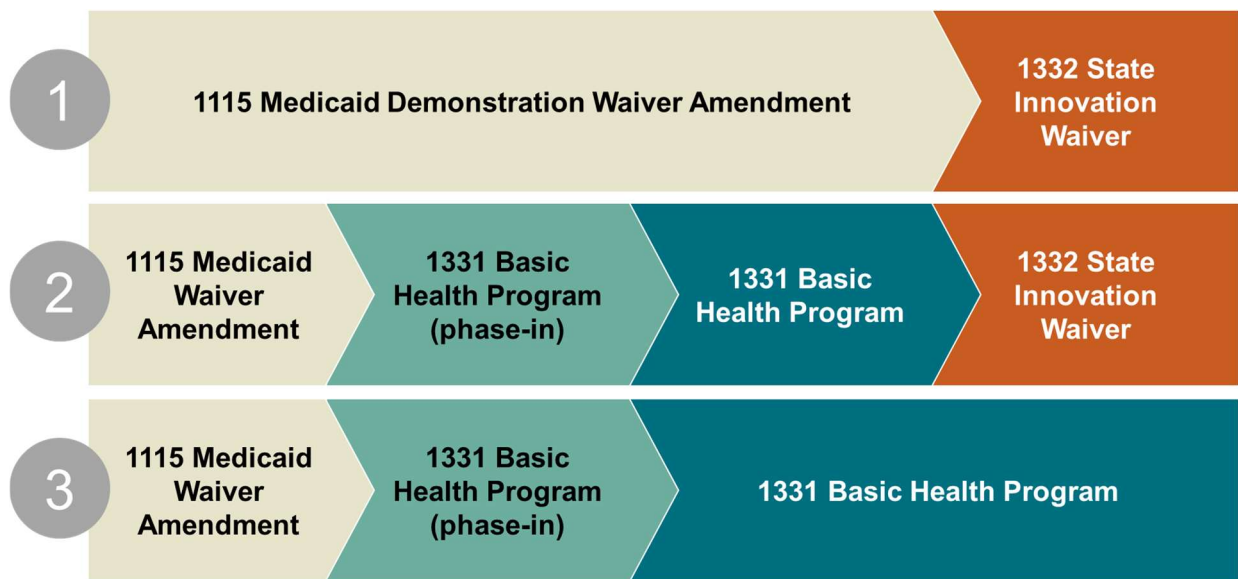
- **An 1115 Medicaid Demonstration waiver.** Section 1115 of the Social Security Act allows states to request approval to waive certain Medicaid program requirements to implement demonstration projects to improve their programs (Centers for Medicare and Medicaid Services, n.d.).
- **A Section 1331 Basic Health Program.** Section 1331 of the ACA allows states to create a program that offers Medicaid-like coverage to people earning less than 200 percent of the FPL 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 ACA 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 percent 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 differ with respect to approval and implementation timelines, impacts to the ACA individual Marketplace, and degrees of uncertainty of federal approval. Appendix A contains further information about these differences.

The Task Force initially explored **three pathways** (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 seeks federal approval for a 1332 waiver to create the Bridge Program;
2. a short-term 1115 waiver amendment while the state seeks federal approval to use a 1331 Basic Health Program 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 plans on the Marketplace; and
3. a short-term 1115 waiver amendment that would preserve OHP coverage for adults whose income is above OHP limits but below 200 percent FPL while the state seeks federal approval for a 1331 Basic Health Program to serve as the permanent federal authority for Oregon’s Bridge Program.

Exhibit F: Federal Pathways to Create the Bridge Program



Source: Oregon Department of Consumer and Business Services

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 HB 4035 due to much higher state funding

requirements under this waiver authority. Accordingly, 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 was, by comparison, a straightforward approach. One drawback to a 1331 program 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 ACA 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.

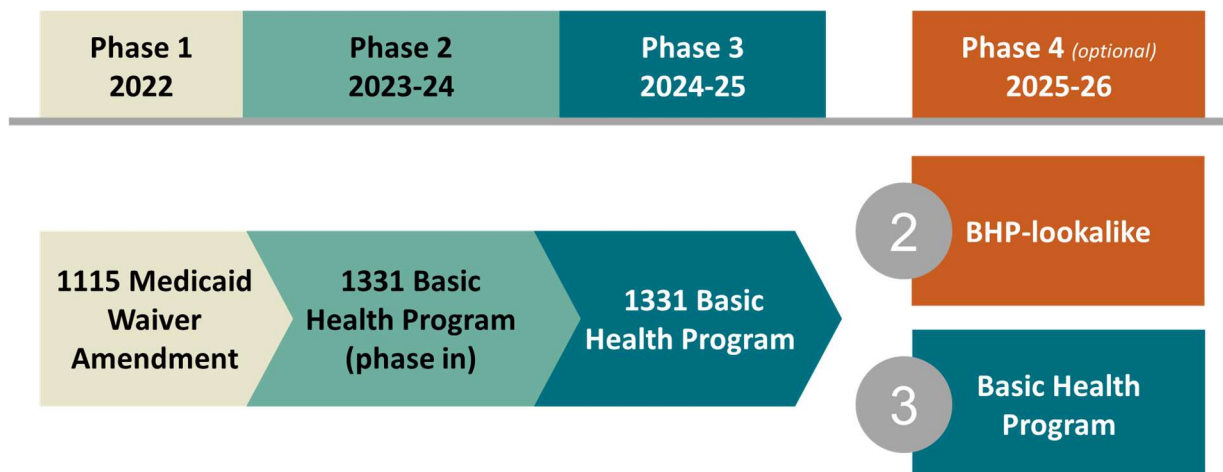
CMS advised that the most straightforward path would be for Oregon to pursue a phased approach to creating the Bridge Program using a 1331 Basic Health Program (see Exhibit G). In the immediate term (Phase One), Oregon would request a Section 1115 waiver to maintain coverage for people at 138-200 percent FPL who are enrolled in Medicaid and will lose coverage when the PHE expires.

In Phase Two, the state would submit a Section 1331 Blueprint to implement a BHP and, once approved, transition the Phase One Medicaid waiver population into the BHP.

In Phase Three, the state would transition to full implementation of the BHP, enrolling people between 138-200 percent FPL who are uninsured or currently enrolled in the Marketplace to the BHP in addition to the individuals who will lose OHP eligibility.

The state could then further explore the use of a Section 1332 waiver for a Phase Four to give enrollees a choice of coverage through the BHP or Marketplace subsidies. The implementation of a Section 1332 waiver to offer this choice requires a state-based Marketplace (SBM). OHA has indicated a goal of transitioning to a SBM by 2025, with recognition that this process will involve other parties such as the Legislative Assembly and the State Chief Information Officer.

Exhibit G. CMS Guidance on Pathway and Phases of Program Implementation



Source: Oregon Department of Consumer and Business Services

The CMS phases provided a framework for the Task Force’s remaining work. The Task Force narrowed its subsequent discussions and recommendations to 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 Three. The Task Force left open the possibility of recommending the state explore a 1332 waiver and BHP-lookalike program in Phase Four, with recognition that this will require additional evaluation of effects to Oregon’s Marketplace.

Recommendations related to the 1331 Basic Health Program form the basis for this report on program design. The Task Force will make additional recommendations related to strategies to mitigate Marketplace impacts of a BHP in December 2022, which may include consideration of a narrow amendment to the state’s 1332 waiver for reinsurance as a mitigation strategy to address the discontinuation of most “silver loading” (described further on p. 30).

III. CONSIDERATIONS FOR DESIGNING THE PROGRAM

Section 1331 of the ACA allows states to request federal approval to create a 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;
- citizens or lawfully present non-citizens with incomes between 138 and 200 percent of FPL who do not qualify for Medicaid or CHIP;
- lawfully present non-citizens with incomes below 138 percent FPL who do not qualify for Medicaid;
- not eligible for other minimum essential coverage, such as affordable employer sponsored insurance; and
- 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 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, which are the responsibility of the state.

To receive federal approval for a BHP, states must submit a 1331 Blueprint application to the 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 its BHP in 2024.

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

Benefit Design

The Task Force considered two primary aspects of benefit design to address the requirements of HB 4035 and provide guidance on the federal BHP application. These include covered services and enrollee cost sharing.

Covered Services. HB 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 EHBs required (as a minimum) in 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; and
- pediatric care, including oral and vision care

In each state, EHBs are more specifically defined by reference to a “benchmark plan” that outlines the covered services and restrictions within the EHB categories for a given plan year. The benchmark plan is established through a DCBS rulemaking process and subject to CMS approval. Oregon’s Marketplace 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 OHP. HB 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 Task Force discussions.

The Task Force reviewed a comparison of the EHB and OHP covered service packages presented by OHA at the July 26th meeting. The detailed comparison is provided in Appendix B. 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 (LTSS) 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 (as described below) or health related services (HRS)² that CCOs may provide.

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

- adult dental care;
- non-emergent medical transportation (NEMT); and
- bariatric surgery.

Additionally, pharmacy benefits vary between OHP and the EHB benchmark. There are four tiered formularies (with varying levels of cost sharing) within the Marketplace and a single open formulary for OHP. Pharmacy rebates are also often available for Medicaid prescription drug coverage are not available for either Marketplace plans or BHP coverage. This difference 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.

² Health related services are defined in OAR 410-141-3500(37) as non-covered services under Oregon’s Medicaid state plan intended to improve care delivery and overall member and community health and well-being.

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 cost of durable medical equipment 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 percent covers 95 percent of the average costs of its members’ care, while the members pay, on average, the remaining 5 percent 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 60 percent;
- **silver** plans, with an AV of 70 percent;
- **gold** plans, with an AV of 80 percent;
- **cost-sharing reduction (CSR) plans**, with an AV of 94 percent; and
- **catastrophic** plans, with lower premiums but higher deductibles and OOP costs than other Qualified Health Plans (QHPs) on the Marketplace. These plans are only available to people age 30 and younger, or who qualify for hardship or affordability exemptions.

In contrast, OHP coverage has an AV of 100% and 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.).

HB 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 (1) an option for no cost sharing or OOP

costs and (2) 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

Source: Legislative Policy and Research Office

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

- **Minnesota’s BHP**, “MinnesotaCare,” originally a state-funded program in 1992 that transitioned to a BHP in 2015. Most MinnesotaCare enrollees pay a monthly premium based on family income. Most enrollees 21 years of age and older also have cost sharing for covered services, including:
 - \$75 copay for emergency department 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 copay per inpatient hospital admission;
 - \$100 copay for ambulatory surgery;
 - \$25 copay for eyeglasses;
 - \$25 (brand) or \$7 (generic and some brand) co-pays 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; and
 - 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 of the FPL have cost sharing for 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. HB 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 introduce **barriers to health insurance coverage**. This can occur when:

- people decline to enroll due to cost barriers (i.e., lower “uptake”);
- people enroll in a plan that is never “effectuated” (activated as coverage) because they do not pay the first months’ premium; or
- 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 \$10³ 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, OHP 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 Standard⁴ 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

³ 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)

⁴ Prior to Oregon’s expansion of Medicaid in 2014 under the Patient Protection and Affordable Care Act, OHP offered a limited benefit (OHP Standard) for adults not eligible for traditional Medicaid. The OHP Standard and Plus benefit packages were consolidated as a part of Oregon’s Medicaid expansion.

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).

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 copays into OHP; they assessed enrollees’ self-reported unmet care needs in the months before and after OHP copays 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 was 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, used only if necessary to ensure program creation or sustainability. Generally, if cost sharing was later determined to be necessary, Task Force members preferred a sliding scale premium tied to enrollees’ monthly income, paired with navigation support for enrollees during coverage transitions. The Task Force wanted further analysis of projected BHP enrollee demographics and microsimulation of enrollee behavior under various cost-sharing scenarios to inform finalization of its cost-sharing recommendation.

Plan Administration, Rates, and Provider Reimbursements

Section 1331 Blueprints provide broad flexibility in how states may administer BHPs, offering options that 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 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 New York’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 QHP 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 New York, 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 the state’s MCOs.

HB 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, HB 4035 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 measure 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 C). The program would be offered by CCOs and broadly align to OHA’s existing procurement process and cycle for OHP. Program implementation would occur according to **phases outlined by CMS**, including:

- **Phase One**, beginning when the PHE expires and extending until federal approval is secured for the 1331 BHP. During this phase, existing OHP members earning between 138-200 percent 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 Two** would begin when federal approval is secured, and relevant infrastructure is operable and end no later than December 31, 2024 (if the PHE is not renewed beyond the end of 2022). During this period, existing OHP enrollees who are eligible for BHP would transition coverage on a rolling basis as they undergo eligibility redeterminations.
- **Phase Three**, 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 Four** was proposed by CMS as an optional phase that could begin one to two years after the creation of Oregon’s BHP if the state transitioned to a state-based Marketplace platform. In Phase Four, 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 (AI/AN) beneficiaries ([ORS 414.631](#)). With HB 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 required consideration. OHA has requested federal waiver approval to create a Medicaid eligibility group for AI/AN individuals to preserve “open card” OHP coverage for this group after the PHE ends and the BHP is created.

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, types, and geographic distribution of providers to ensure members 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.” HB 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 the July 26, 2022, 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 percent 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 percent 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, generally pay provider reimbursements at higher levels than Medicaid. One concern from Task Force 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. HB 4035 also does not address (and the Task Force did not discuss) whether CCO-contracted providers may be required to accept BHP patients, which may affect CCOs’ ability to meet network adequacy requirements.

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.). These direct payments from OHA to providers are not reimbursed from CCOs’ global budgets or reflected in CCO capitation rates for OHP members.

Under existing rules, an enrollee’s status as an OHP member determines whether FQHCs are eligible for cost-based reimbursement for their care. When the PHE ends, FQHCs will no longer be able to bill OHA for wraparound payments for the care of OHP members who transition to BHP coverage. Task Force members raised significant concern that this would result in a decrease in reimbursements for providers. This change is not directly related to the creation of a BHP, but the Task Force desired that Oregon’s Bridge Program be designed in a manner that does not result in lower reimbursements to safety net providers than they would have earned for care of OHP members.

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 percent 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 used publicly available data and focused on **a subset of the BHP-eligible population**, including:

- Approximately 21,300 people who earn between 138-200 percent of the FPL and are uninsured; and
- Approximately 32,500 people earning 138-200 percent 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 (which OHA has estimated at approximately 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 included. 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. Estimated costs did not consider plan administration expenses or the cost of CCO services other than EHBs and adult dental (such as health related services).
- 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 percent; the number of Oregonians gaining coverage would likely be smaller if the program included premiums or cost sharing.

The feasibility study provided initial cost estimates for planning purposes; additional actuarial analysis anticipated in fall 2022 will provide more specific cost estimates based on Task Force program design preferences.

Oregon Health Insurance Survey Findings

At the August 9, 2022, meeting, Oregon Health Authority presented additional information on the population of people currently enrolled in OHP who may be eligible for the BHP. Available data on this population is limited in part by changes in enrollee data collection procedures during the PHE.

Relying on Oregon Health Insurance survey (OHIS) data, OHA provided the following information about **OHP enrollees who may transition to the BHP**:

- Between 2019 and 2021, Oregonians' incomes generally increased relative to the FPL. The number of adults with incomes above 400 percent FPL increased by 26 percent while the share with incomes below 138 percent FPL decreased 25 percent.
- Approximately 140,000 more adults (ages 19 to 64) reported OHP coverage in 2021 compared to 2019, with most of these adults reporting incomes above 138 percent FPL. Of this group, approximately 45,000 reported incomes between 138-200 percent FPL (i.e., the income band corresponding to BHP eligibility).
- People who would transition to BHP from OHP may be younger, on average, than the cohort of commercially insured and uninsured adults in the feasibility study. The percentage of people age 19-44 was 52 percent in the feasibility study cohort compared to 63 percent in the OHIS sample of people reporting OHP coverage.
- Among people reporting OHP coverage in 2021, race, ethnicity, and urbanicity were similar for people earning 138-200 percent FPL and those earning less than 138 percent FPL.

Further analysis beyond the feasibility study and OHIS analysis will be needed to support the Task Force's work, including:

- Actuarial analysis of revenues and costs for people enrolled in OHP who would be eligible for the BHP, and
- Analysis of enrollment and premium impacts for those earning more than 200 percent FPL who would remain in the Marketplace (see "Market Impacts" below).

Data acquisition to support these analyses was underway at the time of this report.

Market Impacts of Creating a BHP

HB 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**:

1. how the creation of a BHP may impact the overall "morbidity" (or burden of poor health) of people remaining in the Marketplace; and
2. the potential effects of carriers largely 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 used publicly available data to determine that morbidity is roughly equal between the BHP study population and remaining individual market population, meaning that transitioning the study population from the Marketplace “risk pool” to the BHP was not projected to significantly change the average morbidity of the remaining pool of people who would continue to buy coverage in the Marketplace. A data request issued by DCBS in summer 2022 will provide more detailed data to update this preliminary finding in the final report.

Discontinuation of Silver Loading. The second market stabilization issue the Task Force has started to discuss is “silver loading.” Silver loading is a practice implemented in most states in 2017 as the preferred approach 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 silver tier plans, including the second lowest cost silver plan (SLCSP) that serves as the benchmark for calculating individuals’ APTC in the Marketplace. Silver loading boosts the value of APTC for most people who buy a plan other than the benchmark plan. Silver loading is most beneficial to people who buy bronze or gold plans since these plans become cheaper in relation to the silver benchmark plan. With silver loading, bronze plans are sometimes free (after APTC) and gold plans are sometimes cheaper than silver plans.

The creation of a BHP is anticipated to eliminate most silver loading, leading to a reduction in the premium value of the benchmark plan for consumers who remain in the Marketplace. This change was anticipated to reduce APTC 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 percent of people in bronze plans (n=48,665) and 80 percent of people in gold plans (n=20,127) reported incomes above 200 percent 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

Metal Level	N	Federal Poverty Level									
		<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-oeep-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 most 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 and create a new gold benchmark, which could give subsidized consumers roughly the same purchasing power as they had with silver loading depending on how gold plans are priced.

These approaches were being explored with CMS at the time of this report. No state has received a 1332 waiver for these purposes, though Colorado recently became the first state to secure CMS approval of a 1332 waiver to recapture federal savings as “pass-through funding” for a state premium reduction program other than a reinsurance program (Centers for Medicare and Medicaid Services, 2022).

Tribal Consultation

HB 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.

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 One of the Bridge Program.
- notification of the Bridge Program more broadly; and
- 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 OHA 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 and CCO Feedback

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 August 30, 2022, the Task Force has heard from over 20 individuals, representing providers, insurers, CCOs, consumer advocates, and potential BHP enrollees (see Appendix F).

A consumer listening session was scheduled for July 21, 2022, to invite community feedback and testimony on program design. However, due to low registration, the event was postponed to ensure adequate time for planning, 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 12, 2022, to solicit input and answer questions about the BHP. The meeting generated a wide range of questions about operational details. OHA staff determined that follow-up and ongoing engagement would be beneficial for discussion and planned 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 could pose implementation challenges for CCOs and required further exploration prior to program launch. These included:

- Consideration of CCOs' and OHA's infrastructure and whether it supported the collection of 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 financial reporting requirements may align or differ from OHP at launch and over time.
- 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, including changes related to 1) enrollment and disenrollment procedures, 2) case management, 3) appeals and grievances, 4) governance, 5) network development, 6) provider contracting, and 7) reporting requirements.
- Need for educational materials for members and providers.

OHA staff and a representative from the Task Force also joined the Health Insurance Marketplace Advisory Committee meeting on July 21, 2022, 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 13, 2022.

IV. PRELIMINARY RECOMMENDATIONS

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



Source: Legislative Policy and Research Office

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 one of the state's 1115 Medicaid waivers to request temporary authority to maintain enrollees' OHP coverage under that waiver if the PHE expired prior to the launch of a BHP. The 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 in October. Thus, the timeline for reinitiating OHP eligibility redeterminations was unknown.

At the July 12, 2022 meeting, the Task Force discussed the timeline to develop its recommendations for designing the Bridge Program given the PHE extensions. The preliminary feasibility analysis conducted in May 2022 suggested Oregon may be able to implement the Bridge Program in alignment with the vision outlined in HB 4035.

There were **several important considerations** that the feasibility analysis did not account for 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 not part of the Manatt feasibility analysis but further analysis by OHA was slated for presentation later in 2022.
- **Federal policy change** extending the enhanced APTC authorized in the American Rescue Plan Act. Congress renewed the APTC enhancements in the Inflation Reduction Act as this report was being finalized. The federal formula for BHP funding ties program revenue to the value of APTC, and these enhancements were anticipated to temporarily increase the revenue Oregon would receive for a BHP. This change did not affect the end date of the PHE.

This additional 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 D) 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 HB 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 uninsured Oregonians.
- The program would continue coverage of an estimated 55,000 Oregonians currently insured through OHP. The phased implementation would streamline coverage transitions between OHP and BHP and reduce the risk of future churn for people earning less than 200 percent FPL who lose OHP eligibility.
- 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 as more information becomes available.

Exhibit K: Recommendations to create Oregon’s Bridge Program

Federal Pathway

1. Oregon’s Bridge Program should be established through a Section 1331 Basic Health Program Blueprint, as recommended by CMS.
2. The Bridge 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 Three implementation by 2025. The implementation timeline should also seek to harmonize program launch with CCO rate filing and DCBS rate review timelines.
3. OHA and DCBS should continue to explore with CMS the option to create a BHP-like product under Section 1332 waiver authority in Phase Four, which could enable Oregon to offer enrollees “optionality,” or a choice between the Bridge Program and retaining federal Marketplace tax credits to purchase subsidized Marketplace coverage.

Program and Plan Administration

4. To promote continuous coverage for Oregonians, CCOs should be required to accept enrollees to the program in the phased implementation manner outlined in this report, including transitioning eligible consumers from OHP in Phase Two using the state’s existing CCO infrastructure, and accepting eligible consumers not enrolled in OHP in Phase Three. 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. BHP enrollment and coverage transition processes should complement existing CCO infrastructure and navigation support systems.
5. Beginning in Phase Three, eligible consumers who are not transitioning from OHP should be able to enroll in the program through Oregon’s Marketplace platform. OHA should achieve this either by requesting modification of the federal Healthcare.gov platform or through a state operated platform, depending on the platform used by Oregon’s Marketplace at that time.
6. OHA should align contracting and implementation processes for the Bridge Program to existing OHP approaches and timelines to minimize CCO administrative burden to operate the program. To promote consistency with, and

enhancement of, the CCO delivery system, OHA should continue to engage CCOs as the program is developed, including creating publicly posted opportunities for CCO leadership engagement.

7. OHA should establish capitation rates that enable CCOs to pay providers at levels higher than OHP, based on preliminary analysis suggesting the program may have a surplus after offering enrollees the CCO covered service package with no enrollee cost sharing and minimal cost to the state budget.
8. Oregon's BHP should provide adequate reimbursements for safety net providers that enable them to serve BHP enrollees in a manner that ensures care continuity for BHP enrollees coming from OHP. OHA should develop a mechanism to achieve this goal that is consistent with Oregon's broader goals for value-based care and that takes into consideration the value of PPS wraparound payments to providers (such as FQHCs and CCBHCs) that care for OHP enrollees who would transition to BHP. This mechanism should be in place by Phase Two, when eligible OHP enrollees transition to BHP, to provide continuity from safety net providers' existing reimbursement arrangements.

Benefit Design

9. The Bridge Program should be designed to fully align to the CCO service package for OHP, including adult dental coverage and all essential health benefits, based on preliminary analysis.
10. The program should be offered to enrollees at no cost, including no monthly premiums and no out-of-pocket costs to access services, based on preliminary analysis.
11. To minimize administrative complexity and enhance the CCO delivery system, Oregon's 1331 Basic Health Program should request waiver of the federal requirement to offer at least two BHP plans to eligible consumers.

The Task Force advanced these recommendations based on the following **fiscal assumptions**, which may change as additional information becomes available.

- **The proposed Bridge Program design maximizes federal financial participation under a Section 1331 BHP.** 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 or the risk of bearing the cost of higher than anticipated enrollment.
- **It will be necessary for Oregon to allocate state funding for certain elements of a BHP.** By federal law, Oregon cannot rely on federal funds to finance the cost of administering the BHP, or the cost of abortion services that are required to be covered by health plans under Oregon law.

- **Preliminary actuarial analysis indicates the proposed design would not require other state funding or enrollee cost sharing to be financially feasible.** These assumptions require further actuarial analysis anticipated in October 2022. The Task Force will update recommendations if subsequent actuarial analysis differs from initial revenue or cost estimates.
- **The proposed design 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.** Congress authorized a 3-year extension of these tax credit enhancements in August 2022 as this report was being finalized. This information will be incorporated in budget discussions in the fall and is expected to temporarily increase federal revenue for the program.

Next Steps

At the time of this report, the federal PHE declaration remained in effect. The future end date of the PHE and the related timeline for Oregon’s redeterminations process were unknown. Like other states, Oregon is proceeding with planning for the PHE unwinding despite this uncertainty.

HB 4035 requires the Task Force to submit a second report no later than December 31, 2022, with recommendations to alleviate disruptions to coverage for individuals and small employers following the creation of the Bridge Program. These recommendations will address in greater detail the market impacts described in section III, including the potential effect on premium affordability for people earning more than 200 percent FPL who would remain in the Marketplace following the creation of the program.

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



Source: Legislative Policy and Research Office

Additional meetings are planned through fall 2022 in support of the Task Force’s remaining work (see Exhibit L). These meetings will include presentation of additional actuarial analysis for the BHP-eligible population and the Marketplace population earning more than 200 percent FPL, as well as microsimulation analysis of Marketplace

enrollment patterns following discontinuation of silver loading. The Task Force will further discuss the potential mitigation options introduced in section III.

As noted above, the Task Force will also revisit the preliminary recommendations in this report as it considers additional information in the fall. In addition to reviewing new actuarial analysis for the BHP program, the Task Force requested to continue discussion of several topics started before finalization of this report, including: 1) potential incorporation of health related services; 2) possible application of the Supporting Health for All through Reinvestment (SHARE) initiative; 3) consumer engagement planning; and 4) BHP provider reimbursements and participation requirements.

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APPENDIX A: QUESTIONS AND ANSWERS

This reference document is a running list of questions submitted or posed by members of the Joint Task Force on the Bridge Health Care Program (Task Force). LPRO staff compiled the responses from information available as of August 19th, 2022. We thank Oregon Health Authority (OHA) and Department of Consumer and Business Services (DCBS) staff for their assistance. The document was updated several times and expected to be revised as the Task Force continued its work. Newer versions may be available with subsequent meeting materials posted at <https://olis.oregonlegislature.gov/liz/202111/Committees/JTBHCP/Overview>.

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 (ACS) ([available at https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256015](https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256015)).

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 Basic Health Program (BHP) are adults ages 18 to 64 who earn less than 200 percent of the federal poverty level (FPL) and who are eligible for premium tax credits but who are not eligible for Medicaid. This population includes lawfully present immigrants who earn less than 138 percent FPL but who are ineligible for Medicaid because they have resided in the United States for fewer than five years. The slides ([available at https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256015](https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256015)) contain ACS estimates of the demographic profile of the population 138-200 percent FPL who are not covered under other public insurance. Oregon Health Authority provided additional estimates from the Oregon Health Insurance Survey on August 9, 2022 ([available at https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256494](https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256494)).

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 Oregon Health Plan (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 Basic Health Program. Manatt estimated 32,500 people currently covered through the Health Insurance Marketplace (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 Coordinated Care Organization (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 (available at <https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256015>) 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 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: 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.

Table 1. Plan Selection by Metal Tier, 2022

Metal Level	N	Federal Poverty Level									Other or Unknown
		<100%	≥100% to ≤138%	≥100% to ≤150%	>150% to ≤200%	>200% to ≤250%	>250% to ≤300%	>300% to ≤400%	>400% to ≤500%	>500%	
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: 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 Affordable Care Act (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 five-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 five-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 percent FPL. Certain non-citizens who have not met the five-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 BHPs, 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 (available at <https://www.medicaid.gov/basic-health-program/index.html>). 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 Centers for Medicare and Medicaid Services (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 percent FPL where Medicaid eligibility ends without creating a new coverage cliff at 200 percent FPL where BHP eligibility ends. While there is reason to believe people at 138 percent FPL experience more frequent income fluctuations than people at 200 percent 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 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 BHP 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 work group to advise on this process as required by House Bill 4035 (2022) (HB 4035). This group will provide ongoing support and guidance to OHA on these topics; information about their work is available at <https://www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx>. OHA provided a report to the Legislature (available at <https://www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx>) 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. HB 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 advised 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 Section 1331 BHP 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 Section 1331 BHP for people earning less than 200 percent FPL preclude the state from pursuing a separate 1332 waiver for people earning more than 200 percent 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 July 12, 2022, meeting and can be found in the slide deck (available at

<https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256185>).

OHA and DCBS are working to finalize the specific parameters for additional analysis over the next four 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, ODHS, 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 BHP and a 1332 waiver. The federal funding formula for a 1331 BHP 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 BHP, 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 percent 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 (<https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204>) simulating Medicaid churn from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling 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 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/>) 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.

Q: Which of the Task Force's recommendations need approval from the Legislature? Does Oregon Health Authority need approval from the Legislature to establish the BHP?

A: Prior to submitting a Blueprint request to CMS, OHA must receive approval from the Oregon Health Policy Board as required in Section 5(1). No explicit legislative approval is necessary to establish the bridge program, as Section 5(2)(a) allows OHA to implement the Program after receiving approval from CMS. Legislative action to support implementation of the Program is contemplated by Section 5(2)(b), which requires OHA to submit a report outlining any federal approval received and the implementation plan for the Program along with any necessary legislative changes. A bill supporting implementation of the Program is planned.

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 26, 2022, Task Force meeting (available at <https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256313>). 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 (see <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>). 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 ACA extends Hyde Amendment exclusions to programs federally funded under the ACA, 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 percent 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 people (1) 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 (available at <https://www.sciencedirect.com/science/article/abs/pii/S0167629614000642>) 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 (available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00345>) estimated that eliminating Marketplace premiums would increase enrollment by 14.1 percent in 2019.

In 2003, the Oregon Health Plan (OHP) implemented new premiums and coverage restrictions following premium-nonpayment due to state budget deficits; research on the impact of these changes (available at https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2005_jul_impact_of_changes_to_premiums_cost_sharing_and_benefits_on_adult_medicaid_beneficiaries_results_f_wright_impact_changes_premiums_medicaid_oregon_pdf.pdf) 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 (available at <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>) finding that co-pays in Medicaid and Children's Health Insurance Program 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: Will BHP members be eligible for Long-Term Services and Supports (LTSS)? Will the reduction in the number of OHP enrollees following redetermination reduce funding the state receives for LTSS?

A: Federal law and House Bill 4035 do not require that Oregon include LTSS in covered services for the BHP. There is also no prohibition on the use of BHP funds for these services. States *are* required to provide LTSS to Medicaid enrollees in specific circumstances. OHA presentations to the Task Force to date have assumed a covered service package that is aligned to the CCO covered service package for OHP. This package does not include LTSS, which are provided to OHP enrollees through the Oregon Department of Human Services (DHS) and not through CCOs.

Unrelated to the BHP, Oregon operates a program called Oregon Project Independence (OPI) that provides home and community-based services (HCBS) to older adults who are lower income but not eligible for Medicaid. Oregon has submitted a request for a Section 1115 waiver to expand OPI eligibility to adults 18 and older who earn up to 400 percent FPL (see <https://www.medicaid.gov/medicaid/section-1115->

[demonstrations/downloads/or-1115s-projectindependence-application-pa.pdf](#)). This population includes adults who may also be eligible for the BHP. This waiver request was pending CMS review as of August 16, 2022.

The impact of the PHE unwinding on Oregon’s receipt of federal funding for LTSS is unclear and will depend on whether significant numbers of OHP enrollees receiving LTSS have experienced income or other changes that affect their OHP eligibility. Broadly, people receiving LTSS may be less likely than other OHP enrollees to lose coverage during the post-PHE redetermination process, though it is not possible to precisely estimate the effect redetermination will have on federal funding the state receives for LTSS.

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.

Table 2. BHP Plan Design in New York and Minnesota

	NY Essential Plan (135 – 150% FPL) (1)	NY Essential Plan (151 – 200% FPL) (1)	Minnesota Care (2)
Preventive Care	\$0	\$0	
Nonpreventive Care			\$25 (behavioral 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, Speech, and 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

Source: (1) <https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20At%20a%20Glance%20Card%20-%20English.pdf>. (2) <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4858A-ENG>

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 clearer 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 (available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01747>) 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 (see <https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care>).

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 percent of FQHC revenue while Section 330 grants accounted for 18 percent (see <https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/#:~:text=Section%20330%20of%20the%20Public%20Health%20Service%20Act,appropriation%20and%20the%20Community%20Health%20Center%20Fund%2028CHCF%29>). 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 (see <https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Page-Update.pdf>). 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 (see <https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-FQHC-RHC.aspx>).

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 (see <https://www.kff.org/policy-watch/community-health-centers-taking-actions-prepare-for-unwinding-public-health-emergency/>). Oregon Primary Care Association has estimated that FQHCs provide care to one in six OHP members (see <https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/255963>). 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.

Q: Will CCOs be allowed and incentivized to provide Health Related Services (HRS) for BHP members? Will CCOs be subject to SHARE Initiative requirements for profits derived from their BHP plans?

A: Health Related Services are non-covered services offered as a supplement to CCO OHP benefits ([OAR 410-141-3500](#)) and provide a funding mechanism for CCOs to address social determinants of health through their “global budgets.” The SHARE initiative is a requirement for CCOs to reinvest a portion of any net income in services to address social determinants of health and equity, including housing-related services and supports. A comparison of these services is available here.

Neither HRS nor SHARE are required to be included in the BHP under HB 4035 or federal law. There is also no prohibition on the use of federal BHP funds for these services. At the July 26, 2022, meeting, OHA noted that CCOs are encouraged to support HRS but they are not an explicit covered service category. Analysis of the potential BHP covered service package have not assumed the inclusion of HRS or SHARE in the BHP.

Appendix B: Covered Services Comparison

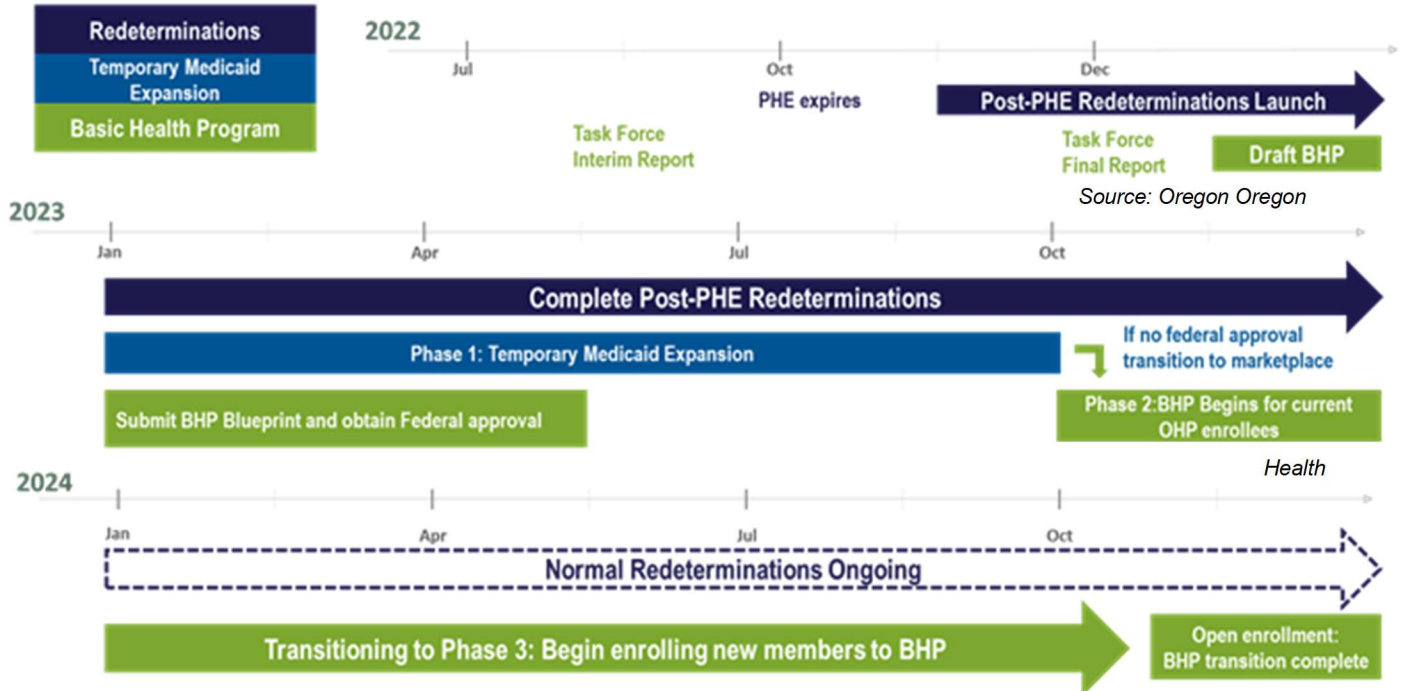
Covered Services Comparison - State EHB Benchmark and CCO	
<p>Notes:</p> <ul style="list-style-type: none"> • Focus of the analysis is the CCO covered services and not OHP more broadly, which includes fee-for-service covered services. • Unless noted, assume no quantitative limit on services. • Children's 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 EQUIPMENT	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.
PROSTHETIC 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 C: Proposed Timeline for Implementing a BHP

*Dates are approximations based on 7/15/22 federal PHE declaration and may change with subsequent PHE renewals and/or CMS or HHS direction.



Authority presentation to the Joint Task Force on the Bridge Health Care Program, July 26, 2022. Available at <https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/256312>

Appendix D: Plan Design Survey for Contingency Planning

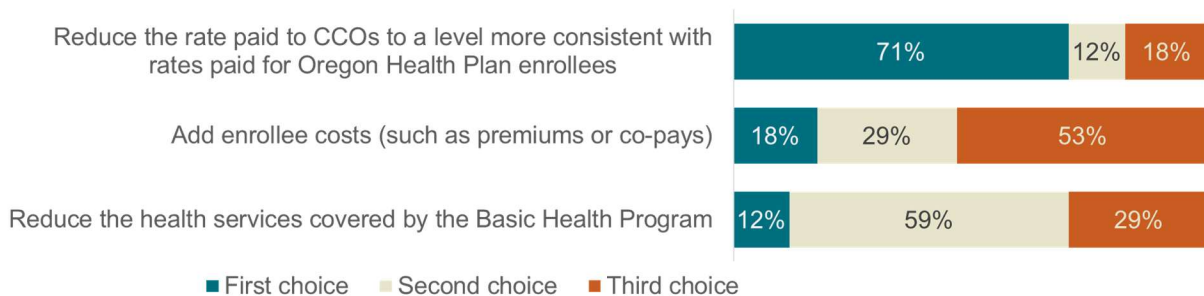
The Task Force developed its preliminary recommendations based on the program revenue and cost information available as of August 9, 2022. Discussions included consideration of alternate scenarios if subsequent analysis indicates projected program funding or costs are different than estimates provided 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.⁵ 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 26, 2022, 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

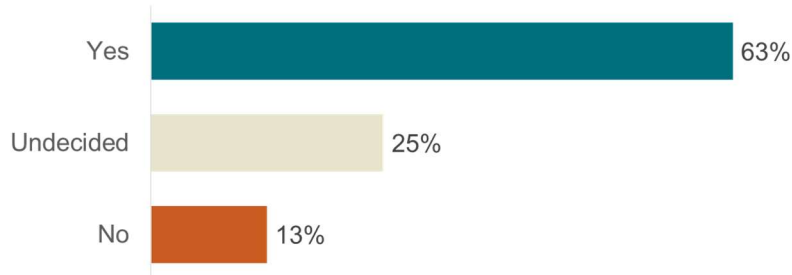


Members were asked to indicate if they would support the creation of the program if federal funding did not support capitation rates to CCOs that were higher than capitation rates paid for OHP members (see Exhibit 2). Roughly two thirds of Task Force

⁵ 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.

members (65 percent) indicated support for the program under this scenario, while one third were undecided (24 percent) or opposed (12 percent).

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

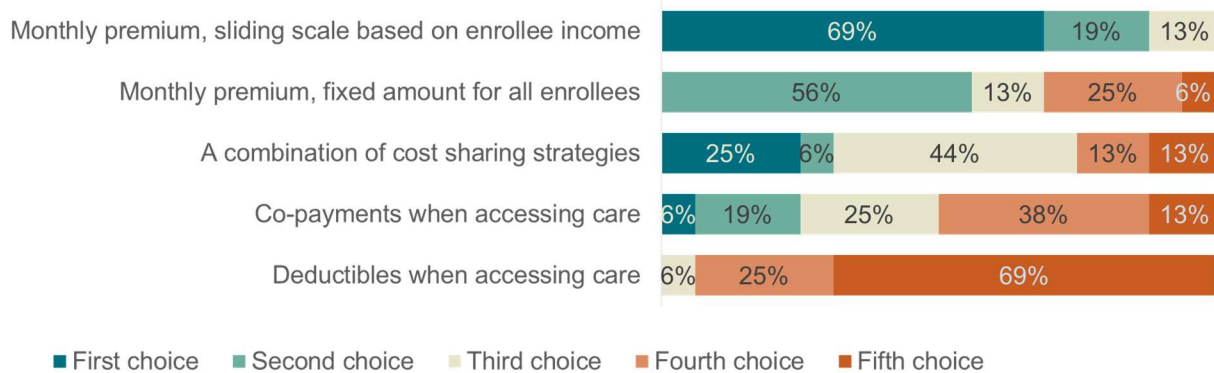


Members offered several comments along with these responses, including:

- 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); and
- that an OHP capitation rate was preferable to unreimbursed or charity care for people without coverage (n=1).

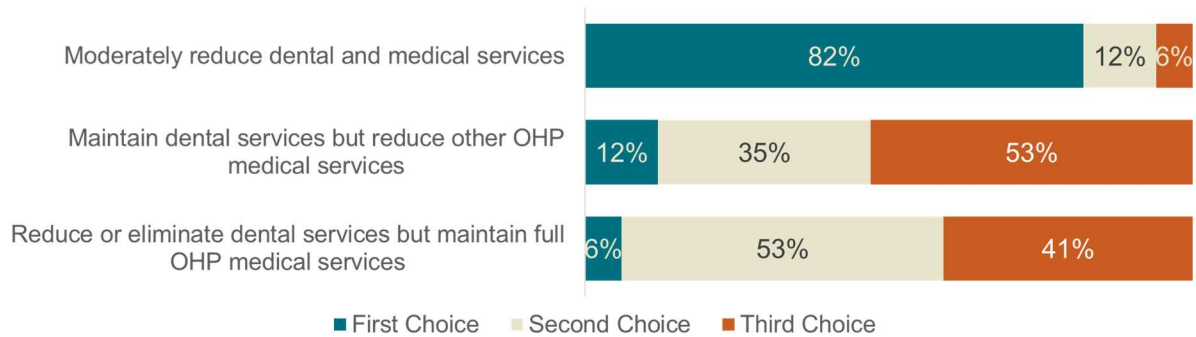
While the survey indicated a preference to avoid introduction of enrollee cost sharing or reduction in services, members were asked to indicate preferences if this design choice was necessary. Results indicated that if it was necessary to add enrollee cost sharing to the program design, the preferred 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. Members also noted concerns that CCOs and OHA do not currently collect premiums or co-pays for OHP, and the feasibility of new infrastructure to do so for BHP was a concern. Members preferred that if cost sharing was a necessary element of program design, that OHA rather than CCOs administer this element of the program.

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 percent) 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 percent) or dental services (6 percent) 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 E: Key Terms and Acronyms

Acronym	Term	Definition
AV	Actuarial Value	<i>Also see metal tiers.</i> 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 percent covers, on average, 80 percent of costs for enrollees in that plan (though costs for individual enrollees may be higher or lower).
APTC	Advance Premium Tax Credit	<i>Also see PTC.</i> 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 percent of the Federal Poverty Level who are not eligible for Medicaid but are eligible for subsidies to purchase coverage on the Marketplace.
	BHP-like	<i>Also see BHP.</i> 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 HB 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	<i>Also see Rates and Reimbursements.</i> 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 percent per year.
	Cost sharing	<i>Also see OOP.</i> 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	<i>Also see Cost sharing, Silver Loading.</i> Additional financial assistance available to individuals with incomes <250 percent 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	<i>Also see HIM.</i> An alternative term for the health insurance Marketplace, a platform for purchasing health insurance.
FFM / FFE	Federally Facilitated Marketplace / Federally Facilitated Exchange	<i>Also see HIM.</i> A Marketplace platform, Healthcare.gov, that is managed by the federal government.
HIM	Health insurance marketplace or marketplace	<i>Also see SBM, SBM-FP.</i> 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	<i>Also see Risk pool, Silver Load, CSR.</i> 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	<i>Also see OHP.</i> 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	<i>Also see Risk pool.</i> 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. <i>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.</i>
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 percent increase to the base funding formula that was established when the federal government discontinued paying Cost Sharing Reductions (<i>also see CSRs above</i>). 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 aggregate 6.5 percent. ^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	<i>Also see HIM.</i> A marketplace platform managed and operated by a state rather than the federal government.
SBM-FP	State Based Marketplace – Federal Platform	<i>Also see SBM, FFM / FFE.</i> 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	<i>Also see cost-sharing reductions.</i> 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 F: Public Comment

The Joint Task Force on the Bridge Health Care Program accepted written public comment on an ongoing basis. The Task Force also held time for public testimony at each meeting following its first meeting on April 26th, 2022.

This appendix contains all written comment submitted by members of the public through August 30, 2022.

April 25, 2022

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

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

On behalf of Oregon's 62 community hospitals and the patients they serve, the Oregon Association of Hospitals and Health Systems (OAHS) appreciated the process for development of House Bill 4035, and we look forward to continuing that conversation as the Joint Task Force on the Bridge Health Care Program carries out its legislative directives. As we have stated previously, this policy discussion is ultimately about ensuring access to health care for those Oregonians who need it most during this transition out of the emergency phase of the pandemic. The discussion should be focused on how to help this group of people in the short term and how to create stability for them moving forward.

We encourage the Task Force to continue a collaborative approach with robust stakeholder input beyond the members of the Task Force as the recommendations for a new bridge program take shape. As a starting point, we highlight the following considerations:

- 1. We maintain that the bridge program should be a temporary solution.** The immediate goal is to ease the transition for individuals who are no longer eligible for the Oregon Health Plan following redeterminations at the end of the federally declared Public Health Emergency. Longer term, the goal should be to transition those individuals to appropriate marketplace or employer-based plans or other currently existing and funded programs. We recognize the affordability challenges some individuals face even when eligible for marketplace subsidies and cost sharing reductions. These challenges are complex and call for a different conversation around understanding and addressing underlying cost drivers – such as in the health care cost growth target program. The recommendations regarding the bridge program must be developed within the context of these overarching policy goals.
- 2. Provider payments must be sufficient to ensure adequate access to care for enrollees in the bridge program.** If the program is not financially sustainable for providers, provider networks could be disrupted, which could result in care gaps and health inequities for the bridge population at a minimum. Further, hospitals across Oregon remain financially and operationally fragile as the impact of the pandemic lingers, and the road to recovery will be long. Adding more cost burdens to the financial pressure hospitals are already facing puts their ability to care for their communities at even greater risk.
- 3. Oversight and accountability over the state financial impact of the program are critical.** OHA stated in "[Oregon's COVID-19 Plan – Resilience in Support of Equity \(RISE\)](#)" that the bridge program will "Be fully funded by the federal government (if approved). The plan would come at no additional cost to Oregon's budget" (p. 23). Any potential need for additional state funds should be part of any proposals presented to the Task Force and stakeholders and should be monitored closely as negotiations with federal regulators unfold. Further, any

assumed state budget savings should stay within the Oregon Health Plan and other programs that are designed to provide health insurance coverage for Oregonians.

- 4. The bridge program should not prevent individuals from enrolling in or continuing marketplace coverage.** Again, we submit that the bridge program should minimize disruptions in coverage and care, serving as a safety net for those in need as the system then navigates them to a more permanent solution. We caution against creating a program that ultimately increases fragmentation in the health insurance continuum and makes navigating the system more complex for consumers.

We look forward to continuing this discussion as we all work together toward uninterrupted coverage and care for the 1.4 million Oregonians currently enrolled in the Oregon Health Plan.

Thank you,



Sean Kolmer
Senior Vice President of Policy and Strategy
Oregon Association of Hospitals and Health Systems



May 5, 2022

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

Delivered electronically.

Co-Chairs Steiner Hayward and Prusak:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in four states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We appreciated the conversation beginning the work of the Task Force on April 26. It is clear that the Task Force shoulders a consequential responsibility impacting the health care of many Oregonians. The Task Force will need timely and useful data in order to inform the decisions it will need to decide in the coming weeks. To that end, we have prepared a non-exhaustive list of questions and data inquiries that the Task Force may need in order to proceed with its legislative charge:

1. More specific information on the number of Oregonians that could lose Oregon Health Plan coverage when the redetermination process begins in earnest, and within that population which Oregonians would be eligible to opt out of a basic health program. This number should reflect what happens if the Congress re-authorizes the enhanced advance premium tax credits enacted under the American Rescue Plan Act.¹
2. If known, the number of Oregonians not covered by any insurance who would be prompted (or encouraged) to enroll in a basic health program.
3. Among Oregonians who purchase insurance through the Oregon Health Insurance Exchange, the numbers of eligible people that would be moved to a basic health

¹ Pub. L. 117-2, 135 Stat. 4.

program, who may elect to enroll in a basic health program, and when all eligible people could move to a basic health program.

4. Any data or information that indicates that among the commercially insured, who cannot reasonably utilize their benefits, and the predominant reasons why benefits go unused.
5. Any aggregated, anonymized statistics on consumer complaints related to premiums or cost sharing. *Note:* these do not need to be confirmed complaints.
6. Any data or information that estimates the costs of uncompensated care to providers and systems. In addition, if known any data or information that would indicate any broader economic losses that may be connected to un-insurance or under-insurance.

In addition to data we believe would be beneficial in making recommendations, we would also ask the Task Force to focus on a few key areas of program design in the coming weeks:

1. Among the other states who operate or who are contemplating basic health programs, how is enrollment effectuated in the basic health program? Does enrollment proceed in a manner more familiar to Medicaid, or to commercial insurance? Would enrollment be completed on a continuous basis, or on a plan year? Are there any barriers Oregon would face in adopting another state model to be administered through coordinated care organizations?
2. The nature and extent of cost sharing under a BHP, and whether the other states that have implemented or who are contemplating a basic health plan also instituted cost sharing. Modest cost sharing appears to be a component of other state basic health plans, though cost sharing is wholly outside of the coordinated care organization model and not actionable within the given timeline.
3. To what extent plan design and implementation follows the Oregon Health Plan, or commercial health benefit plans. Each choice contains risks and opportunities.
4. A detailed implementation timeline – the level of plan complexity and deviation from the current models of health care coverage could complicate (or simplify) implementation of a basic health plan in the given timeline.

Thank you for taking our thoughts into consideration. We look forward to a more fulsome discussion concerning these ideas at future Task Force meetings.

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations



May 10, 2022

From: Coalition for a Healthy Oregon
To: Joint Task Force On the Bridge Health Care Program
Subject: **CCO Principles for a Successful Bridge Health Care Program**

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

House Bill 4035, enacted in the 2022 Legislative Session, raises the exciting possibility of improving health coverage and continuity of care for Oregonians with a focus on reducing the uninsured rate and achieving health equity. The language of HB 4035, the legislative record, and public statements from Oregon Health Authority clearly specify this new benefit ought to build upon the Oregon Integrated and Coordinated Health Care Delivery System, i.e., coordinated care organizations (CCOs). **The seven CCOs in Coalition for a Healthy Oregon (COHO) call your attention to following policy considerations.** We request these principles be incorporated in your proposal pursuant to Section 4 of the bill.

Center the Member Experience

- 1) Use current CCOs to maintain continuity of care**—It is critically important to expand enrollment within existing CCOs rather than create a new layer/silo of health care delivery. Existing CCOs have relationships with members, providers, and community stakeholders; there are robust systems in place to ensure quality and accountability.
- 2) Benefit package should be as close to Oregon Health Plan as possible**—Members will lose trust in the system if they do not understand why they can no longer access services they rely upon.
- 3) Movement from CCO to Bridge Program should not be disruptive for members or providers.**
- 4) Maximize flexibilities for CCO outreach**—This includes outreach to current CCO members, as well as providers and community-based organizations (CBOs) on the redetermination process and the move to the new Bridge Program.

Ensure Provider Participation

5) Capitation based funding—Budgeting on a per-person (capitated) basis encourages the adoption of value-based payments, which aligns with state policy goals.

6) Provider rates should be high enough to sustain the network—A robust provider network is critical protect patient access and choice as well as to support providers from the BIPOC community and other marginalized communities.

7) Additional administrative burden should be minimized.

Leverage The Successful, Local Model

8) Use the CCO model as a basis for plan requirements—This includes local governance, care coordination, Social Determinants of Health and Equity programs, and quality measures, including incentive metrics.

9) Ensure budget neutrality to the state General Fund by maximizing federal funds and existing infrastructure.

10) Provide flexibility and assistance for existing CCOs to meet any new capital reserves or other requirements for offering the Bridge Health Care Program—This is especially needed for CCOs not currently enrolled as health plans on the exchange.

Thank you for your dedication to this important work. We offer our assistance if you have any questions or policy considerations for our experts to review.

Sincerely,

Advanced Health
AllCare Health
Cascade Health Alliance, LLC
InterCommunity Health Network CCO
Trillium Community Health Plan
Umpqua Health Alliance
Yamhill Community Care

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 10, 2022

Re: Bridge Health Care Program Goals and Pathways

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

We write to offer comment on the Goals and Pathways for the Bridge Health Care Program, regarding the health care exchanges and choice of waiver for the establishment of a Bridge Program. OPCA believes that the Bridge Plan is not merely a temporary fix; rather, it is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity. Oregon's community health centers serve a large percentage of the target demographic for this plan; an estimated 41,542 people who accessed care at a health center in 2020 fell between 138% – 200% of FPL. Community health centers are for everybody. Their doors are open to anyone regardless of ability to pay, immigration status, or if a person has health insurance.

Exchanges:

- OPCA supports a Bridge Plan administered within the CCO network; approximately 29%¹ of Oregonians were insured through OHP in 2021, including a large percentage of the target demographic. While we look forward to the shift to a State-Based Marketplace in the future, housing the Bridge Plan in the CCO network will meet the urgent needs of the target population.
- Based on community health center patient population data, OPCA believes that a majority of the Bridge Plan target population is at risk for disenrollment from Medicaid due to redetermination – if the Bridge Plan were managed within the CCO network, this would enhance a smooth transition of coverage and allow for many to maintain continuity of care.
- There should be no wrong pathway to health insurance coverage – Oregonians must have access to information about their options no matter their point of entry, whether that is in the CCO network, the marketplace, or elsewhere.

Waiver Options:

- OPCA supports exploring the use of a 1332 waiver application process to establish a Bridge Plan. While the 1331 waiver option does provide a clear template for a potential plan and may allow for a faster approval process, it would limit enrollee choices in coverage and may prove inflexible to provide for the needs of Oregon's innovative health care system in the future.
- Pursuing the 1332 waiver would preserve Oregonians' autonomy of choice between the Bridge Plan and other marketplace options and would lessen destabilizing effects on the marketplace as fewer eligible Oregonians may be siphoned from the marketplace.
- The 1332 waiver would be malleable to future needs in Oregon and OPCA strongly believes that it would create a short-term plan and pave the way to meet long-term needs in health insurance access.

¹ [255315 \(oregonlegislature.gov\)](https://legislature.oregon.gov/bills/2022/255315)



May 10, 2022

Bridge Plan Task Force Members

RE: 5/10 Joint Task Force on the Bridge Health Care Program Meeting to Discuss Goals & Pathways

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments as the Bridge Plan Task Force (BPTF) discusses the goals and the possible waiver pathways for the Bridge Plan. We appreciate the opportunity to weigh in and share our perspective based on our experience in other states also working to ensure their residents have access to high-quality, affordable health care.

United States of Care is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We work in states across the country to develop pragmatic policy solutions that meet the needs of people and have been engaged in efforts to advance and implement public health insurance options, as well as other efforts to expand access to coverage and improve affordability. United States of Care is unique in its commitment to advancing policies that are designed to respond to the needs of people. We have seen through [our research](#) that the high cost of care is the biggest issue of concern to people, even when you consider varying demographics, geography, and ideologies. The high cost of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. In Oregon, that is no different, and the Bridge Plan provides people with an immediate solution while paving a path for other reforms down the road.

Building on Oregon's History as a Health Care Innovator

Oregon's efforts to address health equity, reduce disparities, and ensure every Oregonian has access to quality, affordable coverage are commendable. Now, Oregon has the opportunity to not only maintain the coverage and affordability gains made over the last few years but to build on those even further. We know that about one-third of individuals who leave Medicaid return within a year, and because that churn won't go away, the Bridge Plan provides a needed safeguard and coverage for populations that may otherwise fall through the cracks. However, the Bridge Plan should not be seen only as a temporary solution for people who churn between Medicaid, the Marketplace, and being uninsured. Instead, the Bridge Plan should be seen as a necessary step now and for promoting continuous coverage for all Oregonians long-term. While the focus of the Bridge Plan is to provide coverage for those with incomes between 138-200% of the federal poverty level (FPL), it is important for the BPTF to recognize

that this is also an important stepping stone for creating additional coverage programs, such as a public health insurance option, that help even more people.

Key Waiver Pathway Considerations

The Bridge Plan builds on Oregon’s history as a pioneer in health care innovation through bold initiatives. The BPTF is charged with making a recommendation to state agencies on the best waiver pathway that maximizes federal funds and minimizes costs to the state and enrollees, and **we believe the 1332 state innovation waiver meets those goals while also creating a long-term solution that helps even more Oregonians.** The BPTF should seek a 1332 waiver to allow for further expansion to eventually meet the needs of all Oregonians struggling to afford high-quality, affordable health care.

The waiver pathway for Oregon’s Bridge Plan should allow for the appropriate flexibility to create a coverage program that best fits the needs of the Bridge Plan population, while also providing a future allowing for a pathway to expand coverage to additional Oregonians through a [public health insurance option](#) in the future. The BPTF should consider the benefits and limitations of the different types of federal waivers on these other long-term needs as they are developing their proposal and related recommendations for the Bridge Plan. We also encourage the BPTF to consider whether to seek approval for multiple waivers in tandem, which can allow for flexibility to cover additional populations in the future and can better support streamlined enrollment across coverage programs.

Specific aspects of waivers the BPTF should take into account as they deliberate the appropriate waiver pathway are outlined below.

- **1332 State Innovation Waiver:** Leveraging a 1332 waiver would design the most flexible option for expanding eligibility for coverage for people with incomes beyond 200% FPL through a public health insurance option. A 1332 waiver would also present the state with more flexibility to leverage pass-through funding to invest in other state coverage programs, as 100% of the funding the state would receive for premium tax credits without a waiver is reinvested in funding programs that meet the needs of the state’s population. We believe 1332 waivers bring great opportunity and potential, and that Oregon can learn from the experiences of [Nevada](#) and [Colorado](#), who have used 1332 waivers to expand coverage and improve affordability for their residents.
 - In addition to preserving Oregonians’ choices when it comes to their coverage and care, ensuring that Marketplace plans remain an option for the population eligible for the Bridge Plan will **lessen the destabilizing effects on the Marketplace.** Instead of separating all Oregonians up to 200% of the federal poverty level from the Marketplace, as would occur under a basic health program (1331 waiver), that population will have private Marketplace plan options available to them under a 1332 state innovation waiver.

- **1331 Basic Health Program:** Creating a Basic Health Program (BHP) under Section 1331 of the ACA may mean Oregon receives less federal funding or has federal limitations to cover future additional populations, beyond those with incomes between 138-200% FPL, through a public health insurance option. Under a BHP, states only receive 95% of the premium tax credit amount that the state would have gotten without a waiver. In addition, individuals deemed eligible to enroll in Basic Health Program coverage are not permitted to enroll in qualified health plans in the Marketplace, so the BHP creates a separate risk pool, which may have implications for the Marketplace risk pool.
- **1115 Medicaid Demonstration Waiver:** 1115 waivers primarily focus on providing additional flexibility for states to design and improve their Medicaid programs. Oregon currently operates its Medicaid program through an 1115 waiver, which implemented the [Coordinated Care Organization](#) (CCO) community-based infrastructure for the Oregon Health Plan. An 1115 waiver on its own would likely not provide the flexibility to align innovative waiver provisions to support expanded access to care across coverage programs and markets.

We strongly believe that the development of the Bridge Plan will continue making progress toward Oregon's goals of developing a low-cost, high-quality plan and will position Oregon to continue to be a national leader in health reform. Overall, we applaud the Task Force for its commitment to ensuring continuity of coverage and affordability for all Oregonians through the design of the Bridge Plan. As you continue to develop the policy in HB 4035 and weigh the various considerations, please consider the team at United States of Care a resource, and if you have any questions regarding these comments, please don't hesitate to reach out.

Sincerely,

Liz Hagan
Director of Policy Solutions
ehagan@usofcare.org

Caitlin Westerson
State External Affairs and Partnerships Director
cwesterson@usofcare.org

Rachel Bonesteel
Policy Manager
rbonesteel@usofcare.org

Dear Members of the Task Force and Policymakers,

Thank you for working hard every day to lower the cost of health care for Oregonians. I am here to support a long-term bridge plan for people in Oregon.

I live in Portland, Oregon and I have spent my career working in the emergency department as an Emergency Medicine doctor. I am here to support healthcare for the folks in Oregon who struggle to get and keep coverage.

Delayed treatment means worsening of outcomes and much more expensive treatments. We know how this works. This past Monday, I saw a patient with a pressure ulcer to bone. If he had come in three days earlier, he would have been able to take an antibiotic and use a topical ointment to control the infection. But he waited because he didn't have health insurance. The infection progressed so rapidly, he will now require a great deal of care. Unfortunately, this case is not an anomaly.

As a physician, I see every day how the high cost of unaffordable health care is the single most common barrier to medical care, individual well-being and public health. High health care costs force people to delay care and put their well-being, even their lives, at risk. So many people simply can't afford to get the early, sustained and coordinated care that can improve their health and even save their lives.

High insurance premiums that keep increasing every year, expensive prescription drugs that keep increasing every year, out-of-pocket costs that keep increasing every year all add up for Oregon families struggling simply to make ends meet. For these reasons, I urge policymakers to create a low-cost, high quality and long-term bridge plan that covers as many people as possible, improves health and helps save lives.

Thank you,

Chris Bugas,
Emergency Medicine Physician



May 10, 2022

TO: Bridge Plan Task Force
FR: Maribeth Guarino, Health Care Advocate, Oregon State Public Interest Research Group (OSPIRG)
RE: Goals & Pathways for a Bridge Plan

OSPIRG is a consumer advocacy group with members across the state working towards a healthier, safer world for all of us. We have been a proponent of health policy solutions that work to lower costs for Oregonians, including the Medicaid churn population, for years. We continue to support the creation of this bridge plan and urge the task force to think carefully about the decision in front of them in terms of where the bridge plan will be housed and which waiver or waivers will be most appropriate to make this plan successful.

The bridge plan is not just a program to help with redetermination; redetermination is the opportunity to implement a long-term solution that helps individuals and families with unsteady incomes that churn in and out of Medicaid to maintain insurance coverage throughout the year. As pointed out by OHA in the first task force meeting, about $\frac{1}{3}$ of individuals who leave Medicaid will return within a year. As long as income restricts eligibility, that churn is not going to go away because income is not fixed for everyone, but this bridge plan can be there to make sure that those folks don't lose health insurance coverage every 6-12 months before they re-qualify for Medicaid.

To that end, the bridge plan needs to be a lasting program with a smooth transition of coverage. Keeping people with their CCOs will keep Oregonians with their providers and systems they are familiar with. It will also cut down on administrative costs in moving patients to private plans, and reduce confusion for consumers, so we're glad to see CCOs at the forefront of the conversation about where to house the bridge plan.

The waiver conversation also needs to be thought about in the long-term..

In discussions around HB 4035 which created this task force, a big concern for consumer advocates was the restrictions placed on consumer choice by a 1331 waiver. As has been discussed by the task force, optionality is limited except with a 1332 waiver. Limited eligibility would create a greater impact on the private market and restrict consumer choice by drawing individuals off of the Marketplace, which is not the goal for this bridge plan and could prevent individuals from choosing plans that work best for them and their families - including choosing coverage for prescription drugs, treatments, specialists, or other medical needs.

A 1332, on the other hand, will draw less people from the Marketplace and lessen any destabilizing effects on it by allowing those individuals to stay there. The target population for the bridge plan is not in the Marketplace - they are currently either uninsured or covered by Medicaid, and we should be aware of how the waiver options affect each of those populations.

The bridge plan is intended to provide an option for health insurance that smooths transitions and fills gaps. It is not intended to replace, exclude, or prevent access to other insurance options. Yes, we have to move quickly with redetermination timelines, but again, this is not a short-term program or a bandaid. We need to build a lasting program that fits in the bigger picture of the Oregon health care system. A 1332 provides more flexibility for consumer choice as well as more stability for the private Marketplace, its risk pool and its costs. It also provides the most flexibility in plan design and enrollment, which means it can fit in more easily with OHP as well as dovetail better with future health policy considerations, such as transitioning to a state-based marketplace, implementing an expanded public option plan, and the work of the universal health care task force which is considering single-payer options.

In our view, a 1332 waiver provides the best path forward to a successful bridge plan program in a way that lets us continue to rise to the challenge of health care innovation in Oregon. In my own experience, very little in health care policy and innovation has been easy, but this is a relatively unique situation we're in as a nation and as a state, so I urge you as task force members to be creative as you make these decisions, and I thank you all for your time and commitment, and the opportunity to speak with you today.

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 24, 2022

Re: Bridge Health Care Program: Plan Design, Part 1

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

We write to offer comment on the first part of the Plan Design for the Bridge Health Care Program, keeping in mind that an estimated **41,000 patients** served by Community Health Centers in Oregon **fall within the target demographic of 138%-200%** of the Federal Poverty Line (FPL). Community Health Center patients must be prioritized in this planning process.

Benefits and Coverage:

- At minimum, benefits must equal those offered within OHP Essential Health Benefits (EHB) to ensure continuity of care for those transitioning from OHP to a bridge health plan.
- Additionally, OPCA supports routine oral and behavioral health care, services for adults outside EHB coverage. Data show that many adults are not accessing preventative oral or behavioral health care due to prohibitive costs. In the interest of health equity, including these benefits is vital¹.

Enrollee Costs:

- OPCA believes the ideal model is no-cost for enrollees wherein there are no premiums, copays, coinsurance or deductibles.
- However, OPCA recognizes the Task Force may recommend consumers bear some cost burden. In that scenario, we would continue to advocate for **no coinsurance or deductible** and **no copays for preventative care**. Cost-sharing could apply to low copays for non-preventative services and low, sliding-scale premiums.
- Premiums, if implemented, should begin at a threshold above the 138% minimum and follow a sliding scale based on income. Minnesota implemented a cost-sharing plan with their MinnesotaCare basic health plan; enrollees pay no premiums up to 160% FPL, at which point a sliding scale is implemented starting at \$4 and ending at \$28 when enrollees are at 200% FPL. Oregon could implement a similar model, adjusted for potential population differences².
 - Reduced cost-sharing for MinnesotaCare did not result in significant fluctuation in private or marketplace plan enrollment; rather, the primary result was a substantial decrease in the uninsured population³.

¹ [OHA Public Option Implementation Report](#)

² [MNCare Premiums](#)

³ [MN Insurance Uptake Rates](#)

- Cost significantly inhibits access to health insurance and priority populations are disproportionately represented in the uninsured population¹. Reducing costs of health insurance is necessary to promote Oregon's health equity goals.

Reimbursement:

- Reimbursement should occur at a rate higher than OHP and should utilize a Value-Based Pay model that adjusts for race, ethnicity, and other social determinants of health.
 - Failure to adjust for race, ethnicity, and other social determinants of health disadvantages those populations and those who serve them.
- Community Health Centers are the primary, oral, and behavioral health care access point for the target demographic, as evidenced by the 41,000 patients between 138-200% FPL served by CHCs. To continue to provide equitable access to services and recognize the complex and unique needs of this population due to social determinants of health, OPCA supports an enhanced reimbursement rate valuation for Community Health Centers (CHC).



To: Co-Chairs Senator Steiner Hayward, Representative Prusak
Vice Chairs Senator Kennemer and Representative Hayden
Members of the Bridge Health Care Program Task Force

From: Oregon Dental Association

Date: May 24, 2022

Re: Inclusion of Dental Benefits in the Bridge Program

The Oregon Dental Association (ODA) represents over 2,100 practicing dentists across all corners of the state. Our members are committed to improving access to dental care and were pleased that House Bill 4035 included language stating that dental benefits should be included in the Bridge Program, “to the extent practicable”. We are pleased that the Task Force has dedicated meeting time to discussing the issue.

Further, ODA was very encouraged to hear Mr. Vandehey’s, Oregon Health Authority, comments at the first meeting, stating that the intent is to include a dental package similar to what is available to adult participants in the Oregon Health Plan (OHP) today.

The Oregon Health Plan offers comprehensive dental coverage, from regular cleanings to fillings, extractions, dentures, crowns, and emergency care. The ODA agrees that the Bridge Program should seek to match this coverage at minimum to provide continuity of care for patients.

Good dental care is a critical piece of overall health. As this Task Force well knows, an untreated dental issue can quickly devolve into significant and costly health issues like, heart disease, cancer or diabetes. Untreated oral pain is also high driver of unnecessary emergency department visits.

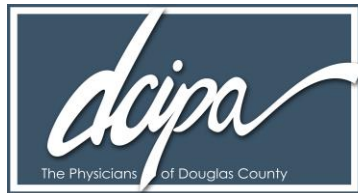
ODA also appreciates Mr. Vandehey’s comments during the first meeting related to provider reimbursement. Participation in OHP provider panels is often hampered due to low reimbursement rates. Dental offices are particularly vulnerable to low reimbursement rates due to high overhead and equipment costs, and we know that low Medicaid reimbursement directly causes dentists to limit the number of Medicaid patients they see. Ensuring a robust— higher than Medicaid—reimbursement structure will enable stronger provider participation and increase access to care to those most in need.

We are very concerned that the 2022 EHB “Oregon Benchmark Plan” included in meeting materials does not include full adult dental benefits. It is not yet clear how these materials will guide the discussion, or if they are meant to be used as a base for the Bridge Program. If that is the case, the ODA urges the committee to expand on the EHB and include dental benefits for all Bridge Program participants, regardless of age, and also include strong reimbursement rates for dental providers that participate in the Bridge Program. A person cannot live a healthy life if they cannot access basic adult oral healthcare.

Sincerely,

A handwritten signature in black ink, appearing to read "Calie Roa", with a long horizontal line extending to the right.

Dr. Calie Roa, ODA President



June 21, 2022

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

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

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

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

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

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

CC:

Courtni Dresser

courtni@theoma.org

Sabrina Riggs

sabrina@daltonadvocacy.com



July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

Respectfully,



William Olson
Chief Executive Officer
Providence Health & Services – Oregon



Don Antonucci
Chief Executive Officer
Providence Health Plan

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 12, 2022

Re: Bridge Health Care Program Marketplace Impact

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

We write to offer comment on the Bridge Health Care Program. OPCA believes that the Bridge Plan is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health. Racial inequities are a fundamental root cause of health disparities, including unequal access to health insurance coverage – during the Public Health Emergency (PHE), Black and African American Oregonians experienced an unprecedented increase in coverage¹. These are upstream health equity gains Oregon cannot afford to lose – systemic disenfranchisement must not be perpetuated by the Bridge Health Program.

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

- Zero out-of-pocket costs for enrollees, as premiums deter enrollment and even small increases in co-pays are correlated with reduced care. Increased cost-sharing of any kind puts a greater burden of cost on individuals with chronic needs who are unlikely to disenroll regardless of cost².
- If cost-sharing is the cost-saving lever chosen by the Task Force, we advocate for sliding scale premiums introduced at a percentage above 138% FPL, zero co-payments for preventative services with minimal co-payments for non-preventative care, and no coinsurance or deductibles.
 - We also encourage Task Force members to articulate protocols around these cost-sharing requirements, such as policies regarding missed premium payments. As cost-sharing would be a significant change for individuals accustomed to OHP, we also advocate for robust education for system navigators as they engage enrollees.
 - Using Minnesota's BHP as a case study, it is important to note that they followed a similar model of cost-sharing. While the BHP reduced uninsurance rates overall, it did not have an equitable impact in all communities – Hispanic and Indigenous Minnesotans experience disproportionately high rates of uninsurance compared to white Minnesotans³. This highlights potential unintended health equity consequences for communities of color if Oregon's Bridge Program includes even minimal cost-sharing.
- Regardless of reimbursement rate, CHCs should receive their PPS wrap payments for this population. As discussed in prior OPCA written and oral testimony as well as in advanced readings, the PHE unwinding will shift many CHC patients off Medicaid, making them PPS ineligible – as many as 10% of CHC patients state-wide⁴. CHCs receive PPS to support uncompensated yet lifesaving services and it is vital that considerations are made to keep CHC programs and services whole.

¹ [Unwinding Federal Public Health Emergency and OHP Continuous Coverage Policies](#)

² [The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF](#)

³ [MN Uninsurance Rates](#)

⁴ [BPTF Questions and Answers](#)

July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

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

Regards,

/s/ Elizabeth Edwards

Elizabeth Edwards
Government Relations Director
Kaiser Permanente Northwest

July 12, 2022

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

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

In developing further recommendations to the legislature, we appreciate that the Task Force is pursuing robust information and thoroughly considering the impact of all available program design options on the population that a new bridge plan would aim to serve. As the Task Force discussions thus far reflect, difficult tradeoffs may be needed to build a program within the confines of the available federal resources as described in HB 4035.

To emphasize our prior comments, one tradeoff that absolutely cannot be made is reducing reimbursement to hospitals, either directly or indirectly. The actuarial analysis of a hypothetical Basic Health Program (BHP) presented at the June 14 Task Force meeting suggested that some federal dollars would be available to raise provider rates above Medicaid. However, even in the best-case scenario with extended ARPA subsidies and elimination of the reinsurance penalty, utilizing the entirety of this surplus to increase provider rates still would not bring them even close to commercial reimbursement levels. Given that a BHP would remove over 30,000 people from the existing commercial market and withhold up to 55,000 others who would be eligible for commercial market subsidies following Medicaid redetermination, this functions as a significant cut to hospital revenue.

Hospitals have come to the rescue time and time again throughout the COVID-19 pandemic, and despite these challenges, have continued to support care for those in need through Medicaid and financial assistance/charity care. Hospitals have also remained engaged in work to reduce the total cost of care. But there is a limit to what costs hospitals can continue to absorb. The latest Oregon Hospital Utilization & Financial Analysis report shows that hospitals in our state are facing their most dire financial circumstances since the start of the pandemic.¹ Ultimately, it is our patients and communities who suffer as the only viable option for some hospitals is to reduce services.²

To protect patient access to hospital services in a hypothetical bridge plan, the Task Force should recommend that health plans meet robust network adequacy requirements and that hospitals have an opportunity to negotiate adequate reimbursement.

While we acknowledge that the Task Force's charge per HB 4035 was specific to the bridge program, we again caution that the conversation around this program cannot occur in a vacuum. We have already articulated examples of unintended consequences that could result from creating a BHP, such as care interruptions and reduced access. Others have since been identified in greater detail, including the likely reduction in "silver loading," which would raise costs for the remaining

¹ *Apprise Health Insights*, June 7, 2022, available at: [Q1 2022 HUFA Report.pdf \(d1o0i0v5q5lp8h.cloudfront.net\)](#).

² See also OAHHS comments to the Cost Growth Target Advisory Committee, June 21, 2022, available at: [OAHHS-Letter-to-CGT-Advisory-Committee-6.21.2022-FINAL.pdf \(oregon.gov\)](#).

consumers in the individual market and create an even larger financial cliff for people just above the income limit for a BHP at 200% FPL.

In addition to these unintended consequences, a new bridge program would impact many other aspects of health reform in Oregon. We previously mentioned the potential impact on the Sustainable Health Care Cost Growth Target program. Other examples include Oregon's next Medicaid waiver, the implementation of Healthier Oregon (formerly Cover All People), and the state budget for the next biennium and beyond. These topics are fundamentally inseparable, and policy discussions about them cannot be siloed.

We support integrating the conversations regarding plan design and the impact of a bridge program on the marketplace and continuing those conversations through the fall. We further urge the Task Force to advise the legislature that the Task Force's recommendations regarding a bridge program should be considered alongside the many other health care reform initiatives currently underway as part of a larger policy discussion in the 2023 legislative session. An extension of the federal Public Health Emergency means that a bridge program is less urgent than was originally thought. There is time to consider how to optimize access to coverage and care for all Oregonians – along with our overarching goals to contain health care costs and eliminate health inequity – in light of the current challenges facing our health care system.

Meanwhile, OHA, DHS, and DCBS should focus their time and resources on the core aspects of the upcoming Medicaid redeterminations process, which will impact many more people than the subset of 55,000 expected to be served by a new bridge program. Conducting robust outreach and streamlining transitions between CCOs and the marketplace will go much further in the near term to preserve coverage, access, and continuity of care for the redetermination population. We look forward to further discussion with the agencies in support of ensuring continued coverage for this population, and we hope additional transparent conversations about process and planning will continue as this work unfolds.

Thank you for the continued opportunity to engage in this process. We look forward to seeing a draft of the Task Force's recommendations.

Thank you,



Sean Kolmer
Senior Vice President of Policy and Strategy
Oregon Association of Hospitals and Health Systems

July 12th, 2022

Oregon Bridge Plan Taskforce

Re: Bridge Plan Market Impacts, Mitigation Strategies, Industry & Consumer Feedback

Submitted by email: jtbhcp.exhibits@oregonlegislature.gov

Chairs Steiner-Hayward and Prusak, Members of the Taskforce:

I write to you today on behalf of Project Access NOW, a community-based organization providing health and health-related resources to un and underinsured individuals in the Portland area. PANOW serves a number of different communities that will be impacted by the introduction of the Bridge Plan: our Outreach, Enrollment, and Access program assists over 4,000 Medicaid-eligible households per year in applying for Oregon Health Plan, and our Premium Assistance program pays the Federal Marketplace premiums that would otherwise be unaffordable for households that make even \$1 too much to qualify for OHP. These communities make up the “churn” population the Bridge Plan intends to serve.

While the Bridge Plan will cover many underserved folks in Oregon, it certainly won't cover all of them, and as a result, it's critical that the introduction of the Plan not destabilize the insurance market and create additional challenges for the consumer. We believe the following should be considered to maintain stability for the Marketplace and therefore, the consumer:

1. **The Bridge Plan must allow individuals the option to purchase private coverage if eligible.** Individuals who qualify for the Bridge Plan should continue to be able to purchase a private insurance plan through the Marketplace, if they so choose. This will minimize destabilization on the Marketplace, allow for more freedom of choice for consumers, and ultimately protect consumers from experiencing the effects of disruption on the market like increased premiums and co-pays, shifting coverage, etc.
2. **The Task Force should consider the ability of smaller CCOs to administer a Bridge Plan.** Many CCOs do not currently administer commercial benefits and do not have the infrastructure to collect premiums, process copays, or to collect for

non-payment. If the benefits between OHP and the Bridge are different (likely dental, NEMT, Health-Related Services, and/or THWs), it will be important to consider the impact on smaller CCOs who may be challenged to implement a program that has significant differences from OHP, particularly on a tight timeline.

We are grateful for your work to develop a vision for a more equitable and healthy future for Oregonians and look forward to working with the Task Force to ensure that the best possible version of that future is actualized. Thank you for your consideration.

Best,



Carly Hood-Ronick MPA, MPH
Executive Director



July 12, 2022

Bridge Plan Task Force Members

RE: 7/12 Joint Task Force on the Bridge Health Care Program Meeting - Market Impacts, Mitigation Strategies, and Industry and Consumer Feedback

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments as the Bridge Plan Task Force (BPTF) discusses market impacts, continued review of results of the preliminary actuarial analysis, and plan design. We appreciate the opportunity to weigh in and share our perspective based on our experience in other states also working to ensure their residents have access to high-quality, affordable health care.

United States of Care is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We work in states across the country to develop pragmatic policy solutions that meet the needs of people and have been engaged in efforts to advance and implement public health insurance options, as well as other efforts to expand access to coverage and improve affordability. United States of Care is unique in its commitment to advancing policies that are designed to respond to the needs of people. We have seen through [our research](#) that the high cost of care is the biggest issue of concern to people, even when you consider varying demographics, geography, and ideologies. The high cost of care impacts every part of people's experience with the health care system, from rising premiums to high deductibles and cost-sharing. In Oregon, that is no different, and the Bridge Plan provides people with an immediate solution while paving a path for other reforms down the road.

Market Impacts

We continue to urge the BPTF to consider additional ways to improve affordability for all Oregonians when designing the Bridge Plan. We appreciate that the BPTF has been thoughtful about taking broader and long-term implications into account when making its recommendations and we were excited to hear the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) sharing their ideas for strategies to mitigate the Bridge Plan's impact on the individual market.

We strongly believe that the best path forward is to pursue a combined approach wherein the state applies for a 1331 Basic Health Plan (BHP) and a 1332 innovation waiver, simultaneously. We understand that navigating feedback and direction from the Centers for Medicare and Medicaid Services (CMS) can be challenging, however, a combined approach will allow the state to still pursue a BHP for the Bridge Plan population **and** attempt

to capture federal savings that will be seen in the individual market as a result of reduction in advanced premium tax credits (APTCs). To this end, we were pleased to hear the update at the July 12 BPTF meeting that OHA is exploring options for submitting a narrow 1332 waiver amendment to address these concerns in the individual market and recapture those federal funds to reduce the impact on consumers.

Because the 1331 pathway requires separate risk pools for the BHP population and the Marketplace population, those with incomes between 138-200% of the federal poverty level (FPL) will move from the Marketplace risk pool to the new Bridge Plan risk pool. In Oregon, that means [about 33,000 people](#) would leave the Marketplace and move to the Bridge Plan. We encourage the BPTF to take into account the potential implications of removing these individuals from the individual market, as other states have. [A recent BHP feasibility study](#) in Illinois, for example, predicted that a decline in Marketplace enrollment by 35% would lead to premium increases of 4-6%.

Further, the majority of consumers currently eligible for cost-sharing reduction plans will be removed from the Marketplace and the need for “silver loading” will dramatically decrease, causing a drop in silver-level premiums and related APTCs. While we understand that the total impact this creates on Marketplace premiums depends on a number of factors (and that further actuarial analysis is forthcoming), we also know that without **1332 waiver, the federal government will reap the benefits of Oregon’s state-level policies and the state will not be able to claim and capture these savings in the future.**

A drop in silver-level premiums also results in reducing the purchasing power of APTCs. **If Oregon is able to secure a 1332 waiver, however, and capture the savings from lower premiums, the state would be in a position to reinvest those savings and mitigate any impact on APTC purchasing power.** Fortunately, Oregon is not the first state to grapple with the consequences of reducing premiums in the individual market. Included in the appendix is information about Colorado’s approach to this specific issue.¹

In addition to reducing APTCs as a result of lowering premiums, the enhanced federal subsidies through the American Rescue Plan Act (ARPA) are set to expire at the end of 2022, which, in the face of federal inaction, leaves Oregonians to face up to a [41% increase](#) in their premium prices on the individual market. While the BPTF has a specific focus, **we encourage the task force to be thoughtful about designing a Bridge Plan that isn’t built at the expense of creating other affordability initiatives in the future.** We know this is a complicated endeavor, but we are confident that with the right balance of interconnected policies Oregon can pursue a BHP without doing harm to the remainder of the individual market. We look forward to hearing more information at future BPTF meetings about conversations between OHA and CMS regarding the ability to leverage a 1322 waiver amendment.

¹ The appendix includes regulations from Colorado’s Division of Insurance outlining how the state aligned their “induced demand” factors across all carriers and metal levels with the federal induced demand factors. This move protected people’s purchasing power by slightly raising silver premiums and slightly lowering gold and bronze premiums. The re-pricing of these plans helped mitigate unintended consequences of state policies intended to improve affordability.

We also understand there are barriers to pursuing certain policies without a State-Based Marketplace (SBM), but that there is legislative interest in [pursuing a SBM](#) during the 2023 legislative session, with the platform operational by 2026. The BPTF should also make recommendations with a [future transition to a SBM](#) in mind to tailor eligibility and enrollment practices to the unique needs of Oregonians. Additionally, as the BPTF considers the process for BHP enrollment, continuous enrollment similar to the Oregon Health Plan (OHP) is the most accessible for consumers, as opposed to open enrollment periods that occur in the federal Marketplace.

Plan Design

We appreciate the deliberations of the BPTF members on important considerations in the Bridge Plan design. We strongly believe that the development of the Bridge Plan will continue making progress toward Oregon's goals of developing a low-cost, high-quality plan and will position Oregon to continue to be a national leader in health reform and health equity. Prioritizing access to a robust network of providers through innovative reimbursement strategies, promoting provider and plan participation to support access to care, limiting or eliminating enrollee costs while prioritizing a robust benefits package, and careful consideration of the impacts of the Bridge Plan on the Marketplace will all be critical in establishing the Bridge Plan as a coverage option and lead to better health outcomes for Oregonians.

Plan Design Scenario Planning

We understand that the BPTF has to balance benefits and costs to enrollees with the costs of the program and that variation in federal funding amounts have implications for how generous the program can be. We appreciate the thoughtful discussion at the July 12 meeting focused on plan design scenario planning that involved various proposals related to cost-sharing and benefit design. If federal funding creates limitations, the BPTF should consider whether there is a way to provide certain benefits on a sliding scale based on income. For example, while we urge the BPTF to include more robust benefits in the benefits package, that could be at the expense of no enrollee premiums and/or lower cost sharing due to program costs. Instead, the Bridge Plan could provide optional benefits on a sliding scale so people still have the option to pay to enroll and access these benefits while the broader plan could still be offered to all eligible people without a monthly premium. We look forward to the thoughtful discussion in regard to benefit design that will take place during future BPTF meetings when additional information from the benefit crosswalk can be used to inform the recommendations. However, **we encourage the BPTF to continue to prioritize the implementation of a Bridge Plan with no premium and cost sharing requirements, provide a benefits package that is at least as comprehensive as OHP, and reimburses providers above Medicaid rates.**

Enrollee Costs

As we outlined in [previous comments](#) to the BPTF, **we recommend that the Bridge Plan eliminate premiums and cost-sharing for individuals** covered under the plan. From a [recent poll](#), we learned that overall cost, including expensive premiums, is a top concern for

Oregonians and we ask the BPTF to prioritize eliminating any premium and cost-sharing requirements under the Bridge Plan. We encourage the BPTF to look to states like Minnesota and New York, that have prioritized affordable coverage for this population, including no premiums or deductibles in [New York's program](#). Zero-dollar premium plans have been shown to increase enrollment of low-income Marketplace enrollees by [14.1 %](#). We also know [even low premiums](#) impact people gaining and keeping coverage. The increased cost burden of making the transition to higher-cost Marketplace coverage may result in some Oregonians choosing to forgo coverage, and these coverage gaps [can lead to](#) delays or lapses in care, higher costs for services, and poorer health outcomes.

The Bridge Plan should include a **comprehensive benefit package**. We encourage the BPTF to prioritize coverage of certain high-value services, including preventive, primary, and behavioral health care services with no cost-sharing in the Bridge Plan design. The COVID-19 pandemic has exacerbated the existing mental health crisis, and Oregonians [continue to report](#) barriers to accessing mental health care, forcing many to forgo care due to high costs. Increasing access to key health care services [can help reduce](#) unnecessary hospital admissions and emergency room utilization, and [improve overall health](#). Focusing specifically on providing coverage with no or minimal cost-sharing for preventive and primary care services where there are gaps in access and utilization for communities of color can also improve racial and ethnic health disparities. For example, the Bridge Plan can be designed with a focus on [chronic disease management services](#) to address issues like heart disease, hypertension, and diabetes, which [disproportionately affect](#) Black and Hispanic communities.

United States of Care appreciates the BPTF's consideration to include dental benefits in the Bridge Plan benefit package, as oral health is closely linked to overall health and well-being. In addition, it has the potential to [reduce](#) overall health spending and [health disparities](#). For example, low-income adults in Oregon are the most likely to [repeatedly visit](#) the emergency department for non-emergent dental care, and are at [increased risk](#) for poor oral health. Oregon provides [extensive](#) dental benefits to OHP beneficiaries [including](#) annual cleanings, fillings, extractions, and more. **The Bridge Plan should provide, at a minimum, the same dental benefits for Bridge Plan enrollees that it does current OHP enrollees** to ensure consistent coverage and prevent further inequities. Additionally, we encourage the BPTF to require Coordinated Care Organizations (CCOs) to contract with Dental Care Organizations, [as is required under OHP](#), to ensure dental benefits are offered to Bridge Plan enrollees.

Provider Reimbursement

As the BPTF identifies key plan design elements to promote the goals of the Bridge Plan, it is important to develop adequate provider reimbursement levels so this population continues to have access to necessary services as they transition to the Bridge Plan. We acknowledge that the BPTF has to balance reimbursement rate setting with the costs of the program and that variation in federal funding amounts have implications for how generous the program can be. If federal funding creates limitations, we ask the BPTF to prioritize the establishment of reimbursement rates that promote access to participating providers. If feasible, **we ask the BPTF to set provider reimbursement rates higher than OHP, and to explore**

value-based payment model options that take into account social drivers of health and address unique patient needs.

Support for providers serving vulnerable populations. We ask the BPTF to support essential community providers that serve as critical care access points for this population. We also encourage the BPTF to look towards the experiences of other states for examples of how to establish sustainable reimbursement rates that promote access to providers that support traditionally underserved populations. For example, under the [Colorado Option](#) set to be implemented in 2023, certain providers, including essential access hospitals, critical access hospitals, specialty pediatric hospitals, and hospitals that serve a high percentage of Medicaid and Medicare patients, will receive higher reimbursement rates under the Colorado Option. Additionally, under [Nevada's Public Option](#), reimbursement rates for certain safety net providers, including federally qualified health centers and community behavioral health providers, will be prioritized to promote access for covered individuals.

According to the Oregon Primary Care Association, federally qualified health centers (FQHCs) provide care to [one in six](#) OHP members. At the end of the public health emergency (PHE), FQHCs will no longer be able to be reimbursed by OHA for the individuals who roll off of Medicaid coverage. We appreciate the BPTF's consideration to replicate the wraparound payment model used in OHP for the Bridge Plan. This will ensure that consumers continue to be able to access the care that they need and support reimbursement continuity for FQHCs for those individuals who transition from OHP to the Bridge Plan. This is critically important, as in general, Medicaid reimburses providers at lower rates than the commercial market.

Advancing equity through provider incentives. We recommend that the BPTF consider additional strategies to promote equitable access to services through provider incentives. We encourage the BPTF to look to other states, such as Colorado, which has included certain requirements in its implementation of the Colorado Option, including the development of [culturally responsive provider networks](#), intending to build a network of providers that can better [validate, understand, and affirm](#) the different cultures of a diverse population. The development of the Bridge Plan also provides an opportunity to explore new and innovative strategies to advance health equity through access to culturally competent providers. For example, we encourage the BPTF to explore opportunities to create reimbursement incentives for providers that speak a second language. Additionally, the Bridge Plan design could include requirements for certain certifications for providers included in their plan networks. For example, CCOs offering the Bridge Plan could indicate on their provider directories which providers have skillsets or completed training that advance health equity, such as those that speak multiple languages, offer translation services, provide alternative office hours, or have expertise in cultural competencies.

Payment design to support long-term health reform efforts. The development of the Bridge Plan will continue making progress toward Oregon's goals of developing a low-cost, high-quality plan, and will position Oregon to continue to be a national leader in health reform. **We urge the BPTF to prioritize value-based payment arrangements, including the use of quality incentive payments and capitation arrangements that are leveraged by CCOs, in developing Bridge Plan reimbursement policies.** Oregon's innovative CCO

model supports the provision of care that prioritizes [value over volume](#) of services by incentivizing providers to ensure their patients stay healthy. Additional strategies could include exploring alternative payment models that support the specific needs of patient populations, including providing services and resources that support social determinants needs and care coordination or navigation. As Oregon continues to explore longer-term health system changes—including a global payment program—that move the system away from a fee-for-service model and prioritize value, we encourage the BPTF to consider how the reimbursement structure of the Bridge Plan will support these long-term endeavors. Although OHA does not set reimbursement rates paid by CCOs, OHA should provide direction if capitation rates for the BHP are higher than those for OHP.

We applaud the BPTF for its commitment to ensuring continuity of coverage and affordability for all Oregonians through this iterative process to design the Bridge Plan. As you continue to develop the policy in HB 4035 and weigh the various considerations, please consider the team at United States of Care a resource, and if you have any questions regarding these comments, please don't hesitate to reach out.

Sincerely,

Liz Hagan
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Caitlin Westerson
State External Affairs and Partnerships Director
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Appendix



Bulletin No. B-4.116

Directives for the Use of Induced Demand Factors in Individual and Small Group Rate Filings

I. Background and Purpose

In developing premium rates for health benefit plans on the individual and small group markets, health insurance carriers may utilize different mathematical factors to adjust rates based on geography, age, tobacco use, and actuarial value. Plans with different actuarial values cover different percentages of medical costs incurred by an average member enrolled in the plan. In the individual and small group markets, actuarial values are reflected, to a first approximation, by a metal level (e.g., bronze plans have an approximate 60% actuarial value while gold plans have an approximate 80% actuarial value).

Plans with different actuarial values have different levels of cost sharing. Induced demand factors are utilized by health insurance carriers to account for differences in consumer behavior in pricing plans of different metal levels.

Individual and small group market health benefit plans filed with the Division in previous years reflect a large variation in assumed induced demand factors across carriers as well as across and within metal tiers. These variations are particularly pronounced for gold plans. Further, the ratio of gold and bronze plan induced demand factors varies widely among carriers. These differences may encourage consumers to enroll in higher cost sharing plans that may not be appropriate for them, or be utilized by carriers in a potentially discriminatory manner to avoid high risk members. The Reinsurance Subsidized Enrollee Impact Study published by the Division in March of 2021 also identified the use of elevated induced demand factors as a source of decreased consumer affordability.



II. Applicability and Scope

This bulletin is intended to provide guidance to all carriers offering individual and small group health benefit plans in the State of Colorado.

III. Division Position

It is the position of the Colorado Division of Insurance that, in the individual and small group markets, consumers who are enrolled in plans with similar actuarial values will exhibit similar consumer behavior regardless of the carrier who offers the plan. The Division seeks to eliminate differences in induced demand factors between different carriers, and between the individual and small group markets. This position is consistent with assumptions embedded in the Risk Transfer Formula for the Federal Risk Adjustment program.¹

For plan years beginning in 2022, the Division will only allow the use of the induced demand factors determined by a formula that is derived from induced demand factors established by CMS and used in the Federal Risk Adjustment program. These federal factors are described in federal guidance.² Carriers should utilize the induced demand factor that results from inputting the actuarial value (AV) determined by the federal AV calculator into the formula below.

$$\text{Induced Demand Factor} = 1.24 - AV + AV^2$$

In the formula above, AV is the actuarial value determined by the federal actuarial value calculator, expressed as a decimal (e.g. 0.6 for a 60% actuarial value bronze plan). Using the formula above, a bronze plan with 62% actuarial value would have an induced demand factor of 1.0044. A silver plan with a 70% actuarial value would have an induced demand factor of 1.03. A gold plan with a 76% actuarial value would have an induced demand factor of 1.0576.

It is the position of the Division that utilizing induced demand factors as determined by the formula above will maximize the purchasing power of exchange consumers whose household income is up to four hundred percent of the federal poverty line, in accordance with 10-16-107 (8), C.R.S.

¹ Pope GC et al. (2014) Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. Medicare & Medicaid Research review. Vol. 4. Number 3.

² See description on page E7 of Pope GC et al. (2014) Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. Medicare & Medicaid Research review. Vol. 4. Number 3.

VI. History

Issued May 19, 2021.

Dear members of the Bridge Plan Task Force,

My name is Wanda Davis and I'm 63 years old.

In eight days it will be three years since the date I took a phone call from my doctor that no patient wants to receive. She told me I had been diagnosed with breast cancer.

I was lucky it was caught very early and also that it was the type of breast cancer easily treated by surgery and radiation over about three months. I then started on a course of aromatase inhibitors that was supposed to last about seven years. Basically, this drug suppresses estrogen, which starves the cancer cells of the hormones that feed them and, with luck, prevents a recurrence of the cancer. Unfortunately, I had a really bad reaction to the drug and had to discontinue taking it after only nine months. This means my chance of this cancer recurring has doubled.

Partially due to the difficulties I'd endured with the cancer and its treatments, I retired last year after working 24 years as a Hearings Representative and an Administrative Rules Coordinator for the Oregon Health Authority. I'm grateful to have had very good coverage with my former employer's group plan and that my out of pocket expenses were affordable.

My husband and I currently have an individual Providence health insurance plan through the Marketplace, which costs us \$97 each month after a federal tax subsidy made available to us by the American Rescue Act. It's a Bronze level plan which basically only covers catastrophic care but this is what we can afford.

Without the subsidy, the full monthly cost of this plan would be \$1,480. That amount is more than half of my monthly pension income.

Based on information on the Oregon Division of Financial Regulation website*, the cost of individual health insurance in Oregon will likely increase by about 7.5 percent beginning January 2023. If the American Rescue Act subsidies end as they are scheduled to do in December of this year, I will be responsible for the entire monthly premium plus the 7.5 percent increase. By my calculations, that will be nearly \$1,600 per month in 2023 to keep health coverage that would allow us to keep our home and avoid bankruptcy if, God forbid, I were to have a recurrence of my breast cancer and need further treatment to stay alive.

Like everyone we are feeling the pinch of inflation and, if the federal subsidies aren't extended, we will either not be able to afford care or will have to make difficult choices about paying for other living expenses. Not having access to care is my biggest nightmare since I potentially have a ticking time bomb deep within my body.

I applaud the Bridge Plan Task Force for its work to cover the 55,000 Oregonians most vulnerable to losing coverage. I also strongly encourage you to consider the hundreds of thousands of Oregonians whose health depends on having insurance but who face becoming

uninsured – falling into the gap of not being eligible for the Oregon Health Plan but unable to afford private market insurance.

Thank you for your consideration.

* <https://dfr.oregon.gov/news/news2022/Pages/2023-health-insurance-rates.aspx>

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Wanda Davis
503-508-1428



July 22, 2022

To Members of the Bridge Health Care Program Task Force:

The Oregon Association of Health Underwriters (OAHU) appreciates the significant effort the Task Force is putting into designing a potential “Bridge Plan,” and also, critically, how it would serve individuals as well as its impact on the Individual insurance market.

OAHU’s members are experts in health insurance benefits. We work with Individuals and businesses to help them select appropriate benefit plans, and we work with our clients on benefits administration issues. Fundamentally, we are advocates for health benefits consumers. In the Individual ACA plan market, too often OAHU members are sought out by people who, through no fault of their own, selected a health plan through the federal marketplace that is not appropriate for them, and they seek OAHU members’ help in moving to a better plan.

Health benefit plans, as you know from your work on the Task Force, are complex products. Selecting one via the Exchange website alone carries much higher risk of error than buying a book on Amazon. A bad book might cost a little time and \$10-\$40. Selecting an inappropriate health plan can cost thousands of dollars and a lot of personal stress.

In regard to the Bridge Plan, we appreciate that it would, in effect, provide needed subsidy for lower income Oregonians who cannot easily absorb large out-of-pocket costs, yet who make “too much” money to qualify for Medicaid. When out-of-pocket costs create barriers to care rather than important economic signals to nudge consumers, these barriers may lead to poor health outcomes and much larger costs. That is why OAHU supported legislation that passed in the recent Session requiring 100% coverage of up to four primary care visits per year.

We urge the Task Force to continue to take additional time to dig into the still-significant unknowns related to the proposed program. Specifically, we recommend considerably more work on the four following questions:

1. What state financial resources would it take to make up the difference between federal funds now paying for Silver Plan subsidies and the actual cost of a Bridge Plan? The Task Force has been presented assumptions that the federal subsidies would be adequate to cover these costs. Yet that requires assuming that a benefit considerably more generous than a Standard Silver Plan will not actually cost considerably more, will not invite adverse selection, and that health care providers broadly will accept below-market payments for care.
2. What effects would the Bridge Plan, as currently outlined, affect the Oregon Individual ACA market and the health plan members who depend on it? While the Individual market has stabilized in recent years, thanks in part to an effective reinsurance program, it remains in an actuarially delicate balance.

3. *If a Bridge Plan is enacted with a mandate to pay below-market rates to providers, then what effects would that policy choice have on plan members' access to provider networks? And to what degree would it worsen cost-shifting to the rest of the commercial market?*
4. *What reasonable cost-sharing strategies could be used to positively influence Bridge Plan member behavior and truly bridge between the "free" benefit experience of Medicaid and higher levels of the commercial market, to which some Bridge Plan members hopefully will progress as their incomes increase?* In general, OAHU would recommend a sliding-scale approach, to avoid creating a benefits cliff. More information about the population-level claims experience of those likely to leave Medicaid would help to inform plan design. As a population, is this a high-risk or high-utilization population, or does it look more like a commercial population in which, as an actuarial rule of thumb holds, 20% of members account for 80% of claims costs and 5% account for 50%?

Because, as widely expected, the Biden administration helpfully has extended the federal COVID-19 State of Emergency, the Task Force has several additional months to further develop detailed information on these and other important questions. OAHU is not suggesting that the Task Force make perfect the enemy of pretty good. Yet we suggest that considerable caution and taking the time to narrow the universe of significant unknowns are in order, and defer judgment on how to proceed until much more complete information can be developed.

Respectfully submitted,

/s/

Julianne Horner
President

/s/

Tim Rasch
Immediate Past President

Good evening. My name is Sue Inahara, and I am from Portland. I decided to attend this listening session today to advocate for the inclusion of robust mental health care coverage in the Bridge Plan. My own experiences have taught me that mental health is an integral component of a person's overall health, wellbeing, and satisfaction, which is why it is so important that mental health services are covered by the proposed plan.

I wanted to share a little bit about my own experiences with mental health and health insurance to demonstrate. In 2019, I went through a very difficult period in my life, and I began to see a therapist. I had purchased health insurance through the marketplace, and at the time, my weekly sessions with my therapist were largely covered by my insurance. Although my therapist was wonderful, I continued to struggle profoundly, so much so that my therapist asked me to meet multiple times a week.

When I started meeting my therapist more frequently, however, my insurance company began to question the legitimacy and necessity of the treatment I was receiving. Despite my therapists' repeated assurances, the insurance company wrongly decided that I was "abusing" the system and taking advantage of the healthcare plan that I was on by meeting with my therapist more than I had to. As a result, they drastically reduced my benefits: they said they would only cover one session per month with my therapist, and they even reduced the session time that they were willing to cover to a third of the initial time.

I couldn't afford to meet with my therapist so regularly without insurance, and I was still paying the full premium despite the insurance company reducing my benefit. so I didn't know what to do. In addition to having to go through this extremely difficult period, I was angry and frustrated. It felt as though my insurance company had pulled the rug out from under me at a time when I was truly struggling. Removing the benefit compounded the effects of my worsening my mental and emotional state.

These experiences taught me the critical importance of affordable and accessible mental health services. Everyone deserves quality, affordable coverage that lets them get the treatment and services they need, and a public health insurance program like the bridge plan should recognize that. As the members of this bridge plan task force consider the benefits offered by this plan, I urge you to prioritize integrated behavioral health services so that others do not have to go through what I did. Coverage for mental health services must be included in the Bridge Plan.

Thank you for your time and effort on this important work.

Mark Sturbois
1100 S E 12th Ave #322
Portland Oregon 97214
msturbois@comcast.net
503 201 9919

Members of The Bridge Plan Task Force:

My name is Mark Sturbois and I have been a Healthcare Advocate for well over 2 decades. I served as Legislative Chair and later advisor for 18 years for CWA 7901. I served several years as the Treasurer of the Oregon Working Families Party and on the state steering committee and have belonged to several healthcare advocacy groups. Oregonians for Health Security, the Archimedes Project and Healthcare for All Oregon. While I am a single payer believer, I am also a realist and will fully support the mission of this task force to preserve the lifeline to affordable coverage to over 50 thousand Oregonians and ultimately expand it.

I am currently on Medicare and am employed in Protection Services at the Portland Art Museum. I also serve on the Multnomah County Citizens Budget Advisory Committee for Human Services.

I have several times in my life been affected by a lack of affordable healthcare. Perhaps the biggest example is being diagnosed with Hepatitis C. I couldn't afford the treatment at the time as I would have been unable to work and would have lost my job and my insurance. I retired before I was medicare eligible and got affordable coverage through the State. Innovations in medicine developed a new cure in the form of 12 weeks of a pill a day with few side effects. A group called PAN [Patient Access Network] picked up the cost of the medication and today I have a normal functioning liver.

I have also been helped in the past when lack of Dental Insurance allowed treatable problems to progress to health threatening abscesses and tooth loss.

This program is absolutely necessary. The pandemic and virtually uncontrolled inflation has victimized so many tax paying Oregonians. The working poor. I'm sure I don't need to give you statistics you already should have. Healthcare is utilized more if it is affordable and treating a problem in the early stages is cheaper than letting it grow into a major ailment.

It is my hope that the federal equivalent to this remains in ARPA and does not sunset in December. It needs to be extended and enhanced. Our state would certainly benefit from the Federal dollars.

Ultimately I would like Dental and Vision included as they should be in every healthcare discussion.

I certainly believe that a true competitive public option would benefit the people and the state perhaps modeled like a CCO.

Regardless I appreciate the work of the Task Force and being able to provide comments.

Mark Sturbois
1100 S E 12th Ave #322
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Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 26, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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

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

Marketplace Impact

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

Plan Development

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 9, 2022

Re: Bridge Health Care Program, Plan Design Part 3

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers (CHCs), also known as federally qualified health centers (FQHCs), in leading the transformation of primary care to achieve health equity for all. Health centers deliver integrated primary, behavioral, and oral health care services to over **416,000 Oregonians**. 41% of health center patients identify as a racial or ethnic minority, 20% are uninsured, 10% are experiencing homelessness, and 3% are veterans. Community health centers provide care to some of Oregon's most vulnerable populations, including **one in six OHP members**.

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

Unintended Consequences

Oregon's Medicaid redetermination will not occur in a vacuum. The end of the PHE will touch off changes to many programs impacting the lives of the target population of adults between 138-200% FPL. For example, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) currently functions under a temporary waiver which allows visits to be conducted remotely – these visits are mandatory to receive benefits. The end of the PHE will eliminate this provision after 90 days and all services will be required to be delivered in-person. WIC-enrolled parents will face new challenges of scheduling, transportation, and [potential disenrollment for non-compliance](#). This will happen concurrently with Medicaid redetermination to an overlapping population, as eligibility for WIC extends to [185% FPL](#). Additionally, throughout the PHE, people on the Supplemental Nutrition Assistance Program (SNAP) have received [emergency allotments](#), which allows them to receive the maximum monthly benefit for their household size or an increase of at least \$95/month if they are already receiving their maximum benefit amount. Even though, in Oregon, SNAP eligibility extends to [200% FPL](#), benefits may decrease drastically at the end of the PHE with little to no increase in income. **Families should never have to choose between feeding themselves and their children or accessing health care.** Designing a program which requires even minimal cost-sharing or other barriers to entry could create this dilemma. Oregon has an opportunity to create a program that is broadly accessible to those who face the most barriers to health coverage and care, and we urge the Task Force to prioritize that accessibility.

Plan Development

We urge the Task Force to eschew designing the Bridge Plan from a scarcity perspective – while we know the actuarial analysis is preliminary and based on pre-COVID-19 data, it does indicate that a Bridge Plan with zero out-of-pocket costs, OHP-like benefits, and above Medicaid reimbursement is feasible. Additionally, based on [revenue forecasting](#) during the 2022 Legislative Session, Oregon is functioning at a surplus and the use of General Funds to support the Bridge Plan, if necessary, is a viable option. [HB 4035](#) and the preliminary [Fiscal Impact](#) and [Budget Reports](#) during the 2022 legislative session explicitly allow the Task Force to advise use of General Funds as a part of their report and we encourage Task Force members to consider this option before cutting benefits, adding enrollee costs, or lowering provider reimbursement rates. **These cost-saving mechanisms** are all associated with [greater barriers](#) to entry, reduced access to care, unintended negative consequences, and may **undermine the overall success of the Bridge Program**.

As the Task Force drafts their September report, OPCA advocates for a plan which:

- **Prioritizes continuous benefits based on current OHP covered services, including routine oral care and behavioral health care.** [Preventative oral care](#) reduces emergency room visits and prevents periodontal diseases and chronic illnesses, resulting in cost saving for the entire health care system. Additionally, [studies](#) show that integrated behavioral health care reduces severity of depression in patients, provides patients with a better overall experience in health care, and [reduces overall costs](#) in health care due, in part, to reduced emergency care visits. Failing to provide expansive services will raise costs of care because of unmet needs, push costs to the state later down the road, and inhibit uptake of the Bridge Plan.
- **Reimburses at rates which are higher than Medicaid and use a cost-based model, such as value-based pay, that adjusts for patient demographics and needs.** As mentioned in previous [OPCA public comment](#), we urge Task Force members to consider the complex health needs of certain historically underrepresented populations, including those who identify as BIPOC, LGBTQIA2S+, and/or have experience with other social determinants of health, and allow for reimbursement adjustment based on their unique health needs.
 - In the most recent [advanced readings](#), we noted that current data collection methods **do not allow disaggregation by race and ethnicity**. We urge the Task Force to **include data collection which disaggregates** by race, ethnicity, age, gender identity and sexual orientation, ability, socioeconomic status, and geographic location to best understand the needs of the Bridge Plan population and enhance efforts towards health equity. The Colorado Public Option has implemented this type of deidentified data collection, as referenced in a recent [United States of Care report](#).
- **Prioritizes zero out-of-pocket costs to enrollees, which includes premiums, copays, deductibles, and coinsurance.** We emphasize that individuals moving from Medicaid will be accustomed to no out-of-pocket costs and an abrupt shift to any amount of [enrollee cost](#) -- even the smallest premium or copay -- could deter them from both enrolling in coverage and accessing covered services.
 - As stated earlier in this testimony, enrollees could also be experiencing loss of other benefits due to PHE unwinding and/or the benefit churn point, incurring higher costs of living. It is vital that the Bridge Program and subsequent Basic Health Plan do not add to this financial burden for those who may be already struggling to afford basic goods and resources.
- **Provides enhanced reimbursement to safety net providers, specifically Federally Qualified Health Centers (FQHC's), who are now and will likely continue to care for this population.** As mentioned in previous OPCA testimony, the testimony of [United States of Care](#), and [OHA advanced readings](#), FQHCs currently receive Medicaid reimbursement (which is below cost) and PPS wrap payments (which is a cost-based payment) for the redetermination population. As individuals move off Medicaid and onto the Bridge Plan, CHCs will no longer receive adequate, cost-based payments for services as they lose PPS

wrap – this will impair their entire service array, not limited to the population impacted by redetermination. **While we recognize that this is not federally required for a BHP, we urge members to consider options which mitigate this impact, including expanding eligibility for PPS wrap payments to 200% FPL.**

- CHCs offer many otherwise unreimbursed services that PPS payments are intended to help offset, such as school-based health centers, expanded dental services, mobile clinics, and many others. These programs will be threatened if CHC funding does not remain intact.
- Current data indicates that as many as 41,000 current CHC patients could be in the target demographic for the Bridge Program. This means that up to 82% of the target population could be cared for in CHCs, as we do not anticipate that a change in coverage will cause patients to change their care home. Failure to adequately reimburse for care provided to this population would severely undermine CHC service provisions.
- **Clearly articulates a [comprehensive engagement and outreach strategy](#)** – this looks like consistent, culturally inclusive messaging about plan benefits, eligibility, costs, and enrollment pathway. We strongly advocate for a no-wrong-door approach, wherein all system navigators can support potential enrollees.

August 9th, 2022

Oregon Bridge Plan Taskforce

Chairs Steiner-Hayward and Prusak, Members of the Taskforce:

Project Access NOW is a community-based organization that provides access to healthcare and health-related resources for un-and-underinsured individuals in the Portland metro area. Since its inception 15 years ago, our outreach team has assisted 50,000 households in the tri-county area in applying for health insurance through the Oregon Health Plan and the Federal Marketplace. For those individuals who make even \$1 too much to qualify for OHP, our Premium Assistance program pays premiums in full that would otherwise be unaffordable through the Health Insurance Marketplace.

We write today to share comment on the Preliminary Recommendations offered by the Bridge Plan Taskforce. PANOW strongly believes in the life-saving potential for a Bridge Plan in Oregon to provide coverage to traditionally underserved communities like the ones we work with every day. As we work to remove systemic inequities in healthcare in our state on the basis of race, class, sexuality and other factors, it's critical that we don't create more gaps and "churn" with our solutions. We would like to thank the Task Force for its work in developing an equitable and progressive Bridge Plan and offer the following comment:

Potential for State Funding

While we fully understand the Task Force's direction from HB 4035 was to minimize costs to the state, the legislation does leave the potential to request state funding if necessary. We would like to encourage the Task Force to utilize that allowance and to avoid discouraging the use of state funds if it will come at the cost of lower provider reimbursement or higher cost-sharing to consumers. We know that these factors have disastrous health outcomes for the populations the Bridge Plan is intended to serve and result in less accessibility and lower utilization and enrolment. If the Bridge Plan is to be successful, it must be properly funded, whether the use of state funds is required or not. At a minimum, the Bridge Plan must meet the following standards:

1. The Plan must be affordable with no monthly premiums and no out-of-pocket costs such as copayments or coinsurance.
2. The Plan must provide clear and transparent cost information to the consumer and avoid a tax credit repayment requirement for mid-year income changes, which will also save administrative costs for the state.
3. The Plan must offer higher-than-Medicaid reimbursement rates to ensure a robust and culturally responsive network of providers.

4. The Bridge Plan must provide equal or equivalent quality of care to OHP (including primary, behavioral, and oral health coverage) to avoid further “churn” for this population between the two plans.
5. The Plan should be offered through the existing Marketplace to allow for easier navigation of the healthcare system and to minimize the burden of transitioning between coverage sources.
6. The Plan should be offered through CCOs with pre-existing infrastructure to allow for a seamless transition for the state and consumers.
7. CCOs, CBOs, and other health entities who have established relationships with eligible communities should be provided with appropriate resources to do the necessary culturally specific outreach and community engagement to get folks enrolled in the Bridge Plan.
8. Finally, the Bridge Plan presents a unique opportunity to lay the framework for a public health insurance option in Oregon and should be designed with how the Bridge Plan system and infrastructure may be used in the future to provide such a public option in mind.

While there is certainly the possibility that all these standards could be met with only federal funding, we would like to discourage the Task Force from ruling out the possibility of utilizing state funding if necessary. All of these standards are critical to the success of the Bridge Plan and should not be cut or adjusted to meet the budgetary requirements of strictly utilizing federal funding.

We are grateful for your commitment to this work and are happy to continue to be a resource given our experience filling the coverage gap on behalf of the health systems in the Portland region. Thank you for your time!

Best,



Carly Hood-Ronick MPA, MPH
Executive Director



**To: Co-Chairs Senator Steiner Hayward, Representative Prusak, Vice Chairs Senator Kennemer, and Representative Hayden
Members of the Bridge Health Care Program Task Force**

From: Oregon Dental Association

Date: August 22, 2022

Re: Inclusion of Robust Dental Benefits and Adequate Provider Reimbursement in the Bridge Program

The Oregon Dental Association (ODA) represents over 2,100 practicing dentists across all corners of the state. Our members are committed to improving access to dental care and were pleased that House Bill 4035 included language stating that dental benefits should be included in the Bridge Program, “to the extent practicable”. We are also pleased that the Task Force has dedicated meeting time to discussing the inclusion of dental benefits, and that many Task Force members and other stakeholders have made supportive comments regarding inclusion of dental benefits at nearly every meeting of the Task Force.

Concern: Maintaining continuity of care with a robust dental benefit under the Bridge Program.

Dental care is a critical piece of overall health. Recognizing this, The Oregon Health Plan offers comprehensive dental coverage, from regular cleanings to fillings, extractions, dentures, crowns, and emergency care. The ODA maintains that the Bridge Program should seek to match this coverage at minimum to provide continuity of care for patients, and we are pleased that the draft report includes a recommendation to fully align with the CCO service package for OHP, which includes adult dental.

As this Task Force well knows, an untreated dental issue can quickly devolve into significant and costly health issues like, heart disease, cancer or diabetes. Untreated oral pain is also high driver of unnecessary emergency department visits.

ODA encourages the Task Force to move forward with a plan design that includes a package that is equal to that offered under the Oregon Health Plan.

Solution: the ODA encourages the Task Force to move forward with the recommendation in the draft report to include dental benefits that align with those offered under the Oregon Health Plan

Concern: Reimbursement to providers must be adequate to ensure actual access.

Dentist participation in OHP provider panels is often hampered due to low reimbursement rates. Dental offices are particularly vulnerable to low reimbursement rates due to high overhead, labor and equipment costs, and we know that low Medicaid reimbursement directly causes dentists to limit the number of Medicaid patients they see. Ensuring a robust— higher than Medicaid—reimbursement structure will enable stronger, more resilient and sustainable, provider participation and increase access to care to those most in need.

Solution: ODA encourages the Task Force to move forward with the recommendation in the draft report to provide capitation rates that allow for provider reimbursement higher than Medicaid rates.



The ODA appreciates that Task Force members are weighing many difficult decisions throughout plan design. ODA appreciates your time and commitment to this issue, and Task Force Members' stated commitment to the inclusion of dental benefits.

Sincerely,

A handwritten signature in black ink, appearing to read "C. Roa", with a long horizontal line extending to the right and a vertical line extending downwards from the end of the horizontal line.

Dr. Calie Roa
ODA President



August 30, 2022

TO: Bridge Plan Task Force
FR: Maribeth Guarino, Health Care Advocate, Oregon State Public Interest Research Group (OSPIRG)
RE: Bridge Plan Task Force Recommendations

My name is Maribeth Guarino, and I'm the health care advocate with OSPIRG. We are a consumer advocacy group with members across the state working towards a healthier, safer world for all of us. We would like to offer some comments in support of the work this task force has done and for the work that still needs to be done in the upcoming months and years.

Health care costs are a problem for Oregonians from all backgrounds and communities. The proposed Basic Health Plan (BHP) and the implementation phases are a good start to helping folks under 200% of the federal poverty level (FPL), and we are especially supportive of the task force's recommendations that the benefit design encompass services delivered by the Oregon Health Plan and essential health benefits required for private plans on the marketplace. As a health plan intended to help Oregonians transition between Medicaid and the marketplace, and as a high-quality plan, offering expansive benefits that align with both markets is important to ensure patients are able to maintain their coverage and any treatments they require.

We are also excited about phase four of implementation which would provide consumers more choice to select a high-quality, low-cost plan that applies their tax credits through the Marketplace. Maintaining consumer choice for their health coverage is important to ensure they can select a plan that meets their needs, and the market provides a platform for competition among health plans to meet those needs.

Finally, we support the no-premium, no-cost-sharing recommendation. Deductibles and other payments are often barriers to accessing or seeking care when it's needed, which can lead to worsening conditions and more expensive care or treatment down the road.

As the task force continues to meet and complete this report, we thank you for your work so far and urge you to continue making low-cost, high-quality health care for Oregonians the priority. As laid out in the redetermination timeline and implementation phases, this is a long-term project, but the work you do now will have long-lasting effects. You're laying the groundwork for future policies and projects that extend these benefits to more people so that every Oregonian can be secure in their health coverage and confident in their health care. We look forward to seeing this work continue in the fall and beyond.

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 30, 2022

Re: Bridge Health Care Program, Finalizing Sept. 1 Report

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers (CHCs), also known as federally qualified health centers (FQHCs), in leading the transformation of primary care to achieve health equity for all. [Health centers](#) deliver integrated primary, behavioral, and oral health care services to over **416,000 Oregonians**. 40% of health center patients identify as a racial or ethnic minority, 18% are uninsured, 8% are experiencing homelessness, and 3% are veterans. Community health centers provide care to some of Oregon's most vulnerable populations, including **one in six OHP members**. 87% of all patients are at or below 200% of the Federal Poverty Level (FPL)

OPCA believes that the Bridge Plan is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health. We applaud the work that has been done to ensure that the Bridge Plan population of adults 19-64 who are between 138-200% FPL are able to access no-cost coverage which is robust and as expansive as the Oregon Health Plan benefits to which they are accustomed. Continuity of care has been a clear priority of the Task Force from the beginning, and we are excited to see that reflected in the [Preliminary Program Design Recommendations](#). Additionally, we appreciate the attention paid to creative forms of reimbursement for safety net providers, specifically the Federally Qualified Health Center network who we support. Doing so ensures that providing care to this population will not come at the cost of other vital, wraparound services and/or services for the uninsured. We believe that these priorities, in addition to others outlined in the report, will build upon the upstream health equity gains made during the Public Health Emergency (PHE) and redetermination pause. During the PHE, Oregonians overall and, more specifically, Black and African American Oregonians, experienced an unprecedented increase in insurance [coverage](#). Building a Basic Health Program which is no-cost to enrollees, reimburses at rates higher than Medicaid, is robust in its covered services, and allows for care to continue in existing primary care homes is vital to maintain this progress and we are glad to see all these elements outlined explicitly in the Recommendations.

Our public comment focuses on three primary topics which we urge Task Force members to keep top of mind, as follows:

1) Cost-Based Payment Models for FQHCs and Other Safety Net Providers

We appreciate the work that Task Force members, legislative representatives, OHA, and legislative staff have done to understand and advocate for the unique needs of the FQHC care model and the inclusion of their payment needs in the Preliminary Program Design Recommendations. As mentioned [in previous OPCA testimony](#), **FQHCs could be responsible for up to 82% of the population** unwinding from OHP and transitioning onto the BHP – these 41,000 individuals comprise 10% of the CHC patient population. **For the past two and a half years**, FQHCs have been receiving [Prospective Payment System \(PPS\)](#) payments for this

population. In the most basic terms, for a Medicaid patient, FQHCs receive the Medicaid-level fee-for-service reimbursement plus PPS, which makes up the difference of the underpayment of Medicaid and represents the actual cost-of-care and is uniquely calculated for each CHC. It is vital to remember that FQHCs must provide care to all patients, regardless of insurance type or ability to pay – which means **they cannot restrict their number of Medicaid patients even when payment rates do not cover costs. They also cannot restrict the number of under- and uninsured patients who receive care and wraparound services at their clinics.** PPS was designed to ensure that federal funds dedicated to uninsured populations and other populations considered medically underserved by the [Health Resources and Services Administration \(HRSA\)](#) are not stretched or redistributed to compensate for Medicaid underpayment.

Under-reimbursement for the BHP population could result in that exact phenomenon – as the result of being inadequately reimbursed, funds otherwise used for care of medically underserved populations would have to be shifted to compensate. This would be detrimental not only to BHP individuals already receiving care at FQHCs, but also to all FQHC patients. **The entire service array would be impaired.** FQHCs are located in underserved areas and inadequate reimbursement could exacerbate the lack of services in areas where needs already go unmet. Data from the Oregon Office of Rural Health indicates that Oregon FQHCs are located in areas on most unmet need (refer to this [map](#)), including areas with the highest concentration of people in the 138-200% FPL category (refer to Figures 1 and 7 in ORH's [Oregon Areas of Unmet Health Care Need Report](#)). FQHCs are clearly already serving this population and must be compensated for the cost of care in order to preserve their care model. **We advocate for a cost-based payment model for FQHCs which reimburses at a PPS-level floor.**

2) All Payment Models Adjust for Race, Ethnicity, and other Social Determinants of Health

In previous [advanced readings](#), we noted that current data collection methods **do not allow disaggregation by race and ethnicity.** We urge the Task Force to **prioritize data collection which disaggregates** by race, ethnicity, age, gender identity and sexual orientation, ability, socioeconomic status, and geographic location to best understand the needs of the Bridge Plan population and enhance efforts towards health equity. This is in keeping with OHA's health equity and data justice strategic goal. Additionally, the Colorado Public Option has implemented this type of deidentified data collection, as referenced in a recent [United States of Care report](#). We know that many elements, beyond merely socioeconomic status, play into the health needs and costs and to truly understand the morbidity of this population moving forward, proactively implementing data collection structures is necessary. As this data becomes available, we urge Task Force members to consider the **complex health needs of certain historically underrepresented populations**, including those who identify as BIPOC, LGBTQIA2S+, and/or have experience with other [social determinants of health](#), and allow for reimbursement adjustment based on their [unique health needs](#).

3) Continued Communication with Outreach and Engagement Stakeholders, Prioritizing Cultural Inclusivity

Providers, resource navigators, community organizations, and other stakeholders must be continually communicated with and informed regarding the direction of the BHP and what their clients/patients can anticipate as the PHE unwinds. Creating a [comprehensive engagement and outreach strategy](#) for distribution of information about the staged redetermination process shared with the Task Force at the previous meeting is vital to keep all parties, from patients to resource navigators to financial and billing staff, informed. **OPCA advocates for a no-wrong-door approach to accessing the BHP or other information regarding redetermination.** This looks like consistent, culturally inclusive messaging available in plain language about plan benefits, eligibility, costs, and enrollment pathways which are updated as the Task Force process and subsequent 2023 legislative session progress.