Joint Task Force on the Bridge Health Care Program
Post Meeting Summary

Attendees	Co-Chair Elizabeth Steiner Hayward (by video) Co-Chair Rachel Prusak (by video) Senator Bill Kennemer (by video) Stefanny Caballero (by video) Adrienne Daniels (by video) Jonathan Frochtzwajg (by video) Antonio Germann (by video) Kelsey Heilman (by video) Lindsey Hopper (by video) Eric Hunter (by video) John Hunter (by video) Heather Jefferis (by video) William Johnson (by video) Keara Rodela (by video) Matthew Sinnott (by video)
Absent	Representative Cedric Hayden Pat Allen Kirsten Isaacson Fariborz Pakseresht Andrew Stolfi Sharmaine Johnson Yarbrough
Date/Time	October 4th, 2022, 8:30am-12pm **(**recording**)**.

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Meeting Topics	• Roadmap of Fall Meetings • Program Design: Consumer Engagement • Program Design: Covered Services • Microsimulation Modeling and Preliminary Results
Discussion of Key Issues	Program Design: Consumer Engagement HB 4035 does not include specific direction about consumer engagement efforts for the Bridge Program design, though it does provide for consumer feedback on the broader redeterminations process through a Community and Partner Workgroup. Time for public comment has been incorporated in each meeting since the first meeting. A virtual consumer listening session was scheduled in July 2022. Despite outreach efforts, the event was ultimately postponed due to low registration. The Task Force has expressed interest in exploring further opportunities for consumer engagement. The Task Force discussed two options that could be the basis for a recommendation: 1) focus groups to engage consumers prior to implementation of the program (because the Task Force will

	complete its work by December 2022, this activity would be carried forward by OHA and DCBS), and 2) the creation of a consumer advisory committee for ongoing feedback on the BHP. Members noted that if this activity occurs, it should include compensation for participants' time and be flexible in approach (e.g., a survey) to accommodate different work schedules. Members recommended engaging with consumer advocacy groups to help with gathering feedback. Topics should include benefit design, the best marketing channels and tools to use to engage or reach people with information about the program, and the specific needs of people who experience churn under OHP. Engagement should consider the amount of flexibility available to change program elements and weigh this against the time and input being requested of consumers. Members expressed a desire to avoid requesting consumer feedback on benefit design prior to clarification of the program budget, design implications, etc., to avoid presenting information that may be subject to change in the future. <u>Program Design: Covered Services</u> Anona Gund from the OHA Transformation Center provided an overview of Health Related Services (HRS) in OHP (OAR 410-141-3845). HRS are additional services that CCOs have the option to provide to members beyond the OHP covered service package (note: because HRS are not defined as covered services, they were not included in the comparison of OHP and essential health benefits provided previously to the Task Force and were not considered in the financial feasibility study). HRS are designed to promote wellbeing, and often address health related social needs such as food, housing, or transportation. There are two categories of HRS: 1) flexible services, which are services delivered to individual members, and 2) community benefit initiatives, which are investments made at the community level that are not tied to a specific member. Community benefit initiatives include health information technology investments to address social needs screening and referral. CCOs have the option to provide HRS, but Oregon's 1115 waiver does not compel them to do so. There is no specific funding mechanism for HRS, which must be paid from CCOs' global budgets. OHA incentivizes spending on HRS two ways. First, CCOs may count HRS toward medical expenditures to meet the required medical loss ratio (MLR, or the ratio of medical spending to plan administration costs and profit). Second, CCOs are eligible for a

performance based reward (PBR) that is intended to counteract decreases in CCOs' rates that could occur if upstream spending on HRS leads to a decrease in downstream medical service spending (sometimes called "premium slide").

In 2021, CCOs spent an average of 0.56 percent on HRS (ranging from 0.19 to 2.68%), equivalent to, on average, $2.35 per member, per month (ranging from $0.51 to $10.70). CCOs will continue to be allowed to provide HRS under the new 1115 waiver approved for 2022-2027, without specific spending requirements. Federal Medicaid rules also now define health related social needs (HRSN) services as a covered Medicaid benefit for certain "transition" populations including people transitioning from foster care, from jails, etc.

While discussion about an HRS-related Task Force recommendation was deferred until actuarial analysis is available, members shared preliminary thoughts including:

1) that the BHP population would benefit from flexible services,
2) that it would be beneficial to offer the ability to appeal denial of flexible services, which is not allowed under OHP,
3) that it would be helpful to better understand changes in OHP definitions applicable to HRS because of the desire to align BHP and OHP benefits,
4) that it would be desirable to continue incentivizing CCOs to spend on HRS (beyond confirming that BHP capitation rates may be adequate to do so),
5) that uncertainty about what OHA will approve as an HRS creates a disincentive for CCOs to provide them, and
6) that CCOs, consumers, and providers would benefit from additional guidance on what are allowable HRS expenditures to reduce the burden of negotiating these expenditures with OHA.

The Task Force will continue this discussion at the November 1st meeting.

<u>Microsimulation Modeling and Preliminary Results</u>
The Task Force heard from Numi Rehfield-Griffith (DCBS), Joel Ario (Manatt Health), and Tammy Tomczyk (Oliver Wyman) with a preview of analysis that will be fully presented at the October 18th meeting.

This analysis is to understand how the creation of the Basic Health Program could affect premiums and coverage decisions for people who are not eligible for the program and would continue to

purchase plans in the Marketplace. The analysis uses a range of available data sources and research to construct a simulation ("model") of how people in the Oregon Marketplace will behave under certain conditions or policy scenarios. The model is then run using a specific set of conditions (i.e., the creation of a Basic Health Program) and a sample population of consumers based on data from the Oregon Marketplace in years 2019-2021.

The analysis produces results in two steps: 1) estimating how the average characteristics of people in the Marketplace (the "risk pool") would change when the BHP is initially created and eligible Marketplace consumers earning less than 200 percent FPL are transitioned to BHP coverage, and 2) estimating how these results may change when changes in consumer behavior are accounted for. This analysis is important in part because carriers who offer plans in the Marketplace use a practice called "silver loading" to make plans more affordable. Silver loading would be largely discontinued following the creation of a BHP. (note: an overview of silver loading was presented at the July 12th meeting and is summarized beginning on page 29 of the first Task Force report).

The preliminary analysis presented to the Task Force on October 4th reviewed results of step #1 above: estimating how the Marketplace risk pool would initially change when the BHP is created and eligible consumers are transitioned to BHP coverage, but before considering changes in consumer behavior.

The analysis finds the overall number of people in the individual market was fairly stable from 2019 to 2022 (YTD), but within this population, the percent of people who received premium tax credits increased from 54.0 percent in 2019 to 59.3 percent in 2022, likely reflecting enhanced subsidies made available through the American Rescue Plan (ARPA). The percent of people in the individual market who purchased coverage through the Marketplace increased from 71.9 percent in 2019 to 77.5 percent in 2022 (YTD).

When the BHP is created, people earning less than 200% FPL will transition to BHP coverage and exit the Marketplace. Compared with the Marketplace population *before* the BHP is created (the "baseline population"), the population remaining in the Marketplace *after* a BHP would initially have these characteristics:

- **A smaller overall population but similarly distributed across the state.** Total individual market enrollment is forecasted to decrease from 183,900 to 146,600 people. Rating region 1 (Portland metro) increases by 0.8% as a percent of total market share. Rating region 7 (Medford)

decreases by 0.8% as a percent of total market share.

- **More likely to be in gold or bronze plans.** The percent of plans that are silver tier decreases from 39 percent to 30 percent of all plans. Gold plans increase from 22 to 25 percent of all plans. Bronze plans increase from 38 to 44 percent of all plans.
- **Higher average income.** Before a BHP, 43 percent of the marketplace population earns more than 400 percent of the federal poverty level (FPL). When the BHP population is removed, 54 percent of the Marketplace population earns more than 400% FPL.
- **Similar in age.** The percent of people under age 18 increases slightly from 11 to 12 percent, while the percent of people age 45-54 decrease from 19 to 18 percent of the marketplace. Other age bands do not change.

The meeting on October 18th will present "step 2" results estimating premiums, enrollment, population composition and morbidity, and tax credit values after the BHP is created, with consideration for changes in consumer behavior. Initial questions from members included:

1) whether the results on 10/18 will explore changes in enrollee cost sharing in addition to premiums (answer: information on actuarial value will be available but not the dollar value of plan deductibles);
2) whether the analysis is based on a specific number of Marketplace consumers known to be at 138-200% FPL or an estimate (answer: the number of Marketplace consumers at this income range is known for years 2019-2022, and these are used to create an estimate for 2024);
3) what the limitations of this modeling approach are (answer: the analysis will not show subsets of the population, for which the confidence of the model is lower; a limitations slide will be included in future presentations);
4) whether the results will show health status for different plan tiers before and after the BHP (answer: Oliver Wyman can present risk scores for different plan tiers but these and other sub-population estimates may be based on small numbers that are less reliable);
5) how funding for the BHP is calculated (answer: this will be reviewed in detail on November 1st);
6) what we know about the population of people who are uninsured and would be eligible for the BHP, and how their morbidity/uptake of the BHP may impact the program's cost (answer: data are limited but estimates can be constructed from, for example, Medical Expenditure Panel Survey).

Action Items and Follow-Up Requests	• Members requested information on the new waiver terms and conditions and detail regarding changes to HRS provisions as context for Bridge Program plan design discussions.
Meeting Materials (OLIS)	• Agenda for the Day and Roadmap of Fall Meetings | slides | handout • Program Design: Consumer Engagement | slides • Program Design: Covered Services | slides • Carrier Table Meeting 1 Summary • Carrier Table Meeting 2 Summary • CCO Table Meeting 1 Summary • Microsimulation Modeling and Preliminary Results | slides • Background readings (v. 9.27.22) • Questions and Answers (v. 9.27.22)

Upcoming meetings (at 8:30am unless otherwise noted):

- October 18th, 2022
- November 1st, 2022
- November 15th, 2022
- November 29th, 2022
- December 13th, 2022