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Legislative Policy and Research Office

Joint Task Force on the Bridge Health Care Program

Final Recommendations

December 2022

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About this Report

This final report follows a preliminary report submitted to the Legislative Assembly in September 2022. Readers are encouraged to reference the earlier report for additional context:

https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256619

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LPRO thanks […] for ongoing support to the Task Force as well as information, analysis, and feedback that informed this report.

LETTER FROM THE CO-CHAIRS

[To be added after report finalization]

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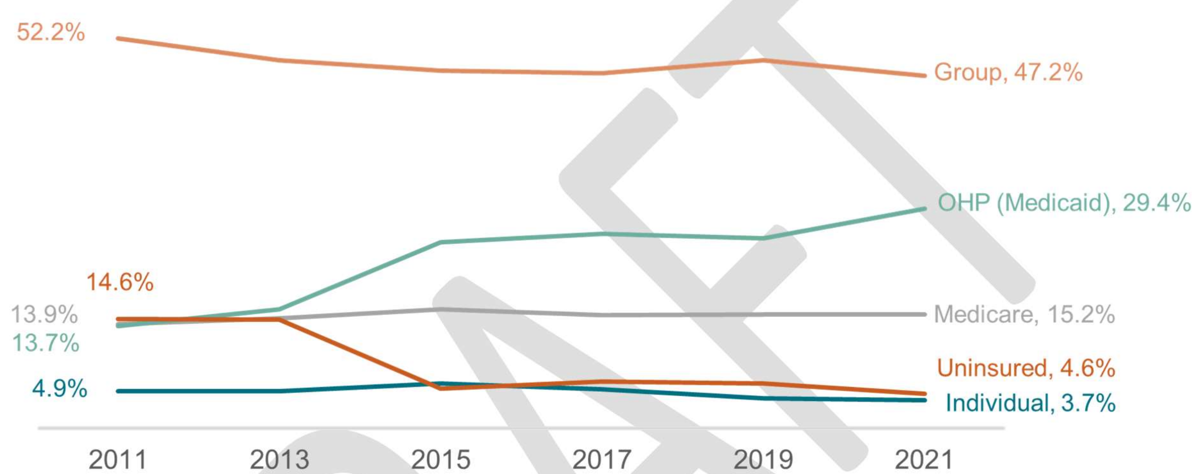
Executive Summary

[To be added after report finalization]

I. Background

Oregonians access health insurance coverage from a range of sources (see Exhibit XX) with roughly one in three Oregonians covered through the state's Medicaid program – the Oregon Health Plan (OHP). Overall, Oregon's rate of insurance coverage has improved over time, though 4.6% of Oregonians were uninsured in 2021 (Oregon Health Authority 2022).

Exhibit XX: Sources of Health Insurance Coverage, by Year



Source: Oregon Health Insurance Survey

Oregon's health insurance landscape was affected by two key **federal policy changes**[1] during the COVID-19 pandemic, including:

1. **changes in federal Medicaid eligibility rules** to maintain coverage for people regardless of income changes, and
2. **new and enhanced federal subsidies** to make individually purchased health insurance coverage more affordable.

Medicaid Eligibility

The federal government allowed states to pause eligibility redeterminations for people currently enrolled in Medicaid, among other public benefit programs, to stabilize health insurance coverage during the early economic disruptions of the public health emergency (PHE) in 2020 (Centers for Medicare and Medicaid Services 2020). This option included enhanced federal funding during the PHE. Oregon (and all states) accepted this option to

[1] Additional background on this topic is provided in an earlier Task Force report issued September 1, 2022 and available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256619

maintain enrollees' coverage until the PHE declaration expires. People enrolled in OHP have been "continuously eligible" for OHP during the pandemic regardless of income changes. During this time Oregon, like other states, has also been eligible for enhanced federal funding to provide coverage to OHP enrollees.

The number of people enrolled in OHP increased from 1,050,179 to 1,323,775 from 2019 to 2021 (Oregon Health Authority 2022), and "churn" – people gaining and losing OHP coverage due to changes in income or barriers during renewal – has ceased during the PHE, as people who would have previously lost coverage stayed enrolled (Vandehey 2022).

The federal government has renewed the PHE declaration on an ongoing basis since 2020 and has not yet announced when the declaration will be allowed to expire. The most recent renewal occurred on October 11, 2022, and was still active at the time of this report. The U.S. Department of Health and Human Services has indicated it will give states at least 60 days of notice prior to letting the PHE expire, and at the time of this report, had not yet done so.

Premium Subsidies

Congress also passed the American Rescue Plan (ARP) in March 2021 to provide additional relief from the economic impacts of COVID-19 (Public Law 117-2 2021). ARP made health insurance more affordable for people buying coverage on the Marketplace (Healthcare.gov) by:

- **enhancing premium tax credits**[2] provided through the Patient Protection and Affordable Care Act (ACA) to lower the cost of individually purchased coverage; and
- **extending eligibility for tax credits** to people earning more than 400% of the federal poverty level (FPL), the maximum income at which people are eligible for subsidies under the original ACA.

These additional premium tax credits, initially established through December 2022, were extended through December 2025 in the Inflation Reduction Act of 2022 (Public Law 117-169 2022). Together, these federal policy changes increased access to coverage for Oregonians during the pandemic. Coverage rates improved overall, and for people earning less than 200 percent of the federal poverty level (FPL), from 2019 to 2021 (see Exhibit XX).

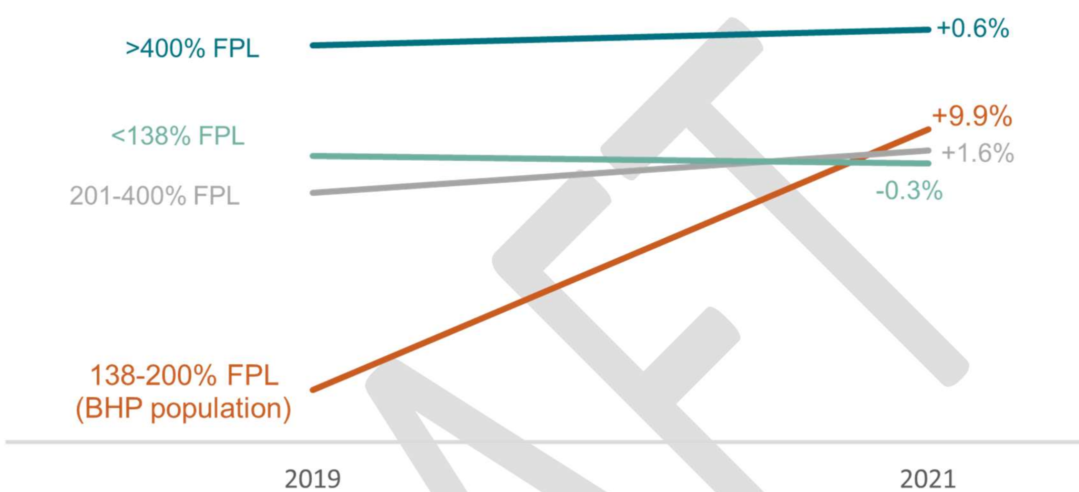
Unwinding from the Public Health Emergency

The Centers for Medicare and Medicaid Services (CMS) have encouraged states to begin administratively preparing for the "unwinding" of the PHE despite the uncertainty surrounding its end date (Centers for Medicare and Medicaid Services 2020). When the

[2] The Affordable Care Act established Advance Premium Tax Credits (APTC) for eligible consumers to lower the cost of purchasing coverage on the exchange. See page XX for further information on APTC.

federal declaration expires, Oregon (and all states) will be required to return to routine Medicaid eligibility redeterminations following a 14-month process outlined by CMS.

Exhibit XX: Change in Health Insurance Coverage Rate from 2019 to 2021, by Household Income as a Percent of FPL



Source: Adapted from Oregon Health Authority presentation to the Task Force on April 26, 2022 (Vandehey 2022)

Oregon Health Authority (OHA) estimated that 55,000 OHP enrollees may lose eligibility when redeterminations restart (Sweeney 2022). While some enrollees would be expected to transition to Marketplace or employer-sponsored coverage, others are anticipated to lose coverage and become uninsured. These challenges may be exacerbated by the future expiration of premium tax credit enhancements in 2025 (Cox, Amin and Ortaliza 2022). An additional 146,602 Oregonians purchase subsidized coverage through the Marketplace and could be affected (Oregon Health Insurance Marketplace 2022).

Goals of House Bill 4035

The Oregon Legislative Assembly passed **House Bill 4035** (HB 4035) in early 2022 to prepare for the PHE unwinding and maintain coverage gains achieved during the pandemic. The measure **established a task force** to:

1) **develop recommendations for a new health insurance program**, the Bridge Program, that will provide coverage to people earning up to 200 percent FPL, and
2) **recommend strategies to stabilize the insurance markets** for individuals and small businesses when the Bridge Program is created.

The Joint Task Force on the Bridge Health Care Program ("the Task Force") first convened on April 26th, 2022.

Members were appointed by Governor Kate Brown to represent a range of sectors, industries and perspectives, and included:

- Senator Elizabeth Steiner, District 17 (co-chair)
- Representative Rachel Prusak, District 37 (co-chair)
- Senator Bill Kennemer, District 20 (vice chair)
- Representative Cedric Hayden, District 07 (vice chair)
- Patrick Allen, Oregon Health Authority
- Stefanny Caballero, Virginia Garcia Memorial Foundation
- Adrienne Daniels, Multnomah County Health Department
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- Lindsey Hopper, PacificSource Health Plans
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- John Hunter, Oregon Health & Science University
- Kirsten Isaacson, Service Employees International Union, Local 49
- Heather Jefferis, Oregon Council for Behavioral Health
- William Johnson, Moda Partners
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- Fariborz Pakseresht, Oregon Department of Human Services
- Keara Rodela, Coalition of Community Health Clinics
- Matthew Sinnott, Willamette Dental Group
- Andrew Stolfi, Oregon Department of Consumer and Business Services
- Kelsey Heilman, Oregon Law Center

The Task Force held meetings through the spring and summer of 2022 (see Exhibit XX) and submitted preliminary recommendations on program design in an earlier report available at:

> *https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256619*

About This Report

The Task Force continued to meet through fall 2022 to review and discuss additional analysis and community feedback as it became available.

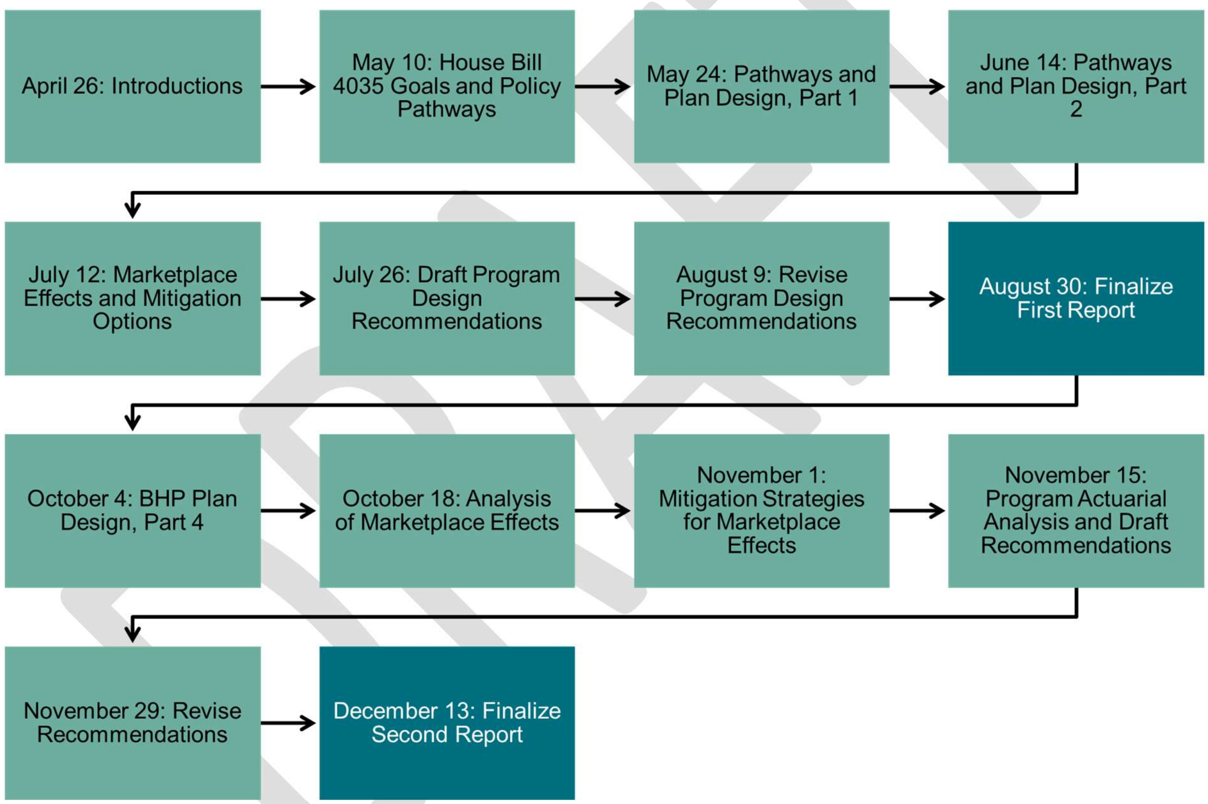
This report contains:

1. An analysis of the potential revenues and costs to operate a Basic Health Plan in Oregon;

2. updates to the preliminary program design recommendations;
3. an analysis of the projected effects on Oregon's Marketplace from creating the program; and
4. recommended strategies to mitigate these effects.

This report is the final submission of the Task Force in fulfilment of its charge in [HB 4035](). The report reflects information available to the Task Force through December 2022, along with remaining questions and future policy considerations for Oregon's evolving coverage landscape.

Exhibit XX: Task Force Meeting Dates and Topics, 2022



Source: LPRO

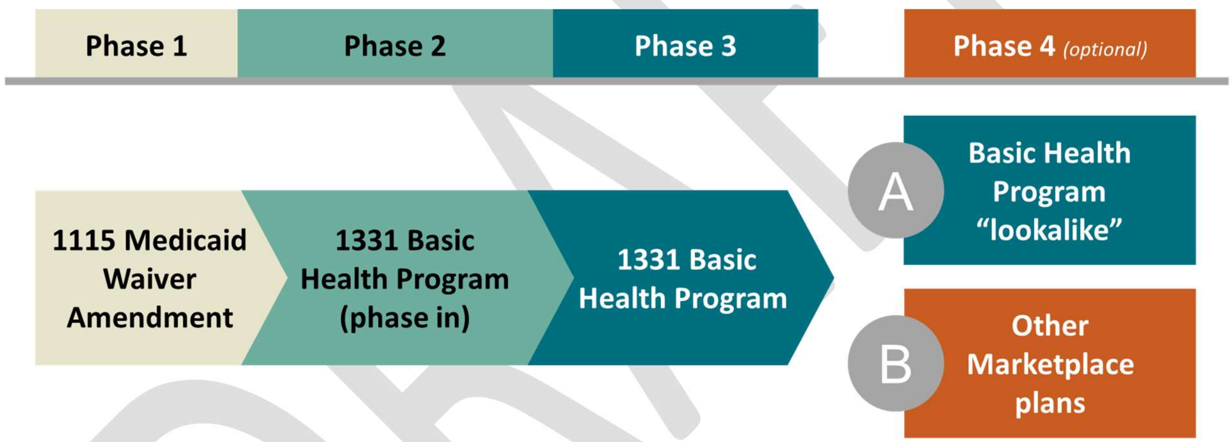
II. Bridge Program Design Recommendations

HB 4035 required the Task Force to develop recommendations on designing the Bridge Program with consideration for specific elements, including:

- the federal pathway and timeline to create the program;
- guidelines for how the state and CCOs should administer the program; and
- the benefits to be offered by the program.

On September 1st, 2022, the Task Force advanced preliminary recommendations based on information available at that time (Joint Task Force on the Bridge Health Care Program 2022). The recommendations called for providing bridge health care coverage via a Section 1331 Basic Health Program. The Task Force further recommended a phased implementation timeline (see Exhibit XX).[3]

Recommended Phased Implementation Timeline



Source: Adapted from Oregon Department of Consumer and Business Services

Projected Revenues and Costs of a Basic Health Program

The potential revenues and costs to operate a Basic Health Program were a key consideration in updating the Task Force's preliminary recommendations. Actuaries and consultants from Manatt Health, Oliver Wyman, and Mercer developed estimates for the

[3] In its earlier *Report on Preliminary Program Design Recommendations* submitted September 1, 2022, the Task Force recommended the creation of a Basic Health Program using a Section 1331 Blueprint. The BHP would be fully implemented in Phase 3. The Task Force considered alternate program models including the use of a Section 1332 State Innovation Waiver to create a program that would resemble a Basic Health Program but could offer additional flexibility for consumers who prefer to buy other Marketplace coverage. This option would require that Oregon operate a state-based marketplace and required additional discussion with federal agencies. The Task Force recommended Oregon continue to explore this option for a possible "phase 4" of the Bridge Program.

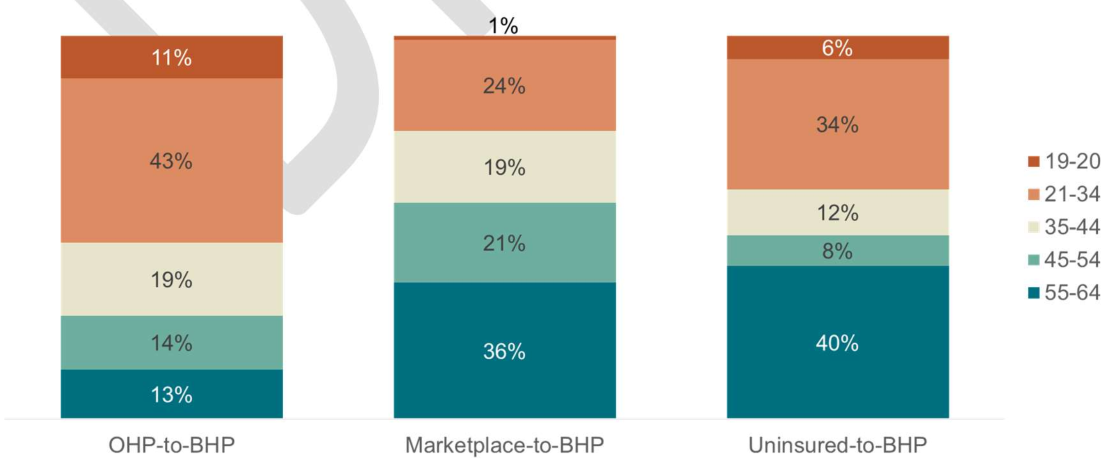
Task Force using a range of data sources including 2021 health care claims from OHP and commercial carriers (Ario and Tomczyk, Examining Marketplace Impacts Following Implementation of a BHP in Oregon 2022).

The analysis focused on **three groups** who will eventually be covered by the BHP, including:

- **OHP-to-BHP.** During phase two, the BHP will enroll 55,000 people with incomes between 138 and 200 percent of FPL who will transition from OHP to BHP coverage. There is substantial uncertainty in constructing estimates for this population due to income fluctuations during the PHE and inability to identify enrollees who may be ineligible for the BHP if they have access to affordable employer sponsored insurance. Actuaries modeled a likely OHP-to-BHP population with consideration for how long enrollees had been covered in OHP, whether they first enrolled during the PHE, and whether they had history of gaining and losing coverage due to income fluctuations.
- **Marketplace-to-BHP.** During phase three the BHP will open to all eligible consumers. An estimated 35,800 people will transition from the marketplace. This estimate was developed based on the number of people in the individual market in 2021 who earned between 138 and 200 percent of FPL, adjusted for population trends through 2025.
- **Uninsured-to-BHP.** When the BHP opens to all eligible consumers, an estimated 11,300 people who are uninsured would enroll. This estimate is based on microsimulation modeling of the uninsured population in 2021 projected to 2025.

The analysis found differences in the expected age distribution of the BHP-eligible populations (see Exhibit XX). The OHP-to-BHP population is much younger, on average, than either the Marketplace-to-BHP or uninsured-to-BHP populations.

Exhibit XX: Age Distribution of the Three BHP-Eligible Populations



Source: Adapted from Manatt Health and Oliver Wyman

Other characteristics of the three populations, including household income, household size, and geographic distribution across rating areas, are similar (see Exhibit XX). Household income and size skew slightly higher for the uninsured-to-BHP population compared with the OHP-to-BHP and Marketplace-to-BHP populations. The uninsured population is also slightly more concentrated in regions 2, 4, and 5, rather than region 7.

Exhibit XX: Estimated Household Income, Size, and Geographic Distribution of the BHP-Eligible Population

	OHP-to-BHP*	Marketplace-to-BHP	Uninsured-to-BHP
Household Income			
176 - 200% FPL	24%	24%	29%
151 - 175% FPL	42%	42%	44%
138 - 150% FPL	34%	34%	27%
Household Size			
1 person	60%	60%	53%
2 people	24%	24%	24%
3 people	7%	7%	12%
4 people	5%	5%	7%
5 or more people	4%	4%	5%
Geographic Distribution**			
Region 1	43%	46%	43%
Region 2	15%	13%	18%
Region 3	9%	6%	7%
Region 4	7%	8%	10%
Region 5	7%	9%	12%
Region 6	7%	6%	5%
Region 7	12%	13%	6%

Source: Manatt Health and Oliver Wyman

*Notes: *Actuaries modeled the OHP-to-BHP population with an assumption that the distribution of household income and household size for this population matched the Marketplace-to-BHP population. **Region 1 is Clackamas, Multnomah, Washington, and Yamhill counties. Region 2 is Benton, Lane, and Linn counties. Region 3 is Marion and Polk counties. Region 4 is Deschutes, Klamath, and Lake counties. Region 5 is Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook counties. Region 6 is Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler counties. Region 7 is Douglas, Jackson, and Josephine counties.*

Revenue calculations. BHP funding is calculated on a per member per month (PMPM) basis with individual-level funding determined by applicable adjustments (see Exhibit XX) (Centers for Medicare and Medicaid Services 2022). The calculation considers the estimated premium tax credit a consumer would be eligible for if purchasing coverage on the Marketplace. This base PTC value considers regional premiums, consumer age, household size, and household income. The funding formula also accounts for enhanced PTCs authorized by Congress through 2025 in the Inflation Reduction Act.

The formula then applies **adjustments** to the base PTC calculation, including:

- **A premium adjustment factor** that accounts for the loss of federal PTC for BHP consumers when a state does not "silver load" premiums for cost sharing reductions. This factor was 1.188 in 2022 (Ario and Tomczyk, Examining Cost and Revenue Estimates for a Basic Health Program in Oregon 2022).

- **A population health adjustment** that accounts for the loss of federal revenue that can occur if a BHP leads to lower Marketplace morbidity and, by extension, lower Marketplace premiums. This factor is optional, set to 1.0 by default, and may be requested by states.

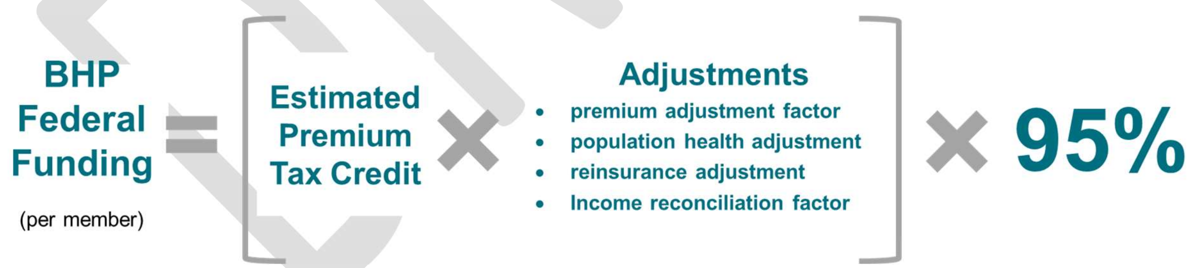
- **A reinsurance adjustment** that offsets any reduction in federal pass-through savings a state incurs when it operates a reinsurance program that reduces PTC under a Section 1332 waiver. This factor was part of a proposed rule not yet finalized at the time of this report.

- **An income reconciliation factor** that accounts for differences between estimated APTC and actual premium tax credits at year end, since there is typically slight variation at the population level between APTC calculated at the point of enrollment and the final PTC a consumer is eligible for based on actual income at year-end. This factor was 1.0063 in 2022.

The adjusted PTC is multiplied by .95 to determine the final BHP funding.[4] This amount is paid by the federal government to states operating a Basic Health Program.

Exhibit XX: Basic Health Program

Federal Funding Formula (2023 Proposed Rule)



Source: Adapted from Manatt Health and Oliver Wyman

[4] The ACA established BHP funding as 95 percent of the available premium tax credits (PTC) and cost-sharing reductions (CSR) that would have been provided to the consumer through the Marketplace. P.L. 111-148 sect. 1331(d)(3).

Cost calculations. The Task Force preferred that the BHP offer the same service package provided to OHP enrollees through CCOs, be provided to enrollees without premiums or cost-sharing, and if possible, pay capitation rates to CCOs that would support reimbursements to providers at levels higher than OHP (Joint Task Force on the Bridge Health Care Program 2022). Based on this guidance, actuaries developed cost estimates based on the service package offered by CCOs to OHP enrollees, including adult dental coverage[5] (Karl and Tomczyk 2022). This service package does not include LTSS or other services that are not paid by CCOs.

These cost estimates assumed OHP-level provider reimbursements as of 2021, projected forward to 2025. The estimate also incorporates CCO administrative expenses equivalent to 12.5 percent of premiums or 14.3 percent of claims costs. No enrollee cost sharing or premiums were included. The analysis did not consider costs that cannot be paid from federal BHP funds, including costs to administer the BHP Trust as well as the cost of abortion services that are required to be covered under state law. State general funds will be necessary for these expenses regardless of federal revenue projections.

The **per member per month cost** to provide this level of coverage was calculated differently for the three populations who would enroll in the BHP, estimated at approximately 111,600 people. Specifically:

1. **OHP-to-BHP population cost** was calculated based on per member per month (PMPM) costs for OHP enrollees. This amount was adjusted for the estimated demographics, geography, and health status of the OHP-to-BHP population, as well as what was known about their likely service utilization.

2. **Marketplace-to-BHP population cost** was estimated from the OHP-to-BHP per member per month cost, adjusted for the estimated demographics, geography and health status of the Marketplace-to-BHP population, and considered what is known about their service utilization.

3. **Uninsured-to-BHP population cost** was estimated using the Marketplace-to-BHP per member per month cost, adjusted for the estimated demographics, geography, and health status of the uninsured population, and considered what is known about their service utilization.

The actuarial team developed estimates for a base scenario and a series of alternative scenarios that modified assumptions about population income, age, and morbidity; consumer behavior; and federal policy; to assess the range of potential revenues and

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[5] This reflects a key difference from the financial feasibility study presented to the Task Force earlier in 2022; that analysis was based on the cost of coverage including the ten ACA essential health benefits plus adult dental coverage (see Appendix XX for a comparison of these covered service packages).

costs for Oregon's BHP. Under each scenario, budget estimates were provided at the population and PMPM levels.

Results. The analysis found that Oregon's BHP is projected to generate approximately $867.87 million in revenue and $723.35 million in expenses per year, for an estimated overall budget surplus of $142.52 million (see Exhibit XX). On a per member per month basis, this surplus equates to $116.33 per member per month, with differences across the OHP-to-BHP, Marketplace-to-BHP, and uninsured-to-BHP populations.

Exhibit XX: Projected Revenues and Costs of Oregon's BHP

	OHP-to-BHP	Marketplace-to-BHP	Uninsured-to-BHP	Total
Per Member Per Month (PMPM)				
*Revenue**	*$616.31*	*$820.14*	*$787.80*	*$706.76*
*Cost***	*$525.91*	*$719.49*	*$495.16*	*$590.43*
Net PMPM Surplus or (Deficit)	$90.40	$100.65	$292.65	$116.33
Population Total (in $ Million)				
*Revenue**	*$406.8*	*$352.5*	*$106.6*	*$865.9*
*Cost***	*$347.1*	*$309.2*	*$67.0*	*$723.4*
Net Population Surplus or (Deficit)	$59.7	$43.3	$39.6	$142.5

Source: Manatt Health and Oliver Wyman

*Notes: *Revenue includes federal funding Oregon would receive for a BHP. It assumes no revenue generated from consumer premiums. **Costs include the cost to CCOs to provide coverage to BHP enrollees as well as CCO administration expenses. Costs to the state to administer the BHP are not included.*

The analysis considered how these results could change if there are differences between the forecast assumptions and the income, age, or morbidity of the population that eventually enrolls in the BHP. Across these alternate scenarios, net program revenue ranged from $106.8 to $131.9 million, or $87.32 to 118.61 PMPM. These supplemental analyses are detailed in Exhibit XX.

Exhibit XX: Alternate Scenarios and Estimated Effects on Revenues and Costs

Scenarios	Net Revenue (population)	Net Revenue (PMPM)
Federal silver loading factor of 1.188 is reduced to 1.14 • The silver loading factor is established by CMS and could vary over time. • If carrier approaches to silver loading change and CMS lowers this factor, net revenues could be reduced. • Reducing the factor from 1.188 to 1.14 results in a 24.9% decrease in projected net revenue.	$107.0 million	$87.32
Estimated claims costs are 3% higher • While population adjustments vary, estimated costs are based on Medicaid claims costs and provider reimbursements from 2021 and projected forward to 2025. • The state could face higher than expected costs if these estimates are too low. For example, if 2025 claims costs are 3% higher than expected, net revenues would decrease by 15.2 percent.	$120.8 million	$98.62
BHP enrollment from Medicaid is smaller than expected and claims are 3% higher • Lower enrollment of consumers transitioning from OHP to BHP could lead to a less healthy population enrolling even with a similar demographic, geographic or income mix. • This could result in similar revenue but higher PMPM claims costs.	$109.7 million	$118.61
Uninsured uptake of BHP is 20% lower than expected and morbidity of this population is 5% higher • If fewer than expected uninsured people enrolled in the BHP, the uninsured population that *does* enroll may be less healthy. • This could lead to similar revenue but higher PMPM claims.	$131.9 million	$110.11

Source: Manatt Health and Oliver Wyman

Implications. The Task Force discussed these results at its November 15, 2022 meeting. Members noted that to ensure financial solvency and sustainability, the BHP will need to generate a budget surplus sufficient to develop and maintain financial reserves within the BHP Trust over time. Members observed the net revenues projected by the actuarial analysis represent a relatively small surplus given the range of potential outcomes implied in further sensitivity testing.

The results suggest the BHP could offer an OHP-like covered service package at no cost to enrollees but likely will not support capitation rates that enable CCOs to pay providers at higher-than-OHP levels in the short term. This finding required the Task Force to revise its preliminary recommendations related to capitation rates and provider reimbursements. The preliminary recommendations had supported capitation rates that would enable provider reimbursements higher than OHP, based on feasibility study findings that suggested a larger budget surplus may be possible (Ario, Actuarial Analysis of a Basic Health Program in Oregon 2022).

The Task Force discussed how Oregon should prioritize budget surpluses when the BHP has achieved sufficient financial reserves in the BHP trust fund. BHP funds can only be used for the benefit of BHP members, such as enhanced benefits or higher levels of provider reimbursement. Promoting recruitment and retention of providers to participate in BHP networks was a strong priority expressed by the Task Force, with particular attention to safety net and behavioral health providers. To reconcile the revenue estimates with members' goal that the BHP support provider reimbursements higher than OHP, members desired that Oregon establish specific targets for BHP trust reserves to ensure the state revisits BHP rates and reimbursements when these targets have been met. Members also requested OHA and DCBS engage in further analysis of the program's ability to achieve network adequacy requirements under the proposed OHP-like rate.

At its [date] meeting the Task Force updated its preliminary recommendations related to BHP capitation rates, provider reimbursements, and trust reserves to reflect the revenue analysis and resulting discussion:

- OHA should establish initial capitation rates to CCOs using a methodology that is consistent with how rates are determined for OHP, based on actuarial analysis suggesting federal revenues can support this level of payment.
- OHA and DCBS should analyze what reserve level is necessary in Oregon's BHP Trust Fund to support program solvency and sustainability. The analysis should include consideration of CCO requirements for financial reserves. The analysis should address how varying reserve thresholds may affect the program's ability to promote provider participation and network adequacy.
- If the BHP Trust Fund exceed established threshold levels OHA shall evaluate use of surplus amounts by considering feedback received from consumer engagement and the priorities established in **House Bill 4035**, including continued availability of a BHP option with no cost-sharing, higher than medical

assistance program reimbursement rates, and enhancement of the CCO delivery system. Initiatives using surplus BHP funds should be presented to the Legislative Assembly and be consistent with Oregon's broader health system reform priorities, particularly the goal of eliminating health inequities.

Additional Program Design Elements

During its October meetings, the Task Force discussed additional **elements of program design** that were not addressed in its earlier preliminary recommendations:

1) enrollment options for American Indian and Alaska Native enrollees,
2) Health Related Services (HRS), and
3) consumer advisory structures and engagement.

Enrollment Flexibility for American Indians and Alaska Natives. Under federal law, states may follow a "managed care" delivery system approach to providing Medicaid coverage, where the state pays a set PMPM payment to an entity called a managed care organization (MCOs) that accepts financial risk for the enrollee as well as responsibility to maintain access to and quality of care (Centers for Medicare and Medicaid Services n.d.). States may require Medicaid enrollees to participate in managed care. When Oregonians enroll in OHP, they are typically auto-enrolled in Oregon's version of Medicaid managed care coverage that is administered by a CCO serving that region (or, in some regions, enrollees have a choice between multiple CCOs) (Oregon Health Authority n.d.).

The OHP offers **exceptions to managed care** auto-enrollment procedures for certain populations, including:

- American Indian and Alaska Native (AIAN) enrollees who, under federal law, may opt out of Medicaid managed care; and
- Youth involved in the foster care system, who can have unique needs for flexibility in where they access health care services (**ORS 414.631(2)**).

For these populations, Oregon offers fee-for-service OHP coverage (sometimes called "open card") that allows them to seek care from any provider accepting Medicaid payment.

On October 18th, 2022, OHA presented to the Task Force on how these unique enrollment procedures in OHP may relate to BHP enrollment (Swerdlow 2022). The Task Force has expressed a desire to align BHP administration as closely as possible to existing OHP procedures to maximize continuity of coverage and minimize burdens on enrollees and CCOs. However, federal law requires that states offer a BHP by contracting with standard health plan offerors through a competitive process that considers the use of managed care or similar process to improve the quality, accessibility, appropriate utilization, and efficiency of services provided to enrollees (42 C.F.R. sect 600.410 (2022)). This means that the federal BHP requirements do not support Oregon directly replicating the open card model used in OHP when designing BHP enrollment procedures.

OHA proposed to maintain the open card coverage option by expanding OHP eligibility for populations that are categorically eligible for open card, but who earn up to 200 percent of FPL (Swerdlow 2022). In this approach, these populations would remain covered through OHP rather than transitioning to a BHP. OHA estimated that as of 2022 there are between 1,000 and 3,000 AIAN enrollees in OHP who may be eligible for BHP coverage based on their age and income. No foster youth enrolled in OHP would qualify for BHP, as this population remains eligible for OHP with incomes up to 305 percent of FPL.

This expansion of OHP coverage for AIAN people earning up to 200 percent of FPL would be achieved through an amendment to the state's Section 1115 Medicaid Demonstration Waiver. OHA consulted with Tribes and received general approval to pursue this approach. The agency submitted the proposed waiver amendment on November 15, 2022.

While recommendations regarding Tribal enrollment procedures are beyond the scope of the Task Force, members expressed support for OHA's continued exploration of options to maintain AIAN enrollment flexibilities consistent with the direction in **HB 4035** that the Bridge Program be consistent with the Oregon Integrated and Coordinated Health Care Delivery System.

Health Related Services. Health Related Services (HRS) are services beyond the OHP covered service package that CCOs have the option to provide (**OAR 410-141-3845**). HRS are designed to improve care delivery and overall member health and well-being.

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. These include health information technology investments.

CCOs have the option to provide HRS to members, but Oregon's 1115 waiver does not require them to do so[6] and there is no dedicated funding mechanism for HRS, which must be paid from CCOs' global budgets. In 2021, an average of 0.56 percent of CCOs' total spending was directed toward HRS (ranging from 0.19 to 2.68% among CCOs) (Gund

[6] HRS are not defined as covered services under the Oregon Health Plan. Thus, the cost of HRS were not considered in the financial feasibility study presented by Manatt Health in June. Similarly, they were not included in the comparison of OHP covered services and the ten ACA Essential Health Benefits that was provided to the Task Force in July.

2022). This is equivalent to $2.35 per CCO member, per month on average (ranging from $0.51 to $10.70 among CCOs).

OHA incentivizes spending on HRS two ways (Oregon Health Authority 2022). First, CCOs may count HRS toward medical expenditures to meet the required medical loss ratio (the ratio of medical spending to plan administration costs and profit). Second, CCOs are eligible for a performance-based reward that is intended to offset decreases in CCOs' capitation rates that could occur if their investments in HRS lead to a decrease in downstream medical service spending (sometimes called "premium slide").

Oregon's primary Section 1115 Medicaid Demonstration Waiver for its OHP program was approved by CMS on September 28, 2022, for years 2022-2027 (Centers for Medicare and Medicaid Services 2022). Under this waiver, OHA will continue to encourage CCOs to invest in HRS without specific spending requirements. The new waiver will expand access to services to address social needs for certain "transition" populations including people transitioning from foster care, from jails, etc. Health related services provided to these transition populations will be covered OHP services in some instances, while HRS to other OHP enrollees will continue to be permitted expenditures from CCOs' global budgets. OHA is still developing implementation strategies and a timeline for the newly approved Section 1115 waiver.

Members discussed the potential relevance of HRS for the BHP program. **Key considerations about HRS** included:

- that the BHP population would benefit from flexible (member-level) services,
- that it would be helpful to better understand changes in OHP definitions applicable to HRS because of the Task Force's desire to align BHP and OHP benefits,
- 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), through mechanisms such as the performance-based reward;
- that uncertainty about what OHA will approve as an HRS expenditure creates a disincentive for CCOs to provide them, and that CCOs, consumers, and providers would benefit from additional guidance on what are allowable HRS expenditures; and
- that it would be beneficial to offer CCOs and enrollees the ability to appeal OHA denial of flexible services under a BHP, which is not allowed under OHP because HRS are not subject to the normal appeals processes for OHP covered services.

Following confirmation that BHP federal funding will support OHP-like benefits and capitation rates, the Task Force recommends:

- The BHP should encourage CCO provision of Health-Related Services (HRS) to enrollees in a manner consistent with the Oregon Health Plan. OHA should provide guidance to CCOs on what services will qualify as HRS expenditures. This guidance should clearly indicate any non-allowable expenditures for BHP enrollees, including how, if at all, BHP-eligible spending differs from OHP qualifications.

Consumer Advisory Structures and 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 timeline for development of the Task Force's recommendations constrained options for further consumer engagement events during the time available. The Task Force discussed two options that could be the basis for a recommendation to continue consumer engagement activities after the Task Force completed its work: 1) OHA and DCBS-led focus groups to engage consumers prior to implementation of the program, and 2) the creation of a standing consumer advisory committee for ongoing feedback on the BHP.

The Task Force supports consumer engagement in ongoing and future BHP development and implementation efforts and advanced the following recommendations specific to that engagement:

- OHA and DCBS should gather consumer feedback prior to program implementation, including engaging consumer advocacy groups to maximize input from communities that experience inequities in the health system. OHA and DCBS should conduct consumer focus groups to explore topics such as: benefit design; marketing channels and tools to reach consumers with information about the program; and specific needs of people who experience churn under OHP. These activities should compensate participants for their time, be flexible in scheduling and ways of giving input, and prioritize topics for which consumer feedback is most likely to be able to inform program planning.

Final Recommendations on Bridge Program Design

The Task Force revisited and updated its preliminary recommendations based on the additional information and analysis reflected in this report. The recommendations were finalized and adopted by the Task Force at its [date] meeting based on information available through late November 2022. These recommendations are summarized below.

Exhibit XX: Final Task Force Recommendations on Program Design

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 no more than 24 months after the implementation of Phase Two. 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.
5. 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.
6. Beginning in Phase Three, all eligible consumers should be able to access 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.

7. 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.
8. OHA and DCBS should gather consumer feedback prior to program implementation, including engaging consumer advocacy groups to maximize input from communities that experience inequities in the health system. OHA and DCBS should conduct consumer focus groups to explore topics such as benefit design; marketing channels and tools to reach consumers with information about the program; and specific needs of people who experience churn under OHP. These activities should compensate participants for their time, be flexible in scheduling and ways of giving input, and prioritize topics for which consumer feedback is most likely to be able to inform program planning.

Program Financing, Plan Rates and Provider Reimbursements

9. OHA should establish initial capitation rates to CCOs using a methodology that is consistent with how rates are determined for OHP, based on actuarial analysis suggesting federal revenues can support this level of payment.
10. OHA and DCBS should analyze what reserve level is necessary in Oregon's BHP Trust Fund to support program solvency and sustainability. The analysis should include consideration of CCO requirements for financial reserves. The analysis should address how varying reserve thresholds may affect the program's ability to promote provider participation and network adequacy.
11. If the BHP Trust Fund exceeds established threshold levels OHA shall evaluate use of surplus amounts by considering feedback received from consumer engagement and the priorities established in House Bill 4035, including: continued availability of a BHP option with no cost-sharing, higher than medical assistance program reimbursement rates, and enhancement of the CCO delivery system. Initiatives using surplus BHP funds should be presented to the Legislative Assembly and be consistent with Oregon's broader health system reform priorities, particularly the goal of eliminating health inequities.

Benefit Design

12. The Bridge Program should align as closely as possible with CCO-covered OHP benefits, including adult dental coverage.
13. The program should be offered to enrollees at no cost, including no monthly premiums and no out-of-pocket costs to access services.

14. 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.
15. The BHP should encourage CCO provision of Health Related Services (HRS) to enrollees in a manner consistent with the Oregon Health Plan. OHA should provide guidance to CCOs on what services will qualify as HRS expenditures. This guidance should clearly indicate any non-allowable expenditures for BHP enrollees, including how, if at all, BHP-eligible spending differs from OHP qualifications.

Source: LPRO

The Task Force advanced these recommendations based on the following **fiscal assumptions:**

- **The proposed 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.
- **Actuarial analysis indicates the proposed design would not require other state funding or enrollee cost sharing to be financially feasible.** These assumptions are based on limited information available about the population who will transition from OHP to BHP during the PHE. More information will be available over time as OHA conducts eligibility redeterminations for OHP.
- **The proposed design could be affected by expiration of premium tax credit enhancements established in the American Rescue Plan Act (2021) and renewed in the Inflation Reduction Act (2022).** These tax credit enhancements will expire at the end of 2025 in the absence of further action by Congress and would reduce federal revenue for Oregon's BHP. The state will need to monitor this issue over time as more information is available.

While the Task Force has based its recommendations in the best available information at the time of this report, OHA, DCBS, and the legislative assembly will need to monitor these issues and confirm assumptions through future analysis as the program launches and additional information becomes available

III. Analysis of Disruptions to Oregon's Individual Marketplace

HB 4035 requires the Task Force to consider how creating the BHP could lead to secondary effects in Oregon's individual and small group insurance markets. This section provides background and analysis the Task Force considered in developing its recommendations.

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010 to expand health care coverage and affordability (**Public Law 111-148** (2010)). The ACA authorized the creation of state health insurance exchanges where individuals and small organizations can purchase coverage. States can follow several **models for establishing an exchange** or "Marketplace" (National Conference of State Legislatures 2021), including:

- **A federally-facilitated Marketplace** (FFM), Healthcare.gov, that is fully managed by CMS.
- **A state-based Marketplace on the federal platform** (SBMFP), where states assume responsibility for consumer outreach and insurer oversight (plan management) but offer plans through the federal Healthcare.gov site.
- **A state-based Marketplace** (SBM), where states assume responsibility for operating an exchange on their own website.

Oregon operates a SBMFP, the Oregon Health Insurance Marketplace (OHIM), administered by OHA. OHIM offers consumer outreach and education, enrollment and financial assistance, and a "window shopping" tool summarizing available plan information for consumers (Button 2022).

Oregonians purchase and enroll in coverage through the federal Healthcare.gov platform. In 2022, 146,602 Oregon consumers purchased coverage from the Marketplace (Button 2022). In plan year 2023, Oregon's Marketplace offers 77 Qualified Health Plans (QHP) from six carriers, and 20 dental plans from six dental carriers (Button 2022).

QHPs are required to meet affordability standards and cover all federally defined essential health benefits (**45 C.F.R. 156.100**, et seq.). The ACA also established two approaches to make Marketplace coverage more affordable: advance premium tax credits (APTC), and cost sharing reductions.

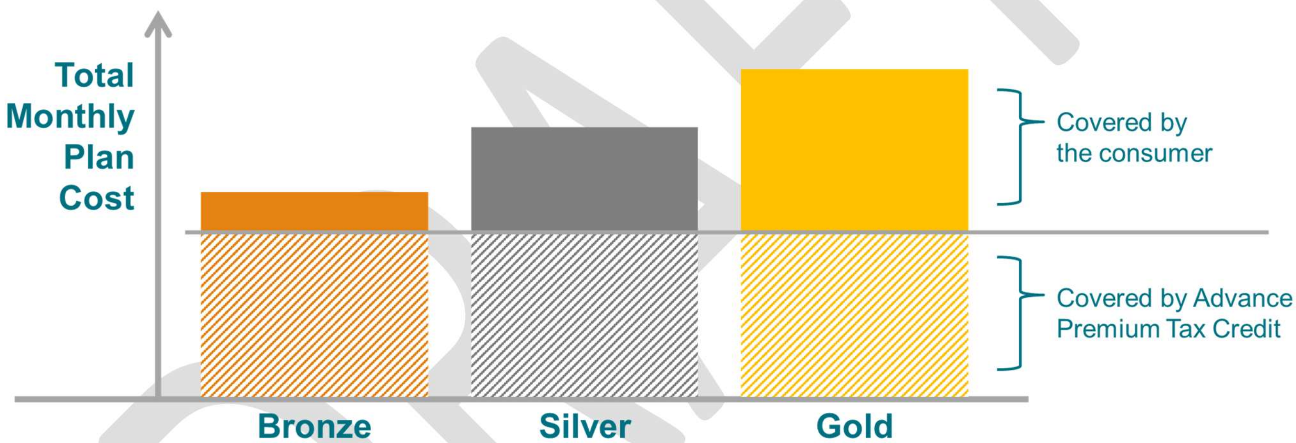
Advance Premium Tax Credits

The ACA (**Public Law 111-148** (2010) established advance premium tax credits to lower the cost of monthly premiums for people who purchase coverage on the exchange. Under the ACA, APTC is available to people who:

- are U.S. citizens and lawfully present non-citizens (including non-citizens who would be eligible for OHP if not for being in their first five years of residency);
- meet income requirements; and
- do not have access to affordable employer sponsored insurance.

APTC is calculated and applied at the point of plan selection to lower the up-front cost of enrollment. APTC can be applied toward any QHP on the Marketplace to lower the net monthly premium paid by the consumer (see Exhibit XX).

Exhibit XX: Individual Premiums and Subsidies



Source: Adapted from DCBS (Rehfield-Griffith 2022)

The value of an individual's APTC is based on a sliding scale formula that considers two factors:

1) the premium of the second lowest cost silver tier plan in each rating area (SLCSP), and
2) an affordability limit (or "applicable percentage", see Exhibit XX) based on an individual's household income as a percent of FPL.

In 2021, Congress passed the American Rescue Plan Act (Public Law 117-2 2021) which increased the value of APTC and temporarily waived the upper limit for APTC eligibility, extending premium subsidies to people earning more than 400 percent of FPL during the pandemic.

Exhibit XX: Household Incomes and Applicable Percentages, 2022

Monthly Household Income as Percent of Federal Poverty Level (FPL)	Applicable Percentage (max premium paid as % of household income)
Up to 150% of FPL	0%[7]
At least 150% but less than 200%	0% to 2%
At least 200% but less than 250%	2% to 4%
At least 250% but less than 300%	4% to 6%
At least 300% but less than 400%	6% to 8.5%
400% or higher	8.5%

Source: 26 U.S.C Section 36B

For many consumers, plans became more affordable in 2021 following these enhancements (see Exhibit XX), which were renewed through December 2025 as part of the Inflation Reduction Act (Public Law 117-169 2022).

Exhibit XX: Monthly Plan Cost Before and After ARPA (2021)

	Lowest Cost Bronze Plan		Lowest Cost Silver Plan		Lowest Cost Gold Plan	
Annual Income	**Before**	**After**	**Before**	**After**	**Before**	**After**
Portland resident, age 35						
$19,140.00	$1	$1	$64	$2	$78	$12
$25,520.00	$1	$1	$141	$40	$151	$54
$38,280.00	$212	$90	$311	$189	$325	$203
$51,040.00	$285	$206	$384	$359	$398	$373
$63,800.00	$285	$285	$384	$384	$398	$398
La Grande resident, age 55						
$19,140.00	$1	$1	$49	$6	$222	$156
$25,520.00	$1	$1	$121	$25	$294	$198
$38,280.00	$88	$1	$296	$174	$469	$347
$51,040.00	$193	$136	$401	$344	$574	$517
$63,800.00	$668	$226	$876	$464	$1,049	$607

Source: Updated APTC and Plan Costs with 2021 Increased Subsidies, Oregon Health Insurance Marketplace.

Cost Sharing Reductions and "Silver Loading"

The ACA also established Cost Sharing Reductions (CSR) to lower out of pocket (OOP) costs, such as copays and deductibles, that individuals can be responsible for in addition to their monthly premiums. The ACA requires Marketplace carriers to offer

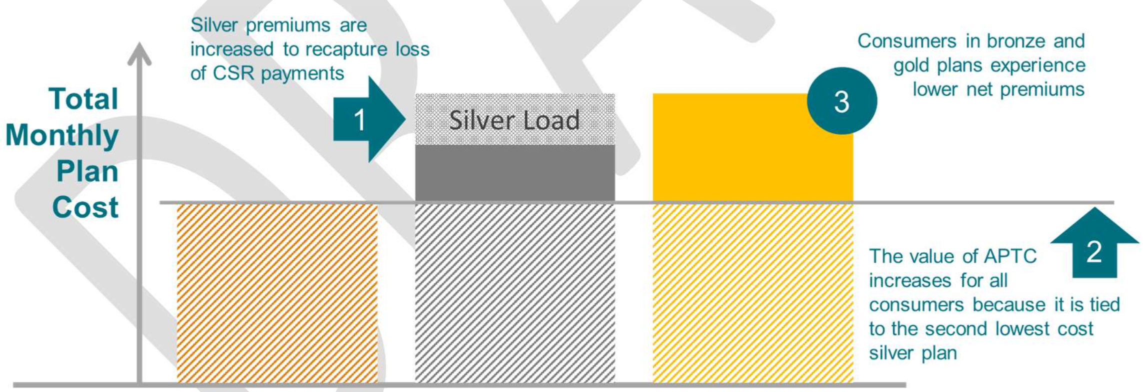
[7] Consumers in this income bracket pay a $1 monthly premium.

discounted silver-CSR plans to eligible consumers, including people who earn less than 250 percent of the FPL, and American Indians and Alaska Natives. These silver-CSR plans reflect lower cost sharing and OOP maximums than base silver plans (see Appendix XX for an illustration of how CSRs lower OOP costs for eligible consumers in silver-CSR plans).

To maintain provider reimbursements across plan variants, carriers were originally reimbursed by the U.S. Department of Health and Human Services (HHS) for offering discounted CSR plans. In 2017, HHS discontinued CSR reimbursements, citing a court ruling that HHS did not have an appropriation from which to make the payments (Keith, Federal Circuit: Insurers Owed Unpaid Cost-Sharing Reductions, Reduced by Higher Premium Tax Credits from Silver Loading 2020). Despite this discontinuation of payments to carriers, the ACA requirement for carriers to offer discounted CSR plans to eligible consumers has remained in effect.[8]

To offset the loss of federal payments, most states, including Oregon, directed insurers to increase premiums for the 2018 plan year (and thereafter) using one of several approaches. The most common approach, "silver loading," increased premiums on silver plans (Griffith 2022). Because consumer APTC is determined based on the SLCSP sold in the Marketplace in a given rating area, when silver loading increases silver premiums, it also increases the value of APTC (see Exhibit XX).

Exhibit XX: Silver Loading Effect on Premiums and APTC



Source: Adapted from Manatt Health presentation on October 4th, 2022 (Ario, Tomczyk and Rehfield-Griffith, An Early Look at Marketplace Impacts Following Implementation of a BHP in Oregon 2022)

[8] In August 2020, a Federal Circuit court panel upheld a lower court decision that the ACA obligates the federal government to pay insurers for CSRs. However, the court found that the federal government was meeting this obligation indirectly through higher APTCs paid as a result of silver loading. See https://www.healthaffairs.org/do/10.1377/forefront.20200817.609922/full/

Consumers - particularly those purchasing gold or bronze plans - experience decreased net premiums, as silver loading increases the value of their APTC relative to monthly premiums (Aron-Dine 2017). Over time, more consumers have opted into gold and bronze plans since silver loading began (Ario, Tomczyk and Rehfield-Griffith, An Early Look at Marketplace Impacts Following Implementation of a BHP in Oregon 2022).

Anticipated Marketplace Disruptions

HB 4035 required the Task Force to identify disruptions that creation of a BHP could cause to the individual and small-group health insurance markets. The Task Force studied potential market disruption issues over the course of several fall meetings, including:

- **Discontinuation of most silver loading**. If a BHP is created for people earning up to 200 percent of FPL, only those consumers earning between 200 and 250 percent of FPL would remain eligible for silver-CSR plans in the Marketplace. This would eliminate the need for most silver loading in the Marketplace. The reduction in silver loading will result in a decrease in silver premiums in the Marketplace and will also reduce the value of APTC and purchasing power for Marketplace consumers.
- **Changes in consumer characteristics such as average morbidity** (or health status) of people in the individual and small group markets after those with incomes less than 200 percent of FPL transition to the BHP. This could drive changes in plan costs to provide coverage.
- **Changes in consumer behavior**, such as selecting less generous coverage or disenrolling from coverage, that could occur following changes in Marketplace premiums and APTC when the BHP is created.

Consultants from Manatt Health and actuaries from Oliver Wyman were contracted to analyze these potential market disruptions. The analysis (Ario and Tomczyk, Examining Marketplace Impacts Following Implementation of a BHP in Oregon 2022) used a range of available data sources and research to construct a simulation ("model") of how people in Oregon's individual market will behave under certain conditions or policy scenarios. The model was configured with a baseline population of consumers using data from the Oregon Marketplace in years 2019-2021 and tailored to a specific set of conditions (i.e., the creation of a BHP).

The analysis depicts the individual market characteristics in 2024 under multiple scenarios (see Exhibit XX).[9] Results and related Task Force discussions are described below.

Exhibit XX: Analysis of BHP Impact on the Individual Market

Source: LPRO

Baseline Conditions. From 2019 to 2022 (YTD), the number of people purchasing individual coverage was stable, though within this group, the percent of people who purchased coverage in the individual market increased from 71.9 percent in 2019 to 77.5 percent in 2022 (YTD). The percent of people who received premium tax credits increased from 54.0 percent in 2019 to 59.3 percent in 2022, reflecting enhanced subsidies available through the American Rescue Plan (ARPA).

Initial changes in the individual market following BHP creation. If the BHP is implemented in 2024, an estimated 37,300 out of 178,000 people will transition to BHP coverage and exit the individual market. Compared with the individual market population before the BHP, the post-BHP individual market (approximately 142,200 people) would initially reflect these characteristics in 2024:

- **Slightly healthier.** Initially, the relative morbidity of the individual market population improves (decreases) by 1.8%. The effect varies across carriers, ranging from no change to a 3.7% decrease in average morbidity.
- **Similarly distributed across the state.** 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.
- **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 individual market. Other age bands do not change.
- **Higher average income.** Before a BHP, 43 percent of the on-exchange Marketplace population earns more than 400 percent of the federal poverty level

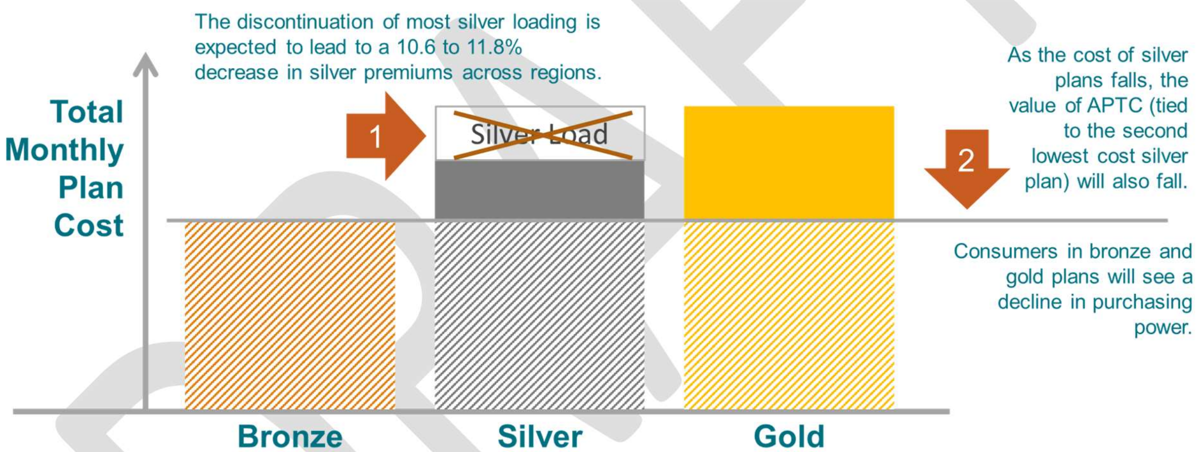
[9] Although the BHP is not likely to be implemented before 2025, the analysis is indicative of the range of changes that are projected to take place in whatever year the BHP is implemented.

(FPL). When the BHP population is removed, 54 percent of the Marketplace population earn more than 400% FPL.

When BHP-eligible consumers transition from the Marketplace to a BHP, the decrease in average morbidity would initially lead to a slight reduction in premiums across the individual market, though these effects vary by age and rating region.

Carriers would also discontinue most silver loading as consumers eligible for silver-CSR plans transition to the BHP, initially lowering silver premiums by 10.6-11.8 percent across rating areas. As the cost of silver plans falls, this will in turn reduce the value of APTC, which is tied to the second lowest cost silver plan in a rating area. People enrolled in silver plans will see little net change in their purchasing power, as both premiums and APTC will decline. Consumers in subsidized gold and bronze plans will see a decline in purchasing power as the value of their APTC falls relative to their gold or bronze premium (see Exhibit XX).

Exhibit XX: Discontinuation of Silver Loading



Source: Adapted from

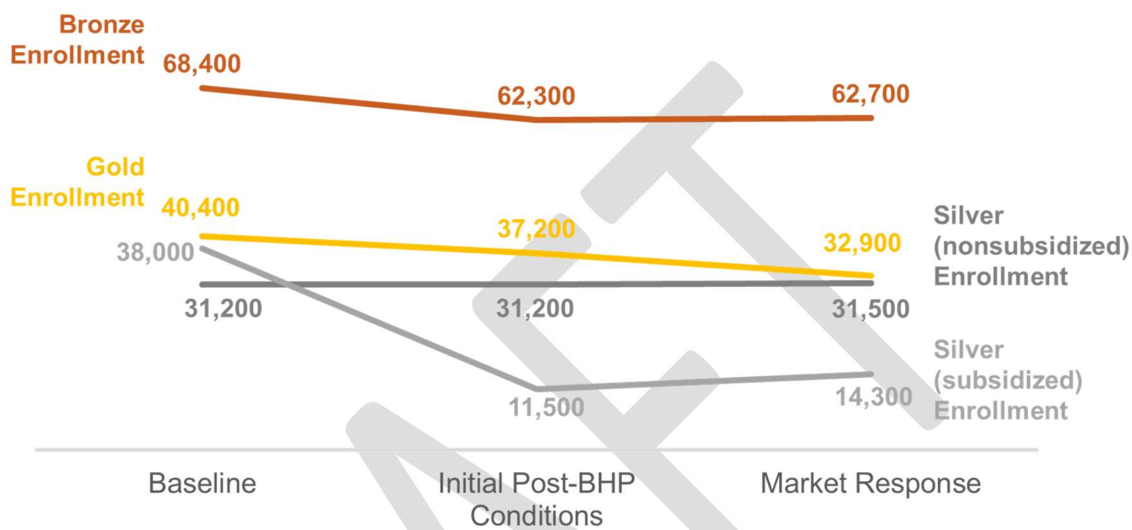
https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257236

Some consumers are expected to respond to these changes in premiums and APTC by altering their plan selections. The analysis also explored these secondary effects.

Secondary Effects on Plan Selection and Enrollment. As remaining individual market consumers respond to changes in premiums and APTC, total enrollment in the market is expected to decline slightly further to 141,400, as approximately 900 people (0.6% of consumers) no longer purchase coverage in the individual market. Overall enrollment declines across all metal tiers other than nonsubdidized silver plans, which remain stable (see Exhibit XX).

The income, age, and geographic distribution of the remaining individual market population do not change substantially further following the initial changes that occur after the BHP population exits the individual market (see appendix XX for details). Average morbidity in the individual market, which initially improves 1.8% following exit of BHP consumers, reverses slightly as the market adjusts, and stabilizes at 1.5% lower than baseline morbidity.

Exhibit XX: Changes in Marketplace Enrollment following BHP Creation



Source: Manatt Health and Oliver Wyman presentation to the Task Force on October 18th, 2022

The effect on premiums for a given consumer would vary depending on age, income, and rating area (see Exhibit XX for examples).

Exhibit XX: Examples of Changes in Marketplace Premiums post-BHP, by Consumer Age, Income, and Rating Area

Age	Income	% of FPL	Changes in Lowest Cost Bronze Premium	Changes in Second Lowest Cost Silver Premium	Changes in Lowest Cost Gold Premium
21	$34,000	250%	$39 to $50	$0	$37 to 48
21	$54,400	400%	($4) to $25	($48) to ($13)	($6) to $23
64	$34,000	250%	$0	$0	$111 to $144
64	$54,400	400%	$116 to $151	$0	$111 to $144

Source: Manatt Health and Oliver Wyman presentation to the Task Force on October 18th, 2022

As these changes in premiums take effect, some consumers would respond by selecting less generous coverage, though these effects are meaningfully different for consumers who qualify for APTC and those who do not. For example:

- **Fewer consumers qualify for subsidies overall.** Whether a given consumer qualifies for APTC depends on the difference between the second lowest cost silver plan premium in their area and their affordability limit (based on income). In this scenario, premiums for silver plans fall relative to household incomes, resulting in fewer households qualifying for APTC. Within metal tiers, this results in a larger share of households purchasing unsubsidized plans; consumers in silver plans see little change in net premium.

- **There is little change in the plans selected by the 58,400 consumers who do not qualify for APTC.** Premiums decrease 1.5 percent overall for people who do not qualify for APTC, reflecting lower individual market morbidity, and these consumers are unaffected by changes in the value of APTC. Approximately 0.2 percent (n=100) upgrade from a bronze to a silver plan.
- **Among the 83,700 consumers who qualify for APTC, 5 percent (n=4,200) respond by switching to less generous plans.** This reflects the net loss of purchasing power experienced by these consumers when the value of their APTC decreases more than the cost of their monthly premium. An additional 3.1 percent switch to more generous coverage (n=2,600) and one percent (n=900) drop coverage.

Plan costs vary by consumer demographics and location but Exhibit XX below provides information about how maximum out of pocket costs could change for consumers who switch between plan tiers.

Exhibit XX: Marketplace Plan Deductibles[10] and Maximum Out-of-Pocket Costs (Plan Year 2023)

	Gold Plans	Silver Plans	Bronze Plans
Average* Deductible (Min, Max)	$1,800 ($0 - $2,000)	$4,800 ($750 - $6,500)	$8,800 ($5,500 - $9,100)
Average* out-of-pocket costs (Min, Max)	$7,300 ($7,300 – $9,100)	$9,100 ($7,400 - $8,100)	$8,800 ($6,900 - $9,100)

Source: Oregon Health Insurance Marketplace.
**Note: Average is most common (mode) deductible in that metal tier in plan year 2023.*

[10] Many services covered by Marketplace QHPs are not subject to deductibles. Every Marketplace insurer offers at least three plans with unlimited office visits offered with a copay but no deductible (including primary care, specialty, behavioral, habilitative and rehabilitative care). Many plans offer pharmacy and urgent care coverage not subject to deductibles. This type of coverage is available at all metal tiers, and in all service areas in Oregon.

Summary and Key Takeaways

In summary, **key findings from this analysis** suggest the following would be expected to occur after the creation of the BHP:

- An estimated 37,300 people transition from the individual market to the BHP.
- The population who remain in the individual market would initially be healthier and higher income on average, but similar in age and geographic distribution to the individual market pre-BHP.
- Insurers would discontinue most silver loading, leading to a 10.6-11.8 percent decrease in silver premiums.
- Fewer people who remain in the Marketplace would qualify for subsidies. This is not driven by a change in premiums for these consumers, but instead reflects that the reference point for subsidies, the second lowest cost silver plan premium, would decline in cost below the affordability threshold for those consumers.
- Unsubsidized consumers would be unaffected by these changes and see a slight 1.5% decrease in premiums. This group would not meaningfully alter their decisions about purchasing coverage.
- However, subsidized consumers would see a decrease in the value of (or elimination of) their APTC. Approximately 4,200 consumers in this group would respond by shifting to more affordable and less generous coverage while 2,600 would purchase more expensive and more generous coverage. A smaller number, estimated at 900, would exit the Marketplace.

HB 4035 required the Task Force to 1) consider mitigation strategies that could be used to address any Marketplace effects from creating the BHP, and 2) make recommendations regarding these strategies. Section IV describes these options and recommendations.

IV. Strategies to Mitigate Disruptions

As described on page XX, when the Bridge program is created, the transition of BHP-eligible consumers from the Marketplace will lead to changes in consumer purchasing power and coverage decisions for those remaining in the Marketplace. While these changes affect a small proportion of the overall market (e.g., approximately 4,200 consumers may select less generous coverage and 900 may drop coverage), mitigation strategies may be able to offset these effects.

The Task Force explored **two potential mitigation strategies**:

1. **Creating a state subsidy program.** Oregon would establish subsidies for Marketplace consumers to address the impact of reduced silver loading when the BHP is created. The subsidies would be distributed to carriers to minimize administrative complexity, and carriers would deduct both APTC and state subsidies from premiums when consumers shop for Marketplace coverage. While this approach would mitigate premium impacts to consumers, it presented operational challenges that required exploration with carriers to implement.
2. **Calculating the value of individual subsidies based on the cost of a gold benchmark**. By de-coupling Marketplace subsidies from the value of the second lowest cost silver plan in a region and instead tying it to a gold benchmark plan, Oregon could potentially offset most of the impact on net premiums when silver loading is discontinued.

Both options could potentially be funded through a Section 1332 State Innovation Waiver, though neither approach had previously been approved by CMS or used by other states. Section 1332 of the ACA allows states to request approval from CMS to waive certain ACA provisions such as requirements for QHPs or a state's Marketplace in order to pursue strategies to improve access to health care. This mechanism could, for example, be used to request a shift from a silver to a gold plan benchmark.

Section 1332 also provides a mechanism for states to receive "pass through" funding from any federal savings generated by a 1332 waiver. These savings are determined based on what the federal government would have paid a state toward Marketplace premium tax credits and cost-sharing reductions in the absence of the waiver (Centers for Medicare and Medicaid Services 2019). Oregon could potentially leverage these pass-through savings to support a subsidy program or to increase APTCs for Marketplace consumers.

Both approaches also presented possible operational challenges, as neither had been previously attempted in Oregon or other states. CMS provided initial guidance to Oregon in summer 2022 to explore the feasibility of implementing these options in its Marketplace.

Carrier and Federal Feedback

OHA and DCBS convened a series of meetings with insurers offering Marketplace plans to gather feedback on these mitigation approaches to inform Task Force planning. This "carrier table" met four times between September and November 2022, providing feedback that was presented back to the Task Force for consideration at its November meetings.

Subsidy Program Feedback. OHA and DCBS met with representatives from insurers to discuss the feasibility of a subsidy program concept. The subsidy program would be designed to support Marketplace consumers by offsetting the decrease in APTC that would occur following creation of the BHP.

Certain **operational considerations** posed up front challenges in the design of a subsidy program concept, including:

- Because Oregon operates its Marketplace on the federal Healthcare.gov platform, these subsidies could not be applied at the point of enrollment and would instead need to be funded through payments made by the state to carriers.
- In order to make the subsidy program operationally feasible, subsidies were proposed as a flat dollar amount with limited variations across consumer categories such as age and family composition. Such a program would address some but not all of the variation in how consumers would be affected by the loss of APTC.
- To implement this subsidy program, insurers would need certain capabilities such as the ability to overwrite Marketplace premiums, assign variable subsidy amounts to consumers, reconcile subsidy information with the federal exchange, and report systematically on consumer subsidies to the state.

Feedback from the carrier table indicated these changes would be operationally infeasible by 2025, when the BHP would begin enrolling Marketplace consumers and mitigation methods would need to be in place. The carrier table did not recommend this approach.

Gold Benchmark Feedback. A gold benchmark would require system change at the federal level to adjust the calculation of a consumer's APTC. It would not likely require further calculations by insurers offering coverage on the Marketplace. In contrast to the subsidy program approach, the carrier table did not identify significant operational concerns with a gold benchmark and indicated support for the Task Force further exploring this option.

Gold Benchmark Analysis

A key consideration in the shift to a gold benchmark is whether Oregon can secure federal approval and funding for this approach. To receive approval of a Section 1332 waiver, states are accountable for complying with **four federal guardrails** (statutory requirements), including:

1. Providing coverage that is equally or more comprehensive in its covered services than what would have been provided without the waiver;
2. Providing coverage that is equally or more affordable, with consideration for cost sharing and out-of-pocket costs;
3. Providing coverage to as many or more members than would have been covered otherwise; and
4. Not increasing the federal deficit (i.e. "deficit neutral") (**31 C.F.R. part 33** (2018)).

To secure approval for a switch to a gold benchmark through a Section 1332 waiver, Oregon would need to demonstrate that it can remain compliant with these guardrails. Because states are prohibited from having multiple separate 1332 waivers, Oregon would also need to pursue this strategy as an amendment to its existing reinsurance program waiver.[11]

At its November 1st meeting, DCBS and OHA presented a preliminary assessment of the **gold benchmark compatibility with the guardrails**. Specifically:

- **Comprehensiveness.** While further analysis was needed, shifting to a gold benchmark was not anticipated to affect the comprehensiveness of coverage for consumers, meeting this benchmark.
- **Coverage.** The shift to a gold benchmark was also anticipated to cover as many or more consumers, meeting this benchmark.
- **Affordability.** Preliminary analysis by DCBS suggested that while a shift to a gold benchmark would result in similar or more generous APTC (and thus, affordability of coverage) for consumers on average, there are a small number of counties where silver loading increases the cost of the SLCSP slightly *higher* than the cost of a gold plan. In these counties, shifting to a gold benchmark could instead result in a slightly lower APTC.
- **Federal deficit neutrality.** Because shifting to a gold benchmark would likely result in more generous APTC than a silver benchmark, this approach is not, on its own, likely to be deficit neutral to the federal government. However, CMS would

[11] Since they became available in 2017, Section 1332 waivers have been used by seventeen states to establish reinsurance programs, though these waivers are not limited to this purpose. Oregon first received approval of a Section 1332 waiver in 2018 (following passage of House Bill 2381) to establish a reinsurance program.

consider the cost of the gold benchmark together with savings from the existing reinsurance program for the purposes of calculating federal deficit neutrality.

OHA and DCBS were engaged in discussions to gather **additional feedback needed from CMS,** including whether the healthcare.gov platform could support a shift to a gold benchmark; and whether shifting to a gold benchmark would be compatible with the Section 1332 affordability guardrail if there was regional variation in benefits to consumers.

The Task Force discussed these issues at its November 1st and November 15th meetings. Members posed **questions about the gold benchmark** for further exploration, including:

- The need for an actuarial analysis of the cost of shifting to the gold benchmark;
- whether Oregon would be able to meet its targets and requirements for the reinsurance program if some savings generated by the program were directed toward offsetting the cost of the gold benchmark;
- the estimated numbers of consumers in regions where shifting to a gold benchmark could lead to a net decrease in purchasing power; and
- how Marketplace consumers' maximum OOP costs would change following creation of the BHP in addition to the effects on premiums.

Manatt Health and Oliver Wyman were engaged to further analyze these issues related to the gold benchmark as a viable mitigation approach. These efforts were expected to extend beyond the target date by which the Task Force would submit its final recommendations.

Final Recommendations on Marketplace Stabilization

The Task Force supports OHA and DCBS exploring and implementing Marketplace mitigation strategies, in particular a shift to a gold benchmark when calculating consumers' APTC, including:

- completing actuarial analysis of the costs to Oregon's reinsurance program and the state general fund;
- continuing discussions with CMS regarding the feasibility of this approach; and
- further analyzing regional variation in consumer impacts.

If these activities indicate that a shift to a gold benchmark is feasible to implement and would mitigate adverse effects for Marketplace consumers when the BHP is created, the Task Force recommends that DCBS request an amendment to Oregon's Section 1332 waiver for this change.

V. Conclusion

This report reflects the final recommendations of the Joint Task Force on the Bridge Health Care Program to establish an affordable coverage option for Oregonians earning between 138 and 200 percent of FPL who do not quality for OHP. The Task Force collectively invested hundreds of hours between April and December 2022 to develop this proposal. Task Force members reviewed a wide range of information and heard diverse perspectives from members of the public, policy and actuarial analysts, and the constituencies represented by the Task Force itself.

The Task Force advanced these recommendations believing that they are consistent with the various goals for **HB 4035**, but most importantly, the legislative assembly's stated goals of

- "creating new options for affordable health insurance that allow for continuity of coverage and care," and
- "adopting processes and policies that maintain or improve the current reductions in uninsured rates for priority populations."

As indicated in this report, the bridge program would provide coverage at no cost to approximately 102,100 people, including an estimated 11,300 people who currently lack coverage. It would achieve this outcome at minimal cost to the state and by leveraging Oregon's existing coordinated care model. While creating the program would have secondary effects on Oregon's Marketplace, shifting to a gold benchmark for premium subsidies may be an effective way to mitigate these effects, and is worthy of further exploration.

Next Steps

HB 4035 directs that following submission of this report, OHA and DCBS shall seek approval from the Oregon Health Policy Board by a majority vote to submit a federal blueprint application to CMS to create the program.

Following CMS approval, OHA and DCBS are directed by **HB 4035** to:

1. begin implementing the program, and
2. provide a report to the Legislative Assembly during its next regular session that addresses details of the federal approval, a plan for implementing the program, and any recommended or needed legislative changes or budgetary actions.

At the time of this report there was continued uncertainty about the possible end date of the PHE, which would extend at least through early 2023. Oregon's PHE-related redeterminations for OHP enrollees may need to be concluded by early 2024. To achieve the continuous coverage goal in **HB 4035**, it is assumed that Oregon will move quickly to seek federal approval for a BHP while continuing to examine the best strategies for program implementation and sustainability.

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APPENDICES

[Forthcoming]

Appendix XX: Oregon Health Insurance Marketplace - Standard Silver Plan Cost Sharing Reductions (Plan Year 2022)

Deductible/OOP Max	Silver	201-250% FPL	151-200% FPL	133-150% FPL
Type of Plan	Deductible	Deductible	Deductible	Deductible
Medical Ded[1]	$3,650	$3,650	$1,200	$100
Rx Ded	$0	$0	$0	$0
Integrated Ded	No	No	No	No
Medical MOOP	$8,550	$6,800	$2,850	$1,000
Rx MOOP	N/A	N/A	N/A	N/A
Integrated MOOP	Yes	Yes	Yes	Yes
Family Deductible/MOOP[2]	2x Individual	2x Individual	2x Individual	2x Individual
Rx Deductible Applies to Tiers	N/A	N/A	N/A	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [3]	30%	30%	10%	10%
Outpatient [4]	30%	30%	10%	10%
ER [5]	30%	30%	10%	10%
Radiology (MRI, CT, PET)	30%	30%	10%	10%
Preventive (Prev)	$0	$0	$0	$0
PCP Office Visit (OV)[6]	$40	$40	$15	$10
Non-Specialist Visit [6]	$40	$40	$15	$10
Specialist Office Visit [6]	$80	$70	$30	$20
Urgent Care (UC)	$70	$70	$40	$30
Ambulance	30%	30%	10%	10%
Rx Generic	$15	$15	$10	$5
Rx Preferred Brand	$60	$55	$25	$10
Rx Non-Preferred Brand	50%	50%	50%	25%
Specialty Drug	50%	50%	50%	25%
Pediatric Vision [7]	$0	$0	$0	$0
Biofeedback	$40	$40	$15	$10
Cardiac Rehabilitation	$40	$40	$15	$10
Outpatient Rehabilitation [8]	$40	$40	$15	$10
Outpatient Habilitation [8]	$40	$40	$15	$10
Diabetes Education	$0	$0	$0	$0
Nutritional Counseling	$0	$0	$0	$0
Diabetic Supplies	$0	$0	$0	$0
Acupuncture - limit 12 visits	$40	$40	$15	$10
Chiropractic - limit 20 visits	$40	$40	$15	$10

Actuarial Values				
Federal AVC - Final Rounded	72%	74%	88%	95%
Federal AVC - Final Exact	71.92%	73.94%	87.91%	94.77%

[1]Deductible does not apply to Prev, OVs, Non-Specialist and Specialist Visits, UC
[2]For Deductible plans, the individual deductible applies to all members while the family deductible applies only if multiple family members incur claims.
[3]Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.

[4]Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.

[5]ER copay is waived if admitted.

[6]MH/SA may be covered as OV or specialist office visit.
[7]Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.
[8]Applies to PT,OT, ST provided in an office setting; PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.