QUESTIONS AND ANSWERS

This reference document is a running list of questions submitted or posed by members of the Joint Task Force on the Bridge Health Care Program (Task Force). LPRO staff compiled the responses from information available as of November 30th, 2022.

We thank Oregon Health Authority (OHA) and Department of Consumer and Business Services (DCBS) staff for their assistance. The document has been updated several times and expected to be revised further as the Task Force continues its work through late 2022. Newer versions may be available with subsequent meeting materials posted at https://olis.oregonlegislature.gov/liz/2021I1/Committees/JTBHCP/Overview.

About the Section 1331 Basic Health Program

Q: Oregon already has an 1115 waiver to deliver Oregon Health Plan coverage through Coordinated Care Organizations. Would a separate 1115 application for a Section 1331 BHP affect the state's currently pending 1115 waiver application?

A: No. A short-term amendment to Oregon's standalone 1115 waiver for substance use disorder can be used to provide temporary coverage for bridge plan consumers pending creation of a Basic Health Program. This 1115 amendment would be unlikely to impact anything related to the state's primary 1115 Medicaid demonstration waiver (aka "the waiver").

Q: Would pursuing a Section 1331 BHP for people earning less than 200 percent FPL preclude the state from pursuing a separate 1332 waiver for people earning more than 200 percent FPL?

A: No. Implementing a Basic Health Program under a 1331 Blueprint does not prevent Oregon from applying for other waivers. New York is pursuing a 1332 waiver to cover people above BHP income eligibility levels in addition to their 1331 Blueprint.

About the Bridge Program Population

Q: What is known about the population of people who lack insurance coverage in Oregon? How does this rate compare to other states?

A: LPRO staff compiled a slide deck on the uninsured population from the 2019 American Community Survey (ACS) (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256015).

Q: What is known about the population of people who may be eligible for the Bridge Program, including their demographics?
A: The population that would be eligible for the Basic Health Program (BHP) are adults ages 18 to 64 who earn less than 200 percent of the federal poverty level (FPL) and who are eligible for premium tax credits but who are not eligible for Medicaid. This population includes lawfully present immigrants who earn less than 138 percent FPL but who are ineligible for Medicaid because they have resided in the United States for fewer than five years.

The slides available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256015 contain ACS estimates of the demographic profile of the population 138-200 percent FPL who are not covered under other public insurance. Oregon Health Authority provided additional estimates from the Oregon Health Insurance Survey on August 9, 2022 (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256494).

Estimates using population survey data are currently the best available information regarding the demographic characteristics of the BHP population. Because the BHP population consists of people who are covered under Oregon Health Plan (OHP), commercial coverage, and uninsured, there is no existing administrative data source that contains comprehensive demographic information about this population, though this information would be available after a BHP is created and begins enrolling members. Demographic data would initially be limited to members transitioning to the BHP from OHP, and would gradually include more complete data on other members as the program began enrolling them in later years.

Limited demographic information such as age will be available in the fall when OHA and DCBS combine OHP and commercial carrier data for actuarial analysis for the Task Force. However, insurers do not consistently collect enrollee-level race and ethnicity and it would not be feasible to collect this data for the Task Force in the time frame in which it is meeting

Q: How many people would be eligible for the Bridge Program?
A: OHA has estimated that 55,000 people currently enrolled in Oregon Health Plan (Medicaid) would be eligible for the Basic Health Program. Manatt estimated 32,500 people currently covered through the Health Insurance Marketplace (Marketplace) and 21,300 people currently uninsured may also be eligible. These are rough estimates. OHA is working to connect eligibility system data, actuarial and other Coordinated Care Organization (CCO) data, and survey data, to provide more precise estimates of eligible population size and demographics.

Q: Among the population who would be eligible for the Bridge Program, how are they geographically distributed across the state?
A: OHA is unable to provide this information at this time, as current estimates of the eligible population are not based on member-level enrollment data. The ACS slide deck available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256015 provides information on the geographic distribution of a population that is similar to those who would be eligible for the Bridge Program.

Q: Among the population of people currently enrolled in Medicaid who would transition to a Bridge Health Care Program, what percent are entering Medicaid via presumptive eligibility determinations in hospitals versus other channels?
A: OHA is unable to provide this analysis at this time, but a relatively small portion of OHP enrollees enter through hospital presumptive eligibility. The percentage of overall OHP enrollees who enter through this process may not be reflective of the subset of enrollees who could be eligible for the BHP.

Q: Among people currently insured through the Marketplace who would be eligible for the Bridge Program, which carriers provide their current coverage?
A: OHA is unable to provide this analysis at this time but this information may be available in late 2022 following completion of a carrier data call and further actuarial analysis.

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

Table 1. Plan Selection by Metal Tier, 2022

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

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

Q: What do we know about the health status of the BHP-eligible population?
A: In a preliminary actuarial analysis that was limited to individuals currently covered through the Marketplace, Manatt estimated the "morbidity" or burden of poor health in the BHP-eligible population is similar to overall morbidity in the individual and small-group market. An analysis of the morbidity of the BHP-eligible population currently enrolled in OHP is underway and will be shared in November 2022.

Q: What portion of the BHP-eligible population is offered employer-sponsored insurance that is considered affordable under current Affordable Care Act (ACA) requirements?
A: OHA does not have access to data that would answer this question.

Enrollment, Marketplace Platforms, and Coverage Transitions

Q: How would the Bridge Program affect coverage options for adults who are non-citizens?
A: Coverage options for Oregon adults and children who are non-citizens vary by income, age, and immigration status.

- Full OHP coverage is generally available to adults who meet eligibility requirements, such as income, and have a qualifying immigration status. People who are Lawful Permanent Residents, (LPR) also known as "green card" holders, must generally wait five years to be eligible for full coverage.
- Adults who don't qualify for full OHP due to immigration status can still qualify for limited benefits. Citizen Waived Medical (CWM) covers emergency care, and CWM Plus covers full OHP benefits regardless of immigration status during pregnancy and for 60 days after a pregnancy ends.
- As of July 1, 2022, a new program called Healthier Oregon covers adults 19–25, or 55 and older, who would be eligible for full OHP if not for immigration status. This includes people in these age ranges who haven't met the five-year LPR waiting period requirement. The Healthier Oregon program will also expand full OHP eligibility to adults ages 26 to 54 in the future as funding becomes available. This expansion may occur before Oregon's Bridge Program is available.
- Until Healthier Oregon expands, adults who have not met the five-year LPR waiting period requirement for full OHP coverage may still be eligible for tax credits and cost-sharing reductions on Marketplace plans.
- Oregon's Bridge Program would provide coverage to adults earning up to 200 percent FPL. Certain non-citizens who have not met the five-year LPR waiting period requirement for OHP coverage may also qualify for the Bridge Program.

However, whether the Bridge Program will offer the same benefits available through Healthier Oregon remains an open question. Further policy development may be needed to both maximize federal funding and consider equity between future OHP and Bridge Program enrollees.

Q: Among states that operate BHPs, how is enrollment effectuated? Is it more similar to Medicaid or to commercial insurance? Does it occur on a continuous basis or during an open-enrollment period?
A: There is flexibility in the Basic Health Program Blueprint (federal application) to design enrollment procedures that are more Medicaid-like or Marketplace-like. The approaches used in Minnesota and New York are documented in their Basic Health Program blueprint applications, Section 4 (available at https://www.medicaid.gov/basic-health-program/index.html). The specific approach to be outlined in Oregon's BHP Blueprint has not yet been determined.

Q: How quickly could Oregon implement a state-based exchange?
A: OHA has indicated that if the Oregon Legislature opted to pursue a state-based exchange during the 2023 legislative session, the platform may be operational by 2026.

Q: Is it possible to offer a Basic Health Program with a two-year eligibility period rather than one year?
A: CMS indicated that this is not an option.

Q: How would enrollees be assigned to CCOs? Would people be able to choose which CCO they enroll in? Could this process be designed with consideration for continuity in provider access?
A: This is still to be determined. OHA has procedures for auto-assignment and manual enrollment (member choice) depending on the members' residence, CCO capacity, and other contributing factors (e.g., whether the member is eligible for auto-assignment exceptions or exemptions) but has not yet considered whether an auto-assignment process for the BHP would differ. At its October 18, 2022, meeting, the Task Force heard a proposal from OHA to maintain OHP coverage in lieu of BHP coverage for American Indian and Alaska Native enrollees earning up to 200 percent FPL. This would preserve the state's existing option for AIAN enrollees to opt out of assignment to a CCO.

Q: What needs to be done to communicate with enrollees about the redetermination process and Public Health Emergency (PHE) "unwinding," including ensuring digital access, language access, etc.?
A: OHA has convened a community and partner work group to advise on this process as required by House Bill 4035 (2022) (HB 4035). This group will provide ongoing support and guidance to OHA on these topics; information about their work is available at https://www.oregon.gov/oha/Pages/phe-maintain-

coverage.aspx. OHA provided a report to the Legislature (available at https://www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx) on May 31, 2022 with an update on planning efforts related to the PHE unwinding.

Q: How would creation of a BHP impact revenues for county health departments?
A: This question has not been explored at this time.

Federal Financing and State Budget Implications

Q: What actuarial analyses are planned and when will they be available?
A: This question was addressed as part of the overall timeline update presented to the Task Force at the July 12, 2022, meeting and can be found in the slide deck (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256185).
A series of analyses have been or will be presented, as follows:

- A microsimulation analysis was presented on October 18th, 2022, of the impact on the existing ACA individual market from creating a BHP, including the impact on premiums in the individual market and analysis of enrollee responses to premium changes. See https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257287
- On November 15th, 2022, the Task Force heard results of an actuarial analysis to project potential enrollment in a BHP as well as the costs to provide coverage to the BHP population and the expected federal funding Oregon would receive.
- These analyses and simulations are not able to report results that are disaggregated by demographics, either for the purpose of estimating enrollee costs of coverage, risk adjusted capitation rates or provider reimbursements. Enrollee-level data are compiled from several sources including OHP, ODHS, and commercial carriers. These data sources do not contain standardized information about enrollee demographics that can be reported across the BHP population as a whole, though this information would be collected after a BHP is created.

Q: What are the state budget implications if the bridge program has higher than expected enrollment?
A: Increasing the level of coverage among the population is consistent with the goals of HB 4035, though the state budget implications of higher-than-expected enrollment are different under a 1331 BHP and a 1332 waiver. The federal funding formula for a 1331 BHP is calculated on a per-person basis and the state

would receive federal funds for the program that would be tied to the number of people enrolled. An overview of this funding formula was presented to the Task Force on November 1st, 2022. (see https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257362) Under a 1332 State Innovation Waiver, the state would receive an aggregated (population-based) amount of federal funds rather than a per person amount. The state would be accountable for "deficit neutrality," meaning federal funds for the waiver could not exceed that aggregated amount if enrollment was higher than expected.

Q: What is the administrative cost of churn, which may not be well captured in analyses of either Medicaid or Marketplace enrollees?
A: A 2015 study (https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204) simulating Medicaid churn from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling one person in coverage within a year incurs administrative costs between $400 and $600, an amount which would be higher in today's dollars. A national study (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/) of Medicaid service utilization and costs estimated that churn resulted in a $650 per-member per-month increase in acute care costs (driven primarily by higher emergency department utilization and inpatient stays) and an overall $310 per-member per-month increase in total costs in the five months following coverage disruption.

Q: Does the cost of administering member cost sharing (such as premiums or co-pays) offset the revenue gained through these strategies?
A: OHA does not expect that the administrative costs of implementing cost sharing will exceed: (1) the revenues gained from these strategies; and (2) reduced costs that result from lower service utilization. OHA has not yet made forecasts of the administrative costs of these strategies or the revenue impacts but aims to explore the operational and fiscal implications of these strategies.

Q: Will actuarial analyses consider the future costs of deferred care that may result from the pandemic?
A: OHA will not be able to answer this question due to limited resources. It is outside the scope of their actuarial analysis.

Q: Which of the Task Force's recommendations need approval from the Legislature? Does Oregon Health Authority need approval from the Legislature to establish the BHP?
A: Prior to submitting a Blueprint request to CMS, OHA must receive approval from the Oregon Health Policy Board as required in Section 5(1). No explicit legislative approval is necessary to establish the bridge program, as Section 5(2)(a) allows OHA to implement the Program after receiving approval from CMS. Legislative action to support implementation of the Program is contemplated by

Section 5(2)(b), which requires OHA to submit a report outlining any federal approval received and the implementation plan for the Program along with any necessary legislative changes. A bill supporting implementation of the Program is planned.

Q. [New] What is the difference between financial reserves in the BHP Trust and CCO requirements for financial reserves?

A: Financial reserves insure a program can meet financial obligations and maintain operations.

Under **federal** law, states operating a BHP are *required* to establish a state trust fund. States are *permitted* to carry over unexpended BHP trust funds as reserves year-to-year (42 C.F.R. Part 600.705(e). These reserves can only be used to lower premiums or cost sharing or to provide additional benefits for eligible individuals.

Under **state** law, CCOs are *required* to maintain minimum amounts in reserve, and are *required* to spend a portion of excess reserves on social determinants of health. Effective January 1, 2023, ORS 414.572(1)(b) will require CCOs to:

> *"(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.*
>
> *(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (Capital and surplus requirements) (6), 732.225 (Impairment of required capitalization prohibited), 732.230 (Order to cure impairment) and 750.045 (Required capitalization).*
>
> *(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315)."*

OAR 410.141.3705(2)(b) further requires CCOs to:

"(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;

(B) Maintain a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities."

Access, Covered Services and Enrollee Costs

Q: What are the differences between covered services under the Essential Health Benefits (EHB) package and OHP package (as delivered through CCOs)?

A: OHP covers all EHBs as defined by federal law. At a high level, the covered services in OHP and Marketplace plans are very similar, though with some nuanced differences such as in limits in the volume of some services allowed. OHP also includes some additional services such as non-emergency medical transport (NEMT), enhanced behavioral health care, bariatric surgery, and dental that are not required in Marketplace plans. OHA provided a comparison of these service packages at the July 26, 2022, Task Force meeting (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256313). OHA also plans to provide more detailed estimates of the cost of providing the OHP service package to BHP enrollees as part of upcoming actuarial analyses.

Q: Does the federal government have the ability to restrict covered services?

A: Federal BHP funds can be used to pay for services that are not part of the EHB or traditionally covered by Marketplace plans with the exception of abortion services subject to the Hyde Amendment (see https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/). The Hyde Amendment prohibits the use of federal funds to pay for abortion except in very narrow circumstances. This amendment covers programs funded through the Department of Health and Human Services, such as Medicaid. The ACA extends Hyde Amendment exclusions to programs federally funded under the ACA, including Basic Health Programs and federal premium tax credits for the purchase of subsidized coverage on the Marketplace. States can cover these services using state revenues as they do with Medicaid.

Q: How much overlap exists in provider networks for people earning 138-200 percent FPL who are covered through OHP and the Marketplace?

A: OHA is investigating this issue through its Medicaid to Marketplace Migration team and working to provide a more complete response to the Task Force.

Q: What options exist for customizing how co-pays may apply to certain services?
A: The ACA limits overall enrollee costs allowable in BHP programs. BHP premiums and cost sharing cannot be higher than what an individual would have paid for a Marketplace plan. The ACA also generally prohibits cost sharing for preventive services except in limited instances such as out-of-network care. States have some flexibility in setting co-payments, though more complicated co-payment designs can cause consumer confusion and increased administration costs.

Q: What research exists regarding the relationship between enrollee cost sharing, coverage, and utilization of health services?
A: Research on health insurance premiums generally shows that premiums reduce the number of people with health insurance coverage. This can occur when people (1) decline to enroll due to cost barriers; (2) enroll in a plan that is never "effectuated" (activated as coverage) because they do not pay the first months' premium; or (3) enroll in a plan that is effectuated but later disenroll due to premium nonpayment. Higher premiums tend to create larger barriers to coverage, though specific estimates of the effect vary by population. Research suggests rates of coverage among lower-income enrollees are highly sensitive to premiums. A 2014 study of Medicaid enrollees in Wisconsin (available at https://www.sciencedirect.com/science/article/abs/pii/S0167629614000642) found that increasing the monthly premium from $0 to $10 reduced the average length of enrollment by 1.4 months and decreased the likelihood of remaining continuously enrolled for 12 months by 12 percent. A simulation study of lower income Marketplace enrollees (available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00345) estimated that eliminating Marketplace premiums would increase enrollment by 14.1 percent in 2019.

In 2003, the Oregon Health Plan (OHP) implemented new premiums and coverage restrictions following premium-nonpayment due to state budget deficits; research on the impact of these changes (available at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2005_jul_impact_of_changes_to_premiums__cost_sharing__and_benefits_on_adult_medicaid_beneficiaries__results_f_wright_impact_changes_premiums_medicaid_oregon_pdf.pdf) found rates of coverage fell 13 percent for OHP Plus and 44 percent for OHP standard in the months following this change. Oregon also temporarily introduced co-pays to the Oregon Health Plan, and later rescinded them. The study assessed enrollees' self-reported unmet care needs in the months before and after co-pays were eliminated, finding that the percent of enrollees with unmet care needs fell from 28 to 19 percent following the elimination of co-pays. These findings are consistent with a KFF review of literature from 2000–2017 (available at

https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/) finding that co-pays in Medicaid and Children's Health Insurance Program even at relatively low levels ($1–$5), are associated with adverse care utilization patterns including reductions in necessary services and increased emergency department utilization.

Q: Will BHP members be eligible for Long-Term Services and Supports (LTSS)? Will the reduction in the number of OHP enrollees following redetermination reduce funding the state receives for LTSS?

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

Unrelated to the BHP, Oregon operates a program called Oregon Project Independence (OPI) that provides home and community-based services (HCBS) to older adults who are lower income but not eligible for Medicaid. Oregon has submitted a request for a Section 1115 waiver to expand OPI eligibility to adults 18 and older who earn up to 400 percent FPL (see https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-1115s-projectindependence-application-pa.pdf). This population includes adults who may also be eligible for the BHP. This waiver request was pending CMS review as of November 8th, 2022.

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

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

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

Table 2. BHP Plan Design in New York and Minnesota

	NY Essential Plan (135 – 150% FPL) (1)	NY Essential Plan (151 – 200% FPL) (1)	Minnesota Care (2)
Preventive Care	$0	$0	
Nonpreventive Care			$25 (behavioral health visits excluded)
Primary Care Physician Visit	$0	$15	
Specialist Visit	$0	$25	
Inpatient Hospital Stay (per admission)	$0	$150	$250
Behavioral Health Outpatient Visit	$0	$15	
Emergency Room	$0	$75	$75
Urgent Care		$25	
Ambulatory Surgery			$100
Radiology			$25/visit
Physical, Speech, and Occupational Therapy	$0	$15	
Durable Medical Equipment (DME)			10% co-insurance
Rx (generic)	$1	$6	$7
Rx (preferred)	$3	$15	$7
Rx (non-preferred)	$3	$30	$25
Dental	$0	$0	$15/non-routine visit
Vision	$0	$0	$25 copay for eyeglasses

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

Q: How would out-of-pocket (OOP) costs change for people who continue to purchase coverage in the Marketplace after a BHP is created?

A: On October 18th, 2022, the Task Force heard results of an analysis of how the Marketplace would be affected by the creation of the BHP. (see https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257287) The analysis found that few consumers would leave the Marketplace (i.e. drop coverage) but an estimated 5,800 may respond by switching from gold tier plans to to less generous, more affordable silver tier plans.

Plan costs vary by consumer demographics and location, but the table below provides information about how maximum OOP costs could change for consumers who switch from gold to silver plans.

Table 3. Marketplace Plan Deductibles 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 OOP maximum (Min - Max)	$7,300 ($7,300 – $9,100)	$9,100 ($7,400 - $9,100)	$8,800 ($6,900 - $9,100)

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

Of note, many services covered under Qualified Health Plans 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 insurers also offer at least six plans that provide this level of coverage. 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.

Plan Administration and Provider Reimbursements

Q: How do provider reimbursements relate to enrollees' access to care? What options exist for directing how CCOs invest funds toward provider reimbursements?

A: OHA does not set provider reimbursement rates paid by CCOs and would not likely consider doing so for a BHP. OHA would seek to develop a program with payment rates to CCOs that are sufficient to ensure members have access to high quality health care services when they are needed. OHA has not yet developed strategies to direct how CCOs should structure reimbursements to providers if capitation rates developed for the BHP assume higher payment rates than current OHP capitation rates. Furthermore, strategies to provide additional direction to CCOs would likely depend on funding available, which will become clearer after upcoming actuarial analysis.

The relationship between plan rates, provider reimbursements and adequacy of provider networks is influenced by a range of economic and workforce factors that can meaningfully vary across regions. Research on Medicaid provider networks (available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01747) suggests that within a contracted provider network, the provision of care to Medicaid enrollees is often concentrated among a small proportion of the network. Increasing reimbursement rates to providers can result in increased access to

services for Medicaid enrollees (see https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care).

Q: How will success (i.e., performance) be measured in a BHP, and how will this relate to plan or provider payment?
A: This has not yet been determined. The BHP could build on the incentives and other provisions in CCO contracts. OHA is working with Manatt to understand how New York and Minnesota have integrated value-based purchasing into their BHP designs.

Q: How would the creation of a BHP impact federal funding for safety net providers or Federally Qualified Health Centers?
A: Federally Qualified Health Centers (FQHCs) are those that receive Section 330 grant funding under the Public Health Service Act to provide care in communities underserved by the health system. KFF estimated that in 2017, Medicaid accounted for 44 percent of FQHC revenue while Section 330 grants accounted for 18 percent (see https://www.kff.org/medicaid/issue-brief/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained/#:~:text=Section%20330%20of%20the%20Public%20Health%20Service%20Act,appropriation%20and%20the%20Community%20Health%20Center%20Fund%20%28CHCF%29). Federal law establishes a Prospective Payment System (PPS) for FQHCs to tie payments to the cost of providing care and ensure that provision of care for Medicaid enrollees does not reduce federal grant funds for care of people who are uninsured (see https://www.nachc.org/wp-content/uploads/2018/06/PPS-One-Pager-Update.pdf). In Oregon, OHA makes quarterly "wraparound" payments to FQHCs based on the number of OHP members served. These payments are intended to make up the difference between CCO (and third party) payments a clinic received for care of OHP members and what clinics would have been paid at their PPS rate (see https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-FQHC-RHC.aspx).

Nationally, half of people served in FQHCs are Medicaid enrollees, and changes in Medicaid caseloads are an important factor in FQHC financial stability during the "unwinding" of the public health emergency (see https://www.kff.org/policy-watch/community-health-centers-taking-actions-prepare-for-unwinding-public-health-emergency/). Oregon Primary Care Association has estimated that FQHCs provide care to one in six OHP members (see https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/255963). When the PHE ends, people who maintained OHP coverage under the continuous eligibility (CE) provision may lose coverage and be disenrolled. When this occurs, FQHCs providing care to these individuals may no longer be able to bill OHA for wraparound payments for their care. This change is not directly related to the creation of a Basic Health Program, though a BHP could be designed to replicate the wraparound payment model used in OHP. The Task

Force included in its preliminary recommendations that OHA should develop a payment mode for BHP safety net providers that considers the value of Medicaid prospective payments.

Q: Will CCOs be allowed and incentivized to provide Health Related Services (HRS) for BHP members? Will CCOs be subject to SHARE Initiative requirements for profits derived from their BHP plans?
A: Health Related Services are non-covered services offered as a supplement to CCO OHP benefits (OAR 410-141-3500) and provide a funding mechanism for CCOs to address social determinants of health through their "global budgets." The SHARE initiative is a requirement for CCOs to reinvest a portion of any net income in services to address social determinants of health and equity, including housing-related services and supports. A comparison of these services is available at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HRS-SHARE-ILOS-Comparison.pdf. Oregon Health Authority presented an overview of HRS at the October 4th meeting (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257235).

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

Q: How are Health Related Services changing under Oregon's recently approved Section 1115 Medicaid demonstration waiver?
A: While OHP previously allowed CCOs to offer HRS (paid from their global budgets), HRS were not a required OHP covered service. The federal government now recognizes a new category of Medicaid services, health related social needs (HRSN) services. HRSN services are similar to Oregon's HRS (such as for housing, food assistance, and protection from climate events). HRSN are available to specific populations experiencing life transitions, including:

- Youth with special health care needs up to age 26
- Youth who are involved with the child welfare system
- People experiencing or at risk of homelessness
- Older adults who have both Medicare and Medicaid coverage
- People being released from incarceration
- People at risk of extreme weather events due to climate change

For these populations, HRSN will largely replace HRS and are now a required OHP covered service. Under its recently approved 1115 waiver renewal, Oregon will continue to offer HRS through the Oregon Health Plan to people who are not

eligible for HRSN, but these services will continue to be offered at CCOs' discretion. More information is available at https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx

Comparing Federal Pathways to Create the Program*

**Note: In May 2022, CMS provided guidance that Oregon should develop a Bridge Program proposal using a 1331 Basic Health Program Blueprint. Questions about differences in federal pathways were raised prior to this point but are documented here for reference.*

Q: Are the federal pathways mutually exclusive? Can they be implemented sequentially?
A: The pathways are not mutually exclusive. A phased or sequential approach is possible and an1115 waiver could be pursued initially and followed by a more permanent 1331 Blueprint or 1332 waiver. HB 4035 directs the state to pursue a temporary, short-term 1115 waiver as part of its' redetermination of Medicaid enrollees' eligibility when the PHE ends. OHA and DCBS have submitted this short term 1115 waiver request.

Oregon could pursue either a 1331 Blueprint or 1332 waiver as a longer-term vehicle for creating the Bridge Program; CMS advised that a 1331 Blueprint is the recommended federal pathway to achieve the goal of HB 4035. CMS clarified that Oregon could implement a BHP under a 1331 Blueprint prior to pursuing a 1332 waiver to create a BHP-like product. However, CMS clarified that the 1331 BHP would need to be fully implemented for a period of 1-2 years before a 1332 waiver should be requested.

Q: Are the federal pathways different with respect to implementation timeframes? Is one pathway more likely to receive federal approval than the other?
A: The federal pathways differ in terms of implementation timeframes. The 1331 Blueprint is a relatively straightforward application process with well-defined statutory parameters that determine whether CMS is directed to approve a state's application.. The 1332 waiver pathway has not previously been utilized for the creation of a BHP-like product and would present many unknowns and potential program design challenges. Section 1332 waivers are made at the discretion of the HHS Secretary, with no requirement for CMS approval if states meet certain parameters. CMS recommended Oregon pursue a 1331 Blueprint for creation of the Bridge Program.

Q: Does one federal pathway (e.g., a 1331 Blueprint versus a 1332 waiver) provide better options for managing the "churn point" or coverage transitions for people transitioning off OHP?

A: OHA discussed options with Centers for Medicare and Medicaid Services (CMS) to implement a Bridge Program under a Section 1331 Blueprint and a Section 1332 waiver. Discussions about the 1332 waiver included exploration of "optionality," a scenario where eligible consumers would be able to choose between a BHP-like product and other subsidized coverage on the Marketplace. The idea behind optionality is to mitigate the coverage "cliff" at 138 percent FPL where Medicaid eligibility ends without creating a new coverage cliff at 200 percent FPL where BHP eligibility ends. While there is reason to believe people at 138 percent FPL experience more frequent income fluctuations than people at 200 percent FPL and are less likely to be offered employer-sponsored insurance (ESI), OHA is not able to confirm these assumptions from existing data.

OHA's vision is to make Bridge Program coverage transitions as seamless as possible under either pathway. The ideal scenario results in an OHP member "transitioning in place." In other words, they would receive a letter from their CCO saying their coverage had switched from OHP to BHP, but they would experience no disruptions in access. This approach requires that a BHP is offered through CCOs; a Marketplace-based option would require different administrative procedures.

Q: Is one of the federal pathways more easily implemented than the other?
A: OHA has indicated that, in general, the more closely a BHP resembles the OHP, the easier it will be for the state and CCOs to implement. The choice of federal pathway is closely linked to how Oregon operates its individual Marketplace. Currently, Oregon operates a state-based Marketplace on the federally facilitated exchange (Healthcare.gov). CMS has indicated that the federal platform can accommodate Oregon's plan to establish a Basic Health Program under a 1331 BHP Blueprint, but the federal platform could not enable "optionality" (e.g., the ability of consumers to choose between BHP-like coverage and subsidized Marketplace coverage) as was proposed by the state under a 1332 waiver.

Q: Are there differences in program administration costs to implement either of the pathways?
A: OHA is currently in the process of developing its budget for the 2023–25 biennium, which will include funding requests necessary to implement bridge program elements recommended by the Task Force.

OHA has not produced cost comparisons related to the difference in implementing a bridge program through either a 1331 or 1332 pathway. There are differences in how federal funds may be used under the two pathways. Under a Section 1331 BHP, federal funds are held in a BHP trust to cover enrollee benefits. Federal funds from the trust may not be used for program administration and these costs must be covered with state dollars. The section 1332 waiver offers more flexibility

in how federal funds may be used (toward enrollee benefits versus program administration), but federal funds are subject to overall deficit neutrality rules that constitute additional financial risks to the state.

Q: Is one federal pathway more financially predictable or stable long-term than the others?
A: Generally, 1115 and 1332 waivers are approved by CMS for three to five years and must be reapproved at the discretion of the sitting federal administration. A Section 1331 Blueprint does not generally need to be renewed once approved. The federal funding formula for the 1331 Basic Health Program has historically been updated on an annual basis; in 2022, CMS proposed to move away from annual formula updates to a formula that would be updated on an as-needed basis. This proposed change is currently open to public comment.

Q: Does one pathway or the other support reduction of uninsurance rates for Oregonians without coverage?
A: Nothing in the basic structure of the 1331 Blueprint and 1332 waiver automatically points toward differences in the likely effect on uninsurance rates. However, enrollment or "uptake" of the BHP by eligible consumers may be sensitive to whether and how cost sharing is incorporated into the benefits design. To the extent that 1331 funding is on a per-capita basis, scalable to varying levels of enrollment, and not subject to deficit neutrality rules, it may be easier for the state to promote higher levels of plan uptake *over time* under a 1331 Blueprint.

The creation of a coverage option for people earning less than 200 percent FPL would, under any federal pathway, lead to a discontinuation of a practice called "silver loading" that makes Marketplace plans more affordable. This change could lead to premium increases in the Marketplace and is the subject of microsimulation analysis to be presented in October, 2022.

Q: Does one federal pathway offer better ability than the other to increase members' access to providers?
A: Generally, no. The differences between a 1331 Blueprint and 1332 waiver would not automatically lead to differences in provider access (though access may be indirectly affected by plan design decisions made under either pathway).

Q: Does the choice of federal pathway have implications for enrollee cost sharing?
A: Generally, no. Oregon has broad flexibility to design enrollee cost sharing as part of a BHP under either pathway.