Joint Task Force on the Bridge Health Care Program

HB 4035 – 2022

Public Comment Log

- The members of the Joint Task Force on the Bridge Health Care Program should review all public comment submitted to inform its work related to HB 4035.
- LPRO staff will post all public comment to the Oregon Legislative Information System (OLIS) on a rolling basis as it is received.
- To streamline the process of reviewing public comment, LPRO staff will also maintain this log of public comment received and a link to materials on OLIS. Snapshots of the log will be provided to members with each meeting packet as a notice of any new comment received since the previous meeting.

This log reflects all public comment received by 4pm on Monday, December 12th, 2022.

Date Added	Submitting Individual	Submitting Organization	Description	Available on OLIS at
4/26/22	Sean Kolmer, Senior Vice President of Policy and Strategy	Oregon Association of Hospitals and Health Systems	A letter from OAHHS stating that: • The bridge program should be a temporary solution, • Provider payments should be sufficient to ensure adequate access to care for enrollees in the bridge program, • Oversight and accountability over the state financial impact of the program are critical, and • The bridge program should not prevent individuals from enrolling in or continuing marketplace coverage.	Link
5/5/22	Richard Blackwell, Director, Oregon Government Relations	PacificSource	A letter from PacificSource containing: • Requests for specific data or information to inform Task Force discussions and decisions. • Recommended areas of focus for the Task Force during program design discussions.	Link
5/9/22	Dan Cushing	Coalition for a Healthy	A letter requesting that the Task Force incorporate three principles into its proposal: • Center the member experience; • Ensure provider participation; and	Link

		Oregon (COHO)	• Leverage the successful, local model	
5/9/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Organization (OPCA)	A letter supporting the utilization of coordinated care organization (CCO) provider networks and also emphasizing that there should be no wrong pathway to health insurance coverage. Also supporting pursuit of a Section 1332 waiver to support administration of the bridge program.	Link
5/10/22	Rachel Bonesteel, Policy Manager	United States of Care	A letter encouraging the Task Force to design the Bridge Program as a long-term coverage option through 1332 State Innovation Waiver authority. The letter: • Supports allowing Oregonians who purchase coverage in the marketplace to retain the option to do so through "optionality." • Urges caution that a 1331 Blueprint may result in less federal funding for the state than a 1332 waiver. • Notes that an 1115 Medicaid demonstration waiver does not offer sufficient flexibility for program design.	Link
5/10/22	Dr. Christine Bugas	N/A	A letter supporting the creation of a long-term Bridge Program that lowers the cost of health care coverage and maximizes the number of people covered. The letter draws on Dr. Bugas' personal perspective as an emergency medicine physician.	Link
5/10/22	Maribeth Guarino, Health Care Advocate	Oregon State Public Interest Research Group (OSPIRG)	A letter encouraging the Task Force to consider • How the Bridge Program can address Medicaid churn as a long-term solution beyond the pandemic-related redeterminations period. • How optionality offered through a 1332 waiver would provide more flexibility for Oregonians to choose plans that best meet their needs.	Link
5/10/22 (updated)	Carly Hood-Ronick, Executive Director	Project Access NOW	A letter encouraging the Task Force to • Achieve affordability in the Bridge Plan through a monthly premium of no more than $50 per month, minimal co-pays and deductibles, and no coinsurance. • Offer the plan at a fixed annual cost to avoid mid-year changes due to enrollee income changes. • Include primary, behavioral and oral health coverage similar to OHP. • Offer the Bridge Plan on the Marketplace with coverage provided through CCOs. • Account for resources needed for CCOs and others to conduct outreach and enrollment assistance. • Design the Bridge Plan with consideration for how it may operationally align with a public insurance option for people earning more than 200% FPL in the future.	Link
5/23/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Organization (OPCA)	A letter encouraging the Task Force to: • Prioritize people who seek care at Community Health Centers (CHCs) in designing the Bridge Program. • Include dental and behavioral health services within the benefits package.	Link

			• Where member costs are necessary, use sliding scale premiums and co-pays for non-preventive services and avoid use of co-insurance, deductibles, or co-pays for preventive services. • Tie provider reimbursement to value-based payment models that incorporate social risk adjustment and provide enhanced reimbursement rates for CHCs.	
5/23/22	Dr. Calie Roa, President	Oregon Dental Association	A letter encouraging the Task Force to include dental benefit that provides full coverage in the Bridge Program benefits. Also supporting a robust reimbursement structure to help encourage provider participation.	Link
5/24/22	Maribeth Guarino, Health Care Advocate	Oregon State Public Interest Research Group (OSPIRG)	A letter encouraging the Task Force to design the Bridge Program so that it aligns coverage with the Oregon Health Plan as much as possible. Also urging the minimization of member costs.	Link
5/24/22	Rachel Bonesteel, Policy Manager	United States of Care	A letter outlining recommendations in 5 areas: 1. Benefit design – should align with Oregon Health Plan coverage, including dental. 2. Beneficiary Costs – premiums and cost-sharing should be minimized or eliminated. 3. Provider Reimbursement – should be sufficient to support continued access to care. 4. Health Equity – same standards that apply to the Oregon Health Plan should apply to the Bridge Program 5. Federal Funding Pathway – should consider the statutory requirements and potential constraints related to benefit design and cost-sharing applicable to the pathways currently being explored.	Link
5/26/22	Sean Kolmer, Senior Vice President of Policy and Strategy	Oregon Association of Hospitals and Health Systems	A letter encouraging the Task Force to not rush its recommendations. Also requesting that hospitals and providers have the ability to negotiate their participation in the Bridge Program, including negotiating commercial-range rates as well as payment mechanisms.	Link
6/13/22	Dr. Robert Lowe	N/A	A letter supporting the establishment of a robust bridge plan. The letter draws on Dr. Lowe's experience as a retired emergency physician.	Link
6/13/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Organization (OPCA)	A letter advocating for: • Extension of prospective payment system (PPS) wrap payments to the bridge plan population; • Reimbursement rates that adjust to the for the unique needs of the target demographic and associated costs of care; • Minimal enrollee out-of-pocket costs; • Elimination of unnecessary barriers to coverage, including a no-wrong-door approach to enrollment; and	Link

			• Broad benefit coverage that builds off of coverage provided by the Oregon Health Plan.	
6/14/22	Rachel Bonesteel, Policy Manager	United States of Care	A letter outlining recommendations for plan design and federal pathway choice, including: • Setting provider reimbursement rates higher than OHP and exploring value-based payment models; • Requiring all CCOs to offer the Bridge Plan; • Eliminating premium and cost-sharing for Bridge Plan enrollees; • Including dental benefits that, at a minimum, aligns with OHP coverage; and • Considering using a combined approach to 1331 and 1332 pathways	Link
6/14/22	Samantha Shepard, Executive Director	CCO Oregon	A letter from the CCO Oregon Oral Health Workgroup urging the inclusion of comprehensive dental coverage in the Bridge Program	Link
6/21/22	Courtni Dresser, VP of Government Relations	Oregon Medical Association	A letter submitted on behalf of the following provider organizations: • Oregon Medical Association • Oregon Society of Anesthesiologists • Oregon Chapter of the American College of Emergency Physicians • Oregon Academy of Opthalmology • Oregon Association of Orthopaedic Surgeons • Oregon Academy of Family Physicians • Oregon Psychiatric Physicians Association • Oregon Pediatric Society • Metropolitan Pediatrics • Douglas County Individual Practice Association • WVP Health Authority • North Bend Medical Center • The Portland Clinic • The Oregon Clinic • Urgent Care Northwest – Astoria • Oregon Council of Child & Adolescent Psychiatry • Oregon Society of Physician Assistants • Oregon Chapter of the American College of Physicians The letter encourages the Task Force to consider four key principles in designing the Basic Health Program: 1) A benefit plan that supports continuity of care as enrollees move between OHP and BHP 2) Minimizing administrative barriers to coverage transitions 3) Funding to support enrollee outreach and equitable enrollment	Link

			4) Rates higher than Medicaid to support a robust provider network	
7/11/22	Jackie Fabrick, Program Manager, Government Relations	Providence Health Services	A letter outlining the following requests to the Task Force: • Ensuring adequate data and time for decisions. • Considering how the elimination of "silver loading" in the Marketplace will impact premiums for people earning more than 200% FPL; • Considering how access to providers may be affected for people who transition from a Marketplace plan to the Basic Health Plan; and making information available to consumers to compare CCO and other plan provider networks; • Designing the program to operate within federal funding without state subsidy and considering plan designs that support provider reimbursements higher than OHP; • Use of navigators trained to help people transition from OHP to other coverage; • Identifying and providing assistance to close gaps in federal and state subsidies.	Link
7/12/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Association	A letter encouraging the Task Force to consider plan design decisions with regard for health equity, including: • No out-of-pocket costs for enrollees • If cost sharing is necessary, a sliding scale premium applied to those earning more than 138% FPL and minimal co-pays for a limited range of non-preventive services • Consideration of the protocols for implementing enrollee cost sharing and the navigation assistance needed to ensure cost sharing does not pose barriers to enrollment • Extending OHP's wrap payments for FQHCs to also cover the BHP population	Link
7/12/22	Elizabeth Edwards, Government Relations Director	Kaiser Permanente Northwest	A letter to the Task Force expressing concern that • The Basic Health Plan may not improve population-level affordability and coverage rates due to impacts on premiums in the individual Marketplace; • The BHP would not address the majority of people projected to lose OHP during the PHE unwinding. The letter encourages the Task Force to delay final recommendations on BHP design until its second report in December 2022 when it also delivers recommendations on strategies to mitigate market impacts. The letter also encourages state agencies to provide additional information on Oregon's outreach and communication plans related to the PHE unwinding.	Link
7/12/22	Sean Kolmer, Senior Vice President of Policy and Strategy	Oregon Association of Hospitals and Health Systems	A letter expressing concern that the BHP would result in reductions in hospital revenues. The letter cites a study reporting that Oregon hospital margins have declined in 2022 due to increasing operating costs and reductions in emergency department visits and inpatient care. The letter encourages the Task Force to • Make recommendations related to plan network adequacy and ensure opportunities for hospitals to negotiate reimbursement.	Link

			• Integrate planning discussions about Bridge Program recommendations and market mitigation strategies and recommend that the legislature consider the Bridge Program recommendations in parallel with other health reform efforts during the 2023 session.	
7/12/22	Carly Hood-Ronick, Executive Director	Project Access NOW	A letter encouraging the Task Force to • Explore options to design the Bridge Plan such that eligible enrollees could opt out and purchase private coverage on the Marketplace. • Consider CCOs' ability to operationalize certain program design options, such as collection of premiums or a service package that differs from the OHP package.	Link
7/12/22	Liz Hagan, Director of Policy Solutions	United States of Care	A letter to the Task Force that • Supports Oregon's exploration of a 1332 waiver to recapture federal savings that would occur following the creation of a Basic Health Program under a 1331 Blueprint due to reductions in premium tax credits in the individual Marketplace. • Encourages recommendations be designed with consideration that the state may pursue the creation of a state-based marketplace and other affordability options in the future. • Encourages a plan design with no cost sharing, covered services similar to OHP, and reimbursements above Medicaid rates; if this plan design cannot be achieved with federal funding, the letter encourages exploration of a service package with no enrollee cost that retains dental coverage, and the option to buy-in to a broader service package. • Supports setting reimbursement rates higher than Medicaid to ensure network adequacy, and consideration of 1) value-based payment strategies to account for social drivers of health, 2) strategies such as FQHC wrap payments to proactively ensure adequate reimbursement of safety net providers, and 3) incentives for the promotion of culturally responsive and health equity-focused provider networks.	Link
7/20/22	Wanda Davis		A letter to the Task Force describing Wanda Davis' experience with cancer treatment, the costs of purchasing coverage on the Marketplace with and without federal subsidies, and how the expiration of the American Rescue Plan Act (ARPA) subsidies may impact Ms. Davis' health care costs going forward. The letter encourages the Task Force to consider Oregonians who are not eligible for OHP but cannot afford Marketplace coverage, who would be covered by a BHP.	Link
7/22/22	Julianne Horner, President, and Tim Rasch, Immediate Past President	Oregon Association of Health Underwriters	A letter encouraging the Task Force to take additional time designing the program and considering: • What state resources would be needed to make up the difference between federal funds for silver plan subsidies and the cost of the Bridge Program; • What effects the Bridge Program would have on people in the individual Marketplace; • How would a mandate to pay below-market rates to providers affect members' access to provider networks, or cause cost-shifting to the commercial market?	Link

			• What cost sharing strategies could be used to positively influence enrollee behavior and bridge between free OHP benefits and commercial coverage as incomes increase?	
7/24/22	Sue Inahara		A letter to the Task Force encouraging the inclusion of robust mental health coverage in the Bridge Plan. The letter draws on Ms. Inahara's personal experiences with inadequate health insurance coverage for mental health treatment, and requests the Task Force to prioritize integrated behavioral health services in the Bridge Plan.	Link
7/24/22	Mark Sturbois		A letter to the Task Force stating support for its work and requesting that the Task Force include dental and vision coverage in the plan. The letter draws on Mr. Sturbois' personal experience as a healthcare advocate and as a patient affected by lack of affordable health insurance coverage. The letter states support for a public option and extension of the federal ARPA subsidies.	Link
7/25/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Association	A letter encouraging the Task Force to pursue market impact mitigation strategies that will incur least burden to the consumer and minimal added implementation obstacles for the Bridge Plan. Also encouraging the Task Force to consider expanded funding options before cutting benefits, adding enrollee costs, or lowering provider reimbursement rates. Reiterating previously submitted comments advocating that the Plan: • Offer at least OHP covered services. • Reimburse at rates higher than Medicaid and that are cost-based. • Prioritizes zero out-of-pocket costs to enrollees. • Provides enhanced reimbursement to safety net providers. • Clearly articulates an outreach and engagement strategy.	Link
8/8/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Association	A letter to the Task Force that notes: • the Bridge Program is an opportunity to address gaps in insurance coverage for people experiencing economic insecurity and racial inequities in coverage. • People undergoing OHP redeterminations may also be affected by redetermination changes in programs such as WIC and SNAP. The letter encourages the Task Force to: • Consider state funding before enrollee cost sharing, covered services, or provider reimbursement rates, if needed. • Design the Bridge Program with the OHP covered services package including dental and behavioral health services and no enrollee cost sharing. • Establish capitation rates higher than Medicaid and adjusted for demographics and needs and provide enhanced reimbursements for FQHCs such as wraparound payments. • Collect data on race, ethnicity, age, gender identity and sexual orientation, ability, socioeconomic status and geographic location to support disaggregated analyses. • Promote a comprehensive engagement and outreach strategy for people undergoing OHP redetermination.	Link

8/8/22	Carly Hood-Ronick, Executive Director	Project Access NOW	A letter to the Task Force that encourages consideration of state funding if federal funds will not support a program with no enrollee costs and higher than OHP capitation rates. Additionally, the letter encourages the Task Force to recommend: • No monthly premiums, out-of-pocket costs, or requirement for a tax credit repayment for mid-year income changes. • Higher than OHP reimbursement rates and quality of care that is equivalent to OHP. • Coverage offered on the Marketplace and provided by CCOs using existing infrastructure but designed with a future public option in mind. • Resources for CCOs, CBOs and other health entities to support culturally specific outreach and community engagement.	Link
8/22/22	Calie Roa, President	Oregon Dental Association	A letter to the Task Force that: • Encourages the Task Force to advance its draft recommendation that BHP dental benefits are equivalent to OHP adult dental coverage; • Expresses concern that providers limit acceptance of OHP patients due to low Medicaid reimbursement levels; and • Encourages the Task Force to advance its draft recommendation that BHP capitation rates allow for provider reimbursements to be higher than OHP.	Link
8/29/22	Maribeth Guarino, Health Care Advocate	OSPIRG	A letter to the Task Force expressing support for its work and: • Supporting a BHP benefit design that aligns to the Oregon Health Plan; • Supporting the pursuit of "phase four" to provide consumers a choice between the BHP and Marketplace plans; • Supporting a plan design with no premiums and no enrollee cost sharing.	Link
8/29/22	Marty Carty, Director of Government Affairs	Oregon Primary Care Association	A letter to the Task Force that expresses support for the recommendations to design the plan with no cost sharing and OHP-like benefits, for emphasizing care continuity and health equity, and for attention to reimbursements for safety net providers. The letter: • Encourages design of a BHP with a cost-based reimbursement model for federally qualified health centers at or above the level of Medicaid. • Encourages BHP design with payment methodologies that are risk adjusted for race, ethnicity, and social determinants of health. • Encourages continued communication with outreach and engagement partners with emphasis on a culturally inclusive process.	Link
10/18/22	Carly Hood-Ronick, Chief Executive Officer	Project Access NOW	A letter to the Task Force that: • Encourages the Task Force to incorporate consumer feedback in its recommendations on program design, and compensate participants if feedback is gathered through activities such as focus groups or surveys. • Supports inclusion of Health-Related Services in the overall benefit design of the Bridge Program.	Link

			• Supports the creation of a BHP-like program for people earning between 200-400 percent of the federal poverty level as part of "Phase 4" of the Bridge Program implementation.	
10/31/22	*Eric Waskowicz, Policy Manager*	*United States of Care*	A letter expressing concern about the potential impact to individuals remaining on the Marketplace and urging the Task Force to explore mitigation strategies to address the potential increased cost-sharing those individuals could face when the Bridge Program starts enrolling people between 138-200% FPL.	Link
11/15/22	*Eric Waskowicz, Policy Manager And Kelsey Wulfkuhle, State External Affairs Manager*	*United States of Care*	A letter to the Task Force that: • expresses support for continuing to explore a shift to a gold benchmark when calculating APTC, and encouraging the state to continue discussions with CMS to identify an approach that is consistent with the affordability guardrail required for approval of a Section 1332 waiver amendment. • Reiterating a request that the Bridge Program be designed with no enrollee cost sharing or premiums. The letter recommends exploring providing benefits on a sliding scale if cost sharing is not avoidable. • Recommending that if premiums are necessary, the program be designed with a 90-day grace period before disenrollment to reduce risk of churn.	Link
11/28/22	*Sean Kolmer, Senior Vice President of Policy and Strategy*	*Oregon Association of Hospitals and Health Systems*	A letter urging the Task Force to prioritize hospital reimbursement that covers the cost of delivering care to the BHP population.	Link
11/29/22	*Eric Waskowicz, Policy Manager And Kelsey Wulfkuhle, State External Affairs Manager*	*United States of Care*	A letter advocating that the Task Force focus on recommending use of excess revenue to: (1) offer additional benefits to enrollees; (2) supporting outreach and enrollment assistance. The letter also advocates for recommending that OHA and CCOs collect robust data on enrollee demographics, benefit utilization, and provider participation and network adequacy. United States of Care also supports efforts to establish sustainable reimbursement rates for providers who treat vulnerable and historically underserved populations, continued discussion with CMS regarding moving to a gold benchmark, and prioritizing consumer engagement before and during Bridge Program implementation.	Link
11/29/22	*Marty Carty, Director of Government Affairs*	*Oregon Primary Care Association*	A letter urging the Task Force to consider recommending use of additional General Fund to support OHP-like coverage with no out-of-pocket costs and higher than OHP reimbursement rates, including cost-based reimbursement for safety net providers.	Link

12/13/22	*Eric Waskowicz, Policy Manager And Kelsey Wulfkuhle, State External Affairs Manager*	*United States of Care*	A letter thanking the Task Force for its work, including the consideration of public comment in developing recommendations.	Link

Oregon Association of Hospitals and Health Systems

April 25, 2022

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

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

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

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

1. **We maintain that the bridge program should be a temporary solution.** The immediate goal is to ease the transition for individuals who are no longer eligible for the Oregon Health Plan following redeterminations at the end of the federally declared Public Health Emergency. Longer term, the goal should be to transition those individuals to appropriate marketplace or employer-based plans or other currently existing and funded programs. We recognize the affordability challenges some individuals face even when eligible for marketplace subsidies and cost sharing reductions. These challenges are complex and call for a different conversation around understanding and addressing underlying cost drivers – such as in the health care cost growth target program. The recommendations regarding the bridge program must be developed within the context of these overarching policy goals.

2. **Provider payments must be sufficient to ensure adequate access to care for enrollees in the bridge program.** If the program is not financially sustainable for providers, provider networks could be disrupted, which could result in care gaps and health inequities for the bridge population at a minimum. Further, hospitals across Oregon remain financially and operationally fragile as the impact of the pandemic lingers, and the road to recovery will be long. Adding more cost burdens to the financial pressure hospitals are already facing puts their ability to care for their communities at even greater risk.

3. **Oversight and accountability over the state financial impact of the program are critical.** OHA stated in "Oregon's COVID-19 Plan – Resilience in Support of Equity (RISE)" that the bridge program will "Be fully funded by the federal government (if approved). The plan would come at no additional cost to Oregon's budget" (p. 23). Any potential need for additional state funds should be part of any proposals presented to the Task Force and stakeholders and should be monitored closely as negotiations with federal regulators unfold. Further, any

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

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

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

Thank you,

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

4000 Kruse Way Place, Bldg. 2, Suite 100
Lake Oswego, Oregon 97035
*Phone 503-636-2204 * Fax 503-636-8310*

PacificSource

May 5, 2022

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

Delivered electronically.

Co-Chairs Steiner Hayward and Prusak:

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

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

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

[1] Pub. L. 117-2, 135 Stat. 4.

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

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

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

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

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

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations

COALITION FOR A HEALTHY OREGON
COMMITTED TO LOCAL CARE

May 10, 2022

From: Coalition for a Healthy Oregon

To: Joint Task Force On the Bridge Health Care Program

Subject: CCO Principles for a Successful Bridge Health Care Program

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

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

Center the Member Experience

1) Use current CCOs to maintain continuity of care—It is critically important to expand enrollment within existing CCOs rather than create a new layer/silo of health care delivery. Existing CCOs have relationships with members, providers, and community stakeholders; there are robust systems in place to ensure quality and accountability.

2) Benefit package should be as close to Oregon Health Plan as possible—Members will lose trust in the system if they do not understand why they can no longer access services they rely upon.

3) Movement from CCO to Bridge Program should not be disruptive for members or providers.

4) Maximize flexibilities for CCO outreach—This includes outreach to current CCO members, as well as providers and community-based organizations (CBOs) on the redetermination process and the move to the new Bridge Program.

COALITION FOR A HEALTHY OREGON

Ensure Provider Participation

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

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

7) Additional administrative burden should be minimized.

Leverage The Successful, Local Model

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

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

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

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

Sincerely,

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

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 10, 2022

Re: Bridge Health Care Program Goals and Pathways

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

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

Exchanges:

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

Waiver Options:

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

[1] 255315 (oregonlegislature.gov)

May 10, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

Building on Oregon's History as a Health Care Innovator

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

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

Key Waiver Pathway Considerations

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

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

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

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

- **1331 Basic Health Program:** Creating a Basic Health Program (BHP) under Section 1331 of the ACA may mean Oregon receives less federal funding or has federal limitations to cover future additional populations, beyond those with incomes between 138-200% FPL, through a public health insurance option. Under a BHP, states only receive 95% of the premium tax credit amount that the state would have gotten without a waiver. In addition, individuals deemed eligible to enroll in Basic Health Program coverage are not permitted to enroll in qualified health plans in the Marketplace, so the BHP creates a separate risk pool, which may have implications for the Marketplace risk pool.

- **1115 Medicaid Demonstration Waiver:** 1115 waivers primarily focus on providing additional flexibility for states to design and improve their Medicaid programs. Oregon currently operates its Medicaid program through an 1115 waiver, which implemented the Coordinated Care Organization (CCO) community-based infrastructure for the Oregon Health Plan. An 1115 waiver on its own would likely not provide the flexibility to align innovative waiver provisions to support expanded access to care across coverage programs and markets.

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

Sincerely,

Liz Hagan
Director of Policy Solutions
ehagan@usofcare.org

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

Rachel Bonesteel
Policy Manager
rbonesteel@usofcare.org

Dear Members of the Task Force and Policymakers,

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

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

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

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

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

Thank you,

Chris Bugas,
Emergency Medicine Physician

May 10, 2022

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

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

The bridge plan is not just a program to help with redetermination; redetermination is the opportunity to implement a long-term solution that helps individuals and families with unsteady incomes that churn in and out of Medicaid to maintain insurance coverage throughout the year. As pointed out by OHA in the first task force meeting, about ⅓ of individuals who leave Medicaid will return within a year. As long as income restricts eligibility, that churn is not going to go away because income is not fixed for everyone, but this bridge plan can be there to make sure that those folks don't lose health insurance coverage every 6-12 months before they re-qualify for Medicaid.

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

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

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

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

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

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

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 24, 2022

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

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

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

Benefits and Coverage:

- At minimum, benefits must equal those offered within OHP Essential Health Benefits (EHB) to ensure continuity of care for those transitioning from OHP to a bridge health plan.
- Additionally, OPCA supports routine oral and behavioral health care, services for adults outside EHB coverage. Data show that many adults are not accessing preventative oral or behavioral health care due to prohibitive costs. In the interest of health equity, including these benefits is vital[1].

Enrollee Costs:

- OPCA believes the ideal model is no-cost for enrollees wherein there are no premiums, copays, coinsurance or deductibles.
- However, OPCA recognizes the Task Force may recommend consumers bear some cost burden. In that scenario, we would continue to advocate for **no coinsurance or deductible** and **no copays for preventative care**. Cost-sharing could apply to low copays for non-preventative services and low, sliding-scale premiums.
- Premiums, if implemented, should begin at a threshold above the 138% minimum and follow a sliding scale based on income. Minnesota implemented a cost-sharing plan with their MinnesotaCare basic health plan; enrollees pay no premiums up to 160% FPL, at which point a sliding scale is implemented starting at $4 and ending at $28 when enrollees are at 200% FPL. Oregon could implement a similar model, adjusted for potential population differences[2].
    - Reduced cost-sharing for MinnesotaCare did not result in significant fluctuation in private or marketplace plan enrollment; rather, the primary result was a substantial decrease in the uninsured population[3].

[1] OHA Public Option Implementation Report
[2] MNCare Premiums
[3] MN Insurance Uptake Rates

- Cost significantly inhibits access to health insurance and priority populations are disproportionately represented in the uninsured population[1]. Reducing costs of health insurance is necessary to promote Oregon's health equity goals.

Reimbursement:

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

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

From: **Oregon Dental Association**

Date: **May 24, 2022**

Re: **Inclusion of Dental Benefits in the Bridge Program**

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

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

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

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

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

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

Sincerely,

Dr. Calie Roa, ODA President

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June 21, 2022

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

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

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

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

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

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

CC:
Courtni Dresser
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Sabrina Riggs
sabrina@daltonadvocacy.com

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Portland, OR 97213
www.providence.org/oregon

July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

William Olson
Chief Executive Officer
Providence Health & Services – Oregon

Don Antonucci
Chief Executive Officer
Providence Health Plan

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 12, 2022

Re: Bridge Health Care Program Marketplace Impact

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

We write to offer comment on the Bridge Health Care Program. OPCA believes that the Bridge Plan is an opportunity to implement a long-term solution to Oregon's continual gaps in health insurance coverage, specifically for those experiencing economic insecurity and other social determinants of health. Racial inequities are a fundamental root cause of health disparities, including unequal access to health insurance coverage – during the Public Health Emergency (PHE), Black and African American Oregonians experienced an unprecedented increase in coverage[1]. These are upstream health equity gains Oregon cannot afford to lose – systemic disenfranchisement must not be perpetuated by the Bridge Health Program.

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

- Zero out-of-pocket costs for enrollees, as premiums deter enrollment and even small increases in co-pays are correlated with reduced care. Increased cost-sharing of any kind puts a greater burden of cost on individuals with chronic needs who are unlikely to disenroll regardless of cost[2].
- If cost-sharing is the cost-saving lever chosen by the Task Force, we advocate for sliding scale premiums introduced at a percentage above 138% FPL, zero co-payments for preventative services with minimal co-payments for non-preventative care, and no coinsurance or deductibles.
    - We also encourage Task Force members to articulate protocols around these cost-sharing requirements, such as policies regarding missed premium payments. As cost-sharing would be a significant change for individuals accustomed to OHP, we also advocate for robust education for system navigators as they engage enrollees.
    - Using Minnesota's BHP as a case study, it is important to note that they followed a similar model of cost-sharing. While the BHP reduced uninsurance rates overall, it did not have an equitable impact in all communities – Hispanic and Indigenous Minnesotans experience disproportionately high rates of uninsurance compared to white Minnesotans[3]. This highlights potential unintended health equity consequences for communities of color if Oregon's Bridge Program includes even minimal cost-sharing.
- Regardless of reimbursement rate, CHCs should receive their PPS wrap payments for this population. As discussed in prior OPCA written and oral testimony as well as in advanced readings, the PHE unwinding will shift many CHC patients off Medicaid, making them PPS ineligible – as many as 10% of CHC patients state-wide[4]. CHCs receive PPS to support uncompensated yet lifesaving services and it is vital that considerations are made to keep CHC programs and services whole.

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[1] Unwinding Federal Public Health Emergency and OHP Continuous Coverage Policies
[2] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF
[3] MN Uninsurance Rates
[4] BPTF Questions and Answers

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July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

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

Regards,

/s/ Elizabeth Edwards

Elizabeth Edwards
Government Relations Director
Kaiser Permanente Northwest

500 NE Multnomah St.
Portland, OR 97232

Oregon Association of Hospitals and Health Systems

July 12, 2022

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

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

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

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

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

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

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

[1] *Apprise Health Insights, June 7, 2022, available at: Q1 2022 HUFA Report.pdf (d1o0i0v5q5lp8h.cloudfront.net).*
[2] *See also OAHHS comments to the Cost Growth Target Advisory Committee, June 21, 2022, available at: OAHHS-Letter-to-CGT-Advisory-Committee-6.21.2022-FINAL.pdf (oregon.gov).*

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

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

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

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

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

Thank you,

Sean Kolmer
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July 12th, 2022

Oregon Bridge Plan Taskforce

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

Submitted by email: jtbhcp.exhibits@oregonlegislature.gov

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

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

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

1. **The Bridge Plan must allow individuals the option to purchase private coverage if eligible.** Individuals who qualify for the Bridge Plan should continue to be able to purchase a private insurance plan through the Marketplace, if they so choose. This will minimize destabilization on the Marketplace, allow for more freedom of choice for consumers, and ultimately protect consumers from experiencing the effects of disruption on the market like increased premiums and co-pays, shifting coverage, etc.

2. **The Task Force should consider the ability of smaller CCOs to administer a Bridge Plan.** Many CCOs do not currently administer commercial benefits and to not have the infrastructure to collect premiums, process copays, or to collect for

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

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

Best,

Carly Hood-Ronick MPA, MPH
Executive Director

July 12, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

Market Impacts

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

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

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

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

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

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

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

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

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

Plan Design

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

Plan Design Scenario Planning

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

Enrollee Costs

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

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

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

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

Provider Reimbursement

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

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

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

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

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

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

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

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

Sincerely,

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Appendix

COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.116

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

I. Background and Purpose

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

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

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

II. Applicability and Scope

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

III. Division Position

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

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

Induced Demand Factor = $1.24 - AV + AV^2$

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

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

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

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

VI. History

Issued May 19, 2021.

Dear members of the Bridge Plan Task Force,

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

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

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

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

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

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

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

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

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

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

Thank you for your consideration.

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

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Wanda Davis
503-508-1428

OAHU
OREGON ASSOCIATION
OF HEALTH UNDERWRITERS

July 22, 2022

To Members of the Bridge Health Care Program Task Force:

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

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

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

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

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

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

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

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

Respectfully submitted,

/s/

Julianne Horner
President

/s/
Tim Rasch
Immediate Past President

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

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

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

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

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

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

Mark Sturbois
1100 S E 12th Ave #322
Portland Oregon 97214
msturbois@comcast.net
503 201 9919
Members of The Bridge Plan Task Force:
My name is Mark Sturbois and I have been a Healthcare Advocate for well over 2 decades. I served as Legislative Chair and later advisor for 18 years for CWA 7901. I served several years as the Treasurer of the Oregon Working Families Party and on the state steering committee and have belonged to several healthcare advocacy groups. Oregonians for Health Security, the Archimedes Project and Healthcare for All Oregon. While I am a single payer believer, I am also a realist and will fully support the mission of this task force to preserve the lifeline to affordable coverage to over 50 thousand Oregonians and ultimately expand it.
I am currently on Medicare and am employed in Protection Services at the Portland Art Museum. I also serve on the Multnomah County Citizens Budget Advisory Committee for Human Services.
I have several times in my life been affected by a lack of affordable healthcare. Perhaps the biggest example is being diagnosed with Hepatitis C. I couldn't afford the treatment at the time as I would have been unable to work and would have lost my job and my insurance. I retired before I was medicare eligible and got affordable coverage through the State. Innovations in medicine developed a new cure in the form of 12 weeks of a pill a day with few side effects. A group called PAN [Patient Access Network} picked up the cost of the medication and today I have a normal functioning liver.
I have also been helped in the past when lack of Dental Insurance allowed treatable problems to progress to health threatening abscesses and tooth loss.
This program is absolutely necessary. The pandemic and virtually uncontrolled inflation has victimized so many tax paying Oregonians. The working poor. I'm sure I don't need to give you statistics you already should have. Healthcare is utilized more if it is affordable and treating a problem in the early stages is cheaper than letting it grow into a major ailment.
It is my hope that the federal equivalent to this remains in ARPA and does not sunset in December. It needs to be extended and enhanced. Our state would certainly benefit from the Federal dollars.
Ultimately I would like Dental and Vision included as they should be in every healthcare discussion.
I certainly believe that a true competitive public option would benefit the people and the state perhaps modeled like a CCO.
Regardless I appreciate the work of the Task Force and being able to provide comments.
Mark Sturbois
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OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 26, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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

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

Marketplace Impact

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

Plan Development

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 9, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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

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

Unintended Consequences

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

Plan Development

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

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

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

wrap – this will impair their entire service array, not limited to the population impacted by redetermination. **While we recognize that this is not federally required for a BHP, we urge members to consider options which mitigate this impact, including expanding eligibility for PPS wrap payments to 200% FPL.**
    - CHCs offer many otherwise unreimbursed services that PPS payments are intended to help offset, such as school-based health centers, expanded dental services, mobile clinics, and many others. These programs will be threatened if CHC funding does not remain intact.
    - Current data indicates that as many as 41,000 current CHC patients could be in the target demographic for the Bridge Program. This means that up to 82% of the target population could be cared for in CHCs, as we do not anticipate that a change in coverage will cause patients to change their care home. Failure to adequately reimburse for care provided to this population would severely undermine CHC service provisions.
- **Clearly articulates a comprehensive engagement and outreach strategy** – this looks like consistent, culturally inclusive messaging about plan benefits, eligibility, costs, and enrollment pathway. We strongly advocate for a no-wrong-door approach, wherein all system navigators can support potential enrollees.

August 9th, 2022

Oregon Bridge Plan Taskforce

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

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

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

Potential for State Funding

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

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

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

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

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

Best,

Carly Hood-Ronick MPA, MPH
Executive Director

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

From: Oregon Dental Association

Date: August 22, 2022

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

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

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

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

ODA encourages the Task Force to move forward with a plan design that includes a package that is equal to that offered under the Oregon Health Plan.
Solution: the ODA encourages the Task Force to move forward with the recommendation in the draft report to include dental benefits that align with those offered under the Oregon Health Plan

Concern: Reimbursement to providers must be adequate to ensure actual access.
Dentist participation in OHP provider panels is often hampered due to low reimbursement rates. Dental offices are particularly vulnerable to low reimbursement rates due to high overhead, labor and equipment costs, and we know that low Medicaid reimbursement directly causes dentists to limit the number of Medicaid patients they see. Ensuring a robust— higher than Medicaid—reimbursement structure will enable stronger, more resilient and sustainable, provider participation and increase access to care to those most in need.
Solution: ODA encourages the Task Force to move forward with the recommendation in the draft report to provide capitation rates that allow for provider reimbursement higher than Medicaid rates.

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

Sincerely,

Dr. Calie Roa
ODA President

August 30, 2022

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

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

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

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 30, 2022

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

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

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

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

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

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

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

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

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

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

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

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

Project Access NOW
Community | Care | Connection

October 18th, 2022

Oregon Bridge Plan Taskforce

Re: Bridge Plan Consumer Input, Health-Related Services, and "Phase 4"

Submitted by email: jtbhcp.exhibits@oregonlegislature.gov

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

I write to you today on behalf of Project Access NOW, a community-based organization providing health and health-related resources to un and underinsured individuals in the Portland area. PANOW serves a number of different communities that will be impacted by the introduction of the Bridge Plan: our Outreach, Enrollment, and Access program assists over 4,000 Medicaid-eligible households per year in applying for Oregon Health Plan, and our Premium Assistance program pays the Federal Marketplace premiums that would otherwise be unaffordable for households that make even $1 too much to qualify for OHP. These communities make up the "churn" population the Bridge Plan intends to serve, as well as the population that won't qualify for the BHP but will experience the market effects of its introduction.

As that Task Force grows closer to finalizing its recommendations to the legislature, we feel strongly that the following considerations should be taken:

1. **The Bridge Plan must incorporate consumer input in a significant capacity.** We were disappointed to see that the Task Force's consumer listening session scheduled in July was cancelled due to low registration, and urge the Task Force to take whatever steps necessary to incorporate consumer input, preferably prior to the conclusion of the Task Force's work. This input should be, if at all possible, included in the Task Force's recommendations. If the Task Force decides to pursue focus groups or surveys as the method of gathering consumer input, consumers who participate should be compensated for their time appropriately.

2. **The BHP should robustly cover Health-Related Services.** Project Access NOW currently administers HRS funding for OHP members on behalf of a number of CCOs for critical services that boost health outcomes and minimize health spending.

While we recognize the upfront financial challenges associated with covering these services, we urge the Task Force to make these services available to those accessing the BHP, as they have been proven to ultimately save the state money by preventing the need for more expensive care down the line as a result of lack of access to resources.

3. **The Bridge Plan should include a "Phase 4" that offers a BHP-like plan for purchase on the Marketplace for those in the 200-400% FPL range.** Individuals in the 200-400% FPL range experience many of the same challenges in accessing health coverage and health care that those in the 138-200% BHP target population do, and these challenges may only become more significant after the introduction of the BHP and market destabilization begins. Many of the individuals in this income range currently require assistance from organizations like Project Access NOW to access coverage and healthcare, and that number may grow if Marketplace plans become more expensive and less accessible to them. We urge the Task Force to consider including an expansion of the Bridge Plan with a state-regulated option that mimics the BHP, available for purchase on the Marketplace for individuals over 200% FPL. Such a plan will protect this population from their already existing challenges in accessing healthcare and the new challenges they may experience as a result of the BHP market destabilization.

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

Best,

Carly Hood-Ronick MPA, MPH
Chief Executive Officer

October 31, 2022

Bridge Plan Task Force Members

RE: 11/1/22 Joint Task Force on the Bridge Health Care Program Meeting
900 Court Street NE, Room 453
Salem, OR 97301

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments ahead of the Bridge Plan Task Force's (BPTF) planned November 1, 2022 public meeting. United States of Care (USofCare) appreciates the opportunity to weigh in and share our perspective based on our experience in Oregon and other states pursuing our mission to ensure people have access to high-quality, affordable health care regardless of health status, social need, or income.

In May 2022, USofCare released its United Solutions for Care, a one-of-a-kind set of twelve concrete and achievable solutions to help build a fairer health care system. These twelve solutions are derived from four goals to address what is lacking in people's health care. Two of these goals for the health care system are that people should have coverage that is both dependable and affordable. **We applaud the BPTF as it constructs a Bridge Plan that centers these two goals, ensuring that people with incomes between 138% and 200% of the federal poverty level (FPL) have comprehensive, accessible health care through the Bridge Plan.**

The results from the BPTF-commissioned microsimulation by Manatt Health and Oliver Wyman include a number of encouraging takeaways. Thanks to the expanded advanced premium tax credits (APTCs) extended under the American Rescue Plan Act (ARPA) in 2021, the overall enrollment of the population on the marketplace remains relatively stable once people with incomes below 200% FPL are removed for the Bridge Plan. Unfortunately, that masks not-insignificant changes people enrolled in these plans may face when the Bridge Plan goes into effect. **As average premiums for silver plans on the marketplace are expected to decrease, average subsidies tied to these plans will also decrease for all people enrolled in the marketplace, meaning people have less "purchasing power." USofCare is concerned that this will push people to choose plans that have higher cost-sharing and out-of-pocket costs, putting them at increased financial risk.**

The microsimulation suggests that the Bridge Plan's introduction will cause more than 7,000 people currently enrolled in gold plans to shift to silver or even bronze plans as their premiums increase. While their premiums could drop, their deductible could rise thousands of dollars, subjecting them to more unpredictable and higher amounts of cost-sharing. **While the BPTF's primary task has been to create a comprehensive Bridge Plan for people**

with incomes under 200% FPL, it is also charged with developing mitigation strategies for impacts on the individual market. The microsimulation notes the unequal impacts by age and income of the Bridge Plan on the individual market, which the BPTF should pay special attention to in further developing recommendations. **We continue to urge the BPTF to continue to consider mitigation strategies for people not eligible for the Bridge Plan – people with incomes above 200% FPL – to prevent any increased cost-sharing this population may face.** This could include recommendations for Oregon to take action against issuer gaming with regards to "induced demand factors," similar to the protections put in place by Colorado's Division of Insurance in 2021.

We thank the BPTF for its tireless work to improve the coverage and affordability options for low-income and all Oregonians and we appreciate the opportunity to submit these comments. Should you have any questions regarding these comments, please don't hesitate to contact Kelsey Wulfkuhle at kwulfkuhle@usofcare.org or Eric Waskowicz at ewaskowicz@usofcare.org.

Sincerely,

Eric Waskowicz
Policy Manager
ewaskowicz@usofcare.org

Kelsey Wulfkuhle
State External Affairs Manager
kwulfkuhle@usofcare.org

November 15, 2022

Bridge Plan Task Force Members

RE: 11/15/22 Joint Task Force on the Bridge Health Care Program Meeting
900 Court Street NE, Room 453
Salem, OR 97301

Dear Members of the Bridge Plan Task Force:

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

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

USofCare seeks to focus its comments on two areas ahead of the BPTF's November 15 meeting - the "gold benchmark" proposal put forward by the Department of Consumer and Business Services (DCBS) as well as the suggestion raised by Manatt that the BPTF may need to consider introducing some form of cost-sharing for people eligible for the Bridge Plan based on estimated cost.

Gold Benchmark
USofCare applauds steps taken by the BPTF to mitigate the downstream effects caused by removing the Bridge Plan population from the existing individual market (and related "silver loading"), as we have raised concerns about this in previous comments. The results of the microsimulations commissioned by the BPTF showed that, for people still enrolled on the individual market, as average premiums for silver plans on the marketplace decreased, average subsidies tied to all plans would also decrease, eroding people's overall "purchasing power." USofCare submitted comments ahead of the BPTF meeting earlier this month expressing concern about the impact on health care affordability for marketplace consumers, including people deciding to move to plans with lower premiums but higher out-of-pocket costs and overall increased levels of financial risk.

We are pleased to see the BPTF take steps to address our concerns and appreciate OHA and DCBS engaging in dialogue with CMS, issuers, and other stakeholders to understand the

feasibility of pursuing various approaches. In particular, we are encouraged by the BPTF's consideration of a "gold benchmark," in which the benchmark plan, currently tied to the second lowest cost silver premium, is moved and pegged to the lowest cost gold premium. Moving it from the silver to gold level would protect enrollees from higher premiums and cost-sharing that exposes them to greater financial risk.

The marketplace overview put together by DCBS found that shifting to a gold benchmark would increase the average premium tax credit and decrease or (depending on the tier level) nearly eliminate the monthly premium cost in most counties, thus increasing the purchasing power of people enrolled in coverage who would see the opposite should no mitigation effect take place. This is encouraging news and addresses many of the concerns USofCare raised ahead of the BPTF's November 1 meeting.

While we understand there is more work to be done with CMS to ensure 1332 guardrails are met, we were encouraged by the potential ability of amending the state's existing Section 1332 waiver to use excess reinsurance pass-through funding to finance the increased costs associated with the transition to a gold benchmark. This represents a serious effort to ensure people on the marketplace don't face changes in coverage that could lead to higher forms of cost-sharing.

Unfortunately, as proposed, DCBS's analysis also found that some people enrolled in the lowest cost gold plans in 5 of the state's 56 counties could see a small premium increase unless the policy changes. Because of Section 1332's affordability guardrail, which prohibits more expensive coverage than would otherwise exist with no waiver, Oregon needs to ensure people do not face higher premiums in order for the waiver to be approved. As noted in the last BPTF meeting, this may be able to be achieved by using excess pass-through funding from the existing 1332 reinsurance waiver to offset more expensive coverage, and we appreciate OHA and DCBS engaging in ongoing conversations with CMS on this issue. **We encourage the state to continue to work with the Centers for Medicare & Medicaid Services (CMS) to identify a solution that would satisfy Section 1332's affordability guardrail and ensure that no one on the individual market would see their premiums increase, including by utilizing excess pass-through funding.**

Enrollee Costs

As the BPTF receives the detailed estimates of costs and revenues for a Basic Health Program (BHP) in Oregon, we recognize that the BPTF may have to make certain plan design decisions to address the underlying cost of the Bridge Plan, including adjusting the preliminary recommendations around no enrollee costs. As we have outlined in previous comments to the BPTF, **we recommend that the Bridge Plan eliminate premiums and cost-sharing for individuals covered under the plan**. The increased cost burden of making the transition from Medicaid coverage may result in some Oregonians choosing to forgo coverage, and these coverage gaps can lead to delays or lapses in care, higher costs for services, and poorer health outcomes that end up costing the system money.

We understand that the BPTF must balance benefits and costs to enrollees with the costs of the program and that variation in federal funding amounts have implications for how robust the program can be. We are pleased with the BPTF's prioritization of not including premiums in the Bridge Program and appreciate that the BPTF has also taken enrollee out-of-pocket costs seriously. While we urge the BPTF to include more robust benefits in the benefits package, we understand that could be at the expense of no enrollee premiums and/or lower cost sharing due to program costs; if program costs create limitations, the BPTF should consider whether there is a way to provide certain benefits on a sliding scale based on income rather than requiring

premiums or cost-sharing across the board. This model would allow Oregon to comply with federal requirements stipulating that BHP premiums may not exceed what an individual receiving premium tax credits would otherwise have paid when purchasing a plan on the exchange ($0 for individuals under 151% of the Federal Poverty Level [FPL]). We also encourage the BPTF to prioritize coverage of certain high-value services, including preventive, primary, and behavioral health care services with no cost-sharing, regardless of income. Other states who have pursued a BHP have implemented similar solutions including:

- New York's "Essential Plan" offers four categories of coverage options, each available to a subsection of enrollees based on their income. Each category's benefit package and cost-sharing are varied, however plans in each category all offer the same coverage at the same cost to enrollees. Premiums for enrollees begin at 151% FPL, with co-payment requirements for those over 100% FPL. Non-immigrant enrollees are also eligible to purchase any dental and vision coverage outside of the essential health benefits at full cost.
- Minnesota's BHP provides another solution – all non-exempt BHP enrollees at or over 160% FPL pay premiums and cost-sharing on a sliding scale, each receiving a standard benefits package. Consumers in both states have reported valuing a BHP design offering predictable and understandable cost-sharing requirements and coverage options, which the BPTF should take into consideration when developing any revised recommendations.

Should the Bridge Plan require premiums, the BPTF should consider establishing grace periods for people who are unable to pay their premium amount on time, mirroring policies included in the design of other state's BHPs and the Health Insurance Marketplace. Research has shown that gaps in coverage due to disenrolling and reenrolling result in higher administrative costs to states, and can lead to higher monthly costs per member due to pent-up demand. These monthly cost impacts are even higher for beneficiaries with chronic conditions, such as diabetes. **The BPTF should consider implementing a 90-day grace period before disenrollment**, allowing Oregonians who are at risk of losing their coverage due to non-payment to avoid a coverage gap by paying past-due and current premium amounts by the end of the 90 days. This measure would help to ensure Oregonians enrolling in the Bridge Plan do not experience a similar eligibility churn to that the BHP is seeking to address.

We thank the BPTF for its tireless work to improve the coverage and affordability options for low-income and all Oregonians and we appreciate the opportunity to submit these comments. Should you have any questions, please don't hesitate to contact Kelsey Wulfkuhle at kwulfkuhle@usofcare.org or Eric Waskowicz at ewaskowicz@usofcare.org.

Sincerely,

Eric Waskowicz
Policy Manager
ewaskowicz@usofcare.org

Kelsey Wulfkuhle
State External Affairs Manager
kwulfkuhle@usofcare.org

Oregon Association of Hospitals and Health Systems

November 28, 2022

Oregon State Legislature
Joint Task Force on the Bridge Health Care Program
900 Court St. NE
Salem, OR 97301
Delivered electronically to: JTBHCP.exhibits@oregonlegislature.gov

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

The Oregon Association of Hospitals and Health Systems (OAHHS) is a mission-driven, nonprofit association representing Oregon's 62 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. OAHHS is committed to fostering a stronger, safer Oregon with equitable access to excellent health care. We appreciate the ongoing opportunity to provide input on the Task Force's recommendations regarding a bridge health care program.

We have been encouraged to hear the Task Force understand the essential connection between provider reimbursement and patient access to care. Currently, hospitals across our state are struggling to provide care while facing overwhelming financial challenges. When hospital reimbursement does not cover the cost of caring for patients, difficult choices need to be made; access reductions may be the only way to keep a hospital available for a community. For patients, that could mean driving across the state for a surgery or waiting hours to be seen in the emergency department.

Hospitals are an indispensable foundation in the community safety net. They are the only health care providers required to keep their doors open 24/7, no matter the circumstances. They provide care for serious health issues and emergencies that cannot be treated in any other environment. They save lives every day. We need our hospitals to have enough beds and enough staff to be ready to care for everyone who walks through their doors, and that cannot happen unless they are adequately funded.

While we do not expect the bridge program to solve the multi-faceted crisis our hospitals are currently facing, the Task Force can make recommendations that would support hospitals' ability to care for the population served by a Basic Health Plan (BHP). **In developing recommendations on the allocation of federal BHP funding, including any surplus above the program costs, we urge the Task Force to prioritize hospital reimbursement that covers the cost of delivering care to the BHP population. We know from our current experience that anything close to OHP reimbursement levels does not support access in a community.**

Thank you for the continued opportunity to engage in this process.

Thank you,

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

4000 Kruse Way Place, Bldg. 2, Suite 100
Lake Oswego, Oregon 97035
*Phone 503-636-2204 * Fax 503-636-8310*

November 29, 2022

Bridge Plan Task Force Members

RE: 11/29/22 Joint Task Force on the Bridge Health Care Program Meeting
900 Court Street NE, Room 453
Salem, OR 97301

Dear Members of the Bridge Plan Task Force:

Thank you for the opportunity to provide comments as the Bridge Plan Task Force (BPTF) prepares to release its final recommendations for the proposed Bridge Health Care Program (Bridge Plan). We appreciate the opportunity to weigh in and share our perspective based on our experience in Oregon and in other states working to ensure their residents have access to high-quality, affordable health care.

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

USofCare seeks to focus its comments on two areas ahead of the BPTF's November 29 meeting - how to spend and prioritize any excess Bridge Plan revenue and provide feedback on proposed recommendations as outlined in the BPTF's November 15 meeting.

Trust Fund Reserves and Prioritization of Excess Revenue
USofCare was encouraged to see that the projected revenues generated by the Basic Health Plan (BHP) are expected to exceed the projected costs for each of the three populations covered by the BHP – the Medicaid, individual market, and uninsured populations – for an excess revenue total of $142 million.

We understand that the BHP must maintain a Restricted Reserve Fund, or cash reserves, in the event of BHP insolvency or some other unforeseen circumstance, and that those funds can only be used for the BHP population. Only after a sufficient reserve threshold is met should additional revenue be re-invested in the BHP to expand the Bridge Program's benefits package,

enhance the beneficiary experience, or further enhance provider participation. USofCare recommends the following:

Enrollee Benefits

The BPTF should primarily focus on utilizing revenue to offer additional health benefits to enrollees. While we commend Oregon on the extensive coverage of dental benefits for adults on Medicaid and thus on the Bridge Plan, the BPTF should look at investing revenue into additional dental services that have been shown to increase not only the oral health, but general well-being of beneficiaries. The Oregon Health Plan (OHP) currently covers limited root canal and crown dental services for adults. Without these services, enrollees are forced to have the affected tooth extracted. Patient reports show that tooth extraction, rather than restoration, often negatively impacts feelings of self-worth and how they are viewed by others in their day-to-day life. It is important to note that Bridge Plan coverage does not fully address access to comprehensive dental services in Oregon. In 2022, 28 of Oregon's 36 counties were designated Dental Health Professional Shortage Areas (Dental-HPSAs), indicating a lack of accessible dentists in these areas. Additional work outside of the BPTF recommendations must continue to recruit and retain dental providers to serve Oregonians in these areas. Furthermore, if feasible the BPTF should look at utilizing a portion of additional revenue to provide additional non-medical benefits, such as non-emergency medical transportation, food assistance, and housing assistance, similar to those benefits provided to OHP beneficiaries through the coordinated care organization (CCO) model.

Outreach and Enrollment Assistance

The success of the Bridge Plan may be dependent on outreach to the Bridge Plan-eligible population, many of whom will be transitioning from OHP coverage and may be unfamiliar with both the Bridge Plan enrollment process and non-Medicaid coverage more generally. **By investing excess revenue in outreach and enrollment assistance, enrollees will be able to successfully navigate the initial enrollment process and have the assistance they need if their circumstances change.** Investing in additional assistance for eligible Oregonians can fulfill the BPTF's goal of a seamless transition of coverage for this population.

As the Bridge Plan represents a new coverage option for eligible Oregonians, many may simply not be aware of their eligibility and the nature of the benefit structure of this new insurance plan. The Bridge Plan can build off the success of existing OHP initiatives, such as its Dental Awareness campaign, to ensure that people are familiar with benefits included in the Bridge Plan. Culturally appropriate navigator assistance during the Medicaid redetermination process can help enrollees understand the transition to the Bridge Plan, answer questions about any differences between Medicaid and the Bridge Plan, and ensure that enrollees are familiar with the no cost-sharing nature of the Bridge Plan's benefits package.

Data Collection

The BPTF should direct OHA and CCOs to collect robust data on enrollee demographics, benefit utilization, and provider participation and network adequacy. We recognize aspects of data collection needs extend outside of the purview of the BPTF, however recommendations from the BPTF could help to address these broader issues. This collection of data by OHA and CCOs will help best inform plan design changes and additional future investments. In doing so, the BPTF should include requirements for enrollee and provider data collection which disaggregates by race, ethnicity, age, gender identity and sexual orientation, ability, socioeconomic status, and geographic location, with special emphasis given to the complex health needs of certain historically underrepresented populations. This will allow Oregon to best understand the needs of the Bridge Plan population, leveraging this data to evaluate and analyze the effectiveness of the Bridge Plan at driving down disparities and improving access to affordable health care.

Additionally, **data identifying what benefits enrollees are utilizing on the Bridge Plan can help to identify barriers to care that may exist, establishing where additional revenue should be deployed to ensure the Bridge Plan is meeting the needs of all Oregonians.** Further, because Oregon currently has limited data on the uninsured population that would be eligible for the Bridge Plan, this data collection can also serve to create a baseline for these individual's health needs. The data on benefit utilization can also help to inform decision making around the use of revenue to inform decisions on future covered benefits.

Furthermore, **Oregon should ensure continued collection of data on provider participation in the Bridge Plan to analyze network adequacy and cultural competency.** Requiring the collection of demographic data on providers, in addition to the enrollee data outlined above, can help to increase cultural competency of the Bridge Plan network. Collecting this information allows enrollees to pick providers based on their preferences. States such as Colorado have implemented culturally responsive regulations that require collection of demographic data on providers to be included in provider directories, furthering health equity. Provider participation data can also help to inform where provider payment rates may need to be reevaluated when distributing additional excess revenue.

Provider Payments

We commend the BPTF's commitment to its goal of adequate payment of providers to ensure that the Bridge Plan-eligible population has continued access to necessary medical services. The BPTF's September 2022 preliminary recommendations found that capitation rates should be set to allow CCOs to pay providers at rates higher than that of OHP. New York's Essential Plan has shown this can be done - the state has set provider payments approximately 25% higher than those of Medicaid and allows for those rates to rise over time. More specifically, we also agree with the BPTF's recommendation that the Bridge Plan should prioritize adequate reimbursement of safety net providers, such as federally qualified health centers and community behavioral health providers, who serve

many of the Bridge Plan enrollees already and who have familiarity with the population's needs. We also support prioritizing higher reimbursement rates for providers utilizing value-based payment models that take into account social drivers of health and address unique and diverse patient needs.

We also support efforts to establish sustainable reimbursement rates for providers who treat vulnerable and historically underserved populations. The Colorado Option, set to be fully implemented in January 2023, is a strong example of how certain providers who have a disproportionately low-income patient panel or other unique population can be prioritized to receive higher reimbursement rates under Oregon's Bridge Plan. We suggest any additional excess funds be used to further support enhanced payment rates for providers who provide a high volume of high-value services, such as preventive screenings, immunizations, prenatal care, and care coordination for people with complex medical needs.

Feedback on Proposed Recommendations

As shared in our November 15 comments to the BPTF, USofCare is supportive of the BPTF's recommendation of a shift to a gold benchmark to protect marketplace enrollees from higher premiums and cost-sharing that would expose them to greater levels of financial risk. We encourage the state to continue its discussions with CMS regarding this approach to ensure that all mitigation strategies, as well as the funding mechanisms for these strategies, remain viable and abide by any restrictions associated with the 1332 waiver process.

We also agree with the BPTF's recommendations to prioritize consumer engagement prior to and during Bridge Plan implementation to ensure that the voices of people who stand to gain coverage through the Bridge Plan are heard throughout this process. USofCare seeks to center people as we work in Oregon and across the country to expand access to affordable, comprehensive health care, and we are pleased to see the BPTF mirror this process through sustained consumer engagement. We encourage the BPTF to prioritize historically underserved groups in its outreach to ensure that equitable access to care remains a primary goal of the Bridge Plan.

We thank the BPTF for its tireless work to improve the coverage and affordability options for low-income and all Oregonians and we appreciate the opportunity to submit these comments. Should you have any questions, please don't hesitate to contact Kelsey Wulfkuhle at kwulfkuhle@usofcare.org or Eric Waskowicz at ewaskowicz@usofcare.org.

Sincerely,

Eric Waskowicz
Policy Manager
ewaskowicz@usofcare.org

Kelsey Wulfkuhle
State External Affairs Manager
kwulfkuhle@usofcare.org

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: November 29, 2022

Re: Bridge Health Care Program, December Report Draft

The Oregon Primary Care Association (OPCA) is a non-profit organization, with a mission to support Oregon's 34 community health centers (CHCs), also known as federally qualified health centers (FQHCs), in leading the transformation of primary care to achieve health equity for all. Health centers deliver integrated primary, behavioral, and oral health care services to over **416,000 Oregonians**. 41% of health center patients identify as a racial or ethnic minority, 18% are uninsured, **68% are publicly insured** (OHP, CHIP, and/or Medicare), 8% are experiencing homelessness, and 3% are veterans. Community health centers provide care to some of Oregon's most vulnerable populations, including **one in six OHP members**.

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

Plan Revisions

We urge the Task Force to eschew revising the Bridge/Basic Health Plan design from a scarcity perspective, especially in light of recent actuarial analyses, which demonstrated that a Basic Health Plan (BHP) with zero out-of-pocket costs and OHP-like benefits, with some margin to spare. **Failing to implement these design elements, in addition to above-OHP provider reimbursement rates,** is associated with greater barriers to entry, reduced access to care, unintended negative consequences, and may **undermine the overall success of the Bridge Program.** HB 4035 and the preliminary Fiscal Impact and Budget Reports during the 2022 legislative session explicitly allow the Task Force to advise use of General Funds as a part of their report and we encourage Task Force members to consider this option before cutting benefits, adding enrollee costs, or lowering provider reimbursement rates. Additionally, previous Medicaid expansion data demonstrates that, overtime, expanding access to Medicaid-like coverage creates savings to the state, both in aggregate and per-capita, with those savings largely hinging on robust plan uptake. We urge the Task Force and Co-Chairs to **seriously consider the negative consequences** of failing to provide broad covered services, zero cost-sharing, and above-Medicaid reimbursement rates on both patients and the health system broadly.

As the Task Force finalizes their December report, OPCA advocates for the following:

- **Cost-based reimbursement to safety net providers, specifically Federally Qualified Health Centers (FQHC's), who are now and will likely continue to care for a large percentage of this population.** OPCA is disappointed to see that this explicit provision was removed from the December Report draft. FQHCs currently receive Medicaid reimbursement (which is below cost) and PPS wrap payments (which is a cost-based payment) for the redetermination population. As individuals move off Medicaid and onto the Bridge Plan, FQHCs will no longer receive adequate, cost-based payments for services as they lose PPS wrap – this will impair their entire service array, not limited to the population impacted by redetermination.
    - **While we recognize that this is not federally required for a BHP, we urge members to consider options which mitigate this impact, including a unique, cost-based payment methodology for FQHCs and other safety net providers.** If primary and preventative care providers are impaired in their ability to care for their population, that has rippling implications for the rest of the already-strained health care system at large. FQHCs are already experiencing workforce challenges and increased material costs, which will exacerbate network adequacy issues when patients move from OHP to the BHP. Task Force members and co-chairs have been clear in their intent that the shift in coverage and services be invisible to patients, but failing to maintain OHP levels of cost-based reimbursement for FQHCs will inhibit that goal.
    - **We are also surprised by statements made which imply that FQHCs are better off with any amount of reimbursement for the BHP population, because otherwise these lives would be uninsured.** Such a perspective is inequitable and untenable in any other business model. An analogy in another field could be asking a teacher to work at half of their previous salary, while nothing in that teacher's life circumstances change to reduce their costs and, in fact, inflation is increasing the cost of living. Inadequate reimbursement will threaten the FQHC model of care and hinder statewide efforts to eliminate health inequities by 2030.
        - In addition, under-reimbursement for the BHP population would threaten **FQHC federal operational grants**. The Prospective Payment System (PPS) was established by Congress to support the cost of unreimbursed services provided at FQHCs. In order to provide wraparound care to patients covered by the BHP, FQHCs would have to **move resources away from other programs and services to vulnerable Oregonians** to avoid diverting their Federal operational grants to patient care.
- **Reimbursement at rates which are higher than Medicaid.** We know that inadequate provider reimbursement is highly correlated with patients struggling to access care and establish a primary care home. We encourage Task Force members to make this recommendation more explicit in the December Report.
    - **FQHCs cannot deny care to any patient,** regardless of insurance type, reimbursement amount, or patient income. This is untrue for other provider types and we anticipate that, if providers are under-reimbursed for the care of the BHP population, FQHCs will see an increasing number of these lives in their patient panels. Meanwhile, FQHCs will have less resources to care not only for these patients, but all their patients across their service array. This threatens network adequacy and wraparound care provision for the most vulnerable Oregonians.
- **Zero out-of-pocket costs to enrollees, which includes premiums, copays, deductibles, and coinsurance.** We emphasize that individuals moving from Medicaid will be accustomed to no out-of-pocket costs and an abrupt shift to any amount of enrollee cost -- even the smallest premium or copay -- could deter them from both enrolling in coverage and accessing covered services.
    - **Actuarial analyses indicate that the model of care outlined in the September Report is feasible.** We urge Task Force members and co-chairs to retain this element of plan design as it, in addition to offering robust benefits, allows for greatest access to care. While the uninsurance gap has narrowed and may continue to be low for communities of color and other priority

populations as a result of the BHP, actual equitable access to care will be undermined if these elements are not prioritized.

December 13, 2022

Bridge Plan Task Force Members

RE: 12/13/22 Joint Task Force on the Bridge Health Care Program Meeting
900 Court Street NE, Room 453
Salem, OR 97301

Dear Members of the Bridge Plan Task Force:

United States of Care wants to thank the Bridge Plan Task Force (BPTF) for working tirelessly since April to bring more affordable and dependable coverage to Oregonians. We appreciate the thought, time, analysis, and dedication that went into each of the many important decisions made by members of the Task Force. Given the BPTF's compressed timeline, we especially appreciate the BPTF's robust stakeholder engagement process that took public comments, such as ours, into account in the Bridge Plan design. Once fully implemented, the Bridge Plan will be a critical lifeline to many Oregonians and it will be a reality, in part, because of the tireless work of BPTF members, including Co-Chairs Senator Steiner and Representative Prusak.

The BPTF's innovative approach will be a model other states will watch and learn from as they, too, work to ensure their residents have access to high-quality, affordable health care. We look forward to continuing to engage with partners on the ground in Oregon to support successful implementation of the Bridge Plan and advocate for even more Oregonians to have affordable health care in the future.

Should you have any questions, please don't hesitate to contact Kelsey Wulfkuhle at kwulfkuhle@usofcare.org or Eric Waskowicz at ewaskowicz@usofcare.org.

Sincerely,

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