Prepared by the
Legislative Policy and
Research Office

Joint Task Force on the
Bridge Health Care Program

Final Recommendations

December 2022

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*The Task Force extends its thanks to Alicia Temple, formerly of Oregon Law Center, for participation in earlier Task Force efforts.

About this Report

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

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

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This report draws extensively from analysis conducted for the Task Force by consultants at Manatt Health and actuaries at Oliver Wyman and Mercer. LPRO also thanks Numi Rehfield-Griffith of the Oregon Department of Consumer and Business Services and Katie Button, Chiqui Flowers, Anona Gund, Nikki Olson, Jeff Scroggin, Tim Sweeney, Laurel Swerdlow, Katie Waldo, Jessica Wilson, Tom Wunderbro, and others at the Oregon Health Authority for ongoing support to the Task Force as well as information, analysis, and feedback that informed this report.

LETTER FROM THE CO-CHAIRS

The 2022 legislative session occurred at a pivotal time for Oregon. Two years into the COVID-19 public health emergency (PHE), and just emerging from the "delta surge," the state faced stark challenges in meeting the health needs of Oregonians.

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One bright spot was the gains in health insurance coverage that occurred during the pandemic. Like other states, Oregon took advantage of a federal option that allowed people to remain enrolled in the Oregon Health Plan during the pandemic. The number of people covered – particularly people of color – reached a record high. Maintaining these gains in coverage is critical for both of us. We were pleased when the Legislative Assembly passed House Bill 4035 to create an affordable insurance option for lower income people who will not qualify for Oregon Health Plan when the PHE ends.

We have been honored to co-chair the Joint Task Force on the Bridge Health Care Program over the past nine months. **This report reflects the Task Force's final recommendations** to design and implement a Bridge Program while promoting stability in Oregon's individual and small group insurance markets. It outlines a path to new affordable coverage for more than 100,000 lower income Oregonians and would secure the progress the state has made towards eliminating coverage inequities.

We sincerely thank our nineteen fellow Task Force members for the time, thoughtfulness, and intention they have invested in this work, as well as the members of the public who provided important public testimony that helped craft these recommendations. Our work was supported and informed by staff at the Legislative Policy and Research Office, Oregon Health Authority, and Department of Consumer and Business Services. We are very grateful for their extensive contributions to this effort.

This report marks an important milestone, but the work is not finished. These recommendations will now be taken up by the Oregon Health Policy Board for consideration and we hope Oregon will move quickly to request federal approval of the program and minimize the risk of coverage loss for some of our most vulnerable Oregonians. We look forward to supporting this effort as it moves forward.

Sincerely,

Senator Elizabeth Steiner Hayward

Senate District 17

Representative Rachel Prusak

House District 37

CONTENTS

EXECUTIVE SUMMARY

During the COVID-19 public health emergency (PHE), the State of Oregon has allowed people to stay enrolled in the state's Medicaid program, the Oregon Health Plan (OHP), regardless of income changes. Since this change, the percent of uninsured Oregonians ~~has fallen~~fell to a historic low, inequities in coverage improved, and "churn" - where people enroll, disenroll, and re-enroll in OHP ~~coverage~~ over short periods - ceased. The ~~Oregon~~ Legislative Assembly sought to maintain these improvements when the PHE ends and established a Task Force to design a program to provide affordable coverage for adults who earn between 138 and 200 percent of the federal poverty level (FPL). The Task Force advanced preliminary recommendations in September 2022. This report presents updated and final recommendations based on additional information through December 2022.

Designing the Bridge Health Care Program

After considering a range of options to secure federal financial participation in Oregon's Bridge Program, the Task Force recommends the state request approval from the Centers for Medicare and Medicaid Services (CMS) for a Basic Health Program (BHP), an option offered under Section 1331 of the Affordable Care Act (ACA). The BHP should provide coverage through ~~Oregon's~~ Coordinated Care Organizations (CCOs) and be accessible through Oregon's Health Insurance Marketplace, with enrollment procedures that complement existing CCO infrastructure, and emphasize continuity of care and provider access when people transition between OHP or the Marketplace and the BHP.

BHP coverage should align with OHP (including dental coverage) with no premiums or out-of-pocket costs for enrollees. The Task Force recommends conducting consumer focus groups to gather additional feedback before implementation, and that ongoing BHP governance should include consumer representation.

Implementing the Program

The Task Force supports a phased implementation of the program as recommended by CMS. Under this **timeline**:

- **Phase 1:** The Oregon Health Authority (OHA) should immediately request an amendment to Oregon's Section 1115 Medicaid waiver to temporarily preserve OHP coverage for BHP-eligible people while the state ~~develops and~~ requests approval for a BHP Blueprint, the federal application required by CMS to establish a ~~Basic Health Plan~~BHP.
- **Phase 2:** After federal approval of the Blueprint, OHA should transition people who are enrolled in OHP and earn between 138 and 200 percent of FPL to the BHP.

- **Phase 3:** Within 24 months after the implementation of Phase 2, the BHP should become accessible to all eligible Oregonians through the Marketplace. The launch of Phase 3 should harmonize with the timelines for CCO rate development and commercial carrier rate reviews.
- **Phase 4:** OHA and the Department of Consumer and Business Services (DCBS) should explore the option to create a BHP-like coverage option under an amendment to Oregon's Section 1332 ~~-~~waiver that could offer consumers a choice between a BHP plan and other subsidized plans on Oregon's Marketplace.

A team of consultants and actuaries led by Manatt Health analyzed this approach and estimated that approximately 55,000 people who will lose OHP coverage in ~~p~~Phase 2 would gain coverage under the BHP. An additional 35,800 people who buy coverage from the Marketplace and 11,300 people who are uninsured would enroll in Phase 3.

Administering and Financing the Program

The ~~actuarial~~ analysis of the proposal estimated the program would generate a modest $116.33 per member per month ~~budget~~ surplus from federal funding. Before the program is implemented, OHA and DCBS should analyze what level of financial reserve is necessary to support program sustainability, aligning initial capitation rates to the methods used for OHP rate development and directing any surplus toward the reserve targets. Once these~~is~~ targets ha~~s~~ves ~~s~~ been achieved, the Task Force recommends prioritizing 1) the maintenance of coverage at no cost to enrollees, 2) increasing capitation rates to enable CCOs to pay providers higher reimbursements, with specific attention to safety net provider reimbursements, and 3) expansion of benefits to provide additional services and promote health equity.

Addressing Secondary Effects on Oregon's Individual Market

A simulation of Oregon's individual market suggested the market would remain relatively stable following the creation of the BHP, but some secondary effects are anticipated. T~~In particular, the~~he exit of the BHP-eligible population from the market could lead to a reduction in average premium subsidies for remaining consumers. ~~This loss of purchasing po~~Awer ~~may result in a~~pproximately 900 people may drop ~~dropping~~ coverage and another 4,200 ~~shifting~~ may shift to less generous coverage. The Task Force recommends OHA and DCBS pursue strategies to mitigate this effect including ~~. In particular, the Task Force recommends~~ studying and, if appropriate, requesting federal approval for an amendment to Oregon's Section 1332 ~~State Innovation Waiver~~waiver to implement a shift in how subsidies are calculated.

Next Steps

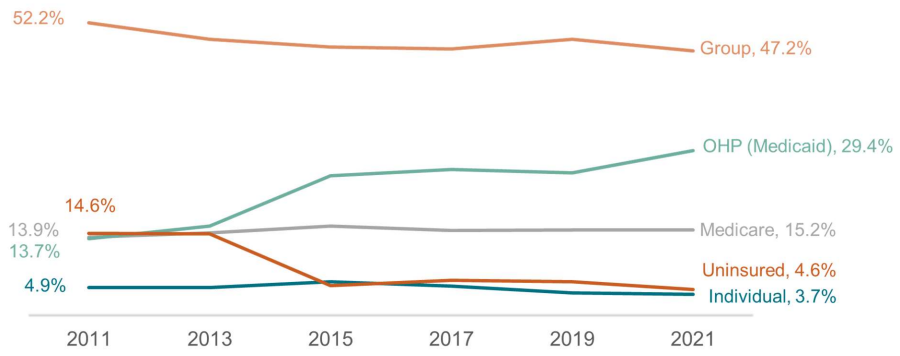
As directed by House Bill 4035, the Task Force advances these recommendations for review by the Oregon Health Policy Board (OHPB). The Task Force recommends that

with OHPB approval, OHA and DCBS should develop a BHP ~~b~~Blueprint for submission to CMS in early 2023 to begin the process of creating the program. This timeline will minimize the risk of coverage disruptions that could occur when the PHE ends and Oregon begins eligibility redeterminations for people enrolled in OHP.

I. BACKGROUND

Oregonians access health insurance coverage from a range of sources, with roughly one in three Oregonians covered through the state's Medicaid program, the Oregon Health Plan (OHP). Overall, Oregon's rate of insurance coverage has improved over time, reflecting increasing enrollment in OHP and a decrease in the percent of people who were uninsured or covered through group insurance (see Exhibit 1) (Oregon Health Authority 2022).

Exhibit 1: Sources of Health Insurance Coverage, by Year



Source: Oregon Health Insurance Survey

Despite overall coverage gains, 4.6 percent of Oregonians remained uninsured in 2021 (Oregon Health Authority 2022). A substantial number of people who receive coverage through Medicaid also experience what is known as "churn," gaining and losing eligibility for the program due to frequent fluctuations in income. Adults whose incomes are near the Medicaid income cap for adults—typically 138 percent FPL—are particularly at risk of churn (Corallo, et al. 2021). Others are at risk of churn if they experience barriers during the renewal process, such as not receiving paperwork they need to complete renewal, missing deadlines to submit information, or missing or inaccurate information submitted on renewal forms.

Churn persists despite state efforts to streamline enrollment processes and remove barriers to continuous enrollment. Nationally, roughly one in 10 Medicaid enrollees (10.3 percent) experience churn over the course of a year. (Corallo, et al. 2021). ~~The Oregon~~

~~Health Authority (~~OHA) estimates that as of September 2019, 34 percent of people enrolling in OHP were returning to the program after less than 12 months, and 25 percent were returning within six months of having been previously covered (Vandehey, Presentation: Needs and Vision for the Bridge Program 2022).

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

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

Churn is also disruptive to health plans and health care providers, increasing administrative costs and undermining the management and monitoring of members' care quality over time (Sugar, et al. 2021). A 2015 study from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling one person in Medicaid within a year incurred administrative costs between $400 and $600 (Swartz, et al. 2015). A national study of Medicaid service utilization and costs estimated that churn resulted in a $650 per ~~-~~member per-month (PMPM) increase in acute care costs (driven primarily by higher emergency department utilization and inpatient stays), and an overall $310 ~~per member per month~~PMPM increase in total costs, in the five months following coverage disruption (Ji, et al. 2017).

Health Insurance Coverage During the COVID-19 Pandemic

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

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

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

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

states) accepted this option to maintain enrollees' coverage until the PHE declaration expires.

People enrolled in OHP have thus been "continuously eligible" ~~for OHP~~ during the pandemic and, as a result, the number of ~~people enrolled in OHP~~enrollees increased from 1,050,179 to 1,323,775 from 2019 to 2021 (Oregon Health Authority 2022), and ~~"~~churn~~"~~ ~~— people gaining and losing OHP coverage due to changes in income or barriers during renewal —~~has ceased during the PHE, as people who would have previously lost coverage stayed enrolled (Vandehey, Presentation: Needs and Vision for the Bridge Program 2022).

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

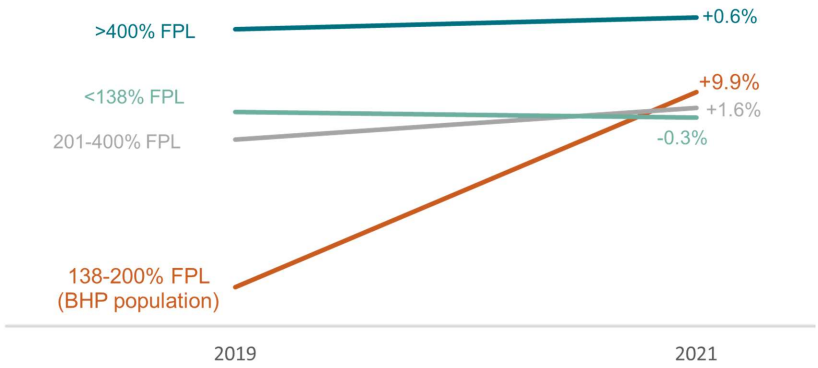
Premium Subsidies. Congress also passed the American Rescue Plan (ARP) in March 2021 to provide additional relief from the economic impacts of COVID-19 (**Public Law 117-2**). ARP made health insurance more affordable for people buying coverage on the Marketplace (Healthcare.gov) by:

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

These additional premium tax credits, initially established through December 2022, were extended through December 2025 in the Inflation Reduction Act of 2022 (**Public Law 117-169**). Together, these federal policy changes increased access to coverage for Oregonians during the pandemic. Coverage rates improved overall, and for people earning less than 200 percent of the ~~federal poverty level (~~FPL~~)~~, from 2019 to 2021 (see Exhibit 2).

[2] The Affordable Care Act established Advance Premium Tax Credits (APTC) for eligible consumers to lower the cost of purchasing coverage on the exchange. See page 28 for further information on APTC.

Exhibit 2: Change in Health Insurance Coverage Rate from 2019 to 2021, by Household Income as a Percent of FPL



Source: Adapted from Oregon Health Authority presentation to the Task Force on April 26, 2022 (Vandehey, Presentation: Needs and Vision for the Bridge Program 2022)

Unwinding from the Public Health Emergency

The Centers for Medicare and Medicaid Services (CMS) have encouraged states to begin administratively preparing for the "unwinding" of the PHE despite the uncertainty surrounding its end date (Centers for Medicare and Medicaid Services 2020). When the federal declaration expires, Oregon (and all states) will be required to return to routine Medicaid eligibility redeterminations following a 14-month process outlined by CMS.

~~The Oregon Health Authority (~~OHA~~)~~ estimated that 300,000 OHP enrollees may lose eligibility when redeterminations restart (Sweeney 2022). While some enrollees would be expected to transition to Marketplace or employer-sponsored coverage, others are anticipated to lose coverage and become uninsured. These challenges may be exacerbated by the future expiration of premium tax credit enhancements in 2025 (Cox, Amin and Ortaliza 2022). An additional 146,602 Oregonians purchase subsidized coverage through the Marketplace and could be affected (Oregon Health Insurance Marketplace 2022).

Goals of House Bill 4035

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

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

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

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

- Senator Elizabeth Steiner, Senate District 17 (~~c~~Co-~~c~~Chair)
- Representative Rachel Prusak, House District 37 (~~c~~Co-~~c~~Chair)
- Senator Bill Kennemer, Senate District 20 (V~~v~~ice C~~c~~hair)
- Representative Cedric Hayden, House District ~~0~~7 (V~~v~~ice C~~c~~hair)
- Patrick Allen, Oregon Health Authority
- Stefanny Caballero, Virginia Garcia Memorial Foundation
- Adrienne Daniels, Multnomah County Health Department
- Jonathan Frochtzwajg, Cascade AIDS Project
- Kelsey Heilman, Oregon Law Center
- Antonio Germann, Salud Medical Clinic and Pacific Pediatrics
- Lindsey Hopper, PacificSource Health Plans
- Eric Hunter, CareOregon
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- Heather Jefferis, Oregon Council for Behavioral Health
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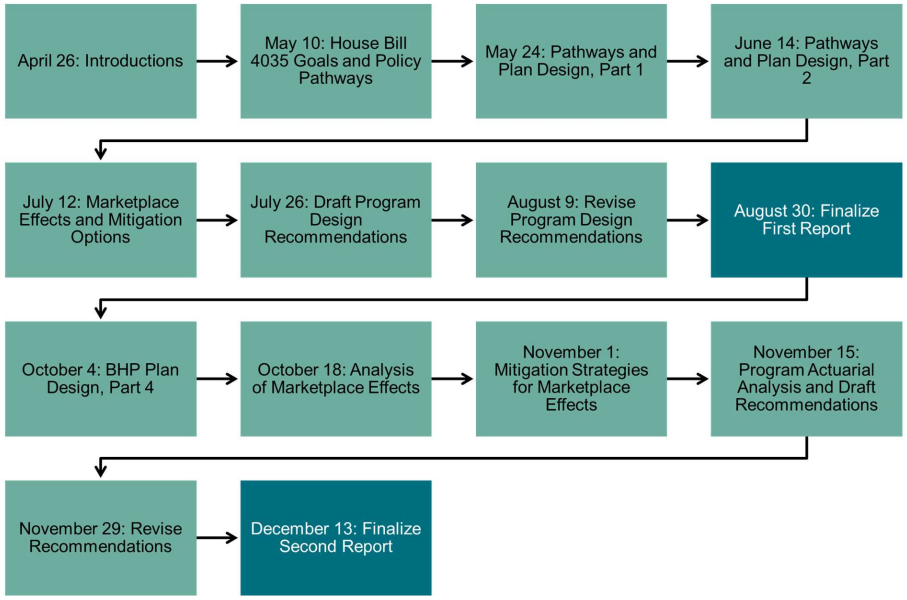
- Fariborz Pakseresht, Oregon Department of Human Services
- Keara Rodela, Coalition of Community Health Clinics
- Matthew Sinnott, Willamette Dental Group
- Andrew Stolfi, Oregon Department of Consumer and Business Services

~~Kelsey Heilman, Oregon Law Center~~The Task Force held meetings through the spring and summer of 2022 (see Exhibit 3) and submitted preliminary recommendations on program design in an earlier report available at:

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

Exhibit 3: Task Force Meeting Dates and Topics, 2022



Source: Legislative Policy and Research Office

About This Report

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

1. An analysis of the potential revenues and costs to operate a Basic Health Plan in Oregon;
2. updates to the preliminary program design recommendations;
3. an analysis of the projected effects on Oregon's Marketplace from creating the program; and
4. recommended strategies to mitigate these effects.

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

II. Bridge Program Design Recommendations

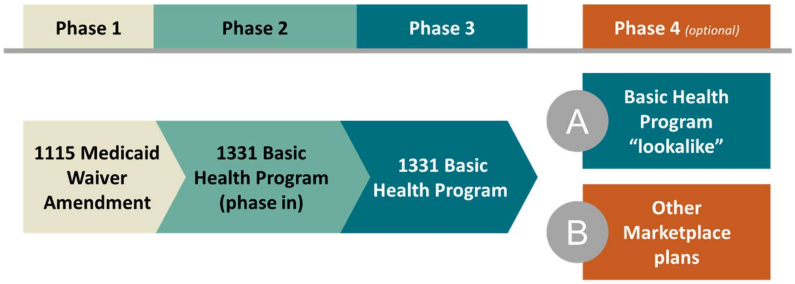
HB 4035 required the Task Force to develop recommendations on designing the Bridge Program with consideration for specific program design **elements**, including:

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

On September 1st, 2022, the Task Force advanced preliminary recommendations based on information available at that time (Joint Task Force on the Bridge Health Care Program 2022). The recommendations called for providing bridge health care coverage via a Section 1331 Basic Health Program (Centers for Medicare and Medicaid Services n.d.).

The Task Force further recommended a phased implementation timeline (see Exhibit 4). This timeline would begin with a Medicaid 1115 waiver amendment in Phase ~~One~~ 1 to temporarily continue OHP coverage for enrollees with incomes between 138 and 200 percent of FPL who would otherwise lose this coverage after the PHE ends.

Exhibit 4: Recommended Phased Implementation Timeline



Source: Adapted from Oregon Department of Consumer and Business Services

Phase ~~Two~~ 2 would begin when Oregon receives federal approval to establish the Basic Health Program. During this phase, people who remained eligible for OHP under the

temporary 1115 waiver authority in Phase ~~One~~ 1 would transition to the BHP. In Phase ~~Three~~3, the program would open to all other eligible consumers.[3]

Projected Revenues and Costs of a Basic Health Program

The potential revenues and costs to operate a Basic Health Program were a key consideration in updating the Task Force's preliminary recommendations. Consultants from Manatt Health and actuaries from Oliver Wyman and Mercer developed estimates using a range of data sources including: 2021 health care claims from OHP and commercial carriers, and final 2023 rates for the individual market (Ario and Tomczyk, Examining Marketplace Impacts Following Implementation of a BHP in Oregon 2022).

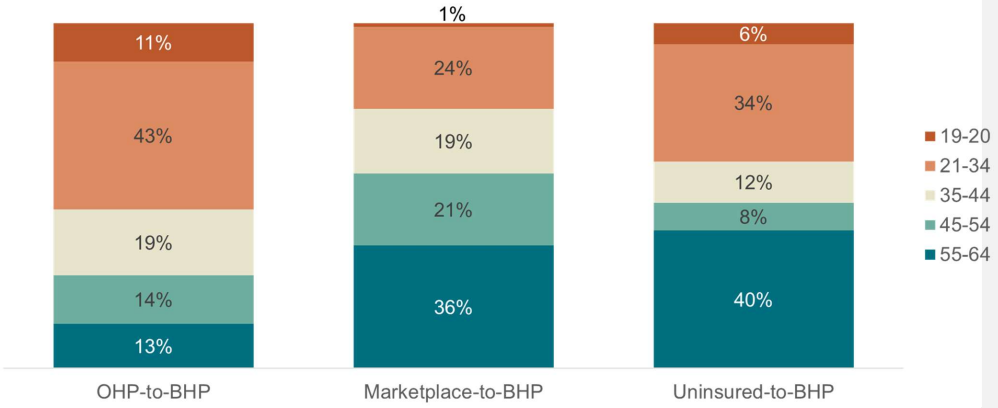
The analysis focused on **three groups** who will eventually be covered by the BHP, including:

- **OHP-to-BHP.** During ~~phase~~ Phase ~~two~~2, the BHP will enroll 55,000 people with incomes between 138 and 200 percent of FPL who will transition from OHP to BHP coverage. There is substantial uncertainty in constructing estimates for this population due to income fluctuations during the PHE and inability to identify enrollees who may be ineligible for the BHP if they have access to affordable employer- sponsored insurance. Actuaries modeled a likely OHP-to-BHP population with consideration for how long enrollees had been covered in OHP, whether they first enrolled during the PHE, and whether they had history of gaining and losing coverage due to income fluctuations.
- **Marketplace-to-BHP.** During ~~phase~~ Phase ~~three~~3, the BHP will open to all eligible consumers. An estimated 35,800 people will transition from the marketplace. This estimate was developed based on the number of people in the individual market in 2021 who earned between 138 and 200 percent of FPL, adjusted for population trends through 2025.
- **Uninsured-to-BHP.** When the BHP opens to all eligible consumers, an estimated 11,300 people who are uninsured would enroll. This estimate is based on microsimulation modeling of the uninsured population in 2021 projected to 2025.

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

The analysis found differences in the expected age distribution of the BHP-eligible populations (see Exhibit 5). The OHP-to-BHP population is much younger, on average, than either the Marketplace-to-BHP or uninsured-to-BHP populations.

Exhibit 5: Age Distribution of the Three BHP-Eligible Populations



Source: Adapted from Manatt Health and Oliver Wyman

Other characteristics of the three populations, including household income, household size, and geographic distribution across rating areas, are similar (see Exhibit 6). Household income and size skew slightly higher for the uninsured-to-BHP population compared with the OHP-to-BHP and Marketplace-to-BHP populations. The uninsured population is also slightly more concentrated in regions 2, 4, and 5, rather than region 7.

Exhibit 6: Estimated Household Income, Size, and Geographic Distribution of the BHP-Eligible Population

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

Source: Adapted from Manatt Health and Oliver Wyman

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

Revenue calculations. BHP funding is calculated on a ~~per member per month (~~PMPM~~)~~ basis with individual-level funding determined by applicable adjustments ~~(see Exhibit 7)~~ (Centers for Medicare and Medicaid Services 2022). The calculation considers the estimated premium tax credit (PTC) a consumer would be eligible for if purchasing coverage on the Marketplace. This base PTC value considers regional premiums, consumer age, household size, household income, and the number of household BHP enrollees. The funding formula also accounts for enhanced PTCs authorized by Congress through 2025 in the Inflation Reduction Act (IRA).

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

- **A premium adjustment factor** that accounts for the loss of federal PTC for BHP consumers when a state does not "silver load" premiums for cost sharing reductions.[4] This factor was 1.188 in 2022 (Ario and Tomczyk, Examining Cost and Revenue Estimates for a Basic Health Program in Oregon 2022).
- **A population health adjustment** that accounts for the loss of federal revenue that can occur if a BHP leads to lower Marketplace morbidity and, by extension, lower Marketplace premiums. This factor is optional, set to 1.0 by default, and may be requested by states.
- **A reinsurance adjustment** that offsets any reduction in federal pass-through savings a state incurs when it operates a reinsurance program that reduces PTC under a Section 1332 waiver. This factor was part of a proposed rule not yet finalized at the time of this report.
- **An income reconciliation factor** that accounts for differences between estimated advance premium tax credits (APTC) and actual ~~premium tax credits~~PTC at year end, since there is typically slight variation at the population level between APTC calculated at the point of enrollment and the final PTC a consumer is eligible for based on actual income at year-end. This factor was 1.0063 in 2022.

The adjusted PTC is multiplied by .95 to determine the final BHP funding.[5] This amount is paid by the federal government to states operating a Basic Health Program (see Exhibit 7).

Exhibit 7: Basic Health Program
Federal Funding Formula (2023 Proposed Rule)

Source: Adapted from Manatt Health and Oliver Wyman

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

Cost calculations. The Task Force recommended that the BHP offer the same service package provided to OHP enrollees through CCOs and be provided to enrollees without premiums or cost-sharing (Joint Task Force on the Bridge Health Care Program 2022). Based on this guidance, actuaries developed cost estimates based on the service package offered by CCOs to OHP enrollees in 2021, including adult dental coverage[6] (Karl and Tomczyk 2022). This service package does not include Long-Term Services and Supports (LTSS) or other services that are not paid by CCOs.

These cost estimates were based on OHP-level provider reimbursements as of 2021, projected forward to 2025.[7] The estimate also incorporates CCO administrative expenses equivalent to 12.5 percent of premiums or 14.3 percent of claims costs. No enrollee cost- sharing or premiums were included. The analysis did not consider costs that cannot be paid from federal BHP funds, including costs to administer the BHP Trust as well as the cost of abortion services that are required to be covered under state law. State gGeneral fFunds will be necessary for these expenses regardless of federal revenue projections.

The ~~per member per month~~**PMPM cost** to provide this level of coverage was calculated differently for the three populations who would enroll in the BHP, estimated at approximately 102,100 people. Specifically:

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

2. **Marketplace-to-BHP population cost** was estimated from the OHP-to-BHP per member per month cost, adjusted for the estimated difference between demographics, geography and health status of the OHP-to-BHP and Marketplace-to-BHP populations.

3. **Uninsured-to-BHP population cost** was estimated using the Marketplace-to-BHP per member per month cost, adjusted for the estimated difference between demographics, geography, and health status of the Marketplace-to-BHP and uninsured-to-BHP populations.

[6] This reflects a key difference from the financial feasibility study presented to the Task Force earlier in 2022; that analysis was based on the cost of coverage including the ten ACA essential health benefits plus adult dental coverage (see Appendix C for a comparison of these covered service packages).
[7] The Task Force recommended that the BHP pay capitation rates to CCOs that would support reimbursements to providers at levels *higher* than OHP. The Task Force also recommended that ongoing efforts to reimburse providers should recognize the unique role of safety-net organizations such as FQHCs and CCBHCs, and the value of payments and programs to these providers that promote continuity of enrollment and reduce churn.

The actuarial team developed estimates for a base scenario and a series of alternative scenarios that modified assumptions about population income, age, and morbidity; consumer behavior; and federal policy; to assess the range of potential revenues and costs for Oregon's BHP. Under each scenario, budget estimates were provided at the population and PMPM levels.

Results. The analysis found that Oregon's BHP is projected to generate approximately $865.9 million in revenue and $723.4 million in expenses per year, for an estimated overall budget surplus of $142.5 million (see Exhibit 8). On a ~~per member per month~~PMPM basis, this surplus equates to $116.33 ~~per member per month~~PMPM, with differences across the OHP-to-BHP, Marketplace-to-BHP, and uninsured-to-BHP populations.

Exhibit 8: Projected Revenues and Costs of Oregon's BHP

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

Source: Adapted from Manatt Health and Oliver Wyman

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

The analysis considered how these results could change if there are differences between the forecast assumptions and the income, age, or morbidity of the population that eventually enrolls in the BHP. Across these alternate scenarios, net program revenue ranged from $107.0 to $131.9 million, or $87.32 to 118.61 PMPM. These supplemental analyses are detailed in Exhibit 9.

Exhibit 9: Alternate Scenarios and Estimated Effects on Revenues and Costs

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

Source: Adapted from Manatt Health and Oliver Wyman

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

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

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

The Task Force updated its preliminary recommendations to reflect the revenue analysis and resulting discussion:

- OHA and DCBS should analyze what reserve level is necessary in Oregon's BHP Trust Fund to support program solvency and sustainability. The analysis should include consideration of CCO requirements for financial reserves. The analysis should address how varying reserve thresholds may affect the program's ability to promote provider participation and network adequacy. OHA and DCBS should establish a target range for financial reserves in the BHP ~~t~~Trust.
- While the program is building reserves toward the targets, OHA should establish initial capitation rates to CCOs using a methodology that is consistent with how rates are determined for OHP. Any surplus revenue during this *initial* period should support the achievement of reserve targets.

- When the BHP Trust has met reserve targets, OHA should prioritize specific goals of House Bill 4035, including:
    1) Maintaining BHP coverage at no cost to enrollees;
    2) Developing BHP capitation rates that allow CCOs to increase provider reimbursement to enhance the CCO delivery system as outlined in House Bill 4035. This should include a mechanism to adequately reimburse safety net providers that is consistent with Oregon's broader goals for value-based care and that takes into consideration the value of prospective payment models to providers (such as Federally Qualitified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs)) that care for OHP enrollees who would transition to BHP; and
    3) Enhancing covered services a) based on consumer and other feedback and b) in alignment with OHP.

  BHP initiatives using surplus funds should be presented to the Legislative Assembly and be consistent with Oregon's broader health system reform priorities, particularly the goal of eliminating health inequities.

Additional Program Design Elements

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

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

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

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

- American Indian and Alaska Native (AI/AN) enrollees who, under federal law, may opt out of Medicaid managed care; and
- Youth involved in the foster care system, who can have unique needs for flexibility in where they access health care services (**ORS 414.631(2) (2021)**).

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

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

OHA proposed to maintain the open card coverage option by expanding OHP eligibility for people who are categorically eligible for OHP open card coverage but whose income is between 138 and 200 percent of FPL (Swerdlow 2022). In this approach, these populations would remain covered through OHP rather than transitioning to a BHP. OHA estimated that as of 2022, there are between 1,000 and 3,000 AI/AN enrollees in OHP who may be eligible for BHP coverage based on their age and income. No foster youth enrolled in OHP would qualify for BHP, as this population remains eligible for OHP with incomes up to 305 percent of FPL.

This expansion of OHP coverage for AI/AN people earning up to 200 percent of FPL would be achieved through an amendment to the state's Section 1115 Medicaid Demonstration Waiver. OHA consulted with ~~T~~tribes and received general approval to pursue this approach. The agency submitted the proposed waiver amendment on November 15, 2022.

While recommendations regarding ~~T~~tribal enrollment procedures are beyond the scope of the Task Force, members expressed support for OHA's continued exploration of options to maintain AI/AN enrollment flexibilities consistent with the direction in **HB 4035** that the Bridge Program be consistent with the Oregon Integrated and Coordinated Health Care Delivery System.

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

There are **two categories of HRS**:

1) **flexible services**, which are services delivered to individual members, and
2) **community benefit initiatives**, which are investments made at the community level that are not tied to a specific member. These include health information technology investments.

CCOs have the option to provide HRS to members, but Oregon's 1115 waiver does not require them to do so[8] and there is no dedicated funding mechanism for HRS, which must be paid from CCOs' global budgets. In 2021, an average of 0.56 percent of CCOs' total spending was directed toward HRS (ranging from 0.19 to 2.68~~%~~ percent among CCOs) (Gund 2022). This is equivalent to $2.35 ~~per CCO member, per month on average~~PMPM (ranging from $0.51 to $10.70 among CCOs).

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

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

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

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

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

The Task Force updated its preliminary **recommendations** regarding covered services as follows:

- The Bridge Program shall minimally cover all 2021 CCO-covered OHP benefits, including adult dental coverage, pending sufficient federal revenue to support initial capitation rates.
- The BHP should encourage CCO provision of ~~Health-Related Services (~~HRS~~)~~ to enrollees in a manner consistent with ~~the Oregon Health Plan~~OHP. OHA should provide guidance to CCOs on what services will qualify as HRS expenditures. This guidance should clearly indicate any non-allowable expenditures for BHP enrollees, including how, if at all, BHP-eligible spending differs from OHP qualifications.

Although the recommendations were developed to reflect what was known about anticipated BHP costs and revenues at the time of the report, members noted that ideally Oregon would continue to explore options to offer additional services to BHP members. Services such as long-term services and supports are covered by OHP but not provided to OHP enrollees by CCOs. These non-CCO services were not considered in the analyses reviewed by the Task Force but could be explored for future inclusion in the BHP benefit design.

Consumer Advisory Structures and Engagement. HB 4035 does not include specific direction about consumer engagement efforts for the Bridge Program design, though it does provide for consumer feedback on the broader redeterminations process through a Community and Partner Workgroup. Time for public comment has been incorporated in each meeting since the first meeting. A virtual consumer listening session was scheduled in July 2022. Despite outreach efforts, the event was ultimately postponed due to low registration.

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

The Task Force supports consumer engagement in future BHP development and implementation efforts, and in ongoing BHP governance, and advanced the following **recommendations** specific to those goals:

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

Final Recommendations on Bridge Program Design

The Task Force revisited and updated its preliminary recommendations based on the additional information and analysis reflected in this report. The recommendations were finalized and adopted by the Task Force at its December 13, 2022 meeting based on information available through late November 2022. These recommendations are summarized in Exhibit 10 below.

Exhibit 10: Final Task Force Recommendations on Program Design

Federal Pathway

1. Oregon's Bridge Program should be established through a Section 1331 Basic Health Program Blueprint, as suggested by CMS.
2. The Bridge Program should offer a transition period for enrollees by following the phased implementation approach suggested by CMS. The state should seek federal approval of the Blueprint on a timeline that will support Phase ~~Three~~ 3 implementation no more than 24 months after the implementation of Phase ~~Two~~2. The implementation timeline should also seek to harmonize program launch with CCO rate filing and DCBS rate review timelines.
3. OHA and DCBS should continue to explore with CMS the option to create a BHP-like product under Section 1332 waiver authority in Phase ~~Four~~4, which could enable Oregon to offer enrollees "optionality," or a choice between the Bridge Program and retaining federal Marketplace tax credits to purchase subsidized Marketplace coverage.

Program and Plan Administration

4. To promote continuous coverage for Oregonians, CCOs should be required to accept enrollees to the program in the phased implementation manner outlined in this report, including transitioning eligible consumers from OHP in Phase ~~Two~~ 2 using the state's existing CCO infrastructure, and accepting eligible consumers not enrolled in OHP in Phase ~~Three~~3.
5. OHA should seek to develop enrollment procedures for each phase that emphasize continuity of care and provider access for enrollees transitioning to the Bridge Program from OHP and the Marketplace. BHP enrollment and coverage transition processes should complement existing CCO infrastructure and navigation support systems.
6. Beginning in Phase ~~Three~~3, all eligible consumers should be able to access the program through Oregon's Marketplace platform. OHA should achieve this either by requesting modification of the federal Healthcare.gov platform or through a

state operated platform, depending on the platform used by Oregon's Marketplace at that time.

7. OHA should align contracting and implementation processes for the Bridge Program to existing OHP approaches and timelines to minimize CCO administrative burden to operate the program. To promote consistency with, and enhancement of, the CCO delivery system, OHA should continue to engage CCOs as the program is developed, including creating publicly posted opportunities for CCO leadership engagement.
8. OHA and DCBS should gather consumer feedback prior to program implementation, including engaging consumer advocacy groups to maximize input from communities that experience inequities in the health system. OHA and DCBS should conduct consumer focus groups prior to implementation of the BHP to explore topics such as benefit design; marketing channels and tools to reach consumers with information about the program; and specific needs of people who experience churn under OHP. These activities should compensate participants for their time, be flexible in scheduling and ways of giving input, and prioritize topics for which consumer feedback is most likely to be able to inform program planning.
9. Ongoing BHP governance and oversight should include consumer representation, consistent with the Medicaid Advisory Committee and Health Insurance Marketplace Advisory Committee models.

Program Financing, Plan Rates and Provider Reimbursements

10. OHA and DCBS should analyze what reserve level is necessary in Oregon's BHP Trust Fund to support program solvency and sustainability. The analysis should include consideration of CCO requirements for financial reserves. The analysis should address how varying reserve thresholds may affect the program's ability to promote provider participation and network adequacy. OHA and DCBS should establish a target range for financial reserves in the BHP Trust.
11. While the program is building reserves toward the targets, OHA should establish initial capitation rates to CCOs using a methodology that is consistent with how rates are determined for OHP. Any surplus revenue during this initial period should support the achievement of reserve targets.
12. When the BHP Trust has met reserve targets, OHA should prioritize specific goals of House Bill 4035, including:
    - maintaining BHP coverage at no cost to enrollees;
    - developing BHP capitation rates that allow CCOs to increase provider reimbursement to enhance the CCO delivery system as outlined in House Bill 4035. This should include a mechanism to adequately reimburse safety net providers that is consistent with Oregon's broader goals for

value-based care and that takes into consideration the value of prospective payment models to providers (such as FQHCs and CCBHCs) that care for OHP enrollees who would transition to BHP; and
    - enhancing covered services a) based on consumer and other feedback, and b) in alignment with OHP.

BHP initiatives using surplus funds should be presented to the Legislative Assembly and be consistent with Oregon's broader health system reform priorities, particularly the goal of eliminating health inequities.

Benefit Design

13. The Bridge Program shall minimally cover all 2021 CCO-covered OHP benefits, including adult dental coverage, pending sufficient federal revenue to support initial capitation rates.
14. The BHP should encourage CCO provision of ~~Health-Related Services (~~HRS~~)~~ to enrollees in a manner consistent with ~~the Oregon Health Plan~~OHP. OHA should provide guidance to CCOs on what services will qualify as HRS expenditures. This guidance should clearly indicate any non-allowable expenditures for BHP enrollees, including how, if at all, BHP-eligible spending differs from OHP qualifications.
15. The program should be offered to enrollees at no cost, including no monthly premiums and no out-of-pocket costs to access services.
16. To minimize administrative complexity and enhance the CCO delivery system, Oregon's 1331 Basic Health Program should request waiver of the federal requirement to offer at least two BHP plans to eligible consumers.

Source: Legislative Policy and Research Office

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

- **The proposed design maximizes federal financial participation under a Section 1331 BHP.** This federal pathway relies on a per capita funding formula that affords flexibility for enrollment to fluctuate over time without subjecting the state to federal budget neutrality requirements or the risk of bearing the cost of higher than anticipated enrollment.
- **It will be necessary for Oregon to allocate state funding for certain elements of a BHP.** By federal law, Oregon cannot rely on federal funds to finance the cost of administering the BHP, or the cost of abortion services that are required to be covered by health plans under Oregon law.

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

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

III. Analysis of Disruptions to Oregon's Individual Marketplace

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

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

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

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

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

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

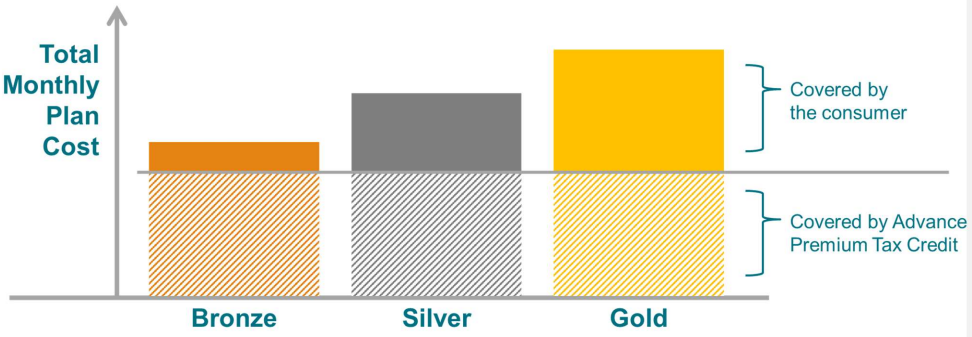
Advance Premium Tax Credits

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

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

APTC are~~is~~ calculated and applied at the point of plan selection to lower the up-front cost of enrollment. APTC can be applied toward any QHP on the Marketplace to lower the net monthly premium paid by the consumer (see Exhibit 11).

Exhibit 11: Individual Premiums and Subsidies



Source: Adapted from Department of Consumer and Business Services (Rehfield-Griffith 2022)

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

1) the premium rate for the second lowest cost silver plan (SLCSP) in the rating area in which they reside ~~(SLCSP),~~; and
2) an affordability limit (or "applicable percentage", see Exhibit 12) based on an individual's household income as a percent of FPL.

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

Exhibit 12: Household Incomes and Applicable Percentages, 2022

Monthly Household Income as Percent of Federal Poverty Level (FPL)	Applicable Percentage (max premium paid as % of household income)
Up to 150% of FPL	0%[9]
At least 150% but less than 200%	0% to 2%
At least 200% but less than 250%	2% to 4%
At least 250% but less than 300%	4% to 6%
At least 300% but less than 400%	6% to 8.5%
400% or higher	8.5%

Source: 26 USC Section 36B(b)(3)(A)

For many consumers, plans became more affordable in 2021 following these enhancements (see Exhibit 13), which were renewed through December 2025 as part of the Inflation Reduction Act (**Public Law 117-169**).

Exhibit 13: Monthly Plan Cost Before and After ARPA (2021)

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

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

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

Cost Sharing Reductions and Silver Loading

The ACA also established Cost Sharing Reductions (CSR) to lower out-of-pocket (OOP) costs, such as copays and deductibles, that individuals can be responsible for in addition to their monthly premiums. The ACA requires Marketplace carriers to offer discounted silver-CSR plans to eligible consumers, including people who earn less than 250 percent of the FPL, and American Indians and Alaska Natives. These silver-CSR plans reflect lower cost sharing and OOP maximums than base silver plans (see Appendix BXX for an illustration of how CSRs lower OOP costs for eligible consumers in silver-CSR plans).

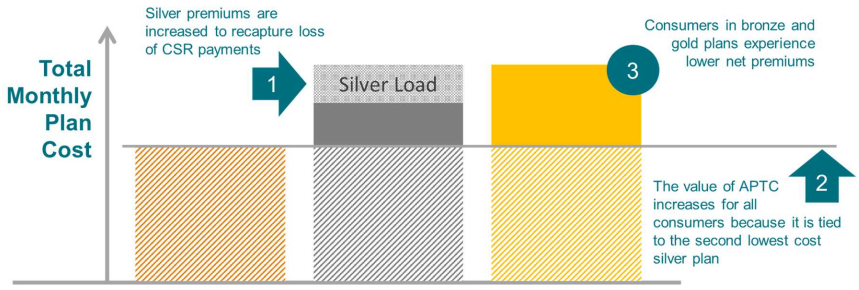
To maintain provider reimbursements across plan variants, carriers were originally reimbursed by the U.S. Department of Health and Human Services (HHS) for offering discounted CSR plans. In 2017, HHS discontinued CSR reimbursements, citing a court ruling that HHS did not have an appropriation from which to make the payments (Keith, Federal Circuit: Insurers Owed Unpaid Cost-Sharing Reductions, Reduced by Higher Premium Tax Credits from Silver Loading 2020). Despite this discontinuation of payments to carriers, the ACA requirement for carriers to offer discounted CSR plans to eligible consumers has remained in effect.[10]

To offset the loss of federal payments, most states, including Oregon, directed insurers to increase premiums for the 2018 plan year (and thereafter) using one of several approaches. The most common approach, "silver loading," increased premiums on silver plans (Griffith 2022). Because consumer APTC is determined based on the SLCSP sold in the Marketplace in a given rating area, when silver loading increases silver premiums, it also increases the value of APTC (see Exhibit 14).

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

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

Exhibit 14: Silver Loading Effect on Premiums and APTC



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

Anticipated Marketplace Disruptions

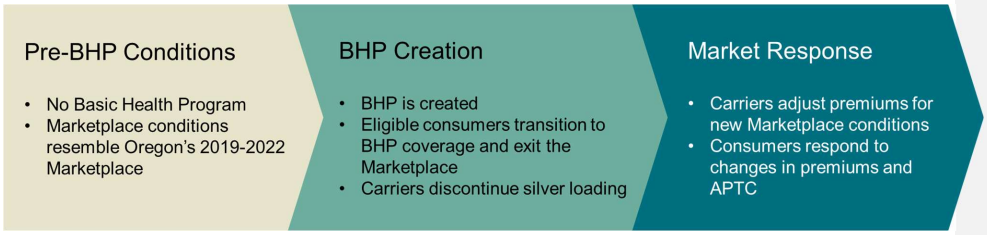
HB 4035 required the Task Force to identify disruptions that creation of a BHP could cause to the individual and small-group health insurance markets. The Task Force studied **potential market disruption issues** over the course of several fall meetings, including:

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

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

The analysis depicts the individual market characteristics in 2024 before and after the BHP is created (see Exhibit 15).

Exhibit 15: Analysis of BHP Impact on the Individual Market



Source: Legislative Policy and Research Office
Note: These changes occur as a single process in pPhase 3 but are depicted step-wise for explanatory purposes. Although the BHP is not likely to be implemented before 2025, the analysis is indicative of the range of changes that are projected to take place in whatever year the BHP is implemented.

Pre-BHP Conditions. From 2019 to 2022 (YTD), the number of people purchasing individual coverage was stable, though within this group, the percent of people who purchased coverage in the individual market on the exchange increased from 71.9 percent in 2019 to 77.5 percent in 2022 (YTD). The percent of people who received premium tax credits increased from 54.0 percent in 2019 to 59.3 percent in 2022, reflecting enhanced subsidies available through ~~the American Rescue Plan Act (~~ARPA~~)~~. These dynamics are projected forward to 2024.

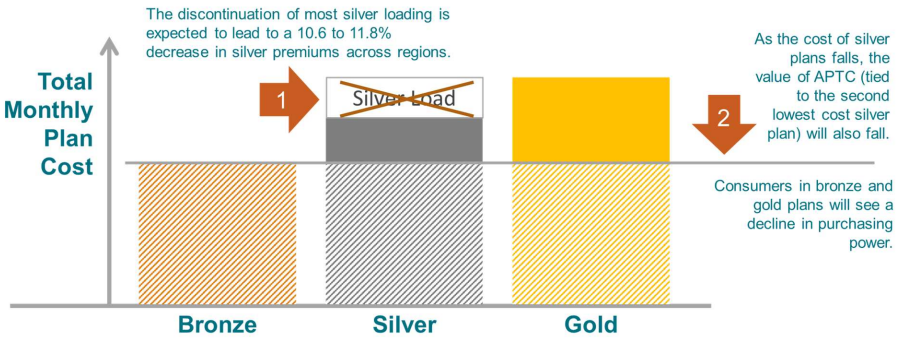
BHP Creation. If the BHP is implemented in 2024, an estimated 35,800 out of 178,000 people would transition to BHP coverage and exit the individual market. The model estimates that in the first year with the BHP, carriers would change premiums to reflect these **changes in the post-BHP Marketplace population** (approximately 142,200 people):

- **Slightly healthier.** Initially, the relative morbidity of the individual market population improves (decreases) by 1.8%. The effect varies across carriers, ranging from no change to a 3.7% decrease in average morbidity.
- **Similarly distributed across the state.** Rating region 1 (Portland metro) increases by 0.8% as a percent of total market share. Rating region 7 (Medford) decreases by 0.8% as a percent of total market share.
- **Similar in age.** The percent of people under age 18 increases slightly from 11 to 12 percent, while the percent of people age 45-54 decrease from 19 to 18 percent of the individual market. Other age bands do not change.
- **Higher average income.** Before a BHP, 43 percent of the individual market population earns more than 400% ~~percent~~ of ~~the federal poverty level (~~FPL~~)~~. When the BHP population exits, 54% ~~percent~~ of the remaining individual market population earn more than 400% FPL.

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

Carriers would also discontinue most silver loading as consumers eligible for silver-CSR plans transition to the BHP, lowering silver premiums by 10.6-11.8 percent across rating areas. As the cost of silver plans falls, this will in turn reduce the value of APTC, which is tied to the second lowest cost silver plan in a rating area. People enrolled in silver plans will see little net change in their purchasing power, as both premiums and APTC will decline. Subsidized consumers in gold and bronze plans will see a decline in purchasing power as the value of their APTC falls relative to their gold or bronze premium (see Exhibit 16).

Exhibit 16: Discontinuation of Silver Loading

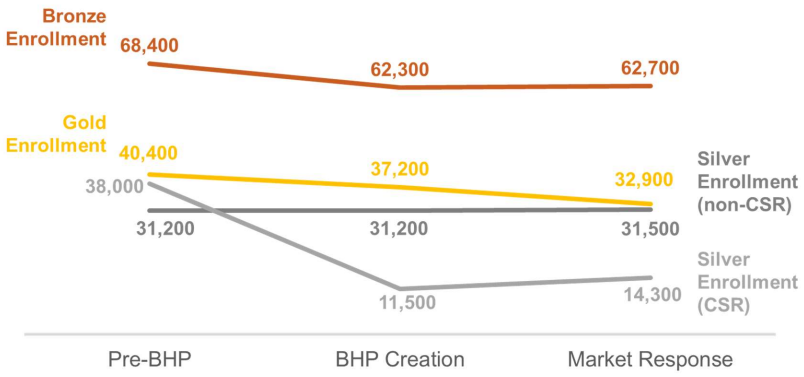


Source: Adapted from Department of Consumer and Business Services (Rehfield-Griffith 2022)

Market Response. The analysis considered how consumers would be expected to respond to these changes in premiums and APTC by altering their plan selections.

The Marketplace is projected to be relatively stable in the first year of full BHP implementation. As remaining individual market consumers respond to changes in premiums and APTC, total enrollment in the market is expected to decline slightly further to 141,400, as approximately 900 people (0.6~~%~~ percent of consumers) no longer purchase coverage in the individual market. Enrollment declines across all metal tiers other than silver plans for consumers who are not eligible for CSRs (which remain stable) (see Exhibit 17).

Exhibit 17: Changes in Marketplace Enrollment following BHP Creation



Source: Adapted from Manatt Health and Oliver Wyman

There is little change in the income, age, and geographic distribution of the remaining individual market population after these carrier and consumer responses to the exit of the BHP population. Average morbidity is estimated to be 1.5~~%~~ percent lower than baseline morbidity after these carrier and consumer responses.

The effect on premiums for a given consumer would vary depending on age, income, and rating area (see Exhibit 18 for examples).

Exhibit 18: Examples of Changes in Marketplace Premiums post-BHP, by Consumer Age, Income, and Rating Area

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

Source: Adapted from Manatt Health and Oliver Wyman

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

- **Fewer consumers qualify for subsidies overall.** Whether a given consumer qualifies for APTC depends on the difference between the second lowest cost silver plan premium in their area and their affordability limit (based on income). In this scenario, premiums for silver plans fall relative to household incomes, resulting in fewer households qualifying for APTC. Within metal tiers, this results in a larger share of households purchasing unsubsidized plans; consumers in silver plans see little change in net premium.
- **There is little change in the plans selected by the 58,400 consumers who do not qualify for APTC.** Premiums decrease 1.5 percent overall for people who do not qualify for APTC, reflecting lower individual market morbidity, and these consumers are unaffected by changes in the value of APTC. Approximately 0.2 percent (n=100) upgrade from a bronze to a silver plan.
- **Among the 83,700 consumers who qualify for APTC, 5 percent (n=4,200) respond by switching to less generous plans.** This reflects the net loss of purchasing power experienced by these consumers when the value of their APTC decreases more than the cost of their monthly premium. An additional 0.6 percent switch to more generous coverage (n=500) and one percent (n=900) drop coverage.

Plan costs vary by consumer demographics and location; ~~but~~ Exhibit 19 ~~below~~ provides information about how maximum out of pocket costs could change for consumers who switch between plan tiers.

Exhibit 19: Marketplace Plan Deductibles[11] and Maximum Out-of-Pocket Costs (Plan Year 2023)

	Gold Plans	Silver Plans	Bronze Plans
Average* Deductible (Min, Max)	$1,800 ($0 - $2,000)	$4,800 ($750 - $6,500)	$8,800 ($5,500 - $9,100)
Average* out-of-pocket costs (Min, Max)	$7,300 ($7,300 – $9,100)	$~~89~~,100 ($7,400 - $8,100)	$8,800 ($6,900 - $9,100)

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

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

Summary and Key Takeaways

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

- An estimated 35,800 people transition from the individual market to the BHP.
- The population ~~who~~ that remains in the individual market would be healthier and higher income on average, but similar in age and geographic distribution to the individual market pre-BHP.
- Insurers would discontinue most silver loading, leading to a 10.6-11.8 percent decrease in silver premiums.
- Fewer people who remain in the Marketplace would qualify for subsidies. This is not driven by a change in premiums for these consumers, but instead reflects that the reference point for subsidies, the second lowest cost silver plan premium, would decline in cost below the affordability threshold for those consumers.
- Unsubsidized consumers would be unaffected by these changes and see a slight 1.5~~%~~ percent decrease in premiums. This group would not meaningfully alter their decisions about purchasing coverage.
- However, subsidized consumers would see a decrease in the value of (or elimination of) their APTC. Approximately 4,200 consumers in this group would respond by shifting to more affordable and less generous coverage while 500 would purchase more expensive and more generous coverage. A smaller number, estimated at 900, would exit the Marketplace.

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

IV. STRATEGIES TO MITIGATE DISRUPTIONS

As described on page 33, when the Bridge program is created, the transition of BHP-eligible consumers from the Marketplace will lead to changes in consumer purchasing power and coverage decisions for those remaining in the Marketplace. While these changes affect a small proportion of the overall market (e.g., approximately 4,200 consumers may select less generous coverage and 900 may drop coverage), mitigation strategies may be able to offset these effects.

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

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

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

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

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

Carrier and Federal Feedback

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

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

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

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

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

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

Gold Benchmark Analysis

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

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

To secure approval for a switch to a gold benchmark through a Section 1332 waiver, Oregon would need to demonstrate that it can remain compliant with these guardrails. Because states are prohibited from having multiple separate 1332 waivers, Oregon would also need to pursue this strategy as an amendment to its existing reinsurance program waiver.[12]

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

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

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

existing reinsurance program for the purposes of calculating federal deficit neutrality.

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

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

- ~~T~~the need for an actuarial analysis of the cost of shifting to the gold benchmark;
- whether Oregon would be able to meet its targets and requirements for the reinsurance program if some savings generated by the program were directed toward offsetting the cost of the gold benchmark;
- the estimated numbers of consumers in regions where shifting to a gold benchmark could lead to a net decrease in purchasing power; and
- how Marketplace consumers' maximum ~~OOP~~ out-of-pocket costs would change following creation of the BHP in addition to the effects on premiums.

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

Final Recommendations on Marketplace Stabilization

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

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

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

V. CONCLUSION

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

The Task Force advanced these recommendations believing that they are consistent with the various goals for **HB 4035**, but most importantly, the ~~l~~Legislative ~~a~~Assembly's stated goals of:

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

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

Next Steps

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

Following CMS approval, OHA and DCBS are directed by **HB 4035** to begin implementing the program, and provide a report to the Legislative Assembly during its next regular session that addresses 1) details of the federal approval, 2) a plan for implementing the program, and 3) any recommended or needed legislative changes or budgetary actions.

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

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APPENDIX A: QUESTIONS AND ANSWERS

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

Commented [PS2]: Added

LPRO thanks staff at the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) for their assistance. The document was updated several times and expected to be revised as the Task Force continued its work.

Newer versions may be available with subsequent meeting materials posted at https://olis.oregonlegislature.gov/liz/2021I1/Committees/JTBHCP/Overview.

About the Section 1331 Basic Health Program

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

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

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

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

About the Bridge Program Population

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

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

Q: What is known about the population of people who may be eligible for the Bridge Program, including their demographics?

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

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

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

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

Q: How many people would be eligible for the Bridge Program?

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

Q: Among the population who would be eligible for the Bridge Program, how are they geographically distributed across the state?

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

Q: Among the population of people currently enrolled in Medicaid who would transition to a Bridge Health Care Program, what percent are entering Medicaid via presumptive eligibility determinations in hospitals versus other channels?

A: OHA is unable to provide this analysis at this time, but a relatively small portion of OHP enrollees enter through hospital presumptive eligibility. The percentage of overall OHP enrollees who enter through this process may not be reflective of the subset of enrollees who could be eligible for the BHP.

Q: Among people currently insured through the Marketplace who would be eligible for the Bridge Program, which carriers provide their current coverage?

A: OHA is unable to provide this analysis at this time but this information may be available in late 2022 following completion of a carrier data call and further actuarial analysis.

Q: Among people currently insured through the Marketplace, what is the breakdown in plan enrollment by metal tier and FPL?

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

Table 1. Plan Selection by Metal Tier, 2022

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

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

Q: What do we know about the health status of the BHP-eligible population?

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

Q: What portion of the BHP-eligible population is offered employer-sponsored insurance that is considered affordable under current Affordable Care Act (ACA) requirements?

A: OHA does not have access to data that would answer this question.

Enrollment, Marketplace Platforms, and Coverage Transitions

Q: How would the Bridge Program affect coverage options for adults who are non-citizens?

A: Coverage options for Oregon adults and children who are non-citizens vary by income, age, and immigration status.

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

Oregon's Bridge Program would provide coverage to adults earning up to 200 percent FPL. Certain non-citizens who have not met the five-year LPR waiting period requirement for OHP coverage may also qualify for the Bridge Program. However,

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

Q: Among states that operate BHPs, how is enrollment effectuated? Is it more similar to Medicaid or to commercial insurance? Does it occur on a continuous basis or during an open-enrollment period?

A: There is flexibility in the Basic Health Program Blueprint (federal application) to design enrollment procedures that are more Medicaid-like or Marketplace-like. The approaches used in Minnesota and New York are documented in their Basic Health Program blueprint applications, Section 4 (available at https://www.medicaid.gov/basic-health-program/index.html). The specific approach to be outlined in Oregon's BHP Blueprint has not yet been determined.

Q: How quickly could Oregon implement a state-based exchange?

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

Q: Is it possible to offer a Basic Health Program with a two-year eligibility period rather than one year?

A: CMS indicated that this is not an option.

Q: How would enrollees be assigned to CCOs? Would people be able to choose which CCO they enroll in? Could this process be designed with consideration for continuity in provider access?

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

Q: What needs to be done to communicate with enrollees about the redetermination process and Public Health Emergency (PHE) "unwinding," including ensuring digital access, language access, etc.?

A: OHA has convened a community and partner work group to advise on this process as required by House Bill 4035 (2022) (HB 4035). This group will provide ongoing

support and guidance to OHA on these topics; information about their work is available at https://www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx. OHA provided a report to the Legislature (available at https://www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx) on May 31, 2022 with an update on planning efforts related to the PHE unwinding.

Q: How would creation of a BHP impact revenues for county health departments?

A: This question has not been explored at this time.

Federal Financing and State Budget Implications

Q: What actuarial analyses are planned and when will they be available?

A: This question was addressed as part of the overall timeline update presented to the Task Force at the July 12, 2022, meeting and can be found in the slide deck (available at https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/256185).

A series of analyses have been or will be presented, as follows:

- A microsimulation analysis was presented on October 18th, 2022, of the impact on the existing ACA individual market from creating a BHP, including the impact on premiums in the individual market and analysis of enrollee responses to premium changes. See https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257287
- On November 15th, 2022, the Task Force heard results of an actuarial analysis to project potential enrollment in a BHP as well as the costs to provide coverage to the BHP population and the expected federal funding Oregon would receive.

These analyses and simulations are not able to report results that are disaggregated by demographics, either for the purpose of estimating enrollee costs of coverage, risk adjusted capitation rates or provider reimbursements. Enrollee-level data are compiled from several sources including OHP, ODHS, and commercial carriers. These data sources do not contain standardized information about enrollee demographics that can be reported across the BHP population as a whole, though this information would be collected after a BHP is created.

Q: What are the state budget implications if the bridge program has higher than expected enrollment?

A: Increasing the level of coverage among the population is consistent with the goals of HB 4035, though the state budget implications of higher-than-expected enrollment are

different under a 1331 BHP and a 1332 waiver. The federal funding formula for a 1331 BHP is calculated on a per-person basis and the state would receive federal funds for the program that would be tied to the number of people enrolled. An overview of this funding formula was presented to the Task Force on November 1st, 2022. (see https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257362) Under a 1332 State Innovation Waiver, the state would receive an aggregated (population-based) amount of federal funds rather than a per person amount. The state would be accountable for "deficit neutrality," meaning federal funds for the waiver could not exceed that aggregated amount if enrollment was higher than expected.

Q: What is the administrative cost of churn, which may not be well captured in analyses of either Medicaid or Marketplace enrollees?

A: A 2015 study (https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204) simulating Medicaid churn from pre-ACA data (2005–2010) estimated that the process of disenrolling and re-enrolling one person in coverage within a year incurs administrative costs between $400 and $600, an amount which would be higher in today's dollars. A national study (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/) of Medicaid service utilization and costs estimated that churn resulted in a $650 per-member per-month increase in acute care costs (driven primarily by higher emergency department utilization and inpatient stays) and an overall $310 per-member per-month increase in total costs in the five months following coverage disruption.

Q: Does the cost of administering member cost sharing (such as premiums or co-pays) offset the revenue gained through these strategies?

A: OHA does not expect that the administrative costs of implementing cost sharing will exceed: (1) the revenues gained from these strategies; and (2) reduced costs that result from lower service utilization. OHA has not yet made forecasts of the administrative costs of these strategies or the revenue impacts but aims to explore the operational and fiscal implications of these strategies.

Q: Will actuarial analyses consider the future costs of deferred care that may result from the pandemic?

A: OHA will not be able to answer this question due to limited resources. It is outside the scope of their actuarial analysis.

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

A: Prior to submitting a Blueprint request to CMS, OHA must receive approval from the Oregon Health Policy Board as required in Section 5(1). No explicit legislative approval is necessary to establish the bridge program, as Section 5(2)(a) allows OHA to implement the Program after receiving approval from CMS. Legislative action to support

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

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

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

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

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

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

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

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

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

Access, Covered Services and Enrollee Costs

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

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

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

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

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

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

Q: What options exist for customizing how co-pays may apply to certain services?

A: The ACA limits overall enrollee costs allowable in BHP programs. BHP premiums and cost sharing cannot be higher than what an individual would have paid for a

Marketplace plan. The ACA also generally prohibits cost sharing for preventive services except in limited instances such as out-of-network care. States have some flexibility in setting co-payments, though more complicated co-payment designs can cause consumer confusion and increased administration costs.

Q: What research exists regarding the relationship between enrollee cost sharing, coverage, and utilization of health services?

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

In 2003, the Oregon Health Plan (OHP) implemented new premiums and coverage restrictions following premium-nonpayment due to state budget deficits; research on the impact of these changes (available at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2005_jul_impact_of_changes_to_premiums__cost_sharing__and_benefits_on_adult_medicaid_beneficiaries__results_f_wright_impact_changes_premiums_medicaid_oregon_pdf.pdf) found rates of coverage fell 13 percent for OHP Plus and 44 percent for OHP standard in the months following this change. Oregon also temporarily introduced co-pays to the Oregon Health Plan, and later rescinded them. The study assessed enrollees' self-reported unmet care needs in the months before and after co-pays were eliminated, finding that the percent of enrollees with unmet care needs fell from 28 to 19 percent following the elimination of co-pays. These findings are consistent with a KFF review of literature from 2000–2017 (available at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/) finding that co-pays in Medicaid and Children's Health Insurance Program even at relatively low levels ($1–$5), are associated with adverse care utilization patterns including reductions in necessary services and increased emergency department utilization.

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

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

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

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

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

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

Table 2. BHP Plan Design in New York and Minnesota

	NY Essential Plan (135 – 150% FPL) (1)	NY Essential Plan (151 – 200% FPL) (1)	Minnesota Care (2)
Preventive Care	$0	$0	
Nonpreventive Care			$25 (behavioral health visits excluded)

Primary Care Physician Visit	$0	$15	
Specialist Visit	$0	$25	
Inpatient Hospital Stay (per admission)	$0	$150	$250
Behavioral Health Outpatient Visit	$0	$15	
Emergency Room	$0	$75	$75
Urgent Care		$25	
Ambulatory Surgery			$100
Radiology			$25/visit
Physical, Speech, and Occupational Therapy	$0	$15	
Durable Medical Equipment (DME)			10% co-insurance
Rx (generic)	$1	$6	$7
Rx (preferred)	$3	$15	$7
Rx (non-preferred)	$3	$30	$25
Dental	$0	$0	$15/non-routine visit
Vision	$0	$0	$25 copay for eyeglasses

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

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

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

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

Table 3. Marketplace Plan Deductibles and Maximum Out-of-Pocket Costs (Plan Year 2023)

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

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

Of note, many services covered under Qualified Health Plans are not subject to deductibles. Every Marketplace insurer offers at least three plans with unlimited office visits offered with a copay but no deductible (including primary care, specialty behavioral, habilitative and rehabilitative care). Many insurers also offer at least six plans that provide this level of coverage. Many plans offer pharmacy and urgent care coverage not subject to deductibles. This type of coverage is available at all metal tiers, and in all service areas in Oregon.

Plan Administration and Provider Reimbursements

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

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

The relationship between plan rates, provider reimbursements and adequacy of provider networks is influenced by a range of economic and workforce factors that can meaningfully vary across regions. Research on Medicaid provider networks (available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01747) suggests that within a contracted provider network, the provision of care to Medicaid enrollees is often concentrated among a small proportion of the network. Increasing reimbursement rates to providers can result in increased access to services for Medicaid enrollees (see https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care).

Q: How will success (i.e., performance) be measured in a BHP, and how will this relate to plan or provider payment?

A: This has not yet been determined. The BHP could build on the incentives and other provisions in CCO contracts. OHA is working with Manatt to understand how New York and Minnesota have integrated value-based purchasing into their BHP designs.

Q: How would the creation of a BHP impact federal funding for safety net providers or Federally Qualified Health Centers?

A: Federally Qualified Health Centers (FQHCs) are those that receive Section 330 grant funding under the Public Health Service Act to provide care in communities underserved

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

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

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

A: Health Related Services are non-covered services offered as a supplement to CCO OHP benefits (OAR 410-141-3500) and provide a funding mechanism for CCOs to address social determinants of health through their "global budgets." The SHARE initiative is a requirement for CCOs to reinvest a portion of any net income in services to address social determinants of health and equity, including housing-related services and supports. A comparison of these services is available at https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HRS-SHARE-ILOS-Comparison.pdf. Oregon Health Authority presented an overview of HRS at the October 4th meeting (available at

https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/257235).

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

Q: How are Health Related Services changing under Oregon's recently approved Section 1115 Medicaid demonstration waiver?

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

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

For these populations, HRSN will largely replace HRS and are now a required OHP covered service. Under its recently approved 1115 waiver renewal, Oregon will continue to offer HRS through the Oregon Health Plan to people who are not eligible for HRSN, but these services will continue to be offered at CCOs' discretion. More information is available at https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx

Comparing Federal Pathways to Create the Program*

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

Q: Are the federal pathways mutually exclusive? Can they be implemented sequentially?

A: The pathways are not mutually exclusive. A phased or sequential approach is possible and an1115 waiver could be pursued initially and followed by a more permanent 1331 Blueprint or 1332 waiver. HB 4035 directs the state to pursue a temporary, short-term 1115 waiver as part of its' redetermination of Medicaid enrollees'

eligibility when the PHE ends. OHA and DCBS have submitted this short term 1115 waiver request.

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

Q: Are the federal pathways different with respect to implementation timeframes? Is one pathway more likely to receive federal approval than the other?

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

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

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

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

Q: Is one of the federal pathways more easily implemented than the other?

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

Q: Are there differences in program administration costs to implement either of the pathways?

A: OHA is currently in the process of developing its budget for the 2023–25 biennium, which will include funding requests necessary to implement bridge program elements recommended by the Task Force.

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

Q: Is one federal pathway more financially predictable or stable long-term than the others?

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

Q: Does one pathway or the other support reduction of uninsurance rates for Oregonians without coverage?

A: Nothing in the basic structure of the 1331 Blueprint and 1332 waiver automatically points toward differences in the likely effect on uninsurance rates. However, enrollment or "uptake" of the BHP by eligible consumers may be sensitive to whether and how cost sharing is incorporated into the benefits design. To the extent that 1331 funding is on a

per-capita basis, scalable to varying levels of enrollment, and not subject to deficit neutrality rules, it may be easier for the state to promote higher levels of plan uptake *over time* under a 1331 Blueprint.

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

Q: Does one federal pathway offer better ability than the other to increase members’ access to providers?

A: Generally, no. The differences between a 1331 Blueprint and 1332 waiver would not automatically lead to differences in provider access (though access may be indirectly affected by plan design decisions made under either pathway).

Q: Does the choice of federal pathway have implications for enrollee cost sharing?

A: Generally, no. Oregon has broad flexibility to design enrollee cost sharing as part of a BHP under either pathway.

Appendix B: Oregon Standard Silver Plan Cost Sharing Reductions

Plan Year 2022

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

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

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

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

[5]ER copay is waived if admitted.

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

Appendix C: Covered Services Comparison

Commented [PS3]: added

Covered Services Comparison - State EHB Benchmark and CCO	
Notes: • Focus of the analysis is the CCO covered services and not OHP more broadly, which includes fee-for-service covered services. • Unless noted, assume no quantitative limit on services. • Children's services not included in the analysis. • Not a covered service for either: Infertility services and adult orthodontia. • "PL" refers to Prioritized List - https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx	
Benefit Type	**Notes**
Services Covered by EHB Benchmark and CCOs **EHB = CCO**	
PRIMARY CARE	n/a
SPECIALIST/PHYSICIAN SERVICES	CCO: Agnostic to provider type. CCOs may limit specialist visits (e.g., require referrals)
OTHER PHYSICIAN SERVICES	CCO: Agnostic to provider type.
OUTPATIENT - HOSPITAL AND PHYSICIAN/SURGICAL	CCO: Agnostic to provider type (if surgery pairs and is funded on the PL). Some surgeries/procedures often covered by commercial insurance may not be covered under OHP.
HOSPITAL SERVICES	EHB: Respite care provided in a nursing facility subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. CCO: 90-day period with subsequent 60-day periods.
URGENT CARE	CCO: Agnostic to provider type.
HOME HEALTH CARE	CCO: Generally covered, but subject to PL.
EMERGENCY SERVICES	CCO: Generally covered, but subject to PL.
EMERGENCY TRANSPORT	n/a
INPATIENT HOSPITAL SERVICES	n/a
INPATIENT PHYSICIAN AND SURGICAL	CCO: Generally covered, but some surgeries or diagnoses may not be covered due to PL.
SKILLED NURSING	EHB: Quantitative limit on services. CCO: Post-hospital extended care. CCOs are responsible for a SNF benefit that is more akin to commercial SNF coverage, does not include coverage for K plan and other services. CCOs responsible for post-hospital extended care benefits with up to 20-day stay to allow discharge from hospitals.
MATERNITY CARE - PHYSICIAN	CCO: PL - includes out of hospital birth for low-risk pregnancies, including licensed direct entry midwives. There is a carveout for this (and a few other services).
MATERNITY CARE - INPATIENT	CCO: PL - includes out of hospital birth for low-risk pregnancies, including licensed direct entry midwives.
BEHAVIORAL HEALTH OUTPATIENT	CCO: PL - generally covered but some conditions not covered.

SUBSTANCE USE DISORDER - OUTPATIENT	n/a
SUBSTANCE USE DISORDER - INPATIENT	n/a
PRESCRIPTION DRUGS	EHB: In accordance with 45 CFR 156.122, EHB plans must cover the same number of prescription drugs in each United States Pharmacopeia (USP) category and class as the benchmark plan and, at a minimum, at least one drug in every USP category and class. CCO: Medicaid more generous because of open formulary. Some drugs not covered according to PL.
OUTPATIENT REHAB & HABILITATION	EHB: Quantitative limit on services. CCO: PL puts limits on OP Rehab and habilitation (similar to EHB). Can also include home health and DMEPOS which is also separately listed.
CHIROPRACTIC CARE	EHB: Quantitative limit on services. CCO: Plan uses the term "spinal manipulation." Subject to PL - some conditions not covered and quantity limits.
DURABLE MEDICAL EQUIPTMENT	CCO: Not covered for unfunded diagnoses, some common DME not covered as medically necessary.
HEARING AIDS	EHB: Quantitative limit on services. One hearing aid per hearing impaired ear if prescribed, fitted, and dispensed by a licensed audiologist with the approval of a licensed physician. Coverage will be provided every 36 months as medically necessary for the treatment of a member's hearing loss. Medicaid: Binaural every 5 years ages 21+, 3 years for children <21, limits on batteries.
IMAGING	n/a
PREVENTIVE CARE/SCREENING/IMMUNIZATION	n/a
ROUTINE FOOT CARE	EHB: Benefit is limited to persons being treated for diabetes mellitus. CCO: PL covers for several high-risk conditions including diabetes.
ACUPUNCTURE	EHB: Quantitative limit on services. CCO: Quantitative limit may vary by condition. Listed as bundled services as a duplication of physician services and nurse practitioner services from existing state plan.
REHABILITATIVE SPEECH THERAPY, OCCUPATIONAL & REHAB PHYSICAL THERAPY	EHB: Quantitative limit on services. 30 visits per condition per calendar year. CCO: Medicaid more generous. Quantity limits for adults 21+. Physical, speech, & occupational therapy - rehab/hab.
LABORATORY OUTPATIENT & PATIENT SERVICES & X-RAYS	n/a
TRANSPLANT	n/a
ACCIDENTAL DENTAL	CCO: Limits on dentures, crown, and periodontal.
DIALYSIS	
ALLERGY TESTING	EHB: Described as "Other medically necessary diagnostic services provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical

	condition." CCO: only covered by PL if patient has a funded comorbidity such as asthma or for severe allergies.
CHEMOTHERAPY	n/a
RADIATION	n/a
DIABETES EDUCATION	EHB: Quantitative limit on services. Covers three hours of education per year if there is a significant change in condition or treatment; covers one diabetes self-management education program at the time of diagnosis. CCO: Medicaid likely more generous.
PROSTHETIC DEVICES	n/a
INFUSION THERAPY	n/a
NUTRITIONAL COUNSELING	EHB: Quantitative limit on services. CCO: Through diabetes prevention program, intensive behavioral counseling (home health).
RECONSTRUCTIVE SURGERY	EHB: Limited to one attempt at cosmetic or reconstructive surgery when necessary to correct a functional disorder; or when necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or when necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. CCO: Non-cosmetic. Subject to PL - may be more or less generous than commercial depending on condition.
COSMETIC SURGERY	EHB: Limited to one attempt at cosmetic or reconstructive surgery when necessary to correct a functional disorder; or when necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or when necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. CCO: OHP concept of cosmetic is different. Generally cosmetic services are in the unfunded region of the PL but may be covered if there is comorbidity and must be considered medically necessary - then considered hospital services.
WEIGHT LOSS PROGRAMS	EHB/CCO: Intensive weight loss counseling, including diabetes prevention program is covered. (Intensive weight loss counseling is also in the EHB because it's a USPSTF preventive service).
Service is not in EHB Benchmark, but is a CCO Covered Service **CCO > EHB**	
DENTAL - ROUTINE	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous.
DENTAL - BASIC	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous, subject to PL and OAR.
DENTAL - MAJOR	CCO: Limits on dentures, crown, and periodontal. Medicaid more generous, subject to PL and OAR.
BARIATRIC SURGERY	CCO: Limitations on types when it is considered medically necessary.
NON-EMERGENT MEDICAL TRANSPORTATION	CCO: Unique to CCO.

Appendix D: Public Comment

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

Commented [PS4]: added

This appendix contains all written comment submitted by members of the public through December 13, 2022.