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Legislative Policy and
Research Office

Joint Task Force on the Bridge Health Care Program

Final Recommendations

December 2022

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*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.

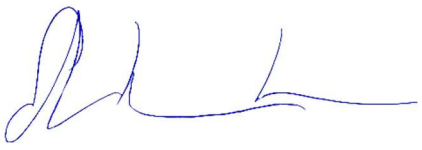
One bright spot was the gains in health insurance coverage that occurred during the pandemic. Like other states, Oregon took advantage of a federal option that allowed people to remain enrolled in the Oregon Health Plan during the pandemic. The number of people covered – particularly people of color – 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.

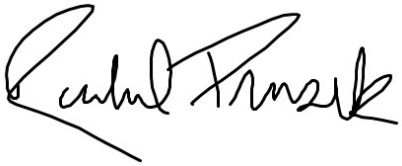
We have been honored to co-chair the Joint Task Force on the Bridge Health Care Program over the past nine months. **This report reflects the Task Force's final recommendations** to design and implement a Bridge Program while promoting stability in Oregon's individual and small group insurance markets. 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

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House District 37

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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 fell to a historic low, inequities in coverage improved, and "churn" - where people enroll, disenroll, and re-enroll in OHP over short periods - ceased. The 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 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 requests approval for a BHP Blueprint, the federal application required by CMS to establish a 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 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 analysis of the proposal estimated the program would generate a modest $116.33 per member per month 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 targets have 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. The exit of the BHP-eligible population from the market could lead to a reduction in average premium subsidies for remaining consumers. Approximately 900 people may drop coverage and another 4,200 may shift to less generous coverage. The Task Force recommends OHA and DCBS pursue strategies to mitigate this effect including studying and, if appropriate, requesting federal approval for an amendment to Oregon's Section 1332 waiver to implement a shift in how subsidies are calculated.

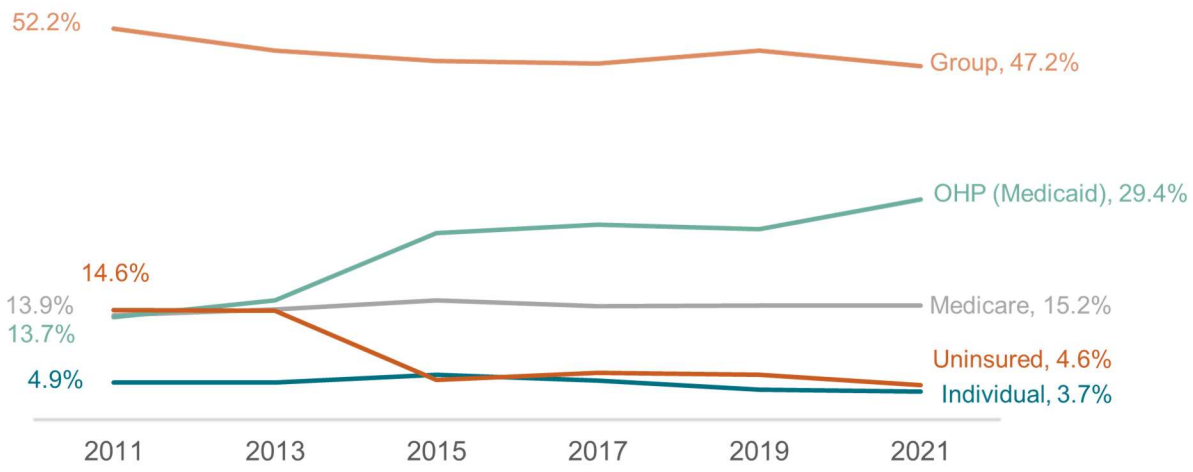
Next Steps

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 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). 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 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 PHE (Centers for Medicare and Medicaid Services 2020). This option included enhanced federal funding during the PHE. Oregon (and all states) accepted this option to maintain enrollees' coverage until the PHE declaration expires.

People enrolled in OHP have thus been "continuously eligible" during the pandemic and, as a result, the number of enrollees increased from 1,050,179 to 1,323,775 from 2019 to 2021 (Oregon Health Authority 2022), and churn has ceased during the PHE,

[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

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.

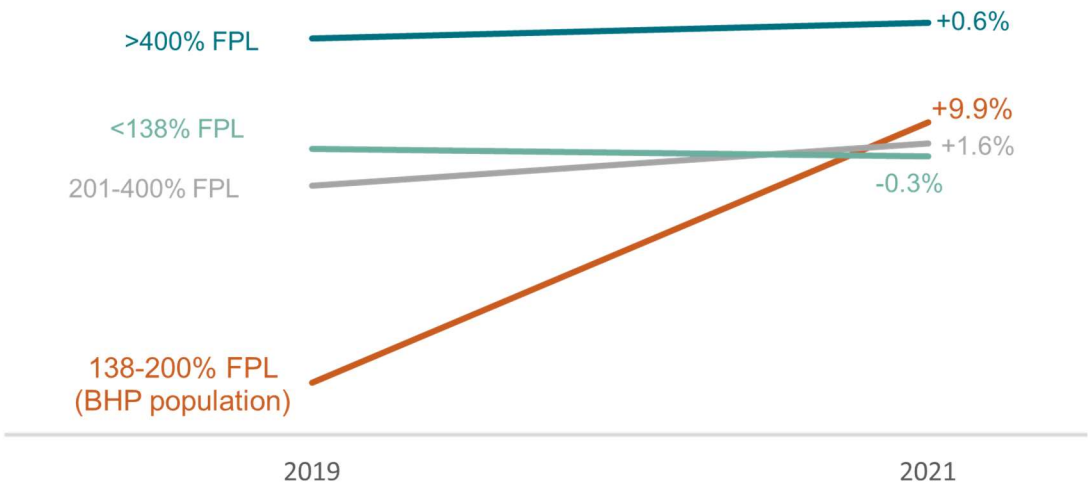
Premium Subsidies. Congress also passed the American Rescue Plan (ARP) in March 2021 to provide additional relief from the economic impacts of COVID-19 (**Public Law 117-2**). ARP made health insurance more affordable for people buying coverage on the Marketplace (Healthcare.gov) by:

- **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 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.

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 ("Task Force") first convened on April 26, 2022. Governor Kate Brown appointed **members** to represent a range of sectors, industries, and perspectives, including:

- Senator Elizabeth Steiner, Senate District 17 (Co-Chair)
- Representative Rachel Prusak, House District 37 (Co-Chair)
- Senator Bill Kennemer, Senate District 20 (Vice Chair)
- Representative Cedric Hayden, House District 7 (Vice Chair)
- 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
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- Lindsey Hopper, PacificSource Health Plans
- Eric Hunter, CareOregon
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- William Johnson, Moda Partners
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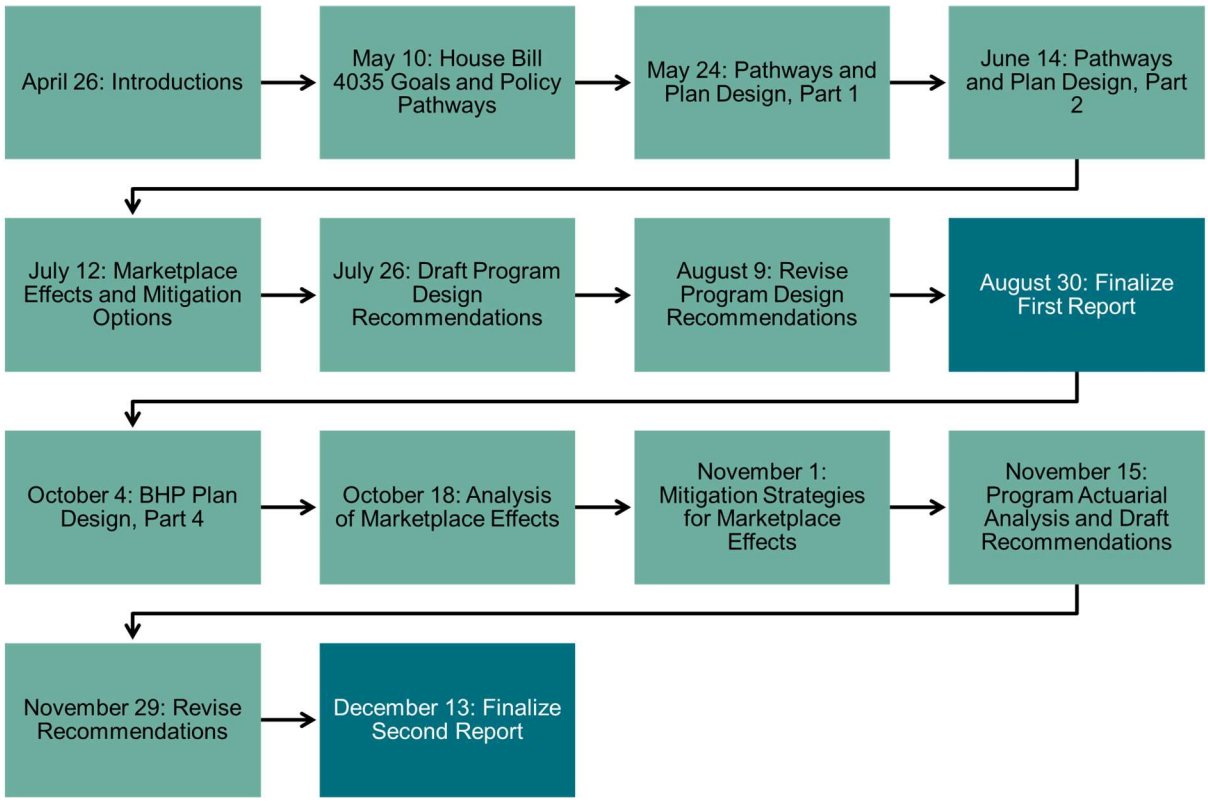
- Fariborz Pakseresht, Oregon Department of Human Services
- Keara Rodela, Coalition of Community Health Clinics
- Matthew Sinnott, Willamette Dental Group
- Andrew Stolfi, Oregon Department of Consumer and Business Services

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

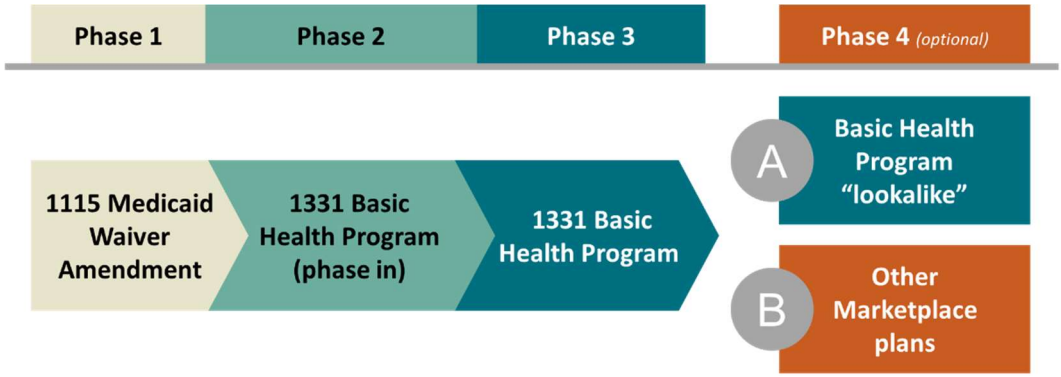
HB 4035 required the Task Force to develop recommendations on designing the Bridge Program with consideration for specific **program design elements**, including:

- 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 1, 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 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 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 1 would transition to the BHP. In Phase 3, the program would open to all other eligible consumers.[3]

[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.

Projected Revenues and Costs of a Basic Health Program

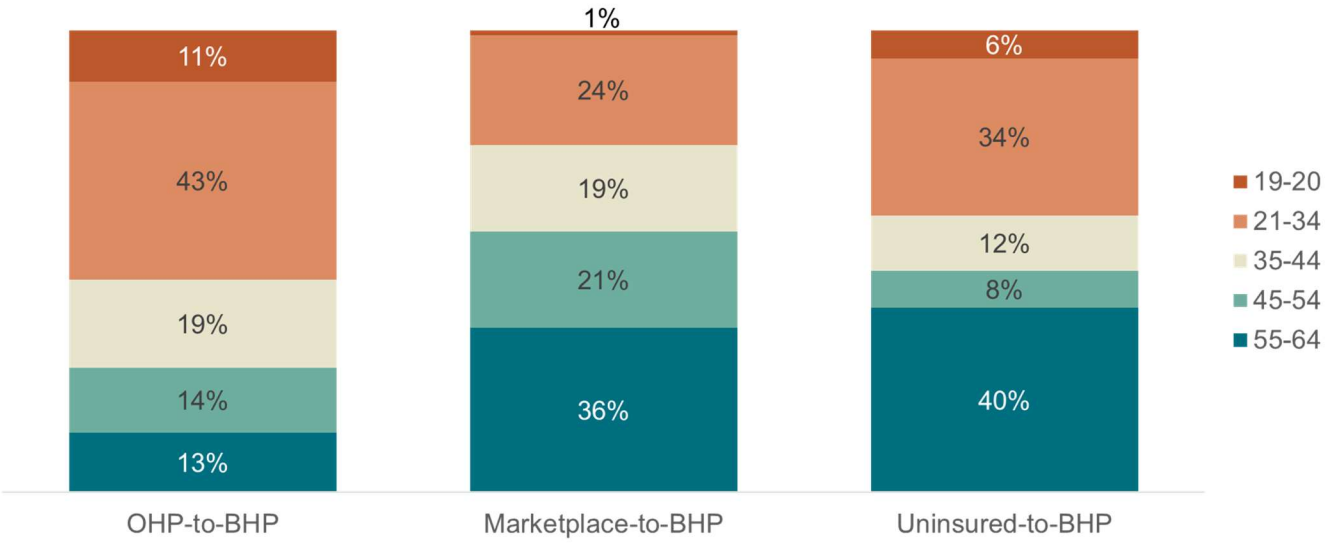
The potential revenues and costs to operate a Basic Health Program were a key consideration in updating the Task Force's preliminary recommendations. Consultants from Manatt Health and actuaries from Oliver Wyman and Mercer developed estimates using a range of data sources including: 2021 health care 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 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 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.

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 PMPM basis with individual-level funding determined by applicable adjustments (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).

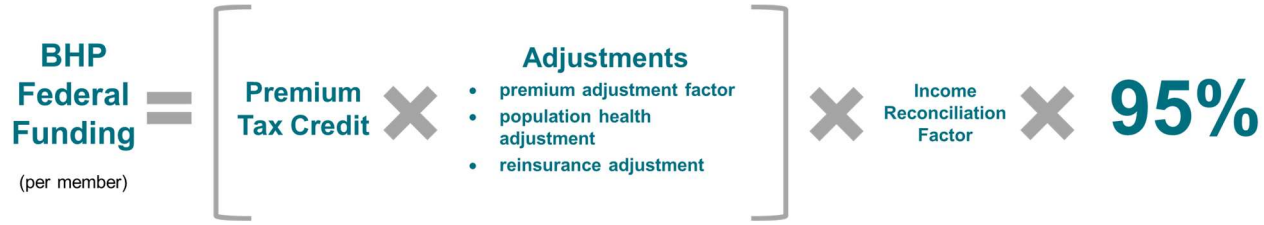
- **A population health adjustment** that accounts for the loss of federal revenue that can occur if a BHP leads to lower Marketplace morbidity and, by extension, lower Marketplace premiums. This factor is optional, set to 1.0 by default, and may be requested by states.

- **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 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 General Funds will be necessary for these expenses regardless of federal revenue projections.

The **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 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 PMPM basis, this surplus equates to $116.33 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 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 Qualified 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 (MCO) 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, 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 tribes and received general approval to pursue this approach. The agency submitted the proposed waiver amendment on November 15, 2022.

While recommendations regarding tribal enrollment procedures are beyond the scope of the Task Force, members expressed support for OHA's continued exploration of options to maintain 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 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 HRS to enrollees in a manner consistent with 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 LTSS 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 3 implementation no more than 24 months after the implementation of Phase 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 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 2 using the state's existing CCO infrastructure, and accepting eligible consumers not enrolled in OHP in Phase 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 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 HRS to enrollees in a manner consistent with 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 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 Legislative Assembly will need to monitor these issues and confirm assumptions through future analysis as the program launches and additional information becomes available.

III. Analysis of Disruptions to Oregon's Individual Marketplace

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

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010 to expand health care coverage and affordability (Public Law 111-148). 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: APTC and cost sharing reductions.

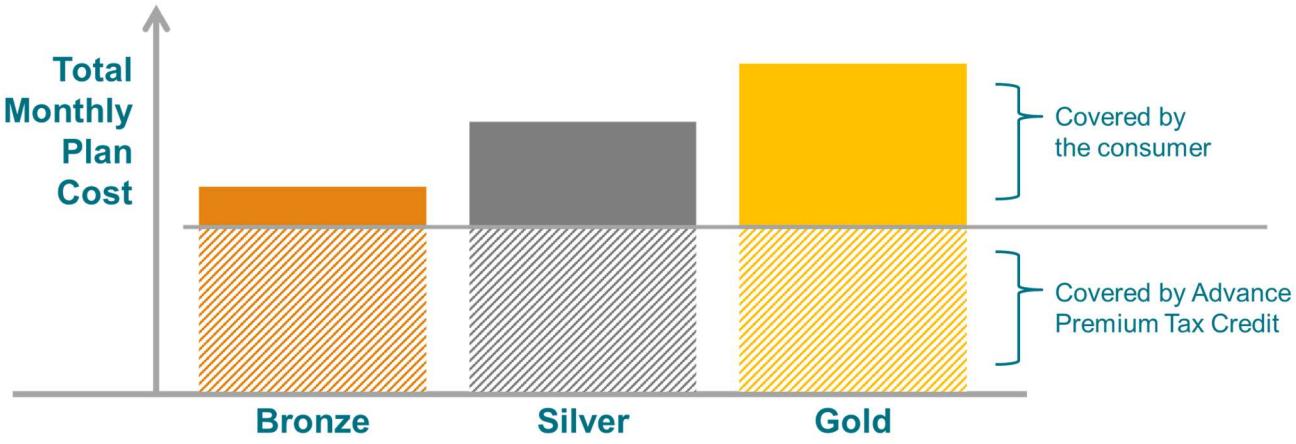
Advance Premium Tax Credits

The ACA (Public Law 111-148) established advance premium tax credits to lower the cost of monthly premiums for people who purchase coverage on the exchange. Under the ACA, 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 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; 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) 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 B 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 4, 2022 (Ario, Tomczyk and Rehfield-Griffith, An Early Look at Marketplace Impacts Following Implementation of a BHP in Oregon 2022)

Anticipated Marketplace Disruptions

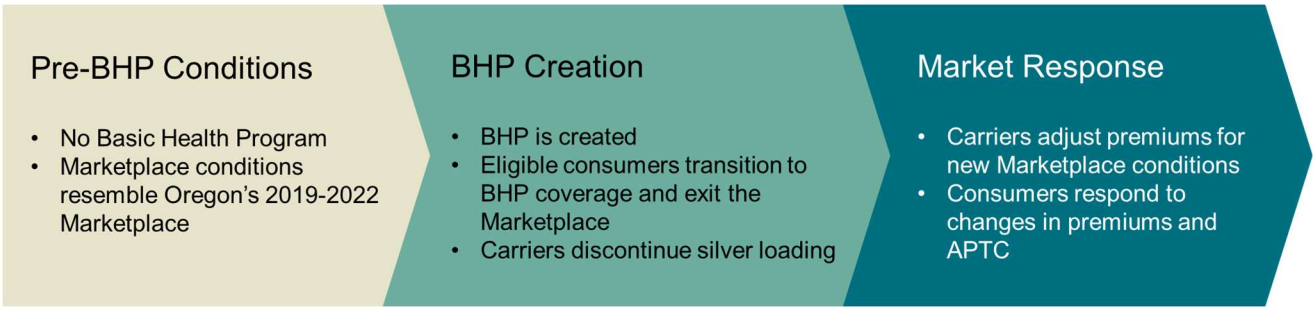
HB 4035 required the Task Force to identify disruptions that creation of a BHP could cause to the individual and small-group health insurance markets. The Task Force studied **potential market disruption issues** over the course of several fall meetings, including:

- **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, 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 Phase 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 ARPA. These dynamics are projected forward to 2024.

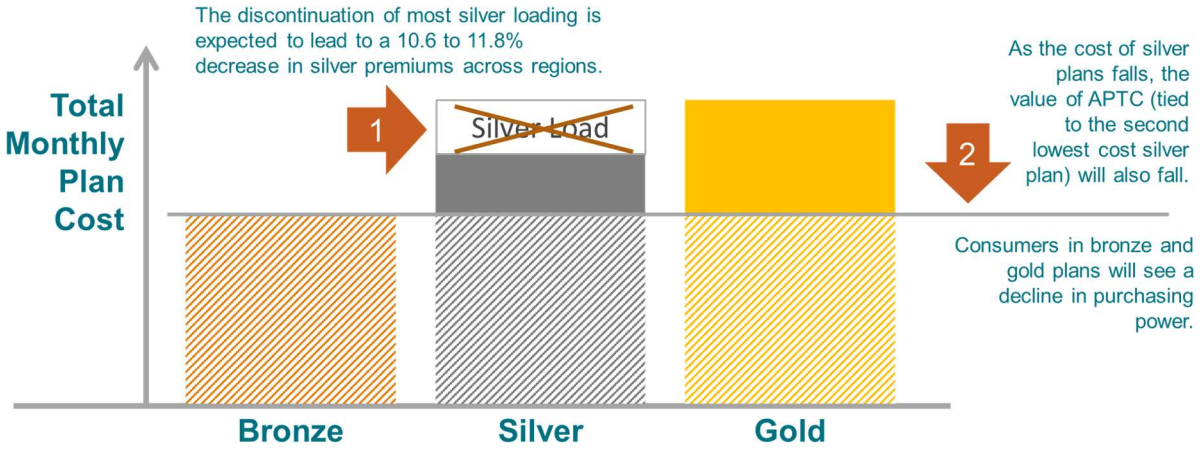
BHP Creation. If the BHP is implemented in 2024, an estimated 35,800 out of 178,000 people would transition to BHP coverage and exit the individual market. The model estimates that in the first year with the BHP, carriers would change premiums to reflect these **changes in the post-BHP Marketplace population** (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% of FPL. When the BHP population exits, 54% 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

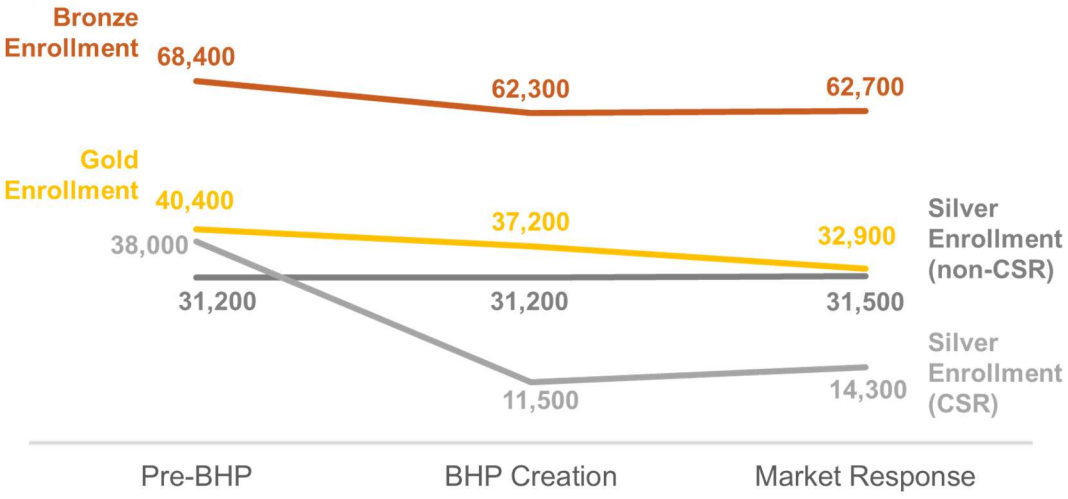


Source: Adapted from Department of Consumer and Business Services (Rehfield-Griffith 2022)

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 **consumer effects** are meaningfully different for people who qualify for APTC than for 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; Exhibit 19 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)	$8,100 ($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 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 SLCSP value 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 the November 1 Task Force 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 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 and November 15 meetings. Members posed **questions about the gold benchmark** for further exploration, including:

- the need for an actuarial analysis of the cost of shifting to the gold benchmark;
- whether Oregon would be able to meet its targets and requirements for the reinsurance program if some savings generated by the program were directed toward offsetting the cost of the gold benchmark;
- the estimated numbers of consumers in regions where shifting to a gold benchmark could lead to a net decrease in purchasing power; and
- how Marketplace consumers' maximum 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 General Fund;
- continuing discussions with CMS regarding the feasibility of this approach; and
- further analyzing regional variation in consumer impacts.

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

V. CONCLUSION

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

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

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

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

Next Steps

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

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

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

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.

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

Oregon Association of Hospitals and Health Systems

April 25, 2022

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

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

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

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

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

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

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

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

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

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

Thank you,

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

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PacificSource

May 5, 2022

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

Delivered electronically.

Co-Chairs Steiner Hayward and Prusak:

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

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

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

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

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

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

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

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

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

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations

COALITION FOR A HEALTHY OREGON
COMMITTED TO LOCAL CARE

May 10, 2022

From: Coalition for a Healthy Oregon

To: Joint Task Force On the Bridge Health Care Program

Subject: CCO Principles for a Successful Bridge Health Care Program

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

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

Center the Member Experience

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

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

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

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

COALITION FOR A HEALTHY OREGON

Ensure Provider Participation

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

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

7) Additional administrative burden should be minimized.

Leverage The Successful, Local Model

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

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

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

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

Sincerely,

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

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 10, 2022

Re: Bridge Health Care Program Goals and Pathways

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

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

Exchanges:

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

Waiver Options:

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

[1] 255315 (oregonlegislature.gov)

May 10, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

Building on Oregon's History as a Health Care Innovator

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

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

Key Waiver Pathway Considerations

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

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

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

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

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

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

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

Sincerely,

Liz Hagan
Director of Policy Solutions
ehagan@usofcare.org

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

Rachel Bonesteel
Policy Manager
rbonesteel@usofcare.org

Dear Members of the Task Force and Policymakers,

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

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

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

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

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

Thank you,

Chris Bugas,
Emergency Medicine Physician

May 10, 2022

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

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

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

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

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

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

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

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

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

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: May 24, 2022

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

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

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

Benefits and Coverage:

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

Enrollee Costs:

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

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

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

Reimbursement:

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

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

From: **Oregon Dental Association**

Date: **May 24, 2022**

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

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

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

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

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

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

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

Sincerely,

Dr. Calie Roa, ODA President

8699 SW Sun Place • Wilsonville, Oregon 97070-3710 • 503.218.2010 / 800.452.5628 • fax 503.218.2009 • www.oregondental.org


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ACP
American College of Physicians
Leading Internal Medicine, Improving Lives
Oregon
Chapter

June 21, 2022

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

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

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

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

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

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

CC:
Courtni Dresser
courtni@theoma.org

Sabrina Riggs
sabrina@daltonadvocacy.com

Providence Health & Services
4400 N.E. Halsey St., Building 2
Suite 599
Portland, OR 97213
www.providence.org/oregon

July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

William Olson
Chief Executive Officer
Providence Health & Services – Oregon

Don Antonucci
Chief Executive Officer
Providence Health Plan

OPCA
Oregon Primary Care Association

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 12, 2022

Re: Bridge Health Care Program Marketplace Impact

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

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

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

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

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

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July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

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

Regards,

/s/ Elizabeth Edwards

Elizabeth Edwards
Government Relations Director
Kaiser Permanente Northwest

500 NE Multnomah St.
Portland, OR 97232

Oregon Association of Hospitals and Health Systems

July 12, 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you,

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

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July 12th, 2022

Oregon Bridge Plan Taskforce

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

Submitted by email: jtbhcp.exhibits@oregonlegislature.gov

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

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

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

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

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

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

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

Best,

Carly Hood-Ronick MPA, MPH
Executive Director

July 12, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

Market Impacts

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

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

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

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

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

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

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

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

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

Plan Design

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

Plan Design Scenario Planning

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

Enrollee Costs

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

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

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

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

Provider Reimbursement

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

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

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

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

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

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

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

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

Sincerely,

Liz Hagan
Director of Policy Solutions
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Appendix

COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.116

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

I. Background and Purpose

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

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

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

II. Applicability and Scope

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

III. Division Position

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

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

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

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

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

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

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

VI. History

Issued May 19, 2021.

Dear members of the Bridge Plan Task Force,

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

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

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

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

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

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

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

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

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

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

Thank you for your consideration.

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

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Wanda Davis
503-508-1428

OAHU
OREGON ASSOCIATION
OF HEALTH UNDERWRITERS

July 22, 2022

To Members of the Bridge Health Care Program Task Force:

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

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

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

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

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

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

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

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

Respectfully submitted,

/s/

Julianne Horner
President

/s/
Tim Rasch
Immediate Past President

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

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

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

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

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: July 26, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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

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

Marketplace Impact

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

Plan Development

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 9, 2022

Re: Bridge Health Care Program, Plan Design Part 3

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

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

Unintended Consequences

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

Plan Development

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

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

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

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

August 9th, 2022

Oregon Bridge Plan Taskforce

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

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

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

Potential for State Funding

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

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

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

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

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

Best,

Carly Hood-Ronick MPA, MPH
Executive Director

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

From: Oregon Dental Association

Date: August 22, 2022

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

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

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

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

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

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

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

Sincerely,

Dr. Calie Roa
ODA President

August 30, 2022

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

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

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

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

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

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

Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: August 30, 2022

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

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

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

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

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

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

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

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

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

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

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

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

Project Access NOW
Community | Care | Connection

October 18th, 2022

Oregon Bridge Plan Taskforce

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

Submitted by email: jtbhcp.exhibits@oregonlegislature.gov

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

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

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

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

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

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

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

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

Best,

Carly Hood-Ronick MPA, MPH
Chief Executive Officer

October 31, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

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

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

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

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

Sincerely,

Eric Waskowicz
Policy Manager
ewaskowicz@usofcare.org

Kelsey Wulfkuhle
State External Affairs Manager
kwulfkuhle@usofcare.org

November 15, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

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

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

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

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

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

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

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

Enrollee Costs

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

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

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

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

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

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

Sincerely,

Eric Waskowicz
Policy Manager
ewaskowicz@usofcare.org

Kelsey Wulfkuhle
State External Affairs Manager
kwulfkuhle@usofcare.org

Oregon Association of Hospitals and Health Systems

November 28, 2022

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

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

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

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

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

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

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

Thank you,

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

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

November 29, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

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

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

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

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

Enrollee Benefits

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

Outreach and Enrollment Assistance

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

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

Data Collection

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

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

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

Provider Payments

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

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

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

Feedback on Proposed Recommendations

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

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

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

Sincerely,

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Memorandum

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

From: Marty Carty, Director of Government Affairs

Date: November 29, 2022

Re: Bridge Health Care Program, December Report Draft

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

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

Plan Revisions

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

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

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

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

December 13, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

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

Sincerely,

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