June 14, 2022

Bridge Plan Task Force Members

RE: 6/14 Joint Task Force on the Bridge Health Care Program Meeting - Plan Design (Rates, Plans, Provider Participation), Consumer Perspectives

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 plan design for the Bridge Plan, including considerations around reimbursement rates, plan and provider participation, and the results of the preliminary actuarial analysis of the impact of the Bridge Plan, including a feasibility study. 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.

Establishing Reimbursement Rates that Support Continued Access to Care

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 the Oregon Health Plan (OHP), and to explore value-based payment model options that take into account social drivers of health and address unique patient needs.** In particular, 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 that are implementing similar models focused on increasing access to high-quality, affordable coverage options as you consider the elements of plan design for the Bridge Plan.

Support for providers serving vulnerable populations. Oregon can look to 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.

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, Coordinated Care Organizations (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.

Provider and Plan Participation

Issuer participation will have a significant impact on the availability of the Bridge Plan and **we urge the BPTF to require all CCOs to offer the Bridge Plan**. This will help ease transitions of Oregonians switching between OHP and the Bridge Plan and will support continuity of care. Oregon can look to states like Nevada, which included a provision in their public option legislation that requires any insurers bidding to offer Medicaid managed care plans to also submit competitive bids to offer public option plans. Similarly, Minnesota's Basic Health Program (BHP) requires all Managed Care Organizations (MCOs) to provide the Basic Health Plan as well. When we talk to people, we learn that they have trouble understanding their care and navigating the health care system. Providing plan design continuity between OHP and the Bridge Plan will mitigate the stress of relearning and navigating the system for all Bridge Plan beneficiaries.

Ensuring that Bridge Plan beneficiaries have access to a robust network of providers is also critical to ensure people have the ability to access needed services and care. Oregon can look to states that have implemented public options or other affordability programs for lessons and ideas. For example:

- Nevada's public option legislation requires providers and facilities that want to continue to participate in the Public Employees Benefits Program or Nevada's Medicaid program to be included in at least one network of the public option.
- When Washington state first enacted its public option, Cascade Care, in 2019 provider participation was voluntary, contributing to only 19 of Washington's 39 counties having a public option plan available. Learning from this and aiming to strengthen their public option, Washington enacted legislation referred to as "Cascade Care 2.0." Now, hospitals that provide services and receive reimbursement from Washington public employee benefits or Medicaid must also provide in-network services for at least one public option plan.
- Due to the joint procurement of Minnesota's BHP and Medicaid issuers, BHP plans include all Medicaid providers. In fact, provider networks in the BHP are more robust than Qualified Health Plans offered on the Marketplace.

Given the considerable overlap between Medicaid and Bridge Plan populations, the BPTF should consider incentivizing Bridge Plan participation by **aligning participation in OHP and the Bridge Plan**. Furthermore, we know that provider participation is closely tied to reimbursement rates and **ask the BPTF to review the considerations above, recognizing that reimbursement rates need to be based on the cost of providing care, while also acknowledging that providers in different communities face varying costs and needs.**

The BPTF can learn more from other states as it considers how to incentivize provider and plan participation. USofCare has compiled a comparison chart that compares and contrasts how states are working to pass and implement public health insurance options, and these lessons can be applied to the Bridge Plan as well.

Enrollee Benefits and 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. We 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.

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 CCOs to contract with Dental Care Organizations, as is required under OHP, to ensure dental benefits are offered to Bridge Plan enrollees.

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. 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.

Federal Funding Pathway & Impact on the Individual Market

We are looking forward to more fully reviewing the actuarial analysis following the June 14 BPTF meeting, and have appreciated the BPTF being thoughtful about taking broader and long-term implications into account when making recommendations on the best federal funding pathway to pursue. When assessing the best pathway, it will continue to be important for the BPTF to not only factor in potential federal funding amounts under each option, but to also factor in the impact each option has on the broader market, as required in HB 4035.

We understand there are practical limitations for pursuing a 1332 waiver to cover the Bridge Plan population and that there has been considerable discussion among the BPTF on moving forward with submitting a 1331 BHP blueprint. However, there are potential challenges and market disruptions that come with a BHP and we urge the BPTF to explore whether pairing the 1331 BHP with a 1332 waiver mitigates those issues. For example, because the 1331 pathway requires separate risk pools for the BHP and marketplace, those with incomes between 138-200% of the federal poverty level (FPL) 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 risk pool to move to the Bridge Plan.

As noted in the initial actuarial analysis, the impact this creates on marketplace premiums will depend on a number of factors, including the potential changed health of the population leaving the marketplace, and the impact of removing "silver loading," which has implications for the level of federal funding available to Oregon.

- While a 2015 analysis showed that removing this population from the marketplace risk pool in Oregon would have a marginal impact on marketplace premiums, it is not clear what the impact will be today given the changes that have taken place since then. We understand there is more actuarial work being done, and it is worth looking at other states that have also explored the BHP pathway. 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%.
- Pursuing a BHP under section 1331 without a 1332 waiver also means the state could potentially lose federal funding it would otherwise have, due to how premium tax credits are determined. Moving a large share of those who receive cost-sharing reductions (i.e. those with incomes under 250% FPL) to a BHP will affect silver loading practices, which boosts premium tax credit amounts for marketplace enrollees and the subsequent pass-through funding the state receives.

The BPTF should consider whether pursuing a combined approach with a 1331 BHP and 1332 waiver addresses these and other issues when first making federal funding pathway recommendations and later when developing the final legislatively-required report on mitigation strategies.

Further, there is more work to be done to improve affordability for all Oregonians, and we continue to urge the BPTF to think long-term about ways to improve affordability beyond the 138-200% FPL population when designing the Bridge Plan. For example, 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 at the end of the year. While the BPTF has a specific focus, the BPTF should be thoughtful about designing a Bridge Plan that isn't built at the expense of creating other affordability initiatives in the future. 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, and 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.

We appreciate the deliberations of the BPTF members on these 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.

We applaud the BPTF 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,

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