July 12, 2022

Bridge Plan Task Force Members

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

Dear Members of the Bridge Plan Task Force:

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

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

Market Impacts

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

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

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

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

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

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

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

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

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

Plan Design

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

Plan Design Scenario Planning

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

Enrollee Costs

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

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

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

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

Provider Reimbursement

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

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

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

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

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

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

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

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

Sincerely,

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Appendix

COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.116

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

I. Background and Purpose

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

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

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

II. Applicability and Scope

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

III. Division Position

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

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

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

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

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

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

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

VI. History

Issued May 19, 2021.