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,

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