February 10, 2022

Representative Rachel Prusak, Chair
Representative Cedric Hayden, Vice-Chair
Representative Andrea Salinas, Vice-Chair
House Committee on Health Care
900 Court Street NE
Salem, OR 97301

Delivered electronically.

Re: Comments on HB 4035, relating to health care.

Chair Prusak, Vice-Chairs Hayden and Salinas, and committee members:

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.

Thank you for the opportunity to comment on House Bill 4035. For the past two years, Oregon experienced larger than normal growth in the Oregon Health Plan due to the declaration of the federal public health emergency. In exchange for a 6.2% increase in the federal medical assistance percentage rate (FMAP), states would provide continuous eligibility throughout the duration of the public health emergency. As a result, enrollment in Oregon steadily climbed from 1,079,613 in 2020 to 1,381,735 in 2022.[1]

Once the public health emergency ends, states will receive 60 days' notice from the Centers for Medicare and Medicaid Services that the normal course of redeterminations must begin. A four-month grace period applies after the end of the federal public health emergency for states to resume timely processing of Medicaid eligibility claims, though within that four-month period are various milestones of work that the state Medicaid agency must undertake.[2] All 1.3 million members of the Oregon Health Plan must go through the process of eligibility verification within a 12-month period.

First, we believe that the health care community shares in the goal that redeterminations remain "job one." This applies to the Oregon Health Authority but also community partners such as the coordinated care organizations. To that end, we believe that a bi-directional, robust plan of data

[1] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/snapshot013122.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf

verification, outreach via multiple modalities, and insurance navigation is crucial. Inclusion of coordinated care organization throughout the process will help alleviate bottlenecks. For example, CCOs could help address the problem with out-of-date contact information by actively updating address data for OHA. We should also engage those issuing health benefit plans on the commercial market to ensure that Oregonians take advantage of advance premium tax credits; this may entail legislative language to temporarily lower barriers to marketing and outreach.

In order to help make redeterminations smoother, CMS has essentially invited states to submit what are known as state plan amendments on topics related to redetermination.[3] These amendments propose a program or operational change to CMS, who may approve or deny the requests. For the purpose of redeterminations, CMS invited states to request state plan amendments to (1) adopt 12 month continuous eligibility for children, (2) provide 12 months of postpartum coverage, (3) leverage SNAP facilitated enrollment authority for adults to ensure faster approval and (4) adopt express lane eligibility for children. We believe that OHA should avail itself of the opportunity and pursue these amendments.

Next, PacificSource believes that the health care community should continue to debate the merits or demerits of state alternatives to the commercial market. PacificSource is very interested in participating in future conversations regarding the enactment of a basic health plan. Enhanced advance tax credits may continue to help individuals with premiums on the Oregon Health Insurance Exchange. But even in the absence or presence of tax credits, data from the Oregon Health Insurance Survey suggests that there may be a subset of Oregon's population that remain uninsured once they lose Oregon Health Plan coverage. There may be multiple reasons why a person never enrolls in commercial coverage, and study of why people "churn" on and off of the Oregon Health Plan is important. If "churn" is the issue keeping Oregon from achieving even lower rates of uninsurance, then options like a basic health plan should certainly be on the table for thorough stakeholder input and vetting.

However, since enactment of a program like a basic health program is a large and complex undertaking and impacts the health care sector at large, we agree that having the Assembly – through the Legislative Policy and Research Office – review and recommend a course of action ensures stakeholder input and raises the visibility of the task.

Finally, in terms of state-based exchange, it is our understanding that even if the Assembly authorizes OHA to replace the federally-facilitated marketplace with a state-based marketplace, the process to implement a large infrastructure technology project means that the platform would not be available in time to assist with the redetermination process. A project of this scope likely needs vetting though the state Chief Information Officer in what is known as the "Stage Gate" process, a complex set of checkpoints put into place after the failure of the Cover Oregon project.[4] As with the basic health plan discussion, this idea merits further vetting and a longer-term plan to implementation.

Sincerely,

/s/

Richard Blackwell
Director, Oregon Government Relations

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[3] https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf
[4] https://www.oregon.gov/das/OSCIO/Documents/Stage_Gate_Review.pdf