Oregon
Kate Brown, Governor

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The Honorable Lamar Alexander
Chairman, U.S. Senate Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander,

Thank you for the opportunity to advise your committee with the insights I have gained from my experiences as director of Oregon's largest consumer protection and business regulatory agency. In particular, I share with you a commitment you described in your letter: proceeding wisely with improvements to the health coverage system and doing no harm. In Oregon, that includes maintaining the coverage gains that have reduced our state's uninsured rate to just 5 percent and saved $530 million in uncompensated care costs. Sustaining these achievements, while making more corrections to the system, are at the core of each of my specific answers to your questions below.

1. **What legislative and administrative actions do you recommend be taken in order to stabilize the individual and group insurance markets for the 2017, 2018, and 2019 plan years? In what timeframe would such actions need to be taken in order to stabilize the market?**

Any change to or replacement of the Affordable Care Act (ACA) should seek to maintain the coverage gains made by the ACA while also stabilizing, rather than disrupting, health insurance markets.

Specifically, federal policymakers should:

a. Avoid any sudden or significant changes to the ACA framework that would disrupt coverage and care.

b. Not repeal any part of the ACA's interlocking policies without simultaneously providing a comprehensive replacement plan that that does not take us backwards in terms of coverage, consumer protections, and market reforms.

c. Take steps to ensure continuous, uninterrupted coverage for Americans who became newly eligible for Medicaid and Americans who became newly insured in the commercial markets since Jan. 1, 2014.

d. Ensure that ACA financial programs are fully funded and that insurers are fully compensated. This includes maintaining premium tax credits, making appropriations for permanent cost-sharing reductions, and ensuring the federal government honors contractual commitments to make reinsurance and risk corridor payments through the end of 2016.

e. Continue to offset the costs for low- and moderate-income individuals using an approach that is means tested.

f. Maintain/establish policies that encourage young and healthy people to enroll in coverage and create incentives for all individuals to obtain and maintain coverage.

g. Provide states greater flexibility to innovate and manage their own markets by establishing benefit benchmarks, plan characteristics, rating requirements, and other market reforms, as well as setting timelines for rates and forms in effective rate review states.

h. Eliminate redundancies and make other improvements in the regulatory environment.

i. Drive down the costs of health care without diminishing quality and coverage, consistent with Oregon's coordinated care model.

Key proposals should also ensure states, health insurers, providers, consumers, and other health care stakeholders are given sufficient notice and time to implement reforms. At a minimum, significant changes to the ACA should not become effective for at least 24 months from the date of passage. This lead time will give public and private stakeholders the time needed to analyze, prepare for, and make the changes necessary to ensure a smooth transition. To avoid mid-year disruptions to individual consumers and the health insurance market generally, we recommend that any proposals, including plan changes, go into effect on Jan. 1 of the year.

2. What steps could be taken to improve the health of risk pools and ensure that high costs incurred by some do not lead to substantial premium increases for others in the pool?

To ensure equity within the commercial risk pools, we think it is essential that the ACA single risk pool and community rating requirements be maintained in the commercial market. Segregating risk pools by demographics, claims experience, or health status creates perverse market incentives for insurers and risks leaving the most vulnerable citizens unable to access the care they need. We believe that each state is in the best position to regulate health insurer conduct in this area, and that state regulators should

retain jurisdiction over all health insurance plans sold within the state. While all insurers within a state should be required to follow the same rating rules, states with effective rate review programs should be given flexibility to tailor rating methodologies and permissible rating factors as necessary to ensure that premiums are equitable and do not unreasonably disadvantage any one group.

To improve the overall health of the risk pool, we believe federal policymakers should adopt policies that seek to achieve the "triple aim" of better health, higher quality, and lower costs. This could include incentives for people to obtain and maintain coverage, as well as the adoption of payment models that reward value and quality and/or incentives for health insurers to provide and expand high value benefits such as preventive and primary care.

Oregon has implemented a comprehensive coordinated care model within its Medicaid program that could be adapted to the commercial market. Through the coordinated care model, those paying for health care get a better value and health plan consumers get higher quality care at a price we can all afford. With a focus on primary care and prevention, health plans and their providers using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.

3. **How would your state define "Essential Health Benefits" if it were given the freedom to define those requirements?**

Oregon considers the benefits offered under a typical employer plan to be the best model for Essential Health Benefits. Increased premiums in the individual commercial market are the result of claims experience and adverse selection, the practice of consumers picking richer plans based on coverage of certain conditions. At the same time, we support the flexibility to design benefits and coverage requirements to accommodate value-based insurance coverage. This encourages lower co-payments for clinical services that are considered effective or high value and aims to shift consumers toward the most effective care. When such designs are allowed, they may expand consumer choice while letting insurers decrease premiums.

Oregon also recommends that Congress maintain federal regulations and guidance for mental health coverage under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; ensure continued support of preventive health services as established by the ACA and its implementing regulation; and prevent application of pre-existing condition exclusions that would bar access to medically necessary care. Other benefit requirements should be regulated at the state level.

4. **Do you view the Section 1332 State Innovation Waivers as a workable option for providing state flexibility? If not, what changes in the law and regulations would you recommend? How long would it take your state to implement a Section 1332 Waiver?**

Oregon has been fortunate to have a successful health insurance exchange with diverse plan offerings and relatively affordable premiums. As the state moves toward its goals of better coverage and care, several potential waiver ideas are being vetted with stakeholders.

As a State-Based Marketplace that uses the Federal Platform (SBM-FP), the inability to make state-specific changes to HealthCare.gov has prevented Oregon from moving forward with innovations that would improve consumer choice and affordability. Allowing SBM-FPs to customize HealthCare.gov through a waiver would greatly increase the usefulness of a 1332 waiver for Oregon.

In addition to the necessary changes to HealthCare.gov, the budget neutrality required by the 1332 waiver guidance prevents Oregon from increasing the effects of health care reform. Allowing the state to shift funds from one program to another does not create enough funding to accomplish Oregon's policy goals. Allowing states to apply for more funding through a 1332 waiver for defined innovations and programs would greatly increase the likelihood that Oregon would pursue one or more 1332 waivers. Additionally, providing states greater flexibility by not requiring budget neutrality in all waiver years would remove disincentives to pursue innovation.

5. **What is your vision of a modern private health insurance market in your state? What would you do to lower health care costs, provide more individualized plan choices, and innovate, and what additional authorities would the states need from Congress to do so?**

Affordability of coverage and care, especially when combined with the other aspects of the triple aim – improved health and rising care quality – is a high priority for Oregon. We recommend the following reforms to help achieve this goal:

a. Strengthen the federally operated risk-adjustment program for insurance carriers. The Centers for Medicare and Medicaid Services has demonstrated its commitment to the program, having explored and then recently adopted modifications[1] designed to better predict high patient costs and fairly compensate carriers who have high-cost members. CMS must continue to monitor and measure the effectiveness of the risk-adjustment program, proposing evidence-based revisions to the methodology when the program falls short. This will not

[1] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CMS-9934-F-Fact-Sheet-12-16-16.pdf

only support stability in the market, but protect patients from sharp premium hikes.

b. Allow high-deductible, HSA-eligible plans to offer proven high-value services not subject to a deductible. Under current federal rules, only preventive services, rendered to a person without symptoms of the condition being prevented, may be offered outside the deductible if a plan is to remain HSA-eligible. Numerous studies have cited the adverse effects HSA-eligible plans, otherwise known as high-deductible health plans, have on low-income patients and those with chronic conditions, and the disproportionate effects because many may not have sufficient assets to meet the out-of-pocket requirements.[2] Patient affordability could be improved by revising the rule to permit, but not mandate, that "secondary preventive services" – selected, evidence-based services that prevent the progression of or complications arising from a chronic condition – be provided before the deductible, or with a deductible smaller than the minimum currently required under the definition of an HSA-eligible plan.[3]

c. Consider more flexibility in plan design with the introduction of a new minimum level of coverage, set at a lower actuarial value than the 60 percent to 90 percent actuarial values associated with the Bronze through Platinum plans. We also support the expansion of catastrophic coverage to consumers older than age 30 and income parameters currently allowed to purchase such coverage. We acknowledge these plans are not the best choice for every consumer and also urge that strong marketing and consumer education requirements specific to these plans be required by each state that chooses to permit such products in its market.

   We arrived at this position after carefully considering the insurance market in Oregon. To cover minimum benefit design costs and maintain adequate financial reserves, insurers respond by adjusting consumer premiums. While maintaining financial stability, ensuring access to required benefits, and keeping premiums affordable, Oregon commercial insurers lost $46 million in 2014, $171 million in 2015, and $2 million through the third quarter of 2016. Some insurers have elected to reduce coverage areas or exit the market to avoid additional losses.

d. Retool HealthCare.gov to allow small businesses to make direct contributions to employees' premium costs. Now that the 21st Century Cures Act allows workers' health premiums to be reimbursed by their small employers without penalty to the

[2] Health Policy Brief: High-Deductible Health Plans," Health Affairs, February 4, 2016. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=152

[3] http://vbidcenter.org/wp-content/uploads/2014/07/HDHP-white-paper_final.pdf

employer or tax on the employee, it is an appropriate time to facilitate these employer contributions through the enrollment portal, HealthCare.gov.

e. Increase price transparency, which is a critical tool to inform the public about health care costs in order to achieve a more efficient health care delivery system. Research has shown that when consumers clearly know and understand the price of a treatment and how much they will pay out of pocket before receiving care, it helps reduce costs in the long run. Further, the historical opacity of health care prices is widely believed to be a major factor driving inefficiency and in effect high health care costs. Transparency in provider and pharmaceutical pricing must occur to significantly drive down health care costs. Leadership on this matter at the federal level is imperative.

f. Increase the promotion of health outcomes as a central driver for health care pricing. Promoting increased use of alternative payments methodologies that incentivize value over volume is desired. While Oregon is moving away from fee-for-service (FFS) pricing, for the foreseeable future, a considerable amount of health care will likely continue to be paid this way. In the interim, promote greater use of the Medicare pricing methodology, which was established by the ACA and has curbed costs in Medicare. This provides a third-party reference point and is used extensively in the commercial market to level the playing field in negotiations of fee schedules and to develop contract pricing methodologies between health plans and providers for individual and group insurance. To address unjustified costs in the complex and often opaque pharmaceutical supply chain, we recommend tying prices and/or patents to health outcomes to recover the cost of government-sponsored research from profits and reinforce current trade laws and regulations to prevent egregious market manipulation. Ultimately, there needs to be fair and adequate reimbursement of goods and services that is commensurate with their contribution to positive health care outcomes.

Thank you for the opportunity to provide Oregon's perspective on health reform. We will be glad to continue this dialogue to ensure Oregonians have access to high quality and affordable health care.

Sincerely,

Patrick M. Allen
Director
Oregon Department of Consumer and Business Services