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The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
H-107, U.S. Capitol Building
Washington, D.C. 20515

Dear Representative McCarthy:

Last week, Oregon Gov. Kate Brown sent you a letter outlining Oregon's health reform vision and promised a follow-up correspondence from her cabinet. Before directly answering each of your questions, we want to make sure you know four of the many important improvements the Affordable Care Act (ACA) has made possible for Oregonians. The ACA has:

1. Increased access to quality affordable health insurance coverage for previously uninsured Oregonians.
2. Expanded health insurance benefits to require coverage of Essential Health Benefits.
3. Ensured that Oregonians with pre-existing conditions can obtain services.
4. Ensured that Oregonians through the age of 26 have insurance through their parents.

On behalf of the Oregon Health Authority (Oregon's Medicaid agency) and the Department of Consumer and Business Services (Oregon's insurance regulator and health insurance exchange administrator), we offer the following answers to your questions.

What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?

Increased premiums result from claims experience, adverse selection, and consumers' choice of richer plans. Even so, Oregon supports increased state flexibility to design benefits and coverage requirements to accommodate value-based insurance coverage.

The existing Essential Health Benefits rules mandate that states choose a benefit package from a limited number of existing health plans. These rules prevent states from developing new and innovative plans that could incentivize prevention and improve health outcomes through reduced or eliminated cost sharing for high-value services. We support continuing to ensure that all Americans have affordable access to essential health services. Also, we encourage providing flexibility to states to experiment with benefit designs that build on that access. Flexible plan design can help expand consumer choice while allowing insurers to moderate future premium increases.

Also, the required metal levels in the individual and small group commercial market may have kept insurers from offering more affordable plan designs. Therefore, we encourage Congress to give states more flexibility in actuarial value requirements. This includes the freedom to design our own levels of coverage and to expand catastrophic coverage to consumers in more age and income level brackets. To secure enhanced access to affordable health care, this flexibility should be accompanied with protections that ensure continued availability of higher levels of coverage and protections against adverse selection.

Oregon also recommends that Congress maintain federal regulations and guidance for mental health coverage, ensure continued support of preventive health services as established by the ACA, and continue to mandate coverage for pre-existing conditions. We support access to comprehensive and affordable health benefits for all, but encourage Congress to provide flexibility for states to build on benefit requirements in innovative ways. Without sacrificing access to comprehensive coverage, regulation of benefit requirements should be delegated to state regulators. These regulators have experience establishing consumer premiums and the most important benefits for the health of the population.

Last, the significant increase in pharmacy costs are a large part of rising heath care costs and are a national problem Congress should address. Egregious price increases drive up costs. Increased demand created by marketing and advertising of promised health improvements also contributes to rising health care costs. We suggest Congress explore solutions that tie prices and patents to health outcomes, recover the cost of government-sponsored research from profits, and reinforce current trade laws and regulations to prevent market manipulation.

What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?

Proposals should maintain coverage gains made by the ACA and serve to stabilize, not disrupt, the health insurance market. Specifically, key reforms should:

a. Avoid sudden, significant changes to the ACA framework that disrupt current coverage and care for Oregonians.

b. Take steps to ensure continuous, uninterrupted coverage for Oregonians who became newly eligible for Medicaid and who became newly insured in the commercial markets since Jan. 1, 2014.
c. Take steps to ensure continuous, uninterrupted coverage for Oregonians who became newly eligible for Medicaid and who became newly insured in the commercial markets since Jan. 1, 2014.
d. Fully fund ACA financial programs and fully compensate insurers who participated in these programs. This includes maintaining premium tax credits, making appropriations for permanent cost-sharing reductions, and ensuring that the federal government honors contractual commitments to make reinsurance and risk corridor payments for debts incurred through the end of 2016.
e. Offset the costs for low- and moderate-income individuals using a means-tested approach.
f. Maintain policies that encourage young and healthy people to enroll in coverage and incentives for all individuals to obtain and maintain coverage.
g. Provide states greater flexibility to innovate and manage our own markets. This includes establishing benefit benchmarks, plan characteristics, rating requirements, and other market reforms, as well as flexibility to set timelines for rates and forms in states with effective rate review systems.
h. Drive down the costs of health care without diminishing quality and coverage, consistent with Oregon's coordinated care model.

What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable.

Oregon has a long history of choosing innovative means to manage its Medicaid program. Like many states, we have faced health care costs that are increasingly unaffordable; cost growth that far outpaces the state's general fund revenue; and a system focused on volume, not value. Rather than attempting to decrease health care spending with a conventional approach (reducing provider payments, the number of people covered, or covered benefits), Oregon developed a coordinated care model for better efficiency, value, and health outcomes while simultaneously expanding Medicaid coverage. In line with Oregon's 1115 Medicaid demonstration waiver, this model is reducing the trend in statewide Medicaid per capita spending while improving access and quality. Expanded coverage and health delivery system reforms have yielded positive financial and health outcomes.

Oregon intends to build on its foundational reform elements, including its 25 years of experience using evidence to inform coverage decisions, and improve the way health care is delivered and paid for. Our state's coordinated care organizations (CCOs) are locally governed managed care organizations. These CCOs have produced significant improvements in the health care outcomes of enrolled Oregonians while holding cost growth to a 3.4 percent rate within an integrated services global budget since 2012. These results stem from the following:

a. Investing in patient-centered primary care

b. Providing preventive, upstream investments outside of the walls of medical clinics (transportation, housing supports, public health partnerships)
c. Integrating physical, behavioral, and oral health
d. Creating value-based payments that incentivize outcomes over service use
e. Investing in information technology, including electronic health records and health information exchanges that improve the delivery system's ability to coordinate care

Federal measures that would enhance Oregon's Medicaid performance include:

a. Removing federal barriers that interfere with effective and timely coordination of care between physical health providers and behavioral health providers, including 42 CFR Part 2
b. Providing greater flexibility to use capitation rates to allow for payment of services provided outside the walls of medical clinics, recognizing that health reflects where Oregonians live, work, learn, and play
c. Addressing the inherent conflicts in the Medicaid rate-setting methodology that may reward inefficiency by setting rates based on entities paying for use instead of health outcomes
d. Removing federal pharmacy price-setting protections and allowing state Medicaid programs to negotiate fair and rational prices
e. Continuing federal funding to develop an information technology infrastructure that facilitates accountable data exchange for care management and coordination
f. Expediting federal administrative review of Medicaid waivers and state plan amendments modeled on those already approved in other states
g. Reducing policy and program conflicts between the federally administered Medicare and Medicaid offices
h. Increasing participation in value-based, multi-payer collaboratives with a focus on performance metrics

Also, reducing federal funding for Medicaid, as proposed by capped-allotment and block-grant reforms, will harm Oregonians and roll back the progress Oregon has achieved. The current level of federal investment in Oregon's Medicaid program has been integral to our health care financing and delivery model success. This is especially true as it relates to the population covered by ACA's expansion, which includes most employed, low-income adults. Further, the economic impacts of reduced federal funding should be assessed.

Oregon's coordinated care model is successful in part due to the recent growth of the Medicaid program. With more covered lives, Oregon's CCOs can better achieve lower cost, higher value health care, and improved health outcomes for a larger population.

Proposals that reduce and cap federal Medicaid funding to states threaten the transformational work happening in states like Oregon in several ways. First, these

proposals would roll back coverage gains made in Oregon that have been critical to the transformative reforms of our coordinated care model.

Second, funding formulas that limit federal investment based on current or historical spending levels penalize states that have already limited growth in federal spending. These caps could also fail to account for differences between states or future growth trends that warrant differences in federal investment from state to state. Federal funding formulas should reward states that:

- Cover more people
- Drive broader health system transformations
- Improve health and limit health spending growth over time

Finally, the stable and predictable funding the Federal Medical Assistance Percentage provides is important for state decision making and for residents who rely on Medicaid. It encourages states to use innovative strategies to better deliver health care services to our residents, without motivating states to unnecessarily limit the scope of coverage provided to families who rely on Medicaid. Reducing federal investment would threaten coverage that is vital to more than a million Oregonians, many of whom are children. Further, it would inhibit the state's ability to ensure that Oregon's doctors, nurses, hospitals, and other health care providers are fairly compensated for the care they provide.

Oregon's Medicaid program already operates under a fixed rate of growth through a global budget while incentivizing performance and discouraging inefficiency by reducing reliance on the fee-for-service payment system.

What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?

Oregon recommends revising the affordability test that currently applies when a family who is eligible for employer-sponsored coverage seeks coverage on the Marketplace. Under current rules, employer-sponsored coverage is considered affordable for an entire family if the cost of "self-only" coverage for the employee does not exceed a fixed percentage of the family's household income. Because the test does not consider the extra premium that is charged for other family members, the test does not reflect the true cost of enrolling in the employer coverage. This means families are considered to have affordable employer-sponsored coverage available (and therefore are not eligible for premium tax credits through the Marketplace), even though the actual cost of enrolling in that coverage is beyond their means. This inequity, sometimes called the "family glitch," forces families to choose between paying the high cost of the employer plan or having some family members go uninsured. Establishing an affordability test that considers the true cost of employer coverage will give these families the ability to access affordable, subsidized individual Marketplace coverage.

We support this change because, according to a December 2016 report from the Department of Health and Human Services, "the average premium for Oregon families with employer coverage grew 4.5 percent per year from 2010-2015, compared with 7.5 percent over the previous decade. Assuming Oregon premiums grew in line with the national average in 2016, family premiums in Oregon are $3,500 lower today than if growth had matched the pre-ACA decade."

Oregon also supports a recently passed Congressional reform found in H.R. 34, allowing small employers to fund health reimbursement arrangements that employees may use to purchase individual health insurance coverage. Beginning on Jan. 1, 2017, a small employer with fewer than 50 employees can use this path to reimburse, on a tax-free basis, employees who purchase individual health coverage.

What key long-term reforms would improve affordability for patients?

Affordability of coverage and care and 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 (CMS) has demonstrated its commitment to the program by exploring and adopting 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 only support stability in the market, but also protect patients from sharp premium hikes.
b. Allow high-deductible, HSA-eligible plans to offer proven, high-value services without subjecting them to a deductible. Under current federal rules, only individuals without symptoms of a condition are eligible to receive preventive services outside the deductible if a plan is to remain HSA-eligible. Patient affordability could be improved by revising the rule to allow, 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.[2]
c. Update HealthCare.gov to facilitate the qualified small employer health reimbursement arrangements. Now that the 21st Century Cures Act allows workers' health premiums to be reimbursed by their small employers without penalty to the employer or tax on the employee, these employer contributions should be facilitated through HealthCare.gov

[1] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CMS-9934-F-Fact-Sheet-12-16-16.pdf
[2] http://vbidcenter.org/wp-content/uploads/2014/07/HDHP-white-paper_final.pdf

Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for State Innovation beginning January 1, 2017?

Oregon is exploring possible 1332 waiver options, specifically which types of health care initiatives Oregon wants to pursue that might require a 1332 waiver.

a. **If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?**

Oregon would not submit a coordinated (Section 1332 and Medicaid 1115) waiver for the 2017 benefit year.

b. **If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?**

We appreciate the efficiency of model waivers for expedited review, but do not expect to use one under current circumstances.

The CMS examples of model waivers from the Part D transition and Hurricane Katrina aftermath were well suited to those specific circumstances. States and the federal government have had several years to develop modifications or alternatives to some provisions of the Affordable Care Act and related health care laws. The current tools for implementing such modifications are suitable. Also, the cost savings and quality improvements spurred by waiver programs are often a result of the careful, state-specific customization of the program to match the resources and needs of the local community. Predesigned, expedited waivers preclude this valuable, in-depth customization.

c. If allowed, which requirements would your state seek to waive under a 1332 waiver?

Oregon is exploring possible 1332 waiver options, specifically which types of health care initiatives Oregon wants to pursue that might require a 1332 waiver. This analysis is being done under the current Affordable Care Act umbrella. Oregon does not have a specific list of provisions it wants to waive under the ACA and is being mindful that any developed list may change depending on changes to the ACA.

d. If allowed—and if applicable—what changes would be necessary to current guidance to accelerate your state's ability to pursue a 1332 waiver?

Oregon has been fortunate to have a successful Marketplace 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 to 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.

Also, the interpretation of budget neutrality required by the 1332 waiver guidance prevents Oregon from taking full advantage of the waiver program to advance its health care reform goals. Under current guidance, state innovations that would lead to more eligible Oregonians enrolling in coverage could be blocked simply because more people would be receiving the assistance they qualify for. Allowing the state to shift funds from one program to another does not create enough flexibility to accomplish Oregon's policy goals. Allowing Oregon to use a 1332 waiver to develop programs that connect more eligible Oregonians to affordable health coverage greatly increases the likelihood that Oregon would pursue one or more 1332 waivers.

As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changes to allow one?

A high-risk pool is not a substitution for the ACA's guaranteed issue individual market and its prohibition on pre-existing condition exclusions. In Oregon, the individual market covers more than 220,000 people while a high-risk pool can cover just a few thousand. Before the ACA, Oregon had a high-risk pool that offered coverage to individuals denied coverage in the commercial market. The availability of risk pool coverage was extremely beneficial to those who could enroll. However, the coverage was often subject to high deductibles and out-of-pocket maximums, as well as annual dollar limits. Despite subsidization by an assessment on all health insurers, premiums for risk pool coverage were frequently too high for those who otherwise qualified. Also, overall enrollment in the pool was small relative to the total number of uninsured Oregonians.

Although we have reservations about re-establishing a high-risk pool, we urge Congress to grant states the flexibility and appropriations allowing us to. Oregon would establish a high-risk pool structured as a backstop to address plan availability and coverage issues that Oregonians may face.

What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making changes?

Oregon endorses a robust and transparent process for form and rate review and supports the existing process established by the U.S. Department of Health and Human Services (HHS). Effective rate review states should be allowed to establish their own timelines for submission and review of rates and forms, with CMS setting the final deadline only for Federally-Facilitated Marketplace (FFM) states.

States should also be granted the flexibility to reopen filings to address a health insurance market emergency without being subject to year-round open enrollment.

The Oregon State Legislature convenes annually in February for a longer session in odd-numbered years and a shorter session in even-numbered years. The federal government should work to ensure any new regulations or notices are finalized months in advance of the Oregon State Legislature commencing. Also, proposed regulations and notices should be issued in a timeframe that provides states and other health care stakeholders sufficient time to review, comment (a minimum of 60-day comment period is appropriate in most cases), and implement.

Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?

Oregon adopted many of the ACA's interlocking reforms into state law. Most notable was the requirement that nongrandfathered individual and small employer health plans offer the essential health benefits, including specified preventive services at no cost to consumers. For the same groups, Oregon also adopted the ACA's reforms that banned underwriting based on pre-existing conditions and discrimination based on health status or claims experience.

Repeal may significantly disrupt Oregon's health insurance market. Since implementation of the ACA, the uninsured rate in Oregon has dropped nearly 60 percent, with more than 400,000 individuals gaining coverage.[3]

Without the ACA, many consumer protections and market reforms would be lost. Specifically, low- and moderate-income individuals would likely not be able to afford health coverage. By repealing the ACA's federal financial assistance to purchase affordable coverage through the Marketplace and help consumers pay for out-of-pocket costs, many Oregonians would not be able to afford necessary services. They would

[3] Impact of the Affordable Care Act in Oregon. HHS.gov. December 13, 2016. Retrieved from https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-oregon/index.html#.

likely delay care and end up using high-cost emergency services, as was common practice before the ACA.

By eliminating or reducing the coverage that is required under the essential health benefits, particularly the preventive services without consumer cost sharing, Oregonians would not be able to access the primary and preventive services that promote and preserve health. Rather, many Oregonians' health would deteriorate because they will not be able to access low-cost health care interventions or manage their chronic conditions. Women and families would have fewer resources to access the services they need for family planning and prevention of unintended pregnancies, or have coverage for prenatal and maternity services when needed.

Finally, commercial health insurance carriers could also experience solvency issues if the individual mandate and tax credits are repealed, but they still must offer coverage on a guaranteed issue basis that includes the robust coverage provided by the essential health benefits and with retention of modified community rating and actuarial standards. As stated earlier, consumers would no longer be able to afford or be incentivized to purchase coverage, leading to adverse selection and skyrocketing premiums.

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,

Lynne Saxton
Director
Oregon Health Authority

Patrick M. Allen
Director
Department of Consumer and Business Services

CC: Governor Kate Brown