

OREGON MEDICAID ADVISORY COMMITTEE
March 26, 2014
10:00am – 1:00pm
Portland State Office Building; Room 1E
800 NE Oregon St; Portland, OR 97232

MEMBERS IN ATTENDANCE: Karen Gaffney, Karen Berkowitz, Leslie Sutton, Kay Dickerson, Tom Turek
 Lenore Bijan, Romnee Auerbach, Carol Criswell

MEMBERS ABSENT: Janet Patin, Kristen Dillon, Rhonda Busek,

PHONE PARTICIPANTS:

PRESENTERS: Brian Nieuburt, OHA; Deborah Bachrach & Kinda Serafi, Manatt Health Solutions

STAFF: Oliver Droppers, Jeannette Nguyen-Johnson

VISITORS: Ellen Lowe, Katy King, Victoria Demchak, Lesa Dixon-Gray

TOPIC	Key Discussion Points	Follow-up Action	Responsible Party
Opening Remarks and Staff Update	Introduction and roll call. Staff reviewed the agenda and the list of topics to cover. Announcement made regarding Dr. Bruce Goldberg’s resignation from Oregon Health Authority (OHA).	NA	Co-Chair(s) & MAC staff
Approval of Minutes	The committee reviewed meeting minutes from February 26 th , 2014. A motion was made to approve the minutes. The motion was seconded; minutes were approved.	Post approved minutes	MAC
Churn Update	Oliver Droppers, MAC staff, reviewed the discussion and materials that have been covered to date regarding churn; the members had a general discussion regarding the subject.		Oliver Droppers, OHA; MAC
2014 Legislative Update	Brian Nieuburt, OHA, provided updates on the 2014 Legislative Session <ul style="list-style-type: none"> • Senate Bill 1526 – OHA to feasibility of using federal matching funds from the Children’s Health Improvement Program (CHIP) to subsidize commercial health insurance for children of families with incomes between 200 and 300% of the federal poverty level (FPL); report due to the Legislature in September 2014. • House Bill 4108 – Requires OHA to contract with non-profit organizations to operate a pilot project that would be used to provide durable medical equipment to Oregon Health Plan (OHP) recipients. • Senate Bill 1582 – Provides OHA the authority to use Oregon Medical Insurance Pool funds for the Temporary Medical Insurance Program. • Senate Bill 1579 – Requires both commercial health plans and Coordinated Care Organizations (CCOs) to adopt a synchronized policy for refilling prescription drugs. • House Bill 4013 – Originally disallowed pharmacists to submit Schedule II drugs in a non- 		Brian Nieuburt, OHA

	<p>emergency situation; has been amended to add a requirement that CCOs make their protocols available to pharmacists.</p> <ul style="list-style-type: none"> • Request from staff: Please speak to House Bill 4109. Response: This bill requires OHA to commission an independent study of the feasibility of operating a basic health program in Oregon. A report from the study is due to the legislature by November 30, 2014. • Comment from staff: Staff is currently working with public stakeholders to begin the RFP process to conduct the BHP study as required by HB 4109. 		
<p>Strategies to Mitigate disruptions as a Result of Churn</p>	<ul style="list-style-type: none"> • Deborah Bachrach and Kinda Serafi from Manatt Health Solutions, gave an overview of churn, its implications for individuals and families, and examined several solutions to mitigate churn’s effects. • Altogether, the committee examined seven different strategies. The first set of strategies are intended to mitigate disruptions as a result of churn (i.e. changes in benefits, premiums and cost sharing, provider network and plan; also the issue of different family members being enrolled in different plans), and included the Basic Health Program option, the Bridge Plan, benefit and/or out-of-pocket wraparound, and aligning benefits and provider network across the different coverage programs. • The second set of strategies are meant to reduce the number of times an individual moves from one coverage vehicle to another and minimize insurance gaps as individuals transition, ultimately reducing or avoiding churn. Strategies to support this goal included aligning income budget period rules, implementing adult 12 month continuous eligibility for Medicaid, and aligning coverage start and end dates by leveraging QHP enrollment rules. • A considerable number of individuals under the age of 65 will experience some change in their coverage from one year to the next; about 32% of individuals will experience a change within six months of enrolling; about 51% will experience a change within one year of enrolling; approximately 27% of Oregonians who are eligible for Medicaid may experience a change in eligibility within one year. • Kinda reviewed various examples of churn and cost-sharing when moving from Medicaid to a Marketplace coverage plan. • Q: Regarding having to change providers due when moving from one coverage vehicle to another (i.e. Medicaid to Marketplace coverage, and vice versa), do you have any idea of what those numbers might be? A: That data is not currently available, although there are pockets of information to help answer that question. The agency recognizes the importance of better understanding the level of alignment between the Medicaid and Marketplace delivery systems and is in the process of examining this issue. • Kinda provided an overview on the Basic Health Program (BHP). • Advantages of a BHP – Premiums and cost-sharing are lower than in a QHP and the 		<p>Deborah Bachrach and Kinda Serafi, Manatt Health Solutions</p>

	<p>benefits could be more robust; by reducing premiums, more people can get coverage; the transition when peoples’ incomes fluctuate is smoother because they may be able to stay with the same provider network</p> <ul style="list-style-type: none"> • Disadvantages of a BHP – The state only gets 95% of the premium tax credits and cost-sharing reductions, if that is not enough to purchase the BHP the state has the exposure; the state has to fund the start-up and all ongoing administrative costs; there is an affordability cliff at 200%; providers would have to be paid at a lower rate than a QHP • Bridge Plan – For example, in Oregon, a Medicaid coordinated care organization (CCO) that has been certified as a QHP would be permitted to limit their enrollment to consumers and family members transitioning from Medicaid to the Marketplace. • Q: If the Bridge Plan is the lowest cost plan won’t it have the highest deductibles and co-pays? A: No; for the individual at 150%, they are buying a high value silver plan and the cost sharing is limited to 6% of the cost of their health care expenses and the plan would pay the other 94%. • Advantages of a Bridge Plan – Plans and provider will stay the same for one year, reduced affordability cliff for one year, all family members can be put on the same plan. • Disadvantages of a Bridge Plan – It is limited to one year, there are administrative and systems complexity, there is also an equity issue. • A number of other churn mitigation strategies were reviewed. Please see slide deck for additional information. In general, committee members emphasized that any approach that was overly complex or administratively burdensome would likely not succeed. • Due to the volume and complexity of issues and strategies related to churn, the committee suggested that an additional meeting to review and consider the subject would be helpful before they make specific recommendations. 		
Public Comment	No public comment		
Closing Comments	The decision was made to have an additional meeting between the April and May meetings to continue to work on the issue of churn and strategies to mitigate its effects.		MAC
Adjourn	The meeting was adjourned at 1:00pm		Co-Chair(s)

**Next MAC meeting:
 April 23, 2014: 9-12pm
 General Services Building
 1225 SE Ferry St. Salem OR, 97301**