Health Care Market Oversight Program
Oregon Health Authority
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October 24, 2023

I am writing in **opposition** to the merger between CareOregon and SCAN. Tom Sincic raises excellent points in his letter of opposition. I offer additional points from a business management perspective.

In my main career I was Director of Primary Operations and Plant Manager for one of the mid-valley's largest employers. Subsequent to that I spent a decade as a management consultant and researcher in medical finance systems. I was a governor appointed member of the Oregon Task Force on Universal Health Care filling the designated task force seat for "Financial Management and Change Management."

I have witnessed many mergers. Again and again, I have watched as exciting promises of "economies of scale" and "synergies" eventually play out in acres upon acres of empty desks. The local phone number for the railroad now rings in Florida. Have a problem with your garbage bill? Call Arizona. Of all the major employers that used to provide vibrant economy in the mid-valley, only a small handful of employees remain. Decisions that used to be made in Corvallis and Albany are now made in Pittsburgh, Denver, Charlotte, Phoenix, and Houston. I challenge anyone to recall even one merger that increased local community involvement and local pride.

But my opposition to the CareOregon / SCAN merger is not about private mergers, it is about the critical importance of maintaining the credibility and integrity of public programs.

The Oregon Health Plan has a high calling in serving the health care needs of Medicaid patients. But it has one even higher calling, which is to preserve the confidence and trust of taxpayers and state residents who will decide whether to continue to support social programs like the Oregon Health Plan. Once lost, trust takes generations to recover, if it can be recovered at all.

A major component of trust in Medicaid programs is the clarity with which the state can account for, and regulate the use of public funds dedicated to the care of patients under Oregon's care. Financial mergers involving Oregon CCO's and private non-CCO entities defeat clarity of purpose and public trust.

a) CCO's were envisioned as quasi-government community organizations dedicated to public service. To see CCO's becoming involved in open market trading of access to government dollars as if such access were a private franchise to be bought and sold for personal benefit can only be viewed by the public as a subversion of their trusted role.

b) Like it or not, our current system pays providers a different amount depending on who the patient is. According to actuarial data from the Oregon Task Force on Universal Health Care, if the current average cost of providing service is $1.00, Medicaid pays $0.69, Medicare pays $0.81, and private insurance makes up the difference by paying $1.37. To break even, medical providers must carefully balance their patient load by limiting the number of slots available to Medicare and Medicaid patients. The multiple level payment system is a precarious balance that sort of works as long as everyone stays in their own lane.

Suppose that the public perceived that a clever private Medicare Advantage insurer could receive federal funds based on the expectation that they reimburse providers at $0.81 or greater on the dollar but they are actually reimbursing providers at the $0.69 rate and pocketing the difference. As a manager and consultant, I know of no way to completely prevent this appearance except for preventing entities expected to reimburse at different rates from operating under the same ownership.

Against the critical need for public programs to be solely accountable to the public interest, much of the public testimony submitted in favor of the merger appears weak.

1) Much of the testimony in support is provided by entities with a financial tie to CareOregon.

2) Much of the testimony is written in support of CareOregon as an organization and is not about the merger. These are actually endorsements that CareOregon should stay as it is.

3) Testimony which mentions the advantages of scale offer no suggestion of who and how this would benefit. Medicaid and Medicare Advantage programs operate under different rules. One must take all patients, the other is a managed risk pool designed to seek some patients and repel others. There should not be economies of scale on the "insurance" side because prudence of clarity requires that they have no interoperability, lest one take advantage of the other. And if there is some advantage to CareOregon by allowing SCAN Medicare Advantage patients to access CareOregon's clinical care programs, this can be accomplished through regular contracting, without requiring a rather complex change in ownership.

4) Testimony touting that that the merger would provide an ability for "the little guy" (SCAN) to get a leg up on the major Medicare Advantage players in Oregon is puzzling and somewhat troubling if accurate. Who pays for this competitive edge for SCAN? How does the state justify the use of its programs to favor one private Medicare Advantage company over another? Even if it might be a good idea, how does the state draw a line in its market interventions?

5) Testimony suggesting that CareOregon's future could be made more stable by a merger with an external Medicare Advantage insurer should be taken with caution. The MA market is not stable and congress may soon be forced to take away the federal overpayments which are currently fueling the Medicare Advantage profits. A more prudent move for CareOregon (and the interests of the state) is not to get involved in external ventures which could turn risky.

6) If there is some unspecified problem with Oregon's CCO program such that CareOregon feels the need to enter into this or any other merger to solve the problem, a better solution would be to solve the problem within the CCO program.

7) At just four to five months of reserves compared to average monthly expenditures, CareOregon is not particularly healthy by the standards used by most businesses and non-profits. Decisions based on the assumption that they have excess cash to play with are not well grounded.

a. Ownership of the reserves is a complex and controversial issue. But at present, the existing reserves are fully available for the contingent benefit of the patients of the CCO. Withdrawing a portion of the reserves and dispersing the money for some other purpose, no matter whether popular, diminishes the current CCO reserves.

b. Regardless of the above arguments, CCO's in Oregon did receive windfall additions to their reserves during the pandemic, and the CCO's and the state are in negotiations to determine how that money should be paid back or what other purposes the money can be spent on. So, the subject of the use of CCO reserves is currently tied up in policy discussion which might result in legislation or other action which could affect how CCO funds can be used.

Preserving credible perception of singularity of public purpose is vital to the continued support of OHP and CCO's by Oregonians whose financial and legislative backing is necessary. Oregon seems at a crossroad of an experiment to allow CCO's to intermix into other speculative markets. These new relationships will be much harder to audit and regulate. Once the experiment is exposed to be detrimental, is will be almost impossible to reverse.

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