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Date: February 7, 2014 (Revised February 10, 2014)

To: Chair Laurie Monnes Anderson, Senator Elizabeth Steiner Hayward, Members of the Senate Committee on Health Care and Human Services

From: Janet Bauer, Policy Analyst

Re: SB 1526: To Require the Oregon Health Authority to Request Federal Approval to Use CHIP Funds to Subsidize Commercial Health Insurance

Thank you for the opportunity to comment on SB 1526, a bill to require the Oregon Health Authority (OHA) to request federal approval to use Children's Health Insurance Program (CHIP) funds to subsidize commercial health insurance for children with household incomes between 200 to 300 percent of the federal poverty level. The bill's chief sponsor, Sen. Steiner Hayward, has expressed the intention to amend the bill to expand the eligible group to children between 138 and 300 percent of the federal poverty level.

According to the Oregon Health Authority, the introduced bill would impact approximately 7,800 children formerly served by Healthy Kids Connect who are now in the Oregon Health Plan.[1] They report the amendment would affect an estimated 70,000 children between 138 and 200 percent of the federal poverty level who would be eligible for the Oregon Health Plan.

The bill and its potential amendment raise a number of concerns which have yet to be examined. Accordingly, we respectfully urge the legislature to take ample time to consider the ramifications of operating a subsidized commercial medical assistance program.

This memo outlines our initial thinking on SB 1526.

Potential Benefits

Allowing OHP-eligible children to participate in commercial coverage could have some benefits to Oregon children and families, as described below.

Expanded access to providers. Where commercial plans have different provider networks than a local CCO, a commercial option could expand the choice of providers for children. Without further analysis we cannot say how provider networks in CCOs generally compare with that of commercial plans. Without further information, we don't know to what extent lack of access to providers will be an issue for OHP kids as compared to their expected experience in a commercial plan.

[1] OCPP telephone conversation with Courtney Westling,, February 6, 2014.

Noting that Medicaid coverage is more protective for the most costly services including outpatient therapies, the proposal likely would either leave OHP-eligible children with subsidized health coverage that is on the whole inferior to what they would have in OHP, or require the state to additionally subsidize the purchase of enhanced commercial plans that are of comparable quality to OHP.

Budget implications. Legislative staff is correct that HHS would likely require a subsidized commercial option to be budget neutral for the federal government. No additional CHIP funds would be available. Should Oregon chose to additionally subsidize the purchase of commercial plans to protect children from the risks associated with a skimpier plan, such a choice would have important budget implications for the state.

Equity and efficiency. Even if Oregon did not provide additional subsidies for the purchase of enhanced commercial plans, it is likely that Oregon would spend more per child in subsidizing a commercial product than it would to provide OHP coverage. This difference would grow, should CCOs continue to improve their efficiency over commercial plans.

Differences in per child spending raises questions about the equitable and efficient use of public resources, important matters that need legislative consideration.

Adverse selection. The risk of adverse selection may not be acute if the eligible group is relatively small, for instance if restricted to the 7,800 children between 200 and 300 percent of the federal poverty level. Should a subsidized QHP be available to many more children as would be the case under the bill as it may be amended, adverse selection would be a concern for the following reason.

Because OHP offers more generous coverage for some costly services, sicker children will be less likely to take up a commercial option unless Oregon were to provide additional subsidies to equalize the coverage packages. In the event Oregon does not equalize the coverage package, OHP will inevitably care for a sicker group of children — giving rise to adverse selection and higher costs to the Medicaid program.

The problem of adverse selection may be exacerbated if the benefit design of commercial products is more attractive to healthier kids. For instance, if a commercial plan offers a sports medicine clinic while a CCO does not, healthier children may be more likely to comprise the pool of children selecting the commercial product than they are the group in OHP.

Both these circumstances for potential adverse selection raise concerns about costs, the need for risk-adjusted subsidies and equity among the groups.