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Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

Dear Co-Chairs and Committee Members:

Please find below some additional information requested at the meeting of the Joint Ways and Means Human Services Sub-Committee on March 7, 2023.

What lessons have we learned from the COVID-19 response?

SB 1554 (2022) called for a comprehensive study of Oregon's public health system's COVID-19 pandemic response. OHA contracted with a neutral third-party to prepare the first of three legislatively mandated reports, which focuses on the government-led and government-funded public health systems response.

Key findings by the contractor were:

- "Prior to 2020, Oregon's public health system was critically underfunded. Efforts to modernize the system by increasing state resources to rebuild the public health system from 2017-2020 were laudable but inadequate. Sustained state funding is necessary to rebuild the public health system and recover from the strains on the system caused by the COVID-19 pandemic.

- "As of the week of July 31, 2022, OHA recorded 860,300 COVID-19 cases in Oregon. There were 34,376 hospitalizations (4%), and 8,291 people died. The COVID-19 case rate peaked at 1,332.3 during the week of January 10, 2022. It is evident that COVID-19 exacerbated already existing health inequities in the state of Oregon. In particular, Tribal Nations and communities of color were impacted by the COVID-19 pandemic disproportionately in comparison to White communities.

- "Health equity was a central focus in Oregon's public health system response to the COVID-19 pandemic. Study participants noted they were highly motivated to center equity in pandemic response efforts and were aligned in naming that the central elements of an equitable pandemic response are equitable access to information and equitable access to resources. LPHAs [local public health authorities] and CBOs [community-based organizations] were seen as invaluable resources in the response.

- "Throughout the pandemic, some state-level primary response agencies in Oregon struggled to collaborate in coordinating the response and defining leadership roles and authorities. The lack of role clarity between the Oregon Health Authority and the Oregon Department of Emergency Management likely led to confusion early on in the pandemic. Issues arising from this confusion affected the overall response but directly impacted Local Public Health Authorities and City and County Emergency Management.

- "Enforcement of public health mandates was inconsistent across Oregon, especially after Stage 1 of the pandemic when the politicization of the response effort took root, and a widespread misinformation campaign marred the compliance landscape. Interviews with State Agencies, Health Care Associations, LPHAs, and City, County, and Tribal Emergency Management highlight pandemic-response inconsistencies across Oregon, not only in enforcing public health mandates but also in other areas of the pandemic. They raised concerns that the localized decision-making of LPHAs created responses that put politics over health. Multiple State Agencies worked together to enforce public health mandates. While laudable, this structure led to confusion and gaps in enforcement."

The full report is available here: https://www.oregon.gov/oha/covid19/Documents/OR-PH-Response-COVID.pdf.

How is All Payer All Claims (APAC) data used to identify people who are dual-covered by Oregon Health Plan and other insurance, to avoid overpayment by OHP?

Identifying people who are dual-covered is not a use identified in statute for APAC data. However, there are other mechanisms for addressing the same issue.

The Office of Payment Accuracy and Recovery (OPAR) works to, among other things, determine when a third party is legally liable for some or all medical expenses paid by Medicaid. OPAR is located within ODHS, but serves both ODHS and OHA as part of Shared Services.

Within OPAR, the Health Insurance Group (HIG) collects information about insurers to make sure that insurers are billed for medical expenses before Medicaid. The HIG identifies or is made aware of Third-Party Liability (TPL) insurance through a web-based referral process. Referrals are received from Medicaid clients, CCOs, providers, pharmacies, eligibility workers and case workers to report other health insurance for Medicaid clients. Eligibility workers also have the ability to enter TPL information into the ONE system. HIG also uses a contractor to perform data matching of our Medicaid eligibility file against their nationwide TPL database.

Once the HIG receives such information, OPAR's Medical Payment Recovery Unit seeks reimbursement from insurers that should have paid before Medicaid.

Who are the 4.6% of the population who remain without health coverage?

Individuals in Oregon without health coverage vary greatly, but overall this population has some general patterns as follows (all figures as of 2021):

- Age: 8.4% of people ages 19 to 34 years old were uninsured, compared with 6% of people ages 35 to 64 years old. Only 1.7% of children and teens 18 years old and younger were uninsured, and 0.9% of adults age 65 and older (as they are generally covered by Medicare).

- Employment status: Uninsurance was highest among people who were unemployed (13.9%) compared to uninsurance rates of 10.2% among self-employed people, 5.2% among employed people, and 2.5% of people who were out of the labor force.

- Race and ethnicity: Among Native Hawaiian or Other Pacific Islander people, 12.6%* were uninsured. Uninsurance rates among Middle Eastern or North African and Latino/a/x groups of people were slightly lower, 11.7%* and 11.5% respectively. 9.4% of American Indian and Alaska Native people in Oregon were uninsured, and 4.7% of Black or African American people were uninsured. Uninsurance rates for White and Asian people were lower than the statewide rate at 3.5% and 2.5% respectively.
  - * = May be statistically unreliable due to small numbers; interpret with caution.
  - These rates of uninsurance use the rarest race methodology for determining a primary race when multiple races were selected.

- Geographic area: By geographic area, 7.7% of people living in Frontier areas were uninsured compared to 5.4% in rural areas and 3.9% in urban areas.

- Family income and poverty level: For families with annual incomes less than 138% of the federal poverty level, 6.7% were uninsured. 5.1% of families with incomes between 138% and 400% of the federal poverty level were uninsured and 3.1% of families with incomes over 400% of the federal poverty level were uninsured.

Please do not hesitate to reach out if you have any further questions or clarifications.

Sincerely,

David Baden
Chief Financial Officer