PacificSource

February 22, 2026

Senator Deb Patterson, Chair
Senator Cedric Hayden, Vice-Chair
Oregon Legislative Assembly
Senate Committee on Health Care
900 Court St. NE
Salem, OR 97309

Delivered via OLIS.

Re: Support for House Bill 4039A; Section-by-Section Analysis

Chair Patterson, Vice-Chair Hayden, and Members of the Committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, and Marion & Polk Counties. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write to express strong support for House Bill 4039A. This product is the result of months of negotiation with the Oregon Health Authority (”agency”) to arrive at a bill which we believe addresses the concerns of both the agency and of interested parties. This bill took great pains to identify process improvements that could augment the duties and capabilities of the agency without requiring new programs, people or expenditures. While we found it difficult to delete sections, we believe we arrived at a good compromise for a short session bill.

Our testimony today will focus on giving the committee a section-by-section analysis of the bill, and where appropriate discuss provisions that ultimately were removed from the bill.

Section 2: Section 2 of the bill addresses the core data and transparency measures that are central to fixing the issues we experienced in the current Medicaid rate setting process. We will go over this section in more detail.

- *Paragraph (2)(a)* requires the agency to reconcile the data it possesses on utilization, claims, and other information with data that individual CCOs maintain. This reconciliation of data will help the agency better understand what is happening in the CCO regions, so that rates can better reflect the realities of health care in the communities we serve. It is important to note that nothing about this paragraph authorizes the agency to widely share all the data it receives with all CCOs. We believe that the contractual relationship the agency maintains with CCOs,

together with this new section, can be read together to not allow information sharing between CCOs.

- *Paragraph (2)(b)* of the base bill places an affirmative duty on the agency to disclose how much it believes a new contractual change will cost the Medicaid system. We have asked for this provision because we think that contractual changes that require expenditures of resources, hiring of staff, and other administrative activities have not been clearly made known to system partners. We agree with the agency that this section was not intended require an exacting estimate down to the penny, so we have agreed to amend this section in the -1 amendment to limit the pricing to "material" cost impacts. Material is an actuarial term used by the Actuarial Standards Board that generally means "*an item or a combination of related items is material if its omission or misstatement could influence a decision of an intended user."*[1] Thus, "material" contract changes should already be instrumental in developing actuarially sound rates.

- *Paragraph (2)(c)* Related to the reconciliation provisions in paragraph (2)(a), paragraph (2)(e) of the base bill directs the agency to develop a list of outlier trends derived from its data. For instance, a high number of behavioral health utilization claims might indicate a trend affecting the Medicaid system statewide and understanding that information can help system partners like CCOs make informed decisions in the contracting process. Similarly, we do not believe this provision requires the agency to share data from one CCO to all CCOs widely.

- *Paragraph (2)(d)* of the base bill requires the agency to give the public 90 days' notice when it alters the fee-for-service fee schedule. The fee schedule is the list of reimbursements that the state directly pays to providers who see members enrolled in the fee-for-service component of Medicaid. Because the schedule is relatively stable and public, providers and payers alike tend to use it as a reference point for negotiations. However, the downside to this approach is that when the fee schedule does change, it automatically changes contracts between CCOs and providers. We think sufficient notice as a matter of normal course will help parties account for changes to the schedule. In the House the bill was amended that curtails the normal 90-day period for non-discretionary changes to the fee schedule when necessary. This change should provide the agency with a "relief valve" if the agency itself is required to change the schedule.

- *Paragraph (2)(e)* directs the agency to make timely reports to the Oregon Health Policy Board on its progress in setting capitation rates under section 2 of the bill as amended. The phrase "timely" allows the agency to determine when in the rate setting process is the most appropriate time to apprise the board on its progress, but before rates are finalized.

Section 3: This provision simply applies these changes to the process for plan years beginning on January 1, 2027. We recognize the rapid turnaround from bill to process by this bill, but the system needs to have greater confidence in the outcome as soon as possible.

Section 4: Section 4 is simply a conforming change to take into account the effect of the new transparency provisions on rate setting and the establishment of CCOs global budgets.

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[1] *See* Actuarial Standards Board, ASOP No. 1, *Materiality* (available at https://www.actuarialstandardsboard.org/glossary/materiality/)

Section 5: Section 5 from the base bill creates an enhanced fiscal impact statement applicable to the Medicaid system. Under the Administrative Procedures Act, agencies like OHA must develop a "statement of fiscal impact identifying state agencies, units of local government and the public that may be economically affected by the adoption, amendment or repeal of the rule and an estimate of that economic impact on state agencies, units of local government and the public."[2]

This section takes that existing legal requirement a step further, and mirrors a provision in law that requires housing cost impact statements on the cost of rules affecting the construction of a 1,500 square foot single family home.[3] The adoption of administrative rules can impart fiscal impacts on providers and other system partners - not to mention CCOs - and this provision should ensure the system is being good stewards of public resources.

We believe that impacts on the "medical assistance program" include the agency as well as system partners in the coordinated care model that make up the program.

Several provisions were removed from the base bill in the House:

- The base bill would have barred the agency from relying on opaque and proprietary assumptions or actuarial models when developing Medicaid rates. A crucial problem we experienced with the rate setting process as written in statute was that by using proprietary models, our own actuaries could not duplicate the mathematical results that were informed by the agency's vendor and its proprietary algorithms. We have been told that this transparency measure will require new contracts and higher fees, thereby initiating a fiscal impact statement. Because we are unable to independently discern whether this exclusion would have a fiscal impact, we agreed to remove this provision for the sake of preserving the bill.

  We do believe that in future sessions the Assembly will need to determine if Medicaid rate setting should be conducted behind closed doors.

- The base bill would have allowed CCOs to calculate its Medicaid medical loss ratio on a three-year average. The Medicaid medical loss ratio directs managed Medicaid organizations to spend at least 85% on medical claims. But due to the cyclical nature of health care, some years may see CCOs spend 90% or more on care, and less than 85% in other years. The three-year average would smooth out these fluctuations, providing stability for CCO finances. Unfortunately, we learned that federal regulation does not allow this approach. We remain open and committed to figuring out how to smooth out fluctuations in utilization and add stability in future sessions without running afoul of federal regulation.

- The base bill called for establishing an independent commission to examine and make recommendations to the Assembly on process improvements to the Medicaid rate setting process, added at the behest of the agency. We agree that the commission's work would be invaluable, but in this budget environment we could not risk this bill's passage with a commission that would likely impart a fiscal impact. We do look forward

[2] ORS 183.335(2)(a)(E)
[3] ORS 183.530-183.538.

to working with the agency in the future on some alternative framework that would examine the process for further efficiencies.

- The base bill would have created a process for the Oregon Health Policy Board to create a path for the public and interested parties outside of the CCOs to have visibility into the rate setting process and an opportunity to comment on the agency's preliminary decisions. The House removed that provision in lieu of timely reporting to the Board by the agency on the rate development process.

- The base bill would have extended the time CCOs have to decide whether to sign a contract from 14 days to 30 days, a net increase of 16 days. In the House, the agency offered to move the date on which restated contracts go out by 7 extra days, so we agreed to remove the statutory extension.

- The base bill would have initiated a pause on "major initiatives," or new rules, programs or contractual requirements requiring the Medicaid system (not just the state) expend $1 million or more. The sections exempted new program requirements from state statute or applicable federal law.

- The base bill proposed a three-year pause on the application of the SHARE program. SHARE, or "Supporting Health for All through REinvestment,"[4] is a program derived from a provision in law that requires CCOs expend a portion of the annual net income or reserves exceeding those necessary under law on health disparities and social determinants of health. While we believe that during a difficult Medicaid budget environment a pause was warranted, we were unable to reach an agreement with the agency.

We hope this information is helpful as you deliberate passage of the bill. We ask for your support in enacting these common sense, transparent reforms to the Medicaid rate setting process.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations

[4] https://www.oregon.gov/oha/hpa/dsi-tc/pages/share.aspx