# Oregon Health Policy Board

## Oregon Health Authority

# Public Employers Health Purchasing Committee
# Report and Recommendations

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# Public Employers Health Purchasing Committee
# 2010 Report to the Oregon Health Policy Board

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## Executive Summary

The Public Employers Health Purchasing Committee ("Committee") was established by the 2009 Oregon Legislature as part of House Bill 2009 to identify and recommend strategies to align purchasing policies and standards to the Oregon Health Policy Board, as well as foster collaboration across public employers and other interested health care purchasers.

The Committee views as its primary focus determining the best strategies to encourage implementation of policy concepts from a practical and operational perspective – our work is the link between policy development and management implementation. As such, the Committee is dependent on receiving recommendations from other Oregon Health Policy Board committees (as well as other organizations) to use as a starting point for our efforts. This report represents the initial work of the committee as some of the recommendations from other committees were received too late to be considered; these will be taken up for further discussion and potential endorsement next year.

The Committee developed two approaches to recommendations – one for benefit or coverage-related changes and the other for contracting (insurance carrier and provider) related changes. With respect to county, city, special districts and private employers, it is important to recognize that adoption of any recommendation is voluntary – in many cases, changes must be approved by governing bodies of elected officials who also have collective bargaining agreements controlling health benefit design and administration to consider.

In this report, the Committee:

- Supports the broad adoption of uniform standards for the electronic exchange of information between providers and carriers, and recommends that employers encourage their carriers or third-party administrators to participate and support the work of the Administrative Simplification technical work group;
- Endorses contract provisions relating to patient safety similar to those used by PEBB/OEBB, and recommends that public and private employers in Oregon discuss with their carriers or third-party administrator including patient safety standards in their contracts;
- Endorses standardizing payment methods (but not rates) to Medicare, and recognized that legislation may be required to accomplish standardization; however, the committee did not recommend endorsing legislation at this time. Should legislation be introduced at a later time, the Committee may choose to take action at that point.

Next year will be an active one as the Committee considers recommendations from other committees and works to develop contract language that can implement the Board's policy directives. The Committee appreciates the opportunity to work towards meaningful health care reform and is looking forward to addressing the challenges that lie ahead.

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## I. Background

Legislative Direction and Charter

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Public Employer Health Purchasing Committee ("Committee") to identify and recommend strategies to align purchasing policies and standards, as well as foster collaboration, across public employers and other interested health care purchasers. Working with the OHPB and relevant committees of the Board, the Committee is developing strategies for disseminating and incorporating uniform quality, cost and efficiency standards and/or model contract terms for use by health care purchasing programs of the state, and for voluntary adoption by local governments and private sector entities. These standards are to be based on the best available clinical evidence, recognized best practices and demonstrated cost-effectiveness for health promotion and disease management. The Committee is working in conjunction with other Oregon Health Authority programs to commission evidenced-based reviews with the Center for Evidenced-Based Policy at Oregon Health Sciences University that will be used in their work.

During its first year, the Committee met six times and heard presentations and/or recommendations on the following topics:

- The market penetration of public purchasers in local and regional health care markets in Oregon;
- Quality measurement and reporting efforts in Oregon;
- Comparative effectiveness research and evidenced-based practice guidelines;
- Patient safety;
- Federal health care reform and its impact on Oregon's initiatives; and
- The work of other OHPB committees and implications for the Committee.

This report represents the initial work of the Committee – some of the recommendations directed to the Committee by other committees were received too late to be fully considered by the Committee and will be taken up for further discussion and potential endorsement next year.

Committee members include representatives from: Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), Public Employees Retirement Systems (PERS), city governments, county governments, special districts, and statewide health care purchasers' organizations. Committee members represent organizations that purchase benefits for as few as 25 people to well over 140,000 people.

*A full roster is included as Appendix A.*

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Purchasing Power of Public Employers

To create the system of world class health and health care for all Oregonians as envisioned by the OHPB, the state must align and coordinate its purchasing power to reach a sufficient critical mass to move the marketplace. Public entities in Oregon purchase one-third of the health benefits for insured people under 65 — this includes the people enrolled in Oregon Health Authority programs (Medicaid, Children's Health Insurance Program, Family Health Insurance Assistance Program, and Oregon Medical Insurance Pool) in addition to state employees, Oregon school employees and local government employees, as well as family dependents within those groups. In some regions, especially smaller and more rural areas, the percentage climbs to almost 50 percent.

**Regional Summary of Impact of Public Purchasers on Insured Market in Oregon -- 2009**

| **Region *(Counties)*** | **State** | **OEBB** | **Local Govt.** | **Total** | **Insured Pop. Under 65** | **Percent Pene-tration** |
|---|---|---|---|---|---|---|
| Northwest Oregon *(Clackamas, Multnomah, Washington, Clatsop, Columbia, Hood River, Tillamook, Yamhill)* | 235,042 | 55,555 | 81,774 | 373,371 | 1,409,566 | 26.4% |
| Salem Area *(Marion, Polk)* | 99,825 | 20,867 | 15,246 | 135,938 | 275,400 | 49.4% |
| Mid-Valley *(Benton, Linn, Lincoln)* | 45,161 | 10,181 | 9,405 | 64,747 | 173,402 | 37.3% |
| Southern Willamette Valley *(Lane, Douglas, Coos)* | 88,736 | 19,083 | 22,354 | 130,173 | 360,345 | 36.1% |
| Southern Oregon *(Jackson, Josephine, Curry)* | 51,339 | 6,288 | 8,455 | 66,082 | 206,143 | 32.1% |
| Central Oregon *(Deschutes, Crook, Jefferson)* | 27,546 | 10,208 | 7,597 | 45,351 | 150,329 | 30.2% |
| Mid-*Columbia (Gilliam, Morrow, Sherman, Umatilla, Wasco, Wheeler)* | 22,454 | 7,494 | 4,847 | 34,795 | 77,889 | 44.7% |
| Southeast Oregon *(Grant, Harney, Klamath, Lake)* | 16,268 | 4,653 | 5,797 | 26,718 | 59,735 | 44.7% |
| Northeast Oregon *(Baker, Malheur, Union, Wallowa)* | 17,101 | 4,488 | 5,552 | 27,141 | 54,287 | 50.0% |
| **State Totals** | **608,976** | **142,966** | **161,027** | **912,969** | **2,767,094** | **33.0%** |

*The full summary is included as Appendix B.*

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***Notes about chart:***

- The "State" category includes Medicaid, Children's Health Insurance Program (CHIP), the Family Health Insurance Assistance Program (FHIAP), Oregon Medical Insurance Pool (OMIP), and Public Employees Benefit Board (PEBB) employees and dependents.
- "OEBB" is the Oregon Educators Benefit Board, and includes employees and dependents.
- "Local Government" is from the Oregon Employment Department, subtracting education figures if they were included.
- "Insured Population Under 65" is from the Populations Research Center at Portland State University.
- "Percent Penetration" is the "Total" divided by "Insured Population Under 65"

<u>The Contracting Process for Public Employers</u>

While the purchasing power of public employers and the programs administered by the Oregon Health Authority is significant, it is important to understand that each of these different government entities operates and administers health benefits under vastly different circumstances. To illustrate these variations, the staff surveyed Committee members about the contracting processes of their organizations. Six questions were asked:

- *What is the effective date of your plan year* – four are in January, the rest spread over June-October.
- *When is your open enrollment date* – One is in May-June; one in June-July; two in July; one in August-September; one in October; two in October-November; one in November; and one in June and December.
- *How long does open enrollment last* – One is 3-4 weeks; six are 30 days; one is 5 weeks; one is 45 days; and one is 60 days.
- *When do you begin considering any changes in benefit designs for the next plan year* – Two are 6 months prior to the plan year effective date; three are 6-9 months prior; one is 11-12 months prior; three are 12 months prior; and one is 2-3 years (finalized 9 months prior).
- *On average, when do you complete contract negotiations with your carrier/TPA (benefit design changes, administrative fees, etc…) for the next plan year* – One is 1 day before plan year; one is 1-2 months prior; two are 3 months prior; one is 3-4 months prior; three are 5-6 months prior; one is 6-9 months prior; and two are 7-8 months prior.
- *The last time you issued an RFP for medical coverage/administration (either insured or self-insured), how many months did you plan on from the date of issue of the RFP to concluding the negotiations with the successful bidder* – One is 5 months prior; two are 6 months prior; one is 9 months prior; one is 9-12 months prior; two are 12 months prior; two are 18 months prior; and one did not issue RFPs.

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A key finding of this survey is that it will take significant time for any changes to work through the system because of the lead time required to incorporate changes into benefit designs and contracts. Many public employers have collective bargaining arrangements where specific health benefits are negotiated. This may have an impact on whether public employers, other than those that are a part of the Oregon Health Authority, can readily adopt measures supported by the Committee and the Board.

However, opportunities do exist to use the purchasing power of public employers to move the marketplace because of the dual nature of the contracting process. Public purchasers typically contract with insurance companies or third-party administrators (TPA). The insurance company/TPAs then contract with providers and hospitals. If a large public purchaser (or several aligned purchasers) requires certain items – like quality or patient safety measures – in their contracts with the insurance company, the company will work to incorporate them in their contracts with the providers. These provider contracts apply to all clients who purchase policies through the insurance company, not just public purchasers.

## II. Committee Endorsements and Potential Contracting Language Recommendations

The Committee recognized that while the Oregon Health Policy Board can have a more direct impact on Oregon Health Authority purchasing standards, with respect to county, city, special districts and private employers, the adoption of any recommendations is voluntary. These groups often have governing bodies of elected officials, and in many cases, collective bargaining arrangements that control health benefit design and administration. The Committee believes that it is important to honor these local decision-making processes, as well as understand the time it might take to work through these processes.

The Committee developed two approaches to recommendations – one for benefit or coverage-related changes, the other for contracting (carrier and provider) related changes – and used an Action and Transmittal form when considering recommendation.

*Benefit-Related Recommendations*
These issues are what the Committee called "member/employee facing" in that they directly impact members/employees through what is covered, cost-sharing provisions, and conditions or limitations on coverage. They must be treated with sensitivity; in some cases, they may be viewed as a "benefit take-away" by members. They may also increase short-term costs.

Here is the benefit-related recommendation template adopted by the Committee:

> *The Public Employer Health Purchasing Committee of the Oregon Health Policy Board has <u>reviewed</u> the attached benefit design proposal, and <u>recommends consideration</u> of this proposal by public and private employers during their annual review and modification of medical benefit package.*

At the local purchaser level, these types of issues must be considered as one part of a number of environmental factors, such as: current benefit design(s), current premium costs and anticipated annual premium increases, collective bargaining framework, and the fiscal situation of the local government entity.

*Contract-Related Recommendations*

These issues are what the Committee called "carrier or provider system facing". These types of provisions may apply to the contract between the purchaser and the health insurance company/TPA, or between the insurance company and the providers.

This is the contract-related recommendation template adopted by the Committee:

> *The Public Employer Health Purchasing Committee of the Oregon Health Policy Board has endorsed the attached contract standard, and recommends that public and private employers discuss this provision with their carrier or third party administrator for inclusion in their contract.*

Administrative Simplification Recommendations

The Committee received a policy proposal from the Administrative Simplification Work Group at the September 27 meeting. The following is a summary of that proposal:

- A public-private technical work group will develop companion guides for the electronic exchange of: a) eligibility verification (by December 2010); b) claims (by July 2011); and c) remittance advices (by January 2012).
- DCBS will adopt administrative rules directing all carriers to implement the companion guides by April 2011 (eligibility verification); October 2011 (claims); and July 2012 (remittance advices) respectively.
- DCBS will seek statutory authority from the 2011 Oregon Legislative Assembly to extend the required use of such companion guides to third-party administrators and clearinghouses not currently under DCBS jurisdiction.

The Committee supported the development of uniform standards for the electronic exchange of information, and approved the following recommendation at the Oct. 25, 2010 meeting.

> *The Public Employers Health Purchasing Committee supports the broad adoption of uniform standards for the electronic exchange of information between providers and carriers. The Committee recommends that public and private employers in Oregon encourage their carriers or third-party administrators to participate in and support the work of the technical work group.*

The Committee did not want to endorse or recommend standards that have not been developed yet, and will consider taking additional action when the draft companion guides are developed and ready for rule-making by the Department of Consumer & Business Services.

*The Action and Transmittal Form, as well as background materials, are included as Appendix C.*

Patient Safety Recommendations

At its May 24 meeting, the Committee heard a presentation on the work of the Patient Safety Commission from Executive Director Jim Dameron and a report from PEBB/OEBB Administrator Joan Kapowich on the patient safety contract provisions being included in the 2010 and 2011 contracts with their insurance companies and TPAs. The following is a summary of those contract provisions:

- CMS Hospital Acquired Conditions (HACs);
- Oregon Patient Safety Commission hospital reporting;
- Oregon Patient Safety Commission hospital surgical checklist;
- Oregon Association of Hospitals & Health Systems non-payment of serious adverse events;
- Oregon Patient Safety Commission adverse events reporting for non-hospital facilities;
- List of "never events" that define "serious adverse events"; and
- Bariatric surgery guidelines (applicable when bariatric surgery is a covered benefit).

The Committee approved the following recommendation at the Oct. 25, 2010 meeting.

> *The Public Employers Health Purchasing Committee endorses contract provisions relating to patient safety similar to those used by PEBB/OEBB, and recommends that public and private employers in Oregon discuss with their carriers or third-party administrator including patient safety standards in their contracts.*

*The Action and Transmittal Form, as well as background materials (including sample contract language), are included as Appendix D.*

Standardized Payment Methodology Recommendations

The Committee heard an initial presentation on Sept. 27 on the work of the Incentives and Outcomes Committee from Dr. Jeanene Smith, administrator of the Office for Oregon Health Policy and Research. At the next meeting in October, Dr. Smith provided the Committee with the draft recommendations of the Incentives and Outcomes Committee. The Committee took action on one of the recommendations that related to standardized payment methodologies – a subject of conversation at prior Committee meetings. Since the recommendation from the

Incentives and Outcomes Committee had not yet received final action from the Oregon Health Policy Board, our Committee voted to send a letter of endorsement to the Board. A summary of that letter follows:

- By unanimous vote, the Committee endorsed Recommendation #1: Standardize payment methods (but not rates) to Medicare, and recognized that legislation may be required to accomplish standardization; should legislation be introduced at a later time, the Committee may choose to take action at that point.
- Furthermore, the Committee supports an implementation plan for this recommendation that begins with the development of a standardized, statewide Diagnostic-Related Group (DRG) methodology for reimbursement of hospital impatient services at DRG hospitals.

The absence of action on the remaining recommendations from the Incentives and Outcomes Committee does not indicate a lack of support for those recommendations. Rather our Committee did not have time to fully address those issues before our report was due. In addition, some of the remaining recommendations require more guidance as to implementation strategies before the Committee feels they can take action.

Health Improvement Plan Recommendations

The Committee received draft recommendations from the Health Improvement Plan (HIP) Committee during the summer and these were presented at the Sept. 27 meeting. A summary of the policy proposal is as follows:

- Model health care benefits provided by all employers include:
  - Tobacco cessation
  - Lactation services and equipment
  - Preventive screenings
  - Chronic disease self-management programs
  - Mental health care
  - Dental care

At the Oct. 25 meeting, the Committee decided to pend action on these recommendations until early 2011 in part because they had not yet been presented to the Board for final action. Committee members, while supportive of the intent of HIP recommendations, also had reservations about endorsing specific wellness or disease management programs, and wanted an opportunity to ask questions of the HIP committee staff. Scheduling conflicts prevented this from happening at the October meeting.

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The Committee approved the following action at the Oct. 25, 2010 meeting.

> *The Public Employers Health Purchasing Committee pended the draft policy proposal from the Health Improvement Plan (HIP) Committee awaiting action by the Oregon Health Policy Board on the final report of the HIP Committee.*

*The Action and Transmittal Form, as well as background materials are included as Appendix E.*

## III. Distribution of Committee Endorsements and Recommendations

After acceptance of this *Report* by the Oregon Health Policy Board, the recommendations will be distributed to a wide range organizations and associations, including but not limited to:

- Public employer organizations, such as:
  - Association of Oregon Counties,
  - League of Oregon Cities, and
  - Special Districts Association of Oregon.
- Public employee unions, such as:
  - SEIU,
  - AFSCME, and
  - IAFF
- Labor-Management Trusts and/or Labor-Management Benefit Committees
- Business organizations, such as:
  - Oregon Business Council,
  - Associated Oregon Industries,
  - Oregon Business Association,
  - Portland Business Alliance,
  - National Federation of Independent Businesses
- Oregon Coalition of Health Care Purchasers
- Oregon Health Leadership Council
- Oregon's 100 largest employers
- Major health insurance companies and third-party administrators (TPAs)

The *Report* will also be posted to our website, as will the work of the Committee developed over the coming months.
http://www.oregon.gov/OHA/OHPB/committees/pub-hlt-bn-prch.shtml

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## IV. Development of Educational Materials for Public Employers

At the first meeting of the Committee in March 2010, it became clear to our members that they would need a slide presentation or other kinds of educational materials to use with their respective boards, councils, commissioners and employees to explain the kinds of changes and reforms that were being contemplated both at a federal level and by the Board. The Committee requested staff develop a draft presentation, but staff quickly realized that the task was bigger than something for use only by the Committee.

A significant and strategic communications effort is needed on multiple fronts to help the public understand both what the changes are to our health system and why they are needed (to make coverage affordable, control cost increases, and to improve health). Efforts are also needed to help people become better consumers of health care. Both public and private sector employers can help with all of these activities, but the State must develop simple and understandable tools for them to use. Several national examples exist and will provide a template with which to create unique tools for Oregon. Our Committee staff will continue to work with Oregon Health Authority communications professionals to develop these materials.

## V. Next Steps

The Public Employers Health Purchasing Committee is somewhat different than other committees of the Board, although our success depends heavily on their work. We realize that our work is really just beginning as recommendations from other committees, workgroups and taskforces receive final action from the Oregon Health Policy Board. We see our work as determining the best strategies to encourage implementation of policy concepts from a practical and operational perspective – the link between policy development and management implementation.

Over the coming months we will continue to develop recommendations and contract language based on the Committee's ongoing work and the work of other committees and the Board. Some of the areas that will be addressed:

- Value-based benefits;
- Health information technology (HIT) "meaningful use" standards;
- Additional payment and quality recommendations from the Incentives and Outcomes Committee;
- Health Improvement Plan Committee recommendations;
- Health Equity Policy Review Committee recommendations relating to health disparities and inequities;
- Workforce Committee recommendations; and
- Evidence-based best practice guidelines.

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The Committee will develop a collaborative process to help foster the broad implementation of uniform purchasing standards and policies by both public and private sector employers. There is a vast wealth of experience and expertise on the Committee, and we have only begun to scratch the surface in terms using their collective knowledge of strategy development and implementation around health care issues.

Understanding local health care markets, and the variations between local markets, will be critical as the Committee moves forward with its work. We will work collaboratively with the Office for Oregon Health Policy and Research (OHPR) to analyze these markets using tools being developed by the Board such as the All-Payer All-Claims database and the Oregon Scorecard.

We will produce, at least bi-annually, a report recommending topics for investigation and study by the Board and its committees, or commissions and forums operating under the auspices of the Oregon Health Authority.

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