

Oregon Health Policy Board

AGENDA

October 12, 2010

Legacy Emanuel Medical Center

Lorenzen Center

2801 N. Gantenbein Ave.

8:30 am to 4:30 pm

AUDIO only will be live web streamed

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call Consent agenda: 8/10/10 and 9/14/10 minutes Comprehensive Plan Update	Chair	X
2	8:35	Director's Report	Bruce Goldberg	
3	9:15	Report on Public Forums and summary of public input on Health Insurance Exchange, Comprehensive Plan and Board agenda	Jeremy Vandehey	
4	9:45	Actuarial Comparison of OHA and HLC Value-Based Benefit Packages	Jeanene Smith	
	10:00	Break		
5	10:15	Draft Recommendations from the Incentives and Outcomes Committee -Quality/Efficiency -Payment Reform	Committee Co-Chairs and staff	
	noon	Lunch		
6	1:00	Publicly-Owned Health Insurance Plan: Strategic Options	Bill Kramer	
7	2:00	<i>Public Testimony on the Publicly-Owned Health Insurance Plan and the Health Insurance Exchange</i>	Public	
	2:20	Break		
8	2:30	Future health planning and the Exchange	Eric Parsons Bruce Goldberg	
9	3:30	Options for Health Insurance Exchange	Staff	X
10	4:15	<i>General Public Testimony</i>	Public	
11	4:30	Adjourn		

Upcoming

Two November meetings, both in the Market Square Bldg., 9th floor, 1515 SW 5th Ave., Portland

November 9th, 8:30 am to 1 pm

November 16th, 8:30 am to 1 pm

Oregon Health Policy Board
DRAFT Minutes
August 10, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
8:30am - noon

Item

Welcome and call to order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, with Felisa Hagins joining by phone. Nita Werner joined by phone at 10 am. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda –

Minutes from July 13, 2010 meeting

The June 8, 2010 minutes were reviewed. It was noted that Tammy Bray's name was misspelled. Final minutes will be posted on the web.

Update on the Comprehensive Plan

The update has been transmitted to the Board.

HITOC Strategic Plan Executive Summary

The HITOC strategic plan has been approved by Dr. Goldberg, but he provided the report to the Board to elicit their comments. The report must be turned in by August 19, 2010, so comments must be made soon.

- ↪ The Board asked that, if it was possible, the report specifically mention that providers may be eligible for some incentives and to give a timeline of when those incentives become available.

All items on the consent agenda were approved by unanimous voice vote.

Director's Report – Bruce Goldberg, MD

- Action in OHA has lately revolved around federal reform and budget issues, as well as continuing to split DHS and OHA.
- Overview of the state budget for the next ten years: this will clearly point to what is known and what needs work as OHA strives for affordability, value and cost containment.
 - ❖ If spending continues at the same rate it has been, there will be a \$2.5 billion budget deficit.
 - ❖ As we progress to 2017-2019, human services spending will increase from 25% of the General Fund budget to 32%. Causes of this are aging population and healthcare costs that outpace inflation. Federal legislation will affect this to an extent, but that extent is not yet known.
 - ❖ In the 2009-2011 budget, the Legislature counted on \$.16 billion in one-time funds. This revenue will not be available in the next biennium.
 - ❖ Dr. Goldberg provided a chart showing budget projections through the 2017-2019 budget.
 - ❖ State revenues are not keeping pace with expenditures. There were several sources of one-time funding that supported the 2009-2011 budget that will not be available in 2011-2013. We will need to find alternatives to continued state spending at 9% growth when state revenues are expected to grow at only 3%.
- Overview of Federal healthcare reform specific to Oregon, showing where opportunities are becoming available and where there are holes
 - ❖ Individual Mandate, federal requirements on large (50+ FTE) employers, coverage through Medicaid and the exchange, and federal small employer tax credit – what will these mean for Oregon?
 - ❖ 2013 – still 600,000 uninsured Oregonians
 - ❖ 2015 – big jump in Medicaid numbers that will continue until 2019. The exchange will have approximately 190,000 participants and will grow to up to 360,000 in 2019.

- ❖ 2019 – uninsured Oregonians will drop to 290,000
- ❖ These numbers include only Oregonians who are under 65
- ❖ Coverage of uninsured Oregonians in 2019 – 35% will remain uninsured, 26% will be covered by Medicaid, 22% will be covered in the exchange, 12% will be insured under a group or an employer, and 4% will be covered individually
- ❖ Tina Edwards noted that Oregon is the second highest state for expected Medicaid growth under the new federal standards.
- ❖ Of the Oregonians who will remain uninsured, 24% will be exempt due to low income, 42% will ignore the mandate, 32% will be undocumented aliens, and 60% will be under the age of 34. Massachusetts chose to offer this young population a different product to entice them to buy in.
- ❖ There will be losses in employer-based coverage out into 2019.
- ❖ Annual financial effect – modeling assumes some increase in wages as employers get tax credits and get relief from what they're currently spending on healthcare, assuming employers give the extra money back to employees. There will be an increase in taxes to pay for this.
- ❖ The Board asked what the major drivers in the shift to the exchange are. Dr. Goldberg answered that the subsidy level will bring people in, as it will be affordable to them. Affordability will make the exchange successful.

Administrative Simplification Recommendations – Tina Edlund

- The workgroup's task was to look at approaches to reduce the administrative costs of healthcare
- Recommendation 1 – Department of Consumer and Business Services (DCBS) should adopt uniform HIPAA guides
- Recommendation 2 – all health plans should be required to conduct administrative transactions electronically
- Recommendation 3 – DCBS should be authorized to implement these plans with third party administrators or clearing houses
- The workgroup worked with the Oregon Medical Association (OMA) to identify small practices and how they would be impacted by administrative simplification.
- Action steps for implementation:
 - ❖ Make sure future workgroups have a broad stakeholder representation
 - ❖ As the first next step, the workgroup should look at prior authorization, referrals and plain language billing
 - ❖ Develop metrics so that savings can be qualified
 - ❖ Explore what kind of mechanisms will convert administrative savings into premiums saving for consumers
 - ❖ Oregon Office for Health Information Technology will develop an implementation plan that addresses issues particular to small medical practices
 - ❖ Workgroup will provide quarterly updates to the Board on the progress of the implementation

Public Testimony

John Bauman – Slocum Orthopedics

Mr. Bauman encouraged the Board to include worker's compensation in the scope of administrative simplification. He also encouraged the Board to eliminate coordination of benefits provisions.

Chris Apgar – Chair of the Oregon and SW Washington Healthcare, Privacy and Security Forum

Mr. Apgar discussed administrative simplification documents that were created in 2003 in Oregon. He expressed frustration that the Board has ignored those documents, despite his requests to consider them. He would appreciate more communication from OHA letting people know that the decision is not yet final about administrative simplification. He also asked whether providers other than medical doctors were consulted.

Martha Perez

Ms. Perez encouraged the Board to support the expansion of Medicare bill being voted on by Congress

and asked the Board to ensure that state healthcare laws match up with federal laws.

Dr. Goldberg responded to the concerns raised in public comment.

- Worker's Compensation – Something that can be discussed as part of the rule-making and implementation of administrative simplification. NO one will be in a position today to recommend inclusion or non-inclusion, but it is certainly something that needs to be considered as we move forward.
- Regarding adoption of the workgroup recommendations – Nothing does become final until it is adopted by the Board, and we appreciate that comment and will work to communicate more clearly.
- Regarding choosing the Minnesota Plan – The workgroup chose the Minnesota Plan because the companion documents are ready to go now and the workgroup felt that by aligning with Minnesota, we are aligning with emerging standards.

The Board commented on the recommendations.

- The Board stressed the importance of looking at this as a living document and that metrics must be developed so that we can determine if the simplification is functioning as we want it to. The quarterly updates to the Board should include these metrics.
- The Board specifically requested a metric that measures cost savings to both consumers and providers.

The Board unanimously approved the Administrative Simplification Recommendations.

➤ Dr. Goldberg will have the first report to Board in November.

Building Oregon's Health Insurance Exchange: DRAFT Recommendations – Barney Speight and Nora Leibowitz

- The Chair asked for as much public comment on the Exchange as possible, either at a meeting or as written testimony submitted to the Board in person or via e-mail
- Barney and Nora presented goals for Oregon's Exchange
 - ❖ Facilitate access to coverage
 - ❖ Simplify
 - Health plan designs and rules
 - Plan enrollment
 - State health insurance regulation
 - ❖ Change the way health services are provided/paid for
 - ❖ Contain costs where possible

This presentation can be found here, starting on page 21: [Building Oregon's Health Insurance Exchange](#)

- The Board asked if the young adult catastrophic plan (YAP) was offered only inside the Exchange. Barney answered that if the YAP is available only in the Exchange, an undocumented immigrant who fits the age requirement couldn't get the YAP. YAPs could be provided outside the Exchange to those who don't otherwise qualify.
- The Board expressed concern that if we aren't explicitly clear now what the mission is, we won't have a way to pull back future members of the board to keep accountability and get to the vision. Barney agreed that it's important to lay out exactly what the intent of the Legislature is when they create this entity.
- The Board pointed out that the public corporation structure allows an organization great flexibility and is an asset. They argued for very broad qualifications for board membership, with the concern that specific membership qualifications may cause various organizations to expect to have memberships on the board, which then creates coalitions or voting blocks.
- The Board remarked that in order to transform the delivery system and reduce the cost, we need to have an Exchange that is a whole market vehicle instead of a dual vehicle. This will allow us to shift how we think about and deliver health care. Can an Exchange with a single market reduce cost? Barney replied that the Exchange can do that, but in some of the areas, if there's a parallel

market to the Exchange, there is the ability to have simultaneous impact in policy areas on the regulation of the insurance characters in general. Can Oregon, through its purchasing power in the Exchange and regulation policies, enact changes in the market outside the Exchange?

- ↩ Dr. Goldberg remarked that this is a substantive question that will come back and asked for some background to frame this issue provided in a written format to the Board.
- The Board emphasized that delivery system reform and cost containment need to be fundamental parts of the Exchange. Nora stated that staff have a strong sense that the exchange is going to be a great tool in creating change.
- The Board is concerned with adverse selection. As time goes on, will payers look to minimize their exposure in the exchange by going outside it?
- Barney said that the survivability of the Exchange will be tested for 36 months and that the cost is vital. The Exchange needs to reach a level where people inside pay the same as people outside and get the same quality of care.
- The Board noted that Healthy Kids is a sort of mini exchange, but that though all insurers are eligible, not all are participating. When we create the main Exchange and invite insurers to participate, can we require insurers who participate in one area, such as Health Kids, to participate in all areas?
- The Board commented that other subcommittees are working on joint contracting standards to drive changes, and we may miss an opportunity if we don't think about how to line up the exchange's purchasing standards with the work of the other committees to drive those changes in the delivery system.
- ↩ The Board asked that issue prioritization and timelines on actions need from the Board be provided.

Public Testimony

Dr. Thomas Clark

Dr. Clark works in telemedicine and expressed concern that patients in the exchange might have problems working with doctors in other states.

Tom Eversole

Mr. Eversole requested that the governance of the exchange contain a majority of consumers who purchase their insurance through the exchange. This creates quality assurance.

Break

A Public Option Within Oregon's Health Insurance Exchange: Laying out the strategic decisions – Bill Kramer

- The chair noted that the point of this presentation is to determine what questions the Board should be asking before the discussion of the public option is started by the Board and the public
- Bill presented the Board with information about the public option
 - ❖ History
 - ❖ What makes a health plan a "public plan"?
 - ❖ Some assumptions about a publicly-owned health insurance plan
 - ❖ Opponents' arguments against a publicly-owned health insurance plan
 - ❖ Key strategic issues
 - ❖ Organization and governance options
 - ❖ How much will this cost?
 - ❖ Elements of the business plan
 - ❖ Decisions for the Board – Preliminary list

This presentation can be found here, starting on page 52: [A Publicly-Owned Health Insurance Plan](#)

- The Board stated that the public option plan must be looked at as a business. What do we need to do to achieve superior value?
- The Board asked if we could use federal reform funds to cover the start up costs of the public option? Bill answered that since the public plan wasn't included in federal health care reform, we

need to be creative in how we use federal funds to do this work. Although a co-op was offered as a substitute for the public option in the federal bill, the public option as we are attempting create it is not a co-op.

- The Board asked about merging OHP and Public Employees Benefit Board (PEBB), which are not currently plans on their own; they contract with providers. If we opened them up to the public, are we allowed to make changes, or would that require legislation? Bill answered that to formally merge them, legislative action would be required. There might be some options on things we could do administratively, such as shared administrative services, that wouldn't require legislative action.

Public Testimony

Mike Huntington – Oregon Physicians for National Health, Corvallis

Mr. Huntington stated that the public plan would be the only plan driven by public inclusion and public good. He proposes that if we are to achieve our goal of increased health, the public plan is a necessity and must be a dominant plan. The incentive of private insurance to avoid risk, creates an unlevel playing field for Oregonians.

Liz Baxter – Archimedes Movement

Ms. Baxter urged the Board to consider co-ops in the emerging structure of health care in Oregon. She also said that public option is not the right term to use. We need to brand this as we take it on the road. If we're going to build a publicly owned health plan, we need to know what it is, how we're going to carry it out, and what its objectives should be.

Betty Johnson – Chair, Midvalley Health Care Advocates

Since 1991, Midvalley Health Care Advocates have been involved in advocating health care for all. This public option plan has to have a mission of public interest as its number one goal. The plan must have superior value, quality, access and outstanding customer service. Changing the delivery system is vital.

Tom Eversole

Mr. Eversole requested that the Board consider requested that the Board consider insuring all public employees through the public option plan. The plan should align accountability and resources in an effective way. If the public option is framed as the last resort, it will not succeed.

Next Steps for Public Input on Health Insurance Exchange, Public Option and the Comprehensive Plan – Jeremy Vandehey

- Jeremy presented information about options for public input and information.
- 08/13/10 – All public plan materials will be posted on-line
- 08/13/10-08/17/10 – Public should e-mail comments to the Board
- 09/1/10-09/16/10 – Community forums will be held in Baker, Bend, Corvallis, Florence, Medford and Portland
- 09/01/10 – Interactive web tool will be launched
- September 2010-October 2010 – The Board will review public input
- 10/12/10 – Recap of input; the Board will give direction to staff
- Dr. Goldberg reminded everyone that public comment is earnestly solicited. Meetings are very full and the ability for public comment is limited, so e-mail is recommended.

Adjourn 12:17 p.m.

Next meeting:

September 14, 2010

1:00-1:15pm

Teleconference Line: 877-455-8688

Participant Code: 915042

**Oregon Health Policy Board
DRAFT Minutes
September 15, 2010
Via Teleconference Call
1:00-1:15pm**

Item

Welcome and call to order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members participated by phone except, Eileen Brady and Felisa Hagins. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda –

Review of OHPB Agenda Schedule, October 2010 – January 2011

All items on the consent agenda were approved by unanimous voice vote.

Adjourn 1:12 p.m.

Next meeting:

October 12, 2010

8:30am – 4:30pm

Legacy Emanuel Hospital, Lorenzen Auditorium

2801 N Gantenbein Avenue

Portland, OR 97227

Oregon Health Policy Board Agenda Schedule (October 2010 to January 2011)	
Month	Board Role
October 12th, 8:30 - 5:00, Legacy Emanuel Medical Center, Portland	
Summary of public input from forums	Informational
Actuarial comparison of value-based benefit package to HLC VBBP.	Review
DRAFT Recommendations -- Incentives and Outcomes Committee (Quality/Efficiency, Payment Reform)	Review/amend core measures and payment reform methodologies. Review Committee strategy and principles. Review/amend payment reform plan/methodologies.
Public Plan Alternatives	Review, endorse/amend.
Discussion of health insurance exchange policy options.	Review, endorse policy options.
November 9th, 8:30 - 1:00, Market Square Building	
Workforce Committee DRAFT recommendations	Review/amend recommendations.
Medical Liability DRAFT Recommendations	Review/amend recommendations.
DRAFT Comprehensive Plan	Review/amend recommendations.
Final business plan for a health insurance exchange and public plan	Review/endorse/amend recommendations
DRAFT recommendations from Health Improvement Plan Committee	Review and endorse/amend HIP Committee recommendations
November 16th, 8:30 - 1:00, Market Square Building	
Draft Public Employers Health Purchasing Committee recommendations	Review/amend
Final recommendations for Value-Based Benefit Package	Review/amend/adopt
HITOC recommendations	Review/amend recommendations.
Final recommendations from Ins and Outs Committee	Review and endorse/amend recommendations
December	
Final recommendations from Workforce Committee	Review/amend recommendations.
Final recommendations from PEHPC	Review and endorse/amend recommendations
Final recommendations from Medical Liability Task Force	Review/amend recommendations.
Final recommendations from Health Improvement Plan Committee	Review/amend recommendations.

Submit Final Business Plan for an Exchange including a public plan	Approve plan for submission to legislature.
Submit Final Comprehensive Plan	Approve plan for submission to legislature.
Legislative Preview	Informational.
January 2011 [FULL DAY]	
RETREAT	
Review 11-13 Revenue Forecast	
2011-2013 Strategic Plan	

Subject to Change

**Oregon Health Policy Board
Oregon's Blueprint for Health**

Working Outline
October 11, 2010

I. Introduction

- OHPB vision for a healthy Oregon
- Overview of strategic direction
- Oregon scorecard in the triple aim format
- Assuring equity throughout reform activities
- Strategies to bend the cost curve
- Capitalizing on federal reform opportunities

II. Action Steps to Achieve a Healthy Oregon

A. Ensuring healthy people in healthy communities

Overview Vision/Strategic Direction/Timeline

- Improve educational attainment
- Reduce obesity and tobacco use
- Stimulate system innovation and integration

B. Transform health care delivery to improve health outcomes, reduce health disparities, and control costs

Overview Vision/Strategic Direction/Timeline

- Quality & payment reform
- Workforce
- Administrative simplification
- Health information exchange
- Medical liability

Subject to Change

C. Ensure that all Oregonians have equitable access to affordable health care

Overview Vision/Strategic Direction/Timeline

Health insurance exchange

Publicly owned health insurance plan

Value-based benefit design

Successful implementation insurance expansions

Access to care for all oregonians

III. Integrating the Reform Components to Achieve the Triple Aim

This section will focus on strategies to integrate reform components across the health authority and community partners, including uniform contracting standards for health insurance purchasing by public employers and coordination across community-level activities.

Appendix: Links to supporting documents

Administrative Simplification Report

Health Information Exchange Strategic Plan

Health Insurance Exchange Recommendations

Healthcare Workforce Committee Report

Incentives and Outcomes Committee Report

Medical Liability Task Force Report

Patient-Centered Primary Care Standards

Public Employers Health Purchasing Committee Report

Publicly Owned Health Insurance Plan Recommendations

Statewide Health Improvement Plan

**Director's Report to
Oregon Health Policy Board
August 10, 2010**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Federal Health Reforms

As I indicated in an email to you last week, new protections for children began on Sept. 23rd:

- Children can no longer be denied coverage because of a pre-existing condition.
 - Guaranteed issue for children without a mandate has prompted some carriers to stop offering child-only coverage on the individual market. In Oregon, that includes Regence BlueCross BlueShield, Lifewise and Health Net.
- No cost sharing for preventive services.
- Young adults may stay on parents' plan up to the age of 26.

I will have more of an update on this at the meeting, as some of the issues regarding the interface with Healthy Kids is changing rapidly.

Healthy Kids Update

Enrollment (see attached chart):

- Through August, Healthy Kids has enrolled 56,631 children.
- Healthy KidsConnect enrollment is about 2,300 through September.
- This increase is a 22% increase over the baseline (June 2009) and 71% of the goal of 80,000 kids.

Marketing:

- New media buy placed statewide, which includes billboards, radio, print, online and advertising in shopping malls.
- Ads in movie theaters will appear later this month and run through the holiday season.
- Limited TV buy will be placed after the election season, when availability increases and cost decreases.

Outreach:

- Continue to work with schools and other community partners to promote Healthy Kids.
- Held an outreach conference in September attended by 120 grantees, assisters and other community partners.

Internal Systems

- Streamlined and improved application has been finalized and will roll out in November.
- Working with eligibility staff on training plan to make sure policy changes are implemented consistently statewide.
- Began Express Lane Eligibility (ELE) with SNAP (food stamps) data last month.
- Will also use ELE with free and reduced lunch applications from willing school districts at the end of the year.
- Working on improved redetermination process expected to roll out later this fall.

OHP Standard

- Enrollment in OHP Standard is now approximately **40,000** and a total enrollment in all OHP/Medicaid programs is 551,316.
- Since October 2009, **164,324** individuals have signed up for the OHP Standard reservation list.
- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- DHS has done eleven random drawings to date and has completed nine random drawings to date where applications have been mailed; the next drawing will be October 20, 2010 for 20,000 names. Given the number of drawings, the list is now much lower and we are again doing outreach to re-populate it.

Board Committee Progress Reports for October 2010

(Attached)

Rather than send these out once a month, I will begin sending them to you within a week of the meeting.

Insurance Rate Filings

I am attaching a spreadsheet that contains two worksheets providing the following information:

- 2010 rate filings (3rd quarter filings highlighted in red) for small employer coverage (SEHI 2010)
- 2010 rate filings (3rd quarter filings highlighted in red) for individual coverage (Indiv 2010)

I will continue to provide these updates following each quarter. You will notice there are not a lot of new filings approved in the 3rd quarter. We expect more action in the 4th quarter.

Board Committee Progress Reports for October 2010

Healthcare Workforce Committee

Next meeting: 1-4 pm on September 29, 2010, Portland

Portland State Office Building, 800 NE Oregon Street, Room 1E-70

The Healthcare Workforce Committee met on August 18th.

Recent Committee decisions and agreements

- Over its June and July meetings, the Committee agreed upon its three immediate priorities and some initial recommendations for each priority. Those priorities are:
 - preparing the current and future workforce for new models of care delivery;
 - increasing the size and capacity of the primary care workforce to help meet the anticipated increase in demand for health care services; and
 - strengthening the healthcare workforce pipeline to ensure that Oregon has enough health care workers with the right training in the right places.

Issue areas discussed

- The primary goal of the August meeting was to identify concrete action steps for each of the Committee's initial recommendations. Committee members divided into groups to develop action steps within three priority areas.
- Committee members also discussed the following as probable points of connection with other advisory Committees:
 - Contractual arrangements regarding student medical liability between educational institutions and clinical training sites (Medical Liability Taskforce);
 - Developing appropriate reimbursement mechanisms for emerging healthcare professions and roles (Payment Reform Subcommittee of the Incentives & Outcomes Committee);
 - Public health workforce recommendations from the Health Improvement Plan Committee;
 - Developing the information technology capacity of the healthcare workforce (HITOC).

Points of agreement and areas for continued discussion

- While there was general agreement on action steps in several areas, Committee members felt that continued conversation was needed.
 - For example, there was general agreement that it would be desirable to standardize student background requirements for clinical training across institutions (e.g. TB testing, criminal history check, etc.). However, recommendations for how to get all parties to come to agreement on the requirements are still under discussion.

Next steps for the Committee

- Further refinement and specification of action steps will continue at the September meeting. Health Policy Board Co-Chairs and OHA leadership have asked the Committee to be clearer about its ultimate goals and to demonstrate how its initial recommendations will move the state along a transformative path to a Triple Aim-oriented system. They have also asked the Committee to be bold and creative, and to suggest reforms for payment policies and scope of practice when they believe the reforms will be helpful. Committee members will respond to these requests in September and October.

Health Incentives & Outcomes Committee

Next meetings:

- **Full Committee will meet following the October 12 presentation of draft recommendations to the Health Policy Board, location and time TBD.**
- **NOTE: Subcommittee meetings previously scheduled for October 14 have been cancelled.**

The two subcommittees of the Incentives & Outcomes Committee met separately on September 9. The full committee met on September 22.

Issue areas discussed:

- At their August and September meetings, Quality & Efficiency Subcommittee members discussed preliminary ideas from the Payment Reform side of the Committee and specific quality and efficiency topics that might provide focus for those reforms. Both groups identified a number of structural, process and outcome measures relevant to each priority topic.
- The committee now has a side-by-side table that lines up the priority conditions and procedures identified by both subcommittees and staff.
- At its August and September meetings, the Payment Reform Subcommittee discussed reports from three workgroups that are assisting staff to develop payment reform concepts to support improvement of the primary care, specialty care, and hospital components of the health care delivery system and agreed on recommendations that will be made to the full committee.
- At the full Committee meeting on September 22, Committee members discussed a straw presentation of joint Committee recommendations that linked the proposals emerging from the two Subcommittees.

Points of agreement

- Five major points of agreement/recommendation emerged from Committee discussion:
 - Standardize payment method—not price—to Medicare for hospital inpatient and outpatient, ambulatory surgical centers, and physician and professional services.

- Move forward decisively on primary care redesign: Adopt Oregon Patient Centered Primary Care Home (PCPCH) standards as the model for Oregon and implement them across the board, in the sense that these are the standards that everyone uses, recognizing that not all payers will pay for primary care homes immediately and practices will progress at varying rates through levels of performance.
- Experiment with different payment incentives or methodologies (P4P, episode bundles, gain-sharing schemes, etc.): encourage pilots that have critical mass of participation, use consistent metrics aligned with Medicare and Oregon standards, and that are well evaluated.
- Focus measurement and payment efforts in areas where the potential for improvement is greatest: areas of high variation, large cost impact, and significant defects in quality of care.
- Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.
- For each point above, members agreed that the following are central to do:
 - Build the business case for why we're doing the activity
 - Outline detailed implementation steps and processes
 - Identify data collection and evaluation needs so that the Board and state can see if the projected business case is playing out and non-financial impacts are as expected
- Finally, members also agreed to recommend adoption of a goal on affordability in line with the statement that health care spending should not increase more rapidly than consumption or personal income. This could be measured by comparing health care spending to CPI or GDP, but the committee did not wish to recommend a specific numerical target for overall decrease in health care expenditures.

Areas for continued discussion

The Committee identified several topics as issues needing further discussion, including:

- Risk adjustment, for both social and medical factors
- Need for state investment in a robust quality measurement infrastructure,
- Potential need for a more in-depth, technical review process (not a political one) to really identify areas of defects in the system with best potential ROI and, subsequently, the most effective strategy for tackling those areas
- Contracting and payment issues in context of P4P, primary care homes, etc. Levels from OHA – Plans – Medical Groups – Providers.

Next steps

Staff will work with the Committee and Subcommittee chairs to continue development of the areas of agreement for presentation to the Board as draft recommendations on October 12, with a new summary distributed to the Committee members for their review.

Medical Liability Task Force

Next meeting: 1-3 pm on October 6, Wilsonville

Wilsonville Training Center, Room 112, 29353 Town Center Loop East

Recent decisions

- The Task Force agreed to recommend changes designed to:
 - make the medical liability system a more effective tool for improving patient safety;
 - ensure that it more effectively compensates individuals injured as a result of medical errors; and
 - reduce its collateral costs (including costs associated with insurance administration, litigation, and defensive medicine).
- The task force has considered policy avenues for supporting early disclosure of medical errors and offers of compensation; health courts as an alternative to the medical liability system; and evidence-based guideline safe harbors.

Issues discussed

- At its August meeting, staff presented a straw set of recommendations for public policy measures to encourage and support programs in which providers disclose medical errors promptly and offer compensation for injuries to patients at an early stage of the claims process. Recommendations included strengthening patient safety disclosure programs and removing barriers to disclosure and offer.
- At its August meeting, the Task Force also heard a presentation by a staff attorney for a group that advocates replacement of the traditional medical liability litigation process with a “health courts” process. Through this process, injured patients are compensated for avoidable injuries (rather than negligence) through an administrative system that offers standardized compensation for similar injuries. Task Force members vigorously questioned the presenter and discussed the possibility of piloting the concept.
- At the September meeting, staff presented and the committee discussed some straw recommendations concerning health courts. They committee considered alternatives including taking a wait-and-see approach, recommending initiation of health court pilots, and doing an intensive feasibility study of an administrative system for compensating patient injuries.
- At its September meeting, the Task Force also heard presentations on the evidence-based research and guidelines work of the Health Resources Commission and the Health Services Commission and the planning grant Oregon has received from the Agency for Healthcare Research and Quality to explore the feasibility of creating evidence-based guideline safe harbors.

Points of agreement

- The Task Force will not recommend creating an excess liability fund. Such a fund would not further the objectives for reform agreed to by the group.

- The Task Force will not recommend undertaking health court pilots because no short-term, voluntary system could truly test the value of the concept. The Task Force will recommend that a feasibility study be done to explore the costs, benefits, and design issues involved in replacing the medical liability system with an administrative system of compensation. It is assumed that the administrative system would not compensate victims of medical negligence only but would compensate a larger class of patient injuries. This would both be necessary for the system to pass constitutional muster. It could also help achieve the Task Force objectives to compensate victims of medical errors more effectively and to reduce defensive medicine by beginning to reduce physician fear of liability claims.

Areas for further discussion

- The Task Force needs more discussion before coalescing around recommendations to support early disclosure and offer programs.

Next steps for the Task Force

- At its next meeting, the Task Force will consider draft recommendations on all three priority study topics.

Administrative Simplification Workgroup: Work group recommendations were adopted by OHPB at its August 10 meeting. Final recommendations can be found at: <http://www.oregon.gov/OHPPR/HEALTHREFORM/AdminSimplification/AdministativeSimplificationWorkgroup.shtml>. No further meetings of the work group are anticipated.

Public Employers Health Purchasing Committee (PEHPC)

Next meeting: 1-4 pm on October 25, Wilsonville

Wilsonville Training Center, Rooms 111/112, 29353 Town Center Loop East

During the spring, the Public Employers Health Purchasers Committee heard introductory presentations from most of the OHPB committees, workgroups and taskforces to provide a background and context for the recommendations the PEHPC will be receiving from the other committees. The committee did not meet during the summer, but in August, some members met with the Physicians Hospital Alignment (PHA) group in Bend, including Board member Mike Bonetto, to learn about efforts to change the delivery system in the tri-county area of Central Oregon. PHA is looking for ways that benefit purchasers can work with their carriers to support the different pilot projects they are planning to undertake.

The Public Employer Health Purchasing Committee (PEHPC) met September 27.

Recent Committee decisions and agreements

- The Committee reviewed committee action alternatives proposed by Barney Speight, lead staff for the Committee, and there was informal agreement to use the two options

proposed. One option relates to contracting standards between employer groups and carriers/TPAs, the other to benefit design.

- For each potential committee recommendation, Committee staff will create a one-page paper with proposed language and a brief summary of why it's important to recommend a particular action.
- Staff went over a draft outline of the PEHPC report to the Board, and there was informal agreement on the structure.

Issue areas discussed

- The Committee received initial recommendations from the Health Improvement Committee and the Administrative Simplification Workgroup, and will review these for potential endorsement or recommendation at the next meeting.
- Jeanene Smith, Administrator of the Office for Oregon Health Policy and Research and lead staff for the Incentives and Outcomes Committee, brought forward some draft preliminary areas of recommendations that the PEHPC will receive formally at the next meeting.

Points of agreement and areas for areas for continued discussion

- It is important to remember that there is no regulatory or statutory authority to compel any public or private employer to adopt any of the measures the PEHPC recommends. The OHA may choose to implement these recommendations for programs it administers, but all other public employers have to view these recommendations in the context of their organization's goals and objectives, the health care market they are in, and the collective bargaining environment.
- In agreeing in concept to two different options for committee action, the Committee recognized the unique position of many public purchasers whose benefit designs are actually bargained for. The Committee felt that recommending consideration of a specific benefit showed support for that element but allowed local governments and other public bodies, as well as private purchasers, an opportunity to tailor the benefit choice to meet their specific organization and/or community's needs and circumstances.
- For actions relating to contracting standards, the Committee felt that endorsing a specific standard and recommending that public and private employers discuss this provision with their carriers for inclusion in contracts was sufficient to show support.
- The Committee discussed potential opportunities for distributing Committee recommendations, and will continue to build the distribution list.

Next steps

- The Committee will review the recommendations from the HIP Committee, the Administrative Simplification Workgroup, and the Incentives and Outcomes Committee, as well as patient safety ("never events") recommendations at their next meeting for possible adoption as Committee recommendations.

Health Information Technology Oversight Council (HITOC)

Next meeting: 1-5 pm on October 7, 2010, Portland

Portland State Office Building, Room 1B, 800 NE Oregon Street

Recent committee decisions/agreements

- At the Sept. 2 HITOC meeting, HITOC members unanimously voted their approval of the charters, membership nominations, and draft work plans for three new workgroups to provide input on HIE planning and implementation: Legal and Policy, Finance, and Technology. They also approved the charters for two advisory panels that will also provide input for HIE planning and implementation: the Consumer Advisory Panel and the HIO Executive Panel.

Issue areas discussed

- HITOC discussed their HIT oversight responsibilities as defined by HB2009.

Points of agreement

- see committee decisions/agreements above

Next steps for the committee

- HITOC will be reviewing the input provided by the newly formed workgroups and panels at subsequent meetings, starting Oct. 7.

Oregon Health Improvement Plan (HIP) Committee

Next meeting: 10 am-2:30 pm on October 8, Salem

Labor & Industries Building, Room 260, 350 Winter Street NE

Recent committee decisions/agreements

The September 10th meeting addressed the OHA Health Policy Board's guidance and direction given to the HIP committee chairs and staff. This guidance requested that the HIP Plan include:

- Three broad goals: health equity; chronic disease prevention; and assuring system change and integration with the health care delivery system;
- Clear outcomes and strategies over one and three years time; and
- Focus on one or two outcomes and clear metrics for each category

Issue areas discussed

- Reviewed the draft HIP plan, with revised goals, strategies and actions based on OHPB feedback since the August 8th committee meeting
- Reviewed previous plan recommendations based on specific review criteria:
 - consistency with HB 2009 mandate and charter;
 - evidence-based, best and promising practices;
 - ability to track with population based data at the county/regional and population group levels; and
 - be attuned to state budget 2011-2013 and future biennia.

Points of agreement

- Revised Goal 1 to maintain a broader focus than educational attainment for achieving health equity; the strategy and outcome will focus on high school and college graduation rates
- Addition/revision of several strategies and action items in Goals I, II and III
- A web-based member survey will define level of support for strategies, implementation timeline and prioritization of action items

Areas of contention (for continued discussion)

- Members had questions about the revisions to the plan, how the current version differed from the previous version and the process by which changes were being made
- Why one strategy (educational attainment) for health equity, while other goals have more than one?

Next steps for the committee in September and October

- Maintain communication to inform committee members of meetings and presentations of the draft HIP plan with stakeholders and OHA, OHPB members
- October 8th meeting – finalizing the HIP plan, incorporating Board feedback, finalizing outcomes and metrics tied to the Plan's actions
- Gather public input on the draft plan through a web-based process
- HIP Committee presentation to the Board in November

Patient-Centered Primary Care Home Pediatric Standards Advisory Committee

Next meeting: 1-3 p.m. on October 7, 2010, Portland

Portland State Office Building, Room 918, 800 NE Oregon Street

The committee was created and convened in August to “review and revise” the Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee’s work in order to ensure pediatric stakeholders’ viewpoints are reflected. Small changes in language of the measures have been suggested, along with pediatric specific consideration for guidelines on implementation of the medical home. In September, two meetings have been held.

Recent committee decisions/agreements

- The committee agreed on revisions made to PCPCH Attributes 1-4. The revisions include language referring to family, as opposed to only patient, involvement in care as well as acknowledging that it is acceptable for providers to coordinate provision of some services as opposed to having to offer those services at the PCH.

- Issue areas discussed
At the most recent meeting the committee discussed changes to Attributes 5 “Coordination and Integration” and 6 “Patient and Family Centered Care”.

Points of agreement

- The group’s discussions have been around refining measures to reflect unique needs of children. Several points which came up in the past two meetings included developmental screening, emphasizing preventive care measures, ensuring immunization status is known, and screening for health behaviors and risks within the family unit.

Areas for continued discussion

- Areas for discussion at the next meeting include the guiding principles of implementation and review of all revised standards.

Next steps for the committee

- Review guiding principles for implementation.
- Decide on review of final document.

Health Equity Policy Review Committee

Next meeting: October 5, 1-5pm, Portland

Room 1E, 800 NE Oregon St, Portland OR

The Health Equity Policy Review Committee held two orientation meetings and the first committee review on September 20th. The Health Equity Policy Review Committee will meet twice a month for four hours between September and February. In each session the committee will hear key considerations, policy recommendations and other strategic issues from representatives of the OHPB and/or OHPR. Upon hearing committee presentations, the HEPRC will make recommendations about how to advance health equity through the framework of the OHPB committees. These recommendations will be summarized and provided to the committee staff and chairs outlining themes and specific recommendations.

Recent Committee decisions and agreements:

- The Health Equity Policy Review Committee has three initial goals for its work this year:
 - Identify the **short term policy recommendations** that need to be integrated into OHPB recommendations for the legislative session and/or determine the administrative decisions
 - Identify **long term opportunities**, that might not necessarily be addressed in the next few months, but needs to be established as strategic goals for creating a lasting equity structure in our healthcare system
 - Develop **training opportunities for staff and volunteers to assure a baseline understanding of health equity**. Identify the tools and capacity needed to develop

and embed health equity knowledge in Oregon's health care reform process. HEPRC can be a pipeline to increase diversity and health equity background of OHPB committees.

Issues Discussed

During the September 20th meeting, the **Healthcare Workforce Committee** and **Staff** familiar with Oregon's work on the **Health Insurance Exchange** each presented. The HEPRC members offered initial policy recommendations and key concepts for creating equity in their work:

- **The Healthcare Workforce Committee:**
 - Create insurance options for undocumented people
 - Create education/mentorship programs for elementary, middle and high school-aged students as a pipeline for entering the field of medicine
 - Develop a disciplinary system to track complaints for doctors who are not practicing culturally appropriate care
 - Require cultural competency continuing education in the re-licensure process for health care professionals
 - Require and reimburse health care interpreters who have demonstrated language proficiency and/or certification using standardized testing processes
 - Expedite re-licensing process for health care professionals who are licensed out-of-country to address provider shortages, and increase diversity in the health care workforce
 - Create a targeted matching system to connect health care workers to culturally defined underserved communities
 - Create payment incentives for working in underserved areas (i.e. loan reimbursement) to reduce barriers to health care careers for individuals from diverse backgrounds

- **Health Insurance Exchange:**
 - When considering relationship between Exchange and Medicaid Program, allow OHP providers to participate in the exchange to ensure continuity of care as patients move in and out of OHP income limitations.
 - Use accessible language throughout the entire application process as to ensure that people are able to access the benefits they are qualified for
 - Employ community health workers and other community leaders so to help navigate individuals through the system
 - Make recertification process for OHP less frequent and less arduous
 - Assure a critical mass of consumers on health care governing boards so as to create a wider, more accurate representation of the population
 - Create targeted marketing of health insurance options by companies who have accurate cultural knowledge – may not always be a mass media campaign
 - Create standards for cultural competence among providers

- Provide health outcome data to the public by race/ethnicity so that individuals may choose a health plan based upon demonstrated best outcomes for his/her race/ethnicity.
- Create protection so that plans do not avoid providing culturally-competent care to communities with higher proportions of individuals experiencing chronic conditions
- Provide information to minority owned and rural businesses so they know their options for providing access to health care for their employees
- Create a multi-state exchange system, allowing increased purchasing power and voice among communities of color
- Provide coverage for extended/non-nuclear families (kinship networks)
- Include complimentary treatment that include traditional, non-Western ways of healing in benefit packages
- Collect data that shows how/if individuals are using the healthcare system by race/ethnicity.

Points of agreement and areas for continued discussion

- While there was agreement on policy recommendations, committee members have also had initial structural conversations that have included requests to be formally chartered
 - to have an ongoing and formal role with the structure of OHPB committees to provide an on-going tailored equity review
 - to have the opportunity to make presentations directly to the OHPB to highlight key issues and recommendations that may cut across committees
 - to be added as members of existing committees
 - to develop a training module on health equity that would be delivered to the OHPB, committee members and OHA staff
 - to attend the OHPB committees in small groups to present final health equity recommendations and to follow-up and continue discussions
 - Agreement on policy recommendations will begin at October 5th meeting.

Next steps for the Committee

- The Committee will present a summary of priority recommendations to the OHPB in November.
- A draft of the Health Equity Policy Review committee charter will be presented to the OHPB in December.
- The committee will finalize short-term policy suggestions for the Healthcare Workforce Committee and Health Insurance Exchange.
- In October, HEPRC will continue discussions of the Oregon Health Improvement Plan Committee, Health Incentives and Outcomes Committee, Public Employers Health Insurance Purchasing Committee and the Oregon Healthcare Blueprint.

Individual (Major Medical) Rate Filings Effective in 2010

When an insurer requests a rate increase, the division looks at many factors, including the cost of medical care and prescription drugs, the company's past history of rate changes, the financial strength of the company, actual and projected claims, premiums, administrative costs, and profit. The division approves the request if the insurer can show that the new rate is reasonable in relation to the benefits provided. If the company's data does not fully support the increase, the division can ask for more information, approve a lesser rate, or reject an increase.

House Bill 2009 strengthens the division's rate review process to help better protect consumers. The new law, effective in April 2010, does the following:

- * Provides consumers with 30 days to comment on insurance company rate requests in individual, small group, and portability markets. In addition, rules adopted by the department have made all information submitted as part of an insurance company's rate request open to the public.
- * Requires insurance companies to separately report and justify increases or decreases in administrative expenses, such as salaries, broker commissions, and advertising.
- * Allows the department to consider an insurance company's overall finances, including profits, investment income, and surplus, when reviewing a proposed rate. Under current law, the review focuses only on the particular type of insurance (such as small group health insurance) rather than more broadly on the insurer's entire business.

<u>SMALL EMPLOYER COVERAGE</u>	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
COMPANY				http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00Nzk%3D
Central United Life Insurance Company	1/1/2010	15.00%	15.00%	
Clear One Health Plans	1/1/2010	6.20%	6.20%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00ODQ%3D
*				
Health Net Health Plan of Oregon	10/1/2010	10.60%	8.00%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lJTJFc2hvdyU1RnBkZiZwZGY9NjUw
LifeWise Health Plan of Oregon	9/1/2010	15.00%	15.00%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj02MDg%3D

Individual (Major Medical) Rate Filings Effective in 2010

COMPANY	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
National Foundation Life Insurance Company	2/1/2010	18.00%	Disapproved	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NjM%3D
Pacificare Life Assurance Company	4/1/2010	8.00%	3.90%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01MTY%3D
PacificSource Health Plans	1/1/2010	15.40%	15.40%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00NjE%3D
Regence BlueCross BlueShield of Oregon	7/1/2010	1.4-6.2%	1.4-6.2%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01ODM%3D
Regence BlueCross BlueShield of Oregon	4/1/2010	25.30%	16.00%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01Mzc%3D
Regence BlueCross BlueShield of Oregon	1/1/2010	26.40%	17.30%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NjA%3D
The Mega Life and Health Insurance Company	1/1/2010	10.00%	Disapproved	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00OTY%3D
Time Insurance Company/John Alden Life Insurance Company	5/1/2010	21.00%	15.00%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00OTg%3D

Individual (Major Medical) Rate Filings Effective in 2010

COMPANY	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
Trustmark Insurance Company	3/1/2010	20.00%	Disapproved	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NDA%3D
<u>INDIVIDUAL COVERAGE</u>				
COMPANY	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
Aetna Life Insurance Company	7/1/2010	9.40%	9.40%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj02MjI%3D
Clear One Health Plans	1/1/2010	12.30%	12.30%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00ODE%3D
Health Net Health Plan of Oregon	4/1/2010	12.20%	12.20%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01OTk%3D
Kaiser Foundation Health Plan of the Northwest	10/1/2010	9.90%	9.90%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01ODU%3D
Kaiser Foundation Health Plan of the Northwest	7/1/2010	9.90%	9.90%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01Njg%3D
Kaiser Foundation Health Plan of the Northwest	4/1/2010	11.70%	11.70%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWwFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01MTQ%3D

Individual (Major Medical) Rate Filings Effective in 2010

COMPANY	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
Kaiser Foundation Health Plan of the Northwest	1/1/2010	11.60%	11.60%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lLnNob3dfcGRmJnBkZi00NjM%3D
LifeWise Health Plan of Oregon	1/1/2010	-5.40%	-5.40%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lLnNob3dfcGRmJnBkZi01ODg%3D
LifeWise Health Plan of Oregon	10/1/2010	3.03%	3.03%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lJTJFc2hvdvU1RnBkZiZwZGY9NjQ4
LifeWise Health Plan of Oregon	10/1/2010	1.93%	1.93%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lJTJFc2hvdvU1RnBkZiZwZGY9NjQw
LifeWise Health Plan of Oregon	10/1/2010	1.04%	1.04%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lJTJFc2hvdvU1RnBkZiZwZGY9NjM5
ODS Health Plans, Inc.	7/1/2010	16.50%	16.50%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lLnNob3dfcGRmJnBkZi01NTQ%3D
PacificCare of Oregon, Inc.	1/1/2010	14.20%	Disapproved	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lLnNob3dfcGRmJnBkZi01ODJ%3D
PacificSource Health Plans	10/1/2010	15.40%	15.40%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzWVFjdGlvbj1ob21lLnNob3dfcGRmJnBkZi02MTk%3D

Individual (Major Medical) Rate Filings Effective in 2010

COMPANY	DATE RATE EFFECTIVE	% Requested	% Approved	Link to Rate Filing Decision Summary
PacificSource Health Plans	1/1/2010	11.52%	11.52%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00NzY%3D
Providence Health Plan	8/1/2010	1.16%	1.16%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NzY%3D
Regence BlueCross BlueShield of Oregon	7/1/2010	12.90%	12.90%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NDY%3D
Regence BlueCross BlueShield of Oregon	4/1/2010	14.60%	14.60%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01MzY%3D
Regence BlueCross BlueShield of Oregon	1/1/2010	19.40%	16.00%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj00NzY%3D
United HealthCare Insurance Company	7/1/2010	-03% to -1.9%	-03% to -1.9%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01Nzk%3D
United HealthCare Insurance Company	6/1/2010	15.40%	15.40%	http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=ZnVzZWFjdGlvbj1ob21lLnNob3dfcGRmJnBkZj01NzY%3D

Healthy Kids Enrollment

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Target Enrollment Increase	Actual Net Increase	Progress Towards Goal	Monthly Enrollment Goal	Monthly net enrollment change	% of Monthly Goal Achieved
Jul-09	271,493	0	271,493	5,000	3,648	73%	5,000	3,648	73%
Aug-09	276,712	0	276,712	10,000	8,867	89%	5,000	5,219	104%
Sep-09	281,374	0	281,374	15,000	13,529	90%	5,000	4,662	93%
Oct-09	289,015	0	289,015	20,000	21,170	106%	5,000	7,641	153%
Nov-09	294,459	0	294,459	25,000	26,614	106%	5,000	5,444	109%
Dec-09	298,600	0	298,600	30,000	30,755	103%	5,000	4,141	83%
Jan-10	303,026	0	303,026	33,333	35,181	106%	3,333	4,426	133%
Feb-10	305,785	205	305,990	36,666	38,145	104%	3,333	2,964	89%
Mar-10	309,047	549	309,596	39,999	41,751	104%	3,333	3,606	108%
Apr-10	312,191	923	313,114	43,332	45,269	104%	3,333	3,518	106%
May-10	314,933	1,133	316,066	46,665	48,221	103%	3,333	2,952	89%
Jun-10	316,891	1,338	318,229	50,000	50,384	101%	3,333	2,163	65%
Jul-10	319,878	1,662	321,540	55,000	53,695	98%	5,000	3,311	66%
Aug-10	322,694	1,948	324,642	60,000	56,797	95%	5,000	3,102	62%
Sep-10				65,000			5,000		
Oct-10				70,000			5,000		
Nov-10				75,000			5,000		
Dec-10				80,000			5,000		

Public Input Update and Summary:

*Health Insurance Exchange and the
Direction of Health Reform in Oregon*

Jeremy Vandehey
Community Engagement Coordinator

October 12, 2010



Input topics and process

Input sought on:

- General direction of board on health reform
- Health insurance exchange

Process:

- E-mail written comments
- Six community meetings
- Online public input tool
- Staff invited to stakeholder meetings



September Community Meetings



Review of community meetings

- **Six community meetings:** Baker City, Bend, Corvallis, Florence, Medford, Portland
- Neutral facilitator - Oregon Consensus at PSU
- Outreach through earned media, social media, local outreach by facilitators
 - Community partners, stakeholders, and consumer advocates outreach included canvassing, e-mail, phone banking
- **More than 850 attended**
- Average satisfaction was **4 out of 5**
- Active participation from diverse attendees, varying experiences and professions
- Input through oral and written comments



Review of community meetings

Attendees:

- Third employed by small business
- Third worked in health care; 15% insurance
- Third obtain insurance through work
- Half satisfied with insurance; third unsatisfied
 - Satisfied: cost and range of services offered
 - Unsatisfied: increasing premiums and deductibles, diminishing coverage and limited choices



Themes on insurance exchange

- Limited but meaningful choices preferred
- Should have higher standards than federal requirements
- Encourage competition
- Assist consumers in selecting appropriate plan; use insurance agents
- Provide comprehensive, integrated care
- Include publicly owned health benefit plan
- Concern that exchange won't contain costs
- Continued community input on exchange
- Reliant on board to make best choices



Themes on direction of board's work

- Overall majority of attendees believe the board is headed in the right direction
- Strong support for:
 - Preventive care
 - Encouraging healthy lifestyles and wellness
 - Primary care
 - Providing comprehensive care (e.g. dental, vision, mental health)



Themes on direction of board's work

- Primary concerns were controlling costs, ensuring coverage for all Oregonians
- Don't be overly focused on insurance
- Work comprehensively on health reform
 - Medical liability
 - Access and choice of providers
 - Eliminating duplicative procedures and paperwork
 - Utilize alternative medicine providers
- Address varying needs across state



Public Input Website



Review of public input website

- 1,459 unique visitors
- Direction of board's work (6 questions)
- Insurance exchange (5 questions)
- 604 submissions
- Not a scientific measure





Insurance exchange summary

- Balancing simplicity and choice
46% limited choice; 20% max. choice
- The role of the exchange
69% want the exchange to drive innovation
- Exchange-only vs. Outside Market
49% maintain outside market
35% exchange only
16% not sure



Qualities of an exchange which would contribute to satisfaction:

- Ease of enrollment and one-stop shopping
- Excellent customer service
- Easy to compare plans; transparent pricing and co-payments
- Ability to choose provider and broad choice of care and network
- Ability to use insurance agent
- Rates negotiated on consumers' behalf
- Governed by independent board



Themes on direction of board

- Majority feel board is taking the right steps to accomplish vision
- Support for prevention and wellness
- Support for evidence-based care
- Ensuring transparency
- Any cost saving should result in lower premiums and out-of-pocket costs
- Local collaboration and innovation will yield best reforms



Next Steps for Public Input

Committee recommendation and public input schedule

2010 Board Meetings and Public Input Periods				
Committee/Issue	Oct 12	Nov 9	Nov 16	Dec 14
Comprehensive Plan For Health Reform		D	Public input ends Nov 29	F A
Health Improvement Plan			D	Public input ends Nov 26 F A
Health Information Technology	Public input should be submitted through the Health Information Technology Oversight Council			
Incentives and Outcomes	D	Public input ends Nov 5		F A
Insurance Exchange and Publicly Owned Health Benefit Plan	Public input occurred Aug-Sept			
Medical Liability		D	Public input ends Nov 29	F A
Public Employer Health Purchasing			D	Public input ends Nov 26 F A
Value Based Benefits Package		Public input ends Nov 5		F A
Workforce		D	Public input ends Nov 29	F A

- Key:
- A Board action on recommendations
 - D Draft recommendations made to Board
 - F Final Recommendation made to Board
 - Public input period on recommendations to Board

Updated schedule at:
www.oregon.gov/OHA/public-input.shtml



Oregon Health Authority and Oregon Health Authority Policy Board
Community Meeting – Summary Report

Overview

The Oregon Health Authority and the Oregon Health Authority Policy Board held six community meetings around the state (Corvallis, Baker City, Portland, Florence, Medford, and Bend) between September 1 and September 16, 2010. The purpose of these meetings was to introduce the OHA and OHPB to the public, provide an update about the progress of health reform in Oregon, and solicit public input on the overall direction of these reforms and key elements of the health insurance exchange. The meetings were facilitated by Oregon Consensus with support from the local community dispute resolution center in each location. Either Bruce Goldberg or Tina Edlund served as the key speaker at these meetings and at least one board member attended each meeting to listen first hand to public comment. Overall, participants expressed both verbally and in writing their appreciation for the effort to reach out to the public. This appreciation was even stronger in the more rural settings, like Baker City, where participants expressed a concern they have unique needs and can be overlooked.

A written summary has been prepared for each individual community meeting. This report serves as an overall summary of common themes that emerged throughout the six meetings.

Attendance and Composition

A total of approximately 850 people attended the six sessions. Portland was predictably the best attended with about 275 people participating and Baker City was the smallest with 40 people signing in. Other meetings were well attended with at least 100 people or more. The following represents an overall average of how participants identified themselves in these meetings:

86%	Lived within 50 miles of the meeting location
30%	Employed by small business
33%	Work in the health care field
15%	Work in the health insurance industry
32%	Obtain their insurance through their work
10%	Had no health insurance
43%	Knew a child without insurance
52%	Satisfied with their current insurance
29%	Unsatisfied with their current insurance

Those satisfied with their current insurance appreciated the cost and range of services covered, including access to alternative care. Having Medicare coverage was also noted as a source of satisfaction. Those who were unsatisfied with their current insurance voiced concern over the increasing cost of premiums and deductibles, diminished coverage, and limited choices.

Feedback on the Overall Direction of Health Reforms in Oregon

Overall, the majority of people (between 50-75%) indicate a belief that the board is heading in the right direction in their comprehensive plan with only a small percentage of people registering serious concern. Support was expressed for the Board's emphasis on prevention, the elimination of duplicative administrative services such as record keeping functions and the emphasis on patient centered, team approaches to treatment. A number of the participants (20-30%) liked the direction of the reforms, but had doubts about whether these reforms were really going to be able to contain costs and provide coverage for all Oregonians, particularly in light of the state budget crisis. They urged that the first priority should be cost control with features of the exchange being secondary. Serious concern was expressed that the reforms did not go far enough in revising an insurance system driven by profit and those participants encouraged the board to go broader and deeper in thinking about health care reform. At the same time serious concern was identified about the danger of adding another level of regulation and bureaucracy to the federal mandates.

Emergent Themes from Community Input

The following themes do not represent a consensus of the group or the full range of responses, but rather highlight common themes that emerged throughout all six meetings.

Limited, yet meaningful choices tend to be preferred in the exchange. The majority of the participants indicated that they would lean toward having a limited, yet meaningful range of choices in insurance plans to enhance simplicity of use. Suggested was a simplified, basic plan with additional layers or services available for supplemental coverage at higher expenses.

An active exchange that exceeds minimal federal standards tends to be preferred although there are concerns this increases the danger of introducing another layer of regulation. There is an overall preference that the exchange would play active role in defining standards. A more robust system, with more participants, is seen as more effective in reducing and containing costs. The board is encouraged to continue to innovate and improve on federal standard. However, some felt that the federal minimal standards would create more national equality in coverage. In addition, there was a sense that Medicare already sets a high standard of practice, with an effective level of federal regulations; additional state regulations would only add another, unnecessary level of regulations.

Assure the same coverage for the whole state and if limiting options, assure this does not mean fewer choices in rural areas. Currently, providers and specialists are limited in rural areas like Baker City and there is concern that limiting plan options will have negative impacts on the quality and availability of care in rural areas.

Include alternative therapies in the exchange coverage. The suggestion is to put alternative health care providers on par with primary care providers and standardize cost sharing.

Provide assistance to help people make good decisions within the exchange. The issue is not a question of the number of plans that would fall within a tier, but rather the issue is how to help people have the capacity to make the best decisions as they navigate the tier system. It was recommended the board ensure easy comparison between plans including specific information about what each plan would cover, i.e. glasses, vitamins.

Provide information that enables consumers a clear comparison between insurance plans that goes beyond just coverage options. Evaluation criteria suggested including information to compare the percentage of premiums collected and/or administrative costs compared to the percentage of money spent on patient care. Consumers need a way to get help and their questions answered as they try to navigate the system to make choices.

Encourage competition between companies to improve insurance products. “Standards should be set high enough to garner competition between companies” and “Market-based solutions should be considered in developing health insurance programs”

Provide coverage for the whole body. Dental and mental health coverage should be included in insurance plans and not separated from the body.

A public option is recommended to be included in the exchange without eliminating the benefit of a free market. A solid majority of those in attendance indicated a strong preference that a public option be one of the exchange choices. Medicare was mentioned as a good model. However, there was also an equally strong support voiced for the free market principles – competition and consumer choice should be considered in the exchange.

Implement a single payer system. “Oregon has an opportunity to demonstrate an effective single payer system that works”. Many saw a public, single payer option as a remedy for corporate profit that drives the insurance industry and would be a way to control costs.

An overall systems reform/paradigm shift less reliant on “for profit” is needed. Containing costs is difficult when the system is driven by “for-profit” insurance companies.

Use care in getting over-focused on “successful outcomes”. Some participants voiced concerns related to physician incentives that “cost” the patient. These comments were raised in the context of “rewarding successful outcomes.”

Remember that “health insurance is not the same as health care” and that health care is a right.

Think more comprehensively about reforms. Health care costs were seen as affected by and integral to a number of other issues that need to be considered in implementing reforms. Medical malpractice needs reformation as part of a systems overhaul. In addition, the quality

of schools is important to retaining local (rural) doctors. Medical review boards are important to analyze medical procedures, standards, and practices to contain costs. In addition the economic impacts of the cost of health insurance and health care on local economies should also be considered.

Address the needs of rural frontier towns reliant on practitioners in other states to get care.

Especially in rural, border cities it is common to utilize specialists and services in Idaho and Washington, and without this option, available healthcare is severely limited due to geographical constraints. OHA should keep flexibility in the exchange so that they still have access to resources across state lines.

Retain the knowledge, experience, guidance, and technology available through insurance agents.

Insurance agents have expertise and technology specifically developed to help consumers navigate the plans and identify what is right for them that could be utilized within the exchange. This is a service valued by consumers.

Encourage wellness based primary care and healthy choice incentives. Prevention was seen as a crucial part of increasing health and reducing health care costs. Many of the ailments that are addressed by practitioners are avoidable with healthy lifestyles and practices; there needs to be a focus on encouraging healthy practices. Include incentives for healthy choices and preventative actions that yield results.

Allow for community input in design of exchange. Establish regional boards/advisory groups to gather information and give findings to the OHPB during the creation and implementation of the exchange. This regional group could continue to function as a monitoring entity. This allows for creative programs that are catered to the local community (ex. Northeast Oregon Network). Local community members better represent the members of their communities that do not have the time and resources to participate in OHA Community Meetings.

Economic health and community health are linked. Increased and sustained economic vitality in Baker City and other communities will help improve the health of community members. Assistance could be given to meet local needs and reward their efforts. Encourage new practices in rural areas to assist progress and innovation. Doing so will limit the need to seek care across state lines and will benefit the local economy.

More information is needed to allow the public to weigh in on the exchange and other aspects of the comprehensive plan. Information is needed to enable more meaningful input to the Board on key elements of the plan and exchange. Specific questions were raised about how details of the comprehensive plan and the exchange. Giving meaningful input is difficult without these details. The board is encouraged to continue to inform and dialogue with the public as key elements get defined.

Summary of Input Obtained on “OHA Feedback”:
*Vision for the Comprehensive Plan for Health Reform and
Oregon’s Health Insurance Exchange*

Submitted by:

Jeremy Vandehey
Community Engagement Coordinator
Oregon Health Authority

October 7, 2010

Overview

OHA launched a public input website (<http://oha.oregon.gov>), titled “OHA Feedback,” on September 5, 2010. The site was used to obtain input on the general direction of the Oregon Health Authority’s (OHA) and Oregon Health Policy Board’s vision for the comprehensive plan for health reform and on decisions before the board regarding the health insurance exchange. The purpose of the tool was to supplement the statewide community meetings by providing an additional opportunity for input. The website will be used in the future to obtain public input on other topics.

Public comment was accepted through the site between September 5, 2010 and September 30, 2010. Eleven questions were presented: six on the comprehensive plan and five on the health insurance exchange. For eight of the questions, users were presented with a question and asked to select between three responses. Five of those questions also had a field for additional comments. Three of the questions solicited only open-ended responses. Users were not required to answer any or all of the questions. Zip code, occupation, and organizational membership could be provided voluntarily.

While the website was open for comment it had 1,950 visits; 1,459 of those visits were unique (not repeat visitors); and the question yielding the most responses received 604 submissions. For questions with a field to provide additional comments, the majority of users did choose to submit additional comments. The short video of board members shown at the community meetings was also available on the website and was viewed nearly 400 times. Visitors from nine countries, 32 states, and 71 Oregon cities viewed the site.

The questions presented and general themes in user responses are outlined below. The themes are not exhaustive. To keep this summary concise, the questions are paraphrased and themes which were prevalent throughout multiple questions are not included multiple times. It should be noted that there was not a mechanism for preventing users from submitting multiple responses.

Comprehensive Plan for Health Reform

Five draft vision statements to describe OHA's and the board's vision for the comprehensive plan for health reform were posted along with examples of work that support the vision. Users were asked whether OHA is taking the right steps to accomplish the vision. An additional open-ended question about capturing savings was presented.

Question 1: Improve the lifelong health of Oregonians.

To accomplish this vision, OHA is taking the following steps:

- Reduce barriers to care and address the racial, ethnic, and geographic disparities in health.
- Focus on wellness and prevention, and encourage healthy lifestyle choices.
- Reduce obesity, tobacco use, and chronic disease.

Is OHA taking the right steps to accomplish this vision?

Total responses:	604	
Yes:	350	58%
No:	82	14%
Unsure:	172	28%

Yes:

- Support focus on prevention and wellness, but would like more detail about what exactly OHA will do as next steps.
- Make sure to look at alternative medicine when looking at preventive care.
- Focusing on eliminating disparities is important. Make sure to look at all disparities, including geographic.
- Reward healthy lifestyles.
- Tie reimbursements to preventive care.
- Include nutrition services with prevention.
- Consider school based health centers as part of prevention and wellness system.
- Include oral health care and chiropractics in preventive care.

No or Unsure:

- Concerned that mental health is being overlooked. Ensure integration of mental and behavioral health with physical health.
- Concerned about how to incentivize healthy behaviors. Concerned that if death is not enough of a motivating factor, nothing else will motivate healthy choices.
- Concerned about whether recommended steps have evidentiary support for being effective.

Question 2: Provide access to high quality, affordable health care.

To accomplish this vision, OHA is taking the following steps:

- Coverage for children through Oregon's Healthy Kids program.
- Launch a health insurance exchange as a central marketplace for health insurance.

- Use federal resources to implement new, affordable health care options for all Oregonians.

Is OHA taking the right steps to accomplish this vision?

Total responses:	480	
Yes:	243	50%
No:	104	22%
Unsure:	133	28%

Yes:

- OHA should include a public option for coverage.
- Include undocumented Oregon residents in access plans to expand health coverage.
- Ensure access to preventive care; nutrition support; alternative health care; mental health care and addition services; and oral health care.
- Need to address provider shortages and other barriers to access before expanding coverage.
- General support for Healthy Kids and its expansion.

No or Unsure

- Oregon should move to a single-payer system instead of the exchange and other programs.
- Oregon and the U.S. cannot afford the subsidies that will be offered in the exchange.
- Concern about loss of federal funding. Ensure that the exchange is sustainable without federal funding.
- Adults should pay for health care to ensure patient responsibility.
- Keep government out of health care and insurance regulation.
- Strong concerns about purpose of the insurance exchange; it will not contain costs.
- Healthy Kids is unaffordable for higher income families.
- Ensure insurance agents are included in OHA’s plans because consumers need face-to-face conversations when making decisions about health coverage.
- Need to focus on access and coverage for adults and elderly, not just children.
- Need to focus on access instead of coverage.

Question 3: Ensure consumers, providers, health systems, and policy makers have the quality and cost information required to make better decisions and keep delivery systems accountable.

To accomplish this vision, OHA is taking the following steps:

- Establish a statewide set of measures to evaluate health system performance.
- Maximize use of cost-effective, high quality health care based on best evidence.
- Ensure transparency in the health care system and place medical decisions back in the hands of patients and their doctors.

Is OHA taking the right steps to accomplish this vision?

Total responses:	445	
Yes:	267	60%
No:	58	13%
Unsure:	120	27%

Yes:

- Support the state focusing on evidence based care and best practices to contain costs and improve quality.
- Need to ensure transparency to the consumer on quality and costs of providers, hospitals, and insurers so consumers can make informed choices with cost in mind.
- Make data on quality and evidence based care available to consumers to help them make more educated medical decisions and increase competition in the marketplace.
- Important to put medical decisions back in the hands of patients.
- Providers need to know the cost of services they provide.
- Ensure care is culturally competent.
- Should include information on quality of insurance companies in addition to health care delivery system, such as rates of claims denials.
- Tie quality measures to focus on prevention.

No or Unsure:

- Would be more efficient to move to a single-payer system and incorporate quality from the start in that new system.
- Concern that the cost of measuring quality will only drive up costs because the cost of reporting will be shifted to consumers. Concerned about the new layers of bureaucracy involved with reporting and tracking quality.
- Need to remember that evidence is not available for all situations and evidence based care may not meet specific patient needs.
- Concerned that evidence based care contradicts putting medical decision making back in the hands of patients.

Question 4: Lower or contain the cost of health care so it is affordable to everyone.

To accomplish this vision, OHA is taking the following steps:

- Coordinate purchasing across all state health programs and ensure efficient use of public funds.
- Streamline administrative processes and support statewide use of secure, private electronic medical records.

Is OHA taking the right steps to accomplish this vision?

Total responses:	420	
Yes :	221	53%
No:	88	21%
Unsure:	111	26%

Yes:

- General support for electronic medical records and that EMR will reduce costs.
- A strong health insurance exchange is necessary to reduce costs; maximize the size of the insurance exchange to reduce costs by including state purchasers (e.g. PEBB, OEBC, OHP).
- Should streamline state programs and plans to make providing services easier for providers.

No or Unsure:

- Focus on medical liability reform.
- Streamline electronic medical records for providers and ensure EMR can be transferred across state lines.
- Focus on prevention and utilization of services. Concerned that EMR and administrative simplification will only chip away at costs and not address the underlying cost issues.
- Concerned that lowering costs equals rationing care, denying services, or reducing quality.
- Concerned costs will go up at first as reforms are implemented.
- Should reduce educational debt of providers if want to reduce costs at provider level.

Question 5: How do you want any cost savings from reform to flow to the consumer?

448 Responses:

- Lower premiums and co-payments.
- Use to create incentives for health behavior and to fund local innovative programs and community health projects.
- Lower out-of-pocket prescription drug costs.
- Increase reimbursements for providers.
- Ensure savings are available to everyone and not just a select group.
- Use to set limits on insurance and provider rates.
- Capture and deposit into health savings accounts.
- Capture and create a rainy day fund to buffer unexpected future premium increases.
- Share between provider and patient.
- Tax credits and deductions for employers to help pay premiums for employees.
- Use for premium assistance for low income individuals and to expand access.
- Put toward under-funded programs, such as mental health.
- Use to fund start up of a public option or single-payer system.

Question 6: Have communities and health systems collaborate on innovative solutions that reduce overall spending, increase access to care, and improve health.

To accomplish this vision, OHA is taking the following steps:

- Share information, reform approaches, and lessons learned to accelerate programs that work.
- Foster state and local partnerships that allow local control and accountability for health improvement.

- Meet Oregonians’ needs for access to medical professionals while respecting and being responsive to patient needs and values.

Is OHA taking the right steps to accomplish this vision?

Total responses:	448	
Yes:	225	50%
No:	76	17%
Unsure:	147	33%

Yes:

- This vision has the most potential to encourage local innovation that will result in reform.
- Look to innovative workforce approaches, including alternative medicine, registered dietitians, naturopathy, chiropractics, acupuncture and massage.
- Focus on local prevention and patient education efforts.
- Need regional coordination and information sharing of successful pilots.

No or Unsure:

- Steps correct but cannot support until see steps implemented and can measure results.
- Concerned about lack of evidence to support some programs.
- Concern that local programs will increase bureaucracy and size of government.

Health Insurance Exchange

Question 1: Balancing simplicity and choice

Users were asked to submit their recommendations between limiting the choice of health plans offered in the exchange between three to four choices in each tier (12-16 total plans) to allow for simpler enrollment, and having as many choices in the exchange as possible even if it makes enrollment and choosing between plans more complicated.

Total responses:	418	
Limit choices:	191	46%
Many choices:	85	20%
Unsure, or somewhere in between:	142	34%

Question 2: The role of the exchange

Users were asked to decide whether the exchange should simply adhere to minimum requirements under federal law in how it operates or take a more active role in health reform by driving innovation.

Total responses:	392	
Very active and drive innovation:	270	69%
Simply enforce federal guidelines:	72	18%
Unsure:	50	13%

Question 3: Exchange only or maintain outside market

Users were asked whether they wanted the exchange to be the only marketplace for small group and individual health insurance or maintain the traditional market outside the exchange.

Total responses:	404	
Traditional market and exchange:	200	49%
Exchange only:	140	35%
Not sure:	64	16%

Question 4: What qualities would contribute to satisfaction in the exchange?

374 Responses:

- Ease of enrollment.
- One-stop shopping and enrollment even if multiple enrollment steps are necessary.
- Ability to keep coverage between jobs.
- Excellent customer service.
- Easy to compare plans; clear and transparent pricing and co-payments.
- Ability to choose provider and non-standard, alternative care; broad choice of network and treatment.

- Linking to an insurance agent if users have additional questions; having a local customer service option.
- Knowing that the rates for minimum coverage have been negotiated on behalf of consumers.
- Customer satisfaction rating of plans; listing a few preferred plan choices with the option of comparing all possible plans for those who want more choice.
- The exchange needs to have an independent board that is not controlled by the insurance industry.
- Include school based health centers in providers that consumers can use with coverage purchased in the exchange.
- Use the exchange as a tool to teach consumers how to use health care and be healthy.

Question 5: Any additional comments regarding the exchange?

302 Responses:

- Include a publicly owned health benefit plan in the exchange.
- Consider a single-payer system.
- Focus on affordability beyond what federal law provides, particularly for those above 400% federal poverty level, for low income families that do not have a high enough tax burden to receive support from tax credits, and for small businesses.
- Ensure the exchange is sustainable without federal funding.
- Include insurance agents in the planning and implementation of the exchange.
- Need a statewide campaign for educating Oregonians on health reform changes.
- Ensure health equity through the exchange.
- Include access to dental, vision and hearing care, mental health, addiction prevention and services, and alternative treatment and providers through the exchange.

OREGON HEALTH AUTHORITY

Comparative Pricing of the Value-Based Essential Benefit Package

Jeanene Smith, MD, MPH and
James Matthisen, ASA, MAAA
October 2010

1 Oregon Health Authority

OREGON HEALTH AUTHORITY

Value-Based Essential Benefits Package (VBEBP)

- Value-based services, basic diagnostic, comfort care
 - No/low cost share
 - For prevention/chronic disease management
- Tiered coinsurance based on best evidence
 - Goal is to steer patients towards more valuable and cost-effective services
- Evidence-based drug formulary

2 Oregon Health Authority

OREGON HEALTH AUTHORITY

VBEBP's Tiered Benefits for Other Services: Cost Sharing Applied Based On Best Evidence

<p>Tier I:</p> <p>Lower cost share Highly effective care for severe chronic disease and life-threatening illness & injury</p> <p>Examples:</p> <ul style="list-style-type: none"> • Emergent dental care • Head injuries • Appendicitis • Heart attack • Third degree burns • Kidney failure • Rheumatoid arthritis • Low birth weight 	<p>Tier II:</p> <p>Next level of cost share Effective care of other chronic disease and life-threatening illness & injury</p> <p>Examples:</p> <ul style="list-style-type: none"> • Breast cancer • Bladder infections • COPD/emphysema • Multiple sclerosis • Post-Traumatic Stress Disorder • Attention Deficit Disorder • Epilepsy • Glaucoma
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3 Oregon Health Authority

VBEBP's Tiered Benefits: Cost Sharing Applied Based On Best Evidence

Tier III:

3rd level of cost share
Effective care for non-life-threatening illness & injury

Examples:

- Broken arm
- Ear/sinus infections
- Dentures
- Kidney stones
- Herniated disk
- Reflux
- Migraines
- Fibroids
- Cataracts
- Obsessive-Compulsive Disorder

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Tier IV:

Highest level of cost share
Less effective care and care for self-limited illness and minor illness & injury

Examples:

- Cold
- Chronic low back pain
- Sprained ankle
- Cracked rib
- Seasonal allergies
- Acne
- Viral sore throat
- Tension headache
- Dental implants
- Liver transplant for cancer

How The VBEBP Compares

	Health Leadership Council's Design	VBEBP
Categories With No Cost Share	Tier 1 <ul style="list-style-type: none"> • Tests and treatments for <u>six</u> chronic diseases (asthma, CAD, CHF, COPD, depression, diabetes) • Annual exam & Preventive screenings • Immunizations 	Value-Based Services <ul style="list-style-type: none"> • Same plus coverage for 14 additional conditions/chronic diseases (e.g., ETOH Tx, bipolar Dz, HTN, ↑ lipids, maternity/newborn) • Basic diagnostics & Comfort care
Next Level (s) of Cost-sharing	Tier 2 <ul style="list-style-type: none"> • Standard medical product design <ul style="list-style-type: none"> – Portion of hospital services – Portion of outpatient services – Portion of Emergency Room cost 	Tiers I-III <ul style="list-style-type: none"> • Encourages care in primary care • Tiered cost sharing by condition/associated service based on evidence
Highest Cost Sharing or Not Covered	Tier 3 <ul style="list-style-type: none"> • Have higher cost sharing • Preference sensitive treatments • Complex outpatient imaging Excluded Services	Tier IV less effective/self-limiting Other <ul style="list-style-type: none"> • Excluded conditions (no coverage) • Discretionary Services (separate benefit limit)

5

Preliminary Actuarial Analysis

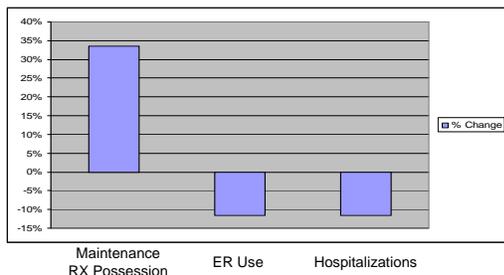
- Using earlier model developed for initial EBP design based on Medicaid data
- Applied for first time to “commercial data”
- OEBB claims data from ODS plans
- OHA/DHS Actuarial Services Unit – significant programming and data handling
- Analysis begins with ODS 2009 claims

6

Preliminary Actuarial Analysis (2)

- Costs are trended to 2010
- Categorizing four tiers relatively straightforward
- Judgment, rules of thumb, and many assumptions to tease out first estimates for value-based services, 2 visits per year, diagnostic services
- Macro comparison of 4 Plan Designs
 - ODS Plan 7 (2009) baseline
 - ODS Plan 7 (2010), Health Leadership Council, Value Based Essential Benefits Package

Asthma as a Value-Based Service



Asthma as a Value-Based Service (In Terms of Cost)

- Overall cost goes down \$0.29 PMPM
- Cost to plan goes up \$1.11 PMPM
- Member saves (on average) \$1.40
- Members with asthma save (on average) \$14.00 per month out-of-pocket

Actuarial Analysis – Assumptions, Approach, Qualifiers

- All work is based on PMPM costs, separate utilization and unit costs were not available
- Some copays were converted to coinsurance for pricing
- Collaboration with OHPH used to ballpark impacts of plan design – especially on value based services (room for additional research and improvement)
- This version includes medical and Rx, but not vision or dental

Example Used: OEBC Plan 7

- Medical has \$500 deductible/\$2,500 OOP max
 - 20% coinsurance for most other services
 - Preventive services have no cost sharing
 - Drug has \$1,000 OOP max
 - \$5 copay for generic, \$25 copay for preferred brand, 50% copay for nonpreferred
- Starting with 2010-2011 added some value-based features
- added additional cost tier (\$500 copays for certain procedures)
 - added \$100 copays for sleep studies, MRI, PET scans, CT scans
 - No “incentive tier” like some of the other OEBC plans
 - Rx value copay level added (\$4/\$8 instead of flat \$5)

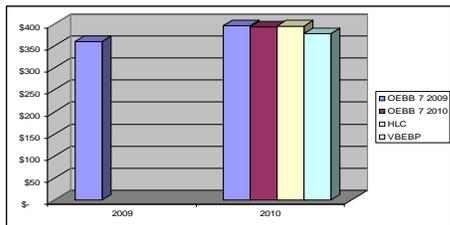
Example Used: HLC Version of OEBC Plan 7

- Begin with OEBC 2009 plan
- Add 6 Value Based Services
- Add Preference Sensitive Tier

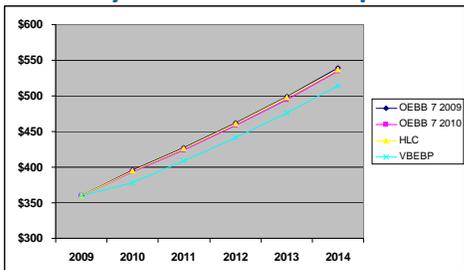
Example Used: VBEBP Version of Plan 7

- Medical \$500 deductible, \$2,500 OOP
- Rx separate \$1,000 OOP
- Value based services, 2 visits, comfort care at 0%
- Tiered coinsurance 10%/20%/30%/50%
- Tiered coinsurance 0%/20%/50% for diagnostic
- RX plan \$0/\$5/\$25/50% with shared \$1,000 OOP

Preliminary PMPM Cost Comparison



Preliminary PMPM Cost Comparison



Let's Review

- All these plan designs are making efforts to encourage the best care, and discourage ineffective care
- Carrots are more expensive than sticks
 - and savings calculations are more challenging
- VBEBP has largest spread between the best and the rest
 - and so is a way to dampen across-the-board cuts

Going Forward

- If the VBEBP concepts are attractive
 - more work on each VBS to weigh costs and savings of each intervention
 - additional modeling work to tighten up all aspects
 - and, of course, continue work with all stakeholders

Focus Group Progress Report

- Conducting focus groups for insurers, providers, large and small employers, consumers (insured and uninsured)
- Conducting in Portland, Southern Oregon, Central Oregon and Eastern Oregon as well as online
- Holding 15 in-person focus groups and 4 online discussions. Groups are mostly complete.
- Results will be available for the November meeting

VBEBP: Summary

- Furthers Oregon’s Triple Aim
 - Improves health without increasing overall costs
 - Improves quality by encouraging most effective services
 - Controls costs by discouraging less effective services
- Preliminary analysis suggests an impact on cost curve
- Analysis of longer term impact will continue
- VBEBP offers a way to soften the impact of budget cost sharing increases
- In an exchange, VBEBP would ensure that more money is steered toward higher-value care

Questions?

Incentives & Outcomes Committee Draft Recommendations

Oregon Health Policy Board Meeting
October 12, 2010



Committee Charter

- Make recommendations to the Board about and continually refine statewide health care quality standards
- Adopt principles for payment
- Develop recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care



Guiding Principles for Provider Payment

- Equity
- Accountability
- Transformation
- Cost Containment
- Simplicity
- Transparency



Committee Process: Quality & Efficiency

- Identified measurement priorities and potential indicators for payment reform work while attempting to balance:
 - Feasibility
 - Alignment with local and national partners
 - Provider burden vs. potential benefit of measurement
 - Value in having a mix of quality measure types
- Priorities and indicators identified within and across settings of care in the following areas:
 - Patient- and family-centeredness
 - Quality, effectiveness, and safety
 - Cost and efficiency
 - (Population health left primary for Health Improvement Plan Committee)



Committee Process: Payment Reform

- Developed guiding principles for payment reform
- Developed transition paths for payment reform across primary care, hospital, and specialty care
- Identified strategies for payment reform across settings and sectors, broadly:
 - Simplify payment by standardizing underlying fee-for-service payment methods that are building blocks for new payment methods
 - Develop and implement payment methods that reward providers who coordinate care across sites of care and increase patient involvement and achieve efficiency and quality improvement
 - Build feedback loop for continuous improvement



Full Committee Recommendations

1. Standardize payment methods (but not rates) to Medicare.
2. Transform primary care delivery system.
3. Focus measurement and payment efforts where the potential for improvement is greatest.
4. Encourage the delivery system to become more patient- and family-centered.
5. Initiate use of new payment incentives and methodologies.
6. Set a global health care spending target.



Recommendation #1

Objective: Reduce administrative costs and create an aligned foundation for new payment methods through standardization of payment methodologies

Recommendation: Standardize payment methods (but not rates) to Medicare

Implementation Steps:

- Enact statute in 2011 specifying the elements of Medicare's payment methodologies that are adopted
- Standardize in 2012 when Medicare annual update rules take effect (for example, October 1 for hospitals)
- Change standard payment method in Oregon as Medicare methods change

Outcomes

Improve the lifelong health of all Oregonians

Reduce administrative costs
Lower or contain the cost of care so it is affordable to everyone

Increase transparency of patient costs for services
Increase the quality, reliability, and availability of care for all Oregonians

Recommendation #2

Objective: Improve care coordination and health outcomes and align incentives for providing the right care, at the right time, in the right place.

Recommendation: Move forward decisively to transform the primary care delivery system.

Implementation Steps:

- Adopt the Patient-Centered Primary Care Home Standards and proposed structure for aligning payment to tiers
- Sponsor development of measurement and evaluation infrastructure for implementing models as basis for payment
- Restructure primary care payment for OHA and other payers, aligning with standards framework

Outcomes

Improved health outcomes through increased care coordination
Improve the lifelong health of all Oregonians

Reduce duplicative or unnecessary services
Lower or contain the cost of care so it is affordable to everyone

Shift reimbursement away from FFS system to outcomes-based payment
Increase the quality, reliability, and availability of care for all Oregonians

Recommendation #3

Objective: Improve delivery system performance in areas of high impact first.

Recommendation: Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

Implementation Steps:

- Obtain technical expertise to support OHA in selection of clinical conditions (like coronary artery disease or diabetes) and process issues (like health care acquired infections) to recommend for focused attention
- Develop specific payment tools addressed to selected conditions and process issues
- Align focus among payers, purchasers, providers, and patients

Outcomes

Progress on issues that make the most difference for the most people, with emphasis on eliminating disparities
Improve the lifelong health of all Oregonians

Progress on issues that produce the greatest savings
Lower or contain the cost of care so it is affordable to everyone

Progress on issues that produce greatest quality improvement
Increase the quality, reliability, and availability of care for all Oregonians

Recommendation #4

Objective: Create a delivery system structured to meet patient needs and support patients to be informed and active members of the health care team.

Recommendation: Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

Implementation Steps:

- Build patient and family engagement into the design of new payment systems
- Develop common measures of patient experience and engagement to be deployed across the system
- Lead (OHA) an effort to use learning networks to provide technical assistance on involving patients and families

Outcomes

Improve health through patient activation
Improve the lifelong health of all Oregonians

Reduce over-utilization when treatment choices reflect patient values – not fee-for-service incentives
Lower or contain the cost of care so it is affordable to everyone

Improve the patient experience of care through attention to all domains of patient and family-centeredness
Increase the quality, reliability, and availability of care for all Oregonians

Recommendation #5

Objective: Create an environment where health care providers work together across settings to provide evidence-based care that produces the best outcomes for patients and avoids unnecessary expense.

Recommendation: Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

Implementation Steps:

- Pilot and rigorously evaluate P4P and episode payment programs, with payers cooperating to achieve critical mass
- Test the value of service agreements and patient engagement strategies
- Give feedback to physicians and information to the public on provider performance
- Set priorities and measures across all OHA programs

Outcomes

Improve health by providing the right services

Improve the lifelong health of all Oregonians

Reduce costs by eliminating complications and waste

Lower or contain the cost of care so it is affordable to everyone

Shift reimbursement away from FFS system to outcomes-based payment

Increase the quality, reliability, and availability of care for all Oregonians

Recommendation #6

Objective: Stop consuming an ever-greater share of public and private resources on health care expenditures

Recommendation: Adopt a global health care spending target and act aggressively to keep spending within the target.

Implementation Steps:

- Adopt a spending target that limits health care spending growth to growth in a measure such as the consumer price index and monitors system performance relative to the target (target to be set by Health Policy Board)
- Develop improved measures of delivery system efficiency
- Develop benchmarks for the cost of delivering high quality care efficiently and use them in payment

Outcomes

Protect resources to spend for education, nutrition, housing and other determinants of health

Improve the lifelong health of all Oregonians

Articulate explicit decisions about spending priorities

Lower or contain the cost of care so it is affordable to everyone

Remove cost as a barrier to access

Increase the quality, reliability, and availability of care for all Oregonians

Linking Cost and Quality - example

Overall Objective: To create a more sustainable health care system in which payment rewards care consistent with Oregon's triple aim goals.

Tactic Objective: Decrease hospital readmissions

Measurement Tactics:

- Require reporting of 3 CMS condition-specific readmission measures
- Develop OR standard for overall readmission measure

Payment Method Tactics:

- Consider discontinuing reimbursement for health care acquired conditions
- Episode-based payments that cover up to 90-days post discharge

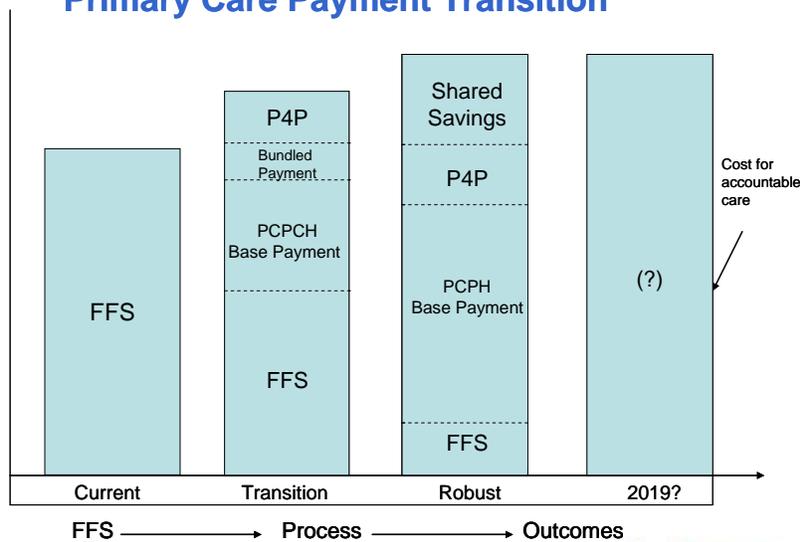
Outcomes

Improved health outcomes by giving appropriate, coordinated care
Improve the lifelong health of all Oregonians

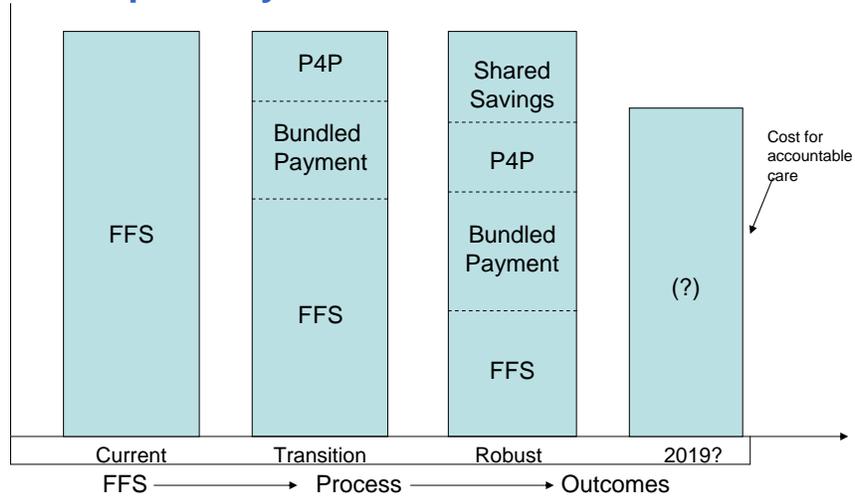
Lower cost of care by avoiding ED visits and hospital stays
Lower or contain the cost of care so it is affordable to everyone

Increased patient satisfaction when complications don't occur
Increase the quality, reliability, and availability of care for all Oregonians

Primary Care Payment Transition

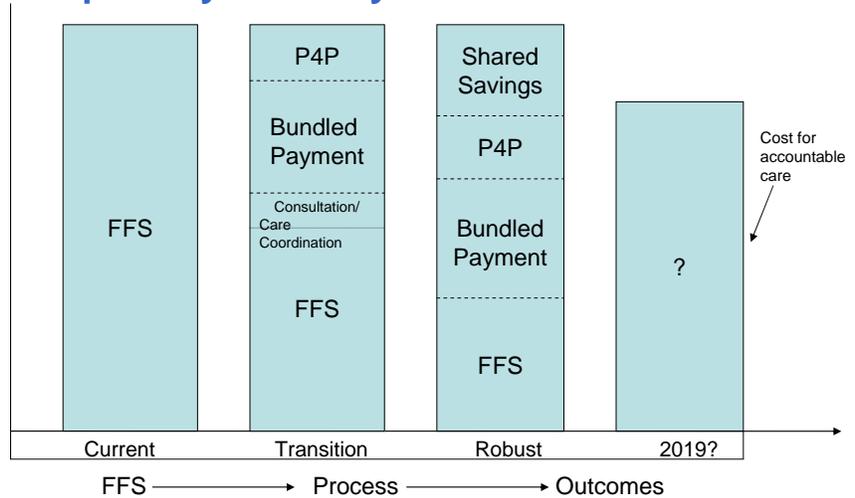


Hospital Payment Transition



Oregon Health Authority

Specialty Care Payment Transition



Oregon Health Authority

Now is a Unique Moment for Delivery System Reform: The Triple Win

Today's Fee-For-Service Health Care System

Fragmented - High Cost - Often Inappropriate - Often Unavailable Care

Comprehensive Reform

Payment Reform

Coverage Expansion

Savings

High Quality, Appropriate Care

Increased Appropriate Expenditures

Impact:

Triple Win

Purchasers

Lower PMPM

Reduced Cost Shift

Providers

P4P & Shared Savings

Increased Appropriate Utilization

Patients

The Right Care at the Right Time

Increased Affordability

Staff Recommended Implementation Timeline

2010	2011	2012	2013	2014	2015	2016	2017
Convene payment standardization workgroup	Introduce standardization bill	Standards effective		Continuous evaluation and refinement			
Adopt PCPCH Standards and payment	Develop cost-benefit and savings measurement methods			Make recommendation on standardizing additional payments			
OHA participates in Health Leadership Council pilot	Develop PCPCH Learning Collab.		Require PCPCH adoption across OHA and plan for statewide adoption				
Develop measurement, evaluation systems and infrastructure	Obtain technical consultation on recommended areas of focus	Foster multi-payer alignment on common focus areas	Incorporate common metrics into OHA contracts	Continuous evaluation, revision, and expansion of priority areas of focus			
Plan PCPCH implementation across OHA	Develop rec. for standard experience of care measure		Require experience of care measurement across OHA		Evaluate effectiveness of patient engagement efforts		
	Extend learning network on patient and family involvement		Extend focus on patient engagement beyond primary care				
	Establish P4P metrics and benchmarks across OHA	Align and expand P4P across OHA	Foster multi-payer P4P alignment	Develop web-based data collection tool			
	Define 5 - 10 service bundles			Continuous evaluation and refinement			
	Make case for non-payment of HAC and develop rules and contracts		Pilot episode payments		Consider standardizing P4P and bundles across Oregon		
		Develop pilot evaluation protocols		Develop cost of care benchmarks across all settings			
	Develop better efficiency measures		Develop efficiency benchmarks		Set cost targets and payment levels		

Recommendation #1
Recommendation #2
Recommendation #3
Recommendation #4
Recommendation #5
Recommendation #6

OHPR Staff Recommendations for OHA Implementation Steps

Recommendation #1: Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services.

- 2010: - Convene payment standardization work group
- 2011: - Introduce legislative measure
- Develop cost/benefit and administrative savings measurement methods
- 2012: - Standardization effective according to Medicare schedule (e.g. October 1 for hospitals).
- 2014: - Evaluate the program
- 2015: - Make recommendations on standardizing additional provider payments

Recommendation #2: Move forward decisively to transform the primary care delivery system.

- 2010: - Adopt PCPCH standards and proposed payment structure
- Participate in Health Leadership Council multi-payer pilot
- Develop measurement and evaluation systems and infrastructure for standards
- Initiate design of primary care homes across OHA populations
- 2011: - Develop learning collaborative to prepare for primary care redesign
- Begin PCPCH implementation in OHA programs
- 2013: - Evaluate medical home pilots and refine PCPCH program as necessary
- Require PCPCH implementation across OHA and develop strategy for statewide adoption

OHPR Staff Recommendations for OHA Implementation Steps

Recommendation #3: Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

- 2011: - Obtain technical consultation on common focus areas and measures
- Actively foster multi-payer alignment on common focus areas
- 2013: - Incorporate common metrics into OHA contracts
- 2014: - Continually assess, revise, and expand priorities for efforts

Recommendation #4: Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

- 2011: - Develop recommendation on patient experience of care and engagement standardization
- 2012: - Extend an existing learning network to increase patient- and family-centered care
- 2013: - Require patient experience of care/engagement measurement across OHA
- Extend focus on patient and family engagement beyond primary care
- 2014: - Develop web-based tool for collection of patient experience of care/engagement data
- Evaluate effectiveness of patient and family engagement efforts

OHPR Staff Recommendations for OHA Implementation Steps

Recommendation #5: Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

- 2011:
- Establish P4P metrics and benchmarks to be used across OHA
 - Define 5-10 bundles for services where there is high opportunity for improvement
 - Develop business case for discontinuing payment for hospital acquired conditions
 - Develop rules for non-payment for hospital acquired conditions that include physicians and hospitals
- 2012:
- Develop contract language and administrative rules for non-payment for hospital acquired conditions
 - Align and expand P4P programs within and across the OHA
 - Actively foster multi-payer alignment on metrics used in OHA for P4P programs
 - Develop a payment reform pilot evaluation protocol
 - Establish a method for aggregating and disseminating data on provider performance
- 2013:
- Pilot multi-payer episode payments
- 2014:
- Evaluate experimental programs
 - Consider standardizing P4P metrics and episode bundles
- 2015:
- Develop benchmarks for efficiency and the total cost of care across all settings

Recommendation #6: To stop spending an ever-greater share of public and private resources on healthcare, adopt a global health care spending target.

- 2011-13:
- Develop improved efficiency measures for hospital, specialty, and primary care
 - Develop cost benchmarks for delivering high quality care efficiently
- 2015:
- Evaluate ROI, patient and provider satisfaction, improvement in health outcomes and refine performance measurement systems as necessary
 - Use benchmarks to set cost targets and payment levels



Potential focus areas for Incentives & Outcomes Committee Proposals

The Incentives and Outcomes Committee believes that the health care system must do better in delivering care that is patient- and family-centered, effective, efficient, safe, timely, and equitable. Subcommittee work and staff research have generated a large number of clinical conditions or procedures that might serve as concrete starting points for pilot testing or initial roll-out of reforms designed to achieve those goals. This document outlines some of the similarities and differences between potential targets and is intended as an informational tool to assist in the identification of a small number of focus areas for reform proposals emerging from the full Committee.

The **Quality & Efficiency Subcommittee** has recommended targets that align with those identified by the National Priorities Partnership as having “the most potential to result in substantial improvements in health and health care, and thus accelerate fundamental change in our healthcare delivery system”.

The **Payment Reform Subcommittee** has identified the following as principles for payment system design: equity; accountability; transformative; cost containment; simplicity; and transparency. Its specialty workgroup has recommended targets based on evidence of variation, high cost, and potential for savings.

OHRP staff has recommended targets that rank high on at least 2 of the following dimensions:

- Potential to improve quality and efficiency where resource use is high or number of people affected is large (impact);
- Feasible to start addressing in the short-term (feasibility);
- Of differential importance to marginalized populations (health equity); and
- Potential for synergy with local or national partner efforts (synergy)

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Heart attack, heart failure (hospital setting – from CMS core measures)</p> <p><u>Rationale:</u> National alignment; existing reporting infrastructure</p>	<p>Cardiac conditions</p> <p><u>Rationale:</u> Key cost driver in commercial coverage</p>	<p>Congestive Heart Failure, Coronary Artery Disease</p> <p><u>Rationale:</u></p> <p>Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; OR commercial inpatient costs are highly variable</p> <p>Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are underutilized;</p> <p>Equity - disparities exist in receipt of recommended tx; Synergy - synergy with local or national partners;</p>

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Low back pain / spine surgery appropriateness <u>Rationale:</u> NPP and local priority; high cost for PEBB; potential for useful physician profiling and intervention; good area for consumer education and shared decision-making.</p>		<p>prevalent chronic diseases</p> <p>Low back pain/surgery <u>Rationale:</u> Impact - High cost for PEBB; OR Medicare utilization high and variability within Oregon is high Feasibility - bundle models for episode payment exist; good patient decision-making tools exist Synergy - synergy with local and national partners</p>
<p>Joint replacement <u>Rationale:</u> NPP priority</p>	<p>Musculoskeletal conditions, particularly joint disease and joint replacement surgery <u>Rationale:</u> Key cost driver in commercial coverage</p>	<p>Osteoarthritis and arthropathies/joint disorders and joint replacement <u>Rationale:</u> Impact: preventable complications are high % of commercial claims; cost driver in Medicare FFS and Oregon Medicare FFS cost is high; represents large share of hospital costs for commercial pop; Oregon Medicare utilization is high; commercial cost highly variable; Feasibility: bundle models for episode payment exist; high-value services are underutilized; Synergy - synergy with local and national partners</p>
<p>Imaging appropriateness <u>Rationale:</u> NPP priority; national and local momentum; potential to address in inpatient and ED settings</p> <p>Cardiac diagnostics <u>Rationale:</u> NPP priority</p>	<p>Oncology <u>Rationale:</u> Key cost driver in commercial coverage</p> <p>Duplicate or inappropriate diagnostic tests</p>	<p>Colon cancer <u>Rationale:</u> Impact: preventable complications are high % of commercial claims; Oregon Medicare FFS cost is high Feasibility: bundle models for episode payment exist; good patient decision-making tools exist Equity: racial disparities exist in screening and mortality</p>

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Skin injuries and falls (hospital setting)</p> <p><u>Rationale:</u> NPP priority</p>		
<p>Readmissions (hospital setting)</p> <p><u>Rationale:</u> measure of defects in coordination of care; cross-setting issue</p>	<p>Readmissions (hospital setting)</p>	
<p>Healthcare acquired infections</p> <p><u>Rationale:</u> NPP priority; national and state momentum; opportunity to further NSQIP; existing state reporting infrastructure</p>	<p>Healthcare acquired infections</p>	
		<p>COPD</p> <p><u>Rationale:</u></p> <p>Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high;</p> <p>Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available;</p> <p>Synergy - synergy with local or national partners; prevalent chronic disease</p>
<p>Maternity care (c-sections)</p> <p><u>Rationale:</u> Difficult issue but huge area for Medicaid; good area for patient-centered and shared-decision making approaches; NPP priority</p>	<p>Maternity care</p>	<p>Pregnancy, delivery, newborns</p> <p><u>Rationale:</u></p> <p>Impact - High cost for OHP, PEBB;</p> <p>Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are under-utilized;</p> <p>Equity - disparities exist by insurance status</p>
<p>Pneumonia (hospital setting – from CMS core measures)</p> <p><u>Rationale:</u> National alignment; existing reporting infrastructure</p>		<p>Pneumonia</p> <p><u>Rationale:</u></p> <p>Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; high cost for OHP; OR inpatient costs are highly variable;</p> <p>Feasibility - high-value services are under-utilized; bundle models for episode payment exist</p>

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Heart attack, heart failure (hospital setting – from CMS core measures) <u>Rationale:</u> National alignment; existing reporting infrastructure</p>		<p>Equity - disparities exist by income and insurance status Synergy - Synergy with national partners</p>
<p>Children’s asthma care (hospital setting – from CMS core measures) <u>Rationale:</u> National alignment; existing reporting infrastructure</p>		<p>Asthma <u>Rationale:</u> Impact - preventable complications are high % of commercial claims Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Disparities - income-based disparities exist Synergy - synergy with local or national partners; prevalent chronic disease</p>
		<p>Diabetes <u>Rationale:</u> Impact - preventable complications are high % of commercial claims; high rate of readmissions; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Equity - disparities exist particularly in complication rates Synergy - prevalent chronic disease</p>
		<p>Mental disorders (undifferentiated) <u>Rationale:</u> Impact - cost driver for Medicare; high cost for OHP, PEBB Disparities - OR suicide rate is high compared to nat'l average</p>

Incentives and Outcomes Committee
Background Materials & Recommendations to the Health Policy Board
10/12/2010

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I. Staff Background

A. The Challenge

Our health care delivery system is broken. Per capita health spending has risen faster than the consumer price index and personal income for decades, and total health spending consumes an ever-growing percentage of our nation’s gross domestic product. Most health care professionals and institutions lack the information, infrastructure and incentive to ensure that the services they provide and bill for actually improve the health of their patients. As a result, health care is too often of poor quality—not safe, timely, effective, efficient, patient-centered, and equitably provided. Moreover, it is estimated that about 30% of services provided to patients is unnecessary or inappropriate.¹

But we have the delivery system we created and we cannot correct flaws that we cannot identify or measure and that providers lack the incentive to change. Currently, measurement of system and provider performance is fragmented and partial. Moreover, the fee-for-service payment system fails to link payment to achievement of desired outcomes. It pays for units of service and procedures; it does not pay for improving health or delivering superior quality and efficiency. It rewards hospital admissions and expensive procedures; it does not reimburse for care coordination, discharge planning, and other activities that are critical to keeping people healthy.

The delivery system is in urgent need of change. Key change strategies will include measuring quality and efficiency and deploying payment strategies that hold all participants in the system accountable for improvement.

B. Charge to the Committee

To assist with addressing the delivery system transformation challenge, the Health Policy Board established an Incentives and Outcomes Committee, charging it to make recommendations relating to quality improvement and payment strategies.

The committee's charter calls on it to:

- Make recommendations to the Board about and continually refine uniform, statewide health care quality standards in support of a high performing health system and the further development of value-based benefit design for use by all purchasers of health care, third-party payers, and health care providers;
- Adopt principles for payment; and
- Develop recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care.

This report provides the committee's initial recommendations made in response to the charge above. The strategic recommendations are preceded by the committee's overall vision or delivery system transformation (see below) and followed by staff recommendations on concrete action steps for implementation (see page 14).

C. An Oregon Strategy to Reach the Triple Aim

Delivery system transformation is necessary to reach the triple aim goals of lifelong health; increased quality, reliability, and availability of care for all Oregonians; and lower costs so that care is affordable to everyone. Transformation will be a product of collaborative efforts to continuously improve the quality of care for individuals and the performance of the system as a whole.

The transformed delivery system should function within a clear total system budget that reflects both the costs of providing care and the capacity and willingness of society to pay—e.g., does not continue to absorb an ever-greater share of private and public resources. It should ensure that access to evidence-based care is not differentially granted or denied particular individuals or populations based on factors unrelated to medical need. This system should:

- Foster provider accountability through a mature measurement infrastructure that provides meaningful, accurate, and actionable data on delivery system performance at the provider, practice, and institutional levels;
- Measure provider performance on both health outcomes and cost metrics relative to historical performance, peer performance, and explicit benchmarks; and
- Include a payment structure that initially rewards performance and ultimately is tied to the budgeted cost of efficient provision of necessary care.

Ultimately, providers will be capable of and responsible to be wise stewards of limited health care dollars working in partnership with patients who are empowered and supported to make health care decisions consistent with their values.

This transformation will not be instantaneous; it will be a process. Some provider organizations—particularly the integrated systems--will be able to respond very quickly to information on performance and changed incentives, but others will require more

support and time. Neither implementing silo-ed quality initiatives nor changing payment incentives will instantly result in the provider and system behavior change that will improve health outcomes. A realistic transformation strategy must include five key elements:

- Payment incentives strong enough to overcome ingrained medical culture;
- Strategic, targeted quality measurement and improvement initiatives;
- Support for change in medical practice and business strategy;
- Meaningful involvement of patients, families, and communities; and
- Time for adjustment.

In the short-term, transformation efforts should focus on:

- Building provider capacity to organize and restructure care processes, coordinate care, and use data to deliver care more effectively and efficiently;
- Increasing patient engagement; and
- Aligning improvement efforts across the system.

During this phase, the state should standardize and align payment methods and experiment with new payment methodologies—in the process building provider capacity to coordinate care and improve care processes.

In the medium-term, we will learn from payment experience, strengthen accountability, and improve tools for setting efficiency targets.

In the long-term, payers will migrate toward payment methods that place greater constraints on spending and responsibility on providers to help allocate spending for greatest benefit to patients.

D. Delivery System Reform Cannot Wait

Change is hard. Oregon will be asking providers and facilities to work with us to avoid things that—in today’s payment environment—produce revenue: Unnecessary office visits, unnecessary procedures, preventable hospital admissions. That means reduced income for some providers. We believe that once providers and facilities learn to reduce their costs, they can share in the savings; but it is very hard for them to choose to be a part of a project that puts at risk the fee-for-service income stream they have counted on.

But now is a unique moment. Beginning in 2014, far more Oregonians will have insurance coverage due to passage of the federal Accountable Care Act. An increase in coverage will likely produce an increase in overall health service utilization. This will bring more revenue to providers, cushioning the blow they might otherwise experience as unnecessary utilization declines. It is a triple win (Figure 1):

- Purchasers: Lower costs for purchasers through both the elimination of the cost shift and the improvement of the quality and efficiency of care.
- Providers: Stable revenue for providers who will have patients and opportunities for rewards for providing good care efficiently.
- All Oregonians: The right care, at the right time, at the right price.

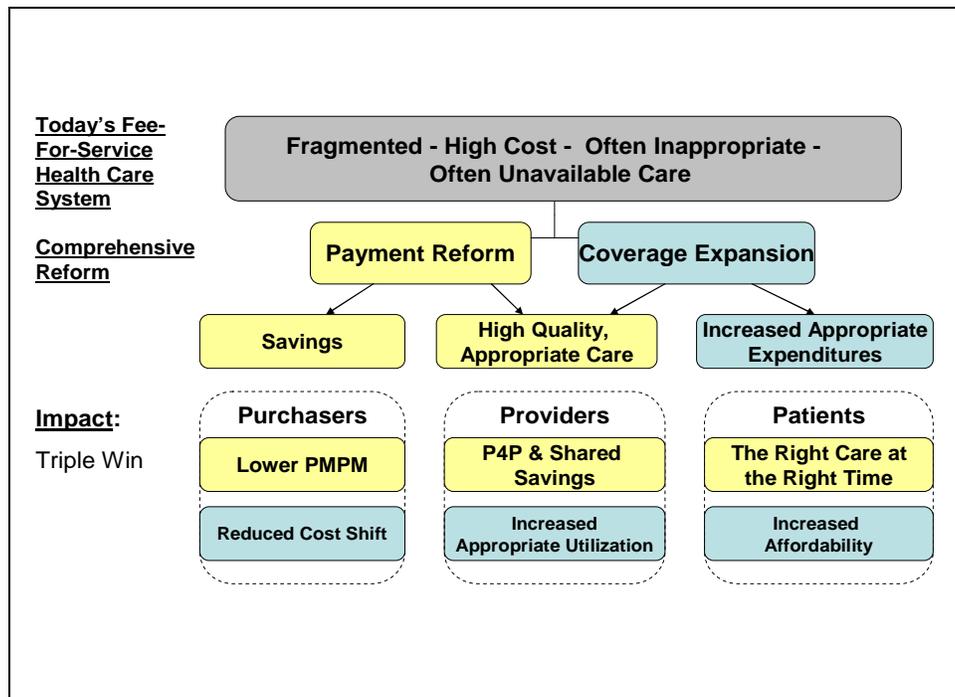


Figure 1. The Triple Win

II. Committee Recommendations

Oregon's health care system is unsustainable. Many professionals and institutions lack the information and infrastructure to ensure that the services they provide actually improve the health of their patients. Current financing and payment mechanisms (such as fee for service) contribute to the problems of the system by failing to link payment for health care goods and services to achieving desired outcomes. The transition from current payment mechanisms to those that will support a sustainable health care system must be grounded in transparent measurement of outcomes supportive of the Oregon Health Authority's Triple Aim goals and should be guided by the principles of equity, accountability, simplicity, transparency, affordability, and transformation.

The committee has made six recommendations designed to support the transformation to a sustainable health care system for Oregon. In addition, the committee identified the following as necessary elements of each recommendation:

- Demonstrate the business case for the reform effort, outlining the expected health improvement outcomes and why the reform makes financial sense for the OHA and the larger health system;
- Develop concrete implementation steps, processes, and timelines; and,
- Develop measurement capacity and evaluation programs so that the Board and state can see if the projected business case is playing out, including whether health improvements are being achieved.

1. Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services

What: Adoption of a standard payment methodology is the first step Oregon must take to restructure payment for value. Medicare offers the most reasonable payment method to adopt for hospital, ambulatory surgery, physician and professional services, except services billed by critical access hospitals or type A and B hospitals. Standardization of payment methodologies is a vital foundation for aligning incentives for payment methods such as episodes of care or other accountable payment methods and an important an important measure to reduce administrative cost.

How: A new statutory requirement should be enacted in 2011, effective in 2012 when Medicare's updated rules go into effect for the particular provider type (e.g. October 1 for hospitals). The standard payment method for Oregon would change as Medicare methods change. The statute would clearly state which elements of Medicare's payment methodologies are adopted in Oregon and what deviations, if any, are permitted.

2. Move forward decisively to transform the primary care delivery system.

What: Primary care homes as described by the Patient Centered Primary Care Home Standards Advisory Committee final report are fundamental to achieving the triple aim and should be rolled out as aggressively as possible. This will require the involvement of all payers and primary care providers.

How:

- The Health Policy Board should adopt the Patient Centered Primary Care Home Standards and the Committee's proposed structure for aligning payments to tiers within those standards as the model for primary care redesign in Oregon.
- The Oregon Health Authority (OHA) should sponsor development of measurement and evaluation systems and infrastructure for implementing the standards as a basis for payment.
- The OHA and other payers should immediately restructure primary care payment, aligning with the standards framework. It is recognized that payers may pay at differing levels for attainment of the same levels of performance and that practices will become robust primary care homes at varying speeds.

3. Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

What: The primary emphasis of the first phase of work to improve quality and reduce cost should be eliminating the most significant defects in care. 'Defects' is a broad term

that includes over- and under-utilization, lack of safety, uncoordinated care, and other examples of poor quality, inefficiency or unreasonable cost.

How:

- Both elements of the Committee have made initial recommendations of focus areas. The Quality and Efficiency Subcommittee has suggested readmissions, low back pain, cardiac care, healthcare acquired conditions, and care coordination, among others, and the Payment Reform Subcommittee has identified cardiac conditions, orthopedic conditions, and cancer treatment. See Attachment 1 for a side-by-side comparison of potential targets.
- Further technical work should begin immediately to finalize these initial proposals as OHA recommendations for common focus areas and to link them with payment.
- Payers, purchasers, providers, and patients should adopt the recommended common focus areas for measurement and payment work to increase the impact of their efforts. In selecting focuses, primary emphasis should be given to potential for reducing costs and eliminating defects, while giving consideration to potential for reducing inequities and aligning with national and local initiatives.

4. Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

What: When patients and families participate as full partners with healthcare professionals to improve their health, system performance improves. A truly patient- and family-centered system will structure services and care to support the patient and family to be full members of the healthcare team. Responsibility for patient engagement should be clearly articulated and allocated among providers, patients, and plans. Evaluation of the success of efforts to increase patient- and family-centeredness should touch the domains of patient and family involvement, support for patient self-management, use of evidence-based shared decision-making tools and processes, coordination of care, respect for patient values, and organizational attention to the patient experience of care.

How:

- This dimension has been built into primary care home standards and should be extended to other parts of the system through the design of new payment systems and other mechanisms.
- To accelerate patient engagement efforts, common measures of patient experience and engagement should be developed and deployed across the system.
- To build provider capacity in this area, OHA should lead efforts to extend an existing learning network that provides technical assistance to organizations to help them learn how involve patients and families as advisors.

5. Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

What: Migrate as rapidly as possible away from exclusively fee-for-service provider payment systems and toward systems that reward desired structures, processes, and outcomes and systems that incent providers to coordinate care, eliminate care defects, and drive unnecessary costs out of the system. To ensure successful transition to new payment methods, it will be necessary to build provider capacity to restructure their practices to respond effectively to new payment incentives.

How:

- The OHA and other payers should pilot new payment programs (or align with and expand existing ones), including pay-for-performance and episode payment programs, cooperating to achieve critical mass sufficient to support and incent delivery system change.
- To accelerate widespread adoption of common priorities and measures, OHA should provide leadership by setting priorities and measures and using them in all of its programs.
- Payment pilot programs should test the value of service agreements and patient engagement strategies and should address a range of clinical issues based on an assessment of potential for measurable delivery system improvement.
- Pilots should be designed to facilitate rigorous evaluation of the payment innovation and to provide feedback to physicians and the public on provider performance.

6. To stop spending an ever-greater share of public and private resources on healthcare, a global health care spending target should be adopted.

What: The Health Policy Board should set a spending target that limits growth of health care spending to growth in a measure of overall consumption or income such as the consumer price index. Aggressive action should be taken to keep spending within the target.

How:

- The Health Policy Board should set the spending target and monitor system performance relative to the target.
- The OHA should develop improved measures of delivery system efficiency.
- The OHA should develop benchmarks for the cost of delivering high quality care efficiently that are based on rigorous examination of the evidence.
- Payers should use benchmarks to set cost targets and payment levels.
- The business case (in terms of expected improvement in health outcomes and system cost) should be demonstrated for all programs and technologies, beginning with new proposals and eventually extending to existing practices.

III. Subcommittee Process and Recommendation Development

The following section provides context and further background information on the development of the short-term policy recommendations made by the Incentives and Outcomes Committee of the Health Policy Board.

A. Quality Measurement in Support of Improvement

Performance measurement can identify and highlight defects in care: over- and under-utilization, lack of safety, uncoordinated care, and other examples of poor quality or inefficiency. Measurement and feedback are critical first steps for broad-based quality improvement efforts.

In its initial body of work, the Quality & Efficiency Subcommittee identified measurement priorities and potential indicators to inspire the work of its sister subcommittee and private sector groups by providing measureable targets for payment reforms. Measurement priorities and potential indicators were selected with the following considerations:

- A focus on measures that would be feasible to implement immediately and that would align with or build on the measurement efforts of local and national partners;
- A desire to balance the benefit of measurement against the burden it may create for providers and healthcare systems; and
- A strong appreciation for the value of having a mix of quality measures: measures of the conditions under which care is provided (structural measures); measures of the processes of care; and outcome measures focused on changes in health status or cost attributable to care provided. This categorization of measures is known as the Donabedian typology.

Measurement priorities and related indicators were identified both within and across settings of care:

1. Patient- and family-centeredness

In a redesigned healthcare system that aligns payment with value, the degree to which patients and families are meaningfully engaged in their care will be a critical factor for success. When patients and families participate as full partners with healthcare professionals, both system performance and the patient experience of care improve significantly. The Quality & Efficiency Subcommittee recognized six distinct domains of patient- and family-centeredness:

- Patient- and family engagement
- Self-management support
- Shared decision-making
- Respect for patient values, preferences, and expressed needs
- Care coordination; and
- Organizational attention to the patient experience of care

Incentives and Outcomes Committee Recommendations

The Committee has made specific recommendations (see page 6) for next steps to improve patient and family-centeredness including establishing standards for measurement of patient experience of care/engagement and developing the capacity of provider organizations to involve patients and families as advisors in all aspects of care delivery. In addition, the Committee recommends measurement of patient- and family engagement and inclusion of related tools and strategies in relevant payment reforms.

2. Hospital and specialty priorities

Quality & Efficiency Subcommittee recommendations for short-term measurement priorities in the hospital setting are:

- Skin injuries (pressure ulcers) and falls because of their frequency, the potential for synergy with national work and partnerships with nursing leadership in the state, and the high cost of care related to these safety failures;
- Readmissions, because these are an indicative of shortcomings in care coordination within and outside the hospital;
- Healthcare acquired conditions because of national and state momentum and the opportunity to advance quality in this area through NSQIP, the National Surgery Quality Improvement Program; and
- The areas of care covered by CMS's core process of care measures: heart failure, heart attack, pneumonia, and surgical safety.

In the area of specialty care, the Subcommittee recommended strengthening system and provider capacity to measure appropriate use of:

- Imaging
- Treatment for low back pain
- Maternity care (particularly cesarean sections)
- Joint replacement
- Cardiac diagnostics and percutaneous coronary interventions

Further technical work is needed to specify how measurement would occur and to link these topics to payment. However, these focus areas align with thinking in the Payment Reform Subcommittee and would create synergy with local and national efforts. The topics listed above represent the Committee's suggestions of the most fruitful starting points for payment reform pilots in hospital and specialty care.

3. Primary care priorities

The Committee strongly supports the primary care home model as articulated by Oregon's Patient-centered Primary Care Home (PCPCH) Standards Advisory Committee in March 2010. The PCPCH Committee identified six core attributes of a primary care home and articulated number of standards that describe how care delivered by a primary care home would embody the core attributes. In addition, the Committee developed a detailed set of patient centered primary care home measures. The six core attributes, with patient-centered language explanations, are:

- Access to care (be there when I need you);

Incentives and Outcomes Committee Recommendations

- Accountability (take responsibility for making sure I receive the best possible health care);
- Comprehensive whole person care (provide or help me get the health care and services I need);
- Continuity (be my partner over time in caring for my health);
- Coordination and integration (help me navigate the health care system to get the care I need in a safe and timely way); and
- Person and family centered care (recognize that I am the most important member of my care team and that I am ultimately responsible for my overall health and wellness).

The full report can be found online at:

http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf.

For initial measurement and implementation, the Quality & Efficiency Subcommittee suggested prioritizing the following standards of each attribute:

- Access: in-person (appointment) and telephone access, followed by electronic access
- Accountability: tracking and reporting of clinical quality indicators, followed by improvements in medication management practices
- Comprehensiveness: provision of behavioral health care
- Continuity: linking patients with a personal clinician or care team
- Coordination: capacity for care planning, followed by evidence of the primary care home's connection to the larger medical neighborhood

Development of a measurement system and support infrastructure for primary care home implementation is one of the Committee recommendations for transforming primary care. The priorities suggested above, along with others identified by the Payment Reform Subcommittee, may serve as an entry-level set of standards for immediate implementation.

B. Transformation of Provider Payment

1. Principles for Provider Payment

The Committee believes getting payment incentives right is a critical element of the transformation project. Its payment reform subcommittee developed detailed principles for a reformed payment system, which are attached as Exhibit #1. In short the guiding principles for the Committee's work became:

- Equity
- Accountability
- Transformation
- Cost Containment
- Simplicity
- Transparency.

2. The Transition Path

The Committee believes that for most providers, the path from fee-for-service payment to comprehensive payments will traverse some intermediate ground wherein providers are paid in a mix of ways. During the intermediate phases, we expect payers to use the following types of payment:

- “Pay-for-performance” incentive payments: These payments are built on a fee-for-service base to reward structure, process, or health outcome achievements. Incentive payments are often calculated as a percentage of the underlying fee-for-service payment. They may result in increased total provider payments. But a payer’s total cost may be kept neutral by reducing base fee-for-service payments payment and using the savings to create an incentive payment pool from which incentive payments can be made to top performers.
- “Shared savings” payments: Shared savings are also built on a fee-for-service base. If a provider or group of providers keeps costs of care below a target while maintaining or improving quality standards, the insurer or other payer may allow the provider to keep a portion of the savings—thereby encouraging coordination or care and efficiency.
- “Bundled” or “episode” payments: A bundled or episode payment is a single payment for all services connected to an episode of care such as a hospital admission for a surgery and post-acute care or a year’s care for a diabetic patient; the payment covers services performed by multiple providers in multiple settings, thereby encouraging coordination of care and avoidance of unnecessary re-admissions.
- “Primary care base payments”: Payments to support primary care practices’ infrastructure development, care coordination, patient engagement, and other activities that the current fee-for-service system does not reimburse. The base payment would also include reimbursement for provision of a bundle of primary care services.

The Committee’s vision for the transition from fee-for-service to more comprehensive, outcomes-oriented payment models is illustrated below for three major categories of providers: primary care practices, specialty practices, and hospitals. Some providers may have the capacity to move more quickly along the path than others. Carrying out the transition process is further complicated by the reality that Oregon providers function in relation to an array of payers of which the Oregon Health Authority is only one. They therefore respond to incentives created by multiple payment systems. Our goal is for all payers to re-configure their payment policies in according with the framework discussed below.

Primary care practices need to take on greater responsibility for care coordination and management, prevention, and support for patient engagement. To take on these new roles practices will incur new expenses such as salaries for nurse case managers and costs of implementing electronic medical records systems, which cannot be recovered by billing

traditional codes. The payment system will need to support those changes through a system of “patient-centered primary care base payments” that could take the form of enhanced rates for billed services or, more likely, risk-adjusted per member per month health plan payments. The Committee envisions that base payments will grow over time to replace fee-for-service payment for preventive and routine care services in addition to continuing to support the primary care home infrastructure and non-billable services.

In addition to the base payment, primary care practices will receive some of their payment in the form of “pay-for-performance” incentive payments that reward achievements not covered under the base payment; “bundled payments;” and “shared savings” payments. Until the fee-for-service model is entirely replaced by something else, primary care practices would also be paid fee-for-service payments for procedural services to encourage providers to practice to the “top of their license”.

The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 2.

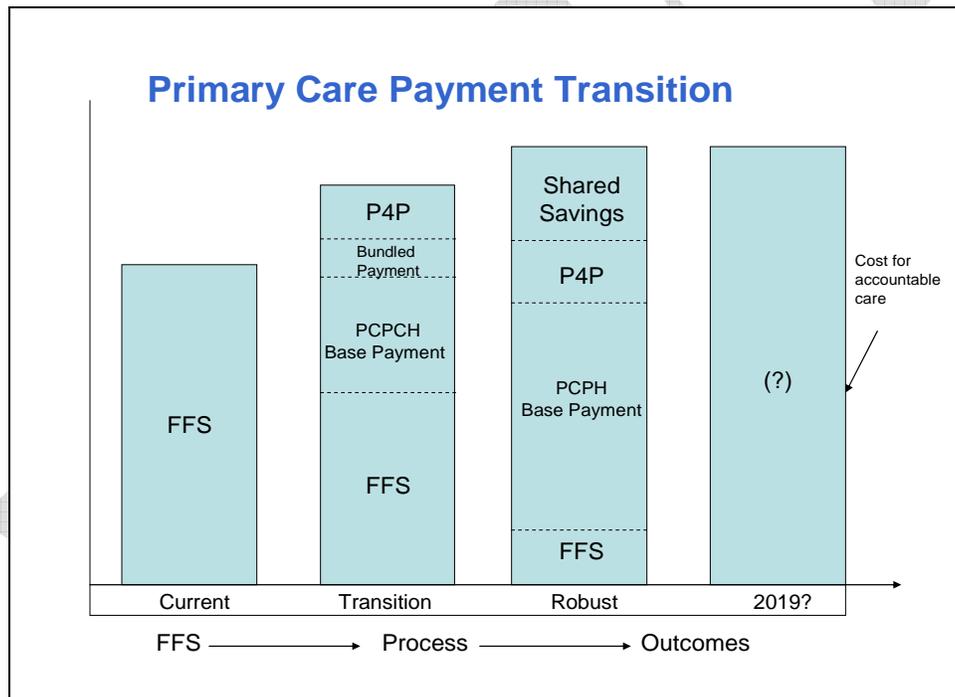


Figure 2. Primary Care Payment Transition

Specialty provider practices will also need to change. In a reformed delivery system, they will coordinate more closely with both primary care practices and hospitals and other care facilities. They will be asked to provide greater support to primary care to manage chronic conditions without unnecessary referrals and to work with hospitals to reduce costs of hospital admissions and avoid preventable admissions. They will be asked to involve patients more in decision-making about their care, which we expect to reduce variation in utilization of certain kinds of procedures that are over-utilized in Oregon relative to the rest of the country. Reimbursement dollars will gradually move away from

the fee-for-service bucket to pay-for-performance, shared savings, and bundled payment buckets. Payers using bundled payment methods may wish to support increased coordination by paying specialists on a fee-for-service basis for advising primary care physicians and other work that is not currently reimbursed.

The committee expects there to be a decline in payments to specialists, as a percentage of total health care spending. This reduction in revenue to specialists will be mitigated by increases in utilization related to increases in coverage supported by federal health reform. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 3.

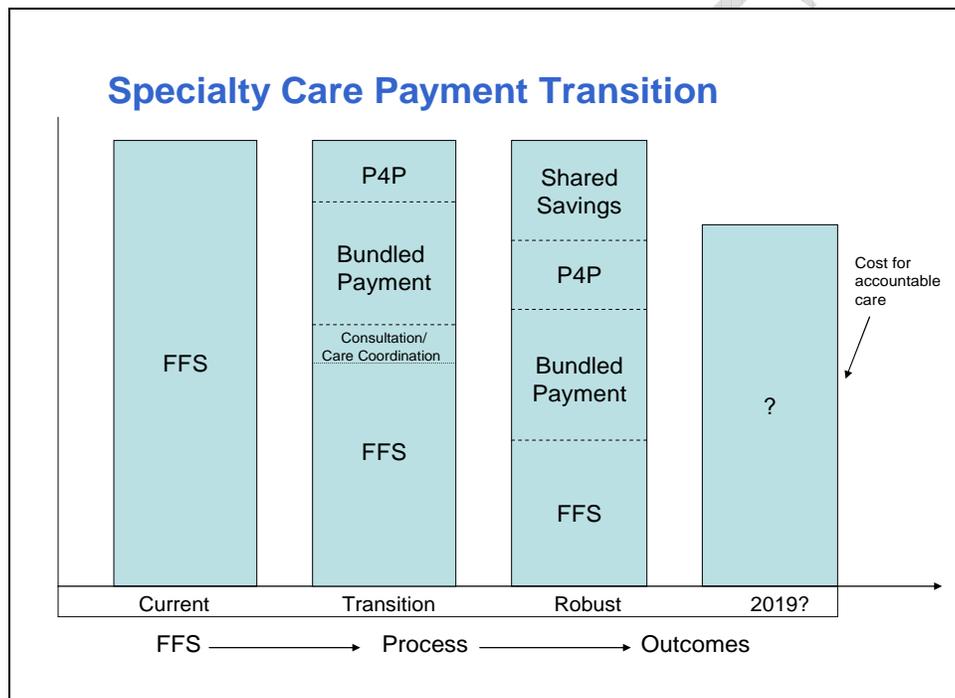


Figure 3. Specialty Care Payment Transition

Hospitals, like specialty care practices, will need to coordinate more closely with providers in other settings to improve quality and efficiency. Whereas the bulk of hospital payments are currently paid on a fee-for-service basis, as a percentage of charges, hospitals should eventually be paid primarily on a bundled basis. Bundles should be constructed so that hospitals no longer make money from readmissions but rather must “guarantee” their work for a period following a patient’s discharge.

The committee expects there to be a decline in payments to hospitals as a percentage of total health care spending, as transitions of care improve, unnecessary hospitalization is avoided, and services are provided in the least intensive setting consistent with good health outcomes. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 4.

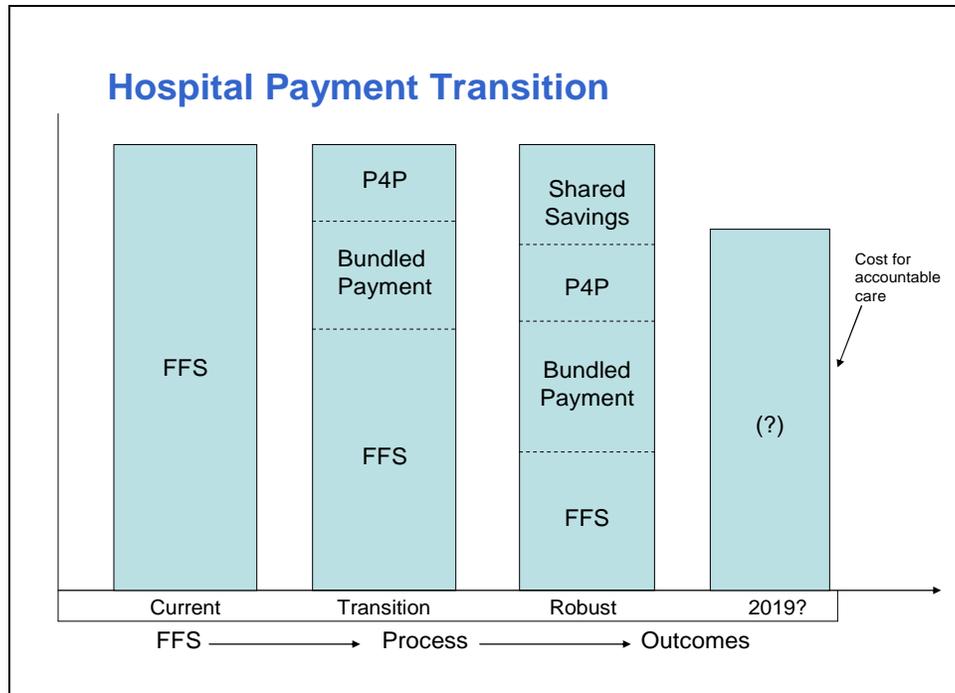


Figure 4. Hospital Payment Transition

IV. Next Steps in Quality and Efficiency Measurement and Payment Reform

Staff Recommendations for Action by the Oregon Health Authority (not reviewed by the committee)

1. Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services.

Short-term

2010

- Convene work group to flesh out details, including exceptions that allow room for episode payment and other more comprehensive payment methods

2011

- Introduce legislative measure
- Develop method to predict cost/benefit and measure actual administrative savings from standardization

2013

- Changes effective January 1

Medium-term

- Evaluate the program (2014)

Incentives and Outcomes Committee Recommendations

- Make recommendations on the value likely to come from standardizing additional provider payments to Medicare (2015)

2. Move forward decisively to transform the primary care delivery system.

Short-term

2010

- Adopt Patient Centered Primary Care Home (PCPCH) standards and proposed structure to align payments to the tiers
- OHA (Medicaid, PEBB, OEBC, OMIP) participates in Health Leadership Council multi-payer pilot
- Sponsor development of measurement and evaluation systems and infrastructure for implementing the standards as a basis for payment
- Initiate design of regional expansion of primary care homes across OHA populations and care settings (e.g. private practice and community health centers) building in appropriate methods for compensating providers

2011

- Develop learning collaborative for OHA providers to prepare for primary care redesign
- Begin PCPCH implementation in regions with high percentage of OHA lives and where OHA can leverage enhanced Medicaid payments authorized by the ACA

2013

- Evaluate medical home pilots, including ROI, patient and provider satisfaction, improvement in health outcomes; refine PCPCH program as necessary
- Require all OHA plans and providers to implement PCPCH and develop strategy to ensure statewide adoption of PCPCH

3. Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

Short term

2011

- Conduct technical work necessary to support selection of common focus areas and measures and to link those with payment. Criteria for targeting to include impact on cost or quality, feasibility, potential to address disparities, and opportunity to create synergy with local or national efforts.
- Actively foster multi-payer alignment on common focus areas for measurement and payment. (2011-12)

2013

- Incorporate metrics into OHA contractual programs for performance improvement, pay-for-performance, and bundled payment (see #5).

Medium term

- Continually assess, revise, and expand priorities for efforts (2014-ongoing).

4. Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

Short-term

2011

- Develop recommendations for statewide standardization of patient experience of care and engagement measures

2012

- Lead efforts to extend an existing learning network to increase provider capacity in patient- and family-centered care and to assist organizations to learn how to involve patients and families as advisors.

2013

- Require measurement of patient experience of care/engagement across OHA contracted providers
- Extend focus on patient and family engagement beyond primary care to other parts of the system through the design of new payment systems and other mechanisms

Medium term

- Develop web-based mechanism to assist smaller organizations in collection of patient experience of care/engagement data (2014)
- Evaluate effectiveness of patient and family engagement efforts (2015)

5. Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

Short-term

2011

- Establish P4P metrics and benchmarks to be used across OHA; aligning with Medicaid and Medicare P4P metrics where possible
- Define 5-10 bundles for services where there is high opportunity for improvement in quality/cost/equity/learning and identifies services required to deliver the bundle without defects (2011-2013)
- Determine whether there is a business case for aligning with Medicare by discontinuing payment to hospitals for hospital acquired conditions (“never events”)
- Develop payment rules that mean physicians as well as hospitals are not paid for hospital acquired conditions (2011-2012)

2012

- Develop contractual language and administrative rules to discontinue payment to hospitals for hospital acquired conditions
- Align and expand P4P programs within and across the OHA

Incentives and Outcomes Committee Recommendations

- Actively foster multi-payer alignment on metrics used in OHA for P4P programs.
- Develop a payment reform pilot evaluation protocol, including a system for sharing findings across payers
- Establish a method for aggregating and disseminating data on provider performance, including a trusted party to do the work

2013

- Pilot episode payments, to include service agreements, in areas with high percentage of OHA lives and/or where alignment can be achieved with other payers

Medium term

- Evaluate experimental programs (2014-2015)
- Consider standardizing P4P metrics and episode bundles that may be used in payment in Oregon (2015)
- Develop benchmarks for efficiency and the total cost of care across all settings (2015)

6. To stop spending an ever-greater share of public and private resources on healthcare, adopt a global health care spending target.

Short term

2011-13

- Develop improved measures of system efficiency hospital, specialty, and primary care
- Develop benchmarks for the cost of delivering high quality care efficiently that are based on rigorous examination of the evidence

Medium term

- Evaluate ROI, patient and provider satisfaction, improvement in health outcomes and refine performance measurement systems as necessary (2015)
- Use benchmarks to set cost targets and payment levels. (2015-17)

¹ IOM, National Academy of Engineering, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: National Academies Press; 2005.

A Publicly-Owned Health Insurance Plan: Strategic Options

For discussion with the Oregon Health Policy Board

*Bill Kramer, Principal
Kramer Health Care Consulting
October 12, 2010*



What Makes a Health Plan a “Public Plan”?

- Owned by a public authority
- Accountable to the general public
- Insurance risk held by a public authority
- Managed by a public organization, although some functions may be outsourced
- Not necessarily a “government-run” delivery system
- Examples: Medicare, Medicaid



Some Assumptions about a Publicly-Owned Health Insurance Plan

- Offered only within the Exchange.
- Operating “under the same rules and regulations as all health insurance plans offered through the exchange” [HB 2009]
- Expected to be self-sustaining
 - Operating expenses and ongoing capital covered by premiums
 - Start-up costs repaid over a reasonable period



Environmental Analysis

- Customers' needs
- Competitive landscape
- Regulatory environment

Environmental Analysis: Customer Needs

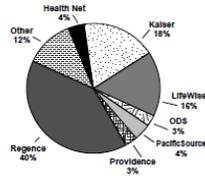
- #1 need: *Affordability*
- Other needs:
 - Good value: good quality of care and customer service for the price
 - Reasonable choice of providers
 - Choice of health plans

Environmental Analysis: Competitive Landscape

Individual Market:

- 196,137 members (2008); will increase dramatically under PPACA
- Regence BCBS is market leader; six other major insurers are offered
- Medical loss ratios (2008):
 - Average: 94%
 - Range: 85-105%
- Wide range of benefit plans and premiums (will be affected by PPACA)

Figure 4-4. Market share by premium, individual market in 2008



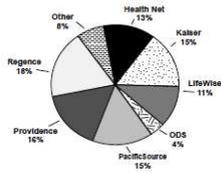
Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

Environmental Analysis: Competitive Landscape

Small Group Market:

- 255,851 members (2008); will increase under PPACA
- Seven major insurers – none dominant
- Medical loss ratios (2008):
 - Average: 89%
 - Range: 81-96%
- Less range of benefit plans and premiums than in individual market

Figure 4-10. Market share by premium, small group market in 2008



Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

Environmental Analysis: Regulatory Environment

Significant changes in PPACA:

- Individual mandate requires insurance coverage for all citizens (with some exceptions)
- Insurance reforms remove barriers to coverage, e.g., guaranteed issue and renewability
- States establish Exchanges for individuals and small employer groups with <100 employees (starts 2014)
- HHS defines minimum benefit package to be offered in Exchange
- Federal premium tax credits and cost-sharing reductions
- Tax credits to low-wage small employers to purchase coverage (2010- 2013) and purchase through the Exchange (starts 2014)

Environmental Analysis – Summary

- Customer needs - #1 is affordability
- Competitive landscape – many private plans currently offered
- Regulatory environment – PPACA likely to increase the number of enrollees and encourage healthy competition within the exchange

Key Strategic Issues

- Organization and governance
 - Standalone plan or “piggy-back” on existing plan (OHP or PEBB)?
- Provider network strategy
 - Broad or narrow network? Payments at market or below? Use of innovative payment mechanisms?
- Administrative functions and expenses
 - How much for medical management? Marketing & sales? Opportunities for efficiencies?

The Basic Question: Can a POHIP deliver better value?

- Medical Costs
 - Generally, there are great opportunities to slow the growth in medical spending, but it's not easy for one insurer to do it.
 - A POHIP will be limited in its ability to negotiate lower provider payment rates (compared to private insurers) unless it uses a narrow provider network.
 - A POHIP may be able to reduce overuse of services by using innovative provider payments and medical management tools, but there's no obvious advantage vs. private insurers.

(cont.)

The Basic Question: Can a POHIP deliver better value? (cont.)

- Administrative Costs
 - Average admin costs among Top 7 Oregon Insurers = 10%
 - Generally, there's a trade-off between administrative and medical costs.
 - Stronger network management, development of innovative payments and use of medical management tools may reduce medical costs but increase administrative costs.
 - Lower spending on marketing and sales would limit enrollment.
 - Overall, there are only modest opportunities for a POHIP to have lower administrative costs.

(cont.)

The Basic Question: Can a POHIP deliver better value? (cont.)

- Profit (Net Underwriting Gain)
 - Average profit among Top 7 Oregon insurers = 2% (5 year average)
 - A POHIP will also need to generate some profit in order to build reserves as it grows, set aside funds for future capital projects, and pay back start-up costs.

Strategic Options: Potential Models

A) Standalone Plans

- 1) Broad Provider Network
- 2) Narrow Provider Network

B) “Piggy-back” Plans

- 1) Link with PEBB
- 2) Link with OHP

Assessment of Models:

A1: Standalone Plan, Broad Network

- Requires creation of new organization and infrastructure, probably higher administrative costs than “piggy-back” option.
- Broad network would attract more enrollees.
- Provider payment levels probably would have to be close to market (i.e., levels paid by other insurers).
 - Maybe opportunity to get discounts if plan is “provider friendly”, e.g., fast claims processing, simple contracts, limited UM. Potential 0-3% savings?
 - The opportunities for innovative provider payments – at least initially – are probably limited due to broad network, added complexity, and higher administrative costs.

Assessment of Models:
A2: Standalone Plan, Narrow Network

- Requires creation of new organization and infrastructure, probably higher administrative costs than “piggy-back” option.
- Narrow network would attract fewer enrollees.
- Better opportunity to negotiate provider payment below levels paid by other insurers
 - Greater opportunities for innovative provider payments – resulting in lower medical costs overall. Potential savings: initially 1-5%, eventually 5-7%.
 - More sophisticated provider contracting function will add administrative costs.



B1: Description of “Piggyback” Plan – with PEBB

- POHIP members would be allowed to enroll in the PEBB Statewide Plan (currently administered by Providence Health Plans).
- POHIP members would have access to the providers in the Statewide Plan.
- The risk pools for POHIP members and PEBB members would be kept separate; premiums would differ based on the experience of the pools.
- The base benefits would comply with the PPACA’s essential benefits package. (The benefits would not be the same as in the current PEBB Statewide Plan.)
- Administrative services would be managed primarily by PEBB. Certain functions (e.g., marketing) may be managed directly by the POHIP or outsourced.
- Governance of the POHIP would be separate from the PEBB Board, but many administrative decisions would be delegated to the PEBB Board.



Assessment of Models:
B1: “Piggyback” Plan – with PEBB

- Would avoid the need to create a new infrastructure.
- May enable the POHIP to minimize its administrative costs due to economies of scale.
- Broad network would attract more enrollees.
- Provider payment rates would be close to market levels, since they are negotiated by Providence Health Plan.
- Would allow the POHIP to take advantage of PEBB’s provider network standards and innovations in benefit design.



B2: Description of “Piggyback” Plan – with OHP

- POHIP members would be allowed to enroll in a new category within OHP.
- POHIP members would have access to providers through enrollment in one of the MCOs.
- The risk pools for POHIP members and OHP members would be kept separate; POHIP premiums would be based on the experience of its pool.
- The base benefits would comply with the PPACA’s essential benefits package. (The benefits would not be the same as in the current OHP.)
- Administrative services would be managed primarily by OHP. Certain functions (e.g., marketing) may be managed directly by the POHIP or outsourced.
- Governance of the POHIP would be separate from the OHP, but many administrative decisions would be delegated to the OHA/OHP.



Assessment of Models: B2: “Piggyback” Plan – with OHP

- Would avoid the need to create a new infrastructure.
- May enable the POHIP to minimize its administrative costs due to economies of scale.
- Narrow network would attract fewer enrollees.
- Provider payments would be probably be set above the current rates paid by MCOs for OHP enrollees, but they may be lower than for commercially-insured enrollees in private plans. Potential savings: 5-8%?
- MCOs would hold the insurance risk, which may reduce the level of required reserves for POHIP.
- Some of the MCOs currently may not have sufficient reserves to take on this new line of business; they would have to increase reserves substantially.



Summary Assessment of Models

	# enrollees	Medical Costs	Administrative Costs & Profits	Other Issues
A1: Standalone, Broad Network	High	Perhaps 0-3% below market?	May be slightly lower than other insurers	
A2: Standalone, Narrow Network	Low-Medium	Eventually 5-7% below market?	Higher than A1 due to network development and management	
B1: “Piggyback” - PEBB	High	Eventually 2-5% below market? (using innovative payments)	Low – use of PEBB infrastructure	
B2: “Piggyback” - OHP	Low	Perhaps 5-8% below market?	Low – use of OHP infrastructure	Lower reserve requirement; impact on MCOs?

Developing the Business Plan: Key Issues and Preliminary Analysis

1. Enrollment projections

- Total enrollment in exchange: 190K (2015) → 360K (2019)
- POHIP market share depends on model selected: broad or narrow network, expected price advantage (if any), marketing effort, etc.

Potential POHIP enrollment	2015	2019
Low Market Share (10%)	19,000	36,000
High Market Share (33%)	63,000	119,000

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Developing the Business Plan: Key Issues and Preliminary Analysis

2. Economies of Scale

- There are some economies of scale, but fixed costs for an insurer are relatively low.
- As a result, an insurer can achieve reasonable administrative costs at a relatively small size. (Rule of thumb: minimum of 40,000 enrollees.)



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Developing the Business Plan: Key Issues and Preliminary Analysis

3. Start-up Costs

- POHIP will incur costs prior to 1/1/2014:
 - Infrastructure development, e.g., IT systems for enrollment, claims, financial management, contracting
 - Sales and marketing
 - Management
- Preliminary estimate: \$20-30 million for standalone plan (to be refined)



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Developing the Business Plan:
Key Issues and Preliminary Analysis

4. Reserve Requirements

- Insurance Code requires minimum \$2.5 million in surplus + \$0.5 million for new insurer.
- DOI uses risk-based capital (RBC) standards to evaluate insurer solvency; amount grows with enrollment.
- Preliminary estimates of reserve requirements:
 - 2014: \$11-30 million
 - 2019: \$38-100 million



Developing the Business Plan:
Key Issues and Preliminary Analysis

5. Financing of Reserves and Start-up Costs

- Initial financing would probably need to be an appropriation from the Legislature.
- Assumption: Start-up costs would be repaid over a reasonable period.
- Options to be explored further.



Developing the Business Plan:
Key Issues and Preliminary Analysis

6. Adverse Selection

- CBO and HHS analyses of public plan in federal reform bills (2009) assumed that less healthy people would be more likely to enroll in POHIP.
- PPACA contains many mechanisms to minimize and offset adverse selection.
- Could affect POHIP premiums and reserve requirements.
- Net effect? to be explored further.



Developing the Business Plan: Key Issues and Preliminary Analysis

7. Risks and Uncertainties – *Most of the key factors have a very high degree of uncertainty:*

- Total enrollment in exchange
- POHIP market share
- Ability to negotiate lower provider payment rates
- Vulnerability to adverse selection

CBO: “Given all of the factors at work, however, [these] estimates are subject to an unusually high degree of uncertainty.” (7/22/10 analysis of H.R. 5808)

CMS: “The actual percentage [of people choosing the public option] could be substantially different.” (11/15/09 analysis of H.R. 3962)

Next Steps

- Selection of a preferred model
- Development of the business plan
 - Including more in-depth analysis of start-up costs, reserves and risk of adverse selection
- Submission of recommendations to the Legislative Assembly by December 31, 2010.

Appendix

History and Legislative Background

2002: CHOICE proposal – California

2007-08: Presidential primary campaigns

2009: Oregon legislation (HB2009): specific language re “publicly-owned health benefit plan” within the exchange

2009-10: National health reform

- Included in initial House bills and Senate HELP bill
- Excluded from Senate Finance bill and final ACA

July 2010: Reintroduced in Congress



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Advocates' Rationale for a Publicly-Owned Health Insurance Plan

[from interviews with and articles by advocates – not reviewed for credibility]

- ✓ Increases choice
- ✓ Promotes competition – incentive for private health insurers to improve value
- ✓ Sets a standard for best practices: model for improved delivery of care, customer service, reduction in disparities, value-based benefit design, etc.
- ✓ Counters the adverse effects of market concentration

(cont.)



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Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Lower costs → lower premiums
 - Lower administrative expenses
 - Less marketing and advertising
 - Lower executive compensation
 - Lower payment rates set or negotiated with providers
 - Innovative provider payment mechanisms
 - No need to generate returns for shareholders

(cont.)



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Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Since there is an individual mandate, people should have a choice of public as well as private health plans
- ✓ Accountability to the general public, not just to shareholders
- ✓ Offers a trusted choice, improves transparency, builds public confidence



Opponents' Arguments against a Publicly-Owned Health Insurance Plan

(from interviews with and articles by opponents – not reviewed for credibility)

- ✗ Unfair competition to private health insurers; it wouldn't really be a "level playing field"
- ✗ Would eventually eliminate the private insurance market
- ✗ Simply a path to a "single payer" system

(cont.)



Opponents' Arguments against a Publicly-Owned Health Insurance Plan (cont.)

- ✗ Misuse of government power to underpay providers
- ✗ Danger of cost shift to privately insured patients, if POHIP pays providers & hospitals less
- ✗ Even if POHIP is set up to be self-sustaining, the government wouldn't let it fail – would step in to bail it out



**Oregon Health Policy Board
EXECUTIVE STAFF RECOMMENDATIONS
Health Insurance Exchange**

Date: October 12, 2010

Action item: Request Board adoption of:

- 1) strategies to achieve the Board's goals for an Exchange identified in the Board's February meeting: simplification of access, regulation and plan rules; increased access to coverage and care; improving the way services are provided and paid for; and containing costs;
- (2) decisions on two key policy issues: the Exchange organizational structure and governance.

(Note: Most of the straw plan elements presented to the Board at its August meeting are not required to develop effective enabling legislation and should be determined by the Exchange Board using the framework adopted by the Health Policy Board.)

Executive staff recommendation:

1. In order to meet the goals of the Exchange as outlined by the Board, executive staff recommends that the Board pursue the following strategies:
 - maintaining costs within a sustainable fixed rate of growth;
 - regionalization of resources and accountability;
 - alignment, coordination and consolidation of purchasing power in the state;
 - standardization of benefits, quality measures, contracting and other relevant areas.

In addition, we recommend that the Board adopt proposals that:

2. Develop Oregon's Exchange as a not-for-profit public corporation with a strong consumer-oriented mission, governing board and consumer advisory board. The public corporation structure offers advantages that are not obtained in either a not-for-profit stand alone or a government agency.
 - The public corporation is accountable to the public and is therefore intended to maximize public benefit rather than profit.
 - A public corporation is able to manage with independence, initiative and is relatively free to adapt because of its autonomous structure.
3. Provide for effective governance by recommending an Exchange governing board large enough to provide for diverse representation, but small enough to get the necessary work done (e.g., 9 to 11 members).
 - The members should be nominated by the Governor and confirmed by the Oregon Senate.

- Only a small minority of the members should be gainfully employed in health care delivery or finance
 - A specified number of Board members should represent those who purchase health insurance coverage through the Exchange (e.g., individual and small business members).
 - Board should include the Director of the Oregon Health Authority, Director of the Department of Consumer and Business Services and a member of the Oregon Health Policy Board.
4. Establish authorities for the Board to meet the requirements in the Patient Protection and Affordable Care Act of 2010 (ACA) and to enable the Board to implement the strategies outlined in recommendation #1 above. For example:
- Authorizing the Exchange to determine participation requirements, standards, and selection criteria for carriers and products offered through the Exchange within the guidance to be created by the HHS Secretary.
 - Authorizing the Exchange to set and charge user fees for the support of the Exchange.
 - Authorizing the Exchange to contract for functions and services. *(Attached document outlines minimum requirements for compliance to ACA).*

Why the project was undertaken: House Bill 2009 directed the Oregon Health Authority to develop a plan for an exchange in conjunction with the Department of Consumer and Business Services. HB 2009 requires recommendations be presented to the Legislature in December 2010. The passage of the federal Patient Protection and Affordable Care Act created a baseline by providing guidance and requirements for state exchanges.

Summary of initial straw plan elements: OHA staff developed straw plan proposals in the following areas: development of an exchange as a public corporation with a strong, consumer-oriented mission, governing board and consumer advisory boards; establishment of a single statewide exchange with individual and small business product lines; parallel markets with strong standards and meaningful carrier and plan choice in the exchange; allowing carriers participating in the exchange to sell young adult/catastrophic plans; allowing insurance brokers to participate in the exchange; opening the exchange to 51-100 employee businesses in 2016; consideration of early implementation under certain circumstances; and ongoing funding for the exchange through a carrier assessment.

New information developed at the request of the Board: Following a presentation to the Board on August 10, an expert panel was convened to identify the policy decisions that would have the greatest impact on premium costs in an exchange. The panel, which included national experts and two of the leadership team that built the Massachusetts Connector Authority, identified the two policy decisions that can have the greatest impact on costs in the exchange: establishing standardized cost sharing packages; and limiting insurance carrier participation in the exchange. The group discussed the concept of a sole market in which all individual and small group insurance purchasers use the exchange, noting that if the exchange is the whole

market it is harder to set a high bar for participating plans in terms of price, quality, and delivery system requirements. The Exchange population estimated by Dr. Gruber's modeling (355,000 individual market consumers) was deemed sufficiently robust to support an exchange in a dual market.

Opportunities: Providing a clear vision for reform offers the structure to ensure the exchange is developed in a holistic, consistent and flexible manner. A well-designed exchange can improve access to insurance and health care, increase consumers' ability to compare health plans and choose ones that work for them, and support Oregon's efforts to improve its health care delivery system. Supported by a federal planning grant, over the next year the state will develop an operational plan based on the Policy Board's framework and strategies as well as a legislative concept that will be considered by the 2011 Legislature.

Conclusion: Agreement on the strategies discussed above will frame the development of the Exchange and ensure that detailed operational planning is consistent with this vision. Most of the straw plan elements presented in August are not required to develop effective enabling legislation, but should be worked out by an Exchange Board using a framework agreed upon by the Policy Board. Staff recommends that Policy Board support the development of the Exchange as a public corporation with a strong consumer-oriented mission and led by a broadly representative governing board. The Health Policy Board's goals and strategies for an Exchange will provide guidance to the legislature as they take up this important topic during the 2011 session.

Next Steps:

- Develop a legislative concept for an Exchange that meets requirements to conform with the ACA, but that also allows the Exchange Board to implement the recommended strategies.
- Complete the business plan for a Health Insurance Exchange for presentation to the legislature in December 2010.
- Initiate the detailed operational plan outlined in the federal exchange planning grant awarded to the state on September 30, 2010.

**Minimum requirements for 2011 Exchange Legislation
to conform with Federal law:**

Relating clause:

Relating to health insurance exchange

Establish an exchange:

- Develop an exchange in Oregon in order to bring the state into compliance with federal requirements in the Patient Protection and Affordable Care Act of 2010 (ACA).
- Establish the exchange consistent with the purpose and mission as identified by the ACA: to make quality and affordable health care coverage available to eligible Oregonians and fulfill the requirements of the ACA.

Exchange operations:

- Give the state authority to establish an exchange as either a state agency, private non-profit or public corporation.
- Give the exchange authority to spend federal grants and other federal funds for exchange development, implementation and administration.
- Structure of exchange board or other organization that will oversee development, implementation and operations, including:
 - Membership
 - Appointment and confirmation
 - Role

Scope

- Small employer groups: if allowing entry to 51-100 employee groups, this will merge the 1-50 and 51-100 markets. Will need language to ensure insurance law and regulation conforms with this change.
- Sub-state exchanges: if establishing regional exchanges within Oregon, authorize establishment of sub-exchanges and identify relationship, if any, with statewide exchange.

Functions of an exchange:

- The exchange makes available qualified health plans to qualified individuals and qualified employers and meets certain other requirements.

- Provide a choice of health plan products in each region of the state, including a choice in each region of the state between the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the ACA.
- Authorize and require the exchange to implement specified functions imposed by the ACA:
 - Certify plans for participation in the exchange, including implementing procedures for plan certification, recertification and de-certification based on federal guidelines.
 - Make qualified health plans available to eligible individuals and employers.
 - Provide customer assistance via telephone and website. Have a toll-free telephone hotline to respond to requests for assistance and maintain a website through which enrollees, prospective enrollees can get standardized comparative plan information.
 - Grade health plans in accordance with criteria to be developed by the federal Department of Health and Human Services. This includes using a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage, and maintaining a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.
 - Provide information to individuals and employers, including providing information regarding eligibility requirements for Medicaid, CHIP and any applicable State/local public program. The exchange will provide an electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction. The exchange will publish: the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse. In addition, the exchange will provide employers with the names of any of their employees who stop coverage under a qualified health plan during a plan year.
 - Administer exemptions to the individual responsibility penalty when: no affordable qualified health plan is available through the exchange; or the individual meets the requirements for another exemption from the requirement or penalty.
 - Provide information to federal government regarding: Oregonians issued an exemption certificate; employees determined to be eligible for premium tax credits; and people who tell the exchange they changed employers and stopped coverage during a plan year.
 - Facilitate community based assistance by establishing a Navigator program. ("navigators" are entities contracted to help individuals enroll in coverage through the exchange) Select and set performance standards and compensation for navigators selected pursuant to subdivision (i) of Section 1311 of the ACA.
 - Have an annual open enrollment period, special enrollment periods, and monthly enrollment periods for Native Americans.

Exchange needs statutory authority to:

- Contract for functions and services (including negotiating as needed and entering into contracts with carriers seeking to offer coverage in the exchange and enter into contracts with entities seeking to become "navigators").
- Authorize the exchange to set and charge user fees for the support of the exchange.
- Determine the participation requirements, standards, and selection criteria for carriers and products offered through the exchange, within the guidance/regulations to be created by the HHS Secretary. These may include, but are not limited to, standards that encourage the use of delivery systems that deliver cost-effective, high-quality care.
- Apply for and receive federal funds for purposes of establishing the exchange and would make those funds available to the exchange and its board for those purposes. Until the exchange is established, give the OHA this authority.

