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# Oregon Health Policy Board

## AGENDA

November 16, 2010

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 am to 1:00 pm

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call	Chair	
2	8:35	Update: Oregon Blueprint for Health	Gretchen Morley	
3	9:15	Draft Report from the Public Employers Health Purchasing Committee	Steve McNannay Lynn McNamara Barney Speight	
	10:00	Break		
4	10:15	Draft Report from the Workforce Committee	John Moorhead Ann Malosh	
5	11:00	Report for Board consideration: Health Insurance Exchange and Publicly Owned Health Insurance Plan.	Nora Leibowitz Barney Speight Bill Kramer	X
6	12:30	<i>General Public Testimony</i>	Public	
7	1:00	Adjourn		

### Upcoming

**December 14, 2010**

**Market Square Building**

**1515 SW 5th Avenue, 9th floor**

**12:00 PM – 5:00 PM**

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# Oregon Health Policy Board

## Oregon's Action Plan for Health

### Draft Introduction/Executive Summary

## An Urgent Call to Action

The Oregon Health Policy Board believes that Oregon must act now to redesign the state's health systems to improve the health of *all* Oregonians and be accountable to the needs of local communities, all at a price that we can afford.

Without action, the current dire circumstances will only get worse:

- The rising costs of health care have made it increasingly unaffordable for individuals, businesses, and for the state. Faced with a 125 percent increase in premiums over the last 10 years, businesses are dropping health insurance coverage because they cannot afford it anymore, leaving thousands of Oregonians without access to primary and preventive health care. Almost 650,000 Oregonians, or 17 percent of the state's population, were uninsured in 2009, which is higher than the national average.
- Even when Oregonians have health insurance coverage, they often have problems getting in to see a doctor. One out of 10 Oregonians who have health insurance still do not have a usual source of care. For Oregon's increasingly diverse population, finding a health care provider who understands their culture or language is an additional challenge.
- The quality of the health care we receive and the resulting health outcomes are inconsistent. Only 50 percent of adult diabetics receive recommended care. Only 44% of adults age 50 or older receive recommended screening and preventive care. Nationally it is estimated that about 30 percent of care provided to patients is either unnecessary or does not lead to improved health. These problems are only more severe for Oregon's communities of color and other underserved or vulnerable populations.

We must address the lack of coordination and integration across our system. Patients often demand and get care that does not improve their health, and never know the true cost of their care. Employers frequently purchase health insurance coverage based on price alone, and not on quality or evidence. Healthcare providers are responsible for patients in their own facilities, but there is typically no coordination between different types of providers. Our mental health, substance abuse, and oral health care needs are too often unaddressed by a fragmented and complicated system. Efforts to improve health in the medical system are too often disconnected from efforts at the community level.

And while the federal healthcare reform package increases access to and funding for health care in a variety of ways, it will not be sufficient or sustainable in and of itself. Without solutions that focus on value and are tailored to our state, costs will continue to spiral upwards and the quality of care will continue to suffer. Oregon deserves better and Oregonians are demanding bold ideas and actions.

The urgent need for immediate action is illustrated by some simple but staggering figures:

- If we had successfully implemented strategies holding the rate of medical inflation to the Consumer Price Index (CPI) over the last five years, health care expenditures in Oregon would have been over \$10 billion or 9 percent lower.<sup>1</sup>
- If we had curbed the *growth* of obesity during the past five years, we would have saved \$1 billion in health care expenditures.
- Using bundled or episode-based payments for care related to 10 common acute and chronic conditions would have reduced expenditures by approximately \$2.25 billion or 2% of total health care expenditures in Oregon over the past five years.<sup>2</sup>

## **Our Vision: World-class Health and Health Care for all Oregonians**

Simple but bold, this statement reflects the Oregon Health Policy Board’s (OHPB) vision for a healthy Oregon. To realize this vision, Oregon must maximize the value of public and private resources spent on health care by achieving world-class results. We believe we can accomplish this vision by focusing on three aims:

- Improve the lifelong health of all Oregonians,
- Increase the quality, reliability and availability of care for all Oregonians, and
- Lower or contain the cost of care so it is affordable for everyone.

This “Triple Aim” is the catalyst for the change that will be required to transform Oregon’s current health care system into a sustainable, high-quality *health* system. This transformation will not be easy and it will not happen overnight. Thoughtful and strategic planning will chart the course for fundamental change.

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<sup>1</sup> The price of consumer goods increased at an average rate of 2.4% per year between 2005 and 2009 according to the Bureau of Labor Statistics’ Consumer Price Index (CPI). In contrast, Oregon’s total health care expenditures increased at an average rate of 7.7% per year between 1991 and 2004 according to the Center for Medicare and Medicaid Services’ National Health Expenditure Data. Although more recent health expenditure data is not available, if health care expenditures grew in line with CPI rather than continued on at 7.7%, Oregon would have saved over \$10 billion from 2005-2009 even after accounting for new medical spending attributable to population growth rather than the price of health care.

<sup>2</sup> Acute conditions include hip replacement, knee replacement, bariatric surgery and acute myocardial infarction. Chronic conditions include asthma, chronic obstructive pulmonary disorder, congestive heart failure, coronary artery disease, diabetes and hypertension.

## **The Health Consequences of a Fragmented Health System**

All across Oregon – in family living rooms, school classrooms and hospital emergency rooms – we see the human impact of the escalating costs of health care every day.

- Children miss school, or come to school sick, because their families can’t afford to take them to the doctor. These children get left behind academically, with consequences that can last a lifetime such as decreased earnings, poorer health, and greater need and use of social support services.
- People with chronic diseases do not see their doctors as often as they should or take the medications they need to control their conditions. Over 19,000 people die each year in Oregon from chronic disease, and those diseases cost the state more than \$1.4 billion annually.
- People with serious mental illnesses die, on average, 25 years earlier than the general population. This is due to largely preventable medical conditions such as cardiovascular disease, diabetes, respiratory illness and infectious diseases.
- One-third of the recent increase in medical costs in Oregon is attributed to obesity.
- Alcohol abuse costs Oregon’s economy \$3.2 billion per year, and the number of Oregon eighth-graders who’ve had a drink in the past 30 days is twice the national average.

## **Oregon’s Solutions**

The ideas in this report come from Oregonians themselves. This *Action Plan* builds directly on the recommendations developed through an extensive public process lead by the Oregon Health Fund Board in 2007 and 2008. Over the past year, the Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) were advised by over 300 people from all walks of life who served on almost 20 committees, subcommittees, workgroups, taskforces, and commissions to examine all aspects of the health and health care system. More than 850 people attended six community meetings across the state to provide feedback to the Board. Likewise, many groups around the state such as the Oregon Health Leadership Task Force, OSPIRG, and other community groups have provided input.

Through this process, OHPB members heard about the problems we face from many different viewpoints and received some conflicting input. While not all perspectives can be represented in this report, it is this diversity of perspectives that will lead to successful reforms. The Board has synthesized and prioritized over 100 recommendations into this *Action Plan* reflecting the next best steps Oregon can take to reform its system. We recognize that as we accomplish these steps, we will need to develop additional strategies. The Board thanks everyone who participated in the process of developing these plans and salutes their efforts and willingness to tackle thorny issues. Without their input, wisdom and support, the concepts outlined in this *Action Plan* would never have been possible.

### **OHPB Committees**

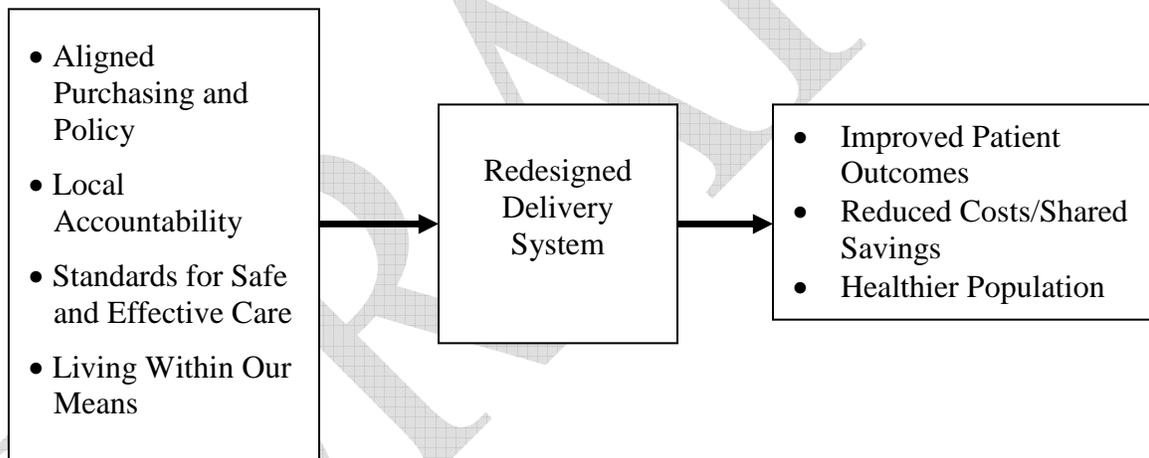
In 2010, the Oregon Health Policy Board convened the following committees to develop recommendations in key system reform areas:

- Administrative Simplification Workgroup
- Health Care Workforce Committee
- Health Equity Policy Review Committee
- Health Improvement Plan Committee
- Health Incentives and Outcomes Committee
- Medical Liability Taskforce
- Public Employers Health Purchasing Committee

## Our Theory of Change

If we want to improve the health of our state and ensure that everyone has access to affordable, effective health care, everyone must work together and be accountable to each other in a new way. We must create a common responsibility for health and for stewardship of our fiscal resources.

This effort will necessitate changing our health care delivery and public health systems so that they get us the outcomes we want at a price we can afford. We must align our reform efforts across the entire health spectrum around the Triple Aim. This will require participation and new accountability from all Oregonians, providers, insurers, governments, employers, and communities. It will also mean developing new partnerships with agencies and organizations not typically thought of in relation to of health – such as the Department of Education, the Department of Agriculture, and the Oregon Liquor Control Commission – to combat population health issues of obesity, alcohol abuse, and improved student health and nutrition.



## Our Foundational Strategies

The Board has identified four key strategies that will establish the foundation for this real change. Each builds on and complements the others, and each element is needed if we are to achieve the Triple Aim. Outlined below are the key next steps that the Board has prioritized under each foundational strategy. While there are many other actions we must take to achieve world class health and health care, the Board strongly believes that our energy must focus on these immediate critical steps to develop the momentum and motivation for lasting change.

### Strategy #1: Aligned purchasing and policy

Smart and coordinated purchasing and policy throughout the public and private sectors, together with payment reform strategies, can and will change the way care is delivered and population health is managed. If instituted thoughtfully, this redesign of the healthcare delivery system will produce better health outcomes at lower costs.

#### Priority Action Steps:

- **Legislative action in 2011 creates a public corporation to implement Oregon’s Health Insurance Exchange.** The Exchange has a broad mission to be accountable to the public for achieving all elements of the Triple Aim and managing public and private funding for individuals using the services of the corporation.
  - The OHA has been awarded federal grant for implementation planning that will be completed September 2011.
  - The Governor appoints the corporation board. This public corporation will have the legislative authorities to act as a strong purchaser to drive high value in the health care system.
- **The Oregon Health Authority aligns purchasing policies** across the State’s existing patchwork of health care programs. Key steps include:
  - The OHA standardizes provider payment methodologies across the OHA lines of business by 2013 including Medicaid fee-for-service and managed care, Public Employees Benefit Board, and the Oregon Educators Benefit Board.
  - Legislative action in 2011 will extend these standards to payers statewide.
  - The OHA will work with stakeholders in 2011 to identify specific health conditions and procedures where the potential to impact cost, quality, and patient experience is the greatest. This work will serve as the basis for OHA and statewide implementation of quality improvement, payment, benefit design, and other reforms where alignment is important.
  - OHA and OHPB work with partners to align background requirements for the clinical portion of health professions training and to revise policies that restrict the availability of health professional training programs.

- **The Oregon Health Authority, in partnership with other state and local agencies, leads the way in improving the health of Oregonians** by making the healthy choice the easy choice. Key steps include:
  - Set healthy standards for food and drink served on state and other public campuses.
  - Similarly, adopt tobacco-free campus policies on state and other public property.

## **Strategy #2: Local accountability**

Health and healthcare – particularly primary care, chronic care management and population health – are best designed and managed within natural health eco-systems. Regional entities will act as integrators, bringing together resources to support the health of the community and ensuring that local health systems continuously improve and innovate to meet the needs of their own communities.

To truly achieve local accountability, the OHPB has prioritized **establishing regional organizations that are responsible and accountable** for meeting the unique health needs of their populations. These new organizations will be accountable for improving the health of their communities and managing health care resources through integration of public health, behavioral health, oral health, physical health, and community services.

### **Priority Action Steps:**

- Legislative action in 2011 provides the **authority for regional accountable health organizations** that can accept, manage, and integrate health resources at the local level.
- The OHA **seeks federal permission to streamline funding** to these regional organizations and works with communities to monitor and ensure local accountability for health outcomes and system costs.
- These regional organizations will be responsible for **integrating public health and behavioral, oral, and physical health care services** locally through the use of community health workers and other innovative approaches.
- The OHPB sets a goal of **five regional organizations in operation by 2012**.

## **Strategy #3: Standards for safe and effective care**

Our health professionals must pool their knowledge to create systems care based on experience and evidence about outcomes, and must then act within these standards to deliver increasingly safe and effective care. Health care purchasers must contract for and expect this level of excellence.

### **Priority Action Steps:**

- OHA leverages increased federal funding and partner with regional accountable health organizations to **implement patient-centered primary care homes** in five regions of the state by 2013, with all Oregonians having access to one of these homes by 2015.
  - These initiatives will: implement Oregon’s patient-centered primary care home standards; integrate physical, behavioral, oral, and public health services; incent an

- adequate distribution of workforce to deliver care; and include private insurers where possible to support system-wide payment restructuring.
- OHA will continue current partnerships and expand efforts to implement these initiatives across all payers within regions.
  - The OHA works with private insurers and other stakeholders to address implementation considerations for a **value and evidence-based benefit plan** so it can be offered across OHA lines of business by January 2012 and the Oregon Health Insurance Exchange in 2014.
  - OHA convenes key stakeholders to **gain consensus around the identification and development of Oregon-based best practice guidelines and standards of care** that can be uniformly applied across public and private health care to drive down costs and reduce unnecessary care.
  - Legislation in 2011 **changes medical liability laws** to encourage physicians and facilities to disclose medical errors and discuss them with their patients, and clarifies insurer and provider responsibilities

#### **Strategy #4: Living within our means**

We cannot continue to dedicate an ever increasing amount of our financial resources to health care – at the expense of all other services, including education and public safety. As such, we must learn to create and innovate within a budget. We must do it now and use our budgeting process to spur a new era of innovation.

##### **Priority Action Steps:**

- The OHPB sets **OHA and statewide targets for overall health care expenditures**, limiting increases to a specified economic index. The Board’s goal is to force innovation and efficiency while maintaining quality.
- The OHA and the Department of Consumer and Business Services (DCBS) partner to **reduce administrative burden in the health care system**.
  - Legislation in 2011 streamlines insurance administrative functions by requiring the same processes and language to be used by all payers.
  - Through administrative rule, DCBS adopts “uniform companion guides” that provide standard instructions for electronic communications between providers and payers, and they also phase-in the requirements for electronic communication by October 2013.
  - OHA begins to implement administrative standardization in Medicaid fee-for-service and managed care, Public Employees Benefit Board, Oregon Educators Benefit Board, and Addictions and Mental Health Division.
- The OHA, working with stakeholders, will target key cost, quality, and efficiency concerns by **implementing bundled payments** through OHA programs and partnerships at the regional level.
- The OHA will seek federal permission and remove administrative barriers in order to **aggregate and better leverage a wide variety of current funding streams** for use by regional health organizations.

## Fundamental Cross-cutting Considerations

The Board acknowledges there are several cross-cutting priorities that frame the work around our key strategies and has identified key next steps to address these concerns.

- **Health Equities** — Efforts to improve our health system must include a focus on eliminating health disparities and inequities, by providing culturally-specific, effective care for all Oregonians. Historical health, economic and social policies in the United States and Oregon disadvantaged communities of color and other diverse communities, often with tragic consequences. Oregon’s population is increasingly diverse and our changing demographics have profound challenges and implications for Oregon’s health care system and our ability to provide effective care, not the least of which is having a provider workforce that reflects Oregon’s growing diversity. Despite these challenges, there are many opportunities to create equitable health outcomes for all of Oregon. Priority action steps for health equity include:
  - OHA incorporates incentives for using **community health workers** as key team members in primary care provision. Community health workers are effective because they are members of the communities in which they work and share language and experience with patients.
  - Health care professional regulatory boards require **cultural competence continuing education** for licensed health care professionals.
  - OHA ensures that **all health data collected and analyzed within OHA includes the appropriate level of detail** about race, ethnicity, national origin, language, ability, sexual orientation, occupation and geography.
- **Health Information Technology and Exchange** — Health Information Technology (HIT) and Health Information Exchange (HIE) are essential supports for the change strategies and priority action steps outlined above. The OHPB supports the Health Information Technology Oversight Committee goal of achieving widespread adoption and use of electronic health records among a majority of Oregon providers by the 2013-2015 biennium. The outcome of this accomplishment will be better support for clinical decision-making, improved patient care and coordination, and enhanced public health data and surveillance. The value of HIT will be enhanced by secure, efficient sharing of health information via a statewide Health Information Exchange (HIE). Information exchange improves safety and quality by giving all medical personnel the information they need to treat patients appropriately, no matter where the patient shows up, and reduces the need for patients to fill out repetitive medical forms for every new provider they see. HIE also has the potential to produce significant cost savings by helping consumers avoid duplicative tests and helping providers use information from previous visits to make care more efficient.
- **Access to Care** — Ensuring all Oregonians have access to affordable health services that are accessible and culturally competent requires a multi-pronged effort. This effort should include: coverage expansions; easier ways for people to assess their coverage options, with streamlined enrollment processes; better access to appropriate care for all

Oregonians; and improvements in health equity that will ensure this promise is met for everyone in the state. However, even with our best efforts around expanding coverage, there will be some Oregonians who remain uninsured. It is critical that we have a strong safety net system to provide this population with high quality, timely care.

For the population to achieve optimal health outcomes, available services must be effective and appropriate to patients’ needs. Barriers to access must be understood and removed in the context of the varied socio-demographic landscape of the state, including diverse culture, language, income level, geography, health status and other social and economic factors.

- As part of ensuring access, OHA should continue **to provide technical assistance and support to local community-based health care access initiatives** including multi-share approaches.
- ***Bending the Cost Curve*** — Healthcare is expensive and becoming more so by the day. Rising healthcare costs threaten our health and our system of medical care. Everyone is feeling the squeeze: businesses struggle to provide their employees with health insurance and increasingly require employees to pay a greater share of the bill; public insurance rolls expand even as deficits strain state budgets; individuals put off necessary care until health problems become emergencies. Left unchecked, this trend will undermine our best efforts to improve the health of Oregonians.

The Oregon Health Policy Board believes that the Oregon Health Authority and the new Oregon Health Insurance Exchange can take a key role in bending the cost curve. By being smart purchasers that seek to drive value and placing more emphasis on preventing disease, the Authority and the Exchange can be catalysts for bringing medical costs in line with what is affordable to the state, businesses, and consumers.

- ***Measuring Progress*** — If Oregon is to transform its health care system, we need to know where things stand now and whether our efforts are moving the state closer towards world-class health for all Oregonians. We also need to put tools into the hands of consumers, purchasers, and policymakers so they have the information they need to make good decisions. Dynamic and robust data systems, and well as in-depth analysis of the data, will provide that type of transparency. The following efforts, among others, will help us achieve it:
  - **Oregon Scorecard and statewide quality metrics** — The Board is developing a Scorecard, or a data snapshot of health and health care in Oregon, to provide a starting point for measuring progress towards the Triple Aim. Additionally, the Board and the Oregon Health Authority will continue working with communities, providers, insurers and others stakeholders to develop quality and efficiency metrics that can be used to inform policy decisions, set targets for future performance and evaluate the impact of reform strategies, especially for populations facing health disparities and inequities.
  - **Oregon All-Payer, All-Claims (APAC) Reporting System** — Beginning in 2012, Oregon will have a consolidated dataset of claims paid by Medicare, Medicaid, commercial insurers, third party administrators and pharmacy benefit

managers. This will enable us to see how performance and costs vary between geographic areas and health systems within the state.

- **Oregon Health Care Workforce Database** — Legislation proposed for 2011 would improve data about Oregon’s health care workforce capacity by requiring all professional licensing boards to submit information to Oregon’s Healthcare Workforce Database.
- **Consumer and Patient Engagement** — At the core of Oregon’s health reform efforts is the patient. Every other player in the system must be responsible for and accountable to this consumer. Likewise, consumers need to be responsible for their own health and behaviors that contribute to their health status. Patient and family engagement are critical and responsibility for patient engagement should be clearly articulated and allocated among providers, payers, and plans. When patients and families participate as full partners with health care professionals, system performance improves. A first action step in this area is:
  - The OHPB works closely with communities and providers to develop **standard measures for patient engagement and experience of care** in 2011 and fold these measures into regional systems of accountability and patient-centered primary care home initiatives.
- **Shifting Focus to Prevention** — Every aspect of the health system needs to prioritize prevention – from benefit design to primary care homes to integration of public health efforts. Efforts are already underway to move towards a benefit design that eliminates barriers to preventive services. Patient-centered primary care homes standards, to which prevention activities and services are central, have been developed and are being piloted across the state. Work must continue on ways to integrate and connect public health activities around prevention with clinical practices on a local and regional basis.
- **Federal Health Reforms** — Oregon’s reform work will be shaped in part by the Patient Protection and Accountable Care Act (PPACA), passed early in 2010. Federal reform by itself will not create healthy Oregonians, control costs, or fundamentally change the delivery system. It does, however, provide us with funding opportunities for planning and implementing the comprehensive reforms we think will accomplish our Triple Aim. Notable elements of federal reform include:
  - **Increased funding for care delivery settings that focus on preventive and primary care**, which will help Oregon toward its goal of making affordable, high-quality primary care available to everyone through patient-centered primary care homes. The PPACA also allows for experimentation with new models of payment and care delivery outside of primary care. Implementation of innovative care models will be supported by the development, recruitment, and retention of a robust health care workforce, trained to deliver care in new ways in the communities where it is most needed.
  - Primarily federally funded **expansions of coverage through Medicaid for adults up to 133 percent of poverty** will mean most low-income people in Oregon will

have access to health insurance coverage by 2014. Increased safety net funding will help provide access to care for people who do not qualify for Medicaid.

- Beginning in 2014, federally funded tax **credits for people up to 400 percent of poverty** will allow more individuals and families afford private health insurance premiums. Many people will also qualify for cost-sharing assistance to help lower their out-of-pocket costs.
- New federal **health insurance reforms** taking effect now through 2014 make insurance companies more accountable and remove barriers that in the past kept sick people from getting the coverage they needed, or charged them much more for coverage if they could find it. Recognizing the changing face of families, federal law now allows adult children to stay on their parents’ health insurance plan until they are 26. This is a population that has historically high rates of uninsurance.

## **Our Infrastructure Proposal: Partners for Health**

The Board proposes an infrastructure for our transformed health care system — one in which existing players may have new roles and functions, while new entities are created to further the Triple Aim.

### **The Oregon Health Authority**

The Oregon Health Authority, which purchases health care for almost 850,000 people, or approximately 1 in every 4 Oregonians, will align purchasing strategies across the state’s health programs, including Public Health, the Oregon Health Plan, HealthyKids, employee benefits and public-private partnerships. This alignment allows the OHA to focus on health and preventive care, provide access to health care, reduce health disparities, and reduce waste in the health care system. OHA can provide technical and policy assistance to local communities as they transition to being accountable for their own health and health care delivery systems. As a major health care purchaser, the OHA can coordinate and partner with the private sector to create and implement system-wide care improvement and cost reductions.

The Oregon Health Policy Board and the Oregon Health Authority leadership, in consultation with the Governor’s Office and Legislature, are responsible for setting annual and long-term targets for the Triple Aim goals in Oregon, and to track and monitor all statewide progress towards achievement of these goals. This includes population health goals, such as reducing obesity and tobacco use, as well as improved patient outcomes. Plans for achieving Triple Aim goals must also take into account the changing demographics of Oregonians and the fiscal realities facing the state.

### **A Public Corporation that will Administer the Health Insurance Exchange**

A public corporation should be established with a broad mission to be accountable for organizing the purchasing of health insurance in the individual and small group insurance markets (at a minimum), as proscribed by federal health reform. It is also responsible for achieving all elements of the Triple Aim, as well as managing and maintaining a global healthcare budget, for lives using the services of the corporation, and should have the flexibility to expand to serve

additional publicly and privately insured populations wanting to use it. The corporation should be responsible for:

- Assuring all health insurance contracts are aligned to achieve the same outcomes and administrative efficiencies.
- Selecting benefit designs and the qualified health plans to administer them for the federal insurance exchange for small groups and individuals.
- Serving as the fiduciary entity for all revenue received and distributed for people using the services of the corporation.
- Furthering policies that move toward locally accountable care.

### **Locally Accountable Care**

The Board believes that communities hold great promise for fundamental change through organizing an efficient use of resources and tailoring health improvement initiatives to meet the needs of their residents. The actual organization of some of these local entities is beginning to develop and there are several communities around the state who are working to organize planning efforts at the local level. The development of these local entities should be a priority of the Oregon Health Authority and the new public corporation that is administering the health insurance exchange.

The Board envisions these local entities will establish governance structures to:

- Create relationships and contracts with providers in a health system that integrates physical, behavioral and public health.
- Assume accountability for quality of services delivered and health outcomes within their integrated health system(s).
- Create a collaborative environment for the local integrated health systems to innovate towards achieving local triple aim goals and staying within the local global budget.
- Create a culture of health in their locality, including programs or initiatives that help people make healthier lifestyle choices.
- Set, measure, and track local progress on Triple Aim goals.

### **Qualified Health Plans**

Federal health reform will dictate the baseline for qualified health plans. Oregon will have an opportunity to set higher standards, particularly for those plans contracting with the new public corporation, to orient their services towards achieving Triple Aim goals while still offering risk management, care coordination and administrative support services.

### **Coordination with Health Care Providers**

Health care providers are key partners in true system reform. Their insight and experience will be critical in changing system incentives in ways that improve the coordination of care and health outcomes, reduce or eliminate unnecessary or duplicative care, and ultimately control costs in a transformed and accountable health system. They also have a vital role in engaging patients in their own health, as well as integrating and coordinating public health activities with their clinical practices.

## Overview of Our Reform Plan

While it is critical we adopt some structural changes to our system immediately to address the urgency of our health care crisis; the Board understands that some reforms must, by necessity, have a more gradual glide path towards change. We recognize that not every insurance company, hospital, health care provider, community, employer or consumer is ready for the changes that must happen to transform our system, and that our strategies must be flexible and accommodate all levels of preparedness. We also understand that our early efforts must earn the confidence of the state before we can move on to implement other necessary reforms.

OHA will create the process and structures in which progress can be made towards aligning state purchasing, creating local accountability, and standardizing care, and do this all while living within our means. But make no mistake, change will happen and everyone needs to take steps to make the transition as graceful as possible. The timeline below provides an outline for implementation of these actions and Board recommended sequencing.

Foundational Strategy	Immediate Actions (now through 2011 legislative session)
<p><b>Align purchasing and policy</b></p>	<p><b>Oregon Health Authority (OHA)</b> begins to better align state purchasing.</p> <p>2011 Legislature establishes a <b>public corporation</b> with strong purchasing authority to operate the <b>Oregon Health Insurance Exchange</b>.</p> <p>2011 Legislature lays the foundation for transition away from fee-for-service payments by requiring <b>standardization of payment methods</b> (not rates) for some services to Medicare methods in OHA and statewide.</p> <p>OHA, in partnership with other state and local agencies, promotes healthy behaviors by setting <b>nutrition standards</b> for food and beverages and adopting <b>tobacco-free campus policies</b> in all state agencies and facilities.</p>
<p><b>Local accountability</b></p>	<p>2011 Legislature establishes statutory authority for <b>regional health organizations</b>.</p>
<p><b>Standards for safe and effective care</b></p>	<p>OHA partners with local delivery systems to pay for <b>patient-centered primary care homes</b> in accordance with Oregon standards.</p> <p>OHA completes design of a <b>value-based benefit package</b> for use in state-purchased coverage and in the future Health Insurance Exchange.</p> <p>OHA works with key stakeholders to gain consensus around identification and development of Oregon-based <b>quality standards, best practice guidelines and standards of care</b> for implementation across OHA and statewide.</p> <p>Legislation in 2011 <b>changes medical liability laws</b> to encourage physicians and facilities to disclose medical errors and discuss them with their patients, and clarifies insurer and provider responsibilities.</p>

Foundational Strategy	Immediate Actions (now through 2011 legislative session)
<p><b>Living within our means</b></p>	<p>OHPB sets OHA and statewide <b>targets for total health care expenditures</b> to incent innovation and efficiency while maintaining quality.</p> <p>DCBS and OHA adopt and apply <b>electronic communication standards for core administrative and financial communications</b>; 2011 Legislature authorizes extension of standards to third party administrators, self-insured plans, and clearinghouses.</p> <p>OHA begins development of <b>bundled payments and other innovative payment approaches</b> for implementation in OHA programs and through private sector partnerships.</p> <p>OHA continues <b>LEAN management</b>, focusing on continuous improvement, efficiency and eliminating processes that do not add value for OHA clients and customers.</p>
<p><b>Fundamental cross-cutting considerations</b></p>	<p>OHA begins to implement strategic and operational plans for <b>Oregon Health Information Exchange</b>.</p> <p>OHA establishes <b>key information tools</b> to educate policy development, address health disparities, and inform evaluation including the all-payer, all-claims database, requirements for collection of race, ethnicity, and other demographic data, and a complete health care workforce database.</p> <p><b>Federal health reforms</b> begin, including elimination of pre-existing coverage limits for children and lifetime limits for everyone, as well as allowing children to remain on parents insurance through age 26.</p>



Foundational Strategy	Next best steps in 2011-2013
<p><b>Align purchasing and policy</b></p>	<p>Oregon Health Authority successfully <b>aligns purchasing policy</b> across all OHA lines of business.</p> <p><b>Health Insurance Exchange Board</b> is established and begins implementation of insurance exchange starting with individuals and small groups.</p> <p>OHA and OHPB work with partners to <b>align background requirements for clinical training</b> and to revise policies that restrict the availability of health professions training programs.</p>
<p><b>Local accountability</b></p>	<p>The OHA works actively with communities to <b>implement regional organizations</b> that integrate public health, behavioral health, oral health, and physical health services and that are responsible and accountable for health care workforce development and improving the health of their communities, with a goal of five organizations in operation by 2012.</p>
<p><b>Standards for safe and effective care</b></p>	<p><b>Patient-centered primary care home</b> payment systems that encourage the most efficient use of the health care workforce—including community health workers as critical links between clinical and community services—are operational in at least five regions of the state by 2013.</p> <p>Oregon’s <b>value-based benefit package</b> is offered through state lines of coverage by January 2012 and in the Oregon Health Insurance Exchange January 2014.</p> <p>OHPB considers if evidence-based practice guidelines can <b>reduce medical errors and malpractice costs</b> and if so, may propose legislation.</p> <p>OHPB and OHA work with stakeholders to develop or endorse desired <b>health care workforce competencies</b> for new models of care delivery.</p>
<p><b>Living within our means</b></p>	<p>OHPB sets OHA and statewide <b>limits on growth</b> in health care expenditures to a specified economic index.</p> <p>OHA continues to change incentives and encourage efficient use of workforce capacity by <b>implementing bundled payment and other innovative payment approaches</b> in key focus areas, both within OHA programs and more broadly through private partnerships.</p> <p>OHA develops <b>standardized processes</b> for prior authorization for services, referrals, and plain language billing for consumers.</p> <p>OHA and regional health organizations seek federal approval to aggregate and leverage <b>multiple funding streams into a single source</b> for use by regional integrated health systems.</p>

Foundational Strategy	Next best steps in 2011-2013
<p><b>Fundamental cross-cutting considerations</b></p>	<p>OHA sets <b>statewide health system performance goals</b>.</p> <p>OHA works with stakeholders to develop or endorse standard measures of <b>patient engagement and activation</b> to be folded into primary care homes, payment reforms, and regional health organizations.</p> <p>Oregon <b>Health Information Exchange</b> is fully operational and supports meaningful use of health information technology by providers to improve care quality and coordination.</p> <p>OHA continues to provide technical assistance and support to <b>community-based health care access initiatives</b>.</p>



Foundational Strategy	Action steps and achievements for the 2013-2015 biennium
<p><b>Align purchasing and policy</b></p>	<p>In January 2014, <b>Oregon Health Insurance Exchange</b> begins operation and enrollment in Exchange plans begins.</p>
<p><b>Local accountability</b></p>	<p>The OHA continues to support development and expansion of regional and community efforts to <b>locally integrate health improvement and health care decisions</b> and be accountable for the outcomes of those decisions, with a goal of an integrated organization in every region of the state by 2015.</p>
<p><b>Standards for safe and effective care</b></p>	<p><b>Patient-centered primary care homes</b> and <b>value-based benefit plans</b> are available across OHA programs and the Health Insurance Exchange.</p> <p>All Oregonians have access to patient-centered medical homes by 2015.</p>
<p><b>Living within our means</b></p>	<p>In January 2014, all health plans and providers are using <b>standard electronic methods</b> for billing, paying, and communicating eligibility and financial information.</p> <p>The <b>Oregon Health Authority and the Oregon Health Insurance Exchange continue to incent quality and efficiency</b> through payment reform, state purchasing and public/private partnerships.</p>
<p><b>Fundamental cross-cutting considerations</b></p>	<p>Achieve <b>widespread adoption and use of electronic health records</b> to support clinical decision-making, improve patient care and coordination, and enhance public health data and surveillance.</p> <p>In 2014, <b>Federal insurance expansions</b> through Medicaid and tax credits begin; all insurance is guarantee issue and renewable.</p>

## **Our Vision for 2015 and Beyond**

- Oregonians health status is ranked among the highest in the nation overall and by sub-populations.
- Every Oregonian has high quality health care at a price we can afford.
- Consumers can get the care and services they need close to home, from a team of health professionals who understand their culture and speak their language.
- Consumers, providers, community leaders, and policy makers have the specific quality information they need to make better decisions and keep delivery systems accountable.
- New payment systems and quality standards contain costs by emphasizing value and outcomes instead of rewarding volume.
- Communities and health systems work together to find innovative solutions to reduce overall spending, eliminate inequities, increase access to care and improve health.
- Electronic health information is available when and where it is needed to improve health and health care through a secure, private health information exchange.

**DRAFT**

**Oregon Health Policy Board  
Oregon’s Action Plan for Health  
Draft Outline**

**I. Introduction: An Urgent Call to Action**

**II. Our Key Strategies**

- Aligned purchasing
- Local accountability
- Standards for safe and effective care
- Living within our means

**III. Our Infrastructure Proposal**

**IV. Fundamental Cross-cutting Considerations**

- Health equities
- Access to care
- Bending the cost curve
- Measuring progress
- Consumer and patient engagement
- Shifting the focus to prevention
- Federal health reform

**V. Next Best Steps to a Healthy Oregon**

- Population health
- Quality and payment reform
- Workforce reforms
- Administrative simplification
- Health information exchange
- Medical liability
- Public corporation to administer the Oregon Health Insurance Exchange
- Value-based Benefit Design
- Successful implementation of insurance expansions

**VI. Timeline for Next Best Steps**

**VII. Conclusion**

**Appendices**

Supporting Documents: List of OHPB Committee Reports  
Summary of Action Plan Recommendations  
Draft Oregon Health and Health Care Scorecard Reference  
Bending the Cost Curve Full Summary  
Summary of Public Input on *Action Plan*

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## Public Employers Health Purchasing Committee Draft Report

Steve McNannay, Chair  
Lynn McNamara, Vice-Chair  
November 2010



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### Our Charge

- Identify and recommend strategies to align purchasing policies and standards, as well as foster collaboration, across public employers and other interested health care purchasers.
- Develop strategies for disseminating and incorporating uniform quality, cost and efficiency standards and/or model contract terms:
  - For use by OHA health care purchasing programs
  - For voluntary adoption by local governments and private sector entities.



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### Our Charge (continued)

- These standards are to be based on the best available clinical evidence, recognized best practices and demonstrated cost-effectiveness for health promotion and disease management.
  - Working with other Health Authority programs to commission evidenced-based reviews with the Center for Evidenced-Based Policy at Oregon Health Sciences University



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## Committee Membership

- Represents organizations that buy benefits for as few as 25 people to over 140,000 people:
  - Public Employees Benefit Board (PEBB)
  - Oregon Educators Benefit Board (OEBB)
  - Public Employees Retirement Systems (PERS)
  - City governments
  - County governments
  - Special districts



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## 2010 – '11 Committee Members

- Cathy Bless, City of Portland
- Ronda Connor, Deschutes County
- Caren Cox, Multnomah County
- Mina Hanssen, Marion County
- Joan Kapowich, PEBB/OEBB
- Diane Lovell, PEBB
- Zue Matchett, PERS Health
- Lynn McNamara, CityCounty Insurance Services
- Steve McNannay, OEBB
- Barbara Prowe, Coalition of Health Care Purchasers
- Linda Shames, Port of Hood River
- Madilyn Zike, Lane County



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## Areas Examined by the Committee

- Committee met 6 times and heard presentations on:
  - Presence of public purchasers in local and regional health care markets
  - Quality measurement and reporting efforts in Oregon
  - Comparative effectiveness research and evidence-based practice guidelines
  - Patient safety
  - Federal reform and its impact on Oregon's reform efforts
  - Other OHPB committee recommendations



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## Role of Public Purchasers

- Public entities in Oregon (excluding Medicare) purchase 1/3 of the health benefits for insured people under 65, including:
  - Oregon Health Authority programs
    - Medicaid (OHP)
    - Children's Health Insurance Program (CHIP)
    - Family Health Insurance Assistance Program (FHIAP)
    - Oregon Medical Insurance Pool (OMIP)
  - State employees and dependents
  - Oregon school employees and dependents
  - Local government employees and dependents
- In some regions, up to 50% of coverage is purchased by public entities




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## Regional Summary of Impact

Region (Counties)	State	OEBB	Local Govt.	Total	Insured Pop. < 65	Percent Penetration
NW Oregon (Clats., Mult., Wash., Clats., Clats., Hood River, Tillam., Yam.)	235,042	55,555	81,774	373,371	1,409,566	26.4%
Salem Area (Marion, Polk)	99,825	20,867	15,246	135,938	275,400	49.4%
Mid-Valley (Benton, Lane, Lincoln)	45,161	10,181	9,405	64,747	173,402	37.3%
S. Willamette Valley (Lane, Douglas, Clatsop)	88,736	19,083	22,354	130,173	360,345	36.1%
S. Oregon (Jackson, Joseph, Curry)	51,339	6,288	8,455	66,082	206,143	32.1%




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## Regional Summary of Impact (cont.)

Region (Counties)	State	OEBB	Local Govt.	Total	Insured Pop. < 65	Percent Penetration
Can. Oregon (Deschutes, Crook, Jefferson)	27,546	10,208	7,597	45,351	150,329	30.2%
Mid-Columbia (Clatsop, Harney, Wheeler, Wasco, Wallowa)	22,454	7,494	4,847	34,795	77,889	44.7%
SE Oregon (Grant, Harney, Klamath, Lake)	16,268	4,653	5,797	26,718	59,735	44.7%
NE Oregon (Baker, Union, Malheur, Wallowa)	17,101	4,488	5,552	27,141	54,287	50.0%
<b>State Totals</b>	<b>608,976</b>	<b>142,966</b>	<b>161,027</b>	<b>912,969</b>	<b>2,767,094</b>	<b>33.0%</b>




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## Public Employer Contracting Process

- Surveyed Committee – Significant variation
- Plan Year effective dates vary –
  - 4 in January, others from June to October
- Annual Open Enrollment periods vary –
  - Between 21 to 60 days, most 30 days
- Lead time required for contract changes –
  - Between 6 months and 2-3 years
  - Finalized between 1 day and 8 months prior to plan year
- Dual nature: purchaser-carrier, carrier-provider contracts



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## Committee Recommendation Process

- With respect to county, municipal, special districts and private employers, the recommendations are voluntary
- Public employers have boards, commissions and/or collective bargaining processes that must ultimately approve any benefit or contract changes
- Two approaches to recommendations:
  - Benefit (coverage) related changes
  - Contracting (carrier & provider) related changes



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## Committee Recommendation Process

- Benefits related (covered services, limits, cost-sharing):  
*"The Public Employer Health Purchasing Committee of the Oregon Health Policy Board has reviewed the attached benefit design proposal, and recommends consideration of this proposal by public and private employers during their annual review and modification of medical benefit package."*



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## Committee Recommendation Process

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



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## Issues Before the Committee

- Administrative Simplification (action)
- Patient Safety (action)
- Standardized Payment Methodology (action)
- Health Improvement Plan (pending)



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## Administrative Simplification

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



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## Administrative Simplification (cont.)

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



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## Patient Safety

- Summary of policy proposal:
  - Relating to various patient safety requirements included in purchaser-carrier/TPA contract, or in carrier/TPA contracts with providers:
    - CMS Hospital Acquired Conditions (HACs)
    - Oregon Patient Safety Commission hospital reporting
    - Oregon Patient Safety Commission hospital surgical checklist
    - Oregon Association of Hospitals & Health Systems non-payment of serious adverse events
    - Oregon Patient Safety Commission adverse events reporting for non-hospital facilities
    - List of "never events" that define "serious adverse events"
    - Bariatric surgery guidelines (applicable when bariatric surgery is a covered benefit)



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## Patient Safety (cont.)

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



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## Standardized Payment Methodology

- Committee action — Letter to Board:
  - At its October 25<sup>th</sup> meeting, the Public Employers Health Purchasing Committee reviewed the draft recommendations of the Incentives & Outcomes Committee which are pending final action by the Health Policy Board.
  - By unanimous vote, the Committee endorsed Recommendation #1: Standardize payment methods (but not rates) to Medicare.
  - Furthermore, the Committee supports an implementation plan for this recommendation that begins with the development of a standardized, statewide Diagnostic-Related Group (DRG) methodology for reimbursement of hospital inpatient services at DRG hospitals.



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## Health Improvement Plan

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



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## Health Improvement Plan (cont.)

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



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## Distribution of Recommendations

- Once Committee Report is accepted by the Board, the recommendations will be distributed to appropriate associations in the public and private sectors, including (but not limited to):
  - Public employer groups
  - Public employee unions
  - Portland Business Alliance,
  - National Federation of Independent Businesses
  - Association of Oregon Industries
  - Health insurance carriers and TPAs
  - State's 100 largest employers



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## Development of Educational Materials

- Committee believes that significant and strategic communication efforts must be undertaken to help public understand:
  - Why these changes are needed
    - Control costs and improve health
  - How to become better consumers of health care
- Committee originally focused on use with their own stakeholders, but realized it was a bigger issue



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## Next Steps

- Continue to develop recommendations and contract language based on Committee's ongoing work and work of other committees
  - Value-based benefits
  - "Meaningful use"
  - Additional payment and quality recommendations
  - Health Improvement Plan recommendations
  - Evidence-based best practice guidelines
  - Health Equity Review Committee recommendations



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**Next Steps (continued)**

- Development of collaborative process to foster broad implementation of uniform purchasing standards and policies
- Continued analysis of local health care markets



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**Questions?**



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**Oregon Health Care Workforce Committee**

**Draft 2010 Recommendations**

Oregon Health Policy Board Meeting  
November 16, 2010



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**Committee Charter**

**Recruit Educate Retain**

A quality health care workforce to meet the demand created by expansion in health insurance coverage, system transformation and an increasingly diverse population

- Coordinate efforts to meet demand
- Develop recommendations & action plans for OHPB



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**Process**

- Reviewed supply and demand data
- Studied implications of reform
- Conducted SWOT analysis

**Principles**

- Build on collaborative & innovative partnerships
- Diversity in students, faculty and workforce
- Maximize resources
- Expand education initiatives



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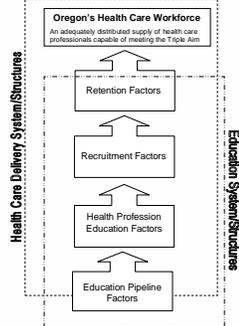
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## Levels of Workforce Policy Interventions




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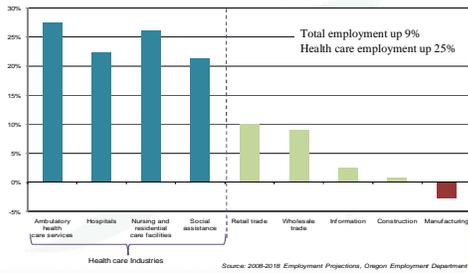
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Quality Information. Informed Choices.

## Strong growth projected in health care industries over next ten years.

Projected Employment Change, Select Industries  
Oregon, 2008-2018



www.QualityInfo.org

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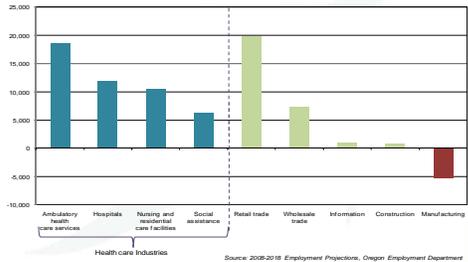
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Quality Information. Informed Choices.

## Many new job opportunities

Total Projected Employment Change, Select Industries  
Oregon, 2008-2018



www.QualityInfo.org

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### Committee Priorities

- **Prepare the workforce for new models of care delivery.** Work of health care will be done differently in the future.
- **Improve the capacity and distribution of the primary care workforce.** Urgent need to meet the anticipated demand in 2014 and beyond.
- **Expand through education, training and regulatory reform to meet the current projected demand of 58,000 additional health care workers.** Most effective way is to grow our own.



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### Short-Term Recommendations

1. Revitalize the state's primary care practitioner loan repayment program.
2. Standardize administrative aspects of student clinical training.
3. Enable educational institutions to respond quickly to health care workforce training needs.
4. Maintain resources for health profession education programs.
5. Expand health care workforce data collection for a more complete picture of Oregon's health care workforce.



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#### Recommendation 1

**Fund Oregon's Primary Care Services Loan Repayment Program to reduce 5% or more of projected need for covered professionals every biennium**

**Priority:** Improve the capacity and distribution of the primary care workforce.

**Rationale:**

- Loan repayment works
- Program targets rural and underserved areas where need is greatest
- Potential for federal matching funds (up to 1:1)
- Loan repayment dollars are tax exempt



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**Recommendation 2**

**Standardize student requirements for clinical training via:**

- Common vendors
  - Student "passports"
  - Uniform standards for student clinical liability
- And by incentivizing employers to serve as clinical training sites**

**Priority:** Expand the workforce through education, training, and regulatory reform.

**Rationale:**

- Current requirements are costly & inefficient for students and clinical sites
- Successful "passport" model exists for nursing
- Differing liability standards complicate contract negotiations between schools and clinical sites
- Streamlined process will encourage more providers and sites to participate



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**Recommendation 3**

**Revise the adverse impact policy**

**Priority:** Expand the workforce through education, training, and regulatory reform.

**Rationale:**

- Private business can use hypothetical action to block new training programs or their locations.
- Training for high-demand occupations is not distributed optimally.
- Enable public educational institutions to respond to industry and community needs for health care professional training while remaining good stewards of public funds.



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**Recommendation 4**

**Maintain resources for health profession education programs**

**Priority:** Expand the workforce through education, training, and regulatory reform.

**Rationale:**

- Success of reform efforts is dependent on the workforce that educational programs produce.
- Priority programs are ones that train students:
  - In key shortage occupations;
  - By leveraging technology to reach non-metro area students;
  - From racially and culturally diverse backgrounds;
  - To deliver patient-centered primary care as part of an inter-professional team.



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**Recommendation 5**

**Expand health care workforce data collection for a more complete picture of Oregon's health care workforce**

**Priority:** All three (prepare workforce for new models; improve capacity & distribution; expand the workforce, through education, training, and regulatory reform)

**Rationale:**

- Complete & accurate information is crucial for workforce development strategies.
- Currently limited to seven professional licensing boards
- First priority for expansion: mental and behavioral health care professionals (psychologists, social workers and professional counselors and therapists).



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**Longer-Term Recommendations**

1. Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of demand.
2. Define or adopt standards for health care workforce competencies needed in new models of care delivery.
3. Adopt a payment system that encourages the most efficient use of the health care workforce.
4. Identify barriers that prevent health care professionals from practicing to the full scope of their licenses.
5. Stimulate regional creativity, accountability, and resource sharing for health care workforce development.
6. Enhance resources for health professions education programs.
7. Maintain and enhance resources for K-12 math, science, and health career exposure.



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**Workforce Committee Next Steps**

**Plans for 2011 include:**

- Provide shared oversight for implementation of short-term recommendations approved by OHPB
- Continue development of longer-term strategies, specifically:
  - Examine workforce implications of delivery system reform pilots;
  - Convene stakeholders to define or adopt workforce competencies appropriate to new models of care;
  - Identify barriers preventing professionals from practicing at the full scope of their licenses;
  - Explore mechanisms for cooperative recruitment and retention across employers, regions, and communities;
  - Work with licensing boards to expedite licensing for qualified professionals from other states or countries;
  - Improve data availability for non-licensed health care professionals.



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**Oregon Health Authority**  
Office for  
Oregon Health Policy and Research



**Oregon Health Care Workforce Committee**

**Draft Recommendations for the  
Oregon Health Policy Board**

**November 2010**

**Health Care Workforce Committee  
2010 Draft Report**

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**Oregon Health Policy Board  
Health Care Workforce Committee - 2010 Roster**

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Deputy Director, Office for Oregon Health Policy and Research

Jennifer Swendsen

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## Executive Summary

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee (“Committee”) to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. In response to this charge, the Committee identified three initial priorities for health care workforce development. These priorities reflect the Committee’s desire for action that will address both the current workforce needs and the needs Oregon might have in the future, when health care delivery looks different than it does today. The priorities are:

1. Prepare the current and future workforce for new models of care delivery;
2. Improve the capacity and distribution of the primary care workforce; and
3. Expand the workforce through education, training, and regulatory reform to meet the current projected demand of 58,000 new workers by 2018.

In this report, the Committee recommends five short-term actions and seven longer-term strategies to help Oregon move forward in these priority areas. In the short term, Oregon should:

- Revitalize the state’s primary care practitioner loan repayment program;
- Standardize the administrative aspects of student clinical training;
- Re-interpret an ‘adverse impact’ policy that makes it difficult for educational institutions to offer programs in response to industry and community needs;
- Maintain funding for health professions education programs; and
- Expand health care workforce data collection.

Longer-term recommendations are to:

- Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand
- Define new standards for health care workforce competencies
- Adopt a payment system that encourages the most efficient use of the health care workforce
- Identify barriers that prevent health care professionals from practicing to the full scope of their licenses
- Stimulate local creativity and resource sharing for health care workforce development
- Enhance resources for health professions education programs
- Maintain and enhance resources for K-12 math, science, and health career exposure.

The Committee emphasized that the eventual success of health care workforce development efforts will be strongly influenced by reforms in other parts of the health care system. In that context, the Committee identified these elements of broad-based health care reform as particularly important sources of support for its targeted workforce recommendations: adoption of more comprehensive and/or accountable payment methods; greater emphasis on prevention and population health; and improved data collection.

The Committee has appreciated the opportunity to address the important task of ensuring an adequate health care workforce for Oregon and looks forward to continuing its work.

## I. Introduction

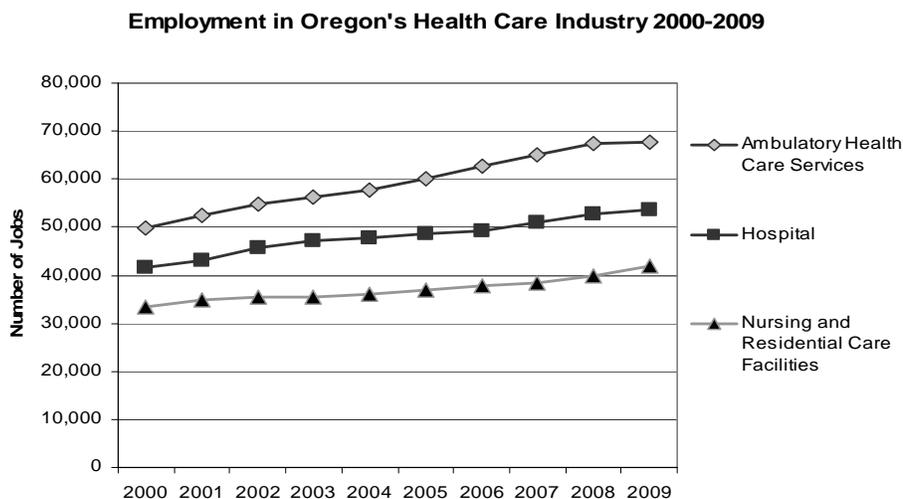
The health care workforce and delivery system of today are stretched to the maximum to meet the growing demands of Oregon's population, yet too many Oregonians are not able to access health care when and where it is needed. At the same time, health care delivery is rapidly moving away from the model of single practitioners focused on units of service to inter-professional teams responsible for health outcomes. These important trends demand bold action for health care workforce development.

The likelihood of substantial changes in health care delivery and payment make it difficult to pinpoint the number and kind of health care providers that would be ideal for the future. Some of the changes that are needed to build an appropriate health care workforce for Oregon must be made at the national level. Nevertheless, decisive action can and must be taken in Oregon to create the health care workforce that we need. This report contains the Health Care Workforce Committee's 2010 recommendations for this action.

## II. Background

### *The Challenge*

State and federal health care reforms aim to improve health care for all Oregonians, yet their success depends on access to a health care workforce able to meet the demand for quality services. Reform efforts add to the current demand created by a growing, aging and diversifying population, the increasing number of people living with chronic diseases, advances in medical technology, and an aging health care workforce. To achieve the triple aim of improved population health, increased quality and availability of care, and reduced costs, Oregon needs a health care workforce strategy that addresses all of these factors.



Source: Oregon Employment Department

Increased demand for health care professionals is reflected in industry employment, which comprises a growing share of the state's workforce and accounts for over ten percent of Oregon's total non-farm employment.<sup>1</sup> According to Oregon Employment Department data, employment in Oregon's health care industry grew 31% between 2000 and 2009 (see chart below). The largest job growth occurred in the ambulatory health care services sector, which added 17,800 jobs between 2000 and 2009, representing a 36% increase in employment. Hospital employment grew 29%, adding 12,000 jobs to the labor market. Employment in Oregon's nursing and residential care facilities grew by 8,400, representing a 25% increase in employment in this sector.

Three of the state's top ten sectors projected to add the most jobs are in the health care industry: ambulatory health care, hospitals, and nursing and residential care.<sup>2</sup> Based on current population trends and health care delivery models, the Oregon Employment Department forecasts a need for nearly 58,000 additional health care workers in the state by 2018.<sup>3</sup> Forty-six percent of the projected job openings are to replace those permanently leaving the occupations' labor pool. See Appendix A for a table of the 50 fastest growing health care occupations in Oregon.

These projections, however, are based on market demand rather than population need and do not account for coverage expansions expected to bring almost 280,000 newly insured people into the system by 2014<sup>4</sup> or the significant changes proposed for how health care is delivered and financed. Nurse Practitioners, for example, are likely to be key players in a revitalized primary care system but are not listed in Table 1 because of data collection limitations. Specifically, the U.S. Department of Labor's Standard Occupational Classification (SOC) system puts nurse practitioners in the broad registered nurse category that also includes RNs, staff nurses, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.<sup>5</sup> Similarly, emerging health care occupations, including those associated with new models of health care delivery, are excluded from employment projections since there are no baseline data on which to estimate employment demand.

Furthermore, the aggregate demand figure masks significant variation by geographic region, provider type and specialty. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area designation.<sup>5</sup> There are seven counties with ten or fewer physician practices, including two counties with only one physician each and twelve counties with fewer than ten dentists, including four counties with no dental practice. Only 38% of Oregon's physicians are practicing in primary care (family medicine, family practice, general practice, general internal medicine, pediatrics, geriatrics, and adolescent medicine).<sup>6</sup> Information about the racial and ethnic diversity of Oregon's health care workforce is currently limited but the state and health professional regulatory boards are collaborating to build a health care workforce data system that will improve the availability and quality of diversity data.

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<sup>1</sup> Beginning in 2011, the U.S. Department of Labor's Standard Occupational Classification (SOC) system creates separate codes for advance practice nurses, nurse midwives and nurse anesthetists

Employment projections also do not reflect the difficulty employers face in filling current job openings. A 2009 statewide vacancy survey by the Oregon Employment Department found that despite the recession, Oregon's health care and social assistance industry had far more vacancies (5,744) than any other industry in the state.<sup>7</sup> Job openings for registered nurses in Oregon represented nearly six percent of all vacancies statewide, ranking the highest of all occupations with job vacancies.<sup>ii</sup> Of the 1,004 reported vacancies for registered nurses, 11% had been open more than 60 days. Of the 457 job openings for nursing assistants, 10% had been vacant more than 60 days. Twenty-nine percent of the 226 reported vacancies for physical therapists and 19% of the 212 vacancies for physicians were open more than 60 days.

Despite these caveats, employment demand projections provide important trend information and are a strong basis for more detailed analyses. The Health Care Workforce Committee has accepted the Oregon Employment Department projections as a reasonable calculation of health care workforce need. Close attention to emerging information on workforce supply and diversity, health care demand, and delivery system changes will be essential for crafting a health care workforce strategy that enables the state to achieve the triple aim.

### *The Oregon Health Care Workforce Committee*

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee ("Committee") to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. The Committee is charged with advising the OHPB and developing recommendations and action plans for implementing the necessary changes to train, recruit and retain a health care workforce that is scaled to meet the needs of new systems of care. The Committee is also intended to become the most complete resource for information about the health care workforce in Oregon by improving data collection and assessment of Oregon's health care workforce through regular analysis and reporting of workforce supply and demand.

Committee members include representatives from community colleges, graduate health and medical education, health system and hospital employers, foundations, Area Health Education Centers, and a range of health professions: nursing, dentistry, allied health, behavioral health, and medicine. The Committee is also connected to a broader range of stakeholders and experts via a formal collaborative relationship established this past summer between the Oregon Health Policy Board and the Oregon Workforce Investment Board (OWIB). The OWIB serves as the advisory board to the Governor on workforce matters and is comprised of leaders representing private sector businesses, labor, and state and local governments. One of the chief duties of the OWIB is to assist the Governor by developing a five-year strategic plan for

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<sup>ii</sup> The occupational groupings of the U.S. Department of Labor's Standard Occupational Classification (SOC) system have limitations when analyzing projections for specialty-trained workers within an occupational category. For example, the current SOC for registered nurses includes employment for staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Similarly, when multiple job titles are grouped within one SOC, such as radiologic, CAT and MRI technologists and technicians, the distinction between levels of training and required certifications is omitted.

Oregon's comprehensive workforce system and building Oregon's health care workforce through job training efforts, which is identified as one of four key initiatives in the plan. The two bodies have agreed to collaborate, seek federal funding opportunities, coordinate recommendations and align efforts to build Oregon's health care workforce. The OWIB has designated the Health Care Workforce Committee as an advisory subcommittee and Oregon Health Policy Board has committed to sharing information, expertise and other resources to support the success of the collaborative relationship.

### *Priorities and Principles*

Committee members started work in Spring 2010 by reviewing health care workforce supply and demand data, considering the impact of health care delivery changes on job roles and training, and analyzing the workforce implications of federal health reform legislation. The Committee identified significant challenges, strengths, barriers, and opportunities for health care workforce development and produced a lengthy list of potential strategic objectives for health care workforce development. First and foremost, the Committee acknowledged the importance of reducing Oregonians' overall need to access health care providers by supporting prevention and health promotion efforts. The Committee recognized the following principles to guide health care workforce development efforts:

1. Build on collaborative and innovative partnerships within and across sectors (education, industry, workforce development, government);
2. Ensure and promote diversity in health profession students, faculty and the health care workforce;
3. Maximize the efficient use of existing and future resources and pursue federal and other non-state funding opportunities that align with the Committee's priorities;
4. Promote the continuation and expansion of successful health profession education initiatives aimed at meeting Oregon's health care workforce needs.

Three priorities emerged from the Committee's careful examination of health care workforce needs. These priorities reflect the Committee's desire for action that will address both our current workforce needs and the needs we might have in the future, when health care delivery looks different than it does today.

1. **Prepare the workforce for new models of care delivery.** If Oregon is to have any chance of solving its health care workforce capacity problems, fundamental changes must be made in how care is provided and how the health care workforce functions. Put simply, the gap between the work that needs to be done and the number of available workers is so big that we have no choice but to do the work differently. Delivery system transformation will prove challenging for a workforce that is already under strain and payment reforms will be necessary to catalyze the needed changes in many cases. But committing to system transformation gives us the opportunity to increase provider satisfaction and retention at the same time that we improve patient health outcomes. Transformation is already underway. Engaging and empowering the health care

workforce to help lead practice transformation is fundamental to the long-term success of health care reform efforts.

2. **Improve the capacity and distribution of the primary care workforce.** There is an urgent need to expand the primary care workforce to meet the anticipated increase in demand for care in 2014 and beyond. Expanding education and training opportunities and increasing the number of health profession graduates is one part of ensuring an adequate workforce, but many health professions require years of training. In the short term, Oregon must take steps to expand the capacity of its existing primary care workforce and to improve its distribution.
3. **Expand Oregon's health care workforce through education, training and regulatory reform to meet the current projected demand for 58,000 additional health care workers.** One of the most straightforward ways to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to “grow our own,” meaning that Oregon must educate more professionals in-state and whenever possible “in-region” to train health care professionals from and in the communities they will serve, to assure both the rural and urban demand is met.

Decisive action in each priority area is needed to ensure that Oregonians have access to appropriate health care providers in their communities when they need care. This document contains the Health Care Workforce Committee’s short- and longer-term recommendations for tackling each priority.

## **II. Short-term Recommendations**

### **1. Revitalize the state’s primary care practitioner loan repayment program.**

*What:* Oregon’s Primary Care Services Program, which provides partial loan repayment to primary care providers in return for service time in rural or underserved areas, should be financed as soon as possible at a level that would reduce at least 5% of the projected need for each professional included in the program every biennium (roughly 30 additional professionals per year).

*Why:* Educational debt combined with the relatively low earning potential of primary care as compared to specialty practice discourages health professionals from entering into primary care, especially in rural or underserved communities where remuneration is typically low. Loan repayment programs that tie repayment to a service requirement have been successful in encouraging primary care practice in rural and underserved areas. Health care professionals who participate in such programs are more likely than non-participants to continue to practice in underserved areas even when their service obligation expires.<sup>8</sup>

Federal health reform doubled the size of the national loan repayment program known as the National Health Service Corps, which could bring 100 or more additional primary care

practitioners to Oregon. Oregon's program is a good complement to federal programs but has no dedicated funding. This recommendation supports the Committee's second priority of improving the capacity and distribution of the primary care workforce.

*How:*

- Funding mechanisms for a loan repayment program include surcharges on health professional licenses or on student fees in health professional programs, federal matching funds, foundation money, state General Fund, dedicated taxes, and other sources alone or in combination. Potential financing options are described in Appendix B. *(Please note: this document is still in progress)*
- The level of investment required to meet the 5% goal is roughly estimated at \$2M per biennium, if repayment is capped at three years.
- Eligibility criteria for the Oregon Primary Care Services Program should be reviewed every biennium in collaboration with the Health Care Workforce Committee to ensure that the program can adapt to address new care models and emerging shortages. For example, mental and behavioral health care professionals could be included to support the establishment of robust medical homes in rural and underserved areas.

## **2. Standardize administrative aspects of student clinical training.**

*What:* The Health Care Workforce Committee recommends three actions to streamline and increase capacity for the clinical portion of health profession student preparation:

- Standardize student background requirements for clinical training (drug testing, criminal background check, HIPAA training, etc.) and identify a common vendor (or set of vendors) to perform those checks and issue a student "passport." This standardization would greatly reduce the administrative burden and expense for students, who often pay for a new round of background checks, tests and training for each clinical training site.
- Establish uniform standards for student clinical liability to reduce the time and expense of contractual negotiations between educational institutions and provider organizations.
- Incent more community-based and outpatient practices to serve as clinical training sites through tax incentives or rebates.

*Why:* Clinical experience is a vital and required element of health profession training, yet it can be difficult for students and educational institutions to find placements and burdensome for provider organizations to serve as training sites and to provide preceptors. Additionally, the inconsistencies in student prerequisites for clinical training across and within health care organizations increase students' education expenses and create costly inefficiencies for schools and health care organizations. This recommendation supports the Committee's third priority of expanding the health care workforce through education, training, and regulatory reform and, less directly, the priority of improving workforce distribution.

*How:*

- OHA, in collaboration with the Oregon Workforce Investment Board, the Oregon Department of Community Colleges and Workforce Development, the Oregon Association of Hospitals and Health Systems, the Oregon Area Health Education Center Program Office, the Oregon Healthcare Workforce Institute and the Oregon Center for Nursing, should convene hospital representatives and educators to agree on a standard, uniform set of requirements (“passport”) in early 2011.
- OHA should identify statewide vendor(s) for background checks, drug tests and related requirements by RFP or OHA certification.
- OHA should require facilities to accept students’ “passports” as proof of student preparedness by Fall 2012.
- The Health Care Workforce Committee should consult with medical liability and contract law experts on options for standardizing student liability (2011).
- OHA should consult with the Oregon Department of Revenue on potential tax credits or other incentives for outpatient practices serving as clinical training sites (2011).

### **3. Enable educational institutions to respond quickly to health care workforce training needs.**

*What:* The state’s “adverse impact” policy should be revised, interpreted and implemented in a way that enables public educational institutions to respond quickly and appropriately to industry needs while demonstrating appropriate stewardship of public funds.

*Why:* Current interpretation of a state law (ORS 348.603) designed to ensure that public investment does not duplicate or adversely impact private business restricts public educational institutions from offering health occupations training and education programs in direct response to industry or community needs and student demand. The result is that training programs for high-demand health care occupations may not be available or equally available to rural and urban students or to rural or underserved communities. This recommendation supports the Committee’s third priority of expanding the health care workforce through education, training, and regulatory reform.

*How:* The OHA should convene stakeholders to redraft the law and/or administrative rules by Spring 2011.

### **4. Maintain resources for health professions education programs.**

*What:* In spite of the state budget shortfall, the Legislature should avoid making cuts to the health professions education programs, particularly programs that educate those professionals who are important to the establishment of patient-centered medical homes or who are in key shortage occupations (see Appendix A) and programs that reach students

in all areas of the state (e.g. distance education). The success of Oregon's health reform efforts is dependent on the workforce that these programs produce.

*Why:* The most direct and effective way to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to "grow our own," meaning that Oregon must educate more health professionals in-state. This is particularly important because other states have significantly increased their efforts to retain their health care workforces, limiting the effectiveness of Oregon's recruitment efforts. Similarly, as Oregon's population becomes more diverse, Oregon needs to build a health care workforce that reflects the state's racial and ethnic population. This recommendation supports the Committee's third priority of expanding the health care workforce through education, training, and regulatory reform.

*How:* While the state's severe budget challenges make it difficult, the Committee urges the Legislature to maintain funding for health professions education in 2011-13.

## **5. Expand health care workforce data collection for a more complete picture of Oregon's health care workforce.**

*What:* The statute that created Oregon's Health Care Workforce Database should be amended to enable collection of accurate and comparable data for all licensed health care providers in the state.

*Why:* Complete and accurate information about Oregon's health care workforce is essential for design and evaluation of workforce development strategies, including efforts to increase the diversity of the workforce. Participation in Oregon's health care workforce database is currently limited to seven professional licensing boards, meaning that the Health Policy Board and other policy makers lack information on key shortage professions such as those providing mental and behavioral health services. Furthermore, legislation governing the database is not flexible enough to include new provider types that may be recognized by professional licensing boards in the future. This recommendation supports all three of the Committee's priorities.

*How:*

- Participation in the health care workforce database should be extended to all health professional licensing boards in 2011, with actual reporting to be phased in according to data priorities and board readiness.
- Information about licensed mental and behavioral health care professionals is currently lacking, so the boards governing these professions should be prioritized for inclusion in 2011: the Board of Psychologist Examiners; the Board of Licensed Social Workers; and the Board of Licensed Professional Counselors and Therapists.
- The information collected should allow for linkages with Oregon Employment Department data on employment and compensation to enable analysis of workforce

development efforts, gaps between supply and demand, and the impact of economic incentives such as loan repayment and rural provider tax credits.

- Also in 2011, the Health Care Workforce Committee should begin to consider how to improve the availability of data on the many certified health care professionals who are not covered by any regulatory board but who make up a substantial portion of Oregon's health care workforce. Examples include: home health aides, qualified mental health professionals, and certified medical assistants.

### **III. Longer-term Recommendations**

#### **1. Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand.**

As Oregon leads the way on critical delivery system reform, it should also take leadership in understanding how those reforms will affect the current and future workforce. This recommendation relates to the Committee's first priority of preparing the workforce for new models of care delivery.

OHA should require delivery system reform pilots (primary care homes, behavioral health integration projects, etc.) to include analysis of workforce staffing levels, roles and skills, correlated with level of risk/complexity of patient mix, and population diversity. (Federal health reform legislation includes potential funding for a variety of reform experiments including medical homes and accountable care organizations.) Analysis results and workforce lessons learned should be reported to the Health Care Workforce Committee and the Oregon Employment Department on an ongoing basis to enable sharing of best practices and to help adjust workforce need estimates based on current models of care. The Workforce Committee will consider any available data as part of its 2011 workplan.

#### **2. Define new standards for health care workforce competencies.**

Although health providers are still exploring new models of care and the workforce implications, some of the skills that health care professionals will need are already evident. The Institute of Medicine identified five core competencies for all health care professionals: providing patient-centered care; the ability to work in inter-professional teams; proficiency with informatics or HIT; competence in quality improvement and methods; and evidence-based practice.<sup>9</sup> Recognizing the importance of addressing health care inequities, the Committee adds cultural competency as a sixth, distinct core skill. Cultural competency is vital not only to improve the quality of care delivered to racially and ethnically diverse patients but also to strength health care professionals' abilities to communicate and collaborate with each other.

Efforts to formalize new competencies in professional practice are already occurring at the national and state levels. For example, the American Board of Medical Specialties has included new requirements regarding interpersonal and communications skills in Maintenance of Certification testing for physicians. The Oregon State Board of Nursing

revised the Oregon Nurse Practice Act to include competencies in nursing informatics. Building on current efforts, the OHA should convene representatives from the Oregon's health care industry, academic programs, licensing boards, professional associations, and culturally diverse communities to guide the development of desired competencies and related curricular standards for Oregon's health professions' education programs. As with the previous recommendation, this work would support the Committee's first priority of preparing the workforce for new models of care delivery.

**3. Adopt a payment system that encourages the most efficient use of the health care workforce.**

A payment environment that restricts who can be reimbursed for service provision encourages practices to use higher-level practitioners to perform functions that could be done just as well—and less expensively—by other qualified providers. This leads to underutilization of existing workforce capacity, with negative consequences for access, quality, and cost. The Committee strongly supports shifting away from this type of payment system to a more comprehensive and/or accountable payment system, as proposed by the Incentives and Outcomes Committee. This recommendation supports the Committee's first and second priorities.

The methods of transitioning to a more integrated payment system should allow practices to build teams that use the best provider for a given function. In primary care, this might mean a base payment sufficient to hire a clinical pharmacist to educate patients about managing their prescriptions or community health workers to serve as bridges between clinical care and population-level prevention. Payment for certified health care interpreter services and the use of telemedicine to make health care more available in rural and remote settings are also strategies that should be considered as components of a comprehensive system.

**4. Identify barriers that prevent health care professionals from practicing to the full scope of their licenses.**

As new models of care delivery develop, the Committee, OHA and the state's health professional licensing boards should examine payment policies, credentialing standards, organizational structures, and other relevant factors to ensure that there are no barriers to utilizing the full potential of each professional's license. This recommendation supports the Committee's first and second priorities.

**5. Stimulate local creativity and resource sharing for health care workforce development.**

In the context of increasing interest in regionalization of health care and local accountability, statewide recruitment programs such as the primary care loan repayment program can only be part of the solution. Some communities may need a professional who is not included in the program's scope; others may find that loan repayment is not the right incentive to attract health professionals to their area. At the same time, thousands of

dollars are expended by individual employers in health professional recruitment efforts, particularly for rural and underserved areas. The OHA should help increase the efficiency of existing health care workforce development efforts by exploring structures in which health care employers, private industry, government representatives and community leaders can come together (similar to a community health collaborative model) to: identify local health care workforce needs; pool financial resources to recruit professionals; and devise appropriate community recruitment and retention incentives.

As a first step, in 2011 the OHA should convene stakeholders and conduct a feasibility study of mechanisms for and identify barriers (e.g. antitrust laws) to cooperative health care professional recruitment and retention across employers and communities. This work would support the Committee's priority of improving the capacity and distribution of the health care workforce.

#### **6. Enhance resources for health professions education programs.**

This proposal is the long-term version of short-term recommendation #4. Assuming a more robust state economy in future years, the Committee urges increased investment in health care professions education to help create the estimated 58,000 health care professionals that Oregon needs by 2018. This recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

#### **7. Maintain and enhance resources for K-12 math, science, and health career exposure.**

In order to build Oregon's health care workforce of the future, we must invest in the K-12 education pipeline to introduce students, particularly those from Oregon's rural and racial and ethnic minority populations, to and prepare them for health profession careers. Unfortunately, cumulative cuts over several years to Oregon's school districts and Area Health Education Centers budgets have reduced funding for math and science education and exposure to health careers, particularly in rural Oregon. The result has produced students who do not meet minimum qualification standards for admissions to post-secondary health profession education programs. Even though the state's budget challenges make it difficult, the Committee urges the Health Policy Board and the state to maintain now and enhance when possible funding for math, science and health career experience in Oregon's primary and secondary schools to prepare Oregon's future health care workforce. As above, this recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

### **IV. Vision, Context, and Constraints**

The short- and longer-term recommendations in this report are proposed as strategies to create an Oregon health care workforce that is:

- **Diverse and culturally competent.** Oregon’s population is becoming increasingly diverse and health care providers in the state should reflect this diversity. Providers should be able to offer services in the patient’s preferred language and to provide care in a manner that is appropriate and acceptable for the patient’s culture. Improving the diversity and cultural competence of Oregon’s health care workforce would produce a range of benefits including increased access to care for vulnerable populations<sup>10</sup>, improved patient-provider communication and quality of care, and expanded availability of living wage careers for racial and ethnic minorities.
- **Comfortable working in inter-professional teams.** Multidisciplinary teams (health care professionals from different fields working together to provide patient-centered care) are a key feature of many models of future primary care and have the potential to increase care coordination, improve quality and efficiency, and enhance job satisfaction and retention for care providers. To work effectively in such teams, health care providers will need a clear understanding of the breadth of knowledge and skills possessed by professionals outside their own disciplines. They will also need training in operational and managerial functions such as team oversight, negotiation, and performance improvement.
- **Practicing in the locations and specialties areas where it is most needed.** All Oregonians should have access to the care they need within a reasonable distance of their own communities. To make this possible, the current trend of decreasing enrollment in primary care disciplines must be reversed and disincentives for practicing in rural and underserved locations must be removed. Recruitment and admissions strategies for health education programs, reimbursement structures, support mechanisms for isolated practitioners, and community incentives should all be examined for their potential to improve the geographic and specialty distribution of the primary care workforce.

The recommendations in this report are strategies proposed by the Oregon Health Care Committee as the most feasible first steps toward creating a workforce that reflects the vision above. However, it is important to note that many of the policies and system changes that would make this workforce vision possible fall outside the traditional arena of workforce development. The Committee recognizes and supports the following elements of broad-based health care reform as necessary context for its more targeted recommendations:

- **Rapid migration away from fee-for-service payment systems.** Paying for units of service or procedures rewards volume and expensive treatments rather than improved health outcomes and superior quality and efficiency. For example, under fee-for-service systems, providers are often not compensated for valuable and time-consuming functions like care coordination, discharge planning, medication management, and other activities that are critical to keeping people healthy. Moreover, restrictions on who can be reimbursed under certain fee-for-service payment systems lead to under-utilization of existing workforce capacity by discouraging mid-level providers and

paraprofessionals from providing care within their scopes of practice. Shifting to more integrated or comprehensive payment structures will enable the workforce reconfiguration that is necessary to help Oregon meet its triple aim objectives.

- **Greater emphasis on prevention and population health.** The increasing burden of chronic diseases and poor health at the population level contribute significantly to the demand for health care professionals. In the long-term, investing in public health strategies that prevent or reduce disease and implementing health care reforms that encourage prevention and patient self-management will alleviate some of need to produce additional health care professionals. In the short-term, however, a greater emphasis on prevention and population health would require expanding the capacity of the public health and primary care segments of the workforce.
- **Improved data collection.** Better data and more meaningful measurement of costs and outcomes will be critical to the success of health care reform as a whole. For workforce development, more detailed and accurate information about the characteristics of the current health care practitioners, the projected supply of new professionals, and the future demand for care are obviously key resources for strategic planning. However, reliable data on cost, accessibility, utilization, quality, equity, and efficiency will also be necessary to track and evaluate the impact of workforce development efforts and to adjust those and other reform strategies as needed. Better data on race, ethnicity, language, and other demographic characteristics are critical to assess whether reform efforts are benefitting everyone equally.

Finally, it is important to recognize the limits of state's role and influence in developing, Oregon's health care workforce. Education standards, policy decisions and regulatory structures at the national and federal levels affect Oregon's health care workforce development efforts.

These include:

- National health profession education accreditation standards that dictate curriculum and clinical training requirements and limit curricular innovation;
- Higher degree requirements for entry-level clinical occupations, also known as "degree creep," which exacerbate shortages and impede career pathways;
- Reimbursement policies that incent students, particularly those with significant student loan debt, to enter specialty practices over primary care and health promotion practices; and
- Limitations on expansion of Graduate Medical Education (post-graduate residency programs).

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- <sup>1</sup> Oregon Employment Department (2010). *Current Employment Statistics*. Available at: <http://qualityinfo.org/olmisj/CES>.
- <sup>2</sup> Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2008-2018 Oregon Statewide*. Available at <http://qualityinfo.org/pubs/projections/projections.pdf>
- <sup>3</sup> Ibid.
- <sup>4</sup> Projection based on modeling by Jonathan Gruber, PhD, presented to Oregon Health Policy Board in August 2010.
- <sup>5</sup> U.S. Department of Health and Human Services Health Resources and Services Administration (2010). *Health Professional Shortage Areas, 2009*. Available at <http://hpsafind.hrsa.gov>.
- <sup>6</sup> Oregon Medical Board data, February 2010
- <sup>7</sup> Beleiciks, N. (2009). *Job Vacancies in Oregon*. Oregon Employment Department. Available at <http://qualityinfo.org>
- <sup>8</sup> Barnighausen & Bloom. (2009). Financial incentives for return of service in underserved areas: a systematic review. *BMC Health Services Research* 9:86.
- <sup>9</sup> Institute of Medicine. *Preparing the workforce*. In: *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press, 2001; 207–223.
- <sup>10</sup> Saha & Shipman. (2006). *Rationale for diversity in the health professions*. HRSA. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/diversity/>

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Appendix A

Top Fifty Fastest Growing Health Care Occupations in Oregon 2008-2018

Occupational Classification	Employment		Projected Openings Due to		Total Projected Openings	Minimum Education	Competitive Education
	2008	2018	Job Growth	Replacement			
Registered Nurses	30,656	37,427	6,771	5,947	12,718	Associate	Bachelor's
Nursing Aides	12,842	15,950	3,108	1,433	4,541	Short OJT	Post-sec.
Physicians & Surgeons	7,456	9,278	1,822	1,472	3,294	1st Prof.	1st Prof. + Work Exp.
Home Health Aides	8,599	10,775	2,176	965	3,141	Short OJT	Post-sec.
Medical Assistants	7,113	8,948	1,835	895	2,730	Moderate OJT	Post-sec.
Dental Assistants	4,360	5,527	1,167	928	2,095	Moderate OJT	Post-sec.
Pharmacy Technicians	3,910	4,465	555	1,056	1,611	Post-sec.	Associate
Dental Hygienists	3,142	4,003	861	729	1,590	Associate	Bachelor's
Licensed Practical Nurses	2,582	3,172	590	900	1,490	Post-sec.	Post-sec. + Work Exp.
Child, Family & School Social Workers	3,332	3,785	453	894	1,347	Bachelor's	Master's
Medical & Health Services Managers	3,112	3,763	651	655	1,306	Bachelor's	Master's
Medical Records & Health Information Technicians	2,639	3,274	635	603	1,238	Post-sec.	Associate
Pharmacists	3,180	3,649	469	757	1,226	1st Prof.	1st Prof. + Work Exp.
Healthcare Support Workers, All Other	3,137	3,804	667	387	1,054	Short OJT	Post-sec.
Substance Abuse & Behavioral Disorder Counselors	2,328	2,796	468	518	986	Associate	Bachelor's
Radiologic, CAT, & MRI Technologists & Technicians	2,261	2,793	532	365	897	Associate	Bachelor's
Medical & Clinical Laboratory Technologists	1,947	2,392	445	412	857	Post-sec.	Bachelor's
Mental Health & Substance Abuse Social Workers	1,675	2,057	382	469	851	Master's	Master's and related work experience
Emergency Medical Technicians & Paramedics	1,768	2,155	387	400	787	Post-sec.	Post-sec. + Work Exp.
Physical Therapists	2,117	2,616	499	286	785	Master's	PhD
Mental Health Counselors	1,675	2,030	355	375	730	Master's	Master's and related work experience
Rehabilitation Counselors	1,726	2,067	341	384	725	Master's	Master's and related work experience
Social Workers, All Other	1,768	1,993	225	472	697	Bachelor's	Master's
Medical & Public Health Social Workers	1,261	1,521	260	349	609	Bachelor's	Master's
Psychiatric Technicians	444	866	422	165	587	Post-sec.	Associate
Health Technologists & Technicians, All Other	1,303	1,592	289	295	584	Post-sec.	Post-sec. + Work Exp.
Dentists, General	1,004	1,270	266	316	582	1st Prof.	1st Prof. + Work Exp.
Medical Transcriptionists	1,589	1,939	350	197	547	Post-sec.	Associate
Clinical, Counseling, & School Psychologists	1,108	1,302	194	342	536	Master's	Doctorate
Medical & Clinical Laboratory Technicians	1,064	1,328	264	227	491	Associate	Associate + Work Exp.
Surgical Technologists	922	1,144	222	260	482	Post-sec.	Associate
Respiratory Therapists	1,077	1,301	224	217	441	Associate	Bachelor's
Psychiatric Aides	667	997	330	83	413	Short OJT	Work Exp.
Occupational Therapists	937	1,137	200	189	389	Master's	Master's + Work Exp.
Opticians, Dispensing	851	1,043	192	193	385	Long OJT	Post-sec.

Occupational Classification	Employment		Projected Openings Due to		Total Projected Openings	Minimum Education	Competitive Education
	2008	2018	Job Growth	Replacement			
Healthcare Practitioner & Technical Workers, All Other	635	761	126	233			
Health Educators	865	1,014	149	199	348	Bachelor's	Master's
Medical Equipment Preparers	985	1,206	221	122	343	Post-sec.	Post-sec. + Work Exp.
Occupational Health & Safety Specialists	725	794	69	254	323	Bachelor's	Master's
Dietitians & Nutritionists	555	663	108	204	312	Bachelor's	Bachelor's + Work Exp.
Physician Assistants	644	813	169	133	302	Bachelor's	Master's
Speech & Language Pathologists	832	958	126	163	289	Master's	PhD
Massage Therapists	808	965	157	118	275	Post-sec.	Post-sec. + Work Exp.
Physical Therapist Aides	602	757	155	98	253	Short OJT	Associate
Optometrists	354	450	96	134	230	1st Prof.	1st Prof. + Work Exp.
Cardiovascular Technologists & Technicians	579	709	130	93	223	Associate	Associate + Work Exp.
Physical Therapist Assistants	529	661	132	86	218	Associate	Associate + Work Exp.
Dentists, All Other	331	416	85	104	189	1st Prof.	1st Prof. + Work Exp.
Health Diagnosing & Treating Practitioners, All Other	456	550	94	92	186	1st Prof.	1st Prof. + Work Exp.
Chiropractors	383	489	106	77	183	1st Prof.	1st Prof. + Work Exp.

Source: Oregon Employment Department

# A Publicly-Owned Health Insurance Plan: Business Plans for 3 Options

For discussion with the  
Oregon Health Policy Board

*Bill Kramer, Principal  
Kramer Health Care Consulting  
November 16, 2010*



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## Definition of 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



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## 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
  - Initial financing for start-up costs and other needs will be repaid over a reasonable period



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## Environmental Analysis – Summary

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

[Detailed analysis presented at October OHPB meeting – see Appendix]



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## Key Strategic Issues

- Organization and governance
  - Standalone plan or “piggy-back” on existing public program?
- Provider network strategy
  - Selective or open 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?



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## Strategic Options: Potential Models

### A) Standalone Plans

- 1) Open Provider Network – used for baseline analysis
- 2) Selective Provider Network – not evaluated further

### B) “Piggy-back” Plans

- 1) **Link with PEBB – selected for detailed analysis**
- 2) **Link with OHP – selected for detailed analysis**

[Detailed descriptions presented at October OHPB meeting – see Appendix]

Other options not evaluated: link with OEBC, SAIF

*Issue: In the eyes of some advocates, a “piggy-back” plan might not meet the definition of a “public plan”.*



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## The Co-op Option

- ACA created Consumer Operated and Oriented Plans (CO-OPs)
  - Must be nonprofit
  - “The governance of the organization is subject to a majority vote of its members.”
  - “Profits inure to benefit of members”
- *Not strictly a “public plan”, but might achieve some of the same objectives*
- \$6 billion in loans (for start-up costs) and grants (to meet solvency requirements) will be available to finance CO-OP plans
- Regulations and distribution formula for CO-OP appropriations – TBD.




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## The Business Plan: Key Assumptions

### 1. Membership projections

- Ultimate market share driven by size of provider network: open (A1, B1) vs. selective (B2); phased in over time.
- Total Exchange includes individuals *and* small employers [revised from October preliminary figures]

	2014	2015	2016	2019	Mkt. Share
A1: Standalone	27,700	55,400	70,175	114,500	25%
B1: PEBB Piggyback	27,700	55,400	70,175	114,500	25%
B2: OHP Piggyback	11,080	22,160	28,070	45,800	10%
<i>Total Exchange</i>	<i>207,500</i>	<i>277,000</i>	<i>327,500</i>	<i>458,000</i>	




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## The Business Plan: Key Assumptions

### 2. Target Premium Rates vs. Private Plans

- In order to meet affordability goals and membership targets, premiums set below average of private plans after year 1 (2014)

% below private plans	2014	2015	2016
A1: Standalone	0	-1%	-2%
B1: PEBB Piggyback	0	-2%	-3%
B2: OHP Piggyback	0	-3%	-5%




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## The Business Plan: Key Assumptions

### 3. Medical/Hospital/Other Claims Expenses

- Ability to manage medical expenses is affected by
    - Size and type of provider network: open (A1, B1) vs. selective (B2).
    - Degree of medical management: moderate (A1, B1) vs. strong (B2)
- [Rationale for these assumptions presented at October OHPB meeting – see Appendix]

% below private plans	2014	2015	2016
A1: Standalone	0	-1%	-2%
B1: PEBB Piggyback	0	-1%	-2%
B2: OHP Piggyback	0	-3%	-5%



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## The Business Plan: Key Assumptions

### 4. 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.
- But ACA contains many mechanisms to minimize and offset adverse selection.
- Model assumes *no adverse selection*, but this is a potential risk.



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## The Business Plan: Key Assumptions

### 5. Administrative Costs

- High costs in first year (2014) due to small membership.
  - Standalone slightly lower than private plan average in 2016
  - PEBB Piggyback lower than Standalone
  - OHP Piggyback lower due to smaller size (but high as % of premium)
- [Rationale for these assumptions presented at October OHPB meeting – see Appendix]

	2014	% of prem.	2015	% of prem.	2016	% of prem.
A1: Standalone	\$24.4M	18%	\$29.4M	10%	\$36.4M	9%
B1: PEBB Piggyback	\$20.4M	15%	\$26.5M	9%	\$32.4M	8%
B2: OHP Piggyback	\$10.9M	20%	\$17.7M	15%	\$19.4M	13%



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## The Business Plan: Key Assumptions

### 6. 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

(cont.)



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## The Business Plan: Key Assumptions

### 6. Start-up Costs (cont.)

- Start-up costs are less than Standalone for PEBB and OHP "Piggyback" options due to use of existing infrastructure.
- OHP Piggyback costs are lowest due to smaller size.

	2013
A1: Standalone	\$19.5M
B1: PEBB Piggyback	\$14.2M
B2: OHP Piggyback	\$ 8.7M



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## The Business Plan: Key Assumptions

### 7. Reserve Requirements

- Insurance Code requires min. \$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.*
- In absence of detailed RBC analysis, the model uses 10% of premium (7% for OHP Piggyback due to risk assumed by MCOs)



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## The Business Plan: Key Assumptions

A Reminder about 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



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## The Business Plan: Financial Projections

Key Inputs and Assumptions:

- Membership
- Premium rates
- Medical/Hospital/Other Claims costs (and effect of adverse selection)
- Administrative costs
- Start-up costs (2013)

Outputs

- Net income or loss
- Reserve requirements – based on premium revenue
- Initial financing requirement for start-up costs, initial losses and reserves



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## Financial Projections A1: Standalone Plan

	2013	2014	2015	2016
Membership - YE	0	27,700	55,400	70,175
Revenue - \$ million	\$0	\$135.7	\$291.5	\$396.6
Expenses - \$ million	\$19.5	\$154.0	\$296.2	\$392.4
Net Income (Loss)	\$(19.5)	\$(18.2)	\$(4.7)	\$4.2



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## Financial Projections B1: PEBB Piggyback

	2013	2014	2015	2016
Membership - YE	0	27,700	55,400	70,175
Revenue - \$ million	\$0	\$135.7	\$288.6	\$392.6
Expenses - \$ million	\$14.2	\$147.8	\$291.2	\$386.3
Net Income (Loss)	\$(14.2)	\$(12.1)	\$(2.6)	\$6.3



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## Financial Projections B2: OHP Piggyback

	2013	2014	2015	2016
Membership - YE	0	11,080	22,160	28,070
Revenue - \$ million	\$0	\$54.3	\$114.3	\$153.8
Expenses - \$ million	\$8.7	\$62.2	\$120.9	\$154.4
Net Income (Loss)	\$(8.7)	\$(8.0)	\$(6.7)	\$(0.6)



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## Financial Projections Reserve Requirements

	Day 1	2014	2015	2016
A1: Standalone	\$3.0M	\$13.6M	\$29.2M	\$39.7M
B1: PEBB Piggyback	\$3.0M	\$13.6M	\$28.9M	\$39.3M
B2: OHP Piggyback	\$3.0M	\$ 3.8M	\$ 8.0M	\$10.8M



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## Financing Requirements

Initial Financing will be required to pay for:

- Start-up costs
- Losses in years 1-2 (and perhaps beyond)
- Contributions to reserves – until net income is sufficient

Minimum Initial Financing	
A1: Standalone	\$78M
B1: PEBB Piggyback	\$62M
B2: OHP Piggyback	\$35M



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## Financing

Financing Options are Limited:

1. Appropriation from the Legislature – unlikely in current fiscal environment
2. General Obligation Bond – State Treasurer has recommended a temporary halt to new GO bonds until state's financial situation improves
3. Direct Revenue Bond (non-tax supported)

Option 3 appears to be the most viable option:

- Fully self-supporting from enterprise revenues
- Would not draw on General Fund or require special taxes
- Will require detailed cash flow projections and risk assessment



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## Summary Assessment of Models

	2016 Membership	Breakeven Year	Initial Financing Requirement
A1: Standalone	70,175	2016	\$78M
B1: PEBB Piggyback	70,175	2016	\$62M
B2: OHP Piggyback	28,070	2017	\$35M



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## Next Steps

- Select preferred model(s)
- Finalize business plan(s)
- Submit report to the Legislative Assembly by December 31, 2010.

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## Appendix

Materials presented at the August and October meetings of the Oregon Health Policy Board

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## 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.)**

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

- ✓ 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.)**

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

- ✓ 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



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## 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.)

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

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

- ✗ 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

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## 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

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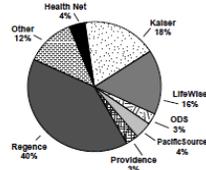
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## Environmental Analysis: Competitive Landscape

### 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

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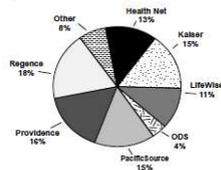
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## Environmental Analysis: Competitive Landscape

### 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

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## 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)

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## 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.)

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## 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.)

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## 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.

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**A1: Description of Standalone Plan (for baseline analysis)**

- POHIP would be established as a standalone public entity, with a board accountable to the general public.
- POHIP would contract directly with a wide range of providers, i.e., an “open” network.
- The base benefits would comply with the PPACA’s essential benefits package.
- Administrative services would be managed directly by the POHIP or outsourced as appropriate.

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**B1: Description of “Piggyback” Plan – with PEBB**

- POHIP members would be allowed to enroll in a plan that mirrored 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.

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**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.

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# Oregon Health Authority



# A Health Benefit Exchange for Oregon: Administrative Functions and Business Plan

Bill Kramer, Principal  
Kramer Health Care Consulting

November 16, 2010



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## Three Key Customer Groups

- Individuals
- Small employers
- Employees of small employers



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## From the Customer's Perspective

A high-performing health benefit exchange can provide *value*:

- **Choice of health plans/providers**
- **Convenience**
  - Easy shopping, ability to make apples-to-apples comparisons
  - Easy choice and enrollment process
  - Easy payment processing
- **Customer Service**
  - Easy to get answers to questions, before and after enrollment
- **Lower Costs**

by establishing a fair marketplace (a "level playing field") in which there is healthy competition among insurers to enroll employees, individuals and the self-employed.



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The Exchange can Provide Value to  
*Individuals & Employees*

by doing the following very well:

- **Determine eligibility** for exchange participation and individual tax credits, using a single portal (“no wrong door”) in coordination with Medicaid/CHIP eligibility determination.
- Establish **standards for insurer participation**, including **certification** of “qualified health plans”
- Develop a **standardized format** for presenting plan options
- **Grade participating insurers** on quality, cost, enrollee satisfaction, etc.
- Develop a **website** that allows people to easily compare health plan options
- Provide an electronic **calculator** to determine cost of coverage, and other decision support tools for individuals



(cont.)

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The Exchange can Provide Value to  
*Individuals & Employees*

by doing the following very well (cont.)

- Manage the **open enrollment process** for individuals and employees and **facilitate enrollment** in health plans
- Operate a **toll-free telephone hotline** to respond to requests for assistance
- Establish a **Navigator** program for outreach and enrollment support
- Develop a process for handling customer **complaints**; establish a grievance and appeal process
- Determine **exemptions** for individual responsibility requirement
- Conduct **public education and outreach**



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The Exchange can Provide Value to  
*Employers*

by reducing the burden of health benefits management  
and doing the following very well:

- Manage the **open enrollment process** for employees
- Provide plan **enrollment information** to employers
- Provide **consolidated billing** and enable simplified premium payment by employers
- Establish the interface and **facilitate the flow of funds** between insurers, employers, individuals – including subsidies and use of “free choice vouchers”



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## From the Perspective of Other Stakeholders

### Insurers want:

- Opportunity to compete on a level playing field
- Easy enrollment, billing and payment processing
- Opportunity to reduce administrative and sales costs
- Protection from adverse selection

### Brokers want:

- Opportunity to provide -- and be paid for -- services to their clients

### Government Agencies want:

- Easy exchange of data: e.g., eligibility for Medicaid and tax credits, verification of coverage, income, exemptions



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## The Exchange Can Meet the Needs of *Other Stakeholders*

by doing the following very well:

- **Monitor the market** to ensure fair competition
- **Facilitate enrollment** in health plans
- Establish the interface and **facilitate the flow of funds** between insurers, employers, individuals
- Administer **contracts** fairly and expeditiously with insurers, TPAs, navigators and other vendors
- Administer **risk adjustment** mechanisms between insurers
- Provide **information** to federal government on exemptions, tax credits, etc.



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## Building the Business Plan

### Background

- Exchanges will begin enrolling people in late 2013 for coverage effective 1/1/2014.
- Start-up expenses will be incurred in prior to 2014.
  - Federal government will fund start-up expenses, per ACA.
- Exchange must be self-supporting by 2015 (year 2 of operations).
  - Federal government will cover operating costs in 2014 (year 1), per ACA



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## The Business Plan: Structural Assumptions

- Dual Market
- Active purchaser role
- 3-4 benefit options in each tier
- Active marketing
- Public corporation structure

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## The Business Plan: Approach

**Membership:** Used forecasts developed by Jonathan Gruber, PhD (MIT), presented at August 2010 Board meeting. Assumed rapid enrollment beginning January 2014.

**Expenses:** based generally on experience of MA Connector

- Similar scale and role

**Fixed and variable expense model**

- Variable: eligibility processing, enrollment, premium billing, customer service
- Fixed: management, marketing/communications, professional services, IT, other infrastructure (cont.)

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## The Business Plan: Approach (cont.)

**Start-up:** Full year of expenses in 2013, prior to 1<sup>st</sup> year of operations (2014)

**Eligibility, enrollment, premium billing, customer service:** higher expenses in start-up year (2013); expenses based on pmpm in subsequent years (2014-)

**Marketing, Website Development, Professional Services:** higher expenses in start-up year (2013) and 1<sup>st</sup> year of operations (2014), declining in subsequent years (2015 - )

**Other fixed expense categories:** increase only for inflation 2014-

**Administrative fees:** amount set to *ensure breakeven in 2015* (year 2 of operations). Same amount used in 2014-2016.

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## The Business Plan: Summary

	2013	2014	2015	2016
Membership (YE):				
Individuals	-	142,500	190,000	232,500
Employees of small groups	-	65,000	87,000	95,000
Operating Revenue - \$ millions	0	\$31	\$42	\$50
Operating Expense - \$ millions	\$37	\$36	\$42	\$48
Net Gain (Loss)*	\$(37)	\$(5)	\$ 0	\$ 2
Admin. fee (% of est. premium)	-	3.1%	2.8%	2.6%

\*Federal government will fund start-up expenses and 2014 operating costs, per ACA. Previously uninsured, covered in the exchange in 2019: 150K individuals, plus additional employees of small groups TBD



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## The Value Proposition

What do we get for the money spent for the Exchange?

- Expanded consumer choice + good decision tools  
→ healthy competition → lower premiums
- Reduced administrative and sales costs for insurers  
→ lower premiums
- Reduced administrative expense (and hassle) for small employers

(cont.)



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## The Value Proposition (cont.)

The exchange is the vehicle through which certain *individuals* will receive tax credits.

	2015	2019
Tax Credit Recipients	150,000	270,000
Value of Premium Tax Credits and Cost-Sharing Subsidies	\$462M	\$922M

(cont.)



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## The Value Proposition (cont.)

Certain *small employers* are eligible for tax credits, beginning in 2010.

	2015	2019
Value of Small Employer Tax Credits	\$43M	\$29M



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## Administrative Policy Issues and Recommendations

1. Insourcing/outsourcing
2. Procurement
3. Financial planning and management



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Administrative Policy Issues and Recommendations:

### 1. Insourcing/outsourcing

- Certain exchange functions are inherently governmental functions and should not be outsourced, e.g.,
  - Establishing standards for qualified health plans
  - Certifying plans to be offered in the Exchange
  - Oversight of marketing activities of insurance plans
  - Determining individual eligibility for tax credits
  - Determining exemptions from individual responsibility requirement



(cont.)  
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Administrative Policy Issues and Recommendations:

### 1. Insourcing/outourcing (cont.)

- Other functions can be outsourced based on:
  - Financial analysis (“make vs. buy”)
  - Capability of existing state agency or public corporation resources
  - Availability of private sector capabilities
- Potential activities for outsourcing:
  - Eligibility and enrollment processing
  - Premium billing
  - Customer service/ call center
  - Website development and maintenance



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Administrative Policy Issues and Recommendations:

### 2. Procurement

- Since outsourcing is likely to be used for at least some important administrative activities, procurement is a critical function.
- Skills required include:
  - Development of business requirements/ technical specifications
  - Contract negotiation
  - Performance monitoring
  - Contract management



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Administrative Policy Issues and Recommendations:

### 3. Financial Planning and Management

- Since there is considerable uncertainty about key financial variables, financial planning and management are critical functions
- Prudent planning will require the development of multiple scenarios and contingency plans
- Skills required include:
  - Forecasting
  - Monitoring
  - Rapid response



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## Other Administrative Issues – To be Addressed During Planning Phase

- Marketing and outreach
- Customer service
- Coordination/integration with other state agencies, esp. coordinated eligibility determination with OHP

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## Lessons from Other States

- Don't underestimate complexity and resources required.
- Growth and size matter to capture economies of scale.
- Importance of outreach and marketing.
- Importance of customer service: for individuals and small employers.
- Be smart about insourcing/outsourcing.
- Strong and robust information systems are a key success factor.
- Priority: eligibility determination system and process – very complex, need long lead time to design and implement.

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## Summary

- Value Proposition: a fair marketplace + healthy competition  
→ improved choice, convenience, customer service, and lower costs (+ individual and small employer tax credits)
- Start-up and first year operating costs to be paid by federal government: est. \$42M
- Ongoing operations (must breakeven by 2015) covered by fee paid by insurers : est. 3% of premium. Should be offset by lower administrative and sales costs by insurers.
- Key administrative issues and capabilities:
  - Insourcing/outsourcing
  - Procurement
  - Financial planning and management

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# Oregon Health Authority



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**Oregon Health Authority**  
**Oregon Health Policy Board**



**Building Oregon's Health Insurance Exchange**  
**A Report to the Oregon Legislature**

**DRAFT**  
**November 2010**

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## **EXECUTIVE SUMMARY**

### **Mission**

With the passage of the Affordable Care Act, Oregon has an opportunity to design and build an exchange that meets the needs of its residents. Oregon will develop a strong, patient-centered exchange that ensures choice, value and access. It will increase access to information for consumers, employers and others and will be developed with the help of stakeholders and the federal government. By building its own Exchange, the state has the chance to use this institution as a vehicle to promote system change at the same time it increases access to affordable, quality coverage for individual and business consumers. This Exchange will be self-supporting by January, 2015, not relying on state general fund or federal support for ongoing operations.

### **Value Proposition**

A successful exchange will provide individual and group consumers: meaningful choice of health plans and providers; convenience, including apples-to-apples comparisons, easy shopping and choice, smooth enrollment processing and easy payment processing; excellent customer service; and clear value for the premium dollar. The Exchange will be easy to use for employers, offering administrative simplicity (consolidated billing, easy premium calculation and streamlined processing) and improved employee choice. Insurers will be able to compete on a level playing field and will have access to easy enrollment, billing and payment processing, as well as protection from adverse selection. A successful exchange will facilitate the flow of information between consumers, plans, and state and federal agencies.

### **Exchange Enrollment**

Enrollment in health insurance coverage accessed through the Exchange will grow over the first several years of operations, rising from 142,500 in 2014 to 232,500 in 2016. An anticipated 150,000 previously uninsured individuals will gain coverage by 2019. Employee coverage is expected to grow from 65,000 employees in 2014 to 95,000 in 2016.

### **Operating Revenue and Expenses**

As set out in the Affordable Care Act, the federal government will fund the development and implementation of state exchanges. This funding runs through December 2014, the first year of coverage accessed through the Exchange. Operating expenses for 2013 are estimated at \$37 million; 2014 expenses are \$36 million. No revenue is expected in 2013, but starting in 2014 the Exchange may assess a fee in order to become self-sustaining starting in 2015. Over the period 2014-2016, operating revenue will rise from \$31 million to \$50 million. A likely revenue source is an administrative fee based on Exchange-covered lives. This fee will be about 3% of premium (3.3% of premium in 2014, down to 2.8% by 2016). Plan expenses associated with an exchange fee will be offset by savings to health plans in marketing, acquisition and enrollment (activities the Exchange can do on behalf of participating health plans).

### **Next Steps**

A detailed operational plan, funded by a federal grant, is currently under development. The plan, to be completed in September 2011, will be the basis of the implementation work to occur in 2011-2013.

## **I. BACKGROUND**

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### **A. Why This Report Was Produced**

#### **House Bill 2009 Directs OHA to Develop an Exchange Plan**

The Oregon Health Fund Board's comprehensive plan for health reform influenced the shape of House Bill 2009 (HB 2009) was passed by the Oregon Legislature in 2009. HB 2009 directed the newly created Oregon Health Authority (OHA) to develop a plan for an exchange in conjunction with the Department of Consumer and Business Services (DCBS). A report on this plan was due to the Oregon Legislature by the end of 2010.

While OHA staff was developing an exchange plan, the Patient Protection and Affordable Care Act of 2010 (ACA) became law. Passed in March 2010, the ACA authorized states exchanges, established their basic functions and requirements and provided federal funding for state exchange development and implementation through December 31, 2014.

The law requires the federal Department of Health and Human Services (DHHS) to assess each state's readiness to run its exchange, certifying state exchanges by January 1, 2013. Exchanges must be operational in 2014, offering information on plan options, helping people determine eligibility for premium tax credits, and enrolling people in coverage through the Exchange.

To meet required federal deadlines, Oregon and other states must begin building their exchanges now. This process has begun with the policy and operational assessments outlined in this report; in September 2010, OHA received a 12-month grant from the federal Office of Consumer Information and Insurance Oversight (OCIO) to develop a detailed operational plan that would meet federal guidelines but tailor the Exchange to Oregon's goals and insurance market. The next step is authorizing legislation for Oregon's Exchange. The federal government will fund the development costs of the Exchange, but its operations must be self-sustaining by January 1, 2015.

Ultimately, if Oregon does not design its own state Exchange, the federal government will establish one that Oregonians will use. The federal exchange will be designed and built without Oregon input or assistance.

### **B. What is an Exchange?**

A health insurance exchange is a central marketplace for health insurance that provides one-stop shopping for individuals and small businesses to compare rates, benefits and quality among plans. The exchange will also administer the new federal health insurance tax credits for those who qualify and make it easier to enroll in health insurance.

Beginning in 2014, an exchange will be available in each state to help consumers make comparisons between plans that meet quality and affordability standards.

### **C. Recent Oregon Reform Proposals Included Exchange**

#### **Oregon Health Policy Commission: *Road Map* Recommendations**

Oregon health reform proposals included the concept of a health insurance exchange long before federal reform contemplated their development. In 2006, the Oregon Health Policy Commission (OHPC) developed recommendations for establishing a system of affordable health care that would be accessible to all Oregonians. In the resulting report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*, the OHPC recommended that the state create a health insurance exchange in order to make affordable coverage options and public subsidies available to individuals and employers. The OHPC recommended that the exchange be governed by an independent board and use all the tools available to purchasers to support value-based purchasing and encourage individuals to manage their medical care and health.

The OHPC's vision included an exchange that offered insurance plans for sale, acted as a smart buyer that worked to drive market change and delivery system reform through plan design, member education, quality reporting and incentives, cost controls and other value-based purchasing approaches. The exchange would reduce employer's administrative burden associated with health benefits management and offer increased employee choice by offering multiple plan options in order to attract small employer participation. The OHPC recommended that the exchange be used on a voluntary basis, driving quality by negotiating and collaborating with insurance carriers and producers.

#### **Oregon Health Fund Board: *Aim High* Recommendations**

Following on the recommendations laid out in the OHPC report, the 2007 Oregon Legislature passed Senate Bill 329, establishing the Oregon Health Fund Board (OHFB). The OHFB was tasked with developing a comprehensive plan for health reform in Oregon.

Access to affordable, quality health care for all Oregonians was a key Oregon Health Fund Board objective. To achieve this, the Board proposed a five-part effort to expand access to affordable health care for all Oregonians. An exchange was proposed as the mechanism for expansion of individual insurance coverage in the state. Like the OHPC, the OHFB recommended a health insurance exchange that would help standardize and streamline administration, promote transparency for consumers, improve quality, stem cost increases for individual insurance purchasers, and coordinate premium assistance for low and middle income Oregonians. As the OHFB report was written prior to federal reform, the Board saw the exchange as an entity that could grow over time and be used to facilitate market changes. Participating insurance carriers would be required to meet standards in: plan options offered; network requirements; adherence to standardized contract requirements based on evidence-based standards; transparency; common tools; and additional administrative cost and rating rule standards that could be developed by the exchange.

The OHFB's Exchange and Market Reform Work Group made additional recommendations regarding an exchange. While the group did not reach consensus on a number of issues, the majority of the group recommended that the exchange operate as a strong market organizer by contracting with carriers and establishing performance benchmarks across carriers. The group

supported an administrative structure that facilitates accountability, transparency and responsiveness, and allows flexibility and market responsiveness.

#### **D. Federal Health Reform**

##### **Federal Reform and Market Changes**

In March 2010, the Affordable Care Act of 2010 (ACA) was adopted by Congress and signed by the President. The law<sup>1</sup> makes a number of changes to the insurance market in the United States. Starting in 2014, individual and small group insurance will be offered on a guaranteed issue basis, meaning that individuals can not be refused insurance for past or current health care use or needs. This provision of the bill is coupled with a requirement that most U.S. citizens and legal residents get health insurance coverage or face an annual financial penalty. Guaranteed issue in the absence of this kind of requirement leads to what is referred to as an insurance death spiral: people will tend to wait until they are sick to purchase insurance, which increases costs, leading to the next healthiest group leaving. Prices increase again and so on.

The federal law creates five benefit levels: bronze; silver; gold; platinum; and a plan with more limited coverage that will be available only to young adults and people exempt from the mandate to get health insurance. While the benefits in these plans are likely to be fairly similar, they differ in terms of the level of cost-sharing allowed under each. Starting in 2014, all health insurance policies must meet the actuarial standards set for the applicable metal level plan.<sup>2</sup>

**Exchange Participation.** Individual market purchasers and small employer groups may use the exchange to buy insurance. Use of the exchange is voluntary, although premium tax credits will be available only for plans purchased through the exchange. Starting in 2014, small employer tax credits will be tied to purchasing group insurance through the exchange.

Adults with household income under 133% of the federal poverty level (\$29,326 for a family of four in 2010) will be eligible for no-cost coverage through their state's Medicaid program. In addition, children with income up to 200% FPL will continue to access the Oregon Health Plan (Oregon's Medicaid program). Medicaid eligible individuals who come to the exchange will be provided assistance with enrollment in OHP. The "no wrong door" philosophy will ensure that everyone receives help enrolling in the appropriate program and receiving premium assistance where eligible, without regard to where they go to access that assistance.

**Premium and Cost Sharing Assistance.** To maximize the number of people who have access to affordable coverage, the law establishes premium tax credits for individual market purchasers with income between 133% and 400% of the federal poverty level (in 2010, \$29,326-\$88,200 for a family of four). The tax credits are advanceable, meaning that they can be used to offset monthly premium costs rather than having a purchaser pay for insurance and get reimbursed annually.

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<sup>1</sup> The Patient Protection and Affordable Care Act is now Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

<sup>2</sup> The one exception is for so-called "grandfathered plans," coverage issued before March 23, 2010.

The premium credits will be based on the second lowest cost silver plan in a geographic area. Credits will be on a sliding scale with participant premium contributions limited to the following percentages of income for given income levels:

- Up to 133% of the federal poverty level (FPL): 2% of income
- 133-150% FPL: 3 – 4% of income
- 150-200% FPL: 4 – 6.3% of income
- 200-250% FPL: 6.3 – 8.05% of income
- 250-300% FPL: 8.05 – 9.5% of income
- 300-400% FPL: 9.5% of income

In addition to making coverage more affordable for many people, the federal law establishes an affordability standard. The law provides cost-sharing subsidies for eligible individuals and families with income up to 250% of the federal poverty level. These credits reduce health insurance cost-sharing amounts and annual cost-sharing limits. These credits increase the actuarial value of the basic benefit plan, with the value of the additional coverage increasing as the participant's income decreases.

Workers whose employers offer coverage can not access premium tax credits for individual market coverage in the exchange. However, if employer-sponsored insurance will cost an employee between 8-9.5% of income, the employer must give the employee a “free choice voucher” equal to the amount the employer would have paid for the employee's coverage in the group product. The worker can then take the voucher and use it to purchase coverage in the exchange. In a situation in which employer coverage would cost the employee more than 9.5% of income, the employee can go to the exchange and purchase individual market coverage using federal premium tax credits.

### **What Federal Law Requires of Exchanges**

Section 1311 of the Affordable Care Act requires states to establish exchanges for individual and small employer group purchasers. The federal law establishes some parameters and lays out areas in which the HHS Secretary will provide guidance and regulations for states' use.

The federal law guides the state's development of an exchange in a number of areas:

- Basic exchange functions
- Open enrollment periods
- Minimum benefits standards for exchange products (to be defined in regulation)
- Requirement that the state exchange be self-sustaining by January 2015.
- Requirement that the exchange consult with stakeholders.

While the law sets out many requirements for state exchanges, there are still many details to be worked out and many policy choices left to states to tailor the federal concept to their needs and goals. The federal Department of Health and Human Services will be offering guidance and promulgate regulations in a number of areas, including requirements for: the certification of qualified health plans; a rating system that states will use to rate plans offered through the exchange on the basis of relative quality and price, for use by individuals and employers; and an enrollee satisfaction survey. In addition, the HHS Secretary will be providing regulatory

guidance on the details of the benefits package that will be considered acceptable minimum coverage to meet the individual insurance mandate.

States have a fair amount of discretion in how their exchanges look and the extent to which they attempt to impact the overall market. However, each state running an exchange must provide the following services:

1. **Certify plans** for participation in the exchange, including implementing procedures for plan certification, recertification and de-certification based on federal guidelines.
2. **Make qualified health plans available** to eligible individuals and employers.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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.
8. **Facilitate community based assistance** by establishing a Navigator program.
9. **Have an annual open enrollment period**, special enrollment periods, and monthly enrollment periods for Native Americans.

The exchange authorizing legislation to be discussed by the Oregon Legislature in 2011 will include these federally-required functions. This will help show the federal government that the Oregon Exchange is making sufficient progress to continue receiving federal support for Exchange development and implementation.

The federal health reform law prescribes some of the market rules that will affect how exchanges and state insurance markets work. The most obvious of these is the requirement that all insurance be offered on a guaranteed issue basis. In addition, the ACA requires that premiums be the same for a given health plan offered both inside and outside of the exchange.<sup>3</sup> State law will follow the federal requirement; rates for plans offered both inside and outside the exchange will be subject to regulation by the Insurance Division, with pricing consistent inside and out.

### **Timing of Exchange Development and Market Reform Implementation**

In September the Oregon Health Authority received a \$1 million exchange planning grant from the federal Department of Health and Human Services, Office of Consumer Information and Insurance Oversight (OCIIO). During the one year grant period, Oregon will use its grant funds to develop a detailed operational plan. This report to the Legislature frames the issues and decisions Oregon will grapple with as it builds a plan that will be submitted to OCIIO in preparation for the implementation of an exchange in Oregon.

The federal government will approve state exchange plans before January 1, 2013. This will allow states to implement their exchanges in time to conduct a public education campaign and an open enrollment period in the summer or fall of 2013. Coverage under plans sold through the exchange will begin January 1, 2014.

Also on January 1, 2014, all health insurance coverage offered in the United States will be guaranteed issue, meaning that an insurer must accept anyone regardless of pre-existing conditions, gender or age. This will apply to all plans, whether sold through an exchange or in the outside market. The national requirement to obtain health insurance coverage also goes into effect on this date.

## **E. Oregon Health Policy Board and Exchange Development**

### **Oregon Health Policy Board Identifies Exchange Goals**

In February 2010, the Oregon Health Policy Board identified the following goals for a state exchange:

- Increase access to health insurance coverage;
- Change the way we pay for care;
- Simplify plan enrollment, health plan rules, state health insurance regulation, and plan designs; and
- Help contain health care costs.

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<sup>3</sup> Public Law 111-148, Section 1301(a)(1)(C)(iii).

At its May meeting the Policy Board further articulated the expectation that an exchange would be a tool that could be used to implement or facilitate delivery system change, making strides to ensure affordability for members and address health equities. This makes the operational sustainability of the exchange a focus, making it imperative that the exchange stresses adequate enrollment, ease of access, and superior customer service. Further the exchange must be developed in the context of the Triple Aim goals: improving the lifelong health of all Oregonians; increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable for everyone.

To ensure that this happens, in October the Policy Board recommended the development of the exchange occur in the context of the four following health reform strategies:

- Develop regional integrated health systems that are accountable for the health of the community and responsible for the efficient use of resources;
- Ensure an affordable and sustainable health system by limiting health spending to a fixed rate of growth;
- Improve the value and quality of care by aligning and coordinating the purchasing of insurance and services across health programs, including the new Oregon Health Insurance Exchange; and
- Reduce duplication and increase efficiencies by establishing common quality measures, payment methodologies, administrative transactions, and other areas where our system is unnecessarily complicated.

While these strategies affect more than just the health insurance exchange, they will also be part of the exchange development work.

### **Technical Advisory Group**

In May and June 2010, a technical advisory work group was convened to provide input to staff on a number of strategic issues. The group included representatives from a variety of perspectives, including consumer advocacy, organized labor, insurance agent, insurance carrier and provider. In its discussion of an exchange, the work group indicated that it valued the following qualities in an exchange: efficiency; flexibility; accountability; and a consumer focus.

The group met three times to talk about a variety of issues on which the state has design flexibility. Feedback from the group's discussions helped staff identify the possible options for the various issues discussed in this report, as well as the implications of various choices.

### **Health Equities Review Committee**

The Health Equities Review Committee provided the following recommendations regarding the development of Oregon's health insurance exchange:

- **Require Medicaid providers to participate in the Exchange** in order to foster long-term patient-provider relationships, ensure continuity of care and eliminate income-based disparity as individuals move between the Exchange and Medicaid/CHIP Programs.
- **Create a targeted, culturally-specific marketing plan** and remove application barriers in order to ensure people are able to access the benefits for which they are eligible.

- **Require the Exchange Board and Consumer Advisory Committees to have a consumer majority**, including members from racially and ethnically diverse populations. Deliberately recruit members of diverse cultural constituencies.
- **Create standards for inclusion in the exchange that measure a provider's cultural competency** (languages spoken, diverse staff, etc).
- **Provide information in multiple languages** to minority-owned and rural businesses.
- **Implement a multi-state exchange program with Washington** in order to gain purchasing power, assure continuity of culturally competent care for communities of color and increase equity in health coverage and input into delivery system governance.
- **Create a coverage plan for extended, non-nuclear families and kinship networks** to ensure healthy outcomes for families regardless of race, ethnicity or sexual orientation.
- **Implement a health coverage policy for undocumented people.**
- **Utilize the patient-centered medical home model**, allowing multiple issues to be addressed in a single visit and reimbursement.
- **Include culturally-specific complimentary treatment and traditional ways of healing in the healthcare system** by covering traditional practices in Exchange plans.

### **Safety Net Advisory Committee**

The Safety Net Advisory Committee offered the following recommendations regarding the development of an exchange in Oregon:

- **The Exchange must ensure options are affordable** and that people know how they can get enrolled and access services. Consider barriers to care for vulnerable populations when determining affordability.
- **Manage costs and care for users of safety net.** Provide incentives for the widespread adoption of primary care, including through the use of primary care homes that can be retained for people who move between Medicaid and the Exchange.
- **Promote community-based outreach and enrollments** efforts that capitalize on strong patient centered provider relationships. Consider involving diverse groups in outreach, enrollment, and service efforts. Clarify the role of clinics play educating patients about the Exchange.
- **Require plans within the Exchange to participate in Medicaid.**
- **Allow provider panels to reflect community needs.**
- **Exchange oversight should ensure operational performance, clinical quality and competency, and community and patient satisfaction.** The exchange should hold both payers and providers accountable.
- **Allow any Oregon resident to buy coverage** if they do not qualify for state programs.

### **Public Meetings with Stakeholders across the State**

In September 2010, the Oregon Health Authority and the Oregon Health Policy Board held six community meetings around the state (Corvallis, Baker City, Portland, Florence, Medford, and Bend). The meetings introduced the OHA and OHPB to the public, provided an update about the progress of health reform in Oregon, and solicited public input on the overall direction of these reforms and key elements of the health insurance exchange. High level state staff and at least one board member participated in each meeting. Attendance at the meetings was strong; approximately 850 people participated in the six meetings. Participants were enthusiastic about

the opportunity to engage in discussions about the development of the state's exchange. While individuals expressed a range of views, the following themes emerged in the various meetings:

- Limited, yet meaningful choices in the exchange;
- An active exchange that exceeds minimal federal standards, although some expressed concerns that this could add a layer of regulation;
- Assure the same coverage for the whole state and make sure changes do not mean fewer choices in rural areas;
- Help people make good insurance choices;
- Provide information that help consumers compare insurance plans on things beyond just coverage options;
- Encourage competition between companies to improve insurance products;
- Think broadly about coverage and providers;
- An overall systems reform/paradigm shift less reliant on "for profit" is needed;
- Think comprehensively about reforms;
- Address the needs of rural frontier towns reliant on practitioners in other states;
- Retain the knowledge, experience and technology available from insurance agents;
- Encourage wellness-based primary care and healthy choice incentives.
- Allow for community input in the design of the exchange.

Section II of the report lays out the operational considerations for an Exchange, including the value the Exchange can offer consumers, employers, health plans and the market generally. Section III identifies the policy decisions that will be made during the planning process based on the Exchange authorizing legislation and guidance from the Oregon Health Policy Board. Analysis and further discussion of these policy issues is presented in the Appendix.

## **II. OPERATIONAL CONSIDERATIONS**

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As important as the policy decisions described in Sections II and IV will be for the successful development and administration of an exchange in Oregon, it is just as vital to understand who Exchange's customers are and what value a high functioning exchange will provide. While the exchange will fulfill the functions laid out in the Affordable Care Act, it must do more to meet the needs of consumers, participating health plans and the market as a whole.

### **A. A High Functioning Exchange Will Provide Value for Consumers and Others**

As envisioned by the Oregon Health Policy Board, the Exchange will provide value for its customers, for participating health plans, and for the overall insurance market in Oregon. In a "parallel" market (in which consumers will have the choice to get insurance through the Exchange or in the outside market), the Exchange will flourish by proving its value to consumers, offering accessible services, including an easy process for determining eligibility for financial assistance, assessing plan options and enrolling in coverage.

#### **The Exchange's Value for Individual and Group Consumers: Access, Choice, Service**

The three key groups of consumers for Oregon's Health Insurance Exchange are individuals, small employers and the employees of these businesses. A successful exchange will provide the following for consumers:

- Meaningful choice of health plans and providers.
- Convenience, including apples-to-apples comparisons, easy shopping and choice, smooth enrollment processing and easy payment processing;
- Excellent customer service; and
- Clear value for the premium dollar.

The Exchange will make it easy for individuals to determine eligibility for individual tax credits and Medicaid/CHIP through a single portal, to choose health plans that best meet their needs, and to enroll in coverage. It will also have an easy to use process for determining eligibility for exemptions from the federal individual insurance requirement.

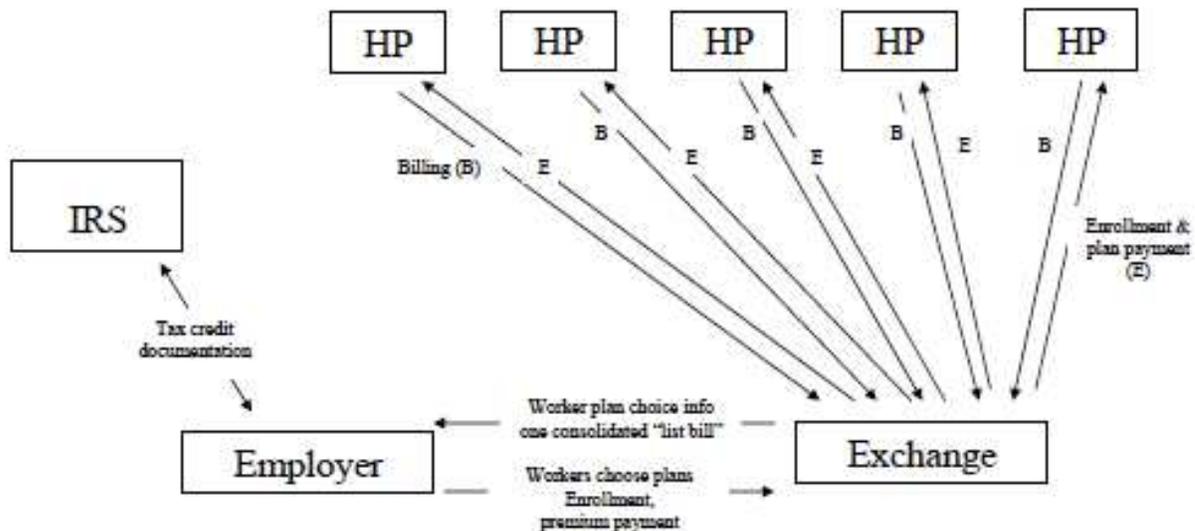
Consumers will know that plans participating in the Exchange will offer quality coverage that provides real access to care. The Exchange will establish standards for insurance carrier participation in the exchange, certifying "qualified health plans" for participation. In addition, consumers will be able to see the results of the Exchange's assessments of participating plans, giving them a better sense of the plans' performance on a variety of measures. Plan comparison will be made easy for consumers, who will be able to see plan information in a standardized format.

Consumers will have access to eligibility and enrollment information and assistance, both through the Exchange web site and through other means (including by telephone, with the help of agents and Navigators). The web site will also provide an electronic calculator that will allow users to determine the real cost of health insurance choices after tax credits and cost sharing assistance are applied. The Exchange will have a consumer complaint process that will respond to any problems with the Exchange process and will help users work through health plan issues.

Navigators, community organizations that will help people determine eligibility and enroll in coverage, will be supported with training and funding. These organizations will also conduct outreach to ensure that diverse individuals and groups across the state are aware of the Exchange and what it can offer, and understand that they may be able to get financial assistance gaining health insurance.

### **Value for Employers: Defined Contribution, Administrative Simplicity, Convenience**

To ensure the Exchange works for employers as well as employees and individual consumers, the Exchange will be designed to make employer participation easy. Employers will be able to provide employees with a defined contribution toward their health care premiums. Employees will choose the plans that work for them and the Exchange will let the employer know the total owed and set up an administratively easy process utilizing consolidated billing. Employers will know how much to deduct from employee paychecks and will give the Exchange a single payment for the sum of all employee and employer premium contributions. The Exchange will direct the appropriate premium amounts to the health plans in which the employees are enrolled.



Source: Institute for Health Policy Solutions

### **Value for Participating Health Plans: Level Playing Field, Administrative Assistance.**

While the individuals and groups that will purchase insurance through an exchange are the organization's main consumers, insurance carriers, brokers and state and federal agencies are also key constituents with whom a successful exchange must work smoothly. Insurers want an opportunity to compete on a level playing field, a process that facilitates easy enrollment, billing and payment processing, and protection from adverse selection. A successful exchange will make the enrollment process work smoothly for consumers and their chosen health plans, and will facilitate the flow of information between consumers, plans, and state and federal agencies.

**Premium Offsets.** The ACA allows exchanges to support operations through an assessment on health plans. Based on enrollment projections, the Exchange operations are anticipated to cost 3% of average premium costs. These expenses will be offset by savings to health plans. For example, the Exchange will provide administrative functions in marketing and acquisition that are now conducted and paid for by health plans. The Exchange can reduce health plans' administrative burden by conducting an enrollment function on behalf of plans.

**Value to Other Stakeholders: Payment for Services, Smooth Information Transfer**

Insurance brokers want the opportunity to provide and be reimbursed for services to their clients. For their part, government agencies need data exchange to work smoothly, whether the information in question is related to Medicaid or tax credit eligibility, coverage verification, income or determination of individuals' exemption from the insurance mandate.

**Value to the Market as a Whole: Transparent, Comprehensive Information, Education & Outreach**

The Exchange will provide value for the entire individual and small group insurance markets, including individuals who choose to purchase outside the Exchange and health plans not participating in the Exchange. All purchasers will be able to get comparable information about the health plans offered in the state, including those that do not become "qualified health plans" sold through the Exchange. The exchange will conduct public education and outreach, not just about the benefits of using the Exchange, but also about: the changes that will go into effect in 2014 (guaranteed issue coverage, individual insurance requirement, etc); how to choose and enroll in coverage; and how to use insurance to improve and maintain health.

The Exchange will be a tool to promote quality and cost effective coverage both for plans participating in the Exchange and for those offering coverage in the outside market. In addition, the exchange will conduct risk adjustment mechanisms in order to minimize adverse risk to plans participating in the Exchange.

**Improving the System: Quality, Cost, Service**

The Health Policy Board has indicated that it does not want Oregon's Exchange to just do the minimum required by the federal government. The Exchange is anticipated to be an active purchaser. This may be done through selective contracting, standard setting, rate negotiation, or a combination of these techniques. No matter what the Exchange board pursues, these efforts will have an impact on the work and administrative costs for an exchange and must be taken into consideration as the Exchange is built.

**Enrollment Projections**

Modeling indicates that exchange participation will be large enough to allow for a robust exchange in Oregon. Modeling indicates that over 140,000 individual consumers and 65,000 employees will get coverage through the exchange in 2014. Those numbers are expected to rise over the next five years, particularly on the individual side as consumers understand their options and become aware of the federal individual insurance requirement. Individual membership in the Exchange is projected to be 360,000 in 2019, with an additional 98,000 enrollees entering as members of employer groups with 1-100 employees.

### Cost to Run the Exchange

Based on the membership projections, the Exchange is anticipated to cost approximately 3% of average premiums. In Oregon, the Exchange is expected to cost 3% of premium. This compares favorably to the Massachusetts "Connector," which has costs equal to approximately 4% of premium. Exchange costs include expenses for: staff salaries and benefits; appeals; marketing, advertising and communications; customer service and premium billing; enrollment and eligibility services; website development and maintenance; professional services and consulting; information technology; and facilities and related expenses.

## B. What Goes into Running an Exchange

### Start-up Activities

Although the Exchange will officially "start" in 2014 (coverage from health plans purchased through the exchange will begin on January 1, 2014) start-up expenses will be incurred significantly in advance that date. The federal government will provide most of the funding for implementation and year one operations expenses, although HHS has indicated that some elements that will impact existing programs (such as eligibility and enrollment solutions that will affect both exchange participants and Medicaid recipients) may require financial contributions from such programs. By January 1, 2015, the Exchange must be self-supporting.

### Determining Overall Costs

The following assumptions were used in the analysis of likely costs: a dual market in which the Exchange is a public corporation acting as an active purchaser offering three to four benefit options per insurance carrier per metal level. These operational assumptions are just for illustration and have not been endorsed by the Policy Board has not endorsed these assumptions.

Fixed costs include management, marketing and communications, professional services, information technology (internal) and other infrastructure costs. Functions such as eligibility processing, health plan enrollment, premium billing and customer service are variable expense based on utilization of the Exchange. Expenses were estimated using the experience of the Massachusetts Connector for similar services.

	2013	2014	2015	2016
Membership				
Individual	NA	142,500	190,000	232,500
Small group employees	NA	65,000	87,000	95,000
Estimated Operating Revenue	0	\$31	\$42	\$50
Estimated Operating Expenses	\$37	\$36	\$42	\$48
Admin fee as a % of premium		3.3%	3.0%	2.8%

Oregon's Exchange costs will depend on membership and the organization's fixed and variable costs. Membership is forecasted using estimates made for Oregon by Dr. Jonathan Gruber of Massachusetts Institute of Technology. Individual exchange participation is projected to rise

from 142,500 in 2014 to 232,500 in 2016. By 2019, approximately 150,000 previously uninsured Oregonians will have gained individual insurance coverage.

	2015	2019
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$150M	\$270M
Small employer tax credits coming into Oregon	\$34M	\$29M

### **C. Administrative Policy Issues**

The Exchange's goal is to give participants choice and value in an administratively simple way. To meet the goal of satisfying the customers, a lot of work will go on behind the scenes. Implementing the Exchange will involve the development of the following administrative decisions and activities. How well the Exchange does in implementing these items will greatly affect the overall success of the endeavor.

#### **Insourcing/Outsourcing**

While some functions will be performed by the Exchange itself, other activities may be contracted out to organizations with skills and experience conducting particular operations. Certain functions are inherently governmental and are most likely to be conducted by the Exchange itself, including:

- Establishing standards for qualified health plans;
- Certifying plans to be offered in the Exchange;
- Conducting oversight of the marketing practices of insurance plans;
- Determining individual eligibility for tax credits; and
- Determining exemptions from the individual insurance requirement.

Based on the capability of the public corporation or existing state resources, other exchange functions could be provided by contracted organizations. These functions include eligibility and enrollment processing, premium billing, customer service/call center operations, and website development and maintenance. The decision whether to conduct such activities or purchase them from a vendor may be made based on a financial analysis of the relative costs, the capability of existing state agency resources and the availability of private sector capabilities.

#### **Procurement**

As at least some important administrative activities will be conducted by contracted organizations, procurement is a critical function for the Exchange. A successful exchange must have the skills to develop business process specifications, conduct performance monitoring and engage in strong contract management.

#### **Financial Planning and Management**

Financial planning and management are necessary for all successful businesses. These capacities will be especially important as there is currently considerable uncertainty regarding key financial variables, and this uncertainty can be expected to last into the Exchange's early years of

operations. Contingency planning must be part of an overall financial planning effort. Forecasting, monitoring and the capacity for rapid response are all required skills.

### **Other Administrative Functions**

In addition to the functions laid out above, the following will also be part of the Exchange's operations:

- Marketing and outreach
- Customer service
- Coordination and integration with other state agencies (including but not limited to working closely with the Oregon Health plan to conduct coordinated eligibility determination)

The individual and small group markets will require different administrative solutions that reflect the differences in consumer needs and market operations.

### **Learning from Other States**

While Oregon is in many ways a leader in the development of a health insurance exchange, there are many things we can learn from other efforts as we move from planning into implementation. Watching and talking to states such as Massachusetts and Utah has taught us some important things. To begin with, do not underestimate the complexity of the resources required. Related to this, recognize that growth impacts an exchange's ability to capture economies of scale. Outreach and marketing are key to this growth.

Once you have the numbers, you need to keep them. Customer service is so important for both individuals and small employer groups. This is tied to a good eligibility determination system and process, which is complex to build and takes a long time to design and implement. The smart use of vendors and considered insourcing and outsourcing are key, as are strong and robust information systems.

## **POLICY RECOMMENDATIONS AND DEVELOPMENT ISSUES**

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### **A. Envisioning a Successful Exchange**

A successful exchange will provide useful and timely assistance to Oregonians, improving access to insurance coverage and health care. The exchange will be available through multiple media, including a web site, telephone, printed materials and in-person assistance. The health plan choices available through the exchange will meet the diverse needs of consumers across the state, providing meaningful choice without confusing consumers with “differences without distinction.” It will make enrollment easy and provide ongoing service, improving access to insurance coverage and health care.

A successful exchange will develop and grow based on consumer's needs over time. It will have robust enrollment, provide a range of health plan choices, score highly in measures of customer service, and be financially sustainable in terms of its administrative costs and participant risk pool. The exchange will be nimble, flexible and responsive, allowing it to be consumer and service oriented. It will use the best available technology support systems, and will grow by earning the trust of its users based on service and value. This will allow the exchange to be financially strong and sustainable over the long term.

As discussed in the introduction, to ensure Oregon's reformed health care system achieves the Triple Aim goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians, and lowering or containing the cost of care so it is affordable for everyone, the exchange should be built in the context of the four health reform strategies identified by the Oregon Health Policy Board:

- Develop regional integrated health systems that are accountable for the health of the community and responsible for the efficient use of resources. Recognize that communities hold the greatest promise for fundamental change by rationalizing the use of resources and tailoring health promotion and health care initiatives to meet the needs of their residents. Oregon's implementation of key delivery system and insurance reforms should give priority consideration to how local systems can take a leadership role in improving the care of their communities within available resources.
- Ensure an affordable and sustainable health system by aggressively limiting health spending to a fixed rate of growth. Health care cost cannot continue to rise at the current rate of growth. We must work together to develop incentives for community-wide planning that will address the rate of cost growth and the resulting disparate health outcomes among Oregonians. Oregon's public and private sectors need to work together to limit spending to a fixed rate of growth.
- Improve the value and quality of care by aligning and coordinating the purchasing of insurance and services across health programs, including the new Oregon Health Insurance Exchange. The Oregon Authority can start this effort by acting as initiator and integrator, reducing unnecessary variations between programs, delivering better health outcomes, and providing better value to Oregon's taxpayers. A publicly-accountable,

consumer focused Oregon Health Insurance Exchange will: provide useful, comparative information on health plan offerings, benefits and costs; help individuals, small employers and their employees to access insurance that meets their needs; help people access federal tax credits; and set standards for health system improvement.

- Reduce duplication and increase efficiencies by establishing common quality measures, payment methodologies, administrative transactions, and other areas where our system is unnecessarily complicated. Currently, inconsistency in how care is delivered, paperwork is processed, and information is exchanged leads to increased costs and poorer outcomes. The Oregon Health Authority and the Oregon Health Insurance Exchange will build partnerships with employers, insurers, and providers, and consumer groups to eliminate unnecessary duplication and administrative complexity. Working together, Oregon's public and private sectors can create guidelines, standards, and common ways of doing business that will increase efficiency, provide better customer service and transparency, and reduce system costs.

The Oregon Health Policy Board believes that while some elements of an exchange should be laid out in statute, many elements of Oregon's Exchange are best determined by the Exchange's governing body itself, in consultation with state policy leaders, consumers and other key stakeholders. To ensure that the needed policy design and operational planning work occur in a timely manner, the Policy Board recommends the following elements are incorporated into the Exchange design:

## **B. Oregon Health Policy Board Recommendations**

### **Recommendation: Establish the Health Insurance Exchange as a Public Corporation**

Oregon's health insurance exchange should be a public corporation chartered by state statute.<sup>4</sup> A public corporation can be accountable to the public interest but not beholden to state politics or budget cycles. No matter what model is chosen for the exchange, the entity must be given authority and flexibility under statute to do its work.

#### **Discussion**

The Exchange Technical Advisory Work Group identified the following characteristics as desirable for an exchange organization:

- *Flexibility and agility*: as federal reform rolls out, best practices change over time and other state and federal changes occur, flexibility is a necessary component.
- *Responsiveness*: to consumers, health plans and the state.
- *Consumer Focus*: provide value and improved access for individual and group purchasers.
- *Ability to work with existing state agencies*: including the Insurance Division and Oregon Health Authority.

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<sup>4</sup> There is no specific public corporation statute in Oregon. An exchange can be built with specific roles, authority and responsibilities in state statute. The State Attorney General's office will be consulted in the development of such statutory language.

In considering whether an exchange would best be created as a public agency, a private non-profit or a public corporation model, staff discussed each option in light of these characteristics.

**Flexibility/Agility.** To facilitate the exchange's ability to focus on consumers and to maintain good relations with the insurance carriers that will serve the consumers, the exchange must be able to act quickly on its consumers' behalf. Due to state procurement, hiring and human resources rules, state agencies are generally not very nimble or flexible. Exemptions can be made from specific rules, but authority to waive specific rules must be given in statute to ensure a state agency exchange has the flexibility it needs to be flexible and responsive. A public corporation can be independent from state fiscal processes and insulated from political wrangling, offering flexibility in the face of change. This model has worked well in other sectors, including the state's Port Authorities. Like a public corporation, a private nonprofit model is inherently more flexible and agile than a state agency.

**Responsiveness.** Oversight is easily achieved for a state agency. Its ability to be responsive to stakeholders outside of the state government would vary, potentially hampered somewhat by the limited flexibility of state rules. Consumer advocates have argued that a state agency would ensure accountability to consumers. A government agency would exist for the benefit of consumers. A public corporation or non-profit can build in accountability and responsiveness to the public by clearly identifying these as core missions of the organization, while simultaneously prioritizing flexibility and agility as well. To ensure this, authorizing legislation may need to specify that the entity will have a consumer-focused mission.

Another way to build in oversight and accountability is to require state officials to participate as ex officio members of the exchange's governing board. While agency representatives are non-voting board members in Massachusetts, to strengthen the link between state agencies and the Oregon exchange, ex officio members could be included as full voting members of the exchange board.

**Consumer Focus.** For an exchange to be a successful business, it must enroll and retain customers. This is a business task as much as anything else. A state agency can provide good customer service if provided with strong leadership. An exchange is federally required to conduct a range of consumer oriented tasks. Concerns exist about the ability of a state-agency exchange to conduct its federally mandated business in tight fiscal times such as the one currently facing Oregon.

**Ability to work within state structures.** A state agency would fit within the Oregon Health Authority's model of state health care programs consolidated in one agency. A non-profit or public corporation could coordinate with state agencies. Statutory direction to all agencies to coordinate would be necessary no matter what structure the exchange takes.

The exchange can not be hobbled by the budget cuts or political wind changes that can greatly affect state agencies. A public corporation funded by user fees would exist outside of the state budgeting and legislative cycles that define many state agencies.

**Public perception.** The public corporation and non-profit models avoids the “welfare” stigma that can hamper a state agency; the perception that a state agency running a government program must be a social service program aimed at the low income population. While many people understand that the subsidy portion of the exchange is available for both moderate and middle-income Oregonians, distaste for public programs could might turn off some potential enrollees.

While some Oregonians may be scared off by a state agency-administered exchange, many people will trust the public models (a state agency or public corporation), knowing that public-sector entities have a public-focused mission. Non-profits can certain have a public mission, but it is not implied that this organization-type will have this orientation.

**Mission, oversight and leadership are key.** In discussion with the technical advisory work group, it became clear that it is less important which type of organization is chosen than it is that the exchange has a clear mission that is carried out by a strong governance board and executive leadership team.

### **Recommendation: Establish a Health Insurance Exchange Governing Board**

To ensure that the exchange is well-governed, sustainable and responsive to individual and group consumers, payers, the state and other stakeholders the exchange should be overseen by a governing board that:

- Oversees the implementation, administration and sustainability of Oregon's health insurance Exchange.
- Is broadly representative and includes as members individuals chosen for their professional and community leadership and experience.
- Includes as members the directors of the Oregon Health Authority and the Department of Consumer and Business Services, as well as a member of the Oregon Health Policy Board.
- Provides policy guidance to exchange leadership.
- Establishes consumer advisory boards to advise the Exchange board.
- Provides direction to the Exchange executive leadership team as it implements and administers the exchange based on board leadership, the organization's mission and the requirements of federal law.

A number of organizations in the state utilize governing boards, including public corporations such as the port authorities and SAIF Corporation. The Massachusetts Connector Authority, which governs that state's exchange programs, utilizes a working board as well.

**Board Role.** The exchange board should meet at least quarterly or more as needed. Initially the board is likely to need to meet once or twice a month for some period as the executive team is brought on and the exchange is planned and implemented. The board will focus on implementation, policy and sustainability issues. It will work closely with the exchange executive leadership.

**Consumer Advisory Committee.** The Exchange governing board should establish one or more stakeholder advisory committees. This committee should include consumers purchasing individual insurance through the exchange, small businesses using the exchange, insurance brokers who assist small businesses, and participating carriers. Establishing one or more such

groups will encourage and facilitate input by a variety of stakeholders on issues related to the functioning of the exchange, the services it provides and related issues, while allowing the exchange governing board to remain a small group of between five and nine members. These groups would be established to provide input and advice to the board and executive leadership of the Exchange.

The Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) requires state exchanges to consult with stakeholders, including qualified health plan enrollees, individuals or organizations that help people enroll in plans, small business and self-employed representatives, state Medicaid, and advocates for enrolling hard-to-reach populations. The exchange board can fulfill this requirement to some extent and it can also facilitate additional consultation through a board appointed advisory committee of stakeholders that would report to the board on a regular basis.

**Executive Leadership Team.** While the exchange board will provide guidance based on the organization's mission, the executive leadership is the group that will act on the mission and board guidance, ensuring that the exchange operates as a consumer-oriented organization that improves access, quality customer service and, in partnership with participating health plans, improves the patient's experience of care and contains costs for health care and insurance. The executive leadership team will draw on their experience with financial management, information technology, the insurance industry, marketing and communications (including a focus on customer care), organizational management and operations.

### **C. Policy Issues: For Additional Development**

In addition to the policy recommendations outlined in Section II, building Oregon's Health Insurance Exchange will require detailed operational planning based on a number of key policy decisions. These policy issues are outlined below. Additional information and analyses on these issues is provided in the Appendix.

#### **1. Governance**

- Develop a clearly articulated mission that guides the work of the Exchange and signals to consumers and business that the exchange exists to improve access and services for them.
- Determine the membership of and roles for the Exchange's governing board and the consumer advisory groups that will advise them.

#### **2. Organizational Structure**

- Determine whether to establish the Exchange as one organization with individual and small group product lines, or as two separate organizations.
- Determine whether to utilize one Exchange that services the whole state, or two build several exchanges each serving a different region of the state.

- Determine whether Oregon will pursue its own Exchange, build a multi-state exchange or pursue other opportunities for partnerships with other states.

### **3. Exchange Operations**

- Determine whether to establish the Exchange as the only place for individuals and small groups to purchase insurance coverage or whether to establish parallel markets inside and outside of the Exchange.
- Assess how to ensure carrier and plan participation provides meaningful consumer choice.
- Determine which carriers may sell young adult/catastrophic insurance plans.
- Establish the minimum standards for plan offerings sold in the individual and small group markets.
- Decide how insurance agents and brokers will participate in the exchange.

### **4. Benefits**

- Determine the ways in which the state can make changes to benefit requirements and mandates as needed over time.

### **5. Timing**

- Determine when Employer Groups with 51-100 Employees will Gain Access to the Exchange.
- Identify the circumstances under which the state would implement its Exchange early.

### **6. Coordination with Public Programs**

- Determine how Existing Public Programs and Population Groups will be Integrated and Transitioned into the Exchange

### **7. Risk Mediation**

- Determine how to Work with the Federal Government to Implement Risk Adjustment Measures

### **8. Funding Operations**

- Determine how to fund Ongoing Exchange Operations

#### **IV. NEXT STEPS IN EXCHANGE DEVELOPMENT**

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Oregon is currently starting to develop its Exchange plan. The state received an Exchange Planning Grant on September 30, with funding available through September 29, 2011. The work has begun with the identification of the policy and operations issues that must be developed and the many decisions that will be made over the next year. A state Exchange Steering Committee was established for the grant, and this diverse group of health and human services leaders will continue to assist the Exchange team throughout the development process by identifying needs, resources and goals, and by providing leadership and support in their various divisions and agencies.

At the end of October, the Office for Consumer Information and Insurance Oversight announced a grant to support the development of the Exchange's information technology solution. Five states or consortia will be funded under this grant, which will provide development and implementation funds for grantees' effort to build an eligibility and enrollment system for the Exchange. As this work will also benefit Medicaid, some expenses will be shared by Medicaid on a cost allocation basis. OCIIO and the Centers for Medicare and Medicaid Services recently announced that the Medicaid expenses for this work may be matched "90-10" by the federal government, meaning that 90 cents on the dollar will be paid by the federal government for eligibility and enrollment system development.

The Oregon Legislature is expected to take up an Exchange bill in the 2011 session. This bill will be the authorizing legislation under which an exchange will be established in the state. The bill will authorize the Exchange to conduct the functions required for exchanges by the federal Affordable Care Act.

In early spring 2011, Oregon will apply for Exchange implementation funds. These funds will support the development and implementation of an Exchange in Oregon based on the work done under the Exchange planning grant.

In late 2012, OCIIO will determine whether the state's exchange planning and implementation work is sufficient to allow the Exchange to allow Oregonians to buy coverage through the exchange. If OCIIO signs off on Oregon's Exchange, a consumer information and marketing campaign will occur in 2013, with an open enrollment planned for mid-year. Coverage in plans purchased through the Exchange will begin January 1, 2014.

Funding from the federal government will continue through December 31, 2014, the end of the first year of the Exchange's operations. At the end of this period each state exchange will need to be self-sustaining.

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# **Building Oregon's Health Insurance Exchange**

## **Appendix: Policy Issues for Further Development**

# **DRAFT**

### **INTRODUCTION**

The Oregon Health Policy Board's report to the Legislature on the development of a state Health Insurance Exchange provides information on the federal requirements for an Exchange; identifies the functions and resources that will be needed for an Exchange, including the costs associated with these tasks and abilities; and highlights the policy decisions that will be worked out during the Exchange operational planning funded by a federal Exchange planning grant (October 2010 – September 2011). This appendix provides additional information and analyses on the policy issues identified in Section IV of the Health Insurance Exchange Report. The policy issues are laid out in operational categories, with discussion of options and implications provided for each item.

### **A. GOVERNANCE**

Governance is the process used and the rules followed to make decisions about how an organization operates. This section addresses proposed structural oversight for the Exchange.

#### **Exchange Mission**

The goals outlined by the Health Policy Board focus on ways of improving access and service for consumers. Facilitating access, simplifying options, enrollment and regulation, changing how services are provided, and containing costs are all intended to improve the experience of getting and keeping insurance coverage for Oregonians.

To ensure that these goals shape the development, implementation and long-term functioning of the Exchange, it will be important to have a clearly articulated, strongly held mission that guides the work of the Exchange board and executive team. This mission would also signal to individual consumers and businesses that the Exchange is working in their best interest and exists to improve access and services for them.

#### **Board Membership**

**How membership is determined.** Among the issues that must be addressed is the make-up of the Exchange board. Board members may be chosen for their professional and community leadership and experience or appointed based on identified constituencies. In either case, the

board should include persons with strong backgrounds in business, consumer advocacy, health care and community service.

**Ex Officio seats.** There is general agreement that one way to ensure that the Exchange is responsive to and coordinated with the state agencies responsible for health care and health insurance is to include key state officials as board members. Including as voting members the Director of the Oregon Health Authority and the Director of the Department of Business and Consumer Services would provide a strong connection between the Exchange and state government. The model for including ex officio<sup>1</sup> members on an Exchange board is the Massachusetts Connector Authority's board. The Connector Authority includes four ex officio members: the state's Secretary of the Executive Office for Administration and Finance; Medicaid Director; Secretary of the Group Insurance Commission; and Commissioner of the Division of Insurance. In addition, a member of the Oregon Health Policy Board could be included on the Exchange board in order to ensure coordination between the two groups and provide an additional link between the Oregon Health Authority and the Exchange.

Traditionally, Oregon board members are appointed by the governor and confirmed by the state Senate. To ensure continuity over time, terms can be staggered and after the first group of appointees serves, last for four years with the potential for one reappointment for an additional four years. The governor can appoint a replacement immediately upon a vacancy.

## **B. ORGANIZATIONAL STRUCTURE**

Organizational Structure addresses how divisions, programs, positions are placed in an organization and how levels of authority are defined. This section provides recommendations regarding the structure of an Exchange in Oregon, including the type of organization, populations served, geographic scope and how to address what functions are kept in house and which are contracted out.

### **One Exchange or Two**

The federal Patient Protection and Affordable Care Act requires states to build an Exchange for individual market purchasers and a Small Business Health Options Program (SHOP) Exchange. The law allows a state to combine the individual and small group Exchanges into one organization or to build two separate organizations.

**Single entry-point.** From a customer service perspective, having "one door" for all purchasers means that people would not be turned away from or frustrated by an attempt to get information or to enroll in insurance through the "wrong" entry point. Technology exists to allow customers to provide some basic information and be seamlessly offered relevant options.

**Efficiency.** The Exchange must determine whether it will be more efficient to develop a single Exchange for both populations or to build two parallel organizations, each with its own

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<sup>1</sup> *Ex Officio* members serve by virtue of their official positions, in this case as the directors of key state departments involved in health and health care. Such members can be voting members of the board.

population focus. The benefit of separate organizations is that each can focus specifically on its own population. However, a single organization could have two sections to fulfill the differing functions of the two product lines, while sharing similar or linked administrative and technological services. In a two organization model the two Exchanges could utilize a shared services model, though it is unclear whether this would be as efficient as building an Exchange as a single entity with two product lines.

**Seamless entry and smooth transitions.** Individuals may need to move between group and individual coverage due to job or other changes. The Exchange will provide increased value for consumers to the extent that it can minimize disruption of health care due to such changes. Many stakeholders have expressed a desire for transitions between individual and group coverage to be made as easily and seamlessly as possible for consumers.

Developing the technology needed to ensure simplified and seamless use of a single entity with multiple product lines will require significant financial and other resources. While the development will take some effort, the resulting infrastructure can improve access for both individual and small group insurance purchasers. This would be easier to accomplish in a single organization, but if separate individual and group Exchanges are built, special attention will need to be paid to ensuring that such transitions occur easily.

To facilitate smooth transitions, the Exchange can actively encourage participating carriers to offer both individual and group market plans. While a carrier's bronze plan for groups may not be identical to its individual bronze product, the network could remain the same across a carrier's plans. Ongoing access to providers is one of the key ways disruption is minimized for people switching between a carrier's group and individual coverage. Carriers will have an incentive to participate in both markets in order to retain individual purchasers who leave group coverage. The Exchange should facilitate smooth transitions between coverage as people move between jobs or make other changes that affect insurance coverage.

### **One Exchange for the Entire State vs. Several Geographically Targeted Exchanges**

The PPACA allows states to operate one or more subsidiary Exchanges in distinct geographic regions of the state. While Oregon includes urban, rural and frontier areas that face different market conditions, for the most part Oregon is a single market. This is in contrast to some larger states such as California or New York that have very distinct geographic and demographic regions within a single state. While larger states could more clearly benefit from regional Exchanges, Oregon's market is statewide with some regional variation.

The general view of stakeholders is that a statewide Exchange could harness one pool of funds to provide web and phone access available statewide, but would also need to be responsive to the differing needs of consumers across the state. A final determination about whether a single statewide Exchange would work best Oregonians across the state, or whether regional sub-Exchanges could do the job better will take into consideration what will be most efficient in terms of cost and what will provide the best benefits to consumers.

**Single State Exchange vs. a Multi-State Exchange**

Some states and the federal government have expressed interest in pursuing multi-state Exchanges. In Oregon much of the discussion has focused on a single state Exchange that would allow the state to pursue its own policy decisions. While partnering with another state to build a regional Exchange could provide some benefits in terms of administrative cost savings, such savings are limited in terms of total dollars, and the effort to align two or more state legislatures, administrations and rules is substantial

If Oregon does pursue its own Exchange, it is worth investigating whether Oregon can partner with another state in order to save money on contracting for specific services. One area in which this could be especially useful is in information technology solutions.

**Benefits of a multi-state partnership.** A successful Exchange will rely on enrolling a meaningful consumer base within a relatively short time period. If two or more states joined together to build an Exchange, this could help guarantee a larger number of participants, which could spread administrative costs over more people. Further, as all states will be setting up similar entities, economies of scale could be expected if two states share Exchange administration. For Oregon, the most obvious partner is Washington, as the two states share some common insurance carriers and health plans, and a sizeable number of people live in one state while working in the other.

**Costs of a multi-state partnership.** While sharing infrastructure development and maintenance can reduce costs, administrative costs for the Exchange are a small portion of the total costs of purchasing insurance. A one percent reduction in administrative costs would be a fraction of a percent reduction in the total cost of insurance purchase for Exchange participants. Such a reduction is not worthless, but should be considered in terms of the additional effort needed to develop and implement a cross-state Exchange. The challenges of working with two sets of state rules, legislatures, and administrations would be significant barriers to the efficient and timely development of an Exchange.

In addition, Exchange development will require legislative action. Building a multi-state Exchange would necessitate getting the approval of two state legislatures and two administrations. Every design issue, from the structure and oversight of the Exchange through the smallest administrative rules and HR policies would have to be agreed to by officials in both states. Adding to the challenge are states' differing legislative timelines and individual economic circumstances facing each state. As the potential savings are not large, the likely hurdles involved in establishing and maintaining a multi-state Exchange appear even more daunting. Pursuing a single state Exchange in Oregon will allow the state to pursue its own policy decisions without compromising those goals and plans in order to reach agreement with another state.

A further consideration is that a successful Exchange is one that is able to provide relevant assistance to individuals in a local area. A multi-state partnership does not improve the Exchange's ability to provide good, locally useful information and support to its customers.

**Other opportunities for multi-state partnerships.** To benefit from the efficiencies of working with another state while avoiding the complications of a full interstate Exchange, the state should investigate ways it can partner with neighboring states on infrastructure development and other operational tasks without entirely yoking its policy development and operations planning to that of another state.

### **C. ELEMENTS OF AN EXCHANGE – Operations**

Operations issues address the functional design components of the Exchange, as well as the environment that will affect those design choices.

#### **Establish Sole Market or Dual Markets**

Consistent with the requirements of federal law:

- Oregon’s Exchange should be available for individuals and small group purchasers.
- Use of the Exchange is voluntary.
- Individuals accessing federal tax credits for insurance purchase will be required to use the Exchange to buy insurance.

The federal health reform bill does not direct states to make the Exchange the sole market for individual and small group purchasers, but it leaves open the possibility for individual states to make rules about the Exchange’s role in their state insurance markets.<sup>2</sup>

Both the Oregon Health Policy Commission and the Exchange Work Group of the Oregon Health Fund Board recommended that an Exchange be the venue for people to access premium subsidies, but that people buying insurance without public subsidies access the Exchange on a voluntary basis.

**Single Market Implications.** An Exchange that is the sole market would be larger than one that would exist in the context of a dual marketplace. An Exchange as the sole market could more easily be a force for change in a marketplace in which it sets the rules for all insurance purchasers. In a split market, the Exchange can still work to improve quality and reduce costs for consumers, but its ability to do this will depend in large part on the size it achieves. A larger population within the Exchange will make it more likely for changes implemented within the Exchange to be implemented in the outside market as well. In a dual market, the Exchange must work to prove its value to consumers. Where choice is available, the Exchange must make itself the preferred option by providing the best possible products, customer service, information and support.

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<sup>2</sup> In addition, House Bill 2009 allows the exchange business plan to address the issue whether the exchange should be the exclusive market for individual and small group purchasers, or whether consumers would continue to have the option of buying insurance inside and outside the exchange. *HB 2009, section 17(b)(C)*

**Limiting Choice, Limiting Risk Selection.** If the Exchange is the only market, this could limit choice for insurance purchasers. An insurance carrier that did not meet the Exchange's standards for participation would effectively be kept out of the state's entire health insurance market.

A single market would eliminate the potential for risk selection between an Exchange and outside market. With two markets, one more insurance carriers could receive unequal risk either inside or outside the Exchange. This could happen randomly or due to the behaviors of one or more carriers in the market. However, in a dual market in which all of a carrier's members form a single pool and premiums for a given product are the same inside and outside, risk selection is greatly mitigated. The federal law requires the pooling of risk across the entire market and mandates that prices for a plan are the same inside and outside of the Exchange. Risk for grandfathered plans (those issued before March 23, 2010) is separate, though the Exchange and free choice vouchers will likely have some impact on them.

**Input from the Technical Advisory Work Group.** Members of the technical advisory work group indicated that they preferred a dual market system. Some members wanted to limit disruption for individuals and business that are happy with their current coverage. Others were concerned that an Exchange that is the only entry point to the market may face challenges in trying to increase quality, cost and efficiency standards. The concern centered on a public corporation playing a regulatory role for the whole state. This was not considered a problem if the Exchange is established as a state agency.

**How Will Benefits or Other Requirements be used to Ensure Carrier and Plan Participation Provides Meaningful Consumer Choice**

The federal health reform law allows states to set insurer participation rules within the framework of the federal law and regulations on the subject. States may limit participation to carriers that meet Exchange standards and for which their participation is considered to be in the state's best interest.<sup>3</sup> In addition, House Bill 2009 allows the Health Policy Board to establish criteria for the selection of insurance carriers to participate in the Exchange and requires the Board to consider ways to maximize the participation of private insurance plans in the Exchange.<sup>4</sup>

In its discussion of plan participation in the Exchange, the Exchange technical advisory work group considered the extent to which plan choice is beneficial to consumers. The group discussed how much choice is valuable and at what point having too many difficult to compare choices becomes a barrier to informed decision-making. The group was in general agreement that while choice is beneficial, it should be meaningful choice for the consumer, rather than a way for carriers to segment the market in a way that does not help consumers.

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<sup>3</sup> Public Law 111-148 (PPACA) Part II, Section 1311(e)

<sup>4</sup> House Bill 2009, section 17(b)(A): "Establishing criteria for the selection of insurance carriers to participate in the exchange." Section 17(a)(H) "Maximizing the participation of private insurance plans offered through the exchange."

**Standard Setting, Selective Contracting, Information Provision.** All carriers wanting to sell products in Oregon's individual and small group markets will continue to have their plan rates approved by the Insurance Division, whether the carriers sells plans inside or outside the Exchange, or both.

Federal law allows the Exchange to establish health plan certification standards for carriers seeking to participate in the Exchange. An Exchange with statutory authority to establish additional plan participation standards could define standards that are strong enough to ensure quality while not so stringent as to unnecessarily limit choice of plans. Meeting the Exchange's requirements is then up to the carriers.

Health plans sold through the Exchange could be required to meet additional participation standards, effectively giving a seal of approval to qualified health plans. This is consistent with the federal requirement that Exchanges develop a rating system for plans and provide consumers with information on plans' ratings based on their quality and price.

Another mechanism for ensuring that qualified health plans are offering value, quality and access is to provide information on the qualities the Exchange is looking for in qualified health plans. Each interested plan will provide information about its qualifications and value, allowing the Exchange to choose the plans that ensure choice, quality and value in a given geography. This may mean that the plans chosen in an area of greater plan competition are working not only to show their value but also to show that value relative to the many other plans available in the area.

To ensure consumers have information on all their options, the Exchange web site can provide information on all plans offered in the market, not just those available through the Exchange. Allowing consumers to make meaningful comparisons across plans will help them see how Exchange based plans offer superior value and quality to members.

**Participation Inside and Outside of Exchange.** The federal law does not eliminate the insurance market outside of state Exchanges. While not specifically addressed in the law, some analysts read the law as leaving the option of doing so to state discretion. This would have the benefit of ensuring a larger pool of enrollees in the Exchange and eliminating risk selection between the Exchange and outside markets. However, it would also mean that undocumented immigrants would not be able to purchase insurance at all. This would undermine the goals of insuring all residents of Oregon and greatly reducing the cost shift now experienced by the insured whose premiums subsidize "free" care for the uninsured.

If there are "parallel markets" (an Exchange market and an outside market), the question then arises whether plan participation in the Exchange should be assured by requiring all carriers wishing to sell health insurance in Oregon to participate in the Exchange. If a carrier has to participate in the Exchange in order to also sell in the outside market, a plan that fails to get certified for Exchange participation would effectively not be available in the outside market either. Whether this is a positive or a negative outcome depends on your perspective. Requiring carriers sell both inside and out could mean that some carriers leave Oregon entirely. This would reduce consumers' carrier and plan choice. However, such a rule could protect consumers against carriers that enter the market in order to attract low risk enrollees without providing a

quality benefit. Carriers in the Exchange will offer plans at multiple coverage levels. A plan seeking to cherry-pick low risk enrollees by only offering a bronze level plan would not be accepted into the Exchange, and thus would effectively be excluded from the Oregon market. Meaningful choice could be retained while protecting consumers from “bottom feeders.”

The state’s Healthy Kids program provides one model for how the Exchange could function. Healthy Kids included all health plans that met the program’s qualifications. The goal was to have two statewide carriers and to give all enrollees a choice of at least two plans.

**State Flexibility to Adjust Standards.** Allowing voluntary participation by insurance carriers gives the Exchange more flexibility to establish quality and other participation criteria, and to adjust those criteria as needed. A plan that fails to meet set standards can be taken out of the Exchange without disrupting coverage for people purchasing the coverage in the outside market.

**Meaningful Variation and Useful Navigation.** There is a tension between standardization and innovation. Variation for its own sake causes confusion, and simplification is one of the Board’s stated goals for an Exchange. The Exchange should encourage rather than limit health delivery innovation in areas such as payment models, delegation of authority and medical home. Rather than limit carrier choice, the group talked about ways the Exchange could make it easier for consumers to figure out what plans best meet their needs. In Massachusetts, the Commonwealth Connector utilizes a web site that allows plan comparison by geography, price and benefits. Additional navigation functions could be built in to Oregon’s tool. The screening tool could help users to navigate choices by asking them the questions they might not know to think about when choosing a plan, such as network participants or care coordination services.

The group also recognized that depending on the area of the state, the issue may be too much choice or not enough of it. In addition, it can be difficult for people to judge future medical need, so making choices about what plan will be best over time can be challenging.

At the plan level the goal is to offer adequate choice in all areas of the state and ensure the consumer’s ability to navigate the options and make meaningful choices. In the longer term, the Exchange may want to change the rules based on the experience seen over time. To this end, the Exchange must have statutory authority to change carrier participation rules in light of experience showing that such changes are needed.

**“High Value” Designation.** One area to explore is the suggestion by an Exchange technical advisory work group member that the Exchange could selectively contract with one or more carriers that participate in the Exchange. Specific health plans could receive a “preferred” or “high value” designation based on their adherence to higher quality and cost standards. This could encourage other carriers to improve quality over time in order to meet the higher standards and get the quality designation.

**Determine Which Carriers may Sell Young Adult/Catastrophic Plans**

The PPACA allows for a catastrophic coverage plan to be sold to individuals under age 30 and people with hardship exemptions from the federal insurance mandate. The catastrophic plan will provide coverage for the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.<sup>5</sup>

As these plans are only open to specific categories of purchasers, it will be necessary to certify that the buyer is eligible to enroll in a catastrophic plan. This can most easily be done through the Exchange. This is particularly important for individuals deemed exempt from the insurance mandate, as the Exchange is responsible for granting exemptions and informing the federal government about which Oregonians receive exemptions. If the plans are sold in the outside market, additional coordination will be required to ensure the Exchange receives the information it needs. Exempt individuals and young adults have a financial stake in the Exchange providing information to the federal government, so that they can be assured that they will not be wrongly penalized for not purchasing a qualified health plan.

Offering young adult and catastrophic coverage plans through Exchange-participating carriers will provide an incentive to carriers to participate in the Exchange.<sup>6</sup> As young adults tend to be healthier than the average under-65 population, this group is a lucrative market. It is also a group that has historically had high uninsurance, meaning that many Oregonians in this age group will be new entries into the health insurance market.

**Determine the Minimum Standards for Plan Offerings Sold in Individual and Small Group Markets<sup>7</sup>**

As required by the federal law:

- All health plans must meet federal essential benefits requirements.
- Exemption exists for “grandfathered” plans sold before March 23, 2010.
- All companies selling insurance in Oregon will offer at least “Bronze” and “Silver” plan offerings. Carriers may also offer plans in addition to these plan levels.

**Minimum Coverage.** The PPACA amends the Public Health Services Act, directing insurers to ensure that the coverage offered through the individual and small group markets includes the essential health benefits package identified in section 1302(a) of the reform law. Exemptions are made for so called “grandfathered plans” (those issued before March 23, 2010) and insurance purchased by large employer groups covered by ERISA law. In addition, young adults under age 30 may purchase “young adult plans” with higher deductibles than allowed with other coverage.

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<sup>5</sup> PPACA, Section 1302(c).

<sup>6</sup> House Bill 2009, Section 17(a)(H) requires the Exchange business plan to consider strategies to maximize the participation of private insurance plans offered through the exchange.

<sup>7</sup> HB 2009 Section 1(a)(A) requires the Exchange business plan to include information on the selection and pricing of benefit plans to be offered through the exchange, including the health benefit package developed under section 9 (1)(j) of this 2009 Act. The plans shall include a range of price, copayment and deductible options.

## **DRAFT Health Insurance Exchange Report Appendix: Policy Issues for Development**

Individuals deemed exempt from the insurance mandate due to economic hardship may also purchase these “catastrophic” packages.

**Coverage Level Requirements.** Oregon will need to ensure that its laws and regulations are consistent with the federal law. In addition, the state can take steps to ensure that insurance carriers do not attempt to market to low risk people by offering only the lowest cost and coverage plans. Requiring that all insurers selling coverage in Oregon offer at least the bronze and silver level plans will help avoid such a scenario.

The Bronze, Silver, Gold and Platinum coverage levels identified in the PPACA each provide coverage for a specified share of the full actuarial value of the essential health benefits (60% for bronze through 90% for platinum). The federal law requires that carriers participating in the Exchange offer at least both a silver and a gold level plan. While carriers not participating in the Exchange may not want to offer all plan levels, the state can require carrier to offer both bronze and silver level plans.

### **Determine How Insurance Agents and Brokers will Participate in the Exchange**

The PPACA allows states to decide whether to use agents in the Exchange, directing states that do utilize them to follow certain rules. Agents are generally knowledgeable about a range of insurance products and can be helpful for individuals and groups seeking to buy insurance through the Exchange. Agents can help explain the benefits of Exchanges for individuals seeking to access tax credits, those not accessing financial assistance, and employers seeking to offer a range of coverage choices to their employees.

**Agent Education and Reimbursement.** Consistent with federal guidelines, the board should have the authority to determine the manner and amount of agent reimbursement. Allow for a certification process with standards set by the Exchange board for agents selling Exchange products. To the extent that the Exchange educates agents on Exchange benefits and offerings, agents can be a useful resource to consumers and can actively help the Exchange become sustainable. An educational program run by for agents by the Exchange would identify agents that have self-selected on their interest and ability to represent what the Exchange has to offer.

**Navigators.** Some agents may seek to become “navigators,” organizations trained and certified to provide assistance to people seeking to get coverage through the Exchange. Other organizations will become navigators as well. Members of the technical advisory work group suggested that to make the best use of navigators, some of their functions could be exempt from producer licensing requirements.

### **Determine the Ways in which the State can Make Changes to Benefit Requirements and Mandates as Needed over Time**

Once the federal government lays out requirements for essential health benefits:

- The state may want to make additional requirements.
- The state should retain its authority to make changes to benefit requirements once more information is known on the federal requirements.

House Bill 2009 Section 17(a)(A) focuses on the selection and pricing of benefit plans to be offered through the Exchange. The law requires that plans must include a range of price, copayment and deductible options. This flexibility will continue to exist under federal reform.

To ensure that the Exchange is responsive to needs identified over time, the Exchange board should be given statutory responsibility for establishing contract standards with an emphasis on quality, access and evidence based care. For benefits requirements that would affect all plans offered both inside and outside the Exchange, the State should retain the authority to change the rules as needed. This is not an Exchange role as it would affect all plans whether they were offered inside the Exchange or not.

**D. ELEMENTS OF AN EXCHANGE – Timing**

Timing issues includes the timing of the Exchange start up and inclusion of various populations as eligible enrollees.

**Determine when Employer Groups with 51-100 Employees will Gain Access to the Exchange**

The federal health reform law gives states flexibility to determine whether to define Exchange eligible small employer groups as 1-50 or 1-100 in 2014 and 2015. In 2016 Exchanges must allow entry to employer groups with up to 100 employees. Numerous market changes will occur in 2014. While many of these changes will benefit many Oregonians, they have the potential to cause disruption for others. Waiting until 2016 to change the definition of a small group will limit disruption for employer groups.

Currently the definition of a “small group” in Oregon is defined as 2-50 for insurance purposes. Small groups are governed by Insurance Division rules that do not apply to large groups. Per federal law, in 2016 the small group definition will change to include groups with 51-100 employees. This will mean changes for these employer groups and those in the 50 and under employee population. To best address and limit the impact of such changes on all employers, staff recommend waiting until 2016 to integrate the 51-100 employee groups into the small group market. This will all for the needed time to work with insurers, employers and agents to educate them about the changes involved and assist them with any transition issues.

**Assess the Circumstances under which the State should Implement its Exchange Early**

One of the key elements that may affect whether Oregon pursues an early Exchange is whether federal tax credits can be made available for individual insurance purchasers prior to January 1, 2014, possibly on a pilot basis. The federal health reform law provides insurance subsidies in the form of tax credits that begin on January 1, 2014. Oregon may want to investigate whether its residents could access subsidies on a state pilot basis in order to implement an Exchange earlier than 2014. Subsidies for insurance purchase will be a key driver for many individual market purchasers to buy insurance through the Exchange. Without access to subsidies, there is little

incentive for the currently insured to change coverage, and many of the uninsured are likely to be unable to buy insurance without the support of federal tax credits.

**Enrollment and Self Sufficiency.** As required by the PPACA, the state Exchange must become self-supporting in 2015. To do this, requires the Exchange to enroll people relatively quickly. The Exchange will have set costs that do not change based on the number of enrollees; more enrollees makes these costs more sustainable and lower on a per-capita basis. If the Exchange can not expect a sizeable population to enroll in advance of tax credit availability, it will make the Exchange hard to fund and could endanger the Exchange's ability to support itself in 2014 and beyond.

**Waiting for Federal Guidance.** Moving an Exchange to become operational a year in advance of the January 2014 date set out in federal law reduces the time available for planning and implementation. The Exchange exists within the framework of a whole set of reforms being implemented in Oregon, including the temporary federal high risk pool, risk-sharing and the transition to a guaranteed issue market. This is particularly a concern as the state Exchange will be built within federal requirements and guidance on benefits and other areas. While this information is forthcoming, there is currently no set deadline for federal guidance on these issues. It is not yet clear when federal grant dollars will be available for Exchange design and implementation.

#### **E. ELEMENTS OF AN EXCHANGE – Public Program Coordination**

##### **Determine how Existing Public Programs and Population Groups will be Integrated and Transitioned into the Exchange**

The Exchange will work with the Oregon Health Authority and the Department of Human Services to ensure the seamless diversion to Medicaid and other programs for individuals identified as eligible for state assistance. The Exchange will develop a plan for this work and will have the flexibility and authority to contract with Medicaid eligibility staff. The Exchange must have the authority to make decisions that work best for the Exchange and people of Oregon, taking into account what will best facilitate seamless coordination and transfer between systems.

#### **F. ELEMENTS OF AN EXCHANGE – Risk Mediation**

##### **Determine how to Work with the Federal Government to Implement Risk Adjustment Measures**

House Bill 2009 allows the Health Policy Board to determine the need to develop and implement a reinsurance program to support the Exchange.<sup>8</sup> The federal health reform law identifies three risk spreading or risk mitigation programs that will begin in 2014: risk adjustment; reinsurance; and a risk corridor. The first two will be administered at the state level, while the risk corridor will be a federal effort. The state risk adjustment program will apply to individual, small group

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<sup>8</sup> HB 2009 Section 17(b)(G).

and some large group products. The program will redistribute money from plans that incur lower than average risk to those with higher than average risk. The federal Health and Human Services Secretary will establish criteria and methods that will structure the state programs.

The reinsurance program is for individual market plans. Although it will be administered at the state level will be based on federal standards. The risk corridor will apply to individual and small group products offered through the Exchange and will be based on the risk corridors used in Medicare Part D.

Reinsurance and the risk corridor will be time limited, lasting only for three years starting in 2014. Risk adjustment will be permanent. In addition, the federal government is working on a short-term reinsurance program for retirees, which ends in 2014. The state will need statutory authority to establish these mechanisms, but no decisions are needed about whether to implement these efforts.

## **G. ELEMENTS OF AN EXCHANGE – Funding Operations**

### **Determine how to Fund Ongoing Exchange Operations**

The federal government will provide states with start up funds in the form of grants for Exchange development and implementation. By January 1, 2014, the state Exchanges must be self-sustaining. The federal reform law allows an Exchange to charge user fees or assessments to support its operations. A user fee will put the Exchange in the position of earning its operating revenue by demonstrating its value to consumers and carriers. Proving its value is something that the Oregon Health Fund Board's Exchange Work Group discussed, and which will encourage efficiency in operations and contracting. To make user fees a viable support mechanism, the Exchange will need to get up to scale quickly. In 2009, the Massachusetts Exchange had a fee of 4% of premium, with enrollment of approximately 187,000.

The fee on plans purchased through the Exchange will not increase the total cost of the plan's premium relative to products purchased outside of the Exchange. The PPACA requires that Qualified Health Plans (those certified to be sold through the Exchange) agree to sell their plans at the same price whether offered inside the Exchange or outside of it.