

Oregon Health Policy Board

AGENDA

December 14, 2010

Market Square Building

1515 SW 5th Avenue, 9th floor

12:00 pm to 5:00 pm

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

#	Time	Item	Presenter	Action Item
1	12:00	Welcome, call to order and roll call Consent agenda: <ul style="list-style-type: none">• 11/9/10 Minutes• 11/16/10 Minutes• Incentives and Outcomes Committee Report• Medical Liability Taskforce Report• Public Employers Health Purchasing Committee Report• Workforce Committee Report	Chair	X
2	12:15	Director's Report	Bruce Goldberg	
3	12:30	Value Based Benefits Package: Focus group results presentation.	Carol Foley Jeanene Smith	
4	1:15	Discussion on the Health Insurance Exchange: Legislative Concepts and direction.	Nora Leibowitz Barney Speight	X
	2:45	Break		
5	3:00	Discussion on the Oregon Health Action Plan, for review and approval.	Gretchen Morley	X
6	4:00	Budget discussion and follow-up on Governor-elect Kitzhaber's comments.	Bruce Goldberg	
7	4:45	<i>General Public Testimony</i>	Public	
8	5:00	Adjourn		

Upcoming

January 11th, 2011

Time and location TBD

Oregon Health Policy Board
DRAFT Minutes
November 9, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
8:30am – 1:00pm

Item

Welcome and call to order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Joe Robertson participated by phone. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

Consent agenda –

Minutes from October 12, 2010 meeting.

The October 12, 2010 minutes were reviewed.

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

Director's Report – Bruce Goldberg, MD

- Oregon's work on its Exchange predates federal health reform and we will continue to move forward, regardless of the outcome of the elections.
- As we move into the next biennium, the fiscal climate will remain poor. It will be necessary to continue to hold the line on expenditures as well as we can.
- Dr. Goldberg informed the Board that in January, Healthy Kids would be an agenda topic.

Oregon Blueprint for Health: Draft Vision and Structure – Jeanene Smith and Gretchen Morley

- Gretchen presented the executive summary of the Blueprint.
 - ❖ It directs strategic actions, articulating the four foundational strategies the Board articulated at the last meeting.
 - ❖ Key strategies include aligned purchasing, local accountability, standards for effective care, and living within our means.
 - ❖ Cross cutting issues are health equity, access to care, bending the cost curve, measuring progress, consumer and patient engagement, shifting focus to prevention, and federal health reforms.
 - ❖ The proposed infrastructure is that OHA will create a public corporation that will administer the exchange, oversee locally accountable care, and qualify health plans.
- The Board stated that it's important to also make sure we align outside state functions around health as well.
- The Board expressed a desire that the document outline next steps more clearly.
- The Board recommended thinking of the Blueprint as a living document to be updated frequently.

Report from Health Equity Policy Review Committee – Tricia Tillman

- Health equity is the attainment of the highest level of health for all people.
- Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to rectify historical and contemporary socially patterned injustices, and the elimination of health disparities.
- To achieve health equity, we have to address both individual choices as well as the broader societal structures that hinder those choices.

This presentation can be found [here](#).

- The Board requested flexibility in guidelines going forward to allow health care providers to use better treatment options for minority patients.
- The Board stated that diversifying the workforce is very important in achieving equity. Patients need access to doctors they feel comfortable seeing.
- Tricia noted that there are better patient outcomes and relationships when there are cultural

matches between providers and patients.

- The Board had mixed feelings about having a separate equity committee. Every subcommittee should be looking at health equity, which the Board agreed on, but questions were raised about whether having a separate committee removed the necessity of the health equity focus from the duties of the other subcommittees or amplified it.
- Tricia responded that it's important to make sure that committees have more than one health equity person in order to avoid marginalizing that voice. Opportunities for training should be explored. A health equity committee can combine cultural experiences, professional disciplines and areas of focus that would be lost in the other subcommittees.
- This committee has been reviewing the reports of the other subcommittees but would prefer to be a resource as reports are being compiled, rather than a filter as they are sent to the Board.
- The board recommended including positions other than just doctors and nurses when thinking about workforce. There may be opportunities to train minorities already working in the healthcare fields to be health care providers.

Break

Report for Board Consideration: Health Improvement Plan Committee – Tammy Bray and Lila Wickham

- Goals of the Health Improvement Plan:
 - ❖ Achieve health equity and population health by improving social, economic and environmental factors.
 - ❖ Prevent chronic diseases by reducing obesity prevalence, tobacco use and alcohol abuse.
 - ❖ Stimulate public health, health system linkages, innovation and integration.
 - ❖ Focus measurement and payment efforts where the potential for improvement is greatest
 - ❖ Encourage the delivery system to become more patient and family centered
 - ❖ Initiate use of new payment incentives and methodologies
 - ❖ Set a global health care spending target

This presentation can be found [here](#).

- The Board stressed the importance of aligning state health assessment data standards with federal standards.

The Board unanimously voted to accept the Health Improvement Plan Committee report.

Draft Report from the Medical Liability Committee – Mic Alexander and Joe Siemienczuk

- The challenges in medical liability reform are
 - ❖ Strongly held points of view
 - ❖ Decades-long battle over tort reform proposals
 - ❖ Commitment to a high-road, patient-centered approach
- Goals of reform:
 - ❖ The medical liability system becomes a more effective tool for improving patient safety.
 - ❖ The medical liability system more effectively compensates individuals who are injured as a result of medical error.
 - ❖ The collateral costs associated with the liability system are reduced (including the costs of insurance administration, litigation, and defensive medicine).
- Reforms should reduce injuries to patients, provide assistance to patients who are injured, and reduce collateral system costs.

This presentation can be found [here](#).

Public Testimony

Kevin Campbell and Mitch Anderson

Messrs. Campbell and Anderson spoke to the committee about behavioral health and how regional care organizations can be of use. They cautioned the Board against creating regulations that cause expert employees in the field to leave. It's also important when creating regional organizations to let the regions form themselves from the ground up.

- **The Board would like Messrs. Campbell and Anderson to return and speak to the Board during a meeting where they could have more time on the agenda.**

Sandra Hernandez – THE-TREE Institute

Ms. Hernandez brought a request from her group that the Board consider four priorities. The first is to assure every Oregonian has access to health care services, regardless of their documentation status. The second is to require all plans to offer health insurance to everyone in Oregon, especially children. The third is to assure cultural and linguistic competency services for all diverse communities. Finally, all undocumented mothers of citizens should be given care.

Sharon Gary-Smith – Cascadia Behavioral Health and Member, Health Equity Policy Review Committee

Ms. Gary-Smith encouraged the Board to continue their work on health equity. She said that this work must be a constant, intentionally, deliberate effort, to look at equity as one would an environmental impact statement. Oregon's boards and decision-making bodies should better reflect the diversity Oregon has.

Midge Purcell – Urban League of Portland

Echoing Ms. Gary-Smith's comments, Ms. Purcell emphasized the need for culturally appropriate health care. Diversifying the workforce is a way to accomplish that. She also encouraged the use of community-based health care delivery models.

Amy Hsio – Student at PSU and Volunteer with Asian Pacific American Network of Oregon, Health Equity and Reform Team (APANO HEART)

Ms. Hsio reported that her organization supports the recommendations from the Health Equity Policy Review Committee. She echoed the need for workforce diversity and cultural and linguistic competency.

Dr. Al Weiland

Dr. Weiland spoke about the hidden barriers that exist when a workforce does not reflect the population it serves. Workforce diversification has to be a community wide approach. It has to involve education and creates a system that helps people where they live, work, and play.

Adjourn 1:03pm

Next meeting:

November 16, 2010

8:30am – 1:00pm

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

Oregon Health Policy Board
DRAFT Minutes
October 12, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
8:30am – 1:00pm

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

The Chair announced that the agenda had been revised, moving the public comment section to 11:45. Some items were moved to December's agenda.

Draft Report from the Public Employers Health Purchasing Committee – Steve McNannay, Lynn McNamara, Barney Speight

- Committee 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 and for voluntary adoption by local governments and private sector entities.
 - ❖ These standards are to be based on the best available clinical evidence, recognized best practices and demonstrated cost-effectiveness for health promotion and disease management.

This presentation can be found [here](#).

- The Board was concerned that insurance purchasers would be reluctant to adopt the Committee's recommendations and that the Committee might not have enough influence to enact change.
- Lynn replied that the purchasers were concerned with cost. They recognize the long-term benefits, but are uncomfortable with the immediate expense.
- The Board was interested in collecting data on how the purchasers were implementing the recommendations, and Barney replied that they planned to do it by checking the contracts of the eight or nine major carriers in the state.

Draft Report from the Workforce Committee – John Moorhead and Ann Malosh

- The Workforce Committee was created to coordinate state efforts to recruit and educate health care professionals and retain a quality of workforce to meet demand. The Committee identified three priorities.
 - ❖ Prepare the current and future workforce for new models of care delivery
 - ❖ Improve the capacity and distribution of the primary care workforce
 - ❖ Expand the workforce through education, training and regulatory reform to meet the current projected demand of 58,000 new workers by 2018

This presentation can be found [here](#).

- The Board was very interested in the Committee's recommendation to standardize the administrative aspects of students' clinical training and felt that a statutory requirement might be the most effective means of accomplishment. There was concern about whether schools would be comfortable with a required set of standards and the Board decided that communication with the schools would be necessary to set a standard that would be acceptable to most schools.
- The Board noted that in order to achieve the diversity of workforce that we are striving for, we must ensure that same diversity exists in health care education faculty.

Break

Report for Board Consideration: Publicly Owned Health Insurance Plan – Nora Leibowitz, Barney Speight and Bill Kramer

- Key strategic issues

- ❖ Organization and governance – Standalone plan or “piggy-back” on an existing plan?
 - ❖ 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 and sales? Opportunities for efficiencies?
- Some advocates feel that a “piggy-back” plan does not truly meet the definition of public option. A piggyback plan that used PEBB would use PEBB for its administrative services. PEBB is self-insured and uses Providence to administer its plan. Advocates feel that using Providence, which is a private provider, does not hold to the true essence of a public plan.
 - A co-op was brought up as an option that had not been fully investigated at the last meeting. Bill feels that a co-op is not truly a public plan, either. It is owned and managed by its members. It could provide a way to achieve some of the goals held by the public option. It’s another choice that might be a competitor in the exchange. There is \$6 billion available in loans and grants to cover start up costs.

This presentation can be found [here](#).

The Board voted to provide the Legislature with the three main options (standalone plan, piggy-back plan and co-op option) for them to consider during the upcoming legislative session.

Report for Board Consideration: Health Insurance Exchange – Nora Leibowitz, Barney Speight and Bill Kramer

- Structural assumptions of the exchange:
 - ❖ Dual market
 - ❖ Active purchaser role
 - ❖ 204 benefits in each tier
 - ❖ Active marketing
 - ❖ Public corporation structure

This presentation can be found [here](#).

- The Board requested that the small employers group be renamed as micro employers and create a group for employers with more than twenty-five employees.
- The Board also asked that staff focus on what can be done to increase more portability in the Exchange.
- The Board stated that it is very important to begin educating people about the Exchange well before it is implemented to ensure greater participation.

Public Testimony

Tom Aschenbrenner – President of Northwest Health Foundation

Mr. Aschenbrenner encouraged the Board to address the social, economic and environmental conditions that create opportunities for health in the comprehensive plan. He urged the Board to be bold when communicating with the Legislature and break the mindset that everything begins and ends with a biennium. Finally, he requested that the Board create a fully chartered committee focused on health equity.

Gary Cobb – Community Outreach Coordinator

Mr. Cobb urged the Board to ensure that coordinated services are available to OHP members suffering from substance abuse. Having access to various kinds of treatment, as well as housing, is of great value.

Caitrin Coccoma – Partnership for Safety and Justice

Ms. Coccoma urged the Board to consider all forms of addiction as a chronic disease, not just tobacco and alcohol.

Update: Oregon Blueprint for Health – Gretchen Morley

This document can be found [here](#), beginning on page 5.

- The Board discussed the difficulty in trying to create a document that outlines where we wish to go and focuses on the immediate needs at hand as well.
- Dr. Goldberg recommended creating a separate document that outlines immediate steps to be taken to bring things into position to enact the farther reaching steps the Blueprint recommends.

Governor-Elect John Kitzhaber Testimony:

Governor-elect Kitzhaber – Mr. Chair, for the record, John Kitzhaber, Governor-elect. I just wanted to take a few minutes.

This issue obviously is one that I've had a long standing interest in. I also think it's an issue that could potentially break the bank for the state of Oregon and for the United States of America, and I think that - I've read your Blueprint and just want to make a couple of comments about sort of what I hope will happen from the work that you've done to date.

I guess the first thing I want to convey is a real sense of urgency.

The federal health care reform legislation officially takes place really between 2014 and 2017, and as you know, it wasn't, in my estimation, really health care reform as much as it was health insurance reform, and it will provide certainly some changes to the private commercial insurance industry that are overdue and also will provide the opportunity for most Oregonians to have financial access to medical care, either through the state insurance exchanges or through expanded Medicaid or subsidies for individuals and small employers. But it does very little to reduce the big drivers of health care cost, and I don't think either the federal government or the state of Oregon can wait until 2017, and I don't think Oregon can wait until 2014. The national debt is increasingly made up of Medicaid and Medicare. Congress is going to have to get their arms around that, and when they do, my concern is that they will be in a very reactive mode, focusing on managing the national debt and making sure we don't default on it, rather than a thoughtful approach to the health care system and changing the financial incentives and the structure of the delivery system, which is really the root cause, I think, of this problem in America.

For the state of Oregon, I think the crisis is now, in this biennium. The cost increase in the Department of Human Services was \$1.8 billion. That's the projected increase in expenditures. One billion of that is replacing one-time federal funds and about \$600 million of that is Medicaid. So, the discussion we're going to have in the next biennium is not how we increase reimbursement for providers to meet medical inflation, but how we take essentially a flat funded or less than flat funded budget and do something different with it that lays the groundwork for some much more substantial health care reform in the next biennium.

And I think that—I know—the administration is looking for a state or several states that can demonstrate that the federal health care legislation wasn't just a big increase in federal spending but is a – provides a pathway to substantial fundamental health care reform. I think that Oregon is a great position to do that. I've had some conversations with Governor Gregoire about the possibility of even doing a regional two-state approach to become somewhat greater than our parts.

But to me, the logical thing for us to do, a place to start in Oregon, is eventually to take those individuals for whom the state has direct responsibility, either as a large employer, PEBB and OEBB, or as a safety net provider, the Oregon Health Plan, which is about 850,000 covered lives and to begin at some point in the future to view those lives as an 850,000 person community-ready risk pool, and then leverage regional delivery system changes with that market power to begin to change the delivery system and hopefully provide a venue, an avenue for small employers to purchase into that if they wish and eventually to look at the whole question of how we change the delivery model in Medicare as well.

So, I think that the things that really need to happen to lay the groundwork for that in the next session is to begin to align state purchasing around Triple Aim metrics, begin to think about how we can regionalize accountability for health outcomes and for financial, and for health financing, to begin standardizing, to get our arms in the upcoming biennium around the fragmentation and inefficiency in the Medicaid program,

which is a must for balancing the budget. And I think that means integrating mental health, physical health and long term care and giving the Medicaid managed care plans the ability to manage a larger part of the health care dollar in exchange for some delivery system changes that drive efficiency and quality.

And I'll guess I'll just say finally, I spent yesterday down in Salem getting a budget briefing, and the fact is, the money's not there. I mean, our K through 12 system is flat funded at best for the next two years, and there's no way we can justify, I think morally or politically, a 15% increase in the Medicaid budget. We just can't do it. So we need to view this as an opportunity to rethink how we change our business models over time to deal with the trapped equity in the current system and to try to make some inroads in that during the upcoming biennium. I don't suggest that it's going to be easy, but I also think that this is something that we have to do together, and we have to do it right. We're not going to get another shot at this, and there's a profound opportunity to do something very important for Oregon and eventually for the country if we proceed together down this path.

Eric Parsons, Chair - Very good. We have some work to do. We have a lot of work to do.

Governor-elect Kitzhaber - Thank you very much for the chance to come down here. That's really all I had. I just - I hope that you take some of those key elements that are in your Blueprint and really lean into those and I think that the sooner we can have a dialogue with the various impacted parties, whether they be consumers or providers or insurers, or how we work through this, I think the better off we'll be. We shouldn't, in other words, we shouldn't wait until January 10, 2011 to begin this process of engagement.

Bruce Goldberg, OHA Director-designee – You know, Governor, as you've laid out, the alignment, the regionalization, the standardization, and how we do all of that, I think is very consistent with how the Board has been, you know, approaching this, and what I – I think we hear from your remarks is that hopefully the board and the Health Authority can bring in—actually making this a reality now because of the urgency of the budget situation around the 850,000 public lives and that if we can do that and do that well, it really sets out the future and that we really need to get at what can happen over the next six months to make that less aspirational and more reality. We're ready to help.

Eric Parsons – Indeed we are. I think a lot of the work we've done is aiming in the right direction. I think we heard a real message of urgency and we'll be on it.

Governor-elect Kitzhaber – Thank you, and obviously I have no authority to direct the Board to do anything until January 10, but I want to suggest that if you lean into this and move aggressively in this direction, I will provide you plenty of cover after January 10.

Adjourn 12:48pm

Next meeting:

December 14, 2010

Noon – 5:00pm

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

**Monthly Report to
Oregon Health Policy Board
December 14, 2010**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Budget and Planning

Much of the past month has been occupied with current and future budget issues and finalizing Board reports. Budget materials will be presented separately at the meeting.

Healthy Kids Program

Enrollment

- Through October, about 67,000 more children have been enrolled.
 - This is 84% of our goal of 80,000 more children and a 25% increase in enrollment since June 2009 (baseline).
 - Just over 3,000 children are now enrolled in Healthy KidsConnect.
 - See the chart below for a more detailed look at Healthy Kids enrollment.

Outreach and Marketing

- Enrollment in October was 33% higher than the previous month (5,657 more children) thanks to the statewide media buy, back-to-school outreach efforts, and the ongoing work of our grantees and assisters.
- Outreach staff continues to do aggressive outreach to community organizations to enlist their help in spreading the word about Healthy Kids.
 - To date, the Office of Healthy Kids has trained over 1,300 people and 200 organizations from all over the state on the Healthy Kids program.
- A new and improved website is being finalized and will go “live” by the New Year.

System Improvements

- An improved application, developed with the Center for Health Literacy, is now being printed and will be implemented later this month.
 - Significant policy changes have been incorporated into the new application to make the process easier for applicants, including a decrease in the amount of income documentation required.
 - The goal of the application is to streamline the application process and reduce the number of applications that are pended or mistakenly denied.

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- Began using an innovative new strategy to simplify things - “Express Lane Eligibility” (ELE) - using SNAP (Food Stamp) data (i.e., use income information in SNAP data to automatically enroll children into Healthy Kids). Will also use ELE with the Free and Reduced Lunch applications from a handful of school districts at the end of the year.
 - Continue to work on streamlining redetermination system, so that eligible families can keep their children enrolled quickly and easily.

OHP Standard

- As of October 15, 2010, enrollment in OHP Standard is now **51,204** and many more applications are coming in each week.
- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- There have now been thirteen random drawings to date. The last drawing was on November 17, 2010 for 10,000 names. The next drawing will be on December 15, 2010, for 10,000 names or exhaustion of the list, whichever is greater.

Upcoming

Next OHPB meeting:

Tuesday, January 11, 2010

Location: TBD

The next Oregon Health Policy Board meeting will be a more informal day long board discussion of how to implement the recommendations that have already been made, which recommendations to move forward with next, and the agenda and plan for the upcoming months. It will be held on Tuesday, January 11th.

Healthy Kids Progress Toward Enrollment Goals

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Target Enrollment Increase	Actual Net Increase	Progress Towards Goal	Monthly Enrollment Goal	Monthly net enrollment change	% of Monthly Goal Achieved
Jul-09	271,493	0	271,493	5,000	3,648	73%	5,000	3,648	73%
Aug-09	276,712	0	276,712	10,000	8,867	89%	5,000	5,219	104%
Sep-09	281,374	0	281,374	15,000	13,529	90%	5,000	4,662	93%
Oct-09	289,015	0	289,015	20,000	21,170	106%	5,000	7,641	153%
Nov-09	294,459	0	294,459	25,000	26,614	106%	5,000	5,444	109%
Dec-09	298,600	0	298,600	30,000	30,755	103%	5,000	4,141	83%
Jan-10	303,026	0	303,026	33,333	35,181	106%	3,333	4,426	133%
Feb-10	305,785	205	305,990	36,666	38,145	104%	3,333	2,964	89%
Mar-10	309,047	549	309,596	39,999	41,751	104%	3,333	3,606	108%
Apr-10	312,191	923	313,114	43,332	45,269	104%	3,333	3,518	106%
May-10	314,933	1,133	316,066	46,665	48,221	103%	3,333	2,952	89%
Jun-10	316,891	1,338	318,229	50,000	50,384	101%	3,333	2,163	65%
Jul-10	319,878	1,662	321,540	55,000	53,695	98%	5,000	3,311	66%
Aug-10	322,694	1,948	324,642	60,000	56,797	95%	5,000	3,102	62%
Sep-10	326,545	2,335	328,880	65,000	61,035	94%	5,000	4,238	85%
Oct-10	331,837	2,700	334,537	70,000	66,692	95%	5,000	5,657	113%
Nov-10	*	3,046	*	75,000			5,000		
Dec-10				80,000			5,000		

*November enrollment data not yet available.

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MEMO

To: Oregon Health Policy Board

From: Dr. Jeanene Smith, Administrator, Office for Oregon Health Policy & Research

Date: December 14, 2010

Re: Value-based Essential Benefit Package

Background: The Office for Oregon Health Policy & Research has spent the past year working on various aspects of the design of a value-based essential benefit package.

- The Oregon Health Services Commission developed a list of value-based benefits that could be used as the core of a value-based essential benefit package.
- Building off the design work of the Oregon Health Fund Board's Benefits Committee, the Office worked with James Matthisen, an actuarial consultant, and the Actuarial Services Unit of the Oregon Health Authority, to develop an actuarial model to determine the costs and potential savings of a value-based essential benefit package.
- Using State Health Access Program (SHAP) grant funds, we hired Dr. Carol Foley to conduct focus groups and one-on-one interviews with potential consumers, employers, insurers, agents, providers and hospitals to better understand consumer reactions and operational considerations of implementing a value-based benefit design.

Proposed Next Steps: Staff proposes the following implementation-related activities:

- Assign accountability within the Oregon Health Authority to develop detailed implementation plans for the value-based benefit plan across all OHA lines of business. Items to consider:
 - Use of pilot programs,
 - Phased implementation and/or implementing the most appropriate elements of the design for different populations.
- Create a sophisticated actuarial tool that:
 - Purchasers can use to compare their current benefits with the value-based essential benefit plan and assess how it will impact their health care expenditures,
 - Incorporates additional actuarial work on each value-based service to weigh costs and savings for each intervention.
- Examine how benefit design can be coupled with payment incentives to increase the use of effective services and treatments to improve health, and reduce the use of less-effective services and treatments.
- Work with impacted stakeholders to address administrative and operational concerns.
- Develop and provide outreach and educational tools to support the implementation and adoption of the benefit plan.

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Value-Based Benefits Design Research

High-level Findings

Prepared For:

Portland State University

&

Office for Oregon Health Policy & Research

December 14, 2010

By

Carol Foley, Ph.D.

Foley Research, Inc.

Value-Based Benefits Design Research – High Level Findings

During a period from late September to mid-October of 2010, a series of research forums were conducted to get feedback from those impacted by a value-based benefits design; the benefit design is intended for employers and individual purchasers in an Oregon health exchange. Insurers, agents/brokers, hospitals, providers, employers, consumers, and consumer advocates participated in the forums. **Attachment A (Methodology)** provides a description of the 20 forums that included meetings, small groups, in-person focus groups and online focus groups that were conducted to gather feedback. The key objectives were to 1) find out how these groups would be impacted by a value-based benefits design, 2) how they react to specific features of the design, and 3) overall how they respond to it given their own circumstances. The State of Oregon's value-based benefit design that was presented to the forums is shown in **Attachment B**.

Following are the high-level findings that cut across multiple groups. These are themes that represent the main ideas expressed over and over again. Following this sections are high-level findings for each of the groups.

A note about qualitative research:

Qualitative research represents an excellent forum for the free-flowing interchange of ideas with respondents. The results of focus group discussions can be seen as representative of ideas held by the persons in the communities from which the respondents are drawn. However, the results cannot be projected to an entire population. This is due to the small sample size, non-random recruiting techniques and the unpredictable effects of small group interaction.

Overall

- **Services that are “value-based” and services with low or no cost-sharing are appealing**

The first level of services (value-based, preventive, diagnostic and comfort care) is well received, primarily because they are at no cost or low out-of-pocket cost for the people. Part of the appeal is the belief that access to these services at low cost will prevent chronic conditions from becoming worse. People also appreciate that the first two diagnostic visits are covered in full and that preventive services will detect problems early when they can be easily treated.

- “If I could get help to stop smoking, that would prevent a lot of future issues.”

Despite the enthusiastic response overall, there are some reservations expressed. One is that there is a perceived inequity, because people with chronic disease – often resulting from poor lifestyle choices – actually get better coverage than people who have made different choices and are healthy. Another concern is the added cost as a result of the comprehensive coverage of value-based services, preventive, diagnostic and comfort care services. Some presume that

the comprehensive coverage will **add** cost to the monthly premium, not reduce the premium. Finally, people do not always understand how decisions are made about what services qualify as “value-based.” They have reservations about the placement of some services/conditions on the list and the absence of others.

- **An emphasis on wellness is desired**

The participants in these groups recognize that benefits such as office visits at low or no cost sharing, as well as some of the value-based services such as smoking cessation and immunizations, will prevent illnesses. Some people want to see an even greater emphasis on “wellness.” People (especially employers, brokers and consumers) expect to see services tied to nutrition, exercise, and healthy lifestyles. In addition, they want to see incentives offered for those who are maintaining a healthy lifestyle.

- “Also, does the tier system have any preventive care attributes? Not just screenings either. Healthy people do not go to the hospital/doctor as much. Is there a benefit [for covering the cost of membership to the] YMCA or similar? I know I had an insurance [plan] that encouraged that but don’t see that here.”

- **The levels and tiers are complicated**

In all the groups, there is the belief that all the levels and tiers are complicated and that consumers will struggle to understand and use their tiered benefits. Insurers, agents, hospitals and medical groups think it will take more of their time and additional administrative costs to explain the benefit design and unravel problems that they believe could happen when people do not have a good understanding of it. Insurers say that re-engineering their claims adjudication system to accommodate payments based on both diagnosis and procedure is complicated and that it could take up to a year to accomplish the changes.

- “I would guess that most patients would not know what they have and what is covered.”

Both insurers and agents believe that the level of complexity is one reason that few employers have adopted the value-based insurance products so far that are already available in the marketplace. Employers fear that their employees will be dissatisfied with something that is difficult to understand and that is perceived to have a greater out-of-pocket expense to them.

- “And small groups, unless it was a significant cost reduction, my gut tells me . . . your small groups, your under 20 groups, [would say something like] ‘Man, this is just too confusing.’”

- **Significant education and communication will be required to introduce this benefits design**

Since this benefits design is different in many ways than what most purchasers and consumers are familiar with, participants in all the groups say there is going to be a significant amount of education required.

- “It has to be in a language that [is understandable] – you have different sets of employees. Not all employees let’s say are created equal. Some will understand this whole concept. Some will be at the lower-end of the scale that this concept is going to be a little bit difficult . . . That’s probably the hardest thing to kind of overcome in a general marketplace.”

Employers say they will require significant education themselves to be comfortable enough with it to make a purchase, explain it to their employees, and provide ongoing support as the employees use their benefits and have questions about claims.

- **Lower premiums is a top criteria in selecting a benefit design**

Costs are the ultimate benchmark as these groups consider the value-based benefit design. First and foremost is the monthly premium. Although a few people say they would consider buying the benefit design if the premium were comparable to a traditional plan, many say it would need to be a significant discount such as 10 percent. Some mention discounts even higher such as 20 or 30 percent. Employers say that they would tend to offer this plan side-by-side with a traditional plan.

- “It has to be less expensive or they’re going to balk at that. Twenty percent or better.”

And some think that the premium for a plan design like this could be higher, not lower, due to the comprehensive coverage of chronic diseases and services that have low cost-sharing.

- “I’m not quite grasping where the cost savings (to the Plan) is realized. If the intent is for early treatment, there seems to be quite a loaded up front cost.”

- **The benefit design has some perceived inequities**

There is a perception that this benefit design could “penalize” healthy consumers both by giving them higher out-of-pocket costs, and also by charging them a premium that covers very comprehensive services for the chronically ill. The belief is that people who are basically healthy are more likely to need the services in Tiers 3 and 4 and therefore have higher cost-sharing. Part of the reasoning also stems from the perception that many of the chronic conditions are the result of poor choices in lifestyle – overeating, lack of exercise, smoking, etc. – and are things that healthy people should not have to subsidize.

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Also, some believe that low income people will fare poorly with this benefit design and be unable to afford the Tier 3 and 4 services when necessary. So for low income people, this benefit design would not merely discouraging those services, it would actually block access due to the higher cost.

- **The underlying philosophy has some supporters as well as detractors**

Some of the people believe that this benefit design will help chronic conditions from becoming worse, make it possible for people to get preventive care, and prompt consumers of health care to think more carefully before getting treatments that are not effective. But others think that there is no track record to determine whether a program like this can control costs. Some think there could be unintended consequences – for example, people that cannot access needed medical care because the disincentives and cost-sharing thresholds (deductibles and out-of-pocket maximums) make it cost-prohibitive.

Another opinion people express is that the benefit design is structured in a way that the consumer cannot find out beforehand what their out-of-pocket costs will be. Some of the service tiers are contingent on diagnosis, but diagnosis is not something that the patient knows before a treatment is offered and often it can be difficult to find out. Insurers say that by combining diagnosis and treatment criteria, it would not only be confusing for the member, but it would present the insurer with a complicated set of criteria to incorporate in their claims and reporting systems.

Some of the people that discussed this benefit design argue that if the benefit design were simplified it would not only make things easier for many of the groups impacted, but would actually save money; insurers, brokers, employers, hospitals and medical groups would not have to add the staff in order to handle added complexity.

- “And so to try to avoid [confusion and complexity] sometimes you have to make hard choices about maybe expanding the benefit a bit even if it’s not necessarily consistent with the intent, but for the ease of administration.”

- **People appreciate that the State asked for feedback on this benefit design**

The participants in these discussions express their appreciation for being asked by the State for input. One of the consumer advocates asked if the presentation is available online so more consideration could be given. A hospital participant in the online discussion is thankful for the opportunity to comment but gives a preference for a face-to-face group instead of an online forum. A medical group participant requests more lead time to schedule involvement, and also the possibility of inviting more than one participant from her medical group.

- “I’m glad people are looking into this and coming up with alternatives. Thanks.”

High-Level Findings Table of Contents

In the report that follows, there is a section of high-level findings for each type of group that gave feedback: Insurers, Agents, Hospitals, Medical Groups, Employers, Consumers, and Consumer Advocates. A small sample of verbatim comments is provided throughout the report.

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Insurers

Three small-group interviews were conducted with ODS, Providence, and PacificSource. (Kaiser declined an interview because they believe their delivery model does not lend itself to this benefit design, and Regence was not available for a group interview.) The sessions were 60 minutes in length. Each insurer's interview included four representatives from different areas of the company that could evaluate the impact of a value-based benefits design on the organization. The representatives included areas such as Executive leadership, Operations, Claims and Customer Service, Product Development, Marketing, Benefits/Provider configuration, Actuarial & Underwriting, and Information Technology. These themes represent the highlights of the insurer discussions.

- **Interest in value-based benefit designs in the market has been low so far**

Although ODS and Providence have developed their own value-based products and are just now rolling them out to the employer market, there have been no takers thus far. One comment is that the “jury is still out on value-based plans” due to their complexity. Another interviewee calls it a “tough sell.” A participant remarks that small groups will find it “too confusing.”

- “We have groups that will mention it as something they’d like to look at. We’ve had nobody that’s said, ‘We want to go with it.’ . . . The market’s telling us that they still don’t either get it or don’t appreciate it yet. “

- **Structure tiers by procedure or diagnosis, but together is difficult for insurers to administer**

Insurers say that it is easy to identify a benefit for claims adjudication based on procedure code **or** on diagnosis code. One participant says that paying a benefit on just the service provided is “straightforward and fairly simple to do.” But all insurers say that the two together – procedure and diagnosis – would not be easy to accommodate in their billing/claims payment system. The concern is that a procedure might be covered one way if it is one diagnosis, and the same procedure might be covered a different way if it is a different diagnosis. Another complication they report is that the diagnosis is not always on a claim.

Sometimes the lab and doctor will have different diagnosis codes. Or a situation with primary and secondary diagnosis codes could confound determination of how the benefit applies. Another concern is that health reform regulations could be at odds with a benefit design such as this. It is believed that some procedures (for example thyroid testing) are required under health reform – regardless of the condition. One interviewee envisions that a system like this could even necessitate looking at chart notes to determine how the benefit applies. The bottom line says one interviewee, is that it is simpler for a consumer to understand benefits based on procedures: “If I had this service then this is what I [have covered].”

- “These categories – there’s hundreds of codes behind them. So if you said, ‘Okay, diabetes is covered in full,’ . . . there could be 10,000 codes that have something to do

with diabetes, so does that mean all 10,000 codes are covered in this manner, and if so, then all 10,000 of those codes have to be identified and lumped together?”

- **Administrative impact is significant**

Throughout the insurer conversations, several areas of administrative impact are discussed. The impact is seen from two perspectives: 1) Handling claims adjudication, and 2) communicating with members and doctors about how the benefits will cover any particular situation.

- *Customer service:* One anticipated difficulty is providing customer service to members about how their benefits will cover a particular situation when the member may or may not know their condition/diagnosis. Customer service would need to determine if this is one of the first two office visits, the status of the deductible, etc. It will be necessary to ask more health information of the member and to make more assumptions about coding to give answers. Primary and secondary diagnoses could impact how a benefit is tiered, and the member may not have that information.
- *Automating information:* One comment is that while some of the information can possibly be automated, perhaps some cannot completely be automated. One of the most difficult areas, it is thought, is adjudicating lab tests/procedures that are diagnosis dependent, for example an EKG that might or might not be subject to the deductible depending on the diagnosis recorded by the lab. Another example of complex claims adjudication is a colonoscopy that involves not only surgery but anesthesiology, lab services, and other ancillary services that may or may not have the colonoscopy code. Polyp removal becomes even more complex, and is sometimes not associated with a colonoscopy procedure. One interviewee estimated there are an estimated 16,000 CPT codes, but another says it is more like 8,000. It would take a minimum of 12 months, estimates one interviewee, to adopt a claims adjudication system for the value-based benefit design.
 - “If it can be defined by a procedure code – that these procedure codes are paid at tier 2, and these procedure codes are paid at tier 3, and these procedure codes are paid tier 4 – we can do it, but somebody has to define those procedure codes. That’s the hardest thing that we have.”
- *Diagnostic tests:* It is also discussed that a balance is needed between the level of detail that can be automated and the amount of details that a member can reasonably be expected to track. One of the most difficult areas, it is thought, is tests/procedures that are diagnosis dependent. One problem is that the diagnosis is not always on a lab claim, or it is a general code. But if the diagnosis is known, it could determine how a procedure is covered. For example an EKG might or might not be subject to the deductible depending on the diagnosis provided by the lab.
 - “So that becomes both difficult to administer as well as difficult to explain to a member or a provider in terms of what is it that you’re paying for . . . is it treatment order, is it diagnosis mode?”

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- *Pharmacy:* Medications under value-based services are difficult to adjudicate because the diagnosis is not on the prescription at the pharmacy.
 - The physician would know [the diagnosis] when they're writing the prescription, but they're not putting on the prescription that this is for [a particular] diagnosis. So when they go to the point-of-service pharmacy and get that filled, we would never know to not apply a co-payment, for instance, for a specific service because we wouldn't know what the diagnosis is.
 - *Physician billing:* One interviewee wonders how physicians can possibly collect co-pays at the beginning of a visit given that the diagnosis and treatments will not yet be determined. Also, this benefits design, it is believed, will make it likely that coding errors increase. With this benefit design, the physician that submits a benefit inquiry transaction for a patient to the insurer would also be required to submit more details about the treatment and diagnosis to find out how the procedure will be covered.
 - *Appeals:* Due to misunderstandings, coding errors, and misinformation or lack of information, insurers predict that the number of appeals will increase; it will be "labor intensive" for all involved including the insurers.
 - *Treatment cost navigator:* According to one interviewer, the treatment cost navigators provided by insurers are not often used even though insurers are required by law to provide them to members. Insurers say that the detail required by the value-based benefit design would require significant modification to their cost navigators. And it would require the member to enter significantly more information at the front end – perhaps information they do not have – to find out how the treatment would be covered.
 - *ICD9 conversion:* Current conversion from ICD9 to ICD10 would coincide and confound converting claims adjudication to a condition-based set of criteria. One insurer sees the ICD conversion as a "massive undertaking" that will span the next two years, with an effective date of 2012 or 2013.
- **The tiers are complex and perceived as arbitrary in some cases**

Insurers say that the tier structure could be simplified. Beginning with the first tier level with no deductible, a uniform cost sharing would simplify it instead of some services having no cost sharing and others having low cost sharing. Also the 4 deductible/cost-sharing tiers plus the 3 pharmacy tiers and the 3 diagnosis tiers could be simplified. One interviewee says that it feels like a "lottery" – depending on your diagnosis, you could get great coverage or poor coverage.

 - “. . .I don't think people are incented at that level of a detail – it's too complicated for them to grasp all of that. “

- **The benefit design may be complicated to explain to members**

When insurers visualize explaining the benefit design to members, whether it is on the phone or in an open enrollment meeting or online, they expect added challenges. Some think that a high-

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level overview and examples will only go so far because 1) it would also be necessary to consult a detailed list and 2) people would not know the exact procedure or diagnosis. People, they say, are used to service-based cost sharing and a shift to diagnosis-based benefits would not be easy. Compared to the tiered services, the first level (value-based/no-deductible services) would be easier to communicate.

- “I have this thing wrong with me, then here’s what it costs me versus if I have this other thing wrong with me.”

Some insurers believe that it will be difficult, but necessary, to explain to members that some types of services have been proven to be less efficacious than others and therefore the member will be charged more. But other insurers feel trepidation about explaining to a member why a specific service/condition is in a particular tier.

- “. . . bladder infections – trying to explain to a consumer as to why a bladder infection would have a lower cost share than a compound fracture or broken arm – I don’t know how you explain that.”

Insurers point out that even the term, “life threatening” will require a definition that is understandable to members and also to insurers and providers so that procedures are coded correctly and without an increased administrative burden.

- “. . . the last thing that we want to do is stop every single claim, request chart notes, have an MD or an RN review it, and then tell us how to pay it. That would be complete cost prohibitive.”

One suggestion is that when customer service tells a member that a service is in a high tier, it is important to be able to explain to the member what the lower cost alternatives are.

- “You have additional [cost sharing] if they do this, but if you do this one, they don’t.”

The greatest concern is explaining the benefits is being able to understand the medical nuances, and getting enough information from the member to give reliable information about how benefits will cover each situation.

- “We’re almost going to have to hire nurses to be customer service reps because I don’t know that a standard customer service rep would know the clinical piece of it.”

Insurers comment that historically there is no benchmark from which to predict how well a benefit design like this can be explained. They go on to say that the OEBC benefit design that incorporates value-based elements is only now being introduced to their membership. The website that supports members is available but not yet being used extensively. As one interviewee points out, however, when tiers and variables are brought into benefit plans, history says that members struggle. For example, when a benefit design incorporates two

different out-of-pocket maximums, one for in-network and one for out-of-network, people struggle to understand.

- “[Currently we have the OEBB] shared decision model, but we try to get people to go out and look at the website, and I think they’re really struggling with it right now because they’re just going through open enrollment. . . . I think that somebody’s got to get creative on how to do this communication. And we haven’t been creative enough. We haven’t been able to figure out how to communicate it really well.”

One concern that insurers have (and consumers, too) is that members will not be able to anticipate or know ahead of time how to budget for their healthcare needs. Overall, they say the design is not “intuitive” so the member can understand what their costs are going to be. Until the member is actually diagnosed with a condition, the coverage and out-of-pocket costs are unknown. Insurers also anticipate that members could get caught between their providers’ billing practices and the benefit tiers.

- “Yeah, I think it’s going to be complicated to administer and to administer accurately 100percent of the time because you fall back to the provider’s billing practices, and it is going to be complicated for a layperson who doesn’t understand healthcare to know where their service is going to land. And this is just a small list, but there’s thousands of conditions.”

- **Customers might see the benefit design as a “take-away”**

Insurers say that the benefit design could be seen as a positive insurance plan, but if “it is not done well” there is potential for customers viewing it as a penalty.

- “. . . it looks like ‘you are trying to tell me what to do and give me worse benefits’ for your benefit. But what we’re really saying is, ‘the evidence is that this will be better for you...’”

Insurers caution that backlash could also occur in other ways. Greater numbers of grievances is one possibility. Another possibility is a greater adversarial relationship with between members and insurers. People might think their condition is in the wrong tier and feel their coverage is inadequate.

- “They’ll say, ‘You, the insurance company, are telling the doctor how to treat me.’ And they don’t like that . . . [But we would] say, ‘Well, we’re not saying you can’t get it, we’re just saying that you have to pay 70 percent co-insurance on it.’”

- **Members might not seek needed care**

Insurers say that deductibles are typically very high (the average being between \$1,500 and \$2,500 in the market) and cost-sharing for the member is already “pushed to the limit.”

Ultimately, with the value-based benefit design, people might not seek care when they truly need it.

- “I just worry about that from an incentive perspective, whether or not you end up with...especially as you look at the tier 4 treatments, are there things that people won’t get treated that should get treated because they’re worried about the cost-share?”

- **Premium price is paramount**

According to insurers, the primary appeal of the value-based benefit design is the first-dollar coverage for value-based/no deductible services. If the premium for that package were equivalent or lower than a comparable PPO plan, it would be strongly attractive to some employers. Insurers are curious if an actuarial analysis of this particular value-based benefits design has yet been done. A lower premium is needed to offset the difficulty of the tiered benefits of the design.

On the other hand, the plan could be appealing, one interviewee says, to employers that are struggling to offer any benefit package that offers their employees some coverage without very high deductibles.

- “But for those groups that do have the high deductibles today, this might be an attractive option for them because they could argue that most of their employees aren’t getting a benefit at all because they’re not meeting their deductible.”

Whether the price of the value-based benefit design is 10 or 20 percent less than a comparable plan, insurers say a lower premium is critical to attracting interested employers and individual purchasers.

- “I think employers would think it’s too confusing unless there was a significant rate decrease for offering a product like this. . . . 20 percent”

Some insurers think there could be some adverse selection. People that have chronic conditions could “flock” to the plan. But others say that perhaps the adverse selection will be no different than other value-based products that are now being offered without any expectation for adverse selection.

- **Explore additional opportunities to control cost**

There are additional opportunities in this benefits plan that insurers say could control costs. First and foremost is a provider network. In-network providers are an effective means to negotiate lower costs. Another suggestion is to put differential co-pays or out-of-pocket maximums on each of the tiers. Furthermore, an observation is made that the out-of-pocket maximum is too low, it can inadvertently impact the incentive to avoid Tier 3 and 4 services.. If it is too low and is easily reached, there is no disincentive to avoid the higher tiers, especially if it is

a costly procedure. This dynamic between tiers and out-of-pocket maximum was noted by several interviewees.

- “If that was the first claim of the year, I know that I have 100 percent paid no matter what the rest of the year, so I don’t care if I have tier 4 services done or not. I don’t think it’s the right incentive for the member”

Some insurers question whether a Tier 4 is needed at all. They say that the incentive achieved by an even higher tier (for example 70 percent) has already been achieved at 40 or 50 percent – the belief is that the last tier adds to complexity and does not have the intended effect.

- “I’m guessing that actuarially speaking you’re not adding that much value when you get to 70 percent cost-sharing.”

- **Impact on the doctors is a consideration**

Insurers are wondering how doctors will know what co-pay to charge upfront when the procedure and diagnosis are not yet determined. They also say that the dynamics of the tiers could potentially pit the patients against their doctors.

- “They go into a doctor’s office and they don’t know what’s going on, and so, ‘Okay, well, I just went in because I had a stomachache and I didn’t know I had a bladder infection, so why are you charging me...’”

A word is being used by insurers, “up-coding,” to describe what could happen when doctors become aware of the financial pressures on their patients and decide to code a procedure or diagnosis so that the patient’s cost sharing is minimized.

- **If there is an incentive to get care in an outpatient setting, 5 percent is not a large enough**

Some insurers say that this kind of an incentive (plus 5 percent for outpatient versus minus 5 percent for inpatient hospital services) is easier than the value-based benefits approach for members to understand. And administratively, it is also more straightforward. However, they say that Medical Home adds another dimension – for example, if a service has been managed within a medical home, it should be eligible for lower co-insurance even if it is inpatient. And the definition of “medical home” itself would be important to determining what benefit is received.

- “. . . you could put that on benefit materials to say, ‘Services received at your medical home: \$15, \$20, \$30. Outside of the medical home [is higher]’”

Some people believe that if a doctor makes a referral, whether it is for care in an outpatient or inpatient setting, it should be a lower co-insurance. The emergency room services are also complicated to adjudicate with this rule. A “true emergency” it is assumed, would have the

lower co-insurance. Other qualifiers such as care needed on nights or weekends might impact the co-insurance rule.

- “It would be administratively difficult because . . . we’d have to look at those [emergency room] claims because . . . we’d then be trying to decide whether it was life [threatening] – well, was there was a true emergency or something they could have even gotten at the medical home?”

- **A step-wise approach to treatment and tier benefits is a good approach**

Some insurers believe that for certain costly treatments in Tier 3 or 4, it is important to try less costly alternatives to treatment first. If, after that, the problem is not resolved, the costlier treatment should be covered at a lower Tier with lower cost sharing for the patient. An example that is given several times is back surgery. Back surgery is an extreme, costly solution for back pain. However, participants are saying that if the other treatments for back pain have been tried and failed, and the severe back pain persists then the “right treatment” could be back surgery.

- “There’s some of these value-based benefit things where it’s more of, if you do step one, step two, step three and you still need surgery then it’s going to get covered at a rate similar to a typical plan because you’ve done step one, step two, step three. But if you don’t do those three and you jump straight to step four then you don’t get coverage. So these are more sort of black and white, one way or another.”

- **Other insurer topics**

Following are some of the other topics that emerged from the discussions with insurers.

- *Equity*: The equity of the value-based benefits design is troubling to some insurers. Since some people have very high deductibles, it seems inequitable that by chance a person has a condition or needs a Tier 3 or 4 treatment and must pay out of pocket for a large sum simply due to chance.
- *Dental, vision, and mental health coverage*: Insurers wonder why dental and vision services included in the tiers when typically those services are offered in separate benefits products. Insurers ask whether dental and vision overall will be incorporated together with medical benefits. Mental health is also a category of services that requires clarification on how health reform will approach them – part of a standard benefit plan, or not.
 - “You can’t pull out obsessive compulsive disorder under mental health and say you’re going cover it differently. [Health reform] kind of lumps everything together.”
- *Healthcare reform*: In general, insurers wonder how the provisions of healthcare reform will be incorporated in the value-based benefit design. As an example, the plus-or-

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minus five percent co-insurance design option that was tested could be at odds with healthcare reform.

- *Terminology clarification:* Terms such as “life threatening” and “basic” lab and x-ray will require detailed definitions, both to help members understand their coverage and also to help the insurers when their claims adjudication systems are modified. The term “tier” itself can be confusing. One insurer has abandoned that term and uses the term, “value level,” instead.
- *Oregon Health Plan:* Insurers and others in this research project associate the value-based benefit design with the Oregon Health Plan. People sometimes assume this design is for the low income population. Some perceive the benefit design as “rationing,” and others are concerned about provider access.
 - “The second bullet [Tier 4] point sounds like the above-the-line and the below-the-line for OHP . . . It does. That’s exactly what I was thinking . . .”
- *Questions:* Other questions elicited by the benefit design are:
 - *Comfort care limits:* “Is there any limits on the comfort care then, or is it just pretty broad?”
 - *Network:* “And this is a non-PPO plan, right, because there’s no in and out of network differentials here? . . . You may have a different deductible . . . you’re still trying to manage the costs and you want to focus under the providers [not just] the services.”
 - *Referrals:* “I would hope that we weren’t going to be requiring referrals at this point. We’re not going back to HMO days are we?”
 - *Tier criteria:* “What’s the split between like a severe chronic disease and other chronic disease, between like the tier 1 and tier 2?”

Agents/Brokers

Three interviews were conducted with insurance agents/brokers. One Portland agent services primarily small businesses under 99 employees, another Portland agent services primarily businesses with 100 to 500 employees, and the third interview was with an agent in Bend that services primarily individuals and groups under 99 employees. The interviews were 60 minutes in length.

- **Some employers would consider this design, but employer demand for a value-based benefit design is low so far**

One agent says that some employers with more than 100 employees are would look seriously at the State's value-based benefit design because they are struggling to offer something affordable to their employees. One estimate is that 30 percent of the market would look at a benefit design that is lower cost and includes basic care the way this benefit design does. It is asserted that some employers are not able to offer "full traditional products" but would see this as an alternative. It is anticipated that employers with large union-covered employees would not see this as an option. Another agent says it would not be difficult to sell this benefit design, especially if the premium is 10 percent lower than a comparable plan. The recommended approach is to present it as an option, with advantages and disadvantages.

- "Here's another option. I can do this and then within that plan, if people do things correctly, there's advantages, there's disadvantages.' I think people will be attracted to that, I really do."

On the other hand, brokers (and insurers) acknowledge that several health plans currently offer a value-based benefit design product, and few employers have adopted or incorporated value-based features thus far. They say that while there has been some interest, but no one seems ready to take the plunge. Not all employers and their employees, they say, are ready for the perceived "restrictions" placed by a plan like this. One agent says that employers see the value-based plans as complicated and pose added difficulty explaining it to employees. Because employers see health benefits as a hiring tool and key to employee satisfaction, they are cautious about significant changes.

- "Three or four health plans offer a value-based plan and the take-up is low. There are trade-offs and (employers) are not willing yet."

- **This is a good approach to save costs**

Agents are positive about the potential for the value-based benefit plan to save costs, especially with chronic conditions. They believe that treatment of these conditions with little or no cost sharing will prevent needless emergency room visits. It is also seen as a way to give people more involvement in their healthcare.

- “So we’ve eliminated that cost sharing, get people to do these things on a more regular basis to affect the bigger picture. I think there could be a lot of value there. It would be positive.”

- **Preventive benefits are important, including incentives to gain/maintain health**

Some see the State’s value-based benefits design as emphasizing prevention by treating and controlling chronic conditions and reducing more expensive costs. The deductibles and cost-sharing that is waived for preventive services is very important. But others want to see a more aggressive approach that provides monetary rewards to the member for being in good health and getting preventive services.

- “There’s also no reward for somebody that does things right, tries to be healthy.”

Upfront services for chronic disease and first two diagnostic visits are embraced philosophically as a way to promote health and provide basic coverage. Some say the two visits will adequately cover the healthy individual who may need a visit or two during the year. But not all agents are sure it will reduce costs.

- “I like that it doesn’t ding those moderate, healthy users of the plan. That it maintains very good benefits for those with certain chronic condition. I like that. I think that is all good.”

- **The perceived confusion and complexity for employees is a disadvantage**

Even though agents support the intent of the benefit design, the complexity of it and resulting confusion for employees is a disadvantage. Understanding the tiers and how the out-of-pocket costs will work will be difficult for people using this coverage. Although it has potential to promote “consumerism” it is also going to create confusion. It may force the consumer to “wait and see” what the price will be because it may be difficult to know ahead of time.

- “Is it under the value-based tier? Is it tier 1 - 2, 3 or 4? What am I going in for?’ I think that is going to be very complicated for an employee trying to understand what they need when they need it.”

It is the tiers that are perceived as counter-intuitive to the agents. One agent assumes the tiers are categorized according to chronic, acute or emergency services. Agents question the placement of certain services in tiers, for example: The placement of reproductive services under value-based services; placement of emergency dental care in a medical plan; putting attention deficit disorder in Tier 2; and placing a liver transplant for cancer in the same tier (4) as low back pain. Some are uncomfortable with categorizing treatments into tiers in the case of a serious illness such as cancer.

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- “To explain to someone why their particular cancer treatment is considered not effective and therefore a lower benefit level. That’s a little offensive I would say.”

- **Overall the tiers will be effective in impacting decisions about when to seek care**

Despite the confusion, some agents think the tiers will be a successful approach to influence member’s decisions about getting services for things that have less costly alternatives. Some say the State’s value-based benefit design is actually simpler and more straightforward than others and it “would not be difficult to communicate.”

- “I love this . . . That a patient will see an immediate incentive to consider the not so expensive scans. The CT, MRI, PET scans. We still don’t see this changing much in the market place in my view. Everyone still thinks they need an MRI.”

- **Significant education and communication with consumers will be needed**

Agents see a large education effort to help employees, and even to help employers, understand how to use this benefit. They recommend education that uses a lot of examples. Other recommendations are to provide: 1) A short explanation in “layman’s terms” that lays out the intent and approach; 2) a list of pro’s and con’s that speaks to the positive benefits; and a 3) good definition of the basic terms which consumers often do not know.

- “I think the biggest issue will be here’s tier one, tier two, tier three, tier four, and are very concise. There can’t be shades of grey . . . Some will understand this whole concept. Some will be at the lower-end of the scale that this concept is going to be a little bit difficult. They’re going to go, “Well, why?” That’s probably the hardest thing to kind of overcome in a general marketplace.”

- **It is all about cost**

Whether it is lower out-of-pocket costs or a reduction in premium, it is cost that will drive the employers’ decisions about a benefit design like this. Agents say that employers may or may not accept that the design will lead to a reduction in claims cost. Offering the benefit design at a lower premium is essential, but there could still be employer skepticism that ongoing savings can be achieved.

- “One thing would be the employer would have to see a pretty good premium reason to do this. The premium for the value-based plan should show a pretty significant decrease in the rate compared to a typical plan . . . I would love to see if this plan was 10 percent cheaper than this [comparable traditional] plan here.”

- **Agents/brokers have perceptions of “government involvement”**

One of the agents expressed concern about government involvement, a concern that was also expressed in other groups. This agent presumes that the government will get involved in areas such as underwriting that has traditionally been the business of insurance companies. There is concern that government involvement will mean new regulations that are perhaps not needed.

- “Here you have the state going in and being a provider. Insurance carriers with underwriting, this is their business . . . The regulations and because of those it costs money to go, ‘Hey, you changed things. Now we’ve got to redo this.’ You’ve got to change all of these pamphlets, redo this, and I think that can create cost.”

- **Incentives for outpatient versus inpatient care receive mixed feedback**

There are varying perceptions of the feature to lower co-insurance by 5 percent for outpatient care and raise co-insurance by 5 percent for inpatient care. Some think that there is already an incentive built into benefits designs by requiring higher co-pays for inpatient care. But others say there would not be resistance by consumers to an incentive such as this. One thought is that most services that can be delivered on an outpatient basis are already being done that way. A concern is expressed that “patient safety” could be jeopardized if people focus on the benefit incentive instead of their doctor’s advice, or they delay needed care in order to avoid an emergency room visit. Assuming that there are still procedures that can be done in either setting, the participants say that 5 percent is not a sufficient incentive – it has to be much more.

- “I think a five percent spread is not going to shift that trait of going, ‘I want healthcare now.’ [It should be] let’s say a 10 or a 15 [percent higher].”

- **Agents have additional questions, concerns, and recommendations, many of which reinforce those made by other groups**

Comments were made during the agent discussions that reflect some of the same themes from other groups, especially employers and consumers. These are some of the repeated themes:

- *Pre-authorizations:* One agent suggests that pre-authorizations would be a helpful step because it would alert the member that it is an advanced/less effective treatment that could bring higher out of pocket costs.
- *Rationing:* While the tiered approach may be the best way to encourage evidence-based treatment, it will be seen by the consumer as someone telling them “no” and a denial of coverage.
- *Provider/patient dynamic:* A concern (also voiced in other groups) is that treatment often hinges on a doctor’s best advice even though it is the patient who pays the price when the advice places the treatment in a high tier.

Value-Based Benefits Design Research – Agent/Broker Findings

- *Step-wise treatment:* Some want to know if the tiered design incorporates the stepped approach wherein people follow less costly treatment options first, and if they are not effective they advance to the treatment that is more costly.
- *Terminology and definitions:* One agent says that “diagnostic” is not a term that is normally used in describing coverage. There is confusion about whether the two upfront visits are only diagnostic or whether it applies to any office visit. He says the definition must be clear when the design is communicated.
- *Adverse selection:* Some agents question whether a value-based benefits design should be offered alongside a more traditional plan. They see it as all-or-nothing, and would offer the value-based benefits design as the sole option.
- *Out-of-pocket maximum:* Agents argue that the out-of-pocket maximum should be a level (\$3-5,000) that will not bankrupt people who have a catastrophic event. Members that have a family out-of-pocket maximum that is often three times the subscriber’s maximum, are especially vulnerable to hardship.

Hospitals

An online focus group was conducted with seven representatives of hospitals in Portland, Corvallis, Hillsboro, Eugene, Salem, and Bandon. The forum spanned a three-day period during which participants logged on for 10-15 minute segments to answer questions posed by the moderator and to comment on the answers of other participants. In addition, separate meetings were held in-person with 1) four Legacy representatives and 2) one representative of St. Charles Hospital. The meetings lasted 45-60 minutes. Across all the participants, the hospital areas included Patient Financial Services, Contracting and Business Development, Managed Care Contracting, Business Planning and Analysis, Financial Operations, and Community Development.

- **This benefit design is a more rational approach than traditional insurance plans**

Some hospital participants believe that this approach is on target because: 1) It is based on evidence, 2) it engages the patients in where to get care, 3) it keeps chronic conditions from getting worse, 4) it reduces high dollar expenditures, and 4) it encourages patients to be proactive.

- “We’re managing via claims management right now, but that’s after the exposure has occurred where here we’re talking about coming back to a chronic care condition, maybe identifying it before its chronic. And I know that’s the principle that underlines the whole essential benefit package.”

But others are not convinced that it brings the right approach. One argument is that the benefit design would use cost-share as a tool to influence patient behavior, but it would not influence the “decision maker” which is the doctor. Another view is similar – that it puts all the pressure on the shoulders of the patient, especially in Tiers 3 and 4 where the evidence may not be the strongest. Another participant says this approach does not address payment reform.

- “My biggest concern with this whole thing all along has been that it’s had very much an insurer view of how to deal with it. I mean the insurance companies have an approach of if something’s out of control you increase the cost share or you put in an authorization requirement or something. And it misses, it doesn’t get to the true decision maker in the doctor essentially, how do you get to that, and does this do that? And I don’t think it does.”

- **Preventive care coverage is good for patients**

Hospitals are in favor of good coverage of preventive services; they think this benefit design will remove cost barriers, encourage patients to better utilize their primary care physician, improve compliance with physician recommendations, and reduce inappropriate use of the emergency room. Ultimately, one participant says, there will be better health outcomes when people get health screenings such as mammograms. One participant suggests that IT tools would be

needed to track compliance and remind patients when screenings are due. Some would like to see financial incentives/disincentives for getting recommended preventive exams and screenings.

- “One question I have is whether there are going to be any ‘sticks’ to go along with the ‘carrot’ for those who don’t get their preventive services as recommended. For example, our employer gives us a discount on our health insurance premium for ‘knowing our numbers’ [cholesterol, blood pressure, etc.] and if, after two years, you don’t ‘know your numbers’ your premiums will increase.”

- **There could be an adverse financial impact on hospitals**

Many hospitals anticipate that the high co-insurance in Tiers 3 and 4 might mean that more people will not be able to pay their medical bills. Hospitals, they say, could have more bad debt as they write off the charges. The other financial impact will be the added cost to administer a more complex benefit design. Hospitals express frustration that they cannot control providers that prescribe inappropriate treatments.

- “I feel that many of our patients may be unable to handle the increased financial burden provided by the additional coinsurance. This would likely increase our organization’s bad debt write-offs and impact our patient satisfaction.”

Others do not see any impact, at least not by the first level of benefits for value-based/no-deductible services. Since many of the services are outpatient treatments, some participants say it would have no impact except perhaps to reduce inappropriate use of the emergency room.

- **The conversation between the doctor and patient could change – some think positively and others negatively**

There are those that think that conversations with patients will not be impacted by the value-based benefit design. Overall, most participants think that clinical care will be impacted less than the hospital’s administration. They say that physicians will continue to take care of patient’s medical needs without regard for how much the patient will pay out-of-pocket or how much the provider will be paid. Others think that the physician-patient conversation could improve as patients become more engaged, and patient compliance could improve. The conversation could shift, they believe, towards prevention, wellness, adherence to treatment plan, medications, and compliance.

- “As a facility based provider we would be performing the service based on order or referral. I foresee more conversation regarding the covered criteria and if there is an out-of-pocket expense to the patient.”

But others predict that conversations between physicians and patients could become adversarial, as physicians attempt to choose the best treatment for a particular patient and the patient struggles with the cost sharing implications.

- “So the struggle I’ve had with this all along is that basically what you’re doing is you’re putting the benefit plan between the patient and the doctor; because what’s going to happen is you’re going to have a doctor that says, ‘Yeah the evidence doesn’t necessarily say this is the best way of treating this, but in your case my professional opinion is this is what we need to do.’ And the patient says, ‘Well my health plan doesn’t think so, so I’m going to have to pay more.’ So it really is designed to manage physician behavior and yet the pressure and cost is on the patient. So you’re throwing a wrench between the patient and their doctor.”

- **Medical home is an optimal way to deliver this benefit design**

A frequent comment by hospital participants is that “medical home” model is the best way for patients to get the care at the correct level and to take responsibility for their own health. This benefit design and the medical home model have the same goals: Link the patient to their primary care physician at every opportunity in order to get the best care, at the correct level. One idea suggested by a participant is to use the medical home approach for as many people as possible, but use the value-based benefit design for those people who are not enrolled in a medical home; this would assure that preventive services are used and that care is received at the right treatment level.

- “. . .[suppose that the VBBD] is the approach you take with people who choose not to enroll with a medical home. And if they do choose to follow that path and follow the rules within the medical home, which means you follow the care that’s being managed for you, with you hopefully, then the tiers are moderated or go away . . .”

- **Hospitals do not always agree with how treatments are assigned to tiers**

Similar to other group discussions, hospital participants do not always agree with how treatments and conditions in the examples are assigned to each tier. The term “rationing” is used in conjunction with this benefit design; they say that a particular set of criteria that favors some treatments over others may not apply in every situation. One argument is that while a particular procedure in Tier 3 or 4 might not be appropriate in many cases, it might be the most appropriate procedure for a particular patient.

- “The simple example is if a patient comes in with a broken arm, the doctor will examine and take care of it. Doing so will cost the patient more money yet the treatment was in fact necessary. The rationale for the tiering of services seems arbitrary and I believe will increase administrative expense for everyone.”

- **Hospitals want doctors and patients to have tools to make sure the best treatment at the correct level is being used**

More than any other group, the hospital participants suggest ideas that can help providers deliver the best treatment at the best level. The first one is the step-wise approach that has been discussed by other groups. The goal is to assure that only the most cost effective and evidence-supported treatments are used initially and if they are not effective, the more costly treatment is used next. Another suggestion is to gather and analyze practice patterns in order to incentivize physicians in addition to the tiering approach. One participant recommends that EMR systems now make it possible for doctors to have access to best practices, standards, and tiering information at their fingertips as well as the evidence behind the tiering. Hospitals say that it is unreasonable to expect most doctors to take the time to get familiar with every patient's health insurance, but electronic tools can give them a customized view of options for each patient and the research behind it.

- "If these exchanges become prevalent, there's a motivation for doctors to become more experienced or to use tools that might be provided. We all know that doctors can't keep current on everything."

- **Make the benefit design simpler**

One recommendation is make the design simpler and to look at the Providence PEBB Choice Plan as an example. Some are concerned that patients will need significant coaching to know the list of 20 services, since it would be impossible to memorize it. Providers also cannot be expected to know all the insurance benefits in detail. Another comment is that this benefit design deviates from the OHPR Administrative Simplification work group; this benefit design could generate more administrative costs that could offset any savings in patient care.

- "Someone goes to the doctor and it is asthma. No deductible, no payment. The bill goes to the payer to process it. The patient does not know until after the fact. The provider (cannot be expected to) say, 'You have asthma and you will be required to pay [a certain amount of the charges] . . .' There are too many (insurance) plans for them to know that detail."

- **Education and communication to patients is crucial**

Hospitals think that poor understanding of the tiers by patients and also providers could lead to mix-ups and confusion. They say that many people do not understand the "intricacies" of their benefit structure, and that education will be of supreme importance.

- "We deal in the reimbursement side of things – we're going to get inundated [by complaints that arise when] a physician may go ahead and provide whatever level of service and the patient's not going to understand that this is a tier 4 service."

Value-Based Benefits Design Research – Hospital Findings

During the hospital online group, despite a full explanation of the benefit design, some participants did not understand the tiers as evidenced by one participant's comment that patients need to have their tier clearly identified on their insurance card – incorrectly thinking that members are assigned to tiers.

Regarding education, hospitals wonder whose responsibility it will be to educate the patient on the benefit design and cost tiers. It is believed that it will take more time to explain this design so that patients can have a better understanding of evidence-based medicine. Some say this will impact hospital and provider productivity and others say it will indirectly impact hospitals financially because those who are caught off-guard by being charged a high co-insurance might not pay their bill.

- “. . . I think a lot of it is just making sure that people truly understand and have more incentive besides just the cost side of things to move into something like this.”

- **Administrative impacts are significant**

Not all hospitals agree that the added administrative demands will be significant, but many say it will. The added demand stems mainly from the complexity of the tiers, although some participants believe they can adapt their administrative systems so that it “can be done” successfully. Verifying benefits and patient responsibility is an important function at the front end of hospital service, and that first step would be more difficult, according to some hospital participants. Some think it will require a “whole new coding paradigm.” And another impact could be lower patient satisfaction due to the difficulty of knowing ahead of time what their cost sharing will be.

- “Some meds and labs are covered at no/low co-pays, for certain medical conditions, yet the associated MD office visit may have a higher cost to the patient because it falls into a higher tier. Isn't this adding to billing complexity? Also, a potential patient and provider ‘dissatisfier’?”

Some hospitals say that the benefit design will require more resources for patient registration and for training in the hospital business office. Business office functions such as cash management, reimbursement, systems, billing and the customer care center will all be impacted. Making system updates will require more resources.

- “Collecting the accurate co-pay/coinsurance from the patient at the time of service would be nearly impossible for registration/front desk reps. I don't know if payers will be able to figure it out, it's a mess [as it is] now!”

- **Hospital strategy could focus more on outpatient services**

Many hospitals say their strategy would not be impacted by value-based benefit designs, but three of the participants say that in the future, this would mean incorporating a greater

Value-Based Benefits Design Research – Hospital Findings

emphasis on outpatient services. Hospitals say they support a preventative approach to medicine, and with this benefit design a greater focus would go to those efforts.

- “Certainly if offering these types of benefits improves patient outcomes (mostly in an outpatient and physician office setting) and overall utilization trends for inpatient services decreased across the population of patients, then how and what services are offered would need to be reviewed. It would make sense to devote healthcare resources to areas where they would be most effective and utilized.”

- **A 5 percent reduction in co-insurance for outpatient care might not have the intended effect**

Predictably, most hospitals object to an additional 5 percent for inpatient services, and some say that 5 percent less for outpatient services would not work as intended. The first problem they have with an incentive for outpatient care is that patients often do not understand the difference. Another problem is that even if they do understand, 5 percent is not a sufficient incentive to change decisions or behavior. For those indigent patients who fail to pay their co-insurance for hospital services, a 5 percent incentive is meaningless. One participant maintains that it is a predicament because some services are not effectively delivered outside a hospital, and it seems an unfair penalty to make the patient pay 5 percent more in co-insurance for something that can only be done in a hospital.

- “If the suggestion is to impose a higher coinsurance for, for example, MRIs or surgical procedures done in a hospital setting, vs. these same types of procedures done in a non-hospital based/free-standing setting... this type of design would be unacceptable to most integrated systems and/or hospitals.”

- **Hospitals have questions, concerns, and recommendations and many are similar to those made by other groups**

- *Low demand:* A hospital participant observes that while three or four insurance plans now offer a value-based style of benefit, few employers have selected them so far.
- *Provider incentives:* Give doctors incentives and better information regarding their practice patterns so that the financial impact is not only on the patient but on the doctor as well.
- *Negative impact on health status:* The tiers could create a disincentive on treatment so that needed care is delayed.
- *Beware unintended outcomes:* Provider dissatisfaction could lead to “disengagement from their contractual arrangements.”
- *Remove the highest tier:* The co-insurance rates of 40 or 50 percent at Tier 3 are significant enough to impact patient decisions, without including an even higher one, i.e. a Tier 4.

Value-Based Benefits Design Research – Hospital Findings

- *Consider new forms of reimbursement:* One participant explained that phone outreach by nurses has been shown as effective in managing compliance with Congestive Heart Failure treatment, but currently it is not possible to be reimbursed for those services.
- *Premium increases:* It is assumed that the expanded services with no deductible and low/no cost sharing will result in higher premiums and lower consumer satisfaction.
- *Authorizations and disputes:* Hospitals wonder how authorizations for services will be handled in conjunction with this benefit design, and whether there will be disputes that arise out of requests for exceptions. If payers and providers have a payment dispute, they wonder how it will be resolved and who decides.
- *Other benefit design options:* Hospital participants question why a simpler benefits design is not being considered. Some are aware of the Health Leadership Council design and they wonder why that simpler design was not adopted. Some of the insurance companies' value-based benefit designs are also thought to be simpler.
- *Comfort care importance:* There are several comments about the comfort care benefit. One is that more training for providers is needed in handling comfort care conversations with patients and families. Another comment is that beyond terminal illnesses, there are some serious illnesses, for example severe disorders of children, which warrant services to promote quality of life. Overall, it is applauded that palliative/comfort care is being covered more broadly. One participant thinks it is important to provide a definition so people know the scope of care that is envisioned.
- *Pharmaceutical benefits:* Since the 20 value-based services will have a significant impact on pharmacy benefits, altering the co-pays will shift the dynamics between the pharmacy providers and payers.

Medical Groups

An in-person focus group was held in Portland that drew participants from Portland, Tigard and Vancouver. Eleven (11) different medical groups were represented including primary care, multi-specialty care, and specialties such as anesthesiology, outpatient surgery, pediatric cardiology, newborns, and women’s specialty. The participants included physicians, practice managers, and billing managers.

An online focus group was also conducted with participants from Coos Bay, Hillsboro, Salem, Portland, Bend, Eugene and Seattle (a medical lab). Thirteen (13) different medical groups were represented including primary care, multi-specialty, and specialties such as plastic surgery, radiology, outpatient surgery, lab testing, cancer treatment, home infusion and specialty pharmacy. The participants included physicians, patient advocate, practice management, billing manager, director of managed care, and claims/payment. The group session spanned a three-day period during which participants logged on for 10-15 minute segments to answer questions posed by a moderator and to comment on the answers of other participants.

Note: During the recruit of medical groups (and hospitals) only one person per organization (with two exceptions) were allowed to participate. The goal was to gather information from as many perspectives as possible and also to prevent any single group from dominating the conversation. However, there were groups that wanted to send more than one representative to the session.

- **There will be added administrative impact on the medical groups**

The participants say that patients often expect the medical group’s receptionist and billing office to know the details of the patient’s insurance. The medical group personnel say they are already overwhelmed by the demands on their time, and believe that educating people on their coverage is the rightful role of the insurance company, not the doctor’s office. With a benefit design such as the value-based design, some providers say it would be very difficult to give their patients accurate information about what would be covered at what benefit tier. For example, a single visit could begin as a screening exam, but due to the symptoms and family history it can become something more intensive that requires lab tests and diagnosis of a condition. When it comes to pharmacy, medical groups wonder how an insurance company will know that a particular medication has been prescribed for a particular condition.

- “Also, what happens when patients have multiple issues, some of which are covered under this first- level benefit, and others that are not? It would be best to structure a benefit plan that takes that into consideration as many patients have multiple conditions and they will be looking to the physicians and office staff for answers as to what is covered and what will cost them out of pocket.”

Value-Based Benefits Design Research – Provider Findings

Medical groups also think that their front office staff will not know which co-pay to charge at the beginning of a visit nor how many visits the patient has already had, especially if the patient has received care at other provider offices. Some wonder if co-pays will need to happen retroactively.

- “So how are we supposed to know when a patient walks in the door with a sprained ankle whether it’s a Tier 3 or a Tier 4 co-pay, because we don’t know yet [whether it is] sprained or broken? If it’s broken it’s Tier 3 and if it’s a sprain it’s Tier 4. So how are we supposed to manage that at the front door?”

Participants that represent specialties say that certain unique aspects of treatment require a different approach. For example, cancer care (Tier 2) probably would require large out-of-pocket costs for the patient with this benefit design because diagnostic workups and cancer treatments are so expensive. Another example is pediatric cardiology – patients are referred by their primary pediatrician but the underlying problem could be anything from gas in the ribs to something more critical; the problem is that the diagnosis happens after the expensive diagnostic tests.

On the other hand, some medical groups do not think the conversation with their patients would change significantly if a patient were to have a value-based benefit plan. They say that it is unusual for patients and doctors to have any discussion about cost sharing or financial matters unless the provider is aware the patient is having financial difficulties. Instead, they say, providers focus their conversations on medical necessity, not their patient’s insurance coverage.

- **Medical groups do not always understand how medical services will align with the structure of benefit tiers**

There are those participants who see the value-based list and the tiers as a “sterile structure” and wonder how ongoing care will be handled that might not neatly fit the evidence-based categories. Some are concerned about childhood chronic illnesses such as ear infections that can sometimes be agony for the child and could result in possible hearing loss if not treated. The access issue is one of affordability balanced against the “child’s best interest.”

- “There are always categories of patients that kind of fall out of the guidelines or sometimes they’re left up to the judgment of the physician so it could put a lot of burden on . . . the clinic [to explain to the patient] why you [are prescribing a] treatment that may not be on that high value list in a particular circumstance. I know geriatrics is a common example . . .”

Others wonder who determines if a medication is effective. They say there are always exceptions when something that is not ordinarily effective is indeed effective for a particular patient. Some are concerned about the authority that a central body such as the Health

Services Commission would have; they are also worried about timely updates, since evidence and research is constantly changing.

Some say that the two-visit benefit (without deductible and low/no cost sharing) seems inadequate in certain circumstances. One situation is newborn care and newborn illnesses, when more frequent visits during the first year are to be expected. Case management is another example when more than two visits are typical. Primary care and specialty care in mental health are normally more than two visits. And finally, there are some evidence-based care guidelines that recommend more than two visits as part of the protocol.

- “So if you’re doing evidence-based care, some of the guidelines for treating these actually tell you to see them more than twice a year. ...if you were going by the evidence and the accepted guidelines, the times a year could adjust for them, I guess, per the disease.”

- **There will be a potential for patient dissatisfaction due to charges in high tiers**

The medical groups are anticipating some dissatisfaction among patients, and also among themselves if patients direct their “disenchantment” towards their providers. It is the benefit design restrictions that providers think will be most troublesome for patients because currently patients see access to care as a right. Medical groups suspect that authorizations and exceptions could be burdensome, and that patients will get angry when they are surprised to learn that a procedure will be a high tier with high cost-sharing.

- “I foresee that we will be spending more time explaining why the service that they need/want is not included in the first level of benefits. Some things that are clearly indicated and cost effective for a patient may not be included in the list of freebies. This will create some confusion and may cause these services to not be accepted. Some of the included services may not be clinically indicated and we will be explaining to patients why they don’t need it.”

- **An administrative impact on medical group is anticipated**

There are some medical groups that do not anticipate difficulty administering the benefit design as long as the program is “clearly defined.”

- “The difference on the provider side would be the ability to collect or charge for co-insurance, co-pay and deductible at the time of service. The provider would need to know what benefit plan is driving the patient care and collect and or bill patient responsibility accordingly. This can be done especially with electronic look up that most insurers currently support.”

However, most of the participants think that this benefit design would mean administration changes, sometimes significant, for their medical group. Many of the medical group participants

expect it would be necessary to add staff to handle a benefit design like this, particularly additional time for educating the patient. When patients are surprised by their tier and cost-sharing, some say they might balk at paying their bill. Medical groups have difficulty envisioning the kind of software at the State level or insurance company level that would be needed to code the benefits and track services, for example the two diagnostic visits.

- “We would attempt to educate the patient on their possible cost sharing amount at the time of the visit but really won’t be able to do any collection at the time of service due to the complexity of this design and they typical patient’s needs.”

Some participants like the design because it helps people afford preventive care or because the tiering could be a good strategy to change patient behavior. But they say those advantages could be outweighed by the cost added to providers and the cost overall to the system and members.

- “I do like the desire to create more access for customers. It is rather complex operationally and would increase provider operating costs, thus increasing cost of care. We’d have to staff up, probably incorporate new pre-visit procedures etc.”

- **An impact on reimbursement is expected**

Medical groups say this benefits design could effectively reduce their reimbursement level in two ways: 1) Less upfront fees collected and 2) more people unable to pay their deductibles and co-insurance bill. Some even say they could not participate in a benefit design like this and that it could “put us out of business.”

- “Patients look to physicians and office staff to understand and explain what is covered, or what is not. We’ll be dealing with very upset patients if they’re surprised by an out-of-pocket expense when they did not expect one. We will have difficulty collecting payment when that happens.”

- **The value-based/no-deductible services will encourage patients to get care**

Although participants think there would be significant administrative changes required by this benefit design, they do not foresee the same degree of influence on clinical practices. Some think that the benefit design would even have a positive impact. For example, medical groups are enthusiastic about the first level of care because they think that patients would be more likely to get the care they need, and that communication with the patient would be enhanced. By covering chronic conditions, it is believed that doctors and their patients would get good control over the illness to prevent it from worsening. Some also believe that it would improve compliance and perhaps diagnosis. One participant says that for the services that are no-deductible/no or low cost-sharing, it would reduce collection costs and make the patient’s upfront interaction with reception staff go more smoothly. Another participant states that to

make the upfront benefits easy to administer it must be very clear when a patient comes in for their service (lab work, for example) that there is no out-of-pocket cost to the patient.

- “Willingness among the population to seek out services will likely rise. And if so, a marked increase in our ability to communicate with patients about healthy lifestyle choices, care management options and the like. Currently, some patients are quite reluctant to seek care because of high co-pays and deductibles.”

Under this benefit design, comfort care is an area that can make a real difference for patients according to some medical groups. They say that with the cost barriers gone, patients (especially cancer patients), will be much more likely to get the care they need, when they need it. However, they also say that it is important to clearly define what is included in comfort care. One participant is worried that when families and patients decide to stop further treatment, then all medications would stop. Another participant wonders if primary care clinics are expected to provide this “specialized focus” of comfort care; if so, she says extensive training would be needed.

- “Again, individual patients need to maintain the option of potentially expensive treatments as a component of comfort care.”

Medical groups say that mental health is another area could be better for patients by being within the value-based benefits coverage. One participant says that primary care doctors often see patients with multiple medical and mental health issues under the existing mental health “carve-out” benefit coverage; with this new benefit design, it could be easier to manage if the doctor can use a mental health diagnosis and address those problems along with the patient’s other issues.

- **An emphasis on education and prevention would help prevent chronic conditions from happening**

Several participants say that treatment of chronic conditions such as obesity, mental illness, and substance abuse should be coupled with strong prevention services that would also be covered in full. One says that “patient activation occurs too far down the health continuum.” They would like to see a stronger education component in this benefit design. And one participant is even concerned that the richer the chronic disease benefit, the less inclined people will be to get involved in their personal health maintenance.

- “The US misses the mark in early and ongoing intervention and education throughout our population’s early growth and development. We are a nation that promotes low personal energy expenditure (lack of exercise), famously high fat and sugar consumption (fast food), and low personal accountability for the resultant health impact. Once in a sad state of health, we have a notion that we can walk in to any healthcare provider and get a quick fix for all that ails.”

Another need for patient education, some say, is to understand the benefits themselves. Health benefits are a “muddy” area for many people, according to one participant. As benefit costs have become more expensive and cost sharing for the member is increasing, people are not always getting more familiar with their coverage. One participant envisions that it would be a shock to some patients when they go to a specialist for treatment and are confronted with Tier 4’s 70 percent co-insurance .

- “Until medical services are required, very few people understand their coverage and most expect it to pay more than it does. Benefit coverage has decreased and cost has increased.”

- **Physicians focus on medical care, not health insurance benefits and will need some new tools to make this work**

Medical groups say physicians cannot be expected to know the intricacies of this benefit design on top of all the other hundreds of designs that their patients may have. That puts the provider at a disadvantage to have conversations with patients about what things will cost.

- “And I think the physicians truly don’t have – at least in my practice – don’t have a high understanding of insurance and what’s covered and not covered and they truly don’t know offhand who’s covered by what.”

Some of the participants envision that their group’s physicians/providers will do what they always have done – deliver the “most cost effective” medicine they can in each situation without regard for insurance benefits. Others see medical groups having perhaps a greater focus on prevention.

- “I would think we would put more time into making sure all our patients have preventive care appointments. Currently it is very hard to know who has and has not that type of care.”

A prediction made by several participants is that those physicians/providers that do have a greater understanding of the benefit design would “up-code” their diagnoses so that their patients have a more favorable cost-sharing arrangement. Up-coding by doctors might happen, participants say, so that doctors can ease the financial burden on their patient or even to ease the burden on a clinic that does not have to collect a co-pay.

- “Unfortunately, there may be some ‘diagnosis shift’ from less reimbursed conditions (URI) to higher reimbursed conditions (Sinusitis). This shift will be asked for by patients, and providers will likely be willing to do this because of the decreased hassles and not needing to bill the co-pay to patients.”

Several suggestions are made to help providers navigate a benefit design like this and to help patients find out what their cost sharing will be:

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- A triage nurse,
- Case management services,
- An educational service that patients could call,
- An online tool for office staff to use to estimate a patient's out of pocket costs.

Participants say that for both patients and providers, tools are needed to explain the overall benefit design and to give determination of what will be covered and the cost sharing for the patient.

- **Medical home is top-of-mind for many medical groups as they evaluate this benefit design**

Medical home is one of the most frequent areas of discussion during the medical group sessions. Although some see a medical home model as more expensive in the short run, they believe there will be much better health outcomes in the long run. Some believe comprehensive case management that is part of a medical home model can achieve some of the same things that the value-based benefits design is attempting to do: 1) Better compliance, 2) get the right care at the right place in the medical system, 3) avoid duplication of services, and 4) ultimately reduced health care costs.

- “This relates to the improved primary care model where a patient chooses a Medical Home and is then welcomed and introduced to the care team at that Medical Home office. This involves a process called ‘on-boarding’ into a physician practice with an initial visit, orientation, patient activation agreement, full exam, treatment plan development, and scheduled next visits or referrals.”

- **Medical groups are skeptical of the benefit design with a 5 percent drop in co-insurance for outpatient care and 5 percent increase for inpatient care**

Although these participants represent medical groups that deliver mostly outpatient types of care, only one participant says the 5 percent incentive would change patient behavior as intended. The others say it could have many unintended consequences such as penalizing people with cancer for getting specialty treatments that are only available in a hospital due to safety for all concerned. Also, patients could be penalized because typically they have no control over the setting for treatment. Furthermore, they say, an incentive like this could sway a doctor to treat a patient in a primary care home to save money when the hospital was truly the best choice. And finally, the patient themselves could make a wrong decision if there was, for example, chest pain and the patient decided to avoid the ER to save on cost. An alternative approach suggested is to have a place for patients to call and find out whether the facility is the right decision given the circumstances. With this approach, when people do make the right choice, there would be no penalty or disincentive for those decisions.

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- “There has to be some way of triaging those people. They’re not going to be able to make the decision. Somebody has to kind of make it for them. Even if they know they’re going to save the money, I don’t know that they will necessarily make the correct decision.”

- **There are other problems with financing healthcare**

There are some medical groups that do not believe that the value-based benefits design will address the fundamental shortcomings of payment for medical care as it exists now. One participant says that an insurance-run healthcare system is a for-profit model that is not suited to paying for needs that are basic to our population. Another says that this benefit design simply covers the least expensive care and shifts the most costly care to the patient. It is thought by another participant that a change in the provider reimbursement model should be incorporated in this benefits design so that doctors are rewarded for effective use of resources. Finally, some are worried that people will delay or forego needed care under a value-based benefits design in order to save costs.

- “As economists will point out, healthcare lacks ‘moral hazard.’ It is viewed by most as an entitlement. Entitled to be made healthy at no cost. I’m not sure how to fix this. It is very personal and very dependent upon a certain willingness to be accountable for the care consumed. Does a no-cost front-end accomplish this if necessary care on the back end is not also fully paid for?”

- **In some cases, medical group strategy might change**

Some medical groups do not foresee any change in their organizational strategy if this benefit design were to become common. But other groups do envision ways that it might impact their strategy such as placing a greater emphasis on educating their patients on the value-based/no-deductible services. One participant says their medical group’s work could actually become easier, although in the long run it might mean that there would be fewer patients overall. And another participant says that by increasing their overhead for education and billing, it could shift their focus to higher margin services instead of higher value services as intended. However, one participant claims that if pay-for-performance were part of the design, it would not necessarily shift their focus to high margin services.

Employers

Feedback on the value-based benefit design was collected during several employer forums. The first session was a focus group in Portland of employers sized 100-500 employees that included eight representatives from a variety of industries including manufacturing, law firms, education, restaurants, healthcare, and car insurance/travel services firms. That session was followed by another Portland focus group of public employers that included eight representatives from state, county and city government as well as one school district. A focus group in Medford of employers sized 25-100 was held that included eight representatives of companies in industries including retail, manufacturing, healthcare, transportation, real estate development, a car dealership, and a retirement community. Additionally, an online focus group of employers ranging in size from 25 to 250 employees had nine representatives that were from these cities: Joseph, Independence, Portland, Klamath Falls, Eugene, Bend, and Salem. They represent industries including construction, real estate, agriculture, restaurants, manufacturing, non-profit services, and banking. Among all the employer groups, the participants are primarily HR or benefits directors/managers, but also their titles included a controller, office manager, employee benefit specialist, bookkeeper, deputy administrator, CFO, Safety Director, payroll specialist, and director of business and support services.

- **The value-based/no-deductible services will be good for employees**

Employers recognize that the upfront value-based/low-cost sharing services will mean healthier employees, and less out-of-pocket costs. The employers that have minimum wage workers say that the two visits per year without co-pay would be helpful to their employees. Several comments acknowledge that employees with chronic conditions such as mental health issues or diabetes will now be able to afford treatment of their condition. Also, several comment that the coverage provides an incentive to get preventive care and to treat conditions before they become severe.

- “I think the positive is that the initial visit is at no cost, therefore employees would be willing to go to the doctor earlier in their sicknesses before they got to the point of needing further care.”

One participant believes that this benefit design would result in lower utilization that would help to keep premiums low, and as a result, minimize the share of premium that employees must pay.

- “As an employer, having lower utilization of the health plan does help keep competitive rates available to the group plan. In our case, this helps keep the cost such that we can cover all of the premiums for our employee’s health insurance. Under our current plan structure, if utilization/rates increase, we may have to have our employees share some of the cost of the insurance premiums.”

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Several employers support the idea that people who would use this benefit design would consider the cost sharing impact before they get treatment and perhaps change their decision about treatment.

- “So it seems like what the thinking here is that typically people will want whatever the doctor will suggest that they do. It doesn’t matter what the cost is. ‘I’m sick; I’ll take it all; give it to me, give it to me.’ And here it’s being set up in such a way that it requires people to think a little bit about what treatments I’m going to take and not just necessarily take anything that the doctor will throw at me.”

Not all the employers believe that two visits with no deductible are sufficient, especially for families with young children.

- “You get two a year, but if you’ve got a 2-year-old you could use those two in the first two weeks . . . You’ve got a young family with three kids and they’re all under age 10 you’re going to be beyond that in the first couple of months you’ve got your plan.”

- **Perceived inequity is a concern regarding coverage of chronic conditions**

While most employers support the comprehensive coverage for chronic conditions to keep illnesses from getting worse, there is an impression that the benefit design means that healthy people “pay more.” They say there is an element of unfairness when those who lead a “cleaner, healthier life style” are getting a lower benefit value, while those that have chronic conditions due to lifestyle choices such as smoking and diet are getting a higher benefit.

- “I have an employee who is having these treatments right now, it is expensive. This employee put herself in the bind by not taking care of herself. There needs to be a careful balance so the people who are putting themselves in these situations don’t feel they are just going to be ‘bailed out’. The people doing the bailing out are going to be the ones who don’t need these services but are going to pay higher premiums.”

- **Prevention of illnesses is a high priority for employers**

Employers associate “value based” with wellness and offering wellness programs to keep employees healthy at a lower cost. Some are concerned that many of the value-based services are chronic conditions due to “lifestyle choice” and they want their benefits program to have an impact on that as well. Employers are focused above all else on controlling costs and many believe that a focus on prevention is a good way to control costs. They support the features of this benefit design such as the two upfront doctor visits without deductible/cost sharing, but they want an even greater emphasis on education and prevention. And some believe that incentives should be offered to people that do follow healthy practices.

- “The part that seems missing, at least at this preliminary start, is what’s being done to control the cost? And not just how often people use it, but what are the physicians

charging for the cost? How is it way more transparent? . . . There's not a lot of preventive from education and teaching so that people don't end up with diabetes. . . . but can't we start when they're young and prevent it instead of, 'Here, let's throw some medication at it.'"

- **Education is important to help employees understand**

While the challenges of educating people about a benefit design like this are significant, one participant maintains it will be worth it in the long run.

- "I'm thinking this should have been done 50 years ago and it would just be second nature to everybody now, so there's a huge learning curve."

Employers do not think it will be easy for employees to understand their out of pocket expenses with this benefit design. One participant asserts that even with less complicated benefit designs, employees are "overwhelmed" trying to understand them. Another participant adds that it would be simpler to let the doctors make decisions about treatment, "instead of the insurance company."

- ". . . I think trying to explain these tiers to the employees would be a nightmare. We have very good coverage right now and our employees have choices, but I can tell you that they do not want to have to look at tiers."

One participant thinks it is important for employees to understand not only the tiers but the foundation of value-based benefit designs – medical evidence and the intention to lower cost behind this benefit design.

- "I think it would be really important to be able to message to the users of the service the kind of the science behind it since it's such a new way of looking at insurance. People aren't used to having things parsed out that way."

Another concern is that people will not have the information they need when they need it. Often the point at which employees need to know their options and cost sharing is when they are at the physician's office. They fear the responsibility of explaining the benefits will be on the provider's office.

- "I think it'll put the burden on doctors to explain how the plan works as opposed to the administrators."

- **Some employers misunderstand the concept of tiers or think that their employees could have difficulty comprehending it**

There are comments during the discussion that suggest even some employers are not able to understand how the tiers work, despite the detailed explanation just given. One participant

assumes that the coverage was limited only to the 20 value-based services. Another assumes that only two exams are covered. Some employers are concerned that their employees will misunderstand; for example the employee might think that approval or authorization is needed for procedures such as an MRI, instead of knowing they should consult their benefits coverage and talk to their physician about whether it is needed or there are other options. Some employers had difficulty understanding how the tiers would work.

- “I have another question. If someone went with the Tier 1 and they’re 21 years old, when would they have the opportunity to change to another plan? When they got married and had kids and upgrade to Tier 3?”

- **Communication of the benefit design is the biggest challenge**

In thinking about communicating this benefit design, employers say they will need significant education themselves in order to do the communications. But one participant perceives that greater consumer involvement would be a “welcome change.” Another states that communication is not merely something that will happen at open enrollment, but throughout the year as employees use coverage and receive their bills. An added comment is that despite an emphasis on education about health benefits, people often do not retain information about their insurance benefits.

- “The tier plan will be very different to our group and will cause confusion for some. More area for questions. More time will be required to explain initially and more time during the work week will go to helping employees with questions. Not a problem but a concern.”

These are some of the employers’ suggestions for communication methods:

- Open enrollment meetings for both employee and spouse as well as Intranet material with lots of examples to explain why cost sharing will be higher for some diagnoses and procedures
- Lots of scenarios showing how the plan works
- Hand-outs and a verbal presentation, because take-home packets will not be sufficient
- A one-page spreadsheet or flyer listing the tiers
- Wallet cards
- Website with FAQs, articles, explanation of the design
- Internet tool to enter diagnosis or treatment and find out tier coverage
- Nurse hotline or advice nurse to call about benefit detail and options
- Newsletter
- Broker and insurance carrier presentations at staff meetings
- Individual sit-down with employees by administrators of the insurance

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Employers say that their staff will require substantial training in this benefit design in order to handle communications. They maintain that the first level of coverage (value-based/no or low cost sharing) is the simplest component to communicate, but they say the tiers are going to be challenging. They believe that providing a good explanation and answering employee questions to reduce the confusion, is going to be a big responsibility.

- “Administration of a tier plan will involve training for benefits manager to completely understand what procedures are covered under which tier level so they can provide answers on coverage questions. Employees will be confused at first and will delay setting appointments until they understand their out of pocket costs. I see my phone and email stacked with questions. If clearly written materials are provided to each employee to look up what tier each prescription or procedure falls under that may reduce the questions and confusion.”

A participant says communication must be a team effort that involves all the players involved so that it does not fall only upon the employer.

- “If this is where it’s going then I think that it’s just going to take a lot of communication, not just by employers offering these plans but by the government or by whoever is running the exchanges. I think it’s got to be a joint effort between insurance companies, medical providers, employers...to get people’s mindset almost flipped around really in some of the cases of how to utilize healthcare and healthcare insurance.”

- **There could be special considerations for employers that have unions, employees in other states, and employees that do not speak English well**

Some employers say they would face added challenges by offering a value-based benefit plan. Employers with segments of their employees in unions must negotiate any changes to the benefit design with the union; employers say that significant changes to union benefits are usually resisted. Employers with employees in multiple states find that educating their out-of-state employees/families is particularly difficult because they cannot hold in-person open enrollment meetings and they cannot offer direct HR assistance. There are some employers who assume that the benefit design will not be available in other states. One participant says a significant change in benefits such as this benefit design is something their company would approach very slowly. Employers with non-English speaking employees say it would be a challenge to communicate benefit designs to them, especially something as complex as the value-based benefit plan.

- “There’s a lot of complexity of the plan so from an administrative standpoint, explaining it and particularly, as she said, in my case we have multiple languages and union, non-union, multiple states and so forth.”

- **Greater administrative resources could be required to help employees understand the tiers and coverage**

In addition to the training needed that was explained earlier, employers think they will spend more time researching coverage levels on behalf of employees and finding out if something is on the value-based services list. In addition to that, they think they will spend more time on following up claims, addressing misunderstandings, and generally assisting employees to use this benefit design.

- “Since I handle all the questions that come in regarding health insurance, I see a potential for a lot of questions from our employees. While this plan makes sense to me since I deal with insurance on a daily basis, I think it would be confusing to the consumer to understand what their costs are going to be. I think there would also be some perception that some employees are ‘getting better coverage’ than others.”

- **Employers do not always agree with how treatments are assigned to tiers**

When employers look at the tiers’ examples, they disagree with the placement of certain conditions/treatments in the tiers and also on the value-based services list. One employer suggests putting all the things that people think of as emergencies in the same tier. Some employers (and employees) think that if a doctor recommends a treatment, it should be covered – at a low tier. The placement of liver surgery for cancer in Tier 4 is often questioned – not just in the employer groups but the other groups as well. Some employers are concerned that by placing expensive treatments in the highest tier, they will be out of reach financially for most employees. One participant wants to know who makes decisions about what “value” is since it will have an impact on the “entire overall health” of our state or nation.

- “I’d much rather pay for x-rays and basic labs knowing that those costs are fairly low and I can afford to pay those, but when you start getting into CTs, MRIs, PET scans I need more help. Those are not inexpensive. They’re not ordered very often, but it doesn’t take more than two of those to break you.”

- **Some employers think the value-based benefit design should be offered together with a traditional plan**

Several employers say it makes most sense to offer this benefit design to employees as a dual choice with a traditional PPO plan or even an HMO plan. But also there is a concern that offering both could threaten the ability to offer the traditional plan; one participant says that if people were to start switching from the self-insured plan to this benefit design, the costs for the self-insured plan would go up. Another employer says this benefits plan is a “tough sell” and unlikely to be offered at all by his company.

- “I guess I’m sitting there thinking would I offer it with an HMO or a PPO? What does this plan offer? What makes this plan unique from any other plan? . . . There are so many plans out there that offer this same exact thing. There’s nothing that stands out differently. . .”

- **Employers wonder whether the benefit design will appeal to young and healthy people, or people with chronic and serious illnesses**

Some employers think the benefit design will appeal strongly to employees with chronic conditions and serious illnesses because under this benefit design their care is covered without any cost sharing. Other employers think it is the employees who rarely see a doctor who will gain the most because their once or twice-yearly visits to the doctor will be covered in full. One participant maintains that the new generation of healthcare consumer is better educated and better able to understand a benefit design like this – they take advantage of the Internet and do their own research before making healthcare decisions. But others disagree, saying that young and healthy people often disregard their health benefits.

- “I know we have a big over-50 group on our company and they use a lot of that stuff. My employees that are 30 and under, they couldn’t care less about any of this stuff.”

- **Employees could see it as a benefit reduction**

Some employers think their employees would object to this benefit design – it was called a “political nightmare” by one participant. They are concerned that employees will have greater out-of-pocket costs for routine services and will not view it as a true benefit. In fact one employer said that since employees of the company are mostly minimum wage, there are some who got their job solely to get the health benefits. Health benefits are also seen as a recruiting tool for professionals such as attorneys, and employers want to offer a benefit that is appealing to the prospective employee.

- “To me, my employees would think that this is just taking something more away and the firm is making more money on healthcare because it’s lowering the cost. Because we pay 100 percent for our employees and I think that they would just think that this is just one more thing that’s going away – that we’re now going to this lower cost to help corporations make more money.”

But not all employers agree. In the end, some employers argue, employees will see the new benefit design as adding to, not taking away, from their health insurance benefits.

- “With the different tiers and percentages offered, it would give employees a little more control in their decision making for health benefits while promoting a team/community atmosphere.”

- **Ultimately, it all comes down to cost**

Employers want to know if the premium for a value-based benefit design will be lower than a comparable traditional plan. Some say they would expect 20-30 percent less than a traditional plan, and some say perhaps as low as 10 percent or break even. One employer says the differential in premium would have to be as much as 50 percent lower. Escalating premiums are the biggest worry. In Portland and throughout the state employers say they are still paying 100 percent of their employees' premiums, and they say they are able to do so only by increasing the deductible from year to year.

- “Many of our employees are in the over 40 group who have more medical expenses and I see this plan benefiting them; however, it will also come at a cost at not only to the company but to the employees as we would have to pass some of the cost on to them.”

Employers say that a benefit design like this, if it were less expensive than a traditional plan, would appeal to those companies that currently cannot afford to offer any kind of coverage to their employees. Some employers that do offer coverage today are struggling to continue due to the increase in costs.

- “I think the plan sounds really good for companies that at this particular time offer no benefits to their employees. My mother-in-law runs a small business and she doesn't offer the health insurance. They have to kind of get everything on their own. I can see this would be a way for somebody to have something at least to get coverage.”

Some employers believe that the value-based/low cost sharing services might add cost, not decrease it. Since premium rates have risen steadily and steeply, employers are questioning whether this benefit design will keep cost increases low. Some of the participants approve of the intent behind the benefit design but they say it is just “theory” and it is unproven that it can lower cost.

- “I'm not quite grasping where the cost savings (to the Plan) is realized. If the intent is for early treatment, there seems to be quite a loaded up front cost.”

- **Employers question whether a benefit design with a 5 percent drop in co-insurance for outpatient care and 5 percent increase for inpatient care, will achieve its goals**

Some employers are not in favor of a disincentive for inpatient care. For one thing, they say, some admissions to the ER are necessary so there should be no “penalty” in those cases. Also they say there are procedures that can only be done in a hospital and again, a penalty is not fair and it could be an added stress for their employees during illness. For services needed at night or on weekends, it is not always possible to get outpatient care in a doctor's office – they say the night/weekend care should not be penalized. Another consideration is that people are making their treatment decisions often during medical emergency situations and an incentive such as plus or minus 5 percent is not top-of-mind. Some employers say that 5 percent is not

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enough of an incentive or disincentive, but rather 15 or 20 percent is more likely to change behavior.

- “Or the kids are hurt. Then it’s just, ‘Get me to where I need to go.’ So all of this little in and out things, I think that it’ll be lost on [our] population. I think that might be too complicated.”

On the other hand, there are employers that see the 5 percent incentive as a way to increase the patient’s responsibility for making decisions about treatment settings and sharing the cost.

- “I think that the individual should bear some of the responsibility in cost if they are choosing to go to an emergency room when they could wait and see their doctor. I also think that they should bear more of the cost if they are having in-patient hospital care as the cost to the plan is more than when they see a primary care physician.”
- **Employers have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**
 - There is concern that this benefit design is not in compliance with the new federal regulations.
 - Employers have a perception that insurance companies are driven by profit,
 - Some are skeptical of “government involvement”, especially if it is to determine “value” of medical services.
 - It is recommended that this benefit design be offered with high out-of-pocket maximums so that when patients consider treatments in the high tiers they are cognizant of the cost sharing impact.
 - There is a fear that providers could “game” the system by coding treatments so that the cost sharing is lowered for the patient, while the employer loses the potential savings.
 - This benefit design does not address many of the most costly aspects of the healthcare system such as 1) the difficulty patients have in knowing ahead of time how much a procedure will cost, and 2) a convoluted billing system that has a patient receiving bills from different sources such as clinics, labs, anesthesiologists, etc., all for a single procedure.
 - A suggestion is made to allow professional associations to offer the value-based benefit design to their member employers.

Some find it difficult to evaluate a benefits design like this without knowing the impact of federal reform. Employers are hearing rumors about government-subsidized plans, fines for not signing up for coverage, and other potential scenarios that make it difficult to place this design in the broader context.

Consumers

Feedback on the value-based benefit design was collected during several consumer forums. The first session was a focus group in Portland of eight consumers – six work for companies with 100 to 500 employees and include a caregiver, customer service clerk, mechanic, phone tech support, mortgage loan officer, and stock order clerk. One consumer purchases health insurance individually, and the other is uninsured (both reported no occupation). That session was followed by a focus group in Bend of eight consumers – six work for companies with 2 to 98 employees and include a teacher’s assistant, operations supervisor, customer service representative, accounting firm owner, office manager, and bank branch manager. One consumer purchases health insurance individually and is the owner of a retail shop. The other is a landscaper and is uninsured. A Pendleton focus group of eight consumers included six employees of companies ranging from 2 to 44 employees and included a president of a manufacturing company, manager of manufacturing, owner/chemist of a water-testing company, auto technician, and funeral director. One consumer is the owner of auto repair shop and purchases coverage individually. The other is uninsured and a real estate broker. Additionally, an online focus group of 13 consumers was conducted that included five employees of companies with 100 to 500 employees; they gave their occupations as customer service rep, behavioral researcher, government policy analyst, teacher, and government clerk. Also five online participants said they purchase their insurance individually and reported their occupation as retiree, student, office manager, office assistant, and someone unemployed. Another three participants in the online consumer group were uninsured and included a home caregiver, real estate salesman, and an unemployed individual.

- **With this benefit design, consumers think more people could get coverage and at a lower cost**

Consumers are very enthusiastic about the benefit design’s low-cost care for chronic conditions and the ability to get the ongoing care needed. One consumer uses the example of diabetes test strips which can be expensive, but which make a big difference in treating the condition successfully. With this benefit design, some consumers believe that people will get care earlier for illnesses and prevent more serious conditions. And some think it could save money.

- “You learn when you really need to go to the doctor’s office. There are some more important services that we need taken care of my family but we just don’t have the money for it. If this insurance policy were to cover just the major things it would help a lot of families like mine.”

The consumers who are currently uninsured are very eager about this benefit design. Those that currently have rich benefits are less inclined to choose it for themselves, but see it as a good option for those with chronic conditions or difficulty affording coverage.

- “Because I feel I have really good healthcare benefits thru my employer I don’t believe I would be tempted to make any kind of switch. But I do think this new plan has a lot of potential to save money for the state and its subscribers.”

- **Under this design, people will think about medical evidence and give more thought to what level of care is needed first**

Several consumers comment that this benefit design will prompt the members to “think twice” about visiting the doctor for things that could wait or may not be necessary. The impact of the tiers on reducing out-of-pocket expenses could be significant. Comments are that the benefit design tiers “makes sense,” and one participant even says that the tiers are “brilliant.”

- “I think I would spend more time looking up stuff to see where I’m going to be in the tier. Right now I’ll go to the doctor if I think I have to, maybe for a chest cold or something like that. Maybe they’ll give me antibiotics, maybe they won’t. Where the other one I’ll be able to look and see what tier that’s going to be in, whether I’m going to have out-of-pocket.”

- **Consumers wonder if both out-of-pocket costs and premiums will be higher or lower**

Some consumers do not understand how overall costs would be lower given that the value-based services such as those for chronic illnesses could actually cost the insurance company more. Some of them question whether a benefit design like this will encourage people to be healthy. And others look at the difficulty of making decisions about what is “important” and “effective” which they doubt can be put into practice.

- “I’m not totally clear on the numbers. It’s not like the people with rare diseases are kind of subsidizing the people with the chronic diseases. Do you know what I’m saying?”

Some are confused about how it will impact their employer coverage. They wonder if the premiums will go up or down with this benefit design.

Consumers struggle to understand how they would balance the out-of-pocket cost in this benefit design against a possible savings in premium or perhaps even a higher premium.

- “Yeah, I think there are a lot of variables here that would be hard for a layman to know. You’d have to be an actuary or whatever. It sounds interesting. It also sounds, because of the significant savings with the fairly common illness of diabetes, it sounds like it would be more expensive.”

- **There is a perception that people who are healthy will pay more for their healthcare than those who have chronic conditions – often caused by unhealthy lifestyles**

Many participants wonder if the incentives are unfairly causing healthy people to pay more than those who are unhealthy, frequently by their own lifestyle choices. One participant predicts that a subsidy like this could “backfire in the long run” and another calls it “punishment for

being in good health.” But another consumer thinks that ultimately it could help get costs under control.

- “If I understand this if you are healthy you pay more and if you have a long-term illness (more expensive) you pay less? That doesn’t seem right.”

- **The levels and tiers are complicated**

Many comments address the complexity of the design and difficulty understanding it. One participant says it is so complicated that people will need a book called, “Benefit Packages for Dummies.” Another participant says she is thankful that her insurance agent has been indispensable in helping her understand her insurance – the agent comes to her home so that her questions and concerns can be addressed.

- “I believe our whole insurance system is way too complicated and even the [insurance] companies themselves cannot give you a straight answer when you ask in advance and the answer never matches the outcome. This Tier program is far too complicated to be able to figure out where you stand.”

People are worried that when a procedure is done, initially they might think it will be reimbursed as a low tier but then find out it is actually a high tier and high cost sharing. Some are confused about the difference between this benefit design and a traditional plan.

- “This plan would need to **clearly** outline which services are covered under each of the tiers. I’d hate to have a procedure done that I thought was covered under [Tier 1] only to find out I now have to pay \$3,000 out-of-pocket.”

The tiers themselves are not perceived as self-explanatory for these participants. One participant asked if the member picks just one tier. Another participant believes that lower tier medical problems would cost the member more out-of-pocket. People are uneasy that they would not understand the cost sharing and then find out they have prohibitive medical bills to pay.

- “You can look and hope that preventative care is going to prevent these things but there are things that hit you out of the ordinary and people go bankrupt for all the time.”

One participant is very comfortable with the tiers and finds the details easier to understand.

- “It is a lot simpler to understand this benefit plan than the one’s that insurance providers bury in their long booklets. Maybe I’m distracted by Tier 1 and two... Most of my problems fall into these categories. Free and low cost really attract my attention. It seems like that each tier is outlined well. A couple of free visit a year would really help get me in to see the doctor.”

Researcher's Note: In the course of explaining the value-based benefit design during the consumer focus groups, the participants began to lose interest during the explanation of tiers. Possibly the benefit design explanation was too lengthy, or possibly the tiers are a very challenging concept for consumers to understand. Either way, this benefit design perhaps exceeds the existing knowledge-base of consumers and/or the attention span regarding health benefits.

- **Consumers are uneasy about being hit with unexpected costs in high tiers**

Several participants say it is going to be difficult to make decisions about treatment if finding out which tier is contingent on having a diagnosis. Some wonder if the doctor's receptionist will explain which tier applies. One participant says that maybe the best option is to simply refuse treatment if a procedure or condition falls in Tier 4.

- “. . . how I can find out exactly what tier it is before I actually go to the doctor because I don't want to end up spending like \$3,000 that I don't want to spend if I didn't have to.”

- **Consumers do not always agree with how treatments are assigned to tiers**

In general, it is difficult for consumers to come to terms with the list of examples for each tier. In some cases, consumers say the list of conditions/procedures for a particular tier do not seem to “go together.”

- “The list seems odd to me. I would find it odd that ADD is plugged in with breast cancer. That seems to be odd to me . . . And head injuries and third-degree burns are all in level one but then where's a broken bone or other urgent care?”

A common example is “liver transplant for cancer.” Most people do not know that with a condition like cancer, a liver transplant is not successful in halting or slowing the disease.

- “Your statements make sense. [But] would a liver transplant really be in the same tier as acne or chronic sinus? That does not make sense.”

There is also confusion about diagnostic visits and prevention visits and how they would be covered.

- “[It says,] ‘Basic diagnostic test at two times a year.’ Okay, diagnostic meaning you actually have something you go in for because you said you needed x-rays and lab tests? So what about... Where does the preventative care fall into that?”

- **People want to know who is making the decisions**

It is not always easy for consumers to understand decisions about what is, and what is not, important. Knowing how, and who, makes the decision is crucial to consumers' acceptance of a tiered benefit design. People believe there will be exceptions and unique circumstances and they wonder how the decision would be made in those cases. One participant says that an evidence-based approach can only go so far, because there are areas of medicine that are not thoroughly tested.

- "I guess my question would be – you're looking for less important services – in certain particular situations that could be the more important option for somebody. For those people they are going to have to pay double because those things are actually written in there. That would be my concern."

- **Wellness and prevention is a high priority, and some think there should be financial incentives for maintaining good health**

Coverage for services that help people get healthy and stay healthy is highly prized by consumers. They recognize that the benefit design incorporates preventive services through low cost sharing for check-ups and basic labs. Most of them applaud the value-based services such as smoking cessation that address unhealthy choices. Even the services for chronic conditions, they say, can prevent a bad condition from becoming worse. However, the consumers want to see more education and financial incentives for people to follow behaviors that will maintain good health.

- "I also feel there should be more encouragement for people to live well, eat properly, stop smoking, exercise and [use] less drugs so freely handed out that have side effects that many aren't aware of or do not understand."

One participant recommends including services to promote exercise and good sleeping habits covered in value-based or Tier 1 benefits.

- **Tools for consumers to navigate the tiers and benefit design could be helpful**

Consumers make numerous suggestions to have tools that would help them understand the benefit design and use it properly when needed. Many of the suggestions are similar to those proposed by Employers.

- Website with symptoms and tiers
- Advice nurse to help determine the tier
- Video or CD
- Chart
- Handbook
- Outline

Value-Based Benefits Design Research – Consumer Findings

- 1-800 number & personal contact
- Booklet
- Insurance agent & personal contact

One innovative suggestion is a website that combines symptom look-up as the first step and tier look-up as the second step. Several people say they want a direct contact with a person on the phone with whom to discuss their own circumstances.

- “I’d want someone on the other end of the phone that I could run my own situation through.”

- **Consumers are uneasy about being able to anticipate their out-of-pocket costs**

One of the concerns for consumers about this design is that they would not be able to anticipate their out-of-pocket costs, either overall for the upcoming year or in any particular situation. That makes it difficult for them to decide if this benefit design is cost effective. One participant expresses concern that the cost of services in the higher tiers will “negate” the savings achieved for value-added and preventive services. Those participants that are buying coverage for a family are particularly cost conscious, and also are very uncertain how the cost would pencil out.

- “It is great on the lower tiers. It depends a lot on the cost of the insurance also. If I had one, with say, \$1,000 out-of-pocket, I would prefer that over the Tier 3 and 4 options, but it would probably cost much more.”

- **An incentive of plus-or-minus 5 percent for outpatient versus inpatient care is seen as effective by some and ineffective by others**

Some consumers think that a 5 percent incentive to get outpatient treatment could save money and prompt the consumer to reconsider getting inpatient services.

- “So what you’re saying is like surgical centers instead of a hospital? There’s nothing wrong with that. The hospitals are one of the biggest problems . . . That’s where you pick up a lot of infections and become worse.”

But others think that if a hospital-based treatment has been prescribed by a physician, the patient should not be penalized. They are concerned that outpatient services may not be an option during nights and weekends. Furthermore some people find it hard to believe that anyone would willingly be admitted to a hospital if it could be avoided. They also believe there could be other extenuating circumstances when inpatient care is the most responsible and humane setting.

- “It sounds good. What happens if the doctor says, ‘Hey you need to go to the hospital for this?’ Would the doctor send you to the hospital without automatically cancelling out the increasing payment for going to the hospital or would it just still be there?”

Finally, there are some consumers that say 5 percent is not enough of an incentive in situations when it is an emergency or the doctor is recommending hospital care.

- “I’m not going to say, ‘I’m going to save myself \$5 by going to the doctor versus the hospital.’ I’m not going to get brain surgery in the doctor’s office.”
- **Consumers have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**
 - *Access:* Access to doctors is a concern – that not all doctors would be “on the plan” or that patient loads will be higher due to more chronic disease treatment and that it will be difficult to make an appointment. In Pendleton, consumers discuss the shortage of physicians in “rural America” and a concern that with the boomers aging there will be an even greater shortage.
 - *Delay in treatment:* If the cost sharing for treatment is unpredictable, some people will delay getting the care they need.
 - *Chronic benefit most:* Chronic people will gain the most from this benefit design.
 - *Healthy benefit most:* Healthy people will find this benefit design most appealing.
 - *Productivity:* An unintended outcome of the tiers is that working people, who delay care and are in pain or need of medications, will lower productivity. Teachers and parents are particularly vulnerable.
 - *Medications:* People are confused about how reimbursement for medications is determined--as part of the value-based services (no cost sharing), Tiers 1 to 4 (medical tier cost sharing), or as part of the pharmacy tiers.
 - *Dental and vision:* Consumers do not understand whether just selected dental and vision procedures are covered by the benefit design (diabetes eye exam, emergency dental care, etc.), or broader dental and vision procedures are part of the benefit design.
 - *Inflation of medical costs:* People are resigned to ever increasing premiums and cost sharing, regardless of this benefit design.
 - *Government’s role:* Some people are wary of “government involvement” and are not familiar with the Oregon Health Authority.
 - *Insurance company:* While some people think it is more logical for an insurance company to administer this benefit design than a government agency, there are those that are highly suspicious of the motivations of the insurance industry.
 - *The doctor’s role:* Certain participants say it is best for insurance companies to defer to doctors’ judgment and “let the doctor do his/her job.”
 - *Families/children:* There is concern that with children accidents and illnesses are to be expected – sprains, broken bones, ear infections, etc. – and that this benefit design will not provide adequate coverage.
 - *Phone services:* One participant recommends that since many services can be done over the phone, it would be more cost effective to cover those services in the benefit design.

Consumer Advocates

A group discussion was conducted at a regular meeting of “Health Allies,” in the Portland area. The Health Allies are an affiliation of organizations that advocate on behalf of healthcare consumers. A total of 19 individuals attended that were interested in giving feedback; they represent organizations such as the Oregon Health Action Campaign, Oregon State Public Interest Research Group (OSPIRG), Healthcare for All, Archimedes Movement, Metropolitan Alliance for the Common Good, and others.

- **The use of evidence in setting benefit coverage levels promising**

There are advocates that welcome the focus on evidence in determining what services are “value-based” and which tier other services fall into. One participant thinks the benefit design’s approach could influence consumers to consider prevention and long-term outcomes, just as long as the assignment of treatments to tiers includes criteria that weigh the impact of early intervention on future health.

- “I think evidence-based is the best thing about this, and the tiers I like because I think if it’s essential benefit it ought to be in tier 1. . . . [but it is important that things that are in tier 1 meet a criteria of] ‘if I intervene now and do this, later on – in other words it’s not going to be a great big thing right now but if I intervene now I prevent long term problems.’”

- **A preventive/holistic approach is valuable together with incentives for healthy behavior**

Several of the participants want to see a benefits design that is focused less on disease treatment and more on a holistic approach to educate consumers so that illnesses can be prevented and unhealthy lifestyles can be changed. One concern is that there is a disincentive for using some medical services, but no incentive to get advice that directs consumer to other options. Conversely, as one participant states, there should be incentives to seek advice early. One suggestion is to use a “negative premium” or a credit of some kind when people follow preventive guidelines. Also, education is seen as an effective way to approach prevention, and should be strongly emphasized in this benefit design.

- “. . . on the surface I totally agree with the incentives. My concern is that it’s very narrowly focused on how health plans operate today, which is all about the medical stuff. And . . . what we’ve also been talking about is encouraging people to use preventive services, to use other supportive things around the medical piece.”

- **Consumers could be confused about their cost sharing**

There are several comments that consumers might not be able to find out, before treatment, what the cost-sharing will be for something such as an ear infection. They think people will not

understand whether their cost sharing is determined by the diagnosis, or by the treatment choices they have.

- “I guess it strikes me at this point that these kind of plans will be very complex and it will be very difficult for people to figure out what they’re getting. So there’s either going to have to be a lot of assistance or you’re going to have people choosing kind of blindly, it seems to me.”

- **Consumers would need direct assistance and advice**

Advocates ask that this benefit design be accompanied with an Advice Line that assists consumers in understanding how their condition/treatment will be covered and how it will impact their cost sharing. One participant says it is not reasonable to assume people will be able to navigate the tiers and get the kind of information needed to prepare for their treatment decisions.

- “But to me the difference between having a kid who’s got like a runny nose and green snot is really different than what do I do with a kid who’s screaming and can’t sleep at night. And they both might be an ear infection and using this approach I have a disincentive to get my child checked. But I would like to have also an incentive [for talking to] somebody who could help me [answer the question], ‘Should I take them in, should I not take them in?’”

Other concerns are that without assistance from a reliable source of advice, people will find themselves trying to self-diagnose their symptoms. Another concern is that people will not get the care they need because they assume their co-pay will be too high.

- **Advocates perceive a need to address exceptions and give physicians discretion, for example the ability to use a step-wise approach**

Consumer advocates express unease with a benefit design that treats all consumers the same in terms of treatment and cost sharing. They are concerned that some of the nuances will be lost that can make a big difference to an individual’s particular situation. They say that physicians need flexibility to decide what will work best for the patient. One example given is an anti-depressant medication that may not be effective for *most* people, but for *certain people* it might work when no other treatments or medications have so far been successful. Another example is a hysterectomy that might be a procedure of convenience for some women, but for other women it could also be a necessary treatment for cancer.

- “. . . but ideally you’d have to allow physicians to say, ‘This is a case where we’ve pursued the low cost option and it doesn’t work for this person but another option does.’ There will be times for example when that prescription drug that’s brand name is the only antidepressant for example that’s going to work for that person. If it’s the only thing that’s going to work, let’s do that but let’s make sure we’ve tried everything else first.

Several advocates suggest that a step-wise approach be used that requires that less-expensive treatments be prescribed first to establish if they are effective, and only if they are not effective are the more-expensive treatments prescribed even if they are more questionable treatments based on evidence. With this approach, the consumer is getting treatment at a favorable cost-sharing level because the most cost-effective treatments have been prescribed first.

An advocate suggests that physicians should be audited for their practice styles and treatment prescriptions; if their treatments are outside the guidelines, that they could be routinely sanctioned or disincentives used.

- “. . . you need to give the physicians enough flexibility to do some of the things that are an exception to what’s the [benefit] package or level one and still call it ‘Level one.’ And then you could audit and see if he’s been using that over time on particular kinds of things. And then if he is, you don’t let them do that anymore or you do something like that. You need to not micromanage using this piece and I don’t know how you’d do that.”

- **Subpopulations of our society have different needs for medical coverage and prevention**

An advocate makes the case that an across-the-board approach to evidence-based medicine will miss important differences for certain segments of the population. The example of lower back pain is given as a condition that has different consequences for a white-collar, middle class consumer versus a farm worker or domestic worker that must bend and lift repetitiously throughout the day, every day. The impact of treatments across all segments of the population is not necessarily the same; for example when back pain is treated, the impact on farm laborers or domestics would be different when considering productivity, wage earning, and suffering.

- “It feels like it’s an attempt to try to improve an existing system rather than be transformative with its approach. And it also continues with what I consider health disparities. . . . it had lower back pain as being something that’s not being paid for, so tier 4. And yet, if you’re in a community working in agriculture, working in the hotel industry, working in the building trades, [then] lower back pain can be indicative of something really major that’s coming down.”

- **Advocates want to know who is making the decisions and the criteria being used**

A comment several advocates make is that it is going to be difficult to set up criteria that can correctly guide decisions about coverage level and cost-sharing. People want to know who determines what is effective and they want to know whether good evidence really exists for all the types of medical care. A concern expressed by one advocate is that when allopathic doctors look at evidence, their focus will not include treatments that are more holistic and preventative.

- “So who determines what’s effective and what do you do about things that are neither proven effective or certain procedures that are either proven not effective, there’s just no data on it.”

Some advocates say that the benefit design overall has inequities because it covers some things comprehensively while others require significant consumer cost-sharing, simply because the patient has by chance contracted a particular illness.

- “You’re [thinking], ‘I wish I had diabetes instead of this low back pain.’ [Laughter]. That’s what it feels like.”

- **An essential benefit package should be part of the benefit design**

Several participants say a benefit design such as this one should be built upon a set of “essential benefits” that are assured to the population regardless of the insurance company or the benefit plan. One advocate recommends that the essential benefit package identified by the Oregon Health Fund Board should be assured and affordable for all Oregonians regardless of whether it is offered by the Exchange or whether it is a particular benefit design. The trouble with this benefit design, some say, is that by incorporating tiers of very high cost-sharing, the consumer is de facto lacking access to those benefits.

- “And I think that perhaps the cart before the horse is the essential benefits package – we should have a determination on that and then figure out how do we pay for and how do we structure this. If you were to come to me and say, ‘. . . you’re covered, you’re insured, but you have a \$3,000 deductible and some things you’d have to pay 50 percent for,’ I am more concerned with what am I covered for . . .when the typical person hears they’re ‘covered’ they equate that with somehow that’s going to get paid for. And I just think that we have to just say kind of as a society, these are the essential things that people are going to get covered for.”

- **Dental, vision and mental health benefits at a low cost are wanted**

People are unsure whether dental, vision, and mental health services are included in the benefit design or whether it is limited to certain treatments and diagnoses. Since some specific dental, vision and mental health services do appear on the lists, some assume that more comprehensive coverage will be available. Also, some are unsure whether it is only the primary care physician who must provide the dental, vision and mental health services that are included. There are advocates that believe comprehensive services for dental, vision and mental health are “essential” and should be covered with little cost sharing.

- “It should speak to mental health, dental and vision for the entire population, because those are part of what I would hope would be part of the essential benefits package.”

- **Out-of-pocket cost and premium are the ultimate benchmarks**

Advocates say that high deductibles and high cost sharing of 50 percent or 70 percent co-insurance in the higher tiers could prevent the benefit design from offering truly affordable coverage. As an example, one participant compares a deductible of \$3,000 to one of \$10,000 regarding the impact it would have on the individual that has sinus surgery. The end result is that the combination of deductible, co-insurance, out-of-pocket maximums, and tiers in this benefit design will determine whether it offers affordable “benefits” to middle income and lower income individuals.

- “But if you’ve got a really high deductible plan, people who are poor are not going to be able to pay for those things. So you may not actually get as much. This will work well for middle-class people maybe, but not necessarily lower income people in terms of getting them to get early care as opposed to later care.”

Similarly, they say, the monthly insurance premium will also determine how affordable and how effective this benefit design will be in insuring people.

- “It’s very hard for me to generalize because it seems to me like a huge amount of this is going to depend on that premium question, well the premium question and the deductible question.”

- **Some advocates want to see other disparities in healthcare addressed**

Some consumer advocates are frustrated that a benefit design being put forward for the Oregon statewide health exchange does little to address some of the significant gaps and inequalities in the healthcare system. They give examples including 1) affordable coverage to low income people, 2) adequate coverage for people with children, 3) incentives for physicians to first try low cost or preventive treatments before more-expensive procedures, 4) rewards for people who live healthy lifestyles, 5) education for the overall population about healthy living, 6) coverage for those who by chance have medical conditions that are not easily treated, and 7) other examples given throughout the discussion.

- **Advocates have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**

- *Physician phone calls/emails:* One advocate says that sometimes a phone call or E-mail to/from a physician is the most cost-effective way to treat a condition, for example diabetes education. Often insurance plans do not cover anything but an in-person visit.
- *Comfort care:* Another says that the consultations that physicians and palliative care specialists have with patients and their families are a critical component of comfort care so that the right medications and treatments are chosen for the particular situation. But insurance plans often do not cover these consultations.

Value-Based Benefits Design Research – Attachments

- *Help people understand:* A comment is made that communications about a benefit design like this must be tailored to the specific needs of each sub-population. Examples or materials that communicate well to African Americans, for example, may not be as meaningful in other communities. Communications that work in Burns or other rural areas, might not resonate in metropolitan communities. The realities of care and even the prevalent illnesses, are not consistent across the whole State, which has implications for communication.
- *Federal health reform:* People are wondering how this benefit design will link up with federal reform. If federal reform includes a basic benefit package, the advocates are asking how the Oregon benefit design will conform to it.

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Attachment A

The focus of this research project was to explore the feasibility of implementing a value-based benefit design (as envisioned by the HSC/OHFB benefits group) and gauge consumer interest in such plans, as well as gather insights into the best way to present the concept of value-based design to employers and other consumers. Through a contract with Portland State University, Foley Research Inc. managed all qualitative components of the study. Multiple qualitative methods were used including individual interviews, small-group discussions, a large-group discussion, traditional in-person focus groups, and online focus groups. Across all the sessions, a total of 141 individuals provided feedback. All except one of the sessions were recorded and transcribed. In each session, the researcher presented a description of the benefit design using PowerPoint slides, and asked questions to probe the opinions, feelings, views and observations of the participants.

Following is a description of each session.

Insurers

1. *ODS Companies*: A 70-minute meeting with 4 representatives of ODS, held at their Portland offices. Interviewer: Carol Foley. Date: September 15, 2010.
2. *Providence Health Plan*: A 60-minute meeting with 4 representatives of Providence, held at their Beaverton offices. Interviewer: Carol Foley. Date: September 20, 2010.
3. *PacificSource*: A 60-minute meeting with 4 representatives of PacificSource, held at their Eugene offices. Interviewer: Carol Foley. Date: October 4, 2010.

Agent/Brokers

4. *Kurt Brunswick*: A 45-minute meeting, held at the offices of Compensation Systems NW in Portland. Interviewer: Carol Foley. Date: September 16, 2010.
5. *April Coiteux*: A 45-minute meeting, held at the offices of Beecher Carlson in Portland. Interviewer: Carol Foley. Date: September 24, 2010
6. *Patrick O'Keefe*: A 55-minute meeting, held at the offices of Cascade Insurance Center in Bend. Interviewer: Carol Foley. Date: October 6, 2010.

Hospitals

Participants for the online session were recruited by Market Decisions Inc. (MDC) and Carol Foley. Carol Foley scheduled the meetings with St. Charles Hospital and the Legacy Hospital system. Across all the participants, the hospital areas included Patient Financial Services, Contracting and Business Development, Managed Care Contracting, Business Planning and Analysis, Financial Operations, and Community Development.

7. *Online focus group (bulletin board)* using the QualBoard platform (hosted by 20/20 Research) was held over a 3-day period from September 29 to October 1, 2010. Seven (7) representatives of hospitals in Portland, Corvallis, Hillsboro, Eugene, Salem, and Bandon, participated. [Note:

Value-Based Benefits Design Research – Attachment A (Methodology)

All the online sessions for this project followed the same format, spanning a 3-day period during which participants logged on for 10-15 minute segments to preview the explanation of the Value-Based Benefit Design, answer questions posed by the moderator and to comment on the answers of other participants.] The session was moderated by Carol Foley.

8. *St. Charles Hospital*: A 60-minute meeting with a representatives of St. Charles Hospital, held at their Bend offices. Interviewer: Carol Foley. Date: October 7, 2010.
9. *Legacy Hospital system*: A 50-minute meeting with 4 representatives of Legacy Hospital system, held at their Portland offices. Interviewer: Carol Foley. Date: October 18, 2010.

Medical Groups

Participants for the in-person focus group and the online session were recruited by MDC and Cynthia Kane (Kane Health Care Consulting).

10. *In-person focus group*, moderated by Carol Foley, was held at the VuPoint focus group facility in Portland on September 23, 2010. Twelve (12) representatives from medical groups in Portland, Tigard and Vancouver, participated. The medical groups that were represented including primary care, multi-specialty care, and specialties such as anesthesiology, outpatient surgery, pediatric cardiology, newborns, and women's specialty. The participants included physicians, practice managers, and billing managers.
11. *Online focus group (bulletin board)* using the QualBoard platform (hosted by 20/20 Research) was moderated by Carol Foley, and held over a 3-day period from September 27 to 29, 2010. Medical group participants from Coos Bay, Hillsboro, Salem, Portland, Bend, Eugene and Seattle (a laboratory), participated. Thirteen (13) different medical groups were represented including primary care, multi-specialty, and specialties such as plastic surgery, radiology, outpatient surgery, lab testing, cancer treatment, home infusion and specialty pharmacy. The participants included physicians, patient advocate, practice management, billing manager, director of managed care, and claims/payment.

Employers

Participants for the employer in-person focus groups and online bulletin board were recruited by MDC. Among all the employer groups, the participants were primarily HR or Benefits directors/managers, but also their titles include controller, office manager, employee benefit specialist, bookkeeper, deputy administrator, CFO, Safety Director, payroll, and director of business and support services.

12. *In-person focus group*, moderated by Carol Foley, was held at the VuPoint focus group facility in Portland on September 21, 2010, in a 90-minute session. Eight (8) representatives participated from employers sized 100-500 employees in the Portland metropolitan area in a variety of industries including manufacturing, law firm, education, restaurant, healthcare, and car insurance/travel services firms.
13. *In-person focus group*, moderated by Carol Foley, was held at the VuPoint focus group facility in Portland on September 22, 2010, in a 90-minute session. Eight (8) representatives participated

Value-Based Benefits Design Research – Attachment A (Methodology)

from public employers in the Portland metropolitan area including representatives of state, county and city government as well as a school district.

14. *In-person focus group*, moderated by Carol Foley, was held at the Rogue Regence Inn & Suites in Medford on October 5, 2010, in a 90-minute session. Eight (8) representatives participated from employers sized 25-100 employees in the Medford area in a variety of industries including retail, manufacturing, healthcare, transportation, real estate development, a car dealership, and a retirement community.
15. *Online focus group (bulletin board)* using the QualBoard platform (hosted by 20/20 Research) was moderated by Nancy Hardwick (Hardwick Research), and held over a 3-day period from September 29 to October 1, 2010. Nine (9) representatives from employers sized 25-250 were from these cities: Joseph, Independence, Portland, Klamath Falls, Eugene, Bend, and Salem. They represented industries including construction, real estate, agriculture, restaurants, manufacturing, non-profit services, and banking.

Consumers

Participants for the consumer in-person focus groups and online bulletin board were recruited by MDC.

16. *In-person focus group*, moderated by Carol Foley, was held at VuPoint focus group facility in Portland on September 23, 2010, in a 90-minute session. Eight (8) consumers included 6 that work for companies with 100 to 500 employees and include a caregiver, customer service clerk, mechanic, phone tech support, mortgage loan officer, and stock order clerk. One consumer purchases health insurance individually, and the other is uninsured (both reported no occupation).
17. *In-person focus group*, moderated by Carol Foley, was held at the Riverhouse Hotel and Convention Center in Bend on October 6, 2010, in a 90-minute session. Eight (8) consumers that participated include 6 that work for companies with 2 to 98 employees and include a teacher's assistant, operations supervisor, customer service representative, accounting firm owner, office manager, and bank branch manager. One consumer purchases health insurance individually and is the owner of a retail shop. The other is a landscaper and is uninsured.
18. *In-person focus group*, moderated by Carol Foley, was held at the Red Lion Hotel in Pendleton on October 7, 2010 in a 90-minute session. Eight (8) consumers that participated include 6 employees of companies ranging from 2 to 44 employees and represented by a president of a manufacturing company, manager of manufacturing, owner/chemist of a water-testing company, auto technician, and funeral director. One consumer is the owner of auto repair shop and purchases coverage individually. The other is uninsured and a real estate broker.
19. *Online focus group (bulletin board)* using the QualBoard platform (hosted by 20/20 Research) was moderated by Nancy Hardwick (Hardwick Research), and held over a 3-day period from October 4 to 6, 2010. Thirteen (13) consumers live in Oregon City, Redmond, Gresham, Medford, Eugene, Salem, Keizer, Springfield, Harrisburg, Bend, Pendleton, and Adams. They included 5 employees of companies with 100 to 500 employees; they gave their occupations as customer service rep, behavioral researcher, government policy analyst, teacher, and government clerk. Also 5 online participants said they purchase their insurance individually and

Value-Based Benefits Design Research – Attachment A (Methodology)

reported their occupation as retiree, student, office manager, office assistant, and someone unemployed. Another 3 participants in the online consumer group were uninsured and included a home caregiver, real estate salesman, and an unemployed individual.

Consumer Advocates

20. *A group discussion* was conducted at a regular meeting of “Health Allies,” in the Portland area on October 19, 2010. The consumer advocate session was facilitated by Carol Foley, for 70 minutes. The Health Allies are an affiliation of organizations that advocate on behalf of healthcare consumers. A total of 19 individuals attended that were interested in giving feedback; they represent organizations such as the Oregon Health Action Campaign, Oregon State Public Interest Research Group (OSPIRG), Healthcare for All, Archimedes Movement, Metropolitan Alliance for the Common Good, and others.

Attachment B

Following are Powerpoint slides for the presentation that accompanied all the qualitative sessions. There are a few slides that were unique to either the 1) insurer/hospital/medical group sessions; or 2) the Employer/Consumer sessions. Those are noted.



Health and Value – A new way to look at insurance benefits

September 2010

1



Insurers/Hospitals/Medical Groups:



Value-Based Benefit Design

- Incentives (or disincentives) in a benefit plan
- Use health services of higher value
- Becoming more popular in the industry:
 - Health Leadership Council
 - OEBC's higher co-pays for sleep studies/waiving co-pays for diabetes medicines

2



Employers/Consumers:

OREGON HEALTH AUTHORITY

Value-based benefit design

Goals

- Encourage people to use health services of higher value
 - Diabetes care
 - Smoking cessation
 - Blood pressure medications
- Discourage less effective/less important services to keep costs low for everyone

2

Oregon Health Authority

Employers/Consumers:

OREGON HEALTH AUTHORITY

Value-based benefit design

- Lowers out of pocket cost for the most important services, and raises out of pocket costs for less important/less effective services
- Would *not* deny coverage completely for services typically covered under traditional insurance policies

3

Oregon Health Authority

Employers/Consumers:

OREGON HEALTH AUTHORITY

Definitions of traditional benefits

- **Co-pays** – Fixed dollar amount payable at time of service
- **Deductible** – Amount the member owes before insurance pays for covered services
- **Co-insurance** – the percentage the member pays for a covered service after the deductible is met

4

Oregon Health Authority

Employers/Consumers:

OREGON HEALTH AUTHORITY

Definitions of traditional benefits (cont.)

- **Out-of-pocket maximum** – the annual maximum amount the member pays out of pocket before the plan pays 100% of covered services
- **Rx plan tiers** – a fixed co-pay or percentage that the member pays for generics, preferred brand name drugs, or non-preferred brand drugs

5

Oregon Health Authority

Oregon's value-based benefit design

- Deductible does not apply
 - Value-based services
- Deductible and cost-sharing tiers
 - Tier 1 (lowest cost-sharing)
 - Tier 2
 - Tier 3
 - Tier 4 (highest cost-sharing)

6

Oregon Health Authority

Deductible does not apply

- Little or no cost sharing for:
 - Value-based services (no cost sharing)
 - Preventive care (no cost sharing)
 - Basic diagnostic services
 - Comfort care

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Value-based services

- Highly effective, low cost, and have a lot of evidence supporting their use
- Includes medications, tests, or treatments
- Mostly outpatient care
- NO cost to patients (no co-pays or coinsurance)

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Examples: Value-based services

- Diabetes: Meds (insulin or oral); blood test to check control; eye exam to check for changes
- Congestive Heart Failure: Generic meds (beta-blocker, ACE inhibitor, diuretic), lab (Annual blood count, metabolic panel, cholesterol/lipid profile, urine test, and a thyroid test once), tests (EKG, Diagnostic echocardiogram), other (nurse case management)
- Coronary Artery Disease: Meds (Generic versions of aspirin, cholesterol lowering statin, and blood pressure medications/ beta-blocker), labs (Annual cholesterol/lipid profile), tests (EKG), other (cardiac rehabilitation for post-heart attack)

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[Handout]

Value-based services summary

Note: Not all treatments are appropriate for all patients. This document is a summary. The complete list of value-based services is available on the Oregon Health Services Commission Web site at <http://www.oregon.gov/OHPPR/HSC/docs/VBS.pdf>.

1. Asthma—Medications and diagnostic tests
2. Bipolar—Medications (Lithium and Valproate), labs, and medication management
3. Cancer screening—Cervical, breast, and colon cancer screening
4. Chemical dependency—Alcohol screening and treatment – medication (acamprosate) and brief interventions by primary care providers; Drug misuse – medication (buprenorphine) and outpatient treatment (methadone maintenance treatment)
5. Chronic obstructive pulmonary disease (COPD)—Inhaler (short-acting inhaled bronchodilator)
6. Congestive heart failure—Medications (beta blockers, ACE inhibitors, diuretics), Labs, EKG, diagnostic echocardiogram, nurse case management
7. Coronary artery disease—Medications (aspirin, statin, beta blockers), lab, EKG, cardiac rehabilitation for post-heart attack patients
8. Child preventive dental care—Fluoride supplements (if indicated for ages 6 months to age 16), fluoride varnish (ages 12 months to 16 years) and sealants for permanent molars of children and adolescents
9. Major depression in adults (Severe only)—Medications (SSRIs), Psychotherapy and medication management
10. Major depression in children and adolescents (moderate to severe only)—Psychotherapy
11. Type I diabetes—Medications (insulin and supplies, ACE inhibitors), labs and retinal exams for adults
12. Type II diabetes—Medications (metformin, sulfonyureas, ACE inhibitors, insulin and supplies), labs and retinal exams for adults
13. High blood pressure—Medications (diuretics, ACE inhibitors, calcium channel blockers, beta blockers), labs
14. Immunizations—Routine childhood and adult immunizations
15. Maternity care—Medications (folic acid, immunoglobulin), screenings
16. Newborn care—Medications (eye ointment to prevent gonococcal disease, Vitamin K), screening labs (sickle cell, congenital hypothyroidism, PKU)
17. Reproductive services—Contraceptives (condoms, combined oral contraceptives, IUDs, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization)
18. Sexually transmitted infections—Medications (antibiotics for syphilis, Chlamydia and gonorrhea), lab tests to detect Chlamydia, gonorrhea, HIV or syphilis
19. Tobacco dependence—Medications (Nicotine replacement therapy, nortryptiline, and bupropion)
20. Tuberculosis (TB), latent and active — Medications, screening, and diagnostic procedures per Centers for Disease Control guidelines

Preventive care

- Certain preventive services recommended by the US Preventive Services Task Force
 - Includes mammography, Pap tests, colon cancer screening, childhood immunizations, flu shots, cholesterol testing, fluoride supplements

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Basic diagnostic services

- Low/no office visit co-pays for 2 visits/yr
- Low/no co-pays for basic office labs and x-rays

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Comfort care

- Services at end of life such as hospice care
- Relieves suffering by easing pain and symptoms
- Improves quality of life

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Deductible and cost-sharing tiers

- Tier 1 – Lowest cost-sharing
- Tier 2 – Next highest cost-sharing
- Tier 3 – Next highest cost-sharing
- Tier 4 – Highest level of cost-sharing
- Rx benefits
- Other diagnostic services

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Tier 1 – Lowest cost-sharing

- Highly effective care
- Severe chronic disease
- Life-threatening illness & injury
- Examples: Emergency dental care, Head injuries, Appendicitis, Heart attack, Third degree burns, Kidney failure, Rheumatoid arthritis, Low birth weight

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Tier 2 – Next highest cost-sharing

- Effective care
- Other chronic disease
- Other life-threatening illness & injury
- Examples: Breast cancer, Bladder infections, Emphysema, Multiple sclerosis, Post-Traumatic Stress Disorder, Attention Deficit Disorder, Epilepsy, Glaucoma

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Tier 3 – Next highest cost-sharing

- Effective care
- Non-life-threatening illness & injury
- Examples: Broken arm, Ear/sinus infections, Dentures, Kidney stones, Herniated disk, Reflux/Heartburn, Migraines, Fibroids, Cataracts, Obsessive-Compulsive Disorder

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Tier 4 – Highest level of cost-sharing

- Less effective care
- Care for conditions that get better on their own
- Minor illness & injury
- Examples: Cold and cough, Chronic low back pain, Sprained ankle, Cracked rib, Seasonal allergies, Acne, Viral sore throat, Tension headaches, Dental implants, Liver transplant for cancer

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Rx benefits

- Cost sharing tiers based on medical evidence:
 - Tier 1: Effective generics by condition
 - Tier 2: The most cost-effective brand drugs for each condition and other generics
 - Tier 3: Other brand drugs

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Diagnostic services

- Cost sharing tiers:
 - Basic (2 diagnostic visits/yr, vision exam/yr, x-rays & basic labs ordered by a primary care physician)
 - Intermediate (e.g., CT scans, MRIs, labs ordered by a specialist)
 - Advanced (e.g., PET scans and labs with more cost-effective alternatives)

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Other components

Excluded conditions

- Non-emergency services that would have no coverage, similar to many commercial plans presently
- Examples: Cosmetic surgery, infertility services, experimental treatments

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Employers/Consumers:

Cost-sharing examples:

- **Deductible:** As low as \$0 or as high as \$3,000
- **Copays:** Low \$5 or high \$50
- **Co-insurance tiers:** Varies
- **Out-of-pocket (OOP) maximums:** Low \$1,500 or high \$5,000+

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Sample value-based benefit plan

	Typical Plan	Value-based plan
Deductible	\$300	\$300
Out-of-pocket (OOP) maximum	\$3,000	\$3,000
Cost sharing	30%	Tiered: 10%/30%/50%/70%
Office visit cost sharing	\$30	Tiered: \$10/\$30/\$50/\$70
Prescription drugs	Tiers: \$10/\$30/50%	Tiers: \$10/\$30/50%

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Example 1

Sinus infection	Typical plan	Value-based plan
Visit to family doctor – Referral to specialist	\$30	No cost sharing – Initial diagnostic visit
Specialist recommends surgery for deviated septum (Tier 4) – Surgery cost \$8,000	\$300 (deductible) \$2,300 (30% cost sharing)	\$300 (deductible) \$5,400 (Tier 4 cost sharing of 70% – total cost sharing of \$5,700 exceeds the OOP max)
Total cost sharing	\$2,600	\$3,000

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Example 2

Routine diabetes care	Typical plan	Value-based plan
Ongoing treatment	Subject to cost sharing (including deductibles, co-pays and co-insurance)	No cost-sharing (value-based services)
Insulin	\$720	\$0
Other drugs for diabetes/cholesterol	\$200	\$0
3 doctor's visits	\$90	\$30 (tier 1)
Podiatrist visit and eye exam	\$60	\$20 (tier 1)
Diabetic labs/supplies	\$600	\$0
Doctor visit (preventive) – foot ulcer diagnosed	\$0	\$0
Antibiotic	\$20 (generic)	\$20 (generic)
Referral to surgeon, surgeon recommends surgery to treat foot ulcer (tier 1) – Surgery cost \$2,000	\$300 (deductible) \$510 (30% cost sharing)	\$300 (deductible) \$170 (Tier 1 cost sharing)
Total cost sharing	\$2,500	\$540

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Oregon Health Authority
Oregon Health Policy Board



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

FINAL DRAFT FOR BOARD APPROVAL
December 2010

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EXECUTIVE SUMMARY

The Choice to be Made

The Affordable Care Act establishes health insurance exchanges that will be run in all states. Each state may choose the federally-administered exchange run based on federal rules, or to run an exchange with state discretion within the federal framework. A State that chooses not to build its own exchange will use one that is designed and built with limited state input or assistance. In building an exchange, the state has the choice between a model with limited intervention and opportunity and an active purchaser model with greater ability to affect costs. Oregon has the opportunity to affect the cost and quality of coverage and care for all Oregonians, whether they get their coverage from the Exchange or not.

Mission

With the passage of the Affordable Care Act, we have an opportunity to design and build an exchange that meets Oregonians' needs. Oregon will develop a strong, patient-centered exchange that ensures choice, value and access. It will increase access to information and affordable health insurance coverage 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 improves access to affordable, quality coverage for individual and business consumers. The federal government is financing exchange development, implementation and first year operating expenses. In 2015 the Exchange must be self-sustaining, not relying on state or federal support for ongoing operations.

Value Proposition

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 successful exchange will provide value to individual and group consumers, offering: 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 for employers to use, offering administrative simplicity (consolidated billing, easy premium calculation and streamlined processing) and improved employee choice. Health 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 and Access to Federal Tax Credits

Enrollment in health insurance coverage accessed through the Exchange will grow over the first several years of operations, rising from 142,500 in 2014 (the first year of operation) 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.

	2013	2014	2015	2016
Individual members	NA	142,500	190,000	232,500
Small group employee members	NA	65,000	87,000	95,000

Federal tax credits will come into the state through the Exchange. In 2015, an estimated 150,000 individuals will sign up for the exchange and receive this federal premium assistance. By 2019, 270,000 individual insurance purchasers will access tax credits. These individual tax credits will be worth an estimated \$462 million in 2015 and \$922 million in 2019.

	2015	2019
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$462M	\$922M
Small employer tax credits coming into Oregon	\$43M	\$29M

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

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), passed by the Oregon Legislature in 2009. HB 2009 directed the newly created Oregon Health Authority (OHA) to develop a plan for a health insurance 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 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, implementation and operation through December 31, 2014.

The ACA requires the federal Department of Health and Human Services (HHS) 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 (OCIIO) 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 and initial operations costs of the Exchange, but its ongoing 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 significant input or assistance from states choosing not to participate in the development process.

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, offer an improved, modern access to Medicaid, and make it easier to enroll in health insurance.¹ Beginning in 2014, an exchange will be available in each state to help consumers make comparisons between plans that meet quality and affordability standards.

¹ Tax credits, which begin in 2014, will be available for individual insurance purchasers with income from 133% to 400% of federal poverty. The amount changes each year; it is \$88,200 for a family of four in 2010. Medicaid eligibility will increase to 133% of federal poverty in 2014 (\$29326 for a family of four).

II. OPERATIONAL CONSIDERATIONS

As important as the policy decisions described in Section III will be for the successful development and administration of a health insurance 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. 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.

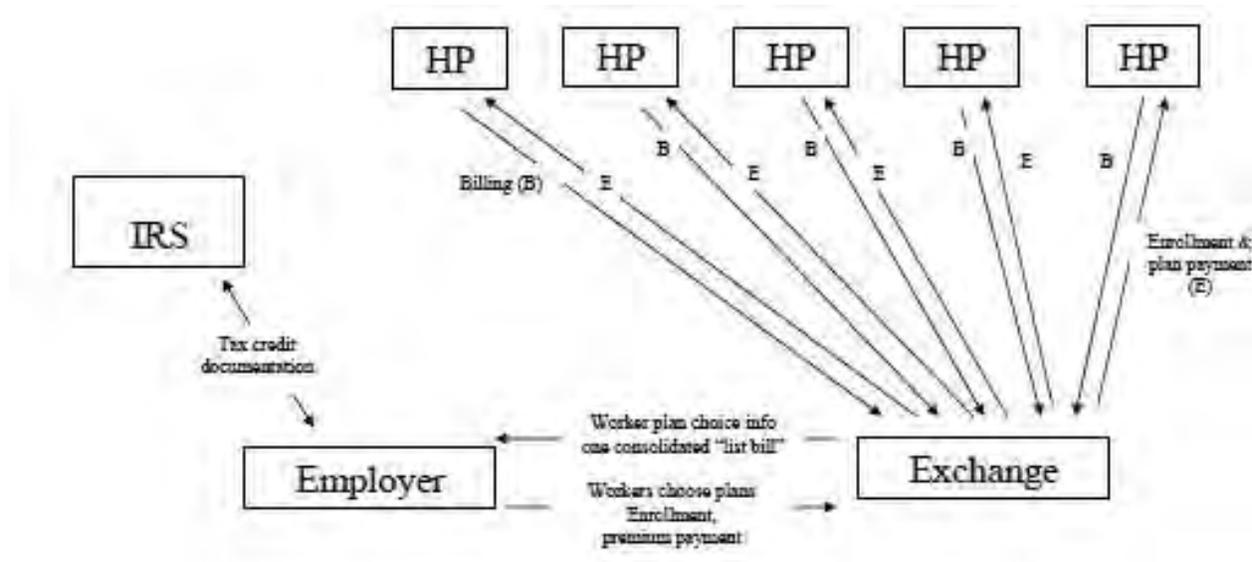
Consumers will know that plans participating in the Exchange will offer quality coverage that provides real access to care. The Exchange will establish standards for insurance carrier participation in the exchange, certifying "qualified health plans" for participation. In addition, consumers will be 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 active purchasing, 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. Running the Exchange

Enrollment and Tax Credit Participation

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.

Table 1: Estimated Exchange Membership, 2013 - 2016

Membership	2013	2014	2015	2016
Individuals	NA	142,500	190,000	232,500
Small group employees	NA	65,000	87,000	95,000

In addition, many Oregonians will qualify for premium assistance accessed through premium tax credits. In addition, small businesses that use the Exchange will also be able to take advantage of tax credits. In 2015, tax credits worth \$505 million will come into the state, rising to a total of \$951 million entering the state for individuals and small businesses in 2019.

Table 2: Tax Credit Recipients and Dollars in Oregon

	2015	2019
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$462M	\$922M
Small employer tax credits coming into Oregon	\$43M	\$29M

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 as the preferred model under which an exchange would work.

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.

Table 3: Projected Exchange Revenue, Expenses and Administrative Fee, 2013-2016

	2013	2014	2015	2016
Estimated Operating Revenue	0	\$31	\$42	\$50
Estimated Operating Expenses	\$37	\$36	\$42	\$48

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. Based on the estimated operating revenues and expenses, the administrative fee that will support the exchange is anticipated to be around 3% (starting closer to 3.3% in 2014 and decreasing to 2.8% by 2016).

Start-up Activities

Although the Exchange will officially "start" in 2014 (coverage from health plans purchased through state exchanges will begin on January 1, 2014) start-up expenses will be incurred significantly in advance that date. In addition to the start up expenses incurred when any business opens, the exchange will be engaged in education, outreach and marketing starting early in 2013.

The federal government will provide most of the funding for implementation and year one operations expenses. For activities related to eligibility and enrollment solutions that will affect both exchange participants and Medicaid recipients the state will contribute 10% of the development costs (with the federal government paying for the other 90%). By January 1, 2015, the Exchange must be self-supporting.

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 keys 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.

III. POLICY RECOMMENDATIONS AND DEVELOPMENT ISSUES

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: Create a mission-driven public corporation to coordinate purchasing strategies for all Oregonians, starting with a health insurance exchange for the individual and small group markets.

Oregon's health insurance exchange should be operated by a public corporation chartered by state statute.² The Exchange will be accountable to the public interest but not beholden to state budget cycles. Legislation can ensure accountability of the Exchange through the establishment of a governing board, strong public participation, annual reporting, and the use of consumer advisory groups and surveys. 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.
- *Accountability/Responsiveness*: to consumers, health plans and the state.
- *Consumer Focus*: provide value and improved access for individual and group purchasers.

² 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.

- *Ability to work with existing state agencies:* including the Insurance Division and Oregon Health Authority.

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.

Accountability/Responsiveness. Accountability can be built in to any organization, but a state agency has some inherent oversight requirements built in that ensure responsiveness to the public. 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.

To ensure accountability in a public corporation model, the statutory charter should have a strongly consumer-oriented mission statement, a board with members subject to appointment by the Governor and confirmation by the Senate, serving four year terms. Three voting ex officio members would participate by virtue of their positions as the Oregon Health Authority director, Department of Consumer and Business Services director and Oregon Health Policy Board chair. Strong conflict of interest language would ensure board members and employees are working in the interest of the Exchange and its members.

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. The exchange mission should be explicitly consumer-focused.

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 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 the chair 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 governing board as well.

To ensure the Exchange is accountable to its members, Oregon taxpayers, the Governor and Legislature, participating health plans and the federal government, the following should be included in the exchange authorizing statute: a strong consumer-oriented mission; inclusion of voting ex-officio members and members who use the Exchange; Governor-appointment and Senate-approval; and conflict of interest language that applies to Exchange board and staff. In addition, the exchange should be statutorily required to: establish consumer advisory groups; conduct consumer surveys to assess consumer satisfaction and exchange performance; consult with relevant state groups such as the Health Resources Commission or the Health Services Commission; be subject to ORS 243 Public Employee Rights and Benefits (as OHSU is); and collaborate with OHA, DCBS and the Employment Department for the efficient operation of all four organizations' programs.

Board Role. The 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 Committees. The Exchange board should consult with and seek the assistance of consumer advisory groups. Members should include consumers purchasing individual insurance through the exchange, small businesses using the exchange, insurance brokers who assist small businesses, and participating carriers. Establishing consumer advisory 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 that state exchanges 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 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

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. Oregon is applying for a grant under this announcement, and expects to hear whether it is selected for this two year grant in mid-February 2011.

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 A: History and Background

FINAL DRAFT

Recent Oregon Reform Proposals Included a Health Insurance 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

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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.

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 law¹ 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.²

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.

¹ 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).

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

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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.

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.

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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

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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.³ 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.

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:

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

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- 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.

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:

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- **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

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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.

Building Oregon's Health Insurance Exchange

Appendix B: Policy Issues for Further Development

FINAL 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

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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 officio¹ 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

¹ *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.

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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.²

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.

² 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)*

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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.³ 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.⁴

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.

³ Public Law 111-148 (PPACA) Part II, Section 1311(e)

⁴ 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

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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.⁵

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.⁶ 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 Markets⁷

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.

⁵ PPACA, Section 1302(c).

⁶ 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.

⁷ 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.

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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

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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.⁸ 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

⁸ HB 2009 Section 17(b)(G).

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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.

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Oregon Action Plan for Health

An urgent call to action

In 2009, the Oregon legislature created the Oregon Health Policy Board and gave it the charge to create a comprehensive plan for health reform for our state. This Plan meets that charge by laying out a timeline for actions and strategies that reflect the urgency of the health care crisis and will lead Oregon to a more affordable world-class health care system.

Over the past ___ months the Board has heard from hundreds of Oregonians around the state – individuals, small business owners, policy makers, members of the health care community, and state and local government.

Everyone is facing the same challenge: costs are too high, outcomes are unsatisfactory, and care is fragmented. As a state, we have an imperative. The cost of health care for the State of Oregon accounts for ___% of state spending in a time when we are facing a \$3.5 billion shortfall. If we do not act today to reign in these costs, they will continue to overwhelm the state budget. The same is happening with family budgets and business budgets.

Meanwhile, for all the dollars we spend, the quality of our care is uneven and the allocation of our resources is illogical.

We can do better. We must do better. And we must take action now.

To achieve a world class quality of health in Oregon, all recommendations in the plan were pointed to achieve three important objectives – also known as the “Triple Aim.” These simply stated objectives are powerful because within them they encompass all that we would hope our state health system would include:

Triple Aim

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.

Under the Triple Aim, this Action Plan includes steps towards creating a health system in Oregon in which:

- 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 quality information they need to make better decisions and keep delivery systems accountable;

- Quality and consistency of care is improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;
- Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health; and,
- Electronic health information are available when and where it is needed to improve health and health care through a secure, private health information exchange;

[Inside cover]

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 more than 100 recommendations into this *Action Plan*, which clearly identifies the next steps Oregon should 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 strategies outlined in this *Action Plan* would never have been identified.

The Oregon Health Policy Board is a nine-member citizen board appointed by the governor. Board members serve four year terms, and include representatives from consumers, business, public health, and health care.

Oregon Health Policy Board

Eric Parsons, Chair, Portland
Lillian Shirley, BSN, MPH, MPA, Vice Chair, Portland
Michael Bonetto, PhD, MPH, MS, Bend
Eileen Brady, Portland
Carlos Crespo, MS, DrPH, Portland
Felisa Hagins, Portland
Chuck Hofmann, MD, MACP, Baker City
Joe Robertson, MD, MBA, Portland
Nita Werner, MBA, Beaverton

Foundational Strategies for Action

The Action Plan for Health calls for actions by policy makers, health care providers, consumers, stakeholders, the Oregon Health Authority and others who are affected by our current broken health system.

These actions are staged to begin immediately and carry through over the next several years until Oregon has the system and infrastructure changes necessary to meet the goals of the Triple Aim of better health, contained cost, and improved access.

To get to this kind of fundamental change, the Board has identified eight key strategies upon which to build the foundation. Each builds on and complements the others, and each has specific actions that are identified on page _____. More detail about actions can be found beginning on page _____.

#1 Spend health care dollars in a better way to lower costs

Align public purchasing, reduce overhead, increase efficiencies and set budgets

Health care is expensive and becoming more so by the day. Health care accounts for 22% of the state budget, which is currently threatened by a \$3.5B shortfall. 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 as deficits strain Oregon's 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. We must act now to bend the cost curve.

While cost reduction will come from a variety of overall improvements to the health system, such as improved prevention strategies, increased equity and other actions, there are specific steps to be taken directly related to costs.

The Action Plan cost reduction tactics include aligning the health care purchasing for the more than 850,000 people who receive health care through the Oregon Health Authority, reducing administrative overhead in the health care industry, crafting value-based essential benefit plans with innovative payment strategies, and setting "global" budgets for health care.

For more information on how these and other strategies will bend the cost curve downward, go to page _____.

#2 - Focus on prevention

Improve health, lower cost and allow smarter allocation of resources

80% of the contribution to lifelong health lies outside of the medical care system. To realize the Triple Aim, the Board is calling for a focus on prevention both within the health care system and beyond it, in the places we live, learn, work and play. The Action Plan for Health

calls for a health system that integrates public health, health care, and community-level health improvements to achieve a high standard of overall health for all Oregonians regardless of income, race, ethnicity, or geographic locations. Reforms must occur in every one of those settings if we hope to improve lifelong health for all Oregonians.

New focus on prevention will also mean our health system will strive to prevent chronic diseases by reducing obesity, tobacco use, and drug and alcohol abuse, among other things. In addition, innovations and integration among public health, addictions and mental health, health systems and communities to increase coordination and reduce duplication must be supported. For more detail about the focus on prevention, go to page ____.

#3 Improve health equity ***Better health and lower costs for everyone***

Health equity means reaching the highest possible level of health for all people. Health inequities are a result of health, economic and social policies that have disadvantaged communities of color, immigrants and refugees, and other diverse groups over generations. These disadvantages result in tragic health consequences for diverse groups and increased health care costs for everyone. We must achieve health equity to reach the Triple Aim.

Oregon's health system must ensure everyone is valued equally and health improvement strategies are tailored to meet the unique needs of diverse population groups. For more detail on the Health Equity strategy, go to page ____.

#4 Make it easier for Oregonians to get affordable health insurance and quality care ***Health insurance exchange***

One of the cornerstones of the Board's reform proposals is a health insurance exchange that will provide a one-stop central marketplace for consumers and small businesses to access insurance products, including a value-based essential benefits package, at an affordable cost. Health plans in the exchange will meet higher standards than those in the market at large on measures such as outcomes, quality and cost.

Oregon's health insurance exchange will be designed to work for individuals, small businesses, and participating insurance carriers by providing useful, comparative information on health plan offerings, benefits and costs; helping individuals, small employers and their employees to access insurance that meets their needs; helping people access premium tax credits and Medicaid; and simplifying options and processes across the industry.

In addition, the exchange will be the conduit through which individuals with income up to 400% of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health insurance much more affordable for many people. In

addition, individuals with income up to 250% of the federal poverty level will gain access to cost-sharing assistance through the exchange.

Additionally, certain small business purchasing through the exchange may be eligible for tax credits of up to 50 percent of their contribution to employee insurance premiums. All small businesses using the exchange can offer a greater number of high-quality plans for their employees to choose from and will have the same type of buying power that large businesses currently enjoy. Using the exchange should also help keep administrative costs lower too.

The exchange should be administered by a mission-drive public corporation with a governing board and high level of public accountability.

#5 Reduce barriers to health care

Adequate insurance, adequate providers, and easy access to care

By 2014, it is estimated that 93% of all Oregonians will have access to health care coverage via insurance market reforms, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits to help make coverage offered through exchanges more affordable. This expanded access to health insurance is an important advancement. The next step is to make sure there is access to health care, both for the newly covered and for the 7% of Oregonians who will remain uninsured. Ensuring access to care means building a robust workforce trained to deliver care in new ways and making sure we have enough health care providers in all areas of the state. It means finding locally relevant solutions to access problems caused by geographic, cultural, or other social and economic barriers. .

For more detail on expanding access to health care through a health insurance exchange, go to page _____. For more detail on how to build Oregon's health care work force go to page _____.

6 Set standards for safe and effective care

Primary care homes, electronic health information, and evidence-based care

There is little consistency across our health system in how care is delivered, paperwork is processed, and information is exchanged. The differences contribute to lack of coordination between providers, poor quality care, unnecessary administrative complexity, and ultimately higher costs. Oregon's public and private sectors can work together to create guidelines, standards, and common ways of doing business that increase efficiency, provide better customer service and transparency, and reduce system costs.

One key improvement endorsed by the Board is the concept of a "patient-centered primary care home." Under this model, people have more than a doctor – they have access to a team of health care professionals that focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs and a patient and family centered approach to all aspects of care.

Standardization and use of evidence-based best practices are strategies that improve care delivery, technology, and health insurance. For more detail on patient-centered primary care homes, go to page _____. For more detail on health information technology, go to page _____. For more information on evidence-based care and benefit design, go to page _____.

#7 Involve everyone in health system improvements

Consumers, patients, health partners and regional health organizations

Health care consumers, patients, and citizens are at the core of Oregon’s health system reform efforts. Under successful reform, consumers and patients will be the ultimate beneficiaries: our social and environmental context will support their individual efforts to stay healthy; it will be easier and more affordable for many of them to get health care; and the care they get will be of higher quality. But patients and consumers are key players on the front end of reform as well. For more information, go to page _____

The Board also proposes an infrastructure of partners to support 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 through collaboration, and patients are at the center of interventions . For more information, go to page _____.

Additionally, in many ways, health is most effectively supported and health care most effectively delivered at the local level. Communities and regions are more likely to have a common vision for health and can develop locally relevant solutions based on shared knowledge and context. Platforms for meaningful dialogue and negotiation are easier to find or create within communities and regions than at the state or national level. Combined with federal health *insurance* reforms, local and regional *delivery system* reforms have the potential to shift Oregon onto a new path toward achieving the triple aim.

The OHPB has prioritized the development of regional frameworks for health care delivery, such as regional accountable health organizations that are responsible for meeting the unique health needs of their populations. Such new regional organizations would be able and accountable for improving the health of their communities, reducing avoidable health gaps between different cultural groups, and managing health care resources through. For more information on regional frameworks for health care delivery, go to: _____.

#8 Measure progress

The best-run and most successful businesses always know where they stand: what raw materials cost, how much inventory they have, how many orders they have for their goods or services, and a clear plan or vision of where they want their business to be in a year or in five to 10 years. If Oregon is to transform its health care system, it needs to know these same types of things.

This *Action Plan* is the clear vision and plan, and a variety of metrics will help us assess whether we are achieving that vision and implementing plans successfully. The Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) are working on three levels to develop strong measurement tools around health outcomes, quality, cost, and health information. For more information on measuring progress, go to: _____.

Actions

In the following table, the Health Policy Board has listed the actions we believe are priorities for moving health reform in Oregon forward. While there are many other actions we must take to achieve world class health and health care, listed in a more detailed timeline in Appendix ____, the Board strongly believes that our energy must focus on these immediate critical steps to develop the momentum and motivation for lasting change. For each action, key dates and actors are shown and checkmarks indicate the foundational strategies with which that action is aligned.

Action	Action dates	Who will Act	Smarter spending	Focus on prevention	Health equity	Exchange	Reduce barriers to health care	Standards for safe and effective care	Impact	
									Make insurance easier through an	Involvement of everyone
<ul style="list-style-type: none"> ▪ Set a target for total health care spending in Oregon (by all payers) 	2011: Set target	OHPB	✓							✓
Align and coordinate health care purchasing <ul style="list-style-type: none"> ▪ Standardize certain provider payments to Medicare methodology (not rates) to set stage for future payment reform 	2011: Pass legislation for standards 2011: Begin implementation in OHA 2013: Statewide implementation	Legislature OHA Partners	✓			✓				✓
<ul style="list-style-type: none"> ▪ Focus quality and cost improvement efforts to achieve critical momentum 	2011: Identify areas with greatest potential for improvement	OHA	✓		✓	✓		✓		✓

<ul style="list-style-type: none"> Introduce innovative payment methods that reward value 	<p>2012: Implement in OHA's focus areas 2013: Extend beyond OHA</p>	<p>OHA Partners</p>	<p>✓</p>			<p>✓</p>		<p>✓</p>	<p>✓</p>
<p>Reduce administrative costs in health care</p>	<p>2011: Require standardized communication between payers and providers about eligibility, claims, etc. 2011: Create authority to extend standards to clearinghouses and third-party administrators 2011-2013: Phase-in standards for OHA, insurance companies, TPAs and clearinghouses</p>	<p>DCBS Legislature DCBS, OHA</p>	<p>✓</p>	<p>□</p>			<p>✓</p>	<p>✓</p>	<p>✓</p>
<p>Decrease obesity & tobacco use</p>	<p>2011: Set nutrition standards for food and beverages in public institutions 2011: Make all state agencies and facilities tobacco-free 2012: Implement standards; work with partners to extend to private sector</p>	<p>OHA Partners</p>	<p>✓</p>	<p>✓</p>	<p>✓</p>		<p>✓</p>	<p>✓</p>	<p>✓</p>
<p>Collect & analyze detailed information (including race, ethnicity, language, etc.)</p>	<p>2011: Set common expectations for OHA data systems 2012-14: Roll-out standards in OHA systems and work with partners to extend to private sector data collection</p>	<p>OHA & partners</p>			<p>✓</p>			<p>✓</p>	

Establish a mission-driven public corporation to run the Oregon Health Insurance Exchange	<p>2011: Establish corporation board and Exchange</p> <p>2011: Receive federal implementation funds.</p> <p>2012-14: Implementation</p> <p>2014: Enrollment and coverage begin Jan. 1</p>	Governor, Legislature OHA	✓			✓	✓	✓	✓	✓	✓	
Promote local and regional accountability for health and health care	<p>2011: Explore regional frameworks in cooperation with community stakeholders.</p>	OHA & partners	✓			✓					✓	
Build the health care workforce												
<ul style="list-style-type: none"> Use loan repayment to attract primary care providers to rural and underserved areas 	<p>2011: Develop sustainable financing</p> <p>2012: Implement and expand loan repayment</p>	Legislature, Office of Rural Hlth.	□	□	□	✓	□	□	□	□	□	✓
<ul style="list-style-type: none"> Standardize prerequisites for clinical training via a student "passport" 	<p>2011: Develop consensus requirements</p> <p>2012: Introduce passport</p>	OHA & partners	□	□	□	✓	□	□	□	□	✓	□
Extend requirement to participate in Oregon's health care workforce database to all health professional licensing boards.	<p>2011: Legislation</p>	Legislature						✓				✓
Establish patient-centered primary care homes (PCPCHs) across the state	<p>2011: OHA implements PCPCHs in regions where is has significant purchasing power</p> <p>2015: 75% of all Oregonians have access to PCPCH</p>	OHA & partners	□	✓	□	✓	□	□	□	□	✓	✓
Introduce value-based benefit designs	<p>2012: Offer value-based benefit package in OHA coverage</p> <p>2014: Offer VBBP in Oregon Exchange</p>	OHA & partners	✓	✓	□	□	□	□	□	□	□	□

Expand the use of health information technology (HIT) and exchange (HIE)	<p>2011: Consolidate HIE planning and implementation in a single Office of Health Information Technology (OHIT)</p> <p>2011: Establish a public-private state-designated entity to connect local, regional, and statewide HIE.</p> <p>2012: Transition HIE services and operation to the state-designated entity</p>	OHA Legislature OHIT	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	
Develop consensus around clinical best practices	2011: Create 10 sets of Oregon-based best practice guidelines and standards of care for use in public and private settings	OHA & partners	□	□	□	✓	□	□	✓
Strengthen medical liability system performance									
<ul style="list-style-type: none"> Remove barriers to full disclosure of adverse events by providers and facilities Clarify that statements of regret or apology may not be used to prove negligence 	<p>2011: Enact law preventing liability insurers from canceling coverage or refusing to defend providers who disclose errors</p> <p>2011: Amend Oregon's "apology" law</p>	Legislature Legislature				□	□	✓ ✓	

These key actions and other steps described in Section III of this Action Plan will result in a coordinated, integrated health system with the patient at the center, where services are high quality, costs are controlled, and every Oregonian enjoys the best possible health.

What will be different after the Action Plan for Health?

Now: Fragmented system with different standards, reporting requirements, and reimbursement methods (often based on who pays for care) and where many people lack access to even basic care.

The future: A coordinated and regionally integrated health system where every Oregonian has high-quality health care and the patient is at the center. Health systems and providers publicly report on common standard measures that improve health, and constantly work to raise the bar on quality. Insurance companies and providers use technology to streamline administrative systems, lower costs and improve timeliness and efficiency.

Now: Treatment of symptoms when they happen.

The future: A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and healthy lifestyles.

Now: Doctors treat patients.

The future: A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick. All the care a patient gets will be coordinated and the patient will be a part of all the decisions concerning their health.

Now: Doctors and hospitals get paid for the amount of services they provide.

The future: Providers get paid for keeping people healthy or returning them to health if they get sick. Just like with a family budget, health systems and doctors will have a “global” budget to manage the care their patients need. To ensure that patient care is not sacrificed to the bottom line, providers will show they are meeting health care quality guidelines and providing the best care for their patients.

Now: Paper-based records in doctor’s offices and hospitals.

The future: Private, secure electronic medical records help providers see the complete health picture of their patient. They can instantly know what tests, medications or procedures a patient has received or what diagnosis has been made, no matter how many health care professionals the patient uses. This eliminates costly duplications or potentially life-threatening complications. Electronic health records also allow patients easier to access their own files so they take more control of their own health.

Now: Insurance premiums have increased 125% over 10 years, and health care costs continue to outpace what we can afford.

The future: Our health care system will be highly efficient. Both providers and insurance companies will be accountable for reducing or controlling costs while consumers will have the information they need to choose providers and affordable insurance plans, based on their health, values, and life circumstances.

Now: Public health organizations take care of communities; doctors take care of individuals.

The future: All parts of the health system will collaborate to assure health. Community-based prevention programs that help keep people healthy will connect seamlessly to preventive clinical services like cancer screenings and immunizations, to self-management services for people living with chronic disease, and to acute or emergency care. Together, clinical and public health providers will be accountable for the health of the whole community.

Now: Public health provides a large amount of medical care to underserved populations.

The future: As more people get health insurance coverage, public health systems will be able to devote more time and resources to the functions essential to assure population health, like assuring the safety of our food and water, responding to outbreaks of flu or other diseases, and developing policies to support healthy individual decisions and community environments.

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Taking Advantage of Federal Reform Opportunities for Real Change

The passage of the Affordable Care Act of 2010 augments Oregon's long history of health addressing problems in the health care system. The insurance reforms contained in the legislation combined with the various funding opportunities and policy changes will leverage our state to drive delivery system reforms and make health care affordable for everyone in the following ways:

Coverage and Access

Federal reform provides resources to make insurance more widely available and affordable including:

- Provisions to make insurance companies more accountable and remove barriers that in the past kept sick people from getting the coverage they needed, dropped coverage for mistakes on insurance applications, or charged them much more for coverage if they could find justifications. These measures will take effect now through 2014. 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. Federal laws also now protect children: insurers can no longer deny coverage for children because of pre-existing conditions.
- Considerable funding for expansions of health insurance coverage options. This additional funding includes expansion of Medicaid to low-income adults up to 138% of poverty, and federally-funded tax credits for individuals up to 400% of poverty to purchase insurance through a state health insurance exchange.

Prevention and Population Health

Federal health reform makes significant investments in prevention and public health by providing funding opportunities to support key strategies for Oregon's Health Improvement Plan. These funding sources enhance and integrate prevention and health promotion in state and community health policy planning.

Delivery System Reform

Federal reform provides increased funding for care delivery settings that focus on preventive and primary care. This additional support should help Oregon toward its goal of making affordable, high-quality primary care available to everyone through patient-centered primary care homes. The ACA 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.

[Title Page]

More information on the Foundational Strategies for Action

OHPB Committees

The Oregon Health Policy Board has two statutory committees that met throughout 2010. Their work was key to informing the Foundational Strategies in Oregon's Action Plan for Health.

- **Public Employers Health Purchasing Committee** – Identifies and make specific recommendations to achieve uniformity across all public health benefit plan designs, develops action plans for ongoing collaboration amongst public and private purchasers, and identifies uniform provisions for state and local public contracts for health benefits.
- **Health Care Workforce Committee** – Has a statutory charge to coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand created by expansions in health insurance coverage, system transformation and an increasingly diverse population.

Additionally, the OHPB convened the following advisory groups in 2010 to develop recommendations on five crucial aspects of health reform.

- **Administrative Simplification Workgroup** – Developed recommendations for standardizing administrative transactions between health plans and health care providers, with the goal of reducing health insurance administrative costs in order to make coverage more affordable.
- **Health Equity Policy Review Committee** – Proactively evaluates recommendations made throughout the policy making process to assure they promote the elimination of inequities and promote health equity.
- **Health Improvement Plan Committee** –Developed recommendations to the Oregon Health Policy Board regarding the development and implementation of a plan incorporating policy, systems, and environmental approaches to promote population health and prevent chronic disease at the state and local levels.
- **Health Incentives and Outcomes Committee** – Evaluated and developed initial recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care. The Committee also made recommendations to the Board about initial quality metrics that could be used by all purchasers of health care, third-party payers and health care providers to evaluate payment reform.
- **Medical Liability Taskforce** – Examined current state medical liability laws and policies, their impact on the cost and delivery of health care, and developed a range of medical liability reform proposals for consideration by the Oregon Health Policy Board and the Oregon Legislature.

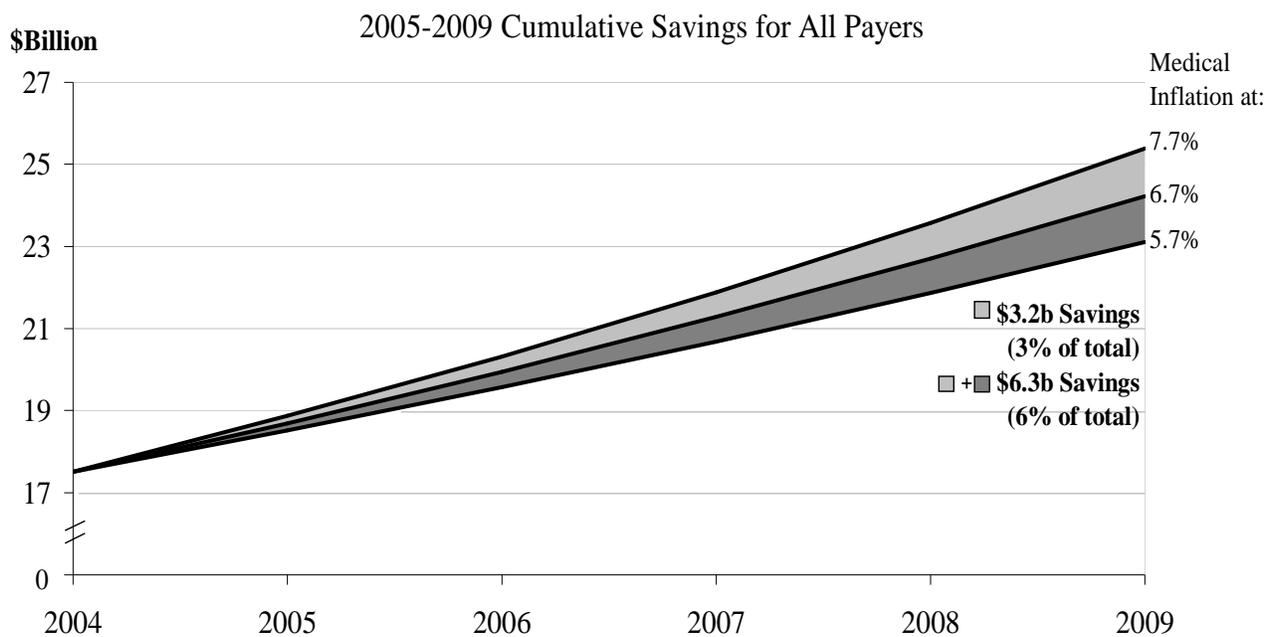
Strategy #1
Spend health care dollars in a better way to lower costs
Align public purchasing, reduce overhead, increase efficiencies

Health care is expensive and becoming more so by the day. Health care accounts for ___% of the state budget, which is currently threatened by a \$3.5B shortfall. 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 as deficits strain Oregon’s 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. We must act now to bend the cost curve.

We can do better.

The Oregon Health Policy Board (OHPB) believes that we need to limit health care spending over time to a fixed rate of growth and plans to flesh out this goal in 2011. The Board believes that through the reforms outlined in this report, we can also foster innovation within fixed resources.

Oregon Could Have Saved \$6.3b in 5 years by Reducing Medical Inflation



Decisive actions to implement the strategies and tactics in this report can help stem rising health care costs and it is important to recognize that delaying these efforts is costly. Had Oregon successfully implemented strategies to reduce the rate of medical inflation by two percentage points over the last five years, it would have saved \$6.3 billion or 6% of total health care expenditures.

The following examples demonstrate savings opportunities that could have been realized by earlier action:

- Had we successfully contained the growth of obesity during the last five years, Oregon would have saved approximately \$1 billion in health care expenditures.
- Instituting bundled or episode-based payments for care related to 10 common acute and chronic conditions in 2005 could have reduced expenditures by approximately \$2.25 billion over the last five years.
- Holding the growth in insurance companies' general administrative expenditures to CPI could have saved \$36 million to \$119 million over the last 5 years.

Developing necessary infrastructure and pursuing cost containment approaches will pose many challenges. Leaders and stakeholders must develop creative and courageous solutions in order to overcome technical, organizational and political roadblocks.

Note: It is important to keep in mind that this attempt to better understand potential cost savings is subject to considerable uncertainty. These estimates of cost savings are considered rough approximations and are subject to revisions in accordance with the changing landscape of health care reform. It is not possible to add up these estimates in order to approximate aggregate potential savings in the Oregon health care system because many of these policies reinforce one another as well as target common instances of unnecessary costs. In many cases, the following estimates predict savings to Oregon's health care system without determining how savings might accrue to individuals, health care providers, carriers or payers.

Key ways that Oregon can bend the cost curve:

- **Focusing on prevention will yield significant returns on investment by improving health.**

Population health initiatives aimed at reducing the prevalence of chronic diseases would yield substantial returns on investments. For example, tobacco use prevention activities will save at least \$1.32 for every \$1 invested. Additional investments to create healthy environments, promote healthy lifestyles and discourage alcohol abuse will likely generate savings on health care expenditures that more than outweigh the costs of these efforts. Please see page ___ for a more in depth description of this strategy.

- **Aligning and coordinating health care purchasing will increase the value of health care while reducing costs.**

The Oregon Health Policy Board (OHPB) believes that the OHA and the new public corporation that will administer the Oregon Health Insurance Exchange discussed on page ___ can play a key role in bending the cost curve. Additionally, the Oregon Health Authority purchases health insurance coverage for nearly one in four Oregonians, approximately 850,000 in total. The Oregon Health Authority aligns purchasing policies across the State's existing patchwork of health care programs. The Board has identified the next steps to achieve this alignment.

- Beginning in 2011 with full implementation by 2013, the OHA standardizes provider payment methodologies to Medicare methodology (not rates) across the OHA lines of business, 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, health equity, 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.
- Working with providers, purchasers and other stakeholders, the OHA will target key cost, quality, and efficiency concerns by introducing innovative payment methods (e.g., bundled payments, pay-for-performance, and others) through OHA programs in 2012 and beyond in 2013.

By being smart purchasers that seek to drive value, the Authority and the exchange can help bring medical costs in line with what is affordable to the State, businesses, and consumers. For example, we estimate that by paying for care for 10 common acute and chronic conditions using bundled or episode-based payments, Oregon would save approximately \$500 million annually by preventing rehospitalizations and unnecessary care.

➤ **Patient-centered primary care homes improve care coordination and appropriate access to preventive services.**

These care improvements can reduce duplicative tests and services and avoid costly hospitalizations through better disease management. Although current patient-centered primary care home proposals target specific subsets of the population, Oregon could expect to save approximately \$650 million or 1.9% of total health care expenditures per year after a 5-year program initiation phase if Oregon were to provide primary care homes to the entire population and employ community health teams to link services and provide additional practice support.

➤ **Standards for safe and effective care can reduce administrative costs and unnecessary care**

Nationally it is estimated that about 30 percent of care provided to patients is either unnecessary or does not lead to improved health. We can improve health outcomes while reducing costs by creating and applying standards based on the most current research and technology.

For example, OHA can generate considerable savings by developing common processes to simplify and expedite various forms of health care administration. Estimates indicate that by encouraging providers and payers to adopt automated electronic communications and a uniform language for these communications, we could save approximately \$92 million to

\$202 million a year upon full implementation. The Board has identified the following next steps:

- Adopt “uniform companion guides” that establish the uniform language for automated communications between providers and health plan offices.
- Phase-in requirements for everyone to use electronic communications, including legislative action to extend requirements to clearinghouses and third-party administrators.

Similarly, developing a standard methodology for determining how much providers are to be paid for a given service could significantly reduce providers’ efforts to ensure they have been reimbursed according to their contracts with insurers and greatly simplify the ensuing negotiations.

Also, OHA could promote efficiency by improving the medical liability system. Encouraging integrated delivery systems to adopt a voluntary program to quickly disclose medical errors to patients and provide early offers to compensate those patients could reduce legal and administrative fees while treating patients with greater respect and fairness. The University of Michigan Health System found that instituting such a program led to a 59% decrease in average monthly cost of medical liability.

➤ **Regional integrated health information systems increase efficiency**

Developing and connecting regionally integrated health information systems can help ensure appropriate, responsive and cost-effective health care across the state. Local and regional Health Information Exchanges (HIEs) are under development in a number of Oregon communities and are a key building block for system improvements to enhance population health and to improve the health care delivery system. A newly established Office for Health Information Technology (OHIT) will provide coordinated health information exchange planning and implementation efforts. Legislation introduced in 2011 to define and enable the designation of the State Designated Entity (SDE) will connect local and regional health information exchange operations that will efficiently leverage resources to maintain and promote statewide availability and secure transfer of electronic health information.

Sharing patient information in a secure, efficient manner has the potential to substantially reduce costs. It will support efforts to track patients’ medical outcomes, reduce errors and make medical processes more efficient. It can empower consumers to better understand their own health, choose high-quality providers and make healthier choices. Information sharing can vastly improve public health agencies’ ability to track disease and combat chronic illness leading to improved population health. It is estimated that health information systems connected across Oregon HIE services will provide significant annual health care savings including:

- \$57.7 to \$90.7 million per year for avoided laboratory testing and imaging services.
- \$33.3 million per year for increased physician practice productivity.

➤ **Federal health reform will reduce health care costs for Oregonians**

Finally, federal health care reform is expected to halve the number of uninsured Oregonians while saving money for businesses and individuals. Current economic forecasts suggest that in 2019 annual individual and family annual health spending will fall by \$1.8 billion and businesses will save \$30 million annually. Also, as more people are able to access health insurance, Oregon will reduce the amount of uncompensated care that providers experience. Hospitals alone could experience a \$340 million reduction in annual uncompensated care by 2015 and \$440 million by 2019 (however, some hospitals will also experience partially offsetting reductions in Medicaid Disproportionate Share Hospital payments beginning in 2014).

Strategy #2: Focus on Prevention

Improve health, lower cost, and allow smarter allocation of resources

It's not a new concept, but it is a powerful one: preventing diseases, injuries, and poor health is more effective and often far less expensive than treating illness when it occurs. To truly transform the health care system, we need to shift our focus from intervention to prevention.

Tobacco use and obesity are priorities because of their enormous impact on longevity, quality of life and health care spending. The human toll of tobacco use in Oregon continues to dramatically surpass all other preventable causes of death and disease. Focused prevention efforts and evidence-based cessation benefits can provide a return of \$1.32 for every dollar Oregon spends on providing tobacco cessation treatments. One-third of the recent increase in medical costs in Oregon is attributed to obesity. The U.S. Centers for Disease Control and Prevention estimate that medical costs for individuals with obesity are \$1,429 higher [[dbl check: annually?]] than those of normal weight. By reducing obesity and obesity-related chronic diseases like diabetes, Oregon stands to realize a significant return on investment.

To come: added language regarding drug and alcohol addiction.

What We Need to Achieve

We need a health system that integrates public health, health care and community-level health improvement efforts to achieve a high standard of overall health for all Oregonians, regardless of income, race, ethnicity, or geographic location.

To achieve this, we must:

- Prevent chronic diseases by reducing obesity and tobacco use;
- Stimulate innovation and integration among public health, health systems and communities to increase coordination and reduce duplication;
- Focus resources for drug and alcohol addiction toward prevention and treatment;
- Improve health equity and population health by improving social, economic and environmental factors.

Next Steps

80% of the contribution to lifelong health lies outside of the medical care system. To realize the triple aim, the Board is calling for a focus on prevention both within the health care system and beyond it, in the places we live, learn, work and play. Reforms must occur in every one of those settings if we hope to improve lifelong health for all Oregonians.

- **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 most convenient choice. Key steps include:
 - To help reduce obesity, legislative action in 2011 provides direction to the Department of Administrative Services to set minimum nutritional standards for

- food and beverages sold in cafeterias, stores and vending machines in state agencies, schools, universities.
 - The OHA will identify the standards used based on scientific evidence, considering standards that are used already nationally such as those used by the federal Centers for Disease Control and Prevention on their campuses.
 - To help reduce tobacco use and exposure, OHA
 - Adopts tobacco-free campus policies in 2011 for state agencies, addictions and mental health facilities contracting with OHA, and hospitals.
 - Supports evidence-based tobacco prevention strategies such as raising the price of tobacco products and dedicating a portion of the proceeds to comprehensive, effective prevention efforts. Every dollar invested in tobacco prevention yields an estimated \$5 return on investment.
 - OHA encourages private entities to align with public obesity and tobacco use prevention policies in future years.
- **Increasing the effectiveness and efficiency of Oregon’s public health system** in the following ways:
- Developing regional frameworks for health, such as regional accountable health organizations. These entities would be responsible for local health policy, health improvement planning, priority setting, system development, financial investment, and health outcomes including reduction of health disparities. A key task for these regional entities would be to conduct community health assessments and, in partnership with all local players, develop local Health Improvement Plans, focused on reducing obesity and tobacco use and improving chronic disease prevention and management. Such plan should include steps for evaluating the impact of recommended actions, including the impact on reducing disparities and achieving health equity.
 - Ensure that existing state data systems have capacity to collect, manage and analyze public health performance measures including demographic data on race, ethnicity, country of origin, language, employment, sexual orientation, ability, income and education level, and to tie those data to clinical, emergency and hospital data through state and regional Health Information Exchanges wherever possible.

Drug and alcohol addiction goes here.

- **Further health equity by:**
- Exploring the most effective ways to support schools and districts in addressing health-related barriers to learning. Decreasing health disparities for Oregon populations requires fundamental social, economic and environmental changes. Key among these is the relationship between educational attainment and health. Poor health in childhood negatively affects educational attainment, which in turn reduces future income and decreases the practice of good health behaviors. Better student health, particularly for diverse populations, will help to increase high school graduation rates and improve health outcomes.

- Maximizing electronic health record adoption and connectivity and ensuring collection of race and ethnicity data to effectively track health disparities. This effort will include partnerships with the Oregon Health Information Technology Extension Center and with statewide health information exchange efforts under the Health Information Technology Oversight Council.

For more information

Please see: Oregon Health Improvement Plan Committee Report and appendices (link to web site and other ways of getting the report – by phone/email)

Health Information Exchange [Strategic](#) and [Operational](#) Plans for Oregon. Health Information Technology Oversight Committee.

http://www.oregon.gov/OHPPR/HITOC/Documents/hitoc_reports.shtml

Strategy #3 –Improve Health Equity ***Better health and lower costs for everyone***

Health inequities are unnecessary, unjust, and avoidable. They are the result of health, economic and social policies that have disadvantaged communities of color, immigrants and refugees, and other diverse groups over generations. These disadvantages result in tragic health consequences for Oregon’s diverse populations and increased health care costs for everyone. Oregon is:

- 47th in the number of African American diabetes deaths per 100,000 population by race/ethnicity (60.5 per 100,000 compared to 40.2 per 100,000 in the United States)
- 47th in the number of African American deaths caused by stroke and other cerebrovascular diseases per 100,000 population (73.1 per 100,000 in Oregon compared to 61.7 per 100,000 in the U.S.)
- 26th in the percentage of African American and Latino live births by cesarean delivery, though both are slightly better than U.S. averages
- 25th in the percentage of African American and 30th for Hispanic Latino mothers beginning prenatal care in the first trimester, both below U.S. averages.

As Oregon’s population becomes increasingly diverse, we must develop a public health and health care system that effectively meets the needs of Oregon’s diverse and geographically disparate populations:

- The Latino population has almost doubled in the last 10 years, and is now the largest minority population with well over 400,000 people.
- Asian Americans number over 130,000 in the state.
- American Indian and Alaska Native and Black/African-American populations number 67,000 and 63,000 respectively but experience disproportionate health burdens that result in unacceptable costs for individuals, families, communities, and health systems.
- International migration is adding to the cultural and language diversity of the state, with the Russian community continuing to grow, along with Somali and Iraqi populations. Oregon is expected to add 197,000 through international immigration over a 30-year period ending 2025.

These demographics create significant opportunities for improvement and challenge Oregon’s health system to provide care in culturally appropriate ways, including developing a provider workforce that reflects our state’s growing diversity. Recruiting and retaining a racially and ethnically diverse workforce is essential to assuring effective health practices, access to care, and health outcomes for populations experiencing significant health burdens. Unfortunately, few of Oregon’s medical school graduates represent minority communities. In 2007, only eight of 121 graduates were Latino, African American, Native American, or Pacific Islander. As these groups and other minority populations continue to grow, it is important to have health care providers who understand the cultural norms and expectations (including patients’ values, beliefs, religion, and communication styles) of each minority population, and who speak the language or who have high quality translation and interpretation services available.

What We Need To Achieve

Reach the highest possible level of health for all people.

In implementing health care reform, the Oregon Health Policy Board and the Oregon Health Authority will strive proactively to avoid creating or maintaining health policies that perpetuate or increase these avoidable and unjust health inequities. OHA and its Board are committed to promoting health equity for all people in all regions of the state, inclusive of race, ethnicity, socioeconomic status, occupation, ability and sexual orientation. Tackling health inequities also requires looking at the ways in which jobs, working conditions, education, housing, social inclusion, media and even political power expand or limit individual and community health. When health and societal resources are distributed equally, population health will be equitable as well.

Next Steps to Realize Health Equity

Despite these challenges, many opportunities exist to create equitable health outcomes for all of Oregon's diverse populations. These are directly connected to the Board's other key foundational strategies.

- **Using Community Health Workers as team members for the delivery of primary care, behavioral health care, and community prevention improves health outcomes** because they are trained and trusted members of the communities in which they work and share culture, language, and experience with patients. This is especially important in communities of color or other underserved communities. Community health workers are already successfully providing culturally specific, preventive, patient-centered health care in some of Oregon's most underserved areas. Creating incentives to encourage the use of community health workers is prioritized in the OHPB's strategies for a healthy Oregon.
- **Ensuring that licensed health care providers receive ongoing training in cultural competence.** With Oregon's increasingly diverse population and strong evidence of racial and ethnic disparities in health care, it is imperative that health care professionals are educated to work effectively with diverse groups. Ongoing training in cultural competence will improve provider-patient communications, public health efforts, and health outcomes.
- **Doing more to collect and analyze data at the most granular levels of race, ethnicity, national origin, language, ability, sexual orientation, education and literacy level, and occupation** will help health systems, community groups, and consumers better understand quality and health outcomes. This helps ensure that our efforts are improving the health and lives of diverse communities within Oregon.

For More Information

Please see: Health Equities Policy Review Committee Report
(link to web site and other ways of getting the report – by phone/email)

Strategy #4

Make it Easier for Oregonians to get Affordable Health Insurance and Quality Care

Health Insurance Exchange

Many Oregonians currently cannot afford insurance for themselves or their families. The uninsured put off needed care and are forced to seek emergency care when small issues turn into large ones due to inattention. The health insurance exchange will help people get insurance coverage, which will help them seek care when they need it and in the most appropriate, lowest cost settings for their needs.

An estimated 150,000 previously uninsured Oregonians will take up individual coverage through the health insurance exchange. Thousands more will gain coverage through the exchange as members of small employer groups. As more Oregonians have health insurance, providers will not need to recoup the costs of providing uncompensated care to the uninsured by increasing charges to the insured population. The newly insured will benefit, as will providers and the currently insured.

What We Need To Achieve

A mission driven public corporation that will coordinate purchasing strategies through a strong health insurance exchange

Oregon's health insurance exchange must work for consumers and participating insurance carriers by: providing useful, comparative information on health plan offerings, benefits and costs; helping individuals, small employers and their employees to access insurance that meets their needs; helping people access premium tax credits and Medicaid; and simplifying options and processes across the industry. Health plans in the exchange will meet higher standards on outcomes, quality, and costs.

An exchange that proves its value to consumers and other stakeholders will flourish, ensuring access to quality, affordable health plans.

Next Steps in Implementing an Exchange

An exchange will be most successful if developed consistently with the overall health reform goals in the state. Together the OHA and Legislature can ensure that Oregon's exchange is consumer-oriented, easy to use and offers value now and in the future.

- **Establishing a mission-driven public corporation to coordinate purchasing strategies for all Oregonians, starting with a health insurance exchange for the individual and small group markets.** The legislation will ensure accountability of the corporation through strong public participation, annual reporting, and the use of consumer advisory groups and surveys. A public corporation with the legislative authorities to act as a strong

purchaser can drive high value in the health care system. This organization will be built to be:

- a publicly accountable organization that is responsive to consumers, health plans and the state but fiscally separate from state budget cycles;
- flexible and agile;
- an entity that effectively works with state and business partners to ensure access for Oregonians of all income levels and in all geographic areas of the state.

To optimize accountability to consumers, the general public, vendors, and state and federal governments, the exchange charter should include a consumer oriented mission statement and provisions such as: public meetings and records; public input processes; Governor appointment and Senate confirmation of Board members; annual reporting to the Governor and Legislature; consumer surveys; inclusion of ex officio board members (the Oregon Health Authority and Department of Consumer Services directors and a member of the Oregon Health Policy Board); and consumer advisory groups.

- **Establishing a governing board to lead the public corporation.** The Policy Board supports the establishment of a public corporation governing board that will implement and run the exchange, guide the corporation, and ensure the exchange mission is the organizing principle for exchange operational planning, implementation and administration.
 - Exchange board members will have experience and knowledge in individual insurance purchasing; business; finance; consumer retailing (especially web-based access for consumers); health benefits administration; individual and small group health insurance; and other areas to be identified.
 - To ensure no conflicts of interest arise, board members should not make their living from the health care or health insurance industry. To ensure the exchange's accountability to consumers and the state, the Corporation board will include two high level state employees: the directors of the Oregon Health Authority and the Department of Consumer and Business Services, as well a member of the Oregon Health Policy Board.
- **Conducting operational planning for the exchange based on the Policy Board's vision and principles.** Under the Policy Board's direction and the exchange legislation to be considered in 2011, continue developing plans to implement an exchange for use by the public by 2014.
- **Building the exchange to advance health equity by taking into consideration the needs of Oregonians of various races, ethnicities, ages, geographies, physical and mental abilities and other considerations.** This includes but is not limited to the following efforts:
 - Education and marketing must be targeted to various communities in order to help people understand the value of the exchange and to learn how to use it to improve their access to insurance and health care services.
 - Community organizations of all types must be encouraged to become trained "navigators" that will help individuals and small businesses use the exchange to determine eligibility for assistance, assess health plan options and enroll in coverage.

- **Improving access to care by ensuring that participating health plans are of high quality and value** for the consumer, and providing consumers with access to premium tax credits and cost-sharing assistance.
 - Information on participating plans, including quality and access measures, will be readily available to consumers seeking to find or change a health plan. Reporting on measures such as access to care will help consumers determine which plans works best for them. Participation in the exchange will be a sign to consumers that a health plan meets higher standards than those in the market at large on measures such as access, quality and cost.
 - Plans participating in the exchange will use innovative payment methods (e.g. bundled payments, pay-for-performance), evidence- and value-based benefit designs, and standards for primary care, care coordination, and other elements to provide value to consumers and purchasers.
 - The exchange will be the conduit through which individuals with income up to 400% of the federal poverty level (\$88,200 for a family of four in 2010) will access the federal premium tax credits that will make health insurance much more affordable for many people. In addition, individuals with income up to 250% of the federal poverty level will gain access to cost-sharing assistance through the exchange.

For more information

Please see: Health Insurance Exchange Report and appendices
(link to web site and other ways of getting the report – by phone/email)

Strategy #5

Address remaining barriers to health care

Enough health care providers and easy access to care

Today, 17% of Oregonians are uninsured. We project that, by 2014, 93% of all Oregonians will have access to health care coverage as a result of insurance market reforms to remove barriers, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits to help make coverage offered through exchanges more affordable. Oregon's Medicaid enrollment is expected to grow by 60%. Despite these gains, 7% of Oregonians will remain uninsured.

We have a responsibility to ensure that newly-covered can find health care providers and a moral obligation to make certain that the remaining uninsured still have access to care. Decisive action must be taken now to ensure that Oregon has a health care workforce capable of meeting the demand for quality services in 2014 and beyond.

What We Need To Achieve

All Oregonians should be able to get the health services they need close to home, from a team of appropriately trained health care providers.

While expansions in health insurance will provide unprecedented levels of coverage, they will also put unprecedented pressure on the delivery system. We also know that having health insurance is not the same thing as having access to care. To ensure that Oregonians can get the health care they need, when and where they need it, we must:

- Foster the development of local and regional solutions for health care access that include Oregon's traditional safety-net providers;
- Improve the capacity and distribution of the primary care workforce;
- Expand education and training opportunities;
- Train, recruit, and retain a workforce that is diverse, culturally competent, and prepared to change the way health care is delivered; and
- Successfully implement insurance expansions.

Next Steps

The strategies below address both our current health care workforce needs and the needs Oregon might have in the future, when health care delivery looks different than it does today.

- **Develop regional frameworks for health in cooperation with community stakeholders.** Communities and regions are uniquely qualified to develop locally relevant strategies to improve health outcomes and address the health disparities that exist within their populations. Oregon's traditional safety net providers have significant experience providing health care services to diverse populations within fixed resources and their expertise would

benefit any regional frameworks. Development of entities such as regional accountable health organizations will reduce fragmentation and improve access by integrating physical, behavioral, oral health, and long-term care at the local level.

- **Revitalize the state's primary care practitioner loan repayment program** to help meet the demand for care and support a renewed emphasis on preventive and primary care across the health system. Loan repayment effectively encourages providers to choose primary care and to practice in rural and underserved communities.
 - 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 funded at a level that would provide these areas of the state with at least 30 additional professionals every year. [[Need to add size of impact]]. The Legislature and the Office of Rural Health should investigate sustainable financing mechanisms.

- **Align student requirements for clinical training.** To streamline and increase capacity in the final stages of training for health professionals, OHA will work with relevant stakeholders to:
 - Standardize student prerequisites for clinical training (drug testing, criminal background check, HIPAA training, etc.) via a student "passport" (2011).
 - Establish uniform standards for student clinical liability to reduce the time and expense of contract negotiations between educational institutions and training sites and explore ways to encourage more community-based and outpatient practices to serve as clinical training sites (2012).

- **Revise policies that prevent public educational institutions from responding quickly to health care workforce training needs.** Current interpretation of a law designed to ensure that public investment does not adversely impact private business means that private entities can block development of new public training programs or program locations even if they do not intend to offer the training themselves. The result is that training programs for high-demand health care occupations may not be equally available to rural and urban students or to rural or underserved communities. OHA will convene stakeholders in the first half of 2011 to draft revisions to the law.

- Use a range of methods to **recruit and retain a workforce that is racially and ethnically diverse and culturally competent.** Improving the diversity and cultural competence of Oregon's health care workforce will produce a range of benefits including increased access to care for vulnerable populations, improved patient-provider communication and quality of care, and expanded availability of living wage careers for racial and ethnic minorities.
 - OHA will collaborate with health care professional regulatory boards and professional societies to identify the best methods of ensuring that licensed health care professionals receive ongoing training in cultural competency.
 - OHA will incorporate incentives for using community health workers into primary care payment reform and implementation of patient-centered primary care home standards.

- **Adopt payment systems that encourage use of the best provider (or provider team) for a given care need.** Payment structures like fee-for-service tend to encourage higher-level practitioners to see patients even when the same care could be provided as well or better—and less expensively—by other qualified providers. This means we are not using our health care workforce as fully as we could be, which reduces access and increases the overall cost of care. Rapid transition to more comprehensive and/or accountable payment systems, particularly in primary care, will enable practices to build teams that use the best combination of providers to meet patient needs in an efficient way.
- **Expand health care workforce data collection** for a more complete picture of Oregon's health care workforce. Complete and accurate information on all licensed providers is essential for design and evaluation of strategies to improve access, including efforts to increase workforce diversity.
 - Legislative action to extend participation requirements for Oregon's health care workforce database to all health professional licensing boards in 2011, with actual reporting to begin with the boards governing licensed mental and behavioral health care professionals.
- **Successful implementation of insurance expansions.** For coverage expansions through Medicaid and a newly created health insurance exchange to be successful, Oregonians must know what their insurance options are and how to access them. This will entail:
 - Developing outreach and marketing plans that effectively utilize community partners;
 - Implementing application assistance strategies;
 - Implementing efficient electronic eligibility and enrollment systems that will increase current system capacity;
 - Developing clear communication strategy about eligibility and coverage information for public and private insurance options; and,
 - Assessing eligibility and enrollment requirements to ensure that current policies do not create inequities and/or unnecessary burden.

For more information

Please see: Healthcare Workforce Committee Report and appendices
(link to web site and other ways of getting the report – by phone/email)

6 - Set standards for safe and effective care

Primary care home, electronic health information, and evidence-based care

The health care each of us receives varies for a number of reasons, leading to less than optimal health outcomes in some instances and overuse of care in others. We need to create the standards and other tools that will ensure that high quality, effective care is uniformly provided to everyone. Oregon's 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. Public and private health care purchasers must expect this level of excellence and build these expectations into contracts.

We need standards to achieve:

- **A sustainable system that links payment to achieving improved value.** The Board envisions a health care system where the tools are available to pay for quality while living with a budget, hold providers responsible for the quality and efficiency of care they provide, and rewards good performance and keeps total spending to a fixed rate of growth. Restructured and incentive payments that reward care coordination in new delivery models such as patient-centered primary care homes (PCPCHs) are key examples. Designed to put patients at the center of their relationship with the delivery system, PCPCHs can reduce unnecessary Emergency Department visits and hospitalizations while increasing adherence to treatments and improving self-care.
- **Electronic health information and administrative data available when and where it is needed.** Increase the quality and safety of health care with better information at the point of care;
 - Increase the efficiency of the health care system with standard electronic processes for claims and payments;
 - Improve population health through better surveillance of disease outbreaks, immunization records and variations in quality/cost by community; and
 - Ensure patients have access to their personal health information to share with others involved in their care and enable better health care and lifestyle choices.
- **Health care is consistently high quality, evidenced based, and safe.** Care should be guided by evidence-based practice guidelines built on the best available research in order to reduce inconsistency, improve health outcomes, and eliminate unnecessary costs. Additionally, our medical liability system should be a more effective tool for improving patient safety, and providing more efficient and equitable compensation for patients who are injured due to medical errors.
- **Health insurance that pays for high-value services which produce the best health results for the money spent on them.** These value-based benefit plans prioritize access to the most effective (or high value) health services and prevention activities and make them available through the exchange. Conversely, these plans reduce or eliminate barriers to the most effective health services and create disincentives for less effective services or ones that have little impact on health through the design of health care benefits.

Next Steps

- **Move forward decisively to transform the primary care delivery system.** Patient-centered Primary Care Homes (PCPCHs), in which teams of health care providers offer coordinated, comprehensive care in collaboration with patients, are fundamental to achieving Oregon's Triple Aim.
 - All payers and primary care providers need to be involved to realize the full benefits of this care model but OHA will take the lead by formally adopting existing Oregon PCPCH standards and a structure to align payment with those standards.
 - The state will begin to implement PCPCHs in 2011, in regions where it has significant purchasing power, with the goal of adoption of the PCPCH model statewide by 2015.

- **Continue to identify and continuously refine a core set of health and health care quality and efficiency measures** that can be used to assess Oregon's progress towards the triple aim. These measures should align with the measures used in focused quality improvement and cost containment initiatives but would be broader in scope to reflect the range of health and health care reforms underway in the state.

- **Refine elements of the value-based benefit package into a marketable and implementable plan design.** Results of focus groups indicate that there are significant administrative, operational and educational challenges to overcome before the design could be successfully implemented. Even so, participants gave positive feedback about the concept of value-based benefit design. Implementation steps include:
 - Assign accountability within OHA to developing implementation plans for the value-based benefit plan across OHA programs – including Medicaid fee-for-service and managed care, Public Employee Benefits Board, and the Oregon Educators Benefit Board - by January 2012. Consider the use of pilot programs, a phased implementation and/or implementing the most appropriate elements of the design for different populations. This would also include assessing what could be implemented now versus what can be implemented in the new Oregon Health Insurance Exchange in 2014.
 - Creating a sophisticated actuarial tool that can be used by different purchasers to compare their current benefits with the value-based essential benefit plan and assess how it will lower their healthcare expenditures. This will include additional actuarial work on each value-based service to weigh costs and savings for each intervention
 - Examining how benefit design can be coupled with payment incentives to increase the use of effective services and treatments to improve health.
 - Working with impacted stakeholders to address administrative and operational concerns.

- **Develop and set health information exchange (HIE) policies, requirements, standards and agreements** to further the exchange of health information between health care providers, hospitals, medical labs, pharmacies, ambulatory surgery centers, long-term care

facilities, and state and local health departments. This would include privacy and security requirements for the secure and appropriate exchange and use of health information.

- **Develop uniform methods for payers to make clinically significant decisions, such as prior authorization of diagnosis or treatment and approval of referrals for further care.** Prior authorization and referral requirements are important ways health plans try to make sure they pay only for appropriate care. However, these processes are unnecessarily time-consuming and costly for providers and plans. In 2011, OHA will lead a process for developing uniform methods for requesting authorization and uniform approval standards that are consistent with good medical practice.
- **Change state law to remove barriers that discourage physicians and facilities from disclosing medical errors and discussing them with their patients.** A critical first step in patient-centered reform is ensuring that when a patient suffers unanticipated harm in the course of treatment, a thorough investigation is done and any errors are disclosed to and discussed with the patient and the patient's family. Disclosure to patients is the first step both for involving patients in managing their own care and in negotiating fair payments to compensate for negligence without unnecessary legal costs.

The following steps will be taken to remove barriers to disclosure:

- We will allay physician fears that discussing an error with a patient will be treated as non-cooperation by their malpractice insurer through legislative action forbidding insurers from refusing to defend a lawsuit or cancelling a policy because a physician discloses an error.
- We will allay concerns that discussing errors with patients will be used to establish liability for medical negligence by legislation to amend the state's apology law, which currently protects physicians, so that it protects health care facilities as well.

In addition, with the legislature's assent, we will invite physician practices to participate in the Patient Safety Commission's error reporting program, which helps physicians learn to assess the cause of errors, how to prevent them from happening again, and how to disclose them to their patients.

- **Identify and develop 10 sets of Oregon-based best practice guidelines and standards** that can be uniformly applied across public and private health care to drive down costs and reduce unnecessary care. This work will be conducted by the Oregon Health Services Commission and the Oregon Health Resources Commission in close collaboration with providers, the Center for Evidence-Based Practice, and other key stakeholders.
- **Exploring the potential of evidence-based guideline safe harbors.** OHA has received federal funding to consider using evidence-based guidelines to replace the traditional medical malpractice rules in specific situations. In other words, for carefully described situations where there is strong evidence that patients do better when physicians follow a particular course of treatment, the malpractice law could require physicians to use best practices rather than just avoiding substandard practices. The hope is that by adopting guidelines clarifying expectations for providers and giving physicians that follow them a

safe harbor from malpractice liability, medical errors and legal costs can both be reduced. During 2011, OHA will continue to investigate the value of the concept and discuss it with a broadly representative group of Oregonians.

For more information

On primary care home and payment reform:

- Oregon Patient-Centered Primary Care Home Standards (*newest one with pediatric update*)
- Incentives and Outcomes Committee Report and appendices (link to web site and other ways of getting the report – by phone/email)

On electronic health technology and exchange, please see:

Health Information Exchange [Strategic](#) and [Operational](#) Plans for Oregon. Health Information Technology Oversight Committee.

http://www.oregon.gov/OHPPR/HITOC/Documents/hitoc_reports.shtml

On administrative simplification, please see:

Administrative Simplification Work Group Report and appendices
(link to web site and other ways of getting the report – by phone/email)

On value-based benefit design, please see:

- Presentations given to the Health Policy Board in August and October
- Health Services Commission's Sets of Value-based Services
<http://www.oregon.gov/OHPPR/HSC/VBS.shtml>
- Oregon Cost-sharing Workgroup website
- Oregon Health Fund Board's Benefits Committee Report
<http://www.oregon.gov/OHPPR/HFB/Benefits/FinalRecommendation.pdf>
- Health Services Commission's Prioritized List of Health Services
http://www.oregon.gov/OHPPR/HSC/current_prior.shtml

#7 – Involve Everyone in Innovations

Consumers, patients, health partners and regional health care organizations

The fragmented and fragile health care system we have now is on verge of collapse. 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, not on quality or evidence. Health care providers are responsible for patients in their own facilities, but coordination with outside facilities and providers is typically lacking. Our mental health, substance abuse, and oral health care needs are too often unaddressed or under addressed by a fragmented and complicated system that is insufficiently tailored to meet the diverse needs of Oregon’s population. Our public health and medical systems operate in silos and efforts to improve health in the medical sector are too often disconnected from prevention at the community level.

What We Need To Achieve

- **A transformed and coordinated health system where every Oregonian has high-quality health care and the patient is at the center of the innovations.**

The Board proposes an infrastructure of partners to support 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.

Strategic and coordinated communication about the changes Oregon is making and active engagement of patients and consumers in the design and implementation of those changes will be critical to the success of this Action Plan for Health.

Next Steps to Inclusive Innovation

The Board recognizes the truism that “all health care is local” is particularly relevant in a state as geographically, politically and increasingly as racially diverse as Oregon. By establishing a framework in which locally-based innovation and creative problem-solving can thrive, Oregon can move forward delivery system reforms which meet the unique health needs of the local or regional populations, while ensuring that the consumer and patient needs remain at the center of all these efforts.

- **Design a framework to foster public-private partnerships.** Each of these partners for health has specific roles to play; some current partners may have different or evolved responsibilities, while new entities are created to fill gaps in the existing system. These partners include:

- ***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 and educator benefits and public-private partnerships. This alignment allows the OHA to focus on health and preventive care, provide access to health care, reduce health inequities, 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, tailored approaches to reduce health inequities, 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.

The Oregon Health Authority also has a responsibility to provide the statewide support and oversight needed to assist local communities and regions in their focus on world class health. The OHA will collaborate with local partners to identify the best in clinical preventive services for the health care system, provide technical assistance to communities seeking to assess and plan for better health outcomes, and together with partners at the regional and local level review and implement policies, like the Indoor Clean Air Act and menu labeling, that can impact the health of all Oregonians.

- ***A mission-driven Public Corporation to coordinate health care purchasing, beginning with the Health Insurance Exchange***

A public corporation should be established with a broad mission to be accountable for organizing the purchasing of health insurance for everyone, beginning with the individual and small group insurance markets, 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 health care budget for lives using the services of the corporation, it 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.

- ***Public Health Infrastructure***

Local and state public health systems will lead and support other partners in shifting their focus to prevention. The Oregon Health Authority can provide the science, data, tools, and technical assistance needed to assist partners and communities in creating a culture of health and improving and tracking overall health outcomes. Additionally, the OHA will remove policy barriers that hinder health promotion efforts and implement statewide policies to support them. At the community level, public health organizations will be active participants in locally accountable health entities and key resources for development and implementation of local health improvement plans.

- ***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.

- ***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.

- ***Patients and the Public***

The people of Oregon are our most important partners.

- **Encouraging the health care delivery system to become more patient- and family-centered** is one of the key strategies to improve health care quality because, when patients and families participate as full partners with health care professionals, system performance improves. As a first step, OHA will work closely with communities and providers to develop standard measures of patient engagement and experience, so we can see where improvements are needed.
- **Engage patients in their own care.** Patients are probably the largest health care workforce available. When patients have the knowledge and resources to manage their health conditions effectively, they can avoid crises and thereby reduce the need for more intensive professional care. In implementing patient-centered primary care homes, OHA will work to incorporate evidence-based chronic disease self-management programs and community health workers to help patients bridge clinical and community-level care. OHA will also explore ways to give provider organizations the technical assistance they may need to involve patients and their families in issues beyond their own care. We will not reach our quality goals without engaging patients and families as advisors in quality improvement and practice design.
- **Develop a comprehensive communication and outreach plan for all health reform activities.** This is different than branding efforts or marketing plans, though it includes those elements, along with educational materials. The changes we are beginning to make are far-reaching and complex and support from patients and consumers will be critical to their success. Communication and outreach must begin immediately so that we can build consumer confidence and patient trust in advance of the large-scale changes to come.
- **Creating effective consumer education** is vital to realizing the potential of value-based benefit designs. For the financial incentives and disincentives of such designs to work, consumers need clear and specific information about what is covered and what their costs would be for a given service. It will be important for the OHA will partner with other public and private sector experts and stakeholders to broadly distribute a variety of consumer education and decision aids in support of new health care and health improvement opportunities, such when value-based benefit plans are made available.
- **Continually improve the public input process** to ensure that we get needed feedback from a wide range of Oregonians throughout the implementation process.

For More Information

Please see:

- Incentives and Outcomes Committee Report and appendices (link to web site and other ways of getting the report – by phone/email)
- Oregon Health Improvement Plan Committee Report and appendices (link to web site and other ways of getting the report – by phone/email)
- Health Insurance Exchange Report and appendices (link to web site and other ways of getting the report – by phone/email)

Strategy #8

Measuring Our Progress

Timely data and meaningful information

The best-run and most successful businesses always know where they stand: what raw materials cost, how much inventory they have, how many orders they have for their goods or services, and a clear plan or vision of where they want their business to be in a year or in five to 10 years. If Oregon is to transform its health care system, it needs to know these same types of things. This *Action Plan* is the clear vision and plan and a variety of metrics will help us assess whether we are achieving that vision and implementing plans successfully.

What We Need To Achieve

Timely, meaningful information about our health and how well Oregon’s health system is performing.

Everyone who participates in the health care system—consumers, providers, employers, insurers, and others—needs timely, accurate information that they can use to help direct their actions and assess the results of those actions. Meaningful data will inform public policy decisions, serve as a resource for patient engagement and development of local solutions, and will help drive broad-based improvements in clinical quality and efficiency.

Next Steps

The Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) are working on three levels to develop strong measurement tools and infrastructure.

- **Oregon Scorecard:** At the big picture level, OHPB is developing an Oregon Scorecard that will provide a simple, statewide overview of the performance of Oregon’s health system with respect to the triple aim: improve the health of all Oregonians; increase the quality, reliability, and availability of care, and reduce or control costs so that care is affordable for everyone.

An early draft of what might be included in an Oregon Scorecard is provided below. This is a work in progress and is intended to provide a starting point for discussion; the indicators may change as health reform progresses or as new data sources and measurement methods are developed. As the scorecard matures, it should serve as one of many resources for informing policy decisions, setting targets for future performance, and evaluating the impact of reform strategies. Please note: a more detailed version of this draft scorecard including information on data sources, indicator definitions, and timeframes is available in Appendix C.

- **Standard quality measures:** On a more operational level, the OHPB and the OHA are also working on standard quality measures that can be used by both public and private entities to evaluate the effect of delivery system changes on health outcomes, the quality of care provided, and return on investment.

- **Improved data sources.** The OHA is working to develop key data sources that are expected to significantly improve the state’s capacity to measure health care quality and cost:
 - *Demographic data collection.* Improving and expanding collection of detailed information on race, ethnicity, language and other demographic factors across all data systems will help the OHPB and OHA identify and address health disparities. This is critical because the data that are available for different population groups reveal unacceptable inequities. For example, the percentage of adults with a tobacco or obesity-related chronic disease is 39% among the general population in Oregon but is 58% among African-Americans and 56% among American Indians and Alaska Natives. Similarly, low-income Oregonians are significantly less likely than middle- or higher-income residents to get recommended cancer screening like mammograms (52% vs. 73%). Action to improve and expand collection of accurate demographic data, as called for earlier in this Plan, will allow us to see if our efforts are truly improving the health and lives of *all* Oregonians.
 - *The Oregon All-Payer, All-Claims (APAC) Reporting System.* By 2012, this system will consolidate health care claims from Medicare, Medicaid, commercial insurers, third party administrators and pharmacy benefit managers. The dataset will include information on diagnoses, procedures, charges, and payments, as well as member demographics and provider information. When the system is fully in place, we will have more timely and detailed cost information and ability to construct claims-based quality indicators that reflect the experience of almost all insured individuals in Oregon. The dataset will also enable OHA to see how performance varies between geographic areas and health systems within the state.
 - *Oregon Health Information Exchange.* Oregon’s plans to develop a system of exchanging electronic medical information across the state will result in vast improvements in the availability and quality of data about health care processes and patient health outcomes. As clinical data—including data from electronic health records or EHRs—become more accessible and better connected, measurement plans will likely be revised to take advantage of this rich information source.

DRAFT Oregon Scorecard

Potential Indicators as of December 2010

Indicator	Oregon	National	Data year
IMPROVE THE HEALTH OF ALL OREGONIANS			
% of adults reporting good or excellent health status	87.1%	84.9%	2009
% of adults with a tobacco- or obesity-related chronic disease	39.0%	Not available	2009
% of Oregonians who currently smoke (adults / 8 th graders)	17.5% / 9.9%	17.9% / not avail.	2009
% of Oregonians who are considered obese (adults / 8 th graders)	24.1% / 11.2%	27.2% / not avail.	2009
% of Oregonians who are physically active (adults / 8 th graders)	56.7% / 57.5%	50.6% / not avail.	2009
Oregon high school graduation rate	66.2%	<i>tbd</i>	2008-9 cohort
Percent of babies born at low birthweight	6.2%	8.2%	2009 (prelim.)
INCREASE THE QUALITY, RELIABILITY, AND AVAILABILITY OF CARE			
Access			
% Oregonians who do not have health insurance			
Overall	17.0%	15.1%	2009
Kids 0 - 18	10.9%	9.0%	2009
Adults 19-64	22.9%	20.7%	2009
Primary care provider density	available Jan 2011	--	--
% adults who had a routine check-up in the last year	67.8%	Not available	2008
% adults who had a dental visit (for any reason) in the last year	71.4%	71.2%	2008
Prevention & chronic disease care quality			
% 2-year olds who are up to date on immunizations	73.8%	71.3%	2008
% women (40-69 years) who got a mammogram to check for breast cancer	73.5%	64.0%	2008 & 2009
% adults (50 years +) who have ever been screened for colorectal cancer	66.8%	61.8%	2008
% diabetics who got an HbA1C test for blood sugar in the last year	86.0%	75.0%	2008 & 2009
Hospital and acute care quality			
% of patient rating hospital quality of care as 'high'	67.0%	66.0%	2008 - 2009
Blood stream infections from central lines (CLABSI) (per 1,000 line days)	0.86	1.92	2009
Hospital deaths related to:			
CABG (coronary artery bypass graft)	2.9%	2.2%	2009
Hip fracture	2.9%	2.2%	2009
Avoidable cost drivers			
Hospital admissions that could have been prevented (per 100,000)			
for chronic heart failure (a chronic disease example)	206.6	415.5	2009
for pneumonia (an acute condition example)	237.7	374.8	2009
for asthma (among kids)	47.6	134.8	2009
% patients with low back pain who got MRIs <i>before</i> more conservative care	36.2%	32.7%	2008
Hospital readmissions rates (ratio of actual to expected readmits):			
for chronic heart failure	23.5	24.7	2006-2009
for heart attack (AMI)	19.1	19.9	2006-2009
for pneumonia	17.1	18.3	2006-2009
Infrastructure			

DRAFT Oregon Scorecard

Potential Indicators as of December 2010

Indicator	Oregon	National	Data year
Rate of EMR adoption (ambulatory settings)	65.0%	44%	2009

REDUCE OR CONTROL THE COST OF CARE

% adults reporting that they didn't get medical care because of cost	10.5%	not available	2008
Average monthly health insurance premium for a family	\$1,069	\$1,085	2009
Per capita expenditures for personal health services	\$4,880	\$5,283	2004
Average annual growth in per capita expenditures	7.7%	6.7%	1991-2004
Per capita personal medical expenditures for:			
Hospital care	\$1,671	\$1,931	2004
Physician and professional services	\$1,433	\$1,341	2004
Rx	\$569	\$757	2004
Dental care	\$354	\$277	2004