



Sustainable healthcare expenditures for the state of Oregon December 2, 2014

Background

In the last several years, Oregon has engaged in efforts to transform the health care system, guided by the Triple Aim of better health, better care, and lower costs. In June 2013, the Governor tasked the Oregon Health Policy Board (OHPB) with developing strategies to better align Oregon's health system reform efforts and spread the triple aim goals across all markets. OHPB responded with a report outlining three key strategies:

1. Create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, which tracks the effect of ACA implementation and Oregon's health system reforms.
2. **Move the health care marketplace toward a fixed and sustainable rate of growth.**
3. Improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure.

To implement the second strategy of moving toward a sustainable rate of growth, OHPB instructed the Oregon Health Authority (OHA) and the Oregon Insurance Division (OID) to create a workgroup to develop a sustainable rate of growth methodology for the total cost of care.

Sustainable Healthcare Expenditures Workgroup Process

The Sustainable Healthcare Expenditures Workgroup (SHEW) was chartered to recommend a method to compute health care expenditures. In April 2014, the OHPB instructed the SHEW to focus exclusively on the technical aspects of the calculations. The workgroup proceeded with the following charges:

The SHEW is comprised of members representing the Oregon Business Council, the Oregon Health Leadership Council, the Oregon State Public Interest Group, health insurance plans, and providers (see Appendix D). Members were appointed by the Commissioner of OID and the Director of OHA. The SHEW conducted five meetings between May and November 2014. The SHEW was charged with the following:

- Select elements to include or exclude from the expenditure calculation
- Identify appropriate data sources
- Comment on caveats, data gaps, and potential areas of improvement

OHA engaged John McConnell, Ph.D., Director of Oregon Health & Science University Center for Health Systems Effectiveness (CHSE) to formulate the expenditure methodology. The group reviewed expenditure efforts from other states, including Vermont, Massachusetts, and Maryland. By October 2014, the group reached a consensus on a calculation methodology focused on measuring spending. Dr. McConnell completed preliminary calculations (see Appendix A), with final calculations to be completed in December 2014.

This report outlines the methodology selected by the SHEW, as well as recommendations to implement the methodology.

Approach

The guiding principles for the SHEW's work include transparency, accuracy, and feasibility. There was also sentiment that existing data sources should be used and the methodology kept simple and practical. The group agreed to begin with a simple model using the OHA All-Payer All-Claims database and build from there to track population and per capita spending and assessment of impacts of population growth and coverage changes.

Given the OHA All-Payer All-claims database was identified as an existing source for calculating expenditures, the SHEW defined total health care expenditure is a measure of statewide spending from both public and private sources on provider-billed services. After much debate about the best approach, the committee decided not to attempt to calculate the true cost of delivering health care, as much of the needed information to compute costs is not readily available. Spending includes patient cost-sharing amounts such as deductibles and co-payments in addition to provider-billed services.

The overall approach includes using available data to construct estimates of per-member, per-month (PMPM) spending for relevant insurance groups. Then, use available data to estimate member months (or member years) in each group to calculate spending in per member and aggregate dollars.

The payer categories included in the estimate are:

- Medicaid
- Medicare – Fee-for-Service
- Medicare Advantage
- Commercial
- Veterans Health Administration
- Medicaid/Medicare dual eligible
- Uninsured

The Medicare population is broken into two categories due to the insurance options available to beneficiaries: Medicare Fee-for-Service and Medicare Advantage. In this measurement framework, Medicare Advantage members are part of the Commercial category, since private insurers administer the insurance product to the Medicare member.

Uninsured is listed as a payer category even though spending by uninsured individuals is not based upon insurance claims. Their spending is based on a different set of assumptions, which will be explained further in the next two sections. Even though the Uninsured group requires different calculations, the SHEW recommended that spending by this population should be calculated and tracked over time. The uninsured are significantly impacted by expanded health insurance coverage from the Affordable Care Act.

More detailed methodology information including data sources, exclusions, and caveats are included in Appendix A.

Results

The total healthcare expenditure measurement framework for Oregon is a work in progress. Preliminary results are available in Appendix A. These results will be updated and finalized in December 2014. Once

Cost vs. Spending

Cost refers to the actual expense of providing health care services, including supplies, labor, and overhead.

Spending refers to the amount paid for health care services. This includes payments by public and private insurers, as well as payments made by patients, such as co-payments.

the initial methodology is finalized, spending across multiple years (2011, 2012, and 2013) will be calculated to assess trends in health care spending across Oregon. Additional analysis could examine where spending is highest, drivers of spending, and possible impacts of health care transformation efforts. This tool is envisioned as one among many tools that can be used to measure transformation and inform health care policy decisions. The committee members had general consensus that focusing on claims spending is a credible and simple approach that represents the best that can be done with existing data sources. The committee expressed a need to track how changes in the health care payment landscape may affect calculations – for example, ICD10 conversion – and make adjustments as appropriate to the methodology or recommendations for use.

The current methodology excludes some aspects of expenditures in the health care market, including services that do not have readily available data sources and which likely do not represent large proportions of overall spending at this time. The committee members were largely comfortable with noting these existing exclusions, and currently there are no plans to incorporate these elements into the methodology. The following are excluded from the calculations:

- Settlement payments – payments resulting from litigation or other mediated processes
- Claims related to substance use are redacted in the All-Payer All-Claims database
- Wrap around payments related to Federally Qualified Health Centers
- Over-the-counter medications
- Alternative care such as massage, naturopaths not offered as a covered benefit
- Patient non-covered or non-submitted spending
- Workers compensation
- Other government programs (Indian Health Services, SAMSHA)

Assessment of next steps:

- Finalize expenditure methodology and source data, and validate estimates against other sources. This work is to be completed by December 15, 2014.
- Expand expenditure categories from payer-specific (Medicaid, Medicare Commercial, etc.) to patient-related descriptors such as pregnant women, non-pregnant adults, children, and infants for all payer categories.
- Add additional time periods so the calculations include expenditures from 2011, 2012, and 2013 to assess trend.
- Include new data components. The measurement framework currently excludes some data components because they were not readily available using existing data sources. The SHEW recommends that these data could contribute to the overall utility and accuracy of the measurement framework, and efforts should be made to examine the feasibility of incorporating some or all of the following and incorporate over time when possible:
 - ♦ Long-term care
 - ♦ Dental care
 - ♦ Vision care
 - ♦ Carrier administrative expense – net of health premiums collected and benefits paid, as well as net additions to reserves, profits, or losses
 - ♦ Medicare Part D Fee-for-Service
 - ♦ Non-claim based or flexible spending by private or public payers on member needs

Committee Recommendations

The SHEW recommends the following four strategies be implemented to refine and utilize the health care spending methodology with the long term goal of moving the health care marketplace toward a fixed and sustainable rate of growth:

1. To continue with a simple, transparent approach to measuring spending using available data sources while recognizing the limitations.
2. To continue working with Dr. McConnell and CHSE to complete and further refine the measurement framework. The target for CHSE is to have more complete calculations in December 2014 for the SHEW to review and provide input. The SHEW recommends an additional December meeting to review the final calculations.
3. To calculate health care spending for multiple years (2011, 2012, and 2013). Examine and describe any difficulties or inaccuracies in making year by year comparisons. Continue work on understanding caveats and validating estimates with existing known sources.
4. To provide clear direction regarding the purpose and use of the total health care expenditure calculations. There was strong consensus among SHEW members that the model is not yet ready for use to examine trends, set targets, or inform policy decisions. A clear mandate from OHPB to further the model would be needed to move the work forward and define a clear purpose.
5. To continue to engage stakeholder groups in discussions regarding use of the total health care expenditure model. The SHEW expressed concerns about how use of this model would impact various stakeholder groups, and identified a need to engage stakeholders in the process of determining appropriate uses for the calculation.

Contact Information

For more information on the Sustainable Healthcare Expenditures Workgroup, please visit:
<http://www.oregon.gov/oha/Pages/srg.aspx>

For questions or comments on this report, please contact Jeff Winkley at (971)673-2313 or jeffrey.winkley@state.or.us.

Office of Health Analytics

The Oregon Health Authority's Office of Health Analytics collects and analyzes data to inform policy development, program implementation, and system evaluation. The Office of Health Analytics supports OHA efforts to further the triple aim goals of improving health, improving health care quality and reducing costs by leveraging qualitative and quantitative data to monitor progress and identify future policy and program opportunities.

Appendix A: Methodology & Preliminary Estimates

Overall approach

The overall approach to spending involves multiplying an estimate of the population within each payer group by the estimate of spending for individuals within that payer category. As noted above, SHEW estimates will be computed into eight payer categories. As an example, total spending for the Medicaid category would consist of average monthly spending (per-member per-month spending, or PMPM) multiplied by 12 (to create average annual spending), multiplied by the total number of Medicaid beneficiaries. This approach is intended to retain simplicity in the presentation and also provide clarity around what is driving spending (such as population growth, increased utilization, or rising prices). Furthermore, SHEW estimates are separated into five cohorts: pregnant women, non-pregnant adults aged 18-64, infants (ages <1), children (ages 1-17), and adults 65 and over.

Note that spending is defined based on the payer perspective, and includes spending on health services paid for by the health plan or out of pocket by the individual.

Medicaid Encounter Data

A substantial portion of Medicaid claims are paid on a capitated or contracted basis, which results in a \$0 “allowed” amount in the claims record. Rather than ignoring these \$0 claims, the SHEW estimates calculate an average payment rate based on available fee-for-service payments for each CPT and DRG and attaches these prices to the claims, creating a “repriced” estimate that accounts for utilization that is recorded in claims but not paid directly through claims.

Data sources

Estimates for enrollment for each payer category were based on data from the following sources:

<u>Payer Category</u>	<u>Data Source</u>
Medicaid	OHA
Medicare Fee-for-Service	Centers for Medicare & Medicaid Services (CMS) summary public use files ¹
Medicare Advantage	Oregon All-Payer All-Claims database ²
Medicaid/Medicare Dual Eligible	Linked Medicaid data from OHA and Medicare data from CMS
Veterans Health Administration	Publicly available Department of Veterans Affairs data ³
Commercial	Oregon All-Payer All-Claims database
Uninsured	CHSE methodology using DCBS data and Kaiser Family Foundation estimates ⁴

¹ Excludes Part D pharmaceutical spending. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

² Information about Oregon All-Payer All-Claims database at: <http://www.oregon.gov/oha/ohpr/rsch/pages/apac.aspx>

³ Available at: <http://www.va.gov/vetdata/Expenditures.asp>

⁴ CHSE methodology at: <http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/current-projects/upload/Impacts-of-the-Affordable-Care-Act-on-Health-Insurance-Coverage-in-Oregon.pdf>. Kaiser Family foundation estimates at: <http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>

Each of these databases provides an estimate of total enrollment. We also compare enrollment numbers to data on enrollment from the Oregon DCBS. Note that DCBS reports show several categories not available in APAC; stop-loss only self-insured, and carriers who have fewer than 5 thousand covered lives.

Note that enrollment numbers are estimates of unique individuals and are not equivalent to “member years” of enrollment. An individual may be enrolled for less than a year if they transition into or out of a coverage category.

Caveats

The current approach does not include several categories of health care spending. These include, for example, “wrap around” payments, settlement payments or payments for quality improvement programs, over the counter medications, alternative care, a wide range of care that may not result in the submission of a claim or payment.

Preliminary Estimates

Table 1: Total spending estimate

Group	Members	PMPM	Total
Commercial*	1,970,794	\$268	\$6,338,073,504
Medicare Advantage	270,138	\$593	\$1,923,111,239
Medicare FFS	360,894	\$593	\$2,569,202,805
Medicaid	651,023	\$289	\$1,686,982,032
Duals (Medicaid)	35,626	\$833	\$277,201,464
Duals (Medicare)	35,626	\$824	\$274,020,608
Veterans Affairs	93,529	\$699	\$784,387,000
Uninsured	550,000	\$42	\$275,000,000
Total	3,967,630		\$14,127,978,652

*Commercial calculation uses estimates to capture spending for the individuals not included in APAC.

Table 2: 2012 Medicaid spending by cohort

Group	Medical PMPM*	Rx PMPM*	Medical + Rx PMPM*	Member Years	Total
Children <1 year	\$1,012	\$5	\$1,017	11,736	\$143,226,144
Children 1-18	\$93	\$14	\$107	336,001	\$431,425,284
Pregnant women	\$1,062	\$21	\$1,083	13,635	\$177,200,460
Non-pregnant adults <65	\$368	\$84	\$452	172,406	\$935,130,144
Total (weighted mean)	\$251	\$38	\$289	533,778	\$1,686,982,032

* Allowed amounts, re-priced

Table 3: 2012 Commercial spending by cohort

Cohort	Med PMPM*	Rx PMPM*	Med + Rx PMPM*	Member Years**	Total
Children <1 year	\$503	\$4	\$507	12,806	\$77,911,704
Children 1-18	\$108	\$11	\$119	342,103	\$488,523,084
Pregnant women	\$1,466	\$18	\$1,484	16,600	\$295,612,800
Non-pregnant adults <65	\$243	\$39	\$282	1,053,109	\$3,563,720,856
Adults 65 and older	\$297	\$99	\$396	90,673	\$430,878,096
Total (weighted mean)	\$233	\$35	\$268	1,515,290	\$4,856,646,540

*Paid (re-priced) and OOP

**Member years reflect medical enrollment; Rx PMPM estimates are likely understated

Table 4: 2012 Medicare Fee-for-Service spending

Group	PMPM	Member Years	Total
Under 65*	\$637	63,750	\$487,604,468
Over 65	\$584	297,144	\$2,081,598,337
Total	\$593	360,894	\$2,569,202,805

*Under 65 includes some duals, but not all (ESRD)

**Excludes Medicare Part D pharmaceutical spending

Table 5: 2010 Dual Eligible spending

Group	PMPM	Member Years	Total
Medicare	\$824	27,728	\$274,020,608
Medicaid	\$833	27,728	\$277,201,464
Total			\$551,222,072

Table 6: 2012 Veterans Health Administration medical spending

PMPM	Member Years	Total
\$699	93,529	\$784,387,000

Table 7: 2013 Uninsured medical spending

PMPM	Member Years	Total
\$42	550,000	\$275,000,000

*PMPM based on Kaiser Family Foundation analysis of out-of-pocket spending for uninsured individuals. Note that this is not an estimate of uncompensated care, charity care, or bad debt.

DRAFT

Appendix B: Governor's Letter to OHPB



JOHN A. KITZHABER, MD
Governor

June 3, 2013

Oregon Health Policy Board
Chair Eric Parsons
Vice-Chair Lillian Shirley

Dear Chair Parsons and Vice-Chair Shirley:

As you and the Board are well aware, beginning in 2014, the Affordable Care Act (ACA) will significantly expand coverage to thousands of currently uninsured Oregonians and alter the regulations governing the individual and small group markets. While the ACA makes historic, nationwide changes in coverage expansion and the regulation of the individual and small group markets, I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health care expenditures that are reasonable and predictable.

For this to occur, I am asking that by the end of this year, the Oregon Health Policy Board take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include, but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division's rate review process;
- alignment of care model attributes within PEBB and OEBC contracts;
- alignment of care model attributes within Cover Oregon's qualified health plans.

Thanks to all of your hard work and leadership over the past several years, Oregon has made significant progress in reforming its health care delivery system. Across the state, communities have begun transforming to deliver more effective, efficient care. Critical partnerships are developing to reward quality care, promote prevention and wellness and manage chronic diseases and are building new networks, products and contracting models.

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Oregon Health Policy Board
June 3, 2013
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We have an amazing opportunity to leverage all of your great work with the implementation of the ACA and I look forward to working with you to achieve further success.

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Kitzhaber". The signature is fluid and cursive, with the first name "John" being the most prominent.

John A. Kitzhaber, M.D.
Governor

MJB/smg

Appendix C: OHPB Final Recommendations, Strategy 2

Strategy 2: Move the marketplace toward a sustainable and fixed rate of growth

The goal of this strategy is to contain health care costs, to improve the affordability and sustainability of health care coverage, and improve Oregon's economic climate by measuring the true cost of the health care system. Oregon should formulate or endorse a sustainable rate of growth methodology aimed at containing and lowering the total cost of health care that includes, but is not limited to, costs for health care entities, individuals and health plans. OHA and OID should create a sustainable rate of growth workgroup that will develop an accurate and stakeholder-driven sustainable rate of growth methodology for the total cost of care and advise on related processes and timelines.

Recommended actions: by January 31, 2014, a sustainable rate of growth workgroup is appointed and its charter is endorsed.

- OHA and OID establish a sustainable rate of growth workgroup to advise a methodology development process.
- The workgroup members are appointed by and serve at the pleasure of the Commissioner of OID and Director of OHA.
- OHA reports quarterly to OHPB regarding progress toward developing a sustainable rate of growth methodology.
- The workgroup consults with stakeholders regarding the methodology and related components of this strategy. Stakeholders include but are not limited to the Oregon Health Leadership Council, the Oregon Student Public Interest Research Group and the Oregon Business Association, PEBB and OEBB

Recommended actions: by December 31, 2014, a sustainable rate of growth methodology is endorsed, measurement begins and potential accountability mechanisms are recommended.

- Sustainable rate of growth measurement includes but is not limited to measurements of health entities and health plan premiums year over year.
- OHA and OID ensure financial modeling is conducted, and that it shows the potential effect of a sustainable rate of growth benchmark on different market segments, the delivery system and overall financial implications.
- Because there is shared responsibility for the total cost of care, OHA and OID explore the benefit of and make recommendations to the Governor's office and 2015 Legislature about potential mechanisms to hold health plans and health entities accountable for cost increases beyond the sustainable rate of growth benchmark.

Appendix D: Sustainable Healthcare Expenditures Workgroup Committee Members

Members

Denise Honzel, Chair
Oregon Business Council

William Ely
Kaiser Permanente

Jesse Ellis O'Brien
OSPIRG

Kraig Anderson
Moda Health

James Gajewski, M.D.
Oregon Medical Association

William Olson
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WVP Health Authority

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