Opportunities to Contain Costs and Improve Value in Oregon Health Care Markets

Oregon Leadership Summit

December 3, 2018

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Oregon Health Authority

If Food Were Health Care

If food prices had risen at medical inflation rates since the 1930's:

• 1 dozen eggs	$ 101.59
• 1 pound apples	$ 15.49
• 1 pound sugar	$ 17.34
• 1 roll toilet tissue	$ 30.65
• 1 dozen oranges	$136.68
• 1 pound butter	$118.37
• 1 pound bananas	$ 20.32
• 1 pound bacon	$155.16
• 1 pound beef shoulder	$ 55.19
• 1 pound of coffee	$ 81.30
10 item total	**$ 732.09**

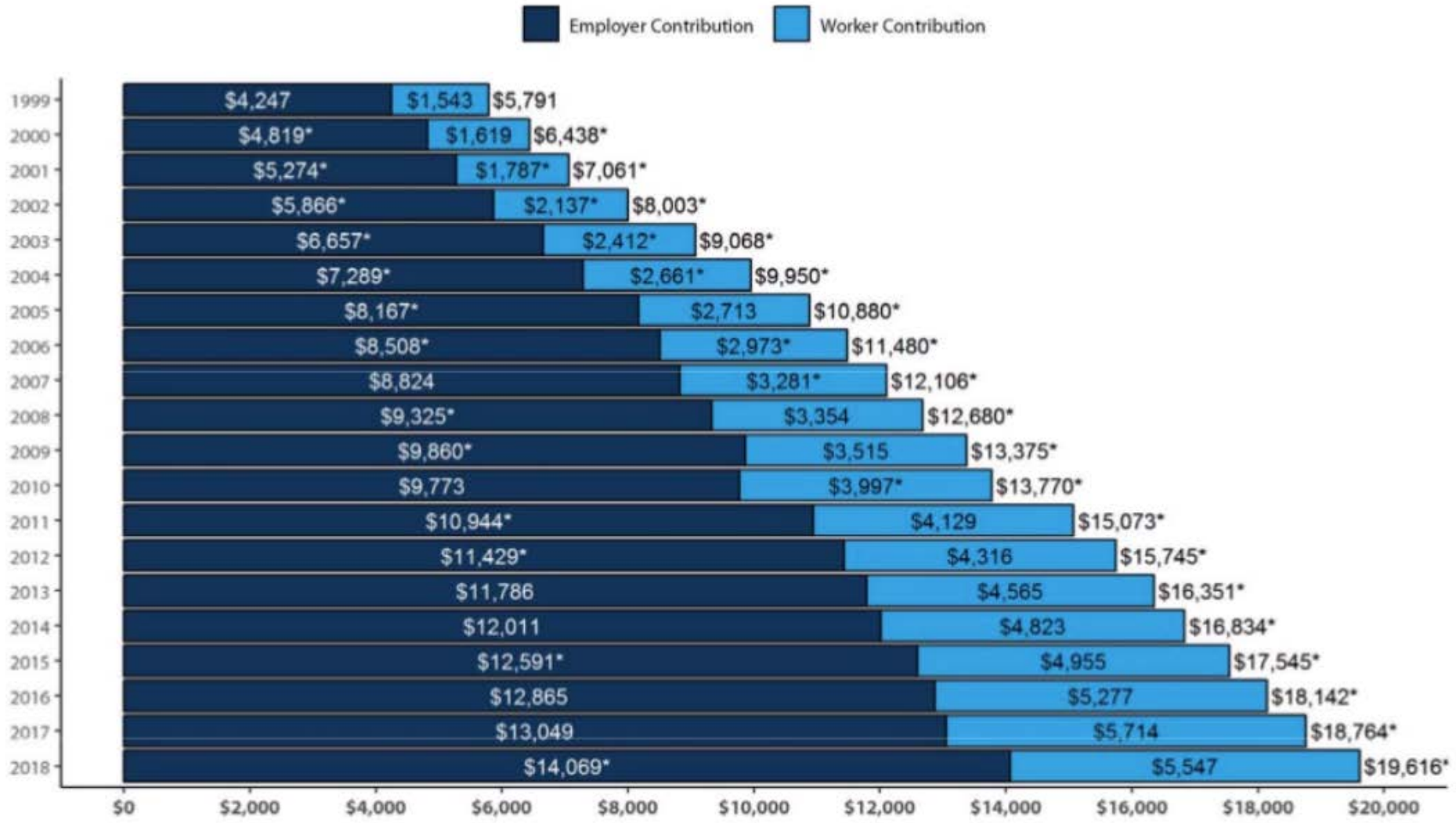
American Institute for Preventive Medicine
An Apple A Day Isn't Enough!

Source: American Institute for Preventive Medicine, 2015

Oregon Health Authority

Figure 2

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2018



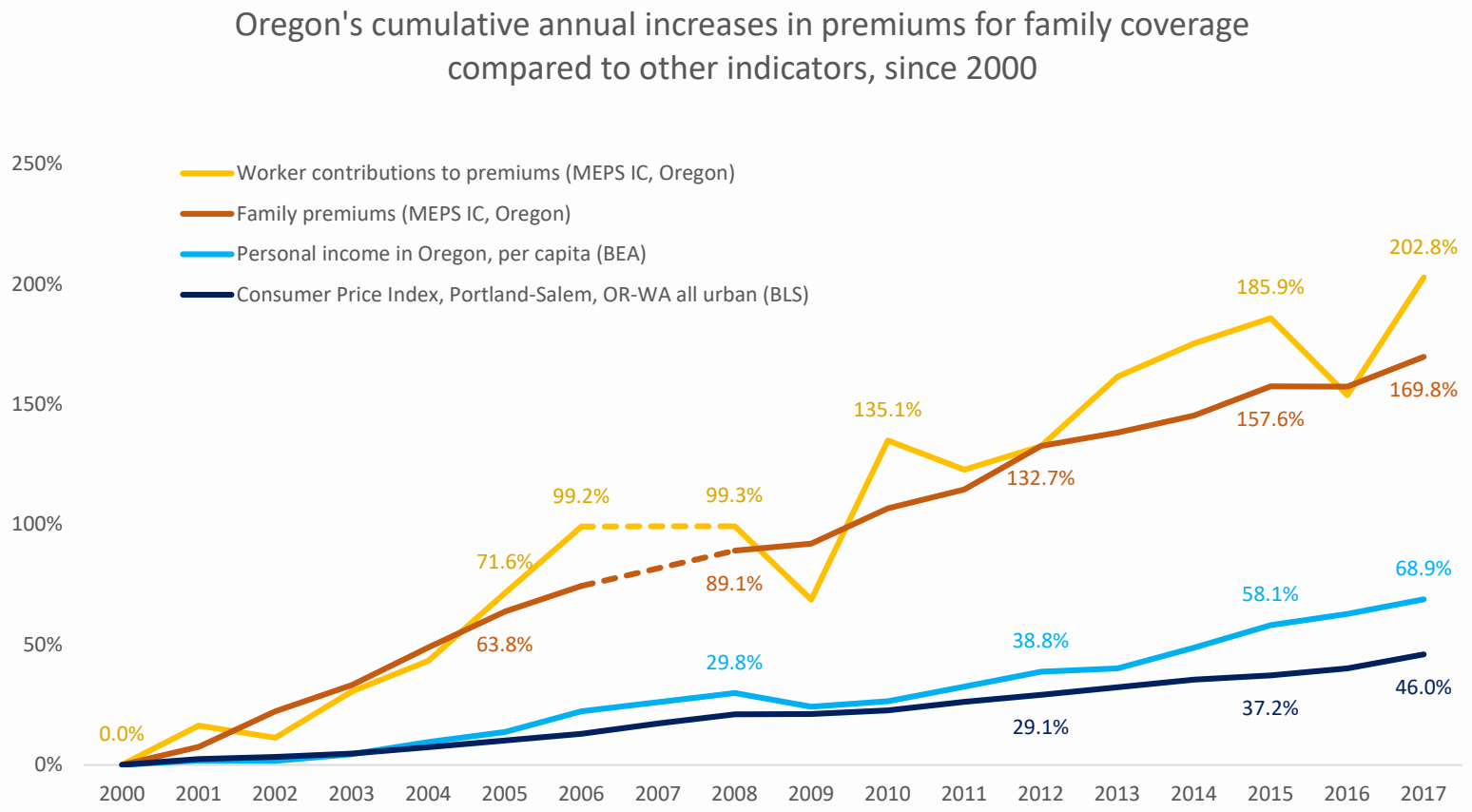
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

KFF
HENRY J KAISER FAMILY FOUNDATION

Since 2000, Oregon employer-sponsored insurance premiums have grown twice as fast as personal income.

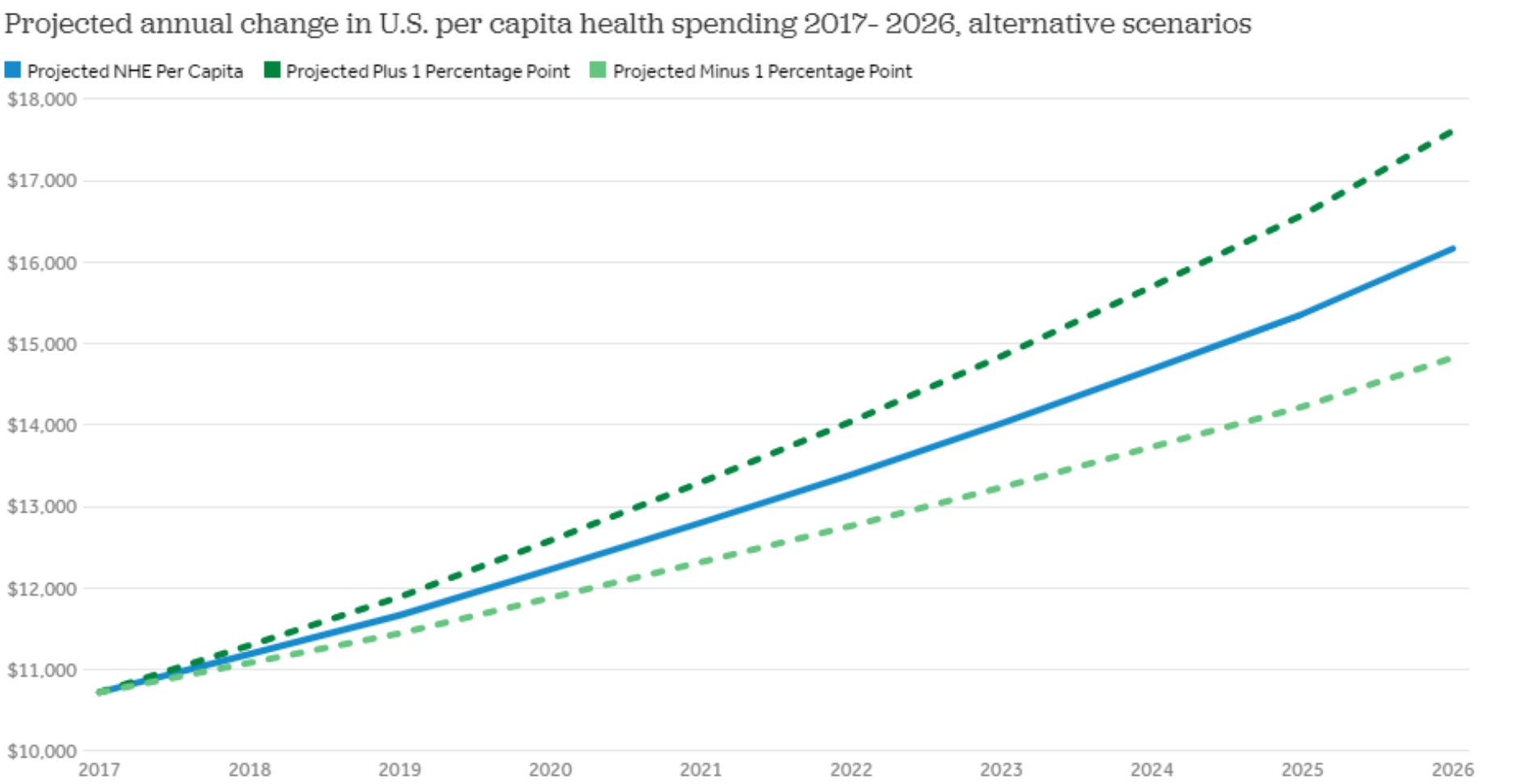
Worker contributions to their premiums grew almost three times faster!



Note: Oregon-specific premium data does not exist for 2007 in the MEPS dataset.

National health care costs outpacing economy

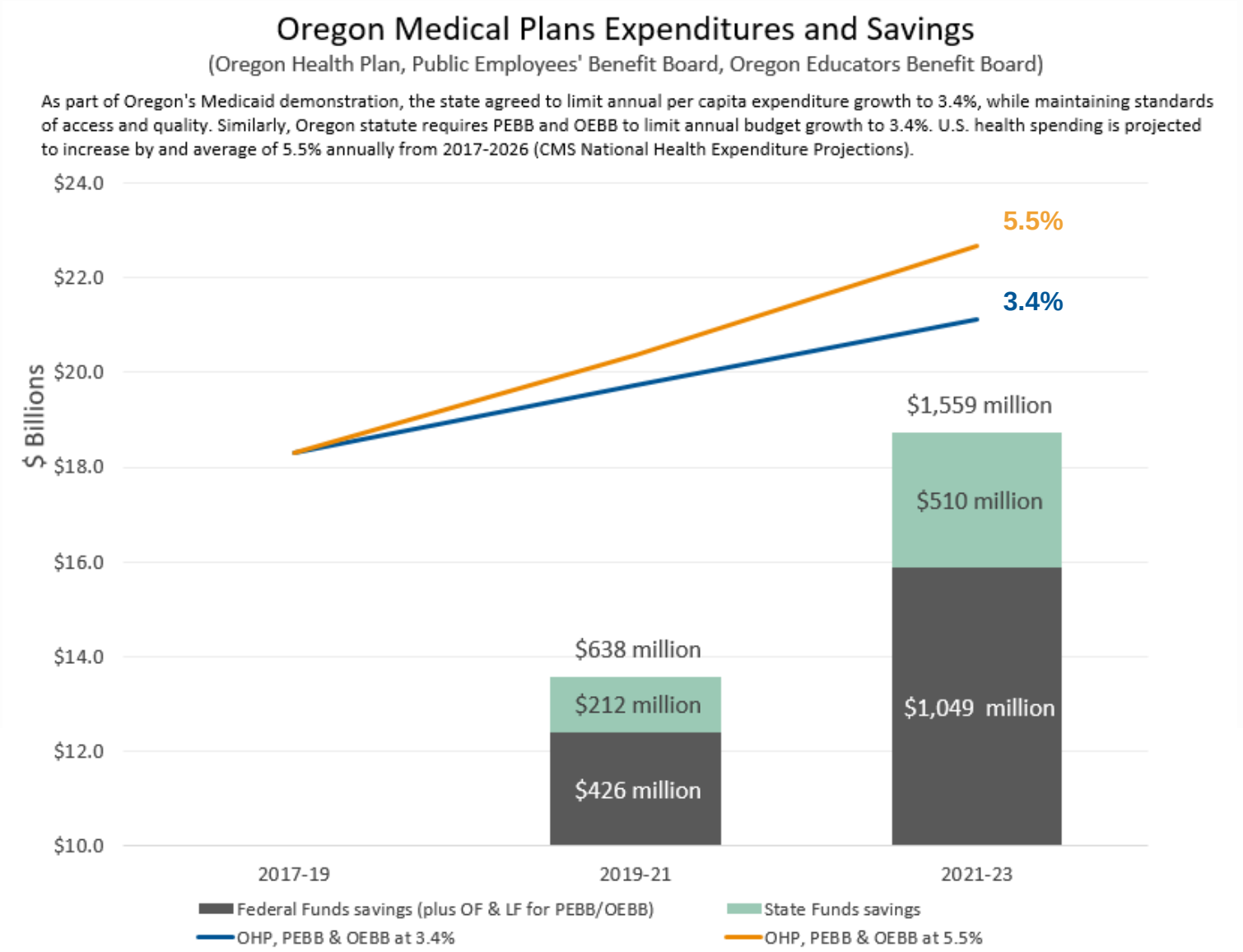
At 5.5% growth rate, health care will be 19.7% of GDP by 2026



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (Accessed on (Accessed on February 14, 2018). • Get the data • PNG

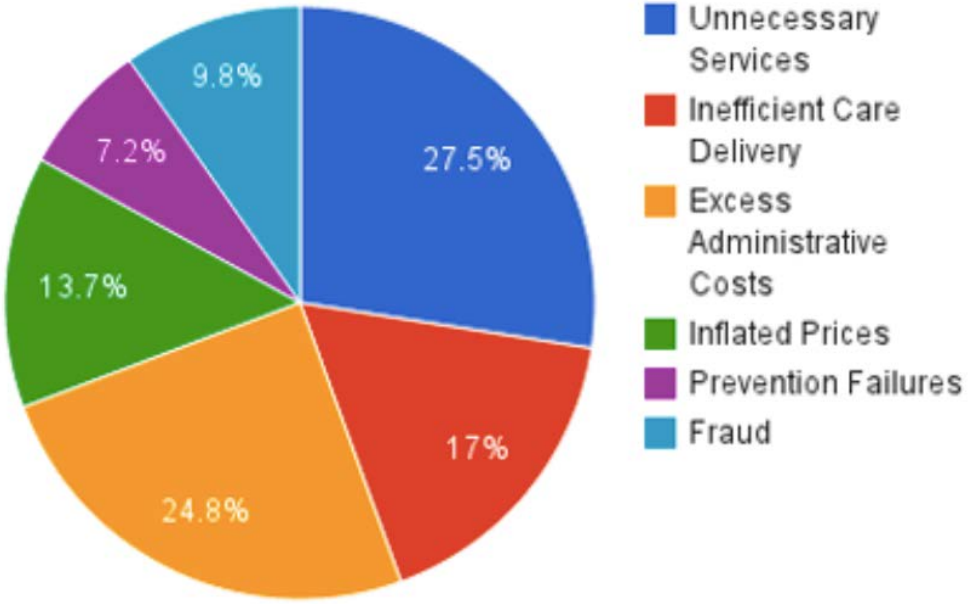
Peterson-Kaiser Health System Tracker

Holding cost growth to 3.4% in state health care programs will save over $700 million in General Fund in the next two biennia.



OPPORTUNITIES

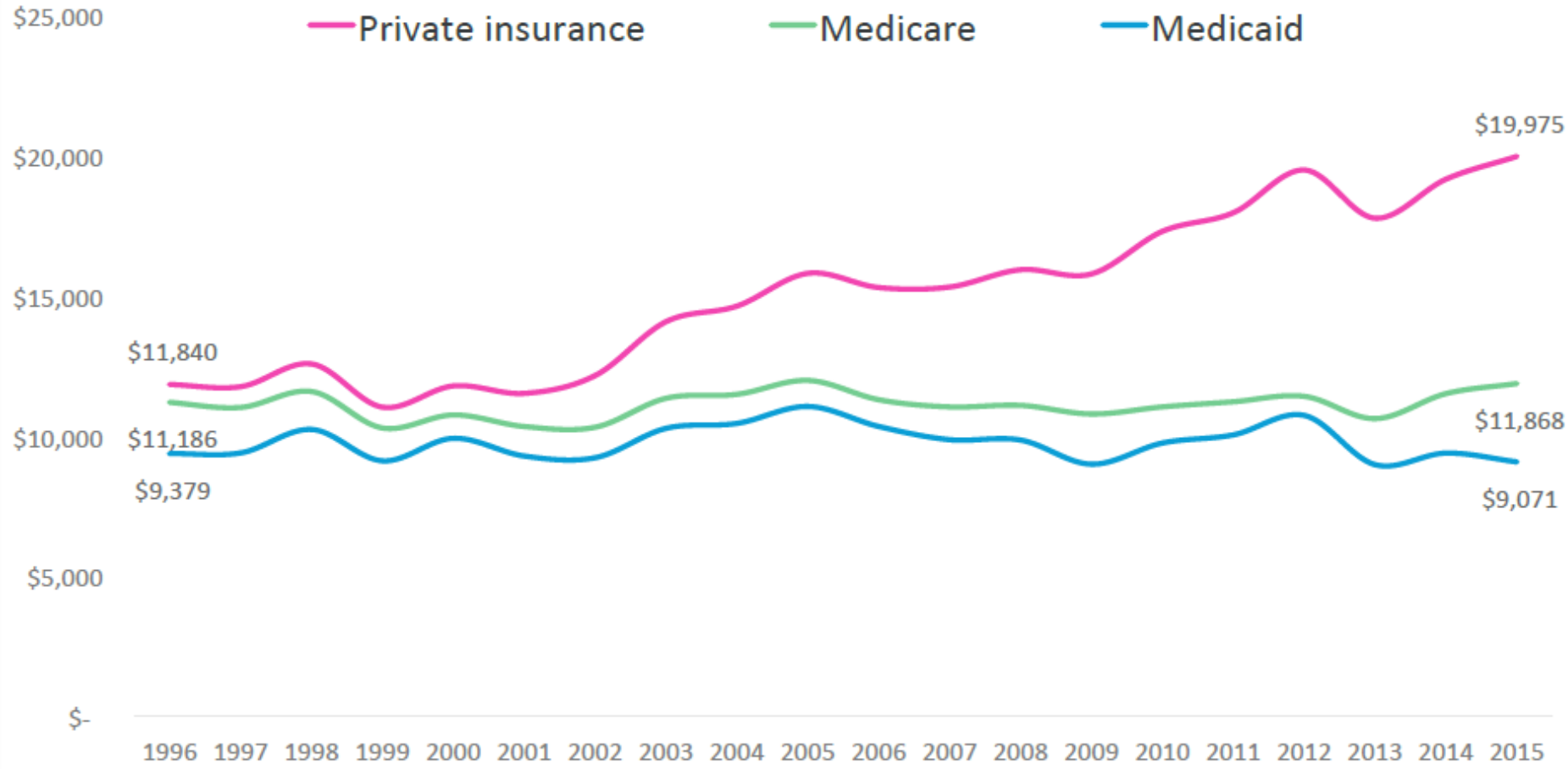
According to the Institute of Medicine, there is $750 billion in annual waste in the health care system.



Source: Brian Fung, "How the U.S. Health-Care System Wastes $750 Billion Annually," The Atlantic, September 7, 2012.

Prices for inpatient hospital stays have grown faster for private insurance than for Medicare or Medicaid

Average inflation-adjusted, standardized payment rates per inpatient hospital stay, by primary payer, 1997-2015



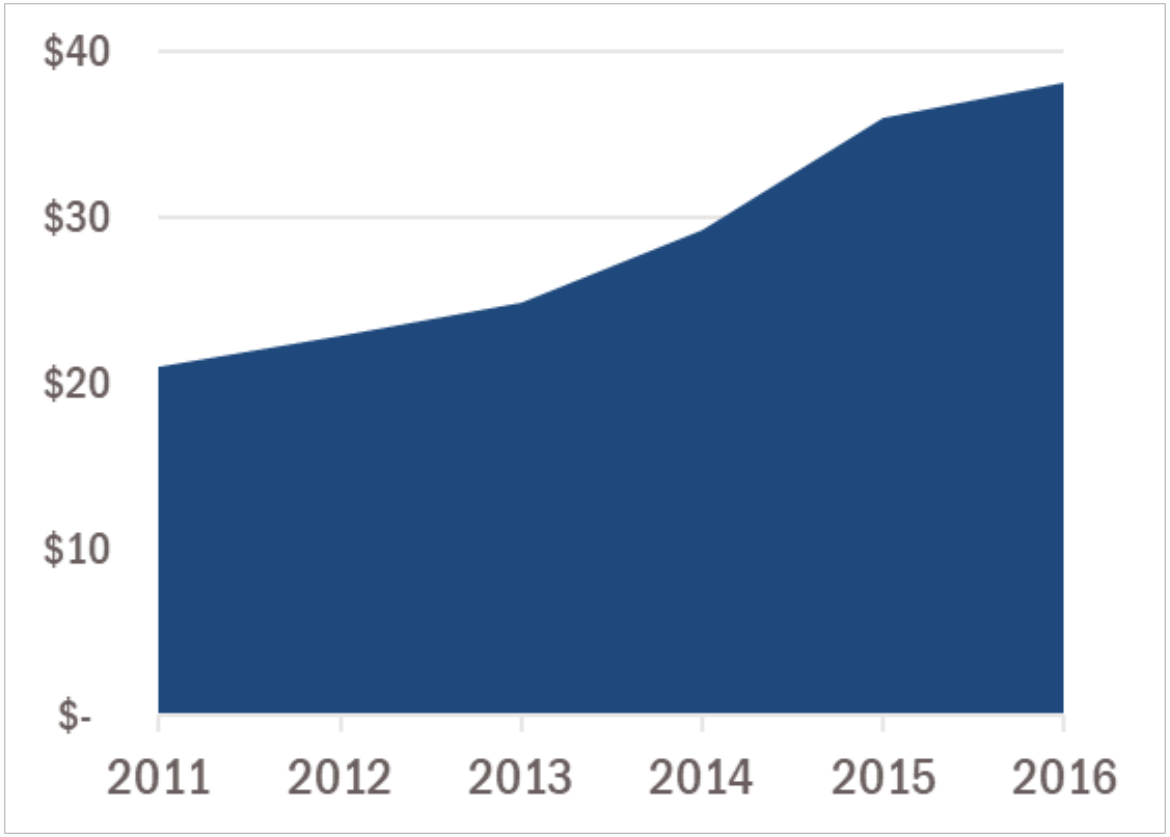
Note: The average payment rates were computed as if each primary payer paid for all non-maternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays.

Source: Thomas M. Selden analysis of AHRQ's Medical Expenditure Panel Survey for the Kaiser Family Foundation. Update of earlier analysis, available here: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0706

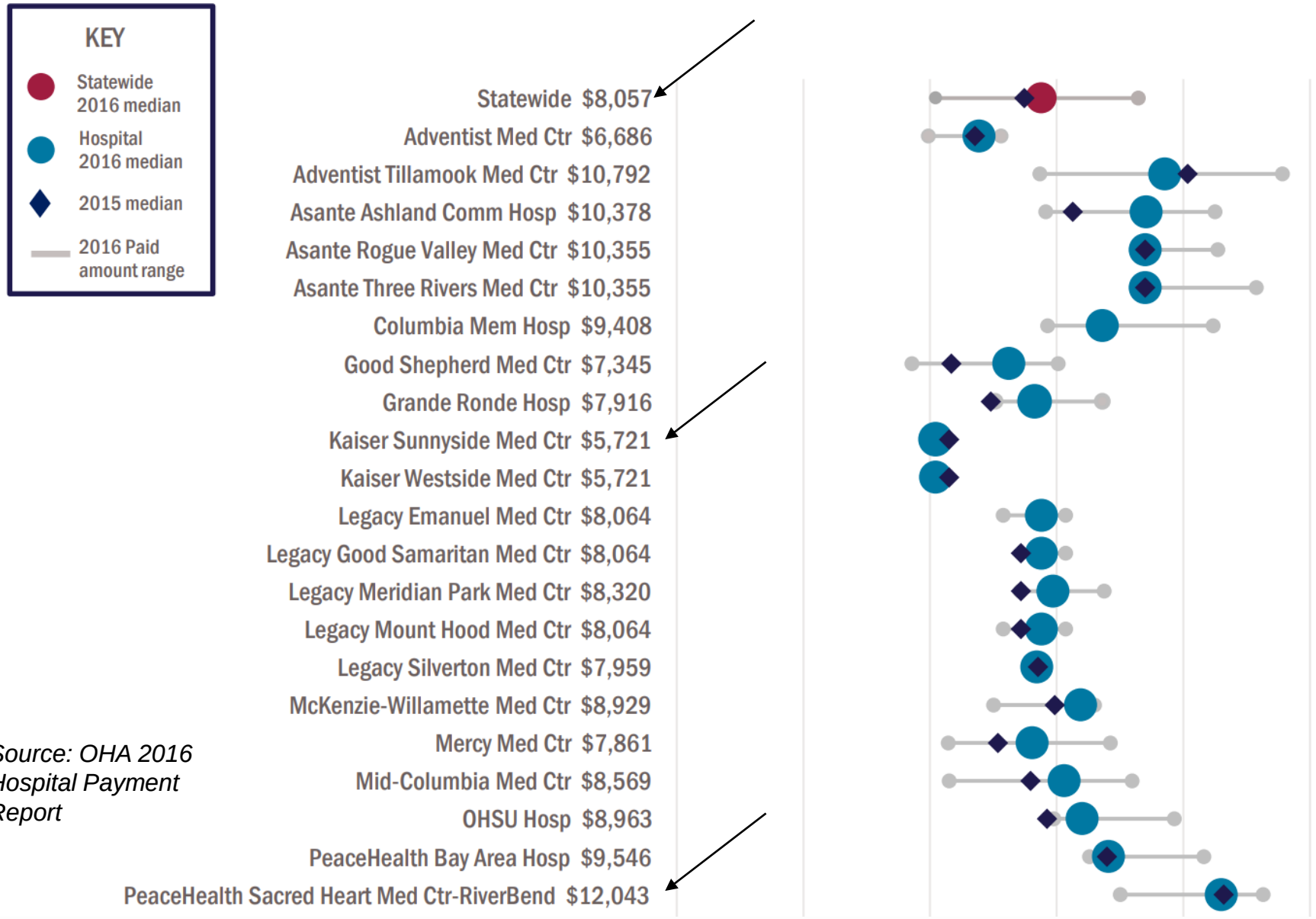
Peterson-Kaiser Health System Tracker

Oregon pharmacy expenditures

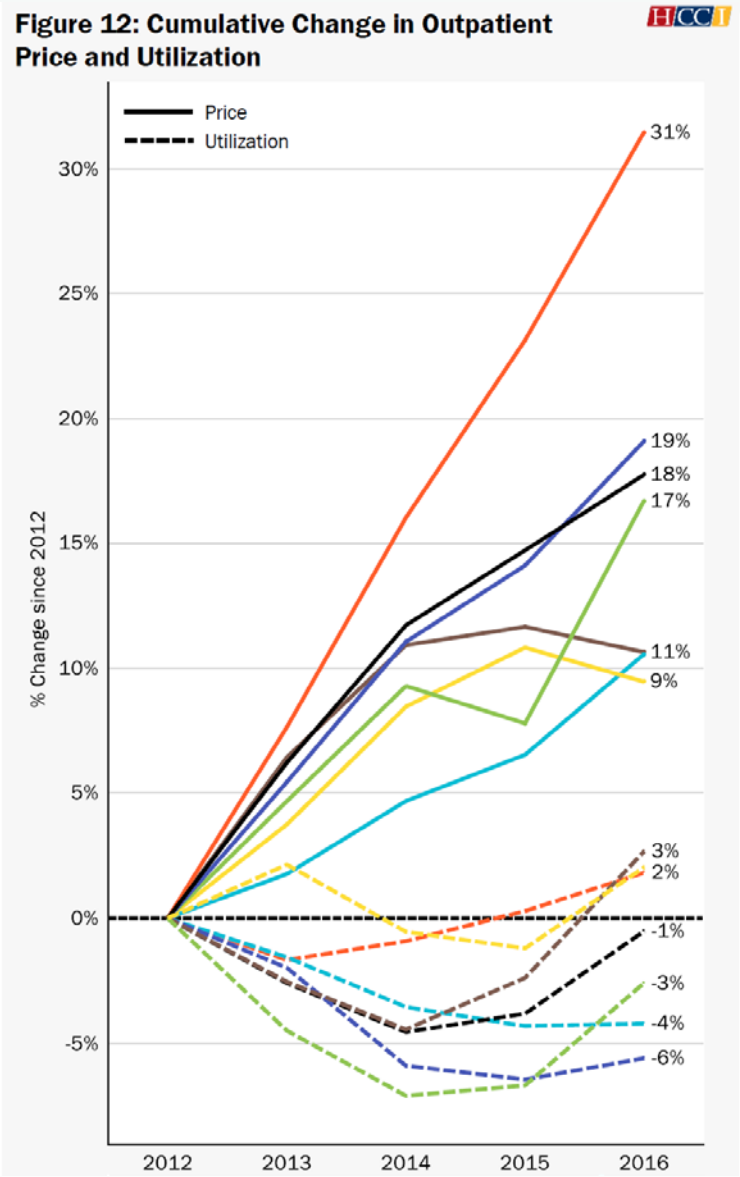
All Payer All Claims Database, figures in $ billions



Variation in costs for normal delivery

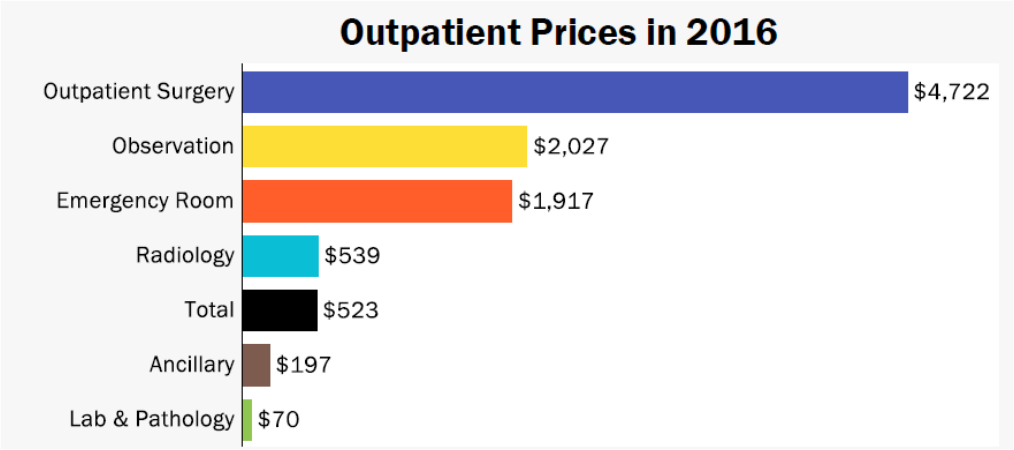


Source: OHA 2016 Hospital Payment Report



Squeezing the balloon:

Utilization goes down, prices go up



Source: HCCI 2016 Cost and Utilization Report

STEPS OREGON CAN TAKE

Establish Statewide Cost Growth Benchmark

- Recommendation of SB 419 Joint Interim Task Force on Health Care Cost Review
- Control total health care expenditures across ***all payers*** and ***providers*** by establishing a health care spending benchmark:

  A statewide target for the annual rate of growth of total health care expenditures indexed to state economic growth indicator.

- Ensure cost growth is fixed, stable, predictable, and economically sustainable. Ensure health care costs do not outpace economy.
- Identify outlier costs, price variation, waste or inefficiency, and cost drivers that contribute to growth.
- Transparency on underlying cost drivers, including annual report on cost drivers to inform future policy options.
- Accountability mechanisms for the system to stay within the growth rate.

Experience in Massachusetts

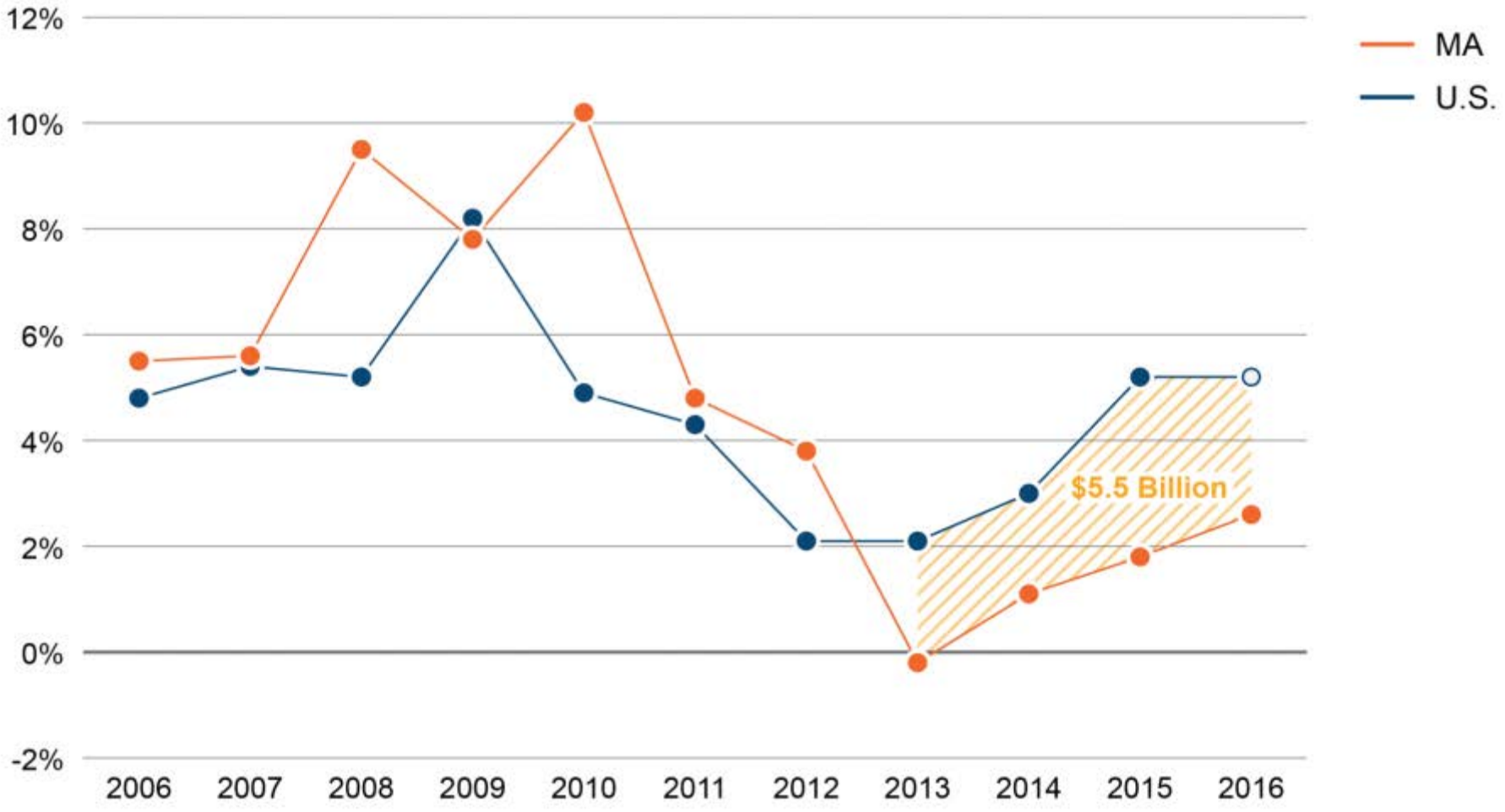
- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state's long-term economic growth rate:

  2013-2017: 3.6%
  2018: 3.1%

- If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring
- Conduct cost and market impact reviews of cost and quality drivers.
- Hold annual hearings on cost drivers that includes broad mix of health care stakeholders
- Submit annual report to Legislature on cost drivers to inform policy.

In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance premium spending from previous year, per enrollee, MA and the U.S.



Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Source: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2015-2016)

HPC

Change How We Pay for Health Care

- Most health care in the U.S. is paid for using a fee-for-service (FFS) model, which pays for each health care service, visit, or test. This system incentivizes the delivery of more health care, instead of better health care.

- The goal of increased use of value-based payments (VBP) is to incentivize delivery system reform that focuses on ***value*** instead of volume of care delivered, ***rewarding*** providers for a combination of ***high-quality care, positive member health outcomes*** and ***cost savings.***

- **CCO 2.0**: OHA will require 20% of payments in VBP in 2020 and 70% by 2024.

Examples

- Oregon Patient-Centered Primary Care Homes: PSU study found that for every dollar spent in PCPCHs, $13 was saved in other parts of the system.

- CCOs: In 2017, six CCOs' cost growth were at or below the Medicaid sustainable rate of growth target. This includes CCOs with value-based payments with their hospitals.

- Massachusetts: Established tiered networks based on efficiency and quality, saving $600/individual without reducing quality.

- Tennessee and Washington: Both have developed bundled payments with shared risk to improve quality while containing costs. Tennessee saved $11 million in the first year.

Oregon Educators Benefit Board: Innovation & Value

Why OEBB?

School Districts were facing skyrocketing premiums and plunging benefits	• Annual double digit increases • Huge variation on quality and cost between districts • Smaller districts were hit hardest
Leverage purchasing power through economy of scale	• 250+ employers – school districts, education service districts, community colleges, cities, counties and special districts • Approximately 150,000 individuals • Require innovation on plan design, benefits and cost
Premium stability & quality benefits	• Large group controls fluctuation in premiums and quality of benefits • Reduces admin overhead and duplication of services • **Saves money** and creates tax payer accountability

Oregon Educators Benefit Board

OEBB

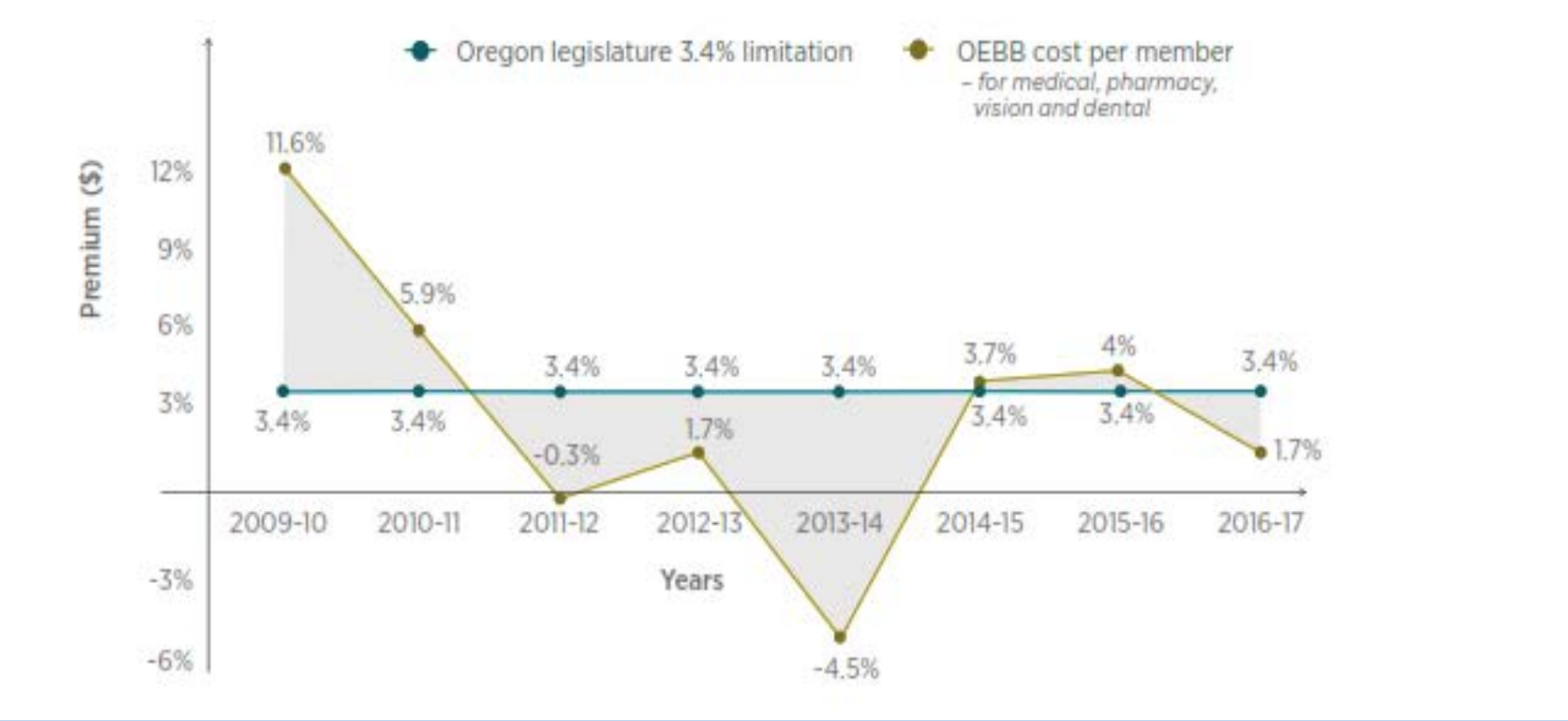
- **Employers**: School Board (2), School Admin (2); Local Govt (1)
- **Employees**: School (4) and Local Govt (1)
- **Experts** in health policy or risk management (2)

Decision-Making

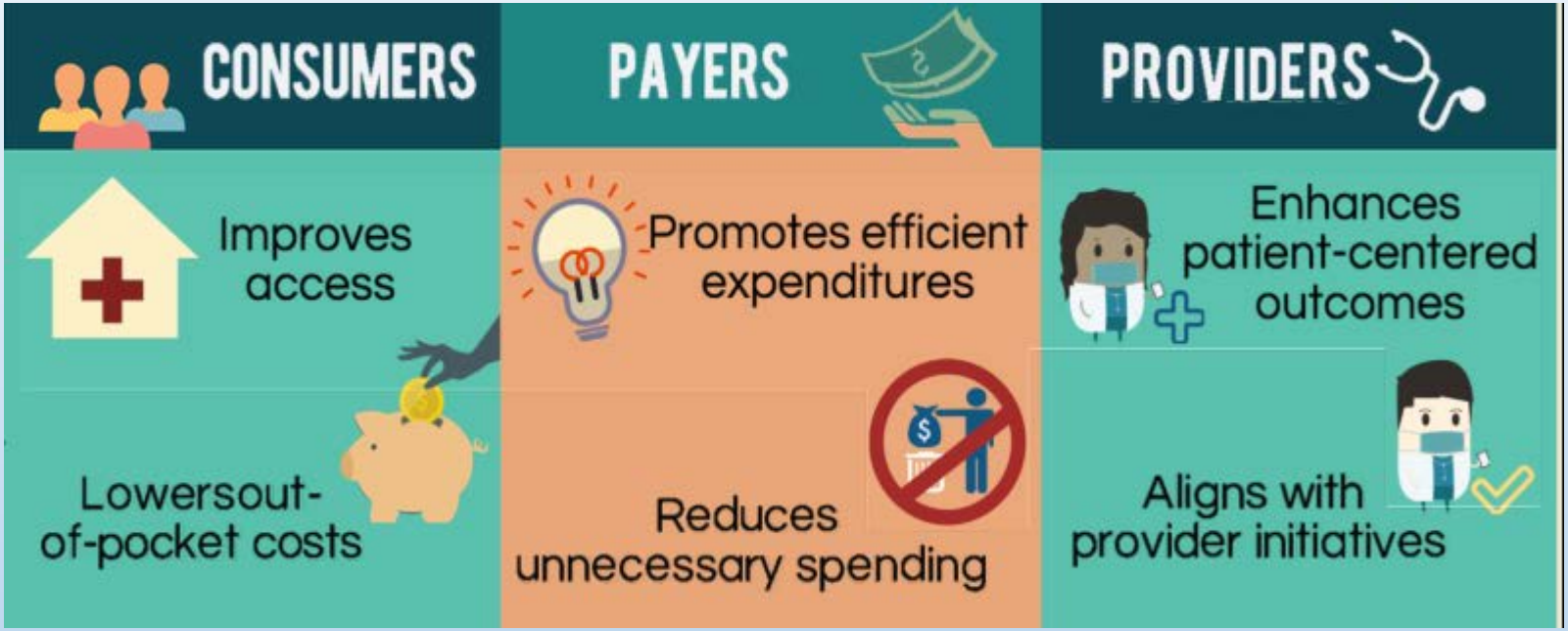
- **Identify** Issues with support from actuaries and carriers
- **Analyze** data and trends
- **Research** options and implement
- **Measure** results
- **Adjust** accordingly
- **Communicate** with constituencies

Managing costs

OEBB continues to bend the cost-curve over time by beating the 3.4% expenditure cap for medical, pharmacy, vision and dental.



Value-based design



OEBB promotes adherence to high-value services through value-based design

- $0 member cost share annual wellness visit
- Low member cost share for chronic condition office visits.
- $0 member cost share for home infusions with Moda's preferred provider.
- $ 0 member cost share for labs through Qwest Labs

http://vbidcenter.org/wp-content/uploads/2016/02/V-BID-Infographic-080217.pdf

Value based plan design: Additional Cost Tier (ACT)

Applies to select procedures that have less invasive option that is equally effective and evidence-based

$100 ACT copayment

- Advanced imaging
- Sleep studies
- Spinal injections for pain
- Outpatient upper endoscopy

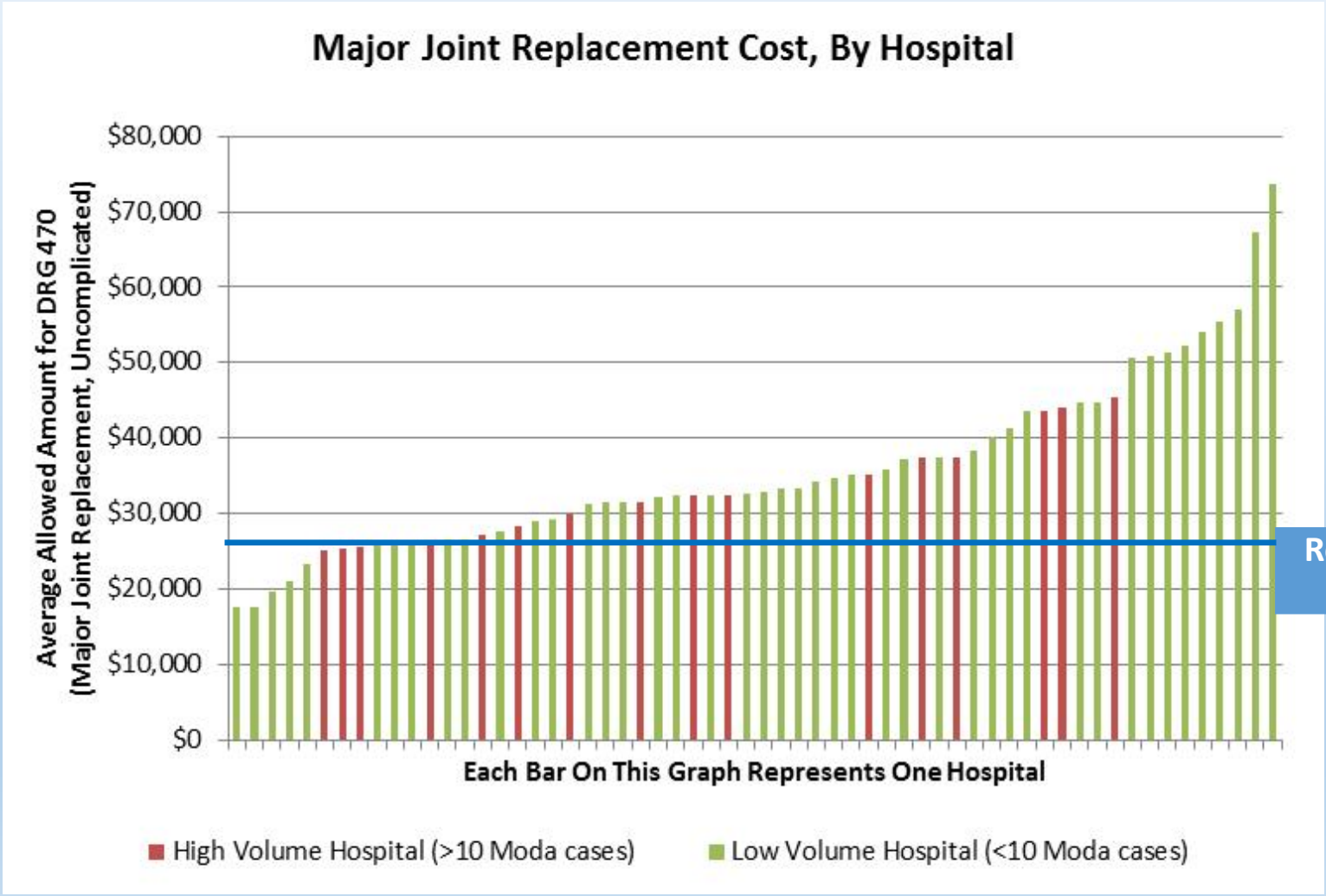
$500 ACT copayment

- Shoulder and knee arthroscopies
- Spine surgery for pain
- Knee and hip replacement

OEBB costs for ACT procedures declined by nearly 15% since 2010!

(Groups without ACT saw an increase of more than 3%)

Variations in cost of care



Value Based Plan Design: Reference-based pricing

Fixed price for certain medical procedures

- Bariatric surgery
- Major joint replacement surgery
- Oral appliances

Average savings of $7300 per member for those having major joint surgery

- Approximately 350 per year

More than $3 million in annual savings for since it began in 2014

Pharmacy management: Site of care

Directs members to clinically appropriate cost-effective sites for specialty drug infusions

- Instead of hospital outpatient sites, members go to provider offices, ambulatory infusion suites, or receive home infusion

Initial phase includes approximately 30 infused specialty drugs

18 OEBB members have successfully moved to alternative sites with 10 additional active cases since program launch on 10/1/2017

Projected OEBB savings for the first year are $1,034,000!

Primary care medical homes

It's not a place… It's a partnership with your primary care provider.

PCMH puts **you** at the center of your care, working with your health care **team** to create a **personalized plan** for reaching your goals.

Your **primary care team** is focused on getting to know you and earning your trust. They care about you while caring for you.

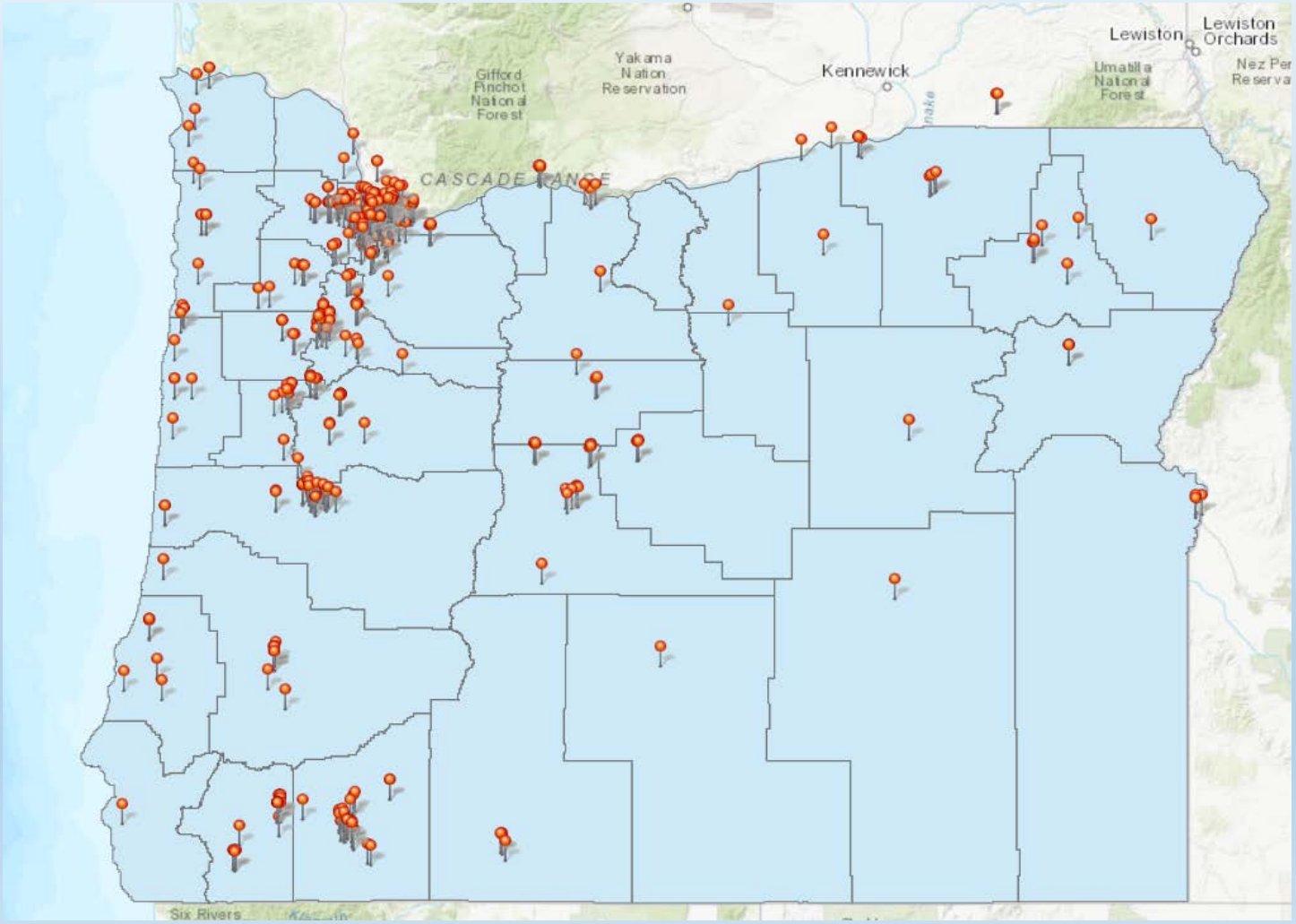
Technology makes it easy to get health care when and how you need it. You can reach your doctor through **email**, **video chat**, or after-hour **phone calls**. **Mobile apps** and **electronic resources** help you stay on top of your health and medical history.

https://www.pcpcc.org/resource/evidence2018

Patient Centered Primary Care Homes (PCPCH)

Primary care medical homes certified by OHA to meet specific high standards

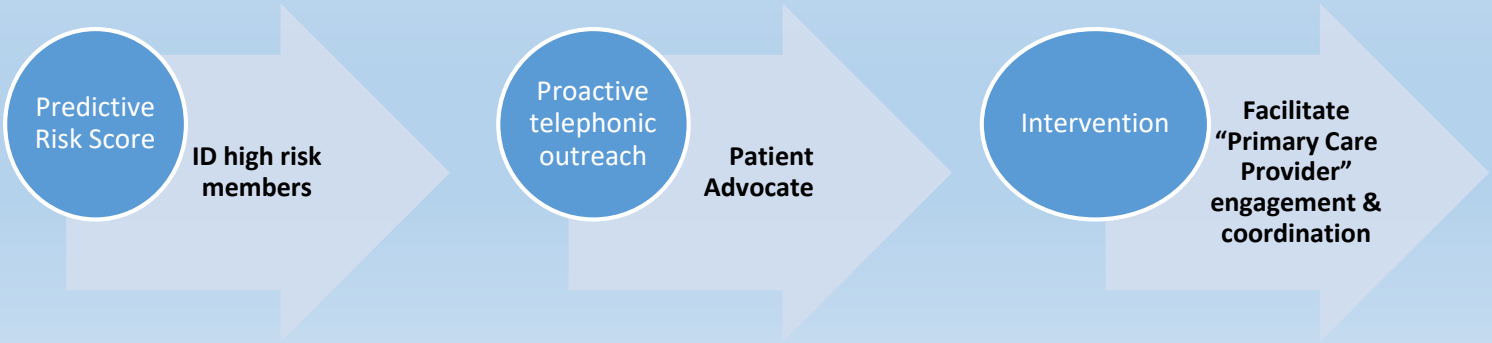
604 PCPCH clinics Statewide as of 10/1/2018 *(more on the way)*



C3 Program: Comprehensive Coordinated Care

- Incentive-based plan design
- Intensive coordinated care
- Identify high-risk utilizers

- Focused on high-risk members with multiple chronic conditions & complex chronic disease
- No copay benefit design
- Guide appropriate benefit use and access



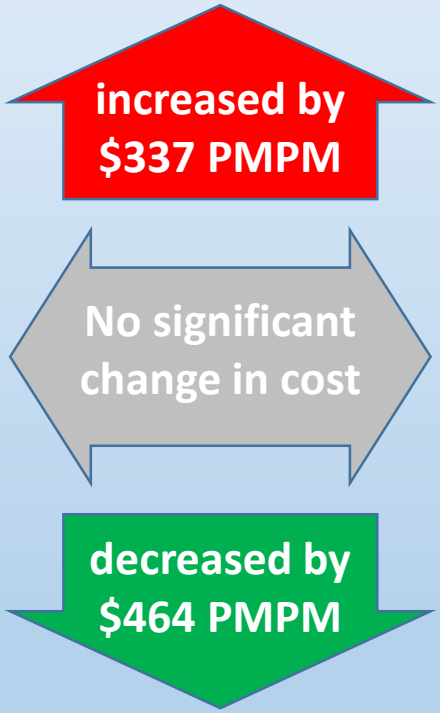
C3 Program works!

- High Risk members **not in** PCPCH and **not enrolled in C3**
- 258 members

- High Risk members **already in PCPCH** and **newly joining C3**
- 731 members

- High Risk members **switching to PCPCH to join C3**
- 725 members

Cost Impact



PCPCH = Patient Centered Primary Care Homes certified by the Oregon Health Authority

Synergy/Summit risk model

Network Management

Regional Risk Model	Coordinated care model promoting regional collaboration
Risk Areas	• Hospital • Primary Care • Specialty Care • Pharmacy

Primary Care Support

CPC+ program	Statewide payer alignment
Performance Based payments	Primary care providers incentivized for meeting quality metrics
Population Based payments	Per member per month payments to recognized Medical Homes based on tier

Looking forward: Policy requirements

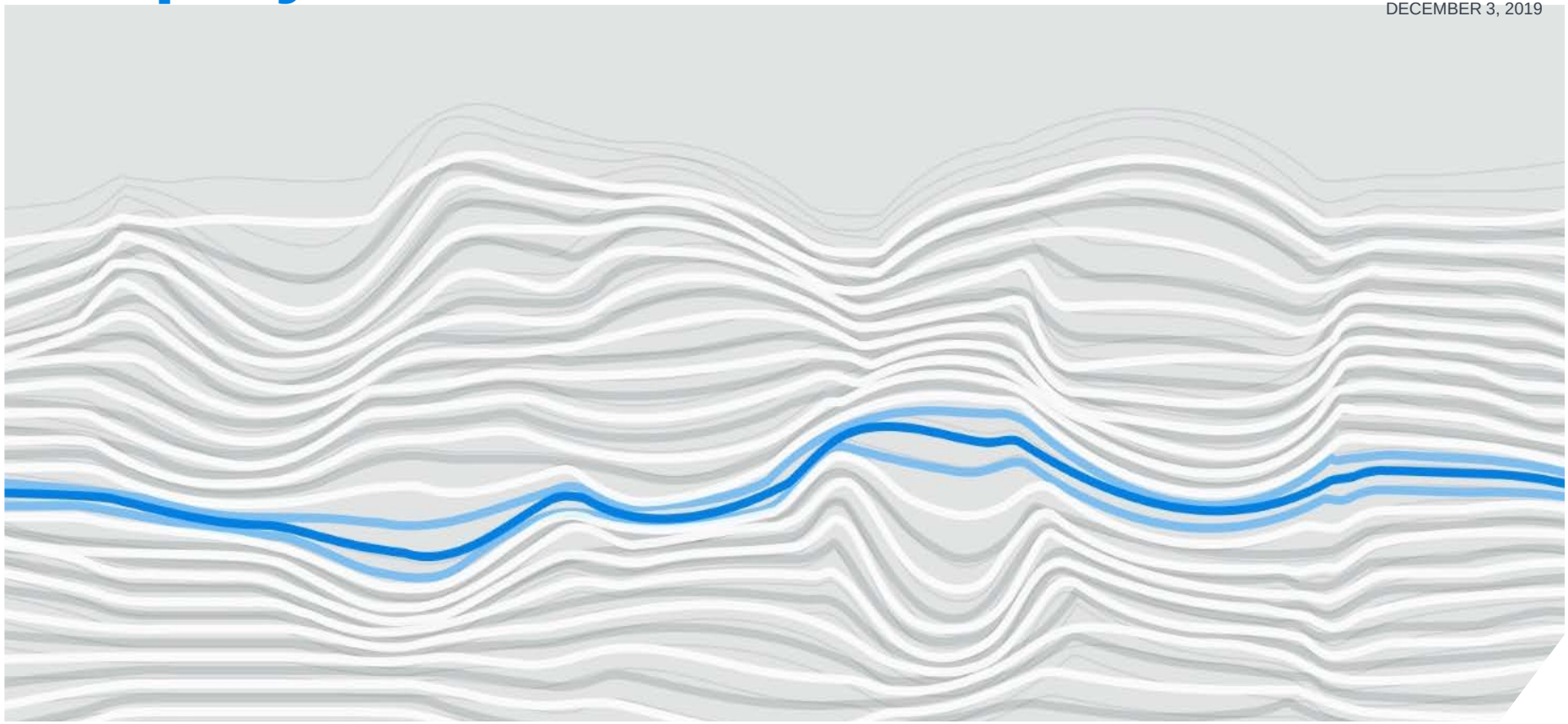
Cost Containment for OEBB & PEBB (SB 1067)	Primary Care Reform Collaborative Initiative (SB 934)	CCO 2.0
• Require larger hospitals to be reimbursed at 200% of Medicare effective 10/1/19 • "Value-based" compensation cannot exceed 200% of Medicare reimbursement limit • 3.4 % annual growth limitation per member on expenditures for health services	• Value-based payment methods • Technical assistance to clinics and payers • Aggregate data across payers and providers • Align metrics • Integrate primary care behavioral and physical health care	• Improve behavioral health system including access and integration of care • Increase value and pay for performance • Focus on social determinants of health and health equity • Maintain sustainable cost growth

OEBBinfo.com

Comparison of Health Benefits Offered to State Employees and Teachers

Ben Diederich

DECEMBER 3, 2019



Background and Overview

Oregon Business Council Charitable Institution commissioned the study to:

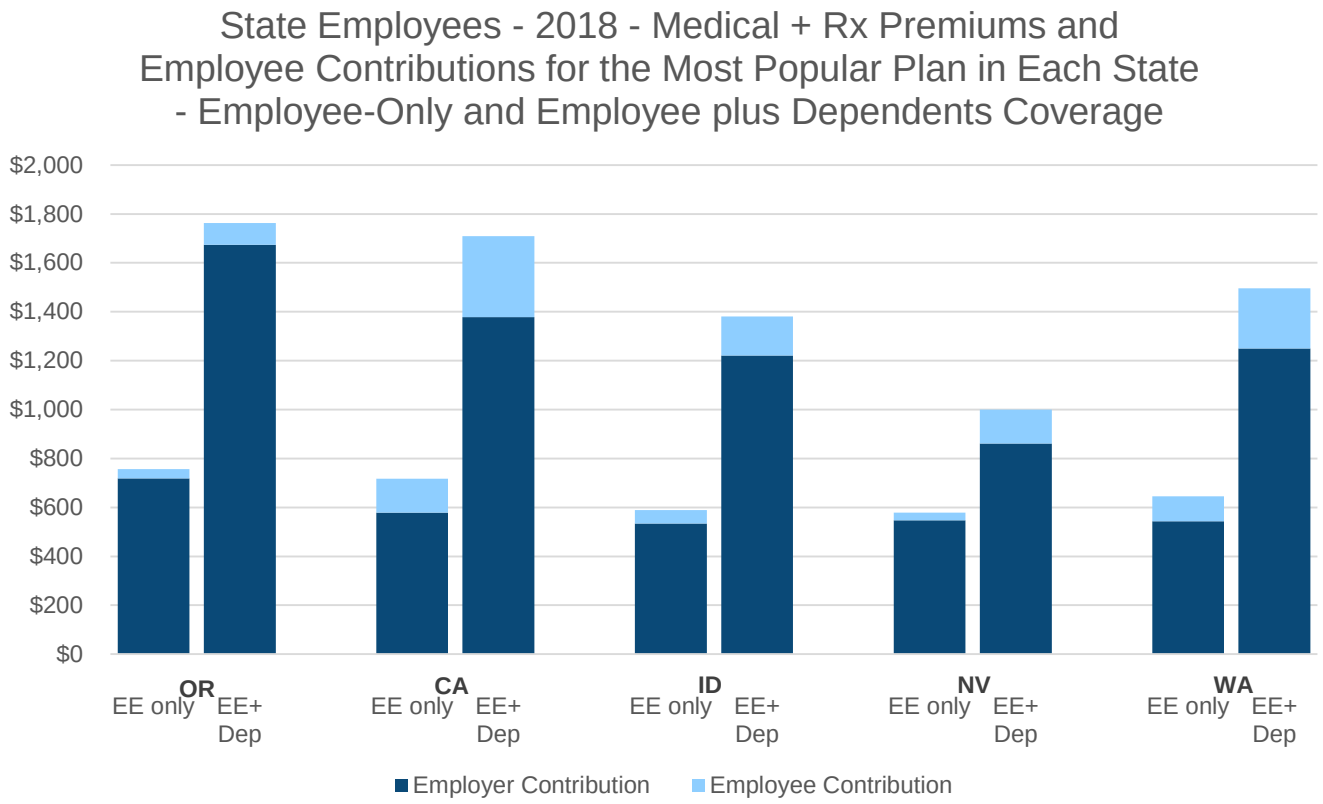
- Compare health benefits for public sector employees in the state of Oregon to those of neighboring states:
  - State Benefit Programs: California, Idaho, Nevada, and Washington
  - School District Employees: California and Washington with a focus on teachers.
- Milliman Atlas of Public Employer Health Plans
  - Benefit Design: copayments, deductibles, coinsurance, and the other components of benefit design.
  - Premiums: total premiums and employer and employee premium contributions by dependent tier
  - Employee census: count of employees by benefit coverage option and dependent tiers
- Comparison Considerations
- Known differences between programs and states

State Employer – General Government Employee

Oregon, California, Idaho, Nevada and Washington

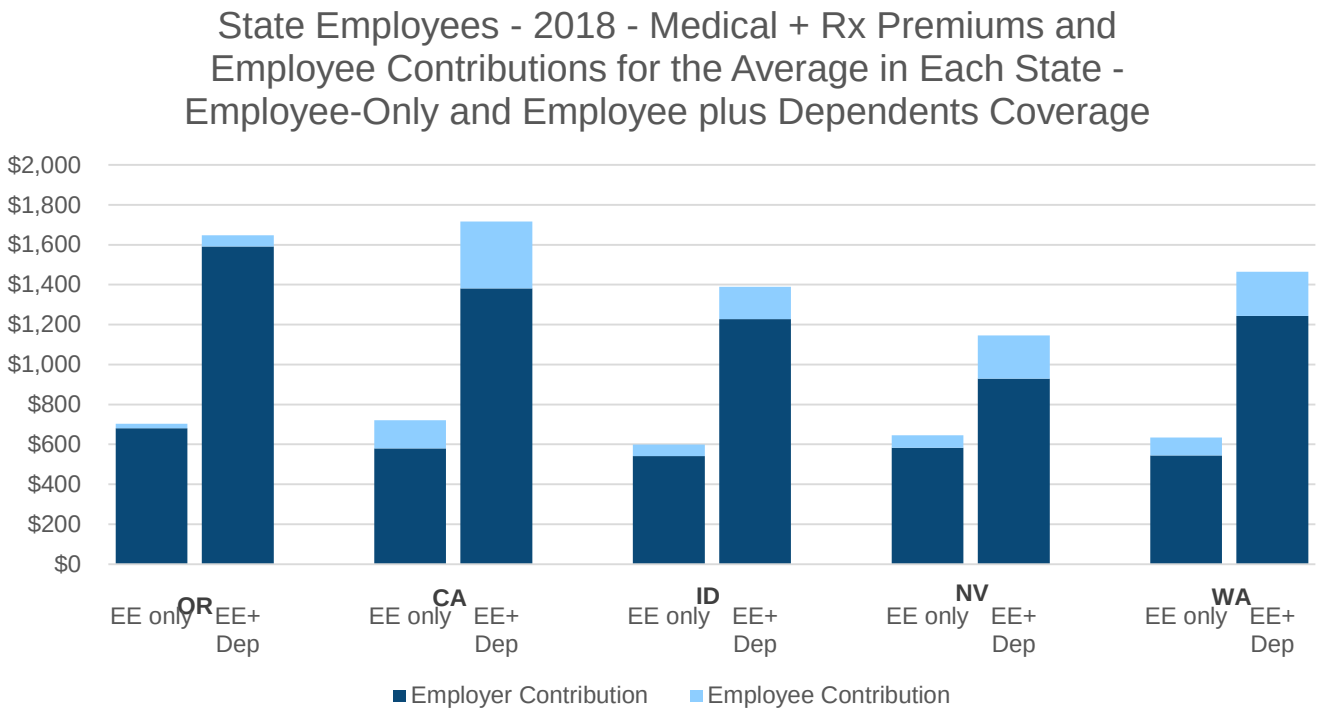
- Range of Benefit Options
  - Benefit Richness expressed as Actuarial Value
  - Consumer Directed or High Deductible Health Plans
- Range of Premium
- Employee Contribution Percentages
  - Risk Adjustment Considerations
  - Philosophy of Contributions to Dependent Coverage
  - Pre-Medicare Retiree Coverage
- Funding Arrangements
- Tier Structures

State Employee Premium Contribution – Most Popular



- OR EE Only 5.0%
  EE + Dep 5.0%
- CA EE Only 19.3%
  EE + Dep 19.3%
- ID EE Only 9.3%
  EE + Dep 11.5%
- NV EE Only 5.5%
  EE + Dep 13.9%
- WA EE Only 15.8%
  EE + Dep 16.4%

State Employee Premium Contribution – Average



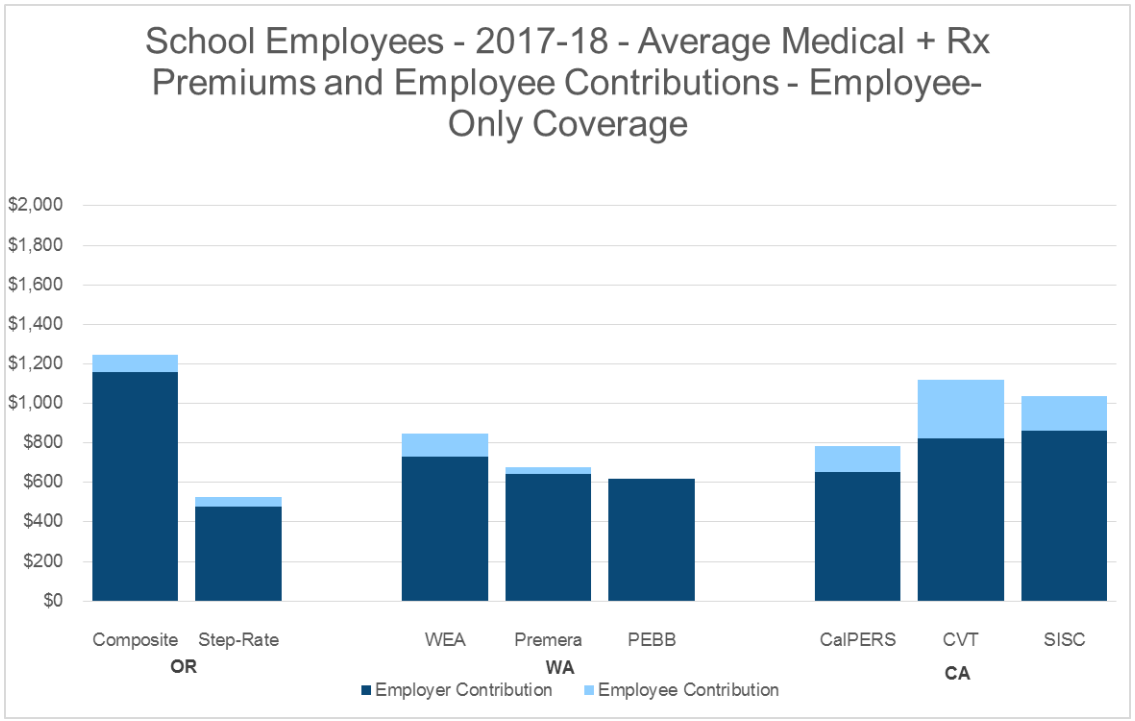
- OR EE Only 3.1%
  EE + Dep 3.4%
- CA EE Only 19.6%
  EE + Dep 19.5%
- ID EE Only 9.6%
  EE + Dep 11.7%
- NV EE Only 9.7%
  EE + Dep 18.9%
- WA EE Only 14.2%
  EE + Dep 15.2%

School Employer – Teachers

Oregon, California and Washington

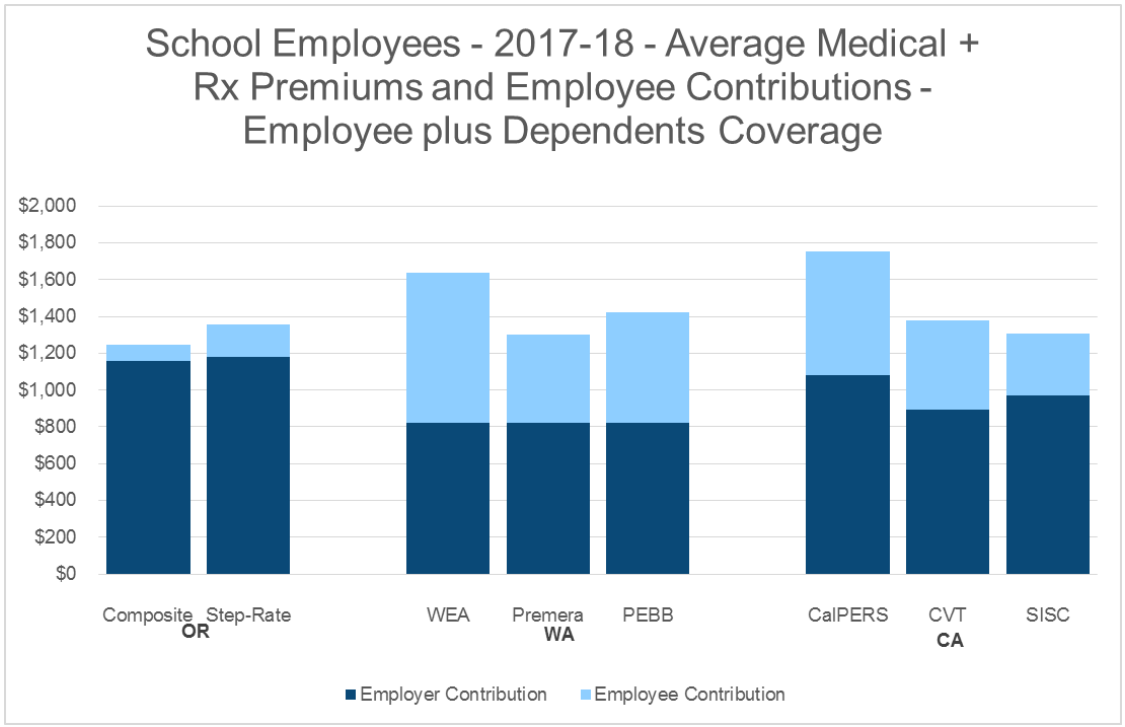
- Range of Premium and Structure of Coverage
  - Local District Roles
  - Various Trusts and Pooling Arrangements
- Impacts from Funding Structure
- Funding Arrangements
- Tiered Rating

School Employees – Average Premium Contribution



- OR Composite 7.4%
  Step Rate 9.3%
- WA WEA 13.9%
  Premera 4.6%
  PEBB 0.0%
- CA CalPERS 16.8%
  CVT 26.4%
  SISC 17.0%

School Employees – Average Premium Contribution



- OR Composite 7.4%
  Step Rate 13.3%
- WA WEA 49.9%
  Premera 37.1%
  PEBB 42.3%
- CA CalPERS 38.3%
  CVT 35.3%
  SISC 25.8%

Challenges of Cost Containment

- Total Premiums face ever increasing cost pressures from
  - Provider Reimbursement for Unit Cost
  - Effectiveness of Utilization Management across various options within a portfolio
- Traditional Solutions
  - Raise Employee Premium Contributions
  - Lower Benefit Richness to increase member cost sharing
  - Consolidate plan options
- Advanced Considerations
  - Risk Adjustment
  - Unit Cost Comparison
  - Accountable Care Networks

Milliman

Thank you

Ben Diederich

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Washington State's Public Employees Benefits Board (PEBB) & School Employees Benefits Board (SEBB) Programs

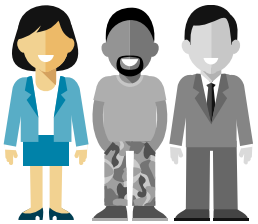
December 3, 2018

David Iseminger, J.D., MPH
Director, Employees and Retirees Benefits (ERB) Division

Washington State Health Care Authority

HCA: Washington State's largest health care purchaser

We purchase care for 1 in 3 non-Medicare Washington residents

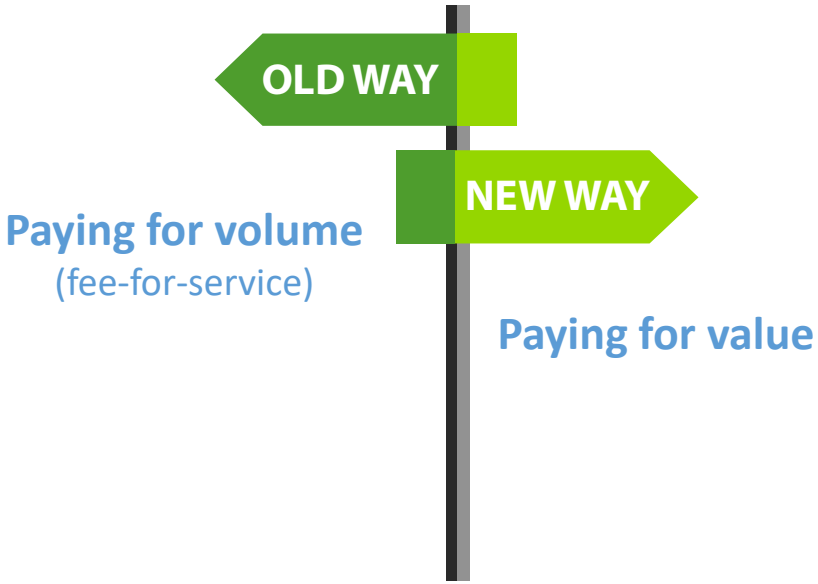


- We create reliability in an unpredictable and complex health care environment
- We lead state efforts to adopt new, sustainable advancements in health care
- We accelerate the modernization and efficacy of our health care system
- We envision a healthier Washington—a sustainable health care system, stronger communities, and healthier people

HCA purchasing goals

By 2021:

- 90% of state-financed health care and 50% of commercial health care will be in value-based payment arrangements (measured at the provider/practice level).
- Washington's annual health care cost growth will be below the national health expenditure trend.



Washington State Health Care Authority

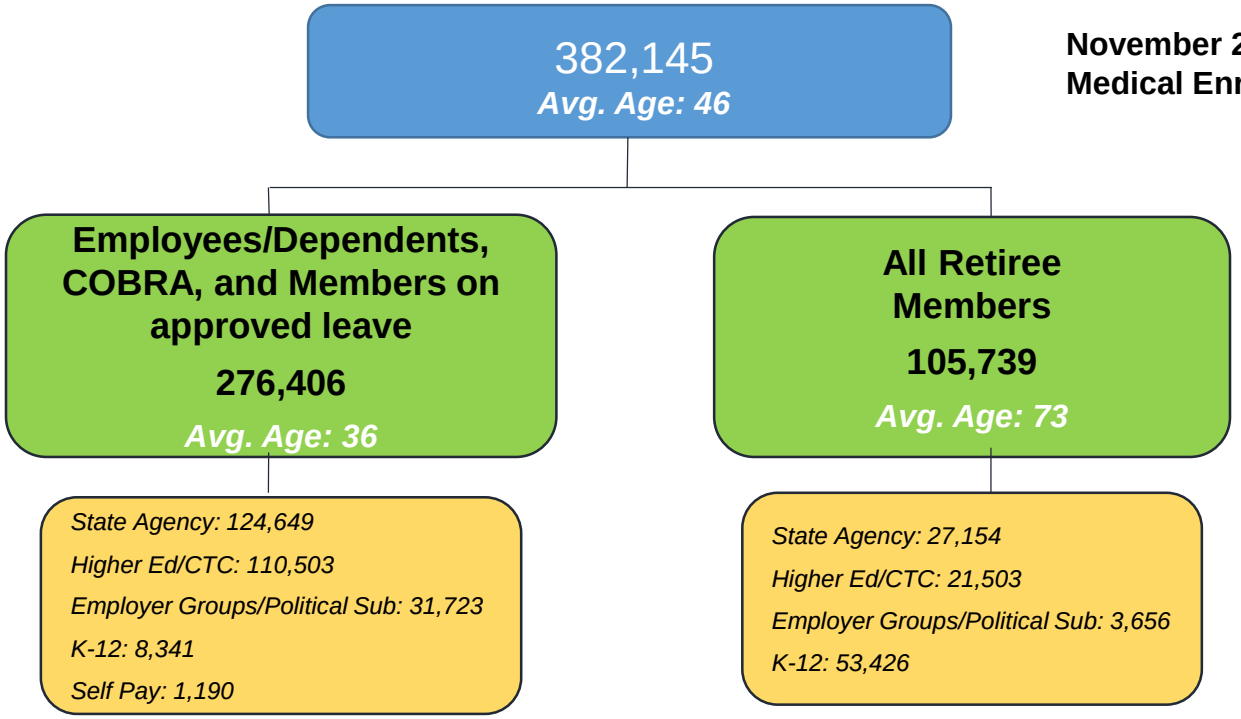
Our approach to clinical quality

We're working toward one evidence-informed standard of care that guides clinical decisions across Apple Health (Medicaid), the PEBB Program, and the SEBB Program.

What this looks like:

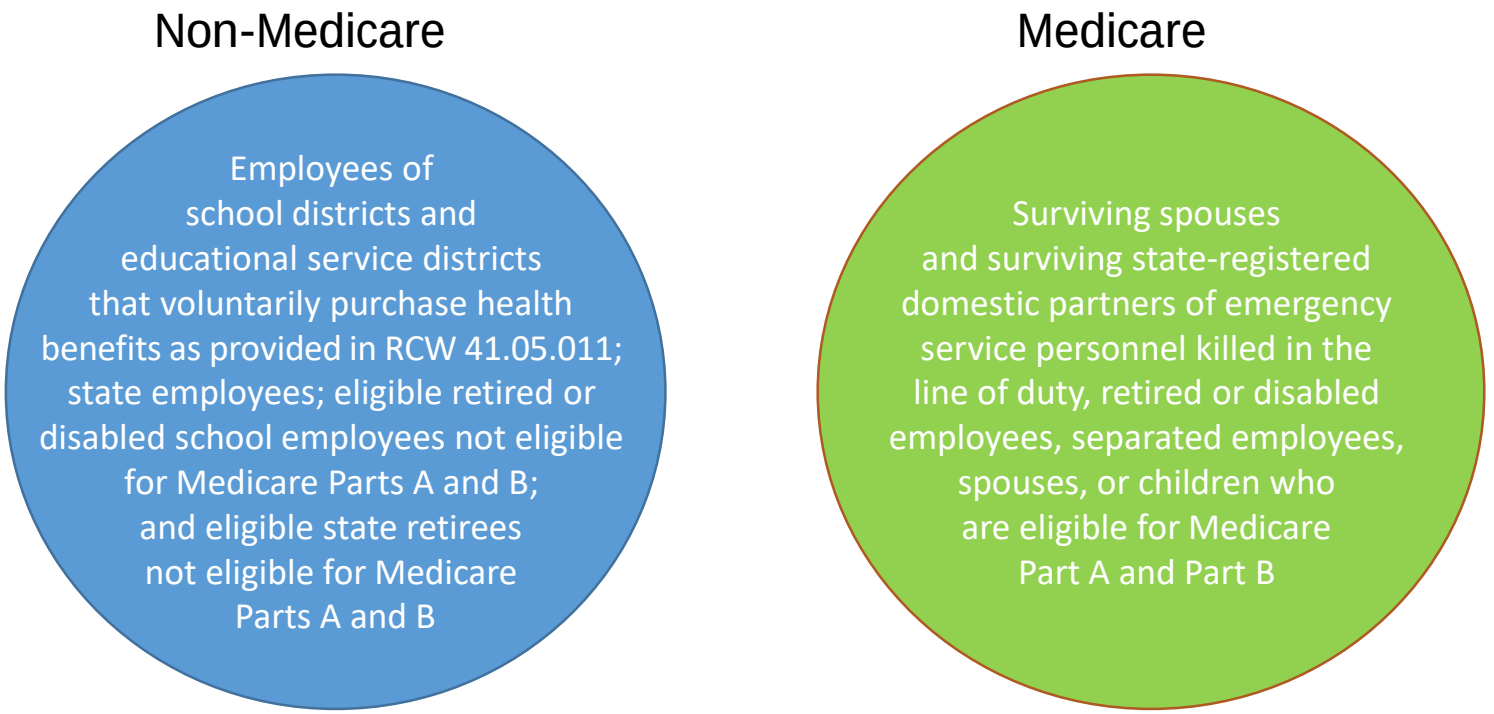
- HCA health plans use science-backed standards to provide the most effective care.
- Innovative pilot projects address critical issues like chronic disease management and the opioid crisis.
- HCA purchases health care using standardized methods to improve efficiency while increasing quality of care.
- Measurements are informed by national and state measurement systems, evaluated by agency analytic experts, and implemented consistently across all vendor contracts for all programs.

PEBB Program Members Served



Washington State Health Care Authority

PEBB Program risk pools



Washington State Health Care Authority

PEBB Program benefits

- Major medical coverage* (including vision and prescriptions)
  - Includes integrated web-based employee wellness program (Smart Health)
- Dental coverage*
- Additional benefits:
  - Life and AD&D insurance (basic* and optional)
  - Long-term disability insurance (basic* and optional)
  - Medical Flexible Spending Arrangement (FSA)
  - Dependent Care Assistance Program (DCAP)
  - Health Savings Account (HSA)
  - Voluntary Employees' Benefit Association Medical Expense Plan (VEBA MEP)
  - Auto and home insurance

* *For state agency and higher education employees, the state pays a significant portion of the premium for medical, and all of the premium for dental, basic life and AD&D, and basic LTD insurance.*

PEBB Program – Employee Medical Plan Choices

- Ten separate offerings between Kaiser Permanente of the Northwest, Kaiser Permanente of Washington, and the Uniform Medical Plan (self-insured)
  - Most PEBB benefit eligible employees have between four and seven options
  - There are 14 counties where two UMP offerings are the only options
- Range of benefit designs
  - PPO, accountable care, and managed care options
  - IRS qualified high deductible health plans (HDHP) since 2012
  - Coinsurance and copayment models
- Range of monthly employee premiums
  - 2019 Employee only coverage from $25/month (HDHPs) to $165/month
    - Largest enrollment is in the UMP Classic plan with a monthly premium of $107/month
  - Tiered premiums for enrolling dependents:
    - Employee + spouse/state-registered domestic partner (2x)
    - Employee + child(ren) (1.75x)
    - Employee + spouse/state-registered domestic partner + child(ren) (2.75x)

SEBB Program – Benefits Begin 1/1/2020

- 25+ year policy debate with at least 9 legislatively directed studies/reports since 1988
  - Consistent findings that benefit packages vary across districts with significant differences in employee cost, particularly those covering dependents
- In 2017 as part of EHB 2242, and as amended in 2018 in ESSB 6241, school employee health care benefits were consolidated under the SEBB Program
  - Starting January 1, 2020, all districts and charter schools must provide eligible employees with health care and other insurance benefits through the SEBB Program
  - All school employees anticipated to work 630 hours in a school year and their dependents are eligible
  - Employee premiums for full family medical coverage cannot be more than 3 times the premium for individual coverage for the same plan
- The SEBB Program was created to:
  - Promote more transparency and accountability in state expenditures for school employee benefits
  - Eliminate differences in school employee benefit offerings and make them more affordable to employees with dependents
  - Consolidate collective bargaining for school employee benefits

SEBB Program – Implementation Overview

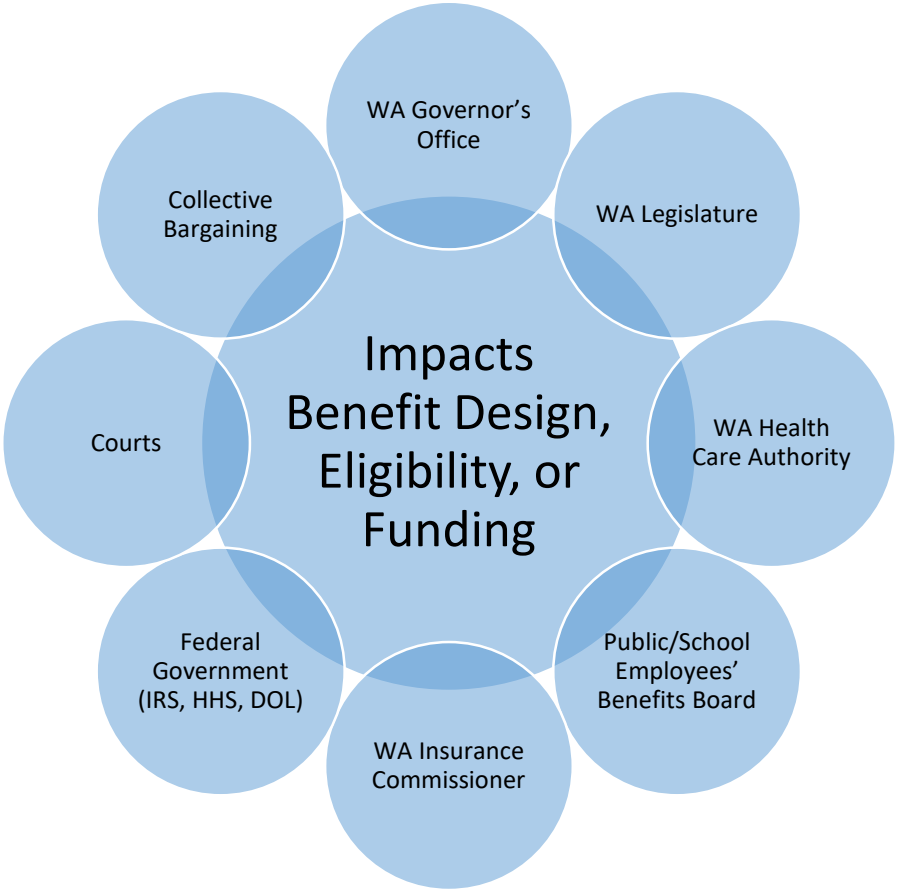
- Major Accomplishments in 2018
  - Collective bargaining tentative agreement reached
  - All benefit procurements completed and contract negotiations in process
  - Board established preliminary benefit design for medical, dental, vision, life, and disability insurance benefits
  - Board adopted core eligibility policies and rules filed
  - HCA started building online enrollment system
  - HCA continuously engaging with key stakeholders about progress

- Upcoming 2019 Milestones
  - Rate development to inform legislative budget process
  - Final execution of contracts with all carriers
  - Complete IT build and perform testing of required integrations (e.g., payroll) with school district partners and carriers
  - After the budget is enacted, Board refinement of benefit designs and setting employee premiums
  - Initial open enrollment in Fall 2019
  - Benefits launch January 1, 2020

SEBB Program – Implementation Challenges

- Requiring significant ongoing financial commitment needed during 2019 legislative session
- Engaging numerous stakeholders
  - 295 autonomous school districts, nine educational service districts, 10+ charter schools
  - Dozens of unions representing ~1,000 bargaining units
- Developing and explaining fundamental changes to risk pooling, premium development, and benefit design
- Leveraging currently 40+ year old technology to manage eligibility records
- Managing multiple overlapping authorities

Authorizing Environment



Washington State Health Care Authority

Key HCA Authorities

1. Administration of the PEBB & SEBB Programs, such as:
   - Support personnel, payroll, and benefit officers
   - Establish and support eligibility appeal processes
   - Manage and monitor the financial performance of the benefits portfolio and program
   - Set and manage the annual open enrollment
   - Create member communications
   - Manage eligibility system(s) of record

2. Administration and support of the PEB Board & SEB Board

Key HCA Authorities (cont.)

3. Perform benefits and vendor procurements, lead rate setting negotiations, execute contracts, and manage contracts
4. Maintain the ERISA exemption for employee benefit plans
5. Establish billing procedures and collect funds from employers
6. Perform Rule-Making
7. Manage the IRS Section 125 Cafeteria Plan
8. Maintain compliance with federal and state laws

Governing Boards

- Public Employees Benefits Board
  - Seven voting members appointed by the Governor
    - One representing each of state employees, state retirees, and K-12 employees
    - Three with experience in health benefit management and cost containment
    - HCA Director (or designee) serves as chair and a voting member
  - Two non-voting members appointed by the Governor
    - One representing K-12 employees
    - One with experience in health benefit management and cost containment

- School Employees Benefits Board
  - Nine voting members appointed by the Governor
    - Two representing certificated staff
    - Two representing classified staff
    - Four with health benefits policy expertise, one of whom represents school business officials
    - HCA Director (or designee) serves as chair and a voting member

Key PEB Board & SEB Board Authorities

1. Study insurance matters and develop school employee benefit plans
   - Authorize benefit designs for medical, dental, disability, vision, life, and AD&D benefits
   - For self-insured plans, set cost shares (deductible, coinsurance/copayment, etc.), treatment limits for services, and exclusions of services/procedures

2. Build on core eligibility and enrollment requirements set in statute
   - Establish dependent eligibility requirements for spouses/SRDPs, children, and disabled dependents
   - Set a 31-day enrollment period after establishing eligibility
   - Determine the effective date of coverage after an employee establishes eligibility for employer premium contributions

3. Authorize the premium contributions for a school employee and the employee's dependents
   - Establish monthly employee premium contributions for medical plans
   - Establish premium tiers and the premium tier ratio for benefits

Questions?

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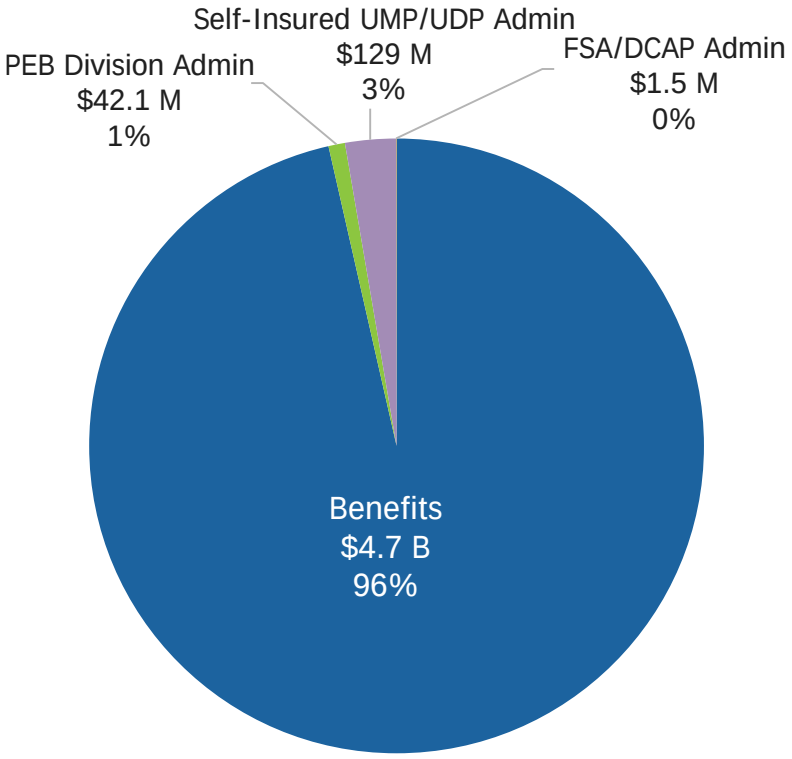
PEBB Program budget

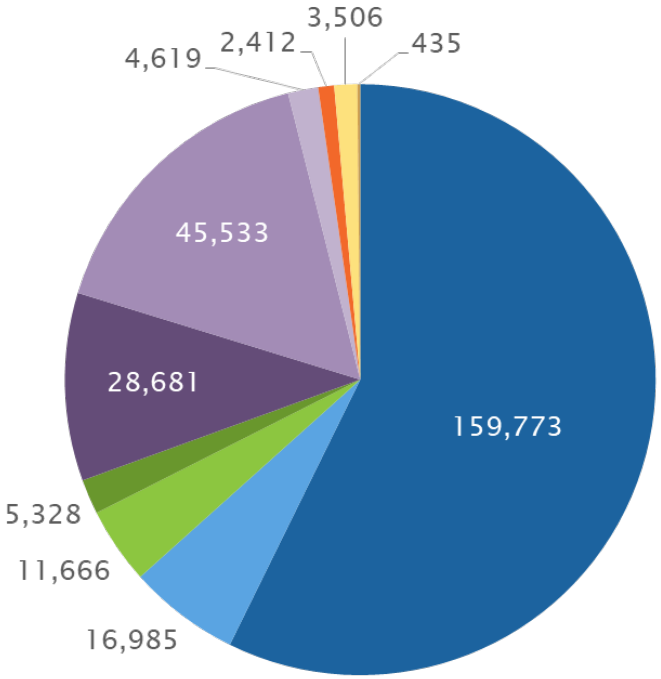


2017-19 Biennium	
Benefits	$4,679,800,000
PEB Division Admin	$42,100,000
Self-Insured UMP/UDP Admin	$129,000,000
FSA/DCAP Admin	$1,500,000
Total PEB Biennial Budget	**$4,852,400,000**

Sources: 2017-19 Expenditure Authority Schedule V10 and PFPM 7.1 Projected Expenditures

Washington State Health Care Authority

PEBB Program enrollment by risk pool and medical plan – Non-Medicare



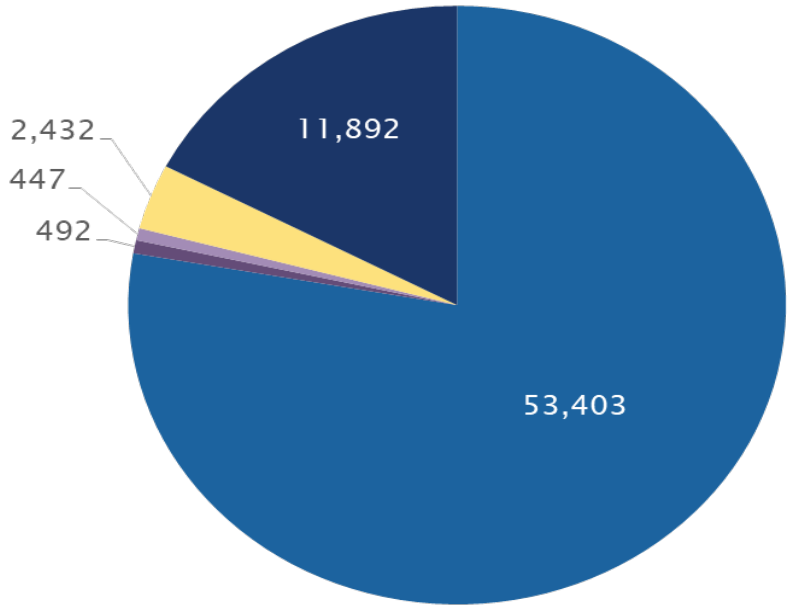
Non-Medicare (Average age 36.8)

- Classic - Uniform Medical Plan
- CDHP - Uniform Medical Plan
- UMP Plus - UW Medicine Accountable Care Network
- UMP Plus - Puget Sound High Value Network
- Classic - Kaiser WA
- Value - Kaiser WA
- CDHP - Kaiser WA
- Sound Choice - Kaiser WA
- Classic - Kaiser NW
- CDHP - Kaiser NW
- Premera Blue Cross Medicare Supplement Plan F

*Enrollment as of **July 2017***

Washington State Health Care Authority

PEBB Program enrollment by risk pool and medical plan - Medicare



Medicare (Average age 74.1)

- Classic - Uniform Medical Plan
- CDHP - Uniform Medical Plan
- UMP Plus - UW Medicine Accountable Care Network
- UMP Plus - Puget Sound High Value Network
- Classic - Kaiser WA
- Value - Kaiser WA
- CDHP - Kaiser WA
- Sound Choice - Kaiser WA
- Classic - Kaiser NW
- CDHP - Kaiser NW
- Premera Blue Cross Medicare Supplement Plan F

*Enrollment as of **July 2017***

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