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Oregon Health Policy Commission
Cost Work Group
Monday August 23, 2004
800 NE Oregon Street, room 120-B
10:00 a.m. – 3:00 p.m.

Members in attendance: Geoff Brown, Alice Dale, Maribeth Healey, Ann Turner, Steve Robinson, Mylia Christensen, Allen Douma, Ruby Haughton

Staff in attendance: Mike Bonetto, Elizabeth Kurtz

Members excused: Terry Smith, William Kramer, Dwight Sangrey, J. Bart McMullan, Jr.,

I. Call to Order/Introductions

Alice Dale and Geoff Brown, Co-Chairs

II. Commission Update

HPC met Thursday August 19, 2004. Cost Work Group made a commitment that it would come up with 2-4 items to be summarized into key cost items. The items that the cost work group submits will get translated into Legislative proposals. Commission has not set time frames in regards to the costs in years to come. Children are not the main focus of the Commission, but every uninsured person in Oregon. The work should not focus on just the cost of health care for children. Issues that the Commission is dealing with are being viewed as universal in relation to all four work groups, not just the cost work group. The Cost work group ties in to all of the work groups in some way. Items for Cost work group to focus on are the prescription drug plan and efficiency. Try not to overlap items with the other work groups. Discussed the community forums. Commission would like any of the members of the work groups to attend any or as many of the forum meetings as possible. Community forums will be as broad based as possible. Employers, individuals, providers, and community groups have been invited to attend.

III. Prioritization of Potential Strategies

Rephrase the Problem Statement to say—The increased costs leading to unaffordable coverage and decreased access leads to poor health status and poor quality. Need to include projections for the State for the next ten years. Doing so will show the Legislature what the costs are now, what they were ten years ago and what they will be ten years from now. In presenting this way, it can show how much money can be saved in the long run. Need to tie into the needs of businesses. Look at what the impact is on health benefits for employees. A major contributor to the increase is health care costs are by the aging population. Make Legislature aware that it is not just about negotiating rates, but the population will be demanding more health care.

IV. Integration of Short-Term and Long-Term Goals

- Group discussion regarding the elderly and retirement issues.
- Group discussion regarding public and private sector health care and health insurance issues.
- Group discussion regarding the Cost Work Group report. Also discussed the other work group reports.

IV. Discussion of Drafting Legislative Concepts

- Group discussion regarding the cost of the prescription drug purchasing pool. Prescription drug purchasing pool should be open to PEBB, large and small employers and individuals. Discussed the effect of a prescription drug purchasing pool would have on OHP, uninsured, underinsured, and the public and private sector.
- Group discussion regarding electronic health records and the cost of this part of the Commission's goals.
- Group discussion regarding establishing a health insurance purchasing pool for small employer groups with 2-25 employees.

VI. Adjournment

Next meeting TBD.

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Oregon Health Policy Commission
Cost Work Group
August 12, 2004
800 NE Oregon Street, room 120-B
12:00 – 3:00 p.m.

Members in attendance: Geoff Brown, Maribeth Healey, Ann Turner, Steve Robinson, Mylia Christensen, Alice Dale, Allen Douma, Ruby Haughton

Staff in attendance: Mike Bonetto, Elizabeth Kurtz

Members excused: Terry Smith, William Kramer, Dwight Sangrey, J. Bart McMullan, Jr.,

I. Call to Order/Introductions
Alice Dale and Geoff Brown, Co-Chairs

II. Discussion of Prescription Drug Costs and Possible State Policy Actions
Kathy Ketchum, Oregon State University and the Office of Medical Assistance Programs (OMAP)
Jim Gardner, Pharmaceutical Research and Manufacturers of America (PHARMA)

Kathy Ketchum distributed handouts that overviewed OHP drug costs. Topics discussed: today's situation, drug cost drivers, cost control approaches available to Medicaid, department actions to limit price, department actions to limit inappropriate utilization, department actions to shift to lower cost alternatives, potential savings from PA enforced PDL.

(*Mike check w/Chris Barber on cost savings of the State Disease Management Program) – Limit Inappropriate Utilization*

Jim Gardner represents the pharmacy lobby. Supportive of the hire of Missy Dolan and her role particularly in support of access to seniors. The missing essential element now in SB 875 is participation by PEBB.

HB 3624 – encourages more people into managed care. It also says prior authorization will not be used to enforce the PDL. It is a work in progress. The basic concept of evidence-based information is good. The updates indicate more head-to-head trials with certain drugs are taking place. There needs to be practitioner discretion on a case-by-case basis. 30-60% of people do not respond to prescribed medication. How do we mitigate the cost incurred for this wasteful purchase of drugs.

SB 875 there is no PA for low-income seniors.

MCO versus fee for service. Fee for service becomes separate silos.

MMIS is on its way in. The RFP is in the works.

Compassionate Care Programs – programs for free drugs. Serves 100K Oregonians. Looking to find ways to increase participation. www.helpingpatients.org.

III. Discussion of System Inefficiencies and Possible State Policy Actions
Mike Rowher, MD, Performance Health Technology

PowerPoint presentation discussing fee for service for medication. Rules exist, but are not being enforced. If they were, costs would be considerably lower.

RFQ 1514 released to explore options with respect to cost/error avoidance and Medicaid claim pre-processing.

Fee for service could save as much as $43M/year. Use existing rules/laws plus the addition of some. Medical management saves money in the long-run. Single medical-management program run by OMAP – in-house management. Proximity is valuable.

(*Mike contact Rick Howard of OMAP)*
Outsourcing versus keeping medical management in-house.

(Mike contact Joan Kapowich at OMAP for HB 3634 update – fee for service versus managed care enrollment - Jackson County and McMinnville)

(Mike find OHP enrollment data by county – send to Allen)

VI. Adjournment 12:20

Next meeting August 23, PSOB, 12 noon – 3 p.m. Room 120-B.

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Oregon Health Policy Commission
Cost Work Group
August 2, 2004
Portland State Office Building
800 NE Oregon Street, room 140
12:30 – 3:30 p.m.

Members in attendance: Geoff Brown, Maribeth Healey, Ann Turner, William Kramer, Steve Robinson

Staff in attendance: Mike Bonetto, Elizabeth Kurtz, Missy Dolan, Janne,

Members excused: Terry Smith, Alice Dale, Ruby Haughton, Allen Douma, Dwight Sangrey, J. Bart McMullan, Jr., Mylia Christensen

I. Call to Order/Introductions

II. Discussion of Prescription Drug Bulk Purchasing and SB 875
Missy Dolan, Director for Oregon Rx Drug Program, Office for Health Policy and Research

SB 815 was established to produce a purchasing pool – includes all government agencies, not Medicaid, or OMAP. Using evidence-based studies to develop a preferred drug list.

HB 875

III. Discussion of Evidence-Based Medicine and Prescription Drugs
Dean Haxby, Oregon State University, College of Pharmacy
Kathy Ketchum, Office of Medical Assistance Programs

Discusses the import of evidence-based medicine. Going outside of a formulary, evidence must be proven that this should take place.

Evidence is based on best scientific information. (literature review, weighing levels of evidence, etc.)

(Oregon PDL, and HRC study – get copies)

Educate physicians to learn formularies to improve prescribing patterns. Make formularies consistent across the board to simplify processes.

IV. Input from Provider Community
Scott Gallant, Oregon Medical Association

Physicians must be allowed to prescribe non-formulary drugs. Troubling trends. Drug costs have been a vexious problem for the state and providers. More is spent more today than in 1993. More is spent on drugs than hospital or physician services. Cost increases are preventing insured and uninsured people from purchasing prescribed medications.

Educate in appropriate and effective use of medication. "Medical literacy".

Determining unnecessary increases – who makes this determination, and which ones will they be? Administrative costs are exceedingly high. It takes funding to initiate new or improved programs (i.e., EMRs).

Cost is not driven by physician use, rather it is driven more by producers and purchasers of medication. Bulk purchasing might be a lever to reduce cost of prescription drugs. Use of generic drugs.

V. Discussion of Strategies/Policy Actions

Regence, OMA, CareOergon, OMAP, OHP, illustrate that each has their own formulary. The suggestion is made to compare formularies, and in an effort to simplify access and knowledge, combine components of each. This could present a more useful set of guidelines to prescribe medication. Customize with relation to target audiences and need.

Invite Kathy Ketchum, OHP, to the next meeting.

Someone to discuss a statewide purchasing pool.

Acknowledge the impending budget shortfall buy coming up with cuts that negatively impact the fewest number of citizens. Efficacious cost of marketing new drug types versus 'me too' drugs.

Invite Mike Kinard to talk to this group. David Pollack on mental health.

Mandate pharmacies to include cost information on the drug interaction information sheet.

Involve OMA to participate in physician education. And/or, at the School of Medicine level, include this in their curriculum.

VI. Adjournment 3:35 pm.

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Oregon Health Policy Commission
Cost Work Group
Monday, July 12, 2004
Portland State Office Building
800 NE Oregon Street, room 140
12 noon – 3 pm.

Meeting begins at 12 noon

Members in attendance: Alice Dale, Geoff Brown, Maribeth Healey, Allen Douma, Mylia Christensen, Ann Turner, J. Bart McMullan, Jr., Dwight Sangrey, Ruby Haughton, Jorge Yant

Staff in attendance: Mike Bonetto, Elizabeth Kurtz, Dr. Bruce Goldberg

Members excused: Terry Smith

I. Call to Order/Introductions

Geoff and Alice begin the meeting at 12:20 pm.

II. Update of Health Policy Commission's Activities

Mike testified before the Health Care Joint Legislative Committee. His charge is to ensure work groups are prepared to present findings and strategies to them in September.

The Governor has recently formed an Oregon Health Plan Task Force to find out if there are any recommended changes for 2005 in terms of operating health policy. It will be a three-phase process. 1) An initial group consisting of staff and policy people are being gathered for round-table discussions. Kerry Barnett, Vanetta Abdellatif, and Vickie Gates, along with Barney Speight, are among those members. In addition there are four legislators: Ben Westlund, Margaret Carter, Mitch Greenlick, and Jim Thompson. Staff includes Mike Bonetto, Bruce Goldberg, and Erinn Kelley-Siel., Gary Weekes, and Lynn Reed. The idea is for this group to come up with ideas they think can be presented to the Oregon Health Plan. 2) These ideas will be taken out to stakeholders and specific groups. 3) Those recommendations will be taken to the Health Policy Commission in November.

Mike introduces Jorge Yant, CEO of Plexis Corp. in Ashland, as the newest member of the Cost Work Group

III. Review Prioritization of Cost Drivers

The group identifies these as the top three in order of importance:

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1. Prescription Drug Costs
   Missy Dolan, OHPR Rx Drug Program Director, will be invited to address this at the next Cost Work Group)

Prescription Drug Cost Drivers

I M P A C T	H Rx Drug Pool L	H
	DIFFICULTY/FEASIBILITY	

Informed consumer versus empowered consumer.

Education and information alone have proven to be worthless. Must be disseminated with levers to motivate the message.

Relationship between physicians and pharmacists

Curb or limit marketing practices to the dissemination of evidence.

Encourage physicians to prescribe medication to treat the cause, rather than only the symptom. Rx drug results in some of the highest causes of elevated health care costs. Develop incentives to motivate physicians/pharmacies to reduce drug cost drivers. Propose mandatory CME for prescribers. Change Rx prescribing patterns/habits.

Mental health drugs make up 50% of prescription drug costs. Corral those.

1 – Physician
2 – Patient
3 - Drug

Step therapy.

Require inclusion of an approved State disclaimer (at point of sale, or point of treatment)

Goals → Objectives → Strategies → Tactics. We should try to stay away from a tactical approach.

2. Unmanaged care, system inefficiencies and (administrative costs)

3. Growing number of uninsured

Reducing cost wherever possible will be the best way to begin, since monetary allocations are not available.

A suggestion is made to consolidate or blend cost drivers.

Use the many suggestions and ideas that are outside the prioritization list, and create a preamble, as a way to establish a concrete and tangible context to present to the legislature.

Goal- effective use of evidence-based formularies

Bulk purchasing program

PEBB cost containment – carriers bid. PEBB narrowed the field of carriers. Evidence-based or reference-based formularies? PEBB self-insured better for Rx drugs.

Side-by-side carrier formulary comparison to create a statewide formulary.

Instead of adding to the plethora of existing formularies, what about improving them?

What criteria were used to determine the order of prioritization of the cost drivers? Identify and include with each cost-driver.

Do not confuse cost shifting with cost escalation. System costs for the insured could be shifted up to accommodate those who are under/uninsured.

Mike describes how the process will flow at the legislative presentation. After strategizing cost drivers, identify overlaps

IV. Discussion of Strategies/Policy Actions

IV. Schedule Future Meeting Dates

Monday August 2, 12-3, PSOB
Thursday August 12, 9-12 noon, PSOB
Monday August 23, 12-3, PSOB

VI. Adjournment 3:00 pm.

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For next meeting:

Invite Missy Dolan to present on Rx costs

Invite Kathy Ketchem, PharmD, OMAP

Invite a representative of OMA to discuss practice patterns and consumer expectations.

Draft a work group Preamble that includes concern around each cost driver, either individually and/or collectively.

Goals, objectives, and strategies for next meeting agenda.

Clarity on Rx issues. Then move on to the next issue.

Work in between meetings in preparation for the next meeting.

Distribute email conversations about process and agenda discussions to everyone in the work group.

Allen Douma's points

1. Position Papers
2. Educate re: issue, (public, prog., etc.)
3. Change Rules
4. Subsidize Programs
5. Create/Manage Program

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Oregon Health Policy Commission
Cost Work Group
Monday, June 14, 2004
Portland State Office Building
800 NE Oregon Street, room 140
1 p.m. – 4 pm.

Meeting began at 1:15 p.m.

Members in attendance: Alice Dale, Geoff Brown, Maribeth Healey, Allen Douma, Mylia Christensen, Ann Turner, J. Bart McMullan, Jr., Dwight Sangrey, Ruby Haughton

Staff in attendance: Mike Bonetto, Elizabeth Kurtz, Dr. Bruce Goldberg

Members excused: Terry Smith

I. Call to Order/Introductions

Geoff and Alice introduce new member Steve Robinson, SAIF Corporation

II. Prioritization of Cost Containment Strategies

<u>11 Cost Drivers are tallied and identified in order of priority (none are unimportant, rather they are prioritized in order of degree of need:</u>

Preventable causes of illness, disability and premature death
XX
Technological change
{underutilization of evidence based medicine}
Increased use of expensive types of care
XXX
Prescription drugs
XXXXXXXXX
Unmanaged care and system inefficiencies
XXXXXXXXX
Health care market problems
XXX
Structure of insurance coverage
XXX
Aging population

Growing number of uninsured
XXXXXXX
Defensive medicine and medical malpractice costs
XXX
Administrative costs
XX

-purchaser
-provider
-regulator
-educator
-collaborator

Mike uses this grid to illustrate the degree of difficulty against the level of impact.

I M P A C T	High Impact Low Difficulty	High Impact High Difficulty
	Low Impact Low Difficulty	Low Impact High Difficulty
	DIFFICULTY	

Distinguish between short and long term cost drivers and remedies for cost drivers.

Membership discusses creating a statewide, open or closed formulary. Will it bring cost down? State and private systems would be individually organized to garner similar results of driving cost down.

Membership asks what role can the state play in improving health care delivery? Electronic medical records.

Incentivize electronic prescriptions 25% to start. In five years

Dovetail with other entities to create a process state and private collaborative electronic system. Incentivize. Oregon Trail Card eliminated the need for paper food stamps. Tie in to a major system. Physician support from the private sector – private/public partnership.

Educating consumers is key to reducing cost – educate them to ask questions. Teach them to know what is available, and they have choices. Educate basic processes and concepts to consumers.

III. Break

IV. Review Cost Performance Indicators

V. Discussion of Next Meeting Agenda

VI. Schedule Future Meeting Dates

VII. Adjournment 4:00 p.m.

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Oregon Health Policy Commission
Cost Work Group
Organizational Meeting
May 25, 2004
200 SW Market, Suite 1200, Portland, OR

Meeting began at 1:15 p.m.

Members in attendance: Alice Dale, Geoff Brown, Maribeth Healey, Mylia Christensen, Ann Turner, Dwight Sangrey, Senator Ben Westlund

Staff in attendance: Mike Bonetto, Elizabeth Kurtz, Liz Baxter

Members excused: Terry Smith, Duncan Wyse, Allen Douma, J. Bart McMullan, Jr., Ruby Haughton

Call to Order/Commission Update
Alice Dale and Geoff Brown, Co-Chairs

Introduced Senator Ben Westlund, who offered the support and encouragement of the legislature to this important work group. Look, listen, and learn process for him so he can assist in developing health care policy. One track, two rails process - long-term solutions with short- term goals and objectives.. Maintain profile and importance to the legislature.

Review PEBB Vision
Mylis Christensen

Copies of PEBB's Executive Summary Strategic Planning 2003, and 2007 Vision Planning were distributed. Presented herself as a channel for PEBB in cooperation with Jean Thorne, PEBB Executive Director, for the benefit of this work group. Handouts were distributed outlining PEBB's statutory beginning in 1997, and chronicled its progress to date. The PEBB Mission is, "To provide a ***high quality*** plan of health and other benefits for state employees at a cost ***affordable*** to both the employees and the state".

PEBB is the largest employer-sponsored insurance group in Oregon. PEBB's membership has grown from 98,000 participants in 1998, to a current participation of 103,000; 110,000 if COBRA and retirees are included - 5% of the population. Of these members, 85% participate in Blue Cross/Blue Shield; 15% participate in Kaiser.

Use PEBB's program design and processes to illustrate ways to proceed reforming and improving affordable health care, to include vision and short-term goals. There are many ways to define affordable. Consider comparing treatment costs between disparate groups.

Break

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Overview of Public Input Process (Health Values Survey) - Liz Baxter

Mike introduced Liz Baxter, and explained the Commission wants each work group to provide public input in each of the four areas. In an effort to avoid reinventing the wheel, they have asked 'Making Health Policy 2000', the most recent survey undertaken, to be used as a guideline. Liz participated in the 2000 survey, and will adapt components of it to fit the charge of each work group. She distributed a draft timeline. Liz explained the charge of Oregon Health Policy and Research is to assemble a summary of the public's input, using approaches of gathering information such as telephone surveys, community meetings, stakeholder's meetings, and targeted interviews. She describes the purpose of gathering public input as a means to educate, build community, and cultivate collaboration. She has three questions, that when answered by this work group, will determine the direction the Cost Work Group wants to go with a public input survey.

1) **What do you want to do with the information you get?**
   What is affordable? What does the public understand about the current condition of the cost drivers of health care? Do people understand whether they participate in their own health care.

2) **Who do you want to hear from?**
   Sample diverse focus groups. Qualitative data to include the insured, uninsured, and end-of-life populations. Collaborate/dove-tail/partner with MACG?

3) **What do you want to hear?**
   Policy piece - reaction to proposals.

The membership wants these surveys to relate to people on their own level.

Liz would like to have input on cost containment from this group to include in the September survey.

Prioritize Cost Drivers

Discussion of Maine's Performance Measures

Discussion of Next Meeting Agenda

Submit list of cost-drivers to Mike Bonetto for the June 14 meeting. Alice recommends referring to the cost-driver grid and NCSL Cost Containment articles.

Adjournment
4:00 p.m.

Next Meeting - Monday, June 14, Portland State Office Building, 800 NE Oregon Street, Room 140, 1 - 4 p.m.

Oregon Health Policy Commission
Cost Work Group
Organizational Meeting
May 4, 2004
200 SW Market, Portland, OR

Meeting commenced at 1:15 p.m. Tuesday,

Members in attendance: Alice Dale, Geoff Brown, Maribeth Healey, Allen Douma, Mylia Christensen, Ann Turner, J. Bart McMullan, Jr., Dwight Sangrey, Ruby Haughton

Staff in attendance: Mike Bonetto and Elizabeth Kurtz

Members excused: Terry Smith, Duncan Wyse

Call to Order/Introductions
Geoff began roundtable introductions

Overview of Group's Charge and Work Plan
Alice distributed a handout summarizing the work group's charge
Blend interests, using existing information as well as adding needed goals, objs.
Performance Measures. Readying to present to the HPC in mid-July.

Attainable deliverables

Initial process – short and long term goals. Focus on State policy solutions. Federal intervention. Last piece will be strategies by September. Legislative support on the HPC. Educate policy-makers.

Matrix hand-out comparing what other states have done. Cost related goals. Supply and/or demand. Distinguishing the difference between goals and strategies. Reduce the broad scope or foundation to begin.

Delaware. Minnesota – public forums. Identified policy-makers. Florida – affordable health insurance/evidence-based medicine. Maine – the state to watch. New plan named Dearago Health. Creative structure. Three years worth of work. Cost related goals are specific. Performance measures identified re: access, cost, quality, health status. Massachusettes – engaging consumers. Disseminating information. Strategies.

NCSL – handout. Framework for Considering Health Care Cost Containment. What drives health care costs. What can the state do to deter cost drivers? Who should the player's be? Identify cost containment strategies.

National Gov. Association – Medicaid - handout

State Health Care Cost Containment – handout

Identify health care costs draining the state budget.

This is not just about the Oregon Health Plan. Rather, expanding the scope and making good choices. Making appropriate exchanges. Segregate costs. True impact. Cost-shifting.

Identify five items that have political viability. Gov. wants a longer focus. 3-5-7 year goals.

Come up with a framework. From cost-driver to possible strategy. Targets. Matrix. Picture. Diagram. Dimensional. Prioritize. Existing solutions. Politically feasible. Political by-in.

Design then figure out how to make it happen.

Identify what 'health care system' is. Transfer of information.

Community-based solutions. Evidence-based medicine. Rewards quality instead of paying……

PEBB piece – stakeholders contribution. Use the PEBB Vision.

'Dialoging' across the state. Focus groups. Find common group. Weigh-in on constructive health-care costs and what they will provide. Random samples of people.

Bring back previous administration's struggles and work to solve them.

Cost or paying for? Will attitudes change to go along with cost-shifting? Giving up something for the common good. Address the need for trade-offs.

Prioritize Oregon-specific health care cost drivers. Then, proceed to identify strategies to correct, reduce, shift those costs.

Is the money currently allocated being spent efficiently, appropriately. Are we maximizing what he DO have? True cost of care. Excessive technology is costly.

Focus on transparency and objectivity. Accuracy and honesty. Interpreting our charge.

Impact of the uninsured to health care costs. Could money be better spent? RX drug reform, to name one example.

Driving down health care costs will be an economic boon to the State. What will that business plan look like? What will the model be?

1. Can we make a difference in cost by focusing on process?
2. Disease management
3. Cost basis – cost shift.

Mercer survey results were handed out – Is the status-quo sustainable?. Outlined the costs of health benefits to employers and employees, and percentages of wages and incomes. Trends would indicate that at current rates, significant change is needed to avoid running out of money to cover the costs of health care within a relatively short period of time.

Moral imperative.

5% of employees generate 50% of the cost. Bariatric surgery was sighted as an example of this data. Elective procedure with high rate of complications. High mortality rate from this procedure.

End of life care.

Stockdale Paradox. Have to acknowledge how really bad we are in trouble. Only then can we see the hope needed to get us out of trouble.

Necessary versus unnecessary medical treatment.

Certificates of Need.

Can the plan design include the effectiveness of disease prevention?

	Short-Term	**Long-Term**
Process (electronic records-EMR)		
Disease Management		
Cost Shift direct/indirect		

Opportunities - High, Low, Medium

List of cost drivers

Discussion of Next Meeting:
1. PEBB material from Mylia prior.
2. Review cost drivers and/or add to them.

3. **Maine Performance Measures will be sent out.**
4. **List of priorities.**

Add list of duties to Agenda in next mailing for this work group.

Change meeting date for June. Monday June 14, 1-4 p.m. (PSOB)

Overview of Cost Task Forces in Other States

Break

Discussion of Cost Goals, Objectives, and Performance Measures

Adjournment 4:15 p.m.