Oregon Health Policy Commission
Road Map for Health Care Reform

Creating a High-Value, Affordable Health Care System

Please direct questions on this report or about the OHPC to Gretchen Morley, OHPC Director, at 503-373-1641

July 2007

Office for Oregon Health Policy & Research

Oregon
Theodore R. Kulongoski, Governor

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July 2007

The Honorable Theodore R. Kulongoski
900 Court Street NE, Room 160
Salem, Oregon 97301-4047

Dear Governor Kulongoski:

On behalf of the Oregon Health Policy Commission, I respectfully submit the attached final report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*. The Commission presents this report in response to your February 2006 letter requesting the Commission develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians.

Throughout 2006, the Commission worked collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years. In early 2007, a draft version of the report was shared with the public and feedback was solicited. The final report, which outlines the Commission vision and provides a framework Oregon can use to move the health care system forward, reflects the Commission's work and input from a wide range of stakeholders. The Commission's recommendations were among the many ideas discussed and included in the development of Senate Bill 329 passed by the 2007 Oregon Legislature.

The Commission recommendations are based on a vision of universal participation in an affordable health care system that offers high-value health care and adequate financial protection. High-value health care is high quality, coordinated and safe, efficient and evidence-based, and continuously improving. The following principles shaped the Commission's recommendations:

- Recognize that health care is a shared social responsibility;
- Recommend reforms that can be realistically implemented over the next five years that both improve current existing structures and define new ways to provide more effective health care;
- Recognize that access, cost, transparency, and quality are intertwined and must all be addressed;
- Achieve access for all Oregonians through rational coverage decisions;
- Maintain a broad, strong safety net;
- Encourage delivery system integration and alignment of payment incentives that prioritize prevention, continuity of care, and care management;
- Maximize available financing; and
- Coordinate with other reform efforts in the state.

To create a high-value health system, the Commission recommends the following reforms:

- Create a Health Insurance Exchange to connect individuals and employers with affordable coverage options and public subsidies in a way that currently does not exist in Oregon;
- Require that every Oregonian purchase affordable health insurance;
- Expand publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Explore sustainable, broad-based financing sources that ensure everyone's participation and equalize the burden between employers that offer employee coverage and those that do not.

To create a sustainable system that delivers value and controls costs, the Commission recommends private and public delivery system reforms, including:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a primary care home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care.

This report is a resource for the Legislature, state agencies and other stakeholders. The information and reform recommendations provided can be used during the implementation of SB 329 and beyond. As tasked by SB 329, the Commission will participate in reform planning and implementation by developing detailed recommendations for a state health insurance exchange, by participating in Health Fund Board subcommittee work on reform financing, and by providing other information, analysis and support to the Health Fund Board.

Recognizing that real reform requires delivery system change, the Commission plans to include in this work a focus on changing system incentives to improve health care quality, safety, and transparency. The Commission's Quality and Transparency Work Group also stands ready to help the Office for Oregon Health Policy and Research develop a quality institute model as directed by SB 329.

The Commission looks forward to engaging in additional health care reform discussions with you, the State Legislature and other interested parties across the state. Together we can make the changes that will improve Oregonians' access to high quality, effective and efficient care.

Sincerely,

Kerry Barnett
Chair

Oregon Health Policy Commission
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The Commission acknowledges the contribution to this report from:
OHPC Local Delivery Systems Workgroup
OHPC Quality and Transparency Workgroup
Safety Net Advisory Council
(See Appendix A for a full listing of workgroup and council members.)
Dr. John McConnell, Oregon Health and Science University, Portland, Oregon whose work was supported by a grant from The Northwest Health Foundation, Portland, Oregon.

Oregon Health Policy Commission
Road Map for Health Care Reform

Executive Summary

The Oregon Health Policy Commission (OHPC) was asked by Governor Kulongoski to develop recommendations for a system of affordable health care that is accessible to all Oregonians. The Commission has worked diligently and collaboratively to develop concrete, realistic reforms that can be implemented over the next five years. The recommendations outlined in this report propose a road map for reform and act as a resource for the Governor, state legislators, state agencies, and other stakeholders during the implementation of Senate Bill 329 and beyond.

Vision

Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives. A high-value health care system is one in which all Oregonians: participate in both the benefits and the costs of a reformed system; have access to affordable, coordinated, high quality health care; and are adequately protected against financial ruin associated with catastrophic medical expenses. A high-value health care system will ensure efficient, evidence-based care and support continuous improvement.

Why Reform Is Needed

The health care system we have now is inefficient, expensive and often fails to ensure good outcomes. Health care costs are high and continue to rise. Increasingly unaffordable health care jeopardizes Oregonians' health status and the state's economic future. In 2006, one in six Oregonians (576,000 people, including over 116,000 children) were uninsured. Low-income Oregonians are at increased risk, but many employed individuals also lack insurance coverage. The uninsured are less likely to get routine care and more likely to delay treatment, resulting in serious and costly conditions. In addition, many Oregonians lack both access to care and to information about costs and quality standards. Without good information, it is difficult for people to be active participants in their own care.

All Oregonians pay for system inefficiencies and services for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. Providers treat uninsured patients, providing care for which they are not paid. To recoup their costs, providers must increase costs to insured patients through higher charges to insurers. Employers pay more for insurance for their employees and are hurt by work time lost to illness. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost an annual total of $65 billion to $130 billion.

The economic and human costs of these system inefficiencies must be addressed. To do this, the Commission started with the following guiding principles for health care reform.

OHPC Guiding Principles for Health Care System Reform

- Health care is a shared social responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that can be realistically implemented over the next five years by improving existing system structures and defining new ways to provide care more effectively.
- The health care system will be sustainable only if reforms address the relationship between access, cost containment, transparency, and quality.
- Resources will always be limited, so coverage decisions must be made through a rational process to achieve access for all Oregonians.
- Reforms must both increase insurance coverage and maintain a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention, continuity of care, and care management.
- We must reduce health disparities based on race, ethnicity, geography, and income.
- Reforms must maximize available federal (especially Medicaid), state, and private financing.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

Reform Recommendations

Create a high-value health care system through the following state policies:

- A Health Insurance Exchange, an entity that can bring individuals, affordable coverage options, employers, and public subsidies together in a new and more effective way;
- A requirement that every Oregonian obtain affordable health insurance;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Sustainable system financing, including a broad-based employer contribution**.**

Create a high-value health care system by implementing both public and private delivery system changes including:

- Drive public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent;
- Develop widespread and sharable electronic health records;
- Improve health care safety;
- Help all Oregonians establish a primary care home; and
- Support community-based innovations that align resources for more cost-effective, higher quality care.

The OHPC reform plan also underscores the need for a thoughtful evaluation plan to monitor the success of reforms.

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Road Map for Health Care Reform

Overview of Recommendations

Vision: Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.

Recommendation 1: Establish universal health insurance coverage for children.

Lack of insurance affects 116,000 Oregon children; 12.6 percent of the state's children have no insurance. These children represent 20% of Oregon's total uninsured population. Providing affordable health care to all children is a concrete investment in Oregon's future. Proposals currently being discussed in the state would:

- Improve and expand access to Oregon's Medicaid and SCHIP programs;
- Expand health care coverage for children by giving parents with moderate family income (income above the current cut-off for federal program eligibility) the opportunity to buy affordable, state-subsidized group coverage for their children; and
- Continue to expand school-based health centers.

Recommendation 2: Create a Health Insurance Exchange to bring together individuals and employers with affordable coverage options and public subsidies.

The Exchange will operate as a central forum for individuals and small business to buy health insurance. It will be governed by an independent board that will use all of the tools currently available to purchasers, including plan design, to support value-based (quality and cost) purchasing and encourage individuals to manage their medical care and their health. Individuals will use the Exchange as a one stop shop for information and access to insurance options, including access to subsidies for private market coverage.

The Exchange will:

- Define an array of insurance plans available for purchase through this entity;
- Be a "smart buyer" for government and participating individuals and business, driving market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls, and other value-based purchasing;
- Define an "affordability standard," an assessment of how much Oregonians can be expected to spend for health care and still afford to pay for housing, food, and other necessities;
- Be utilized on a voluntary basis;

- Attract small employers by minimizing employer administrative burden and providing increased employee plan options;
- Drive quality by negotiating and collaborating with insurers and producers; and
- Act as a market organizer that can respond to and implement future state health care reforms.

Recommendation 3: Require all Oregonians to have health insurance to protect their health and financial security, spread health care costs over the whole community, and reduce the impact of uncompensated care.

All Oregonians will be required to have health insurance. Affordable access to insurance will be ensured through the Health Insurance Exchange, expanded publicly-funded coverage and subsidies, and concerted delivery system reforms. Universal coverage will reduce premiums for the currently insured. Currently, providers recoup the cost of caring for the uninsured by increasing what they charge insurers for their members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers. With everyone in the market, uncompensated care costs will decrease sharply. In addition, employer-based insurance offerings will increase as all Oregonians demand access to affordable insurance.

Recommendation 4: Offer low-income Oregonians publicly-financed subsidies to ensure insurance is affordable.

Publicly-financed insurance assistance will be made available on a sliding scale to Oregonians with income up to 300% of the federal poverty level (FPL). Preliminary analyses indicate that individuals and families can only begin to afford both necessary household expenses and health care between 250% and 300% FPL.[1] To support this effort, the state will request federal Medicaid matching funds to the highest income level possible.[2]

The OHPC recommends assistance in two forms: direct Medicaid coverage (the Oregon Health Plan) and premium subsidies. Medicaid coverage would be an option for all children with family income up to 200% FPL, and adults with income up to 200% FPL who lack access to employer sponsored insurance.[3] Adults with access to employer coverage and everyone with income over

200% FPL will have access to premium subsidies to purchase insurance. Premium subsidies can be used to purchase insurance in the employer or individual markets.

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[1] http://egov.oregon.gov/DAS/OHPPR/HPC/HealthReformResources.shtml

[2] Federal Medicaid funds provide approximately 60 cents on every dollar spent on federally approved insurance coverage. Recently, Massachusetts received approval from the federal Centers for Medicare and Medicaid Services for its Medicaid waiver amendment allowing federal matching funds up for premium subsidy expenditures paid on behalf of individuals with income up to 300% FPL. Until this approval it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

[3] The OHPC recommends maintaining Medicaid coverage currently available for populations that are "categorically" eligible under federal Medicaid law (including children, pregnant women, the elderly, and people with disabilities).

Publicly-financed coverage will be comprehensive and emphasize preventive services and care for chronic conditions. The Prioritized List of Health Services, including proposed changes to increase the List's prevention and chronic care focus, will provide guidance to public coverage decisions.

Recommendation 5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.

To ensure quality health care for all Oregonians, reform must both improve the delivery system and expand access. Access and delivery issues exist at the local as well as the state level. With this in mind, the OHPC recommends the following:

- Create an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting;
- Continue efforts to create a stronger, more coordinated statewide effort on value-based purchasing to improve the ability to measure, report, and improve the system.
- Provide leadership and support to further the development of widespread and shared electronic health records;
- Assure a workforce that can capitalize on health information technology;
- Encourage purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care;
- Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and
- Mobilize a coordinated effort among all state purchasers (PEBB, OMIP, Medicaid) and insurers to support new delivery models and new reimbursement strategies that are more effectively supporting infrastructure investments, integrated care, and improved health outcomes.

Recommendation 6: Support community efforts to improve health care access and delivery.

Reform efforts need to be flexible enough to provide local communities the ability to align available resources with the needs and characteristics of their communities. To support local innovation in health care delivery, the Commission recommends the following:

- Promote the primary care model;
- Support local access collaboratives; and
- Create pilot projects to demonstrate ways to realign payment incentives to improve health outcomes.

Recommendation 7: Establish sustainable and equitable financing for reform.

The OHPC proposes simultaneously working toward universal coverage and improved system efficiency. To fund a coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that can be phased out as system efficiencies take hold over the following years.

The financing needed to fund public coverage and premium subsidies is an investment that will make Oregonians healthier and produce savings throughout the state. This investment, implemented along with the delivery system initiatives outlined in this report, will lead to more productive employees, increased efficiency, and reduced system costs.

To implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. Financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Recommendation 8: Design and implement evaluation of system reform.

The OHPC recommends developing a coherent, stable and coordinated evaluation infrastructure prior to reform implementation. To assess success and inform future policy decisions made by the Legislature and state officials, any reform plan should include a well-developed evaluation plan that includes assessment of changes from the pre- to post-reform period and the extent to which reform implementation matches program goals and intentions. The evaluation plan should include metrics for provider capacity, population demand, provider and consumer participation, utilization patterns, changes in health outcomes, health disparities and quality, financial impacts and special issues of concern such as crowd-out, use of technology, and transparency. Sustainable evaluation funding and a central evaluation entity must be identified in order to assure evaluation is coordinated with reform.

Oregon Health Policy Commission Road Map for Health Care Reform

Introduction

Background

Throughout 2006, public interest in solving the growing problems in Oregon's health care system has increased dramatically. There is widespread agreement that our health care system is too expensive, confusing, inefficient and inaccessible, and does not adequately promote health.

Since 2004, the Oregon Health Policy Commission (OHPC) has served as a forum for exploring broad health reform ideas and evaluating promising improvements to the state's health care system. In February 2006, Governor Kulongoski asked the Commission to develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians. Throughout 2006, the Commission worked diligently and collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years.

This report outlines the OHPC vision and provides a framework Oregon can use to move the health care system forward. The OHPC report is intended as a resource for the Governor, Legislature, state agencies and other interested stakeholders, providing information and recommendations on reform options and funding mechanisms. The Commission will use this document as it participates in reform discussions during and beyond the legislative session, providing information, participating in analysis and discussions, and encouraging action on comprehensive, meaningful reform at the state level.

Vision for a High-Value, Affordable Health Care System

The Commission presents reforms that would **provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.** [4]

Affordable access requires:

> **Universal Participation.** A reformed health care system is a shared social responsibility. All Oregonians must participate in both the benefits and costs. Everyone must seek out affordable health insurance whether through a private or public option.

[4] In developing its reform vision, the OHPC drew significantly on the Commission's 2004-2006 discussions and the vision statement of the Commonwealth Fund's Commission on a High Performance Health Care System. Additional sources included the Oregon Public Employees' Benefit Board 2007 Vision, SB 27 (1989 legislation that created the Oregon Health Plan), the Senate Interim Commission on Health Care Access and Affordability (2006), the Archimedes Movement, the Oregon Business Council's Healthcare Initiative and the federal Citizens Health Care Working Group (2006).

Universal participation also means everyone must accept the personal responsibility to seek preventive and disease management services in order to avoid later serious illness that negatively impact health and increase health care costs.

Affordable Health Care for Everyone. Every individual and family not only has affordable health insurance, but also insurance that provides access to affordable health care. Insurance that does not provide adequate access to providers or requires individuals to pay more out of pocket than they can reasonably afford does not provide access to affordable health care. A system with real access provides care in a way that reduces health disparities between population subgroups.

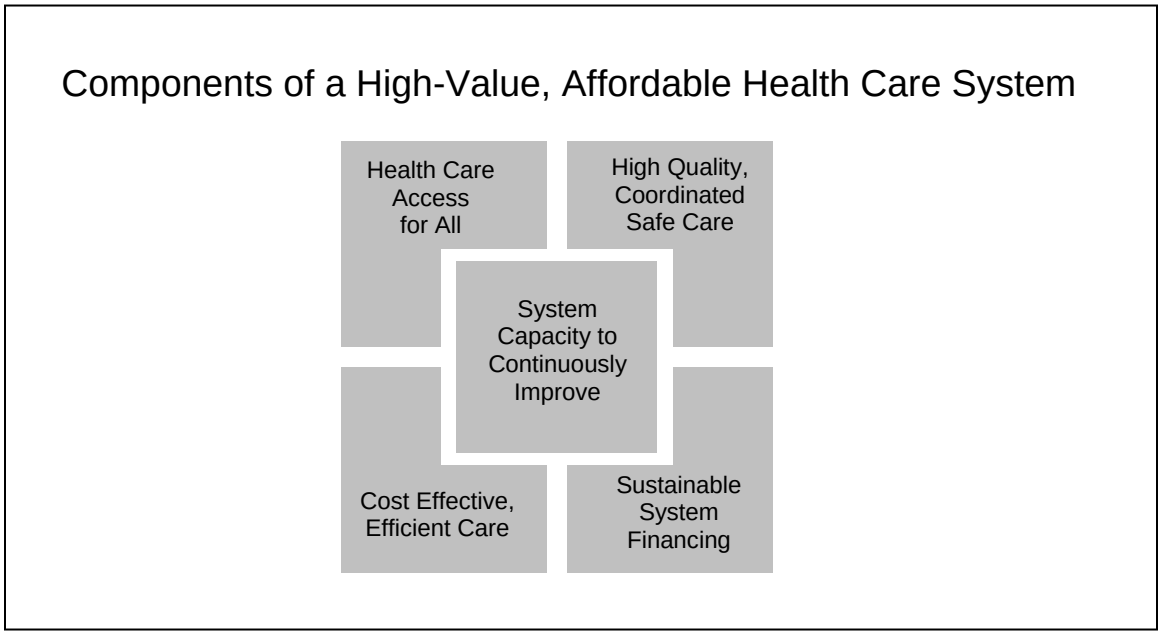
Adequate Financial Protection. A well-operating system will adequately shield individuals and families from the devastating debt that can occur from unexpected accidents and illness.

High-value health care is:

High Quality, Coordinated and Safe. The system should focus on improving quality and health outcomes. Everyone needs a primary care home where care is organized, coordinated, and integrated across providers and over the life of the individual. The care provided must be patient-centered, consciously involving patients as informed and active participants.

Efficient and Evidence-based. Our health care system must be an integrated system that gives consumers and providers the market incentives to provide the right care at the right time and in the right setting. Access to health care does not mean access to all available services. New technologies, procedures, and treatments must be evaluated for effectiveness and value. The health care system needs to use evidence-based medicine to maximize health and utilize dollars wisely.

Continuously Improving. Our health care system needs the tools to capitalize on innovation and integrate research findings into practice. We need system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. We need an information technology infrastructure that supports integration, transparency, and quality and is available when and where both patients and providers need information for decision-making. We must have a statewide strategy to address the critical needs for the health care workforce of the future.



Symptoms of the Broken System We Have Now

Cost Increases Harm Oregon

Health care expenditures in the United States were almost $1.9 trillion in 2004, over two and a half times the 1990 spending and 16.0% of the Gross Domestic Product. Since 1998, health insurance premiums have risen substantially, outpacing inflation and impacting individuals, employers, and government. Rising costs jeopardize Oregonians' health status, make the state and nation less competitive, and make adequate investment in other crucial areas such as education more difficult.

System Impacted by Poor Quality of Care

The Institute of Medicine has documented the existence of a "quality chasm" in the United States.[5] Recent research indicates that Americans receive recommended care only about 55 percent of the time.[6] The IOM estimates that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. Almost one third of health care expenditures pay for care that is duplicative, fails to improve patient health, or may even make it worse.[7] A recent Commonwealth Fund study found the United States health care system less efficient than other countries, as measured by duplicated tests, repeated medical histories, and medical records not available at the time of the visit.[8]

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[5] A list of IOM reports on quality issues is available at http://www.iom.edu/CMS/8089.aspx.
[6] "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" Asch SM, et al., *New England Journal of Medicine*, Vol. 354, No. 11, March 16, 2006, pp. 1147-1156.
[7] "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Elliott S. Fisher, et al., Annals of Internal Medicine, February 2003; 138: 273 - 287.
[8] "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," Schoen, Cathy et al. *Health Affairs.* Nov 28, 2005.

Too Many Oregonians Lack Insurance
In 2006, 15.6% of Oregonians were uninsured.[9] Over 576,000 Oregonians, or one in six residents, were uninsured; 116,000 of those were children. Another 258,000 Oregonians experienced a gap in their health care coverage at some time during the year.

While 15.6% of Oregonians aged 19 to 64 are uninsured, 44% of poor adults lack coverage. In 2004, 21% of children in families with income under 100% of the Federal Poverty Level were uninsured, compared to 19% of all children in Oregon. Even when a parent has access to coverage, their children may be uninsured because family coverage is not offered or affordable. Many families do not know their children are eligible for Oregon Health Plan coverage; still others find it too difficult to enroll or prefer not to access a public program.

Employment Not a Guarantee of Coverage for Low and Moderate Income Oregonians
Contrary to what many believe, a high percentage of employed persons do not have insurance. Even those working for employers that offer insurance may not be able to afford the insurance offered. Seventeen percent of individuals in families with at least one full time worker lack health insurance, and 33% of those with part-time employment lack health insurance. 56% of uninsured Americans are not eligible for Medicaid or other public sector health programs and cannot afford to buy coverage on their own.[10]

Lack of Coverage Hurts Access to Cost-Effective Prevention, Health Maintenance
Although insurance coverage does not guarantee access to services, the uninsured are less likely to access cost-saving preventative services or to seek treatment for illness or injury until the problem is not manageable and the hospital emergency room seems the only option.

The uninsured are less likely to seek regular care, and they are four times less likely to have a regular source of care than are the insured.[11] Uninsured children are nearly three times less likely to have seen a physician in the past year than are children with insurance coverage.[12] Almost 40% of people who delay care cite lack of insurance and cost as the main reasons they did not see a provider.[13] Without treatment, chronic problems can become acute and require costly and avoidable emergency treatment.[14] Lack of insurance both shortens productive years of work and undermines the standard of living for families and individuals faced with large medical

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[9] *Profile of Oregon's Uninsured, 2006*, Office for Oregon Health Policy and Research. February 2007. Report is based on the 2006 Oregon Population Survey, a biennial statewide telephone survey of Oregon households. CPS data released in August 2006 indicates the national uninsurance rate was 15.9% in 2005.
[10] "The Uninsured and the Affordability of Health Insurance Coverage," Lisa Dubay, John Holahan, Allison Cook. *Health Affairs* 26, no. 1 (2007).
[11] "Demographic Characteristics of Persons Without a Regular Source of Medical Care – Selected States, 1995," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 1998, 47: 277-79. For general statistics, see http://www.eoionline.org/HealthCareUninsuredDilemmaFS.pdf.
[12] *Health Insurance? Its Enough to Make You Sick*. Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999.
[13] "Entry Into Prenatal Care --- United States, 1989-1997," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, May 12, 2000, 49 (18): 393-8. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm.
[14] "Unmet Health Needs of Uninsured Adults in the United States," John Ayanian, et al., *Journal of the American Medical Association,* October 25, 2000, 284:2061.

expenditures. Nationally, the 41 million uninsured cause an estimated annual loss of $65 billion to $130 billion due to poorer health and earlier death.[15]

All Oregonians Impacted by the State's High Uninsurance Rate
The uninsured delay needed care, but can not avoid it entirely. When people without insurance get care in high cost settings such as emergency departments or hospitals, they can often not afford to pay for the services they have received. Providers that have cared for these individuals must make up for their expenses. For the most part, providers rely on the insured to help pay for services for the uninsured. Providers recoup the cost of caring for the uninsured by charging insurance carriers more for services rendered to carriers' members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers.

Lack of Information Is Endemic
In our current system, it is difficult for patients to get clear and comparable information about health care costs and standards of care. Individuals pay different amounts for the same procedures based on their insurance status. The lack of information makes it hard for patients and their families to be active participants in their own care. Without full information, patients can not make the best clinical and economic decisions.

Fragmented Service Delivery Does Not Support Quality
Most behavioral health providers and treatments operate separately from physical health care. The historic lack of parity in insurance coverage for behavioral health care exacerbates the difficulties many people have accessing mental health care and substance abuse treatment. While a mental health parity law took effect in Oregon on January 1, 2007, more must be done to ensure that those in need can have behavioral health issues effectively and responsively identified and treated. Another area of care that remains disconnected from acute care services is long term care. Although integration would improve patients' health, acute care providers are generally not given incentives or other support to coordinate with long term care providers.

A fragmented delivery system also makes it very difficult to design a reimbursement system with incentives that align for payers and providers. In the current system, it is too easy to push financial responsibility to other parts of the system, making the system less accountable for results. It is relatively easy for each piece of the system to maximize its reimbursement when no one takes responsibility for the big picture or the interrelationships.

[15] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004. The Institute of Medicine, in its June 2003 report *Hidden Costs, Value Lost: Uninsurance in America*, estimated the value of improved health for a currently uninsured individual who gains coverage at between $1,645 and $3,280 a year.

OHPC Guiding Principles for System Reform

Recognize that assuring health care is a shared social responsibility. This includes both a public responsibility for the health and security of all Oregonians, and the responsibility of everyone to contribute. Individuals, employers, government, and providers are mutually responsible for creating, financing, and sustaining an affordable health care system.

Develop reform recommendations that can be implemented over the next five years. The OHPC recommendations primarily focus on what Oregon can do right now to achieve significant reform. The OHPC recognizes there are efforts underway to reform state and federal health policy to achieve broader reform. By outlining steps the state can take today, the OHPC recommendations are not inconsistent with these other reform efforts.

Support and improve current programs and structures that work, overhaul the ones that do not. To promote short-term reforms that help achieve the longer term vision of a high-value, affordable health care system, the reform plan needs to both utilize existing programs and define new ways for the uninsured to access care. Unnecessary complexity leads to confusion, cost, and errors. Both the delivery system and the administration of new and existing programs must be streamlined in order to be accessible and comprehensible. Changes must improve access and care for Oregon's vulnerable populations, including racial and ethnic minorities, individuals in geographically underserved areas, and low-income Oregonians.

Recognize that access, cost, transparency, and quality are intertwined. To develop a high-quality system, we must address problems such as an inefficient delivery system, medical errors, and uncontrolled cost growth. Access, cost containment and quality must all be valued in order to achieve a sustainable system. Quality care relies on patients, providers, and employers having transparent access to appropriate health care information.

Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to promote access to primary and chronic care services rather than limiting services to emergency access. Services can be limited and directed in order to maximize the number of people who get both health insurance and real access to needed services. The Prioritized List of Health Services has been used successfully in Oregon's Medicaid program since 1989. The Commission believes the expansion of basic health care to all Oregonians should utilize the Prioritized List and prioritize health promotion, disease prevention and disease management.

Emphasize care that prevents and manages disease, engages patients in their own care, and protects families from catastrophic health care costs. Ten percent of our population is responsible for 69% of health care costs. In order to produce the greatest return on investment and control health care costs, health reform must emphasize health care services that seek to prevent and manage disease and must find more effective ways to engage patients in their own care. Additionally, as with car insurance, health insurance must provide protection against catastrophic losses. A recent Commonwealth Fund study found that 21 percent of adults surveyed (both insured and uninsured) said they are struggling to pay off medical debt.

Maintain a broad, strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin. We recognize that there will always be times of transition during which individuals are not eligible for available coverage. A meaningful coverage system requires a strong safety net to provide quality care and access to both patients without access to insurance coverage and those with insurance.

Encourage delivery system integration and alignment of payment incentives. Consumers and providers must have incentives and information to make health care decisions that drive quality and control cost. The state should take a clear leadership role through its public insurance programs. Additionally, state policy should recognize and support the many community efforts underway across Oregon to align resources and form partnerships to improve local health care delivery systems.

Maximize available financing. Coverage for all Oregonians can only be achieved by doing all that is possible to optimize available sources of revenue. As everyone in Oregon is sharing in the cost of the current inefficient system, we must identify, capture, and reinvest savings produced from successful reforms. Maximizing available federal Medicaid financing is paramount.

Coordinate with other reform efforts in the state. Many groups are working to develop policy reforms and garner support to move reforms forward. The OHPC will draw ideas from and seek connections between these efforts to the extent possible in order to help channel this energy into true change.

Public Health and Disease Prevention: Health Is More than Health Care

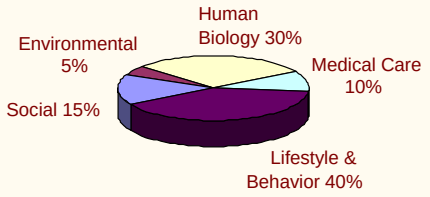
When it comes to our health, we leave the barn door open until the horses get out. In spite of the billions of dollars funneled into the U.S. health care system, we fail to capitalize on the profound and far-reaching impact that disease prevention and wellness programs can have in improving our quality of life and reducing the social and economic burden of avoidable acute and chronic diseases. We know that health is determined by far more than medical care.[1] Both Oregon and the nation are falling short of achieving the best health for our citizens when we focus most of our resources on acute care after our health is lost.

Invest in Health

Historically, public health interventions have had a greater effect on health outcomes that any medical interventions. Life expectancy has quadrupled in the last 150 years due to basic (though often controversial) measures such as municipal water treatment, hand washing, food safety measures, vaccination programs, and fortification of food staples such as bread and milk with essential vitamins and minerals. Yet for the first time in American history, a child born today has a shorter life expectancy than her parents.[5] Modern technology has created new obstacles to health in our society and we are again faced with changing our public environment to maintain and improve the public's health.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths in Oregon.[2] Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease.[3] These chronic diseases reduce the quality of life of individuals, burden families and friends, and are responsible for massive health care expenditures.

Factors Influencing our Health [4]



Invest in Knowledge

There is also a need for more public health research, particularly in the area of health disparities between racial and ethnic groups. Such disparities are reflected in stark differences in life expectancy; rates of disease; disability and death; disease severity; and access to treatment.

[1] Oregon Vital Statistics Annual Report 2004, Vol. II, Chapter 6. Mortality.
[2] *Ibid*
[3] *Ibid*
[4] McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs,* 21(2), 83.
[5] "A Potential Decline in Life Expectancy in the United States in the 21st Century," S. Jay Olshansky, et al., *The New England Journal of Medicine*, March 17, 2005, Volume 352:1138-1145, Number 11.

What can be done?

Public/private partnerships - our public health interventions and health care systems can work together on disease prevention and effective care management, giving us a fighting chance to overcome the unhealthy behaviors and racial health disparities that we face today.

Make the healthy choice the easy choice - foster environments that encourage healthy lifestyle choices in our daily lives. That means making health a priority in schools, the workplace, community development, and in our homes.

Some of this work is already underway

This fall, Northwest Health Foundation and Community Health Partnership: Oregon's Public Health Institute were successful in bringing public and private health entities together around a common agenda for the 2007 legislative session.[1] Some needed policy changes supported by these groups, as well as the OHPC, include:

- More data collection that is targeted to relevant policy and spending decisions
- Community water fluoridation
- Statewide school nutrition standards

The Commission's report, *Promoting Physical Activity and Healthy Eating among Oregon's Children* provides public officials and the public at large with a detailed resource for attacking the trend of obesity and resulting illnesses in Oregon's children.[2] This report was assembled by a team of local and national experts from a variety of fields, including medicine, public health, education, and land-use planning.

Additionally, an exciting new partnership between the Northwest Health Foundation, the Oregon Public Health Division and the OHPC will make public health data accessible to policymakers and generate the community engagement vital for effective public health programs.

1 For more information, see http://www.communityhealthpartnership.org/images/pages/newsletters/dec_06.pdf.
2 *Promoting Physical Activity and Healthy Eating among Oregon's Children: Draft Recommendations to the Oregon Health Policy Commission*, DHS Office of Family Health. October 2006.
3 Community-Created Health Care Solutions in Oregon, Oregon Health Policy Commission, January 2006.

Solutions for the world we live in

We know intractable social issues like poverty and poor education have significant negative health impacts, yet there is much that can be done within the health care system to mitigate the impact of those larger problems. To begin:

1. Put high priority on prevention services, such as immunizations and health education, to avoid illness and injury in the first place. Public and private purchasers and insurers need to align payment incentives to encourage preventive care and chronic disease management.

2. Integrate public health and health care systems. Currently the public health system and the health care system operate separately and often in competition. Collaborative community efforts are underway in 19 counties across the state to coordinate local resources and improve the health of their communities[3]. These community partnership efforts are well positioned to help public health and health care systems begin to work in concert.

Oregon Health Policy Commission Road Map for Health Care Reform

Recommendations: Building a High-Value, Affordable Health Care System in Oregon

This section outlines the concrete reforms Oregon can implement to move the state toward realizing a high-value, affordable health care system over the next five years. Reform will only be sustainable if it is both short- and long-term focused. In the short term, Oregon needs to expand health care access to the growing number of uninsured. However, Oregon also needs to recognize that uninsurance is a symptom of a much deeper problem with how health care is delivered and financed. Over the long-term, we need to address these deeper systemic problems or our efforts to expand access will not be sustainable.

No one actor can make it happen. Reform is an effort that requires all of us – consumers, health care providers, insurance carriers, policymakers – to look beyond our immediate separate interests, to a future with a more equitable, higher quality, and efficient health care system for all. Reform cannot happen overnight. While there is no magic bullet, there are "pressure points" in the system that can be leveraged to achieve reform. The Oregon Health Policy Commission (OHPC) recommendations spotlight those pressure points, outlining how they can be enhanced and be more effective. These recommendations are a reference for health care reform discussions in the implementation of Senate Bill 329 and beyond.

Note on the OHPC Approach

Of the guiding principles upon which the OHPC recommendations were built, two form the backbone of the recommendations.

First, the Commission recognized that reforming the health care system is a shared responsibility. In order to ensure affordable access to health care for everyone, everyone must contribute. The OHPC recommendations operationalize this principle through an individual coverage requirement, publicly-financed subsidies, and a broad-based financing source that includes employers. The OHPC also recommends establishing a Health Insurance Exchange, an entity that can bring these pieces together in a new way to serve individuals and small business.

Second, the Commission sought to develop reforms that can be implemented in the near term in order to work toward reform now and over the next few years. This report recommends changes that do not require large-scale federal changes occur before reform can be implemented in Oregon. The Commission believes that changes to federal policy and funding mechanisms are needed but are not necessary for implementing the recommendations in this report. All of the

reforms outlined in this report can be implemented over the next several years, and can be modified later to take advantage of federal policy changes.

Federal Policy Changes to Support Health Reform in Oregon

The Oregon Health Policy Commission's reform proposals seek to create a road map to affordable health care access, outlining reforms the state can implement within current federal constraints. The state should not wait until major policy changes are made at the federal level to push forward with reform. However, there are many federal policy changes that would give Oregon needed flexibility and institute greater equity and stability in the health care system. Some of OHPC's top federal priorities are outlined below.

Force a national dialogue on health care reform and federal health care financing: The OHPC supports comprehensive health reform at the federal level that rationalizes how federal funds are spent on health care.

Increase Medicare provider payment rates: Medicare provider payment rates in Oregon are among the lowest in the country, increasing the cost-shift to those insured through the private sector.

Adjust the Medicaid matching formula to avoid penalizing states during an economic recession: The current Medicaid federal medical assistance percentage (FMAP) formula does not adjust quickly enough to changes in states' economic conditions. The FMAP should be modified to account for periods of economic downturn to ensure that states are getting more federal funding when the demand for their programs is greatest.

Provide states with flexibility under ERISA: The Employer Retirement Income Security Act (ERISA) of 1974 preempts states' ability to regulate employer benefit offerings, including health insurance. This blanket preemption limits states' ability to develop reforms that establish minimum requirements for employer-sponsored insurance. In absence of federal reform, the OHPC supports instituting a waiver process that allows states to apply for waivers of ERISA in order to enact state-level reforms.

Change federal tax policy to support individual insurance purchase: While people who purchase health insurance through an employer can pay premiums with pre-tax dollars, individuals buying insurance in the individual market get no such benefit. To encourage insurance purchase by the self-employed and others without access to employer-sponsored insurance, the federal government should allow individual insurance purchase to be federally tax deductible.

Recommendation #1: Establish Universal Health Insurance for Children

Proposal Overview

Governor Kulongoski's 2007-2009 Recommended Budget included implementation of the Healthy Kids Plan.[16] The Oregon Health Policy Commission (OHPC) supports the funding and implementation of Healthy Kids, which will provide comprehensive health care (including medical, dental, vision, and mental health) to all of Oregon's uninsured children up to age 19. Building on existing programs, it will allow low-income families to enroll their children in public coverage or to use subsidies to purchase private coverage for their children. In addition, the program provides an opportunity for families not eligible for public programs or subsidies to buy affordable coverage through a separate program. The OHPC supports the Healthy Kids efforts to improve and expand access to comprehensive health insurance and continue expanding school-based health centers to increase access to care.

Programs for Children Based on Income, Access to Private Coverage
For children in families with income up to 200% of the federal poverty level (FPL), benefits will continue to be provided through the Oregon Health Plan, with dental, vision, and mental health care, no co-payments and no family premium share. Low-income families may also access the Family Health Insurance Assistance Program, which provides premium assistance allowing a family to purchase insurance through a parent's employer.

Children in families with income at 200% FPL and above with no access to employer-sponsored insurance will have access to comprehensive coverage through a private insurance product. Families will have assistance in choosing a plan and premium subsidies will be based on income. Health plans may compete to participate. Children in families with income above 350% FPL may still enroll in Healthy Kids but must pay the full cost of the coverage.

Cost to Families
The Healthy Kids program was designed based on conversations with Oregon families about what is affordable. Premium assistance will be income-based. Higher income families will pay affordable monthly premiums and co-payments.

[16] The Governor's Healthy Kids Plan draws on recommendations from the Medicaid Advisory Committee and a series of public hearings. For more information, see: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

Why Change Is Needed

In 2006, an estimated 116,000 Oregon children were without health insurance. About half of them qualify for state programs but are not enrolled. Many children in Oregon lack access to providers and basic health care services. Uninsured children face additional barriers to care. They are half as likely to get preventive care or see a doctor as those who are insured.[17] Children without insurance are more likely to use expensive emergency room for care and to be hospitalized. Poor health makes it harder for children to learn. Illness and chronic conditions lead to missed days of school and poorer performance. Keeping kids healthy also saves money.

More than half the uninsured children in Oregon have employed parents. Many families earning between $40,000 and $80,000 a year make too much for their kids to qualify for state programs but struggle to afford health insurance. Families lack coverage for their children for many reasons. Employer-sponsored coverage may not be available to the family or premiums for dependent coverage may be too expensive. In addition, enrollment barriers keep some families from enrolling their eligible children in public coverage. The OHP application process can pose difficulties to working families The requirement that eligibility be recertified every six months means that families must re-do paperwork twice a year. Some families are unaware that their children are eligible for OHP even when their parents are not.

Selected Implementation Considerations

To make Healthy Kids work, the state will partner with community organizations to reach out to uninsured children and help families enroll their children (and keep them enrolled). To facilitate enrollment and maintain eligibility, the state will utilize a shorter application, 12-month enrollment period, a reduced (two month) uninsurance requirement, and no asset test. To assist children where they are, school-based health centers (SBHC) will be expanded and supported. At least five new SBHCs will be funded in counties without existing health centers. At least five additional SBHCs will be funded in counties that already operate one or more SBHC.

Other Healthy Kids programs include the expansion of the dental sealant program that will seal the teeth of 50% of all 8-year-olds by 2010. This compares to 30% of uninsured children who currently have dental sealants. Additionally, a nurse advice line will provide families with access to information that will allow children to get the best care in the most appropriate setting.

[17] *Children's Access Survey*, Jen DeVoe, Lisa Krois, Tina Edlund, Jeanene Smith. January 2006.

Recommendation #2: Establish a Health Insurance Exchange to Bring Together Individuals, Coverage Options, Employers, and Public Subsidies

Proposal Overview

The Oregon Health Insurance Exchange is a market organizer that helps purchasers to buy value. It acts as a central forum for individuals and businesses to purchase affordable health insurance.[18] The Exchange is also the mechanism through which individuals can access subsidies for private market coverage.

The Exchange will define an "affordability standard," which is a calculation of how much individuals and families can be expected to spend for health insurance and still afford to pay for housing, food, and other necessities. This affordability standard will be used to define both the insurance packages available through the Exchange and the public subsidies for coverage.

While the Exchange will exist in addition to existing purchasing venues, it should particularly appeal to small employers as an easy, reliable, cost effective insurance source for them and their employees.

The Exchange will be a vehicle for driving quality by negotiating or collaborating with the community of insurers and providers. It will work with insurers to develop packages that manage care, quality and cost. Quality will be built in, through contractually established expectations on insurance carriers, such as pay for performance requirements, including quality measures, prevention focus, self-management, and employee education.

As the Exchange grows, it can create a critical mass of customers who can influence providers and insurers. To ensure enrollment stability, the Exchange will require those insured through the Exchange stay in for a mandatory period.

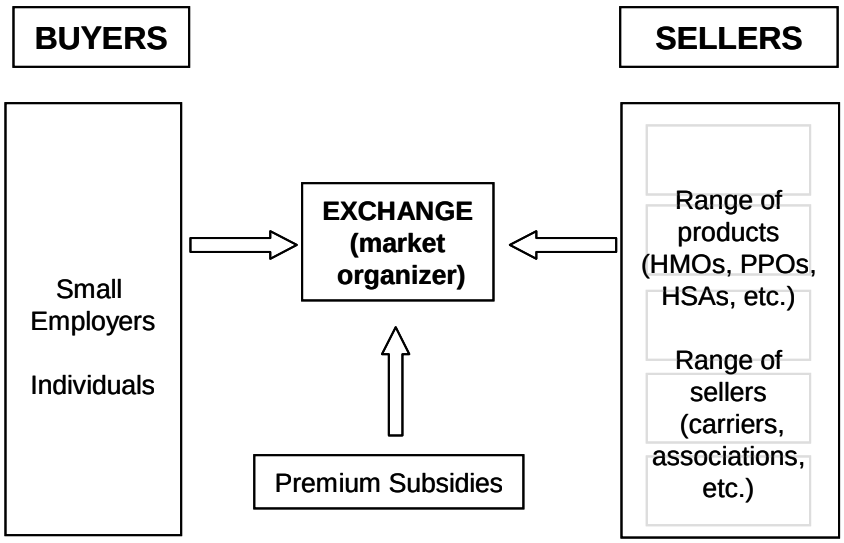
The OHPC recommends establishing the Exchange as an independent organization. It should be shielded from politics and be responsive to stakeholders. The Exchange requires legal, actuarial, and negotiation expertise and must be explicitly given the power to conduct activities such as contracting for services.

Funding for the Exchange should be sustainable and internally generated. Funding mechanisms could include a transaction fee on policies sold through the Exchange, a premium on policies, and a membership fee for insurance providers. Additional funding mechanisms include

[18] The Health Insurance Exchange is similar to the Commonwealth Connector established by Massachusetts, and to the Trust Fund proposed by the Senate Interim Commission on Health Care Access and Affordability.

Medicaid administrative funds. To cover the initial costs, the state should provide the Exchange with start up funds to be repaid once the entity is on solid financial footing.

OVERVIEW OF THE HEALTH INSURANCE EXCHANGE



What Can An Exchange Do For Oregon?

- Act as a single, statewide, centralized exchange for buying and selling insurance in non-large group market
- Aggregate people to influence quality and efficiency of non-large group market
- Facilitate transactions among individuals, insurers, employers, and government
- Provide people with familiar feel of employer-group coverage, with added benefits of individual portability, choice and control

Why Change Is Needed

Employers

Researching insurance options is complex and time consuming, and often falls outside of an employer's expertise. Many small employers, even those who work with brokers, spend considerable effort and time researching available plans and weighing the financial impact of a given insurance product.

Small businesses that provide health insurance for their employees consistently get less for their money, suffering faster premium increases and steeper jumps in deductibles over time than large firms.[19] Small employers can often offer only one plan, which makes it harder to find a plan that fits the needs of all employees.

While small employers face special difficulties in researching and procuring health insurance for their employees, all employers regardless of size face challenges in choosing health coverage that is affordable for employer and employees. The Health insurance Exchange would provide a resource to help employers find quality, affordable coverage.

Individuals
Individuals who lack employer-sponsored health insurance (ESI) and who do not qualify for Medicaid must find their own health insurance. This can be a daunting task for an individual who must weigh costs, coverage limitations and lifetime caps. Information is often not comparable across products and insurers, and legal and medical language is confusing to the lay person.

How an Exchange Adds Value

The Exchange Benefits Employers
The Health Insurance Exchange will offer a variety of insurance product options, from traditional indemnity plans to managed care options and high-deductible health plans with affiliated Health Savings Accounts. This will allow employers to offer employees a range of insurance options - low cost, high coverage and in between. While this is of special interest to small employers that have traditionally been limited to offering a single plan that may not fit all employees' needs, all employers benefit from this function. The Exchange will develop an on-line decision support tool to assist employees, employers, and brokers to compare the benefits and cost of a variety of plans.

The Exchange will be a sustainable source over time for employers offering coverage to their employees. It will be available to employers on a voluntary basis; employers may continue to seek insurance as they currently do. However, the Exchange will be a favorable option for employers because it offers them increased choice and reduced administrative burden.

When working through the Exchange, the employer can allow employees to choose a plan that fits their finances and health needs. The Exchange acts as the pooling mechanism on the employer's behalf, giving employees increased options without increasing employer costs. By providing the employer services such as facilitated plan selection and streamlined access to employee premium subsidies, the employer will experience reduced administrative burden while still providing insurance to their employees.

[19] *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Jon R. Gabel, M.A., and Jeremy D. Pickreign, M.S., The Commonwealth Fund, April 2004. Authors' analysis of Kaiser/HRET 2003 survey of employer sponsored health benefits.

Individuals with greater health needs are more likely to choose plans that are more comprehensive and expensive. Healthier people often value cost savings over more benefits. The Exchange will institute provisions to ensure that the existence of range of plans does not lead to adverse selection by workers with more care needs.

The Exchange Benefits Individuals
The Exchange provides individuals with affordable options. In addition to serving as the access point for eligible individuals' use of subsidies, the Exchange will offer a range of insurance packages, allowing individuals to choose plans that fit their health and financial needs. For example, plans featuring low premiums and streamlined benefits may appeal to young people who currently do not enter the market because they do not think they need insurance.

The Exchange will also allow employed individuals who purchase insurance on their own to use pre-tax dollars to pay health insurance premiums. While pre-tax funds can currently only be used for purchasing insurance when an individual gets insurance through an employer, a statutory change at the state level would allow the self-employed and others purchasing insurance outside of employer-sponsored plans to take advantage of this tax benefit.

For individuals, the Exchange increases insurance portability; the insurance is not tied to an employer or lost when employment changes. An individual whose employer utilizes the Exchange can choose to retain that same insurance through the Exchange even when the individual leaves that employer. This can help people avoid pre-existing condition limitations often associated with changing insurance providers.

The Exchange will offer people a source for coverage they can count on if they need it. Use of the Exchange will be optional with one exception. Individuals and families accessing publicly funded premium subsidies in the individual market will be required to purchase insurance through the Exchange.

Selected Implementation Considerations

Risk Adjustment Options for Consideration
Some insurance carriers may be concerned about unknown risk of a new consumer base. While the Exchange offers the chance for significant new business through the enrollment of previously uninsured populations given the individual mandate, insurers may worry that something unforeseen could cause one carrier to enroll a disproportionately higher number of sicker members. To address this risk selection concern, the state could engage in risk adjustment. Two possible risk adjustment strategies are retrospective smoothing of costs among carriers, and excess-loss claims subsidies to carriers.

Retrospective risk adjustment would involve the state looking back at the costs borne by insurers during a given period, and reimbursing a percentage of costs to carriers with above-average claims costs. With claims subsidies, the state helps pay claims costs for plan enrollees with costs above a set annual limit. Within the risk corridor, the state would pay a percentage of claims.

Realizing the Exchange's Potential Added Value: Areas for Further Research
One potential benefit of utilizing an Exchange for the purchase of health insurance is the expansion of tax benefits to employed individuals not insured through an employer. Currently, individuals purchasing insurance through an employer-sponsored plan can use pre-tax dollars to pay premiums. This effectively lowers the purchase price of the insurance for these individuals.

The Exchange faces additional tax issues upon implementation. Massachusetts (which recently implemented a "Connector" entity that acts like Oregon's proposed Exchange) is currently addressing tax issues related to the implementation of its program. The OHPC recognizes that additional work is needed to identify and respond to tax considerations raised by the goals of a fully functioning Exchange.

One added benefit for employed people that needs additional development is allowing an employee with multiple employers to have more than one employer contribute to the individual's premium. This is not currently available to individuals with more than one job, but could allow people with multiple employers to get help with insurance premiums from employers that may be unable or unwilling to individually contribute the full cost of coverage.

Recommendation #3: Require All Oregonians to Have Health Insurance

Proposal Overview

A central element of the Oregon Health Policy Commission's (OHPC) reform plan is universal health insurance coverage. The OHPC recommends requiring that all Oregonians obtain insurance. To ensure affordability for lower income Oregonians, this individual mandate must be coupled with sliding scale subsidies to help make health insurance premiums affordable (Recommendation #4). Low-income individuals without access to employer-sponsored insurance will be eligible for the Oregon Health Plan. A Health Insurance Exchange (Recommendation #2) will be established to provide a one-stop-shop to facilitate enrollment in a selection of plans and access to publicly-funded subsidies.

Why Change Is Needed

Everyone needs to be insured to protect their health and financial security, spread health care costs over the whole community, and reduce the amount of uncompensated care.

The uninsured who find themselves in a medical crisis have few alternatives to the emergency room. While emergency room care is needed in some situations, it is costly and can often be avoided by making prevention, primary care and chronic care services available and affordable. Making such services financially accessible reduces reliance on high intensity, high cost emergency care, and increases individuals' ability to obtain care in the most appropriate settings.

Bringing everyone into the market will do more than benefit the currently uninsured. It will also reduce the burden of uncompensated care in the system. Hospitals receive state and federal funds to offset some "uncompensated" care; they also pass much of these costs on to insurers. These added costs drive up claims costs which are then reflected in higher insurance premiums. This cost-shift for uncompensated care represents 10% percent of premium costs for insured persons.[20]

Some employees who are offered insurance do not enroll, either because they do not think they need it or because the cost is prohibitive. An individual mandate will require everyone to obtain insurance. This will encourage employees with access to employer-sponsored insurance to use it, capitalizing on the existing employer market.

[20] Calculations by John McConnell, PhD, Oregon Health and Sciences University.

Selected Implementation Considerations

Affordability

The question of what is affordable has four components:

- What can people afford to spend on health care?
- What are the overall program costs (what can society afford to spend)?
- What subsidies are needed to make health care affordable for Oregonians?
- What benefit package can be afforded and sustained given the answers to the three questions above?

In order to calculate what families at different income levels can afford to spend on health care, the OHPC used the Economic Policy Institute's Family Budget Calculator to estimate necessary household expenses on housing, food, childcare, transportation, taxes and other necessities in Oregon.[21] The OHPC removed the health care costs and added 10% for savings. The goal was to estimate the cost of making essential health care affordable for lower income individuals and families in Oregon.

Based on this work, the OHPC proposes affordability levels that policymakers can use to guide reform discussions. The affordability levels presented below represent a maximum portion of family income to be spent on health care costs for a family of three up to 300% of the Federal Poverty Level.[22]

Family income (% of federal poverty level)	Family income (dollars per month)[23]	Maximum percent of income for health care	Maximum family spending on health care (per month)
0 - 149% FPL	$0 - $2,075	0%	$0
150 - 199% FPL	$2,075 - $2,766	5%	$104 - $138
200 - 249% FPL	$2,766 - $3,458	10%	$277 - $346
250 - 299% FPL	$3,458 - $4,149	15%	$519 - $622

Definition of Coverage

To mandate coverage, the state needs a general definition of a basic package of services. The OHPC recommends using Oregon's current broad definitions of insurance that will permit a wide range of insurance plans.

[21] The Economic Policy Institute's Family Budget Calculator is located at: http://www.epi.org/content.cfm/datazone_fambud_budget.

[22] For more information on the affordability analysis used by the OHPC, please see our companion report, available on the OHPR web site at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[23] All dollar figures are shown for a family of three. Source: Federal Register, Vol. 71, No 15, January 24, 2006, pp.3848-3849.

For example, the definition of insurance used by Oregon's Family Health Insurance Assistance Program (FHIAP) is as follows:

> A "Health benefit plan" as a policy or certificate of group or individual health insurance that provides payment or reimbursement for hospital, medical and surgical expenses. Such a health benefit plan includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act.
>
> A health benefit plan does have limitations, and does not include accident-only coverage, insurance limited to care for a specific disease or condition, limited parts of the body (vision only or dental only coverage), or for services within a particular setting (hospital-only, for example). Other excluded coverage types are credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.[24]

Enforcement
Oregonians with access to affordable coverage who choose not to purchase it will face financial penalties. The OHPC proposes that non-participants lose their individual exemption on state taxes and perhaps forfeit their kicker. Implementation of enforcement measures must be carefully planned to provide adequate time for Oregonians to understand their new personal responsibility to seek out insurance and enroll in available plans.

Care for Remaining Uninsured
Although the goal is 100 percent coverage, the OHPC recognizes that individuals at times will lack coverage for a variety of reasons. Those entering and leaving the state, changing jobs or undergoing a variety of life changes may temporarily be without coverage. Some people, such as the mentally ill and chronically homeless, may not be in a position to obtain and utilize health insurance. In addition, uninsured visitors to the state may need emergency care.

To ensure access to care for the uninsured and vulnerable populations facing significant financial, geographic, language, cultural, and other barriers to care, we must continue to develop a strong safety net. Local providers serving low-income and uninsured individuals offer culturally appropriate, trusted services. Recommendation #7 outlines some ways that Oregon can support local efforts to deliver health care more effectively and efficiently to all a community's residents.

[24] Oregon Revised Statutes 735.720.

Recommendation #4: Offer Low-Income Oregonians Publicly-Financed Support to Ensure Insurance Is Affordable

Proposal Overview

The Oregon Health Policy Commission (OHPC) recommends pairing an individual coverage mandate (Recommendation #3) with publicly-financed assistance that would make coverage affordable for individuals and families with incomes up to 300% of the Federal Poverty Level (FPL).[25] The goal is to ensure that everyone can afford the coverage that all Oregonians will be required to attain.

Publicly subsidized insurance would come in two forms: direct Medicaid coverage (the current Oregon Health Plan) and insurance premium assistance. The OHPC recommends a structure in which direct Medicaid coverage is an option for all children with family income up to 200% FPL, and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income between 200% and 300% FPL will utilize premium subsidies. These premium subsidies could be used to purchase insurance in the employer or individual markets.[26]

Subsidies will be graduated based on income and an affordability standard created by the Health Insurance Exchange (Recommendation #2), phasing out by 300% FPL. The Exchange would also act as a one-stop shop for Oregonians seeking out coverage options, serving as a connection point between individuals, coverage options, and public subsidies.

In order to most efficiently utilize state resources, the OHPC recommends maximizing federal Medicaid match to the highest income level that the federal government will approve. Under the Medicaid program, state dollars are matched with Federal funds, reimbursing the state 60 cents for every Medicaid dollar spent. Based on recent federal demonstration approvals for Massachusetts, Oregon should be able to receive federal Medicaid matching payments for much of the cost of a coverage expansion to 300% FPL.[27]

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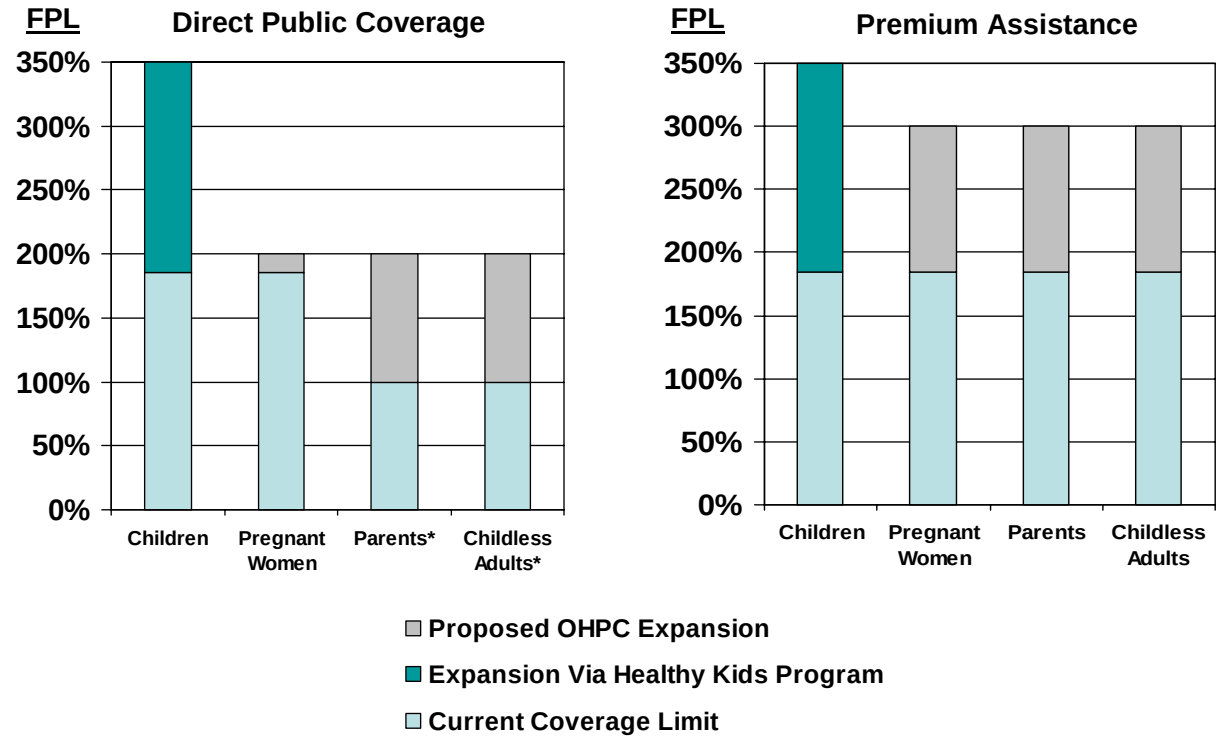
[25] In 2006, 300% of the Federal Poverty Level was $29,400 per year for an individual and $49,800 per year for a family of three.

[26] The OHPC recommends maintaining the coverage currently available for populations that are "categorically" eligible under federal Medicaid law, including children, pregnant women, elderly, and people with disabilities.

[27] Recent Medicaid waiver amendments approved by the federal Centers for Medicare and Medicaid Services for Massachusetts granted federal matching funds up to 300% FPL for premium subsidies for employer-based insurance. Up until this approval, it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options



*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Why Change Is Needed

An individual insurance mandate is only meaningful if all Oregonians have access to affordable coverage. In a survey of adults aged 18 and over, seventy percent of uninsured adults say the cost of insurance is the main reason they are without coverage, while only 6% say they are uninsured because they do not think they need it.[28] With 15.6% of Oregonians lacking health insurance coverage, insurance is prohibitively expensive for many in the state.[29]

The OHPC used the Economic Policy Institute's Family Budget Calculator which estimates necessary household expenses such as housing and food to develop recommendations on the income level at which people require assistance to make health insurance affordable. These data indicate that families do not begin to have discretionary income above necessary household expenses and household savings until they approach 250-300% of poverty. Based on this preliminary analysis, the OHPC recognizes that Oregonians up to 300% FPL require some assistance to make health care affordable.

[28] The *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, "Health Care Costs Survey" August 2005.
[29] 2006 Oregon Population Survey.

Although 60% of Oregon employers offer health insurance to their full-time employees, a significant number of working people are not offered employer-sponsored insurance or cannot afford to purchase it. This is a particular problem for low-income individuals, for whom health insurance is often not offered as compensation for part-time and low-skilled employment.

Selected Implementation Considerations

Potential Negative Market Effects of Public Coverage Expansions
Encouraging employers to financially contribute to their employees' health insurance is essential to an affordable system where everyone contributes to the costs. One often cited concern with public coverage expansions is that employers may drop coverage if their employees become eligible for public coverage. Conversely, employees may decline employer insurance if public coverage is available, increasing public subsidy costs. To mitigate such issues, efforts must be undertaken to maintain employer participation in health care. Oregon could learn from the experience of other states' efforts to address these concerns in their public coverage expansions.

Publicly-Subsidized Insurance Can Push for Quality Coverage
The state has a responsibility to ensure that public health care funds purchase high quality, cost effective health care to promote a healthy Oregon. To that end, the state is currently investigating changes to the OHP Prioritized List of Health Services that will emphasize prevention, primary care and the proper management of chronic care.[30]

Another way the state can use its payer role to be a smart buyer is to require subsidies be used to purchase quality health coverage that promotes access to primary care, prevention, and chronic care management. To that end, individuals who access state subsidies to offset premium costs will purchase insurance products that promote preventive and primary care services.

[30] The Health Services Commission ranks health services by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. In order to encourage effective and efficient medical evaluation and treatment, the Commission uses peer-reviewed medical literature to determine both the clinical effectiveness and cost-effectiveness of health services, and their relative importance. The Commission may also include clinical practice guidelines in its prioritized list of services.

Recommendation #5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes

The Oregon Health Policy Commission believes that true reform is more than just assuring access to health care. It also requires the creation of a high-value health care system that:

- *Provides high quality, safe care* that is organized, coordinated, and integrated across providers and over the life of the individual;
- *Ensures evidence-based care* that provides the right care at the right time and setting in a cost-efficient manner; and
- *Supports continuous improvement* through information transparency, reliable health information exchange, adequate workforce development and a culture of improvement.

Everyone must participate to achieve change. To achieve a high-value health system, the OHPC, along with numerous national and state level policy organizations, supports bringing the state, providers, purchasers, and individuals together to push the system forward in some key areas:

- Improving information collection, reporting, and outcomes measurement;
- Improving the system's ability to manage for quality and become more transparent;
- Encouraging public-private collaboration on value-based purchasing;
- Developing widespread and shared electronic health records;
- Assuring a well-trained health care workforce; and
- Increasing health care safety.

This section outlines some concrete reforms Oregon can implement now to create a health care system that continually improves quality, safety, and efficiency to reduce costs and improve outcomes. The OHPC acknowledges the efforts of the Commission's Quality and Transparency Workgroup in developing these recommendations.

Overview of Proposals

Make targeted state investments

The OHPC supports the use of targeted state investments to achieve increases in health care quality, efficiency and value. The OHPC encourages the Governor and the Oregon Legislature to include such investments in the 2007-2009 state budget. A variety of organizations and efforts would benefit greatly from small investments in state staff and funding, as state involvement would help assure more rapid progress with the following:

- The success of the Oregon Patient Safety Commission's mission;
- The improvement of data available for managing the system;
- Increased transparency regarding health system performance; and

- The coordination of efforts to expand electronic health records and connect health information across providers.

Create the collaborative structure to improve quality information collection, measurement, and reporting

Building on current collaborations among private organizations and the Office for Oregon Health Policy and Research (OHPR), the OHPC recommends that the Oregon Legislature direct OHPR to work with stakeholders to develop a model for a public-private quality institute. The purpose of this institute would be to coordinate the creation, collection and reporting of quality information to improve health care purchasing and delivery. An independent public-private entity is critical for gaining the trust of all key stakeholders. The institute should be financially stable and make efficient use of available public and private funds. An organized, stable structure will help Oregon attract additional resources from federal and private funders.

Responsibilities of a quality institute would include:

- Collecting quality data and information in a central location;
- Coordinating reporting of quality information from numerous sources in a central location;
- Complementing individual stakeholder efforts;
- Supporting and encouraging collaboration between quality efforts in the state;
- Examining state regulations for opportunities to increase efficiency and reduce administrative complexity;
- Addressing issues of legal discovery and liability;
- Fostering provider capacity to collect and use data for improvement;
- Encouraging dissemination of data in formats that are useful to a broad range of audiences; and
- Engaging Oregonians to use available quality data when choosing health care providers.

Encourage all purchasers, providers, and state agencies to further develop data and tools to improve system transparency and quality

The OHPC encourages all purchasers, providers, and state agencies to support and expand on current public-private efforts to improve data and tools to manage quality and to improve data available to the providers and consumers:

- Hospital quality including: participation in efforts such as the Surgical Care Improvement Project (SCIP), the National Surgical Quality Improvement Program (NSQIP), 100,000 Lives, and Leapfrog reporting in addition to state and federal mandated reporting;
- Hospital cost reporting;
- Ambulatory care quality measures;
- Actual cost of service reporting, including cost of services provided in Oregon Health Plan Medicaid managed care plans;
- HEDIS and HEDIS-like quality measures; and

- Collaborative public/private strategies to make consumers more knowledgeable about quality and value in health care and the resources available to them.

Encourage increased public-private collaboration to create stronger, more coordinated statewide value-based purchasing

The State should strongly encourage value-based purchasing. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) and health care entities (providers, health plans) to improve quality, efficiency, and outcomes. The Public Employees Benefit Board (PEBB) should have a strong role in such a coordinated effort, along with the Department of Human Services, the Oregon Medical Insurance Pool (OMIP), university health, the SAIF Corporation and the Department of Corrections. Collaboration with other private and public purchasers to develop a consistent value-based purchasing approach in the community is an important part of this effort.

Through this coordinated effort, state agencies should implement the following reforms:

- **Ensure state health care purchasers use purchasing standards that explicitly include quality measures in the criteria for selecting which health plan options to offer.** PEBB could provide leadership in this arena, as it currently does this in its biennial Request for Proposals to health plans.

- **Collect information on quality performance regularly and rigorously and distribute this information widely to help employees and their dependents make informed choices among health plans and providers.** PEBB has established a comprehensive set of performance measurements for its health plans and is participating in community efforts to identify common measures for evidence-based care.

- **Offer state employees information and incentives to choose high-value health plans and providers.** Medicaid should also consider how best to provide value information to its enrollees.

- **Reinstitute prior authorization to manage access to Medicaid pharmaceuticals.** Utilizing prior authorization to enforce the Prioritized List has great potential for cost savings.[31] This requires statutory change, as prior authorization for the Oregon Health Plan preferred drug list is currently prohibited by statute.

- **Improve the Oregon Health Plan's access to technology.** The Department of Human Services has the opportunity to manage the prudent use of technology in its Medicaid program. Line zero of the Prioritized List (the line that covers diagnostic services) can be managed by incorporating evidence-based reimbursement and/or prior authorization. At the

[31] "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan," Daniel M. Hartung, et al., *Health Affairs*, 25, no. 5 (2006): 1423-1432**.**

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.

- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.

- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.[32] These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.

- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.

- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

[32] The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

using technology (such as electronic medical records) and be comfortable using the technology. As technology changes, health care staff from nurses and physicians to medical office and hospital staff need training to remain current in their knowledge.

Increase collaboration and state leadership to improve health care safety

The OHPC recommends further developing the work of the Oregon Patient Safety Commission in order to:

- Encourage the participation of all hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and other health care facilities in the Oregon Patient Safety Commission's voluntary reporting program of serious adverse events.
- Incorporate a surgical events reporting program (specifically, the National Surgical Quality Improvement Program) within the Patient Safety Commission to encourage cross-institutional sharing and learning. The OHPC recognizes that implementation of this recommendation requires finding a way for rural hospitals to be financially able to participate. Direct OHPR to establish public reporting of quality measures at the institutional level.
- Provide state financial support for the Oregon Patient Safety Commission's work in order to give the Commission the means to build awareness of and to develop strategies to reduce serious adverse events and their costs.

Why These Reforms Are Needed

Information, Measurement, Collaboration Are Key to Quality Care
Numerous public and private efforts are underway to push for improvements in quality, transparency, and coordination of care. Many of these efforts will be more effective if accomplished collaboratively between public and private entities. Involving more provider and payer organizations in the data collection process improves the quality of information provided and increases providers' and insurers' interest in using the information collected to improve care quality and efficiency.

For example, quality information on evidence-based care becomes more valid and useful to providers when data is consolidated across the community rather than by individual health plan. An excellent example of the power of a collaborative public-private approach is the recent Oregon Health Care Quality Corporation's leadership in developing common measures of ambulatory care and the strategic plan for market-driven change supported by a Robert Wood Johnson Foundation grant. This grant is, however, only a three year project, leaving the funding for continuation and enhancement unknown at this time.

There is a need for a stable model to continue such efforts into the future and consolidate a variety of information beyond the limited scope of the Robert Wood Johnson grant. Public and private interests should explore the model most likely to provide stability for the critical function of providing a range of quality information to a range of users. The answer could come in

strengthening existing organizations, new collaborations, or new institutions meeting basic functions detailed in the recommendation.

Information Transparency Will Improve the System's Ability to Manage for Quality
The OHPC continues to recognize and support the need for performance information to guide purchasers, providers, and consumers in their efforts to make wise decisions, spend resources wisely and perhaps most importantly, improve performance. Experience has shown that publicly available information can result in both improved performance and in more focused attention to quality improvement efforts. Providers need to benchmark their performance, purchasers need ways to identify and reward quality performance, and consumers need information to help them make critical decisions.

Much of the value of public information to date has been to promote quality in the provider community itself. Consumers need to be more aware of why they need to care about health care quality and information that will help them make wise personal health decisions. Major health plans are becoming both more concerned and in many cases are making significant investments to offer more tools to consumers and employers. Consumer organizations are increasingly interested in promoting a more active and aware consumer. The state should participate in collaborative efforts such as the Robert Wood Johnson Foundation Grant program linking public and private organizations (including consumer organizations) in an effort to inform consumers about quality variations and to improve the tools available to help consumers seek quality in the delivery of their health care.

There are many efforts currently at the national and state level to improve quality information and to make information transparent. Often, however, these efforts are not coordinated. One of the positive national trends is for the major federal purchasers (Centers for Medicare and Medicaid Services) and quality organizations (Agency for Healthcare Research and Quality) to collaborate with important professional organizations (such as the College of Surgeons and the Joint Commission for the Accreditation of Health Organizations) and private non-profit entities such as the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. This has resulted in new programs and strategies such as the Surgical Care Improvement Program, the 100,000 Lives Initiative, the National Surgery Quality Improvement Program, and payment increases being tied to increased quality reporting by hospitals to CMS. Many of these efforts improve data transparency. For example, the CMS Hospital Compare program or the State of Oregon website that provides mortality data for 8 procedures and volume data for 7. Some efforts are not fully transparent, but are associated with significant quality improvement tools designed to help organizations address the issues that data identifies such as NSQIP and 100,000 Lives.

Public/Private Collaboration Is Needed to Promote Value-Based Purchasing
The OHPC supports an expansion of purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) or health care entities (providers, health plans).

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency
Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.[33] They found average start up costs of $44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was $15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

[33] "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs,* September/October 2005, 24 (5): 1127–3.

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from "errors in medical care" across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer's, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon's health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission's role and impact.

Recommendation #6: Support Community Efforts to Improve Health Care Access and Delivery

The Oregon Health Policy Commission (OHPC) recognizes that no one service delivery model will assure access for all people, communities, or providers. Health care delivery is local. Reform approaches need to be flexible enough to provide local communities the ability to tailor their local systems to the needs and characteristics of their community. There are two community responses to local health care needs that the Commission believes requires the urgent attention and involvement of the state, businesses, insurers, and community members alike – the health care safety net and local community health care access collaboratives.

The following are recommendations submitted to the Commission from the Safety Net Advisory Council and the OHPC Local Delivery System workgroup that the Commission supports to further local innovation in health care delivery.[34]

Overview of Proposals

Promote the primary care home model

The OHPC recommends creating a pilot grant program to support community efforts to provide Oregonians with a primary care medical "home" where they can receive timely, affordable, and comprehensive care. The OHPC believes this will enhance quality and reduce cost for vulnerable Oregonians.

Successful applicants will need to demonstrate a measurable short-term impact on cost and health outcomes, particularly for patients with chronic conditions, and a longer-term impact on patient health through preventive services. Successful applicants will have a demonstrated commitment to serve uninsured and Medicaid patients and collaborate with the broader healthcare system. Primary care home components to be supported through grants would include building the provider-patient relationships, comprehensive and integrated care, and assist patients with health system navigation and coordination.

Support local access collaboratives

The OHPC supports legislation establishing a state matching grant program to support development of local access collaboratives. The Community must demonstrate that the project is collaborative (public/private partnerships). Possible parameters for projects include:

- Increasing capacity and/or access;
- Coordinating the process of delivering comprehensive health care services;

[34] See Appendix A for a list of Safety Net Advisory Council and Delivery System Workgroup members.

- Aligning available resources and leveraging financial commitments from stakeholders;
- Engaging multiple, diverse, public and private stakeholders;
- Sharing the risks and rewards across stakeholders;
- Offering significant stability to the local health care system;
- Reducing health disparities and increasing efficiencies and savings;
- Promoting the development of information technology infrastructure; and
- Promoting a continuum of care.

Include safety net providers and local community collaboratives in initiatives to realign payment incentives

The OHPC believes that reforming how our health care system pays for services is key to system reform. The OHPC will to embark on a thoughtful planning process to develop a collaborative initiative which will drive reimbursement reform forward in Oregon (See Section on "Priority Policies for Further Development by OHPC"). Payment reform must provide incentives for cost-effective care that improves health outcomes, as well as fuel the development of electronic health records, data sharing, and reporting systems. Safety net providers and the local community collaboratives should be at the table for this discussion to ensure that reforms support local innovation in providing high-value health care.

Why These Reforms Are Needed

The Health Care Safety Net

The health care safety net is a community's response to the needs of people who experience barriers to appropriate, timely, affordable and continuous health services. Health care safety net providers include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Core safety net providers are a subset of the larger safety net and are especially adept at serving people who experience significant barriers to care, including homelessness, cultural and language barriers, geographic and social isolation, mental illness, substance abuse, cognitive impairment, decreased functional status, health literacy barriers, financial barriers, lack of insurance or undersinsurnace and other barriers. . These providers have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need.

The Health Care Safety Net Advisory Council (SNAC) was created in 2005 as an advisory body that promotes understanding and support for safety net patients and providers in Oregon. SNAC provides the Governor and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed health services to vulnerable Oregonians.

Community Health Care Access Collaboratives

Throughout 2005 and 2006, the Commission convened the Local Delivery Systems Workgroup to bring together experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improving access to health care within Oregon communities. Nineteen of Oregon's 36 counties are designing and implementing local solutions that ensure access to timely, quality, and affordable services delivered in an effective, efficient and sustainable manner. In order to promote the health of an entire community, these local health system collaborative efforts are working to:

- Coordinate comprehensive health services;
- Offer stability and accountability;
- Leverage existing dollars;
- Involve multiple, diverse, public and private sector stakeholders;
- Require local leadership or champions;
- Share risks and rewards.

The Commission released a report prepared by the workgroup in January 2006 highlighting ways the state could support these community efforts including recognizing the importance of the efforts, facilitating information sharing between communities, and creating flexible state policies to permit local delivery system redesign.[35]

[35] The OHPC Local Delivery Systems Workgroup report on community collaboratives is on the OHPC website at: http://www.oregon.gov/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf

Recommendation #7: Establish Sustainable and Equitable Financing for Reform

Proposal Overview

Health care reform requires improvements on multiple fronts: the uninsured must gain coverage and the provision of services must be made more efficient and less costly. While many people agree that there are sufficient resources in the system to fund care for everyone, the difficult part is capturing and distributing the funding where it is needed. Rather than waiting for system reforms to be implemented before bringing the uninsured into the system, the Oregon Health Policy Commission (OHPC) proposes working toward both universal coverage and improved system efficiency simultaneously. To fund coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that will be phased out as system efficiencies take hold over the following years.

Preliminary pricing of the OHPC reform plan indicate that approximately $550 million per year is needed initially to finance the public coverage and premium subsidies structure proposed in this report.[36] This upfront investment in Oregonians' health will produce savings throughout the state. This investment, to be implemented along with delivery system and other reforms, will lead to more productive employees, improved outcomes, and reductions in system costs.

The OHPC recognizes that to implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. The OHPC also recognizes that many employers currently provide insurance to their employees. These employers are already subsidizing the system and should be rewarded for their ongoing contribution. To recognize this participation, financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Table 1 includes initial estimates of various payroll tax and employer fee scenarios that could fund the necessary revenue of $550 million per year; and Table 2 provides some other revenue sources that may be proposed during reform discussions.

[36] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
The actual cost may be less or more, depending on a number of factors included in the modeling, such as whether an asset test or waiting period are required for public coverage and subsidies, and extent of crowd out into public programs.

Why This Change Is Needed

Universal Coverage Reduces Burden of Cost Shift

The current system funds care for the uninsured primarily through higher premiums for the insured. Providers pass the costs of caring for the uninsured on to insurers. The insured and employers that offer insurance pay more, as insurers pass on their increased costs to members. With universal health insurance in Oregon, providers will experience great reductions in "uncompensated" care. This will allow them to charge the insured for the actual cost of their care. Premiums should be adjusted in response. The insured will pay premiums that reflect a truer cost of providing care.

An Initial Investment Will Pay Off in the Future

Oregon bears a heavy cost for having a large uninsured population. The estimated cost of hospital uncompensated care was $299 million in 2004, and that number continues to increase. Researchers estimate that total uncompensated care (hospital, physician and out of hospital care) will be $534 million in 2008.[37] Both state government and the insured pay for this care. Uncompensated care accounts for ten percent of the cost of insurance premiums.

As the Institute of Medicine noted in its 2003 report, these costs are not just due to the costs of providing free health services to persons without insurance coverage.[38] Much of the cost is due to the poorer health experienced by the uninsured, who receive too little care. The economic value of better health outcomes that would accrue from continuous health insurance coverage (and appropriate health care use) for all Americans is between $65 and $130 billion a year.[39] The savings include higher expected lifetime earnings and educational and developmental outcomes.

System savings will accrue through reductions in uncompensated care costs and improvements that ensure people are getting the right care at the right time. However, as outlined in this report, to reap the benefits of an insurance market that covers everyone in the state, Oregon must implement a system of publicly financed subsidies that facilitate access to affordable insurance.

An investment in universal insurance coverage will reap the greatest gains if change is paired with delivery system reforms that make the system more efficient and accountable. The following are a few delivery system improvements that can control costs and improve care.

- Small practices that implement electronic health records recoup their initial investments in technology and training in an average of 30 months.[40]
- Reducing hospital acquired infections could reduce the rate of increase in insurance premiums and help make coverage more affordable. The average hospital stay was $32,000 higher when the patient experienced a hospital acquired infection (HAI).[41]

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[37] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
[38] *Hidden Costs, Value Lost: Uninsurance in America*, Institute of Medicine Committee on the Consequences of Uninsurance. 2003.
[39] Wilhelmine Miller, et al., op cit.
[40] H. Miller, et al., op cit.

- Medication errors are expensive and can be costly in terms of health outcomes. The Institute of Medicine estimated there are 7,000 deaths annually due to medication errors.[42] Each preventable adverse drug event added $2,000 to the cost of hospitalization, totaling $2 billion nationally in hospital care costs. The cost of medication errors is likely even higher, as drug errors and other problems arising from lack of medication reconciliation exist in other settings, including at nursing facilities, physician offices and medical clinics.

Everyone Must Contribute to Reform
Health care is a shared social responsibility and that everyone should contribute to health insurance coverage. Many employers are doing their share and more, subsidizing care for the uninsured through higher premium payments. New financing considerations should recognize these contributions and help equalize the burden of health insurance costs across employers.

Sustainable Reform Requires Sustainable Financing
Reform requires a stable funding source. A broad-based employment payroll assessment is one sustainable funding option that can be used to finance public coverage. Whether such a tax or fee is paid only by employers or is shared by employers and employees, such a source would ensure a stable funding base to which everyone contributes.

Implementation Consideration

ERISA and the Structure of an Employer Assessment
Table 1 outlines various options for a payroll assessment. If a payroll tax or fee is considered, the OHPC recommends a structure where employers who offer insurance are allowed to recoup all or a portion of the assessment paid.

The OHPC does not recommend a specified level of coverage in order for an employer to be eligible for a tax benefit provision. Any such requirement would likely face legal challenge under the Employee Retirement Income Security Act (ERISA). ERISA substantially limits states' ability to regulate employee benefit plans, including health insurance. While a state employer health insurance mandate has not received full legal vetting, recent court rulings indicate that states might be vulnerable to legal challenges if they attempt to require employers to provide a certain level of health insurance.[43] ERISA poses a serious implementation issue that must be considered in the design of a reform plan. Appendix D includes some guidelines provided by the National Academy for State Health Policy.

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[41]"Infections Due to medical Care in Oregon Hospitals, 2003-2005" Research Brief by Office for Oregon Health Policy & Research. November 2006. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/.
[42] "To Err Is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors, Institute o f Medicine. National Academy Press, 2000.
[43] On July 19, 2006, U.S. District Judge J. Frederick Motz overturned Maryland's Fair Share Health Care law, which had required large employers to spend at least 8 percent of their payroll on health care for employees or pay the equivalent in fees to the state. The judge's decision noted that the federal ERISA law preempted the Maryland law. .Judge Motz's rule is available at <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf>.

Table 1. Various Payroll Assessment Scenarios to Fund OHPC Proposed Public Coverage Expansion
Estimated Initial Direct Public Investment: $550 million per year

INITIAL ESTIMATES - FOR ILLUSTRATION ONLY

	Assessment Scenario	Approx. Assessment % required to raise revenue		Average Annual Payment Per Employee			
				2007	2008	2009	2010
a)	• Employer financed payroll assessment • No employer credit for offering insurance	0.8%	Employer share	$320	$320	$330	$350
b)	• Employer & employee financed payroll assessment (50/50) • No employer credit for offering insurance	0.8%	Employer share	$160	$160	$165	$175
			Employee share	$160	$160	$165	$175
c)	• Employer financed payroll assessment • Full employer credit for offering insurance	2.8%	Employer share (if offers insurance)	$0	$0	$0	$0
			Employer share (if no insurance offered)	$1,040	$1,040	$1,090	$1,150
d)	• Employer financed payroll assessment • Partial employer credit for offering insurance (50%)	1.25%	Employer share (please see table notes)	$1,070	$1,060	$1,120	$1,180
e)	• Employer financed payroll assessment • No employer credit for offering insurance • Additional surcharge per employee ($300/year) • Full credit for surcharge for employers offering insurance	0.6% + $300/yr if not offering insurance	Employer share (if offers insurance	$240	$240	$250	$260
			Employer share if (if no insurance offered)	$540	$540	$550	$560

Source: Preliminary revenue estimates, OHPC, January 2006. Based on public and private payroll estimates (see reference below).
Notes: Option B is included as illustration that assessments could be split between employers and employees. Options c, d, and e could also be jointly financed by employers and employees. Option D provides an estimate of the average payment per employee for all employers. Employers who provide insurance would pay less per employee as they would be eligible for the 50% tax credit. Employers who do not would pay more per employee.

REFERENCE:	**2007**	**2008**	**2009**	**2010**
Total Oregon Public & Private Payroll ($ in billions)	67.6	71.1	74.8	78.7
Total Number of Oregon Workers ($ in millions)	1.7	1.8	1.8	1.8

Source: Payroll and employment estimates, December 2004 Oregon Economic Forecast

Table 2. Additional Funding Options for Discussion

The following are some other funding sources that could be considered to finance the cost of proposed public insurance expansions.

Funding Source (in millions)[44]	FY 2007-08	FY 2008-09	Broad Tax	Targeted Tax
Broad Retail Sales Tax – 1% Rate (exempts shelter and groceries)	$860.2	$910.9	✓	
Restricted Retail Sales Tax – 1% rate (exempts shelter, groceries, public transport, health care, education, personal insurance, utilities, gasoline, tobacco products)	$607.2	$642.7	✓	✓
Increase Tobacco Tax – Increase Cigarette Tax by 84 cents per Pack[45]	$180-190	TBD	✓	✓
Increase Beer Tax – Increase Beer Tax by $1 per barrel	$2.6	$2.6		✓
Increase Wine Tax – Increase Wine Tax by 25 cents per gallon	$2.4	$2.4		✓
Medical luxury tax – Ex. 1% on cosmetic surgery not resulting from trauma or medical condition	TBD	TBD		✓
Provider Tax – Amount of tax depends on scope of provider types included	TBD	TBD		✓

[44] Information from 2006 Oregon Public Finance: Basic Facts, Research Report #1-06. Legislative Revenue Office. February 24, 2006. http://www.leg.state.or.us/comm/lro/home.htm.
[45] Tobacco tax data (per pack amount and total revenue for the 2007-2009 biennium) are from the Governor's recommended budget.

Recommendation #8: Design and Implement System Reform Evaluation

Health Care Reform Demands a Strong Evaluation Component

The Health Policy Commission recognizes evaluation is an integral component of any successful health reform package. The purpose of evaluation is to measure health care capacity and access and to determine whether policy changes are having the intended impact on access, quality, and health outcomes. The OHPC recommends that a coherent, stable and coordinated evaluation infrastructure be developed prior to implementation to assess success and inform future policy decisions. Oregon's research infrastructure can be formalized and expanded to evaluate any global reform efforts. Building on this infrastructure is cost-efficient and timely.

Components of the Evaluation Infrastructure

- A well-designed baseline evaluation plan, capturing the data necessary to demonstrate 'pre-post' changes and attribute changes to specific reform policies;
- An evaluation of reform implementation, ensuring that implemented programs and practices are in line with the intention of policies;
- Identified sustainable funding for on-going evaluation identified during passage of any reform legislation;
- A central entity responsible for:
  - Collecting statewide and community level data, with the authority to collect data from providers and other entities that is integral to successful reform evaluation;
  - Coordinating existing state and community resources to develop shared units of measurement and metrics of change;
  - Developing a dissemination protocol that would ensure policymakers receive evaluation results in a timely manner and understandable format in order to be useful;
  - Developing and maintaining an integrative and interactive website where communities and policymakers could access relevant local and state data to inform their programmatic, practice, and local policy approaches.

Recommended Metrics of Change

A health reform evaluation plan would develop metrics from the outcomes described below. Some of the metrics outlined below can be extracted from current national and state surveys. However, several metrics are not currently collected in a manner that would be representative of all demographic subsets of Oregonians, such as race/ethnicity and geographic location. An Oregon population survey related to health care would be needed and health care providers

would need to begin providing capacity data by insurance type, provider type, FTE, and clinic location.

- Provider and Consumer participation
  - Managed care participation
  - Use and usefulness of Health Insurance Exchange
  - Insurance status rates across demographic variables
- Provider capacity
  - By primary care and by specialty care
  - By clinic location
  - By provider type
  - By insurance type (e.g. Medicare, Medicaid)
- Population demand by age subgroups (e.g. pediatric care) and by disease subsets (e.g. chronic diseases)
- Utilization patterns that emphasize on preventative care and chronic disease management
  - Access to the appropriate level of care in a timely fashion:
    - Emergency Department visits by IC-9 codes
    - Number of primary care visits by age/demographic subsets
    - Appropriate use of diagnostic and specialty care
  - By insurance type (to assess impacts of co-pays and high-deductible plans)
- Changes in health outcomes and disparities, particularly members of vulnerable subgroups
- Health care quality measures
- Financial impacts that reflect affordability for the state, providers, employers, individuals and families
- Special concerns such as "crowd-out", effective and efficient use of technology and transparency

Infrastructure

This necessary evaluation component will build on current infrastructure at the State:

- The Office for Oregon Health Policy and Research (OHPR), Research Unit: The OHPR Research & Data Unit has extensive experience developing comprehensive evaluation plans, creating data collection instruments, managing evaluation contracts, and analyzing data from state-wide surveys.
- The Health Indicators Project (HIP): Under the HIP project, leaders in state-wide community access organizations: 1) define a common unit of analysis across the urban and rural areas of the state, termed Primary Care Service Areas (PCSA); 2) identify shared metrics of access to allow communities within PCSAs to compare themselves locally, state-wide, and nationally; and 3) develop a "tool-kit" for local access organizations to tap into existing data resources to answer their community-specific questions in a cost-efficient manner.
- The Oregon Health Research and Evaluation Collaborative (OHREC): OHREC supports evidence-based decision-making by collaborating with health researchers from Oregon's universities, state agencies, advocacy organizations, local community health-care access

initiatives, and a variety of other stakeholders. OHREC is committed to creating a bridge between health-care decision-makers and the research community; thus creating a feedback loop of rapid-cycle research findings that informs policy.

Oregon Health Policy Commission Road Map for Health Care Reform

Sequencing Reforms: A Five-Year Plan

The goal of the Commission's reform work is to develop a five year reform plan that would create a health care system in Oregon in which everyone has access to affordable health care. This section outlines a recommended approach to implementation.

Getting Started in the 2007 Legislative Session

- Pass universal health coverage for children. Ensuring coverage for children is a strong first step in ensuring affordable coverage to all Oregonians.

- Pass legislation outlining the major components of full scale reform, providing guidance to public and private cooperative work throughout 2007-2009.

Years 1 and 2

- Implementation of universal health care for children will occur in Year 1.

- Implementation planning for the Health Insurance Exchange, the publicly-financed coverage expansion, and an employer assessment or fee will take place throughout Year 1 into Year 2.
  - This provides over a year for the Exchange to be created carefully by establishing an independent oversight board, promulgating operating regulations, developing initial benefit packages for individuals and small businesses, and developing affordability standards and the subsidy structure.
  - Also during this time, the state will negotiate the terms of the needed Medicaid waiver amendments to implement the publicly-financed subsidy structure.
  - Implementation of the Exchange, the publicly-funded subsidy structure, and the employer fee will occur by the middle of Year 2.

- Also during the second year, the Office for Oregon Health Policy and Research (OHPR), in partnership with other state agencies, the Oregon Health Research and Evaluation Collaborative (OHREC), policymakers, and national experts, will develop a comprehensive five-year plan for evaluating the reform implementation and initial outcomes.

Years 3, 4, & 5

Individuals have from the passage of the enacting legislation until Year 3 to seek out available coverage. The child coverage expansion, the publicly-funded subsidy structure, and the Health Insurance Exchange are all in place to assist individuals in finding affordable options. Only after the beginning of Year 3 will individuals be subject to penalties if affordable insurance is available per the Exchange affordability standard.

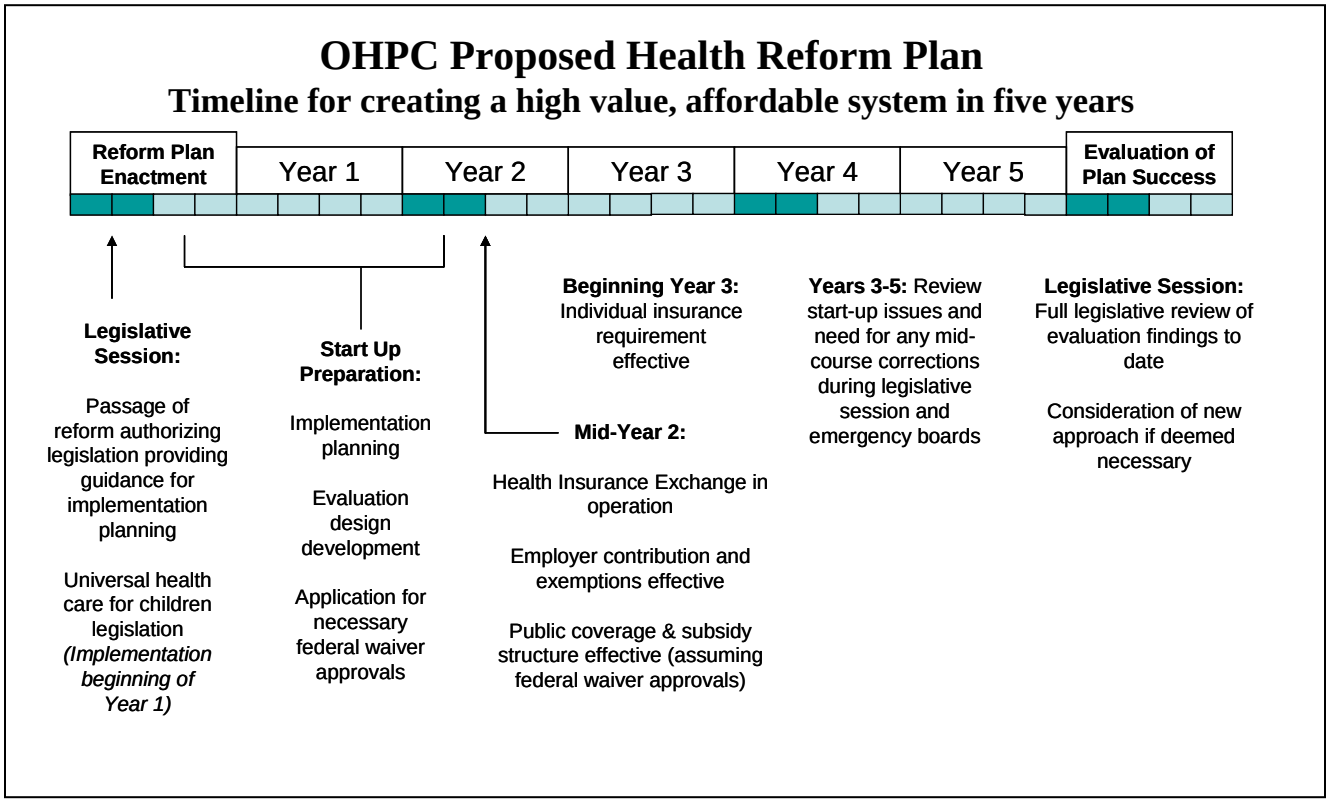
During the legislative session and emergency boards during years 3 through 5, the Governor and Legislature will review implementation progress to date and assess whether any mid-course legislative corrections are required.

Evaluating the Success of Reforms

Upon completion of year 5, the Governor and the Legislature will conduct a public review of progress to date through:

- Preliminary results for review through initial evaluation findings from OHPR and other researchers;
- Feedback from constituents, advocates, providers, insurers, and other stakeholders; and
- Any updated recommendations from the OHPC and other advisory bodies.

Both minor adjustments and full scale direction changes should be on the table for discussion at this point.



Oregon Health Policy Commission
Road Map for Health Care Reform

Priority Policies for Further Development by OHPC

Implementing Senate Bill 329

Senate Bill 329, which outlines a work plan to design comprehensive reform in Oregon, was passed in June 2007. Signed into law by Governor Kulongoski, the bill's goal is the completion of a comprehensive plan by late 2008, followed by reform implementation legislation for consideration in the 2009 session.

The bill includes a detailed timeline for fleshing out a full-scale reform plan in the 2008 legislative session. Under SB 329, the Oregon Health Fund Board, a newly created governmental entity will oversee the development of a comprehensive reform plan and implementation proposal. Five subcommittees will develop recommendations for the Board focused on: 1) financing, 2) delivery system reform, 3) benefit definition (based on Oregon's Prioritized List of Health Services), 4) eligibility and enrollment policies, and 5) federal policy impacts and opportunities. To facilitate the work of the Board and its subcommittees, existing state commissions and committees will form the backbone of the subcommittees.

The Oregon Health Policy Commission is tasked with forming the backbone of the financing subcommittee. As such, the Commission will spend the majority of the remaining time in 2007 researching options for financing the Oregon Health Fund program, and developing recommendations for the Oregon Health Fund Board. Several of the issues the Commission will tackle in this capacity include:

- Developing an implementation plan for a health insurance exchange by February 2008;
- Collecting and pooling employer, employee and individual health care premium contributions; and,
- Developing a model for a Quality Institute to improve how health care information is collected and utilized.

During the public comment period, the Commission received input that reform plans should include consideration of end-of-life care, medical liability, and other topics not covered by this report. The Commission opted to not add these topics in this final report as many of them are listed as topics to consider in implementation of SB 329.

Delivery System Reform

While much of the focus of health care reform is on insurance coverage, real reform must also change our delivery system to ensure that everyone has access to quality and affordable care provided in the most appropriate setting. In our current system, care is often fragmented, with services such as behavioral health and long-term care not well integrated with physical health care. This is in part due to the way services are paid for, and is exacerbated by a system that does not reward provider collaboration.

The OHPC believes that reforming how our health care system pays for services is key to system reform. As discussed under Recommendation #5 in this report, there are numerous entities in the state and nationally focused on reforming how health care is financed and reimbursed. The OHPC will continue to focus on furthering delivery system reform in Oregon. Some key areas of OHPC's work will include:

- Encouraging the most effective care in the most appropriate setting. Our payment incentives should place a particular emphasis on promotion of preventive care, chronic care management, and coordinating care for patients over their lifetime in a continuous way rather than episodically.
- Motivating health care providers to utilize health information technology to improve quality, safety, and transparency by permitting patient information to be available at the point of decision making by both providers and patients. Building the capacity for such infrastructure development in safety net providers and small physician practices should be a focus.
- Ensuring adequate provider capacity to ensure the demand for needed health care is met throughout the state.
- Integrating cost-containment in the system in a way that levels out growth and makes the system more sustainable. Ideally, mechanism for "capturing" savings can be created in order to demonstrate the effect of system reforms.

Appendix A: Acknowledgements

The Oregon Health Policy Commission recognizes the valuable contributions of the following individuals:

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Appendix B: Reference on designing the employer contribution to reform in compliance with ERISA

Excerpt From: "Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints." Patricia A. Butler, JD, Dr.P.H. for National Academy for State Health Policy, May 2002.

Do not require employers to offer health coverage to their workers. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

Establish a universal coverage program funded in part with employer taxes. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

Do not refer to ERISA plans. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

Remain neutral regarding whether employers offer health coverage or pay the tax. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

Impose no conditions on employer coverage to qualify for the tax credit. Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

Minimize administrative impacts on ERISA plans. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems.