More For Your Money

How The Oregon Health Fund Board's Draft Health Reform Plan Reins In Skyrocketing Health Care Costs

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Executive Summary

Oregon businesses and consumers are facing unsustainable increases health insurance premiums and out-of-pocket costs, with health care costs rising at more than double the rate of inflation.

Given this, Oregon officials are developing a major health reform plan to cut costs, improve health outcomes, and ensure Oregonians have access to affordable quality health care.

The officials charged with this task, the Oregon Health Fund Board, released a draft reform plan for public comment in early September 2008. The Board will release a final proposal in November, and the Oregon Legislature is expected to consider it in the 2009 session.

Key Findings

• The Oregon Health Fund Board's draft plan's consumer-friendly cost containment provisions have the potential to cut health care costs an estimated $5.4 billion over ten years.

• Strengthening the plan's provisions to cut waste, improve smart use of technology, boost purchasing power and watchdog insurance and hospital rates would result in even greater savings, helping further stabilize costs for businesses, taxpayers and consumers.

• The draft plan proposes cutting costs – not by cutting care – but through three consumer-friendly strategies: cutting waste in the health care system, boosting Oregon consumers' and taxpayers' ability to leverage purchasing power to negotiate better deals, and by strengthening the state's role to watchdog excessive health care costs:

Cutting Waste: Consumer-friendly Cost Containment

One key area where Oregon can cut health care costs is through cost control methods that maintain or even *improve* the quality of care. This type of cost-containment systematically cuts waste, makes smart use of new technology and clinical models, and uses prevention to keep people healthy.

Cutting Drug Costs – Require health plans purchased with public dollars to use the Oregon drug purchasing pool unless the health plan got a better deal on prescription drugs.
Estimated potential savings: *$1.6-6.3 million in 2009 and $24-95 million over 10 years.*
Quality impact: *Neutral*

Administrative Simplification – Develop and require standard electronic formats for eligibility, claims, payments, etc.
Estimated potential savings: *$400 million over 10 years.*
Quality impact: *Neutral*

The Best Primary Care, an "Integrated Health Home" – Shift to this proven method of care where teams of health providers center care on each patient, focusing on prevention, early detection and disease management methods.
Estimated potential savings: *$50 million in the first year and $2.5 billion over 10 years**
Quality impact: *Quality improves*

Health Information Technology – Help health providers more quickly incorporate the best health information technology into their practices, and use the technology to deliver better care

and communicate information to other providers caring for the same patient. Doing so would increase short-term health care spending in Oregon, but result in net savings in the long term.
Estimated potential savings: *$990 million over 10 years*[*]
Quality impact: *Quality improves*
Estimated potential savings if health IT achieves widespread use: $1 billion per year in 12 years.

Keeping Healthy to Prevent Disease – Invest in proven programs to cut smoking and obesity.
Estimated potential savings: *$32 million in the first year and $1.7 billion over 10 years.*
Quality impact: *Health outcomes improve*

Unifying Consumer and Taxpayer Purchasing Power

In addition to initiatives to directly reform the health care system, the Board's plan recommends harnessing market forces to reduce costs. The plan proposes methods to help purchasers of health care and health insurance negotiate better prices, and to drive out waste and improve quality in the health care system. The plan proposes to do this in two ways.

First, it establishes a public employers health cooperative which would strengthen the purchasing power of state and local government entities to save taxpayer dollars. Second, it unifies the purchasing power of individuals, and potentially small businesses, through the Oregon Health Insurance Exchange, a purchasing pool designed to negotiate lower rates and better coverage. Ultimately, these purchasing pools could partner to create greater savings and choices through combined purchasing power.

Watchdog Insurance Administrative Rates

A third key area the Board includes in its draft plan is in the area of regulatory oversight. Aimed at eliminating excessive insurance administrative costs, the draft report recommends the Legislature authorize the Insurance Division to develop standards for reviewing the administrative portion of health insurance rates.
Estimated potential savings: *$735 million over 10 years*
Impact on quality: *Neutral*

The draft report also recommends an appropriate agency be charged with setting ceilings on the rates charged by hospitals and other providers.

Recommendations

OSPIRG recommends the cost containment elements in the Oregon Health Fund Board's final proposal to the 2009 Legislature be strengthened in the following ways to further boost savings:

Cut Waste – Consumer Friendly Cost Containment

* Note: Estimated savings due to health information technology and integrated health homes should not be added together to obtain a total savings number. Both result in improved use of evidence-based care which reduces costs, and effectiveness of each depends on implementation of the other.

• The plan gives people with state-sponsored coverage access to an Integrated Health Home, the patient-centered primary care model proven to cut costs while improving health outcomes. OSPIRG recommends all Oregonians have access to this model of care.

• The plan accelerates usage of health information technology. OSPIRG recommends Oregon set the strongest possible standards for privacy and security to protect patients. The shift to electronic records and networks should be made to result in improved privacy and security over today's paper systems.

• The plan requires publicly-sponsored health plan to use Oregon's drug purchasing pool (OPDP) for prescription drugs unless the health plan can obtain better prices for consumers using an alternative method. OSPIRG recommends health plans meet this standard across the board.

• The plan establishes the new Oregon Health Authority, in part to continue the job of identifying waste in the system. OSPIRG recommends the Authority also be given the duty to eliminate the waste it identifies. We also recommend the plan direct the Authority to develop rules cutting health care advertising and marketing expenses if they are wasteful and do not result in improved access or quality of care, and to prevent duplicative capital projects through coordinated local planning.

Unify Purchasing Power

• OSPIRG recommends that in addition to individuals, small businesses be allowed to use the Exchange, the new purchasing pool to negotiate lower health care rates.

Watchdog Health Care Rates

• The plan recommends the Legislature authorize the Insurance Division to rein in insurance administrative rates exceeding inflation. OSPIRG recommends Insurance Division be more specifically directed to evaluate health insurance administrative costs, and deny unnecessary increases in administrative costs higher than the rate of inflation.

• In addition to evaluating the administrative portion of health insurance rates, OSPIRG recommends the plan strengthen the Insurance Division's evaluation of proposed rate hikes in their entirety to include an assessment of affordability. Such evaluation should include factors such as the health insurance company's investment income, profits, and reserve levels when determining whether an insurance premium increase is reasonable and necessary.

Introduction

Oregonians are facing unsustainable increases in health care premiums and out of pocket costs for medical care. Health care premium rate hikes have made front page news this year, with many Oregonians seeing increases reaching 10 percent to 20 percent or higher.

Since 1999, health care premiums for families with employer-sponsored insurance across the nation have more than doubled. In addition, more and more people have annual deductibles of $1000 or greater, including one out of three employees who have coverage through their small businesses employer.[1]

Rising health care costs have not only contributed to the problem of large numbers of people going without insurance. Increasing numbers of people *with insurance* are unable to pay their medical bills. An estimated 57 million Americans live in families having problems paying their medical bills, and 43 million of those Americans have insurance.[2]

In response to the high costs of health care and the growing numbers of uninsured and under-insured Oregonians, the 2007 Oregon Legislature passed a major health reform bill called the Healthy Oregon Act. The bill set strong goals for health reform: rein-in costs, improve health outcomes and provide affordable, quality health care to all Oregonians.

The Healthy Oregon Act also established a new entity, the Oregon Health Fund Board, and charged its seven Governor-appointed citizen members, aided by numerous expert committees, with developing a detailed reform plan.

The Board and its committees met in 2007 and 2008, and the Board released a draft plan, *Aim High: Building a Healthy Oregon,* for public comment in September, 2008. In November of 2008, the Board will release a final plan, which is expected to be considered by the 2009 Legislative Assembly.

To prepare this analysis, OSPIRG staff culled from the Board's draft plan the elements designed to reduce the increase in rising health care costs. Cost-containment recommendations in the draft plan fall into three main strategies:

- Change the health care delivery and insurance systems to cut waste and improve care;
- Boost purchasing power to negotiate a better deal for consumers and taxpayer dollars; and
- Watchdog insurance and hospital rates

In this analysis, we review each strategy and element, evaluate its strength and effectiveness, and note if available the estimated cost savings Oregon could potentially realize if it were implemented.

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[1] Kaiser Family Foundation and Health Research & Educational Trust. *2008 Employer Health Benefits Survey.* 2008

[2] Center for Studying Health System Change. *Trade-offs Getting Tougher: Problems Paying Medical Bills Increase For U.S. Families, 2003-2007.* 2008

Consumer-Friendly Cost-Containment

When it comes to looking for places to cut costs, it makes sense to first locate where there is waste in the system. The good news in health care is that we do not need to ration necessary care to bring down costs. One key area where Oregon can cut health care costs is through what we call "consumer-friendly cost-containment" – cost control methods that maintain or even *improve* the quality of care. This type of cost-containment systematically cuts waste, makes smart use of new technology and clinical models, and uses prevention to keep people healthy.

In this analysis, OSPIRG identified numerous consumer-friendly cost-containment elements in the Oregon Health Fund Board's draft report.

The Best Primary Care

In recent years, doctors and nurses have developed a new way to deliver primary care, called the "Integrated Heath Home" or "primary care home" model. Best known for resulting in dramatically improved health of patients, this model has a powerful side effect – it cuts costs.

The old model of health care is all to familiar to many of us. A disjointed system of providers, each looking at your chart for the first time as they walk in the door for a rushed 10 minute visit. Providers bogged down in paper work. Missed opportunities for prevention and early detection of disease. A maze-like bureaucracy for patients and their families to navigate.

Central to the new model is that the fact that care is "patient-centered," it is organized primarily around what will work best for the patient and his or her health. Coordinated by a team of health providers, care in an Integrated Health Home uses evidence-based medicine, health information technology, and focuses on prevention, early detection and disease management to keep patients their healthiest and reduce hospitalizations. Patients are often able to get same-day appointments, and report high levels of satisfaction. [3]

This model has been implemented in Pennsylvania's Geisinger Health System, North Carolina's and Illinois' Medicaid programs, Alaska Native Medical Center, Intermountain Health Care in Salt Lake City, as well as several pilot programs in Oregon such as at the OHSU Richmond Clinic in Southeast Portland. Integrated health homes have resulted in lower costs and healthier people compared with the old model of primary care.

The Oregon Health Fund Board's draft plan proposes to bring Integrated Health Homes to the Oregon Health Plan, and estimates doing so would save $50 million in the first year, and $2.5 billion over 10 years. The report also suggests that other health plans and services purchased with public funds, such as benefits for public employees, should require the plans offer Integrated Health Homes to enrollees.

Greater savings, and better quality care could be realized if all Oregonians had access to this "best practice" primary care. Geisinger Health System's preliminary data show an impressive 7 percent cost savings in medical costs, and a 20 percent reduction in hospital admissions due to implementation of patient-centered medical homes.[4] If Oregon were to implement robust Integrated Health Homes with

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[3] The Office for Oregon Health Policy and Research. *The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act*. December 2007

[4] R.A. Paulus, et al. *Continuous Innovation in Health Care: Implications of the Geisinger Experience*. Health Affairs. September/October 2008.

strong health information technology and payment reform, and experienced savings along the line of Geisinger, we could cut an estimated $1.4 billion from our current $20 billion spending on health care in Oregon.

The Healthy Oregon Act, which established the Oregon Health Fund Board, charged the board with the task of designing a plan to give all Oregonians such a primary care home. OSPIRG recommends the Oregon Health Fund Board's final proposal set a path for all Oregonians to have an Integrated Health Home, and set clear benchmarks for requiring insurance companies and health providers to put these best practices in place.

A Key to Integrated Health Homes: Update the Way Health Providers are Paid

To make Integrated Health Homes are effective at cutting costs and improving care, experts agree that it is necessary to change the way providers are paid, so that payment systems are aligned with the goals of delivering quality care and cutting waste. This is because currently, most hospitals and health providers are paid according to how much health care they deliver – how many office visits, how many tests, and how many procedures. This naturally encourages high volume of care, but does not reward providers who are able to keep people healthier, and does nothing to cut duplicative care or other waste.

The Oregon Health Fund Board draft report recommends payment reform be instituted, calling for a Payment Reform Council to be established to decide on the precise new payment model to use. As with the use of Integrated Health Homes, OSPIRG recommends the Oregon Health Fund Board's plan for payment reform extend beyond the OHP and SCHIP programs, so that payment for all the care that Oregonians receive is reformed to align with the goal of keeping people their healthiest.

Electronic Health Information Technology

Information technology has potential to greatly improve health outcomes, by giving health providers caring for a patient timely access to critical information about the patient's health history, current medications, allergies and other health information. It can give patients greater access to their own health information, and can link health providers with the most up to date medical and scientific evidence, so they have the best information at their fingertips when they are treating patients. If implemented properly and with strict accountability, health information technology can also improve the privacy and security of health information.

If used to its full capacity, health information technology not only has the potential to improve the quality of care, but also to cut costs, by reducing errors and duplication, saving time, and improving the use of evidence-based medicine. To ensure it is used to its full capacity, health information technology should be implemented together with integrated health homes and payment reform.

The Commonwealth Fund's "Bending the Curve" report suggests Oregon can greatly reduce health care costs over ten years if health providers more quickly incorporate the best health information technology into their practices, and use the technology to inform their decision-making and to communicate information to other providers caring for the same patient. Doing so would increase short-term health care spending in Oregon, but in 10 years, the cumulative savings could reach $990 million.

According to a 2007 report of the Oregon Health Quality Corporation and the Office for Oregon Health Policy and Research, the net potential annual savings from implementing widespread health information

technology could range from $1.0 to $1.3 billion per year. The report states that these savings could be realized within 12 years.[5]

OSPIRG recommends the Board's final plan include strong standards for health information technology quality and effective interoperability with other systems. It should also include standards to ensure strict privacy and security of the information in electronic health records, so that the shift to electronic records and networks results in improved and privacy and security over today's paper systems.

Cutting Drug Costs

Prescription drug prices continue to skyrocket in the United States, rising much faster than the rate of inflation. Insurance companies cite rising drug costs as a key reason why they charge rapidly rising amounts for health insurance premiums.

In 2003, Oregon established The Oregon Prescription Drug Program (OPDP) to negotiate lower costs with the prescription drug companies on behalf of the people and state agencies that opt into the program. Through OPDP, individual members are saving an average of 43%, and up to 60% on generic drugs.

The Oregon Health Fund Board draft report recommends Oregon expand use of this successful program. All health insurance plans purchased with public dollars, such as plans for public employees and Medicaid enrollees, would automatically use the OPDP for prescription drugs, unless the health insurer could, through negotiation of its own with the drug companies, obtain better prices on the same prescription drugs.

Doing so could save in the estimated range of $1.6-6.3 million in 2009; 10-year cumulative potential savings would range from $24-95 million. These estimates anticipate that 115,000 people would move to OPDP for prescription drugs, and that doing so would cut costs between 2 percent and 7 percent. This is a conservative estimate, given the experience of Washington State's public employees when they joined OPDP last year, and saw savings of 7.8 percent in the first quarter alone.

Given these impressive savings, OSPIRG recommends the Oregon Health Fund Board's final plan be strengthened to require insurance companies use OPDP for prescription drugs unless they can obtain better prices for consumers using an alternative method.

Administrative Simplification

Needless administrative paperwork drains money and time away from the health system. With health providers and insurance companies each having their own version of forms for administrative functions such as billing, paying claims, and determining eligibility, its no wonder administrative expenses are significant.

The Oregon Health Fund Board's draft report recommends Oregon adopt a similar approach as Minnesota's, which replaces the myriad of forms with standard electronic forms. Based on Minnesota's experience, the Oregon Health Fund Board draft report estimates Oregon could reduce health care spending in Oregon by more than $5 million in 2009 and $450 million in 2009-2018.

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[5] Oregon Health Care Quality Corporation and the Office of Oregon Health Policy and Research. *Potential Impact of Widespread Adoption of Advanced Health Information Technologies on Oregon Health Expenditures.* September 2007.

Keeping Healthy to Prevent Disease

Chronic diseases, such as asthma, diabetes and high blood pressure account for most of the spending on health care. Early intervention and chronic disease management are critical elements of keeping people their healthiest and reducing expensive health emergencies. But equally important is preventing chronic disease from developing in the first place.

Because smoking and obesity are the two most influential risk factors in serious chronic diseases that can often be reduced or eliminated with changes in behavior, the Oregon Health Fund Board's draft report recommends Oregon make smart use of programs proven to reduce smoking and obesity levels.

The Oregon Health Fund Board draft report estimates that if Oregon invested $10 per person on existing effective community-based programs, it could result in estimated savings of $32 million in the first year and cumulative savings of $1.7 billion over 10 years.

Oregon Health Authority

To implement the consumer-friendly cost containment elements outlined above, and other elements designed to improve quality and expand access to affordable care, the Oregon Health Fund Board draft report recommends streamlining all the departments, offices, programs and commissions that deal with health care, and organize them together under the Oregon Health Authority.

The Oregon Health Authority would conduct ongoing detailed monitoring and public reporting of costs and quality in the health care system, and would use that information to identify other sources of waste in the system, and set standards to protect consumers.

OSPIRG recommends this element be strengthened in the Board's final plan, by including delegation to the Authority the power to not only identify waste in the health care system, but to set rules to eliminate that waste, to cut costs and maintain or improve health care quality. OSPIRG recommends the Authority be specifically charged to develop rules to cut health care advertising and marketing expenses if they are wasteful and do not result in improved access or quality of care, and to prevent duplicative capitol projects through thorough and coordinated local health care planning.

Unify Purchasing Power

In addition to direct changes to the way health care is delivered in Oregon, the Oregon Health Fund Board draft report recommends harnessing market forces to help purchasers of health care and health insurance negotiate better prices, and to drive out waste and improve quality in the health care system. The plan proposes to do this by strengthening the purchasing power of state and local government entities to save taxpayer dollars, and by unifying the purchasing power of individuals, and potentially small businesses, to save consumer and business dollars.

Making the most of purchasing power is not a new idea. Large businesses, federal agencies and programs, and state and local governments have purchasing power relative to their size, and they commonly use selective contracting – calling for bids that meet certain standards – to get the best deal.

Saving Taxpayer Dollars

The Oregon Health Fund Board report recommends coordinating purchasing among public employers such as cities, counties, public schools, and the state. These entities and others currently purchase health care separately, but could negotiate a better deal by working together. To accomplish this, the Board's plan establishes the Public Employers Health Cooperative.

Additionally, the report recommends these purchasing entities have coordinated contracting standards that push insurers and providers to cut waste and improve care. Standards would be in alignment with the consumer-friendly cost containment outlines earlier in this analysis, such as use Integrated Health Homes, evidence-based medicine, guidelines for using new technologies, and use of most effective and least-cost prescription drugs.

Saving Consumers and Small Businesses Dollars

Over time, the insurance and health care services negotiated by the Public Employers Health Cooperative could be open to all consumers and businesses. The way this would work initially is for individuals to unify their own purchasing power through a separate purchasing pool, called the Exchange. The Exchange would negotiate a variety of health plans people could choose from, and offer clear information about the differences between the plans. The draft report recommends the Exchange be given authority to investigate the need for a publicly-owned health plan option, and to develop that option if necessary. The Board's draft plan recommends letting small business into this purchasing pool once it is established and operating.

OSPIRG urges the Board's final proposal specifically allow small businesses to use the Exchange. Doing so would help small business benefit from being part of a larger pool to negotiate lower costs. Because small businesses often can only offer one insurance plan choice to employees, the Exchange may be attractive to small businesses and their employees, given that the Exchange would offer a range of options for health insurance plans, and employees could add their own resources to "buy up" to a more expensive plan if they chose. Additionally, giving small businesses the option to offer their employees health coverage through the exchange would increase the negotiating power of the Exchange.

Watchdog Insurance and Hospital Rates

Insurance Premiums

Currently, the Oregon Insurance Division reviews and approves or denies rate increases proposed by health insurance companies for individual insurance plans, portability plans, and plans bought by small groups, employers with between 2 and 50 people eligible for the plan.

When rate increase proposals are made and approved, the rate increase applies to two different parts of the premium. The first is the medical portion, which is the part that gets paid to health providers. The second is the administrative portion, which includes administrative costs such as billing, but also includes executive pay, marketing and advertising, and profits.

The Oregon Heath Fund Board report notes that currently, *both* portions of premiums have been rising by the rate of medical inflation, which is of course much higher than the general rate of inflation. While that may make sense for the medical portion of rates, it does not make sense for the administrative portion of rates.

The Oregon Health Fund Board draft report recommends the Legislature authorize the Insurance Division to develop standards for reviewing the administrative portion of rates. Assuming the overall increase in the medical portion of rates continues at 8%, if the increases in the administrative portion of health insurance premium rates were contained to the rate of inflation, Oregon would save a cumulative $735 million over 10 years.

OSPIRG urges the Board to strengthen the element of rate regulation in the final version of the plan, and to do so in several ways. First, the Board's plan should recommend the legislature *direct* the Insurance Division to develop standards for the administrative portion of rates, instead of only authorizing the Division to do so. The plan should also clearly recommend the insurance division to deny increases in administrative costs exceeding the rate of inflation, unless the insurer can demonstrate how higher costs will result in lower long term costs or improved care.

Second, the Board's plan should recommend the legislature direct the Insurance Division evaluate the affordability of proposed insurance premium rates, and assess the reasonableness of a rate increase by looking at additional factors about the insurer, such as investment income, profits, and reserve levels. This would be a change from the current system.

Currently, factors that the Insurance Division looks at during rate review are somewhat limited. In large part, the review is ensuring that the premium rates are *high* enough, to prevent insurers from undercutting their rates to such an extent that they don't have enough money in reserves to pay for health care claims. That is an important aspect of rate review, and ultimately protects consumers and patients from bankrupt insurance companies.

However, the problem of our day is not insurance rates that are too low. It is instead that insurance rates are too high, rising so steeply over the past decade that increasing numbers of individuals and businesses cannot afford the costs and are becoming uninsured or under-insured. Increasing numbers of people with inadequate or non-existent coverage puts a strain on hospital emergency rooms, a strain which drives up hospital rates overall, which are then past on to insurance companies and then onto consumers in the form of yet higher premiums, perpetuating the cycle and making it worse.

To prevent collapse, not from rates that are too low, but from rates that are too high, it is reasonable to require the Insurance Division to conduct a rate review process to examine the affordability of rates and determine whether a rate increase is necessary.

Factors the Division might use to determine this include an evaluation of the insurer's investment income, reserve levels that exceed the minimum requirement, and whether the insurer is using its own negotiating power to the full extent to reduce waste in the delivery system. Requiring the Division to factor in the affordability of rates and these additional factors would enable the Division to deny rate increases if an insurer could charge lower premiums by reducing its reserve levels, or reducing the rate of growth of its reserve levels, while still remaining in a healthy financial position.

Prices Charged By Hospitals and Other Health Providers

Just like insurance rates, the cost of care is increasing at a rate greater than inflation. Currently, there is no state or federal regulation of the prices that hospitals and other providers can charge consumers, insurance companies or other purchasers. Instead, rates depend on what the providers and the purchaser can negotiate. Given the lack of competition in many locations in Oregon, there is concern that market forces may be inadequate to prevent excessive rates. The board's draft plan recommends the Legislature consider authorizing an appropriate state agency to establish limits on rate increases charged by providers, either limiting increases to a set percent higher than the general rate of inflation, or linking it to an established negotiated rate, such as the Medicare reimbursement rate.

Recommendations

The Oregon Health Fund Board is heading in the right direction with their recently released draft health reform proposal. It's good news for consumers that the plan proposes cutting costs, not by cutting care, but by cutting waste. OSPIRG recommends the cost containment elements in the Oregon Health Fund Board's final proposal to the 2009 Legislature be strengthened in the following ways to further boost savings:

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