HEALTH POLICY AND ANALYTICS DIVISION
Tina Kotek, Governor

Oregon Health Authority

500 Summer Street NE
Salem OR 97301
PHONE: 971-673-0440
FAX: 971-673-0457

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TO: The Honorable Rep. Rob Nosse, Chair
The Honorable Rep. Christine Goodwin, Vice-Chair
The Honorable Rep. Travis Nelson, Vice-Chair
House Committee on Behavioral Health and Health Care

FROM: Ali Hassoun, Interim Director of Health Policy and Analytics, Oregon Health Authority – Health Policy and Analytics Division

SUBJECT: HB 2878, Relating to the Aligning for Health Pilot Program

Thank you for the opportunity to provide information on House Bill 2878. The Oregon Health Authority (OHA) has no position on House Bill 2878 but conducted considerable related research and produced technical information about a regional global budget health care delivery model pilot, primarily in the form of a legislative report required by House Bill 2010 (2021 session). Below you will find information on relevant issues that may provide useful context to the Committee as you consider HB 2878.

HB 2010 tasked OHA with making recommendations to the Legislature for a regional, global budget pilot that takes into account "state and private participation in the health insurance exchange" (i.e. Oregon's Health Care Marketplace) and "may include employer-sponsored plans." The bill also required the pilot align with the state's health care transformation goals, including value-based payment, as well as the state's health care cost growth target.

In 2021 and 2022, OHA contracted with three external consultants, Tenfold Health, BerryDunn, and Michael Anderson-Nathe, to develop recommendations, analysis and technical considerations available in the final report. The "Aligning for Health" model presented in the report was designed to fundamentally change incentives for payers and health care providers from the current system—which promotes delivering and paying for individual services—to a global budget model that would incentivize improving health for a full population in a region under a sustainable rate of cost

growth. The regional global budget model described in the report was developed under certain assumptions:

- The pilot would take place in at least one region of the state with a flexible definition of region as long as it meets adequate enrollment.
- Participation in the pilot would be voluntary, which may require incentives for purchaser, payer, provider, and member participation.
- Payers would manage global budgets and provider contracts and would be held to value-based payment targets and align with state cost growth targets.
- Eventually all purchaser types would participate (i.e., public and private), but given regulatory considerations some purchasers (e.g., larger employers) may be able to join earlier than others.

Several factors are key to ensuring that goals of the global budget model presented in OHA's legislative report are achieved. These include having a sufficient number of lives enrolled in coverage under the global budget arrangement; specific health insurance market segments participating (i.e. public, employers, Marketplace, etc.); an adequate number and composition of providers serving pilot members; feasibility and affordability of risk mitigation and approaches for all participants; and adherence to a sustainable rate of cost growth. Per OHA's legislative report, under the model OHA would conduct a formal procurement, including a Request for Proposals (RFP), to seek payers to participate in the pilot. Payers selected under the pilot would need to demonstrate adequate provider networks, high quality, success in medical and population health management, commitment to advancing health equity, and plans for community engagement and social determinants of health.

Under HB 2878, OHA would develop requirements, administer a procurement and contract with payers, and launch a pilot (including engaging community and partners), as well as administer, monitor, evaluate, and report on its progress. The bill prescribes a limited timeline for program launch – compressed in the -1 amendment to 30 months – from effective date to launch. Populations included in the program would initially include employees covered under the Public Employees' Benefit Board (PEBB) and Oregon Educator's Benefit Board (OEBB), as well as any private employer groups that elect to opt in. In subsequent years of the pilot, the bill would provide an opportunity to add participants and, pending regulatory approvals, this could possibly include non-commercial purchaser types (e.g., public insurance). The state would be required to consider social needs and health inequities in selecting potential pilot regions and establish a payer-funded health equity fund for community-based interventions. Participating purchasers, payers, and providers would be held to certain requirements, such as including all enrollees in a selected region (purchasers), adhering to the state value-based payment compact (payers and providers) and, possibly, investing a portion of annual revenue in social determinants of health (payers). The -1 amendment would additionally provide a broad exemption for participating payers from the state review process for material change transactions (Health Care Market Oversight), set payer global budgets above the state's cost growth targets, and set thresholds for insurance to mitigate payer risk.