Oregon Association of Hospitals and Health Systems

June 9, 2017

Oregon State Legislature
Joint Committee on Ways and Means
Subcommittee on Capital Construction
900 Court St. NE
Salem Oregon 97301

Re: Senate Bill 1067 – Cost containment through cost shifting

Co-chairs Girod and Holvey and Members of the Committee:

Thank you for the opportunity to testify on Senate Bill 1067. I am Jenn Welander, Chief Financial Officer of St. Charles Health System and a member of the Oregon Association of Hospitals and Health System's (OAHHS) health care finance policy advisory committee. On behalf of Oregon's 62 hospitals, health systems, and the patients we serve, the association opposes SB 1067, Sections 29 – 34, which sets arbitrary caps on reimbursement for hospital services under the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB).

Oregon has been on a tremendous health care transformation journey the past five years. Hospitals have been integral, and in fact often leading, participants in this work. As the health care delivery system has gone through significant transformation so too has payment methodology. Because of this work, hospitals and health systems are increasingly paid based on performance and at-risk cost of care, instead of the almost entirely fee-for-service reimbursement of years past.

In contrast, the sections outlined would push us back into a fee-for-service model based on Medicare rates. Those rates are set to accommodate external factors, such as the federal budget, they do not keep pace with general inflation costs, and do not come close to covering the actual cost of care. They also have no relationship to quality of care, patient safety, or outcomes.

The Medicare system was also developed to meet the needs people over the age of 65 and a small number of younger people with certain disabilities. The PEBB and OEBB population demographics are much more diverse, including over 160,000 dependents, many of which are children. Using functionally inapplicable Medicare rates for health care services for this population is inappropriate and short-sighted.

SB 1067, Sections 27 and 28, provide for a cap of 3.4% on PEBB and OEBB spending growth, while Sections 29 – 34 will not generate any true savings. Instead, Sections 29 – 34, will institutionalize underpayment of health care services to the PEBB and OEBB population. The result will be a cost shift of tens of millions of dollars to other Oregonians, including small businesses and those buying commercial health insurance.

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The answer to long-term containment of health care costs for employees requires effective incentives for screening and early detection; evidence-based tools for chronic disease self-management; community and workplace investments; and ensuring patients get the right care at the right time in the right setting.

We encourage PEBB and OEBB to use a wide range of tools to ensure state agencies and schools are acting to support the 3.4% growth cap included in Sections 27-28 and share in the responsibility of keeping employees healthy, just like businesses and communities are stepping up to support population and community health initiatives.

Hospitals strongly believe that we must continue moving forward with transformation and that cost containment measures are part of that work. Like any significant systems change, we must collectively be aware of the consequences and merits, and carefully consider these changes so we can lessen potential negative impacts.

At the same time, we want to be solution-oriented. Oregon hospitals urge the Legislature to support SB 419A which establishes a *Task Force on Health Care Cost Review* to develop recommendations on all-payer rate setting using lessons learned from Maryland and other states to inform a comprehensive approach to payment reform inclusive of PEBB, OEBB, commercial payers and coordinated care organizations.

Thank you for your consideration.

Jenn Welander
Chief Financial Officer
St. Charles Health System