Public Testimony Submitted to the Joint Task Force on Universal Health Care
Richard Gibson MD PhD – Portland, Oregon – 29 April 2021
Avoid Regional Risk-Bearing Care Groups

I am very concerned with the current proposed plan to implement regional risk-bearing care groups to pay providers throughout Oregon for the following reasons:

- Chunhuei Chi clearly stated that it is crucial to have a single risk pool in the state. Separate regional risk-bearing care groups, some perhaps quite small, are ill-suited to the task and specifically contradict Dr. Chi's principal admonition.
- Paying providers based on patient risk is very expensive administratively, especially done in multiple smaller groups, and such administrative overhead would dramatically decrease the savings we expect from a single payer plan.
- An 2016 whitepaper from the Society of Actuaries shows that risk-adjustment methodologies prospectively account for only about 20% of the variance in cost of patients. Providers will continue to be undercompensated for their very ill patients and this may lead to avoiding complex patients and worsening inequities.
- Why overturn the simplicity of "everyone in Oregon is covered to see any licensed provider in Oregon?" Especially in rural regions of the state, patients will be getting care in a widely dispersed geographic area. How will rural primary care providers be held responsible for managing down the cost of specialists and facilities their patients see in distant, big cities?
- Value-based payment strategies and accountable care organizations have not demonstrated significant financial success despite years of working on this methodology. Only a few CMS ACOs have demonstrated savings beyond the cost of program administration. How could multiple regions within Oregon possibly acquire the expertise to make this approach successful when many large, sophisticated medical groups around the country have failed to save money?
- SB 770 (Section 1(5)(a-c)) specifically prohibits a risk-bearing entity coming between providers and the State as a single payer.
- The idea of regional groups representing their local needs is sound, but that idea does not need to extend to building a risk-bearing entity. Regional groups can have input on the capital infrastructure needs and the services provided in their community while still maintaining the administrative simplicity and cost savings of a truly single payer system.
- Providers in different parts of the state can be paid different rates based on the cost of providing care and on the ability to attract providers to practice in underserved locales without the need for regional risk-bearing entities.
- In 2012, Connecticut stopped doing Medicaid managed care and moved back to fee-for-service. Costs went down, and cost growth went down. Administrative expenses average 3% vs. 12% for Medicaid managed care. Financial details are available. Kate McEvoy, Connecticut's Medicaid Director, said that she would be a resource for Oregon, if we needed her. Let's invite her to speak to the Joint Task Force or the Provider Payment TAG so that Oregon can understand how to manage Medicaid costs without the expensive overhead of managed care.
- Why are we pursuing regional risk-based entities? Is it to limit cost? Connecticut has demonstrated that managed care is not needed to manage cost.
- No other developed country in the world substantially relies on providers taking risk. All other developed countries benefit from different versions of single payer healthcare. Why does Oregon wish to go against the experience of all other developed countries without significant evidence that regional risk-based entities work?