SUBJECT: Alternative payment method pilot program for ERS health care

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Kolkhorst, J. Davis, Gonzales, Hopson, S. King, McReynolds, Truitt, Zerwas

2 nays — Naishtat, Coleman

1 absent — Laubenberg

SENATE VOTE: On final passage, May 4 — 31-0

WITNESSES: For — (*Registered, but did not testify*: Starr West, Texas Hospital Association)

Against — Ann Fickel, Texas Classroom Teachers Association; Richard Kouri, Texas State Teachers Association; Ted Melina Raab, Texas AFT; (*Registered, but did not testify*: Enrique Flores, Jr., United Auto Workers; Rene Lara, Texas AFL-CIO)

On — Bill Barnes, Tim Lee, Texas Retired Teachers Association; John Holcomb, Texas Medical Association, Texas Academy of Family Physicians, TPS; Robert Kukla, Employees Retirement System; Josh Sanderson, Association of Texas Professional Educators; (*Registered, but did not testify*: Derrick Osobase, Texas State Employees Union)

BACKGROUND: Insurance Code. ch. 1551 contains the Texas Employees Group Benefits Act, whose purpose includes:

- providing uniformity in life, accident, and health benefit coverages for all state officers and employees and their dependents;
- enabling the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry;

- fostering, promoting, and encouraging employment by and service to the state as a career profession for individuals of high standards of competence and ability;
- recognizing and protecting the state's investment in each permanent employee by promoting and preserving economic security and good health among employees and their dependents; and
- fostering and developing high standards of employer-employee relationships between the state and its employees.

DIGEST:

CSSB 10 would amend ch. 1551 of the Insurance Code to authorize the board of trustees of the Employees Retirement (ERS) to adopt a pilot program that would provide an alternate method of payment to healthcare providers. The program would test alternatives to traditional fee-for-service payments made under the group benefits program.

An alternative payment system would include the following systems for compensating a physician or health care provider for arranging for or providing health care services to participating enrollees:

- a global payment system, based on a predetermined payment per enrollee for a specified period, without regard to the quantity of services actually provided;
- an episode-based bundled payment system, based on a flat payment for all services provided in connection with a single episode of medical care;
- a pay-for-performance payment system, based on the physician or health care provider meeting or exceeding certain defined performance measures. A pay-for-performance payment system could include bonuses to or the sharing of realized savings with physicians and other health care providers;
- a blended payment system, that included one or more features of a global payment system, a pay-for-performance payment system, and an episode-based bundled payment system; and
- another system other than fee-for-service.

To ensure effective operation of the pilot program, ERS would establish reasonable limits for participation and could limit participation in the pilot program to:

- one or more regions of the state; or
- one or more organized networks of physicians, hospitals, and other health care providers.

The pilot program would operate for at least one plan year, and could be extended if ERS found appropriate quality of service and cost-effectiveness. ERS could continue an extended pilot program as a permanent program.

ERS could work with the administering firm of a self-funded health benefit plan to establish one or more pilot programs, under which physicians and health care providers who provided health care services to individuals who participated in the group benefits program were compensated under an alternative payment system.

Pilot programs would ensure that:

- a physician or health care provider was available for each participating enrollee; and
- a payment made for health care services provided by the pilot program under an alternative payment system was made in a manner that compensated appropriately each physician or health care provider for the services provided.

ERS could contract with appropriate entities, including qualified actuaries, to assist the board in determining appropriate payment rates for the pilot program. ERS also could modify a payment rate as necessary to adjust for inflation.

Contracting, purchasing, procurement, and program and project-related responsibilities of any pilot program would be the responsibility of ERS. ERS would administer an established pilot program and could adopt rules, plans, and procedures and enter into appropriate agreements to administer it.

Pilot program standards. ERS would ensure that a coverage plan in the pilot program was at least equivalent to the basic coverage plan provided to state employees. To the extent practicable, the pilot program would be based on nationally recognized quality-of-care standards and evidence-based best practices and would include policies designed to promote clinical integration of health care providers and other policies and

practices as necessary to ensure high-quality and effective health care services.

Clinical integration would be defined as a network of health care providers implementing an active and ongoing program to evaluate and modify practice patterns by the network's participants and create a high degree of independence and cooperation to control costs and ensure quality.

Pilot program evaluation. ERS would develop a process to evaluate the pilot program. The evaluation process would solicit the opinions of participating enrollees on:

- the availability and quality of the health care received through the pilot program; and
- the costs incurred for health care provided through the pilot program, including copayments, fees for service, and other analogous costs.

The bill would take effect September 1, 2009.

SUPPORTERS SAY:

CSSB 10 would create a pilot program within the group health insurance plan of the Employees Retirement System (ERS) to test alternatives to traditional fee-for-service payments to healthcare providers. Academic research shows that savings and better health care outcomes can be achieved by moving away from the current reimbursement system based on volume toward alternatives that improve efficiency and use best practices. The bill would allow ERS to establish pilot programs that would offer incentives to all health care provides to work together to ensure that patient care was coordinated and evaluated for quality and effectiveness by using nationally recognized quality-of-care standards and evidence-based practices. Additionally, state employees participating in the pilot program would have the ability to evaluate the program, ensuring constructive feedback.

The pilot program would pay for health care services on a global basis (per-person), on an episode basis (per-disease or health care need), on a performance basis, or a combination of methods to align payments with quality of service rather than quantity. Currently, provider groups that are achieving higher quality and improving outcomes through alternative payment models are losing money through the payment system, since payments are based on volume rather than quality and outcomes. As a

result, there is little incentive to improve quality of care. The bill would allow ERS to pilot these alternative payment options as a way to improve the delivery of health care services.

The language in the committee substitute addresses many of the concerns expressed about provisions contained in the Senate-passed version of the bill. The committee substitute is the product of a stakeholder process to ensure that ERS could implement the pilot program effectively.

OPPONENTS SAY:

While there are merits to the concept of providing health care in a more cost-effective and coordinated manner, the pilot program offered under CSSB 10 has too many unanswered questions for state employees. The bill would, in effect, turn current employees and retirees of state agencies and higher education institutions into "guinea pig" test subjects to reduce state spending for health insurance. The bill contains no limit on the number of employees and retirees who would be required to participate in the pilot program, does not define the number of pilot programs that would be allowed to operate, or allow state employees to opt out of the pilot program. Also, geographic limits to the pilot program are not outlined in the bill, and it would guarantee only that no more than basic coverage was covered by the pilot program. These unanswered questions led the Teacher Retirement System to be taken out of the bill, and it should be clarified before a pilot program that could impact thousands of current and retired state employees is allowed to operate.