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OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE

January 15, 2008 Meeting Packet

Oregon Health Fund Board
Benefits Committee Meeting

Tuesday, January 15, 2008
9:00 am – 11:30 am
Room 218
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:00 am	Call to Order	Susan King	
5 min	Approval of Agenda and 12/11/07 Minutes	Susan King	X
9:05 am 25 min	Identification of Principles and Policy Objectives for Defining Essential Health Services	Susan King, Darren Coffman	X
9:30 am	Overview of Models for Defining Essential Services and Their Adherence to the Principles/ Policy Objectives		
25 min	OHP Plus	Som Saha, Darren Coffman	
25 min	Commercial Plan	Nina Stratton, Brandon Repp	
25 min	OHP Standard	Som Saha, Jeanene Smith	
10:45 pm 30 min	Discussion of Options for Defining What Are Essential Health Services	Susan King	
11:15 pm 10 min	Public Testimony	Susan King	
11:25 am 5 min	Next Steps	Susan King	
11:30 am	Adjourn	Susan King	

Draft Minutes
Oregon Health Fund Board Benefits Committee
December 11, 2007

Members Present: Susan King, RN, Chair; Gary Allen, DMD; Lisa Dodson, MD; Tom Eversole; Leda Garside, RN, BSN (arrived at 9:50 am); Betty Johnson; Bob Joondeph; Jim Lussier (by phone); Somnath Saha, MD, MPH (arrived at 9:45 am), Nina Stratton; Kathryn Weit; Kevin Wilson, ND; Susan Pozdena; Hugh Sowers Jr.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Brandon Repp; Judy Morrow; Jeanene Smith, MD, MPH; Barney Speight.

Also Attending: Mallen Kearn, Archimedes; Myra Himmelfarb, MACG; Jen Lewis, OMA; Patricia Murphy, OAA; Beryl Fletcher, ODA; Denise Honzel, OBC; Phil Donovan, American Heart Assoc.; Craig Kuhn, OPHP; Nancy Murray, League of Women Voters; Sonciray Bonnel, WPALHB; Laura Sisulak, OPCA; Kim Wirtz, Regence; Jim Stumm, Oregon Health News; David Pollack, OHSU; Dave Roberts, Lilly; Susan Baumbergen, Oregon Physical Therapy Assn.

I. Call to Order

- Ms. Susan King, RN, called the Benefits Committee meeting to order at 9:32 AM in Room 218 of the Clackamas Community College Wilsonville Training Center, Wilsonville, OR.

II. Approval of Draft Agenda and Minutes

- No revisions were made to the draft agenda.

MOTION: To accept the minutes from the November 8, 2007 meeting as submitted. MOTION CARRIES: 13-0.

III. Update on Board/Committee Activities

- Mr. Speight reported that the Oregon Health Fund Board (OHFB) will have their 4th meeting tomorrow, December 12, 2007, and noted that the Board will meet once a month through April, twice a month beginning in May, and advised members to check the website for calendar updates on committee meetings.

IV. Review of Charter/Report on Leadership Conference Call

- Mr. Darren Coffman referred members to the draft charter for review.
- Discussion centered on whether the focus of the committee should include cost-sharing considerations in addition to defining essential health services.
- Nina Stratton wondered whether the Prioritized List can be used to set essential services?

- The question was raised whether or not to look at commercial markets to define services.
- Dr. Saha believes neither the list nor the commercial approach is perfect for defining essential services, but list comes closer.
- A conference call was held in late November between committee leadership and staff. The call resulted in a plan to deal with those services that do not appear on the Prioritized List (i.e., diagnostic, ancillary, and end-of-life services).
- The question was raised whether the use of the Prioritized List should focus on the OHP Plus model or on the OHP Standard model.
- Tom Eversole advocated for establishing a set of essential services to be applicable population-wide.
- Mr. Speight: OHFB had pot of money. Essential package does not reach beyond realm of OHFB. Doesn't apply to commercial or self insured.
- Susan King believes defining subsidy levels belongs in another committee.
- Dr. Dodson thinks tasks need to be structured into manageable "chunks" to move process forward, allowing application of different types of medical costs; preventative, chronic care, palliative, acute care, etc.

MOTION: Change wording on the charter under "Scope" in the second paragraph to read "***consider*** subsidy levels and cost-sharing strategies" instead of "***examine*** subsidy levels and cost-sharing strategies" as shown in Attachment A. Motion caries: 13-0.

V. Discussion on Desired Level of Detail for Recommendations to Board

- Essential benefits should be grouped into categories (e.g., preventative, curative, palliative, etc.).
- Public health services be added as a category.
- Mr. Speight suggested broad categories of narrative description to guide actuaries when obtaining estimates of costs.
- Look different sources/studies of evidence-based outcomes in determining definition of basic benefits.
- Evidence-based guidelines could be developed to specify covered services.
- Additional topics for discussion:
  - palliative care
  - other health care considerations (e.g., health club membership)
  - potential public health strategies
- It was noted the OHFB has authority to go directly to legislative council to draft legislation for 2009 session.

VI. Next Steps

- Next meeting will be January 15, 2008.
- The time was altered to 9:00-11:30 AM to account for OHFB meeting.

- Agenda will include review of staff developed checklist of principles/ policy objectives and presentations comparing the use of the Prioritized List vs. commercial plans.
- Another meeting will be scheduled for the week of January 29, 2008, for breaking out into workgroups. An email will be sent to confirm date and time.

VII. Public Testimony

Patricia Murphy - Oregon Acupuncture Association

- Asked for clarification of "medical home" definition as opposed to term "primary care home," to which the response was they are seen as seen as synonymous.
- She also asked member physicians about patient diagnoses that are below the line and was informed that sometimes physicians treat and write off the fees, or bill the patients depending on circumstance.
- She also expressed concern that acupuncture did not seem to appear in any of the categories, and was informed that complimentary care would be discussed along with behavioral health and dental care by the full committee.

Mallan Kearn - Portland Archimedes Group

- Public wants integrated systems.
- Provide consistency through life changes.

David Pollack – OHSU

- Concerned about essential benefits differentially applied to different populations.
- Suggested looking at:
  - Extent of coverage limits
  - Extent of out-of-pocket expenditures
  - Tiering of benefits, with sections based on level of importance (e.g., use a sliding scale copay)

VIII. Adjourn

- Ms. King adjourned the meeting at 1:15 pm.

DRAFT 01/14/08 **ATTACHMENT A**

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER
Approved by OHFB on _____

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for their primary objective of defining a set(s) of essential health services the committee shall consider:

1) Mechanisms for setting priorities that optimize the health of Oregonians;
2) The applicability of the HSC Prioritized List of Health Services;
3) The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
4) Approaches that promote integrated systems of care centered on a primary care home;
5) An emphasis on preventive care and chronic disease management;
6) Education activities that further health and wellness promotion;
7) The definition and inclusion of services for dignified end-of-life care; and,
8) The needs of vulnerable populations in order to reduce health disparities.

Secondarily, the committee will consider subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages, taking into consideration:

1) Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
2) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.
3) Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
4) Methods for collecting and incorporating public values of those who will potentially benefit from/contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
5) The demographic characteristics of the uninsured (e.g., age, gender, family status, income);

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, RN, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC)	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Hugh Sowers, Jr.	Retired, AARP	McMinnville
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council on Developmental Disabilities	Salem
Kevin C. Wilson, ND	Naturopathic Physician	Hillsboro

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director, OHPR, Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research Analyst, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OHFB Benefits Committee Guiding Principles/Policy Objectives Checklist

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan.

A. Is the set of defined benefits established by this committee:

- ☐ a. essential to the public health of Oregonians? (SB329)
- ☐ b. based upon a proven benefit model? (SB329)
- ☐ c. reflective of the values of Oregonians? (OHP)
- ☐ d. easy to adjust in response to new information on cost and effectiveness? (OHP)
- ☐ e. affordable/economically sustainable? (SB329)
- ☐ f. developed in a transparent manner? (SB329, OHP)

B. Does the set of defined benefits place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care (SB329, OHP community meetings)
- ☐ b. Chronic disease management (SB329)
- ☐ c. Primary care medical homes (SB329)
- ☐ d. Dignified end-of-life care (SB329)
- ☐ e. Patient-centered care (SB329)
- ☐ f. Provision of care in the least restrictive environment (SB329)
- ☐ g. Care for infants and small children? (Public survey)

C. Does the set benefit package help promote:

- ☐ a. wellness? (SB329)
- ☐ b. patient education? (SB329)
- ☐ c. coordination of care? (SB329)
- ☐ d. population health? (SB329)
- ☐ e. cost-effective care? (SB329, HB3624 of 2003, OHP community meetings)
- ☐ f. cost-control/reductions in over-utilization? (SB329, OHP)
- ☐ g. access to early diagnosis and treatment? (Task Force on Basic Benefits)

D. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine (SB329, HB3624 of 2003)
- ☐ b. Reduction of health disparities (SB329)
- ☐ c. Personal responsibility (SB329, OHP community meetings)
- ☐ d. Incentives to encourage appropriate use of effective services

PRIORITIZED LIST – OHP PLUS

Inclusions – Condition/treatment pairings in funded region of list as defined by ICD-9-CM, CPT and HCPCS medical codes, which include:

- **Behavioral health services**
- **Dental services**
- **Vision services**
- **Complementary care**

All diagnostic services

Ancillary services for funded conditions

- **Prescription drugs only covered under formulary by MCOs**

Limitations – As established by HSC in guidelines associated with list or as determined by DMAP/MCOs.

Exclusions – Non-diagnostic condition/treatment pairings in non-funded region of list.

Method for determining exclusions based on:

Categories of care:

1) Maternity/newborn care
2) Primary/secondary prevention
3) Chronic disease mgmt.
4) Reproductive services
5) Comfort care
6) Fatal conditions where tx aimed at cure/disease modification
7) Nonfatal conditions where tx aimed at cure/disease modification
8) Self-limited conditions
9) Inconsequential care

Other considerations:

- **Treatment effectiveness**
- **Impact on healthy life years**
- **Pain and suffering**
- **Population benefits**
- **Impact on vulnerable populations**
- **Tertiary prevention**
- **Net cost of treatment**

Cost-sharing – Nominal copays ($1–3) on ambulatory services

KEY QUESTION: If the Prioritized List were used "as is" would the Committee be comfortable recommending a line defining essential health services that is significantly higher than that currently used to define benefits for OHP?

COMMERCIAL PLAN

Inclusions – All medical services/supplies subject to individual plan limitations, exclusions, and cost-sharing.

Limitations – As established by individual plan guidelines associated with specific services/equipment. The following is a non-inclusive list of limitation types:

- service/supply category or quantity
  - durable medical equipment (e.g., comfort or luxury items)
  - Rx (e.g., a 34-day supply maximum per prescription)
  - home health care (e.g., care a non-professional could provide)
- medical condition
  - mental health treatment for chronic or organic psychoses, paraphilias, and intractable personality disorders
- patient demographics
  - well-child visits (covered through age 2)
- enrollment period
- provider network
- service area
- prior authorization requirements

Exclusions – As established by individual plan guidelines associated with specific services/equipment. Dependent upon the addition of supplemental benefits, the following non-inclusive list of benefit categories may be excluded:

- non-emergent transportation
- employer or governmental required services
- health education
- infertility services
- obesity-related services
- vision services
- dental services
- complementary care
- cosmetic services
- custodial care
- prescription drugs
- investigational treatments

Method for determining exclusions:

Any services/supplies not deemed to be "medically necessary" are also excluded. "Medical necessity" is defined as the following (NOTE: This information is taken directly from the Regence BCBSO website [http://www.or.regence.com/pebb/docs/pebbMbrHandbk2007.pdf]):

Medical Necessity
Medically necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which, in our judgment, are:

- consistent with the symptoms or diagnosis and treatment of your conditions;
- appropriate with regard to standards of good medical practice;
- not primarily for your convenience or that of the provider of services or supplies; and,
- the least costly of the alternative supplies or levels of service which can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home, without harm to the patient.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.
Medically necessary care does not include care that is primarily custodial care. This is care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help in bathing, eating, dressing, or getting in or out of bed. Custodial care also includes care that is primarily for the purpose of separating a patient from others or preventing a patient from harming himself or herself.

Utilization reviews may be administered by healthcare professionals to determine whether a service/supply is to be deemed "medically necessary".

Cost-sharing – The following methods of cost-sharing are utilized, with each specific method and degree of application varying with individual plan:

- premiums
- deductibles
- copayments
- coinsurance
- out-of-pocket maximums
- lifetime benefit maximums

Prescription drugs that are covered may also be subject to cost-sharing, limitations, and exclusions based upon the use of a formulary.

KEY QUESTION: If the Prioritized List were used "as is" would the Committee be comfortable recommending a line defining essential health services that is significantly higher than that currently used to define benefits for OHP?

PRIORITIZED LIST – OHP STANDARD

Inclusions – Condition/treatment pairings in funded region of list as defined by ICD-9-CM, CPT and HCPCS medical codes that are not a part of a service category that is otherwise specifically excluded (see below).

Physical health services and behavioral health services fully integrated (Note: outpatient mental health and chemical dependency services were excluded from 3/03-7/04).

All diagnostic services

Ancillary services for funded conditions

- Prescription drugs only covered under formulary by MCOs

Limitations – As established by HSC in guidelines associated with list or as determined by DMAP/MCOs.

Exclusions – Non-diagnostic condition/treatment pairings in non-funded region of list.

Method for determining exclusions based on Prioritized List are the same as those indicated for OHP Plus.

Services specifically not funded by the legislature, including:

- Non-emergent hospitalizations
- Dental services (other than extractions)
- Vision services (for other than medical conditions)
- Non-emergent transportation
- Complementary care
- Therapies (PT, OT, Speech)

Cost-sharing – Premium share between $9 and $20 per individual.

No point-of-service cost-sharing since June 2004. Prior to that, copays included $5 for office visits, $3/$5/$10 tiering for prescription drugs, and $250 per hospital admission.

KEY QUESTION: Can the non-essential as defined by the Prioritized List be translated into an exclusion list for a commercially offered health plan?

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Regence BlueCross BlueShield of Oregon
An Independent Licensee of the Blue Cross and Blue Shield Association

PPO Plan

Effective January 1, 2007

Your **Preferred Provider Plan** provides coverage for services provided by Preferred Provider Plan Network and Non-Preferred physicians and other professional providers as listed below. For assistance in locating a **Preferred Provider Plan Network** physician or provider please refer to your provider directory or visit our Web site at **www.or.regence.com**.

Benefit Features	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit	$2,000,000	
Deductible per calendar year	None	
Maximum out-of-pocket per calendar year (covered expenses paid at 100% and copays do not accumulate toward the maximum out-of-pocket)	$1,000 Per Individual $3,000 Per Family	$2,000 Per Individual $6,000 Per Family
Preventive Care Services	**Member Responsibility**	
Immunizations all ages	0%	0%
Well-baby care	0%	30%
Routine periodic health appraisals including related lab and x-ray	0%	30%
Annual women's exam including Pap test and mammogram	$10 copay	30%
Hearing examinations (does not apply toward the maximum out-of-pocket)	15%	30%
Professional Services		
Office visits and therapeutic injections including allergy shots	15%	30%
Outpatient mental illness/chemical dependency	15%	30%
Diagnostic radiology and lab	15%	30%
Maternity care	15%	30%
Surgery	15%	30%
Chiropractic, naturopathic, and acupuncturist care (does not apply toward the maximum out-of-pocket)	30%	30%
Hospital Services		
Inpatient stay including maternity and rehabilitation	15%	30%
Inpatient and residential mental illness/chemical dependency stay	15%	30%
Outpatient surgery	15%	30%
Emergency room care for medical emergency	15%	15%
Emergency room care for non-emergency	15%	30%
Other Services		
Ambulance	15%	30%
Skilled nursing and home health care	15%	30%
Durable medical equipment and supplies	15%	30%
Rehabilitation including occupational, speech, and physical therapy	15%	30%
Infertility (does not apply toward the maximum out-of-pocket)	50%	50%

Prescription Medications (does not apply toward the maximum out-of-pocket)	**Retail (34-day supply)**	**Mail Order (90-day supply)**
Generic medications	$5	$12.50
Preferred Brand medications	$15	$37.50
Non-Preferred Brand medications	Greater of $50 or 50% (plus the difference between generic and brand for multi source brands)	Greater of $125 or 50% (plus the difference between generic and brand for multi source brands)
Diabetic supplies including insulin	0%	0%

Please see page 2 for limitations, exclusions, and the preventive care frequency schedule >

Limitations and Exclusions

Preventive Care Frequency Schedule	
Immunizations	
All ages	As indicated by provider
Well-baby care	
Newborn	Nursery care including initial exams
First two years	8 well-baby exams
Annual women's examinations	
Annual breast & pelvic	Every calendar year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every calendar year
Routine periodic health appraisals	
Age 2-18	Once every three years
Age 19-34	Once every five years
Age 35-59	Once every two years
Age 60+	Once every year
Hearing examinations	
All ages	Once every 12 months

These Pharmacy Benefits Are Limited

- Some medications may be limited by quantity rather than day supply or may require preauthorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

These Pharmacy Benefits Are Not Covered

- Non-prescription medications
- Prescription medications with no proven therapeutic indication or that are not medically necessary.
- Prescription mediation for weight loss, treatment of obesity, infertility, Impotence, or cosmetic purposes.
- Experimental or investigational medications.

These Benefits Are Limited

- We provide transplant coverage only to those who have been covered by us, or another insurer with similar transplant coverage, for a total of at least 24 months (or since birth), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's.
- Residential care for mental illness is limited to 45 days in a 12-month period.
- Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Benefits are increased to 60 days per calendar year for head and spinal cord injuries or stroke.
- Outpatient rehabilitation benefits are limited to 60 sessions per calendar year.
- Skilled Nursing Facility care is limited to 180 days per calendar year.
- Home health care is limited to 180 visits per calendar year.
- Infertility services are limited to artificial insemination, including services related to or supporting artificial insemination, when medically necessary.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months of the injury.
- Hearing aids are limited to $500 every 36 months.
- Ground ambulance is limited to 500 miles per calendar year.

Services And Supplies Not Covered

- Services provided by a member of the patient's immediate family.
- Treatment not medically necessary.
- Routine tests and screening procedures except as specifically listed.
- Eye examinations, the fitting, provision or replacement of eyeglasses and eye exercises.
- Self-help, training, and instructional programs including physical exercise programs.
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education.
- Treatment for obesity or weight control including complications arising from such treatment except as specifically listed in the contract.
- Surgery to alter the refractive character of the eye.
- Massage or massage therapy.
- Orthopedic shoes or arch supports.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Orthognathic services including surgery.
- Infertility medications, in vitro and in vivo fertilization, or GIFT and ZIFT procedures, including services related to or supporting in vitro fertilization, and reversal of sterilization procedures.
- Dental examinations, dental treatment, and orthodontic treatment except as specifically listed.
- Services or supplies for the treatment of personality and gender identity disorders.
- Custodial care.
- Developmental and learning disabilities.
- Behavior modification.
- Counseling or treatment in the absence of illness.
- Experimental or investigational services including treatments, procedures, equipment, medications, devices, and supplies.

***Please note**: This benefit summary provides a brief description of your health care plan benefits and is not a guarantee of payment. Once enrolled, your benefits booklet can be viewed online at our Web site, **www.or.regence.com**. Please refer to your benefits booklet for a complete list of benefits and the limitations and exclusions that apply.*

Toll-free, all areas 1 (800) 228-0978
TDD Line for people with hearing impairments 1 (800) 382-1003
www.or.regence.com

PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

Regence BlueCross BlueShield of Oregon

Member Handbook

for Employees & Dependents
and
Non-Medicare Eligible Retirees & Dependents

Regence BlueCross BlueShield of Oregon

Effective January 1, 2007

Oregon

John A. Kitzhaber, M.D., Governor

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TO: State Employees and Non-Medicare Eligible Retirees

FROM: Public Employees' Benefit Board (PEBB)

The benefits described on the following pages were designed to provide you and your dependents with the best possible medical care at competitive rates. In addition, this medical plan offers a variety of activities that help contain the rising cost of medical insurance.

Should you require additional information concerning this medical plan or any other topic related to your medical insurance, please contact the insurance company at (503) 220-3849 or 1-800-826-9813, or PEBB at (503) 373-1102, 1-800-788-0520 (outside Salem), or via e-mail at inquiries.pebb@state.or.us.

If more than one year has lapsed since the effective date of your member handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

INTRODUCTION

The following pages are the booklet, a written description of the terms of the group health care benefit plan that this booklet describes.

Please read this booklet as soon as you get it. It will tell you how the plans work. You'll then be able to obtain all the benefits to which you're entitled and avoid delays in processing your claims.

This booklet is designed to explain the benefits and other provisions of the plan clearly and completely. This booklet is part of the group policy between Regence BlueCross BlueShield of Oregon (an independent licensee of the Blue Cross and Blue Shield Association) and the Public Employees' Benefit Board.

Throughout this booklet, we use the term ''insured employee'' to refer to the employee or retiree. The terms ''insured dependents'' and ''family members'' are used interchangeably to refer to your spouse, domestic partner, and eligible children. The term ''you'' applies to the insured employee or retiree and insured family members unless we indicate otherwise.

A special feature of your coverage is its ''hold harmless'' clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable coinsurance or copay will continue to apply. Physicians who are not participating, however, may bill you for any balances over the maximum allowable charge.

This booklet describes benefits effective January 1, 2007, or the date after that on which your coverage became effective.

CONTENTS

DEFINITIONS

The following are definitions of some important terms used in this employee plan description. Other terms are defined where they are first used in the text.

Illness means a disease or bodily disorder.

Injury means a personal bodily injury to you or your insured dependent caused directly and independently of all other causes by external, violent, and accidental means.

Chemical dependency conditions means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Mental health conditions means Mental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this contract. Mental Disorders that accompany an excluded diagnosis are covered.

Mental health and chemical dependency services means medically necessary outpatient, residential, partial hospital or inpatient services provided by an approved licensed facility or licensed individuals who meet our credentialing requirements with the exception of skilled nursing facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health care services, and court ordered treatment (unless the treatment is determined by us to be medically necessary). Mental health and chemical dependency services do not include:

- educational programs for drinking drivers;
- voluntary mutual support groups, such as Alcoholics Anonymous; and
- family education or support groups.

Residential care is care in a licensed residential facility, hospital, or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Oregon Mental Health

Division (or the equivalent agencies, if the services are provided outside Oregon).

A preexisting condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date. Your coverage has no waiting periods or exclusions for preexisting conditions.

An emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means those services and supplies furnished by a facility to the extent they are required for the stabilization of a patient who is experiencing an emergency medical condition.

Enrollment date means, for individuals who apply during their initial period of eligibility, your or your enrolled dependent's effective date of coverage or the first day of any group eligibility waiting period applicable to you or your dependent, whichever is earlier. For all others (i.e. including those who applied as late enrollees or during a special enrollment or open enrollment period), enrollment date means the effective date of coverage.

An insured dependent or family member is an eligible dependent, spouse, or domestic partner of an insured employee or retiree whose application is accepted by Regence BlueCross BlueShield of Oregon and who is insured by this policy.

An insured employee or retiree is an employee or retiree of the group whose application is accepted by Regence BlueCross BlueShield of Oregon and who is insured by this policy.

An insured member is an insured dependent or an insured employee or retiree.

A Preferred facility is a hospital, skilled nursing facility, or special facility that has an effective Preferred Provider Plan contract with Regence BlueCross BlueShield of Oregon to provide services and supplies to the insured individuals under this policy.

Preferred professional provider means a professional provider who has an effective Preferred Provider Plan contract with Regence BlueCross

BlueShield of Oregon to provide services and supplies to the insured individuals under this policy.

Contracting agency means any of the following with whom Regence BlueCross BlueShield of Oregon has contracted to provide services and supplies to the insured individuals under this policy:

- home health care agency;
- home infusion therapy agency; and
- hospice care program.

Contracting durable medical equipment supplier means a supplier of durable medical equipment with whom we have contracted to provide services and supplies to insured individuals.

Maximum allowable charge means the contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier, or the billed amount, whichever is less.

Annual out-of-pocket maximum means the maximum dollar amount of coinsurance or copayments you could pay for eligible charges in a calendar year. The amount of the annual out-of-pocket maximum is shown in the SUMMARY OF BENEFITS.

Reasonable amount means an amount, determined by us according to: our proprietary database on medical/dental billings; or use of pharmacy or Medicare data, which is usual (not more than the provider's normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in our service area).

Health benefit plan means any hospital-medical-surgical expense policy or certificate issued by insurers including health care service contractors and health maintenance organizations, and includes any benefit plan provided by a multiple employer welfare arrangement or by another benefit arrangement, as defined in the federal Employee Retirement Income Security Act of 1974 as amended (ERISA).

You or your means the insured employee, retiree, or dependent.

A special feature of your coverage is its ‘‘hold harmless’’ clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable coinsurance will continue to apply. Physicians who are not participating, however, may bill you for any balances over the maximum allowable charge.

ELIGIBLE CHARGES

Subject to the terms of this policy, eligible charges means the following when incurred for the services and supplies (including medications) listed in the following sections and when medically necessary for diagnosis and/or treatment of an illness or injury:

- the contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier;

- the reasonable charge for listed services and supplies provided by a nonparticipating facility;

- the billed amount for listed services received from a nonparticipating professional provider, or the contracted amount for a participating professional provider for the same service, whichever is less;

- the billed amount for listed services and supplies provided by an agency other than a contracting agency for home health care, home infusion therapy, or palliative hospice care or the contracted amount for a contracting agency for the same service or supply, whichever is less;

- the billed amount for listed services and supplies provided by a durable medical equipment supplier that is not a contracting durable medical equipment supplier or the contracted amount for a contracting durable medical equipment supplier for the same service or supply, whichever is less;

- the billed amount for listed services and supplies, or the contracted amount that would have been paid to a participating professional provider for the same service or supply, whichever is less, rendered by a nonparticipating professional provider located in any of the following counties in the state of Oregon: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler.

- the reasonable amount for services and supplies provided by all other categories of providers that are neither participating nor nonparticipating (ambulance providers and non-DME suppliers for example).

For emergency services only (excluding ambulance transportation), we pay a nonpreferred professional provider the same percentage of

benefits as we would have paid a preferred professional provider for a similar service.

In addition, if your or your insured dependent's medical condition necessitates emergency services at a nonpreferred facility, we pay the same percentage of benefits we would have paid for a similar service or supply at a preferred facility. However, after receiving covered emergency services at a nonpreferred facility, we can require you to transfer to a preferred facility as soon as your medical condition safely permits. Payment for eligible charges for a nonpreferred facility for care beyond the date we reasonably determine you can be safely transferred will revert back to the percentage payable for a nonpreferred facility.

Preferred and participating providers will not charge you or your insured dependents for any balances beyond any coinsurance amount for eligible charges. Facilities and professional providers that do not have a preferred or participating contract with us, however, may bill you for any balances over the maximum allowable charge in addition to any coinsurance amount.

Example Of How Benefits Are Paid - Nonparticipating Professional Provider

Nonparticipating professional provider's charge for a service:	$50.00
Amount allowed to a participating professional provider for the same service (the contracted amount):	$45.00
Amount considered an eligible charge for the nonparticipating professional provider's charge would be: (nonparticipating professional provider's charge, not to exceed a participating professional provider's contracted amount for the same service)	$45.00

How That Eligible Charge Would Be Paid

Policy coinsurance: (our responsibility is 70%, your responsibility is 30%)	70%
Amount we would pay to the nonparticipating professional provider:	$31.50
Amount you would pay to the nonparticipating professional provider:	$18.50
Total	$50.00

Difference Between Participating And Nonparticipating Professional Provider Payment

If the $50 charge had been for a visit to a participating professional provider, our payment to that provider would have been: (70% of the contracted amount)	$31.50

Your responsibility would have been: $13.50

The above is only an example. It assumes that you or your insured dependent has not met the annual out-of-pocket maximum amount. Not all eligible charges are subject to the annual out-of-pocket maximum. The actual benefits of the plan may vary. Read the SUMMARY OF BENEFITS thoroughly to determine how your benefits under the plan are paid.

Medical Necessity

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which, in our judgment, are:

- consistent with the symptoms or diagnosis and treatment of your conditions;
- appropriate with regard to standards of good medical practice;
- not primarily for your convenience or that of the provider of services or supplies; and
- the least costly of the alternative supplies or levels of service which can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home, without harm to the patient.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

Medically necessary care does not include care that is primarily custodial care. This is care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help in bathing, eating, dressing, or getting in or out of bed. Custodial care also includes care that is primarily for the purpose of separating a patient from others or preventing a patient from harming himself or herself.

Participating Providers

The important difference between the benefits for participating and preferred professional providers and nonparticipating and nonpreferred professional providers is the balance you may be required to pay. Participating and preferred professional providers will not charge you or your dependents any balances for eligible charges over any applicable coinsurance amount required under your plan. Nonparticipating and

nonpreferred providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

Ask your professional provider if he or she is a participating or preferred Regence BlueCross BlueShield of Oregon provider. You can also get a list of participating and preferred professional providers from any Regence BlueCross BlueShield of Oregon office or the PEBB office, or access on-line via the PEBB website.

IMPORTANT NOTE: It is extremely important to use participating and preferred facilities and participating and preferred professional providers in order to receive the maximum benefits available under this plan.

Preauthorization

Preauthorization is a tool we use to find the most appropriate and cost-effective level of medical care for our members. Many types of treatment may be available for certain conditions; the preauthorization process helps your physician work together with you or your insured dependent, other providers, and Regence BlueCross BlueShield of Oregon to determine the treatment that best meets your or your insured dependent's medical needs. This teamwork helps save thousands of dollars in premiums each year, which translates into savings for you.

Preauthorization refers to the process by which we determine that a proposed service or supply (including medications) is medically necessary and provide approval for it before it is rendered.

What Needs To Be Preauthorized
Some services and supplies (as may be described in this benefits booklet) must be preauthorized before we will consider paying the claim. These services and supplies are listed on our Focused Notification List which we give to our providers twice a year. Note that we do not preauthorize services or supplies which are not included on our Focused Notification List.

Preauthorization By Contracting Providers -- Providers that have contracted with us know how the preauthorization process works and will normally request preauthorization, if necessary, for your or your insured dependent's proposed service or supply.

Preauthorization By Noncontracting Providers -- Your or your insured dependent's provider knows how this process works and will normally request preauthorization, if necessary, for your or your insured dependent's proposed service or supply. However, if you or your insured dependent receives care from a provider with whom we have not contracted, you or your insured dependent may be liable for charges we deny because the service or supply is not medically necessary. Avoid that risk by asking your or your insured dependent's provider to contact

our Preauthorization Department. Please note that for treatment of chemical dependency conditions and/or mental health conditions, providers with whom we have not contracted are bound by law to follow our preauthorization requirements the same as providers with whom we have contracted.

Preauthorization Process

When we receive a preauthorization request from you or your insured dependent, or your or your insured dependent's provider, we will notify you or the provider of our decision within 15 days of our receipt of the preauthorization request. However, this 15-day period may be extended an additional 15 days in the following situations:

- When we cannot reach a decision due to circumstances beyond our control, we will notify you or the provider within the initial 15-day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to reach a decision.

- When we cannot reach a decision due to lack of information, we will notify you or the provider within the initial 15-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You or your provider must provide us with the requested information within 45 days of receiving the request for additional information. Once we receive the needed information, we will notify you of our decision within 48 hours after you supplied it to us or at the end of the period we allowed you to supply the needed information to us.

Our Preauthorization Department may be reached by phone or mail at:

Mail: Regence BCBSO Preauthorization Department
PO Box 1271, E-9B
Portland, OR 97201-1271

Telephone: Portland area: (503) 525-6593
Toll-free: 1-800-824-8563

To preauthorize care for transplants:

Mail: PO Box 1271, E-9B
Portland, OR 97207-1271

Telephone: Portland: (503) 226-8783
Toll-free: 1-800-560-0749
Fax: (503) 226-8754

If we approve a preauthorization request from a provider, we are bound to cover the authorized service or supply as follows:

If your or your insured dependent's coverage terminates within five business days of the preauthorization date, we will cover the preauthorized service or supply if the service or supply is actually incurred within those five business days regardless of the termination date unless we are aware the coverage is about to terminate and we disclose this information in our written preauthorization. In that case, we will only cover the preauthorized service or supply if incurred prior to termination.

If your or your insured dependent's coverage terminates later than five business days after the preauthorization date, but before the end of 30 calendar days, no services incurred after termination will be covered even if preauthorized.

If coverage remains in effect for at least 30 calendar days after the preauthorization, we will cover the preauthorized service or supply if incurred within the 30 calendar days.

When counting the days described above, day one will begin on the calendar or business day after we preauthorize the service or supply.

Comprehensive Case Management

Comprehensive case management is a program administered by us which is designed to provide early detection and intervention in cases of serious illness or injury with the potential for major continuing claims expense. We will, at our sole discretion, identify appropriate cases, evaluate recommended treatment plans, and propose alternative benefits.

Alternative benefits means payment for services or supplies which are not otherwise benefits of the contract, but which we believe to be medically necessary and cost effective. We will not cover alternative benefits until we have determined, at our sole discretion, to do so, and have received agreement in writing on the specific terms and conditions for payment signed by an enrollee or an enrollee's legal representative. The fact that we pay alternative benefits for an enrollee shall not obligate us to pay such benefits for other enrollees, nor shall it obligate us to pay continued or additional alternative benefits for the same enrollee. Benefits for alternative benefits are covered expenses for all purposes under this contract.

Medical Bill Audit

Enrollment in one of the Regence BlueCross BlueShield of Oregon (Regence BCBSO) plans makes you eligible for a medical bill audit incentive. If you find an overcharge on your medical bill and convince the hospital or medical provider to correct it, you will be rewarded with up to 50 percent of the amount of the error. There is a minimum reward of $25

(error of $50) and a maximum reward of $100 (error of $200 or greater). To collect your reward, you must submit copies of the following: 1) original bill showing error, 2) your Regence BCBSO Claims Processing Report, and 3) a completed PEBB Medical Bill Audit Claim Form (including the hospital or medical provider's acknowledgment of the error). Submit your claim(s) to the Public Employees' Benefit Board, 775 Court Street NE, Salem, OR 97301. Claim forms may be obtained by calling PEBB at (503) 373-1102 or 1-800-788-0520 (outside Salem). This program may be changed or discontinued without notice.

Coverage Outside The United States

Regence BlueCross BlueShield of Oregon provides coverage for medically necessary health care services received outside the United States. You may be required to pay for services when they are performed. It is important that you obtain the most itemized billing possible, and ask to have bills written in a foreign language translated into English. If this is not possible, the bills will be translated by Regence BlueCross BlueShield of Oregon. Reimbursement for services received in a foreign country is based on the rate of exchange in effect on the date the service was provided.

Once you have returned to the United States, forward these bills to our office and include your group and identification numbers. Claims for all types of health care services must be submitted within one year of the date of service.

Out-Of-Area Claims Service - BlueCard Program

All Blue Cross and Blue Shield licensees ("Plans") participate in the BlueCard Program. This Program benefits insured individuals who incur eligible charges outside our service area. Not all claims incurred outside of our service area, dental claims for example, are processed through the BlueCard Program.

Under BlueCard, when you or an insured dependent incurs eligible charges within the geographic area served by another BlueCross and/or BlueShield Plan, we will remain responsible for meeting our obligations under the policy. The local Blue Plan will only be responsible for providing such services as contracting with its participating providers and handling the interaction with those providers according to BlueCard policies.

When you or an insured dependent receives covered health care services outside our service area from a provider who has a participating contract with the local Blue Cross and/or Blue Shield Plan and the claim is processed through BlueCard, the amount you pay for eligible charges is usually calculated on the lower of:

- the actual billed charges; or

- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this “negotiated price” will consist of a simple discount. But, sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, or other nonclaims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your liability for eligible charges that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, we would then calculate your liability for any covered health care services using the methods outlined by the applicable state statute in effect at the time you or your insured dependent received care.

Emergency Care

You and your insured dependents are covered for emergency medical screening exam expenses (see DEFINITIONS Section) under the various sections of this policy without preauthorization.

Should you or your insured dependent experience an emergency medical condition, you or your insured dependent should seek medical attention from the nearest appropriate facility (physician's office, clinic setting, urgency care center, or hospital emergency room), or call 911.

SUMMARY OF BENEFITS

This section is a summary of the benefits of the plan. It states at what percentages eligible charges are paid and describes any annual out-of-pocket maximum amounts. It also states benefit maximums applicable to the coverage. You may also be responsible for payment of part of the premium for coverage under the plan. Check with your plan administrator for information on any required premium contribution. The sections following this SUMMARY OF BENEFITS spell out the benefits and the conditions, limitations, and exclusions of the plan in detail.

We have contracted with professional providers and facilities to provide services and supplies to insured employees and their insured family members under this plan. Your provider directory lists which panel of providers applies to your benefits under the plan. This listing of participating providers is available to you, at no cost, upon enrollment or at any other time from your plan administrator or from us on our website at www.or.regence.com or through our Customer Service Department.

PPO Plan

This plan includes a percentage coinsurance amount each time you receive a covered service. Active full and part-time employees, retirees, insured family members, COBRA participants and self pay individuals may be enrolled in this plan.

PPO Part-Time And Retiree Plan

This plan includes a percentage coinsurance amount each time you receive a covered service. Part-time employees receiving less than a full time state contribution, retirees, and their insured family members may be enrolled in this plan.

Eligible Charges

All services must be medically necessary and all payments are based on eligible charges for such services and supplies (see definition on page 4).

Eligible Charges - Designated Rural Counties

For insured employees and their insured family members residing and receiving care in designated rural counties, claims for eligible charges will be processed at the preferred level of benefits, regardless of whether the provider rendering the service or supply is a preferred, nonpreferred or nonparticipating provider. In order for this benefit to apply, you must reside in one of the following counties in the state of Oregon: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler. All services must be medically

necessary and all payments are based on eligible charges for such services and supplies (see definition on page 4).

HOW BENEFITS ARE PAID

PPO Plan Out-of-Pocket Maximum

Preferred Provider (including Rural County Residents)

- 85 percent of eligible expenses until $1,000 out-of-pocket per person/$3,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $1,000 out-of-pocket per person/$3,000 out-of-pocket per family has been incurred each calendar year.*

Nonpreferred Provider

- 70 percent of eligible expenses until $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

*Not all expenses accrue to the annual out-of-pocket maximum amount. Expenses that do not accrue to the annual out-of-pocket maximum may include, but are not limited to, the following:

- prescription medication copayments or coinsurance;

- alternative care coinsurance;

- VSP vision examination copayments or any amounts over $160 for eyewear for the PPO Plan;

- any coinsurance for hearing examinations or amounts over $500 for hearing aids;

- coinsurance amounts for infertility services; and

- any amounts over the maximum allowable charge when a nonparticipating professional provider's services are used.

PPO Part-Time And Retiree Plan Out-of-Pocket Maximum

Preferred Provider (including Rural County Residents)

- 50 percent of the first $1,000 of eligible expenses per person/$3,000 per family each calendar year.*

- 80 percent of eligible expenses until a $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

Nonpreferred Provider

- 50 percent of eligible expenses until $4,000 out-of-pocket per person/$12,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $4,000 out-of-pocket per person/$12,000 out-of-pocket per family has been incurred each calendar year.*

*Not all expenses accrue to the annual out-of-pocket maximum amount. Expenses that do not accrue to the annual out-of-pocket maximum may include, but are not limited to, the following:

- prescription medication copayments or coinsurance (the Prescription Medication Program has its own $1,000 annual out-of-pocket maximum amount);

- alternative care coinsurance;

- any coinsurance for hearing examinations or amounts over $500 for hearing aids;

- coinsurance amounts for infertility services; and

- any amounts over the maximum allowable charge when a nonparticipating professional provider's services are used.

Copayment/Coinsurance

This is the amount you must pay for services received as described in the SUMMARY OF BENEFITS. Copayment is a flat dollar amount. Coinsurance is a percentage of eligible charges.

Maximum Lifetime Benefit

The maximum lifetime benefit is $2,000,000 per covered member.

How Long Coverage Lasts

Each person’s coverage lasts until your group’s agreement with Regence BlueCross BlueShield of Oregon ends, or until the $2,000,000 lifetime maximum of benefits is used up, whichever comes first.

Restoration Of Benefits

If you or one of your insured dependents receives medical benefits under this policy, the amount of those benefits up to $25,000 will be restored each January 1 to your or your insured dependent's maximum lifetime benefit.

Stop-Loss And Out-Of-Pocket Maximum Renewal

Stop-loss and out-of-pocket maximum provisions are calculated on a calendar year basis (January 1 to December 31). This policy also renews each calendar year, therefore stop-loss and out-of-pocket maximums renew each January 1.

BENEFITS FOR PPO PLAN

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Hospital inpatient care	15% of semi-private room rate for unlimited days	30% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	15% of semi-private room rate for up to 180 days per calendar year	30% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	15%	30%
Other hospital charges	15%	30%
Hospitalization for rehabilitation	30 days per calendar year at 15%	30 days per calendar year at 30%
Hospital outpatient care	15%	30%
Care in outpatient birthing center	15%	30%
Hospital emergency room**	15%	30%
Outpatient rehabilitation (refer to page 30 for limitations on this benefit)	15% (60 visits maximum per calendar year)	30% (60 visits maximum per calendar year)
Surgeon	15%	30%
Assistant surgeon	15%	30%
Anesthesiologist	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits (excluding ambulance transportation) will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition. See page 1.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Surgical supplies	15%	30%
Preadmission testing	15%	30%
Physician visits in hospital, home, or office for illness or injury	15%	30%
Maternity care professional services	15%	30%
Contraceptive services	15%	30%
Well-baby care	0% (see page 33)	30% (see page 33)
Immunizations	0% (see page 34)	0% (see page 34)
Durable medical equipment (we cover medically necessary durable medical equipment and supplies which relate directly to the treatment of an illness or injury)	15% (see page 40)	30% (see page 40)
Therapeutic injections	15%	30%
Annual women's examinations	$10 per visit (see page 34)	30% (see page 34)
Routine periodic health appraisals**	0% (see page 33 for frequency schedule)	30% (see page 33 for frequency schedule)

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 33.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals**	0%	30%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	15%	30%
Pap smears and mammograms	0%	30%
Scan and interpretation fee for Magnetic Resonance Imaging Services	15% (see page 35)	30% (see page 35)
X-ray, radioisotopic, and radium therapy	15%	30%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 33.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Palliative hospice care	0%	0%
Home infusion therapy	15%	30%
Treatment of mental illness		
- Inpatient	15% (see page 35)	30% (see page 35)
- Residential	15% (see page 35)	30% (see page 35)
- Outpatient	15% (see page 35)	30% (see page 35)
Treatment of alcohol and medication abuse		
- Inpatient	15% (see page 35)	30% (see page 35)
- Residential	15% (see page 35)	30% (see page 35)
- Outpatient	15% (see page 35)	30% (see page 35)
Hearing examination	15% every 12 months (see page 35)	30% every 12 months (see page 35)
Hearing aid	Any amount above the $500 maximum allowance every 36 months (see page 35)	Any amount above the $500 maximum allowance every 36 months (see page 35)
Ambulance service to the nearest hospital (up to 500 miles per calendar year) **	15% (see page 36)	30% (see page 36)
Blood or blood plasma	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

**Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

Benefits for PPO Plan *(continued)*

OTHER COVERED EXPENSES	Amount You Pay Based On Eligible Charges
Vision care Vision services are provided through Vision Service Plan (VSP).	Not Covered
Chiropractic care* Naturopathic care* Acupuncturist care*	30% 30% 30%
Prescription medications (see page 67) NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	Pharmacy (34-day supply) $5 generic $15 preferred Greater of $50 or 50% nonpreferred (plus difference between generic and brand for multisource brands Mail Order (90-day supply) $12.50 generic $37.50 preferred Greater of $125 or 50% nonpreferred (plus difference between generic and brand for multisource brands
Surgical treatment of morbid obesity	Subject to plan limitations (see page 44)

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

BENEFITS FOR PPO PART-TIME AND RETIREE PLAN

THIS PLAN PAYS 50 PERCENT OF THE FIRST $1,000 OF ELIGIBLE EXPENSES INCURRED FROM PREFERRED AND NONPREFERRED PROVIDERS PER PERSON/$3,000 PER FAMILY EACH CALENDAR YEAR. BENEFITS ARE THEN PAID AS INDICATED IN THE FOLLOWING SUMMARY:

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Hospital inpatient care	20% of semi-private room rate for unlimited days	50% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	20% of semi-private room rate for up to 180 days per calendar year	50% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	20%	50%
Other hospital charges	20%	50%
Hospitalization for rehabilitation	30 days per calendar year at 20%	30 days per calendar year at 50%
Hospital outpatient care	20%	50%
Care in outpatient birthing center	20%	50%
Hospital emergency room**	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits (excluding ambulance transportation) will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition. See page 1.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Outpatient rehabilitation (refer to page 30 for limitations on this benefit)	20% (60 visits maximum per calendar year)	50% (60 visits maximum per calendar year)
Surgeon	20%	50%
Assistant surgeon	20%	50%
Anesthesiologist	20%	50%
Surgical supplies	20%	50%
Preadmission testing	20%	50%
Physician visits in hospital, home, or office for illness or injury	20%	50%
Maternity care professional services	20%	50%
Contraceptive services	20%	50%
Well-baby care	0% (see page 33)**	50% (see page 33)
Immunizations	0% (see page 34)**	50% (see page 34)

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of $1,000 requirement when services are rendered by preferred professional providers.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Durable medical equipment (we cover medically necessary durable medical equipment and supplies which relate directly to the treatment of an illness or injury)	20% (see page 40)	50% (see page 40)
Therapeutic injections	20%	50%
Annual women's examinations	$10 per visit (see page 34)**	50% (see page 34)
Routine periodic health appraisals***	0% (see page 33 for frequency schedule)**	50% (see page 33 for frequency schedule)
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals***	0%**	50%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	20%	50%
Pap smears and mammograms	0%**	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of $1,000 requirement when services are rendered by preferred professional providers.

*** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 33.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Scan and interpretation fee for Magnetic Resonance Imaging Services	20% (see page 35)	50% (see page 35)
X-ray, radioisotopic, and radium therapy	20%	50%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	20%	50%
Palliative hospice care	0%	0%
Home infusion therapy	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Treatment of mental illness		
- Inpatient	20% (see page 35)	50% (see page 35)
- Residential	20% (see page 35)	50% (see page 35)
- Outpatient	20% (see page 35)	50% (see page 35)
Treatment of alcohol and medication abuse		
- Inpatient	20% (see page 35)	50% (see page 35)
- Residential	20% (see page 35)	50% (see page 35)
- Outpatient	20% (see page 35)	50% (see page 35)
Hearing examination	20% every 12 months (see page 35)	50% every 12 months (see page 35)
Hearing aid	Any amount above the $500 maximum allowance every 36 months (see page 35)	Any amount above the $500 maximum allowance every 36 months (see page 35)
Ambulance service to the nearest hospital (up to 500 miles per calendar year)**	20% (see page 36)	50% (see page 36)
Blood or blood plasma	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

OTHER COVERED EXPENSES	Amount You Pay Based On Eligible Charges
Vision care	Not Covered
Chiropractor care*	50%
Naturopathic care*	50%
Acupuncturist care*	50%
Prescription medications (see page 67) NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	Pharmacy (34-day supply) $10 generic 20% preferred Greater of $50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands) Mail Order (90-day supply) $25 generic $62.50 preferred $125 nonpreferred (plus difference between generic and brand for multi-source brands)
Surgical treatment of morbid obesity	Subject to plan limitations (see page 44)

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

WHAT KINDS OF SERVICES AND SUPPLIES ARE COVERED

NOTE: Throughout this section, the term ‘‘physician’’ means:

- doctor of medicine or osteopathy;
- podiatrist;
- a dentist (doctor of medical dentistry or doctor of dental surgery, or a denturist), but only for treatment of accidental injuries as described under the Special Dental Care benefit;
- psychologist;
- nurse practitioner;
- direct entry midwives;
- Christian Science practitioner;
- licensed counselor;
- acupuncturist*;
- naturopath*;
- chiropractor*;
- registered physical, occupational, speech, or audiological therapist;
- registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services which nurses customarily bill patients;
- licensed professional counselor and licensed marriage and family therapist;
- audiologists; and
- licensed clinical social worker.

* Eligible charges for services of an acupuncturist, a naturopath, and/or a chiropractor will be paid as shown in the SUMMARY OF BENEFITS, subject to plan exclusions listed in the GENERAL EXCLUSIONS Section.

The patient must personally see the provider for the billed services in order for us to pay benefits. Each of these providers must act within the scope of a valid license.

The term ‘‘professional provider’’ does not include any other class of provider not named previously, and no benefit of the policy will be paid for their services.

The Free & Clear® Quit For Life™ Program, Special Beginnings®, CareEnhance®, AdviCare[SM], and Regence Health Coach programs are covered benefits during the term of this Agreement for Regence members.

Care When You Are Admitted To A Hospital Or Skilled Nursing Facility

If a physician orders you admitted to a hospital or skilled nursing facility, we will pay a percentage of the eligible charge based on the daily semi-private room charge.

The semi-private room charge normally includes the cost of meals and general nursing care. We'll also pay the percentage shown in the SUMMARY OF BENEFITS for most other hospital services and supplies that are necessary for treatment and ordinarily furnished by the hospital. If your physician orders you hospitalized in an isolation area or intensive care unit, we'll pay the percentage of the charge listed in the SUMMARY OF BENEFITS.

Please note, skilled nursing facility admissions are limited to a maximum of 180 days per admission.

Rehabilitative Hospital Care

Eligible charges are limited to 30 days of rehabilitative care each calendar year for an inpatient stay in a hospital that has a specialized department for providing such care. However, for treatment required following head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. These benefits will continue only as long as you or your insured dependent requires the full rehabilitative team approach and services can only be provided on an inpatient basis. In order to be an eligible charge, rehabilitative services must be part of a physician's formal written program to improve and restore lost function following illness or injury. The services must be consistent with the condition that is being treated. We will cover neurodevelopmental therapy for children age six years and under when such services are for maintenance of a child whose condition would otherwise deteriorate without the service.

Newborn Nursery Care

We cover routine nursery care of a well-newborn infant under the newborn's own coverage. However, this benefit does not cover professional provider charges for well-baby care except as may be specifically provided elsewhere in the contract, nor does it cover pediatric standby charges for vaginal delivery.

Please Note: Benefits for the covered expenses of an ill or injured newborn are paid under the other provisions of this contract.

If Benefits Under This Contract Change
If benefits under this contract change while you or an enrolled dependent is in the hospital, covered expenses will be based on the benefits in effect when the stay began. The same rule applies to stays in other kinds of medical facilities.

Care In A Special Facility

Your inpatient hospital benefit can be used for services provided in an approved non-hospital facility that offers specialized care, such as a birthing center. We pay benefits for eligible charges in these facilities as an alternative to your inpatient hospital benefit.

Your Benefits Won't Change While You Are Hospitalized

If your plan's benefits change while you are in the hospital, we'll cover your entire hospital stay at the level of benefit that was in effect when you were admitted. The same rule applies to stays in other kinds of medical facilities.

Hospital Outpatient Care (Other Than Emergency Room)

We will pay eligible charges as listed in the SUMMARY OF BENEFITS for eligible services and supplies you receive in the outpatient department. Examples include:

- surgery; and
- x-ray, radium, and radioisotope therapy.

Outpatient Rehabilitation

We cover up to 60 sessions each calendar year for rehabilitative services provided by a professional provider to a patient who is not confined to a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Rehabilitative services also include neurodevelopmental therapy for children age six and under when such

services are for maintenance of a child whose condition would otherwise significantly deteriorate without the service. In order for us to cover any therapy, it must be part of a written plan of treatment prescribed by a physician.

Eligible charges do not include more than one session of any one kind of rehabilitation on one day. Nor do they include rehabilitative care provided in the patient's home and covered under the Home Health Care benefit, recreational or educational therapy, self-help or training, or treatment of psychotic or psychoneurotic conditions.

Physician Bills For Surgery

The surgery benefit applies to the physician's fee for operations as well as for treatment of dislocations and fractures.

Eligible charges for surgery (operative and cutting procedures), including treatment of fractures, dislocations, and burns are covered as follows:

- the primary surgeon;
- the assistant surgeon;
- the anesthesiologist or certified anesthetist;
- surgical supplies, such as sutures and sterile set-ups, when surgery is performed in the physician's office; and
- colonoscopy, sigmoidoscopy, and barium enemas.

When more than one surgical procedure is performed through the same incision during a single operative session, benefits will be payable on only the major procedure.

For bilateral procedures or procedures performed through different incisions in a single operative session, we will pay as follows:

- for the first procedure, the covered expense will be paid as stated in the SUMMARY OF BENEFITS;
- for the second procedure, the covered expense will be reduced by 50 percent and the remainder paid as stated in the SUMMARY OF BENEFITS; and
- for any subsequent procedures, the covered expense will be reduced by 75 percent and the remainder paid as stated in the SUMMARY OF BENEFITS.

Assistant Surgeon

Your coverage will pay eligible charges shown in the SUMMARY OF BENEFITS for the services of an assistant surgeon.

Anesthesiologist

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for the services of a professional anesthesiologist.

Surgical Supplies

Your plan pays eligible charges as shown in the SUMMARY OF BENEFITS for surgical supplies, such as suture kits and sterile setups.

Physician Visits In The Hospital

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for visits by your physician during your hospital or skilled nursing facility stay unless you are recuperating from surgery. If that is the case, your doctor's visits will probably be included in his or her surgical fee. Visits by a consulting specialist will be paid for eligible charges as shown in the SUMMARY OF BENEFITS.

Physicians' Home And Office Visits

Your coverage provides benefits for physicians' home and office visits for eligible charges shown in the SUMMARY OF BENEFITS.

Therapeutic Injections

We cover therapeutic injections, such as allergy shots, when given in a professional provider's office, except when comparable results can be obtained safely with home self-care or through oral use of a prescription medication.

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Covered expenses under this therapeutic injection benefit apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the other provisions of the policy, subject to any deductible and/or coinsurance.

Acupuncture, Chiropractic, And Naturopathic Care

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for services within the scope of the

provider's license. Eligible providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists.

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Coinsurance amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Exclusions
Nutritional supplements are not covered (see Vitamins And Fluoride exclusion in the GENERAL EXCLUSIONS Section). Procedures and tests that are not medically necessary and/or are investigational are not covered (see Experimental Or Investigational Services provision of the GENERAL EXCLUSIONS Section). Diagnoses which are considered plan exclusions (see GENERAL EXCLUSIONS Section) such as obesity, smoking cessation, are ineligible for coverage.

Preventive Care Benefits

Preventive care benefits are provided under four categories: periodic screening, well-baby care, routine periodic health appraisals, and immunizations. The benefit we pay is based upon the diagnosis that the doctor puts on your bill. If the diagnosis shows that the purpose of your care was preventive, then this benefit will be applied instead of any other benefit. If the diagnosis shows that care was for treatment of an illness or injury, regular policy benefits will be applied instead of preventive care benefits. If a claim has two diagnoses, we will pay claims on the diagnosis that will give you the higher benefit. However, we will pay benefits based on one diagnosis only.

Well-Baby Care Including Periodic Screening
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals and periodic screening of your insured dependent children under two years of age. **For insured dependents two years of age and over, see Routine Periodic Health Appraisals information**.

We will pay for standard hospital exams at birth plus eight well-baby visits the first two years of life. Examinations include related laboratory tests and x-ray examinations.

Routine Periodic Health Appraisals
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals based on the schedule that follows:

Age 2 - 18	Once every three years
Age 19 - 34	Once every five years
Age 35 - 59	Once every two years

Age 60 and over	Once every year

Routine periodic health appraisals include routine physical examinations, physical examinations required for school and/or to participate in athletics according to the schedule noted above, physician charges, and related laboratory and x-ray tests (handling fees are not covered).

Included in the above examinations are prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test for men age 50 or older, or as determined by the treating physician for men of any age who are at high risk for prostate cancer.

Commercial Driver's License Examinations
Employment related Commercial Driver's License (CDL) examinations for the insured state employee only are covered under this routine periodic health appraisal provision. This benefit includes the urinalysis required with the initial examination, but does not include additional urinalysis testing that may be required by the employer.

Annual Women's Examinations
Annual women's breast, pelvic, and Pap smear examinations are covered once every calendar year. However, more frequent examinations will be covered if medically necessary and recommended by the woman's health care provider. By breast examination, we mean a complete and thorough exam of the breast for women age 18 or older, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Except for Pap smears and mammograms, which are paid according to this Annual Women's Examinations benefit, any covered expenses for laboratory and x-ray procedures that accompany the examination will be covered according to the Diagnostic X-Rays And Laboratory Services provision. Note that routine mammographic breast screening will be covered according to the following schedule:

- Age 35 - 40, one mammogram in that period; and
- Age 40 and above, one mammogram per calendar year.

More frequent mammograms will be covered if medically necessary and recommended by the woman's health care provider.

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Immunizations
We will pay as listed in the SUMMARY OF BENEFITS for immunizations and inoculations regardless of your or your insured dependent's age. Immunizations for purposes of travel are eligible.

Hearing Examinations And Hearing Aids
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for one hearing examination every 12 months. We will also allow for the purchase of hearing aids once every 36 months up to a maximum of $500.

Exclusions
Routine examinations and immunizations for the purpose of employment, insurance, or licensing are not covered except CDL coverage as described above.

Mental Health And Chemical Dependency Services

We will cover mental health and chemical dependency services under the various sections of the contract the same as illness. Covered expenses for residential care for treatment of mental health conditions, however, is limited for you and for each of your enrolled dependents to 45 days per calendar year.

Women's Health And Cancer Rights

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, we will provide coverage for:

reconstruction of the breast on which the mastectomy was performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., coinsurance, and annual out-of-pocket maximums).

Diagnostic X-Rays And Laboratory Tests

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for diagnostic x-rays and laboratory tests ordered by a physician. The x-rays or tests must be related to the treatment of an illness or injury, except that we will pay the laboratory charges for administration of the following diagnostic tests when ordered by a physician:

- Pap smears*;

- mammograms*; and
- hemocult

* Eligible charges for Pap smears and mammograms are paid at the percentage shown in the SUMMARY OF BENEFITS.

Preadmission testing performed on an outpatient basis is covered in full.

Magnetic Resonance Imaging (MRI) is an imaging device used as a diagnostic tool for certain internal conditions. Benefits for the eligible charges of this service will be provided just as if this policy had no Preferred provider provision unless the facility or professional provider rendering the service has a special Preferred MRI contract with us. In that case, benefits will be paid at the Preferred provider level.

X-Ray, Radium, And Radioisotope Therapy

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for x-ray, radium, and radioisotope therapy. Eligible charges for these therapies other than for professional services are also covered under the hospital outpatient benefit of this plan.

Ambulance Benefits

Your coverage pays eligible charges based on community standards as determined by Regence BlueCross BlueShield of Oregon for local ground transportation by state certified ambulance up to 500 miles per calendar year. This is for transportation to the nearest hospital that has facilities to give the necessary treatment. Certified air ambulance transportation will be covered if it is medically necessary, based on usual and customary or reasonable charges. Emergency benefits, excluding ambulance transportation, will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition (see page 1).

We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Infertility Services

Covered infertility services will be limited to artificial insemination, including services related to or supporting artificial insemination, when medically necessary, subject to a 50 percent coinsurance. Infertility medications, in vitro and in vivo fertilization, including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures we determine to be experimental or investigational in nature will not be covered.

Coinsurance amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Outpatient Diabetic Instruction

(This benefit is not subject to any copayment or coinsurance provisions of the policy.)

Services and supplies used in outpatient diabetes self-management programs as described here are covered under this policy when they are provided by a health care professional or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes. For the purposes of this benefit, a health care professional means a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with demonstrated expertise in diabetes. We will waive any required copayment and pay 100 percent of the billed charges for one outpatient diabetes self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medications, supplies, and equipment not included in the charge for the outpatient diabetes self-management program are covered elsewhere under the policy.

The benefits paid for diabetic instruction under this policy do not apply to the annual out-of-pocket maximum.

Maternity Benefit

We will pay eligible charges shown in the SUMMARY OF BENEFITS for maternity care.

To the extent this policy provides coverage for maternity care, we will not limit benefits for the mother and her newborn's length of inpatient stay (beginning with the time of admission) to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. Such hospitalization does not need to be preauthorized.

Contraceptive Services

Eligible charges for certain professional provider contraceptive services are covered, including but not limited to vasectomy, tubal ligation, and insertion of IUD or Norplant (the actual prescription contraceptive may be covered elsewhere under the policy).

Home Health Care

Home health care services and supplies as described in this section when provided by a home health care agency for a patient who is

homebound. By ‘‘homebound’’ we mean that the condition of the patient is such that there exists a general inability to leave home. If the patient does leave home, the absences must be infrequent, of short duration and mainly for receiving medical treatment. A home health care agency is a licensed public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in the patient’s home.

We will cover up to 180 intermittent medically necessary home health care visits per calendar year. A ‘‘visit’’ must be for intermittent care of not more than two hours in duration. Home health care services must be ordered by a physician and be provided by and require the training and skills of one of the following providers:

- a registered or licensed practical nurse;
- a physical, occupational, speech, or respiratory therapist; or
- a licensed social worker.

Note that this home health care benefit does not include home care services provided as part of a hospice treatment plan or ongoing hourly shift care in the home. See the ‘‘Palliative Hospice Care’’ benefit for a description of those benefits.

Maximum visits -- There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.

Preauthorization -- If home health care is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such care. See ‘‘Preauthorization’’ subsection for a description of the preauthorization process.

Special Dental Care

Your plan covers treatment of accidental injury to natural teeth or a fractured jaw if the treatment is given by a physician or dentist. Natural teeth are healthy teeth, teeth that have been restored to a sound condition, or teeth that have been replaced by a fixed or removable partial denture or bridge. Diagnosis must be made within six months of the injury and benefits will be available for treatment provided within 12 months of the injury except when completion is delayed due to healing time following medically necessary surgery. The injury must be one that occurred while you or your insured dependent was enrolled under this policy. For purposes of this Special Dental Care benefit, injury does not include accidents that occur during eating, biting, or chewing.

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Medications

Your coverage pays for the following medically necessary medications when required by standard treatment practices for the treatment of an illness or injury:

- nonprescription elemental enteral formula for home use when ordered by the patient's physician as long as:
  - the formula is medically necessary for the treatment of severe intestinal malabsorption; and
  - the formula comprises the sole or an essential source of the patient's nutrition;
- **medical foods**, such as PKU formula, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which there exists medically standard methods of diagnosis, treatment, and monitoring. Medical foods means foods that are:
  - formulated to be consumed or administered enterally under the supervision of a physician;
  - specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts;
  - for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or have other specific nutrient requirements as established by medical evaluation; and
  - essential to optimize growth, health, and metabolic homeostasis.

  Charges for diagnosis, treatment, and monitoring of the disorder requiring medical foods are covered elsewhere in the policy.

Durable Medical Equipment And Supplies

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for medically necessary artificial eyes, limbs, and appliances when required by standard treatment practices for the treatment of an illness or injury.

The term durable medical equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the insured person's home. Examples include oxygen equipment and wheelchairs. Durable medical equipment may not serve solely as a comfort or convenience item.

Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts, usually serve as convenience items. They are generally not eligible for benefits unless medical necessity can be established from diagnosis and treatment. However, if medical necessity is established and preauthorization is granted, we will cover motor-driven wheelchairs and seat-lift mechanisms.

Environmental modifications such as wheelchair ramps or elevators for the home, and devices and equipment used for environmental control or to enhance the environmental setting such as air conditioners, humidifiers, air filters, and portable whirlpool pumps, are not considered durable medical equipment under this policy and are not covered.

We cover the following durable medical equipment and supplies:

- casts, trusses, limb or back braces, crutches, and orthotics (must be custom made; casting charges included);

- artificial limbs and eyes and maxillofacial prosthetic devices (maxillofacial prosthetic devices must be medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function);

- rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, or other durable medical equipment. If your physician thinks you will need the equipment long enough for the rental costs to exceed the purchase price, your coverage will be applied toward the purchase price; and

- other supplies including:

  – contraceptive devices;

- nonself-administered injectable medications; and
- outpatient diabetic supplies, such as glucose monitors, insulin pumps, infusion sets and reservoir syringes

- up to a maximum 90-day supply at any one time.

Palliative Hospice Care

We cover palliative hospice care as described in this section when provided by a Medicare or state certified hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. A patient-family unit is the patient and any family members who are caring for the patient. These services include acute, respite and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying.

Palliative hospice care means medical services provided by a hospice care program that alleviate symptoms or afford temporary relief of pain but are not intended to effect a cure. If palliative hospice care is elected by the patient, then he or she is not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, the patient's physician must certify that the patient is terminally ill with a life expectancy of six months or less if the illness runs its normal course.

Levels of Care -- Palliative hospice care benefits are limited to the following treatment settings:

- routine home care;
- continuous home care;
- inpatient respite care; and
- inpatient hospice care.

Additionally, eligible charges for palliative hospice care include the following when provided under one of the previously listed levels of care:

- durable medical equipment;
- medications, including infusion therapy;
- care by any member of the hospice interdisciplinary team; and

- any other supplies required for the palliative hospice care.

Exclusions -- In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, expenses for the following services and supplies are not covered:

- care that is not palliative;
- services provided to other than the terminally ill patient, including charges for bereavement counseling for the insured employee, retiree, or insured dependents, except when provided and billed by the hospice care program;
- pastoral and spiritual counseling;
- services performed by family members or volunteer workers;
- homemaker or housekeeping services, except by home health aides as ordered by a hospice treatment plan;
- supportive environmental materials, including but not limited to, hand rails, ramps, air conditioners and telephones;
- normal necessities of living, including but not limited to food, clothing and household supplies;
- food services, such as ‘‘Meals on Wheels’’;
- separate charges for reports, records or transportation;
- legal and financial counseling services;
- services and supplies not included in a hospice treatment program or not specifically set forth as a hospice benefit; and
- services and supplies in excess of the stated maximums or services and supplies provided more than six months after the initial date of covered palliative hospice care, unless specifically approved by us.

Preauthorization -- If palliative hospice care is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such care. See ‘‘Preauthorization’’ subsection for a description of the preauthorization process.

Home Infusion Therapy

We cover home infusion therapy services and supplies as described in this section when they are medically necessary and are required for

administration of a home infusion therapy regimen when ordered by a physician and provided by an accredited home infusion therapy agency.

Limited Services -- Home infusion therapy is limited to the following:

- aerosolized pentamidine;
- intravenous medication therapy;
- total parenteral nutrition:
- enteral nutrition (under certain circumstances);
- hydration therapy;
- intravenous/subcutaneous pain management;
- terbutaline infusion therapy;
- SynchroMed pump management;
- IM/SC bolus/push medications; and
- blood product administration.

Additionally, eligible charges include only the following medically necessary services and supplies:

- solutions, medications, pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment;
- ancillary medical supplies;
- nursing services associated with:
  - patient and/or alternative care giver training;
  - visits necessary to monitor intravenous therapy regimen;
  - emergency services;
  - administration of therapy; and
- collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.

Preauthorization -- If home infusion therapy is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such therapy. See ''Preauthorization'' subsection for a description of the preauthorization process.

Surgical Treatment Of Morbid Obesity

The plan will only cover the Roux-en-Y gastric bypass and adjustable gastric banding (i.e., Lap-Band) for the treatment of morbid obesity, and only when the criteria defined below are met. No other surgical procedures are covered by the plan, including, but not limited to, other gastric banding, vertical banded gastroplasty, mini-gastric bypass (gastric bypass using a Billroth II type of anastomosis), distal gastric bypass (long-limb gastric bypass), biliopancreatic bypass, and biliopancreatic bypass with duodenal switch.

The Roux-en-Y gastric bypass and complications as a result of this procedure may be covered for the treatment of morbid obesity when surgery and all related pre- and post-surgical care is performed in a Center of Excellence recognized by Regence BlueCross BlueShield of Oregon for the performance of such a procedure and when all of the following criteria are met:

1. BMI $\geq$ 35mg/k^2 with a diagnosis of diabetes; or BMI 40mg/k^2 with any comorbid condition; or BMI $\geq$ 50mg/k^2 with or without comorbid conditions.

2. A presurgical work-up is completed that includes all of the following:

   - dietary counseling and education;
   - medical evaluation;
   - psychological evaluation.

3. Weight loss of >5% over the 6 months prior to surgery.

LIMITATIONS APPLICABLE TO YOUR PLAN

A few limitations (affecting benefits for medications, maternity care, and nursing services, for instance) have already been listed. In addition, there are several general limitations that apply to your plan. They are described in the following paragraphs.

Biofeedback Therapy

Eligible charges for biofeedback therapy services are limited to treatment of tension headaches or migraine headaches.

Transplants

Benefits for services and supplies (including medications) rendered in connection with a transplant, including pretransplant procedures such as ventricular assist devices (VADs), organ or tissue harvesting (donor costs), post-operative care (including antirejection medication treatment), and transplant related chemotherapy for cancer are limited as described here.

A covered transplant means a medically necessary transplant of one of the following organs or tissues only and no others:

- heart;
- heart/lung or lung;
- liver;
- kidney;
- pancreas;
- small bowel;
- small bowel/liver;
- autologous hematopoietic stem cells whether harvested from bone marrow or peripheral blood when determined to be medically necessary;
- allogeneic or syngeneic hematopoietic stem cells whether harvested from bone marrow, peripheral blood, or from any other source when determined to be medically necessary; and

- other transplants determined by us to be a medically necessary transplant since this booklet was issued. You may obtain a copy of any current transplant medical policy by contacting our Customer Service Department or over the internet at www.or.regence.com.

Donor costs means all costs, direct and indirect (including program administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;

- preserving it; and

- transporting it to the site where the transplant is performed.

A **transplant** means a procedure or a series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or

- removed from and replaced in the same person's body (called a self-donor).

For purposes of this limitation, the term ''transplant'' includes a ventricular assist device (VAD) when used as a bridge to a heart transplant for a patient who is suffering from severe congestive heart failure, is in imminent risk of dying before a heart is available, and has been approved as a heart transplant candidate. In addition, in treatment of cancer, the term ''transplant'' includes any chemotherapy and related course of treatment which the transplant supports.

For purposes of this limitation, the term ''transplant'' does not include transplant of blood or blood derivatives (except hematopoietic stem cells), or cornea. These services are considered as nontransplant related and are covered elsewhere in the policy.

Benefits
Benefits for a Covered Transplant are payable as follows:

Facility Benefits. We will waive any otherwise applicable coinsurance of the policy and pay 100 percent of the Contracted Amount for Facility Transplant Services for a Covered Transplant performed at a Contracting Transplant Facility. Payments of the Contracted Amount at 100 percent do not accumulate toward the stop-loss amount (the point at which coinsurance is no longer payable) under the policy.

Payments of the Contracted Amount at 100 percent do not accumulate towards the annual out-of-pocket maximum amount (the point at which coinsurance is no longer payable) under the policy.

We pay 60 percent of reasonable charges towards the cost of Facility Transplant Services for a Covered Transplant performed at other than a Contracting Transplant Facility. Any deductible amount under the contract shall apply but the percentage of payment (60 percent) will remain the same throughout the calendar year. These payments do not accumulate toward the stop-loss amount under the policy.

The exception to the above facility benefits payment schedule is when the Covered Transplant is for a ventricular assist device (VAD), in which case we pay facility expenses according to the benefits for facilities under the policy.

Professional Provider Benefits. We will pay for Professional Provider Transplant Services according to the benefits for professional providers under the policy.

Benefits for Donor Costs. If the recipient or self-donor is insured under this policy, we will pay up to a maximum of $8,000 per Covered Transplant for Donor Costs. If the donor is insured under this policy and the recipient is not, we will not pay toward Donor Costs. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the policy if the donor or self-donor is insured under the policy.

Benefits for Anti-Rejection Medications. For anti-rejection medications following the Covered Transplant, we will pay according to the benefits for prescription medications, if any, under the policy.

Limited Waiver of Policy Maximum Benefit. If the expenses of a Transplant at a Contracting Transplant Facility would cause an insured person to exceed his or her lifetime maximum benefit under the policy, we will waive the lifetime limit to the extent such expenses for Facility and Professional Provider Transplant Services and Donor Costs exceed the limit. This waiver will not apply to the cost of anti-rejection medications, a Transplant at a noncontracting facility or to any subsequent Transplants.

Preauthorization
All transplant procedures must be preauthorized for type of transplant and be medically appropriate according to criteria established by us.

All transplant procedures must be preauthorized for type of transplant and be medically necessary according to criteria in The Regence Group medical policy.

Preauthorization is a part of the benefit administration of the policy and is not a treatment recommendation. The actual course of medical

treatment you or your insured dependent chooses remains strictly a matter between you or your insured dependent and your or your insured dependent's physician.

Preauthorization Procedures
To preauthorize a transplant procedure, your or your insured dependent's physician must contact our Preauthorization Department before the transplant admission. Preauthorization should be obtained as soon as possible after you or your insured dependent has been identified as a possible transplant candidate. See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Only written approval from us on a proposed transplant will constitute preauthorization. If time is a factor, preauthorization will be made by telephone followed by written confirmation.

24-Month Exclusionary Period
No benefits for Covered Transplants will be payable during the first 24 months an individual is insured under this policy except as follows:

- the 24-month exclusion period will not apply if the insured person or self-donor has been continuously covered under this policy since birth; or

- we will reduce the duration of the 24-month exclusion period by the amount of your or your insured dependent's combined periods of prior creditable coverage if the most recent period of creditable coverage ended within 63 days of your or your enrolled dependent's enrollment date. Creditable coverage means any of the following coverages:

- group coverage (including FEHBP and Peace Corp);

- individual coverage (including student health plans);

- Medicaid;

- Medicare;

- CHAMPUS/Tricare;

- Indian Health Service or tribal organization coverage;

- plans of a state, the US, a foreign country, or a political subdivision of one of these;

- state high risk pool coverage; and

- public health plans.

Prior creditable coverage is determined separately for each insured person. However, if benefits for the transplant would not have been payable under the previous coverage for any reason, no credits for such prior creditable coverage will be given under this policy toward the 24-month exclusion period. The insured person is responsible for furnishing evidence of the terms of transplant coverage under the previous coverage.

Exclusions
In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, we will not pay for the following:

- any transplant procedure that has not been preauthorized;
- any transplant performed outside of the United States;
- purchase of any organ or tissue;
- donor or organ procurement services and costs incurred outside the United States, unless specifically approved by us;
- donation related services or supplies provided to an insured donor if the recipient is not insured under this policy and eligible for Transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;
- services or supplies for any Transplant not specifically named as covered including the Transplant of animal organs or artificial organs; and
- chemotherapy with autologous, allogeneic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered.

GENERAL EXCLUSIONS

We will not pay for the following:

Treatment Prior To Enrollment: Services or supplies you or an insured dependent received before you were first insured by this policy.

Treatment After Insurance Ends: Services or supplies you or an insured dependent receives after your insurance coverage under this policy ends. The only exception is that when you or an insured dependent is in the hospital on the day the insurance ends, we will continue to pay toward eligible charges for that hospitalization until your discharge from the hospital or your benefits have been exhausted, whichever comes first.

Services Provided By A Member Of Your Immediate Family

Treatment Not Medically Necessary: Services or supplies that are not medically necessary for the treatment of an illness or injury (See page 6).

The Following Services And Supplies: We do not cover the following services and supplies:

- routine tests and screening procedures, except as specifically listed (see page 33);
- treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;
- eye examinations, the fitting, provision or replacement of eyeglasses;
- orthoptics (eye exercises);
- telephone consultations that are not in conjunction with the Free & Clear Quit For Life, CareEnhance or AdviCare Programs, missed appointments, completion of claim forms, or completion of reports requested by Regence BlueCross BlueShield of Oregon in order to process claims;
- self-help or training programs including, but not limited to court-ordered treatment, those to provide general fitness, wilderness experience programs; also included are those programs that teach a person how to use durable medical equipment or how to care for a family member;
- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically

provided for under the ‘‘Outpatient Diabetic Instruction’’ benefit of this policy;

- appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights;

- private duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility; and

- speech therapy unless it is to improve or restore lost function due to illness or injury.

Treatment For Obesity Or Weight Control: Except as specifically provided under the Surgical Treatment Of Morbid Obesity provision (page 44). This exclusion includes any treatment of obesity and complications related to non-covered medical and surgical treatments of obesity, even if you or your insured dependent has other medical conditions related to or caused by obesity. Exclusions include, but are not limited to, diet programs except as specifically provided under the Surgical Treatment of Morbid Obesity provision, exercise programs, behavior modification programs, hypnosis, biofeedback, neurolinguistic programming, guided imagery, and other forms of relaxation training as well as subliminal suggestion used to modify eating behavior.

Surgery To Alter Refractive Character Of The Eye: Surgical procedures which alter the refractive character of the eye, including, but not limited to, radial keratotomy, keratomileusis (LASIK), keratoprosthesis, and other surgical procedures of the refractive keratoplasty type. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.

Orthodontic Treatment

Massage Or Massage Therapy: Except as may be provided by a physical therapist or licensed chiropractor. Massage therapists are not eligible providers.

Orthopedic Shoes Or Arch Supports

Cosmetic/Reconstructive Services And Supplies: Services and supplies (including medications) rendered for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery, except as follows:

- if the surgery is performed to correct a functional disorder or as the result of an accidental injury;

- if the surgery is performed for correction of congenital anomalies in children under age 18; or

- the surgery is related to breast reconstruction following a mastectomy necessary because of illness or injury in accordance with the Women's' Health And Cancer Rights benefit.

''Cosmetic'' means services and supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance or enhancing self-esteem.

''Reconstructive'' means services, procedures and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Orthognathic Services: Repair, surgical alteration, or reconstruction of the upper or lower jaw in the absence of significant dysfunction, including but not limited to when used for altering or improving bite or for improvement of appearance. However, orthognathic services may be covered if the services are medically necessary because of significant dysfunction due to illness, injury, congenital anomaly, or developmental anomaly.

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Infertility Medications, In Vitro and In Vivo Fertilization: Including services related to or supporting in vitro fertilization, reversal of sterilization procedures, or GIFT and ZIFT procedures.

Dental Examinations And Treatments: Except as specifically provided in the ''Special Dental Care'' and/or, if applicable, the ''Covered Dental Expenses'' or ''Dental Benefits'' section of the policy. For the purposes of this exclusion, the term ''dental examinations and treatment'' means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies rendered to repair defects which have developed because of tooth loss and services or supplies rendered to restore the ability to chew.

Physical Exercise Programs: Even though they may be prescribed for a specific condition.

Counseling Or Treatment In The Absence Of Illness: For example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; EAP services; wilderness programs; premarital or marital counseling; family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment).

Sexual Dysfunction: Services and supplies (including drugs) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.

Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.

Mental Health Treatment For Certain Conditions: We will not cover treatment of paraphilias no matter the age of the enrollee. Additionally, we will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger. By "V code," we mean diagnosis codes as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) that describe Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Custodial Care: Including routine nursing care and rest cures; and hospitalization for environmental change.

Developmental Disabilities/Learning Disabilities/Autism: Developmental disabilities/learning disabilities and autism for your insured dependent age seven years or older.

Counseling Or Treatment In The Absence Of Illness: Including individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems; or treatment of ‘‘normal’’ transitional response to stress.

Experimental Or Investigational Services: Treatments, procedures, equipment, medications, devices, and supplies (hereafter called services) which are, in our judgment, experimental or investigational for the specific illness or injury of the insured employee or insured family member receiving services are excluded. Services which support or are performed in connection with the experimental or investigational services

are also excluded. For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services which at the time they are rendered and for the purpose and in the manner they are being used:

- have not yet received final US Food and Drug Administration (FDA) approval for other than experimental, investigational, or clinical testing. However, if a medication is prescribed for other than its FDA approved use and the medication is recognized as effective for the use for a particular diagnosed condition, benefits for the medication when so used will not be excluded under this exclusion. To be considered effective for other than its FDA approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or

- are determined by us to be in an experimental and/or investigational status. The following will be considered in making the determination whether the service is in an experimental and/or investigational status:

  – whether there is sufficient scientific evidence to permit conclusions concerning the effect of the services on health outcomes. "Scientific evidence" consists of:

  – well-designed and well-conducted clinical trials documenting improved health outcomes published in peer reviewed medical (or dental) literature. Peer reviewed medical (or dental) literature means a US scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication; and

  – evaluations by national professional medical (or dental) organizations, national consensus panels or other national technology evaluation bodies which have published a technology assessment or practice guideline based on peer reviewed medical (or dental) literature;

  – whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;

  – whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects;

- whether the scientific evidence improves health outcomes as much or more than established alternatives;

- whether any improved health outcome from the service is attainable outside investigational settings; and

- the advice of participating professional providers medical (or dental).

AN EXPERIMENTAL OR INVESTIGATIONAL SERVICE IS NOT MADE ELIGIBLE FOR BENEFITS BY THE FACT THAT OTHER TREATMENT IS CONSIDERED BY YOUR DOCTOR TO BE INEFFECTIVE OR NOT AS EFFECTIVE AS THE SERVICE OR THAT THE SERVICE IS PRESCRIBED AS THE MOST LIKELY TO PROLONG LIFE.

Service-Related Conditions: The treatment of any condition caused by or arising out of service in the armed forces of any country.

Work-Related Conditions: Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation. The only exception would be if you or your insured dependent is exempt from state or federal workers' compensation law.

Services Otherwise Available: A category that includes:

- services or supplies for which payment could be obtained in whole or in part if you or your dependent had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;

- services and supplies you could have received in a hospital or program operated by a government agency or authority; unless reimbursement under this policy is otherwise required by law;

- charges for services and supplies your or your dependent cannot be held liable because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply; and

- services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance.

Charges Over Usual And Customary Or Reasonable: Any charge over the usual and customary or reasonable charge for services or supplies.

Standby Charges When The Provider Renders No Actual Treatment To The Patient.

Benefits Not Stated: Services and supplies not specifically described as benefits under this policy.

Care Of Inmates: Services and supplies you or your insured dependent receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.

Growth Hormones: Growth hormone conditions other than growth hormone deficiency in:

- children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or

- adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met (preauthorization is required).

Impotence Medications: Any medication therapy for the treatment of impotence regardless of cause.

Prescription Medications: For prescription medication plan exclusions, see page 75.

BENEFITS TO BE PAID BY OTHER SOURCES

Situations may arise in which health care expenses are also covered by a source other than Regence BlueCross BlueShield of Oregon. If so, we won't provide benefits that duplicate the other coverage.

Right Of Reimbursement And Subrogation

PLEASE NOTE: In the following Section the terms you and your also include your insured dependents.

We will exclude any medical (or dental, if applicable) or prescription medication expenses you incur for treatment of an injury or illness if the costs associated with the injury or illness may be recoverable from a third party or through workers' compensation or from any other source. This includes first party payer payments for any automobile personal injury protection or medical payments and uninsured or underinsured motorist coverages. We may choose, at our discretion, reimbursement or subrogation as a means to recovery.

If you have a potential right of recovery for illness or injuries for which a third party may have legal responsibility, we may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, you agree that we are entitled to reimbursement of the full amount of benefits that we have paid out of any settlement or recovery from any source, including any judgment, settlement, disputed claim settlement, uninsured motorist payment, or any other recovery related to the injury or illness for which we have provided benefits.

  This right applies without regard to the characterization as payment for medical expenses, or other designation of the recovery by you and/or any third party or the recovery source. Our right to reimbursement, however, will not exceed the amount of recovery.

- We may require you to sign and deliver all legal papers and take any other actions we may ask to secure our rights (including an assignment of rights to pursue your claim if you fail to pursue your claim). If we ask you to sign a trust agreement or other document to reimburse us from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits. If benefits were paid before the agreement is signed, you agree to reimburse us for these upon receipt of recovery in any form from or on behalf of a third party.

- You must agree that you will do nothing to prejudice our rights and will cooperate fully with us, including signing any documents

within the required time and providing prompt notice of any settlement. You must notify us of any facts that may impact our right to reimbursement or subrogation, including but not necessarily limited to the following:

- the filing of a lawsuit,
- the making of a claim against any third party;
- scheduling of settlement negotiations (including but not necessarily limited to a minimum of 21 days advance notice of the date, time, location, and participants to be involved in any settlement conferences or mediations); and
- intent of a third party to make payment of any kind to your benefit or on your behalf which is in any manner related to the injury or illness which gives rise to our right of reimbursement or subrogation (notification of a minimum of 5 business days prior to the settlement is required).

You must acknowledge that we are authorized but not obligated to recover directly from any third party any benefits paid from any party liable to you upon mailing of a written notice to the potential payer, to you, or to your representative.

We are entitled to reimbursement from the first dollars received from any recovery and we will not reduce our lien due to you not being made whole. We shall not be liable for any expenses or fees you incur in connection with obtaining a recovery. You, however, may request us to pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits we paid. We have discretion whether to grant such requests.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees depends on whether or not your attorney has funds sufficient to satisfy our asserted lien in a client trust account, until such lien is satisfied or released. In the event you and/or your agent or attorney fails to comply with the terms of these provisions, we may recover any benefits advanced for any illness or injury resulting from the action or omission of a third party through legal action.

If you incur health care expenses for treatment of the illness or injury after receiving a recovery, we will exclude benefits for otherwise covered expenses until the total amount of health expenses incurred after the recovery exceeds the net recovery amount.

Please contact our Customer Service Department to obtain third party reimbursement forms and to obtain additional information.

Motor Vehicle Coverage: If you are involved in a motor vehicle accident, you may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, this Right Of Reimbursement And Subrogation provision still applies.

Workers' Compensation: Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify us in writing within five days of filing a workers' compensation claim.

- If the entity providing workers' compensation coverage denies your or your insured dependent's claims and you have filed an appeal, we may advance benefits for covered expenses if you or your insured dependent agrees to hold any recovery obtained in trust for us.

Medicare

In certain situations, this policy is primary to Medicare. This means that when you or your insured dependent is insured in Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are:

- when you or your insured spouse is age 65 or over and by law Medicare is secondary to your employer group health plan;

- when you or your insured dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and

- when you or your insured dependent is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan.

In all other instances, we will not cover any part of a covered expense to the extent that covered expense is actually paid or would have been paid under Medicare Part A or B had you or your insured dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare-eligible insured member incurs from providers who have opted out of Medicare participation.

Coordination Of Benefits

It is often the case that when a husband and wife both work, each is protected under a group health insurance plan at his or her place of employment. If each spouse obtains coverage for the other and for their

children, questions may arise as to which plan should pay what amount in the event illness or injury occurs.

What we call ‘‘coordination of benefits’’ is a method for determining which plan has the primary responsibility to provide benefits in a given situation.

A principal reason for doing this is to protect you by keeping insurance rates down. If both plans paid full allowances for a covered claim, the total benefits might well amount to more than the actual expenses for health care. This could lead to unnecessary use of health care services and to higher insurance rates. We generally request this information be updated on our files yearly.

How Coordination Of Benefits Works

If one of the insurance plans has no provision for coordination of benefits, it always pays first. If both plans have coordination clauses, which is usually the case, the following rules generally apply:

- The plan which covers the patient as a subscriber and not as a dependent pays first. Under this plan the subscriber is the insured employee or retiree.

- The plan of the parent whose birthday falls earlier in the year pays first. If both parents have the same birthday, the plan in effect longest will pay first. If the rules of the plans disagree, then the benefits of the other plan will pay before the benefits of this plan provided those rules are based on the parent’s gender.

  However, if the patient is a dependent child of parents who are separated or divorced, the following rules will apply instead:

  – if a court order requires one parent to provide health insurance for the couple’s children (and the health insurer is aware of that court order), that parent’s coverage will pay first;

  – in the absence of a court order, the plan of the parent having custody pays first, followed by that of the stepparent and then by that of the parent without custody.

- The plan that covers an active employee and his or her dependents will pay before a plan that covers an inactive employee and his or dependents. (If one plan does not have this rule, it is disregarded.)

- If none of the first three rules applies, the plan that has covered the patient longer pays first.

Claims Recoveries

If we mistakenly make a payment for you or your insured dependent to which you or your insured dependent is not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any of your insured dependents even if the mistaken payment was not made on that person's behalf.

We regularly engage in activities to identify and recover claims payments which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit to your group's experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in obtaining the recoveries.

HOW TO FILE A CLAIM

We process claims as we receive them. The date we receive a claim may not be the date the service or supply is rendered.

You must submit claims within one year of the time you receive services or supplies for us to pay benefits. Claims submitted beyond that date are not eligible for benefits. If circumstances beyond your control prevent you from submitting a claim within one year, the time period will be extended to 30 days beyond the time you reasonably could have submitted the claim.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Regence BlueCross BlueShield of Oregon to the extent of the payment.

If we receive an inquiry regarding a properly submitted claim and we believe that you expect a response to that inquiry, we will respond to the inquiry within 30 days of when we first received it.

Please submit medical and/or vision claims to your local Blue Cross and/or Blue Shield plan. Call your local plan for questions or claims. Send all claims to:

PO Box 30805
Salt Lake City, UT 84130-0805

Hospital Charges

If you or a dependent is hospitalized in one of our participating hospitals, all you need to do is present your Regence BlueCross BlueShield of Oregon identification card to the admitting office. In most cases, the hospital will bill us directly for the entire cost of the hospital stay. We'll pay the hospital and send you copies of our payment record. The hospital will then bill you for any of the charges that weren't covered by your Regence BlueCross BlueShield of Oregon benefits.

Sometimes, however, the hospital will ask you, at the time of discharge, to pay amounts that might not be covered by your benefits. If this happens, you must pay these amounts yourself. We will, of course, reimburse you if any of the charges you pay are covered by your Regence BlueCross BlueShield of Oregon plan.

The same procedure will apply if you or a family member is hospitalized outside our service area (Oregon and Clark County, Washington) in a hospital that has an agreement with the local Regence BlueCross BlueShield of Oregon plan. Your claim will be processed by the Blue Cross plan serving that area and your benefits will be provided by that plan.

When The Hospital Bills You

You will be billed for inpatient care you or a dependent receives in a nonparticipating hospital, and for outpatient care you receive in any hospital outside our service area. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following information:

- the name of the insured person who was treated;
- your name and your group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

If you have already paid for the services or supplies, please note that fact boldly on the billing.

The same procedure should be followed with bills for hospital or physician care you receive outside the United States. Reimbursement will be made at the current rate of exchange at the time of service.

Physicians' Charges

Your physician may bill charges directly to us. If not, you may send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill:

- the patient's name and the group and identification numbers;
- the date treatment was given;
- the diagnosis; and
- an itemized description of the services given and the charges for them.

If you have already paid for the services and supplies, please note that fact boldly on the billing.

If the treatment is for an accidental injury, include a statement explaining the date, time, place, and circumstances of the accident when you send us the physician's bill.

Filing A Lawsuit

Any legal action arising out of this policy and filed against us by an insured person or any third party must be filed within three years of the time written proof of loss is required to be furnished under this policy.

Other Health Care Charges

As we explained previously in the description of benefits, your Regence BlueCross BlueShield of Oregon plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. Or you may send them to us at regular intervals -- for example, once a month. *Again, if you have already paid for the services and supplies, please note that fact boldly on the billing*.

Prescription Medication Rebates

Regence BlueCross BlueShield of Oregon participates in arrangements with medication manufacturers which allow us to receive rebates based, among other things, on the volume of certain prescription medications purchased on behalf of insured individuals. Any rebates we receive from medication manufacturers are credited directly or indirectly to the group to reduce prescription medication claims expense and thereby help reduce future premium rate increases. We will withhold a percentage of the total rebate to cover our costs of collecting and administering the rebate program.

Appliances

By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your claim. Always include your group and identification numbers and the patient's name.

Ambulance Service

Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name and group and identification numbers. We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Claim Determinations

Within 30 days of our receipt of a claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30-day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the claim.

- When we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You must provide us with the requested information within 45 days of receiving the request for additional information. If we do not receive the requested information to process the claim within the 45 days we have allowed, we will deny the claim.

Claims Processing Reports

We will report to you on the action we take on a claim on a form called a Claims Processing Report.

If we deny all or part of a claim, the reason for our action will be stated on the Claims Processing Report. The Claims Processing Report will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your or your insured dependent's claim.

When Benefits Are Available

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to the patient.

There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for that hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person is entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Regence BlueCross BlueShield of Oregon to the extent of the payment.

Out-of-Area Claims Service - BlueCard Program

All Blue Cross and Blue Shield Plans participate in a national program called the BlueCard Program. This national program benefits insured individuals who incur eligible charges outside our service area. Not all claims incurred outside of our service area, dental claims for example, are processed through the BlueCard Program.

Under BlueCard, when you or an insured dependent incurs eligible charges within the geographic area served by another BlueCross and/or BlueShield Plan, we will remain responsible for meeting our obligations under the policy. The local Blue Plan will only be responsible for providing such services as contracting with its participating providers and handling the interaction with those providers according to BlueCard policies.

When you or an insured dependent receives covered health care services outside our service area from a provider who has a participating contract with the local Blue Cross and/or Blue Shield Plan and the claim is processed through BlueCard, the amount you pay for eligible charges is usually calculated on the lower of:

- the actual billed charges; or
- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this ‘‘negotiated price’’ will consist of a simple discount. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, or other nonclaims transactions with

your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield Plan to use a basis for calculating your liability for eligible charges that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard program method noted above or require a surcharge, we would then calculate your liability for any covered health care services using the methods outlined by the applicable state statute in effect at the time you or your insured dependent received care.

PRESCRIPTION MEDICATION PROGRAM

This Regence BlueCross BlueShield of Oregon prescription medication plan is administered through a nationwide network of participating pharmacies. Pharmacies that participate in this network submit claims electronically on-line, which are then processed according to your plan benefits.

Your Regence BlueCross BlueShield of Oregon identification card identifies your medical program, and enables you to use the pharmacies that participate in this prescription medication program. If you would like a listing of the participating pharmacies, you may obtain one from your employer or from Regence BlueCross BlueShield of Oregon.

Prescription Medication Benefits

The benefits of this medication plan are described below, and any balances over the maximum amount available under this plan are not eligible for payment under any other provision of the policy.

Definitions

The definitions which appear here apply to this plan.

Brand name medication means a prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Generic medication means a prescription medication that is an equivalent medication to the brand name medication, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references as a generic medication or is specified as a generic medication by us. Equivalent medication means the US Food and Drug Administration (FDA) ensures that the generic medication must:

- have the same active ingredients;
- meet the same manufacturing and testing standards; and
- be absorbed into the bloodstream at the same rate and same total amount as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication. If listings in widely accepted references are conflicting or indefinite about whether a prescription medication is a generic or brand medication, we will determine whether the prescription medication is a generic or brand name medication.

Brand name medication (single source brand) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Multi-source brand name medication means a brand name medication for which a generic medication may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located.

Compound medication means two or more medications that are mixed together by the pharmacist. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend drug or one state restricted drug.

Coinsurance, for purposes of this prescription medication benefit, means any percentage amount you or your insured dependent must pay for a covered prescription medication. Coinsurance or copayment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Copayment, for purposes of this prescription medication benefit, means any flat dollar amount you or your insured dependent must pay for a covered prescription medication. Coinsurance or copayment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Covered prescription medication expense means, for participating pharmacies, the amount we have agreed to pay participating pharmacies for a prescription medication. For nonparticipating pharmacies, covered prescription medication expense means the pharmacy's retail price for a prescription medication or the amount we would have paid a participating pharmacy for the same prescription medication, whichever is less. For mail order suppliers, covered prescription medication expenses means the amount we have agreed to pay mail order suppliers for a prescription medication.

Generic medication means a prescription medication that is an equivalent medication to the brand name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic medication must:

- have the same active ingredients;
- meet the same manufacturing and testing standards; and

- be absorbed into the bloodstream at the same rate and same total amount

as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication.

Mail order supplier means a mail order pharmacy that has contracted with us to provide mail order services to insured employees and their insured family members.

Maintenance medication means a prescription medication that we have determined is intended to treat a chronic illness that requires medication therapy for more than 12 continuous months.

A Pharmacist means an individual licensed to dispense prescription medications and counsel a patient about how the medication works and its possible adverse effects.

A Pharmacy means any duly licensed outlet in which prescription medications are regularly compounded and dispensed.

A Participating Pharmacy means a Pharmacy that has signed a participating pharmacy agreement with us and that submits claims electronically on-line at the time of dispensing.

Preferred medication list means a list comprised of generic medications and selected brand name medications, which is established, reviewed, and updated routinely by us.

Prescription medications are medications and biologicals that relate directly to the treatment of an illness or injury and cannot legally be dispensed without a prescription order, and that by law must bear the legend: "Caution - federal law prohibits dispensing without prescription," or which are specifically designated by us. For purposes of this prescription medication benefit, prescription medications also include insulin and diabetic supplies, self-injectable medications, and compound medications. Although insulin and diabetic supplies, do not require a prescription, they still require a prescription order to be covered under this benefit.

Prescription order is a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Self-injectable medication means an outpatient injectable prescription medication intended for self-administration and approved by us for self-injection.

How To Use The Prescription Medication Benefit

At a participating pharmacy, you or your insured dependent is required to present your identification card at the pharmacy in order to have the prescription medication claim submitted by the pharmacy electronically on-line. You or your insured dependent must pay your copayment or coinsurance at the time of purchase.

If you or your insured dependent uses a nonparticipating pharmacy or you or your insured dependent uses a participating pharmacy but the claim is not submitted by the pharmacy electronically on-line, you or your insured dependent must pay for the medication. You then must complete a Prescription Medication Claim Form and mail the form and receipt to us. How you will be reimbursed is described later.

PPO Plan
You pay a $5 copayment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed by a participating pharmacy is subject to $15 copayment. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to a copayment of $50 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan
You pay a $10 copayment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed by a participating pharmacy is subject to a coinsurance of 20% of the covered prescription medication expense. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to a copayment of $50 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands. Once you have paid $1,000 out-of-pocket during the calendar year, your prescription medications will be paid in full.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

All Plans
The amount we cover and the amount you must pay depends on whether or not the pharmacy is a participating pharmacy.

- **Participating Pharmacy**
  Eligible charges incurred at a participating pharmacy will be covered at 100 percent, less the copayment or coinsurance

depending which plan you are enrolled in for a 34-day supply. You or your insured dependent need only present your identification card to the participating pharmacy and pay any copayment or coinsurance at the time of purchase.

- **Nonparticipating Pharmacy**
  You or your insured dependent must pay a nonparticipating pharmacy the full charge at the time of purchase and then submit a Prescription Medication Claim Form for reimbursement. You will be reimbursed 100 percent of the covered expense less the copayment or coinsurance depending which plan you are enrolled in for a 34-day supply. Payment will be sent directly to the insured employee or retiree.

Maximum Out Of Pocket Expense - PPO Part-Time and Retiree Plan Only

The copayment for prescription medications obtained from a participating pharmacy will be waived during the remainder of a calendar year in which your or your insured dependent's out-of-pocket expenses (copayments and coinsurance) reach $1,000. The out-of-pocket maximum applies separately to each insured employee and their insured family members.

In order for the copayment or coinsurance to be waived, you or your insured dependent must present your identification card to the participating pharmacy at the time of purchase and the participating pharmacy must submit the claim electronically on-line.

Expenses incurred at both participating pharmacies and nonparticipating pharmacies and expenses incurred for mail order prescription medications accumulate toward the out-of-pocket maximum.

Mail Order Benefit

Mail order is an optional method of obtaining maintenance medications under this prescription medication plan. Not all prescription medications are available from the mail order supplier and mail order benefits are available only when prescription medications are dispensed and the claim is submitted electronically on-line by the mail order supplier.

PPO Plan
Under this benefit, you or your insured dependent pays a copayment of $12.50 each time a generic medication is dispensed or refilled by the mail order supplier. You or your insured dependent pays a copayment of $37.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to a copayment of $125 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan
Under this benefit, you or your insured dependent pays a copayment of $25 each time a generic medication is dispensed or refilled by the mail order supplier. You or your insured dependent pays a copayment of $62.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to a copayment of $125, plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

How To Obtain Mail Order Medications

To use the mail order plan, you or your insured dependent must send all of the following items to the mail order supplier at the address shown on the prescription mail order form obtained from your group:

- a completed prescription mail order form;
- the original prescription order; and
- the copayment.

Refills
If a prescription order includes refills, they may also be obtained from the mail order supplier. You must complete the ‘‘refill’’ section on the back of the prescription order form, including the mail order supplier’s prescription number, and send it to the mail order supplier along with the copayment. Subsequent mail order prescription refills are available once you have used 75 percent of the supply from the previous mail order prescription.

Regence BlueCross BlueShield of Oregon contracts with two mail order companies:

Postal Prescription Service (PPS)
Postal Prescription Service is a full service mail order pharmacy based in Portland, Oregon, offering you:

- Free standard shipping;
- Convenient hours, 6am – 6pm, Pacific time, Monday – Friday, 9am – 2pm, Saturdays;
- Access to a registered pharmacist during business hours at 1 (800) 552-6694;

- Use of PPS Website after filling one prescription. Visit www.PPSRX.com to;
- Refill your prescription(s);
- Print out new prescription order forms or medical expense forms;
- Review your order status and history;
- Submit prescription transfer requests.

Postal Prescription Services
PO Box 2718
Portland, OR 97208

Walgreens Healthcare Plus (Mail Order Service)
Walgreens offers fully integrated retail and mail service with convenient delivery to your home or office:

- Free shipping;
- Convenient hours, 7am to 7pm. (Central time), Monday – Friday, and 7am to noon, Saturdays;
- 24/7 access via 1 (800) RX-REFILL 1 (800) 797-3345 to place an order, check order status and account balance;
- 24/7 access to a Walgreens representative or pharmacist at 1 (888) 832-5462;
- Online ordering at www.walgreensmail.com or print a form to fax or mail. Walgreens will send you Rx Order Status emails telling you when your order was received, when it ships, and delivery service provider.

You can choose which Walgreens Mail Service facility to have your prescriptions filled. Locations include:

Walgreens Healthcare Plus
PO Box 29061
Phoenix, AZ 85038

Walgreens Healthcare Plus
PO Box 5957
Portland, OR 97228

Walgreens Healthcare Plus
PO Box 628001
Orlando, FL 32862

Exceptions Process For Non-Preferred Brand-Name Medications

A formulary is a list of generic and preferred brand-name prescription drugs covered by your health plan.

What To Do When Your Doctor Prescribes A Drug That Isn't On The Drug List:

- If your doctor prescribes a non-formulary drug to treat your condition, he or she can fax a request to 1(888) 437-1510 or submit a request online at www.regencerx.com.

- Exceptions may be granted if formulary drugs have failed to treat your condition or have caused side effects that made you stop taking them. If an exception is granted, your copayment is the preferred brand level.

- When you get an exception, the copay for the non-preferred drug will not apply to your deductible. (The copay of a preferred brand drug does apply to your deductible.)

Contact us for more information or call 1(800) 643-5918.

Prescription Medication Plan Limitations

The following limitations apply to the benefits of this prescription medication plan:

Maximum Supply
The largest allowable quantity for most outpatient prescription medications purchased from a pharmacy is a 34-day supply. There are no exceptions to the maximum 34-day supply. The provider, however, may choose to prescribe some medications in smaller quantities or you or your insured dependent may wish to purchase some medications in smaller quantities. The amount payable is always based on each dispensing. Some examples of how the maximum 34-day supply works:

- if one tablet per day is prescribed, up to 34 tablets for a 34-day supply will be covered; or

- if one tablet per week is prescribed, up to four tablets for a 34-day supply will be covered.

The largest allowable quantity at one time per prescription medication purchased from the mail order supplier is a 90-day supply. The maximum quantity for self-injectable medications purchased from the mail order supplier is a 30-day supply. The provider, however, may choose to prescribe some prescription medications in smaller quantities or you or your insured dependent may choose to purchase some

prescription medications in smaller quantities. The amount payable and copayment is always based on each dispensing. Some examples of how the maximum 90-day supply works:

- if one tablet per day is prescribed, up to 90 tablets for a 90-day supply will be covered; or
- if one tablet per week is prescribed, up to 12 tablets for a 90-day supply will be covered.

Maximum Quantities
For certain medications, we have established a maximum quantity of medication allowed. This means that there is a limit for the amount of medication that will be covered during a period of time. We use information from the US Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities.

Any amount over the established maximum quantity is not covered, except if we determine the amount is medically necessary. The medication information must be provided by the health care provider who prescribed the medication in order to establish if the amount is medically necessary. Some examples of established maximum quantities include:

- Imitrex (used for migraines) - up to 9 tablets every 34 days;
- Tamiflu (used for flu) - up to one treatment course every 6 months; and
- Diflucan 150 mg (antifungal agent) - up to 2 tablets every 34 days.

When you or your insured dependent take a prescription order to a participating pharmacy or requests a prescription medication refill and an identification card is used, the pharmacy will let you or your insured dependent know if a quantity limitation applies to the medication. To find out in advance whether a limit applies, contact Customer Service (number on the back of your identification card) or check our website at www.or.regence.com.

Prescription Refills
Refills obtained from a pharmacy or the mail order supplier are allowed after 75 percent of the supply from the previous prescription order is used. You or your insured dependent is responsible for the full cost of any prescription medications that are denied at the participating pharmacy for 'refill too soon' due to this quantity limitation.

Prescription Medication Plan Exclusions

In addition to other exclusions of the policy, the following exclusions apply to the benefits of this prescription medication plan:

Non-Prescription Medications
Medications that by law do not require a prescription order and which are not included in our definition of prescription medications.

Contraceptives
Certain contraceptive prescription medications and devices are covered under this prescription medication plan, however, Norplant, surgically inserted contraceptive devices, IUDs, Depo-Provera and other nonself-administered contraceptives are not. These may be covered under other provisions of the policy.

Administration Or Injection Of Medications

Prescription Medications With No Proven Therapeutic Indication

Prescription Medications That Are Not Medically Necessary

Immunization Agents, Biological Sera, Blood Or Blood Plasma

Vitamins And Fluoride
Except those that by law require a prescription order.

Injectable Prescription Medications
Except those defined as self-injectable. Excluded are all injectable prescription medications administered in a physician's office, hospital, outpatient facility, or skilled nursing facility.

Prescription Medications Dispensed In Facility
Prescription medications dispensed to an insured person while a patient in a hospital, skilled nursing facility, nursing home or other health care institution.

Prescription Medications For Weight Loss Or Treatment Of Obesity
Including, but not limited to amphetamines.

Prescription Medications For Treatment Of Infertility

Growth Hormones
Growth hormone conditions other than growth hormone deficiency in:

- children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or

- adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met (preauthorization is required). See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Prescription Medications For The Treatment Of Impotence Regardless Of Cause

Medications Prescribed For Cosmetic Purposes

Tretinoin (i.e. Retin-A) For Insured Employees And Insured Family Members Age 26 Or Over

Medications Prescribed For Treatment Of Hair Loss Regardless Of Cause
Including but not limited to topical minoxidil.

Renova

Medications Prescribed For Hair Removal Regardless Of Cause
Including but not limited to Vaniqa.

Newly Approved Prescription Medications
Prescription medications newly approved by the Federal Food and Drug Administration (FDA) may be excluded for up to 18 months after the approval date. The list of newly approved prescription medications currently excluded is provided to participating pharmacies and is available to insured members on our website (www.or.regence.com) and in paper form from us.

Refills Needed for Stolen, Lost, Spilled Or Destroyed Prescription Medications

Prescription Medications For Which Claims Are Submitted 12 Months Or More After The Date Of Purchase

Any Medication Not Specifically Described As A Benefit Under This Prescription Medication Benefit

Prior Authorization

There are certain prescription medications which must be preauthorized before they will be considered for payment under this prescription medication benefit. Prior authorize and prior authorization mean the process by which we determine that a prescription medication is medically necessary, based on the information provided to us, before it is dispensed. Coverage for medications that have been preauthorized begins on the date we determine that the medication is medically necessary. Any medication that requires prior authorization that is purchased without such prior authorization or is purchased before the date that we determined the medication was medically necessary is not covered under this prescription medication plan, even if purchased from a participating pharmacy.

Participating providers, including participating pharmacies, are notified which prescription medications require prior authorization. The medical information necessary to determine medical necessity for medications that require prior authorization must be provided by the health care provider who is prescribing the medication.

If you or your insured dependent take a prescription order to a participating pharmacy and show your identification card, the pharmacy will let you or your insured dependent know if prior authorization is necessary for the prescription medication. To find out in advance whether a prescription medication requires prior authorization, contact Customer Service (number on back of your identification card) or check our website at www.or.regence.com. For more information on prior authorization, including how we are bound to cover an authorized service or supply, please see Prior Authorization under the ELIGIBLE CHARGES Section.

General Medication Plan Provisions

Right To Examine Records

Regence BlueCross BlueShield of Oregon can require you or your insured dependent to authorize any participating pharmacy furnishing prescription medications under this plan to make available to us information relating to a prescription order or any other records we need in order to approve a claim payment.

Group Coverage Benefits Only

This plan is provided only under group coverage. There is no conversion privilege, nor is this plan available under any nongroup plan.

We Are Not Responsible

We cannot be held liable for any claim or damages connected with illness or injuries suffered by you or your insured dependent arising out of the use of any prescription medication or insulin.

Right To Deny Benefits Or Prescription Orders

We reserve the right to deny benefits for any medication prescribed or dispensed in a manner contrary to normal medical practices. In addition, a pharmacy need not dispense a prescription order which, in the pharmacist's professional judgment, should not be filled.

Utilization Review Program

Included as part of this prescription medication benefit is a medication utilization review program. Utilizing a database of information on each of your prescription medication claims, the program alerts a dispensing pharmacist of potential conflicts in medication therapy, duplicate prescription medications, and overuse before you obtain the prescription medication. Prescription medication claims submitted electronically on-line by a participating pharmacy are analyzed with your active medication

profile for potential medication problems. Claims determined to be excessive utilization and therefore not medically necessary will be denied.

Recovery Of Benefits Paid By Mistake
If we mistakenly make a payment for you or your insured dependent, or on your or your insured dependent's behalf, we have the right to recover the payment from you or your insured dependent, not the pharmacy. This includes the right to deduct the amount paid by mistake from future benefits we provide to you, even if the mistaken payment was not made on that person's behalf.

General Medication Plan Provisions
The provisions described in the WHAT KIND OF SERVICES AND SUPPLIES ARE COVERED and ELIGIBILITY Sections of this policy also apply to this prescription medication plan.

MEMBER APPEALS AND GRIEVANCE PROCESS

This procedure is designed to keep lines of communication open and to provide an opportunity for mutual understanding among our enrollees, providers, and us. Grievances and appeals are promptly directed to appropriate individuals within Regence BlueCross BlueShield of Oregon so action can be taken quickly, and on an informal basis if possible. Final decisions may be decided by an independent review organization (IRO), as explained below under the third step in the grievance and appeals process.

If you believe a policy, action, or decision of ours is incorrect, please contact our Customer Service Department. If we cannot resolve your concern to your satisfaction, you (or an individual authorized to represent you in the grievance and appeal process) may file a verbal or written appeal with us within 180 days of the claim denial or other action giving rise to the grievance. The Customer Service contact information is provided below. Failure to appeal within this time period will preclude all further rights to appeal and may jeopardize your right to contest the action in any forum.

If you have concerns regarding a decision, action, or statement by your provider, we encourage you to discuss these concerns with the provider. If you remain dissatisfied after discussing your concern with your provider, you may file a grievance with our Customer Service Department. However, if you would prefer to discuss your concern with us rather than your provider, please contact our Customer Service Department.

First Step – Filing A Grievance

There are three steps to our grievance and appeal process. The first level of review is filing a grievance. You must file your grievance within 180 days of the claim denial or other action giving rise to the grievance by writing us a letter, filling out a grievance form, or by contacting our Customer Service Department by phone. Within five business days of receiving a grievance, we will send you or your representative an acknowledgment letter outlining your issues as well as advising you of your rights. Within 30 calendar days, you or your representative will receive a written decision from our grievance coordinator. For preservice claims, you or your representative will receive a written decision within 14 days of our receipt of your grievance.

Second Step – Filing Second Appeal

If you remain dissatisfied after the initial grievance review, you have the right to file an appeal verbally or in writing within 180 days of receiving a response from us. Within five business days of receiving the appeal, we will send you or your representative an acknowledgment letter. Your issue will be reviewed by someone not previously involved in your case. For clinical issues, a practitioner that specializes in your medical condition

or procedure will be involved in the review of your appeal. A panel of representatives will evaluate your case and your appeal coordinator will notify you or your representative of the decision in writing. The written decision will be sent:

- for appeals of preservice (preauthorization) claims, within 14 calendar days of our receiving your appeal; or

- for appeals of postservice claims, within 30 calendar days of our receiving your appeal.

Third Step – Voluntary Appeal - External Independent Review

A voluntary external review is available for certain types of appeals and will be decided by an independent review organization (IRO). Appeals qualifying for external appeal must first have been considered through internal review, unless you and we have mutually agreed to waive that requirement. You or your representative must request a voluntary external appeal in writing or verbally within 180 days of receipt of the written notification of the second appeal decision. An external independent review may not be available in all situations. If you are not sure whether your appeal is eligible for an independent review or you want more information, please contact our Customer Service Department. The Customer Service contact information is provided below. At a minimum, a voluntary external review will be available for the following types of appeals:

- an adverse determination based on medical necessity (cosmetic or out-of-network services, for example);

- an adverse determination for treatment determined as experimental or investigational; or

- for purposes of continuity of care (no interruption of an active course of treatment).

You should know that in order to have the appeal decided by an IRO, you or your enrolled dependent must:

- sign a waiver granting the independent review organization access to medical records; and

- have exhausted all other appeals and grievance opportunities under this contract unless, with your consent, we waive this requirement.

An IRO is not part of the Regence BlueCross BlueShield of Oregon company. The IRO is independent and may be assigned by the Director of Consumer and Business Services (DCBS). You are not responsible for the costs of the independent review.

A written response to your appeal will be sent to you or your representative within 5 days after the IRO makes its determination. We are bound by the decision made by the IRO, even if it conflicts with our definition of medical necessity.

If you want more information regarding external review, please contact our Customer Service Department at (Portland area) (503) 225-5336, or toll-free at (800) 452-7390.

Expedited Procedure

In the event you or your physician reasonably believes a decision denying a preauthorization of a service is clinically urgent and that application of the regular appeal timeframes could jeopardize your life, health, or ability to regain maximum function, you or your representative may request an Expedited Appeal. Expedited Appeal also is available if a physician with knowledge of your medical condition concludes that application of the regular appeal timeframes to the review of our denial of preauthorization of a service would subject you to severe pain that cannot be adequately managed without the disputed service. The appeal request must be made verbally or in writing within 180 days after you receive notice of the initial written preauthorization denial, should state the need for a decision on an expedited basis, and must include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to the appeal coordinator. However, if the appeal issue doesn't meet the expedited criteria, the appeal will be handled through the standard appeal process. If the appeal meets the expedited criteria, a verbal notice of the decision will be provided to you or your representative no later than one working day or seventy-two hours of receipt of the request. A written notice will be provided within one working day of the verbal notification. If you are not satisfied with that decision, you may ask for an expedited, second level appeal similar to the Second Step appeal process described above.

How To Contact Us

If you have any questions about the grievance and appeal process outlined here, you may contact our Customer Service Department at (Portland area) (503) 225-5336, or toll-free at (800) 452-7390 or you can write to our Customer Service Department at the following address:

Regence BlueCross BlueShield of Oregon
Customer Service Department
Grievance or Appeal Coordinator, C-7A
PO Box 1271
Portland, OR 97207-1271

Assistance From The Department Of Consumer And Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: http://www.cbs.state.or.us/external/ins/

Please note that your enrolled dependents also have the right to grievance and appeal as described here.

DISCLOSURE STATEMENT - PATIENT PROTECTION ACT

In accordance with Oregon law (Senate Bill 21, known as the Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform you and your insured dependents about the benefits and policies of this health insurance plan.

What Are My Rights And Responsibilities As A Member Of Regence BlueCross BlueShield of Oregon?

No one can deny you or your insured dependent the right to make your own choices. As a member, you and your insured dependents have the right to:

- be treated with dignity and respect;
- impartial access to treatment and services without regard to race, religion, gender, national origin, or disability;
- know the name of the physicians, nurses, or other health care professionals who are treating you or your insured dependent;
- the medical care necessary to correctly diagnose and treat any covered illness or injury;
- have providers tell you or your insured dependent about the diagnosis, the treatment ordered, the prognosis of the condition, and instructions required for follow-up care;
- know why various tests, procedures, or treatments are done, who the persons are who give them, and any risks you or your insured dependent needs to be aware of;
- refuse to sign a consent form if you or your insured dependent does not clearly understand its purpose, cross out any part of the form you or your insured dependent doesn't want applied to care, or have a change of mind about treatment you or your insured dependent previously approved;
- refuse treatment and be told what medical consequences might result from your or your insured dependent's refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain your or your insured dependent's rights to make health care decisions, in advance, if you or your insured dependent becomes unable to make them);

- expect privacy about care and confidentiality in all communications and in your or your insured dependent's medical records;

- expect clear explanations about benefits and exclusions;

- contact our Customer Service Department and ask questions or present complaints; and

- be informed of the right to appeal an action or denial and the related process.

You and your insured dependents have a responsibility to:

- tell the provider you or your insured dependent is covered by Regence BlueCross BlueShield of Oregon and show an identification card when requesting health care services;

- be on time for appointments and to call immediately if there is a need to cancel an appointment or if you or your insured dependent will be late. You or your insured dependent is responsible for any charges the provider makes for "no shows" or late cancellations;

- provide complete health information to the provider to help accurately diagnose and treat your or your insured dependent's condition;

- follow instructions given by those providing health care to you or your insured dependent;

- review this health care booklet to make sure services are covered by the plan;

- make sure services are preauthorized when required by this plan before receiving medical care;

- contact our Customer Service Department if you or your insured dependent believes adequate care is not being received;

- read and understand all materials about your health benefits and make sure family members that are covered under this plan also understand them;

- give an identification card to your insured family members to show at the time of service; and

- pay any required copayments at the time of service.

How Do I Access Care In The Event Of An Emergency?

If you or your insured dependent experiences an emergency situation, you or your insured dependent should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether your or your insured dependent's condition requires emergency treatment, you or your insured dependent can always call the provider for advice. The provider is able to assist you or your insured dependent in coordinating medical care and is an excellent resource to direct you or your insured dependent to the appropriate care since he or she is familiar with your or your insured dependent's medical history.

How Will I Know If My Benefits Change Or Are Terminated?

If you are insured through a group plan at work, your employee benefits administrator will let you know if and when your benefits change. In the event your group policy terminates and your employer does not replace the coverage with another group policy, your employer is required by law to advise you in writing of the termination.

What Happens If I Am Receiving Care And My Doctor Is No Longer A Contracting Provider?

When a professional provider's contract with us ends for any reason, we will give notice to those insured that we know, or should reasonably know, are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected insured individual, whichever is later. The exception to our sending the notice is when the professional provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those insured.

When Continuity Of Care Applies

If you or your insured dependent is undergoing an active course of treatment by an in-network professional provider and benefits for that provider would be denied (or paid at a level below the benefit for an out-of-area provider) if the provider's preferred contract with us is terminated or the provider is no longer participating in our preferred provider network, we will continue to pay plan benefits for services and supplies provided by the professional provider as long as:

- you or your insured dependent and the professional provider agree that continuity of care is desirable and you or your insured dependent requests continuity of care from us;

- the care is medically necessary and otherwise covered under the policy;

- you or your insured dependent remains eligible for benefits and insured under the policy; and

- the policy has not terminated.

Continuity of care does not apply if the contractual relationship between the professional provider and us ends in accordance with quality of care provisions of the contract between the provider and us, or because the professional provider:

- retires;

- dies;

- no longer holds an active license;

- has relocated outside of our service area;

- has gone on sabbatical; or

- is prevented from continuing to care for patients because of other circumstances.

How Long Continuity Of Care Lasts

Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling you or your insured dependent to continuity of care is completed; or

- the 120th day after notification of continuity of care.

If you or your insured dependent becomes eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earlier of the following dates:

- the 45th day after the birth;

- the day following the date on which the active course of treatment entitling you or your insured dependent to continuity of care is completed; or

- the 120th day after notification of continuity of care.

The notification of continuity of care will be the earlier of the date we or, if applicable, the provider group notifies you of your or your insured

dependent of the right to continuity of care, or the date we receive or approve the request for continuity of care.

Complaint And Appeals: If I Am Not Satisfied With My Health Plan Or Provider What Can I Do To File A Complaint Or Get Outside Assistance?

To voice a complaint with us, simply follow the process outlined in the MEMBER APPEALS AND GRIEVANCE PROCESS Section of this booklet, including, if applicable, information about filing an appeal through an independent review organization without charge to you.

You and your insured dependents also have the right to file a complaint and seek assistance from the director of the Department of Consumer and Business Services (DCBS). You or your insured dependent can write to the Director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: http://www.cbs.state.or.us/external/ins/

How Can I Participate In The Development Of Your Corporate Policies And Practices?

Your or your insured dependent's feedback is very important to us. If you or your insured dependent has suggestions for improvements about the plan or our services, we would like to hear from you or your insured dependent.

We have formed several advisory committees -- the Member Advisory Committee for insured employees and their insured family members, the Marketing Advisory Panel for employers, and the Provider Advisory Committee for health care professionals -- to allow participation in the development of corporate policies and to provide feedback. If you or your insured dependent would like to become a member of the Member Advisory Committee, send your or your insured dependent's name, identification number, address, and phone number to the vice president of Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon
ATTN: Vice President, Customer Service, C-7A
P.O. Box 1271
Portland, OR 97207-1271

Or send your comments to us over the internet at:

www.or.regence.com

Please note that the size of the committees may not allow us to include all those who indicate an interest in participating.

What Are Your Prior Authorization And Utilization Review Criteria?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact our Customer Service Department at the phone number on the back of your identification card, or ask your or your insured dependent's provider for a list of services that need to be preauthorized. Many types of treatment may be available for certain conditions; the preauthorization process helps the provider work together with you or your insured dependent, other providers, and us to determine the treatment that best meets your or your insured dependent's medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, preauthorization is your and your insured dependents' assurance that medical services won't be denied because they are not medically necessary.

Utilization review is a process in which we examine services you receive to ensure that they are medically necessary—appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of medically necessary in the DEFINITIONS Section of this booklet.

Let us know if you or your insured dependent would like a written summary of information that we may consider in our utilization review of a particular condition or disease. Simply call the Customer Service phone number on the back of your identification card.

How Are Important Documents (Such As My Medical Records) Kept Confidential?

We have a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your or your insured dependent's coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

My Neighbor Has A Question About The Policy That He Has With You And Doesn't Speak English Very Well. Can You Help?

Yes. Simply have your neighbor call our Customer Service Department at the number on his or her identification card. One of our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

What Additional Information Can I Get From You Upon Request?

The following documents are available by calling a Customer Service representative:

- Rules related to our medication formulary, including information on whether a particular medication is included or excluded from the formulary and information on what medications require preauthorization from Regence BlueCross BlueShield of Oregon.
- Provisions for referrals for specialty care, behavioral health services, and hospital services, and how you may obtain the care or services.
- A copy of our annual report on complaints and appeals.
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care.
- Information about our prior authorization and utilization review procedures.

What Other Source Can I Turn To For More Information About Your Company?

The following information regarding the health benefit plans of Regence BlueCross BlueShield of Oregon is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of our health promotion and disease prevention activities.

- Samples of the written summaries delivered to policyholders.
- An annual summary of grievances and appeals.
- An annual summary of utilization review policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, write to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: http://www.cbs.state.or.us/external/ins/

ELIGIBILITY

The Public Employees' Benefit Board (PEBB) Eligibility Rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

Special Eligibility -- If you and/or your eligible dependents are enrolled under another group health benefit plan and subsequently lose coverage under such plan, you and/or your eligible dependents will be considered eligible to enroll under this policy retroactive to the first of the month in which coverage terminates. Coverage under this policy will begin on the effective date described above as long as there is no lapse in coverage between the two plans (except when the prior plan does not end on the day before the normal effective date, in which case we will waive this no lapse requirement as long as enrollment is made as soon as is possible).

See the PEBB eligibility rules for more information.

NOTICE OF TERMINATION

In the event the group policy is terminated and the insurance coverage is not replaced by the group, we will mail to the group a notice of termination. It is then the duty of the group to send each insured employee or retiree a notice of the termination. The notice will explain the insured employee's or retiree's rights to continuation or conversion of coverage under federal and/or state law. Our notice to the group will be mailed within 10 working days of the policy termination date or, in the event of termination due to nonpayment of premium, the notice will be mailed within 10 working days of expiration of the grace period for payment of premium under the policy. If we fail to give notice as required in this provision, we will waive the premiums and the policy will continue in full force and effect from the end of the 10-day period to the date notice is received by the group. In this case, the period in which an insured person has to apply for continuation or conversion will begin on the date the group receives notice.

RESCINDING COVERAGE

We may rescind your and/or your insured dependent's coverage under this policy from the beginning as never effective or deny a claim at any time for fraud, material misrepresentation, or concealment by you or your insured dependent in obtaining or attempting to obtain benefits under this policy or for knowingly aiding or permitting such actions by another.

If we rescind coverage as described above, we will retain premiums paid as liquidated damages and reserve the right to recover from you or your insured dependent the benefits paid as a result of such wrongful activity that are in excess of the premium payments. In addition, we may deny

future enrollment of the group or insured person under any Regence BlueCross BlueShield of Oregon policy or the policy of any of our subsidiaries for a period of up to five years.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Notice

This notice includes important information about your rights and obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under federal COBRA law, the State of Oregon is required to offer covered employees and family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage"). This Continuation Coverage is offered at group rates when coverage under the medical plan would otherwise end due to certain qualifying events. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the Continuation Coverage provisions. Should an actual qualifying event occur in the future, the COBRA Administrator will send you additional information and the appropriate election notice at that time.

Note that Medicare entitlement, as referred to later in this provision, very seldom causes a loss of coverage, so very rarely triggers COBRA continuation.

The Plan Administrator is the Public Employees' Benefit Board (PEBB) located at 775 Court Street NE in Salem, Oregon. You can contact PEBB at (503) 373-1102 or 1-800-788-0520. COBRA continuation is administered by a third party administrator (TPA).

Continuation Coverage

COBRA coverage is continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees and dependent children of employees may be qualified beneficiaries.

Qualifying Events For Covered Employee

If you are an employee, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. A reduction in your hours of employment; or
2. Your employment ends for any reason.

Qualifying Events For Covered Spouse Or Domestic Partner

If you are the covered spouse or domestic partner, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of the employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both); or
4. Divorce or legal separation from the employee or termination of your domestic partnership.

Qualifying Events For Covered Dependent Children

Your dependent children become qualified beneficiaries if they lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of the employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both);
4. The employee's divorce or legal separation, or termination of a domestic partnership; or
5. The child ceases to qualify as a dependent child under PEBB eligibility.

Important Employee, Spouse Or Domestic Partner, And Dependent Notification Requirements

Under the law, the employee or family member is responsible to inform the agency's payroll/personnel office or benefits office within 60 days of the following qualifying events:

1. A divorce;
2. A legal separation;
3. A termination of domestic partnership; or
4. A dependent child losing dependent status under PEBB eligibility.

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employer Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in

Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of the date coverage ends.

Election Period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the COBRA Administrator. The Administrator will notify qualified beneficiaries by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions, each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your policy during the COBRA time period has the right to elect Continuation Coverage. You, your spouse or domestic partner can elect continuation coverage for any combination of individuals who would otherwise lose coverage.

Under the law, you have 60 days from the date you would lose coverage due to a qualifying event or the date on your notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an employee or covered family member to change their plan choices upon experiencing a qualifying event. This means that not only is the employee or family member given the right to continue coverage under COBRA, but may also choose any medical plan at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, rights to continue medical insurance will end.

If you choose Continuation Coverage, PEBB is required to offer you coverage that is identical to the coverage provided under the group plan to similarly situated active employees and family members. Should coverage change or be modified for active employees, then the change or modification will be made to your coverage as well. COBRA participants will also be offered an annual open enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. If you add family members, the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length Of Continuation Coverage

The law requires that you receive the opportunity to maintain Continuation Coverage from the time of the qualifying event for the following periods:

1. Up to 18 months if you qualify due to termination or reduction in working hours;

2. Up to 29 months if you qualify due to termination or reduction in working hours and are deemed disabled by the Social Security

Administration at the time of your qualifying event or at any time prior to or during the first 60 days of Continuation Coverage. You must inform the COBRA Administrator within 60 days of receipt of the Social Security disability determination and within the 18-month continuation period to qualify for this extended coverage which will be at an increased premium of up to 150%. Newborns and children placed for adoption must be disabled during the first 60 days after birth or placement to qualify for this extension.

3. Up to 36 months for spouses or domestic partners and dependents after the employee's enrollment in Medicare (if the enrollment is 18 months or less prior to termination of employment or reduction of hours), if you qualify due to Medicare entitlement (enrollment in), death of a covered employee, divorce or legal separation, termination of a domestic partnership, or if you are a dependent child who is no longer eligible to be on the plan.

4. Up to 10 years if you are the spouse or domestic partner of a covered employee and you are 55 years of age or older and qualify due to death of a covered employee, divorce or legal separation, or termination of domestic partnership (ORS 743.600 - 743-602).

However, the law also provides that your Continuation Coverage will end for any of the following reasons:

1. The State of Oregon no longer provides group medical coverage to any of its employees;

2. Any required premium for Continuation Coverage is not paid in a timely manner;

3. A qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan that does not exclude or limit coverage for specific conditions solely because they are pre-existing condition(s) which apply to you or to a covered dependent (this does not apply to CHAMPUS or Tri-Care);

4. A qualified beneficiary becomes covered (after the date of COBRA election) under Medicare.

5. The Social Security Administration no longer considers you disabled under the provision of the disability extension, but COBRA coverage will not terminate earlier than the end of the original 18 month continuation period.

6. A qualified beneficiary notifies the COBRA Administrator they wish to cancel COBRA continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you or your family members become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated while the limitation is in effect. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, PEBB may terminate your COBRA coverage.

Eligibility And Premiums

Qualified beneficiaries do not have to show they are insurable to choose Continuation Coverage. However, they must have been covered by the active group plan on the day before the event to be eligible for Continuation Coverage. An exception to this rule is if, while on Continuation Coverage, a baby is born to, adopted, or placed for adoption by a covered employee. The newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

A qualified beneficiary will have to pay all of the premium plus a 2% administration charge for Continuation Coverage. These premiums will be adjusted during the continuation period if the active employee premiums change. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the State of Oregon will charge 150% of the premium during the extended coverage period. Beneficiaries will be billed on a monthly basis for the premiums due. There is a maximum grace period of 30 days for payment of the regularly scheduled premium.

At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual portability plan provided by the same insurance carrier, as long as portability plans continue to be offered. You may contact the insurance carrier to enroll in a portability plan before, during, or following your COBRA continuation period. To qualify for a portability plan you must make application directly to the medical carrier within 63 days following the end of your Continuation Coverage or any time during your Continuation Period. Coverage on a portability plan will differ from the group plan and may exclude certain conditions or services offered under the group plan. Contact the carrier for further details.

Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family

members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Questions

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your COBRA rights at that time. If any covered individual does not understand any part of this summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at:

- (503) 373-1102 or (800) 788-0520 (outside Salem).
- inquiries.pebb@state.or.us
- http://pebb.das.state.or.us

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONVERSION TO PORTABILITY HEALTH BENEFIT PLANS

If you or your insured dependents lose eligibility for coverage under this policy, you and/or your insured dependents may be entitled to coverage under one of our portability health benefit plans, or one of our products for Medicare eligible individuals which we are offering at that time. ''Portability health benefit plans'' are health benefit plans for eligible individuals that are required to be offered by all group carriers in Oregon. The purpose of portability plans is to improve the availability and affordability of health benefit plans for individuals leaving group coverage.

Eligibility For A Portability Plan

To be eligible for one of the portability plans, you or your insured spouse or any eligible dependents must:

- have terminated coverage or been terminated from coverage due to loss of eligibility;
- not be eligible for Medicare coverage or coverage under this policy (except under federal COBRA or Oregon State continuation coverage) or any other health benefit plan;
- have been continuously covered up to the time of termination of coverage under this policy as follows:
  - for at least 180 days under this policy (including federal COBRA or Oregon State continuation coverage) or this policy

and one or more prior Oregon group medical insurance contracts; or

– for at least 18 months of prior credible coverage but less than 180 days of combined Oregon group medical insurance coverage. In that situation, if you or your insured dependent are eligible for either federal COBRA or Oregon State continuation coverage at the time of termination from this policy, you or your insured dependent must enroll on continuation coverage until you or your insured dependent has a total of at least 180 days of continuous Oregon group medical insurance coverage. If you or your insured dependent is not eligible for continuation coverage, this continuation coverage requirement does not apply;

- have been a resident of the State of Oregon at the time coverage under this policy terminated (including any federal COBRA or Oregon State continuation coverage) or within 63 days of such coverage termination; and

- satisfy any other provisions of the portability plan.

How To Apply For A Portability Plan

In order to exercise the right to one of the portability plan options, the person must:

- submit a written application to us;

- apply within 63 days of termination of prior Oregon group medical insurance coverage or at any time during continuation coverage under federal COBRA or Oregon State law; and

- make the required premium payment.

Please note that once you enroll in a portability plan, you may not reenroll under this policy unless you are again eligible for coverage under the policy.

Portability Health Benefit Plan Options

For eligible individuals leaving their group coverage, we offer the following types of portability health benefit plans:

– a ‘‘prevailing cost plan’’, which includes benefit coverages and premiums that are prevalent in the Oregon group health insurance market; and

– a ‘‘low cost plan,’’ which emphasizes affordability for eligible individuals.

For information regarding the individual portability coverage, a special representative in our Member Services department is available to answer your questions.

Telephone: (503)-220-6363
Toll-free: 1-800-777-3168

GENERAL PROVISIONS

The following section explains various provisions concerning the relationship between the group and us.

Group Is The Agent

The group is your and your insured dependent's agent for all purposes under this policy and not the agent of Regence BlueCross BlueShield of Oregon.

Relationship To Blue Cross And Blue Shield Association

The group on behalf of itself and its insured employees hereby expressly acknowledges its understanding that this policy constitutes a policy solely between the group and Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, and association of independent Blue Cross and Blue Shield Plans (the ''Association''), permitting Regence BlueCross BlueShield of Oregon to use the Blue Cross and Blue Shield Service Marks in the State of Oregon and a portion of the State of Washington, and that Regence BlueCross BlueShield of Oregon is not contracting as the agent of the Association. The group on behalf of itself and its insured employees further acknowledges and agrees that it has not entered into this policy based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon shall be held accountable or liable to the group or the insured employees for any of our obligations to the group or the insured employees created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of this policy.

CUSTOMER SERVICE

The Regence BlueCross BlueShield of Oregon home office in Portland and the branch offices are maintained to meet your servicing needs. Blue Cross and Blue Shield plans are located in cities throughout the United States with additional offices in Puerto Rico, Jamaica, and Canada.

Regence BlueCross BlueShield of Oregon Customer Service hours are 7:30 a.m. to 5:15 p.m.

- From Portland dialing area, call (503) 220-3849.
- From Oregon outside the Portland area, call 1-800-826-9813.

HEALTH PROMOTION PROGRAMS

The descriptions of the following health promotion programs are provided in this member handbook as a convenience. These programs are not insurance. They are a complement to, but do not form a part of, the group health plan.

FREE & CLEAR ® QUIT FOR LIFE™ PROGRAM

Regence BCBSO is excited to offer PEBB members the Free & Clear® Quit For Life™ Program. This program addresses tobacco dependence, through a clinically proven, comprehensive approach to tobacco cessation that treats all 3 aspects of tobacco use: physical addiction, psychological dependence and behavioral patterns. The expert Quit Coaches will create a quit plan just for you that includes:

- One-on-one phone based treatment sessions
- Unlimited toll-free telephone access to Quit Coaches
- A Quit Kit of materials designed to help participants quit tobacco through active self-management
- Recommendations on an direct fulfillment of nicotine replacement therapy, if appropriate
- Information and decision support for bupropion, if appropriate

Free & Clear can be reached at: 1-866-QUIT-4-LIFE (784-8454).

- Hours: Monday – Sunday 5:00 a.m. – 9:00 p.m. Pacific Time
- Hours: Monday – Sunday 6:00 a.m. – 10:00 p.m. Mountain Time
- Hours: Monday – Sunday 7:00 a.m. – 11:00 p.m. Central Time
- Hours: Monday – Sunday 8:00 a.m. – Midnight Eastern Time
- After hours voicemail: All messages returned within 24 hours

Languages Spoken

- Translation services for many languages
- English/Spanish tobacco treatment staff and supervisors
- TTY available 1-877-777-6534

To find out more about the Free & Clear Quit For Life Program, call 1-866-QUIT-4-LIFE (784-8454).

SPECIAL BEGINNINGS®

Special Beginnings® is an optional program providing a coordinated method of prenatal risk assessment and support for expectant mothers, designed to decrease the incidence of pregnancy complications and increase the chances of giving birth to full-term, healthy babies. Participation by the expectant mother (you, your enrolled spouse, or an enrolled dependent female child) is voluntary and confidential, and is offered at no additional cost to you.

Registering for the program is easy: Simply call Regence BlueCross BlueShield of Oregon at 1-888-JOY-BABY (569-2229). After registration, everything the expectant mother needs to participate will be sent directly to your home in a prenatal kit that includes:

- a confidential questionnaire which is used to evaluate the expectant mother's risk for potential problems;
- a pregnancy calendar; and
- an illustrated book on prenatal care.

Other benefits of the program include:

- personalized monitoring of the expectant mother's care throughout the pregnancy, along with 24-hour, toll-free telephone access to registered nurses who are experienced in working with expectant mothers and newborns;
- educational materials based on information provided in the prenatal risk assessment you return to Special Beginnings®;
- referrals to maternity services available in your area; and
- a gift upon completion of the program.

CAREENHANCE®

Active Employees Only

CareEnhance® Nurse Advice Line is a service brought to you by The Regence Group. This service is designed to give you accurate, reliable answers and get you on the road to recovery as quickly as possible by providing access to a registered nurse **24 hours a day**, **7 days a week**.

Registered nurses can help you understand health issues and treatment options, review specific questions to ask your providers, offer insights into current research on treatments and diagnostic procedures, and explain the risks and benefits of various options.

While nurse advisors cannot necessarily prescribe or give medical advice, they do empower you to make informed decisions and give you the support and information you need to maximize your care.

Call the CareEnhance® Nurse Advice Line at (1-800-267-6729):

- when you're sick, hurt or need health care advice;
- when you're not sure whether to go to the emergency room, see your doctor, or treat your problems at home; or
- if you have health questions about things like medications and medical procedures;

CareEnhance® nurses will help you:

- learn self care for minor illnesses and injuries;
- understand diagnosed conditions;
- discover and evaluate possible benefits and risks of various treatment options; and
- choose the best time and place for care.

You can also logon to http://www.or.regence.com/careenhance for online health care information. Please note that all CareEnhance® calls are confidential.

Don't forget to use your employee ID for access to the nurse line and website.

ADVICARE[SM]

AdviCare[SM] is a series of Disease Management and High-Risk Case Management programs provided to assist members with chronic and other health conditions in managing their health. The program identifies eligible participants and provides personalized contact with a nurse, educational materials, Internet tools, and other services for members.

AdviCare is helpful for people who want to take control of serious health conditions. The program is designed to work with members' schedules and personal health needs. The major objectives of AdviCare are to:

- improve member health status and outcomes;
- enhance patient satisfaction with the overall care experience;
- improve physician satisfaction;
- reduce total health-care costs; and
- reduce employee absenteeism.

Conditions managed with the program are:

- asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease;
- impact conditions: atrial fibrillation, acid-related stomach disorders, chronic back pain, decubitus ulcers, fibromyalgia, hepatitis C, irritable bowel syndrome, inflammatory bowel disease, osteoarthritis, osteoporosis and urinary incontinence; and
- high-risk case management.

Members receive:

- introductory packet and welcome call;
- conveniently scheduled "care calls" for members that provide individual support based on claims and a clinical assessment;
- self-care goal reminders mailed to members whenever new goals are established;
- nurses available toll-free 24 hours a day, seven days a week;
- mailed reminders about important screening tests and standards of care, and

- an online health risk assessment tool.

For general questions regarding this program you may contact Customer Service from the Portland dialing area at (503) 220-3849 or from Oregon outside the Portland area at 1-800-826-9813. Eligible members with a qualifying condition may also self-refer by calling (866) 782-7241.

REGENCE HEALTH COACH

The Regence Health Coach program provides information and support to avoid health problems or to improve and protect your health. The program is a benefit of your health-insurance policy and is free of charge.

Here is what you will receive from the program:

- An enrollment questionnaire that helps you assess your current health habits.
- A follow-up consultation with one of our health coaches that reviews your enrollment questionnaire and helps you choose a goal or two toward better health. The health coach is there to provide you with educational materials on any health-related subject, and to offer encouragement and support as you work toward meeting your goal(s).
- A free pedometer and walking log.
- Telephone contact from your health coach for ongoing education and support as you are working toward those healthy lifestyle goals.
- Toll-free access to your health coach to address any of your health-related concerns or for continued encouragement and support.
- A $25 gift certificate upon completion of the program.

Why is PEBB participating in this?
We know that making lifestyle changes can prevent some illnesses and diseases. That is why PEBB has partnered with Regence BlueCross BlueShield of Oregon to provide employees and dependents with health coaches, who can help people set and reach goals for a healthier life. Everyone wins – the employee who is healthier, PEBB who has a healthier workforce with less absenteeism and Regence BlueCross BlueShield of Oregon because it costs less to insure healthier people.

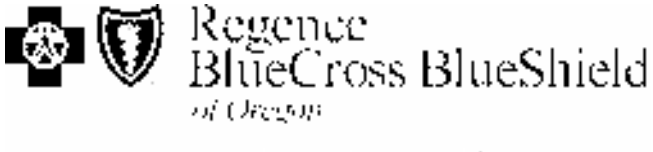
Will PEBB or my boss know that I'm participating or will they know what my medical conditions are?
Your participation and your medical information are confidential. PEBB will receive summary reports showing totals only. No individuals are identified.

What if I set a goal and don't reach it?
There are no repercussions if you don't reach your goal. It is a personal goal you set for yourself and your health coach will provide you with

materials, encouragement and support to try to help you reach those goals.

Can my family members join?
Anyone who has insurance coverage through PEBB is eligible to enroll.

Is it mandatory?
Enrollment and participation are voluntary. Please consider joining *the Regence Health Coach Program*. What do you have to lose? To enroll, or to ask questions, please call (800) 632-2022, choose menu option 4, then extension 6558.


Regence
BlueCross BlueShield
of Oregon

Order of Prioritized Benefit Categories for OHP Standard

	Mandated Medicaid Services
1	- Inpatient Hospital
2	- Outpatient Hospital
3	- Emergency Room
4	- Physician
5	- Lab/X-ray
6	- Ambulance
	Optional Medicaid Services
7	- Prescription Drugs
8	- Mental Health/Chemical Dependency
9	- Durable Medical Equipment
10	- Dental
11	- Vision
12	- Non-emergent Transportation

Oregon Health Fund Board

Benefits Committee
February 28, 2008

Clackamas Community College
Wilsonville Campus Training Center, Room 112
29353 Town Center Loop East
Wilsonville, Oregon

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OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE

February 28, 2008 Meeting Packet

Oregon Health Fund Board
Benefits Committee Meeting

Thursday, February 28, 2008
9:30 am – 1:30 pm
Room 112
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Susan King	
5 min	Approval of Agenda and 1/15/08 Minutes	Susan King	X
9:35 am 15 min	Update on Board/Committee Activities	Jeanene Smith	
9:50 am 30 min	Overview of Draft Tool for Defining Essential Health Services	DarrenCoffman, Staff Review Panel	
10:20 am 2 hrs	Discussion on Use of Draft Tool for Defining Essential Health Services	Susan King	
12:20 pm 40 min	Discussion of Other Issues Not Entirely Addressed by the Draft Tool • Diagnostic services • Ancillary services • Enabling services	Susan King	
1:00 pm 20 min	Public Testimony	Susan King	
1:20 am 10 min	Next Steps	Susan King	
1:30 pm	Adjourn	Susan King	

Draft Minutes
Oregon Health Fund Board Benefits Committee
January 15, 2008

Members Present: Susan King, RN, Chair; Gary Allen, DMD; Tom Eversole; Leda Garside, RN, BSN; Betty Johnson; Bob Joondeph; Jim Lussier; Susan Pozdena (arrived at 9:10 am); Somnath Saha, MD, MPH (arrived at 9:25 am); Hugh Sowers, Jr; Nina Stratton; Kathryn Weit; Kevin Wilson, ND.

Members Absent: Lisa Dodson, MD.

Staff Present: Barney Speight; Jeanene Smith, MD, MPH; Darren Coffman; Ariel Smits, MD, MPH; Brandon Repp; Nathan Hierlmaier.

Also Attending: Pat Murphy, L.Ac., Martin Brother, L.Ac. & Stephen Kafoury, Oregon Acupuncture Association; Dave Roberts, Lilly; Beryl Fletcher, Oregon Dental Association; Denise Honzel, Oregon Business Council; Kelly Harms, Office of Private Health Partnerships, Laura Sisulak, OPCA; Tanya Stewart, MD.

I. Call to Order

- Ms. Susan King, RN, called the Benefits Committee meeting to order at 9:00 AM in Room 218 of the Clackamas Community College Wilsonville Training Center, Wilsonville, OR.

II. Approval of Draft Agenda and Minutes

- No revisions were made to the draft agenda.

MOTION: To accept the minutes from the December 11, 2007 meeting as submitted. MOTION CARRIES: 10-0 (Absent: Dodson, Pozdena, Saha).

III. Identification of Principles and Policy Objectives for Defining Essential Health Services

- Mr. Darren Coffman presented a draft document outlining a checklist of the Benefits Committee's guiding principles and policy objectives based on SB 329 and the tenets of the Oregon Health Plan.
- Discussion took place regarding the phrase "Based on a proven benefit model." Taken from SB 329, the term "proven" may refer to the number of individuals covered or a model that bases coverage on interventions that are cost-effective and/or evidence-based, with interpretations varying.
- See Attachment A for a revised version of the checklist that indicates the changes resulting from the discussions taking place during the meeting as underlined text.

IV. Overview of Models for Defining Essential Services and Their Adherence to the Principles/Policy Objectives

- Dr. Jeanene Smith gave an overview of the creation of OHP 2, which became OHP Standard, and offers a more limited benefit package to qualifying individuals who are not considered categorically eligible for Medicaid.
- A study was conducted to outline the various health plans and benefits being offered commercially and compared those things to the Prioritized List of Health Services.
- The analysis showed that the commercial plans rely on exclusion and limitation of benefits but is less transparent than the Prioritized List, which lists each condition/treatment pair plainly. The result of the comparison showed there were very few differences in actual coverage, rather, just the way it was presented.
- The members would like to see cost models for Medicaid, OMIP, etc. Mr. Coffman explained that while looking at cost data from differing systems it is difficult to have a true comparison of like costs. He stated that this group may engage the services of an actuary to get a more clear picture.
- Discussed was the need to consider costs when creating a benefit package so that is economically feasible.

V. Next Steps

- The Vice Chairs, Chair and staff will put together a proposal to divide the committee's work to be emailed to the members.
- Next meeting is scheduled for February 7, 2008.

VI. Public Testimony

- Dr. Tanya Stewart, an internist, is a palliative care specialist. She stated that there seems to be a gap between aggressive interventions for curative or restorative health and hospice care. Lacking may be the opportunity for a patient-physician discussion to set goals early in the disease process that might change the direction in the treatment during course of the disease.
- Stephen Kafoury, lobbyist for the Oregon Acupuncture Association, addressed the Committee regarding the role of acupuncture. Martin Brother, L.Ac., read highlights from written testimony, advocating for the inclusion of acupuncture and oriental medicine in the benefit design.

VII. Adjourn

- Ms. King adjourned the meeting at 11:42 am.

ATTACHMENT A

OHFB Benefits Committee Guiding Principles/Policy Objectives Checklist

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan.

A. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians? (SB329)
- ☐ b. based upon a proven benefit model (preferably Prioritized List, also could be a commercial plan)? (SB329)
- ☐ c. reflective of the values of Oregonians? (OHP)
- ☐ d. easy to adjust in response to new information on cost and effectiveness? (OHP)
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable? (SB329)
- ☐ f. developed in a transparent manner? (SB329, OHP)
- ☐ g. address the acute and tertiary care needs of the population?

B. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care (SB329, OHP community meetings)
- ☐ b. Chronic disease management (SB329)
- ☐ c. Primary care medical homes (SB329)
- ☐ d. Dignified end-of-life care (SB329)
- ☐ e. Patient-centered care (SB329)
- ☐ f. Provision of care in the least restrictive environment (SB329)

C. Does the set of essential health services help promote:

- ☐ a. wellness? (SB329)
- ☐ b. patient engagement (including education towards self-management)? (SB329)
- ☐ c. coordination and integration of care? (SB329)
- ☐ d. population health? (SB329)
- ☐ e. cost-effective care? (SB329, HB3624 of 2003, OHP community meetings)
- ☐ f. cost-control/reductions in over-utilization? (SB329, OHP)
- ☐ g. access to timely and appropriate diagnosis and treatment? (Task Force on Basic Benefits)

D. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine (SB329, OHP)
- ☐ b. Efficacy of treatments (SB329, HB3624 of 2003)
- ☐ c. Reduction of health disparities (SB329)
- ☐ d. Personal responsibility (SB329, OHP community meetings)
- ☐ e. Impact on vulnerable populations (including pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services

DRAFT ESSENTIAL SERVICES MATRIX

Categories of Care (listed in priority given by Health Services Comm.)	Primary Care Home Services	Outpatient & Elective Specialty Care	Home Care	Facility-Based Long-Term Care	Acute Hospital-Based Care	Examples
Maternity/Newborn Care						Prenatal visits, ultrasounds, pregnancy complications, delivery, low birthweight babies, birth trauma, infections acquired from mother
Primary/Secondary Prevention						Immunizations, well-child visits, screening colonoscopies/mammograms, smoking cessation, high cholesterol, dental exams/cleanings, colon polyps
Chronic Disease Management						
High effectiveness/ population health impact						Alcohol & drug treatment, severe depression, asthma, high blood pressure, HIV disease, diabetes, rheumatoid arthritis
Moderate effectiveness/ population health impact						Post-traumatic stress disorder, dementia, sleep apnea, Parkinson's disease, multiple sclerosis, anorexia, COPD, gout, cirrhosis of liver
Marginal effectiveness/ population health impact						Bulemia, self-abusive behaviors (e.g., headbanging) due to neurologic dysfunction, allergies (e.g., hayfever)
Reproductive Services						Birth control pills, vasectomy, tubal ligation, therapeutic abortion, miscarriage
Comfort Care						Medication for symptom control/pain relief, hospice, medical equipment, Oregon Death with Dignity Act services
Treatable Fatal Conditions						
High effectiveness/ population health impact						GI bleeding, heart attack, severe head injury, acute leukemia, broken arm/leg (open), breast cancer, viral hepatitis, pneumococcal pneumonia
Moderate effectiveness/ population health impact						Aortic valve disease, melenoma, heart transplant, abnormal heart rhythm, chronic leukemia, stroke, acute renal failure, acute sinusitis
Marginal effectiveness/ population health impact						Croup, delerium, gallbladder cancer, hardening of the aorta, liver transplant for liver cancer, bariatric surgery for non-diabetic
Treatable Nonfatal Conditions						
High effectiveness/ population health impact						Gonorrhea, eye diseases leading to blindness, kidney infection, disloca- tion of joint (closed), wheelchair for ALS, cleft palate, enlarged prostate
Moderate effectiveness/ population health impact						Broken arm/leg (closed), strep throat, kidney stones, reflux disease, migraines, eyeglasses, acute bronchitis, dentures
Marginal effectiveness/ population health impact						Fungal infection of nail, acne, erectile dysfunction, uncomplicated hernia, muscular low back pain, cold sores, minor burns
Self-limited Conditions						Mono, thrush, viral sore throat, corns/calluses, tendonitis, diaper rash, simple muscle sprian/strain, common cold, laryngitis, pink eye
Inconsequential Care						Insomnia, orthodontics, minor head injury, viral warts, benign skin lesions, smoker's cough, varicose veins w/o pain, uncomplicated hemorrhoids
Excluded Services						Infertility services, cosmetic treatments, experimental treatments

The Prioritized List of Health Services determines which specific condition-treatment pairs within the categories of care are clinically effective and cost-effective and are appropriate for coverage.

Ancillary services (e.g., Rx, DME) and enabling services (e.g., coordination of care, translation) are given the same priority as the conditions they are being used to manage.

Utilization management strategies should be employed for ED visits (triage fee for non-emergent conditions), imaging (guidelines, PA for CT/MRI/PET), and Rx (evidence-based formulary).

Cost-sharing strategies can be used to encourage utilization of timely and cost-effective services in the most appropriate setting. Examples could include no copays on preventive services and tiered copays for Rx and office/urgent care/ED visits.

Categories of Care as Prioritized by the Health Services Commission

Maternity & Newborn Care

Primary Prevention and Secondary Prevention

Chronic Disease Management

- High effectiveness/population health impact
- Moderate effectiveness/population health impact
- Marginal effectiveness/population health impact

Reproductive Services

Comfort Care

Treatable Fatal Conditions

- High effectiveness/population health impact
- Moderate effectiveness/population health impact
- Marginal effectiveness/population health impact

Treatable Nonfatal Conditions

- High effectiveness/population health impact
- Moderate effectiveness/population health impact
- Marginal effectiveness/population health impact

Self-limited Conditions

Inconsequential Care

Excluded Services

- Infertility services
- Cosmetic treatments
- Experimental treatments

Maternity and Newborn Care

Total lines on Prioritized List: 24 **Highest Rank: 1**

Number of Funded Lines: 24 **Median Rank: 34**

Costs as a % of OHP Benefit Package: 14.8% **Lowest Rank: 374**

Examples:

- **Maternity care (e.g., prenatal visits, delivery, treatment of complications of pregnancy) (3)**
- **Newborn care, including routine care after normal delivery and treatment of conditions intrinsic to the pregnancy such as infections and birth trauma (23 lines between 2 and 374)**

Primary and Secondary Prevention

Total lines on Prioritized List: 11 **Highest Rank: 3**

Number of Funded Lines: 11 **Median Rank: 104**

Costs as a % of OHP Benefit Package: 3.6% **Lowest Rank: 257**

Examples:

- **Preventive services for children under age 10 (e.g., immunizations and well-child visits) (3)**
- **Preventive services for children age 10 and older and adults (e.g., flu shots, colonoscopies, mammograms, and pap smears) (4)**
- **Services to help quit smoking (6)**
- **Pre-cancerous conditions of the cervix (31)**
- **High cholesterol (66)**
- **Preventive dental services including regular exams, cleaning, and fluoride for children (105)**
- **Preventive foot care for people with diabetes (173)**
- **Colon polyps (174)**
- **Pre-cancerous skin lesions (257)**

Chronic Disease Management:
High Effectiveness/Population Health Impact

Total lines on Prioritized List: 34 **Highest Rank: 5**
Number of Funded Lines: 34 **Median Rank: 36**
Costs as a % of OHP Benefit Package: 12.0% **Lowest Rank: 152**

Examples:

- **Services to help quit smoking (5)**
- **Intensive counseling on nutrition, physical activity and other behaviors (8)**
- **Severe depression (9)**
- **Asthma (11)**
- **High blood pressure (12)**
- **HIV disease (15)**
- **Cystic fibrosis (26)**
- **Schizophrenia (27)**
- **Type II (adult onset) diabetes (33)**
- **Epilepsy (36)**
- **Rheumatoid arthritis (52)**
- **Chronic renal failure requiring dialysis (65)**
- **Congestive heart failure (109)**
- **Attention deficit disorder (134)**
- **Moderate and severe psoriasis (135)**
- **Glaucoma (150)**
- **Lupus (152)**

Chronic Disease Management:
Moderate Effectiveness/Population Health Impact

Total lines on Prioritized List: 19 **Highest Rank: 180**
Number of Funded Lines: 19 **Median Rank: 234**
Costs as a % of OHP Benefit Package: 3.1% **Lowest Rank: 359**

Examples:

- **Post-traumatic stress disorder (181)**
- **Dementia (210)**
- **Sleep apnea (211)**
- **Parkinson's disease (266)**
- **Multiple sclerosis (268)**
- **Anorexia (304)**
- **Chronic obstructive pulmonary disease (COPD) (305)**
- **Gout (325)**
- **Cirrhosis of the liver (359)**

Chronic Disease Management:
Marginal Effectiveness/Population Health Impact

Total lines on Prioritized List: 6 **Highest Rank: 395**
Number of Funded Lines: 5 **Median Rank: 421**
Costs as a % of OHP Benefit Package: 0.1% **Lowest Rank: 574**

Examples:

- **Bulimia (409)**
- **Self-abusive behaviors (e.g., headbanging) due to neurological dysfunction (456)**
- **Allergies (e.g., hayfever) (574)**

Reproductive Services

Total lines on Prioritized List: 3
Number of Funded Lines: 3
Costs as a % of OHP Benefit Package: 0.6%

Highest Rank: 7
Median Rank: 41
Lowest Rank: 391

Examples:

- **Reproductive services, including birth control and sterilization (7)**
- **Therapeutic abortion (41)**
- **Miscarriage (391)**

Comfort Care

Total lines on Prioritized List: 0 **Highest Rank: N/A**
Number of Funded Lines: N/A **Median Rank: N/A**
Costs as a % of OHP Benefit Package: ? **Lowest Rank: N/A**

Comfort care services were initially placed on line 71 of the reprioritized list. The HSC received a report from the Division of Medical Assistance Programs (DMAP) that there was some question as to the commission's intent in what constituted comfort care according to the guideline attached to this line and a separate line in the nonfunded region of the list for treatments of a medical conditions that would result in less than a 5% five-year survival. The HSC determined that the best way to make their intent clear was to delete both and attach a new statement of intent to the list that would apply to all diagnoses, which reads as follows:

> It is the intent of the Commission that comfort/palliative care treatments for patients with an illness with <5% expected 5 year survival be a covered service. Comfort/palliative care includes the provision of services or items that give comfort to and/or relieve symptoms for such patients. There is no intent to limit comfort/palliative care services according to the expected length of life (e.g., six months) for such patients, except as specified by Oregon Administrative Rules.
>
> It is the intent of the Commission to not cover diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness which are intended to prolong life or alter disease progression for patients with <5% expected 5 year survival.
>
> Examples of comfort/palliative care include:
> 1) Medication for symptom control and/or pain relief;
> 2) In-home, day care services, and hospice services as defined by DMAP;
> 3) Medical equipment (such as wheelchairs or walkers) determined to be medically appropriate for completion of basic activities of daily living;
> 4) Medical supplies (such as bandages and catheters) determined to be medically appropriate for management of symptomatic complications or as required for symptom control; and
> 5) Services under ORS 127.800-127.897 (Oregon Death with Dignity Act), to include but not be limited to the attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.
>
> Examples of services which are not intended to be covered as comfort/palliative care include:
> 1) Chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression; and
> 2) Medical equipment or supplies which will not benefit the patient for a reasonable length of time.

Treatable Fatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *High Effectiveness/Population Health Impact*

Total lines on Prioritized List: 147 **Highest Rank: 22**
Number of Funded Lines: 147 **Median Rank: 136**
Costs as a % of OHP Benefit Package: 15.4% **Lowest Rank: 222**

Examples:

- **Spina bifida (40)**
- **Intestinal obstruction (48)**
- **Tuberculosis (TB) (55)**
- **Gastrointestinal (GI) bleeding (61)**
- **Acute bacterial meningitis (75)**
- **Myocardial infarction (heart attack) (76)**
- **Moderate/severe head injury (101)**
- **Acute leukemia (103)**
- **Testicular cancer (124)**
- **Anemia (128)**
- **Malaria (136)**
- **Open fracture of the arm or leg with a break in the skin (144)**
- **Pneumothorax (collapsed lung) (154)**
- **Cervical (neck) fracture (159)**
- **Colon cancer (168)**
- **Ruptured spleen (178)**
- **Intracerebral hemorrhage (bleeding in the brain) (186)**
- **Breast cancer (198)**
- **Acute pancreatitis (201)**
- **Viral hepatitis (206)**
- **Mild/moderate depression (213)**
- **Pneumococcal pneumonia (214)**
- **Abscesses and cellulitis (215)**
- **Uterine cancer (219)**
- **Thyroid cancer (221)**

Treatable Fatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *Moderate Effectiveness/Population Health Impact*

Total lines on Prioritized List: 109
Number of Funded Lines: 109
Costs as a % of OHP Benefit Package: 6.3%

Highest Rank: 226
Median Rank: 299
Lowest Rank: 396

Examples:

- **Kidney cancer (229)**
- **Anaphylactic shock (235)**
- **Aortic valve disease (237)**
- **Rheumatic fever (239)**
- **Facial fracture (242)**
- **Melanoma (243)**
- **Peripheral vascular disease (250)**
- **Ovarian cancer (252)**
- **Life-threatening nosebleed (262)**
- **Chronic bone infection (271)**
- **Lung cancer (278)**
- **Heart transplant (279)**
- **Amputation of the foot due to trauma (287)**
- **Life-threatening arrhythmia (abnormal heart rhythm) (303)**
- **Chronic leukemia (309)**
- **Oral cancer (311)**
- **Brain cancer (319)**
- **RSV pneumonia in small children (329)**
- **Liver transplant (332)**
- **Liver cancer (338)**
- **Stroke (340)**
- **Acute renal failure requiring dialysis (350)**
- **Prostate cancer (354)**
- **Viral myocarditis (infection of the heart) (366)**
- **Pancreatic cyst (386)**
- **Acute sinusitis (388)**

Treatable Fatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *Marginal Effectiveness/Population Health Impact*

Total lines on Prioritized List: 14 **Highest Rank: 398**
Number of Funded Lines: 11 **Median Rank: 453**
Costs as a % of OHP Benefit Package: 0.4% **Lowest Rank: 608**

Examples:

- **Anemia due to kidney disease (405)**
- **Croup (415)**
- **Delerium (428)**
- **Gallbladder cancer (453)**
- **Atherosclerosis (hardening of the artery) of the aorta (465)**
- **Liver transplantation for liver cancer (575)**
- **Bariatric surgery for obesity in non-diabetic patients (608)**

Treatable Nonfatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *High Effectiveness/Population Health Impact*

Total lines on Prioritized List: 30 **Highest Rank: 56**
Number of Funded Lines: 30 **Median Rank: 322**
Costs as a % of OHP Benefit Package: 4.3% **Lowest Rank: 369**

Examples:

- **Gonorrhea (56)**
- **Diseases/injuries of the eye that can lead to significant vision impairment or loss (e.g. retinal detachment and cataract) (18 lines between175 and 363)**
- **Kidney infection (290)**
- **Dislocation of a joint without a break in the skin (296)**
- **Wheelchairs for people with disabilities (317)**
- **Cleft palate and/or cleft lip (324)**
- **Enlarged prostate causing urinary obstruction (349)**

Treatable Nonfatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *Moderate Effectiveness/Population Health Impact*

Total lines on Prioritized List: 109
Number of Funded Lines: 109
Costs as a % of OHP Benefit Package: 13.0%

Highest Rank: 371
Median Rank: 444
Lowest Rank: 503

Examples:

- **Atherosclerosis (hardening of the arteries) of the arms and legs (373)**
- **Foreign body in eye (378)**
- **Broken arm/leg without breaking the skin (379)**
- **Hearing aids for children still developing speech (380)**
- **Knee/hip replacement (381)**
- **Lice (383)**
- **Strep throat (392)**
- **Giardiasis (diarrhea from contaminated water) (393)**
- **Surgery for conditions of the back involving the nerves (397)**
- **Benign lung tumors (399)**
- **Short-term rehabilitation (e.g., after a stroke) to restore self-care activities (404)**
- **Bed sores (407)**
- **Panic attacks (414)**
- **Kidney stones (418)**
- **Reflux disease (419)**
- **Venereal warts, not pre-cancerous (420)**
- **Uterine fibroids (423)**
- **Migraine headaches (430)**
- **Carpal tunnel syndrome (435)**
- **Torn knee ligament (e.g., ruptured ACL) (449)**
- **Macular degeneration (466)**
- **Eyeglasses (468)**
- **Urinary incontinence (470)**
- **Acute bronchitis (476)**
- **Obsessive-compulsive disorders (479)**
- **Complicated hemorrhoids (492)**
- **Chronic ear infections (493)**
- **Dentures (499)**
- **Benign breast cysts (501)**

Treatable Nonfatal Conditions Where Treatment is Aimed At Disease Modification or Cure: *Marginal Effectiveness/Population Health Impact*

Total lines on Prioritized List: 109
Number of Funded Lines: 0
Costs as a % of OHP Benefit Package: 0%

Highest Rank: 504
Median Rank: 561
Lowest Rank: 662

Examples:

- **Repair of broken dental appliances (504)**
- **Bell's palsy (508)**
- **Fungal infection of nail (510)**
- **Cracked rib (512)**
- **Cross-gender identification (514)**
- **Plugged salivary gland causing dry mouth (519)**
- **Acne (522)**
- **Persistent dizziness (530)**
- **Excessive sweating (533)**
- **Erectile dysfunction (536)**
- **Uncomplicated hernia in adults (538)**
- **Food poisoning not requiring hospitalization (541)**
- **Skin allergy (546)**
- **Muscular low back pain (552)**
- **Tension headache (554)**
- **Mild psoriasis (555)**
- **Hives (559)**
- **Excessive shyness in children (566)**
- **Deviated septum and other acquired deformities of nose (591)**
- **Hair transplants (607)**
- **Cold sores (621)**
- **Minor burns (625)**
- **Vocal cord polyps (singer's nodes) (655)**
- **TMJ surgery (662)**

Self-limited Conditions

Total lines on Prioritized List: 22 **Highest Rank: 548**
Number of Funded Lines: 0 **Median Rank: 610**
Costs as a % of OHP Benefit Package: 0% **Lowest Rank: 651**

Examples:

- **Mononucleosis (mono) (595)**
- **Thrush (602)**
- **Viral sore throat (609)**
- **Corns and calluses (610)**
- **Tendonitis (e.g., tennis elbow) (611)**
- **Diaper rash (616)**
- **Simple muscle sprains and strains (628)**
- **Common cold (634)**
- **Laryngitis (636)**
- **Pink eye (651)**

Inconsequential Care

Total lines on Prioritized List: 42 **Highest Rank: 613**
Number of Funded Lines: 0 **Median Rank: 659**
Costs as a % of OHP Benefit Package: 0% **Lowest Rank: 680**

Examples:

- **Insomnia (626)**
- **Orthodontics (braces) (630)**
- **Minor head injury with no loss of consciousness (631)**
- **Viral warts (other than venereal warts) (633)**
- **Routine circumcision (643)**
- **Benign skin lesions (646)**
- **Chronic bronchitis (e.g., smoker's cough) (654)**
- **Asymptomatic varicose veins (657)**
- **Asymptomatic gallstones (659)**
- **Baby born with all or part of lung missing (665)**
- **Uncomplicated hemorrhoids (668)**

Examples for Use of the Essential Services Matrix

Diabetes and Other Chronic Conditions

The Prioritized List ranks all treatments (with the exception of pancreas/kidney transplant) for type I diabetes on line 10 and type II diabetes (including bariatric surgery) on line 33. Preventive care, which helps to reduce blood sugar levels and prevent long-term complications of diabetes (e.g. regular checkups, insulin and supplies, and nutritional counseling), is given the same priority on the List as hospital or ER care for complications from non-optimally treated diabetes. The matrix could be used to encourage more cost-effective preventive care while still ensuring that necessary emergency care is available: higher priority could be given to early, preventive care services such as regular checkups (e.g., 10 on a scale of 0 to 10), a somewhat lower (but still high) priority for more expensive specialty care (e.g., 9) including visits to an endocrinologist or bariatric surgery, and a yet lower priority (e.g., 7) to the diabetic patient who presents in the emergency room in a diabetic coma. Similar distinctions could be made between preventive maintenance and crisis management for other chronic diseases requiring ongoing management such as asthma and congestive heart failure.

Mental Health Diagnoses

The Prioritized List integrates mental and physical health (and dental) diagnoses in its line rankings using the same methodology. For example, major depression is on line 9 and schizophrenia is on line 27. Like diabetes, different types of care for mental health diagnoses are treated equally on the List. Similar to the diabetes example, the matrix would allow a higher priority to care delivered in certain settings: care for depression in the primary care home could be given a higher priority (e.g. 10) than a psychiatric consultation (e.g. 9) or hospitalization for depression (e.g. 7). Other mental health diagnoses could have care similarly incentivized based on what evidence and best practice indicates in the most appropriate and cost-effective care setting.

Non-Fatal Conditions

The matrix could be used to emphasize the most appropriate care setting for non-fatal conditions which are above the funding line on the Prioritized List. Currently, all effective treatments for diagnoses such as strep throat (line 392) and acute bronchitis (line 476) are covered as these diagnoses fall above the funding line. However, strep throat and bronchitis are more appropriately and cost-effectively treated in the primary care home than in the ER or specialist's office. The matrix could be used to give higher priority to these preferred care settings: office visits in the primary care home for strep throat or acute bronchitis could be prioritized above specialty visits (e.g., 5 vs. 3) or ER visits (e.g., 2). Similarly, other non-fatal conditions could have location of care given differential priorities. In this example, note how the highest priority rating (5) is lower than the lowest priority rating in the chronic disease example (7) to reflect their comparative essentiality.

Comfort Care

The Prioritized List fails to deal with comfort care services well because there are no diagnosis codes to differentiate between stages within a disease process (e.g., stage I vs. stage IV cancers). Whereas the Health Services Commission removed these services from the list and created a statement of intent to direct coverage, the matrix would allow priorities to be indicated as for other categories of care. For instance, hospice care (using the 'Specialty Care' column) could be given a higher priority than inpatient pain management.

BENEFITS COMMITTEE UPDATE

The fourteen-member Benefits Committee is chaired by Susan King, RN of the Oregon Nurses Association, and has two vice-chairs, Nina Stratton of The Stratton Company (a private insurance brokerage firm), and Somnath Saha, MD, MPH with the VA Medical Center. Other members of the committee represent diverse groups such as the AARP, alternative medicine providers, Kaiser Permanente, the Archimedes Movement, public health, rural health, and other groups. The committee has held four meetings from October 17, 2007 through January 15, 2008. They focused on organizational issues at their first meeting. Further discussion established their primary objective as defining a single set of essential health services that should be made available to all Oregonians under the comprehensive reform plan, while recognizing that vulnerable populations, such as those with low-incomes, may need to have their benefits supplemented. While the committee recognizes that cost-sharing will be an important tool in insuring a sustainable plan, they do not believe that it is their primary responsibility to recommend cost-sharing levels associated with the set of essential services.

The majority of the committee's November and December meetings were spent hearing presentations from Health Services Commission members and staff on the history of the Prioritized List of Health Services and its recent reprioritization using a new methodology emphasizing preventive care and chronic disease management. The committee is initially looking to the Prioritized List as a tool in identifying what is essential healthcare, as is encouraged by SB 329. Commercial benefit plans are also being examined as a possible model to borrow from in accomplishing their charge.

At their January meeting, the committee developed a checklist of principles and policy objectives. This checklist will be use as a tool to measure the degree to which the options being deliberated fit the committees stated goals. Items on the checklist include the promotion of population health through access to timely and appropriate diagnosis and treatment, the use of evidence-based medicine, and the incorporation of incentives to encourage the appropriate use of services. As the Benefits Committee begins to delineate between essential and non-essential services, they will work with an actuarial consultant in estimating costs to make sure that the package of services is an affordable one.

February 12, 2008

Benefits Committee
Oregon Health Fund Board
General Services Building
1225 Ferry Street SE, 1st Floor
Salem OR 97310

RE: Essential Benefits Package – Written Testimony

Dear Chair King and Members of the Committee:

Following please find an example of an essential benefits package I think worth considering. It was prepared at the request of the Senate Health and Affordability Committee in preparation for the 2007 Legislative Session and the introduction of SB 329.

The package was designed with input from a variety of stakeholders including small business, health care providers, consumers and government. The purpose was to design an essential benefits package that was similar to basic benefit packages commercially available with adjustments made to address preventative medicine and include wellness incentives.

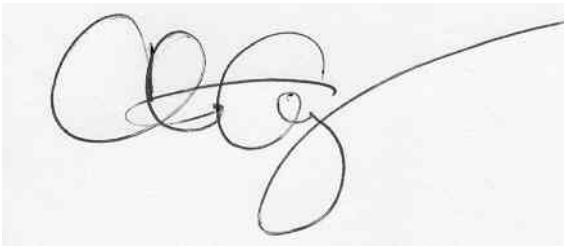
The success of any final essential benefits package in terms of improving the health of Oregonians and reducing the cost of health care is greatly dependent on the inclusion of preventative services. It is far more cost effective to, as an example, provide wellness incentives and pay for services such as regular dental, health and vision examinations. Finding and treating what could be life threatening and expensive illnesses early on significantly reduces costs and improves the quality of life versus not

10730 Southwest 62nd Place | Portland, Oregon 97219
503-977-9432 | 503-245-2626 Fax | www.ApgarAndAssoc.com

providing treatment until an individual's health has already deteriorated to a great extent.

More and more health plans are adding preventive services but, unfortunately, not at the level really needed to significantly impact cost and quality of life. The following essential benefits package balances the cost of the package itself while offering much needed benefits for preventative care. Any package that does not include sufficient attention to preventative benefits and wellness incentives will likely, in the short and long run, continue to add to the cost of care and the reduced quality of life for Oregonians. If you have any questions or need additional information, please let me know.

Sincerely,



Chris Apgar, CISSP
President, Apgar & Associates, LLC
Chair, Oregon Small Businesses for Responsible Leadership Healthcare Committee

Oregon Small Businesses for Responsible Leadership
Health Insurance Essential Benefits – Version 3
October 14, 2006

NOTE: The following assumes a PPO model with in and out of network providers. Health plan members choosing to see in network providers will pay a lower co-pay.

Benefit Plan General Limitations	In Network	Out of Network
Lifetime limit	$1,000,000	$1,000,000
Individual deductible per calendar year	$500	$1,000
Family deductible per calendar year	$1,500	$3,000
Maximum out-of-pocket after deductible	$2,000	$3,000
Coverage after out-of-pocket max is met	100%	100%
Preventative Care & Office Visits	**In Network (deductible does not apply)**	**Out of Network (deductible does not apply)**
Immunizations for adults and children	$15 co-pay	$30 co-pay
Well-baby care to age 2 and well-child exams	$15 co-pay	$30 co-pay
Annual women's exam including Pap test and mammogram	$15 co-pay	$30 co-pay
Annual men's exam including PSA test	$15 co-pay	$30 co-pay
Office visits including urgent care visits	$15 co-pay	$30 co-pay
Dental exams and teeth cleaning	$15 co-pay	$30 co-pay
Vision exam	$15 co-pay	$30 co-pay
Other Professional Services	**In Network (after deductible)**	**Out of Network (after deductible)**
Office procedures	20% co-pay	30% co-pay
Therapeutic injections including allergy shots	20% co-pay	30% co-pay

Surgery	20% co-pay	30% co-pay
Maternity care	20% co-pay	30% co-pay
Mental health out-patient visits	20% co-pay	30% co-pay
Diagnostic radiology and lab including routine colorectal cancer screening	20% co-pay	30% co-pay
Needed dental services (fillings, root canals, etc.)	20% co-pay	30% co-pay
Glasses and fitting	20% co-pay	30% co-pay

Hospital Services	In Network (after deductible)	Out of Network (after deductible)
Inpatient stay including maternity and rehabilitation	20% co-pay	30% co-pay
Inpatient mental health stay	20% co-pay	30% co-pay
Outpatient surgery	20% co-pay	30% co-pay
Emergency room care (co-pay waived if admitted to hospital)	$100 plus 20% co-pay	$100 plus 30% co-pay
Other Services	**In Network (after deductible)**	**Out of Network (after deductible)**
Ambulance	20% co-pay	30% co-pay
Outpatient rehabilitation (physical, speech, and occupational therapy)	20% co-pay	30% co-pay
Skilled nursing facility, home health, and hospice care	20% co-pay	30% co-pay
Durable medical equipment and supplies	20% co-pay	30% co-pay
Transplant	20% co-pay	30% co-pay
Prescription Benefits	**Benefit Level**	
Generic	$15 co-pay	
All other prescriptions	50% co-pay or half the cost of the prescription, whichever is higher	

Essential Benefit Limitations

Preventive Care Schedule:

- **Immunizations** (Not covered for travel or passport purposes) - All ages as indicated by physician
- **Well-baby care -** Up to age 2 As indicated by physician
- **Well-child exam -** Age 2+ Every calendar year
- **Women's exam -** Annual breast & pelvic Every calendar year

  - Mammograms - Age 35-40 Once during this time; Age 40+ Every calendar year
- **Men's exam including PSA test and digital rectal exam -** Age 50+ Every calendar year
- **Skilled nursing facility/residential care/in-patient care -** 45 days per calendar year
- **Alcoholism treatment setting -** Inpatient, residential and outpatient care Combined $4,500 allowance every 24 consecutive months for all levels of care
- **Dental cleaning and exam** – Once every six months
- **Vision exam** – Once every two years for adults over the age of 18; annually for minors under the age of 18

Wellness Incentives:

- **Obesity** – The annual plan benefit deductible will be reduced by $200 the following plan year for individuals considered obese who successfully complete a weight loss program over the course of a year.
- **Tobacco Use –** The annual plan benefit deductible will be reduced by $200 the following plan year for individuals who successfully complete a tobacco cessation program over the course of a year and remain non-tobacco users.
- **Alcohol/Chemical Dependency** - The annual plan benefit deductible will be reduced by $200 the following plan year for individuals addicted to alcohol or illicit drugs who successfully complete an abuse treatment program.

Other Benefit Limitations:

- Transplant coverage available only to plan members who have been covered by the plan, or another insurer with similar transplant coverage, for a total of at least 24 months (or since birth), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's. Payment for all covered transplant services and supplies is limited to a lifetime maximum of $250,000 per enrollee.
- Inpatient rehabilitation benefits are limited to 45 inpatient days per calendar year. Benefits are increased to 60 days per calendar year for head and spinal cord injuries or stroke.

- Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions per calendar year for head and spinal cord injuries or stroke.
- Physical exercise programs are not included.
- Temporomandibular joint disorder benefit is limited to $1,000 per calendar year.

Other Benefit Limitations (continued):

- The following will be covered only after twelve months of enrollment: sterilization procedures. Additionally, pre-existing conditions will be covered only after 12 months of enrollment unless plan member moves from one group plan to another in which case no pre-existing condition clause will apply (pursuant to the Health Insurance Portability & Accountability Act of 1996). Plan members may receive credit from prior creditable medical coverage, providing there is a less than 63-day lapse between the two coverages.
- Elective procedures are not included.
- Glasses and fitting are limited to once every two years for adults over the age of 18; annually for minors under the age of 18.

Pharmacy Benefit Limitations:

- Maximum quantity for pharmacy purchased medications is a 30-day supply.
- Some medications may be limited by quantity rather than day supply.
- Some medications may require prior authorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

Services And Supplies Not Covered:

- Services provided by a member of immediate family.
- Charges in excess of the amount allowed according to the terms of the contract.
- Services or supplies not medically necessary.
- Chiropractic, acupuncture, naturopathic, homeopathic, faith healing, alternative care services, and spinal manipulations even when provided by plan participants.
- Services related to or supporting infertility and reversal of sterilization procedures.
- Orthognathic surgery.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services or supplies for the treatment of personality disorders and gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods except through such programs established by the plan. Coverage does not include the cost of any related medication or supplements such as nicotine supplements.
- Appliances or equipment primarily for personal comfort or convenience.

- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training or instructional programs.

Pharmacy Benefits Not Covered:

- Impotence, infertility, and contraceptive medications even if prescribed for a medical condition.
- Experimental/investigational medications.
- Medications prescribed for cosmetic purposes.
- Smoking cessation products.

To the Chairs and Vice Chairs of the Oregon Health Fund Board and Committee:

Members of the Oregon Health Reform Collaborative have been discussing the importance of public engagement to the success of the work of the OHFB. This engagement is important for several reasons - 1) to inform the public of the process and key questions before the Board and its Committees; 2) to gauge the public's position on various trade-offs that will be considered; and 3) to begin to have the public take ownership of the process and potential proposals that come out of this process. As you have heard in prior communication the Oregon Health Reform Collaborative shares a common goal of broad and diverse engagement in the health reform dialogue.

In order to make the public engagement tangible and worthwhile it is critical for the public to learn about actual questions that are before the committees and the board. This is not an attempt to answer technical questions or provide expert opinions; rather it is to inform the board about the public's thoughts and understanding of key issues, which may in turn influence policy options that are proposed by the Board.

We are asking the chairs and vice chairs of each committee to consider this scenario – If you were in a room, not to present information but to solicit input, what would you be asking Oregonians to weigh in on, or to tell you where they stand? Once we get your first thoughts on those questions we'd like to send you a draft of how we would approach getting information that could help you learn what Oregonians are thinking about, including potential strategies and how we'd get information to you.

We have discussed some topic areas that we know committees are currently discussing, including accountable health plans, a health insurance exchange and a possible payroll tax. Some of these are too complex to ask the public directly, so for example, one area of engagement may be around whether the public would support a health system that is open to everyone, another might be about an employer payroll tax. But before we move forward we want to make sure that we've captured questions whose responses will be valuable to you and the work before you. We will build in flexibility to adjust as your questions/discussions evolve. We'd also want to make sure that we use multiple formats and forums to gather information, reaching a broad and diverse population.

The members of the Collaborate have a broad reach into diverse communities. Our goal is to focus on questions that you need to hear from Oregonians about. Three members of the Collaborative work group discussing public engagement are available to meet with you – person or by phone – to further discuss what some of those questions might be: 1) myself (Executive Director, The Archimedes Movement and Board Member of Oregon Health Decisions), 2) Carole Robinson (Executive Director, the Oregon Health Forum) and 3) Jo Ann Bowman (Executive Director, Oregon Action). Our shared goal is to get a broad and diverse group of Oregonians informed, learn from them, and move towards statewide support for efforts to reform the health care system.

On behalf of the Oregon Health Reform Collaborative we thank you for your consideration and await your response.

Liz Baxter, Executive Director
The Archimedes Movement
Liz@WeCanDoBetter.org

Carole Robinson, Executive Director
Oregon Health Forum
carol@healthforum.org

Jo Ann Bowman, Executive Director
Oregon Action
joann@oregonaction.org

Oregon Health Fund Board

Benefits Committee
March 13, 2008

Oregon Medical Association
Sommer-McLoughlin Room
11740 SW 68th Parkway #100
Portland, Oregon

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OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE

March 13, 2008 Meeting Packet

Oregon Health Fund Board
Benefits Committee Meeting

Thursday, March 13, 2008
9:30 am – 1:30 pm
Sommer/McLoughlin Room
Oregon Medical Association
11740 SW 68th Parkway
Portland, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Susan King	
5 min	Approval of Agenda and 2/28/08 Minutes	Susan King	X
9:35 am 10 min	Discussion on Process for Rating Services in Essential Services Matrix	Susan King, Som Saha	
9:45 pm 3 hrs 15 min	Entering Ratings of Essentiality to Essential Services Matrix • Primary/Secondary Prevention • Treatable Fatal Conditions • Comfort Care • Chronic Disease Management • Maternity/Newborn Care • Treatable Nonfatal Conditions • Reproductive Services *Note: Categories not completed will be carried over to the 4/2/08 agenda. Ten minute breaks will occur at approximately 10:45 am and noon.*	Susan King, Som Saha	X
1:00 pm 20 min	Public Testimony	Susan King	
1:20 am 10 min	Next Steps	Susan King	
1:30 pm	Adjourn	Susan King	

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

February 28, 2008
9:30 a.m.

CCC, Wilsonville Campus Training Center, Room 112
Wilsonville, Oregon

MEMBERS PRESENT:
Susan King, RN, Chair
Nina Stratton, Vice Chair
Somnath Saha, MD, Vice Chair
Betty Johnson
Gary Allen, DMD
Tom Eversole
Bob Joondeph
Kevin Wilson, ND
Leda Garside, RN
Hugh Sowers, Jr.
Kathryn Weit

MEMBERS ABSENT:
Lisa Dodson, MD
Jim Lussier
Susan Pozdena

OTHERS ATTENDING:
Marilyn Berardinelli, OCCYSHN
Martin Brother, Oregon Acupuncture Association
Lynn-Marie Crider, SEIU, Member-Finance Committee
Andi Easton, Oregon Assoc. of Hospitals & Health Systems
Beryl Fletcher, Oregon Dental Association
Beth Gebstadt, American Heart Association
Amy Goodall, Oregon Medical Association
Kelly Harms, Office of Private Health Partnerships
Fawn McNeely, ODS Health Plans
Glen R. Patrizio, MD, OHA, Providence Hospice & Connections
David Pollack, MD, Oregon Health Sciences University
Tracy Rutten, Oregon Physical Therapy Association
Laura Sisulak, Oregon Primary Care Association
Jane-ellen Weidanz, Oregon Assoc. of Hospitals & Health Systems
Kim Wirtz, Regence

STAFF PRESENT:
Darren Coffman, Health Services Commission Director
Ariel Smits, MD, MPH, Health Services Comm. Medical Director
Jeanene Smith, MD, MPH, OHPR Administrator
Brandon Repp, Research Analyst
Nate Hierlmaier, Policy Analyst

ISSUES HEARD:

- Call to Order/Approval of Agenda and 01/15/08 Meeting Minutes/Review of Revised Work Plan
- Update on Oregon Health Fund Board/Committee Activities
- Overview of Draft Tool for Defining Essential Health Services
- Discussion on Use of Draft Tool for Defining Essential Health Services
- Discussion of Other Issues not Entirely Addressed by the Draft Tool: Diagnostic, Ancillary, Enabling Services
- Public Testimony
- Next Steps

Chair King **I. Call to Order**

- Meeting called to order at 9:34 a.m. There is a quorum.

Chair **II. Approval of Agenda/January 15, 2008 Meeting Minutes**

- Review of January 15 meeting minutes. Attachment A (Principles & Policy Objectives Checklist) clarifications:
  - Section A, line g. move to section D.
  - Section D, line e., impact on vulnerable populations, change from "including" to "including but not limited to."
  - Suggestion to create document of definitions.

Motion to approve the minutes as amended is seconded (see Exhibit Materials 1 for revised checklist). **Motion passed unanimously.**

Jeanene Smith **III. Update on Oregon Health Fund Board (OHFB)/Committee Activities**

- Jeanene Smith reported on the OHFB meeting of 02/18/08.
  - Guest speaker was George Halvorson, Chairman and CEO, Kaiser Permanente, and author of "Epidemic of Care." Staff will provide Power Point presentation and materials to committee members.
  - Reports were given from Enrollment and Eligibility Committee on affordability recommendation and Health Equities Committee.
- Delivery Systems Committee is working on recommendations for an integrated health home, plus identifying cost containment strategies in delivery system with staff to quantify later.
- Finance Committee is meeting 02/29/08 and will have input from the Minnesota Department of Health, by phone, on the state's healthcare transaction tax and is continuing to research options.
  - Exchange Work Group is continuing to delineate where exchange will reside. A preliminary report was given to legislature by Barney Speight, OHFB Director.
- Federal Laws Committee continues to receive testimony:
  - Legislature granted extension to obtain public input.
  - Researching the effects on healthcare reform of Medicaid, Medicare, EMTALA, HIPAA and other federal laws.
- Quality Institute is addressing how to collaboratively shape it into a public-private hybrid, coordination of efforts around quality improvement, collection of data to assess performance and a "bricks-and-mortar" versus virtual institute.

Nina Stratton overviewed and distributed written questions and comments by the Exchange Work Group to the Benefits Committee on benefit design.

Discussion on subsidy levels based on affordability as stated by federal poverty levels (FPL) and the relation of this information to the Benefits Committee.

Darren Coffman, Staff Review Panel **IV. Overview of Draft Tool for Defining Essential Health Services (See Exhibit Materials 2 for revised version)**

Staff overviewed the Draft Essential Services Matrix prepared by a staff review panel consisting of staff and committee members, Nina Stratton,

Susan King, Bob Joondeph, Tom Eversole, Som Saha, and Betty Johnson. The matrix factors in the elements of a prioritized list (using the Health Services Commission's (HSC) Prioritized List as a starting point) and adds a horizontal axis to incorporate some aspects of a commercial plan.

- Nine categories of care plus "excluded services" make up vertical axis.
- Discussed chronic disease, treatable fatal conditions and treatable nonfatal conditions. These 3 categories include the 3 subcategories:
  - High effectiveness/population health impact
  - Moderate effectiveness/population health impact
  - Marginal effectiveness/population health impact
- Discussion of subcategories and the meaning of term "population health impact."
  - An example of scoring the matrix given.
  - Importance of focusing on the population health as a whole.
- Confusion between population health and public health measures could be clarified in a definitions section?
- Discussion on how the list is compiled.
- Will work on developing more definitive labels.
- Add footnote that the heavy horizontal black line represents the OHP funding level as determined by the Oregon Legislature.
- Supporting materials giving examples of conditions in each category of care of the matrix was presented.
- Discussion on factoring in a nutritional perspective and utilizing all credentialed providers (allopathic and nonallopathic).
- Designing a benefit package to motivate change and one for the current delivery system is debated.
- Discussion concerning services not from a medical provider or facility, e.g., community based services, chronic disease self-management, hospice, homecare, etc.
- Discussion on enhancing details of matrix.
- Should the word effectiveness be taken out? Confusion of linking both high effectiveness and population impact and assuming that it is highly effective.

Chair **VI. Discussion of Other Issues Not Entirely Addressed by the Draft Tool: Diagnostic, Ancillary and Enabling Services**

- Chair King summarized the matrix's horizontal descriptors. Other services that span list and could be included in the horizontal axis are:
  - enabling or ancillary services (e.g., enabling could include translation, transportation, etc.) and
  - Diagnostic services.
- One or two staff review panels will be formed to address these areas. Staff will contact for volunteers.
- Discussion of a third group: end-of-life care.
  - Jeanene Smith related input to Delivery Committee on palliative care and that the Benefits Committee may use this work for forming a narrative when addressing "comfort care."

Chair **V. Discussion on Use of Draft Tool for Defining Essential Health Services**

- Presumption: 1 (highest priority) is maternity, etc., primary care services to 10 (lowest priority) inconsequential hospital care.
- Ability of the actuary to use the ratings in the essential services matrix in establishing cost-sharing is discussed.

- Hierarchical structure allows for movement of coverage depending on actuarial pricing.
- Refinement over time could be assigned to HSC or similar body.
- Involving public by providing options.
- Will another committee take this product and look at incentivizing services in the most cost-effective setting? Discussion regarding Delivery Services Committee payment reform.

Public Testimony (taken out of order):
Lynn-Marie Crider, SEIU 49 Public Policy Director and member of the Finance Committee, gave testimony. Ms. Crider asked the group if they could identify elements from the matrix that should be offered with no co-pay or deductible attached to it.

- Testimony was followed by committee discussion including:
  - Difference in meaning of an "essential" and "minimal" benefit package.
  - Individual mandate and effects of benefits package on market.
  - Debate on building a package from an insurance market perspective.
- Discussed differences of healthcare issues of Oregon and Massachusetts.
- Discussion on deductibles and diagnostic services.

Committee returned to discussion of horizontal descriptors of matrix:

- Change heading of "Outpatient and Elective Specialty Care" to "Specialty Care: Outpatient and Elective"
- Change "Primary Care Home" to "Integrated Health Home" to be consistent with the Delivery Systems Committee
- Home Care changes to In-Home Services
- Facility based long term care – broadened from skilled nursing facility. Discussion including not just where it is but who is doing it. Cchange to column for "Skilled Nursing Facility" and one for "In-Home/Community-Based Services".
- Acute hospital based care should have ER added to it.
- Urgent care was discussed.

Chair **VII. Public Testimony**

- Glen Patrizio, MD, Providence Medical Center, testified on a proposal to add a benefit of a nurse to the community setting to deliver palliative-based care to help with management of chronic disease. Written testimony was provided.
- David Pollack, Mental Health Services, OHSU, testified on factoring in patient preference in care, integrated health home, and public health functions. Suggested committee read report by county health and county mental health directors.
- The chair noted for the record written communications from:
  - Liz Baxter, Carole Robinson and Jo Ann Bowman, on public response of the OHFB committees work; and
  - Chris Apgar, Chair, Oregon Small Business for Responsible Leader-ship Healthcare Committee, on a proposed health benefit plan.
- Committee member submitted copy of Harvard Health Care Letter.

Chair **VIII. Next Steps**

- Filling in matrix over the next two committee meetings: 1) Primary/Secondary Prevention, Reproductive Services, self-limited conditions; Treatable fatal conditions and its sub-categories; and

2) Maternity/newborn care; chronic disease management, comfort care, treatable nonfatal conditions, inconsequential care

- Put priority numbers in the boxes (e.g. 1-10)
- Upcoming Meeting date: March 13, April 2, April 15.
- Staff will email links of appropriate documents to committee members.

Chair **IX. Adjourn**

The Chair adjourned the meeting at 1:30 p.m.

Submitted By:
Paula Hird

Reviewed By:
Darren Coffman

Next meeting is Thursday, March 13, 2008.

EXHIBIT MATERIALS:

1. Revised Principles & Policy Objectives Checklist
2. Revised Draft Essential Services Matrix

EXHIBIT 1

OHFB Benefits Committee Guiding Principles/Policy Objectives Checklist

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan.

I. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians? (SB329)
- ☐ b. based upon a proven benefit model (preferably Prioritized List, also could be a commercial plan)? (SB329)
- ☐ c. reflective of the values of Oregonians? (OHP)
- ☐ d. easy to adjust in response to new information on cost and effectiveness? (OHP)
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable? (SB329)
- ☐ f. developed in a transparent manner? (SB329, OHP)

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care (SB329, OHP community meetings)
- ☐ b. Chronic disease management (SB329)
- ☐ c. Primary care medical homes (SB329)
- ☐ d. Dignified end-of-life care (SB329)
- ☐ e. Patient-centered care (SB329)
- ☐ f. Provision of care in the least restrictive environment (SB329)

III. Does the set of essential health services help promote:

- ☐ a. wellness? (SB329)
- ☐ b. patient engagement (including education towards self-management)? (SB329)
- ☐ c. coordination and integration of care? (SB329)
- ☐ d. population health? (SB329)
- ☐ e. cost-effective care? (SB329, HB3624 of 2003, OHP community meetings)
- ☐ f. cost-control/reductions in over-utilization? (SB329, OHP)
- ☐ g. access to timely and appropriate diagnosis and treatment? (Task Force on Basic Benefits)

IV. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine (SB329, OHP)
- ☐ b. Efficacy of treatments (SB329, HB3624 of 2003)
- ☐ c. Reduction of health disparities (SB329)
- ☐ d. Personal responsibility (SB329, OHP community meetings)
- ☐ e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services
- ☐ g. Acute and tertiary care needs of the population

EXHIBIT 2: REVISED ESSENTIAL SERVICES MATRIX

Categories of Care (listed in priority given by Health Services Comm.)	Integrated Health Home Services	Specialty Care: Outpatient & Elective	In-Home & Community-Based Care	Skilled Nursing Care	Acute Hospital-Based Care (including ER)	Examples
Maternity/Newborn Care						Prenatal visits, ultrasounds, pregnancy complications, delivery, low birthweight babies, birth trauma, infections acquired from mother
Primary/Secondary Prevention						Immunizations, well-child visits, screening colonoscopies/mammograms, smoking cessation, high cholesterol, dental exams/cleanings, colon polyps
Chronic Disease Management						
High health impact						Alcohol & drug treatment, severe depression, asthma, high blood pressure, HIV disease, diabetes, rheumatoid arthritis
Moderate health impact						Post-traumatic stress disorder, dementia, sleep apnea, Parkinson's disease, multiple sclerosis, anorexia, COPD, gout, cirrhosis of liver
Marginal health impact						Bulemia, self-abusive behaviors (e.g., headbanging) due to neurologic dysfunction, allergies (e.g., hayfever)
Reproductive Services						Birth control pills, vasectomy, tubal ligation, therapeutic abortion, miscarriage
Comfort Care						Medication for symptom control/pain relief, hospice, medical equipment, Oregon Death with Dignity Act services
Treatable Fatal Conditions						
High health impact						GI bleeding, heart attack, severe head injury, acute leukemia, broken arm/leg (open), breast cancer, viral hepatitis, pneumococcal pneumonia
Moderate health impact						Aortic valve disease, melenoma, heart transplant, abnormal heart rhythm, chronic leukemia, stroke, acute renal failure, acute sinusitis
Marginal health impact						Croup, delerium, gallbladder cancer, hardening of the aorta, liver transplant for liver cancer, bariatric surgery for non-diabetic
Treatable Nonfatal Conditions						
High health impact						Gonorrhea, eye diseases leading to blindness, kidney infection, disloca- tion of joint (closed), wheelchair for ALS, cleft palate, enlarged prostate
Moderate health impact						Broken arm/leg (closed), strep throat, kidney stones, reflux disease, migraines, eyeglasses, acute bronchitis, dentures
Marginal health impact						Fungal infection of nail, acne, erectile dysfunction, uncomplicated hernia, muscular low back pain, cold sores, minor burns
Self-limited Conditions						Mono, thrush, viral sore throat, corns/calluses, tendonitis, diaper rash, simple muscle sprian/strain, common cold, laryngitis, pink eye
Inconsequential Care						Insomnia, orthodontics, minor head injury, viral warts, benign skin lesions, smoker's cough, varicose veins w/o pain, uncomplicated hemorrhoids
Excluded Services						Infertility services, cosmetic treatments, experimental treatments

The Prioritized List of Health Services determines which specific condition-treatment pairs within the categories of care are clinically effective and cost-effective. The **bold line** indicates the 1/1/08 funding level at line 503, below which no treatments are covered under the Oregon Health Plan.

Ancillary services (e.g., Rx, DME) and enabling services (e.g., coordination of care, translation) are given the same priority as the conditions they are being used to manage.

Utilization management strategies should be employed for ED visits (triage fee for non-emergent conditions), imaging (guidelines, PA for CT/MRI/PET), and Rx (evidence-based formulary).

Cost-sharing strategies can be used to encourage utilization of timely and cost-effective services in the most appropriate setting. Examples could include no copays on preventive services and tiered copays for Rx and office/urgent care/ED visits.

Revised 3/11/08

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klaliam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

527 SW Hall
Suite 300
Portland, OR 97201
☎ (503) 228-4185
FAX (503) 228-8182
www.npaihb.org

SENT VIA TELEFAX: (503) 378-5511

January 31, 2008

Barney Speight, Executive Director
Oregon Health Fund Board
General Services Building
1225 Ferry Street SE, 1st Floor
Salem, OR 97310

Dear Mr. Speight:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization[1] that represents the health care issues of the forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. We are writing on behalf of our nine Oregon Tribes with respect to the work that the Oregon Health Fund Board (OHFB) is currently undertaking.

As we are all aware, the Healthy Oregon Act (SB 329) created the Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. To accomplish this work, the OHFB has appointed committees to develop recommendations on various issues related to developing a comprehensive plan to reform Oregon's health care system. The OHFB and its committees are charged with a very difficult task to develop a comprehensive plan for health care while at the same time taking into consideration the needs of all Oregonians.

As the OHFB works to develop its recommendations there are some special circumstances for Tribal health programs that the committees should be aware of as they undertake their work. Most important is the unique relationship between the United States and Indian Tribes. This relationship forms the basis of a "federal trust relationship" and creates a federal obligation to provide health services to Indian people. Thus, any changes in the health care system must take into consideration this special relationship and the unique needs of Indian people who suffer the worst health disparities of any population in America. Any proposed changes in Oregon's health care system must carefully be evaluated for their impact on Tribal health programs. Changes in federal program eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing will have profound consequences for our people, our health care providers, and the economic well-being of our communities.

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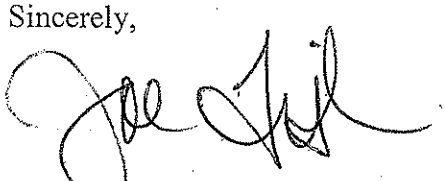
[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

To assist in your effort, we have prepared a set of guiding principles that should be taken into consideration by each OHFB committee. The guiding principles provide a framework that should be followed as the OHFB develops its recommendations for universal health care in Oregon. If followed, this framework will serve to protect the vital interests and needs that Indian people have in the health care system. Recommendations to address the core principles are also included in the areas of financing, managed care, access and benefits, and cultural considerations. Our hope is that by following the guiding principles we will not create any harm to the fragile health care system that provides care to Indian people.

Thank you for the opportunity to provide our advice and guidance to the Oregon Health Fund Board as it works to develop universal access to health care in Oregon. We support you in your work and offer our assistance for advice and guidance at any time. We also want to thank you for recognition and inclusion of Tribal health leaders on the various OHFB committees and look forward to the work ahead.

Again, thank you for your consideration!

Sincerely,



Joe Finkbonner,
Executive Director

cc: Susan King, Chair Benefits Committee
Kerry Barnett, Chair Finance Committee
Dick Stenson, Chair Delivery Systems Committee
Ellen Lowe, Chair Eligibility & Enrollment Committee
Frank Baumeister, Chair Federal Laws Committee
Ella Booth, Chair Health Equities Committee

Enclosure: Guiding Principles & Recommendations

Recommendations & Guiding Principles
to Reform the Oregon Health System

As the Oregon Health Fund Board (OHFB) develops a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care, it is important to honor the unique health care obligations that the United States has to Tribes and Indian people. This document outlines principles and recommendations for Indian health program delivery that were established in previous health care reform activities and adopted by the consensus of all Tribes.[1]

Recommendations to Address the Core Principles[2,3,4]

The provision of health care to American Indians and Alaska Natives (AI/AN) is a legal and moral obligation of the federal government stemming from treaties with sovereign Indian Tribes and subsequent federal legislation and court decisions. This unique relationship requires that all federal health care funding for AI/AN people—in this case Medicare, Medicaid, and SCHIP programs—be directly available to Indian health programs. Any reform or changes in these programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

Trust Responsibility: Medicare, Medicaid, and SCHIP reform initiatives and regulations must be consistent with the federal government's obligation to Tribes and their programs. It is federal government and its agencies' responsibility to protect this trust; and as such can not shift the responsibility to the states. The legislation and regulations must contain specific protections for AI/AN consumers and specific directions that will assure Indian health programs are adequately compensated.

100% FMAP: As a federal responsibility, CMS must provide 100 percent FMAP for services covered in the State Medicaid Plan delivered to Medicaid beneficiaries by or through IHS or Tribal programs. The Indian health system is reimbursed for services at 100% Federal Medical Assistance Percentage (SSA Title IXX §1905(b)) for Medicare, Medicaid, and SCHIP-eligible related services provided by an Indian health provider. This provision makes services budget neutral for state Medicaid programs and must be factored when determining benefits packages and reimbursement methods.

Cost Sharing: Eliminate or waive American Indian/Alaska Native beneficiaries of all cost sharing. Legislation and regulation must extend the current SCHIP premium and cost sharing exemptions to

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[1] National Summit on Indian Health Care Reform, Washington D.C., Returning to a Natural State of Good Health," March 1993. Reaffirmed at National Roundtable on the Indian Health System and Medicaid Reform, October 1, 2005, Washington D.C. by NPAIHB, Urban Institute, and Kaiser Family Foundation.

[2] CMS List of 24 Issues raised during consultation with Tribes during 1999 and through other meetings and request, CMS Website, American Indian and Alaska Native Beneficiaries, Issues

[3] National Indian Health Board, Medicaid and Manage Care, 1998

[4] National Indian Health Board, Indian Health in Ten State Medicaid, Managed Care & SCHIP Programs, 2001

Medicaid and the co-payments for Medicare. Because of the 100% FMAP requirement States must adhere to exempting Indian beneficiaries in cost sharing requirements.

Benefits Design: Since Medicaid services are reimbursed at 100%FMAP, the OHBF should be make sure that any benefit packages for AI/AN Medicaid beneficiaries that are less in amount, duration, or scope than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This "most favored nation" rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.

Managed Care: If reform includes managed care, Indian programs and AI/AN people must have the following flexibility.

- Choice: AI/AN individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer.
- Default Assignment to Indian Health Program: Individual AI/AN must NOT be involuntarily assigned to non-Indian managed care plan when an Indian health program is available.
- Out of Plan Service: Require managed care plans or contractors to pay the Indian health providers when providing services to AI/AN people, who exercise their right to use Tribal/IHS programs.

Traditional Practices: Respect for cultural beliefs, blending of traditional practices with a modern medical model and emphases on public health and community outreach. CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.

Access to CMS Program Eligibility: Simplify and improve AI/AN outreach, enrollment and eligibility determination. Provide funding to Indian health programs for conducting outreach and linkage activities. Simplify the application process by reducing required documents, providing "real time" determination, and allowing self-declaration for residency and income. Allow Tribes the option to provide program enrollment and eligibility determination on-site.

Guiding Principles

1. Special Legal Obligations Involving American Indians

It is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to Indians and to provide existing health services with all resources necessary to affect that policy (P.L. 94-437 Indian Health Care Improvement Act).

2. Cultural Considerations in Indian Health Care

A community-based and culturally appropriate approach to health care is essential to accommodate the needs of Indian people and their cultures.

3. The Distinctive Needs of Indian People

The poor state of health across Indian Country is another factor that demands...focused attention and funding in order to break the cycle of illness and addiction that began with the destruction of a balanced Tribal lifestyle.

4. The Right to Comprehensive Health Care

It is comprehensive health care to which Indian Tribes are entitled under federal law.

5. Existing Indian Health Care Systems

Indian health care does not currently operate simply as an extension of the mainstream health system in America. To the contrary, federal support has built a system that is designed to serve Indian people. It is important...not to undo the existing system but instead build upon those programs that Tribes, the IHS and other Indian health providers have started.

6. *American Indian Tribes as Sovereign Government*

Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. It is unacceptable either legally or pragmatically to distribute funds or program authority to state governments (private insurance companies or HMOs) for distribution to Tribes and Indian people.

Tribes exercise powers of government. They form their own governing systems, determine who belongs to the Tribe, and elect their own leaders. Tribal Leaders, representatives of their nations, expect full, open communication with Federal leaders and expect to be consulted about changes that affect them.

Tribes have greater control over their health programs when they have access to, but not limited to, the following:

a) *direct federal funding or allocation*
b) *flexibility in setting eligibility and program design criteria*
c) *equal access to any federal or state-administered grants or programs*
d) *deemed certified given that the program meets Indian Health Service, Tribal or national certification standards*

In closing, there is a need to chart a delicate course between the goals of improving access and controlling costs while recognizing and supporting the special legal relationship with American Indian and Alaska Native Tribes.

Prepared 2/4/08 by the Northwest Portland Area Indian Health Board, 527 S.W. Hall Suite 300, Portland, OR 97201. Special thanks to the CMS Tribal Technical Advisory Group for assistance in preparing document. For questions, please contact Jim Roberts, Policy Analyst at (503) 228-4185 or by email at jroberts@npaihb.org.

Oregon Health Fund Board
Benefits Committee Meeting

Tuesday, April 15, 2008
9:30 am – 1:30 pm
Room 111
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Susan King	
5 min	Approval of Agenda and 3/10/08 Minutes	Susan King	X
9:35 am 40 min	Presentation on Draft Proposal for an Essential Benefit Package • Incorporates discussions of Alternative Methodologies, Diagnostic Services and Ancillary & Enabling Services Staff Review Panels	Ariel Smits, Darren Coffman, Staff Review Panel Members	
10:15 pm 1 hr 45 min	Discussion of Draft Proposal for an Essential Benefit Package	Susan King	
12:00 pm 40 min	Public Testimony	Susan King	
12:40 pm 30 min	Decision on Framework of an Essential Benefit Package	Susan King	X
1:10 pm 20 min	Next Steps • Identification of issues requiring further discussion • Preliminary pricing of an essential benefit package	Susan King, Darren Coffman	
1:30 pm	Adjourn	Susan King	

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

March 13, 2008
9:30 a.m.

Oregon Medical Association
Portland, Oregon

MEMBERS PRESENT: Susan King, RN, Chair
Somnath Saha, MD, Vice Chair
Tom Eversole
Bob Joondeph
Kevin Wilson, ND
Leda Garside, RN
Hugh Sowers, Jr.
Kathryn Weit
Lisa Dodson, MD
Susan Pozdena
Gary Allen, DMD

MEMBERS ABSENT: Jim Lussier
Betty Johnson
Nina Stratton, Vice Chair

OTHERS ATTENDING: Kelly Harms, Office of Private Health Partnerships
Tracy Rutten, Oregon Physical Therapy Association
Laura Sisulak, Oregon Primary Care Association
Kim Wirtz, Regence
Tina Kitchin, Department of Human Services
Jen Lewis, Oregon Medical Association
Lisa Trussel, Health Net
Bruce Bishop, Harrang Long Gary Rudnick

STAFF PRESENT: Darren Coffman, Health Services Commission Director
Ariel Smits, MD, MPH, Health Services Comm. Medical Director
Jeanene Smith, MD, MPH, Oregon Health Policy & Research (OHPR) Administrator
Brandon Repp, Research Analyst
Nate Hierlmaier, Policy Analyst

ISSUES HEARD:

- Call to Order/Approval of Agenda and 02/28/08 Meeting Minutes/Review of Revised Work Plan
- Update on Oregon Health Fund Board/Committee Activities
- Discussion on Process for Rating Services in Essential Services Matrix
- Entering Ratings of Essentiality to Essential Services Matrix
- Public Testimony
- Next Steps

Chair King **I. Call to Order**

- Meeting called to order at 9:43 a.m. There is a quorum.

Chair **II. Approval of Agenda/February 28. 2008 Meeting Minutes**

- Review of February 28 meeting minutes

Motion to approve the minutes as submitted is seconded. **Motion passed unanimously.**

Jeanene Smith

III. Update on Oregon Health Fund Board (OHFB)/Committee Activities

- Dr. Smith reported that the Health Fund Board meeting on the March 20th is moved to Airport Sheridan and will focus on cost containment and other delivery system issues.
- There is a new email service allowing individual to receive notices for OHFB/OHPR groups that interest them. Please sign up at: http://www.oregon.gov/OHPPR/HFB/govdelivery.shtml
- Review the March Newsletter for updates on other Committees.

Chair King, Vice Chair Saha

IV. Discussion on Process for Rating Services in Essential Services Matrix Services

- Staff overviewed the process for rating services in the Essential Services Matrix. The vertical axis represents categories of care for the Prioritized List; horizontal axis, types and places of services.
- Exercise undertaken to prioritize the category of care where most of the care should take place, from 1 to 5.
    - Example: Maternity/Newborn Care: most care to be received in a primary care (Integrated Health Home Services) or specialty care setting and would be scored as 1.
    - Scoring will incorporate essential services within the categories (rows) as:
        - 1 = Most optimal/beneficial place to receive these types of services
        - 2 = Next most optimal/beneficial place, depending on circumstances
        - 3
        - 4
        - 5 = Least optimal/beneficial
    - The members worked through the category 'Chronic Disease Management - Moderate Health Impact' by way of another example:
        - Integrated Health Home Services - 1
        - Specialty Care - 2
        - In-Home & Community-Based Care - 3
        - Skilled Nursing Care - 4
        - Acute Hospital-Based Care - 5
    - Possible alternative gradation scale of 1 to 10, representing most to least essential across entire matrix.
- Members will meet with their staff review panels (Diagnosic and Ancillary & Enabling) to determine appropriate handling of these services and will discuss their findings at the next Benefits Committee meeting.
- Suggestions were made by members to default to using a re-tooled version of the Prioritized List.
- After a break it was suggested that this discussion be tabled until a smaller group can provide more insight.

Chair King **V. Discussion of Previously Unaddressed Issues**

References to the "List" refer to OHP Plus, rather than OHP Standard.

- There should be a robust primary care workforce for Oregon.
  - Rural Oregon has little access to primary care.
  - Special populations must be considered.
- What are the exact pieces of information that this group needs to provide for actuarial analysis?
  - Suggested: the Prioritized List of Health Services from lines 1 – 503, with vision and dental services included.
  - Creating levels of varying co-payments (e.g., three-tiered as commonly done for Rx) based on income and level of essential service.

Chair **VI. Public Testimony**

- No public testimony was offered at this time.

Chair **VII. Next Steps**

- A smaller group will look at different options for developing a benefit package.
  - Establish the Alternative Methodologies Staff Review Panel
  - Volunteers: Chair King, Dr. Saha, others
  - Short time frame – Two meetings before next Benefits Committee.
- The Health Fund Board will be developing their recommendations based on all Committee's work in May and June.
- Keep April 2 open for a potential Benefits Committee meeting or one of the staff review panels.

Chair **VIII. Adjourn**

The Chair adjourned the meeting at 1:30 p.m.

Submitted By:
Dorothy Allen

Reviewed By:
Darren Coffman

Next meeting is Tuesday, April 15, 2008.

The Essential Benefit Package

Draft Proposal

Table of Contents

The Essential Benefit Package
Executive Summary

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health care homes become the basis for cost-effective, patient-centered care
- All parts of the body are treated equally
  - Mental health and dental services are covered just like other physical health conditions
- Coverage of services will be evidence-based
  - The Health Services Commission or other body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Preventive services are emphasized
- Coverage focuses on care which reduces the overall cost and complications of disease
  - Value-based services are an integral part of the package, representing evidence-based services that reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility will be rewarded
  - Value-based services will include incentives and rewards for patients who actively participate in their own health care

The EBP is **affordable for individuals and the state**:

- Preventive care, value-based services, and diagnostic services are available to all with no or low cost barriers
- Other types of care are covered after the beneficiary meets a high deductible amount (adjusted for those close to or in poverty). This:
  - Protects individuals from profound financial losses from unforeseen catastrophic illness or injury
  - Reduces the cost of premiums
- After the deductible is met, personal financial responsibility for services increase for lower priority conditions as reflected in the Health Services Commission's Prioritized List of Health Services

The EBP would serve as the **"basement level" of health care coverage** below which no individual should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease specific plans that do not serve the overall health of an individual

Introduction

When creating a set of essential services, several goals must be met. The Essential Benefit Package (EBP) as described here would:

1) Improve the overall health of the people of Oregon. This goal will be met through improved immunization rates to reduce vaccine transmissible disease, improved screening for diseases which are more cost-effective to treat at an early stage, reduced smoking rates, and improved population health markers such as fewer low-birthweight babies.
2) Incentivize a rational redesign of the health care system. The EBP would improve access to and utilization of services in an integrated health home. All body parts are treated equally; mental health and dental services are included with the same coverage as other physical health conditions.
3) Reward personal responsibility. Value-based services should be developed with rewards and incentives for individuals to actively participate in their own health care.
4) Reduce overall health care costs. This goal would be met through incentivizing patients to receive treatment for early disease in the less expensive outpatient setting rather than waiting until their disease process worsens and requires extensive hospitalization and surgeries. Mechanisms should be put in place to encourage patients to seek care in their health care home rather than the ER for common outpatient complaints. Certain diagnostic tests, procedures, medications, and treatments high cost, high utilization, and/or high variability in usage should be subject to robust, efficient and swift prior authorization processes. Additionally, the EBP would minimize uncompensated care and cost-shifting in the system.
5) Be innovative. The EBP includes value-based services, which are a selected group of evidence-based cost-effective outpatient health care treatments that have been shown to help prevent hospitalizations, ER visits, and expensive complications for particular health care conditions. The EBP would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.
6) Provide a social safety net. The EBP would protect individuals from devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury.
7) Be affordable for the individual and the state. The lowest acceptable "basement" package should be priced low enough to be affordable to all Oregonians above 400% of FPL and be fiscally responsible for the state to subsidize for/offer to Oregonians in or near poverty. It is anticipated that private insurers would be innovative in creating plans which offer a richer benefit package at higher premiums than the EBP.
8) Reflect the values of Oregonians. The EBP would provide services to special populations such as pregnant women and small children and provide dignified end-of-life care, which were values expressed by Oregonians in public meetings on health care reform.
9) Be evidence-based. The EBP would require that the Health Services Commission (HSC) be enhanced, meet more often, and be given greater financial resources to allow for a thorough and timely surveillance of the evidence and provide regular guidance to the system. It is further recommended that the Health Resources Commission become a standing body under the HSC to allow in-depth reviews of technologies and treatments.

It is also anticipated that the HSC will collaborate with other evidence-based bodies in the state, such as the Drug Effectiveness Review Program, the Evidence-Based Practice Center, and the Medical Evidence-Based Decisions (MED) Project.

The Essential Benefit Package responds to the goals above by having few financial barriers to preventive care, access to diagnostic visits and tests, and graduated personal contributions for health care based on priorities set by the Oregon Health Services Commission in the Prioritized List of Health Services. In addition, the plan incorporates both low barriers and incentives for certain "value-based services." These services include cost-effective outpatient treatments which have been shown to reduce hospitalization and ER visits for certain diseases, or which help encourage outpatient care for conditions which constitute a large proportion of current health care spending. Plan members are protected from profound financial loss by having a "cap" placed on out-of-pocket expenses.

The Essential Benefit Package is a "basement level" plan. No insurance plan should be allowed to offer a lower level of benefits. However, private purchasers and governmental programs such as Medicaid could offer a plan that provides more benefits and/or less cost sharing than the EBP. Companies could elect to buy up to a richer plan for employees and individuals could buy up to a richer plan through higher premiums. However, the low barriers to preventive services and value-based services must be maintained for a plan to qualify as meeting the minimum plan requirements. Additionally, such plans must provide the same services as the EBP with no greater cost sharing. It is anticipated the private market would create products which would help reduce premiums through competition and bulk purchasing as well as offer plans with additional, supplemental coverage. Purchase of these supplemental products would be at the discretion of the plan member, employer or other purchaser.

Basic Principles of the Essential Benefit Package

1) Services
    a. The Essential Benefit Package (ESB) is based on the Health Services Commission's Prioritized List of Health Services
        i. Coverage of conditions is not based solely on the part of the body affected, nor is the coverage of services based solely on the type of provider. Evidence and public values will drive coverage decisions.
            1. Dental and mental health conditions will be included as they appear on the Prioritized List
            2. Services such as physical and occupational therapy and complementary and alternative medicine services will be included as they appear on the Prioritized List, with guidelines as appropriate
        ii. Low priority conditions and services may not have any coverage
    b. Preventive services and "value-based services" should have low if any barriers to access
        i. Preventive services are included in Lines 1-7 of the 2008-09 Prioritized List
        ii. Value-based services will be a list of evidence-based services that reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
            1. Value-based services are to be developed using evidence-based sources such as the Agency of Healthcare Research and Quality (AHRQ) Ambulatory Sensitive Conditions
            2. Value-based services are to be developed by the Health Services Commission and be a dynamic list reflecting changing evidence and the values of Oregonians
            3. Value-based services will include incentives and rewards for patients who actively participate in their own health care
    c. Diagnostic tests and visits will have some coverage, but may be subject to limitations and have varying cost sharing associated with them
        i. Basic point-of-service tests, such as lab tests or EKGs, and a limited number of diagnostic visits may be covered with limited or no cost sharing
        ii. Certain diagnostic tests, procedures, medications, and treatments with high costs, high utilization, and/or high variability in usage should be subject to limitations and cost sharing to promote the most appropriate use of resources. This should be accomplished using the following hierarchy of approaches:
            1. The used of evidence-based guidelines, where available, that are regularly reviewed and updated.
            2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
            3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those of high cost or which do not have an impact on the clinical management of the patient

   d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
   e. Enabling services such as translation services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services
   f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient care
2) Financial considerations
   a. Personal financial responsibility should increase for services which are of lower priority on the Prioritized List
   b. Premiums, deductibles and out-of-pocket maximums should be scaled according to the individual's income level
   c. A limit on out-of-pocket (OOP) expenses should be included to prevent profound financial loss
   d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan.
      i. The deductible and OOP maximums could be set numbers or could vary with total income
      ii. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive health care utilization decisions
   e. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.
3) Medications
   a. A drug formulary should be utilized
   b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
   c. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
   d. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
4) Integrated health home
   a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
   b. Integrated health homes should include case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system
   c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)
   d. Ideally, mental health services would be available within the integrated health home

e. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee

5) The EBP is a "basement level" package
   a. Government, private companies, and individuals can purchase or offer a more generous package. The private market can and should develop supplemental plans
   b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
      i. No package should have any higher barriers to preventive and value-based services
      ii. Value-based services must be included as designed by the Health Services Commission and offered with the same or lower cost-sharing as the EBP
      iii. Basic diagnostic services must be offered as outlined in the EBP with no higher cost sharing
      iv. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ER services.
   c. Equivalence between a commercially available plan and the Essential Benefit Package must be based on actual coverage equivalence and not on the equivalence of actuarial value of the plans

Value-Based Services

Value-based services are to be a selected group of cost-effective health care treatments based primarily in the integrated health home which have been shown to prevent hospitalizations, ER visits, and other expensive treatments for particular health care conditions. By encouraging ambulatory use of these services, overall health care costs should be reduced and the population health improved. The Essential Benefit Package would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.

Conditions

Qualifying conditions and cost-effective outpatient treatments for these conditions should be determined by the Health Services Commission or other body designated by the Health Fund Board or Oregon Legislature. Candidates for possible value-based services should come from the list of AHRQ Ambulatory Sensitive Conditions and other evidence-based sources. Examples of value-based service conditions include diabetes, asthma, congestive heart failure, and low birthweight.

Once a list of conditions has been developed, then cost-effective outpatient treatments for these conditions would be determined. Next, evidenced-based guidelines would be created for the use of these treatments. Standards for compliance with these guidelines would be established according to condition and the incentive for meeting the acceptable compliance level would then be determined.

The lists of conditions and value-based services for these conditions would be continuously updated by the HSC or other oversight body based on changing evidence.

Value based services do NOT include all treatments for a condition. Conditions with possible value-based services, such as diabetes or asthma, are currently associated with a wide range of treatments on the Prioritized List of Health Services. These treatments range from inexpensive preventive care, such outpatient visits, to expensive services aimed at treating disease complications, such as ICU admissions and surgeries. A condition which is determined to have value-based services associated with it will remain on its designated Prioritized List line with all relevant **non**-value-based services. Only certain cost-effective outpatient treatments will be moved to the Value-Based Services List. For example, treatments for diabetes such as outpatient primary care visits, yearly diabetic eye exams, and care coordination could be placed on the Value-Based Services List while treatments such as ICU admissions for ketoacidosis or leg amputation surgery would remain on the diabetes line of the Prioritized List, which is currently in Tier I services.

Potential Value-Based Service Examples

The examples are provided for illustrative purposes only and may or may not ultimately be included in a list of value-based services.

1) Chronic disease
    - A patient with a chronic disease would have minimal cost sharing for outpatient provider visits, medications, and other cost-effective treatments for that condition. A patient who sees his or her doctor at recommended intervals, fills his or her prescriptions as prescribed, and actively participates in other aspects of his or her care would have a reduction in the cost sharing for the ER visits and hospitalizations for complications of his or her chronic condition.
2) Maternity care
    - Pregnant women would have no cost sharing for prenatal care. A patient who attends the recommended number of prenatal visits and otherwise completes the recommended portions of her prenatal care would have a no cost share towards the delivery of his or her child.
3) Smoking-related diseases
    - A patient with a chronic disease which is caused by or exacerbated by smoking would have a reduction in cost sharing for outpatient office visits and medications related to that condition if he or she quits smoking. Patients who continue to smoke would pay more for treatments and medications for the smoking-related condition.
4) Integrated health home incentives
    - A patient would have lower cost sharing for visits in the integrated health home compared to the specialty office or ER. In addition, a patient who is enrolled in an integrated health home would have points awarded that he or she could use to reduce the cost sharing for medication or other covered services.
5) Preventive care
    - Preventive services, such as immunizations, flu shots, pap smears, mammograms and screening colonoscopies, would have minimal cost sharing. Plan members who are up-to-date on current screening recommendations could have points awarded that he or she could use to reduce the cost sharing for medication or other covered services, or could use them for wellness activities (e.g., assistance in purchasing a gym membership).
6) Dental
    - Preventive dental exams and cleanings, and fillings for dental caries would have minimal cost sharing. Plan members who receive regular cleanings could have points awarded to use to reduce the cost sharing for restorative dental or other covered services.

Preventive and Family Care Services

Preventive and Family Care Services are a group of services located in Lines 1-7 of the 2008 Health Services Commission Prioritized List of Health Services. These services focus on primary prevention of disease through immunization and behavior change, and screening and early treatment of disease when primary prevention is not possible.

Preventive and Family Care Services include the following:

1) Maternity care
    - Examples: Prenatal visits, routine prenatal testing, high risk obstetrical care, vaginal and cesarean deliveries
2) Newborn care
    - Examples: Newborn preventive services and hospital nursery care
3) Preventive services for children
    - Examples: Well child checks, immunizations, screening for developmental and other problems
4) Preventive services for adults
    - Examples: Physical examinations, Pap smears, colonoscopies, immunization updates, prostate cancer screening, mammography
5) Abuse or dependence of psychoactive substances
    - Examples: Alcohol abuse or drug abuse treatment, both inpatient and outpatient
6) Tobacco dependence
    - Examples: Limited number of visits and medications for smoking cessation assistance
7) Reproductive services
    - Examples: Birth control prescriptions, tubal ligation, vasectomy, IUD devices and placement
    - Elective abortion is NOT included in this category

Preventive and Family Care Services could be subject to limitations through guidelines, prior authorization, or other means. For example, the number of obstetrical ultrasounds provided during an uncomplicated pregnancy could be limited by a guideline or the types of medications for smoking cessation assistance could be subject to a formulary.

The types of services included in this category should be regularly reviewed and updated by the Health Services Commission using evidence-based sources such as the US Preventive Services Taskforce on Preventive Services reports.

Organizational Considerations

• The Health Services Commission (HSC) should be given governance over the Essential Benefit Package (ESB) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of dealing with these types of issues.

- The HSC should adjust the Prioritized List, Plan Tiers, and other parts of the ESB based on changing evidence and public values
- The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
- The HSC should create and update the list of value-based services using available evidence

•To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support will need to be provided

- Consideration should be given to having part- or full-time paid members
- It will need to meet more often, perhaps bi-weekly rather than bi-monthly
- It will need to be given adequate research and support staff

•To effectively lever state funds and scarce human resources, the HSC will need to collaborate with other evidence-based bodies in the state

- Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
- AHRQ Evidence-Based Practice Center for assistance with evidence reviews
- Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation

•The Health Resources Commission (HRC) should become a standing committee under the HSC in order to provide reports for use in determining evidence-based benefits and value-based services

•An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body

The Essential Benefit Package

Category of Care[1]	Cost-Sharing[2]			Deductible/OOP Max[3]
	Integrated Health Home	**Specialist, Procedures, Other**	**Inpatient, ER**	
Basic Preventive and Family Care Services (Lines 1-7)[4]	0%	5%	10%	•Deductible waived •$4,000-$20,000 OOP max applies (income-based)
Value-Based Services	0%	5%	Not applicable	
Basic Diagnostic Services (2 visits, basic office diagnostics)	0%	5%	No coverage	
Vision Exam (1 per year)	0%	5%	No coverage	
Comfort Care	0%	5%	20%	
Tier I (Lines 8-109)	20%	30%	40%	•$1,000-$7,500 deductible applies (income-based) •OOP max applies
Tier II (Lines 110-309)	40%	50%	60%	
Tier III (Lines 310-503)	60%	70%	80%	
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Excluded Conditions	No coverage	No coverage	No coverage	
Ambulance	$100 copayment, waived if paramedic or EMS standards determines meets transport criteria			
Medications	•$5 copay for generics, $15 copay for preferred brands, 50% co-insurance for other brands[5] •Evidence-based formulary will be used[6] •No coverage for medications for non-covered conditions			•Deductible waived •OOP max applies
Diagnostic Services	•In addition to 2 basic diagnostic visits and basic office diagnostics above •Co-insurance varies based on type of test (e.g., basic office tests 5%, MRIs 50%) •Limitations according to evidence-based guideline(s), location of service or other criteria •Certain high volume, high cost, or high risk laboratory studies, imaging, procedures and office diagnostics subject to prior authorization			Deductible and OOP max apply
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			Deductible and OOP max apply

Notes

[1]Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. Excluded conditions do not appear on the Prioritized List and include experimental treatments, infertility services, or cosmetic procedures.

[2]Co-insurance amounts are examples and can be adjusted until actuarial pricing is acceptable.

[3]Deductible amounts and out-of-pocket maximums should be varied based on income level. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

[4]Reproductive services could be moved to Line 5 and Tobacco Dependence and Drug/Alcohol Dependence removed from the Basic Preventive Services Category (i.e. consisting then of Lines 1-5).

[5]All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

[6]An evidence-based formulary should be utilized and based on sources such as Drug Effectiveness Review Project (DERP).

[7]Mental health and dental conditions are in the Tier which contains their relevant line number(s) on the Prioritized List or should be included as value-based services.

Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon healthcare marketplace.

To be a qualifying plan:

1) The plan must provide all services provided under the EBP at no higher level of cost sharing
    a. Preventive care and comfort care must have no or minimal co-insurance
    b. Value-based services must be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
    c. Basic diagnostic services must be offered as outlined in the EBP with no higher cost sharing
    d. Additional coverage must include at least those condition-treatment pairings included in the 2008-09 Prioritized List through line 503 with the same or lower cost sharing.
        i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ER services.
2) Additional conditions and services can be covered
3) A plan will not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package is required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than preventive, value-based services, basic diagnostic services, and comfort care) with a 20% cost-sharing, which is the lowest cost sharing amount permitted under the Essential Health Package "Tiers." Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in the following table. Note that these are simply example plans; numerous other variations would and could be expected.

Examples of Essential Benefit Package and Supplemental Plans

	Essential Benefit Package			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	$7,500			$2,500			$500		
Out-of-Pocket Maximum	$15,000			$10,000			$2,000		
Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income									
Co-insurance Level (No Deductible Required)									
	Integrated Health Home	Other OP Care	Inpatient, ER	Integrated Health Home	Other OP Care	Inpatient, ER	Integrated Health Home	Other OP Care	Inpatient, ER
Basic Preventive/Family Care Services (Lines 1-7)	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Value-Based Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Vision Exam (1)	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Co-Insurance Level (Deductible Applies)									
Tier I (lines 8-109)	20%	30%	40%	10%	15%	20%	5%	10%	15%
Tier II (lines 110-309)	40%	50%	60%	20%	30%	40%	10%	15%	20%
Tier III (lines 310-503)	60%	70%	80%	40%	50%	60%	20%	30%	40%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	80%	No coverage	No coverage	60%	70%	80%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Prescription Medication	Generic $5, Preferred Brand $15, Other Brand 50% co-insurance			Generic $5, preferred brand $10, other brand 30% co-insurance			Generic $5, preferred brand $10, other brand $25		
Ambulance	$100 copay, waived if criteria met			$75, waived if criteria met			$50, waived if criteria met		
Other Diagnostic Services	Varies			Varies			Varies		

The Essential Benefit Package
Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is at 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a dental cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ER via LifeFlight and spends several weeks in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a $1,000 deductible, then 40% of her bills until she reaches an out-of-pocket maximum of $4,000 (her deductible and out-of-pocket maximum were reduced due to her income level).

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. She would have a 10% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Jones' are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough, and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bronchitis. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a $5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting bronchitis in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and surgeries after meeting their $7,500 deductible. However, once the family meets the $15,000 out-of-pocket maximum for their plan, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year they are in the Oregon

Exchange. They are pleased that there are no pre-existing condition limitations in the Exchange. With this plan, Jenny's doctor visits are covered with a 5% co-insurance and her surgeries and hospitalizations are covered with a 15% co-insurance. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 30% co-insurance instead of the 50% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 90% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are $5 a prescription, but his preferred brand cholesterol medication is $15. Mary is able to get her screening colonoscopy with no cost sharing as it is in the basic preventive portion of their plan.

Bob starts to feel chest pain while watching the Bears game and goes to the ER where he is diagnosed with a heart attack and admitted to the hospital. Heart attack is a Tier I condition and requires a 20% co-insurance for ER and hospital inpatient care after Bob meets his $2,500 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his ER and hospital cost sharing to the outpatient level (10%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Migraine is in Tier III, carrying a 60% co-insurance for her ER visit after Mary's $2,500 deductible. She does not qualify for a reduction in cost sharing and must pay the full 60% unless that amount takes them above their $10,000 out-of-pocket maximum.

The next year, the Browns again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ER care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a home-maker. They have one daughter. The family is concerned about paying high cost sharing for

unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% co-insurance for this hospitalization, after meeting his $500 deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered with a 5% co-insurance under his diagnostic benefit. His broken ankle is in Tier III, making the casting and subsequent orthopedic surgeon office visit covered with a 30% co-insurance.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% co-insurance after she reaches her $500 deductible and purchases her generic medications with a $5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians?
- ☐ b. based upon a proven benefit model?
- ☐ c. reflective of the values of Oregonians?
- ☐ d. easy to adjust in response to new information on cost and effectiveness?
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable?
- ☐ f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care
- ☐ b. Chronic disease management
- ☐ c. Primary care medical homes
- ☐ d. Dignified end-of-life care
- ☐ e. Patient-centered care
- ☐ f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- ☐ a. wellness?
- ☐ b. patient engagement (including education towards self-management)?
- ☐ c. coordination and integration of care?
- ☐ d. population health?
- ☐ e. cost-effective care?
- ☐ f. cost-control/reductions in over-utilization?
- ☐ g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine
- ☐ b. Efficacy of treatments
- ☐ c. Reduction of health disparities
- ☐ d. Personal responsibility
- ☐ e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services
- ☐ g. Acute and tertiary care needs of the population

Appendix B: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of healthcare. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include:

1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
    - Examples include IMTALA, HIPAA, Medicaid and Medicare administrative rules, etc.
3) Workforce issues which must be addressed to allow creation of integrated health homes for all Oregonians
4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
    - Examples include educational interventions, non-emergent transportation, or personal health aides

Appendix C: Glossary

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

co-insurance A defined percentage of the total charges for a service that the patient is responsible for.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the price of services.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by CMS.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium, towards health care expenses covered by their insurance plan over the course of a year.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Oregon Health Fund Board

Benefits Committee
May 27, 2008

Clackamas Community College
Wilsonville Campus Training Center, Room 112
29353 Town Center Loop East
Wilsonville, Oregon

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OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE

May 27, 2008 Meeting Packet

Oregon Health Fund Board
Benefits Committee Meeting

Tuesday, May 27, 2008
11:00 am – 3:00 pm
Room 112
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
11:00 am	Call to Order	Susan King	
5 min	Approval of Agenda and 4/15/08 Minutes	Susan King	X
11:05 am 5 min	Goals of Meeting	Susan King	
11:10 am 20 min	Report from Staff Review Panel on Cost Sharing	Darren Coffman, Ariel Smits, Som Saha	
11:30 am 30 min	Overview of Changes Reflected in 5/20/08 Draft Recommendations for an Essential Benefit Package	Ariel Smits, Darren Coffman	
12:00 pm 1 hr	Discussion of Recommendations for the Essential Benefit Package Other Than Cost Sharing	Susan King	
1:00 pm 20 min	Pricing the Essential Benefit Package	James Matthisen	
1:20 pm 40 min	Discussion of Cost Sharing Levels for the Essential Benefit Package/Those with Limited Financial Means	Susan King	
2:00 pm 30 min	Public Testimony	Susan King	
2:30 pm 20 min	Final Recommendations for the Oregon Health Fund Board on the Essential Benefit Package	Susan King	X
2:50 pm 10 min	Next Steps • 6/25/08 Presentation to the Oregon Health Fund Board	Susan King, Darren Coffman	
3:00 pm	Adjourn	Susan King	

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

April 15, 2008 **CCC, Wilsonville Campus Training Center, Room 111**
9:30 a.m. **Wilsonville, Oregon**

MEMBERS PRESENT:
Susan King, RN, Chair
Somnath Saha, MD, Vice Chair
Nina Stratton, Vice Chair
Tom Eversole
Leda Garside, RN
Betty Johnson
Bob Joondeph
Hugh Sowers, Jr.
Kathryn Weit
Kevin Wilson, ND

MEMBERS ABSENT:
Gary Allen, DMD
Lisa Dodson, MD
Jim Lussier
Susan Pozdena

OTHERS ATTENDING:
Mallen Kear, Archimedes Movement
Kelly Harms, Office of Private Health Partnerships
Lisa Trussel, Health Net
Laura Sisulak, Oregon Primary Care Association
Bob Clements, WSU
Claudia Flores, Salud Services/OHSU Nursing Student
Lorey Freeman, Office of Legislative Council
Dana Tierney, Regence
Beryl Fletcher, Oregon Dental Association
Denise Honzel, Oregon Health Fund Board (OHFB) Exchange Workgroup
Bill Kramer, Consultant, OHFB
Ellen Lowe, Oregon Association of Hospitals & Health Systems (OAHHS)
Dave Roberts, Lilly
Bruce Bishop, OAHHS
Phil Donovan, American Heart Association
Fawn McNeely, ODS Health Plans
William T. Walsh, Jr., Walsh Associates Inc
Delores Foglio, Corporate Health NW
Betsy Earls, Associated Oregon Industries (AOI)

STAFF PRESENT:
Darren Coffman, Health Services Commission Director
Ariel Smits, MD, MPH, Health Services Comm. Medical Director
Barney Speight, OHFB Executive Director
Jeanene Smith, MD, MPH, Oregon Health Policy & Research (OHPR) Administrator
Brandon Repp, Research Analyst
Nate Hierlmaier, Policy Analyst
Dorothy Allen, Administrative Staff

ISSUES HEARD:

- **Call to Order/Approval of Agenda and 03/13/08 Meeting Minutes/Review of Revised Work Plan**
- **Presentation on Draft Proposal for an Essential Benefit Package**
- **Public Testimony**
- **Next Steps**

Chair King

I. Call to Order

- Meeting called to order at 9:40 a.m. There is a quorum.

Chair

II. Approval of Agenda/March 13. 2008 Meeting Minutes

- Review of March 13 meeting minutes

Motion to approve the minutes as submitted is seconded.
Motion passed unanimously.

Ariel Smits, MD MPH, Darren Coffman, Staff Review Panel Members

III. Presentation on Draft Proposal for an Essential Benefit Package

Dr. Smits reviewed the document entitled "The Essential Benefit Package, Draft Proposal dated 4/11/08"

Highlights of the presentation include:

- The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state.
- This EBP incentivizes the rational redesign of the health care system by:
  - Utilizing integrated health care homes to their fullest extent, treating all parts of the body equally (mental health and dental parity), basing coverage decisions on evidence when available, and providing ongoing evidence surveillance and enhanced guidance for the system.
- This EBP has the following features:
  - Based on the Health Services Commission's Prioritized List of Health Services.
  - Services for categorical Medicaid clients (OHP Plus) would remain unchanged. OHP Standard clients would see an increase in services as the proposal is currently constructed.
  - Preventive services are emphasized, value-based services will include incentives and rewards, personal responsibility will be rewarded.
  - The EBP would serve as the "foundational level" of health care coverage below which no individual should fall. Purchase of supplemental coverage would be at the discretion of the plan member, employer or other purchaser.
  - Financial considerations include a high deductible, a limit on out-of-pocket expenses, certain considerations for financial sustainability of the plan and minimize uncompensated care and cost-shifting in the market.
  - An evidence-based drug formulary should be utilized.
  - Services provided in the integrated health home would be incentivided by having the lowest level of cost sharing, with other outpatient care and inpatient hospital services each having progressively higher cost sharing.
  - Value-based services are to be a selected group of cost-effective health care treatments based primarily in the integrated health home which have been shown to prevent hospitalizations, ER visits, and other expensive treatments for particular health care conditions

- Diagnostic tests and visits will have some first-dollar coverage (outside of the deductible), but would otherwise be subject to limitations and have varying cost sharing associated with them.
- There would not be a life-time plan maximum.

- Discussion:
  - The committee members and audience members expressed approval for the frame work of the Essential Benefits Package. Mr. Barney Speight added that it should be recognized that there will be a two-to-four year transition period, to help manage expectations.
  - Suggestions to be considered when refining the Essential Benefit Package proposal include the definition and consideration of value-based services, co-morbidity rule and integrated health care homes.

Motion to approve and support the framework of the Essential Benefits Package proposal as described is seconded. **Motion passed unanimously.**

Chair **VI. Public Testimony**

- Nurse Practitioner Delores Foglio, Corporate Health NW, addressed the committee.
  - Practices at a Nurse Practitioner run clinic for a self-insured employer, focused on prevention and wellness, since 2005.
  - Small premium to the employee, all clinic care is free; visits are on paid work time in addition to a yearly $1,000 credit for services and labs not preformed by the clinic.
  - Incentive to not smoke by reducing the premium by $20/family member/month who does not smoke. $500 benefit for smoking cessation.
  - Free weight loss program, weekly counseling and exercise facility.
  - In the first year, this program saved the company $350,000.
  - Ms. Foglio urged the Committee to consider a model such as this in a public setting.

Chair **VII. Next Steps**

- Identification of issues requiring further discussion
- Refine the Essential Benefit Package proposal with the Cost Sharing Staff Review Panel
- Work with the actuary on the preliminary pricing of an essential benefit package
- Report to the Oregon Health Fund Board in June, 2008

Chair **VIII. Adjourn**

The Chair adjourned the meeting at 1:15 p.m.

Submitted By:
Dorothy Allen

Reviewed By:
Darren Coffman

Next meeting is Tuesday, May 27, 2008.

The Essential Benefit Package

Recommendations of the Oregon Health Fund Board's Benefits Committee

The Essential Benefit Package is an affordable, sustainable package of benefits which emphasizes evidence-based care provided in the integrated health home. It protects enrollees from profound financial losses due to medical expenses, and rewards patients who actively participate in their own care. Enrollees would have little or no cost sharing for outpatient visits for certain chronic diseases and evidence-based preventive services. Other disease conditions and services will be covered after the enrollee meets a relatively high deductible (adjusted for financial means), based on the Health Services Commission's Prioritized List of Health Services. Cost sharing would be "capped" by an out-of-pocket maximum. This package would provide the foundation that defines what is considered essential coverage; it is anticipated that richer plans with higher premiums would continue to be offered in the private market.

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The Essential Benefit Package
Executive Summary

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state. The Benefits Committee developed the list of guiding principles shown in Appendix A to frame these recommendations.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health homes become the basis for cost-effective, patient-centered care
- Health care services are not segregated based on the part of the body they involve or the qualified health professionals who deliver them
  - Coverage for mental health and dental services should be based on the same criteria as other physical health conditions
- Coverage of services should be evidence-based to the highest degree possible
  - The Health Services Commission or other similar body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Coverage focuses on care which reduces the overall cost and complications of disease
  - Value-based services are an integral part of the package, representing evidence-based services that maintain or improve health, prevent illness and illness complications, and/or reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility should be rewarded
  - Value-based services should include incentives and rewards for patients who actively participate in their own health care

The EBP would be **affordable for individuals and the state**:

- Value-based services (including evidence-based preventive services) and basic diagnostic services should be available to all with no or low cost barriers
- Other types of care should be covered after the beneficiary meets a high deductible amount (adjusted for financial means). A limited number of discretionary services may have separate coverage maximums. These limitations in the plan will help result in a reduction in the cost of premiums.
- After the deductible is met, personal financial responsibility for services increases for conditions that appear lower on the Health Services Commission's Prioritized List of Health Services
- The introduction of an out-of-pocket maximum protects individuals and families from profound financial losses from catastrophic illness or injury

The EBP would serve as the **"foundation level" of health care coverage** below which no individual's coverage should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease-specific plans that do not serve the overall health of an individual or insured population
- Under this proposal, the current benefits offered to the categorically eligible Medicaid populations would not differ from the current OHP Plus benefit package with nominal copays.

Introduction

When creating a set of essential services, several goals must be met. The Essential Benefit Package (EBP) as described here would achieve the following:

1) Improve the overall health of the people of Oregon. This goal would be met through measures such as improved immunization rates to reduce vaccine transmissible disease, improved screening for diseases which are more cost-effective to treat at an early stage, reduced smoking rates, and improved population health markers (e.g., fewer low-birthweight babies).
2) Incentivize a rational redesign of the health care system. The EBP would improve access to and utilization of services in an integrated health home. It is anticipated that this redesign will revitalize primary care in the state. Services would not be segregated based on body part; mental health and dental conditions would be covered according to priority, need, and evidence, just like other physical health conditions.
3) Reward personal responsibility. Cost-sharing principles should be developed with rewards and incentives for individuals to actively participate in their own health care. To facilitate this, the health care system will need to have supports in place to assist individuals in this process.
4) Reduce overall health care costs. This goal would be met through incentivizing patients to receive timely diagnosis, management, prevention, and treatment in the most appropriate and cost-effective setting rather than care for later-stage illness requiring acute, hospital-based care or other intensive and costly services. Mechanisms should be put in place to encourage patients to seek care in their integrated health home rather than in the emergency department for common outpatient complaints. Certain diagnostic tests, procedures, medications, and treatments that exhibit high cost, high utilization, and/or high variability in usage should be subject to robust, efficient and swift prior authorization processes. Additionally, the EBP would minimize uncompensated care and cost-shifting in the system. Some services, particularly in the mental health and chemical dependency arena, may actually reduce costs of other social services (e.g., corrections, public safety).
5) Be innovative. The EBP includes value-based services, which are a selected group of evidence-based, cost-effective health care services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. The EBP would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.
6) Provide a social safety net. The EBP would protect individuals from devastating financial losses and bankruptcy due to catastrophic illness or injury.
7) Be affordable for the individual and the state. The lowest acceptable "foundation level" package should be priced low enough to be affordable to all Oregonians above 400% of FPL and be fiscally responsible for the state to contribute towards the health care coverage of Oregonians in or near poverty. To keep the cost of the plan low, cost containment measures such as limits on certain discretionary services as well as a reasonably high deductible will be included. It is anticipated that private insurers would

be innovative in creating plans which offer a richer benefit package with potentially higher premiums than the EBP.

8) Reflect the values of Oregonians. The EBP would provide services to special populations such as pregnant women, small children, seniors, and people with disabilities, as well as provide dignified end-of-life care, which have been values consistently expressed by Oregonians in public meetings on health care reform.
9) Be evidence-based. The EBP would require that the Health Services Commission (HSC) be enhanced, meet more often, and be given greater financial resources to allow for a thorough and timely surveillance of the evidence and provide regular guidance to the system. It is further recommended that the Health Resources Commission (HRC) work collaboratively with the HSC to allow in-depth reviews of technologies and treatments. It is also anticipated that the HSC and HRC would collaborate with other evidence-based bodies in the state, such as the Drug Effectiveness Review Project (DERP), the Oregon Evidence-Based Practice Center, and the Medical Evidence-Based Decisions (MED) Project.

The Essential Benefit Package responds to the goals above by having few financial barriers to evidence-based preventive care, access to diagnostic visits and basic tests, and graduated personal contributions for health care based on priorities set by the Oregon Health Services Commission in the Prioritized List of Health Services. In addition, the plan incorporates both low barriers and incentives for certain "value-based services." These services include cost-effective outpatient services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Plan members would be protected from profound financial loss by having a "cap" placed on out-of-pocket expenses.

The Essential Benefit Package is a "foundation level" plan. No insurance plan should be allowed to offer a lower level of benefits. However, private purchasers and governmental programs such as Medicaid could offer a plan that provides more benefits and/or less cost sharing than the EBP. Companies could elect to buy up to a richer plan for employees and individuals could buy up to a richer plan through higher premiums. However, the low barriers to value-based services (including evidence-based preventive services) would have to be maintained for a plan to qualify as meeting the minimum plan requirements. Additionally, such plans would have to provide the same services as the EBP with no greater cost sharing. It is anticipated the private market would create products which would help reduce premiums through competition and bulk purchasing as well as offer plans with additional, supplemental coverage. Purchase of these supplemental products would be at the discretion of the plan member, employer or other purchaser.

Basic Principles of the Essential Benefit Package

1) Services
    a. The Essential Benefit Package (EBP) being recommended by the Benefits Committee is based on the Health Services Commission's Prioritized List of Health Services
        i. Coverage of conditions should not be segregated based on the part of the body affected or the type of qualified health care provider delivering the service. Evidence and public values will drive coverage decisions.
            1. Dental and mental health conditions would be included as they appear on the Prioritized List
            2. Services such as physical and occupational therapy and complementary and alternative medicine services would be included as they appear on the Prioritized List, with guidelines as appropriate
        ii. Conditions and services appearing low on the Health Services Commission's Prioritized List of Health Services may not have any coverage
        iii. Nearly all conditions and services with state mandated coverage are currently included on the Prioritized List. See item #5 under Issues of Note on page 16.
        iv. The Prioritized List of Health Services only considers the relative importance of treatments for individual conditions. Those who have comorbid conditions may warrant special consideration in regards to coverage or cost sharing issues.
    b. "Value-based services" should have low if any cost sharing
        i. Value-based services should be identified using trusted, evidence-based sources
        ii. Value-based services should be developed by the Health Services Commission and be a dynamic list reflecting changing evidence and the values of Oregonians
        iii. Value-based services should include evidence-based preventive services
        iv. Value-based services should include outpatient services that reduce the overall cost of caring for common chronic diseases
        v. Value-based services should include patient incentives for those who actively participate in their own health care, which could result in reductions in patient cost sharing or may provide credits toward other health-promoting benefits
        vi. It is anticipated that most, if not all, value-based services will be delivered in the outpatient setting. A limited number of services, such as flu shots, may be delivered in the acute care setting.
        vii. Value-based services will include supports to assist the patient in assuming responsibility for their own health care
    c. Diagnostic tests and visits will have some coverage, but may be subject to limitations and have varying cost sharing associated with them
        i. Basic point-of-service tests, such as lab tests or EKGs, and a limited number of diagnostic visits should be covered with limited or no cost sharing

ii. Certain diagnostic tests, procedures, medications, and treatments with high costs, high utilization, and/or high variability in usage should be subject to limitations and cost sharing to promote the most appropriate use of resources. This should be accomplished using the following hierarchy of approaches:
    1. The use of evidence-based guidelines, where available, that are regularly reviewed and updated
    2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
    3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those either of high cost that have effective, lower-cost alternatives or which do not have a major impact on the clinical management of the patient.

d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
e. Enabling services such as translation services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services,
    i. Selected care coordination services will likely be included as Value-Based Services
f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient or home-based care
g. Telephone nurse triage systems are strongly encouraged to allow appropriate direction to the most appropriate and cost-effective care settings for patients with urgent medical issues

2) Financial considerations
    a. Personal financial responsibility should increase as the service appears lower on the Prioritized List
    b. Premiums, deductibles and out-of-pocket (OOP) maximums should be scaled according to the individual/family's financial means
    c. A limit on OOP expenses should be included to prevent profound financial loss
        i. OOP maximums should be established for both individuals and families and should be adjusted for financial means
    d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan
        i. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive appropriate and cost-effective health care utilization decisions
    e. Certain "discretionary services" may have separate coverage maximums or other limitations
        i. A list of discretionary services should be developed by the Health Services Commission or other body designated by the Health Fund Board and be dynamic in its reflection of changing evidence and the values of Oregonians

ii. The services placed in this list would fall into one or more of the following categories:
    1. Have limited efficacy or equal efficacy to a lower cost service
    2. Have little impact on overall health or functioning of the individual
    3. Have little impact on the health of the population
    4. Have little value in reducing overall health care costs
iii. Placing limits on discretionary services will allow more affordable premiums or otherwise reduce costs to the system
    1. This should allow sustainability of the system and affordability to individuals and the state

f. There should be no overall lifetime maximum limits on benefits
    i. To allow such benefit limits in the context of an individual mandate would be counter intuitive.
    ii. In order to keep this package affordable, this may mean that this "foundational level" of coverage may not include some very high cost treatments that show some evidence of a very marginal level of benefit.
g. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.

3) Medications
    a. A drug formulary should be utilized
    b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
    c. A governing body should be responsible for formulary reviews and the administration of an appeals process
    d. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
    e. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
4) Integrated health home
    a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
    b. Integrated health homes should include primary physical and mental health care, case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system
    c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)
    d. The integrated health home may be a single provider group practice or clinic, or an integrated network of providers
    e. Ideally, mental health services would be available within the integrated health home
    f. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee

g. The Benefits Committee recognizes that the integrated health home does not currently exist for the majority of Oregonians. The incentives for receiving services in an integrated health home may need to be implemented in a graduated fashion to allow the health care delivery system time to develop the necessary components for the integrated health home throughout the state. In the interim, consideration should be given to lowering the cost-sharing levels for a service that could otherwise be obtained in an integrated health home were one available.

5) The EBP is a "foundation level" package
   a. Government, private companies, and individuals could purchase or offer a more generous package. The private market would be able to and should develop supplemental plans
   b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
      i. No package should have barriers to preventive and value-based services higher than those specified in the EBP
      ii. Value-based services would need to be included as designed by the Health Services Commission and offered with the same or lower cost-sharing as the EBP
      iii. Basic diagnostic services would need to be offered as outlined in the EBP with no higher cost sharing
      iv. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and emergency department services.
   c. Equivalence between a commercially available plan and the Essential Benefit Package must be based on actual coverage equivalence and not on the equivalence of actuarial value of the plans (i.e., equivalence requires coverage of at least the services provided in the EBP with the same or lower levels of cost sharing).

Value-Based Services

Value-based services are to be a selected group of cost-effective health care services based primarily in the integrated health home that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. By encouraging use of these primarily ambulatory services, overall health care costs should be reduced and population health improved. The Essential Benefit Package would incentivize these services through two mechanisms: 1) minimal cost sharing for these services and 2) financial incentives for following treatment recommendations.

Conditions Which May Have Value Based Services Associated With Them

Qualifying conditions and cost-effective services for these conditions should be determined by the Health Services Commission or other body designated by the Health Fund Board or Oregon Legislature. A list of value-based services whose use is intended to avoid preventable hospitalization and emergency department visits, through timely and appropriate care in an integrated health home, will be designed for conditions amenable to such services, as identified using sources such as the Agency for Healthcare Research and Quality (AHRQ) list of ambulatory care sensitive conditions. Examples of these conditions include diabetes, schizophrenia, asthma, congestive heart failure, and low birthweight. Other candidates for value-based services should come from the U.S. Preventive Services Taskforce recommendations for preventive care and screening services, and other evidence-based sources.

Once a list of conditions has been developed, then cost-effective services for these conditions would be determined. Next, evidenced-based guidelines would be created for the use of these services. Standards for compliance with these guidelines would be established according to condition and the incentive for meeting the acceptable compliance level would then be determined.

The lists of conditions and value-based services for these conditions would be continuously updated by the HSC or other oversight body based on changing evidence.

Value based services do NOT include all treatments for a condition. Conditions with possible value-based services, such as diabetes or asthma, are currently associated with a wide range of treatments on the Prioritized List of Health Services. These treatments range from inexpensive preventive care, such as outpatient visits, to expensive services aimed at treating disease complications, such as intensive care unit admissions and surgeries. A condition which is determined to have value-based services associated with it will remain on its designated Prioritized List line with all relevant **non**-value-based services prioritized according to the position of that line on the Prioritized List. Only certain cost-effective services will be on the Value-Based Services List. For example, treatments for diabetes such as outpatient primary care visits, periodic diabetic eye exams, and care coordination could be placed on the Value-Based Services List while treatments such as ICU admissions for ketoacidosis or leg amputation surgery would remain on their respective lines within the Prioritized List. Both Type 1 and Type 2 diabetes are currently listed as Tier I conditions.

It is anticipated that most, if not all, value based services will be delivered in the outpatient setting. However, certain services may be delivered in the acute care setting. Such services may include flu shots during ER visits or day surgery center visits for colonoscopies.

Potential Value-Based Service Examples

The examples are provided for illustrative purposes only and may or may not ultimately be included in a list of value-based services.

1) Preventive care
    - Preventive services, such as immunizations, Pap smears, mammograms and colorectal cancer screening, should have minimal or no cost sharing. Plan members who are up-to-date on current screening recommendations could have points awarded that he or she could use to reduce the cost sharing for medication or other covered services, or could use them for wellness activities (e.g., assistance in purchasing a gym membership).
2) Chronic disease management
    - A patient with a chronic disease could have minimal cost sharing for outpatient provider visits, selected medications, self-treatment education, care coordination, and other cost-effective treatments for that condition. A patient who sees his or her doctor at recommended intervals, fills his or her prescriptions as prescribed, and actively participates in other aspects of his or her care could have a reduction in the cost sharing for emergency department visits and hospitalizations for complications of his or her chronic condition.
3) Maternity care
    - Pregnant women could have no cost sharing for prenatal care. A patient who adheres to the recommended timing and number of prenatal visits and otherwise completes the recommended portions of her prenatal care could have no cost share towards the delivery of her child.
4) Smoking-related diseases
    - A patient with a chronic disease that is caused by or exacerbated by smoking could have a reduction in cost sharing for outpatient office visits and medications related to that condition if he or she quits smoking. Patients who continue to smoke could pay more for treatments and medications for the smoking-related condition.
5) Dental services
    - Preventive dental exams and cleanings, and fillings for dental caries could have minimal cost sharing. Plan members who receive regular cleanings could have points awarded that could be used to reduce the cost sharing for restorative dental or other covered services.
6) Vision services
    - Regular vision exams for age groups where such exams are recommended by the U.S. Preventive Services Task Force could have minimal cost sharing at a defined interval, such as every two years. Plan members who receive regular exams could have points awarded that could be used to reduce the cost sharing for other covered vision services or corrective lenses.

Services Included in Each Tier

The services included in each tier are based on the HSC Prioritized List of Health Services. Tier I generally contains preventive services as well as severe chronic diseases and acute life-threatening conditions with very effective treatments. Tier II generally contains common chronic diseases with less impact on overall heath and other diseases/conditions which can be life-threatening that have effective treatments. Tier III generally contains non-life threatening trauma, conditions with less effective treatments, and non-life threatening acute and chronic health problems. Tier IV contains self-limited conditions, conditions with no effective treatments, and conditions with limited effects on overall health. Because Tiers I and II both contain serious and life-threatening health conditions, the recommended cost-sharing difference between these two tiers is smaller than between Tier II and Tier III (which generally contain less serious conditions).

The line ordering is subject to review and revision by the Health Services Commission. It is anticipated that the HSC will likely reprioritize some lines once the value-based services are removed from that line, based on the remaining contents. It is further anticipated that the HSC may reorder some lines and/or change the location of tier breaks based on evidence and/or public feedback.

Tier I (Lines 1-113): Examples of Services and Conditions in this Tier (Note: the services associated with each of these lines would exclude those identified as value-based services)

- Preventive services
- Pregnancy and delivery
- Alcohol and drug treatment
- Life-threatening newborn conditions (e.g., very low birthweight or serious birth trauma)
- Life-threatening chronic diseases (e.g., treatments for asthma, diabetes, congestive heart failure, and HIV disease)
- Life-threatening mental health disorders (e.g., major depression, bipolar disorder, schizophrenia)
- Imminently life-threatening trauma (e.g., internal injuries, severe head injuries, major wounds)
- Imminently life-threatening acute illness (e.g., meningitis, appendicitis, intestinal obstruction, heart attack)
- Conditions of public health concern (e.g., tuberculosis, sexually transmitted diseases)

Tier II (Lines 114-311): Examples of Services and Conditions in this Tier

- Potentially life-threatening trauma (e.g., neck and limb fractures, limb amputations, joint dislocation)
- Cancers with effective treatments (e.g., cervical, kidney and bone cancers)
- Chronic disease with less impact on health or less effective treatment (e.g., attention deficit hyperactivity disorder (ADHD), peripheral vascular disease, mild depression, chronic hepatitis, dementia)
- Potentially-life threatening acute illness (e.g., pancreatitis, pneumonia, urinary tract infection (UTI))

Tier III (Lines 312-503): Examples of Services and Conditions in this Tier

- Non-life-threatening trauma (e.g., severe sprains and strains)
- Non-life-threatening mental health disorders (e.g., acute stress disorder, dysthmia)
- Non-life-threatening acute and chronic disease (e.g., gout, migraines, kidney stones, miscarriage, tooth loss)
- Cancers with less effective treatments (e.g., pancreatic, esophageal and liver cancers)
- Non-life-threatening infections (e.g., sinusitis, otitis media, acute bronchitis)

Tier IV (Lines 504-680): Examples of Services and Conditions in this Tier

- Conditions with no effective treatment or no treatment necessary (e.g., rib fractures, benign cysts and growths, non-venereal warts)
- Self-limited conditions (e.g., colds, minor burns, cold sores)
- Conditions with limited effects on health (e.g., seasonal allergies, acne, diaper rash)

Excluded conditions

- Cosmetic surgery
- Infertility services
- Services shown to result in harm
- Experimental treatments

Discretionary Services

Discretionary services are those health care services which are of limited efficacy or of equal efficacy to less expensive services. Alternatively, these services may be efficacious but do not have a significant impact on the health of an individual or population.

Discretionary services may have limits placed on them in the Essential Benefits Package. There may be separate coverage maximums placed on these services or other limitations. Such limitations will help ensure that premium costs are affordable to Oregonians and the state.

Like value-based services, a list of discretionary services would be developed by the Health Services Commission or other body designated by the Health Fund Board, using evidence-based sources. This list would be updated to reflect changing evidence and the values of Oregonians.

Possible examples of Discretionary Services

- Dental care - Restorative dental services may have coverage maximums imposed upon them, such as a maximum dollar amount covered per year. Additionally, amalgam fillings may be covered rather than the more expensive porcelain fillings due to having a lower cost for the same level of efficacy.

- Vision services -eyeglasses, and other vision care supplies may be limited. For example, glasses may have price limitations, allowing only coverage of a basic, non-designer pair which works equally well as a more expensive designer frame.

- Conditions which do not impact overall health of the individual - Some conditions, while having a modest affect on quality of life, do not affect overall health significantly. Examples of such conditions include acne and mild to moderate psoriasis. Specialty visits and types of medications for these types of conditions may have limits or other maximums placed upon them.

When discretionary services are removed from lines on the Prioritized List and placed on the Discretionary Services List, the overall ranking of the remaining diagnoses and services on those lines may rise to a higher priority level. The Health Services Commission will carefully consider re-prioritization of lines once the discretionary services have been removed.

The limitations placed on Discretionary Services may take the form of maximum coverage or type of coverage for a particular type of care or equipment, maximums for the total costs of all discretionary services, or some combination of these.

Organizational Considerations

- It is recommended that the Health Services Commission (HSC) should provide governance over the Essential Benefit Package (EBP) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of prioritizing and developing guidelines for health care services for Oregonians.
  - The HSC should adjust the Prioritized List, tier break points, and other parts of the EBP based on changing evidence and public values
  - The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
  - The HSC should create and update the list of value-based services using available evidence

- To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support would need to be provided
  - Consideration should be given to having part- or full-time paid members
  - The HSC or its subcommittees may need to meet more often, perhaps bi-weekly rather than bi-monthly
  - The HSC would need adequate research and support staff

- To effectively leverage state funds and scarce human resources, the HSC would need to collaborate with other evidence-based bodies in the state
  - Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
  - Oregon Evidence-Based Practice Center for assistance with evidence reviews
  - Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation

- The Health Resources Commission (HRC) and the HSC would need to work in close collaboration in order to complete reports for use in determining evidence-based benefits and value-based services

- An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body. This would involve the placement of services within the tiers of the Prioritized List and the inclusion of services within the list of value-based services and basic diagnostic services. A separate appeals process would be necessary in order to hear the merits of individual cases.

The Essential Benefit Package

Category of Care[1]	Cost Sharing[2]			Deductible/OOP Max[3]
	Integrated Health Home	Specialist, Procedures, Other Outpatient[4]	Inpatient	
Value-Based Services	0 – 5% depending on service provided and location of care			•Deductible waived •$4,000-$15,000 OOP max applies per individual (income-based, family = 3 times individual)
2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics	0%	5%	Not applicable	
Comfort Care	0%	5%	20%	
Tier I (Lines 1-113)	20%	25%	30%	•$1,000-$7,500 deductible applies per individual (income-based, family=3x) •OOP max applies
Tier II (Lines 114-311)	30%	35%	40%	
Tier III (Lines 312-503)	40%	45%	50%	
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Excluded Conditions	No coverage	No coverage	No coverage	
Discretionary Services	40%	45%	50%	•Deductible applies •OOP max does not apply •$2,000/yr limit
Ambulance	$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			
Prescription Medications	•$5 copay for generics, $25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)[5] •Evidence-based formulary will be used[6] •No coverage for medications for non-covered conditions			•Deductible waived •OOP max applies
Emergency Room	$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
Diagnostic Services	•Beyond 2 diagnostic/well-person visits and basic office diagnostics above •Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%) •Limitations according to evidence-based guidelines, location of service, etc. •Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization			
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			

Notes

[1]Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. The placement of tier break-points could change based on further review by the Commission, future changes to the Prioritized List, and/or public comment.

[2]Cost sharing amounts are based on income level – those below 100% of the Federal Poverty Level would have, at most, nominal copays at point-of-service. Amounts shown here are examples and can be adjusted until actuarial pricing is acceptable.

[3]Deductible amounts and out-of-pocket maximums are based on income level – those below 100% of the Federal Poverty Level would have no deductibles. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

[4]Some specialist services and procedures may be provided within the integrated health home for certain individuals.

[5]The cost share is reduced to 50% coinsurance for generic prescriptions and preferred drugs if this is less than the copay level and increased to a $50 copay for non-preferred brand drugs if this is more than the 50% coinsurance amount. All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

[6]An evidence-based formulary should be utilized and based on sources such as the Drug Effectiveness Review Project (DERP).

Issues of Note

Several issues arose in the creation of the Essential Benefits Package for which it was difficult to determine the best solution. These areas have either competing demands or other issues. The solutions proposed in the Essential Benefit Package are only some of several viable solutions for each of these areas. It is anticipated that the Health Fund Board or other body will deliberate further on these areas, with public input to determine the solutions which best meet the needs and values of Oregonians.

1) **ER copayment/coinsurance**
    a. Goal: incentivize use of the integrated health home whenever feasible, yet not disincentivize use of the ER for those conditions which are truly emergent
        i. Example: a cold should be seen in the integrated health home, while a broken leg is most appropriately seen in the ER
    b. Conflict: how to disincentivize inappropriate ER use while not placing undue barriers to appropriate ER use
    c. Other issue: some patients are not given a diagnosis after being evaluated in the ER; these patients would not have a readily determinable coinsurance level based on the current tier system
    d. The Committee acknowledges that the individual may not have choices in alternatives to the emergency department in the current system but hope that the development of integrated health homes will provide such a choice.
    e. Solutions
        i. Selected: relatively high copayment which is waived for patients meeting EMS transport criteria (likely emergent conditions) plus a coinsurance level commensurate with mid-level Tier for hospitalization. This solution may need to be delayed until integrated health homes are in place to provide alternatives to the emergency room.
        ii. Other options:
            1. A more robust triage system with a triage fee; patients who are determined by triage to have non-emergent conditions would be referred to their integrated health home while those with emergent conditions would have a coinsurance level charged for the ER visit commensurate with the integrated health home level for that condition
            2. A flat copayment high enough to discourage casual ER use

2) **Well-person visit**
    a. Goal: incentivize evidence-based preventive care while not encouraging unneeded care
    b. Conflict: most current plans allow a well-person visit once a year, but much of the screening and services provided are not evidence-based

c. Solutions
    i. Selected: cover well-person visits that evidence indicates are effective (i.e., one every 2-3 years for children over 5, etc.)
    ii. Other options:
        1. Cover the office visit costs for one well-person visit a year, but not cover those screenings or other services provided that are not evidence-based
        2. Allow one well-person visit a year, but this would have to take the place of one of the two diagnostic office visits covered for that year

3) Lifetime maximum

a. Goal: allow coverage of conditions and treatments for patients beyond an arbitrary lifetime maximum amount of services, but maintain financial solvency for the system as a whole
b. Conflicts
    i. Some expensive services and treatments do not have much efficacy and may need to be limited due to overall costs to the system
    ii. Most private insurance plans have lifetime maximums. Patients with very expensive medications or treatments may reach these maximums quickly and either elect to change to the Essential Benefit Plan, causing "crowd out," or will end up in the Essential Benefit Plan due to reaching these maximums. Without cost controls, the increasing numbers of such patients would become a significant financial burden on the system
c. Example
    i. A medication for a rare genetic condition costs $500,000 a year and must be given for life, with little improvement in overall health. If no lifetime maximum exists, then a patient with that rare condition would consume a very large amount of health care resources
d. Solutions
    i. Adopted: no lifetime maximum overall, but certain treatments, medications, and other services may have financial maximums placed on them
        1. Example: a patient with the rare condition above would have a $1 million medication limit for that particular medication, but would still have coverage for hospitalization and antibiotics for a condition such as pneumonia
    ii. Other solutions include no lifetime maximum for any condition or treatment, maximums placed on certain conditions, or price controls placed at the level of not covering certain expensive treatments/medications

4) Prescription medication cost sharing

a. Goal: incentivize generic medication use when possible and desirable, otherwise incentivizing preferred brand name drug use while disincentivizing use of non-preferred drugs
b. Issue: Financial barriers to brand name and non-preferred drugs need to be high enough to affect utilization but not be higher than actual drug costs
c. Solutions
    i. Adopted: combination of graduated copays and significant coinsurance. For generic and preferred brand drugs, the amount paid would be the smaller of these two cost sharing levels while non-preferred brand drugs would require payment of the larger of the two out-of-pocket costs.
    ii. Other solutions: simple copay, simple coinsurance, other levels of cost sharing

5) Mandated services

a. The Prioritized List of Health Services appears to not cover mandated benefits in at least specific instances:
    i. Some forms of surgery to the contralateral breast performed post-mastectomy to achieve symmetry after breast reconstruction
    ii. Maxillofacial prosthetics for unilateral anomalies of the ear that impact hearing or bilateral anomalies of the ear that do not impact hearing
    iii. Orthotics for some low ranking conditions of the feet and lower limbs (e.g., flat feet). This may or may not reflect a mandated service as medical necessity must be shown.
b. Solution
    i. Adopted: Acknowledge these omissions and bring them to the attention of the Health Services Commission for discussion
    ii. Other solutions: dictate that state mandated benefits will be a part of the Essential Benefit Package regardless of cost or benefit.

Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon health care marketplace.

Under the EBP as proposed, to be a qualifying plan:

1) The plan would have to provide all services provided under the EBP at no higher level of cost sharing
    a. Comfort care should have no or minimal coinsurance, at levels no higher than prescribed in the EBP
    b. Value-based services would have to be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
    c. Basic diagnostic services would have to be offered as outlined in the EBP with no higher cost sharing
    d. Additional coverage would have to include at least those condition-treatment pairings included in the 2008-09 Prioritized List through Tier III (currently up to an including line 503) with the same or lower cost sharing.
        i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be set at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ER services.
2) Additional conditions and services could be covered
3) A plan would not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package should be required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than value-based services, basic diagnostic services, and comfort care) with a 20% coinsurance, which is the lowest cost sharing amount permitted under the Essential Benefit Package "Tiers." Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in the following table. Note that these are simply example plans; numerous other variations would and could be expected.

Examples of the Essential Benefit Package with Supplemental Plans

	Essential Benefit Package*			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	$7,500 individual $11,250 individual + 1 $15,000 family			$2,500 individual $5,000 individual + 1 $7,500 family			$500 individual $1,000 individual + 1 $1,500 family		
Out-of-Pocket Maximum	$15,000 individual $22,500 individual + 1 $30,000 family			$7,500 individual $15,000 individual + 1 $22,500 family			$4,000 individual $8,000 individual + 1 $12,000 family		
Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income									
Coinsurance Level (Deductible Does Not Apply)									
	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient
Value-Based Services	0-5% depending on service and site			0-5% depending on service and site			0-5% depending on service and site		
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Coinsurance Level (Deductible Applies)									
Tier I (lines 1-113)	20%	25%	30%	10%	15%	20%	5%	10%	15%
Tier II (lines 114-311)	30%	35%	40%	20%	25%	30%	10%	15%	20%
Tier III (lines 312-503)	40%	45%	50%	30%	35%	40%	20%	25%	30%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	50%	No coverage	No coverage	40%	45%	50%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Discretionary Services	40%	45%	50%	30%	35%	40%	20%	25%	30%
Prescription Medications	Generic $5, Preferred Brand $25, Other Brand 50% coinsurance			Generic $5, preferred brand $20, other brand 40% coinsurance			Generic $5, preferred brand $15, other brand 20% coinsurance		
Ambulance	$100 copay, waived if criteria met			$75, waived if criteria met			$50, waived if criteria met		
Emergency Room	$100 copay (waived if admitted or transport criteria met), then 50% coinsurance			$75 copay (waived if admitted or transport criteria met), then 40% coinsurance			$50 copay (waived if admitted or transport criteria met), then 20% coinsurance		
Other Diagnostic Services	Varies			Varies			Varies		

*Please see description of Essential Benefit Package on pages 13-14 for more detail

The Essential Benefit Package
Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a scheduled preventive dental exam and cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ER via LifeFlight and spends several days in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a $2,500 deductible, then 30% of her bills until she reaches an out-of-pocket maximum of $7,500 (her deductible and out-of-pocket maximum were reduced due to her income level). In fact, her total bills reached $150,000 and so her effective cost sharing rate was $7,500/$150,000 = 5%.

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. As a value-based service, she may only have a 5% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Joneses are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bacterial pneumonia. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a $5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting lung infections in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and 30% for the surgeries after meeting their $15,000 deductible. However, once the family meets its $30,000 out-of-pocket maximum, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year. With this plan, Jenny's doctor visits are covered with a 5% coinsurance, while her surgeries and hospitalizations are covered with a 10% and 15% coinsurance, respectively. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 15% coinsurance instead of the 30% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 95% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are $5 a prescription, but his preferred brand cholesterol medication is $20. Mary is able to get her colon cancer screening test with no cost sharing as it is in the value-based services portion of their plan.

Bob starts to feel chest pain and goes to the ER where he is diagnosed with a heart attack and admitted to the hospital. The heart attack requires a $75 copay and 40% coinsurance for the ER visit and 20% coinsurance for hospital inpatient care after Bob meets their $5,000 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his hospital cost sharing to the outpatient level (15%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Mary visits the ER, resulting in a $75 copay, and 40% coinsurance after the $5,000 family deductible is met. She does not qualify for a reduction in cost sharing and must pay the full 40% unless that amount takes them above their $15,000 out-of-pocket maximum.

The next year, the Swerskis again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ER care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a homemaker. They have one daughter. The family is concerned about paying high cost sharing for unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non-value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% coinsurance for this hospitalization, after meeting the $1,500 family deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered services with a 5% coinsurance under his diagnostic benefit. His broken ankle is in Tier II, making the casting and subsequent orthopedic surgeon office visit covered with a 15% coinsurance.

While convalescing from his fracture, Fred realizes that he needs reading glasses. Because glasses are on the Discretionary List, Fred needs to pay extra for the designer frames that he picks out and the $200 eyeglass maximum contribution from the Plan is applied to his $2000 discretionary maximum.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% coinsurance after reaching the $1,500 family deductible and purchases her generic medications with a $5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians?
- ☐ b. based upon a proven benefit model?
- ☐ c. reflective of the values of Oregonians?
- ☐ d. easy to adjust in response to new information on cost and effectiveness?
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable?
- ☐ f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care
- ☐ b. Chronic disease management
- ☐ c. Primary care medical homes
- ☐ d. Dignified end-of-life care
- ☐ e. Patient-centered care
- ☐ f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- ☐ a. wellness?
- ☐ b. patient engagement (including education towards self-management)?
- ☐ c. coordination and integration of care?
- ☐ d. population health?
- ☐ e. cost-effective care?
- ☐ f. cost-control/reductions in over-utilization?
- ☐ g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine
- ☐ b. Efficacy of treatments
- ☐ c. Reduction of health disparities
- ☐ d. Personal responsibility
- ☐ e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services
- ☐ g. Acute and tertiary care needs of the population

Appendix B: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of health care. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include the following:

1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
    - Examples include EMTALA, ERISA, HIPAA, and Medicaid and Medicare administrative rules
3) Workforce and organizational issues which must be addressed to allow creation of integrated health homes for all Oregonians
4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
    - Examples include educational interventions, non-emergent transportation, and personal health aides

Appendix C: Benefits Committee Membership and Staff

Committee Membership

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
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Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Member, Health Services Commission
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
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Bob Joondeph
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Susan King, RN. Chair
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Jim Lussier
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Bend

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Somnath Saha, MD, Vice-Chair
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Member, Health Services Commission
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Hubert (Hugh) Sowers, Jr.
Retired
AARP Member
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Committee Membership (Cont'd)

Nina Stratton, Vice-Chair
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Kathryn Weit
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Salem

Kevin C. Wilson, ND
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Committee Staff

Darren Coffman
Lead Staff

Ariel Smits, MD, MPH
Clinical Staff

Brandon Repp
Research Analyst

Nathan Hierlmaier
Policy Analyst

Dorothy Allen
Administrative Staff

Appendix D: Glossary

actuarial value The present value of future expected benefits calculated using economic and demographic assumptions.

AHRQ (Agency for Healthcare Research and Quality) The lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness *of health care for all Americans*.

ambulatory care sensitive condition An inpatient diagnosis for which timely and effective ambulatory care may have reduced the need for hospital admission.

care coordination An often highly structured and clinically intense set of processes that attempts to facilitate access to health care resources, decrease the "hassle" factor and improve an individual's overall health care experience.

case management A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote high-quality, cost-effective outcomes.

complementary and alternative medicine Any of various systems of healing or treating disease that are not included in the traditional curricula taught in medical schools of the United States and Britain. Examples include acupuncture, Chinese herbal medicine, chiropractic, and homeopathy.

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

coinsurance A defined percentage of the total charges for a service that the patient is responsible for.

clinical effectiveness The measurement of a treatment's ability to achieve a desired health outcome.

cost-effective Achieving the smallest cost for a given benefit, i.e., when a purchase is considered economical.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

cost shifting The transfer of uncompensated care costs from providers to insurance carriers, ultimately borne by consumers through increased insurance costs.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the cost of services.

discretionary services Those health care services, to be identified by the Health Services Commission or other body, which are of limited efficacy, or of equal efficacy to less expensive services. Alternatively, these services may be efficacious but do not have a significant impact on the health of an individual or population. Some discretionary services are efficacious and improve health, but are not required at a high frequency or at an advanced care level.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

EBP (Essential Benefit Package) The defined set of health services recommended by the Benefits Committee as the foundation level below which no individual should be without. This includes cost sharing and incentives, set according to financial means, designed to encourage patients to receive timely and appropriate diagnosis and treatment of their health conditions.

enabling services Services such as translation and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

evidence-based medicine The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

formulary A listing of medications approved for use.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by the Centers for Medicare and Medicaid Services (CMS).

HRC (Health Resources Commission) Commission administered through the Office for Oregon Health Policy & Research that analyzes and disseminates information concerning the effectiveness and cost of medical technologies and prescription drugs.

HSC (Health Services Commission) Commission administered through the Office for Oregon Health Policy & Research that prioritizes health services for the Oregon Health Plan.

incentivize In health care, to encourage desired behaviors (e.g., getting regular prenatal care) through the use of monetary or other rewards.

integrated health home A health care setting which provides patients with an established and continuous relationship with a provider or provider group trained to provide longitudinal health care services. Key aspects of an integrated health home include: team-based care, whole person orientation, coordinated and integrated care, high-quality and safe care, and enhanced access.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, the elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of the Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines but have a household income at or below the FPL. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium towards health care expenses covered by their insurance plan over the course of a year.

patient-centered care Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

point-of-service cost sharing Contributions made by individuals towards their health care in the form of copayments or coinsurance for each service they receive. This is in contrast to contributions made through deductibles and premium share.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Prioritized List of Health Services The list of health services used as the basis for providing benefits under the Oregon Health Plan. Created and maintained by the Health Services Commission, the Prioritized List ranks services according to importance, taking into account clinical effectiveness, cost, and public values. See also *OHP Plus*.

therapeutically equivalent Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

value-based services Those cost-effective services, to be identified by the Health Services Commission or other body, which have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Examples may include certain evidence-based preventive care and outpatient treatments for ambulatory care sensitive conditions.

Oregon Health Fund Board

Essential Benefits Package – early modeling

James Matthisen
The Mosier Group

Conceptual Framework

- Prioritized List PMPM costs
  - Aggregate and disaggregate lines
- Population synthesis
- Standard pricing for deductibles and out-of-pocket-max
- Benchmark costs – medical, dental, mental health

Source Data – Prioritized List

- PMPM – per member per month costs for all subpopulations estimated by Price Waterhouse Coopers for CY08/09
- Easy to aggregate
- Others helped disaggregate
  - Value based, 2 visits, comfort care, Rx, ambulance, ER, diagnostic
  - Special consideration for line 0

Population Assumptions

- OHPFAM and OHPAC blended to form relative cost by line item (8:1)
- TANF population used for dental cost proxy
- 1.3 cost increase applied to source data to adjust for commercial reimbursement

Standard Pricing – deductibles and coinsurance

- Used large group population continuance table, adjusted for costs of population and plan design specified
- With large coinsurance, OOP is strong cost driver

Benchmark Costs

- Developed rough comparisons based on average cost in group insurance
- Used these to help refine population blend and cost factors

Summary of Model

- First cut on the impacts of never before tried plan design
- Based on “artful” combination of existing data and methods
- Any implementation would require significant pricing based on fresh data analysis

TABLE OF CONTENTS

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE
Teleconference

June 11, 2008 Meeting Packet

SECTION 1 AGENDA

Oregon Health Fund Board
Benefits Committee Meeting

Wednesday, June 11, 2008
11:00 am – 11:30 am

General Services Building, 1st Floor
1225 Ferry Street SE – OHPR Conference Room
Salem, OR 97301

REVISED DRAFT AGENDA

Time (est)	Item	Lead	Action Items
11:00 am	Call to Order	Susan King	
3 min	Approval of Agenda and 5/27/08 Minutes	Susan King	X
11:03 am 20 min	Discussion of Suggested Changes to 6/4/08 Draft Recommendations With a Separate Vote on Whether to Accept or Reject Each Change After it is Discussed	Darren Coffman	X
11:23 am 3 min	Public Comment on Changes Discussed	Susan King	
11:26 am 2 min	Final Approval of Recommendations to Board	Susan King	X
11:28 am 2 min	Next Steps • 6/25/08 Presentation to the Oregon Health Fund Board	Susan King, Darren Coffman	
11:30 am	Adjourn	Susan King	

SECTION 2 MINUTES

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

May 27, 2008
11:00 am to 3:00 pm

CCC, Wilsonville Campus Training Center, Room 112
Wilsonville, Oregon

MEMBERS PRESENT:
Susan King, RN, Chair
Somnath Saha, MD, Vice Chair
Nina Stratton, Vice Chair (left at 1:00 pm)
Gary Allen, DMD
Betty Johnson
Bob Joondeph
Hugh Sowers, Jr.
Kathryn Weit
Kevin Wilson, ND
Jim Lussier (by phone)

MEMBERS ABSENT:
Lisa Dodson, MD
Tom Eversole
Leda Garside, RN
Susan Pozdena

OTHERS ATTENDING:
Denise Honzel, Oregon Business Association/Health Fund Board (OHFB) Exchange Workgroup
Kelly Harms, Office of Private Health Partnerships
Chenya Chin, Portland State University
Kristin Jordan, Portland State University
Mallen Kear, Archimedes Movement, Federal Laws Committee
Ellen Lowe, Chair, Eligibility and Enrollment Committee
David Pollack, OHSU
Laura Sisulak, Oregon Primary Care Association
Tina Kitchin, DHS
Dana Tierney, Regence
Bruce Bishop, Oregon Association of Hospitals & Health Systems
Jane-ellen Weidanz, Oregon Association of Hospitals & Health Systems
Doug Barber, ULUM
Phil Donovan, Oregon Association of Naturopathic Physicians/American Heart Association

STAFF PRESENT:
Darren Coffman, Health Services Commission Director
Ariel Smits, MD, MPH, Health Services Comm. Medical Director
Jeanene Smith, MD, MPH, Oregon Health Policy & Research (OHPR) Administrator
Nate HierImaier, Policy Analyst
Dorothy Allen, Administrative Staff

ISSUES HEARD:

- Call to Order/Approval of Agenda and 04/15/08 Meeting Minutes
- Goals of Meeting
- Report from Staff Review Panel on Cost Sharing
- Overview of Changes Reflected in 05/20/08 Draft Recommendations for an Essential Benefit Package
- Pricing the Essential Benefit Package

- Discussion of Cost Sharing Levels for the Essential Benefit Package/Those with Limited Financial Means
- Public Testimony
- Final Recommendations for the Oregon Health Fund Board on the Essential Benefit Package
- Next Steps: 06/25/08 Presentation to the Oregon Health Fund Board
- Adjourn

Chair King **I. Call to Order**

- The meeting was called to order. There was a quorum.

Chair King **II. Approval of Agenda and 04/15/08 Meeting Minutes**

- Suggestion to revise agenda to move presentation by James Matthisen to follow agenda item III, Goals of Meeting.

Motion to approve the revised agenda is seconded. **Motion passed unanimously.**

Motion to approve the minutes of 04/15/08 as written is seconded. **Motion passed unanimously.**

Chair King **III. Goals of Meeting**

- The Essential Benefits Package (EBP) with explanatory documents was distributed. Chair thanked the staff for their work. Benefits Committee recommendations are expected to be presented at the OHFB meeting on June 25.
- Jim Lussier related Barney Speight's (OHFB Director) presentation at the Oregon Economic Summit in Central Oregon.
- *Question: Are we comfortable that the recommendations being made are consistent with the other committees?*
  - Staff related how cost sharing levels being reviewed later are reflective of recommendations of the Eligibility and Enrollment Committee (E&E) and what is being modeled at the Finance Committee.
  - It will be the Board's job to make them fit together yet it is important to keep the work of the others committee's in mind.
- Delivery System Committee presentation to the Board summarized by Chair King, noting the emphasis on an integrated health home (IHH) and other issues. Related that specificity will be a problem for all of the committees.
  - Darren Coffman stated that this Committee has developed some needed specifics.

James Matthisen **IV. Pricing the Essential Benefit Package (See Exhibit Materials 3 & 4).**

James Matthisen began presentation stating he used the draft grid **shown in Exhibit 3, page 14 in developing the preliminary pricing of the Essential Benefit Package**.

- Areas of consideration included:
  - Population that would be in the Exchange.

        - Utilization data for OHP Standard used, with emphasis on "healthier" OHP Families eligibility group.
        - Early analysis indicates that the Exchange population would be similar to commercial insurance, perhaps more expensive.
    - Things not in data set, e.g., deductibles, out-of-pocket expenses, etc.
    - Benchmarked aggregate cost at $400 per member per month (PMPM) for a 40-44 year-old (without dental)
    - Data set from PricewaterhouseCoopers helped to get the relative costs by tiers and other special categories, e.g., value based services.
    - Discussed conceptual framework of how PMPMs for three tiers were aggregates of PMPMs for individual lines on Prioritized List. Related difficulties of disaggregating data by site of service, noting help from Darren and Ariel in establishing average cost sharing values by tier.
    - There would not be a life-time plan maximum.
    - Since prior meeting, Darren Coffman related a change to the plan due to a law prohibiting charging more than 50% coinsurance. Streamlined administration in Exchange.
- Discussion on the results of the pricing followed:
    - James Matthisen related that even with a 42% cost sharing rate being borne by members, the cost of the package is nearing $300 PMPM in 2008 dollars.
    - PMPM rates are Per Adult Member Per Month; age-rating would result in a PMPM of about half an average adult rate for a child and a little more than half for a 19-26 year-old.
    - Currently, administrative fee rates are based on a percentage of the medical claims. Suggestion to make statement that administrative fees should be separated from medical claims.
        - *Q: How did you come up with the 10% administrative figure?*
          A: Difficulty in obtaining administration fees data related. Lower administrative costs of operating through the Exchange stated by staff.
        - *Q: Did you manipulate the data for an instance starting in emergency care but rest of care would be in IHH?*
          A: No. Based on current system.
    - A lot of cost is driven by deductible and out-of-pocket maximum.
    - Medication costs are broken out separately.
- Driving down the costs with the new direction of focusing on preventive care will take time.
- Behavioral effects of coinsurance discussed, e.g., does not account for people stopping to seek care if their coinsurance is 50%.
- This includes a set of comprehensive dental services.

Chair King **V. Report from Staff Review Panel on Cost Sharing**

- Darren Coffman and Som Saha reported on the Staff Review Panel on Cost Sharing, noting that James Matthisen presented and it was attended by a cross-section of the different committees.
- Two main points from panel discussion included:
  1) More discussion of phase-in period is needed as assumptions/ recommendations are made in terms of a final form.
        - Situations where IHHs are not available (early start up period/rural areas).

        - Added language relating that when these sites/services are unavailable, there should not be a penalty and can be charged at the lower coinsurance levels
    2) Benefit Package is richer than what is offered commercially as it includes wide "gambit" of services, i.e., physical, mental, dental. Concerns expressed on cost of package as a result.
        - New category of discretionary services related.
- Related Eligibility and Enrollment Committee recommendation that the total personal cost share for services should not exceed 5% of household income for those receiving subsidies.
- Discretionary services: **(see Exhibit Materials 3, page 12)** bundling dental, vision and other care discussed, including capping these services.
    - Managed care term of medically necessary and discussion of discretionary care vs. non-discretionary may depend on severity of illness. It was suggested that the Health Services Commission (HSC) would be part of that decision making.
    - Staff noted that, due to time, this change related to discretionary care was not reflected in James Matthisen's model.
    - OHP plan limitations noted (e.g., physical therapy) and transparency of Prioritized List.
    - Preventive services would still be covered as value-based.
    - Ellen Lowe, Chair of the Eligibility and Enrollment Committee, urged the 5% limitation be maintained.
- Darren Coffman introduced spreadsheets with scenarios that attempted to reflect Eligibility & Enrollment Committee recommendations and modeling done for the Finance Committee.
- Variables, including payroll taxes, discussed with a note that 30% of those below 300% FPL are working.
- *Question to James Matthisen on what the average person spends during the course of a year if we were to limit total out-of-pocket costs expenses to 5% of gross income?*
    - Average percent of premium is 25% cost sharing. Did not have estimate of percentage of income.
- Treatment options and importance of practitioner's choice in deciding treatments discussed, including capping some services.
- The problem of affordability related with acknowledgement that there will be start-up costs.

Ariel Smits/ Darren Coffman

VI. Overview of Changes Reflected in 05/20/08 Draft Recommendations for an Essential Benefit Package

Darren Coffman and Ariel Smits overviewed changes reflecting results from the Staff Review Panel on Cost Sharing and comments from last meeting.

- Law prohibiting over 50% cost sharing.
- Lifetime maximum for benefits explained. Concern expressed that it could be viewed as discriminatory.
    - In response to a question on lifetime maximum staff responded that it would not single out conditions or treatments, but globally, look at cost and clinical effectiveness, noting that some tough decisions regarding exclusion may have to be made.

- Prioritized List does not take into account co-morbidity issues. Allowance for coverage of "below the line" services in specific situations could follow current OHP rules.
- Staff overviewed *Issues of Note* **(see Exhibit Materials 3, page 16)** including cost sharing for ER care, preventive care (well-person visits), difficulty with lifetime limits, and prescription drug cost sharing.
  - Levels of medication cost sharing explored with consideration that some drugs would not include any cost sharing if value-based.

Chair King **VII. Discussion of Recommendations for the Essential Benefit Package Other Than Cost Sharing**

- Concern for special needs required for a person to maintain function, i.e. wheelchairs, etc. and that all of those services are in Tier III with high cost sharing.
  - Suggestion for a category of ancillary services.
  - Caution against creating too many categories.
  - Agreement to call out in Items of Note section. It was noted that there are existing guidelines for wheelchairs.

David Pollack, MD, Psychiatrist, OHSU, member of HSC's Mental Health Care and Chemical Dependency Committee, related three suggestions:

- Suggestion to move smoking-related diseases under chronic disease management bullet in value-based services section and incorporate substance abuse/addiction disorders.
- Impact of psychological trauma leading to psychiatric and addiction problems as well as impacting how medical problems are manifested is addressed. Amendment to "Reduce overall health care costs" section **(Exhibit Materials 3, page 2, #4)**. Suggests dropping word "additionally" from the 2nd to last sentence of paragraph and add following statement: "Additionally, the significant impact, both acute and cumulative, that psychologically traumatic experiences have on a broad range of health and behavioral health considerations in terms of service utilization and cost should not be underestimated."
- IHH for some patients may be the behavioral health specialty provider clinic, hopefully with collocated primary care services. Suggested to add to **Page 6, 4e**.

Chair King **VIII. Discussion of Cost Sharing Levels for the Essential Benefit package/Those with Limited Financial Means**

- Staff presented spreadsheets with cost scenarios introduced previously.
- It was related that 6-9% of the average premium is payment for people who don't have insurance.
- The closer to poverty, the larger the percentage of your income is spent on health care.
- Cost shift of delayed treatment, the underinsured and its relation to uncompensated care stated.
- E & E Committee chose not to include assets in determining eligibility.
- Straw Plan A of the Finance Committee was used to price second scenario. Discussion on Finance Committee modeling.

Chair King **X. Public Testimony**

- Jane-ellen Weidanz, OAHHS, testified that biasing individuals on where to receive services puts a burden on "near-poor individuals." Gave examples. Need further research on appropriateness of ED use. Copayments impact accessing primary care/prescriptions but not inpatient services. 10% of uncompensated care comes from people underinsured and can't pay copay. Goal should be preventing cost shift. Testified that this plan does not alleviate cost shift, it will drive it up, and will penalize those who need inpatient services.
    - *Question: How would you call this out or what suggestion do you have for this?*
        - Educate individuals and give them decision-making tools. Need further level of definition of appropriate level of where care needs to take place, and not disincentivizing those that need to use it. Copayments should not be punitive when ER is used appropriately.
        - It was debated that it would raise costs and that it will be impossible to eliminate cost shift without an infusion of cash.
        - It was related that Oregon is about a billion dollars behind on per capita spending on behavioral health.
        - Research shows that some ED patients go there because their own physicians cannot see them timely.
        - Take global approach and put structures and principles in place to work with over a period of time, because it is an imperfect system. Caution against getting stymied by trying to create a perfect system.
        - The U.S. pays twice as much on health care than other industrialized countries making it hard to claim we don't have enough financial resources in system.
        - The need of the system to evolve over time stated.

Chair King **IX. Final Recommendations for the Oregon Health Fund Board on the Essential Benefit Package**

Motion to adopt recommendations in principal is seconded.

Chair and staff itemized changes discussed:

- From the HSC, Mental Health Care and Chemical Dependency Subcommittee:
    - Group smoking related and addiction under chronic disease management.
    - Call out trauma as a cause for other physical and emotional problems
    - Calling out with greater emphasis on integrating mental health services and primary care
- In *Issues of Note,* talk specifically about not penalizing individuals for receiving care in a setting that we may not see as a priority when they may have no choice.
- Include cost sharing for services in Prioritized List's dysfunction lines under *Issues of Note*.
- No copays for value-based medications.

- Adding provision of anesthesia for Pap smear and similar services when appropriate.
- Capping cost to state using reinsurance.
- A recommendation that administrative costs be changed to a dollar amount rather than a percentage.
- Question on whether the Committee wants to make statement on recommendation of 5% as set by the Eligibility and Enrollment Committee. Do not want cost sharing to become a barrier but do not include recommendation on specific levels of cost sharing for those with lower incomes.
- Include James Matthisen's modeling as a stand-alone piece (appendix) for reader to refer to.

Call for the question: **Motion passed unanimously.**

Ellen Lowe, Chair, Eligibility and Enrollment Committee, urged everyone to read that committee's recommendations on eligibility stating that it is "a different world with an individual mandate" and the need for "social marketing" to enlist all Oregonians as partners.

Chair related Australia's "Slip, Slap, Slop" campaign on the use of sunscreen.

Chair King **XI. Next Steps**

- Staff will circulate updated draft
- Another meeting or teleconference will be scheduled for perusal of updated draft and voting.
- Chair related that she will not be able to attend the June 25 OHFB Board meeting in person and urged other members to attend.

Chair King **XII. Adjourn**

The Chair adjourned the meeting at 1:15 p.m.

Submitted By:
Paula Hird

Reviewed By:
Darren Coffman

Next meeting is June 11, 2008.

Exhibit Materials:

1. **Agenda**
2. **Minutes 4/15/08**
3. **Essential Benefit Package (4/4/08 draft)**
4. **Pricing Model Overview**
5. **HSC Presentations:**
   a. **Presentation to HSC on Allergic Rhinits**
   b. **Presentation to HSC on Chronic Urticaria**
   c. **Presentation to HSC on Sinusitis**
   d. **Presentation to HSC on Asthma**
   e. **Allergy Network Letter of Support**
   f. **Cost-effectiveness of Allergists Presented to HSC**
   g. **Ariel Smits, MD, Summary on Allergy Visits and Treatment**

SECTION 3

RECOMMENDATIONS TO THE OREGON HEALTH FUND BOARD

Suggested Changes

Suggested Change 1

Original language, Cover page

Cost sharing would be "capped" by an out-of-pocket maximum.

Suggested language

Cost sharing would be "capped" by an out-of-pocket maximum <u>(also adjusted for financial means)</u>.

Suggested Change 2

Original language, Page 5

e. Enabling services such as translation services and care coordination should be incorporated into the administration component…

Suggested language

e. Enabling services such as <u>interpretative</u> services and care coordination should be incorporated into the administration component…

Suggested Change 3

Original language, Page 6

1. This should allow sustainability of the system and affordability to individuals and the state

Suggested language

1. This should <u>achieve</u> sustainability of the system and affordability to individuals and the state

Suggested Change 4

Original language, Page 7

d. The integrated health home may be a single provider group practice or clinic, or an integrated network of providers.

Suggested language

d. The integrated health home may be a single provider<u>,</u> group practice or clinic, or an integrated network of providers. <u>The specific structure of an integrated health home may look somewhat different in different communities around the state but should (eventually) meet some general guidelines.</u>

Suggested Changes

Suggested Change 5

Original language, Page 10

6. End-of-life care

- **Patients who have an advanced directive and/or POLST about their wishes for end-of-life care immediately available at the point of care could have a reduction in their copays for ED care and/or hospitalization.**

Suggested language

6. End-of-life care

- **Patients who have a <u>completed POLST form on file with a POLST registry (as recommended by the Delivery Systems Committee)</u> about their wishes for end-of-life care could have a reduction in their copays for ED care and/or hospitalization.**

Suggested Change 5

Original language, Page 13

In addition to coverage limits or other restrictions, it is expected that discretionary services would have cost sharing associated with them at the same level as other services in the Tier containing that service. For example, dental caries fall in Tier III and would have a 40% coinsurance for amalgam fillings *if done in the integrated health home.* The patient would have no coverage for composite fillings.

Suggested language

In addition to coverage limits or other restrictions, it is expected that discretionary services would have cost sharing associated with them at the same level as other services in the Tier containing that service. For example, dental caries fall in Tier III and would have a <u>45%</u> coinsurance for amalgam fillings. The patient would have no coverage for composite fillings.

Suggested Change 6

Original language, Page 15

For instance, not every Oregonian will immediately have access to an integrated health home *(and may never in some rural areas)* and cost sharing in higher intensity settings (e.g., an emergency department) should be reduced to integrated health home levels in such instances.

Suggested Changes

Suggested language

For instance, not every Oregonian will immediately have access to an integrated health home and cost sharing in higher intensity settings (e.g., an emergency department) should be reduced to integrated health home levels in such instances.

Suggested Change 7

Original language, Page 18

3. **No copayment for patients *with conditions requiring emergent care that does* not meet transport criteria *and does not require admission.***

Suggested language

3. **No copayment for patients that <u>do</u> not meet transport <u>or admission</u> criteria <u>but have conditions for which the ED is the most appropriate site of care.</u>**

Suggested Change 8

Original language, Page 36

enabling services Services such as translation and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

Suggested language

enabling services Services such as <u>interpretative services</u> and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

TYPOS:

Page 5: "dealth" changed to "death"

Page 28: "behavioral" changes to "behavior"

The Essential Benefit Package

Recommendations of the Oregon Health Fund Board's Benefits Committee

The Essential Benefit Package is an affordable, sustainable package of benefits which emphasizes evidence-based care provided in the integrated health home. It protects enrollees from profound financial losses due to medical expenses, and rewards patients who actively participate in their own care. Enrollees would have little or no cost sharing for outpatient visits for certain chronic diseases and evidence-based preventive services. Other disease conditions and services will be covered after the enrollee meets a relatively high deductible (adjusted for financial means), with cost sharing levels based on the Health Services Commission's Prioritized List of Health Services. Cost sharing would be "capped" by an out-of-pocket maximum. This package would provide the foundation that defines what is considered essential coverage; it is anticipated that richer plans with higher premiums would continue to be offered in the private market.

Table of Contents

I. Executive Summary

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state. The Benefits Committee developed the list of guiding principles shown in Appendix A to frame these recommendations.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health homes become the basis for cost-effective, patient-centered care
- Health care services are not segregated based on the part of the body they involve or the qualified health professionals who deliver them
  - Coverage for mental health and dental services should be based on the same criteria as other physical health conditions
- Coverage of services should be evidence-based to the highest degree possible
  - The Health Services Commission or other similar body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Coverage focuses on care which reduces the overall cost and complications of disease
  - Value-based services are an integral part of the package, representing evidence-based services that maintain or improve health, prevent illness and illness complications, and/or reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility should be rewarded
  - Value-based services should include incentives and rewards for patients who actively participate in their own health care

The EBP would be **affordable for individuals and the state**:

- Value-based services (including evidence-based preventive services) and basic diagnostic services should be available to all with no or low cost barriers
- Other types of care should be covered after the beneficiary meets a high deductible amount (adjusted for financial means). A limited number of discretionary services may have separate coverage maximums. These limitations in the plan will help result in a reduction in the cost of premiums.
- After the deductible is met, personal financial responsibility for services increases for conditions that appear lower on the Health Services Commission's Prioritized List of Health Services
- The introduction of an out-of-pocket maximum protects individuals and families from profound financial losses from catastrophic illness or injury

The EBP would serve as the **"foundation level" of health care coverage** below which no individual's coverage should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease-specific plans that do not serve the overall health of an individual or insured population
- Under this proposal, the current benefits offered to the categorically eligible Medicaid populations would not differ from the current OHP Plus benefit package with nominal copays.

II. Introduction

When creating a set of essential services, several goals must be met. The Essential Benefit Package (EBP) as described here would achieve the following:

1) Improve the overall health of the people of Oregon. This goal would be met through measures such as improved immunization rates to reduce vaccine transmissible disease, improved screening for diseases which are more cost-effective to treat at an early stage, reduced smoking rates, and improved population health markers (e.g., fewer low-birthweight babies).
2) Incentivize a rational redesign of the health care system. The EBP would improve access to and utilization of services in an integrated health home. It is anticipated that this redesign will revitalize primary care in the state. Services would not be segregated based on body part; mental health and dental conditions would be covered according to priority, need, and evidence, just like other physical health conditions.
3) Reward personal responsibility. Cost-sharing principles should be developed with rewards and incentives for individuals to actively participate in their own health care. To facilitate this, the health care system will need to have supports in place to assist individuals in this process.
4) Reduce overall health care costs. This goal would be met through incentivizing patients to receive timely diagnosis, management, prevention, and treatment in the most appropriate and cost-effective setting rather than care for later-stage illness requiring acute, hospital-based care or other intensive and costly services. Mechanisms should be put in place to encourage patients to seek care in their integrated health home rather than in the emergency department for common outpatient complaints. Certain diagnostic tests, procedures, medications, and treatments that exhibit high cost, high utilization, and/or high variability in usage should be subject to robust, efficient and swift prior authorization processes. Additionally, the EBP would minimize uncompensated care and cost-shifting in the system. Some services, particularly in the mental health and chemical dependency arena, may actually reduce costs of other social services (e.g., corrections, public safety).
5) Be innovative. The EBP includes value-based services, which are a selected group of evidence-based, cost-effective health care services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. The EBP would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.
6) Provide a social safety net. The EBP would protect individuals from devastating financial losses and bankruptcy due to catastrophic illness or injury.
7) Be affordable for the individual and the state. The lowest acceptable "foundation level" package should be priced low enough to be affordable to all Oregonians above 400% of FPL and be fiscally responsible for the state to contribute towards the health care coverage of Oregonians in or near poverty. To keep the cost of the plan low, cost containment measures such as limits on certain discretionary services as well as a reasonably high deductible will be included. It is anticipated that private insurers would

be innovative in creating plans which offer a richer benefit package with potentially higher premiums than the EBP.

8) Reflect the values of Oregonians. The EBP would provide services to special populations such as pregnant women, small children, seniors, and people with disabilities, as well as provide dignified end-of-life care, which have been values consistently expressed by Oregonians in public meetings on health care reform.
9) Be evidence-based. The EBP would require that the Health Services Commission (HSC) be enhanced, meet more often, and be given greater financial resources to allow for a thorough and timely surveillance of the evidence and provide regular guidance to the system. It is further recommended that the Health Resources Commission (HRC) work collaboratively with the HSC to allow in-depth reviews of technologies and treatments. It is also anticipated that the HSC and HRC would collaborate with other evidence-based bodies in the state, such as the Drug Effectiveness Review Project (DERP), the Oregon Evidence-Based Practice Center, and the Medical Evidence-Based Decisions (MED) Project.

The Essential Benefit Package responds to the goals above by having few financial barriers to evidence-based preventive care, access to diagnostic visits and basic tests, and graduated personal contributions for health care based on priorities set by the Oregon Health Services Commission in the Prioritized List of Health Services. In addition, the plan incorporates both low barriers and incentives for certain "value-based services." These services include cost-effective outpatient services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Plan members would be protected from profound financial loss by having a "cap" placed on out-of-pocket expenses.

The Essential Benefit Package is a "foundation level" plan. No insurance plan should be allowed to offer a lower level of benefits. However, private purchasers and governmental programs such as Medicaid could offer a plan that provides more benefits and/or less cost sharing than the EBP. Companies could elect to buy up to a richer plan for employees and individuals could buy up to a richer plan through higher premiums. However, the low barriers to value-based services (including evidence-based preventive services) would have to be maintained for a plan to qualify as meeting the minimum plan requirements. Additionally, such plans would have to provide the same services as the EBP with no greater cost sharing. It is anticipated the private market would create products which would help reduce premiums through competition and bulk purchasing as well as offer plans with additional, supplemental coverage. Purchase of these supplemental products would be at the discretion of the plan member, employer or other purchaser.

III. Basic Principles of the Essential Benefit Package

1) Services
    a. The Essential Benefit Package (EBP) being recommended by the Benefits Committee is based on the Health Services Commission's Prioritized List of Health Services
        i. Coverage of conditions should not be segregated based on the part of the body affected or the type of qualified health care provider delivering the service. Evidence and public values will drive coverage decisions.
            1. Dental and mental health conditions would be included as they appear on the Prioritized List
            2. Services such as physical and occupational therapy and complementary and alternative medicine services would be included as they appear on the Prioritized List, with guidelines as appropriate
        ii. Conditions and services appearing low on the Health Services Commission's Prioritized List of Health Services may not have any coverage
        iii. Nearly all conditions and services with state mandated coverage are currently included on the Prioritized List. See item #5 under Issues of Note on page 16.
        iv. The Prioritized List of Health Services only considers the relative importance of treatments for individual conditions. Those who have comorbid conditions may warrant special consideration in regards to coverage or cost sharing issues.
    b. "Value-based services" should have low if any cost sharing
        i. Value-based services should be identified using trusted, evidence-based sources
        ii. Value-based services should be developed by the Health Services Commission and be a dynamic list reflecting changing evidence and the values of Oregonians
        iii. Value-based services should include evidence-based preventive services
        iv. Value-based services should include outpatient services that reduce the overall cost of caring for common chronic diseases
        v. Value-based services should include patient incentives for those who actively participate in their own health care, which could result in reductions in patient cost sharing or may provide credits toward other health-promoting benefits
        vi. It is anticipated that most, if not all, value-based services will be delivered in the outpatient setting. A limited number of services, such as flu shots, may be delivered in the acute care setting.
        vii. Value-based services will include supports to assist the patient in assuming responsibility for their own health care
    c. Diagnostic tests and visits will have some coverage, but may be subject to limitations and have varying cost sharing associated with them
        i. Basic point-of-service tests, such as lab tests or EKGs, and a limited number of diagnostic visits should be covered with limited or no cost sharing
        ii. Certain diagnostic tests, procedures, medications, and treatments with high costs, high utilization, and/or high variability in usage should be subject to limitations and cost sharing to promote the most appropriate use of resources. This should be accomplished using the following hierarchy of approaches:

1. The use of evidence-based guidelines, where available, that are regularly reviewed and updated
2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those either of high cost that have effective, lower-cost alternatives or which do not have a major impact on the clinical management of the patient.

d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
e. Enabling services such as translation services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services,
    i. Selected care coordination services will likely be included as Value-Based Services
f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient or home-based care
g. Telephone nurse triage systems are strongly encouraged to allow appropriate direction to the most appropriate and cost-effective care settings for patients with urgent medical issues

2) Financial considerations
    a. Personal financial responsibility should increase as the service appears lower on the Prioritized List
    b. Premiums, deductibles and out-of-pocket (OOP) maximums should be scaled according to the individual/family's financial means
    c. A limit on OOP expenses should be included to prevent profound financial loss
        i. OOP maximums should be established for both individuals and families and should be adjusted for financial means
    d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan
        i. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive appropriate and cost-effective health care utilization decisions
    e. Certain "discretionary services" may have separate coverage maximums or other limitations
        i. A list of discretionary services should be developed by the Health Services Commission or other body designated by the Health Fund Board and be dynamic in its reflection of changing evidence and the values of Oregonians
        ii. The services placed in this list would fall into one or more of the following categories:
            1. Non-emergent services which do not substantially avert downstream medical costs or adverse consequences of a disease or condition, including death, worsening illness, hospitalization, or ED visits.

2. Services which can avert downstream costs or adverse consequences of a disease or condition, but which are used to treat a disease or condition for which there are more cost-effective alternative treatments or services available.

iii. Services on the discretionary list might be limited by one or more of the following:
1. An overall cap on reimbursable expenses for all discretionary services
2. Further limitations including some or all of the following:
a. Limitations on reimbursable expenses for a class of services, such as vision services or dental care
b. Limitations on the type of treatments/services covered
c. Guidelines around utilization of services

iv. Placing limits on discretionary services will allow more affordable premiums or otherwise reduce costs to the system
1. This should allow sustainability of the system and affordability to individuals and the state

f. There should be no overall lifetime maximum limits on benefits
i. To allow such benefit limits in the context of an individual mandate would be counter-intuitive.
ii. In order to keep this package affordable, this may mean that this "foundational level" of coverage may not include some very high cost treatments that show some evidence of a very marginal level of benefit.

g. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.

3) Medications
a. A drug formulary should be utilized
b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
c. A governing body should be responsible for formulary reviews and the administration of an appeals process
d. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
e. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
f. Some medications may be considered to be value-based services and may not be subject to cost sharing when use of these medications is shown to be highly cost-effective in terms of reducing complications, hospitalizations, ED utilization, etc.

4) Integrated health home
a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
b. Integrated health homes should include primary physical and mental health care, case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system
c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's

medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)

d. The integrated health home may be a single provider group practice or clinic, or an integrated network of providers
e. Ideally, mental health services would be available within the integrated health home. In addition, the preferred integrated health home for some patients with significant chronic behavioral health conditions may be the behavioral health specialty provider clinic, hopefully with direct access to collocated primary care services.
f. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee
g. The Benefits Committee recognizes that the integrated health home does not currently exist for the majority of Oregonians. The incentives for receiving services in an integrated health home may need to be implemented in a graduated fashion to allow the health care delivery system time to develop the necessary components for the integrated health home throughout the state. In the interim, consideration should be given to lowering the cost-sharing levels for a service that could otherwise be obtained in an integrated health home were one available.

5) The EBP is a "foundation level" package
   a. Government, private companies, and individuals could purchase or offer a more generous package. The private market would be able to and should develop supplemental plans
   b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
      i. No package should have barriers to preventive and value-based services higher than those specified in the EBP
      ii. Value-based services would need to be included as designed by the Health Services Commission or other body and offered with the same or lower cost-sharing as the EBP
      iii. Basic diagnostic services would need to be offered as outlined in the EBP with no higher cost sharing
      iv. Discretionary services should be identified by the Health Services Commission or other body with a dollar cap or other appropriate limitations placed on these services
      v. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and emergency department services.
   c. Equivalence between a commercially available plan and the Essential Benefit Package must be based on actual coverage equivalence and not on the equivalence of actuarial value of the plans (i.e., equivalence requires coverage of at least the services provided in the EBP with the same or lower levels of cost sharing).

IV. Value-Based Services

Value-based services are to be a selected group of cost-effective health care services based primarily in the integrated health home that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. By encouraging use of these primarily ambulatory services, overall health care costs should be reduced and population health improved. The Essential Benefit Package would incentivize these services through two mechanisms: 1) minimal cost sharing for these services and 2) financial incentives for following treatment recommendations.

Conditions Which May Have Value Based Services Associated With Them

Qualifying conditions and cost-effective services for these conditions should be determined by the Health Services Commission or other body designated by the Health Fund Board or Oregon Legislature. A list of value-based services whose use is intended to avoid preventable hospitalization and emergency department visits, through timely and appropriate care in an integrated health home, will be designed for conditions amenable to such services, as identified using sources such as the Agency for Healthcare Research and Quality (AHRQ) list of ambulatory care sensitive conditions. Examples of these conditions include diabetes, schizophrenia, asthma, congestive heart failure, and low birthweight. Other candidates for value-based services should come from the U.S. Preventive Services Taskforce recommendations for preventive care and screening services, and other evidence-based sources.

Once a list of conditions has been developed, then cost-effective services for these conditions would be determined. Next, evidenced-based guidelines would be created for the use of these services. Standards for compliance with these guidelines would be established according to condition and the incentive for meeting the acceptable compliance level would then be determined.

The lists of conditions and value-based services for these conditions would be continuously updated by the HSC or other oversight body based on changing evidence.

Value based services do NOT include all treatments for a condition. Conditions with possible value-based services, such as diabetes or asthma, are currently associated with a wide range of treatments on the Prioritized List of Health Services. These treatments range from inexpensive preventive care, such as outpatient visits, to expensive services aimed at treating disease complications, such as intensive care unit admissions and surgeries. A condition which is determined to have value-based services associated with it will remain on its designated Prioritized List line with all relevant **non**-value-based services prioritized according to the position of that line on the Prioritized List. Only certain cost-effective services will be on the Value-Based Services List. For example, treatments for diabetes such as outpatient primary care visits, periodic diabetic eye exams, and care coordination could be placed on the Value-Based Services List while treatments such as ICU admissions for ketoacidosis or leg amputation surgery would remain on their respective lines within the Prioritized List. Both Type 1 and Type 2 diabetes are currently listed as Tier I conditions.

It is anticipated that most, if not all, value based services will be delivered in the outpatient setting. However, certain services may be delivered in the acute care setting. Such services may include flu shots during ED visits or day surgery center visits for colonoscopies.

Potential Value-Based Service Examples

The examples are provided for illustrative purposes only and may or may not ultimately be included in a list of value-based services.

1) Preventive care
    - Preventive services, such as immunizations, Pap smears, mammograms and colorectal cancer screening, should have minimal or no cost sharing. Plan members who are up-to-date on current screening recommendations could have points awarded that he or she could use to reduce the cost sharing for medication or other covered services, or could use them for wellness activities (e.g., assistance in purchasing a gym membership).
2) Chronic disease management
    - A patient with a chronic disease could have minimal cost sharing for outpatient provider visits, selected medications, self-treatment education, care coordination, and other cost-effective treatments for that condition. A patient who sees his or her doctor at recommended intervals, fills his or her prescriptions as prescribed, and actively participates in other aspects of his or her care could have a reduction in the cost sharing for emergency department visits and hospitalizations for complications of his or her chronic condition.
    - A patient with a chronic disease that is caused by or exacerbated by smoking or the use of alcohol or illicit drugs could have a reduction in cost sharing for outpatient office visits and medications related to that condition if he or she quits smoking, drinking and/or using drugs. Patients who continue to use these substances could pay more for treatments and medications for the substance-related condition.
3) Maternity care
    - Pregnant women could have no cost sharing for prenatal care. A patient who adheres to the recommended timing and number of prenatal visits and otherwise completes the recommended portions of her prenatal care could have no cost share towards the delivery of her child.
4) Dental services
    - Preventive dental exams and cleanings, and fillings for dental caries could have minimal cost sharing. Plan members who receive regular cleanings could have points awarded that could be used to reduce the cost sharing for restorative dental or other covered services.
5) Vision services
    - Regular vision exams for age groups where such exams are recommended by the U.S. Preventive Services Task Force could have minimal cost sharing at a defined interval, such as every two years. Plan members who receive regular exams could have points awarded that could be used to reduce the cost sharing for other covered vision services or corrective lenses.

6) End-of-life care
    - Patients who have an advanced directive and/or POLST about their wishes for end-of-life care immediately available at the point of care could have a reduction in their copays for ED care and/or hospitalization.

V. Services Included in Each Tier

The services included in each tier are based on the HSC Prioritized List of Health Services. Tier I generally contains preventive services as well as severe chronic diseases and acute life-threatening conditions with very effective treatments. Tier II generally contains common chronic diseases with less impact on overall heath and other diseases/conditions which can be life-threatening that have effective treatments. Tier III generally contains non-life threatening trauma, conditions with less effective treatments, and non-life threatening acute and chronic health problems. Tier IV contains self-limited conditions, conditions with no effective treatments, and conditions with limited effects on overall health. Because Tiers I and II both contain serious and life-threatening health conditions, the recommended cost-sharing difference between these two tiers is smaller than between Tier II and Tier III (which generally contain less serious conditions).

The line ordering is subject to review and revision by the Health Services Commission. It is anticipated that the HSC will likely reprioritize some lines once the value-based services are removed from that line, based on the remaining contents. It is further anticipated that the HSC may reorder some lines and/or change the location of tier breaks based on evidence and/or public feedback.

Tier I (Lines 1-113): Examples of Services and Conditions in this Tier (Note: the services associated with each of these lines would exclude those identified as value-based services)

- Preventive services
- Pregnancy and delivery
- Alcohol and drug treatment
- Life-threatening newborn conditions (e.g., very low birthweight or serious birth trauma)
- Life-threatening chronic diseases (e.g., treatments for asthma, diabetes, congestive heart failure, and HIV disease)
- Life-threatening mental health disorders (e.g., major depression, bipolar disorder, schizophrenia)
- Imminently life-threatening trauma (e.g., internal injuries, severe head injuries, major wounds)
- Imminently life-threatening acute illness (e.g., meningitis, appendicitis, intestinal obstruction, heart attack)
- Conditions of public health concern (e.g., tuberculosis, sexually transmitted diseases)

Tier II (Lines 114-311): Examples of Services and Conditions in this Tier

- Potentially life-threatening trauma (e.g., neck and limb fractures, limb amputations, joint dislocation)
- Cancers with effective treatments (e.g., cervical, kidney and bone cancers)
- Chronic disease with less impact on health or less effective treatment (e.g., attention deficit hyperactivity disorder (ADHD), peripheral vascular disease, mild depression, chronic hepatitis, dementia)
- Potentially-life threatening acute illness (e.g., pancreatitis, pneumonia, urinary tract infection (UTI))

Tier III (Lines 312-503): Examples of Services and Conditions in this Tier

- Non-life-threatening trauma (e.g., severe sprains and strains)
- Non-life-threatening mental health disorders (e.g., acute stress disorder, dysthmia)
- Non-life-threatening acute and chronic disease (e.g., gout, migraines, kidney stones, miscarriage, tooth loss)
- Cancers with less effective treatments (e.g., pancreatic, esophageal and liver cancers)
- Non-life-threatening infections (e.g., sinusitis, otitis media, acute bronchitis)

Tier IV (Lines 504-680): Examples of Services and Conditions in this Tier

- Conditions with no effective treatment or no treatment necessary (e.g., rib fractures, benign cysts and growths, non-venereal warts)
- Self-limited conditions (e.g., colds, minor burns, cold sores)
- Conditions with limited effects on health (e.g., seasonal allergies, acne, diaper rash)

Excluded conditions

- Cosmetic surgery
- Infertility services
- Services shown to result in harm
- Experimental treatments

VI. Discretionary Services

Discretionary services are those non-emergent health care services which do not substantially avert downstream costs or adverse consequences of a disease or condition, including death, worsening illness, hospitalization, or ED utilization. Alternatively, discretionary services are those services which may substantially avert downstream costs or consequences of a disease or condition, but which are used to treat a disease or condition for which there are lower cost or more efficacious treatments available.

Discretionary services may have limits placed on them in the Essential Benefits Package. First, the entire category of discretionary services is expected to be subject to a cap on reimbursable expenses. Second, particular services within this group may be further limited. These limits may take the form of an additional cap on reimbursable expenses for a certain class or type of services, limitations on the type of treatments/services covered, or guidelines for utilization of services or some combination of these limits. Such limitations will help ensure that premium costs are affordable to Oregonians and the state.

Like value-based services, a list of discretionary services would be developed by the Health Services Commission or other body designated by the Health Fund Board, using evidence-based sources. This list would be updated to reflect changing evidence and the values of Oregonians.

Possible examples of Discretionary Services

- Dental care - Restorative dental services may have coverage maximums imposed upon them, such as a maximum dollar amount covered per year. Additionally, amalgam fillings may be covered rather than the more expensive composite fillings due to having a lower cost for the same level of efficacy.

- Vision services - eyeglasses, and other vision care supplies may be limited. For example, glasses may have price limitations, allowing only coverage of a basic, non-designer pair which works equally well as a more expensive designer frame.

- Dermatologic conditions - Specialty visits, number of visits, or types of medications for conditions such as acne and mild to moderate psoriasis may be limited or subject to guidelines.

In addition to coverage limits or other restrictions, it is expected that discretionary services would have cost sharing associated with them at the same level as other services in the Tier containing that service. For example, dental caries fall in Tier III and would have a 40% coinsurance for amalgam fillings if done in the integrated health home. The patient would have no coverage for composite fillings.

VII. Organizational Considerations

- It is recommended that the Health Services Commission (HSC) should provide governance over the Essential Benefit Package (EBP) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of prioritizing and developing guidelines for health care services for Oregonians.
  - The HSC should adjust the Prioritized List, tier break points, and other parts of the EBP based on changing evidence and public values
  - The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
  - The HSC should create and update the list of value-based services using available evidence

- To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support would need to be provided
  - Consideration should be given to having part- or full-time paid members
  - The HSC or its subcommittees may need to meet more often, perhaps bi-weekly rather than bi-monthly
  - The HSC would need adequate research and support staff

- To effectively leverage state funds and scarce human resources, the HSC would need to collaborate with other evidence-based bodies in the state
  - Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
  - Oregon Evidence-Based Practice Center for assistance with evidence reviews
  - Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation

- The Health Resources Commission (HRC) and the HSC would need to work in close collaboration in order to complete reports for use in determining evidence-based benefits and value-based services

- An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body. This would involve the determination of placement of services within the tiers of the Prioritized List and the inclusion of services within the list of value-based services and basic diagnostic services. A separate appeals process would be necessary in order to hear the merits of individual cases. Such an individual appeals process would need to be streamlined and easy to access.

VIII. The Essential Benefit Package

Figure 1 shows the Essential Benefit Package (EBP) as recommended by the Benefits Committee in a summary format. The EBP is the minimum ("foundational") level of coverage and while commercial health insurance should not be allowed to include higher cost sharing levels on services than those in the EBP, it is expected that many individuals and families will choose to "buy-up" to a richer level of coverage that includes a lower deductible, lower out-of-pocket maximum and/or lower coinsurance amounts.

The Benefits Committee believes that the cost sharing levels depicted here are reasonable for individuals with incomes above 300% FPL. The Committee recognizes that the Oregon Health Fund Board will have to weigh many factors, including the structure of the proposed Exchange, the amount of additional revenues that can feasibly be raised, and the impacts from a restructured delivery system, to name a few, and that these cost sharing levels may need to be adjusted to some extent. However, the Committee does feel strongly that the general cost sharing structure be maintained as described in Section III.5.b. Namely that minimal or no cost sharing be in place for value-based services, discretionary services have a separate benefit limit, and that cost sharing be incrementally higher for lower priority services according to the Prioritized List of Health Services and according to the intensity of the resources used at the site at which their services are accessed. The Benefits Committee recognizes that it will take some time before a comprehensive health care reform plan can be implemented and that certain allowances may be necessary, particularly in the early stages of the process. For instance, not every Oregonian will immediately have access to an integrated health home (and may never in some rural areas) and cost sharing in higher intensity settings (e.g., an emergency department) should be reduced to integrated health home levels in such instances. For a broader discussion of this and other issues of note that the committee identified, including alternative solutions that were considered, please see Section IX of this report.

The Committee also feels that the cost sharing levels should be reduced in a graduated fashion as income levels decrease with nominal, if any, cost sharing for those below the federal poverty level. A preliminary pricing estimate of the Essential Benefit Package shown in Figure 1 appears in Appendix B, along with estimates for similarly structured benefit packages at varying levels of cost sharing as examples.

Figure 1. Summary of the Essential Benefit Package

Category of Care[1]	Cost Sharing[2]			Deductible/OOP Max[3]
	Integrated Health Home	Specialist, Procedures, Other Outpatient[4]	Inpatient	
Value-Based Services	0 – 5% depending on service provided and location of care			•Deductible waived •$4,000-$15,000 OOP max applies per individual (income-based, family = 3 times individual), includes deductible
2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics	0%	5%	Not applicable	
Comfort Care	0%	5%	20%	
Tier I (Lines 1-113)	20%	25%	30%	•$1,000-$7,500 deductible applies per individual (income-based, family=3x) •OOP max applies
Tier II (Lines 114-311)	30%	35%	40%	
Tier III (Lines 312-503)	40%	45%	50%	
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Excluded Conditions	No coverage	No coverage	No coverage	
Discretionary Services	40%	45%	50%	•Deductible applies •OOP max does not apply •$2,000/yr limit
Ambulance	$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			
Prescription Medications	•$5 copay for generics, $25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)[5] •Evidence-based formulary will be used[6] •No coverage for medications for non-covered conditions			•Deductible waived •OOP max applies
Emergency Department	$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
Diagnostic Services	•Beyond 2 diagnostic visits, well-person visits and basic office diagnostics above •Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%) •Limitations according to evidence-based guidelines, location of service, etc. •Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization			
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			

Notes

[1]Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. The placement of tier break-points could change based on further review by the Commission, future changes to the Prioritized List, and/or public comment.

[2]Cost sharing amounts are based on income level – those below 100% of the Federal Poverty Level would have, at most, nominal copays at point-of-service. Amounts shown here are examples and can be adjusted until actuarial pricing is acceptable.

[3]Deductible amounts and out-of-pocket maximums are based on income level – those below 100% of the Federal Poverty Level would have no deductibles. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

[4]Some specialist services and procedures may be provided within the integrated health home for certain individuals.

[5]The cost share is reduced to 50% coinsurance for generic prescriptions and preferred drugs if this is less than the copay level and increased to a $50 copay for non-preferred brand drugs if this is more than the 50% coinsurance amount. All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

[6]An evidence-based formulary should be utilized and based on sources such as the Drug Effectiveness Review Project (DERP).

IX. Issues of Note

Several issues arose in the creation of the Essential Benefits Package for which it was difficult to determine the best solution. These areas have either competing demands or other issues. The solutions proposed in the Essential Benefit Package are only some of several viable solutions for each of these areas. It is anticipated that the Health Fund Board or other body will deliberate further on these areas, with public input to determine the solutions which best meet the needs and values of Oregonians.

1) **Emergency department copayment/coinsurance**
    a. Goal: incentivize use of the integrated health home whenever feasible, yet not disincentivize use of the ED for those conditions which are truly emergent
        i. Example: a cold should be seen in the integrated health home, while a broken leg is most appropriately seen in the ED
    b. Conflict: how to disincentivize inappropriate ED use while not placing undue barriers to appropriate ED use
    c. Other issue: some patients are not given a diagnosis after being evaluated in the ED ; these patients would not have a readily determinable coinsurance level based on the current tier system
    d. The Committee acknowledges that the individual may not have choices in alternatives to the emergency department in the current system but hope that the development of integrated health homes will provide such a choice.
    e. Solutions
        i. Selected: relatively high copayment which is waived for patients meeting EMS transport criteria (likely emergent conditions) plus a coinsurance level commensurate with mid-level Tier for hospitalization.
            1. Some modification of the ED cost sharing may need to be developed or the ED cost sharing phased in over time.until integrated health homes are in place to provide alternatives to the emergency department.
        ii. Other options:
            1. A more robust triage system with a triage fee; patients who are determined by triage to have non-emergent conditions would be referred to their integrated health home while those with emergent conditions would have a coinsurance level charged for the ED visit commensurate with the integrated health home level for that condition
            2. A flat copayment high enough to discourage casual ED use
            3. No copayment for patients with conditions requiring emergent care that does not meet transport criteria and does not require admission.

2) **Well-person visit**
    a. Goal: incentivize evidence-based preventive care while not encouraging unneeded care

b. Conflict: most current plans allow a well-person visit once a year, but much of the screening and services provided are not evidence-based solutions
    i. Selected: cover well-person visits that evidence indicates are effective (i.e., one every 2-3 years for children over 5, etc.)
    ii. Other options:
        1. Cover the office visit costs for one well-person visit a year, but not cover those screenings or other services provided that are not evidence-based
        2. Allow one well-person visit a year, but this would have to take the place of one of the two diagnostic office visits covered for that year

3) Lifetime maximum

a. Goal: allow coverage of conditions and treatments for patients beyond an arbitrary lifetime maximum amount of services, but maintain financial solvency for the system as a whole
b. Conflicts
    i. Some expensive services and treatments do not have much efficacy and may need to be limited due to overall costs to the system
    ii. Most private insurance plans have lifetime maximums. Patients with very expensive medications or treatments may reach these maximums quickly and either elect to change to the Essential Benefit Plan, causing "crowd out," or will end up in the Essential Benefit Plan due to reaching these maximums. Without cost controls, the increasing numbers of such patients would become a significant financial burden on the system
c. Example
    i. A medication for a rare genetic condition costs $500,000 a year and must be given for life, with little improvement in overall health. If no lifetime maximum exists, then a patient with that rare condition would consume a very large amount of health care resources
d. Solutions
    i. Adopted: no lifetime maximum overall, but certain treatments, medications, and other services may have financial maximums placed on them
        1. Example: a patient with the rare condition above would have a $1 million medication limit for that particular medication, but would still have coverage for hospitalization and antibiotics for other conditions they may develop such as pneumonia
    ii. Other solutions include no lifetime maximum for any condition or treatment, maximums placed on certain conditions, or price controls placed at the level of not covering certain expensive treatments/medications

4) Prescription medication cost sharing

a. Goal: incentivize generic medication use when possible and desirable, otherwise incentivizing preferred brand name drug use while disincentivizing use of non-preferred drugs
b. Issue:
    i. Financial barriers to brand name and non-preferred drugs need to be high enough to affect utilization but not be higher than actual drug costs
    ii. Some medications should have no cost sharing associated with them
        1. Regular use of these medications have been associated with lower complication rates and thus lower health care costs
c. Solutions
    i. Adopted:
        1. Combination of graduated copays and significant coinsurance. For generic and preferred brand drugs, the amount paid would be the smaller of these two cost sharing levels while non-preferred brand drugs would require payment of the larger of the two out-of-pocket costs.
        2. Consideration of addition of certain highly effective medications to the value based-services list with no cost sharing associated with them
    ii. Other solutions:
        1. Simple copay
        2. Simple coinsurance
        3. Other levels of cost sharing

5) Mandated services

a. Goal: meet all state mandates on coverage of services
b. Issue:The Prioritized List of Health Services appears to not cover mandated benefits in at least specific instances:
    i. Some forms of surgery to the contralateral breast performed post-mastectomy to achieve symmetry after breast reconstruction
    ii. Maxillofacial prosthetics for unilateral anomalies of the ear that impact hearing or bilateral anomalies of the ear that do not impact hearing
    iii. Orthotics for some low ranking conditions of the feet and lower limbs (e.g., flat feet). This may or may not reflect a mandated service as medical necessity must be shown.
c. Solution
    i. Adopted: Acknowledge these omissions and bring them to the attention of the Health Services Commission for discussion
    ii. Other solutions: dictate that state mandated benefits will be a part of the Essential Benefit Package regardless of cost or benefit.

6) Ancillary services

a. Goal: have some cost containment strategies in place for ancillary services and durable medical supplies to maintain solvency in the system

b. Issues:
    i. Ancillary services and durable medical supplies, such as wheelchairs, may be of variable importance to a patient depending on his or her other medical conditions.
    ii. Some types of ancillary services may need to be limited to the most cost-effective type available
        1. Example: traditional wheelchair may be covered but power wheelchair may not have coverage for use for a particular condition
    iii. Some services which are considered ancillary for most situations may be vital for someone in special circumstances
        1. Example: a person with developmental delay may require conscious sedation for a Pap smear
c. Solutions
    i. Adopted:
        1. Cost sharing commensurate with the Tier of the condition for which the ancillary service is required
            a. Certain ancillary services may be considered value-based services and therefore subject to minimal or no copays instead.
        2. Total cost to the patient would be limited by the out-of-pocket maximum
        3. An appeals process would be created to allow approval of any coverage, lower cost sharing, or other coverage modifications for ancillary services in special circumstances. It would be anticipated that such an appeals process would be streamlined (for example, a person requiring sedation for procedures would have sedation approved for all procedures if appropriate after a request is placed for one particular procedure).

X. Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon health care marketplace.

Under the EBP as proposed, to be a qualifying plan:

1) The plan would have to provide all services provided under the EBP at no higher level of cost sharing
    a. Comfort care should have no or minimal coinsurance, at levels no higher than prescribed in the EBP
    b. Value-based services would have to be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
    c. Basic diagnostic services would have to be offered as outlined in the EBP with no higher cost sharing
    d. Additional coverage would have to include at least those condition-treatment pairings included in the 2008-09 Prioritized List through Tier III (currently up to an including line 503) with the same or lower cost sharing.
        i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be set at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ED services.
2) Additional conditions and services could be covered
3) A plan would not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package should be required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than value-based services, basic diagnostic services, and comfort care) with a 20% coinsurance, which is the lowest cost sharing amount permitted under the Essential Benefit Package "Tiers." Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in Figure 2. Note that these are simply example plans; numerous other variations would and could be expected.

Figure 2. Examples of the Essential Benefit Package with Supplemental Plans

	Essential Benefit Package*			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	$7,500 individual $11,250 individual + 1 $15,000 family			$2,500 individual $5,000 individual + 1 $7,500 family			$500 individual $1,000 individual + 1 $1,500 family		
Out-of-Pocket Maximum (includes deductible)	$15,000 individual $22,500 individual + 1 $30,000 family			$7,500 individual $15,000 individual + 1 $22,500 family			$4,000 individual $8,000 individual + 1 $12,000 family		
Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income									
Coinsurance Level (Deductible Does Not Apply)									
	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient
Value-Based Services	0-5% depending on service and site			0-5% depending on service and site			0-5% depending on service and site		
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Coinsurance Level (Deductible Applies)									
Tier I (lines 1-113)	20%	25%	30%	10%	15%	20%	5%	10%	15%
Tier II (lines 114-311)	30%	35%	40%	20%	25%	30%	10%	15%	20%
Tier III (lines 312-503)	40%	45%	50%	30%	35%	40%	20%	25%	30%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	50%	No coverage	No coverage	40%	45%	50%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Discretionary Services	40%	45%	50%	30%	35%	40%	20%	25%	30%
Prescription Medications	Generic $5, Preferred Brand $25, Other Brand 50% coinsurance			Generic $5, preferred brand $20, other brand 40% coinsurance			Generic $5, preferred brand $15, other brand 20% coinsurance		
Ambulance	$100 copay, waived if criteria met			$75, waived if criteria met			$50, waived if criteria met		
Emergency Department	$100 copay (waived if admitted or transport criteria met), then 50% coinsurance			$75 copay (waived if admitted or transport criteria met), then 40% coinsurance			$50 copay (waived if admitted or transport criteria met), then 20% coinsurance		
Other Diagnostic Services	Varies			Varies			Varies		

*Please see description of Essential Benefit Package on pages 13-14 for more detail

XI. Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a scheduled preventive dental exam and cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ED via LifeFlight and spends several days in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a $2,500 deductible, then 30% of her bills until she reaches an out-of-pocket maximum of $7,500 (her deductible and out-of-pocket maximum were reduced due to her income level). In fact, her total bills reached $150,000 and so her effective cost sharing rate was $7,500/$150,000 = 5%.

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. As a value-based service, she may only have a 5% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Joneses are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bacterial pneumonia. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a $5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting lung infections in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and 30% for the surgeries after meeting their $15,000 deductible. However, once the family meets its $30,000 out-of-pocket maximum, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year. With this plan, Jenny's doctor visits are covered with a 5% coinsurance, while her surgeries and hospitalizations are covered with a 10% and 15% coinsurance, respectively. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 15% coinsurance instead of the 30% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 95% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are $5 a prescription, but his preferred brand cholesterol medication is $20. Mary is able to get her colon cancer screening test with no cost sharing as it is in the value-based services portion of their plan.

Bob starts to feel chest pain and goes to the ED where he is diagnosed with a heart attack and admitted to the hospital. The heart attack requires a $75 copay and 40% coinsurance for the ED visit and 20% coinsurance for hospital inpatient care after Bob meets their $5,000 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his hospital cost sharing to the outpatient level (15%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Mary visits the ED, resulting in a $75 copay, and 40% coinsurance after the $5,000 family deductible is met. She does not qualify for a reduction in cost sharing and must pay the full 40% unless that amount takes them above their $15,000 out-of-pocket maximum.

The next year, the Swerskis again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ED care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a homemaker. They have one daughter. The family is concerned about paying high cost sharing for unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non-value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% coinsurance for this hospitalization, after meeting the $1,500 family deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered services with a 5% coinsurance under his diagnostic benefit. His broken ankle is in Tier II, making the casting and subsequent orthopedic surgeon office visit covered with a 15% coinsurance.

While convalescing from his fracture, Fred realizes that he needs reading glasses. Because glasses are on the Discretionary List, Fred needs to pay extra for the designer frames that he picks out and the $200 eyeglass maximum contribution from the Plan is applied to his $2000 discretionary maximum.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% coinsurance after reaching the $1,500 family deductible and purchases her generic medications with a $5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians?
- ☐ b. based upon a proven benefit model?
- ☐ c. reflective of the values of Oregonians?
- ☐ d. easy to adjust in response to new information on cost and effectiveness?
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable?
- ☐ f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care
- ☐ b. Chronic disease management
- ☐ c. Primary care medical homes
- ☐ d. Dignified end-of-life care
- ☐ e. Patient-centered care
- ☐ f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- ☐ a. wellness?
- ☐ b. patient engagement (including education towards self-management)?
- ☐ c. coordination and integration of care?
- ☐ d. population health?
- ☐ e. cost-effective care?
- ☐ f. cost-control/reductions in over-utilization?
- ☐ g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine
- ☐ b. Efficacy of treatments
- ☐ c. Reduction of health disparities
- ☐ d. Personal responsibility
- ☐ e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services
- ☐ g. Acute and tertiary care needs of the population

Appendix B: Estimated Pricing of the Essential Benefit Package and Projected State Contribution Levels Under Example Scenarios

The Oregon Health Fund Board contracted with James Matthisen of The Mosier Group to conduct a preliminary actuarial pricing of the Essential Benefits Package (EBP) developed by the Benefits Committee. The timelines for this project did not allow for the use of robust actuarial methods. Once efforts move forward on the implementation of this or a similar benefit package, a much more intensive analysis using a claims-based approach should be undertaken. Assumptions used in this preliminary pricing include:

- EBP offered within an Exchange under an individual mandate
- Provider reimbursement rates near current commercial levels
- Changes in behavioral resulting from cost sharing not included in the model
- Potential cost savings due to increased utilization of preventive services, chronic disease management and timely care in an integrated health home are not taken into account
- Savings due to an overall benefit cap and other potential limitations on discretionary services not included (this was incorporated too late in the recommendations to include in the pricing model)

The per-member per-month estimate of $246.80 shown in Figure B.1 represents the estimated cost of the EBP (shown in Figure 1 on page 16) for a 40-44 year-old adult in 2008 dollars using these and other necessary assumptions.

The Benefits Committee was also presented with examples of what cost sharing might look like if it were graduated downward at lower income levels, with no cost sharing assumed for individuals with household incomes under 100% FPL. The first example shown in Figure B.2 has out-of-pocket maximums limited to 5% of gross income. The graduation of the individual contributions toward premium are in the fashion recommended by the Eligibility & Enrollment Committee, however it is was that committee's intent that all cost sharing (including deductibles/coinsurance) should be limited to these levels, not just the premium share. This spreadsheet shows that the average contribution of the state towards premium for those with family incomes between 100% and 300% FPL would be $389 per-person per-month (PMPM) in 2008 dollars, assuming all parents under 200% FPL would not have an individual contribution towards the premium. The percentages towards the bottom of the page show the percentage of gross income represented by the individual contribution toward premium, deductible and out-of-pocket maximum for different family sizes. The same information was presented using cost sharing patterned after a scenario referred to as 'Straw Plan A' modeled for the Finance Committee (see Figure B.2). In this example the state's average contribution towards the premium for those between 100-300% FPL would be $320 PMPM. The Benefits Committee was dismayed to learn that even these high levels of cost sharing did not result in the $300 PMPM state contribution most recently assumed in the modeling done for the Finance Committee.

Figure B.1
Oregon Health Fund Board Benefits Committee
Preliminary Pricing and Plan Design Impact Analysis

Category of Care	PMPM Costs	Avg Cost Sharing	Net PMPM
Value-Based Services	29.46	**1%**	29.16
Basic Diagnostic Services (2 visits, basic office diagnostics)	11.77	**1%**	11.65
Comfort Care	3.24	**5%**	3.08
Tier I (Lines 1-113)	75.22	**23%**	58.30
Tier II (Lines 114-311)	81.49	**38%**	50.93
Tier III (Lines 312-503)	43.25	**45%**	23.79
Ambulance	6.72	3%	6.50
Emergency Room	21.85	55%	9.83
Medications	69.02	18%	56.77
Diagnostic Services	94.55	**20%**	75.64
Total/Avg	436.57	25%	325.66
Deductible		**$7,500**	($123.04)
OOP Max		**$15,000**	21.75
Total Cost without Admin	436.57	49%	224.36
Admin Load	**10%**		22.44
Total Cost PMPM			246.80

Figure B.2
Oregon Health Fund Board Benefits Committee
Projected State Contribution Levels With Out-of-Pocket Maximum Limited to 5% of Gross Income For An Individual

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-399%	400+%
Median Monthly Income	$975	$1,192	$1,408	$1,625	$1,842	$2,058	$2,275	$2,492	$3,033	$ 3,467+
Deductible	$250	$250	$400	$400	$500	$500	$700	$700	$2,500	$5,000
Out-of-Pocket Max	$500	$500	$800	$800	$1,000	$1,000	$1,400	$1,400	$5,000	$10,000
Individual Monthly Contribution	$0	$0	$28	$33	$55	$62	$114	$125	$332	$278
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?
State Contribution	$450	$450	$407	$403	$372	$365	$299	$288	Tax break	None
Total Monthly Premium	$450	$450	$436	$436	$427	$427	$412	$412	$332	$278
Percent of Premium from State Contribution	100%	100%	94%	93%	87%	86%	72%	70%		
Avg State Contribution for 100-300% FPL	$385		***Avg State Contribution with No Premium Share for Parents < 200% FPL***				$389			

		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes	**Individual**	**$867**	**$1,083**	**$1,300**	**$1,517**	**$1,733**	**$1,950**	**$2,167**	**$2,383**	**$2,600**	**$3,033**	**$3,467**
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	*12.8%*	*11.0%*	9.6%
	Deductible	2.4%	1.9%	2.6%	2.2%	2.4%	2.1%	2.7%	2.4%	8.0%	6.9%	6.0%
	OOP max	4.8%	3.8%	5.1%	4.4%	4.8%	4.3%	5.4%	4.9%	16.0%	13.7%	12.0%
	Individual+1	**$1,167**	**$1,458**	**$1,750**	**$2,042**	**$2,333**	**$2,625**	**$2,917**	**$3,208**	**$3,500**	**$4,083**	**$4,667**
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	*19.0%*	*16.3%*	11.9%
	Ded	3.6%	2.9%	3.8%	3.3%	3.6%	3.2%	4.0%	3.6%	11.9%	10.2%	17.9%
	OOP max	7.1%	5.7%	7.6%	6.5%	7.1%	6.3%	8.0%	7.3%	23.8%	20.4%	35.7%
	Family of 3	**$1,467**	**$1,833**	**$2,200**	**$2,567**	**$2,933**	**$3,300**	**$3,667**	**$4,033**	**$4,400**	**$5,133**	**$5,867**
	Premium	0.0%	0.0%	3.8%	3.8%	5.7%	5.6%	9.3%	9.3%	*22.7%*	*19.4%*	14.2%
	Ded	4.3%	3.4%	4.5%	3.9%	4.3%	3.8%	4.8%	4.3%	14.2%	12.2%	21.3%
	OOP max	8.5%	6.8%	9.1%	7.8%	8.5%	7.6%	9.5%	8.7%	28.4%	24.4%	42.6%
	Family of 4	**$1,767**	**$2,208**	**$2,650**	**$3,092**	**$3,533**	**$3,975**	**$4,417**	**$4,858**	**$5,300**	**$6,183**	**$7,067**
	Premium	0.0%	0.0%	*3.2%*	*3.2%*	4.7%	4.7%	7.7%	7.7%	*18.8%*	*16.1%*	11.8%
	Ded	3.5%	2.8%	3.8%	3.2%	3.5%	3.1%	4.0%	3.6%	11.8%	10.1%	17.7%
	OOP max	7.1%	5.7%	7.5%	6.5%	7.1%	6.3%	7.9%	7.2%	23.6%	20.2%	35.4%

Figure B.3
Oregon Health Fund Board Benefits Committee
Projected State Contribution Levels With Cost Sharing Aligned With Straw Plan A

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-400%	400+%
Median Monthly Income	$975	$1,192	$1,408	$1,625	$1,842	$2,058	$2,275	$2,492	$3,033	$ 3,467+
Deductible	$500	$500	$1,000	$1,000	$2,500	$2,500	$5,000	$5,000	$7,500	$7,500
Out-of-Pocket Max	$1,000	$1,000	$2,000	$2,000	$5,000	$5,000	$10,000	$10,000	$15,000	$15,000
Individual Monthly Contribution	$0	$0	$28	$33	$55	$62	$114	$125	$247	$247
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?
State Contribution	$427	$427	$366	$361	$277	$271	$164	$154	Tax break	None
Total Monthly Premium	$427	$427	$394	$394	$332	$332	$278	$278	$247	$247
Percent of Premium from State Contribution	100%	100%	93%	92%	83%	81%	59%	55%		
Avg State Contribution for 100-300% FPL	$316		***Avg State Contribution with No Premium Share for Parents < 200% FPL***				$320			

Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
	Individual	**$867**	**$1,083**	**$1,300**	**$1,517**	**$1,733**	**$1,950**	**$2,167**	**$2,383**	**$2,600**	**$3,033**	**$3,467**
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	*9.5%*	*8.1%*	7.1%
	Deductible	4.8%	3.8%	6.4%	5.5%	12.0%	10.7%	19.2%	17.5%	24.0%	20.6%	18.0%
	OOP max	9.6%	7.7%	12.8%	11.0%	24.0%	21.4%	38.5%	35.0%	48.1%	41.2%	36.1%
	Individual+1	**$1,167**	**$1,458**	**$1,750**	**$2,042**	**$2,333**	**$2,625**	**$2,917**	**$3,208**	**$3,500**	**$4,083**	**$4,667**
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	*14.1%*	*12.1%*	10.6%
	Ded	7.1%	5.7%	9.5%	8.2%	17.9%	15.9%	28.6%	26.0%	35.7%	30.6%	26.8%
	OOP max	14.3%	11.4%	19.0%	16.3%	35.7%	31.7%	57.1%	51.9%	71.4%	61.2%	53.6%
	Family of 3	**$1,467**	**$1,833**	**$2,200**	**$2,567**	**$2,933**	**$3,300**	**$3,667**	**$4,033**	**$4,400**	**$5,133**	**$5,867**
	Premium	0.0%	0.0%	3.8%	3.3%	5.7%	5.0%	9.3%	8.5%	*16.8%*	*14.4%*	12.6%
	Ded	8.5%	6.8%	11.4%	9.7%	21.3%	18.9%	34.1%	31.0%	42.6%	36.5%	32.0%
	OOP max	17.0%	13.6%	22.7%	19.5%	42.6%	37.9%	68.2%	62.0%	85.2%	73.1%	63.9%
	Family of 4	**$1,767**	**$2,208**	**$2,650**	**$3,092**	**$3,533**	**$3,975**	**$4,417**	**$4,858**	**$5,300**	**$6,183**	**$7,067**
	Premium	0.0%	0.0%	*3.2%*	*2.7%*	4.7%	4.2%	7.7%	7.0%	*14.0%*	*12.0%*	10.5%
	Ded	7.1%	5.7%	9.4%	8.1%	17.7%	15.7%	28.3%	25.7%	35.4%	30.3%	26.5%
	OOP max	14.2%	11.3%	18.9%	16.2%	35.4%	31.4%	56.6%	51.5%	70.8%	60.6%	53.1%

Appendix C: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of health care. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include the following:

1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
    - Examples include EMTALA, ERISA, HIPAA, and Medicaid and Medicare administrative rules
3) Workforce and organizational issues which must be addressed to allow creation of integrated health homes for all Oregonians
4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
    - Examples include educational interventions, non-emergent transportation, and personal health aides

Appendix D: Benefits Committee Membership and Staff

Committee Membership

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
Administrator, Benton County Health Department
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Member, Health Services Commission
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Susan King, RN. Chair
Executive Director, Oregon Nurses Association
Portland

Jim Lussier
CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena
Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD, Vice-Chair
Staff Physician, Portland Veterans Affairs Medical Canter
Member, Health Services Commission
Portland

Hubert (Hugh) Sowers, Jr.
Retired
AARP Member
McMinnville

Committee Membership (Cont'd)

Nina Stratton, Vice-Chair
Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit
Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Kevin C. Wilson, ND
Naturopathic Physician
Hillsboro

Committee Staff

Darren Coffman
Lead Staff

Ariel Smits, MD, MPH
Clinical Staff

Brandon Repp
Research Analyst

Nathan Hierlmaier
Policy Analyst

Dorothy Allen
Administrative Staff

Appendix E: Glossary

actuarial value The present value of future expected benefits calculated using economic and demographic assumptions.

advanced directive Advanced directives are specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future. Advanced care directives allow patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury. Advanced care directives can also designate someone the patient trusts to make decisions about medical care if the patient becomes unable to make (or communicate) these decisions.

AHRQ (Agency for Healthcare Research and Quality) The lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness *of health care for all Americans*.

ambulatory care sensitive condition An inpatient diagnosis for which timely and effective ambulatory care may have reduced the need for hospital admission.

care coordination An often highly structured and clinically intense set of processes that attempts to facilitate access to health care resources, decrease the "hassle" factor and improve an individual's overall health care experience.

case management A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote high-quality, cost-effective outcomes.

complementary and alternative medicine Any of various systems of healing or treating disease that are not included in the traditional curricula taught in medical schools of the United States and Britain. Examples include acupuncture, Chinese herbal medicine, chiropractic, and homeopathy.

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

coinsurance A defined percentage of the total charges for a service that the patient is responsible for.

clinical effectiveness The measurement of a treatment's ability to achieve a desired health outcome.

cost-effective Achieving the smallest cost for a given benefit, i.e., when a purchase is considered economical.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

cost shifting The transfer of uncompensated care costs from providers to insurance carriers, ultimately borne by consumers through increased insurance costs.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the cost of services.

discretionary services Those health care services, to be identified by the Health Services Commission or other body, which are of limited efficacy, or of equal efficacy to less expensive services. Alternatively, these services may be efficacious but do not have a significant impact on the health of an individual or population. Some discretionary services are efficacious and improve health, but are not required at a high frequency or at an advanced care level.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

EBP (Essential Benefit Package) The defined set of health services recommended by the Benefits Committee as the foundation level below which no individual should be without. This includes cost sharing and incentives, set according to financial means, designed to encourage patients to receive timely and appropriate diagnosis and treatment of their health conditions.

enabling services Services such as translation and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

exchange A health insurance exchange is a market organizer that acts as a central forum for individuals and businesses to purchase health insurance. It can also act as a mechanism through which individuals can access subsidies for private market coverage.

evidence-based medicine The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

formulary A listing of medications approved for use.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by the Centers for Medicare and Medicaid Services (CMS).

HRC (Health Resources Commission) Commission administered through the Office for Oregon Health Policy & Research that analyzes and disseminates information concerning the effectiveness and cost of medical technologies and prescription drugs.

HSC (Health Services Commission) Commission administered through the Office for Oregon Health Policy & Research that prioritizes health services for the Oregon Health Plan.

incentivize In health care, to encourage desired behaviors (e.g., getting regular prenatal care) through the use of monetary or other rewards.

integrated health home A health care setting which provides patients with an established and continuous relationship with a provider or provider group trained to provide longitudinal health care services. Key aspects of an integrated health home include: team-based care, whole person orientation, coordinated and integrated care, high-quality and safe care, and enhanced access.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, the elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of the Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines but have a household income at or below the FPL. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium towards health care expenses covered by their insurance plan over the course of a year.

patient-centered care Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

point-of-service cost sharing Contributions made by individuals towards their health care in the form of copayments or coinsurance for each service they receive. This is in contrast to contributions made through deductibles and premium share.

POLST (Physician's Order for Life-Sustaining Treatment) A form developed for use by emergency medical personnel containing information about an individual's end of life decisions such as the use of cardiopulmonary resuscitation (CPR) and choices regarding medical treatment issues such as tube feedings and the use of antibiotics.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Prioritized List of Health Services The list of health services used as the basis for providing benefits under the Oregon Health Plan. Created and maintained by the Health Services Commission, the Prioritized List ranks services according to importance, taking into account clinical effectiveness, cost, and public values. See also *OHP Plus*.

therapeutically equivalent Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

value-based services Those cost-effective services, to be identified by the Health Services Commission or other body, which have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Examples may include certain evidence-based preventive care and outpatient treatments for ambulatory care sensitive conditions.

Oregon Health Fund Board

Benefits Committee
December 11, 2007

Clackamas Community College
Wilsonville Campus Training Center, Room 218
29353 Town Center Loop East
Wilsonville, Oregon

Oregon Health Fund Board
Benefits Committee Meeting

Tuesday, December 11, 2007
9:30 am – 1:30 pm
Room 218
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

The Committee will be served a working lunch at Noon

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Susan King	
5 min	Approval of Agenda and 11/8/07 Minutes	Susan King	X
9:35 am 20 min	Update on Board/Committee Activities	Susan King, Darren Coffman	
10:05 am 10 min	Review of Charter	Susan King	X
10:10 am 20 min	Report on Leadership Conference Call	Susan King, Nina Stratton, Som Saha	
10:30 am 30 min	Discussion on Desired Level of Detail for Recommendations to Board	Susan King	X
11:00 am 50 min	Workgroup Formation and their Charges	Susan King	X
11:50 am 10 min	Break		
12:00 pm 60 min	Discussion of Strategies for Defining What Are Essential Health Services Using the Prioritized List	Susan King	
1:00 pm 20 min	Public Testimony	Susan King	
1:20 pm 10 min	Next Steps	Susan King	
1:30 pm	Adjourn	Susan King	

Draft Minutes
Oregon Health Fund Board Benefits Committee
November 8, 2007

Members Present: Susan King, RN, Chair; Gary Allen, DMD; Lisa Dodson, MD; Tom Eversole; Leda Garside, RN, BSN (arrived at 10:00 am); Betty Johnson; Bob Joondeph; Somnath Saha, MD, MPH (arrived at 9:40 am), Nina Stratton; Kathryn Weit; Kevin Wilson, ND; Susan Pozdena.

Members Absent: Jim Lussier, Hugh Sowers, Jr.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Brandon Repp; Nathan Hierlmaier, MPH; Dorothy Allen; Jeanene Smith, MD, MPH.

Also Attending: Andy Smith, Addictions & Mental Health Division; Kelly Harms, OPHP; Sean Kolmer and Jeanene Smith MD, MPH, Oregon Health Policy & Research (OHPR); Cheryl Martinis, FHIAP; Tracy Rutten, Susan Bamberger and Rich Snsick, Oregon Physical Therapy Association; Ann Uhler, Governor's Council on A & D; Laura Sisulak, Oregon Primary Care Association; Don Stecher, NOVARTIS; Tom Hart, Schering-Plough; Lorey Freeman, LC; Fawn McWealy, ODS; Kim Wirlz, Regence; Betsy Earls, KPNW; Jen Lewis, Oregon Medical Association; Rick Bennett, AARP; Len Bergstein, Northwest Strategies; Lisa Trussell, Health Net; David Pollack, MD, OHSU.

I. Call to Order

Ms. Susan King, RN called the Benefits Committee meeting to order at 9:32 a.m. in room 112 at the Clackamas Community College Wilsonville Training Center.

II. Approval of Draft Agenda and Approval of Minutes

- No revisions were made to the draft agenda.
- MOTION: To accept the minutes from the October 17, 2007 meeting. MOTION CARRIES: 11-0 (Absent: Garside).

III. Update on Board/Committee Activities

- Ms. King reported that the Oregon Health Fund Board (OHFB) met on November 6, 2007 and heard presentations on the drivers of health care costs.
- Mr. Darren Coffman reported that the Board held a mini-retreat on October 30, 2007 that included presentations:
    - On coverage trends in Oregon
    - From Anne Gauthier, Commonwealth Fund, spoke about other state's healthcare reform efforts
    - From the Oregon Business Council and Health Policy Commission on their recommendation for healthcare reform
    - The Board reviewed the draft charters and assumptions but has not finalized these documents.

- All of the committees except Federal Laws and a new committee, Health Equities, have held their first organizational meetings.

IV. Nominations & Election of Vice Chair(s)

- Ms. King opened the nominations for Vice-Chair(s) of the Benefits Committee.
- Ms. Nina Stratton and Dr. Somnath Saha expressed interest in serving as vice-chairs.
- MOTION: Dr. Saha and Ms. Stratton be elected Committee Vice Chairs. MOTION CARRIES: 11-0 (Absent: Garside).

V. Review of Charter

- Ms. King proposed the Benefits Committee Charter "Scope" should be prioritized.
    - Defining a set of essential health services
    - Defining what populations should be subsidized, including cost-sharing.
- The committee agreed that the goal is to create a "floor" of basic benefits that every Oregonian should have.
- There may be policy reasons to provide an enriched package for specific segments of the population.
- Staff will revise the charter to reflect this discussion.

VI. Demographic Characteristics of the Uninsured in Oregon

The members heard a presentation from Mr. Sean Kolmer, OHPR Research and Data manager, entitled "Coverage Trends in Oregon, 2006."

VII. Overview of OHP Benefits and the Prioritized List of Health Services

Mr. Coffman and Dr. Saha gave a presentation on the work of the Health Services Commission (HSC) based on the paper entitled "A Brief History of Health Services Prioritization in Oregon".

VIII. Discussion on the Use of the Prioritized List for Defining a Set of Essential Health Services

- The concept of the list and the results have been viewed positively in the State, probably due in part to the richness of the benefit package.
- The funding line has only moved in one direction (to reduce services), and more recently has not been allowed to move at all by CMS.
- No commercial plans have used a design similar to the Prioritized List, but PEBB has discussed the possibility. MN, WI and NC have shown interest and South Africa uses a design based on the list.
- The list was constructed for the coverage of a population and does not lend itself well as a marketing tool to individuals. The list gives a covered vs. not covered result while a commercial plan provides consumer choice through levels of cost-sharing.

- David Pollack, MD, and Ann Uhler, members of the HSC's Mental Health Care & Chemical Dependency (MHCD) Subcommittee since 1989 added their perspective on the history of the list.
    - National advocates for vulnerable populations came out against the list while their Oregon counterparts were personally involved in the process and supported it.
    - Use of same methodology for determining the importance of treating both physical health and behavioral health conditions was a big step in breaking the mind vs. body duality.
    - The elimination of visit limits under OHP pointed out the absurdity of having insurance coverage dictate access to A&D treatments and paved the way for parity.
- Further refinements could be made to list to delineate cost-effectiveness of services for the same condition within line items.
- It has been estimated that the list provides the State with a savings of approximately $65 million/year. The HSC's use of evidence-based research to evaluate new technologies should be having an impact on future trend rates.
- Issues identified by members for consideration in the committee's process:
    - cost-effectiveness
    - improving health outcomes
    - contain costs by reigning in over-utilization of services, perhaps using deductibles on a sliding-scale basis to accomplish this
    - try to have same rules for benefits across all populations (with the exception of Medicaid categorical eligibles and Medicare) to reduce cost-shift and reduce administrative burden on providers
    - spread risk across plans as much as possible to make it fairer (guaranteed issue for all populations would accomplish this)
    - make benefit package palatable(e.g., administrative hassles) to primary care so as not to push away members of an already short workforce
    - build incentives into package to encourage preventive care
    - look at OHP managed care plan experience using list to gauge impact on private market

IX. Public Testimony

Susan Bamberger spoke on behalf of the Oregon Physical Therapy Association

- Stated that outpatient rehabilitation therapies including physical therapy was not originally covered under OHP and still have some difficulty in reimbursement for services to TBI, spinal cord injury and stroke patients.*
- Pointed out a few efforts in the US and abroad in which physical therapy has successfully been incorporated into a primary care setting, resulting in improved access and cost controls:
    - Jan. 2007 Wall St. Journal article reported that per episode costs at spine clinic at Virginia Mason Hospital in Seattle, WA were reduced from just over $2,000 to just under $900 when patients required to see a physical therapist first.

    - 2004 BMJ article on TEAM (Target Early Access to Musculoskeletal services) project that increased referrals to general practitioners and physical therapists while significantly reducing referrals to neurosurgeons and orthopedic specialists.
    - 2003 Journal of Physical Therapy reported on effort in The Netherlands in which physical therapists used diagnostic skills to determine appropriate level of referral (if any).
- Mr. Coffman clarified that physical therapy was initially identified as an ancillary service prior to implementation of the Prioritized List and was covered for any condition appearing in the funded portion of the list. Rehabilitation therapies have been excluded from coverage under OHP Standard. In 2004 these therapies did become subject to guideline limitations and are now only covered for specific conditions for OHP Plus recipients.

X. Next Steps

- The next meeting was scheduled for Tuesday, December 11 from 9:30 am – 1:30 pm at a location to be determined.
- Future meetings will be scheduled electronically using Meeting Wizard.
- Ms. King, Ms. Stratton, and Dr. Saha will hold a conference call involving staff prior to the next meeting to identify issues around benefits requiring discussion by the committee and potential parking lot issues which may help determine where workgroups would be useful in the future.

XI. Adjourn

Ms. King adjourned the meeting at 1:35 pm.

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER
Approved by OHFB on _____

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for their primary objective of defining a set(s) of essential health services the committee shall consider:

1) Mechanisms for setting priorities that optimize the health of Oregonians;
2) The applicability of the HSC Prioritized List of Health Services;
3) The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
4) Approaches that promote integrated systems of care centered on a primary care home;
5) An emphasis on preventive care and chronic disease management;
6) Education activities that further health and wellness promotion;
7) The definition and inclusion of services for dignified end-of-life care; and,
8) The needs of vulnerable populations in order to reduce health disparities.

Secondarily, the committee will examine subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages, taking into consideration:

1) Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
2) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.
3) Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
4) Methods for collecting and incorporating public values of those who will potentially benefit from/contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
5) The demographic characteristics of the uninsured (e.g., age, gender, family status, income);

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, RN, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC)	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Hugh Sowers, Jr.	Retired, AARP	McMinnville
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council on Developmental Disabilities	Salem
Kevin C. Wilson, ND	Naturopathic Physician	Hillsboro

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director, OHPR, Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research Analyst, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

On the conference call between staff and Benefits Committee leadership on 11/20/07 it was decided to propose that the full Committee:

- Strive to define a single set of essential health services that can apply to all populations, with acknowledgement that certain populations (e.g., Medicaid categorical eligibles) may require a supplemental package of services;
- Build on work that has already been done, including:
    - the Health Services Commission's Prioritized List of Health Services;
    - the Health Resources Commission's Practitioner-Managed Preferred Drug List;
    - technology assessments performed by the Health Resources Commission, the multi-state collaborative involving Oregon (MED) and other nationally and internationally recognized evidence-based research centers;
    - recommendations of the Health Policy Commission from their report, "The Road to Health Care Reform";
    - other state reform efforts that further the Committee's goal in defining a set of essential health services.
- Keep discussions and resulting recommendations to the Health Fund Board at a relatively high level in order to complete the Committee's charge in the limited timeline;
- Form three workgroups given straightforward charges to examine the work of the Health Services Commission (and others) in the areas of:
    - ancillary services (e.g., prescription drugs, durable medical equipment, transportation);
    - end-of-life care (e.g., hospice care, palliative care, futile care);
    - diagnostic services (e.g., office visits, emergency department visits, imaging services, laboratory services, exploratory procedures).

  The workgroups should:
    - include a mixture of clinicians and non-clinicians on each workgroup, inviting others with expertise not represented within the Committee to participate where necessary;
    - identify issues that still need to be addressed within each area;
    - develop recommendations for the Committee on what is essential within the subcategories of services within each area.
- Continue to examine the Prioritized List as a full Committee in order to better understand the strengths and weaknesses in using it as the basis for defining a set of essential health services.

Health Resources Commission
Proposal for Subcommittee Reorganization

WHEREAS:

- Sixteen years have passed since Senate Bill 1077 (1991) established the Oregon Health Resources Commission. The Commission was originally charged with developing "a medical technology assessment program that addresses the introduction, diffusion and utilization of medical technologies and their associated services and shall make recommendations regarding the program's implementation." ORS 442.583(1)(a).

- In 2001, Senate Bill 819 created the Oregon Practitioner-Managed Prescription Drug Plan. The Plan was created to ensure that enrollees of Oregon's Medicaid Program, the Oregon Health Plan, (among others) receive the most effective prescription drug available at the best possible prices. ORS 414.332. The Commission is responsible for advising the Department of Human Services on the drugs for inclusion on the Plan Drug List. ORS 414.334; OAR 410-121-0030. Existing drugs must be reviewed periodically and new drugs are not added to the List until they have been reviewed by the Commission. OAR 410-121-0030(3)(c).

- In 2007, the Oregon legislature passed House Bill 2918, directing the Commission to conduct a review of evidence based treatments of pervasive developmental disorders and autism spectrum disorders.

- To accomplish its various legislative charges, the Commission is authorized to appoint "advisory committees or subcommittees." ORS 414.581(4).

- The Commission presently selects and appoints advisory subcommittees comprising of physicians, pharmacists, nurse practitioners, and other individuals with specialized knowledge regarding the technology to be reviewed. For each review, a new subcommittee is convened.

- The Commission's workload is increasing with the passage of House Bill 2918 and an increase of medical technology evaluations from the "Med Project" at the Center for Evidence Based Policy.

- To handle the increasing workload, the Commission must solicit and train additional qualified volunteer specialists with a strong knowledge of and commitment to the principles of evidence based medicine. The pool of such individuals is limited and recruitment is growing more challenging.

- At this juncture, a new advisory committee structure is needed to efficiently produce the consistently high quality output expected by its stakeholders – *i.e.*, fewer subcommittees of qualified individuals who are charged with broader responsibility.

NOW THEREFORE, IT IS PROPOSED THAT:

- The Commission would create three advisory subcommittees: Pharmaceutical, Technology, and Mental Health.

- The Pharmaceutical subcommittee would expand upon the current Standing Update subcommittee because most pharmaceutical classes will be evaluated in the context of updating existing reports. The individuals who serve on the current standing update committee represent an experienced, effective group who could start their work immediately.

- The Technology subcommittee would address non-pharmaceutical medical treatments, including the evaluation of medical equipment and devices and medical or surgical procedures and techniques. The subcommittee would be comprised by a broad spectrum of individuals representing the various parts of the medical technology field with expertise in biomedical engineering, medical electronics, surgery, and IT, as deemed advisable by the Commission among others.

- The Mental Health subcommittee would be initially charged with addressing House Bill 2918, and may additionally address treatments for other mental health issues that have been proposed by the Commission. It is anticipated that this committee's work will eventually be continued by the pharmaceutical and technology subcommittees once initial evaluations are completed.

- Recognizing the impossibility of having expertise in all possible fields and the desirability of keeping the committees to a manageable size, each subcommittee would enlist the aid of experts when needed, as well as including members of the advocacy community when appropriate.

- All members of the subcommittees, including temporary advisors, would continue to be approved by the Commission.

- All subcommittee meetings would adhere to state public meeting laws. Interested persons would still be allowed to make presentations at subcommittee meetings in accordance with the Commission's Public Testimony Policy.

Practitioner-Managed Prescription Drug Plan PROCESS

NEW DRUG CLASS:

- OMAP presents drug class review recommendations to HRC
- HRC makes decision, with OMAP, which drug classes to review
- HRC Director takes recommendations to DERP collaboration
- DERP Collaboration chooses classes to review
- HRC Director in collaboration with Pharmaceutical Subcommittee participates in the process of defining and development of the final scope of the report through the DERP collaboration
- Upon receipt of the final EPC review the HRC Director convenes Pharmaceutical Subcommittee public meetings to evaluate the EPC review and create report
- Subcommittee presents report to HRC
- HRC finalizes report and commends to OMAP for use in the Plan Drug List (PDL) and publishes report, along with executive summary and patient information report to the Oregon Rx website

DRUG CLASS ANNUAL / BI-ANNUAL UPDATES:

- EPC develops draft Key Question (KQ) document
- HRC Director emails draft KQ to Pharmaceutical Subcommittee for feedback
- HRC Director presents Pharmaceutical Committee KQ recommended changes to DERP collaboration
- DERP collaboration finalizes Key Questions and prepares review.
- Upon receipt of the EPC updated review the HRC director convenes Pharmaceutical Committee public meetings to evaluate the EPC review and create report.
- Subcommittee presents report to the HRC
- HRC finalizes the report and commends to OMAP for use in the PDL and publishes updated documents to the Oregon Rx website.

Acronyms-

HRC – Health Resources Commission
OMAP – Oregon Medical Assistance Program
DERP – Drug Effectiveness Review Program
EPC – Evidence-based Practice Center

Health Resources Commission Subcommittee Process

Thank you for expressing interest in participating in a Health Resources Commission subcommittee. The project embarked upon by the State of Oregon through the Health Resources Commission (HRC) is revolutionary in scope. It represented the first time in the country that preferred drugs for a State Medicaid population were being chosen by an evidence-based public process. The HRC was created to assess health care technologies, including prescription drugs, and to encourage their rational and appropriate use.

The HRC has completed 23 comparative drug classes and two medical technology assessments. The goal of the PDL is to identify the most effective prescription drugs available for OHP enrollees at the best possible price for taxpayers. In addition we do periodic updates to keep abreast of new developments. A consortium of thirteen States and the Provinces of Canada has joined in the Drug Effectiveness Review Project to take advantage of global evidence, yet preserving local decisions. For further information see: http://www.ohsu.edu/drugeffectiveness/

Considering both efficacy and safety, subcommittees comprised of six to eight members are using an evidence-based process to identify preferred drugs in various drug classes. The PDL is unique because the drugs are chosen in a public process of evaluating medical evidence. Subcommittees work with an Evidence-Based Center that conducts systematic literature reviews and prepares a detailed report including evidence tables. The subcommittee utilizes this information plus the expertise of its members to develop a report which evaluates the relative efficacy, and possible safety concerns among drugs in the specified class. Using the subcommittee report, the HRC makes a final report to the Division of Medical Assistance Programs (DMAP) who then considers individual drugs for inclusion in the PDL. Further information about the Oregon Health Resources Commission can be found on the HRC website: http://egov.oregon.gov/DAS/OHPPR/HRC/index.shtml . Located on the HRC website is a section that is devoted to the HRC reports.

Meetings are held at Legacy Meridian Park Hospital, Health Education Center in Tualatin, Oregon. For those who cannot attend in person because of distance or schedule conflict, we arrange telephone conference calls. A CV or Resume and a Conflict of Interest (COI) statement are required.

Should you have any further questions, please contact us by e-mail at HRC.Info@state.or.us . You may also contact Tina Huntley, Assistant, Health Resources Commission at (503)373-1629(phone), or (503)378-5511(Fax). Tina is available to answer questions or receive your documents.

Please let me know if you would be interested and available to participate in this project. I would also appreciate notification if you are unable to participate.

Sincerely,

David Pass, MD
Director, Health Resources Commission
Office for Oregon Health Policy and Research

Enrolled
Senate Bill 819

Sponsored by Senator CLARNO; Senators L BEYER, BROWN, BURDICK, CASTILLO, CORCORAN, DUNCAN, HARTUNG, MESSERLE, METSGER, MINNIS, Representatives NELSON, NOLAN, C WALKER

CHAPTER .....

AN ACT

Relating to Oregon Health Plan; creating new provisions; amending ORS 414.325; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Legislative Assembly finds that:

(1) The cost of prescription drugs in the Oregon Health Plan is growing and will soon be unsustainable;

(2) The benefit of prescription drugs when appropriately used decreases the need for other expensive treatments and improves the health of Oregonians; and

(3) Providing the most effective drugs in the most cost-effective manner will benefit both patients and taxpayers.

SECTION 2. It is the policy of the State of Oregon that a Practitioner-managed Prescription Drug Plan will ensure that:

(1) Oregonians have access to the most effective prescription drugs appropriate for their clinical conditions;

(2) Decisions concerning the clinical effectiveness of prescription drugs are made by licensed health practitioners, are informed by the latest peer-reviewed research and consider the health condition of a patient or characteristics of a patient, including the patient's gender, race or ethnicity; and

(3) The cost of prescription drugs in the Oregon Health Plan is managed through market competition among pharmaceutical manufacturers by publicly considering, first, the effectiveness of a given drug and, second, its relative cost.

SECTION 3. (1) The Department of Human Services shall adopt a Practitioner-managed Prescription Drug Plan for the Oregon Health Plan. The purpose of the plan is to ensure that enrollees of the Oregon Health Plan receive the most effective prescription drug available at the best possible price.

(2) Before adopting the plan, the department shall conduct public meetings and consult with the Health Resources Commission.

(3) The department shall consult with representatives of the regulatory boards and associations representing practitioners who are prescribers under the Oregon Health Plan and ensure that practitioners receive educational materials and have access to training on the Practitioner-managed Prescription Drug Plan.

(4) Notwithstanding the Practitioner-managed Prescription Drug Plan adopted by the department, a practitioner may prescribe any drug that the practitioner indicates is medically necessary for an enrollee as being the most effective available.

(5) An enrollee may appeal to the department a decision of a practitioner or the department to not provide a prescription drug requested by the enrollee.

(6) This section does not limit the decision of a practitioner as to the scope and duration of treatment of chronic conditions, including but not limited to arthritis, diabetes and asthma.

SECTION 4. The President of the Senate and the Speaker of the House of Representatives shall designate an appropriate interim legislative committee or legislative commission to:

(1) Receive regular reports on the development and implementation of the Practitioner-managed Prescription Drug Plan;

(2) Review the impact of the implementation of the Practitioner-managed Prescription Drug Plan, including but not limited to a review of whether the program realizes any savings, whether there is an increase in physician and hospital costs for individuals receiving medical assistance, and whether there is an impact on the ability of an individual receiving medical assistance to obtain prescribed drugs; and

(3) Report its findings and recommendations periodically to the Emergency Board and to the Seventy-second Legislative Assembly.

SECTION 5. ORS 414.325 is amended to read:

414.325. (1) As used in this section, "legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the [*division*] **Department of Human Services** unless the practitioner prescribes otherwise and an exception is granted by the [*division*] **department**.

(3) [*Except as provided in subsections (4) and (5) of this section, the division shall place no limit on the type of legend drug that may be prescribed by a practitioner, but*] **The department** shall pay only for drugs in the generic form **if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards,** unless an exception has been granted by the [*division*] **department**.

(4) [*Notwithstanding subsection (3) of this section,*] An exception must be applied for and granted before the [*division*] **department** is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the [*division*] **department**.

(5)[*(a)*] Notwithstanding subsections (1) to (4) of this section**,** [*and except as provided in paragraph (b) of this subsection, the division*] **the department** is authorized to:

[*(A)*] **(a)** Withhold payment for a legend drug when federal financial participation is not available; and

[*(B)*] **(b)** Require prior authorization of payment for drugs [*which*] **that** the [*division*] **department** has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

[*(b) The division may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the division, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:*]

[*(A) Asthma;*]

[*(B) Sinusitis;*]

[*(C) Rhinitis; or*]

[*(D) Allergies.*]

(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as approved by the federal Food and Drug Administration to treat mental illness, HIV and AIDS, and cancer.

SECTION 5a. If House Bill 2497 becomes law, section 5 of this 2001 Act (amending ORS 414.325) is repealed and ORS 414.325, as amended by section 1, chapter _____, Oregon Laws 2001 (Enrolled House Bill 2497), is amended to read:

414.325. (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner.

(b) "Pharmacy network" means a group of pharmacies using a shared database or employing other electronic means to access prescription information of enrollees from multiple points of service.

(c) "Practitioner" has the meaning given that term in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) [*Except as provided in subsections (4) and (5) of this section, the department shall place no limit on the type of legend drug that may be prescribed by a practitioner, but*] **The department** shall pay only for drugs in the generic form **if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards,** unless an exception has been granted by the department.

(4) [*Notwithstanding subsection (3) of this section,*] An exception must be applied for and granted before the department is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(5)(a) Notwithstanding subsections (1) to (4) of this section [*and except as provided in paragraph (b) of this subsection*], the department is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs [*which*] **that** the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

[*(b) The department may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the department, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:*]

[*(A) Asthma;*]

[*(B) Sinusitis;*]

[*(C) Rhinitis; or*]

[*(D) Allergies.*]

[*(c)*] **(b)** Notwithstanding subsections (1) to (4) of this section and [*paragraphs (a) and (b)*] **paragraph (a)** of this subsection, the department may require prior authorization of payment for drugs for individuals whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as approved by the federal Food and Drug Administration to treat mental illness, HIV and AIDS, and cancer.

[*(6)*] **(7)** When a practitioner prescribes a legend drug under this chapter, the practitioner shall write on the prescription:

(a) The diagnosis code for the condition on the prioritized list of services covered for payment for which the legend drug is being prescribed; and

(b) The practitioner's Office of Medical Assistance Programs provider number.

[*(7)(a)*] **(8)(a)** At the time of enrollment or reenrollment in a fee-for-service payment system, an enrollee shall designate a primary pharmacy or pharmacy network to dispense legend drugs covered by the medical assistance program.

(b) The department shall adopt rules establishing procedures that allow an enrollee to:

(A) Obtain a legend drug at a pharmacy other than a designated primary pharmacy or pharmacy network; and

(B) Change a designation of a primary pharmacy or pharmacy network.

[*(8)*] **(9)** The department shall adopt rules that:

(a) Establish procedures to ensure that a primary pharmacy or pharmacy network will receive notice when an enrollee obtains a legend drug at another pharmacy; and

(b) Allow payment at the point of sale to a pharmacy other than a primary pharmacy or pharmacy network for a legend drug obtained by an enrollee as described in subsection [*(7)(b)(A)*] **(8)(b)(A)** of this section.

SECTION 6. ORS 414.325, as amended by section 5 of this 2001 Act, is amended to read:

414.325. (1) As used in this section, "legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) **Except as provided in subsections (4) and (5) of this section, the department shall place no limit on the type of legend drug that may be prescribed by a practitioner, but** the department shall pay only for drugs in the generic form [*if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards,*] unless an exception has been granted by the department.

(4) **Notwithstanding subsection (3) of this section,** an exception must be applied for and granted before the department is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(5)**(a)** Notwithstanding subsections (1) to (4) of this section **and except as provided in paragraph (b) of this subsection**, the department is authorized to:

[*(a)*] **(A)** Withhold payment for a legend drug when federal financial participation is not available; and

[*(b)*] **(B)** Require prior authorization of payment for drugs that the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The department may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the department, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

[*(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as approved by the federal Food and Drug Administration as the primary treatment for mental illness, HIV and AIDS and cancer.*]

SECTION 6a. If House Bill 2497 becomes law, section 6 of this 2001 Act (amending ORS 414.325) is repealed and ORS 414.325, as amended by section 5a of this 2001 Act, is amended to read:

414.325. (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner.

(b) "Pharmacy network" means a group of pharmacies using a shared database or employing other electronic means to access prescription information of enrollees from multiple points of service.

(c) "Practitioner" has the meaning given that term in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515, 689.854 and 689.857 and pursuant to rules of the Department of Human Services unless the practitioner prescribes otherwise and an exception is granted by the department.

(3) **Except as provided in subsections (4) and (5) of this section, the department shall place no limit on the type of legend drug that may be prescribed by a practitioner, but** the department shall pay only for drugs in the generic form [*if the federal Food and Drug Administration has approved a generic version of a particular brand name drug that is chemically identical to the brand name drug according to federal Food and Drug Administration rating standards,*] unless an exception has been granted by the department.

(4) **Notwithstanding subsection (3) of this section,** an exception must be applied for and granted before the department is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the department.

(5)(a) Notwithstanding subsections (1) to (4) of this section **and except as provided in paragraph (b) of this subsection**, the department is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs that the department has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The department may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the department, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

[*(b)*] **(c)** Notwithstanding subsections (1) to (4) of this section and [*paragraph (a)*] **paragraphs (a) and (b)** of this subsection, the department may require prior authorization of payment for drugs for individuals whose prescription drug use exceeded 15 drugs in the preceding six-month period.

[*(6) Notwithstanding subsection (3) of this section, the department may not limit legend drugs when used as approved by the federal Food and Drug Administration to treat mental illness, HIV and AIDS, and cancer.*]

[*(7)*] **(6)** When a practitioner prescribes a legend drug under this chapter, the practitioner shall write on the prescription:

(a) The diagnosis code for the condition on the prioritized list of services covered for payment for which the legend drug is being prescribed; and

(b) The practitioner's Office of Medical Assistance Programs provider number.

[*(8)(a)*] **(7)(a)** At the time of enrollment or reenrollment in a fee-for-service payment system, an enrollee shall designate a primary pharmacy or pharmacy network to dispense legend drugs covered by the medical assistance program.

(b) The department shall adopt rules establishing procedures that allow an enrollee to:

(A) Obtain a legend drug at a pharmacy other than a designated primary pharmacy or pharmacy network; and

(B) Change a designation of a primary pharmacy or pharmacy network.

[*(9)*] **(8)** The department shall adopt rules that:

(a) Establish procedures to ensure that a primary pharmacy or pharmacy network will receive notice when an enrollee obtains a legend drug at another pharmacy; and

(b) Allow payment at the point of sale to a pharmacy other than a primary pharmacy or pharmacy network for a legend drug obtained by an enrollee as described in subsection [*(8)(b)(A)*] **(7)(b)(A)** of this section.

SECTION 7. The amendments to ORS 414.325 by section 6 of this 2001 Act become operative on January 2, 2007.

SECTION 7a. If House Bill 2497 becomes law, section 7 of this 2001 Act is amended to read:

Sec. 7. The amendments to ORS 414.325 by section [*6*] **6a** of this 2001 Act become operative on January 2, 2007.

SECTION 8. This 2001 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2001 Act takes effect on its passage.

Passed by Senate July 6, 2001

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Secretary of Senate

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President of Senate

Passed by House July 7, 2001

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Speaker of House

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

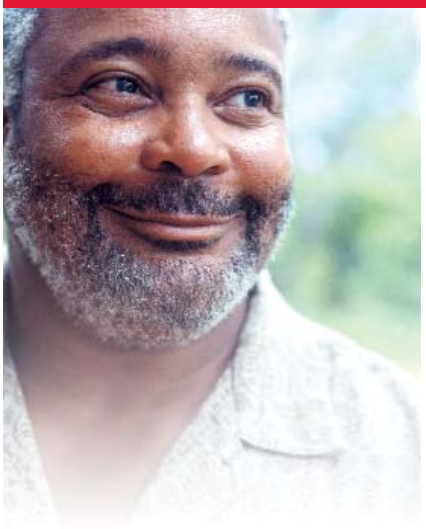
Filed in Office of Secretary of State:

.....M.,....., 2001

.....
Secretary of State

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare & You 2008



This is the official government handbook with important information about the following:

- ★ 2008 costs
- ★ What's covered
- ★ Preventive services
- ★ Health plans
- ★ Prescription drug plans
- ★ Your rights and appeals

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Part B-Covered Services

Abdominal Aortic Aneurysm Screening	A one-time screening ultrasound for people at risk (like people who have smoked). Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam. See "physical exam" on page 23. You pay coinsurance.
Ambulance Services	When you need to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle would endanger your health. You pay coinsurance, and Part B deductible applies.
Ambulatory Surgery Center Fees	Facility fees for approved services at an Ambulatory Surgery Center (facility where surgical procedures are performed, and the patient is released the same day). You pay coinsurance, and Part B deductible applies.
Blood	Pints of blood you get, starting with the 4th, as an outpatient or as part of a Part B-covered service. The first three pints aren't covered. You pay coinsurance, and Part B deductible applies.
Bone Mass Measurement	To help see if you are at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay coinsurance, and Part B deductible applies.
Cardiovascular Screenings	To help prevent a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. No cost.
Chiropractic Services (limited)	To correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. You pay coinsurance, and Part B deductible applies.
Clinical Laboratory Services	Including certain blood tests, urinalysis, some screening tests, and more. No cost.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Clinical Research Studies	To help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical research studies test new types of medical care, like how well a new cancer drug works. Usual patient care costs are covered if you take part in a qualifying clinical research study. If the item or service isn't covered outside of a clinical research study, the cost of the investigational item or service may not be covered. You pay coinsurance, and Part B deductible applies.
Colorectal Cancer Screenings	To help find precancerous growths and help prevent or find cancer early, when treatment is most effective. One or more of the following tests may be covered. Talk to your doctor. ■ Fecal Occult Blood Test—Once every 12 months if age 50 or older. No cost. ■ Flexible Sigmoidoscopy—Generally, once every 48 months if age 50 or older, or for those not at high risk, 120 months after a previous screening colonoscopy. You pay coinsurance. ■ Screening Colonoscopy—Generally once every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidoscopy. No minimum age. You pay coinsurance. ■ Barium Enema—Once every 48 months if age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay coinsurance.
Diabetes Screenings	To check for diabetes. These screenings are covered if you have any of the following risk factors: high blood pressure (hypertension), dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Tests are also covered if you answer yes to two or more of the following questions: ■ Are you age 65 or older? ■ Are you overweight? ■ Do you have a family history of diabetes (parents, siblings)? ■ Do you have a history of gestational diabetes (diabetes during pregnancy), or did you deliver a baby weighing more than nine pounds? Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. No cost.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Diabetes Self-management Training	For people with diabetes. Your doctor or other health care provider must provide a written order. You pay coinsurance, and Part B deductible applies.
Diabetes Supplies	Including glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases). Syringes and insulin are only covered if used with an insulin pump, but may be covered by Medicare prescription drug coverage (Part D). You pay coinsurance, and Part B deductible applies.
Doctor Services	Services that are medically necessary or covered preventive services. Doesn't cover routine physical except for the one-time "Welcome to Medicare" physical exam (see page 23). You pay coinsurance, and Part B deductible applies.
Durable Medical Equipment	Items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home. For certain equipment, such as wheelchairs and hospital beds, Medicare pays rental fees for up to 13 months (36 months for oxygen). After this, you own the equipment, and Medicare pays for maintenance. For Medicare to cover your equipment, you must go to a supplier that is enrolled in Medicare. You pay coinsurance, and Part B deductible applies. In some cases, if you buy the equipment without renting it first, Medicare pays no part. **NEW:** In 2008, you may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.
Emergency Room Services	When you believe your health is in serious danger. You may have a bad injury, a sudden illness, or an illness that quickly gets much worse. You pay coinsurance, and Part B deductible applies.
Eye Exams	For people with diabetes to check for diabetic retinopathy once every 12 months. You pay coinsurance, and Part B deductible applies.
Eyeglasses (limited)	One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Flu Shots	To help prevent influenza or flu virus. This is covered once a flu season in the fall or winter. The flu is a serious illness. You need a flu shot for the current virus each year. No cost.
Foot Exams and Treatment	If you have diabetes-related nerve damage and/or meet certain conditions. You pay coinsurance, and Part B deductible applies.
Glaucoma Tests	To help find the eye disease glaucoma. This is covered once every 12 months for people at high risk for glaucoma. You are considered high risk for glaucoma if you have diabetes, a family history of glaucoma, are African-American and age 50 or older, or are Hispanic and age 65 or older. Tests must be done by an eye doctor who is legally authorized by the state. You pay coinsurance, and Part B deductible applies.
Hearing and Balance Exams	If your doctor orders it to see if you need medical treatment. Hearing aids and exams for fitting hearing aids aren't covered. You pay coinsurance, and Part B deductible applies.
Hepatitis B Shots	To help protect people from getting Hepatitis B. This is covered (three shots) for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), or a condition that lowers your resistance to infection. Other factors may increase your risk for Hepatitis B, so check with your doctor to see if you are at high or medium risk. You pay coinsurance, and Part B deductible applies.
Home Health Services	Limited to reasonable and necessary part-time or intermittent skilled care or continuing need for physical therapy, occupational therapy, or speech-related pathology ordered by the doctor and provided by a Medicare-certified home health agency. Home health services may also include medical social services, home health aide services or other services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and medical supplies for use at home. No cost for home health services. You pay coinsurance, and Part B deductible applies for durable medical equipment.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Kidney Dialysis Services and Supplies	Either in a facility or at home when your doctor orders it. You pay coinsurance, and Part B deductible applies.
Mammograms (screening)	A type of x-ray to check women for breast cancer before they or their doctor may be able to feel it. Screening mammograms are covered once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between age 35 and 39. You pay coinsurance.
Medical Nutrition Therapy Services	Medicare may cover medical nutrition therapy if you have diabetes or kidney disease and your doctor refers you for the service. You pay coinsurance, and Part B deductible applies.
Mental Health Care (outpatient)	To get help with mental health issues such as depression or anxiety. Includes services generally given outside a hospital or in a hospital outpatient department, including visits with a doctor, clinical psychologist or clinical social worker, and lab tests. Certain limits and conditions apply. You pay coinsurance, and Part B deductible applies. **Note:** Talk to your doctor if you feel sad, have little interest in things you used to enjoy, or have thoughts about ending your life. See page 13 for more information about inpatient mental health care.
Occupational Therapy	Services to help you return to usual activities (such as bathing) after an illness when your doctor orders them. You pay coinsurance, and Part B deductible applies.
Outpatient Hospital Services	Services you get as an outpatient as part of a doctor's care. You pay coinsurance, and Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Medicare's Covered Services

Part B-Covered Services

Pap Tests and Pelvic Exams (includes clinical breast exam)	To check for cervical and vaginal cancers. Medicare covers these screening tests once every 24 months for women at low risk, and once every 12 months for women at high risk and for women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past three years. No cost for the Pap lab test. You pay coinsurance for Pap test collection, and pelvic and breast exams.
Physical Exam (one-time "Welcome to Medicare" physical exam)	A one-time review of your health, and education and counseling about preventive services, including certain screenings and shots and referrals for other care if needed. **Important:** You must have the physical exam within the first 6 months you have Part B for it to be covered by Medicare. You pay coinsurance, and Part B deductible applies.
Physical Therapy	Evaluation and treatment of injuries and disease using various procedures, such as exercises and testing, when your doctor orders it. It may also include heat, light, and ultrasound therapy. You pay coinsurance, and Part B deductible applies.
Pneumococcal Shot	To help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. Talk with your doctor. No cost.
Practitioner Services	Such as services provided by clinical social workers, physician assistants, and nurse practitioners. You pay coinsurance, and Part B deductible applies.
Prescription Drugs (limited)	Includes certain injectable cancer drugs or immunosuppressive drugs. You pay coinsurance, and Part B deductible applies. **Note:** See pages 52–66 for information about additional Medicare prescription drug coverage (Part D).
Prostate Cancer Screenings	These tests help detect prostate cancer. Medicare covers a digital rectal exam (you pay coinsurance, and Part B deductible applies for the exam) and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50. No cost for the PSA test.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Prosthetic/ Orthotic Items	Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy). For Medicare to cover your prosthetic or orthotic, you must go to a supplier that is enrolled in Medicare. You pay coinsurance, and Part B deductible applies.
Rural Health Clinic and Federally-Qualified Health Center Services	A broad range of primary care services usually provided on an outpatient basis. You pay coinsurance, and Part B deductible applies for rural health clinic services.
Second Surgical Opinions	Covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay coinsurance, and Part B deductible applies.
Smoking Cessation (counseling to stop smoking)	Covered if your doctor orders it. Includes counseling for 2 cessation attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Counseling for each cessation attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.
Speech-Language Pathology Services	Treatment given to regain and strengthen speech skills when your doctor orders it. You pay coinsurance, and Part B deductible applies.
Surgical Dressing Services	For treatment of a surgical or surgically-treated wound. You pay coinsurance, and Part B deductible applies.
Telemedicine	In some rural areas, under certain conditions and only in a provider's office, a hospital, or a federally-qualified health center. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Bring the **preventive services checklist** on page 108 when you see your doctor.

Part B-Covered Services

Tests	Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. You pay coinsurance, and Part B deductible applies.
Transplants	Including doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Bone marrow and cornea transplants are covered (under certain conditions). Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan that was required to pay before Medicare paid for it. You must have been entitled to Part A at the time of the transplant and entitled to Part B at the time you get immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility. If you join a Medicare Advantage Plan, check with the plan for information on transplant coverage. You pay coinsurance, and Part B deductible applies. **Note:** Medicare drug plans may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.
Travel (health care needed when traveling outside the United States)	Limited to medical services provided in Canada when you travel on the most direct route through Canada between Alaska and another state. Medicare also covers hospital, ambulance, and doctor services if you are in the U.S., but the nearest hospital that can treat you isn't in the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). In some limited cases, Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. You pay coinsurance, and Part B deductible applies.
Urgently-Needed Care	To treat a sudden illness or injury that isn't a medical emergency. You pay coinsurance, and Part B deductible applies.

Part B deductible and coinsurance amounts are on page 112. Use the **preventive services checklist** on page 108 when you see your doctor.

What's NOT Covered by Part A and Part B?

Items and services that Medicare doesn't cover include, but aren't limited to, the following:

- Acupuncture
- Chiropractic services (except as listed on page 18)
- Cosmetic surgery
- Custodial care (like help with bathing or using the bathroom), except when you also get skilled nursing care in a skilled nursing facility, at home, or in a hospice
- Deductibles, coinsurance, or copayments when you get certain health care services. See pages 111–112 for these amounts. People with limited income and resources may get help paying these costs. See pages 76–82.
- Dental care and dentures (with only a few exceptions)
- Eye care (routine exam), eye refractions (exam that measures your ability to see at specific distances), and most eyeglasses (except as listed on page 20)
- Foot care (routine), like cutting corns or calluses (with few exceptions)
- Hearing aids and exams for the purpose of fitting a hearing aid
- Hearing tests that haven't been ordered by your doctor
- Laboratory tests for screening purposes, except those listed on pages 18–25
- Long-term care, for example, if you only need custodial care in a nursing home
- Orthopedic shoes (with few exceptions)
- Physical exams (routine or yearly). Medicare will cover a one-time physical exam within the first 6 months of enrolling in Part B (coinsurance and Part B deductible applies). See page 23.
- Prescription drugs. Most prescription drugs aren't covered by Part A or Part B. See pages 52–66 for information about Medicare prescription drug coverage (Part D).
- Shots to prevent illness, except as listed on pages 18–25
- Syringes or insulin, unless the insulin is used with an insulin pump, but it may be covered by Medicare prescription drug coverage (Part D)
- Travel (health care while you're traveling outside the United States, except as listed on page 25)

Blue words in the text are defined on pages 103–107.

Medicare Advantage Plans (Part C)

Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called "Part C" or "MA plans." Medicare pays an amount for your care every month to these private health plans. Medicare Advantage Plans must follow rules set by Medicare. Medicare Advantage Plans aren't supplemental insurance.

How Do Medicare Advantage Plans Work?

Medicare Advantage Plans provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) benefits and must cover at least all of the medically-necessary services that the Original Medicare Plan provides. However, Medicare Advantage Plans can charge different copayments, coinsurance, and deductibles for these services. It's important to call any plan before joining to find out what your services will cost and to make sure the plan meets your needs.

Blue words in the text are defined on pages 103–107.

Medicare Advantage Plans may offer extra benefits, such as vision, hearing, dental, and/or health and wellness programs, and most include Medicare prescription drug coverage (usually for an extra cost). Medicare Advantage Plans generally have provider networks. This means you probably have to see doctors who belong to the plan or go to certain hospitals to get covered services. You may need a referral to see specialists.

If you use providers who aren't in the network, you may have to pay the entire cost of the covered service. Some plans may let you use out-of-network providers, sometimes for a higher cost. You should check with your doctors or hospital to find out if they accept the plan.

How Do Medicare Advantage Plans Work? (continued)

There are five different kinds of Medicare Advantage Plans. Most of these plans, like HMOs, have networks of doctors that see you if you belong to the plan. Others, such as Private Fee-for-Service (PFFS) Plans, allow you to go to any doctor **if the doctor agrees to accept the plan's terms of payment before treating you**. There are also Medicare Advantage Plans called Medicare Special Needs Plans (SNPs) that serve certain people with Medicare who are chronically ill, who live in institutions like nursing homes, or who have other special needs.

The different benefits offered by the various types of Medicare Advantage Plans are outlined in the chart that starts on page 42. Below is a list of the different kinds of Medicare Advantage Plans and the page number where you can find more information about each type of plan. In all plan types, you are always covered for emergency and urgent care.

Medicare Advantage Plans include the following:

- Preferred Provider Organization (PPO) Plans. See page 42.
- Health Maintenance Organization (HMO) Plans. See page 42.
- Private Fee-for-Service (PFFS) Plans. See page 43.
- Medical Savings Account (MSA) Plans. See page 43.
- Special Needs Plans (SNP). See page 44.

How Do Medicare Advantage Plans Work? (continued)

Who Can Join?

You can generally join a Medicare Advantage Plan if you meet these conditions:

- You have Part A and Part B.
- You live in the service area of the plan. Contact the plan you're interested in to find out about its service area.
- You don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) except as explained on page 46.

Note: In most cases, you can join a Medicare Advantage Plan only at certain times. See page 48.

If You Join a Medicare Advantage Plan

Blue words in the text are defined on pages 103–107.

- You are still in the Medicare Program.
- You still have Medicare rights and protections, including the right to appeal. See pages 83–88.
- You still get Part A and Part B coverage. See pages 13 and 18–25.
- You usually get prescription drug coverage (Part D) through the plan. In most Medicare Advantage Plans, if you want drug coverage, and your plan offers it, you must get it from your Medicare Advantage Plan. If you are in a Medicare Advantage Plan, you usually can't join a Medicare Prescription Drug Plan unless you are in a Medicare Medical Savings Account (MSA) Plan or certain Medicare Private Fee-for-Service (PFFS) Plans. **In most cases, if you are in a Medicare Advantage Plan and you join a Medicare Prescription Drug Plan, you will be disenrolled from your Medicare Advantage Plan and returned to the Original Medicare Plan.**

  No Medicare MSA Plans and only some Medicare PFFS Plans offer Medicare prescription drug coverage. If your Medicare PFFS Plan doesn't offer Medicare prescription drug coverage, or if you have a Medicare MSA Plan, you can join a Medicare Prescription Drug Plan to get this coverage. See pages 52–66.
- You may be able to get extra benefits, like some coverage for vision, hearing, dental, and/or health and wellness programs.

How Do Medicare Advantage Plans Work? (continued)

If You Join a Medicare Advantage Plan (continued)

- You can join or switch plans only during certain times of the year. See page 48.
- You generally still pay the monthly Part B premium. You also pay the Medicare Advantage Plan's premium (if they charge one) that includes coverage for Part A and Part B benefits, prescription drug coverage (Part D, if offered), and any other extra benefits (if offered).
- You may have to use providers who belong to the plan.
- You must follow plan rules, like getting a referral to see a specialist or getting prior authorization for certain procedures. Check with the plan.
- You usually will have to pay some other costs (such as copayments, deductibles, or coinsurance) for the services you get. Out-of-pocket costs in these plans vary by the services you get. Check with your plan before you get a service to find out what your costs may be.
- You don't need to (and can't) buy a Medigap policy. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.
- If you see a doctor who doesn't belong to the plan, your services won't be covered, or your costs could be higher.
- The plan will send you an Evidence of Coverage each year. This document gives you details about what benefits the plan will cover, how much you pay, how to file an appeal, and more.
- Plan benefits may change each year. The plan will send you an Annual Notice of Change each fall. This notice has information about any changes in benefits, costs, or service area that will be effective in January. If the plan covers prescription drugs, the notice will include changes to the formulary. You should review this notice carefully to learn about changes for the upcoming year to decide if you want to look at other plans in your area.
- If the plan decides to no longer participate in the Medicare program, you will have to join another Medicare Advantage Plan or return to the Original Medicare Plan. See page 48.

If your former employer or union pays for your Medicare Advantage Plan, see page 69.

How Do Medicare Advantage Plans Work? (continued)

(continued)

	Preferred Provider Organization (PPO) Plan	Health Maintenance Organization (HMO) Plan
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want drug coverage, you must enroll in a PPO Plan that offers prescription drug coverage.	In most cases, yes. Ask the plan. If you want drug coverage, you must enroll in an HMO Plan that offers prescription drug coverage.
Do I need to choose a primary care doctor?	No.	Yes. You generally must see a primary care doctor to get a referral before you see any other health care provider.
Can I get my health care from any doctor or hospital?	Yes. PPOs have network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.	No. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). If the plan has a Point-of-Service option, you can go out-of-network, but it will cost more.
Do I have to see a primary care doctor to get a referral to see a specialist?	In most cases, no.	In most cases, yes. Exceptions include yearly screening mammograms and in-network Pap tests and pelvic exams (at least every other year), which don't require a referral.
What else do I need to know about this type of plan?	You may be able to get extra benefits for an additional premium.	• If your doctor leaves, your plan will notify you. You can choose another doctor in the plan. • If you get health care outside the plan's network, you may have to pay the full cost. • It's important that you follow the plan's rules, like getting prior authorization when needed. • You may be able to get extra benefits for an extra premium.

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you follow the plan's rules.

(continued)

(continued)

Private Fee-for-Service (PFFS) Plan	Medical Savings Account (MSA) Plan
Sometimes. If your PFFS Plan doesn't offer drug coverage, you can to join a Medicare Prescription Drug Plan to get coverage.	No. You can join a Medicare Prescription Drug Plan to get drug coverage.
No.	No.
In most cases, yes. You can go to any Medicare-approved doctor or hospital if they agree to the plan's terms and conditions of payment before treating you. Not all providers will accept the plan's payment terms or agree to treat you.	Yes. Some plans may have network doctors and hospitals you could go to for a lower cost.
No.	No.
• PFFS Plans aren't the same as the Original Medicare Plan and they have different rules from other Medicare Advantage Plans. • PFFS Plans are offered by private companies. The private company, not Medicare, decides how much the plan will pay and how much you pay for services. • You may be able to get extra benefits for an extra premium. • Before you join a PFFS Plan, make sure you find doctors, hospitals, and other types of providers willing to contact the plan for payment information and accept the plan's payment terms.	• Medicare MSA Plans have two parts: a high-deductible health plan and a bank account. Medicare gives the plan an amount each year for your health care, and the plan deposits a portion of this money into your account. • You can use the money in your account to pay your health care costs. When you use account money for Medicare-covered Part A and Part B services, it counts toward your plan's deductible. After you reach your deductible, your plan will cover your Medicare-covered services. • Any money left in your account at the end of the year is added to your next deposit.

You should also contact the plan before you get a service to find out if the service is covered and how much it costs.

(continued)

How Do Medicare Advantage Plans Work? (continued)

	Special Needs Plan (SNP)
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage. Formularies may be designed to cover the drugs members need most.
Do I need to choose a primary care doctor?	In some cases, yes, or you may need to have a care coordinator help you develop personal care plans and coordinate your care.
Can I get my health care from any doctor or hospital?	You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). Plans typically have specialists for the diseases or conditions that affect their members.
Do I have to see a primary care doctor to get a referral to see a specialist?	In most cases, yes. Yearly screening mammograms and an in-network Pap test and pelvic exam (at least every other year) don't require a referral.
What else do I need to know about this type of plan?	• SNPs serve people who either 1) live in certain institutions (like a nursing home) or who require nursing care at home, or 2) are eligible for both Medicare and Medicaid, or 3) have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, mental illness, or HIV/AIDS). • A plan may limit membership to people in one of these groups or further limit membership within these groups. It may also enroll other people. • Plans manage the services and providers you need to help you stay healthy and follow your doctor's orders. For example, a SNP for people with diabetes might use a care coordinator to help you monitor your blood sugar, get needed preventive services, and get the right medicines to prevent complications. A plan for people with both Medicare and Medicaid may help you get help from your community and coordinate your health care. • If you have Medicare and Medicaid, check to make sure that all of the plan doctors or other health care providers you use accept Medicaid. • If you live in an institution, check to make sure that plan doctors or other health care providers serve people where you live. • You may be disenrolled if you no longer meet the plan's membership requirements, like if you lose Medicaid or leave the nursing home. If you are disenrolled, you will be returned to the Original Medicare Plan and will have 3 months to join another Medicare health or drug plan.

Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048.

Extrapolated Calculation of Oregon's Current Savings Attributable to the Use of the Prioritized List of Health Services

Background

In 1994, the State of Oregon began using its Prioritized List of Health Services to establish the benefit package for its Medicaid population under an 1115A demonstration waiver. The Health Services Commission, a volunteer, Governor-appointed 11-member body, prioritizes all health services based on their relative importance, using clinical effectiveness, cost-effectiveness, and social values gleaned from public forums (e.g. the importance of preventive measures and compassionate care) to establish the rankings. The current list being implemented is 730 line items long, with each line representing a combination of conditions and their treatments that the Commission has found to have similar rates of effectiveness and social importance (e.g. Line 1 includes treatments for moderate and severe head injuries and Line 730 includes the use of laser surgery for the treatment of nearsightedness or farsightedness). When the Oregon Legislative Assembly convenes every two years, they then set the funding level for the Prioritized List for the coming biennium, taking into consideration the resources needed for other state-funded programs such as education and public safety.

Overview of Methodology

This paper provides a rough estimate of the savings that can be attributed to Oregon's use of the Prioritized List of Health Services for the 2005-07 biennium and, using very broad assumptions, what those savings might extrapolate to on a national level should a similar model be used as part of a federal Medicaid reform package. It is stressed that an actuarial analysis would need to be performed in order to provide an accurate assessment of the savings being achieved by Oregon or potentially reached by other states.

This estimated savings for Oregon's use of the Prioritized List will be based on the actuarial pricing done by PricewaterhouseCoopers (PwC). The last period for which PwC priced the services falling below the funding line on the Prioritized List was for the 1997-99 biennium. At this point an adjustment will be made in order to account for those services that could likely continue to be excluded under Medicaid rules in the absence of a waiver, as these costs could not be counted as savings if they aren't being spent otherwise. This per-member per-month estimate will then be trended forward to 2005-07 dollars[1]. This will be done by looking at the increase in

[1] Oregon's budget cycle runs for two years from July 1st of an odd-numbered year through June 30th of the subsequent odd-numbered year. However, the State contracts with its managed care plans on a federal fiscal year and so PwC's projections are for the midpoint of the resulting two-year contracting period. Therefore this paper trends all numbers forward to the midpoint of the 2005-07 contracting period (October 1, 2006).

costs attributed to the services in the funded portions of Lists over the two time periods and then applying that same rate of increase to the costs of the below the line services.

Estimating Oregon's Savings Through the Use of the Prioritized List

The services appearing in the non-funded region of the Prioritized List for the 1997-99 biennium were calculated to have a PMPM of $20.18 by PwC[2]. One method for trending this amount forward into 2005-07 dollars is to use the increase seen in the funded services over this same time period and use that as an adjustment to the non-funded services. The PMPM for the anticipated benefit package to be funded for 2005-07 is $367.45 (Line 530)[3,4]. The nearest equivalent level on the 1997-99 Prioritized List for which pricing is available is Line 563, with a PMPM of $226.20. This results in an estimated cost for the non-funded services on the 2005-07 List of:

$20.18 * ($367.45/$226.20) = $32.78 PMPM

In an exercise in which four Oregon physicians familiar with the Prioritized List and Medicaid rules examined services falling below the funding line. It was estimated that 23% of the costs of below the line services can directly be attributed to the use of the Prioritized List and would be relatively easy to implement. Conversely, about 30% of these costs can be attributed to such items as infertility services, weight loss services, and radial keratotomy, which were excluded under Oregon's traditional Medicaid program prior to implementation of the Oregon Health Plan.

The degree to which the remaining 47% of the costs can be considered savings depends largely on how aggressively other states would deny coverage using the List and the degree to which they use current Medicaid rules to deny coverage now. Medicaid rules allow the denial of services that are considered cosmetic, not medically necessary, ineffective, or experimental. Examples of treatments in these categories could include: surgery for minor curvature of the spine; medical and surgical treatment of a simple goiter (enlarged thyroid); psychotherapy for anti-social personality disorders; and, liver transplantation for cancer of the liver. Another reason to be cautious in assuming too much savings from this 'grey area' is that there will need to be some exceptions process put in place. Oregon's current Medicaid

[2] Both the Prioritized List of Health Services and the PricewaterhouseCoopers actuarial pricing of the 1997-99 List are included in the Health Services Commission's report, Prioritization of Health Services: A Report to the Governor and Legislature, 1997.

[3] The Prioritized List of Health Services for the 2005-07 biennium is included in the Health Services Commission's report, Prioritization of Health Services: A Report to the Governor and 73rd Oregon Legislative Assembly, March 2005, available at www.oregon.gov/DAS/OHPPR/HSC/docs/BiReport05-07.pdf.

[4] PricewaterhouseCoopers' actuarial pricing for the 2005-07 Prioritized List of Health Services is included in the report, Oregon Health Plan Medicaid Demonstration, Analysis of Federal Fiscal Years 2006-2007: Average Costs, available at www.dhs.state.or.us/healthplan/data_pubs/rates-costs/pcc-report2005-2007.pdf.

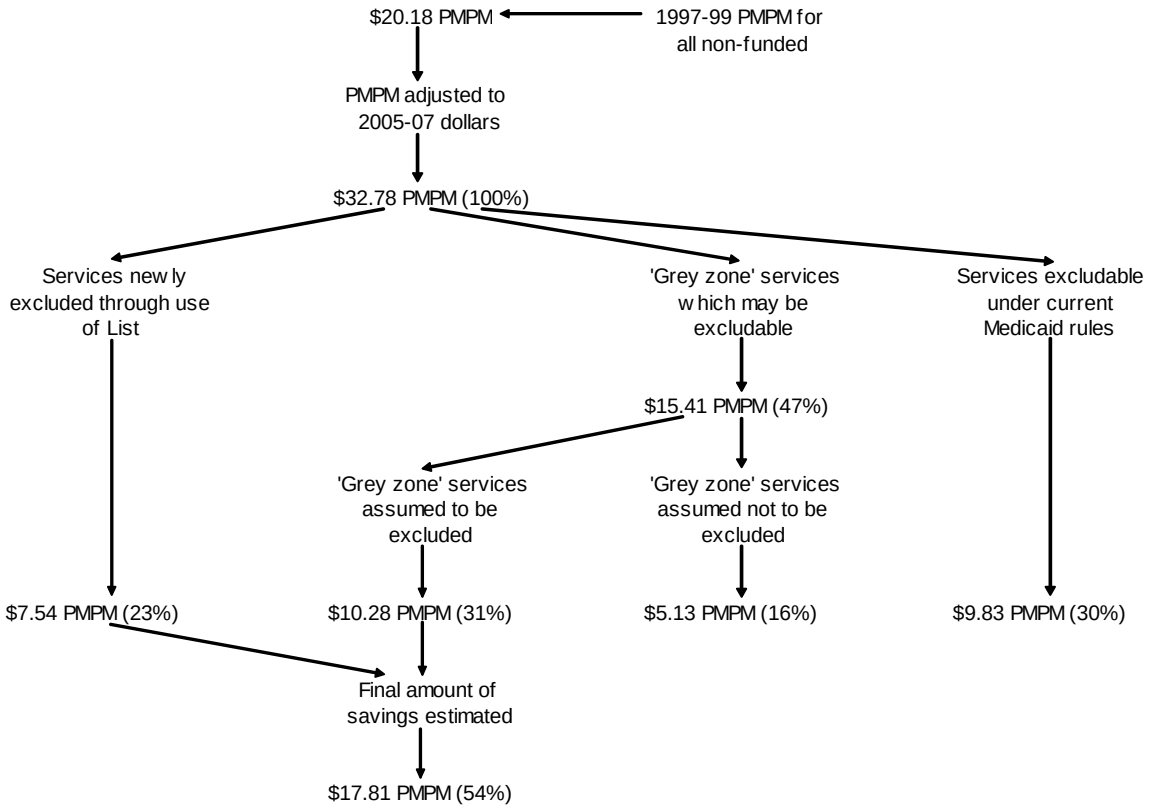
waiver requires what is known as the comorbidity rule. It states that if the treatment of a below-the-line condition will improve the effectiveness of services being used to treat an above-the-line condition, then coverage of the below-the-line service should be allowed. Of course the less stringent the exceptions process, the more savings to be realized.

For all of these reasons, the calculations do not include 100% of the costs of these 'grey area' services as savings specific to the use of the Prioritized List. If one assumes that, at best, 2/3 of these costs could be avoided after implementation of the List, this results in a total savings of 0.23 + (2/3*0.47) = 54% of the costs of services falling below the current funding line. The estimated savings Oregon can attribute to the use of the Prioritized List in 2005-07 dollars is then:

$$\$32.78 * [0.23 + (2/3*0.47)] = \$17.81 \text{ PMPM}$$

Figure 1 graphically summarizes the steps in arriving at this estimate. This equates to an estimated annual savings of $32.5 million to the State in general funds or $65 million for the 2005-07 biennium.

FIGURE 1
STEPS IN ESTIMATING OREGON'S SAVINGS



Caveats to the Calculation of Oregon's Savings

When considering the results of these calculations, a few caveats should be mentioned. Many changes have occurred in the Oregon Health Plan since the 1997-99 actuarial pricing was performed:

- The funding line has moved twice since then, resulting in a total of the exclusion of eleven additional line items. Examples include treatments for acute conjunctivitis, benign neoplasms of the bone, and contact dermatitis.
- The Health Services Commission has made many changes to the Prioritized List over this period that resulted in changes in the placement of line items and individual codes, again impacting their coverage status. Examples of conditions moving from a funded position of the List to a non-funded position include tension headaches and nasal polyps. While more lines tended to move downward (to a non-funded position) than upward during this period, an example of a service gaining coverage by way of a higher placement on this List is the treatment of Hepatitis C.
- The pricing associated with some of the below-the-line services would likely look very different today for some services. Most notably, additional savings would be seen from the denial of gastroplasty for morbid obesity when reflecting today's utilization levels.
- The populations covered in 1997-99 looked much different that they do now. At that time, expansion populations made up approximately 20% of the total enrollees, and they now account for only about 6%. Also, eligibility for pregnant women and children (as part of Oregon's SCHIP) was increased from 170% of the federal poverty level (FPL) to 185% of FPL.

In addition to these cautions, the actuarial pricing of prescription drugs is particularly problematic. The absence of ICD-9-CM diagnosis codes from prescriptions, and the use of specific drugs for the treatment of multiple conditions, makes it impossible to directly associate these costs with line items on the List. Therefore the manner in which these costs were apportioned over the entire Prioritized List will deviate from actual prescribing practices and the true savings will be somewhat different.

Extrapolating Oregon's Level of Savings to Other States

This methodology makes a fundamental assumption that should make it easier to approximate the savings to other states and the nation if Oregon's model were to be adopted elsewhere. The focus is on the savings achievable should the services appearing in the non-funded region of Oregon's List be treated as new exclusions to a benefit package. This assumes that all other benefits would be equal both before and after the implementation of the List took place in some other state.

The savings to Oregon of $17.81 PMPM translates into an estimated annual savings in federal funds of $48.5 million. Using the rule of thumb that Oregon accounts for

1% of the national Medicaid expenditures, this would extrapolate to a savings of $4.85 billion annually if adopted by all states.

Care should be taken when applying Oregon's experience to other states. The savings estimates presented here are based on factors specific to Oregon. The Medicaid populations covered, the overall benefit package offered, and the reimbursement rates paid to providers will be different in every state and will undoubtedly play a role in the potential savings attainable. Of these three areas, the one which may not be as apparent as the others is the effect of a state's overall benefit package. Here, the degree to which other states currently cover the services that are in the non-funded region of the Prioritized List will affect the level of savings. If a state doesn't currently cover a service in the non-funded region, there cannot be any savings by "adding" an exclusion for it.

OHFB Benefits Committee
Proposed Delineation of Responsibilities

Diagnostic Services Workgroup

Imaging services
Laboratory services
Genetic testing/counseling
Emergency department visits
Office visits
Exploratory surgery/biopsies

Ancillary Services Workgroup

Prescription drugs
Chemotherapy/radiation therapy
Injectibles
DME and medical supplies
Communication devices
Prosthetics/orthotics
Anesthesia
PT/OT/Speech therapy
Rehabilitation services
Translation services
Nutritional counseling
Enteral/parenteral nutrition
Case management
Care management
Patient education
Wellness promotion/incentives
Transportation
Home health services
Private duty nursing

End-of-life Care Workgroup

Hospice care
Palliative care
Pain management
Death With Dignity Act services
Heroic treatment
Polst registry

Benefits Committee

Medical-surgical services
Behavioral health services
Dental care
Vision services
Hearing services
Reproductive services
Infertility services
Complimentary care
Preventive services
Chronic disease management
Evidence-based medicine
Personal responsibility
Reduction of health disparities

Oregon Health Fund Board

Benefits Committee

November 8, 2007

Clackamas Community College
Wilsonville Campus Training Center, Room 112
29353 Town Center Loop East
Wilsonville, Oregon

Oregon Health Fund Board

Benefits Committee Meeting

Thursday, November 8, 2007
9:30 am – 1:30 pm
Room 112
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Susan King	
5 min	Approval of Agenda and Minutes	Susan King	X
9:35 am 20 min	Update on Board/Committee Activities - Action on By-laws and Charter	Susan King, Darren Coffman	
9:55 am 5 min	Nominations & Election of Vice Chair(s)	Susan King	X
10:00 am 10 min	Review of Charter	Susan King	
10:10 am 40 min	Demographic Characteristics of the Uninsured in Oregon	Sean Kolmer	
10:50 am 50 min	Overview of OHP Benefits and the Prioritized List of Health Services	Darren Coffman, Som Saha	
11:40 am 10 min	Break		
11:50 am 70 min	Discussion on the Use of the Prioritized List for Defining a Set of Essential Health Services - Working lunch served at Noon	Susan King	?
1:00 pm 20 min	Public Testimony	Susan King	
1:20 pm 10 min	Next Steps	Susan King	
1:30 pm	Adjourn	Susan King	

Draft Minutes
Oregon Health Fund Board Benefits Committee
October 17, 2007

Members Present: Susan King, RN, Chair; Gary Allen, DMD; Lisa Dodson, MD (arrived at 9:42 a.m.); Tom Eversole; Leda Garside, RN, BSN; Betty Johnson; Bob Joondeph; Somnath Saha, MD, MPH, Nina Stratton; Kathryn Weit.

Members Absent: Jim Lussier; Susan Pozdena.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Nathan Hierlmaier, MPH; Dorothy Allen; Barney Speight; Tina Edlund.

Also Attending: Bill Kramer, Dept. of Business and Consumer Services; Cheryl Martinis, Office of Private Health Partnerships; Laura Smith, Dave Barroughs & Associates; Emily Katz, CareOregon; Diane Danowski Smith, The Ulum Group; Beryl Fletcher and Fawn McNeely, Oregon Dental Association; Jane-ellen Weidanz, Oregon Association of Hospitals and Health Systems; Amy Goodall, Oregon Medical Association; Kim Wirtz; Regence; Diane Danowslei; Jake Oken-Berg, Kaiser Permanente.

I. Call to Order

Darren Coffman, serving as lead staff, called the Benefits Committee meeting to order at 9:35 a.m. in room 110 at the Clackamas Community College Wilsonville Training Center, 29353 SW Town Center Loop East, Wilsonville, Oregon. He then called the roll.

Mr. Coffman welcomed the committee members and thanked them for serving in this important endeavor.

II. Review of Bylaws

Mr. Coffman indicated that the Oregon Health Fund Board (Board) would be maintaining control over the committee bylaws so that they can be uniform across all committees. Barney Speight said that they had been patterned after the bylaws approved at the Board level. It was felt that they were unclear as to whether members would be allowed to add agenda items at the beginning of the meeting.

MOTION: Recommended that the Board adopt the committee by-laws as submitted by staff (see Attachment A), with additional clarification in Article IV that the committee will finalize the agenda at the beginning of each meeting. MOTION CARRIES: 9-0 (Absent: Saha).

III. Introductions of Committee Members & Staff

Committee members, staff, and audience members went around the room and introduced themselves.

IV. Nominations & Election of Committee Chair and Vice Chair

Mr. Coffman outlined the duties of chair and vice-chair as laid out in the bylaws and opened the nominations for Chair of the Benefits Committee. Kathryn Weit nominated Susan King. Hearing to further nominations, a motion was passed unanimously to close the nomination process.

MOTION: Susan King be elected Committee Chair. MOTION CARRIES: 10-0.

Hearing no nominations nor volunteers for vice-chair it was decided to postpone election of that position until the next meeting.

V. Introduction to SB 329 Reform Process and Assumptions for Reform

Mr. Speight thanked the members on behalf of the Board and the Governor for their willingness to serve on the Committee.

He described the charge of Board as the development of a comprehensive plan to extend coverage to Oregon's uninsured through a delivery system that is efficient and effective and provides timely access to quality health care in a sustainable manner. The work will be done through the five committees called for in the bill, those on benefits, finance, delivery systems, enrollment & eligibility, and federal policy, as well as a sixth on health disparities. The latter committee being established at the request of the Board will make recommendations on reducing disparities due to race, ethnicity, gender and geography.

Mr. Speight went through the set of design assumptions shown in page two of Attachment B that will frame the work of the Board. The assumptions were developed from the nine recommendations of the Health Policy Commission in their report to the legislature titled *A Roadmap to Health Care Reform* and the similar conclusions reached by the Oregon Business Council. Key to these assumptions is the inclusion of an individual mandate, a 'pay or play' requirement of employers, and an exchange through which subsidies can be administered. He pointed to the plan enacted by Massachusetts and that currently being negotiated in California between the Governor and the legislature as being potential models to borrow from.

Mr. Speight noted that SB 329 calls for the Benefits Committee to define a single set of essential health services, but suggested that conversations occur as to whether a range of benefit options may be more appropriate. For example, should a fully-subsidized plan for the poor look the same as non-subsidized benefits available to families with incomes of 400% of the federal poverty level (FPL) and above. He described the uninsured population as a triad: 1) those in or near poverty up to 100-150% FPL

through which the Oregon Health Plan (OHP) was designed to serve, which he assumes will be heavily if not fully subsidized, 2) those at relatively high incomes levels who would be required to pay for their own insurance plan without subsidy, and 3) those in the middle, maybe up to 350-400% FPL, which will likely require subsidies on a sliding-scale basis and will be the one segment of the three that will likely present the most challenge to the committee. While the minimum benefit package may be different for these populations, a floor could be established below which no coverage could fall below. He sees the discussion around benefit design as including a comparison of the use of the Prioritized List of Health Services versus the structure of commercial benefit plans. Staff will bring examples of what other states are providing to various populations, including the Washington Basic Health Plan.

Susan King clarified that the committee's initial charge from SB 329 is to look at establishing a single set of essential health services and first examining the Prioritized List as a tool for accomplishing this. Mr. Speight confirmed this, but suggested that the committee may find that this works very well for low-income populations, but as focus shifts to higher income populations the benefit package may have to more closely resemble a commercial plan.

Bob Joondeph wondered how the essential benefits established through this process would be affected by other legislative mandates. Mr. Speight acknowledged that there would likely continue to be forces mandating benefits outside of this process but that the committee would have to work under the assumption of the current system. He believes the essential benefit package would establish a floor for the individual market but was unsure of what affect there would be on benefits offered in the group market. On a positive he noted the issue of mental health parity has already been resolved.

Dr. Som Saha felt that there was a question of whether the committee should work towards 'building the perfect beast' or designing something that was more pragmatic in nature. He is concerned that time will not allow intercommunication with the Delivery Systems Committee to insure that the resulting benefit package is feasible. Mr. Speight answered through a comment that arose from Senator Bates' comments during a meeting of the Interim Senate Committee on Health Care Reform that he is not looking for a narrative report that simply collects dust, but rather something that can truly be implemented. Therefore the committee should keep an eye on what is pragmatic, but be driven by the principles. Further, staff communications, the chairs of the committees acting as ex-officio members of the Board, and a board member acting as a liaison to each committee, should hopefully foster communication between the committees. An example of this will be discussions to occur in multiple arenas on the revitalization of primary care and the fact that staff can provide consistent materials to all of the groups having those conversations.

VI. Review of Draft Committee Charter, Use of Workgroups vs. Ad Hoc Task Forces; Timeline

Staff developed a draft charter that Mr. Speight reviewed with the committee (page 1 of Attachment B). The Board will hold a mini-retreat on October 30th where they will finalize the charters for all of the committees.

The committee will have the option of breaking into smaller workgroups should particular topics warrant that. Individuals with particular expertise will also be brought into the discussions, with a contractor for independent actuarial analysis being a part of this towards the spring.

A timeline was distributed that used the Board's report to the legislature on October 1, 2008 as the endpoint, and then worked backwards from there. This means that sometime in March or April the core recommendations of the committees will need to have been formed. Modeling will then need to be done, hopefully by Jonathan Gruber, who sits on the Massachusetts Connector Board and did all of the modeling for both Massachusetts and California. Then the Board can develop the draft comprehensive plan to take out for public comment in late June and into July. Those comments can then be taken into consideration as the plan is refined and documented in the final report.

Of further note is that the Enrollment & Eligibility Committee will be looking at issues around affordability, which will need to align with the work of the Benefits Committee down the road.

Susan King commented that the tight timeline would require the committee to stick to their core directives and identify as secondary those topics that overlapped with the work of other committees. Mr. Speight agreed and suggested that the committee start with an examination of the work of the Health Services Commission and initially focus discussions on the low-income portion of the triad. The key question being should the Prioritized List continue to form the basis of the benefits for these individuals and, assuming a stable funding stream, should the OHP Standard benefit package continue to look as it currently does, or should it more resemble the OHP Plus package. A single meeting may be all that is required to look at essential benefits for the higher-income population and by that time the Enrollment & Eligibility Committee will have reached conclusions on affordability, which the Benefits Committee can then use in discussing benefits for the partially-subsidized population. He warned that the time constraints will likely force the committee to move faster than they would like. He envisions that staff will bring options forward to the committee for consideration to move the process along.

Dr. Saha sees cost-sharing as being an important tool in defining what is essential. Those services that are more essential can have less or no cost-sharing and those that are less essential require more individual contribution. He sees keys to this process as understanding the target populations and the incorporation of value-based insurance design. The latter concept was defined as one in which services with more value, such as chronic disease management, have lower cost-sharing and services with little value have higher cost-sharing (as opposed to value-based purchasing where purchasers

being able to identify value, in the way of better outcomes, in the benefits that they are buying for their employees/clients).

Susan King would like to see discussion around whether the committee should be defining a single set of essential services for everyone under the comprehensive reform plan or should define different sets of services for target populations (e.g., by income, age). She felt that someone who is 62 years old, thin and rich will have the same health care needs as someone 24 years old, thin and poor. Dr. Saha confirmed that the Health Services Commission had reached similar conclusions in prioritizing services, but the distinction could shift from what is a covered service to what cost-sharing may be imposed on a particular service. It was observed that most services are covered under a commercial benefit plan (with cost-sharing being the variable), whereas the Prioritized List is unique in that it explicitly identifies services that are not covered at all (and has little or no cost-sharing associated with the services defined to be covered).

Betty Johnson urged that the legislature be kept apprised on the Board's work instead of just handing them a report when it is finished. Mr. Speight indicated that discussions occurred at the legislative committee meeting the day before about how that can take place.

Nina Stratton asked whether a brief overview of the Massachusetts plan could be distributed. Mr. Speight indicated that such a document was already under construction. Ms. Stratton also asked whether there were examples of evidence-based design already in place, particularly in the area of chronic disease management. Mr. Speight report that locally there are team-based approaches being piloted in primary care settings that integrate behavioral and physical care and are showing savings in a public setting.

VII. Public Testimony

No public testimony was offered at this time, although it was noted in response to a question that all materials distributed to the committee will be made available to the public through the Board's website at http://healthfundboard.oregon.gov.

VIII. Future Meetings

The next meeting was set for Thursday, November 8, 2007 from 9:30 am – 1:30 pm at a location to be determined. Polling of members using Meeting Wizard will be done to schedule further meetings. The agenda for the November 8 meeting will include presentations on the work of the Health Services Commission in prioritizing health services using an evidence-based approach and the characteristics of the uninsured.

IX. Adjourn

Susan King adjourned the meeting at 11:27 am.

ATTACHMENT A

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE
Draft By-Laws
Adopted by OHFB _____

ARTICLE I
The Committee and its Members

- The Benefits Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.
    - Coordinate meeting agendas after consultation with Committee staff.

- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

ATTACHMENT B

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for the defined set(s) of essential health services, the committee shall consider:

- Mechanisms for setting priorities that optimize the health of Oregonians;
- The demographic characteristics of the uninsured (e.g., age, gender, family status, income) in examining what services would best meet their needs in an affordable manner;
- The applicability of the HSC Prioritized List of Health Services;
- Methods for collecting and incorporating public values of those who will potentially benefit from and potentially contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
- The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
- An emphasis on preventive care and chronic disease management;
- Approaches that promote integrated systems of care centered on a primary care home;
- Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
- The needs of vulnerable populations in order to reduce health disparities;
- The definition and inclusion of services for dignified end-of-life care;
- Education activities that further health and wellness promotion;
- Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
- Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

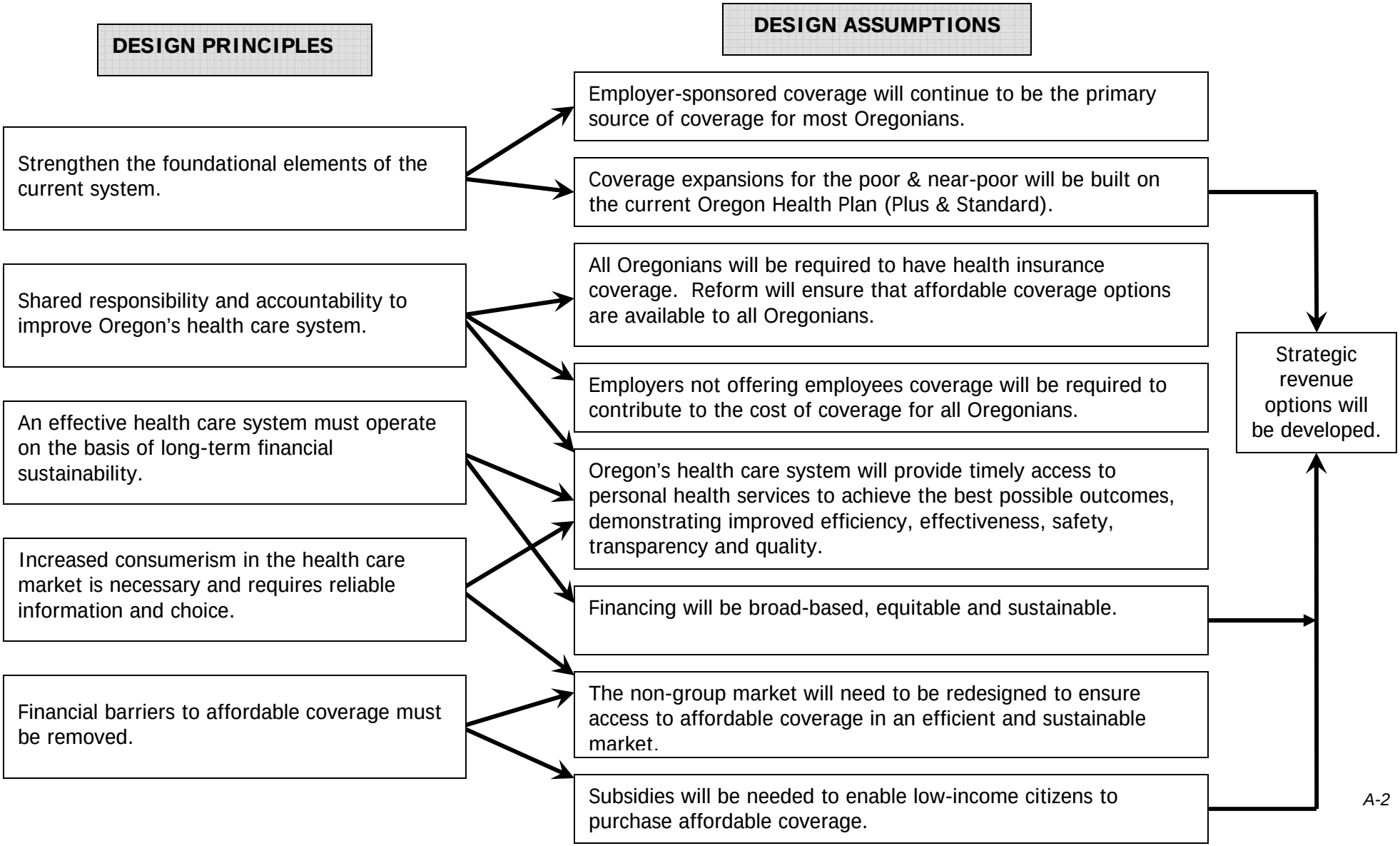
Staff Resources

Darren Coffman – Lead staff
Ariel Smits, MD – Clinical staff
Dorothy Allen – Administrative staff
Barney Speight – Director, OHFB
Brandon Repp – Research staff
Nate Hierlmaier – Research staff

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OREGON HEALTH FUND BOARD
A Comprehensive Plan for Reform: Design Principles and Assumptions
Approved by OHFB _____



DRAFT 11/2/2007

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER
Approved by OHFB on _____

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13) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council Developmental Disabilities	Salem

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director - Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research staff, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

2007 Federal Poverty Levels

	Average Hourly Income*						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 4.91	$ 9.09	$ 9.82	$ 14.73	$ 17.18	$ 19.64
$ 13,690	2	$ 6.58	$ 12.18	$ 13.17	$ 19.75	$ 23.04	$ 26.33
$ 17,170	3	$ 8.26	$ 15.28	$ 16.51	$ 24.77	$ 28.89	$ 33.02
$ 20,650	4	$ 9.93	$ 18.37	$ 19.86	$ 29.79	$ 34.75	$ 39.72
$ 24,130	5	$ 11.60	$ 21.47	$ 23.20	$ 34.81	$ 40.60	$ 46.41
$ 27,610	6	$ 13.28	$ 24.56	$ 26.55	$ 39.83	$ 46.46	$ 53.10
$ 3,480	*each add'l person*	$ 1.67	$ 3.10	$ 3.35	$ 5.02	$ 5.86	$ 6.69

	Average Monthly Income**						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 851	$ 1,575	$ 1,702	$ 2,553	$ 2,978	$ 3,404
$ 13,690	2	$ 1,141	$ 2,111	$ 2,282	$ 3,423	$ 3,993	$ 4,564
$ 17,170	3	$ 1,431	$ 2,648	$ 2,862	$ 4,293	$ 5,008	$ 5,724
$ 20,650	4	$ 1,721	$ 3,184	$ 3,442	$ 5,163	$ 6,023	$ 6,884
$ 24,130	5	$ 2,011	$ 3,721	$ 4,022	$ 6,033	$ 7,038	$ 8,044
$ 27,610	6	$ 2,301	$ 4,257	$ 4,602	$ 6,903	$ 8,053	$ 9,204
$ 3,480	*each add'l person*	$ 290	$ 537	$ 580	$ 870	$ 1,015	$ 1,160

	Average Yearly Income***						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 10,210	$ 18,889	$ 20,420	$ 30,630	$ 35,735	$ 40,840
$ 13,690	2	$ 13,690	$ 25,327	$ 27,380	$ 41,070	$ 47,915	$ 54,760
$ 17,170	3	$ 17,170	$ 31,765	$ 34,340	$ 51,510	$ 60,095	$ 68,680
$ 20,650	4	$ 20,650	$ 38,203	$ 41,300	$ 61,950	$ 72,275	$ 82,600
$ 24,130	5	$ 24,130	$ 44,641	$ 48,260	$ 72,390	$ 84,455	$ 96,520
$ 27,610	6	$ 27,610	$ 51,079	$ 55,220	$ 82,830	$ 96,635	$ 110,440
$ 3,480	*each add'l person*	$ 3,480	$ 6,438	$ 6,960	$ 10,440	$ 12,180	$ 13,920

* Computed using Monthly Family Income divided by 173.33 (average monthly work hours for a full time employee) and rounded using normal round

** Computed using HHS Yearly Income multiplied by FPL percent, divided by 12 (months) and then rounding the product up to the nearest dollar.

*** Computed using HHS Yearly Income multiplied by FPL percent and rounded using normal rounding conventions (0-49 down and 50-100 up)

Trends in Coverage Oregon, 2006

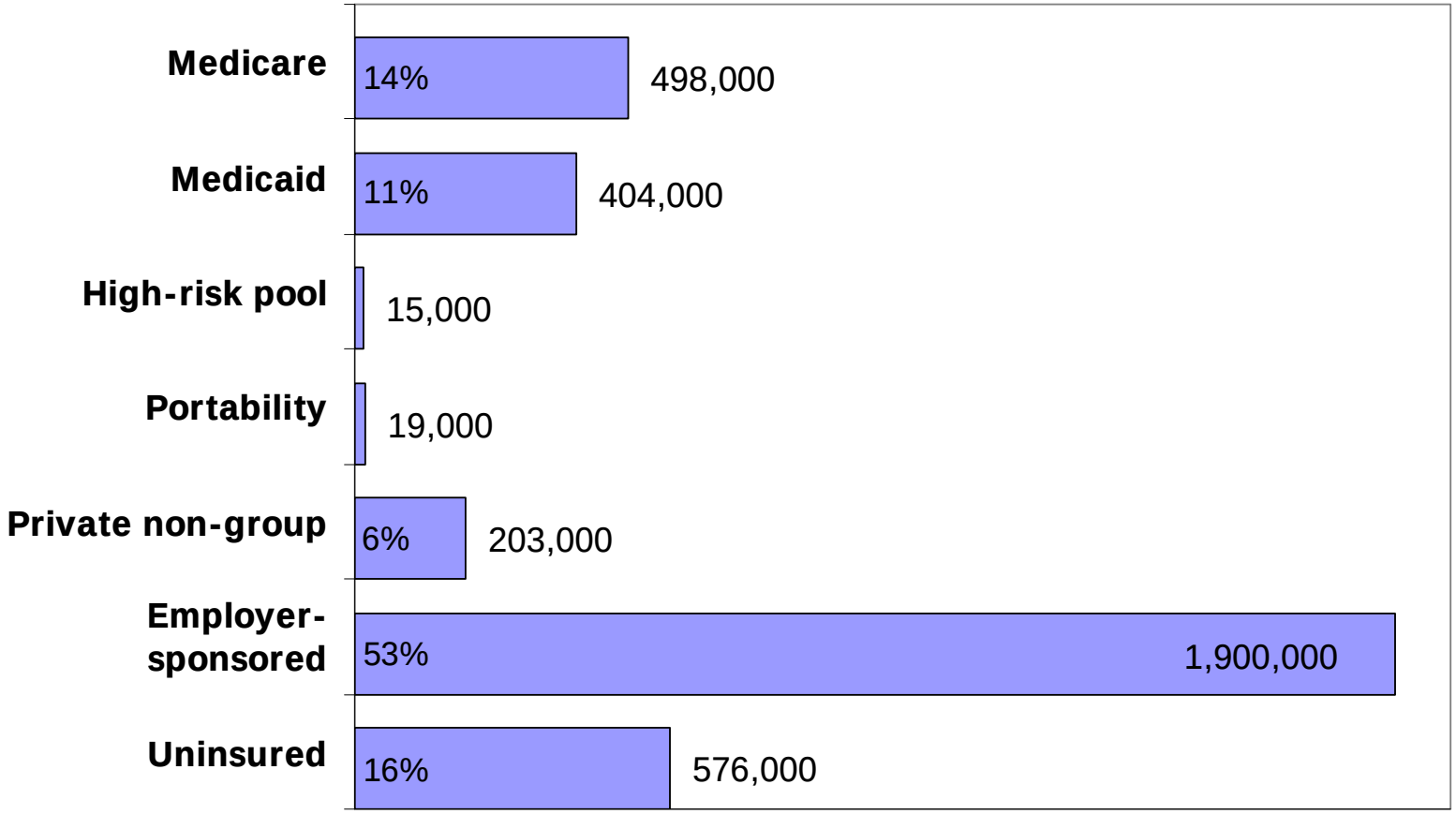
Presentation to the

Oregon Health Fund Board

October 30, 2007

The majority of Oregonians are covered by employer-sponsored insurance

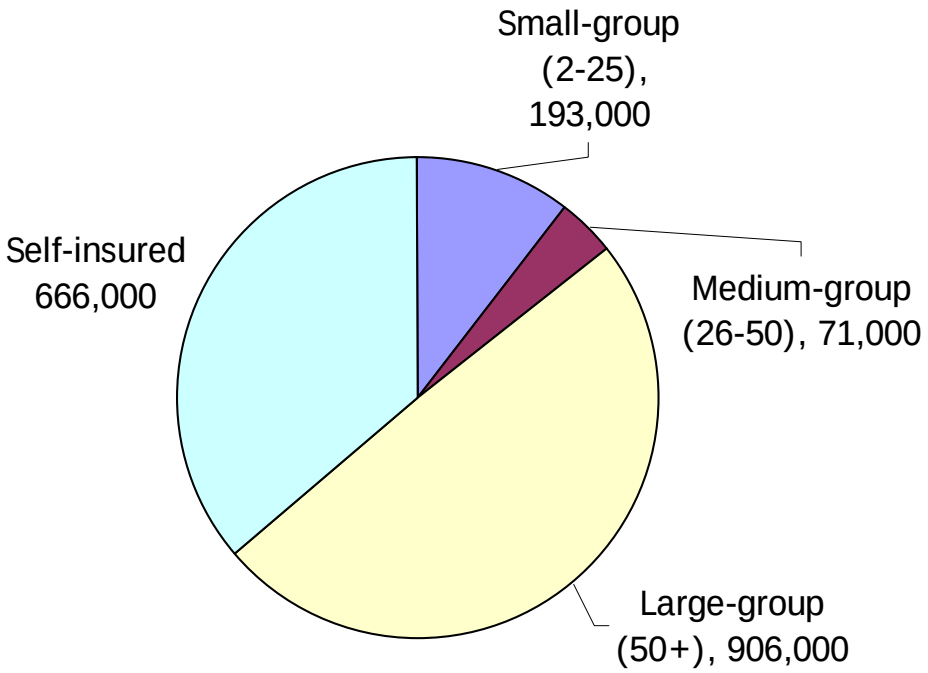
(Oregon population = 3.7 million)



Sources: Uninsured: 2006 Oregon Population Survey, Medicaid: DMAP August 2006 Eligibility Report, Medicare: CMS, 2005 State Report, High-Risk Pool, Portability and Private Non-Group: DCBS, "Health Insurance in Oregon", Jan. 2007, Employer-Sponsored: Kaiser Family Foundation, www.kff.org.

Roughly half of commercially insured are in large group coverage…

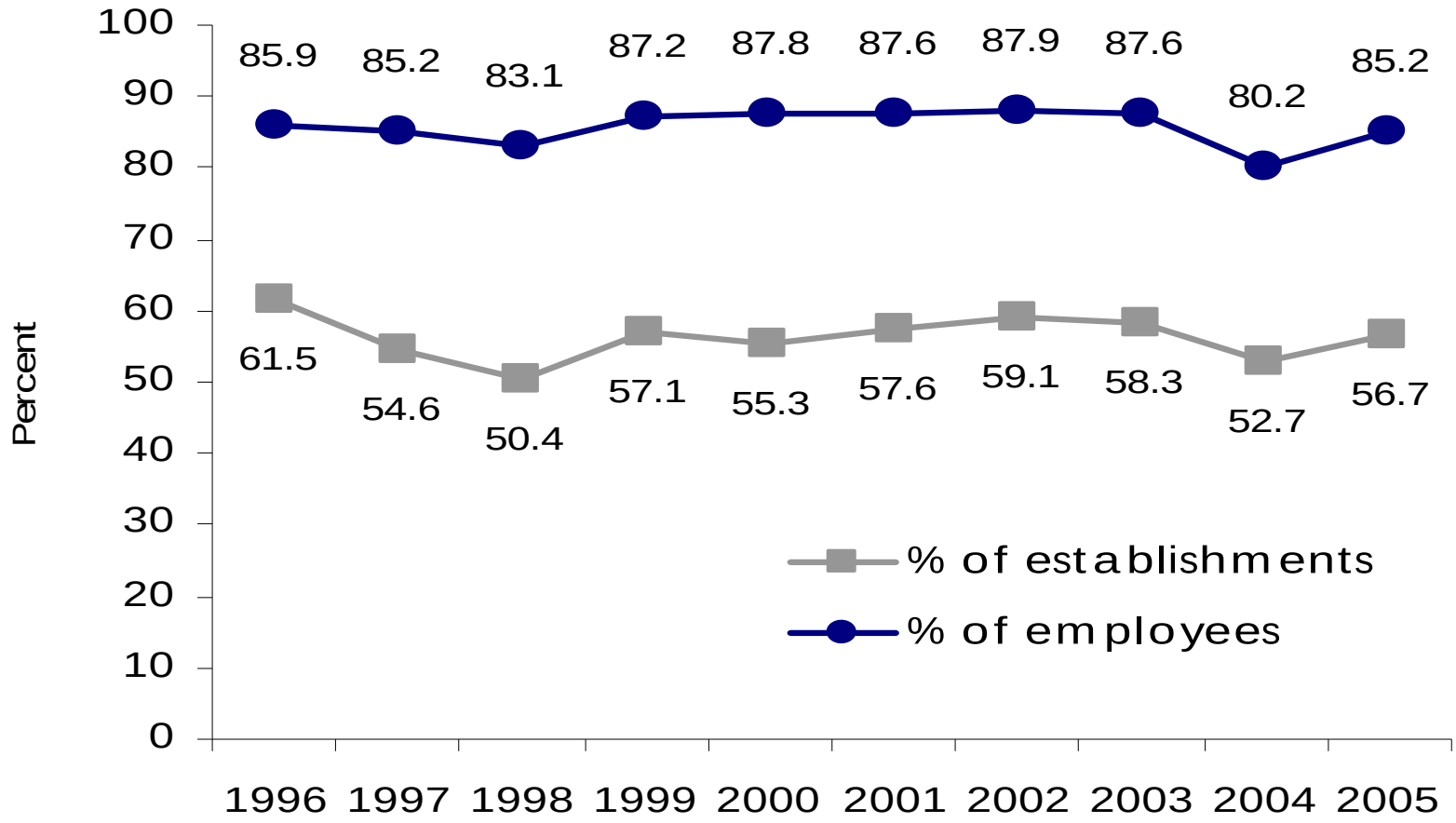
Distribution of commercial insurance in Oregon



Source: Department of Consumer and Business Services, January 2007

The percent of private businesses offering health insurance coverage has not changed significantly…

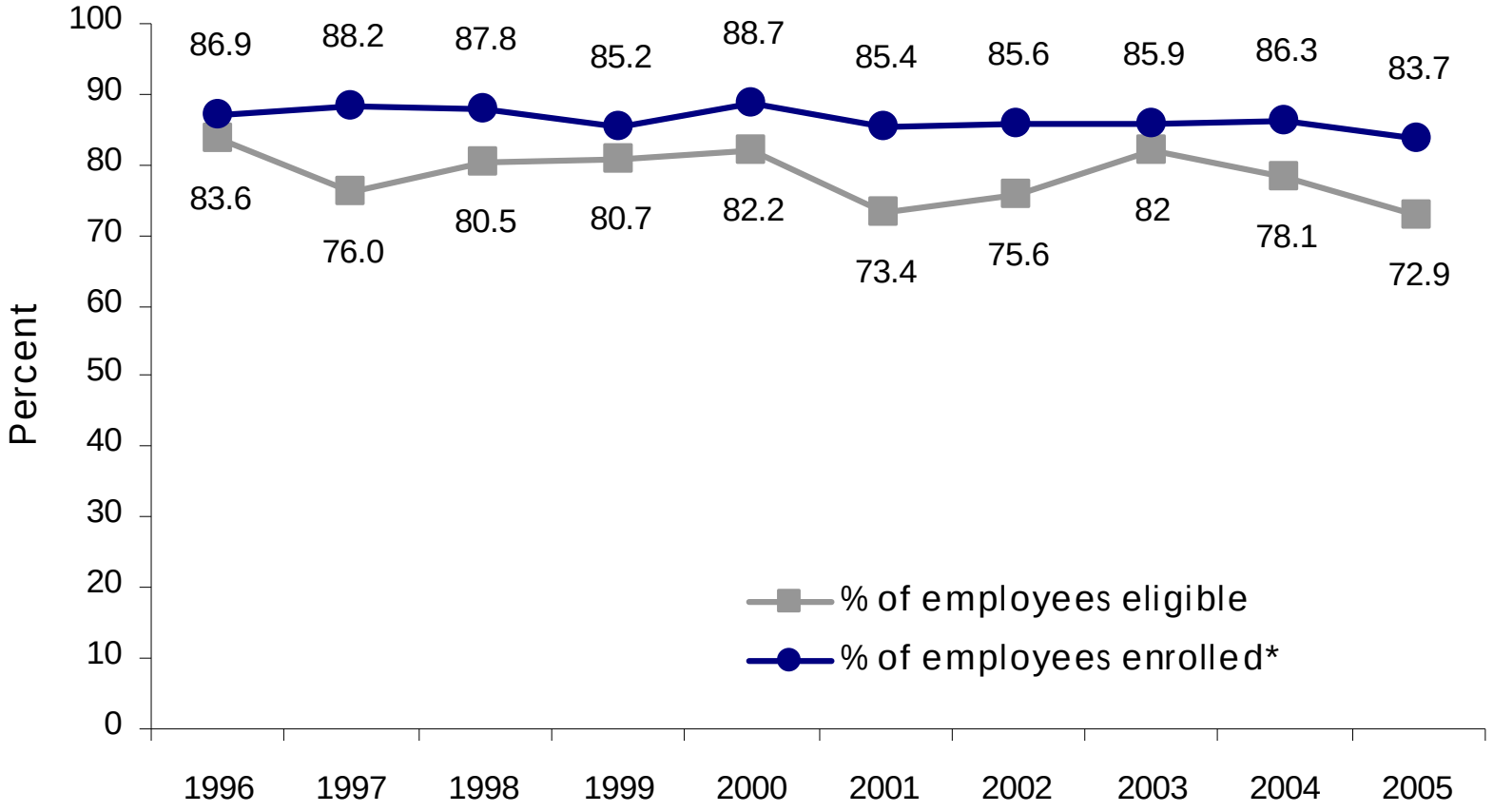
Percent of private establishments providing health insurance and percent of private employees working for businesses that offer insurance, Oregon



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

But the percentage of Oregon employees who are eligible has declined

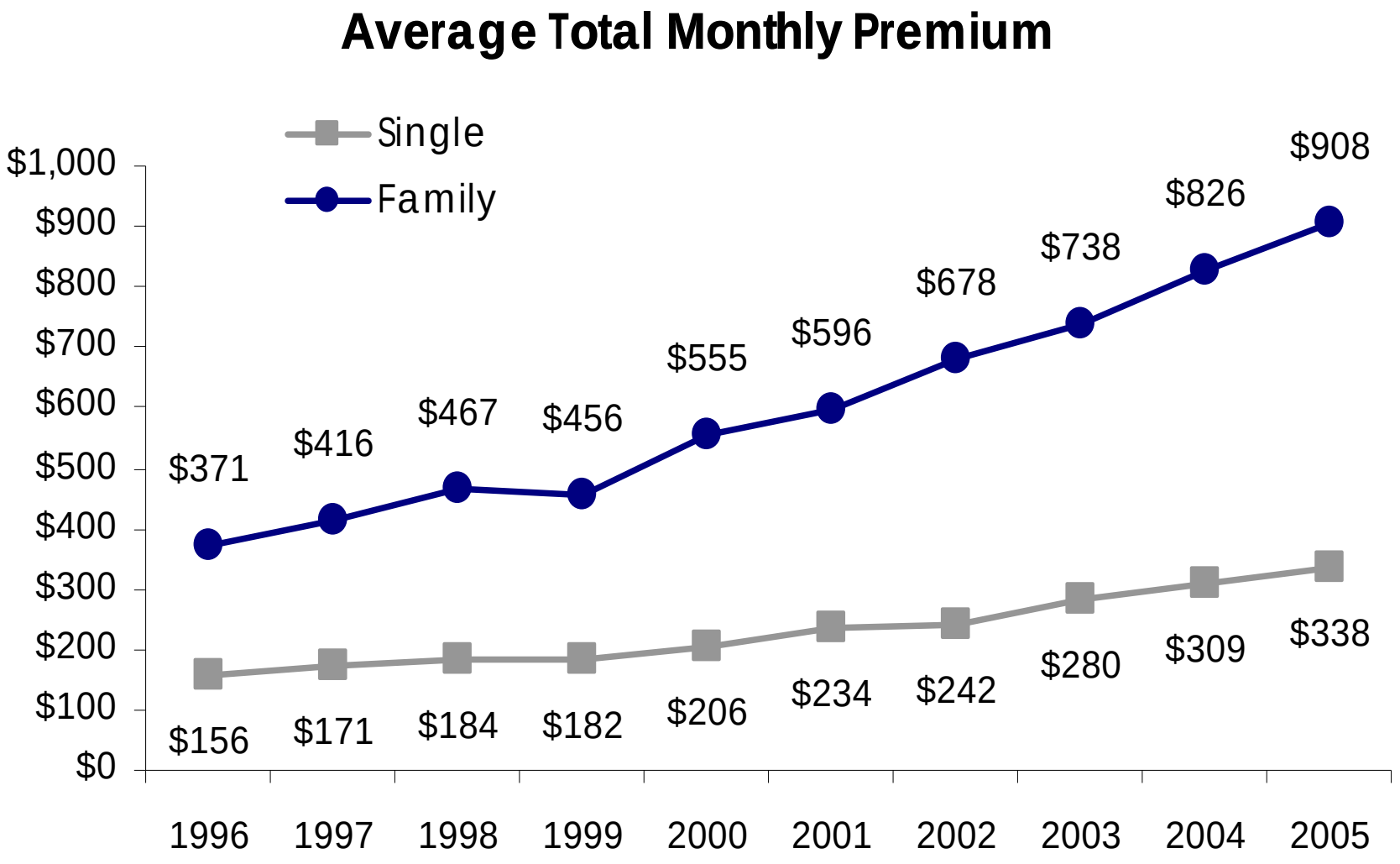
Percent of private employees eligible for employer-sponsored insurance and the percent of those eligible who are enrolled, Oregon



*As a percent of those eligible.

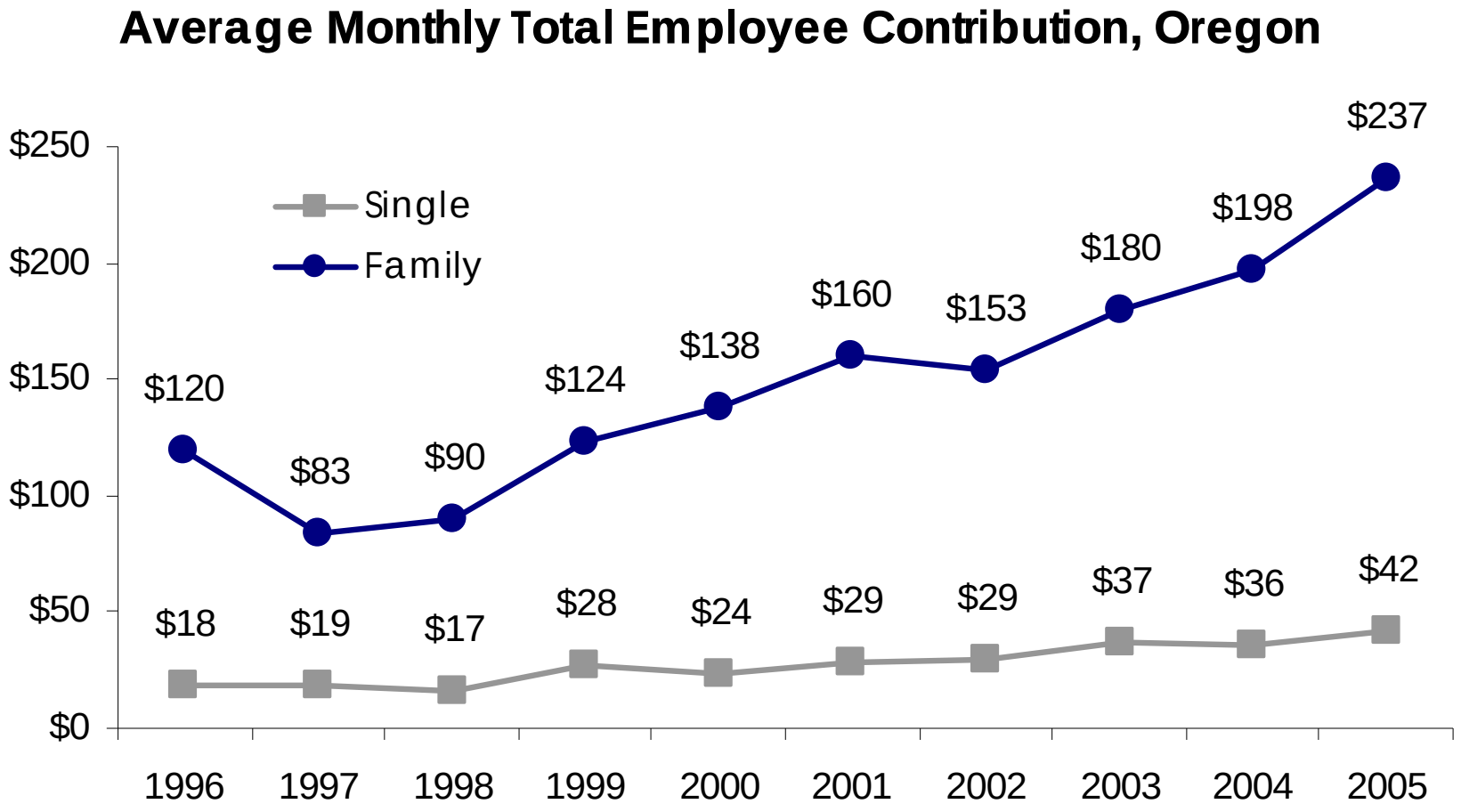
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Premium costs have steadily increased in Oregon.



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Employee contribution requirements have increased as premium costs grow…

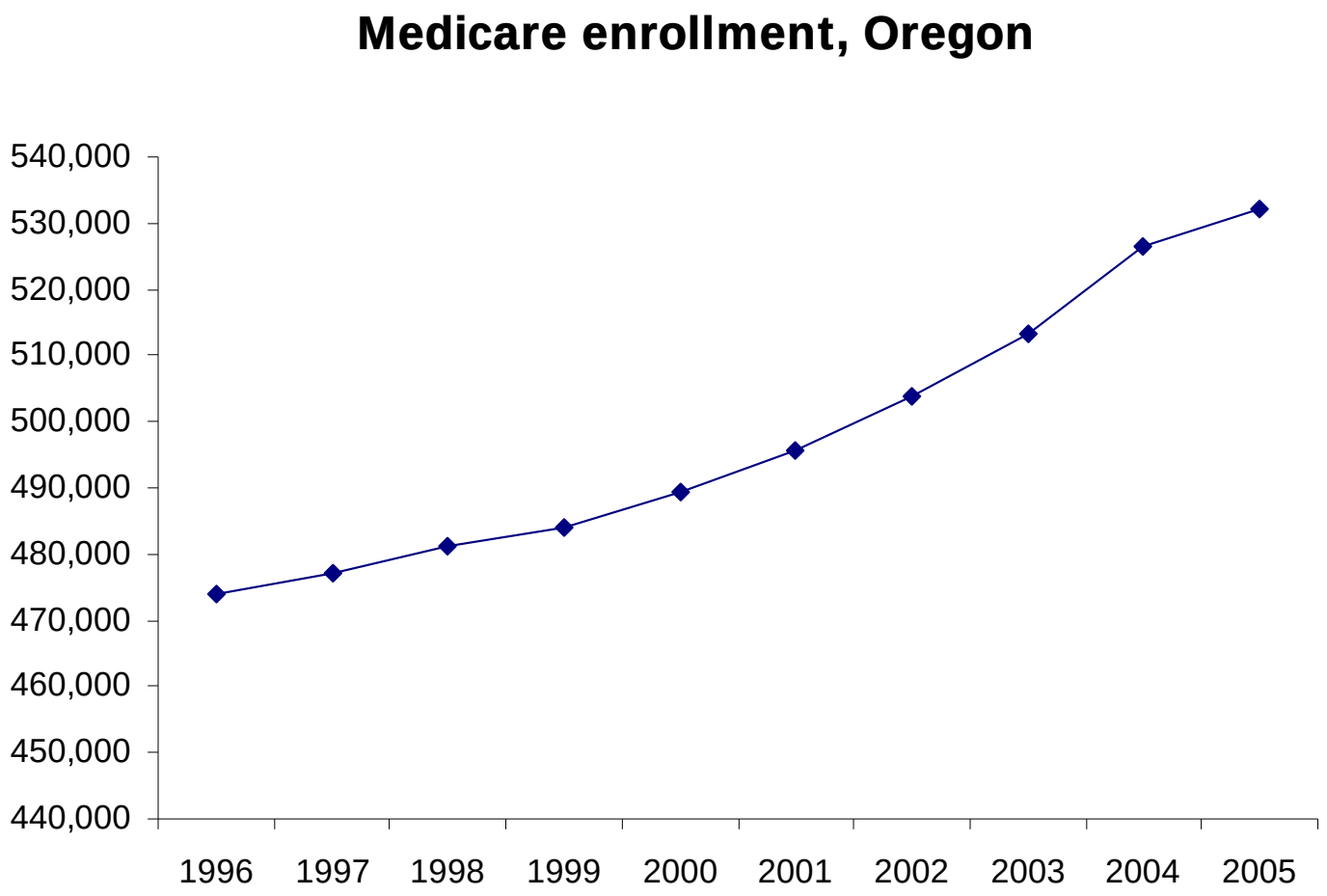


Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Medicare

- Medicare is a federal insurance program for people age 65 and older and certain disabled people. The Centers for Medicare & Medicaid Services (CMS) operates Medicare.
- Medicare is funded by the federal government with no state participation.

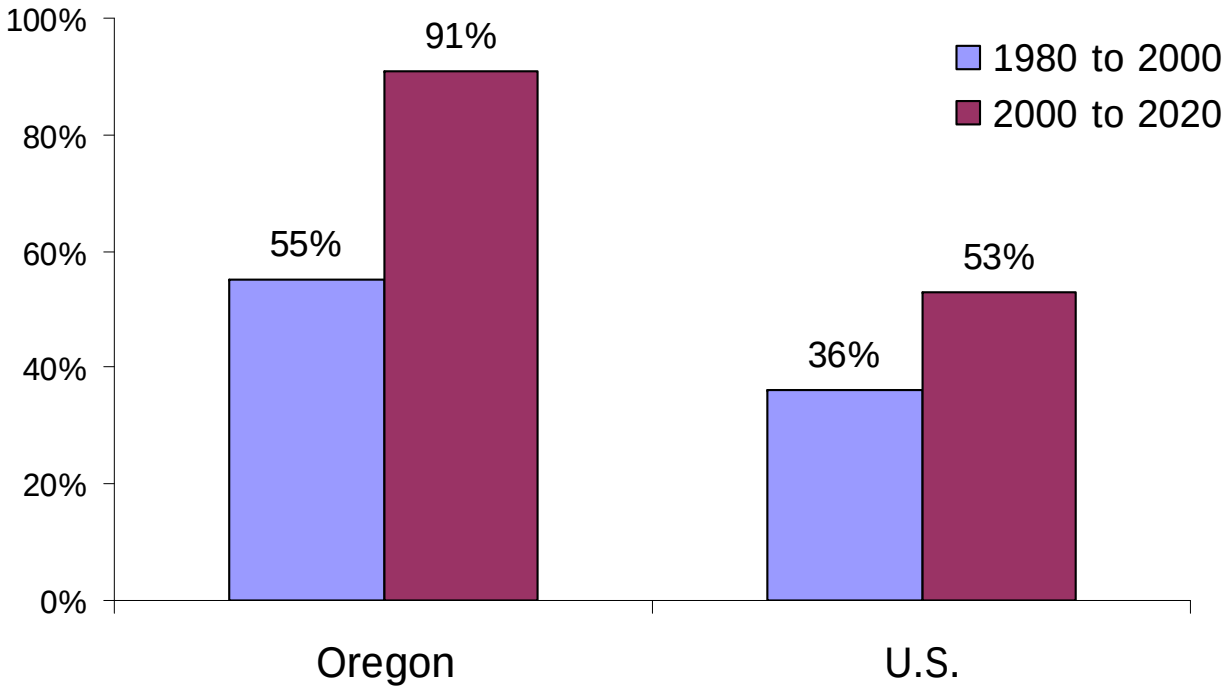
Medicare enrollment has grown as the population ages…



Source: Centers for Medicare & Medicaid Services, Medicare State Enrollment, 2005.

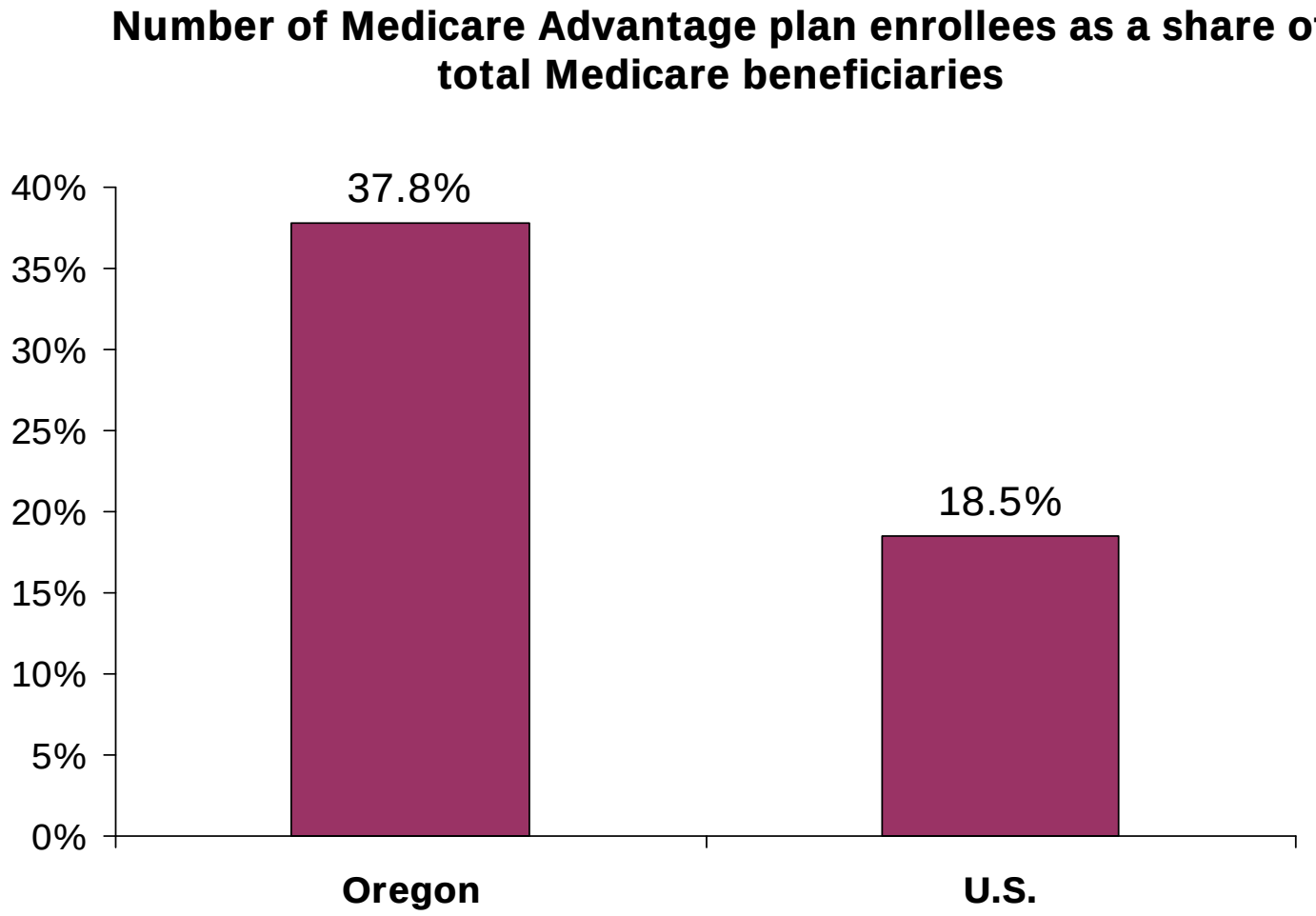
Oregon's 65+ population is increasing rapidly…

Projected percentage change in population 65+ years of age



Source: 2000 HRSA Report – Oregon Profile

Oregon leads country in Medicare Advantage enrollment *



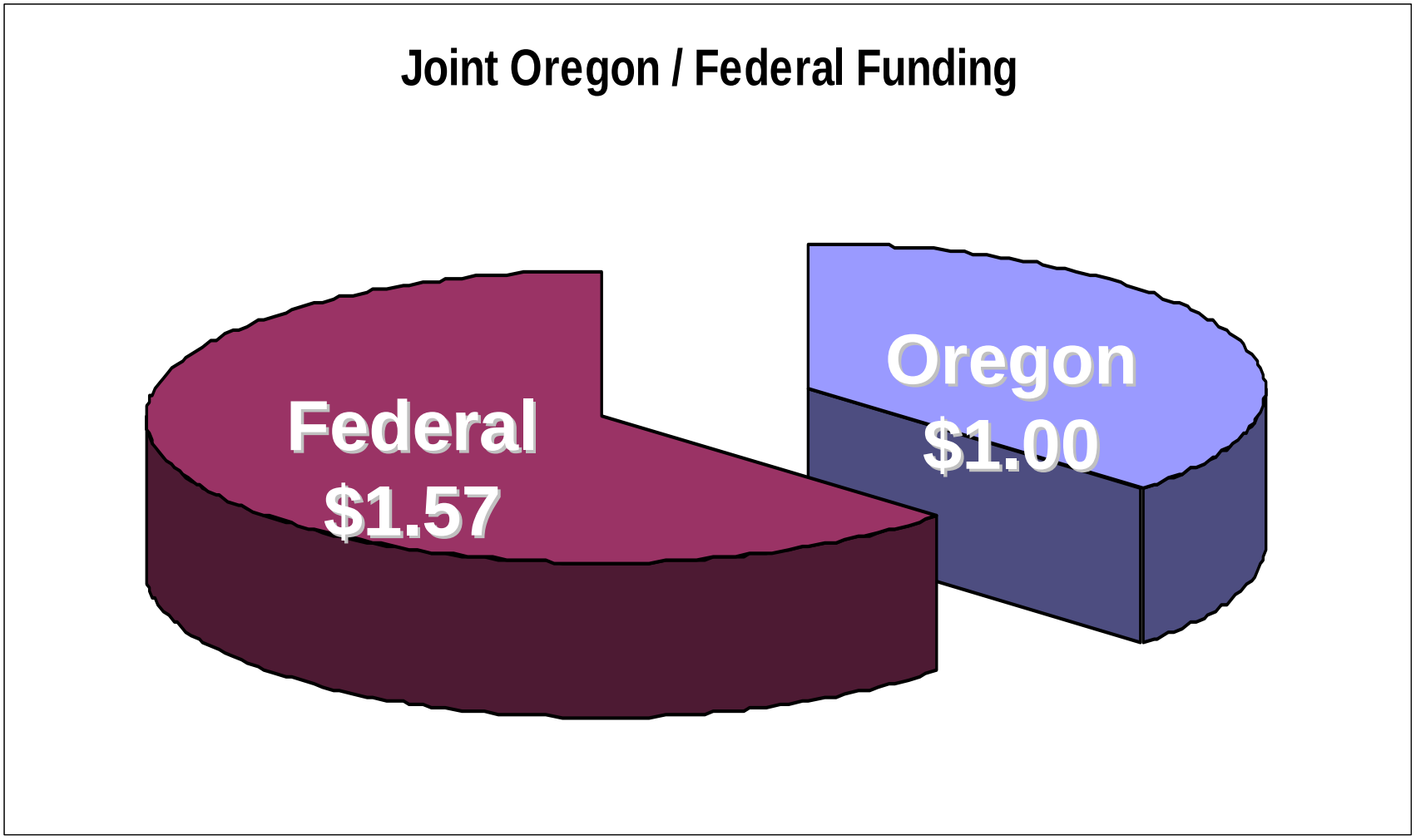
*Puerto Rico has MA penetration rate of 53.3%; OR has highest rate of states

Source: Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker

Medicaid

- Medicaid is a program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals and nursing home residents. These individuals must meet certain income and other requirements.
- Medicaid funding is shared between the federal and state government.

Medicaid is a State/Federal Partnership



Who is covered by the Oregon Health Plan?

"OHP Plus" program

Mandatory Medicaid Populations

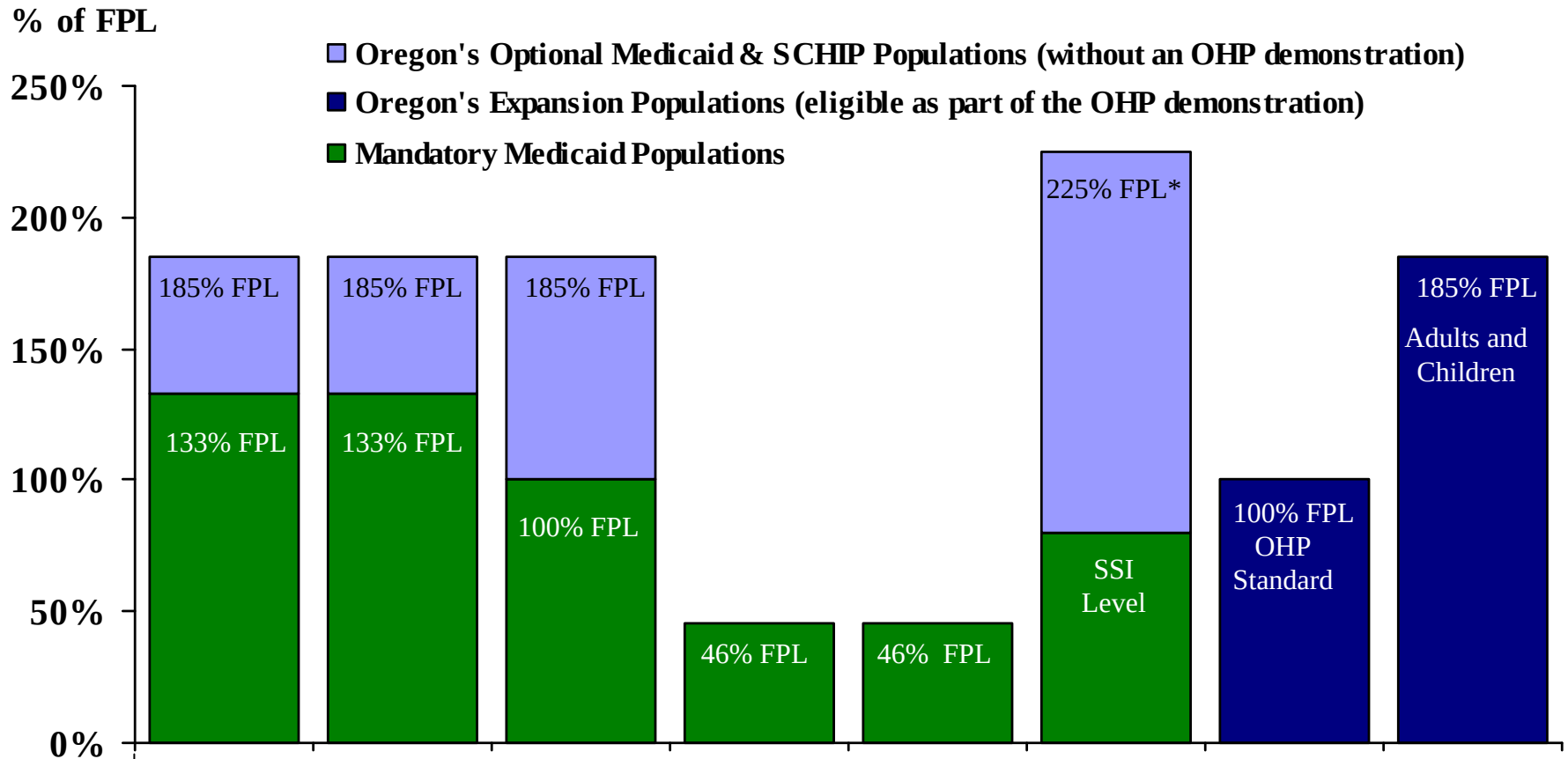
- Low-income elderly, blind & disabled
- Families receiving Temporary Assistance for Needy Families (TANF)
- Low-income foster children
- Low-income children
- Low-income pregnant women

Who is covered by the Oregon Health Plan?

Expansion Populations:

- Low-income uninsured adults (OHP Standard)
- Subsidies to help low-income adults and families purchase private insurance (Family Health Insurance Assistance Program (FHIAP))

Oregon Health Plan Eligibility Categories by Percentage of Poverty Level (FPL)



Eligibility Category	Pregnant Women	Children (Ages 0-5)	Children (Ages 6-18)	Foster Children	TANF Families	Aged, Blind & Disabled*	Uninsured Adults	Subsidized Private Insurance**
Dec. 2006 Enrollment	9,598	53,989	60,636	17,522	117,534	92,228	21,052	15,506

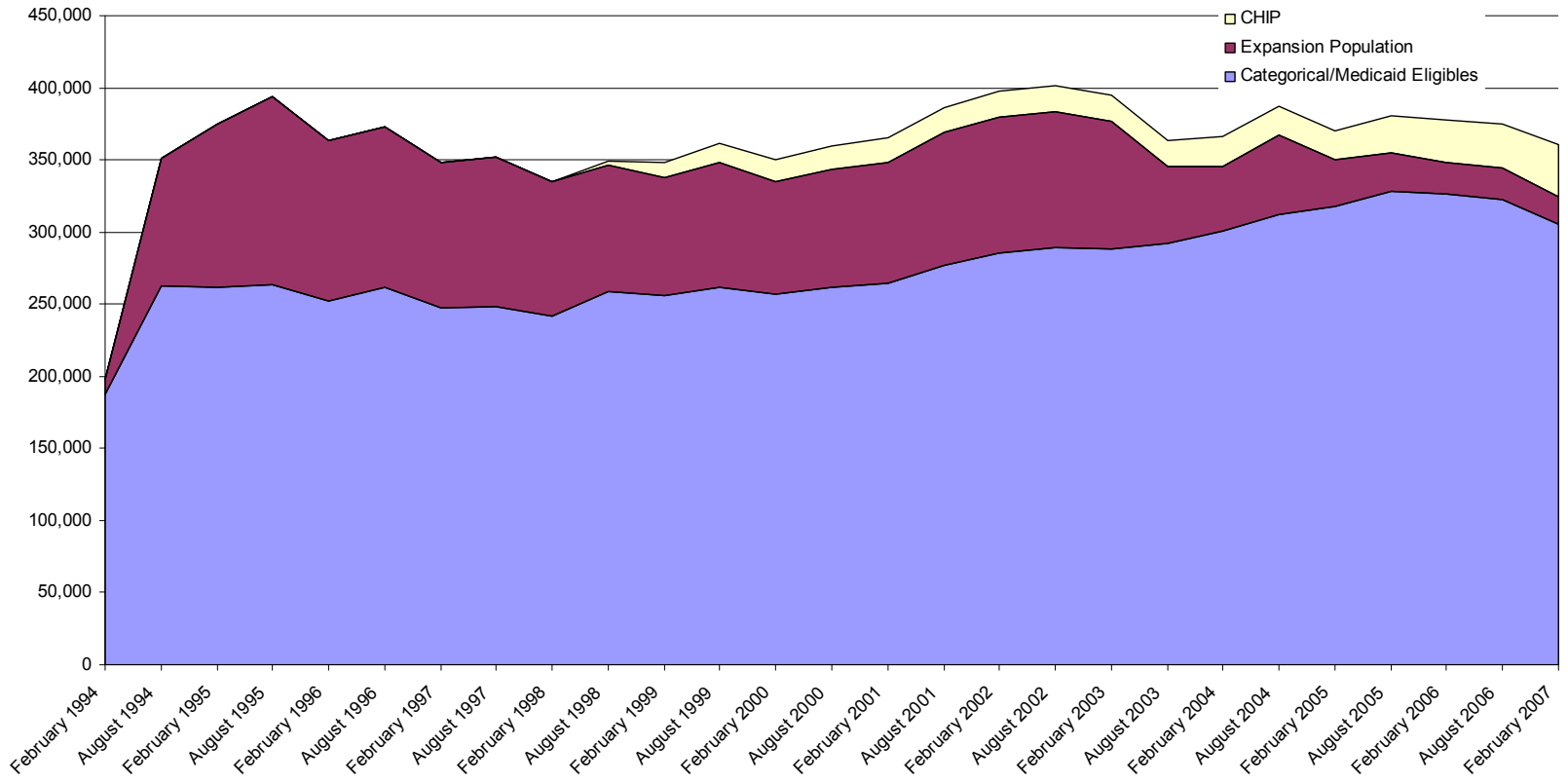
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level

**The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% FPL must enroll if they have employer sponsored insurance. Parents and childless adults over 100% FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

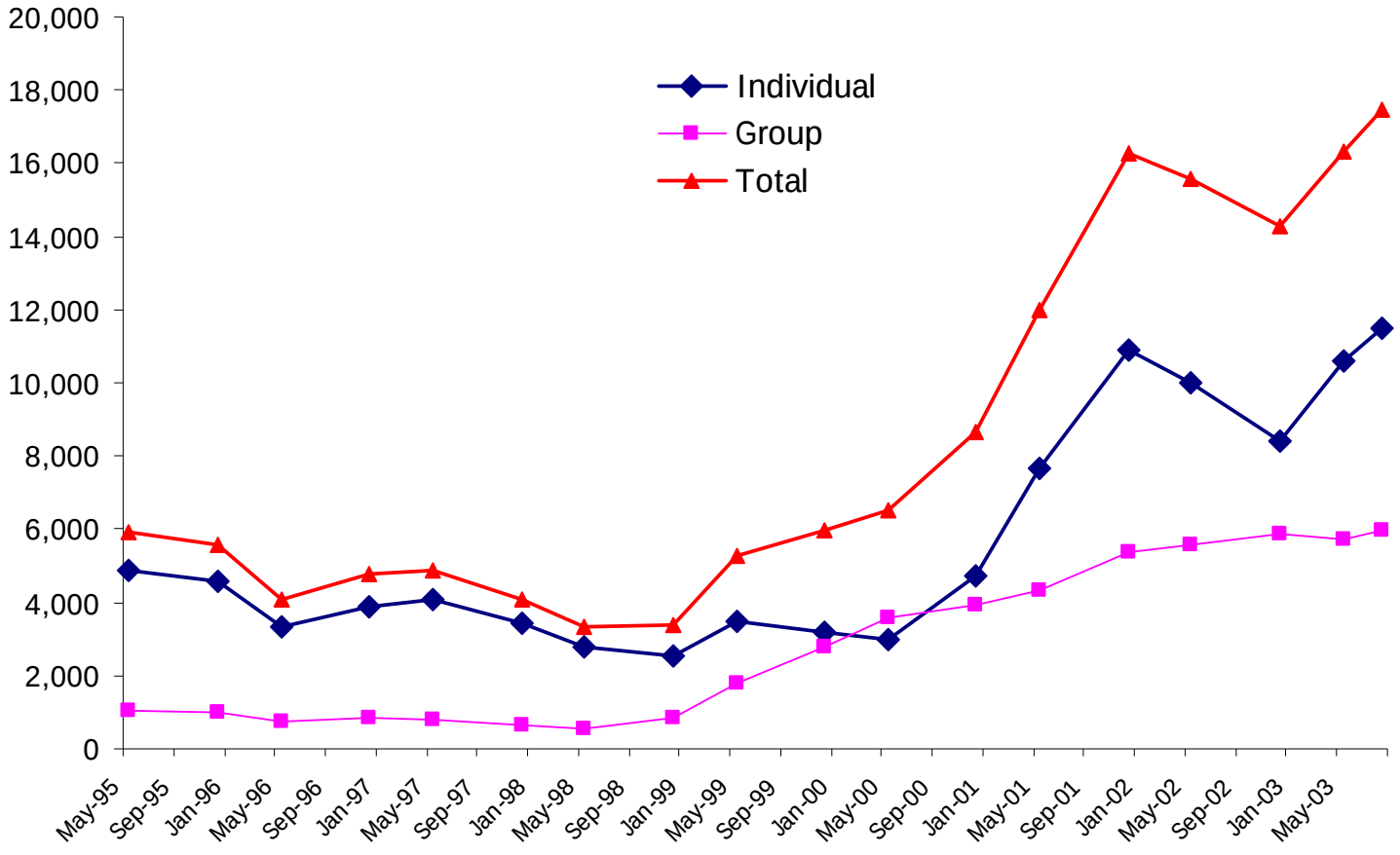
Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Total enrollment is fairly flat over time, but OHP expansion population is shrinking

Total Medicaid enrollment, Oregon, 1994 to 2007



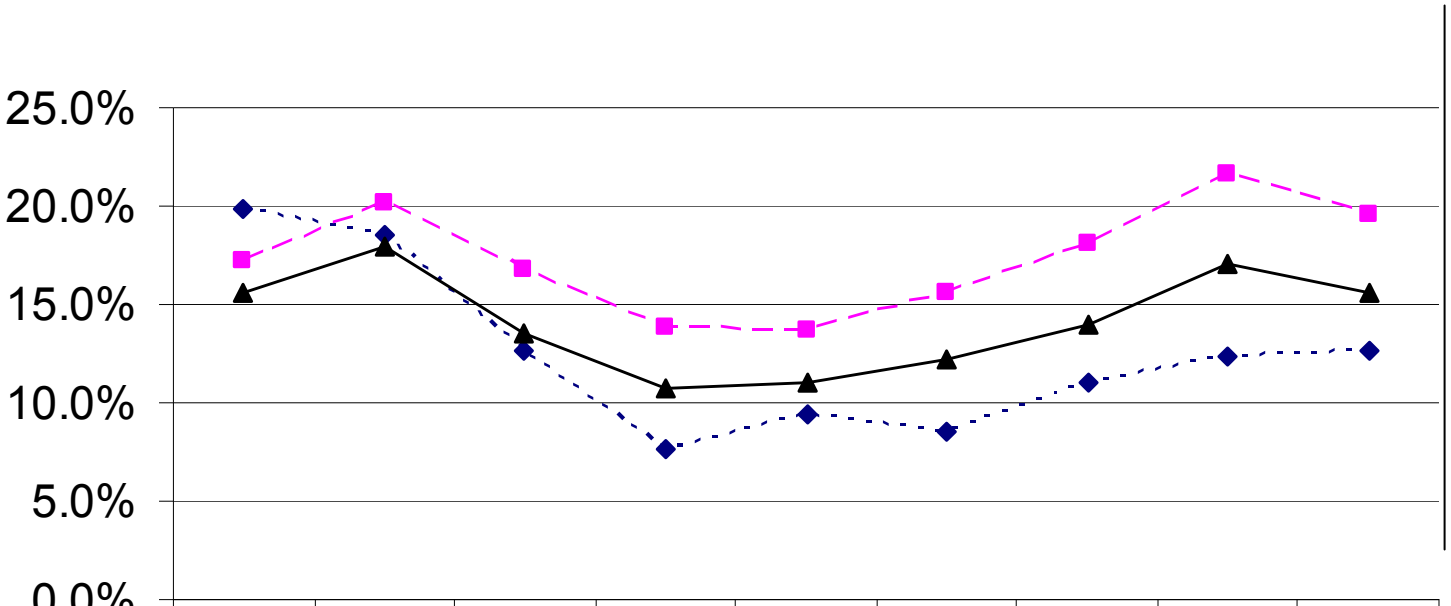
Family Health Insurance Program (FHIAP) enrollment continues to grow.



Who are the uninsured?

Almost one in five adults and one in six children are uninsured

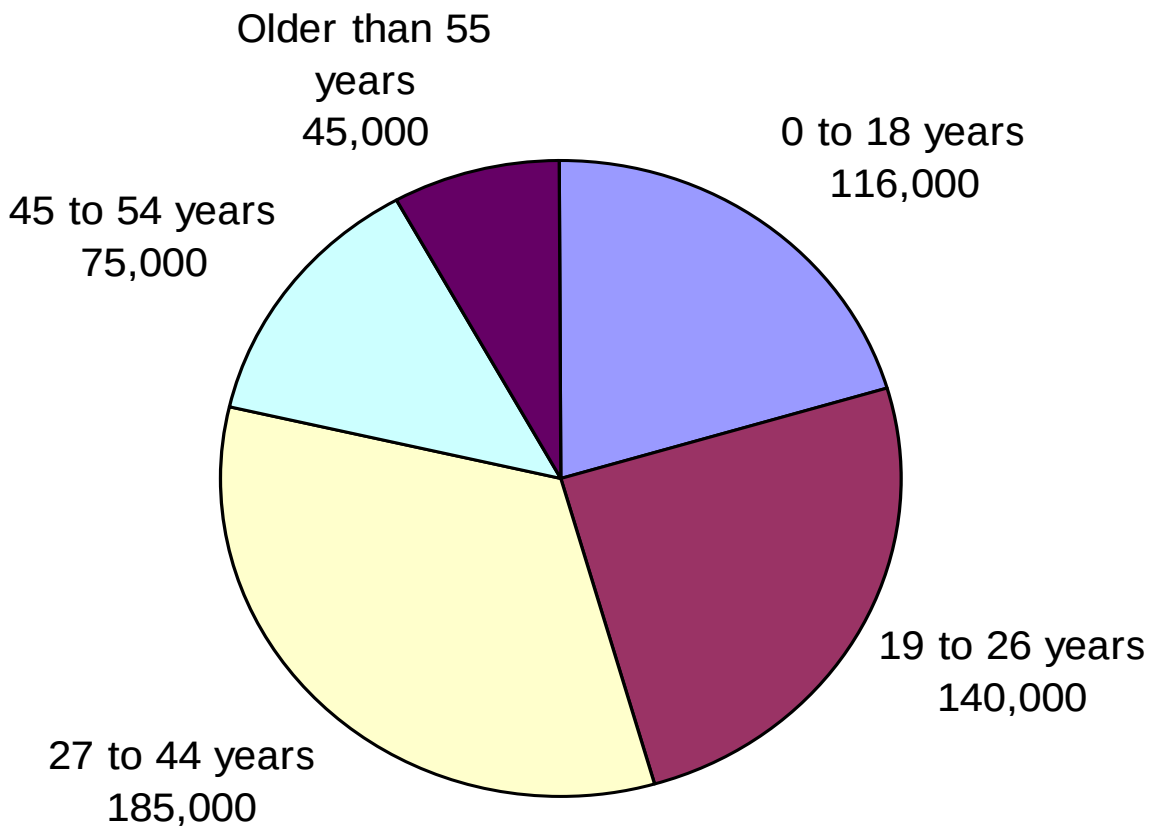
Health Uninsurance Trends, Oregon



	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

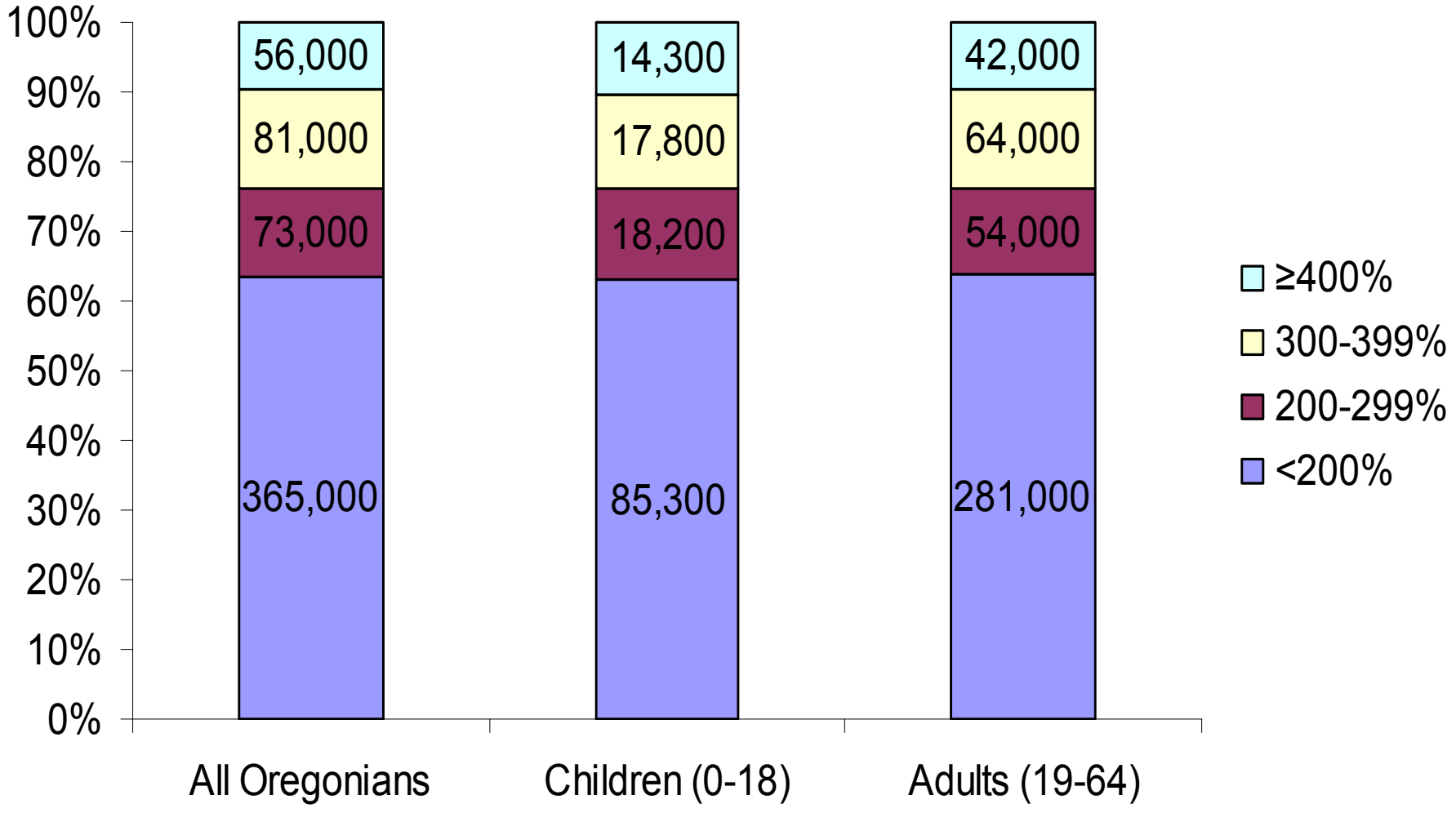
Source: Oregon Population Survey, 1990 to 2006.

Adults are more likely than children to be without insurance.



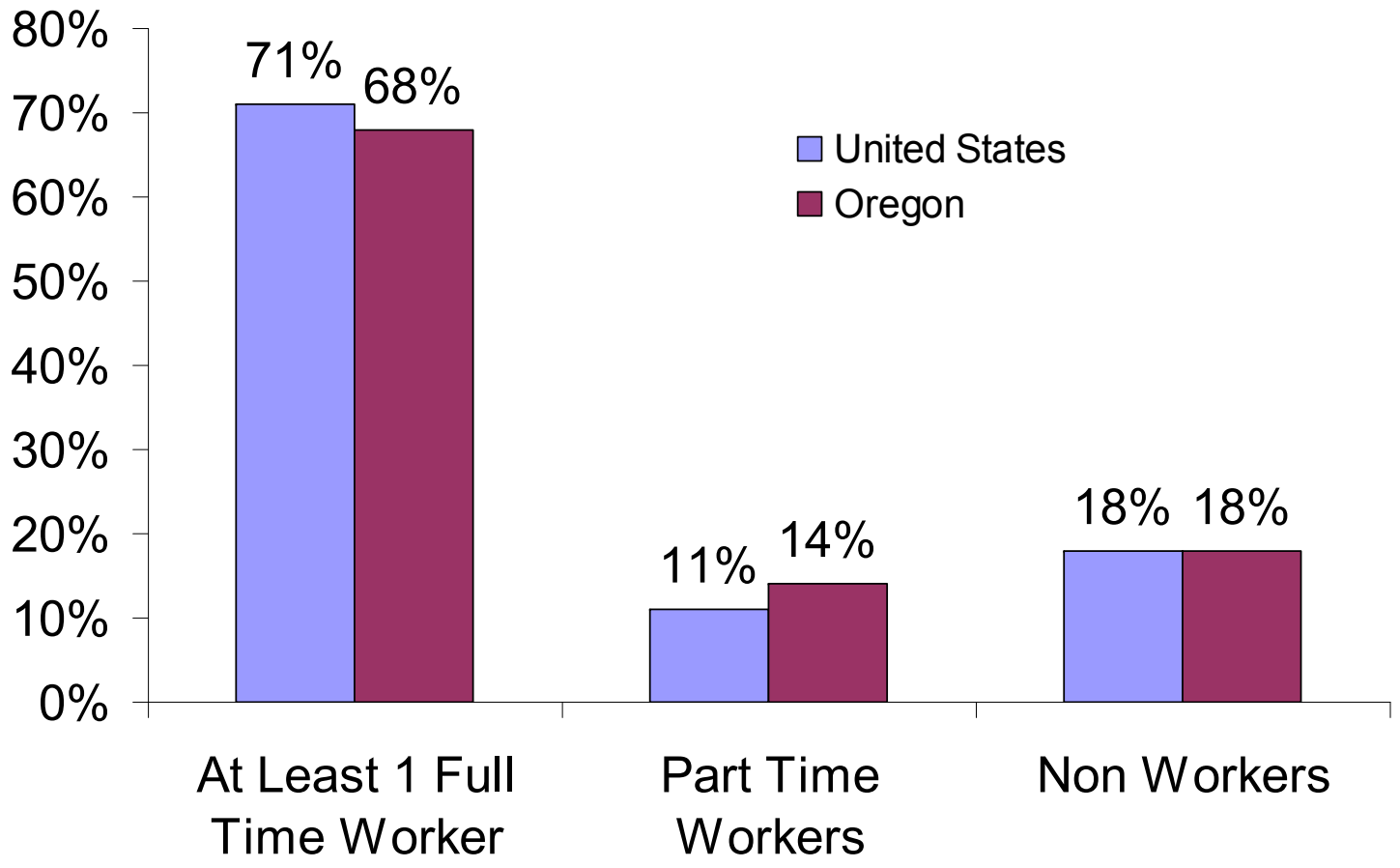
Source: 2006 Oregon Population Survey.

Over 60% of the uninsured are below 200% FPL



Source: 2006 Oregon Population Survey.

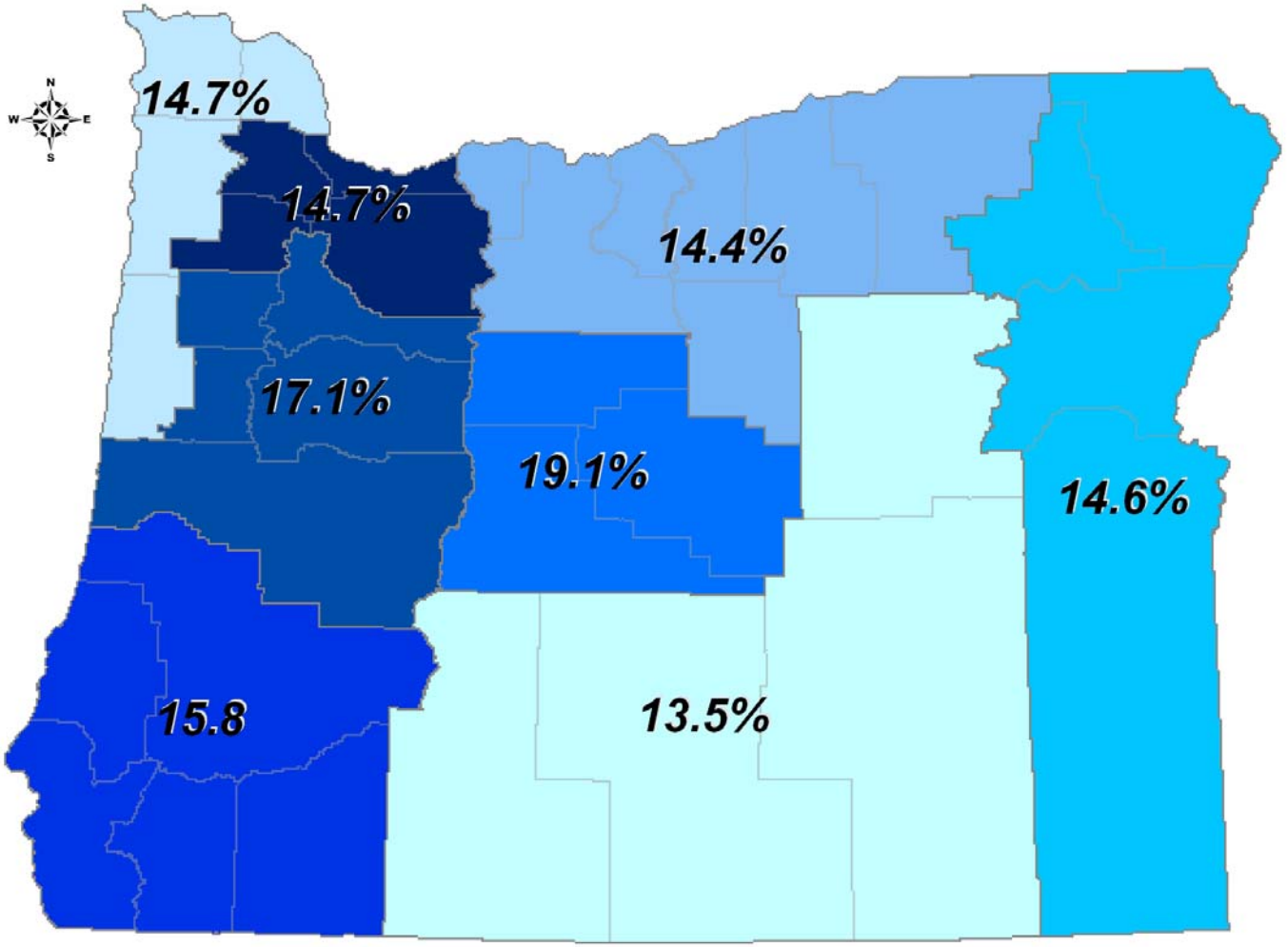
68% of uninsured in Oregon are from families with at least 1 full-time worker



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

Mid-Willamette Valley and Central Oregon have the highest rate of uninsured

Regional Percentages of the Uninsured, Oregon 2006



Hispanics are most likely to be uninsured

Percent Uninsured by Race and Ethnicity:

- Asian – 9.7%
- White, non-Hispanic – 13.3%
- African-American – 14.1%
- American Indian – 27%
- Hispanic, any race – 32.5%

Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Consequences of being uninsured include:

- Reduced access to health care: Uninsured receive too little medical care and receive it too late
- Poorer medical outcomes: Uninsured are sicker and die sooner
- More expensive medical care

Lack of insurance results in avoidable hospitalizations

Uninsured are:

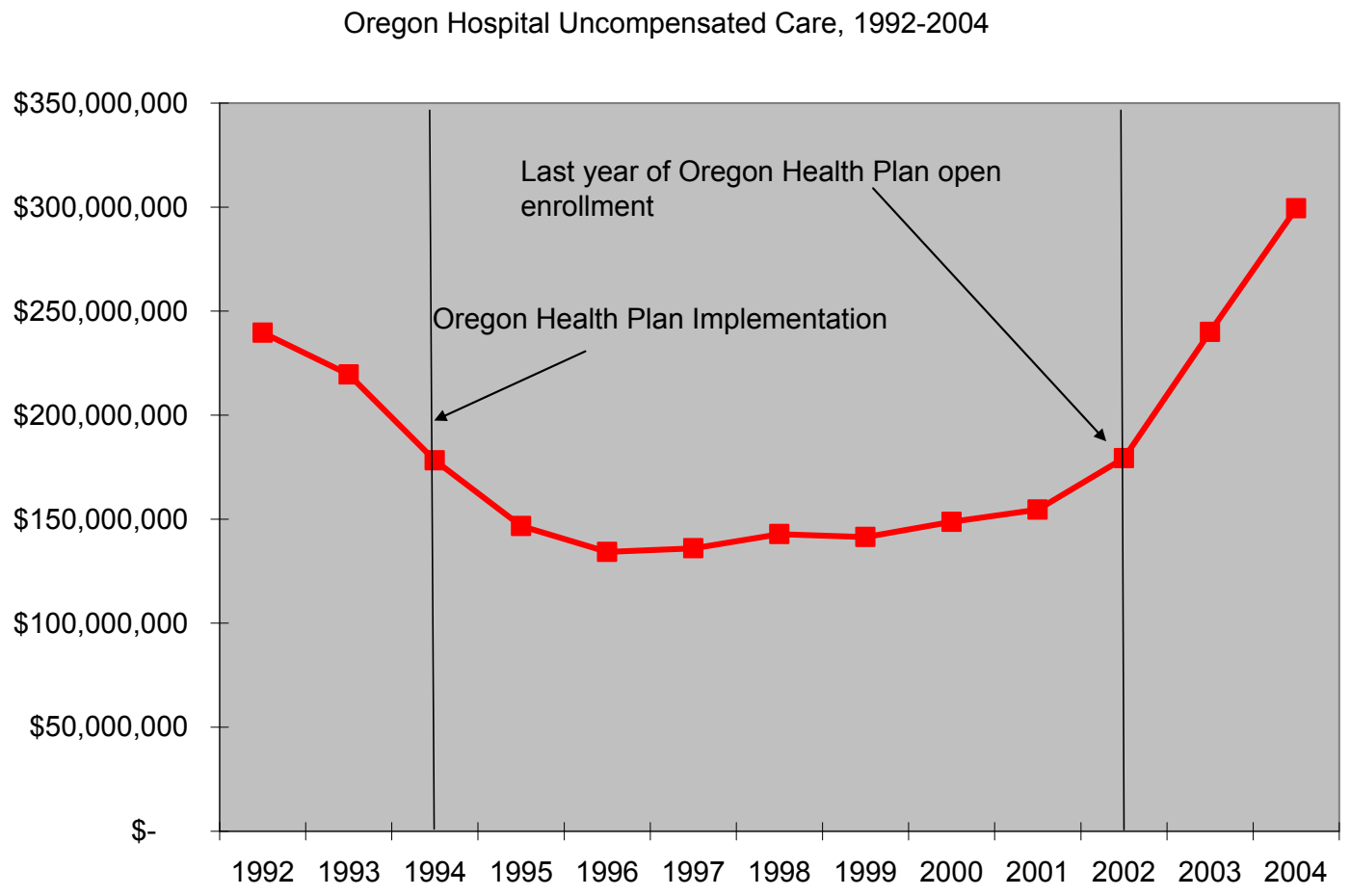
- 2.8X more likely to be hospitalized for diabetes
- 2.4x more likely to be hospitalized for hypertension
- 1.6x more likely to be hospitalized for pneumonia
- 1.6x more likely to be hospitalized for ulcers

Illness and medical costs are a major cause of bankruptcy

- 45.6% of all personal bankruptcies involve a medical reason or large medical debt
- 7 per 1000 single women, and 5 per 1000 men suffered medical-related bankruptcy in 1999
- An increasing number of medical-related bankruptcy involves those with health insurance coverage

Source: Norton's Bankruptcy

In the absence of coverage, uncompensated care increases...



A Brief History of Health Services Prioritization in Oregon

By Bob DiPrete and Darren Coffman

Abstract: *Aware of the need for accountable and effective funding of health care, Oregon established a set of policy objectives to guide the development of a methodology for setting health care priorities. In 1989, the Oregon Legislature created the Health Services Commission and directed it to develop a prioritized list of health services ranked in order of importance to the entire population to be covered. The Commission first tested a formulaic approach using a cost/utility analysis, but the results were unsatisfactory. Subsequent successful approaches rank- order general categories of health services (e.g., Maternity and newborn care; Comfort care) based on relative importance as gauged by public input and on Commissioner judgment. Within these general categories, individual condition/treatment pairs are prioritized according to impact on health, effectiveness and (as a tie-breaker) cost. The resulting prioritized list is used by the Legislature to allocate funding for Medicaid and SCHIP, but the Legislature cannot change the priorities set by the independent Commission. The benefits based on the prioritized list are administered primarily through managed care plans, and approximately 1.5 million Oregonians have gained health coverage due to the expanded access made possible by explicitly prioritizing health services.*

BACKGROUND

In 1987, the Oregon Legislature realized that it had no method for allocating resources for health care that was both effective and accountable. Over the next two years, policy objectives were developed to guide the drafting of legislation to address this problem. These policy objectives included:

- Acknowledgment that the goal is health rather than health services or health insurance
- Commitment to a public process with structured public input
- Commitment to meet budget constraints by reducing benefits rather than cutting people from coverage or reducing payments to levels below the cost of care
- Commitment to use available resources to fund clinically effective treatments of conditions important to Oregonians
- Development of explicit health service priorities to guide resource allocation decisions

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- Commitment to maintain the integrity of the prioritization process, including a prohibition against changes to the priorities as part of Legislative funding decisions

The strategy was to move away from "rationing" by excluding people from health coverage or reducing access through underpayment. Instead, when budget limits required reductions in budget costs, health services would be eliminated according to explicit priorities established by an independent commission through an accountable, public process.

Based on these policy objectives, legislation was passed in 1989 creating the Health Services Commission, which was charged with developing a list of health services prioritized from most important to least important to the entire population to be covered.[1] Commission membership is stipulated in statute and must include 5 physicians, one public health nurse, and one social worker with the remaining 4 representing purchasers and consumers of health care.

METHODOLOGY

In setting about its work, the Commission immediately realized that it required the best available information on clinical effectiveness in order to set meaningful priorities, and that specificity would be necessary in defining a particular service for a particular condition. A review of outcomes studies revealed that clinical experience and judgment would need to be the basis for identifying outcomes for most treatments. Accordingly, the Commission worked with hundreds of specialists and sub-specialists to gauge the relative effectiveness of thousands of condition/treatment (CT) pairs defined in terms of ICD-9-CM and CPT-4 codes. Probable health outcomes for a given condition were compared for a) a given treatment, b) alternative treatments, and c) no treatment at all. Also, the Commission obtained information on the cost of the services being prioritized from providers, hospitals, and claims data.

In addition to this information on clinical effectiveness, the Commission also requested information on public values concerning health care. Three methods were used to gather this public input: 1) twelve public hearings in which testimony was taken from Oregonians concerning their health care experiences and preferences; 2) approximately 50 focus groups around the state in which facilitators helped citizens to identify health values on which there was some degree of consensus; and 3) a survey of 1001 Oregonians to identify the impact on overall health resulting from a broad range of hundreds of conditions such as shortness of breath, limited range of motion, social dysfunction, and hearing loss. These three methods provided the Commission with a sense of the relative importance of treating a condition as expressed by those who would be covered by the benefit package resulting from the prioritization of services.

Finding no other examples of such an attempt at health care prioritization anywhere else in the world from which to borrow , the Commission began from scratch. Its first approach to prioritization used the formula shown in Figure 1 to derive cost/utility values for each CT pair, and then ranked these CT pairs as health services accordingly.

[1] Although it was envisioned at this time that the prioritized list would determine the minimum acceptable benefit package for all Oregonians, in fact the only application has been to determine covered benefits for those on Medicaid and SCHIP.

Figure 1. Cost/utility formula used in first prioritization attempt

$$B_n = \frac{c}{Y * [\sum_{i=1}^{5}(p_{i1} * QWB_{i1}) - \sum_{i=1}^{5}(p_{i2} * QWB_{i2})]}$$

[With Treatment] [Without Treatment]

$$\text{with } QWB_{ik} = 1 + \sum_{j=1}^{30} d_{ijk} w_j \qquad k=1,2$$

where:

- Bn = the net benefit value ratio for the nth condition/treatment pair to be ranked.
- c = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.
- Y = the years for which the treatment can be expected to benefit the patient with this condition.
- [term] = the difference in probability weighted QWBs with and without treatment.
- QWB = subjectively weighted sum of health limitations associated with a specific outcome.

The result was deemed unacceptable because it conflicted substantially with the judgment of all Commission members, both physicians and non-physicians. In brief, the problem was that very inexpensive, very effective treatments for relatively unimportant conditions (e.g. malocclusion due to thumb sucking) ranked higher than moderately expensive, moderately effective treatments for very serious conditions. The lesson learned was that while a cost/utility analysis can gauge the cost of remedying a condition, it cannot address the importance of treating the condition in the first place. The Commission's response was to abandon the cost/utility formula and base its prioritization on general categories of treatment, which were ranked to reflect relative importance based on public input first, and effectiveness and cost secondarily. These categories are:

Category 1:	Acute fatal condition, treatment prevents death with full recovery
Category 2:	Maternity care
Category 3:	Acute fatal condition, treatment prevents death without full recovery
Category 4:	Preventive care for children
Category 5:	Chronic fatal condition, treatment improves life span and quality of life
Category 6:	Reproductive services (excluding maternity and infertility services)
Category 7:	Comfort care
Category 8:	Preventive dental care
Category 9:	Proven effective preventive care for adults
Category 10:	Acute non-fatal conditions, treatment causes return to previous health state
Category 11:	Chronic non-fatal condition, one-time treatment improves quality of life
Category 12:	Acute non-fatal condition, treatment does not result in a return to previous health state
Category 13:	Chronic non-fatal condition, repetitive treatment improves quality of life
Category 14:	Self-limiting conditions where treatment expedites recovery
Category 15:	Infertility services

Category 16: Less effective preventive care for adults
Category 17: Fatal or non-fatal condition, treatment causes minimal or no improvement in quality of life

Within these ranked categories, specific services were prioritized based on effectiveness and cost. The Commission also established three subcommittees: the Mental Health Care and Chemical Dependency Subcommittee, the Subcommittee on the Aged, Blind and Disabled, and the Health Outcomes Subcommittee. These subcommittees helped to ensure that the needs of vulnerable populations were fully taken into account, and that the best information on health outcomes was continually available to the Commission as it established and maintained the prioritized list.

As a final step in prioritizing health services, Commission members moved CT pairs "by hand" to assure that the prioritized list reflected their best judgment as clinicians and as representatives of those to be covered under the resulting benefit package.

At this point in the development of the first prioritized list, an unforeseen political problem emerged. Attorneys within the federal Department of Health and Human Services (DHHS) interpreted the Americans with Disabilities Act (ADA) in such a way that they construed the Commission's methodology for setting priorities to be in conflict with that law. Put briefly, the perceived problem was that in asking the public for input on social values, the Commission may have come under the influence of biases against people with disabilities. As a result, the Commission was required to remove all public input obtained from the survey described above. The federal position was that in order to avoid problems with the ADA, priorities could only be based two objective factors: 1) whether the treatment prevents death and, 2) the cost of the treatment. While the Commissioners did not feel that their original methodology was biased against any group, they reluctantly agreed to modify it in order to achieve the goal of greater health care access. Because most objective measures representing health outcomes were not allowed, the subjective collective judgment of the Commissioners became more of a factor. As a result, many of the public values on health that had been expressed through the community meetings, the telephone survey, and in public testimony were reflected through the application of Commissioner judgment in the final prioritization process.

Since its inception in 1993, the prioritized list of health services has been revised every two years as part of Oregon's biennial budget process. An example of a change resulting from these biennial revisions is the movement of cochlear implants to a higher position based on improved outcomes information. Additionally, interim modifications can be made to the list between biennial reviews to account for changes in medical codes and medical advancements that need immediate attention. Examples of the latter include a higher placement for chronic hepatitis C with the treatment of interferon and the inclusion of services related to physician assisted-suicide (which became legal in the state of Oregon in 1997). The Commission also establishes guidelines for those instances where over-utilization is a known problem (e.g. back surgery, hysterectomy) or where ICD-9-CM codes do not provide the necessary differentiation between conditions with significantly varying severity levels (e.g. psoriasis).

In 2006 the Commission completed the first revision in the methodology since implementation, resulting in a complete reprioritization of the entire list. Like the methodology that produced the 1991 list, a ranked set of broad categories defines the framework of the list. This time greater emphasis is placed on preventive services and chronic disease management, reflecting the fact that providing health care before reaching crisis mode will prevent avoidable morbidity and mortality. The nine categories in the methodology in ranked order (with weights which are discussed below), are:

Category 1: Maternity and newborn care *(100)*
Category 2: Primary and secondary prevention *(95)*
Category 3: Chronic disease management *(75)*
Category 4: Reproductive services *(70)*
Category 5: Comfort care *(65)*
Category 6: Fatal conditions where the focus of treatment is on disease modification or cure *(40)*
Category 7: Nonfatal conditions where the focus of treatment is on disease modification or cure *(20)*
Category 8: Self-limiting conditions *(5)*
Category 9: Inconsequential care *(1)*

To sort and rank the line items assigned within categories, the Commission decided that the following measures best capture the impacts on both individual health and population health, considered essential in determining the relative importance of a condition-treatment pair:

- Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact)*
- Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact)*
- Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects)*
- Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability)*
- Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications)*

These impact measures were combined with two additional factors,

- Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness)*
- Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required)*

using the following formula to arrive at a total score,

Category Weight	Healthy Life Years + Suffering + Population Effects + Population Vulnerability + Tertiary Prevention	X	Effectiveness	X	Need for Service

where the category weight is between 1 and 100 as identified on the previous page in parentheses after the category title. The net cost of treatment *(0=high cost, 5=cost saving)* was used to break any ties. While this new list looks significantly different in its rankings, the set of nonfunded services will remain virtually unchanged should it be funded at a level equivalent to funding for the current list. The new list will be implemented no sooner than January 1, 2008 pending State legislative acceptance and DHHS approval. The Legislature will allocate funding based on the new prioritized list, but cannot change the methodology or the priorities.

IMPACT

The prioritized list has succeeded in guiding decisions about the allocation of public resources for health coverage and in making these decisions more explicit and accountable. It has also succeeded in making health policy more reflective both of the best evidence available on clinical effectiveness and of the preferences of those affected by these health policy decisions. Also, physician practice has altered over time to reflect the benefits defined by the prioritized list.

The prioritized list has not succeeded in shifting responses to budget constraints entirely to reductions in benefits, although this was a major policy objective from the beginning. This is because the federal government has been reluctant to allow Oregon to reduce benefits when revenues decline, forcing the state to make adjustments in eligibility and in payment levels to keep within budget. This political constraint has prevented a full exploration of the effectiveness of the prioritization of services in meeting budget limits while maintaining the commitment to cover all those in need and the commitment to pay providers at levels sufficient to cover the cost of care. Even if Oregon were free to move the line further, the range just above line 530 begins to include some serious but treatable conditions. Reducing benefits to within this range would present serious medical and ethical difficulties, as this population would likely not be able to afford the care otherwise.

The prioritized list has had a modest impact on costs per member per month. The actuary has estimated that the costs associated with the funded portion of the list are approximately 90% of the cost of funding the entire list. The reason the impact is not greater is that much of the more expensive care is found high on the list. In fact, diagnostic services - which are very expensive

and growing even more costly every year - are in effect ranked at line zero in the sense that the care required to arrive at a diagnosis is always covered.

Public support for the prioritization process was strong at the outset and has never weakened, and the integrity of the prioritized list has never been questioned by providers or consumers of health services. Moreover, the legislators who make the decisions on allocating public resources for health care have accepted the independence of the prioritization process from the legislature.

In 2002, at the Governor's request, the Commission developed a second prioritized list at a much more summary level to be used in further expanding health coverage. This list prioritizes broad categories of service (e.g. hospital inpatient, physician, prescription drugs, and mental health) and identifies cost sharing levels for each category of service at each priority level (so that a given category of service may appear more than once on the list with two or more levels of cost sharing). This methodology does not require analysis at the ICD-9-CM/CPT-4 level, and its goal was to develop a public program benefit package that approximates the typical private insurance benefits purchased by Oregon businesses for employees.

A reduced benefit package, called "OHP Standard" was created by overlaying the more detailed prioritized list of CT pairs with the prioritized categories of services so that within a category (e.g. physician care) nothing is covered that is not "above the line" on the larger prioritized list of health services. This package is available to the optional Medicaid populations that gained eligibility under Oregon's Medicaid Demonstration. The "original" prioritized list of CT pairs is still used exclusively to define the "OHP Plus" benefits provided to the mandatory Medicaid populations.

Coverage under the prioritized list has been primarily in managed care, and many participating managed care plans have developed mechanisms for accommodating practice patterns to the benefit package defined by the list. Participating health plans have included Oregon's Blue Cross & Blue Shield HMO, hospital-based plans, and IPA-based plans. In addition, the delivery system has included partial-capitation health plans and primary care case managers outside major population centers.

Since its inception, over 1.5 million Oregonians have been covered under the prioritized list. Over that same time period, between 5 and 6 million people have lived in the state. In effect, roughly one-third of the state's population has been touched by the expanded access made possible by setting explicit health service priorities.

Overview of 2006 Biennial Review of Prioritized List

Background on the Health Services Commission

The Oregon Legislative Assembly, led by then Senate President John Kitzhaber, created the Health Services Commission (HSC) through the passage of Senate Bill 27 in 1989 in the creation of the Oregon Health Plan. The HSC is made up of eleven volunteer members, who are appointed by the Governor and confirmed by the Senate for four-year terms. The members include five physicians (one of whom must be a doctor of osteopathy), one public health nurse, one social services worker, and four consumer representatives. The HSC's charge is to provide a biennial report to the Governor and Legislature to include a list of health services "ranked by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served." The Prioritized List of Health Services developed by the HSC is priced at various levels of coverage by an independent actuarial firm and then the Oregon legislature draws a line on the list to indicate what services will be reimbursed under the OHP Medicaid Demonstration (those services appearing above the funding line on the list) and those that will not (those appearing below the funding line).

Background on the Prioritized List of Health Services

The Prioritized List of Health Services represents a rank ordering of condition-treatment pairs using ICD-9-CM, CPT, and HCPCS medical codes to define the services on each of the line item on the list. The list assumes that all diagnostic services necessary to determine a diagnosis are covered. Ancillary services necessary for the successful treatment of the condition are to be presumed to be a part of the line items. This means that codes for prescription drugs, durable medical equipment and supplies, laboratory services, and most imaging services are not included on the prioritized list but are still reimbursed as long as the condition for which they are being used to treat appears in the funded region. The state currently covers lines 1-530 of the 710 line items on the list.

The 2006 Biennial Review of the Prioritized List

In the summer of 2005, as the HSC began to prepare for the biennial review of the list. The Commission was encouraged to ask themselves whether the basic structure of the list represented what they truly considered to be the most important to the least important. It was suggested that a higher emphasis on preventive services and chronic disease management would ensure a benefit package that provides the services necessary to best keep a population healthy, not waiting until an individual gets sick before higher cost services are offered to try to restore good health again.

The HSC believed that placing a higher value on prevention and chronic disease management was a good idea on its face and could be crucial in maintaining a sustainable program as we face an aging population. The Commission put together a task force that included HSC members, stakeholders, and health policy experts to study the issue further. This task force reviewed the principles on which the OHP was based, the values expressed in the four sets of public forums held by the HSC since 1990, and the results of the biennial public surveys on health care conducted by Oregon Health Decisions. The task force found evidence in all of these sources that supported such a shift in health care priorities and recommended the HSC pursue a reprioritization of the list to reflect this new emphasis.

New Methodology

In December 2005 the HSC embarked on the developing a new prioritization methodology for the first time since the list was first implemented in February 1994. First the HSC developed the framework of what they thought the new list should look like by defining a rank ordered list of nine broad categories of health care (see Table 1).

Next, each of the 710 on the 2005-07 list were assigned to one of the nine health care categories. During this process, as has occurred with all biennial reviews, lines were merged or split in an attempt to where appropriate. For example, all superficial abscesses where combined into one line as outcomes and costs are similar regardless of where the abscess is located. In contrast, the Commission found relatively minor birth traumas lumped together with imminently life-threatening conditions and split these into two separate lines. As more lines were merged together than split, the new list is 680 lines long compared to the current list of 710. As most of these mergers involved currently funded condition-treatment pairs, new line 503 best equates to the benefit package represented in lines 1-530 of the current list.

Once the condition treatment pairs were assigned to one of the nine health care categories, a list of criteria was developed to sort the line items within the categories (see Table 2). These measures were felt to best capture the impacts on both the individual's health and the population health that HSC thought were essential in determining the relative importance of a condition-treatment pair. The HSC Medical Director and HSC Director worked with two HSC physician members to established ratings for the criteria for over 100 lines in order to establish a general scale to follow for each of the criteria. The HSC Medical Director (and in most cases HSC Director) then met with individual HSC physician members and other volunteer physicians

Table 1
Rank Order of Health Care Categories

1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*
2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*
3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*
4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*
5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*
6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*
7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*
8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*
9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

Table 2
Population and Individual Impact Measures

Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - the cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

with OHP experience. After ratings were established for all 710 lines, they were reviewed by the HSC Medical Director and HSC physician members for accuracy and consistency. A total score was then calculated for each line using the following formula to sort all line items within each of the health care categories, with the lowest net cost used to break any ties:

Impact on Healthy Life Years				
+ Impact on Suffering				Need for
+ Population Effects	X	Effectiveness	X	Service
+ Vulnerable of Population Affected				
+ Tertiary Prevention (categories 6 & 7 only)				

A workgroup of the HSC members then met to explore the best method for intermixing condition-treatment pairs across health care categories. While the nine health care categories were meant to establish the framework of the new list it was always clear that not every service in Category 1 was more important than every service in Category 2 and so on. In the methodology used to develop the initial prioritized list implemented in February 1994, approximately 75% of the line items where hand adjusted after an initial computer sort on the

treatment's prevention of death and cost of the treatment. The workgroup found that applying a weight to each category that was then multiplied by the total criteria score for each condition-treatment pair achieved an appropriate adjustment in the majority of the cases. The full commission agreed with the conclusions of the workgroup and approved the weights shown in parentheses after the title for each category in Table 1. Hand adjustments were applied where the application of this methodology did not result in a ranking that reflected the importance of the service, which was the case in fewer than 5% of the line items.

The following two examples illustrate line items that were given a very high score and a very low score as a result of this process.

Schizophrenic Disorders	Grade I Sprains of Joints and Muscles
(Old line: 159, New line: 27)	(Old line: 626, New line: 628)
Impact on Healthy Life Years: 8	Impact on Healthy Life Years: 1
Impact on Suffering: 4	Impact on Suffering: 1
Effects on Population: 4	Effects on Population: 0
Vulnerability of Population Affected: 0	Vulnerability of Population Affected: 0
Effectiveness: 3	**Effectiveness: 2**
Need for Service: 1	Need for Service: 0.1
Net Cost: 5	*Net Cost: 4*
Category 3 Weight: 75	Category 8 Weight: 5
Total Score: 3600	Total Score: 2
[(8+4+4+0) x 3 x 1] x 75 = 3600	[(1+1+0+0) x 2 x 0.1 x 5 = 2

Some of the services moving towards the top of the list as a result of this reprioritization include maternity care and newborn services, preventive services found to be effective by the US Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

PUBLIC INPUT

The HSC solicited public and stakeholder input throughout the process. As always, all commission meetings are open to the public and time is set aside for public testimony. When the HSC was initially considering reprioritizing the list, they sent out a survey to over 200 stakeholders. This included physicians randomly selected from the Board of Medical Examiners mailing list, specialty societies, hospitals, safety net clinics and school-based health centers. Thirty-one responses were received and, of these, thirty were supportive of a new emphasis on prevention and chronic disease management.

After the methodology had taken shape, the HSC conducted five focus groups with specialty society presidents, members of the Oregon Academy of Family Practice, representatives from service providers (hospitals, physicians, OHP managed care plans, mental health, chemical dependency, dentistry and home health), consumers, and consumer advocates. There was no objection to the direction that the HSC was taking.

Medical directors and administrators for the contracted managed care plans were kept up to date on the HSC's work and also were supportive of the reprioritization effort.

DRAFT PRIORITIZATION METHODOLOGY
FOR HSC'S 2006 BIENNIAL REVIEW OF LIST

Each line item on the Prioritized List will initially be assigned to one of the following ranked categories of care.

1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*
2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*
3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*
4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*
5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*
6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*
7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*
8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*
9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

It was felt that the dysfunction lines will have to be handled separately as they were in the prioritization of the initial list.

A preliminary weight (in parentheses) has been assigned to each category to be used later in the process.

Population & Individual Impact Measures

Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - the cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

To arrive at a total score for a line item the ratings for the first four measures (five for categories 6 and 7) will be summed and then multiplied by the effectiveness rating, the need for medical services, and finally the weight of the category to which it is assigned. The rating for net cost will be used as a tiebreaker in the case of equal total scores for two or more line items. It may also be considered along with other factors in making "hand-adjustments" after the initial computer sort.

EXAMPLES OF LINES REVIEWED TO DATE

All values are subject to change

Schizophrenic Disorders (Line: 159)
Impact on Healthy Life Years: 8
Impact on Suffering: 4
Effects on Population: 4
Vulnerability of Population Affected: 0
Effectiveness: 3
Need for Service: 1
Net Cost: 5
Category 3 Weight: 75
Total Score: 3600

Type II Diabetes Mellitus (Line: 311)
Impact on Healthy Life Years: 7
Impact on Suffering: 2
Effects on Population: 0
Vulnerability of Population Affected: 2
Effectiveness: 4
Need for Service: 1
Net Cost: 4
Category 3 Weight: 75
Total Score: 3300

Acquired Hemolytic Anemias (Line: 116)
Impact on Healthy Life Years: 6
Impact on Suffering: 1
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 5
Effectiveness: 4
Need for Service: 1
Net Cost: 3
Category 6 Weight: 40
Total Score: 1920

Basic Restorative Dental (Line: 495)
Impact on Healthy Life Years: 4
Impact on Suffering: 0
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 4
Effectiveness: 5
Need for Service: 1
Net Cost: 3
Category 7 Weight: 20
Total Score: 900

Dysplasia of Cervix (Line: 268)
Impact on Healthy Life Years: 6
Impact on Suffering: 0
Effects on Population: 0
Vulnerability of Population Affected: 1
Effectiveness: 4
Need for Service: 1
Net Cost: 3
Category 2 Weight: 95
Total Score: 3325

Appendicitis (Line: 12)
Impact on Healthy Life Years: 9
Impact on Suffering: 2
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 5
Effectiveness: 5
Need for Service: 1
Net Cost: 4
Category 6 Weight: 40
Total Score: 3200

Closed Joint Dislocation/Deformity (Line: 472)
Impact on Healthy Life Years: 6
Impact on Suffering: 4
Effects on Population: 0
Vulnerability of Population Affected:
Tertiary Prevention: 2
Effectiveness: 5
Need for Service: 1
Net Cost: 2
Category 7 Weight: 20
Total Score: 1200

Acute Tonsillitis Other Than Strep (Line: 647)
Impact on Healthy Life Years: 1
Impact on Suffering: 1
Effects on Population: 1
Vulnerability of Population Affected: 1
Effectiveness: 3
Need for Service: 0.5
Net Cost: 4
Category 8 Weight: 5
Total Score: 15

Report of the Task Force on Basic Benefit Plans

INTRODUCTION

The Task Force on Basic Benefit Plans was created within the Oregon Health Council at the request of Mark Gibson, the Governor's Advisor on Healthcare, and John Santa, MD, Administrator of the Office for Oregon Health Plan Policy and Research. The Task Force was composed of members of the Oregon Health Council (OHC), Health Services Commission (HSC), and other key individuals with knowledge and interest in providing health care to the uninsured[1]. Five meetings were held from June - August 2000, culminating in this report to be presented at the Governor's Health Summit at the Eugene Hilton on September 13, 2000.

The Task Force was directed to hold public discussions on the complex issues involved in defining a basic benefit plan. Specifically, they were asked to explore whether the health care needs of the low-income uninsured would be better met by being covered only for a core set of benefits and services rather than remaining uninsured for all services. It was explained to the Task Force that such a program would represent a new form of health coverage in Oregon, extending assistance beyond the Oregon Health Plan, in order to reduce the number of uninsured. By expanding coverage to a greater number of Oregonians, everyone should indirectly benefit from a healthier population and a more cost-efficient health care system.

Discussion of the Task Force members included the characteristics of the population to be served, the clinical implications of including different services in the plan, costs to the individual and the plan, and ways in which the services would be delivered. The Task Force, while not asked to develop a final product, did produce a list of points that should be considered when developing a basic benefit plan. The Task Force also agreed that a basic benefit plan designed to serve the low-income uninsured should promote access to primary health care services rather than crisis or "catastrophic" coverage to protect the patient's assets. The Task Force unanimously agreed that work on expanding access to health care through the use of a basic benefit plan should be continued.

IDENTIFICATION OF ISSUES

The Task Force on Basic Benefit Plans touched on many issues that will require more in-depth research if the effort of defining a basic benefit plan continues.

Target Population

The Task Force considered a basic benefit plan that would be offered to uninsured individuals, predominately adults, living in households with an income between 100 – 200% of the Federal Poverty Level (FPL). The assumption was made that children and pregnant women in families of this income range would be covered under expansions of the Children's Health Insurance

[1] Ross Dwinell (OHC), Chair; Tina Castañares, MD; Andrew Glass, MD (HSC); Bruce Goldberg, MD; Ellen Gradison; Amy Klare (OHC, HSC); Mildred Lane (OHC); Alison Little, MD (HSC); Ellen Lowe (HSC); Eric Walsh, MD (HSC); and, Daniel Williams (HSC).

Program (CHIP) and the Oregon Health Plan Medicaid Demonstration (OHP), which currently cover these individuals up to 170% FPL.

Clinical Issues

The Task Force considered the clinical implications as it discussed which types of services are of most need to the target population. The expected health outcomes are predictably worse for the uninsured, resulting in higher costs for everyone. Adverse outcomes are often due to diagnosis occurring later in the progression of the disease, and therefore a delay in treatment. Access to primary care for this population would lead to better treatment results at a lower cost.

Concern was voiced by many Task Force members that a basic benefit plan include necessary treatments in addition to diagnostic services. Due to a lack of resources, many individuals would not be able to afford even moderate expenses associated with treating an illness. Without coverage of treatment, their outcomes would be no different than if they remained uninsured.

Private-Side Issues

Oregon enjoys a relatively high percentage of employers who offer health insurance to their employees compared to other states. The majority of insured adults get their coverage through their employer[2]. In addition, about 80% of households between 100 – 200% FPL include an adult who is employed[3]. If expansion were to occur as part of a publicly funded program, the phenomenon of "crowd-out" becomes a concern. If the government is too generous with the basic benefit package, then a subset of the employers will choose to discontinue insurance coverage, assuming their employees will choose to be covered under the new program. Crowd-out is then said to have occurred when the number of insured remains nearly the same with the financing for health insurance moving from employer-based to government-based.

Cost

Costs for an expansion of this magnitude could be significant. It currently costs about $260 per-person per-month to provide the benefit package under the OHP. There are nearly 97,000 adults between 100 – 200% FPL who are uninsured in the state of Oregon[4]. Providing an equivalent benefit package would result in an annual cost of over $300 million, and probably more, since the expansion population wouldn't include children, who are relatively inexpensive to cover.

In addition to reducing the benefit package, cost sharing[5] would likely be necessary in order to make the plan affordable. Various levels of premium contribution, copays, coinsurance, deductibles, and stop-loss protection[6] could be employed to make the costs of the plan

[2] The Uninsured in Oregon 1998, p. 1. The Office for Oregon Health Plan Policy & Research.
[3] Oregon Population Survey, 1998.
[4] *Ibid*.
[5] Cost sharing refers to the amount of contribution the individual must pay towards their health care. This can be in the form of a portion of the insurance premium, a nominal amount at the time services are used (copay) , or a percentage of the billed charges for services (coinsurance).
[6] The insurance company pays a greater portion or all of the medical expenses beyond a certain level (e.g. $10,000).

manageable. It was also suggested that alternative actuarially equivalent benefit plans be available to encourage more participation by both managed care plans and potential enrollees.

One possible method mentioned to contain costs of the program would see it as an expansion of the Family Health Insurance Assistance Program (FHIAP). Expanding group coverage under the program could help reduce per-capita costs. For those that are employed, the subsidy could be used towards the employee's share of the premium for family coverage. Also, the subsidies under FHIAP could be restructured, possibly including a fourth tier and/or changing the subsidy amounts for the three current ones[7].

Examination of Existing Approaches

A variety of insurance products currently on the market were examined in terms of their benefits and cost. These included both comprehensive and non-comprehensive indemnity plans as well as various managed care plans. In addition, other unique solutions were presented. An example is the Health New York program, which uses the private market to provide plans with limited benefits and high copays to targeted businesses that do not offer health insurance and have a high proportion of low-salaried employees. More research is needed to determine whether these approaches would be applicable in reducing the number of uninsured in Oregon.

Delivery System Issues

The Task Force discussed the following ways in which the delivery system could be changed in order to remove barriers to access for this population and increase the utilization, efficiency, and effectiveness of the services:

- Provide evening hours
- Ensure neighborhood accessibility
- Use mobile clinics in rural areas
- Integrate mental health & dental services
- Diversify the delivery system to provide choices to the client
- Use safety net clinics (as an option rather than a substitute for access to other providers)
- Emphasize the role of primary care providers
- Ensure resources to handle additional capacity
- Increase the time spent with clients

FRAMEWORK OF A BASIC BENEFIT PLAN

The Task Force thought that it would be valuable to gain an understanding of the underlying values that should frame a basic benefit plan. It was noted that commercial plans might be driven by an entirely different set of values, not all of which may be shared by the target population. As the Task Force members took turns identifying these values, the scope broadened to include more general items. The resulting list of points for consideration when defining a basic benefit plan compiled by the Task Force for this population appears in Attachment A.

[7] 95% subsidy for incomes from 100-125% FPL, 90% for 126-150% FPL, and 70% for 151-170% FPL.

Access Promotion vs. Asset Protection

Early on in their discussions, the Task Force encountered a fundamental question -- should a basic benefit plan for the low-income uninsured provide "access promotion" or "asset protection?" Access promotion was defined as a system that encourages early diagnosis through routine health care in order to increase the potential for better outcomes of treatment and reduced costs. Asset protection is exemplified by a catastrophic plan within the insurance model where the individual is protected from losing their assets due to a severe illness.

Consensus was reached that a basic benefit plan for uninsured adults between 100% and 200% of FPL should stress access promotion rather than asset protection. This segment of the population generally does not have a good deal of assets to protect and therefore that type of coverage would not be useful to them.

Benefit Inclusions/Exclusions

Three approaches were identified as possible ways to define a basic benefit plan:

1) Use condition-treatment pairs similar to the Prioritized List of Health Services constructed by the Health Services Commission;
2) Use broad categories of services; or,
3) Use a sliding scale approach, including the possibility of having different benefits available to different populations.

An analysis was performed on how the Health Services Commission's seventeen original categories of care[8] relate to the current Prioritized List of Health Services. Most of the condition/treatment pairs in categories 1-9 and deemed essential by the Commission appear in the upper half of the List. Providing just this reduced set of services was estimated to cost 75% of providing the full OHP benefit package. In addition to relatively high costs, there were concerns about the complexities of administering a basic plan using condition/treatment pairs. Similarly, having tiered levels of benefits was viewed as being administratively difficult, and not in line with the premise that the target population needed most of the same services that were available under the OHP. The use of broad categories of services similar to the Commission's was thought to hold the most promise and further discussion was based on this premise.

Basic Benefit Matrix

As the benefits needed by the target population were viewed as being broad, discussion turned to ways that cost sharing could be put in place to make the plan affordable. A matrix was developed to represent the full range of benefits available. Rows of the matrix represented a condensed list of the seventeen categories of health care used by the Health Services Commission in their original methodology. The columns of the matrix included eight general types of services. The Task Force members were then asked to enter, for each cell of the matrix, the level of contribution (zero, low, medium, or high) they thought was appropriate for this population. A summary of the most common responses to this exercise appears in Attachment B. There was very good agreement on appropriate levels of contribution for many of the category of care/type of service combinations. The distribution of responses within the

[8] Prioritization of Health Services: A Report to the Governor Legislature, 1991, pp. G-11, G-12. Oregon Health Services Commission.

cells of the matrix fell into one of three categories: 1) strong agreement in areas where a single level of contribution was listed by at least half of the respondents, 2) good agreement where two consecutive levels of contribution represented the majority of the responses, and 3) areas with little agreement where the responses were evenly distributed across three or more levels of contribution or there was a bimodal distribution with at least one level of contribution separating two equally popular responses.

As shown in the attachment, the Task Force assigned zero or low levels of contribution to the categories of treatable fatal conditions, maternity care, and comfort care. Treatable nonfatal conditions were primarily assigned either medium or high contribution levels. The two categories with the least amount of agreement were for preventive care and family planning. In these instances, appropriate contributions were tied to the type of service involved. Even so, there were significant areas of disagreement in the areas of mental health and chemical dependency services, oral health services, and enabling services for these categories. The only other areas in which consensus was lacking was for prescription drug benefits for both fatal and nonfatal treatable conditions.

When the responses of the matrix were presented to the Task Force, it became apparent that there were two reasons behind the lack of agreement on the appropriate levels of contribution. The first was due to philosophical reasons. While all members seemed to agree that enabling services were important in assuring true access to these services, some thought that they should not be provided as a part of health insurance. For example, requiring a health plan to provide interpretive services can be more expensive and less timely than if provided through a community-based program. Other differences of opinion were due to definitional reasons. When responding under levels of contribution for prescription drugs, some members recognized that a low copay of $10 could in fact be more than a high coinsurance of 50% in certain cases.

The completion of the benefit matrix was undertaken by the Task Force as an exercise and is not meant to be interpreted as a recommendation on how a basic benefit plan should be structured. More detailed definitions would need to be given, which could lead to greater agreement. For instance, does the prescription drug column include inpatient as well as outpatient prescriptions and what are the ranges of low, medium, and high levels of contribution for each type of service?

RECOMMENDATIONS

Summary of Findings

The Task Force unanimously agreed that further investigation on the use of a basic benefit plan for expanding coverage to the low-income uninsured is a worthwhile endeavor. They found a sufficient level of agreement in the importance of broad categories of services and reasonable levels of individual contribution to suggest that the definition of a basic benefit plan can be achieved.

It was generally recognized that the target population between 100 – 200% FPL needed many of the same services as the OHP population. At a minimum, the basic benefit plan should emphasize access promotion, increasing the prospects for preventive care, early intervention, improved outcomes, and overall savings to the health care system. Further study of the characteristics of this population, such as the distribution in education level, ethnicity,

disposable income, employment type (e.g. seasonal, part-time), could be useful in designing a meaningful basic benefit plan.

Plans for Further Study

It is the Governor's intention that further work on developing the Task Force's recommendations be taken on by the Health Services Commission, utilizing their ten years of experience in prioritizing health services. The Commission would likely organize a subcommittee to separate this task from their current work on maintaining the Prioritized List of Health Services. The Commission will not be limited to previous policies or the methodologies used in the development of the Prioritized List, but rather use their accumulated knowledge in discussing any and all approaches to extending health care coverage to this target population. Special consideration should be given to cost (including cost sharing), the role of the safety net[9], and integration with any private side efforts.

For more information on the work of the Task Force on Basic Benefit Plans, please contact Darren Coffman of the Office for Oregon Health Plan Policy and Research at (503) 378-2422 or Darren.D.Coffman@state.or.us.

[9] The Institute of Medicine defines the *safety net* as "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations". They further state that, "in most communities there is a subset of the safety net defined as *core safety net providers*. These providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission, they maintain an "open door", offering access to services for patients regardless of their ability to pay, and (2) a substantial share of their patient mix is uninsured, Medicaid, or other vulnerable patients."

ATTACHMENT A

Points for Consideration when Defining a Basic Benefit Plan

Services
Comprehensive primary care
Ancillary care
Urgent and emergent hospital and surgical care
Elective hospital and surgical care
Preventive care
Mental health integration
Cafeteria plan of extras
Condition-treatment pairs
Non-experimental

Financial considerations
Incentives
Cost Sharing
Minimize public assistance
Tiered subsidy
Affordability
Avoid crowd-out
Cost reimbursement
Tax credits
Buy-in option

Systems issues
Utilize existing administrative structure
Portability
Recognize barriers to care

General considerations
Equity
Flexibility
Evidence-based
Cost-effective
Private side involvement

ATTACHMENT B

Categories of Care (listed in priority given by Health Services Comm.)	Service Type							
	Inpatient services	Outpatient services	ER	MH/CD	Oral health	Rx	Other ancillary	Enabling services
Treatable Fatal Conditions	0 - L	0 - L	0 - L	0 - L	N/A	0, L, M	L	0 - L
Maternity Care	0 - L	0 - L	0	0	N/A	0 - L	0 - L	0 - L
Preventive Care	N/A	0 - L	N/A	0, M	0, M	L - M	L	0, M
Family Planning	0 - L	0 - L	H	N/A	N/A	0 - L	M	0, H
Comfort Care	L	0 - L	0 - L	0 - L	N/A	0 - L	0 - L	0 - L
Treatable Nonfatal Conditions	M - H	M - H	M - H	M	M - H	L, M, H	M - H	0, M
Self-limited Conditions	X	X	X	X	X	X	X	X
Infertility Services	X	X	X	X	X	X	X	X
Futile Care	X	X	X	X	X	X	X	X

Legend: 0 = No contribution
L = Low contribution
M = Medium contribution
H = High contribution
X = Not covered, full contribution
N/A = Not applicable

The above levels of contribution (0, L, M, H, or X) are approprate to ask of an individual living in a house- with income between 100-200% FPL. Different levels of contribution are listed for services of a specific type (columns) to be used in the treatment of conditions within certain categories of care (rows) as part of a basic benefit package emphasizing access promotion.

Outpatient services include office visits, lab, x-ray, and outpatient surgery.

Other ancillary services include DME, PT/OT, speech therapy, and hearing services.

Enabling services include transportation, interpretive services, and coordination of care.

The categories of care are based on the 17 categories ranked by the Health Services Commission (HSC) as part of their original prioritization methodology.

Treatable fatal conditions include the HSC categories: acute fatal, treatment prevents death with full recovery (HSC1), acute fatal, treatment prevents death without full recovery, (HSC3) and chronic fatal, treatment improves life span and quality of life (HSC5).

Maternity care (HSC2) includes obstetrical care for pregnancy and most disorders of the newborn.

Preventive care includes services for children (HSC4) and adults (HSC8) that have been rated as A or B by the US Preventive Services Task Force. Consider services under the oral health heading as including cleaning and fluoride for children and those at high risk who cannot provide self-care (HSC9). Less effective preventive services (HSC16) rated as C, D, or E by the Task Force are not included in any of these categories of care.

Family planning (HSC6) include contraceptive management, vasectomy, and tubal ligation

Comfort care (HSC7) includes palliative therapy for terminal illness. Services covered under OHP include pain management, hospice care, symptom relief, and services under the Oregon Death with Dignity Act.

Treatable nonfatal conditions include the HSC categories: acute nonfatal, treatment causes return to previous health state (HSC10), chronic nonfatal, one-time treatment improves quality of life (HSC11), acute nonfatal, treatment without return to previous health state (HSC12), and chronic nonfatal, repetitive treatment improves quality of life (HSC13).

Self-limited conditions (HSC14) includes acute, nonfatal conditions where treatment expedites recovery (e.g. treatment for a viral sore throat).

Infertility services (HSC15) include medical therapy for anovulation, microsurgery for tubal disease, and in-vitro fertilization.

Futile care (HSC17) include fatal and nonfatal conditions where treatment causes minimal or no improvement in quality of life.

Extracted from the Report of the Task Force on Basic Benefit Plans, Office for Oregon Health Plan Policy Research

Oregon Health Services Commission

Prioritized List of Benefit Packages for OHP Standard

Interim Report to the Governor and Legislative Leadership

July 2002

Prioritized List of Benefit Packages for OHP Standard

Interim Report to the Governor and Legislative Leadership

If you would like additional copies of this report, or if you need this material in an alternate format, please call (503) 378-2422.

Department of Administrative Services
Oregon Health Policy and Research
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July 2002

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Chapter 1

Introduction

Introduction

This interim report chronicles the work of the Health Services Commission (HSC) and Waiver Application Steering Committee (WASC) in the development of the Oregon Health Plan (OHP) Standard benefit package for the 2001–03 biennium, providing an update to the information appearing in the HSC's October 2001 report.[1] The OHP Standard Prioritized List of Benefit Packages for the 2003–05 biennium is also presented. A subsequent report including the actuarial pricing of this list will be submitted once all terms and conditions of the necessary Medicaid waivers are known.

HB 2519 and the OHP2 Waiver

Efforts to maintain the OHP and the desire to extend coverage to more Oregonians resulted in the passage of House Bill (HB) 2519 during the 2001 legislative session. The bill outlines the policy framework and the process to expand the number of persons eligible for the OHP, using the savings from creating a basic benefit package within OHP and obtaining additional federal matching funds. The reduction in benefits for select groups within OHP will require a new Medicaid waiver.

The Oregon Health Plan 2 (OHP2) Waiver will serve as a bridge from traditional Medicaid/SCHIP benefits to private coverage benefits. OHP2 will maintain the current Oregon Medicaid/SCHIP benefit package (to be renamed OHP Plus) for certain vulnerable populations, add a second reduced benefit package (to be known as OHP Standard) for other populations, and subsidize private insurance for people eligible for OHP2 who have qualified employer-sponsored insurance (ESI) available to them or, if ESI is not available, individual coverage. The ESI subsidies will be provided through the Family Health Insurance Assistance Program. Savings from the reduced benefit package and additional federal financial participation will be allocated to finance the results of outreach and an eligibility expansion for adults and children at higher income levels than are currently in place.

Overview of OHP Plus

Under OHP2, the Health Services Commission will continue to maintain the existing Prioritized List of Health Services. This list will be used to establish the OHP Plus benefit package of health care services. OHP Plus will be provided for all mandatory and certain optional populations. The groups that will receive OHP Plus include:

[1] *Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard; October 2001.*

- The elderly and disabled at the current eligibility levels;
- The TANF population at the current eligibility levels;
- All children (Medicaid and SCHIP) up to 185 percent of FPL;
- Pregnant women up to 185 percent of FPL; and
- General Assistance recipients at the current eligibility levels.

Changes to benefits in OHP Plus will be determined by the legislature through the movement of the funding level on this prioritized list. This will continue to be a public process, with changes in benefit levels requiring approval by the Centers for Medicare and Medicaid Services (CMS). Oregon will be requesting of CMS, as part of the terms and conditions of the OHP2 Waiver application, a streamlined process through which Oregon can move the coverage line further up or down the list.

Overview of OHP Standard

With the OHP2 Waiver, Oregon is requesting the ability to alter the OHP Standard benefit package so it can be adjusted to available revenue as necessary, and still preserve basic services. Specifically, Oregon is seeking permission to adjust the OHP Standard benefit package as long as it is at least actuarially equivalent to the federally mandated Medicaid benefit package. The mandated package is equivalent to approximately 56 percent of the value of the current OHP benefits. The OHP Standard benefits described in Chapter 2 of this document are the benefits as recommended for initial OHP2 program implementation. In subsequent biennia, Oregon will set the OHP Standard benefits at a level that can be supported by available revenue.

The groups that will receive OHP Standard include only those adults in the optional and expansion Medicaid populations (not included in OHP Plus) that do not have qualified employer-sponsored insurance (ESI) available. The maximum income level will initially be up to 110 percent of the federal poverty level (FPL) and incrementally increased to 185 percent of FPL as funding allows.

Cost sharing and benefit reductions in OHP Standard will be overlaid on the Prioritized List of Health Services. Services excluded from OHP Plus coverage because they are "below the line" on that list will also be excluded from OHP Standard coverage. The Prioritized List of Benefit Packages will be reviewed prior to each legislative session as outlined in HB 2519, with the HSC determining a re-ordering of benefit categories as necessary.

Chapter 2

Summary of Activities
(October 2001—January 2002)

Summary of Activities
(October 2001–January 2002)

Health Services Commission

Section 5 of the HB 2519 outlines the charge to the Health Services Commission (HSC) to develop a standardized benefit package that is actuarially equivalent to the Medicaid-mandated level of care. The HSC also was asked:

> *…to rank in priority order additional packages of health care services that may be provided to the extent the Legislative Assembly has provided funds for additional benefit packages*.

HB 2519 further states that:

> *... the commission shall recommend whether Oregonians receiving subsidies for OHP Standard be required to pay premiums and copayments based on the individual's ability to pay and how to structure the copayments and premiums in a manner that encourages the use of preventive services.*

After receiving the charge from the Governor and the Legislature, the HSC debated how best to structure the OHP Standard benefit package called for by HB 2519. They initially considered defining the benefit package using the Prioritized List of Health Services currently in use under the existing Medicaid Demonstration waiver. This approach would define coverage based on the cost-effectiveness of a treatment, the impact of the treatment on a person's health status, and the inherent public values used in the creation of that list. However, in order to reach the projected 22 percent reduction in benefits necessary to reach budget neutrality under OHP2, substantial cuts in the funding of the Prioritized List of Health Services would have been necessary. It was estimated that the coverage level on that list would have to be reduced from line 566 (out of 736 total lines) up to line 350 or above. This dramatic rise in the funding line would be necessary because most of the life saving and more costly services are found towards the top of the list. Since this would mean eliminating the treatment of most non life-threatening diseases (e.g., glaucoma, closed fractures) and coverage for some treatable cancers, the Commission quickly dismissed this as a viable option. The current Prioritized List of Health Services will remain, however, as the basis for determining coverage for specific conditions and treatments for both OHP Plus and OHP Standard.

Since HB 2519's aim was to create a bridge between traditional Medicaid benefits and those seen in the commercial insurance market, the HSC turned to the insurance model as

a basis for defining the OHP Standard benefit package. Access promotion and an emphasis on preventive services and early intervention were determined by the Commission to be key factors in the benefit design. They looked to the incorporation of cost-sharing as a means of gaining more flexibility in the package beyond the basic categories of benefits. This allowed inclusion of vital benefits such as prescription drugs and mental health services, which are optional under Medicaid, to be included in addition to mandatory benefits such as hospital and physician services.

After obtaining public input and completing a year of benefit analysis, the Health Services Commission (HSC) prepared a report in October 2001 that included a prioritization of benefit packages for OHP Standard and recommendations for cost-sharing. The Commission's report was forwarded to the Waiver Application Steering Committee, the Joint Interim Legislative Leadership Committee on Health Care Costs and Trends, and the Joint Interim Committee on Health and Human Services as required by HB 2519.

Waiver Application Steering Committee

As required by HB 2519, the Department of Human Services (DHS) established the Waiver Application Steering Committee (WASC) to:

1) recommend a benefit package for the OHP Standard population; and
2) assist and advise DHS in the preparation of the waiver application.

The WASC included legislators and representatives of a broad range of interest groups. The committee met for ten sessions from September 2001 through January 2002, hearing testimony from a variety of different stakeholders and the public about the Commission's recommendations for OHP Standard benefit priorities. The WASC needed to balance many factors in reaching their decision. Among these were:

- The need to obtain greater flexibility in managing the costs of OHP and its benefit package;
- The level of benefit reductions necessary in the OHP Standard benefit package to achieve a meaningful expansion in Medicaid coverage for the Federal government to grant a waiver;
- The value of expanding health insurance coverage to uninsured Oregonians above 100 percent of FPL, and the number to be insured under the waiver;
- The requirement that implementation of HB 2519 be budget neutral;
- The impact of the implementation of HB 2519 on other state programs;

- The ability of those served by OHP Standard to afford the explicit cost-sharing represented by copays and premiums and the implicit cost-sharing imposed through benefit elimination; and
- The effect of cost-sharing on reimbursement levels and how that impacts access to an adequate number of providers for an expanded Medicaid population.

While the WASC accepted the ordering of benefit packages given by the HSC in their October 2001 report, the committee had concerns about the high levels of cost-sharing being recommended, particularly in the areas of inpatient hospital services and prescription drugs. Based on extensive discussions and recommendations from advocates and health plans, including several alternative benefit package proposals, the WASC recommended the OHP Standard benefit package and the cost-sharing requirements shown in Table 2.1. For the most part, cost-sharing is recommended to be in the form of copays for each service received. Of note is a tiered-copay structure for prescription drugs that requires lower copay amounts for those with incomes below the federal poverty level (FPL) and also encourages the use of generic drugs through significantly lower contribution amounts.

In order to satisfy the parameters established by the Governor and the legislative leadership that called for a benefit package of no more than 78 percent of the current level, the WASC also recommended that premiums for OHP Standard be required according to the schedule in Table 2.2. This represents an increase in premiums beyond those already in place for the current OHP program in the form of:

- A new tier for individuals from 11–50 percent of FPL, now at $9 instead of $6 dollars;
- A premium rate for couples at twice that of single adults (the current rate in OHP for couples is about 1.15 times the single rate); and
- Additional contributions for those between 100–185 percent of FPL.

The contribution rates for 100–185 percent of FPL were developed to result in a linear progression starting from those premiums currently required in OHP for new eligible populations <100 percent of FPL, and taking into account the contributions required in the Family Health Insurance Assistance Program (FHIAP).[2]

The WASC also discussed other issues related to the OHP2 Waiver (e.g., eligibility, waiver strategy, and the balance between public and private programs) and advised DHS on

[2] *For information on current OHP and FHIAP premiums, see the Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard; October 2001, Chapter 3.*

Table 2.1: WASC-Recommended OHP Standard Benefits & Cost-sharing

Service	*Cost Share %*	*Recommended Cost-sharing Mechanism*
Inpatient Hospital	5%	$250 copay per admission
Outpatient Hospital	4.5%	Â $20 copay/surgery Â $5 copay other outpatient services
Emergency Room	12%	$50 copay, waived if admitted
Physician Services	4.3%	Â $5 copay office visits Â $3–$10 copay medical & surgical procedures
Lab & X-ray	5.7%	$3 copay for each lab and X-ray
Ambulance	11.7%	$50 copay
Prescription Drugs	15.2%	0–100% FPL: Â $2 generic; Â $3 MH/cancer/ HIV brand drugs; Â $15 other brand 101–185% FPL: Â $5 generic; Â $10 MH/cancer/ HIV brand drugs; Â $25 other brand
Mental Health and Chemical Dependency	6.1%	Â $5 copay Â No copay on dosing/dispensing or case management services
Durable Medical Equipment	53.2%	Â Recurrent: $2 copay per 30-day supply Â No coverage for one-time DME
Dental	50%	Â Dx & Preventive: zero/minimal copays Â Restorative: graduated copays Â $500 benefit limit
Cumulative Cost	*86.1%*	
Behavioral Offset	*-6.0%*	
Premium Offset	*-2.1%*	*See Table 2.2 for revised premium structure*
Net Cost	***78%***	

Table 2.2: WASC-Recommended OHP Standard Premium Structure

	Single	*Couple*	*% of Package*
0–10% FPL	$6	$12	2.4%
11–50% FPL	$9	$18	3.6%
51–65% FPL	$15	$30	6%
66–85% FPL	$18	$36	7.2%
86–100% FPL	$20	$40	8%
101–125% FPL	$23[1]	$46	9.2%
126–150% FPL	$35	$70	14%
151–170% FPL	$75	$150	30%
171–185% FPL	$125	$250	50%
Percentage savings to OHP Standard Benefit package: 2.1%[2]			

[1] *Premiums for people with incomes 101–185% of FPL will be based on the percentage cost of the OHP Standard Benefit package (shown in the far-right colum), not fixed at these dollar amounts.*

[2] *Savings assumes a 95% collection rate during the month in which the premiums are due.*

these issues. In addition, the WASC reviewed the recommendations regarding the benefits benchmark for FHIAP.

The final OHP Standard benefit package and premium structure recommendations of the WASC were incorporated into the OHP2 Waiver application and forwarded to the Joint Legislative Leadership Commission on Health Care Costs and Trends and the Emergency Board in January 2002. The OHP2 Waiver application was approved at the May 1, 2002 meeting of the Emergency Board, with no adjustments to the WASC-recommended OHP Standard benefit package and premium structure for the 2001–03 biennium. DHS submitted the Medicaid waivers to the Centers for Medicare and Medicaid Services (CMS) on May 31, 2002.

Chapter 3

Prioritization of OHP Standard Benefit Packages

Prioritization of OHP Standard Benefit Packages

The Prioritized List of Benefit Packages for OHP Standard for the 2003–2005 biennium appears in Table 3.1. The Health Services Commission (HSC) was responsible for the ordering of the benefit packages represented by columns 1 and 2 of this table. In fact, the prioritization order has not changed from the list included in the Commission's October 2001 report on OHP Standard. The Waiver Steering Application Committee (WASC) recommended the cost-sharing percentages shown in column 3 of Table 3.1. The corresponding types of cost-sharing mechanisms recommended by WASC were outlined previously in Table 2.1 of Chapter 2.

The benefit packages that make up each row on the list represent broad categories of benefits (column 2) in combination with a level of cost-sharing required from the individual as services are used (column 3). Benefit categories appearing within the shaded region of the table represent benefits mandated for coverage by Medicaid laws. Those categories not appearing within the shaded region are considered optional services under Medicaid and need not be covered for adult populations. In the second column, a single benefit category may appear more than once on the list. This provides flexibility in applying different cost-sharing levels to a benefit category depending on how far down the funding line is drawn. For instance, a funding line drawn just below row 11 on the list would result in a benefit package requiring an average contribution by the individual of 53.2 percent towards the cost of durable medical equipment (DME) supplies. A funding level drawn just below row 20 on the list would result in the individual paying, on average, 20 percent in cost-sharing towards these same services.

The fourth column in the table represents the relative cost of that benefit package in comparison to the total cost of the current OHP benefit package. For example, the addition of prescription drugs at a cost-share of 15.2 percent to the individual represents 20 percent of the costs of the current package. By totaling up the percentages in this column for the four prescription drug lines, these services alone currently account for 23.6 percent of the total OHP costs for this population. These calculations are based on utilization data for that segment of the current OHP population, known as the OHP Families and OHP Adults/ Couples categories, which would receive services as defined by OHP Standard. These figures represent a continuation of the same utilization rates historically seen for this population. The percentages do not reflect any decrease in utilization that may result from the imposition of cost-sharing (referred to as "behavioral offset") nor reflect the utilization rates of those individuals who would gain coverage under this portion of the OHP2 Waiver.

Table 3.1: OHP Standard Prioritized List of Benefit Packages for the 2003–05 Biennium

Row	*Benefit Category*	*% Cost-sharing*	*% of Package*	*Cumulative %*
1	Hospital, Physician, Lab, X-ray	0%	56.0%	56.0%
2	Â Inpatient Hospital	5%	-1.0%	
3	Â Outpatient Hospital	4.5%	-0.3%	
4	Â Emergency Room	12%	-0.2%	
5	Â Physician	4.3%	-0.8%	
6	Â Lab/X-ray	5.7%	-0.5%	
7	Â Ambulance	11.7%	-0.1%	
8	Cost-sharing on Mandated Services		-2.9%	53.1%
9	Prescription Drugs	15.2%	20.0%	73.1%
10	Mental Health/Chemical Dependency	6.1%	8.0%	81.1%
11	Durable Medical Equipment	53.2%	0.3%	81.4%
12	Dental	50%	4.7%	86.1%
13	Vision	48%	0.5%	86.6%
14	Dental	35%	1.4%	88.0%
15	Inpatient Hospital	2.5%	0.5%	88.5%
16	Ambulance	5.8%	0.05%	88.6%
17	Prescription Drugs	10%	1.2%	89.8%
18	Non-emergent Transportation	50%	0.3%	90.1%
19	Dental	20%	1.4%	91.5%
20	Durable Medical Equipment	20%	0.2%	91.7%
21	Prescription Drugs	5%	1.2%	92.9%
22	Emergency Room	6%	0.1%	93.0%
23	Physician	0%	0.8%	93.8%
24	Mental Health/Chemical Dependency	0%	0.5%	94.3%
25	Inpatient Hospital	0%	0.5%	94.8%
26	Outpatient Hospital	0%	0.3%	95.1%
27	Emergency Room	0%	0.1%	95.2%
28	Lab/X-ray	0%	0.5%	95.7%
29	Ambulance	0%	0.05%	95.7%
30	Prescription Drugs	0%	1.2%	96.9%
31	Dental	0%	1.9%	98.8%
32	Durable Medical Equipment	0%	0.1%	98.9%
33	Vision	0%	0.5%	99.4%
34	Non-emergent Transportation	0%	0.6%	100.0%

The final column shows the cumulative percentage for the relative cost of all benefit packages included up to that point. Using a funding line drawn under row 12, as recommended by the WASC, results in a benefit package that would be 86.1 percent of the cost of providing the current OHP benefit package. As shown previously in Chapter 2, the last three rows of the WASC-recommended OHP Standard benefits and cost-sharing package (Table 2.1) reflect the additional estimated effect of the behavioral offset and an additional offset due to increased premium levels (detailed in Table 2.2). This results in a final benefit package valued at 78 percent of the current OHP package.

The final number in the last column is 100 percent, meaning that all services currently covered under the current OHP benefit package are represented. Also note that the list presumes those services currently excluded under the current Medicaid Demonstration (and therefore in OHP Plus) will be excluded in OHP Standard as well. HB 2519 specifically states that OHP Standard cannot exceed those benefits offered in OHP Plus.

All numbers appearing in Tables 2.1 and 3.1 represent estimates made by OHPR staff based on the previous work of PricewaterhouseCoopers (PwC) that led to the pricing that appeared in the HSC's October 2001 report. The final actuarial pricing for the list appearing in Table 3.1 will be performed by PwC upon the conclusion of the negotiations between the state of Oregon and CMS leading to the approval of the OHP2 Waiver. The final terms and conditions of the OHP2 Waiver will then be known and can be incorporated into the calculations. Depending on the timing of the Waiver approval, the final pricing of the OHP Standard Prioritized List of Benefit Packages for the 2003–05 biennium will either appear as an addendum to this report or as a part of the HSC's Biennial Report to the Governor and 72nd Oregon Legislative Assembly on the Prioritization of Health Services.

Chapter 4

Ongoing Activities and Next Steps
(January 2002—Present)

Ongoing Activities and Next Steps
(January 2002–Present)

As the deliberations of the Waiver Application Steering Committee (WASC) reached conclusion over the OHP Standard benefit package, there were concerns raised over the cost-sharing components of the resulting benefit package. It was requested that the Health Services Commission (HSC) take a closer look at the individual condition-treatment pairs on the Prioritized List of Health Services to determine if there are less effective treatments that could either be eliminated from coverage or managed by therapy guidelines. The aim would be to allow reductions in overall costs of the OHP, while preserving basic services, or lower cost-sharing components.

As with endeavors to create the first Prioritized List of Health Services, the HSC called upon the various provider groups to help identify those diagnoses and procedures within their purview that might be less important for the adult expansion population under OHP2. During the Commission's initial deliberations over the development of the OHP Standard Prioritized List of Benefit Packages, the HSC worked closely with the Dental Care Organizations (DCOs) to determine if any savings could be obtained from some restrictions in benefit service levels and the addition of cost-sharing. The DCOs' public input into the HSC process provided a means of continuing coverage within OHP Standard for a core package of dental benefits with cost sharing. The dental community's response to this challenge has served as a model for the HSC, the Mental Health and Chemical Dependency (MHCD) Subcommittee of the HSC and the OHP Medical Directors.

Non-lethal conditions, primarily affecting adults, between Line 400 through Line 566 of the Prioritized List of Health Services were considered for review. The OHP Medical Directors focused initially on twenty-one lines that dealt with the areas of orthopedics, general medicine, otolaryngology, and gynecology. Besides examining specific conditions and treatments, the OHP Medical Directors, with input from various stakeholders, considered the feasibility of using less expensive sites of service for certain conditions such as colonoscopy, endoscopy and other outpatient procedures.

The MHCD Subcommittee established workgroups to consider benefit changes in the areas of treatments for less severe mental health conditions, chemical dependency management, and non-hospital (sub-acute) detoxification. Also reviewed for exclusion or limitations on coverage were a few pharmaceutical classes, especially those used to commonly treat conditions that fall below the funding line on the Prioritized List of Health Services such as benzodiazepines, muscle relaxants, and sleeping medications. In addition,

the MHCD Subcommittee extensively reviewed the use of acupuncture for chemical dependency.

To assist the benefit management discussions for the OHP Medical Directors and the MHCD Subcommittee, utilization data was obtained from the Office of Medical Assistance Programs for the OHP adults and couples populations to be covered by OHP Standard. This helped to quantify the actual use of the services being considered for exclusion or guideline management. Also, providers representing the various medical and surgical specialty organizations were convened to discuss these potential limits on services and their impact on overall quality of care. The OHP Medical Directors and MHCD Subcommittee compiled their lists of services to be considered for either elimination or for new or revised management guidelines in the OHP Standard population. These recommendations were forwarded to the HSC for their consideration. The overall savings to the proposed OHP Standard benefit package for the adult expansion populations was estimated to be between 2–3 percent.

The Emergency Board asked, as a condition of the approval of the the OHP2 Waiver, that the HSC work towards a goal of lowering overall costs of the entire OHP program by 10 percent. This would include those covered under OHP Plus, as well as the adults under OHP Standard. The Commission is currently re-examining those conditions and treatments initially considered for elimination or guideline management by the OHP Medical Directors and MHCD Subcommitte to see if these changes can be applied to the broader OHP Plus population. The Commission will be presenting that information as they make their recommendations for the Prioritized List of Health Services for the 2003–05 biennium.

Process for Future OHP Standard Recommendations

For subsequent biennia, HB 2519 calls for the Health Services Commission to submit a new Prioritized List of Benefit Packages for OHP Standard. Beginning with this report, the Commission will submit a new prioritized list on July 1 of each even-numbered year for consideration by the following year's legislative assembly.

OHP Standard Additional Limitations and Exclusions

410-120-1210

Medical Assistance Benefit Packages and Delivery System

(3) The benefit limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in individual program Provider rules. The benefits and limitations included in each OHP Benefit Package follow:

(d) OHP Standard benefits adhere to the following provisions:

(B) The following services have limited coverage for the OHP Standard benefit package (Refer to the cited OAR chapters and divisions for details):

(i) Selected Dental (OAR chapter 410 division 123);

410-123-1670

OHP Standard Emergency Dental Benefit

(1) The definition of Dental Emergency is limited to section (2) in this rule for clients eligible for OHP Standard.

(2) The intent of the OHP Standard Limited Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(3) Services are limited to those procedures listed in Table 123-1670-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain;

(d) Tooth re-implantation when clinically appropriate; and

(e) Extraction of teeth are limited only to those teeth that are symptomatic.

(4) Hospital Dentistry is not a covered benefit for the OHP Standard population except:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(5) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit. Table 123-1670-1

[ED. NOTE: Tables referenced are available from the agency.]

OHP Standard Additional Limitations and Exclusions

(ii) Selected Durable Medical Equipment and medical supplies (OAR chapter 410, division 122 and 130);

410-122-0055

OHP Standard Benefit Package Limitations

(1) The Division of Medical Assistance Programs (DMAP) limits coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the Oregon Health Plan (OHP) Standard benefit package to the codes referenced in ***Table 122-0055****. Coverage requirements and limitations, as specified in chapter 410, division 122, apply. For more information about the OHP Standard benefit package, see DMAP General Rules (chapter 410, division 120).*

(2) ***Table 122-0055***

[ED. NOTE: Tables referenced are available from the agency.]

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

410-148-0090

Standard Benefit Package

(1) Some procedure codes/services are not covered for the Standard Benefit Package population. See General Rules 410-120-1210 for additional information.
(2) The OHP Standard benefit package includes limited Home Enteral/Parenteral and IV services:
(a) Drugs that are usually self-administered by the patient such as oral pill form or self-injected medications, are not covered;
(b) Oral nutrition services and supplies are not covered, except when the nutritional supplement meets the criteria specified in 410-148-0260(3), and is the sole source of nutrition for the client;
(c) Nursing assessment and nursing visits must be directly related to administration of the home enteral/parenteral nutrition and intravenous services pursuant to Oregon's Nurse Practices Act (OAR 851-001-0000). Home Health and Private Duty Nursing are not covered services under the Standard benefit package (General Rules 410-120-1210), except nursing assessment and nursing visits under this limited Home Enteral/Parenteral and IV benefit are covered.

(iv) Selected Hospital services (OAR chapter 410, division 125);

410-125-0047

Limited Hospital Benefit Package for the OHP Standard Population

OHP Standard Additional Limitations and Exclusions

(1) The Oregon Health Plan (OHP) Standard population has a limited hospital benefit for urgent or emergent inpatient and emergency room services effective on August 1, 2004 through August 31, 2004. The limited hospital benefit for inpatient, outpatient, and emergency room services is effective on and after September 1, 2004.

(2) The limited hospital benefit includes the ICD-9 CM codes listed in the OHP Standard Population -- Limited Hospital Benefit Code List. This rule incorporates by reference the OHP Standard Population -- Limited Hospital Benefit Code List. This list includes diagnoses requiring prior authorization indicated by letters prior authorization (PA) next to the code number. The most current list, dated September 1, 2004, is available on the web site (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact the Division of Medical Assistance Programs (DMAP) for hardcopy.

(3) DMAP will reimburse hospitals for inpatient (diagnostic and treatment) services, outpatient (diagnostic and treatment services) and emergency room (diagnostic and treatment) based on the following:

(a) For treatment, the diagnosis must be listed in the OHP Standard Population -- Limited Hospital Benefit Code List;

(b) For treatment the diagnosis must be above the funding line on the Prioritized List of Health Services (HSC List) (OAR 410-141-0520);

(c) The diagnosis (ICD-9) must pair with the treatment (CPT code); and

(d) Prior authorization (PA) must be obtained for codes indicated in the OHP Standard Population -- Limited Hospital Benefit Code List. PA request should be directed to the DMAP contracted Quality Improvement Organization (QIO) and will follow the present (current) PA process. PAs must be processed as expeditiously as the client's health condition requires;

(e) Medically appropriate services required to make a definitive diagnosis are a covered benefit.

(4) Some non-diagnostic outpatient hospital services (e.g. speech, physical or occupational therapy, etc.) are not a covered benefits for the OHP Standard population (see the individual program for coverage).

(5) For benefit implementation process and PA requirements for the client enrolled in a Fully Capitated Health Plan (FCHP) and/or Mental Health Organization (MHO), contact the client's FCHP or MHO. The FCHP and/or MHO may have different requirements than DMAP.

(v) Other limitations as identified in individual DMAP program administrative rules.

(C) The following services are not covered under the OHP Standard Benefit Package. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for chemical dependency treatment (OAR chapter, 410 division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

OHP Standard Additional Limitations and Exclusions

(iv) Home Health Services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency Medical Transportation (OAR chapter 410, division 136);

(vi) Occupational Therapy services (OAR chapter 410, division 131);

(vii) Physical Therapy services (OAR chapter 410, division 131);

(viii) Private Duty Nursing Services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and Language Therapy services (OAR chapter 410, division 129);

(x) Vision Services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

Potential OHP Standard Benefit Design Options Based on the 2007-09 Prioritized List and Funding Reflected by the DHS Agency Recommended Budget[1]

Lines on Prioritized List

		HSC Health Care Categories								
	Approx. OHP Standard Population	1) Maternity/Newborn Care	2) Prevention	3) Chronic Disease Management	4) Reproductive Services	5) Comfort Care	6) Fatal - Disease Modification/Cure	7) Nonfatal - Disease Modification/Cure	8) Self-Limited Conditions	9) Inconse-quential
100	41,000	100% of costs (18/24 lines)	55% of costs (5/11 lines)	79% of costs (25/59 lines)	95% of costs (2/3 lines)	100% of costs (1/1 line)	22% of costs (49/270 lines)	0%	0%	0%
200	33,000	100% of costs (21/24 lines)	100% of costs (10/11 lines)	89% of costs (37/59 lines)	95% of costs (2/3 lines)	100% of costs (1/1 line)	50% of costs (127/270 lines)	0%	0%	0%
300	28,000	100% of costs (22/24 lines)	100% of costs (11/11 line)	92% of costs (49/59 lines)	95% of costs (2/3 lines)	100% of costs (1/1 line)	82% of costs (203/270 lines)	3% of costs (12/248 lines)	0%	0%
400	24,000	100% of costs (24/24 line)	100% of costs (11/11 line)	100% of costs (54/59 lines)	100% of costs (3/3 lines)	100% of costs (1/1 line)	99% of costs (257/270 lines)	43% of costs (50/248 lines)	0%	0%
503[2]	22,000	100% of costs (24/24 line)	100% of costs (11/11 line)	100% of costs (58/59 lines)	100% of costs (3/3 lines)	100% of costs (1/1 line)	100% of costs (267/270 lines)	100% of costs (141/248 lines)	0% of costs (0/22 lines)	0% of costs (0/42 lines)
680	*20,000*[3]	*Actuarial pricing of below the line services has not been performed since the development of the 1997-99 per capita cost report.*								

[1] **The percentages in the matrix represent the portion of expenditures within an HSC category of care covered through various funding levels in comparison to an OHP Plus equivalent benefit package (i.e., assuming no additional exclusions such as a limited hospital benefit, emergency dental only).**

[2] **Line 503 on 2007-09 Prioritized List is best equivalence to current benefits thru line 530 on 2005-07 List.**

[3] **Assumes nonfunded portion of the list represents 10% of the costs of the entire list. 28,000 individuals could be covered if ALL services on list were covered; fewer individuals could be covered if exclusions similar to commercial plans were still in place.**

Oregon Health Fund Board

Benefits Committee
October 17, 2007

Clackamas Community College
Wilsonville Campus Training Center, Room 110
29353 Town Center Loop East
Wilsonville, Oregon

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Oregon Health Fund Board
Benefits Committee Meeting
October 17, 2007

Oregon Health Fund Board
Benefits Committee Meeting

Wednesday, October 17, 2007
9:30 – 11:30 am
Room 110
Clackamas Community College
Wilsonville Campus Training Center
29353 Town Center Loop East
Wilsonville, OR

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
9:30 am	Call to Order	Darren Coffman	
10 min	Introductions of Committee Members & Staff	Darren Coffman	
9:40 10 min	Review & Adoption of By-laws	Darren Coffman	X
9:50 10 min	Nominations & Election of Committee Chair and Vice Chair	Darren Coffman	X
10:00 30 min	Introduction to SB 329 Reform Process and Assumptions for Reform	Barney Speight	
10:30 30 min	Review of Draft Committee Charter, Use of Workgroups vs. Ad Hoc Task Forces; Timeline	Chair	
11:00 10 min	Future Meetings	Chair	
11:10 20 min	Public Testimony	Chair	
11:30 am	Adjourn	Chair	

Next Meeting: TBD

EXHIBIT MATERIALS:
A. OHFB Committee Members List
B. OHFB Organizational Documents
C. SB 329 *
D. Summary of SB 329
E. Oregon Health Policy Committee Roadmap for Health Care Reform**
F. Oregon Business Policy Playbook±
G. Description of OHPR Programs

* Available at: http://www.leg.state.or.us/07reg/measpdf/sb0300.dir/sb0329.en.pdf
** Available at: http://egov.oregon.gov/DAS/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf
± Available at: http://www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf
(see pages 57-69 of the PDF)

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE
Draft By-Laws
Adopted by OHFB _____

ARTICLE I
The Committee and its Members

- The Benefits Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for the defined set(s) of essential health services, the committee shall consider:

- Mechanisms for setting priorities that optimize the health of Oregonians;
- The demographic characteristics of the uninsured (e.g., age, gender, family status, income) in examining what services would best meet their needs in an affordable manner;
- The applicability of the HSC Prioritized List of Health Services;
- Methods for collecting and incorporating public values of those who will potentially benefit from and potentially contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
- The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
- An emphasis on preventive care and chronic disease management;
- Approaches that promote integrated systems of care centered on a primary care home;
- Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
- The needs of vulnerable populations in order to reduce health disparities;
- The definition and inclusion of services for dignified end-of-life care;
- Education activities that further health and wellness promotion;
- Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
- Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

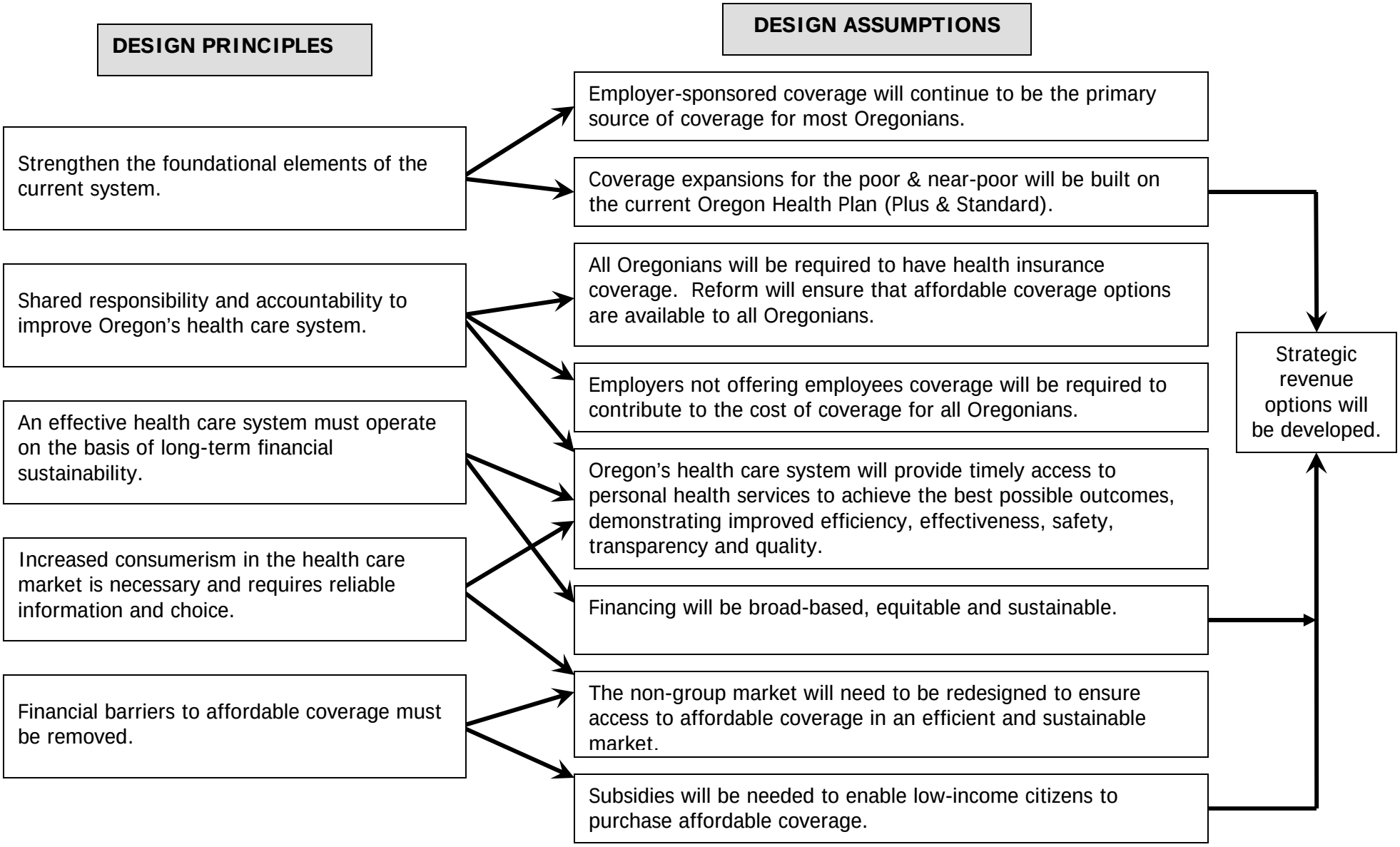
Staff Resources

Darren Coffman – Lead staff
Ariel Smits, MD – Clinical staff
Brandon Repp – Research staff
Nate Hierlmaier – Research staff
Dorothy Allen – Administrative staff
Barney Speight – Director, OHFB

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OREGON HEALTH FUND BOARD
A Comprehensive Plan for Reform: Design Principles and Assumptions
Approved by OHFB _____



Oregon Health Fund Board
Benefits Committee
Members Appointed as of October 2, 2007

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
Public Health Administrator, Benton County
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Susan King, RN
Executive Director, Oregon Nurses Association
Portland

Jim Lussier
CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena
Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD
Staff Physician, Portland Veterans Affairs Medical Canter
Member, Health Services Commission
Portland

Nina Stratton
Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit
Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Oregon Health Fund Board
Delivery System Committee
Members Appointed as of October 2, 2007

Vanetta Abdellatif
Director of Integrated Clinical Services, Multnomah County Health Department
Member, Oregon Health Policy Commission & Safety Net Advisory Council
Portland

Mitch Anderson
Director, Benton County Mental Health Program
Corvallis

Tina Castanares, MD
Physician, La Clinica Del Carino Family Health Care Center
Hood River

David Ford
CEO, CareOregon, Inc.
Portland

Vickie Gates
Health Care Consultant
Member, Oregon Health Policy Commission
Lake Oswego

Maribeth Healey
Director, Oregonians for Health Security
Member, Archimedes Movement
Clackamas

Diane Lovell
Staff Representative, Association of Federal, State, County and Municipal Employees
Chair, Oregon Public Employees' Benefits Board
Canby

John Barton (Bart) McMullan, Jr., MD
President, Regence BlueCross BlueShield of Oregon
Portland

Dale Johnson, Jr.
Vice President, Corporate Human Resources, Blount International, Inc.
Portland

Ken Provencher
President and CEO, PacificSource Health Plans, Inc.
Member, Oregon Safety Net Advisory Council
Eugene

Steve Sharp
Chairman, TriQuint Semiconductor
Member, Oregon Health Policy Commission
Hillsboro

Lillian Shirley, RN
Director, Multnomah County Health Department
Portland

Richard Stenson
President and CEO, Tuality Healthcare
Member, Medicaid Advisory Committee
Hillsboro

Douglas Walta, MD
Physician, Gastroenterologist
Portland

Rick Wopat, MD
Vice President and Chief Quality Office, Samaritan Health Services
Member, Oregon Health Policy Commission & Medicaid Advisory Committee
Lebanon

Oregon Health Fund Board
Eligibility & Enrollment Committee
Members Appointed as of October 2, 2007

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Dean Kortge
Senior Insurance Specialist, Pacific Benefits Consultants
Eugene

Ellen Lowe
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Carlton James (CJ) McLeod
Senior Vice President and Chief Marketing Office, The ODS Companies
Portland

Bill Murray
CEO, Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney
Health Policy Advocate, Oregon Health Action Campaign
Corbett/Salem

Carole Romm
Director, Community Partnerships and Strategic Development, Central City Concern
Co-chair, Medicaid Advisory Committee
Portland

Jim Russell
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Mike Shirtcliff, DMD
Dentist and CEO, Advantage Dental Plan, Inc.
Member, Medicaid Advisory Committee
Redmond

Ann Turner, MD
Physician and Co-Medical Director, Virginia Garcia Memorial Health Center
Portland/Cornelius

Oregon Health Fund Board
Federal Laws Committee
Members Appointed as of October 2, 2007

Frank Baumeister, Jr., MD
Physician, Northwest Gastroenterology Clinic
Portland

Mike Bonetto
Vice President of Planning & Development, Clear Choice Health Plans
Bend

Chris Bouneff
Director Marketing and Development, DePaul Treatment Centers
Portland

Ellen Gradison
Attorney, Oregon Law Center
Corvallis

Michael Huntington, MD
Retired Physician, Radiation Oncology
Member, Archimedes Movement
Corvallis

Julia James
Consultant
Bend

Mallen Kear, RN (ret.)
Leader, Eastside Portland Archimedes Chapter
Portland

Sharon Morris
Health Care Administrator (ret.)
Grants Pass

Larry Mullins
President and CEO, Samaritan Health Services
Corvallis

Nicola Pinson
Director of Policy and Legal Counsel, Oregon Primary Care Association
Portland

Thomas Reardon, MD
Retired Physician
Gresham

Oregon Health Fund Board
Finance Committee
Members Appointed as of October 2, 2007

Richard (Andy) Anderson
Chief Financial Officer & Senior Vice President, Cascade Corporation
Portland

Kerry Barnett
Executive Vice President, The Regence Group
Chair, Oregon Health Policy Commission
Portland

Peter Bernardo, M.D.
Private Practice, General Surgery
Salem

Terry Coplin
CEO, Lane Individual Practice Association, Inc.
Eugene

Lynn-Marie Crider
Public Policy Director, Service Employees International Union (SEIU) Local 49
Portland

Jim Diegel
CEO and President, Cascade Healthcare
Bend

Steven Doty
President and Owner, Northwest Employee Benefits, Inc.
Portland

Cherry Harris
Labor Representative, International Union of Operating Engineers, Local 701
Gladstone/Oregon City

David Hooff
Vice President of Finance, Northwest Health Foundation
Portland

Denise Honzel
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission
Portland

John Lee
Consultant, Strategic Affairs, Providence Health System
Portland

John Worcester
Compensation and Benefits Manager, Evraz Oregon Steel Mills
Portland

Enrolled
Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER .....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon's health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon's financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon's health care crisis and comprehensive reform is required; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

SECTION 3. The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

SECTION 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. (1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. (1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.

SECTION 8. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. (1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians' access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients' compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees' Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee's physical worksite, regardless of the employee's state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. (1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. (1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. (1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

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Secretary of Senate

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President of Senate

Passed by House June 22, 2007

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Speaker of House

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

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Secretary of State

Summary of SB 329

<u>Section 1</u> – Names provisions of SB 329 the "Healthy Oregon Act"

<u>Section 2</u> – Definitions

<u>Section 3</u> - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	The health care safety net	…is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

Section 5 – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

Section 5 – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

Section 5 – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

Section 6 – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

Section 7 – Purchasing Rules

The Board is generally exempt from public contracting statutes.

Section 8 – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

Section 9 – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan
- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board
- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

- Standards for disenrollment and changing enrollment in AHPs
- Outreach plan regarding the program, eligibility requirements and enrollment procedure
- Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

<u>Section 10</u> – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

<u>Section 11</u> – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

<u>Section 12</u> – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

DRAFT 10-16-07

OREGON HEALTH FUND BOARD
Preliminary Board and Committee Timeline

	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08
Board	Health Care Cost Drivers	Primary Care	Approve Exchange report by end Jan.	Exchange report to Leg. Feb 1, Progress Report Feb. 29	Board begins to receive recommendations from committees		Board develops "Straw Person" Plan by mid-June	Statewide Public Hearings on Plan		Board receives revised draft of plan from staff by 8/31	Board meets to review revised plan by mid Sept.	Board presents plan to Leg.
Finance Committee	Strategic Revenue Options	Review Modeling	Finalize initial Exchange report and send to Board mid-Jan	Review Modeling	Refine exchange and strategic financing recommendations by 4/30							
Exchange Work Group	Exchange Options		Initial report to full committee by beg. Jan	Finalize work group recommendations								
Delivery Committee	Strategies to create High Performance Delivery System				Refine Institute and High Performance Delivery recommendations by 4/30							
Health care quality insitute work group	Developing a health care quality institute for Oregon		Finalize work group recommendations									
Eligibility & Enrollment Committee	Affordability Across Market Segments		Barriers to eligibility/outreach strategy/portability		Refine E&E recommendations by 4/30							
Benefits Committee	Defined set of essential health services and cost sharing				Refine Benefits recommendations by 4/30							
Health Equities Committee	Multicultural outreach/ Strategies to reduce health disparities through delivery reform and benefit design				Refine Committee recommendations by 4/30							
Federal Policy Committee	Effects of Federal Policies on Oregon's Health Care System						Public Hearings on Federal Policy Report		Final Federal Policy Report to Leg.			
Evaluation Plan									Evaluation plan developed			Eval plan incorporated into comp. plan

SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee
- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee
- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee
- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee
- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee
- Benefit Package(s)
- Cost Sharing

OHPR
- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

Health Disparities & Vulnerable Populations Committee
- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

The Office for Oregon Health Policy and Research (OHPR)

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

OHPR Programs

The *Oregon Health Policy Commission (HPC),* enacted in the 72nd Legislative session, is responsible for health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR.

The *Health Services Commission (HSC)* prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan.

The *Health Resources Commission (HRC),* established in 1991, conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with OHSU's Evidence-based Practice Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans.

The *Medicaid Advisory Committee (MAC)* advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan.

The *Oregon Health Research and Evaluation Collaborative (OHREC)* is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population.

The *Oregon Prescription Drug Program (OPDP)* is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP meets these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP unites Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines.

Oregon Health Policy Commission
Road Map for Health Care Reform

Creating a High-Value, Affordable Health Care System

Please direct questions on this report or about the OHPC to Gretchen Morley, OHPC Director, at 503-373-1641

July 2007

Office for Oregon Health Policy & Research

Oregon
Theodore R. Kulongoski, Governor

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July 2007

The Honorable Theodore R. Kulongoski
900 Court Street NE, Room 160
Salem, Oregon 97301-4047

Dear Governor Kulongoski:

On behalf of the Oregon Health Policy Commission, I respectfully submit the attached final report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*. The Commission presents this report in response to your February 2006 letter requesting the Commission develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians.

Throughout 2006, the Commission worked collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years. In early 2007, a draft version of the report was shared with the public and feedback was solicited. The final report, which outlines the Commission vision and provides a framework Oregon can use to move the health care system forward, reflects the Commission's work and input from a wide range of stakeholders. The Commission's recommendations were among the many ideas discussed and included in the development of Senate Bill 329 passed by the 2007 Oregon Legislature.

The Commission recommendations are based on a vision of universal participation in an affordable health care system that offers high-value health care and adequate financial protection. High-value health care is high quality, coordinated and safe, efficient and evidence-based, and continuously improving. The following principles shaped the Commission's recommendations:

- Recognize that health care is a shared social responsibility;
- Recommend reforms that can be realistically implemented over the next five years that both improve current existing structures and define new ways to provide more effective health care;
- Recognize that access, cost, transparency, and quality are intertwined and must all be addressed;
- Achieve access for all Oregonians through rational coverage decisions;
- Maintain a broad, strong safety net;
- Encourage delivery system integration and alignment of payment incentives that prioritize prevention, continuity of care, and care management;
- Maximize available financing; and
- Coordinate with other reform efforts in the state.

To create a high-value health system, the Commission recommends the following reforms:

- Create a Health Insurance Exchange to connect individuals and employers with affordable coverage options and public subsidies in a way that currently does not exist in Oregon;
- Require that every Oregonian purchase affordable health insurance;
- Expand publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Explore sustainable, broad-based financing sources that ensure everyone's participation and equalize the burden between employers that offer employee coverage and those that do not.

To create a sustainable system that delivers value and controls costs, the Commission recommends private and public delivery system reforms, including:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a primary care home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care.

This report is a resource for the Legislature, state agencies and other stakeholders. The information and reform recommendations provided can be used during the implementation of SB 329 and beyond. As tasked by SB 329, the Commission will participate in reform planning and implementation by developing detailed recommendations for a state health insurance exchange, by participating in Health Fund Board subcommittee work on reform financing, and by providing other information, analysis and support to the Health Fund Board.

Recognizing that real reform requires delivery system change, the Commission plans to include in this work a focus on changing system incentives to improve health care quality, safety, and transparency. The Commission's Quality and Transparency Work Group also stands ready to help the Office for Oregon Health Policy and Research develop a quality institute model as directed by SB 329.

The Commission looks forward to engaging in additional health care reform discussions with you, the State Legislature and other interested parties across the state. Together we can make the changes that will improve Oregonians' access to high quality, effective and efficient care.

Sincerely,

Kerry Barnett
Chair

Oregon Health Policy Commission
Road Map for Health Care Reform

Table of Contents

Oregon Health Policy Commission

The Commission acknowledges the contribution to this report from:
OHPC Local Delivery Systems Workgroup
OHPC Quality and Transparency Workgroup
Safety Net Advisory Council
(See Appendix A for a full listing of workgroup and council members.)
Dr. John McConnell, Oregon Health and Science University, Portland, Oregon whose work was supported by a grant from The Northwest Health Foundation, Portland, Oregon.

Oregon Health Policy Commission
Road Map for Health Care Reform

Executive Summary

The Oregon Health Policy Commission (OHPC) was asked by Governor Kulongoski to develop recommendations for a system of affordable health care that is accessible to all Oregonians. The Commission has worked diligently and collaboratively to develop concrete, realistic reforms that can be implemented over the next five years. The recommendations outlined in this report propose a road map for reform and act as a resource for the Governor, state legislators, state agencies, and other stakeholders during the implementation of Senate Bill 329 and beyond.

Vision

Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives. A high-value health care system is one in which all Oregonians: participate in both the benefits and the costs of a reformed system; have access to affordable, coordinated, high quality health care; and are adequately protected against financial ruin associated with catastrophic medical expenses. A high-value health care system will ensure efficient, evidence-based care and support continuous improvement.

Why Reform Is Needed

The health care system we have now is inefficient, expensive and often fails to ensure good outcomes. Health care costs are high and continue to rise. Increasingly unaffordable health care jeopardizes Oregonians' health status and the state's economic future. In 2006, one in six Oregonians (576,000 people, including over 116,000 children) were uninsured. Low-income Oregonians are at increased risk, but many employed individuals also lack insurance coverage. The uninsured are less likely to get routine care and more likely to delay treatment, resulting in serious and costly conditions. In addition, many Oregonians lack both access to care and to information about costs and quality standards. Without good information, it is difficult for people to be active participants in their own care.

All Oregonians pay for system inefficiencies and services for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. Providers treat uninsured patients, providing care for which they are not paid. To recoup their costs, providers must increase costs to insured patients through higher charges to insurers. Employers pay more for insurance for their employees and are hurt by work time lost to illness. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost an annual total of $65 billion to $130 billion.

The economic and human costs of these system inefficiencies must be addressed. To do this, the Commission started with the following guiding principles for health care reform.

OHPC Guiding Principles for Health Care System Reform

- Health care is a shared social responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that can be realistically implemented over the next five years by improving existing system structures and defining new ways to provide care more effectively.
- The health care system will be sustainable only if reforms address the relationship between access, cost containment, transparency, and quality.
- Resources will always be limited, so coverage decisions must be made through a rational process to achieve access for all Oregonians.
- Reforms must both increase insurance coverage and maintain a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention, continuity of care, and care management.
- We must reduce health disparities based on race, ethnicity, geography, and income.
- Reforms must maximize available federal (especially Medicaid), state, and private financing.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

Reform Recommendations

Create a high-value health care system through the following state policies:

- A Health Insurance Exchange, an entity that can bring individuals, affordable coverage options, employers, and public subsidies together in a new and more effective way;
- A requirement that every Oregonian obtain affordable health insurance;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Sustainable system financing, including a broad-based employer contribution**.**

Create a high-value health care system by implementing both public and private delivery system changes including:

- Drive public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent;
- Develop widespread and sharable electronic health records;
- Improve health care safety;
- Help all Oregonians establish a primary care home; and
- Support community-based innovations that align resources for more cost-effective, higher quality care.

The OHPC reform plan also underscores the need for a thoughtful evaluation plan to monitor the success of reforms.

Oregon Health Policy Commission
Road Map for Health Care Reform

Overview of Recommendations

Vision: Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.

Recommendation 1: Establish universal health insurance coverage for children.

Lack of insurance affects 116,000 Oregon children; 12.6 percent of the state's children have no insurance. These children represent 20% of Oregon's total uninsured population. Providing affordable health care to all children is a concrete investment in Oregon's future. Proposals currently being discussed in the state would:

- Improve and expand access to Oregon's Medicaid and SCHIP programs;
- Expand health care coverage for children by giving parents with moderate family income (income above the current cut-off for federal program eligibility) the opportunity to buy affordable, state-subsidized group coverage for their children; and
- Continue to expand school-based health centers.

Recommendation 2: Create a Health Insurance Exchange to bring together individuals and employers with affordable coverage options and public subsidies.

The Exchange will operate as a central forum for individuals and small business to buy health insurance. It will be governed by an independent board that will use all of the tools currently available to purchasers, including plan design, to support value-based (quality and cost) purchasing and encourage individuals to manage their medical care and their health. Individuals will use the Exchange as a one stop shop for information and access to insurance options, including access to subsidies for private market coverage.

The Exchange will:

- Define an array of insurance plans available for purchase through this entity;
- Be a "smart buyer" for government and participating individuals and business, driving market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls, and other value-based purchasing;
- Define an "affordability standard," an assessment of how much Oregonians can be expected to spend for health care and still afford to pay for housing, food, and other necessities;
- Be utilized on a voluntary basis;

- Attract small employers by minimizing employer administrative burden and providing increased employee plan options;
- Drive quality by negotiating and collaborating with insurers and producers; and
- Act as a market organizer that can respond to and implement future state health care reforms.

Recommendation 3: Require all Oregonians to have health insurance to protect their health and financial security, spread health care costs over the whole community, and reduce the impact of uncompensated care.

All Oregonians will be required to have health insurance. Affordable access to insurance will be ensured through the Health Insurance Exchange, expanded publicly-funded coverage and subsidies, and concerted delivery system reforms. Universal coverage will reduce premiums for the currently insured. Currently, providers recoup the cost of caring for the uninsured by increasing what they charge insurers for their members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers. With everyone in the market, uncompensated care costs will decrease sharply. In addition, employer-based insurance offerings will increase as all Oregonians demand access to affordable insurance.

Recommendation 4: Offer low-income Oregonians publicly-financed subsidies to ensure insurance is affordable.

Publicly-financed insurance assistance will be made available on a sliding scale to Oregonians with income up to 300% of the federal poverty level (FPL). Preliminary analyses indicate that individuals and families can only begin to afford both necessary household expenses and health care between 250% and 300% FPL.[1] To support this effort, the state will request federal Medicaid matching funds to the highest income level possible.[2]

The OHPC recommends assistance in two forms: direct Medicaid coverage (the Oregon Health Plan) and premium subsidies. Medicaid coverage would be an option for all children with family income up to 200% FPL, and adults with income up to 200% FPL who lack access to employer sponsored insurance.[3] Adults with access to employer coverage and everyone with income over

200% FPL will have access to premium subsidies to purchase insurance. Premium subsidies can be used to purchase insurance in the employer or individual markets.

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[1] http://egov.oregon.gov/DAS/OHPPR/HPC/HealthReformResources.shtml

[2] Federal Medicaid funds provide approximately 60 cents on every dollar spent on federally approved insurance coverage. Recently, Massachusetts received approval from the federal Centers for Medicare and Medicaid Services for its Medicaid waiver amendment allowing federal matching funds up for premium subsidy expenditures paid on behalf of individuals with income up to 300% FPL. Until this approval it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

[3] The OHPC recommends maintaining Medicaid coverage currently available for populations that are "categorically" eligible under federal Medicaid law (including children, pregnant women, the elderly, and people with disabilities).

Publicly-financed coverage will be comprehensive and emphasize preventive services and care for chronic conditions. The Prioritized List of Health Services, including proposed changes to increase the List's prevention and chronic care focus, will provide guidance to public coverage decisions.

Recommendation 5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.

To ensure quality health care for all Oregonians, reform must both improve the delivery system and expand access. Access and delivery issues exist at the local as well as the state level. With this in mind, the OHPC recommends the following:

- Create an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting;
- Continue efforts to create a stronger, more coordinated statewide effort on value-based purchasing to improve the ability to measure, report, and improve the system.
- Provide leadership and support to further the development of widespread and shared electronic health records;
- Assure a workforce that can capitalize on health information technology;
- Encourage purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care;
- Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and
- Mobilize a coordinated effort among all state purchasers (PEBB, OMIP, Medicaid) and insurers to support new delivery models and new reimbursement strategies that are more effectively supporting infrastructure investments, integrated care, and improved health outcomes.

Recommendation 6: Support community efforts to improve health care access and delivery.

Reform efforts need to be flexible enough to provide local communities the ability to align available resources with the needs and characteristics of their communities. To support local innovation in health care delivery, the Commission recommends the following:

- Promote the primary care model;
- Support local access collaboratives; and
- Create pilot projects to demonstrate ways to realign payment incentives to improve health outcomes.

Recommendation 7: Establish sustainable and equitable financing for reform.

The OHPC proposes simultaneously working toward universal coverage and improved system efficiency. To fund a coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that can be phased out as system efficiencies take hold over the following years.

The financing needed to fund public coverage and premium subsidies is an investment that will make Oregonians healthier and produce savings throughout the state. This investment, implemented along with the delivery system initiatives outlined in this report, will lead to more productive employees, increased efficiency, and reduced system costs.

To implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. Financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Recommendation 8: Design and implement evaluation of system reform.

The OHPC recommends developing a coherent, stable and coordinated evaluation infrastructure prior to reform implementation. To assess success and inform future policy decisions made by the Legislature and state officials, any reform plan should include a well-developed evaluation plan that includes assessment of changes from the pre- to post-reform period and the extent to which reform implementation matches program goals and intentions. The evaluation plan should include metrics for provider capacity, population demand, provider and consumer participation, utilization patterns, changes in health outcomes, health disparities and quality, financial impacts and special issues of concern such as crowd-out, use of technology, and transparency. Sustainable evaluation funding and a central evaluation entity must be identified in order to assure evaluation is coordinated with reform.

Oregon Health Policy Commission Road Map for Health Care Reform

Introduction

Background

Throughout 2006, public interest in solving the growing problems in Oregon's health care system has increased dramatically. There is widespread agreement that our health care system is too expensive, confusing, inefficient and inaccessible, and does not adequately promote health.

Since 2004, the Oregon Health Policy Commission (OHPC) has served as a forum for exploring broad health reform ideas and evaluating promising improvements to the state's health care system. In February 2006, Governor Kulongoski asked the Commission to develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians. Throughout 2006, the Commission worked diligently and collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years.

This report outlines the OHPC vision and provides a framework Oregon can use to move the health care system forward. The OHPC report is intended as a resource for the Governor, Legislature, state agencies and other interested stakeholders, providing information and recommendations on reform options and funding mechanisms. The Commission will use this document as it participates in reform discussions during and beyond the legislative session, providing information, participating in analysis and discussions, and encouraging action on comprehensive, meaningful reform at the state level.

Vision for a High-Value, Affordable Health Care System

The Commission presents reforms that would **provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.** [4]

Affordable access requires:

> **Universal Participation.** A reformed health care system is a shared social responsibility. All Oregonians must participate in both the benefits and costs. Everyone must seek out affordable health insurance whether through a private or public option.

[4] In developing its reform vision, the OHPC drew significantly on the Commission's 2004-2006 discussions and the vision statement of the Commonwealth Fund's Commission on a High Performance Health Care System. Additional sources included the Oregon Public Employees' Benefit Board 2007 Vision, SB 27 (1989 legislation that created the Oregon Health Plan), the Senate Interim Commission on Health Care Access and Affordability (2006), the Archimedes Movement, the Oregon Business Council's Healthcare Initiative and the federal Citizens Health Care Working Group (2006).

Universal participation also means everyone must accept the personal responsibility to seek preventive and disease management services in order to avoid later serious illness that negatively impact health and increase health care costs.

Affordable Health Care for Everyone. Every individual and family not only has affordable health insurance, but also insurance that provides access to affordable health care. Insurance that does not provide adequate access to providers or requires individuals to pay more out of pocket than they can reasonably afford does not provide access to affordable health care. A system with real access provides care in a way that reduces health disparities between population subgroups.

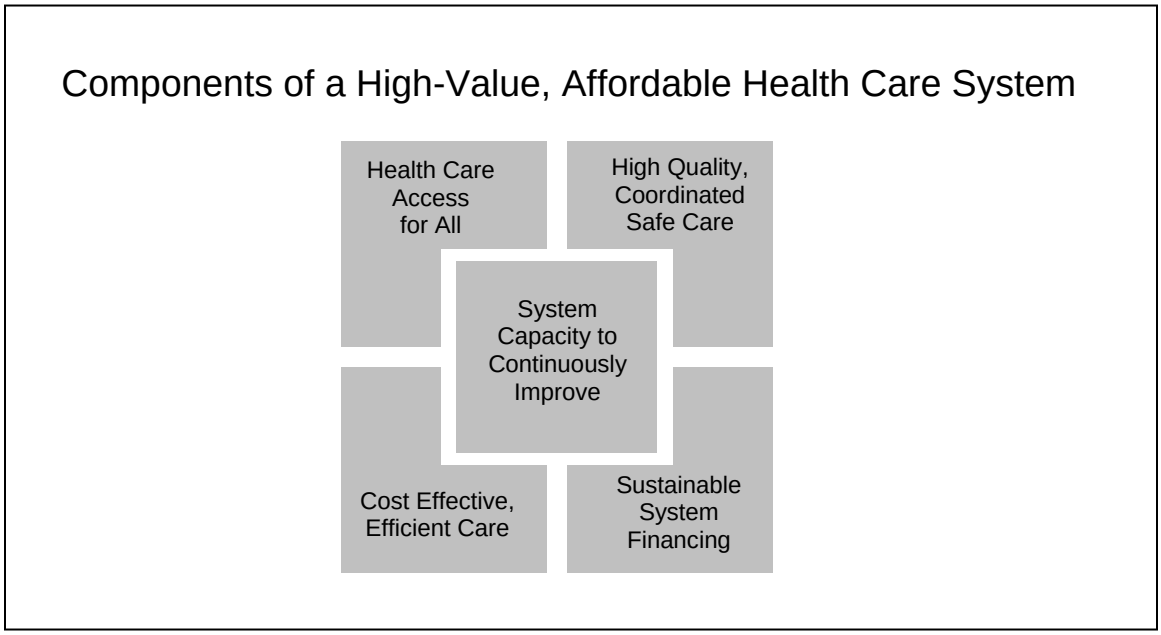
Adequate Financial Protection. A well-operating system will adequately shield individuals and families from the devastating debt that can occur from unexpected accidents and illness.

High-value health care is:

High Quality, Coordinated and Safe. The system should focus on improving quality and health outcomes. Everyone needs a primary care home where care is organized, coordinated, and integrated across providers and over the life of the individual. The care provided must be patient-centered, consciously involving patients as informed and active participants.

Efficient and Evidence-based. Our health care system must be an integrated system that gives consumers and providers the market incentives to provide the right care at the right time and in the right setting. Access to health care does not mean access to all available services. New technologies, procedures, and treatments must be evaluated for effectiveness and value. The health care system needs to use evidence-based medicine to maximize health and utilize dollars wisely.

Continuously Improving. Our health care system needs the tools to capitalize on innovation and integrate research findings into practice. We need system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. We need an information technology infrastructure that supports integration, transparency, and quality and is available when and where both patients and providers need information for decision-making. We must have a statewide strategy to address the critical needs for the health care workforce of the future.



Symptoms of the Broken System We Have Now

Cost Increases Harm Oregon

Health care expenditures in the United States were almost $1.9 trillion in 2004, over two and a half times the 1990 spending and 16.0% of the Gross Domestic Product. Since 1998, health insurance premiums have risen substantially, outpacing inflation and impacting individuals, employers, and government. Rising costs jeopardize Oregonians' health status, make the state and nation less competitive, and make adequate investment in other crucial areas such as education more difficult.

System Impacted by Poor Quality of Care

The Institute of Medicine has documented the existence of a "quality chasm" in the United States.[5] Recent research indicates that Americans receive recommended care only about 55 percent of the time.[6] The IOM estimates that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. Almost one third of health care expenditures pay for care that is duplicative, fails to improve patient health, or may even make it worse.[7] A recent Commonwealth Fund study found the United States health care system less efficient than other countries, as measured by duplicated tests, repeated medical histories, and medical records not available at the time of the visit.[8]

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[5] A list of IOM reports on quality issues is available at http://www.iom.edu/CMS/8089.aspx.
[6] "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" Asch SM, et al., *New England Journal of Medicine*, Vol. 354, No. 11, March 16, 2006, pp. 1147-1156.
[7] "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Elliott S. Fisher, et al., Annals of Internal Medicine, February 2003; 138: 273 - 287.
[8] "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," Schoen, Cathy et al. *Health Affairs.* Nov 28, 2005.

Too Many Oregonians Lack Insurance
In 2006, 15.6% of Oregonians were uninsured.[9] Over 576,000 Oregonians, or one in six residents, were uninsured; 116,000 of those were children. Another 258,000 Oregonians experienced a gap in their health care coverage at some time during the year.

While 15.6% of Oregonians aged 19 to 64 are uninsured, 44% of poor adults lack coverage. In 2004, 21% of children in families with income under 100% of the Federal Poverty Level were uninsured, compared to 19% of all children in Oregon. Even when a parent has access to coverage, their children may be uninsured because family coverage is not offered or affordable. Many families do not know their children are eligible for Oregon Health Plan coverage; still others find it too difficult to enroll or prefer not to access a public program.

Employment Not a Guarantee of Coverage for Low and Moderate Income Oregonians
Contrary to what many believe, a high percentage of employed persons do not have insurance. Even those working for employers that offer insurance may not be able to afford the insurance offered. Seventeen percent of individuals in families with at least one full time worker lack health insurance, and 33% of those with part-time employment lack health insurance. 56% of uninsured Americans are not eligible for Medicaid or other public sector health programs and cannot afford to buy coverage on their own.[10]

Lack of Coverage Hurts Access to Cost-Effective Prevention, Health Maintenance
Although insurance coverage does not guarantee access to services, the uninsured are less likely to access cost-saving preventative services or to seek treatment for illness or injury until the problem is not manageable and the hospital emergency room seems the only option.

The uninsured are less likely to seek regular care, and they are four times less likely to have a regular source of care than are the insured.[11] Uninsured children are nearly three times less likely to have seen a physician in the past year than are children with insurance coverage.[12] Almost 40% of people who delay care cite lack of insurance and cost as the main reasons they did not see a provider.[13] Without treatment, chronic problems can become acute and require costly and avoidable emergency treatment.[14] Lack of insurance both shortens productive years of work and undermines the standard of living for families and individuals faced with large medical

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[9] *Profile of Oregon's Uninsured, 2006*, Office for Oregon Health Policy and Research. February 2007. Report is based on the 2006 Oregon Population Survey, a biennial statewide telephone survey of Oregon households. CPS data released in August 2006 indicates the national uninsurance rate was 15.9% in 2005.
[10] "The Uninsured and the Affordability of Health Insurance Coverage," Lisa Dubay, John Holahan, Allison Cook. *Health Affairs* 26, no. 1 (2007).
[11] "Demographic Characteristics of Persons Without a Regular Source of Medical Care – Selected States, 1995," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 1998, 47: 277-79. For general statistics, see http://www.eoionline.org/HealthCareUninsuredDilemmaFS.pdf.
[12] *Health Insurance? Its Enough to Make You Sick*. Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999.
[13] "Entry Into Prenatal Care --- United States, 1989-1997," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, May 12, 2000, 49 (18): 393-8. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm.
[14] "Unmet Health Needs of Uninsured Adults in the United States," John Ayanian, et al., *Journal of the American Medical Association,* October 25, 2000, 284:2061.

expenditures. Nationally, the 41 million uninsured cause an estimated annual loss of $65 billion to $130 billion due to poorer health and earlier death.[15]

All Oregonians Impacted by the State's High Uninsurance Rate
The uninsured delay needed care, but can not avoid it entirely. When people without insurance get care in high cost settings such as emergency departments or hospitals, they can often not afford to pay for the services they have received. Providers that have cared for these individuals must make up for their expenses. For the most part, providers rely on the insured to help pay for services for the uninsured. Providers recoup the cost of caring for the uninsured by charging insurance carriers more for services rendered to carriers' members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers.

Lack of Information Is Endemic
In our current system, it is difficult for patients to get clear and comparable information about health care costs and standards of care. Individuals pay different amounts for the same procedures based on their insurance status. The lack of information makes it hard for patients and their families to be active participants in their own care. Without full information, patients can not make the best clinical and economic decisions.

Fragmented Service Delivery Does Not Support Quality
Most behavioral health providers and treatments operate separately from physical health care. The historic lack of parity in insurance coverage for behavioral health care exacerbates the difficulties many people have accessing mental health care and substance abuse treatment. While a mental health parity law took effect in Oregon on January 1, 2007, more must be done to ensure that those in need can have behavioral health issues effectively and responsively identified and treated. Another area of care that remains disconnected from acute care services is long term care. Although integration would improve patients' health, acute care providers are generally not given incentives or other support to coordinate with long term care providers.

A fragmented delivery system also makes it very difficult to design a reimbursement system with incentives that align for payers and providers. In the current system, it is too easy to push financial responsibility to other parts of the system, making the system less accountable for results. It is relatively easy for each piece of the system to maximize its reimbursement when no one takes responsibility for the big picture or the interrelationships.

[15] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004. The Institute of Medicine, in its June 2003 report *Hidden Costs, Value Lost: Uninsurance in America*, estimated the value of improved health for a currently uninsured individual who gains coverage at between $1,645 and $3,280 a year.

OHPC Guiding Principles for System Reform

Recognize that assuring health care is a shared social responsibility. This includes both a public responsibility for the health and security of all Oregonians, and the responsibility of everyone to contribute. Individuals, employers, government, and providers are mutually responsible for creating, financing, and sustaining an affordable health care system.

Develop reform recommendations that can be implemented over the next five years. The OHPC recommendations primarily focus on what Oregon can do right now to achieve significant reform. The OHPC recognizes there are efforts underway to reform state and federal health policy to achieve broader reform. By outlining steps the state can take today, the OHPC recommendations are not inconsistent with these other reform efforts.

Support and improve current programs and structures that work, overhaul the ones that do not. To promote short-term reforms that help achieve the longer term vision of a high-value, affordable health care system, the reform plan needs to both utilize existing programs and define new ways for the uninsured to access care. Unnecessary complexity leads to confusion, cost, and errors. Both the delivery system and the administration of new and existing programs must be streamlined in order to be accessible and comprehensible. Changes must improve access and care for Oregon's vulnerable populations, including racial and ethnic minorities, individuals in geographically underserved areas, and low-income Oregonians.

Recognize that access, cost, transparency, and quality are intertwined. To develop a high-quality system, we must address problems such as an inefficient delivery system, medical errors, and uncontrolled cost growth. Access, cost containment and quality must all be valued in order to achieve a sustainable system. Quality care relies on patients, providers, and employers having transparent access to appropriate health care information.

Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to promote access to primary and chronic care services rather than limiting services to emergency access. Services can be limited and directed in order to maximize the number of people who get both health insurance and real access to needed services. The Prioritized List of Health Services has been used successfully in Oregon's Medicaid program since 1989. The Commission believes the expansion of basic health care to all Oregonians should utilize the Prioritized List and prioritize health promotion, disease prevention and disease management.

Emphasize care that prevents and manages disease, engages patients in their own care, and protects families from catastrophic health care costs. Ten percent of our population is responsible for 69% of health care costs. In order to produce the greatest return on investment and control health care costs, health reform must emphasize health care services that seek to prevent and manage disease and must find more effective ways to engage patients in their own care. Additionally, as with car insurance, health insurance must provide protection against catastrophic losses. A recent Commonwealth Fund study found that 21 percent of adults surveyed (both insured and uninsured) said they are struggling to pay off medical debt.

Maintain a broad, strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin. We recognize that there will always be times of transition during which individuals are not eligible for available coverage. A meaningful coverage system requires a strong safety net to provide quality care and access to both patients without access to insurance coverage and those with insurance.

Encourage delivery system integration and alignment of payment incentives. Consumers and providers must have incentives and information to make health care decisions that drive quality and control cost. The state should take a clear leadership role through its public insurance programs. Additionally, state policy should recognize and support the many community efforts underway across Oregon to align resources and form partnerships to improve local health care delivery systems.

Maximize available financing. Coverage for all Oregonians can only be achieved by doing all that is possible to optimize available sources of revenue. As everyone in Oregon is sharing in the cost of the current inefficient system, we must identify, capture, and reinvest savings produced from successful reforms. Maximizing available federal Medicaid financing is paramount.

Coordinate with other reform efforts in the state. Many groups are working to develop policy reforms and garner support to move reforms forward. The OHPC will draw ideas from and seek connections between these efforts to the extent possible in order to help channel this energy into true change.

Public Health and Disease Prevention: Health Is More than Health Care

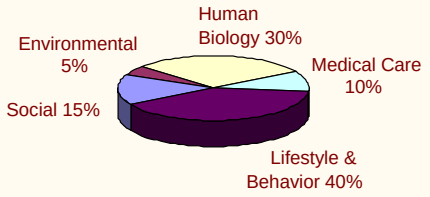
When it comes to our health, we leave the barn door open until the horses get out. In spite of the billions of dollars funneled into the U.S. health care system, we fail to capitalize on the profound and far-reaching impact that disease prevention and wellness programs can have in improving our quality of life and reducing the social and economic burden of avoidable acute and chronic diseases. We know that health is determined by far more than medical care.[1] Both Oregon and the nation are falling short of achieving the best health for our citizens when we focus most of our resources on acute care after our health is lost.

Invest in Health

Historically, public health interventions have had a greater effect on health outcomes that any medical interventions. Life expectancy has quadrupled in the last 150 years due to basic (though often controversial) measures such as municipal water treatment, hand washing, food safety measures, vaccination programs, and fortification of food staples such as bread and milk with essential vitamins and minerals. Yet for the first time in American history, a child born today has a shorter life expectancy than her parents.[5] Modern technology has created new obstacles to health in our society and we are again faced with changing our public environment to maintain and improve the public's health.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths in Oregon.[2] Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease.[3] These chronic diseases reduce the quality of life of individuals, burden families and friends, and are responsible for massive health care expenditures.

Factors Influencing our Health [4]



Invest in Knowledge

There is also a need for more public health research, particularly in the area of health disparities between racial and ethnic groups. Such disparities are reflected in stark differences in life expectancy; rates of disease; disability and death; disease severity; and access to treatment.

[1] Oregon Vital Statistics Annual Report 2004, Vol. II, Chapter 6. Mortality.
[2] *Ibid*
[3] *Ibid*
[4] McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs,* 21(2), 83.
[5] "A Potential Decline in Life Expectancy in the United States in the 21st Century," S. Jay Olshansky, et al., *The New England Journal of Medicine*, March 17, 2005, Volume 352:1138-1145, Number 11.

What can be done?

Public/private partnerships - our public health interventions and health care systems can work together on disease prevention and effective care management, giving us a fighting chance to overcome the unhealthy behaviors and racial health disparities that we face today.

Make the healthy choice the easy choice - foster environments that encourage healthy lifestyle choices in our daily lives. That means making health a priority in schools, the workplace, community development, and in our homes.

Some of this work is already underway

This fall, Northwest Health Foundation and Community Health Partnership: Oregon's Public Health Institute were successful in bringing public and private health entities together around a common agenda for the 2007 legislative session.[1] Some needed policy changes supported by these groups, as well as the OHPC, include:

- More data collection that is targeted to relevant policy and spending decisions
- Community water fluoridation
- Statewide school nutrition standards

The Commission's report, *Promoting Physical Activity and Healthy Eating among Oregon's Children* provides public officials and the public at large with a detailed resource for attacking the trend of obesity and resulting illnesses in Oregon's children.[2] This report was assembled by a team of local and national experts from a variety of fields, including medicine, public health, education, and land-use planning.

Additionally, an exciting new partnership between the Northwest Health Foundation, the Oregon Public Health Division and the OHPC will make public health data accessible to policymakers and generate the community engagement vital for effective public health programs.

1 For more information, see http://www.communityhealthpartnership.org/images/pages/newsletters/dec_06.pdf.
2 *Promoting Physical Activity and Healthy Eating among Oregon's Children: Draft Recommendations to the Oregon Health Policy Commission*, DHS Office of Family Health. October 2006.
3 Community-Created Health Care Solutions in Oregon, Oregon Health Policy Commission, January 2006.

Solutions for the world we live in

We know intractable social issues like poverty and poor education have significant negative health impacts, yet there is much that can be done within the health care system to mitigate the impact of those larger problems. To begin:

1. Put high priority on prevention services, such as immunizations and health education, to avoid illness and injury in the first place. Public and private purchasers and insurers need to align payment incentives to encourage preventive care and chronic disease management.

2. Integrate public health and health care systems. Currently the public health system and the health care system operate separately and often in competition. Collaborative community efforts are underway in 19 counties across the state to coordinate local resources and improve the health of their communities[3]. These community partnership efforts are well positioned to help public health and health care systems begin to work in concert.

Oregon Health Policy Commission Road Map for Health Care Reform

Recommendations: Building a High-Value, Affordable Health Care System in Oregon

This section outlines the concrete reforms Oregon can implement to move the state toward realizing a high-value, affordable health care system over the next five years. Reform will only be sustainable if it is both short- and long-term focused. In the short term, Oregon needs to expand health care access to the growing number of uninsured. However, Oregon also needs to recognize that uninsurance is a symptom of a much deeper problem with how health care is delivered and financed. Over the long-term, we need to address these deeper systemic problems or our efforts to expand access will not be sustainable.

No one actor can make it happen. Reform is an effort that requires all of us – consumers, health care providers, insurance carriers, policymakers – to look beyond our immediate separate interests, to a future with a more equitable, higher quality, and efficient health care system for all. Reform cannot happen overnight. While there is no magic bullet, there are "pressure points" in the system that can be leveraged to achieve reform. The Oregon Health Policy Commission (OHPC) recommendations spotlight those pressure points, outlining how they can be enhanced and be more effective. These recommendations are a reference for health care reform discussions in the implementation of Senate Bill 329 and beyond.

Note on the OHPC Approach

Of the guiding principles upon which the OHPC recommendations were built, two form the backbone of the recommendations.

First, the Commission recognized that reforming the health care system is a shared responsibility. In order to ensure affordable access to health care for everyone, everyone must contribute. The OHPC recommendations operationalize this principle through an individual coverage requirement, publicly-financed subsidies, and a broad-based financing source that includes employers. The OHPC also recommends establishing a Health Insurance Exchange, an entity that can bring these pieces together in a new way to serve individuals and small business.

Second, the Commission sought to develop reforms that can be implemented in the near term in order to work toward reform now and over the next few years. This report recommends changes that do not require large-scale federal changes occur before reform can be implemented in Oregon. The Commission believes that changes to federal policy and funding mechanisms are needed but are not necessary for implementing the recommendations in this report. All of the

reforms outlined in this report can be implemented over the next several years, and can be modified later to take advantage of federal policy changes.

Federal Policy Changes to Support Health Reform in Oregon

The Oregon Health Policy Commission's reform proposals seek to create a road map to affordable health care access, outlining reforms the state can implement within current federal constraints. The state should not wait until major policy changes are made at the federal level to push forward with reform. However, there are many federal policy changes that would give Oregon needed flexibility and institute greater equity and stability in the health care system. Some of OHPC's top federal priorities are outlined below.

Force a national dialogue on health care reform and federal health care financing: The OHPC supports comprehensive health reform at the federal level that rationalizes how federal funds are spent on health care.

Increase Medicare provider payment rates: Medicare provider payment rates in Oregon are among the lowest in the country, increasing the cost-shift to those insured through the private sector.

Adjust the Medicaid matching formula to avoid penalizing states during an economic recession: The current Medicaid federal medical assistance percentage (FMAP) formula does not adjust quickly enough to changes in states' economic conditions. The FMAP should be modified to account for periods of economic downturn to ensure that states are getting more federal funding when the demand for their programs is greatest.

Provide states with flexibility under ERISA: The Employer Retirement Income Security Act (ERISA) of 1974 preempts states' ability to regulate employer benefit offerings, including health insurance. This blanket preemption limits states' ability to develop reforms that establish minimum requirements for employer-sponsored insurance. In absence of federal reform, the OHPC supports instituting a waiver process that allows states to apply for waivers of ERISA in order to enact state-level reforms.

Change federal tax policy to support individual insurance purchase: While people who purchase health insurance through an employer can pay premiums with pre-tax dollars, individuals buying insurance in the individual market get no such benefit. To encourage insurance purchase by the self-employed and others without access to employer-sponsored insurance, the federal government should allow individual insurance purchase to be federally tax deductible.

Recommendation #1: Establish Universal Health Insurance for Children

Proposal Overview

Governor Kulongoski's 2007-2009 Recommended Budget included implementation of the Healthy Kids Plan.[16] The Oregon Health Policy Commission (OHPC) supports the funding and implementation of Healthy Kids, which will provide comprehensive health care (including medical, dental, vision, and mental health) to all of Oregon's uninsured children up to age 19. Building on existing programs, it will allow low-income families to enroll their children in public coverage or to use subsidies to purchase private coverage for their children. In addition, the program provides an opportunity for families not eligible for public programs or subsidies to buy affordable coverage through a separate program. The OHPC supports the Healthy Kids efforts to improve and expand access to comprehensive health insurance and continue expanding school-based health centers to increase access to care.

Programs for Children Based on Income, Access to Private Coverage
For children in families with income up to 200% of the federal poverty level (FPL), benefits will continue to be provided through the Oregon Health Plan, with dental, vision, and mental health care, no co-payments and no family premium share. Low-income families may also access the Family Health Insurance Assistance Program, which provides premium assistance allowing a family to purchase insurance through a parent's employer.

Children in families with income at 200% FPL and above with no access to employer-sponsored insurance will have access to comprehensive coverage through a private insurance product. Families will have assistance in choosing a plan and premium subsidies will be based on income. Health plans may compete to participate. Children in families with income above 350% FPL may still enroll in Healthy Kids but must pay the full cost of the coverage.

Cost to Families
The Healthy Kids program was designed based on conversations with Oregon families about what is affordable. Premium assistance will be income-based. Higher income families will pay affordable monthly premiums and co-payments.

[16] The Governor's Healthy Kids Plan draws on recommendations from the Medicaid Advisory Committee and a series of public hearings. For more information, see: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

Why Change Is Needed

In 2006, an estimated 116,000 Oregon children were without health insurance. About half of them qualify for state programs but are not enrolled. Many children in Oregon lack access to providers and basic health care services. Uninsured children face additional barriers to care. They are half as likely to get preventive care or see a doctor as those who are insured.[17] Children without insurance are more likely to use expensive emergency room for care and to be hospitalized. Poor health makes it harder for children to learn. Illness and chronic conditions lead to missed days of school and poorer performance. Keeping kids healthy also saves money.

More than half the uninsured children in Oregon have employed parents. Many families earning between $40,000 and $80,000 a year make too much for their kids to qualify for state programs but struggle to afford health insurance. Families lack coverage for their children for many reasons. Employer-sponsored coverage may not be available to the family or premiums for dependent coverage may be too expensive. In addition, enrollment barriers keep some families from enrolling their eligible children in public coverage. The OHP application process can pose difficulties to working families The requirement that eligibility be recertified every six months means that families must re-do paperwork twice a year. Some families are unaware that their children are eligible for OHP even when their parents are not.

Selected Implementation Considerations

To make Healthy Kids work, the state will partner with community organizations to reach out to uninsured children and help families enroll their children (and keep them enrolled). To facilitate enrollment and maintain eligibility, the state will utilize a shorter application, 12-month enrollment period, a reduced (two month) uninsurance requirement, and no asset test. To assist children where they are, school-based health centers (SBHC) will be expanded and supported. At least five new SBHCs will be funded in counties without existing health centers. At least five additional SBHCs will be funded in counties that already operate one or more SBHC.

Other Healthy Kids programs include the expansion of the dental sealant program that will seal the teeth of 50% of all 8-year-olds by 2010. This compares to 30% of uninsured children who currently have dental sealants. Additionally, a nurse advice line will provide families with access to information that will allow children to get the best care in the most appropriate setting.

[17] *Children's Access Survey*, Jen DeVoe, Lisa Krois, Tina Edlund, Jeanene Smith. January 2006.

Recommendation #2: Establish a Health Insurance Exchange to Bring Together Individuals, Coverage Options, Employers, and Public Subsidies

Proposal Overview

The Oregon Health Insurance Exchange is a market organizer that helps purchasers to buy value. It acts as a central forum for individuals and businesses to purchase affordable health insurance.[18] The Exchange is also the mechanism through which individuals can access subsidies for private market coverage.

The Exchange will define an "affordability standard," which is a calculation of how much individuals and families can be expected to spend for health insurance and still afford to pay for housing, food, and other necessities. This affordability standard will be used to define both the insurance packages available through the Exchange and the public subsidies for coverage.

While the Exchange will exist in addition to existing purchasing venues, it should particularly appeal to small employers as an easy, reliable, cost effective insurance source for them and their employees.

The Exchange will be a vehicle for driving quality by negotiating or collaborating with the community of insurers and providers. It will work with insurers to develop packages that manage care, quality and cost. Quality will be built in, through contractually established expectations on insurance carriers, such as pay for performance requirements, including quality measures, prevention focus, self-management, and employee education.

As the Exchange grows, it can create a critical mass of customers who can influence providers and insurers. To ensure enrollment stability, the Exchange will require those insured through the Exchange stay in for a mandatory period.

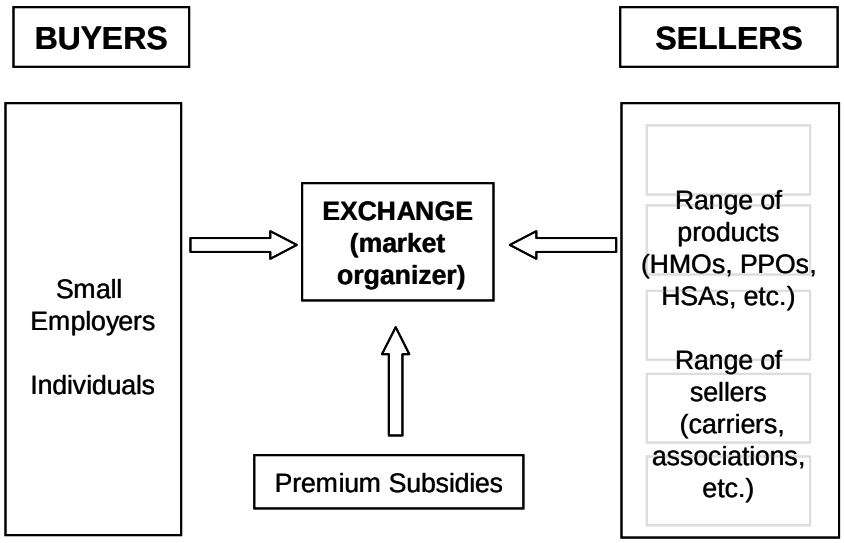
The OHPC recommends establishing the Exchange as an independent organization. It should be shielded from politics and be responsive to stakeholders. The Exchange requires legal, actuarial, and negotiation expertise and must be explicitly given the power to conduct activities such as contracting for services.

Funding for the Exchange should be sustainable and internally generated. Funding mechanisms could include a transaction fee on policies sold through the Exchange, a premium on policies, and a membership fee for insurance providers. Additional funding mechanisms include

[18] The Health Insurance Exchange is similar to the Commonwealth Connector established by Massachusetts, and to the Trust Fund proposed by the Senate Interim Commission on Health Care Access and Affordability.

Medicaid administrative funds. To cover the initial costs, the state should provide the Exchange with start up funds to be repaid once the entity is on solid financial footing.

OVERVIEW OF THE HEALTH INSURANCE EXCHANGE



What Can An Exchange Do For Oregon?

- Act as a single, statewide, centralized exchange for buying and selling insurance in non-large group market
- Aggregate people to influence quality and efficiency of non-large group market
- Facilitate transactions among individuals, insurers, employers, and government
- Provide people with familiar feel of employer-group coverage, with added benefits of individual portability, choice and control

Why Change Is Needed

Employers

Researching insurance options is complex and time consuming, and often falls outside of an employer's expertise. Many small employers, even those who work with brokers, spend considerable effort and time researching available plans and weighing the financial impact of a given insurance product.

Small businesses that provide health insurance for their employees consistently get less for their money, suffering faster premium increases and steeper jumps in deductibles over time than large firms.[19] Small employers can often offer only one plan, which makes it harder to find a plan that fits the needs of all employees.

While small employers face special difficulties in researching and procuring health insurance for their employees, all employers regardless of size face challenges in choosing health coverage that is affordable for employer and employees. The Health insurance Exchange would provide a resource to help employers find quality, affordable coverage.

Individuals
Individuals who lack employer-sponsored health insurance (ESI) and who do not qualify for Medicaid must find their own health insurance. This can be a daunting task for an individual who must weigh costs, coverage limitations and lifetime caps. Information is often not comparable across products and insurers, and legal and medical language is confusing to the lay person.

How an Exchange Adds Value

The Exchange Benefits Employers
The Health Insurance Exchange will offer a variety of insurance product options, from traditional indemnity plans to managed care options and high-deductible health plans with affiliated Health Savings Accounts. This will allow employers to offer employees a range of insurance options - low cost, high coverage and in between. While this is of special interest to small employers that have traditionally been limited to offering a single plan that may not fit all employees' needs, all employers benefit from this function. The Exchange will develop an on-line decision support tool to assist employees, employers, and brokers to compare the benefits and cost of a variety of plans.

The Exchange will be a sustainable source over time for employers offering coverage to their employees. It will be available to employers on a voluntary basis; employers may continue to seek insurance as they currently do. However, the Exchange will be a favorable option for employers because it offers them increased choice and reduced administrative burden.

When working through the Exchange, the employer can allow employees to choose a plan that fits their finances and health needs. The Exchange acts as the pooling mechanism on the employer's behalf, giving employees increased options without increasing employer costs. By providing the employer services such as facilitated plan selection and streamlined access to employee premium subsidies, the employer will experience reduced administrative burden while still providing insurance to their employees.

[19] *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Jon R. Gabel, M.A., and Jeremy D. Pickreign, M.S., The Commonwealth Fund, April 2004. Authors' analysis of Kaiser/HRET 2003 survey of employer sponsored health benefits.

Individuals with greater health needs are more likely to choose plans that are more comprehensive and expensive. Healthier people often value cost savings over more benefits. The Exchange will institute provisions to ensure that the existence of range of plans does not lead to adverse selection by workers with more care needs.

The Exchange Benefits Individuals
The Exchange provides individuals with affordable options. In addition to serving as the access point for eligible individuals' use of subsidies, the Exchange will offer a range of insurance packages, allowing individuals to choose plans that fit their health and financial needs. For example, plans featuring low premiums and streamlined benefits may appeal to young people who currently do not enter the market because they do not think they need insurance.

The Exchange will also allow employed individuals who purchase insurance on their own to use pre-tax dollars to pay health insurance premiums. While pre-tax funds can currently only be used for purchasing insurance when an individual gets insurance through an employer, a statutory change at the state level would allow the self-employed and others purchasing insurance outside of employer-sponsored plans to take advantage of this tax benefit.

For individuals, the Exchange increases insurance portability; the insurance is not tied to an employer or lost when employment changes. An individual whose employer utilizes the Exchange can choose to retain that same insurance through the Exchange even when the individual leaves that employer. This can help people avoid pre-existing condition limitations often associated with changing insurance providers.

The Exchange will offer people a source for coverage they can count on if they need it. Use of the Exchange will be optional with one exception. Individuals and families accessing publicly funded premium subsidies in the individual market will be required to purchase insurance through the Exchange.

Selected Implementation Considerations

Risk Adjustment Options for Consideration
Some insurance carriers may be concerned about unknown risk of a new consumer base. While the Exchange offers the chance for significant new business through the enrollment of previously uninsured populations given the individual mandate, insurers may worry that something unforeseen could cause one carrier to enroll a disproportionately higher number of sicker members. To address this risk selection concern, the state could engage in risk adjustment. Two possible risk adjustment strategies are retrospective smoothing of costs among carriers, and excess-loss claims subsidies to carriers.

Retrospective risk adjustment would involve the state looking back at the costs borne by insurers during a given period, and reimbursing a percentage of costs to carriers with above-average claims costs. With claims subsidies, the state helps pay claims costs for plan enrollees with costs above a set annual limit. Within the risk corridor, the state would pay a percentage of claims.

Realizing the Exchange's Potential Added Value: Areas for Further Research
One potential benefit of utilizing an Exchange for the purchase of health insurance is the expansion of tax benefits to employed individuals not insured through an employer. Currently, individuals purchasing insurance through an employer-sponsored plan can use pre-tax dollars to pay premiums. This effectively lowers the purchase price of the insurance for these individuals.

The Exchange faces additional tax issues upon implementation. Massachusetts (which recently implemented a "Connector" entity that acts like Oregon's proposed Exchange) is currently addressing tax issues related to the implementation of its program. The OHPC recognizes that additional work is needed to identify and respond to tax considerations raised by the goals of a fully functioning Exchange.

One added benefit for employed people that needs additional development is allowing an employee with multiple employers to have more than one employer contribute to the individual's premium. This is not currently available to individuals with more than one job, but could allow people with multiple employers to get help with insurance premiums from employers that may be unable or unwilling to individually contribute the full cost of coverage.

Recommendation #3: Require All Oregonians to Have Health Insurance

Proposal Overview

A central element of the Oregon Health Policy Commission's (OHPC) reform plan is universal health insurance coverage. The OHPC recommends requiring that all Oregonians obtain insurance. To ensure affordability for lower income Oregonians, this individual mandate must be coupled with sliding scale subsidies to help make health insurance premiums affordable (Recommendation #4). Low-income individuals without access to employer-sponsored insurance will be eligible for the Oregon Health Plan. A Health Insurance Exchange (Recommendation #2) will be established to provide a one-stop-shop to facilitate enrollment in a selection of plans and access to publicly-funded subsidies.

Why Change Is Needed

Everyone needs to be insured to protect their health and financial security, spread health care costs over the whole community, and reduce the amount of uncompensated care.

The uninsured who find themselves in a medical crisis have few alternatives to the emergency room. While emergency room care is needed in some situations, it is costly and can often be avoided by making prevention, primary care and chronic care services available and affordable. Making such services financially accessible reduces reliance on high intensity, high cost emergency care, and increases individuals' ability to obtain care in the most appropriate settings.

Bringing everyone into the market will do more than benefit the currently uninsured. It will also reduce the burden of uncompensated care in the system. Hospitals receive state and federal funds to offset some "uncompensated" care; they also pass much of these costs on to insurers. These added costs drive up claims costs which are then reflected in higher insurance premiums. This cost-shift for uncompensated care represents 10% percent of premium costs for insured persons.[20]

Some employees who are offered insurance do not enroll, either because they do not think they need it or because the cost is prohibitive. An individual mandate will require everyone to obtain insurance. This will encourage employees with access to employer-sponsored insurance to use it, capitalizing on the existing employer market.

[20] Calculations by John McConnell, PhD, Oregon Health and Sciences University.

Selected Implementation Considerations

Affordability

The question of what is affordable has four components:

- What can people afford to spend on health care?
- What are the overall program costs (what can society afford to spend)?
- What subsidies are needed to make health care affordable for Oregonians?
- What benefit package can be afforded and sustained given the answers to the three questions above?

In order to calculate what families at different income levels can afford to spend on health care, the OHPC used the Economic Policy Institute's Family Budget Calculator to estimate necessary household expenses on housing, food, childcare, transportation, taxes and other necessities in Oregon.[21] The OHPC removed the health care costs and added 10% for savings. The goal was to estimate the cost of making essential health care affordable for lower income individuals and families in Oregon.

Based on this work, the OHPC proposes affordability levels that policymakers can use to guide reform discussions. The affordability levels presented below represent a maximum portion of family income to be spent on health care costs for a family of three up to 300% of the Federal Poverty Level.[22]

Family income (% of federal poverty level)	Family income (dollars per month)[23]	Maximum percent of income for health care	Maximum family spending on health care (per month)
0 - 149% FPL	$0 - $2,075	0%	$0
150 - 199% FPL	$2,075 - $2,766	5%	$104 - $138
200 - 249% FPL	$2,766 - $3,458	10%	$277 - $346
250 - 299% FPL	$3,458 - $4,149	15%	$519 - $622

Definition of Coverage

To mandate coverage, the state needs a general definition of a basic package of services. The OHPC recommends using Oregon's current broad definitions of insurance that will permit a wide range of insurance plans.

[21] The Economic Policy Institute's Family Budget Calculator is located at: http://www.epi.org/content.cfm/datazone_fambud_budget.

[22] For more information on the affordability analysis used by the OHPC, please see our companion report, available on the OHPR web site at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[23] All dollar figures are shown for a family of three. Source: Federal Register, Vol. 71, No 15, January 24, 2006, pp.3848-3849.

For example, the definition of insurance used by Oregon's Family Health Insurance Assistance Program (FHIAP) is as follows:

> A "Health benefit plan" as a policy or certificate of group or individual health insurance that provides payment or reimbursement for hospital, medical and surgical expenses. Such a health benefit plan includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act.
>
> A health benefit plan does have limitations, and does not include accident-only coverage, insurance limited to care for a specific disease or condition, limited parts of the body (vision only or dental only coverage), or for services within a particular setting (hospital-only, for example). Other excluded coverage types are credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.[24]

Enforcement
Oregonians with access to affordable coverage who choose not to purchase it will face financial penalties. The OHPC proposes that non-participants lose their individual exemption on state taxes and perhaps forfeit their kicker. Implementation of enforcement measures must be carefully planned to provide adequate time for Oregonians to understand their new personal responsibility to seek out insurance and enroll in available plans.

Care for Remaining Uninsured
Although the goal is 100 percent coverage, the OHPC recognizes that individuals at times will lack coverage for a variety of reasons. Those entering and leaving the state, changing jobs or undergoing a variety of life changes may temporarily be without coverage. Some people, such as the mentally ill and chronically homeless, may not be in a position to obtain and utilize health insurance. In addition, uninsured visitors to the state may need emergency care.

To ensure access to care for the uninsured and vulnerable populations facing significant financial, geographic, language, cultural, and other barriers to care, we must continue to develop a strong safety net. Local providers serving low-income and uninsured individuals offer culturally appropriate, trusted services. Recommendation #7 outlines some ways that Oregon can support local efforts to deliver health care more effectively and efficiently to all a community's residents.

[24] Oregon Revised Statutes 735.720.

Recommendation #4: Offer Low-Income Oregonians Publicly-Financed Support to Ensure Insurance Is Affordable

Proposal Overview

The Oregon Health Policy Commission (OHPC) recommends pairing an individual coverage mandate (Recommendation #3) with publicly-financed assistance that would make coverage affordable for individuals and families with incomes up to 300% of the Federal Poverty Level (FPL).[25] The goal is to ensure that everyone can afford the coverage that all Oregonians will be required to attain.

Publicly subsidized insurance would come in two forms: direct Medicaid coverage (the current Oregon Health Plan) and insurance premium assistance. The OHPC recommends a structure in which direct Medicaid coverage is an option for all children with family income up to 200% FPL, and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income between 200% and 300% FPL will utilize premium subsidies. These premium subsidies could be used to purchase insurance in the employer or individual markets.[26]

Subsidies will be graduated based on income and an affordability standard created by the Health Insurance Exchange (Recommendation #2), phasing out by 300% FPL. The Exchange would also act as a one-stop shop for Oregonians seeking out coverage options, serving as a connection point between individuals, coverage options, and public subsidies.

In order to most efficiently utilize state resources, the OHPC recommends maximizing federal Medicaid match to the highest income level that the federal government will approve. Under the Medicaid program, state dollars are matched with Federal funds, reimbursing the state 60 cents for every Medicaid dollar spent. Based on recent federal demonstration approvals for Massachusetts, Oregon should be able to receive federal Medicaid matching payments for much of the cost of a coverage expansion to 300% FPL.[27]

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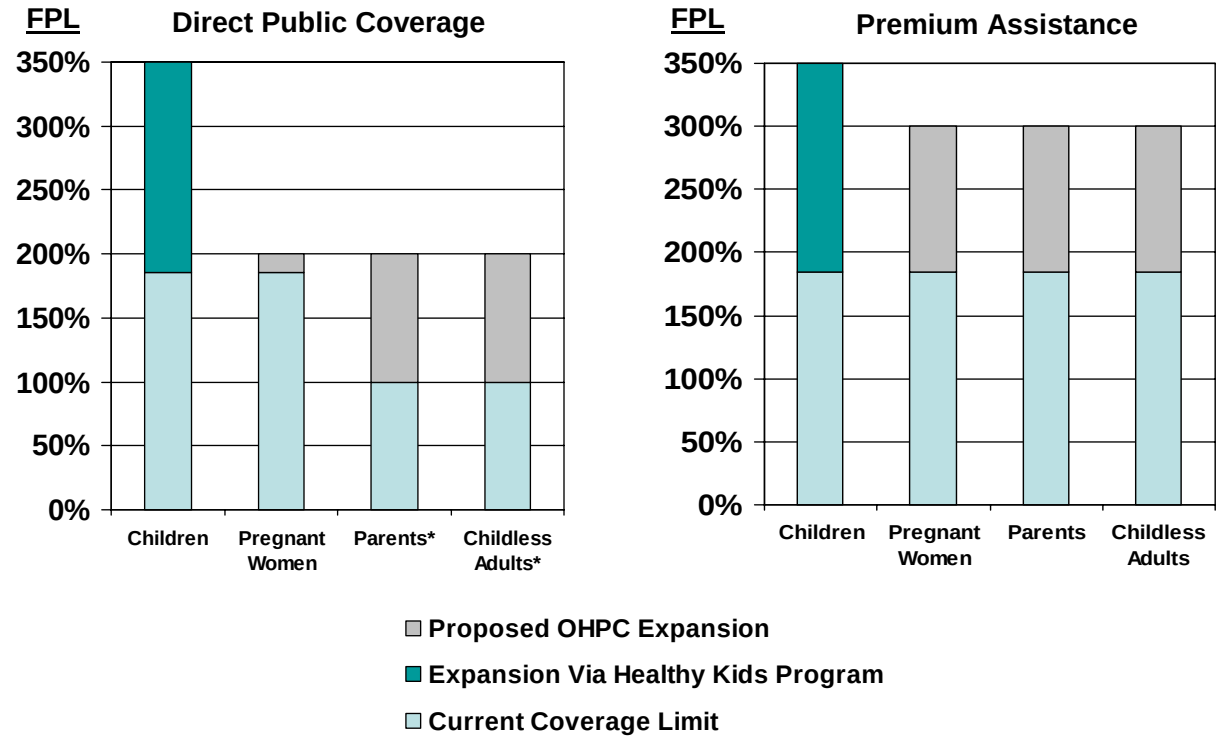
[25] In 2006, 300% of the Federal Poverty Level was $29,400 per year for an individual and $49,800 per year for a family of three.

[26] The OHPC recommends maintaining the coverage currently available for populations that are "categorically" eligible under federal Medicaid law, including children, pregnant women, elderly, and people with disabilities.

[27] Recent Medicaid waiver amendments approved by the federal Centers for Medicare and Medicaid Services for Massachusetts granted federal matching funds up to 300% FPL for premium subsidies for employer-based insurance. Up until this approval, it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options



*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Why Change Is Needed

An individual insurance mandate is only meaningful if all Oregonians have access to affordable coverage. In a survey of adults aged 18 and over, seventy percent of uninsured adults say the cost of insurance is the main reason they are without coverage, while only 6% say they are uninsured because they do not think they need it.[28] With 15.6% of Oregonians lacking health insurance coverage, insurance is prohibitively expensive for many in the state.[29]

The OHPC used the Economic Policy Institute's Family Budget Calculator which estimates necessary household expenses such as housing and food to develop recommendations on the income level at which people require assistance to make health insurance affordable. These data indicate that families do not begin to have discretionary income above necessary household expenses and household savings until they approach 250-300% of poverty. Based on this preliminary analysis, the OHPC recognizes that Oregonians up to 300% FPL require some assistance to make health care affordable.

[28] The *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, "Health Care Costs Survey" August 2005.
[29] 2006 Oregon Population Survey.

Although 60% of Oregon employers offer health insurance to their full-time employees, a significant number of working people are not offered employer-sponsored insurance or cannot afford to purchase it. This is a particular problem for low-income individuals, for whom health insurance is often not offered as compensation for part-time and low-skilled employment.

Selected Implementation Considerations

Potential Negative Market Effects of Public Coverage Expansions
Encouraging employers to financially contribute to their employees' health insurance is essential to an affordable system where everyone contributes to the costs. One often cited concern with public coverage expansions is that employers may drop coverage if their employees become eligible for public coverage. Conversely, employees may decline employer insurance if public coverage is available, increasing public subsidy costs. To mitigate such issues, efforts must be undertaken to maintain employer participation in health care. Oregon could learn from the experience of other states' efforts to address these concerns in their public coverage expansions.

Publicly-Subsidized Insurance Can Push for Quality Coverage
The state has a responsibility to ensure that public health care funds purchase high quality, cost effective health care to promote a healthy Oregon. To that end, the state is currently investigating changes to the OHP Prioritized List of Health Services that will emphasize prevention, primary care and the proper management of chronic care.[30]

Another way the state can use its payer role to be a smart buyer is to require subsidies be used to purchase quality health coverage that promotes access to primary care, prevention, and chronic care management. To that end, individuals who access state subsidies to offset premium costs will purchase insurance products that promote preventive and primary care services.

[30] The Health Services Commission ranks health services by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. In order to encourage effective and efficient medical evaluation and treatment, the Commission uses peer-reviewed medical literature to determine both the clinical effectiveness and cost-effectiveness of health services, and their relative importance. The Commission may also include clinical practice guidelines in its prioritized list of services.

Recommendation #5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes

The Oregon Health Policy Commission believes that true reform is more than just assuring access to health care. It also requires the creation of a high-value health care system that:

- *Provides high quality, safe care* that is organized, coordinated, and integrated across providers and over the life of the individual;
- *Ensures evidence-based care* that provides the right care at the right time and setting in a cost-efficient manner; and
- *Supports continuous improvement* through information transparency, reliable health information exchange, adequate workforce development and a culture of improvement.

Everyone must participate to achieve change. To achieve a high-value health system, the OHPC, along with numerous national and state level policy organizations, supports bringing the state, providers, purchasers, and individuals together to push the system forward in some key areas:

- Improving information collection, reporting, and outcomes measurement;
- Improving the system's ability to manage for quality and become more transparent;
- Encouraging public-private collaboration on value-based purchasing;
- Developing widespread and shared electronic health records;
- Assuring a well-trained health care workforce; and
- Increasing health care safety.

This section outlines some concrete reforms Oregon can implement now to create a health care system that continually improves quality, safety, and efficiency to reduce costs and improve outcomes. The OHPC acknowledges the efforts of the Commission's Quality and Transparency Workgroup in developing these recommendations.

Overview of Proposals

Make targeted state investments

The OHPC supports the use of targeted state investments to achieve increases in health care quality, efficiency and value. The OHPC encourages the Governor and the Oregon Legislature to include such investments in the 2007-2009 state budget. A variety of organizations and efforts would benefit greatly from small investments in state staff and funding, as state involvement would help assure more rapid progress with the following:

- The success of the Oregon Patient Safety Commission's mission;
- The improvement of data available for managing the system;
- Increased transparency regarding health system performance; and

- The coordination of efforts to expand electronic health records and connect health information across providers.

Create the collaborative structure to improve quality information collection, measurement, and reporting

Building on current collaborations among private organizations and the Office for Oregon Health Policy and Research (OHPR), the OHPC recommends that the Oregon Legislature direct OHPR to work with stakeholders to develop a model for a public-private quality institute. The purpose of this institute would be to coordinate the creation, collection and reporting of quality information to improve health care purchasing and delivery. An independent public-private entity is critical for gaining the trust of all key stakeholders. The institute should be financially stable and make efficient use of available public and private funds. An organized, stable structure will help Oregon attract additional resources from federal and private funders.

Responsibilities of a quality institute would include:

- Collecting quality data and information in a central location;
- Coordinating reporting of quality information from numerous sources in a central location;
- Complementing individual stakeholder efforts;
- Supporting and encouraging collaboration between quality efforts in the state;
- Examining state regulations for opportunities to increase efficiency and reduce administrative complexity;
- Addressing issues of legal discovery and liability;
- Fostering provider capacity to collect and use data for improvement;
- Encouraging dissemination of data in formats that are useful to a broad range of audiences; and
- Engaging Oregonians to use available quality data when choosing health care providers.

Encourage all purchasers, providers, and state agencies to further develop data and tools to improve system transparency and quality

The OHPC encourages all purchasers, providers, and state agencies to support and expand on current public-private efforts to improve data and tools to manage quality and to improve data available to the providers and consumers:

- Hospital quality including: participation in efforts such as the Surgical Care Improvement Project (SCIP), the National Surgical Quality Improvement Program (NSQIP), 100,000 Lives, and Leapfrog reporting in addition to state and federal mandated reporting;
- Hospital cost reporting;
- Ambulatory care quality measures;
- Actual cost of service reporting, including cost of services provided in Oregon Health Plan Medicaid managed care plans;
- HEDIS and HEDIS-like quality measures; and

- Collaborative public/private strategies to make consumers more knowledgeable about quality and value in health care and the resources available to them.

Encourage increased public-private collaboration to create stronger, more coordinated statewide value-based purchasing

The State should strongly encourage value-based purchasing. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) and health care entities (providers, health plans) to improve quality, efficiency, and outcomes. The Public Employees Benefit Board (PEBB) should have a strong role in such a coordinated effort, along with the Department of Human Services, the Oregon Medical Insurance Pool (OMIP), university health, the SAIF Corporation and the Department of Corrections. Collaboration with other private and public purchasers to develop a consistent value-based purchasing approach in the community is an important part of this effort.

Through this coordinated effort, state agencies should implement the following reforms:

- **Ensure state health care purchasers use purchasing standards that explicitly include quality measures in the criteria for selecting which health plan options to offer.** PEBB could provide leadership in this arena, as it currently does this in its biennial Request for Proposals to health plans.

- **Collect information on quality performance regularly and rigorously and distribute this information widely to help employees and their dependents make informed choices among health plans and providers.** PEBB has established a comprehensive set of performance measurements for its health plans and is participating in community efforts to identify common measures for evidence-based care.

- **Offer state employees information and incentives to choose high-value health plans and providers.** Medicaid should also consider how best to provide value information to its enrollees.

- **Reinstitute prior authorization to manage access to Medicaid pharmaceuticals.** Utilizing prior authorization to enforce the Prioritized List has great potential for cost savings.[31] This requires statutory change, as prior authorization for the Oregon Health Plan preferred drug list is currently prohibited by statute.

- **Improve the Oregon Health Plan's access to technology.** The Department of Human Services has the opportunity to manage the prudent use of technology in its Medicaid program. Line zero of the Prioritized List (the line that covers diagnostic services) can be managed by incorporating evidence-based reimbursement and/or prior authorization. At the

[31] "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan," Daniel M. Hartung, et al., *Health Affairs*, 25, no. 5 (2006): 1423-1432**.**

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.

- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.

- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.[32] These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.

- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.

- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

[32] The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

using technology (such as electronic medical records) and be comfortable using the technology. As technology changes, health care staff from nurses and physicians to medical office and hospital staff need training to remain current in their knowledge.

Increase collaboration and state leadership to improve health care safety

The OHPC recommends further developing the work of the Oregon Patient Safety Commission in order to:

- Encourage the participation of all hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and other health care facilities in the Oregon Patient Safety Commission's voluntary reporting program of serious adverse events.
- Incorporate a surgical events reporting program (specifically, the National Surgical Quality Improvement Program) within the Patient Safety Commission to encourage cross-institutional sharing and learning. The OHPC recognizes that implementation of this recommendation requires finding a way for rural hospitals to be financially able to participate. Direct OHPR to establish public reporting of quality measures at the institutional level.
- Provide state financial support for the Oregon Patient Safety Commission's work in order to give the Commission the means to build awareness of and to develop strategies to reduce serious adverse events and their costs.

Why These Reforms Are Needed

Information, Measurement, Collaboration Are Key to Quality Care
Numerous public and private efforts are underway to push for improvements in quality, transparency, and coordination of care. Many of these efforts will be more effective if accomplished collaboratively between public and private entities. Involving more provider and payer organizations in the data collection process improves the quality of information provided and increases providers' and insurers' interest in using the information collected to improve care quality and efficiency.

For example, quality information on evidence-based care becomes more valid and useful to providers when data is consolidated across the community rather than by individual health plan. An excellent example of the power of a collaborative public-private approach is the recent Oregon Health Care Quality Corporation's leadership in developing common measures of ambulatory care and the strategic plan for market-driven change supported by a Robert Wood Johnson Foundation grant. This grant is, however, only a three year project, leaving the funding for continuation and enhancement unknown at this time.

There is a need for a stable model to continue such efforts into the future and consolidate a variety of information beyond the limited scope of the Robert Wood Johnson grant. Public and private interests should explore the model most likely to provide stability for the critical function of providing a range of quality information to a range of users. The answer could come in

strengthening existing organizations, new collaborations, or new institutions meeting basic functions detailed in the recommendation.

Information Transparency Will Improve the System's Ability to Manage for Quality
The OHPC continues to recognize and support the need for performance information to guide purchasers, providers, and consumers in their efforts to make wise decisions, spend resources wisely and perhaps most importantly, improve performance. Experience has shown that publicly available information can result in both improved performance and in more focused attention to quality improvement efforts. Providers need to benchmark their performance, purchasers need ways to identify and reward quality performance, and consumers need information to help them make critical decisions.

Much of the value of public information to date has been to promote quality in the provider community itself. Consumers need to be more aware of why they need to care about health care quality and information that will help them make wise personal health decisions. Major health plans are becoming both more concerned and in many cases are making significant investments to offer more tools to consumers and employers. Consumer organizations are increasingly interested in promoting a more active and aware consumer. The state should participate in collaborative efforts such as the Robert Wood Johnson Foundation Grant program linking public and private organizations (including consumer organizations) in an effort to inform consumers about quality variations and to improve the tools available to help consumers seek quality in the delivery of their health care.

There are many efforts currently at the national and state level to improve quality information and to make information transparent. Often, however, these efforts are not coordinated. One of the positive national trends is for the major federal purchasers (Centers for Medicare and Medicaid Services) and quality organizations (Agency for Healthcare Research and Quality) to collaborate with important professional organizations (such as the College of Surgeons and the Joint Commission for the Accreditation of Health Organizations) and private non-profit entities such as the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. This has resulted in new programs and strategies such as the Surgical Care Improvement Program, the 100,000 Lives Initiative, the National Surgery Quality Improvement Program, and payment increases being tied to increased quality reporting by hospitals to CMS. Many of these efforts improve data transparency. For example, the CMS Hospital Compare program or the State of Oregon website that provides mortality data for 8 procedures and volume data for 7. Some efforts are not fully transparent, but are associated with significant quality improvement tools designed to help organizations address the issues that data identifies such as NSQIP and 100,000 Lives.

Public/Private Collaboration Is Needed to Promote Value-Based Purchasing
The OHPC supports an expansion of purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) or health care entities (providers, health plans).

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency
Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.[33] They found average start up costs of $44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was $15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

[33] "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs,* September/October 2005, 24 (5): 1127–3.

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from "errors in medical care" across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer's, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon's health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission's role and impact.

Recommendation #6: Support Community Efforts to Improve Health Care Access and Delivery

The Oregon Health Policy Commission (OHPC) recognizes that no one service delivery model will assure access for all people, communities, or providers. Health care delivery is local. Reform approaches need to be flexible enough to provide local communities the ability to tailor their local systems to the needs and characteristics of their community. There are two community responses to local health care needs that the Commission believes requires the urgent attention and involvement of the state, businesses, insurers, and community members alike – the health care safety net and local community health care access collaboratives.

The following are recommendations submitted to the Commission from the Safety Net Advisory Council and the OHPC Local Delivery System workgroup that the Commission supports to further local innovation in health care delivery.[34]

Overview of Proposals

Promote the primary care home model

The OHPC recommends creating a pilot grant program to support community efforts to provide Oregonians with a primary care medical "home" where they can receive timely, affordable, and comprehensive care. The OHPC believes this will enhance quality and reduce cost for vulnerable Oregonians.

Successful applicants will need to demonstrate a measurable short-term impact on cost and health outcomes, particularly for patients with chronic conditions, and a longer-term impact on patient health through preventive services. Successful applicants will have a demonstrated commitment to serve uninsured and Medicaid patients and collaborate with the broader healthcare system. Primary care home components to be supported through grants would include building the provider-patient relationships, comprehensive and integrated care, and assist patients with health system navigation and coordination.

Support local access collaboratives

The OHPC supports legislation establishing a state matching grant program to support development of local access collaboratives. The Community must demonstrate that the project is collaborative (public/private partnerships). Possible parameters for projects include:

- Increasing capacity and/or access;
- Coordinating the process of delivering comprehensive health care services;

[34] See Appendix A for a list of Safety Net Advisory Council and Delivery System Workgroup members.

- Aligning available resources and leveraging financial commitments from stakeholders;
- Engaging multiple, diverse, public and private stakeholders;
- Sharing the risks and rewards across stakeholders;
- Offering significant stability to the local health care system;
- Reducing health disparities and increasing efficiencies and savings;
- Promoting the development of information technology infrastructure; and
- Promoting a continuum of care.

Include safety net providers and local community collaboratives in initiatives to realign payment incentives

The OHPC believes that reforming how our health care system pays for services is key to system reform. The OHPC will to embark on a thoughtful planning process to develop a collaborative initiative which will drive reimbursement reform forward in Oregon (See Section on "Priority Policies for Further Development by OHPC"). Payment reform must provide incentives for cost-effective care that improves health outcomes, as well as fuel the development of electronic health records, data sharing, and reporting systems. Safety net providers and the local community collaboratives should be at the table for this discussion to ensure that reforms support local innovation in providing high-value health care.

Why These Reforms Are Needed

The Health Care Safety Net

The health care safety net is a community's response to the needs of people who experience barriers to appropriate, timely, affordable and continuous health services. Health care safety net providers include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Core safety net providers are a subset of the larger safety net and are especially adept at serving people who experience significant barriers to care, including homelessness, cultural and language barriers, geographic and social isolation, mental illness, substance abuse, cognitive impairment, decreased functional status, health literacy barriers, financial barriers, lack of insurance or undersinsurnace and other barriers. . These providers have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need.

The Health Care Safety Net Advisory Council (SNAC) was created in 2005 as an advisory body that promotes understanding and support for safety net patients and providers in Oregon. SNAC provides the Governor and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed health services to vulnerable Oregonians.

Community Health Care Access Collaboratives

Throughout 2005 and 2006, the Commission convened the Local Delivery Systems Workgroup to bring together experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improving access to health care within Oregon communities. Nineteen of Oregon's 36 counties are designing and implementing local solutions that ensure access to timely, quality, and affordable services delivered in an effective, efficient and sustainable manner. In order to promote the health of an entire community, these local health system collaborative efforts are working to:

- Coordinate comprehensive health services;
- Offer stability and accountability;
- Leverage existing dollars;
- Involve multiple, diverse, public and private sector stakeholders;
- Require local leadership or champions;
- Share risks and rewards.

The Commission released a report prepared by the workgroup in January 2006 highlighting ways the state could support these community efforts including recognizing the importance of the efforts, facilitating information sharing between communities, and creating flexible state policies to permit local delivery system redesign.[35]

[35] The OHPC Local Delivery Systems Workgroup report on community collaboratives is on the OHPC website at: http://www.oregon.gov/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf

Recommendation #7: Establish Sustainable and Equitable Financing for Reform

Proposal Overview

Health care reform requires improvements on multiple fronts: the uninsured must gain coverage and the provision of services must be made more efficient and less costly. While many people agree that there are sufficient resources in the system to fund care for everyone, the difficult part is capturing and distributing the funding where it is needed. Rather than waiting for system reforms to be implemented before bringing the uninsured into the system, the Oregon Health Policy Commission (OHPC) proposes working toward both universal coverage and improved system efficiency simultaneously. To fund coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that will be phased out as system efficiencies take hold over the following years.

Preliminary pricing of the OHPC reform plan indicate that approximately $550 million per year is needed initially to finance the public coverage and premium subsidies structure proposed in this report.[36] This upfront investment in Oregonians' health will produce savings throughout the state. This investment, to be implemented along with delivery system and other reforms, will lead to more productive employees, improved outcomes, and reductions in system costs.

The OHPC recognizes that to implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. The OHPC also recognizes that many employers currently provide insurance to their employees. These employers are already subsidizing the system and should be rewarded for their ongoing contribution. To recognize this participation, financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Table 1 includes initial estimates of various payroll tax and employer fee scenarios that could fund the necessary revenue of $550 million per year; and Table 2 provides some other revenue sources that may be proposed during reform discussions.

[36] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
The actual cost may be less or more, depending on a number of factors included in the modeling, such as whether an asset test or waiting period are required for public coverage and subsidies, and extent of crowd out into public programs.

Why This Change Is Needed

Universal Coverage Reduces Burden of Cost Shift

The current system funds care for the uninsured primarily through higher premiums for the insured. Providers pass the costs of caring for the uninsured on to insurers. The insured and employers that offer insurance pay more, as insurers pass on their increased costs to members. With universal health insurance in Oregon, providers will experience great reductions in "uncompensated" care. This will allow them to charge the insured for the actual cost of their care. Premiums should be adjusted in response. The insured will pay premiums that reflect a truer cost of providing care.

An Initial Investment Will Pay Off in the Future

Oregon bears a heavy cost for having a large uninsured population. The estimated cost of hospital uncompensated care was $299 million in 2004, and that number continues to increase. Researchers estimate that total uncompensated care (hospital, physician and out of hospital care) will be $534 million in 2008.[37] Both state government and the insured pay for this care. Uncompensated care accounts for ten percent of the cost of insurance premiums.

As the Institute of Medicine noted in its 2003 report, these costs are not just due to the costs of providing free health services to persons without insurance coverage.[38] Much of the cost is due to the poorer health experienced by the uninsured, who receive too little care. The economic value of better health outcomes that would accrue from continuous health insurance coverage (and appropriate health care use) for all Americans is between $65 and $130 billion a year.[39] The savings include higher expected lifetime earnings and educational and developmental outcomes.

System savings will accrue through reductions in uncompensated care costs and improvements that ensure people are getting the right care at the right time. However, as outlined in this report, to reap the benefits of an insurance market that covers everyone in the state, Oregon must implement a system of publicly financed subsidies that facilitate access to affordable insurance.

An investment in universal insurance coverage will reap the greatest gains if change is paired with delivery system reforms that make the system more efficient and accountable. The following are a few delivery system improvements that can control costs and improve care.

- Small practices that implement electronic health records recoup their initial investments in technology and training in an average of 30 months.[40]
- Reducing hospital acquired infections could reduce the rate of increase in insurance premiums and help make coverage more affordable. The average hospital stay was $32,000 higher when the patient experienced a hospital acquired infection (HAI).[41]

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[37] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
[38] *Hidden Costs, Value Lost: Uninsurance in America*, Institute of Medicine Committee on the Consequences of Uninsurance. 2003.
[39] Wilhelmine Miller, et al., op cit.
[40] H. Miller, et al., op cit.

- Medication errors are expensive and can be costly in terms of health outcomes. The Institute of Medicine estimated there are 7,000 deaths annually due to medication errors.[42] Each preventable adverse drug event added $2,000 to the cost of hospitalization, totaling $2 billion nationally in hospital care costs. The cost of medication errors is likely even higher, as drug errors and other problems arising from lack of medication reconciliation exist in other settings, including at nursing facilities, physician offices and medical clinics.

Everyone Must Contribute to Reform
Health care is a shared social responsibility and that everyone should contribute to health insurance coverage. Many employers are doing their share and more, subsidizing care for the uninsured through higher premium payments. New financing considerations should recognize these contributions and help equalize the burden of health insurance costs across employers.

Sustainable Reform Requires Sustainable Financing
Reform requires a stable funding source. A broad-based employment payroll assessment is one sustainable funding option that can be used to finance public coverage. Whether such a tax or fee is paid only by employers or is shared by employers and employees, such a source would ensure a stable funding base to which everyone contributes.

Implementation Consideration

ERISA and the Structure of an Employer Assessment
Table 1 outlines various options for a payroll assessment. If a payroll tax or fee is considered, the OHPC recommends a structure where employers who offer insurance are allowed to recoup all or a portion of the assessment paid.

The OHPC does not recommend a specified level of coverage in order for an employer to be eligible for a tax benefit provision. Any such requirement would likely face legal challenge under the Employee Retirement Income Security Act (ERISA). ERISA substantially limits states' ability to regulate employee benefit plans, including health insurance. While a state employer health insurance mandate has not received full legal vetting, recent court rulings indicate that states might be vulnerable to legal challenges if they attempt to require employers to provide a certain level of health insurance.[43] ERISA poses a serious implementation issue that must be considered in the design of a reform plan. Appendix D includes some guidelines provided by the National Academy for State Health Policy.

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[41]"Infections Due to medical Care in Oregon Hospitals, 2003-2005" Research Brief by Office for Oregon Health Policy & Research. November 2006. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/.
[42] "To Err Is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors, Institute o f Medicine. National Academy Press, 2000.
[43] On July 19, 2006, U.S. District Judge J. Frederick Motz overturned Maryland's Fair Share Health Care law, which had required large employers to spend at least 8 percent of their payroll on health care for employees or pay the equivalent in fees to the state. The judge's decision noted that the federal ERISA law preempted the Maryland law. .Judge Motz's rule is available at <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf>.

Table 1. Various Payroll Assessment Scenarios to Fund OHPC Proposed Public Coverage Expansion
Estimated Initial Direct Public Investment: $550 million per year

INITIAL ESTIMATES - FOR ILLUSTRATION ONLY

	Assessment Scenario	Approx. Assessment % required to raise revenue		Average Annual Payment Per Employee			
				2007	2008	2009	2010
a)	• Employer financed payroll assessment • No employer credit for offering insurance	0.8%	Employer share	$320	$320	$330	$350
b)	• Employer & employee financed payroll assessment (50/50) • No employer credit for offering insurance	0.8%	Employer share	$160	$160	$165	$175
			Employee share	$160	$160	$165	$175
c)	• Employer financed payroll assessment • Full employer credit for offering insurance	2.8%	Employer share (if offers insurance)	$0	$0	$0	$0
			Employer share (if no insurance offered)	$1,040	$1,040	$1,090	$1,150
d)	• Employer financed payroll assessment • Partial employer credit for offering insurance (50%)	1.25%	Employer share (please see table notes)	$1,070	$1,060	$1,120	$1,180
e)	• Employer financed payroll assessment • No employer credit for offering insurance • Additional surcharge per employee ($300/year) • Full credit for surcharge for employers offering insurance	0.6% + $300/yr if not offering insurance	Employer share (if offers insurance	$240	$240	$250	$260
			Employer share if (if no insurance offered)	$540	$540	$550	$560

Source: Preliminary revenue estimates, OHPC, January 2006. Based on public and private payroll estimates (see reference below).
Notes: Option B is included as illustration that assessments could be split between employers and employees. Options c, d, and e could also be jointly financed by employers and employees. Option D provides an estimate of the average payment per employee for all employers. Employers who provide insurance would pay less per employee as they would be eligible for the 50% tax credit. Employers who do not would pay more per employee.

REFERENCE:	**2007**	**2008**	**2009**	**2010**
Total Oregon Public & Private Payroll ($ in billions)	67.6	71.1	74.8	78.7
Total Number of Oregon Workers ($ in millions)	1.7	1.8	1.8	1.8

Source: Payroll and employment estimates, December 2004 Oregon Economic Forecast

Table 2. Additional Funding Options for Discussion

The following are some other funding sources that could be considered to finance the cost of proposed public insurance expansions.

Funding Source (in millions)[44]	FY 2007-08	FY 2008-09	Broad Tax	Targeted Tax
Broad Retail Sales Tax – 1% Rate (exempts shelter and groceries)	$860.2	$910.9	✓	
Restricted Retail Sales Tax – 1% rate (exempts shelter, groceries, public transport, health care, education, personal insurance, utilities, gasoline, tobacco products)	$607.2	$642.7	✓	✓
Increase Tobacco Tax – Increase Cigarette Tax by 84 cents per Pack[45]	$180-190	TBD	✓	✓
Increase Beer Tax – Increase Beer Tax by $1 per barrel	$2.6	$2.6		✓
Increase Wine Tax – Increase Wine Tax by 25 cents per gallon	$2.4	$2.4		✓
Medical luxury tax – Ex. 1% on cosmetic surgery not resulting from trauma or medical condition	TBD	TBD		✓
Provider Tax – Amount of tax depends on scope of provider types included	TBD	TBD		✓

[44] Information from 2006 Oregon Public Finance: Basic Facts, Research Report #1-06. Legislative Revenue Office. February 24, 2006. http://www.leg.state.or.us/comm/lro/home.htm.
[45] Tobacco tax data (per pack amount and total revenue for the 2007-2009 biennium) are from the Governor's recommended budget.

Recommendation #8: Design and Implement System Reform Evaluation

Health Care Reform Demands a Strong Evaluation Component

The Health Policy Commission recognizes evaluation is an integral component of any successful health reform package. The purpose of evaluation is to measure health care capacity and access and to determine whether policy changes are having the intended impact on access, quality, and health outcomes. The OHPC recommends that a coherent, stable and coordinated evaluation infrastructure be developed prior to implementation to assess success and inform future policy decisions. Oregon's research infrastructure can be formalized and expanded to evaluate any global reform efforts. Building on this infrastructure is cost-efficient and timely.

Components of the Evaluation Infrastructure

- A well-designed baseline evaluation plan, capturing the data necessary to demonstrate 'pre-post' changes and attribute changes to specific reform policies;
- An evaluation of reform implementation, ensuring that implemented programs and practices are in line with the intention of policies;
- Identified sustainable funding for on-going evaluation identified during passage of any reform legislation;
- A central entity responsible for:
  - Collecting statewide and community level data, with the authority to collect data from providers and other entities that is integral to successful reform evaluation;
  - Coordinating existing state and community resources to develop shared units of measurement and metrics of change;
  - Developing a dissemination protocol that would ensure policymakers receive evaluation results in a timely manner and understandable format in order to be useful;
  - Developing and maintaining an integrative and interactive website where communities and policymakers could access relevant local and state data to inform their programmatic, practice, and local policy approaches.

Recommended Metrics of Change

A health reform evaluation plan would develop metrics from the outcomes described below. Some of the metrics outlined below can be extracted from current national and state surveys. However, several metrics are not currently collected in a manner that would be representative of all demographic subsets of Oregonians, such as race/ethnicity and geographic location. An Oregon population survey related to health care would be needed and health care providers

would need to begin providing capacity data by insurance type, provider type, FTE, and clinic location.

- Provider and Consumer participation
  - Managed care participation
  - Use and usefulness of Health Insurance Exchange
  - Insurance status rates across demographic variables
- Provider capacity
  - By primary care and by specialty care
  - By clinic location
  - By provider type
  - By insurance type (e.g. Medicare, Medicaid)
- Population demand by age subgroups (e.g. pediatric care) and by disease subsets (e.g. chronic diseases)
- Utilization patterns that emphasize on preventative care and chronic disease management
  - Access to the appropriate level of care in a timely fashion:
    - Emergency Department visits by IC-9 codes
    - Number of primary care visits by age/demographic subsets
    - Appropriate use of diagnostic and specialty care
  - By insurance type (to assess impacts of co-pays and high-deductible plans)
- Changes in health outcomes and disparities, particularly members of vulnerable subgroups
- Health care quality measures
- Financial impacts that reflect affordability for the state, providers, employers, individuals and families
- Special concerns such as "crowd-out", effective and efficient use of technology and transparency

Infrastructure

This necessary evaluation component will build on current infrastructure at the State:

- The Office for Oregon Health Policy and Research (OHPR), Research Unit: The OHPR Research & Data Unit has extensive experience developing comprehensive evaluation plans, creating data collection instruments, managing evaluation contracts, and analyzing data from state-wide surveys.
- The Health Indicators Project (HIP): Under the HIP project, leaders in state-wide community access organizations: 1) define a common unit of analysis across the urban and rural areas of the state, termed Primary Care Service Areas (PCSA); 2) identify shared metrics of access to allow communities within PCSAs to compare themselves locally, state-wide, and nationally; and 3) develop a "tool-kit" for local access organizations to tap into existing data resources to answer their community-specific questions in a cost-efficient manner.
- The Oregon Health Research and Evaluation Collaborative (OHREC): OHREC supports evidence-based decision-making by collaborating with health researchers from Oregon's universities, state agencies, advocacy organizations, local community health-care access

initiatives, and a variety of other stakeholders. OHREC is committed to creating a bridge between health-care decision-makers and the research community; thus creating a feedback loop of rapid-cycle research findings that informs policy.

Oregon Health Policy Commission Road Map for Health Care Reform

Sequencing Reforms: A Five-Year Plan

The goal of the Commission's reform work is to develop a five year reform plan that would create a health care system in Oregon in which everyone has access to affordable health care. This section outlines a recommended approach to implementation.

Getting Started in the 2007 Legislative Session

- Pass universal health coverage for children. Ensuring coverage for children is a strong first step in ensuring affordable coverage to all Oregonians.

- Pass legislation outlining the major components of full scale reform, providing guidance to public and private cooperative work throughout 2007-2009.

Years 1 and 2

- Implementation of universal health care for children will occur in Year 1.

- Implementation planning for the Health Insurance Exchange, the publicly-financed coverage expansion, and an employer assessment or fee will take place throughout Year 1 into Year 2.
  - This provides over a year for the Exchange to be created carefully by establishing an independent oversight board, promulgating operating regulations, developing initial benefit packages for individuals and small businesses, and developing affordability standards and the subsidy structure.
  - Also during this time, the state will negotiate the terms of the needed Medicaid waiver amendments to implement the publicly-financed subsidy structure.
  - Implementation of the Exchange, the publicly-funded subsidy structure, and the employer fee will occur by the middle of Year 2.

- Also during the second year, the Office for Oregon Health Policy and Research (OHPR), in partnership with other state agencies, the Oregon Health Research and Evaluation Collaborative (OHREC), policymakers, and national experts, will develop a comprehensive five-year plan for evaluating the reform implementation and initial outcomes.

Years 3, 4, & 5

Individuals have from the passage of the enacting legislation until Year 3 to seek out available coverage. The child coverage expansion, the publicly-funded subsidy structure, and the Health Insurance Exchange are all in place to assist individuals in finding affordable options. Only after the beginning of Year 3 will individuals be subject to penalties if affordable insurance is available per the Exchange affordability standard.

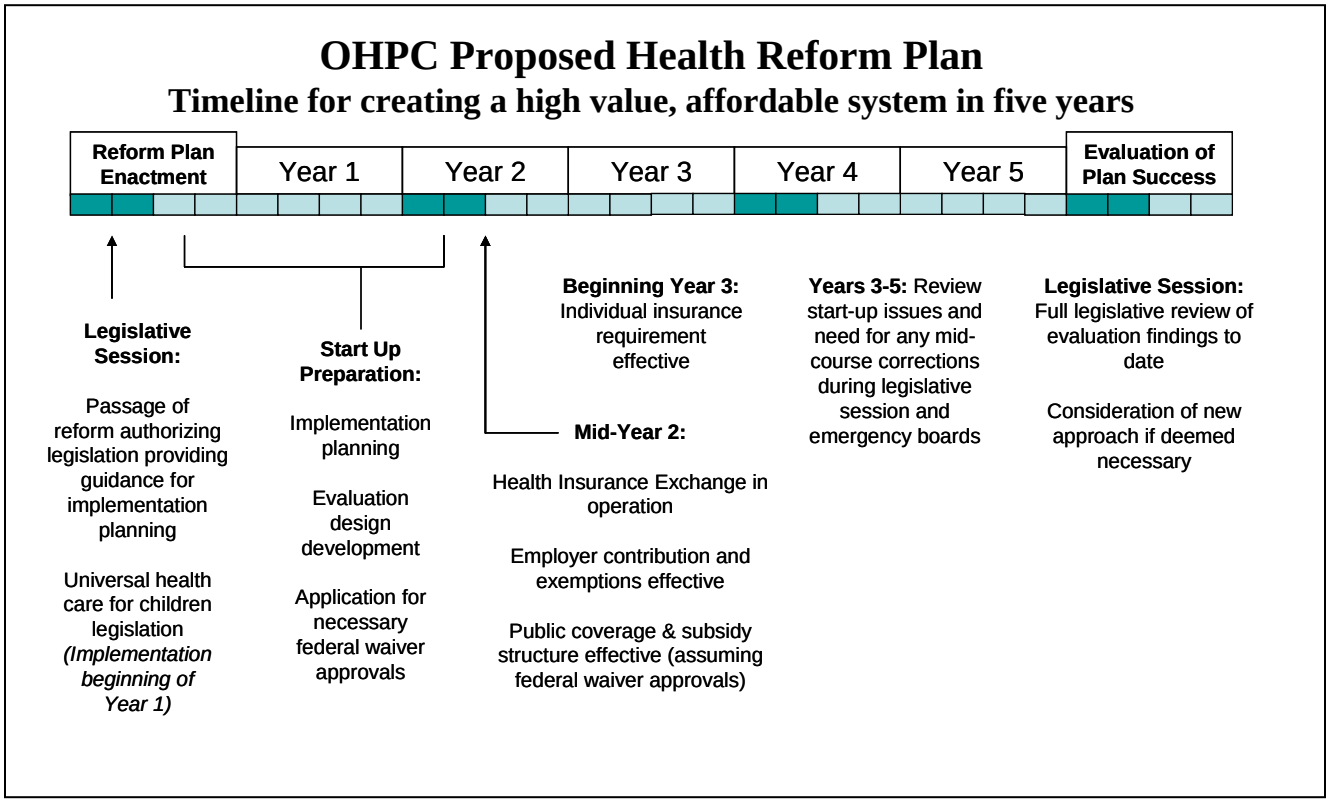
During the legislative session and emergency boards during years 3 through 5, the Governor and Legislature will review implementation progress to date and assess whether any mid-course legislative corrections are required.

Evaluating the Success of Reforms

Upon completion of year 5, the Governor and the Legislature will conduct a public review of progress to date through:

- Preliminary results for review through initial evaluation findings from OHPR and other researchers;
- Feedback from constituents, advocates, providers, insurers, and other stakeholders; and
- Any updated recommendations from the OHPC and other advisory bodies.

Both minor adjustments and full scale direction changes should be on the table for discussion at this point.



Oregon Health Policy Commission
Road Map for Health Care Reform

Priority Policies for Further Development by OHPC

Implementing Senate Bill 329

Senate Bill 329, which outlines a work plan to design comprehensive reform in Oregon, was passed in June 2007. Signed into law by Governor Kulongoski, the bill's goal is the completion of a comprehensive plan by late 2008, followed by reform implementation legislation for consideration in the 2009 session.

The bill includes a detailed timeline for fleshing out a full-scale reform plan in the 2008 legislative session. Under SB 329, the Oregon Health Fund Board, a newly created governmental entity will oversee the development of a comprehensive reform plan and implementation proposal. Five subcommittees will develop recommendations for the Board focused on: 1) financing, 2) delivery system reform, 3) benefit definition (based on Oregon's Prioritized List of Health Services), 4) eligibility and enrollment policies, and 5) federal policy impacts and opportunities. To facilitate the work of the Board and its subcommittees, existing state commissions and committees will form the backbone of the subcommittees.

The Oregon Health Policy Commission is tasked with forming the backbone of the financing subcommittee. As such, the Commission will spend the majority of the remaining time in 2007 researching options for financing the Oregon Health Fund program, and developing recommendations for the Oregon Health Fund Board. Several of the issues the Commission will tackle in this capacity include:

- Developing an implementation plan for a health insurance exchange by February 2008;
- Collecting and pooling employer, employee and individual health care premium contributions; and,
- Developing a model for a Quality Institute to improve how health care information is collected and utilized.

During the public comment period, the Commission received input that reform plans should include consideration of end-of-life care, medical liability, and other topics not covered by this report. The Commission opted to not add these topics in this final report as many of them are listed as topics to consider in implementation of SB 329.

Delivery System Reform

While much of the focus of health care reform is on insurance coverage, real reform must also change our delivery system to ensure that everyone has access to quality and affordable care provided in the most appropriate setting. In our current system, care is often fragmented, with services such as behavioral health and long-term care not well integrated with physical health care. This is in part due to the way services are paid for, and is exacerbated by a system that does not reward provider collaboration.

The OHPC believes that reforming how our health care system pays for services is key to system reform. As discussed under Recommendation #5 in this report, there are numerous entities in the state and nationally focused on reforming how health care is financed and reimbursed. The OHPC will continue to focus on furthering delivery system reform in Oregon. Some key areas of OHPC's work will include:

- Encouraging the most effective care in the most appropriate setting. Our payment incentives should place a particular emphasis on promotion of preventive care, chronic care management, and coordinating care for patients over their lifetime in a continuous way rather than episodically.
- Motivating health care providers to utilize health information technology to improve quality, safety, and transparency by permitting patient information to be available at the point of decision making by both providers and patients. Building the capacity for such infrastructure development in safety net providers and small physician practices should be a focus.
- Ensuring adequate provider capacity to ensure the demand for needed health care is met throughout the state.
- Integrating cost-containment in the system in a way that levels out growth and makes the system more sustainable. Ideally, mechanism for "capturing" savings can be created in order to demonstrate the effect of system reforms.

Appendix A: Acknowledgements

The Oregon Health Policy Commission recognizes the valuable contributions of the following individuals:

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Appendix B: Reference on designing the employer contribution to reform in compliance with ERISA

Excerpt From: "Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints." Patricia A. Butler, JD, Dr.P.H. for National Academy for State Health Policy, May 2002.

Do not require employers to offer health coverage to their workers. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

Establish a universal coverage program funded in part with employer taxes. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

Do not refer to ERISA plans. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

Remain neutral regarding whether employers offer health coverage or pay the tax. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

Impose no conditions on employer coverage to qualify for the tax credit. Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

Minimize administrative impacts on ERISA plans. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems.

6. HEALTH CARE

RECOMMENDATIONS

In order to lower health care costs, improve quality, and expand access to care, the Oregon Business Plan recommends the following:

- Use value-based purchasing strategies by employers and public sector purchasers to improve quality and lower costs. Employers should encourage a culture of wellness and personal responsibility, and design benefit plans to improve health, including coverage of preventive services, management of chronic conditions, protection from catastrophic costs, and incentives for wellness. Employers should also create an effective market for health care: consumer choice of health plans, better consumer information, and appropriate consumer cost sharing. Employers should develop expectations and incentives for health plans and providers to encourage higher quality and use of evidence-based care.
- Encourage investment in health care information infrastructure: electronic medical records, secure exchange of health information among providers, standardized measures of quality, and transparent information on costs and quality.
- Expand Medicaid to reduce the number of uninsured and improve access to care. Use additional state revenue to maximize federal matching funds. Increase payments to providers who serve Medicaid patients to improve access to care. In exchange, providers and health plans should reduce the cost shift by lowering charges to privately-insured employers and individuals.
- Increase access to coverage for individuals and small businesses: require individuals to have health insurance, subsidize low-income workers and individuals to enable them to afford coverage, and create an "insurance exchange" to make it easier for individuals and employees of small businesses to purchase insurance.

Vision

We support actions to give all Oregonians access to quality health care. This can best be accomplished by creating a fair market where everybody is motivated to improve health, ensure quality, and control costs. In such a system, individuals, employers, health plans, and providers have incentives to encourage good health, and consumers make informed choices about health practices and treatment options based on understandable health information and transparent prices and quality.

The Problem

The current health care system in the U.S. and Oregon is not delivering value.

- The U.S. spends a much higher share of its GDP on health care than other developed countries.
- Health insurance premiums have been increasing at an unsustainable rate.
- The quality of care in the U.S. is inconsistent

ACCOMPLISHMENTS TO DATE

√ Published a white paper summarizing the problems and root causes of high health care costs and inconsistent quality

√ Developed the business case for a pilot project to enhance the exchange of health information among providers and locations of care.

√ Supported efforts to develop websites to provide comparative information on hospital prices and quality.

√ Collaborated with initiative to develop standardized quality measures for outpatient care.

√ Developed a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP) to educate employers and encourage them to use more effective purchasing strategies for health benefits.

and often below the standards of other developed countries.

- Our health care system leaves many people – nearly one-sixth of the population -- without health insurance coverage.

Why is this important for businesses and all Oregonians? The Oregon business community has identified health care as one of the most serious cost problems it faces. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees

The Oregon business community has identified health care as one of the most serious cost problems it faces.

In addition, the high cost of publicly-financed health care crowds out needed public investment in education and transportation.

Lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. The lack of access to coverage for many Oregonians is unacceptable in our society, and the costs for caring for the uninsured are shifted to those who have insurance, putting an additional cost burden on businesses and individuals.

Health Care Task Force

In response to these concerns, the OBC Health Care Task Force was commissioned in the spring of 2004.

The task force had four primary objectives:

- Understand the health care problem in Oregon and the impact on businesses and the community
- Educate businesses and the community regarding the problem and its impact
- Develop a long-term vision and principles to address these problems
- Create a proposal for comprehensive redesign of the health care system.

Challenges

The health care system is badly broken and needs to be redesigned. The problems of cost, quality and access are driven by three closely related factors:

- Fundamental cost drivers
- Lack of effective market forces
- The vicious cycle of costs and access to care

[Note: These factors are described in more detail in the OBC's white paper, "A New Vision for Health Care," December 2004.]

Fundamental Cost Drivers

- *Aging.* The percentage of the population over 65 is increasing steadily.

- *Chronic conditions.* It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer, and trauma) have driven a large portion of overall cost increases during the past 15 years.
- *Technology.* New advancements in diagnostic and treatment technologies are providing new alternatives, many of which extend life or improve health, but at increased cost.
- *Unhealthy lifestyles.* Poor health choices and the lack of personal accountability for health -- exacerbated by limitations on public health initiatives – contribute to higher costs. For example, the scope and impact of the obesity epidemic are well-documented.

Lack of Effective Market Forces

There are four important levers that have the potential to drive improvements in the value – cost, quality and service – delivered by our health care system:

- Consumer choice
- Price sensitivity
- Information to support informed consumer choice
- Healthy competition between providers

How is this working in the current U.S. health care system?

*Choice***.** The majority of employed Americans do not have a choice of health plans offered by their employers.

Price sensitivity. Most consumers are shielded from the real costs of health care. In this situation, consumers lack financial incentives to manage their demand for health care services, and they lack strong economic incentives to shop for efficient health care providers. (Although new benefit plans with considerably higher cost sharing – often known as "high deductible health plans" – have been introduced in recent years, they are still a relatively small share of the market.) Furthermore, many employers pay the full premium or a high percentage of the full premium, regardless of the cost. As a result, there is little incentive for employees to choose the most efficient health plan. In addition, many physicians are unaware of the costs of providing services and are not in a position to assist patients in making cost-effective choices.

Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment is needed. Publicly available information on health care costs and quality is gradually reaching consumers, but it is currently inadequate to support informed decision-making by most of them.

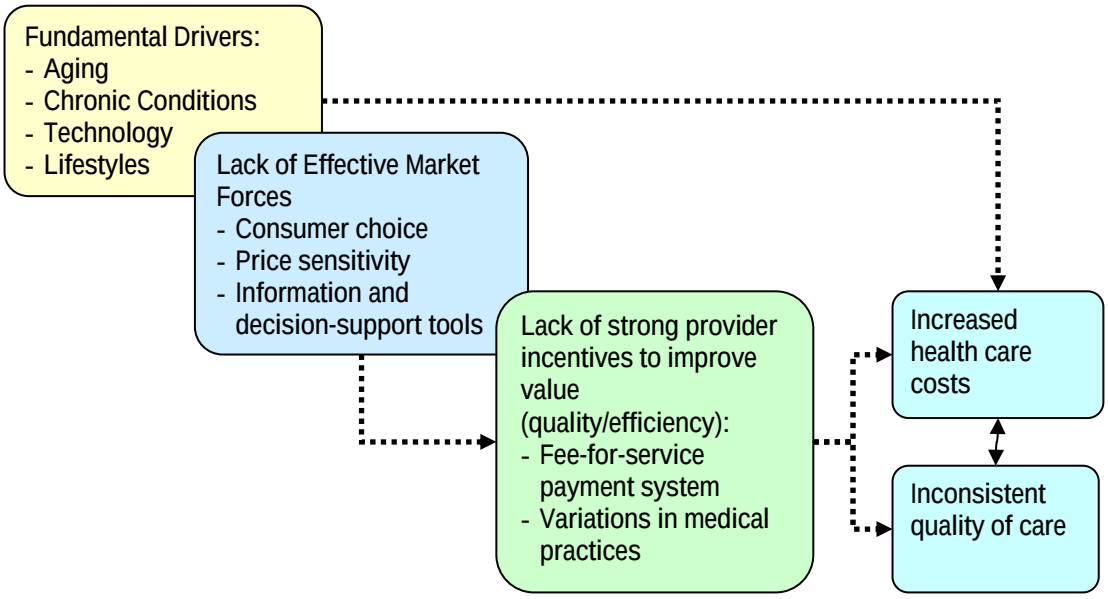
Healthy Competition. Given this situation, there is little incentive for health plans or providers to differentiate themselves and compete on cost or quality. Exacerbating this problem is the fact that most providers – especially physicians – are paid on a fee-for-service basis, i.e., a fee for each service delivered. This compounds the effects of the fundamental drivers of demand for medical care. For a physician to be successful financially, s/he is driven to provide a greater number of services. While this may or may

not result in improved health outcomes, it can cause more services to be delivered than are necessary. In some cases, over-treatment can also cause poor medical outcomes. (See Figure 1 for a graphic summary of these factors.)

The problems of lack of consumer choice, useful information and healthy competition are

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



especially acute for employees of small businesses and non-employed individuals. Health plans will usually provide coverage to small groups only on an exclusive basis, thereby eliminating the opportunity for consumers to make choices. The lack of choice also reduces "portability" by making it more difficult for employees to stay with a particular health plan when they move from one job to another. Small businesses seldom have the time or expertise to shop effectively for health insurance, thereby weakening their purchasing power. From the health plans' perspective, small group and individual coverage incurs higher administrative and selling costs, and the claims costs for this segment are subject to higher risk variation. As a result, the rates charged to small groups and individuals are higher and less stable year-to-year, although rate regulations dampen these problems to some degree.

Other Factors

- The medical care delivery system is very fragmented. Most physicians are self-employed in solo practices, and only 25 percent are in practices of eight or more. This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of

common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

- The U.S. health care system has very complicated administrative processes. As a result, administrative costs are high – 7 percent of total health care expenditures according to government statistics. Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31 percent). Part of this is due to the market fragmentation among providers, health plans, and purchasers. As a result, the system has a high level of duplication and a lack of standardization.
- The lack of a well-developed infrastructure or standards for health care information systems has also been a major obstacle. Health care information exists in a multitude of places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and health plans is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information can lead to compromised safety and quality.

There is a complex but powerful relationship between rising costs and deteriorating access to care.

The Vicious Cycle of Costs and Access

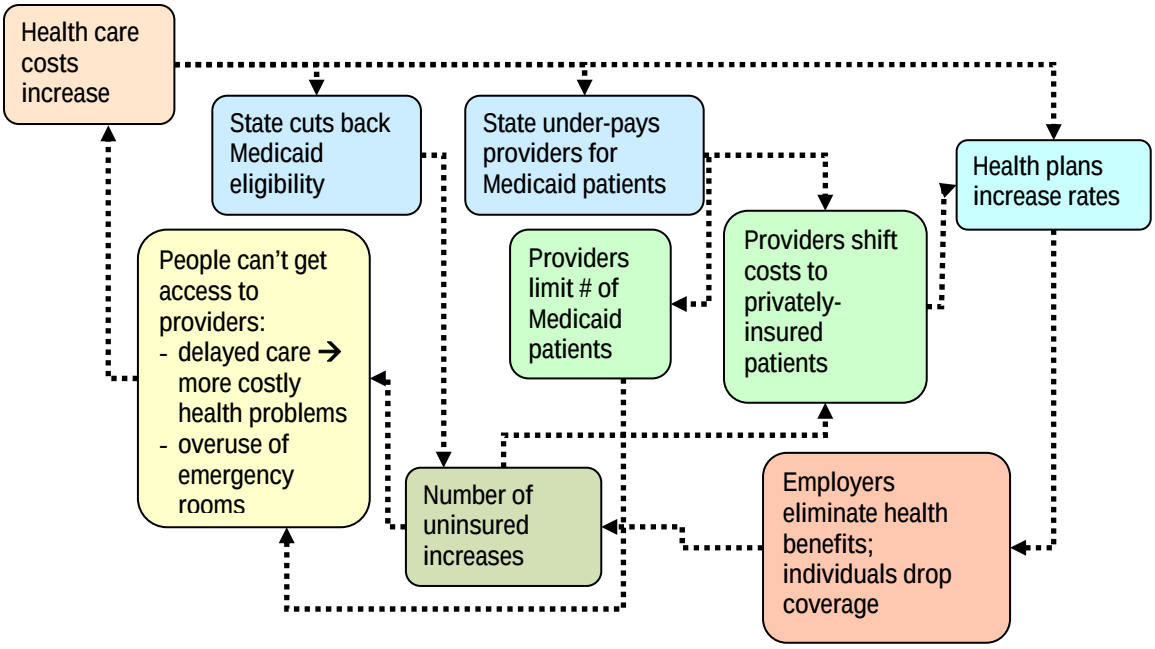
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- The most basic dynamic starts with cost increases that drive higher health insurance rates. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. Similarly, increasing health care costs have forced the state to reduce the number of people in the Medicaid program (Oregon Health Plan). These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.
- The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital emergency departments for non-emergency care. This further increases costs, creating a vicious cycle by increasing insurance rates and putting additional pressure on employers and the state to reduce coverage.
- The increasing number of uninsured non-paying patients in hospital emergency departments also forces hospitals to charge higher rates for insured patients. This cost shift results in higher insurance rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.
- Higher costs have also forced the state and federal governments to under-pay for care provided to Medicare and Medicaid patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as providers increase charges for insured patients to offset the low payments for Medicare and Medicaid patients.

As a result, employers and individuals with health insurance carry an additional burden. In addition to higher insurance rates caused by the fundamental cost drivers described earlier, the rates are increased further due to the cost shift. The magnitude of the cost shift is estimated to be 10 to 15 percent in addition to basic health insurance rates. (See Figure 2 for a graphic summary of these factors.)

Figure 2

THE VICIOUS CYCLE OF HEALTH CARE COSTS AND ACCESS



The linkage between costs and access is further complicated by the complex health care financing system in the United States. There are three primary ways in which health benefits are financed:

- *The employer-based system, which covers 52 percent of the total population in Oregon.* Employees and their dependents receive benefits that are largely paid by employers. The benefits are determined by the employer or through collective bargaining. The value of the health benefits is exempt from personal income taxes. (Individuals who purchase health insurance directly account for an additional 6 percent of the population.)
- *Medicaid, which covers 12 percent of Oregonians.* Low-income people in certain eligibility categories receive benefits. The eligibility rules and benefits are set by the federal government, with some flexibility at the state level.
- *Medicare, which covers 13 percent of Oregonians.* Elderly and disabled people are eligible to receive benefits. The benefits are established and administered by the federal government.

Each of these major categories has different funding mechanisms, eligibility requirements, benefit designs and administrative jurisdiction. As a result, many people fall between the cracks of these categories. For example, many part-time or seasonal employees, dependents, and employees of small businesses do not have benefits. Many

low-income people are not eligible for Medicaid because they do not fit into one of the aid categories, but they are unable to afford health coverage. By limiting eligibility to the very poorest, we effectively discourage work.

Agenda for 2007 and Beyond

The OBC Health Care Task Force has developed a set of recommendations to address the problems with the current health care system. The proposals are built upon an understanding of the root causes and a set of core principles:

Principles

1. There are three essential issues to address: cost, quality and access. Many reform proposals focus only on access. We believe this is insufficient. Any proposal that does not address the system changes needed to reduce costs will be unaffordable. We are committed to finding solutions that are economically sustainable.

2. The health care system is badly broken and needs fundamental change. Fixing the problems of high costs, inconsistent quality, and poor access will take sustained and focused effort over many years. Ultimately, the system of delivering health care services requires major restructuring. Some improvements can be driven by changes in health care financing and purchasing, but those changes alone will not be sufficient to improve the cost and quality of health care services.

3. This is a systemic problem that requires collaborative problem-solving. It's easy to look for and blame villains, but that won't fix the problem. All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution. The business leaders working on this initiative are committed to collaborating with key stakeholders and policy-makers to achieve reform.

All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution.

4. All stakeholders must accept their responsibilities for improving the system. Consumers have a responsibility to keep themselves healthy and be well-informed purchasers. Providers have a responsibility to help keep their patients healthy and to offer evidence-based, cost-effective care to all who need it – including publicly-subsidized as well as privately-insured patients. Employers have a responsibility to offer health benefits to their employees and dependents, if they can afford it, and help keep their employees healthy and productive. Health plans have a responsibility to offer coverage to all who need it and work with providers to reduce costs and improve health outcomes. The government has a responsibility to ensure access to coverage and care to all who need it and use value-based purchasing strategies to encourage efficiency and quality.

5. We believe that a system that is built on the private health care delivery system and uses market forces is most likely to achieve the goals of cost control and quality. While there is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons, we believe that the private

delivery system – with the right incentives for providers – is the best way to improve quality and cost effectiveness**.** Consumer engagement and personal accountability are critical. Consumers must have real choices, an appropriate level of price sensitivity, and access to information and decision support tools.

6. We need practical solutions that can be implemented. Although it is necessary to have a long-term vision for a redesigned health care system, it isn't fruitful to imagine an ideal future system that is impossible to achieve. We must find pragmatic approaches that build a bridge from the existing health care system to a future system that delivers value and provides access to evidence-based care. We recognize that investments in basic infrastructure, e.g., development and publication of standardized quality data, electronic health records, and the exchange of health information among providers, etc., are needed to support a new health care system.

7. Business leadership is needed to drive improvements in the health care system. As the primary purchaser of health benefits, employers – on behalf of their employees –have a major stake in ensuring that the money spent is producing value. Building on the employer-based system makes sense; it already covers the majority of Oregonians reasonably well. In addition, this will help to ensure that employers continue to have a stake in keeping employees healthy and productive. Building on the employer-based system also allows employers to customize their health benefit programs to meet their employees' needs.

A Responsible Plan for Sustainable Reform

The following are the key elements of a comprehensive redesign of the health care system in Oregon. We have focused on state-level initiatives at this time, recognizing that even greater improvements could be made with reform at the national level. The first two elements focus on actions by purchasers – working with health plans and providers – to improve the quality and lower the costs of the health care system. The remaining four elements address the vicious cycle of costs and access to care.

Improve Quality and Lower Costs Through Purchaser Action

Use value-based purchasing by employers and public sector purchasers. Private and public sector employers can play a major role in driving improved quality and lower costs. There are several general principles and approaches that purchasers should use:

Private and public sector employers can play a major role in driving improved quality and lower costs.

- Encourage a culture of wellness and personal responsibility in the workplace.
- Offer benefits that are designed to improve health; coverage should include:
  - Preventive services
  - Management of chronic conditions
  - Protection from catastrophic costs
  - Incentives for wellness
- Create an effective market for health care:
  - Offer employees a choice of health plans and providers

  - Engage employees in their health care decision making by using a defined contribution approach to fund employees' health benefits and requiring cost sharing at the time of service – while avoiding financial barriers to preventive services or chronic care management Provide employees with decision support tools, including understandable cost and quality data, to support their ability to make informed choices of health plans, providers, and alternative treatments and services.

- Contract more effectively with health plans, using standardized RFI tools and setting expectations for health plans and providers to improve transparency, cost-effectiveness, quality of care, and use of evidence-based care.

In addition, public sector programs such as Medicaid must operate as efficiently as possible to ensure that beneficiaries and taxpayers are getting the best value for the money. The Medicaid program should be allowed to use the same tools (e.g., use of a preferred drug list, integration of mental and physical health programs) that businesses use in managing their health benefit programs. With these tools, any expansion of the Medicaid program would be more cost-effective.

Invest in information infrastructure development. Private and public sector purchasers should work with health plans and providers to stimulate the development of health care information infrastructure, including:

- Electronic Health Records should be adopted by all health care providers.
- Providers should have access to necessary patient health information through secure data exchange mechanisms in order to provide continuity of care.
- Data transparency is needed to allow purchasers and consumers to be more informed buyers.
- Standardized and easily understood measures of quality are needed to enable purchasers and consumers to compare the performance of providers.

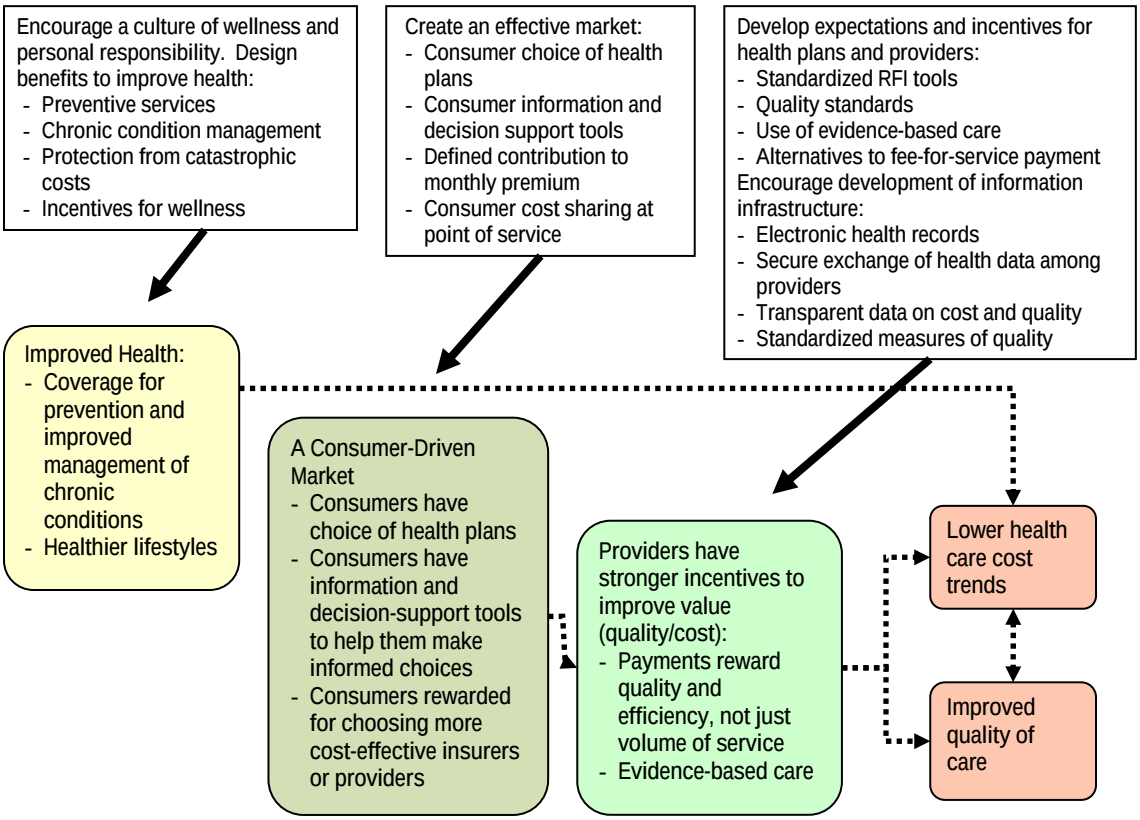
(See figure 3 for a graphic summary.)

Break the Vicious Cycle of Costs and Access.

Reduce the number of uninsured by expanding Medicaid. Use additional state revenue to maximize Federal matching funds that are currently available to the state. Increasing state funding by $700 million would generate over $1 billion in additional federal funds annually.

Improve access to care by increasing payments to providers who serve Medicaid patients. Use a portion of the additional Medicaid funds to reduce the gap between provider payments for publicly- and privately-insured services.

Figure 3
USING VALUE-BASED PURCHASING TO IMPROVE VALUE: QUALITY/COST

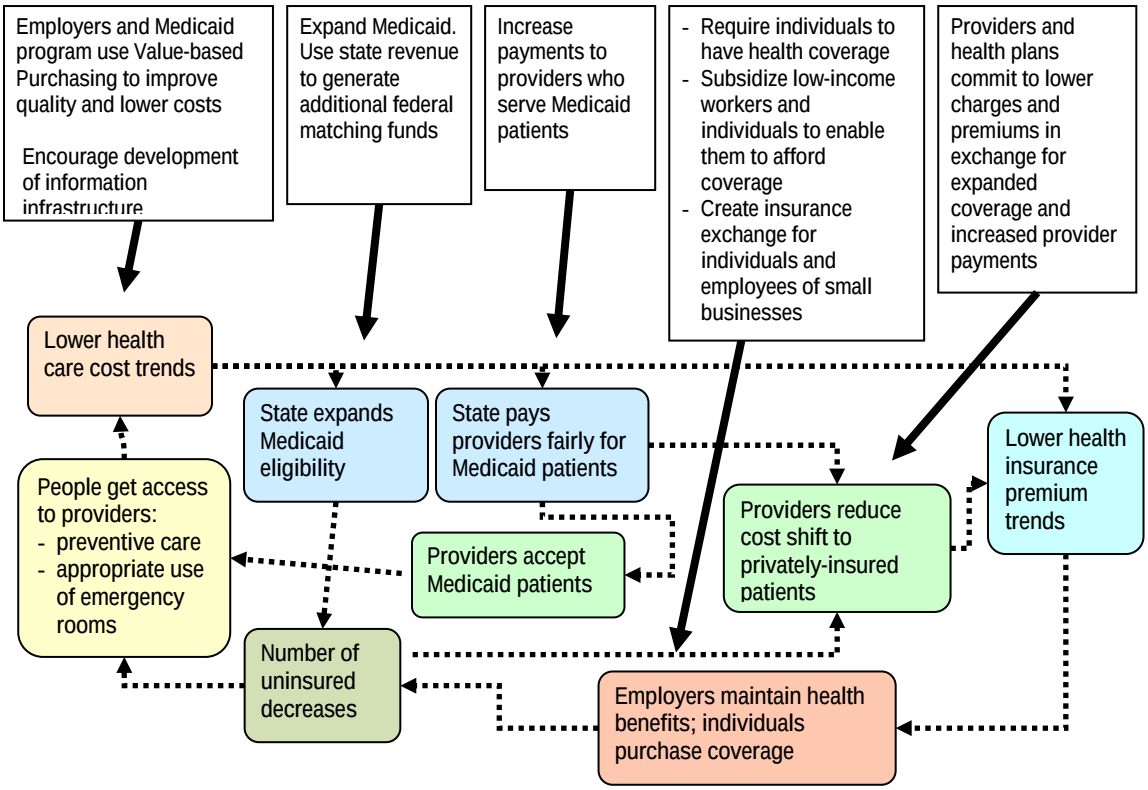


Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they become seriously sick or injured, they rely on hospitals which are required to serve everyone regardless of coverage. The health care costs for these "free riders" are borne by those who have insurance, via the cost shift described above. Three specific steps are needed:

- Require individuals to have health insurance.
- Subsidize low-income workers and individuals to enable them to afford coverage.
- Create an "insurance exchange" for individuals and employees of small businesses

Reduce the cost shift to employers and individuals. In return for expanded coverage and increased provider payments, health plans and providers should reduce the cost shift by lowering charges to privately-insured employers and individuals. (See Figure 4 for a graphic summary of these recommendations.)

Figure 4
BREAKING THE VICIOUS CYCLE



Short-term Initiatives (2007-08)

Focus on Improving Quality and Reducing Costs

1. Use Value-based Purchasing by employers to improve quality and lower costs.
2. Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers, e.g., use of a preferred drug list, integration of mental and physical health programs
3. Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures
4. Support Medicare initiatives for improved transparency, quality improvement and pay for performance

Improve Access and Reduce the Cost Shift

5. Support the cigarette tax to fund comprehensive and affordable health coverage for children – the Healthy Kids Plan
6. Support the use of state revenue to gain federal matching funds and expand the Oregon Health Plan
7. Support efforts to increase provider payments for Oregon Health Plan patients and reduce the cost shift to privately-insured patients

8. Oppose efforts by Medicare to further reduce payment rates to providers, or other steps that would exacerbate the cost shift to privately-insured patients
9. Create a forum and collaborate with other organizations to develop a plan for comprehensive redesign of the health care system to provide all Oregonians with access to high quality and affordable care.

Measuring our Progress

We will measure our progress against the following goals [specific targets to be developed]:

Health and Wellness of Employees. Employers incorporate the value of employee health and wellness in the culture of their organizations and their decision making processes.

Outcomes:

- Employers use health risk assessments to develop wellness and prevention programs with incentives to engage employees and to take personal responsibility
- Employees and their families do not have financial barriers to needed preventive and chronic care
- Employers offer evidence-based disease management programs
- Overall health status of employees and dependents improves.

Access. Provide access to care for all Oregonians.

Outcomes:

- Reduce the number of uninsured in Oregon..
- Increase the number of providers willing to care for Medicaid and Medicare patients..

Create appropriate incentives to drive efficiency in health care. Structure the health care market to offer informed consumer choice and encourage healthy competition among providers.

Outcomes:

- All consumers have a choice of health plans
- Information regarding cost, quality and service is easily accessible for consumers and group purchasers to make informed choices between health plans and providers.
- Consumers have the appropriate degree of cost sharing, without creating barriers to needed care
- Providers have the appropriate financial incentives to provide high quality and cost effective services.

Costs. Create a health care system that is affordable and economically sustainable.

Outcomes:

- Reduce the annual increase in overall health care costs,
- Reduce the annual increase in health insurance premiums.

Quality. Improve the quality of health care services.

Outcomes:

- Patient health information is available to providers across systems.

- Employees with chronic conditions are well managed.
- Employers measure health care quality through standard metrics.
- Evidence-based guidelines are used by clinicians.

If we are able to achieve these outcomes, Oregon businesses will have a competitive advantage, thereby increasing economic growth and jobs. The people of Oregon will be healthier and lead more productive and rewarding lives. And Oregon can strengthen its reputation as an innovative leader in social and economic policies.

Health Care Initiative Leaders

Peggy Fowler, President & CEO, Portland General Electric
Mark B. Ganz, President & CEO, The Regence Group.

Background Resources

OBC white paper, "A New Vision for Health Care," December 2004.