OREGON HEALTH FUND BOARD – Benefits Committee Meeting Conference Call

June 11 2008 **General Services Building, OHPR Conference Room**
11:00 am to 11:30 am **Salem, Oregon**

MEMBERS PRESENT:
Susan King, RN, Chair
Somnath Saha, MD, Vice Chair
Gary Allen, DMD
Betty Johnson
Bob Joondeph
Hugh Sowers, Jr.
Kevin Wilson, ND
Tom Eversole

MEMBERS ABSENT:
Lisa Dodson, MD
Jim Lussier
Nina Stratton, Vice Chair
Kathryn Weit
Leda Garside, RN
Susan Pozdena

OTHERS ATTENDING:
Ellen Lowe, Chair, Eligibility and Enrollment Committee
Jane-ellen Weidanz, Oregon Association of Hospitals & Health Systems
John Powell, Regence

STAFF PRESENT:
Darren Coffman, Health Services Commission Director
Ariel Smits, MD, MPH, Health Services Comm. Medical Director
Nate Hierlmaier, Policy Analyst
Dorothy Allen, Administrative Staff

ISSUES HEARD:

- Call to Order/Approval of Agenda and 05/127/08 Meeting Minutes
- Discussion of Suggested Changes to 6/4/08 Draft Recommendation
- Final Approval of Recommendations to Board on the Essential Benefit Package
- Public Testimony
- 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 05/27/08 Meeting Minutes**

Motion to approve the revised agenda is seconded. **Motion passed unanimously.**

- Ms. Johnson asked that, on page four, the response to a question presented to James Matthisen be clarified.

Motion to approve the minutes of 05/27/08 with clarification is seconded. **Motion passed unanimously.**

Chair King **III.** **Discussion of Suggested Changes to 6/4/08 Draft Recommendation**

- See Attachment A for a summary of those approved suggestions.

Chair King **IV.** **Final Approval of Recommendations to Board on the Essential Benefit Package**

Motion to approve the Suggested Changes is seconded. **Motion passed unanimously.**

Chair King **V.** **Minority Report**

- A question was raised regarding issuing a minority report around the issue of health savings account.
- The By-laws do not mention minority reports.
- Chair King suggested that issue be brought directly to the Health Fund Board. Members concurred.
- Chair King will draft a letter to address the issue.

Chair King **VI.** **Public Testimony**

- Jane-ellen Weidanz, OAHHS, testified that she feels a piece of the proposal missing is an acknowledgement that there are times when only hospitalization is the appropriate place for treatment.

Chair King **VII.** **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 **VIII.** **Adjourn**

The Chair adjourned the meeting at 12:20 p.m.

Submitted By:
Dorothy Allen

Reviewed By:
Darren Coffman

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

May 27, 2008 **CCC, Wilsonville Campus Training Center, Room 112**
11:00 am to 3:00 pm **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 Hierlmaier, 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?*
  - o 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.

- o Law prohibiting over 50% cost sharing.
- o 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**

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**

- o 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:	Reviewed By:
Dorothy Allen	Darren Coffman

Next meeting is Tuesday, May 27, 2008.

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

March 13, 2008 — **Oregon Medical Association**
9:30 a.m. — **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.

OREGON HEALTH FUND BOARD – Benefits Committee Meeting

February 28, 2008 | CCC, Wilsonville Campus Training Center, Room 112
9:30 a.m. | 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

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

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.

<u>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.</u>

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);

DRAFT 01/14/08

ATTACHMENT A

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.

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.
- <u>MOTION: To accept the minutes from the October 17, 2007 meeting. MOTION CARRIES: 11-0 (Absent: Garside).</u>

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.

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.

DRAFT

DRAFT **10/16/07**

OREGON HEALTH FUND BOARD
A Comprehensive Plan for Reform: Design Principles and Assumptions
Approved by OHFB ___________