

Oregon Health Policy Board

AGENDA
May 11, 2010
Market Square Building
1515 SW 5th Avenue, 9th floor
1pm to 5pm

Live web streamed at: [OHBP Live Web Streaming](#)

#	Estimated Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: <ul style="list-style-type: none">• Minutes from April 13, 2010 meeting• Updated committee and staff work plans, incorporating changes driven by federal health reform legislation	Chair	X
2	1:05	Director's Report	Bruce Goldberg	
3	1:20	Federal Exchange Design and OHPB Goals Board Discussion: Federal Health Reform: How Oregon can lead the way	Nora Leibowitz Chair	
	3:30	Break		
4	3:45	Temporary Federal High Risk Pool	Tom Jovick	
5	4:30	Public Comment		
	5:00	Adjourn	Chair	

Next meeting:
June 8th, 2010
8:30 am to 12:00 pm

Oregon Health Policy Board
DRAFT Minutes
April 13, 2010
St. Charles Medical Center, Bend
Conference Room A&B
8:00 am to 12:30 pm

Item
<p>Welcome and call to order</p> <p>Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present with the exception of Nita Werner. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund. The Board thanked Mike Bonetto and his staff for the use of St. Charles Medical Center. The Board is also available via live web streaming. Questions and comments will be received during the meeting and brought forward to the Board for comment during the public comment period.</p> <p><u>Consent agenda:</u></p> <p><i>Minutes from March 9, 2010 meeting</i></p> <p>The March 9, 2010 minutes were reviewed. No changes were noted. Minutes were approved by unanimous voice vote. Final minutes will be posted on the web.</p> <p><i>Addition to Incentives and Outcomes Committee: Dan Clay representing Taft-Hartley Trust</i></p> <p>Dan clay, representing Taft-Hartley Trust was added to the Incentives and Outcomes Committee.</p> <p><i>Addition to Health Care Workforce Committee: Paula Crone, DO, Executive Associate Dean of the new College of Osteopathic Medicine (COMP-NW)</i></p> <p>Paula Crone, DO, Executive Associate Dean of the new college of Osteopathic Medicine (COMP-NW) was added to the Health Care Workforce Committee.</p>
<p>Director's Report – Bruce Goldberg, MD</p> <p>Dr. Goldberg presented the Director's Report. The report outlines current Healthy Kids Plan enrollment and outreach and the current OHP Standard enrollment information on community outreach efforts. The transition to and formation of OHA activities remain on track. Dr. Goldberg also provided the latest POLST update and an update on federal health reform in addition to an update on Board committee progress and an update on the current budget allotments. The past month has been dominated by federal reform. We will be able to move our work forward and focus on delivery systems, cost quality and value and population based health discussions. All state agencies will submit an agency request budget for the 2011-13 biennium along with lists of budget reduction options by the end of summer. DHS, in conjunction with OHA, will be holding a series of forums around the state throughout April and May to solicit community input on budget choices. DHS has been asked to put together a 25 percent reduction list in anticipation of a difficult budget climate of a \$2 to \$2.5 billion shortfall. Updates will be provided to the Board.</p>
<p>Behavioral Health Integration and Health Reform – Richard Harris</p> <p>Richard Harris presented a report on integrating health services for people with mental illness or substance use disorders, beginning with why changes need to be made now. The report pointed out that people with serious mental illness die 25 years earlier than the general population and outlined the demands versus the ability to serve this vulnerable population. The guiding principles for integration and its connection with the Triple Aim goals was a</p>

topic of discussion. Four quadrant models were discussed, as well as outcomes specified in the budget notes, and an update of the process to date. The report also highlighted Central Oregon and the Links 4 Health and integration, as well as a review of North East Oregon data and processes. In conclusion the presentation outlined the adult mental health initiative.

The Board asked about the connection integration plays in relation to criminal justice and alcohol and substance abuse as well as mental illness. The Board asked if staff has looked at this population after release. Community justice programs have made efforts to provide housing, employment and treatment. This population has many underlying health problems and is consuming a large number of services as a result of their condition. Staff noted that NE Oregon is working on emergency projects to identify people who are utilizing these programs to help reduce the number of emergency room visits. The Board also asked if acute care programs can be established for younger in order to prevent early hospitalization.

Central Oregon Regional Efforts – Mike Bonetto, Alisha Hopper, Mike Boileau, MD & Scott Johnson

HealthMatters of Central Oregon – Mike Bonetto

Dr. Goldberg provided the Board with the framework for this discussion. What is happening in Central Oregon around integration is just the beginning of what is a larger strategy for accountability for the organization and the delivery of health care. An operational principal needs to be established. It is about accountability and responsibility for health and health services across the state. The focus should also be at the local and regional level. OHA needs to stimulate new structures to create fundamental community change. There needs to be a clear accountability and joint responsibility for keeping people healthy when linking networks of care across the state. Mike Bonetto began his presentation with the goal of the Triple Aim, which is to enhance the patient experience, improve the health of Oregonians, and reduce per capita costs and the challenges of implementation as it relates to the local level. The solution is to bridge the existing gap at the regional level between medical care and health and human services constituents, which sets the stage of health collaboration. Healthmatters is dedicated to improving the health of central Oregonians through *these initiatives* – shared care, links 4 health, living well and Trails to Health.

Multi-Share program – Alisha Hopper

The goal offers affordable health care by encouraging effective use of health services and community resources, care coordination, health education, member responsibility. Provides healthcare coverage to uninsured workers in small businesses with 1 to 50 employees.

Care coordination pathways – Alisha Hopper

This program will cover only a portion of the gap. Federal legislation may be able to provide a community option. This is the population that is most likely to fall through the cracks. This is the community coming together with a benefit structure. People outside the Central Oregon counties are not covered. People who are not in the labor workforce are not covered. This is a health improvement plan and a health collaborative. It is a new way of looking at community resources to help the population in central Oregon.

Physician Hospital Alignment for Central Oregon - Mike Boileau, MD

St. Charles Health System, along with physicians, caregivers and community partners, is embarking on an exiting path toward what is believed will result in meaningful regional health care reform. Much of the work is centered around the Triple Aim. Health care delivery came under significant pressure and negativity. Because of this, surgical specialists began having informal conversations about changes and regulatory structure. This group pulled together to address the element of distrust and political poison in the community which led to discussions about physician

and hospital alignment. The physicians developed a mission statement and a code of conduct to align with the hospital philosophy. The board of directors adopted and embraced the idea about physician hospital alignment in July. Doctors are beginning to embrace communication with the concept. This is a step toward building an integrated delivery system.

Behavioral Health Integration Project – Scott Johnson & Robin Henderson

The current system is not sustainable, produces poor outcomes, is fragmented, and has higher costs for people with chronic conditions. This project is integrating and aligning behavioral health services and primary care services in the community in order to better understand the efforts that are under way to improve the Central Oregon health care system for people with mental illnesses and addictions.

Break

OHA Primary Care Pilots – Jeanene Smith

Jeanene Smith, the Administrator for the Office for Oregon Health Policy and Research, provided a brief overview of implementing the patient centered primary care home model of care, and the next steps. The presentation outlined the goal of the Oregon Health Fund Board and House Bill 2009, steps towards implementing primary care homes, partnering with the Health Leadership Task Force (HLTF) and the high value medical home pilot which builds on successful pilots at Boeing, and focuses on the top 10 percent of adult patients by risk. There was discussion about the care model, focus on the Triple Aim, evaluation of components including utilization, quality and patient experience, the goal of short-term return on investment in 1 to 2 years, and payment methodology. The steps toward implementing primary care homes were to develop PCH standards, partner with the health leadership task force on multi-payer pilot during the summer of 2010 and to expand to more sites or develop additional pilots.

Board questions centered around whether consumers or patients are giving input, and if the Board would be receiving that feedback. Jenanene clarified that the provider engages the patient at the site to be part of the pilot. This is just one step in the implementation process. Additional pilots will be added. The Board also expressed the need for improvement in patient care. Self Insured programs should also participate in addition to the 850,000 individual lives. Dr. Goldberg summarized by stating that there are two takeaways from the discussion. One is consumer involvement and reaching out to the self insured. We are involving a number of self insured lives in PEBB.

Federal Reform: The interaction of federal and state health reform and impact on the OHPB Work Plan - Amy Fauver, Gretchen Morley and Tina Edlund

Gretchen Morley provided an overview of the overall impact of federal law as it relates to population health and delivery system reform, and coverage and access in 2014. The report also outlined what the federal law doesn't do. The presentation provided details on improving population health, transforming care delivery, and coverage and access to care as well as federal health reform timeline highlights, and key issues such as timing, federal flexibility, and how we ensure strategic alignment of design choices as well as how we ensure strategic alignment of funding and pilot opportunities presented by federal reform.

Amy Fauver added that a detailed timeline is on the OHA website and will be updated regularly. That is the most accurate place to see information. Staff will be monitoring the regulatory process over the next year in Washington DC and will highlight opportunities for us to engage Oregon in the decision making process.

General reactions and direction from OHPB to staff are that public options need to be a part of the exchange. The

Board should make certain that the dollars coming in are aligned with our objectives. Staff was asked to ensure the business plan aligns resources for the Board's review in order to be comprehensive in its decision making process. Focus on how we spend federal dollars; there are stakeholders who are at real risk in federal health reform. We need to name those and call them out; we need to be honest about the consequences. We need to identify what is at risk and make sure that overall focus is on public health and the delivery system. Dr. Goldberg summarized the discussion by stating that we need to understand the opportunities when they happen as well as making strategic choices about what to invest our time and energy. We are putting project management in place as we move forward with opportunities. We also need to look at focus on committee work to produce deliverables in a short time.

In preparation for the next Board meeting, staff should be staffing committees to look at how federal reform changes the work plans. Committees are having regular meetings and working on aligning work plans and timelines. Staff can go through the questions with Dr. Goldberg and Chair Parsons, and they will involve Board members in the discussion as needed.

Public Testimony

David Coutin, MD, Allergist, Bend, Oregon

Dr. Coutin stated his belief that the Policy Board will be both in charge of the application of the priority list and in developing the basic insurance plans to be offered to state and county employees as well as teachers. Physicians are trained with the Hippocratic oath to "do no harm" and with the dictum that patients come first. He encouraged the Board to look at cost effective studies and to openly seek testimony from patients and physicians, and that the Board re-examine the priority list itself and the methodology used to make such line determinations. Now it is possible for the Oregon Health Commission by itself or with the aid of OHSU to look retrospectively at the overall costs associated with withholding coverage of standard care. It is also important to compare overall costs to a group of presently insured patients who do have access to such treatment and measure the effects of higher quality health care. Dr. Coutin encourages the Board to immediately authorize such studies. Dr. Coutin also asked the Board how it plans to expand this OHP type system to 800,000 working Oregonians and develop a basic plan without addressing these issues. It is Dr. Coutin's hope that organized medicine will closely monitor the Board's progress and alert the Board and their patients as to their concerns.

Public Comments/Questions via live web streaming

1. What obstacles do we now face with the public option after passage of federal reform? When are we going to discuss those and are we going to discuss the possibility of a statewide non-profit system?

The federal legislation does not prevent a public option. By statute, the Board has an obligation to put forth a plan to the legislature that includes a public option. The Board will be deciding how best to proceed on that topic and the issue will be on the agenda of future board meetings.

2. How will the ban on rescissions and the regulations on lifetime limits be enforced in Oregon?

The Insurance Division of the Department of Consumer and Business Services is responsible for enforcement of insurance regulations. The Board and Oregon Health Authority work with the Insurance Division on proposed changes to those regulations.

3. Will the federal high risk insurance pool have out-of-pocket cost sharing and how will community input be taken about implementing the pool?

At this time, we do not yet know what the requirements will be for the federal high risk pool, including any cost sharing requirements. We must first determine whether the state has the authority to make any decisions about the federal high risk pool. If it does, we will seek community input on those issues.

5. In theory, adding coverage for currently uninsured Oregonians should generate a cost savings to the health care systems; for instance, by providing access to preventive care. How can we capture those savings and return it to consumers?

How to pass savings on to consumers is an important question and one that the Board and its committees are working on. Ultimately, the question of how to capture savings and where those savings will go will be a question for the Board and the Legislature.

6. How do we ensure that Oregon is not penalized-- for instance, by receiving less federal funding than other states--because of our efforts to provide health insurance to uninsured adults and children with state funds?

We are working closely with Oregon's Congressional delegation to ensure Oregon is not penalized for its efforts to expand coverage to uninsured adults and children. At this time, we do not believe Oregon will be penalized. We will continue to work with our Congressional delegation to ensure federal administrative rules are not written in a way that will disadvantage Oregon.

Adjourn 12:20 p.m.

Next meeting:

May 11, 2010

1 pm to 5 pm

Market Square Building

1515 SW 5th Avenue (Between Market and Clay), 9th floor

Questions can be submitted to the Board during the meeting at ohpb.info@state.or.us.

Monthly Report to
Oregon Health Policy Board
May 11, 2010

Bruce Goldberg, M.D.

I. PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Plan

Enrollment

- Through March, we've enrolled 41,750 children into Healthy Kids – we've crossed the halfway mark towards goal of 80k by end of the year.
- This includes just over 800 children enrolled in Healthy KidsConnect.

Outreach

Outreach grantees and Application Assisters are busy reaching out to and enrolling families. Enrollment events are taking place all over the state.

- Office of Healthy Kids is facilitating regional collaborative meetings, so grantees, assisters, providers, Healthy KidsConnect carriers and other volunteer partners in each region are working together and taking advantage of all outreach opportunities.

School and youth sports campaigns are underway:

- Making sure outreach grantees are working effectively with schools.

- Working with individual school districts to send Healthy Kid mailings to parents.
- Working with Oregon Student Activities Association, which will send monthly mailings to coaches and advertise Healthy Kids at all high school sports state championship games through the year.
- Working with CMS on a coaches' campaign that will be piloted in Oregon and five other states.
- Healthy Kids is sponsoring a Portland-area soccer tournament for Latino youth over Memorial Day Weekend.

Have been conducting focus groups this past month with eligible families in order to test Healthy Kids promotional materials and messages:

- This month will refine materials based on feedback and roll out next phase of paid advertising.
- Will be posting a Spanish version of the Healthy Kids website at www.hijossaludables.org

Working with CAF to automatically enroll children on SNAP (food stamps) caseload who are not already enrolled:

- As many as 40,000 households with children on SNAP caseload indicate at least one child doesn't already have medical coverage through Healthy Kids.

Working on streamlining the application and renewal systems.

OHP Standard

- As of April 30, 2010, 108,175 individuals had signed up for the OHP Standard reservation list since it opened in October 2009. About 20,000 are "opt-ins"¹ from the 2008 list, and about 88,000 are from new sign-ups.

¹ This is the group of people who were on the 2008 reservation list and who affirmed they wanted to be on the new list.

Factoring in the drawings that have occurred, there are 79,818 individuals active.

- DHS has completed five random drawings:

Month of random selection	Number of names drawn
October 2009	2,000 (opt-in list only)
January 2010	2,000
February 2010	2,000
March 2010	6,000
April 2010	8,000
May 3, 2010	10,000

The next drawing will be:

- May 21, 2010 -- 20,000 names
- Applications are mailed out approximately 30 days after the drawings, and the individuals whose names are drawn have up to 90 days to return their completed application. (There are 45 days from the mailing date for the potential applicant to submit an application or establish a date of request. If a date of request is established, the individual has an additional 45 days to submit the application).
 - The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
 - The department continues to conduct a statewide media campaign to encourage and assist more uninsured adults in Oregon to sign up, with the help of community partner organizations throughout the state and a grant from the federal Health Services and Resources Administration (HRSA).

Transition to/Formation of OHA

Activities remain on track.

Federal Health Reform

Key activity this month has been the work surrounding the high risk insurance pool. See attached letter from Governor. Update at the meeting.

Board Committee Progress

The **Administrative Simplification Workgroup** last met on April 20, 2010 in Wilsonville. The workgroup discussed two alternative strategies for state-level administrative simplification work. Each envisioned moving toward greater use of uniform electronic methods of conducting business transactions between health care providers and facilities and insurers. One proposed to await adoption of federal uniform operating rules and the other proposed to move more quickly, adapting an approach taken in Minnesota. The workgroup directed staff to flesh out the “move quickly” approach because of its high potential for short-term savings and an assessment indicates that the cost of making any adjustments that may be necessary to comply with future federal operating rules will be low. The next meeting is scheduled for May 11, 2010 at 1 pm at the Meridian Park Hospital Educational Center (19300 SW 65th Avenue, Tualatin). The group intends to finalize recommendations to the Department of Consumer and Business Services and the Health Policy Board.

The **Cost Sharing Workgroup** cancelled its previously scheduled meeting to be held on April 15, 2010 to provide staff additional time to understand the federal health reform plan and its potential implications on benefit design. The next meeting is to be held May 27, 2010 from 8 to 10 a.m. at the Wilsonville Training Center of Clackamas Community College (Room 112, 29353 Town Center Loop East, Wilsonville), where the workgroup will discuss how to approach the development of a baseline benefit package for the Oregon Health Insurance Exchange based on the Prioritized List of Health Services given what is know about the requirements within the federal plan.

The **Health Care Workforce Committee** met on April 29, 2010 in Lake Oswego and had a thorough discussion of a number of draft strategic recommendations that had arisen from the Committee's first two meetings. Committee members identified a selection of issues for potential attention in the short-term and began to add details about relevant stakeholders and action needed to all of the recommendations. The Committee will continue work to specify the recommendations between meetings. The group's next meeting is scheduled for May 26, 2010 from 9 a.m. to 12 p.m. at the Wilsonville Training Center (29353 Town Center Loop E, Wilsonville). The agenda is still in development but topics will likely include development of strategic recommendations, discussion of an inventory of workforce grants and other resources around the state, and review of information from the new workforce database created by HB 2009.

The **Health Incentives & Outcomes Committee** held its first meeting on April 8, 2010 in Tualatin. The committee reviewed its charter and discussed the task before it. The full committee next meets in July. The **Payment Reform Subcommittee of the Health Incentives & Outcomes Committee** met on April 29, 2010 in Portland. The subcommittee clarified its role by reviewing its charter. The subcommittee discussed the principles that payment systems should meet and how to ensure that the committee is able to produce recommendations for changes that can be made over the next year or two. The next meeting is scheduled for May 13, 2010. The subcommittee will address current methods of payment for specialists and hospitals and review a staff effort to summarize the principles discussed at the first meeting. The **Quality & Efficiency Subcommittee of the Health Incentives & Outcomes Committee** also met on April 29, 2010 in Portland. The subcommittee discussed its scope and role, as outlined in the full Committee charter and a draft logic model, and identified some areas for clarification. The group reviewed potential frameworks and principles for the work of creating a common set of quality and efficiency metrics for Oregon and a few volunteers agreed to work with staff on modifications to the draft logic model and principles for the subcommittee's consideration at its next meeting, scheduled for May 13, 2010 from 10 a.m. to 12 p.m..

The **Medical Liability Task Force** has been appointed but has not yet met. The first meeting has been scheduled for May 17 at the Wilsonville Training Center of Clackamas Community College (29353 Town Center Loop E, Wilsonville). The Task Force will review its charter; receive a staff report on trends in medical

liability system costs; and discuss this question: “Does the medical liability system increase direct and indirect costs of health care out of proportion to its benefits to patients and others?” No decisions will be made.

The **Public Employers Health Purchasing Committee** held its second meeting on April 26, 2010 in Meridian Park Hospital’s Health Education Center in Tualatin. The committee heard presentations on: quality and contracting from Nancy Clark of Quality Corp; comparative effectiveness and clinical guidelines from Dave Pass of the Health Resources Commission; and an update on the work of the Incentives and Outcomes Committee from Gretchen Morley, the Office for Oregon Health Policy and Research. The committee also discussed the focus of its work for the next six months. The next meeting is May 24, 2010 from 1 to 4 p.m. at the Wilsonville Training Center of Clackamas Community College (29353 Town Center Loop E, Wilsonville). The committee is tentatively scheduled to review a draft slide presentation to be used in stakeholder engagement efforts, an update on federal reforms, discussion of patient safety, a review of selected Oregon Health Authority legislative concepts, and a report on the Physician Hospital Alliance in Central Oregon.

The **Health Information Technology Oversight Council (HITOC)** met on April 1, 2010 in Portland. HITOC is currently focused on the development of the Strategic and Operational Plans for a Statewide Health Information Exchange (HIE). These plans are required to be submitted to the Office of the National Coordinator for Health Information Technology by August 31, 2010. At the April meeting, the HITOC discussed the progress to date on the plans and received input from the HITOC Strategic Workgroup on the technology domain that must be included in the plans. Additionally, HITOC discussed its other responsibilities as outlined in HB 2009, including the Medicaid Transformation Grant, the Medicaid Health Information Planning Process (P-APD), and Electronic Health Record (EHR) adoption strategies. The next HITOC meeting will be on May 6, 2010, 10:00 a.m. to 5:00 p.m. at the Oregon State Library (Room 103, 250 Winter St NE, Salem). At the May meeting, HITOC will receive input from the HITOC Strategic Workgroup on the legal and policy, business operations and finance elements of the HIE plans and will review a high level outline of the plans. HITOC will also receive updates from representatives from Oregon Health & Science University and Portland Community College on workforce development issues, from Oregon Health Network, and from O-HITEC, Oregon’s Regional Extension Center. HITOC will hold

two meetings in June to review the draft HIE Strategic and Operational Plans and release it for public comment: June 3, 2010, 1:00 to 5:00 pm at the Oregon State Library (Rooms 102-103, 250 Winter Street, NE, Salem) and June 17, 2010, 1:00 to 5:00 pm at Portland State University (Smith Memorial Student Union, Room 333, Portland).

The **Oregon Health Improvement Plan Committee** held meetings on April 9, 2010 in Portland and April 30, 2010 in Pendleton. The Pendleton meeting began the first of five community listening sessions and committee meetings that have a regional focus with invited testimony to hear about local activities and issues that will inform the development of the statewide health improvement plan. The committee heard presentations in April on a community and stakeholder engagement framework, health reform, health status of Oregonians and population health, and a synthesis of effective policy strategies from statewide chronic disease plans. Small groups discussed additional opportunities for health improvement from health system, worksite, family and school, and environmental perspectives and settings. The committee will hold two meetings in May, each with an accompanying listening session the night before the committee meeting: May 14, 2010, 8:30 a.m. to 1:00 p.m. in Medford (Rogue Community College/Southern Oregon University, Higher Education Center, Rooms 127 and 129, 101 South Bartlett, Medford) and May 27, 10:00 a.m. to 2:30 p.m. in Portland (DoubleTree Lloyd Center, 1000 NE Multnomah Street, Portland).

Administrative Simplification

The Administrative Simplification Workgroup has discussed two potential strategies for state-level administrative simplification work. Each envisioned moving toward greater use of uniform electronic methods of conducting business transactions between health care providers and facilities and insurers. One proposed to await adoption of federal uniform operating rules and the other proposed to move more quickly, adapting an approach taken in Minnesota. The workgroup directed staff to flesh out the “move quickly” approach because of its high potential for short-term savings and an assessment indicates that the cost of making any adjustments that may be necessary to comply with future federal operating rules will be low. On Wednesday the group plans to finalize recommendations to the Department of Consumer and Business Services and the Health Policy Board.

All-Payer All-Claims Reporting Program

The All-Payer All Claims reporting program remains on track for an operational program in 2010. The administrative rules became effective March 1, 2010 and require collection of claims for services performed on or after January 1, 2010. OHPR has interviewed both public and private experts on best practices to inform the internal development of the request for proposal that is in the final stages of approval with an anticipated release in May.

Benefits/Cost Sharing

This month the Health Services Commission is finalizing its biennial review of the Prioritized List of Health Services. This list will be considered for funding by the 2011 legislature for implementation during the 2012-13 calendar years. The new list will include the first iteration of a list of value-based services, representing those preventive and chronic disease management services with the highest level of evidence that they are very effective, improve health and have a low cost. The new Prioritized List will also include the first restructuring of the lines representing oral health services in more than ten years, resulting from over a years worth of work of its Dental Services Subcommittee.

The Cost Sharing Workgroup cancelled its scheduled April 15 meeting to give staff additional time to understand the federal health reform plan and its potential implications on benefit design. In May the workgroup will discuss how to approach the development of a baseline benefit package for the Oregon Health Insurance Exchange based on the Prioritized List of Health Services given what is know about the requirements within the federal plan.

Comprehensive Plan

The proposed outline for the OHPB Blueprint for Health Reform is being further developed by OHPR staff in the context of the committee work underway. The Board will receive an update on this work at its June meeting. As the work on the Blueprint's components (including the items listed in this update) is developed over the coming months, staff will work iteratively with the Board to develop draft sections of the Blueprint. Our current timeline has a draft report available for public comment in August of this year.

Exchange/Public Plan

The Health Policy Board will be discussing the impact of federal reform on the exchange, as well as the remaining areas of state flexibility. A technical advisory work group is meeting in May and June to help staff identify the options in these areas of flexibility, as well as the implications of the various options. Also this month a contract is being finalized that will allow a contractor to conduct the background and research on the feasibility of a public plan option, including the resources and plan participation that would be required to develop and sustain a public plan in the state.

Oregon Health Authority
July 2009 - February 2010 Actual Expenditures vs LAB Spending Plan
(Millions)

<u>Program</u>	<u>\$ Variance</u>	<u>% Var</u> <u>GF</u>	<u>\$ Variance</u>	<u>% Var</u> <u>OF & FF</u>	<u>\$ Variance</u>
	<u>General</u> <u>Fund</u>		<u>Other & Federal</u> <u>Funds</u>		<u>Total</u> <u>Funds</u>
Addictions & Mental Health Division	(2.2)	-1.2%	(2.4)	-3.0%	(4.6)
Division of Medical Assistance Programs	(0.4)	-0.1%	(39.5)	-3.1%	(39.8)
Public Health Division	0.2	1.7%	(5.8)	-4.2%	(5.6)
Oregon Medical Insurance Pool	-	-	1.8	1.6%	1.8
<i>Public Employee's Benefit Board**</i>	-	-	(266.1)	-77.1%	(266.1)
Oregon Educators Benefits Board	-	-	7.2	1.6%	7.2
Office of Private Health Partnerships	<u>(0.2)</u>	-3.3%	<u>(5.7)</u>	-33.2%	<u>(5.9)</u>
Total	(2.5)	-0.5%	(310.4)	-13.0%	(312.9)
Negative numbers reflect underspent projections					

** This report reflects actual expenditures to date. With the switch to self insurance in January 2010, there is a lag in these expenditures at the beginning of the program, but expenditures will come into alignment with the budget later in the year.

Oregon Health Authority
Total 2009-11 Legislatively Approved Budget
(Millions)

<u>Program</u>	<u>General</u> <u>Fund</u>	<u>Other & Federal</u> <u>Funds</u>	<u>Total</u> <u>Funds</u>
Addictions & Mental Health Division	622.9	316.7	939.6
Division of Medical Assistance Programs	873.8	5,223.8	6,097.6
Public Health Division	48.9	474.9	523.8
Public Employee's Benefit Board	-	1,035.9	1,035.9
Oregon Educators Benefits Board	-	1,344.8	1,344.8
Oregon Medical Insurance Pool	-	409.0	409.0
Office of Private Health Partnerships	<u>21.3</u>	<u>123.0</u>	<u>144.3</u>
Total	1,566.9	8,928.1	10,495.0



THEODORE R. KULONGOSKI
GOVERNOR

May 5, 2010

The Honorable Kathleen Sebelius, Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

I am writing in response to your letter of April 2, 2010 to inform you that the State of Oregon is interested in participating in the temporary federal high risk pool program. Oregon looks forward to partnering with CMS in implementing this first phase of national health care reform. We propose using the Oregon Medical Insurance Pool (OMIP) to implement the federal high risk pool if federal requirements for implementation and operation can be mutually agreed upon.

OMIP has an extended track record of successfully administering coverage for chronically ill, high risk individuals since 1990. We do this under a Third Party Administrator contract with Regence BlueCross BlueShield of Oregon, which has had years of experience with the pool since its inception. OMIP has had the consistent support of the insurance industry, which currently contributes funds through a semi-annual assessment to cover half of the pool's costs. The remainder of the cost is covered by enrollee premiums. The State of Oregon and federal governments have not contributed any funds to support the ongoing operation of the OMIP.

Oregon has been a partner with CMS in establishing innovative programs to provide health care coverage for uninsured individuals, through waiver programs, state plan designs and creative use of OMIP. When the federal government expanded requirements for portability coverage, Oregon responded with a comprehensive alternative mechanism that designated OMIP as the portability option for individuals who lost group insurance and exhausted COBRA coverage, but did not have a commercial portability available to them. In addition, when the Health Coverage Tax Credit program (HCTC) was established for individuals who lost their jobs to foreign competition or who lost their pensions due to company bankruptcy, Oregon designated OMIP as the state's qualified health plan for these individuals to take advantage of available federal premium subsidies.

In a state-federal partnership to implement the federal high risk pool, we request consideration of the following:

1. We are concerned that there may be an expectation under the Maintenance of Effort (MOE) requirement that Oregon will maintain the 2009 expenditure levels in its current state high risk pool. We expect that OMIP will lose enrollment over the next years partly due to the fact that individuals without prior coverage who otherwise would be eligible for OMIP will enroll in the federal high risk pool.

OMIP enrollment will also be impacted by our new Healthy Kids program that provides coverage and subsidies for children in either the CHIP program or through special contracts with commercial insurers. This initiative has been a high priority of my administration. It is a program that provides guaranteed issue health insurance coverage with no pre-existing condition limitations for all children in the State. I am pleased to see that the federal health reform bill includes a requirement that all commercial carriers must provide guaranteed issue coverage for children and exclude the use of pre-existing condition limitations. These federal requirements in combination with Oregon's Healthy Kids program should eliminate the need of any child in Oregon to obtain coverage from either OMIP or the federal high risk pool.

2. We seek an assurance that Oregon will have no liability to cover any costs related to the federal high risk pool in the event the federal allocation is exhausted. We expect that the federal government will bear the cost of any claims costs that exceed enrollee premiums. Consequently, we anticipate working with the Division of High Risk Pool Programs to develop policies and procedures to monitor and control the enrollment in and projected costs of Oregon's federal high risk pool. We seek assurance that Oregon's federal allocation will be sufficient to cover all costs.

We would appreciate the flexibility to implement the federal high risk pool under the following principles that will benefit Oregonians eligible for coverage:

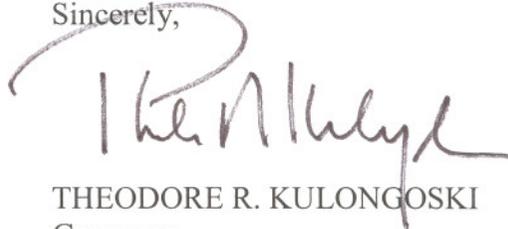
- Offer a single application for both OMIP and the federal high risk pool to avoid confusion, expedite eligibility determination and promote timely enrollment.
- Administer the federal high risk pool using the current Third Party Administrator arrangement with Regence BlueCross BlueShield of Oregon to minimize any start-up training or administrative costs and take advantage of current infrastructure efficiencies to process applications, provide customer service, pay claims, and implement disease and care management programs relevant to the population.

The Honorable Kathleen Sebelius
May 5, 2010
Page Three

- Establish comprehensive benefit plan designs as consistent as possible with the current OMIP benefit designs to minimize confusion for enrollees and assure consistency in administration.
- Allow coordination by the OMIP Board of Directors, which is a nine-member board that includes four insurance industry executives, a physician, two public representatives, the Oregon Insurance Commissioner and the Director of the Oregon Health Authority. This coordination will assure consistency in the implementation of policy issues that apply to both pools and a comprehensive perspective on the operation of the federal high risk pool.

The State of Oregon sincerely appreciates the opportunity to partner again with CMS by expanding coverage to uninsured Oregonians through the federal high risk pool. If the above issues can be worked out, Oregon would be interested in participating in the temporary federal high risk pool program.

Sincerely,



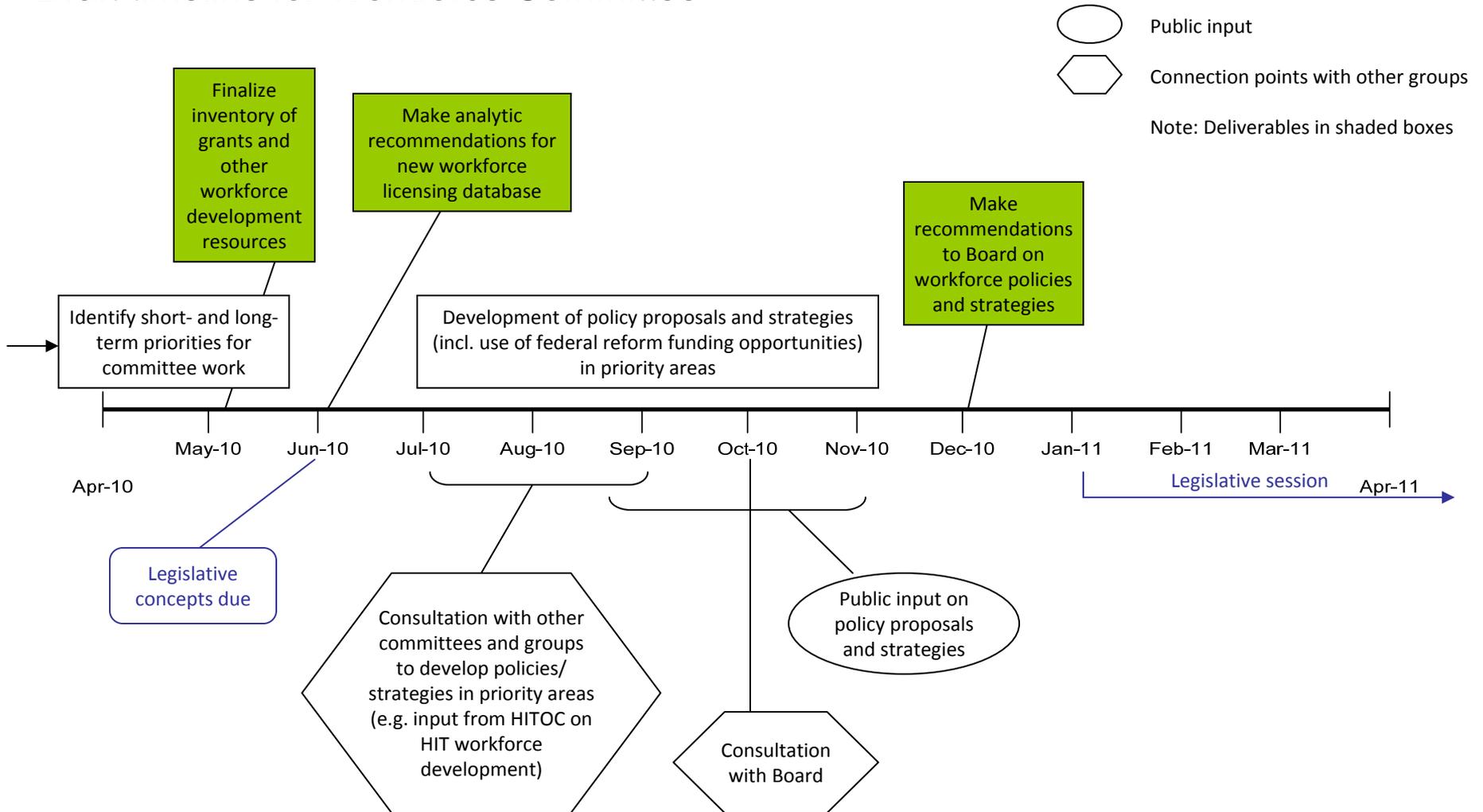
THEODORE R. KULONGOSKI
Governor

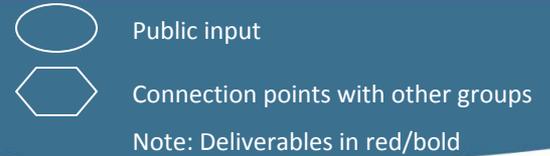
TRK:tn:tj:ab
Oregon Congressional Delegation
Dan DeSimone, Oregon Federal Affairs Director

OHPB Committees, OHA Councils and Advisory Group Interaction Timelines

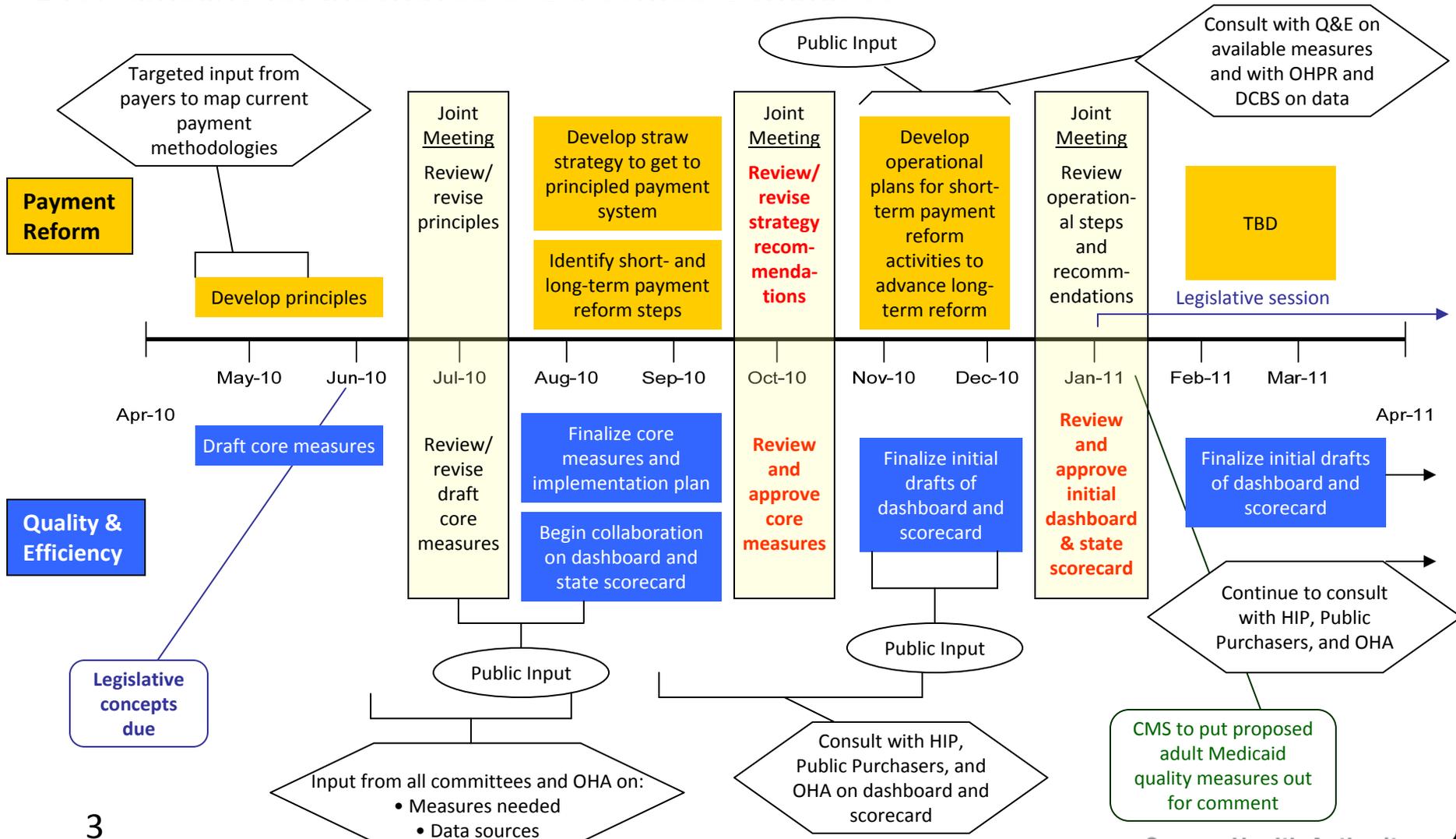
Working Draft – May 2010

Draft timeline for Workforce Committee



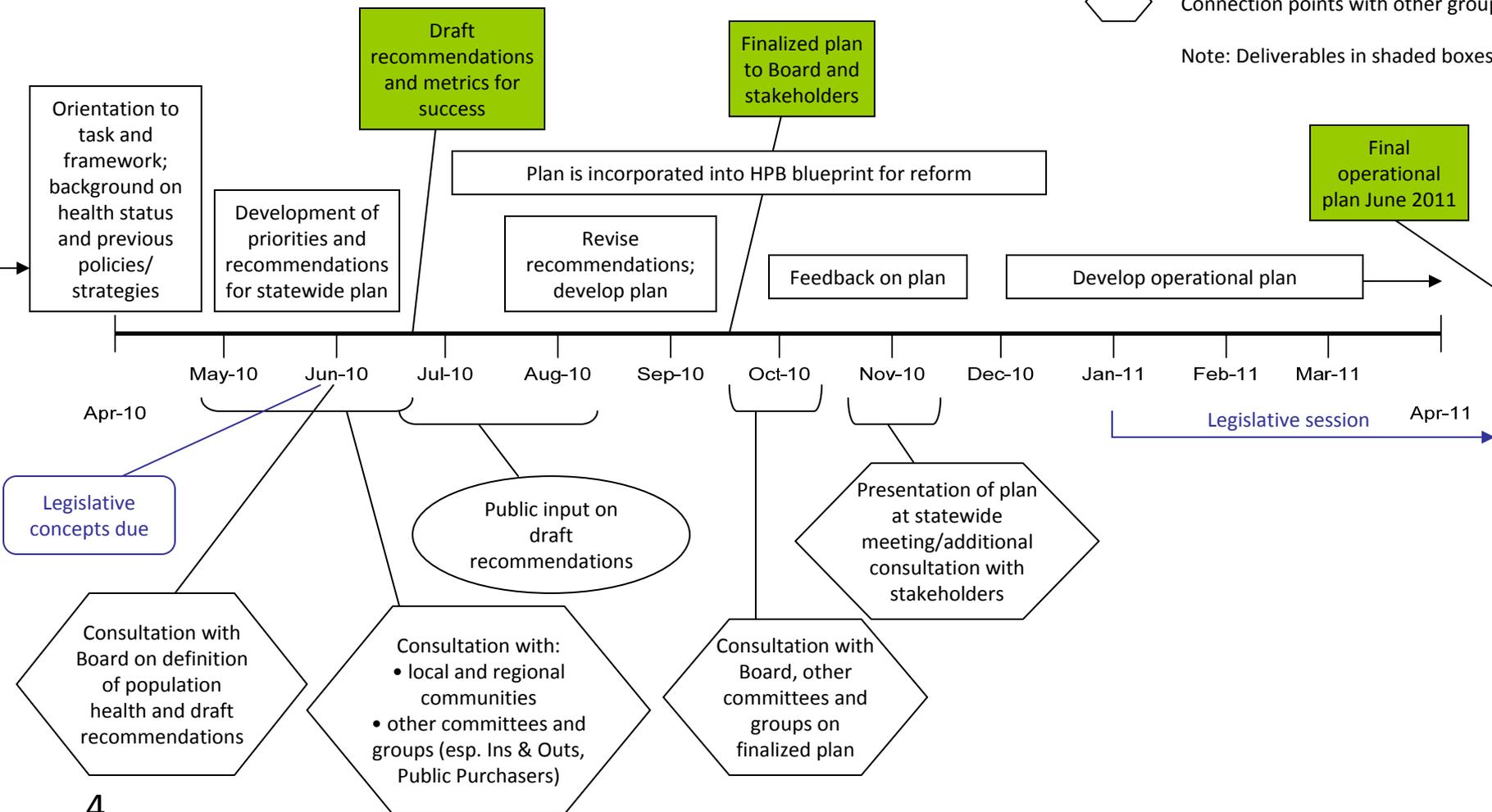


Draft timeline for Incentives & Outcomes Committee

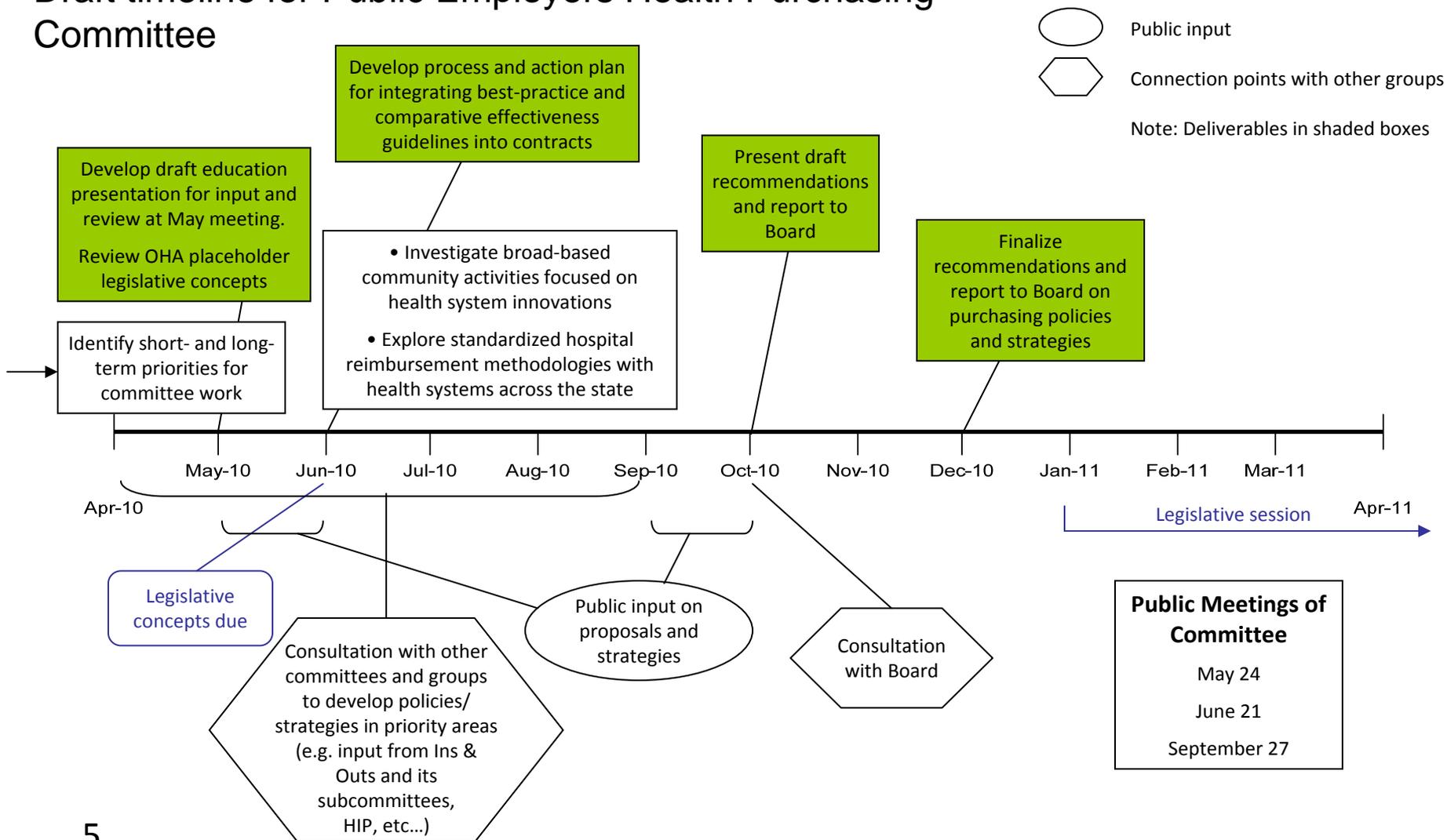


Draft timeline for Health Improvement Plan Committee

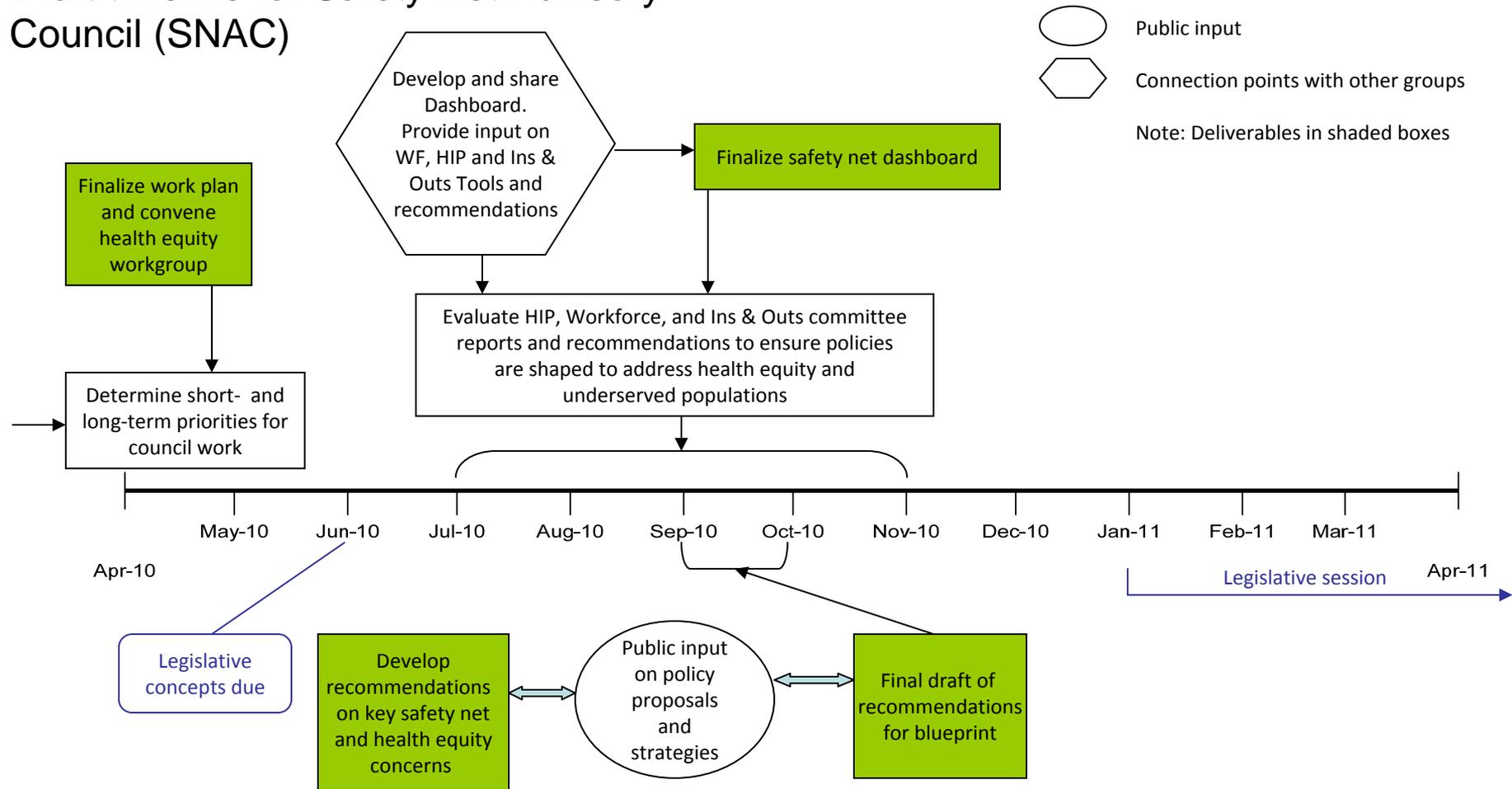
○ Public input
 ⬡ Connection points with other groups
 Note: Deliverables in shaded boxes



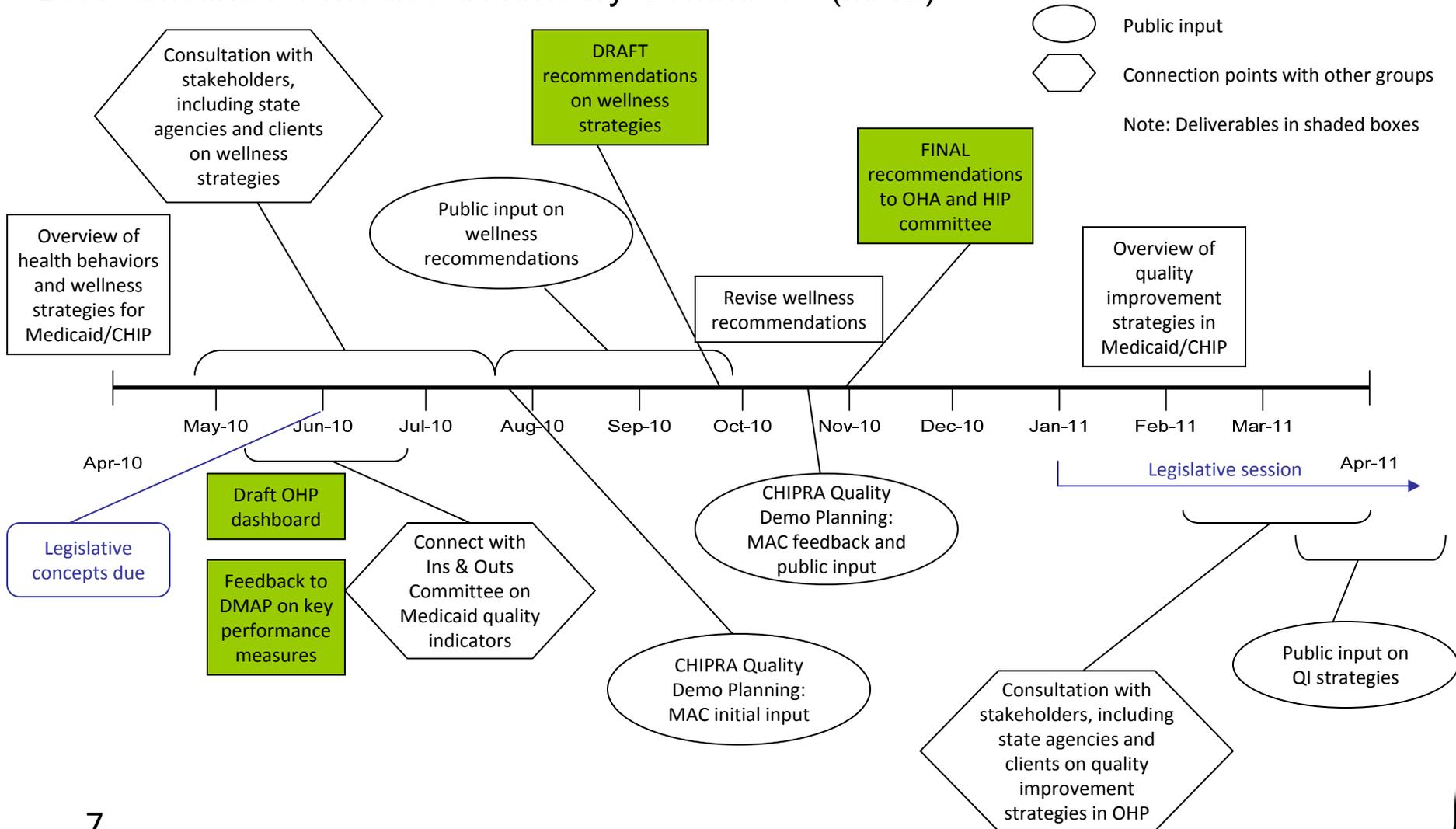
Draft timeline for Public Employers Health Purchasing Committee



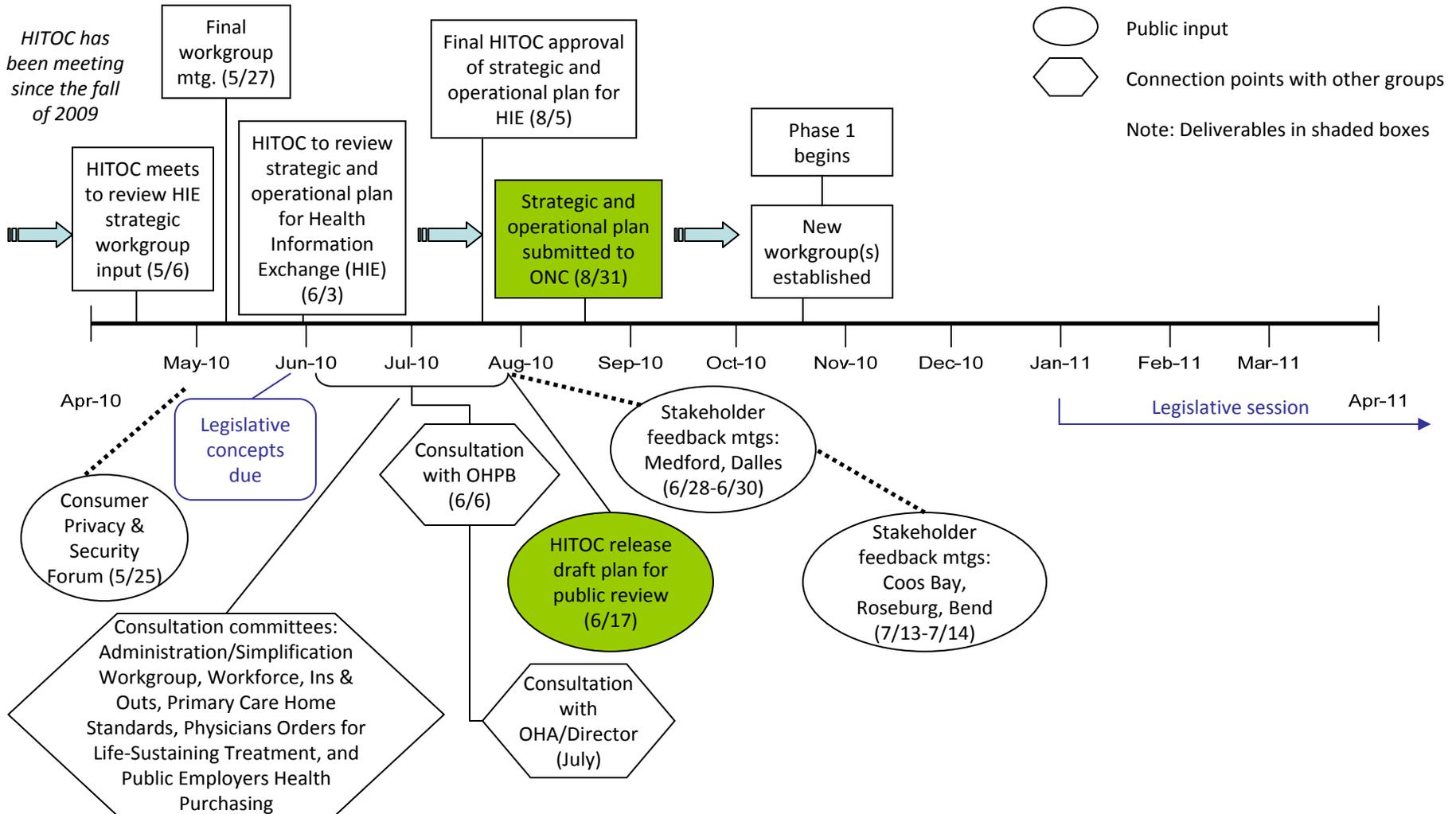
Draft timeline for Safety Net Advisory Council (SNAC)



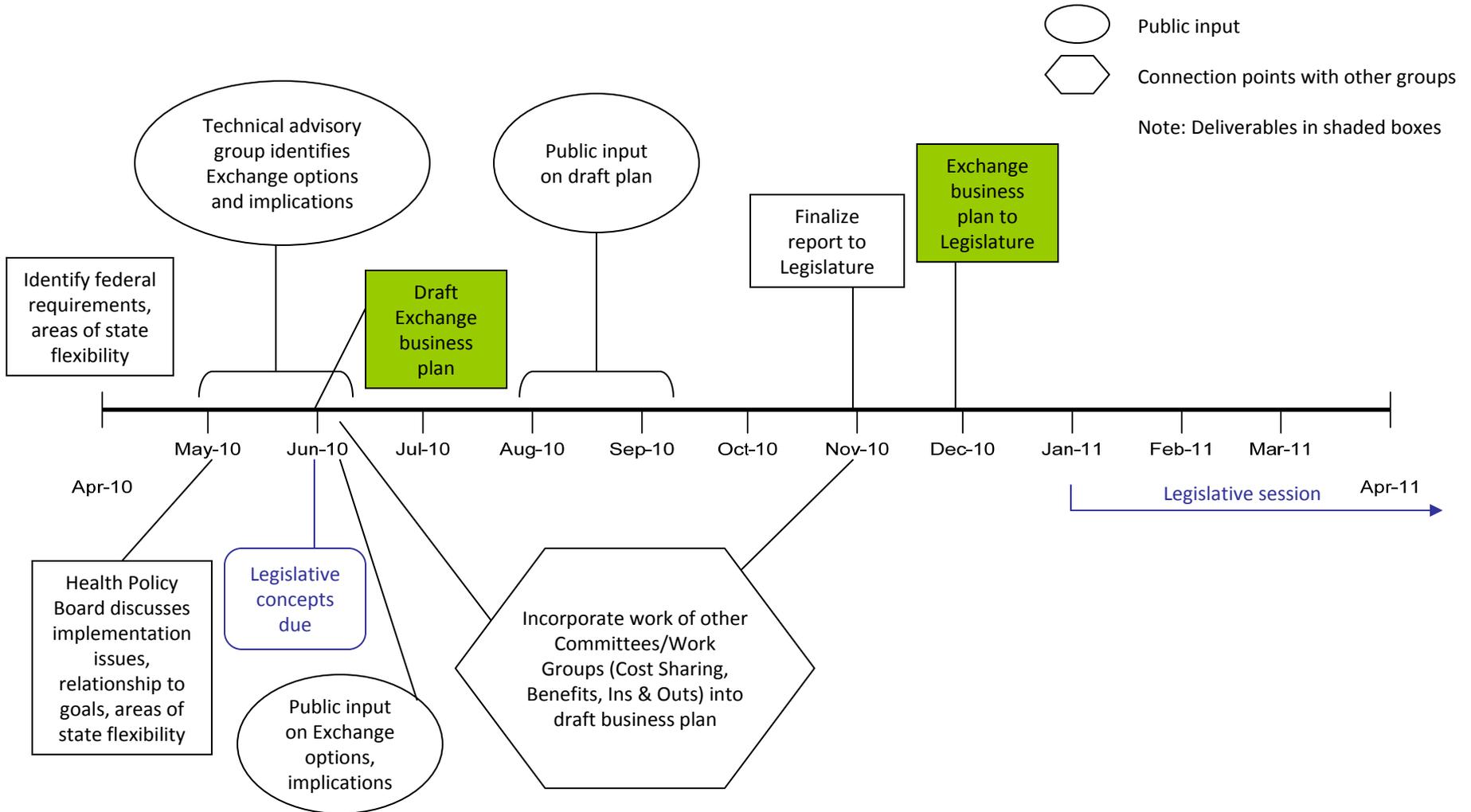
Draft timeline for Medicaid Advisory Committee (MAC)



Draft timeline for Health Information Technology Oversight Council (HITOC)



Draft timeline for Exchange Business Plan



Development of a Health Insurance Exchange in Oregon

- Oregon's goals
- Federal Guidance and Requirements
- State Flexibility

Nora Leibowitz, Oregon Health Policy & Research

Barney Speight, Oregon Health Authority

What is a Health Insurance Exchange?

- Exchanges are “shopping centers” where individuals and small businesses purchase health insurance coverage.
- Beginning in 2014, each state will have an exchange to help consumers compare and choose between plans that meet benchmarks for quality and affordability.
- Exchanges will also administer the new federal health insurance tax credits and make it easier to enroll in health insurance.

What are the Benefits of an Exchange?

- Access to tax credits and cost sharing assistance
- Ability to compare insurance products quickly and easily
- Minimum benefit standard and cost sharing limits ensure minimum standard for insurance purchased through exchange
- Information accessible in a variety of formats (phone, web site, with Agent help)

Who will use Exchanges?

Starting 2014:

- Individuals
- Small employer groups with <100 employees
- Individuals and small groups can still buy insurance outside of Exchange
- To access tax credits and assistance with cost-sharing expenses (deductibles and co-payments) people will purchase insurance through the exchange
 - Federal premium tax credits and cost-sharing reductions are available for people with income up to 400% of the federal poverty level (\$88,200 for a family of 4)
 - Federal assistance will reduce out-of-pocket expenses for many people

Goals for Oregon's Exchange

The goals identified by the Health Policy Board:

- Cost containment
- Changing the way services are provided/paid for
- Simplify (access, regulation, plan rules)
- Increased access to care

Federal Law Lays Out Many Exchange Functions

- Provide Consumer Information
- Certify Health Plan to Participate
- Grade Health Plan
- Offer Meaningful Coverage Choices
- Provide Customer Assistance
- Facilitate Community-based Assistance
- Administer Exemptions
- Provide Information to the Federal Government

Goals and Federal Requirements

Provide Information to Consumers (Individuals, groups)	
Public program eligibility information	<ul style="list-style-type: none"> • Simplify • Increase access
Provide electronic calculator to determine cost of coverage with premium tax credit/cost sharing reduction	<ul style="list-style-type: none"> • Simplify
Publish exchange's administrative costs	<ul style="list-style-type: none"> • Contain costs
Provide plan enrollment information to employers	<ul style="list-style-type: none"> • Simplify
Maintain website with standardized comparative plan information	<ul style="list-style-type: none"> • Simplify

Certify Health Plans to Participate & Grade Health Plan Performance

<p>Implement procedures for certification, recertification, decertification (consistent with HHS guidelines)</p>	<ul style="list-style-type: none"> • Simplify
<p>Use a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage</p>	<ul style="list-style-type: none"> • Simplify
<p>Maintain a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information</p>	<ul style="list-style-type: none"> • Simplify
<p>HHS Secretary will develop guidelines for states to use in certifying and grading health plans.</p>	

Offer Coverage Choices, Provide Customer Assistance

<p>Make qualified health plans available to eligible individuals and employers</p>	<ul style="list-style-type: none"> • Increase Access • Simplify
<p>Operate a toll-free telephone hotline to respond to requests for assistance</p>	<ul style="list-style-type: none"> • Increase Access • Simplify
<p>Operate a web site that allows consumers to compare plan options and costs</p>	<ul style="list-style-type: none"> • Increase Access • Simplify

Administer Exemptions, Provide Information to Federal Government

<p>Grant exemption from individual responsibility penalty when:</p> <ul style="list-style-type: none"> (1) no affordable qualified health plan is available through exchange; or (2) the individual meets requirements for another exemption from the requirement or penalty 	<ul style="list-style-type: none"> • Simplify
<p>Give the Secretary of the Treasury the name/tax ID of:</p> <ul style="list-style-type: none"> (1) Each person issued an exemption certificate; (2) Employee deemed eligible for premium tax credit (no employer coverage/coverage not affordable); or (3) Person who tells the exchange they changed employers and stopped coverage during a plan year 	<ul style="list-style-type: none"> • Simplify

Areas of State Flexibility

- Should Oregon's Exchange be operated by the state or a non-profit entity?
- Should Oregon run separate individual and small group market (SHOP) exchanges or have a single Exchange for both markets?
- What should the Exchange's oversight look like?
- Should there be additional state-funded assistance in the Exchange to help lower costs to Oregonians?
- Should Oregon explore working with other states on a regional (multi-state) Exchange?

Technical Assistance Work Group

- Will help staff identify options, understand implications
- Participation by individuals with experience with exchange development and broad range of perspectives
- Meeting 4-6 times in May and June
- Identifying issues and options, not making recommendations

Time Line

- May 2010: Health Policy Board meeting to discuss areas of state flexibility
Technical Advisory work group identifies options, implications
- June-July Stakeholder input
- August Deliver TA group's info to Board for discussion, decision making
- September Draft report to Legislature
- October Additional stakeholder input, report editing
- November Finalize report
- December Deliver Exchange business plan report to Legislature

Exchange Technical Advisory Work Group

Andy Anderson

Senior Vice President and CFO
Cascade Corporation

Anthony Behrens

Senior Policy Analyst
Insurance Division
Oregon Department of Business and Consumer Services

Barbara Christensen

Chief Sales and Marketing Officer
Providence Health Plans

Aelea Christofferson

Owner
ATL Communications, Inc

Mark Danburg-Wyld

Senior Actuarial Analyst
PacificSource Health Plans

Laura Etherton

Advocate
Oregon State Public Interest Research Group

Rocky King

Senior Policy Advisor for Health Reform
Oregon Department of Consumer and Business Services

Patrick O'Keefe

Partner/Account Manager
Cascade Insurance Center

Anna Roberts

Organizer
SEIU Local 49

Barney Speight

Director of Healthcare Purchasing
Oregon Health Authority

Nita Werner

President and CFO
Ornelas Enterprises, Inc.
Oregon Health Policy Board member

May 11th Discussion Guide:

Integrating federal health reform into Oregon's reform efforts: developing decision principles

Expected outcome: A set of principles that provide a lens for which state policy and resource decisions related to federal reform can be made. Staff will evaluate recommendations against these principles.

Three questions:

- a. Do we know enough now to make decisions/recommendations?
- b. What do we need to know in order to make them?
- c. Through what lens should staff evaluate the issues? How would we like staff to evaluate the pros and cons?

Key issues identified at April 13th meeting:

- I. **Timing?** Should we go early with federal reforms? Do we continue with initiatives that will be superseded by federal legislation?
 - a. Should Oregon explore setting up an Exchange sooner than 2014?
 - b. Should Oregon implement standards for electronic transactions when federal standards starting in 2013 will supersede them?
 - c. Should OHA/DCBS continue to work on a small business plan that will be superseded by products offered within the Exchange?
 - d. Should OHA expand Medicaid and/or subsidy assistance programs prior to 2014?

- II. **Should we do more?**
 - a. Should Oregon have a public plan to sell inside and/or outside the Exchange?
 - b. Should there be additional state-funded assistance in the Exchange to help lower costs to Oregonians?
 - c. Should Oregon require additional benefits within their benefit structures knowing that it must pay for benefits beyond the federal requirements?

- III. **How do ensure strategic alignment with our goals when there is federal flexibility?**
 - a. Should Oregon explore working with other states on a regional (multi-state) exchange?
 - b. Should Oregon's Exchange be operated by the state or contracted to a non-profit entity?

- IV. **How do we ensure strategic alignment of funding and pilot opportunities presented by federal reform?**



High Risk Pools (HRP) 2010

OMIP
Oregon Medical Insurance Pool

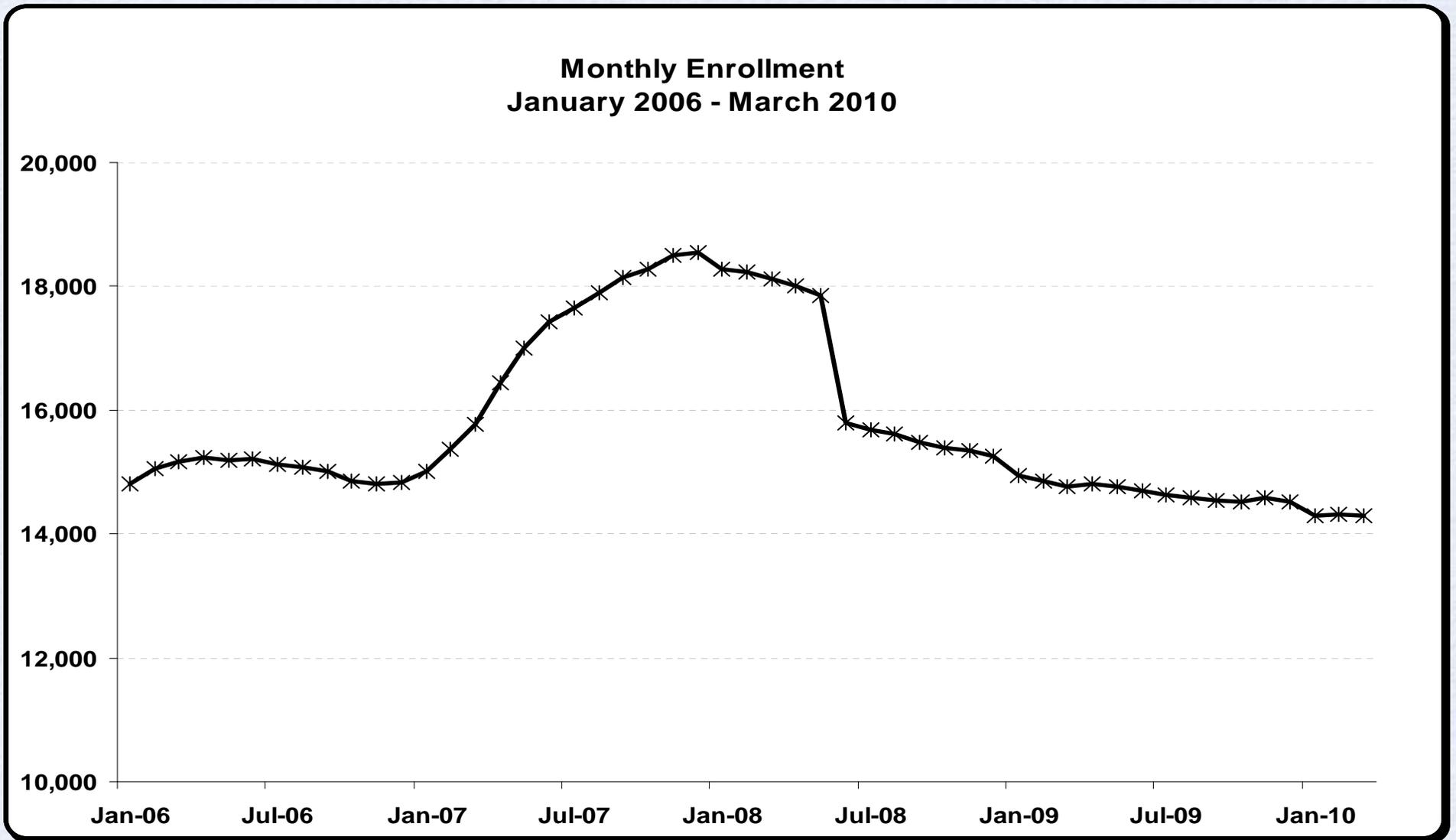
Agenda

- Background
 - Oregon Medical Insurance Pool (OMIP)
 - Federal High Risk Pool (FHRP)
- Eligibility
- Administration
- Funding & Rates
- Benefit Plans & Pre-existing Conditions
- Timeline

OMIP Background

- Enacted in 1987 by Oregon Legislature
- First policy issued in July 1990
- Enrollment as of March 2010
 - ▶ 14,227 people insured
 - ⊙ 85% medical eligibles
 - ⊙ 15% portability eligibles
- Over 60,000 people served since inception

OMIP Enrollment



FHRP Background

- Enacted in 2010 by Federal Government
- Targeted to Start in July 2010
- Ends on January 1, 2014
 - Projecting 4,000 peak enrollment
 - ⊙ 100% medical eligibles
- Projecting 6,700 people served

FHRP Background

- Secretary of Health & Human Services (HHS) will contract with state or alternative source
- 32 states expressed interest; 19 opted out
- Governor sent letter of intent on April 30, 2010
 - ▶ Administer FHRP through OMIP
 - ◉ Authority established in 2010 special session (HB 3659A)
 - ▶ Assurance of no state financial liability
 - ▶ Agreement that OMIP will not be required to maintain expenditure levels realized in 2009 (MOE)

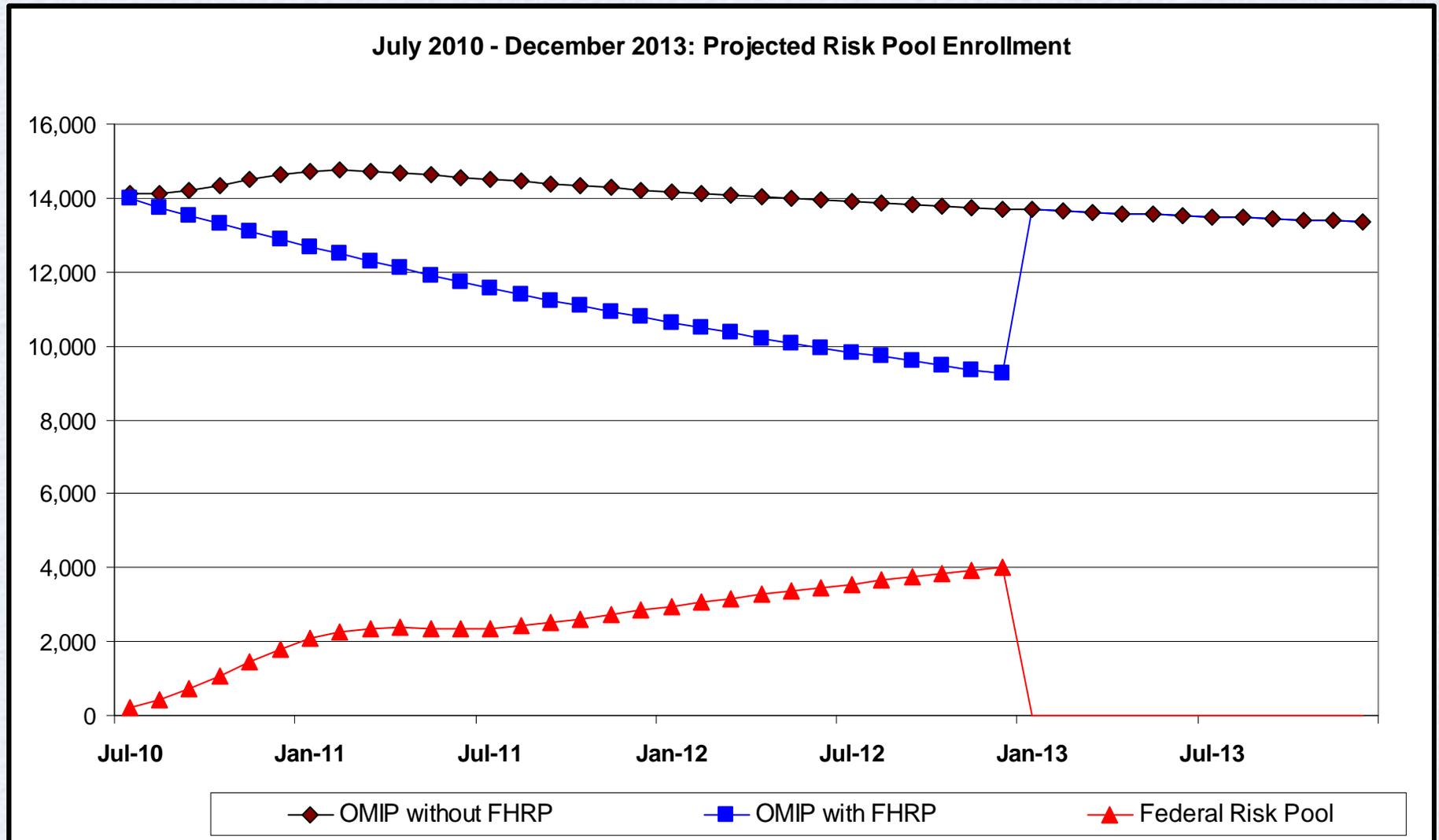
OMIP Eligibility

- **Medical**
 - ▶ Individuals denied individual insurance due to pre-existing medical conditions
 - ▶ Medical condition checklist
- **Portability**
 - ▶ Individuals who exhaust COBRA benefits and/or have no portability options
- **Federal Health Coverage Tax Credit (HCTC)**

FHRP Eligibility

- Medical
 - ▶ Individual with a pre-existing medical condition
 - ▶ Uninsured for six months
 - ▶ US citizen or lawfully present
- Potentially, more than 50 percent of enrollees that would normally enroll with OMIP will be eligible for FHRP

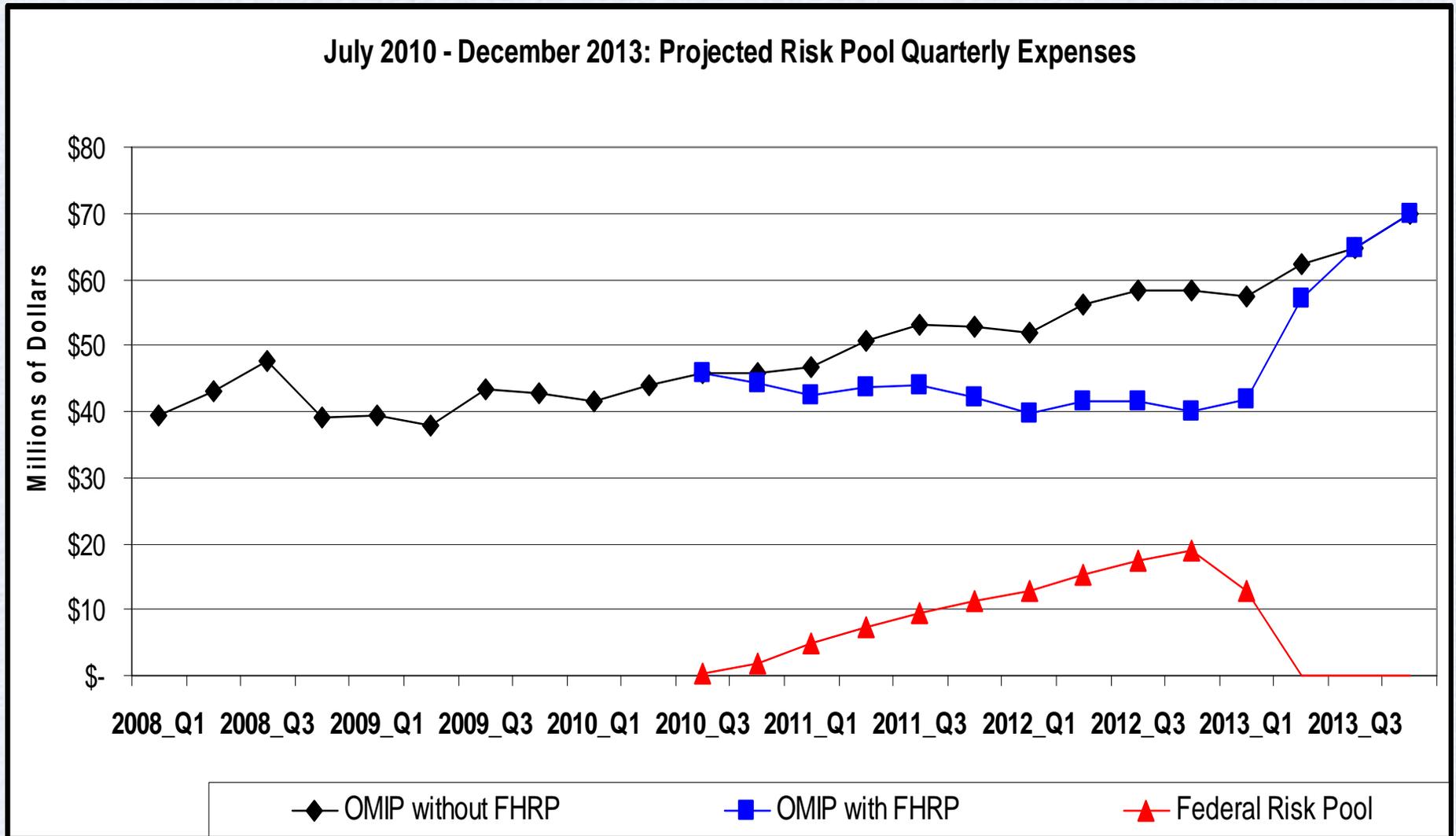
Impact: Enrollment



Administration

- The addition of the FHRP:
 - ▶ Not expected to increase overall enrollment of high risk Oregonians
 - ▶ Will create new federal funding source for new enrollment of high risk Oregonians
 - ▶ Will reduce OMIP operating cost
- OMIP contracts with Regence BlueCross BlueShield of Oregon to administer
 - ▶ Eligibility, enrollment, benefits, claims, case/disease management, provider panel, and customer service

Impact: Operating Cost



OMIP Funding

- Sources
(no state/federal funds)
 - ▶ Member Premiums
 - ⊙ Currently 50 percent
 - ▶ Insurance company assessments
 - ⊙ Currently 50 percent



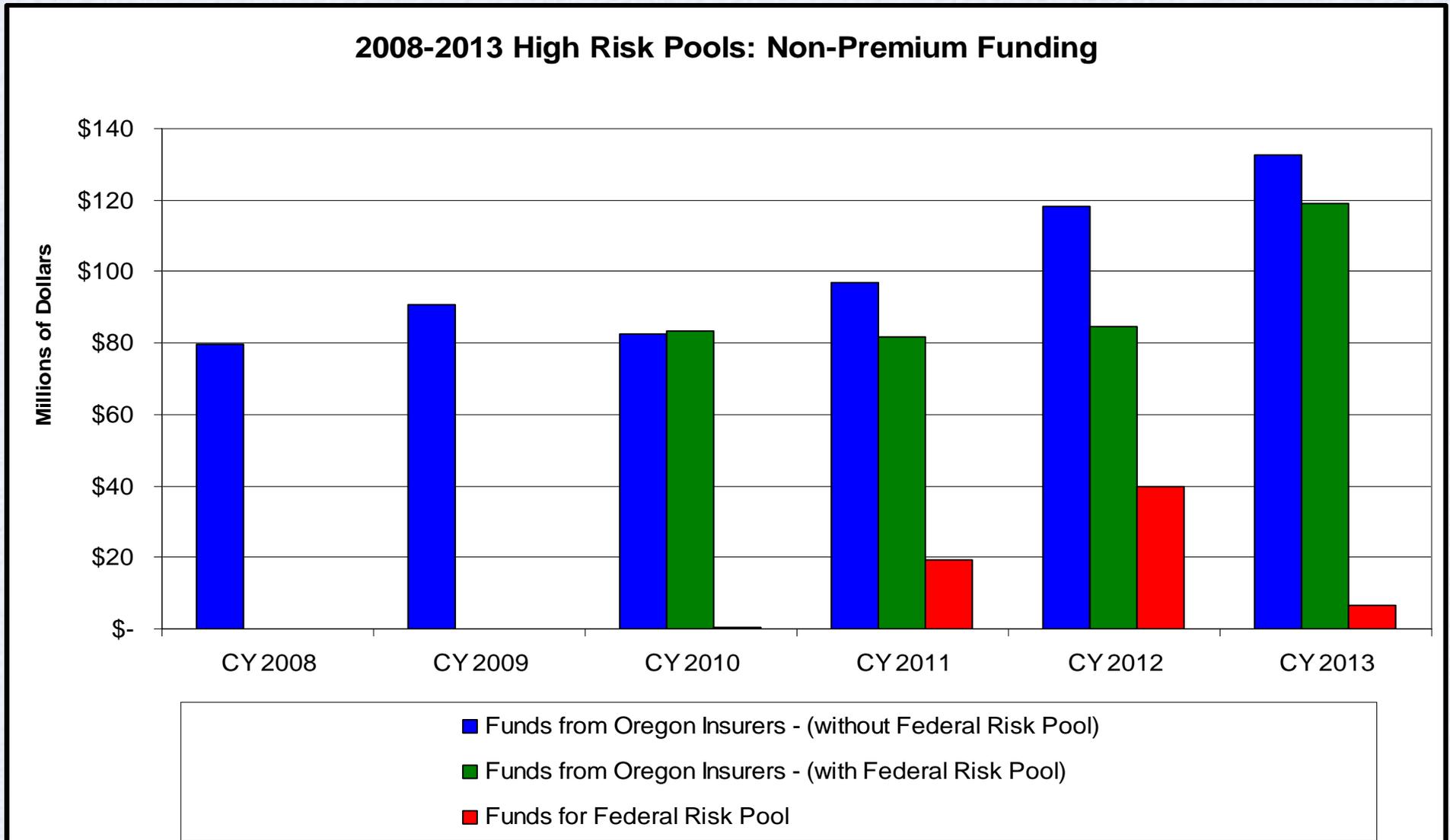
FHRP Funding

- Sources

- ▶ Member Premiums
- ▶ Federal Funding
 - ⦿ Estimated \$66 million for Oregon



Impact: Non-premium funding



OMIP Premium Rates

- Medical eligibles - can be as much as 25 percent higher than individual market rates
- Portability eligibles - same as portability market rates



FHRP Premium Rates

- Equal to average market rate for comparable benefit plan
- Subject to final program requirements prescribed by HHS



OMIP Plans

- Four PPO benefit plans
 - ▶ Plan 500: 20/40 PPO \$1,000 out-of-pocket max
 - ▶ Plan 750: 20/40 PPO \$3,000 out-of-pocket max
 - ▶ Plan 1000: 20/40 PPO \$4,000 out-of-pocket max
 - ▶ Plan 1500: 30/50 PPO \$6,000 out-of-pocket max
- Proposing same plans for FHRP
 - ▶ Subject to HHS approval and contracting

Pre-existing Conditions

- A medical condition that care or treatment was recommended or received during 6-month period before insurance contract enrollment date, including
 - ▶ Medical advice and/or
 - ▶ Diagnosis
- Includes pregnancy

Pre-existing Conditions

- FHRP not subject to six month pre-existing condition waiting period
- OMIP Portability not subject to six month pre-existing condition waiting period
- OMIP Medical is subject to six month pre-existing condition waiting period
 - ▶ Creditable coverage may reduce the pre-existing condition waiting period

Expected Timeline

- Next steps

1. HHS delivers contract application and program requirements second week of May 2010
2. Completed application due by end of May 2010
3. HHS approval by end of June 2010
4. Program operational by July 2010

Questions?

For more information
about OMIP or updated
information about
FHRP please view
our Web site at:

www.omip.state.or.us





THANK You!

Oregon Medical Insurance Pool (OMIP) Federal High Risk Pool (FHRP) Comparison Chart

Provision	OMIP	FHRP
Funding	<ul style="list-style-type: none"> • Premium & Carrier Assessment 	<ul style="list-style-type: none"> • Premium & Federal Funds - HHS estimates \$66 million for Oregon
Medical Eligibility	<ul style="list-style-type: none"> • Pre-existing Condition - Condition list or coverage denial • Oregon Resident 	<ul style="list-style-type: none"> • Pre-existing Condition - Condition list or coverage denial • Oregon Resident • U.S. Citizen or Lawfully Present • Uninsured for six months
Benefit Plan	<ul style="list-style-type: none"> • Four PPO Plans – \$500, 750, 1000, 1500 deductibles • Six month pre-existing condition exclusion • As much as 25 percent higher than individual market rates (currently 17 percent) 	<ul style="list-style-type: none"> • Four PPO Plans – \$500, 750, 1000, 1500 deductibles (with HHS approval) • No pre-existing condition exclusion • Equal to average market rate for comparable plan
Premium Rate	<ul style="list-style-type: none"> • Generally 3 to 1 	<ul style="list-style-type: none"> • Not greater than 4 to 1
Age Band		

Note: The purpose of the federal high-risk pool is to provide health insurance for Americans who are uninsured and have a pre-existing medical condition. This program will provide insurance coverage for people with pre-existing conditions until 2014, when private insurance companies can no longer deny a person coverage based on his/her medical history or health conditions.

The Secretary of Health & Human Services (HHS) will contract with individual states for the administration of the federal pool. If a state opts out, the federal government will make the pool available through alternative sources. Currently, thirty-two states have expressed an interest in operating the federal pool, and nineteen states have opted to have the federal government operate their pool.

On April 30, Governor Ted Kulongoski sent a letter to the Secretary of HHS indicating Oregon's interest in administering the federal funded high risk pool through the existing Oregon Medical Insurance Pool (OMIP). There are two prominent issues that may have an impact on whether Oregon contracts with the federal government. First, we seek assurance that Oregon will have no financial liability to cover any costs related to the federal high risk pool in the event the federal allocation is exhausted. Second, we need agreement that OMIP will not be required to maintain the same expenditure level it realized in 2009. If Oregon chooses not to enter into a contract with HHS, the federal government will make the pool available to Oregon residents through another source.

Federal -Funded High- Risk Pool Questions & Answers

What is the new federal funded high risk insurance pool?

The purpose of the federal high-risk pool is to provide health insurance for Americans who are uninsured and have a pre-existing condition. This program will provide insurance coverage for people with pre-existing conditions until 2014, when private insurance companies can no longer deny a person coverage based on his/her medical history or health conditions.

The Secretary of Health & Human Services (HHS) will contract with individual states for the administration of the federal pool. If a state opts out, the federal government will make the pool available through alternative sources. Currently, thirty two states have expressed an interest in operating the federal pool, and nineteen states have opted to have the federal government operate their pool.

On April 30, Governor Ted Kulongoski sent a letter to the Secretary of HHS indicating Oregon's interest in administering the federal funded high risk pool through the existing Oregon Medical Insurance Pool (OMIP). There are two prominent issues that may have an impact on whether Oregon contracts with the federal government. First, we seek assurance that Oregon will have no liability to cover any costs related to the federal high risk pool in the event the federal allocation is exhausted. Second, we need agreement that OMIP will not be required to maintain the same expenditure level it realized in 2009. If Oregon chooses not to enter into a contract with HHS, the federal government will make the pool available to Oregon residents through another source.

When will the states have more details about the federal funded pool?

The following is a tentative timeline outlined by HHS:

- During the first week of May, HHS plans to issue a formal solicitation for state high risk pool proposals. States that have indicated interest will receive a contract application packet.
- The due date for state proposals will be sometime at the end of May 2010.
- During the first week of June 2010, HHS plans to issue an interim final regulation for the high risk pool program.
- By the end of June 2010, the Center for Medicare and Medicaid Services (CMS) and the state will make a decision on whether to proceed with contracting for the high- risk pool program.
- Funding for the high-risk pool contracts is scheduled to be available by July 2010.

When does the program start?

The new federal-funded pool is expected to begin accepting applications on July 1, 2010 and will be administered by the Oregon Medical Insurance Pool (OMIP) board (subject to negotiation and contracting with the U.S. Department of Health & Human Services (HHS)).

Who is eligible for this pool?

An Oregon resident who is also a U.S. citizen (or lawfully present in the United States) with a pre-existing health condition. The U.S. Secretary of Health & Human Services will be defining "pre-existing condition" in the coming weeks. The individual must have been uninsured for at least six months at the time of application.

How is funding for the federal pool different than the current OMIP?

The biggest difference is that the current OMIP program is funded by a combination of member premiums and an assessment on health insurance companies while the new federal-funded pool will be funded by a combination of member premiums and funds from the federal government. The intent of the OMIP board is to structure the federal pool to be nearly identical to OMIP. A seamless and transparent structure will simplify the application process, aid in communicating the benefit plan details, and make better use of program funds. For example, we expect to have one application for both programs.

What will the health insurance coverage look like?

The intent is to offer the existing four OMIP plans. However, there will be no six month waiting period for pre-existing conditions for those eligible for the federal pool coverage.

How much will the new plans cost?

The premiums will be equal to the average premiums in the private market for comparable plans. This amount will not be known until the HHS Secretary provides final clarifications on benefit design.

How long will this federal pool coverage last?

January 1, 2014. At that time, private insurance companies will not be able to deny coverage for a pre-existing condition, and both the federal funded pool and OMIP will not be needed. However, we may be required to cap enrollment if the federal funds allocated to Oregon are insufficient to allow unlimited enrollment.

Will currently enrolled participants in OMIP see a reduction in their premium costs with new federal healthcare dollars?

We do not know at this point. Although we are only in the beginning stages of working with the federal government in structuring the federal-funded high-risk pool, it is our current understanding that the \$5 billion appropriated for this program is to be used only to pay a portion of the claims and administration costs of the new pool. However, the existence of the new federal-funded pool may have the affect of shifting future cost (new medical eligible enrollment) from the current OMIP pool to the federal-funded pool and therefore may reduce the cost of running the existing OMIP pool over time.

Will current OMIP enrollees be able to join the federal funded pool?

Current OMIP enrollees would not be eligible for the new federal funded pool due to the eligibility requirement that the individual be uninsured for at least six months prior to application.

Please visit the OMIP website at: <http://www.omip.state.or.us/> for continuing updates to this information.

MEMORANDUM

To: Oregon Health Policy Board

From: Office for Oregon Health Policy & Research

Re: Potential Impacts of Federal Reform on OHPB Committees and Councils

The enacted federal reform legislation (H.R. 3590) includes provisions that provide coverage to 32 million uninsured people, adopt reforms in insurance industry practices, and make major investments in public health and health delivery systems.

The attached documents provide an overview of the major provisions under federal reform which will impact the work of the committees and councils of the Oregon Health Policy Board and the Oregon Health Authority.

This analysis is ongoing as further guidance will be provided by federal agencies. We will provide updated documents as new information is known.

Key Elements for the Workforce Committee

Where Does Federal Reform Get Us?

- **Prioritizes the primary care workforce:**
 - Primary care payment bonuses in Medicare (starting 2011) and Medicaid (2013-14).
 - Increased loan amounts, better repayment terms, and tax exclusions under the National Health Service Corps.
 - Primary care extension program to support local primary care physicians.
 - Unused residency slots redistributed with priority to primary care.

- Takes some steps towards **interdisciplinary education and training providers** for new models of care delivery, e.g.:
 - Gives preference to primary care training programs that “propose innovate approaches using models of primary care such as the patient-centered medical home, team management of chronic disease, and inter-professional integrated models of healthcare” for grant awards.
 - Includes training in “team-based service” in the new Public Health Sciences track.
 - Authorizes physician assistants working in collaboration with physicians to order post-hospital extended care services under Medicare, effective Jan 2011.

The bill also creates opportunities for state- and local-level experimentation with new models of care delivery, such as medical homes, community care teams, or accountable care organizations.

- Takes some steps towards **reducing the debt burden** for health professions students and faculty, e.g.:
 - New loan repayment programs for public health professionals, pediatric subspecialists, allied health professionals, dentistry.
 - Increased loan amounts for nursing students and faculty.
 - Increased faculty loans and student scholarships for minorities.
 - Tuition remission and stipend in return for service in Public Health Sciences Track.
 - See also note under first bullet about loan changes for the NHSC.
- Creates structures for **coordinated workforce data collection, analysis, and planning**:
 - National Center for workforce analysis created; state and regional centers authorized.

What Doesn't It Do?

- Does not say much about *where* the workforce should be trained or deployed, or *how* it should be used (with the possible exception of new flexibility in what kinds of training locations count for DGME and IME funding, which may allow medical residents to spend more time in community and independent settings instead of hospitals).
- Limited provisions to address immediate workforce needs, with a few exceptions:
 - Medicare 5% payment increase for psychotherapy in 2010 and 10% primary care payment bonus starts January 2011.
 - Flexibility in Medicare funding for medical education (DGME and IME) starts July 2010.
 - National Health Service Corps funding increase starts FY2010, ***if appropriated***.
- The law's provisions aimed at increasing the number of health profession students, improving the pipeline into professional healthcare training, or retaining currently employed professionals may not be large enough to have a significant impact in Oregon.

Of Note –

- The list of high-priority topics for **National Healthcare Workforce Commission** includes:
 - Integrated workforce planning and maximizing skill sets across disciplines.
 - Needs for HIT.
 - Aligning Medicare & Medicaid policies with national workforce goals.
 - Education and training capacity, projected demands, and delivery system integration of: nursing (all levels), oral health, mental & behavioral health, allied and public health, EMS, geographic distribution of providers as compared to need.

Key Payment Provisions for Incentives and Outcomes Committee

Where Does Federal Reform Get Us?

Medicare Payment –

- **Modifies payments to physicians:**
 - Increased payments for primary care physicians.
 - Beginning January 1, 2011 and continuing for five years, primary care providers will receive 10% bonus payments for evaluation and management services.
 - Increased payments for general surgeons practicing in physician shortage areas.
 - Beginning January 1, 2011, the bonus payment program for physicians practicing in physician shortage areas will be extended to include a 10% bonus for general surgeons on major procedure codes (in addition to the existing 10% bonus for primary care physicians practicing in shortage areas).
 - Quality-based payment adjustments for physicians in Medicare.
 - Physicians will continue to be paid a bonus to report quality data through 2014; beginning 2015 physicians will be penalized for not reporting the data.
 - Beginning in 2013, physician base payments will be modified based on quality, according to risk-adjusted measures of health outcomes and costs.
 - Feedback to physicians on resource use.
 - CMS must develop an episode grouper to allow measurement of resource utilization by physicians for episodes of care and must make the methodology public.
 - Geographic adjustments to physician payment.
 - CMS must revise the practice expense adjustment to the physician base payment to more accurately reflect practice expense variations by 2012.
 - In the meantime, the amount by which payments are modified downward to reflect lower than average practice expense under the current formula will be reduced by 50%. This affects Oregon physicians outside the Portland payment area because their practice expense under the current formula is 93% of the national average. Portland area physicians are unaffected because the geographic modifiers raise their payments above the base.
 - In addition, the legislation re-instated the physician work floor, which means that the physician work adjustment will continue to be used only to upward adjust physician payments — not to downward adjust them in communities where professionals are paid less than average.
- **Modifies payments to hospitals:**
 - Hospital inpatient payment adjustments for high readmission rates.

- Base payments will be reduced for hospitals with higher than expected risk adjusted readmission rates for conditions identified by CMS, beginning with heart attacks, heart failure and pneumonia. Reductions cannot exceed 1% in FY 2013, 2% in FY 2014, and 3% in FY 2015.
- Readmission rates will be posted on the CMS website.
- Hospital inpatient payment adjustments for high incidence of hospital acquired infections.
 - Base payments will be reduced 1% for hospitals in the top quartile for incidence of hospital acquired infections beginning FY 2014. Rates will be made public.
- Quality-based payment adjustments for hospital inpatient services (“Hospital Value-based Purchasing Program”).
 - CMS must develop a program of incentive payments that would hold back a percentage of the base rate (1% in federal fiscal year 2013 and increasing to 2% in 2017) and use those funds to reward hospitals that meet quality and efficiency standards.
 - The program does not apply to critical access hospitals or hospitals with insufficient numbers to measure quality, but requires CMS to conduct demonstration programs to test systems for rewarding quality in such hospitals.
- Geographic adjustments to hospital payments.
 - CMS must revise the hospital wage index to address specified issues.
- Bonus payments for hospitals in low cost communities.
 - Medicare will spend \$200 million each year in FY 2011 and 2012 to increase hospital payments in counties that rank in the lowest quartile for Medicare fee for service spending. Assuming Oregon hospitals qualify, they are likely to receive increases to their base pay of something less than one-half of one percent each year.
- Reduces Medicare disproportionate share hospital payments beginning FY 2014.
- Modifies **payments to other facilities and providers:**
 - Prospective payment system for federally qualified health clinics.
 - CMS must develop a payment neutral prospective payment system for FQHCs and implement it in 2012.
 - Quality reporting and payment programs for other facilities and providers.
 - CMS must begin quality reporting programs for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, cancer hospitals, and hospice programs by FY 2014. CMS must submit a plan for value-

based purchasing for skilled nursing facilities and home health programs by FY 2012.

- Modifies **Medicare Advantage**:
 - Reduces Medicare Advantage payments.
 - Beginning in 2012, payments for Medicare Advantage plans will be calculated under a new formula. Benchmarks, which are the basis of payments, have averaged 116% of fee for service cost (are old law and have resulted in payments to Medicare Advantage plans well above the cost of covering fee for service beneficiaries).
 - Under the new law the benchmarks will be no higher than 115% of fee for service cost after a six-year phase-in period. Benchmarks will be set as high as 115% of fee for service cost for counties with low fee for service costs and as low as 95% of fee for service cost for counties with high fee for service costs. [Benchmarks are the maximum Medicare will pay a plan to provide Medicare covered services. Plans that “bid” (contract with Medicare) to provide services at less than the benchmark receive the bid amount plus “rebates” (additional payments) equal to 75% of the difference between the benchmark and the bid. The average benchmark rate for Oregon plans has been well-above the new 115% cap, so Medicare Advantage payments will be reduced under the new law.]
 - Minimum loss ratios for Medicare Advantage plans.
 - Beginning in 2014, Medicare Advantage plans must have a minimum loss ratio of 85%.
- Creates an **Independent Payment Advisory Board** to develop a Medicare savings plan.
 - Beginning in 2014, a new Independent Payment Advisory Board will provide Congress savings plans if Medicare spending exceeds targets. The plans will go into effect if not overridden by Congress.
 - Reductions cannot be achieved by “rationing care,” increasing beneficiary premiums or cost-sharing, or (until 2019) reducing payments for most hospitals.
- Increases **Medicaid payments for primary care** while **decreasing payments for disproportionate share hospitals (DSH)**
 - Increases payments for primary care in Medicaid.
 - During calendar years 2013 and 2014, primary care physicians must be paid 100% of Medicare rates for evaluation and management and immunization services. The incremental costs for increasing the reimbursement rate over what it was in July 2009 will be 100% federally funded.
 - Reduces Medicaid disproportionate share hospital payments beginning FY 2014.

- Creates opportunities for **testing payment reform strategies**:
 - National Medicare pilot on payment bundling addressing chronic and acute conditions involving select provider.
 - National Medicaid demonstration beginning January 1, 2012 in eight states for episode payment.
 - National two-year Medicaid demonstration beginning October 1, 2011 in five states for global capitated payments to safety net hospitals or networks.
 - National shared savings pilots 2012-2016:
 - Medicare – accountable care organizations taking responsibility to care for 5,000 or more fee for service enrollees and measure quality receive shared savings achieved over a benchmark savings amount set by CMS over average fee for service costs (ACO is applicant).
 - Medicaid – accountable care organizations taking responsibility to care for children receive incentive payments if they exceed minimum savings levels established by CMS and the applicant state

Of Note –

- Center for Medicare and Medicaid Innovation funding for payment innovation.

Key Quality Standards and Measures for Incentives and Outcomes Committee

Where Does Federal Reform Get Us?

- Directs HHS to undertake **quality activities that may align with committee activities**.
 - HHS is directed to develop a National Quality Strategy to improve care delivery, patient health outcomes, and population health. An initial strategy must be submitted by January 2011 with annual updates thereafter. As part of this effort, HHS will:
 - Assemble an interagency working group on Health Care Quality to help federal agencies coordinate and collaborate on the national strategy aims. Avoiding duplication of effort and streamlining processes for quality reporting and compliance are among the goals of the working group.
 - Establish a federal health care quality website no later than January 2011.
 - In support of the national quality strategy, HHS must publish initial national quality measures by December 2011 and is authorized to receive up to \$75M over 5 years for quality measure development, improvement, updates or expansions. Measurement priorities include:
 - health outcomes and functional status of patients;
 - the management and coordination across episodes of care and care transitions
 - the efficiency of care;
 - experience, quality, and use of information to inform decision making about treatment options,
 - the meaningful use of health information technology;
 - the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;
 - the equity of health services and health disparities across populations and geographic areas;
 - patient experience and satisfaction.
 - CMS is directed to develop adult quality measures for Medicaid, similar to the child health quality measures recently published for children's health insurance (CHIPRA). (Sec. 2701). A recommended set of measures must go out for comment by January 2011 and must be finalized in 2012. State reporting on the measures begins after that point but the effective date is not clear; the Secretary has a deadline of September 2014 to "collect, analyze, and make [the data] publicly available."
 - Grants to refine and test the measures (likely very similar to the CHIPRA grant that Oregon was recently awarded) should be announced by Jan 2012 and must be funded at the same level as the CHIPRA grants.
 - An eight-member "Commission on Key National Indicators" is to be established by the National Academy of Sciences within 30 days of the law's enactment. It is not

known to what extent health (care) quality measures would be part of the national indicators; the law just instructs the Academy to identify issue areas and measures.

- By 2014, HHS must make plans for quality measurement and, ultimately, value-based purchasing in long-term care hospitals, ambulatory surgery centers, inpatient rehabilitation and inpatient psychiatric facilities, cancer hospitals, and hospices.
- Creates new approaches for **quality reporting**
 - HHS will begin a Medicare hospital quality reporting and value-based purchasing program in FY2013. Measures used must address heart attacks, heart failure, pneumonia, surgeries, and hospital-acquired infections and, starting in FY2014, efficiency measures such as adjusted Medicare spending per beneficiary.
 - The program will include demonstrations in critical access hospitals and hospitals too small to participate in the general program.
 - On the physician side, the law starts to move Medicare from pay-for-reporting to value-based purchasing:
 - Extends incentives for reporting through 2014 and begins to penalize non-participation starting in 2015.
 - 0.5% additional Medicare bonus to physicians who report via a qualified Maintenance of Certification Program 2011-14.
 - Provides physicians with feedback on their resource use, as compared to peers, beginning in 2012.
 - HHS must develop a “Physician Compare” website (like the current Hospital Compare) by January 1, 2011 for consumers to compare Medicare physician quality and patient satisfaction, using data reported as part of the Physician Quality Reporting Initiative.
 - Within 2 years of the law’s enactment, private sector health plans and insurers will be required to report to the Secretary on how their benefit designs and/or payment structures: improve health outcomes (via strategies such as quality reporting, care coordination, medical homes, etc.); reduce hospital readmissions; increase patient safety; and support wellness and health promotion.
 - Within two years of enactment, all federally-supported programs must, to the extent practicable, collect and report data on race, language, ethnicity, and disability status as well as rural or under-served populations. The Secretary will establish uniform standards for the data.

Of Note –

- Establishes a **Patient-Centered Outcomes Research Institute** in 2010 to identify priorities for and support comparative effectiveness research.
 - The Institute's findings may not be construed as mandates for practice guidelines or coverage decisions.

- Establishes a **Center for Medicare and Medicaid Innovation** by January 1, 2011, to test care delivery and payment models that reduce the cost of care while maintaining or enhancing quality.
 - The Center is funded at \$5M for 2010 and at \$10B for 2011 – 2019.

Key Provisions for Medical Liability Task Force

Where Does Federal Reform Get Us?

- **Provides Funding for States Test Tort Alternatives** (HB 3590, sec. 10607) – Authorizes the Secretary of Health and Human Services (HHS) to award five-year demonstration grants to states to develop, implement and evaluate alternatives to civil tort litigation. Models are required to emphasize patient safety, disclosure of health care errors, and early resolution of disputes. \$50 million in funds appropriated beginning in 2011; first report to Congress required by December 31, 2016.

Alternatives should:

- Make the medical liability system more reliable by increasing the availability of prompt, fair and efficient resolution of disputes.
 - Encourage the disclosure of health care errors.
 - Enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events.
 - Improve access to liability insurance.
 - Fully inform patients about the differences in the alternative and current tort litigation.
 - Provide patients the ability opt out of the alternative to tort litigation.
 - Not conflict with state law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation.
 - Not limit a patient's existing legal rights to file a malpractice claim.
-
- **Extends Medical Liability Coverage to Free Clinics** (HB 3590, sec. 10608) – Extends medical liability protections for free clinics under the Federal Tort Claims Act to clinic officers, governing board members, employees and contractors. [Effective date of enactment].

Key Elements of Interest to the Public Employer Purchasers Committee

Where Does Federal Reform Get Us?

- Defines **essential benefit package** for use in health insurance Exchange and as basis for coverage satisfying the individual mandate:
 - All plans must include essential benefit package (Jan. 2014).
 - The package must cover these general categories of care:
 - Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; prevention and wellness services and chronic disease management; and pediatric services, including oral and vision care.
 - The scope of the essential benefit package should be equal to that of a typical employer-based plan, as determined by a survey by Department of Labor.
- Outlines areas of **federal insurance regulations or requirements**:
 - Guarantee issue and renewability (Jan. 2014).
 - Rate bands — allows variation based on age 3:1, rating area, family composition, tobacco use 1.5:1 (for non-grandfathered plans, Jan. 2014).
 - Pre-existing condition exclusions prohibited for children 6 months from enactment and for adults by 2014.
 - Eliminates waiting periods of more than 90 days for group coverage (Jan. 2014).
 - Prohibits lifetime limits, allows certain annual limits until 2014.
 - Dependent coverage up through age 26 for all plans 6 months from enactment.
 - Coverage of preventative services with no cost-sharing (for plan years beginning after Sept. 2010).
 - Coverage for individuals participating in approved clinical trials for cancer or a life-threatening disease or condition (Jan. 2014).
- Defines **employer responsibilities** in Oregon:
 - Waiting periods for coverage may not exceed 90 days (Jan. 2014).
 - Non-offering employers with 50+ full-time equivalent employees pay an assessment if one or more full-time employees receives a premium tax credit. (Fee is \$2,000 per full-time employee, excluding the first 30 employees.) Offering employers pay \$3,000 per subsidized full-time employee per year. (Jan. 2014)
 - Employers with fewer than 50 full-time equivalent employees exempt from assessment.
 - Employer must provide a “free choice voucher” equal to the employer’s contribution to an employer-sponsored plan to employees below 400% FPL whose premiums for

- the employer's plan are between 8-9.5% of income. Voucher allows employee to purchase non-subsidized coverage in the Exchange using employer dollars.
- Employers with 200+ full-time employees must automatically enroll full-time employees in coverage offered by the employer. Employees may opt out of coverage.
 - Excise tax on high-cost insurance plans of 40% of excess over a cap. Applies to self-insured plans and plans sold in group market (Jan. 2018).
 - All plans to pay an assessment for transitional reinsurance program (beginning in 2014 for 3 years.)
- Outlines **specific roles and duties of an Exchange** within the marketplace in Oregon:
 - Small employers with fewer than 100 employees are eligible; larger plans in 2017.
 - HHS defines the benefits package that must be offered in Exchange plans, with package be similar in scope to employer-based plans.
 - HHS establishes additional criteria for qualified health plans that may be sold in the Exchange, sets open enrollment periods, reviews insurance rate increases.
 - Plans offered in the Exchange pay for a standardized percentage of the actuarial value of covered services (bronze to platinum).
 - Federal tax credits and cost-sharing reduction payments are available only in the Exchange.
 - Establishes a federal **temporary reinsurance program for early retirees** – Plans may apply to participate, and can be reimbursed for 80% of costs in excess of \$15,000 and below \$90,000. [Within 90 days of enactment.]
 - Creates federal framework for **administrative simplification**:
 - Establishes deadlines for HHS to issue new and revised HIPAA standards for electronic transactions to eliminate variation. Compliance deadlines phased in from Jan. 2013 to Jan. 2016.
 - Requires Medicare providers to accept electronic remittance advice and funds transfer by Jan. 2014.
 - Directs HHS to develop **national quality improvement strategy**.
 - Creates a **Patient-Centered Outcomes Research Institute** at CMS.
 - Directs CDC to provide technical assistance to **worksite wellness programs** and periodic evaluation survey.

What We Don't Know

- We don't know exactly what impact the various insurance reform regulations will have on premiums, both short- and long-term.
- May be difficult to do actuarial and cost analyses until CMS provides guidance on what types of benefits are included in the essential benefit package.
- The early retiree reinsurance program will have varying degrees of impact on employers, but public employers could potentially realize significant savings.
- It will be interesting to see the reaction and response of large employers to the Exchange, since the Exchange is the only way for employees to use tax credits or cost-sharing reduction assistance.
- The administrative complexity of the insurance changes, tax credits, cost-sharing reduction assistance, and other reform implications may overwhelm employers (especially small employers) and undermine compliance.

Key Provisions for Safety Net Advisory Council

Where Does Federal Reform Get Us?

- **Expands access to coverage:**
 - Medicaid to cover all nonelderly individuals with incomes up to 133% FPL, beginning in 2014.
 - CHIP reauthorized through September 2015.

High/Direct Impact on safety net.

- **Increases funding:**
 - Mandatory Federally Qualified Health Centers (FQHC) funding increased by \$11 billion over five years (through 2015);
 - Establishes Community Health Center and National Health Service Fund to sustain national investment.

High/Direct impact on safety net, impact on state access strategies.

- Establishes a **Prevention and Public Health Fund.**
 - Appropriates \$7 billion for 2010-2015 and after for Prevention and Public Health Fund, which can be used to fund mandatory public health activities authorized by the Public Health Service Act as well as new grants and programs created by the law (e.g. Community Transformation grants).

Intermediate impact/depends on how state public health and OHA approach opportunity.

- **Authorizes School-based Health Center (SBHC) Program.**
 - Provides a federal definition.
 - Allocates \$50 million between FY 2010-2013 emergency funding for SBHC construction and the purchase of equipment. No funds allocated for operating expenses. Not a lot of money when distributed nationally.

Intermediate impact on SBHC network in Oregon.

- Provides **access to comprehensive health care services to the uninsured** at reduced fees through a demonstration project.
 - HRSA grants in up to 10 states, total funds up to \$20 million. Requires state-based public private partnership.
 - Limited impact when funds are distributed over 10 states, however Oregon could be competitive.

- Establishes a process of “**negotiated rulemaking**” between HHS and stakeholders.
 - Determines new criteria and methodology for defining Health Professional Shortage Areas (HSPA) and Medically Underserved Area (MUA) measurements.

May have Direct/High impact on designations and thus programs eligible for services. Important to track.
- Requires basic exchange plans to contract with “**essential community providers**” such as eligible 340 B entities.
 - Many plans are already contracting with these providers; however may reinforce this trend and broaden it to include more MHO’s and DCO’s

Intermediate to mild impact.
- Establishes **multiple demonstration projects and pilots:**
 - Medicaid and Medicare demonstration projects.
 - Medical Home and Payment Reform pilots.

Intermediate to high impact depending on federal and state approaches.

 - Health Care Workforce pilots.

Limited impact unless there is a highly coordinated and effective approach to optimize the number of pilot demonstrations. Somewhat limited in its impact on the safety net.
- Increases funding for the **National Health Service Corp:**
 - \$320 million in 2010 building to \$1.5 billion in 2010.
 - Increases annual maximum loan repayment.

Intermediate/High impact on safety net – some relief to state and community budgets.

Of Note –

- Establishes **Office of Minority Health** including individual offices within seven HHS agencies. *Limited impact that could build over time depending on effectiveness.*
- Requires **health disparities data collection and analysis:**
 - For federally conducted or supported programs.
 - Required within two years of enactment.

Limited impact initially but will improve data collection over time.
- Targets at-risk communities with **Maternal, Infant and Early Home Visiting Programs.**
 - Grant program optional – Title V programs eligible entities but if states do not apply, can be opened up to NGO’s (non governmental organizations).
- Improves communications by requiring “plain language” to be used.
 - Plans in the state exchanges must submit information in “plain language” including language that can be readily understood by individuals with limited English proficiency.

Intermediate/High impact on safety net population over time.

Key Provisions for Medicaid Advisory Committee

Where Does Federal Reform Get Us?

- **Expands access to coverage:**
 - Medicaid to cover all nonelderly individuals with incomes up to 133% FPL, beginning in 2014.
 - Requires income to be determined using Modified Adjusted Gross Income with a few population exceptions.
 - Option to cover all nonelderly individuals with incomes up to 133% FPL at current FMAP, beginning 2010.
 - Medicaid to cover all former foster care children up to age 26, beginning in 2014.
 - CHIP continued through at least 2019; funding reauthorized through September 2015.
 - Option to enroll children of state employees into CHIP if the employee's premium and cost-sharing contributions exceed 5% of the family's income.
- **Requires maintenance of effort:**
 - States required to maintain existing Medicaid eligibility levels for adults until 2014.
 - States required to maintain existing Medicaid and CHIP eligibility levels and enrollment procedures for children through 2019.
 - Option to provide tax credits through state Health Insurance Exchange to CHIP-eligible children unable to enroll in CHIP program due to enrollment cap.
- **Increases federal financial assistance:**
 - The federal government will pay 100% of the cost of covering newly eligible adults in "expansion states" for CY 2014 - 2016. The rate decreases gradually to 90% by CY 2020.
 - Oregon's current match rate, including the American Recovery and Reinvestment Act (ARRA) extension, is 72.6%. Prior to the ARRA enhancement, the match rate was 62.5%.
 - Oregon will likely be categorized as an expansion state as defined in the federal legislation. Further guidance from the federal Department of Health and Human Services is required to clarify this definition.
 - States will receive a 23% point increase in the CHIP match rate up to a cap of 100%, beginning FY 2015.
 - Oregon's current CHIP match rate is 73.7%.
- **Defines required benefits:**
 - Newly eligible individuals must be provided a benchmark benefit package that provides the essential health benefits as defined by HHS.
 - Free-standing birth centers become eligible for Medicaid reimbursement.

- States must offer premium assistance wrap-around benefits to Medicaid clients who are offered employer sponsored insurance (ESI) only if premium subsidies are cost-effective, beginning 2014.
 - Prohibits State from requiring that individual or parent apply for enrollment in qualified ESI.
- **Defines new reimbursement and allotment provisions:**
 - Increases Medicaid drug rebate percentages and extends rebates to Medicaid managed care plans.
 - Decreases disproportionate share hospital (DSH) allotments gradually beginning FFY 2014 based on a State's uninsurance rate and DSH designation.
 - States, such as Oregon, designated as low-DSH states will have smaller initial reductions imposed.
 - Prohibits federal payments to states for services related to health care acquired conditions.
 - Increases payment for Medicaid primary care services to 100% of Medicare payment rates for 2013 and 2014 with 100% federal financing.
 - Revises payments to institutions of mental disease for adult emergency stabilization.
- **Creates options for delivery system reform:**
 - Allows Medicaid enrollees with or at risk of developing multiple chronic conditions to designate provider as a health home. State receives 90% match rate for all services provided to individual through health home.
 - Creates opportunity for episode of care bundled payment projects.
 - Creates opportunity for safety net hospital system global capitated payment projects.
 - Creates opportunity for pediatric accountable care organization projects.

What Doesn't It Do? What We Don't Know –

- May not solve affordability issue if premium subsidies offered through health insurance exchange are not sufficient for individuals above 133% FPL.
- It is unclear how the benefits provided using the prioritized list aligns with the benchmark benefit package.
- It is not yet definitive whether Oregon will be defined as an expansion state and receive the higher federal match increase.
- We do not know what Oregon's reduction in DSH payment will be.

Key Health Insurance Exchanges Provisions

Where Does Federal Reform Get Us?

- Identifies **specific exchange functions**:
 - Certify plans:
 - Implement procedures for certification, recertification, and decertification (consistent with HHS guidelines).
 - Offer coverage:
 - Make qualified health plans available to eligible individuals and employers
 - Customer assistance:
 - Have a toll-free telephone hotline to respond to requests for assistance.
 - Maintain a website through which enrollees, prospective enrollees can get standardized comparative plan information
 - Grade health plans (in accordance with criteria to be developed by HHS):
 - Use a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage.
 - Maintain a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.
 - Provide information to individuals, employers:
 - For anyone the exchange determines is eligible for a program, provide information regarding eligibility requirements for Medicaid, CHIP and any applicable State/local public program.
 - Provide electronic calculator to determine actual cost of coverage after application of any premium tax credit/cost sharing reduction.
 - Publish: the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
 - Give each employer the name of each employee who stops coverage under a qualified health plan during a plan year.
 - Administer exemptions:
 - Grant exemption certificates to individual responsibility penalty when: (1) no affordable qualified health plan is available through the exchange; or (2) the individual meets the requirements for another exemption from the requirement or penalty.
 - Provide information to federal government:
 - Give the Secretary of the Treasury the name/tax ID of each person: (1) issued an exemption certificate; (2) who was an employee and deemed eligible for

the premium tax credit because the employer did not provide minimum essential coverage or provided coverage unaffordable to the employee/didn't meet minimum actuarial value; or (3) who tells the exchange they changed employers and stopped coverage during a plan year.

- Facilitate community based assistance:
 - Establish a Navigator program.
- Directs HHS to **promulgate regulations** regarding –
 - Certification of qualified health plans.
 - A rating system to rate plans offered through the exchange (on the basis of relative quality and price, for use by individuals and employers).
 - An enrollee satisfaction survey.

Areas of State Flexibility –

- An exchange may operate in **more than one state** (requires HHS approval).
- A state may operate **one or more subsidiary exchanges**.
- A state may **contract with an eligible entity** to carry out some exchange functions. The eligible entity. An “eligible entity” is either the State Medicaid agency or an entity with experience in the individual and small group health insurance markets and in benefits coverage and that is not a health insurance issuer (or treated by the IRS as one).
- The state can **implement payment structures** that provide incentives for improving health outcomes.
- The exchange may be run by the state **government or a non-profit entity**.
- The structure of the exchange, including but not limited to its **governance**.
- The state can require that health plans sold through the exchange have **additional benefits** beyond the federal minimum, but it must defray the cost of any additional benefits.

What Doesn't It Do?

- It doesn't mandate changes to the way we pay for care or otherwise specify changes to the delivery system (though it does promote incentives for quality, etc....)
- It doesn't eliminate the possibility that insurance coverage will still be unaffordable (especially, but not only, those who work for employers offering coverage.)

Of Note –

- HHS will provide **start up grants** to states to implement exchanges.
- An exchange must have **annual open enrollment period**, special enrollment periods and monthly enrollment periods for Native Americans.
- Exchange must be **self-sustaining** by 1/1/15 by means including the use of user fees or assessments to support operations.
- Exchange must **consult with stakeholders**, including qualified health plan enrollees, individuals or organizations that help people enroll in plans, small business and self-employed representatives, state Medicaid, and advocates for enrolling hard-to-reach populations.

Key Elements for Public and Population Health – the Health Improvement Plan Committee

Highlights

- Creates a National Prevention, Health Promotion, and Public Health Council, charged with creating a national health improvement strategy.
- Appropriates \$7B for 2010-2015 and after for a Prevention and Public Health Fund, which can be used to fund mandatory public health activities authorized by the Public Health Service Act as well as new grants and programs created by the law.
- Provides Federally Qualified Health Centers (FQHCs) with \$11 billion over five years (through 2015); establishes Community Health Center and National Health Service Fund to sustain national investment.
- Authorizes many grant opportunities for community-based prevention and health promotion activities.

Where Does Federal Reform Get Us from the perspective of the Health Impact Pyramid?¹

The public health provisions of the law **do not address socioeconomic factors/social determinants of health** (the first/bottom level of the Freidan Health Impact Pyramid).

The law contains some **provisions for changing the context to make individuals' default decisions healthy** (level 2) and for **long-lasting preventive interventions** (pyramid level 3); population impact is greater at these levels:

- Menu labeling is required at chains with 20+ locations and for vending machines. The federal law preempts most provisions of existing Oregon law.
- Community Transformation Grants available through CDC for policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce health disparities. Open to state and local governments, national CBO networks and tribes; “sums as necessary” authorized for 2010-14.
- Requires employers with more than 50 employees to provide reasonable break time and a private location (other than a bathroom) for nursing mothers to pump until their children are 1 year of age.
- 5-year grants to small businesses to establish comprehensive worksite wellness programs; CDC to provide employers with technical assistance for evaluation of worksite wellness programs and conduct a national worksite health policies and programs survey.
- Grants for maternal and child health home visiting programs FY 2010-14. States, tribes or (if state does not apply) non-profits entities eligible.
- Grants for states to improve vaccine coverage among children, adolescents, and adults.

¹ Frieden TR. A framework for public health action: The health impact pyramid. *AJPH*. 2010;100(4): 590-595.

The majority of the **policy provisions and funding opportunities in federal reform address the top two levels of Frieden’s Health Impact Pyramid** (clinical interventions and counseling & education), where population impact is less and the level of individual effort required is greater, e.g.:

- Prohibits cost-sharing for preventive services in plans offered through new Exchanges; same for evidence-based preventive services, adult vaccines, and individualized wellness planning followed by annual wellness visits under Medicare. Also incentives for states to offer evidence-based preventive services without cost-sharing under Medicaid, which Oregon already does to a large extent.
- “Healthy Aging Living Well” 5-year pilot through CDC for prevention services to pre-Medicare population (55 – 64). \$50 million available to state and local health departments and, tribes.
- Allows private insurance plans and insurers to offer incentives representing up to 30% of the cost of coverage for participation and achievement in wellness programs
- Pilot projects in 10 community health centers to develop individualized wellness plans with patients.
- 3-year demonstration to provide access to comprehensive health care services to the uninsured at reduced fees. Up to 10 states, total funds up to \$20 million. Requires state-based public private partnership.
- Grants to use community health workers to support positive health behaviors and outcomes for populations in medically underserved communities.
- Appropriates \$50M/y for 2010-2013 for grants to open and operate school-based health centers.

What Does Federal Reform Do for Public Health Infrastructure?

The law contains a few provisions that could be used to **strengthen public health infrastructure**, including:

- Competitive grants to state and local health departments and tribal jurisdictions to increase epidemiologic and laboratory capacity in order to track and control communicable disease. \$190 million/year is authorized for FY 2010-2013.
- Potential grant funding through HHS for public health systems and services research; details are not provided.
- Several investments in public health workforce training, including:
 - Loan repayment for public health professionals starting FY 2010
 - Scholarships for mid-career public and allied health professionals FY 2010-15
 - Elimination of the current 2,800-person cap on the Public Health Service Commissioned Corps

- Fellowship training in public health (e.g. Epidemiologic Intelligence Service or similar) to address documented workforce shortages FY 2010-13
- Establishment of a U.S. Public Health Sciences Track (tuition support in return for services in the Commissioned Corps) to train 800 health professionals annually, beginning FY 2010.

What Doesn't It Do?

- The law **does not make fundamental transformations to the relationship between public health and healthcare** or reinvent the U.S. healthcare system. . However, it does provide funding opportunities for states and communities to innovate or experiment around integration and transformation; see previous notes.
- As noted earlier, the law has no provisions to address socioeconomic determinants of health (the bottom level of the Freidan pyramid, where health impact is the greatest) and a relatively small number of provisions for broad contextual or environmental changes in support of population health (level 2) or long-lasting preventive interventions (level 3).
- The law has **limited provisions beyond chronic disease prevention**. However, this focus aligns with the charge to Oregon's Statewide Health Improvement Plan Committee as stated in HB2009. Provisions on other public health topics include: a national campaign on oral healthcare and grants for caries disease management activities; competitive grants for National Centers of Excellence for Depression; research and support services for post-partum depression & psychosis; funding for comprehensive sexuality education *and* abstinence-only education, and others.