

**Oregon Health Policy Board**  
**DRAFT Minutes**  
**November 16, 2010**  
**Market Square Building**  
**1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor**  
**8:30am – 1:00pm**

**Item**

**Welcome and Call To Order**

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

The Chair announced that the agenda had been revised, moving the public comment section to 11:45. Some items were moved to December's agenda.

**Draft Report from the Public Employers Health Purchasing Committee – Steve McNannay, Lynn McNamara, Barney Speight**

- Committee charge:
  - ❖ Identify and recommend strategies to align purchasing policies and standards, as well as foster collaboration across public employers and other interested health care purchasers.
  - ❖ Develop strategies for disseminating and incorporating uniform quality, cost and efficiency standards and/or model contract terms for use by OHA health care purchasing programs and for voluntary adoption by local governments and private sector entities.
  - ❖ These standards are to be based on the best available clinical evidence, recognized best practices and demonstrated cost-effectiveness for health promotion and disease management.

*This presentation can be found [here](#).*

- The Board was concerned that insurance purchasers would be reluctant to adopt the Committee's recommendations and that the Committee might not have enough influence to enact change.
- Lynn replied that the purchasers were concerned with cost. They recognize the long-term benefits, but are uncomfortable with the immediate expense.
- The Board was interested in collecting data on how the purchasers were implementing the recommendations, and Barney replied that they planned to do it by checking the contracts of the eight or nine major carriers in the state.

**Draft Report from the Workforce Committee – John Moorhead and Ann Malosh**

- The Workforce Committee was created to coordinate state efforts to recruit and educate health care professionals and retain a quality of workforce to meet demand. The Committee identified three priorities.
  - ❖ Prepare the current and future workforce for new models of care delivery
  - ❖ Improve the capacity and distribution of the primary care workforce
  - ❖ Expand the workforce through education, training and regulatory reform to meet the current projected demand of 58,000 new workers by 2018

*This presentation can be found [here](#).*

- The Board was very interested in the Committee's recommendation to standardize the administrative aspects of students' clinical training and felt that a statutory requirement might be the most effective means of accomplishment. There was concern about whether schools would be comfortable with a required set of standards and the Board decided that communication with the schools would be necessary to set a standard that would be acceptable to most schools.
- The Board noted that in order to achieve the diversity of workforce that we are striving for, we must ensure that same diversity exists in health care education faculty.

**Break**

**Report for Board Consideration: Publicly Owned Health Insurance Plan – Nora Leibowitz, Barney Speight and Bill Kramer**

- Key strategic issues

- ❖ Organization and governance – Standalone plan or “piggy-back” on an existing plan?
  - ❖ Provider network strategy – Selective or open network? Payments at market or below? Use of innovative payment mechanisms?
  - ❖ Administrative functions and expenses – How much for medical management? Marketing and sales? Opportunities for efficiencies?
- Some advocates feel that a “piggy-back” plan does not truly meet the definition of public option. A piggyback plan that used PEBB would use PEBB for its administrative services. PEBB is self-insured and uses Providence to administer its plan. Advocates feel that using Providence, which is a private provider, does not hold to the true essence of a public plan.
  - A co-op was brought up as an option that had not been fully investigated at the last meeting. Bill feels that a co-op is not truly a public plan, either. It is owned and managed by its members. It could provide a way to achieve some of the goals held by the public option. It’s another choice that might be a competitor in the exchange. There is \$6 billion available in loans and grants to cover start up costs.

*This presentation can be found [here](#).*

**The Board voted to provide the Legislature with the three main options (standalone plan, piggy-back plan and co-op option) for them to consider during the upcoming legislative session.**

### **Report for Board Consideration: Health Insurance Exchange – Nora Leibowitz, Barney Speight and Bill Kramer**

- Structural assumptions of the exchange:
  - ❖ Dual market
  - ❖ Active purchaser role
  - ❖ 204 benefits in each tier
  - ❖ Active marketing
  - ❖ Public corporation structure

*This presentation can be found [here](#).*

- The Board requested that the small employers group be renamed as micro employers and create a group for employers with more than twenty-five employees.
- The Board also asked that staff focus on what can be done to increase more portability in the Exchange.
- The Board stated that it is very important to begin educating people about the Exchange well before it is implemented to ensure greater participation.

### **Public Testimony**

Tom Aschenbrenner – President of Northwest Health Foundation

Mr. Aschenbrenner encouraged the Board to address the social, economic and environmental conditions that create opportunities for health in the comprehensive plan. He urged the Board to be bold when communicating with the Legislature and break the mindset that everything begins and ends with a biennium. Finally, he requested that the Board create a fully chartered committee focused on health equity.

Gary Cobb – Community Outreach Coordinator

Mr. Cobb urged the Board to ensure that coordinated services are available to OHP members suffering from substance abuse. Having access to various kinds of treatment, as well as housing, is of great value.

Caitrin Coccoma – Partnership for Safety and Justice

Ms. Coccoma urged the Board to consider all forms of addiction as a chronic disease, not just tobacco and alcohol.

### **Update: Oregon Blueprint for Health – Gretchen Morley**

*This document can be found [here](#), beginning on page 5.*

- The Board discussed the difficulty in trying to create a document that outlines where we wish to go and focuses on the immediate needs at hand as well.
- Dr. Goldberg recommended creating a separate document that outlines immediate steps to be taken to bring things into position to enact the farther reaching steps the Blueprint recommends.

Governor-Elect John Kitzhaber Testimony:

**Governor-elect Kitzhaber** – Mr. Chair, for the record, John Kitzhaber, Governor-elect. I just wanted to take a few minutes.

This issue obviously is one that I've had a long standing interest in. I also think it's an issue that could potentially break the bank for the state of Oregon and for the United States of America, and I think that - I've read your Blueprint and just want to make a couple of comments about sort of what I hope will happen from the work that you've done to date.

I guess the first thing I want to convey is a real sense of urgency.

The federal health care reform legislation officially takes place really between 2014 and 2017, and as you know, it wasn't, in my estimation, really health care reform as much as it was health insurance reform, and it will provide certainly some changes to the private commercial insurance industry that are overdue and also will provide the opportunity for most Oregonians to have financial access to medical care, either through the state insurance exchanges or through expanded Medicaid or subsidies for individuals and small employers. But it does very little to reduce the big drivers of health care cost, and I don't think either the federal government or the state of Oregon can wait until 2017, and I don't think Oregon can wait until 2014. The national debt is increasingly made up of Medicaid and Medicare. Congress is going to have to get their arms around that, and when they do, my concern is that they will be in a very reactive mode, focusing on managing the national debt and making sure we don't default on it, rather than a thoughtful approach to the health care system and changing the financial incentives and the structure of the delivery system, which is really the root cause, I think, of this problem in America.

For the state of Oregon, I think the crisis is now, in this biennium. The cost increase in the Department of Human Services was \$1.8 billion. That's the projected increase in expenditures. One billion of that is replacing one-time federal funds and about \$600 million of that is Medicaid. So, the discussion we're going to have in the next biennium is not how we increase reimbursement for providers to meet medical inflation, but how we take essentially a flat funded or less than flat funded budget and do something different with it that lays the groundwork for some much more substantial health care reform in the next biennium.

And I think that—I know—the administration is looking for a state or several states that can demonstrate that the federal health care legislation wasn't just a big increase in federal spending but is a – provides a pathway to substantial fundamental health care reform. I think that Oregon is a great position to do that. I've had some conversations with Governor Gregoire about the possibility of even doing a regional two-state approach to become somewhat greater than our parts.

But to me, the logical thing for us to do, a place to start in Oregon, is eventually to take those individuals for whom the state has direct responsibility, either as a large employer, PEBB and OEBB, or as a safety net provider, the Oregon Health Plan, which is about 850,000 covered lives and to begin at some point in the future to view those lives as an 850,000 person community-ready risk pool, and then leverage regional delivery system changes with that market power to begin to change the delivery system and hopefully provide a venue, an avenue for small employers to purchase into that if they wish and eventually to look at the whole question of how we change the delivery model in Medicare as well.

So, I think that the things that really need to happen to lay the groundwork for that in the next session is to begin to align state purchasing around Triple Aim metrics, begin to think about how we can regionalize accountability for health outcomes and for financial, and for health financing, to begin standardizing, to get our arms in the upcoming biennium around the fragmentation and inefficiency in the Medicaid program,

which is a must for balancing the budget. And I think that means integrating mental health, physical health and long term care and giving the Medicaid managed care plans the ability to manage a larger part of the health care dollar in exchange for some delivery system changes that drive efficiency and quality.

And I'll guess I'll just say finally, I spent yesterday down in Salem getting a budget briefing, and the fact is, the money's not there. I mean, our K through 12 system is flat funded at best for the next two years, and there's no way we can justify, I think morally or politically, a 15% increase in the Medicaid budget. We just can't do it. So we need to view this as an opportunity to rethink how we change our business models over time to deal with the trapped equity in the current system and to try to make some inroads in that during the upcoming biennium. I don't suggest that it's going to be easy, but I also think that this is something that we have to do together, and we have to do it right. We're not going to get another shot at this, and there's a profound opportunity to do something very important for Oregon and eventually for the country if we proceed together down this path.

**Eric Parsons, Chair** - Very good. We have some work to do. We have a lot of work to do.

**Governor-elect Kitzhaber** - Thank you very much for the chance to come down here. That's really all I had. I just - I hope that you take some of those key elements that are in your Blueprint and really lean into those and I think that the sooner we can have a dialogue with the various impacted parties, whether they be consumers or providers or insurers, or how we work through this, I think the better off we'll be. We shouldn't, in other words, we shouldn't wait until January 10, 2011 to begin this process of engagement.

**Bruce Goldberg, OHA Director-designee** – You know, Governor, as you've laid out, the alignment, the regionalization, the standardization, and how we do all of that, I think is very consistent with how the Board has been, you know, approaching this, and what I – I think we hear from your remarks is that hopefully the board and the Health Authority can bring in—actually making this a reality now because of the urgency of the budget situation around the 850,000 public lives and that if we can do that and do that well, it really sets out the future and that we really need to get at what can happen over the next six months to make that less aspirational and more reality. We're ready to help.

**Eric Parsons** – Indeed we are. I think a lot of the work we've done is aiming in the right direction. I think we heard a real message of urgency and we'll be on it.

**Governor-elect Kitzhaber** – Thank you, and obviously I have no authority to direct the Board to do anything until January 10, but I want to suggest that if you lean into this and move aggressively in this direction, I will provide you plenty of cover after January 10.

**Adjourn** 12:48pm

**Next meeting:**

**December 14, 2010**

**Noon – 5:00pm**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

**Portland, OR 97201**