

**OREGON HEALTH FUND BOARD**

April 24, 2008  
11:00am – 5:00 pm  
(Digitally Recorded)

Holiday Inn, Portland Airport Hotel  
Salon A & B  
8439 NE Columbia Blvd  
Portland, OR

- MEMBERS PRESENT:** William Thorndike, Chair  
Jonathan Ater, Co-Vice Chair  
Eileen Brady, Co-Vice Chair  
Thomas Chamberlain  
Charles Hofmann, M.D.  
Raymond Miao  
Marcus Mundy
- OTHERS PRESENT:** Ellen Lowe, Chair, Eligibility and Enrollment Committee  
Ella Booth, Chair, Health Equities Committee  
Susan King, Chair, Benefits Committee  
Dick Stenson, Chair, Delivery Systems Committee  
Maribeth Healey, Vice Chair, Delivery Systems Committee  
Vicki Gates, Chair, Quality Institute Workgroup  
Frank Baumeister, Chair, Federal Laws Committee  
Kerry Barnett, Chair, Finance Committee  
Denise Honzel, Chair, Exchange Workgroup
- STAFF PRESENT:** Barney Speight, Executive Director, OHFB  
Jeanene Smith, M.D., Administrator, OHPR  
Tina Edlund, Deputy Administrator, OHPR  
Sean Kolmer, Research Analyst  
Heidi Allen, Program Manager, OHREC  
Tami Breitenstein, Executive Assistant, OHFB  
Gretchen Morley, Health Policy Commission Director  
Nora Leibowitz, Senior Policy Analyst, OHPR  
Darren Coffman, Director, Health Services Commission  
Nathan Hierlmaier, Policy Analyst  
Brandon Repp, Research Analyst  
Illana Weinbaum, Policy Analyst  
Alyssa Holmgren, Policy Analyst

- ISSUES HEARD:**
- Call to Order/Review Agenda/Approve Minutes
  - Update on *Your Oregon, Your Health* Community Meetings
  - Committee Updates
  - Discussion of March 20 Facilitated Session
  - Exchange Work Group: Update & Discussion
  - Delivery System Transformation: A Conversation
  - Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

- Chair Thorndike     I.    Call to Order/Review Agenda/Approve 03/20/08 Meeting Minutes.  
(See Exhibit Materials 1 and 2)

The meeting was called to order. There was a quorum.

AGENDA CHANGE: "Delivery System Transformation" conversation will be presented before the "Exchange Workgroup" report.

Barney Speight provided an overview of the agenda. There will be opportunity for individual input on what will be the first steps in Delivery Systems reform followed by presentation of Exchange Workgroup.

Draft minutes reviewed. Page 4 (bottom) regarding reference to Montana should be Minnesota. No other changes, additions or deletions. Minutes will stand as amended.

Barney introduced Cynthia Griffin as the new Communications Director who will be assisting in outreach to the communities, including drafting technical information into an understandable frame for the public. Chair Thorndike welcomed her.

## II. **Update on *Your Oregon, Your Health* Community Meetings (See Exhibit Materials 4 and 5)**

**Chris DeMars, NW Health Foundation**, began the presentation quoting from a letter from the Oregon Health Reform Collaborative on the importance of public engagement and stated that NW Health Foundation is supporting Oregon Health Forum and the Oregon Health Decisions in planning meetings.

**Carol Robinson, Oregon Health Forum**, related meeting with Eileen Brady and Marcus Mundy for filming a public service announcement (can be viewed at [www.healthforum.org](http://www.healthforum.org)). This message will be distributed to television and radio stations throughout Oregon. Barney Speight, Maribeth Healey and herself met for an editorial board meeting with the Oregonian for an editorial to be published. Thanked the Board for their participation.

- Presented list of scheduled meetings (**see Exhibit Materials 4**).
- Provided chart created by Mike Garland, OHSU Ethicist, involved in meetings process, capturing information flow to OHFB. (**See Exhibit Materials 13**)
- Key points about meetings:
  - Meetings will provide a process for Oregonians to talk to each other. Designed to bring out the value systems and tradeoffs.
  - Have invited local hosts at each meeting (usually elected officials).
  - Meeting process includes: brief introduction of process by a facilitator from the American Leadership Forum; overview by OHFB representative.
  - Script provided. (**See Exhibit Materials 14**)
  - Used abbreviated version of Barney's Kinsman Conference slide presentation.
  - Designed scenarios from hopeful to fearful. Example of scenario overviewed.
  - Detailed notes will be taken, a scribe will write comments on "grafetti wall," and the meetings will be videotaped.
  - Doing email and phone banking.
  - Importance of interaction of Board/government with community.
  - *Question: In the report that you provide, will it contain survey data or will it be the impressions drawn from the meetings?*
    - Is not meant to be quantitative data, but will do some surveying.

**Chris DeMars,**  
NW Health Foundation  
**Carol Robinson,**  
Oregon Health Forum  
**Michael Garland**  
Oregon Health Decisions

- *Question: Issue raised that other communities are requesting meetings (specifically Corvallis) and do we want to operate outside of schedule or do we want to add meetings?*
  - Regarding Corvallis, offered to provide support if Board member wants to attend.
  - Discussion of difference in data collected from meetings that use a different process.
  - Meeting limitations due to time, costs and travel restraints noted.
- *Question: Are we going to have conversations about health and healthcare or are we going to have conversations about State government changing its role?*
  - Starting point is the initiating legislative action. Whether to ask Oregonians what State's role should be is up to the OHFB.
  - Role of State government, whether or not explicitly mentioned, will be related by responses from public.
- *Question: Who do you think will be the hardest groups to have represented at the meetings?*
  - Small employers with statement on importance of employer involvement.
- Scenarios evoke value statements. It is noted that the script includes a clear statement that these scenarios are not designed by OHFB.
- Importance of relating tradeoffs to communities is stressed. Barney will distribute the Kinsman Conference report which includes issues on tradeoffs.
- Meeting on May 20 (election primary deadline) will be rescheduled.

### **Staff and Chairs III. Committee Updates**

- Benefits Committee (BC) – Darren Coffman, Lead Staff to BC, Health Services Commission Director reported:
  - Prioritized list is being used for the basis of the Essential Services Benefit package.
  - Moving the funding line higher on the list has previously not met with stakeholder support in regards to the OHP Standard.
  - The higher on the list the lower the cost sharing.
  - BC considering extracting certain value-based services, provided on an outpatient level, to be given higher priority status that will have little or no cost sharing as it is built to reduce inpatient care and improve health outcomes.
  - There will probably be a high deductible within package for affordability to State and individual with an out-of-pocket maximum.
  - Evidenced based guideline to limit diagnostic tests.
  - Expectation that private insurers would market supplementary plans beyond the basic plan related.
  - Currently convening Staff Review Panel involving members from the Benefits, Delivery Services and Eligibility and Enrollment committees to look at pricing of benefit package with the contracted actuary.
  - *Question: Do you have a range of the high deductible that is being considered?*
    - Looking at current plan deductibles and going higher than that.
    - High enough so there will not be crowd-out.
  - Barney related that the BC is looking at three variations of the Essential Services Benefit (will be on a sliding scale):
    - The basic benefit for the mandate for those who don't have coverage and don't have a subsidy.
    - The Essential Services Benefit for those that receive a subsidy.

- Package where there is no cost sharing.
  - OHP Plus benefit package would not change, less clear is if and how the Standard plan might change.
- Health Equities Committee (HEC) - Heidi Allen, Lead Staff to Committee, OHREC Project Manager related that the Committee has made five global recommendations which will be submitted in a final report to the Board before its next meeting.
  - The recommendation on eligibility was submitted to the Board at a previous meeting.
  - Other recommendations pertain to: the Integrated Health Care Home, outreach, work force (adequate and diverse), language access, benefit design, preventing health disparities prior to clinical visits (in home and community), healthy lifestyle choices, data quality and initiatives.
  - Ella Booth, HEC Chair, thanked the members of the Committee and related the following:
    - Cynicism exists in committees and in the public;
    - HEC members would like an opportunity to receive feedback; and offered to be available to the Board as needed.
  - Chair Thorndike related it is the goal to keep the process interactive.
  - Request for clarification of the cynicism was responded to by Ella Booth relating lack of results from past task forces. Heidi Allen added that there is hope that this Board will be the mechanism for change.
- Eligibility and Enrollment (E & E) Committee – Tina Edlund, Lead Staff to the Committee, and OHPR Deputy Administrator, thanked the committee members and staff for their efforts.
  - First recommendation on affordability has been forwarded to the Board. In summary, this three-pronged approach consisted of:
    - Expansion of OHP to maximize federal match;
    - State premium contributions:
      - below 150% of Federal Poverty Level (FPL) - no personal contribution;
      - 150% to 300% FPL - sliding scale of contribution;
      - 300%-400% FPL would receive an affordability tax credit.
  - Recommendation for strong public education and outreach.
  - Ellen Lowe, E & E Chair, thanked the staff for their efforts and stressed the importance of developing common language relating committee.s use of the term “State contribution” in lieu of “subsidy.”
- Federal Laws Committee – Barney gave an overview of the federal issues that have been studied by the committee: Medicaid, Medicare, Employee Retirement Income Security Act (ERISA), federal tax policy, Emergency Medical Treatment & Active Labor Act (EMTLA) and federal health care work force policy.
- Finance Committee -
  - Committee has spent extensive time weighing the merits of various financing options against committee principles.
  - Very difficult to reach consensus.
  - Two taxes seem as most viable options to create broad based financing for reform
    - Payroll tax combined with a credit for employers funding health services for their employees
    - Health Services Transaction tax that would broadly tax across all health care providers at a low rate
  - Some interest in other taxes including income tax, tobacco, and beverage.

- Modeling is currently underway working with Institute for Health Policy Solutions and Jonathan Gruber at MIT in an interactive process to test reform scenarios.
- Committee will be meeting May 1 and 29 before it wraps up its work. A draft report is in development.

**Barney Speight**

**V. Discussion of March 20 Facilitated Session (See Exhibit Materials 5,6,7,8)**

- Overviews lists developed from March 20 facilitated session.
- Addressed process feedback and integration of committees' work.
- Barney suggested Committee involvement would involve:
  - Involvement of Committee chairs and vice chairs.
  - Once Board has overviewed a committee's draft report return it to them with feedback.
  - Have a small "on-call" group to be available to provide feedback on behalf of the committee they represent.
- Discussion by the Board on creating an overarching term or phrase to be identified with the reform work. Initial suggestions included:
  - "A Healthy Oregon";
  - "Moving toward a world class healthcare system for Oregon," or,
  - "A healthy Oregon with a world class healthcare system" which combines the two above.
  - "Redesigning the Delivery System so that we are providing world class healthcare system."
- Concerns expressed about a "silo" effect, needing to be more explicit and public perception of what a "world class system" would mean.
- Suggestion that the Communications Director should work on phrase.
- Social revolution, changing people's paradigms and that it involves more than the medical system is debated.
- Draft Statement by Staff: "To achieve a healthy Oregon we believe a transformation of our delivery systems is a necessary prerequisite for sustainable reform."
- Encompass dramatic shift that is required for existing structural problems.
- Support for "Healthy Oregon" as it is not exclusive. Suggestion: "Building a Foundation for a Health Oregon."
- Barney discussed blending social and market ethics.
- Concern that Health Equities is not being clearly represented in the goals.
- There is a need to look at the legality of the reforms.

**Delivery System Committee Leaders**

**V. Delivery System Transformation: A Conversation**

Barney Speight discussed the process of transformation and asked the Board to think about "what are the most important first steps" to "start or help move the momentum of change."

Jeanene Smith, M.D., Lead Staff to the Delivery Committee and OHP Administrator, reported on the progress and provided the Board with a diagram on the "Framework for Delivery System Reform" (**see Exhibit Materials 11**). It was noted that the Board has received the Quality Institute (QI) Workgroup recommendations (available on the OHFB website). These recommendations will be folded into the Delivery Systems full report.

Dick Stenson, Delivery Systems Committee (DSC), related the most important components from the DSC.

- A patient decision making, interactive process and the tools needed to make decisions
- QI workgroup raised concerns over adding a new government entity.
- Maximize comparative evidence with technology and pay for what works.
- *Question: If the government lowers payment for a particular services involving technology, how does that play out in reducing unnecessary procedures?*
  - Dropping prices in the past has had some success.
  - Tying quality and outcomes to evidenced based should minimize use.
- Payment reform in the Integrated Health Home, team approach to care and paying for services not covered in the past are related.
- Disincentives for services over-utilized.
- Transparency.
- Collection of data and the Quality Institute's role.
- *Question: Is there other ways to acquire data other than from claims? Have you looked at other states to see if it is being done?*
  - Currently, easiest way to get data is through a claims data base.
  - A change in the way data is collected may be forthcoming in the future with electronic records.
  - Concepts from the Dartmouth Vermont model were related.
- Reported discussion of regulatory measures and monitoring excess profit margins or expanding Certificate of Need, but it is not clear what direction this would take. More transparency is needed.
- *Question: Have you discussed the concept of reimbursing case management?*
  - Yes. It was addressed in discussions on payment reform which included a robust primary care payment system.
  - Combination of fee-for-service payment and case-based payment.
  - Incentives for physicians to go into primary care.
  - Discussion on staging, incentivizing toward quality standards and accountability. Accountable Care Districts (ACDs) will help in aggregating. Collaborative efforts to help offices to switch.
- *Question: It seems the first step would be to do some modeling of Elliot Fisher's strategy (ACDs) for different regions throughout the state before implementing. Is that correct? And if so where are we at in the process?*
  - John McConnell and Elliot Fisher have been communicating, suggesting five or six regions be modeled first for piloting.
  - Possible communities for pilots discussed.
  - Suggestion to first gather existing data from an area and see if it works before implementing into communities.
  - Staff related the possibility of Elliot Fisher coming to Oregon and to develop a "pre-pilot" test.
- CareOregon's creation of "containers" where participants agree to try to obtain specific goals and how this relates to ACDs. Data transparency and a collaborative learning system could create change. Suggestion to look at the CareOregon's concept and the Fisher model.
- *Question: Is there any way to go back and request an analysis of all of the regulations and laws under which medical practitioners operate.*
  - Staff related discussion with Palliative Care group.
  - Most are federal rules (Medicaid) with suggestion to review the resource based value scale.
  - Example of clinic incorporating managed care, reducing hospital costs, saving federal money, but not reimbursed due to regulations, but would have been reimbursed in a hospital setting.
  - Shift broader health care budgeting to chronic disease management.

- Regarding #7 on curbing profits, if delivery system is doing well, will they be penalized?
  - It is not the intent to penalize for doing well and related the public's need to know that interests in health care are being held accountable.
  - *Question: Are there hurdles regarding the scope of practice in integrated health home?*
    - Payment of services by healthcare workers, case management payment.
    - Lag between when systems change to real savings. How do we get around this?
    - Looking at capital costs on a regional basis. Becomes more than a tracking mechanism but a basis for funding.
    - Think about it in two different respects: (1) Professional licensing and moving toward team-based care and what care must be performed by licensed professionals and (2) paying for process and outcomes.
    - Broad system-wide delivery reform and how do we move from the current system into the envisioned system? This is where we need to have five or six key points that will be a leverage point.
  - *Question: Is there going to be some kind of prioritization that comes out of the committee? For example, in 2009 will be one step, in 2011, second step, etc.*
    - Staff related that the Minnesota model does have steps.
    - Discussion on the first steps, difficulty of building a statewide model, local business models and approach on how to effect changes.
  - Suggestion to obtain grant money to look at Fisher's model in a couple of regions.
  - Establishing measures for outcome discussed.
  - Discussion on QI recommendations, staffing that entity, establishing measurements and giving some grants for technological improvements and abilities and a 2.3 million dollar request for the legislature. Asking the legislature for a ten-year commitment.
  - Funding models discussed. Quality Corp has been bringing together stakeholders on some measurements.

Denise Honzel/  
Nora Leibowitz

**VI. Exchange Workgroup Update and Discussion  
(See Exhibit Materials 10)**

**Vice Chair Jonathan Ater** spoke to making changes at the community level, balancing a free-market ethic and a social ethic, and structural opportunities suggesting that it does not need to be highly regulated, as well as creating an exchange that helps create market forces to inspire change.

Denise Honzel related that the Market Reform recommendations have been presented, but not vetted, by the Finance Committee (FC). The Workgroup is not recommending any change in group coverage as it raised many issues. Recommendations are for the individual market and reforms necessary to achieve universal access.

**Market Reform**

- Starting assumptions listed on the bottom of page 2 included individual mandate, guaranteed issue, State contributions/credits available on a sliding scale basis for low and moderate income individuals and families.

- Provided information on current individual market described as three pools: existing/new individual market participants; Oregon Medical Insurance Pool (OMIP) (about 18,000 individuals) that covers “uninsurables” who can be charged up to 125% of average premium; and portability market (about 19,000 covered) and portability market (about 19,000 covered)
  - All are rated differently.
- Under reform, 150,000 more would be covered in the individual pool.
- Recommends combining the three individual pools into one pool so it is similar to a community rating.
- Recommends transitioning the high risk/high cost of individuals in the OMIP slowly and use assessment to mitigate market disruption.
- Critical component includes a risk adjustment method and a mechanism to receive funds from carriers that cover low-risk individuals to help offset cost of high risk individuals. Protects carriers and pays them appropriately for the risks that they have.
- Apply same rating rules for all carriers, would allow for geographic differences in costs.
- *Question: On the high risk portion, is that a retrospective methodology of going back and evening the playing field?*
  - No. Currently, Regence provides the administrative services in which people are enrolled as self-insured with the Office of Private Health Partnerships projecting claims cost.
  - Would be prospective risk adjustment with premiums adjusted in advance. Collection of money made prospectively.
  - Challenge in individual market reform would involve the function of looking at the risk of all players.
  - Workgroup has discussed using a risk adjuster.
- Maintain the existing age band and that all carriers use the same rate which is currently about a 5.6:1 spread.
- Recommendation on benefits assumptions (waiting for report from Benefits Committee) included that all carriers participating in the individual market would offer the base level benefit package and at least one buy-up option to avoid potential gaming.
- Actuary is modeling this information and the possible need to develop transitional approaches to minimize the impact.
- Enforcement of individual mandate coupled with guaranteed issue a a requirement. Washington’s reform problems due to not having both.
  - Related that workgroup is continuing exploring penalty options for individuals who do not enroll. Suggestions have included:
    - Having to wait for annual open enrollment and then only eligible for the Essential Services Benefit package for the first year.
    - Penalty fines of 50% to 100% of average annual premium but more discussion is needed including cost of administration.
- There is concern regarding the sustainability of the high risk pool.
  - Currently \$3.50 per member/per month is charged to group payers and reinsurance carriers whose premium is not comparable to a healthcare premium amount.

### **What would an Exchange Look Like?**

- Adverse selection management discussed.
- Three levels of Exchange function discussed:
  - Level 1 – information, enrollment and administration (limited value)
  - Level 2 – Consists of Level 1 plus contracting and benchmarking.

- Level 3 – Consists of Levels 1 & 2, negotiates rates and selectively contracts (minimizes adverse selection).
- Group is leaning toward recommending Level 2 and retaining level 3 as an option.
- Requirement of employers to offer a 125 plan.
- Four categories of individuals would be required to use the Exchange:
  - Recipients of direct state contribution:
  - Individuals eligible for affordability tax credit:
  - Employees of employers not offering coverage; and
  - Classes of employees not eligible for Employer Sponsored Insurance (ESI) (at employer's discretion).
- *Question: Would this include PEBB?*
  - No. Recommendation focuses on individual coverage.
- *Question: Did you discuss an option of a public plan being in the exchange?*
  - Discussed briefly, stated that "people like being in the commercial market."
  - They can pick standards that could mirror some standards in PEBB.
  - Health Care Purchasers Coalition and Quality Corp is trying to get standards. Developing a common set of standards is discussed.
- *Question: What does public plan mean?*
  - Maribeth Healey responded that it gives the opportunity for individuals or small employers to buy into the health plan.
  - Payment amount to providers and assumptions regarding Medicaid recipients discussed.
- Clarification that a carrier certified by Department of Consumer Business and Services (DCBS) for the commercial market could operate within the Exchange.
- Open question of what payment rate would providers be paid.
- Third category (employees not eligible for ESI) could take advantage of the premium only plan (POP) (employer pays into the system).
- Fourth Category that involves classes of employees that are not eligible for coverage through employer (e.g. part-time employees). The employer of this group must decide if the entire group goes through employer or the Exchange (includes about 100,000 individuals).
  - Must involve entire group of an employer in order to avoid adverse selection.
  - Employers with part-time or low-wage employees may prefer going through the exchange as individuals may be eligible for state contribution or tax credit.
  - *Question: How does the 125 plan funding mechanism work for someone who works more than one part-time job?*
    - Discussion by Workgroup has included 125 plans and partial contribution by employers.
    - Has not been resolved.
    - Advantage of Exchange noted as being an option for employers.
- Discussion on voluntary use of Exchange. For those buying direct, would involve a dual tract: enroll through exchange or directly with a carrier. More discussion needed in relation to gaming.
- Increases market competition.
- Risk adjuster would probably go through DCBS.

### **Small and Large Groups**

- There was discussion on including small groups whose employers do not offer coverage of being in the Exchange.

- Complex issue of whether to offer group rates or individual rates?
- In considering group rates, employer has option of going with a carrier based on their own risk experience, through an association pool/trust, or through the Exchange. Large potential for adverse selection.
- Small group market changed to 2-50 employees (from 2-25).
- Combining small group and individual pools was discussed by the group.
- There have been recent disruptions for small employers, recommends to not include groups initially and stabilize the individual market first.

Denise Honzel related that the message of the committee is to reform the individual market you must have an individual mandate and risk adjustor.

### **Business Meetings Information**

Barney Speight related information on presentations (independent of the thirteen scheduled meetings) to groups.

- Oregon Business Council Healthcare Committee attended by himself, Bill Thorndike and Jonathan Ater; Oregon Business Association presentation by Jonathan Ater and himself; Oregon Advisory Group of the National Federation of Independent Businessmen in which Bill Kramer, consultant, also attended; and Healthcare Committee of the Association of Industries (AOI).
- Concerns and interests of the groups included: delivery system bending the curve on cost containment (affordability) (seen as a strategic business viability issues); individual mandate and how it works, taxes, and equity issues around pay-or-play payroll tax.
- Input from businesses and business groups are encouraged.

### **Other Issues**

Description and location of Paradigm Conference Center in Milwaukie where the May meeting will be held is given. Recommendations by Delivery Systems Committee will be addressed. June meeting will include results from modeling, recommendations from Finance and Eligibility and Enrollment Committees, including coverage strategies.

Staff related that there will be a small office in the State Office Building in Portland for OHFB use.

## **VI. Public Testimony**

**Rick Bennett, Director of Public Relations, AARP Oregon**, testified.

Submitted AARP principles for Health Care Reform and AARP definitions of adequate benefit package and affordability. AARP will make a decision on their position of the Board's work product as it is developed.

- *Question: Can you provide comments to the Benefits Committee before that report is submitted to the Board so that information can be included in the Boards review?*
  - Will take information received to form input.
- *Question: The Eligibility and Enrollment Committee has discussed the importance of treating with equity Medicare recipients who find themselves below 300% of the FPL. Not to change Medicare package, but a possible state contribution for supplemental package. Can you respond on this?*
  - Prepared to discuss Medicare at the national level in context of national healthcare reform. Depending on Oregon's plan, a state exchange or pool could be perceived as a Medicare Advantage plan.

- o Recently completed a survey on Oregon healthcare reform and hopefully that will be provided at May meeting.
- **Jennifer Valley** testified on medical marijuana reducing pill intake and healthcare costs by 85%. Work for the Board of Directors of Voter Power, Willamette Valley Normal, closely with Oregon Green Free. Need more research. Related problem for patient access. Details of Medical Marijuana dispensary supply system legislation action on Medical Marijuana provided.

**Chair Thorndike VII. Adjourn**

The meeting was adjourned.

**The next meeting for the OHFB is May 21, 2008, at the Paradigm Conference Center, Milwaukie.**

Submitted By:  
Paula Hird

Reviewed By:  
Barney Speight

**EXHIBIT SUMMARY**

1. Agenda for 04/24/08
2. Minutes for 03/20/08 OHFB Meeting
3. Media Advisory Final – Northwest Health Foundation
4. "Your Oregon, Your Health" – Northwest Health Foundation
5. "What would a Comprehensive Plan Look Like?"
6. "What would a Successful Process Look Like?"
7. "Principles of Oregon Health Fund Board"
8. "Goals of the Oregon Health Fund Board"
9. Commonwealth Survey
10. Exchange Committee Recommendations
11. Progress Report from the Delivery Systems Committee
12. Delivery Systems Reform Diagram
13. OHFB Flow Chart by Mike Garland
14. Oregon Health Forum Script