OREGON HEALTH FUND BOARD

May 21, 2008
9:00am – 5:00 pm
(Digitally Recorded)

Paradigm Conference Center
3009 Chestnut
Milwaukie, 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
Oregon Senator Alan Bates

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
- Summary of Kinsman Ethics Conference
- Delivery System Committee Report: 1) Managed Care, Managing Chronic Disease; 2) Improving Quality, Increasing Transparency; 3) New Reimbursement Models; 4) Comparative Effectiveness, Medical Technology Assessment; 5) Shared Decision Making; 6) Public Health, Prevention, Wellness; 7) Administrative Simplification, Standardization; 8) Pharmaceutical Spending
- 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 04/24/08 Meeting Minutes. (See Exhibit Materials 1 and 2)**

- Meeting was called to order. There was a quorum.
- Review of minutes deferred to June meeting.

John Forsyth, MD/ Susan Tolle, MD **II. Summary of Kinsman Ethics Conference (See Exhibit Materials 6)**

Dr. Forsythe addressed the Committee on the value of ethics in health care reform and provided background information on the Kinsman Ethics Conference.

- 125 Oregon health care leaders met for a two-day discussion focused on issues faced by the OHFB. Barney Speight spoke at the conference.
- Ethics brings to the table:
  - Application of values: compassion, autonomy, justice, fairness and stewardship.
  - Necessity for cost containment.
  - Change in perspective by powerful stakeholders.
  - Use ethics as a tool to join with clinical science, technology, electronic records, finance and economics.
- Section 2, Page 2 (Table) Five values from conference listed. Of these, three have to do with substance: compassion, autonomy, and justice; two have to do with process: fairness and stewardship.
  - Compassion, including importance of universal access.
  - Autonomy, including advanced directives, POLST forms, and the unanticipated reduction of cost relating to patient end-of-life decision making. Dartmouth Atlas Research Project results that Medicare spending could be reduced by 30% is related.
  - Justice: Market justice (focuses on profit) and social justice (health of entire community). Participation by all is needed.
  - Stewardship and Fairness: Speech by Dr. James Sabin, keynote speaker at conference emphasized reasonableness and four hallmarks. His advice to OHFB was *"do not be afraid to be bold,"* that *"incremental change is unlikely to achieve success,"* and avoid mistake by Massachusetts and address cost containment.
- Kinsman Conference gave attendees appreciation for five things:
  - Task of OHFB.
  - Necessity to control cost.
  - Importance of ethics in decisions the Board will be making.
  - Health care reform process must be effective, sustainable and ethical.
  - Opportunity to be a model and improve the health of all.

Introduction of **Dr. Susan Tolle, Director of the Oregon Health Sciences Univer (OHSU) Center for Ethics in Health Care and co-Chair of the Conference.** She related background as a general internist and has primary care perspective. She is not representing OHSU at this presentation.

- *"Something's got to give"* and implications.
- Universal access needed, noting that the number of uninsured/under-insured increases every year.
  - High cost shifting burdening employers is so great amount of coverage and number of people covered has dropped.
    - Rigorous cost management and sustainability is necessary.

- From Kinsman Conference: 1) clearly prioritize and paying higher percentage for evidenced-based services.
- End-of-life care and electronic POLST registry related.
  - Directives for care inaccessible 25% of time in private homes, resulting in some unwanted treatment.
- Conflict of interest includes gifts/incentives from industry and the need for evidenced based rather than marketing.
- Reform of system may mean loss of money and will be met with strong political forces.

Discussion

- *Question: Referring to David Clark's book "They Can't Find Anything Wrong," relates other components of health that can be identified by listening to patient, which relates to billing and cost containment.*
  - Stress related illness discussed. Changes in behavior of patients and moving emphasis in payment and training upstream, and do preventive care. Example given.
- *Question: How do you balance ethically individuals right to demand for care vs. societal sustainability of health care?*
  - Demands made are not currently being delivered.
  - Dr. Forsyth related limits can be set and noted Massachusetts Board that determines what is reasonable in paying for health care.
- Dr. Tolle urged Board to contact them if needed.

Barney Speight **III. Framing Today's Work**

- Overviewed materials focusing on Delivery System Committee's draft report. **(See Exhibit Materials 3)**
- Barney will act as facilitator and Tina Edlund will capture comments.
- Staff Advisory Panel to be formed with two or three Board members to work with Delivery leadership.
- Discussion of moving from Committee recommendations to Board plan and working through an interive process including emails and teleconferencing to develop Delivery System's "chapter" for the plan.
- Matrix developed by Health Equities Committee (HEC) related by Ella Booth, Chair, and Heidi Allen, staff. **(See Exhibit Materials 4)**
  - In addressing recommendations, consider how HEC's 18 recommendations will be woven through plan.
- Accountable Health Districts (ACDs) will be discussed with input from Dr. John McConnell.

Committee Leadership, Staff, John McConnell **IV. Delivery System Committee Report: 1. Primary Care, Managing Chronic Disease (See Exhibit Materials 3/PowerPoint Presentation)**

Introduction of staff and leadership of Delivery Systems Committee: Jeanene Smith, MD, Lead Staff; Dick Stenson, Chair; Maribeth Healey, Vice Chair and Ilana Weinbaum, Staff.

- Dick Stenson provided opening comments relating Visionary Statement **(See Exhibit Materials 3, page 7).**
- Noted underlined words on presentation recently added not yet finalized by the Committee.
- Barney stated that there are 8 Integrated Health Home (IHH) recommendations and about 14 of the HEC's recommendations relate to IHHs and primary care.

- *Question: How do we get from where we are now to having medical homes for everyone? Is chronic disease management a first step? Is there a phasing recommendation?*
  - Committee focus on chronic disease management discussed.
  - Workforce issues noted.
  - Role of government as a purchaser and able to launch change stated.
  - Involving stakeholders to commit to change needed.
  - Phasing problem of private sector delivery systems and purchasers in benefit design and reimbursement reform and multiple perspectives on how to accomplish this are discussed.
  - Conflict of what role insurance carriers should play and the potential of carriers making decisions about medical care.
  - Radical change vs. realigned components.
    - IHH as a tool to make radical changes discussed.
  - Recommendation for strong public education and outreach.
  - Ellen Lowe, Eligibility and Enrollment Committee Chair, stressed the importance of developing common language, relating Committee's use of the term "State contribution" in lieu of "subsidy."
- *Question: What are we getting for these bold transformations and how long is it going to take us to get there? The need to be clear about outcomes expectations and cost impacts. (Cited Committee charter, page 49, criteria to improve the "value equation" of cost/quality.)*
  - Supportive information exists, including altering expenditure patterns, particularly in relation to the six chronic conditions.
  - Bending the cost curve, page 64 of draft report, is noted.
  - Suggestion to begin report with outcomes.
  - Committee deliberation on timeframes and first steps related.
  - Problems, including workforce and multi-disciplinary teams, with being able to meet a specific timeframe related.
  - *Question: Are there public clinics and resources that exist now that can provide health care, e.g. paramedics?*
    - Staged changes and timeframes with cost benefit analyses needed. Workforce issues are also being addressed by a legislative interim reform committee.
    - Community based care by Federally Qualified clinics is related.
    - Strategic workforce plan for Oregon is needed including utilizing existing resources.
  - Role of specialists in providing primary care and payment for team approach discussed.
  - Is there a role for state government relative to establishing a standard for an IHH or is that left to private partnerships?
  - Multi-payers and multi-definitions of medical home and outcomes discussed.
  - Is there a possibility of costly over-use of specialists?
  - Suggestion to identify existing models for effectiveness. The work of Barbara Starfield's 30 years of study of primary care across multiple countries related that those with robust primary care system have decreased mortality, increased health, happier patients and practitioners. How did they get there?
    - Making the hard decisions,
    - Moving resources upstream: payment reform; government oversight with stakeholder participation.
  - System in Tai Wan is related and it was asked, *Should we be spending more time analyzing what has been done?* Assertion that

there has never been health care cost containment without government control.
  - Board can have a "broad brushed" directional recommendations regarding standards, accountability and reorganization. Representatives from Sweden will be visiting who have contained costs to 3%/year for the past six years.
  - Accountability and change problems when each physician may have own set of tools and the need to set a standard are discussed.
  - Suggestion to look at what PEBB is doing, as well as CareOregon, to provide a look at outcomes.

Committee Leadership/Staff John McConnell

V. Delivery System Committee Report: Improving Quality, Increasing Transparency

- Staff related that there is no change in Quality Institute (QI) recommendations.
- There are three recommendations: one on financial transparency and two on Accountable Care Districts (ACDs).
- Financial transparencies in report covers hospitals, health care providers, but not insurance. Staff will broaden to include regulated insurers.
- *Question: Regarding Quality Institute what were the other alternatives to the public-private recommendation?*
  - Discussion on publically chartered corporation being chosen due to flexibility and other possibilities discussed by the Committee.
  - Barney Speight provided some background information, including needing a "safe" place for competitors to work on standard setting.
  - Necessity of State funding commitment related.
- *Regarding Quality Recommendation II, 1), who sets the goals? Why is goal setting part of the QI?*
  - It would be a group focusing on quality measurement and understanding data to set broad outcomes. Does not preclude OHFB.
  - Concern expressed about accountability of an information based, data research group setting goals. Stakeholder involvement suggested.
  - Staff related that SB 329 specifically requires development of model for quality.
  - NCQA and other standards noted with concern expressed over duplicating existing work that could be adjusted for Oregon.
    - Staff related that the QI has an inventory of existing efforts. National and local standards were reviewed and identified that there are different standards set by different groups and the difficulties this may propose for individual practitioners.
- *Question: Regarding the Assessment of quality needs vs. community needs, where is the voice of the community mentioned?*
  - Staff illustrated community involvement through ACDs aggregating data and how communities would use data. Related webinar in June with Eliot Fisher regarding ACD modeling.
  - Suggestion that it is too early to determine if a QI is needed.
- *Question: Concern related about the quality of data obtained through ACDs. Do we have any information out of Vermont and how are we doing on starting to develop information on Oregon?*
  - John McConnell related ACDs help with:
    - performance measurement, and
    - local accountability and payment reform which would come later after data is collected.

- Vermont's efforts related. There is interest at the federal level to involve Medicare.
- ACDs are using data that is already out there.
- First step, performance management and seeing what data looks like. Eliots team can do that for Oregon to identify patterns.

- *Question: Regarding community based efforts, getting all stakeholders from a region together towards meeting two-three key goals Is transparency, by itself, sufficient? Does it change the culture of health care?*
  - John McConnell stated that before engaging the community, collection of data uniformly is needed and will involve learning.
  - Related public display of data and influence on hospitals.
  - Issue of who is organizing data is important and using transparency to support moving forward. Caution in choosing balanced language.
- *Question: I have heard that it could take 3-5 years to set up a data system for an ACD, is that true?*
  - John McConnell could verify a timeline, but related that Vermont's was shorter.
  - Jeanene Smith related that in Utah it was one year.
    - Current available data could be used in model.
- Barney Speight asked for other thoughts or reactions of the domains covered for the record
- Ella Booth and Heidi Allen overviewed HEC matrix and recommendations. **(See Exhibit Materials 4)**
  - Ella Booth, HEC Chair, noted recommendations 1, 6 and 7 that pertain to earlier discussions. Supported creating a QI to ensure uniformity, to identify disparities and align resources.
  - HEC workforce issues are related in recommendations 8, 9, and 10.
- Consensus of Board to submit a letter of support to the Health Information Infrastructure Advisory Committee (HIIAC) overviewing Delivery System recommendations for input as they craft electronic health records recommendations which are intended to feed into delivery system reform.
  - First meeting of HIIAC overviewed by Dr. Jeanene Smith and Ree Sailors, Governor's Office and Co-Chair of HIACC. Draft of Delivery System Committee's recommendations has been shared with the HIIAC and areas relevant to Health Information Technology (HIT) have been highlighted.

Committee Leadership/Staff

VI. Delivery System Committee Report: 3. New Reimbursement Models (See Exhibit Materials 3, page 23)

Payment Reform Recommendations 1 (addresses performance standards and outcomes) and 2 (experimentation at several levels, OHP has ability to do some and things in the commercial market we can learn from.)

- *Question: What will the State's role be legally in payment reform and where can the State intersect on this topic?*
  - State roles include that of purchaser, administration of OHP and can aid in working on new models with little legislative action needed. Current legislative efforts of looking at new insurance codes for reimbursement are noted.
- *Question: In a Medicaid-type program can you pay for health outcomes as opposed to procedures or visits?*
  - Dr. Smith related that there is a new set of codes that would pay for case management and other things that would further an IHH.

    - New reimbursement models is addressed beginning on page 34 of report, but consensus over exact measures left up to payment reform entity to ensure alignment with other ongoing efforts.
- *Concerning PEBB, what influence does PEBB have with the carriers or are the carriers going in that direction anyway?*
    - Can require certain attributes for payment, assumes the carriers are able to carry that out, they would be the mechanism.
    - PEBB contracts have a layer promoting medical homes, electronic health record adoption, but that is in addition to a fee-based system.
    - Next step is that there has to be a relationship between carrier and provider which is tens of thousands of relationships.
    - Payment reform is a key point to delivery reform.
    - Role of ACDs in Vermont that are going to use information to change the way to pay in ACD areas is discussed.
    - Suggestion made to form a payment reform group for a pilot ACD.
    - Support for Recommendation I to be bolder. Using State purchasing power to have certain standards as there will be entrepreneurial opportunity.
    - *Question: What can be done and where are the teeth?*
        - Legislative action discussed.
- *Question: Can we do it with plans under ERISA?*
    - Kerry Barnett responded that in self-funding plans, he is not sure, but states that "*it is entirely possible it would survive ERISA"* if it were a statute aimed at providers generally.
- Assertion that this is more of a provider issue than a carrier issue.
- *Question: What would be the down side? Would there be push back in consumer groups?*
    - Steps for a case management reimbursement system wouldn't include much push back, but there will still be an issue with Medicare's low payments. In trying to increase Medicare reimbursement, must decrease payment for other services.
    - Two potential push backs:
        - Possible cost increase and how long it would take a robust reimbursement strategy to show cost savings from the shift.
        - From a consumer viewpoint, make this work in a Taft-Hartley or insured product with a benefit design for chronic care management. Are these purchasers ready for that benefit design?
    - Two different approaches to same issue: 1) legislatively mandate; 2) incentivize folks to use it. Can be legislative but there will be a period where costs goes up.
    - Mechanisms for measuring and designing criteria for reimbursement discussed.
    - Minnesota bill of payment reform related. Staff related that Medicaid program could move faster than any program and payment reform connected to chronic disease of the poor would provide: more wrap around care and will outcome change. Do those models relate to experimentation on the commercial side.
- Increased cost in short-run may be the result of putting everyone into a new system, while there may not be big increases with transitioning and models. Discussion on putting money into existing programs, i.e., safety net clinics, and whether there is a real savings when ER use decreases, other ways of recovering costs, and community involvement which led to further discussion on experiments and demonstrations including:
    - Starting with info from ACDs and community involvement.
    - Support for demonstration project, possibly with Medicaid.

- Suggestion that self-insured company could institute a payment reform program in cooperation with provider agreement. Obstacles related. Suggestion that some carriers may want to differentiate themselves in the market.
- Need for reasonable social agreement about how to pay for managed care expressed with doubt that producers will change their products.

- Clarification and background information requested for underlined statement of slide presentation **(slide 23)**: "While holding . . . to the CPI costs as measured over a five year period."
  - It was part of broader discussion in trying to bend the curve and have some parameter.
  - It was noted that it came from the charter from the OHFB.
  - Twelfth goal of the act.

Committee Leadership/Staff **VII. Delivery System Committee Report: 4. Comparative Effectiveness, Medical Technology Assessment**

- Goal of having a system using work being done, e.g., private, government and other health systems across the country, then to set standards that providers, delivery systems and communities will embrace as sound and engage the consumer/patient in knowledge through endorsing decision agents in some of these areas.
- *Question: Regarding recommendation* 5, *what about providing a high level of protection from litigation in relation to physicians following standards set by the state even though they did not agree with it?*
  - Suggestion to have a funded forum.
  - How do you uniformally get standards adopted that providers are comfortable with? Medical effectiveness from technology is looked at and analyzed.
  - Public perspective discussed.
  - Dr. Hoffman reported work being done on the Healthy Americans Act to strengthen the liability issue. He will distribute information.
  - *Question to Dr. Hoffman: Knowing that this is being addressed in the legislature does it really have a place in health reform, what about a Professional Liability Fund (PLF) and what have you been doing on the Health Americans Act?*
    - Dr. Hoffman responded with a strong "yes" for liability reform.
    - A PLF for physicians should be explored as well as other things.
    - Reported on Senator Wyden's Healthy Americans Act in regards to liability reform.
  - *Is there any thought how we as a state could encourage benchmarking with regional data or national data to be more proactive as well as looking outside our own borders?*
    - Staff related that the Health Resources Commission (HRC) reviews literature from around the U.S. and the world in looking at local key questions concerning drugs/best treatments.
    - Talk at National level about putting more dollars through federal agencies to provide that meta-analysis.
  - Current malpractice referred to as "jackpot justice." Overuse of technology can be related to fear of litigation.
  - Understanding the cost built in for malpractice insurance and problem should be pointed out in the draft.
  - Relating it as a workforce issue in that physicians may choose areas of the medical field that are "safer".

- Concern expressed of addressing malpractice reform without discussion of the needs of the consumer related.
- The need for the legislature to act and risk sharing related.

Committee Leadership/Staff

VIII. Delivery System Committee Report: Shared Decision Making

- There are four recommendations, with the last one relating to Dr. Susan Tolle's presentation including a statewide registry. Input was received from those involved in palliative care.
- There is a lack of reimbursement for palliative care counseling.
- Clarification of all recommendations requested.
  - Staff noted that these are key elements, and could be included in training, payment reform, and statewide effort to enable EMS workers timely access to this information.
  - QI involvement vs. using existing entities discussed.
- Methods for determining costs discussed.
  - Bill 2213 passed requiring regulated carriers to have on web a place where consumers can estimate costs based on benefit design.
  - Comparison of hospital costs is currently on website and further data being collected. QI Workgroup debated cost vs. quality. Delivery Committee felt that cost was important part in transparency.
  - Cost of educating and training of programs was raised.
  - Educating providers with skills for improved patient communicating.
  - Data available that when a plan has robust patient information and decision-making partnership how utilization changes.
  - POLST empowerment for patient decision-making first impact is having a partnership with physician, secondarily is cost savings.
- *Question: Where are we at in cost containment?*
  - Committee prespective is that all of these recommendations have a cost containing dimension.
  - Page 36, #3 addresses cost control.
  - Part of next step may be estimating costs and savings of the recommendations.

Committee Leadership Staff

IX. Deliver System Committee Report: 6. Public Health, Prevention, Wellness

Modest modification from last meeting on Recommendation 2. Staff related that there was input from Public Health Division and advisory boards. Underfunding of Public Health and its role as a player in the community and in change is related.

- Community Center Health Initiatives fund (CCHI) explained where funds would be channeled to communities that are spending money efficiently. Small towns would be included in regional funding.
- Duplicating other efforts raised as a concern.
  - Add value to existing efforts and create collaboratives for where needed.
  - Support for campaigns, e.g., tobacco use, obesity, etc., is related.
- Last recommendation pertains to State as an employer and issue of wellness prevention and workplace wellness activities. Input was received from PEBB.

Committee Leadership/Staff

X. Deliver System Committee Report: 7. Administrative Simplification and Standardization

- Recommendation 1 refers to financial transparency with note that at the back of report is cost containment strategies and matrix.
  - Interpretation of data in spikes in administrative costs discussed.
- Recommendation 2 refers to uniformity to standardize formats by providers and purchasers.
  - Currently, there are voluntary conversations of provider and payer organizations that are looking at simplification.
  - If organizations are unable to accomplish, may be appropriate for government to set standards.
- Recommendation 3 relates to pharmaceutical issues, including promotion of generic drugs and Oregon Prescription Drug Program (OPDP).

Committee Leadership/Staff **XI. Delivery System Committee Report: 8. Pharmaceutical Spending**

- Discussion of the Oregon Prescription Drug Program (OPDP).
  - Is a Washington-Oregon consortium.
  - Oregon has about 92,000 individuals and a couple of small groups.
  - Comparison with Wal-Mart prices, OPDP is usually lower.
  - Delivery Committee discussion related that participation in OPDP should not be required if can show cost savings.
  - More transparency with OPDP than with pharmacy benefit managers negotiating with drug companies.
  - Debate on using ODPD and rebates in private contracts.

Discussion of Delivery System Topics

Barney Speight asked the Board to make further comments to direct staff on overarching areas, relating there is further developing on modeling and putting together cost savings.

- Further work on the recommendations including on technical piece and cost savings.
- Board thanked Delivery System Committee and staff for their work.
- Support for creating QI expressed.
- Suggestion to include a mechanism to keep administrative costs, construction costs, etc., in check, including capturing costs shifts.
- Staff Review Panels will be formed to move from recommendations to a plan.
- Recommendations on potential roles for government to be made.
- Suggestion that next meeting include report from Bill Kramer on strategy document. **(See Exhibit Materials 5)**
- Original charge of access, quality and value and the need to provide choices stated.
- Preliminary draft by mid-summer with some time for revision in October.
- Regarding Kinsman Report, voice of community and that of ethicist.
- Ella Booth, Chair, HEC, related that areas of health equities need to be more clearly identified.
  - Staff related that Delivery System plan draft would specifically reference HEC recommendations, as well as other committee recommendations, to provide a holistic view of the plan.

Chair Thorndike XII. Public Testimony

- **Jerry Cohen, State Director, Oregon AARP,** provided results of a survey of persons age 35+ that indicate Oregonians are ready for a change and highlighted the following results:
  - Three of four Oregonians have experienced significant increases in out-of-pocket costs.
  - Eighty percent are very concerned about increased costs.
  - Age 50-64 (not eligible for Medicare) must stay in current job due to coverage and a growing sense of loss of security.
  - Is an election issues as over 50% indicated importance of candidates stand on the issue.
  - Agreement that employers, federal and state government, and individuals should share in contribution with a belief that employers who don't offer insurance should pay a fee to help provide coverage.
- **Dr. Joann Lamphere, AARP, National Coordinator of the State Health and Long Term Care,** testified that the survey reflects a strong desire by Oregonians to change the system. Belives public is on your side. Cautioned on "*comprehensiveness exponentially increases the political challenge and the fiscal cost of interventions*" and that it becomes complex to manage politically with suggestion for changes in stages. Victories in the past month in Iowa and Minnesota related. The importance of bi-partisan support stated. Specifics of these states' reform provided. Fiscal realities and the obstacle on the federal level of the deficit related.
  - Does include commercial payers.
  - Minnesota bill will be provided with analytical framework.
- **Laura Etherton, OSPIRG Advocate**, **(See Handout)** representing a number of consumer organizations across the state (Oregon Action, Oregon Health Action Campaign, Oregonians for Health Security and Mid-Valley Health Advocates).
  - Urged a bold plan, highlighted key elements and brought several thousand public comments, including written and online petitions.
  - Acknowledged the progress of the OHFB.
  - Need for affordability, eliminating health inequities, and public outreach related.
- **Steve Dixon, Oregonians for Health Security** – covered principles of accountability with three points:
  - Hospitals, health care providers and health plans should be held publicly accountable.
  - Needs community based planning for services and technologies for creating centers of excellence and avoiding unnecessary duplication.
  - Health care and insurance charges should cover reasonable costs and not reward waste or excess profits or reserves.
- **Betty Johnson, organizer of Mid-Valley Health Care Advocates, past chair of Health Care for all of Oregon**, testified for the need for a public funded/administered health plan. Related comments of petition signers. Cited goal 6 of SB 329. Related webcast by Jacob Hacker and the merits of including public plan and his proposal called "Health Care for America." Importance of accomplishing the 15 priorities in the plan.
- **Joann Bowman, Executive Director, Oregon Action,** testified of the importance of access to health care and quality strategies.
- **Ellen Pinney, Oregon Health Action Campaign,** stressed the importance of accountability in protecting consumers. Specifically, 1) no one should be denied health care coverage, and 2) there be an

independent Ombuds office as part of transparency. Support for publicly accountable, administered, and owned plan.

- **Mallen Kear, Member of Federal Laws Committee,** thanked the Board for their efforts.

Discussion

- Request from Board that staff provide information and prototype of publicly owned health plan.
  - Barney related that he has been talking with Rocky King, Administrator of the Office of Private Partnerships and will compose such a plan and distribute.
- Request from Board to send email of the table of contents for articles from this month's "Health Affairs" journal as the issue is dedicated to health care reform.
  - Stafff will also obtain copies.

Chair Thorndike **XIII. Adjourn**

The meeting was adjourned.

The next meeting for the OHFB is June 25, 2008, at the Paradigm Conference Center, Milwaukie.

Submitted By:
Paula Hird

Reviewed By:
Barney Speight

EXHIBIT SUMMARY

1. **Agenda for 05/21/08**
2. **Kinsman Participant Survey**
3. **Delivery Recommendations**
4. **Health Equities Committee Matrix**
5. **Strategy Overview**
6. **Kinsman Handout**
7. **Public Testimony: AARP Handout**
8. **Public Testimony: OSPIRG Handout**