

Oregon Health Policy Board

AGENDA

April 12, 2011

Lane Community College

CENTER for Meeting and Learning

4000 E. 30th Avenue, Bldg 19, Room 104

Eugene, OR 97405

12:30 PM to 4:45 PM

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

#	Time	Item	Presenter	Action Item
1	12:30	Welcome, call to order and roll Action item: Consent agenda 2-8-11 minutes	Chair	X
2	12:35	Director's Report	Bruce Goldberg	
3	1:00	Health Insurance Exchange Bills Update • SB 99, HB 3137	Nora Leibowitz Amy Fauver	
4	1:45	Health Systems Transformation Team (HSTT): • Strawperson summary • Timeline • Federal permissions • Oregon Health Policy Board Committees	Health System Transformation Team Members and Bruce Goldberg, Mike Bonetto, Tina Edlund	
	2:45	Break		
5	3:00	Local Community Integration Efforts	Terry Coplin, LIPA Ken Provencher, PacificSource Bruce Abel, Lane Co. Mental Health Jeri Weeks, Comm. Health Centers Rob Rockstroh, Lane Co. H&HS Karen Gillette, Lane Co. Public Health	
6	3:30	Medicaid Update	Judy Mohr Peterson	
7	3:40	PEBB/OEBB Update	Joan Kapowich	
8	3:50	HSTT Implications for Oregon Health Policy Board Work Plan	Tina Edlund	
9	4:15	Public Testimony		
10	4:45	Adjourn		

Next meeting:

May 10, 2011

8:30 am to noon

Market Square Building

Oregon Health Policy Board
DRAFT Minutes
March 8, 2011
1515 Market Square
8:30am – noon

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. Lillian Shirley participated by phone. Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p> <p>Consent Agenda:</p> <p>Minutes from the February 8, 2011 meeting were unanimously approved.</p>
<p>Director's Report – Dr. Bruce Goldberg</p> <ul style="list-style-type: none">➤ Dr. Goldberg updated the Board on the status of the Health Insurance Exchange (HIX).➤ SB 99 is being deliberated in the Senate Health Care, Human Services, and Rural Health Policy Committee. Legislators are beginning to come to consensus with the work the Board has done around the HIX.➤ Much of the discussion of the legislators has centered around the board of the HIX.➤ The final bill that comes out of the committee is expected to look very similar to the bill the Board submitted. <p><i>This report can be found here, starting on page 5.</i></p>
<p>PEBB/OEBB Update – Joan Kapowich</p> <ul style="list-style-type: none">➤ The PEBB plan offers two medical home options: Providence and Kaiser. OEBB only has Kaiser.➤ In 2012, it is expected that both plans will expand their medical home options, and contracts will be updated to include language about care standards and payment reform. A meeting is being planned with OHA and PEBB/OEBB Board representatives to discuss joint strategies on purchasing.➤ Because PEBB had a higher than anticipated enrollment for 2011, some changes were adopted to help offset the additional cost, including increasing the emergency room co-pay to \$100 and decreasing the coverage on dental crowns. These changes will be implemented on April 1, 2011.↪ The Board asked for a report from Providence on the number of out of state providers they have in their network for PEBB members in rural areas.
<p>Medicaid Update – Judy Mohr Peterson</p> <ul style="list-style-type: none">➤ Patient-centered health homes are being explored, as well as ways to implement them within Medicaid. The Oregon Health Leadership Council has a pilot program in Medford that we are participating in. We hope to expand it and implement it elsewhere.➤ We are also exploring options to apply for a federal match to help fund patient-centered health homes.➤ General data about the Medicaid program was presented.
<p>Summary Report from January Retreat: Driving System Change Through a Medicaid/PEBB/OEBB Purchasing Strategy – Diana Bianco</p> <ul style="list-style-type: none">➤ Diana presented the main themes that came out of the small discussion groups at the January retreat.<ul style="list-style-type: none">❖ Overall, the participants felt that Medicaid, PEBB, and OEBB should be working together and that leveraging their purchasing power could make a big difference.❖ One of the challenges is that the stigma around Medicaid could make alignment and buy in difficult.❖ Delivery system reform and payment reform should occur at the same time.❖ The Health Insurance Exchange should be utilized as we move forward.❖ A focus on value-based benefits, as well as a robust primary care system is important.➤ Next steps included forming a group to create a work plan and to continue looking at the budget and metrics.

Oregon Health Insurance Rate Review Process – Teresa Miller

- Ms. Miller presented background on the Oregon Insurance Division and its rate review process.
- Financial regulation – monitors insurer finances to ensure they can pay claims
- Policy form review – reads health policies to ensure
 - ❖ Mandated benefits are included
 - ❖ Consumer protections are included
 - ❖ Compliance with new federal reform law
- Oregon's rate review law
 - ❖ Oregon has one of the strongest rate review laws in the country
 - ❖ Model for other states – only half of the states in the country have prior approval process; this means the regulator must approve market rates before they can be used
- Rate review process
 - ❖ Insurer submits rate filing at least 60 days before proposed effective date
 - ❖ Rate filing request posted on website
 - ❖ All information submitted with rate request is public
 - ❖ Includes summary of rate request with 5-year history of rate increases
- Rate review factors
 - ❖ Past and projected loss ratios
 - ❖ Medical claims costs – monthly premium vs. medical claims cost
 - ❖ Administrative costs
 - ❖ Insurer profit
 - ❖ Surplus and rate review
 - ❖ Profit (loss) in state-regulated markets
 - ❖ Benefit issues
 - ❖ Distribution of a rate increase

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

BREAK

Health System Transformation Team Update: Transformation Savings, Legislative Concepts – Bruce Goldberg and Mike Bonetto

- The Health System Transformation Team (HSTT) is made up of 45 people, including eleven legislators, stakeholders, consumers and providers.
- It's estimated that between 25-35% of care is delivered that doesn't provide value. The team divided that care into three categories.
 - ❖ Preventable conditions and lack of care coordination – With better coordinated care, we should be able to reduce inefficiency in this category by 25%.
 - ❖ Unwarranted use issues (e.g. an inappropriate diagnostic test or use of a less cost-effective treatment). This happens because of our cultural/medical/legal climate, and in a future meeting, the HSTT will discuss ways to address that.
 - ❖ Service delivery errors and inefficiencies – We intend to combat these by creating a system of robust primary care homes.
- The HSTT is working on a legislative approach that will address these issues.
- The Board was pleased with the work of the HSTT and the direction of the legislative approach.

More information on this topic can be found [here](#), beginning on page 35.

Invited testimony

Richard Harris – Assistant Director, Addictions and Mental Health Division (AMH)

- The mission of AMH is to assist Oregonians to achieve optimum physical, mental and social well being by providing access to health, mental health and addiction services and supports, to meet the needs of adults and children to live, be educated, work and participate in their communities.
- Oregon provides
 - ❖ Services to prevent and/or treat the problems created by addictions, including problem gambling
 - ❖ Services to treat major mental illness such as schizophrenia, major depression, bipolar disorder and the disabling effects of childhood trauma.
- How services are delivered
 - ❖ AMH funds services for more than 161,000 people each year through contracts with 32

mental health programs covering 36 counties, 9 mental health organizations covering the entire state, and 2 state hospitals.

- ❖ Of the total number served, 1,400 people are served in the state hospitals.
- The Oregon State Hospital (OSH) provides psychiatric treatment for people who suffer from severe and persistent mental illness and whose needs are best met in an institutional setting.

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

Joann Fuller – Director of Human Services, Multnomah County

Multnomah County's Human Services department is responsible for mental health, addictions, developmental disabilities, aging and disability services, housing and homelessness, anti-poverty services and domestic violence. Working with counties enables the state to work across issues that aren't health care focused and provide opportunities for working on psycho/social issues. Ms. Fuller stressed the connection between county mental health services and the criminal justice system. 20% of prison inmates have serious and persistent mental illness, but Medicaid won't pay for treatment there, even if they're eligible for Medicaid. She urged the Board to consider how to create a system that allows counties to continue receiving and allocating their blended funding resources in collaboration with Medicaid funding.

Jeff Heatherington – President, Family Care

Mr. Heatherington spoke about Family Care, which is an integrated physical and mental health care organization. One of the benefits of this organization is that data can be organized in one place for providers. One of the barriers Family Care faces is that it interacts with different divisions within DHS and OHA that result in two contracts and two sets of rules that sometimes contradict each other. He asked that DHS and OHA be cognizant of this as we move forward. He recommended that the Board pay attention to possible tensions between physical and mental health care providers and to mitigate them if possible.

Public Testimony

Tom Eversole – Chair of Oregon Public Health Advisory Board

Mr. Eversole provided some comments to the Action Plan. These comments are available [here](#), starting on page 79. He also urged the Board to communicate with the counties about the lessons they've learned in coordinating mental and physical care for their residents.

Mary Lou Hennrich – Director of Oregon Public Health Institute

Ms. Hennrich spoke about the importance of prevention as a driver for a healthy population. She stressed that there is more to prevention than immunizations and screenings and advocated for more funding for communities to help them become more active and get better access to healthy food.

Adjourn 12:09 pm

Next meeting:

April 12, 2011

1:00 – 4:30pm

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Bldg 19, Room 104

Eugene, OR 97405

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**Monthly Report to
Oregon Health Policy Board
April 12, 2011**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

Enrollment

- Through February 2011, **84,788** more children have been enrolled into Healthy Kids for a total child enrollment of 354, 861.
- This is 106% of our goal of 80,000 more children and a 31% increase in enrollment since June 2009 (baseline).
- 4,081 children are now enrolled in Healthy KidsConnect.
- *See the chart below for a more detailed look at Healthy Kids enrollment.*

Child Insurance Rate

- The Oregon Health Insurance Survey developed by OHPR will estimate the number of children covered by health insurance along with those currently eligible but not enrolled.
- SSRS, a national survey firm that has conducted a number of other state health insurance and status surveys, is currently fielding the survey. Phase I data will be available in mid-April and with more detailed data available in May.
- Healthy Kids has surpassed enrollment targets, but the impact of enrollment efforts on child uninsurance rates will be the best measure of Healthy Kids success thus far.

OHP Standard

- As of February 15, 2011, enrollment in OHP Standard is now **73,905**.
- There have now been fourteen random drawings to date. The last drawing was on December 15, 2010 for 10,563 names. The next drawing will occur on April 6.

Health System Transformation Team Completes Its Charge

The Team's last meeting was on Wednesday, March 23. Over the course of eight weeks, the group of industry leaders, doctors, specialists, community health workers, and state legislators convened with the goal of closing the health care budget gap, as well as creating health system delivery changes that would save money and deliver better care. There will be an in-depth review of the Team's final work products later in today's meeting.

All documents, presentations, meeting recordings and work products can be found on the Health System Transformation website:

<http://www.oregon.gov/OHA/health-system-transformation.shtml>

Legislative Update

See the attached update.

Co-Chairs Budget

The Co-Chairs of the Joint Ways and Means Committee released their 2011-2013 biennium budget on Tuesday, March 29. They describe it as being revenue-based, as opposed to expenditure-based. They also say that the efforts of the Governor and Legislature to transform Oregon's Medicaid delivery service are crucial for successfully balancing the upcoming biennium's budget.

Upcoming

Next OHPB meeting:

May 10, 2011

8:30 AM to 12:00 PM

Market Square Building

Legislative Update: Status of OHPB Bills as of 04/04/11

Changes from previous updates are in italics.

Align Purchasing

HB 3559: Uniform payment methodologies. This bill directs OHA to establish by rule uniform methodologies for payment of hospitals and ambulatory surgery centers (ASC) and for health services that are paid based on the Medicare resource-based relative value scale (RBRVS). It also requires that OHA convenes an advisory work group to assist in developing the methodologies.

Public hearing was held in House Health Care Committee on 03/21/11. No further hearings are scheduled at this time.

Some of the discussion has been around whether all payment contracts with hospitals—public and private—would be required to use this methodology or whether it should be limited to just OHA programs. Some other questions have been on who or how this would be enforced and the timeline for implementation. Rep. Kotek (who is sponsoring this bill) is hoping to have a work session scheduled soon where these issues could be resolved through an amendment. All bills have to be scheduled for a work session by this Friday, April 8th if they are to move forward this session.

Reduce Administrative Costs in Health Care

SB 94 – Administrative Simplification: This bill creates a work group within OHA to make recommendations to DCBS and OHA on administrative simplification standards which would then be codified in rule by DCBS, OHA, and DHS. This bill gives authority for DCBS to set standards for all payers, including third party administrators, managed care organizations, clearinghouses, and self-insured plans. Through discussions with stakeholders—primarily hospitals—this bill was amended to reflect that only one set of standards would be created for all payers, public and private. A federal law issue arose around a rule that requires OHA, as the single state Medicaid agency, to make its own rules for Medicaid and not be bound by another agency, such as DCBS. A compromise was made by adding language to clarify that only one set of standards will be used in the state, despite that DCBS and OHA will have separate rules, and that the two agencies will confer to ensure their rules are consistent. We also added language around what other administrative simplification issues the work group and agencies could address, including:

- *Eligibility inquiry and response;*
- *Claim submission;*
- *Payment remittance advice;*
- *Claims payment or electronic funds transfer;*
- *Claims status inquiry and response;*
- *Claims attachments;*
- *Prior authorization;*
- *Provider credentialing; or*
- *Health care financial and administrative transactions.*

Passed out of Senate Health Care Reform Subcommittee; held work sessions in the Senate Health Care, Human Services and Rural Health Policy Committee on 03/28/11 and 3/30/11.

The bill as amended moved out of the Senate committee without opposition.

Mission-Driven Public Corporation as Legal Entity for Oregon Health Insurance Exchange

SB 99: Held a work session in Senate Health Care Reform Subcommittee on 03/28/11 and 3/31/11; returned to the full Committee on 3/31/11.

The Senate's Health Care Reform Subcommittee adopted the -5 amendment to SB 99 and returned it to the Senate's full health care committee with a "do pass" recommendation. The full committee will hear the bill and this amendment this week. Some of the major issues ironed out by the subcommittee between the -3, -4, and -5 amendments included composition of the public corporation board, whether or not to allow industry representatives on the board (i.e. individuals employed or paid by health insurers or health care), the roll of agents and brokers, the authority of the public corporation to limit or accept plans or insurers, standards set by the exchange for health plans, and the fee charged to fund the exchange. The -5 amendment brings the bill back into alignment with OHPB's recommendations, including:

- *The committee returned to a 2-person exception for members of the board to also be employed in the health care or insurance industry (however, the ex officio position for the chair of OHPB or designee was removed, leaving two ex officio positions for the directors of OHA and DCBS, and 7 governor-appointed positions;*
- *The bill allows for agents/brokers to be included in accordance with the rules set by the federal government;*
- *The fee to fund the exchange was limited to being assessed only on plans within the exchange;*
- *The exchange can limit the number of plans offered in the exchange, but that limit has to apply equally to all insurers;*
- *The exchange cannot arbitrarily exclude an insurer from offering a qualified health plan in the exchange, but only plans which meet both federal standards as well as state standards are considered qualified can be offered (the exchange was given broad authority to set state standards; something eventually agreed to by the health insurers so long as plans are excluded only the basis of not meeting those standards and not for arbitrary, non-transparent reasons).*

The House Health Care Committee began hearing its own exchange bill, HB 3137, focusing on the differences between the -3, -4, -5 amendments that were considered by the Senate and the role of agents/brokers. Rep. Greenlick mentioned at the hearing on April 1, 2011 that the committee may hear concerns over negotiation power and other issues raised by consumer organizations, but the Friday hearing was primarily a preliminary review by Legislative Counsel on what each section of the bill will do. There was not discussion on specific policy decisions.

Build Healthcare Workforce

HB 2400 – Funds the primary care loan repayment program: This bill passed the House Health Care Committee but was referred to Ways and Means because of the estimated fiscal impact of \$3.1 million in General Fund. Funding for this program was not included in the Governor’s Balanced Budget or the Co-Chairs budget. Given the current budget environment and challenges, this bill faces an uphill battle. No further hearings scheduled at this time.

SB 96 – Expands the workforce database: This bill allows OHA to include all health care regulatory board licensees in the Oregon Healthcare Workforce Database, which was created in 2009 by HB 2009.

Referred to Ways & Means with a Do Pass recommendation on 03/07/11. No hearings scheduled at this time. Bills in Ways and Means are not yet receiving hearings. We will be working to have the bill scheduled for a hearing later this session.

SB 879 – Student passport: This bill directs OHA to convene work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon and report to interim legislative committee on or before June 30, 2012.

There was a lot of support for this bill at the public hearing, including from hospitals and other employers and educational institutions. This bill passed out of the Senate committee without any amendments and with the full support of the committee. It will go to the Senate floor this week.

Strengthen Medical Liability System

SB 95: Passed the Senate by a vote of 29-0 (one was absent). Referred to House Healthcare Committee.

- Ensures that an insurer cannot refuse to defend a physician being sued for malpractice because the provider disclosed an error to the patient or their family.
- Amends Oregon’s apology law to clarify that health care employers are also protected by the law.
- Current law allows the Patient Safety Commission to require reporting only of errors causing or creating a significant risk of serious *physical* injury or death. The measure gives the commission the flexibility to determine what serious adverse events can be addressed most productively through its reporting system.

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
Jul-09	271,493	0	271,493	3,648	3,648	5%
Aug-09	276,712	0	276,712	8,867	5,219	11%
Sep-09	281,374	0	281,374	13,529	4,662	17%
Oct-09	289,015	0	289,015	21,170	7,641	26%
Nov-09	294,459	0	294,459	26,614	5,444	33%
Dec-09	298,600	0	298,600	30,755	4,141	38%
Jan-10	303,026	0	303,026	35,181	4,426	44%
Feb-10	305,785	205	305,990	38,145	2,964	48%
Mar-10	309,047	549	309,596	41,751	3,606	52%
Apr-10	312,191	923	313,114	45,269	3,518	57%
May-10	314,933	1,133	316,066	48,221	2,952	60%
Jun-10	316,891	1,338	318,229	50,384	2,163	63%
Jul-10	319,878	1,662	321,540	53,695	3,311	67%
Aug-10	322,694	1,948	324,642	56,797	3,102	71%
Sep-10	326,545	2,335	328,880	61,035	4,238	76%
Oct-10	331,837	2,700	334,537	66,692	5,657	83%
Nov-10	334,120	3,046	337,166	69,321	2,629	87%
Dec-10	337,498	3,441	340,939	73,094	3,773	91%
Jan-11	342,272	3,712	345,984	78,139	5,045	98%
Feb-11	348,660	4,081	352,741	84,896	6,757	106%

Oregon Health Insurance Exchange: Oregon Health Policy Board Recommendations vs. Senate Bill 99 -5

A Comparison of the Oregon Health Policy Board Recommendations with Senate Bill 99 -5

Oregon Health Policy Board Recommendations ¹	Senate Bill 99 -5
Organization	
<p>Create a mission-driven public corporation to coordinate purchasing strategies for all Oregonians, starting with a Health Insurance Exchange for the individual and small group markets.</p>	<p>Section 2 establishes the Oregon Health Insurance Exchange Corporation as a public corporation.</p> <p>Section 2 establishes the Exchange mission to:</p>
<p>Ensure the Health Insurance Exchange has a strong, consumer-oriented mission statement rooted in the Triple Aim.</p>	<ul style="list-style-type: none"> (a) incorporate the goals of the Triple Aim; (b) administer health insurance in the public interest for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families and their employers through the Exchange; (c) Empower Oregonians by giving them the information and tools they need to make health insurance choices that meet their needs and values; (d) improve health care equality and public health, mitigate health disparities linked to race, ethnicity, primary language and similar factors, control costs and ensure access to affordable, equitable, and high-quality health care throughout the state; (e) be accountable to the public; and (f) encourage the development of new health insurance products that offer innovative benefit packages, health care delivery systems, and payment mechanisms. <p>Section 3 authorizes the board to screen, certify, recertify and decertify health plans as qualified health plans according to federal and state standards and ensure that qualified health plans provide choices of coverage.</p> <p>Section 11 requires the board to adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans. Requires plans at a minimum to provide essential health benefits and have acceptable consumer and provider satisfaction ratings.</p>

¹ Unless otherwise noted, OHPB recommendations were taken from *Building Oregon's Health Insurance Exchange: A Report to the Oregon Legislature*. Final Report, December 2010.

Oregon Health Insurance Exchange: Oregon Health Policy Board Recommendations vs. Senate Bill 99 -5
A Comparison of the Oregon Health Policy Board Recommendations with Senate Bill 99 -5

Oregon Health Policy Board Recommendations ¹	Senate Bill 99 -5
	Section 11 authorizes the corporation to enter into contracts, including but not limited to contracting with all insurers that meet the requirements to offer qualified health plans through the Exchange. The Exchange may limit the number of qualified health plans that may be offered through the Exchange as long as the same limit applies to all insurers.
Establish the Health Insurance Exchange as an organization serving individual and small business consumers across the state.	SB 99 establishes a single Exchange.
Build a single statewide Health Insurance Exchange with individual and small group product lines.	<p>Section 2 states “the corporation shall exercise and carry out statewide all the powers, rights, and privileges that are expressly conferred upon the corporation, are implied by law or are incident to such powers.”</p> <p>Under Section 11 the following individuals and groups may purchase qualified health plans through the Exchange as follows: Beginning January 1, 2014, individuals and employers with no more than 50 employees. Beginning January 1, 2016, employers with 51 to 100 employees.</p>
Establish an Oregon Exchange but investigate opportunities to work across state lines on procurement or other development and operations tasks.	<p>Section 3 broadly authorizes the board to adopt rules necessary to carry out its mission, duties and functions.</p> <p>Section 19(2) authorizes the board to “contract with any state agency or other entity for the performance of such duties, function and powers as the board or executive director considers appropriate.”</p> <p>Nothing in SB 99 would prohibit the board from adopting this recommendation.</p>
Governance/Board Composition	
Establish an Exchange Governing Board with experience and knowledge in individual insurance purchasing, business, finance, consumer retailing, health benefits administration, individual and small group health insurance, and other areas to be identified.	<p>Sections 4 and 5 establish the Exchange Governing Board:</p> <ul style="list-style-type: none"> • A nine member board with two voting ex officio members. • At least two members must be consumers. • No more than two members in total may represent the insurance and health care provider industries.
Select Board members for their experience and knowledge.	Section 4(d) requires that the non ex officio members collectively offer expertise, knowledge and experience in individual insurance purchasing, business, finance, sales, health benefits administration, individual and small group health insurance and use of the health insurance exchange.
Include Exchange Consumers as Board Members.	
Include voting ex officio members on the Exchange Board.	

Oregon Health Insurance Exchange: Oregon Health Policy Board Recommendations vs. Senate Bill 99 -5
A Comparison of the Oregon Health Policy Board Recommendations with Senate Bill 99 -5

Oregon Health Policy Board Recommendations¹	Senate Bill 99 -5
No more than two Board members will be employed by or affiliated with the health care or health insurance industry.	
Accountability/Consumer Advisory Committee	
Ensure accountability through the establishment of consumer advisory committees.	<p>Section 2 establishes a consumer-focused mission.</p> <p>Section 6 provides that the Governing Board, the Individual and Employer Consumer Advisory Committee and any other advisory and technical committees are subject to open meetings rules.</p> <p>Section 7 requires the Exchange board to establish the Individual and Employer Consumer Advisory Committee to facilitate input from a variety of stakeholders on issues related to the duties of the corporation, the operation of the Exchange and related issues.</p> <p>Section 8 authorizes the board to establish such advisory and technical committees as the board consider necessary to aid and advise the board.</p> <p>Section 21 requires the Secretary of State to</p> <ul style="list-style-type: none"> (a) annually conduct a financial audit of the Exchange; (b) biennially conduct a performance audit of the Exchange; and (c) report its findings and recommendations to OHA, OHPB, DCBS, and the appropriate federal authorities. The Exchange is required to respond within 90 days of its issuance. <p>Section 22 requires the Executive Director of the Exchange to quarterly report to the Legislature on</p> <ul style="list-style-type: none"> (a) the financial condition of the Exchange; (b) the implementation of the business plan adopted by the board; (c) the development of the information technology system for the Exchange; and (d) any other information requested by the leadership of the Legislature. <p>Section 22 requires the Exchange to annually report to the Legislature, governor, OHA and OHPB on</p> <ul style="list-style-type: none"> (a) the activities of the Exchange in the previous year; (b) the financial condition of the Exchange as of December 31 of the previous year; (c) the role of insurance producers in the Exchange; and (d) recommendations, if any, for additional groups to be eligible to purchase qualified health plans through the Exchange.

Oregon Health Insurance Exchange: Oregon Health Policy Board Recommendations vs. Senate Bill 99 -5
A Comparison of the Oregon Health Policy Board Recommendations with Senate Bill 99 -5

Oregon Health Policy Board Recommendations ¹	Senate Bill 99 -5
	<p>Section 27 makes the operation of the Exchange contingent upon legislative approval of a formal business plan submitted by the Exchange.</p> <p>Section 6 provides that board members not vote on any issue in which they have a conflict of interest.</p> <p>Section 20 requires the Exchange to perform criminal background checks on Exchange employees, and certain other individuals such as those working with IT, confidential information, and payroll.</p>
Added Value	
<p>Plans participating in the Exchange will provide value to consumers and purchasers through innovative payment methods, evidence- and value-based benefit designs, and standards for primary care, care coordination, and other elements.</p> <p>Oregon's Action Plan for Health, December 2010</p>	<p>Part of the Exchange mission under Section 2 (f) is to encourage the development of new health insurance products that offer innovative benefit packages, health care delivery systems, and payment mechanisms.</p> <p>Section 3 authorizes the board to screen, certify, recertify and decertify health plans as qualified health plans according to federal and state standards and ensure that qualified health plans provide choices of coverage.</p> <p>Section 11 requires the board to adopt by rule uniform requirements, standards and criteria for the certification of qualified health plans. Requires plans at a minimum to provide essential health benefits and have acceptable consumer and provider satisfaction ratings.</p>

**PROPOSED AMENDMENTS TO
SENATE BILL 99**

1 On page 1 of the printed bill, delete lines 4 through 30 and delete pages
2 2 through 8 and insert:

3 **“SECTION 1. Definitions. As used sections 1 to 11 and 13 to 23 of**
4 **this 2011 Act:**

5 **“(1) ‘Essential health benefits’ means the health care services**
6 **identified by the United States Secretary of Health and Human Ser-**
7 **vices pursuant to 42 U.S.C. 18022 or approved by the secretary pursuant**
8 **to a waiver granted under 42 U.S.C. 18052.**

9 **“(2) ‘Health care service contractor’ has the meaning given that**
10 **term in ORS 750.005.**

11 **“(3) ‘Health insurance’ has the meaning given that term in ORS**
12 **731.162, excluding disability income insurance.**

13 **“(4) ‘Health insurance exchange’ or ‘exchange’ means an American**
14 **Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033**
15 **and 18041 that is operated by the Oregon Health Insurance Exchange**
16 **Corporation.**

17 **“(5) ‘Health plan’ means health insurance or health care coverage**
18 **offered by an insurer.**

19 **“(6) ‘Insurer’ means an insurer as defined in ORS 731.106 that offers**
20 **health insurance, a health care service contractor or a prepaid man-**
21 **aged care health services organization.**

22 **“(7) ‘Insurance producer’ has the meaning given that term in ORS**

1 **731.104.**

2 **“(8) ‘Prepaid managed care health services organization’ has the**
3 **meaning given that term in ORS 414.736.**

4 **“(9) ‘State program’ means a program providing medical assistance,**
5 **as defined in ORS 414.025, and any health plan offered through the**
6 **Public Employees’ Benefit Board or the Oregon Educators Benefit**
7 **Board.**

8 **“SECTION 2. Oregon Health Insurance Exchange Corporation. (1)**
9 **The Oregon Health Insurance Exchange Corporation is established as**
10 **a public corporation performing governmental functions and exercis-**
11 **ing governmental powers. The corporation shall exercise and carry out**
12 **statewide all the powers, rights and privileges that are expressly con-**
13 **ferred upon the corporation, are implied by law or are incident to such**
14 **powers. Nothing in this section or section 3 or 11 of this 2011 Act is**
15 **intended to affect the regulatory responsibilities of the Department**
16 **of Consumer and Business Services under the Insurance Code.**

17 **“(2) The mission of the corporation is to:**

18 **“(a) Incorporate the goals of improving the lifelong health of all**
19 **Oregonians, increasing the quality, reliability and availability of**
20 **health insurance for all Oregonians and lowering or containing the**
21 **cost of health insurance so that health insurance is affordable to ev-**
22 **eryone.**

23 **“(b) Administer a health insurance exchange in the public interest**
24 **for the benefit of the people and businesses that obtain health insur-**
25 **ance coverage for themselves, their families and their employees**
26 **through the exchange.**

27 **“(c) Empower Oregonians by giving them the information and tools**
28 **they need to make health insurance choices that meet their needs and**
29 **values.**

30 **“(d) Improve health care quality and public health, mitigate health**

1 **disparities linked to race, ethnicity, primary language and similar**
2 **factors, control costs and ensure access to affordable, equitable and**
3 **high-quality health care throughout this state.**

4 **“(e) Be accountable to the public.**

5 **“(f) Encourage the development of new health insurance products**
6 **that offer innovative:**

7 **“(A) Benefit packages for the coverage of health care services;**

8 **“(B) Health care delivery systems; and**

9 **“(C) Payment mechanisms.**

10 **“SECTION 3. Oregon Health Insurance Exchange Corporation du-**
11 **ties, powers and functions. (1) The duties of the Oregon Health Insur-**
12 **ance Exchange Corporation are to:**

13 **“(a) Administer a health insurance exchange in accordance with**
14 **federal law to make qualified health plans available to individuals and**
15 **groups throughout this state.**

16 **“(b) Provide information in writing, through an Internet-based**
17 **clearinghouse and through a toll-free telephone line that will assist**
18 **individuals and small businesses in making informed health insurance**
19 **decisions, including:**

20 **“(A) The grade of each health plan as determined by the corpo-**
21 **ration and the grading criteria that were used;**

22 **“(B) Quality and enrollee satisfaction ratings; and**

23 **“(C) The comparative costs, benefits, provider networks of health**
24 **plans and other useful information.**

25 **“(c) Establish and make available an electronic calculator that al-**
26 **lows individuals and employers to determine the cost of coverage after**
27 **deducting any applicable tax credits or cost-sharing reduction.**

28 **“(d) Using procedures approved by the corporation’s board of di-**
29 **rectors and adopted by rule by the corporation under section 11 of this**
30 **2011 Act, screen, certify and recertify health plans as qualified health**

1 **plans according to federal and state standards and ensure that quali-**
2 **fied health plans provide choices of coverage.**

3 **“(e) Decertify or suspend, in accordance with ORS chapter 183, the**
4 **certification of health plans that fail to meet federal and state stan-**
5 **dards in order to exclude them from participation in the exchange.**

6 **“(f) Promote fair competition of carriers participating in the ex-**
7 **change by certifying multiple health plans as qualified under section**
8 **11 of this 2011 Act.**

9 **“(g) Grade health plans in accordance with criteria established by**
10 **the United States Secretary of Health and Human Services and by the**
11 **corporation.**

12 **“(h) Establish open and special enrollment periods for all enrollees,**
13 **and monthly enrollment periods for Native Americans in accordance**
14 **with federal law.**

15 **“(i) Assist individuals and groups to enroll in qualified health plans,**
16 **including defined contribution plans as defined in section 414 of the**
17 **Internal Revenue Code and, if appropriate, collect and remit premiums**
18 **for such individuals or groups.**

19 **“(j) Facilitate community-based assistance with enrollment in**
20 **qualified health plans by awarding grants to entities that are certified**
21 **as navigators as described in 42 U.S.C. 18031(i).**

22 **“(k) Provide information to individuals and employers regarding the**
23 **eligibility requirements for state medical assistance programs and as-**
24 **sist eligible individuals and families in applying for and enrolling in**
25 **the programs.**

26 **“(L) Provide employers with the names of employees who end cov-**
27 **erage under a qualified health plan during a plan year.**

28 **“(m) Certify the eligibility of an individual for an exemption from**
29 **the individual responsibility requirement of section 5000A of the**
30 **Internal Revenue Code.**

1 “(n) Provide information to the federal government necessary for
2 individuals who are enrolled in qualified health plans through the ex-
3 change to receive tax credits and reduced cost-sharing.

4 “(o) Provide to the federal government:

5 “(A) Information regarding individuals determined to be exempt
6 from the individual responsibility requirement of section 5000A of the
7 Internal Revenue Code;

8 “(B) Information regarding employees who have reported a change
9 in employer;

10 “(C) Information regarding individuals who have ended coverage
11 during a plan year; and

12 “(D) Any other information necessary to comply with federal re-
13 quirements.

14 “(p) Take any other actions necessary and appropriate to comply
15 with the federal requirements for a health insurance exchange.

16 “(q) Work in coordination with the Oregon Health Authority, the
17 Oregon Health Policy Board and the Department of Consumer and
18 Business Services in carrying out its duties.

19 “(2) The corporation may sue and be sued.

20 “(3) The corporation may:

21 “(a) Acquire, lease, rent, own and manage real property.

22 “(b) Construct, equip and furnish buildings or other structures as
23 are necessary to accommodate the needs of the corporation.

24 “(c) Purchase, rent, lease or otherwise acquire for the corporation’s
25 use all supplies, materials, equipment and services necessary to carry
26 out the corporation’s duties.

27 “(d) Sell or otherwise dispose of any property acquired under this
28 subsection.

29 “(4) Any real property acquired and owned by the corporation under
30 this section shall be subject to ad valorem taxation.

1 “(5) The corporation may adopt rules necessary to carry out its
2 mission, duties and functions.

3 “SECTION 4. Board of directors; appointment; membership; re-
4 moval of members. (1) The Oregon Health Insurance Exchange Cor-
5 poration shall be governed by a board of directors consisting of two
6 ex officio members and seven members who are appointed by the
7 Governor and subject to confirmation by the Senate in the manner
8 prescribed by ORS 171.562 and 171.565.

9 “(2) The ex officio voting members of the board are:

10 “(a) The Director of the Oregon Health Authority or the director’s
11 designee; and

12 “(b) The Director of the Department of Consumer and Business
13 Services or the director’s designee.

14 “(3)(a) The term of office of each member who is not an ex officio
15 member is four years. The Governor may remove any member at any
16 time for incompetence, neglect of duty or malfeasance in office, after
17 notice and a hearing that shall be open to the public, but the Governor
18 may not remove more than three members within any four-year period
19 except for corrupt conduct in office.

20 “(b) Before the expiration of the term of a member who is not an
21 ex officio member, the Governor shall appoint a successor whose term
22 begins on January 1 next following. A member who is not an ex officio
23 member is eligible for no more than two reappointments. If there is
24 a vacancy for any cause, the Governor shall make an appointment to
25 become immediately effective for the unexpired term.

26 “(4) The members who are not ex officio members must be individ-
27 uals who:

28 “(a) Are United States citizens and residents of the State of Oregon;

29 “(b) Have demonstrated professional and community leadership
30 skills and experience;

1 “(c) To the greatest extent practicable, represent the geographic,
2 ethnic, gender, racial and economic diversity of this state; and

3 “(d) Subject to subsections (5) and (6) of this section, collectively
4 offer expertise, knowledge and experience in individual insurance
5 purchasing, business, finance, sales, health benefits administration,
6 individual and small group health insurance and use of the health in-
7 surance exchange.

8 “(5) No more than two of the members who are not ex officio
9 members may be individuals who are:

10 “(a) Employed by, consultants to or members of a board of directors
11 of:

12 “(A) An insurer or third party administrator;

13 “(B) An insurance producer; or

14 “(C) A health care provider, health care facility or health clinic;

15 “(b) Members, board members or employees of a trade association
16 of:

17 “(A) Insurers or third party administrators; or

18 “(B) Health care providers, health care facilities or health clinics;

19 or

20 “(c) Health care providers, unless they receive no compensation for
21 rendering services as health care providers and do not have ownership
22 interests in professional health care practices.

23 “(6)(a) At least two of the members who are not ex officio members
24 shall be consumer members.

25 “(b) One consumer member must be an individual consumer pur-
26 chasing a qualified health plan through the exchange.

27 “(c) One consumer member must be a small business employer
28 purchasing a qualified health plan through the exchange.

29 “(7) The board of directors shall adopt a formal business plan for
30 the corporation, which shall include a plan for developing metrics to

1 measure customer service and provider satisfaction, and shall estab-
2 lish the policies for the operation of the exchange, consistent with
3 state and federal law.

4 **“SECTION 5. Transition and implementation.** (1) Notwithstanding
5 the term of office specified by section 4 of this 2011 Act, of the mem-
6 bers first appointed to the Oregon Health Insurance Exchange Corpo-
7 ration board of directors who are not ex officio members:

8 **“(a) Two shall serve for terms ending December 31, 2013.**

9 **“(b) Two shall serve for terms ending December 31, 2014.**

10 **“(c) Three shall serve for terms ending on the earlier of four years**
11 **after appointment or December 31, 2015.**

12 **“(2) Notwithstanding section 4 (6) of this 2011 Act, until qualified**
13 **health plans become available for purchase through the health insur-**
14 **ance exchange, the consumer members shall be individuals or small**
15 **business employers that will be eligible under section 11 (1) of this 2011**
16 **Act to purchase qualified health plans through the exchange. One of**
17 **the consumer members shall serve for one of the terms ending De-**
18 **cember 31, 2013, and one shall serve for one of the terms ending De-**
19 **cember 31, 2014.**

20 **“(3) Notwithstanding section 6 (1) of this 2011 Act, the Governor**
21 **shall select from the membership of the board the chairperson and the**
22 **vice chairperson, who shall serve for the first two years of the board’s**
23 **operation.**

24 **“(4) Notwithstanding section 9 of this 2011 Act, the Governor may**
25 **appoint an interim executive director of the corporation, who may**
26 **serve for a period of no more than 120 days.**

27 **“(5) The President of the Senate, the Senate Minority Leader, the**
28 **Speaker of the House of Representatives and the House Minority**
29 **Leader shall each select one member from their respective chambers**
30 **to serve on a committee that will provide advice to and legislative**

1 oversight of the corporation during the implementation of the corpo-
2 ration and the exchange. In the event that there are Co-Presidents or
3 Co-Speakers, each Co-President or Co-Speaker shall select one member
4 to serve on the committee. The committee may:

5 “(a) Recommend individuals for nomination to the board;

6 “(b) Review the development of the formal business plan of the
7 corporation, including proposals developed by the staff of the corpo-
8 ration or the Oregon Health Authority to be presented to the board;
9 and

10 “(c) Advise the corporation and the Oregon Health Authority on
11 any other matters concerning the implementation of the health in-
12 surance exchange.

13 “(6) The Oregon Health Authority shall regularly report to the
14 Legislative Fiscal Office on the implementation of an information
15 technology system for the exchange, including:

16 “(a) The business case for the project;

17 “(b) Requirements analyses;

18 “(c) Any requests for proposals and statements of work;

19 “(d) The project charter;

20 “(e) The project work plan or schedule;

21 “(f) The project financial plan;

22 “(g) The hiring of the quality assurance contractor; and

23 “(h) All quality assurance reports.

24 “(7) The corporation shall report the information described in sub-
25 section (6) of this section to the appropriate interim committees of the
26 Legislative Assembly no later than October 3, 2011 and to the Joint
27 Committee on Ways and Means during the 2012 regular session of the
28 Legislative Assembly.

29 “(8) The corporation shall deliver and report to the appropriate in-
30 terim committees and to the Joint Committee on Ways and Means

1 before the convening of the 2012 regular session of the Legislative As-
2 sembly:

3 “(a) The formal business plan adopted by the board of directors of
4 the corporation; or

5 “(b) If the board has not adopted the formal business plan, the draft
6 business plan to be considered or under consideration by the board.

7 “(9) No later than February 1, 2012, the corporation shall deliver to
8 the Legislative Assembly the formal business plan adopted by the
9 board in accordance with section 4 (7) of this 2011 Act.

10 **“SECTION 6. Meetings of board.** (1) The Oregon Health Insurance
11 Exchange Corporation board of directors shall select one of its mem-
12 bers as chairperson and another as vice chairperson, for such terms
13 and with duties and powers necessary for the performance of the
14 functions of those offices as the board determines.

15 “(2) A majority of the members of the board constitutes a quorum
16 for the transaction of business.

17 “(3) The board shall meet at least once every three months at a
18 place, day and hour determined by the board. The board shall meet
19 at such other times and places specified by the call of the chairperson
20 or of a majority of the members of the board.

21 “(4)(a) Whenever a member of the board has a conflict of interest
22 on an issue that is before the board, the member shall declare to the
23 board the nature of the conflict and the declaration shall be recorded
24 in the official records of the board. The member may participate in
25 any discussion on the issue but may not vote on the issue.

26 “(b) As used in this subsection:

27 “(A) ‘Business’ has the meaning given that term in ORS 244.020.

28 “(B) ‘Business with which the member or the member’s relative is
29 associated’ has the meaning given the term ‘business with which the
30 person is associated’ in ORS 244.020.

1 “(C) ‘Conflict of interest’ means that by taking any action or mak-
2 ing any decision or recommendation on an issue, the member, the
3 member’s relative, or any business with which the member or the
4 member’s relative is associated, would receive a private pecuniary
5 benefit or detriment, unless the pecuniary benefit or detriment would
6 affect to the same degree a class consisting of all consumers of or
7 payers for health care in this state.

8 “(5) A member of the board is entitled to compensation and ex-
9 penses as provided in ORS 292.495, subject to the availability of funds
10 in the Oregon Health Insurance Exchange Fund.

11 “(6) ORS 192.610 to 192.690 apply to the board, to the Individual and
12 Employer Consumer Advisory Committee established by section 7 of
13 this 2011 Act and to any advisory and technical committees established
14 by the board under section 8 of this 2011 Act.

15 “SECTION 7. Individual and Employer Consumer Advisory Com-
16 mittee. (1) The Oregon Health Insurance Exchange Corporation board
17 of directors shall establish an Individual and Employer Consumer Ad-
18 visory Committee for the purpose of facilitating input from a variety
19 of stakeholders on issues related to the duties of the corporation, the
20 operation of the health insurance exchange and related issues. The
21 board shall determine the membership, terms and organization of the
22 committee and shall appoint the members. Members of the committee
23 shall be representative of:

24 “(a) Individuals and employers that purchase health plans through
25 the exchange;

26 “(b) Individuals who enroll in state medical assistance through the
27 exchange;

28 “(c) Racial and ethnic minorities in this state;

29 “(d) All geographic regions of this state; and

30 “(e) Organizations that help individuals to enroll in health plans

1 through the exchange, including insurance producers and advocates
2 for hard-to-reach populations.

3 “(2) Members of the committee who are not members of the board
4 are not entitled to compensation, but at the discretion of the board
5 may be reimbursed from funds available to the board for actual and
6 necessary travel and other expenses incurred by them in the per-
7 formance of their official duties, in the manner and amount provided
8 in ORS 292.495.

9 “SECTION 8. Authority of board to establish advisory and technical
10 committees. (1) In addition to the Individual and Employer Consumer
11 Advisory Committee established under section 7 of this 2011 Act, the
12 Oregon Health Insurance Exchange Corporation board of directors
13 may establish such advisory and technical committees as the board
14 considers necessary to aid and advise the board in the performance of
15 the board’s functions. These committees may be continuing or tem-
16 porary committees. The board shall determine the representation,
17 membership, terms and organization of the committees and shall ap-
18 point the members of the committees. In lieu of establishing an advi-
19 sory or technical committee, the board may directly solicit input and
20 assistance from insurance producers that assist small businesses, car-
21 riers that offer qualified health plans through the exchange and health
22 care professionals.

23 “(2) Members of the committees who are not members of the board
24 are not entitled to compensation, but at the discretion of the board
25 may be reimbursed from funds available to the board for actual and
26 necessary travel and other expenses incurred by them in the per-
27 formance of their official duties, in the manner and amount provided
28 in ORS 292.495.

29 “SECTION 9. Executive director; appointment; functions. (1) The
30 Oregon Health Insurance Exchange Corporation is under the super-

1 **vision of an executive director appointed by the corporation board of**
2 **directors. The executive director serves at the pleasure of the board.**
3 **The executive director shall be paid a salary as prescribed by the**
4 **board.**

5 **“(2) Before assuming the duties of the office, the executive director**
6 **shall:**

7 **“(a) Give to the state a fidelity bond, with one or more corporate**
8 **sureties authorized to do business in this state, in a penal sum pre-**
9 **scribed by the Director of the Oregon Department of Administrative**
10 **Services, but not less than \$50,000. The premium for the bond shall be**
11 **paid from the Oregon Health Insurance Exchange Fund.**

12 **“(b) Subscribe to an oath that the executive director faithfully and**
13 **impartially will discharge the duties of the office and that the execu-**
14 **tive director will support the Constitution of the United States and the**
15 **Constitution of the State of Oregon. The executive director shall file**
16 **a copy of the signed oath with the Secretary of State.**

17 **“(3) The executive director may establish a line of credit under ORS**
18 **293.214 and has such other powers as are necessary to carry out the**
19 **duties of the corporation, subject to policy direction by the board.**

20 **“(4) The executive director may employ, supervise and terminate**
21 **the employment of such staff as the executive director deems neces-**
22 **sary. The executive director shall prescribe their duties and fix their**
23 **compensation, in accordance with the personnel policies adopted by**
24 **the board. Employees of the corporation may not be individuals who**
25 **are:**

26 **“(a) Employed by, consultants to or members of a board of directors**
27 **of:**

28 **“(A) An insurer or third party administrator;**

29 **“(B) An insurance producer; or**

30 **“(C) A health care provider, health care facility or health clinic;**

1 **“(b) Members, board members or employees of a trade association**
2 **of:**

3 **“(A) Insurers or third party administrators; or**

4 **“(B) Health care providers, health care facilities or health clinics;**
5 **or**

6 **“(c) Health care providers, unless they receive no compensation for**
7 **rendering services as health care providers and do not have ownership**
8 **interests in professional health care practices.**

9 **“(5) The board shall adopt personnel policies, subject to ORS 236.605**
10 **to 236.640, for any transferred public employees. The board may elect**
11 **to provide for participation in a health benefit plan available to state**
12 **employees pursuant to ORS 243.105 to 243.285 and may elect to partic-**
13 **ipate in the state deferred compensation plan established under ORS**
14 **243.401 to 243.507. If the board so elects, employees of the corporation**
15 **shall be considered eligible employees for purposes of ORS 243.105 to**
16 **243.285 and eligible state employees for purposes of ORS 243.401 to**
17 **243.507.**

18 **“(6) With respect to the Public Employees Retirement System, em-**
19 **ployees of the corporation shall be considered employees for purposes**
20 **of ORS chapter 238 and eligible employees for purposes of ORS chapter**
21 **238A.**

22 **“(7) Employees of the corporation may participate in collective**
23 **bargaining in accordance with ORS 243.650 to 243.782.**

24 **“SECTION 10. Operational assistance by the Oregon Health Au-**
25 **thority. (1) The Oregon Health Authority shall provide staff and re-**
26 **sources and take actions the authority deems necessary or appropriate**
27 **to develop and assist in the organization and implementation of the**
28 **Oregon Health Insurance Exchange Corporation and to ensure com-**
29 **pliance with the requirements for an American Health Benefit Ex-**
30 **change under 42 U.S.C. 18031, 18032, 18033 and 18041 and other**

1 applicable federal laws.

2 “(2) The authority may apply for and accept federal grants, other
3 federal funds and grants from nongovernmental organizations for
4 purposes of developing and implementing the health insurance ex-
5 change and carrying out the functions and duties described in sub-
6 section (1) of this section. Moneys received by the authority under this
7 section are continuously appropriated to the authority for purposes
8 of this section.

9 **“SECTION 11. Operations of the health insurance exchange. (1) The**
10 **following individuals and groups may purchase qualified health plans**
11 **through the health insurance exchange:**

12 “(a) Beginning January 1, 2014, individuals and employers with no
13 more than 50 employees.

14 “(b) Beginning January 1, 2016, employers with 51 to 100 employees.

15 “(2)(a) Only individuals who purchase health plans through the ex-
16 change may be eligible to receive premium tax credits under section
17 36B of the Internal Revenue Code and reduced cost-sharing under 42
18 U.S.C. 18071.

19 “(b) Only employers that purchase health plans through the ex-
20 change may be eligible to receive small employer health insurance
21 credits under section 45R of the Internal Revenue Code.

22 “(3) Only an insurer that has a certificate of authority to transact
23 insurance in this state and that meets applicable federal requirements
24 for participating in the exchange may offer a qualified health plan
25 through the exchange. Any qualified health plan must be certified
26 under subsection (4) of this section. Prepaid managed care health
27 services organizations that do not have a certificate of authority to
28 transact insurance may serve only medical assistance recipients
29 through the exchange and may not offer qualified health plans.

30 “(4) The Oregon Health Insurance Exchange Corporation shall

1 adopt by rule uniform requirements, standards and criteria for the
2 certification of qualified health plans, including requirements that a
3 qualified health plan provide, at a minimum, essential health benefits
4 and have acceptable consumer and provider satisfaction ratings. The
5 corporation may limit the number of qualified health plans that may
6 be offered through the exchange as long as the same limit applies to
7 all insurers.

8 “(5) Notwithstanding subsection (4) of this section, the corporation
9 shall certify as qualified a dental only health plan as permitted by
10 federal law.

11 “(6) The corporation shall establish one streamlined and seamless
12 application and enrollment process for both the exchange and the state
13 medical assistance program.

14 “(7) The corporation, in collaboration with the appropriate state
15 authorities, may establish risk mediation programs within the ex-
16 change.

17 “(8) The corporation shall establish by rule a process for certifying
18 insurance producers to facilitate the transaction of insurance through
19 the exchange, in accordance with federal standards and policies.

20 “(9) The corporation shall ensure, as required by federal laws, that
21 an insurer charges the same premiums for plans sold through the ex-
22 change as for identical plans sold outside of the exchange.

23 “(10) The corporation is authorized to enter into contracts for the
24 performance of duties, functions or operations of the exchange, in-
25 cluding but not limited to contracting with:

26 “(a) All insurers that meet the requirements of subsections (3) and
27 (4) of this section, to offer qualified health plans through the ex-
28 change; and

29 “(b) Navigators certified by the corporation under section 3 of this
30 2011 Act.

1 “(11) **The corporation is authorized to apply for and accept federal**
2 **grants, other federal funds and grants from nongovernmental organ-**
3 **izations for purposes of developing, implementing and administering**
4 **the exchange. Moneys received under this subsection shall be deposited**
5 **in and credited to the Oregon Health Insurance Exchange Fund es-**
6 **tablished under section 18 of this 2011 Act.**

7 “SECTION 12. Section 11 of this 2011 Act is amended to read:

8 “**Sec. 11.** (1) [*The following individuals and groups*] **Individuals and**
9 **employers with no more than 100 employees** may purchase qualified
10 health plans through the health insurance exchange[:].

11 “[(a) *Beginning January 1, 2014, individuals and employers with no more*
12 *than 50 employees.*]

13 “[(b) *Beginning January 1, 2016, employers with 51 to 100 employees.*]

14 “(2)(a) Only individuals who purchase health plans through the exchange
15 may be eligible to receive premium tax credits under section 36B of the
16 Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

17 “(b) Only employers that purchase health plans through the exchange may
18 be eligible to receive small employer health insurance credits under section
19 45R of the Internal Revenue Code.

20 “(3) Only an insurer that has a certificate of authority to transact insur-
21 ance in this state and that meets applicable federal requirements for partic-
22 ipating in the exchange may offer a qualified health plan through the
23 exchange. Any qualified health plan must be certified under subsection (4)
24 of this section. Prepaid managed care health services organizations that do
25 not have a certificate of authority to transact insurance may serve only
26 medical assistance recipients through the exchange and may not offer quali-
27 fied health plans.

28 “(4) The Oregon Health Insurance Exchange Corporation shall adopt by
29 rule uniform requirements, standards and criteria for the certification of
30 qualified health plans, including requirements that a qualified health plan

1 provide, at a minimum, essential health benefits and have acceptable con-
2 sumer and provider satisfaction ratings. The corporation may limit the
3 number of qualified health plans that may be offered through the exchange
4 as long as the same limit applies to all insurers.

5 “(5) Notwithstanding subsection (4) of this section, the corporation shall
6 certify as qualified a dental only health plan as permitted by federal law.

7 “(6) The corporation shall establish one streamlined and seamless appli-
8 cation and enrollment process for both the exchange and the state medical
9 assistance program.

10 “(7) The corporation, in collaboration with the appropriate state authori-
11 ties, may establish risk mediation programs within the exchange.

12 “(8) The corporation shall establish by rule a process for certifying in-
13 surance producers to facilitate the transaction of insurance through the ex-
14 change, in accordance with federal standards and policies.

15 “(9) The corporation shall ensure, as required by federal laws, that an
16 insurer charges the same premiums for plans sold through the exchange as
17 for identical plans sold outside of the exchange.

18 “(10) The corporation is authorized to enter into contracts for the per-
19 formance of duties, functions or operations of the exchange, including but
20 not limited to contracting with:

21 “(a) Insurers that meet the requirements of subsections (3) and (4) of this
22 section, to offer qualified health plans through the exchange; and

23 “(b) Navigators certified by the corporation under section 3 of this 2011
24 Act.

25 “(11) The corporation is authorized to apply for and accept federal grants,
26 other federal funds and grants from nongovernmental organizations for pur-
27 poses of developing, implementing and administering the exchange. Moneys
28 received under this subsection shall be deposited in and credited to the
29 Oregon Health Insurance Exchange Fund established under section 18 of this
30 2011 Act.

1 **“SECTION 13. Federal law compliance. (1) To the extent that there**
2 **is any conflict between sections 1 to 11 and 13 to 23 of this 2011 Act**
3 **and the Patient Protection and Affordable Care Act, P.L. 111-148, as**
4 **amended by the Health Care and Education Reconciliation Act of 2010,**
5 **P.L. 111-152, the federal law in effect on the date the Legislative As-**
6 **sembly enacts sections 1 to 11 and 13 to 23 of this 2011 Act controls.**

7 **“(2) In all cases where federally granted funds are involved and the**
8 **applicable federal laws, rules and regulations conflict with any pro-**
9 **vision of sections 1 to 11 and 13 to 23 of this 2011 Act, or require ad-**
10 **ditional conditions not required under state statute, the applicable**
11 **federal requirement governs.**

12 **“SECTION 14. Information required by the exchange. (1)(a) The**
13 **Oregon Health Insurance Exchange Corporation shall adopt by rule**
14 **the information that must be documented in order for a person to**
15 **qualify for:**

16 **“(A) Health plan coverage through the health insurance exchange;**

17 **“(B) Premium tax credits; and**

18 **“(C) Cost-sharing reductions.**

19 **“(b) The documentation specified by the corporation under this**
20 **subsection shall include but is not limited to documentation of:**

21 **“(A) The identity of the person;**

22 **“(B) The status of the person as a United States citizen, or lawfully**
23 **admitted noncitizen, and a resident of this state;**

24 **“(C) Information concerning the income and resources of the per-**
25 **son as necessary to establish the person’s financial eligibility for cov-**
26 **erage, for premium tax credits and for cost-sharing reductions, which**
27 **may include income tax return information and a Social Security**
28 **number; and**

29 **“(D) Employer identification information and employer-sponsored**
30 **health insurance coverage information applicable to the person.**

1 “(2) The corporation shall adopt by rule the information that must
2 be documented in order to determine whether the person is exempt
3 from a requirement to purchase or be enrolled in a health plan under
4 section 5000A of the Internal Revenue Code or other federal law.

5 “(3) The corporation shall implement systems that provide elec-
6 tronic access to, and use, disclosure and validation of data needed to
7 administer the duties, functions and operation of the corporation, to
8 comply with federal data access and data exchange requirements and
9 to streamline and simplify processes of the corporation.

10 “(4) Information and data that the corporation obtains under this
11 section may be exchanged with other state or federal health insurance
12 exchanges, with state or federal agencies and, subject to section 15 of
13 this 2011 Act, for the purpose of carrying out exchange responsibilities,
14 including but not limited to:

15 “(a) Establishing and verifying eligibility for:

16 “(A) A state medical assistance program;

17 “(B) The purchase of health plans through the exchange; and

18 “(C) Any other programs that are offered through the exchange;

19 “(b) Establishing and verifying the amount of a person’s federal tax
20 credit, cost-sharing reduction or premium assistance;

21 “(c) Establishing and verifying eligibility for exemption from the
22 requirement to purchase or be enrolled in a health plan under section
23 5000A of the Internal Revenue Code or other federal law;

24 “(d) Complying with other federal requirements; or

25 “(e) Improving the operations of the exchange and other programs
26 administered by the corporation and for program analysis.

27 “SECTION 15. Information that is confidential or not subject to
28 disclosure; public officer privilege; permitted uses of confidential in-
29 formation. (1) Except as provided in subsection (3) of this section,
30 documents, materials or other information that is in the possession

1 or control of the Oregon Health Insurance Exchange Corporation for
2 the purpose of carrying out sections 3, 11 and 14 of this 2011 Act or
3 complying with federal health insurance exchange requirements, and
4 that is protected from disclosure by state or federal law, remains
5 confidential and is not subject to disclosure under ORS 192.410 to
6 192.505 or subject to subpoena or discovery or admissible into evidence
7 in any private civil action in which the corporation is not a named
8 party. The executive director of the corporation may use confidential
9 documents, materials or other information without further disclosure
10 in order to carry out the duties described in sections 3, 11 and 14 of
11 this 2011 Act or to take any legal or regulatory action authorized by
12 law.

13 “(2) Documents, materials and other information to which sub-
14 section (1) of this section applies is subject to the public officer privi-
15 lege described in ORS 40.270.

16 “(3) In order to assist in the performance of the executive director’s
17 duties, the executive director may:

18 “(a) Authorize the sharing of confidential documents, materials or
19 other information that is subject to subsection (1) of this section
20 within the corporation and subject to any conditions on further dis-
21 closure, for the purpose of carrying out the duties and functions of the
22 corporation or complying with federal health insurance exchange re-
23 quirements.

24 “(b) Authorize the sharing of confidential documents, materials or
25 other information that is subject to subsection (1) of this section or
26 that is otherwise confidential under ORS 192.501 or 192.502 with other
27 state or federal health insurance exchanges or regulatory authorities,
28 the Oregon Health Authority, the Department of Consumer and Busi-
29 ness Services, law enforcement agencies and federal authorities, if re-
30 quired or authorized by state or federal law and if the recipient agrees

1 to maintain the confidentiality of the documents, materials or other
2 information.

3 “(c) Receive documents, materials or other information, including
4 documents, materials or other information that is otherwise confi-
5 dential, from other state or federal health insurance exchanges or
6 regulatory authorities, the Oregon Health Authority, the Department
7 of Consumer and Business Services, law enforcement agencies or fed-
8 eral authorities. The executive director shall maintain the
9 confidentiality requested by the sender of the documents, materials
10 or other information received under this section as necessary to com-
11 ply with the laws of the jurisdiction from which the documents, ma-
12 terials or other information was received and originated.

13 “(4) The disclosure of documents, materials or other information
14 to the executive director under this section, or the sharing of docu-
15 ments, materials or other information as authorized in subsection (3)
16 of this section, does not waive any applicable privileges or claims of
17 confidentiality in the documents, materials or other information.

18 “(5) This section does not prohibit the executive director from re-
19 leasing to a database or other clearinghouse service maintained by
20 federal authorities a final, adjudicated order, including a certification,
21 recertification, suspension or decertification of a qualified health plan
22 under section 3 of this 2011 Act, if the order is otherwise subject to
23 public disclosure.

24 “SECTION 16. Agreements with other agencies regarding sharing
25 and use of confidential information; contents. (1) The executive direc-
26 tor of the Oregon Health Insurance Exchange Corporation may enter
27 into agreements governing the sharing and use of information con-
28 sistent with this section and section 15 of this 2011 Act with other state
29 or federal health insurance exchanges or regulatory authorities, the
30 Oregon Health Authority, the Department of Consumer and Business

1 Services, law enforcement agencies or federal authorities.

2 “(2) An agreement under this section must specify the duration of
3 the agreement, the purpose of the agreement, the methods that may
4 be employed for terminating the agreement and any other necessary
5 and proper matters.

6 “(3) An agreement under this section does not relieve the executive
7 director of any obligation or responsibility imposed by law.

8 “(4) The executive director may expend funds and may supply ser-
9 vices for the purpose of carrying out an agreement under this section.

10 “(5) Agreements under this section are exempt from ORS 190.410 to
11 190.440 and 190.480 to 190.490.

12 **“SECTION 17. Charges and fees.** (1) The Oregon Health Insurance
13 Exchange Corporation board of directors shall establish, and the cor-
14 poration shall impose and collect, an administrative charge from all
15 insurers and state programs participating in the health insurance ex-
16 change in an amount sufficient to cover the costs of grants to
17 navigators certified under section 3 of this 2011 Act and to pay the
18 administrative and operational expenses of the corporation in carrying
19 out sections 1 to 11 and 13 to 23 of this 2011 Act. The charge shall be
20 paid in a manner and at intervals prescribed by the board and shall
21 be deposited in the Oregon Health Insurance Exchange Fund estab-
22 lished in section 18 of this 2011 Act.

23 “(2) Each insurer’s charge shall be based on the number of indi-
24 viduals, excluding individuals enrolled in state programs, who are en-
25 rolled in health plans offered by the insurer through the exchange.
26 The assessment on each state program shall be based on the number
27 of individuals enrolled in state programs offered through the ex-
28 change. The charge may not exceed:

29 “(a) Five percent of the premium or other monthly charge for each
30 enrollee if the number of enrollees receiving coverage through the

1 exchange is at or below 175,000;

2 “(b) Four percent of the premium or other monthly charge for each
3 enrollee if the number of enrollees receiving coverage through the
4 exchange is above 175,000 and at or below 300,000; and

5 “(c) Three percent of the premium or other monthly charge for
6 each enrollee if the number of enrollees receiving coverage through
7 the exchange is above 300,000.

8 “(3) If charges collected under subsection (1) of this section exceed
9 the amounts needed for the administrative and operational expenses
10 of the corporation, the excess moneys collected shall be held and in-
11 vested and, with the earnings and interest, used by the corporation to
12 offset future net losses or reduce the administrative costs of the cor-
13 poration. The maximum amount of excess moneys that may be held
14 under this subsection is the total administrative and operational ex-
15 penses anticipated by the corporation for a six-month period. Any
16 moneys received that exceed the maximum shall be applied by the
17 corporation to reduce the charges imposed by this section.

18 “(4) Charges shall be based on annual statements and other reports
19 deemed necessary by the corporation and filed by an insurer or state
20 program with the exchange.

21 “(5) In addition to charges imposed under subsection (1) of this
22 section, to the extent permitted by federal law the corporation may
23 impose a fee on insurers and state programs participating in the ex-
24 change to cover the cost of commissions of insurance producers that
25 are certified by the corporation to facilitate the participation of indi-
26 viduals and employers in the exchange.

27 “(6) The board shall establish the charges and fees under this sec-
28 tion in accordance with ORS 183.310 to 183.410 and in such a manner
29 that will reasonably and substantially accomplish the objective of
30 subsections (1) and (5) of this section.

1 **“SECTION 18. Oregon Health Insurance Exchange Fund.** The
2 **Oregon Health Insurance Exchange Fund** is established in the State
3 **Treasury, separate and distinct from the General Fund.** Interest
4 **earned by the Oregon Health Insurance Exchange Fund shall be cred-**
5 **ited to the fund. The Oregon Health Insurance Exchange Fund con-**
6 **sists of moneys received by the Oregon Health Insurance Exchange**
7 **Corporation through premiums or the imposition of fees under section**
8 **17 of this 2011 Act and moneys received as grants under section 11 of**
9 **this 2011 Act. Moneys in the fund are continuously appropriated to the**
10 **Oregon Health Insurance Exchange Corporation for carrying out the**
11 **purposes of sections 1 to 11 and 13 to 23 of this 2011 Act.**

12 **“SECTION 19. Oregon Health Insurance Exchange Corporation ex-**
13 **empt from certain laws; contracts with state agencies for services.** (1)
14 **Except as otherwise provided by law, the provisions of ORS 279.835 to**
15 **279.855 and ORS chapters 240, 276, 279A, 279B, 279C, 282, 283, 291, 292**
16 **and 293 do not apply to the Oregon Health Insurance Exchange Cor-**
17 **poration.**

18 **“(2) In carrying out the duties, functions and powers imposed by**
19 **law upon the corporation, the corporation board of directors or the**
20 **executive director of the corporation may contract with any state**
21 **agency or other qualified person or entity for the performance of such**
22 **duties, functions and powers as the board or executive director con-**
23 **siders appropriate.**

24 **“(3) ORS 30.210 to 30.250, 30.260 to 30.300, 30.310, 30.312, 30.390 and**
25 **30.400 apply to the members of the board, the executive director and**
26 **employees of the corporation.**

27 **“(4) Notwithstanding subsection (1) of this section, ORS 293.235,**
28 **293.240, 293.245, 293.260, 293.262, 293.611, 293.625 and 293.630 apply to the**
29 **accounts of the corporation.**

30 **“(5) Notwithstanding subsections (1) and (2) of this section, ORS**

1 243.305, 279A.100 and 659A.012 apply to the members of the board,
2 executive director and employees of the corporation.

3 **“SECTION 20. Criminal records check; fingerprints required; per-**
4 **sons subject to requirement.** The Oregon Health Insurance Exchange
5 Corporation shall conduct a state or nationwide criminal records
6 check under ORS 181.534 on, and for that purpose may require the
7 fingerprints of a person who:

8 **“(1) Is employed by or applying for employment with the corpo-**
9 **ration; or**

10 **“(2) Is, or will be, providing services to the corporation in a posi-**
11 **tion:**

12 **“(a) In which the person is providing information technology ser-**
13 **VICES and has control over, or access to, information technology sys-**
14 **tems that would allow the person to harm the information technology**
15 **systems or the information contained in the systems;**

16 **“(b) In which the person has access to information that is confi-**
17 **dential or for which state or federal laws, rules or regulations prohibit**
18 **disclosure;**

19 **“(c) That has payroll functions or in which the person has respon-**
20 **sibility for receiving, receipting or depositing money or negotiable in-**
21 **struments, for billing, collections or other financial transactions or for**
22 **purchasing or selling property or has access to property held in trust**
23 **or to private property in the temporary custody of the corporation;**

24 **“(d) That has mailroom duties as a primary duty or job function;**

25 **“(e) In which the person has responsibility for auditing the corpo-**
26 **ration;**

27 **“(f) That has personnel or human resources functions as a primary**
28 **responsibility;**

29 **“(g) In which the person has access to Social Security numbers,**
30 **dates of birth or criminal background information; or**

1 “(h) In which the person has access to tax or financial information
2 about individuals or business entities.

3 “SECTION 21. Financial and performance audits of Oregon Health
4 Insurance Exchange Corporation and Oregon Health Insurance Ex-
5 change Fund; report of audit. (1) The Oregon Health Insurance Ex-
6 change Corporation shall keep an accurate accounting of the operation
7 and all activities, receipts and expenditures of the corporation and the
8 health insurance exchange.

9 “(2) Beginning after the first 12 months of the operation of the ex-
10 change and every 12 months thereafter, the Secretary of State shall
11 conduct a financial audit of the corporation and the fund pursuant to
12 ORS 297.210, which shall include but is not limited to:

13 “(a) A review of the sources and uses of the moneys in the fund;

14 “(b) A review of charges and fees imposed and collected pursuant
15 to section 17 of this 2011 Act; and

16 “(c) A review of premiums collected and remitted.

17 “(3) Beginning after the first 24 months of the operation of the ex-
18 change and every two years thereafter, the Secretary of State shall
19 conduct a performance audit of the corporation and the exchange.

20 “(4) The corporation board of directors, the executive director of the
21 corporation and employees of the corporation shall cooperate with the
22 Secretary of State in the audits and reviews conducted under sub-
23 sections (2) and (3) of this section.

24 “(5) The audits shall be conducted using generally accepted ac-
25 counting principles and any financial integrity requirements of federal
26 authorities.

27 “(6) The cost of the audits required by subsections (2) and (3) of this
28 section shall be paid by the corporation.

29 “(7) The Secretary of State shall issue a report to the Governor, the
30 President of the Senate, the Speaker of the House of Representatives,

1 the Oregon Health Authority, the Oregon Health Policy Board, the
2 Department of Consumer and Business Services and appropriate fed-
3 eral authorities on the results of each audit conducted pursuant to
4 this section, including any recommendations for corrective actions.
5 The report shall be available for public inspection, in accordance with
6 the Secretary of State's established rules and procedures governing
7 public disclosure of audit documents.

8 “(8) To the extent the audit requirements under this section are
9 similar to any audit requirements imposed on the corporation by fed-
10 eral authorities, the Secretary of State and the corporation shall make
11 reasonable efforts to coordinate with the federal authorities to pro-
12 mote efficiency and the best use of resources in the timing and pro-
13 vision of information.

14 “(9) Not later than the 90th day after the Secretary of State com-
15 pletes and delivers an audit report issued under subsection (7) of this
16 section, the corporation shall notify the Secretary of State in writing
17 of the corrective actions taken or to be taken, if any, in response to
18 any recommendations in the report. The Secretary of State may ex-
19 tend the 90-day period for good cause.

20 **SECTION 22. Quarterly and annual reports.** (1) The executive di-
21 rector of the Oregon Health Insurance Exchange Corporation shall
22 report to the Legislative Assembly each calendar quarter on:

23 “(a) The financial condition of the health insurance exchange, in-
24 cluding actual and projected revenues and expenses of the adminis-
25 trative operations of the exchange and commissions paid to insurance
26 producers out of fees collected under section 17 (5) of this 2011 Act;

27 “(b) The implementation of the business plan adopted by the cor-
28 poration board of directors;

29 “(c) The development of the information technology system for the
30 exchange; and

1 “(d) Any other information requested by the leadership of the Leg-
2 islative Assembly.

3 “(2) The corporation board of directors shall provide to the Legis-
4 lative Assembly, the Governor, the Oregon Health Authority, the
5 Oregon Health Policy Board and the Department of Consumer and
6 Business Services, not later than April 15 of each year:

7 “(a) A report covering the activities and operations of the corpo-
8 ration during the previous year of operations;

9 “(b) A statement of the financial condition of the Oregon Health
10 Insurance Exchange Fund as of December 31 of the previous year;

11 “(c) A description of the role of insurance producers in the ex-
12 change; and

13 “(d) Recommendations, if any, for additional groups to be eligible
14 to purchase qualified health plans through the exchange under section
15 11 of this 2011 Act.

16 “SECTION 23. Complaints and investigations confidential; permit-
17 ted disclosures. (1) A complaint made to the executive director of the
18 Oregon Health Insurance Exchange Corporation with respect to any
19 prospective or certified qualified health plan, and the record thereof,
20 shall be confidential and may not be disclosed except as provided in
21 sections 15 and 16 of this 2011 Act. No such complaint, or the record
22 thereof, shall be used in any action, suit or proceeding except to the
23 extent considered necessary by the executive director in the prose-
24 cution of apparent violations of section 11 of this 2011 Act or other law.

25 “(2) Data gathered pursuant to an investigation of a complaint by
26 the executive director shall be confidential, may not be disclosed ex-
27 cept as provided in sections 15 and 16 of this 2011 Act and may not be
28 used in any action, suit or proceeding except to the extent considered
29 necessary by the executive director in the investigation or prosecution
30 of apparent violations of section 11 of this 2011 Act or other law.

1 “(3) Notwithstanding subsections (1) and (2) of this section, the
2 executive director shall establish a method for making available to the
3 public an annual statistical report containing the number, percentage,
4 type and disposition of complaints received by the corporation against
5 each health plan that is certified or that has been certified as a qual-
6 ified health plan by the corporation.

7 “SECTION 24. False or misleading filings. A person may not file or
8 cause to be filed with the executive director of the Oregon Health In-
9 surance Exchange Corporation any article, certificate, report, state-
10 ment, application or any other information required or permitted by
11 the executive director to be filed, that is known by the person to be
12 false or misleading in any material respect.

13 “SECTION 25. Civil penalties. (1) The executive director of the
14 Oregon Health Insurance Exchange Corporation, in accordance with
15 ORS 183.745, may impose a civil penalty under section 24 of this 2011
16 Act of no more than \$10,000. The penalty may not be imposed on car-
17 riers for violations of section 24 of this 2011 Act unless imposed by the
18 Department of Consumer and Business Services pursuant to the
19 department’s regulatory functions.

20 “(2) All penalties recovered under this section shall be paid to the
21 State Treasury and credited to the General Fund.

22 “SECTION 26. Repeal and delayed operative date. (1) Section 5 of
23 this 2011 Act is repealed January 2, 2016.

24 “(2) Section 10 of this 2011 Act is repealed January 2, 2014.

25 “SECTION 27. Operation of exchange delayed pending legislative
26 approval of formal business plan. (1) Section 11 of this 2011 Act be-
27 comes operative on the date the Legislative Assembly approves the
28 formal business plan submitted by the Oregon Health Insurance Ex-
29 change Corporation under section 5 (9) of this 2011 Act. This sub-
30 section does not prohibit the implementation, on or after the effective

1 date of this 2011 Act, of the responsibilities of the Oregon Health Au-
2 thority or the Oregon Health Insurance Exchange Corporation in ad-
3 ministering federal grants received for planning, administration or
4 information technology for the exchange.

5 “(2) The amendments to section 11 of this 2011 Act by section 12 of
6 this 2011 Act become operative on the later of the date the Legislative
7 Assembly approves the formal business plan submitted by the corpo-
8 ration under section 5 (9) of this 2011 Act or January 1, 2016.

9 “SECTION 28. Captions. The section captions used in this 2011 Act
10 are provided only for the convenience of the reader and do not become
11 part of the statutory law of this state or express any legislative intent
12 in the enactment of this 2011 Act.

13 “SECTION 29. Emergency clause. This 2011 Act being necessary for
14 the immediate preservation of the public peace, health and safety, an
15 emergency is declared to exist, and this 2011 Act takes effect on its
16 passage.”.

17

Coordinated Care Organization (CCO)

Definition

- CCO means an organization that serves as a single-point of accountability for the cost of health care within a global budget and for access to and quality of a coordinated system of physical health, behavioral health and oral health care services delivered to the specific population of patients enrolled with the organization.
- A CCO is also responsible for managing health care for persons in long-term care as part of an overall treatment plan.
- A CCO is a local, community-based organization or a statewide organization with community-based participation in governance. A CCO may be a single corporate structure or a network of providers organized through contractual relationships.

Populations

- A CCO will be accountable for the health care of its members, including serving members who are dually-eligible for Medicare and Medicaid. Oregon's Medicaid program will serve as an early demonstration of a health care delivery system based on CCOs;
- The goal is that all Medicaid clients in the state will be enrolled with a CCO as rapidly as possible.
- Begin a formal process to examine how to best extend this model to public employees and other commercial populations.

Governance

- Governance needs to reflect the responsibility for risk, the major components of the health care delivery system, and the community at large. Flexibility is needed to address the operational needs of the CCO, while remaining accountable to community values and population health needs.
- Because counties are the local mental health and public health authorities, CCOs must have a formal, contractual relationship with the county or counties in which they operate.
- Consumers must have a role in governance of the CCO.
- CCOs will establish Community Advisory Committees to ensure that the needs of consumers and the community are being addressed; the membership would include county representation.
- Specific mechanisms will not be outlined in statute, but CCO decision-making will meet policy objectives identified in statute and reflect input from:
 - Consumers including seniors, people with disabilities, people using behavioral health services, and
 - Racially and ethnically diverse populations reflective of the CCO service area; and
 - Providers in the CCO

Coordinated Care Organization (CCO): Strawperson Summary

Geography and Size

- A CCO should be of sufficient size to effectively manage risk and address capacity and access issues. There will not be a specific designation of the number of CCOs or the number of service areas.
- Where appropriate in terms of systems of care and provider capacity, OHA may authorize through the RFP process more than one CCO in a given service area.
- The goal is to have all Medicaid members enrolled with a CCO as rapidly as possible; OHA will develop strategies in partnership with communities to ensure a smooth transition from the delivery system structures currently in place. *[Note: Still need to work out a process for areas of the state where the RFP process does not identify a qualified CCO]*

Integration and Scope

- CCOs are responsible for the full integration of physical, behavioral and oral health care services for the specific population of persons enrolled with the organization, including their members who are dually eligible for Medicaid and Medicare.
- The goal is to achieve optimal health outcomes. Medicaid services expected to be provided are those outlined by the Prioritized List of Health Services currently provided through existing contracts, which will be regularly updated based on the best evidence. Medicare services will comply with federal regulations and include those services provided in Medicare Parts A, B and D.
- A CCO will be responsible for the **health care** of members who are also in long term care. There is no intent for the management of long term care budgets to be part of the CCO.
- To allow for necessary integration and risk sharing, state and federal safe harbors should be requested that protect CCOs and providers from antitrust, Stark, anti-kickback and civil monetary penalty laws.
- To allow for effective integration and risk management, privacy laws need to permit CCOs to access essential individual-level data while protecting the privacy and security of its members.
- A CCO should prioritize working with CCO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the avoidable use of services provided in emergency rooms and hospital readmissions. Safeguards will be outlined in contract and rule to avoid risk selection practices.
- Individuals should receive comprehensive transitional care, including appropriate follow-up, when there is a change in care setting, including but not limited to entering and leaving inpatient hospital or nursing facility to other care settings or return to their home, or for a significant change in care providers.
- CCOs should develop and participate in Learning Collaboratives to ensure the sharing and implementation of best practices.

Coordinated Care Organization (CCO): Strawperson Summary

Provider Networks

- Providers may participate in the networks of multiple CCOs.
- CCOs should demonstrate excellence of operations including but not limited to network provider creation and management functions. They will use, to the maximum extent feasible, person-centered health homes and best practices in primary care, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. Specialty services must include access to statewide resources as needed.
- Members should have a choice of providers within the CCO's network.
- FQHCs, Rural Health Clinics (RHCs), School-Based Health Clinics and other safety net clinics should be supported to ensure their critical role in providing primary care and primary care home services for underserved populations.

Budget and Payment

- Global budget
 - A global budget means a total amount established prospectively by the state to be paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management, access and quality of care delivered to the people enrolled with the CCO.
 - OHA is required to establish a process to develop global budgets based on available revenue and on expected patterns of care after transformation of the finance and delivery system.
 - Global budgets will be developed with adequate risk adjustment mechanisms and other activities associated with analysis and monitoring of CCO utilization and cost data and other financial metrics. This will be done utilizing national and statewide expertise and include legislative input. Budgets will be established that grow at an established fixed rate. *[Note: Still need to establish mechanisms to ensure that mental health crisis system, medical education and other community needs are supported in the context of a global budget.]*
 - The global budget should be configured to hold CCOs accountable for outcomes.
 - In order that providers engage in long-term delivery system changes, mechanisms should be developed that ensure that as outcomes improve and service delivery is reconfigured, that savings are shared and that the CCO's provider payments are also reconfigured to reflect the system changes.
 - Risk adjustment mechanisms or risk mitigation strategies will be addressed in contract and rule.
- Payment:
 - CCOs are required to demonstrate how they will apply alternative payment methodologies that move from predominantly fee-for-service to alternate payment methods in order to base reimbursement on quality and value rather than volume of services and to realign incentives to support transformation policy objectives.
 - Restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered health homes.

Coordinated Care Organization (CCO): Strawperson Summary

- Shared savings:
 - CCOs are required to identify cost savings and coordinate the sharing of any overall achieved cost savings with the CCO providers and practitioners in a transparent manner that furthers the goals of the CCO to improve quality and accessibility while reducing costs of health care throughout the CCO service area.
 - A shared savings methodology will be developed to identify and capture Medicare dollars.

Consumer Protection and Accountability

- Consumer Protection:
 - Requirements for CCOs includes some provision for system navigation and for engaging the patient in their care and care planning:
 - Consumers must have access to competent advocates, including qualified peer wellness specialists where appropriate; system navigators; and qualified community health workers who are part of the care team to provide assistance that is culturally and linguistically appropriate to their needs to access appropriate services and participate in processes affecting their care/services.
 - Consumers will be encouraged within all aspects of the care and services system to use wellness and prevention resources, and to make healthy lifestyle choices.
 - Consumers are encouraged to work with their care teams, including providers and community resources appropriate to the consumer's needs as a whole person.
 - Consumers have the right to appeal decisions about their care and services, and to receive a timely response, within the CCO and with the Oregon Health Authority.
- Accountability:
 - An expert workgroup convened by the Oregon Health Policy Board will identify key outcomes and develop metrics to be included in the RFP, with an emphasis on the key priorities to improve value.
 - Detailed requirements for accountability and metrics will be addressed in contract and rule.
 - *Financial Accountability*—CCOs will need to demonstrate through specified financial reporting requirements excellence of operations, including best practices in financial management capabilities. Specific expectations regarding assessment of adequacy of reserves and solvency will need to be demonstrated by the CCOs and monitored by OHA.
 - *Community Accountability*—CCOs have **shared** accountability for the overall health of **members** in their area, and will need to work cooperatively and form relationships with community partners to address public health issues that affect the health of the community, including prioritizing health equity.
 - *Individual accountability*—A component of shared accountability resides with the individual members of a CCO. CCOs will develop, in collaboration and coordination with providers and OHA, strategies that encourage healthy behaviors and healthy lifestyles, prevention and wellness activities, developing skills in help-seeking behavior including self-management and illness management. Strategies include, but are not limited to incentive systems, patient education, and improved access to primary care and behavioral health services through patient-centered health homes, home-based services, and

Coordinated Care Organization (CCO): Strawperson Summary

telephone and web-based communication by culturally and linguistically appropriate means.

- *Quality of Care and Outcomes* – Quality metrics will include measures of quality for ambulatory care, inpatient care, behavioral health care and oral health care. Key quality metrics of interest, including health status, experience of care, and patient activation, will be evaluated on a regular and ongoing basis. Metrics will be stratified by key demographic variables including race and ethnicity. Quality metrics will be consistent with standard quality measures adopted by and reported to the Oregon Health Authority to evaluate value and population health.
- CCOs need to demonstrate how they are holding their provider networks accountable for the care delivered.

Transparency

- All members should have the information they need to make informed choices among CCOs and among providers. CCOs and OHA will ensure transparency of financial data, including payer and provider costs, provider payments; and outcomes, quality measures and other information necessary to discern the value of health care services; CCO's role is to submit appropriate data and information to OHA, and OHA role is to serve as data aggregator and reporter.
- As information and data collection systems improve, the intent is to move from demonstrating process metrics to outcomes metrics. The OHA will be responsible for developing or endorsing metrics that will evolve over time as capabilities for reporting improve.
- Better utilize available data systems for reporting and eliminate any redundant or reporting of limited value.

Implementation

- Administrative simplification and Regulatory Relief
 - To the extent allowable, regulatory and administrative requirements will be streamlined and consolidated, including federal standards, certification, and reporting.
- Federal Approvals
 - The Oregon Health Authority will be seeking federal approvals to establish global budgets, to blend Medicare and Medicaid funding for people who are dually-eligible for Medicare and Medicaid, to manage medical care more effectively across the full spectrum of service needs, and to pay differently for services and care. There may be additional areas that will also require exception from certain administrative requirements within federal Medicaid and Medicare rules.

Medical Liability

- Tort reform has been identified as a central component to health system transformation. Specific details around a proposal will need to be developed in order to move forward.

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Federal Flexibility and State Statutory Changes For Health System Transformation

For Oregon to implement Coordinated Care Organizations (CCO) in the Oregon Health Plan we will need to request flexibility from the federal Centers for Medicare and Medicaid Services (CMS); some changes will be required in state statute as well. This document identifies the major areas staff have identified that may require federal permission or changes in state law.

Federal flexibility

The Oregon Health Authority will seek federal approval for the following design components of Coordinated Care Organizations and Health System Transformation. This list is not comprehensive; as the Oregon legislature further develops the CCO concept additional areas may be identified where Oregon will need flexibility from CMS.

Global Budget. Capped total spending with strict year-over-year budget targets was identified as an essential element of an accountable organization. Establishing a global budget for each of the CCOs will require federal permission.

Global budgets will be pre-paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management and quality of care delivered to the people enrolled with the CCO. OHA will establish a process to develop global budgets and other activities associated with analysis and monitoring of CCO utilization and cost data and other financial metrics.

Integration and Scope. Oregon has the ability to accomplish some integration under its current authority, but a number of the Health System Transformation Team's innovations will require federal approval, specifically:

- Proposing to blend Medicare and Medicaid funding for people who are dually eligible for Medicare and Medicaid.
- Utilizing non-traditional personnel to deliver services, supports, and supplies not traditionally part of Medicaid. These services, supports and supplies should be included in the CCO global budget.
- Requesting safe harbor protection from antitrust, Stark, anti-kickback and Civil Monetary Penalty Laws to allow development creation and implementation of Coordinated Care Organizations and their well coordinated provider networks.

Consumer Protection. Strong consumer protections were also identified as an essential element of Coordinated Care Organizations. While federal law includes consumer protections, they are not necessarily aligned across Medicare and Medicaid. Oregon will ask to streamline and simplify due process rights such as complaints, appeals, and grievances including aligning Medicare and Medicaid while maintaining appropriate consumer protections.

Administrative simplification and Regulatory Relief. To the extent allowable, regulatory and administrative requirements will be streamlined in Oregon's delivery system redesign:

- Where regulatory and administrative requirements differ between Medicare and Medicaid, Oregon will ask to streamline and consolidate, including alignment of requirements for Quality Assurance and Performance Improvement; and
- Allow covered individuals to authorize the state and Coordinated Care Organizations to provide notices and informational materials via e-mail, text or other alternatives to mail.

Mandatory Enrollment and Churn: In order to maximize the potential value of integration and to minimize administrative costs associated with enrollment and disenrollment (churn), it will be important to maximize and stabilize enrollment in CCOs. Oregon will ask for federal flexibility to require:

- Mandatory enrollment in a CCO, with appropriate criteria for opting out; and
- Include individuals eligible for Medicare and Medicaid; and
- Require that individuals enroll in a CCO for a specified length of time, with appropriate criteria for changing CCOs.

Privacy: Current privacy laws for some special classes of diagnosis and treatment (e.g., substance abuse) act as barriers to the effective coordination of care. Oregon will request authority for CCO's to share patient identifiable information for the purposes of care coordination and treatment.

Operational Adjustments: Oregon will request the authority to make ongoing operational adjustments without first going through detailed federal approval processes.

Changes in State Law

In order to implement the Coordinated Care Organization system, state law changes will need to address:

Delivery system changes that are consistent with the new delivery system for coordinated care:

- For the medical assistance program, replacing the "prepaid managed health care" delivery system with the coordinated care organization delivery system
- Reshaping the health care delivery system to include a person-centered focus, accountability to community and consumer values, implement consumer protections, and other issues that have been developed with HSTT input
- Reforming payment methodologies that promote prevention and person-centered care, measure outcomes, and contain costs

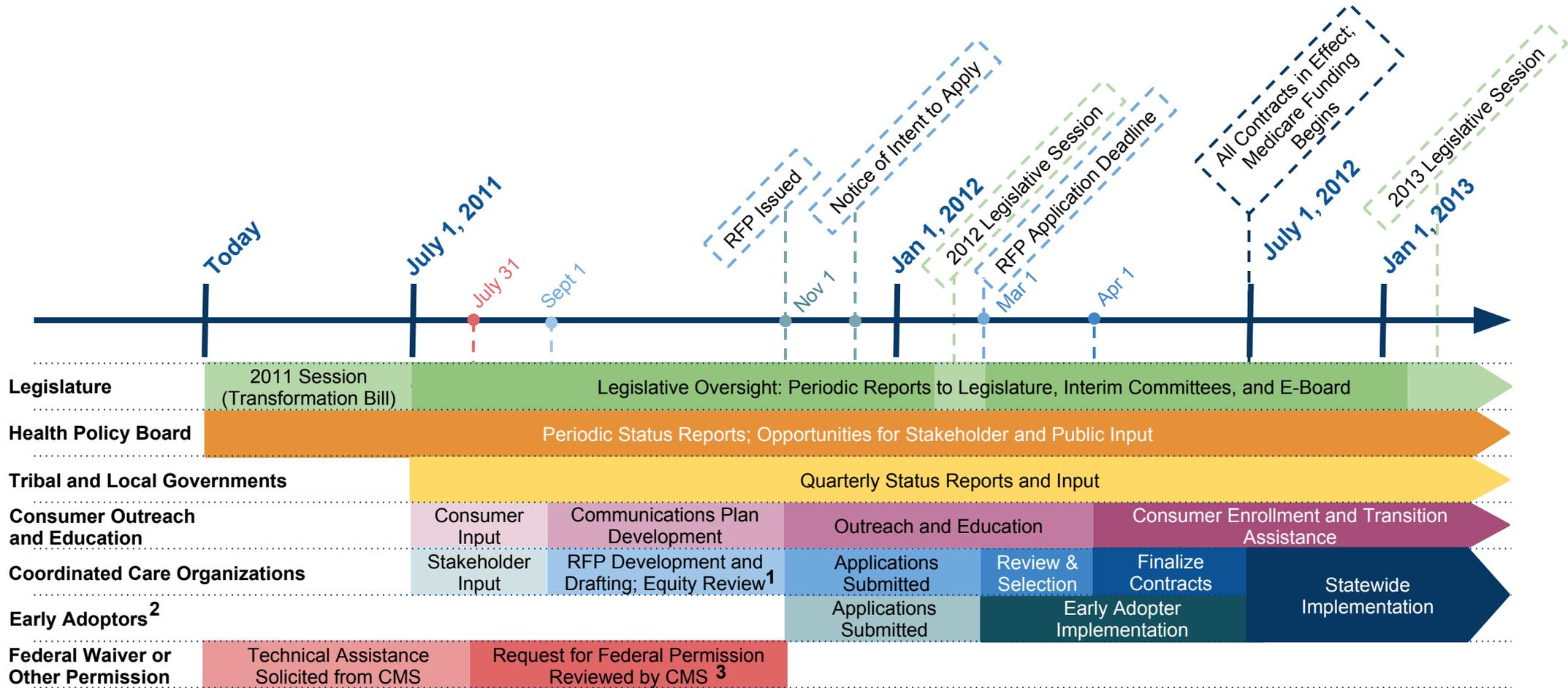
Individuals eligible for both Medicare and Medicaid. Statute should provide explicit authority to include the health services for individuals who are dually eligible for Medicaid and Medicare within the new delivery system.

Operational components that will make coordinated care successful:

- Addressing state law barriers to information sharing by providers and the coordinated care organization;
- Requiring measures of quality of care and outcomes, and transparency, that inform decision making;
- Streamlining regulatory and administrative requirements imposed by state law.

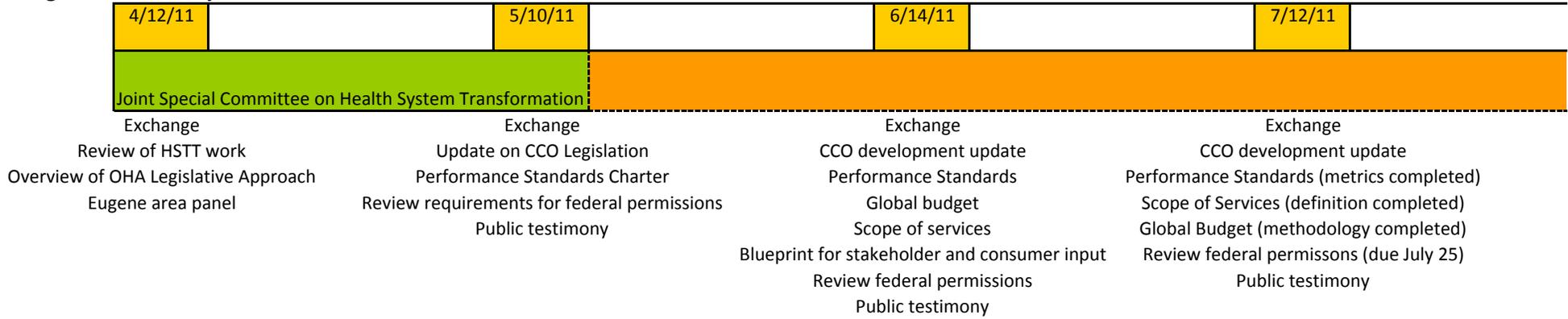
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DRAFT - HEALTH SYSTEM TRANSFORMATION TIMELINE



¹ Request for Proposals for Coordinated Care Organizations.
² Early adopters must meet the same criteria as the regular RFP applications.
³ Federal permission would be sought for global budgeting, combining Medicare funding for dual-eligibles beneficiaries with Medicaid, and payment reform.

2011 Oregon Health Policy Board Work Plan



Senior & Disabled Services

a division of LCOG

MEMO

To: Oregon Health Policy Board
From: Kay Metzger, Director
Senior & Disabled Services, Lane Council of Governments
Subject: Health Systems Transformation Work in Lane County
Date: April 12, 2011

Dear Health Policy Board members,

I apologize for not being able to attend your meeting scheduled for April 12th in Lane County. I would have liked to have been part of the presentation you will be hearing from LIPA and LaneCare regarding our work together. Since previous commitments prevent me from participating I am sending this brief memo of support.

First, given that Oregon's current system of long term care services and supports is strong and the most cost efficient in the nation, the decision to remove the responsibility of its management from the Coordinated Care Organization is a sound and prudent one. However, this doesn't mean that a greater connection between our social service system and our health care system isn't needed. It is. If we wish to impact the social determinants of health care costs, building a bridge between social services and health care is critical. The work that is currently under way in Lane County is doing just that, laying a strong foundation for new systems based on agreed-upon principles, collaboration and consumer-focus. We recognize that together we can serve our consumers better, leveraging the strengths of our respective organizations.

As the Lane County group continues to evolve, it is my hope that a sustainable structure will be created that incorporates the best of what we each have to offer. We still have much work ahead of us but I am excited about what this opportunity brings, which is the possibility of serving our vulnerable consumers more fully and effectively.

Thank you.

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Public Input for the Oregon Health Policy Board

March 23, 2011 – April 5, 2011

Doc #	Summary	Comment Type	Writer
1	The concept of peer wellness programs solves several problems at once: it is a perfect fit for a new, integrated health care system; it will save the state money; properly certifying and training persons who self-identify as consumers/survivors of mental illness will allow them to help others in a very positive way.	Email Submitted: 3/23/11	Mark Fisher
2	It is important for health transformation legislation to include enrollee advocacy, health disparity provisions, careful outcomes metrics, and a rejection of new co-payment proposals. See email for details.	Email Submitted: 3/23/11	Janet Bauer
3	A personal story of a woman's experience with Oregon's health care system. She advocates for proactive care, rather than reactive, both for the patient's sake and the budget's sake. Proactive care should include things like chiropractors and Body Talk.	Email Submitted: 3/28/11	Sheila Walker
4	If "Navigators" are going to be doing things like advising people about what level of coverage to buy, then they should be required to be licensed.	Email Submitted: 4/4/11	Dan Howe
5	Recommendation to charge a \$10 co-pay whenever an OHP client has an emergency room visit.	Email Submitted: 4/4/11	G. Hickey

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From: "Mark Fisher" <mfisher88@msn.com>
To: <ohpb.info@state.or.us>
Date: 3/23/2011 3:35 PM
Subject: Peer Wellness Coaches

i have recently read Megan Caughley concept concerning peer wellness coaches to deliver services in the mental health system. What a great idea. With the proper state certified training of persons who self-idenrify as consumers/survivors of mental illness , this is a way to save money while delivering services in an integrated health care system. With the combination of training in peer delivered mental health services as a Peer Support Specialist, A&D training, plus appropriate medical training, this seems like the best way to reach an aging mentally ill population with serious medical conditions at the same time. The mentally ill die on the average of 25 years sooner than the other adults. The peer wellness coaches would also be able to serve younger adults because of their shared experience of mental illness. Most younger adults want to know about recovery and how they can stay away from a lifetime of involvement in the mental system. The concept of peer wellness coaches solves several problems at once and seems like a timely concept to put into action since Oregon is moving towards an integrated health care system .

Sincerely,

Mark Fisher
Peer Support Coordinator
Columbia Care Services
mfisher@columbiacare.org

From: "Janet Bauer" <jbauer@ocpp.org>
To: "Jeremy Vandehey" <jeremy.vandehey@state.or.us>
CC: "Chuck Sheketoff" <csheketoff@ocpp.org>
Date: 3/23/2011 4:35 PM
Subject: OCPP comment on health system transformation proposal

Jeremy:

While OCPP has not yet had an opportunity to fully review the latest proposal for transforming Oregon's public medical assistance programs (released yesterday), in the interest of time, we want to share what we see as important guidelines for evaluating any such effort. Thank you for forwarding this communication to OHA director Dr. Bruce Goldberg and other appropriate staff at OHA.

Priorities for system change involving Oregon's Medicaid populations
* * * *

1. Enrollees should have strong advocacy support

The role of an ombudsman will be important in ensuring that enrollees are able to understand the new system and get the care they need. The ombudsman officials, and later when the exchange is operating, Navigators, must be clearly defined as an enrollee advocate. These individuals should be subject to the same whistle-blowing protections as nurses and doctors under current Oregon Revised Statutes. They should not hold a vested interest in any health care organization or receive bonuses or incentives regarding care that is provided. These officers should be well-integrated into the social model of care and familiar with community and social-based services.

2. The health system transformation legislation should have strong health disparities provisions.

If CCOs are to be effective, they will need to meaningfully reduce health disparities related to race and ethnicity. Contracts with CCOs should include commitments for improving cultural competency and measures by which CCOs will be held accountable for specific health disparities reduction targets.

3. An outside review structure should evaluate whether CCOs are providing desired, required services

An innovative health system may provide a broad array of care and treatment options to enrollees, some of which may be more effective in encouraging health and managing disease than required services. However, at no time should enrollees be barred or discouraged from receiving required care according to their preference. To ensure enrollees continue to have access to required care, CCOs should be routinely audited for provision of preferred required care.

4. Enrollees should know the services they are entitled to receive and have access to a clearly-defined appeals process

To ensure that enrollees are making an informed choice when opting for care options that depart from required services, CCOs should establish an effective program to inform and remind enrollees of services they are entitled to receive.

5. Protect current covered services and increase flexibility in use of the Prioritized List

The current level of covered services under the Oregon Health Plan, set by the Health Services Commission in its "Prioritized List," can be an obstacle in beneficiaries getting needed services. Some barred services are typically offered under private insurance plans. Limiting access to needed services works against health reform goals of promoting health and controlling costs.

In the federal waiver that allowed Oregon to use its Prioritized List, Oregon was required to establish a flexible system whereby exceptions to barred services could be allowed. However, flexibility under Oregon's current system is not sufficient to allow the state to reach its social and economic goals. For instance, some individuals have difficulty getting the treatment for a hernia they need to be able to get back to work.

In a re-designed health system in which Coordinated Care Organizations are responsible for the full continuum of care for a defined population, CCOs will need to provide comprehensive benefits. Although CCOs may not be barred from providing services outside those on the List, there will need to be more flexibility in the rules that govern covered services than is currently

allowed to ensure that enrollees have access to services they need to prevent illness and work productively.

6. Simplify Oregon's medical assistance programs

An effectively transformed health system would address the problems created by Oregon's inordinately complex array of medical assistance programs. Oregon currently administers approximately 20 different programs that have their own eligibility and benefit rules. This situation increases the likelihood that people are wrongfully denied benefits or put into the wrong program. The complexity means expensive and complicated administration for the state and for contractors.

***7. Reject new co-payment proposals** ***

The Governor's 2011-13 Balanced Budget calls for new co-payments for individuals enrolled in Medicaid managed care plans. However, past efforts to impose such co-payments did not result in savings. Plans rightly refused to implement the charges, calculating that the cost of collecting the small fees would not justify the revenue generated.

Co-payments imposed on households with limited incomes can be barriers to accessing care. Although children, seniors and pregnant women would be exempt, the complex rules about who pays and who is exempt can create confusion. Parents may not understand that their children don't have co-pays while they may have them for their own care, and that some services such as preventive care may not have charges while other kinds of care do. Therefore, proposals to impose new co-payments should be rejected, as they can be expected to backfire in saving on costs and inhibit access to preventive and necessary care.

--

Janet Bauer
Policy Analyst
Oregon Center for Public Policy
204 N. First Street, Suite C
Portland, OR 97381
503-873-1201 (office)
503-577-6589 (cell)

From: "Sheila W" <smee48@hotmail.com>
To: <ohpb.info@state.or.us>
Date: 3/28/2011 3:20 PM
Subject: I was asked to share my story with anyone willing to listen..

My name is Sheila Walker, I was asked by Janet Reuger to share my medical journey over the last few years with you. We have hopes that my story may inspire meaningful change in Oregon's Health Care situation.

About 4 years ago, I started getting ill. I had drainage from my ears and my privates were itchy. I went to see the only doctor who would see me at that time. No insurance, no income... no help. Emergency room. So, the doctor decided that I had a yeast infection after a cursory look and prescribed medication. That seemed to help for a few weeks and then it was back, only worse. I got steadily sicker and sicker prompting more visits to the ER where I was told, it's Yeast, take a pill.

This went on, month after month, until I finally saved up enough money to go to Valley Immediate Care. When I got in to VIC I was given a cursory exam by the Nurse and the Doctor sat across the room from me saying that I needed to be in the hospital on IV medications for this yeast infection. By this time, any moist spot or opening in my body had patches of crust and oozed all the time. I was a disaster and felt like I was going to die. I'd been unable to do much of anything for months. Just lay in bed and sleep. My body hurt. My mind hurt. I really wanted out. The Doctor prescribed massive doses of anti-fungal medication and that frightened me.

I stopped, on the way home, at the Hospital and told them that the doctor had said I needed to be hospitalized. I finally saw an ER doctor who told me, "We don't hospitalize for yeast infections." She then told me not to take those massive doses of Yeast Meds because they would shut my liver down. She prescribed a smaller dose and referred me to Dr. Miriam Soriano.

A few days later, Dr. Soriano saw me. Within minutes of walking in to the exam room, Nurse Judy said, "You have Staph, I can smell it." She was right. I was diagnosed with MRSA as well as Candida that we already knew about. I managed one payment to Dr. Soriano but after that she saw me for two solid years for nothing. She wrote me off on her taxes each year. Dr. Soriano also excised a large strep cyst in my armpit and saw me every day

for two weeks to change the packing for free. For FREE! No other doctor I have ever seen would do this. Sundays even. For FREE!

I was later diagnosed with Type 2 Diabetes. After talking with a lot of people on-line, I've discovered that my diagnoses of Diabetes after MRSA is not at all uncommon.

I was also diagnosed with Arthritis, some mystery joint swelling and fibromyalgia.

I was unable to walk more than a block at a time without having to sit down. I could not sit more than half an hour and lying down was good until my body cramped up. At first, I slept for about 18 out of 24 hours each day.

I recently was given disabled status so that I could get Care Oregon HMO. This was a big bonus for me, as some of my meds were incredibly expensive. However, Care Oregon does not pay for Acto plus Met which works much better than taking Glyburide and Metformin separately.

I've always had a slight scoliosis and have, over time and over weight developed lordosis also. My lower back clicks, grinds and hurts all the time. It prevents me from doing many things. It hurts all the way to my toes some days and other days all the way to my skull. I called Care Oregon to find out if Chiropractic was covered. They said maybe.

I contacted Janet Reuger DC and set up an appointment as she was willing to give a shot to seeing if they'd pay her. Most Chiropractors were not interested in trying. The one Chiro they referred me to no longer exists. Janet, being a tiny woman, doesn't do the manipulations of regular Chiropractors, she uses foam blocks to force your body to realign on it's own. She is also a Body Talk practitioner. I'd never heard of Body Talk before. Janet called in a request for six visits and then re-evaluate and was verbally approved. However, I recently received notification that Care Oregon will not cover her services. Another medical bill on my \$500 per month income. I say that because no matter what, I will find a way to continue my treatments with her. The power of what she's doing is so evident in every portion of my life.

Through the six visits with Janet, however, I discovered that a lot of my pain and illness is because of things that happened in my past. I've regained a

LOT of flexibility and strength in just six visits. That's three weeks! Three weeks! I am now able to stand for up to an hour, to walk much farther and without near the limp that I had before. (My Knees are both arthritic and I am receiving treatment from Ashland Orthopedics, Dr. Knoblich)

My question and my desire is to know why this kind of treatment is not covered by the State of Oregon? Why? It would be far less expensive, in the long run, for me to see Janet twice a week for a few months and get control on my issues than it would to keep medicating me and eventually have to do surgeries which may or may not work.

Does it not make more sense to take a proactive stance on treatment rather than reactive? Work through the issues to become a viable part of society again rather than sit my butt on disability? It certainly makes more sense to me.

I hope that my story will aid you in making changes to our Medical system and to help others to receive treatments that they may desperately need.

Sincerely,

Sheila Walker
65 Woolen Way #4
Ashland, OR 97520

From: "Dan Howe" <dan.howe@comcast.net>
To: <ohpb.info@state.or.us>
Date: 4/4/2011 3:56 PM
Subject: Navigators

I'm an insurance producer. I've read the December 2010 Report to the Oregon Legislature. It says that some suggest that Navigators should be exempt from the licensing requirements. I disagree with that. Obtaining a state insurance license isn't that hard. The level of education required to pass the exam is minimal. I can't imagine a person in a position of helping consumers that doesn't at least have that minimum level of knowledge.

I have to admit that I don't really know what Navigators are going to do. Will they just be telling people what website to go to? Are they just going to answer the phones? If so, then you can exempt them. However, if they will be advising people about what level of coverage to buy, then they need to be licensed. If the state really thinks that licensing requirements are too hard, then they should lower the requirements. Although I wouldn't advice it.

I have seen examples of how things can go wrong when insurance people aren't properly trained. Some of the national carriers (just some) don't have sufficient training. When you ask their customer service people questions, they either don't know the answer or actually give the wrong answer. With health care, the wrong answer is usually devastating.

Insurance agents should be good at making things understandable. To some, that may look very easy. If someone thinks what I'm telling them sounds easy to understand, then I know I'm doing a good job. The job of properly explaining health insurance takes a huge amount of skill. We should be making it look easy.

Dan Howe

503-336-1111

From: <ghickey@frontiernet.net>
To: <ohpb.info@state.or.us>
Date: 4/4/2011 8:54 PM
Subject: Cost control

If you want to control the cost of providing health care to poor people do this: Charge a small co-pay for every emergency room visit. Ten dollars would put an end to all of the needless ED visits by OHP clients. If they couldn't pay at time of service it would come out of their other state aid checks. This would give these clients pause when they order an ambulance to take them to the ED for a toothache or sore throat or some other nonsense. These clients would learn how to be "responsible" and "wise" consumers of healthcare.

G. Hickey
ED RN