

Monthly Report to
Oregon Health Policy Board
March 5, 2009

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I. PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Plan

Enrollment

- Through January, we've enrolled about 34,909.*
 - A 13% increase in enrollment since June, about a 19% increase since January last year.
 - This puts us slightly ahead of our target for January and well on the way to achieving our goal of 80,000 kids by December.

**Note: Numbers do not yet reflect KidsConnect – OHP only through January.*

Program Expansion

- KidsConnect, low cost private insurance option for moderate income families, is now enrolling children in coverage.

- This means we're now offering low cost coverage to families up to 300% federal poverty level or \$66,000 for family of four (same as median family income in Portland).
- Rates are affordable: Range from \$18 to \$42 for one child / \$31 - \$73 for two to four kids depending on family income / plan selected (see Attachment 1).
- Most areas of state have choice between a statewide carrier (PacificSource) or regional carriers (Clear One, Kaiser, Samaritan and Trillium).

Marketing

- Paid media campaign continues to roll out. Have transportation ads up and down the state. Radio ads and more billboards are in production.
 - Thanks to a federal grant (HRSA-SHAP), conducting message testing of materials and ads with families starting this month, including testing with Spanish-speaking families. Will refine materials / marketing based on their feedback.
 - Working with a Latina marketing consultant to create Spanish language materials, website and ads that are not just translations of English materials. Materials will be in several other languages.

Outreach

- Awarded grants to a total of 27 community based organizations around the state.
 - Good geographic representation among grantees and most of them are focused on reaching out to communities of color, historically hard to reach communities and other communities underrepresented on health plan.

- Continue to do aggressive outreach to community organizations to enlist their help in outreach.
 - To date, Office of Healthy Kids has trained over 550 people around the state on Healthy Kids and how they can help families apply.
 - Establishing regional collaboratives, so grantees, application assisters and other community partners doing outreach in regions of the state coordinate with and support each other.
- Hired Schools Campaign Coordinator who will begin work on school campaign mid-March.
- Oregon's outreach efforts continue to receive national attention:
 - The Georgetown Center for Children and Families is highlighting our work at a conference of western states in early April.
 - CMS has invited the Office of Healthy Kids to present our “promising practices” in a webinar on outreach and enrollment.

OHP Standard

- As of January 15, 2010, there were 25,188 adults enrolled in OHP Standard.
- As of Friday, February 26, there were nearly 78,000 names on the reservation list. About 20,000 are “opt-ins”¹ from the 2008 list, and about 58,000 are from new sign-ups.

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

- DHS has completed four random drawings: November 2009 when we drew 2,000 names from the opt-in list only and January and February when we drew 2,000 names each from the full list. The fourth was March 1, with a drawing of 6,000 names. Through April, we will draw progressively more names, allowing us to ramp staffing up for the increase. *Note: not all names that are drawn end up qualifying for the health plan.*
- The department is in the process of conducting a statewide campaign to encourage and assist more uninsured adults in Oregon to sign up, with the help of community partner organizations throughout the state and a grant from the federal Health Services and Resources Administration (HRSA).
- The biennial goal is to have an enrollment of 60,000 people in the OHP Standard program by June 30, 2011.
- We will draw 8,000 names in April. After that, resources and systems will be ramped up to process much larger numbers, so we can likely look for drawings of 10,000 or more, depending on how uptake runs for April and the following few months.

Transition to/Formation of OHA

On track.

Legislative Session

A list of health related legislation is attached (see Attachment 2). Given the short session, there was no large scale health reform activity. Of particular note, however, was a bill to extend Oregon Health Plan for children “aging out” of the foster care system. Health benefits were extended to age 21 and they are no longer cut off from health benefits at age 18. Many of these children are high risk and many have serious mental health conditions. In addition, a bill was passed to provide us legislative authority to administer any federal funds that might come to Oregon to extend coverage to individuals in high risk pools.

Federal Health Reform

We had a White House Briefing on the President's plans on March 3. In addition to outlining plans for passing reform legislation through a reconciliation process, staff outlined some of the issues that are likely to be highlighted in a reconciliation process. Of note is that there will be efforts to help provide an early start on some reform efforts such as resources to states to get health insurance exchanges up and going. As more develops we will keep you posted. An outline of the President's plan is in Attachment 3.

The board's letter to the delegation regarding early pilots was well received. Unfortunately, it appears that the reconciliation process as currently outlined will offer little opportunity for our delegation to get these types of changes. If that changes, I will let you know. We are now trying to pursue with executive branch staff. On Thursday I spoke with U.S. Health and Human Service leadership about opportunities for demonstration projects.

Board Committee Progress

Health Care Workforce Committee

Chair: John Moorhead, MD

Vice-Chair: Ann Malosh

The Oregon Healthcare Workforce Committee held its first meeting February 23. The committee reviewed its charter and by-laws and discussed an initial work plan, which will be finalized at the next meeting. Committee members also heard from the Employment Department about current trends in health care workforce demand and supply and received an update about the health care workforce database created by HB 2009. The next meeting is scheduled for March 31 from 9 a.m. – noon, location to be determined.

State Health Improvement Program Committee

Chair: Tammy Bray

Vice-Chair: Lila Wickham

The Oregon Health Improvement Plan Committee's first meeting will be Tuesday, March 30, 2010, 10 a.m. - 4 p.m. in Salem (specific location TBD). The agenda will include orientation to the charter, approval of by-laws, discussion of core values, principles and issues for the committee's work, and review of the work plan and organizational structure for the health improvement plan. Dates for subsequent meetings will be determined by mid-March.

Public Employers Health Purchasing Committee

Chair: Steve McNanny

The Public Employers Health Purchasing Committee held its initial meeting on Monday, March 1, from 1 p.m. to 4 p.m. in Wilsonville at the Clackamas Community College Training Center. All members of the committee were present either in person or via telephone conferencing.

The agenda items included:

- Presentations by Denise Honzel, health care consultant, on the Health Leadership Taskforce Medical Home Pilot project and Jeanene Smith, MD on the Patient-Centered Primary Care Home Standards work group report.
- Review and discussion of the statutory provisions governing the committee, its charter and by-laws.
- Review of analysis of public employer aggregated lives by county to demonstrate the value of collaboration and coordination among public employers in local health care markets.
- A presentation by Joan Kapowich, PEBB/OEBB Administrator, on the purchasing visions and principles of both PEBB and OEBB.
- Discussion of how to engage organized labor representatives into the work of the committee.

Next meetings are planned for April, May, June and September. Dates and times to be determined by survey of committee.

Health Incentives and Outcomes Committee

Co-Chairs: Denise Honzel and John Worcester

Chair, Payment Reform Subcommittee: Bart McMullan

Chair, Quality and Efficiency Subcommittee: Glenn Rodriquez, MD

The Health Incentives and Outcomes Committee was chartered and membership confirmed at the February Health Policy Board meeting. The committee will hold its organizational meeting in late March or early April. The meeting date is being determined by survey of the committee.

II. BUDGET

Will be providing budget reports on a bi-monthly basis.

III. HEALTH CARE PERFORMANCE

As I indicated last month, one of our primary challenges is to bring together data from across programs that are joining the Health Authority. As we continue to work on that, this month I will take this opportunity to update you on some of the strategies we are developing to reduce or at least better control the per capita cost of health care (one of our “triple aims”) within the Oregon Health Authority programs. The list below outlines some initial thinking and work and is by no means exhaustive or final.

As we seek to better align our health care purchasing, Attachment 4 provides you a sense of the “presence” of public employers in the market around the state.

Identifying and Better Controlling High Cost or High Variation Services

Barney Speight is reviewing data and meeting with health plans and clinicians to discuss health care services that might be candidates for development of evidence based or best practice “guide posts.” At the same time, we are working toward convening groups of clinician experts to develop those guides. The products of this effort will be first integrated into utilization management of PEBB and other state purchased health plans, followed by working collaboratively with other public and private purchasers and domestic health plans to use uniformly.

Payment Reform

We are developing an initial list of payment methodologies that can provide better value. These will be presented to leaders from PEBB and OEBB to use in discussions with various health systems. We will dovetail these efforts with the Payment Reform Subcommittee and in discussions with plans providing services within the Oregon Health Plan.

Patient Centered Primary Care Homes

Developing a common approach to primary care medical homes is a key part of our strategy to help control costs and improve quality. PEBB and OEBB will be participating in the pilot project sponsored by the Health Leadership Task Force (HLTF) and participating health plans. We are also developing plans for supporting this in our Medicaid program. OHA staff is working closely with HTLF on selection of clinics participating in pilot project.

Value Based Benefit Design

OEBB is reviewing the whole range of services that may be subject to additional cost sharing due to limited evidence of effectiveness and will develop a plan to introduce some such services as “value based.”

Pharmaceutical Costs

On January 1, The Oregon Prescription Drug Program launched a Government Purchasing Organization. This creates a new bulk government discount that OEBB, SIAF and OHSU are taking advantage of. It will save approximately \$1 million statewide per year.

In the final stages of developing a 340B pricing proposal for specialty drugs within OHP. This should go out to bid on May 1 and will save about \$500,000/year.

Beginning to look at opportunities to better align the multiple preferred drug lists currently utilized. This will help decrease administrative expenses to providers and get better value.

Public Purchasers Committee

Update provided earlier.

Engaging with Local Health Systems

We have begun to identify and have discussions with communities that have or are organizing local health system forums for discussions with purchasers, payers, providers and others in the community. These forums hold promise for a venue in which to discuss long term transformation of local systems of care.

Connecting Health Information

Statewide strategies are being developed through HITOC as presented at the last meeting.

2010 Monthly Premium Rates for Healthy KidsConnect

Five carriers are participating in Healthy KidsConnect: one statewide carrier (PacificSource) and four regional carriers (Clear One, Trillium, Kaiser and Samaritan). Most families will have the choice between the statewide carrier and a regional carrier. Following are the full premium rates for each carrier. Note that all but one carrier charge a higher rate for children under two.

Carrier	Rate per Child	
	Ages 0 – 24 Months	Ages 2-18
PacificSource	\$464	\$233
Clear One*	\$271	\$202
Trillium	\$475	\$265
Kaiser	\$282	\$282
Samaritan	\$357	\$165

*Average of rates for seven different service areas.

Families above 300% of the Federal Poverty Level (\$66,157 for a family of four) will pay the full cost rates for each child they wish to enroll in coverage.

Premium Share Rates for Families between 200 and 300% FPL

Children in families between 200 and 300% of the Federal Poverty Level will receive a sliding scale subsidy for the cost of their premium.

Families between 201 and 250% FPL* will receive a 90% subsidy and pay:

Family Size	Statewide Carrier Rate (PacificSource)	Regional Carriers	
		Range of Rates	Average Rate
1-child	\$25	\$18 - \$28	\$22
2-4 children	\$43	\$31 - \$49	\$38
5 or more children	\$62	\$45 - \$70	\$54

*\$44,101 - \$55,128 for family of 4

Families between 251 and 300% FPL* will receive a 85% subsidy and pay:

Family Size	Statewide Carrier Rate (PacificSource)	Regional Carriers	
		Range of Rates	Average Rate
1-child	\$38	\$27 - \$42	\$33
2-4 children	\$66	\$47 - \$73	\$57
5 or more children	\$95	\$67 - \$105	\$81

*\$55,129 - \$66,156 for family of 4

Attachment 2

Key Health & Health Care-Related Bills Passed by the Legislature February 2010

Bill #	Summary	Chief Sponsor
HB 3626	Directs Department of Education (DOE) to establish vision screening pilot program in three school districts. Vision screening programs in schools help identifying students with visual impairments that can affect the physical, intellectual, social and emotional development of children.	Kotek
HB 3631	Prohibits insurers from treating injuries from sexual violence as a preexisting condition for coverage, underwriting or rating purposes, thereby ensuring that survivors' access to insurance will not be affected by seeking treatment for the violence perpetuated against them. Also provides clarification to current law that the protection against discrimination applies to physical as well as mental injuries sustained as a result of the violence, and to treatment obtained as a result of the violence. According to the Attorney General's Sexual Assault Task Force, approximately one in six Oregon women will experience sexual assault in her lifetime. Increased health care costs as a result of sexual assault include mental health care, and disease processes resulting from drugs, nicotine and alcohol addiction, heart disease and hypertension.	VanOrman
HB 3639	Creates the Primary Care Services Program to provide loan repayments to primary care providers who agree to practice in qualifying practice sites. The loan repayment program will be administered by OHSU's Office of Rural Health and will have distinct methods for distributing funding for rural and urban providers. Also makes Naturopathic Doctors eligible for the program. Becomes operative July 1, 2011. No funding was appropriated for the current biennium.	Smith
HB 3642	Allows a group of supervising physicians to collectively supervise physician assistant rather than linking specific physician assistants to specific supervising physicians.	Nathanson
HB 3659	Positions Oregon to be eligible to receive approximately \$50 million should federal health care reform pass as current envisioned in the Senate bill. Establishes the Temporary High Risk Pool Program and program fund to be administered by the Oregon Medical Insurance Pool Board (OMIP Board). Authorizes Oregon Health Authority to seek approval from U.S. Department of Health and Human Services for federal funding for the program if federal funding becomes available. National health reform legislation proposals have	Holvey

Key Health & Health Care-Related Bills Passed by the Legislature February 2010

Bill #	Summary	Chief Sponsor
	included an expansion of state high-risk pools as an interim way to make health insurance available to more uninsured people prior to the expansion of Medicaid. Sunsets January 2, 2016.	
HB 3664	Extends health care coverage through the Oregon Health Plan to former foster children until they are 21. Costs to be covered with receipts from the one percent premium assessment on commercial insurers.	House Health Care Committee
HB 3665	Prohibits dental service contracts from restricting the prices a dental health services provider may charge an enrollee of the plan for noncovered services. Nationally, a number of companies that sell dental benefit plans have required, as part of their contract with dentists that these dentists give a discount for services to a plan enrollee for services not covered by the plan.	House Health Care Committee
HB 3666	Permits electronic administration of small employer group or individual health insurance and authorizes the Director of the Department of Consumer and Business Services to approve discounted rates for electronic administration of health insurance. Specifies that an insurer who elects to offer discounted rates for a health insurance plan utilizing electronic administration must include the schedule of as part of rate filing. The rate discounts may be graduated and must be proportionate to the amount of administrative cost savings the insurer anticipates as a result of the use of electronic transactions.	House Health Care Committee
SB 1003	Allows Department of Consumer and Business Services to grant an exemption from 95 percent retention rate requirement for association health plan according to rules adopted by director. The passage of House Bill 3321 (2007) allowed group health insurers more flexibility in selling association and trust health benefit plans to small employer groups. The bill established protections to keep groups insured under these plans from losing coverage due to high claims, and made out-of-state association and trust health plans subject to the same requirements as Oregon-based associations. The bill also prohibited associations and insurers from denying membership or coverage to any small employer group based on health; limited how much the initial premium rate may vary between groups of small employers; required associations to maintain retention rates of 95 percent (or follow the more stringent regulations of small group health	Monnes Anderson

Key Health & Health Care-Related Bills Passed by the Legislature February 2010

Bill #	Summary	Chief Sponsor
	insurance laws); and, required DCBS to monitor association health plans. The provisions of HB 3321 sunset in 2014 to allow the Legislative Assembly to evaluate its impact on Oregon's health insurance market. Some associations have reportedly been struggling to maintain a 95percent retention rate, and some have failed altogether. Senate Bill 1003 allows associations to seek a waiver of the retention rate. DCBS would establish standards to review the requests.	
SB 1025	Requires radon-resistant construction standards for residential and commercial buildings. Radon gas is the second leading cause of lung cancer.	Dingfelder
SB 1046	Allows licensed psychologists, who meet certain requirements, to prescribe certain medications. Establishes a Committee on Prescribing Psychologists, within the Oregon Medical Board, to develop a formulary of approved drugs and make recommendations on training programs, qualifications, address complaints and report on the program.	Senate Health Care Committee
SB 1047	Exempts health insurance policies delivered or issued for delivery outside of Oregon from the one percent premium assessment on commercial insurers. As originally written, out-of-state health care purchasers that cover Oregon residents would have to track and be assessed for each Oregon premium. Premiums being exempted by this bill were not in the original revenue projections for HB 2116.	House Health Care Committee

THE PRESIDENT'S PROPOSAL
February 22, 2010

The President's Proposal puts American families and small business owners in control of their own health care.

- It makes insurance more affordable by providing the largest middle class tax cut for health care in history, reducing premium costs for tens of millions of families and small business owners who are priced out of coverage today. This helps over 31 million Americans afford health care who do not get it today – and makes coverage more affordable for many more.
- It sets up a new competitive health insurance market giving tens of millions of Americans the exact same insurance choices that members of Congress will have.
- It brings greater accountability to health care by laying out commonsense rules of the road to keep premiums down and prevent insurance industry abuses and denial of care.
- It will end discrimination against Americans with pre-existing conditions.
- It puts our budget and economy on a more stable path by reducing the deficit by \$100 billion over the next ten years – and about \$1 trillion over the second decade – by cutting government overspending and reining in waste, fraud and abuse.

The President's Proposal bridges the gap between the House and Senate bills and includes new provisions to crack down on waste, fraud and abuse.

It includes a targeted set of changes to the Patient Protection and Affordable Care Act, the Senate-passed health insurance reform bill. The President's Proposal reflects policies from the House-passed bill and the President's priorities. Key changes include:

- Eliminating the Nebraska FMAP provision and providing significant additional Federal financing to all States for the expansion of Medicaid;
- Closing the Medicare prescription drug “donut hole” coverage gap;
- Strengthening the Senate bill's provisions that make insurance affordable for individuals and families;
- Strengthening the provisions to fight fraud, waste, and abuse in Medicare and Medicaid;
- Increasing the threshold for the excise tax on the most expensive health plans from \$23,000 for a family plan to \$27,500 and starting it in 2018 for all plans;
- Improving insurance protections for consumers and creating a new Health Insurance Rate Authority to provide Federal assistance and oversight to States in conducting reviews of unreasonable rate increases and other unfair practices of insurance plans.

A detailed summary of the provisions included in the President’s Plan is set forth below:

Policies to Improve the Affordability and Accountability

Increase Tax Credits for Health Insurance Premiums. Health insurance today often costs too much and covers too little. Lack of affordability leads people to delay care, skip care, rack up large medical bills, or become uninsured. The House and Senate health insurance bills lower premiums through increased competition, oversight, and new accountability standards set by insurance exchanges. The bills also provide tax credits and reduced cost sharing for families with modest income. The President’s Proposal improves the affordability of health care by increasing the tax credits for families. Relative to the Senate bill, the President’s Proposal lowers premiums for families with income below \$44,000 and above \$66,000. Relative to the House bill, the proposal makes premiums less expensive for families with income between roughly \$55,000 and \$88,000.

Tax Credits: Maximum Percent of Income Paid for Premiums

Income for a Family of Four		House	Senate	President's Proposal
From:	To:			
\$22,000	\$29,000	1.5%	2.0%	2.0 - 3.0%
\$29,000	\$33,000	1.5 - 3.0%	4.0 - 4.6%	3.0 - 4.0%
\$33,000	\$44,000	3.0 - 5.5%	4.6 - 6.3%	4.0 - 6.3%
\$44,000	\$55,000	5.5 - 8.0%	6.3 - 8.1%	6.3 - 8.1%
\$55,000	\$66,000	8.0 - 10.0%	8.1 - 9.8%	8.1 - 9.5%
\$66,000	\$77,000	10.0 - 11.0%	9.8%	9.5%
\$77,000	\$88,000	11.0 - 12.0%	9.8%	9.5%

Ranges from 133-150% of poverty, then 150-400% of poverty in 50% increments, rounded to the nearest \$1,000

The President’s Proposal also improves the cost sharing assistance for individuals and families relative to the Senate bill. Families with income below \$55,000 will get extra assistance; the additional funding to insurers will cover between 73 and 94% of their health care costs. It provides the same cost-sharing assistance as the Senate bill for higher-income families and the same assistance as the House bill for families with income from \$77,000 to \$88,000.

Reduced Cost Sharing: Percent of Costs Paid for by Health Insurance Plan

Income for a Family of Four		House	Senate	President's Proposal
From:	To:			
\$29,000	\$33,000	97%	90%	94%
\$33,000	\$44,000	93%	80%	85%
\$44,000	\$55,000	85%	70%	73%
\$55,000	\$66,000	78%	70%	70%
\$66,000	\$77,000	72%	70%	70%
\$77,000	\$88,000	70%	70%	70%

Ranges from 133-150% of poverty, then 150-400% of poverty in 50% increments, rounded to the nearest \$1,000

Close the Medicare Prescription Drug “Donut Hole”. The Medicare drug benefit provides vital help to seniors who take prescription drugs, but under current law, it leaves many beneficiaries without assistance when they need it most. Medicare stops paying for prescriptions after the plan and beneficiary have spent \$2,830 on prescription drugs, and only starts paying again after out-of-pocket spending hits \$4,550. This “donut hole” leaves seniors paying the full

cost of expensive medicines, causing many to skip doses or not fill prescriptions at all – harming their health and raising other types of health costs. The Senate bill provides a 50% discount for certain drugs in the donut hole. The House bill fully phases out the donut hole over 10 years. Both bills raise the dollar amount before the donut hole begins by \$500 in 2010.

Relative to the Senate bill, the President’s Proposal fills the “donut hole” entirely. It begins by replacing the \$500 increase in the initial coverage limit with a \$250 rebate to Medicare beneficiaries who hit the donut hole in 2010. It also closes the donut hole completely by phasing down the coinsurance so it is the standard 25% by 2020 throughout the coverage gap.

Invest in Community Health Centers. Community health centers play a critical role in providing quality care in underserved areas. About 1,250 centers provide care to 20 million people, with an emphasis on preventive and primary care. The Senate bill increases funding to these centers for services by \$7 billion and for construction by \$1.5 billion over 5 years. The House bill provides \$12 billion over the same 5 years. Bridging the difference, the President’s Proposal invests \$11 billion in these centers.

Strengthen Oversight of Insurance Premium Increases. Both the House and Senate bills include significant reforms to make insurance fair, accessible, and affordable to all people, regardless of pre-existing conditions. One essential policy is “rate review” meaning that health insurers must submit their proposed premium increases to the State authority or Secretary for review. The President’s Proposal strengthens this policy by ensuring that, if a rate increase is unreasonable and unjustified, health insurers must lower premiums, provide rebates, or take other actions to make premiums affordable. A new Health Insurance Rate Authority will be created to provide needed oversight at the Federal level and help States determine how rate review will be enforced and monitor insurance market behavior.

Extend Consumer Protections against Health Insurer Practices. The Senate bill includes a “grandfather” policy that allows people who like their current coverage, to keep it. The President’s Proposal adds certain important consumer protections to these “grandfathered” plans. Within months of legislation being enacted, it requires plans to cover adult dependents up to age 26, prohibits rescissions, mandates that plans have a stronger appeals process, and requires State insurance authorities to conduct annual rate review, backed up by the oversight of the HHS Secretary. When the exchanges begin in 2014, the President’s Proposal adds new protections that prohibit all annual and lifetime limits, ban pre-existing condition exclusions, and prohibit discrimination in favor of highly compensated individuals. Beginning in 2018, the President’s Proposal requires “grandfathered” plans to cover proven preventive services with no cost sharing.

Improve Individual Responsibility. All Americans should have affordable health insurance coverage. This helps everyone, both insured and uninsured, by reducing cost shifting, where people with insurance end up covering the inevitable health care costs of the uninsured, and making possible robust health insurance reforms that will curb insurance company abuses and increase the security and stability of health insurance for all Americans. The House and Senate bills require individuals who have affordable options but who choose to remain uninsured to make a payment to offset the cost of care they will inevitably need. The House bill’s payment is

a percentage of income. The Senate sets the payment as a flat dollar amount or percentage of income, whichever is higher (although not higher than the lowest premium in the area). Both the House and Senate bill provide a low-income exemption, for those individuals with incomes below the tax filing threshold (House) or below the poverty threshold (Senate). The Senate also includes a “hardship” exemption for people who cannot afford insurance, included in the President’s Proposal. It protects those who would face premiums of more than 8 percent of their income from having to pay any assessment and they can purchase a low-cost catastrophic plan in the exchange if they choose.

The President’s Proposal adopts the Senate approach but lowers the flat dollar assessments, and raises the percent of income assessment that individuals pay if they choose not to become insured. Specifically, it lowers the flat dollar amounts from \$495 to \$325 in 2015 and \$750 to \$695 in 2016. Subsequent years are indexed to \$695 rather than \$750, so the flat dollar amounts in later years are lower than the Senate bill as well. The President’s Proposal raises the percent of income that is an alternative payment amount from 0.5 to 1.0% in 2014, 1.0 to 2.0% in 2015, and 2.0 to 2.5% for 2016 and subsequent years – the same percent of income as in the House bill, which makes the assessment more progressive. For ease of administration, the President’s Proposal changes the payment exemption from the Senate policy (individuals with income below the poverty threshold) to individuals with income below the tax filing threshold (the House policy). In other words, a married couple with income below \$18,700 will not have to pay the assessment. The President’s Proposal also adopts the Senate’s “hardship” exemption.

Strengthen Employer Responsibility. Businesses are strained by the current health insurance system. Health costs eat into their ability to hire workers, invest in and expand their businesses, and compete locally and globally. Like individuals, larger employers should share in the responsibility for finding the solution. Under the Senate bill, there is no mandate for employers to provide health insurance. But as a matter of fairness, the Senate bill requires large employers (i.e., those with more than 50 workers) to make payments only if taxpayers are supporting the health insurance for their workers. The assessment on the employer is \$3,000 per full-time worker obtaining tax credits in the exchange if that employer’s coverage is unaffordable, or \$750 per full-time worker if the employer has a worker obtaining tax credits in the exchange but doesn’t offer coverage in the first place. The House bill requires a payroll tax for insurers that do not offer health insurance that meets minimum standards. The tax is 8% generally and phases in for employers with annual payrolls from \$500,000 to \$750,000; according to the Congressional Budget Office (CBO), the assessment for a firm with average wages of \$40,000 would be \$3,200 per worker.

Under the President’s Proposal, small businesses will receive \$40 billion in tax credits to support coverage for their workers beginning this year. Consistent with the Senate bill, small businesses with fewer than 50 workers would be exempt from any employer responsibility policies.

The President’s Proposal is consistent with the Senate bill in that it does not impose a mandate on employers to offer or provide health insurance, but does require them to help defray the cost if taxpayers are footing the bill for their workers. The President’s Proposal improves the transition to the employer responsibility policy for employers with 50 or more workers by subtracting out the first 30 workers from the payment calculation (e.g., a firm with 51 workers that does not

offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount). It changes the applicable payment amount for firms with more than 50 employees that do not offer coverage to \$2,000 – an amount that is one-third less than the average House assessment for a typical firm and less than half of the average employer contribution to health insurance in 2009. It applies the same firm-size threshold across the board to all industries. It fully eliminates the assessment for workers in a waiting period, while maintaining the 90-day limit on the length of any waiting period beginning in 2014.

Policies to Crack Down on Waste, Fraud and Abuse

The House and Senate health reform bills contain an unprecedented array of aggressive new authorities to fight waste, fraud and abuse. The President’s Proposal builds on those provisions by incorporating a number of additional proposals that are either part of the Administration’s FY 2011 Budget Proposal or were included in Republican plans.

Comprehensive Sanctions Database. The President’s Proposal establishes a comprehensive Medicare and Medicaid sanctions database, overseen by the HHS Inspector General. This database will provide a central storage location, allowing for law enforcement access to information related to past sanctions on health care providers, suppliers and related entities. (Source: H.R. 3400, “Empowering Patients First Act” (Republican Study Committee bill))

Registration and Background Checks of Billing Agencies and Individuals. In an effort to decrease dishonest billing practices in the Medicare program, the President’s Proposal will assist in reducing the number of individuals and agencies with a history of fraudulent activities participating in Federal health care programs. It ensures that entities that bill for Medicare on behalf of providers are in good standing. It also strengthens the Secretary’s ability to exclude from Medicare individuals who knowingly submit false or fraudulent claims. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Expanded Access to the Healthcare Integrity and Protection Data Bank. Increasing access to the health care integrity data bank will improve coordination and information sharing in anti-fraud efforts. The President’s Proposal broadens access to the data bank to quality control and peer review organizations and private plans that are involved in furnishing items or services reimbursed by Federal health care program. It includes criminal penalties for misuse. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Liability of Medicare Administrative Contractors for Claims Submitted by Excluded Providers. In attacking fraud, it is critical to ensure the contractors that are paying claims are doing their utmost to ensure excluded providers do not receive Medicare payments. Therefore, the President’s Proposal provision holds Medicare Administrative Contractors accountable for Federal payment for individuals or entities excluded from the Federal programs or items or services for which payment is denied. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Community Mental Health Centers. The President’s Proposal ensures that individuals have access to comprehensive mental health services in the community setting, but strengthens

standards for facilities that seek reimbursement as community mental health centers by ensuring these facilities are not taking advantage of Medicare patients or the taxpayers. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Limiting Debt Discharge in Bankruptcies of Fraudulent Health Care Providers or Suppliers. The President’s Proposal will assist in recovering overpayments made to providers and suppliers and return such funds to the Medicare Trust Fund. It prevents fraudulent health care providers from discharging through bankruptcy amounts due to the Secretary from overpayments. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Use of Technology for Real-Time Data Review. The President’s Proposal speeds access to claims data to identify potentially fraudulent payments more quickly. It establishes a system for using technology to provide real-time data analysis of claim and payments under public programs to identify and stop waste, fraud and abuse. (Source: Roskam Amendment offered in House Ways & Means Committee markup)

Illegal Distribution of a Medicare or Medicaid Beneficiary Identification or Billing Privileges. Fraudulent billing to Medicare and Medicaid programs costs taxpayers millions of dollars each year. Individuals looking to gain access to a beneficiary’s personal information approach Medicare and Medicaid beneficiaries with false incentives. Many beneficiaries unwittingly give over this personal information without ever receiving promised services. The President’s Proposal adds strong sanctions, including jail time, for individuals who purchase, sell or distribute Medicare beneficiary identification numbers or billing privileges under Medicare or Medicaid – if done knowingly, intentionally, and with intent to defraud. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill))

Study of Universal Product Numbers Claims Forms for Selected Items and Services under the Medicare Program. The President’s Proposal requires HHS to study and issue a report to Congress that examines the costs and benefits of assigning universal product numbers (UPNs) to selected items and services reimbursed under Medicare. The report must examine whether UPNs could help improve the efficient operation of Medicare and its ability to detect fraud and abuse. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill), Roskam Amendment offered in House Ways & Means Committee markup)

Medicaid Prescription Drug Profiling. The President’s Proposal requires States to monitor and remediate high-risk billing activity, not limited to prescription drug classes involving a high volume of claims, to improve Medicaid integrity and beneficiary quality of care. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes of care where possible. Requiring States to monitor high-risk billing activity to identify prescribing and utilization patterns that may indicate abuse or excessive prescription drug utilization will assist in improving Medicaid program integrity and save taxpayer dollars. (Source: President’s FY 2011 Budget)

Medicare Advantage Risk Adjustment Errors. The President’s Proposal requires in statute that the HHS Secretary extrapolate the error rate found in the risk adjustment data validation (RADV) audits to the entire Medicare Advantage contract payment for a given year when

recouping overpayments. Extrapolating risk score errors in MA plans is consistent with the methodology used in the Medicare fee-for-service program and enables Medicare to recover risk adjustment overpayments. MA plans have an incentive to report more severe beneficiary diagnoses than are justified because they receive higher payments for higher risk scores. (Source: President's FY 2011 Budget)

Modify Certain Medicare Medical Review Limitations. The Medicare Modernization Act of 2003 placed certain limitations on the type of review that could be conducted by Medicare Administrative Contractors prior to the payment of Medicare Part A and B claims. The President's Proposal modifies these statutory provisions that currently limit random medical review and place statutory limitations on the application of Medicare prepayment review. Modifying certain medical review limitations will give Medicare contractors better and more efficient access to medical records and claims, which helps to reduce waste, fraud and abuse. (Source: President's FY 2011 Budget)

Establish a CMS-IRS Data Match to Identify Fraudulent Providers. The President's Proposal authorizes the Centers for Medicare & Medicaid Services (CMS) to work collaboratively with the Internal Revenue Service (IRS) to determine which providers have seriously delinquent tax debt to help identify potentially fraudulent providers sooner. The data match will primarily target certain high-risk provider types in high-vulnerability areas. This proposal also enables both IRS and Medicare to recoup any monies owed to the Federal government through this program. By requiring the Internal Revenue Service (IRS) to disclose to CMS those entities that have evaded filing taxes and matching the data against provider billing data, this proposal will enable CMS to better detect fraudulent providers billing the Medicare program. (Source: President's FY 2011 Budget)

Preventing Delays in Access to Generic Drugs. Currently, brand-name pharmaceutical companies can delay generic competition through agreements whereby they pay the generic company to keep its drug off the market for a period of time, called "pay-for-delay." This hurts consumers by delaying their access to generic drugs, which are usually less expensive than their branded counterparts. The Federal Trade Commission (FTC) recently estimated that this could cost consumers \$35 billion over 10 years. The President's proposal adopts a provision from the bipartisan legislation that gives the FTC enforcement authority to address this problem. Specifically, it makes anti-competitive and unlawful any agreement in which a generic drug manufacturer receives anything of value from a brand-name drug manufacturer that contains a provision in which the generic drug manufacturer agrees to limit or forego research, development, marketing, manufacturing or sales of the generic drug. This presumption can only be overcome if the parties to such an agreement demonstrate by clear and convincing evidence that the pro-competitive benefits of the agreement outweigh the anti-competitive effects of the agreement. The proposal also requires the Chief Executive Officer of the branded pharmaceutical company to certify to the accuracy and completeness of any agreements required to be filed with the FTC.

Policies to Contain Costs and Ensure Fiscal Sustainability

Improve Medicare Advantage Payments. Medicare currently overpays private plans by 14 percent on average to provide the same benefits as the traditional program – and much more in some areas of the country. The Medicare Advantage program has also done little to reward quality. Moreover, plans have gamed the payment system in ways drive up the public cost of the program. All of this is why Medicare Advantage has become a very profitable line of business for some of the nation’s largest health insurers. The Senate bill creates a bidding model for payment rates and phases in changes to limit potential disruptions for beneficiaries. The House proposal phases payments down based on local fee-for-service costs.

The President’s Proposal represents a compromise between the House and Senate bills, blending elements of both bills, while providing greater certainty of cost savings by linking to current fee-for-service costs. Specifically, the President’s Proposal creates a set of benchmark payments at different percentages of the current average fee-for-service costs in an area. It phases these benchmarks in gradually in order to avoid disruption to beneficiaries, taking into account the relative payments to fee-for-service costs in an area. It provides bonuses for quality and enrollee satisfaction. It adjusts rebates of savings between the benchmark payment and actual plan bid to take into account the transition as well as a plan’s quality rating: plans with low quality scores receive lower rebates (i.e., can keep less of any savings they generate). Finally, the President’s Proposal requires a payment adjustment for unjustified coding patterns in Medicare Advantage plans that have raised payments more rapidly than the evidence of their enrollees’ health status and costs suggests is warranted, based on actuarial analysis. This is the primary source of additional savings compared to the Senate proposal.

Delay and Reform the High-Cost Plan Excise Tax. Part of the reason for high and rising insurance costs is that insurers have little incentive to lower their premiums. The Senate bill includes a tax on high-cost health insurance plans. CBO has estimated that this policy will reduce premiums as well as contribute to long-run deficit reduction. The President’s Proposal changes the effective date of the Senate policy from 2013 to 2018 to provide additional transition time for high-cost plans to become more efficient. It also raises the amount of premiums that are exempt from the assessment from \$8,500 for singles to \$10,200 and from \$23,000 for families to \$27,500 and indexes these amounts for subsequent years at general inflation plus 1 percent. To the degree that health costs rise unexpectedly quickly between now and 2018, the initial threshold would be adjusted upwards automatically. To ensure that the tax affects firms equitably, the President’s Proposal reforms it by including an adjustment for firms whose health costs are higher due to the age or gender of their workers, and by no longer counting dental and vision benefits as potentially taxable benefits. The President’s Proposal maintains the Senate bill’s permanent adjustment in favor of high-risk occupations such as “first responders.”

Broaden the Medicare Hospital Insurance (HI) Tax Base for High-Income Taxpayers. Under current law, people who earn a salary pay the Medicare HI tax on their earned income, but those who have substantial unearned income do not, raising issues of fairness. The House bill includes a 5.4% surcharge on high-income households to improve the fairness of the tax system and to support health reform. The Senate bill includes an increase in the HI tax for high-income households for similar reasons, an increase of 0.9% on earnings above a specific threshold for a total employee assessment of 2.35% on these amounts. The President’s Proposal adopts the Senate bill approach and adds a 2.9 percent assessment (equal to the combined employer and

employee share of the existing HI tax) on income from interest, dividends, annuities, royalties and rents, other than such income which is derived in the ordinary course of a trade or business which is not a passive activity (e.g., income from active participation in S corporations) on taxpayers with respect to income above \$200,000 for singles and \$250,000 for married couples filing jointly. The additional revenues from the tax on earned income would be credited to the HI trust fund and the revenues from the tax on unearned income would be credited to the Supplemental Medical Insurance (SMI) trust fund.

Increase in Fees on Brand Name Pharmaceuticals. As more Americans gain health insurance, more will be able to pay for prescription drugs. Moreover, the President's plan closes the Medicare "donut hole," ensuring that seniors do not skip or cut back on needed prescriptions. Both policies will result in new revenue for the pharmaceutical industry. The President's Proposal increases the revenue from the assessment on this industry which is \$23 billion in the Senate bill by \$10 billion over 10 years. It also delays the implementation of these fees by one year, until 2011, and makes changes to facilitate administration by the IRS.

Close Tax Loopholes. Adopts two House proposals to close tax loopholes: (1) Current law provides a tax credit for the production of cellulosic biofuels. The credit was designed to promote the production and use of renewable fuels. Certain liquid byproducts derived from processing paper or pulp (known as "black liquor" when derived from the kraft process) were not intended to be covered by this credit. The President's Proposal adopts the House bill's policy to clarify that they are not eligible for the tax credit. (2) The President's Proposal helps prevent unjustified tax shelters by clarifying the circumstances under which transactions have "economic substance" (as opposed to being undertaken solely to obtain tax benefits) and raises the penalties for transactions that lack economic substance. In so doing, it adopts the House's policy, with minor technical changes.

OTHER POLICY IMPROVEMENTS

Improve the Fairness of Federal Funding for States. States have been partners with the Federal government in creating a health care safety net for low-income and vulnerable populations. They administer and share in the cost of Medicaid and the Children's Health Insurance Program (CHIP). The Senate bill creates a nationwide Medicaid eligibility floor as a foundation for exchanges at \$29,000 for a family of 4 (133% of poverty) – and provides financial support that varies by State to do so.

Relative to the Senate bill, the President's Proposal replaces the variable State support in the Senate bill with uniform 100% Federal support for all States for newly eligible individuals from 2014 through 2017, 95% support for 2018 and 2019, and 90% for 2020 and subsequent years. This approach resembles that in the House bill, which provided full support for all States for the first two years, and then 91% support thereafter. The President's Proposal also recognizes the early investment that some States have made in helping the uninsured by expanding Medicaid to adults with income below 100% of poverty by increasing those States' matching rate on certain health care services by 8 percentage points beginning in 2014. The President's Proposal also provides additional assistance to the Territories, raising the Medicaid funding cap by 35% rather than the Senate bill's 30%.

Simplify Income Definitions. The President's Proposal seeks to simplify eligibility rules for various existing programs as well as for the new tax credits. Consistent with some of the policies in the House bill, the President's Proposal will conform income definitions to make the system simpler for beneficiaries to navigate and States and the Federal government to administer by: changing the definition of income used for assistance from modified gross income to modified adjusted gross income, which is easier to implement; creating a 5% income disregard for certain Medicaid eligibility determinations to ease the transition from States' current use of income disregards; streamlining the income reconciliation process for determining tax credits and reduced cost sharing; and clarifying the tax treatment of employer contributions for adult dependent coverage.

Delay and Reform of Fees on Health Insurance Providers. Like the drug industry, the health insurance industry stands to gain as more Americans get coverage. The Senate bill includes a \$67 billion assessment on health insurers over 10 years to offset some of the cost of enrolling millions of Americans in their plans. The President's Proposal delays the assessment until 2014 to coincide with broader coverage provisions which will substantially expand the market for health insurance providers. It provides limited exemptions for plans that serve critical purposes for the community, including non-profits that receive more than 80 percent of their income from government programs targeting low-income or elderly populations, or those with disabilities, as well as for voluntary employees' beneficiary associations (VEBAs) that are not established by employers.

Delay and Convert Fee on Medical Device Manufacturers to Excise Tax. The medical device industry also stands to gain from expanding health insurance coverage. Both the House and Senate bills raise \$20 billion in revenue from this industry over 10 years. The President's Proposal replaces the medical device fee with an excise tax (yielding the same revenue) that starts in 2013 to facilitate administration by the IRS.

Strengthen the CLASS Act. The House and Senate health insurance reform proposals include the Community Living Assistance Services and Supports (CLASS) Program, a voluntary, privately-funded long-term services insurance program. The CLASS Program offers workers an optional payroll deduction for an insurance program that provides a cash benefit if they become disabled. The President's Proposal makes a series of changes to the Senate bill to improve the CLASS program's financial stability and ensure its long-run solvency.

Protect the Social Security Trust Funds. The President's Proposal provides that, if necessary, funds will be transferred to the Social Security Trust Funds to ensure that they are held harmless by the Proposal.

Ensure Effective Implementation. The policy changes in health insurance reform will require careful, effective, deliberate, and transparent implementation. The President's Proposal appropriates \$1 billion for the Administration to implement health insurance reform policies. It also delays several of the policies to ensure effective implementation and improve transitions: the therapeutic discovery credit, elimination of the deduction for expenses allocable to the

Medicare Part D subsidy, the pharmaceutical and medical device industry fees, and the health insurance industry fee.

Learn more about the President's Proposal at <http://www.whitehouse.gov/health-care-meeting>

Summary of Impact of Public Purchasers on Insured Market in Oregon

County	Medicaid	FHIAIP	OMIP	PEBB	Total State	OEBB	Local Gov't	Grand Total	<65 Pop	Number of Uninsured Under 65	Total Insured Population Under 65	% Penetration
BAKER	2,250	51	67	744	3,112	844	847	4,803	13,026	2,475	10,551	45.5%
BENTON	5,758	82	251	8,151	14,242	2,473	2,930	19,645	76,962	11,775	65,187	30.1%
CLACKAMAS	29,322	418	1,540	6,833	38,113	11,750	8,910	58,773	333,795	39,722	294,073	20.0%
CLATSOP	4,098	49	213	828	5,188	2,059	2,396	9,643	31,816	6,045	25,771	37.4%
COLUMBIA	5,424	64	153	577	6,218	2,105	1,327	9,650	41,892	7,959	33,933	28.4%
COOS	10,184	98	273	1,367	11,922	3,146	4,495	19,563	50,195	9,336	40,859	47.9%
CROOK	2,778	25	128	468	3,399	942	503	4,844	23,067	5,421	17,646	27.5%
CURRY	2,491	35	192	320	3,038	837	1,287	5,162	15,020	2,794	12,226	42.2%
DESCHUTES	15,746	144	1,002	2,804	19,696	8,206	5,346	33,248	146,891	29,084	117,807	28.2%
DOUGLAS	15,939	126	355	1,257	17,677	4,341	3,604	25,622	85,176	14,395	70,781	36.2%
GILLIAM	165	3	15	61	244	143	255	642	1,487	349	1,138	56.5%
GRANT	824	29	51	311	1,215	541	881	2,637	6,109	1,436	4,673	56.4%
HARNEY	921	22	41	311	1,295	512	1,024	2,831	6,326	1,240	5,086	55.7%
HOOD RIVER	2,839	25	110	420	3,394	1,385	891	5,670	18,935	4,450	14,485	39.1%
JACKSON	26,838	295	1,012	4,049	32,194	4,640	5,465	42,299	173,088	33,233	139,855	30.2%
JEFFERSON	3,862	8	47	534	4,451	1,060	1,748	7,259	19,446	4,570	14,876	48.8%
JOSEPHINE	14,218	201	484	1,204	16,107	811	1,703	18,621	66,415	12,353	54,062	34.4%
KLAMATH	10,027	43	276	1,918	12,264	3,216	3,069	18,549	56,043	10,984	45,059	41.2%
LAKE	967	11	38	478	1,494	384	824	2,702	6,115	1,199	4,916	55.0%
LANE	43,509	631	1,657	13,340	59,137	11,596	14,256	84,989	297,850	49,145	248,705	34.2%
LINCOLN	6,677	64	314	1,019	8,074	1,558	2,317	11,949	35,480	6,741	28,739	41.6%
LINN	17,200	184	390	5,071	22,845	6,150	4,158	33,153	93,833	14,356	79,477	41.7%
MALHEUR	5,657	19	87	1,457	7,220	1,934	2,699	11,853	27,224	5,336	21,888	54.2%
MARION	51,195	456	761	29,515	81,927	16,302	15,246	113,475	279,860	55,972	223,888	50.7%
MORROW	1,639	1	45	383	2,068	710	893	3,671	11,141	2,618	8,523	43.1%
MULTNOMAH	93,670	996	2,867	12,086	109,619	16,859	49,500	175,978	647,893	106,902	540,991	32.5%
POLK	8,950	102	181	8,665	17,898	4,565	NA	22,463	58,536	7,024	51,512	43.6%
SHERMAN	204	0	16	47	267	147	216	630	1,413	332	1,081	58.3%
TILLAMOOK	2,936	26	148	708	3,818	1,380	1,327	6,525	20,546	3,904	16,642	39.2%
UMATILLA	10,974	90	200	4,078	15,342	4,965	2,119	22,426	62,800	11,932	50,868	44.1%
UNION	3,514	52	132	1,995	5,693	1,367	1,241	8,301	21,414	4,069	17,345	47.9%
WALLOWA	766	17	81	212	1,076	343	764	2,183	5,559	1,056	4,503	48.5%
WASCO	3,576	33	120	583	4,312	1,405	1,208	6,925	20,161	4,738	15,423	44.9%
WASHINGTON	44,712	378	1,584	7,396	54,070	15,019	14,652	83,741	477,039	67,262	409,777	20.4%
WHEELER	158	0	7	56	221	124	156	501	1,119	263	856	58.6%
YAMHILL	12,189	134	309	1,990	14,622	4,998	2,772	22,392	83,970	10,076	73,894	30.3%
Unknown/out of state	303	0	0	5,201	5,504	4,149	0	9,653	0	0	0	
STATE TOTAL	462,480	4,912	15,147	126,437	608,976	142,966	161,027	912,969	3,317,641	550,548	2,767,094	33.0%

Regional Summary of Impact of Public Purchasers on Insured Market in Oregon

Region	State	OEBB	Local Govt	Total	Insured Population Under 65	% Penetration
NW Oregon						
Clackamas	38,113	11,750	8,910	58,773	294,073	20.0%
Multnomah	109,619	16,859	49,500	175,978	540,991	32.5%
Washington	54,070	15,019	14,652	83,741	409,777	20.4%
<i>Sub Total</i>	201,802	43,628	73,062	318,492	1,244,841	25.6%
Clatsop	5,188	2,059	2,396	9,643	25,771	37.4%
Columbia	6,218	2,105	1,327	9,650	33,933	28.4%
Hood River	3,394	1,385	891	5,670	14,485	39.1%
Tillamook	3,818	1,380	1,327	6,525	16,642	39.2%
Yamhill	14,622	4,998	2,772	22,392	73,894	30.3%
<i>Sub Total</i>	33,240	11,927	8,712	53,879	164,725	32.7%
Region Total	235,042	55,555	81,774	372,371	1,409,566	26.4%
Salem Area						
Marion / Polk	99,825	20,867	15,246	135,938	275,400	49.4%
Mid Valley						
Benton	14,242	2,473	2,930	19,645	65,187	30.1%
Linn	22,845	6,150	4,158	33,153	79,477	41.7%
Lincoln	8,074	1,558	2,317	11,949	28,739	41.6%
Region Total	45,161	10,181	9,405	64,747	173,402	37.3%
Lane County	59,137	11,596	14,256	84,989	248,705	34.2%
Douglas						
Douglas	17,677	4,341	3,604	25,622	70,781	36.2%
Coos	11,922	3,146	4,495	19,563	40,859	47.9%
Region Total	29,599	7,487	8,098	45,184	111,640	40.5%
Southern Oregon						
Jackson	32,194	4,640	5,465	42,299	139,855	30.2%
Josephine	16,107	811	1,703	18,621	54,062	34.4%
Curry	3,038	837	1,287	5,162	12,226	42.2%
Region Total	51,339	6,288	8,455	66,082	206,143	32.1%
Central Oregon						
Deschutes	19,696	8,206	5,346	33,248	117,807	28.2%
Crook	3,399	942	503	4,844	17,646	27.5%
Jefferson	4,451	1,060	1,748	7,259	14,876	48.8%
Region Total	27,546	10,208	7,597	45,351	150,329	30.2%

Region	State	OEBB	Local Govt	Total	Insured Population Under 65	% Penetration
Mid-Columbia						
Gilliam	244	143	255	642	1,138	56.5%
Morrow	2,068	710	893	3,671	8,523	43.1%
Sherman	267	147	216	630	1,081	58.3%
Umatilla	15,342	4,965	2,119	22,426	50,868	44.1%
Wasco	4,312	1,405	1,208	6,925	15,423	44.9%
Wheeler	221	124	156	501	856	58.6%
Region Total	22,454	7,494	4,847	34,795	77,889	44.7%
Southeastern Oregon						
Grant	1,215	541	881	2,637	4,673	56.4%
Harney	1,295	512	1,024	2,831	5,086	55.7%
Klamath	12,264	3,216	3,069	18,549	45,059	41.2%
Lake	1,494	384	824	2,702	4,916	55.0%
Region Total	16,268	4,653	5,797	26,718	59,735	44.7%
Northeastern Oregon						
Baker	3,112	844	847	4,803	10,551	45.5%
Malheur	7,220	1,934	2,699	11,853	21,888	54.2%
Union	5,693	1,367	1,241	8,301	17,345	47.9%
Wallowa	1,076	343	764	2,183	4,503	48.5%
Region Total	17,101	4,488	5,552	27,141	54,287	50.0%
Unknowns	5,504	4,149	0	9,653	0	NA
State Totals	608,976	142,966	161,027	912,969	2,767,094	33.0%