
Oregon Health Fund Board



OHFB Committee and Workgroup Executive Summary Recommendations to the Oregon Health Fund Board

July 2008

COMPILATION OF COMMITTEE AND WORKGROUP
EXECUTIVE SUMMARY RECOMMENDATIONS
TO THE OREGON HEALTH FUND BOARD

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BENEFITS COMMITTEE EXECUTIVE SUMMARY

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state. The Benefits Committee developed the list of guiding principles to frame these recommendations.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health homes become the basis for cost-effective, patient-centered care
- Health care services are not segregated based on the part of the body they involve or the qualified health professionals who deliver them
 - Coverage for mental health and dental services should be based on the same criteria as other physical health conditions
- Coverage of services should be evidence-based to the highest degree possible
 - The Health Services Commission or other similar body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Coverage focuses on care which reduces the overall cost and complications of disease
 - Value-based services are an integral part of the package, representing evidence-based services that maintain or improve health, prevent illness and illness complications, and/or reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility should be rewarded
 - Value-based services should include incentives and rewards for patients who actively participate in their own health care

The EBP would be **affordable for individuals and the state**:

- Value-based services (including evidence-based preventive services) and basic diagnostic services should be available to all with no or low cost barriers
- Other types of care should be covered after the beneficiary meets a high deductible amount (adjusted for financial means). A limited number of discretionary services may have separate coverage maximums. These limitations in the plan will help result in a reduction in the cost of premiums.
- After the deductible is met, personal financial responsibility for services increases for conditions that appear lower on the Health Services Commission's Prioritized List of Health Services
- The introduction of an out-of-pocket maximum protects individuals and families from profound financial losses from catastrophic illness or injury

The EBP would serve as the **"foundation level" of health care coverage** below which no individual's coverage should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease-specific plans that do not serve the overall health of an individual or insured population
- Under this proposal, the current benefits offered to the categorically eligible Medicaid populations would not differ from the current OHP Plus benefit package with nominal copays.

Figure 1. Summary of the Essential Benefit Package

Category of Care ¹	Cost Sharing ²			Deductible/OOP Max ³
	Integrated Health Home	Specialist, Procedures, Other Outpatient ⁴	Inpatient	
Value-Based Services	0 – 5% depending on service provided and location of care			<ul style="list-style-type: none"> •Deductible waived •\$4,000-\$15,000 OOP max applies per individual (income-based, family = 3 times individual), includes deductible
2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics	0%	5%	Not applicable	
Comfort Care	0%	5%	20%	<ul style="list-style-type: none"> •\$1,000-\$7,500 deductible applies per individual (income-based, family=3x) •OOP max applies
Tier I (Lines 1-113)	20%	25%	30%	
Tier II (Lines 114-311)	30%	35%	40%	
Tier III (Lines 312-503)	40%	45%	50%	<ul style="list-style-type: none"> •OOP max applies
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	
Excluded Conditions	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Discretionary Services	40%	45%	50%	<ul style="list-style-type: none"> •Deductible applies •OOP max does not apply •\$2,000/yr limit
Ambulance	\$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			
Prescription Medications	<ul style="list-style-type: none"> •\$5 copay for generics, \$25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)⁵ •Evidence-based formulary will be used⁶ •No coverage for medications for non-covered conditions 			<ul style="list-style-type: none"> •Deductible waived •OOP max applies
Emergency Department	\$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
Diagnostic Services	<ul style="list-style-type: none"> •Beyond 2 diagnostic visits, well-person visits and basic office diagnostics above •Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%) •Limitations according to evidence-based guidelines, location of service, etc. •Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization 			
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			

Benefits Committee Executive Summary

Notes

- ¹Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. The placement of tier break-points could change based on further review by the Commission, future changes to the Prioritized List, and/or public comment.
- ²Cost sharing amounts are based on income level – those below 100% of the Federal Poverty Level would have, at most, nominal copays at point-of-service. Amounts shown here are examples and can be adjusted until actuarial pricing is acceptable.
- ³Deductible amounts and out-of-pocket maximums are based on income level – those below 100% of the Federal Poverty Level would have no deductibles. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.
- ⁴Some specialist services and procedures may be provided within the integrated health home for certain individuals.
- ⁵The cost share is reduced to 50% coinsurance for generic prescriptions and preferred drugs if this is less than the copay level and increased to a \$50 copay for non-preferred brand drugs if this is more than the 50% coinsurance amount. All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.
- ⁶An evidence-based formulary should be utilized and based on sources such as the Drug Effectiveness Review Project (DERP).

DELIVERY SYSTEMS COMMITTEE EXECUTIVE SUMMARY

Background

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations on specific aspects of the reform plan. One of these committees, the Delivery Systems Committee, was assigned the difficult task of providing the Board with policy recommendations to create high-performing health delivery systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

While the Oregon Health Fund Board did not aim to limit the scope of the investigation and recommendations from the Delivery Systems Committee, the Committee's charter from the Board listed a number of priority areas of interest. These included: revitalizing primary care; managing chronic disease; developing new reimbursement models; increasing information transparency by collecting, measuring and reporting quality data; encouraging the diffusion of health information technology; ensuring the appropriate diffusion and utilization of clinical technology; strengthening public health and prevention; and improving end-of-life.

Vision Statement

The Delivery Systems Committee has a bold vision for health care in Oregon: *World Class Health Care for Each Oregonian*. This includes world class physical, behavioral and oral health. The current delivery system is broken and unsustainable and world class care cannot be achieved within the existing framework. Achieving world class care requires a radical transformation, as part of larger comprehensive reform. This must include a revitalization of primary care and a focus on preventing and managing chronic diseases, while improving the quality of care across the health care system. The people and the economy of the state cannot wait any longer – transformation is needed now.

Delivery System Change as Part of Comprehensive Reform

The Committee developed a series of recommendations which the members believe will help to contain costs over the long term, while improving population health and improving patient experience with care. Many of these recommendations are aligned with the Board's priority areas, with some additional ideas drawn from health service research and experience in other states. The main recommendations are captured in the Committee's "Framework for Delivery System Reform" presented in Section V of this report. The Delivery System Committee recognizes that most of the recommendations put forth in this report represent long-term goals that cannot be accomplished in isolation and must be viewed as one piece of larger reform. In the short term, many of the recommendations that follow will require an investment in sustainable change and the Health Fund Board must look for opportunities to reduce short-term spending in other parts of the system that can be reinvested in delivery system reform.

The recommendations presented below call for transformational change in the fundamental way things are done. The recommendations represent a significant cultural change in the organization and delivery of care and require strong public/private partnerships in the design, delivery, and

monitoring of health care services. The Committee recognizes that there will be strong opposition to many of its proposals and challenges the Health Fund Board, the Oregon Legislature and the entire state to have the political will to push for the changes needed to move Oregon toward a world class health system.

Committee Recommendations

Primary Care and Chronic Disease Management/ Integrated Health Homes

Primary Care/Integrated Health Homes Recommendation 1: Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Primary Care/Integrated Health Homes Recommendation 2: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual statewide adoption to ensure integrated health homes are available to all Oregonians.

Primary Care/Integrated Health Homes Recommendation 3: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health (including Employee Assistance Programs), oral health, and social services to improve population health.

Primary Care/Integrated Health Homes Recommendation 4: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes.

Primary Care/Integrated Health Homes Recommendation 5: Develop a plan to ensure that Oregon has a workforce able to meet population need, especially safety net providers and those serving vulnerable populations.

Primary Care/Integrated Health Homes Recommendation 6: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Primary Care/Integrated Health Homes Recommendation 7: Develop funding, payment and incentivizing strategies that promote and sustain integrated health homes and other system of care partners. Primary Care/Integrated Health Homes Recommendation 8: Recognize, strengthen and integrate the role of the safety net in delivering services to Oregon's vulnerable populations.

Improving Quality and Increasing Transparency

An Oregon Quality Institute

While there are numerous public and private efforts underway across the state to improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency. The Committee recommends the state establish and provide substantial, long-term funding for a publicly chartered Oregon Quality Institute.

Quality Institute (QI) Recommendation 1: An Oregon Quality Institute should be established as a publicly chartered public-private organization. The state should provide stable long-term funding to support the Institute.

QI Recommendation 2: The Quality Institute’s overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency.
2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services
3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.
4. Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Set standards for what metrics are collected and reported and how data is collected and reported. Set performance benchmarks that can be adapted over time.
5. Advise the Governor and the Legislature on policy changes/regulations to improve quality and transparency.

QI Recommendation 3: As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities:

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects.

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures.
- Lessen the burden of reporting that currently complicates the provision of health care.
- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.
- Align with recommendations of the Governor’s Health Information Infrastructure Advisory Committee (HIIAC) about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. Support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensures that the right information is available at the right time to patients, providers, and payers.
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions.

Financial Transparency

There needs to be greater transparency about health care costs and provider operating and financial data. While there are a number of state-sponsored projects working to increase financial transparency in Oregon, access to this type of information remains limited.

Financial Transparency Recommendation 1: Require health care providers, including but not limited to hospitals, ambulatory surgery and imaging centers to be more transparent and public about fiscal information.

Accountable Care Districts

Accountable care districts will act as a vehicle to foster shared accountability for quality and cost among all of the providers (including physicians, other health care professionals, hospitals, and other centers where health care is delivered) serving a defined population across the continuum of care.

Accountable Care District (ACD) Recommendation 1: Define accountable care districts within Oregon’s delivery system. All health care quality and utilization data reported by the Oregon Quality Institute will be aggregated to allow for meaningful comparisons of quality and utilization across the state and across ACDs.

ACD Recommendation 2: Engage and incentivize communities at the onset, to use ACD data to inform health planning and resource utilization discussions.

Payment Reform Models

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. This system rewards providers based on the volume of care delivered, without including incentives that encourage high-quality care and efficient resource utilization. New reimbursement models are needed that incentivize health care providers to be accountable for quality, efficiency and care coordination.

Payment Reform Recommendation 1: Health care providers (physicians, other health care professionals, hospitals, and other centers delivering care) should be accountable for quality, efficiency, health outcomes and care coordination. Payment reform should be designed to incentivize these desired outcomes, while holding global Oregon health care costs to Consumer Price Index as measured over a five year period.

Payment Reform Recommendation 2: New payment models should be tested within the infrastructure established by delivery system reform.

Comparative Effectiveness and Medical Technology Assessment

Comparative effectiveness research provides valuable information about the relative effectiveness and cost-effectiveness of alternative treatment options. This information can be used to develop standard clinical guidelines and inform benefit design to ensure that health resources are utilized in a manner that maximizes health gains. There are currently a number of comparative effectiveness and medical technology assessment initiatives in place in Oregon and across the nation, but no mechanism to facilitate collaboration across efforts or to ensure that coverage decisions across the state are informed by the best available research and data.

Comparative Effectiveness Recommendation 1: Streamline and strengthen efforts to support comparative effectiveness research and ensure policy decisions are informed by the best available evidence.

Comparative Effectiveness Recommendation 2: Endorse patient decision aids shown to increase the use of cost-effective care.

Comparative Effectiveness Recommendation 3: Develop standard sets of evidence-based guidelines for Oregon based on comparative effectiveness research.

Comparative Effectiveness Recommendation 4: Develop common policies across public and private health plans regarding the coverage of new and existing treatments, procedures and services based on comparative effectiveness research.

Shared Decision Making

In a world class health system that delivers patient-centered care, providers work with patients and their families to make health care decisions aligned with their values and goals. Decision support processes can help patients understand the likely outcome of various care options, think

about what is personally important about the risks and benefits of each option and make decisions with the support of their care team.

Shared Decision Making Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse evidence-based standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs.

Shared Decision Making Recommendation 2: New payment methods should be used to encourage providers in state funded and private health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes.

Shared Decision Making Recommendation 3: The state should partner with public and private stakeholders to develop and offer training courses to providers in facilitating shared decision making processes.

Shared Decision Making Recommendation 4: A statewide electronic Physician Orders for Life Sustaining Treatment (POLST) Registry should be created to ensure the availability of the POLST form at the time of need.

Public Health, Prevention and Wellness

Three in five deaths in Oregon are from heart disease, stroke, cancer, diabetes and chronic lower respiratory diseases and these diseases cost the state more than \$1.4 billion every year. Chronic behavioral health conditions also account for a significant amount of morbidity and mortality and a large portion of health care spending. In 2006, the economic costs of substance abuse in Oregon were nearly \$6 billion.¹ With better funded, evidence-based community efforts to detect and treat risk factors, a significant amount of chronic disease could be prevented, thus improving population health and reducing utilization of expensive and invasive acute treatments.

Public Health Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention of chronic disease and other physical, oral and behavioral health conditions and reduction of unhealthy behaviors that contribute most to the mortality of Oregonians.

Public Health Recommendation 2: The state should partner with local boards of health (including public and behavioral health), providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals and a process for evaluating progress toward these goals.

¹ R. Whelan, A. Josephson, and J. Holcombe. 2008. The Economic Costs of Alcohol and Drug Abuse in Oregon in 2006. EcoNorthwest.

Public Health Recommendation 3: The state should establish and fund a Community-Centered Health Initiatives Fund (CCHI) to fund primary and secondary prevention activities.

Public Health Recommendation 4: All state agencies, in partnership with PEBB, should develop a strategic plan for creating a culture of health for state employees.

Administrative Simplification and Standardization

Administrative expenses account for a large percent of total health care spending and there are significant opportunities to contain costs by increasing administrative efficiency.

Administrative Simplification Recommendation 1: Increase transparency surrounding health plan and provider administrative spending.

Administrative Simplification Recommendation 2: Develop standard formats and processes for eligibility, claims and payment and remittance transactions.

Administrative Simplification Recommendation 3: Simplify and streamline prescribing processes to reduce the administrative burden to providers of being required to prescribe from multiple formularies.

Reduced Pharmaceutical Spending

Pharmaceuticals account for eleven percent of total health care spending in Oregon.² Bulk purchasing arrangements established by purchasers and insurers can help reduce the cost of drugs and reduce overall health care spending.

Reduced Pharmaceutical Spending Recommendation 1: Utilize bulk purchasing arrangements to maximize savings in pharmaceutical spending.

² Office for Oregon Health Policy and Research. 2007. Trends in Oregon's Healthcare Market and the Oregon Health Plan: Report to the 74th Legislative Assembly. Available: http://www.oregon.gov/OHPPR/RSCH/docs/LegRpt2007_Final.pdf.

Quality Institute Work Group (Delivery Systems Committee) Executive Summary

On April 17, 2008 the Delivery Systems Committee received the enclosed report from its Quality Institute Work Group. The Committee agrees that ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system and must be a central focus of any health reform plan. A single entity is needed to set the quality agenda for Oregon and lead and unify existing quality initiatives in a collaborative effort to move the state toward a higher performing health system. Therefore, the Delivery Systems Committee endorses the recommendations, but suggests that the Board consider the following issues before making final recommendations. The points below reflect suggestions made by Committee members during the April 17 meeting.

Clarify and strengthen language about aligning stakeholders around common quality metrics and setting standards for data collection and reporting. The Quality Institute should set standards for what metrics are collected and reported and how data is collected and reported. Standards should aim to simplify and streamline processes, allow for meaningful comparisons across the health care system and reduce administrative costs associated with reporting different sets of measures to different purchasers and health plans. In addition, the Quality Institute should set performance benchmarks that can be adapted over time.

Efforts of the Quality Institute must support and be aligned with Accountable Care Districts and reform evaluation. The data collected and reported by the Quality Institute should support performance evaluation within the healthcare system, but must also support community evaluation of performance. The Quality Institute should report data in a way that allows for meaningful comparisons across communities and accountable care districts. In addition, the Quality Institute must collect and report data that aligns and supports efforts to evaluate state funded health programs and health care reform.

Providing understandable and meaningful information about quality to consumers must be a priority. “Understandable” should be added to the definition of transparency to reflect the need to ensure that public reporting be done in a way that is meaningful to lay persons. Recommendations should be reordered to put more of an emphasis on the need to engage and support consumers in quality improvement initiatives.

- **The recommended structure should be revisited after a comprehensive plan is developed.** Members questioned whether there would be a need for a separate and distinct Quality Institute with all of the entities created through reform. Members also suggested that the Board assess the role of private stakeholders in the public-private structure and suggested that these stakeholders provide specific testimony as to how a Quality Institute could enhance current efforts.

- **Greater transparency around cost is vital to reform and cost containment efforts.** The Delivery Committee did not necessarily recommend that the Quality Institute should take a more significant role in reporting data associated with costs than was recommended by the Work Group, but suggested that cost transparency needs to be addressed throughout the reform process.

ELIGIBILITY AND ENROLLMENT COMMITTEE EXECUTIVE SUMMARY

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations including recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program, eligibility for state premium contributions within a health insurance exchange, as well as implementation issues regarding maximizing enrollment and increasing retention in public programs. In developing these recommendations, the Committee met 12 times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, February 13th and 26th, March 11, April 8th and 23rd and May 13th 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The Committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

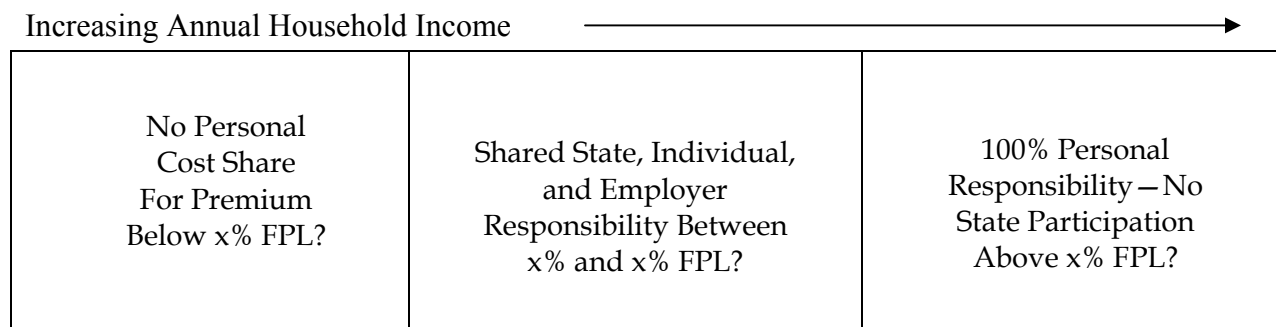
Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

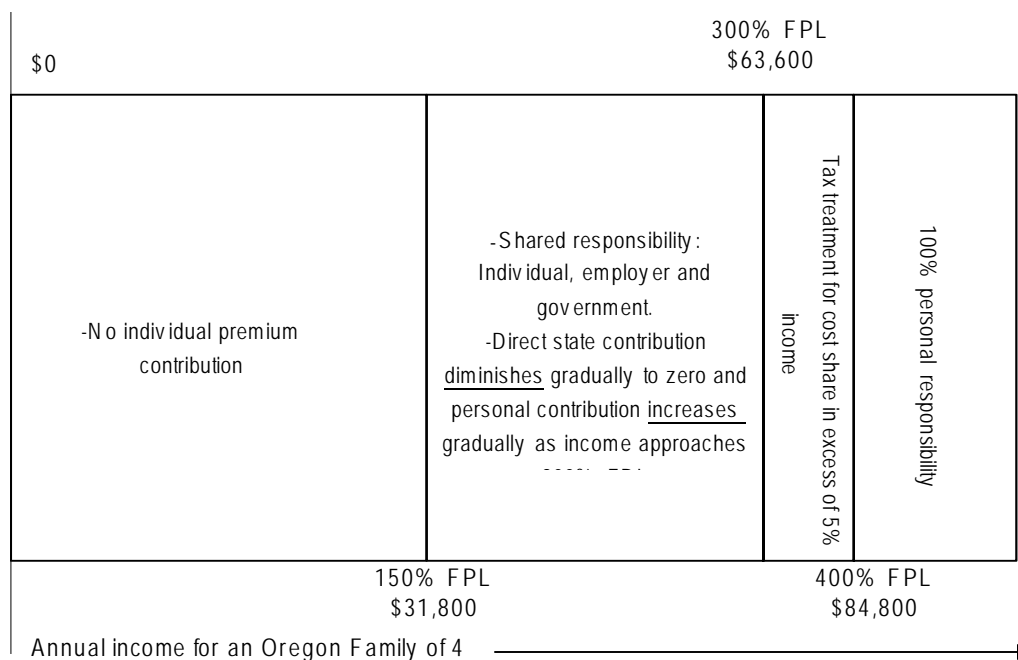
The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee’s task was to determine at what income the lines would be drawn to define income eligibility for state contribution:



Recommendations

- ❖ For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- ❖ Structure the personal cost share to emphasize premiums over other types of cost sharing.
 - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
 - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- ❖ Design state premium contribution as a gradual sliding scale to avoid a “notch effect” or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- ❖ Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability guidelines as recommended by the Eligibility and Enrollment Committee:



- ❖ State premium contribution eligibility for people who have employer-sponsored insurance:
 - All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored insurance. In order to mitigate the potential loss of employer contributions if employees and dependents switch from employer -sponsored insurance to state contributions--ALL employers in the state should contribute to the Oregon Health Fund.
 - Further, the Committee supports a requirement that the employer contribution be coupled with a mechanism to credit employers who continue to provide an essential benefits plan. The specific mechanism should be included as part of the overall financing strategy developed by the Finance Committee of the Health Fund Board.
- ❖ Oregon residency: A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.
- ❖ Non-qualified Oregon residents: All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide non-qualified Oregon resident with access to health care services as it is a goal under health reform to minimize/eliminate the cost shift. To the extent that specific groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.

- ❖ Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.
- ❖ Presumptive eligibility for state contributions: An applicant who initially appears to meet income and other program eligibility criteria should be presumed eligible. Additionally, individuals who can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.
- ❖ Period of uninsurance: The Committee recommends against any period of uninsurance as a requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.
- ❖ Assets: There should be no asset limit placed on eligibility for a direct state contribution.
- ❖ Guaranteed Issue: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status. There must be a comprehensive plan to transition the state's high risk pool system, the Oregon Medical Insurance Pool, into a guaranteed issue insurance market.
- ❖ Federal Matching Funds: For all components of the Oregon Health Fund Program, the state should maximize the use of matching federal dollars available to Oregon.
- ❖ Medicare: Develop mechanisms to provide low-income (<300% FPL) Medicare beneficiaries with the same level of affordability protection advanced to all other Oregonians in the Health Fund Board program. To the extent that Medicare products do not meet the essential benefit plan low-income seniors should have access to state premium contributions for comparable coverage.
- ❖ Outreach:
 - There should be an appropriately funded social marketing campaign on state requirements to have health coverage as well as aggressive outreach effort to bring individuals and families into the Oregon Health Fund program for affordability assistance.
 - Social marketing and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to: Schools (public and private and school-based health services, home school associations and support groups, Head Start, child care, safety-net clinics (including rural and migrant clinics), Tribal Health Centers, physician and dental offices, hospitals, pharmacies, social service agencies, accountants, health insurance brokers, 211 Info.
 - Identify uninsured individuals and inform them about Oregon Health Fund program.
 - Increase outreach and retention for those individuals already eligible but not enrolled.

- To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.
 - A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
 - Literacy levels, disability status and linguistic and cultural diversity of Oregon’s communities should be reflected in all outreach, eligibility, and enrollment materials and activities (e.g., explanation of benefits).
 - Work with employers and other agencies to include information about Oregon Health Fund in their regular communications with employees and stakeholders.
- ❖ Application
- Application processes should be streamlined to increase the likelihood that eligible individuals will be covered. As part of this streamlining, there should be a “common application screening form” for the Oregon Health Fund Program and it should be as short and straightforward as possible.
 - With appropriate privacy safeguards and protections, there should be modification to current state laws that may preclude state agencies from verifying income and other information with existing state databases (i.e. income information from the Oregon Department of Revenue) for state programs to extend health coverage.
 - Allow applicants to use the previous year’s tax return as a verification option.
 - There should be passive reenrollment for the Oregon Health Fund Program as recertification of eligibility for state premium contribution should not create new barriers to enrollment.
 - Establish administrative mechanisms needed to prevent participation of non-residents or individuals that move out of the state.
 - Optimize the ability of families to be enrolled within the same plan.
 - Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.
- ❖ Grievance and Appeals
- A grievance, mediation and appeal process as well as an independent ombudsman should be established for any health plans operating in the state to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- ❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- ❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- ❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- ❖ Explore potential tax treatments for individuals between 300% and 400% FPL.
- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)
- ❖ Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.
- ❖ Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.
- ❖ Request the opportunity of returning to previous documentation methodology employed by the Department of Medical Assistance Programs for citizenship. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
- ❖ Eliminate the five year ineligibility period for immigrants that become legal permanent residents.
- ❖ Eliminate the two-year waiting period for Medicare eligibility after a Social Security disability determination.
- ❖ Investigate the methodology applied in determining the Medicare reimbursement levels in Oregon, which currently punishes the state for being efficient.

FEDERAL LAWS COMMITTEE EXECUTIVE SUMMARY

Senate Bill 329 charged the Federal Laws Committee with examining the impact of federal law requirements on achieving the goals of the Health Fund Board. The twelve-member Committee met ten times from November 2007 to November 2008. The members represent a wide range of stakeholders, including physicians and other health care providers, advocates, policy experts, health services administrators, and a tribal council chair. The Committee heard presentations from nearly 50 subject matter experts on the following areas of federal law:

- Medicare
- Medicaid
- Health Care Provider Workforce
- ERISA
- Federal Tax Policy
- EMTALA
- HIPAA
- Indian Health Service Programs
- Comparative Effectiveness Research
- New Federal Grant Program to Support State Reform

MEDICARE

Medicare is a federal program that covers over 571,000 people in Oregon. Of this total, about 86% are aged 65 or older and 14% are people with disabilities. An estimated 79,000 Oregonians are dual Medicare/Medicaid eligible. In Oregon, the number of those aged 65 or older is expected to increase 67% by 2020.

Medicare Reimbursement: The most critical federal barrier to health reform in Oregon relates to the historically low Medicare reimbursement rates paid to Oregon's providers compared to other states and regions. Low rates could undermine the reform efforts of the Board due to the growing number of physicians who are not accepting new Medicare patients. From 2004 to 2006, the percentage of Oregon primary care physicians refusing new Medicare patients doubled from 11.8% to 23.7%. Low reimbursement rates were found to be the most significant barrier to Medicare participation by providers. Further, Medicare's payment system is focused on encounter-based payments, restricting Oregon's flexibility to reform its delivery system.

Recommendations:

1. Congress should reform the process for setting Medicare rates to more equitably align reimbursement across the country. In particular, the Centers for Medicare and Medicaid Services (CMS) should be authorized to limit physician payment updates in high-cost areas, so that rates in low-cost, high efficiency areas such as Oregon would increase over time while high cost areas' rates remain level. One approach to accomplishing this has been proposed by the Commonwealth Fund.
2. *State Recommendation: Oregon's Congressional delegation and interested stakeholders should build support for Medicare rate reform by joining with other states experiencing low Medicare reimbursements.*
3. Congress and CMS should pursue Medicare payment reform that places a policy priority on primary care and emphasizes evidence based care, integrated health homes and an array of services that support these models.

Medicare Advantage: Nearly 39 percent of all Oregon Medicare beneficiaries (nearly 210,000 Oregonians) are enrolled in Medicare Advantage plans, which is the highest rate in the nation. In Oregon, Medicare Advantage HMO and PPO plans offer an opportunity to address access problems while providing coordinated care to beneficiaries, controlling costs, and increasing reimbursement to providers. The third type of Medicare Advantage plan, Private Fee-For-Service (PFFS) plans, is much less popular in Oregon, except in many of Oregon's rural areas that have little access to HMO or PPO-type plans. Medicare Advantage plans are the subject of much debate in Congress relative to reimbursement models and concerns about inappropriate marketing behavior by some PFFS plans.

Approximately 17,500 Oregon beneficiaries are enrolled in Special Needs Plans (SNPs) which are Medicare Advantage plans that target a particular population: dual eligibles, beneficiaries in institutions, or persons with severe or disabling chronic conditions. CMS is no longer accepting applications for new SNP plans and will not allow the expansion of existing SNP plans after January 2009.

Recommendations:

4. Medicare Advantage HMO and PPO plans play an important role in providing affordable health coverage to Oregon's Medicare beneficiaries. Congress should preserve this option for Oregon with active oversight and evaluation to ensure that enrolled beneficiaries are protected. Medicare Advantage oversight should ensure that additional payments (beyond what would be paid under traditional Medicare) and rebates given to Medicare Advantage plans benefit enrolled beneficiaries by enhancing access to providers, improving benefits or reducing cost sharing.
5. Congress should permit the expansion of Special Needs Plans, particularly plans that serve beneficiaries who are eligible for both Medicare and Medicaid.
6. The Committee applauds Congress's action to improve the oversight of Medicare Advantage PFFS plans by passing the Medicare Improvements for Patients and Providers Act of 2008. However, this Act stops short of bringing oversight of PFFS plans in line with the oversight of HMO and PPO Medicare Advantage plans. Congress and CMS should consider additional significant reforms to Medicare Advantage PFFS plans, including more rigorous state and federal oversight.
7. *State Recommendation: Existing Medicare Advantage HMO and PPO plans in Oregon should consider extending service options to underserved areas in the state. Alternately, local provider organizations in these areas should consider becoming Medicare Advantage HMO or PPO plans or inviting existing plans to expand into their area.*
8. Congress should delegate authority to State Insurance Commissioners to oversee marketing practices of Medicare Advantage plans similar to the framework in place for Medicare Supplement plans.
9. *State Recommendation: The Oregon legislature should pass a joint resolution requesting Congressional action to correct reimbursement inequities in Medicare and preserve the Medicare Advantage HMO and PPO options for Oregon beneficiaries.*

MEDICAID

Oregon covers more than 386,000 individuals under its Medicaid program, known as the Oregon Health Plan (OHP). OHP operates under a demonstration waiver approved by the federal

Centers for Medicare and Medicaid Services (CMS) to expand coverage of pregnant women and children up to 185% of the Federal Poverty Level (FPL) and aged, blind, disabled individuals to 225% FPL under the OHP Plus program. Oregon's waiver includes coverage for childless adults up to 100% FPL under the OHP Standard program.

Oregon also has a waiver from CMS to offer a premium assistance program that subsidizes insurance for individuals up to 185% FPL. Currently, more than 10,000 individuals receive these subsidies.

Expanding Eligibility: The Board's Action Plan proposes to expand eligibility beyond the levels allowed under Oregon's current waivers, so Oregon will need CMS approval to obtain additional federal matching funds. If CMS denied these requests, program expansions would rely solely on state funds and thus be significantly more expensive to implement.

Recommendations:

10. When Oregon's reform plan is enacted, CMS should approve Oregon's request to expand coverage under waiver applications.
11. *State Recommendation: OHP Standard is funded solely by provider taxes on Medicaid Managed Care Organizations and hospitals, which both sunset in September 2009. The Oregon Legislature should be aware of and develop contingency plans for the OHP Standard program to avoid experiencing a gap between the expiration of provider taxes and the implementation of a reform plan.*

Payment Structure Flexibility: Additional flexibility is required to change the Medicaid Managed Care Organization and provider payment structures from encounter-based and fee-for-service payments to payments for best practices. The Board's Action Plan proposes establishing a Payment Reform Council to explore changes in the payment structure to reward services that result in healthier outcomes and emphasize quality primary care. These new payment models may not be reimbursed under the current OHP waiver. To change its Medicaid payment structure, Oregon would need to seek CMS approval through an amendment to its OHP waiver.

Recommendations:

12. CMS should adopt a framework and expedited approval process to assist states that want to launch demonstration projects in payment reform within the Medicaid program.
13. CMS should review, renew and approve state Medicaid waivers in a collaborative and timely manner. Lengthy, multi-year waiver approval greatly hinders states' reform efforts.

Federal Citizenship Documentation Requirements: New CMS citizenship documentation requirements mandated in the 2005 Deficit Reduction Act (DRA) appear to be preventing eligible Oregonians, including children, from enrolling in the Oregon Health Plan.

Recommendation:

14. States that can demonstrate quality standards and good Medicaid enrollment processes should be allowed to revert to pre-DRA citizenship documentation requirements.

Recent CMS Rules: Recent CMS rulings have tended to decrease state flexibility in terms of benefits, eligibility, and delivery of health care. Many recent policies have resulted in significant shifting of health care costs to the states. Congress recently passed a moratorium on several such proposed regulations which expires April 2009. Six of these rules would have reduced federal payments to Oregon by up to \$921.4 million between fiscal years 2008-2013.

Recommendation:

15. Congress should seek to permanently eliminate the CMS proposed regulations recently placed under moratorium.

PROVIDER WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

A robust, diverse health care workforce is critical to Oregon's ability to achieve the goals of the Health Fund Board. However, current workforce projections indicate an impending shortfall of providers in Oregon, especially in primary care fields.

Recommendations:

16. Congress should oppose any efforts to reduce federal funding for health care workforce education. Moreover, Congress should enhance such funding in select critical shortage areas. Congress should consider a block grant program to allow states to customize scholarships, loan forgiveness and loan repayment programs to meet their unique needs.
17. Congress should examine the financing structure for GME residencies and either raise the federal cap on Medicare funding for GME residencies or create a more stable and equitable method of federal funding. This cap limits residency slots at each institution to 1996 levels.
18. Congress should allow states to waive the CMS requirement for physicians to approve nurse practitioner treatment plans in order to receive payment.
19. *State Recommendation: The OHFB should support current plans, led by the Oregon Health Workforce Institute, to collect data on Oregon's health care workforce through state licensing agencies*
20. *State Recommendation: The Oregon legislature should fund the proposed Oregon Medicine Collaborative (ORMED) to increase residency training opportunities in rural and underserved communities in Oregon.*

ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private sector retirement, health, and other welfare benefit plans. ERISA creates an obstacle to health reform efforts through a broad provision that preempts state laws that "relate to" private sector, employer-sponsored benefit programs. This provision leaves states at risk for ERISA-based lawsuits, particularly in relation to health reform funding options such as "pay-or-play" employer payroll taxes, taxes on insurance plans and state efforts to set minimum standards for acceptable health insurance coverage offered by self-insured employer plans. Further, ERISA hinders states' ability to collect even basic data on self-insured plans, including the number of lives covered under such plans, impeding state public policy efforts.

Recommendations:

21. Congress should create “safe harbor” policies for state health care reform elements (such as “pay or play” payroll taxes) that would protect states from ERISA court challenges.
22. Congress should permit states to collect a uniform set of data from self-insured employers.
23. Congress should consider the National Association of Insurance Commissioners’ proposal to grant the Secretary of Labor the authority to issue waivers from ERISA for states implementing comprehensive reform proposals.

FEDERAL TAX BENEFITS

Federal income tax codes provide inequitable benefits around health care expenses, including health insurance premiums. Self-employed individuals and individuals buying health insurance on the open market are not able to obtain the same tax benefits as those receiving employer-sponsored health insurance.

Recommendations:

24. To increase the affordability of health insurance, Congress should modify the federal personal income tax code to provide equal tax benefits to all taxpayers purchasing health insurance, whether purchasing via an employer, as a self-employed person, or as an individual on the open market.
25. In addition, Congress should offer low income individuals the choice of a refundable credit against their tax liability for health insurance premiums.

EMTALA AND OREGON’S EMERGENCY DEPARTMENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) was designed to prevent hospitals from transferring uninsured patients to public hospitals without first screening patients to ensure they were stable for transfer. The key issues facing Oregon’s Emergency Departments appear not to be related to EMTALA, but rather are problems relating to a lack of health insurance and access to primary care in the community.

Recommendation:

26. *State Recommendation: The Committee finds that EMTALA provides important protections for patients. Further study is recommended, however, on the potential for alleged EMTALA violations arising from inter-hospital transfers based on the availability of appropriately trained physicians.*

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) sets out requirements for ensuring the privacy and security of patient information. Because HIPAA permits treating providers to exchange patient information without a patient’s consent, it does not present a barrier to coordinating care.

Recommendation:

27. *State Recommendation: The Committee has no recommendations to Oregon’s Congressional delegation, but did learn of a misunderstanding among providers concerning HIPAA requirements around the exchange of patient information. DHS should consider conducting a provider education effort to clarify HIPAA requirements.*

INDIAN HEALTH SERVICE TRIBAL AND URBAN PROGRAMS

Oregon's American Indian/Alaskan Native (AI/AN) population is woefully underserved and suffers significant health disparities, due, in part, to a lack of access to health services and insufficient federal funding. Unlike other racial or ethnic minority groups, Tribes are sovereign entities that operate in a unique government-to-government relationship with the United States government.

Because of the United States' legal and political relationship with Tribes, there is a federal obligation to provide health services to AI/AN people. One example of this unique federal responsibility is that services received through an Indian Health Service facility are reimbursed at a rate of 100 percent the federal medical assistance percentage (FMAP). This means that there is no cost to the State for services provided to an AI/AN Medicaid beneficiary served by an IHS or Tribal facility. Because the Indian health system has been chronically under funded, access to health care services is very limited, which contributes to the significant health disparities of AI/AN people. In fact, some Oregon Tribes spend part of each year rationing services based on a "life or limb" test due to inadequate funding. The Health Fund Board's efforts to provide affordable health insurance should help AI/AN individuals greatly.

Recommendations:

28. Given the unique relationship between Tribes and the Federal government, Congress should adequately fund Tribal health services.
29. CMS should approve Oregon's waiver request to allow AI/AN enrollees in the OHP Standard program to receive OHP Plus benefits (pending since 2003).
30. *State Recommendation: In any reform effort, the Oregon legislature should honor the unique "federal trust relationship" between the United States government and the Tribes.*

RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF NEW TECHNOLOGIES

Unbiased comparative effectiveness research will provide a foundation for the Board's efforts to increase the use of evidence-based medicine. Increased federal involvement in conducting this research would assist Oregon in meeting its goals.

31. Given the important, but limited, work currently conducted by the federal Agency for Healthcare Research and Quality, Congress should enhance funding for comparative effectiveness research to inform evidence based health care decisions by providers, patients, and policy makers. Any such program must be considered objective and highly credible to have value.

NEW FEDERAL GRANT PROGRAM TO SUPPORT STATE REFORM

There is much interest at the state and national level in reforming health care and decreasing the number of uninsured Americans.

Recommendation:

32. Congress should create a federal grant program to support states pursuing innovative reform concepts.

FINANCE COMMITTEE EXECUTIVE SUMMARY

INTRODUCTION

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007), calling for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve quality. The Board assigned the Finance Committee the difficult task of developing recommendations on financing strategies for a comprehensive reform plan. The eighteen-member Finance Committee met thirteen times from October 2007 to May 2008. The members represent a wide range of stakeholders, including health plans, medical and dental care providers, businesses, labor, and consumers, and several members of the Oregon Health Policy Commission.

COMMITTEE PROCESS

To guide its discussion of various revenue options, the Committee developed a set of principles and strategic policy questions. The principles state that the revenue source(s) should:

- have limited administrative cost
- be broad-based, sustainable, and equitable
- be transparent
- withstand legal challenge under federal law (ERISA)
- ensure broad public support
- avoid creating disincentives for employer-sponsored insurance
- maximize federal matching funds
- encourage cost control

All of the revenue strategies considered by the Committee were examined in light of each principle.

The Committee's charter highlighted several revenue options of particular interest to the Board. These included: a payroll tax; a health services transaction tax; an individual or corporate income tax surcharge; and taxes on commodities such as tobacco, beer, or wine. To its list of revenue options to consider, the Committee added a tax on hard liquor, a bottle or carbonated beverage tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, general fund revenues, and eliminating the tax deductibility of health insurance premiums.

The Committee members agreed that any reform of the health care system that is designed to substantially increase access to currently uninsured individuals will require new revenues, at least in the short term. While the Committee strongly believes broader system reforms must focus on containing costs, it is not reasonable to expect that the system can support hundreds of thousands of new individuals in the short term without new funding

RECOMMENDATIONS

Based on design parameters received from the Board and other committees, the Finance Committee had the task of identifying revenue for a program that will cost the state between \$900 million and \$1.6 billion annually.

Payroll Tax:

After weighing the various tax options, the Committee's recommendation is that the predominant revenue source should be a payroll tax. While not unanimous, a strong majority believes that 60-100% of new revenue should come from this source. Several members would prefer that the payroll tax be 40%-50% of the revenue or less to reduce the amount paid by business.

Regarding the design of a payroll tax, a majority of the Committee members agreed that:

- All employers that have payroll should be subject to the tax as a cost of doing business in Oregon; there should be no exemptions.
- The tax should be levied as a flat percentage of payroll.
- There should be a cap on the payroll base, but the cap should be relatively high, perhaps up to two times the social security cap.
- The tax rate should be set to achieve a significant portion of the needed revenue (meaning a tax of probably 5-7% of payroll), but not so high as to create an undue burden on employers operating at the margin or so that it creates an insurmountable barrier to passage.
- A credit, or offset, against the tax should be allowed on a dollar-for-dollar basis for expenditures an employer makes toward health services for employees. All employers would be required to contribute 0.25-1% of payroll that would not be offset.

Additional Revenue Source(s):

While a strong majority of the Committee members believe there should be, or it will be necessary to have, an additional source of revenue to support health reform, the members were divided over whether the revenue should come from a health services transaction tax or from adding a new state income tax bracket. The majority support a second funding source because of concern that a payroll tax would be too high if it were the sole funding source. Almost a third of the members felt that a payroll tax should be the exclusive source of revenue in order to simplify the revenue "story."

Health Services Transaction Tax: About a third of the Committee believes that the additional source of revenue should be a relatively small tax (1-2%) applied to gross patient revenues from all health care services, except those provided as part of Medicare or Medicaid. Some members had the view that certain services should be exempt from the tax, such as primary care and long term care. Others thought that beginning a list of exemptions opened the Committee up to criticism over why one set of providers should be exempt instead of another. Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax. Committee members in support of a health services transaction tax believe it to be a stable funding source that will keep up with medical inflation. Committee members not in favor of this option were concerned about the opposition this tax could generate and the impact of this type of

tax on providers and the cost of health care. The Committee was generally split on the question of whether the tax should automatically be passed on to payers.

Income Tax: Another third of the members favor adding an additional bracket on the state income tax. This would be in lieu of the health services transaction tax and would lower the burden from the payroll tax on employers.

Other Taxes: Several Committee members are interested in additional revenue combinations to fund the reforms. Two members propose implementing both a health services transaction tax and a new income tax bracket in order to keep the payroll tax as low as possible. Another member suggests a compilation of several taxes to encourage healthy behavior (e.g. taxes on tobacco, alcohol, etc.).

REVENUE REQUIREMENTS: INITIAL ESTIMATES OF POTENTIAL PAYROLL TAX SCENARIOS

The Finance Committee worked with consultants from the Massachusetts Institute of Technology and the Institute for Health Policy Solutions to model the effects on cost and coverage of the reforms being proposed by the Health Fund Board committees. Three alternate scenarios were modeled, all of which assume an individual mandate.

In all the scenarios, the full cost of covering those eligible for and not currently enrolled in public coverage (the Oregon Health Plan – OHP) is around \$1.1 billion. Across the three scenarios, which incorporate different assumptions regarding eligibility levels and cost-sharing, the cost for those with incomes too high to qualify for OHP but who will be eligible for premium assistance from the state for private coverage is between \$650 million and \$1.5 billion annually, depending on the program structure. After factoring in \$600 to \$660 million in revenue from a payroll tax and \$660 to \$730 million in federal funding, the estimates of state costs across the scenarios ranged from \$300 to \$950 million annually. This amount would need to be raised through additional funding sources.

ADDITIONAL ANALYSIS NEEDED

The Committee identified two areas of additional analysis that should be performed. There was insufficient time for the Committee to identify and recommend a mechanism for capturing the “cost shift” or the hidden costs of uninsurance. Such a mechanism would ideally help fund reform or increase confidence in reforms by ensuring that health care costs are reduced. Additionally, the Committee urges the Board to sponsor an evaluation of the economic impact a payroll and other proposed taxes would have in Oregon.

Exchange Work Group (Finance Committee) Executive Summary

INTRODUCTION

The 2007 Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007), which established a seven-member Oregon Health Fund Board tasked with developing a comprehensive plan to: ensure access to health care for all Oregonians, contain health care costs, and improve health care quality. The Board gave the Finance Committee's Exchange Work Group the task of developing recommendations for individual (non-group) market changes within a comprehensive reform plan. The Work Group was asked to recommend the role a health insurance exchange would play in such an environment. The thirteen member Work Group met twelve times between November 2007 and May 2008.

COMMITTEE PROCESS

The Work Group was guided by the Board's assumption that reform would include an individual insurance requirement and state premium contributions for lower-income Oregonians. To support these assumptions, the group agreed that the following conditions would also need to exist:

- A guaranteed issue and guaranteed renewal individual market;
- An affordable, accessible and consumer-valued essential services benefit package; and
- Carriers that compete based on the efficiency of their administration, on delivery system and network adequacy, and on other quality and service differences, not on a carrier's ability to enroll lower risk members.

The Work Group identified the following goals for a reformed individual market. Coverage must be affordable for both healthy and high-risk Oregonians, and rates must be stable over time. Entry into coverage must be easy, with information on all options made available. Market conditions should encourage insurance carrier participation by managing risk selection and minimizing carriers' administrative costs. Risk adjustment should be used to mitigate the effect of adverse risk on carriers. A sustainable financing approach should be utilized for high-risk populations in order to minimize the impact on rates for the currently insured.

Within this context, the Work Group identified the problems with the current health insurance markets, recommended reforms to the individual market, proposed functions and participant populations for an exchange, and identified possible administrative and financing options for an exchange. Work Group members expressed a range of views on these topics. While consensus was not reached on all topics, the group took great efforts to identify points of agreement and express the implications of the various options.

RECOMMENDATIONS

Individual Market Reforms:

Ensure affordable access to insurance in the individual market, establish a single individual market risk pool, and limit market disruption for current enrollees. The majority of the

Work Group recommended the state discontinue pre-enrollment medical screening and create a single, guaranteed issue market for individual insurance coverage. This would mean that individuals would no longer be required to fill out a medical screening form and could not be denied coverage based on health status. The existing underwritten market would be combined with the portability market and the state high-risk pool, the Oregon Medical Insurance Pool (OMIP). Other members preferred maintaining a modified version of the current system. All members encouraged changes that would ensure fair and equitable movement into insurance, and incorporate new populations and their costs in a way that limits disruption to the currently insured population.

If the market becomes guaranteed issue, many members suggested that during a short transition period, the assessment that now partially funds OMIP be used to moderate the rate impact of combining three pools into one unified individual market. After one to two years, the assessment would be discontinued. If an individual mandate is not implemented or enforced, the group would not recommend guaranteed issue, and would instead suggest the underwritten market be maintained.

Manage risk in the reformed individual market with a strong risk adjustment mechanism.

To support a guaranteed issue individual market, the Work Group recommends using a strong risk adjustment method to shift revenue between insurance carriers based on the risk of each carrier's enrolled population. In any scenario, some carriers will have higher cost enrollees. Risk adjustment would help ensure carriers are paid for enrolled populations and compete on medical management, quality and price, not risk selection. The Work Group did not recommend a specific methodology, but notes that the methodology adopted should be rigorous and be applied and routinely reviewed by qualified, independent personnel and outside experts to ensure its ongoing value and efficacy.

Maintain a strong individual market by making rating rules consistent and transparent.

The majority preferred a natural rate band, in which the oldest enrollees pay approximately 5.5 times the rate paid by the youngest. However, several members believe this is too broad a spread. The group supports some age rating, basing the medical component of rates on all of a carrier's enrollees, and increased rate transparency. They would allow rate adjustments for geography and "healthy behaviors," but not for gender and health status. The group would continue the Department of Consumer and Business Services' (DCBS) role in reviewing carrier rates, including monitoring for risk selection issues, and the majority would not initially change small group rating rules. Small groups have different rating rules than individuals and are pooled separately from individuals. M Work Group members were concerned about how to address these differences. As there was disagreement on several issues, the majority of the group supports a thorough evaluation of rating bands and the small group market, which could lead to changes in the bands and small group rules after other individual market changes are implemented.

Use the essential services benefit definition to establish product foundation and tiers. The Work Group recommends that all individual market carriers offer the essential services benefit. Each carrier may offer other "buy up" plans within benefit tiers defined by the Board. The group recommends insurance products continue to be reviewed by DCBS, including a carrier demonstration that products offered meet or exceed the essential services benefit.

Maintain current treatment of self-employed sole employees. The Work Group felt that in order to avoid adverse selection issues, self-employed individuals with no other employees should be allowed to continue buying individual market insurance, but not group market coverage.

Section 125 Premium Only Plans:

All employers should be required to establish Section 125 Premium Only Plans for their employees. This would apply to employers whether or not they offer health benefits. Employers that pay 100% of premiums for all employees would be exempt from this requirement. The Work Group agreed that this should be required because use by employees is voluntary and can significantly reduce the cost of individual insurance purchase by letting individuals use pre-tax dollars for premium purchase.³

Exchange Functions:

While the group's charge was to develop the role of an exchange, some members questioned the need for an exchange, arguing that the Family Health Insurance Assistance Program and individual agents and brokers already provide many of the functions of an exchange. Others argued a well organized exchange could have a greater impact on the efficiency of the non-group market.

The exchange should operate as a strong market organizer by contracting with carriers and establishing performance benchmarks across carriers. While the Work Group did not come to consensus on the level at which an exchange should function, most members of the group were in general agreement that an exchange should have a strong role in moving the market by standardizing benefits offered by carriers and establishing performance benchmarks across carriers. All carriers that meet the benchmark standards could offer coverage through the exchange.

Exchange Participant Populations:

Individuals who use state premium contributions or access tax credits must get coverage through the exchange. Higher income workers not offered or eligible for employer-sponsored coverage can enter the exchange and use Section 125 Premium Only Plans to reduce premium costs. A majority of the Work Group wanted to provide choice for purchasers not utilizing direct or indirect state assistance by allowing other individual market purchasers to use the exchange without requiring them to do so. Some members argued the exchange would be stronger and less complex if all individual purchasers were required to enroll through the exchange; the majority wanted the exchange to prove itself through efficiency and by offering value to consumers. The decision about whether to offer individuals a choice of the exchange or direct market should be reevaluated after some period. The group agreed that voluntary enrollment for the unsubsidized group should be tied to the implementation of the individual market reforms laid out in the first section of the report.

³ Federal law limits the use of Section 125 Plans for individual insurance premiums to guaranteed issue markets.

Exchange Administration and Financing:

The exchange's administrative structure should facilitate accountability, transparency and responsiveness, and allow flexibility and market responsiveness. The Work Group believes an exchange should be strongly responsive to the public. Although no recommendation was made on administrative structure, the group leaned toward a public entity that balances public accountability and responsiveness.

The exchange should be relatively self-supporting. The Work Group supported the concept of a fee to support the exchange's administration of subsidies, with other sources of funding for customer service, marketing the exchange and other functions. The group did not reach a consensus on the actual sources to be used or how much funding should come from which source.

Employer Groups and the Exchange:

Do not initially offer small employer groups coverage in the exchange. Small employer groups could benefit from access to an exchange, and some Work Group members support immediately merging the small group and individual markets. However, many in the Work Group thought the policy and administrative goals of doing so are not yet clear enough to fully consider how to include small groups. Issues that would need to be addressed include: the role of the small group pool; the impact of combining pools; the different rating rules between the individual and small group markets; and how to manage adverse selection in a voluntary exchange. Work Group members hoped that once the exchange was established, employer groups would have the opportunity to participate in the future. The Work Group recognizes that in the current scenario, employers that are currently providing insurance to employees may decide to drop group coverage in order to provide their employees with access to the exchange.

HEALTH EQUITIES COMMITTEE EXECUTIVE SUMMARY

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations regarding what the reform plan will look like. While several elements of the Act contained references to equity and fairness, no specific mechanism for developing equity strategies was included in the legislation. The newly established Oregon Health Fund Board, in an effort to create that mechanism, created the Health Equities Committee. The Health Equities Committee became the sixth committee of the Oregon Health Fund Board and was chartered with developing multiple strategies to reduce health disparities in Oregon and to ensure that any health reform would specifically include elements to ensure that all Oregonians benefit equally from an improved and expanded health care system.

The Health Equities Charter directed the Committee to develop multicultural strategies for program outreach, eligibility, and enrollment procedures as well as to make policy recommendations for reducing health disparities through delivery system reform and the benefit design of the Oregon Health Fund program.

The Committee developed a series of recommendations aligned with the Board's priority areas, which the members believe will result in increased access to health care; an improved delivery system for Oregon's vulnerable populations; an affordable benefit package that meets the needs of Oregon's diverse communities; and healthier individuals, families, and communities.

Preventing Health Disparities before they Occur: Health Promotion and Chronic Disease Prevention and Management

Eliminating health disparities in chronic disease will have a profound economic impact on the state's health care system and will increase earnings over a lifetime as well as lower poverty rates, particularly for ethnic minorities.⁴ The Committee recommends addressing the sustainability of the health care system by recognizing that the health of the individual begins at home and within the context of families, cultures, and communities (both locational and relational). Many chronic diseases have had a disproportional impact on communities of color.⁵ Eliminating these disparities requires culturally-specific approaches to promoting health and preventing chronic disease.

Recommendation 1: Promote population-based approaches

The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease and promote the health of Oregonians.

⁴ E.D. Crook and M. Peters, *Health Disparities in Chronic Diseases: Where the Money Is*, (The American Journal of Medical Sciences, 335(4):266-270, April 2008).

⁵ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

Culturally-specific approaches to disease prevention and health promotion must be part of this investment.

Recommendation 2: Strengthen the relationship between health-focused Community-Based Organizations and the health care delivery system.

The Health Equities Committee recommends designing a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Recognizing that not every organization providing an integrated health home is focused on serving vulnerable populations, an alternative to renewable contracts should exist that will enable a provider to purchase community-based and/or culturally-specific services.

The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services be eligible for direct reimbursement. Accountable Health Plans must reimburse a broader range of health professionals including, but not limited to, Community Health Workers, and a broader range of services including, but not limited to, peer-led disease management support groups in culturally-specific programs to maximize the health and function of individuals, families, and communities.

Recommendation 3: Develop programs to incentivize healthy personal decision-making

The Health Equities Committee recommends that the state create a Wellness Account for individuals participating in the Oregon Health Fund program who receive a subsidy.

The state would deposit money in the Wellness Account based on completion of wellness activities. Monies accrued in the account could be used towards program cost-sharing expenses such as premiums and co-pays, or towards non-covered wellness activities, such as gym memberships or yoga classes. Financial incentives would encourage individuals to engage in activities that promote health, such as participating in a smoking-cessation program, getting recommended tests and procedures, and chronic disease management activities.

The Wellness Account is modeled after Enhanced Benefit Accounts (EBAs) that are currently being implemented in several state Medicaid programs.

Reducing Barriers to Health Care

Low-income individuals, who are disproportionately from communities of color, are more likely to be uninsured and to experience other barriers to accessing health care.⁶ Reducing these barriers also impacts many other aspects of people's lives. In California, parents of children newly enrolled in the State Children's Health Insurance Program reported that their children

⁶ Agency for Healthcare Research and Quality, *National Healthcare Disparities Report*. 2003–2006; Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy of Sciences, 2003).

performed better in school, felt better physically, and were able to get along better with their peers than they did before they had insurance.⁷

Recommendation 1: Implement universal eligibility

It is a long-held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise, and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.

Recognizing the political and fiscal implications of this recommendation, the Health Equities Committee believes the Oregon Health Fund Board should establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified Oregon residents [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] who cannot afford to purchase health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the 'play or pay' requirement of the employer mandate based on the percentage of employees who would qualify for the Oregon Primary Care Benefit Plan.

Recommendation 2: Address citizenship documentation barrier

As consistent with current practices in the private marketplace, the Health Equities Committee recommends that citizenship documentation should not be a requirement to participate in the Oregon Health Fund program.

The Health Equities Committee further recommends investigating the possibility of obtaining a federal waiver to exempt Oregon from the citizenship documentation requirements imposed by the CMS through administrative rule, based on the Deficit Reduction Act of 2006.

Recommendation 3: Conduct targeted and aggressive outreach to multicultural communities

A media-only approach to outreach for the Oregon Health Fund program is not an adequate response to reducing disparities in health insurance status in Oregon.

The Health Equities Committee recommends a sustainable funding mechanism, with additional Medicaid matching funds, to support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, and language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

⁷ M. Seid, J.W. Varni, L. Cummings and M. Schonlau, *The Impact of Realized Access to Care in Health-Related Quality of Life in the California State Children's Health Insurance Program*, (Journal of Pediatrics, 149:354-61, September, 2006).

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund program is the object, and resources and interventions must be targeted towards this goal.

Recommendation 4: Implement affordable cost-sharing policies

The Health Equities Committee recommends equitable and fair sharing of health care costs.

Health insurance coverage with high deductibles and out-of-pocket costs disproportionately hurts low-income individuals' ability to obtain needed care, further contributing to health disparities. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access. Specific recommendations on how to promote equitable and fair sharing of health care costs are detailed on pages 26-27 of this report.

Improving the Quality of Care

There are several strategies that have been demonstrated to be effective at reducing the disparities of care that occur within the context of health care delivery.⁸

Recommendation 1: Promote integrated health homes

Elements of the integrated health home (also referred to as the “medical home”) model that have been demonstrated to reduce health disparities must be encouraged in any medical service organization purporting delivery of an integrated health home. Examples of these successful approaches are on page 28 of this report.

For some populations, an integrated health home may be best provided outside of the traditional primary care service delivery system and a definition of integrated health home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

The integrated health home needs to be viewed in the context of the social and education system, hospital and specialty care system, and public health system in a community.

Recommendation 2: Benefit package design should support the health of vulnerable populations by ensuring their health care needs are met and that care is affordable

Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs, and after-hours/walk-in primary care.

The benefit program designed should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations to assist in health

⁸ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

promotion. The benefit program should also reward patients who actively participate in their own care, through incentives for patients who follow through with the medical treatment plan agreed upon with their health care providers. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting, rather than waiting until disease progression requires extensive inpatient care will benefit both individuals and society. The state should also encourage providers to expand availability to patients (e.g. operating during evening and weekend hours). Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

Support direct reimbursement for Community Health Workers (CHWs) for publicly-sponsored health programs.

Community Health Workers (CHWs), also known as promotores/as, Community Health Representatives (CHRs), lay health advisors, and outreach workers, among other names, are trained members of medically underserved communities who work to improve health outcomes. CHW programs have proven effective in teaching disease prevention, reducing barriers to care, improving patient-provider communication, and improving community health. Oregon can stimulate these programs by providing a variety of funding sources, including direct reimbursement. Establishing direct reimbursement may involve developing a certification system for CHWs. Any certification system should be designed and governed by CHWs and CHW advocates.

Analyze the cost-effectiveness and health equity benefits of alternative and complementary medicine including, but not limited to, traditional Chinese medicine for the inclusion of such health services in the benefit design of publicly-sponsored health programs

Ensure that Oregonians have access to affordable evidence-based alternative and complementary medicine.

Alternative and complementary medicine can reduce health disparities by providing culturally-specific approaches to improving health. These types of health services should also be vetted by the same standards as allopathic medicine and promoted in the commercial market of health care as allopathic medicine.

Recommendation 3: Ensure language access

Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth.

Seek federal matching funds for interpreter services through Medicaid. This helps ensure affordable interpreter services for providers who see Medicaid patients.

Use state regulation to impose mandates with funds to offset subsequent costs.

Recommendation 4: Address workforce issues

The Health Equities Committee focused their workforce recommendations on two domains. The first domain the committee felt should be addressed in health reform policy would aim to ensure an adequate workforce that reflects the diversity of Oregonians.

Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels.

Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness).

Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students.

This includes convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution.

Utilize existing agencies to establish and report on diversity goals for health & hospital systems and health care training institutions to the Oregon Health Fund Board on a biennial basis.

Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

The second domain of healthcare workforce the committee felt was crucial to eliminating health disparities is to ensure providers are trained to be culturally-sensitive healthcare practitioners.

Mandate a minimum level of educational credits for health care providers that must be earned in coursework specifically designed to increase cultural competence and/or awareness.

Recommendation 5: Expand data collection efforts

In Oregon there is such a dearth of data related to race, ethnicity, and primary language in health care that it is difficult to identify, let alone address, disparities in health care access, health care utilization, disease status, and/or quality of care. Where data exists, sources of are difficult to combine or compare due to differences in definitions and data collection protocols.

Recommendation: All health care providers and health plans participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency.

Recommendation 6: Implement initiatives to enhance quality

In its role as convener and collaborator, the Quality Institute should be responsible for:

- **Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.**
- **Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.**
- **Aligning resources to support quality healthcare across all demographic populations in Oregon.**
- **Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.**

Concluding Thoughts of the Health Equities Committee

The social determinants of health must be acknowledged in any explicit effort to reduce health disparities. Social determinants of health acknowledge that an individual's health is not solely understood by determining insurance status, by isolating the experience between patient and provider, nor can it be adequately addressed by focusing on individuals and individual responsibility. Health is more than health care. A review of population health factors determined that non-medical factors (genetic predispositions, social circumstances, environmental conditions, and behavioral patterns) are responsible for a large proportion of preventable mortality in the United States, perhaps 85-90 percent.^{9,10}

In the acclaimed PBS documentary series, *Unnatural Causes: Is Inequality Making Us Sick?*, Dr. David Williams aptly frames the scope necessary to truly address health inequities through social policy when he argues: "Housing policy is health policy, educational policy is health policy, anti-violence policy is health policy, neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy". Other states have acknowledged this by passing legislation giving members of the legislative body, or other policy-makers, an opportunity to

⁹ Schroeder S, *We Can Do Better—Improving the Health of the American People*, (The New England Journal of Medicine, 357(12):1221-1228, September 20, 2007;).

¹⁰ McGinnis JM, Williams-Russo P, and Knickman JR, *The case for more active policy attention to health promotion*, (Health Affairs, 21(2):78-93, March/April 2002).

request an assessment of how any proposed policy might impact the health of vulnerable populations. Health impact-assessment tools provide policy-makers with information to evaluate how education policy, housing policy, economic policy, land-use policy (as examples) might benefit or harm the health of individuals, families, or communities.¹¹

The Health Equities Committee strongly encourages the Oregon Health Fund Board and other policy-makers to consider creating avenues for racial, ethnic, and cultural minorities to participate in an on-going effort to address health disparities in Oregon. These communities are the first to identify and understand the problems that affect them and will have the best ideas about how to address these problems effectively. Health care is experienced locally and solutions for health care dilemmas must be addressed by engaging, supporting, and allowing the impacted communities to lead the way.

Finally, efforts to reduce health disparities can begin immediately, outside of health care reform, or as part of any staged implementation that involves expanding Medicaid.

¹¹ B. Smedley, B. Alvarez, R. Panares, C. Fish-Parcham, and S. Adland, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (New York: The Commonwealth Fund, April 2008).