

# Oregon Health Policy Board

## AGENDA

June 12, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

1 to 4 p.m.

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

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: 5/24/12 minutes	Chair	X
2	1:05	Director's Report	Bruce Goldberg	
3	1:20	CMS Waiver	Tina Edlund	
4	1:45	All Payer All Claims dashboard	Gretchen Morley	
5	2:00	Essential Health Benefits workgroup	Jeanene Smith Lou Savage	
	2:30	Break		
6	2:45	Review of OHPB retreat feedback and next steps	Diana Bianco	
7	3:30	Public Comment	Chair	
8	4:00	Adjourn	Chair	

**Next Meeting:**  
**July 10, 2012**  
**Market Square Bldg.**  
**8:30 a.m. to noon**



**Oregon Health Policy Board**  
**DRAFT Minutes**  
**May 24, 2012**  
**9 a.m. to 3 p.m.**  
**980 Chemawa Rd, Keizer, Oregon**

Item
<p><b>Welcome and Call To Order</b> Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Carla McKelvey.</p> <p>Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p>
<p><b>Consent Agenda:</b> The minutes from the April 12, 2012 meeting were unanimously approved.</p>
<p><b>Agenda Overview and Goals – Diana Bianco</b> Diana Bianco spoke about the agenda and goals for the planning session.</p>
<p><b>Review of OHPB’s Founding Agreements – Diana Bianco</b> Diana Bianco facilitated a discussion about the Oregon Health Policy Board’s Founding Agreements. The Board voted to reconfirm the agreements.</p>
<p><b>Board Role – Diana Bianco</b> Diana Bianco summarized Board member interviews that she conducted in May and facilitated a discussion about the Board’s role moving forward.</p> <p>Board members decided that their role should include the following:</p> <ul style="list-style-type: none"><li>• Provide focused and strategic oversight on directional goals, keeping an eye on the goals of transformation over the long-term.</li><li>• Ensure accountability to the goals, direction and outcomes of transformation.</li><li>• Be a catalyst for change – use information in an inspirational way, rather than for regulatory purposes (a function of OHA).</li><li>• Utilize its role as a public and transparent body to facilitate transformation.</li><li>• Be evangelical and spread the word about transformation successes.</li><li>• Support creativity and innovation in transformation.</li><li>• Ask consistently – “what have we done to drive transformation?”</li><li>• Identify themes as CCOs develop -- both successes and challenges.</li><li>• Consider and address the policy implications of opportunities and obstacles in CCO development.</li></ul>
<p><b>Where We’ve Been; Where We’re Going – Bruce Goldberg and Tina Edlund</b> Bruce Goldberg and Tina Edlund led a discussion about Board accomplishments and future tasks. Goldberg said what distinguishes Oregon’s attempt at health system transformation from that of other states is that Oregon has a clearly developed strategic direction. He also spoke about the fact that Oregon’s plan [SB 1580] passed the legislature with bipartisan support in an “extremely politically charged environment, at a time when healthcare has become a politically divisive topic.”</p> <p>Tina Edlund spoke about the status of Board action items, including:</p> <ul style="list-style-type: none"><li>• Set a target for health care spending in Oregon</li><li>• Align purchasing</li><li>• Reduce administrative costs in health care</li><li>• Decrease obesity and tobacco use</li><li>• Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange</li><li>• Promote local and regional accountability for health and health care</li><li>• Build the health care workforce</li></ul>

- Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, state employees, educators) and then statewide
- Introduce a value-based benefit design that removes barriers to preventive care.
- Expand the use of health information technology (HIT) and exchange (HIE)
- Develop guidelines for clinical best practices
- Strengthen medical liability system
- Performance measurement

*The OHPB Action Plan Status Update can be found [here](#), starting on page 7.*

### **Work Plan Priorities for the Coming Year – Diana Bianco**

Diana Bianco led a discussion about work plan priorities. The Board decided that it will focus on transformation of care and dedicate more energy to community health. The Board decided to focus on the following areas:

#### **Transformation of care**

- Aligning purchasing
- CCO effectiveness
- Workforce
- Goals and measurements

#### **Community health**

- Public health/prevention
- Community health assessments and improvement plans
- Workforce
- Potential focus on obesity, tobacco, pregnancy
- Coordination with education (Early Learning Council)
- Education about when to use which systems
- Goals and measurements

### **Summary and Next Steps – Diana Bianco**

Diana Bianco summarized work plan priorities and facilitated a discussion about next steps. The Board decided on the following steps for community health:

In the immediate future, the Board wants to gather information about the following:

- Oregon's Health Improvement plan
- The board's Action Plan related to community health
- The state of public health in Oregon
- What Oregonians think about prevention and public health
- Other initiatives
- Examples of other successful shifts in public culture and lessons learned (e.g., smoking, seatbelts)

The Board decided that the following steps are critical to ensure success in addressing community health:

- Create a burning platform -- make the problem big enough.
- Get stakeholder support.
- Consider who might help
- Understand ways to incentivize community health.
- Identify opportunities – where can the OHPB be the catalyst for change?
- Identify what Oregon could do differently than what has come before?

**Public Comment - Chair Eric Parsons**

The Board heard public testimony from two people:

Ruth McEwen, Oregon Disabilities Coalition, spoke about discontinuing the use of the term "client." She said using first-person language will empower people to make decisions for themselves. McEwen also said she would like to know how CCOs will educate members about empowerment.

Doug Barber, Eugene resident, said a way to reduce obesity could be paying people to lose weight. Barber said the OHA could hold a contest by city or by county and the award could go to fund something recreational in that area.

**Adjourn****Next meeting:****June 12, 2012****1:00 p.m. to 5:00 p.m.****Market Square Building****1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor****Portland, OR 97201**

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# Essential Health Benefits (EHB) Workgroup

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Progress Update (June 6, 2012)

## **What is the EHB Workgroup?**

The EHB Workgroup was established by Governor Kitzhaber to recommend essential health benefits for Oregon's individual and small group market both inside and outside the Exchange as mandated by the Affordable Care Act. Because the selection will have far reaching effects on health care reform, the health insurance market, and the operations of the Oregon Health Insurance Exchange (ORHIX), the Oregon Health Policy Board (OHPB) and the ORHIX Board jointly chartered the EHB Workgroup. Workgroup members include representatives from health plans, small businesses, advocates, providers, agents, and other stakeholders. The Workgroup also includes one member of both the ORHIX Board and the OHPB.

## **How will EHBs be determined?**

In December 2011, the United States Department of Health and Human Services (HHS) released a bulletin outlining that EHBs include ten statutory benefit categories and must be defined using a benchmark approach reflecting a "typical employer plan." The EHB Workgroup is chartered to recommend one of ten EHB benchmark plans specified by HHS and ensure that it is inclusive of ten statutory-required categories of services or if it will need to be supplemented with benefits as directed by HHS.

## **What has the Workgroup accomplished?**

On April 16, 2012, the first EHB Workgroup meeting was conducted and included an overview of the EHB process and expectations of the Workgroup. The second meeting, conducted a month later, included a benchmark plan analysis prepared by Wakely, an actuarial consulting firm assisting with this process. Workgroup members were also provided with information on the related SB 91 (2011) process involving the determination of actuarial value for metal plans (e.g., platinum, gold, silver, and bronze). At the conclusion of the third meeting, the benchmark plan options were consolidated from the ten choices outlined by HHS to just one, which is the PacificSource small group plan. The elimination of the other plans was a result of discussion regarding which benchmark plan options include benefits the Workgroup felt were essential to Oregonians with consideration of which plans were too costly for the market to sustain them.

## **What are the next steps?**

The Workgroup's decision on PacificSource being the chosen benchmark plan has been posted for public comment. At the next EHB Workgroup meeting, scheduled for June 22<sup>nd</sup> at the Meridian Park Hospital in Tualatin, the Workgroup will review public comment and decide on supplements to be incorporated into the chosen benchmark plan to ensure coverage of the ten statutory categories (e.g., prescription drug, pediatric dental and vision, and habilitative services coverage). The Workgroup's final recommendation will then be posted for additional public comment through July. A summary of all public comments, Workgroup discussion, and the recommendation will be presented to the ORHIX Board and the OHPB at a joint meeting on August 14, 2012. Once the recommendation is approved, the ORHIX Board and the OHPB must forward it to the Governor for communication to HHS.

## **Is there opportunity for public comment?**

All EHB Workgroup meetings are open for the public to attend and 15 minutes are allotted at the end of each meeting for public comment. Individuals can also submit public comment or testimony by visiting the EHB Workgroup website or submitting it to staff. Public comment and testimony are also welcome at the ORHIX Board's and the OHPB's Board's monthly meetings or through their respective public comment processes, and will be shared with the Workgroup as they develop their recommendation.

For more information, refer to the EHB website at [www.oregon.gov/OHA/OHPR/EHB/index.shtml](http://www.oregon.gov/OHA/OHPR/EHB/index.shtml).

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# Actuarial Value, Metal Level Plans, & SB 91

## INTRODUCTION

Beginning in 2014, the Affordable Care Act (ACA) requires non-grandfathered plans sold in the individual and small group markets to provide coverage for a comprehensive “essential health benefits package.” The selection of Oregon’s essential health benefits benchmark plan is a critical piece of the overall essential health benefits package. However the essential health benefits package also includes ACA-mandated requirements for each health plan’s actuarial value. This paper discusses these requirements and how they will be implemented in Oregon.

## ACTUARIAL VALUE

Actuarial value is an estimate of the expected health care costs a health plan will cover. It can be thought of as a measure of health plan generosity. In technical terms, it is the share of total medical spending that a health plan will cover for a defined set of services for a “standard population”<sup>1</sup>.

Expressed as an equation, the calculation of actuarial value looks like this:

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For example, the typical employer PPO-style health plan has an actuarial value of approximately 83%. So, on average, the plan pays for 83% of medical spending for covered services. The insured pays the remaining 17% out-of-pocket in the form of deductibles, copays, and coinsurance.

It is important to note that actuarial value is only an *estimate* of a health plan’s overall expected value. In reality, a health insurance plan will pay different percentages of medical spending for different people, depending on the level and types of services they use during the year – typically more for those who are sick and less for those who are healthy. Thus, assigning an actuarial value to a health plan does NOT guarantee that a health plan will actually provide a certain level of coverage to individual policyholders. It is only a summary view of what the plan would typically pay, *on average*, for the population expected to enroll in the plan.

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<sup>1</sup> A “standard population” is a population of average morbidity that represents the average medical experience within a defined area.

## ACA METAL LEVELS

Under the ACA, all non-grandfathered health plans offered in the individual and small group markets after December 31, 2013 must cover essential health benefits at one of four actuarial value (AV) levels<sup>2</sup>:

- Bronze – 60% AV
- Silver – 70% AV
- Gold – 80% AV
- Platinum – 90% AV

These requirements apply to non-grandfathered plans, regardless of whether they are sold inside or outside the Exchange. However, certain individuals<sup>3</sup> will be eligible to purchase a catastrophic health plan. Catastrophic plans must cover essential health benefits, but will not have to meet the actuarial value requirements.

The federal government recently issued initial guidance about the calculation of actuarial value under the ACA. According to this guidance, the United States Department of Health and Human Services (HHS) will create and publish an actuarial value calculator based on a standard population. Health insurers and state regulators will input a plan's cost-sharing information into the calculator to determine that plan's actuarial value.

Actuarial value takes into account a number of factors, including:

- The medical services covered by the plan,
- The expected utilization of those services, and
- The plan's cost-sharing design (deductible, coinsurance, copayments, and out-of-pocket limit)

Even though all plans subject to the essential health benefits requirement must offer substantially similar benefits, these plans can still achieve a specified metal level in multiple ways. For example, two health plans could have significantly different cost sharing design but still have the same actuarial value. This variation within a metal level can make it difficult for consumers to compare plans from different insurers on cost and quality alone.

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<sup>2</sup> The AV requirements do not apply to grandfathered plans, large group plans, or self-insured plans.

<sup>3</sup> Persons under 30 and persons who do not meet an ACA-mandated affordability test may purchase the catastrophic plan.

## OREGON SENATE BILL 91 (2011)

Recognizing this, the Oregon Legislative Assembly passed Senate Bill 91 (SB 91) in 2011. SB 91 gives the Department of Consumer and Business Services (DCBS) authority to establish standardized, or “cookie cutter” plans at the bronze and silver metal levels. Under SB 91, insurers must offer these “cookie cutter” plans to individuals and small groups in any market in which they participate. (A carrier must offer the standardized plans in the Exchange if it offers plans through the Exchange and outside of the Exchange if it offers plans outside of the Exchange.)

Because the standardized plans will have identical cost sharing, they enable consumers to make true apples to apples comparisons among carriers. The standardized plans will also be a useful tool for DCBS when reviewing rate requests and monitoring market conditions.

DCBS will use the essential health benefit benchmark plan ultimately selected by the Governor as the basis for the SB 91 rulemaking. DCBS also expects to develop a standardized gold plan during the rulemaking, but the gold plan will not be a requirement for participation in Oregon insurance markets at this time. The standardized plans, in turn, will likely serve as bases for the qualified health plans that carriers will offer through the Exchange.

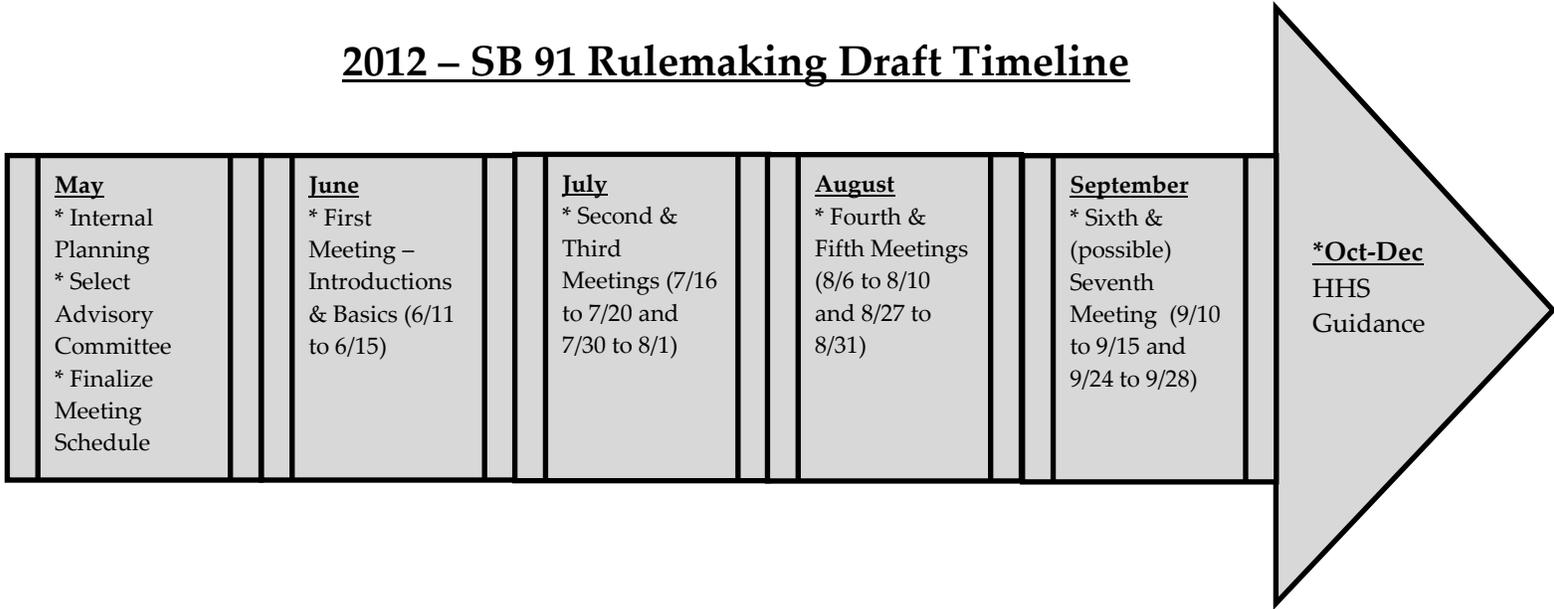


Currently, there is little cost-sharing guidance available for the development of the metal level plans. The ACA, however, does limit annual out-of-pocket costs to the limit in Health Savings Account qualified plans (currently \$6,050 for an individual and \$12,100 for a family). Further federal guidance on cost sharing is expected later this year.

Nonetheless, with ACA reforms set to begin in 2014 and the initial open enrollment for the Exchange starting on October 1, 2013, timelines are already extremely tight. To ensure that carriers will have product standards to timely file 2014 plans, DCBS must begin planning for the SB 91 rulemaking now. DCBS plans to select a Rules Advisory

Committee this month and to hold an initial planning meeting in June. DCBS intends to begin discussions now so that the rules can become effective as soon as possible after the the Governor selects the essential health benefits benchmark and HSS issues the AV calculator. As shown below, DCBS has tentatively scheduled a series of meeting through the summer and will be issuing invitations to participate on the rulemaking committee very soon.

### 2012 – SB 91 Rulemaking Draft Timeline



**State of Oregon**  
**Essential Health Benefits (EHBs) Benchmark Plan Comparison**  
 Grouped into the 10 categories of EHBs required by the ACA

**Selected Plan** (Does not include required supplements for prescription drug, pediatric dental and vision, and habilitative services coverage)

Benefit	Small Group			State Plans			HMO	Federal Plans			Reference Plans	
	Regence Innova	Kaiser Deductible Plan	PacificSource Preferred CoDeduct	PEBB Providence Statewide	OEBB	PEBB Providence Choice	Kaiser	BCBS Plan Standard	BCBS Plan Basic	GEHA Plan Standard	OMIP	Individual (Regence)
<b>1. Ambulatory patient services</b>												
a. Primary care to treat illness/injury	√	√	√	√	√	√	√	√	√	√	√	√
b. Specialist visits	√	√	√	√	√	√	√	√	√	√	√	√
c. Outpatient surgery	√	√	√	√	√	√	√	√	√	√	√	√
d. Acupuncture	NC (optional rider)	limit 12 visits / yr	NC (optional rider)	√	√	√	limit 12 visits / yr	limit 24 visits / yr	√	limit 20 visits / yr	NC	√
e. Chiropractic	NC (optional rider)	√	NC (optional rider)	limit 60 visits / yr	limit \$2,000 / yr	limit lesser of 60 visits / yr or \$1,000 / yr	√	limit 12 visits / yr	limit 20 visits / yr	limit 12 visits / yr	NC	limit 8 visits / yr
f. Naturopath	NC (optional rider)	√	NC (optional rider)	√	√	√	√	NC	NC	NC	NC	√
g. Chemotherapy services	√	√	√	√	√*	√	√	√	√	√	√	√
h. Radiation therapy	√	√	√	√	√*	√	√	√	√	√	√	√*
i. Infertility treatment services	√ diagnosis only	excludes assisted reproductive technology except artificial insemination	NC	excludes assisted reproductive technology except artificial insemination	NC	excludes assisted reproductive technology except artificial insemination	excludes assisted reproductive technology except artificial insemination	excludes assisted reproductive technology	excludes assisted reproductive technology	excludes assisted reproductive technology limit \$3,000 / yr	NC	√ diagnosis only
j. Sterilization	√	√*	√	√	√	√	√*	√	√	√	√	√*
k. Home health care	limit 130 visits / yr	limit 130 visits / yr	√	limit 180 visits / yr	limit 140 visits / yr	limit 180 visits / yr	limit 130 visits / yr	limit 25 visits / yr	limit 25 visits / yr	limit 50 visits / yr	limit 130 visits / yr	limit 130 visits / yr
l. Telemedical services	√	√*	√	√	√	√	√*	NC	NC	NC	√	√
m. Foot care	medical conditions only	medical conditions only *	medical conditions only	medical conditions only	medical conditions only	medical conditions only	medical conditions only *	medical conditions only	medical conditions only	medical conditions only	medical conditions only	medical conditions only
n. Medical contraceptives	√	√*	√	√	√	√	√*	√	√	√	√	√
o. TMJ services	√	√	NC	√	√	√	√	√	√	√	√	NC
p. Dental - diagnostic & preventive	NC	NC	NC	NC	NC	NC	NC	limit 2 visits / yr limited benefit	limit 2 visits / yr	limit 2 visits / yr	NC	NC
q. Dental - basic	NC	NC	NC	NC	NC	NC	NC	limited benefit	NC	limited benefit	NC	NC
r. Dental - major	NC	NC	NC	NC	NC	NC	NC	NC *	NC *	NC *	NC	NC
<b>2. Emergency services</b>												
a. Emergency room - facility	√	√	√	√	√	√	√	√	√	√	√	√
b. Emergency room - physician	√	√	√	√	√	√	√	√	√	√	√	√
c. Ambulance service - ground and air	√	√	√	√	√	√	√	√	√	√	√	√
<b>3. Hospitalization</b>												
a. Inpatient medical and surgical care	√	√	√	√	√	√	√	√	√	√	√	√
b. Organ & tissue transplants	limited to organs specified	limited to organs specified	limited to organs specified \$5000 limit for travel expenses	limited to organs specified	limited to organs specified \$5000 limit for donor costs	limited to organs specified	limited to organs specified	limited to organs specified	limited to organs specified	limited to organs specified	limited to organs specified	limited to organs specified
c. Bariatric surgery	NC	NC	NC	√	NC	√	√	√	√	√	NC	NC
d. Anesthesia	√	√	√	√	√	√	√	√	√	√	√	√
e. Breast reconstruction (non-cosmetic)	√	√	√	√	√	√	√	√	√	√	√	√
f. Blood transfusions	√	√	√	√	√	√	√	√	√	√	√	√
g. Hospice / respite care	respite limit 14 visits / lifetime	respite limit 5 consecutive days / 30 days	√	respite limit of 120 hrs	√	excludes respite care	respite limit 5 consecutive days / 30 days	respite limit 7 consecutive days every 30 days	respite limit 7 consecutive days every 30 days	limit \$15,000	respite limit 14 days / lifetime	respite limit 14 days / lifetime
<b>4. Maternity and newborn care</b>												
a. Pre- & postnatal care	√	√	√	√	√	√	√	√	√	√	√	√
b. Delivery & inpatient maternity services	√	√	√	√	√	√	√	√	√	√	√	√
c. Newborn child coverage	√	√	√	√	√	√	√	√	√	√	√	√
d. Nonprescription elemental enteral formula	√	√	√	√	√	√	√*	NC *	NC *	NC	√	√*
<b>5. Mental health and substance use disorder services, including behavioral health treatment</b>												
a. Inpatient hospital - mental/behavioral health	limit 45 days / yr for residential treatment	limit 45 days / yr for residential treatment	limit 45 days / yr for residential treatment	√	√	√	√	√	√	√	limit 45 days / yr for residential treatment	limit 6 days / yr
b. Outpatient hospital - mental/behavioral health	√	√	√	√	√	√	√	√	√	√	√	limit 12 visits / yr
c. Inpatient hospital - chemical dependency	√	√	√	limit 180 days / yr for residential treatment	√	limit 180 days / yr for residential treatment	√	√	√	√	√	limit 10 days / yr alcoholism treatment only
d. Outpatient hospital - chemical dependency	√	√	√	√	√	√	√	√	√	√	√	limit 40 visits / yr alcoholism treatment only
e. Detoxification	√	√	√*	√	√	√	√	√	√	√	√*	√
f. Counseling or training in connection with family, sexual, marital, or occupational issues	NC	NC *	NC	NC	√	NC	NC	NC	NC	NC	NC	NC
<b>6. Prescription drugs</b>												
a. Retail	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√
b. Mail order	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√
c. Generic	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√
d. Brand	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√
e. Specialty	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√*	√*
f. Insulin/needles for diabetics	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√
g. Tobacco cessation drugs	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√	√

√ = Covered benefit, limits noted NC = Not a covered benefit \* = Assumed, not specifically stated

**State of Oregon**  
**Essential Health Benefits (EHBs) Benchmark Plan Comparison**  
 Grouped into the 10 categories of EHBs required by the ACA

**Selected Plan** (Does not include required supplements for prescription drug, pediatric dental and vision, and habilitative services coverage)

Benefit	Small Group			State Plans			HMO	Federal Plans			Reference Plans	
	Regence Innova	Kaiser Deductible Plan	PacificSource Preferred CoDeduct	PEBB Providence Statewide	OEBB	PEBB Providence Choice	Kaiser	BCBS Plan Standard	BCBS Plan Basic	GEHA Plan Standard	OMIP	Individual (Regence)
h. Contraceptives	√	NC (optional rider)	NC (optional rider)	√	√	√	NC (optional rider)	√	√	√	√*	√
i. Fertility drugs	NC	NC (optional rider)	NC (optional rider)	NC	NC	√	NC (optional rider)	NC	NC	NC	NC	NC
j. Growth hormone therapy	medical conditions only	NC (optional rider)	NC (optional rider)	medical conditions only	medical conditions only	medical conditions only	NC (optional rider)	√*	√*	√	medical conditions only	medical conditions only
<b>7. Rehabilitative and habilitative services and devices</b>												
a. Inpatient rehabilitation	√ limit 30 days / yr	√ limit 60 days / yr	√ limit 30 days / yr additional 30 days for head/spinal cord injury	√ limit 30 days / yr additional 30 days for head/spinal cord injury or stroke	√ limit 30 days / yr additional 30 days for head/spinal cord injury	√ limit 30 days / yr additional 30 days for head/spinal cord injury or stroke	√ limit 60 days / yr	√	√	√	√ limit 60 days / yr	√ limit 5 days / yr
b. Physical, speech & occupational therapy (outpatient)	√ limit 25 visits / yr	√ limit 20 visits / yr for each	√ limit 30 visits / yr additional 30 visits / condition for specified conditions	√ limit 60 visits / yr	√ limit 30 visits / yr additional 30 visits for head or spinal cord injury	√ limit 60 visits / yr	√ limit 20 visits / yr for each	√ limit 75 visits / yr	√ limit 50 visits / yr	√ limit 60 visits / yr combined for PT & OT 30 visits / yr for ST	√ limit 60 visits / yr	√ limit 25 visits / yr
c. Massage therapy	NC	NC	NC	NC	NC	NC	limit 20 visits / yr combined with PT	NC	NC	NC*	NC	NC
d. Durable medical equipment	√	√	√ limit \$5000 for non-essential DME	√	√	√	√	√	√	√	√	√
e. Prosthetics	√	√	√	√	√	√	√	√	√	√	√	√
f. Orthotics	√	√	√	√	√	√	√	√	√	√	√	√
g. Vision hardware	NC	NC	NC	NC	NC	NC	NC	medical condition or accident only	medical condition or accident only	medical condition or accident only	NC*	limit \$150 / yr (exam and hardware)
h. Hearing aids - adults	NC	NC	NC	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs	NC	√ limit \$1250 per ear / 3 yrs	√ limit \$1250 per ear / 3 yrs	√ limit \$250 per ear / 5 yrs	NC	NC
i. Cochlear Implants	√	√*	√	√	√	√	√*	√	√	√	√*	√*
j. Skilled nursing	√ limit 60 days / yr	√ limit 100 days / yr	√ limit 60 days / yr	√ limit 180 days / yr	√ limit 60 days / yr	√ limit 180 days / yr	√ limit 100 days / yr	√ limit 30 days but only with Medicare Part A	NC	√ limit 14 days, \$700 limit per day	√ limit 60 days / yr	√ limit 30 days / yr
k. Habilitative services (not currently defined)	NC*	NC*	NC*	NC*	NC*	NC*	NC*	NC*	NC*	NC*	NC*	NC*
<b>8. Laboratory services</b>												
a. Lab tests, x-ray services, & pathology	√	√	√	√	√	√	√	√	√	√	√	√
b. Imaging / diagnostics (e.g., MRI, CT scan, PET scan)	√	√	√	√	√	√	√	√	√	√	√	√
c. Genetic testing	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary	medically necessary
<b>9. Preventive and wellness services and chronic disease management</b>												
a. Preventive care	√	√	√	√	√	√	√	√	√	√	√	√
b. Immunizations	√	√	√	√	√	√	√	√	√	√	√	√
c. Colorectal cancer screening	√	√	√	√	√	√	√	√	√	√	√	√
d. Screening mammography	√	√	√	√	√	√	√	√	√	√	√	√
e. Routine eye exams (separate office visit)	NC	√	NC	NC	NC	NC	√	NC	NC	NC	NC	limit \$150 / yr (exam and hardware)
f. Routine hearing exams (separate office visit)	NC	NC	medically necessary	√	√	√	NC	limited to injury or illness	limited to injury or illness	limited to injury or illness	NC*	NC
g. Nutritional counseling	√ limit 3 visits / lifetime	medically necessary	√ limit 5 visits / lifetime	√ limit 4 visits / yr	medically necessary	√ limit 4 visits / yr	medically necessary	√	√	√ \$250 limit / yr	√ limit 3 visits / lifetime	NC
h. Diabetes education	√	√	√	√	√	√	√	√	√	√	√	√
i. Smoking cessation program	√	√*	√	√	√	√	√*	√	√	√ 2 attempts / yr, 4 sessions / attempt	√	√
j. Allergy testing & injections	√	√	√	√	√	√	√	√	√	√ \$500 / yr for testing	√	√*
k. Diabetes - medically necessary equip. & supplies	√	√	√	√	√	√	√	√	√	√	√	√
l. Screening pap tests	√	√	√	√	√	√	√	√	√	√	√	√
m. Prostate cancer screening	√	√	√	√	√	√	√	√	√	√	√	√
<b>10. Pediatric services, including oral and vision care</b>												
a. Preventive care - physician services	√	√	√	√	√	√	√	√	√	√	√	√
b. Immunizations	√	√	√	√	√	√	√	√	√	√	√	√
c. Metabolic formula & low protein food for inborn errors of metabolism	√	√	√	√	√	√	√	√	√	√*	√	√
d. Routine eye exams (separate office visit)	NC	√	NC*	NC	NC	NC	√	NC	NC	NC	NC	limit \$150 / yr (exam and hardware)
e. Routine hearing exams (separate office visit)	NC	√	medically necessary	√	√	√	√	limited to injury or illness	limited to injury or illness	limited to injury or illness	NC*	NC
f. Hearing aids	√	√ limit \$4000+CPI / 4 yrs excludes bone anchored and implanted hearing aids	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs	√ limit \$4000+CPI / 4 yrs excludes bone anchored and implanted hearing aids	√ limit \$1250 per ear / yr	√ limit \$1250 per ear / yr	√ limit \$250 per ear / 5 yrs	√ limit \$4200 / 4 yrs	√
g. Dental - diagnostic & preventive	NC	NC	NC	NC	NC	NC	NC	√ limit 2 visits / yr limited benefit	√ limit 2 visits / yr	√ limit 2 visits / yr	NC	NC

√ = Covered benefit, limits noted    NC = Not a covered benefit    \* = Assumed, not specifically stated

**State of Oregon**

**Essential Health Benefits (EHBs) Benchmark Plan Comparison**

Grouped into the 10 categories of EHBs required by the ACA

**Selected Plan** (Does not include required supplements for prescription drug, pediatric dental and vision, and habilitative services coverage)



Benefit	Small Group			State Plans			HMO	Federal Plans			Reference Plans	
	Regence Innova	Kaiser Deductible Plan	PacificSource Preferred CoDeduct	PEBB Providence Statewide	OEBB	PEBB Providence Choice	Kaiser	BCBS Plan Standard	BCBS Plan Basic	GEHA Plan Standard	OMIP	Individual (Regence)
h. Dental - basic	NC	NC	NC	NC	NC	NC	NC	√ limited benefit	NC	√ limited benefit	NC	NC
i. Dental - major	NC	NC	NC	NC	NC	NC	NC	NC *	NC *	NC *	NC	NC

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**OHPB PLANNING SESSION**  
**SUMMARY OF DISCUSSION ON BOARD ROLES AND WORKPLAN**  
**MAY 24, 2012**

At its planning session on May 24, 2012, the Oregon Health Policy Board discussed its role and workplan for the coming year. Board decisions are summarized below.

**Board role**

The Oregon Health Policy Board will:

- Provide focused and strategic oversight on directional goals, keeping an eye on the goals of transformation over the long-term.
- Ensure accountability to the goals, direction and outcomes of transformation.
- Be a catalyst for change – use information in an inspirational way, rather than for regulatory purposes (a function of OHA).
- Utilize its role as a public and transparent body to facilitate transformation.
- Be evangelical and spread the word about transformation successes.
- Support creativity and innovation in transformation.
- Ask consistently – “what have we done to drive transformation?”
- Identify themes as CCOs develop -- both successes and challenges.
- Consider and address the policy implications of opportunities and obstacles in CCO development.

**Workplan focus areas**

The board will focus on two broad areas for change – transformation of care and community health. Within each, there are subcategories of work, some of which overlap. The OHPB decided that determining strategies around community health require more attention. Much work has been dedicated to transformation of care over the last few years, and this is the right time to dedicate more energy to community health.

**Transformation of care**

- Aligning purchasing
- CCO effectiveness
- Workforce
- Goals and measurements

**Community health**

- Public health/prevention
- Community health assessments and improvement plans
- Workforce
- Potential focus on obesity, tobacco, pregnancy
- Coordination with education (Early Learning Council)
- Education about when to use which systems
- Goals and measurements

### **Next steps on community health**

Much of the board's workplan around transformation of care will be driven by the development of CCOs. The OHPB's work on community health is less clear. Staff will help the board get up to speed by determining next steps.

In the immediate future, the board wants to gather information about the following:

- Oregon's Health Improvement plan
- The board's Action Plan related to community health
- The state of public health in Oregon
- What Oregonians think about prevention and public health (e.g., NWHF polls)
- Other initiatives (e.g., Healthiest State Initiative in Iowa, Colorado)
- Examples of other successful shifts in public culture and lessons learned (e.g., smoking, seatbelts)

The board had the following initial input on what is critical to ensure success in addressing community health:

- Create a burning platform -- make the problem big enough. An economic analysis and more.
- Get stakeholder support.
- Consider who might help (e.g., RWJ, Trust for America's Health).
- Understand ways to incent community health.
- Identify opportunities – where can the OHPB be the catalyst for change?
- Identify what Oregon could do differently than what has come before?

## Public Input for the Oregon Health Policy Board

April 9 – May 25, 2012

Doc #	Summary	Comment Type	Writer
1	For health system transformation do not leave any detail open to interpretation, be as clear as possible in all expectations. Dot every i and cross every t.	Email Received 4/9/2012	Rosemary Bean
2	I urge all of you to have a moratorium on all forestry pesticide spraying until industry proves that the long and short-term effects of these chemicals do not cause harm.	Email Received 4/10/2012	Planet Glassberg
3	Concern that CCOs will replicate and then make immutable the problems that we already experience in mental health care services for OHP clients, especially in Southern Oregon.	Email Received 4/21/2012	Ellen Wilfong- Grush
4	Part of why insurance rates continue to increase is for unnecessary treatment, but also for unnecessary <i>billing</i> . Personal story of a trip to the doctor in which the doctor charged extra for a two minute, unnecessary demonstration of a medical device.	Email Received 4/22/2012	BJ Merriman
5	Concerns about new health care system. Also, please be as transparent as possible moving forward.	Email Received 4/23/2012	M. Bagon
6	Promoting the notion of “direct practices.” See <a href="http://www.dpcare.org">www.dpcare.org</a> for more details.	Email Received 4/27/2012	L. Baskin
7	Personal story of how recent PEBB decisions affected one’s family. Includes prescription costs, deductibles, mental health coverage and low-income premium subsidies.	Email Received 5/1/2012	Lisa Pierson
8	One vital piece is missing from health care reform: the cooperation, commitment and accountability of the patient/client themselves. How can we teach people about taking responsibility for their own lives and future?	Email Received 5/7/2012	Elgonda Brunkhorst
9	Hopefully the CCO model is the first step toward a state and eventually federal single payer model that can cut costs by nearly half while improving patient care.	Email Received 5/11/2012	Rick Staggenborg
10	Cut back on the budget; live within your means. Stop CCOs.	Email Received 5/14/2012	Ann Metz
11	There is an organization called <a href="http://Planetree.org">Planetree</a> that focuses on patient-centered care and has certified three hospitals in Oregon. NPR recently did a story on Planetree. It could be a great resource for CCO implementation and partnership.	Email Received 5/24/2012	Alison Babich
12	Concern that the burden of covering the costs of Marion Co.’s large population of low-income citizens could become too much to bear.	Email Received 5/24/2012	Lara Million
13	Nurses need to be included explicitly in CCO expectations. They are educated to encourage proactive health and prevention.	Email Received 5/25/2012	Terri Wenzig
14	Report from the joint meeting of the Dental Products Panel and the Peripheral and Central Nervous System Drugs Advisory Committee.	Letter Received 3/7/2011	John Costa