Health Equity definition in HCMO statute versus administrative rules—Document review

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Statute:

The following are relevant statute mentions of health equity in the HCMO statute HB 2362

Section 1

(2) “Essential services” means: (a) Services that are funded on the prioritized list described in ORS 414.690; and (b) **Services that are essential to achieve health equity.**

(5) **“Health equity” has the meaning prescribed by the Oregon Health Policy Board and adopted by the authority by rule.**

Section 2

(9) A health care entity may engage in a material change transaction if, following a comprehensive review conducted by the authority and recommendations by a review board appointed under subsection (7) of this section, the authority determines that the transaction meets the criteria adopted by the department by rule under subsection (2) of this section and: (a)(A) The parties to the transaction demonstrate that the transaction will benefit the public good and communities by: (i) Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is the best interest of the public; (ii) Increasing access to services in medically underserved areas; or **(iii) Rectifying historical and contemporary factors contributing to a lack of health equities or access to services**; or (B) The transaction will improve health outcomes for resident of this state

The key issue is whether the Oregon Health Policy Board “prescribed” health equity as defined in the current HCMO admin rule. My conclusion is OHPB did not do so.

Current HCMO Administrative rule

Definitions

(14) In accordance with ORS 415.500(2), "essential services" means:
(a) Services that are funded on the prioritized list of health services described in ORS 414.690, as in effect at the time of notice submission; and
(b) Services that are essential to achieve health equity.

This is identical to the language in the statute

(18) "Health equity" means a health system having and offering infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or their socially determined circumstances.

This is a very different definition than the OHA/OHPB Definition of Health Equity---at that time and now. Here is current definition current from the OHA website. This definition has been used repeatedly and is reinforced at almost every OHPB meeting and by every OHPB committee.

"Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- **The equitable distribution or redistribution of resources and power; and**
- **Recognizing, reconciling and rectifying historical and contemporary injustices."**

The bolded language has disappeared in the HCMO rule, essentially removing the 2 most important statements in the definition of Health Equity---equitable distribution or redistribution and rectifying historical injustice.

Interestingly the rule retains the "historical injustice" language in the Comprehensive review section 6:

(6) Subject to any conditions prescribed under OAR 409-070-0065, the Authority shall approve a material change transaction that does not involve a domestic insurer, or in the case of a material change transaction involving a domestic health insurer, recommend to the Department that the transaction be approved, if pursuant to ORS 415.501(9), the Authority determines that the transaction satisfies (a) below and also satisfies either (b) or (c) below:
(a) There is no substantial likelihood that the transaction would:
(A) Have material anticompetitive effects in the region (such as significantly increased market concentration among providers when contracting with payers, carriers, or coordinated care organizations, or among carriers when establishing health benefit premiums that is likely to increase costs for consumers) not outweighed by benefits in increasing or maintaining services to underserved populations;
(B) Be contrary to law;
(C) Jeopardize the financial stability of a health care entity involved in the transaction; or
(D) Otherwise be hazardous or prejudicial to consumers or the public.
(b) The transaction will benefit the public good and communities by:
(A) Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the best interest of the public;
(B) Increasing access to services in medically underserved areas; or
(C) Rectifying historical and contemporary factors contributing to a lack of health equity or access to services.
(c) The transaction will improve health outcomes for residents of this state.

While the historic injustice language is retained, it only applies to comprehensive reviews. Most transactions by HCMO have been approved at the preliminary stage.

Revised Administrative rules

There is no change in the current revised administrative rules in these sections. The health equity definition is unaffected by the other changes proposed.

OTHER

In my review of the Guidance FAQs that are currently in place for HCMO I see the following:

What is this program? What does it do? Who does it apply to?

The Health Care Market Oversight (HCMO) reviews proposed material change transactions involving health care entities, including,

• Hospitals,

• Health insurance companies,

• Coordinated Care Organizations,

• Individual licensed health professionals, and

• Other entities providing health care products or services.

Reviews ensure that these proposed material change transactions support OHA's goals of:

• Health equity,

• Lower costs for consumers and payers,

• Increased access, and

• Better patient care OHA does not review transactions involving long-term and residential care facilities.

The "Health Equity" statement is actually a link that goes to the Equity and Inclusion Division and in its description emphasizes the "agency health equity definition" which is the definition I have referred to above, including the two key bullets on equitable distribution and redistribution and historical injustice. This language clearly says reviews will follow OHA's health equity definition.

I have followed the administrative rules back to the first draft shared in October of 2021. It contains the same language as now---ie inconsistent with the OHA definition and with the OHPB definition. As far as I can tell this definition came from whoever drafted the first administrative rules draft not from an outside source via comment or testimony.

Advocates did participate in rule making but focused on the inclusion of 4 key service descriptions related to health equity. So far, I have not found any mention that the health equity definition itself had been fundamentally changed and was inconsistent with statute. I don't think it was ever brought back to OHPB but assumed to have been approved in the "broad policy framework" OHA staff presented to OHPB in the fall of 2021. But this definition of health equity was the single most discussed policy issue at OHPB from 2019 on. OHA was specifically directed by OHPB to put the definition into the statute, and they did. But then they made fundamental changes at the rules committee and never informed OHPB of that. Ironically HCMO documents continue to refer to the original OHPB definition. Why would OHA use two different definitions and not coordinate with OHPB?