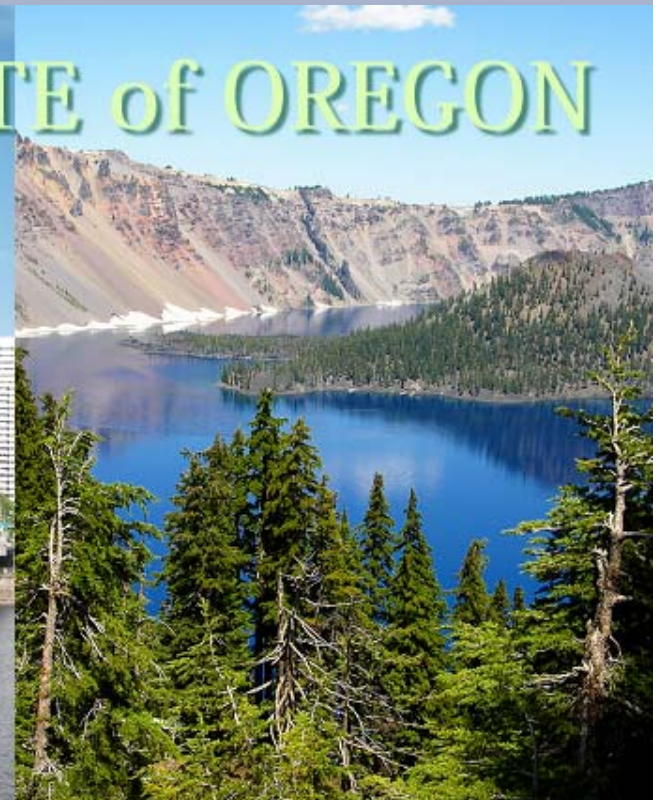


# Cost Sharing Workgroup

March 25, 2010



STATE of OREGON

# Work group overview

- Reform initiative overview
- Context
- Timeline and deliverables

# Legislative charge to the Oregon Health Policy Board

SECTION 9. (1) The duties of the Oregon Health Policy Board are to:

...

(j) Establish a health benefit package in accordance with section 16 of this 2009 Act to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange.

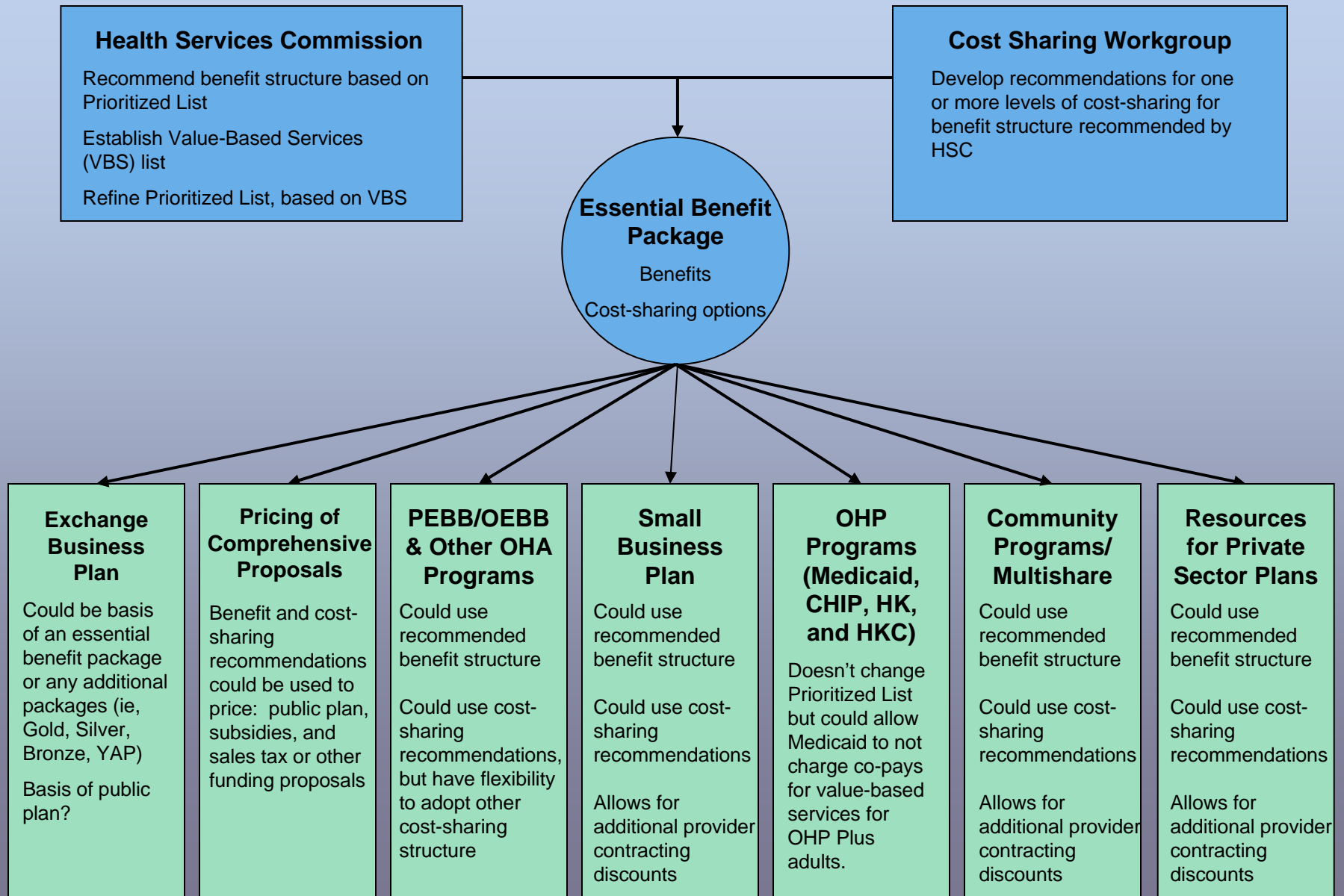
...

SECTION 16. The Oregon Health Authority, in developing and offering the health benefit package required by section 9 (1)(j) of this 2009 Act, may not establish policies or procedures that discourage insurers from offering more comprehensive health benefit plans that provide greater consumer choice at a higher cost. The health benefit package approved by the Oregon Health Policy Board shall:

# Legislative charge

- (1) Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.
- (2) Require little or no cost sharing for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illnesses.
- (3) Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.
- (4) Require a greater contribution by an enrollee to the cost of elective or discretionary health services.
- (5) Include a defined set of health care services that are affordable, financially sustainable and based upon the prioritized list of health services developed and updated by the Health Services Commission under ORS 414.720.

# Potential Uses of Benefit and Cost-sharing Recommendations



# OHFB Benefits Committee

## Essential Benefits Package

- Based on the Prioritized List
  - Integrates dental, medical, vision, mental health
  - Includes acupuncture, PT, other types of services
- First dollar coverage for basic diagnostic tests, comfort care, value based services
- Stresses care that is
  - Evidence-based
  - Delivered in the integrated health home

# OHFB Benefits Committee

## Essential Benefits Package

- Affordable, sustainable
  - Relatively high deductible
  - Cost sharing levels based on tiers in prioritized list.
- Protects patients from medical bankruptcy
  - Out-of-pocket maximum

# Benefits committee recommended EBP

Category of Care	Cost Sharing			Deductible/OOP Max
	Integrated Health Home	Specialist, Procedures, Other Outpatient	Inpatient	
<b>Value-Based Services</b>	0 – 5% depending on service provided and location of care			<ul style="list-style-type: none"> <li>• Deductible waived</li> <li>• \$4,000-\$15,000 OOP max applies per individual (income-based, family = 3 times individual)</li> </ul>
<b>2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics</b>	0%	5%	Not applicable	
<b>Comfort Care</b>	0%	5%	20%	
<b>Tier I (Lines 1-113)</b>	20%	25%	30%	<ul style="list-style-type: none"> <li>• \$1,000-\$7,500 deductible applies per individual (income-based, family=3x)</li> <li>• OOP max applies</li> </ul>
<b>Tier II (Lines 114-311)</b>	30%	35%	40%	
<b>Tier III (Lines 312-503)</b>	40%	45%	50%	
<b>Tier IV (Lines 504-680)</b>	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
<b>Excluded Conditions</b>	No coverage	No coverage	No coverage	
<b>Discretionary Services</b>	40%	45%	50%	<ul style="list-style-type: none"> <li>• Deductible applies</li> <li>• OOP max does not apply</li> <li>• \$2,000/yr limit</li> </ul>
<b>Ambulance</b>	\$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			
<b>Prescription Medications</b>	<ul style="list-style-type: none"> <li>• \$5 copay for generics, \$25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)<sup>5</sup></li> <li>• Evidence-based formulary will be used<sup>6</sup></li> <li>• No coverage for medications for non-covered conditions</li> </ul>			<ul style="list-style-type: none"> <li>• Deductible waived</li> <li>• OOP max applies</li> </ul>
<b>Emergency Room</b>	\$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
<b>Diagnostic Services</b>	<ul style="list-style-type: none"> <li>• Beyond 2 diagnostic/well-person visits and basic office diagnostics above</li> <li>• Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%)</li> <li>• Limitations according to evidence-based guidelines, location of service, etc.</li> <li>• Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization</li> </ul>			
<b>Ancillary Services</b>	<ul style="list-style-type: none"> <li>• Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.</li> </ul>			

# Value based services

- First dollar coverage (no co-pay, deductible, etc.)
- Highly cost-effective, low upfront cost, improve health and/or reduce system costs
- Include medications, diagnostic tests, procedures, and some office visits in the medical home
- Strongly supported by evidence
- Ideally highly utilized
- Examples:
  - Mammograms
  - Childhood vaccinations
  - Generic blood pressure medications
  - SSRIs for severe depression
  - Routine periodic bloodwork for diabetes

# Tiers

- **Tier I Conditions**

- Maternity care
- Life-threatening newborn conditions (birth trauma, respiratory distress, PKU)
- Life-threatening chronic diseases (diabetes, asthma, major depression)
- Imminently life-threatening conditions (GI bleed, head injury)
- Public health concerns (TB, syphilis)

- **Tier II Conditions**

- Cancers with effective treatments (cervical cancer, colon cancer, lymphoma)
- Chronic diseases with less impact on health (osteomyelitis, diverticulitis, ADHD)
- Potentially life-threatening conditions (pneumonia, abscesses, crush injuries)

# Tiers

- **Tier III Conditions**

- Cancers with less effective treatments (pancreatic cancer, esophageal cancer)
- Non-life-threatening chronic diseases (Gout, bulimia, esophagitis)
- Other generally non-life-threatening conditions (extremity fractures, acute sinusitis, otitis media, sprains and strains)

- **Tier IV Conditions**

- Conditions with no effective treatment or no treatment necessary (skin lipomas, warts, gynecomastia)
- Self-limited conditions (upper respiratory infections, canker sores, laryngitis)
- Conditions with limited effects on health (diaper rash, calluses, orthodontics, deviated septum, varicose veins)

- **Excluded Conditions**

- Infertility, cosmetic surgery, sex reassignment surgery

# Discretionary services

- May have individual cost controls
- Services with little overall benefits to health
- Examples:
  - Eyeglasses may have yearly reimbursement limit
  - Restorative dental services may have caps
- Allow better integration with current private insurance plans

# OHFB Benefits Committee recommendations on “equivalent insurance”

- No barriers to value-based services or basic diagnostic services
- Co-pays and other coverage must vary by tier
  - May have richer package with lower co-pays but cannot have higher
- Cannot simply use actuarial value equivalence

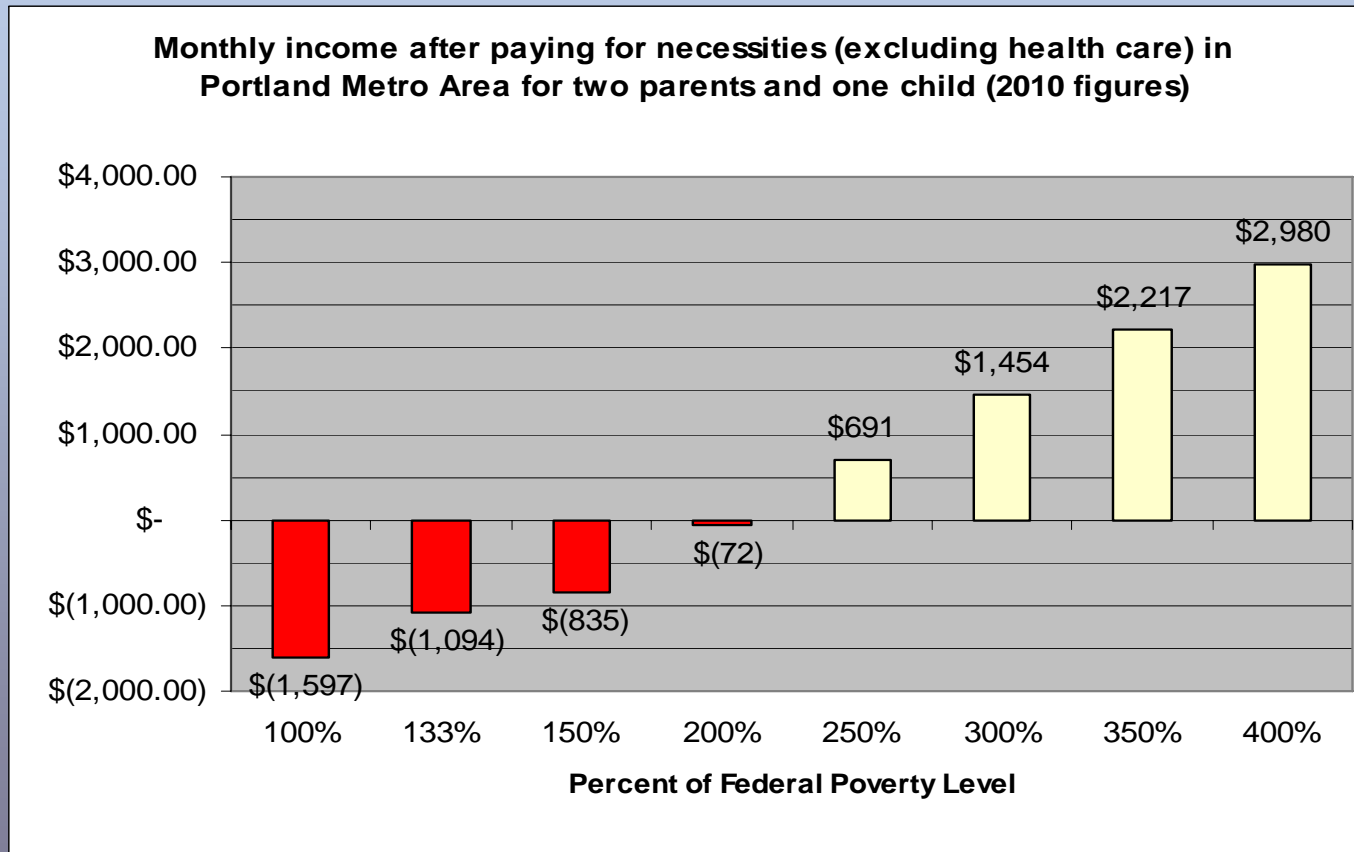
$$AV = \frac{\text{Plan benefits}}{\text{Total covered expenses}}$$

# Highlights from OHFB Eligibility and Enrollment Committee

- State subsidies would limit members' premium to 5% of income.
- Subsidies would phase out at 300% of the federal poverty level with no “cliffs” for small income increases.
- Copays, *not* deductible/coinsurance.
- Copays to encourage desired utilization.

Family composition (Adults are 40 years old)	Monthly income at 300% FPL	Monthly premium target (E&E)
Single adult under 65	\$2,790	\$140
Two adults under 65	\$3,592	\$180
Two adults + 2 children	\$5,439	\$272

# Low-income family budgets



Source: Economic Policy Institute. [http://www.epi.org/content/budget\\_calculator](http://www.epi.org/content/budget_calculator) (accessed 3/23/2010)

# Cost sharing “levers”

Action	Effect
Copays which do not apply to a high deductible	Allow limited number of services before applying expenses to deductible. Makes deductible less intimidating to member; avoids discouraging basic level care.
Tiered copays for certain services	Higher copays encourage members to use lowest-cost service location. Primary example is specialist doctors, urgent care, and emergency room services. Could also be used with outpatient surgeries, or ICUs.
Service/visit limits	Limit costs for services which may be overused--Examples include: chiropractic, physical therapy, mental health, complimentary medicine, skilled nursing, home health, hospice.
Step therapy	For conditions where a low-cost service or drug is effective for most patients, require patients to try it before the high-cost service or drug.
Raise out-of-pocket limit	Discourage utilization after deductible is met.
Benefit limits	Limit costs for certain services: Bariatric surgery, transplants, DME, ambulance, mental health, alcoholism, chemical dependency, rehab, etc.

Note: These tools are offerings in the marketplace, but some may not be appropriate for the EBP.

# Cost sharing “levers”

Action	Effect
Raise deductible	Discourage utilization, but only until deductible is met. Biggest impact on premium.
Separate deductible	Usually RX, to simplify administration with pharmacy benefit managers.
Lower cost share for wellness	Encourage wellness by offering incentives to those who meet targets (like BMI, cholesterol) or participate in programs. Incentives can be as much as 30% of premium.
Vary coinsurance by service	Discourage utilization of higher-cost or less important services after deductible, before out-of-pocket limit is met. Examples include MRI.
Lower cost share for disease mgmt.	Lower cost share for chronic disease patients who participate in disease management programs (and comply).
Lower/raise cost share based on condition	For MRI, higher cost share within 6 weeks of injury. Waive deductible for certain conditions.
Copays instead of deductible	Even cost sharing throughout plan year. May or may not apply to out-of-pocket limit. Minimizes balance billing.

# Massachusetts bronze level

- 53-60% actuarial value.
- Cost sharing:
  - \$250 deductible/35% coinsurance
  - \$2,000 with 20% coinsurance. Some are HSA-compatible.
- Include RX benefits and routine vision but no dental.
- Monthly premium \$793-\$1,180 for a family of four.
- Exception: Young Adult Program.
  - RX coverage is optional,
  - Annual benefit limits allowed.
  - Premium \$144 vs \$238 for a non-YA Bronze plan

# Insurance exchange federal requirements

- Based on new federal health reform
  - Actuarial value of 60%
  - OOP limited to \$5,950/\$11,900; lower for low-income individuals
  - Deductibles limited to \$2,000/\$4,000 in small group market
  - No cost sharing for preventive, no annual or lifetime limits.
  - Allows stronger incentives for rewarding healthy behaviors (BMI, cholesterol, smoking cessation).

# Federal reform and affordability

- Increases the number of people eligible for OHP
- Adds premium subsidies for households under 400% FPL (9.5% of income rather than 5% recommended by OHFB.)
- Cost sharing subsidies (to higher AV) for low-income households.

# Balancing recommendations

- Benefits committee
  - Focus on incentives for high value care
  - High deductibles, copays
- Eligibility and enrollment
  - Copay, not deductible
  - Strong focus on affordable premium, cost share
- New federal law
  - Subsidizes premium, cost sharing for low/middle-income households
  - Removes barriers to incentives for wellness
  - Limits deductible, OOP limits for small group market

# Key decisions

- Define an Oregon insurance exchange benefit package aligned with federal requirements for cost sharing and benefits.
- Which cost sharing levers to use to achieve the following goals:
  - Promote patient-centered primary care health home
  - Encourage use of value based services
  - Incentives to actively participate in health care/improve health status
  - More cost sharing for discretionary services
- Strike a balance between affordable premium and affordable cost sharing.

# Timeline and deliverables

- March 25—Background and overview
- April 15—Discussion of principles, objectives and alignment with federal requirements
- May (tbd)
  - Determine cost sharing structure for insurance exchange benefit package for pricing
  - Consider how to apply to other settings
  - Actuarial review
- Early June (tbd)—Review actuarial work and make final recommendation to OHPB.

# Potential Uses of Benefit and Cost-sharing Recommendations

