

Cost Sharing Workgroup

March 25, 2010

**Meridian Park Hospital
Community Health Education Center, Room 104
19300 SW 65th Avenue
Tualatin, Oregon**

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Meridian Park Hospital Health Education Center
Room 104
Tualatin, Oregon
March 25, 2010

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DRAFT AGENDA

**Cost Sharing Workgroup
Meridian Park Hospital Health Education Center
Room 104
Tualatin, Oregon
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(All agenda items are subject to change and times listed are approximate)

- I. Call to Order 9:00 am
- II. Purpose of Workgroup – Jeanene Smith 9:05 am
- III. OHFB Benefits Committee Recommendations – Ariel Smits 9:15 am
- IV. Prioritized List of Health Services – Ariel Smits 9:45 am
- V. Cost Sharing Issues – Jason Gingerich 10:00 am
- VI. Discussion 10:15 am
- VII. Next Steps 10:40 am
- VIII. Public comment 10:55 am
- IX. Adjournment 11:00 am

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DRAFT
Oregon Health Policy Board
Cost Sharing Workgroup
Work Plan

I. Reform Initiative Overview

Section 16 of HB 2009 directs the Health Policy Board to approve a health benefit package to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange, where the benefit package shall:

- Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.
- 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.
- Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.
- Require a greater contribution by an enrollee to the cost of elective or discretionary health services.
- 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.

II. Context

In June 2008 the Oregon Health Fund Board's Benefits Committee presented its report recommending a high-deductible essential benefit package (EBP) for potential use in conjunction with an individual mandate. The EBP used the Health Services Commission's Prioritized List as a basis, dividing it into four different tiers, with cost sharing increasing as one moves to lower tiers on the List, with no coverage for Tier IV services (corresponding to nonfunded services under OHP Plus). Within the same tier, the EBP calls for reduced cost sharing for services accessed within a patient-centered primary care home. Also recommended was the development of a set of "value-based services" that should be provided with little or no cost sharing (outside of any deductible). These services should reduce downstream costs by lowering the incidence of preventable complications and preventing unnecessary emergency department visits. The EBP also calls for the identification of "discretionary services" that: 1) do not substantially avert downstream costs or adverse consequences of a disease or condition or 2) may substantially avert downstream costs or consequences of a disease or condition, but which are used to treat a disease or condition for which there are lower cost or more efficacious treatments available. The EBP suggests that additional limitations on coverage by duration, frequency and/or total dollar amount for these services be put in place.

The OHFB's Eligibility and Enrollment (E&E) Committee also provided recommendations regarding cost-sharing and affordability. They noted that affordability must take into account more than just premium share and must also look at out-of-pocket costs and other variables. The E&E committee recommended that cost sharing for Oregon residents receiving a state contribution (people up to 300% FPL) not exceed 5% of gross household income. They also recommended that personal cost sharing: emphasize premiums over other types of cost-sharing, be on a gradual slide scale, and begin after 150% FPL for individuals and 200% FPL for families. They recommended state tax relief (tax deductions, pre-tax premium payments, or tax credits) for households between 300-400% FPL. The committee supported structuring co-pays to incentivize desired utilization, recommending that evidenced-based preventive services and medically-necessary services should have low or no co-pays. In addition, the committee recommended the use of co-pays over deductibles and co-insurance.

III. Timeline and Deliverables

- OHP has:
 - Gathered information on cost sharing mechanisms and amounts being employed in public and private benefit packages, within other state health care reform efforts (e.g., Massachusetts) and within proposed federal legislation.

- OHPR will:
 - Assemble a workgroup to re-examine and refine the work of the Oregon Health Fund Board's Benefits and Eligibility & Enrollment Committees regarding cost sharing for the baseline benefit package within the Exchange and, potentially, other levels of cost sharing that would be affordable for the State, employers, and individuals and families at various income levels.
 - Conduct three or four meetings of the workgroup from March to June 2010 to consider staff reports and stakeholder and the public input concerning affordability and administrative complexity.
 - Contract with an actuary to estimate the costs of various benefit designs using different levels of cost sharing.
 - Prepare recommendations for the Health Policy Board to be delivered in June 2010 on cost sharing for a baseline benefit package for an exchange, along with examples of benefit plans for at least three other levels of actuarial value.

IV. Dependencies

- OHPR will monitor federal legislative activities that could dictate coverage mandates, maximum allowed levels of deductibles and out-of-pocket maximums, and/or bands for the actuarial values of baseline benefit packages offered.
- OHPR will inform the workgroup of the recent work of the Health Services Commission to identify value-based services within the Prioritized List of Health Services.
- OHPR will receive input from and provide information to entities/programs that may incorporate some or all of the cost sharing strategies associated with the baseline benefit package for the Exchange into plans they administer, including:
 - PEBB/OEBB
 - Department for Consumers and Business Services [small group products]
 - OHP
 - Healthy KidsConnect
- OHPR will make recommendations to:
 - Oregon Health Authority [recommended statutory changes]
 - Oregon Health Policy Board [recommended cost sharing levels]

V. Stakeholder Input Process

OHPR will include representatives from the Oregon Health Fund Board's Benefits Committee, Enrollment & Eligibility Committee, and Delivery Systems Committee, the Health Services Commission, PEBB/OEBB, hospitals, physicians, employers, insurers, brokers and consumers in convening the workgroup. OHPR will plan to post the cost sharing options to be considered by the workgroup on the web, open workgroup meetings to the public, and share public comment with the workgroup.

VI. Opportunities for Board Input

OHPR will provide education sessions on the Prioritized List and EBP (April/May 2010) and a report of the recommendations on cost sharing, including an actuarial analysis (June 2010).

- VII. **Staff Resources:** Darren Coffman, Ariel Smits, Jeanene Smith, Jason Gingerich and Kelly Harms, Office for Oregon Health Policy and Research

The Essential Benefit Package

Recommendations of the Oregon Health Fund Board's Benefits Committee

The Essential Benefit Package is an affordable, sustainable package of benefits which emphasizes evidence-based care provided in the integrated health home. It protects enrollees from profound financial losses due to medical expenses, and rewards patients who actively participate in their own care. Enrollees would have little or no cost sharing for outpatient visits for certain chronic diseases and evidence-based preventive services. Other disease conditions and services will be covered after the enrollee meets a relatively high deductible (adjusted for financial means), with cost sharing levels based on the Health Services Commission's Prioritized List of Health Services. Cost sharing would be "capped" by an out-of-pocket maximum (also adjusted for financial means). This package would provide the foundation that defines what is considered essential coverage; it is anticipated that richer plans with higher premiums would continue to be offered in the private market.

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I. 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 shown in Appendix A 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.

II. Introduction

When creating a set of essential services, several goals must be met. The Essential Benefit Package (EBP) as described here would achieve the following:

- 1) Improve the overall health of the people of Oregon. This goal would be met through measures such as improved immunization rates to reduce vaccine transmissible disease, improved screening for diseases which are more cost-effective to treat at an early stage, reduced smoking rates, and improved population health markers (e.g., fewer low-birthweight babies).
- 2) Incentivize a rational redesign of the health care system. The EBP would improve access to and utilization of services in an integrated health home. It is anticipated that this redesign will revitalize primary care in the state. Services would not be segregated based on body part; mental health and dental conditions would be covered according to priority, need, and evidence, just like other physical health conditions.
- 3) Reward personal responsibility. Cost-sharing principles should be developed with rewards and incentives for individuals to actively participate in their own health care. To facilitate this, the health care system will need to have supports in place to assist individuals in this process.
- 4) Reduce overall health care costs. This goal would be met through incentivizing patients to receive timely diagnosis, management, prevention, and treatment in the most appropriate and cost-effective setting rather than care for later-stage illness requiring acute, hospital-based care or other intensive and costly services. Mechanisms should be put in place to encourage patients to seek care in their integrated health home rather than in the emergency department for common outpatient complaints. Certain diagnostic tests, procedures, medications, and treatments that exhibit high cost, high utilization, and/or high variability in usage should be subject to robust, efficient and swift prior authorization processes. Additionally, the EBP would minimize uncompensated care and cost-shifting in the system. Some services, particularly in the mental health and chemical dependency arena, may actually reduce costs of other social services (e.g., corrections, public safety).
- 5) Be innovative. The EBP includes value-based services, which are a selected group of evidence-based, cost-effective health care services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. The EBP would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.
- 6) Provide a social safety net. The EBP would protect individuals from devastating financial losses and bankruptcy due to catastrophic illness or injury.
- 7) Be affordable for the individual and the state. The lowest acceptable “foundation level” package should be priced low enough to be affordable to all Oregonians above 400% of FPL and be fiscally responsible for the state to contribute towards the health care coverage of Oregonians in or near poverty. To keep the cost of the plan low, cost containment measures such as limits on certain discretionary services as well as a reasonably high deductible will be included. It is anticipated that private insurers would be innovative in creating plans which offer a richer benefit package with potentially higher premiums than the EBP.

- 8) Reflect the values of Oregonians. The EBP would provide services to special populations such as pregnant women, small children, seniors, and people with disabilities, as well as provide dignified end-of-life care, which have been values consistently expressed by Oregonians in public meetings on health care reform.
- 9) Be evidence-based. The EBP would require that the Health Services Commission (HSC) be enhanced, meet more often, and be given greater financial resources to allow for a thorough and timely surveillance of the evidence and provide regular guidance to the system. It is further recommended that the Health Resources Commission (HRC) work collaboratively with the HSC to allow in-depth reviews of technologies and treatments. It is also anticipated that the HSC and HRC would collaborate with other evidence-based bodies in the state, such as the Drug Effectiveness Review Project (DERP), the Oregon Evidence-Based Practice Center, and the Medical Evidence-Based Decisions (MED) Project.

The Essential Benefit Package responds to the goals above by having few financial barriers to evidence-based preventive care, access to diagnostic visits and basic tests, and graduated personal contributions for health care based on priorities set by the Oregon Health Services Commission in the Prioritized List of Health Services. In addition, the plan incorporates both low barriers and incentives for certain “value-based services.” These services include cost-effective outpatient services that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Plan members would be protected from profound financial loss by having a “cap” placed on out-of-pocket expenses.

The Essential Benefit Package is a “foundation level” plan. No insurance plan should be allowed to offer a lower level of benefits. However, private purchasers and governmental programs such as Medicaid could offer a plan that provides more benefits and/or less cost sharing than the EBP. Companies could elect to buy up to a richer plan for employees and individuals could buy up to a richer plan through higher premiums. However, the low barriers to value-based services (including evidence-based preventive services) would have to be maintained for a plan to qualify as meeting the minimum plan requirements. Additionally, such plans would have to provide the same services as the EBP with no greater cost sharing. It is anticipated the private market would create products which would help reduce premiums through competition and bulk purchasing as well as offer plans with additional, supplemental coverage. Purchase of these supplemental products would be at the discretion of the plan member, employer or other purchaser.

III. Basic Principles of the Essential Benefit Package

1) Services

- a. The Essential Benefit Package (EBP) being recommended by the Benefits Committee is based on the Health Services Commission's Prioritized List of Health Services
 - i. Coverage of conditions should not be segregated based on the part of the body affected or the type of qualified health care provider delivering the service. Evidence and public values will drive coverage decisions.
 1. Dental and mental health conditions would be included as they appear on the Prioritized List
 2. Services such as physical and occupational therapy and complementary and alternative medicine services would be included as they appear on the Prioritized List, with guidelines as appropriate
 - ii. Conditions and services appearing low on the Health Services Commission's Prioritized List of Health Services may not have any coverage
 - iii. Nearly all conditions and services with state mandated coverage are currently included on the Prioritized List. See item #5 under Issues of Note on page 16.
 - iv. The Prioritized List of Health Services only considers the relative importance of treatments for individual conditions. Those who have comorbid conditions may warrant special consideration in regards to coverage or cost sharing issues.
- b. "Value-based services" should have low if any cost sharing
 - i. Value-based services should be identified using trusted, evidence-based sources
 - ii. Value-based services should be developed by the Health Services Commission and be a dynamic list reflecting changing evidence and the values of Oregonians
 - iii. Value-based services should include evidence-based preventive services
 - iv. Value-based services should include outpatient services that reduce the overall cost of caring for common chronic diseases
 - v. Value-based services should include patient incentives for those who actively participate in their own health care, which could result in reductions in patient cost sharing or may provide credits toward other health-promoting benefits
 - vi. It is anticipated that most, if not all, value-based services will be delivered in the outpatient setting. A limited number of services, such as flu shots, may be delivered in the acute care setting.
 - vii. Value-based services will include supports to assist the patient in assuming responsibility for their own health care
- c. Diagnostic tests and visits will have some coverage, but may be subject to limitations and have varying cost sharing associated with them
 - i. Basic point-of-service tests, such as lab tests or EKGs, and a limited number of diagnostic visits should be covered with limited or no cost sharing
 - ii. Certain diagnostic tests, procedures, medications, and treatments with high costs, high utilization, and/or high variability in usage should be subject to limitations and cost sharing to promote the most appropriate use of resources. This should be accomplished using the following hierarchy of approaches:

1. The use of evidence-based guidelines, where available, that are regularly reviewed and updated
 2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
 3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those either of high cost that have effective, lower-cost alternatives or which do not have a major impact on the clinical management of the patient.
- d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
 - e. Enabling services such as interpretive services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services,
 - i. Selected care coordination services will likely be included as Value-Based Services
 - f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient or home-based care
 - g. Telephone nurse triage systems are strongly encouraged to allow appropriate direction to the most appropriate and cost-effective care settings for patients with urgent medical issues
- 2) Financial considerations
- a. Personal financial responsibility should increase as the service appears lower on the Prioritized List
 - b. Premiums, deductibles and out-of-pocket (OOP) maximums should be scaled according to the individual/family's financial means
 - c. A limit on OOP expenses should be included to prevent profound financial loss
 - i. OOP maximums should be established for both individuals and families and should be adjusted for financial means
 - d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan
 - i. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive appropriate and cost-effective health care utilization decisions
 - e. Certain "discretionary services" may have separate coverage maximums or other limitations
 - i. A list of discretionary services should be developed by the Health Services Commission or other body designated by the Health Fund Board and be dynamic in its reflection of changing evidence and the values of Oregonians
 - ii. The services placed in this list would fall into one or more of the following categories:
 1. Non-emergent services which do not substantially avert downstream medical costs or adverse consequences of a disease or condition, including death, worsening illness, hospitalization, or ED visits.

- 2. Services which can avert downstream costs or adverse consequences of a disease or condition, but which are used to treat a disease or condition for which there are more cost-effective alternative treatments or services available.
 - iii. Services on the discretionary list might be limited by one or more of the following:
 - 1. An overall cap on reimbursable expenses for all discretionary services
 - 2. Further limitations including some or all of the following:
 - a. Limitations on reimbursable expenses for a class of services, such as vision services or dental care
 - b. Limitations on the type of treatments/services covered
 - c. Guidelines around utilization of services
 - iv. Placing limits on discretionary services will allow more affordable premiums or otherwise reduce costs to the system
 - 1. This should achieve sustainability of the system and affordability to individuals and the state
 - f. There should be no overall lifetime maximum limits on benefits
 - i. To allow such benefit limits in the context of an individual mandate would be counter-intuitive.
 - ii. In order to keep this package affordable, this may mean that this “foundational level” of coverage may not include some very high cost treatments that show some evidence of a very marginal level of benefit.
 - g. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.
- 3) Medications
- a. A drug formulary should be utilized
 - b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
 - c. A governing body should be responsible for formulary reviews and the administration of an appeals process
 - d. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
 - e. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
 - f. Some medications may be considered to be value-based services and may not be subject to cost sharing when use of these medications is shown to be highly cost-effective in terms of reducing complications, hospitalizations, ED utilization, etc.
- 4) Integrated health home
- a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
 - b. Integrated health homes should include primary physical and mental health care, case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system

- c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)
 - d. The integrated health home may be a single provider, group practice or clinic, or an integrated network of providers. The specific structure of an integrated health home may look somewhat different in different communities around the state but shall (eventually) meet general guidelines.
 - e. Ideally, mental health services would be available within the integrated health home. In addition, the preferred integrated health home for some patients with significant chronic behavioral health conditions may be the behavioral health specialty provider clinic, hopefully with direct access to collocated primary care services.
 - f. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee
 - g. The Benefits Committee recognizes that the integrated health home does not currently exist for the majority of Oregonians. The incentives for receiving services in an integrated health home may need to be implemented in a graduated fashion to allow the health care delivery system time to develop the necessary components for the integrated health home throughout the state. In the interim, consideration should be given to lowering the cost-sharing levels for a service that could otherwise be obtained in an integrated health home were one available.
- 5) The EBP is a "foundation level" package
- a. Government, private companies, and individuals could purchase or offer a more generous package. The private market would be able to and should develop supplemental plans
 - b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
 - i. No package should have barriers to preventive and value-based services higher than those specified in the EBP
 - ii. Value-based services would need to be included as designed by the Health Services Commission or other body and offered with the same or lower cost-sharing as the EBP
 - iii. Basic diagnostic services would need to be offered as outlined in the EBP with no higher cost sharing
 - iv. Discretionary services should be identified by the Health Services Commission or other body with a dollar cap or other appropriate limitations placed on these services
 - v. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and emergency department services.

- c. Equivalence between a commercially available plan and the Essential Benefit Package must be based on actual coverage equivalence and not on the equivalence of actuarial value of the plans (i.e., equivalence requires coverage of at least the services provided in the EBP with the same or lower levels of cost sharing).

IV. Value-Based Services

Value-based services are to be a selected group of cost-effective health care services based primarily in the integrated health home that have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. By encouraging use of these primarily ambulatory services, overall health care costs should be reduced and population health improved. The Essential Benefit Package would incentivize these services through two mechanisms: 1) minimal cost sharing for these services and 2) financial incentives for following treatment recommendations.

Conditions Which May Have Value Based Services Associated With Them

Qualifying conditions and cost-effective services for these conditions should be determined by the Health Services Commission or other body designated by the Health Fund Board or Oregon Legislature. A list of value-based services whose use is intended to avoid preventable hospitalization and emergency department visits, through timely and appropriate care in an integrated health home, will be designed for conditions amenable to such services, as identified using sources such as the Agency for Healthcare Research and Quality (AHRQ) list of ambulatory care sensitive conditions. Examples of these conditions include diabetes, schizophrenia, asthma, congestive heart failure, and low birthweight. Other candidates for value-based services should come from the U.S. Preventive Services Taskforce recommendations for preventive care and screening services, and other evidence-based sources.

Once a list of conditions has been developed, then cost-effective services for these conditions would be determined. Next, evidenced-based guidelines would be created for the use of these services. Standards for compliance with these guidelines would be established according to condition and the incentive for meeting the acceptable compliance level would then be determined.

The lists of conditions and value-based services for these conditions would be continuously updated by the HSC or other oversight body based on changing evidence.

Value based services do NOT include all treatments for a condition. Conditions with possible value-based services, such as diabetes or asthma, are currently associated with a wide range of treatments on the Prioritized List of Health Services. These treatments range from inexpensive preventive care, such as outpatient visits, to expensive services aimed at treating disease complications, such as intensive care unit admissions and surgeries. A condition which is determined to have value-based services associated with it will remain on its designated Prioritized List line with all relevant **non**-value-based services prioritized according to the position of that line on the Prioritized List. Only certain cost-effective services will be on the Value-Based Services List. For example, treatments for diabetes such as outpatient primary care visits, periodic diabetic eye exams, and care coordination could be placed on the Value-Based Services List while treatments such as ICU admissions for ketoacidosis or leg amputation surgery would remain on their respective lines within the Prioritized List. Both Type 1 and Type 2 diabetes are currently listed as Tier I conditions.

It is anticipated that most, if not all, value based services will be delivered in the outpatient setting. However, certain services may be delivered in the acute care setting. Such services may include flu shots during ED visits or day surgery center visits for colonoscopies.

Potential Value-Based Service Examples

The examples are provided for illustrative purposes only and may or may not ultimately be included in a list of value-based services.

- 1) Preventive care
 - Preventive services, such as immunizations, Pap smears, mammograms and colorectal cancer screening, should have minimal or no cost sharing. Plan members who are up-to-date on current screening recommendations could have points awarded that he or she could use to reduce the cost sharing for medication or other covered services, or could use them for wellness activities (e.g., assistance in purchasing a gym membership).
- 2) Chronic disease management
 - A patient with a chronic disease could have minimal cost sharing for outpatient provider visits, selected medications, self-treatment education, care coordination, and other cost-effective treatments for that condition. A patient who sees his or her doctor at recommended intervals, fills his or her prescriptions as prescribed, and actively participates in other aspects of his or her care could have a reduction in the cost sharing for emergency department visits and hospitalizations for complications of his or her chronic condition.
 - A patient with a chronic disease that is caused by or exacerbated by smoking or the use of alcohol or illicit drugs could have a reduction in cost sharing for outpatient office visits and medications related to that condition if he or she quits smoking, drinking and/or using drugs. Patients who continue to use these substances could pay more for treatments and medications for the substance-related condition.
- 3) Maternity care
 - Pregnant women could have no cost sharing for prenatal care. A patient who adheres to the recommended timing and number of prenatal visits and otherwise completes the recommended portions of her prenatal care could have no cost share towards the delivery of her child.
- 4) Dental services
 - Preventive dental exams and cleanings, and fillings for dental caries could have minimal cost sharing. Plan members who receive regular cleanings could have points awarded that could be used to reduce the cost sharing for restorative dental or other covered services.
- 5) Vision services
 - Regular vision exams for age groups where such exams are recommended by the U.S. Preventive Services Task Force could have minimal cost sharing at a defined interval, such as every two years. Plan members who receive regular exams could have points awarded that could be used to reduce the cost sharing for other covered vision services or corrective lenses.
- 6) End-of-life care

- Patients who have an advanced directive and/or POLST immediately available at the point of care or on file with a state registry could have a reduction in their copays for ED care and/or hospitalization. These documents are intended to direct health care providers on the patient's wishes regarding medical care in the event that the patient is not able to communicate them.

V. Services Included in Each Tier

The services included in each tier are based on the HSC Prioritized List of Health Services. Tier I generally contains preventive services as well as severe chronic diseases and acute life-threatening conditions with very effective treatments. Tier II generally contains common chronic diseases with less impact on overall health and other diseases/conditions which can be life-threatening that have effective treatments. Tier III generally contains non-life threatening trauma, conditions with less effective treatments, and non-life threatening acute and chronic health problems. Tier IV contains self-limited conditions, conditions with no effective treatments, and conditions with limited effects on overall health. Because Tiers I and II both contain serious and life-threatening health conditions, the recommended cost-sharing difference between these two tiers is smaller than between Tier II and Tier III (which generally contain less serious conditions).

The line ordering is subject to review and revision by the Health Services Commission. It is anticipated that the HSC will likely reprioritize some lines once the value-based services are removed from that line, based on the remaining contents. It is further anticipated that the HSC may reorder some lines and/or change the location of tier breaks based on evidence and/or public feedback.

Tier I (Lines 1-113): Examples of Services and Conditions in this Tier (Note: the services associated with each of these lines would exclude those identified as value-based services)

- Preventive services
- Pregnancy and delivery
- Alcohol and drug treatment
- Life-threatening newborn conditions (e.g., very low birthweight or serious birth trauma)
- Life-threatening chronic diseases (e.g., treatments for asthma, diabetes, congestive heart failure, and HIV disease)
- Life-threatening mental health disorders (e.g., major depression, bipolar disorder, schizophrenia)
- Imminently life-threatening trauma (e.g., internal injuries, severe head injuries, major wounds)
- Imminently life-threatening acute illness (e.g., meningitis, appendicitis, intestinal obstruction, heart attack)
- Conditions of public health concern (e.g., tuberculosis, sexually transmitted diseases)

Tier II (Lines 114-311): Examples of Services and Conditions in this Tier

- Potentially life-threatening trauma (e.g., neck and limb fractures, limb amputations, joint dislocation)
- Cancers with effective treatments (e.g., cervical, kidney and bone cancers)
- Chronic disease with less impact on health or less effective treatment (e.g., attention deficit hyperactivity disorder (ADHD), peripheral vascular disease, mild depression, chronic hepatitis, dementia)
- Potentially-life threatening acute illness (e.g., pancreatitis, pneumonia, urinary tract infection (UTI))

Tier III (Lines 312-503): Examples of Services and Conditions in this Tier

Non-life-threatening trauma (e.g., severe sprains and strains)

Non-life-threatening mental health disorders (e.g., acute stress disorder, dysthymia)

Non-life-threatening acute and chronic disease (e.g., gout, migraines, kidney stones, miscarriage, tooth loss)

Cancers with less effective treatments (e.g., pancreatic, esophageal and liver cancers)

Non-life-threatening infections (e.g., sinusitis, otitis media, acute bronchitis)

Tier IV (Lines 504-680): Examples of Services and Conditions in this Tier

Conditions with no effective treatment or no treatment necessary (e.g., rib fractures, benign cysts and growths, non-venereal warts)

Self-limited conditions (e.g., colds, minor burns, cold sores)

Conditions with limited effects on health (e.g., seasonal allergies, acne, diaper rash)

Excluded conditions

Cosmetic surgery

Infertility services

Services shown to result in harm

Experimental treatments

VI. Discretionary Services

Discretionary services are those non-emergent health care services which do not substantially avert downstream costs or adverse consequences of a disease or condition, including death, worsening illness, hospitalization, or ED utilization. Alternatively, discretionary services are those services which may substantially avert downstream costs or consequences of a disease or condition, but which are used to treat a disease or condition for which there are lower cost or more efficacious treatments available.

Discretionary services may have limits placed on them in the Essential Benefits Package. First, the entire category of discretionary services is expected to be subject to a cap on reimbursable expenses. Second, particular services within this group may be further limited. These limits may take the form of an additional cap on reimbursable expenses for a certain class or type of services, limitations on the type of treatments/services covered, or guidelines for utilization of services or some combination of these limits. Such limitations will help ensure that premium costs are affordable to Oregonians and the state.

Like value-based services, a list of discretionary services would be developed by the Health Services Commission or other body designated by the Health Fund Board, using evidence-based sources. This list would be updated to reflect changing evidence and the values of Oregonians.

Possible examples of Discretionary Services

- Dental care - Restorative dental services may have coverage maximums imposed upon them, such as a maximum dollar amount covered per year.
- Vision services - eyeglasses, and other vision care supplies may be limited.
- Dermatologic conditions - Specialty visits, number of visits, or types of medications for certain conditions may be limited or subject to guidelines.

In addition to coverage limits or other restrictions, it is expected that discretionary services would have cost sharing associated with them at the same level as other services in the Tier containing that service.

VII. Organizational Considerations

- It is recommended that the Health Services Commission (HSC) should provide governance over the Essential Benefit Package (EBP) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of prioritizing and developing guidelines for health care services for Oregonians.
 - The HSC should adjust the Prioritized List, tier break points, and other parts of the EBP based on changing evidence and public values
 - The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
 - The HSC should create and update the list of value-based services using available evidence
- To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support would need to be provided
 - Consideration should be given to having part- or full-time paid members
 - The HSC or its subcommittees may need to meet more often, perhaps bi-weekly rather than bi-monthly
 - The HSC would need adequate research and support staff
- To effectively leverage state funds and scarce human resources, the HSC would need to collaborate with other evidence-based bodies in the state
 - Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
 - Oregon Evidence-Based Practice Center for assistance with evidence reviews
 - Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation
- The Health Resources Commission (HRC) and the HSC would need to work in close collaboration in order to complete reports for use in determining evidence-based benefits and value-based services
- An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body. This would involve the determination of placement of services within the tiers of the Prioritized List and the inclusion of services within the list of value-based services and basic diagnostic services. A separate appeals process would be necessary in order to hear the merits of individual cases. Such an individual appeals process would need to be streamlined and easy to access.

VIII. The Essential Benefit Package

Figure 1 shows the Essential Benefit Package (EBP) as recommended by the Benefits Committee in a summary format. The EBP is the minimum (“foundational”) level of coverage and while commercial health insurance should not be allowed to include higher cost sharing levels on services than those in the EBP, it is expected that many individuals and families will choose to “buy-up” to a richer level of coverage that includes a lower deductible, lower out-of-pocket maximum and/or lower coinsurance amounts.

The Benefits Committee believes that the cost sharing levels depicted here are reasonable for individuals with incomes above 300% FPL. The Committee recognizes that the Oregon Health Fund Board will have to weigh many factors, including the structure of the proposed Exchange, the amount of additional revenues that can feasibly be raised, and the impacts from a restructured delivery system, to name a few, and that these cost sharing levels may need to be adjusted to some extent. However, the Committee does feel strongly that the general cost sharing structure be maintained as described in Section III.5.b. Namely that minimal or no cost sharing be in place for value-based services, discretionary services have a separate benefit limit, and that cost sharing be incrementally higher for lower priority services according to the Prioritized List of Health Services and according to the intensity of the resources used at the site at which their services are accessed. The Benefits Committee recognizes that it will take some time before a comprehensive health care reform plan can be implemented and that certain allowances may be necessary, particularly in the early stages of the process. For instance, not every Oregonian will immediately have access to an integrated health home and cost sharing in higher intensity settings (e.g., an emergency department) should be reduced to integrated health home levels in such instances. For a broader discussion of this and other issues of note that the committee identified, including alternative solutions that were considered, please see Section IX of this report.

The Committee also feels that the cost sharing levels should be reduced in a graduated fashion as income levels decrease with nominal, if any, cost sharing for those below the federal poverty level. A preliminary pricing estimate of the Essential Benefit Package shown in Figure 1 appears in Appendix B, along with estimates for similarly structured benefit packages at varying levels of cost sharing as examples.

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.			

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).

IX. Issues of Note

Several issues arose in the creation of the Essential Benefits Package for which it was difficult to determine the best solution. These areas have either competing demands or other issues. The solutions proposed in the Essential Benefit Package are only some of several viable solutions for each of these areas. It is anticipated that the Health Fund Board or other body will deliberate further on these areas, with public input to determine the solutions which best meet the needs and values of Oregonians.

1) Emergency department copayment/coinsurance

- a. Goal: incentivize use of the integrated health home whenever feasible, yet not disincentivize use of the ED for those conditions which are truly emergent
 - i. Example: a cold should be seen in the integrated health home, while a broken leg is most appropriately seen in the ED
- b. Conflict: how to disincentivize inappropriate ED use while not placing undue barriers to appropriate ED use
- c. Other issue: some patients are not given a diagnosis after being evaluated in the ED ; these patients would not have a readily determinable coinsurance level based on the current tier system
- d. The Committee acknowledges that the individual may not have choices in alternatives to the emergency department in the current system but hope that the development of integrated health homes will provide such a choice.
- e. Solutions
 - i. Selected: relatively high copayment which is waived for patients meeting EMS transport criteria (likely emergent conditions) plus a coinsurance level commensurate with mid-level Tier for hospitalization.
 1. Some modification of the ED cost sharing may need to be developed or the ED cost sharing phased in over time.until integrated health homes are in place to provide alternatives to the emergency department.
 - ii. Other options:
 1. A more robust triage system with a triage fee; patients who are determined by triage to have non-emergent conditions would be referred to their integrated health home while those with emergent conditions would have a coinsurance level charged for the ED visit commensurate with the integrated health home level for that condition
 2. A flat copayment high enough to discourage casual ED use
 3. No copayment for patients that do not meet transport or admission criteria but have conditions for which the ED is the most appropriate site of care.

2) Well-person visit

- a. Goal: incentivize evidence-based preventive care while not encouraging unneeded care
- b. Conflict: most current plans allow a well-person visit once a year, but much of the screening and services provided are not evidence-based solutions

- i. Selected: cover well-person visits that evidence indicates are effective (i.e., one every 2-3 years for children over 5, etc.)
- ii. Other options:
 - 1. Cover the office visit costs for one well-person visit a year, but not cover those screenings or other services provided that are not evidence-based
 - 2. Allow one well-person visit a year, but this would have to take the place of one of the two diagnostic office visits covered for that year

3) Lifetime maximum

- a. Goal: allow coverage of conditions and treatments for patients beyond an arbitrary lifetime maximum amount of services, but maintain financial solvency for the system as a whole
- b. Conflicts
 - i. Some expensive services and treatments do not have much efficacy and may need to be limited due to overall costs to the system
 - ii. Most private insurance plans have lifetime maximums. Patients with very expensive medications or treatments may reach these maximums quickly and either elect to change to the Essential Benefit Plan, causing “crowd out,” or will end up in the Essential Benefit Plan due to reaching these maximums. Without cost controls, the increasing numbers of such patients would become a significant financial burden on the system
- c. Example
 - i. A medication for a rare genetic condition costs \$500,000 a year and must be given for life, with little improvement in overall health. If no lifetime maximum exists, then a patient with that rare condition would consume a very large amount of health care resources
- d. Solutions
 - i. Adopted: no lifetime maximum overall, but certain treatments, medications, and other services may have financial maximums placed on them
 - 1. Example: a patient with the rare condition above would have a \$1 million medication limit for that particular medication, but would still have coverage for hospitalization and antibiotics for other conditions they may develop such as pneumonia
 - ii. Other solutions include no lifetime maximum for any condition or treatment, maximums placed on certain conditions, or price controls placed at the level of not covering certain expensive treatments/medications

4) Prescription medication cost sharing

- a. Goal: incentivize generic medication use when possible and desirable, otherwise incentivizing preferred brand name drug use while disincentivizing use of non-preferred drugs
- b. Issue:
 - i. Financial barriers to brand name and non-preferred drugs need to be high enough to affect utilization but not be higher than actual drug costs
 - ii. Some medications should have no cost sharing associated with them
 - 1. Regular use of these medications have been associated with lower complication rates and thus lower health care costs
- c. Solutions
 - i. Adopted:
 - 1. Combination of graduated copays and significant coinsurance. For generic and preferred brand drugs, the amount paid would be the smaller of these two cost sharing levels while non-preferred brand drugs would require payment of the larger of the two out-of-pocket costs.
 - 2. Consideration of addition of certain highly effective medications to the value based-services list with no cost sharing associated with them
 - ii. Other solutions:
 - 1. Simple copay
 - 2. Simple coinsurance
 - 3. Other levels of cost sharing

5) Mandated services

- a. Goal: meet all state mandates on coverage of services
- b. Issue: The Prioritized List of Health Services appears to not cover mandated benefits in at least specific instances:
 - i. Some forms of surgery to the contralateral breast performed post-mastectomy to achieve symmetry after breast reconstruction
 - ii. Maxillofacial prosthetics for unilateral anomalies of the ear that impact hearing or bilateral anomalies of the ear that do not impact hearing
 - iii. Orthotics for some low ranking conditions of the feet and lower limbs (e.g., flat feet). This may or may not reflect a mandated service as medical necessity must be shown.
- c. Solution
 - i. Adopted: Acknowledge these omissions and bring them to the attention of the Health Services Commission for discussion
 - ii. Other solutions: dictate that state mandated benefits will be a part of the Essential Benefit Package regardless of cost or benefit.

6) Ancillary services

- a. Goal: have some cost containment strategies in place for ancillary services and durable medical supplies to maintain solvency in the system

- b. Issues:
 - i. Ancillary services and durable medical supplies, such as wheelchairs, may be of variable importance to a patient depending on his or her other medical conditions.
 - ii. Some types of ancillary services may need to be limited to the most cost-effective type available
 - 1. Example: traditional wheelchair may be covered but power wheelchair may not have coverage for use for a particular condition
 - iii. Some services which are considered ancillary for most situations may be vital for someone in special circumstances
 - 1. Example: a person with developmental delay may require conscious sedation for a Pap smear
- c. Solutions
 - i. Adopted:
 - 1. Cost sharing commensurate with the Tier of the condition for which the ancillary service is required
 - a. Certain ancillary services may be considered value-based services and therefore subject to minimal or no copays instead.
 - 2. Total cost to the patient would be limited by the out-of-pocket maximum
 - 3. An appeals process would be created to allow approval of any coverage, lower cost sharing, or other coverage modifications for ancillary services in special circumstances. It would be anticipated that such an appeals process would be streamlined (for example, a person requiring sedation for procedures would have sedation approved for all procedures if appropriate after a request is placed for one particular procedure).

X. Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon health care marketplace.

Under the EBP as proposed, to be a qualifying plan:

- 1) The plan would have to provide all services provided under the EBP at no higher level of cost sharing
 - a. Comfort care should have no or minimal coinsurance, at levels no higher than prescribed in the EBP
 - b. Value-based services would have to be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
 - c. Basic diagnostic services would have to be offered as outlined in the EBP with no higher cost sharing
 - d. Additional coverage would have to include at least those condition-treatment pairings included in the 2008-09 Prioritized List through Tier III (currently up to an including line 503) with the same or lower cost sharing.
 - i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be set at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ED services.
- 2) Additional conditions and services could be covered
- 3) A plan would not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package should be required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than value-based services, basic diagnostic services, and comfort care) with a 20% coinsurance, which is the lowest cost sharing amount permitted under the Essential Benefit Package “Tiers.” Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in Figure 2. Note that these are simply example plans; numerous other variations would and could be expected.

Figure 2. Examples of the Essential Benefit Package with Supplemental Plans

	Essential Benefit Package*			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	\$7,500 individual \$11,250 individual + 1 \$15,000 family			\$2,500 individual \$5,000 individual + 1 \$7,500 family			\$500 individual \$1,000 individual + 1 \$1,500 family		
Out-of-Pocket Maximum (includes deductible)	\$15,000 individual \$22,500 individual + 1 \$30,000 family			\$7,500 individual \$15,000 individual + 1 \$22,500 family			\$4,000 individual \$8,000 individual + 1 \$12,000 family		
<i>Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income</i>									
Coinsurance Level (Deductible Does Not Apply)									
	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient
Value-Based Services	0-5% depending on service and site			0-5% depending on service and site			0-5% depending on service and site		
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Coinsurance Level (Deductible Applies)									
Tier I (lines 1-113)	20%	25%	30%	10%	15%	20%	5%	10%	15%
Tier II (lines 114-311)	30%	35%	40%	20%	25%	30%	10%	15%	20%
Tier III (lines 312-503)	40%	45%	50%	30%	35%	40%	20%	25%	30%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	50%	No coverage	No coverage	40%	45%	50%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Discretionary Services	40%	45%	50%	30%	35%	40%	20%	25%	30%
Prescription Medications	Generic \$5, Preferred Brand \$25, Other Brand 50% coinsurance			Generic \$5, preferred brand \$20, other brand 40% coinsurance			Generic \$5, preferred brand \$15, other brand 20% coinsurance		
Ambulance	\$100 copay, waived if criteria met			\$75, waived if criteria met			\$50, waived if criteria met		
Emergency Department	\$100 copay (waived if admitted or transport criteria met), then 50% coinsurance			\$75 copay (waived if admitted or transport criteria met), then 40% coinsurance			\$50 copay (waived if admitted or transport criteria met), then 20% coinsurance		
Other Diagnostic Services	Varies			Varies			Varies		

*Please see description of Essential Benefit Package on pages 13-14 for more detail

XI. Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a scheduled preventive dental exam and cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ED via LifeFlight and spends several days in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a \$2,500 deductible, then 30% of her bills until she reaches an out-of-pocket maximum of \$7,500 (her deductible and out-of-pocket maximum were reduced due to her income level). In fact, her total bills reached \$150,000 and so her effective cost sharing rate was $\$7,500/\$150,000 = 5\%$.

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. As a value-based service, she may only have a 5% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Joneses are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bacterial pneumonia. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a \$5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting lung infections in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and 30% for the surgeries after meeting their \$15,000 deductible. However, once the family meets its \$30,000 out-of-pocket maximum, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year. With this plan, Jenny's doctor visits are covered with a 5% coinsurance, while her surgeries and hospitalizations are covered with a 10% and 15% coinsurance, respectively. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 15% coinsurance instead of the 30% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 95% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are \$5 a prescription, but his preferred brand cholesterol medication is \$20. Mary is able to get her colon cancer screening test with no cost sharing as it is in the value-based services portion of their plan.

Bob starts to feel chest pain and goes to the ED where he is diagnosed with a heart attack and admitted to the hospital. The heart attack requires a \$75 copay and 40% coinsurance for the ED visit and 20% coinsurance for hospital inpatient care after Bob meets their \$5,000 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his hospital cost sharing to the outpatient level (15%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Mary visits the ED, resulting in a \$75 copay, and 40% coinsurance after the \$5,000 family deductible is met. She does not qualify for a reduction in cost sharing and must pay the full 40% unless that amount takes them above their \$15,000 out-of-pocket maximum.

The next year, the Swerskis again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ED care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a homemaker. They have one daughter. The family is concerned about paying high cost sharing for unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non-value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% coinsurance for this hospitalization, after meeting the \$1,500 family deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered services with a 5% coinsurance under his diagnostic benefit. His broken ankle is in Tier II, making the casting and subsequent orthopedic surgeon office visit covered with a 15% coinsurance.

While convalescing from his fracture, Fred realizes that he needs reading glasses. Because glasses are on the Discretionary List, Fred needs to pay extra for the designer frames that he picks out and the \$200 eyeglass maximum contribution from the Plan is applied to his \$2000 discretionary maximum.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% coinsurance after reaching the \$1,500 family deductible and purchases her generic medications with a \$5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- a. essential to the public health of Oregonians?
- b. based upon a proven benefit model?
- c. reflective of the values of Oregonians?
- d. easy to adjust in response to new information on cost and effectiveness?
- e. affordable (to the individual, employer, and state) and economically sustainable?
- f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- a. Preventive care
- b. Chronic disease management
- c. Primary care medical homes
- d. Dignified end-of-life care
- e. Patient-centered care
- f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- a. wellness?
- b. patient engagement (including education towards self-management)?
- c. coordination and integration of care?
- d. population health?
- e. cost-effective care?
- f. cost-control/reductions in over-utilization?
- g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- a. Use of evidence-based medicine
- b. Efficacy of treatments
- c. Reduction of health disparities
- d. Personal responsibility
- e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- f. Incentives to encourage appropriate use of effective services
- g. Acute and tertiary care needs of the population

Appendix B: Estimated Pricing of the Essential Benefit Package and Projected State Contribution Levels Under Example Scenarios

The Oregon Health Fund Board contracted with James Matthisen of The Mosier Group LLC to conduct a preliminary actuarial pricing of the Essential Benefits Package (EBP) developed by the Benefits Committee. The complexity of the EBP prevented the completion of a data-driven model within the given timeframe and limited the use of robust actuarial methods. Once efforts move forward on the implementation of this or a similar benefit package, a much more intensive analysis using a claims-based approach should be undertaken. Assumptions used in this preliminary pricing include:

- EBP offered within an Exchange under an individual mandate
- Provider reimbursement rates near current commercial levels
- Potential cost savings due to increased utilization of preventive services, chronic disease management and timely care in an integrated health home are not taken into account
- Savings due to an overall benefit cap and other potential limitations on discretionary services not included (this was incorporated too late in the recommendations to include in the pricing model)
- The higher-than-average levels of cost sharing are assumed to reduce demand for services by 5%. This assumption is based on an assumption that the net cost sharing is designed such that equal incentives for reduced use are incorporated at all income levels.

The per-member per-month estimate of \$235.18 shown in Figure B.1 represents the estimated cost of the EBP (shown in Figure 1 on page 16) for a 40-44 year-old adult in 2008 dollars using these and other necessary assumptions.

The Benefits Committee was also presented with examples of what cost sharing might look like if it were graduated downward at lower income levels, with no cost sharing assumed for individuals with household incomes under 100% FPL. The first example shown in Figure B.2 has out-of-pocket maximums limited to 5% of gross income. The graduation of the individual contributions toward premium are in the fashion recommended by the Eligibility & Enrollment Committee, however it is was that committee's intent that all cost sharing (including deductibles/coinsurance) should be limited to these levels, not just the premium share. This spreadsheet shows that the average contribution of the state towards premium for those with family incomes between 100% and 300% FPL would be \$353 per-person per-month (PMPM) in 2008 dollars, assuming all parents under 200% FPL would not have an individual contribution towards the premium. The percentages towards the bottom of the page show the percentage of gross income represented by the individual contribution toward premium, deductible and out-of-pocket maximum for different family sizes. The same information was presented using cost sharing patterned after a scenario referred to as 'Straw Plan A' modeled for the Finance Committee (see Figure B.2). In this example the state's average contribution towards the premium for those between 100-300% FPL would be \$292 PMPM. The Benefits Committee was dismayed to learn that even these high levels of cost sharing did not result in the \$300 PMPM state contribution most recently assumed in the modeling done for the Finance Committee.

Figure B.1
Oregon Health Fund Board Benefits Committee
Preliminary Pricing and Plan Design Impact Analysis

Category of Care	PMPM Costs	Avg Cost Sharing	Net PMPM
Value-Based Services	27.99	1%	27.71
Basic Diagnostic Services (2 visits, basic office diagnostics)	11.18	1%	11.07
Comfort Care	3.08	5%	2.93
<hr/>			
Tier I (Lines 1-113)	71.46	23%	55.38
Tier II (Lines 114-311)	77.42	38%	48.39
Tier III (Lines 312-503)	41.09	45%	22.60
<hr/>			
Ambulance	6.39	3%	6.18
Emergency Room	20.76	55%	9.34
Medications	65.57	18%	53.94
Diagnostic Services	89.82	20%	71.85
<hr/>			
Total/Avg	414.75	25%	309.37
<hr/>			
Cost Sharing Utilization Offset		5%	
Deductible		\$7,500	(\$119.14)
OOP Max		\$15,000	19.95
<hr/>			
Total Cost without Admin	414.75	49%	210.18
Admin Load			\$25
Total Cost PMPM			235.18

Figure B.2
Oregon Health Fund Board Benefits Committee
Projected State Contribution Levels With Out-of-Pocket Maximum Limited to 5% of Gross Income For An Individual < 300% FPL

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-399%	400+%	
Median Monthly Income	\$975	\$1,192	\$1,408	\$1,625	\$1,842	\$2,058	\$2,275	\$2,492	\$3,033	\$ 3,467+	
Deductible	\$250	\$250	\$400	\$400	\$500	\$500	\$700	\$700	\$2,500	\$2,500	
Out-of-Pocket Max	\$500	\$500	\$800	\$800	\$1,000	\$1,000	\$1,400	\$1,400	\$5,000	\$5,000	
Individual Monthly Contribution	\$0	\$0	\$28	\$33	\$55	\$62	\$114	\$125	\$308	\$308	
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?	
State Contribution	\$408	\$408	\$371	\$367	\$337	\$330	\$265	\$254	Tax break	None	
Total Monthly Premium	\$408	\$408	\$400	\$400	\$392	\$392	\$379	\$379	\$308	\$308	
Percent of Premium from State Contribution	100%	100%	93%	92%	86%	84%	70%	67%			
Avg State Contribution for 100-300% FPL	\$349		<i>Avg State Contribution with No Premium Share for Parents < 200% FPL</i>				\$353				

		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes	Individual	\$867	\$1,083	\$1,300	\$1,517	\$1,733	\$1,950	\$2,167	\$2,383	\$2,600	\$3,033	\$3,467
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	11.9%	10.2%	8.9%
	Deductible	2.4%	1.9%	2.6%	2.2%	2.4%	2.1%	2.7%	2.4%	8.0%	6.9%	6.0%
	OOP max	4.8%	3.8%	5.1%	4.4%	4.8%	4.3%	5.4%	4.9%	16.0%	13.7%	12.0%
	Individual+1	\$1,167	\$1,458	\$1,750	\$2,042	\$2,333	\$2,625	\$2,917	\$3,208	\$3,500	\$4,083	\$4,667
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	17.6%	15.1%	13.2%
	Ded	3.6%	2.9%	3.8%	3.3%	3.6%	3.2%	4.0%	3.6%	11.9%	10.2%	8.9%
	OOP max	7.1%	5.7%	7.6%	6.5%	7.1%	6.3%	8.0%	7.3%	23.8%	20.4%	17.9%
	Family of 3	\$1,467	\$1,833	\$2,200	\$2,567	\$2,933	\$3,300	\$3,667	\$4,033	\$4,400	\$5,133	\$5,867
	Premium	0.0%	0.0%	3.8%	3.8%	5.7%	5.6%	9.3%	9.3%	21.0%	18.0%	15.8%
	Ded	4.3%	3.4%	4.5%	3.9%	4.3%	3.8%	4.8%	4.3%	14.2%	12.2%	10.7%
	OOP max	8.5%	6.8%	9.1%	7.8%	8.5%	7.6%	9.5%	8.7%	28.4%	24.4%	21.3%
	Family of 4	\$1,767	\$2,208	\$2,650	\$3,092	\$3,533	\$3,975	\$4,417	\$4,858	\$5,300	\$6,183	\$7,067
	Premium	0.0%	0.0%	3.2%	3.2%	4.7%	4.7%	7.7%	7.7%	17.5%	15.0%	13.1%
	Ded	3.5%	2.8%	3.8%	3.2%	3.5%	3.1%	4.0%	3.6%	11.8%	10.1%	8.8%
OOP max	7.1%	5.7%	7.5%	6.5%	7.1%	6.3%	7.9%	7.2%	23.6%	20.2%	17.7%	

Figure B.3
Oregon Health Fund Board Benefits Committee
Projected State Contribution Levels With Cost Sharing Aligned With Straw Plan A

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-400%	400+%	
Median Monthly Income	\$975	\$1,192	\$1,408	\$1,625	\$1,842	\$2,058	\$2,275	\$2,492	\$3,033	\$ 3,467+	
Deductible	\$500	\$500	\$1,000	\$1,000	\$2,500	\$2,500	\$5,000	\$5,000	\$7,500	\$7,500	
Out-of-Pocket Max	\$1,000	\$1,000	\$2,000	\$2,000	\$5,000	\$5,000	\$10,000	\$10,000	\$15,000	\$15,000	
Individual Monthly Contribution	\$0	\$0	\$28	\$33	\$55	\$62	\$114	\$125	\$235	\$235	
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?	
State Contribution	\$392	\$392	\$334	\$330	\$253	\$247	\$148	\$137	Tax break	None	
Total Monthly Premium	\$392	\$392	\$363	\$363	\$308	\$308	\$262	\$262	\$235	\$235	
Percent of Premium from State Contribution	100%	100%	92%	91%	82%	80%	57%	52%			
Avg State Contribution for 100-300% FPL	\$288		Avg State Contribution with No Premium Share for Parents < 200% FPL				\$292				

		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes	Individual	\$867	\$1,083	\$1,300	\$1,517	\$1,733	\$1,950	\$2,167	\$2,383	\$2,600	\$3,033	\$3,467
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	9.0%	7.8%	6.8%
	Deductible	4.8%	3.8%	6.4%	5.5%	12.0%	10.7%	19.2%	17.5%	24.0%	20.6%	18.0%
	OOP max	9.6%	7.7%	12.8%	11.0%	24.0%	21.4%	38.5%	35.0%	48.1%	41.2%	36.1%
	Individual+1	\$1,167	\$1,458	\$1,750	\$2,042	\$2,333	\$2,625	\$2,917	\$3,208	\$3,500	\$4,083	\$4,667
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	13.4%	11.5%	10.1%
	Ded	7.1%	5.7%	9.5%	8.2%	17.9%	15.9%	28.6%	26.0%	35.7%	30.6%	26.8%
	OOP max	14.3%	11.4%	19.0%	16.3%	35.7%	31.7%	57.1%	51.9%	71.4%	61.2%	53.6%
	Family of 3	\$1,467	\$1,833	\$2,200	\$2,567	\$2,933	\$3,300	\$3,667	\$4,033	\$4,400	\$5,133	\$5,867
	Premium	0.0%	0.0%	3.8%	3.8%	5.7%	5.6%	9.3%	9.3%	16.0%	13.7%	12.0%
	Ded	8.5%	6.8%	11.4%	9.7%	21.3%	18.9%	34.1%	31.0%	42.6%	36.5%	32.0%
	OOP max	17.0%	13.6%	22.7%	19.5%	42.6%	37.9%	68.2%	62.0%	85.2%	73.1%	63.9%
	Family of 4	\$1,767	\$2,208	\$2,650	\$3,092	\$3,533	\$3,975	\$4,417	\$4,858	\$5,300	\$6,183	\$7,067
	Premium	0.0%	0.0%	3.2%	3.2%	4.7%	4.7%	7.7%	7.7%	13.3%	11.4%	10.0%
	Ded	7.1%	5.7%	9.4%	8.1%	17.7%	15.7%	28.3%	25.7%	35.4%	30.3%	26.5%
OOP max	14.2%	11.3%	18.9%	16.2%	35.4%	31.4%	56.6%	51.5%	70.8%	60.6%	53.1%	

Appendix C: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of health care. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include the following:

- 1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
- 2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
 - Examples include EMTALA, ERISA, HIPAA, and Medicaid and Medicare administrative rules
- 3) Workforce and organizational issues which must be addressed to allow creation of integrated health homes for all Oregonians
- 4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
 - Examples include educational interventions, non-emergent transportation, and personal health aides

Appendix D: Benefits Committee Membership and Staff

Committee Membership

Gary Allen, DMD

Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD

Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole

Administrator, Benton County Health Department
Corvallis

Leda Garside, RN, BSN

Registered Nurse, Tuality Healthcare
Member, Health Services Commission
Lake Oswego/Hillsboro

Betty Johnson

Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph

Executive Director, Oregon Advocacy Center
Portland

Susan King, RN, Chair

Executive Director, Oregon Nurses Association
Portland

Jim Lussier

CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena

Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD, Vice-Chair

Staff Physician, Portland Veterans Affairs Medical Center
Member, Health Services Commission
Portland

Hubert (Hugh) Sowers, Jr.

Retired
AARP Member
McMinnville

Committee Membership (Cont'd)

Nina Stratton, Vice-Chair

Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit

Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Kevin C. Wilson, ND

Naturopathic Physician
Hillsboro

Committee Staff

Darren Coffman

Lead Staff

Ariel Smits, MD, MPH

Clinical Staff

Brandon Repp

Research Analyst

Nathan Hierlmaier

Policy Analyst

Dorothy Allen

Administrative Staff

Appendix E: Glossary

actuarial value The present value of future expected benefits calculated using economic and demographic assumptions.

advanced directive Advanced directives are specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future. Advanced care directives allow patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury. Advanced care directives can also designate someone the patient trusts to make decisions about medical care if the patient becomes unable to make (or communicate) these decisions.

AHRQ (Agency for Healthcare Research and Quality) The lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness *of health care for all Americans*.

ambulatory care sensitive condition An inpatient diagnosis for which timely and effective ambulatory care may have reduced the need for hospital admission.

care coordination An often highly structured and clinically intense set of processes that attempts to facilitate access to health care resources, decrease the “hassle” factor and improve an individual’s overall health care experience.

case management A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote high-quality, cost-effective outcomes.

complementary and alternative medicine Any of various systems of healing or treating disease that are not included in the traditional curricula taught in medical schools of the United States and Britain. Examples include acupuncture, Chinese herbal medicine, chiropractic, and homeopathy.

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

coinsurance A defined percentage of the total charges for a service that the patient is responsible for.

clinical effectiveness The measurement of a treatment’s ability to achieve a desired health outcome.

cost-effective Achieving the smallest cost for a given benefit, i.e., when a purchase is considered economical.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

cost shifting The transfer of uncompensated care costs from providers to insurance carriers, ultimately borne by consumers through increased insurance costs.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the cost of services.

discretionary services Those health care services, to be identified by the Health Services Commission or other body, which are of limited efficacy, or of equal efficacy to less expensive services. Alternatively, these services may be efficacious but do not have a significant impact on the health of an individual or population. Some discretionary services are efficacious and improve health, but are not required at a high frequency or at an advanced care level.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

EBP (Essential Benefit Package) The defined set of health services recommended by the Benefits Committee as the foundation level below which no individual should be without. This includes cost sharing and incentives, set according to financial means, designed to encourage patients to receive timely and appropriate diagnosis and treatment of their health conditions.

enabling services Services such as interpretive services and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

exchange A health insurance exchange is a market organizer that acts as a central forum for individuals and businesses to purchase health insurance. It can also act as a mechanism through which individuals can access subsidies for private market coverage.

evidence-based medicine The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

formulary A listing of medications approved for use.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by the Centers for Medicare and Medicaid Services (CMS).

HRC (Health Resources Commission) Commission administered through the Office for Oregon Health Policy & Research that analyzes and disseminates information concerning the effectiveness and cost of medical technologies and prescription drugs.

HSC (Health Services Commission) Commission administered through the Office for Oregon Health Policy & Research that prioritizes health services for the Oregon Health Plan.

incentivize In health care, to encourage desired behaviors (e.g., getting regular prenatal care) through the use of monetary or other rewards.

integrated health home A health care setting which provides patients with an established and continuous relationship with a provider or provider group trained to provide longitudinal health care services. Key aspects of an integrated health home include: team-based care, whole person orientation, coordinated and integrated care, high-quality and safe care, and enhanced access.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, the elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of the Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines but have a household income at or below the FPL. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium towards health care expenses covered by their insurance plan over the course of a year.

patient-centered care Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

point-of-service cost sharing Contributions made by individuals towards their health care in the form of copayments or coinsurance for each service they receive. This is in contrast to contributions made through deductibles and premium share.

POLST (Physician's Order for Life-Sustaining Treatment) A form developed for use by emergency medical personnel containing information about an individual's end of life decisions such as the use of cardiopulmonary resuscitation (CPR) and choices regarding medical treatment issues such as tube feedings and the use of antibiotics.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Prioritized List of Health Services The list of health services used as the basis for providing benefits under the Oregon Health Plan. Created and maintained by the Health Services Commission, the Prioritized List ranks services according to importance, taking into account clinical effectiveness, cost, and public values. See also *OHP Plus*.

therapeutically equivalent Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

value-based services Those cost-effective services, to be identified by the Health Services Commission or other body, which have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Examples may include certain evidence-based preventive care and outpatient treatments for ambulatory care sensitive conditions.

Value-Based Services Overview

HB 2009 directs the Health Policy Board to approve a baseline health benefit package to be used for all health benefit plans offered through the Oregon Health Insurance Exchange. One of the requirements of the benefit package is to 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.

The Health Services Commission has created a list of health care services, known as “value-based services,” that meet this specification and would be available without any cost-sharing (no co-pays or deductibles). The goal with this Value Based Services (VBS) List is to reduce barriers to obtaining health care services that are highly effective, low-cost, and improve health. Services comprising the list had to meet the following criteria:

- Ambulatory services (i.e. outpatient), and include medications, diagnostic tests, procedures, and some office visits
- Primarily offered in the medical home
- Primarily focused on chronic illness management, preventive care, and/or maternity care
- Of clear benefit, strongly supported by evidence
- Cost-effective
- Reduce hospitalizations or Emergency Department visits, reduce future exacerbations or illness progression, or improve quality of life
- Low cost up front
- Ideally highly utilized
- Low risk for overutilization

The development of the VBS list was based on the Health Fund Board Benefit Committee work, further developed through a series of public workgroup and Health Services Commission meetings. The VBS list has been vetted by several stakeholder groups, including the Medicaid managed care plans and the Division of Medicaid Assistance Programs (DMAP). Similar proposals from the Health Leadership Taskforce and the American Heart Association have been examined, and incorporated where applicable. Inclusion of specific health care services on the VBS list required high quality supporting evidence (such as Cochrane systematic reviews of randomized controlled clinical trials, and evidence-based guidelines). It is anticipated that the VBS list will be reviewed and updated annually, to ensure that the most current evidence is followed for designing coverage.

Value-Based Services will be applied to Oregon Health Plan recipients as well as to insurance packages offered within the Insurance Exchange. Because OHP recipients usually are required to pay zero to minimal co-pays (\$1 to \$3), it is very likely that this will not have a financial impact on OHP recipients. It is expected to have a financial impact on other insurance plan recipients, as these services explicitly would be offered without copays or coinsurance, and would help to incentivize utilization of these services.

Charge to the Health Services Commission

Excerpted from PRIORITIZATION OF HEALTH SERVICES, A Report to the Governor and the 75th Oregon Legislative Assembly. Updated March 18, 2010.

The Health Services Commission was established to:

“[R]eport to the Governor and Legislature a list of health services, including health care services of the aged, blind and disabled...and including those mental health and chemical dependency services...ranked by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served....The recommendation shall include practice guidelines reviewed and adopted by the Commission....”¹ (emphasis added)

The Commission is composed of twelve members. There are five physicians, including one Doctor of Osteopathy, a dentist, four consumer representatives, a public health nurse, and a social services worker. The Commission relies heavily on the input from its subcommittees and ad hoc task forces. A Commissioner will often chair a subcommittee or task force, with its composition depending on the purpose of that body. If appropriate, membership from outside of the Commission will generally include representatives of specialty-specific providers, consumers, and advocacy groups within the area of interest.

The Commission’s Prioritized List of Health Services is made up of condition-treatment pairs composed of diagnosis and treatment codes used to define the services being represented. The conditions on the list are represented by the coding nomenclature of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Medical treatments are listed using codes from the American Medical Association’s Current Procedural Terminology, Fourth Edition (CPT-4), and the Healthcare Common Procedure Coding System (HCPCS), with the latter also capturing dental procedures.

The Commission maintains the Prioritized List by making changes in one of two ways:

1. The Biennial Review of the Prioritized List of Health Services, which is completed prior to each legislative session according to the Commission’s established methodology.
2. Interim Modifications to the Prioritized List that consist of:
 - a. Technical Changes due to errors, omissions, and changes in ICD-9-CM, CPT-4, or HCPCS codes; and,
 - b. Advancements in Medical Technology that necessitate changes to the list prior to the next biennial review.

The list assumes that all diagnostic services necessary to determine a diagnosis are covered. Ancillary services necessary for the successful treatment of the condition are to be presumed to

¹ Oregon Revised Statutes (ORS) 414.720(3).

be a part of the line items. This means that codes for prescription drugs, durable medical equipment and supplies, laboratory services, and most imaging services are not included on the Prioritized List but are still reimbursed as long as the condition for which they are being used to treat appears in the funded region (currently lines 1-503 of the April 1, 2009 list).

A New Prioritization Methodology

In December 2005, the HSC embarked on the development of a new prioritization methodology for the first time since the list was initially implemented in February 1994². First, the HSC developed the framework of what they thought the new list should look like by defining a rank ordered list of nine broad categories of health care (see Figure 1.1). The new methodology places a higher emphasis on preventive services and chronic disease management to ensure a benefit package that provides the services necessary to best keep a population healthy, not wait until an individual gets sick before higher cost services are offered to try to restore good health.

The next phase of the methodology calls for each of the line items on the Prioritized List to be assigned to one of the nine health care categories. Once the line items were assigned to one of the nine health care categories, a list of criteria was developed to sort the line items within the categories (see Figure 1.2). These measures were felt to best capture the impacts on both the individual's health and the population health that the Commission thought were essential in determining the relative importance of a condition-treatment pair. The HSC Medical Director and HSC Director worked with two HSC physician members to establish ratings for the criteria for over 100 lines in order to establish a general scale to follow for each of the criteria. The HSC Medical Director (and in most cases HSC Director) then met with individual HSC physician members and other volunteer physicians with OHP experience. After ratings were established for all (then) 710 lines, they were reviewed by the HSC Medical Director and HSC physician members for accuracy and consistency.

A workgroup of the HSC members then met to explore the best method for intermixing CT pairs across health care categories. While the nine health care categories were meant to establish the framework of the new list it was always clear that not every service in Category 1 was more important than every service in Category 2 and so on. In the methodology used to develop the initial Prioritized List implemented in February 1994, approximately 75% of the line items were hand adjusted after an initial computer sort on the treatment's prevention of death and cost of the treatment. The workgroup found that applying a weight to each category that was then multiplied by the total criteria score for each condition-treatment pair achieved an appropriate adjustment in the majority of the cases. The full commission agreed with the conclusions of the workgroup and approved the weights shown in parentheses after the title for each category in Figure 1.1. A total score was then calculated for each line using the following formula to sort all

² For a detailed history of the prioritization process, please see Chapter 1 of the Health Services Commission's 2007 Report to the Governor and 74th Oregon Legislative Assembly at the following address:
www.oregon.gov/OHPPR/HSC/docs/07HSCBiennialReport.pdf.

FIGURE 1.1
RANK ORDER OF HEALTH CARE CATEGORIES

- 1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*
- 2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*
- 3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*
- 4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*
- 5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*
- 6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*
- 7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*
- 8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*
- 9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

FIGURE 1.2 POPULATION AND INDIVIDUAL IMPACT MEASURES

Impact on Healthy Life Years - To what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - To what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - The degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due to the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - To what degree does the condition affect vulnerable populations such as those of certain racial/ethnic descent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - In considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - To what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - The percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - The cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

line items within each of the health care categories, with the lowest net cost used to break any ties:

$$\text{Category Weight} \times \left\{ \begin{array}{l} \text{Impact on Healthy Life Years} \\ + \text{Impact on Suffering} \\ + \text{Population Effects} \\ + \text{Vulnerable of Population Affected} \\ + \text{Tertiary Prevention (categories 6 \& 7 only)} \end{array} \right\} \times \text{Effectiveness} \times \text{Need for Service}$$

Hand adjustments were applied where the application of this methodology did not result in a ranking that reflected the importance of the service, which was the case in fewer than 5% of the line items.

The following two examples illustrate line items that were given a very high score and a very low score as a result of this process.

Schizophrenic Disorders
Category 3 Weight: 75
 Impact on Healthy Life Years: 8
 Impact on Suffering: 4
 Effects on Population: 4
 Vulnerability of Population Affected: 0
Effectiveness: 3
Need for Service: 1
Net Cost: 5
 Total Score: 3600

$$75 \times [(8+4+4+0) \times 3 \times 1] = 3600$$

Grade I Sprains of Joints and Muscles
Category 8 Weight: 5
 Impact on Healthy Life Years: 1
 Impact on Suffering: 1
 Effects on Population: 0
 Vulnerability of Population Affected: 0
Effectiveness: 2
Need for Service: 0.1
Net Cost: 4
 Total Score: 2

$$5 \times [(1+1+0+0) \times 2 \times 0.1] = 2$$

Some of the services moving towards the top of the list as a result of this reprioritization include maternity care and newborn services, preventive services found to be effective by the U.S. Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

Biennial Review of the Prioritized List

The Commission conducted its ninth biennial review of the Prioritized List of Health Services in the spring of 2008. Having developed a new prioritization methodology and conducted a reprioritization of the entire list for the first time in fourteen years in 2006, there was little need in embarking on an ambitious undertaking just two years later. Also reducing the need for an intensive biennial review was the fact that the interim modifications to the Prioritized List have taken on a larger importance as the list matures, to the point that they are now including nearly all of the changes that involve individual codes (as opposed to the creation, deletion, merging or splitting of entire line items). The creation and modification of practice guidelines are now also

being handled exclusively as part of the interim modification process (see Chapter Two for a discussion of all new and modified guidelines during the last two years). Finally, it was with great pride that four Health Services Commission members and its staff played key roles in the work of the Oregon Health Fund Board's Benefits Committee³ in defining an essential benefit package for consideration as part of the health reform plan envisioned for the state.

The revised Prioritized List of Health Services was then forwarded to the independent actuarial firm of PricewaterhouseCoopers for pricing determinations. The actuarial analysis of the expected per capita costs of providing various levels of services for the different Medicaid eligibility groups appears in their September 2008 report titled, "Oregon Health Plan Medicaid Demonstration: Analysis of Calendar Years 2010-11 – Average Costs⁴." Starting next biennium, the new Actuarial Services Unit within the Department of Human Services will be pricing the Prioritized List and developing capitation rates for contracting purposes.

Upon the approval of this Health Services Commission report, the 75th Oregon Legislative Assembly set a funding level for the Prioritized List of Health Services covering services on lines 1-502 for calendar years 2010-11. This establishes the basis for the OHP Plus and OHP Standard benefit packages for the Medicaid Demonstration, whereby further exclusions may be applied.

Interim Modifications to the Prioritized List

In addition to the work on the biennial review of the Prioritized List, the Commission continues to maintain the list as necessary during the interim periods. They were aware from the outset that this unique process for determining health benefit coverage would need further refinement as feedback was received after implementation and to account for changes in the medical codesets on which the list was built. The Commission asked for the authority to make adjustments to the list during the interim period that was granted in 1991 in the following statute:

"The commission may alter the list during the interim only under the following conditions:

- a) technical changes due to errors and omission; or,*
- b) changes due to advancements in medical technology or new data regarding health outcomes.*

If a service is deleted or added and no new funding is required, the Commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the Commission must report to the Emergency Board for funding."⁵
(emphasis added)

³ The Oregon Health Fund Board's report to the 75th Oregon Legislative Assembly can be found at www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf and the recommendations of its Benefits Committee at www.oregon.gov/OHPPR/HFB/docs/BenefitCommitteeFinal.pdf.

⁴ Available at http://www.oregon.gov/DHS/healthplan/data_pubs/rates-costs/main.html.

⁵ ORS 414.720(5)a, (5)b and (6)

The Commission accepts recommendations for interim modifications from staff, other state agencies, participating health care plans, health care providers, OHP clients and other interested entities. The requests are initially forwarded for consideration to the Health Outcomes Subcommittee for physical health services, the Subcommittee on Mental Health Care and Chemical Dependency Subcommittee or the newly created Dental Services Subcommittee, as appropriate. A Subcommittee will often require at least two meetings to first hear the request and then have staff collect the necessary information in order to make a decision. If the recommendation is for approval of the modification to the list, that issue is then considered at the next Health Outcomes Subcommittee meeting (if it was initially taken to one of the other two subcommittees) before getting passed along to the full Commission meeting⁶. A requesting party can assume that it will likely take 3-4 months, and possibly longer, depending on the completeness of the information initially provided and the timing of the receipt of the request in comparison to the next scheduled Commission meeting. It should also be noted that the Commission's decisions are based on what is best for the entire OHP population, not on any one individual case.

While these considerations continue to be used when new line items are created or entire line items are moved, most changes to the Prioritized List over the last fifteen years since its implementation have involved decisions to place/move individual codes representing specific medical treatments. Prior to 2003, most new technologies were added to the list in the absence of specific knowledge on the effectiveness of such a service. However, legislation passed during the 2003 session has had a profound effect on which services are included on the Prioritized List since then. House Bill 3624 directed that the Health Services Commission:

“Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743.695.”⁷

The Commission incorporated both clinical effectiveness and cost-effectiveness into an algorithm describing the Health Services Commission's process for following the direction given by HB 3624, resulting in that shown in Figure 1.3. Finally, Figure 1.4 describes in which instances the prioritization methodology involving line rankings is employed and when the change can be done during the interim period between biennial reviews of the Prioritized List, using evidence-based research when available.

Technical Changes

As the Prioritized List attempts to match some 16,000+ ICD-9-CM diagnosis codes with 8,000+ CPT-4 treatment codes, the Commission is aware that some appropriate condition-treatment groupings do not appear on the list. Some of these codes are omitted purposefully. For instance, appropriate diagnostic services are covered under OHP whether or not the final diagnosis appears in the funded region. Additionally, appropriate ancillary services such as prescription

⁶ Health Services Commission meetings are usually scheduled immediately after Health Outcomes Subcommittee meetings on the same day.

⁷ ORS 414.720 (4b).

drugs and durable medical equipment are covered if the condition which they are being used to treat lie in the funded region. Because of the volume of codes that represent diagnostic and ancillary services, and the fact that they are often associated with many different

**FIGURE 1.3
PROCESS FOR INCORPORATING OR REVISING EVIDENCE-BASED HEALTH
TECHNOLOGY ASSESSMENT AND COST-EFFECTIVENESS INTO THE
PRIORITIZED LIST**

- The HSC will examine pooled data from one of the recognized sources/websites (see “Sources Of Information For Evidence-Based Health Technology Assessment” on the following page)
- Exceptions may be made for rare diseases
- The HSC will consider new sources/websites as they are identified
- Evidence regarding the effectiveness of a treatment will be used according to the following algorithm:

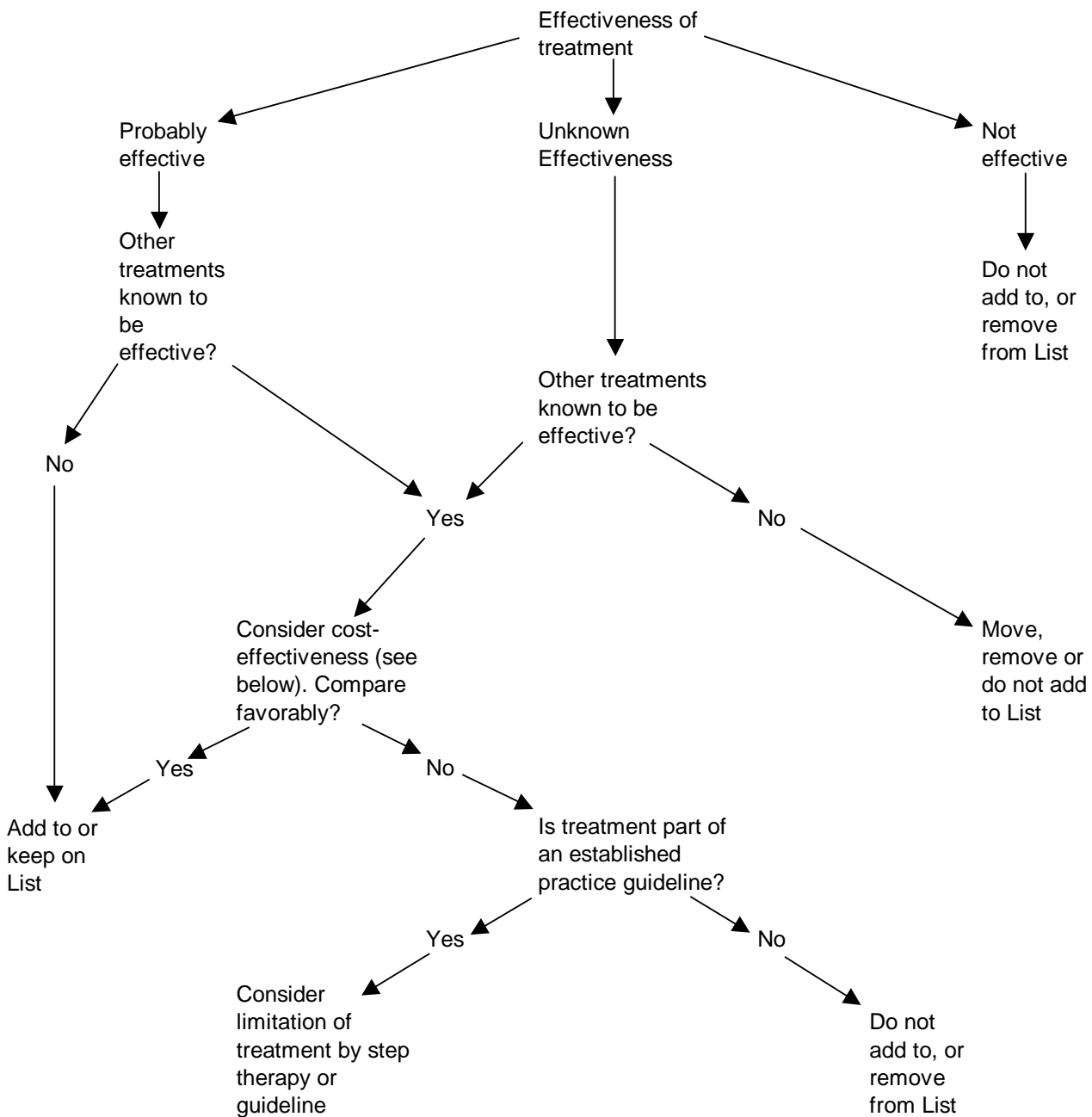


FIGURE 1.3 (CONT'D)

The cost of a technology will be considered according to the grading scale below, with “A” representing compelling evidence for adoption, “B” representing strong evidence for adoption, “C” representing moderate evidence for adoption, “D” representing weak evidence for adoption and “E” being compelling evidence for rejection:

- A = more effective and cheaper than existing technology
- B = more effective and costs < \$25,000/LYS or QALY > existing technology
- C = more effective and costs \$25,000 to \$125,000/LYS or QALY > existing technology
- D = more effective and costs > \$125,000/LYS or QALY > existing technology
- E = less or equally as effective and more costly than existing technology

Sources Of Information For Evidence-Based Health Technology Assessment

Sources of evidence must have the following characteristics:

- The research must be current (either completed in, or updated within, the last three years)
- The investigator cannot have a vested interest in the outcome of the research
- The investigator must use accepted methods of research based on the outcomes of *multiple studies*
- The research must be peer-reviewed and published in the scientific literature

Below is a list of the sources that have been identified to date. Clinical judgment will still need to be used by the Commission to determine the strength of evidence appearing on any of these sites.

First Priority

- a. BMJ Clinical Evidence <http://www.clinicalevidence.com>
- b. Evidence-Based Practice Centers (EPC) www.ahcpr.gov/clinic/epc
- c. Cochrane Collaboration www.cochrane.org/cochrane/revabstr/mainindex.htm
- d. University of York nhscrd.york.ac.uk
- e. Agency for Healthcare Research and Quality (AHRQ) www.ahcpr.gov
- f. Health Technology Assessment Programme – United Kingdom
<http://www.hta.nhsweb.nhs.uk/ProjectData>
- g. National Institute for Clinical Excellence (NICE) – United Kingdom
www.nice.org.uk/Cat.asp?pn=professional&cn=toplevel&ln=en
- h. Canadian Coordinating Office for Health Technology Assessment (CCOHTA)
www.ccohta.ca
- i. Blue Cross Blue Shield Technology Evaluation Center (TEC)
www.bcbs.com/tec/index.html

Other Sites Which May Be Considered

- j. Bandolier www.jr2.ox.ac.uk/bandolier
- k. ECRI www.ecri.org
- l. National Guideline Clearinghouse www.guideline.gov
- m. Institute for Clinical Systems Improvement <http://www.icsi.org>

- n. CMS Medicare Coverage Advisory Committee (MCAC)
cms.hhs.gov/ncdr/mcacindex.asp

FIGURE 1.4

OVERVIEW OF THE HEALTH SERVICES COMMISSION'S PRIORITIZATION PROCESS

Placement of a New ICD-9-CM Code

In most cases a new ICD-9-CM code will simply be a higher specificity for an existing code and will be placed on the list where its third or fourth-digit parent code already exists. In cases where the ICD-9-CM code represents a new disease or where the code of higher specificity does not belong on the line where the existing code is placed, the code is placed on the most appropriate line according to the methodology shown in Figures 1.1 and 1.2. This will be done as an interim modification effective October 1.

Placement of a New CPT-4 Code

Use the criteria described in Figure 1.3 to determine whether the use of the procedure is experimental and, if not, whether evidence warrants its placement on the line in which the diagnosis code for which pairing is desired exists. If evidence does not support placement at this level of priority, use the process described in Figures 1.1 and 1.2 to determine where the pairing should be placed. This will be done as an interim modification effective April 1.

Placement of a Previously Non-paired CPT-4 Code

Use the criteria described in Figure 1.3 to determine whether the use of the procedure is experimental and, if not, whether evidence warrants its placement on the line in which the diagnosis code for which pairing is desired exists. If evidence does not support placement at this level of priority, use the process described in Figures 1.1 and 1.2 to determine where the pairing should be placed. This will be done as an interim modification unless a significant fiscal impact results.

Deletion of an Existing CPT-4 Code

Use the criteria described in Figure 1.3 to determine whether the use of the procedure is experimental or if evidence dictates that the code should be removed from a line or the list in general. This can be done as either an interim modification or, if public or provider input is desired, as a biennial review change.

Movement of an Existing Line Item

This can only be done during the biennial review process. Use the process described in Figures 1.1 and 1.2 to determine new placement.

Movement of an Existing ICD-9-CM/CPT-4 Code Pairing

This can be done either during the biennial review process or as an interim modification if there is no significant fiscal impact. Use the process described in Figures 1.1 and 1.2 to determine placement.

Creation of a New Guideline

As this is likely to result in a cost savings, a new guideline can usually be created as an interim modification.

Revision of an Existing Guideline

This can likely be done as an interim modification, but a significant change or deletion of the guideline in its entirety could potentially need to be done as a biennial review change.

diagnoses, these codes usually do not appear on the list. Instead, the Division of Medical Assistance Programs (DMAP) maintains electronic files to account for these codes and their fee-for-service reimbursement. Other appropriate pairings of condition and treatment codes may have been left off inadvertently. As these pairings are identified through DMAP's claims processing system, providers, or managed care plans, the necessary changes are made to the list as interim modifications.

Technical changes are typically made to the list only twice during a calendar year. Implementation of these technical changes coincide with the release of new ICD-9-CM, CPT and HCPCS codes. Technical changes that include the new ICD-9-CM codes always become effective on October 1st of each year. Changes involving new CPT and HCPCS codes are made as early as possible in the new year, but the timing of their release combined with the volume of new codes for review have not allowed the Commission to make their decisions in time to allow for the successful implementation of these changes at the first of the year. In order to assist DMAP and the managed care plans in being HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant, the HSC places information on their probable action involving new procedure codes in mid-December, prior to their effective date. Detailed documentation on all interim modifications to the Prioritized List of Health Services dating back at least three years can be found on the Commission's website at the following address: www.oregon.gov/OHPPR/HSC.

On January 15, 2009, the Centers for Medicare and Medicaid Services (CMS) announced that the implementation of ICD-10-CM will take place on October 1, 2013. The Health Services Commission will begin work on the conversion of the Prioritized List of Health Services from ICD-9-CM to ICD-10-CM codes in the summer of 2010. This will necessitate a complete revision of every line item of the Prioritized List, which is anticipated to take 2-3 years to complete.

Advancements in Medical Technology

The Commission periodically receives requests to modify the placement or content of condition-treatment pairs to reflect significant advancements in medical technology. These requests often come from medical providers and commercial developers of emerging technologies, but will be accepted from any source. The Commission staff assembles needed background information and arranges to have experts testify before the Health Outcomes Subcommittee as it prepares a recommendation for the full Commission.

If an added service is projected by the actuary for the Department of Human Services to have a significant fiscal impact on the OHP Medicaid Demonstration, the Health Services Commission is required to appear before the Legislative Emergency Board to request additional funding. To date, no interim modifications have been found to have such a significant fiscal impact.

HSC Policy Regarding Medications, DME, and Other Ancillary Services

Multiple questions have come to the HSC in the past two years which directly address coverage of particular medications. Oregon has a process in place to evaluate medications and other types of treatments through the reviews of the Health Resources Commission (HRC) and the Division of Medical Assistance Program's (DMAP's) Drug Utilization Review (DUR) Board. As discussed in the previous section, the HSC considers prescription drugs to be ancillary treatments. Therefore they have only reviewed a drug in the context of whether its effectiveness of treating a condition will affect the ranking of that condition on the list. HSC staff has worked with HRC and DMAP staff to clarify the HSC's role and authority on the coverage of specific medications and similar ancillary services. As part of these discussions, the HSC developed the following policy, currently under legal review by the state Department of Justice:

The Health Services Commission (HSC) has authority over the Prioritized List, including placement of conditions and treatments on the list. The HSC is expected to include cost-benefit assessments for treatments considered for inclusion on the list, balancing the needs of the OHP population as a whole and the expenditures of limited resources. The HSC can create, in an open and public manner, guidelines which recommend restrictions or limitations on the coverage of medications, durable medical equipment (DME), or other ancillary services, as they relate to conditions and treatments on the Prioritized List. Such guidelines are expected to be implemented to the best ability of DMAP and prepaid managed care health services organizations, as allowed by federal and state rules and regulations. These guidelines set a minimum coverage level for DMAP and the prepaid managed care health services organizations. Decisions of the HSC regarding medications, DME, or other ancillary services which are not placed into guidelines are considered advisory only.

Oregon Health Fund Board



Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

June 2008

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Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

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Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

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. 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.

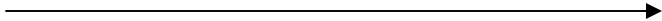
During this time the E & E Committee discussed and debated various approaches to defining affordability, fairness to individuals in similar financial circumstances (horizontal equity), and program sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee 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, and the access to, quality health care.
 - A critical aspect of this responsibility was the determination that all Oregon residents (regardless of federal requirements) 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.
 - Recognizing that a disproportionate amount of the uninsured are at lower income levels signifies that the cost of coverage is beyond the grasp of many Oregonians in this financial situation. Therefore, state contributions are necessary to help achieve coverage at the following levels:
 - 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).
 - 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.
 - 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.
- ❖ *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.
 - 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.
 - ❖ *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.
 - 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.
 - ❖ *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 would be a vital feature of health care reform in Oregon.
 - ❖ *Maximizing Coverage.* The Committee identified a need for program outreach and social marketing efforts about health care reform. They also recognized numerous administrative barriers to enrollment that must also be alleviated, and that a grievance, mediation and appeal process as well as an independent ombudsman should be established.

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:

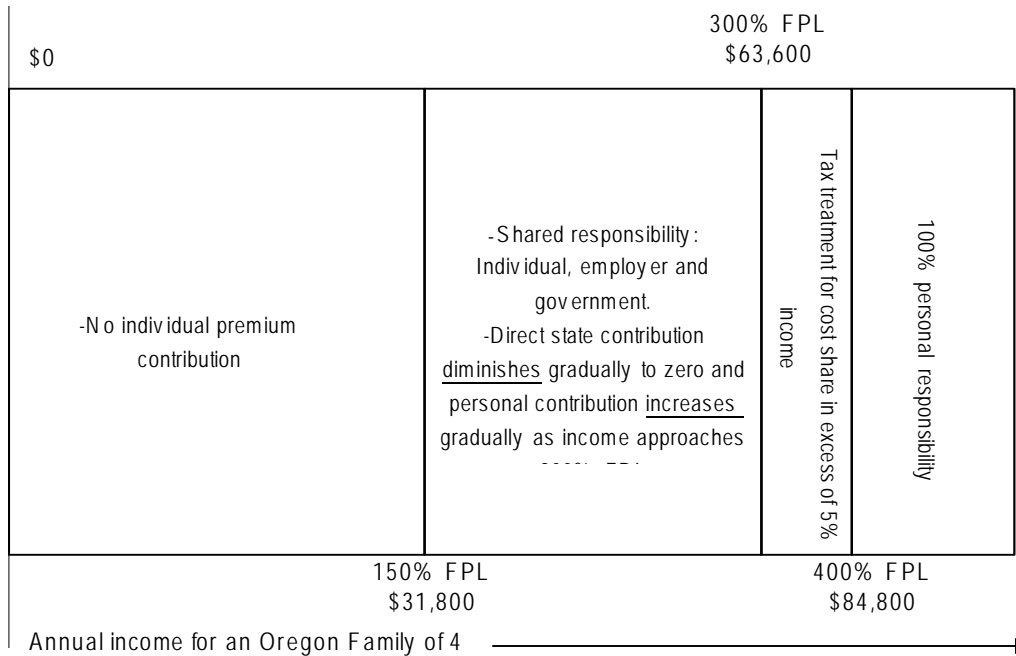
Increasing Annual Household Income 

<p>No Personal Cost Share For Premium Below x% FPL?</p>	<p>Shared State, Individual, and Employer Responsibility Between x% and x% FPL?</p>	<p>100% Personal Responsibility – No State Participation Above x% FPL?</p>
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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.

Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the twelve meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	208,000	42%	46,000	40%
150% to below 200%	67,000	13%	29,000	25%
200% to below 250%	60,000	12%	10,000	9%
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	499,000	100%	114,000	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- State of Oregon Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [See www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance."¹

¹ Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at <http://econ-www.mit.edu/files/128>.

- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.*"²
- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, "*Impact of Copays on a Medicaid Population.*"
www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf
- MAC Eligibility and Enrollment Recommendations.
- State of Oregon Revised Statutes and federal law regarding eligibility and enrollment in state programs.
- Analysis Jonathan Gruber and invited testimony by Rick Curtis from the Institute for Healthcare Improvement on horizontal equity.

Proposed Cost Sharing Structure Options

- A. The first question addressed by the committee was: *At what income should a family reasonably be expected to share responsibility for premium cost?*

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

- B. The second question addressed by the committee was: *At what income level should premium cost be 100% personal responsibility?*

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated

² Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit (\$15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable

About employer responsibility, one member commented, “The affordability we are defining is set within the context of an ‘individual mandate’ as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute.”

Third, in discussing the responsibility of the health care industry, a member commented, “329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the ‘essential’ benefits package sets a state standard; if Oregon is to create a workable ‘insurance exchange’ by any definition; if accountable health plans in which “all Oregonians are required to participate” are to be ‘accountable’ in the many ways described in 329 – the current market MUST be changed.” Another noted, “The premium for health coverage needs to provide a basic, adequate benefit package.”

Fourth, the state also shares responsibility. One member commented, “Top Ramen may be affordable.....Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions.”

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, “I’m supportive of the concept that everyone in Oregon should have health insurance. I’m most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process.”

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, “Going higher than the first option [150% FPL] increases the inequity with private insurance” since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, “Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar” in the context of structuring state contributions tailored to family composition. For example, two adults earning \$50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, “Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is.”

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers

participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I ... favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

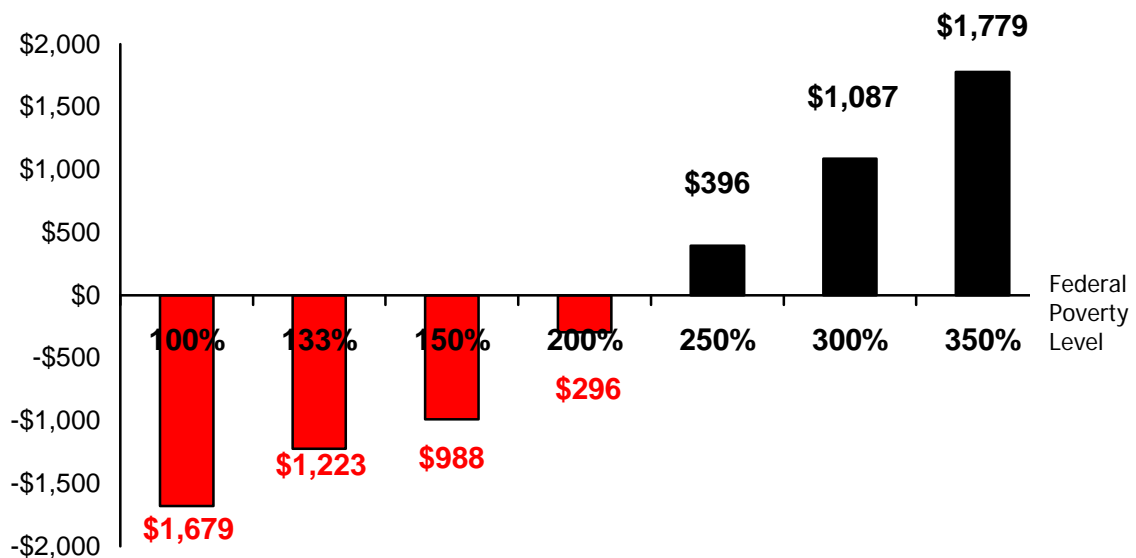
Recommendations

- 1. For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.**

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute’s review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee’s recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee’s review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family’s income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



Source: Economic Policy Institute “Basic family budget calculator” Accessed online <12.05.06>
http://www.epi.org/content.cfm/datazone_fambud_budget

As one member noted, “A model that looks only at subsidies for ‘insurance premium’ costs when ... out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums...is unknown, cannot hope to succeed on the basis of ‘equity’ or ‘sustainability’. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring ‘affordability’.” Another member echoed the “administrative simplicity” sentiment by suggesting potentially

simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

2. Structure individual cost sharing to emphasize premiums over other types of cost sharing.

- a) **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**
- b) **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.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee's approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *unaffordable*?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- ❖ A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of the federal poverty level (FPL) or \$53,000 annually for the Portland area, 200% of FPL or \$42,400 annual income for rural Oregon.

- ❖ A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL (\$42,000) in the Portland area, 250% FPL (\$35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level (\$15,600 for an individual or \$31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

3. Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them – Scale in VERY small increments, particularly for those between 150-200%."

4. 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 the 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 Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

5. State premium contribution eligibility for people who have employer-sponsored insurance:

- a) 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.**
- b) 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.**

The Committee's underlying principle in making this recommendation was that all employers in the state should contribute to the cost of health care for their employees and that it would be inequitable to allow the state to absorb the premium costs of low-income employees alone. The intent of the Committee with Recommendation 1a was to require broad-based employer contribution, but to avoid potential challenges from employers on the basis of the Employee Retirement Income Security Act of 1974 (ERISA). However, the Committee was also compelled by the principle of equity for employers as well as their workers and therefore supports the notion of crediting employers for offering coverage to their workers, as is reflected in Recommendation 1b. The Eligibility and Enrollment Committee supports the work of the Finance Committee as it develops financing mechanisms that would integrate these two broad recommendations.

The Oregon Health Fund Board should adopt eligibility policies that maximize health coverage and at the same time encourage the continuation of employer contributions. Policies providing access to state premium contributions for low-income individuals who are currently offered employer-sponsored insurance risk crowding out of that coverage. Because federal law such as ERISA constrains the ability of the state to require employers to provide health coverage—a broad-based requirement for all employers to contribute to a state health fund coupled with a credit mechanism would allow financial support for any potential loss of employer contributions.

The committee considered multiple policy options regarding allowing low-income individuals that have access to employer-sponsored insurance, and eliminated one from consideration: establishing a "firewall" that prevents anyone who is currently offered employer-sponsored insurance from coming into a health insurance exchange to obtain access to a state premium contribution. It seemed to committee members that denying the state contribution to those who enrolled in employer coverage but not to like persons who declined such coverage is untenable and unfair under an individual mandate, and it penalizes those who "did the right thing" by taking up coverage.

Denying a state contribution to low-income workers runs contrary to “horizontal equity” or treating people with similar incomes equitably. Similarly, employers who provide adequate coverage to their employees should also be given consideration in the financing structure adopted by the Board.

Calculations from the 2001 Current Population Survey (CPS) show that only 7% of those offered insurance are uninsured.³ Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 7%.⁴

6. 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.

The Committee believes that the Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP). Residency definitions will also define when the individual mandate clock begins. As one Committee member stated, the message in Oregon should be, “Welcome to Oregon, you have xx days to get health insurance coverage.”

The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents. The United States Supreme Court ruling on *Saenz v. Roe*, 1999 barred states from limiting welfare benefits on the basis on length of residency.

7. 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.

Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance, primarily because the average health insurance premium for a family of four is roughly \$12,000, nearly half of the average annual income of an immigrant worker. As a result, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardizing their health and welfare, and creating some cost-shifting.

The Committee views that if employers of such individuals are contributing to the cost of health care coverage in the state through a payroll tax or some contribution

³ J. Gruber and E. Washington, Subsidies to employee health insurance premiums and the health insurance market, *Journal of Health Economics* Volume 24, Issue 2, , March 2005, Pages 253-276.

⁴ Ibid

requirement— all of their workers should be eligible. The committee, however, struggled with the issue eligibility for state premium contribution for individuals who lack documentation of their legal status. However, there was general acknowledgement and support for ensuring that there is access to health care services for all Oregonians.

Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care.⁵ High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and admission to the hospital for potentially preventable complications of chronic and acute conditions. Moreover, insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by creating barriers to timely access to effective care.^{6,7}

The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between \$65 million and \$90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.⁸ Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence. The Pew Hispanic Center estimates Oregon's 2005 undocumented immigrant population at between 125,000 and 175,000.⁹

8. Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.

The following points summarize Committee agreement on periods of enrollment:

- ❖ Twelve months of enrollment is consistent with commercial coverage.
- ❖ A longer enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
- ❖ Less frequent recertification will result in administrative savings.

⁵ A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, *Arch Intern Med.* 2007;167(21):2354-2360.

⁶ S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York, The Commonwealth Fund, Apr. 2006)

⁷ Schoen et al., Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, (New York, The Commonwealth Fund, Sept. 2006)

⁸ Oregon Center for Public Policy, *Undocumented Workers Are Taxpayers, Too*, Apr. 2006

⁹ Pew Hispanic Center, "Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS," *Fact Sheet dated April 26, 2006.*

- ❖ A passive reenrollment process, where families do not complete a renewal form unless changes occur that affect eligibility, will further support continuous coverage and affordability goals.
- ❖ Results from the baseline OHP cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.¹⁰

9. 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.

The Committee viewed that a principle goal Oregon Health Fund Board is to provide coverage and access to all Oregon residents and therefore supported reducing administrative barriers to state programs. For the Medicaid program, delayed verification is an option under federal law that allows the program to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

10. 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.

Requiring that individuals have a period of time without health care coverage works in opposition to an individual mandate provision, which is one of the Oregon Health Fund Board assumptions. Additionally, requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

11. Assets: There should be no asset limit placed on eligibility for a direct state contribution.

Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources. Collecting and verifying information about assets is complex for both applicants and eligibility workers. Eliminating the need to determine family assets supports a goal of

¹⁰ Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" *Annals of Family Medicine* 4(5): 391-398, 2006

administrative simplicity. Some members of the Committee felt that establishing a high asset limit may ensure appropriate targeting of state premium contributions.

Asset tests may discourage low-income families from accumulating savings. Research has demonstrated that asset tests were associated with less savings and elimination of asset tests were associated with higher savings.¹¹ About 78 percent of uninsured adults with incomes below 200 percent of the federal poverty level have net assets (excluding home ownership) low enough to meet median Medicaid asset limit guidelines (\$2,000). Of this group, fewer than 40 percent own a home.¹² 47 of 51 Medicaid programs in the country, including Oregon's, do not have an asset limit for its traditional Medicaid population (OHP Plus), although it does have a \$5,000 asset limit for the expansion population (OHP Standard). Oregon is also one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs.¹³

12. 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.

If all individuals are required to purchase health insurance, the ability of health insurers to deny coverage based on health status would undercut this requirement. As most individuals are healthy, each person's share of these costs would be modest if excess costs associated with high medical needs are spread across the entire population through an individual mandate. The Committee recognizes that there will be a direct impact on the insurance market by allowing individuals enrolled in the high risk pool into the general market that needs to be mitigated.

13. 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.

In exchange for covering certain groups of individuals, the federal government matches the state's Medicaid spending at an established rate called the Federal Medical Assistance Percentage (FMAP). Each state also receives federal matching payments to cover additional groups of individuals and provide additional services. This federal match allows states to maximize their capacity to meet the needs of their low-income population: Oregon's match rate is about 61% and approximately 72% for the State Children's Insurance Program (SCHIP). The Committee assumes that waiver provisions will allow Oregon to have access to Medicaid funding for Oregonians up to 200% FPL for childless adults and parents and SCHIP funding up to 300% FPL for children.

¹¹ J. Gruber and A. Yelowitz, "Public Health Insurance and Private Savings," *Journal of Political Economy*, 107(6):1249-1274. December 1999.

¹² D. M. Cutler & A. M. Garbe. "Frontiers in health policy research. Vol. 6." NBER Frontiers in Health Policy Research Series. Cambridge, Mass: MIT. 2003.

¹³ Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

If the state were to cover all eligible low-income Oregonians under the Oregon Health Plan with limitations of 100% FPL for adults and 200% FPL for children, it would reduce the uninsured population by an estimated 250,000 people. This would require an investment of \$390 million from the state that would be matched with \$680 million from the federal government. The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. One example would be assuring eligibility to segments of the population such as American Indians that would not require state funds because of federal agreements.

14. 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.

Low-income Oregonians covered by Medicare may exceed the affordability standards established by the Committee. There are three significant limitations in Medicare that expose low-income individuals to financial risk:

- ❖ Medicare does not cover some important health care products and services. For example, the program does not cover many preventive services (such as annual physical exams), routine eye and dental care.
- ❖ It has high cost sharing on some covered services such as outpatient care and none on others. These variations may lead to inefficient choices by beneficiaries and providers that could inappropriately affect patients' or providers' decisions about the setting for care.
- ❖ It has no limit on total cost sharing (catastrophic cap).
- ❖ The Part B premium in 2008 has risen to \$96.40 per month. For someone living solely on the Social Security benefit, they will receive, on average, \$1,079 per month in 2008.¹⁴ In other words, this is a low income population without adequate health care access. That example means that person would spend 8.9% of their income on the premium alone, with considerable additional out of pocket costs for Medigap or Medicare Advantage, co-pays, deductibles, etc.
- ❖ The coinsurance liability for hospital outpatient services (20-55%) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20%). The high (50%) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services.¹⁵

¹⁴ Social Security Administration – all workers with disabilities – amount varies according to family composition and other eligibility factors.

¹⁵ G.M. Hackbarth. "Medicare Cost-Sharing and Supplemental Coverage" Statement before the Subcommittee on Health Committee on Ways and Means U.S. House of Representatives May 1, 2003.

Oregon residents who are eligible for Medicare are a critical component of the state's health system. Health care reform should include this population in identifying potential cost savings, addressing fragmentation in delivery systems, ensuring access to primary care and preventive services, improving accountability for health outcomes, exploring incentives for appropriate use of medical services and reducing administrative differences and barriers between Medicare and Medicaid. Furthermore, reducing financial barriers to early treatment of chronic conditions for Medicare beneficiaries, particularly those with cardiovascular disease or diabetes may have considerable social and economic value for the state of Oregon by improving health outcomes.

Although there was general consensus that affordability protections should be provided by the state to low-income Medicare beneficiaries on the basis of equity – many of the Committee members felt that a primary goal of SB 329 is to design a health reform plan that has a primary focus on the uninsured and a secondary focus on those who currently have health coverage.

15. Outreach

- a) 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.**

A social marketing campaign applies marketing principles to influence behavior to improve health or benefit society. Social marketing is particularly useful in reducing barriers that limit behavior change such as promoting the benefits of health coverage and affordability support given by the state.¹⁶

Oregon state budget constraints and economic downturns have severely constrained the state's ability to engage in an outreach campaign to enroll eligible individuals into state sponsored health coverage. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures.¹⁷ Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts that have been effective and necessary to expand coverage to uninsured Oregonians.

- b) 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**

¹⁶ "The Basics of Social Marketing, How to Use Marketing to Change Behavior," Turning Point National Program Office, University of Washington School of Public Health and Community Medicine: www.turningpointprogram.org

¹⁷ E. M. Lewit, C. Bennett and R.E. Behrman, (2003) "Health Insurance for Children: Analysis and Recommendations," *Future of Children* 13(1):1-25

- **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**

Public testimony to the Oregon Medicaid Advisory Committee (MAC) from advocacy organizations, programs that serve the uninsured, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

c) Identify uninsured individuals and inform them about Oregon Health Fund program.

While media outreach can be effective, targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. For example, Washington State's new insurance laws mandate a "proactive, targeted outreach and education effort" to enroll children in health coverage, with a focus on populations with the highest rates of uninsurance.

d) Increase outreach and retention for those individuals already eligible but not enrolled.

There are high numbers of uninsured who are eligible for public coverage but are not enrolled – this may be due to lack of knowledge about program availability and not valuing coverage. In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

e) To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.

The Medicaid Advisory Committee's (MAC) community meetings that were part of developing the Healthy Kids Plan revealed possible duplication of effort among various social service agencies that could offer savings of time and money. Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of

bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

- f) **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.**
- i. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
 - ii. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
 - iii. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.
- g) **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).**

This is especially true in communicating the advantage of being enrolled in health coverage to communities that may have a limited understanding of health insurance and what the scope of benefits mean.

- h) **Work with employers and other agencies to include information about Oregon Health Fund in their regular communications with employees and stakeholders.**

Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

16. Application

- a) **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.**

A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, Oregon has relied on a lengthy and complex Medicaid application. Recently, however, the complicated application has been replaced with a shorter form. Making provisions for additional avenues such as on line applications will further simplify the process. This effort should extend to new state programs created by the Oregon Health Fund Board.

- b) 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.**

Administrative barriers such as submitting paycheck stubs for a defined period of time, as is done for the Oregon Health Plan, can be onerous on the applicant and have led states to innovate in changes to application requirements. For example, Lewit et al. note that 13 states do not require families to provide verification of the income they report on their applications. The authors contend that this system greatly reduces the paperwork burden on families – noting that these states now verify income and other information by matching identifying information provided by the family with existing state databases.¹⁸ Other studies have also noted that states adopting self-declaration of income report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.¹⁹

- c) Allow applicants to use the previous year's tax return as a verification option.**

Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant barrier to families with unstable or variable income such as self-employed and seasonal workers.

- d) 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.**

The recertification process for enrollees is an area where administrative barriers may actively disenroll or prevent continuation of health coverage. Studies have found that "churning" – when individuals fail to renew their coverage during the eligibility redetermination period required by the programs, but re-apply for coverage after the redetermination period is over – increases administrative costs and consumes limited staff time. Moreover, the most valuable benefit of continuous coverage is beneficiaries' improved health when services are not

¹⁸ *Ibid*, Lewit et al. 2003.

¹⁹ Neuschler, E., and Curtis, R. *Premium assistance: What works?* Washington, DC: Institute for Health Policy Solutions, March 2003.

arbitrarily interrupted. Timely preventive and primary care visits can diminish costly hospitalizations and emergency room visits for uninsured residents.²⁰

e) Establish administrative mechanisms needed to prevent participation of non-residents or individuals that move out of the state.

Steps should be taken similar to other public programs such as the Oregon Health Plan that do not allow non-state residents to remain enrolled if that individual moves from Oregon to another state.

f) Optimize the ability of families to be enrolled within the same plan.

Feedback from the Healthy Kids public meetings indicated that various health plans and programs can often lead to confusion and bewilderment of families if certain members of the family are enrolled in different plans that have different rules, benefits and providers.

g) 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.

Public testimony to the MAC from advocacy organizations, as well as public testimony, supports a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

17. 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.

According to a National Health Law Program study, low-income individuals and families often face significant challenges when resolving service disputes with a managed care organization.²¹ People with limited resources, may find it difficult to obtain medical records, understand notices, and even call their health plan for assistance. These difficulties are compounded for individuals who are illiterate or lack access to a telephone and have to go to separate state agencies for resolving complaints in Medicaid and the commercial market. An effective grievance and appeals process becomes even more important within a program that requires every resident to have health care coverage. The Committee would like these processes and administrative functions streamlined in order to avoid confusion and duplication of efforts, while allowing for an independent medical review of appeals.

²⁰ D.C. Ross and I.T. Hill. (2003). "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13(1):81-97

²¹ J. Perkins, K. Olson, L. Rivera, and J. Skatrud. (1996). *Making The Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction*. Chapel Hill, NC: National Health Law Program.

While grievance and appeal processes have important formal standing, an independent ombudsman role is also recommended. This function, if done properly, can often resolve issues in lieu of a grievance or appeal. In addition, the ombudsman can steer a consumer to appeal and grievance processes if appropriate. As an example in a system with universal coverage, the Parliamentary and Health Service Ombudsman in the United Kingdom works to hold the National Health Service accountable and notes the following, in consumer friendly language: “we work to put things right where we can and share lessons learned to improve public services.” Currently, Minnesota and Vermont are examples of health care ombudsmen in the United States. A healthcare ombudsman program developed in Oregon should have statutorily defined responsibilities to include investigation, negotiation, advocacy, and reporting functions.

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.

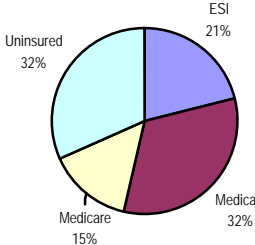
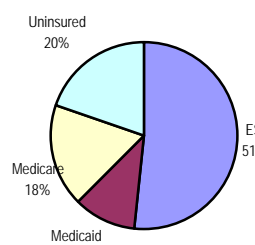
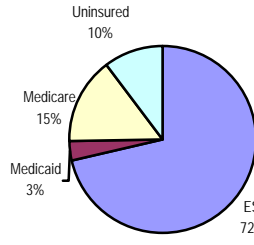
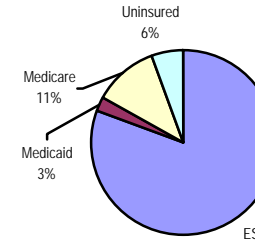
For the Federal Laws Committee

- ❖ 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.

Appendix A

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
<p>806,000 Oregonians -550,000 insured (68%) -255,000 uninsured (32%)</p> <p>Insurance source for < 150% FPL:</p> 	<p>1,032,000 Oregonians -828,000 insured (80%) -204,000 uninsured (20%)</p> <p>Insurance source for 150% FPL to below 300% FPL:</p> 	<p>513,000 Oregonians -458,000 insured (89%) -55,000 uninsured (11%)</p> <p>Insurance source for 300% FPL to below 400% FPL:</p> 	<p>1,311,000 Oregonians -1,211,000 insured (93%) -99,000 uninsured (7%)</p> <p>Insurance source for 400% FPL and above:</p> 

Data from CPS 2-year average, Data collected in 2006 and 2007.

Appendix B

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	\$10,400	\$15,600	\$20,800	\$26,000	\$31,200	\$36,400	\$41,600
2	\$14,000	\$21,000	\$28,000	\$35,000	\$42,000	\$49,000	\$56,000
3	\$17,600	\$26,400	\$35,200	\$44,000	\$52,800	\$61,600	\$70,400
4	\$21,200	\$31,800	\$42,400	\$53,000	\$63,600	\$74,200	\$84,800
5	\$24,800	\$37,200	\$49,600	\$62,000	\$74,400	\$86,800	\$99,200
6	\$28,400	\$42,600	\$56,800	\$71,000	\$85,200	\$99,400	\$113,600
Each add'tl person, add	\$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Appendix C

Alternative policy options for horizontal equity in recommendation #1, on employer-sponsored insurance (in order of Committee preference) include:

- a) **No Firewall with a two-part employer “pay-or-play” test.** Employers would be required to spend at least x% of payroll overall on health care for their workers – or pay the same percent of payroll to the state as a tax – employers would also be required to either:
- ❖ Require employers to spend at least a specified amount per hour worked by each employee individually – or pay the equivalent amount as a tax. (This approach would assure that “offering” employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer’s coverage), or
 - ❖ Spend a specified average amount per hour, or % of wage, per worker on all workers earning less than a specified amount – e.g. less than \$20,000 per year. (This approach would assure that offering employers would either spend a “fair share” amount towards coverage of their low income workers or pay the state such an amount toward their coverage.)

The workers included in such a “low-earner” definition would include all modest income part-time and temporary workers not eligible for employer coverage and would allow the state to combine “fair share” contributions from multiple workers towards stable coverage through an insurance exchange.

It is possible in such an approach that employers may take actions to contract with workers or create subsidiaries of workers to avoid state designation of employee responsibility.

- b) **Employer “Buy-in”/“Vouchers”:** Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if, and only if, their employer transfers to the pool or public system either, (a) the amount the employer would contribute to the employer’s own plan or (b) a specified amount up to (a).

This approach would have good “horizontal equity” in that employees are not excluded from the state program, and it retains employer contributions. It also may be simpler to administer than “premium assistance.”

Due to ERISA, employers cannot be directly compelled to cooperate. Therefore, this approach would leave the worker hostage to employer willingness to cooperate with the state, and it creates the potential for adverse selection cost exposure for the state. There may also be risk selection issues if an employer

chooses to keep low-risk employees and allow higher-risk employees to go to the state program.

- c) **Benchmark Group Plan option: Alternative approach to the employer buy-in or voucher approach using insurance regulation to make low income benchmark plans available through group health plans.** *(Would work where employers offer at least one insured [as opposed to self-insured] plan.)*

This approach requires group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state “benchmark” plan for low income persons.

Where carriers choose not to directly administer such a plan, they would have the option of coordinating with insurance exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)

Low-income worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the “parallel” product, less the employer and (subsidized) worker contributions.

- d) **“No Firewall”:** **Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.**

This option provides very good “horizontal equity” in that it gives people with the same incomes equitable access to publicly subsidized coverage. Doing so may be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions. This approach is similar to the Committee recommendation but does not have a financing mechanism to recapture potentially lost employer contributions.

- e) **“Firewall”:** **Deny eligibility for subsidies to anyone who is offered employer coverage.**

This approach attempts to conserve limited state funds by maintaining existing employer responsibility /contributions

But would result in either:

- ❖ Some low-income workers with employer coverage paying more out of pocket than they can afford, or
- ❖ Increased number of uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

The following options were discussed, but are not recommended:

- f) **“Firewall with Premium Assistance”**: As a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make “premium assistance” payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

This approach has very good “horizontal equity” but is more expensive than a firewall, and if broad-scale premium assistance “fills in” for shortfall of employer contributions relative to the premium it creates strong incentives to lower employer contributions.

Maintaining employer contributions along with state contributions would be very difficult to administer as obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult.

To make this more feasible, the state might:

- ❖ Require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal. This could be easier for the state and for employers, but would not include employers who offer only self-insured plans, or
- ❖ Require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays. This might be a requirement except where an employer provides such information through its insurer or Third Party Administrator.

This alternative can be more difficult yet if supplemental or “wrap-around” coverage is to be provided, since employer plans vary considerably. It also requires the system to make “premium assistance” payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification)

