

DRAFT AGENDA

**Cost Sharing Workgroup
Clackamas Community College Wilsonville Training Center
Room 112
Wilsonville, Oregon
May 27, 2010**

(All agenda items are subject to change and times listed are approximate)

- I. Call to Order 8:00 am
- II. Purpose of Meeting – Jeanene Smith 8:05 am
- III. Value-Based Services – Som Saha 8:15 am
- IV. Examples of Silver Plans at Different Income Levels – Darren Coffman 8:30 am
- V. Impact of Federal Health Reform on Affordability – Jason Gingerich 9:00 am
- VI. Discussion 9:15 am
- VII. Next Steps 9:40 am
- VIII. Public comment..... 9:55 am
- IX. Adjournment..... 10:00 am

Minutes

**Cost Sharing Workgroup
Meridian Park Hospital
Health & Education Center Room 104
Tualatin, Oregon
March 25, 2010**

Members Present: Ellen Lowe, Co-Chair; Susan Rasumssen; Dick Smith; Bob Joondeph; Janet Meyer; Kathy Savicki; Jami Thielman; Alison Little, MD, MPH; Diane Rushcamp; Jackie Shaw (via teleconference).

Members Absent: Som Saha, MD, MPH, Co-Chair; Ralph Nauman.

Staff Present: Jeanene Smith, MD, MPH; Ariel Smits, MD, MPH; Kelly Harms; Jason Gingerich.

Guests: Dana Tierney & Brandon Emerson, Regence; Kathleen Greenfield & Jerry Greenfield, DPO Health Caucus; Dayna Steringer, Family Care.

I. Call to Order

Ms. Ellen Lowe called the workgroup to order at 9:05 am in room 104 of Meridian Park Hospital's Health & Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. She asked the group members to introduce themselves.

II. Purpose of Workgroup

Dr. Jeanene Smith stated that the recent federal health reform passage may affect this workgroup's scope. One directive from House Bill 2009 is to design a health benefit package that could be used for Oregon's health insurance exchange. The report is due to the Oregon Health Policy Board (OHPB) by June and should include the following provisions as specified by HB 2009 (2009):

- 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.

III. OHFB Benefits Committee Recommendations

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. Examples include routine blood work for diabetes management, mammograms and generic blood pressure medications.

Tier I examples: Maternity care, Life-threatening newborn conditions, Life-threatening chronic diseases (diabetes, asthma and major depression), Imminently life-threatening conditions (GI bleed, head injury) and Public health concerns (TB, syphilis).

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

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

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

Excluded Conditions: Infertility, cosmetic surgery, sex reassignment surgery.

IV. Prioritized List of Health Services

The Health Services Commission (HSC), established in 1989, 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 who analyze health conditions and treatments and rank them according to importance based on a number of factors, including comparative effectiveness research studies, prevention and population effects.

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.

V. Cost Sharing Issues

The OHFB's Enrollment & Eligibility Committee discussed and debated various approaches to defining affordability, fairness to individuals in similar financial circumstances (horizontal equity), and program sustainability such as:

- Shared Responsibility: 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.
- State subsidies would limit members' premium to 5% of income and should phase out at 300% of the federal poverty level with no "cliffs" for small income increases.
- 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 when they lose their direct state contribution.

Many insurance and health plans use cost-containment techniques to keep premiums affordable and plans sustainable. Some examples are:

- Co-pays which do not apply to a high deductible.
- Service/visit limits.
- Medication step therapy.
- Raise out-of-pocket (OOP) limit.
- Benefit limits (*limit costs for certain services: Bariatric surgery, transplants, DME, ambulance, mental health, alcohol & chemical dependency, rehab*).
- Lower/raise cost share based on condition.
- Co-payment instead of deductible.

Federal Reform:

Insurance exchange, federal requirements

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

Affordability

- Increases the number of people eligible for OHP.

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

VI. Discussion

The members expressed their concern over consumer costs and their desire to make out-of-pocket costs more transparent. Set co-pays seem to be more desirable than paying a percentage of costs. There is a real need for transparency to the consumer.

There is a consensus that changes will have to be made in the delivery system to make this work possible.

VII. Next Steps

Key decisions to strike a balance between Oregon's goals and Federal reform:

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

Future meetings:

- April 15, 2010
 - Discussion of guiding principles, objectives and alignment with federal requirements.
- May (TBD)
 - Determine cost sharing structure for insurance exchange benefit package for pricing.
 - Consider how to apply to other settings.
 - Actuarial review.
- Early June (TBD)
 - Review actuarial work and make final recommendation to OHPB.

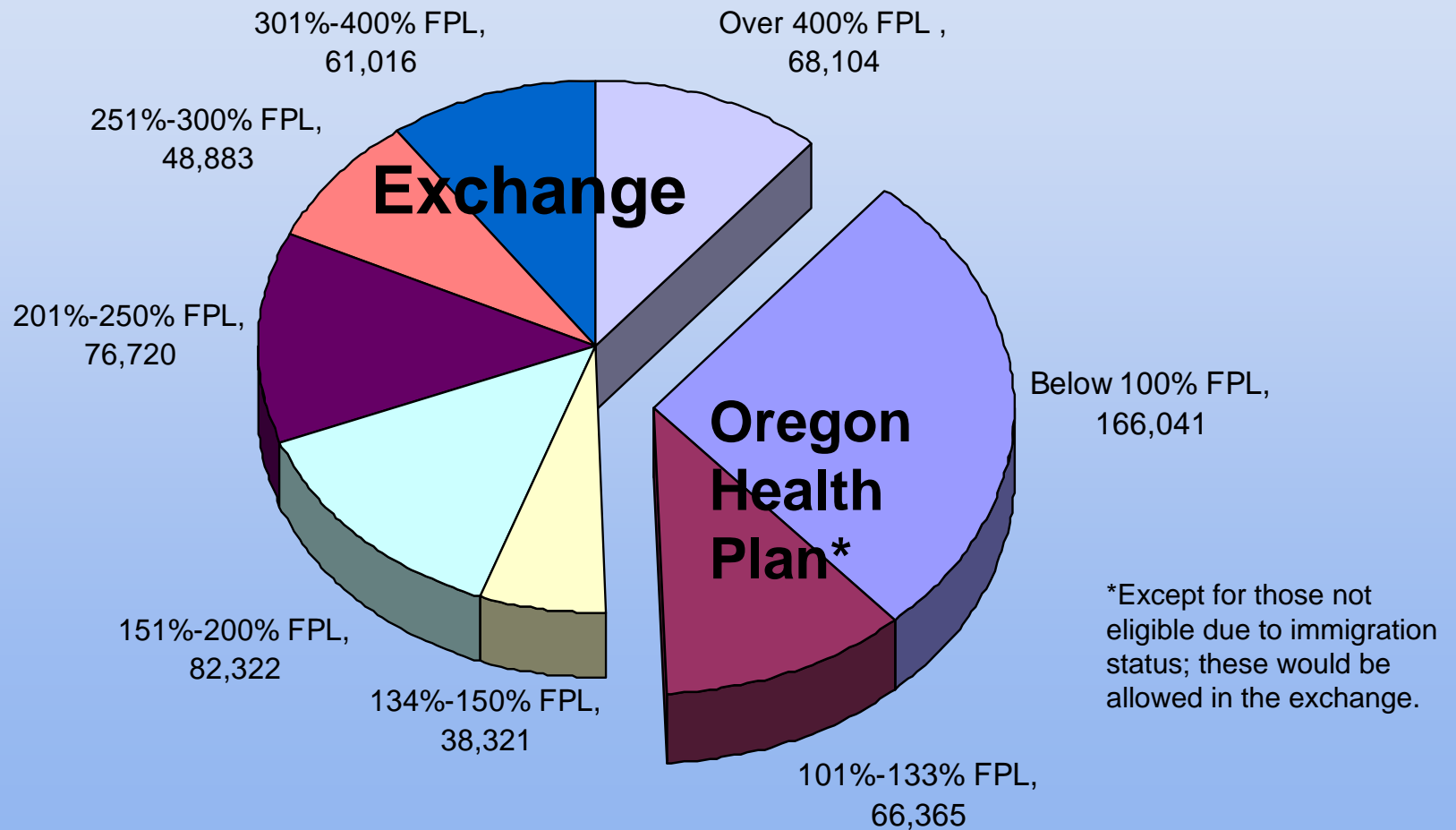
VIII. Public comment

No public comment was offered at this time.

IX. Adjournment

Ms. Ellen Lowe adjourned the workgroup at 11:00 am.

Oregonians with No Health Insurance Coverage, 2008



Source: American Community Survey, 2008.

Standard Commercial Design Features

- No cost share for some preventive services
- Single coinsurance for most services
 - May be in the form of copays for office visits
- See page 8 of handout

DRAFT Sample Commercial Silver Benefit Plan Description
70% Actuarial Value
>250% Federal Poverty Level

Plan Year individual deductible	\$1,700
Out-of-pocket maximum	\$5,950

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> • Some preventive care 	None
Prescription drugs <small>(Copays provide for up to a 30-day supply)</small>	
<ul style="list-style-type: none"> • Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> • Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
<ul style="list-style-type: none"> • Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 50% or \$50 copay
Emergency services <small>(copays waived if admitted or if transport criteria are met)</small>	
<ul style="list-style-type: none"> • Ambulance 	\$150 copay
<ul style="list-style-type: none"> • Emergency services 	\$150 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services	
<ul style="list-style-type: none"> • Value-based services • Other preventive care • Comfort care • Professional services • Hospital services • DME & supplies 	30%
Diagnostic services	
<ul style="list-style-type: none"> • Basic, Intermediate, Advanced 	30%

DRAFT Sample Commercial Silver Benefit Plan Description
73% Actuarial Value
200-250% Federal Poverty Level

Plan Year individual deductible	\$1,750
Out-of-pocket maximum	\$4,075

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> • Some preventive care 	None
Prescription drugs (Copays provide for up to a 30-day supply)	
<ul style="list-style-type: none"> • Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> • Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
<ul style="list-style-type: none"> • Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 50% or \$50 copay
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<ul style="list-style-type: none"> • Emergency services 	\$150 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services	
<ul style="list-style-type: none"> • Value-based services • Other preventive care • Comfort care • Professional services • Hospital services • DME & supplies 	30%
Diagnostic services	
<ul style="list-style-type: none"> • Basic, Intermediate, Advanced 	30%

DRAFT Sample Commercial Silver Benefit Plan Description
87% Actuarial Value
151-200% Federal Poverty Level

Plan Year individual deductible	\$275
Out-of-pocket maximum	\$1,600

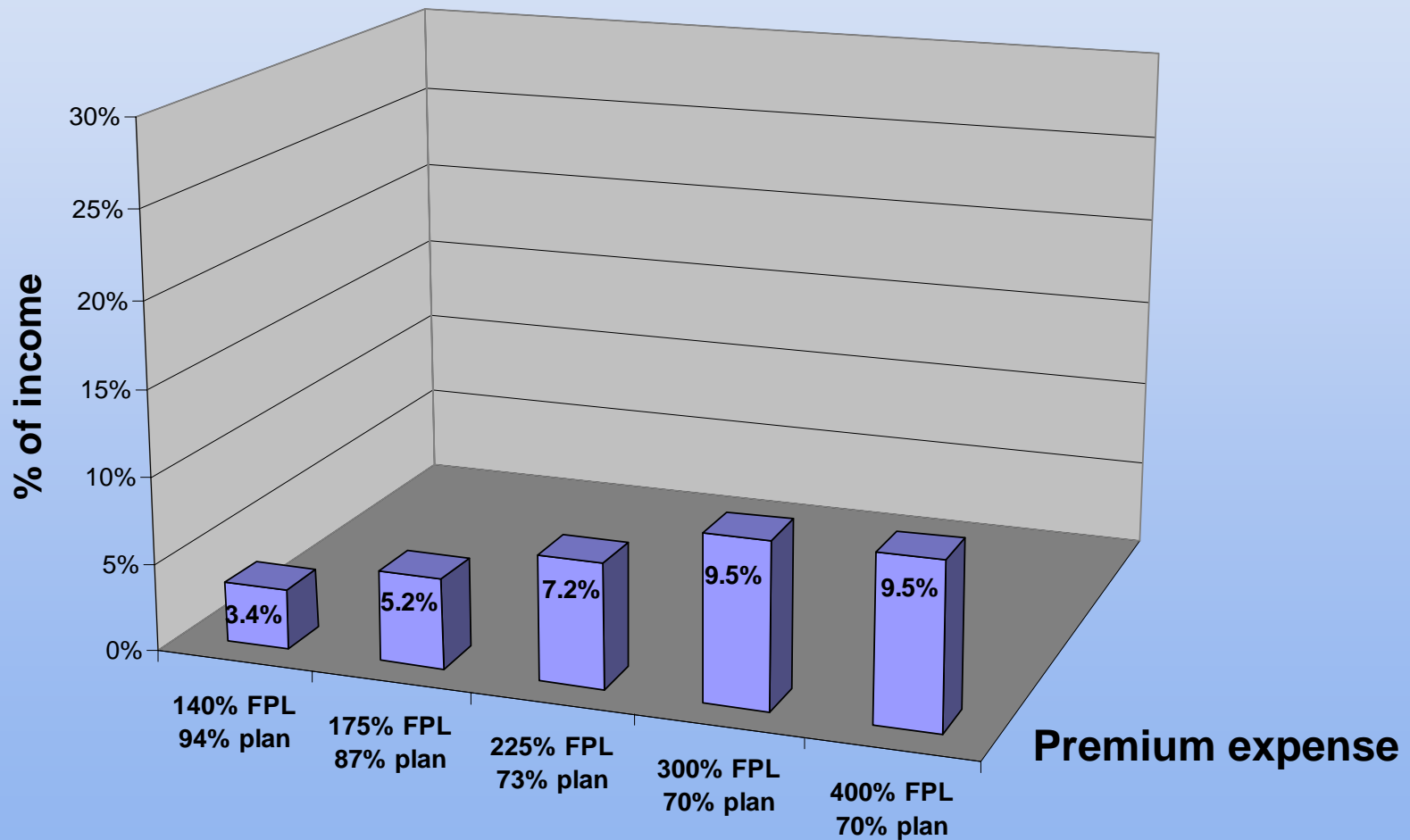
DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> • Some preventive care 	None
Prescription drugs <small>(Copays provide for up to a 30-day supply)</small>	
<ul style="list-style-type: none"> • Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> • Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
<ul style="list-style-type: none"> • Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 50% or \$50 copay
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<ul style="list-style-type: none"> • Ambulance 	\$100 copay
<ul style="list-style-type: none"> • Emergency services 	\$100 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services	
<ul style="list-style-type: none"> • Value-based services • Other preventive care • Comfort care • Professional services • Hospital services • DME & supplies 	30%
Diagnostic services	
<ul style="list-style-type: none"> • Basic, Intermediate, Advanced 	30%

DRAFT Sample Commercial Silver Benefit Plan Description
94% Actuarial Value
100-150% Federal Poverty Level

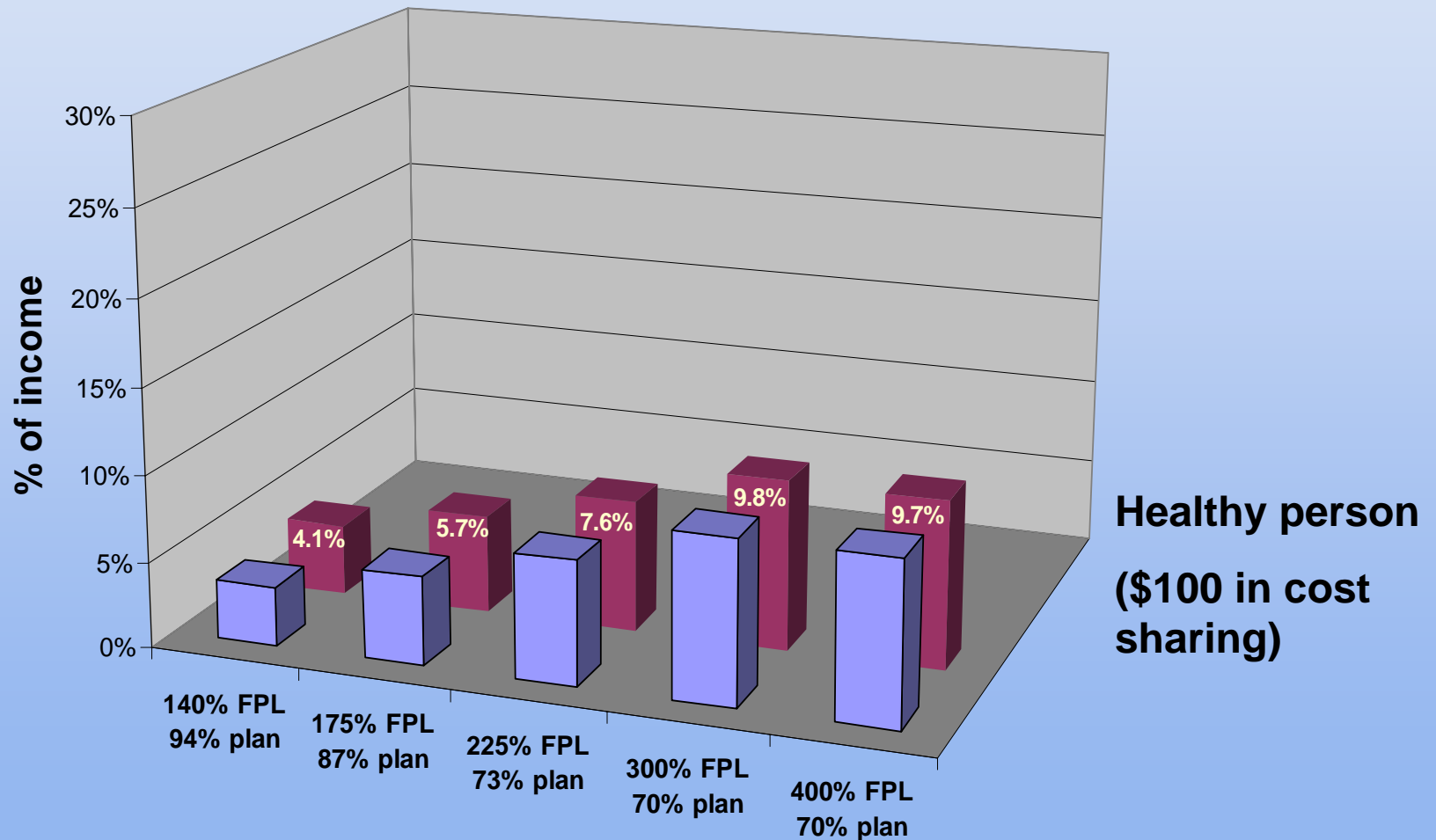
Plan Year individual deductible	\$150
Out-of-pocket maximum	\$750

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> • Some preventive care 	None
Prescription drugs <small>(Copays provide for up to a 30-day supply)</small>	
<ul style="list-style-type: none"> • Tier 1: Generic 	Lesser of \$5 copay or 50%
<ul style="list-style-type: none"> • Tier 2: Preferred brands for most appropriate conditions 	\$10 copay
<ul style="list-style-type: none"> • Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 20% or \$20 copay
Emergency services <small>(copays waived if admitted or if transport criteria are met)</small>	
<ul style="list-style-type: none"> • Ambulance 	\$50 copay
<ul style="list-style-type: none"> • Emergency services 	\$50 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services	
<ul style="list-style-type: none"> • Value-based services • Other preventive care • Comfort care • Professional services • Hospital services • DME & supplies 	10%
Diagnostic services	
<ul style="list-style-type: none"> • Basic, Intermediate, Advanced 	10%

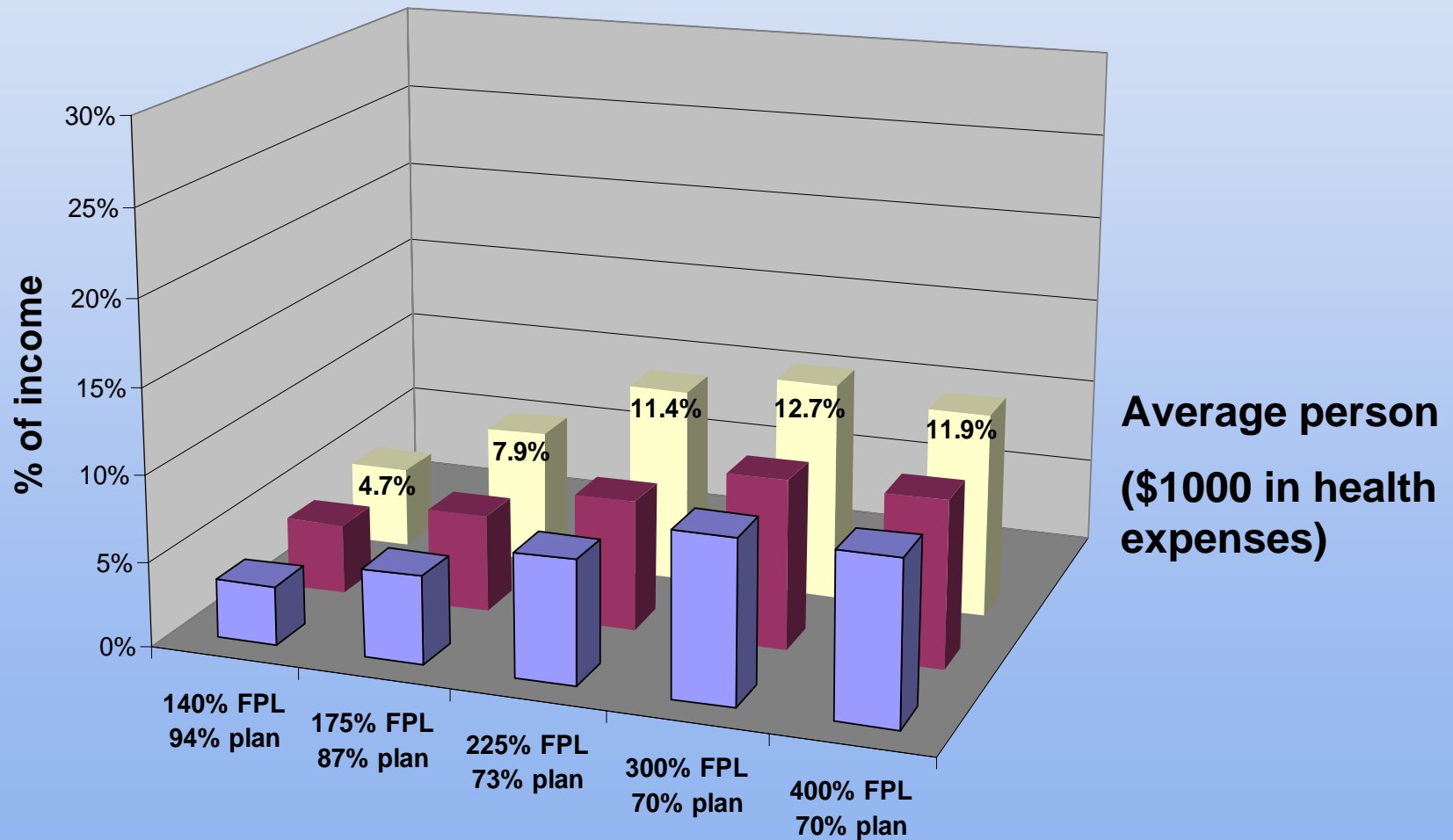
Premium and estimated cost sharing under federal reform



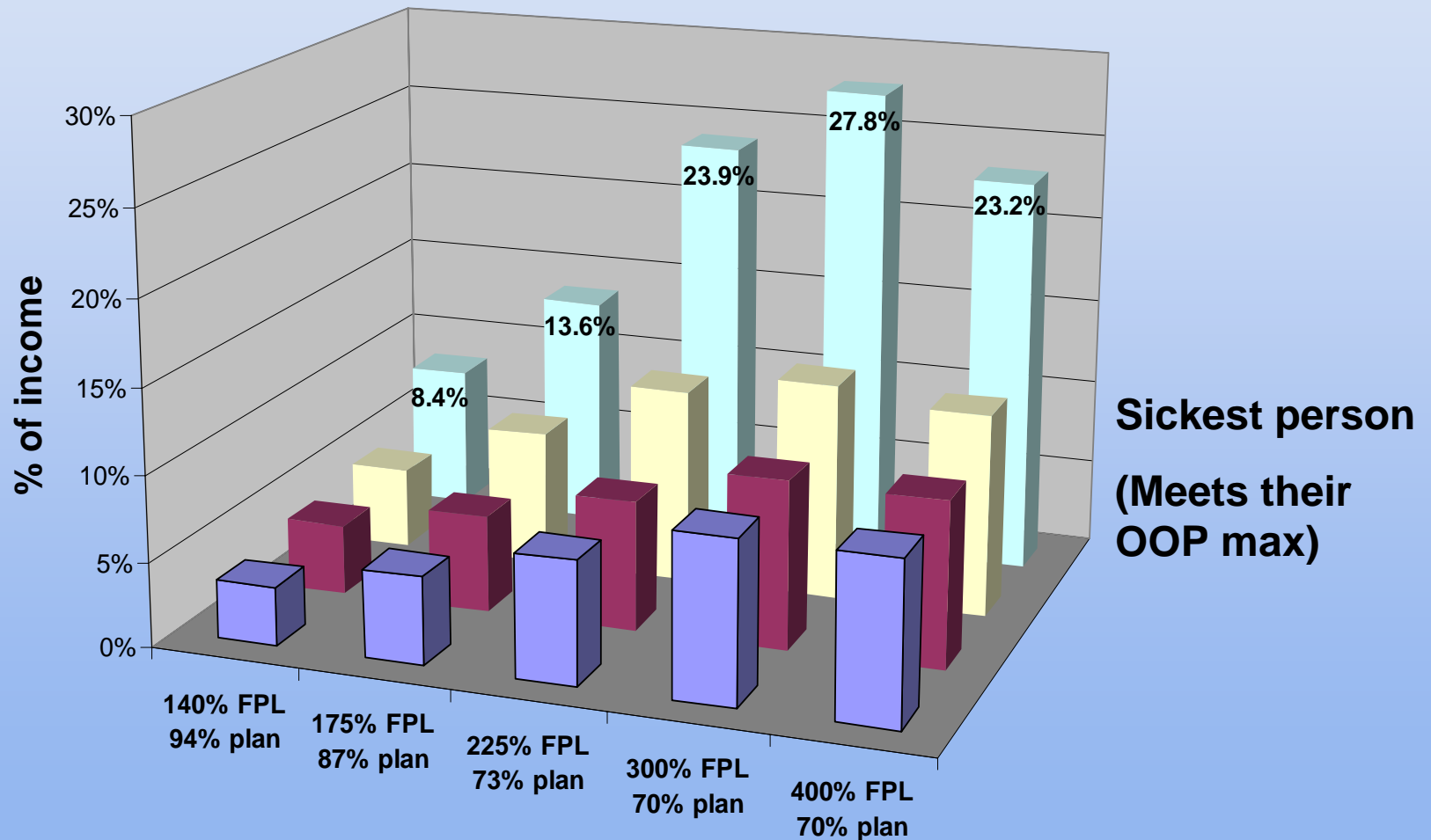
Premium and estimated cost sharing under federal reform



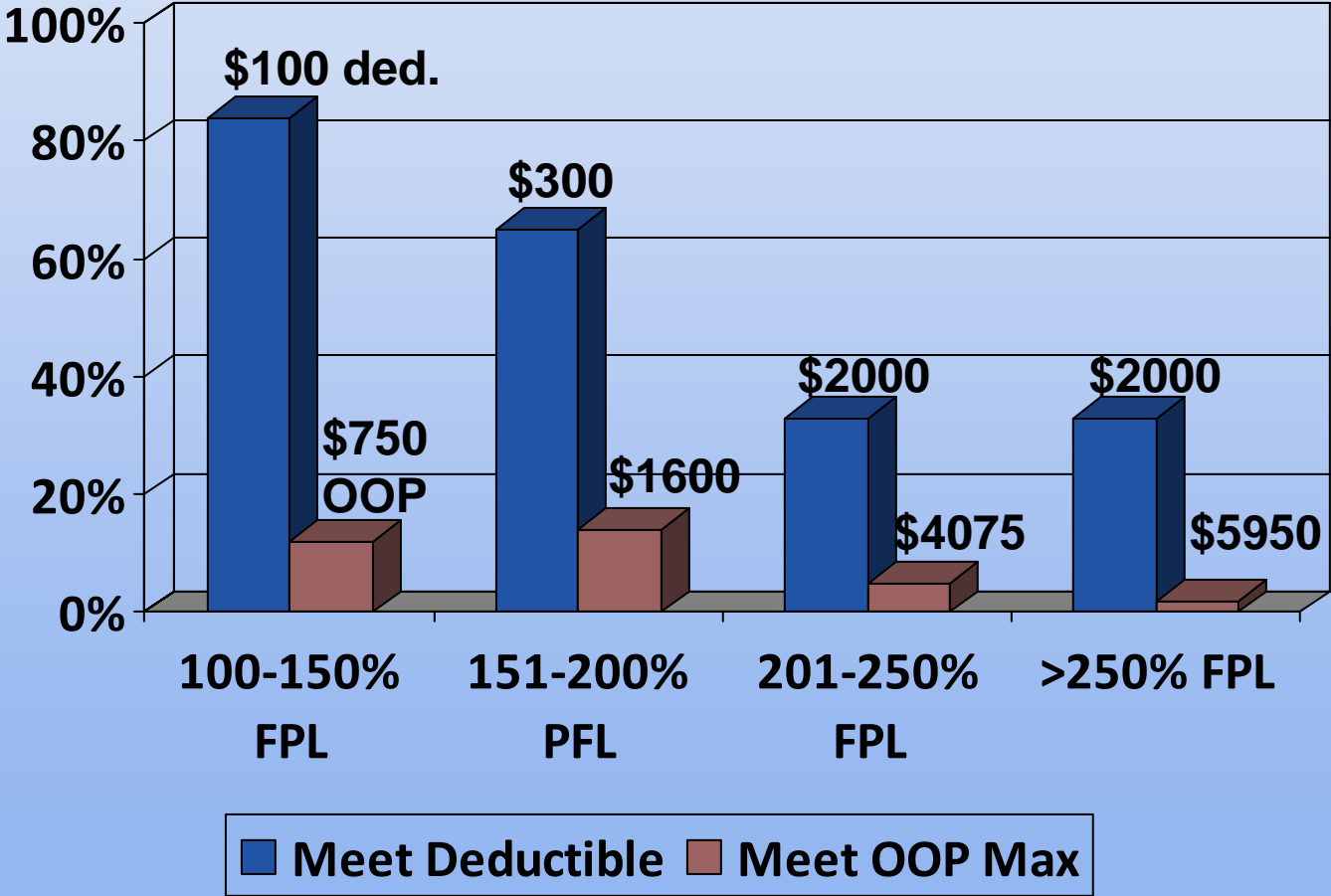
Premium and estimated cost sharing under federal reform



Premium and estimated cost sharing under federal reform



What percent of people would meet their deductible/out-of-pocket max?



Value-Based Benefit Design Features

- No cost share for:
 - Value-based services
 - Basic diagnostic services
 - Comfort care
- Value-based formulary
- Tiered coinsurance
 - Lower cost share on more beneficial services
- See page 18 of handout

**DRAFT Sample Value-Based Silver Benefit Plan Description
70% Actuarial Value (>250% Federal Poverty Level)**

Plan Year individual deductible	\$2,000
Out-of-pocket maximum	\$5,950

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> Value-based and preventive services 	None
<ul style="list-style-type: none"> Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays) 	None
<ul style="list-style-type: none"> Comfort care 	None
Prescription drugs¹ (Copays provide for up to a 30-day supply)	
<ul style="list-style-type: none"> Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
<ul style="list-style-type: none"> Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 50% or \$50 copay
Emergency services (copays waived if admitted or if transport criteria are met)	
<ul style="list-style-type: none"> Ambulance 	\$150 copay
<ul style="list-style-type: none"> Emergency services 	\$150 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services²	
<ul style="list-style-type: none"> Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury) 	10%
<ul style="list-style-type: none"> Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury) 	30%
<ul style="list-style-type: none"> Tier 3 (Primarily includes effective care for non-life threatening illness or injury) 	50%
<ul style="list-style-type: none"> Tier 4 (Less effective care & care for self-limited illness or minor injury) 	70%
Other Diagnostic services	
<ul style="list-style-type: none"> Intermediate (e.g. CT, MRI) 	30%
<ul style="list-style-type: none"> Advanced (e.g. PET scan) 	50%

¹ Drug formulary will be based on evidence, such as the Drug Effectiveness Review Project (DERP). This will require pharmacy benefit managers to track diagnosis codes.

² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.

Service Tiers in the Sample Value-Based Benefit Plan

Services Not Subject to the Deductible

Priority Services:

- Value-Based Services - Services that should be provided with no cost sharing in order to maximize population health that meet the following criteria:
 - Ambulatory (i.e. outpatient) services, including 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 clinical benefit, supported by at least one systematic review of evidence
 - Cost-effective
 - Reduces hospitalizations or Emergency Department visits, reduces future exacerbations or illness progression, or improves quality of life
 - Low cost up front
 - Ideally highly utilized
 - Low risk for overutilization
- Preventive Services – Services with a level A or B recommendation by the U.S. Preventive Services Task Force
- Basic Diagnostic Services
 - Well-person visits according to approved schedules
 - Two diagnostic primary care visits per year
 - X-rays
 - Basic labs (i.e., labs ordered by a primary care provider)
- Comfort Care
 - Hospice care
 - Palliative care

Prescription Drugs:

- Tier 1:
 - Generics
- Tier 2:
 - Preferred brands prescribed for the most appropriate conditions
- Tier 3:
 - Non-preferred brands
 - Preferred brands prescribed for less appropriate conditions

Emergency Services:

- Ambulance Services
 - Copay waived if transport criteria is met
- Emergency Department
 - Copay waived if admitted

Services Subject to the Deductible

General Services:

- Tier I: Preventive Services & the Most Effective Care for Severe Chronic Disease and Life-Threatening Illness and Injury
 - Preventive services
 - Pregnancy and delivery
 - Alcohol and drug treatment
 - Life-threatening newborn conditions (e.g., very low birthweight/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: Effective Care for Other Chronic Disease & Life-Threatening Illness and Injury
 - 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: Effective Care for Non-Life-Threatening Illness and Injury
 - 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: Less Effective Care & Care for Self-Limiting Illness and Minor Injury
 - 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)

Other Diagnostic Services:

- Intermediate diagnostic services
 - Additional primary care diagnostic visits
 - Specialty care diagnostic visits
 - Inpatient diagnostic work-ups
 - Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans
 - Intermediate lab tests (i.e., labs ordered by a specialty care provider)
- Advanced diagnostic services
 - Positron Emission Tomography (PET) scans
 - Advanced lab tests (i.e., labs with little evidence for utility)

**DRAFT Sample Value-Based Silver Benefit Plan Description
73% Actuarial Value (201-250% Federal Poverty Level)**

Plan Year individual deductible	\$2,000
Out-of-pocket maximum	\$4,075

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> Value-based and preventive services 	None
<ul style="list-style-type: none"> Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays) 	None
<ul style="list-style-type: none"> Comfort care 	None
Prescription drugs¹ (Copays provide for up to a 30-day supply)	
<ul style="list-style-type: none"> Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
<ul style="list-style-type: none"> Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 50% or \$50 copay
Emergency services (copays waived if admitted or if transport criteria are met)	
<ul style="list-style-type: none"> Ambulance 	\$150 copay
<ul style="list-style-type: none"> Emergency services 	\$150 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services²	
<ul style="list-style-type: none"> Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury) 	10%
<ul style="list-style-type: none"> Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury) 	30%
<ul style="list-style-type: none"> Tier 3 (Primarily includes effective care for non-life threatening illness or injury) 	50%
<ul style="list-style-type: none"> Tier 4 (Less effective care & care for self-limited illness or minor injury) 	70%
Other Diagnostic services	
<ul style="list-style-type: none"> Intermediate (e.g. CT, MRI) 	30%
<ul style="list-style-type: none"> Advanced (e.g. PET scan) 	50%

¹ Drug formulary will be based on evidence, such as the Drug Effectiveness Review Project (DERP). This will require pharmacy benefit managers to track diagnosis codes.

² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.

**DRAFT Sample Value-Based Silver Benefit Plan Description
87% Actuarial Value (151-200% Federal Poverty Level)**

Plan Year individual deductible	\$300
Out-of-pocket maximum	\$1,600

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> Value-based and preventive services 	None
<ul style="list-style-type: none"> Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays) 	None
<ul style="list-style-type: none"> Comfort care 	None
Prescription drugs¹ (Copays provide for up to a 30-day supply)	
<ul style="list-style-type: none"> Tier 1: Generic 	Lesser of \$10 copay or 50%
<ul style="list-style-type: none"> Tier 2: Preferred brands for most appropriate conditions 	\$30 copay
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Emergency services (copays waived if admitted or if transport criteria are met)	
<ul style="list-style-type: none"> Ambulance 	\$100 copay
<ul style="list-style-type: none"> Emergency services 	\$100 copay
DEDUCTIBLE APPLIES	
Service	Member share
General services²	
<ul style="list-style-type: none"> Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury) 	10%
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Other Diagnostic services	
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² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.

**DRAFT Sample Value-Based Silver Benefit Plan Description
94% Actuarial Value (100-150% Federal Poverty Level)**

Plan Year individual deductible	\$100
Out-of-pocket maximum	\$750

DEDUCTIBLE DOES NOT APPLY	
Service	Member share
Priority services	
<ul style="list-style-type: none"> Value-based and preventive services 	None
<ul style="list-style-type: none"> Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays) 	None
<ul style="list-style-type: none"> Comfort care 	None
Prescription drugs¹ <small>(Copays provide for up to a 30-day supply)</small>	
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<ul style="list-style-type: none"> Tier 2: Preferred brands for most appropriate conditions 	\$10 copay
<ul style="list-style-type: none"> Tier 3: Non-preferred brands or preferred brands for less appropriate conditions 	Greater of 20% or \$20 copay
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<ul style="list-style-type: none"> Emergency services 	\$50 copay
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Service	Member share
General services²	
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<ul style="list-style-type: none"> Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury) 	10%
<ul style="list-style-type: none"> Tier 3 (Primarily includes effective care for non-life threatening illness or injury) 	20%
<ul style="list-style-type: none"> Tier 4 (Less effective care & care for self-limited illness or minor injury) 	40%
Other Diagnostic services	
<ul style="list-style-type: none"> Intermediate (e.g. CT, MRI) 	10%
<ul style="list-style-type: none"> Advanced (e.g. PET scan) 	20%

¹ Drug formulary will be based on evidence, such as the Drug Effectiveness Review Project (DERP). This will require pharmacy benefit managers to track diagnosis codes.

² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.

**DRAFT Comparison of Sample Value-Based and Commercial Standard Silver Benefit Plans
For 73% and 70% Actuarial Value Plans**

	VB 70% AV	Std 70% AV	VB 73% AV	Std 73% AV
Plan year individual deductible	\$2000	\$1700	\$2,000	\$1,750
Out-of-pocket maximum	\$5950	\$5950	\$4,075	\$4,075
DEDUCTIBLE DOES NOT APPLY				
Prescription drugs				
• Tier 1	Lesser of \$10 copay or 50% ¹	Lesser of \$10 copay or 50%	Lesser of \$10 copay or 50% ¹	Lesser of \$10 copay or 50%
• Tier 2	\$30 copay ¹	\$30 copay	\$30 copay ¹	\$30 copay
• Tier 3	Greater of 50% or \$50 copay ¹	Greater of 50% or \$50 copay	Greater of 50% or \$50 copay ¹	Greater of 50% or \$50 copay
Emergency services	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Priority services				
• Preventive services	None	None	None	None
• Value-based services	None	See below	None	See below
• Basic diagnostic services				
• Comfort care				
DEDUCTIBLE APPLIES				
General services				
• Tier 1	10% ²	30%	10% ²	30%
• Tier 2	30% ²		30% ²	
• Tier 3	50% ²		50% ²	
• Tier 4	70% ²		70% ²	
Other Diagnostic services				
• Intermediate	30% ²		30% ²	
• Advanced	50% ²		50% ²	

¹ Drug formulary will be based on evidence, such as the Drug Effectiveness Review Project (DERP). This will require pharmacy benefit managers to track diagnosis codes.

² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.

**DRAFT Comparison of Sample Value-Based and Commercial Sample Silver Benefit Plans
For 94% and 87% Actuarial Value Plans**

	VB 87% AV	Std 87% AV	VB 94% AV	Std 94% AV
Plan year individual deductible	\$300	\$275	\$100	\$150
Out-of-pocket maximum	\$1600	\$1600	\$750	\$750
DEDUCTIBLE DOES NOT APPLY				
Prescription drugs				
• Tier 1	Lesser of \$10 copay or 50% ¹	Lesser of \$10 copay or 50%	Lesser of \$5 copay or 50% ¹	Lesser of \$5 copay or 50%
• Tier 2	\$30 copay ¹	\$30 copay	\$10 copay ¹	\$10 copay
• Tier 3	Greater of 50% or \$50 copay ¹	Greater of 50% or \$50 copay	Greater of 20% or \$20 copay ¹	Greater of 20% or \$20 copay
Emergency services	\$50 copay	\$100 copay	\$50 copay	\$100 copay
Priority services				
• Preventive services	None	None	None	None
• Value-based services	None	See below	None	See below
• Basic diagnostic services				
• Comfort care				
DEDUCTIBLE APPLIES				
General services				
• Tier 1	10% ²	30%	5% ²	10%
• Tier 2	30% ²		10% ²	
• Tier 3	50% ²		20% ²	
• Tier 4	70% ²		40% ²	
Other Diagnostic services				
• Intermediate	30% ²		10% ²	
• Advanced	50% ²		20% ²	

¹ Drug formulary will be based on evidence, such as the Drug Effectiveness Review Project (DERP). This will require pharmacy benefit managers to track diagnosis codes.

² Coinsurance percentages shown are for procedures and other outpatient care and may be in the form of copays for office visits. Coinsurance percentages are 5 percentage points higher for inpatient/emergency department services and 5 percentage points lower for services provided in a qualified medical home.