

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.