Oregon Health Policy Board
Health Incentives and Outcomes Committee, Payment Reform Subcommittee
AGENDA

June 10, 2010
1:00-3:00 pm

Northwest Health Foundation
221 NW 2nd Ave. Bamboo Room
Portland, Oregon

#	Time	**Item** (related materials)	Presenter(s)	Action Item
1	1:00	Welcome and introductions	Bart McMullan, Chair	
2	1:05	Approve 5/13 Meeting Summary	Bart McMullan	Y
3	1:10	Discussion of Preamble to Payment Reform Principles	Bart McMullan	Y
4	1:40	Discussion of Revised Payment Reform Principles	Bart McMullan Denise Honzel	Y
5	2:00	Gain Sharing Presentation	David Schlactus	
6	2:15	Scope of Work and Committee Updates	Jeanene Smith Gretchen Morley	
7	2:30	Public Comment	Bart McMullan	
8	2:40	Discussion of Next Steps	Bart McMullan	
9	3:00	Adjourn	Bart McMullan	

If you experience problems calling in, please call:
Judy Morrow 503-373-1538 or Gretchen Morley 503-931-3332

Meeting Materials:
1) DRAFT 5/13 Meeting Summary
2) DRAFT Payment Reform Principles and Preamble
3) Gain Sharing Presentation (to be distributed on site)
4) DRAFT Materials from Quality and Efficiency Subcommittee
5) DRAFT Materials from Cost Sharing Workgroup
6) Overview Presentation (to be distributed on site)

DRAFT

Payment Reform Subcommittee of the Health Incentives & Outcomes Committee
Meeting Summary - DRAFT

May 13, 2010
1:00 – 3:00 p.m.

Subcommittee Members in Attendance
Bart McMullan, MD, Chair, Payment Reform Subcommittee
Denise Honzel, Co-Chair, Incentives and Outcomes Committee
Chris DeMars, MPH
Megan Haase, FNP (phone)
Steve Jasperson
Robert Marsalli (phone)
William Murray (phone)
William Olson
Morgan O'Toole
Jim Russel
David Schlactus
Rick Wopat, MD (phone)

Subcommittee Members Not In Attendance
David Dorr, MD, MS
Stephanie Dreyfuss
David Labby, MD
Sujata Sanghvi

OHPR Staff in Attendance
Jeanene Smith
Lynn-Marie Crider
Gretchen Morley
Rob Stenger

Public Attendance
5 members of the general public were present for the meeting, none offered public comments.

<u>Meeting Summary</u> (**Committee actions or decisions in bold**)

Dr. McMullan convened the meeting at 1:00.

Committee approved minutes from the 4/29 meeting.

Gretchen Morley (OHPR) provided a brief update on efforts to coordinate the work of the Health Policy Board and its committees and answered questions. Key points:

- OHA is convening a monthly meeting of the chairs (or designees) and staff of all committees. In addition, the OHA communications office will produce a monthly newsletter containing an update on each committee's work that will be distributed to the Health Policy Board and all committees.
- Chris DeMars attended the first committee chairs' meeting on 5/4/10 as a representative of the PR subcommittee. Committees represented at the meeting included:
    - Incentives and Outcomes Committee
        - Payment Reform Subcommittee
        - Quality and Efficiency Subcommittee
    - State Health Improvement Plan Committee
    - Workforce Committee
    - Public Purchasers Committee
    - Safety Net Advisory Committee
    - Medicaid Advisory Committee
    - Medical Liability Task Force
    - Insurance Exchange Advisory Group
    - Health Resources Commission
    - Health Services Commission
    - Health Information Technology Oversight Committee (HITOC)
    - Administrative Simplification Advisory Group
- Legislative concepts from the Health Policy Board and Committees for the 2011 Legislative Session are due in September. Committee members discussed whether the committee should propose a legislative concept relating to antitrust protection to facilitate multi-payer collaboration on payment reform.
- The Payment Reform subcommittee will interact most closely with the Public Purchasers committee and the Quality and Efficiency subcommittee to develop and implement its recommendations.

Bart McMullan led a discussion on the Draft Payment Reform Principles (see meeting materials). Key discussion points and recommendations:

- Add a separate principle that specifically addresses cost containment.
- Accountability should be required of all parties, not just physicians/hospitals. Revise language under all principles to reflect this more inclusive notion of accountability.
- There is a tension between "transformation" and incremental payment reforms that represent improvements over the status quo. Principles should reflect that system transformation and incremental improvement are both valuable.

- Revise equity principle to focus on "evidence-based care."
- Transparency principle should focus on 3 key issues: payment method/incentives, price of treatment options (to consumers/payers), and price and quality variations.
- Distinguish clearly between "cost" and "price". Cost is internal to a provider, price is the amount paid by consumers and purchasers. Mostly we're interested in price.
- Try to link the principles more closely to the triple aim.

Robert Stenger (OHPR) provided a brief overview of Oregon data on cost, utilization and quality trends in Oregon. (Slides were distributed to committee members.) Key points raised by members of the committee:

- Current Oregon-specific data on payment is very limited.
- Comparative price information that exists for hospitals is very limited because of the lack of standardization in how hospitals bill for services (e.g. whether anesthesia charges for a surgery are billed by the hospital or separately by the physician).
- Despite being a "low cost/low utilization" State in the eyes of Medicare, Oregon is actually a fairly high cost state in the commercial insurance market.

John McConnell, PhD. (OHSU) provided an overview of Accountable Care Organizations (ACOs). (Slides were distributed to committee members). Dr. McConnell has been participating in an ACO Learning Network co-sponsored by the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. Key points and discussion questions included:

- ACOs are different from managed care in that they separate insurance/actuarial risk from performance/clinical risk and only hold the ACO accountable for performance risk.
- Any entity meeting CMS criteria as ACOs will be eligible to receive Medicare payments for ACOs starting in 2012 under the Medicare "shared savings" program. There are also more limited ACO demonstrations planned for the Medicaid program as part of Federal health reform.
- Some Oregon communities (e.g. Bend) are developing organizational relationships among health care providers that could form the basis for developing an ACO. Other regions with a large number of small independent medical practices are much further from the organizational structure needed to create an ACO.
- ACOs could be supported by a variety of payment methods, ranging from fee-for-service to capitation. Regardless of the payment method, the focus is on accountability for care outcomes.
- There are no good estimates on the amount of money that could be saved if ACOs were developed across Oregon, but early national trials in Medicare were promising in demonstrating savings.
- Primary Care Homes are an important care delivery structure within ACOs, the models fit well together.
- The Health Leadership Task Force is developing a multi-payer medical home pilot project focusing on intensive nurse management of high-risk patients in a small number of primary care clinics.

Dr. McMullan moderated a discussion among the committee regarding next steps. Key points included:

- Staff will revise payment reform principles and send out to committee members for further comment. Revised principles will be shared with the Quality and Efficiency committee.
- Staff will poll the committee on current payment problems in Oregon that fail to adhere to the draft payment reform principles and prevent progress towards the triple aim. Committee members offered several examples of problems:
    - cost shifting resulting in inequity,
    - lack of price transparency for consumers,
    - incentives to “cherry pick” healthier patients when services are underpaid.
- Committee members would like to have a more detailed understanding of federal reforms relating to payment reform.
- Committee members would appreciate the input of technical experts, such as Dr. McConnell, during future discussions about specific payment reform proposals.

Dr. McMullan adjourned the meeting at 3:00.

Guiding Principles for Payment Reform

Preamble

Oregon's health care system is unsustainable. Current financing and payment mechanisms (such as fee for service) contribute to the problems of the system by creating perverse incentives to increase the volume and intensity of services without regard to their quality, cost or impact on health. To create a more sustainable health care system, payment must reward care consistent with Oregon's triple aim goals. The transition from current payment mechanisms to those that will support a sustainable health care system must be grounded in transparent measurement of desired outcomes and guided by the following principles within the triple aim goals.

Payment Reform Principles

1. Improve the lifelong health of all Oregonians.

   ***Equity* -** Payment for health care should provide incentives for delivering evidence-based care to all people, not creating advantages or disadvantages for certain individuals or populations based on factors unrelated to medical need.

   > *Consumer perspective – I expect to be offered the same services as others with similar health needs.*

2. Increase the quality, reliability, and availability of care for all Oregonians.

   ***Accountability* -** Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's triple aim goals.

   > *Consumer perspective – I expect my providers to deliver high quality care and supportive services that meet my needs.*

   ***Transformative* -** Payment for health care should encourage innovation by aligning incentives across all payers and encouraging providers and consumers to coordinate care across the care continuum.

   > *Consumer perspective – I expect to buy health care based on value, not volume – I want the right care delivered at the right time in the right way.*

3. Lower or contain the cost of care so it is affordable to everyone.

Cost Containment **-** Payment for health care should create incentives for providers and consumers to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

Consumer perspective – I expect the health care I need to be affordable. In return, I have a responsibility to keep myself healthy to the extent that my environment allows and to use only the care I need.

Simplicity **-** Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.

Consumer perspective – I should be able to understand how my health care is paid for.

Transparency **-** Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.

Consumer perspective – I expect to know how much treatment options will cost and what value I am receiving so I can make informed decisions about my health care.

DRAFT
Purpose & principles for development of Oregon health care quality & efficiency measures
Quality and Efficiency Subcommittee, OHPB

Purpose
The Quality & Efficiency Subcommittee will develop, continuously refine, and recommend to the Oregon Health Policy Board (OHPB) a set of quality and efficiency measures that will:

• Promote public accountability, inform public policy decisions, and help drive broad-based improvements in clinical quality and efficiency for health care in Oregon;	TIMEFRAME: ongoing creation & maintenance
▪ Serve as an accessible resource for public engagement, so that patients, families, employers, and communities can participate actively in partnerships to improve health and identify and address health disparities;	TIMEFRAME: ongoing creation & maintenance
▪ Form the core of a statewide scorecard that will be used by the OHPB, policymakers, and the public to assess how well health care works in Oregon and to set goals for health care transformation and improvement;	TIMEFRAME: initial scorecard Jan. 2011
▪ Be incorporated into an Oregon Health Authority (OHA) dashboard used to monitor and manage OHA programs and set goals for future program performance; o Note: OHA programs include Medicaid, Healthy Kids, Public Health, PEBB, OEBB, the Oregon Medical Insurance Pool (OMIP), FHIAP, and Addictions & Mental Health;	TIMEFRAME: initial dashboard Jan. 2011
▪ Be translated by the Public Health Care Purchasers Committee into contacting language to be embedded in OHA health care purchasing contracts; and	TIMEFRAME: draft report in June; final in September
▪ Inspire the work of the Payment Reform subcommittee and private sector groups by providing measureable targets for potential payment reform initiatives.	TIMEFRAME: as soon as possible

Approach
In developing measures, the subcommittee will endeavor to balance the following principles:

- Focus on what can practically and usefully be measured in the short term but also consider longer-term goals, so that the short-term work moves Oregon toward a redesigned healthcare system that produces optimal health for all;
- Make use of the best data sources and measurement methodologies that are currently available, while also identifying sources that may provide better information in the future (e.g. EHRs);

- Utilize previous quality and efficiency measurement initiatives (e.g., patient-centered primary care home standards)
- Collaborate and maximize alignment with the wide range of health care quality & efficiency stakeholders;
- Balance the benefit of collecting and reporting quality or efficiency information against the burden it may create for providers and healthcare systems;
- Be as transparent as possible, both in the measures and standards identified as well as the process for identifying them;
- Provide meaningful information that is actionable by policymakers, consumers, communities, employers, and other stakeholders.

The subcommittee will ensure that its recommended measures:

- Are few in number, providing the only the most critical information;
- Focused on outcomes (as opposed to process or structural measures) for individuals & populations;
- Allow for assessment of inequities;

and, to the extent possible, that its recommended measures:

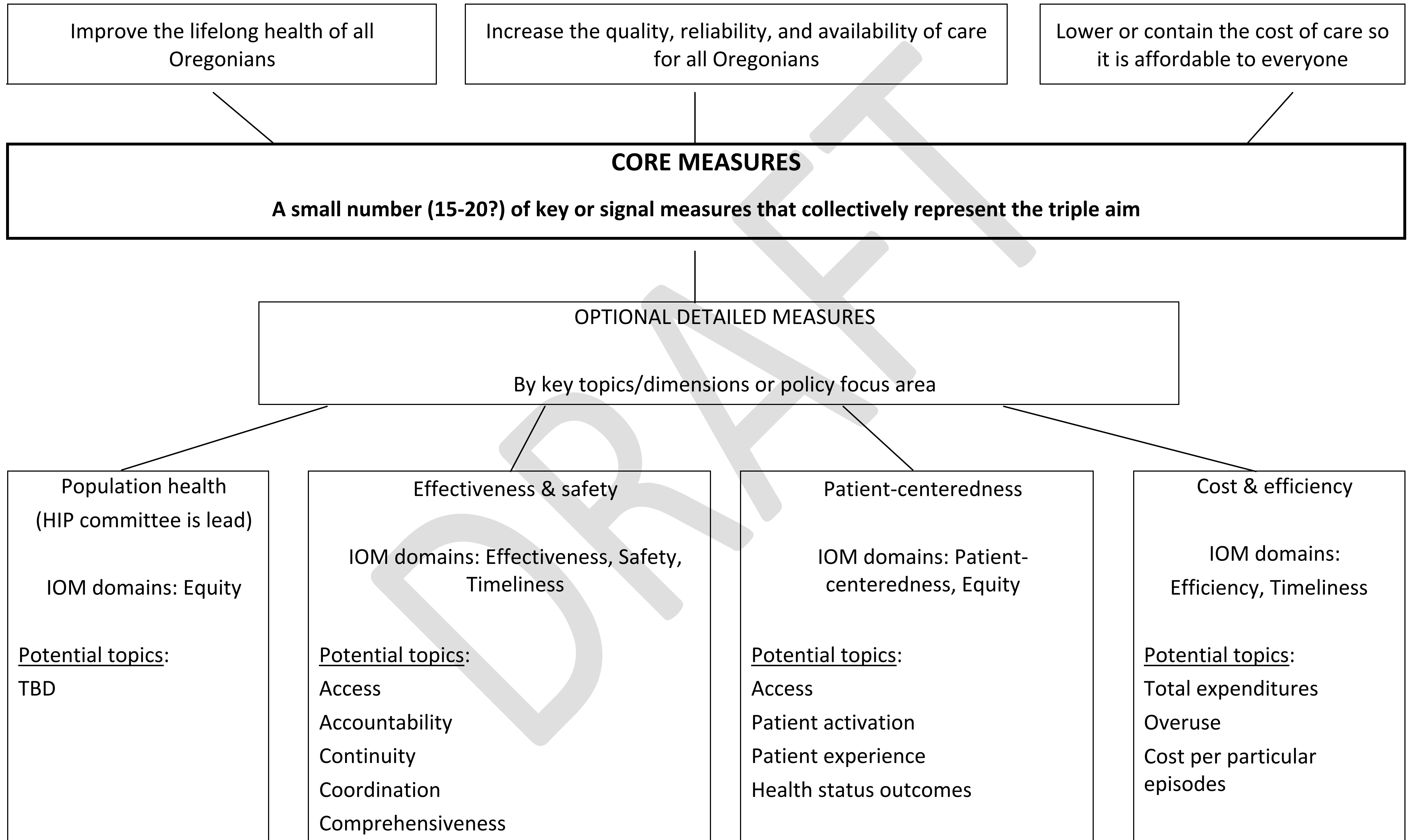
- Are nationally validated/approved (e.g. endorsed by NQF); and
- Allow for meaningful comparisons to other states or systems.

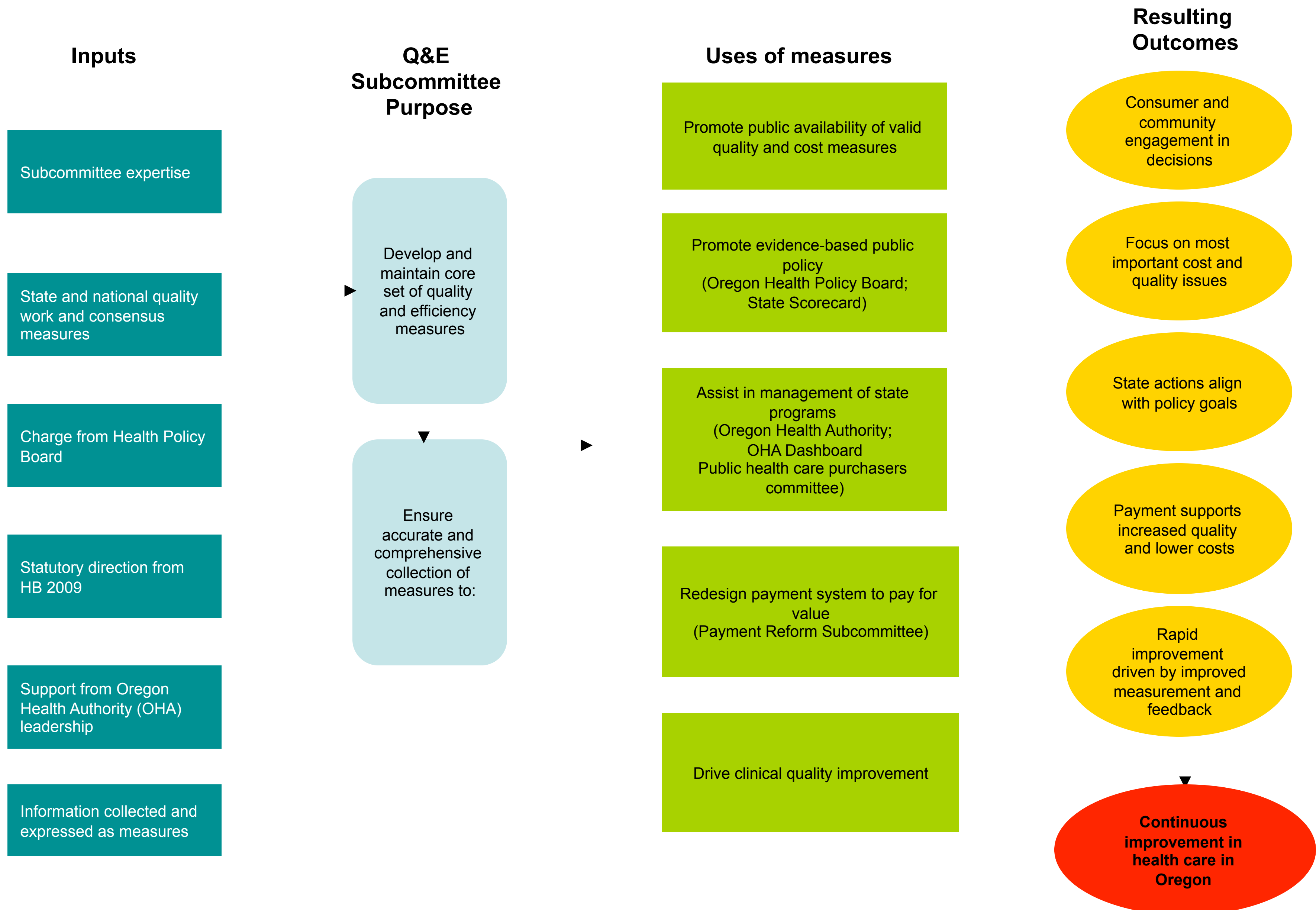
Sources Referenced: (1) Incentives & Outcomes Committee charter; (2) Oregon Health Fund Board Quality Institute Workgroup report to Delivery Systems Committee; (3) Consumer-Purchaser Disclosure Project: 7 Key Measurement Issues; (4) Minnesota Dept. of Health - final recommendations on quality measures for public reporting; (5) QualityCorp Guiding principles for health care quality measurement and reporting initiative.

****WORKING DOCUMENT – DRAFT Metric Structure Visual****

VISION

Triple Aim for Oregon:




DRAFT logic model for work of Quality & Efficiency Subcommittee
Incentives and Outcomes Committee, Oregon Health Policy Board
Inputs
Subcommittee expertise
State and national quality work and consensus measures
Charge from Health Policy Board
Statutory direction from HB 2009
Support from Oregon Health Authority (OHA) leadership
Information collected and expressed as measures
Q&E Subcommittee Purpose
Develop and maintain core set of quality and efficiency measures
Ensure accurate and comprehensive collection of measures to:
Uses of measures
Promote public availability of valid quality and cost measures
Promote evidence-based public policy (Oregon Health Policy Board; State Scorecard)
Assist in management of state programs (Oregon Health Authority; OHA Dashboard Public health care purchasers committee)
Redesign payment system to pay for value (Payment Reform Subcommittee)
Drive clinical quality improvement
Resulting Outcomes
Consumer and community engagement in decisions
Focus on most important cost and quality issues
State actions align with policy goals
Payment supports increased quality and lower costs
Rapid improvement driven by improved measurement and feedback
Continuous improvement in health care in Oregon

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 (osteomylitis, 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.

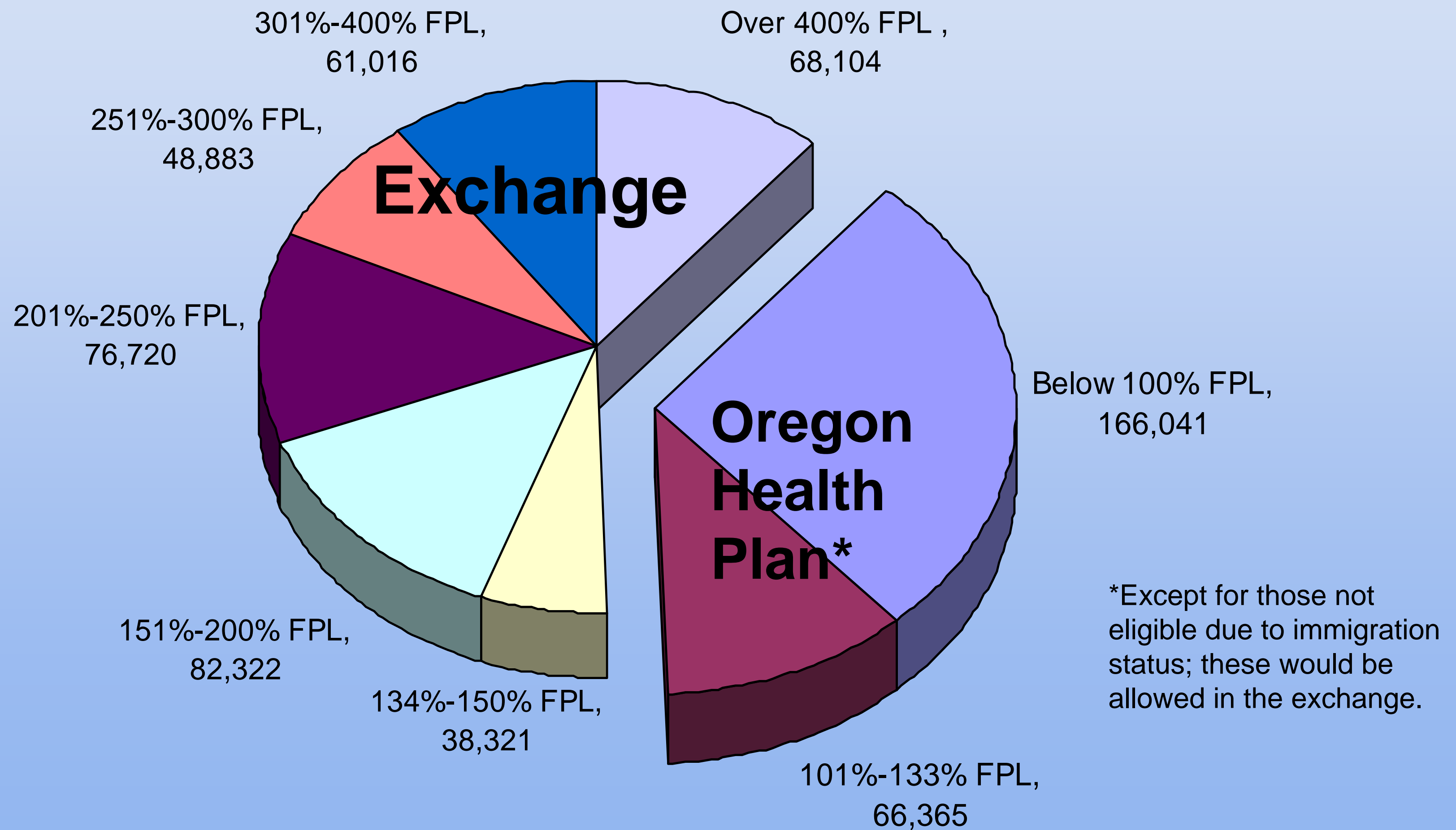
VIII. Public comment

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

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	
• Value-based and preventive services	None
• Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays)	None
• Comfort care	None
Prescription drugs[1] (Copays provide for up to a 30-day supply)	
• Tier 1: Generic	Lesser of $10 copay or 50%
• Tier 2: Preferred brands for most appropriate conditions	$30 copay
• 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)	
• Ambulance	$150 copay
• Emergency services	$150 copay
DEDUCTIBLE APPLIES	
Service	**Member share**
General services[2]	
• Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury)	10%
• Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury)	30%
• Tier 3 (Primarily includes effective care for non-life threatening illness or injury)	50%
• Tier 4 (Less effective care & care for self-limited illness or minor injury)	70%
Other Diagnostic services	
• Intermediate (e.g. CT, MRI)	30%
• 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, dysthmia)
  - 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	
• Value-based and preventive services	None
• Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays)	None
• Comfort care	None
Prescription drugs[1] (Copays provide for up to a 30-day supply)	
• Tier 1: Generic	Lesser of $10 copay or 50%
• Tier 2: Preferred brands for most appropriate conditions	$30 copay
• 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)	
• Ambulance	$150 copay
• Emergency services	$150 copay
DEDUCTIBLE APPLIES	
Service	**Member share**
General services[2]	
• Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury)	10%
• Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury)	30%
• Tier 3 (Primarily includes effective care for non-life threatening illness or injury)	50%
• Tier 4 (Less effective care & care for self-limited illness or minor injury)	70%
Other Diagnostic services	
• Intermediate (e.g. CT, MRI)	30%
• 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	
• Value-based and preventive services	None
• Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays)	None
• Comfort care	None
Prescription drugs[1] (Copays provide for up to a 30-day supply)	
• Tier 1: Generic	Lesser of $10 copay or 50%
• Tier 2: Preferred brands for most appropriate conditions	$30 copay
• 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)	
• Ambulance	$100 copay
• Emergency services	$100 copay
DEDUCTIBLE APPLIES	
Service	**Member share**
General services[2]	
• Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury)	10%
• Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury)	30%
• Tier 3 (Primarily includes effective care for non-life threatening illness or injury)	50%
• Tier 4 (Less effective care & care for self-limited illness or minor injury)	70%
Other Diagnostic services	
• Intermediate (e.g. CT, MRI)	30%
• 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
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	
• Value-based and preventive services	None
• Basic diagnostic services (well-person, 2 office visits per year, plus basic office labs and x-rays)	None
• Comfort care	None
Prescription drugs[1] (Copays provide for up to a 30-day supply)	
• Tier 1: Generic	Lesser of $5 copay or 50%
• Tier 2: Preferred brands for most appropriate conditions	$10 copay
• Tier 3: Non-preferred brands or preferred brands for less appropriate conditions	Greater of 20% or $20 copay
Emergency services (copays waived if admitted or if transport criteria are met)	
• Ambulance	$50 copay
• Emergency services	$50 copay
DEDUCTIBLE APPLIES	
Service	**Member share**
General services[2]	
• Tier 1 (Primarily includes preventive services & the most effective care for severe chronic disease and life-threatening illness or injury)	5%
• Tier 2 (Primarily includes effective care for other chronic disease and life-threatening illness or injury)	10%
• Tier 3 (Primarily includes effective care for non-life threatening illness or injury)	20%
• Tier 4 (Less effective care & care for self-limited illness or minor injury)	40%
Other Diagnostic services	
• Intermediate (e.g. CT, MRI)	10%
• 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.