

The Essential Benefit Package

Recommendations of the
Oregon Health Fund Board's
Benefits Committee

June 25, 2008

Committee Membership

- **Gary Allen, DMD**
- **Lisa Dodson, MD**
- **Tom Eversole**
- **Leda Garside, RN, BSN**
- **Betty Johnson**
- **Bob Joondeph**
- **Susan King, RN, Chair**
- **Jim Lussier**
- **Susan Pozdena**
- **Somnath Saha, MD, Vice-Chair**
- **Nina Stratton, Vice-Chair**
- **Kathryn Weit**
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- **Kevin C. Wilson, ND**
- **Staff: Darren Coffman (Lead); Ariel Smits MD MPH, Brandon Repp; Nathan Hierlmaier; Dorothy Allen**



Features of the Essential Benefit Package

- Based on the Prioritized List of Health Services
- Promotes use of the integrated health home
- Incentivizes use of preventive care and chronic disease management
- Cost sharing can be modified to make it more affordable to individual or state

Guiding Principles

- 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?

Guiding Principles (cont'd)

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

Guiding Principles (cont'd)

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?

Guiding Principles (cont'd)

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



The Essential Benefit Plan

- High deductible (adjustable for income)
- Significant copays for many services
 - Cost sharing tiers based on the Prioritized List
- Cap on out-of-pocket maximum (adjustable for income)
- Current Medicaid population would see no reductions in current benefits and have cost sharing no higher than current levels

Services Not Subject to Deductible Out-Of-Pocket Max Applies

	Integrated Health Home	Specialist, Other OP	Inpatient
Value-Based Services	0-5% depending on service		
Basic Diagnostics	0%	5%	N/A
Comfort Care	0%	5%	20%
Prescription Drugs	Generics - \$5 copay, Preferred - \$25 copay Other Brand – 50% & OOP max doesn't apply Use of evidence-based formulary		



Value-Based Services

- Seen primarily in the integrated health home
- Shown to prevent illness progression and/or disease complications
- Avoids preventable hospitalizations or ED visits
- Patient incentives to follow treatment recommendations



Value-Based Services (cont'd)

Examples

- Evidence-based preventive care
- Chronic disease management
 - regular provider visits
 - selected medications
 - self-treatment education
 - care coordination
- Prenatal care
- Preventive dental exams & cleanings

Services Subject to Deductible Out-Of-Pocket Max Applies

	Integrated Health Home	Specialist, Other OP	Inpatient
Tier I (1-113)	20%	25%	30%
Tier II (114-311)	30%	35%	40%
Tier III (312-503)	40%	45%	50%
Tier IV (504-680) & Excluded Services	No coverage (costs do not apply towards deductible or OOP max)		
Discretionary Services	40%	45%	50%
	\$2000 limit separate from OOP max applies		
Ambulance	\$100 copay, waived if admitted/meet criteria		
Emergency Dept.	\$100 copay (can be waived), then 50%		
Other Diagnostics	5-50% depending on test, subject to guidelines		
Ancillary Services	Commensurate with tier of condition treated		

Examples of Conditions in Tiers

Tier I Conditions

- Life-threatening newborn conditions
- Life-threatening chronic diseases
- Imminently life-threatening conditions
 - Trauma
 - Acute illness
- Public health concerns

Tier II Conditions

- Cancers with effective treatments
- Chronic diseases with less impact on health
- Potentially life-threatening conditions
 - Trauma
 - Acute illness

Examples of Conditions in Tiers

Tier III Conditions

- Cancers with less effective treatments
- Non-life-threatening chronic diseases
- Other non-life-threatening conditions
 - Trauma
 - Acute illness

Tier IV Conditions

- Conditions with no effective treatment or no treatment necessary
- Self-limited conditions
- Conditions with limited effects on health

Non-covered services: cosmetic procedures, infertility, etc.

Discretionary Services

- Non-emergent health care
- Doesn't substantially avert downstream costs/adverse consequences of condition
- Subject to annual maximum and other possible limitations
 - Restorative dental care
 - Eyeglasses
 - Certain dermatologic conditions

Issues of Note

- Emergency Department copayments/ coinsurance
- Well person visits
- Lifetime maximum
- Prescription drug cost sharing
- Mandated services
- Ancillary services

Questions?

Finance Committee Presentation to the OHFB

Kerry Barnett and
Gretchen Morley
June 25, 2008



Good People, Tough Assignment

- Big committee
- Diverse perspectives
- Extremely complex and difficult task
- Many moving parts
- Good faith participation
- True consensus elusive

Expanded Access Will Require New Money...

- ...at least in the short term
 - Cost-reducing initiatives will take time
- If we value it, we must be willing to pay for it
- We must be honest and transparent about this

Political Barriers Loom Large

- The “ask” is substantial
 - \$1 billion-plus per year
- Failure of the tobacco tax
 - In the legislature AND at the ballot
- Anti-tax politics are alive and kicking
 - There are no easy, popular tax increases
- The 84% with insurance must be willing to support those without
- Concentrated interest versus diffused benefit
 - Every constituency will likely find something to dislike

There Must Be a Credible Story to Tell

- Clear and compelling
- A detailed commitment to broader system reforms
- Credible expectations of enhanced quality and lower cost...
 - As well as lower cost
 - And lower cost
 - And lower cost, too
- ...particularly in the business community

Quality Improvements & Savings Must Be Identified

- We do not believe that there will be adequate support for new taxes for health care expenditures unless the public reasonably believes that such expenditures will be coupled with rational and substantial system improvements.

There Must Be a Political Strategy Around Reform

- Oriented around key political constituencies
- Sensitive to the risk of system changes
- With a focus on timing and sequencing of reforms
- It is relatively easy to defeat large, complex new programs

Strategic Revenue Principles

- Limit administrative cost
- Broad-based, sustainable, and equitable
- Transparent
- Limit likelihood of a legal challenge under federal law (ERISA)
- Broad public support
- Do not create disincentives for employer-sponsored insurance
- Maximize federal matching funds
- Encourage cost control

Taxes Considered

- Payroll tax
- Provider Tax
- Income tax
- Corporate income tax surcharge
- Cigarette tax
- Beverage tax
 - Beer/wine, hard liquor, carbonated beverage, or bottles
- Health plan revenue tax
- Property tax
- Gasoline tax
- Sales tax
- General fund dollars
- Eliminating the tax deductibility of health care premiums

Recommendation 1: Payroll Tax

- **The predominant revenue source should be a payroll tax**
- A strong majority believes that 60-100% of new revenue should come from a payroll tax

Design:

- No exemptions
- Levied as a flat percentage of payroll
- Relatively high cap on the payroll base
 - Up to two times the social security cap
- Tax rate should probably be 5-7%
- A credit against the tax should be allowed on a dollar-for-dollar basis for employer spending on health services
 - All employers contribute 0.25-1% that would not be offset

Recommendation 2: Additional Revenue Source

- A strong majority believes an additional source of revenue is needed
- Additional revenue should come from a provider tax or a new state income tax bracket

Provider Tax

- A 1-2% tax applied to gross patient revenues from all health care services, except Medicare or Medicaid
- Minority: exempt primary care and long-term care
- Minority: target one or two provider groups

Recommendation 2: Additional Revenue Source (continued)

Income Tax

- Add an additional, higher bracket to the state income tax
- Easily administered as part of existing income tax system

Other Taxes

- Minority: both a provider tax and a new income tax bracket to reduce the payroll tax
- Minority: taxes that encourage healthy behavior (e.g. taxes on tobacco, alcohol, etc.)

Recommendation 3: Additional Analysis Needed

1. Quantifying and capturing the cost shift
2. Assessing the economic impact of proposed new taxes

“Line of Sight” Scenarios

- To build consensus among Oregonians, there should be a clear “line of sight” between the sources and uses of funding

Two Parts of the Access Model

1. A new program that provides a state contribution (subsidy) towards premium costs for private insurance coverage purchased through an Exchange
2. Expanded eligibility for the Oregon Health Plan (OHP)
 - Leverage federal matching funds

Target Populations

1. Exchange

- Individuals and families whose incomes make them ineligible for OHP
- Most of these people are currently working for employers who do not offer health benefits or they are ineligible for employer coverage

2. Expanded OHP program

- Very low-income people, most of whom are not currently employed

“Line of Sight” → Payroll Tax

- Clear line of sight between payroll tax and first target population
- Subsidize private insurance coverage for employees through an Exchange
 - an extension of our current employer-based system
- Lower-income working uninsured unlikely to be offered health insurance by their employers
- Rationale: Would make the employer-based system more fair by “leveling the playing field”
 - i.e., all employers would be helping to fund health reform – they fund their employees’ health services directly and/or contribute to the new subsidy program.

“Line of Sight” → Provider Tax

- The health care community receives additional revenue due to increased access
 - Uncompensated care is reduced as providers are now paid for those services
- Health care community contributes its “fair share” of additional revenue coming into the system

“Line of Sight” → Income Tax

- “Line of sight” is less clear
- Oregon has a very flat income tax structure
- Adding a new tax bracket would be the least regressive of the proposed tax options
- Administration would be relatively simple and transparent through tax forms

Scenario 1: 60% Payroll Tax 40% Provider Tax

Illustration:

- 5% payroll tax paid by all employers
 - Credit against tax for employers funding health services for employees up to 4.75%
 - All employers pay 0.25% of payroll
 - Would raise approximately \$620 million a year
- 1.6% tax paid by all health care providers
 - Would raise approximately \$389 million a year

Scenario 2: 60% Payroll Tax 40% Income Tax

Illustration:

- 5% payroll tax paid by all employers
 - Credit against tax for employers funding health services for employees up to 4.75%
 - All employers pay 0.25% of payroll
 - Would raise approximately \$620 million a year
- New 10% income tax bracket for annual incomes over \$50,000
 - Would raise approximately \$330 million a year

Scenario 3: 100% Payroll Tax

Illustration:

- An 8% payroll tax paid by all employers
 - Credit against tax for employers funding health services for employees up to 7.1%
 - All employers would be required to pay at least 0.9% of payroll
 - Would raise approximately \$1.2 billion annually

Next Steps: Put the Pieces Together

- The OHFB must “solve” for many variables to create a balanced reform package.
 - Benefit level
 - Premium cost
 - Eligibility
 - New revenue for subsidies and OHP

Director's Straw Person Plan: An Overview

Barney Speight
June 25, 2008

This Draft Is...

- A framework for discussion
- A distillation of the work of many:
 - Committees & Work Groups
 - Board Hearings
 - Community “Listenings”
 - Formal & informal input over 10 months
- More illustrative (with a few specifics) than definitive; greater detail is available when appropriate

Components of a Plan:

- Vision & Goals
 - Where do we want to go?
- Structure (Organizational Framework)
 - Who's going to help us get there?
- Strategies & Actions
 - How will we get there?
- Resources
 - What will we need to get there? What's in the "toolkit"?
- Timeframe
 - How long will it take? Key milestones?
- Benchmarks & Evaluation
 - How will we know the plan is working?

Problems

- Health care costs too much
- Lack of focus on maintaining/improving health
- Coverage & access are declining

Goals

- Contain the annual increases in health care costs to the CPI
- Continuous improvement in quality & outcomes
- Improve the health of ALL citizens
- Expand coverage to uninsured Oregonians

A Proposed Vision for 20xx:

- Less than 5% of Oregonians are without health care coverage
- The annual rate of increase in health care costs has been maintained at CPI + (1% to 2%) for the previous 5 consecutive years
- Oregon meets or exceeds every major national quality benchmark (both acute & ambulatory)
- Oregon leads the nation in key population health benchmarks...across all population subgroups

The Role of State Government

- Create the vision & goals for Oregon
- Set benchmarks and standards
- Measure, analyze & report to public on performance
- Purchase health care services wisely
- Regulate (e.g., health insurers, licensing)
- Act as a convener (or participant) for collaboration & voluntary, coordinated action

Who Leads?

Integrated & Coordinated Health Policy

- Create Oregon Health Commission (OHC)
 - Replaces Fund Board & Health Policy Commission
 - Modifies Health Services Commission & Health Resources Commission
 - Integrated staff, financial & related resources
- Statutory structure similar to OHFB
 - Add 4 ex-officio members
 - Director, Department of Human Services
 - Director, Department of Consumer & Business Services
 - Director, PEBB & OEBC
 - Administrator, OPHP

Parallel Strategic Actions (2009-15):

- Transformation of Oregon's health care systems
 - Optimize Value: cost, quality, safety, outcomes, population health
 - Reward Innovation
- Affordable coverage for ALL
 - Reduce the number of uninsured
 - Ensure sustainable coverage

System Transformation, Phase I (2009-2010):

- Focus on “building the foundation”
 - Information & Reporting
 - Setting Standards
 - State Purchasing Policy
 - Public Health Initiatives
 - Community Collaboratives

Information & Reporting:

- Uniform statewide data sets (OHC, DCBS, DHS)
 - Statewide, regional, community
 - Longitudinal & comparative
- Insurance carrier performance (DCBS, DHS, OHC)
 - Commercial + OHP contractors
- Health care facility performance (OHC, DHS)
- “System” performance (OHC)
- Routine, understandable reporting to public
 - Joint OHC, DCBS, DHS responsibility
 - Directed to providers, purchasers, citizens, policy makers

Setting Standards:

- Data reporting (claims, financial, utilization)
- Administrative standardization
- Uniform quality & outcome measures
- Integrated health home (IHH) standards
- Clinical standards, guidelines & protocols
 - Evidence based treatments
 - Comparative effectiveness

State Purchasing Policy:

- Common Contract Standards
 - Quality & outcome performance standards
 - IHH criteria
 - Case management payment policy
 - Incentives for innovation with special populations
 - Evidence-based coverage & utilization management policies
 - Payment for administration (PMPM basis)
 - Patient decision aids (for preference sensitive care)
 - Oregon Prescription Drug Program (OPDP) as benchmark
- Collaborate with other public & private sector purchasers

Public Health:

- Tobacco Use & Obesity
 - Set statewide goals for a 10-year plan
 - Establish standards for Community Health Initiatives
 - Community partnership requirements
 - Accountability/performance targets
 - Measure results: \$\$ tied to performance
- POLST
 - Establish statewide registry for Physician Orders for Life-Sustaining Treatment

Community Collaboratives:

- Stimulate integration/coordination of physical, mental and oral health (DHS)
 - Establish performance measures
 - Waive administrative requirements that stifle community innovation
 - Engage & partner with multicultural communities
- State support of n local collaboratives
 - Matching \$\$ for tri-share programs
 - Technical assistance
 - Accountable Care Communities ?

Affordable Coverage for ALL

- Note: Expanding coverage should have an impact on costs if *cost shift* \$\$ are recovered & returned to private payers.
- Strategic Options for Coverage Expansion:
 - One Giant Leap ?
 - Staged Expansion ?
- Pragmatism + Sustainability suggests a staged expansion of coverage

Coverage Expansion, Phase I (2009-2010):

- Preserve and expand the Oregon Health Plan
 - Healthy Kids (< 200% FPL)
 - OHP Standard (adults < 100% FPL)
 - RETAIN, REVISE and RENEW
- Financing (revenue) strategy

System Transformation, Phase II (2010-2011):

- Implement 2009 legislation; monitor medical & premium trends
- Develop recommendations for enhanced state purchasing policies
 - “Centers of Excellence” contracting
 - State programs, public employers, others?
- Convene OHC Payment Reform Council
 - Recommendations on emerging concepts
 - Bundle services, “baskets of services”

Coverage Expansion, Phase II (2010-201?):

- Develop Essential Benefit Package alternatives at various price points
- Related issues
 - Minimum coverage standards
 - Those currently covered
 - Those receiving state contribution
 - Assuring participation
 - Network options (commercial, OHP, other)
- Detailed business plan for Insurance Exchange
 - Pathway to individual & small group market reforms
- Assess sustainability factors

Timeline & Milestones (TBD)

2009	2010	2011	2012	2013
> Legislation		> Legislation		> Legislation
> OHC Work Plan				