The Essential Benefit Package

Recommendations of the Oregon Health Fund Board's Benefits Committee

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

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I. Executive Summary

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state. The Benefits Committee developed the list of guiding principles shown in Appendix A to frame these recommendations.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health homes become the basis for cost-effective, patient-centered care
- Health care services are not segregated based on the part of the body they involve or the qualified health professionals who deliver them
  - Coverage for mental health and dental services should be based on the same criteria as other physical health conditions
- Coverage of services should be evidence-based to the highest degree possible
  - The Health Services Commission or other similar body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Coverage focuses on care which reduces the overall cost and complications of disease
  - Value-based services are an integral part of the package, representing evidence-based services that maintain or improve health, prevent illness and illness complications, and/or reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility should be rewarded
  - Value-based services should include incentives and rewards for patients who actively participate in their own health care

The EBP would be **affordable for individuals and the state**:

- Value-based services (including evidence-based preventive services) and basic diagnostic services should be available to all with no or low cost barriers
- Other types of care should be covered after the beneficiary meets a high deductible amount (adjusted for financial means). A limited number of discretionary services may have separate coverage maximums. These limitations in the plan will help result in a reduction in the cost of premiums.
- After the deductible is met, personal financial responsibility for services increases for conditions that appear lower on the Health Services Commission's Prioritized List of Health Services
- The introduction of an out-of-pocket maximum protects individuals and families from profound financial losses from catastrophic illness or injury

The EBP would serve as the **"foundation level" of health care coverage** below which no individual's coverage should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease-specific plans that do not serve the overall health of an individual or insured population
- Under this proposal, the current benefits offered to the categorically eligible Medicaid populations would not differ from the current OHP Plus benefit package with nominal copays.

II. Introduction

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

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

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

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

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

III. Basic Principles of the Essential Benefit Package

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

1. The use of evidence-based guidelines, where available, that are regularly reviewed and updated
2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those either of high cost that have effective, lower-cost alternatives or which do not have a major impact on the clinical management of the patient.

d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
e. Enabling services such as interpretive services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services,
    i. Selected care coordination services will likely be included as Value-Based Services
f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient or home-based care
g. Telephone nurse triage systems are strongly encouraged to allow appropriate direction to the most appropriate and cost-effective care settings for patients with urgent medical issues

2) Financial considerations
    a. Personal financial responsibility should increase as the service appears lower on the Prioritized List
    b. Premiums, deductibles and out-of-pocket (OOP) maximums should be scaled according to the individual/family's financial means
    c. A limit on OOP expenses should be included to prevent profound financial loss
        i. OOP maximums should be established for both individuals and families and should be adjusted for financial means
    d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan
        i. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive appropriate and cost-effective health care utilization decisions
    e. Certain "discretionary services" may have separate coverage maximums or other limitations
        i. A list of discretionary services should be developed by the Health Services Commission or other body designated by the Health Fund Board and be dynamic in its reflection of changing evidence and the values of Oregonians
        ii. The services placed in this list would fall into one or more of the following categories:
            1. Non-emergent services which do not substantially avert downstream medical costs or adverse consequences of a disease or condition, including death, worsening illness, hospitalization, or ED visits.

2. Services which can avert downstream costs or adverse consequences of a disease or condition, but which are used to treat a disease or condition for which there are more cost-effective alternative treatments or services available.

iii. Services on the discretionary list might be limited by one or more of the following:
    1. An overall cap on reimbursable expenses for all discretionary services
    2. Further limitations including some or all of the following:
        a. Limitations on reimbursable expenses for a class of services, such as vision services or dental care
        b. Limitations on the type of treatments/services covered
        c. Guidelines around utilization of services

iv. Placing limits on discretionary services will allow more affordable premiums or otherwise reduce costs to the system
    1. This should achieve sustainability of the system and affordability to individuals and the state

f. There should be no overall lifetime maximum limits on benefits
    i. To allow such benefit limits in the context of an individual mandate would be counter-intuitive.
    ii. In order to keep this package affordable, this may mean that this "foundational level" of coverage may not include some very high cost treatments that show some evidence of a very marginal level of benefit.

g. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.

3) Medications
    a. A drug formulary should be utilized
    b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
    c. A governing body should be responsible for formulary reviews and the administration of an appeals process
    d. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
    e. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
    f. Some medications may be considered to be value-based services and may not be subject to cost sharing when use of these medications is shown to be highly cost-effective in terms of reducing complications, hospitalizations, ED utilization, etc.
4) Integrated health home
    a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
    b. Integrated health homes should include primary physical and mental health care, case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system

c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)
d. The integrated health home may be a single provider, group practice or clinic, or an integrated network of providers. The specific structure of an integrated health home may look somewhat different in different communities around the state but shall (eventually) meet general guidelines.
e. Ideally, mental health services would be available within the integrated health home. In addition, the preferred integrated health home for some patients with significant chronic behavioral health conditions may be the behavioral health specialty provider clinic, hopefully with direct access to collocated primary care services.
f. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee
g. The Benefits Committee recognizes that the integrated health home does not currently exist for the majority of Oregonians. The incentives for receiving services in an integrated health home may need to be implemented in a graduated fashion to allow the health care delivery system time to develop the necessary components for the integrated health home throughout the state. In the interim, consideration should be given to lowering the cost-sharing levels for a service that could otherwise be obtained in an integrated health home were one available.

5) The EBP is a "foundation level" package
   a. Government, private companies, and individuals could purchase or offer a more generous package. The private market would be able to and should develop supplemental plans
   b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
      i. No package should have barriers to preventive and value-based services higher than those specified in the EBP
      ii. Value-based services would need to be included as designed by the Health Services Commission or other body and offered with the same or lower cost-sharing as the EBP
      iii. Basic diagnostic services would need to be offered as outlined in the EBP with no higher cost sharing
      iv. Discretionary services should be identified by the Health Services Commission or other body with a dollar cap or other appropriate limitations placed on these services
      v. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and emergency department services.

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

IV. Value-Based Services

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

Conditions Which May Have Value Based Services Associated With Them

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

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

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

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

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

Potential Value-Based Service Examples

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

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

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

V. Services Included in Each Tier

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

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

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

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

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

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

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

- Non-life-threatening trauma (e.g., severe sprains and strains)
- Non-life-threatening mental health disorders (e.g., acute stress disorder, 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 (Lines 504-680): Examples of Services and Conditions in this Tier

- Conditions with no effective treatment or no treatment necessary (e.g., rib fractures, benign cysts and growths, non-venereal warts)
- Self-limited conditions (e.g., colds, minor burns, cold sores)
- Conditions with limited effects on health (e.g., seasonal allergies, acne, diaper rash)

Excluded conditions

- Cosmetic surgery
- Infertility services
- Services shown to result in harm
- Experimental treatments

VI. Discretionary Services

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

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

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

Possible examples of Discretionary Services

- Dental care - Restorative dental services may have coverage maximums imposed upon them, such as a maximum dollar amount covered per year.

- Vision services - eyeglasses, and other vision care supplies may be limited.

- Dermatologic conditions - Specialty visits, number of visits, or types of medications for certain conditions may be limited or subject to guidelines.

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

VII. Organizational Considerations

- It is recommended that the Health Services Commission (HSC) should provide governance over the Essential Benefit Package (EBP) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of prioritizing and developing guidelines for health care services for Oregonians.
  - The HSC should adjust the Prioritized List, tier break points, and other parts of the EBP based on changing evidence and public values
  - The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
  - The HSC should create and update the list of value-based services using available evidence

- To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support would need to be provided
  - Consideration should be given to having part- or full-time paid members
  - The HSC or its subcommittees may need to meet more often, perhaps bi-weekly rather than bi-monthly
  - The HSC would need adequate research and support staff

- To effectively leverage state funds and scarce human resources, the HSC would need to collaborate with other evidence-based bodies in the state
  - Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
  - Oregon Evidence-Based Practice Center for assistance with evidence reviews
  - Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation

- The Health Resources Commission (HRC) and the HSC would need to work in close collaboration in order to complete reports for use in determining evidence-based benefits and value-based services

- An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body. This would involve the determination of placement of services within the tiers of the Prioritized List and the inclusion of services within the list of value-based services and basic diagnostic services. A separate appeals process would be necessary in order to hear the merits of individual cases. Such an individual appeals process would need to be streamlined and easy to access.

VIII. The Essential Benefit Package

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

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

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

Figure 1. Summary of the Essential Benefit Package

Category of Care[1]	Cost Sharing[2]			Deductible/OOP Max[3]
	Integrated Health Home	Specialist, Procedures, Other Outpatient[4]	Inpatient	
Value-Based Services	0 – 5% depending on service provided and location of care			•Deductible waived •$4,000-$15,000 OOP max applies per individual (income-based, family = 3 times individual), includes deductible
2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics	0%	5%	Not applicable	
Comfort Care	0%	5%	20%	
Tier I (Lines 1-113)	20%	25%	30%	•$1,000-$7,500 deductible applies per individual (income-based, family=3x) •OOP max applies
Tier II (Lines 114-311)	30%	35%	40%	
Tier III (Lines 312-503)	40%	45%	50%	
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Excluded Conditions	No coverage	No coverage	No coverage	
Discretionary Services	40%	45%	50%	•Deductible applies •OOP max does not apply •$2,000/yr limit
Ambulance	$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			
Prescription Medications	•$5 copay for generics, $25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)[5] •Evidence-based formulary will be used[6] •No coverage for medications for non-covered conditions			•Deductible waived •OOP max applies
Emergency Department	$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
Diagnostic Services	•Beyond 2 diagnostic visits, well-person visits and basic office diagnostics above •Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%) •Limitations according to evidence-based guidelines, location of service, etc. •Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization			
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			

Notes

[1]Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. The placement of tier break-points could change based on further review by the Commission, future changes to the Prioritized List, and/or public comment.

[2]Cost sharing amounts are based on income level – those below 100% of the Federal Poverty Level would have, at most, nominal copays at point-of-service. Amounts shown here are examples and can be adjusted until actuarial pricing is acceptable.

[3]Deductible amounts and out-of-pocket maximums are based on income level – those below 100% of the Federal Poverty Level would have no deductibles. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

[4]Some specialist services and procedures may be provided within the integrated health home for certain individuals.

[5]The cost share is reduced to 50% coinsurance for generic prescriptions and preferred drugs if this is less than the copay level and increased to a $50 copay for non-preferred brand drugs if this is more than the 50% coinsurance amount. All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

[6]An evidence-based formulary should be utilized and based on sources such as the Drug Effectiveness Review Project (DERP).

IX. Issues of Note

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

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

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

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

3) Lifetime maximum

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

4) Prescription medication cost sharing

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

5) Mandated services

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

6) Ancillary services

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

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

X. Enhanced Market-Driven Products

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

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

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

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

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

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

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

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

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

XI. Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

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

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

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

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

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

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

The Swerski Family—The Essential Benefit Package + Supplement A

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

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

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

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

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

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

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

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

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

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

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These items include the following:

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

Appendix D: Benefits Committee Membership and Staff

Committee Membership

Gary Allen, DMD
Dentist, Willamette Dental
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Lisa Dodson, MD
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Hubert (Hugh) Sowers, Jr.
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AARP Member
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Nathan Hierlmaier
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Dorothy Allen
Administrative Staff

Appendix E: Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

formulary A listing of medications approved for use.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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