Oregon Health Services Commission

Prioritized List of Benefit Packages for OHP Standard

Interim Report to the Governor and Legislative Leadership

July 2002

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Department of Administrative Services
Oregon Health Policy and Research
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Chapter 1

Introduction

Introduction

This interim report chronicles the work of the Health Services Commission (HSC) and Waiver Application Steering Committee (WASC) in the development of the Oregon Health Plan (OHP) Standard benefit package for the 2001–03 biennium, providing an update to the information appearing in the HSC's October 2001 report.[1] The OHP Standard Prioritized List of Benefit Packages for the 2003–05 biennium is also presented. A subsequent report including the actuarial pricing of this list will be submitted once all terms and conditions of the necessary Medicaid waivers are known.

HB 2519 and the OHP2 Waiver

Efforts to maintain the OHP and the desire to extend coverage to more Oregonians resulted in the passage of House Bill (HB) 2519 during the 2001 legislative session. The bill outlines the policy framework and the process to expand the number of persons eligible for the OHP, using the savings from creating a basic benefit package within OHP and obtaining additional federal matching funds. The reduction in benefits for select groups within OHP will require a new Medicaid waiver.

The Oregon Health Plan 2 (OHP2) Waiver will serve as a bridge from traditional Medicaid/SCHIP benefits to private coverage benefits. OHP2 will maintain the current Oregon Medicaid/SCHIP benefit package (to be renamed OHP Plus) for certain vulnerable populations, add a second reduced benefit package (to be known as OHP Standard) for other populations, and subsidize private insurance for people eligible for OHP2 who have qualified employer-sponsored insurance (ESI) available to them or, if ESI is not available, individual coverage. The ESI subsidies will be provided through the Family Health Insurance Assistance Program. Savings from the reduced benefit package and additional federal financial participation will be allocated to finance the results of outreach and an eligibility expansion for adults and children at higher income levels than are currently in place.

Overview of OHP Plus

Under OHP2, the Health Services Commission will continue to maintain the existing Prioritized List of Health Services. This list will be used to establish the OHP Plus benefit package of health care services. OHP Plus will be provided for all mandatory and certain optional populations. The groups that will receive OHP Plus include:

[1] *Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard; October 2001.*

- The elderly and disabled at the current eligibility levels;
- The TANF population at the current eligibility levels;
- All children (Medicaid and SCHIP) up to 185 percent of FPL;
- Pregnant women up to 185 percent of FPL; and
- General Assistance recipients at the current eligibility levels.

Changes to benefits in OHP Plus will be determined by the legislature through the movement of the funding level on this prioritized list. This will continue to be a public process, with changes in benefit levels requiring approval by the Centers for Medicare and Medicaid Services (CMS). Oregon will be requesting of CMS, as part of the terms and conditions of the OHP2 Waiver application, a streamlined process through which Oregon can move the coverage line further up or down the list.

Overview of OHP Standard

With the OHP2 Waiver, Oregon is requesting the ability to alter the OHP Standard benefit package so it can be adjusted to available revenue as necessary, and still preserve basic services. Specifically, Oregon is seeking permission to adjust the OHP Standard benefit package as long as it is at least actuarially equivalent to the federally mandated Medicaid benefit package. The mandated package is equivalent to approximately 56 percent of the value of the current OHP benefits. The OHP Standard benefits described in Chapter 2 of this document are the benefits as recommended for initial OHP2 program implementation. In subsequent biennia, Oregon will set the OHP Standard benefits at a level that can be supported by available revenue.

The groups that will receive OHP Standard include only those adults in the optional and expansion Medicaid populations (not included in OHP Plus) that do not have qualified employer-sponsored insurance (ESI) available. The maximum income level will initially be up to 110 percent of the federal poverty level (FPL) and incrementally increased to 185 percent of FPL as funding allows.

Cost sharing and benefit reductions in OHP Standard will be overlaid on the Prioritized List of Health Services. Services excluded from OHP Plus coverage because they are "below the line" on that list will also be excluded from OHP Standard coverage. The Prioritized List of Benefit Packages will be reviewed prior to each legislative session as outlined in HB 2519, with the HSC determining a re-ordering of benefit categories as necessary.

Chapter 2

Summary of Activities
(October 2001—January 2002)

Summary of Activities
(October 2001–January 2002)

Health Services Commission

Section 5 of the HB 2519 outlines the charge to the Health Services Commission (HSC) to develop a standardized benefit package that is actuarially equivalent to the Medicaid-mandated level of care. The HSC also was asked:

> *…to rank in priority order additional packages of health care services that may be provided to the extent the Legislative Assembly has provided funds for additional benefit packages*.

HB 2519 further states that:

> *... the commission shall recommend whether Oregonians receiving subsidies for OHP Standard be required to pay premiums and copayments based on the individual's ability to pay and how to structure the copayments and premiums in a manner that encourages the use of preventive services.*

After receiving the charge from the Governor and the Legislature, the HSC debated how best to structure the OHP Standard benefit package called for by HB 2519. They initially considered defining the benefit package using the Prioritized List of Health Services currently in use under the existing Medicaid Demonstration waiver. This approach would define coverage based on the cost-effectiveness of a treatment, the impact of the treatment on a person's health status, and the inherent public values used in the creation of that list. However, in order to reach the projected 22 percent reduction in benefits necessary to reach budget neutrality under OHP2, substantial cuts in the funding of the Prioritized List of Health Services would have been necessary. It was estimated that the coverage level on that list would have to be reduced from line 566 (out of 736 total lines) up to line 350 or above. This dramatic rise in the funding line would be necessary because most of the life saving and more costly services are found towards the top of the list. Since this would mean eliminating the treatment of most non life-threatening diseases (e.g., glaucoma, closed fractures) and coverage for some treatable cancers, the Commission quickly dismissed this as a viable option. The current Prioritized List of Health Services will remain, however, as the basis for determining coverage for specific conditions and treatments for both OHP Plus and OHP Standard.

Since HB 2519's aim was to create a bridge between traditional Medicaid benefits and those seen in the commercial insurance market, the HSC turned to the insurance model as

a basis for defining the OHP Standard benefit package. Access promotion and an emphasis on preventive services and early intervention were determined by the Commission to be key factors in the benefit design. They looked to the incorporation of cost-sharing as a means of gaining more flexibility in the package beyond the basic categories of benefits. This allowed inclusion of vital benefits such as prescription drugs and mental health services, which are optional under Medicaid, to be included in addition to mandatory benefits such as hospital and physician services.

After obtaining public input and completing a year of benefit analysis, the Health Services Commission (HSC) prepared a report in October 2001 that included a prioritization of benefit packages for OHP Standard and recommendations for cost-sharing. The Commission's report was forwarded to the Waiver Application Steering Committee, the Joint Interim Legislative Leadership Committee on Health Care Costs and Trends, and the Joint Interim Committee on Health and Human Services as required by HB 2519.

Waiver Application Steering Committee

As required by HB 2519, the Department of Human Services (DHS) established the Waiver Application Steering Committee (WASC) to:

1) recommend a benefit package for the OHP Standard population; and
2) assist and advise DHS in the preparation of the waiver application.

The WASC included legislators and representatives of a broad range of interest groups. The committee met for ten sessions from September 2001 through January 2002, hearing testimony from a variety of different stakeholders and the public about the Commission's recommendations for OHP Standard benefit priorities. The WASC needed to balance many factors in reaching their decision. Among these were:

- The need to obtain greater flexibility in managing the costs of OHP and its benefit package;
- The level of benefit reductions necessary in the OHP Standard benefit package to achieve a meaningful expansion in Medicaid coverage for the Federal government to grant a waiver;
- The value of expanding health insurance coverage to uninsured Oregonians above 100 percent of FPL, and the number to be insured under the waiver;
- The requirement that implementation of HB 2519 be budget neutral;
- The impact of the implementation of HB 2519 on other state programs;

- The ability of those served by OHP Standard to afford the explicit cost-sharing represented by copays and premiums and the implicit cost-sharing imposed through benefit elimination; and
- The effect of cost-sharing on reimbursement levels and how that impacts access to an adequate number of providers for an expanded Medicaid population.

While the WASC accepted the ordering of benefit packages given by the HSC in their October 2001 report, the committee had concerns about the high levels of cost-sharing being recommended, particularly in the areas of inpatient hospital services and prescription drugs. Based on extensive discussions and recommendations from advocates and health plans, including several alternative benefit package proposals, the WASC recommended the OHP Standard benefit package and the cost-sharing requirements shown in Table 2.1. For the most part, cost-sharing is recommended to be in the form of copays for each service received. Of note is a tiered-copay structure for prescription drugs that requires lower copay amounts for those with incomes below the federal poverty level (FPL) and also encourages the use of generic drugs through significantly lower contribution amounts.

In order to satisfy the parameters established by the Governor and the legislative leadership that called for a benefit package of no more than 78 percent of the current level, the WASC also recommended that premiums for OHP Standard be required according to the schedule in Table 2.2. This represents an increase in premiums beyond those already in place for the current OHP program in the form of:

- A new tier for individuals from 11–50 percent of FPL, now at $9 instead of $6 dollars;
- A premium rate for couples at twice that of single adults (the current rate in OHP for couples is about 1.15 times the single rate); and
- Additional contributions for those between 100–185 percent of FPL.

The contribution rates for 100–185 percent of FPL were developed to result in a linear progression starting from those premiums currently required in OHP for new eligible populations <100 percent of FPL, and taking into account the contributions required in the Family Health Insurance Assistance Program (FHIAP).[2]

The WASC also discussed other issues related to the OHP2 Waiver (e.g., eligibility, waiver strategy, and the balance between public and private programs) and advised DHS on

[2] *For information on current OHP and FHIAP premiums, see the Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard; October 2001, Chapter 3.*

Table 2.1: WASC-Recommended OHP Standard Benefits & Cost-sharing

Service	*Cost Share %*	*Recommended Cost-sharing Mechanism*
Inpatient Hospital	5%	$250 copay per admission
Outpatient Hospital	4.5%	▪ $20 copay/surgery ▪ $5 copay other outpatient services
Emergency Room	12%	$50 copay, waived if admitted
Physician Services	4.3%	▪ $5 copay office visits ▪ $3–$10 copay medical & surgical procedures
Lab & X-ray	5.7%	$3 copay for each lab and X-ray
Ambulance	11.7%	$50 copay
Prescription Drugs	15.2%	0–100% FPL: ▪ $2 generic ▪ $3 MH/cancer/ HIV brand drugs ▪ $15 other brand 101–185% FPL: ▪ $5 generic ▪ $10 MH/cancer/ HIV brand drugs ▪ $25 other brand
Mental Health and Chemical Dependency	6.1%	▪ $5 copay ▪ No copay on dosing/dispensing or case management services
Durable Medical Equipment	53.2%	▪ Recurrent: $2 copay per 30-day supply ▪ No coverage for one-time DME
Dental	50%	▪ Dx & Preventive: zero/minimal copays ▪ Restorative: graduated copays ▪ $500 benefit limit
Cumulative Cost	*86.1%*	
Behavioral Offset	*-6.0%*	
Premium Offset	*-2.1%*	*See Table 2.2 for revised premium structure*
Net Cost	***78%***	

Table 2.2: WASC-Recommended OHP Standard Premium Structure

	Single	*Couple*	*% of Package*
0–10% FPL	$6	$12	2.4%
11–50% FPL	$9	$18	3.6%
51–65% FPL	$15	$30	6%
66–85% FPL	$18	$36	7.2%
86–100% FPL	$20	$40	8%
101–125% FPL	$23[1]	$46	9.2%
126–150% FPL	$35	$70	14%
151–170% FPL	$75	$150	30%
171–185% FPL	$125	$250	50%
Percentage savings to OHP Standard Benefit package: 2.1%[2]			

[1] *Premiums for people with incomes 101–185% of FPL will be based on the percentage cost of the OHP Standard Benefit package (shown in the far-right colum), not fixed at these dollar amounts.*

[2] *Savings assumes a 95% collection rate during the month in which the premiums are due.*

these issues. In addition, the WASC reviewed the recommendations regarding the benefits benchmark for FHIAP.

The final OHP Standard benefit package and premium structure recommendations of the WASC were incorporated into the OHP2 Waiver application and forwarded to the Joint Legislative Leadership Commission on Health Care Costs and Trends and the Emergency Board in January 2002. The OHP2 Waiver application was approved at the May 1, 2002 meeting of the Emergency Board, with no adjustments to the WASC-recommended OHP Standard benefit package and premium structure for the 2001–03 biennium. DHS submitted the Medicaid waivers to the Centers for Medicare and Medicaid Services (CMS) on May 31, 2002.

Chapter 3

Prioritization of OHP Standard Benefit Packages

Prioritization of OHP Standard Benefit Packages

The Prioritized List of Benefit Packages for OHP Standard for the 2003–2005 biennium appears in Table 3.1. The Health Services Commission (HSC) was responsible for the ordering of the benefit packages represented by columns 1 and 2 of this table. In fact, the prioritization order has not changed from the list included in the Commission's October 2001 report on OHP Standard. The Waiver Steering Application Committee (WASC) recommended the cost-sharing percentages shown in column 3 of Table 3.1. The corresponding types of cost-sharing mechanisms recommended by WASC were outlined previously in Table 2.1 of Chapter 2.

The benefit packages that make up each row on the list represent broad categories of benefits (column 2) in combination with a level of cost-sharing required from the individual as services are used (column 3). Benefit categories appearing within the shaded region of the table represent benefits mandated for coverage by Medicaid laws. Those categories not appearing within the shaded region are considered optional services under Medicaid and need not be covered for adult populations. In the second column, a single benefit category may appear more than once on the list. This provides flexibility in applying different cost-sharing levels to a benefit category depending on how far down the funding line is drawn. For instance, a funding line drawn just below row 11 on the list would result in a benefit package requiring an average contribution by the individual of 53.2 percent towards the cost of durable medical equipment (DME) supplies. A funding level drawn just below row 20 on the list would result in the individual paying, on average, 20 percent in cost-sharing towards these same services.

The fourth column in the table represents the relative cost of that benefit package in comparison to the total cost of the current OHP benefit package. For example, the addition of prescription drugs at a cost-share of 15.2 percent to the individual represents 20 percent of the costs of the current package. By totaling up the percentages in this column for the four prescription drug lines, these services alone currently account for 23.6 percent of the total OHP costs for this population. These calculations are based on utilization data for that segment of the current OHP population, known as the OHP Families and OHP Adults/ Couples categories, which would receive services as defined by OHP Standard. These figures represent a continuation of the same utilization rates historically seen for this population. The percentages do not reflect any decrease in utilization that may result from the imposition of cost-sharing (referred to as "behavioral offset") nor reflect the utilization rates of those individuals who would gain coverage under this portion of the OHP2 Waiver.

Table 3.1: OHP Standard Prioritized List of Benefit Packages for the 2003–05 Biennium

Row	*Benefit Category*	*% Cost-sharing*	*% of Package*	*Cumulative %*
1	Hospital, Physician, Lab, X-ray	0%	56.0%	56.0%
2	■ Inpatient Hospital	5%	-1.0%	
3	■ Outpatient Hospital	4.5%	-0.3%	
4	■ Emergency Room	12%	-0.2%	
5	■ Physician	4.3%	-0.8%	
6	■ Lab/X-ray	5.7%	-0.5%	
7	■ Ambulance	11.7%	-0.1%	
8	Cost-sharing on Mandated Services		-2.9%	53.1%
9	Prescription Drugs	15.2%	20.0%	73.1%
10	Mental Health/Chemical Dependency	6.1%	8.0%	81.1%
11	Durable Medical Equipment	53.2%	0.3%	81.4%
12	Dental	50%	4.7%	86.1%
13	Vision	48%	0.5%	86.6%
14	Dental	35%	1.4%	88.0%
15	Inpatient Hospital	2.5%	0.5%	88.5%
16	Ambulance	5.8%	0.05%	88.6%
17	Prescription Drugs	10%	1.2%	89.8%
18	Non-emergent Transportation	50%	0.3%	90.1%
19	Dental	20%	1.4%	91.5%
20	Durable Medical Equipment	20%	0.2%	91.7%
21	Prescription Drugs	5%	1.2%	92.9%
22	Emergency Room	6%	0.1%	93.0%
23	Physician	0%	0.8%	93.8%
24	Mental Health/Chemical Dependency	0%	0.5%	94.3%
25	Inpatient Hospital	0%	0.5%	94.8%
26	Outpatient Hospital	0%	0.3%	95.1%
27	Emergency Room	0%	0.1%	95.2%
28	Lab/X-ray	0%	0.5%	95.7%
29	Ambulance	0%	0.05%	95.7%
30	Prescription Drugs	0%	1.2%	96.9%
31	Dental	0%	1.9%	98.8%
32	Durable Medical Equipment	0%	0.1%	98.9%
33	Vision	0%	0.5%	99.4%
34	Non-emergent Transportation	0%	0.6%	100.0%

The final column shows the cumulative percentage for the relative cost of all benefit packages included up to that point. Using a funding line drawn under row 12, as recommended by the WASC, results in a benefit package that would be 86.1 percent of the cost of providing the current OHP benefit package. As shown previously in Chapter 2, the last three rows of the WASC-recommended OHP Standard benefits and cost-sharing package (Table 2.1) reflect the additional estimated effect of the behavioral offset and an additional offset due to increased premium levels (detailed in Table 2.2). This results in a final benefit package valued at 78 percent of the current OHP package.

The final number in the last column is 100 percent, meaning that all services currently covered under the current OHP benefit package are represented. Also note that the list presumes those services currently excluded under the current Medicaid Demonstration (and therefore in OHP Plus) will be excluded in OHP Standard as well. HB 2519 specifically states that OHP Standard cannot exceed those benefits offered in OHP Plus.

All numbers appearing in Tables 2.1 and 3.1 represent estimates made by OHPR staff based on the previous work of PricewaterhouseCoopers (PwC) that led to the pricing that appeared in the HSC's October 2001 report. The final actuarial pricing for the list appearing in Table 3.1 will be performed by PwC upon the conclusion of the negotiations between the state of Oregon and CMS leading to the approval of the OHP2 Waiver. The final terms and conditions of the OHP2 Waiver will then be known and can be incorporated into the calculations. Depending on the timing of the Waiver approval, the final pricing of the OHP Standard Prioritized List of Benefit Packages for the 2003–05 biennium will either appear as an addendum to this report or as a part of the HSC's Biennial Report to the Governor and 72nd Oregon Legislative Assembly on the Prioritization of Health Services.

Chapter 4

Ongoing Activities and Next Steps
(January 2002—Present)

Ongoing Activities and Next Steps
(January 2002–Present)

As the deliberations of the Waiver Application Steering Committee (WASC) reached conclusion over the OHP Standard benefit package, there were concerns raised over the cost-sharing components of the resulting benefit package. It was requested that the Health Services Commission (HSC) take a closer look at the individual condition-treatment pairs on the Prioritized List of Health Services to determine if there are less effective treatments that could either be eliminated from coverage or managed by therapy guidelines. The aim would be to allow reductions in overall costs of the OHP, while preserving basic services, or lower cost-sharing components.

As with endeavors to create the first Prioritized List of Health Services, the HSC called upon the various provider groups to help identify those diagnoses and procedures within their purview that might be less important for the adult expansion population under OHP2. During the Commission's initial deliberations over the development of the OHP Standard Prioritized List of Benefit Packages, the HSC worked closely with the Dental Care Organizations (DCOs) to determine if any savings could be obtained from some restrictions in benefit service levels and the addition of cost-sharing. The DCOs' public input into the HSC process provided a means of continuing coverage within OHP Standard for a core package of dental benefits with cost sharing. The dental community's response to this challenge has served as a model for the HSC, the Mental Health and Chemical Dependency (MHCD) Subcommittee of the HSC and the OHP Medical Directors.

Non-lethal conditions, primarily affecting adults, between Line 400 through Line 566 of the Prioritized List of Health Services were considered for review. The OHP Medical Directors focused initially on twenty-one lines that dealt with the areas of orthopedics, general medicine, otolaryngology, and gynecology. Besides examining specific conditions and treatments, the OHP Medical Directors, with input from various stakeholders, considered the feasibility of using less expensive sites of service for certain conditions such as colonoscopy, endoscopy and other outpatient procedures.

The MHCD Subcommittee established workgroups to consider benefit changes in the areas of treatments for less severe mental health conditions, chemical dependency management, and non-hospital (sub-acute) detoxification. Also reviewed for exclusion or limitations on coverage were a few pharmaceutical classes, especially those used to commonly treat conditions that fall below the funding line on the Prioritized List of Health Services such as benzodiazepines, muscle relaxants, and sleeping medications. In addition,

the MHCD Subcommittee extensively reviewed the use of acupuncture for chemical dependency.

To assist the benefit management discussions for the OHP Medical Directors and the MHCD Subcommittee, utilization data was obtained from the Office of Medical Assistance Programs for the OHP adults and couples populations to be covered by OHP Standard. This helped to quantify the actual use of the services being considered for exclusion or guideline management. Also, providers representing the various medical and surgical specialty organizations were convened to discuss these potential limits on services and their impact on overall quality of care. The OHP Medical Directors and MHCD Subcommittee compiled their lists of services to be considered for either elimination or for new or revised management guidelines in the OHP Standard population. These recommendations were forwarded to the HSC for their consideration. The overall savings to the proposed OHP Standard benefit package for the adult expansion populations was estimated to be between 2–3 percent.

The Emergency Board asked, as a condition of the approval of the the OHP2 Waiver, that the HSC work towards a goal of lowering overall costs of the entire OHP program by 10 percent. This would include those covered under OHP Plus, as well as the adults under OHP Standard. The Commission is currently re-examining those conditions and treatments initially considered for elimination or guideline management by the OHP Medical Directors and MHCD Subcommitte to see if these changes can be applied to the broader OHP Plus population. The Commission will be presenting that information as they make their recommendations for the Prioritized List of Health Services for the 2003–05 biennium.

Process for Future OHP Standard Recommendations

For subsequent biennia, HB 2519 calls for the Health Services Commission to submit a new Prioritized List of Benefit Packages for OHP Standard. Beginning with this report, the Commission will submit a new prioritized list on July 1 of each even-numbered year for consideration by the following year's legislative assembly.