Trends in Coverage Oregon, 2006

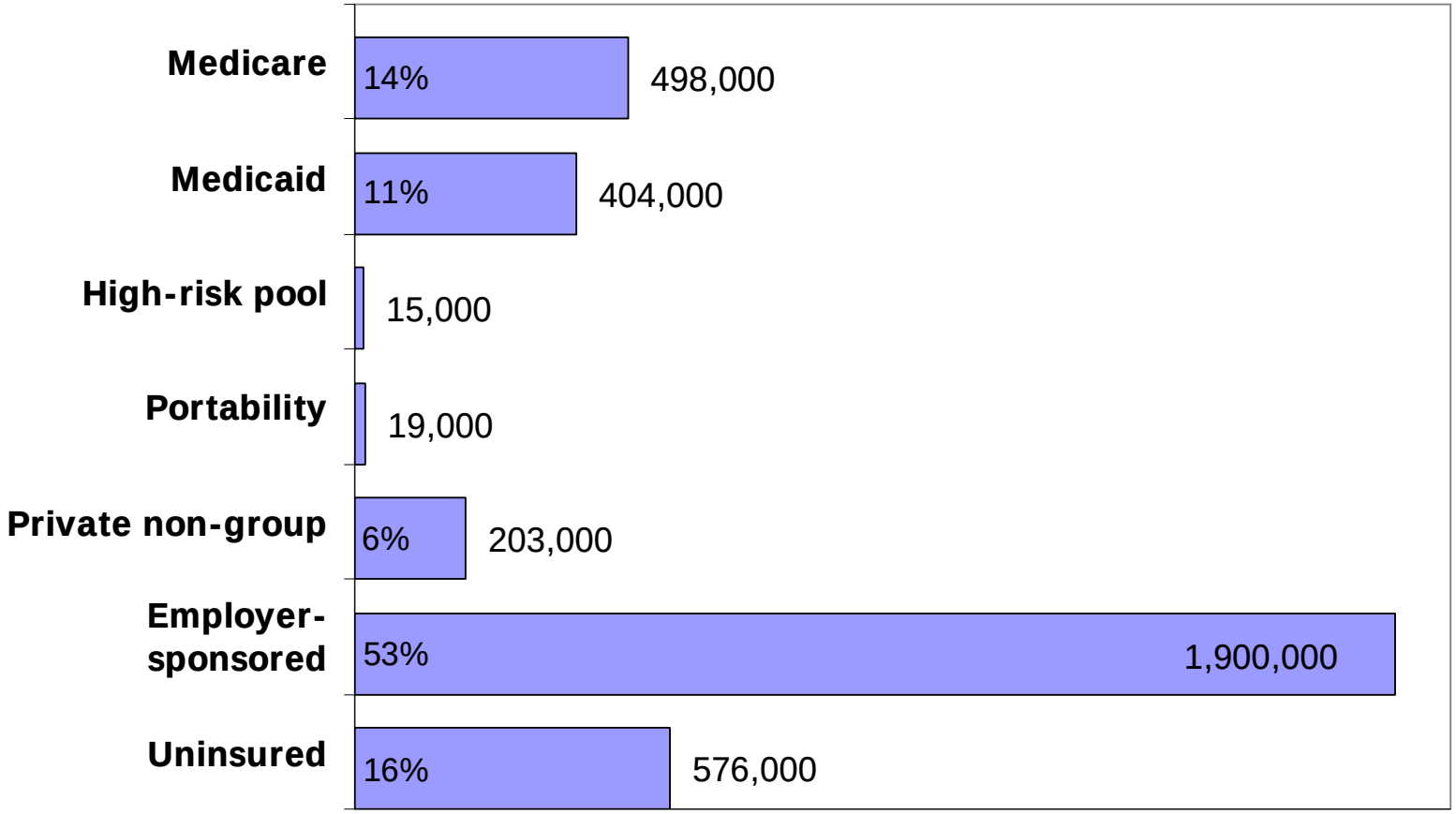
Presentation to the

Oregon Health Fund Board

October 30, 2007

The majority of Oregonians are covered by employer-sponsored insurance

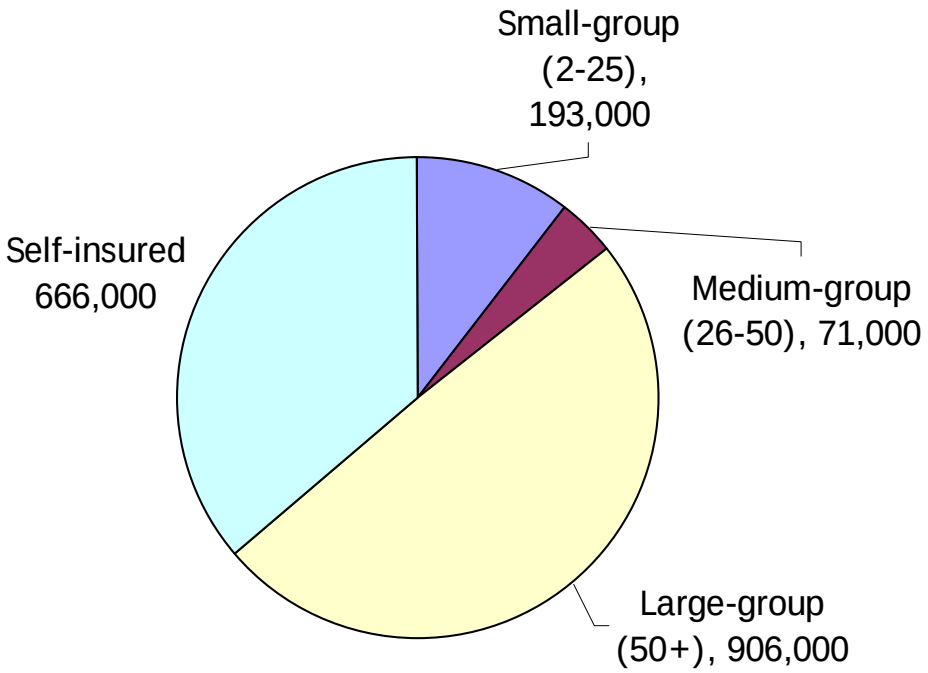
(Oregon population = 3.7 million)



Sources: Uninsured: 2006 Oregon Population Survey, Medicaid: DMAP August 2006 Eligibility Report, Medicare: CMS, 2005 State Report, High-Risk Pool, Portability and Private Non-Group: DCBS, "Health Insurance in Oregon", Jan. 2007, Employer-Sponsored: Kaiser Family Foundation, www.kff.org.

Roughly half of commercially insured are in large group coverage…

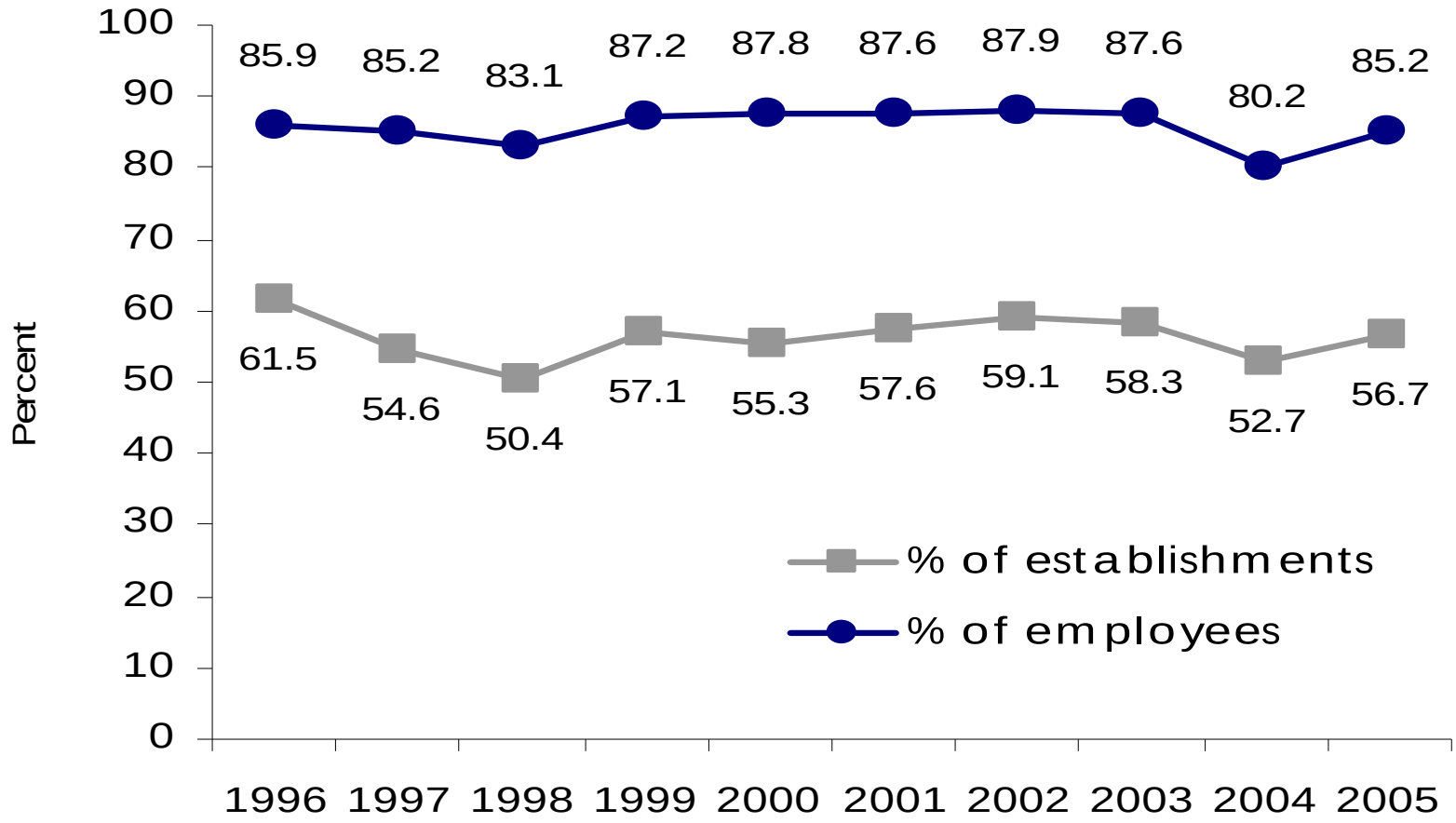
Distribution of commercial insurance in Oregon



Source: Department of Consumer and Business Services, January 2007

The percent of private businesses offering health insurance coverage has not changed significantly…

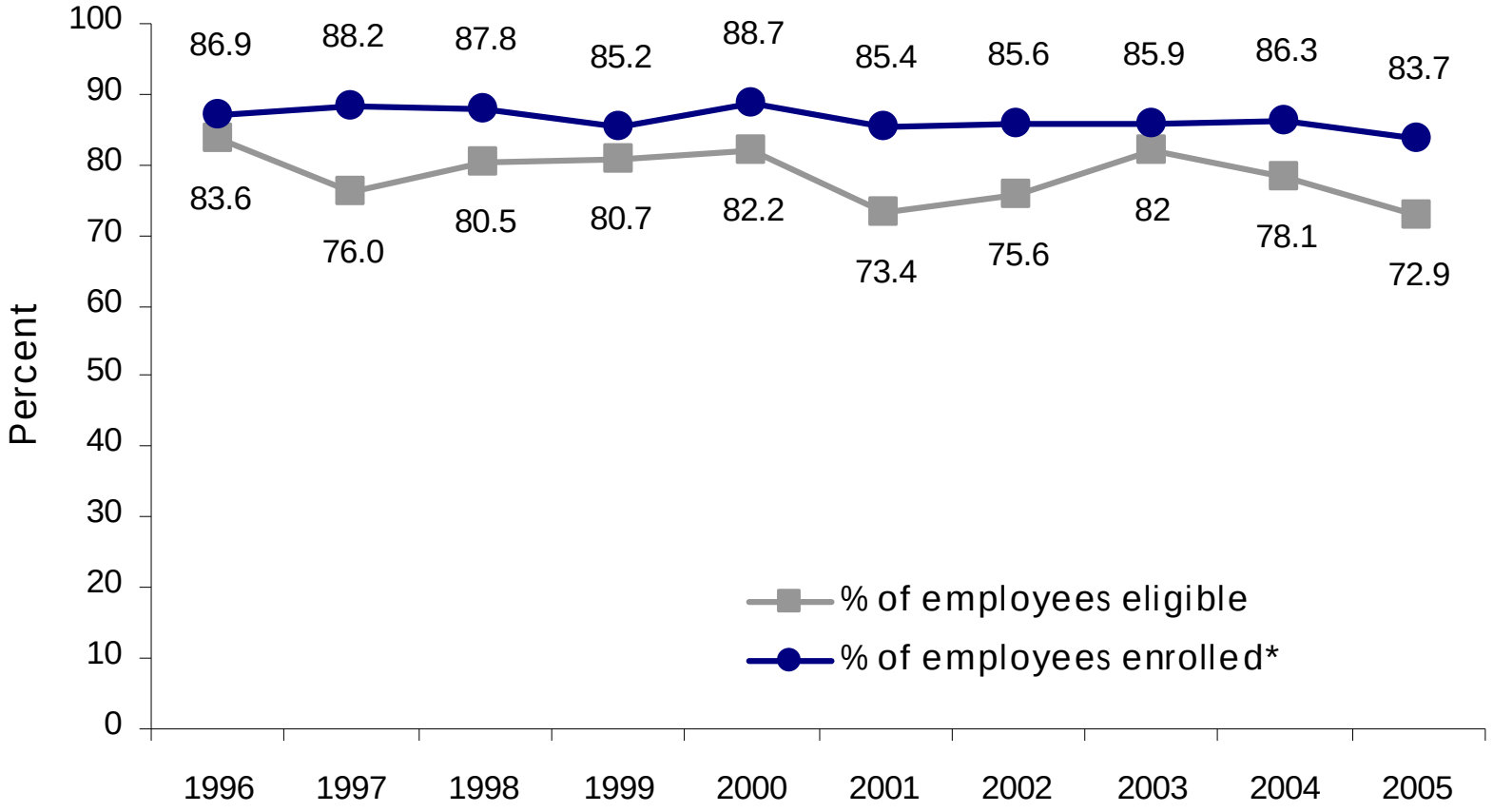
Percent of private establishments providing health insurance and percent of private employees working for businesses that offer insurance, Oregon



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

But the percentage of Oregon employees who are eligible has declined

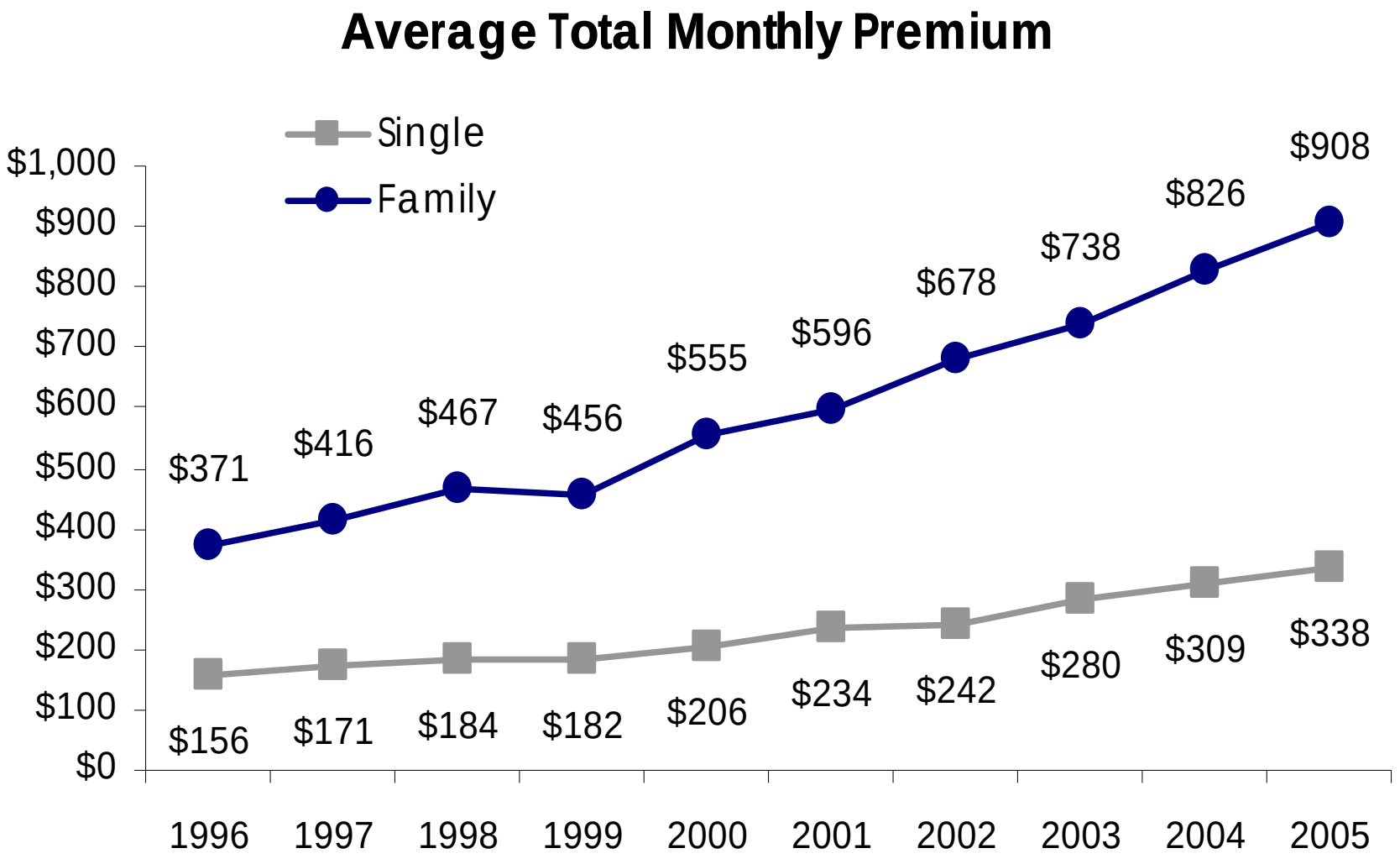
Percent of private employees eligible for employer-sponsored insurance and the percent of those eligible who are enrolled, Oregon



*As a percent of those eligible.

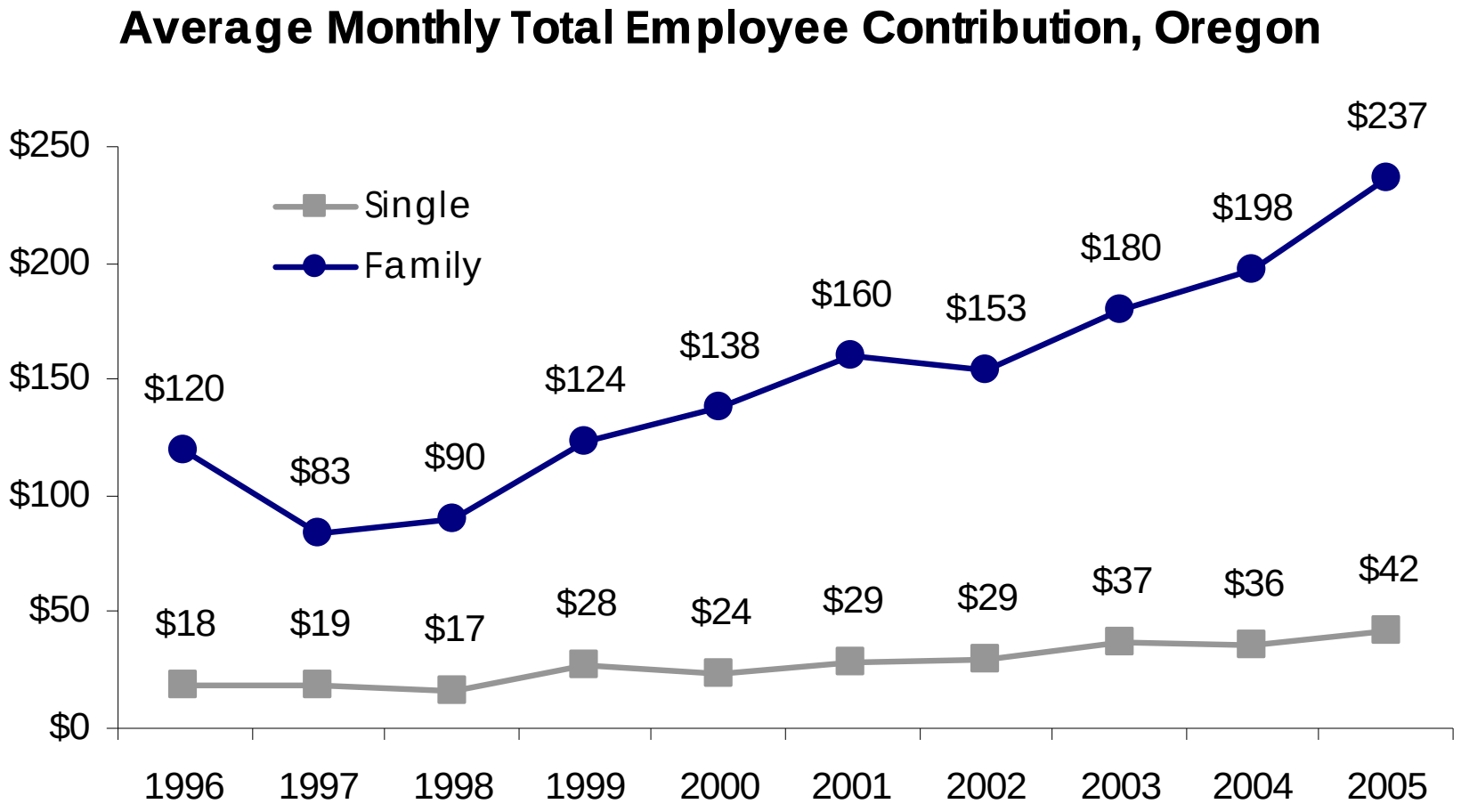
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Premium costs have steadily increased in Oregon.



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Employee contribution requirements have increased as premium costs grow…

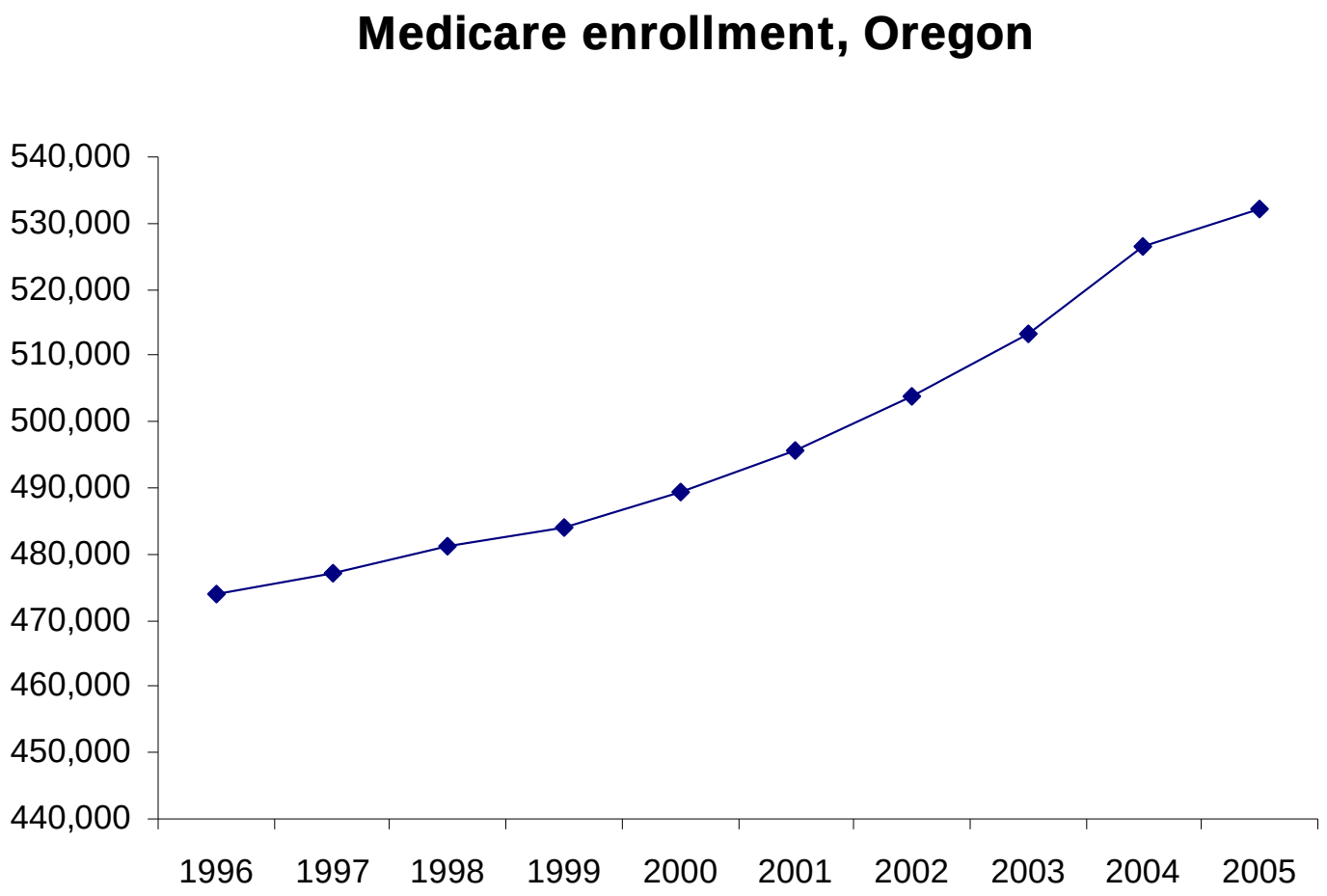


Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Medicare

- Medicare is a federal insurance program for people age 65 and older and certain disabled people. The Centers for Medicare & Medicaid Services (CMS) operates Medicare.
- Medicare is funded by the federal government with no state participation.

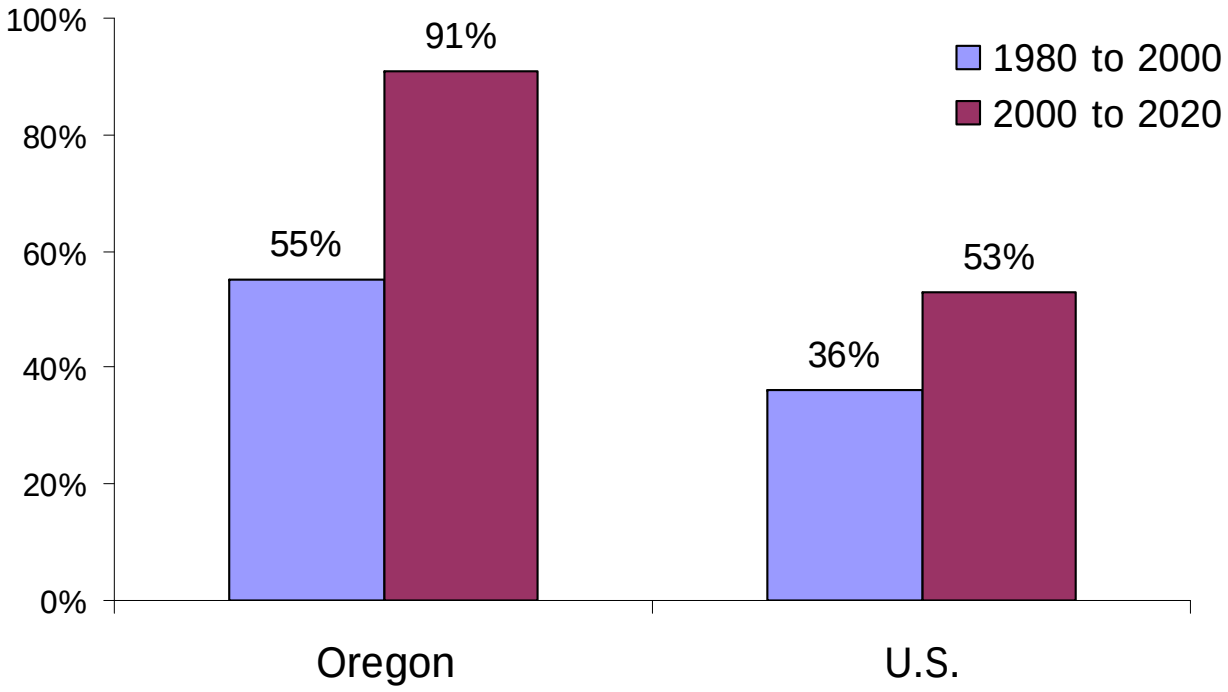
Medicare enrollment has grown as the population ages…



Source: Centers for Medicare & Medicaid Services, Medicare State Enrollment, 2005.

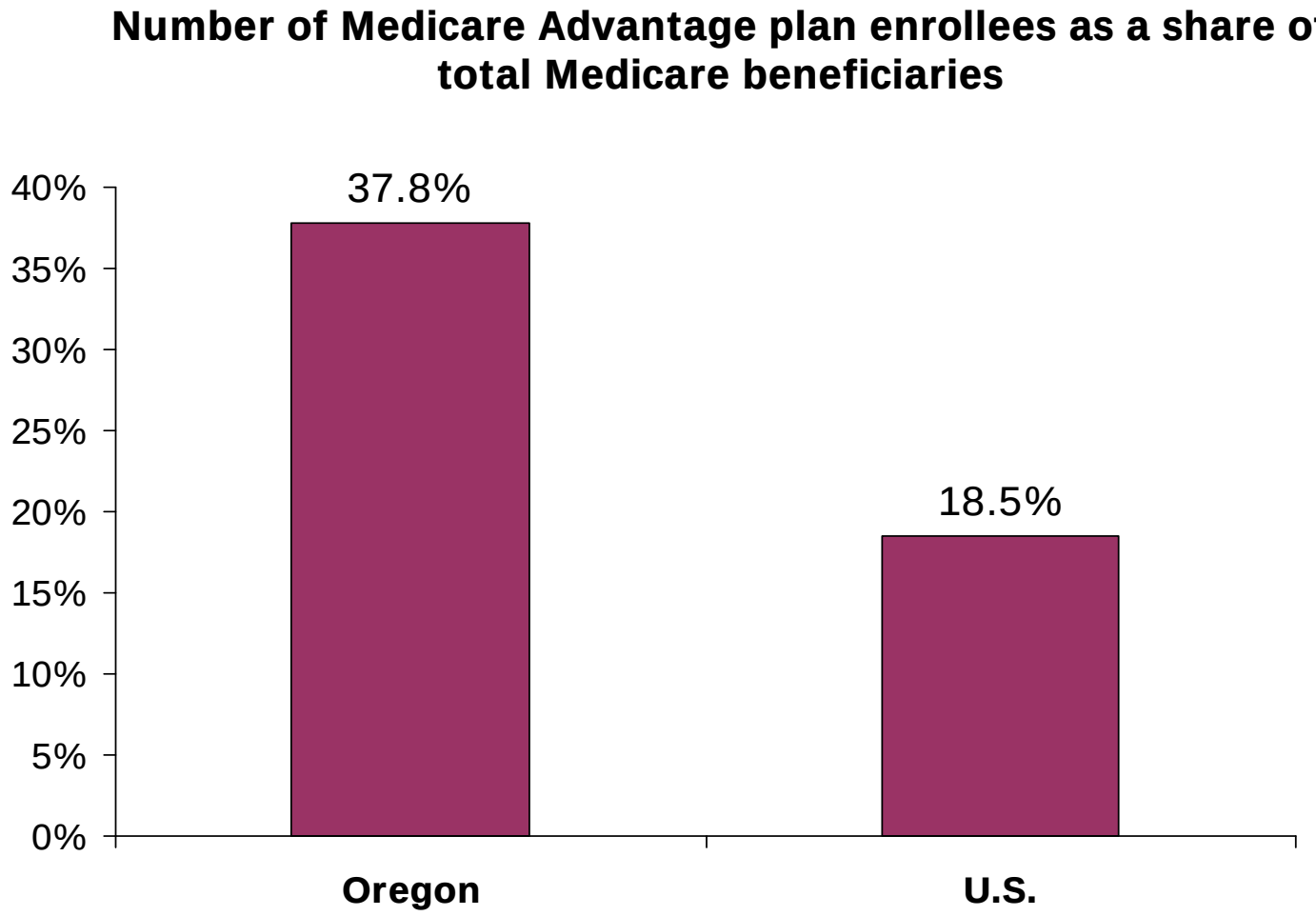
Oregon's 65+ population is increasing rapidly…

Projected percentage change in population 65+ years of age



Source: 2000 HRSA Report – Oregon Profile

Oregon leads country in Medicare Advantage enrollment *



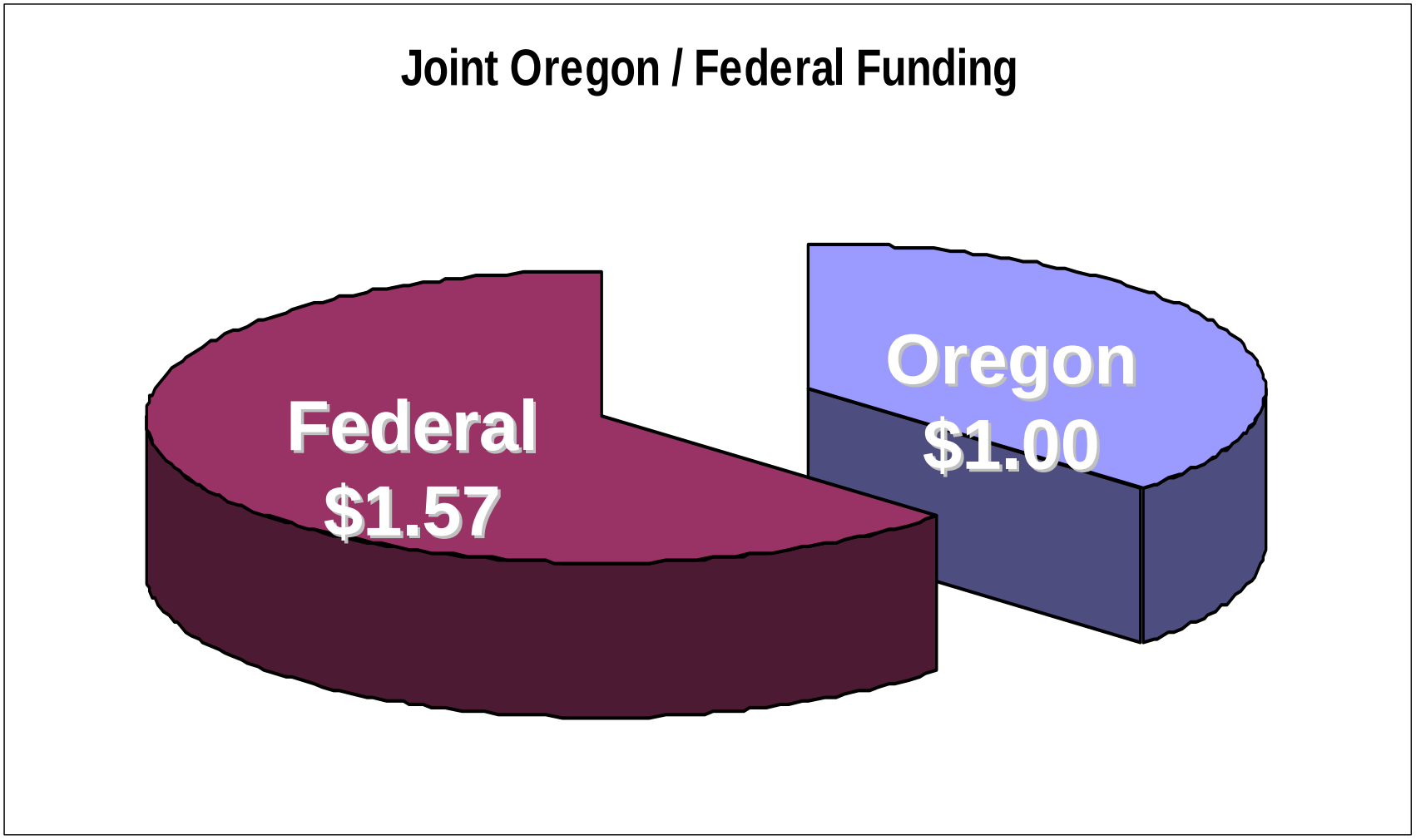
*Puerto Rico has MA penetration rate of 53.3%; OR has highest rate of states

Source: Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker

Medicaid

- Medicaid is a program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, disabled individuals and nursing home residents. These individuals must meet certain income and other requirements.
- Medicaid funding is shared between the federal and state government.

Medicaid is a State/Federal Partnership



Who is covered by the Oregon Health Plan?

"OHP Plus" program

Mandatory Medicaid Populations

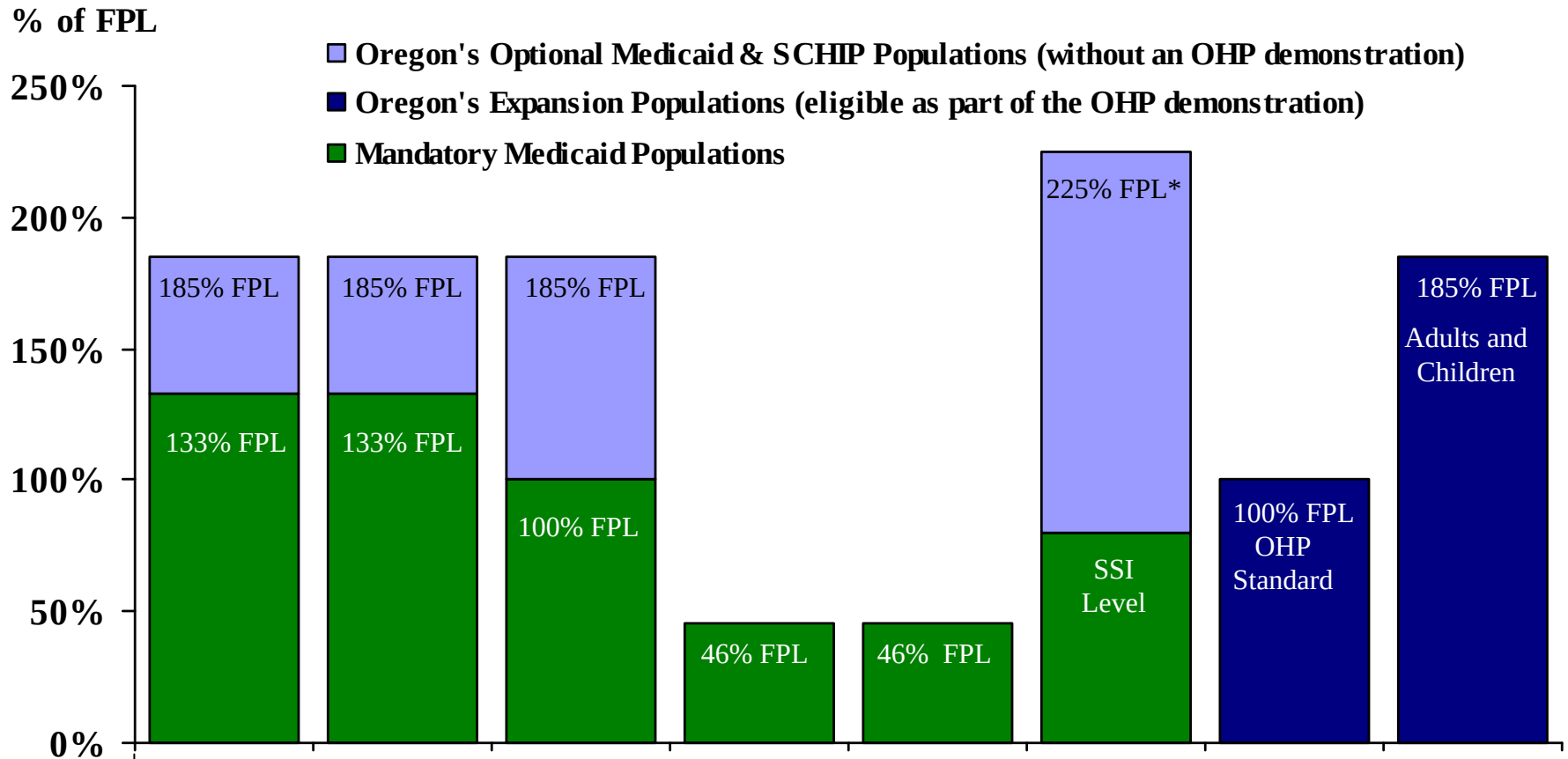
- Low-income elderly, blind & disabled
- Families receiving Temporary Assistance for Needy Families (TANF)
- Low-income foster children
- Low-income children
- Low-income pregnant women

Who is covered by the Oregon Health Plan?

Expansion Populations:

- Low-income uninsured adults (OHP Standard)
- Subsidies to help low-income adults and families purchase private insurance (Family Health Insurance Assistance Program (FHIAP))

Oregon Health Plan Eligibility Categories by Percentage of Poverty Level (FPL)



Eligibility Category	Pregnant Women	Children (Ages 0-5)	Children (Ages 6-18)	Foster Children	TANF Families	Aged, Blind & Disabled*	Uninsured Adults	Subsidized Private Insurance**
Dec. 2006 Enrollment	9,598	53,989	60,636	17,522	117,534	92,228	21,052	15,506

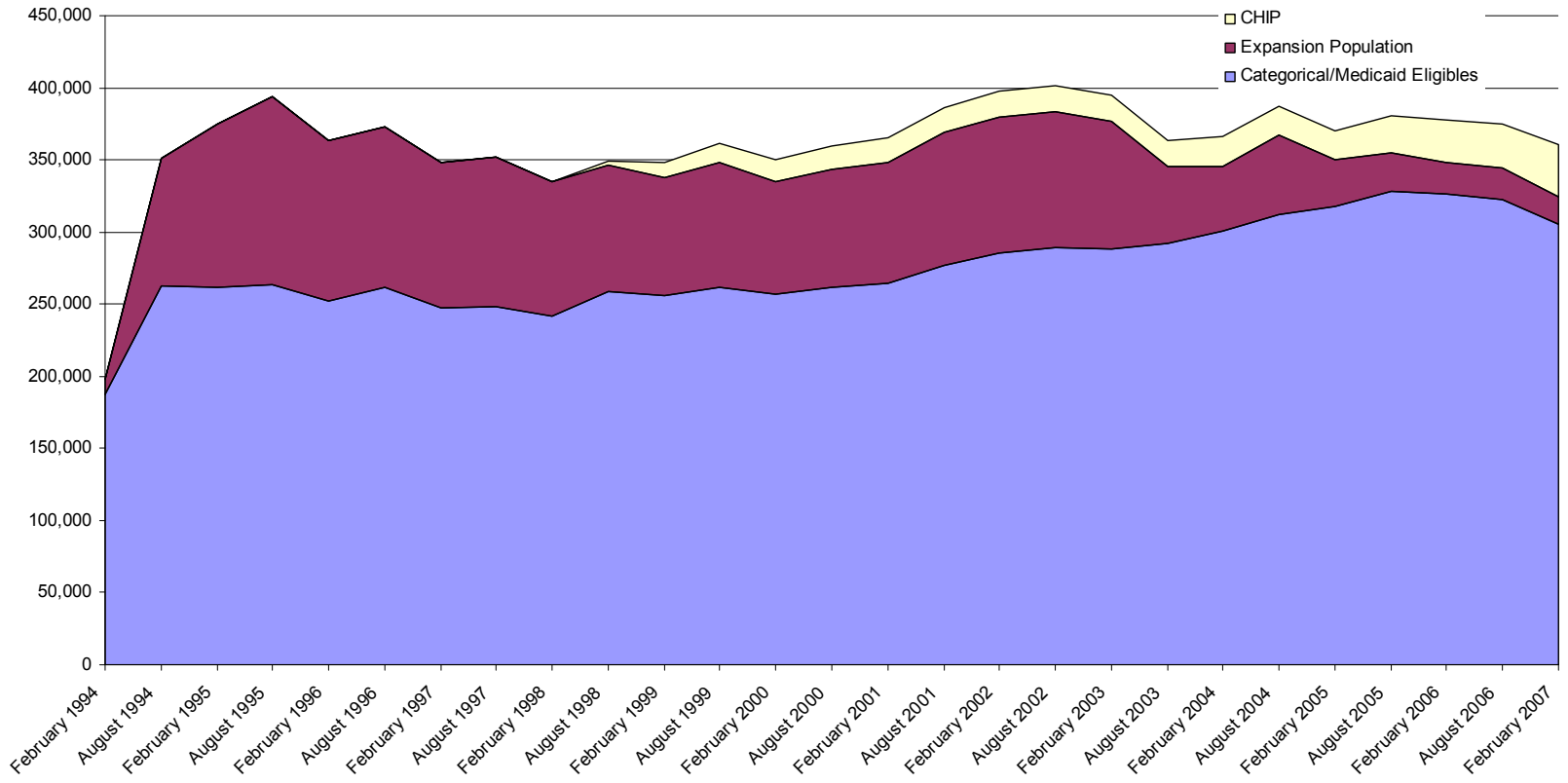
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level

**The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% FPL must enroll if they have employer sponsored insurance. Parents and childless adults over 100% FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

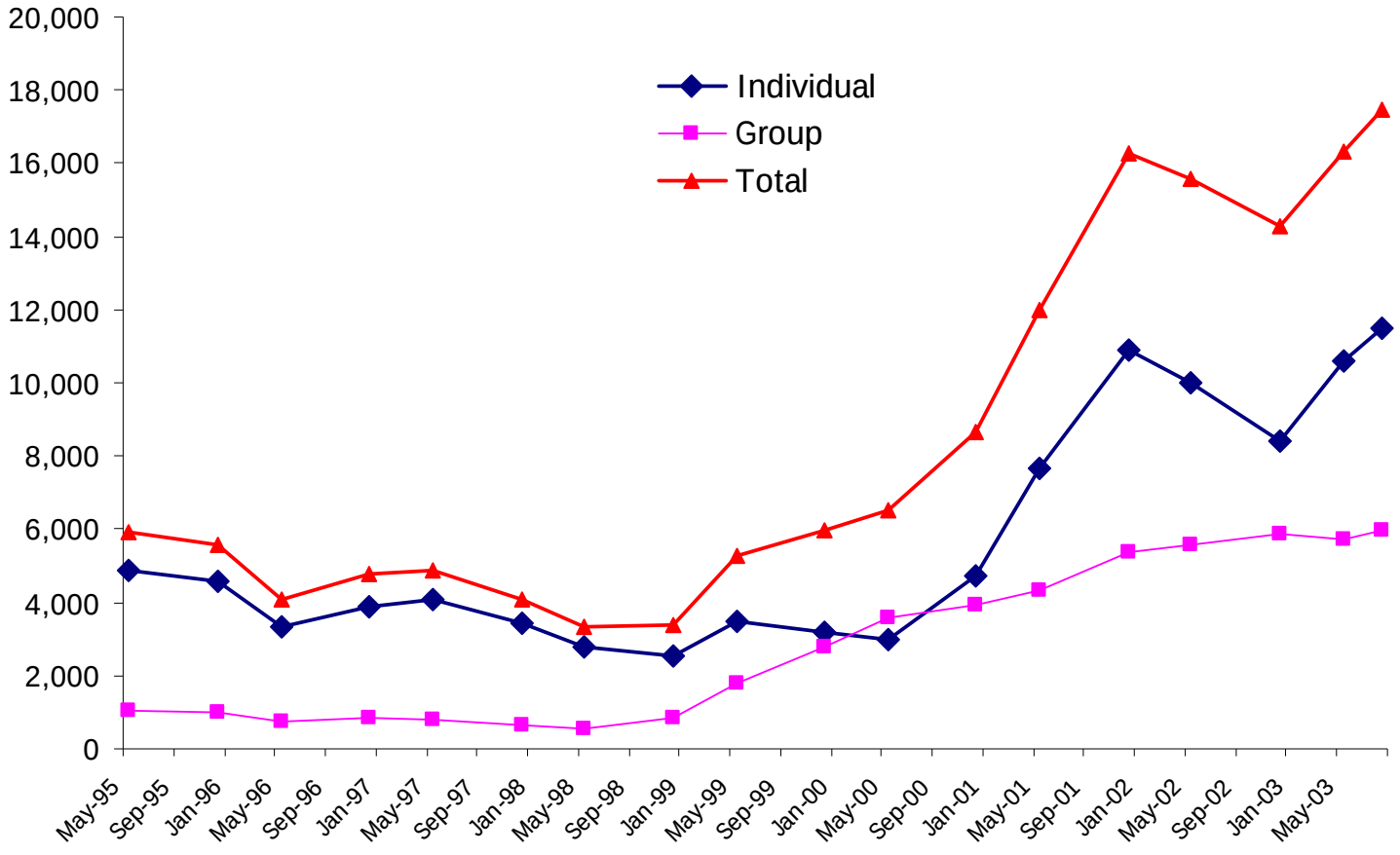
Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Total enrollment is fairly flat over time, but OHP expansion population is shrinking

Total Medicaid enrollment, Oregon, 1994 to 2007



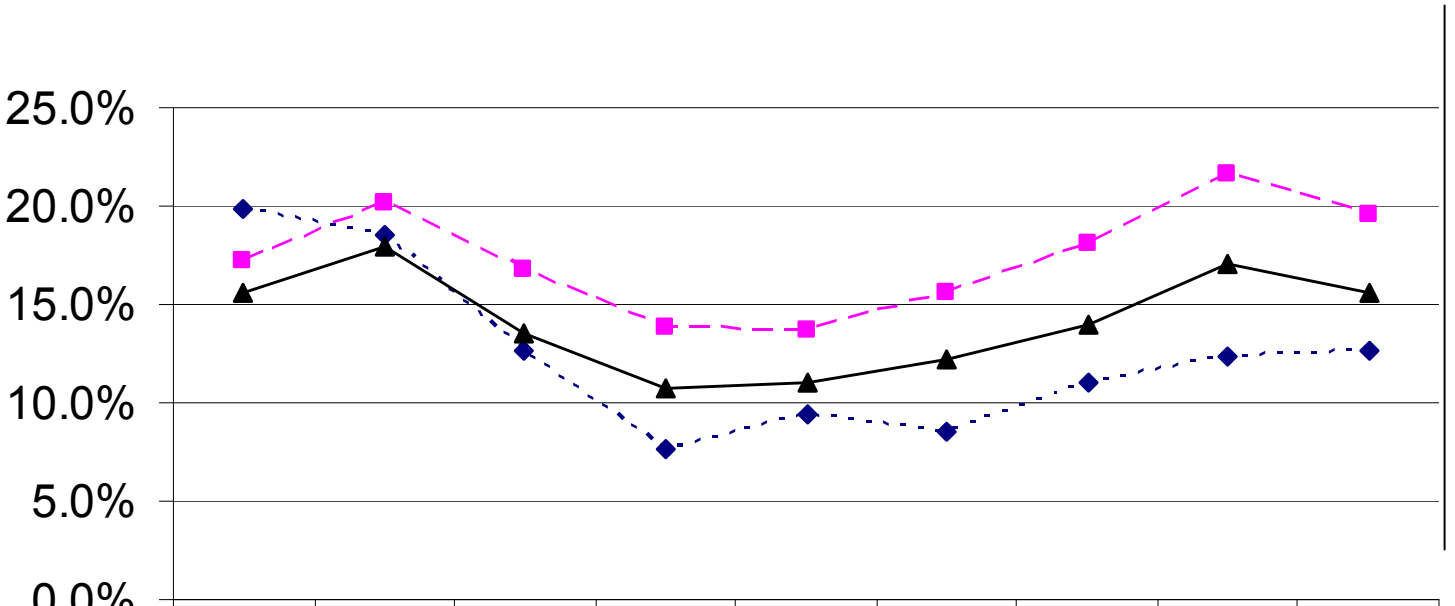
Family Health Insurance Program (FHIAP) enrollment continues to grow.



Who are the uninsured?

Almost one in five adults and one in six children are uninsured

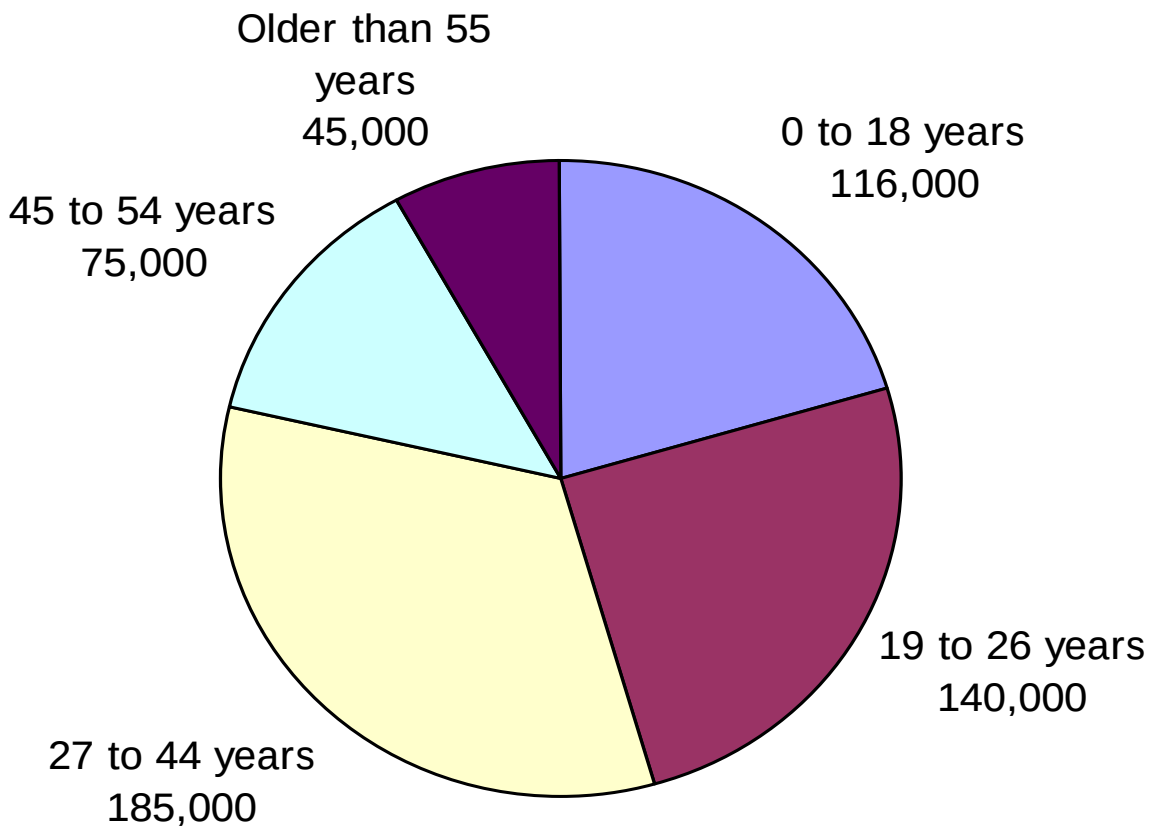
Health Uninsurance Trends, Oregon



	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

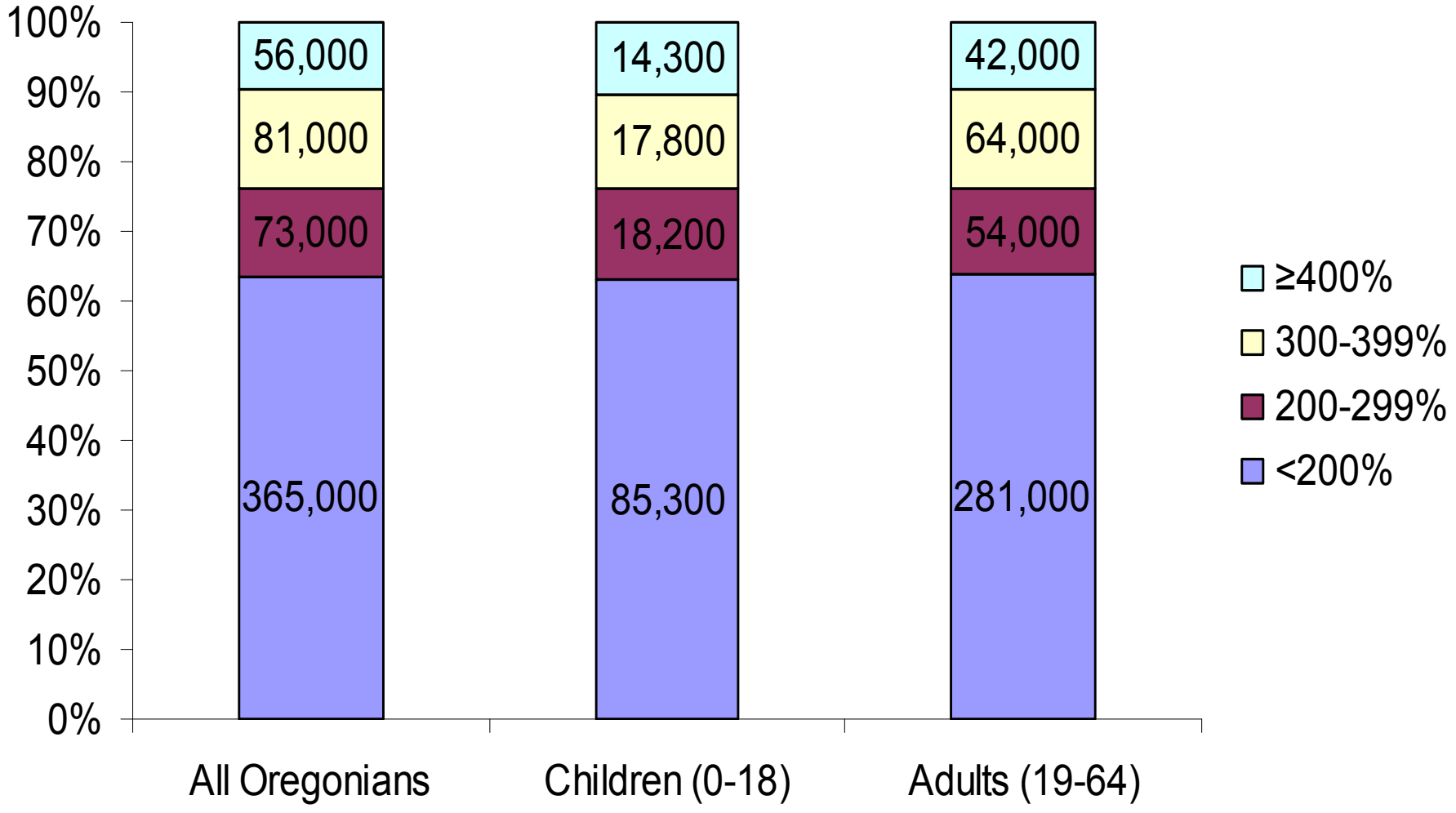
Source: Oregon Population Survey, 1990 to 2006.

Adults are more likely than children to be without insurance.



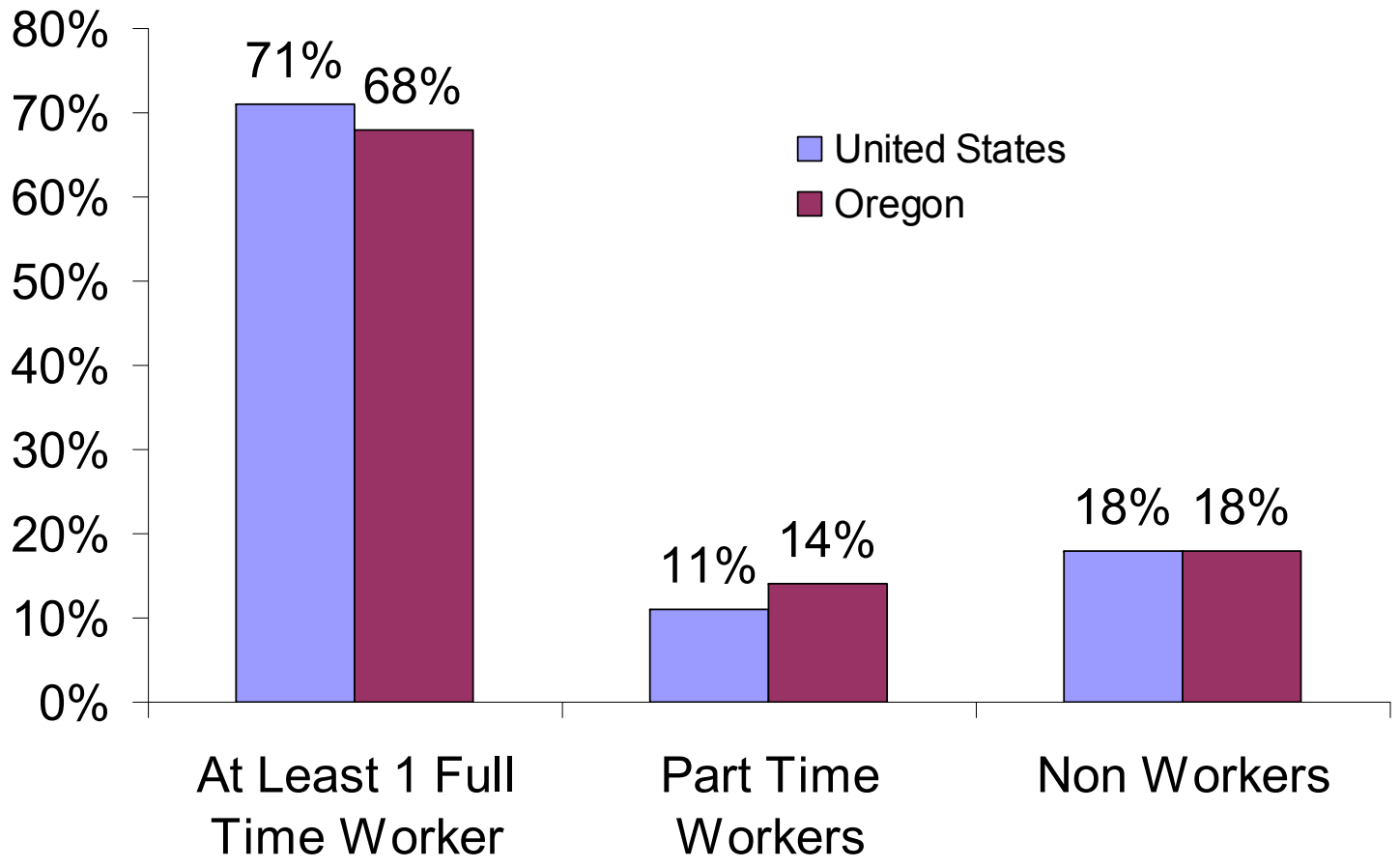
Source: 2006 Oregon Population Survey.

Over 60% of the uninsured are below 200% FPL



Source: 2006 Oregon Population Survey.

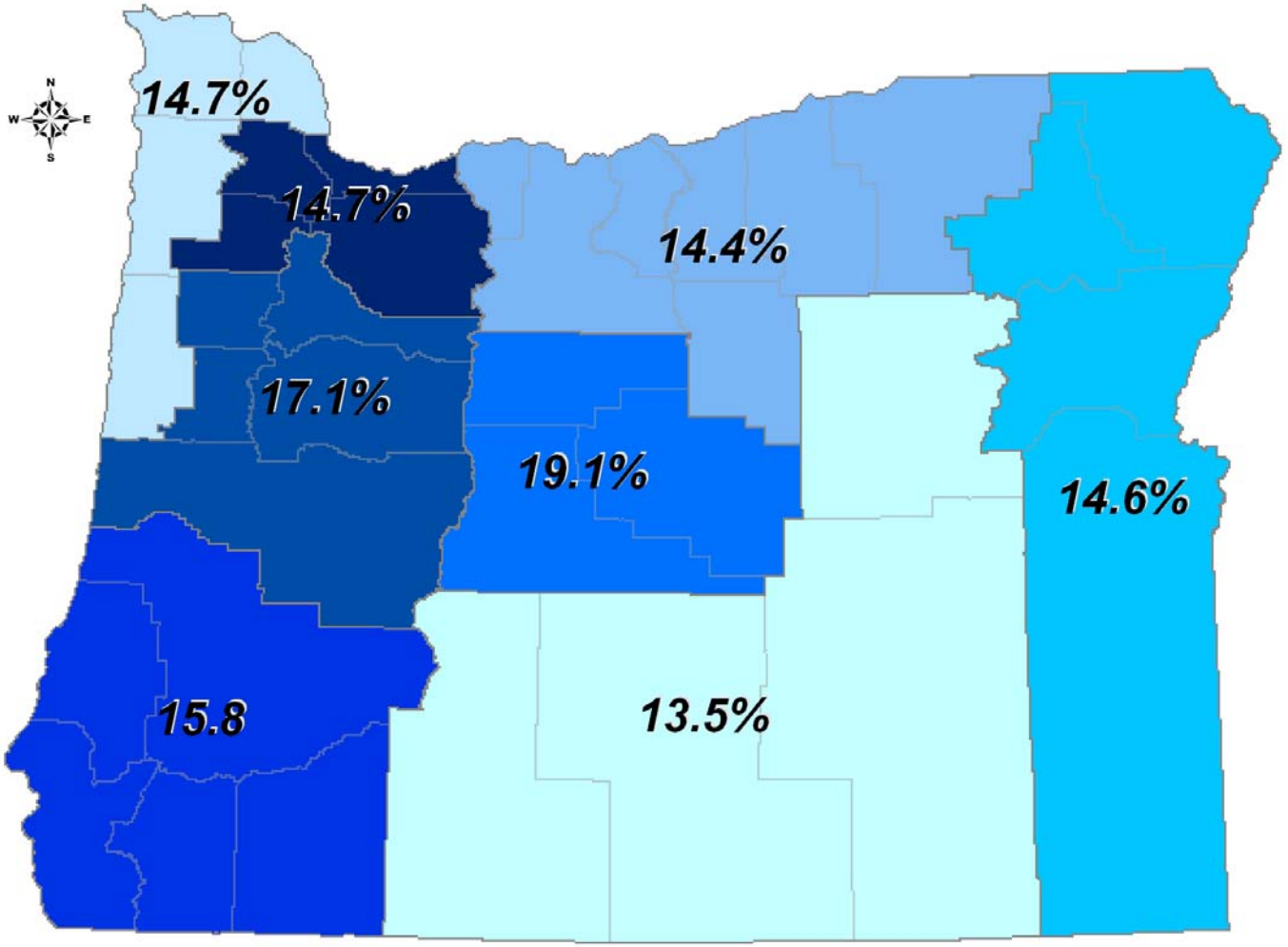
68% of uninsured in Oregon are from families with at least 1 full-time worker



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

Mid-Willamette Valley and Central Oregon have the highest rate of uninsured

Regional Percentages of the Uninsured, Oregon 2006



Hispanics are most likely to be uninsured

Percent Uninsured by Race and Ethnicity:

- Asian – 9.7%
- White, non-Hispanic – 13.3%
- African-American – 14.1%
- American Indian – 27%
- Hispanic, any race – 32.5%

Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Consequences of being uninsured include:

- Reduced access to health care: Uninsured receive too little medical care and receive it too late
- Poorer medical outcomes: Uninsured are sicker and die sooner
- More expensive medical care

Lack of insurance results in avoidable hospitalizations

Uninsured are:

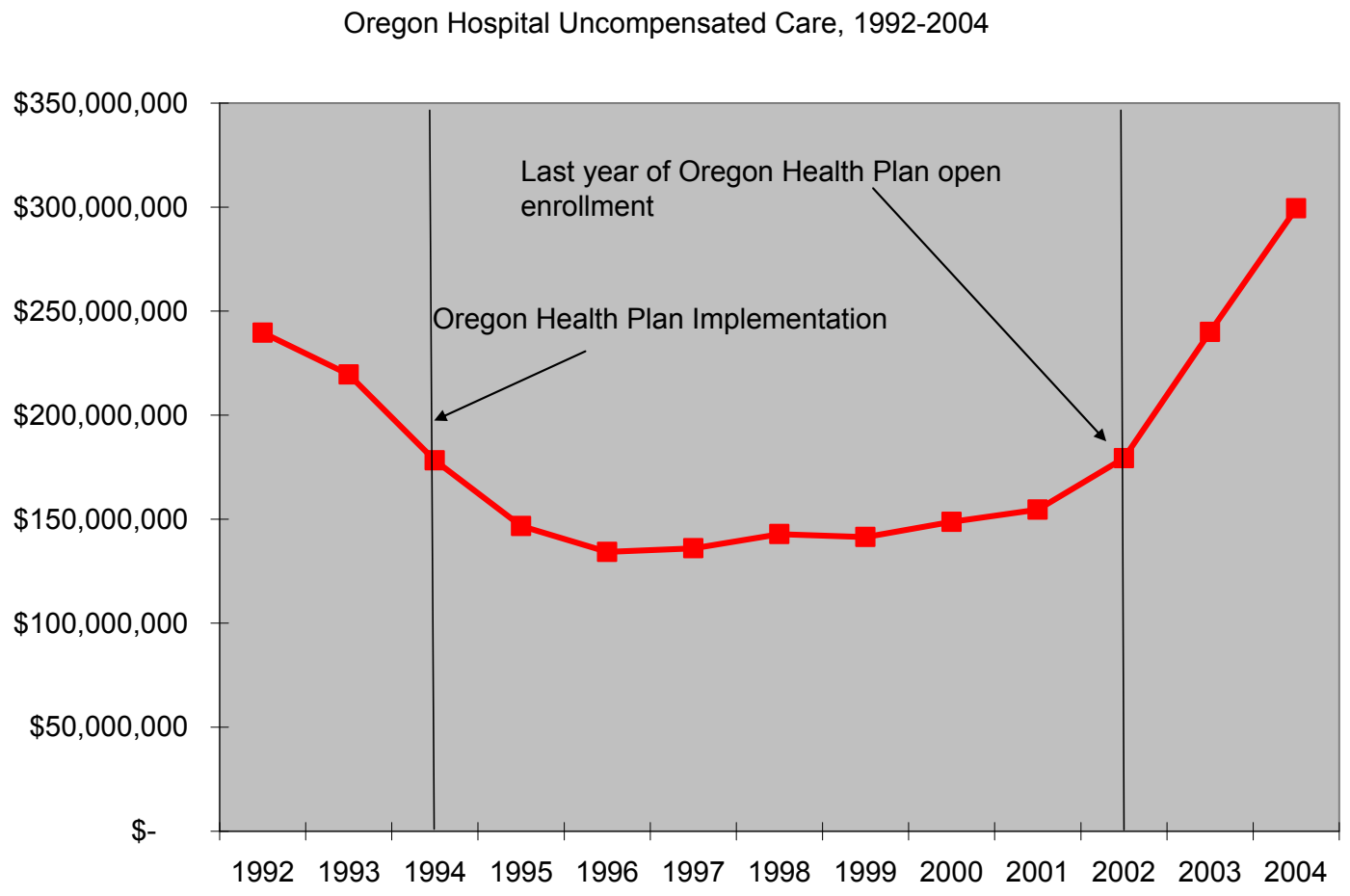
- 2.8X more likely to be hospitalized for diabetes
- 2.4x more likely to be hospitalized for hypertension
- 1.6x more likely to be hospitalized for pneumonia
- 1.6x more likely to be hospitalized for ulcers

Illness and medical costs are a major cause of bankruptcy

- 45.6% of all personal bankruptcies involve a medical reason or large medical debt
- 7 per 1000 single women, and 5 per 1000 men suffered medical-related bankruptcy in 1999
- An increasing number of medical-related bankruptcy involves those with health insurance coverage

Source: Norton's Bankruptcy

In the absence of coverage, uncompensated care increases...



A Brief History of Health Services Prioritization in Oregon

By Bob DiPrete and Darren Coffman

Abstract: *Aware of the need for accountable and effective funding of health care, Oregon established a set of policy objectives to guide the development of a methodology for setting health care priorities. In 1989, the Oregon Legislature created the Health Services Commission and directed it to develop a prioritized list of health services ranked in order of importance to the entire population to be covered. The Commission first tested a formulaic approach using a cost/utility analysis, but the results were unsatisfactory. Subsequent successful approaches rank- order general categories of health services (e.g., Maternity and newborn care; Comfort care) based on relative importance as gauged by public input and on Commissioner judgment. Within these general categories, individual condition/treatment pairs are prioritized according to impact on health, effectiveness and (as a tie-breaker) cost. The resulting prioritized list is used by the Legislature to allocate funding for Medicaid and SCHIP, but the Legislature cannot change the priorities set by the independent Commission. The benefits based on the prioritized list are administered primarily through managed care plans, and approximately 1.5 million Oregonians have gained health coverage due to the expanded access made possible by explicitly prioritizing health services.*

BACKGROUND

In 1987, the Oregon Legislature realized that it had no method for allocating resources for health care that was both effective and accountable. Over the next two years, policy objectives were developed to guide the drafting of legislation to address this problem. These policy objectives included:

- Acknowledgment that the goal is health rather than health services or health insurance
- Commitment to a public process with structured public input
- Commitment to meet budget constraints by reducing benefits rather than cutting people from coverage or reducing payments to levels below the cost of care
- Commitment to use available resources to fund clinically effective treatments of conditions important to Oregonians
- Development of explicit health service priorities to guide resource allocation decisions

About the authors:

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Darren Coffman has served as staff to the Health Services Commission since November 1989 and as its Director since April 1997. Contact: Darren.D.Coffman@state.or.us

- Commitment to maintain the integrity of the prioritization process, including a prohibition against changes to the priorities as part of Legislative funding decisions

The strategy was to move away from "rationing" by excluding people from health coverage or reducing access through underpayment. Instead, when budget limits required reductions in budget costs, health services would be eliminated according to explicit priorities established by an independent commission through an accountable, public process.

Based on these policy objectives, legislation was passed in 1989 creating the Health Services Commission, which was charged with developing a list of health services prioritized from most important to least important to the entire population to be covered.[1] Commission membership is stipulated in statute and must include 5 physicians, one public health nurse, and one social worker with the remaining 4 representing purchasers and consumers of health care.

METHODOLOGY

In setting about its work, the Commission immediately realized that it required the best available information on clinical effectiveness in order to set meaningful priorities, and that specificity would be necessary in defining a particular service for a particular condition. A review of outcomes studies revealed that clinical experience and judgment would need to be the basis for identifying outcomes for most treatments. Accordingly, the Commission worked with hundreds of specialists and sub-specialists to gauge the relative effectiveness of thousands of condition/treatment (CT) pairs defined in terms of ICD-9-CM and CPT-4 codes. Probable health outcomes for a given condition were compared for a) a given treatment, b) alternative treatments, and c) no treatment at all. Also, the Commission obtained information on the cost of the services being prioritized from providers, hospitals, and claims data.

In addition to this information on clinical effectiveness, the Commission also requested information on public values concerning health care. Three methods were used to gather this public input: 1) twelve public hearings in which testimony was taken from Oregonians concerning their health care experiences and preferences; 2) approximately 50 focus groups around the state in which facilitators helped citizens to identify health values on which there was some degree of consensus; and 3) a survey of 1001 Oregonians to identify the impact on overall health resulting from a broad range of hundreds of conditions such as shortness of breath, limited range of motion, social dysfunction, and hearing loss. These three methods provided the Commission with a sense of the relative importance of treating a condition as expressed by those who would be covered by the benefit package resulting from the prioritization of services.

Finding no other examples of such an attempt at health care prioritization anywhere else in the world from which to borrow , the Commission began from scratch. Its first approach to prioritization used the formula shown in Figure 1 to derive cost/utility values for each CT pair, and then ranked these CT pairs as health services accordingly.

[1] Although it was envisioned at this time that the prioritized list would determine the minimum acceptable benefit package for all Oregonians, in fact the only application has been to determine covered benefits for those on Medicaid and SCHIP.

Figure 1. Cost/utility formula used in first prioritization attempt

$$B_n = \frac{c}{Y * [\sum_{i=1}^{5}(p_{i1} * QWB_{i1}) - \sum_{i=1}^{5}(p_{i2} * QWB_{i2})]}$$

[With Treatment] [Without Treatment]

$$\text{with } QWB_{ik} = 1 + \sum_{j=1}^{30} d_{ijk} w_j \qquad k=1,2$$

where:

- Bn = the net benefit value ratio for the nth condition/treatment pair to be ranked.
- c = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.
- Y = the years for which the treatment can be expected to benefit the patient with this condition.
- [term] = the difference in probability weighted QWBs with and without treatment.
- QWB = subjectively weighted sum of health limitations associated with a specific outcome.

The result was deemed unacceptable because it conflicted substantially with the judgment of all Commission members, both physicians and non-physicians. In brief, the problem was that very inexpensive, very effective treatments for relatively unimportant conditions (e.g. malocclusion due to thumb sucking) ranked higher than moderately expensive, moderately effective treatments for very serious conditions. The lesson learned was that while a cost/utility analysis can gauge the cost of remedying a condition, it cannot address the importance of treating the condition in the first place. The Commission's response was to abandon the cost/utility formula and base its prioritization on general categories of treatment, which were ranked to reflect relative importance based on public input first, and effectiveness and cost secondarily. These categories are:

Category 1:	Acute fatal condition, treatment prevents death with full recovery
Category 2:	Maternity care
Category 3:	Acute fatal condition, treatment prevents death without full recovery
Category 4:	Preventive care for children
Category 5:	Chronic fatal condition, treatment improves life span and quality of life
Category 6:	Reproductive services (excluding maternity and infertility services)
Category 7:	Comfort care
Category 8:	Preventive dental care
Category 9:	Proven effective preventive care for adults
Category 10:	Acute non-fatal conditions, treatment causes return to previous health state
Category 11:	Chronic non-fatal condition, one-time treatment improves quality of life
Category 12:	Acute non-fatal condition, treatment does not result in a return to previous health state
Category 13:	Chronic non-fatal condition, repetitive treatment improves quality of life
Category 14:	Self-limiting conditions where treatment expedites recovery
Category 15:	Infertility services

Category 16: Less effective preventive care for adults
Category 17: Fatal or non-fatal condition, treatment causes minimal or no improvement in quality of life

Within these ranked categories, specific services were prioritized based on effectiveness and cost. The Commission also established three subcommittees: the Mental Health Care and Chemical Dependency Subcommittee, the Subcommittee on the Aged, Blind and Disabled, and the Health Outcomes Subcommittee. These subcommittees helped to ensure that the needs of vulnerable populations were fully taken into account, and that the best information on health outcomes was continually available to the Commission as it established and maintained the prioritized list.

As a final step in prioritizing health services, Commission members moved CT pairs "by hand" to assure that the prioritized list reflected their best judgment as clinicians and as representatives of those to be covered under the resulting benefit package.

At this point in the development of the first prioritized list, an unforeseen political problem emerged. Attorneys within the federal Department of Health and Human Services (DHHS) interpreted the Americans with Disabilities Act (ADA) in such a way that they construed the Commission's methodology for setting priorities to be in conflict with that law. Put briefly, the perceived problem was that in asking the public for input on social values, the Commission may have come under the influence of biases against people with disabilities. As a result, the Commission was required to remove all public input obtained from the survey described above. The federal position was that in order to avoid problems with the ADA, priorities could only be based two objective factors: 1) whether the treatment prevents death and, 2) the cost of the treatment. While the Commissioners did not feel that their original methodology was biased against any group, they reluctantly agreed to modify it in order to achieve the goal of greater health care access. Because most objective measures representing health outcomes were not allowed, the subjective collective judgment of the Commissioners became more of a factor. As a result, many of the public values on health that had been expressed through the community meetings, the telephone survey, and in public testimony were reflected through the application of Commissioner judgment in the final prioritization process.

Since its inception in 1993, the prioritized list of health services has been revised every two years as part of Oregon's biennial budget process. An example of a change resulting from these biennial revisions is the movement of cochlear implants to a higher position based on improved outcomes information. Additionally, interim modifications can be made to the list between biennial reviews to account for changes in medical codes and medical advancements that need immediate attention. Examples of the latter include a higher placement for chronic hepatitis C with the treatment of interferon and the inclusion of services related to physician assisted-suicide (which became legal in the state of Oregon in 1997). The Commission also establishes guidelines for those instances where over-utilization is a known problem (e.g. back surgery, hysterectomy) or where ICD-9-CM codes do not provide the necessary differentiation between conditions with significantly varying severity levels (e.g. psoriasis).

In 2006 the Commission completed the first revision in the methodology since implementation, resulting in a complete reprioritization of the entire list. Like the methodology that produced the 1991 list, a ranked set of broad categories defines the framework of the list. This time greater emphasis is placed on preventive services and chronic disease management, reflecting the fact that providing health care before reaching crisis mode will prevent avoidable morbidity and mortality. The nine categories in the methodology in ranked order (with weights which are discussed below), are:

Category 1: Maternity and newborn care *(100)*
Category 2: Primary and secondary prevention *(95)*
Category 3: Chronic disease management *(75)*
Category 4: Reproductive services *(70)*
Category 5: Comfort care *(65)*
Category 6: Fatal conditions where the focus of treatment is on disease modification or cure *(40)*
Category 7: Nonfatal conditions where the focus of treatment is on disease modification or cure *(20)*
Category 8: Self-limiting conditions *(5)*
Category 9: Inconsequential care *(1)*

To sort and rank the line items assigned within categories, the Commission decided that the following measures best capture the impacts on both individual health and population health, considered essential in determining the relative importance of a condition-treatment pair:

- Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact)*
- Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact)*
- Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects)*
- Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability)*
- Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications)*

These impact measures were combined with two additional factors,

- Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness)*
- Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required)*

using the following formula to arrive at a total score,

Category Weight	Healthy Life Years + Suffering + Population Effects + Population Vulnerability + Tertiary Prevention	X	Effectiveness	X	Need for Service

where the category weight is between 1 and 100 as identified on the previous page in parentheses after the category title. The net cost of treatment *(0=high cost, 5=cost saving)* was used to break any ties. While this new list looks significantly different in its rankings, the set of nonfunded services will remain virtually unchanged should it be funded at a level equivalent to funding for the current list. The new list will be implemented no sooner than January 1, 2008 pending State legislative acceptance and DHHS approval. The Legislature will allocate funding based on the new prioritized list, but cannot change the methodology or the priorities.

IMPACT

The prioritized list has succeeded in guiding decisions about the allocation of public resources for health coverage and in making these decisions more explicit and accountable. It has also succeeded in making health policy more reflective both of the best evidence available on clinical effectiveness and of the preferences of those affected by these health policy decisions. Also, physician practice has altered over time to reflect the benefits defined by the prioritized list.

The prioritized list has not succeeded in shifting responses to budget constraints entirely to reductions in benefits, although this was a major policy objective from the beginning. This is because the federal government has been reluctant to allow Oregon to reduce benefits when revenues decline, forcing the state to make adjustments in eligibility and in payment levels to keep within budget. This political constraint has prevented a full exploration of the effectiveness of the prioritization of services in meeting budget limits while maintaining the commitment to cover all those in need and the commitment to pay providers at levels sufficient to cover the cost of care. Even if Oregon were free to move the line further, the range just above line 530 begins to include some serious but treatable conditions. Reducing benefits to within this range would present serious medical and ethical difficulties, as this population would likely not be able to afford the care otherwise.

The prioritized list has had a modest impact on costs per member per month. The actuary has estimated that the costs associated with the funded portion of the list are approximately 90% of the cost of funding the entire list. The reason the impact is not greater is that much of the more expensive care is found high on the list. In fact, diagnostic services - which are very expensive

and growing even more costly every year - are in effect ranked at line zero in the sense that the care required to arrive at a diagnosis is always covered.

Public support for the prioritization process was strong at the outset and has never weakened, and the integrity of the prioritized list has never been questioned by providers or consumers of health services. Moreover, the legislators who make the decisions on allocating public resources for health care have accepted the independence of the prioritization process from the legislature.

In 2002, at the Governor's request, the Commission developed a second prioritized list at a much more summary level to be used in further expanding health coverage. This list prioritizes broad categories of service (e.g. hospital inpatient, physician, prescription drugs, and mental health) and identifies cost sharing levels for each category of service at each priority level (so that a given category of service may appear more than once on the list with two or more levels of cost sharing). This methodology does not require analysis at the ICD-9-CM/CPT-4 level, and its goal was to develop a public program benefit package that approximates the typical private insurance benefits purchased by Oregon businesses for employees.

A reduced benefit package, called "OHP Standard" was created by overlaying the more detailed prioritized list of CT pairs with the prioritized categories of services so that within a category (e.g. physician care) nothing is covered that is not "above the line" on the larger prioritized list of health services. This package is available to the optional Medicaid populations that gained eligibility under Oregon's Medicaid Demonstration. The "original" prioritized list of CT pairs is still used exclusively to define the "OHP Plus" benefits provided to the mandatory Medicaid populations.

Coverage under the prioritized list has been primarily in managed care, and many participating managed care plans have developed mechanisms for accommodating practice patterns to the benefit package defined by the list. Participating health plans have included Oregon's Blue Cross & Blue Shield HMO, hospital-based plans, and IPA-based plans. In addition, the delivery system has included partial-capitation health plans and primary care case managers outside major population centers.

Since its inception, over 1.5 million Oregonians have been covered under the prioritized list. Over that same time period, between 5 and 6 million people have lived in the state. In effect, roughly one-third of the state's population has been touched by the expanded access made possible by setting explicit health service priorities.

Overview of 2006 Biennial Review of Prioritized List

Background on the Health Services Commission

The Oregon Legislative Assembly, led by then Senate President John Kitzhaber, created the Health Services Commission (HSC) through the passage of Senate Bill 27 in 1989 in the creation of the Oregon Health Plan. The HSC is made up of eleven volunteer members, who are appointed by the Governor and confirmed by the Senate for four-year terms. The members include five physicians (one of whom must be a doctor of osteopathy), one public health nurse, one social services worker, and four consumer representatives. The HSC's charge is to provide a biennial report to the Governor and Legislature to include a list of health services "ranked by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served." The Prioritized List of Health Services developed by the HSC is priced at various levels of coverage by an independent actuarial firm and then the Oregon legislature draws a line on the list to indicate what services will be reimbursed under the OHP Medicaid Demonstration (those services appearing above the funding line on the list) and those that will not (those appearing below the funding line).

Background on the Prioritized List of Health Services

The Prioritized List of Health Services represents a rank ordering of condition-treatment pairs using ICD-9-CM, CPT, and HCPCS medical codes to define the services on each of the line item on the list. The list assumes that all diagnostic services necessary to determine a diagnosis are covered. Ancillary services necessary for the successful treatment of the condition are to be presumed to be a part of the line items. This means that codes for prescription drugs, durable medical equipment and supplies, laboratory services, and most imaging services are not included on the prioritized list but are still reimbursed as long as the condition for which they are being used to treat appears in the funded region. The state currently covers lines 1-530 of the 710 line items on the list.

The 2006 Biennial Review of the Prioritized List

In the summer of 2005, as the HSC began to prepare for the biennial review of the list. The Commission was encouraged to ask themselves whether the basic structure of the list represented what they truly considered to be the most important to the least important. It was suggested that a higher emphasis on preventive services and chronic disease management would ensure a benefit package that provides the services necessary to best keep a population healthy, not waiting until an individual gets sick before higher cost services are offered to try to restore good health again.

The HSC believed that placing a higher value on prevention and chronic disease management was a good idea on its face and could be crucial in maintaining a sustainable program as we face an aging population. The Commission put together a task force that included HSC members, stakeholders, and health policy experts to study the issue further. This task force reviewed the principles on which the OHP was based, the values expressed in the four sets of public forums held by the HSC since 1990, and the results of the biennial public surveys on health care conducted by Oregon Health Decisions. The task force found evidence in all of these sources that supported such a shift in health care priorities and recommended the HSC pursue a reprioritization of the list to reflect this new emphasis.

New Methodology

In December 2005 the HSC embarked on the developing a new prioritization methodology for the first time since the list was first implemented in February 1994. First the HSC developed the framework of what they thought the new list should look like by defining a rank ordered list of nine broad categories of health care (see Table 1).

Next, each of the 710 on the 2005-07 list were assigned to one of the nine health care categories. During this process, as has occurred with all biennial reviews, lines were merged or split in an attempt to where appropriate. For example, all superficial abscesses where combined into one line as outcomes and costs are similar regardless of where the abscess is located. In contrast, the Commission found relatively minor birth traumas lumped together with imminently life-threatening conditions and split these into two separate lines. As more lines were merged together than split, the new list is 680 lines long compared to the current list of 710. As most of these mergers involved currently funded condition-treatment pairs, new line 503 best equates to the benefit package represented in lines 1-530 of the current list.

Once the condition treatment pairs were assigned to one of the nine health care categories, a list of criteria was developed to sort the line items within the categories (see Table 2). These measures were felt to best capture the impacts on both the individual's health and the population health that HSC thought were essential in determining the relative importance of a condition-treatment pair. The HSC Medical Director and HSC Director worked with two HSC physician members to established ratings for the criteria for over 100 lines in order to establish a general scale to follow for each of the criteria. The HSC Medical Director (and in most cases HSC Director) then met with individual HSC physician members and other volunteer physicians

Table 1
Rank Order of Health Care Categories

1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*
2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*
3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*
4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*
5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*
6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*
7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*
8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*
9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

Table 2
Population and Individual Impact Measures

Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - the cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

with OHP experience. After ratings were established for all 710 lines, they were reviewed by the HSC Medical Director and HSC physician members for accuracy and consistency. A total score was then calculated for each line using the following formula to sort all line items within each of the health care categories, with the lowest net cost used to break any ties:

Impact on Healthy Life Years				
+ Impact on Suffering				Need for
+ Population Effects	X	Effectiveness	X	Service
+ Vulnerable of Population Affected				
+ Tertiary Prevention (categories 6 & 7 only)				

A workgroup of the HSC members then met to explore the best method for intermixing condition-treatment pairs across health care categories. While the nine health care categories were meant to establish the framework of the new list it was always clear that not every service in Category 1 was more important than every service in Category 2 and so on. In the methodology used to develop the initial prioritized list implemented in February 1994, approximately 75% of the line items where hand adjusted after an initial computer sort on the

treatment's prevention of death and cost of the treatment. The workgroup found that applying a weight to each category that was then multiplied by the total criteria score for each condition-treatment pair achieved an appropriate adjustment in the majority of the cases. The full commission agreed with the conclusions of the workgroup and approved the weights shown in parentheses after the title for each category in Table 1. Hand adjustments were applied where the application of this methodology did not result in a ranking that reflected the importance of the service, which was the case in fewer than 5% of the line items.

The following two examples illustrate line items that were given a very high score and a very low score as a result of this process.

Schizophrenic Disorders	Grade I Sprains of Joints and Muscles
(Old line: 159, New line: 27)	(Old line: 626, New line: 628)
Impact on Healthy Life Years: 8	Impact on Healthy Life Years: 1
Impact on Suffering: 4	Impact on Suffering: 1
Effects on Population: 4	Effects on Population: 0
Vulnerability of Population Affected: 0	Vulnerability of Population Affected: 0
Effectiveness: 3	**Effectiveness: 2**
Need for Service: 1	Need for Service: 0.1
Net Cost: 5	*Net Cost: 4*
Category 3 Weight: 75	Category 8 Weight: 5
Total Score: 3600	Total Score: 2
[(8+4+4+0) x 3 x 1] x 75 = 3600	[(1+1+0+0) x 2 x 0.1 x 5 = 2

Some of the services moving towards the top of the list as a result of this reprioritization include maternity care and newborn services, preventive services found to be effective by the US Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

PUBLIC INPUT

The HSC solicited public and stakeholder input throughout the process. As always, all commission meetings are open to the public and time is set aside for public testimony. When the HSC was initially considering reprioritizing the list, they sent out a survey to over 200 stakeholders. This included physicians randomly selected from the Board of Medical Examiners mailing list, specialty societies, hospitals, safety net clinics and school-based health centers. Thirty-one responses were received and, of these, thirty were supportive of a new emphasis on prevention and chronic disease management.

After the methodology had taken shape, the HSC conducted five focus groups with specialty society presidents, members of the Oregon Academy of Family Practice, representatives from service providers (hospitals, physicians, OHP managed care plans, mental health, chemical dependency, dentistry and home health), consumers, and consumer advocates. There was no objection to the direction that the HSC was taking.

Medical directors and administrators for the contracted managed care plans were kept up to date on the HSC's work and also were supportive of the reprioritization effort.

DRAFT PRIORITIZATION METHODOLOGY
FOR HSC'S 2006 BIENNIAL REVIEW OF LIST

Each line item on the Prioritized List will initially be assigned to one of the following ranked categories of care.

1) Maternity & Newborn Care (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*
2) Primary Prevention and Secondary Prevention (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*
3) Chronic Disease Management (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension. Medical/psychotherapy for schizophrenia.*
4) Reproductive Services (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*
5) Comfort Care (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*
6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*
7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*
8) Self-limiting conditions (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*
9) Inconsequential care (1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

It was felt that the dysfunction lines will have to be handled separately as they were in the prioritization of the initial list.

A preliminary weight (in parentheses) has been assigned to each category to be used later in the process.

Population & Individual Impact Measures

Impact on Health Life Years - to what degree will the condition impact the health of the individual if left untreated, considering the median age of onset (i.e., does the condition affect mainly children, where the impacts could potentially be experienced over a person's entire lifespan)? *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - to what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) should also be factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - the degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - to what degree does the condition affect vulnerable populations such as those of certain racial/ethnic decent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - in considering the ranking of services within new categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - to what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - the percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - the cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

To arrive at a total score for a line item the ratings for the first four measures (five for categories 6 and 7) will be summed and then multiplied by the effectiveness rating, the need for medical services, and finally the weight of the category to which it is assigned. The rating for net cost will be used as a tiebreaker in the case of equal total scores for two or more line items. It may also be considered along with other factors in making "hand-adjustments" after the initial computer sort.

EXAMPLES OF LINES REVIEWED TO DATE

All values are subject to change

Schizophrenic Disorders (Line: 159)
Impact on Healthy Life Years: 8
Impact on Suffering: 4
Effects on Population: 4
Vulnerability of Population Affected: 0
Effectiveness: 3
Need for Service: 1
Net Cost: 5
Category 3 Weight: 75
Total Score: 3600

Type II Diabetes Mellitus (Line: 311)
Impact on Healthy Life Years: 7
Impact on Suffering: 2
Effects on Population: 0
Vulnerability of Population Affected: 2
Effectiveness: 4
Need for Service: 1
Net Cost: 4
Category 3 Weight: 75
Total Score: 3300

Acquired Hemolytic Anemias (Line: 116)
Impact on Healthy Life Years: 6
Impact on Suffering: 1
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 5
Effectiveness: 4
Need for Service: 1
Net Cost: 3
Category 6 Weight: 40
Total Score: 1920

Basic Restorative Dental (Line: 495)
Impact on Healthy Life Years: 4
Impact on Suffering: 0
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 4
Effectiveness: 5
Need for Service: 1
Net Cost: 3
Category 7 Weight: 20
Total Score: 900

Dysplasia of Cervix (Line: 268)
Impact on Healthy Life Years: 6
Impact on Suffering: 0
Effects on Population: 0
Vulnerability of Population Affected: 1
Effectiveness: 4
Need for Service: 1
Net Cost: 3
Category 2 Weight: 95
Total Score: 3325

Appendicitis (Line: 12)
Impact on Healthy Life Years: 9
Impact on Suffering: 2
Effects on Population: 0
Vulnerability of Population Affected: 0
Tertiary Prevention: 5
Effectiveness: 5
Need for Service: 1
Net Cost: 4
Category 6 Weight: 40
Total Score: 3200

Closed Joint Dislocation/Deformity (Line: 472)
Impact on Healthy Life Years: 6
Impact on Suffering: 4
Effects on Population: 0
Vulnerability of Population Affected:
Tertiary Prevention: 2
Effectiveness: 5
Need for Service: 1
Net Cost: 2
Category 7 Weight: 20
Total Score: 1200

Acute Tonsillitis Other Than Strep (Line: 647)
Impact on Healthy Life Years: 1
Impact on Suffering: 1
Effects on Population: 1
Vulnerability of Population Affected: 1
Effectiveness: 3
Need for Service: 0.5
Net Cost: 4
Category 8 Weight: 5
Total Score: 15