

Draft Elements of the Oregon Better Health Act

December 2, 2006 DRAFT

Eligibility

Who will be “eligible” for a public subsidy to help them finance the cost of their health care, whether that is public coverage or a public subsidy to purchase private coverage?

All Oregonian residents will be eligible for the core benefit.

This means that we would eliminate categorical eligibility (including the 28 different eligibility categories in the Medicaid program).

Financing

Where the money to purchase the core benefit will come from?

Our approach to financing is based on the belief that, in the final analysis, the responsibility to ensure financial access to a core benefit will fall to the public sector, not the private sector. It can be done in one of three ways: (1) public resources can be used to finance a basic level of care (“core benefit”) for everyone (the “public education” model); (2) public resources can be used to provide a sliding scale subsidy to those with lower incomes to ensure financial access to the core benefit (means testing); or (3) a combination of these two approaches can be used.

Basic assumptions concerning Financing:

- (1) The core benefit will be portable and not tied to employment
- (2) The financing mechanism to pay for this core benefit must be broad-based and equitable (everyone should contribute and everyone should benefit).
- (3) Financing must be transparent and explicit with no hidden subsidies or cost-shifting.
- (4) It is the responsibility of society to pay for the core benefit for those who do not have the financial means to do so themselves.

So ultimately, the “core benefit” is going to be the level of care we are willing to pay for with public resources. People who are unable to afford to pay for their own care are going to rely on public resources (“society”) to

finance it for them. People with disposable income can always purchase more (above the core benefit). People who have little or no disposable income cannot buy more -- and if funding is explicit with no hidden subsidies or cost shifting -- the level of care we provide to them is the floor or the “core benefit.”

The major public subsidies in the current system lie in three places: (1) Medicare; (2) Medicaid; and (3) the public subsidy of employer-sponsored coverage. Since public resources are resources held in common they should be allocated in a way that benefits the larger population from which they flow – not just some of it. Everyone who pays taxes contributes to the funding of Medicare and Medicaid and, through the tax expenditure (incentive), to the publicly subsidized tax benefit for employer sponsored coverage – yet millions of these same people receive no public subsidy whatsoever and cannot afford health insurance for themselves and their families.

Pooling the resources from Medicaid and Medicare is fairly straight forward (through not necessarily easy from a political standpoint) while dealing with the public subsidy for employer sponsored coverage is more complicated because not all employers offer health insurance. There are a number of ways to address this -- and there are significant issues associated with each option.

For example, one way might be through a payroll tax (on employers and employees) to help finance the “core” benefit and allowing employers who offer coverage to use the value of the tax exclusion to offset the tax. We must recognize, however that smaller employers often have less margin in which to contribute to the cost of their employees’ health care and that over 15 percent of Oregon workers today are “self-employed” and thus would not be subject to a traditional payroll tax.

Regardless of how we ultimately deal with the employer-sponsored component of the system, however, our approach must result in lower net costs for employers who are offering coverage; must not create a new disincentive for employers to offer coverage through the workplace; and must address the current inequities between employers which do and do not offer coverage.

Clearly, there needs to be some “core benefit” that is not tied to the workplace given the mobility of the population and the frequency with which people change jobs. That does not mean that people will not continue to receive some element of their health care financed through their place of employment -- but the role of employers in the health care system of the future must take into account: the realities of a highly competitive global economy; the mobility of the workforce and the changing structure of the workplace; and the fact that not all employers offer health insurance coverage today.

The objective of our financing structure is to create a pool of [public] funds with which to finance the core benefit. This pool must be both “broad based and equitable” -- all Oregonians (except the very poor) must contribute to it and all Oregonians (regardless of their income) must be eligible for the core benefit financed through the pool. [Everyone contributes/everyone benefits].

Benefit

What will be paid for (covered) with the financing?

Note: Since we are proposing to include Medicare funds in the financing pool, the benefit design must strive to identify the medical and health needs of an aging population and to ensure that those needs are met with quality services, delivered in a timely and cost-effective manner.

Clearly, we have the ability to describe the process by which we can develop a “Core Benefit.” In fact, we have done it before in Senate Bill 27 (which created the Oregon Health Plan) and it does not need to be overly prescriptive. (Attached is the exact language from Section 4 of Senate Bill 27 which established the Health Services Commission and outlined the criteria and process to be used to establish priorities). The detailed methodology that we relied on to determine the benefit under the OHP, however, was worked out by the Commission during the implementation phase. Obviously we will need to add more and different criteria for this bill as we are considering more than just the Medicaid population. The point is that we have some history here. Here is one place to start.

A “core benefit,” which will seek *to maximize the health of the population*, will be defined from among health services -- both physical (including dental and vision) and mental health and chemical dependency services -- involved with providing nine broad categories of care:

Preventive Care (including wellness and health promotion)
 Pregnancy and Childbirth
 Treatment of Acute Life Threatening Conditions
 Treatment of Acute non-Life Threatening Self-limiting Conditions
 Catastrophic Care
 Chronic Care
 End of Life Care
 Rehabilitation
 Elective Care.

In the development of the core benefit, the needs of different populations must be taken into account including, but not limited to: pregnant women and infants, children, adolescents, working adults, the elderly and those with special needs (e.g. the blind and those with other disabilities).

To define the core benefit, a Health Services Commission will be established. To insulate the work of the Commission from the political process it will be modeled after the Federal Reserve Board. Through a transparent process, the Commission will seek public input to prioritize these health services from the most important to the least important in terms of the comparative health benefits of each service to the entire population served and based on a consideration of criteria that are publicly debated and agreed upon including but not limited to:

Social values

Clinical effectiveness

The degree to which medical evidence exists to support the relationship between the service and the desired health outcome

The relative cost effectiveness of new drugs, procedures and technologies in terms of the health benefit for the entire population served.

Delivery

How the delivery of the covered benefit will be organized?

Once we have agreement on a process to define the “Core Benefit,” the next question is how to organize the delivery of the care. Answering this question in a way that ensures quality but reduces cost is one of the most important aspects of what we are trying to do.

How the delivery of care is organized will be driven in large part by the priorities established in the benefit design – which will be a reflection of

what we value in the new system. *We should not necessarily assume what the priorities will be*, but must build broad consensus on the process and criteria that will be used to establish the priorities. Changes in the delivery system will reflect these priorities.

For example:

- If prevention and primary care is highly prioritized and elective procedures are given a lower priority major changes would be needed in delivery system. For instance, better prevention might well require primary care that includes sophisticated information systems and maximizes the use of nurse practitioners and physician assistants -- uses many less expensive practitioners -- will be needed for better prevention. Likewise, if elective surgery was given a lower priority, ambulatory surgery centers might be deemphasized with a likely shift by such surgery centers to focus exclusively on those with private resources.
- If chronic care management is more highly prioritized concepts related to “medical homes” might need to be pursued. (For chronic conditions like diabetes -- which carry co-morbidities influenced by behavioral, family and community factors -- the “medical home” provides a way to integrate the management of these conditions with a full spectrum of services). Administrative efficiencies become much more important in chronic care than in acute care and it is easy to imagine very different systems emerging that devote less to administration in order to provide more resources to actual care.

Our biggest challenge here is to do with the delivery system, what we have been able to do with the benefit. That is, to provide enough detail to generally shape how the delivery of care will be organized to reflect the priorities, while not being over-prescriptive and allowing a lot of latitude and flexibility for working out details during the implementation phase.

Payment and Cost-Sharing

Payment is the amount that providers will be paid for delivering the covered benefit. Cost-sharing is the amount that individuals will pay for their own health care as opposed to what will be paid by someone else (a third party payer).

The way payment and cost-sharing are structured will help create the financial incentives for both the supply side (provider) and the demand side (consumer) side. These financial incentives (“market solutions”) must be aligned (or realigned) with what we want the new system to accomplish. Thus, the establishment of payment and cost-sharing parameters must be done in the context of the priorities set for determining the covered benefit.

For example, there is much less competition for mental health and chemical dependency services than for cardiac services. The reason, of course, is that providing cardiac services is a financial winner while providing mental health services is a financial loser. This problem is exacerbated by the fact that the current system prioritizes virtually all cardiac services---even ineffective ones (note recent studies on angioplasty and stents) -- while it rations resources for mental health and substance abuse.

***Note:** This is a great example of how current financial incentives focus on individual rather than population health. Mental health and addiction are the primary cause of school failure, school drop out and drive much of the cost in our social services and criminal justice systems. And investment here would have a huge social return on investment in terms of the health of the population and, over time, a huge avoided cost.*

There are also dramatic disparities in reimbursement between procedural specialties and primary care – largely because our current system assigns a higher priority to the former. Thus, the actuarial determination of payment to providers must take into consideration not just the cost of providing a given service but also the relative importance of that service towards maximizing population health. In other words, reimbursement policy must create the necessary financial incentives to ensure that the services in the core benefit are widely available.

By the same token, cost sharing (e.g. co-payments and deductibles) should not be viewed simply as a tool to shift costs from third party payers to individuals – and thus generate additional private funding -- but rather as a tool to help create the necessary financial incentives and disincentives to influence consumer behavior. For example, if someone wants a very expensive brand name drug when a much cheaper generic is just as effective clinically and just as safe, there may be a co-payment associated with the brand name drug but not the generic. From this perspective, cost sharing

becomes an effective way to communicate to consumers that a particular drug, device or service is not as effective or is not as important from the standpoint of maximizing population health.