

In Focus

That Day's Gonna' Come

They Said It

Arizona Governor Jan Brewer: "The state only has so much money and we can only provide so many optional kinds of care."

When we think of Oregon, some of us may envision Portland, beautiful on its own and even more so when nearby Mt. Hood is included in the picture. Sports fans will immediately have the national football title contending University of Oregon's Ducks in mind. But we would be making a big mistake not also to ponder seriously what the State of Oregon is doing in shaping health care for nearly 300,000 of its public education employees and its even larger Medicaid population.

Briefly, what Oregon is doing is to take a three-tier approach to its public educational health plan coverage levels:

- Tier 1: Make free, or heavily subsidized, those medical services that have a proven high and positive impact on health and also are cost effective
- Tier 2: Apply standard cost sharing to medical services that are widely accepted as medically necessary and not generally subject to overuse
- Tier 3: Make some medical services more expensive for plan members if evidence shows that those services produce insufficient clinical benefits, are preference or supply sensitive or are not cost effective

Tier 1 applies the familiar "value-based" plan design incentives that are aimed at increasing the use of preventive services and prescription drugs and supplies to manage chronic condition. For years, value-based proponents have encouraged benefits managers to provide those services, drugs and supplies for free or with very low employee cost sharing.

Of greater interest are the medical services that Oregon has put into Tier 3. These services are deemed to be of questionable value. What are they?

Emergency department visits; arthroscopy; hip and knee replacement; hysterectomy; magnetic resonance imaging, computed tomography and positron emission tomography scans; upper endoscopy; coronary angioplasty and stents; spinal surgery for lower back pain. Cancer treatments are exempt from the higher cost share.

These services fall into a classification known as "preference-sensitive" services. Such services contain an element of discretion; they are not services that every patient could, should or would decide to have performed. They are thought to be over performed. Hence, in Tier 3 Oregon applies a \$500 add-on co-payment when these services are used.

For benefits managers, a question is: does Oregon's approach to allocating finite and increasingly scarce public employee health care dollars presage what's ahead in the private sector? Employers hardly have unlimited money for employee health care. Are your plan members any different than the teachers in Oregon? They have accepted this approach; would your plan members? **Should** yours? Is this what health plan design leadership looks like?

Think the approach used for Oregon teachers is too aggressive? If not, you might also be interested in what Oregon does for

Medicaid. Its approach has been to decide which medical services are worth paying for and which aren't. For the patient, it's the ultimate in zero-sum health care.

Acting under legislation passed in 1989, Oregon has delivered health care to its Medicaid and SCHIP participants by reference to a list of covered services. Quite simply, if the medical service is "above the line" of all the services on the list, it's covered. If it's below the line, it's not covered *at all*. The list is chosen by the Oregon Health Services Commission and is not subject to change by the Oregon state legislature. For 2011, there are 502 medical procedures above the line. From Oregon's Commissioners:

The Oregon Legislature created the Health Services Commission and directed it to develop a prioritized list of health services ranked in order of importance. 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. Approximately 1.5 million Oregonians have gained health coverage due to the expanded access made possible by explicitly prioritizing health services.

How do the Commissioners decide what condition/treatment pairs go above the line and which don't? The Commission bases its prioritization on assessments of treatment, like the following:

- **Impact on health life years** - to what degree will the condition impact the health of the individual if left untreated
- **Impact on suffering** - to what degree does the condition result in pain and suffering?
- **Population effects** – to what degree will individuals other than the person with the illness be affected?
- **Vulnerability of population affected** - to what degree does the condition affect

vulnerable populations such as those of certain racial/ethnic descent?

- **To what degree does early treatment** prevent complications of the disease (not including death)?

The above impact measures are combined with two additional factors:

- **Effectiveness** - to what degree does the treatment achieve its intended purpose?
- **Need for medical services** – to what degree will medical services be required after the diagnosis has been established?

The health care coverage consequences of lack of funds reached its nadir several weeks ago when, claiming poverty, the State of Arizona began denying transplant coverage in certain Medicaid cases.

Are Oregon and Arizona's approaches merely precursors to what the private sector will have to consider (if employees don't get sent to the Exchanges)? Is coverage triage based on efficacy our future touchstone for plan design?

Year-after-year, health care costs rise at rates we say are unacceptable and unsustainable. Yet, can it be said that the steps we take match the problem we bewail?

Random acts of wellness and marginal steps of cost shifting are having little impact. If we don't get more aggressive, we may find ourselves in the same boots as Arizona.

Click [here](#) for a printable version of this In Focus.

The Chelko Consulting Group LLC is not offering legal advice. Our comments should be accepted subject to legal review and confirmation by your legal counsel.