SB 122 Evidence-Based Health Insurance Benefits

Background: Evidence-based medical practice reviews are performed by professional societies (e.g. American College of Physicians) and standard setting organizations such as the *Oregon Health Evidence Review Commission* (HERC) (ORS 414.690) to encourage the use of best current scientific evidence and analysis of comparative effectiveness in the *delivery* of medical care (pharmaceuticals, technologies, medical equipment, services and procedures) and *third-party coverage* decisions.

These reviews and guidelines (or guidances) represent a proven strategy for quality improvement and practice consistency. In many instances, empirical evidence has demonstrated that they have generated considerable *cost-savings*, as well.

Problem and Opportunity: Although the strategy, itself, has been shown to be effective, its overall impact depends on the degree to which practitioners apply the reviews and guidelines in actual patient care. Adherence rates have varied geographically and by service or procedure. A study of cancer specialists in a large specialty network reported that 54% complied with evidence-based guidelines; a similar study of Michigan cardiologists indicated statewide average adherence to guidelines for cardiac angioplasty of 57% with a range of 45%-82% across hospital referral regions.

The *problem* is: how to increase practitioner adherence to gold-standard evidence-based medical reviews and guidelines.

Approach: Insurance benefit design can be an important element of a robust strategy for reducing healthcare costs and improving quality and consistency of care. One way the strategy could work would be to limit covered benefits to those services (including procedures, pharmaceuticals, devices and supplies) that met evidence-based guidelines. This approach could be applied to a limited number of covered benefits on a *pilot* basis to demonstrate its feasibility and to work out any kinks.

Proposal: ORS 743.010 and ORS 742.005(3) already give the Insurance Division authority to establish standards (by rule) for the coverages (benefits) written by health insurers. Although this authority has been applied sparingly by state insurance regulators in healthcare (some examples being the

disapproval of "dread disease" policies in some states and the issuance, by the NAIC, of model health insurance regulations incorporating prohibited provisions), it has been used more widely in the property and casualty sector (e.g. the standardization of homeowners' coverage.)

SB 122 would authorize the Insurance Department to select a limited number of evidence-based medical guidances issued by the HERC and to promulgate a rule (pursuant to the authority of ORS 743.010 and ORS 742.005(3) that would require carriers to offer coverages that were consistent with the HERC guidelines. (In our opinion the Division would pilot no more than six HERC guidances.) We have also proposed an amendment (see below) that would explicitly provide for the design and application of an "individual exceptions" process (a waiver) for situations where the defined coverage was regarded as inappropriate. The process would be administered by the Individual Review Organizations and would be funded by the carriers on behalf of their insureds thereby mitigating state expenditure.

By bringing insurance coverages into line with evidence-based guidances, an strong indirect incentive is created to increase practitioner adherence to these guidances.

Proposed Amendment: A provision along the following lines to create an individual exceptions process has been forwarded to LC for their review.

In Section 1 add a new subsection 4.

(4) Any rules shall also include standards and a process for granting individual exceptions to the evidence-based benefit guidelines promulgated from time to time by the HERC and adopted by the Insurance Division for purposes of approving coverages. Any application for individual exception shall be administered by an Independent Review Organizations (IRO) or similar entity to be designated by the Insurance Division and shall be conducted in accordance with the standards promulgated by the Division. Each insurance carrier shall be responsible for the full costs of an IRO review on behalf of its insureds.

Example of Cost-Savings: For purposes of illustration, we have drawn an example from the published medical literature reporting the cost-savings associated with the adoption of an evidence-based medical guideline for a relatively common procedure—clearing a blockage in a coronary artery.

Comparative Costs of (a) guideline recommendation of *medical management* versus (b) *percutaneous coronary intervention* in patients with *stable* coronary artery disease. Costs are average per patient.

	PCI	**Medical Mgt.**
Initial cost	$12,162	$752
1st Year Trial cumulative cost	20,170	8,643
2nd Year Trial cumulative cost	23,554	11,806
3rd Year Trial cumulative cost	26,847	15,653
Lifetime cost	99,820	90,370

Note: Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart disease. Medical management includes pharmaceuticals and other items.

Source: William S. Weintraub, et.al., "Cost-Effectiveness of Percutaneous Coronary Intervention in Optimally Treated Stable Coronary Patients," Circulation: Cardiovascular Quality and Outcomes. 2008; 1: 12-20 (Table 5-Costs and Lifetime Cost by Treatment Group). Data are from the COURAGE Trial.

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