Summary of Updated Benefits Proposal

The EBA TAG, along with additional members of the Task Force, met on April 12, 2021 to respond to Task Force feedback on the Benefits proposal and revise the original proposal for the Task Force to consider at its April 29th meeting.

Meeting participants included: Glendora Claybrooks (TAG Lead), Michael Collins, Dr. Zeenia Junkeer, Dr. Ed Junkins, Dr. Sam Metz, Cherryl Ramirez, Dr. John Santa and Chuck Sheketoff.

Specifically, the TAG's discussion focused on 4 areas:

(1) how to incorporate evidence-based recommendations/bodies into Plan benefit design;
(2) whether premiums should be added for higher income Oregonians;
(3) whether limitations on specific benefit categories should be imposed; and
(4) whether to recommend that a single formulary be used for the Plan prescription drug benefit.

The following recommendations and considerations emerged from the TAG as revisions to the original benefits proposal:

Recommendation 1: The PEBB plan should remain the basis for a Plan benefits package.

Considerations:

- The idea of using the Oregon Benchmark plan was rejected as it is not sufficiently comprehensive to meet the values and goals of the Task Force. PEBB provides coverage for certain benefit categories not included under the ACA Essential Services or Oregon Benchmark (complementary care, adult dental, adult vision), or OHP (infertility).
- The mental health benefit design should also be influenced by OHP. Members noted that OHP is more flexible and has wider coverage in mental health benefits (provider type, place of service, array of services) than most commercial coverages. PEBB operates more like commercial plans and the TAG wants to ensure that behavioral health is comprehensively covered.

Recommendation 2: Coverage details within each benefit category should be guided where possible by evidence-based recommendations and bodies (e.g., USPSTF, HERC, ACIP) with a commitment to identifying evidence that is inclusive of diverse populations.

Considerations:

- This moves the Plan away from "no limits" recommendations into a benefits plan that would align with best-available evidence-based best practice; it may be helpful to look at how OHP incorporates annual or biannual limits on categories such as hearing and vision based on evidence-based literature.
- Some members of the TAG expressed concern, however, that certain types of benefits and services and their impact on some populations are not always well represented in the medical literature (e.g., gender-affirming care, complementary medicine) and there needs to be a way of ensuring that an evidence-based "wrap" is not applied rigidly.

Recommendation 3: The Plan should not impose premiums, copays, deductibles, or any other cost-sharing on any members.[1]

Considerations:

- Higher income individuals should contribute more to the cost of the plan; however, this contribution should be handled in the financing of the plan (progressive income tax, payroll tax, etc.) rather than through cost sharing.
- Peer-reviewed literature is largely unsupportive of the idea that co-pays lead to better outcomes or less costly utilization.
- It is unlikely that premiums and co-pays would be a significant source of revenue to offset Plan costs while still remaining affordable to members.
- Non-members will be billed for services.

Recommendation 4: The Plan should adopt a single state formulary for its prescription drug benefit.

Considerations:

- This recommendation does not deal with purchasing; however, it would allow for the Plan to operate under a single drug list developed based on evidence such as Oregon's current Practitioner Managed Preferred Drug List with similar considerations for including evidence criteria inclusive of diverse populations.
- The Single Payer should also work on other purchasing arrangements or other means to reduce the cost of prescription drugs.
- There are specialty drugs for cancer and other serious conditions that may not be traditionally covered by a formulary. The Plan must have a way of identifying access to these drugs.
- It may be helpful to solicit community input to govern development of the formulary.

[1] The workgroup was clearly opposed to premiums. However, there was some discussion that if premiums are needed for revenue, it would be recommended that they be collected via the Dept of Revenue to optimize efficiency and reduce administrative costs to the Single Payer and that clinical care not be withheld in order to confirm premium payment.