HB2519 AND COST SHIFT:
Estimated Effects On Various Types of Service

The OHP2 expansion will mean health coverage for thousands of uninsured Oregonians and additional millions of dollars in resources available to pay for health care to OHP and FHIAP enrollees. The result will be a substantial net increase in revenue available to the health care delivery system overall, as well as better health outcomes. The same logic that applies to the current OHP applies to the OHP2 expansion called for in HB 2519—by insuring thousands of people who would otherwise be uninsured, the current OHP brings hundreds of millions of federal dollars into Oregon that the health care industry would otherwise not receive. The OHP2 expansion will mean substantially greater resources available for health care in Oregon.

Prior to the DHS rebalance figures, the OHP2 expansion increase in revenue was estimated at an additional $72 million to fund health care in Oregon during the 2003/2005 biennium. With the increased caseload estimates in the DHS rebalance plan, this increase is even greater, as is the estimated revenue gain for hospital services and physician services. The negative cost shift resulting from OHP2 will affect dentists and providers of durable medical equipment, non-emergency transportation, and vision care.

Based on the January DHS rebalance figures, there would be an estimated $136 million (versus $72 million estimated prior to rebalance) revenue gain overall for the first full biennium (2003/2005) while still maintaining budget neutrality. In addition to new revenue[1], approximately $45 million in OHP resources would be redistributed among categories of care through benefit reductions and changes in cost sharing.

Increased cost sharing will apply to the population moving from OHP Plus (current OHP benefits) to OHP Standard. However, the 58,000 who are currently uninsured but will gain health insurance through the OHP2 expansion will move from 100% cost sharing to health insurance provided through OHP Standard, OHP Plus, or FHIAP.

[1] Including federal matching funds, premium collections, and employer and employee contributions.

The OHP2 expansion will mean that an estimated 58,000 (versus 43,000 prior to January rebalance figures) currently uninsured Oregonians will be enrolled in OMAP and FHIAP programs. This expansion will be funded in part by increased CHIP match, in part by federal funding for FHIAP, in part by OHP enrollee premiums, and in part by the leveraging of employer and employee contributions for private health coverage. The OHP2 expansion will be budget neutral to the State.

With the DHS rebalance caseload estimates, the estimated impact of the OHP2 expansion on revenues overall would increase by more than 50%. This would mean significant changes in revenue for the various categories of service. With approximately 34,000 more OHP enrollees moving from OHP Plus to OHP Standard (127,000 rather than 93,000) the resulting savings would mean that approximately 15,000 additional uninsured Oregonians could be included under the OHP2 expansion (58,000 rather than the previous estimate of 43,000) while still maintaining budget neutrality through the 2003/2005 biennium. As a result of expanding OHP coverage to 15,000 additional Oregonians who are currently uninsured, there would be a greater increase in additional revenues for hospital services, physician services, mental health services, and prescription drugs. There would still be a decrease in revenue for dental services, vision care, and non-emergency transportation. For Oregon's hospitals taken as a whole, the DHS rebalance caseload estimates indicate that additional revenue for hospitals as a result of the OHP2 expansion would increase to an estimated $104 million. The estimate prior to the rebalance caseload estimates was approximately $70 million in additional revenue for hospital services. For physician services taken as a whole, the estimate for additional revenue increases from $25 million to $39 million.

This analysis indicates that with the OHP2 expansion, the thousands who gain health insurance will bring with them additional revenue that will more than off-set overall losses in revenue due to eliminated benefits and cost sharing. The relevant question becomes: Which sectors of the delivery system will receive those additional dollars and in what proportion, and to what extent will this additional revenue counter-balance cost sharing that is not collected?

Assume the following factors for particular categories of service from an overall, statewide perspective[2]:

1. Benefits overall are reduced in OHP Standard by approximately 20% using the Contractors' proposal, with amendments passed at the December 13, 2001 meeting of the Waiver Application Steering

[2] These assumptions are based on estimates developed by DHS and on the recommendations made by the WASC.

Committee (WASC). Another 2% comes from additional premium contributions. This overall reduction results from benefit eliminations (e.g., vision and non-emergency transportation and some dental care) and cost sharing (e.g., hospital cost sharing at 5.7% (including ER), physician cost sharing at 4.3%, and dental cost sharing at 25% (with 25% further reduction through elimination of benefits).

2. The OHP expands by 58,000 people through a combination of CHIP, OHP Standard, and FHIAP employer-sponsored insurance.[3]
3. The fully implemented OHP2 expansion, a "steady state" enrollment over a full biennium without ramp-up.
4. A worst-case scenario: that none of the cost sharing would be collected.[4]
5. DHS projections of the distribution of OHP2 expansion population among OHP Standard, CHIP, and FHIAP.
6. Current distribution of resources for the 2003/2005 biennium for the adults/couples population, among the service categories (e.g., hospital, physician, dental, mental health, prescription drugs).

The three spreadsheets attached to this narrative show the projected increase in number of persons enrolled and additional revenues available through the OHP2 expansion. The first spreadsheet (OHP2 Cost Shift Analysis – Summary Figures) summarizes the increases in funding available for hospital services, physician services, mental health services, and prescription drugs, and the decrease in funding available for dental services. Resources are distributed among the types of service (hospital, physician, prescription drugs, mental health, dental) according to the per member per month factors developed by PricewaterhouseCoopers and used by OMAP, the Health Services Commission, and the Waiver Application Steering Committee. The second spreadsheet (Computing Final Distribution of OHP2 Weighted-average Capitated Rate by Service Category) shows the dollar and percentage distribution of per member per month costs among the categories of service. The third spreadsheet (OHP2 Cost Shift Analysis – Detailed Calculations) shows the relationship between reduced coverage/decreased premium and net gain (or loss) for each service category for the entire expansion population, according to the various federal funding categories applicable to OHP Medicaid, CHIP, and FHIAP. Note that an 8%

[3] The DHS rebalance figures increase the estimated OHP expansion population from approximately 43,000 to approximately 58,000. Similarly, the rebalance figures increase the estimated population changing from OHP Plus to OHP Standard from approximately 93,000 to approximately 127,000. These changes result in an increase in the additional revenue for health care.

[4] This scenario is "worst-case" in the sense that there is widespread agreement that some portion of cost sharing would be collected. In fact, safety net clinics and FHIAP report successful collection of copays and coinsurance from patients above and below federal poverty level.

administrative cost is assumed.[5] Administrative dollars at 8% for the biennium would increase by an estimated $10 million overall with the OHP2 expansion.

For **hospital services *overall***, the OHP2 expansion would mean an estimated gain of $104 million for the biennium based on the January DHS rebalance estimates. Given this level of additional funding and the fact that hospitals already provide most of the inpatient care needed by the uninsured[6], there would be a substantial revenue gain for hospital services if the proposed expansion were implemented. Reduced ER use and reduced hospitalization overall due to prevention and early diagnosis and treatment would further reduce uncompensated care. The higher rate of reimbursement for an increased number of FHIAP enrollees would further increase revenue for hospital services. The OHP2 expansion will mean more revenue to pay for hospital services and reduced uncompensated care.

With the OHP2 expansion, **physician services *overall*** would receive an estimated $39 million in additional revenue (versus $25 million estimated before the January DHS rebalance). With the OHP2 expansion, physicians would provide new services—preventive care, early diagnosis, and anticipatory treatment - not currently provided with any consistency to the uninsured. Like hospitals, physicians would also begin receiving payment for those services they already provide to the uninsured, including some physician services provided through the safety net system. Physician services already being provided range from preventive and primary care for existing patients without coverage to urgent care for new patients who are uninsured. As with hospitals, physician payments will benefit from FHIAP's commercial insurance payment levels as FHIAP enrollment grows through the OHP2 expansion. Access to care, and to physician care in particular, will continue to be monitored for both OHP Plus and OHP Standard enrollees to determine that there is sufficient capacity.

For dentist services *overall*, the OHP2 expansion would mean a <u>decrease</u> in available funding estimated at $29 million (versus $26 million estimated prior to the rebalance figures). This reduction is based on a 25% elimination of benefits and on cost sharing at the 25% level. This may be overstated to the extent that some of the dental work not covered under OHP Standard would not be provided and would be replaced by other services that are covered. This is not unlikely, given the current overall demand for dental care. On the other hand, it could be argued that needed but not covered dental care may increase statewide, creating a reservoir of untreated dental disease.

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[5] This may be somewhat larger given the administrative requirements of subsidizing private coverage and the administrative requirements of OHP2 in its initial phase.

[6] Sandi Hunt of PricewaterhouseCoopers estimates that hospital services utilization by the uninsured is approximately 2/3 the level of utilization by the insured, based on a review of relevant studies.

For prescription drugs *overall,* the OHP2 expansion would mean an estimated $11 million increase in revenue for the biennium. This additional revenue would be predominantly for drugs not already provided to the uninsured.

For mental health services *overall,* the OHP2 expansion would mean an estimated $10 million increase in revenue for the biennium.

For all other services *overall*, the OHP2 expansion would mean an estimated $9 million decrease in revenue for the biennium (Lab/X-ray and ambulance would gain revenue, while DME, non-emergent transportation, and vision would lose revenue).

This analysis indicates that covering an additional 58,000 currently uninsured through the OHP expansion will result in an estimated $136 million additional revenue available for health care in Oregon. This additional revenue will include $78.6 million in new federal matching funds, $25.0 million in premiums paid by OHP Standard enrollees, $25.6 million in employer contributions for FHIAP coverage, and $7.2 million in employee contributions for FHIAP coverage. Additional revenue from the OHP2 expansion will both reduce uncompensated care for services already provided, and pay for health care services that would otherwise not have been received by the 58,000 newly insured Oregonians. The impact of this additional revenue will be greatest in communities where the health plans, hospitals, and physicians already provide most needed health care to the entire population, including OHP enrollees and the uninsured. These communities will receive additional funding for services that are, to a large extent, already being provided.