The Oregon Health Plan and Oregon's Health Care Market

A Report to the 71st Legislative Assembly

Prepared by:
Office for Oregon Health Plan Policy and Research
August 2000

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Dear Readers:

The Office for Oregon Health Plan Policy and Research (OHPPR) is proud to publish the attached report entitled ***"The Oregon Health Plan and Oregon's Health Care Market: A Report to the 71st Legislative Assembly."***

This report documents the current state of the Oregon health care market, changes over recent years and potential future implications. Major topics discussed include uninsurance in the state, the innovative Oregon Health Plan Medicaid program and trends in employer-sponsored coverage in Oregon.

This report is not intended to be a completely comprehensive view of the state of affairs in Oregon, but rather straightforward, background information for those interested in knowing more about health and healthcare in the state. OHPPR will continue to update this information as new data becomes available. Current projects within OHPPR that will be presented in the future include information on physician manpower based on a statewide survey, more comprehensive information on hospital financial solvency and detailed findings of a survey regarding state agency spending on prescription drugs.

We hope you find this document useful and welcome any questions or comments you may have.

Regards,

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Administrator

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Introduction

Over the past decade the healthcare market in Oregon has seen structural and policy changes that have affected the way hospitals, health plan, physicians and purchasers do business and how consumers access healthcare services. As healthcare costs have continued to rise at a rate higher than those in the rest of the market, managed care has been relied on as one method for controlling medical inflation. As a result, hospital utilization has declined in many areas while access to primary care has increased.

The Oregon Health Plan (OHP), launched in 1989 as a series of legislative actions aimed at "ensuring access to affordable healthcare for all Oregonians", is comprised of several pieces, including:

- Medicaid Demonstration project which makes coverage available to everyone in the state up to 100% of the federal poverty level;
- Coverage in a high-risk pool for those turned down in the commercial market;
- Small business purchasing pool to make coverage more affordable;
- Market reforms in the small employer market, such as guaranteed issue, portability and limits on rate variation.

More recently the state has implemented the Children's Health Insurance Program (CHIP) and Family Health Insurance Assistance Program (FHIAP) to assist people in moderate-income families gain access to coverage.

Just as important, as the role of the public sector in increasing access to coverage, has been the growth in private-side coverage. Oregon remains one of the few states in the country that has simultaneously expanded publicly sponsored coverage while seeing increases in employer-sponsored insurance.

The attached documents provide an overview of Oregon's healthcare market and changes in the structure of the market affecting access to care. Additional information on each section is available from the Office for Oregon Health Plan Policy and Research (OHPPR).

Successes of the OHP

- More than 1,000,000 people have gained access to healthcare as a result of the Medicaid expansion.
  (Office of Medical Assistance Programs)

- More Than 60,000 individuals have obtained coverage in the private market through the IPGB.
  (Insurance Pool Governing Board)

- More than 15,000 individuals who had previously been denied coverage due to pre-existing medical conditions have obtained coverage through the Oregon Medical Insurance Pool (High-Risk Pool also known as OMIP).
  (Insurance Pool Governing Board)

- More than 21,000 employers have taken advantage of the IPGB.
  (Insurance Pool Governing Board)

- Uninsured in **Oregon**: 1990-18%, 1992-17%, 1994-14%, 1996-11%, 1998-11%, 1999-10%.
  (Oregon Population Surveys 1990-1998)

- Uninsured Kids in **Oregon:** 1990-21%, 1996-8%, 1998-10%, 1999-8%.
  (Oregon Population Surveys 1990-1998)

- Overall per capita healthcare costs 1998: Oregon-$3,303, U.S.-$3,760.
  (1993 State Health Expenditure Account Estimates-OHPPR, Healthcare Financing Administration)

- Enrollment in Managed Care: 1996-Portland 49%, Oregon 46%, OHP Medicaid 88%, U.S. 36%.
  (Office of Medical Assistance Programs, Employee Benefits Research Institute, Interstudy-Medical Benefits)

- Hospital charity care has declined more than 30% since inception of Medicaid Demonstration (1994-1999).
  (Oregon Hospital Financial Reports, Office of Medical Assistance Programs)

- Emergency room use has declined almost 10% since inception of Medicaid Demonstration (1994-1999).
  (Oregon Association of Hospitals and Health Systems)

Description of the OHP

Overview

The Oregon Health Plan consists of a number of programs designed to promote the objective – access to quality healthcare at an affordable cost – for a subset of Oregon's population. These individuals and families face barriers to obtaining health insurance, and thus the ability to pay unforeseen medical expenses. The following is an overview of the various programs, including the number of individuals served and dollars budgeted for the 1999-01 biennium.

OHP-Medicaid

Beginning in 1994, the State of Oregon implemented a variety of Medicaid program reforms, granted by federal Health Care Financing Administration (HCFA) waivers. Reforms consisted of the following: expanded eligibility criteria to cover more people - 100% Federal Poverty Level (FPL) across the board, 133% FPL for children and pregnant women; incorporated a prospective payment arrangement and managed care model to insure efficient and appropriate service delivery; and created budgetary controls using a prioritized list of conditions to determine eligible treatments given authorized funding levels.

OHP-CHIP

With the help of additional funds provided under the federal government's Children's Health Insurance Program, Oregon extended availability of the Medicaid benefit to children in low-income families up to 170% of the Federal Poverty Level. The OHP-CHIP program went into effect in July 1998 and currently serves approximately 16,000 children statewide.

The Family Health Insurance Assistance Program

The 1997 Legislature passed legislation to provide health insurance benefits coverage to low-income, uninsured Oregonians. The Family Health Insurance Assistance Program provides direct subsidies to qualified Oregonians to help them buy health insurance through their employer or through the individual market. Participation requires a minimum level of employer cost sharing when employer-based coverage is involved. For the 1999-01 biennium, the FHIAP budget is $21,831,650, composed entirely of tobacco tax.

The Insurance Pool Governing Board

Established in 1987, the 1999 Legislature revised the IPGB's mission to focus on marketing activities promoting access to health insurance coverage for small businesses, the self-employed, and individuals. The IPGB provides extensive continuing education training to insurance agents, as well as general health insurance and Oregon Health Plan educational seminars to community partners and stakeholders throughout Oregon. In addition, the Board provides referrals to insurance agents for consumers and employers and conducts health insurance marketing campaigns touting the benefits of providing and/or using health insurance. The 1999-01 biennial budget for the marketing component of the IPGB is $546,235, with $495,767 in general funds and $50,468 in other funds.

Oregon Medical Insurance Pool

In 1987, legislation created the Oregon Medical Insurance Pool to provide affordable health insurance to individuals denied coverage elsewhere due to a previously existing condition. Rates for each type of plan are capped at a percentage above a typical portability product of the same type (i.e., indemnity, preferred provider, and managed care). The program's losses are distributed across all health insurance companies in the State in proportion to their market share. The OMIP budget for 1999-01 is $42,028,345, comprised of premiums and assessments on insurers in the state.

Small Market Reforms

To promote the availability of health insurance coverage for workers in small businesses, Oregon's Legislature enacted a number of small-employer insurance market reforms in Senate Bills, SB152 (1995) and SB1076 (1993). Major components of the two laws included: guaranteed issue and renewability; pre-existing condition clause restrictions; minimum benefit package requirements; community rating; portability requirements; and extension of small employer reforms to the individual market. Small business reforms were phased in beginning in 1993 and implemented for the most part by 1996.

The Uninsured in Oregon

Summary

Uninsurance rates in Oregon have been consistently declining since the start of the Oregon Health Plan (OHP). In the early 90's, approximately 18 percent of all Oregonians, and more than 20 percent of children, were without healthcare coverage[1]. By 1998, implementation of the OHP, combined with a strong economy and a private-sector commitment to providing health insurance coverage, resulted in major reductions in the proportion of uninsured individuals. Overall 11 percent of Oregonians and approximately 10 percent of children were uninsured in 1998.

While progress was made in this area, it was not uniform across geographic, socioeconomic or racial and ethnic boundaries. Those living in the more rural areas of the state, people in households with low incomes, and racial and ethnic minorities-particularly Hispanics-all experienced higher than average rates of uninsurance.

In July 1998 two new programs were begun, aimed at addressing these issues. The Family Health Insurance Assistance Program (FHIAP) is a state-funded program that provides cash subsidies to families with incomes between 100 percent and 170 percent of the federal poverty level (FPL) to purchase coverage and by July 1999 had enrolled more than 6,000 people. The Children's Health Insurance Program (CHIP) is a Medicaid look-alike program that provides coverage to children under the age of 19 with family incomes below 170 percent FPL. More than 13,000 children were enrolled in the program in July 1999. During the implementation phase of each of these programs, special outreach efforts were made to advertise these programs to the more rural areas of the state and to minority populations.

These efforts appear to be working. By mid 1999, the uninsurance rate statewide had declined to only ten percent and the rate of uninsurance among children was as low as it had been in a decade, at less than eight percent. Further, the rate of uninsured Hispanics had declined from more than 24 percent in 1996 to below 20 percent by 1999. Finally, some rural counties in the state experienced the greatest declines in uninsurance, with Gilliam, Klamath, Morrow and Lake Counties all seeing decreases of 2 percentage points or more.

[1] All estimates presented here are based on data from the Oregon Population Survey (OPS). Nationally produced estimates are derived from the U.S. Census Bureau's Current Population Survey (CPS), which is believed to be less reliable than the OPS due to smaller sample size and poor geographic representation.

1999 Statewide Estimates of the Uninsured Population

	1998	1999
All Oregonians		
Number	362,698	326,942
Percentage	11%	10%
Children (0-18)		
Number	87,047	68,109
Percentage	10%	8%
Adults (19+)		
Number	275,651	259,235
Percentage	12%	11%
Hispanic		
Number	42,291	37,606
Percentage	22%	19%
Non-Hispanic		
Number	320,407	289,335
Percentage	9%	9%

Sources: 1998 Oregon Population Survey, Family Health Insurance Assistance Programs weekly reports, Office of Medical Assistance Programs eligibility records and Pink Book, PSU Center for Population Research and Census population estimates

Oregon Counties Uninsurance Rates

	7/1/98 Estimated Uninsured %	7/1/98 Estimated Uninsured #	7/1/99 Estimated Uninsured %	7/1/99 Estimated Uninsured #	Change 1998-1999
BAKER	15%	2,505	14%	2,402	-1%
BENTON	11%	8,426	10%	7,838	-1%
CLACKAMAS	10%	32,360	9%	30,657	-1%
CLATSOP	12%	4,164	11%	3,767	-1%
COLUMBIA	5%	2,115	3%	1,491	-2%
COOS	19%	11,666	18%	10,787	-1%
CROOK	13%	2,165	11%	1,912	-2%
CURRY	15%	3,300	15%	3,234	0%
DESCHUTES	12%	12,588	10%	10,969	-2%
DOUGLAS	17%	17,051	15%	15,543	-2%
GILLIAM	12%	252	9%	184	-3%
GRANT	15%	1,200	15%	1,169	0%
HARNEY	15%	1,140	14%	1,100	-1%
HOOD RIVER	15%	2,925	13%	2,648	-2%
JACKSON	14%	24,192	13%	22,038	-1%
JEFFERSON	15%	2,610	14%	2,490	-1%
JOSEPHINE	15%	10,950	13%	9,833	-2%
KLAMATH	14%	8,680	12%	7,368	-2%
LAKE	15%	1,110	13%	962	-2%
LANE	7%	21,910	6%	18,186	-1%
LINCOLN	18%	7,776	16%	7,071	-2%
LINN	11%	11,242	9%	9,729	-2%
MALHEUR	18%	5,256	17%	5,192	-1%
MARION	13%	35,347	12%	32,127	-1%
MORROW	12%	1,128	10%	934	-2%
MULTNOMAH	11%	70,609	10%	62,183	-1%
POLK	11%	6,545	10%	6,270	-1%
SHERMAN	12%	228	11%	200	-1%
TILLAMOOK	12%	2,880	11%	2,604	-1%
UMATILLA	13%	8,723	12%	8,134	-1%
UNION	10%	2,440	8%	2,059	-2%
WALLOWA	14%	1,008	14%	973	0%
WASCO	12%	2,712	10%	2,338	-2%
WASHINGTON	6%	23,856	5%	21,288	-1%
WHEELER	12%	192	11%	183	-1%
YAMHILL	9%	7,371	8%	6,736	-1%
STATEWIDE	11%	362,698	10%	326,941	-1%

Health Effects of Uninsurance

The American College of Physician/American Society of Internal Medicine (an organization representing 115,000 internal medicine physicians) reviewed studies published in the last ten years that analyzed the effects of "uninsurance" on the health of the uninsured individual. Over 1,000 documents were reviewed. Highlights of their study:

Uninsured Americans, compared with the insured, are:

- 3.8x less likely to obtain medical/surgical care
- Up to 3.9x less likely to obtain dental care
- 4.7x less likely to obtain prescriptions drugs
- 3.3x less likely to obtain needed eyeglasses

Uninsured adult Americans, compared with the insured, are:

- 4x more likely to use the emergency room as a regular place of care

Uninsured children, compared with the insured, are:

- 5x more likely to use the emergency room as a regular place of care

Uninsured Americans, compared with the insured, are more likely to experience an avoidable hospitalization:

- Up to 2.8x more likely to be hospitalized for diabetes
- Up to 2.4x more likely to be hospitalized for hypertension
- Up to 1.6x more likely to be hospitalized for pneumonia
- Up to 1.6x more likely to be hospitalized for a bleeding ulcer
- More likely to experience an avoidable hospitalization for asthma

Uninsured Americans, compared with the insured, are

- Up to 3.2x more likely to die in-hospital (have a higher in-hospital mortality)

Uninsured Americans, compared with the insured, are:

- 1.7x more likely to be diagnosed with colon cancer at a late stage
- 2.6x more likely to be diagnosed with melanoma at a late stage

Uninsured women with breast cancer, compared with the insured:

- Have a 49% higher adjusted risk of death from breast cancer

Uninsured children, who are ill, compared with the insured, are:

- 1.7x less likely to receive medical treatment for sore throat or tonsillitis
- 1.9x less likely to receive medical treatment for an acute earache
- 2.1x less likely to receive medical treatment for a recurrent earache
- 1.7x less likely to receive medical treatment for asthma

Uninsured children under 16 years of age presenting with appendicitis, compared with the insured:

- Wait almost 2x as long before seeking care
- Have a hospital visit almost 2x as long

Uninsured pregnant women, compared with insured:

- Have a 31% higher likelihood of an adverse hospital outcome

Uninsured men, compared with the insured, are:

- 1.5x more likely to be diagnosed with prostrate cancer at a late stage

The entire study is available at the ACP/ASIM website:
http://www.acponline.org/uninsured/lack-exec.htm

Poverty in Oregon

Many of the major healthcare issues in Oregon, such as insurance coverage, excessive emergency room use and charity care can be directly correlated with the number of people in the state who are in poverty. Several of the state's programs (Medicaid, FHIAP, and CHIP), aimed at providing healthcare support, have eligibility criteria that are tied to the Federal Poverty Level (FPL). To the extent that policy-makers have the ability to make reasonable estimates of the population in poverty, they are able to make some predictions about where the need for new programs exists. Additionally, the potential costs of new or expanded programs and the effects of new policies on healthcare in the state can be assessed.

Below is the 1998 proportional estimate of the state's uninsured population by age and FPL.

1998 Uninsured Proportions:
Percentage with age and FPL category that is uninsured

Age	Total	<100%	<150%	<200%	>200%
0-5	7.5%*	15.3%	14.8%	11.5%	3.9%
6-11	10.1%	18.4%	18.7%	18.2%	3.5%
12-18	11.1%	14.6%	23.4%	20.2%	5.1%
19+	11.6%	27.2%	27.0%	23.0%	6.9%
Overall	11.1%	23.1%	24.3%	20.9%	6.3%

*Figures represent the proportion of individuals having the combined characteristics who are uninsured (e.g., 7.5% of children aged 0-5 are uninsured). Neither row nor column totals will add to 100%, as the denominator does not represent the total population in either the age or FPL groups.

The Medical and Consumer Price Indexes in Oregon

Methodology

The following report is based on two sources of data: consumer price indices (CPI) published by the federal Bureau of Labor Statistics (BLS) and annual cost adjustment factors provided by Oregon's Office of Medical Assistance Programs (OMAP), the state's Medicaid administrator. The consumer price figures are presented for two regions – the Portland/Salem metropolitan area (including Vancouver, WA, and hereafter referred to as the "Portland Metro area") and an average for all U.S. urban areas – as well as two consumer goods bundles – a "medical care" bundle and an "all items less medical care" bundle. It should be noted that in Oregon no indexes are calculated for the rural areas outside of the Portland-Metro region.

BLS provides the following information:

The CPI market basket – both bundles combined – represents all the consumer goods and services purchased by urban households. Price data are collected for over 180 categories, which BLS has grouped into eight major groups. These major groups are as follows:

- Food and beverages
- Housing
- Apparel
- Transportation
- Medical care
- Recreation
- Education and communication
- Other goods and services

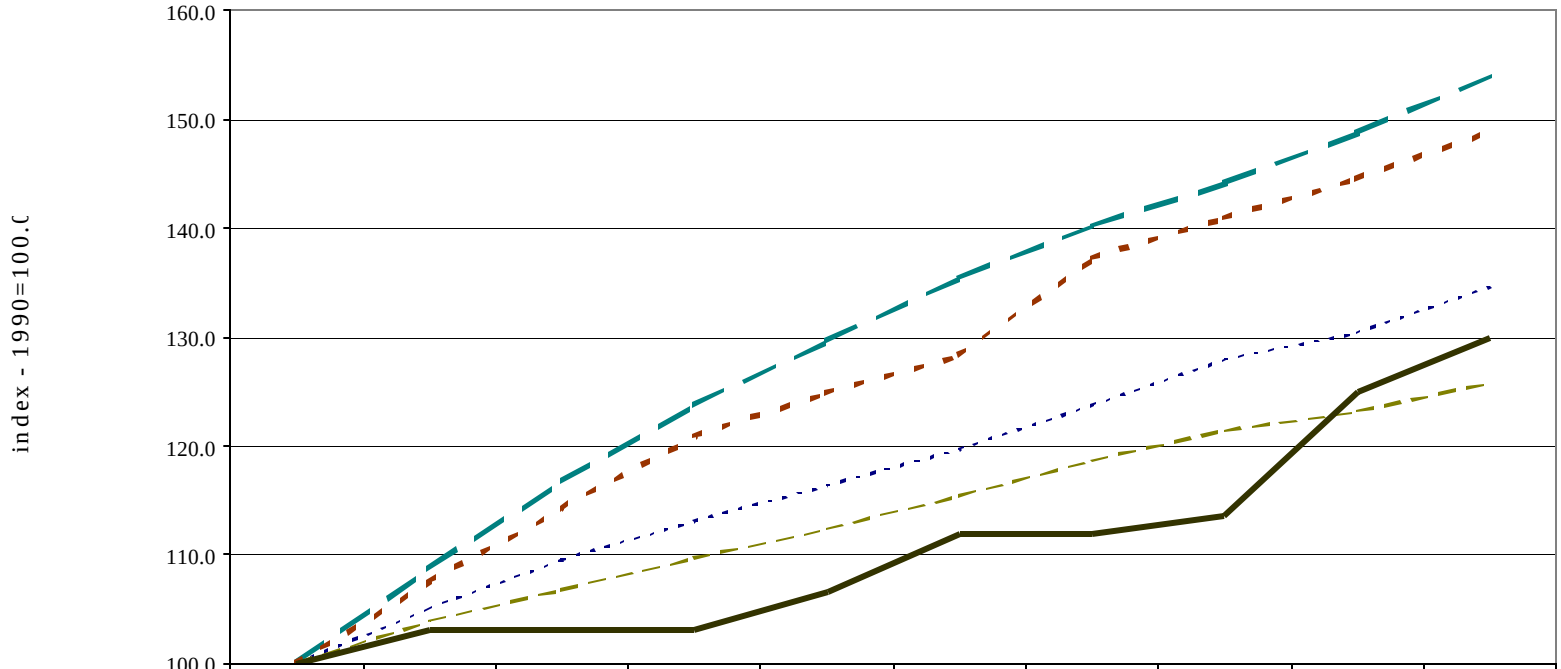
Indexes are published at the U.S. city average level. Due to limitations in sample size, however, many of the smaller expenditure categories are not available at regional and local area levels. Instead, related categories are aggregated and published as part of a more comprehensive category. For example, physicians' services and eyeglasses and eye care are combined with similar categories and published as professional medical services at the regional level. At the metropolitan area level, professional medical services is, in turn, combined further and published as medical care.

The following information is provided by OMAP:

- Inflation adjustments prior to FY 95 are from the OMAP rule filings.
- Inflation adjustments for FY 95 and forward refer to the increase in the managed care capitation rate given in October. For example, the 10/99 adjustments are listed as FY 00.

All series are indexed on a 1990=100 basis to illustrate the variation in price growth throughout the 1990s.

Medical Care Price Increases - Portland Metro and the U.S.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
US Med	100.0	108.7	116.7	123.7	129.6	135.4	140.2	144.1	148.7	153.9
PDX Med	100.0	107.5	114.3	120.9	124.9	128.3	137.3	140.9	144.5	148.9
PDX ALM	100.0	105.1	109.5	113.1	116.4	119.7	123.7	127.9	130.4	134.6
US ALM	100.0	103.9	106.8	109.7	112.3	115.4	118.7	121.4	123.1	125.8
OMAP	100.0	103.0	103.0	103.0	106.6	111.9	111.9	113.6	125.0	130.0

year

Price Indices are published by the Bureau of Labor Statistics. Series are rebased at 1990 = 100 to illustrate relative growth over the last ten years. "Med" denotes indices for consumer spending on medical care; "ALM" denotes indices for all items excluding medical care; "OMAP" is an index created from the Office of Medical Assistance Programs' annual cost adjustments for reimbursement rates through 1994 and capitation from 1995 on.

Overview of Oregon's Healthcare Market

Public and Private Funding for Healthcare in Oregon

Spending on healthcare in Oregon ranks relatively low when compared to other states across the nation. In both the private and public sectors, Oregon's spending on healthcare and health insurance ranks in the bottom third (least spending per individual) nationally.
The following table presents several sources of healthcare funding in Oregon and the state's rank, nationally. Spending in Washington, Idaho and Utah is included for comparison purposes.

Healthcare Funding Streams: Ranking by State (Highest=1)

Medicare Spending[2] Oregon	Statewide AAPCC $320/month Rank: 36				
Medicaid Spending[3]	Year	1994	1995	1996	1997
	$/Medicaid Eligible: Rank	41	34	36	47
	$/Oregon Resident: Rank	43	35	35	35
Commercial/Private Health Insurance Spending in Oregon	1999 National average premium costs rank: 46[4] 1999 rank among 9 western states: 8[5] 1998 rank among 11 western states: 10[6]				
Worker's Compensation[7] **(WC)**	Of all WC costs, medical costs make up approximately 44% in Oregon. Oregon ranks 17th nationally for spending on the medical portion of WC				

[2] Healthcare Financing Administration (http://www.hcfa.gov).
[3] Oregon Office of Medical Assistance Programs.
[4] Health Affairs, January 2000.
[5] Milliman & Robertson, 1999.
[6] Milliman & Robertson, 1998.
[7] State of Oregon Department of Consumer and Business Services, Worker's Compensation Division (http://www.cbs.state.or.us).

Healthcare Funding Streams: Ranking by State (Highest=1)

Medicare Spending[8]

Washington	Statewide AAPCC $342/month Rank: 25
Idaho	Statewide AAPCC $263/month Rank 47
Utah	Statewide AAPCC $238/month Rank 49

Medicaid Spending[9]

	Year	1994	1995	1996	1997
Washington	$/Medicaid Eligible: Rank	47	48	48	49
	$/Washington Resident: Rank	19	21	19	22
Idaho	$/Medicaid Eligible: Rank	30	31	27	23
	$/Idaho Resident: Rank	48	49	48	47
Utah	$/Medicaid Eligible: Rank	32	39	42	40
	$/Utah Resident: Rank	49	50	49	49

Worker's Compensation[10] **(WC)**

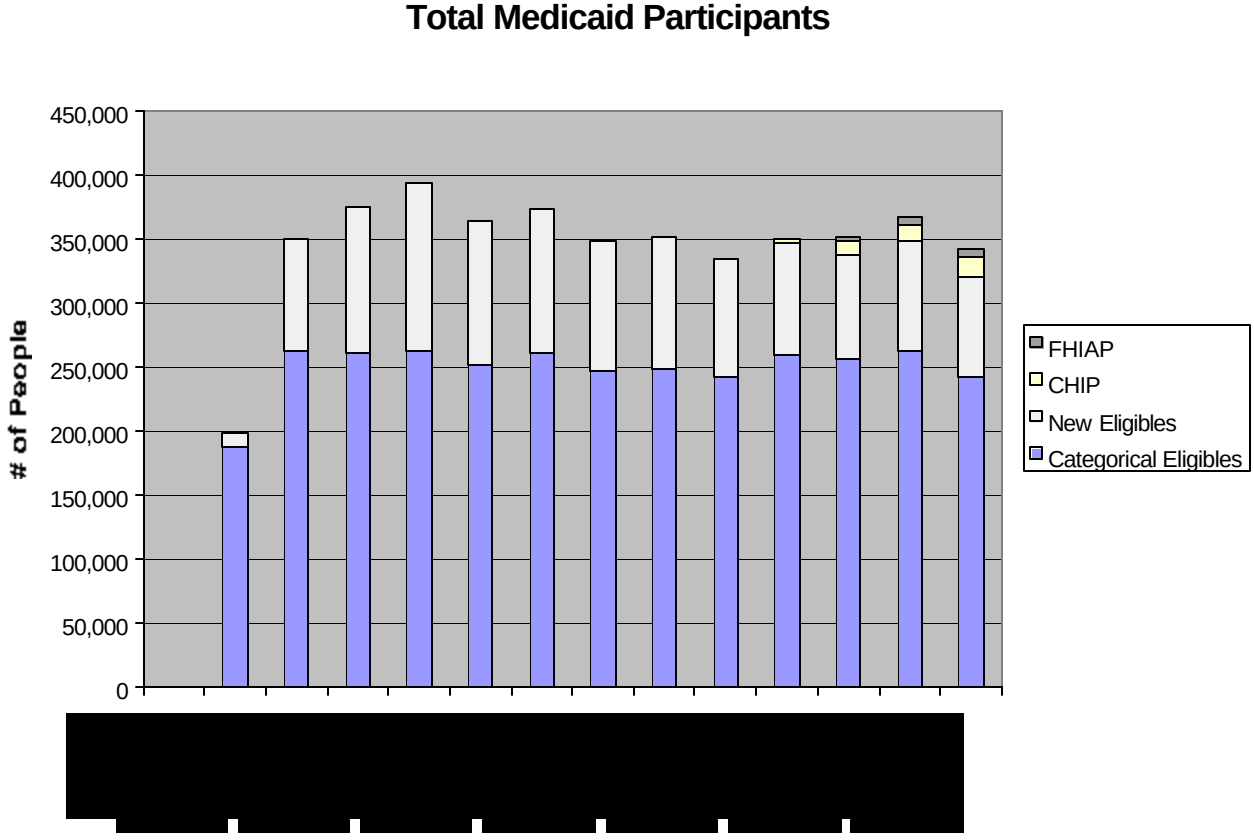
Of all the cost, medical costs make up approximately
33% in Washington
45% in Idaho
47% in Utah
Washington ranks 14th nationally for spending on the medical portion of WC
Idaho ranks 43rd nationally for spending on the medical portion of WC
Utah ranks 35th nationally for spending on the medical portion of WC

[8] Healthcare Financing Administration (http://www.hcfa.gov)
[9] Oregon Office of Medical Assistance Programs.
[10] State of Oregon Department of Consumer and Business Services, Worker's Compensation Division (http://www.cbs.state.or.us).

Historical OHP Enrollment and Cost Data

Medicaid Participation by Category

Beginning in February 1994, with the start of the OHP Medicaid Demonstration, the State saw continuous increases in Medicaid participation until mid 1995. OHP Medicaid enrollment peaked in November 1995 at more than 400,000 participants, and then began to decline steadily until early 1998. The development and implementation of the new CHIP and FHIAP programs in 1998 had not only the direct effect of covering additional people in these programs, but also the "woodwork effect" of bringing more people into the Medicaid program who were previously eligible, but not participating.



Unduplicated Medicaid Enrollment

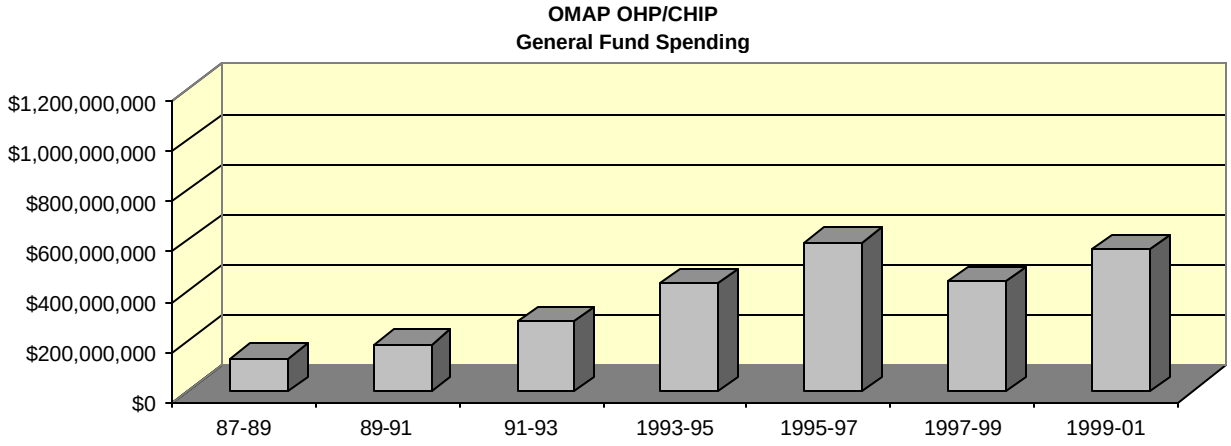
Since the beginning of the Oregon Health Plan Medicaid Demonstration, more than 1,000,000 Oregonians have received health coverage under this program. The following table depicts, by year and eligibility group, as well as how many individuals have had coverage during that year.

Group	1994*	1995	1996	1997	1998	1/1-6/30/99
CHIP	0	0	0	0	11,515	6,788
Medicaid	507,033	583,854	570,226	540,035	528,763	459,751

**1994 represents 11 months of data.*

Total Unduplicated Medicaid Recipients: 1,060,150
2/1/1994 through 6/30/1999

Over that same period of time, there have been a total of approximately 3.7 million Oregon residents. This means that approximately 30 percent of all state residents have received services through the Medicaid system at some time since 1994.



One source of concern is the degree to which the general fund (GF) portion of the OMAP budget has increased since the program's inception and how that has affected other state services[11]. In fact, the actual GF spending decreased between the '95-97 and '99-01 biennia by approximately one percent. The increase in the OMAP budget was largely supported by funds from tobacco taxes, which increased 366 percent over the same period, and increased federal funds, which rose nearly 25 percent.

[11] All budget figures exclude spending due to mental health and chemical dependency services to maintain consistency between budget measurements.

OMAP Spending by Component

Costs for the Oregon Health Plan have increased significantly over the last decade. The following graph demonstrates that cost increases have occurred for a number of reasons.

- Cost of the categorical Medicaid population has increased modestly over the decade.
- Cost of the non-categorical Medicaid population is driven primarily by number of new eligibles.
- Cost of drugs has tripled over the decade. While some of these costs are due to new eligibles, increased price and utilization is the major cause of the increase.
- Costs of dental services increased significantly in the first four years of OHP, due to addition of adult dental benefits and addition of new members. Since the mid 90's costs have been moderate, in parallel with the rest of the plan.
- Mental health costs were not previously part of OMAP's budget.

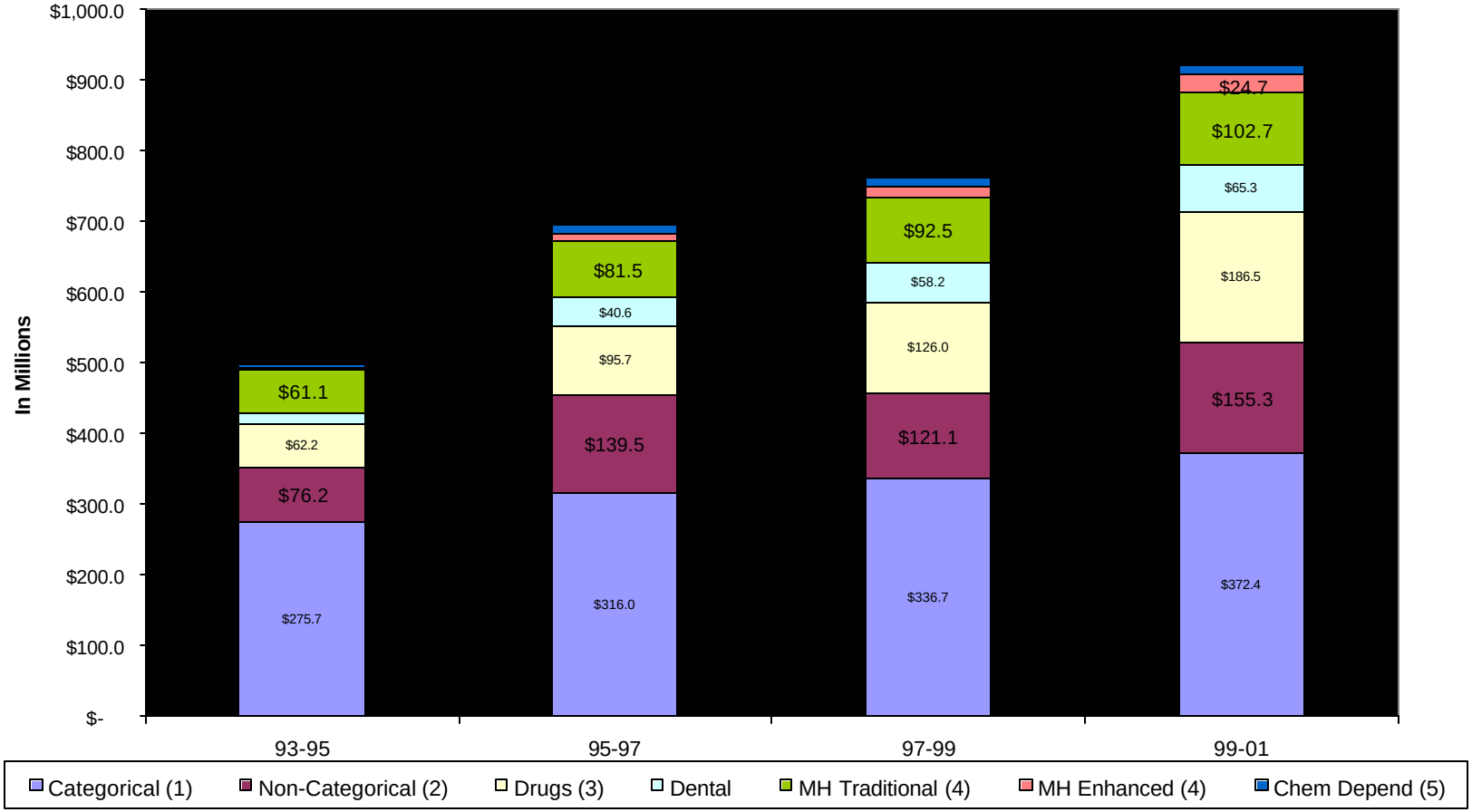
These results suggest that specific benefit areas can explain much of the cost increase in the Oregon Health Plan (OHP): drugs, dental, possibly mental health. Remaining cost increases in the OHP are driven primarily by eligibility. Underlying costs in the plan, hospitals and doctors, have increased modestly (35% over the 4 biennia).

Cost trends in 1999 and 2000 suggest that the modest cost increases for hospital and physician services of the 90's are being replaced by more substantial cost trends.

Office of Medical Assistance Programs

Comparison of OHP Categorical Eligibles, OHP Non-Categorical Eligibles. Drugs, Dental, Mental Health (Traditional and OHP-Enhanced), and Chemical Dependency Expenditures

General Fund + Tobacco Tax



(1) Categorical costs include TANF, PLM Women and Children, FC, SAC, AB/AD, OAA and CHIP eligibles, exclusive of Drug, Dental, Mental Health, and Chemical Dependency dollars.

(2) Non-Categorical costs include GA, Families, and Adults/Couples, exclusive of Drug, Dental, Mental Health and Chemical Dependency dollars.

(3) Drug costs are reduced by funds collected from manufacturer rebates.

(4) Mental Health costs include those costs, which are included in the MHDDSD and OHP budgets for all four biennia. Traditional Mental Health includes Mental Health costs budgeted in the OHP and MHDDSD, which would still occur even if the OHP ended. Enhanced Mental Health includes Mental Health costs that result because we have the OHP (e.g., coverage for new eligibles, different benefits for all eligibles as a result of the prioritized benefit package, a different Mental Health care delivery system and capitation rates base on reasonable cost).

(5) Chemical Dependency costs include those costs, which are included in the OADAP and OHP budgets for 1993-95. These costs include Chemical Dependency costs that result because we have the OHP, as well as costs, which would still occur even if the OHP ended.

County-by-County Flow of State and Federal Funds for Healthcare

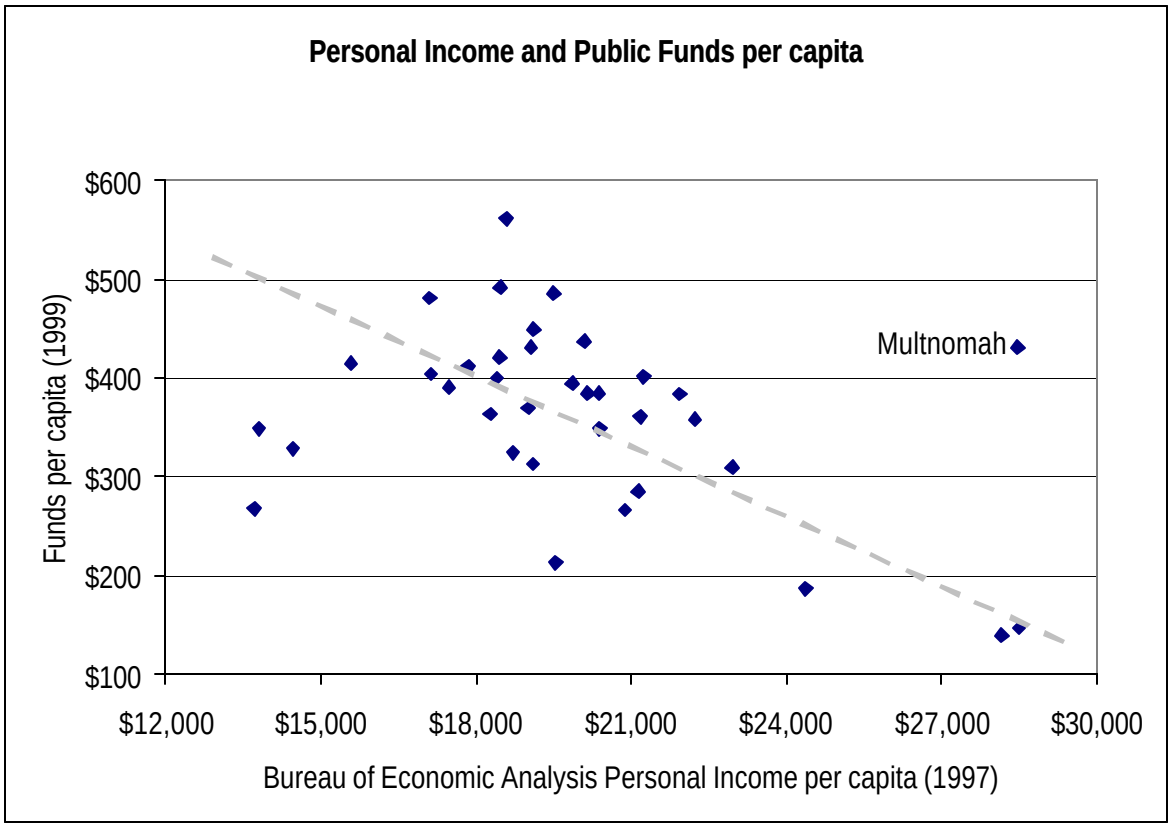
Funding per-capita

More than $1.1 billion in public funds[12] flowed through the state of Oregon for direct healthcare services in 1999. These funds were not distributed equally throughout the state, as the following table displays.

	Total Flow of Funds for Medicaid, CHIP and FHIAP	Per-Capita Spending
CLACKAMAS	$ 46,731,271	$ 142.97
WASHINGTON	$ 60,646,923	$ 149.84
BENTON	$ 14,569,414	$ 188.97
POLK	$ 12,895,785	$ 214.57
SHERMAN	$ 491,585	$ 258.73
YAMHILL	$ 22,330,596	$ 268.72
COLUMBIA	$ 12,016,964	$ 281.76
GILLIAM	$ 631,978	$ 300.94
DESCHUTES	$ 33,622,112	$ 315.11
WALLOWA	$ 2,276,162	$ 316.13
TILLAMOOK	$ 7,933,277	$ 329.18
CLATSOP	$ 2,479,107	$ 359.11
WHEELER	$ 575,092	$ 359.43
LANE	$ 114,238,348	$ 361.86
CROOK	$ 6,175,056	$ 367.56
UMATILLA	$ 25,199,291	$ 370.58
CURRY	$ 8,204,551	$ 372.09
HARNEY	$ 2,862,394	$ 376.63
JACKSON	$ 67,365,221	$ 385.94
LINN	$ 39,913,779	$ 387.51
WASCO	$ 8,967,685	$ 395.92
HOOD RIVER	$ 7,812,242	$ 396.56
UNION	$ 9,953,292	$ 406.26
MARION	$ 111,902,247	$ 406.55
MORROW	$ 3,891,512	$ 407.49
GRANT	$ 3,295,089	$ 411.89
BAKER	$ 6,969,826	$ 417.35
JEFFERSON	$ 7,388,290	$ 418.60
DOUGLAS	$ 43,297,268	$ 429.32
MULTNOMAH	$ 283,063,034	$ 437.60
LINCOLN	$ 18,991,604	$ 438.10
LAKE	$ 3,363,860	$ 454.58
MALHEUR	$ 14,115,916	$ 459.80
KLAMATH	$ 30,953,704	$ 496.85
COOS	$ 30,638,194	$ 499.40
JOSEPHINE	$ 41,741,358	$ 568.68
STATEWIDE	$ 1,119,303,595	$ 339.10

[12] These include state general funds, tobacco taxes and federal matching funds made available in the Medicaid, CHIP and FHIAP programs

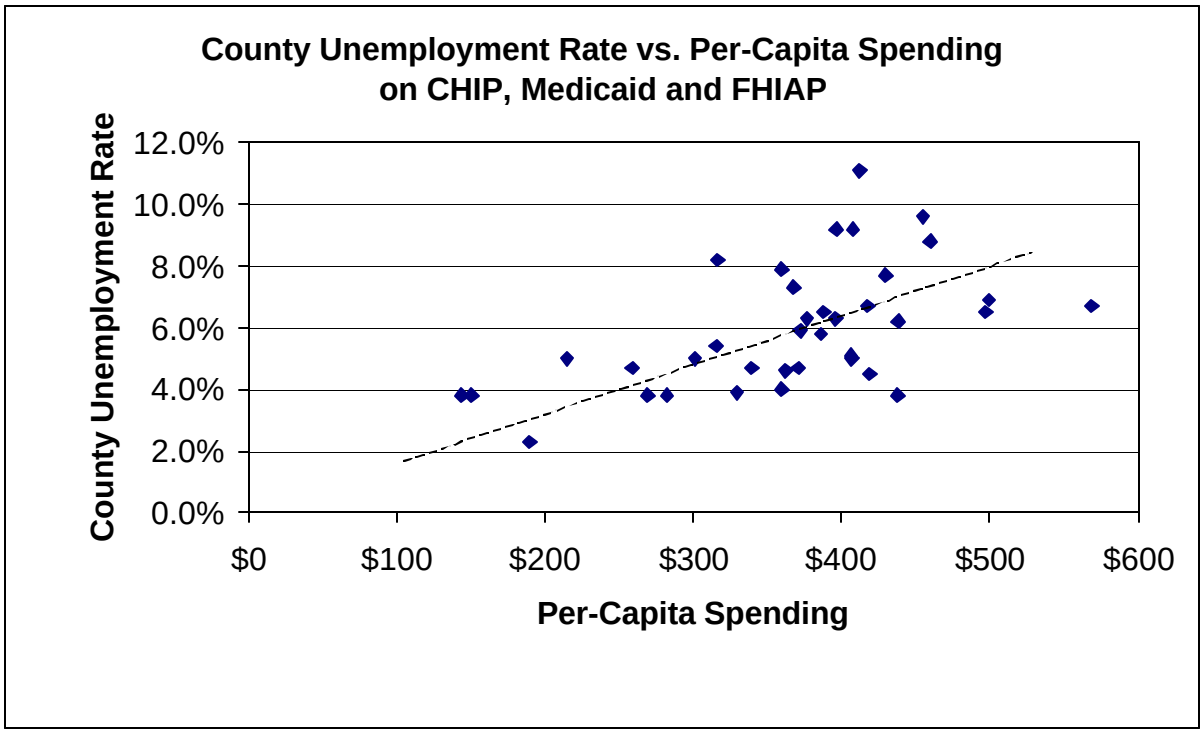
Three counties with higher levels of per capita personal income, Clackamas, Washington and Benton, receive the lowest amount of public funding per capita, while counties with more modest per capita income levels, Josephine, Coos and Klamath receive the largest amount. Moreover, the disparity in public funding per-capita is nearly fourfold between the richest and poorest counties, suggesting public policies for these funding streams are targeted at the appropriate areas.



A statistical analysis of the relationship between incomes by county and per-capita OHP spending shows an inverse relationship of modest significance. Of note, Multnomah County is a major exception to this relationship.

Funding relative to unemployment

Another perspective to consider is the relationship between spending on these programs on a per-capita basis relative to county-level unemployment rates. To the extent that unemployment rates represent the strength of a local economy and thus the need for social services, one would expect a positive relationship to exist. This is what is generally demonstrated across the state



Employer-Sponsored Coverage in Oregon

Data from the Medical Expenditure Panel Survey
Health Affairs January/February 2000

Oregon's innovative Medicaid expansion program has received a great deal of attention nationally, and much of the credit for the state's continually expanding number of insured. Often lost in this discussion is the success of the private market in helping control rising costs of healthcare and increase healthcare coverage. A recent (January/ February 2000) article in *Health Affairs*[13] documents some of Oregon's accomplishments in the private health insurance market.

While virtually all other states that have expanded their publicly sponsored insurance programs have seen declines in the private market, Oregon remains one of the few that has actually seen increased employer-sponsored coverage. According to the Health Affairs article, Oregon ranks sixth best nationwide in the proportion of the state's population that has employer-sponsored insurance (ESI) coverage at 56 percent. The national average is roughly 53 percent[14]

	% of Employers Offering Health Insurance
U.S. Average	**53%**
Highest	
1: Hawaii	84%
2: Ohio	61%
3: Massachusetts	60%
Oregon (6)	**56%**
Lowest	
3: Oklahoma	46%
2: Arkansas	45%
1: Mississippi	43%

[13] Branscome, er.al., *Private Employer-Sponsored Health Insurance: New Estimates by State.* Health Affairs

[14] All data are from the authors' analysis of 1996 Medical Expenditure Panel Survey-Insurance Component, sponsored by AHCPR.

In addition to expanding coverage, Oregon businesses have worked hard and been successful at not only controlling growth in health insurance premium costs, but also providing significant subsidies.

Total private-sector premiums in Oregon are the sixth lowest in the country, at around $4,500 per year for family coverage. The national average for family coverage is slightly less than $5,000, with Massachusetts being the highest at an average of $6,016 and South Carolina having the lowest at just over $4,000 per year.

	Average Family Premium
U.S. Average	**$4,953**
Highest	
1: Massachusetts	$6,016
2: New Jersey	$5,870
3: Connecticut	$5,656
Oregon (6)	**$4,462**
Lowest	
3: Arkansas	$4,197
2: New Mexico	$4,142
1: South Carolina	$4,041

Oregon employers contribute significantly to the cost of premiums, enabling employees to purchase coverage. Average employer contribution toward family coverage is almost $2,900, or nearly 65 percent of the premium. Employer sponsorship of individual coverage in Oregon ranks fourth nationally, with employers picking up an average of nearly 90 percent of the premium for single-coverage approximately $1,755 per year.

A Historical Perspective on Hospital Finances

In 1981 there were approximately 74 community hospitals in Oregon. By 1998 that number was reduced to 59. Some hospitals closed while others were purchased. A few lost a separate identity through merger and consolidation. While the number of licensed community hospitals has decreased, the proportion of facilities that are a part of a health system has increased. Also the number of health systems has risen. In 1981 there were three health systems in Oregon that operated more than one hospital in this state. By 1998 approximately nine health systems provided acute care at more than one location.

Hospitals attempt to generate enough revenues to cover expenses and generate a positive net income. Some sources of revenue such as Medicare and Medicaid prospectively designate what they will pay a hospital for inpatient services. For the majority of other insurers, a hospital will typically negotiate reimbursement rates. In some cases a facility bills the insurer the retail price for services provided. For uninsured patients the list price is likely to be charged unless a reduced amount is negotiated or free care is offered.

Hospitals consider a variety of factors in budgeting the total expenses that need to be supported by facility revenues. These include wage inflation for nursing, maintenance and

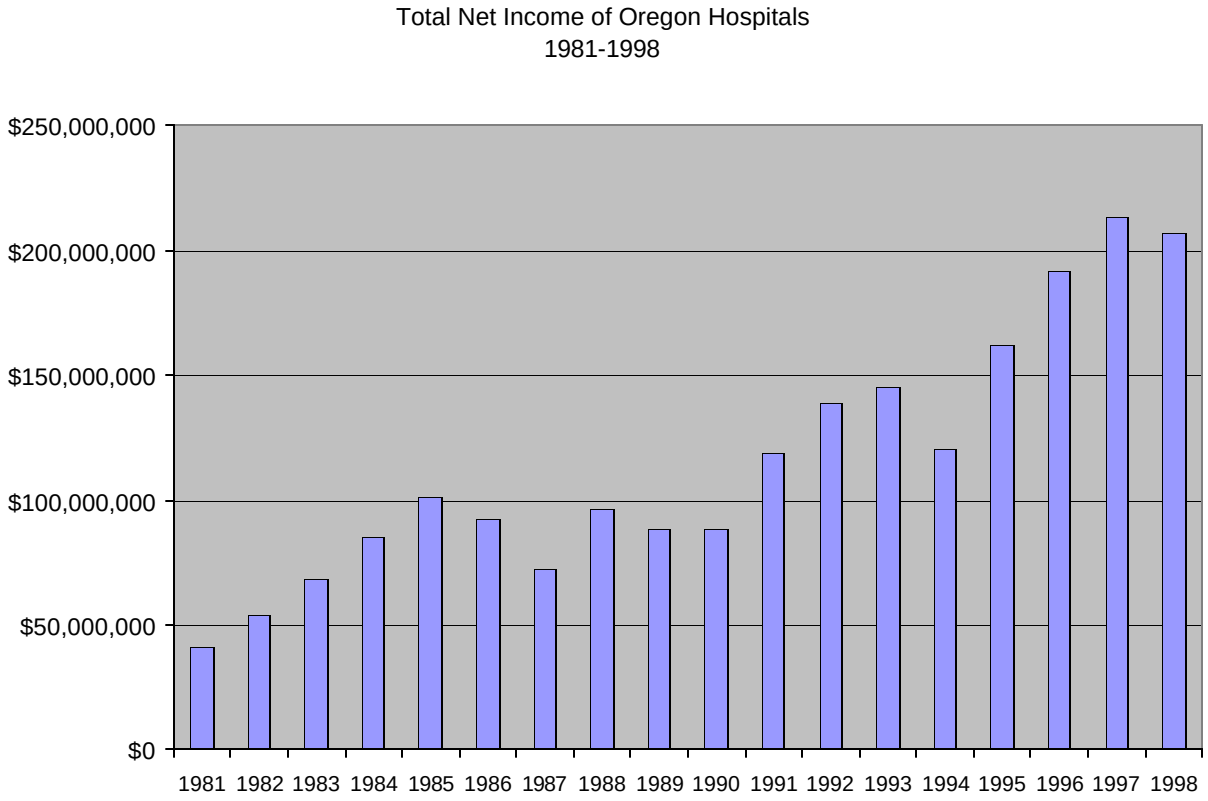
	Average Employer Contribution Toward Single Coverage	Average Employer Contribution Toward Family Coverage
U.S. Average	**83%**	**71%**
Highest		
1: Hawaii	90%	84%
2: Michigan	90%	80%
3: Washington	89%	60%
Oregon (Rank)	**88% (4)**	**64% (33)**
Lowest		
3: (Four states)	76%	63%
2: Alabama	75%	58%
1: New Mexico	70%	57%

administrative staff. Hospitals also purchase significant amounts of medical/surgical supplies, pharmacy products and dietary provisions for which prices change. Other items include insurance, utilities, purchased services and plant and equipment. While hospital expense inflation will increase each year this may not be true of each component. Supplies or utilities, for example, could drop in price in a particular year. Over time, the mix of goods and services purchased may change as the services offered by the facility evolve due to administrative decisions, technology or other reasons. As a result, hospital expenses may vary from year to year, irrespective of inflationary causes. The hospital also considers the expected volume of patients and related need for staff, supplies and other support.

Another expense budgeted is bad debts. This expense is the unpaid portion of bills for which payment is expected. In 1998 bad debt accounted for more than 2.9 percent of all hospital expenses in the state. Interest expense is also incurred by many facilities. This can be due to temporary borrowing. Typically, interest expense is a part of debt service related to construction or renovation of a facility or lease or purchase of equipment. When a facility has or plans to incur debt it will consider its need for cash to service the debt – principal and interest-related to those obligations. In some cases facilities will have sufficient accumulated earnings to finance equipment acquisitions or construction projects without incurring debt.

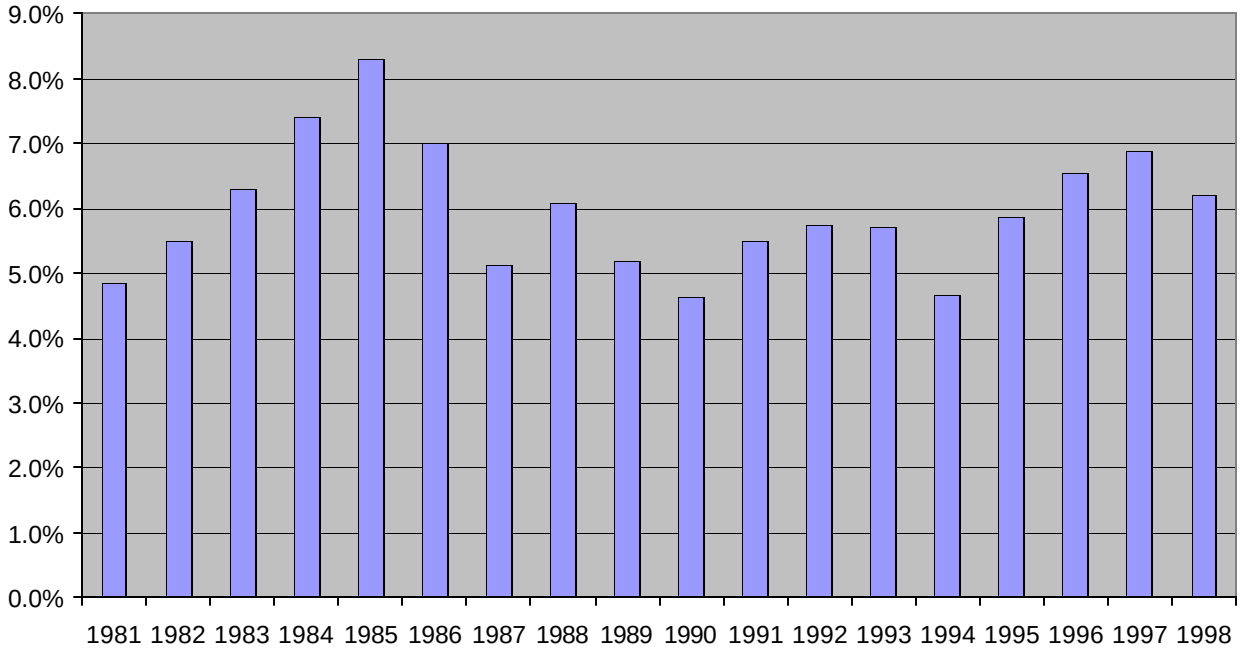
Total operating revenues of Oregon hospitals, net of contractual adjustments and charity care, first exceeded $1 billion in 1983. In 1991, eight years later, the $2 billion level of revenues was reached. It took six years for net revenues to grow to the $3 billion level. Total operating expenses followed essentially the same pattern, except that expenses did not go over $3 billion until 1998.

The net income of Oregon hospitals, in excess of $41 million in 1981, topped $100 million in 1985 at $101 million. With reduced earnings in subsequent years this level was not reached again until 1991. From 1991 to 1997 net income increased each year, except for 1994. In 1997 combined hospital net income first went over the $200 million mark at $214 million. While the amount of net income has both gained and lost ground in individual years it has increased over time.

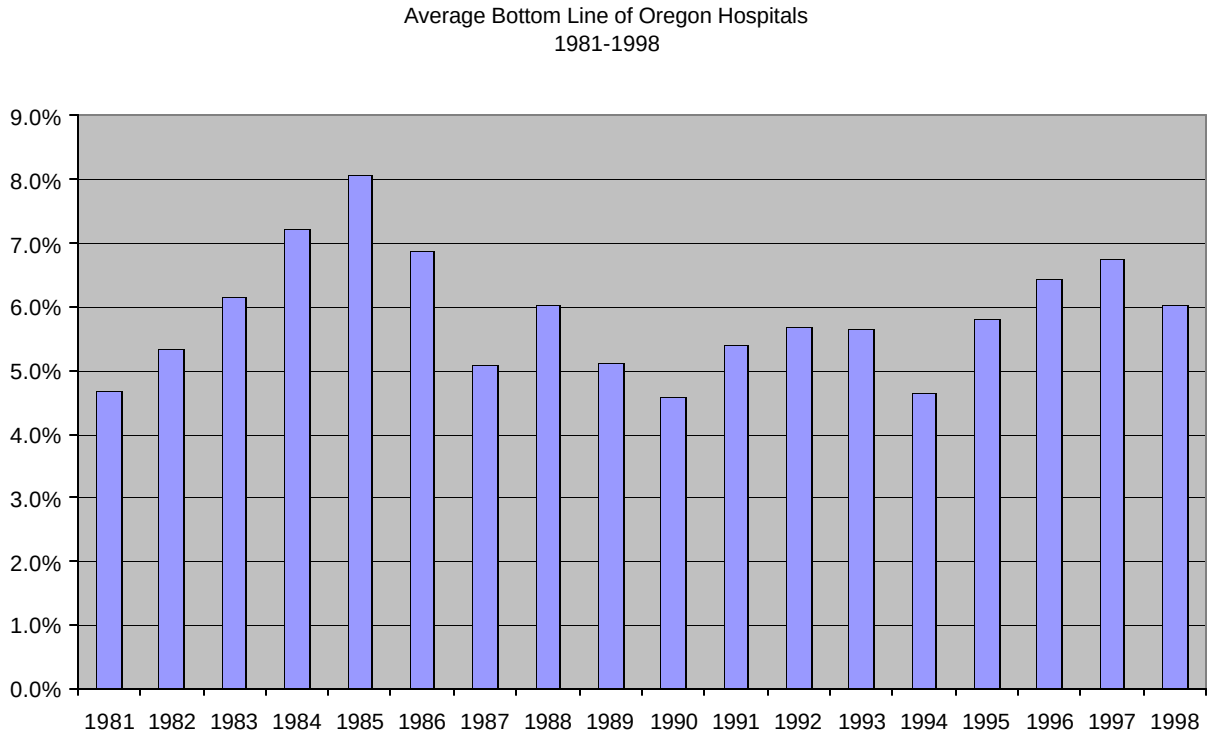


When viewed as a proportion of total revenues, however, net income shows more variability and recent yearly results that do not exceed performance achieved in some earlier periods.

Net Income as a Proportion of Total Revenues:
Oregon Hospitals 1981-1998



The combined bottom line ratio of Oregon hospitals compares net income to the total operating revenue plus net non-operating revenue, expressed as a percent. This represents an additional measure of the financial stability or success of a hospital. Average bottom line ratio ranged from approximately 4.6% to 8.1% over the period 1981 to 1998. At 4.7% in 1981, the bottom line ratio increased each year to 8.1% in 1985. Subsequently, it moved generally downward to 4.6% in 1990. Bottom line results improved in 1991, to 5.4% and generally thereafter maintained or improved on the prior years' performance through 1997 at 6.7%. An exception is the 4.6% ratio in 1994. In 1998 the bottom line ratio moderated from the 1997 level to 6%.



This summary of hospital operating results shows aggregate performance. For any year there will be facilities that had proportionally greater earnings than the overall result. Correspondingly, there are other hospitals that did less well and some that lost money in a particular year. Thus, there is a wide range of performance that makes up the combined results.

Hospital Utilization in Oregon

According to data from the American Hospital Association's 1998 Annual Survey of Hospitals, Oregon remains the nation's lowest cost and most efficient inpatient hospital care provider. Oregon continues to have the most consistently low indicators for inpatient costs and utilization of any state in the U.S. In eight categories measured, Oregon ranked lowest in four (the same as the previous year), second lowest in one, third lowest in one, forth in one and fifth in one.

In summary, the 1998 AHA Annual Survey of Hospitals by state found the following:

- Oregon's age adjusted hospital admissions of 92.7 per 1000 population ranked 47th, 19.9% below the U.S. average. Washington ranked 48th in this category and California 39th.

- Oregon's age adjusted inpatient days/1000 of 386.7-ranked 51st in the nation, 38.2% below the U.S. average. New York at 897.6 was highest. Washington ranked 50th in this category and California 38th.

- Oregon's age adjusted hospital expenses per capita of $922 ranked 46th in the nation, 20.8% below the U.S. average. Massachusetts at $1586 was highest and Nevada at $771 was lowest. Washington ranked 43rd in this category and California 36th.
- Oregon's Medicare billings per capita of $4,341 were 51st in the nation, 39.8% below the U.S. average. Alaska led the nation with Medicare billings per capita of $10,198, almost $6,000 higher than Oregon. Washington ranked right behind Oregon in 50th place, while California's Medicare billings of $7,249 per capita placed it 18th in the nation.

- In terms of actual Medicare receipts per capita, Oregon's $2,743 ranked it 48th in the nation, 25.7% below the U.S. average. Alaska led the nation with Medicare receipts per capita of $5,922, while Nevada was the lowest in the nation at $2,579. Washington ranked 44th in this category, while California was 39th.

Even though Oregon continues to fare extremely well in these national comparisons, trends do indicate that in some areas the rest of the nation appears to be catching up. While the average hospital length of stay nationwide remained at 5.3 days, Oregon saw an actual increase from 3.9 days to 4.1 days. Although Oregon still has the shortest average hospital length of stay in the country, it appears that our downward trend has come to a halt.

Hospital Profitability Analysis 1994 To 1999[1]

Distressed Hospitals

These facilities, as a group have experienced eroding profitability that has turned increasingly negative the last three years. Complete FY99 data, however, could modify this trend. A few of these facilities did fairly well in terms of profitability in the early part of the comparison period but performance for most deteriorated in later years. There are fourteen hospitals included in this group:

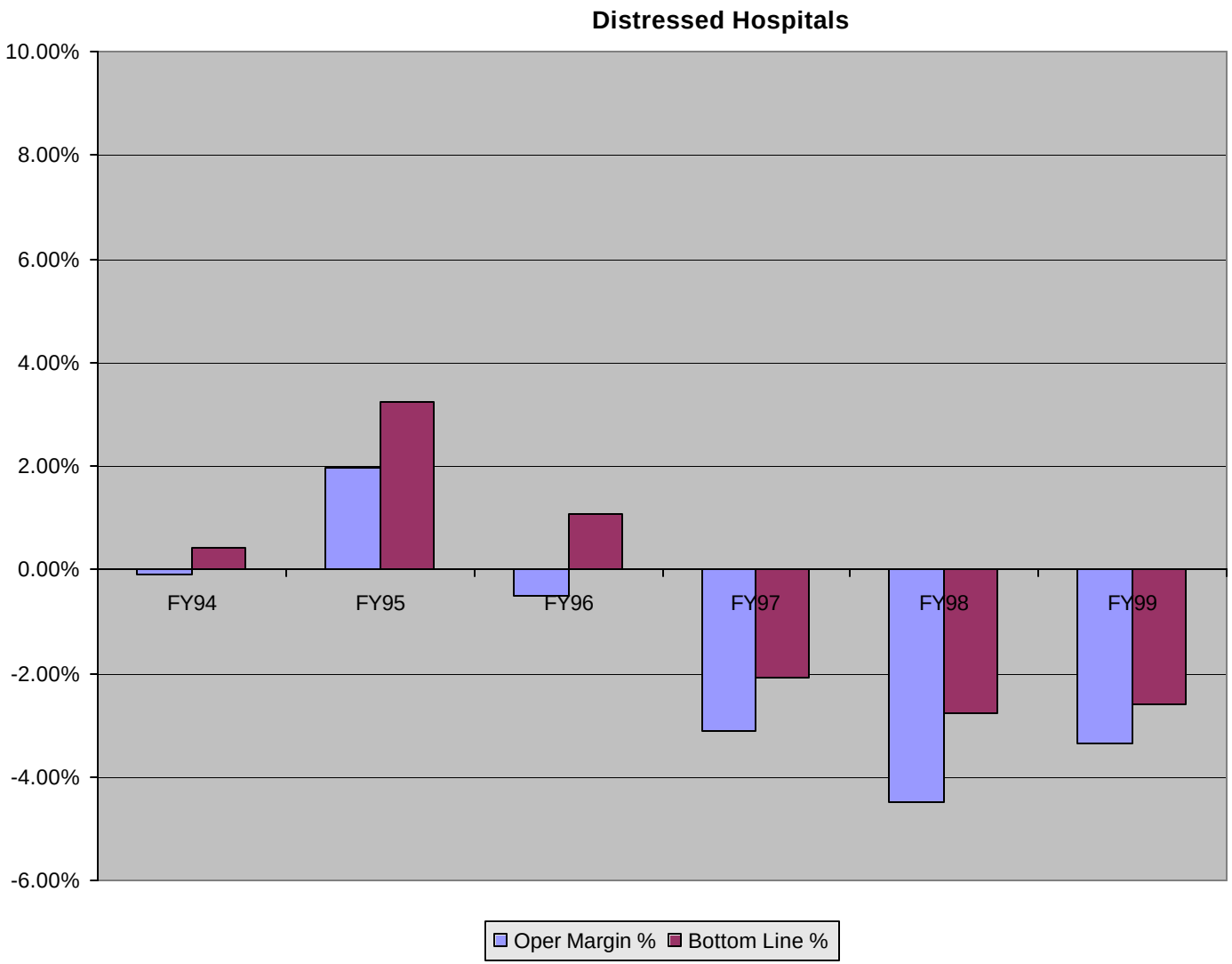
Type A:
Blue Mountain Hospital District
Curry General Hospital
Pioneer Memorial- Heppner
St. Elizabeth Health Services

Type B:
Cottage Grove Healthcare Community (closed during FY98)
North Lincoln Hospital
Pioneer Memorial- Prineville

Other Facilities:
Douglas Community Medical Center (closed Feb. 2000)
Eastmoreland Hospital
Legacy Mt. Hood Medical Center
Merle West Medical Center
Providence Medford Medical Center
Tuality Community Hospital (including Forest Grove)[2]
Woodland Park Hospital

[1] 1999 data is preliminary and based on 53 hospital financial statements of a total of 58 facilities. 1999 data may change materially as more information becomes available.

[2] Type B status is to be repealed for this facility according to the Office of Rural Health.


Distressed Hospitals
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
-2.00%
-4.00%
-6.00%
FY94
FY95
FY96
FY97
FY98
FY99
Oper Margin %
Bottom Line %

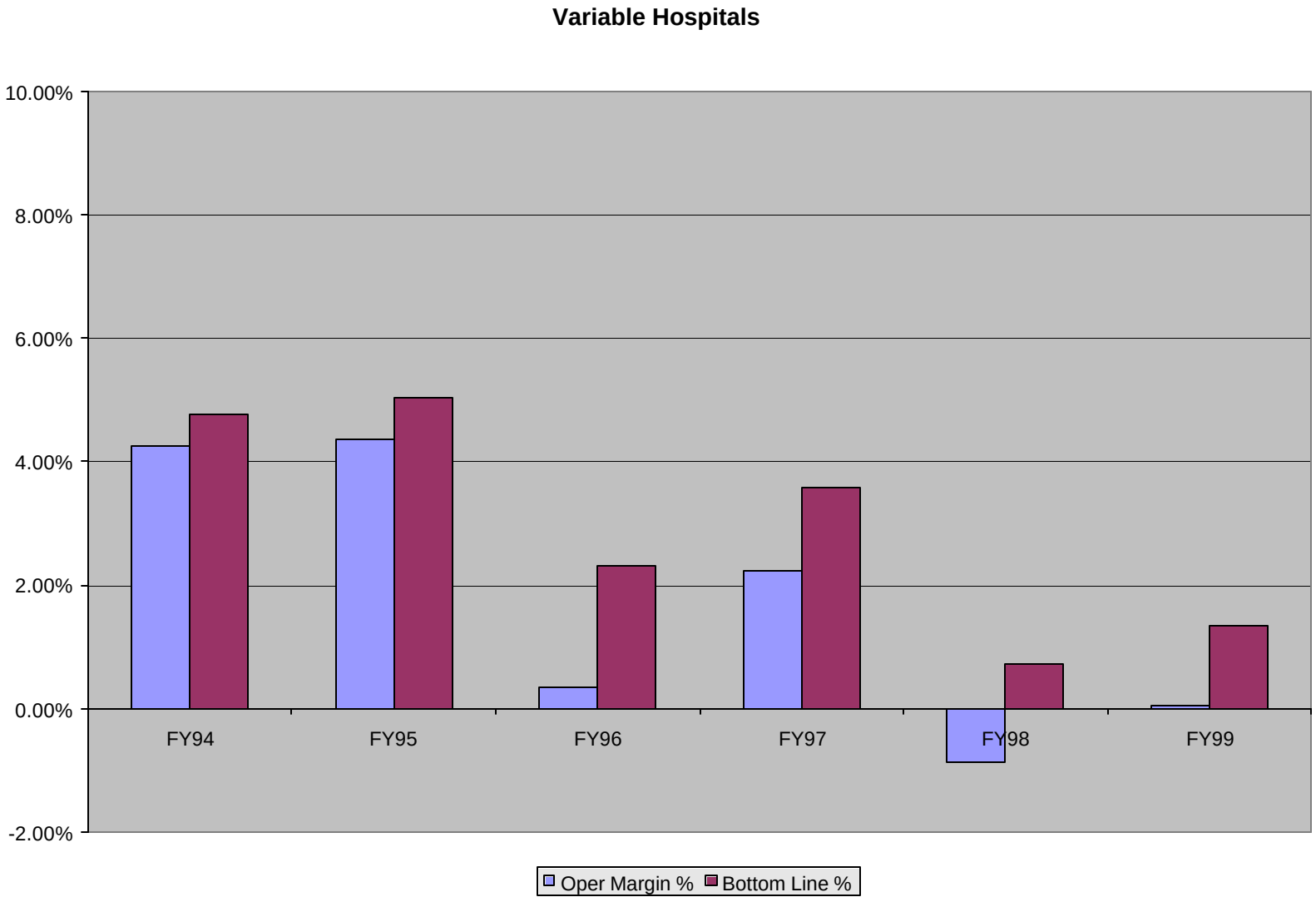
Variable Hospitals

These facilities have had varied performance, with some good years in terms of profitability but usually also with a couple years of poor results. Some hospitals had profitability that approached the state average in FY94 and FY95. Others have had reasonable results in later periods. Most, however, have stumbled at some point over the comparison period. While profitability for the group has declined over time, a few have experienced a turn-a-round with a rebounding net income. These eleven hospitals include:

Type A:
Harney District Hospital
Lake District Hospital
Wallowa Memorial Hospital

Type B:
Coquille Valley Hospital
Providence Hood River
Mt. View Hospital District
Peace Harbor Hospital
Southern Coos General Hospital
Valley Community Hospital

Other Facilities:
OHSU Hospital & Clinics
Portland Adventist Medical Center


Variable Hospitals
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
-2.00%
FY94
FY95
FY96
FY97
FY98
FY99
Oper Margin %
Bottom Line %

Other Hospitals

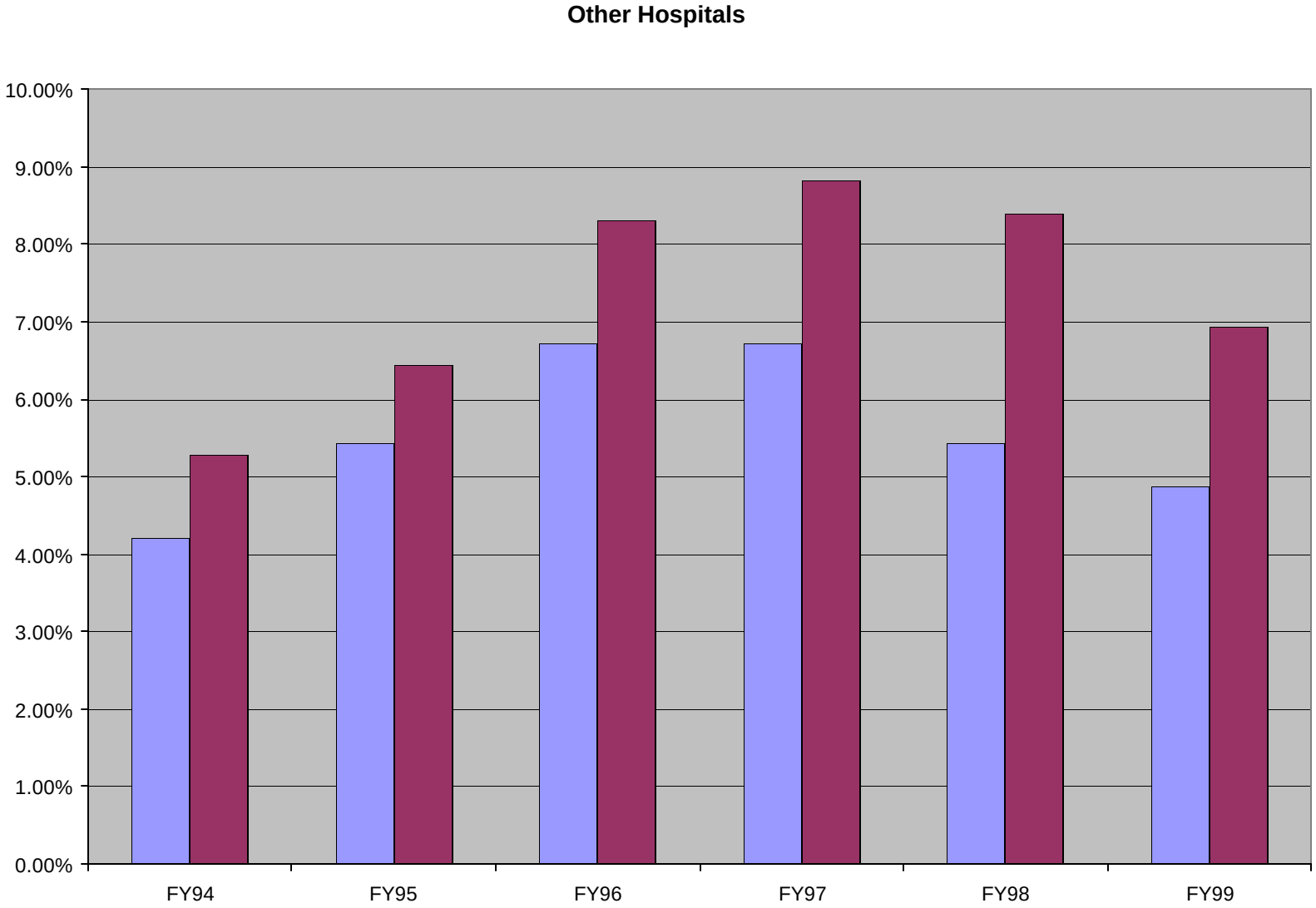
The remaining thirty-four facilities show combined performance superior to that for Oregon hospitals as a whole. Performance of some hospitals has been mediocre for individual years, at times less than the average performance for Oregon facilities. These hospitals are less a particular group than facilities that did not seem to fall into either the distressed or variable categories. In some cases it was tax support of district hospitals that turned a loss from operations into a positive bottom line and led to inclusion here rather than classification as distressed or variable. These other hospitals include:

Type A:
Good Shepherd Community Hospital
Grande Ronde Hospital
St. Anthony Hospital
Tillamook County General Hospital

Type B:
Ashland Community Hospital
Central Oregon District Hospital
Columbia Memorial Hospital
Lower Umpqua Hospital
Mid-Columbia Medical Center
Mid-Valley Healthcare (Lebanon)
Pacific Communities Hospital
Providence Newberg Hospital
Providence Seaside Hospital
Santiam Memorial Hospital
Silverton Hospital

Other Facilities:
Albany General Hospital
Bay Area Hospital
Good Samaritan Hospital – Corvallis
Holy Rosary Medical Center
Legacy Emanuel Hospital and Health Center
Legacy Good Samaritan Hospital and Medical Center
Legacy Meridian Park Hospital
McKenzie-Willamette Hospital
Mercy Medical Center
Providence Milwaukie Hospital
Providence Portland Medical Center
Providence St. Vincent Medical Center
Rogue Valley Medical Center
Sacred Heart Medical Center
St. Charles Medical Center

Salem Hospital
Three Rivers Community Hospital
Willamette Falls Hospital
Willamette Valley Medical Center (McMinnville)


Other Hospitals
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
FY94
FY95
FY96
FY97
FY98
FY99

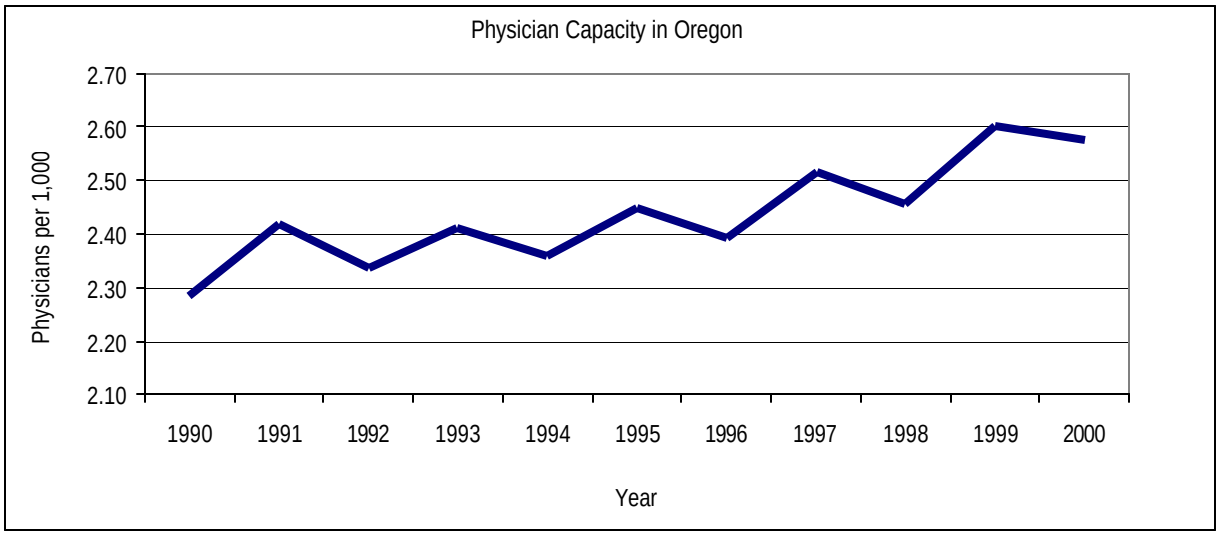
Physician Capacity in Oregon 1990 through 2000

This report examines the number of licensed physicians in Oregon relative to the state's population and presents the trend in physician capacity over the past decade. The State of Oregon's Board of Medical Examiners (BME) provided data concerning physician licensing, while Portland State University's Center for Population Research and Census developed the state population estimates.

The primary purpose of this analysis is to examine changes in physician capacity in recent years. It does not assess the sufficiency of a given capacity level. A few caveats are necessary regarding the data presented in this report. First, the data provided by the BME distinguish between active and inactive licensees in a given year. Not all physicians maintaining an active status serve patients on a regular basis, if at all. They may choose to pursue executive, teaching, research, or consulting careers and retain an active status for a variety of reasons. For the purposes of this report, we assume that the proportion of physicians actively practicing medicine remained relatively constant in recent years.

Second, the data do not indicate type of practice. The general trend in physician capacity may not be indicative of the trend in a specific field, such as primary care. Finally, limited license holders, comprised entirely of residents and faculty at Oregon Health Sciences University, are not included in this report.

The table below presents the number of actively licensed physicians per 1,000 Oregonians between for the years 1990 through 2000. The figures represent a snapshot of licenses as of April 30 in each year, and include physicians residing out of state that practice at least part-time in Oregon.


Physician Capacity in Oregon
Physicians per 1,000
2.70
2.60
2.50
2.40
2.30
2.20
2.10
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
Year

The number of physicians per 1,000 Oregonians increased modestly during the 11-year span, from 2.28 in 1990 to 2.58 in 2000. The cyclical pattern is attributable to the BME's biennial renewal cycle. All licensees are required to renew during this period, which occurs roughly at the end of each odd year. Thus, lapsed licenses are only reflected in snapshots taken during even years.

A survey conducted by the Area Health Education Center at Oregon Health Sciences University beginning Spring 2000 will provide additional information regarding medical professionals in Oregon. Surveys were sent to all licensed practitioners – with the exception of registered nurses, who were sampled due to the large numbers involved – and response rates are between 52% for physicians and 67% for dental hygienists. The survey covers a variety of information, including demographic and professional characteristics, location of practice, client characteristics, and career expectations. Published reports are expected as early as Fall 2000.

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