Office of Oregon Health
Policy and Research

The Oregon Health Plan and its Components

Report to the 72nd Legislature of the State of Oregon

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A Report to the 72nd Legislature of the State of Oregon

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I. Executive Summary

The Oregon Health Plan (OHP) has been a part of the Oregon landscape since the 1980s. The initial goals of the Oregon Health Plan were to control health care costs in Oregon, while providing people access to health care that had traditionally been denied them. Through this innovative program, public and private services for health care and how these services are delivered have been re-envisioned. For example, low-income people (under 100% of the federal poverty level) have become eligible for health care, regardless of their health status. On the private side, people suffering from acute and chronic diseases, who had been denied individual coverage in the marketplace, can now gain access to health care through the Oregon Medical Insurance Pool.

Oregon continues to re-envision the future of health care. As the pressures on the U.S. health care system mount, Oregon is in a unique position to try out new ideas. In this paper you will see where the Oregon Health Plan has been and where Oregon Health Plan 2 (OHP2) is headed in the future.

Health care financing is a tricky business. Unlike other parts of a budget, the lack of health care can lead to predictable consequences. For instance, if someone is uninsured and avoids going to the doctor for some small complaint, that person will more than likely end up in an emergency room for treatment of a more serious problem. Some budget items in a household can be put off as frivolous. Health care often is not one of those items. For that reason it has been carefully thought out what role the State should play in governing health care. Here are some of the successes that the State has achieved through nearly 20 years of rethinking health care.

Successes of the Oregon Health Plan

- More than **1,400,000** people have gained access to healthcare as a result of the Oregon Health Plan Medicaid Program (OHP-DHS). ***Source:*** *Department of Human Services, Office of Medical Assistance Programs, Analysis & Evaluation Unit.*

- Nearly **90,000** children have been served in the State Children's Health Insurance Program (SCHIP) since its inception. *Source: Department of Human Services, Office of Medical Assistance Programs, Analysis & Evaluation Unit.*

- More than **29,000** individuals who had previously been denied coverage due to pre-existing medical conditions have obtained coverage through the Oregon Medical Insurance Pool (OMIP, also known as the high-risk pool). *Source: Oregon Medical Insurance Pool Statistical and Financial Report, February 2002.*

- More than **20,000** employers took advantage of the IPGB-certified employment-based health insurance plans, enrolling more than 60,000 employees and their dependents into coverage. *Source: IPGB Budget Report.*

- Hospital charity care, as a percentage of gross patient revenue, **has declined more than 53%** since the inception of the Medicaid Demonstration project (1994-2000) *Source: Office of Health Policy & Research, Research & Data Unit, August 2002.*

- The number of uninsured individuals in **Oregon has dropped**: *Source: Oregon Population Surveys 1990-2000*

Table 1

	All Oregonians
1990	**18.0%**
1992	**17.0%**
1994	**13.6%**
1996	**10.7%**
1998	**11.0%**
2000	**12.2%**

- The number of uninsured **Kids** in **Oregon has dropped**

Table 2

	All Children
1990	**21%**
1992	**18.5%**
1994	**12.6%**
1996	**7.6%**
1998	**9.4%**
2000	**8.5%**

- Overall, per capita healthcare costs are low. In **Oregon it is $3,334** per person per year, while the **U.S. average is $3,759** per person per year.

Table 3

State	Dollar Amount Per Person	Rank of 50 states + D.C.
Oregon	**$3,234**	**44**
Washington	3,370	39
Idaho	2,673	51
California	3,305	42
Nevada	3,016	47

Source: State Health Expenditure Accounts from the Centers for Medicare and Medicaid, formally known as the Health Care Financing Administration, website at http://cms.hhs.gov/researchers/projects.
1998 civilian population data based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured tabulations of the March 1999 CPS (active duty military not included).

- OHP Medicaid's **Emergency Room utilization is clearly lower** than the rest of the nation reporting results from the Consumer Assessment Health Plan Survey (CAHPS®) as depicted in Table 4.

Adult *utilization characteristics- From CAHPS®*

The table below presents comparative utilization information about the Oregon Health Plan Adult and the National Consumer Benchmarking Database sample. Oregon's Health Plan (OHP) population (DHS-OHP) and Other State's Medicaid Adult Population National Consumer Assessment of Health Plans Survey Benchmarking Database (NCBD 2002)

Table 4

Utilization Characteristic	DHS-OHP	NCBD 2002
Have a personal doctor or nurse?		
Yes	86%	77%
No	14%	23%
See a specialist?		
Yes	41%	39%
No	59%	61%
Call a doctor's office?		
Yes	67%	60%
No	33%	40%
Appointment for routine care?		
Yes	68%	69%
No	32%	31%

Illness/injury that needed care right away?		
Yes	43%	43%
No	57%	57%
Visits to the emergency room?		
None	**73%**	**64%**
1-3	24%	32%
4-5	2%	3%
5+	1%	1%
Visits to doctor's office or clinic?		
None	22%	21%
1-2	33%	34%
3-4	23%	22%
5-9	15%	15%
10+	7%	8%

Child *utilization characteristics*

In Table 5 below, it presents comparative utilization information about the Oregon Health Plan Child and the NCBD child data.

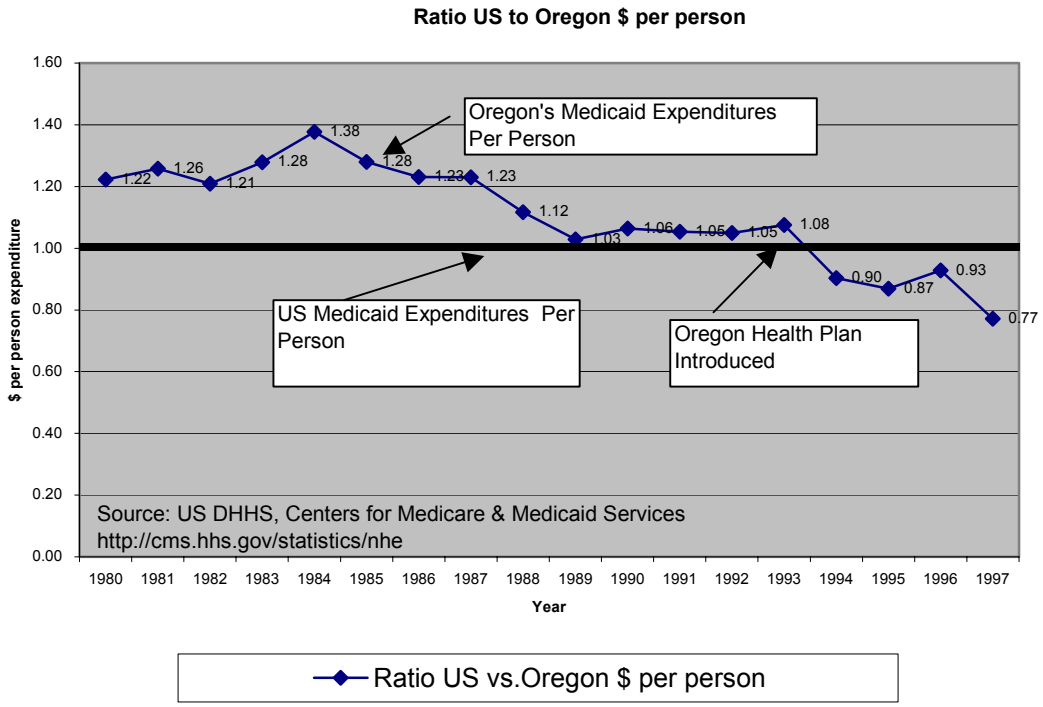
Table 5

Utilization Characteristic	DHS-OHP	NCBD 2002
Does your child have a personal doctor or nurse?		
Yes	83%	81%
No	17%	19%
Did your child see a specialist?		
Yes	15%	23%
No	85%	77%
Call a doctor's office?		
Yes	63%	61%
No	37%	39%
Appointment for routine care?		
Yes	60%	66%
No	40%	34%

Illness/injury that needed care right away?		
Yes	36%	42%
No	64%	58%
Visits to the emergency room?		
None	**80%**	**69%**
1-3	19%	29%
4-5	1%	1%
5+	0%	1%
Visits to doctor's office or clinic?		
None	27%	18%
1-2	46%	45%
3-4	18%	23%
5-9	6%	6%
10+	2%	3%

- Oregon's spending per-person on Medicaid has **decreased**, as depicted in Figure 1, on the next page.

Figure 1



- **Multiple studies consistently show improved health outcomes for populations covered by the Oregon Health Plan, especially outcomes related to prevention. For a complete list of these studies, please see the DHS website at: http://www.omap.hr.state.or.us/library/archive/**

Oregon Health Plan 2 (OHP2)

OHP2 is a restructuring of the Oregon Health Plan Medicaid waiver. It was approved by CMS on October 15, 2002. It gives the state greater flexibility in providing health care benefits and eligibility, which enables the Legislature to keep the Medicaid and Children's Health Insurance Program budgets within resource limits. OHP2 includes a new benefit package called OHP Standard, which resembles private insurance both in benefits covered and in cost sharing.

With OHP2, Oregon gains federal matching funds for the Family Health Insurance Assistance Program (FHIAP), which subsidizes private insurance for previously uninsured families and individuals. This allows FHIAP to increase eligibility to 185% of federal poverty level (FPL), which means an expansion of health insurance up to an additional 25,000 uninsured Oregonians. The Office of Medical Assistance Programs (OMAP) Medicaid and the State Children's Health Insurance Program (SCHIP) also expand by approximately 35,000, for a total expansion of approximately 60,000 people.

The following are important points to keep in mind about the restructuring of OHP:

1) OHP2 does **not cost the state any additional funds** – it is budget neutral.

2) OHP2 does **not take benefits away from vulnerable populations** like children, pregnant women, aged, blind or disabled, very low income parents or the general assistance population (those applying for disability benefits). These populations will keep their current (OHP Plus) benefits.

3) Further, OHP2 will mean **federal matching funds for FHIAP**, a program funded with state monies only. OHP2 will mean that a total of 60,000 uninsured Oregonians will gain health coverage through expansion of FHIAP and OHP Medicaid and CHIP.

OHP2 will help make the OHP sustainable by maximizing federal matching funds and by giving the Legislature greater control over program budget.

By reading this report you should become familiar with the state of health care in Oregon.

II. Description of the Traditional Oregon Health Plan Components

Overview

The Oregon Health Plan consists of a number of programs designed to promote the objective of access to quality healthcare at an affordable cost for Oregon's low-income 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.

Medicaid and SCHIP

Beginning in 1994, the State of Oregon implemented a variety of Medicaid program reforms, granted by the former Health Care Financing Administration (now renamed the Centers for Medicare and Medicaid Services or CMS) under Title XIX Waivers.

Reforms consisted of the following:

1. Expanded eligibility criteria to cover more people.

    - Original OHP served people up to 100% of the Federal Poverty Level (FPL) and
    - 133% FPL for children up to age six
    - Up to 170% FPL for children under Title XXI SCHIP
    - 170% for infants (<1 year old) and pregnant women

2. Incorporated a prospective payment arrangement (capitation) and managed care model to insure efficient and appropriate service delivery.

3. Created budgetary controls using a prioritized list of conditions to determine eligible treatments given authorized funding levels.

Oregonians served per year: About **500,000**
Oregonians served since 1994: About **1,400,000**

More information is available at: http://www.omap.hr.state.or.us/

State Children Health Insurance Program (SCHIP)

With the help of additional funds provided under the federal government's State CHIP (known as SCHIP) program, Oregon extended availability of the Medicaid benefit to children in low-income families up to 170% of FPL. The OHP-SCHIP program went into effect in July 1998 and has served **88,998** children statewide since its inception. See CMS website for a full report: http://www.cms.hhs.gov/schip/schip01.pdf

More information is available at: http://www.omap.hr.state.or.us/chip/

The Insurance Pool Governing Board (IPGB)

As part of the Oregon Health Plan, the IPGB was created to encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds. At the time IPGB began offering health insurance plans, 60 percent of Oregonians received employer-based health insurance. By 1998, that figure had climbed to 72 percent at a time when other states were experiencing a reduction in employer-based insurance.

Initially, the IPGB designed a basic, no-frills benefit package that was offered by small group insurance companies at a set price to both small employers and the self-employed. Exempt from certain insurance mandates, the IPGB-certified plans were only available to employers (including the self-employed) who had not offered group health insurance benefits in two years – essentially a first-time buyer's plan. For six years, businesses who purchased IPGB-certified plans received a small, declining, non-refundable tax credit, which sunset in 1995. Eventually, insurance carriers offering IPGB-certified plans were allowed to offer higher benefit (and higher cost) plans to interested small employers.

From 1989 to 2000, over 20,000 employers purchased IPGB-certified plans, enrolling more than 60,000 employees and their dependents into coverage. In 1993, the Legislature provided funding for a marketing program within the IPGB to increase enrollment in the certified plans, though part of this marketing was of an "institutional" nature touting the benefits of health insurance. For the next three years, IPGB's enrollment reached new record levels, with the peak enrollment occurring in 1996 when more than 32,000 people received health benefit coverage with an IPGB-certified plan.

However, major health insurance market reforms enacted by the Legislature during the 1990s decreased the need for the specialized IPGB benefit plans and the protections and affordability they offered. There was a slow migration from the IPGB plans to the regular market beginning in 1997. By 1998, enrollments had dropped to around 17,000 employees and dependents. The

Board recommended dropping the certified plans in 1998, and during the 1999 Legislative Session Senate Bill 414 removed certification of plans from IPGB's statutes.
The 1999 Legislature revised the IPGB's mission to encourage and assist Oregon small businesses and consumers in making informed health insurance choices by providing outreach, education, and referral services, as well as provide access to health insurance through a program for low-income, uninsured Oregonians and those unable to obtain insurance because of pre-existing health conditions.

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 IPGB has administered the FHIAP program since its inception.

As of the IV Special Session, the 2001-03 biennial budget for the FHIAP portion of IPGB is **$20,691,135**, in other funds, predominantly **Tobacco Settlement Funds**. (See **FHIAP** for an explanation of these funds)

The **marketing outreach and information budget** for IPGB is **$454,735 General Fund**, **$51,731 Other Funds**. The IPGB Budget is **$21,197,601** Total Funds.

More information is available at: http://www.ipgb.state.or.us/

The Family Health Insurance Assistance Program (FHIAP)

The 1997 Legislature created FHIAP, a subsidy to low-income Oregonians (< 170% FPL) to aid them in buying private health insurance. The FHIAP program provides direct subsidies to qualified Oregonians to help them buy health insurance through their employer or through the individual market. For the 2001-03 biennium the FHIAP budget is **$20,691,135**, composed predominantly of **tobacco settlement dollars**. Enrollment is capped in FHIAP to serve about **4,000** Oregonians every year, subject to availability of funds. There is a waiting list for FHIAP of about **20,000** Oregonians currently. More than **11,000** Oregonians have used FHIAP at one time or another to obtain affordable health insurance.

More information is available at: http://www.ipgb.state.or.us/Docs/fhiaphome.htm

Oregon Medical Insurance Pool (OMIP)

The 1987 Legislature created the Oregon Medical Insurance Pool to provide affordable health insurance to individuals denied individual coverage due to pre-existing medical conditions. In 1996, OMIP also became the portability option for people who have exhausted their COBRA, state continuation, and portability options. In OMIP, premium rates for the medically eligible group are capped at 125% above the individual market. Portability plans are capped at 100% of the average cost of a portability plan in the market. Regence BlueCross BlueShield of Oregon administers the insurance program, offering four different plans statewide. **The program is paid for entirely by a combination of the premiums paid by members and an assessment on the health insurance companies** doing business within the State of Oregon. It will serve about **9,200** people in 2002, and enrollment is growing. Since its inception over 10 years ago, over **29,000** Oregonians have been served.

More information is available at: http://www.omip.state.or.us/

III. Medicaid and SCHIP Enrollment, Sources of Funding and Costs of Program

Medicaid and SCHIP 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 nearly 400,000 participants, and then began to decline until early 1998. There has been a steady increase in enrollment since. The development and implementation of the new CHIP program in 1998 had not only the direct effect of covering additional people in these programs, but also the outreach effect of bringing more people into the Medicaid program who were previously eligible, but not participating.

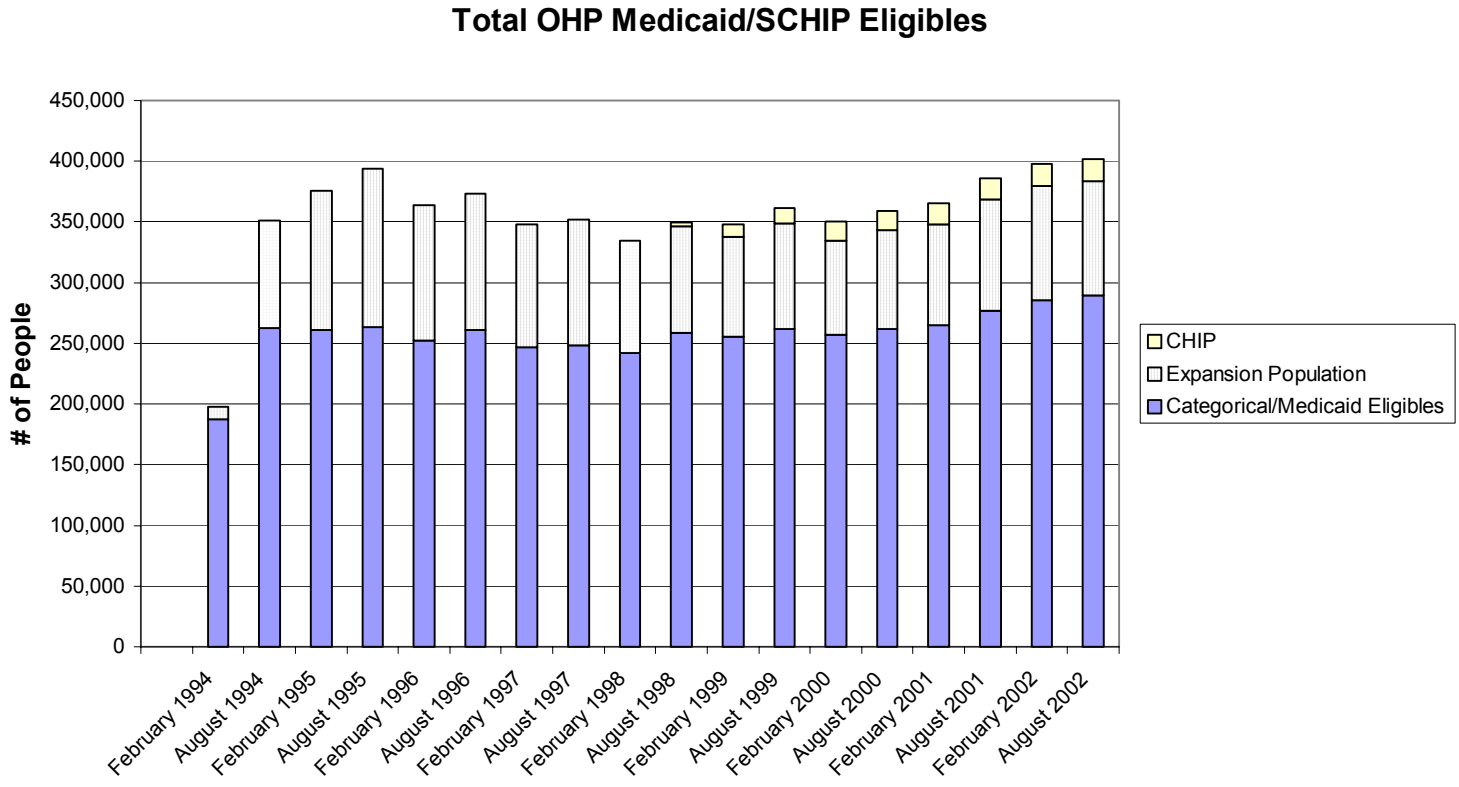


Figure 2

Source: Department of Human Services, Office of Medical Assistance Programs, Office of Finance & Policy Analysis, Budget Section.

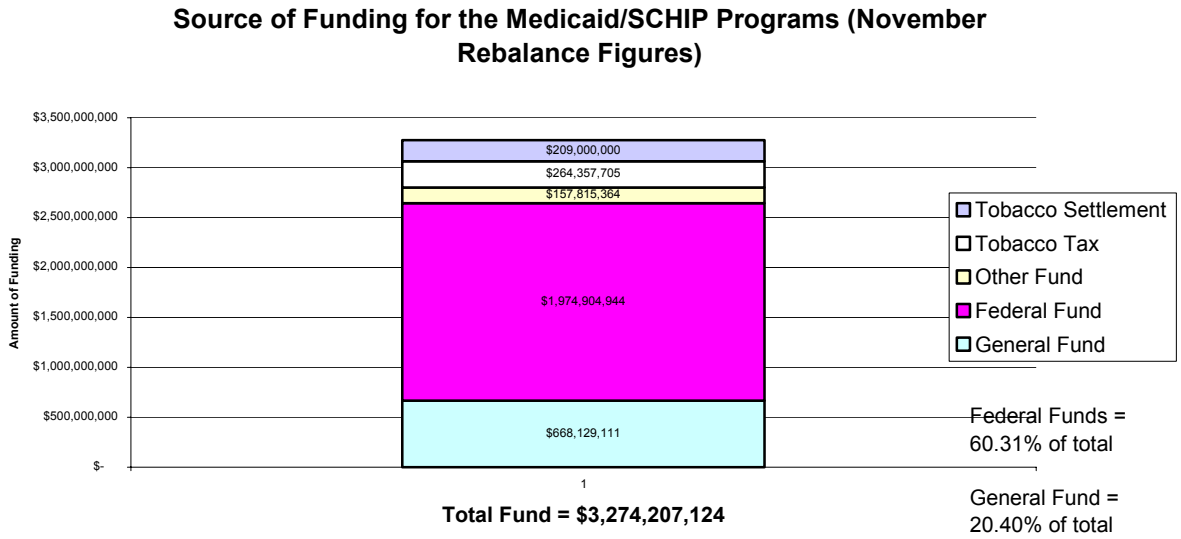
It is unclear why enrollment has fluctuated since 1994, but perhaps it was a combination of factors. Those factors could include a better economy in the 1990s that facilitated people on welfare to move off Medicaid; a movement by low-income populations from Medicaid to other programs, namely SCHIP and the FHIAP program. Some have theorized that the federal Welfare Reform legislation facilitated people to leave Medicaid.

Unduplicated Medicaid/SCHIP Enrollment

Since the beginning of the Oregon Health Plan Medicaid Demonstration, more than 1,400,000 Oregonians have received health coverage under this program. In that time period, approximately 4.1 million people have migrated into and out of Oregon. This means that the Oregon Health Plan Medicaid and SCHIP programs have served nearly 34% of Oregon's population since inception of these programs.

Funding and Expenditures for Medicaid/SCHIP Programs 2001-2003 Biennium

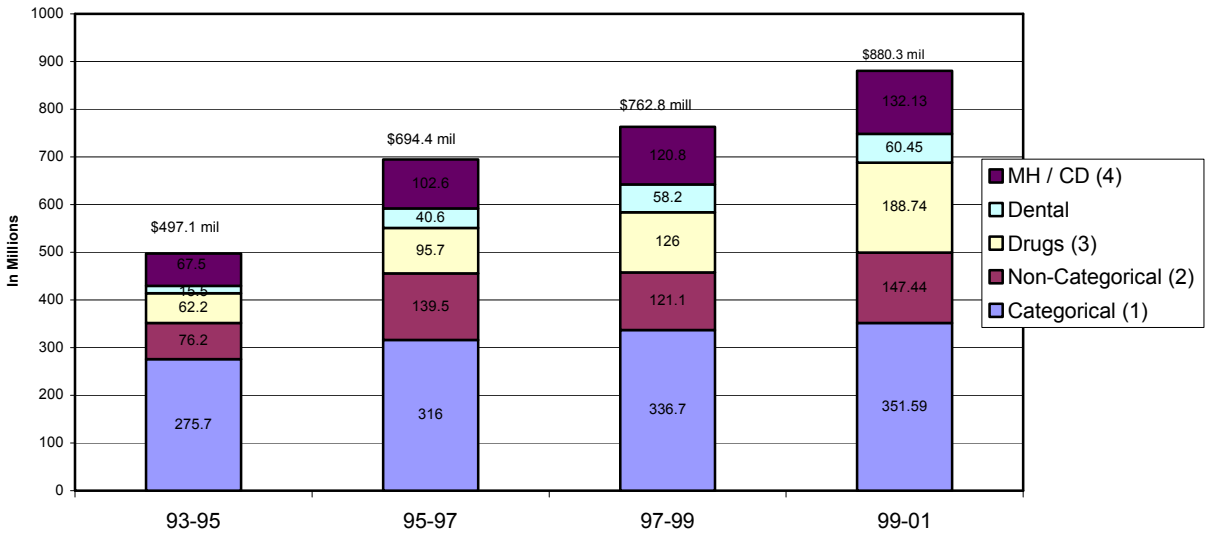
Figure 3



Source: Department of Human Services, Office of Medical Assistance Programs, Office of Finance & Policy Analysis, Budget Section.

Figure 4 shows the actual **state-fund only** expenditures by the Medicaid and SCHIP programs since the inception of the program.

Medicaid and SCHIP Actual State-Fund Expenditures



(1) Categorical costs include Temporary Assistance to Needy Families, PLM Women and Children, Foster Children, Children in Substitute or Adoptive Care, Blind or Disabled Adults, Old Age Assistance and SCHIP eligibles, exclusive of Drug, Dental, Mental Health, and Chemical Dependency dollars.

(2) Non-Categorical costs include General Assistance, 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 and Chemical Dependency costs include those costs that are included in the MHDDSD and OHP budgets for all four biennia.

Figure 4

Source: Department of Human Services, Office of Medical Assistance Programs, Office of Finance & Policy Analysis, Budget Section.

Medicaid and SCHIP Estimated Spending By County - September 2002, 01-03 Biennium

The Oregon Health Plan is a vital part of Oregon's economy. Table 6 shows, by County, an estimate of how many Medicaid dollars are spent in each county **in one month**.

Table 6

	---------- TOTAL MEDICAID ELIGIBLES----------		
COUNTIES	Actual Eligibles	Projected Expenditure Per County*	Percent Receiving Benefits**
BAKER	2,182	$621,087	13.07%
BENTON	4,898	$1,400,949	6.28%
CLACKAMAS	23,022	$6,363,197	6.92%
CLATSOP	4,032	$1,185,143	11.44%
COLUMBIA	4,374	$1,228,182	10.12%
COOS	9,251	$2,799,050	14.99%
CROOK	2,312	$624,208	12.74%
CURRY	2,496	$780,798	11.77%
DESCHUTES	11,370	$3,079,380	10.37%
DOUGLAS	15,039	$4,205,861	14.90%
GILLIAM	157	$49,545	7.67%
GRANT	884	$254,519	11.05%
HARNEY	995	$272,715	13.10%
HOOD RIVER	2,388	$573,570	11.70%
JACKSON	22,750	$6,331,785	12.71%
JEFFERSON	3,305	$818,379	17.77%
JOSEPHINE	13,432	$3,851,356	17.94%
KLAMATH	9,783	$2,714,211	15.58%
LAKE	1,008	$284,086	13.62%
LANE	38,417	$11,005,427	12.08%
LINCOLN	6,733	$1,963,122	15.36%

LINN	13,510	$3,735,960	13.12%
MALHEUR	4,737	$1,198,436	15.18%
MARION	36,922	$9,614,914	13.00%
MORROW	1,365	$341,318	13.58%
MULTNOMAH	87,234	$25,698,603	13.34%
POLK	6,296	$1,732,716	10.29%
SHERMAN	201	$53,779	10.59%
TILLAMOOK	2,604	$753,517	10.76%
UMATILLA	8,375	$2,257,942	12.14%
UNION	3,145	$870,996	12.83%
WALLOWA	649	$194,700	9.01%
WASCO	3,257	$893,344	14.32%
WASHINGTON	28,273	$7,390,905	6.61%
WHEELER	145	$42,178	9.08%
YAMHILL	8,380	$2,251,574	10.00%
STATE TOTAL	383,916	$107,437,452	11.41%

* Expenditures projected using Third Special Session (June 2002) authority

** Based on July, '00 Population numbers.

Source: Report: Oregon Health Plan Medicaid Eligibles by County Reporting and Projecting for the Month Ending September 2002 Using Projections from the Third Special Session, Office of Medical Assistance Programs, Office of Finance & Policy Analysis, Budget Section.

IV. Explanation of OHP2

Overview and Background

Since 1994, Oregon has had federal permission (waivers of regulation and statute) to provide Medicaid coverage to individuals with incomes up to 100 percent of the federal poverty level (FPL) and to provide benefits based on the explicit prioritization of health services. The Oregon Health Plan (OHP) is widely held to be a successful program. However, it became apparent during the 2001-2003 biennium that without restructuring the OHP was not sustainable for a number of reasons:

- The current benefit package could not support all program enrollees if the program is to expand to more low-income Oregonians. Oregon needed more flexibility to adjust benefits to meet resource limitations;

- Employer-sponsored insurance (ESI) was an integral part of the original OHP design. The OHP employer mandate could not be implemented because of the Employee Retirement Income Security Act (ERISA). However, public/private partnership remains a basic part of the OHP. Many Oregonians prefer private insurance coverage even if the benefit package is less comprehensive and cost sharing is greater than in Medicaid. Employer and employee contributions mean ESI is cost-effective for the State;

- The income limits for OHP eligibility are low. Thus, many families and individuals alternated between OHP enrollment and uninsurance. This "churning" puts a strain on the delivery system and makes it more difficult to achieve the benefits of population-based preventive care.

The Conditions That Resulted in HB 2519

As the design and policy objectives of the Oregon Health Plan were revisited, certain factors strengthened the State's commitment to achieving affordable health care coverage for all Oregonians. Among these factors were:

- ***Income eligibility was too low***. Although approximately 100,000 low-income Oregonians gained health coverage through the OHP, Oregon has noted a significant "churning" effect as people went on and off health coverage as their monthly incomes fluctuated around 100 percent FPL. As a result, many faced the prospect of moving from comprehensive health coverage to no health coverage at all. This can create a disincentive for people to move toward greater self-sufficiency.

- ***Uninsurance remained a problem***, and may be getting worse. Oregon's rate of uninsurance decreased from 18 percent when OHP started in 1994 to as low as 10 percent in 1998. However, in 2000 the uninsured rate rose to 12.2 percent based on Census 2000 weighting factors and Oregon Population Survey data analysis.
- ***Continuing cost increases threatened the sustainability of the program***. Despite Oregon's well-established record for health care cost efficiency, costs for the program have increased significantly over the last eight years, as have health care costs in general. The cost of drugs is the fastest growing component of the budget.
- ***More flexibility on benefits was needed***. The OHP is based on the concept of a basic benefit package built around the prioritization of medical services. With greater flexibility on benefits, prioritization of health services provides an open and accountable way to make the difficult choices required by tightening of fiscal limits.

Concerns like these led to the passage of House Bill 2519 during the 2001 Legislative session, a bipartisan agreement to restructure the OHP in order to:

1) ***Sustain*** the current OHP and FHIAP programs
2) ***Expand*** coverage to higher income levels to stabilize insurance coverage and reach more uninsured Oregonians, and
3) ***Leverage*** private employer-sponsored insurance.

The restructured program as a whole is referred to as "OHP2". OHP2 has three components:

- ***OHP Plus***. OHP Plus provides the current OHP benefit package to people eligible for Medicaid without any waivers (including the aged, people with disabilities, General Assistance recipients, pregnant women, children, and very low-income parents.

- ***OHP Standard***. OHP Standard provides a new benefit package that is more similar to private insurance coverage for adults of working age. Enrollment into OHP Standard is capped so that it will remain budget neutral to the state.

- ***Family Health Insurance Assistance Program (FHIAP)***. FHIAP will provide premium subsidies for the purchase of private health insurance for uninsured Oregonians with incomes up to 185 percent FPL. Enrollment in FHIAP will be capped so that it cannot reach the level where it would require state funds beyond the budget.

In order to implement OHP2, Oregon submitted and received new waivers from the federal government. These waivers allowed Oregon to:

- ***Expand*** coverage to 185% FPL for children and pregnant women and for all adults not

eligible for Medicare. Enrollment for adults (except pregnant women) is capped at a level that assures budget neutrality for the state.

- *Receive* federal matching funds for the OHP Standard benefits package with more limited benefits and greater cost sharing, and with greater flexibility for change, than the OHP Plus benefit package;
- Receive ***federal matching funds for the FHIAP program*** (both individual and group insurance) including those currently enrolled in the program as well as those who become eligible under the capped enrollment expansion up to 185 percent FPL.

The restructuring of the OHP has taken into account the tightening fiscal limits on the state's ability to provide publicly funded health care benefits. Oregon is the only state in the nation to set explicit health care priorities based on clinical effectiveness, and to use priority setting as a tool for allocating sufficient public resources to expand Medicaid coverage up to 100 percent of the federal poverty level (FPL). Tightening fiscal limits, explicit priorities, and coverage expansion are all reflected in the design of OHP2. Increased flexibility on benefits and cost sharing will help to stabilize the OHP and to further expand eligibility through both private and public insurance coverage.

The Public Process

The OHP2 design builds on years of public policy discussion, and is the direct result of bipartisan efforts in the Oregon Legislature.

Spring 2000 Public Outreach

In the spring of 2000 more than 1,000 Oregonians from diverse backgrounds participated in 16 community meetings. This was combined with focus groups and a telephone survey of more than 700 Oregonians to gather public input on how best to restructure the health care system to better serve all Oregonians. Four main findings resulted from this public outreach:

1) Cost and affordability are important issues and new strategies are needed to sustain progress toward covering more Oregonians;
2) Extending access to all Oregonians gained increased support compared with previous community meetings in 1996;
3) All Oregonians should have access to a basic package of health care benefits, consistent with a clear recognition of the limits of financial resources available for health care;

4) The delivery system should be more efficient, streamlined and flexible to address the needs of the public.

Basic Benefits Task Force

In the summer of 2000, a task force on basic benefits was created in association with the Oregon Health Council. The Basic Benefits Task Force held public discussions on the complex issues involved in defining a basic benefit plan. The Task Force considered two models for benefit design:

1) *Access promotion* – this model encourages screenings and early diagnosis through routine care in order to increase the chances for better treatment outcomes and reduced costs;
2) *Asset protection* – this model provides the insured person protection from substantial financial losses due to severe illness or "catastrophic" events.

The Basic Benefits Task Force concluded that coverage for the uninsured between 100 and 200 percent FPL should stress access promotion to increase preventive and early intervention health care. This model was felt by the Task Force to be consistent with the public policy objective of improving health outcomes for the entire population.

The Health Services Commission (HSC)

In December 2000, Governor John Kitzhaber directed the members of the Health Services Commission to work on defining a new standard benefit package to expand health care access to uninsured Oregonians with modest household incomes. The Commission's working premise was that the new standard package would be at least the benefit level required by the federal government under Medicaid. The Governor directed that "OHP Standard" should be comparable to typical small employer group coverage plans, or about 78 percent of the value of the traditional OHP benefit package (now called "OHP Plus").

Enabling Legislation and Planning Process: HB 2519

The ongoing commitment to maintain the OHP and to extend coverage to more Oregonians resulted in the passage of House Bill 2519 by the 2001 Oregon Legislature. HB 2519 identified the policy framework and the process to expand the OHP using savings created from enactment of a basic benefit package (OHP Standard). HB 2519 passed by a 45-5-10 vote in the House of Representatives and a 27-2-1 vote in the Senate, demonstrating strong bipartisan commitment to increase access to affordable health care coverage for modest-income uninsured Oregonians.

A key policy objective of HB 2519 was to encourage the transition to Employer-Sponsored

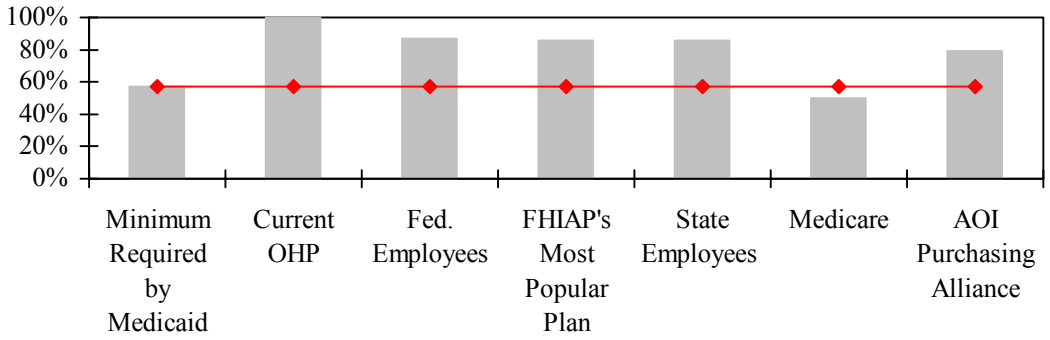
Insurance (ESI) rather than reliance on Medicaid. OHP2 expanded FHIAP, with an explicit emphasis on ESI coverage. By accessing federal match for FHIAP, thousands of additional people would receive health care coverage through their employer(s).

The policy direction specified in the bill was that the State would:

1) "…in partnership with the private sector, move toward providing affordable access to basic health care services" for low-income, uninsured children and families;
2) Provide subsidies to low-income Oregonians to expand coverage, with responsibility for coverage shared among all parties in the public and private sector;
3) Clearly define the roles and responsibilities of all stakeholders;
4) Base subsidies on an individual's ability to pay; and
5) Encourage the use of evidence-based health care services, including education, intervention and prevention, and procedures that are effective in producing good health.

Actuarial comparison of various plans to the traditional OHP benefit package modeled by the HSC in 2001 showed the following level of benefits by differing health insurance plans:

Figure 5



Source: Health Services Commission, June 21, 2001 Meeting. Report by James Matthisen, PriceWaterhouse actuary.

The HSC compared different plans' actuarial values with the current OHP, which has very little cost sharing (currently only premiums for "new eligible adults"). The HSC also reviewed models of various cost-sharing options, including co-insurance, co-payments, out-of-pocket maximums, and deductibles. Many scenarios were analyzed to see how the different cost-sharing elements affected the overall value. In addition, the HSC debated exclusions and limitations of specific services, comparing OHP to commercial products. The cost-sharing literature was also reviewed

to assess the impact of cost sharing on enrollees. Based on its deliberations the HSC prepared a report that included a "Prioritized List of Benefit Packages" and recommendations for cost sharing.

Summer 2001 Public Outreach

Community meetings were designed to encourage the general public to discuss changes to the benefit structure and cost-sharing options. During July and August 2001, nine community meetings involving more than 300 participants were conducted throughout Oregon. To gather further opinion and comment about the changes being planned, over 40 stakeholder meetings involving another 300 participants were also conducted in association with the public meetings. The results of these meetings were given to the Health Services Commission to aid them in making decisions about the new benefit package.

Insurance Pool Governing Board (IPGB)

The IPGB developed a group coverage benefits benchmark; taking into account the most common employer-sponsored health benefit plans then available. The IPGB did not create a new health benefit plan, merely a benchmark that subsidy-eligible plans measured against.

Waiver Application Steering Committee (WASC)

The Department of Human Services (DHS) established the Waiver Application Steering Committee (WASC) to 1) recommend a benefit package for the OHP Standard population, and 2) assist and advise DHS in the preparation of the waiver application. The WASC included legislators and representatives of a broad range of interest groups.

The Health Services Commission report was forwarded to the WASC. After extensive discussions and input from advocates and health plans, the WASC recommended the OHP Standard benefit package, including cost sharing. The WASC also advised DHS on other issues related to the waiver application (e.g. eligibility, premium levels, and the choice between public and private programs). In addition, the WASC reviewed the recommendation regarding the FHIAP group coverage benefits benchmark.

Joint Leadership Commission on Health Care Costs and Trends

The Joint Leadership Commission on Health Care Costs and Trends consists of eight legislators. The role of the Leadership Commission with regard to OHP2 was in an oversight capacity. The Leadership Commission received reports from the Health Services Commission on the costs of the basic benefit packages of health care services under OHP Standard and from the Insurance Pool Governing Board on the group coverage benefits benchmark for employer-sponsored

insurance. In addition, the Leadership Commission received a draft of the waiver application before it was forwarded to the Emergency Board for review.

Legislative Emergency Board

Finally, the draft application was submitted to the Legislative Emergency Board on January 7, 2002. By April 2002 the waivers were approved by the Legislative Emergency Board and submitted to the Centers for Medicare and Medicaid Services on May 31, 2002. The waivers were approved by CMS October 15, 2002. Since then, because of budget concerns, further changes have been made by the Emergency Board, including eliminating Durable Medical Equipment, Dental, Chemical Dependency and Mental Health benefits from the OHP Standard benefit package.

Benefits Overview

Oregon requested the ability to adjust OHP Standard benefits as necessary to continue coverage when revenue constraints tighten. Specifically, Oregon sought and received permission to adjust the OHP Standard benefit level as long as this benefit level was at least equivalent to the federally mandated Medicaid benefit package. That level is equivalent to approximately 56 percent of the value of the OHP Plus benefit package. The OHP Standard benefits described below were the initial benefits as recommended for program implementation. In subsequent biennia, Oregon will set the OHP Standard benefits at a level that can be supported by available revenue, and OHP Standard benefits will always be set equal to or higher than the level equivalent to the federally mandated Medicaid benefits.

OHP Plus provides services for all mandatory and Medicaid populations. The groups that will receive OHP Plus include:

- The elderly and disabled at the current eligibility levels;
- The TANF population at the current eligibility levels;
- All children up to 185 percent FPL;
- Pregnant women up to 185 percent FPL;
- General Assistance recipients at the current eligibility levels.

OHP Standard will provide basic coverage more similar to private insurance coverage. The benefit level recommended by the WASC is equivalent to approximately 78 percent of the value of the OHP Plus benefit package. The groups that may receive OHP Standard are:

- Non-TANF parents with incomes below 185% FPL;
- Childless Adults/Couples below 185 percent FPL.

OHP Plus Benefits and Cost-Sharing

Under OHP2 the Health Services Commission will continue to maintain its Prioritized List of Health Care Services, using it to establish the OHP Plus benefit package of health care services. The Legislature decides where the line will be drawn on the prioritized list, subject to approval by CMS. Coverage is currently provided through line 566 on the prioritized list. It is anticipated that any change in benefits in OHP Plus would be through a public process and would need to be approved by the Legislature or the Legislative Emergency Board.

OHP Standard Benefits and Cost Sharing

The initial OHP Standard benefit package was designed to more closely mesh with private insurance products. The initial OHP Standard package covered basic services, with cost sharing. Services excluded from OHP Plus coverage because they are "below the line" will also be excluded from OHP Standard coverage.

As initially funded, the following benefits were included in OHP Standard:

- Inpatient hospital
- Outpatient hospital
- Emergency room
- Physician services
- Lab and X-ray
- Ambulance
- Prescription drugs
- Mental health and chemical dependency
- Durable medical equipment (needed on an ongoing, not one-time, basis)
- Dental

The following benefits were not included in OHP Standard:

- Vision
- Non-emergency transportation

As noted above, the Emergency Board in November cut the OHP Standard benefit package even further, eliminating dental, durable medical equipment, chemical dependency and mental health services.

OHP Standard benefits appear in an order that reflects the value placed on the services in community forums, stakeholder meetings, and the Health Services Commission's judgment as to the priority in a benefit package designed to promote access to care.

The first six benefits (through Ambulance in the list above) of the OHP Standard package are Medicaid mandatory services. In order to add optional services such as prescription drugs and achieve a benefit package that was comparable to the packages available in the private health insurance market, cost sharing was added to the mandated services as well as the optional services included in the package.

Anticipated co-payments in the re-worked benefit package will be as follows:

Table 7

Service	**Co-payment**
Inpatient Hospital	$250 co-payment per admission
Outpatient Hospital	• $20 co-payment/surgery • $5 co-payment for other outpatient services
Emergency Room	$50 co-payment, waived if admitted
Physician Services	• $5 co-payment for office visits • $5 co-payment for medical & surgical procedures
Lab and X-ray	$3 co-payment lab and X-ray
Ambulance	$50 co-payment
Prescription Drugs	<u>0% up to100% FPL</u> • $2 generic • $3 MH/cancer /HIV brand drugs • $15 other brand <u>100% up to185% FPL</u> ● $5 generic ● $10 MH/cancer/ HIV brand drugs ● $25 other brand

In keeping with the objectives of OHP and OHP2 to provide access to care at the appropriate time, co-payments will not be required for most preventive services.

Except as noted above, co-payments will be required of all OHP Standard enrollees. Providers will be responsible for collecting co-payments. However, unlike in OHP Plus, providers may refuse to provide a service (other than emergency services) if the co-payment is not paid.

The anticipated premium structure for OHP Standard will be as follows:

Table 8

Percent FPL	Per Person Per Month	Premium Share
0% up to 10% FPL	$6.00	2.4%
10% up to 50% FPL	$9.00	3.6%
50% up to 65% FPL	$15.00	6.0%
65% up to 85% FPL	$18.00	7.2%
85% up to 100% FPL	$20.00	8.0%
100% up to 125% FPL	$23.00[1]	9.2%
125% up to 150% FPL	$35.00	14.0%
150% up to 170% FPL	$75.00	30.0%
170% up to 185% FPL	$125.00	50.0%

As is currently done, the State will collect premiums. However, under OHP2, persons in OHP Standard who fail to pay their premiums will be disenrolled after receiving adequate notice. People who want to come back into the program after having been disenrolled will be subject to a period of uninsurance of six months.

FHIAP Benefits and Cost Sharing

The FHIAP benchmark identifies a minimum level of benefits qualifying for FHIAP subsidy; it does not define a benefit plan to be offered to enrollees.

The original FHIAP benchmark included:

Table 9

Benefits:	The following maximum cost-sharing levels:
A ***six-month*** pre-existing condition waiting period	***$500*** annual individual deductible
Twenty-one benefit categories (See Table 10)	***$2,500*** maximum out-of-pocket per individual or ***$10,000 stop-loss***
	$1,000,000 lifetime maximum benefit.

In addition, since prescription drug benefits are generally purchased separately from medical coverage as an optional benefit, the IPGB established a prescription drug cost-sharing level of 25 percent with no out-of-pocket maximum.

[1] *Premiums for people with income above 100 percent FPL will be based on percentage of the OHP Standard benefit package, not fixed at these dollar amounts.*

FHIAP group coverage will include persons who have qualified employer-sponsored insurance (ESI) available. An ESI plan will qualify if it meets or exceeds the FHIAP benchmark. ESI is considered available if the employer offers it to the employee, and the employer contributes appropriately to the cost of coverage.

Insurance subsidies will also be available for individual health insurance policies in specific circumstances and will be subject to a cost-effectiveness test. Individuals and families accepted into FHIAP individual coverage may only purchase health insurance from FHIAP-certified carriers. The FHIAP benchmark for the individual market is identical to the ESI benchmark.

Oregon was granted the ability to adjust the FHIAP benefit benchmark as necessary to continue to subsidize benefit coverage commonly found in Oregon's small employer health insurance market. The FHIAP benefit benchmark will always be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

Here is a complete list of the benefits and cost-sharing levels for the FHIAP benchmark for group health insurance plans:

Table 10

FHIAP Benchmark for Group Health Insurance Plans	
Pre-existing Condition Waiting Period	6 Month
Annual Deductible	$500 individual
Maximum Out-of-pocket or	$2,500 individual or
Stop Loss	$10,000 individual
Lifetime Maximum	$1,000,000
Prescription Drugs	25% enrollee cost-sharing
Prescription Drug Maximum Out-of-pocket	No out-of-pocket maximum
Doctor Visits	Covered Benefit*
Immunization	Covered Benefit*
Well Baby Care	Covered Benefit*
Well Child Care	Covered Benefit*
Women's Health Care Services	Covered Benefit*
Maternity	Covered Benefit*
Diagnostic X-Ray/Lab	Covered Benefit*

Hospital	Covered Benefit*
Outpatient Surgery	Covered Benefit*
Emergency Room	Covered Benefit*
Ambulance	Covered Benefit*
Transplant	Covered Benefit*
Mental Health/Chemical Dependency Outpatient	Covered Benefit*
Mental Health/Chemical Dependency Inpatient	Covered Benefit*
Skilled Nursing Care	Covered Benefit*
Durable Medical Equipment	Covered Benefit*
Rehabilitation Inpatient	Covered Benefit*
Rehabilitation Outpatient	Covered Benefit*
Hospice	Covered Benefit*
Home Health	Covered Benefit*

*Covered benefit means services are offered in a benefit category. Benchmark does not specify durational, internal, or cost-sharing limits beyond those imposed by the annual deductible, maximum out-of-pocket, stop loss, and lifetime maximums.

FHIAP Subsidy

The current FHIAP subsidy levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution. The anticipated FHIAP subsidy levels under OHP2 are as follows:

Table 11

Federal Poverty Level (FPL)	Amount of Subsidy
0% up to 125% FPL	95% subsidy
125% up to 150% FPL	90% subsidy
150% up to 170% FPL	70% subsidy
170% up to185% FPL	50% subsidy

People enrolled in an employer's plan are reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits

verification that the premium is being withheld. Copies of paycheck stubs serve as verification. After a written warning, failure to provide verification will result in termination from the program.

Enrollees in the individual market are billed by FHIAP each month for their portion of the premium. The State then combines the enrollee's portion with the subsidy and pay the carrier. As with OHP Standard enrollees, FHIAP enrollees who fail to pay their premium are disenrolled. Also as with OHP Standard, people who want to re-enroll in the program after being disenrolled for failure to pay premiums will be subject to a period of uninsurance up to six months and any applicable waiting period.

V. Cost Control Measures

Prioritized List

A unique feature of Oregon's approach to Medicaid reform has been the use of the prioritized list of treatment/condition pairs. Initially the list was responsible for significant reductions in health care expenses to Oregon. (For example, Oregon is the only Medicaid program that does not pay for the cost of Viagra) Subsequent requests to further number of services covered were met with resistance by the federal government and as a result savings from the list have moderated. However, recently the federal government did approve eliminating eight lines from coverage and the state is currently preparing a request to reduce coverage further. Decisions regarding the prioritized list are made by the Health Services Commission, a commission made up of eleven members appointed by the Governor on a volunteer basis. This commission consists of five physicians, a public health nurse, a social worker and four consumer representatives who meet regularly to improve and maintain the prioritized list. The legislature determines the benefit package for the Medicaid population based on where the funding level is drawn on the list.

OHP2 as Cost-Control Measure

As indicated above, OHP2 is the most significant cost-containment measure that the State has taken to control the rising cost of health care. The State is a large and influential purchaser in a complex health care market. However, the State responds to complex market forces as other purchasers do; health care costs under our current system are not in the State's or anyone else's control. The original formulation of the Oregon Health Plan gave the state additional, but in retrospect, not sufficient tools to control costs. OHP2 gives the state additional tools to do so.

Practitioner Managed Prescription Drug Plan (PMPDP)

One of the largest increases in health care costs is the prescription drug bill the Office of Medical Assistance Programs (OMAP) faces each month for its fee-for-service population. In response to this trend, which is a problem both on the national level as well as the state level, the 2001 Legislature created the Practitioner Managed Prescription Drug Plan, which in turn allowed OMAP to prepare and implement a Plan Drug List for its fee-for-service members (about 100,000 members of OHP currently).

SB 819 (2001 Legislature) authorized the Health Resources Commission (staffed by volunteer health care providers from throughout the State) to do an evidence-based review of prescription

drug families used in the Oregon Health Plan population. In essence, the legislation required the state to provide the most effective prescription drugs in the most cost-effective manner to the Oregon Health Plan population. In order to accomplish this goal, the Health Resources Commission hired the Oregon Health & Science University's Evidence-based Practice Center to review the published studies. Also, pharmaceutical companies are given the opportunity to submit information regarding their products.

Selected drug families, not to include HIV/AIDS/Cancer and Mental Health drugs, either have been or will be reviewed for effectiveness. The information is passed onto OMAP for decisions regarding benchmark drugs to be used in the fee-for-service OHP population through OMAP's Plan Drug List (PDL).

Education programs for practitioners and clients have been done. It is important to note that ***no drug is completely unavailable to the Oregon Health Plan population*.** If a practitioner wants to prescribe a non-PDL drug, the practitioner must simply make a notation on the prescription.

On August 1, 2002 the first two families of pharmaceuticals (Proton Pump Inhibitors and Opioids) were placed on the OHP Plan Drug List. On September 1, 2002 the next two families (NSAIDs and Statins) were added to the PDL. The next families to be reviewed are ACE-Inhibitors, Estrogens, Triptans, Skeletal Muscle Relaxants, Oral Hypoglycemics, Calcium Channel Blockers, Beta Blockers and Urinary Incontinence Drugs. For more information please visit the website at www.oregonrx.org.

Pharmacy Lock-In Program

Another cost control measure regarding pharmacy usage in the DHS-OHP is the Pharmacy Lock-In Program. Members of fee-for-service DHS-OHP are mandated in this program to pick one pharmacy and use it for all their prescriptions. On July 1, 2002, OMAP started phasing in this program across the state. As of December 2002 45,000 members have been locked-in to a pharmacy of their choice. This will better enable pharmacists to review medication usage with clients who have poly-pharmacy needs, as well as control costs by making duplication of medications impossible. OMAP will review this program in Fall 2003 and will consider implementing the program for its managed care clients if warranted.

Case and Disease Management Programs

Also in the fee-for-service population OMAP has a case management and a disease management program for those high users of medical services. In those programs, claim records identify high

users and managers are assigned to manage these patients. The manager and client work together to alter unhealthy behavior patterns, emphasize and highlight preventive care, and coordinate the care among providers.

VI. Ongoing Major Healthcare Issues

The Uninsured in Oregon

Uninsurance rates in Oregon consistently declined from the implementation of the Oregon Health Plan in the early 1990s. Before the Oregon Health Plan was implemented, approximately 18 percent of all Oregonians, and more than 20 percent of children, were without healthcare coverage[1]. By 1998, with the implementation of the OHP combined with a strong economy and a private-sector commitment to providing health insurance coverage, it 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. But by 2000 the uninsured rate rose again to 12.2%. This could be due to many economic or demographic factors or due to the fact that a decennial census did a better job counting the number of people within the state.

Table 12

Estimates, Range Statistics, and Approximate Number of Uninsured in Oregon, 1990–2000

Year	*Estimate of % Uninsured*	*% Uninsured Lower Range*	*% Uninsured Upper Range*	*Approximate Number Uninsured*
1990	16.4%	15.5%	17.2%	467,740
1992	18.1%	17.4%	18.8%	539,956
1994	13.6%	13.0%	14.2%	424,796
1996	10.7%	10.2%	11.3%	348,597
1998	11.0%	10.4%	11.6%	367,904
2000	12.2%	11.6%	12.8%	419,812

P≤ .05, 95% Confidence Intervals

While progress was made in this area, it was not uniform across geographic, socioeconomic or racial and ethnic boundaries. Those living in the certain 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.

[1] All estimates presented here are based on data from the Oregon Population Survey (OPS). The Oregon Population Survey in its entirety can be viewed online at: http://www.ohppr.state.or.us.

With the advent of two new programs in 1998, some of the problems have been alleviated. The Family Health Insurance Assistance Program (FHIAP), aimed at individuals and families with incomes between 100 percent and 170 percent of the federal poverty level, provides a subsidy to purchase private health insurance. However, because of its limited funds the enrollment must be capped. There is currently a waiting list of about 20,000 people. The State Children's Health Insurance Program (SCHIP) is aimed at serving children under the age of 19 with family incomes below 170 percent FPL. 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, but more work needs to be done. The uninsurance rates seemed to have leveled off at about 12% of the population as a whole. Among children the rate is as low as it has been in a decade, at less than eight percent.

While the rate of uninsured Hispanics had declined from more than 24 percent in 1996 to below 20 percent by 1998, the numbers in the 2000 Oregon Population Survey were not reassuring: nearly 24% of Hispanics were again uninsured. This could be due to the accuracy of the 2000 US Census and that the Oregon Population Survey racial oversample did a better job of finding the true number of uninsured Hispanics in Oregon's communities.

Table 13

Uninsurance Rates by Regions and Selected Counties for All Age Groups in 2000

Estimates for uninsurance rates vary from a low of 7.2% in Columbia County to a high of 17.5% in Wasco County.

Region	*Counties*	*Uninsured*
Central Oregon	***Deschutes***	***12.5%***
	Crook/Jefferson	***9.6%***
Eastern Oregon	***Umatilla***	***13.9%***
	Baker/Grant/Harney/Malheur/Morrow/Union/Wallowa	***15.6%***
Gorge	***Wasco***	***15.6%***
	Hood River/Gilliam/Sherman/Wheeler	***13.6%***
Metro	***Clackamas***	***10.8%***
	Multnomah	***13.2%***

	Washington	***8.8%***
Mid-Valley	***Marion***	***11.5%***
	Polk/Yamhill	***7.7%***
North Coast	***Columbia***	***7.2%***
	Clatsop/Tillamook	***12.3%***
South Valley	***Lane***	***15.2%***
	Benton/Lincoln/Linn	***10.1%***
Southern/Central	***Klamath/Lake***	***12.7%***
Southwest	***Jackson***	***16.9%***
	Coos/Curry/Douglas/Josephine	***14.3%***

Source: Oregon Population Survey 2000, Office of Oregon Health Policy & Research, available online at: http://www.ohppr.state.or.us/data/ops/data_ops_index.htm.

Health Care Costs

Nationally, despite a respite from the inflation of health care costs during the mid-1990s, health care costs have increased sharply since 1999. The reason for the increase seems to be two factors: the aging of the U.S. population as a whole and the rapid development of expensive technologic advancements, including prescription drugs and medical equipment.

About 12% of the U.S. population is elderly (older than 65 years of age) yet the elderly comprise nearly half of the top five percent of all health care users.[2] Technological advancements may be expensive but an argument made by manufacturers is that they decrease the need for other types of treatments. It seems that the advancements in technology can also make treatments for some conditions more palatable, encouraging new groups of people to get treatment for conditions. The budgets for the treatments may never catch up to the costs of treating more people.[3]

[2] Berk and Monheit, "The Concentration of Health Expenditures, Revisited," *Health Affairs* Vol. 20, No. 2, 2001.

[3] Aaron, H., "The Unsurprising Surprise of Renewed Health Care Cost Inflation," *Health Affairs*, January 23, 2002.

Across the board prescription drug costs have increased dramatically. Within the Medicaid/SCHIP population it has nearly tripled in the last few years. This problem has been addressed in a variety of ways, including the Practitioner Managed Prescription Drug Plan (See Section V of this report).

Table 14 shows what the actuarial amount of funding paid for both managed care members and fee-for-service members of the Oregon Health Plan since its inception February 1, 1994. **Please note** that lines have been consolidated over the years and services provided to members have changed. The 566 funded lines shown in the 2001 prioritized list roughly equal funding to Line 578 in the 1995 prioritized list. The increase in the blended rate reflects a rising utilization of health services by the population, the increase in the costs of technology, inflation in health care costs, and adding services to members (e.g. chemical dependency services and mental health outpatient services).

Table 14

Year (Biennium)	Lines Funded/total lines	Blended Per Member Per Month Rate for Entire OHP Population
1993 (beginning Feb. 1, 1994)	606/745	$183.96
1995	581/745	$199.72
1997	574/743	$227.02
1999	574/743	$259.51
2001	566/736	$309.72

Source: Prioritization of Health Services Reports, Oregon Health Services Commission, 1993-2001.

Racial and Ethnic Health

In 2000, the U.S. Census Bureau collected race and ethnicity information from respondents differently than in past years. Previously, persons who were *ethnically* (or culturally) Hispanic would self-select their *racial* category as Hispanic because it was included in the set of responses delineated under race. In 2000, the Census started to collect race and ethnicity ("Hispanicity") as separate measures of diversity in order to account for the well-accepted difference between the two. For example, a person of Hispanic ethnicity could be a member of any racial group.

The Bureau asked respondents to indicate *all* racial groups with which they self-identified. Responses included the following races and corresponding percentage of the Oregon Population; White, 86.6%; Asian or Asian American, 3.0%; Native Hawaiian and Other Pacific Islander,

0.2%; Native American or Indian, 1.3%; Black or African American, 1.6%; and other or refusal to answer, 4.2%. In addition, respondents could mark as many races as applied; the corresponding percentage of two or more races was 3.1%. The percentage of the population who self-identified being Hispanic or Latino was 8.0%.

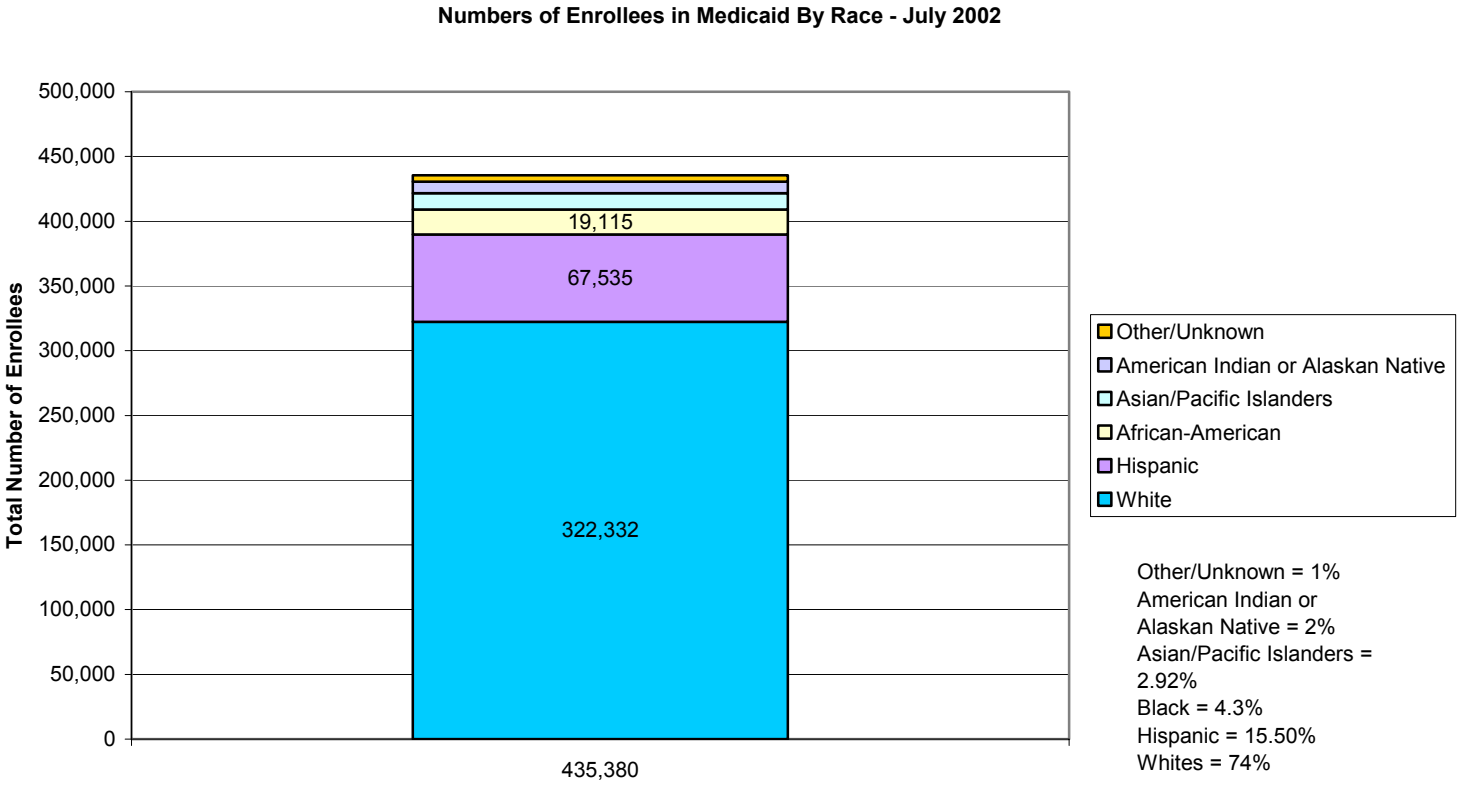


Figure 6

Source: Department of Human Services, Office of Medical Assistance Programs, Analysis & Evaluation Unit.

When comparing the general racial/ethnic population of Oregon to the Medicaid population eligible under the Oregon Health Plan an obvious disproportional representation of some minority racial/ethnic populations is apparent, notably Hispanic and Black or African-American.

VII. CONCLUSION

The Oregon Health Plan, and its many components, is about keeping Oregonians well. Although it is a complicated system, it encompasses many levels of society and provides services to a large percentage of the population. Although health care is expensive in the United States, Oregonians actually spend less than the national average on health care. And, although the costs of delivering the services has increased over the years, the state has responded by introducing cost-containment measures and increasing the amount of federal dollars to the State to pay for low-income populations' health care needs.

The State continually strives to improve services and looks forward to working with this legislature to provide the best medical outcomes for all the Oregonians served through its diverse programs.

Glossary of Health Care Terms

ADVERSE SELECTION
An unequal or inefficient exchange on the market caused by differences in information (or information asymmetry) between the two parties. A common example of adverse selection is the insurance industry. Adverse selection occurs when customers who are sick hide their risk while applying for health insurance. The effect is to undermine the entire premise of risk pooling by attempting to identify the risks for individuals.

CAPITATION
A financial arrangement in which a health plan or provider is paid a flat monthly fee for each enrolled member (also called PMPM or per-member per-month rate), regardless of the level of service provision

CARVE-OUT
A service that is not included in the calculation of the capitation rate that is reimbursed on a fee-for-service basis. Typically these include higher-risk or higher cost services.

CMS (Centers for Medicare and Medicaid Services)
Formerly known as HCFA (Health Care Financing Administration). This is the federal agency within the Department of Health & Human Services (HHS) that administers both Medicare and Medicaid payments to the states.

CAWEMS (CITIZEN/ALIEN-WAIVED EMERGENT MEDICAL)
Medicaid coverage of emergent medical needs for clients who are not eligible for other medical programs solely because they do not meet citizenship and status requirements.

CPI (Consumer Price Index)
The CPI represents changes in prices of all goods and services purchased for consumption by urban households.

CAH (Critical Access Hospital)
Critical Access Hospitals (CAH) are hospitals that have entered into an agreement to limit inpatients to 15 at any given time with a length of stay average of no longer than 96 hours and limit Skilled Nursing Facility (SNF) patients to 10 in order to receive Medicare cost based reimbursement.

DCO (Dental Care Organization)
Managed care organization for dental care.

ENTITLEMENT
A legal term for a government benefit to which individuals are entitled given that the individual meets eligibility requirements set by law.

ERISA (Employee Retirement Income Security Act of 1974)
Enacted by Congress to ensure that employees receive the pension and other benefits promised by their employers. ERISA also incorporates and is tied to provisions of the Internal Revenue Code (IRC) designed to encourage employers to provide retirement benefits and other benefits to their employees. Many provisions of ERISA and the Internal Revenue Code (IRC) are intended to ensure that tax-favored pension plans do not favor the highest-paid employees over rank-and-file employees in the way benefits are provided. To achieve these ends, ERISA has a complex series of rules that cover pension, profit-sharing stock bonus, and most "welfare benefit plans," such as health and life insurance. ERISA supersedes almost all state laws that affect employee benefit plans and has thus created a single federal standard for employee benefits.

ESI (Employer Sponsored Insurance)
The term used for health insurance provided by an employer. These health insurance policies are exempt from taxable income by the employee and are not exempt from taxable wages by the employer.

FHIAP (Family Health Insurance Assistance Program)
The FHIAP program provides direct subsidies to qualified Oregonians to help them buy health insurance through their employer or the individual market.

FFS (Fee For Service)
A financial arrangement in which a provider of health care services is paid directly for those services.

FISCAL YEAR
A yearly accounting period that does not start or finish with the calendar year. For the federal government, the fiscal year begins October 1 and ends on September 30. The fiscal year is

designated by the calendar year in which it ends -- for example, a fiscal year that ends on September 30, 1997 is called fiscal year 1997.

FCHP (Fully Capitated Health Plans)
Traditional managed care plans for the Oregon Health Plan services. They are paid on a capitated basis.

HRC (Health Resources Commission)
A Commission that exists within OHPR that reviews medical technology and, more recently, prescription drugs for efficacy. The Commission's role is to encourage the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians.

HSC (Health Services Commission)
A Commission that exists within OHPR to govern the prioritization of health services to the OHP population. According to its enabling statute, the commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services. Then, the Joint Legislative Committee on Health Care shall determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and shall advise the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly shall fund the report to the extent that funds are available to do so.

IPGB (Insurance Pool Governing Board)
State agency established in 1987 to address issues of health insurance for all Oregonians. It currently runs the FHIAP program.

OHPR (Office of Oregon Health Policy and Research)
Umbrella state agency that sets health policy for the State of Oregon by coordinating the Health Resources Commission, the Health Services Commission and the Oregon Health Council. Collects, reviews and analyzes financial and utilization data from hospitals, nursing homes and ambulatory surgical centers. Analyzes the uninsurance numbers from the Oregon Population Survey.

OMAP (Office of Medical Assistance Programs)
Office of Medical Assistance Programs, responsible for operation and oversight of the state's Medicaid Demonstration Project and the SCHIP program.

OHP (Oregon Health Plan)
A series of initiatives aimed at reducing the overall uninsurance rate in the State of Oregon. The three initial parts of the program was to expand eligibility for the Medicaid program, while limiting the benefits available to its recipients; establishing a high-risk insurance pool for the uninsurable and guaranteeing employer-sponsored insurance for workers.

OMIP (Oregon Medical Insurance Pool)
Oregon's high-risk pool offering capped premiums for uninsurable Oregonians, as well as offering coverage to HIPAA-eligible beneficiaries.

OPS (Oregon Population Survey)
A biennial survey of Oregonians since 1990 over a variety of topics, most notably their health insurance status.

PMPDP (PRACTITIONER MANAGED PRESCRIPTION DRUG PLAN)
A 2001 legislatively enacted project to do an evidence-based review of prescription drug families used in the Oregon Health Plan population.

PDL (Plan Drug List)
OMAP's list of medications approved for the fee-for-service OHP population.

SNF Patients (Skilled Nursing Facility Patients)
A patient (usually elderly) that is entitled to Medicare reimbursement. This is the only type of long-term care patient that Medicare pays for.

SCHIP (State Children's Health Insurance Program)
A federal program run by CMS under Title XXI to the states to insure children.

TYPE A HOSPITALS
Rural Hospitals that are small and remote. They have less than 50 beds, and **more than 30 miles** from the nearest hospital.

TYPE B HOSPITALS
Rural Hospitals that are small. They have less than 50 beds and are **30 miles or less** from the nearest hospital.

Websites of Interest:

Kaiser Family Foundation State Health Facts Online:
http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?

Centers for Medicare and Medicaid Services
http://www.cms.gov/

Office of Medical Assistance Programs
http://www.omap.hr.state.or.us/

SCHIP Program
http://www.omap.hr.state.or.us/chip/

Insurance Pool Governing Board
http://www.ipgb.state.or.us/

Family Health Insurance Assistance Program
http://www.ipgb.state.or.us/Docs/fhiaphome.htm

Oregon Medical Insurance Pool
http://www.omip.state.or.us/

Office of Oregon Health Policy & Research
http://www.ohppr.state.or.us/

Oregon's Practitioner Managed Prescription Drug Plan (PMPDP)
www.oregonrx.org

Table of Figures and Tables