The Oregon Health Plan:

An Historical Overview

Department of Human Services
Health Services
Office of Medical Assistance Programs

February 2004

OHP Defined

The Oregon Health Plan (OHP) is a public and private partnership to assure access to health care for all Oregonians. The major components are:

- Medicaid reform
- Insurance for small businesses
- High risk medical insurance pool.

In addition, OHP includes provisions for oversight, research, and analysis to achieve the best use of health care funding.

Contents

Background

The conditions in the 1980s that prompted the formation of the Oregon Health Plan (OHP) were similar to those faced by the rest of the country in the last half of the 20th Century. The rising costs of medical care and the growing number of people unable to afford it threatened the social and economic health of the nation. The root of the problem lay in the lack of an explicit health policy and rational and equitable means of allocating health care resources.

About 18 percent of all Oregonians, and more than 20 percent of our children, were without medical coverage. They were, in effect, excluded from our health care system.

Millions of Americans had no guaranteed benefits because they didn't qualify for public assistance (Medicaid), were not covered by an employer, and couldn't afford individual coverage. About 18 percent of all Oregonians, and more than 20 percent of our children, were without medical coverage. They were, in effect, excluded from our health care system. Instead of seeking early preventive care, people sought expensive emergency care when their illnesses became severe. When emergency room doctors are not compensated, the care isn't really free. The cost of care is shifted to patients who are able to pay by means of rising medical bills and insurance premiums.

States traditionally responded to rising costs by reducing the number of people eligible for coverage and reducing reimbursements to providers. In the private sector, employers reduced or dropped coverage. The result: ever-escalating costs as more people were priced out of coverage and into the "cost-shift."

OHP History

Beginning in 1987, a group of Oregonians appointed by Gov. Neil Goldschmidt agreed on a common objective—keep Oregonians healthy. The group was composed of representative health care providers and consumers, business, labor, insurers, and lawmakers.

They developed a political strategy to attain their objective, answering three main questions about Oregon's health plan: (1) who is covered, (2) what is covered, and (3) how is it financed and delivered.

OHP Goals

The appointed group agreed that:

- All citizens should have universal access to a basic level of care.
- Society is responsible for financing care for poor people.
- There must be a process to define a "basic" level of care.
- The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole.
- The health care delivery system must encourage use of services and procedures that are effective and appropriate, and discourage over-treatment.
- Health care is one important factor affecting health; funding for health care must be balanced with other programs that also affect health.
- Funding must be explicit and economically sustainable.
- There must be clear accountability for allocating resources and for the human consequences of funding decisions.

Blueprint Objectives

1. Insurance Reforms

OHP is a blueprint for universal access to basic and affordable health coverage that offers:

A. A basic health care package for low-income persons.

B. Health insurance for individuals who have been denied coverage for medical reasons.

C. Two voluntary group insurance plans available to small employers — one offers low premiums, the other guarantees availability.

D. Reforms to make insurance more available and affordable.

E. Assessment of new technologies and their need in particular geographic regions.

F. Assessment of service expansions and cost-containment.

2. Stewardship of Public Resources

A. The Oregon Health Plan also seeks to lower costs by:

1. Reducing cost shifts.
2. Emphasizing managed care, preventive care, early intervention, and primary care.
3. Not covering ineffective care.

B. OHP provides a political dynamic for controlling costs by:

1. Addressing the reality of fiscal limits.
2. Recognizing medical care as one investment affecting health.
3. Providing a political framework for balancing public spending to keep people healthy.
4. Requiring decision-makers to be publicly accountable for funding decisions.

Implementation Timeline

To put the goals and objectives into practice, the Oregon Legislature passed a number of bills over successive sessions that created the framework for a private/public partnership that collectively became the Oregon Health Plan. OHP has expanded and contracted over time in response to society's economic fluctuations.

1987

Governor Neil Goldschmidt

The Insurance Pool Governing Board (IPGB) is established. It will offer uninsured self-employed and small businesses (1-25 employees) the opportunity to purchase affordable small group health insurance from private companies (HB 2594).
The Oregon Medical Insurance Pool (OMIP) is created by SB583 to offer health benefits to people who can't buy individual health insurance because of a health condition. The bill establishes OMIP as a quasi-public agency with no funding.

1989

IPGB makes insurance available to uninsured small businesses and offers a tax credit.
Employer Mandate is established and scheduled to begin January 1, 1994. It requires employers to provide medical insurance to those employees working 17.5 hours or more per week and their dependents. The alternative is to pay into a special state insurance fund that offers coverage to their employees (SB 935). It requires a Congressional exemption to the Employee Retirement Income Security Act (ERISA).
The Oregon Health Services Commission (HSC) is created to rank medical services from most to least important to the low-income populations. The Legislature defines the health care package benefits from this list.
The Oregon Medical Insurance Pool (OMIP) is established as a state agency with funding by SB 534. OMIP offers health insurance to people who cannot buy coverage because of pre-existing medical problems.
A framework is developed for Phase I of the OHP Medicaid demonstration (SB 27).

1991

Governor
Barbara Roberts

A framework is developed for Phase II of the Medicaid demonstration. (SB 44) including preparations to offer mental health and chemical dependency services (SB1076).
The Health Resources Commission (HRC) is established to develop a process for deciding the allocation of medical technologies in Oregon (SB1077).
Several insurance reforms are legislated, including a guaranteed-issue policy that all small-business insurance carriers in Oregon must offer. The Employer Mandate is postponed until July 1, 1995 (SB 1076).

The HSC recommends its first Prioritized List to the Governor and Legislature. It is funded through line 587/709 pending US Health Care Financing Administration (HCFA) approval.
The Medicaid waiver application is sent to HCFA.

1992

HCFA denies the waiver application because of possible violations of the Americans with Disabilities Act.
HSC revises the prioritization methodology and reorders the list.
The waiver application is resubmitted to HCFA.

1993

Small business insurance policies go on sale.
Legislature directs HSC to review and adopt clinical practice guidelines (SB 757).
Employer Mandate is postponed until March 31, 1997 (HB5530).
Funding package passes for Medicaid expansion, using General Funds and a 10-cents-a-pack cigarette tax increase and matching federal funds. Graduated funding levels on the Prioritized List are approved over time (HB5530). Beneficiaries to include seniors and people with disabilities. The initial Prioritized List approved by HCFA funded through line 606/745. Benefits will include mental health and chemical dependency services.
Expanded Mental Health coverage is approved on a demonstration basis in 20 counties, representing about 25 percent of the OHP client base.
The Oregon Health Plan Administrator position is created.

1994

Medicaid expanded to include Oregonians under 100 percent of federal poverty level (FPL) providing a Basic health care benefit package using the Prioritized List.

1995

Governor John Kitzhaber, M.D.

Medicaid seniors and people with disabilities, as well as children in foster/substitute care, are folded into the Basic benefit package.

A gradual expansion of coverage for mental health services begins for Medicaid clients. Chemical dependency services are added to OHP.

The Legislature approves premiums and a $5,000 liquid asset limit for people newly eligible for Medicaid under OHP. It removes full-time college students from those eligible for OHP benefits.

Protections for managed care clients are introduced (SB979).

A major insurance reform package is introduced, including provisions to ensure that health insurance coverage comparable to that available to large groups is available to individuals or groups of two or more. It also addresses "portability," to ensure that coverage for these small groups would continue if a covered person leaves the group (SB152).

The Oregon Health Council is transferred from the Department of Human Resources to the Office of the Oregon Health Plan Administrator (SB1079). Covered services on the Prioritized List are funded through line 581/745 resulting in a reduction in coverage of 27 lines.

1996

The Employer Mandate is repealed since Congress did not grant an exemption from the Employee Retirement Income Security Act (ERISA) by the deadline named by the Oregon Legislature.

1997

HB3445 makes all OHP clients eligible for expanded mental health benefits that are provided through mental health organizations (MHOs). MHOs include private non-profit agencies or consortiums, county mental health departments and regional consortiums of agencies.

A subsidy program is created to help low-income working people pay for private group or individual health care coverage. The Family Health Insurance Assistance Program (FHIAP) is administered by the Insurance Pool Governing Board (HB2894).

The name of the Office of OHP Administrator is changed to the Office for Oregon Health Plan Policy Research (OHPPR) by HB2894.

Covered services are reduced from line 581/745 to 578/745 instead of line 573/745 as requested of HCFA.

1998

Eligibility is restored to full-time college students who meet OHP income and asset criteria, are otherwise uninsured, and meet family economic standards for federal Pell grant eligibility.

OHP benefit package is extended to pregnant women with income up to 170 percent FPL.

FHIAP begins accepting reservations, and sending out applications with the first enrollments in July.
Children's Health Insurance Program (CHIP) begins for uninsured children (through age 18). OHP eligibility rises to 170 percent FPL for these children.

1999

Small hospitals (< 50 beds) that do not contract with managed care plans are guaranteed cost-based reimbursement (SB676).
Legislature approves reducing services to line 564 on the Prioritized List for coverage for 1999-2001 (however, HCFA never approved it).
IPGB is released from obligation to certify health insurance policies that are sold by health insurance carriers to uninsured small businesses (SB414).
Liquid asset limit is lowered to $2,000. Services to line 574/743 are funded.

2001

Legislature directs Oregon to seek new Medicaid waivers from the federal government to change the benefit package for some OHP recipients, and use the savings to pay for an expansion of OHP to people earning up to185 percent FPL (HB2519). The waiver will also allow federal money to be used to expand coverage to more people in FHIAP (HB2519).
Legislature directs IPGB to develop a basic benchmark health benefit plan(s) for subsidized individual or employer-sponsored coverage (HB2519).
Changed the name of OHPPR to Office for Oregon Health Policy and Research (OHPR) (HB 2101)
OHPR is researching alternative methods of determining the capitation rate paid to the fully-capitated health plans providing medical services to enrollees of OHP (HB 2519).

Legislature adopts Prioritized List funding through line 566/736.
Practitioner Managed Prescription Drug Plan is established to create preferred drug list for OHP through evidence-based process for fee-for-service clients (SB819).

2002

Breast & cervical cancer program begins.
Emergency Board approves OHP2 waivers with incremental expansion of Medicaid to 115 percent FPL (delayed indefinitely) & expansion of FHIAP.
DHS submits its second 5-year OHP project waiver request to Centers for Medicare and Medicaid Services (CMS, formerly HCFA).
The Pharmacy Management program begins, limiting clients to a single pharmacy provider of their choice. Simultaneously, the Practitioner Managed Prescription Drug Program (PMPDP) begins, identifying the most cost-effective drugs, limiting client supplies, and reducing reimbursements.
The Disease Management Program begins targeting clients with specific health conditions and providing case management.
CMS approves OHP waivers.
FHIAP begins expansion in November toward a goal of 25,000 enrollees.

2003

Governor Theodore Kulongoski

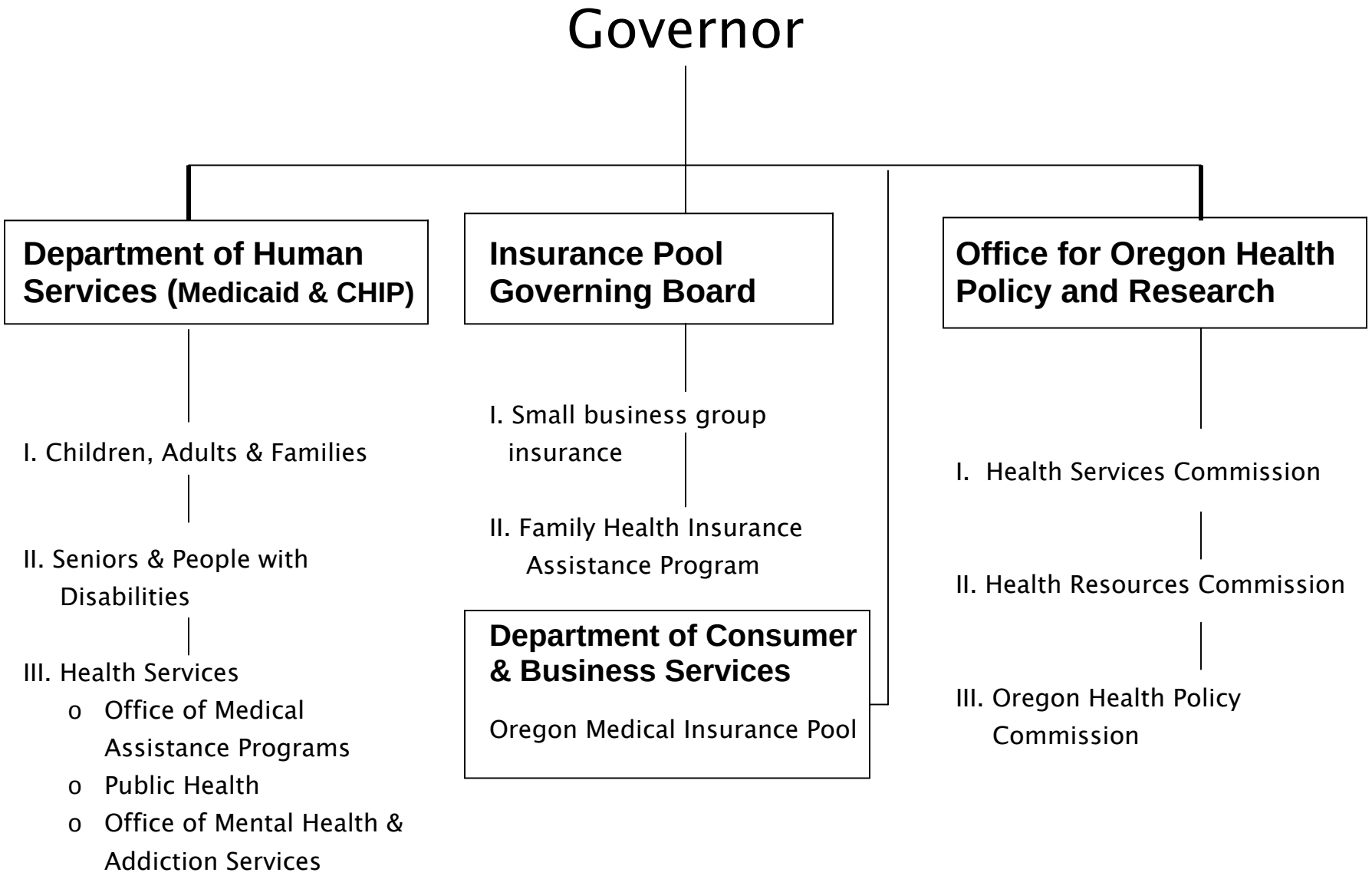
Covered services on Prioritized List drop from line 566 to 558. Copayments are instituted for most adult fee-for-service clients using specified services. Exemptions are given to pregnant women and long-term care clients receiving waivered services.

Two new benefit packages, Standard and Plus, take effect. The former Basic package is renamed OHP Plus and the covered services remain the same for categorically eligible clients. The Standard package offers reduced benefits, higher copays and requires premiums.
A new mail order vendor is contracted to provide discounted prescription drugs to OHP clients. Plus clients are exempted from copayments for this service.
The Medically Needy (MN) and General Assistance programs are discontinued in February. A few MN clients are given back a prescription-only benefit for certain life-threatening conditions (SB 5548).
Eligibility is expanded in February to cover pregnant women and children with incomes up to 185 percent FPL.
Most OHP Standard applicants must have been uninsured for at least six months. Eligible, employed Standard clients who have employer-sponsored health insurance available to them must apply for FHIAP coverage.
Routine visual, hearing services, durable medical equipment and non-emergent medical transportation are discontinued in February for OHP Standard clients.
Premiums and copayment amounts are increased for OHP Standard clients. Penalties are put in place for failure to pay premiums.
Long-Term Care (LTC) clients at lesser impaired priority levels 15-17 lose eligibility.
Dental benefits, outpatient mental health and chemical dependency services are discontinued in March for OHP Standard clients as well as medical supplies.
Eligibility date for OHP Standard begins the month following approval.
LTC clients at survivability levels 12-14 lose eligibility.
Legislature requires Fully Capitated Health Plan (FCHP) enrollment for all but a few exceptions (HB3624). OMAP begins auto-enrolling clients in FCHPs by service area with a goal to increase enrollment to 70 percent and stay there for remainder of the biennium.

2004

The Health Services Commission revised list becomes effective in January 2004 with funding through line 549.
Legislature requests a 30-line move on the Prioritized List from 549 to 519. Process begins to obtain CMS waivers for this and several other actions in order to implement early in 2004.
Legislature revises OHP Standard to include physician, lab & X-ray, prescription drugs, outpatient mental health/chemical dependency and limited emergency dental services as a core benefit package, pending CMS approval. A limited hospital benefit will be added subject to CMS approval of provider taxes (HB2511).
Legislature directs OMAP to expand CHIP coverage to 200 percent FPL (HB2511) by early 2004.
Legislature establishes a prescription drug program, Medical Expansion to people with Disabilities and Seniors (MEDS), to begin in 2004 (SB2511) and imposes several cost-saving measures to prescription drug services (pending CMS approval).
Legislature establishes Medicaid managed care plan and hospital provider taxes (HB2747) to begin in 2004.
Legislature directs use of Physician Care Organization (PCO) program beginning July 2004 (HB3624). A PCO is a partially capitated plan.
Legislature directs dissolution of the Oregon Health Council. It is replaced by the Oregon Health Policy Commission (HB3653).
Legislature directs FHIAP to expand coverage up to 200 percent FPL in both HB 2511 and HB2189.
Legislature directs IPGB to develop health insurance plans for small, uninsured businesses (HB2537).

Oregon Health Plan Agencies



Medicaid Expansion and Reform

In February 1, 1994, the state embarked on a campaign to make Medicaid available to thousands of people who previously did not qualify, even though their income was below the poverty level.

The Oregon Health Plan originally operated as a five-year Medicaid demonstration project, which required a waiver from traditional Medicaid rules. The waiver was granted in March 1993 by the former U.S. Health Care Financing Administration (HCFA).

The Oregon Health Plan's Medicaid expansion was unique in at least two ways:

- It made Medicaid available to most people living in poverty regardless of age, disability or family status.
- Its benefits were based on a priority list of health-care conditions and treatments.

OHP extended a Basic Health Care Benefit Package to approximately 100,000 newly eligible persons, in addition to about 250,000 Oregonians who previously qualified for Medicaid. 1994

OHP extended a Basic Health Care Benefit Package to approximately 100,000 newly eligible persons, in addition to about 250,000 Oregonians who previously qualified for Medicaid. It covered most people below the federal poverty level, as well as many seniors, persons with disabilities, and foster children. It also covered pregnant women and children under age six with income up to 133 percent of the federal poverty level (FPL).

When OHP was introduced in 1994, it offered one "Basic" benefit package for nearly all members. Exceptions were made, for example, for persons eligible for Medicare or those with exceptionally high medical expenses but with income over the poverty level (the Medically Needy Program). It was a way of offering Medicaid benefits to more Oregonians.

In January 1995, the state added some previously exempted groups and began integrating mental health and chemical dependency services into the OHP Basic Health Care Package. All OHP clients were made eligible for expanded mental health benefits by July 1997. Mental health benefits were provided through mental health organizations (MHOs), which included private non-profit agencies or

consortiums, county mental health departments and regional consortiums of agencies.

In 1997, Congress created a new program to increase funding to states for coverage of low-income children. Oregon's Children's Health Insurance Program (CHIP) is administered by OMAP.

With this increased state and federal funding, the OHP benefit package was extended to pregnant women with income up to 170 percent FPL on March 1, 1998. CHIP extended OHP Medicaid benefits to uninsured children to age 19 up to 170 percent FPL beginning July 1, 1998.

In order to help control costs, and to make OHP available to even more uninsured people, the Oregon Legislature in 2001 approved changes in the Medicaid part of the Oregon Health Plan. The Centers for Medicare and Medicaid Services (CMS—formerly HCFA) granted Oregon another five-year waiver in October 2002 for a revised OHP demonstration project. Client copayments were introduced for most adults. The Basic benefit package gave way to two newly defined packages beginning in February 2003—Plus and Standard. The clients in the Standard package receive a reduced set of benefits, pay premiums and higher copays.

The Oregon Health Plan changed Medicaid policy in four major ways:

- Eligibility—who can receive benefits
- Benefits—what is covered
- Service delivery—how clients receive their benefits
- Payment—how providers are reimbursed

Federal Poverty Level (FPL) effective February 2004

No. in family	100%	133%	185%
1	776	1032	1435
2	1041	1384	1926
3	1306	1737	2416
4	1571	2089	2906
5	1836	2442	3396
6	2101	2794	3887
7	2366	3147	4377
8	2631	3499	4867
9	2896	3851	5357
10	3161	4204	5848
Add'l	265	352	490

Eligibility

Individuals and families with income below federal poverty guidelines are eligible for OHP Medicaid coverage. Pregnant women and children under 19 in households with earnings up to 185 percent of the poverty level also

are eligible. The Legislature has approved extending CHIP eligibility to 200 percent FPL but it has not been implemented as of this writing. Generally, eligibility is for six months at a time, compared to traditional Medicaid's month-to-month eligibility.

OHP greatly simplifies the eligibility test and process for those not on public assistance. Eligibility is based primarily on income, which is averaged over a three-month period. Applicants fill out a simple form—either in person or by mail. Most persons with liquid assets of $2,000 or more are not eligible.

During March to May 2003, OMAP Telecommunications and Application Center handled over 36,000 requests for new OHP applications and mailed almost 50,000 redetermination (*i.e.*, enrollment renewal) packets to current OHP clients. Statistics are from the "OHP Medicaid Demonstration Project Report," Second Quarter 2003.

Beginning in 2003, Standard applicants must have been uninsured for at least six months before they can qualify for OHP coverage. If they are employed and eligible for FHIAP, they must first apply for that coverage. Also, OHP Standard coverage now begins the month following approval for the program.

People who would not be eligible for Medicaid if it weren't for OHP must pay monthly premiums of $6 to $23 per person depending on income.

Benefits

Most Oregonians eligible for the Oregon Health Plan's Medicaid coverage now receive the Plus Benefit Package. Clients receiving the Plus Benefit Package include children under 19, pregnant women, blind, aged, people with disabilities, and other special need populations.

The Health Services Commission (HSC), in hearings over more than 18 months involving more than 25,000 volunteer hours, originally devised a list of health services ranked by clinical effectiveness and value to society. Actuaries determined how much it would cost to provide the services on the list. The HSC reviews the Prioritized List at least every two years. The Legislature then decides how much of the list to include in the health care budget. The Legislature can fund services only in numerical order, and it cannot rearrange the order of the list. The state must have federal approval from CMS to move the funding line.

The OHPR Web site also gives more detail about how the list was formulated. The current Prioritized List of Health Services is available at:

http://www.ohppr.state.or.us/hsc/index_hsc.htm

The Prioritized List emphasizes prevention and patient education. In general, services that help prevent illness are nearer to the beginning of the list (also referred to as "higher on the list") than services that treat illness after it occurs. Treatment of advanced cancers, for instance, has a lower priority on the list than regular checkups, in the belief that early detection or lifestyle changes may reduce the frequency of cancers that become untreatable.

As of January 1, 2004, OHP covers services up to line 549 of the 730 condition/ treatment pairs on the list. The 72nd Legislative Assembly has directed Oregon to request CMS approval for a line change to 519.

Covered services include:

- Preventive services to promote health and reduce risk of illness.
- Comfort care or hospice treatment for terminal illnesses, regardless of where the conditions are on the list.

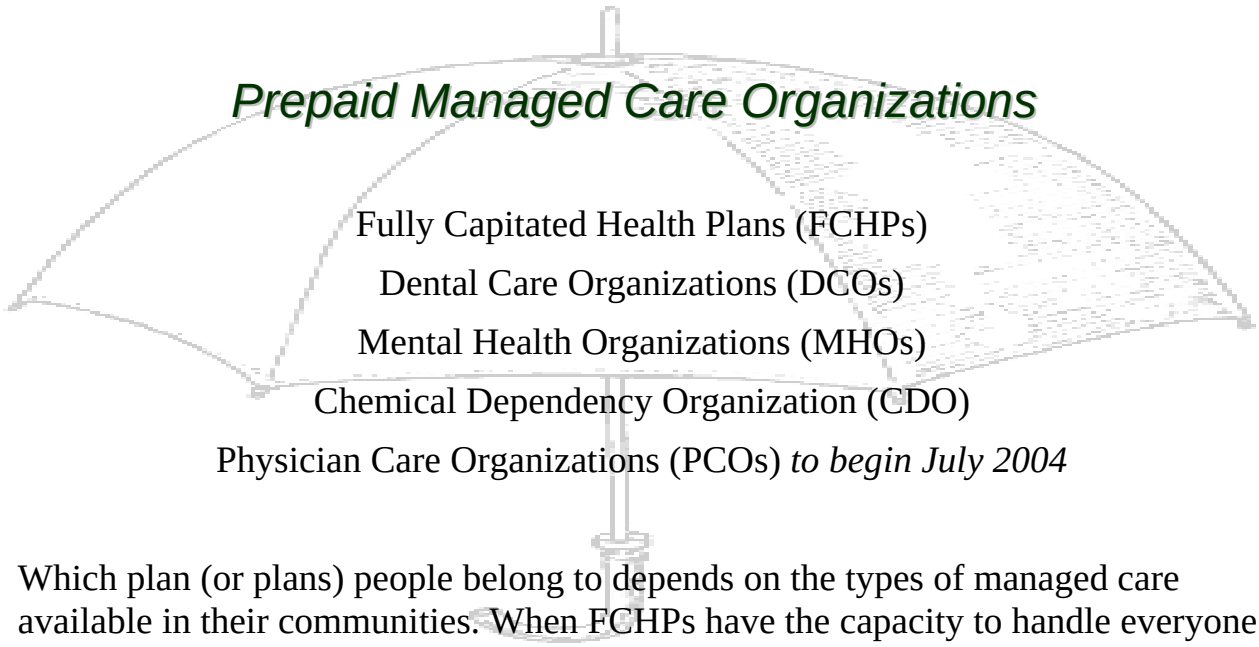
OHP benefits generally *do not* cover:

- Conditions that get better on their own (such as viral sore throat).
- Conditions for which home treatment works (such as food poisoning, sprains).
- Cosmetic procedures (such as scar removal).
- "Conditions for which treatment is generally ineffective," such as aggressive treatment of some advanced cancers." (See p.3, Blueprint Objectives).

Service delivery—managed care

Most OHP Medicaid clients receive their care through prepaid health plans and a primary care practitioner who is a member of a plan. This service delivery system is in direct response to the original Blueprint Objective, "Emphasizing managed care, preventive care, early intervention, and primary care." Other clients have a Primary Care Manager (PCM). And others continue to receive care through fee-for-service (FFS) billing.

The Oregon Health Plan currently offers several types of organizations under the umbrella term, Managed Care Organization (MCO).



Prepaid Managed Care Organizations

Fully Capitated Health Plans (FCHPs)

Dental Care Organizations (DCOs)

Mental Health Organizations (MHOs)

Chemical Dependency Organization (CDO)

Physician Care Organizations (PCOs) *to begin July 2004*

Which plan (or plans) people belong to depends on the types of managed care available in their communities. When FCHPs have the capacity to handle everyone who is eligible in a given area, clients generally must choose one of those plans. A few exceptions are made, however, and PCMs also play a role in areas where there are prepaid health plans.

A provider may belong to more than one FCHP and also be enrolled as a PCM for Medicaid patients who are not enrolled in a managed care plan. For plan distribution, see chart on next page.

Fully Capitated Health Plans (FCHPs)

These prepaid plans contract with OMAP to provide a full range of services under the Oregon Health Plan. FCHPs are similar to health maintenance organizations (HMOs) in that they receive a set monthly fee for each enrolled person (*i.e.*, a capitation fee). The FCHP manages each member's care, from routine office visits to hospitalization or treatment by specialists. Wherever possible, OHP clients are enrolled in FCHPs as the best means of controlling costs of health care. OMAP's goal is to keep 70 percent of OHP clients enrolled in managed care.

Dental Care Organizations (DCOs)

DCOs receive a monthly fee to provide dental services to clients.

Chemical Dependency Organization (CDO)

One CDO, in Deschutes County, receives a monthly fee to provide managed chemical dependency services in that county.

County	Mental Health Organizations	Dental Care Organizations	Fully Capitated Health Plans
Baker	1	2	0
Benton	1	4	3
Clackamas	2	6	4
Clatsop	1	2	1
Columbia	1	2	1
Coos	1	2	2
Crook	1	3	1
Curry	1	1	0
Deschutes*	1	4	1
Douglas	1	3	4
Gilliam	1	1	0
Grant	1	3	1
Harney	1	2	1
Hood River	1	3	1
Jackson	1	5	4
Jefferson	1	3	1
Josephine	1	4	3
Klamath	1	3	3
Lake	1	2	1
Lane	1	5	1
Lincoln	1	3	0
Linn	1	4	3
Malheur	1	2	0
Marion	1	4	2
Morrow	1	2	2
Multnomah	2	6	3
Polk	1	4	2
Sherman	1	2	1
Tillamook	1	2	0
Umatilla	1	4	2
Union	1	2	0
Wallowa	1	1	0
Wasco	1	4	1
Washington	3	5	4
Wheeler	1	2	1
Yamhill	1	2	3
* Descutes County also has 1 CDO			January 2004

Mental Health Organizations (MHOs)

Three types of MHOs deliver mental health services under the OHP's Medicaid program:

- **Fully Capitated Health Plans (FCHPs)** selected by the Department of Human Services (DHS) Office of Mental Health and Addiction Services (OMHAS) provide managed mental health services.
- **County or regional governmental organizations** that operate or contract for community mental health services, may contract with OMHAS to manage the provision of OHP mental health services.
- **Private Mental Health Organizations** selected by OMHAS.

Physician Care Organizations (PCOs)

PCOs, proposed to begin July 2004, receive set fees for each member, but are not capitated for hospital services. PCO members receive hospital care on a fee-for-service basis.

Primary Care Managers (PCMs)

In areas where there are not enough FCHPs to handle the client load, and for other specific purposes, OMAP contracts with physicians, physician assistants, nurse practitioners and naturopathic physicians to serve as primary care managers (PCMs). PCMs receive a small monthly payment to manage each client's health care, and bill OMAP on a fee-for-service basis for care provided. In addition to individual providers, Rural Health Clinics, Tribal Health Clinics, County Health Departments and similar organizations may serve as PCMs. There is at least one PCM serving every Oregon county.

Payment for services

Although payment is still on a fee-for-service basis in some instances, the Oregon Health Plan depends on prepaid health plans as a way of ensuring more reasonable reimbursement rates to providers. This is an attempt to avoid shifting the cost of Medicaid onto other health care consumers as prescribed in the Blueprint Objectives.

The Prioritized List of Health Services determines which services are potential benefits under the Oregon Health Plan. Once a patient's condition has been diagnosed and a course of treatment proposed, providers must use the list to find

out whether the condition and treatment fall between Line 1 and the currently funded line number.

Prepaid health plans and fee-for-service providers can choose to provide services beyond the currently funded line and bill the client. As long as the member is informed in advance and has agreed to this arrangement, this is an option.

Insurance Reforms

Oregon Medical Insurance Pool (OMIP)

The Oregon Medical Insurance Pool (OMIP) is a "high risk pool." It addresses the Blueprint Objective, "Health insurance for individuals who have been denied coverage for medical reasons." The following information comes from the OMIP Web site: http://www.omip.state.or.us

OMIP is a "high risk pool" of insurance for individuals who have been denied coverage for medical reasons."

OMIP provides medical insurance coverage for all Oregonians who are unable to obtain medical insurance because of health conditions. OMIP also provides health benefit portability coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them. OMIP has four medical plans from which enrollees may choose: a traditional indemnity plan, a preferred provider plan, a managed care plan, and a limited benefit traditional indemnity plan.

The 1987 Legislature established the program, and OMIP issued its first policy in July 1990. OMIP is a component of the Oregon Health Plan and a part of Oregon's Department of Consumer & Business Services. Since issuing its first policy, OMIP has insured more than 30,000 Oregonians who otherwise would have had no health benefit coverage. A citizen board of directors guides policy for the program.

OMIP has insured more than 30,000 Oregonians who otherwise would have had no health benefit coverage.
2003

Regence BlueCross BlueShield of Oregon is OMIP's administering insurer and handles eligibility, enrollment, member services, and claims processing.

The premiums that OMIP enrollees pay actually cover only about 60 percent of the medical and drug claims costs in the program. The commercial insurance companies that conduct business in Oregon pay a special fee to OMIP to cover the remaining 40 percent. For individuals who enroll because they meet the medical eligibility criteria, the premiums are higher than those charged by the commercial insurance carriers for similar individual benefit coverage. For individuals who use OMIP as their

portability coverage option, the premiums are an approximate average of what the commercial carriers charge for their portability products in Oregon.

Individuals who enroll themselves or family members in an OMIP Plan must have the financial resources to pay the premiums. The program does not subsidize premiums or reduce them according to an individual's ability to pay.

Some lower-income people who are eligible for OMIP and who have not had health insurance coverage for at least six months may also be eligible for premium subsidy assistance from a different program called the Family Health Insurance Assistance Program (FHIAP). Otherwise, OMIP expects the enrollees to pay the full premiums each month to continue insurance coverage.

Insurance reform for small employers

Small employers have found it particularly difficult to purchase health insurance. In order to address the Blueprint Objective requesting "two voluntary group insurance plans available to small employers," the Legislature created two programs—one offers low premiums, the other guarantees availability to help small businesses meet the goals of the Oregon Health Plan.

OHP created two, voluntary, group insurance plans available to small employers.

The Small Employer Insurance Reform law of 1991 created a conventional insurance plan and a health maintenance organization (HMO) plan accessible to all companies employing two to 50 people. Any insurance company in Oregon's small business market must offer this "basic" plan, and no employer in that category may be refused. The plan's benefits are "substantially similar" to the original Basic Health Care Package, and include mental health and alcohol and chemical dependency benefits.

The 1991 law took steps to address problems that small businesses face in obtaining group policies, including:

- Limiting denial of benefits due to preexisting medical conditions and excluding pregnancy from the definition of preexisting conditions.
- Outlawing "selective cancellation" of policies, even for individuals who develop high-risk conditions.
- Controlling premium rates. Rates for new businesses must be within 33 percent of the midpoint in a geographic area; on renewals, the carrier must be within the approved annual trend (usually about 12 percent) plus 15 percent—*e.g.*, a small employer could receive up to a 27 percent increase annually, based on the group's claims experience. After October 1, 1996, the

rate for both new and renewal policies is based solely on the group's composite age.

The Department of Insurance and Finance (now Department of Consumer and Business Services) approved the basic plan, and it went on sale March 1, 1993.

Insurance Pool Governing Board (IPGB)

The following text is taken from the Insurance Pool Governing Board's home page on the Internet http://www.ipgb.state.or.us .

IPGB is a small state agency created by the 1987 Oregon Legislature, dedicated to helping all Oregonians gain access to health benefit coverage.

In 1989, IPGB began certifying low-cost health insurance plans for uninsured small businesses and the self-employed. Over the years, insurance market reforms decreased the need for certified plans as these businesses found plans in the regular Small Employer Health Insurance (SEHI) market that fit both their insurance needs and their budgets. Because of this, the 1999 Oregon Legislature removed the certified plan function of the IPGB, leaving the agency to concentrate its efforts in providing resources to help small businesses and the self-employed obtain health insurance for themselves, their employees, and the employees' dependents (SB414).

IPGB-certified plan enrollment peaked in 1996 at over 33,000 and eventually served over 60,000 Oregonians.

IPGB began working with insurance agents and carriers to develop a transition plan for the certified plan policyholders. The policyholders received information from the IPGB and their insurance carrier about their options in mid-1999, and moved to their new plan by either January 1, 2000, or July 1, 2000, depending on their carrier.

Since that time, insurance market pressures have made it increasingly difficult for small businesses to afford health insurance. Rising health care costs and double-digit premium rate increases have forced many employers to pass along these increases to employees or drop health care coverage altogether. HB2537, passed in the 2003 Legislative Session, directed the IPGB to develop affordable plans for small, uninsured businesses and then contract with carriers to offer those plans across the state.

Family Health Insurance Assistance Program (FHIAP)

FHIAP is administered by the staff of the Insurance Pool Governing Board. It further satisfied Blueprint Objective that asked for "reforms to make insurance more available and affordable." Most of this information is taken from their Web site: http://www.ipgb.state.or.us/fhiap/index.html

FHIAP helps Oregon families afford the protection and benefits of a health insurance plan. FHIAP subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums. This helps families and individuals obtain health insurance, maybe for the first time ever. Oregon voters in 1996 approved an additional 30-cent cigarette tax to increase OHP funding and pay for the new FHIAP program. FHIAP is currently a General Fund agency.

FHIAP subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums.

In an effort to reduce the number of low-income, uninsured Oregonians, the 2001 Oregon Legislature passed House Bill 2519. This bill directed Oregon to seek new Medicaid waivers from the federal government to change the benefit package for some OHP recipients, and use the savings to pay for an expansion of the Health Plan and FHIAP up to 185 percent of the federal poverty level. The federal government approved the waivers on October 15, 2002. This federal action means that both the Medicaid program and the FHIAP could be expanded.

PERCENT OF FEDERAL POVERTY LEVEL (PFL)	AMOUNT OF FHIAP SUBSIDY
0 up to 125 percent FPL	95 percent subsidy
125 up to 150 percent	90 percent subsidy
150 up to 170 percent	70 percent subsidy
170 up to 185 percent	50 percent subsidy

Employer Mandate

Full implementation of the Medicaid expansion and the Oregon Medical Insurance Pool would still leave more than 400,000 people uninsured, most of them workers and their dependents. Originally, a major piece of the Oregon Health Plan's design was a requirement that businesses offer insurance to workers, to assure coverage to most Oregonians. Implementation of this so-called employer mandate would have resulted in health care coverage for an estimated 165,000 additional Oregonians.

The employer mandate was repealed January 2, 1996, because Oregon did not receive federal exemptions.

Part of the 1989 legislative package that created OHP, the employer mandate would have required all employers to either offer group health insurance or pay into a statewide insurance pool through a payroll tax, for all "permanent" workers. This was referred to as the "play or pay" option. A permanent employee was defined as one who is not seasonal or temporary and who works at least 17.5 hours per week. The employer mandate was to take effect in July 1995.

Small employers received tax credits for voluntary coverage before July 1995. The 1993 Legislature delayed implementation until March 31, 1997, for businesses employing 26 or more; and to January 1, 1998, for those with 25 or fewer employees.

To take effect, the employer mandate needed a Congressional exemption to the federal Employee Retirement Income Security Act (ERISA). The 1993 legislation set a deadline of January 2, 1996, for that exemption. Because it didn't occur by the deadline, the employer mandate was repealed.

Office for Oregon Health Policy and Research

In 1993, the Legislature created the Office of the Oregon Health Plan Administrator. In 1995, the Legislature transferred the Office of Health Policy to the Office of the Health Plan Administrator to create one focal point for health policy and reform in the state.

In addition to coordination and oversight responsibilities for OHP, the Office for Oregon Health Policy and Research (renamed in 2001) works with the Health

Services Commission, the Oregon Health Policy Commission (replaces the Oregon Health Council in January 2004) and the Health Resources Commission to prioritize services, advise the governor and legislature on health care policy, and conduct medical technology assessments.

The OHPR Web site has information on the three commissions, legislative history, and other related topics. Its web address is http://www.ohppr.state.or.us/.

Health Resources Commission (HRC)

The following information is taken from the HRC Web site:
http://www.ohppr.state.or.us./hrc/abouthrc/index_hrcabout.htm

The HRC is a component of the Oregon Health Plan to help it achieve its goal of assuring all Oregonians access to high quality, effective health care at an affordable cost, whether that care is purchased by the state or by the private sector.

The Commission's role is to encourage the rational and appropriate allocation and use of medical technology in Oregon.

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. Through its activities, the Commission can contribute to reducing the cost and improving the effectiveness of health care, thereby increasing the ability of public and private sources to provide more Oregonians with financial access to that care.

Health Services Commission (HSC)

This material is adapted from the HSC Web site:
http://www.ohppr.state.or.us./hsc/index_hsc.htm

The HSC is responsible for creating and maintaining the Prioritized List of Health Services, ranking services from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The list is accompanied by a report of an independent actuary retained for the

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commission to determine rates necessary to cover the costs of the services.

The Joint Legislative Committee on Health Care determines whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and advises the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly funds the report to the extent that funds are available to do so.

Oregon Health Policy Commission (formerly, the Oregon Health Council, or OHC)

The 2003 Legislature abolished the OHC and established the Oregon Health Policy Commission in its place, effective January 1, 2004. According to SB 3653, in addition to previous OHC duties, the new commission will serve as the policy-making body responsible for health policy and planning for the state. They are directed to:

> The new commission will serve as the policy-making body responsible for health policy and planning for the state. 2004

- Develop a plan for and monitor the implementation of state health policy.
- Act as the policy-making body for a statewide data clearinghouse established within OHPR for the acquisition, compilation, correlation and dissemination of data from health care providers, other state and local agencies including the state Medicaid program, third-party payers and other appropriate sources.
- Review reports on such findings, trends and long-term implications.
- Provide a forum for discussion of health care issues facing the citizens of the state.
- Identify and analyze significant health care issues affecting the state and make policy recommendations to the Governor.
- Prepare and submit to the Governor and the Legislative Assembly resolutions relating to health policy and health care reform.
- Review state Medicaid Plan amendments, modifications in operational protocols, applications for waivers to CMS proposed by DHS, and administrative rules for the state's medical assistance programs and other health care programs.
- Act as primary advisory committee to OHPR, the Governor, and the Legislative Assembly.

Acronyms

CAF	Children, Adults and Families is a cluster within DHS that provides specialized case management services to eligible families.
CDO	A Chemical Dependency Organization is an MCO providing chemical dependency and addiction services.
CHIP	The Children's Health Insurance Program was created by Title XXI of the Social Security Act in 1997.
CMS	The Centers for Medicare and Medicaid Services, formerly called HCFA, is the federal administrator of these national benefits.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985. A federal law that requires employers sponsoring group health plans to offer continuation of coverage under the group plan.
DCO	A Dental Care Organization is an MCO providing dental care.
DHS	Oregon's Department of Human Services and its clusters provide OHP administration and case management services to OHP clients.
ERISA	The Employee Retirement Income Security Act is federal legislation.
FCHP	Fully Capitated Health Plan. These prepaid plans contract with OMAP to provide a full range of services under the OHP.
FFS	Fee-for-service is a billing method for services not covered by a capitated plan.
FHIAP	The Family Health Insurance Assistance Program subsidizes health insurance for eligible families with no other coverage for at least six months.
FPL	Federal Poverty Level
HCFA	Health Care Financing Administration is the former name for CMS.
HIPAA	The Health Insurance Portability and Accountability Act is a comprehensive privacy protection law.
HMO	A Health Maintenance Organization is a type of managed care plan. Generally, HMOs have a select list of providers, a limited choice of hospitals, and an emphasis on preventive care.

HPC	The Health Policy Commission is a policy-making body and primary advisory committee to the Oregon Health Plan Administrator, the Governor and the Legislative Assembly.
HRC	The Health Resources Commission was created as a component of the Oregon Health Plan to help it achieve its goal of assuring all Oregonians access to high quality, effective health care at an affordable cost, whether that care is purchased by the state or by the private sector.
HSC	The Health Services Commission is the body responsible for creating and maintaining the Prioritized List of Health Services covered by OHP.
IPGB	The Insurance Pool Governing Board is a small state agency created by the 1987 Oregon Legislature, dedicated to helping all Oregonians gain access to health benefit coverage.
LTC	Long-term care
MCO	A Managed Care Organization also known as Prepaid Health Plan (PHP). Organizations (DCO, FCHP, MHO, CDO, PCO) contract with DHS to provide specific services in exchange for capitation payments.
MHO	A Mental Health Organization is an MCO offering mental health services.
OHC	The Oregon Health Council is the former name for the Health Policy Commission.
OHP	Oregon Health Plan is an umbrella term for a range of medical insurance assistance benefits available to Oregonians.
OHPR	The Office for Oregon Health Policy and Research has coordination and oversight responsibilities for OHP.
OMAP	The Office of Medical Assistance Programs is part of the Health Services cluster of the DHS that administrates the Oregon Health Plan.
OMIP	The Oregon Medical Insurance Pool is a high-risk health insurance pool, created to provide medical coverage for all Oregonians who are unable to obtain medical insurance because of health conditions.
PCM	A Primary Care Manager is a physician or other OMAP-approved medical provider who is responsible for providing primary care and maintaining continuity of care, supervising and coordinating care to patients, initiating referrals for consultations and specialist care.
PCO	A Physician Care Organization is a partially capitated managed care plan.

PHP	Prepaid Health Plans (DCO, FCHP, MHO, CDO, PCO) contract with DHS to provide specific services in exchange for capitation payments. Also known as a Managed Care Organization (MCO).
SPD	Seniors and People with Disabilities is a cluster within DHS that provides specialized case management services to those clients.
SSA	The Social Security Administration
SSI	Supplemental Security Income is for low-income people who are aged, blind or have disabilities as determined by SSA. Oregonians on SSI are automatically eligible for OHP Plus coverage.

For more information

The Oregon Health Plan: An Historical Overview
http://www.dhs.state.or.us/healthplan/data_pubs/index.html
OMAP Communications
500 Summer St. NE, E-35
Salem, OR 97310-1077
503-945-5772
800-527-5772

Legislative bills & Oregon Revised Statutes (ORS)
http://www.leg.state.or.us/billsset.htm
Capitol Bill Room
(503) 528-8891

Oregon Administrative Rules (OARs) for Medical Assistance Programs
http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_tofc.html

Prioritized List of Health Services
http://www.ohppr.state.or.us/hsc/index_hsc.htm

Oregon Health Plan Applications
OHP Application Center
800-359-9517 or TTY 800-621-5260.

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