Office for Oregon Health
Policy and Research

TRENDS IN OREGON'S HEALTHCARE MARKET AND THE OREGON HEALTH PLAN

A Report to the 74th Legislative Assembly

February 2007

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Executive Summary

Over the past decade the healthcare market in Oregon has experienced significant economic, structural and policy changes that have affected the way hospitals, health plans, physicians and purchasers do business and how consumers access healthcare services. In Oregon and the rest of the country, healthcare costs have increased at a rate higher than those in the rest of the market. Healthcare expenditures currently account for over 20% of the Oregon state budget in programs such as the Oregon Health Plan (OHP), Seniors and People with Disabilities, Public Employees Benefit Board (PEBB), the State Children's Health Insurance Program (SCHIP), public health, corrections health and University health.

Understanding this critical component of the state budget requires that we also have a picture of the healthcare market, its major components and the key drivers of healthcare costs. This report to the 74th Legislative Assembly presents a broad representation of the healthcare marketplace in Oregon. To that end, the report is organized as follows:

Chapter 1 focuses on *Oregon population trends and demographics* as well as *how much we spend on healthcare, healthcare affordability* and *the main drivers of healthcare costs*.

- One driver of changing healthcare needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, and healthcare utilization and costs in the years to come.
- Between 2006 and 2013, the fastest growing segments of the population in Oregon are those 65 to 64 years of age (26% projected growth) and those 70 to 74 years of age (45% projected growth). As these individuals age, their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program. As a result, Medicare spending will begin to rise.
- Approximately 72% of healthcare dollars spent in Oregon are spent on hospital care, physician services, and prescription drugs.
- Total spending for acute healthcare services in Oregon is estimated at $16.8 billion in 2006 and is projected to be $19.3 billion by 2008.
- Budget studies based on work completed by the Economic Policy Institute show that Oregon families do not have the financial capacity to contribute significantly toward healthcare costs until they are earning at least 250% of the federal poverty level ($51,625 for a family of four in 2007).
- New medical technology is generally thought to be the most important long-term driver of healthcare cost, accounting for one-half to two thirds of the increase in healthcare spending in excess of general inflation.. Other cost drivers include the rise in medical treatment, waste and inefficiency in the healthcare system, the overall structure of health insurance and medical errors and medical liability.

Chapter 2 focuses on *the Oregon Health Plan* looking at trends and program changes from 2003 to 2006.

- Budget cuts in both entitlement and discretionary programs at the federal level due have resulted in significant challenges for Oregon. The Deficit Reduction Act of 2005, with new rules and requirements around citizenship, third party resources, targeted case management, provider taxes, transportation and rehabilitative services affects the Oregon Health Plan (OHP), the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP).
- There were a total of 401,008 total OHP Medicaid and SCHIP enrollees in September 2006. Of total eligibles, 55% were children 18 years and under, 35% were adults 19-64 years of age, and 9% were adults 65 years and older. The OHP expansion population (OHP Standard) has decreased over 78,000 people or 78% since changes were made to the program in 2003. The OHP Standard program operates entirely without General Fund resources, using provider taxes, which are set to sunset in 2008, from the hospitals and managed care organizations.
- For every $1 that Oregon invests in Medicaid, the federal government matches with approximately $1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state, triggering successive rounds of earning and purchases as they continue to circulate through the economy.

Chapter 3 focuses on *health insurance,* looking at trends in Medicare and private sources of coverage.

- Medicare provides health insurance coverage to over 531,000 Oregonians who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.
- Under the new Medicare prescription drug program that began on January 1, 2006, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. The revised payment by Oregon to CMS for was $57.1 million dollars ($6.1 million dollars less than the original scheduled payment) for 2006.
- As of January 2007, 62% of Oregon's Medicare population and 54% of the U.S. Medicare population was enrolled in Medicare Part D plans.
- The average annual increase in Oregon's health insurance premiums for most years between 1997 and 2004 far outpace the growth in per capita income or inflation. Due to an economic downturn and rising unemployment during the early 2000s, employers in Oregon offering insurance and employees eligible for insurance during 2004 was at the lowest point in nine years.

- The percent of private sector establishments in Oregon that offer health insurance to their employees has dropped from 86% in 1996 to 80% in 2004. The percent of employees working in establishments that offer health insurance has declined from 62% to 53% from 1996 to 2004.
- Health Savings Accounts have increased in popularity both nationally and in Oregon in recent years and premiums for these products are generally lower than the average single or family health insurance product. However, some economists remain skeptical that HSAs will significantly increase health insurance coverage in the U.S.—primarily because 71 percent of the uninsured in the United States are in a 10-percent-or-lower income tax bracket (55% are in the 0% tax bracket), and they have little to gain from the tax savings imparted by HSAs.

Chapter 4 focuses on *who's not covered* examining the impacts, trends and characteristics of the uninsured in Oregon.

- Oregon's recovering economy has not resulted in improvements in health insurance coverage—increasingly expensive health insurance premiums and declining employer-sponsored coverage are both likely contributors to Oregon's uninsured population, which remained statistically flat from 2004 at 17% uninsured to 15.6% uninsured in 2006.
- 43% of adults from age 18 to 64 who earn less than 100% of the federal poverty level (FPL), and 35% of adults who earn less than 200% FPL are uninsured in Oregon.
- OHP changes since 2003 have had impacts on access to healthcare for vulnerable populations, with most who lost coverage remaining uninsured and facing higher unmet needs for medical care, urgent care, mental healthcare and prescription medications. This is especially true for those with chronic illness. This could result in increased costs for these populations stemming from deferring or delaying care.

Chapter 5 focuses on *access* presenting information about the healthcare safety net in Oregon.

- A 2004 survey of children from low-income families in Oregon found that only 68% of those without healthcare coverage had a regular source of care. Children without a usual source of care were three times more likely to be taken to an emergency room or an urgent care clinic for regular care.
- Access to care for the uninsured and underinsured is provided in large part by the healthcare safety net. The healthcare safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Oregon's healthcare safety net includes Federally Qualified Health Centers (FQHC), Rural Health Centers, Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC)

Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments, as well as some private healthcare providers.

- The provision of uncompensated care serves as an indicator of both the need for healthcare among people who are unable to pay, and the willingness and capacity of healthcare providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect increasing numbers of uninsured individuals and families in the community.

Chapter 6 focuses on *racial and ethnic health disparities* in Oregon by looking at what is known about disparities in healthcare, the changing make-up of Oregon's population, and the need for increased data collection efforts.

- In 1990, racial and ethnic minorities made up 9.2% of Oregon's population; in 2005, an estimated 17% of Oregon's population self-identifies as African-American, Native American, Asian/Pacific Islander and/or of Hispanic ethnicity.
- Disparities in access and coverage have serious negative health consequences: the infant death rate among African-Americans in Oregon is almost twice that of non-Hispanic whites.
- The physician workforce in Oregon, while largely representative of the underlying population, is under-represented for African-American physicians (.6%) and over-represented for Asian physicians (6.3%).
- Data is not routinely collected on access, health status or utilization for Oregon's racial and ethnic minorities. Standardized data collection is critically important to inform policy and to understand and eliminate racial and ethnic disparities in Oregon.

Chapter 7 focuses on *health status* by looking at the prevalence of chronic disease, high-risk conditions and modifiable risk behaviors.

- Access to healthcare services impacts health status, but health status also influences demand for and the cost of healthcare. It is important, therefore, to examine healthcare both in the context of health status and as an important determinant of health outcomes.
- Chronic disease in Oregon represents areas of opportunity for the state where improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions. Although heart disease has decreased over the last fifteen years, diabetes has increased.
- High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many chronic conditions. Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population.

Chapter 8 focuses on *healthcare reform* by looking at current challenges and opportunities in Oregon as well as in other states.

- In 2006, Governor Kulongoski directed the Oregon Health Policy Commission (OHPC) to write a blueprint for building a sustainable system that provides access to affordable healthcare to every Oregonian, to set measurable goals for healthcare system change, and to recommend ways to finance the system.
- OHPC recommendations include:
    - Universal health insurance for children
    - Creation of a Health Insurance Exchange to bring together individuals, coverage options, employers, and public subsidies
    - Offer low-income Oregonians publicly-financed coverage subsidies to ensure coverage is affordable
    - Requirements that all Oregonians purchase health insurance coverage
    - Encourage and organize public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes
    - Support for community efforts to improve healthcare access and delivery
    - Establish financing for reform that is sustainable and equitable with a broad-based employer contribution
    - Design and implement comprehensive evaluation of system reform

About the Office for Oregon Health Policy and Research

The Office for Oregon Health Policy and Research (OHPR) provides analysis, technical, and policy support to the Governor and the Legislature on issues relating to healthcare costs, utilization, quality, and access and serves as the policy making body for the Oregon Health Plan. OHPR also provides staff support to statutorily-established advisory bodies, including the Oregon Health Policy Commission, the Health Resources Commission, the Health Services Commission, the Advisory Committee on Physician Credentialing and the Medicaid Advisory Committee. In addition, the Office coordinates the work of the Oregon Health Research and Evaluation Collaborative. For more information about OHPR, visit http://www.oregon.gov/DAS/OHPR or contact the office at (503) 373-1779.

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CHAPTER 1
BACKGROUND

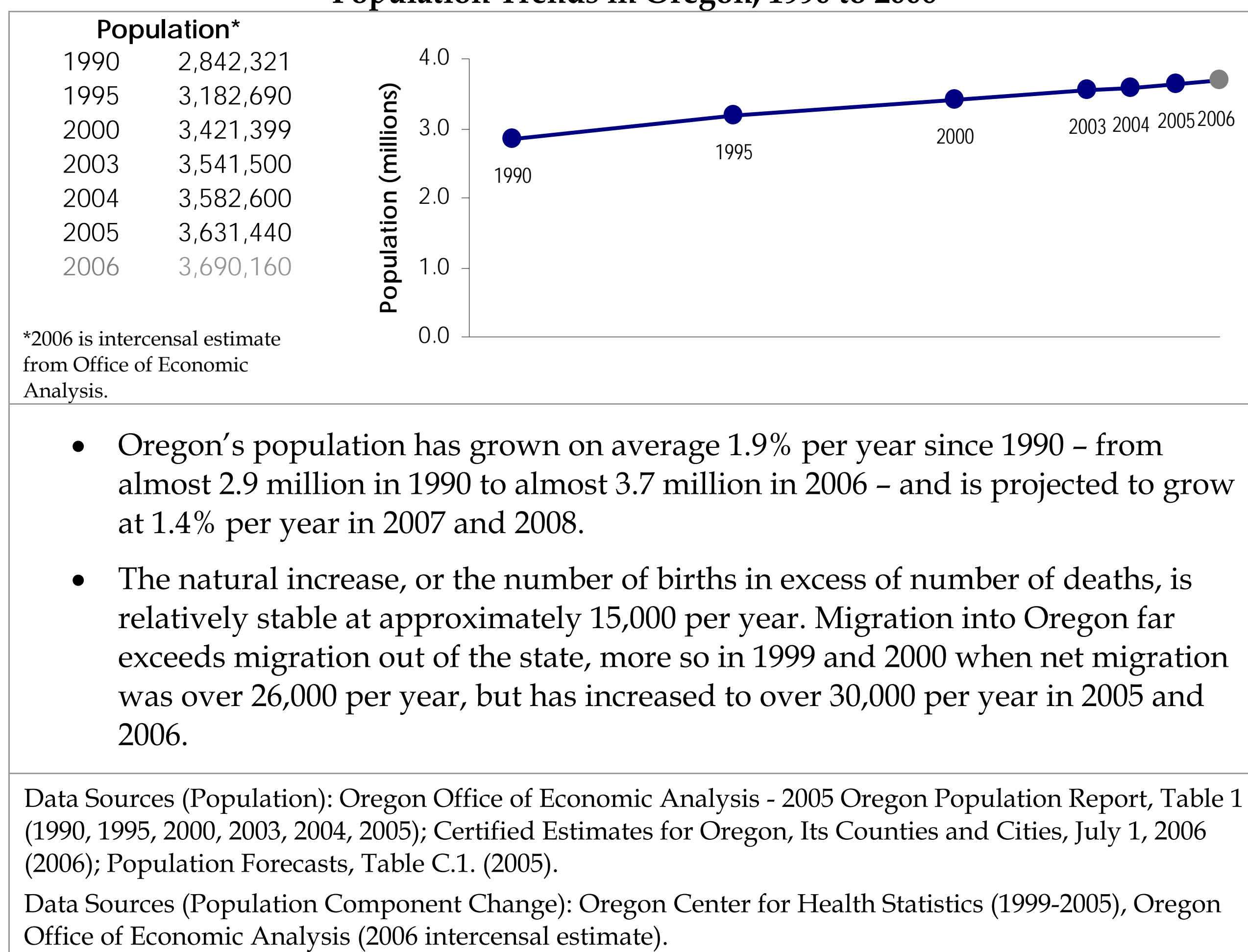
In this chapter:

- Oregon Population Trends and Demographics
- Healthcare Spending
- Healthcare Affordability
- Drivers of Healthcare Costs

Oregon Population Trends and Demographics

One driver of changing healthcare needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, healthcare utilization and costs in the years to come. Following are a set of charts and tables that describe the changes in detail.

Population Trends in Oregon, 1990 to 2006



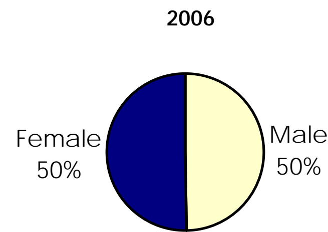
- Oregon's population has grown on average 1.9% per year since 1990 – from almost 2.9 million in 1990 to almost 3.7 million in 2006 – and is projected to grow at 1.4% per year in 2007 and 2008.
- The natural increase, or the number of births in excess of number of deaths, is relatively stable at approximately 15,000 per year. Migration into Oregon far exceeds migration out of the state, more so in 1999 and 2000 when net migration was over 26,000 per year, but has increased to over 30,000 per year in 2005 and 2006.

Data Sources (Population): Oregon Office of Economic Analysis - 2005 Oregon Population Report, Table 1 (1990, 1995, 2000, 2003, 2004, 2005); Certified Estimates for Oregon, Its Counties and Cities, July 1, 2006 (2006); Population Forecasts, Table C.1. (2005).

Data Sources (Population Component Change): Oregon Center for Health Statistics (1999-2005), Oregon Office of Economic Analysis (2006 intercensal estimate).

Gender in Oregon, 2006 and 2013 projection

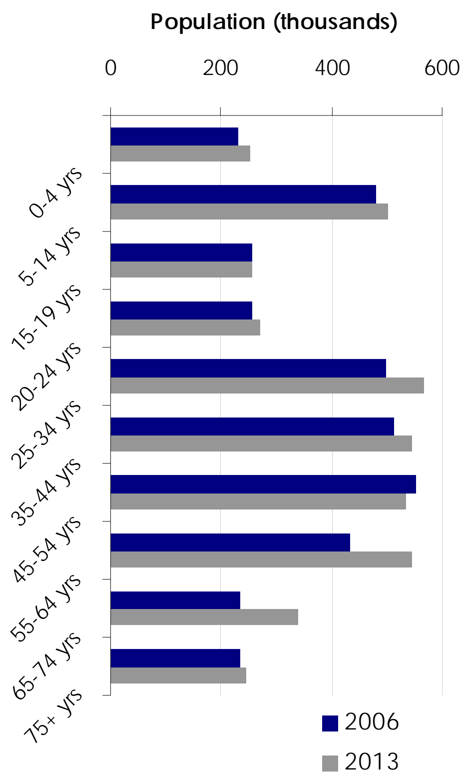
	2006	2013	% Change
Male	1,839,769	2,035,565	10.6%
Female	1,850,391	2,025,633	9.5%



- The ratio of males to females in Oregon is projected to remain stable at about 50:50. Growth in the number of men is expected to slightly outpace that of women.

Data Sources: Oregon Office of Economic Analysis, Population Forecasts by Age and Sex, Table C.2.

Age Distribution in Oregon, 2006 and 2013

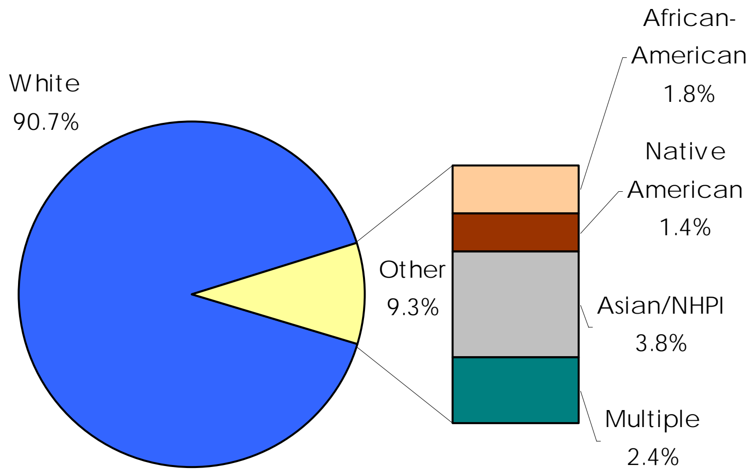


	2006	2013	% Change
0-4 yrs	230,056	251,630	9.4%
5-14 yrs	480,232	502,156	4.6%
15-19 yrs	255,636	256,777	0.4%
20-24 yrs	256,248	272,655	6.4%
25-34 yrs	499,284	567,361	13.6%
35-44 yrs	513,847	544,473	6.0%
45-54 yrs	551,654	533,374	-3.3%
55-64 yrs	433,473	545,369	25.8%
65-74 yrs	235,430	340,575	44.7%
75+ yrs	234,300	246,828	5.3%

- Consistent with national trends, Oregon's population is aging. The fastest growing age groups are 55-64 and 65-74 years, projected to grow in size by 26% and 45%, respectively, by 2013.

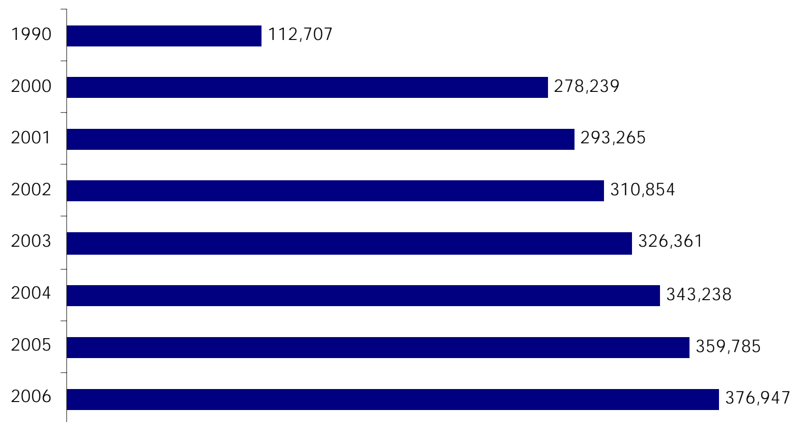
Data Sources: Oregon Office of Economic Analysis, Population Forecasts, Components of Change, Table C.2.

Race* and Ethnicity, 2006



	2006	2010	% Change
White	3,345,215	3,253,348	-2.7%
African- American	66,936	70,758	5.7%
Native American	50,497	53,439	5.8%
Asian/NHPI**	139,898	147,170	5.2%
Multiple	87,615	--	--

Oregon's Growing Hispanic Population



- Oregon's population includes 90.7% Caucasian and 9.4% racial minorities.
- Oregon is becoming more diverse, and its minority population is growing, especially among younger ages.
- The number of Native Americans is projected to grow by 5.8% by 2010, African-Americans by 5.7% and Asian/Pacific Islanders by 5.2%.
- In some rural counties, an aging white, non-Hispanic population is shrinking and the minority population is growing, especially Hispanic populations.
- The Hispanic population currently makes up 10.2% of Oregon's population and is forecast to continue growing.

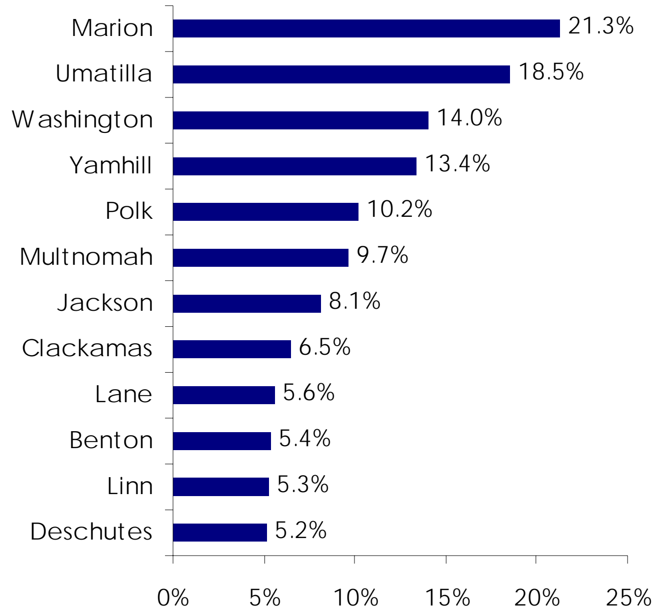
*Race categories are independent of Hispanic ethnicity.

**NHPI = Native Hawaiian and Other Pacific Islander.

Data Sources: Population Division, U.S. Census (2006), Oregon Office of Economic Analysis (2010 projections).

Hispanics in Specified Oregon Counties, 2005

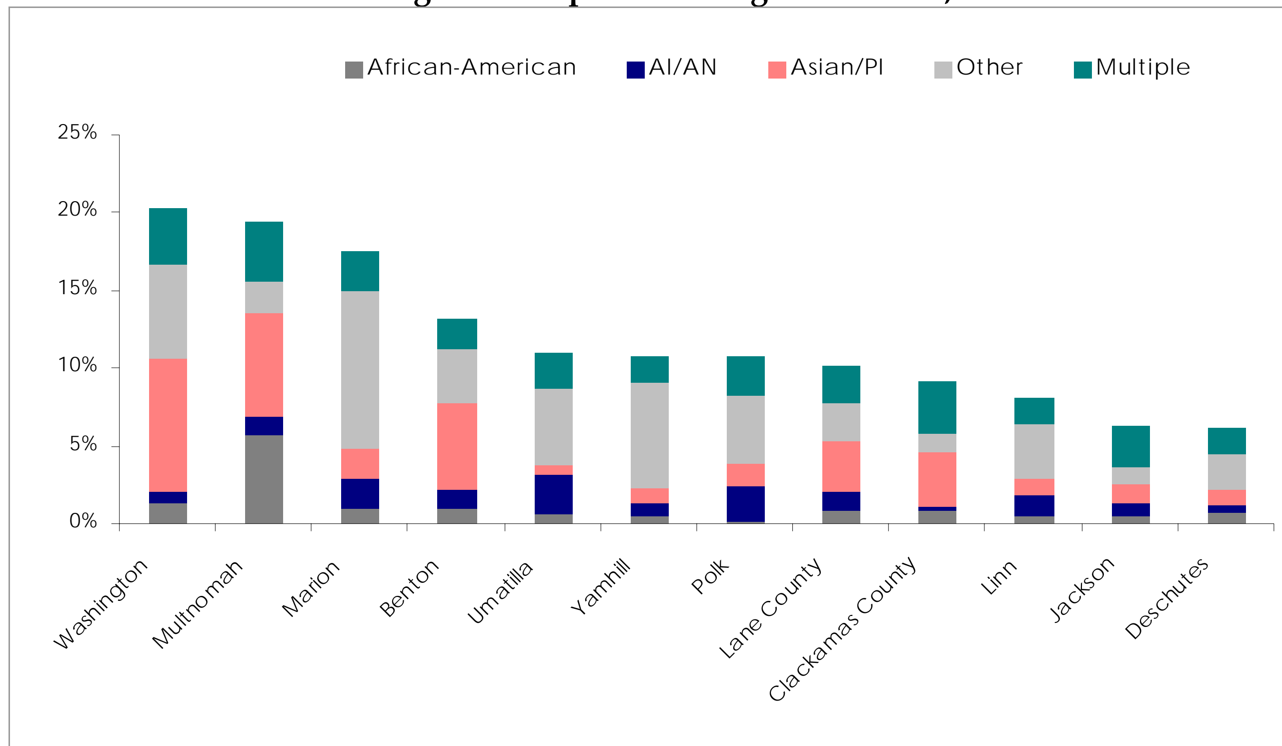
- While the statewide population is largely non-Hispanic white, there are large Hispanic populations in some counties*, including Marion, Umatilla, and Washington counties.



*Counties displayed were limited to those with sufficient sample size.

Data Source: American Community Survey, 2005.

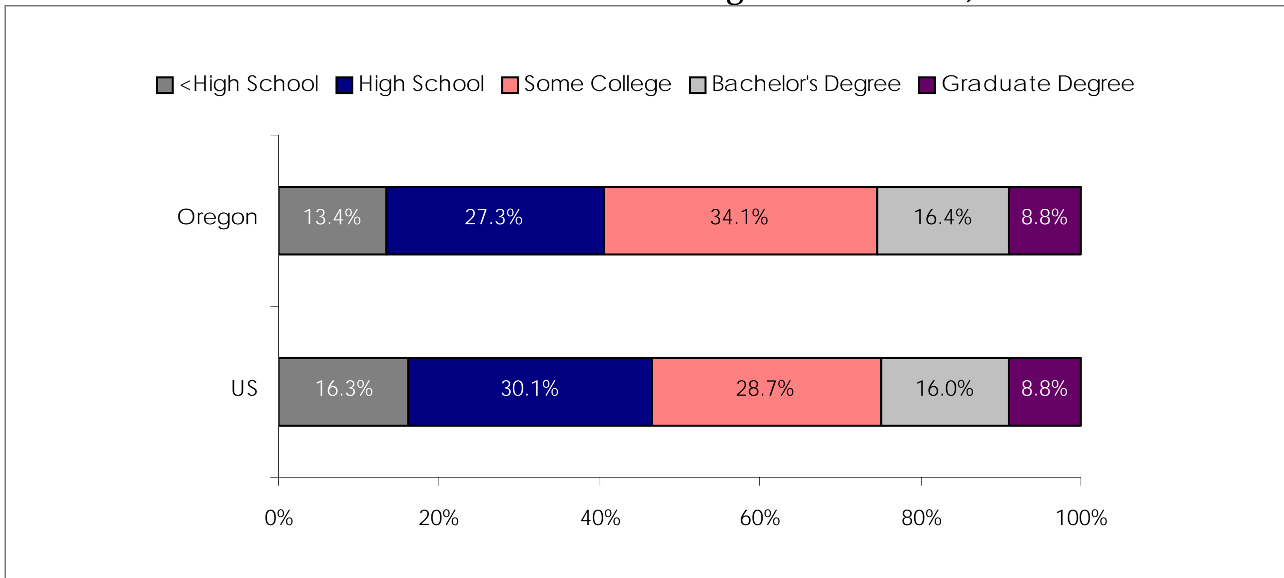
Race Categories in Specified Oregon Counties, 2005



- Washington County has the most diverse population, with 20% racial and/or ethnic minorities.

Data Source: American Community Survey 2005.

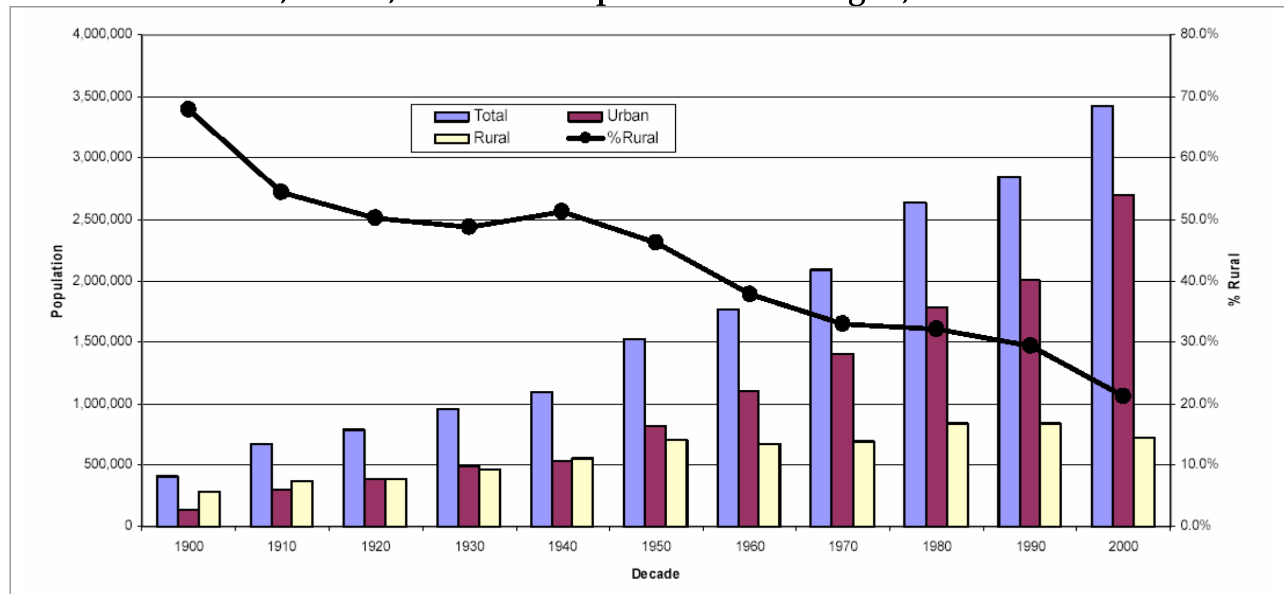
Educational Achievement in Oregon and the U.S., 2005



- In 2005, 27.3% of Oregonians had only a high school diploma or equivalent, 16.4% had a Bachelor's degree, and 8.8% had a graduate degree. Over 59% had attended at least some college.

Data Source: American Community Survey 2005.

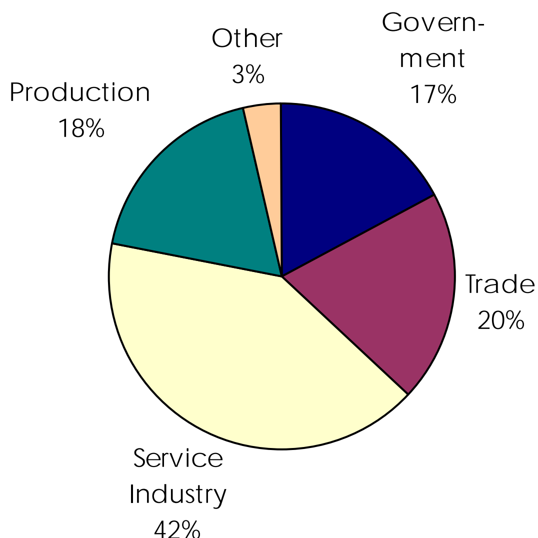
Total, Urban, and Rural Populations for Oregon, 1900 to 2000



- Urban/rural populations from 1900 to 2000 reflect the movement from rural to urban areas in Oregon over the last century.

Data Source: Population Research Center, Portland State University.

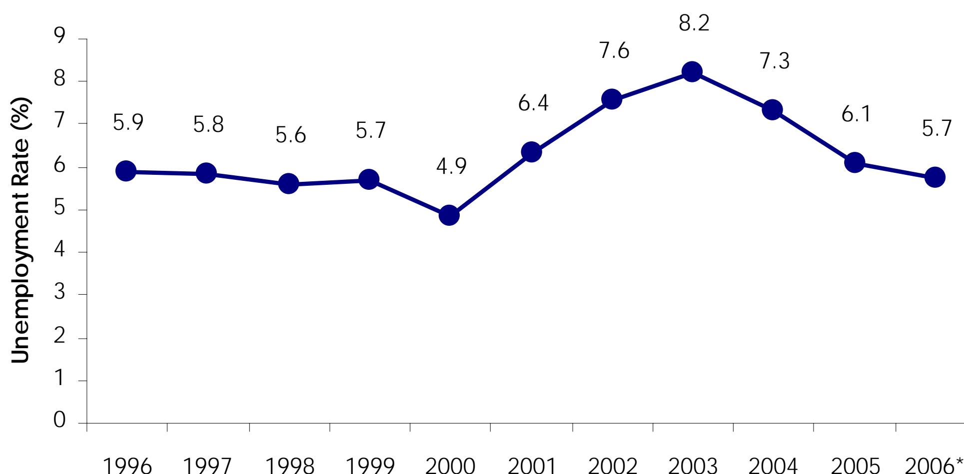
Employment Sectors in Oregon, 2005



- In 2005, the service industry was the largest employment sector, providing 42% of employment in Oregon.
- Trade provided 20%, production 18%, government 17%, and other employment sectors 3%.

Data Source: Oregon Economic and Community Development Department.

Unemployment in Oregon, 1996-2006



*Unemployment for Jan-Sep 2006.

- After increasing 4.9% from 2000 to 8.2 in 2003, the unemployment rate has since decreased to 5.7 in 2006.

Data Source: U.S. Department of Labor, Bureau of Labor Statistics, seasonally adjusted.

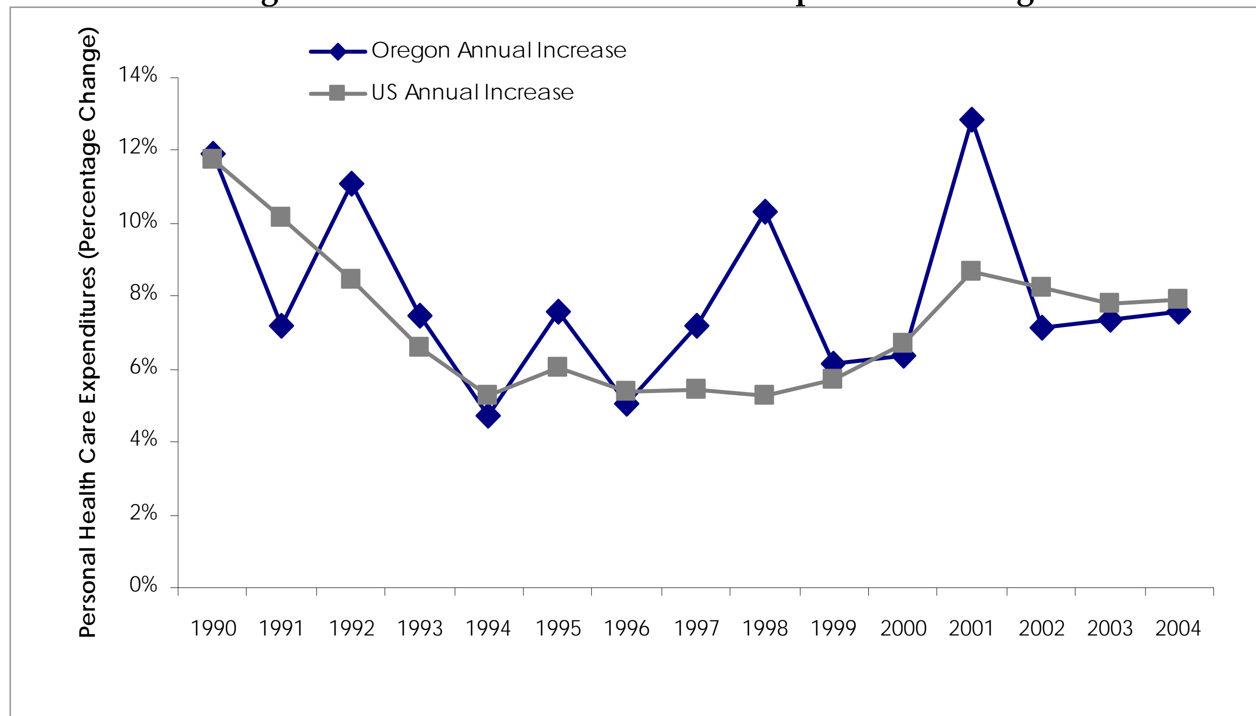
Healthcare Spending

Healthcare costs are the single largest component of the U.S. economy, accounting for 16% of the U.S. gross domestic product (GDP), or $2.1 trillion in total U.S. spending on healthcare in 2006. The National Health Statistics Group within the Centers for Medicare and Medicaid Services (CMS) projects that healthcare spending will grow an average 6.9% annually, reaching $4.1 trillion by 2016. Further, the growth in healthcare spending is expected to outstrip the growth in the GDP by 2.1 percent per year, "resulting in a health share of the GDP that reaches 19.6% by 2016." [1]

This report looks at healthcare costs in three distinct ways: the first examines personal healthcare spending in the state, the second looks at state healthcare spending by payer source, and the last examines healthcare spending as part of the state budget.

Personal Healthcare Expenditures include spending for all public and privately-funded healthcare services, including premium payments and other out-of-pocket spending for services such as hospitals, physician services, nursing services, and prescription drugs.

Percent Change in Annual Personal Healthcare Expenditures Oregon and U.S.

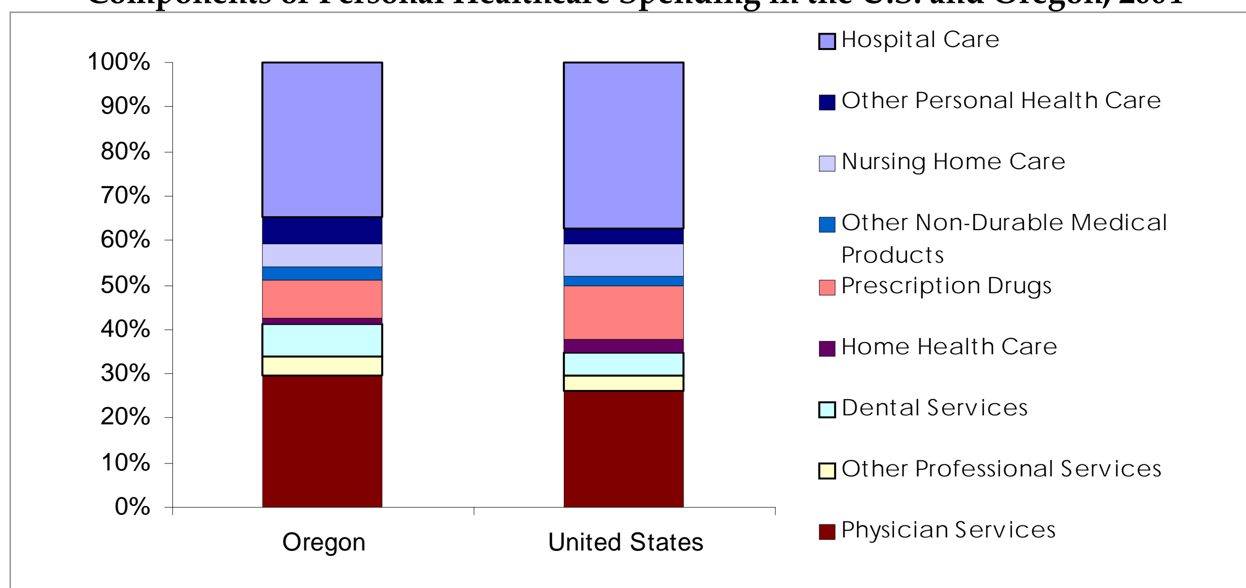


Source: Centers for Medicare and Medicaid Services, Office of the Actuary, 2006.

[1] Poisal JA, Truffer C, Smith S, Sisko A, Cowan C, Keehan S, Dickensheets B, "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact", Health Affairs, Vol 26, no. 2, w242-w253.

The components of Oregonians' personal healthcare spending in 2004 were as follows:

Components of Personal Healthcare Spending in the U.S. and Oregon, 2004



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2006.

Components of Personal Healthcare Spending in the U.S. and Oregon, 2004

- Oregon mirrors the U.S. in many of its healthcare spending components.
- The highest components of personal healthcare spending for both the U.S. and Oregon during 2004 were hospital care and physician services (62% and 64% respectively).
- Prescription drugs were 12% of health spending nationally and 8.5% in Oregon.

	Oregon	US
Hospital Care	34.3%	36.6%
Physician Services	29.3%	25.6%
Other Professional Services	4.1%	3.4%
Dental Services	7.3%	5.2%
Home Health Care	1.1%	2.8%
Prescription Drugs	8.5%	12.1%
Other Non-Durable Medical Prod	1.6%	1.5%
Nursing Home Care	5.2%	7.4%
Other Personal Health Care	5.6%	3.4%

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2006.

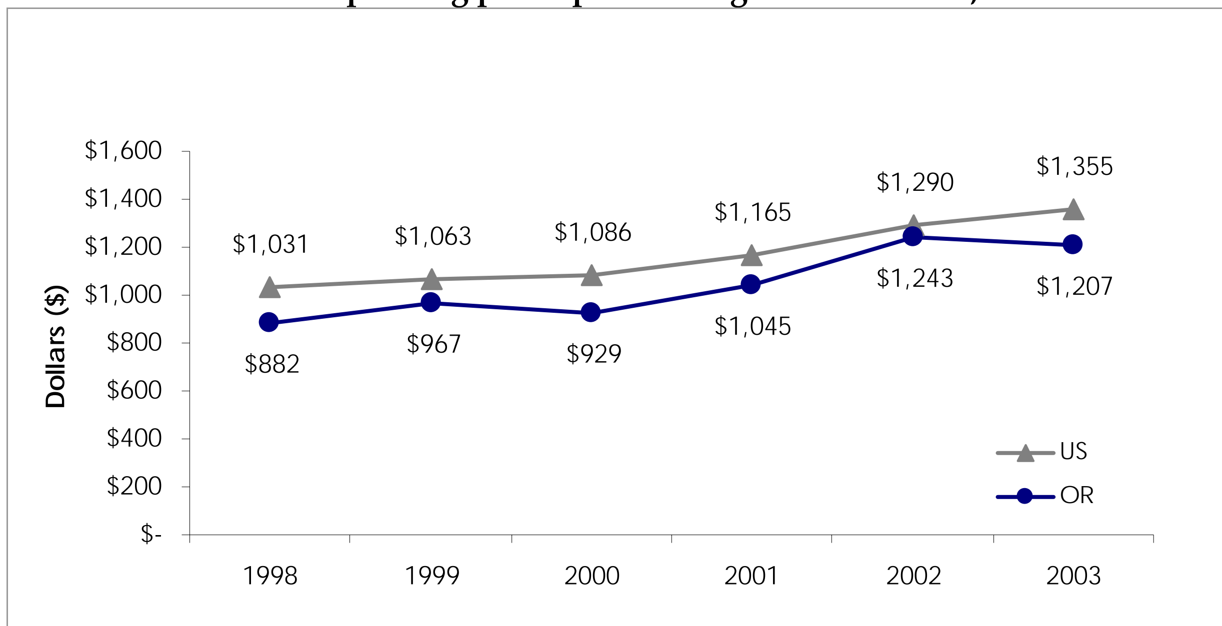
Hospital care growth has averaged 8.2% since 2000. Physician services grew by 9.0% in 2004, up from 8.5% in 2003.

Growth in prescription drug has slowed in recent years; it is estimated at 6.5% in 2006, down from 8.2% in 2004. However, the growth in prescription drug spending is projected to increase to 7.5% in 2007 and then to an average of 8.6% through 2016. This

projection is driven by a leveling out of generic prescription rates and an expected approval of new drugs for cancer and other conditions. [2]

Healthcare Expenditures in the State Budget. Combined state spending for healthcare, including Medicaid, public employees' health benefits, corrections health, university health services, and public health account for more than 20% of Oregon's state general fund budget.[3] On a per capita basis, Oregon state budget expenditures have increased 55% overall from 1998 to 2003, compared to 48% nationally.

State Healthcare Spending per Capita in Oregon and the U.S., 1998 to 2003



Source: Milbank Memorial Fund Report, 2002-2003 State Healthcare Expenditure Report (2005) adjusted to 2007 dollars by the U.S. Department of Labor, Bureau of Labor Statistics Consumer Price Index. Includes combined state spending for Medicaid, public employees' health benefits, corrections health, university health services, and public health services.

Oregon Healthcare Spending by Purchaser. Another important way to look at healthcare expenditures is to examine payer sources. This report focuses on four main categories of healthcare payers in the state: Medicare, Medicaid, Employer-Sponsored Insurance and Individual Market Insurance, which can be estimated in Oregon for 2006 using a variety of published and unpublished sources.[4] Further, spending is projected to 2008 by applying a 7% annual medical inflation factor. These estimates do not include any public or private spending for long term care. The following tables show total healthcare spending (excluding long-term care) in the state for all payers—public, private, and individual--is estimated at $16.8 billion in 2006 and projected to be $19.3 billion in 2008.

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[2] Poisal, op.cit., w250..

[3] State of Oregon, Legislative Fiscal Office, "Budget Highlights: 2005-07 Legislatively Adopted Budget." (10/ 05).

[4] Estimates for this brief were developed for the Office for Oregon Health Policy and Research and the Oregon Health Policy Commission by John McConnell, PhD, a Research Assistant Professor in the Emergency Medicine Department at the Oregon Health and Sciences University (OHSU), Chris Allanach, Oregon Legislative Revenue Office (LRO), and Bill Kramer of Kramer Healthcare Consulting, Portland, OR.

Medicare: Healthcare spending estimates for Medicare are derived from data from the Centers for Medicare and Medicaid Services (CMS). It assumes 531,000 Oregon Medicare enrollees multiplied by Oregon's average Medicare program payments per beneficiary of $6,466 (2002 Oregon average of $4,933 inflated at 7%) or $3.4 billion total.[5]

Oregon Healthcare Spending 2006 Estimate and 2008 Projection (Four Main Spending Categories)		
	2006 *(Estimated)*	2008 *(Projected)*
Medicare:	$3.4 billion	$4.0 billion
Medicaid:	$1.9 billion	$2.2 billion
Employer-Sponsored Health Insurance:	$6.4 billion	$7.3 billion
Individual Market Health Insurance:	$0.5 billion	$0.6 billion
Total	*$12.2 billion*	*$14.1 billion*

Medicaid: Estimates for Medicaid are based on the Oregon Division of Medical Assistance Program (DMAP), "Fall 2006 Forecast for the 2007-2009 Biennium" and the actuarial analysis provided by PriceWaterhouseCoopers.[6] This estimate includes all eligibility categories of Oregon's Medicaid program.

Oregon Healthcare Spending 2006 Estimates and 2008 Projection Other Categories		
	2006 *(Estimated)*	2008 *(Projected)*
Household Out-of-pocket	$2.3 billion	$2.6 billion
Other Federal	$1.4 billion	$1.6 billion
Other State	$0.9 billion	$1.0 billion
Total "Other" Spending	*$4.6 billion*	*$5.2 billion*

Employer-Sponsored (ESI) and Individual Market Health Insurance: Estimates for employer-sponsored and individual market health insurance are derived from the 2006 U.S Census Current Population Survey (CPS). The estimates assume various levels of coverage and adult versus child rates in 2006 dollars (adjusted by 7% inflation for medical cost growth in 2008). Also included in the ESI estimate is cost-shifting resulting from hospital uncompensated care given to the uninsured or underinsured.

Other Healthcare Spending Categories: Healthcare spending for household out-of-pocket and other federal and state spending are estimated to add another $4.6 billion in 2006 and $5.2 billion in 2008. Household out-of-pocket spending is the amount of money which an enrollee or family is required to pay directly to a provider for a medical service. The Other Federal and State spending estimates include Veterans Affairs, CHAMPUS, TRICARE, and state and federal public health spending as well as corrections health and university health clinics.

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[5] Note: Using the national average calculation of payments per Medicare beneficiary rather than the Oregon average results in estimated Medicare spending of $4.4 billion in 2006 and $5.0 billion in 2008.

[6] PriceWaterhouseCoopers, Oregon Health Plan Demonstration, "Analysis of Federal Fiscal Years, 2006-2007, Average Costs", March 7, 2005.

Healthcare Affordability

Another important aspect of healthcare spending is affordability at the individual and household level. Oregon's health values surveys have shown that Oregonians value personal responsibility. They also believe that families should share in the cost of healthcare on a sliding scale according to their ability to pay.[7]

To better understand what families in Oregon can afford to contribute for healthcare, OHPR reviewed information about regional household expenses developed by the Economic Policy Institute (EPI).[8] The following tables exhibit the summary data from our review, with healthcare removed as a specific budget item.

Family Monthly Income Available to Contribute to Healthcare in Oregon, 2006

Monthly Expenses for a Family in Portland Metro Area with 2 Parents/2 Children, 2006

Monthly housing	$766
Monthly food	$627
Monthly child care	$913
Monthly transportation	$401
Monthly other necessities	$376
Monthly taxes	$444
Monthly total	$3,528
Annual total	$42,330

Monthly Expenses for a Family in Rural Oregon with 2 Parents/2 Children, 2006

Monthly housing	$629
Monthly food	$627
Monthly child care	$702
Monthly transportation	$449
Monthly other necessities	$340
Monthly taxes	$262
Monthly total	$3,009
Annual total	$36,108

Source: Economic Policy Institute "Basic family budget calculator" Accessed online <12.05.06> http://www.epi.org/content.cfm/datazone_fambud_budget.

[7] Oregon Health Decisions, Oregon Health Values Survey 2004, available at <http://www.oregonhealthdecisions.org/PDFs/HVS04_Report.pdf>.

[8] This discussion is based on the presentation given by Heidi Allen for OHREC to the Medicaid Advisory Committee on March 22, 2005. Primary Source: Economic Policy Institute (www.epinet.org) 2006 Family Budget Calculator(2004 dollars adjusted to 2006 with the consumer price index. Methodology available from "Family Budget Technical Documentation," (Allegretto & Fungard) and the United States Department of Health & Human Services 2006 HHS Poverty guidelines.

Budget Estimate Methodology. Approximating how much money families living in Oregon can afford to contribute to healthcare (through premiums, co-pays, and deductibles) means considering how many wage-earners are in the home, how many children are in the home, monthly income, and geographic area of residence (urban vs. rural). These factors frame the average family budget and are relevant in determining discretionary income.

After considering family composition, regional demographics, and income, the Economic Policy Institute used the following six major components to calculate a conservative estimate of average family expenses in Oregon:[9]

- Housing: based on the Department of Housing and Urban Development's fair market rents (FMR) representing apartment rent and utilities for "privately owned, decent, structurally safe, and sanitary rental housing of modest (non-luxury) nature with suitable amenities", calculated for rural and urban Oregon.
- Food: based on the Department of Agriculture's "Official USDA Food Plans: Cost of Food at Home at Four Levels" report, EPI used the "low-cost" plan which assumes a very basic diet with almost all food prepared at home.
- Transportation: includes cost-per-mile rate determined by the Internal Revenue Service (cost of gas, insurance, registration fees, maintenance and depreciation) which assumes only non-social trips (work, school, church, and errands for the first adult and only work trips for the second adult).
- Child Care: based on child care centers and varies by urban vs. rural. Budget assumes a 4 year-old in one-child families, one 4 year-old and one school-age child in two-child families and a 4 year-old and two school-age children in three-child families.
- Taxes: includes federal personal income tax, federal Social Security and Medicare payroll taxes, state income taxes, as well as local income or wage taxes. Budgets assume all families are renters, all income is from work and all tax advantages are taken.
- Other Necessities: includes clothing, personal care expenses, household supplies, reading materials, and school supplies (estimated at 27% of housing and food costs).[10]

A presentation with budget and discretionary income models for a variety of Oregon urban and rural family compositions is available at the Office for Oregon Health Policy and Research website: www.oregon.gov/DAS/OHPR/index.shtml.

[9] Budget estimates do not include debt, or higher than normal interest rates that might affect families with less than perfect credit. Estimates are conservative (particularly regarding child care, housing and food). For example, housing estimates assume that families do not own a home and are renting a two bedroom apartment. Additionally, budgets do not include savings or catastrophic expenses.

[10] Based on data from the Consumer Expenditure Survey (*http://www.bls.gov/cex*)

Drivers of Healthcare Costs

National health spending has doubled its share of gross domestic product (GDP) in the past twenty-five years. [11] Absent some fundamental change, this trend may result in a doubling again in the next twenty-five years, seriously straining federal and state public finances.[12] The rising cost of healthcare is increasingly placing private insurance out of reach for employees provided by their employer and slowing wage growth for those who are covered.[13]

Healthcare cost trends are influenced not only by the allocation of health dollars into various products and services, but also by the growth (or decline) in each cost category. As noted previously, hospital care, physician services and prescription drugs account for almost three-quarters of total healthcare dollars. But what is driving the rise in cost in these areas over time? Research has shown that if healthcare costs rise at a significantly faster rate than incomes, more people will become uninsured.[14]

Outlined below are the main drivers in the costs of healthcare services. [15]

Innovation in Medical Technology

- New medical technology and its enthusiastic acceptance into mainstream medical practice are thought to be the most important long-term driver of healthcare costs, accounting for 50% of the growth by some estimates. This includes new drug therapies, innovations in diagnostic imaging and treatments as well as new non-invasive surgical techniques.[16]

  Even if technology improves health on average, there are concerns that technology is not always used in an optimal fashion. In some cases, innovations are not used soon enough. In other cases, innovations with minimal benefit are overused. Moreover, there is no clear accountability or leadership for managing the current process of medical innovation.[17]

- While it is true that increased use of established technologies (for example, magnetic resonance imaging) may contribute more to cost increases than new technologies, "...research has shown that, on balance, changing technology in medicine results in

[11] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group," National Health Expenditures: Historical and Projection, 1965-2015," (2005).
[12] Ibid.
[13] Chernew et al., "Competition, Markets, and Insurance; Increasing Health Insurance Costs and the Decline in Insurance Coverage," Health Services Research, 40; 4 (August, 2005); Baicker K, "Improving Incentives in Healthcare Spending; Properly Designed Health Spending Can Be A Major Step," Business Economics (April, 2006).
[14] Kronick, R and Gilmer, T, "Explaining the Decline in Health Insurance Coverage, 1979-1995," Health Affairs, Vol. 18, No. 2 (March/April 1999).
[15] This section is based on a presentation by John McConnell (OHSU Center for Policy Research in Emergency Medicine) to the Oregon Senate Health Policy Commission on April 14, 2006.
[16] Nichols LM. "Can defined contribution health insurance reduce cost growth?" Employee Benefit Research Institute, Issue Brief No. 246 (June, 2002), Goldman et al., "Consequences of Health Trends and Medical Innovation for the Future Elderly," Health Affairs Web Exclusive 24(2):W5R5-17(September, 2005); Bodenheimer T, "High and rising healthcare costs. Part 2: Technologic Innovation," Annals of Internal Medicine, 142(11): 932-37 (June 7, 2005).
[17] Galvin R, "Technology, Productivity and Healthcare Costs," AcademyHealth, 2006 National Health Policy Conference http://www.academyhealth.org/nhpc/2006/index.htm.

increased spending and accounts for one-half to two-thirds of the increase in healthcare spending in excess of general inflation."[18]

- There are some indications that drug prices are high and opportunistic in some cases, yet as noted earlier in "components of healthcare spending", pharmaceuticals only account for 11% of total healthcare expenditures. The introduction of Medicare Part D drug coverage in 2006 produced a significant shift in spending across payers but aggregate spending growth remains about the same.[19]

Rise in Medical Treatment

A recent analysis points to increases in modifiable risk factors, such as obesity and stress, and changes in clinical thresholds for treatment as key contributors to rising healthcare costs.[20]

- Increasingly, conditions such as diabetes, high blood pressure, and high cholesterol are treated before they become symptomatic. Intervening before symptoms emerge reduces the severity of disease, but it also means that millions more Americans are targeted for treatment.[21]
- Scientists with the Centers for Disease Control (CDC) estimate that unhealthy behaviors account for about 50% of all deaths in the U.S. Their analysis showed that tobacco use remained the leading cause of death (18.1%), with poor diet and physical inactivity a close second at 16.6%.[22]
- Much of the growth in healthcare spending over the past twenty years can be linked to modifiable population risk factors such as obesity and stress. Health behaviors such as over eating, lack of exercise, smoking, and stress accounts for approximately 40-50% of morbidity and mortality.[23]
- Disease management programs are designed to provide earlier clinical intervention for patients with chronic conditions. Although savings from such programs have been difficult to demonstrate, targeting individuals in the top 10% of healthcare spenders has resulted in effective management of congestive heart failure, asthma, and diabetes nationally and in Oregon.[24] [25]

[18] Ginsburg PB, "Controlling Healthcare Costs", New England Journal of Medicine, Vol 351: 1591-1593, No. 16, Oct. 14, 2004.
[19] Borger et al., "Health spending projections through 2015: changes on the horizon," Health Affairs Web Exclusive, 25(2): 61-73, (March/April 2006).
[20] Thorpe K, "The Rise in Healthcare Spending and What To Do About It," Health Affairs, 24(6): 1436-45 (November/December 2005).
[21] Ibid.
[22] Mokdad AH, Marks JS, Stroup DF, Gerberding JS, "Actual Causes of Death in the United States, 2000." JAMA, March 10, 2004, Vol 291, No. 10 p. 1238-1245.)
[23] Ibid.
[24] Bodenheimer T and Fernandez A, "High and Rising Healthcare Costs. Part 4: Can Costs Be Controlled While Preserving Quality?" Annuals of Internal Medicine, 143 (1):26-31 (July 5, 2005).
[25] Hershberger et al. "Prospective evaluation of an outpatient heart failure disease management program designed for primary care: the Oregon model." Journal of Cardiac Failure, 11(4):293-8 (May 11, 2005).

Waste and Inefficiency

- In 2003, the U.S. had fewer practicing physicians, nurses and acute care bed days per capita than half of the world's industrialized nations, but spends two and a half times as much on a per capita basis. [26] Less than one-fifth of U.S. physicians reported routine use of electronic health records (EHRs), compared with 60-90% in leading industrialized countries in 2003.[27] Many believe that broad adoption of EHR will lead to major healthcare savings, reduce medical errors, and improve health services.[28] A recent survey of healthcare clinics in Oregon showed that 59% of the ambulatory physicians in Oregon have either implemented an EHR or are in the process of implementing an EHR.
- Regional variations in health spending among Medicare patients around the U.S. have found that increased spending did not have better outcomes or satisfaction with care received.[29] Based on these variations, it is also estimated that 20% to 30% of health spending could be eliminated.[30]
- Public and private investment in initiatives such as the Medicaid Evidence-Based Decisions Project (MED) coordinated by the Center for Evidence-Based Policy at Oregon Health Science University provides ten states (including Oregon) with evidence-based medical services. This program allows states to resist vendors and advocates when they promote healthcare services that are not clearly demonstrated to be beneficial. The use of evidence in purchasing pharmaceuticals through the Practitioner-Managed Prescription Drug Plan (PMPDP), for example, saved Oregon $4 million in pharmaceutical spending for the Oregon Health Plan after implementation of physician "soft" prior authorization and education enforcement methods.[31]

Health Insurance

- Health insurance also plays a role in the rise of healthcare costs. Consumers do not usually know the cost or quality of health services. Furthermore, there is often little incentive for consumers to utilize care in a cost-effective manner.
- There are over 1,000 private insurance companies in the U.S. System fragmentation and administrative complexity have contributed to the increase in administrative costs as a share of overall healthcare costs (estimates from California in 2004 note that billing related administration was 20% of private health insurance spending)[32].

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[26] Reinhardt et al., "Healthcare Spending And Use Of Information Technology In OECD Countries," Health Affairs, 25(3): 819-31 (May/June, 2006).
[27] Ibid.
[28] Hillestad et al., "Can Electronic Medical Record Systems Transform Healthcare? Potential Health Benefits, Savings and Costs," Health Affairs 24(5):1103-1117 (September/October, 2005).
[29] Fisher et al., "The Implications of Regional Variations in Medicare Spending. Parts 2: Health Outcomes and Satisfaction with Care." Annals of Internal Medicine 138(4):288-98 (2003).
[30] Skinner et al., "The Efficiency of Medicare,"NBER Working Paper no. 8395 (Cambridge, Mass.: National Bureau of Economic Research, July 2001), available at <www.dartmouthatlas.org>.
[31] *Hartung et al., "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan." Health Affairs, 25(5):1423-32 (September/October 2006).*
[32] J.G. Kahn et al., "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," Health Affairs, 24(6); 2005.

- After the spread of managed care and the refinement of Medicare's DRG system in the early and mid 1990s, increases in annual healthcare spending in the U.S. slowed *(see previous section)*. From 1993 to 1998, the share of GDP devoted to health spending declined and premiums for employer-sponsored insurance grew slower than per capita GDP.
- During the mid-1990s consumer cost sharing fell as a share of health expenditures (16.3% in 1993 to 15% in 1997) while participation in managed care plans increased from 41% to 76% of the population. Since the decline of managed care, health insurance plans have developed products and options that allow employers to buy down their premiums through higher cost sharing. Proponents of increased cost-sharing believe that consumer awareness will lead to an increased demand for cost transparency and an emphasis on cost effectiveness that does not currently exist in our healthcare system.[33] Critics do not view consumer cost sharing as a panacea for controlling healthcare costs because the majority of healthcare costs are concentrated in a small group of individuals with very high expenditures. For example, 70% of the population account for only 3% of all expenditures. *(See Chapter 3 for more details on Consumer-Driven Healthcare.)*

Medical Errors and Medical Liability

- There is increasing agreement that patient safety and medical liability are linked and that patient safety should be at the center of the medical liability debate. In 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published a white paper on strategies for reducing medical liability and improving patient safety. To improve both patient safety and the medical liability climate and ultimately reduce medical malpractice liability insurance premiums, JCAHO recommends the following:[34]
  - promote patient safety, reducing the rates of preventable patient injuries
  - promote open communication between patients and practitioners
  - create an injury compensation system that is patient-centered (e.g., early offer mediation, no-fault liability, enterprise liability that shifts liability from the individual provider to provider organizations)
- In the late 1980s, the American Society of Anesthesiologists launched a project to analyze all historical claims brought against its members and to develop new approaches to reduce medical error. By 2002, the specialty had one of the highest safety ratings in the profession, and its average insurance premium plummeted to its 1985 level, bucking nationwide trends.[35]

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[33] Wilensky G, "Consumer-Driven Health Plans: Early Evidence And Potential Impact on Hospitals," Health Affairs 25(1):175-85 (January/February 2006).
[34] Joint Commission on Accreditation of Healthcare Organizations (JCAHO), "Healthcare at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury," 2005.
[35] *E.C. Pierce, Jr., Anesthesia: Standards of Care and Liability, JAMA 262(6):773 (1989); and Stephen C. Schoenbaum and Randall R. Bovbjerg, Malpractice Reform Must Include Steps to Prevent Medical Injury, 140:51-53 Annals of Internal Medicine (2004).*

- Similarly, feeling embattled by a high rate of malpractice claims, the University of Michigan Medical System in 2002 analyzed all adverse claims and used the data to restructure procedures to guard against error. They also developed a robust medical error disclosure program. Since instituting the program, the number of suits has dropped by half, and the university's annual spending on malpractice litigation is down two-thirds.
- The costs of malpractice litigation (including legal fees, insurance costs, and payouts) nationally consist of 0.5% of total national health-care spending.[36]
- Another study examined the effects of the recent increases in malpractice insurance premiums on the delivery of healthcare services and the impacts of state tort reforms. Reviewing existing studies, the report concluded that the deteriorating liability environment has had only a modest effect on the supply of physician services. "The best evidence shows, at most, a small overall decrease in the number of physicians practicing in high-liability states compared to lower-risk states, though some rural areas have been more affected." Aside from caps on non-economic damages, most tort reforms adopted by states in response to malpractice crises have not been effective in boosting physician supply or reducing insurance or litigation costs. Damages caps "help constrain growth in litigation costs and insurance premiums over time, but disproportionately burden the most severely injured patients."[37]

[36] Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," New England Journal of Medicine, 354(19):2024-33 (May 11, 2006).
[37] Mello et al., "Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms," Robert Wood Johnson Foundation, Research Synthesis Report No. 10 (May, 2006).

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CHAPTER 2
HEALTH INSURANCE COVERAGE: THE OREGON HEALTH PLAN

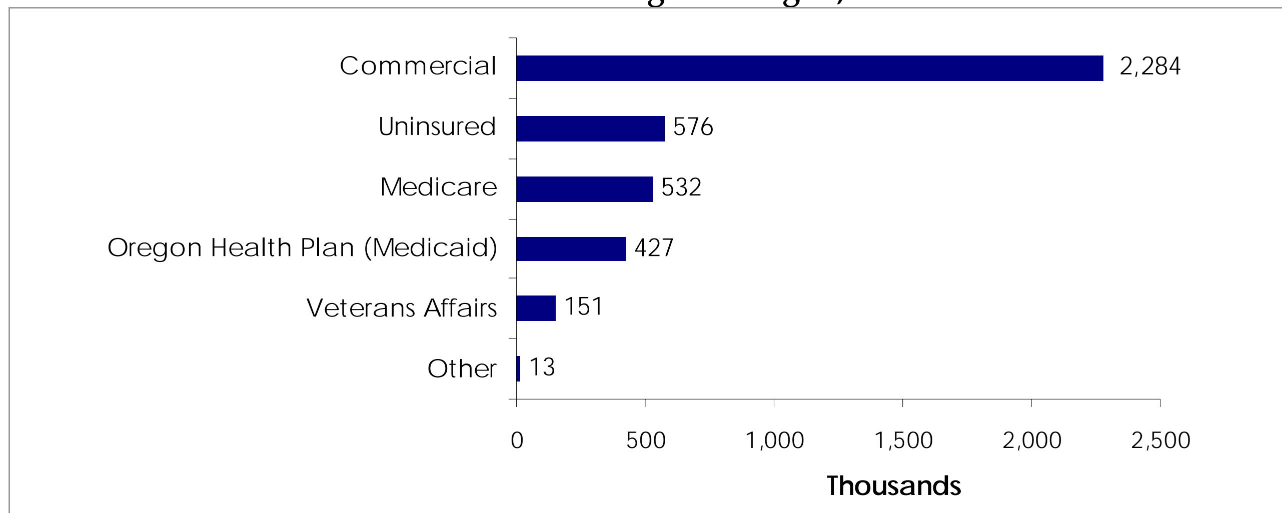
In this chapter:

- Overview: Medicaid
- Medicaid Expenditures
- Impact of OHP2 Policy Changes
- Public-Private Partnership: Family Health Insurance Assistance Program (FHIAP)
- Long-Term Care

Overview

Employers are still the primary source for health insurance in the U.S., 59.5% of all Americans were covered by health insurance provided by their employer in 2005.[38] However, government is a major provider of health insurance, both as an employer and through Medicaid and Medicare.

Healthcare Coverage in Oregon, 2006



- By far the most common source of healthcare coverage is employer-sponsored or commercial insurance.
- An estimated 576,000 Oregonians are uninsured.
- Approximately 910,000 Oregonians have Medicare, Medicaid, or both.
- Will not sum to total population because individuals may have multiple sources of coverage.

Data Sources: Medicare - CMS, 2005; Medicaid – DSSURS/DMAP; Duals – DMAP; Uninsured, Commercial, Veterans Affairs – 2006 Oregon Population Survey (OPS); Other (Railroad Retirement, COBRA and Prison Population) – 2006 OPS and Department of Corrections (DOC).

[38] DeNavas-Walt D, Proctor B, Lee CH, U.S. Census Bureau, Current Population Reports, P60-231, "Income, Poverty and Health Insurance Coverage in the United States, 2005, U.S. Government Printing Office, Washington DC, 2006.

Overview: Medicaid

Medicaid provides health and long-term care services to low-income populations through a financing structure shared by the federal and state government. Nationally, Medicaid is a source of health insurance for 38.1 million low-income children and parents, and a critical source of acute and long-term care coverage for 14 million elderly and disabled individuals, including more than six million low-income Medicare beneficiaries.[39] In addition, the State Children's Health Insurance Program (SCHIP), adopted in 1997, provides capped federal funds to states expanding coverage to children who are not eligible under Medicaid.

Medicaid is also a major engine in state economies, supporting millions of jobs across the country. Its guarantee of federal financing that matches state spending enables states to respond to losses of private health insurance attributable to unemployment, rising health insurance premiums, increases in healthcare costs, emergencies and disasters, and an aging society.

Oregon's Medicaid program, the Oregon Health Plan, is a first-in-the-nation system that provides basic healthcare coverage for more Oregonians by explicitly prioritizing covered health services. The Prioritized List of Health Services ranks services with a high likelihood of success, or a high likelihood of a death or disability outcome if not provided, under a set of "diagnosis-treatment" pairs on a ranked list of 745 conditions.

Recent federal budget cuts in both entitlement and discretionary programs have resulted in significant challenges for Oregon. In addition, the Deficit Reduction Act of 2005 (DRA), which was primarily aimed at reducing federal Medicaid spending, has a significant impact on the state's provision of health services, even while granting the state greater flexibility in designing public programs. *[See Key Medicaid Provisions of the Deficit Reduction Act of 2005, Appendix A].* New rules and requirements around citizenship, targeted case management, provider taxes, transportation, third party resources, and rehabilitative services affect the Oregon Health Plan (OHP), the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP). The President's Federal Fiscal Year 2007 proposed budget also reflects the intent to further reduce funding to states for the federal share of social and medical programs.

Under both Medicaid and SCHIP, each state decides how to structure eligibility, benefits, service delivery and payment rates within guidelines established by federal law. In exchange for covering certain groups of individuals (referred to as "mandatory groups") and offering a minimum set of services (referred to as "mandatory benefits"), the federal government matches the state's Medicaid spending at an established rate called the Federal Medical Assistance Percentage (FMAP). Each state also receives federal matching payments to cover additional ("optional") groups of individuals and provide additional ("optional") services. This federal match allows states to maximize their capacity to meet the needs of their low-income population: Oregon's match rate is

[39] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance" May 2006.

61.07% for fiscal year (FY) 2007.[40] There is a slightly higher match rate for the SCHIP program, where every state dollar is matched at 72.75% for FY 2007.[41]

Economic Impact of Medicaid. With federal matching dollars, for every $1 that Oregon invests in Medicaid, the federal government matches it with approximately $1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state. These dollars trigger successive rounds of earning and purchases as they continue to circulate through the economy. For example, healthcare employees spend their salaries on cars, appliances and other non-health related goods and services. This ripple effect is called an economic "multiplier effect." The estimated economic multiplier effect in Oregon is that every $1 million in state Medicaid expenses accounts for $3.14 million in business activity, 30 jobs, and $1.15 million in wages.[42]

However, state budget crises, a growing and aging population, inflation, increased utilization of health services and increased use of new technology have all contributed to increased fiscal pressure within Medicaid programs nationally. For Oregon, the downturn in the State's economy starting in the late 1990s led to high unemployment and the paradoxical increased demand for publicly financed healthcare at a time when the state budget was least able to sustain services at previous levels.

The Oregon Health Plan. In 1987, Oregon initiated its healthcare reform efforts, collectively referred to as the Oregon Health Plan (OHP), in an attempt to reduce the number of uninsured Oregonians, strengthen its economy, and improve the health status of its citizens. At that time 18% of Oregon's 2.85 million population was uninsured, and the unemployment rate was 5.7%. In addition, the cost of healthcare was consuming an ever-growing portion of public and private sector budgets. The goal of the OHP was universal access to an adequate level of high quality healthcare at an affordable cost.

The major components of the original Oregon Health Plan were:

- Medicaid reform
- Insurance for small business
- High risk medical insurance pool
- Employer mandate for health insurance

Medicaid Reform. The Oregon Health Plan (OHP) has been an innovative example of Medicaid reform, with a basic benefit package that expanded public coverage to the federal poverty level (FPL)[43] for families and adults, built upon a managed care delivery system with prioritization of health services and integration of mental, physical, and dental healthcare services. The OHP sought to lower costs by reducing cost shifts with expanding coverage, emphasizing managed care, preventive care, early intervention,

[40] Federal Register, November 30, 2005 (Volume 70, Number 229), pp. 71856-71857, at http://aspe.os.dhhs.gov/health/fmap07.htm.
[41] Ibid.
[42] Rachel Klein, Kathleen Stoll, and Adele Bruce, Medicaid: Good Medicine for State Economies, 2004 Update (Washington: Families USA, May 2004).
[43] For 2006 Federal Poverty Guidelines, see Appendix B .

and primary care, and not covering ineffective care. As of February 2007, the OHP covers:

- Low-income adults beyond the mandatory groups up to 100% of the Federal Poverty Level (FPL) *(Currently closed to new enrollment)*
- Children (Under 19 years of age) up to 185% of FPL either through Medicaid or SCHIP funding
- Pregnant women up to 185% of FPL

Insurance for Small Business. As part of the Oregon Health Plan, the Office of Private Health Partnerships (OHHP) (formerly the Insurance Pool Governing Board) [44] was created to encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds. In 1997, Oregon's Legislative Assembly created the Family Health Insurance Assistance Program (FHIAP), which currently offers premium subsidies to assist Oregonians up to 185% FPL to gain access to coverage.

High-Risk Medical Insurance Pool. The 1987 Legislature created the Oregon Medical Insurance Pool (OMIP) to provide affordable health insurance to individuals denied individual coverage due to pre-existing medical conditions. (See later section for more details)

Employer Mandate. It was understood that even on full implementation of the OHP Medicaid expansion and OMIP high risk pool, more than 400,000 people would remain without health insurance coverage, most of them workers and their dependents. Part of the 1989 legislative package that created the OHP was an employer mandate that would have required all employers to offer full-time permanent workers and their dependents insurance via a "play or pay option," beginning in July 1995. The mandate defined a permanent full-time employee as one who is not seasonal or temporary and who works at least 17.5 hours per week.

Implementation of the mandate would have resulted in healthcare coverage for an estimated 165,000 additional Oregonians. However, the 1993 Legislature delayed implementation of the mandate from 1993 to March 31, 1997 for businesses employing 26 or more, and to January 1, 1998 for those with 25 or fewer employees. To implement the employer mandate would have required a Congressional exemption from the federal Employee Retirement Income Security Act (ERISA) by January 2, 1996, a deadline imposed by the legislature. When this exemption was not obtained by the deadline, the employer mandate was repealed January 2, 1996.[45]

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[44] *IPGB designed a basic, no-frills benefit package that was offered by small group insurance companies at a set price for both small employers and self-employed, exempt from some insurance mandates, and if the employer had not offered group health insurance benefits for two years. At its peak, over 20,000 employers purchased these IPGB-certified plans, enrolling more than 60,000 employees and their dependents. Later insurance reforms enacted by the Oregon Legislature during the 1990's decreased the need for these specialized plans, and there was a migration to plans in the regular market.*

[45] Oregon Department of Human Services, Division of Medical Assistance Programs "Oregon Health Plan: A Historical Overview" July, 2006.

Oregon's healthcare reform was in many ways extraordinarily successful; in the fifteen years since it was launched, the OHP has provided access to quality healthcare services for more than one million uninsured people and helped to decrease uninsurance in the state to as low as 10 percent in 1998, although was estimated at 15.6% in 2006.

Changes to OHP in 2003 and 2004. Facing the same kind of challenges it had in 1987, the highest unemployment rate in the nation and an unprecedented budget deficit, Oregon turned to cost sharing and benefit reduction in the Oregon Health Plan in 2003. Building on its 1115 waiver and using the flexibility provided by the Health Insurance Flexibility Act (HIFA) initiative, Oregon developed changes to the program in a waiver referred to as OHP2. These efforts separated the Medicaid program into two benefit packages—OHP Plus and OHP Standard. OHP2 waiver changes also resulted in including the State's premium subsidy program, the Family Health Insurance Assistance Program (FHIAP) under Medicaid so it could receive federal match for what had been previously funded with only state dollars.

The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves low-income seniors, people with disabilities, families meeting the eligibility criteria for Temporary Aid to Needy Families (TANF) and children and pregnant women. The OHP Standard benefit package, designed for Oregon's expansion population (who are adults, 19 to 64 years of age up to 100 percent of the FPL), implemented in February 2003 was leaner in benefits and implemented significant co-pays. Premiums were increased for those enrolled in OHP Standard and administrative rules were tightened, including a six-month lockout for nonpayment of premiums. *[See Timeline of OHP2 Changes, Appendix C].* These changes were derived from objectives developed through extensive community input and advisory groups. The objectives were to:

- Generate revenue to provide flexibility in designing the OHP Standard benefit package that would otherwise have a very limited coverage level.
- Instill in clients the value of healthcare and ongoing coverage by structuring the program to include costs for accessing certain services (co-payments) and for maintaining eligibility (premiums).
- Make OHP Standard similar to commercial plans as a transitional step to private health insurance.

The original policy goal of OHP2 was to expand coverage to 185% FPL for children, pregnant women, and adults through savings accrued by implementing the leaner OHP Standard benefit package, cost sharing and premiums. However, as the severity of Oregon's budget shortfall intensified, changes to OHP Standard were implemented and coverage was increased to 185% FPL for pregnant women and children, but not to other adults.

OHP 2 Waiver Changes, February 2003. The Oregon Legislature in February 2003 eliminated the optional Medicaid benefits of outpatient mental health and chemical dependency for the OHP Standard population. These benefits were reinstated in August 2004. Prescription drug coverage for OHP Standard was also eliminated but reinstated after two weeks following intense public pressure.

Elimination of Co-payments for OHP Standard. In early 2003, the Oregon Law Center filed a legal challenge to the OHP Standard premium and co-payment policies authorized by the Centers for Medicare and Medicaid Services (CMS). The litigation (Spry v. Thompson) found that OHP Standard co-payments violated federal law and, therefore, were eliminated effective June 19, 2004, according to the court order. While the court decision did not affect OHP premium policies, OHP Standard co-payments are no longer a consideration as a cost sharing mechanism for future OHP Standard program changes.

OHP Standard Status as of Fall, 2006. OHP Standard operates entirely without General Fund resources, using provider taxes from the hospitals and managed care organizations. The program now serves a reduced number of clients based on the availability of provider tax revenue, premium revenue, and federal matching funds.

Hospital Provider Tax[46]

- Implemented in July, 2004.
- Applies to income of all DRG hospitals in Oregon.
- Does not apply to Type A and B rural hospitals.
- Tax rate is currently set at 0.82% of net revenue.
- FFS inpatient hospital DRG rates have been raised to 100% of Medicare.
- Tax sunsets January 2, 2008.
- DHS has proposed (in a Policy Option Package) to extend this tax to January 2, 2010.

Managed Care Provider Tax

- Implemented in May, 2004.
- Applies to Oregon managed care organizations with Medicaid line of business.
- Tax rate is 5.8% of capitation payments.
- Administrative fee paid to Managed Care Organizations (MCO) has been raised from 8% to 13.34% of capitation payments.
- Tax sunsets January 2, 2008.
- Federal requirements will eliminate this tax because it is not "broad-based" (does not apply to managed care organizations without a Medicaid line of business).

[46] *Hospitals in Oregon are categorized into the following categories for the purposes of Medicaid reimbursement: Diagnostic Related Group (DRG), Type A (50 or fewer beds and greater than 30 miles from another acute inpatient care facility); and Type B (50 or fewer beds and 30 miles or less from another acute inpatient care facility).*

- States with an MCO-only tax in place when the new federal regulations took place are allowed to continue this tax until October 1, 2009.
- DHS has proposed (in a Policy Option Package) to extend this tax to October 1, 2009.

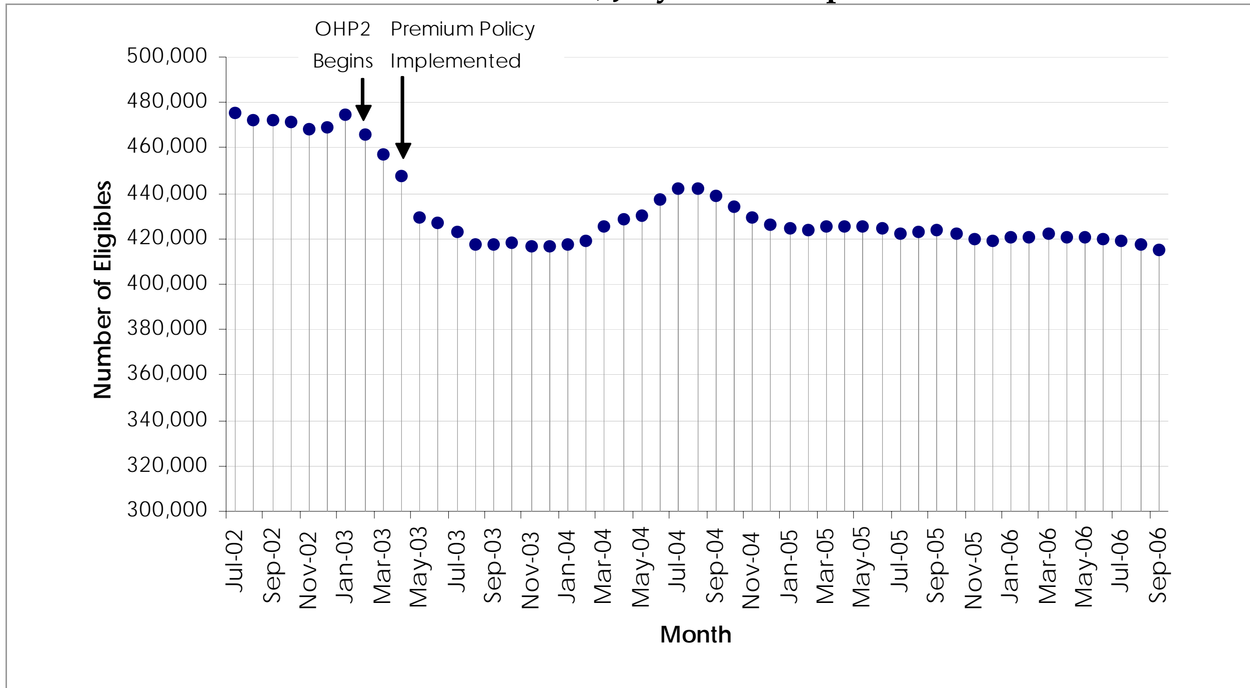
Other Changes

- As of July 2004, the OHP Standard program closed to new enrollment.
- Following concerns arising from impact studies, beginning June 1st, 2006 clients who had been certified eligible based on income at or below 10% of the FPL were exempt from paying premiums, and the exempt clients were no longer be billed premiums for the remaining months of their certification period. Clients with incomes above 10% of the FPL are not disqualified from coverage based on past-due premiums, but they are required to pay all past-due premiums in full as a condition of being found eligible at recertification. If a client recertifies at 10% or less of FPL, any existing premium arrears are waived.
- Limits were set on inpatient hospital coverage at DRG hospitals (those with 50 or more beds) starting September, 2006 to 18 days per person per year. This applies to persons age 21 and over who are enrolled in the OHP Plus and Standard benefit packages.
- OHP Standard also has a redefined benefit package effective August 2004 (as provided in HB 2511 from the 2003 legislative session). *For summary of OHP Standard benefit package, see next page.*

Service	OHP Standard Benefits (As of Fall 2006)
Premiums	• $6-$20 according to income level
Hospital Benefit (Inpatient and Outpatient)	"Limited" benefit at approx. 85% of full hospital benefit • Includes: evaluation, lab, x-ray and other diagnostic tests to determine diagnosis (line zero on the prioritized list) • Hospital treatment for all emergency services • Urgent conditions for which prompt treatment will prevent life threatening health deterioration (a selected set will require prior authorization • No copays
Emergency Room	No copay
Physician Services	No office visit copay
Lab Services	No copay
Imaging Studies (X-ray)	No copay
Ambulance	No copay
Preventive Care	No copay
Prescription Drugs	No copay
Mental Health & Chemical Dependency	Outpatient services coverage resumes
Durable Medical Equipment and Supplies	Some medical equipment and supplies, limited to: • Diabetic supplies (including blood glucose monitors) • Respiratory & oxygen equipment, ventilators • Suction pumps • Tracheostomy, urology and ostomy supplies
Dental Services	Emergency dental services only
Hospice	Covered

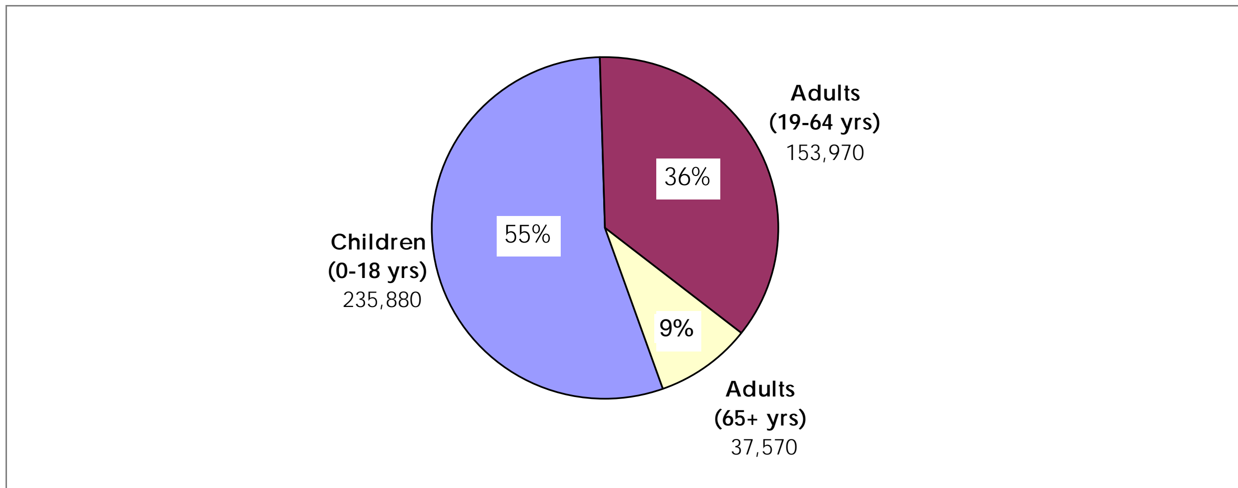
The following chart shows OHP enrollment trends during the period of OHP2 implementation:

OHP Enrollment Trends, July 2002 to September 2006



The following chart shows the distribution of OHP enrollees as of December 2006. For specific eligibility categories see the following pages.

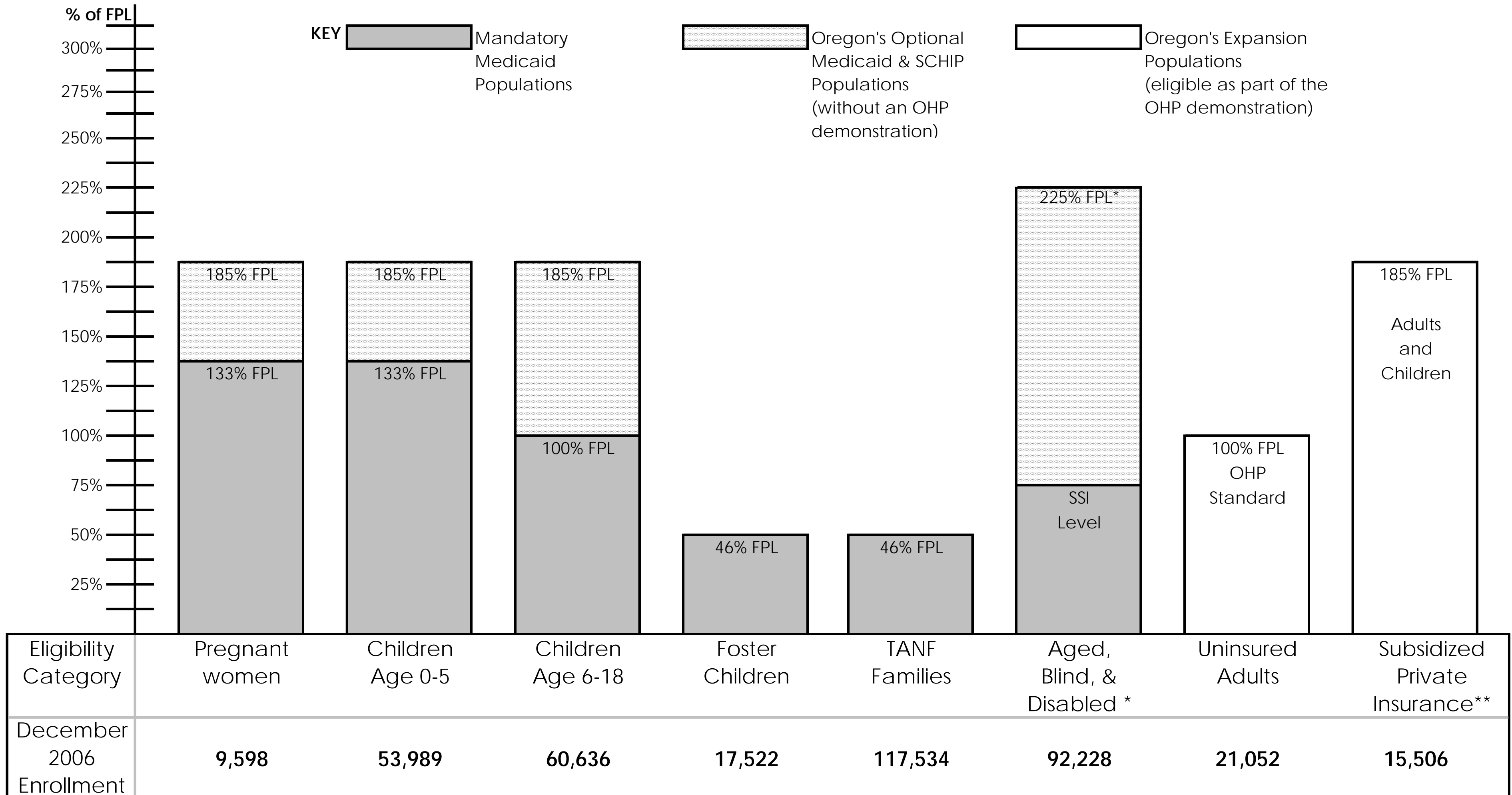
OHP Medicaid and CHIP Enrollees, December 2006



- There were a total of 427,420 total OHP Medicaid and CHIP enrollees in December 2006.
- Of total eligibles, 55% were children 18 years and under, 35% were adults 19-64 years of age, and 9% were adults 65 years and older.

Data Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP).

Oregon Health Plan Eligibility Categories by Percentage of Federal Poverty Level (FPL)



Eligibility Category	Pregnant women	Children Age 0-5	Children Age 6-18	Foster Children	TANF Families	Aged, Blind, & Disabled *	Uninsured Adults	Subsidized Private Insurance**
December 2006 Enrollment	**9,598**	**53,989**	**60,636**	**17,522**	**117,534**	**92,228**	**21,052**	**15,506**

* Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.

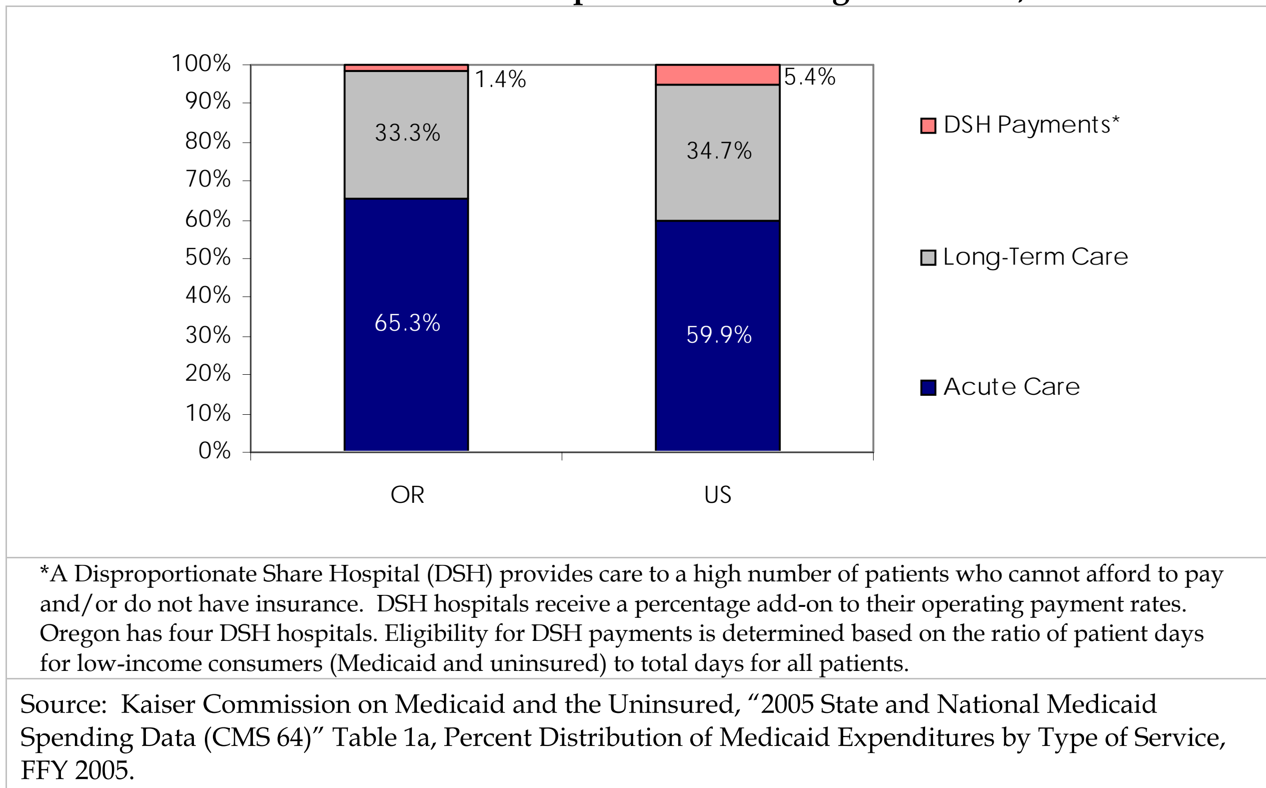
** The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the federal poverty level (FPL) must enroll in FHIAP if they have employer sponsored insurance. Parents and childless adults over 100% FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Medicaid Expenditures

Oregon spends slightly less as a proportion of overall expenditures on long-term care when compared to the U.S. Acute care services account for over 65% of the Medicaid budget—providing services to over 400,000 people, while long-term care accounts for approximately 33% of the budget and provides services to approximately 39,000 people.[47]

Distribution of Medicaid Expenditures in Oregon and U.S., 2005



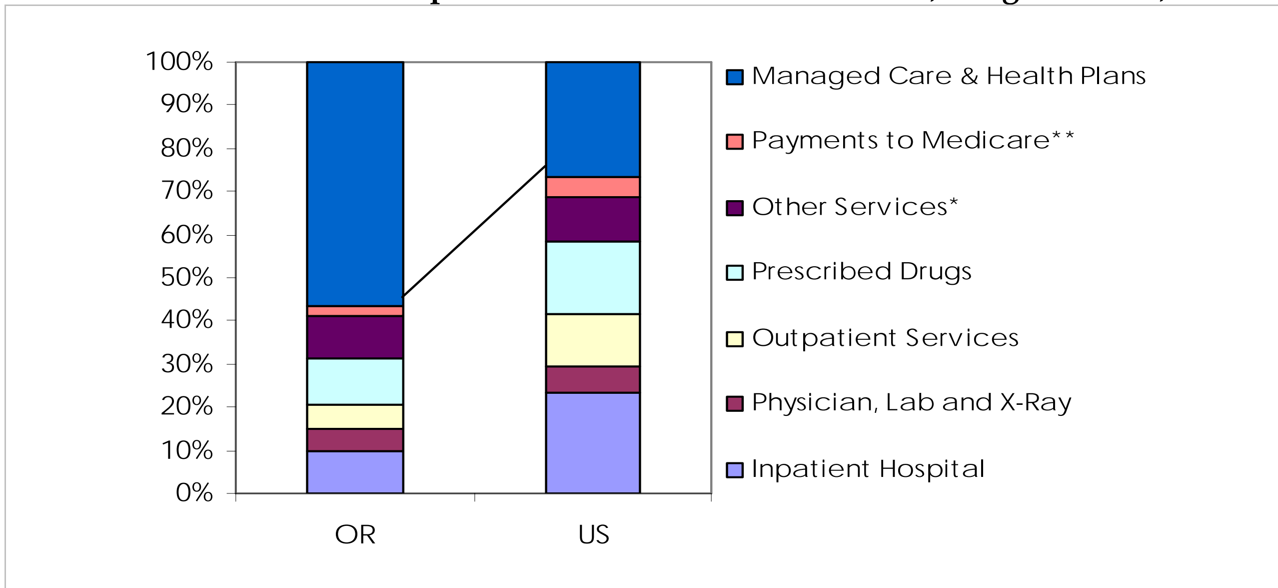
*A Disproportionate Share Hospital (DSH) provides care to a high number of patients who cannot afford to pay and/or do not have insurance. DSH hospitals receive a percentage add-on to their operating payment rates. Oregon has four DSH hospitals. Eligibility for DSH payments is determined based on the ratio of patient days for low-income consumers (Medicaid and uninsured) to total days for all patients.

Source: Kaiser Commission on Medicaid and the Uninsured, "2005 State and National Medicaid Spending Data (CMS 64)" Table 1a, Percent Distribution of Medicaid Expenditures by Type of Service, FFY 2005.

The chart on the following page shows the distribution of acute care expenditures for Oregon's Medicaid program compared to the U.S. As the chart shows, a much larger proportion of Oregon's acute care services are delivered through managed care systems. Oregon's costs for prescription drugs, inpatient services, and other components of Medicaid spending cannot be directly compared with national expenditures because many of the component services are delivered by managed care organizations and are therefore wrapped into the managed care expenditure category.

[47] *Oregon Department of Human Services, Seniors and People with Disabilities.*

Distribution of Medicaid Expenditures on Acute Care Services, Oregon & U.S., 2005



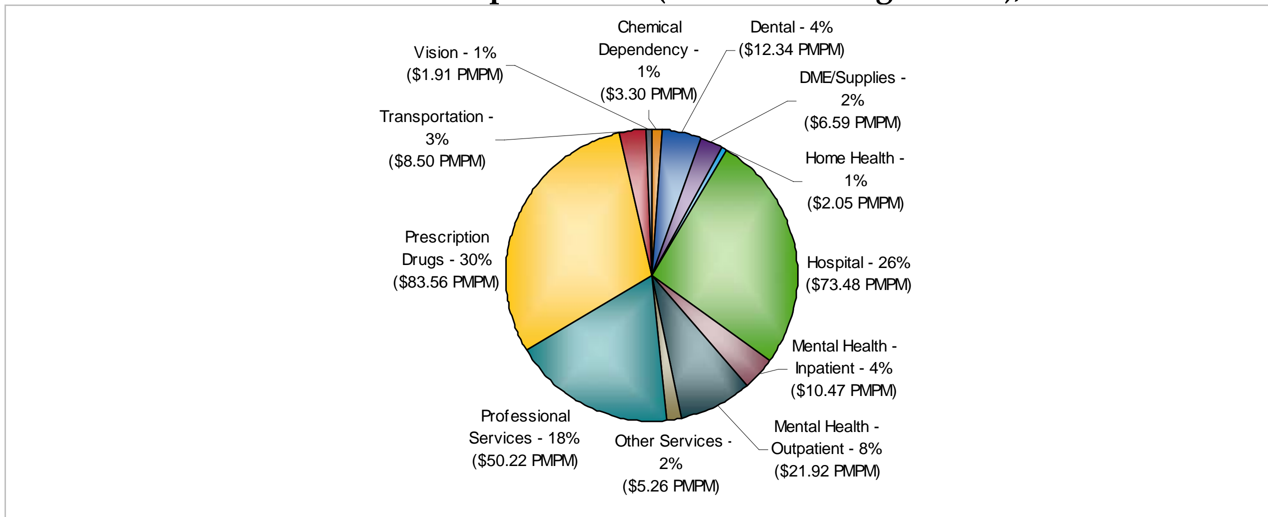
Source: Kaiser Commission on Medicaid and the Uninsured, "2005 State and National Medicaid Spending Data (CMS 64)" Table 2a: Percent Distribution of Expenditures on Acute Care Services, FFY 2005.

*"Other Services" includes dental, other practitioners, dentures, eyeglasses, etc.

**Payments to Medicare are primarily premiums paid by Medicaid for Medicare enrollees.

Because of the high penetration of Medicaid managed care, Oregon-specific data is not directly comparable to other states; the following chart shows components of all spending (FFS and Managed Care) for the Oregon Health Plan in 2004.

Distribution of OHP Expenditures (FFS and Managed Care), 2004



Source: Office for Oregon Health Policy and Research, Health Services Commission, "CY 2008/2009 Benchmark Rate Study: Oregon Health Plan", February 2007.

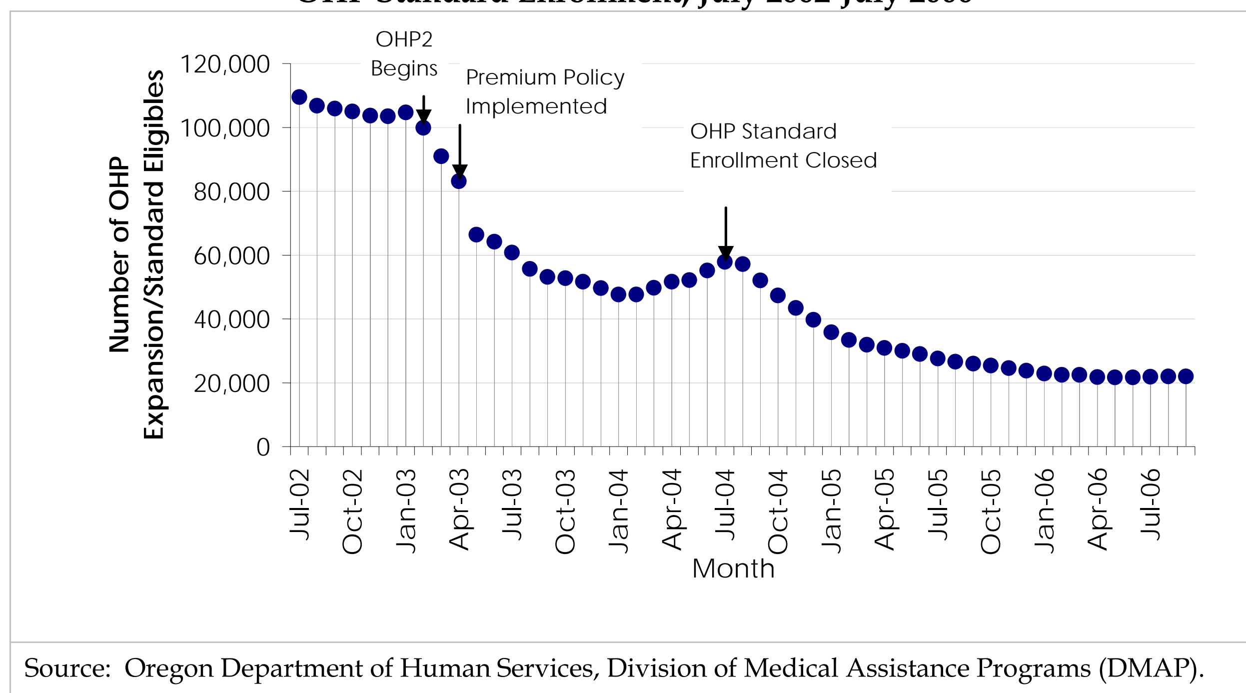
Impact of OHP2 Policy Changes

The Oregon Health Research and Evaluation Collaborative (OHREC), a unique and innovative partnership of the policy and academic health services research communities in the state, has focused its efforts toward understanding the impact of the OHP2 Waiver changes in early 2003 to the Oregon Health Plan (OHP). The Office for Oregon Health Policy and Research (OHPR), working with the Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP) brought together a team of health services researchers to study these changes through several initial studies, using funding from Oregon's Robert Wood Johnson Foundation State Coverage Initiatives grant. Through these studies, the following impacts have been identified:

Enrollment Impacts

As presented earlier in this chapter, OHP enrollment declined by about 12% from the month preceding the implementation of OHP2 in February 2003 to December 2003. This decline was especially pronounced for the OHP expansion population, later called the OHP Standard population, for which enrollment fell over 80% from July 2002 to July 2006.

OHP Standard Enrollment, July 2002-July 2006

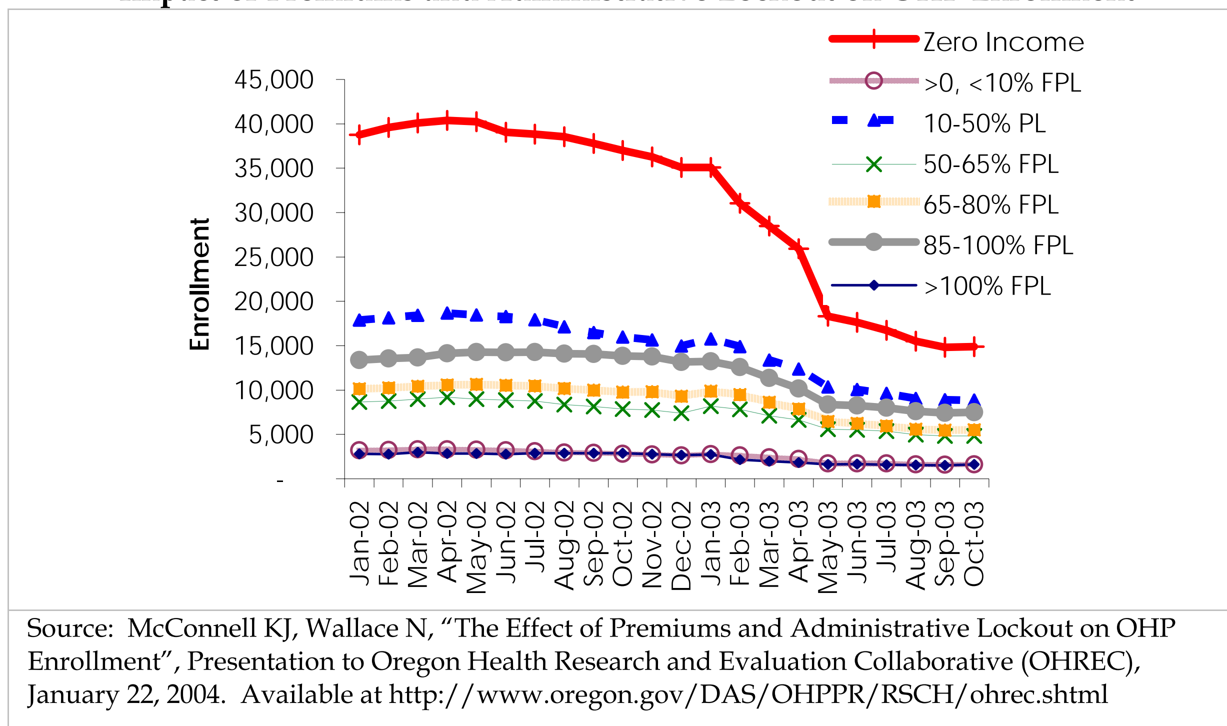


Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP).

- Low-income single adults were the most susceptible to the premium policy changes in OHP Standard, with the zero income group most affected (58% decline in enrollment).
- Premium cost was the most common reported reason for loss of OHP Standard coverage
- Most (72%) clients who lost coverage remained uninsured at the time the study was undertaken

While the OHP Standard caseload declined for all income groups, the implementation of the co-payment and premium policy changes were not exclusively responsible for the decreasing enrollment trends. Significant reductions in the OHP Standard benefit package (elimination of outpatient behavioral health and chemical dependency coverage and temporary loss of prescription drug coverage) also influenced client enrollment. The chart below shows changes to enrollment for OHP Standard clients at various income levels.

Impact of Premiums and Administrative Lockout on OHP Enrollment



Source: McConnell KJ, Wallace N, "The Effect of Premiums and Administrative Lockout on OHP Enrollment", Presentation to Oregon Health Research and Evaluation Collaborative (OHREC), January 22, 2004. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/ohrec.shtml

OHREC research also showed the following[48]:

Unmet Need. For clients who lost OHP Standard coverage:

- 60% reported unmet need for medical care
- 80% reported unmet mental healthcare need
- Those with chronic illnesses were more likely to report unmet needs

Utilization Impacts. Clients who lost OHP Standard coverage were:

- Nearly three times more likely to lack a usual source of care
- More likely to skip filling a prescription due to cost than those remaining on OHP (57% vs. 48%)[49]
- 4 to 5 times more likely to go to the emergency department for care

[48]Complete research results are available at www.oregon.gov/das/ohpr/rsch/ohrec.shtml.

[49] *At the time the survey was undertaken, OHP Standard required co-payments for prescription drugs ranging from $2 to $15 per prescription.*

Public-Private Partnership: Family Health Insurance Assistance Program (FHIAP)

Overview. Another key tenet of the Oregon Health Plan was to build on public-private partnerships. The state's health insurance premium subsidy program is an example of such a partnership. The Family Health Insurance Assistance Program (FHIAP) provides families with subsidies to help them pay for their private health insurance premiums.

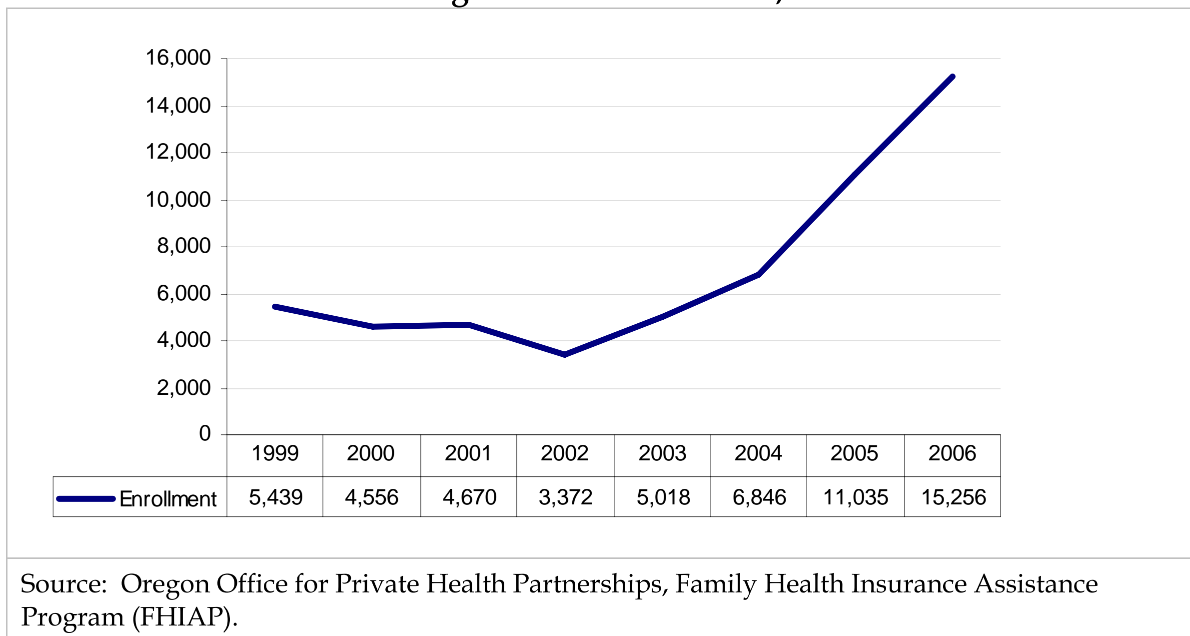
The program was created in 1997 to address the needs of families who, through their tax dollars, help pay for both Medicaid and Medicare, but do not qualify for either program and can't afford private coverage. In 2002, as part of the OHP2 waiver, Oregon received permission from CMS to match state dollars with federal dollars to fund FHIAP, allowing the program to serve more people and expand access to health insurance in the private market, with an emphasis on employer-sponsored insurance.

Program eligibility. Eligibility for FHIAP is as follows:

- Oregonians who earn less than 185% of Federal Poverty Level
- Uninsured for at least six months (except for people leaving OHP/Medicaid or SCHIP, and former FHIAP members)
- Other criteria, including citizenship and assets tests ($10,000 liquid asset limit)

Benefits. Members must enroll in their employer's group insurance plan if the employer pays part of the premium; otherwise they enroll in an individual plan. Once enrolled, if a member loses their group coverage due to loss of employment, or the employer discontinues the group plan, FHIAP will subsidize a COBRA portability, or individual plan. Members are responsible for the co-payments, co-insurance, and deductibles of their private insurance plans.

FHIAP Average Annual Enrollment, 1999 – 2006



	1999	2000	2001	2002	2003	2004	2005	2006
Enrollment	5,439	4,556	4,670	3,372	5,018	6,846	11,035	15,256

Source: Oregon Office for Private Health Partnerships, Family Health Insurance Assistance Program (FHIAP).

FHIAP Enrollment by Subsidy Level, January 2007

Subsidy Level	% FPL	OMIP	Individual	Group	Total
95%	<=125%	2,601	3,464	2,800	8,865
90%	126% - 149%	521	813	1,489	2823
70%	150% - 169%	226	386	890	1502
50%	170% - 185%	60	125	484	669
Total	**Na**	**3,408**	**4,788**	**5,663**	**13,859**

Source: FHIAP Snapshot of Program Activity, 01/08/2007;
http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

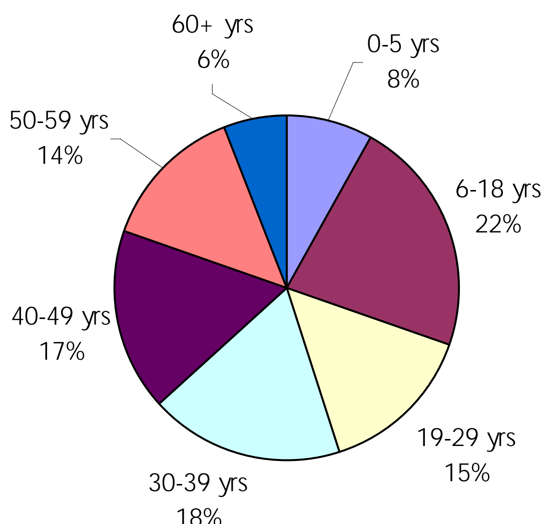
FHIAP Enrollment by Region

Region	Lives	% of FHIAP Enrollment	% of Population	% of Uninsured
Metropolitan Portland	4,777	34%	45%	31%
Willamette Valley	3,960	29%	25%	27%
Southern/South Coast	2,577	19%	13%	18%
Central	654	5%	4%	6%
NW/North Coast	659	5%	4%	5%
Mid-Columbia	478	3%	4%	5%
Southeast	347	3%	3%	4%
Northeast	386	3%	2%	4%
Other	21	0%	0%	0%
Total	**13,859**	**100%**	**100%**	**100%**

- FHIAP enrollment is concentrated in the population centers in Oregon – Metropolitan Portland, the Willamette Valley, and the Southern and South Coast. They account for 83% of the state population, 76% of the state's uninsured and 82% of FHIAP enrollees.
- While it appears that Metropolitan Portland may be under-represented, and the Southern/South Coast over-represented in FHIAP relative to Oregon's population distribution, FHIAP enrollment matches closely with the distribution of uninsured throughout the state.

Source: FHIAP Snapshot of Program Activity, 01/08/2007;
http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

FHIAP Enrollment by Age Group, January 2007

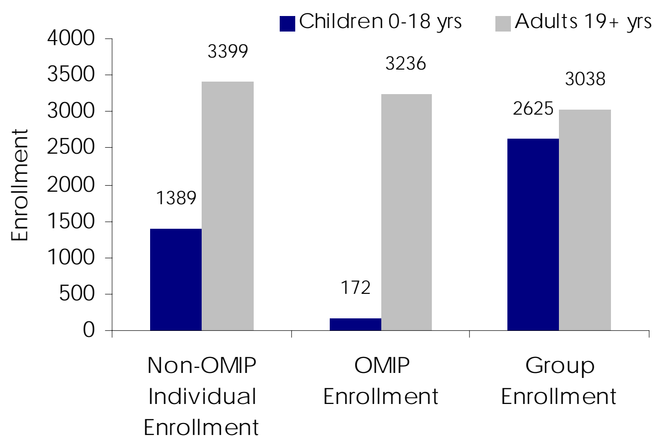


- FHIAP enrollees are composed of 30% children 0-18 years, 64% adults 19-59 years, and 6% older adults 60 years and older.

Source: FHIAP Snapshot of Program Activity, 01/08/2007; http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

FHIAP Enrollment in Individual and Group Plans, January 2007

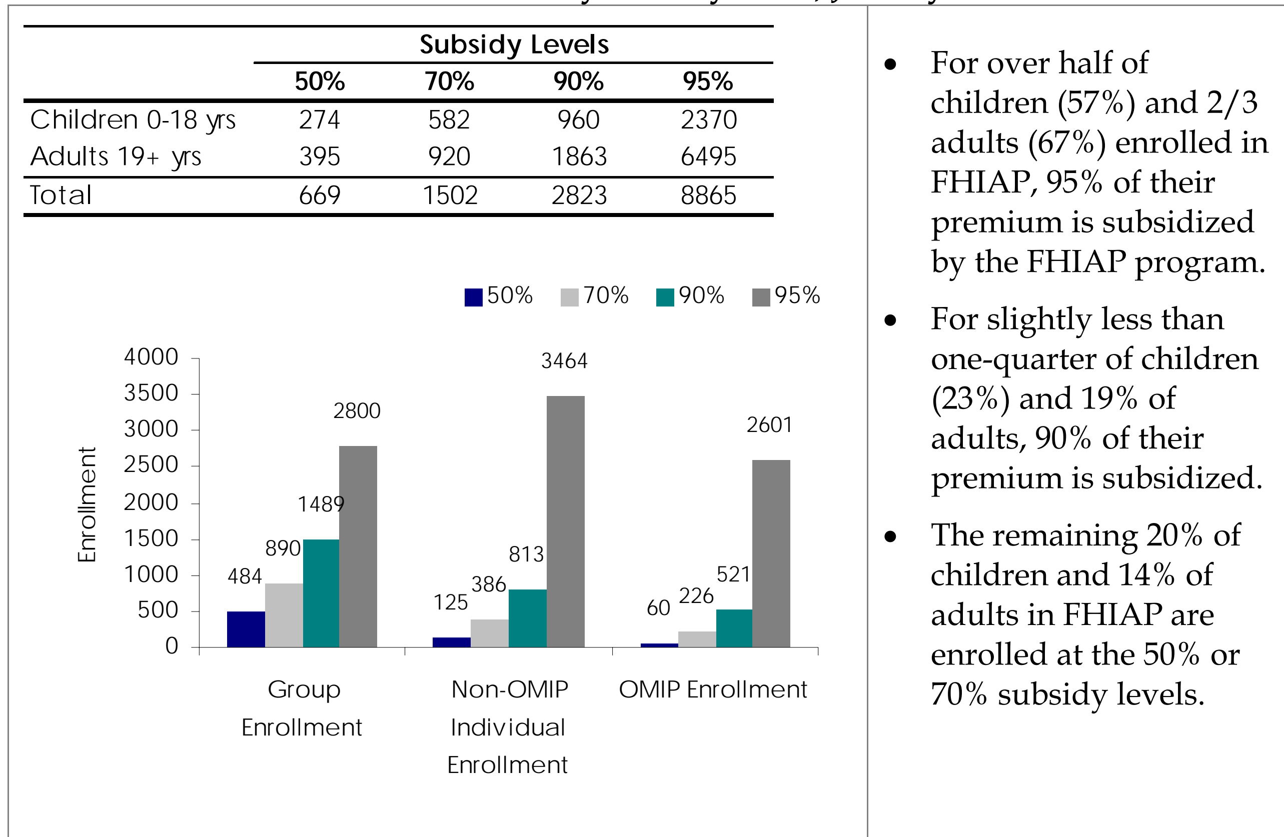
	Children 0-18 yrs	Adults 19+ yrs
Non-OMIP* Individual Enrollment	1389	3399
OMIP* Enrollment	172	3236
Total Individual Enrollment	1561	6635
Group Enrollment	2625	3038



- 59% of FHIAP enrollees are enrolled in individual plans, and 41% are enrolled in group plans.
- The majority of children in FHIAP are enrolled in <u>group</u> plans (63%).
- The majority of adults in FHIAP are enrolled in <u>individual</u> plans (69%).

Source: FHIAP Snapshot of Program Activity, 01/08/2007; http://www.oregon.gov/OPHP/FHIAP/statistics.shtml
* OMIP= Oregon Medical Insurance Pool

FHIAP Enrollment by Subsidy Level, January 2007



	Subsidy Levels			
	50%	70%	90%	95%
Children 0-18 yrs	274	582	960	2370
Adults 19+ yrs	395	920	1863	6495
Total	669	1502	2823	8865

- For over half of children (57%) and 2/3 adults (67%) enrolled in FHIAP, 95% of their premium is subsidized by the FHIAP program.
- For slightly less than one-quarter of children (23%) and 19% of adults, 90% of their premium is subsidized.
- The remaining 20% of children and 14% of adults in FHIAP are enrolled at the 50% or 70% subsidy levels.

Source: FHIAP Snapshot of Program Activity, 01/08/2007; http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

Average FHIAP Subsidy, January 2007

Average Subsidy for Group Market

	Subsidy Levels				Weighted Average
	50%	70%	90%	95%	
Member Contribution	$68.37	$42.16	$13.99	$7.71	$19.96
FHIAP Subsidy Per Month	$68.37	$98.37	$125.91	$146.47	$126.83
Total Employee Premium Share	$136.74	$140.54	$139.90	$154.18	$146.79
Employer Contribution	$114.80	$109.24	$104.07	$93.42	$100.53

Average Premium and Subsidy for Individual Market

	Subsidy Levels				Weighted Average
	50%	70%	90%	95%	
Member Contribution	$109.83	$72.10	$26.72	$13.60	$22.28
FHIAP Subsidy Per Month	$109.83	$167.74	$240.44	$258.42	$245.37

- Those on group plans contribute on average $20 to their premiums per month
- Those on individual plans contribute on average $22 to their premiums per month.

Source: FHIAP Snapshot of Program Activity, 01/08/2007; http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

FHIAP Benchmark Plan

In 2001, House Bill 2519 directed the Insurance Pool Governing Board (now the Office of Private Health Partnerships) to establish a basic benchmark benefit plan for subsidized employer-sponsored coverage that is comparable to coverage commonly found in the small group health insurance market. This benchmark would be used as a tool to determine which health insurance plans offered by employers would be eligible for subsidy with federal matching funds under the auspices of FHIAP. The benchmark was developed out of a survey of Oregon-based insurance companies that determined what benefits were being offered in the HMO and indemnity markets.

The value of benefit plans must meet or exceed the following benchmark:

FHIAP Benchmark for Group Health Insurance

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Pre-existing Condition Waiting Period	6 Month
Medical Cost Sharing	
Annual Deductible	$1,000 individual
Coinsurance Level	30%
Stop Loss Level	$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual
Required Services: Prescription Medication Cost Sharing[1]	
Member Coinsurance Level	$15 or 50% whichever is greater
Out-of-pocket Maximum	No out-of-pocket maximum
Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Women's Healthcare Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Department	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

Data Source: FHIAP Snapshot of Program Activity; http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

FHIAP Carriers, January 2007

Health Net
Diamond $250 Deductible
Diamond $500 Deductible
Diamond $1000 Deductible
HMO PLAN
PPO Plan (80/50) ($500 Ded)
PPO Plan (80/50) ($500 Ded) w/PCB
PPO Plan (80/60) ($500 Ded)
PPO Plan (80/60) ($1000 Ded)
Value Plan $500 Deductible

Kaiser Permanente
Kaiser Platinum Rx
Kaiser Gold Rx, $500 deductible
Kaiser Gold Rx, $1000 deductible

Life Wise Health Plan of Oregon
Choice Plan $500 Deductible
Choice Plan $1000 Deductible
Plus Plan $500 Deductible
Preferred Plan $500 Deductible
Preferred Plan $1000 Deductible

ODS Health Plans:
Plus (POS) $1000 Deductible
Preferred (PPO) $1000 Deductible
Traditional (Ind) $1000 Deductible
Beneficial Rx $1000
Beneficial Rx $1000 w/ Preferred Dental
Beneficial Rx $1000 w/ Premier Dental

Oregon Medical Insurance Pool (OMIP)
Plan 500 (deductible)
Plan 750 (deductible)
Plan 1000 (deductible)

PacifiCare
Individual Plan I
Individual Plan II

Pacific Source
Elect Plus - $500 deductible
Elect Plus - $1,000 deductible
Elect FlexPerks - $1,000 deductible

Regence BlueCross BlueShield of Oregon
Blue Selections Basic
Blue Selections Basic w/Dental
Blue Selections Plus $500 Ded
Blue Selections Plus $500 Ded w/Dental
Blue Selections Plus $1000 Ded
Blue Selections Plus $1000 Ded w/Dental
CHEC/$500
CHEC/$1,000
Consumer Advantage/$500
Consumer Advantage/$1,000

Source: FHIAP Snapshot of Program Activity, 01/08/2007;
http://www.oregon.gov/OPHP/FHIAP/statistics.shtml

Long-Term Care

Medicaid is the largest single payer for long-term care services in the U.S., and long-term care expenditures account for approximately one third of Oregon's Medicaid budget. Every state is required to pay for nursing facility care and home health services for eligible people over 21 years of age who are "nursing home eligible." States also have the option of covering other services such as personal care, intermediate care facilities for individuals with developmental disabilities (ICF/MR), and Home and Community-Based Services (HCBS).

Oregon Background and Trends. Prior to 1981, Medicaid financing for long-term care was limited to home health, personal care services and to institutional settings (hospitals, nursing facilities, and some intermediate care facilities). Because of this narrowly focused financing stream, low-income senior or disabled citizen's only option for long term care was often institutionalization. Two major legislative changes in 1981 allowed Oregon to move away from institutionalization and toward a home and community-based long-term care system. First was Section 1915c of the Social Security Act, the Medicaid Home and Community-Based Services (HCBS) Waiver program. Section 1915c allows certain low-income and disabled persons to live in their own homes and communities. Oregon was the first state in the country to be granted a waiver of some Medicaid rules under the HCBS program. Oregon currently has HCBS waivers for Intermediate Care Facilities/Mental Retardation (ICF/MR), aged and disabled, and disabled. Second, the Oregon legislature also enacted state policy that guides the state to serve seniors and persons with disabilities in the least restrictive way possible (ORS 410.010).

In keeping with this 1981 legislative guidance, the Department of Human Services built a system of long-term care for seniors and people with disabilities based on a philosophy that emphasizes home and community-based services.

Who's Eligible. Medicaid provides long-term care services only to the poor or those who have become poor after paying out-of-pocket for their long-term care costs. To be eligible for nursing home and community-based care services, seniors and people with disabilities must be both financially eligible for Medicaid and have impairments that limit their ability to perform common every day tasks. These tasks are called activities of daily living and include the following categories: mobility, eating, elimination, cognition, bathing/personal hygiene, dressing and grooming. Individual need for long term care services is determined in Oregon by a comprehensive assessment through the Client Assessment and Planning System (CA/PS) based on the degree to which the person seeking services needs assistance with activities of daily living. Once the assessment is completed, individuals are assigned a priority score on a seventeen-level scale. Eligibility at specific priority levels is determined by the available budget.

Long-term care priority levels are as follows:

Level 1 Client needs full assistance in all major activities of daily living. They need another person to provide hands-on care throughout the entire day.

Level 2 Client requires full assistance in mobility, eating and cognition. The major difference with clients in level 1 is these individuals do not need help with elimination.

Level 3 Client needs full assistance in at least one of the following activities of daily living; mobility, cognition or eating.

Level 4 Client needs full assistance in elimination.

Level 5 Client is only slightly less impaired then individuals assessed at the higher levels. At this level the client needs substantial assistance with mobility and eating and requires assistance with elimination.

Level 6 Client requires substantial assistance with mobility and eating.

Level 7 Client needs substantial assistance with mobility and assistance with elimination.

Level 8 Client needs assistance with mobility and eating and elimination.

Level 9 Client needs assistance with eating and elimination.

Level 10 Client needs substantial assistance with mobility.

Level 11 Client needs assistance with elimination and minimal assistance with ambulation.

Level 12 Client needs assistance with eating and minimal assistance with ambulation.

Level 13 Client needs assistance with elimination.

Level 14 The individual needs assistance with eating.

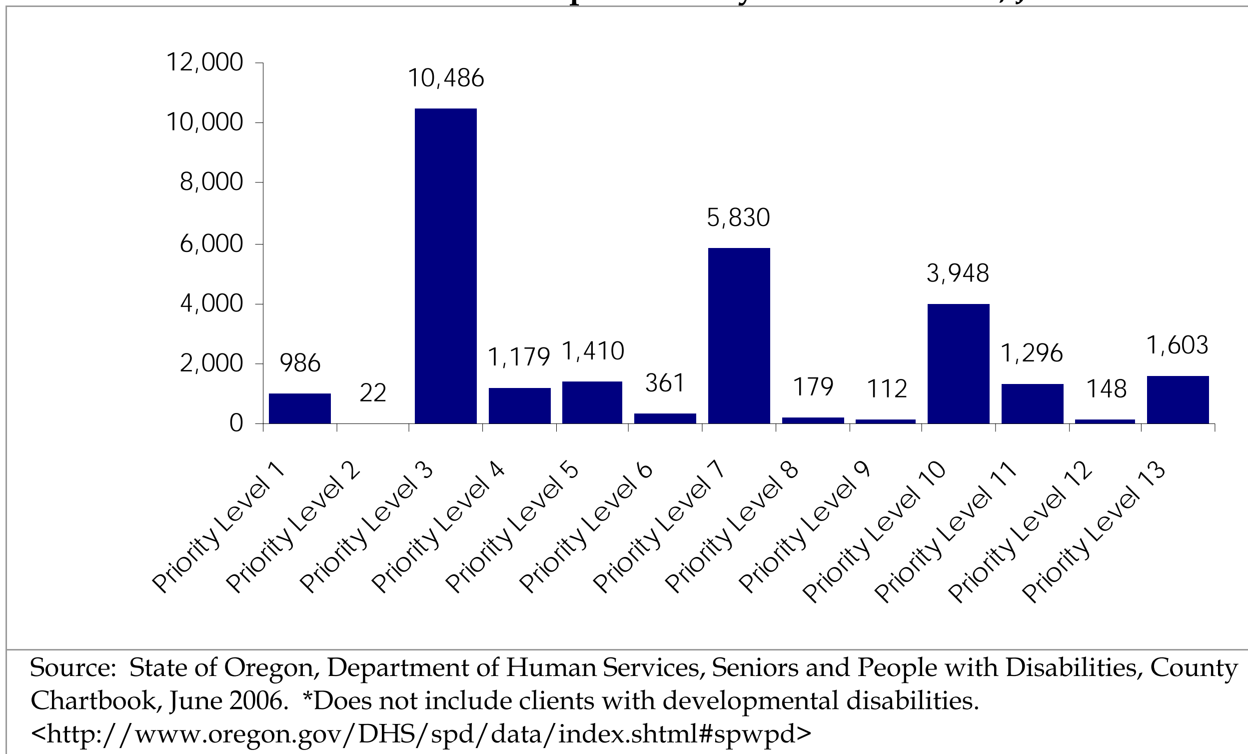
Level 15 The individual needs minimal assistance with ambulation.

Level 16 The individual needs full assistance with bathing or dressing.

Level 17 The individual needs assistance with bathing or dressing.

The state currently funds priority levels 1 through 13. The following chart shows the distribution of clients with physical disabilities (27,705) by service level.

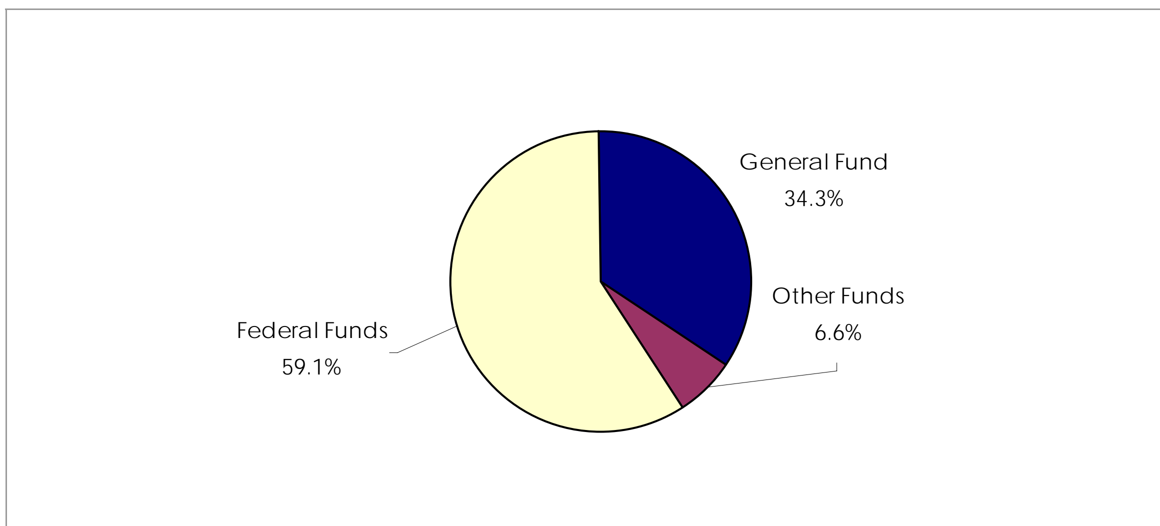
Distribution of Seniors and People with Physical Disabilities, June 2006



Source: State of Oregon, Department of Human Services, Seniors and People with Disabilities, County Chartbook, June 2006. *Does not include clients with developmental disabilities. <http://www.oregon.gov/DHS/spd/data/index.shtml#spwpd>

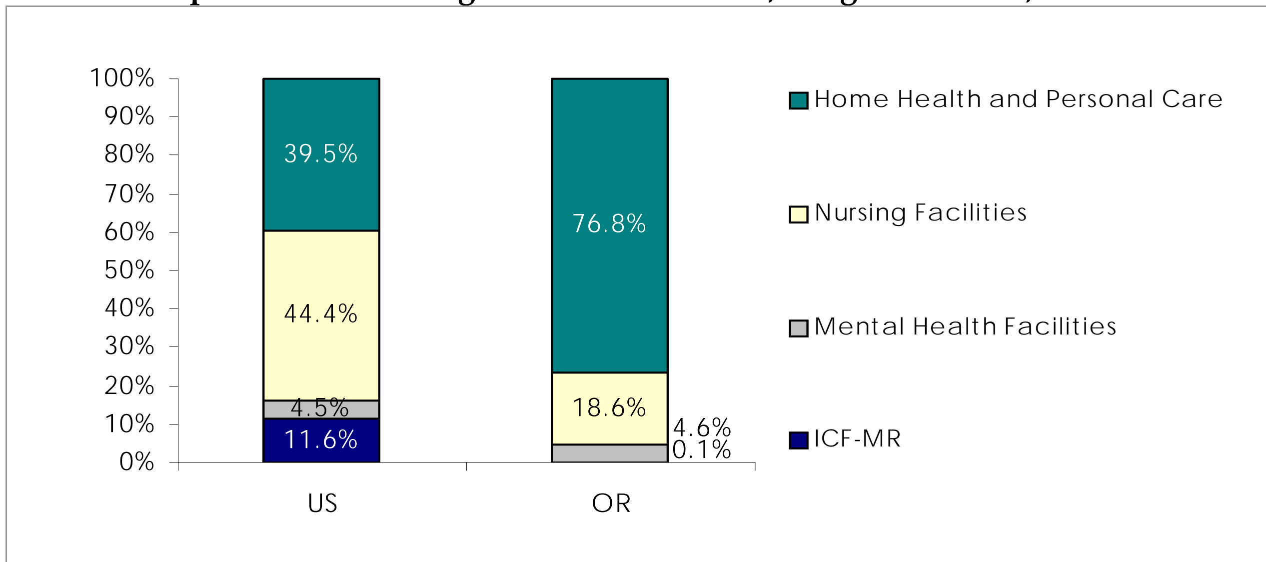
Sources of Funds. As in the rest of the country, Medicaid is the major funder of long-term care in Oregon. Federal Medicaid funds require state match that varies depending upon relative state per capita income. Oregon's match requirement fluctuates around 40% state funds to 60% Federal funds. In addition, the budget includes other funds, revenue from client contributions for in-home care, and estate recoveries.

Oregon Long-Term Care Budget Components, 2005-2007 Biennium



The following charts clearly reflect Oregon's emphasis on home and community-based services:

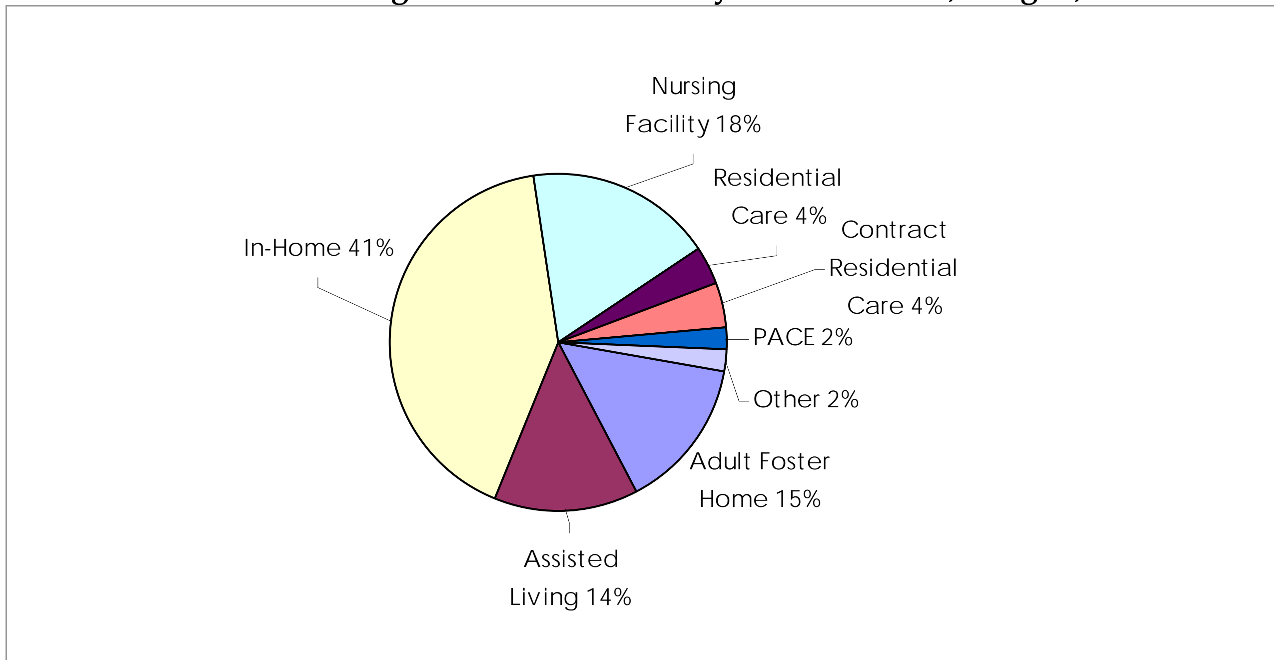
Expenditures on Long-Term Care Services, Oregon and U.S., 2005



*ICF-MR=Intermediate Care Facility – Mental Retardation

Source: Kaiser Commission on Medicaid and the Uninsured, "2005 State and National Medicaid Spending Data" (CMS 64), August 2006

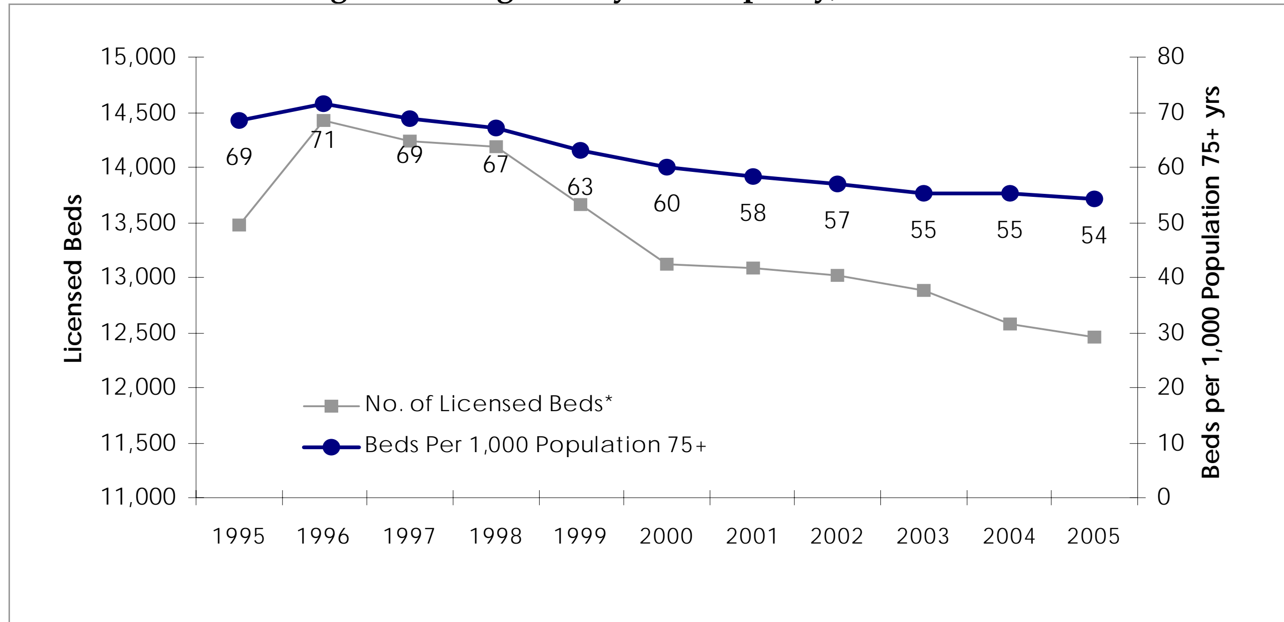
Distribution of Long-Term Care Clients by Site of Service, Oregon, 2006



Source: Source: State of Oregon, Department of Human Services, Seniors and People with Disabilities, County Chartbook, July 2006.

Oregon's emphasis on community-based care is reflected in the steady decline in nursing facility beds in Oregon over the last 20 years.

Oregon Nursing Facility Bed Capacity, 1995 to 2005



- The number of licensed nursing facility beds in Oregon has declined over time, even more so relative to the size of the population over 75 years of age.

Data Source: OHPR Annual Nursing Facility Survey, 1995-2006

Finally, nursing homes have become extensions of hospital units with average lengths of stay in terms of days instead of months or even years.

Lengths of Stay in Oregon Nursing Facilities, 2005

Lengths of Stay	Number	% of total
Less than 1week	5,193	16%
7 to 14 days	6,792	22%
2 weeks to 30 days	8,800	28%
1 to 3 months	6,026	19%
3 to 6 months	1,781	6%
6 to 12 months	1,007	3%
1 to 2 years	851	3%
2 to 4 years	633	2%
4+ years	504	2%
Total	31,587	100%

- Nursing facility lengths of stay are relatively short in Oregon.
- In 2005, 38% of nursing facility admissions lasted less than two weeks.
- 66% stayed less than one month, and 85% stayed less than 3 months.

Data Source: OHPR Annual Nursing Facility Survey, 2006

The Deficit Reduction Act. In February 2006, Congress passed the Deficit Reduction Act of 2005 (DRA) which made several major changes to Medicaid long-term care services. The DRA is expected to reduce Medicaid spending by $11.5 billion over the next five years, but includes both spending increases and reductions to Medicaid long-term care services. Key changes to long- term care services include:

- **Asset Transfers**: Limits Medicaid eligibility by lengthening the look back period for asset transfers from 3 to 5 years and excludes coverage for individuals with home equity exceeding more than $500,000 (or up to $750,000 at state option).
- **Long-Term Care Partnerships**: Lifts moratorium on states expanding new partnership programs to increase the role of private LTC insurance.
- **Family Opportunity Act**: Creates a new option for families with disabled children with income up to 300% of poverty to "buy-in" to the Medicaid program.
- **Money Follows the Person Demonstration**: Gives states enhanced matching funds to transition beneficiaries from institutional to community-based settings.
- **State Option to Provide Home and Community-Based Services (HCBS)**: Creates a new option to provide all HCBS waiver services without a waiver for seniors and people with disabilities up to 150% of poverty. The provision allows states to cap enrollment, maintain waiting lists, and provide services that are not statewide. It also requires states to establish more stringent eligibility criteria for institutional services.
- **Cash and Counseling Option**: Allows consumer-directed personal assistance services without a waiver.[50]

[50] Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long Term Care Services" July, 2006.

CHAPTER 3
HEALTH INSURANCE COVERAGE: MEDICARE & PRIVATE COVERAGE

In this chapter:

Medicare Overview
Medicare Part D
Private Health Insurance
Private Health Insurance: Consumer-Driven Health Plans

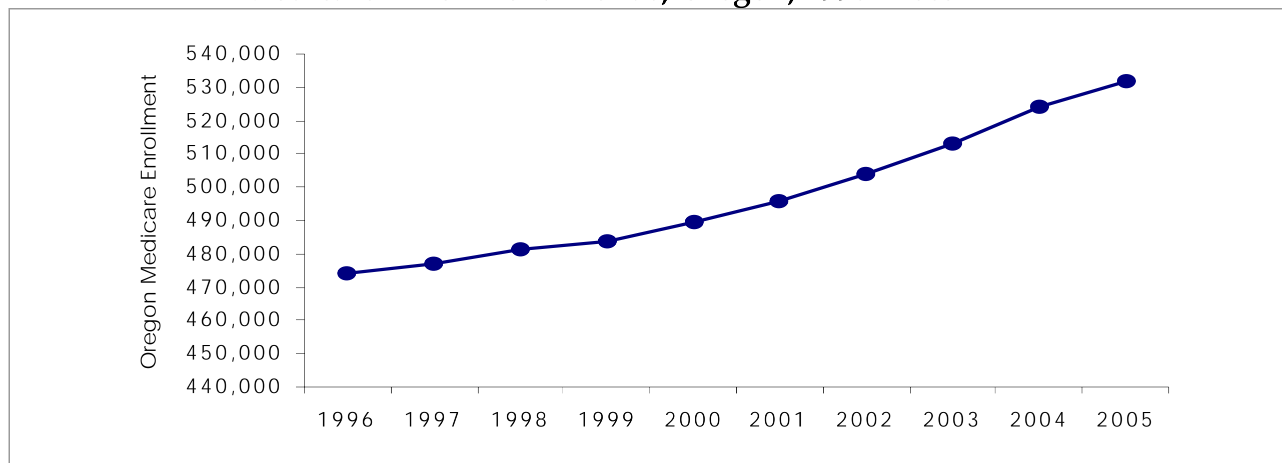
Medicare Overview

Medicare is a federal health insurance program covering over 531,000 Oregonians[51] who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.

Medicare is made up of four component parts:

- Part A includes hospitalization, limited skilled nursing, limited home health, hospice care, and blood. Part A does not include long-term care, and the individual is responsible for any co-payments or deductibles.
- Part B is medical insurance and includes physician services and outpatient visits, lab and x-ray, ambulance and some preventive care. Part B includes an out-of-pocket coinsurance and a premium for Part B coverage.
- Part C, formerly known as "Medicare + Choice," is now known as "Medicare Advantage". If an individual is entitled to Medicare Part A and enrolled in Part B, he or she is eligible to switch to a Medicare Advantage plan, if a plan is available.
- Part D, the new prescription drug benefit, implemented in January 2006.

Medicare Enrollment Trends, Oregon, 1996 - 2005

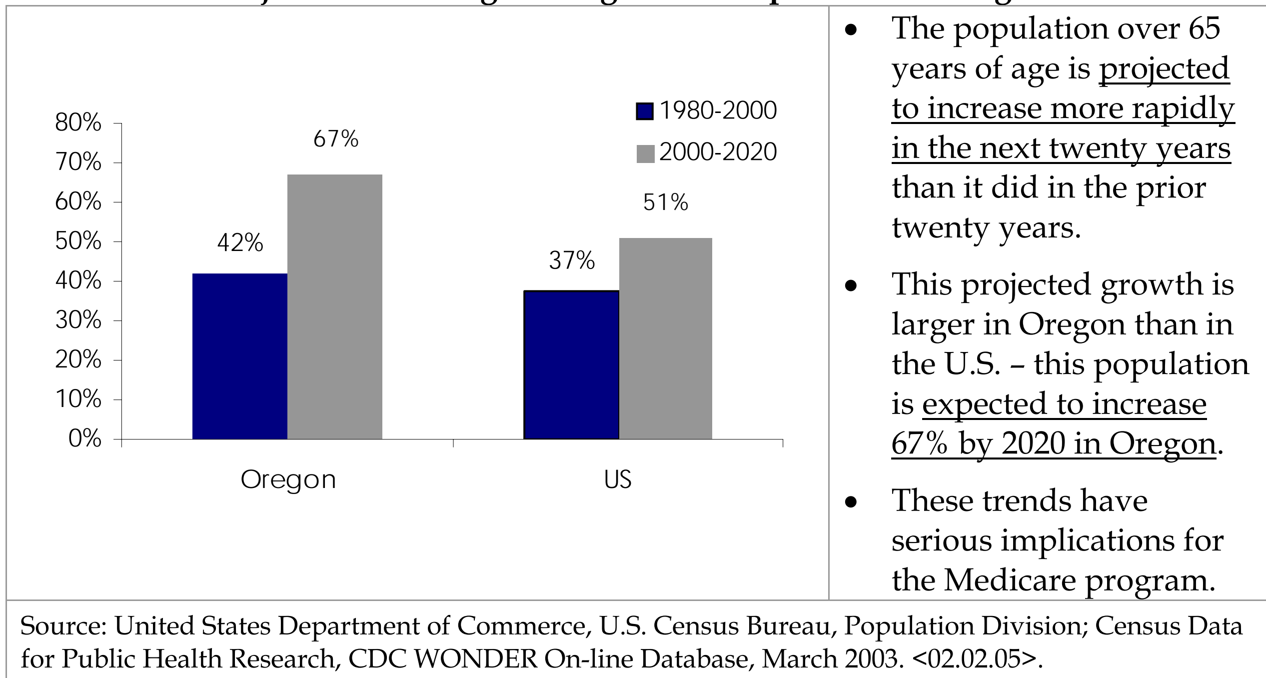


- Total Oregon Medicare enrollment has steadily increased 11.5% from 1996 to 2005.

Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2005.

[51] *http://www.cms.gov*

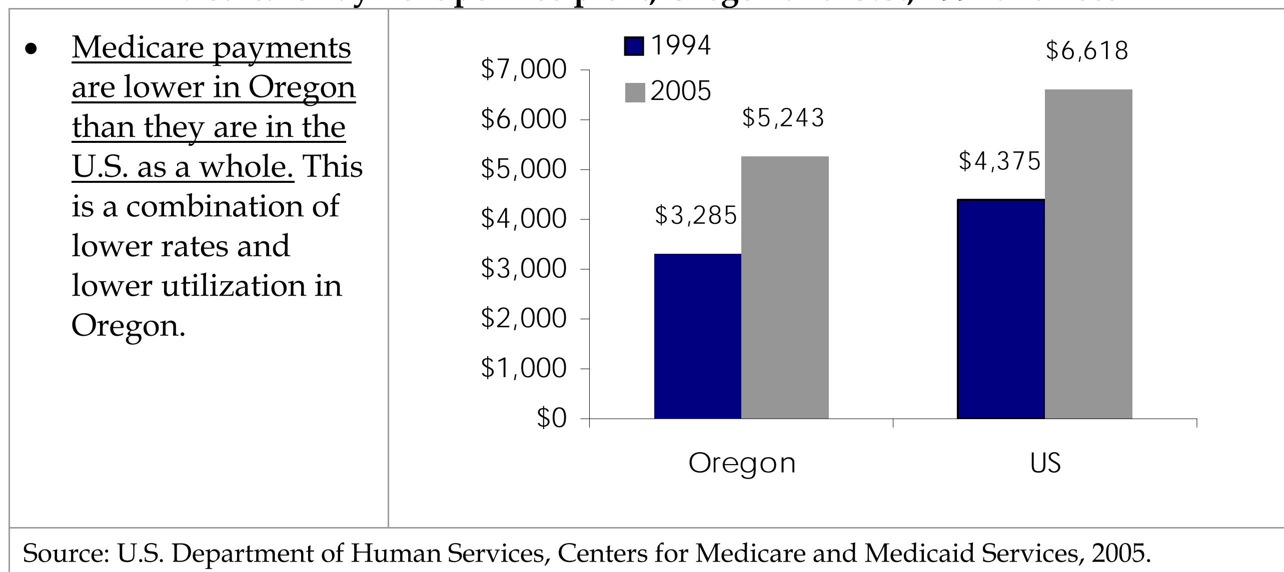
Projected Percentage Change in 65+Population in Oregon



- The population over 65 years of age is projected to increase more rapidly in the next twenty years than it did in the prior twenty years.
- This projected growth is larger in Oregon than in the U.S. – this population is expected to increase 67% by 2020 in Oregon.
- These trends have serious implications for the Medicare program.

Source: United States Department of Commerce, U.S. Census Bureau, Population Division; Census Data for Public Health Research, CDC WONDER On-line Database, March 2003. <02.02.05>.

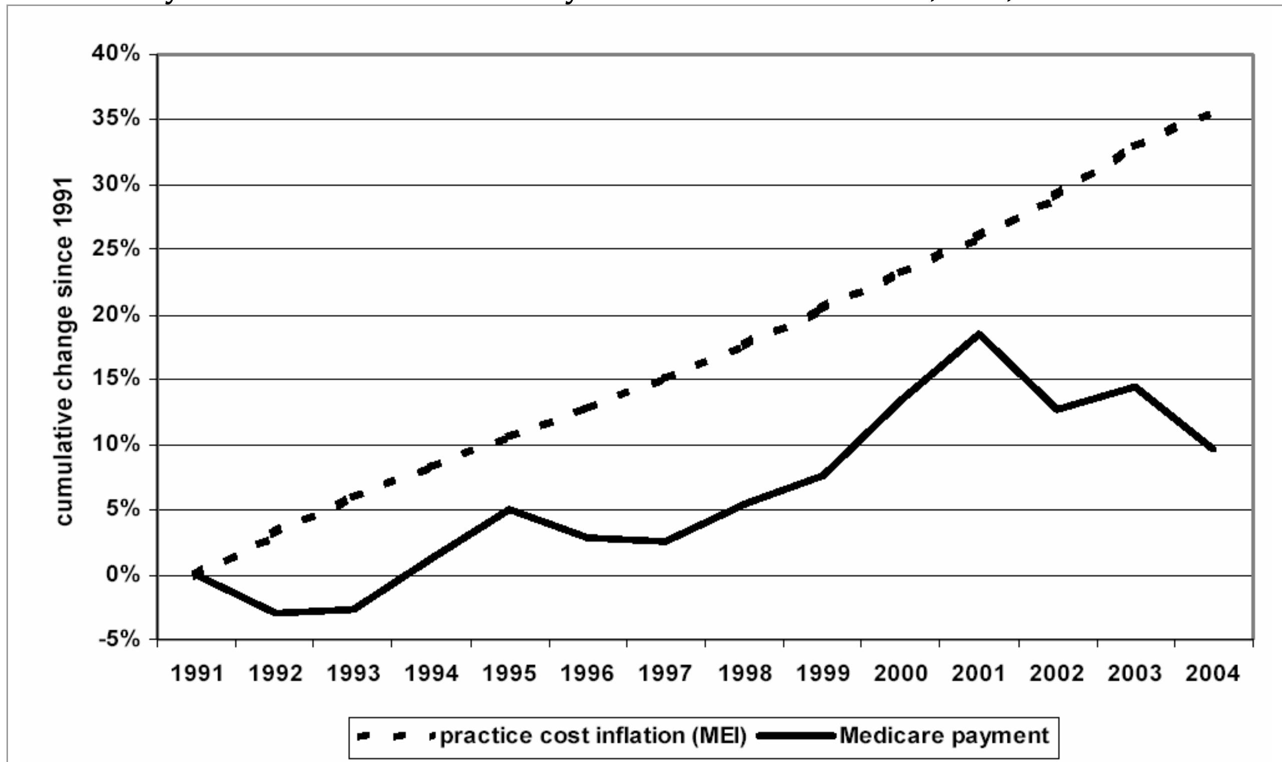
Medicare Payment per Recipient, Oregon and U.S., 1994 and 2005



- Medicare payments are lower in Oregon than they are in the U.S. as a whole. This is a combination of lower rates and lower utilization in Oregon.

Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2005.

Payment Trends: Medicare Payments vs. Cost Inflation, U.S., 1991-2004



- Medicare payment growth has not kept pace with practice cost inflation, making care of Medicare patients less affordable for providers.

Sources: Practice cost inflation all years, Center for Medicare and Medicaid Services (CMS); 1992-1997 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS.

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created a Medicare prescription drug benefit (Medicare Part D) that began on January 1, 2006. Surveys conducted by the Kaiser Family Foundation show that substantial majorities of pharmacists (86%) and physicians (71%) believe that the prescription drug law is helping people on Medicare save money on their medications. At the same time, the surveys also found that pharmacists (91%) and doctors (92%) believe the law is too complicated. A majority in both professions report that Medicare beneficiaries are encountering problems getting their medications, sometimes with serious consequences.[52]

Financing for the prescription drug benefit includes payments to the Federal government from state Medicaid programs. States are required to provide funding for the MMA based on their level of Medicaid prescription drug spending in fiscal year 2003 for the portion of the Medicaid population known as "dual eligibles." Dual eligibles are eligible for both the Medicare and Medicaid programs, either because they have a disability or are aged and have incomes that would qualify them for Medicaid

[52] Kaiser Family Foundation "National Surveys of Pharmacists and Physicians, Findings on Medicare Part D," Publication No. 7554 and No. 7555

and therefore Medicaid Part D. As of June 2006, there were 43,811 dual eligibles in Oregon.

Under the new Medicare prescription drug program, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. This is referred to as the "claw back." Essentially, states are being required to continue paying for a prescription drug benefit for dual eligibles. The impact of this provision is that states like Oregon, which has what is considered a generous drug benefit, will pay more per "dual eligible" than states having a less generous Medicaid drug benefit.

With the release of the President's FY 2007 Budget in February 2006, however, CMS revised each state's per capita claw back obligation based on an update to one of the key factors in the formula used to calculate claw back payments.[53] Oregon's revised payment to CMS is $57.1 million dollars ($6.1 million dollars less than the original scheduled payment) in 2006.[54]

Oregon Medicare Beneficiaries Prescription Drug Coverage. As of January 2007, 62% of Oregon's Medicare population and 54% of the U.S. Medicare population were enrolled in Medicare Part D plans. Data provided by CMS shows that prescription drug coverage for Oregon's Medicare population closely mirrors the U.S. national average with a few notable exceptions. *See chart on following page.*

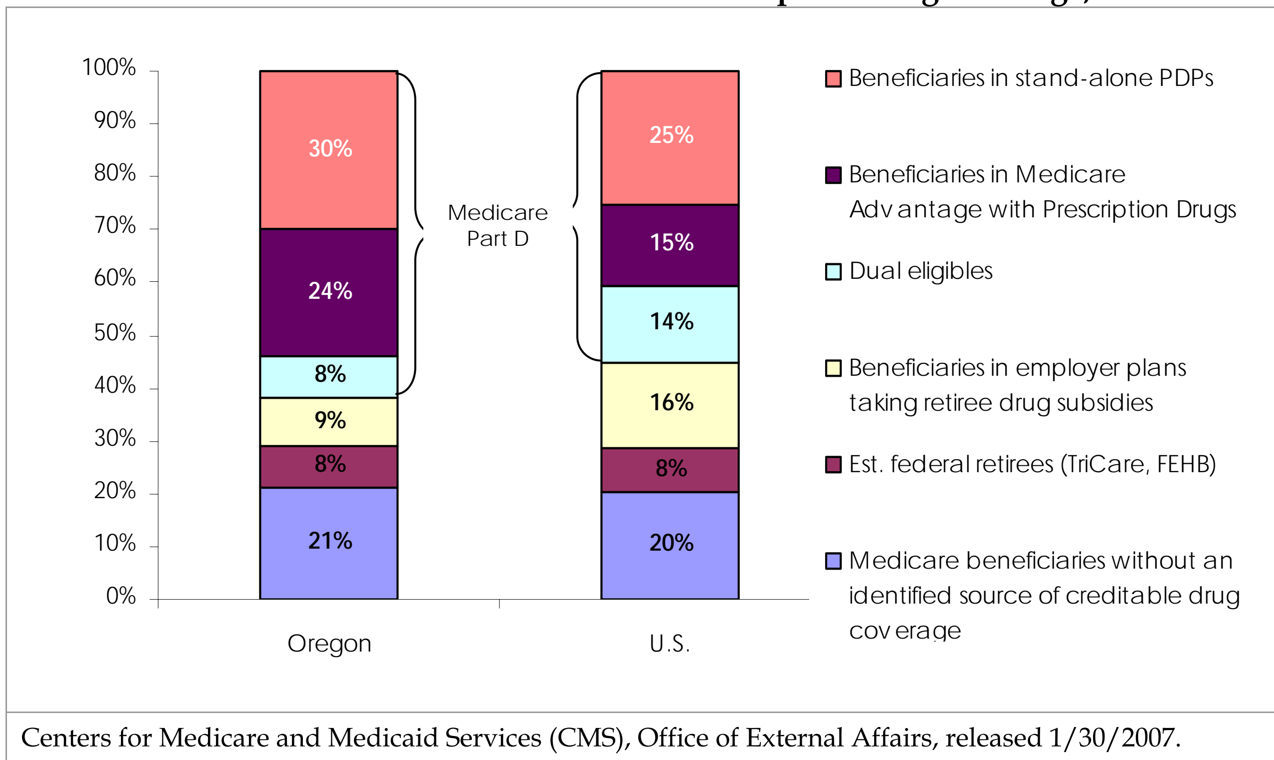
- **Beneficiaries without an Identified Source of Creditable Drug Coverage**: Creditable drug coverage is defined as drug coverage that meets or exceeds the actuarial value of the standard Part D benefit. CMS could not identify a source of creditable drug coverage for about one-fifth of Medicare beneficiaries in both Oregon and the U.S.
- **Estimated Federal Retirees:** The federal employee health benefit program (FEHB) and the U.S. Military TriCare Program provide health insurance coverage to federal employee retirees, active duty and retired uniformed services members and their dependants. Both Oregon and the U.S. national averages were at 8% of their Medicare populations that provided prescription drug coverage.
- **Employer Subsidized Retiree Plans:** The population of Medicare beneficiaries in Oregon that received prescription drug coverage that was subsidized by an employer plan was nearly half (9%) of the U.S. national average (16%).
- **Dual Eligibles:** CMS auto-enrolled dual eligibles (those enrolled in both Medicare and Medicaid) in prescription drug plans at or below the benchmark

[53] Letter from Mark McClellan, Administrator, The Centers for Medicare and Medicaid Services (CMS), to Kim Belshe, Secretary, California Health and Human Services Agency. The letter was received by California on February 6, 2006 and is available from The National Conference of State Legislatures at *http://www.ncsl.org/print/health/Clawback.pdf*.
[54] Kaiser Commission on Medicaid and the Uninsured (KCMU), "An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit, Table 2," March 2006. Available at http://www.kff.org/medicaid/7481.cfm.

premium. Dual eligibles are deemed automatically eligible for Part D low-income subsidies. Oregon's dual eligible population accounts for 8% of those with creditable prescription drug coverage compared to the 14% U.S. average.

- **Medicare Advantage with Prescription Drugs (MAPD):** Oregon's Medicare Advantage (Medicare managed care) accounted for 24% of those with creditable prescription drug coverage compared to the national average of 15%.
- **Stand-Alone Prescription Drug Program (PDP):** Medicare prescription drug plans that cover only prescription drugs were 30% of the creditable prescription drug coverage in Oregon and 25% nationally.

Medicare Beneficiaries with Creditable Prescription Drug Coverage, 2007



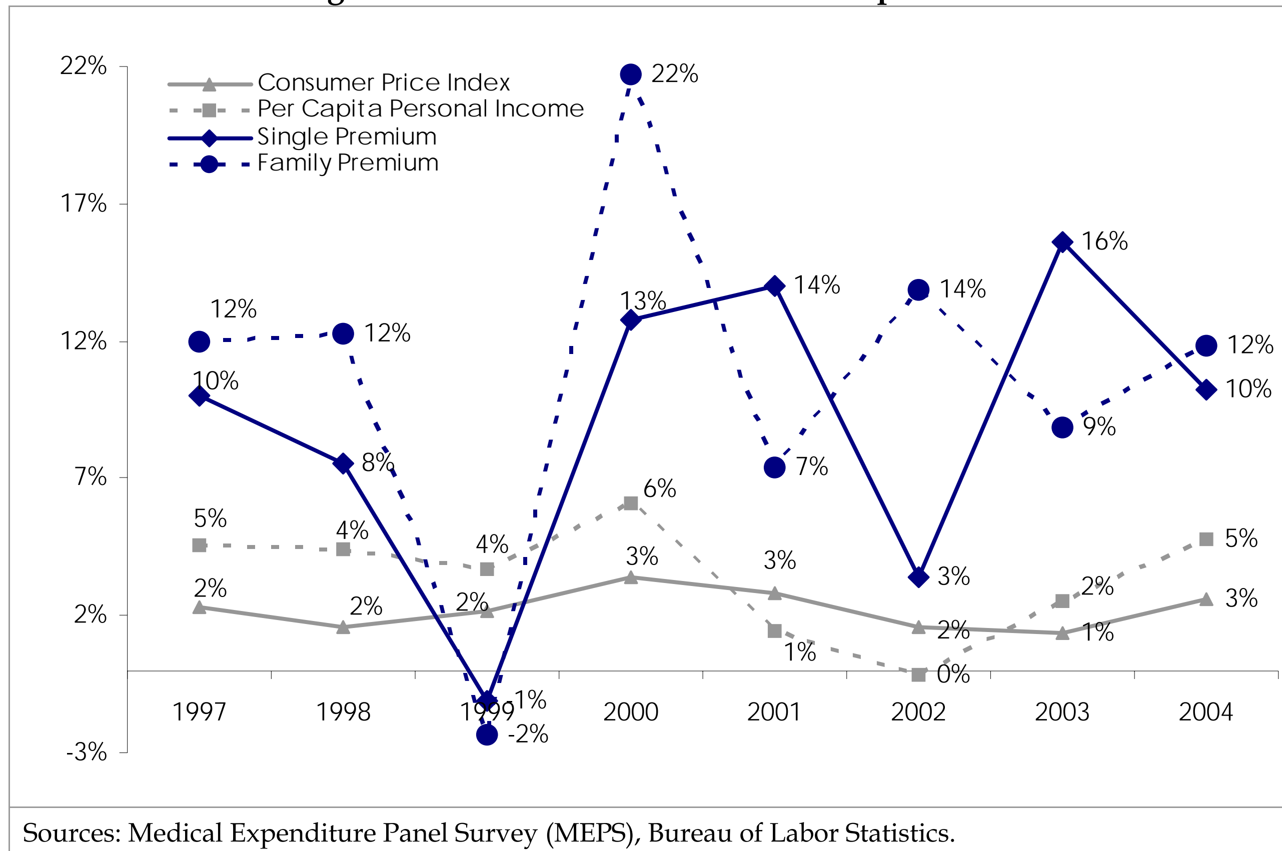
Centers for Medicare and Medicaid Services (CMS), Office of External Affairs, released 1/30/2007.

Private Health Insurance

Employer-sponsored insurance remains the primary avenue to health insurance for most Oregonians, covering an estimated 62% of the population in 2006.[55] However, with premiums growing at approximately 12% a year, there is evidence nationally that employers, especially smaller employers are dropping health insurance as a covered benefit for their employees. A recent study by the Kaiser Family Foundation of employers nationwide revealed that the number of small employers (3 to 199 employees) offering health insurance had dropped from 68% in 2001 to 63% in 2004.

As is shown in the chart below, the average annual increase in Oregon's health insurance premiums for most years between 1997 and 2002 far outpace the growth in per capita income or inflation.

Increases in Oregon Health Insurance Premiums Compared to Other Indices

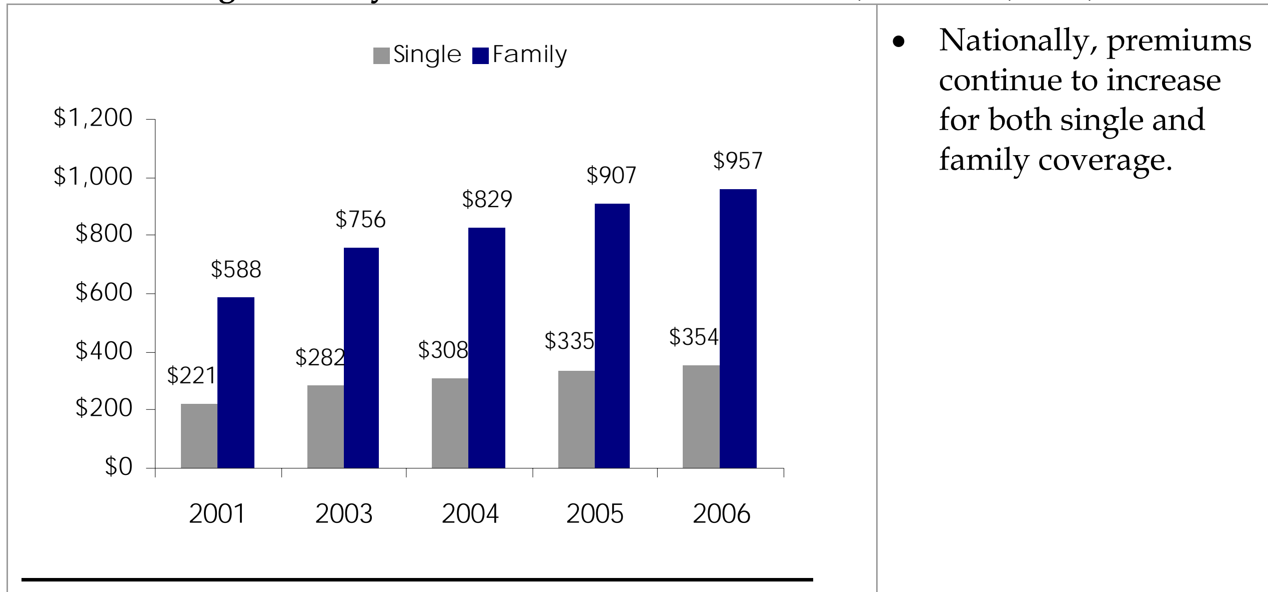


Sources: Medical Expenditure Panel Survey (MEPS), Bureau of Labor Statistics.

[55] Office for Oregon Health Policy and Research, 2006 Oregon Population Survey.

The average monthly premium for covered workers in the U.S. now exceeds $900 for family coverage and $300 for single coverage:

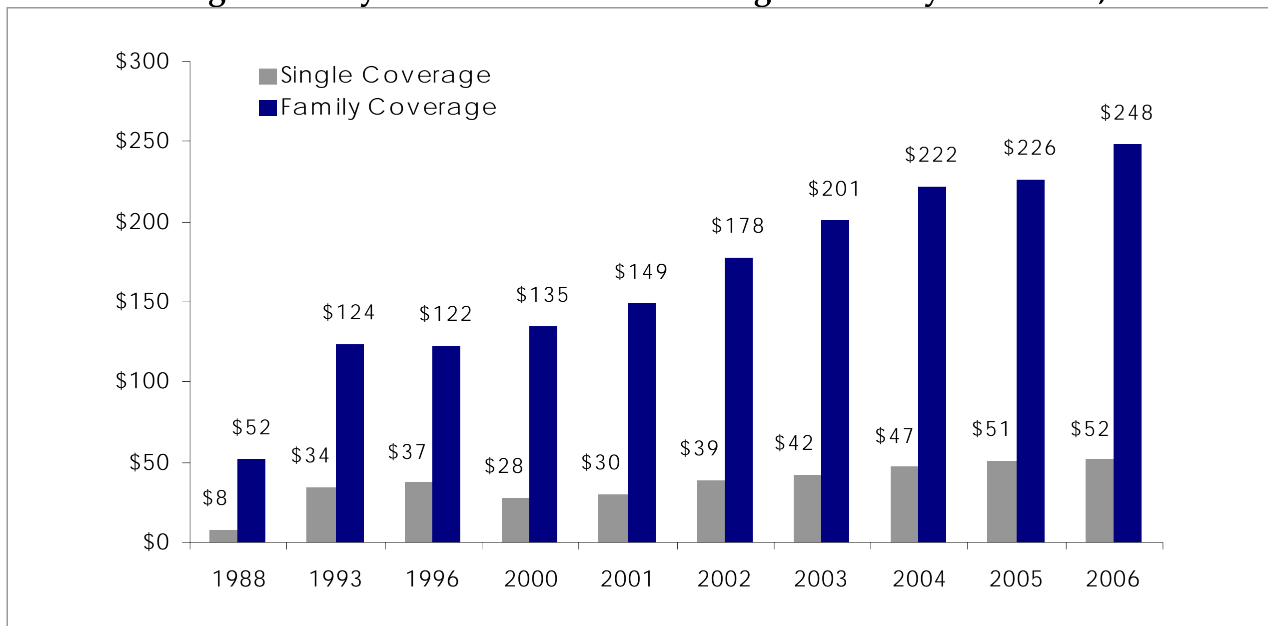
U.S.: Average Monthly Premiums for Covered Workers, All Plans, 2001, 2003-2006



- Nationally, premiums continue to increase for both single and family coverage.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2003, 2004, 2005, 2006

U.S.: Average Monthly Worker Contribution Single & Family Premiums, 1988-2006

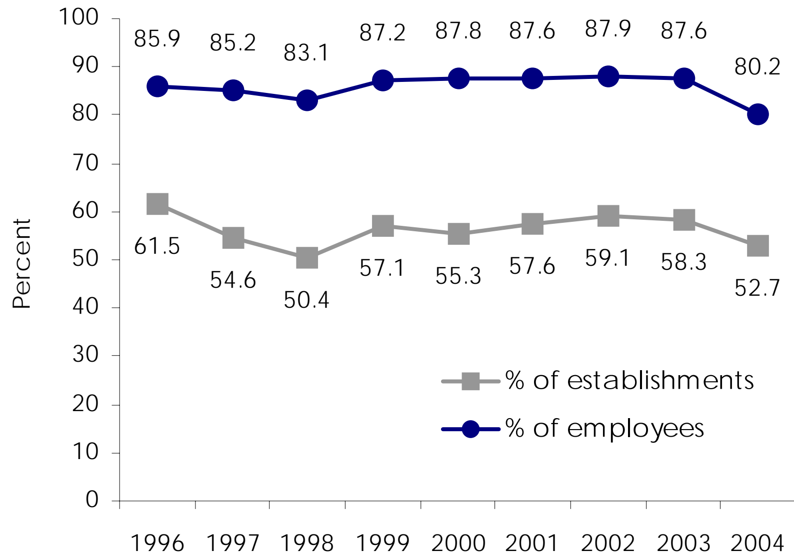


- Worker contributions for premiums have increased most dramatically for family premiums.

Source: National data from Kaiser/HRET Employer Health Benefits 2006 Chartpack at http://www.kff.org/insurance/7527/upload/7561.pdf; Kaiser/HRET Survey of Employer-Sponsored Health Benefits (2000-2006), KPMG Survey of Employer-Sponsored Health Benefits (1993, 1996), The Health Insurance Association of America (HIAA): 1988.

Oregon Establishments Offering Health Insurance, 1996 to 2004

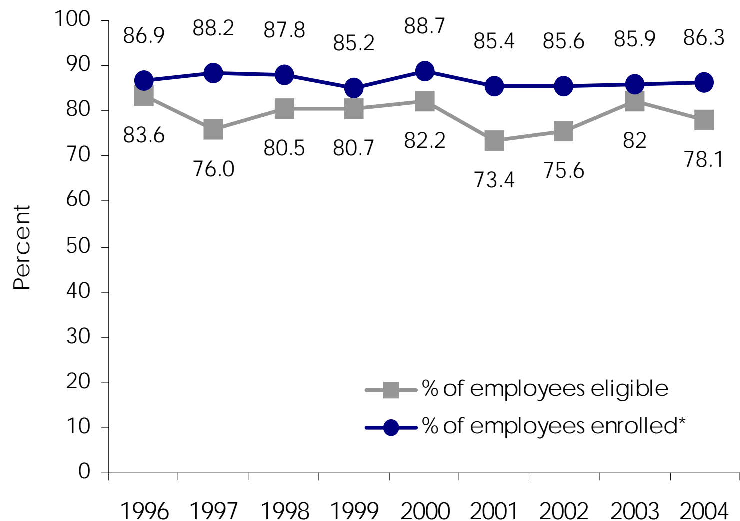
- The percent of private sector establishments that offer health insurance to their employees in 2004 was at the lowest point since 1998.
- Additionally, the percent of employees who work at these establishments in 2004 was at the lowest point in nine years.



Source: Medical Expenditure Panel Survey (MEPS).

Oregon Eligibility and Enrollment in Health Insurance, 1996 - 2004

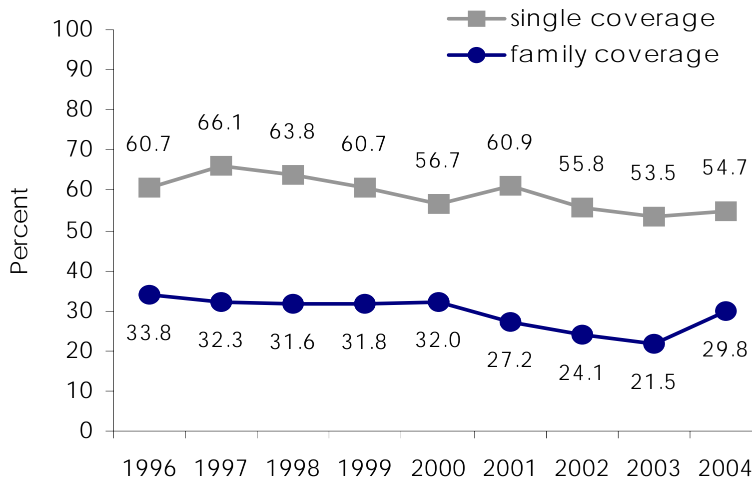
- While employers continue to offer health insurance, there has been a decline in the percent of employees who are eligible for health insurance.
- Among employees who are eligible for health insurance, about 86% enroll. This proportion has remained constant.



*Percent enrolled among those eligible

Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2004.

Oregon Establishments Offering Coverage with no Employee Contribution

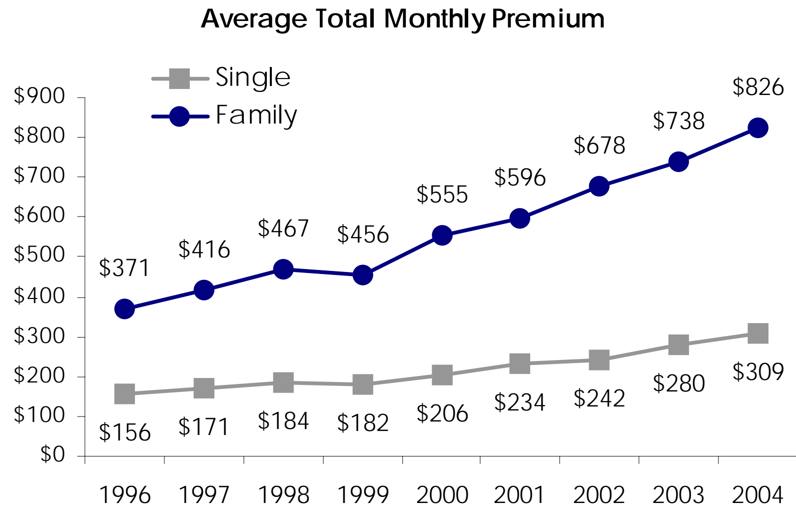


- The percent of establishments that offer health insurance for single and family coverage at no cost to the employee has remained relatively constant with a recent increase in family coverage.

Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2004.

Oregon Premiums, 1996 - 2004

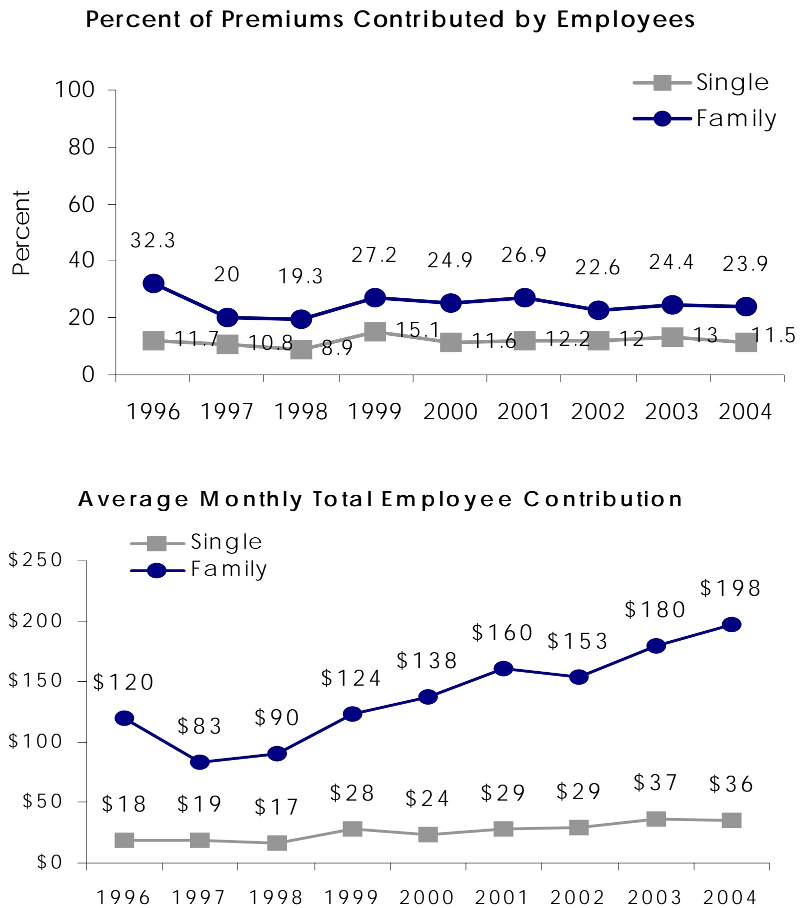
- Monthly premiums have increased for single and family plans, but to a greater extent for family plans.



Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2006.

Oregon Employee Contribution, 1996 - 2004

- Despite increasing premiums, employee contribution as a percent of total premiums has remained steady for single and family coverage.
- Monthly employee contribution has increased to a greater extent for family than single coverage
- It appears that both employers and families are sharing the impact of these increasing premiums



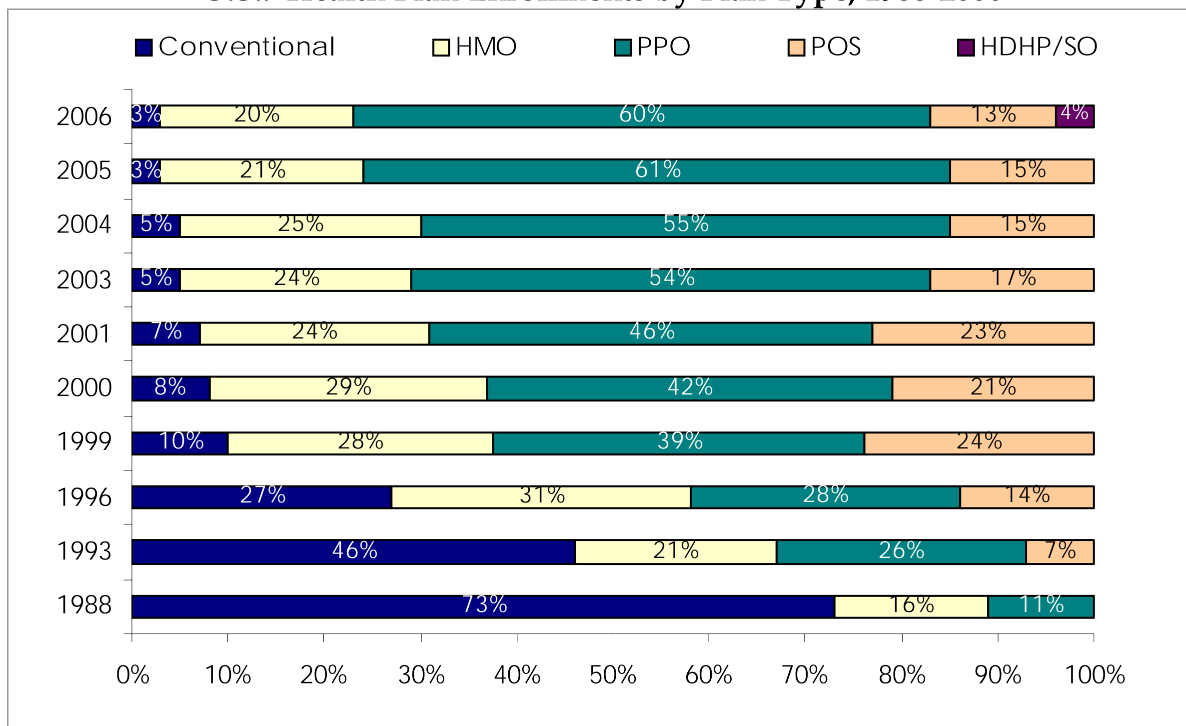
Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2004.

The other major market shift to take place in the U.S. over the last ten years is the shift away from conventional indemnity plans and toward preferred provider organizations as exhibited on the following page.

Oregon has experienced a dramatic shift away from managed care. Managed care penetration in the state peaked in 1999, with slightly more than 50% of population enrolled in one of the state's 11 managed care plans.[56] Partially due to consumer backlash, managed care has been largely abandoned in the Oregon; in 2005, only 30% of the population was enrolled in one of the five remaining commercial managed care plans.[57] The strongest remaining sector of managed care in the state is within the Medicaid delivery system, where 15 managed care plans deliver care to about 76% of the Medicaid population.

[56] *http://www.managedcaredigest.com/edigests/hm2000/hm2000c01s07g01.html. <December 2004>.*
[57] *http://www.statehealthfacts.kff.org. <October 2006>.*

U.S.: Health Plan Enrollments by Plan Type, 1988-2006



- There was a shift from traditional indemnity plans to Preferred Provider Organizations (PPO), Point of Service (POS) during the 1990's; this shift has slowed substantially but continues from 1999 through 2006. The High Deductible Health Plan with a Savings Option (HDHP/SO) is a relatively new insurance plan (see next section for details).

Source: National data from Kaiser/HRET Employer Health Benefits 2006 Chartpack at http://www.kff.org/insurance/7527/upload/7561.pdf. Kaiser/HRET Survey of Employer-Sponsored Health Benefits (1999-2006), KPMG Survey of Employer-Sponsored Health Benefits (1993, 1996), The Health Insurance Association of America (HIAA): 1988.

Private Health Insurance: Consumer-Driven Health Plans

Health Savings Accounts. In 2003, the U.S. Congress enacted legislation to allow people to establish health savings accounts (HSAs) to work with qualifying high-deductible health coverage to help people finance medical expenses. Beginning January 1, 2004, individuals or employers were allowed to make contributions to these accounts.

HSAs, or consumer-driven health plans, are tax-free accounts that can be set up by individuals or employers; they are personal accounts that are owned by individuals, even when employers establish and contribute to them. Interest earned is not taxed, and funds that are not used may carry over to the following year. HSAs are required to be established with a high-deductible health plan (HDHPs). A health plan qualifies as an HDHP if it has an annual deductible of at least $1,050 ($2,100 for families) and annual out-of pocket expenses – deductibles, co-payments, and coinsurance – that do not exceed $5,250 ($10,250).

There are key differences among health savings accounts (HSAs) and previous tax-preferred accounts such as medical savings accounts (MSAs), flexible savings accounts (FSAs) and health reimbursement arrangements (HRAs) with regard to eligibility rules, the tax benefit, and the type of health coverage that can be used to coordinate with the account.

Although similar to medical savings accounts, HSAs are not as restrictive, have broader eligibility rules, provide a bigger tax break, and allow for an annual deductible that is lower than that for MSA-qualified policies. States' decisions about whether to promote HSAs and the required high-deductible health insurance may affect the type and price of coverage that is available in their healthcare markets. For example, encouraging people to buy high-deductible coverage further shifts the cost of healthcare from employers and health plans to individuals. With more of their dollars at stake, consumers may make more cost-efficient choices regarding their healthcare services. On the other hand, cost shifting might also result in people not getting or delaying necessary care—which could ultimately increase healthcare costs for employers and health insurers if people develop more serious conditions because of postponing services, and could perhaps increase costs for states if people turn to state-funded programs. A 2005 survey conducted by the Employee Benefit Research Institute (EBRI) and The Commonwealth Fund showed that an estimated 31% of those enrolled in an HSA incurred out-of-pocket costs that exceeded 5% of their income; this compares to 12% of individuals with comprehensive health insurance who have out-of-pocket costs in excess of 5% of their income.[58]

A review of current studies focusing on HSAs found that personal accounts would reduce health spending by 2-7%; however, HMO enrollee spending was found to be less than HSAs. [59] The early effects of such health insurance arrangements on quality are mixed, with evidence of both appropriate and inappropriate changes in care use.[60] Additionally, studies show that there is moderately favorable income and health selection among early adopters of HSAs leaving lower-income and sicker Americans in other plans.[61]

[58] Fronstin P, Collins SR, "Early Experience with High Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Healthcare Survey", The Commonwealth Fund, December 2005.
[59] Buntin et al., "Consumer-Directed Healthcare: Early Evidence About Effects On Cost and Quality." Health Affairs Web Exclusive 25w516-w530 (October 24, 2006).
[60] Ibid.
[61] Ibid.

Comparison of Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs)[62]

	HSAs	MSAs	FSAs	HRAs
Health plan type	High-deductible only	High-deductible only	High-deductible and comprehensive	High-deductible and comprehensive
Carry over from year to year?	Yes	Yes	No	Yes
Portable?	Yes	Yes	No	No (up to employer)
Type of coverage?	Individual and job-based health coverage	Small business or self-employed health coverage only	Job-based only	Job-based only
Who contributes?	Individuals, employees, and employers	Employee, self-employed, or small business employer (50 or less empl.) Employee and employer cannot both contribute in a tax year	Employee	Employer
How is it taxed?	"Above the line" deduction (employer contribution not taxed as income)	"Above the line" deduction (employer contribution not taxed as income)	Not taxed as income	Not taxed as income

Public Opinion. An October, 2006 ABC News/Kaiser Family Foundation/USA Today Healthcare in America Survey found: [63]

- Americans believe that allowing individuals to shop for healthcare would be more effective at controlling costs (79%) than the current system of employer-based coverage (67%) or government regulation of healthcare costs (62%).
- However, most Americans are not currently interested in a broadly defined plan that would cover major medical problems but leave consumers to handle the rest of their medical needs out of a pool of money over which they have control. This survey found that two in three (66%) say they would oppose such a plan—60% of registered Republicans and 73% of registered Democrats.

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[62] *Kofman, M "Health Savings Accounts: Issues and Implementation Decisions for States" Issue Brief Vol V, No 3 State Coverage Initiatives, Academy Health, (September 2004)*

[63] Kaiser Family Foundation, Publication No. 7572, (October 2006) < http://www.kff.org/kaiserpolls/pomr101606pkg.cfm>

Adoption of HSAs by employers. The Kaiser Family Foundation/Health Educational Trust Employer Health Benefits 2006 Annual Survey[64] found:

- Among firms offering health benefits, 6% offer an HSA qualified HDHP. Firms with 1,000 or more workers are more likely (12%) than firms with 3 to 999 workers (6%) to offer an HSA qualified HDHP.
- Average annual premiums for HSA qualified HDHPs are $3,176 for single coverage and $8,515 for family coverage. These premium amounts are lower than the single and family premiums for other plan types.
- Over one-third (37%) of employers who offer these plans do not contribute to their employee's HSAs.

Considerations for state policymakers:

- Economists Sherry Glied and Dahlia Remler have estimated that fewer than one million currently uninsured Americans will likely obtain coverage through HSAs. This is primarily because 71 percent of the uninsured in the United States are in a 10-percent-or-lower income tax bracket (55% are in the 0% tax bracket), and they have little to gain from the tax savings imparted by HSAs.[65]
- HSAs could have an impact in segmenting risk in the private market: when choosing between low-cost, high-deductible coverage and more costly comprehensive coverage, healthy individuals tend to choose the lower cost alternative. This can leave fewer healthy people covered by traditional insurance, contributing to a rise in premiums for that type of coverage.
- HSAs do not remedy the fact that a minority of people, typically the elderly and individuals with chronic conditions, account for the vast majority of healthcare costs. These individuals may have difficulty maintaining HSAs because of their significant healthcare expenses.
- Cost-sharing reduces the use of healthcare, especially primary and preventive services, and low-income individuals and those who are sicker are particularly sensitive to cost-sharing increases. For example, 38% of adults with deductibles of $1,000 or more reported at least one of four cost-related access problems: not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up, or having a medical problem.[66]
- When employers contribute to savings accounts in HSAs, they are distributing some portion of the healthcare benefit directly to all enrollees (the account), not just those needing care. These account dollars may exceed annual healthcare spending for healthier workers, while they will be quickly expended by the chronically ill.

[64] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2006 Annual Survey,"< www.kff.org/insurance/7527/index.cfm>

[65] Glied SA, Remler DK, "The Effect of HSAs on Health Insurance Coverage," The Commonwealth Fund, Issue Brief, April 2005.

[66] Davis, K, "Consumer-Driven Healthcare: Will it Improve Health System Performance? Health Services Research 39:1219-34 (2004); See also: Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits, New England Journal of Medicine 354(22):2349-59 (2006).

CHAPTER 4
WHO'S NOT COVERED: THE UNINSURED

In this chapter:

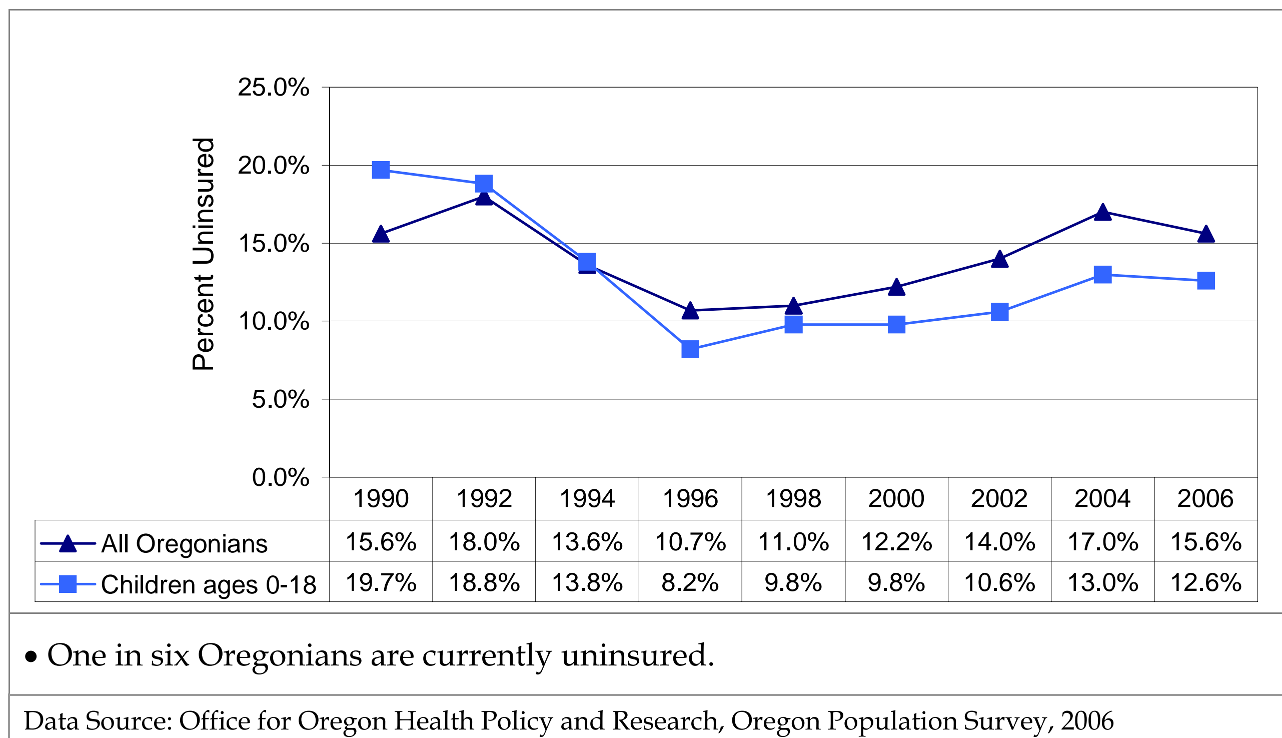
- Health Insurance Trends in Oregon
- Characteristics of the Uninsured
- The Impact of Being Uninsured

Health Insurance Trends in Oregon

Oregon collects data on health insurance trends through the Oregon Population Survey (OPS), a statewide telephone survey of Oregon households conducted every other year since 1990. The survey's primary objective is to track numerous health, social and economic "benchmarks", including measures of Oregonians' health insurance status. The 2006 survey included 4,332 households with data from 10,120 individuals.

As evident from the previous chapters, insurance rates are influenced by many factors, including the economy and employment rates, Medicaid and Medicare policy, and the costs of health insurance for employers and employees. Oregon's increasingly expensive health insurance premiums and the erosion of employer-sponsored insurance are contributors to Oregon's uninsured population, which went from 14% in 2002 to 17% in 2004 and 15.6% in 2006.

Trends in Oregon's Uninsured Rate, 1990 to 2006

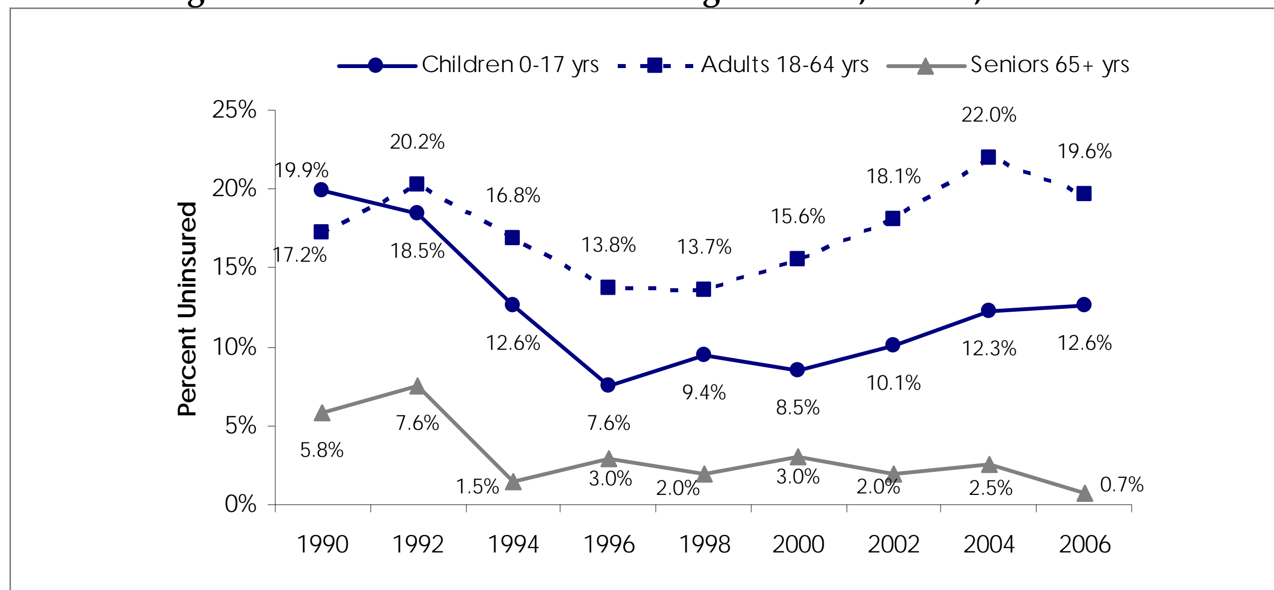


	1990	1992	1994	1996	1998	2000	2002	2004	2006
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%
Children ages 0-18	19.7%	18.8%	13.8%	8.2%	9.8%	9.8%	10.6%	13.0%	12.6%

- One in six Oregonians are currently uninsured.

Data Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006

Oregon Health Insurance Trends among Children, Adults, and Seniors



- The percentage of uninsured children (age 17 and under) has continued to increase in recent years, despite increased children's coverage within the Oregon Health Plan.

Data Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Insurance in the Last 12 Months. Capturing an accurate estimate of Americans lacking health insurance and understanding the dynamic nature of this population is vital to designing effective policy. The Office for Health Policy and Research estimates the percentage of uninsured from the Oregon Population Survey's (OPS) point-in-time estimates, providing only a snapshot of the uninsured, which ignores the ongoing stream of people who flow quickly into and out of the uninsured "pool."

The OPS also asks those who state that they are currently insured if they've been uninsured at any time in the previous 12 months. Another 8.3 percent of the respondents reported a gap in their coverage at some time in the previous year.

This finding is mirrored in a recent study examining the stability of Americans' health insurance status over a continuous, four-year period from 1996 to 1999. The authors found that relatively few Americans were continuously uninsured for the four years, but a sizable number of uninsured lacked a stable source of coverage.[67]

Key findings from the national study included:

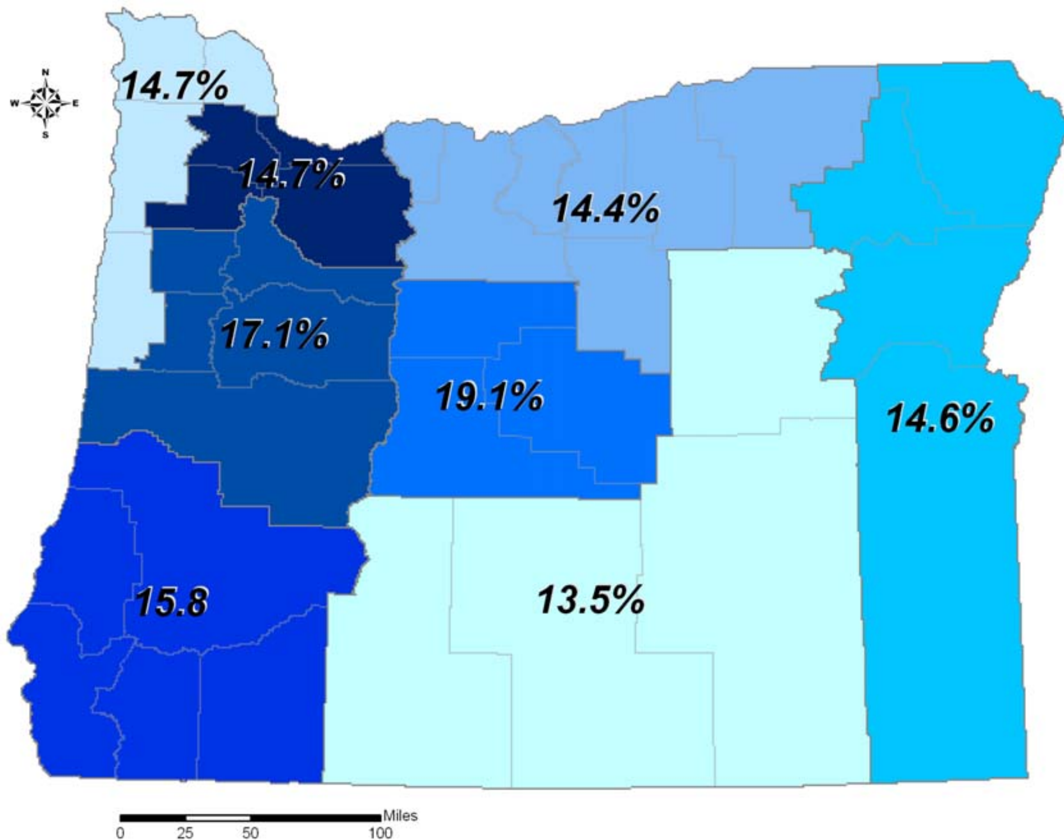
- The repeatedly uninsured represent the largest group with 33% having at least two uninsured and two covered spells;
- Only 12% were uninsured for the entire four years; and
- 19% experienced a single gap in coverage, while 6% had temporary coverage and were otherwise uninsured.

[67] *Pamela Farley Short and Deborah R. Graefe. Battery-Powered Health Insurance? Stability In Coverage of the Uninsured. Health Affairs,November/December 2003; 22(6): 244-255*

These findings have important policy implications; the "uninsured" essentially refers to gaps in coverage that people experience repeatedly over time rather than isolated incidents.

Regional Differences. The following map displays regional differences in the uninsured rates across the state.

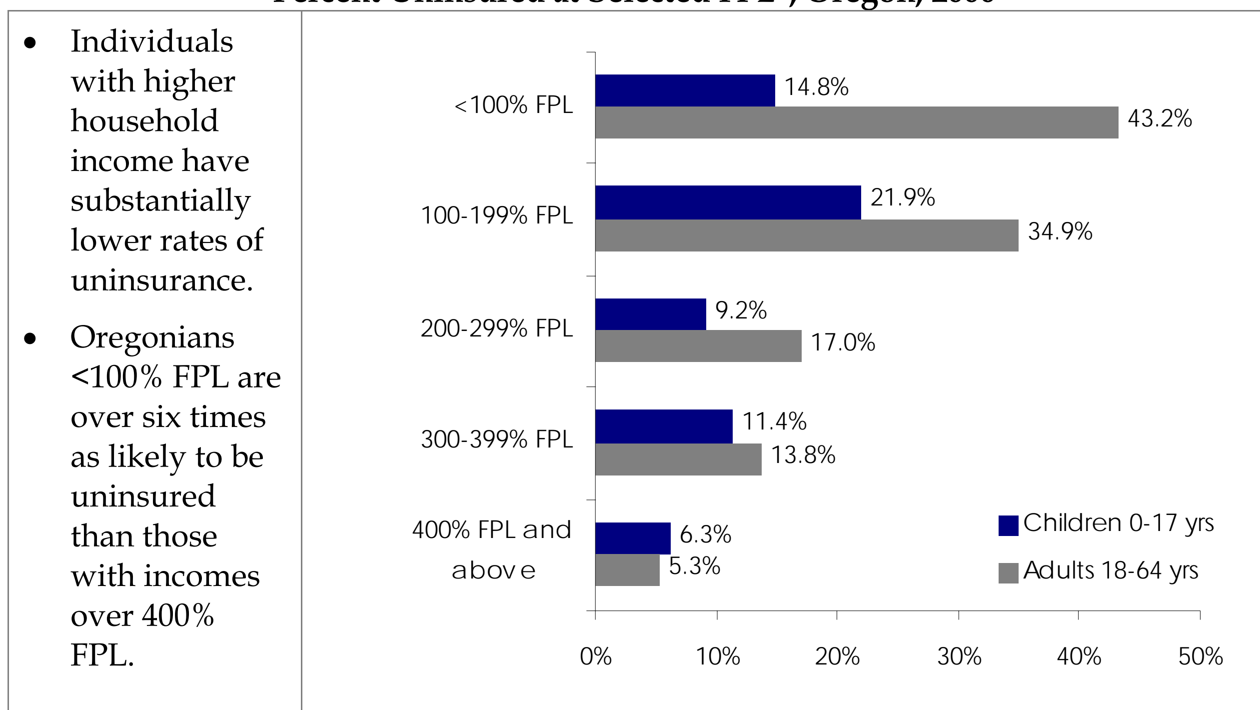
Regional Percentages of the Uninsured in Oregon, 2006



Characteristics of the Uninsured

The ability to obtain and keep health insurance coverage is not distributed equally across the population. Since most health insurance in the U.S. is employer-based, many of the same characteristics that impact employment status and income also impact health insurance status. Young adults tend to have less coverage than any other age group. Education, income and age are all correlated with health insurance as well. Finally, healthcare disparities persist for racial and ethnic groups and those are reflected in health insurance coverage as well.

Percent Uninsured at Selected FPL*, Oregon, 2006



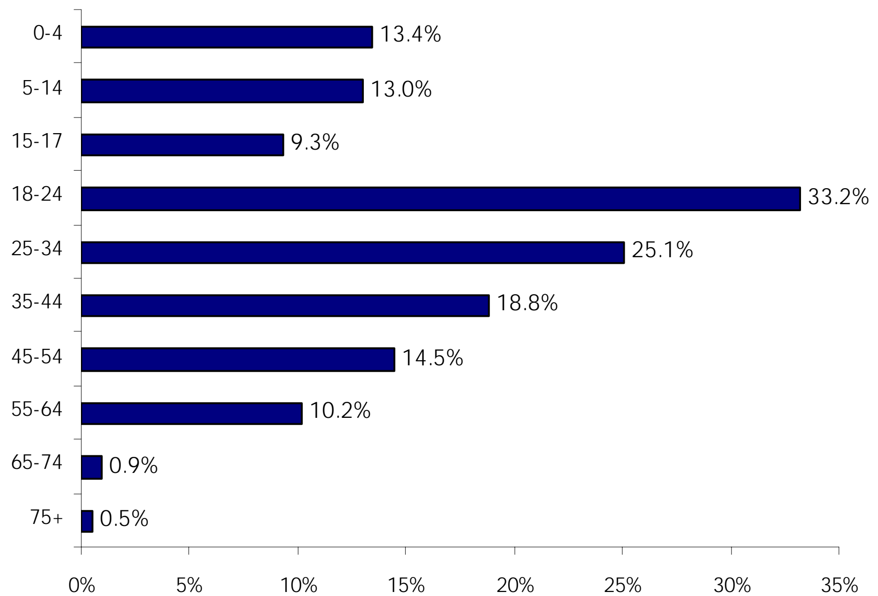
- Individuals with higher household income have substantially lower rates of uninsurance.
- Oregonians <100% FPL are over six times as likely to be uninsured than those with incomes over 400% FPL.

*FPL=Federal Poverty Level, which is based on household size and income. Income is presented as a percent of FPL; for example, <100% of FPL means that the household income is below the federal poverty level, 200% FPL means that the household income is twice the federal poverty level. Percent of FPL is approximated based on broad income categories.

Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Percent Uninsured by Age, Oregon, 2006

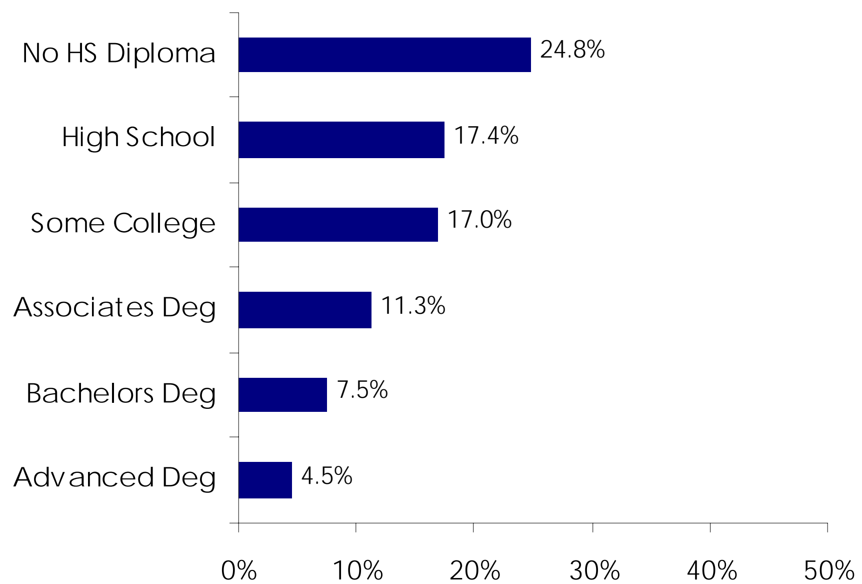
- Young adults are most at risk for being without health insurance; one-third of young adults between 18 and 24 in Oregon are without health insurance.
- Almost all individuals 65 and older are covered by Medicare.
- Only those without enough work credits or those who choose not to enroll remain without Medicare after 65.



Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Percent Uninsured by Level of Education, Oregon, 2006

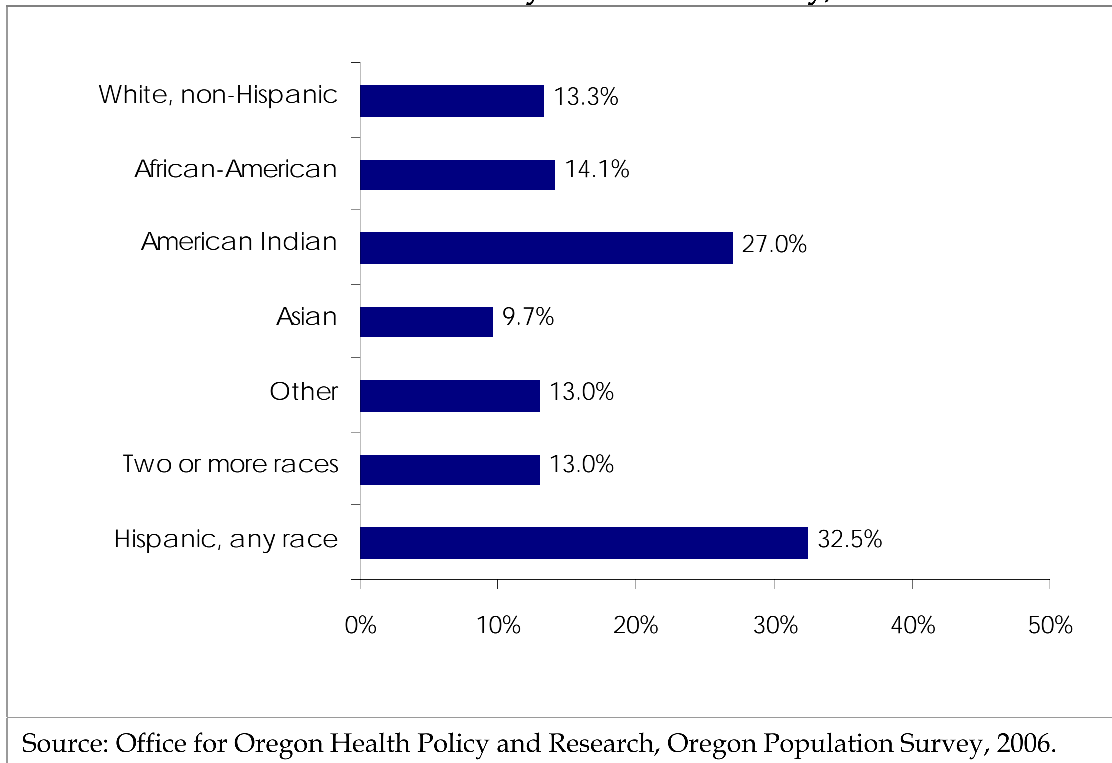
- Health insurance coverage increases as the level of education increases: adults with no high school diploma are over four times more likely to be uninsured than adults with advanced degrees.



Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006. Data restricted to adults 25 years old and older.

Racial and Ethnic Disparities. Oregon's racial and ethnic minority populations are disproportionately without health insurance. Oregon's Hispanic population is more than two times as likely to be without health insurance as the white, non-Hispanic population.

Percent Uninsured by Race and Ethnicity, 2006



Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

The Impact of Being Uninsured

Uninsured Children. Some children who do not have health insurance coverage go without care, and the consequences of this can be deadly.[68] Other children eventually receive care from emergency rooms or other safety net providers, where the cost of care is often greater than it would have been if these children had received preventive care or early treatment for a health problem.[69] The healthcare that uninsured children do receive is paid for through a combination of payments by their parents, government programs, and philanthropy. The remainder of the cost is considered "uncompensated care" and is built into the cost base of physician and hospital revenue. One way physicians and hospitals recover this revenue is by charging more for health services paid for by private insurance. Private insurers then pass these costs along to employers

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[68] *Institute of Medicine, Hidden Costs, Value Lost: Uninsurance in America (Washington: National Academy Press, 2003); Robert C. Bradbury, Joseph H. Golec, and Paul M. Steen, "Comparing Uninsured and Privately Insured Hospital Patients: Admission Severity, Health Outcomes, and Resource Use," Health Services Management Research 321(8): 508-13 (August 2001), as cited in Jack Hadley, Sicker and Poorer: The Consequences of Being Uninsured, A Review of the Research on the Relationship Between Health Insurance, Health, Work, Income and Education (Washington: The Kaiser Commission on Medicaid and the Uninsured, May 2002); American College of Physicians-American Society of Internal Medicine, "No Health Insurance? It's Enough to Make You Sick," (Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999).*

[69] *Stoll K, "Paying a Premium: The Added Cost of Care for the Uninsured," (Washington: Families USA, June 2005).*

by charging higher premiums for employer-sponsored coverage.[70] This triggers a cycle in which increases in premiums cause fewer employers to offer coverage or to pass on additional costs to workers who then cannot afford the cost of dependent coverage. The resulting increase in the number of uninsured further drives up the cost of healthcare and thus health insurance premiums.

The cost of not covering children. Families USA has estimated that in 2005 uninsured children and adults increased private health insurance premiums in Oregon by $372 for individual coverage and $1,128 for family coverage. In 2010, these figures are projected to be $544 additional for individual and $1,886 for family coverage in the state. [71]

When compared to uninsured children, insured children in the U.S. are:

- Eight times more likely to have a regular source of care,[72] have a "medical home," and receive preventive and primary medical care.[73] For example, 70% of uninsured children are less likely to obtain needed care for ear infections, sore throats and asthma, and 30% less likely to receive medical attention when they are injured,
- Five times less likely to use the emergency room as a regular place of care, [74]
- Wait half as long before receiving care, and stay in the hospital half as long due to increased complications,[75]
- Three times more likely to have healthcare needs met than uninsured children who are eligible for, but not enrolled in, Medicaid,[76]
- Four times more likely than uninsured children to have a met need for prescription drugs,
- Three times as likely as uninsured children to have a met need for mental health services,
- Ten times more likely to have received all needed medical care.[77]

Working Status of Families with Uninsured Children in the U.S.[78]

- The majority of uninsured children—88.3 percent—come from families where at least one parent works.
- Among 70 percent of uninsured children living with a parent, at least one family member works full-time, year-round.

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[70] Ibid.
[71] Ibid.
[72] *American College of Physicians-American Society of Internal Medicine, "No Health Insurance? It's Enough to Make You Sick," (Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999).*
[73] *Ku L and Nimalendran S, "Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP," (Washington: Center on Budget and Policy Priorities, January 2004).*
[74] *American College of Physicians-American Society of Internal Medicine, op. cit.*
[75] *Kozak, L.J. et al (2001). Trends in Avoidable Hospitalizations: 1980-1998. Health Affairs 20 (2), p. 225-232.*
[76] O'Brien E and Mann C, Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP (Washington: Covering Kids &Families, Robert Wood Johnson Foundation, June 2003).
[77] Covering Kids & Families, Going Without: America's Uninsured Children (Washington: Robert Wood Johnson Foundation, August 2005).
[78] Families USA, "No Shelter From the Storm: America's Uninsured Children," (Campaign for Children's Healthcare: Publication No. CCHC-0601, September 2006).

- Still, 71 percent of uninsured children come from low-income families (families with incomes at or below two times the federal poverty level—$33,200 a year for a family of three in 2006).
- Among uninsured children living with a parent, more than half—59 percent—live in two-parent households.
- In more than half of all two-parent families with uninsured children, both parents work.

Uninsured Adults. [79] Healthcare coverage does not guarantee access to quality care or any care at all, but it has long been accepted that there are negative consequences to being uninsured, not just for the individual lacking in coverage, but also for the community. Some of the major impacts documented have been:

Impacts on Early Diagnosis

- Adults without coverage are less likely to receive preventive care; they are more than 30% less likely to have had a check-up in the past year.
- Adults without coverage more often go without recommended screenings for hypertension, cancer, diabetes and other chronic conditions, delaying diagnosis until the disease is more advanced.
- Uninsured pregnant women have a 30% higher likelihood of an adverse outcome of their pregnancy, leading to increased use of neonatal intensive care units.

Impacts on Ability to Manage Chronic Disease and Its Complications

- Adults who have no coverage for a year or more miss timely eye, foot and blood pressure exams that help prevent blindness, amputation, and cardiovascular disease.
- Reduced access to healthcare: uninsured receive too little medical care and receive it too late.

Impacts on the Use of the Emergency Department (ED) and Hospital Admissions

- It is estimated that 10% to 50% of all ED admissions could be treated in primary care offices.
- Uninsured adults are 30% to 50% more likely to have avoidable hospitalizations (e.g., treatment for diabetes or pneumonia).
- Communities with poor access to care had higher rates of hospitalizations for certain chronic conditions.

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[79] *This discussion is derived from the following sources:*
The Uninsured and Their Access to Healthcare - Kaiser commission on Medicaid and the Uninsured Key Facts Sheet, January 2003, obtained at www.kff.org on 5/2003.
Fihn, S.D., land J.B. Wicher (1988). Withdrawing routine outpatient medical services. Journal of General Internal Medicine 3 (July/August): 356-62.
Hadley, J (2002) Sicker and Poorer: The Consequences of Being Uninsured – A Review of the Literature. From the Cost of Not Covering the Uninsured Project, an initiative of the Henry J. Kaiser Family Foundation, obtained at www.kff.org on 5/2003.
Hadley, J (2003) Economic consequences of Being Uninsured: Uncompensated Care, Inefficient Medical Care Spending, and Foregone Earnings. Presentation on May 14, 2003 to the Senate Subcommittee on Labor and HHS Appropriations.
Kozak, L.J. et al (2001). Trends in Avoidable Hospitalizations: 1980-1998. Health Affairs 20 (2), p. 225-232.

- 41% of adults who lost coverage had uncontrolled high blood pressure (compared to 8% of adults with continuous coverage).

Impacts on the Cost of Healthcare

- In 2002, the average cost of an avoidable hospitalization was estimated to be $3,300.
- ED visits for complication of untreated chronic illness can cost 20 to 50 times more than one primary care visit.
- Providing primary care in the ED costs three times as much as in a primary care office.

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CHAPTER 5
ACCESS TO HEALTHCARE

In this chapter:

- Overview
- Children's Access
- The Healthcare Safety Net

Insurance status does not guarantee access to needed medical care. There are many other factors that determine access to care, such as:

- Availability of providers within a particular area. This issue is particularly important in rural areas, where population is sparse, and providers have found it much more difficult to maintain their practices.
- Availability of providers who will accept health coverage, particularly Medicare and Medicaid, which reimburse providers at lower levels than commercial payers.
- Accessibility of healthcare services for patients with special needs, such as translation services, alternative formats for written material, or physical accommodations.

Access to healthcare services is compounded for those without health insurance coverage. There are essentially two healthcare systems in the U.S.; one, the mainstream system supported by commercial health insurance and two, the safety net system, which is made up of a wide range of providers.

Children's Access

Results from an Oregon survey on children's access to healthcare conducted by the Office for Oregon Health Policy and Research found that in 2004 only about 68% of uninsured children reported having regular access to a provider of primary care services, compared with nearly all of the children with health insurance (93%). Children without health insurance were almost six times more likely than insured children to lack a usual source of care and three times more likely to be taken to the emergency department or an urgent care clinic for regular care.

Gaps in insurance coverage were also associated with not having access to a usual source of primary care:

- 16.9% of children with a gap of greater than six months in the past year had no usual source of care, compared with only 2.6% of children with continuous insurance coverage.
- 39.4% of children with gaps had to change clinics due to insurance change or loss compared with only 23.3% of children with no gaps.

Unmet Medical Care and Prescription Medication Needs

Being without health insurance coverage was associated with higher rates of unmet need:

- 37.6% of Oregon's uninsured children had unmet medical needs, compared to 13.5% of insured children.
- 40.6% of children with health insurance gaps greater than six months had unmet prescription medication need, compared with 17.7% of children with no gaps.
- Oregon children with no insurance and no usual source of care were the most vulnerable to unmet healthcare needs:
  - 39.3% of uninsured children with no usual source of care had unmet need while only
  - 12.4% of children with both insurance and a usual source of care had unmet need.
- The rate of Oregon high school students with one or more unmet healthcare need rose from 29% to 36% between 1999 and 2005. Rates of unmet healthcare needs vary substantially by racial/ethnic group, where Black, Hispanic and Pacific Islander students have much higher rates of unmet need.
- Only 10.4% of the children with no insurance and no usual source of care always received timely urgent care, compared with 57.6% of insured children with a usual source of care who always received urgent care as soon as they needed it.

Access to Healthcare Providers and Facilities

- Over one-third of Oregon children without health insurance (38.5%) did not visit a doctor's office or primary healthcare clinic in the past 12 months, compared with just over ten percent of children with current insurance.
- Only 18.9% of the uninsured children in Oregon received all of the dental care that they needed, compared with 57.9% of privately insured children.
- Over three-quarters of uninsured children (76.7%) in Oregon had a problem gaining access to specialty care, compared to 47.8% of children with private insurance coverage.

The Healthcare Safety Net

Access to care for the uninsured and underinsured is provided in large part by the healthcare safety net. In 2004, Oregon's Healthcare Safety Net Policy Team defined the healthcare safety net as follows:

- The healthcare safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Healthcare safety net patients often experience barriers to accessing services from other healthcare providers due to cultural, linguistic, geographic and financial

issues. Safety net patients tend to be uninsured, underserved, Medicaid/Medicare enrollees, and other vulnerable/special populations.

- Healthcare safety net providers deliver services to persons experiencing barriers to accessing the services they need. These providers include a broad range of local non-profit organizations, government agencies, and individual providers.
- Core healthcare safety net providers are especially adept at serving people regardless of their ability to pay. They have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need, and serve a substantial share of Medicaid/Medicare enrollees, people who have no health insurance, as well as other vulnerable/special populations.

Oregon's healthcare safety net includes Federally Qualified Health Centers (FQHC), Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC) Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments as well as some private providers. For those with federal or state designations, some definitions are useful to understanding the array of safety net providers in the state:

Federally Qualified Health Centers (FQHC's). Federally Qualified Health Centers (FQHC's) are eligible for federal grants and enhanced Medicare and Medicaid reimbursement. There are 24 FQHCs with over 140 sites in Oregon. In order to be designated as a Federally Qualified Health Center the following requirements must be met. A Health Center must:

- Serve a federally designated health professional shortage area, medically underserved area or medically underserved population
- Provide services to patients regardless of insurance status
- Use a sliding fee scale for uninsured patients based on income status
- Operate as a nonprofit corporation governed by a board of directors of which a majority are users of the Health Center

There are three types of Federally Qualified Health Centers: Section 330 Health Centers, Federally Qualified Health Center-Look Alikes, and Tribal Health Programs.

Section 330 Health Centers. There are four types of Section 330 Health Centers:

- Community and Migrant Health Centers
- Healthcare for the Homeless Programs
- Public Housing Primary Care Programs
- School-Based Health Centers

Community and Migrant Health Centers. Community and Migrant Health Centers provide comprehensive primary healthcare for adults, children and families. These Health Centers are public or private corporations governed by consumer-majority boards of directors that represent the communities they serve. Health Centers receive reimbursement for services from patients according

to their ability to pay. Health centers also receive third party reimbursement from private insurance, Medicare and Medicaid. Federally funded Community and Migrant Health Centers receive operating grants under Section 330 of the Public Health Service Act. Migrant health centers in Oregon include La Clinica del Carino in The Dalles and La Clinica del Valle in Medford, Salud and Virginia Garcia Memorial Center (in multiple locations).

Healthcare for the Homeless Programs. Healthcare for the Homeless programs provide outreach and case management services, primary medical and dental care, 24-hour emergency services, mental health and substance abuse counseling and treatment to homeless individuals. They also provide referrals to other services, such as emergency food, clothing and shelter programs, placement services for long term employment and housing.

Unlike the Health Center model, homeless people are not charged directly for services. Healthcare for the Homeless programs in Oregon include The Old Town Clinic, the Portland Alternative Health Center, and Outside In.

School-Based Health Centers. Forty-seven percent of Oregon's School-Based Health Centers are either FQHCs or affiliated with an FQHC. School-Based Health Centers (SBHC) are located in a school or on school grounds and operate year-round for at least 30 hours per week. SBHCs are designed to ease access to healthcare by reducing the barriers that have historically prevented adolescents from seeking the health services they need including inconvenience, cost, transportation, concerns surrounding confidentiality, and apprehension about discussing personal health problems. The practitioners provide a full range of services for all students, regardless of whether or not they have health insurance coverage. There are 45 school-based health centers in 17 counties in Oregon. During service years 2004-2005, the centers served more than 18,000 clients in over 56,000 visits.

Federally Qualified Health Center- Look-Alikes. The Federally Qualified Health Center provision is also available to organizations that meet all of the federally funded Community Health Center program expectations, but do not receive federal operating grants under the Section 330 Public Health Service Act. Such organizations are formally designated Federally Qualified Health Center Look-alikes by the U.S. Department of Health and Human Services. There are two FQHC Look-Alikes in Oregon, Oregon Health & Science University's (OHSU) Richmond Clinic in Portland and the Waterfall Clinic in North Bend.

Tribal Health Centers. Tribal health programs seek to provide a framework that encourages tribal, inter-tribal and interagency collaboration, coordination and communication to assure that comprehensive, high-quality healthcare is available and accessible to the Oregon Native American population. There are three Indian Health Service clinics that also have FQHC status in Oregon, the Coquille Community Health Center, Grande Ronde Health Center and the Siletz Community Clinic. There are a total of ten Tribal Health Centers in Oregon, serving over 15,000 unduplicated members in a year.

In addition to the Federally Qualified Health Centers, there are other key safety net providers in the state, including rural health clinics, non-FQHC Tribal Clinics and hospitals.

Rural Health Clinics (RHCs). Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act in 1977. The purpose of RHCs is to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs ownership/governance structure can operate as public, private, or non-profit. The main requirements to obtain RHC status include that the clinic is not located in an "Urbanized Area" as designated by the U.S. Census Bureau. RHCs are located in Health Professional Shortage Area (HPSA), or Medically Underserved Area (MUA), generally determined by information from the State Health Department.

RHC status qualifies the clinic for enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. There are currently 53 RHCs in the state.

Health Professional Shortage Areas. An inequitable distribution of providers in urban and rural areas impedes the ability of all healthcare systems, both safety net and non-safety net, to deliver adequate care in rural areas. Accurate numbers on capacity of rural providers and the entire healthcare safety net are lacking, but a 1998 study of primary care capacity conducted by the Office for Rural Health in 102 rural areas found that 35% of these areas had less than 25% of their primary care needs met. In contrast, only about 14% of the rural areas had more primary care capacity than needed.

The federal Health Resources and Services Administration (HRSA) develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a Health Professional Shortage Area (HPSA) or a Medically Underserved Area or Population (MUA/MUP). HPSAs may have shortages of primary medical care, dental or mental health providers and may be urban or rural areas, population groups or medical or other public facilities.

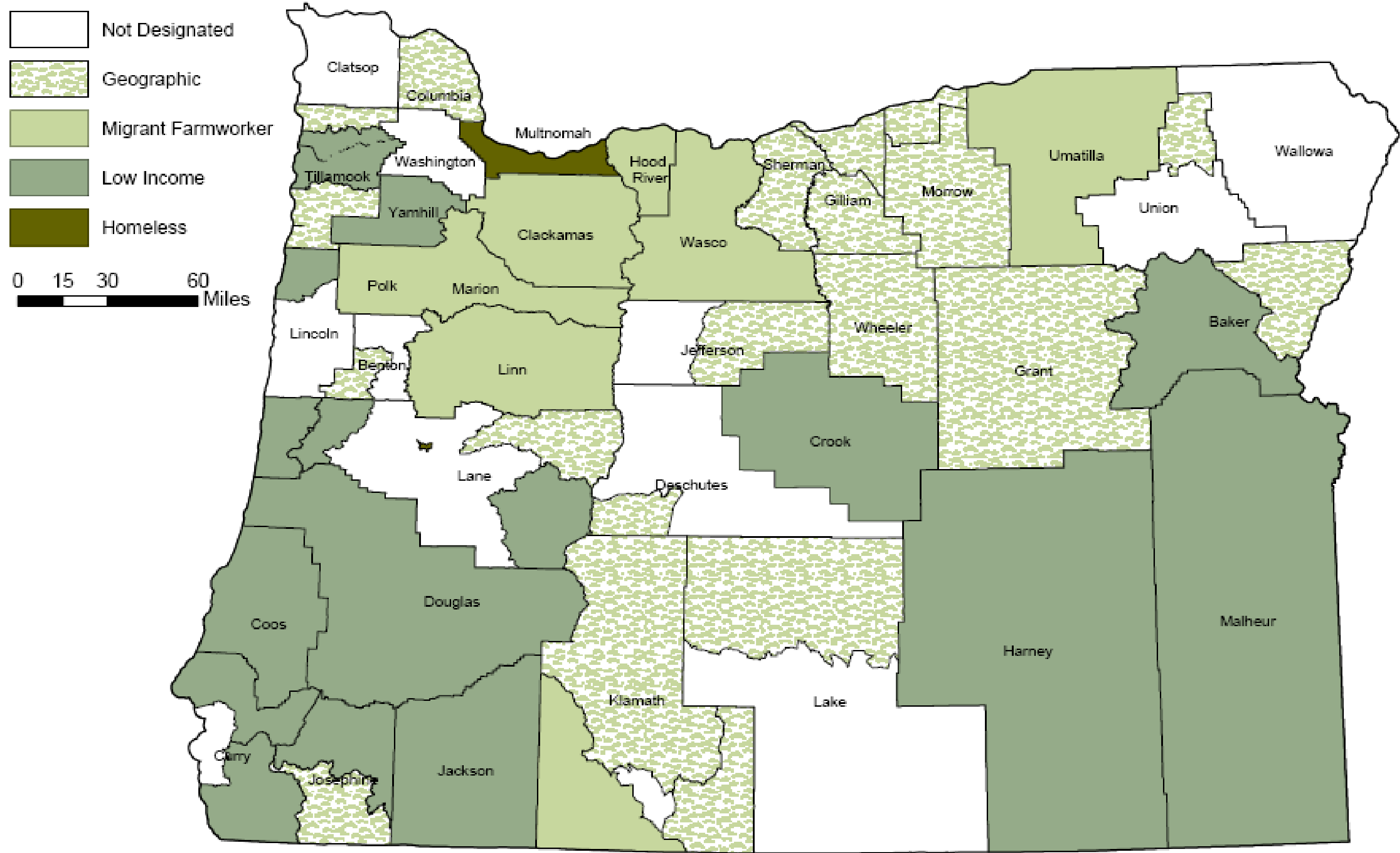
HPSA Map. The white areas on the on the following HPSA map indicate areas that do not currently have a HPSA designation. This does not necessarily mean that they do not meet the criteria, as areas must ask to be considered for designation. There are three major types of HPSA designations:

- Geographic HPSAs (a shortage for the total population)
- Population HPSAs (an underserved population in geographic area such as the Low-Income or Migrant Farm Workers)
- Facility designations (Community Health Clinics, Rural Health Clinics, federal and state correctional facilities)

The map on the following page shows currently designated Primary Care Health Professional Shortage Areas (HPSAs) in Oregon.

Oregon Health Professional Shortage Areas (HPSA)

Primary Care Designations as of 6/06/2006



Data Source: Health Resources & Services Administration (HRSA), Bureau of Health Professions
Prepared By: Health Systems Planning 7/13/06

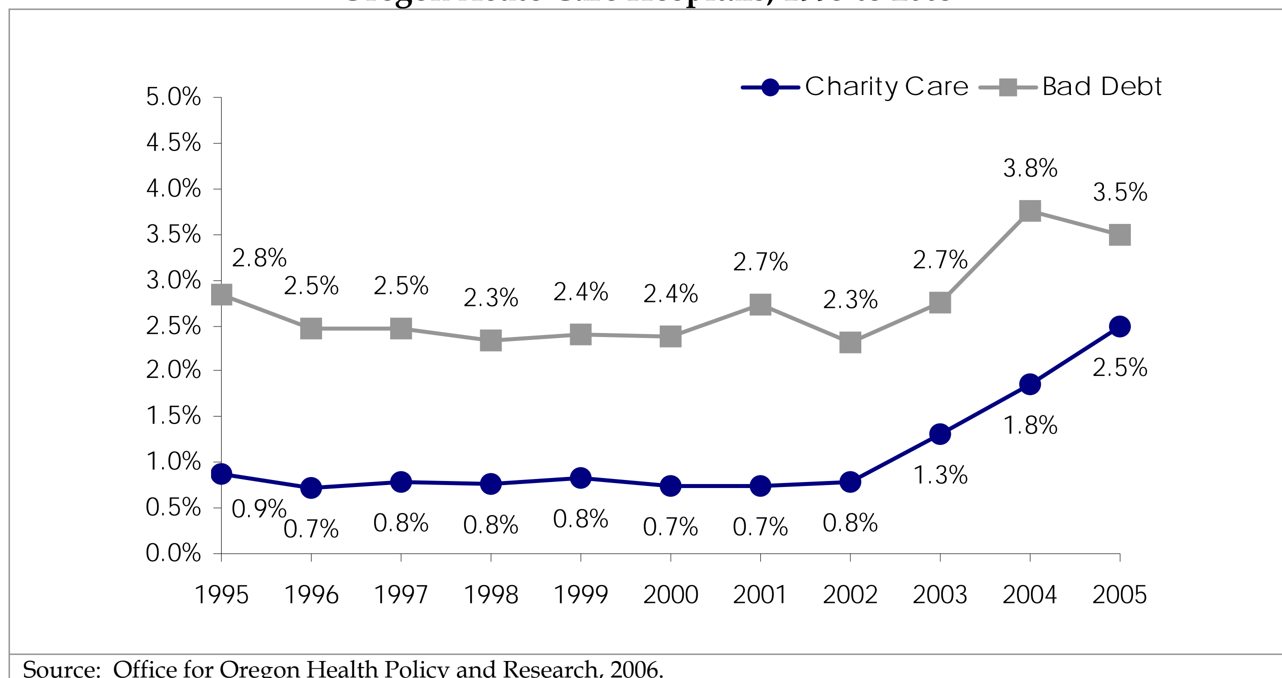
Hospitals

To the extent that hospitals provide uncompensated care, provide care to a disproportionate share of Medicaid patients, or provide primary care services in the Emergency Department (ED), they play a role in the healthcare safety net.

The provision of uncompensated care serves as an indicator of the need for care, both among people who are unable to pay, and the willingness and/or capacity of healthcare providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect uninsurance trends in the community.

The following chart shows the trends in hospital uncompensated care in Oregon from 1995 to 2005:

Median Uncompensated Care as Percent of Gross Patient Revenue, Oregon Acute Care Hospitals, 1995 to 2005



Source: Office for Oregon Health Policy and Research, 2006.

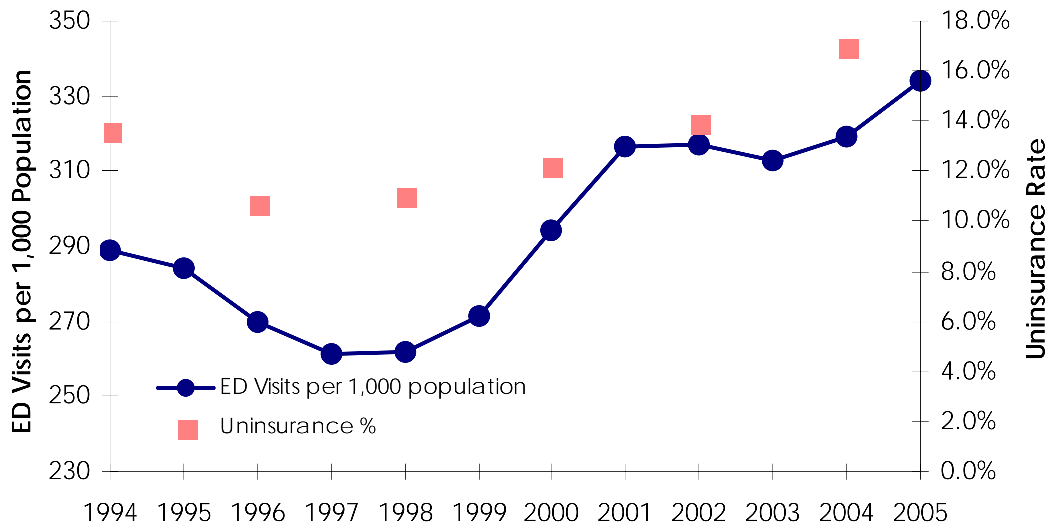
Finally, emergency department (ED) utilization can serve as an early warning system of capacity problems in a local community's primary care system. To the extent that practices are closed to new patients or individuals cannot afford physician visits, people will turn to the ED as their primary care provider. A recent study of individuals who lost their Oregon Health Plan coverage reported that 10% (vs. 2% of those maintaining coverage) used the ED as their usual source of care.[80]

[80] *Carlson M, Wright B, Gallia C, Presentation, "The Impact of Program Changes on Healthcare for the OHP Standard Population", http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC2004Presentations.pdf.* <January 2005>

The following table and chart shows ED visits increasing as the number of uninsured increase in Oregon:

Emergency Department Visits and the Uninsured, Oregon, 1994 - 2005

Year	ED Visits	Oregon Population	ED Visits per 1,000 population
1994	901,059	3,119,940	289
1995	904,791	3,182,690	284
1996	875,456	3,245,100	270
1997	863,190	3,302,140	261
1998	877,994	3,350,080	262
1999	921,414	3,393,410	272
2000	1,008,428	3,421,399	295
2001	1,098,201	3,471,700	316
2002	1,117,313	3,504,700	319
2003	1,113,166	3,541,500	314
2004	1,147,196	3,582,600	320
2005	1,216,163	3,625,100	335



Source: Databank (ED Visits); Oregon Office of Economic Analysis, 2006 Oregon Population Report, Table 1 (Oregon Population); 1994 to 2005 Oregon Population Survey (Uninsurance)

CHAPTER 6
RACIAL AND ETHNIC HEALTH DISPARITIES

In this chapter:

- Racial and Ethnic Minorities in Oregon
- Racial and Ethnic Health Disparities

Racial and Ethnic Minorities in Oregon

Demographic data indicates that there are a growing number of racial and ethnic minorities in the United States and in Oregon. Furthermore, the number of racial and ethnic minorities in Oregon is expected to continue to grow over the next decade. According to population data for Oregon, racial and ethnic minorities (i.e., African Americans, Native Americans, Asians/Pacific Islanders, and Hispanics) made up about 9.2% of the population in 1990.[81] By 2000, these groups represented 16.5% of the population[82], increasing further by 2005 to 17%.[83] These demographic changes magnify the importance of examining the health of racial and ethnic minorities and addressing existing and preventing future disparities.[84] *See Chapter One of this report for more detailed data on racial and ethnic minorities in Oregon.*

Racial and Ethnic Health Disparities

Disparities in "healthcare" and in "health" are often referred to as if they are one and the same. For example, a healthcare disparity refers to differences in coverage, access, or quality of care that are not due to health needs. A health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one population group in relation to another. The two concepts are related in complex ways, most clearly in that disparities in access to healthcare can contribute to health disparities. For example, differences in access to care, use of services, quality, and provider-patient communication have all been shown to contribute to health disparities.[85] However, other factors such as family medical history, personal behavior, educational attainment, income, and other socio-economic factors also are determinants of a population's health.

Racial and ethnic disparities in healthcare—whether in insurance coverage, access, or quality of care—are factors in health status in the United States. The importance of race and ethnicity in determining what care is provided is described in the Institute of Medicine (IOM) 2000 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. After a comprehensive literature review, the IOM concluded that racial

[81] *U.S. Bureau of the Census, 1990 Census of Population and Housing*
[82] *U.S. Bureau of the Census, 2000 Census of Population and Housing*
[83] *U.S. Bureau of the Census, 2005 American Community Survey*
[84] *Satcher, D. Our Commitment to Eliminate Racial and Ethnic Health Disparities. Yale Journal of Health Policy, Law, and Ethics. (2001).*
[85] *Goode et al., "The Evidence Base for Cultural and Linguistic Competency in Healthcare," Commonwealth Fund No.* 962 (October, 2006).

and ethnic minority Americans "tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."[86] Furthermore, the IOM states that "although myriad sources contribute to these disparities some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care."

The IOM report recommended the use of a comprehensive multi-level strategy to address potential causes of racial and ethnic disparities in care that arise from interactions at the patient, provider, and healthcare system levels. These recommendations point to four broad areas of policy challenges:[87]

- Raising public and provider awareness of racial and ethnic disparities in care;
- Expanding health insurance coverage;
- Improving the capacity and number of providers in underserved communities;
- And increasing the knowledge base on causes and interventions to reduce disparities.

National Healthcare Disparities Report.[88] The U.S. Congress has also provided leadership on the issue by legislatively mandating the Department of Health and Human Services (DHHS) to produce an annual report, starting in 2003, on the nation's progress in reducing healthcare disparities. The National Healthcare Disparities Report (NHDR) is released by the Agency for Healthcare Research and Quality (AHRQ) as an overview of disparities in healthcare among racial, ethnic, and socioeconomic groups in the general U.S. population and within priority populations. The report tracks disparities measures focused around four dimensions of care: effectiveness, patient safety, timeliness, and patient centeredness. The measures also cover four stages of care: staying healthy, getting better, living with illness or disability, and coping with the end of life. Measures of access include both patient perception of getting needed care as well as actual utilization.

The 2006 NHDR released in January 2007 had four key themes:

Disparities in the U.S. remain prevalent.

- In the U.S., Hispanics received poorer quality of care than non-Hispanic Whites for 77% of the core measures; African Americans received poorer quality of care for 73% of the core measures; Asians for 32% of core measures and American Indians were worse in 41% of the core measures.
- Poor people[89] received lower quality care than high income people for 71% of core measures.

[86] Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.
[87] Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.
[88] Agency for Healthcare Research and Quality, National Healthcare Disparities Report, 2006(Rockville, Md.: AHRQ, 2007
[89] "Poor" is defined as having family income less than 100% of the Federal Poverty Level (FPL) and "high income" is defined as having family income 400% or more of the FPL, see Appendix B for income breakdowns.

Some disparities are diminishing, while others are increasing.

- The rate of new AIDS cases remained the same for Whites (7.1 per 100,000 population over 13) but decreased for African Americans (from 75.4 to 72.1).
- The proportion of adults in the U.S. over 64 years of age who did not receive a pneumonia vaccine decreased for Whites (from 48% to 41%) but increased for Asians (from 59% to 65%).

Opportunities for reducing disparities remain:

- Although many disparities are diminishing, there remain many areas where the quality of healthcare is worsening rather than getting better for specific racial and ethnic groups.
- For instance, African Americans in the U.S. fare worse than Whites and are getting worse in the measures for late stage colorectal cancer, children with all vaccines, elderly with pneumoccocal vaccine, hospital treatment of pneumonia, patients with diabetes, illness or injury care as soon as wanted, and children hospitalized for asthma, among others

Information about disparities is improving, but gaps still exist:

- New measures on obesity, asthma management, hospice care, patient safety, patient-centeredness in hospital care, workforce diversity, and health insurance coverage have been added to the 2006 National Healthcare Disparities Report because of the development of new datasets or improvements in existing datasets.
- Significant gaps still exist, particularly when there are insufficient sample sizes for some racial or ethnic groups to produce reliable estimates.

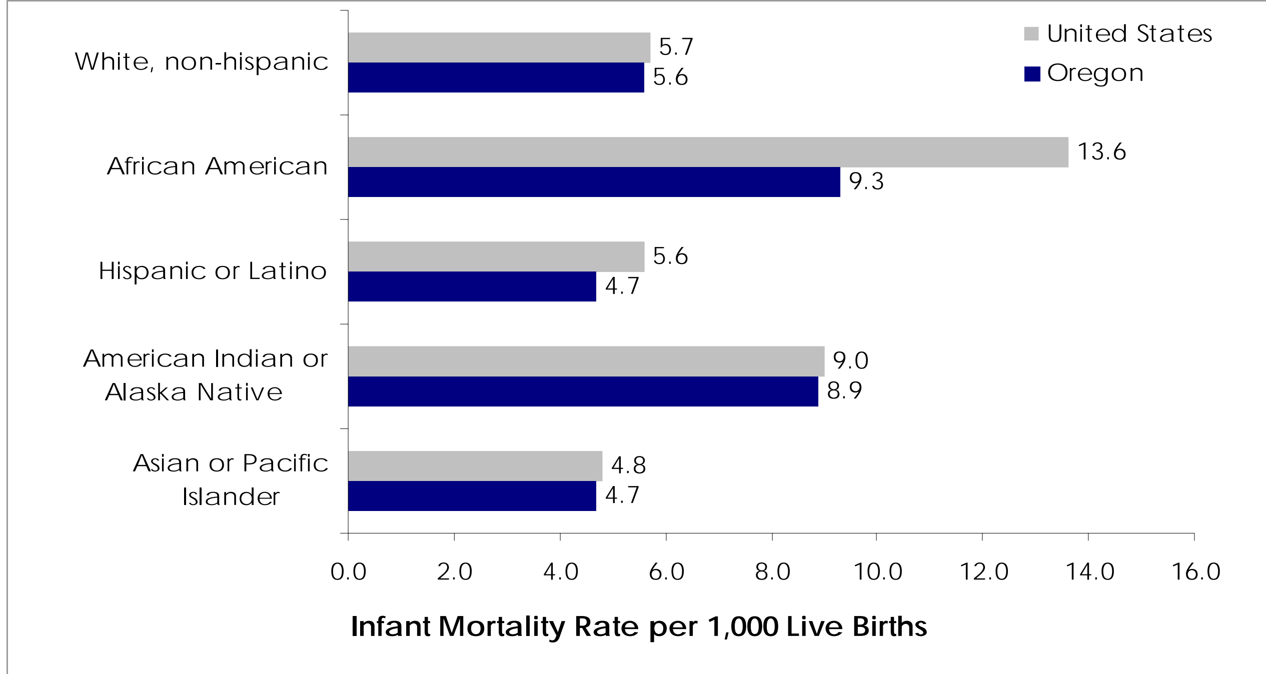
Racial Disparities in Oregon. Unfortunately, the information gaps cited by the National Healthcare Disparities Report are a significant problem in Oregon. Limited data on health behaviors, disease burden, and mortality among racial and ethnic minorities are available.

Multnomah County's Health Department released a report in October 2006 focusing on 17 health status indicators for four racial or ethnic populations: African Americans, Asians, American Indians and Hispanics. Across the 17 indicators of health status monitored in the Multnomah County report, African Americans experienced the greatest number of disparities, although the magnitude of disparities is diminishing. The report shows no significant health disparities for Asians, American Indians, and Hispanics for most of the reported health status indicators.[90]

[90] *Racial and Ethnic Health Disparities in Multnomah County: 1990-2004. http://www.co.multnomah.or.us*

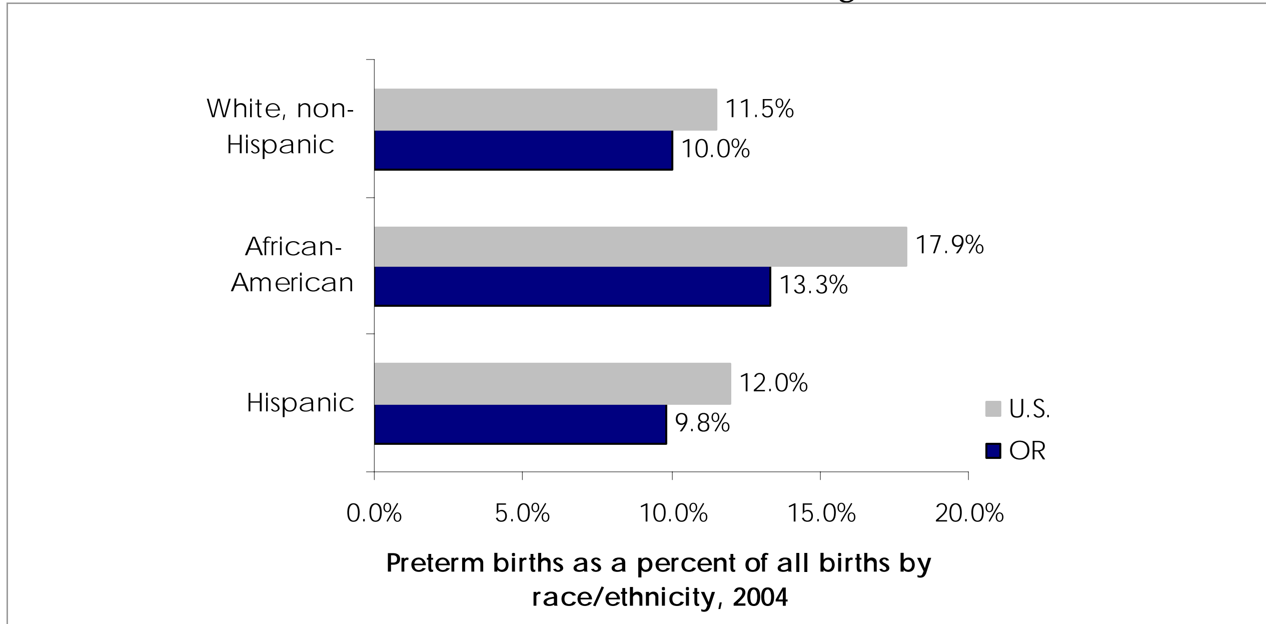
There are, however, certain public health vital statistics such as infant mortality, preterm births and prenatal care where data is available by race and ethnicity so that comparisons can be made between the U.S. and Oregon.

Infant Mortality Rates by Race, Oregon and U.S. 2001-2003



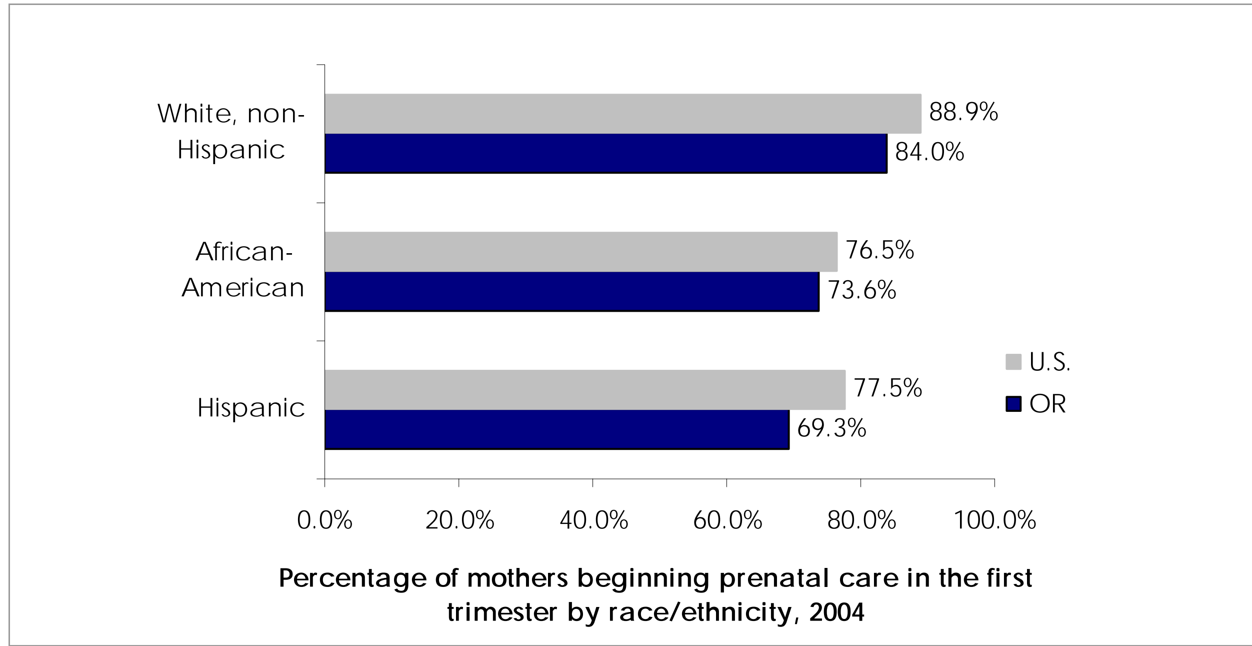
Source: National Center for Health Statistics, *Health, United States, 2006;* Table 23 (November 2006).

Preterm Births as a Percent of All Births, Oregon and U.S., 2004



Source: Martin JA, et.al., Births: Final Data for 2004, Table 33. National Vital Statistics Report, Vol. 55, No. 1, September 29, 2006, Division of Vital Statistics, National Center for Health Statistics.

Percentage of Mothers Beginning Prenatal Care in the First Trimester by Race/Ethnicity, Oregon and U.S., 2004



Source: Martin JA, et.al., Births: Final Data for 2004, Table 26(a) and Table 26(b). National Vital Statistics Report, Vol. 55, No. 1, September 29, 2006, Division of Vital Statistics, National Center for Health Statistics.

Health Insurance Coverage—Race and Ethnicity. Racial and ethnic minorities make up about a third of the U.S. population, but disproportionately comprise 47% of the uninsured—22.1 million of the 46.6 million uninsured in 2005.[91] Differences in health insurance coverage across racial and ethnic groups are partially explained by differences in types of employment and eligibility for public programs. Although employer-sponsored insurance is the major source of coverage for whites as well as racial and ethnic minority groups, Medicaid is an important safety net for 26% of non-elderly African Americans and 22% of Hispanics, as compared to 10% of whites nationally.[92] Oregon shows similar patterns, with 19% of non-elderly Hispanics and 21% of those of other racial and ethnic minorities enrolled in Medicaid, as compared to 13% of whites.[93]

Racial and Ethnic Healthcare Workforce. Despite efforts to increase the number of racial and ethnic minority health professionals, few practice or are educated in Oregon. After an exhaustive literature review, the IOM recommended that expanding the racial and ethnic diversity of the health professions workforce and developing provider training programs and tools in cross-cultural education in order to strengthen patient-provider communication and relationships.[94] These recommendations are based on

[91] *Healthcare and the 2004 Elections. Kaiser Family Foundation. www.kff.org*
[92] *March 2006 Current Population Survey, accessed through Kaiser Family Foundation http://www.statehealthfacts.org.*
[93] *Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates based on pooled March 2003 and 2004 Current Population Surveys. Total U.S. numbers are based on March 2004 estimates, http://www.statehealthfacts.org.*
[94] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.*

evidence that racial and ethnic minority providers are more likely than whites to practice in communities of color and medically underserved areas. Furthermore, research indicates that when patient and providers are of the same race there is greater satisfaction and adherence to treatment.[95]

These concerns are mirrored in a recent survey of Oregon physicians, which shows that only 10% of physicians are racial minorities, and just 2% are Hispanic *(See table below)*.

Physician Race/Ethnicity vs Oregon Population Race/Ethnicity, (2006)

	Percent of Physician Workforce, 2006*	Percent of Oregon Population, 2005*
White	89.7%	90.8%
African-American	0.6%	1.8%
Asian	6.3%	3.4%
Native Hawaiian or Pacific Islander	0.2%	0.3%
Native American/Alaska Native	0.1%	1.4%
Other Race	1.9%	1.0%
Multiple Races	1.2%	2.3%
Hispanic ethnicity	2.2%	9.9%

Source: *Oregon Department of Human Services, Division of Medical Assistance Programs, Oregon Physician Workforce Survey, 2006, **U.S. Census Bureau. Accessed at <http://quickfacts.census.gov/qfd/states/41000.html>, 2005.

Racial and ethnic diversity is substantially higher among Oregon medical school graduates from the 2002/2003 academic year, with 26% of racial or ethnic minority Americans. However, the majority (73%) of Oregon's racial and ethnic minority medical school graduates were Asian, 13.6% Hispanic, and 13.6% Native American. None of these graduates were African American.[96]

Racial and Ethnic Data. Data about access to healthcare and quality of healthcare for Oregon's racial and ethnic minorities, and the ability to track changes over time, are essential not only for developing health policy, but also for monitoring and evaluation purposes. The Governor's Racial and Ethnic Health Task Force identified the central need for enhanced data collection utilizing culturally appropriate methods.[97]

Little is known about the health status and utilization of health services for racial and ethnic groups in Oregon in part because data was simply not collected, methods to collect such data were outdated and/or inaccurate, or administrative procedures were not reliable.[98] Exacerbating these data collection and analysis challenges are the relatively few numbers of racial and ethnic minorities in Oregon.

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[95] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.*
[96] *Association of American Medical Colleges, Applicant-Matriculant File, 2003; accessed through Kaiser Family Foundation http://www.statehealthfacts.org*
[97] *Governor's Racial and Ethnic Health Task Force Final Report. (November 2000). http://www.dhs.state.or.us/publichealth.*
[98] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*

Standardized data collection is critically important to understanding and ultimately eliminating racial and ethnic disparities in healthcare. Data on patient and provider race and ethnicity would allow:

- Policy makers to create more effective policies and regulations
- Researchers to better sort out factors that are associated with healthcare disparities
- Health plans to better monitor performance
- Ensure accountability to enrolled members and payers
- Improve patient choice
- Allow for evaluation of intervention programs
- Help identify discriminatory practices[99]

A number of concerns present challenges to data collection and monitoring, including the need to protect patient privacy, the costs of data collection, and resistance from healthcare providers, institutions, plans and patients.[100] The challenges, however, need to be addressed, for the costs of failing to assess racial and ethnic disparities in care likely outweigh burdens caused by data collection and analysis.

Other Strategies. Other strategies to improve the health of racial and ethnic minorities as well as the delivery of healthcare exist. For example, the Governor's Affirmative Action Office in conjunction with the State of Oregon Employment Department identifies prospective employees and recruitment strategies needed to create a culturally /linguistically diverse and competent work force.

Furthermore, the Department of Human Services, Office of Multicultural Health provides training to healthcare workers regarding services to racial and ethnic groups and works with the Diversity Development Coordinating Council, which addresses access to health services, language issues, diversity in planning and decision-making, and workforce diversity and training. Similarly the Governor's Office of Affirmative Action identified prospective contractors to assess organizational cultural competence and design agency-specific training activities regarding diversity.

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[99] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*
[100] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*

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CHAPTER 7
HEALTH STATUS

In this chapter:

- Chronic Disease
- Risk Conditions
- Modifiable Risk Factors

Chronic Disease

The preceding chapters focused on *healthcare* – costs of healthcare, healthcare coverage, and access to healthcare. Implicit in our discussion of healthcare is the assumption that *healthcare* impacts *health status*, but health status also influences demand for and the cost of healthcare. It is important, therefore, to examine healthcare both in the context of health status and as an important determinant of health outcomes.

The following charts focus on the prevalence of specific chronic diseases in Oregon. These represent areas of opportunity for the state, whereas improved quality and access to primary healthcare can improve health status and reduce costs associated with these conditions.

Deaths and Hospitalizations Due to Selected Conditions in Oregon, 2000-2004

Disease	Total Deaths	% of all Deaths	Total Hospitalizations	Hospitalization Charges
Coronary Heart Disease	35,130	23%	83,893	$1,788,017,331
Stroke	12,860	9%	27,267	$421,915,060
Cancer	35,756	23%	98,018	$1,767,069,706
Chronic Lung Disease	8,869	6%	30,852	$271,044,546
Diabetes	5,018	3%	17,523	$192,192,958
Total	151,765	64%	257,553	$4,440,239,601

- Chronic disease contributes not just higher mortality, but also increased healthcare utilization and costs.
- In Oregon, these major chronic diseases accounted for over 151,000 deaths, over 257,000 hospitalizations, and over $4.4 billion in hospitalization charges during calendar years 2000 to 2004.

Source: Vital Statistics, Oregon Department of Human Services, 2000–2004

Primary Sources: Oregon resident death certificates, Oregon Hospital Discharge Data 2000–2004

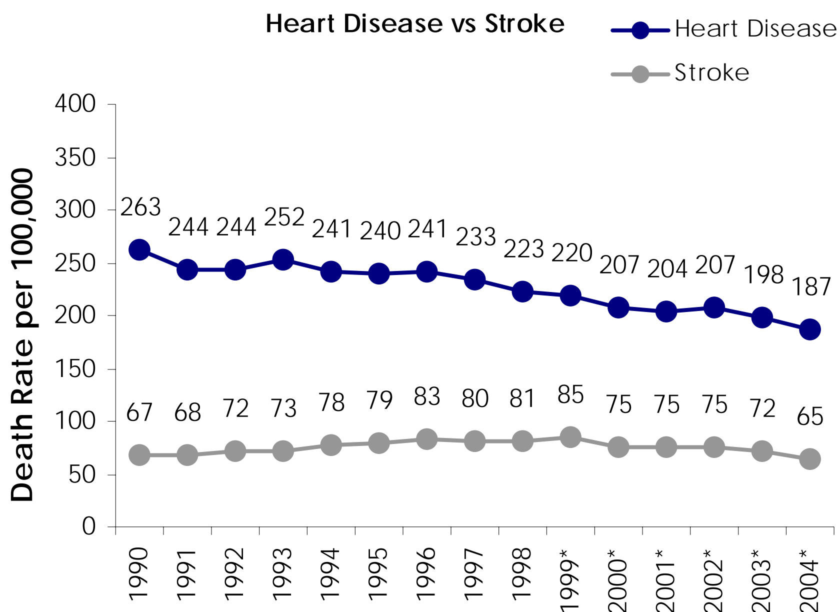
Prevalence of Selected Chronic Diseases, Oregon, 2005

Prevalence	% of Oregon Adults
Arthritis	35%
Asthma	10%
Heart Attack	4%
Coronary Heart Disease	4%
Stroke	3%
Diabetes	7%

- Over a third of adults in Oregon report a chronic disease.
- Those with chronic diseases have higher death rates, incur higher costs, experience higher rates of depression, and are more frequently limited from performing their usual activities.

Source: Oregon Department of Human Services, Public Health Division, BRFSS 2005, located at http://www.dhs.state.or.us/dhs/ph/chs/brfs/05/

Heart Disease and Stroke in Oregon, 1990 - 2004

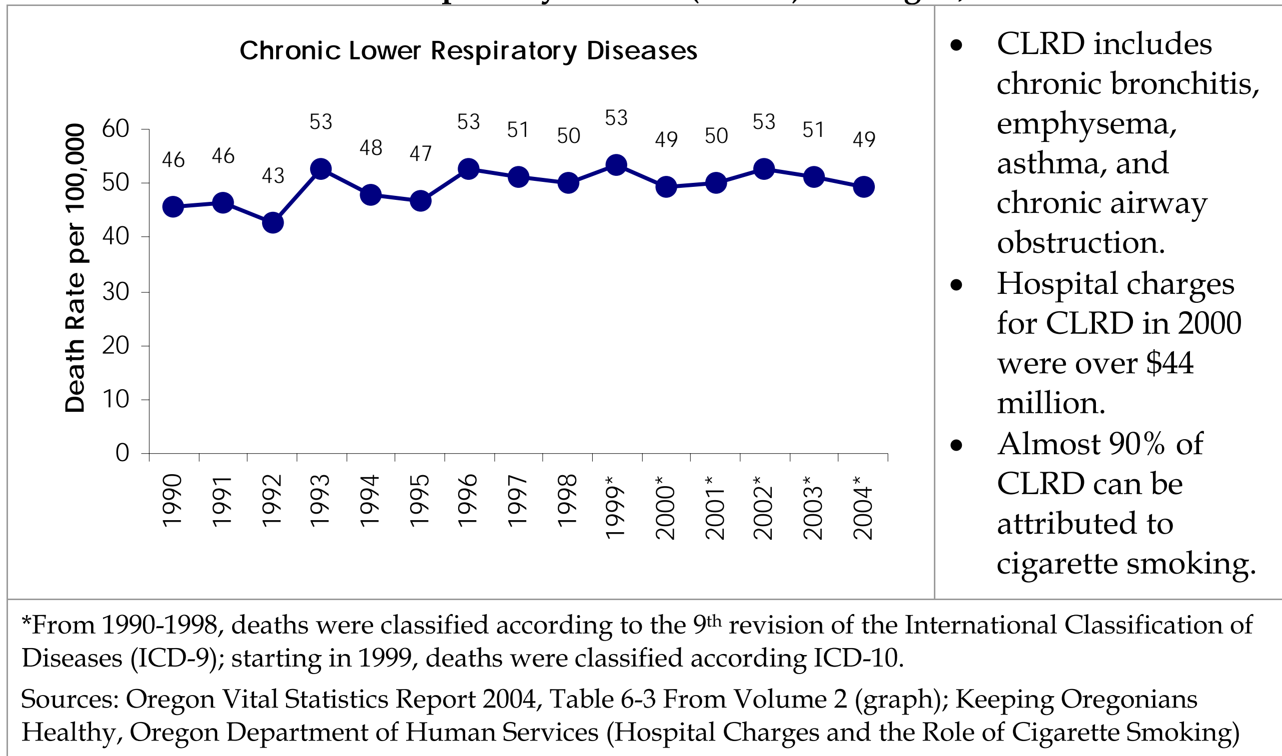


- Heart disease and stroke account for over 91% of cardiovascular disease deaths in Oregon.
- While heart disease death rates have declined since 1990, stroke death rates have remained steady in Oregon.
- In 2003, Oregon had the 3rd highest stroke death rate in the nation.

*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2004, Table 6-3 From Volume 2

Chronic Lower Respiratory Disease (CLRD) in Oregon, 1990 - 2004

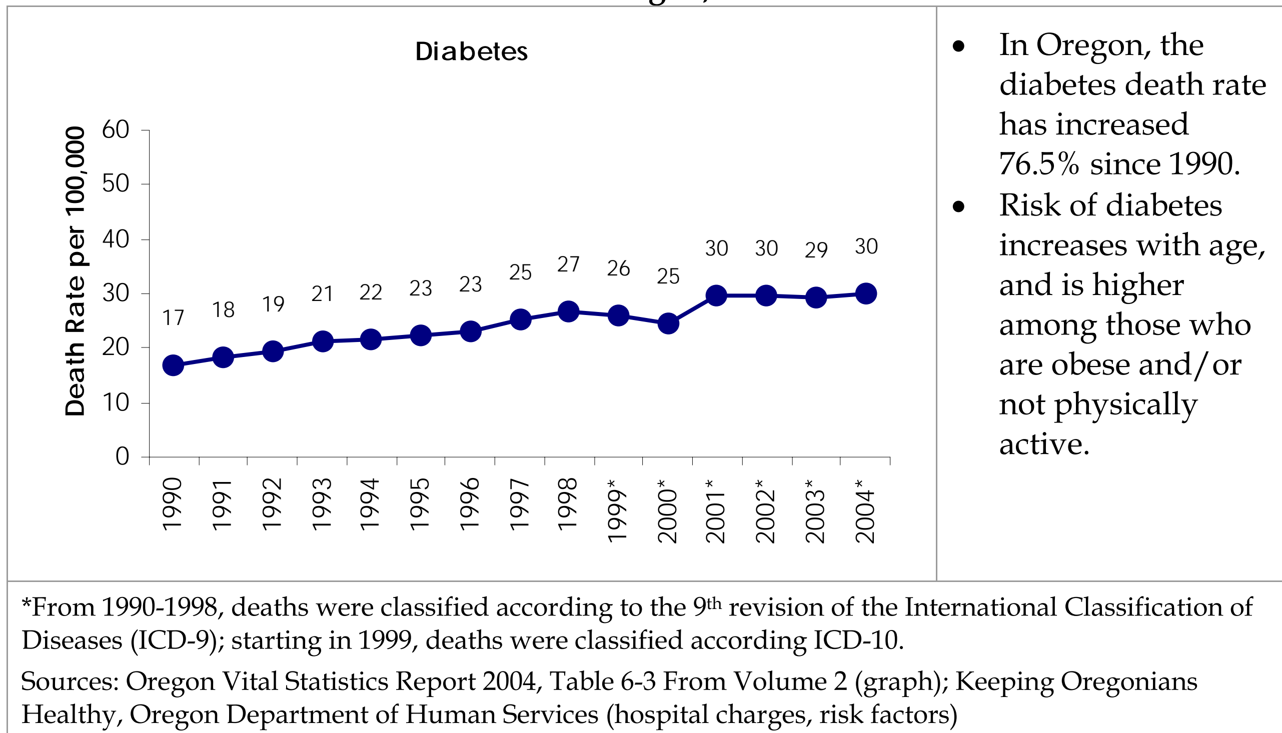


- CLRD includes chronic bronchitis, emphysema, asthma, and chronic airway obstruction.
- Hospital charges for CLRD in 2000 were over $44 million.
- Almost 90% of CLRD can be attributed to cigarette smoking.

*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2004, Table 6-3 From Volume 2 (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (Hospital Charges and the Role of Cigarette Smoking)

Diabetes in Oregon, 1990 - 2004



- In Oregon, the diabetes death rate has increased 76.5% since 1990.
- Risk of diabetes increases with age, and is higher among those who are obese and/or not physically active.

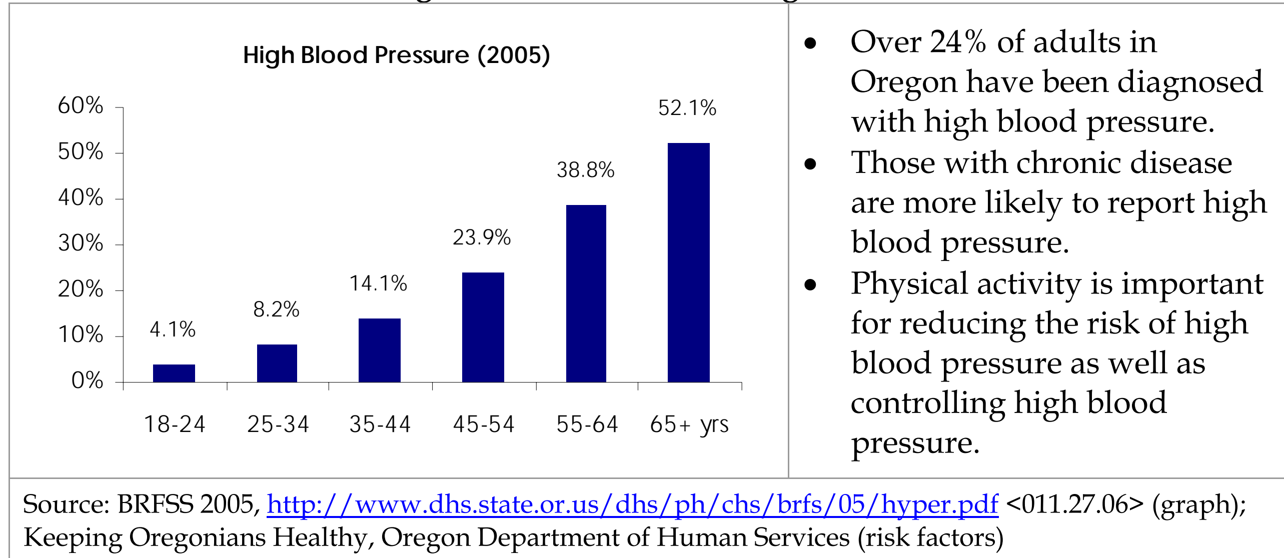
*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2004, Table 6-3 From Volume 2 (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (hospital charges, risk factors)

Risk Conditions[101]

Risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many of the chronic diseases described above. Screening for these conditions can help to detect chronic disease early in its development, and decreasing prevalence of these conditions is important to reducing chronic disease burden in the population.

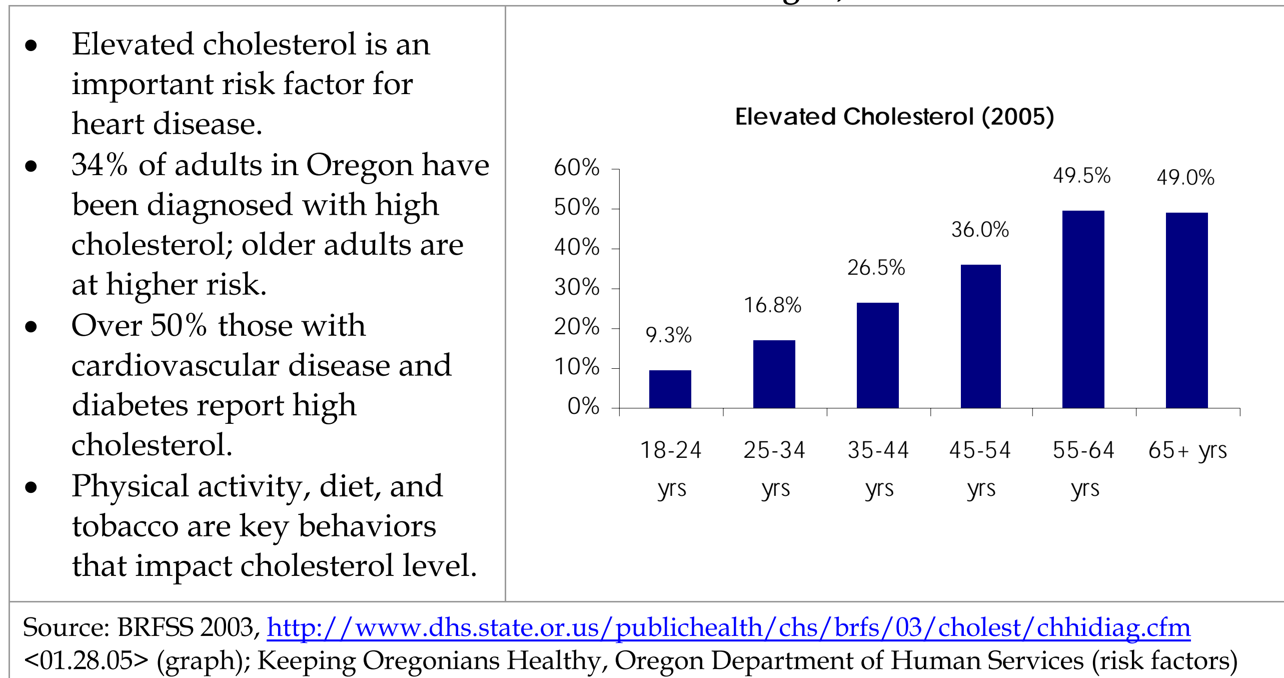
High Blood Pressure in Oregon, 2005



- Over 24% of adults in Oregon have been diagnosed with high blood pressure.
- Those with chronic disease are more likely to report high blood pressure.
- Physical activity is important for reducing the risk of high blood pressure as well as controlling high blood pressure.

Source: BRFSS 2005, http://www.dhs.state.or.us/dhs/ph/chs/brfs/05/hyper.pdf <011.27.06> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

Elevated Cholesterol in Oregon, 2005

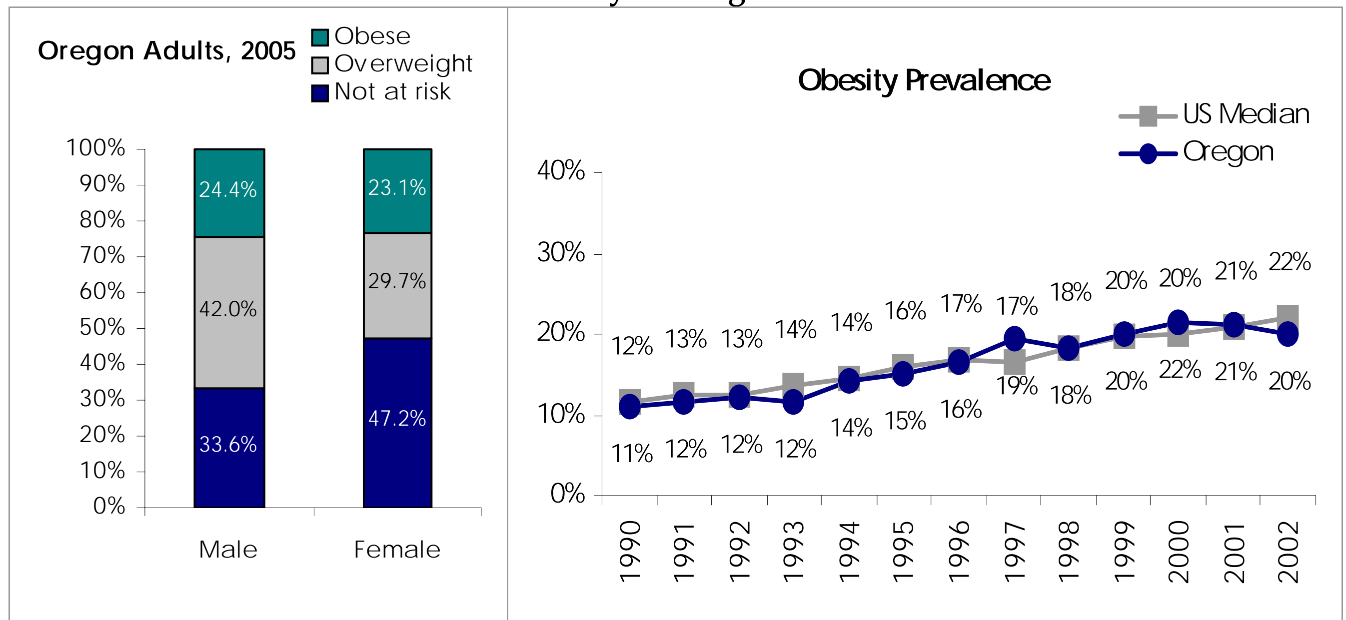


- Elevated cholesterol is an important risk factor for heart disease.
- 34% of adults in Oregon have been diagnosed with high cholesterol; older adults are at higher risk.
- Over 50% those with cardiovascular disease and diabetes report high cholesterol.
- Physical activity, diet, and tobacco are key behaviors that impact cholesterol level.

Source: BRFSS 2003, http://www.dhs.state.or.us/publichealth/chs/brfs/03/cholest/chhidiag.cfm <01.28.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

[101] *This section is based in large part on Oregon Department of Human Services' "Keeping Oregonians Healthy" report, June 2003.*

Obesity in Oregon



Source: BRFSS 2005, http://www.dhs.state.or.us/dhs/ph/chs/brfs/05/weight.pdf <11.27.06> (2005 data); Centers for Disease Control and Prevention, BRFSS, http://apps/nccd/cdc.gov/brfss/trends/TrendData.asp (prevalence trends); Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003 (risk factors and consequences)

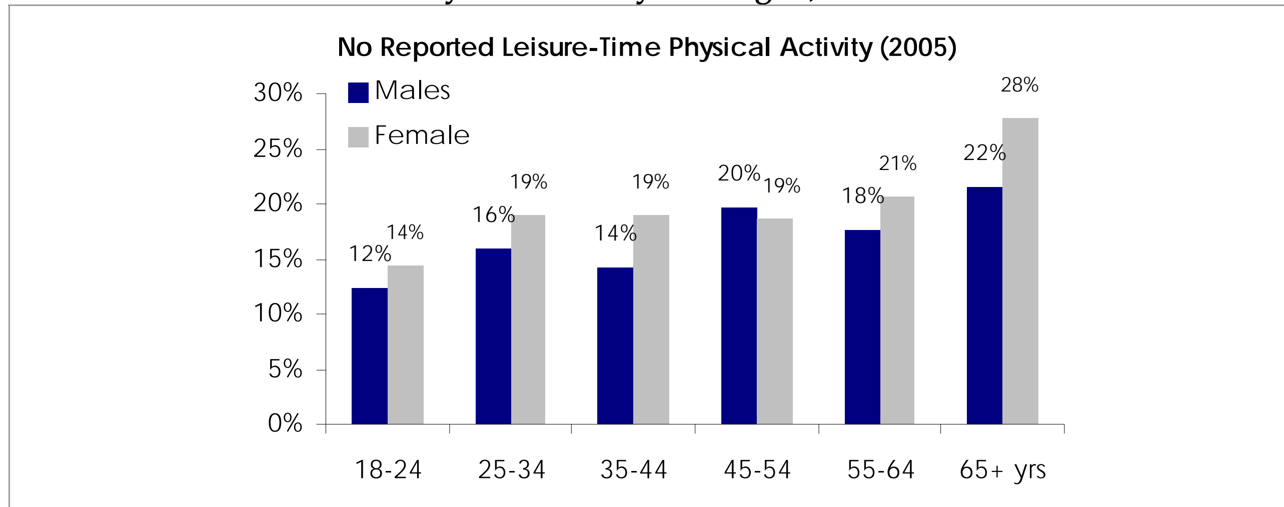
- Overweight and obesity are usually a result of poor diet and physical inactivity.
- Obesity is linked to a wide range of diseases including cardiovascular disease, some cancers, and especially diabetes.
- In 2005, 23.8% of adults in Oregon were obese, and 59.7% were either overweight or obese. Overweight and obesity are more prevalent among men than women.
- Obesity prevalence in adults and children combined has almost doubled since 1990 both nationally and in Oregon. Overweight is also a growing problem among children and particularly among adolescents.
- Key facts about childhood obesity in Oregon[102]:
    - Proportion of 8th graders who were overweight or at risk of it in 2005: 1 in 4.
    - Percentage of 11th graders who were overweight in 2005: 11%
    - Among 11th graders the relative increase since 2001 was (or "Relative increase since 2001 that this represents, among 11th graders": 63%.
    - Proportion of 8th graders who don't eat five or more servings of fruits and vegetables a day: 3 in 4.
    - Proportion of 11th graders who don't eat five or more servings of fruits and vegetables a day: 4 in 5.

[102] Oregon Department of Human Services "Promoting Physical Activity and Healthy Eating among Oregon's Children" Draft 4.0 (October 3, 2006).

Modifiable Risk Factors[103]

The chronic diseases and risk conditions described above are influenced by many inter-related factors including genetic predisposition, environmental exposure, social circumstances such as socioeconomic status, medical care, and behavioral patterns. Some of these factors can be changed, while others cannot. Three key behavioral factors – tobacco use, physical activity, and diet – can impact the development of chronic and/or risk conditions and are discussed in this section. Further, behavior, while modifiable, is influenced by one's community conditions; for example, sidewalks, transit facilities, recreation facilities and greenways located closer to people's homes make it easier to incorporate exercise into a daily routine.

Physical Activity in Oregon, 2005

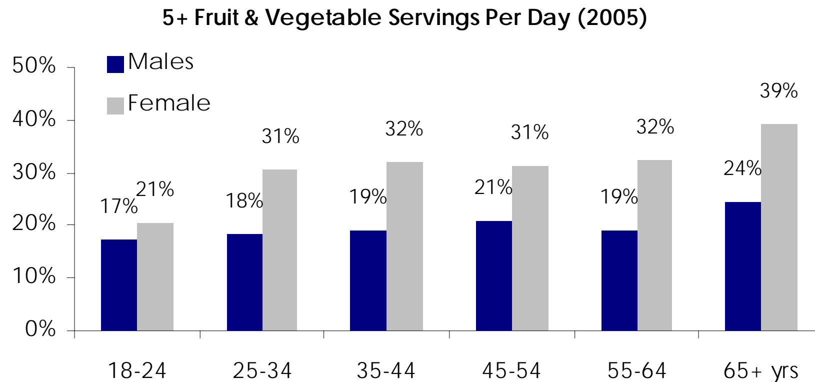


- 18.6% of Oregon adults did not report any leisure-time physical activity in 2005.
- Lack of physical activity is more common with increasing age and for females.
- Sedentary lifestyles increase the risk for obesity and many chronic diseases.
- Physical activity is strongly related to one's community surroundings.

Source: BRFSS 2005, http://www.dhs.state.or.us/dhs/ph/chs/brfs/05/exercise.pdf <11.27.06> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

[103] *This section is based in large part on Oregon Department of Human Services' "Keeping Oregonians Healthy" report, June 2003.*

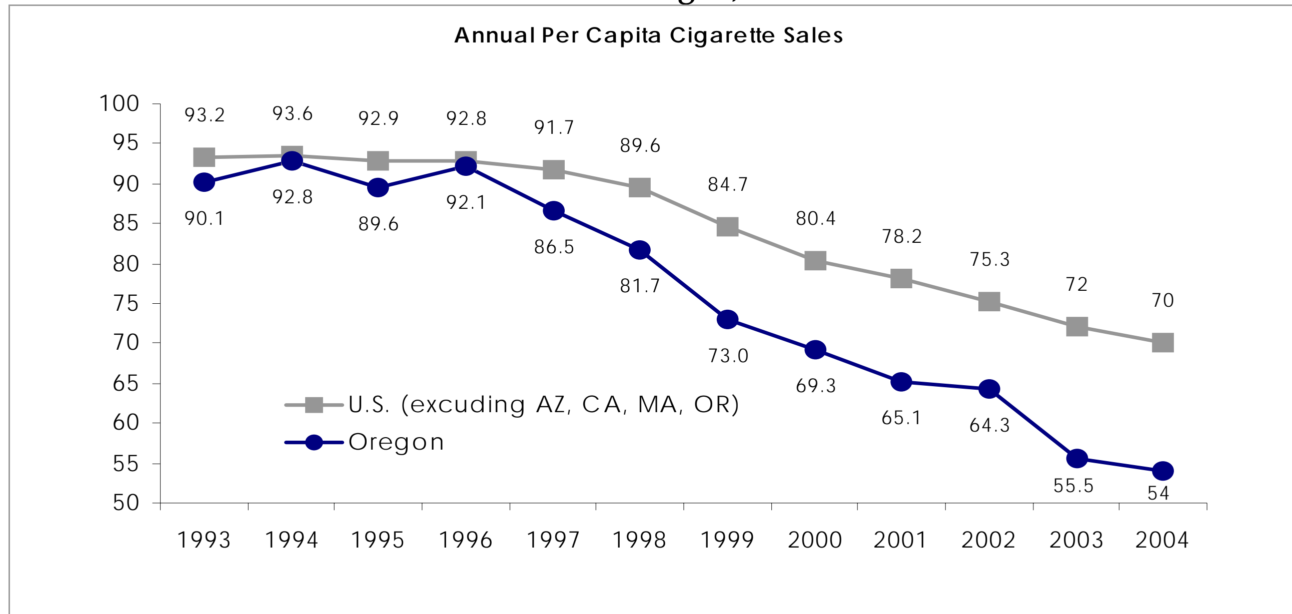
Healthy Diets in Oregon, 2005

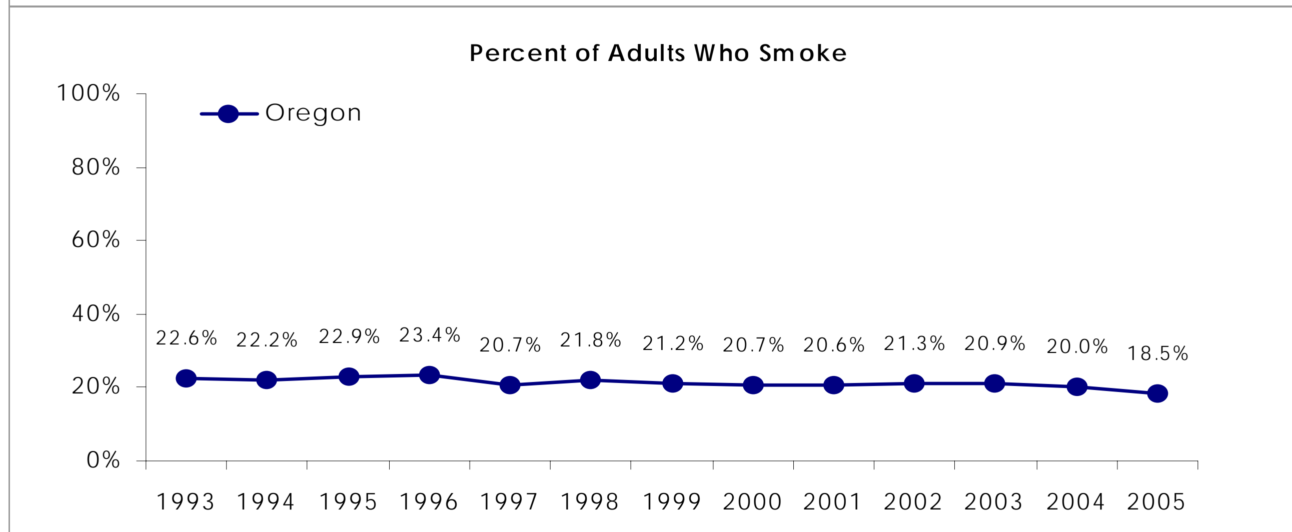


- While a healthy diet is composed of a wide variety of foods, fruit and vegetable consumption is a good marker for diet quality.
- Only 25.9% of Oregon adults report eating five or more servings of fruits and vegetables per day.
- Women are more likely than men to meet this recommendation, especially in older age groups.
- Only about a quarter of young Oregonians meet the recommendation.

Source: BRFSS 2002, http://www.dhs.state.or.us/publichealth/chs/brfs/02/nutrition/frtindx.cfm <01.25.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

Tobacco Use in Oregon, 1993 - 2004





- While cigarette sales have declined, smoking trends have remained relatively flat. In 2004, over 540,000 Oregon adults reported using tobacco.
- Younger adults and those with lower education attainment and household income are more likely to report tobacco use.
- Tobacco elevates the risk of developing cardiovascular disease, some cancers, respiratory diseases, and others. According to Oregon physician reports through death certificates, tobacco contributed to 6,933 deaths in 2003 (23% of all deaths). In addition, there are an estimated 800 deaths caused by secondhand smoke in Oregon annually.

Source: Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003;
Primary Data Sources: Oregon Department of Revenue, Research Triangle Institute, BRFSS

CHAPTER 8
HEALTHCARE REFORM

In this chapter:

- Current Challenges and Opportunities
- Oregon Principles and Basic Pathways for Healthcare Reform
- Other State Approaches to Healthcare Reform

Current Challenges and Opportunities

Previous chapters have focused on Oregon's healthcare system challenges and opportunities such as cost, quality, access and equity. Each of these areas provides vexing problems that other states around the country are currently facing. Oregon, however, has a long history of providing leadership in healthcare reform and has enacted innovative measures in the Oregon Health Plan, the Oregon Prescription Drug Program, the Oregon Medical Insurance Pool and the Family Health Insurance Assistance Program. Each of these programs provides a unique starting point from which to enact future healthcare reform.

The programs mentioned above have become critical aspects of the healthcare system in Oregon, yet improvement still remains on the horizon:

- Unless healthcare costs can be brought within a more manageable growth rate, Oregon will not be able to afford to cover the uninsured.
- Covering the uninsured will help lower hospital uncompensated care costs which affect premiums paid by the insured.
- Consumer-driven healthcare is only possible if consumers have available health services information such as provider costs, quality and impartial advice from health professionals.
- Public health initiatives and appropriate attention to healthy lifestyles and disease prevention are essential elements of an effective healthcare reform strategy.

Oregon Principles and Basic Pathways for Healthcare Reform

The 2003 Oregon Legislature passed House Bill 3653, creating the Oregon Health Policy Commission (OHPC), to develop and oversee health policy planning for the state. The Commission identifies and analyzes healthcare issues affecting the state and makes policy recommendations to the Governor and Legislature. The Commission partners with healthcare experts and stakeholders around the state to develop projects focused on improving Oregonians' health status and access to effective and efficient healthcare services.

In 2006 Governor Kulongoski directed the Oregon Health Policy Commission to:

- Write a blueprint for building a sustainable system that provides access to affordable healthcare to every Oregonian.
- Set measurable goals for healthcare system change.
- Recommend ways to pay for the system.

The OHPC report, *Oregon Health Policy Commission Healthcare Reform Road Map* (to be released in March 2007), envisions a system that provides all Oregonians affordable access to a high value health system that ensures positive outcomes and promotes healthy lives. The reforms outlined are based on the principle that everyone contributes to and participates in the healthcare system. They strengthen and build on existing public and private insurance structures, integrate cost, quality, transparency, and public health reforms, as well as complement healthcare reform efforts in the state.

OHPC Guiding Principles for Healthcare System Reform

- Assuring healthcare is a shared responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that cane be realistically implemented over the next five years by improving on existing system structures, and develop new ways to provide care more effectively.
- The healthcare system is sustainable only if reforms recognize the relationship between access, cost containment, transparency and quality.
- Limited resources must be coupled with rational coverage decisions in order to achieve access for all Oregonians.
- Insurance coverage reforms must not neglect a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention and care management.
- Reforms must maximize available federal (especially Medicaid), state, and private funding.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

OHPC Recommendation Pathways for Basic Healthcare Reform

1. Establish universal health insurance for children.
2. Create a Health Insurance Exchange to bring together individuals, coverage options, employers, and public subsidies.
3. Offer low-income Oregonians publicly-financed coverage subsidies to ensure insurance is affordable.
4. Require all Oregonians to have health insurance to protect health and financial security, spread healthcare costs over the whole community, and reduce the impact of uncompensated care.

5. Encourage and organize public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.
6. Support community efforts to improve healthcare access and delivery.
7. Establish financing for reform that is sustainable and equitable and includes a broad-based employer contribution.
8. Design and implement evaluation of system reform.

Other State Approaches to Healthcare Reform

Since the defeat of former President Clinton's healthcare proposal at the federal level more than twelve years ago, the efforts within a few states around the country to move toward universal coverage have become a promising alternative. Several states have enacted incremental reforms that expand public insurance or provide a subsidy to encourage employer-sponsored insurance so that more children and low-income adults have access to healthcare. A few other states have also enacted varying degrees of comprehensive reform legislation to facilitate pooling, reducing regulatory costs, to promote healthy lifestyles and increase competition and efficiency. Most notably, two states (Massachusetts and Vermont) enacted far-reaching healthcare reform legislation in 2006 joining another Northeast state (Maine) that enacted legislation in 2003 aimed at universal coverage by 2009.

While other states around the country offer valuable healthcare reform lessons to Oregon, there remain many factors or variables that may limit the transferability of such reforms. These include demographic factors such as the larger percentage of the uninsured in Oregon compared to Northeast states. Funding and resource allocation differences are also important to consider, for example Massachusetts had a $1 billion safety-net fund at the time of the state's reform. Differences in insurance market structure differences such as Massachusetts' long history of health insurance regulation in small group and non-group insurance may also result in a different insurance market environment for a possible individual mandate in Oregon. Nonetheless, certain elements from new programs in Arizona, Maine and Vermont may bring new insight into chronic care management and healthcare access.[104]

The following pages from AcademyHealth's State Coverage Initiative include a broad overview of recent state healthcare reform laws including key features and the enrollment experience of select state coverage programs—as well as in-depth summary of comprehensive reform and covering all kids laws enacted from 2003-2006. Appendix D further details comprehensive reform issues in Maine, Massachusetts, Vermont, Illinois, and Pennsylvania.

[104] AcademyHealth, State Coverage Initiatives, "State of the States" (January 2007).

Key Features of State Healthcare Reforms[105]

State	Initiative	Key Features
Comprehensive Reforms		
Massachusetts	Commonwealth Care	• Individual mandate • Employer Fair Share assessment • Free Rider surcharge • Health Insurance Connector • Insurance market reforms • Commonwealth Care*
Maine (2003)	Dirigo Health	• DirigoChoice* • Cost containment reforms • Maine Quality Forum
Vermont	Catamount Health	• Employer assessment • Premium assistance for low-income workers • Catamount Health Plan* • Chronic care initiatives
Covering All Kids		
Illinois	All Kids	• Universal coverage for children • Sliding scale premiums based on family income
Pennsylvania	Cover All Kids	• Universal coverage for children • Sliding scale premiums based on family income
Tennessee	CoverKids	• Separate stand-alone SCHIP program for children in families with incomes up to 250% FPL • Buy-in for children in families above 250 FPL
Public-Private Partnerships		
Arkansas	ARHealthNet	• Safety Net benefit package • Provided through private insurers • Open to businesses with 2-500 employees that have not offered insurance within last 12 months • Subsidy provided for workers with incomes below 200% FPL
Montana	Insure Montana	• Purchasing pool with a subsidy available to previously uninsured firms (2-9 employees) that have not offered insurance for 24 months • Employer and employee premium subsidies • Tax credit available for currently insured small firms (2-9 employees)

** Includes Subsidies for Low Income workers*

[105] AcademyHealth State Coverage Initiatives, "State of the States" Figure 6 (January 2007).

State	Initiative	Key Features
New Mexico	State Coverage Insurance	• New subsidized insurance product delivered by Medicaid managed care organizations • Available to low-income, uninsured, working adults with family income below 200% FPL • An individual may enroll through their employer or as a self-employed individual • Premium paid by employer/employee contributions and state/federal funds
Oklahoma	Oklahoma Employer/ Employee Partnership for Insurance Coverage (O-EPIC)	• Premium assistance voucher available for small firms (2-50 employees) who offer a qualified plan and income eligible employees with incomes below 185 % FPL • Individual plan available to uninsured workers whose firm does not offer insurance and self-employed (who earn less than 185 % FPL)
Rhode Island	WellCare	• New health plan expected to be 25% below market rates • Assisting Low-Income Small Businesses save an additional 10% through reinsurance pool (legislation passed, but no funding approved) • Making healthcare cost and quality data more transparent • High Risk Pool • Certificate of Need reform
Tennessee	CoverTN	• New affordable health insurance product for working uninsured and small firms that don't offer coverage • At least two statewide private plans • Plans to develop benefit package • Cost limited to $150/month, split by employer, employee and state
Utah	Premium Partnership for Health Insurance (UPP)	• New premium assistance program under the Primary Care Network • $150 subsidies for low-income workers enrolled in employer-sponsored insurance • Subsidies up to $100 for employee's children

Enrollment Experience of Select State Coverage Programs[106]

Target Population	Program (start date)	Eligibility	Enrollment Fall 2006 (individuals)
Small Business	Maine DirigoChoice (2005)	Small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance and with incomes below 300 percent FPL.	12,000
	Insure Montana (2006)	Previously uninsured firms (2-9 employees) that have not offered insurance for 24 months	6,995
	New Mexico State Coverage Insurance (2005)	Low-income, uninsured, working adults with family income below 200 percent of FPL. Participating employers must have <50 employees and have not voluntarily dropped a commercial health insurance in past 12 months.	4,400
	Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) (2005)	Workers and their spouses, who work in firms with 50 or fewer workers and contribute up to 15 percent of premium costs; self- employed ; unemployed individuals currently seeking work ; and individuals whose employers don't offer health coverage with household incomes at or below 185 percent FPL. Small employers must contribute at least 25 percent of eligible employee's premium costs and offer an OEPIC qualified health plan.	1,200
	West Virginia Small Business Plan (2005)	Small businesses (2 – 50 employees) that have not had health benefit coverage for their employees during the preceding 12 months. Employers must pay at least 50 percent of the premium cost.	1,200
	Arizona Healthcare Group (1986)	Small business, the self-employed, and political sub-divisions. No income limits apply, but HCG does have employee participation requirements and crowd-out requirements.	24,000
	Healthy New York (2001)	Small employers that have previously not offered insurance and with 30 percent of workers whom earn less than $34,000 annually. Sole proprietors	125,000

[106] AcademyHealth State Coverage Initiatives, "State of the States" Figure 8 (January 2007).

Target Population	Program (start date)	Eligibility	Enrollment Fall 2006 (individuals)
		and working individuals without access to ESI who earn less than 250% FPL and have been uninsured 12 months.	
Low-Income Adults	Washington Basic Health (1988)	Individuals with family incomes below 200 percent FPL.	100,000
	Pennsylvania adultBasic (2001)	Adults with incomes up to 200 percent FPL who have been without health insurance for 90 days prior to enrollment	55,000
	Minnesota Care (1992)	Families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent of FPL.	117,000
	Maryland Primary Care (2006)	Individuals below 116 percent of FPL	23,000
	Utah Primary Care Network (2002)	Adults below 150 percent of FPL	Waiver capped at 25,000
	District of Columbia Alliance (2001)	Uninsured individuals with family incomes below 200 percent FPL	35,000
Children above SCHIP Incomes levels	Illinois AllKids (2006)	Any child uninsured for a year or more with family income above the SCHIP level (200% FPL).	28,600
	Connecticut Husky B Buy-In (1997)	Allows uninsured children in families above 300 percent FPL the opportunity to buy-in to the state's SCHIP program, Husky B.	800

Comprehensive State Reform Comparisons[107]

	Massachusetts	Vermont	Maine	California Proposal
Individual Mandate	Yes	No, will consider if targets are not met	No	Yes
Purchasing Pool	Health Insurance Connector	Catamount Health	DirigoChoice	(Purchasing Pool)
Subsidies for Low-income	Up to 300% FPL	Up to 300% FPL	Up to 300% FPL	Up to 250% FPL
Public Program Expansion	Adults <100% FPL and Children <300% FPL	Children <300% FPL Parents <185% FPL Childless Adults <150 %FPL	Parents <200% FPL Childless Adults <125% FPL	Adults <100% FPL All Children <300% FPL
Employer Requirements	$295 per employee fee for non-offering of health insurance and must offer a 125 Plan	$365 per full-time employee for non-offering of health insurance	Voluntary participating employers must pay 60% of premium	4% payroll tax for non-offering of health insurance and must offer a 125 Plan
Financing	**Revenue**: Federal safety-net revenue, Federal Medicaid matching revenue, hospital assessment, third-party payer assessment, free rider surcharge, "fair share" assessment, Commonwealth General Fund. **Spending:** Supplemental funding to MassHealth managed care organizations, uncompensated care pool/hospital safety-net	**Revenue**: Federal Medicaid matching revenue (Global Commitment Waiver[108]) tobacco taxes, Vermont General Fund and employer assessments. **Spending:** premium subsidies for Dr. Dynasaur Health (SCHIP program), Catamount Health, Vermont Health Access Plan (Medicaid program), Employer-sponsored insurance subsidy	**Revenue:** Federal Medicaid match, employer contributions, individual contributions, Maine General Fund (first year only [2004]) and assessment on gross revenues of insurers and third-party administrators. **Spending**: MaineCare (state Medicaid program) and the Dirigo Health Plan.	**Revenue**: Employer payroll tax of 4% of Social Security Wages In-Lieu Fee (employers with <10 employees excluded), Provider Coverage Dividend (4% Gross Revenues from Hospitals, 2% from Physicians), County Funds Available from Relief of County Obligations, elimination of State programs[109]. **Spending**: Increased Medi-Cal/Healthy Families Program Coverage,

[107] *The document above is based on "Healthcare Coverage and Reform: The National Perspective, Figure 12: Strategies for Comprehensive Reform" by Jennifer Tolbert, Kaiser Commission of the Medicaid and Uninsured; State Coverage Initiatives 2007 National Meeting (Jan. 26, 2007).*

[108] In exchange for a fixed amount of federal Medicaid financing over the next five years (2006-2011), the waiver gave the state an "extra" $500,000 that it could use for other health initiatives, including Catamount Health.

[109] The Access for Infants and Mothers program, Managed Risk Medical Insurance Program and Medi-Cal Share-of-Cost eliminated.

	Massachusetts	Vermont	Maine	California Proposal
	fund, MassHealth children to 300% FPL, MassHealth Benefit restoration, MassHealth rate increases, Commonwealth Care subsidies	Subsidized for people with incomes up to 300% of poverty so that their premiums and copayments will be no higher than public programs		Subsidy for persons 100-250% FPL, Persons without Green Cards Provided Coverage by Counties, Prevention and Wellness Measures, Section 125 Tax Treatment (State Income Tax Deduction), Medi-Cal Rate Increase.
Cost-Containment Mechanism(s)	The new law also establishes a quasi-public entity called the Commonwealth Health Insurance Connector Authority to reduce the health insurance administrative burden for small businesses (fifty or fewer workers), and individuals to afford coverage. Reduce in cost-shift from uninsured.	The "Blueprint for Health," Vermont's name for its chronic health initiative, would develop a registry of those with chronic illnesses and promote the use of prevention and chronic care management techniques among all insurers, including the state employee health plan. Reduce in cost-shift from uninsured.	Certificate of Need (CON) reviewing for hospitals and new technology costing more than $1.2 million and capital expenditures over $2.4 million; requires access to information on hospital and physician prices; mandates electronic health records; state regulation of insurance premiums; and reduce in cost- shift from uninsured.	Prevention, Health Promotion and Wellness Programs (restructures benefits and incentives/rewards in diabetes, reducing medical errors, obesity, and tobacco); extends tax breaks for individuals and employers; increases regulation for providers in health spending and reduces regulation for delivery; and, expands health information technology.
Other	It is estimated that the increase in economic well-being from improved health in Massachusetts will be about $1.5 billion.[110]	Encourages people now enrolled in public coverage to instead use employer-sponsored insurance (when it is offered), provided it meets certain standards, and for the state to assist with premiums for that coverage.	Dirigo Health requests that hospitals and other providers voluntarily limit their cost growth to 3% and their operating margins to 3.5%. Insurers are also asked to limit their operating margin to 3.5 %.	Anti crowd-out provisions are included to disincentivize employers and employees from dropping coverage. These include the 4% employer "in-lieu" fee and unfair business practice provisions.

[110] Holahan J and Blumberg L, "Massachusetts Healthcare Reform: A Look at the Issues," Health Affairs Web Exclusive 25:w432-w443 (September, 2006). This figure only estimates the value of healthy life years gained as a result of expanding insurance coverage to those who lack it, and it does not include other benefits associated with universal coverage that are much more difficult to quantify. The authors estimate $2,635 to be the discounted present value of lost health over time as a result of being uninsured and conversely the gain of being insured multiplied by approximately 550,000 uninsured people in the state for 2006.

APPENDIX A
DEFICIT REDUCTION ACT OF 2005

The Deficit Reduction Act of 2005 (DRA) grants states flexibility to modify their Medicaid programs in ways that could affect both child and adult access to care. On the other hand, some of the provisions allow states to expand eligibility and thus access to services. The following table analyzes key provisions of the DRA, including the latest guidance from the Centers for Medicare and Medicaid Services (CMS).[111]

Summary of Key Medicaid Provisions Pre and Post 2005 Deficit Reduction Act (DRA)

Provision	Pre-DRA	Post-DRA
Eligibility: Citizenship Documentation Requirements	Oral affirmation of citizenship status was sufficient. Legal residents required to provide written proof of legal status.	U.S. citizens must show primary documents of citizenship.
Eligibility: Disabled Children with Low and Moderate Family Incomes	Coverage options for disabled children with low and moderate family incomes exceeding SSI eligibility thresholds included special rules for children in need of institutional care, medically needy coverage, and the use of general program flexibility to vary financial eligibility rules in order to recognize extraordinary costs of care for children with disabilities.	Optional eligibility for children with disabilities under age 19 who meet SSI program rules for severity of disability but do not meet income requirements.
Premiums	Except for very limited circumstances, states prohibited from charging premiums and enrollment fees.	States can impose premiums on children and parents if their family income is above 150% of FPL.

[111] *Rosenbaum* S and Markus A, (October, 2006) "The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services." The Commonwealth Fund Issue Brief (958): vi-viii, Table ES-1.

Provision	Pre-DRA	Post-DRA
Cost-Sharing	Cost-sharing prohibited for children and, for parents, capped at $3 copayments for prescriptions.	Cost-sharing allowed for persons with family income between 100% of FPL and 150% of FPL. Cost-sharing may not exceed 10% of the cost of the service or item, and total cost-sharing (including prescription drugs and nonemergency use of emergency departments) may not exceed 5% of family income. Cost-sharing for persons with family income above 150% of FPL may not exceed 20% of the cost of the service or item, and the combined total cost of premiums and cost-sharing (including prescription drugs and non-emergent use of emergency departments) may not exceed 5% of family income.
Benefit Standards	States required to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21.	States have a benefit option that is tied to a "benchmark" or "benchmark-equivalent" plan in use in the state. Individuals under age 19 with mandatory coverage must receive the full EPSDT benefit. If the benchmark plan or benchmark-equivalent plan does not provide the full benefit, the state must provide wraparound benefits.

Provision	Pre-DRA	Post-DRA
Targeted Case Management	*Medical assistance case management.* Services assist eligible individuals in gaining access to needed medical, social, educational, and other services. All federal rules applicable to medical assistance access, coverage, claims, and payment apply. *Case management billed as an administrative service.* Federal guidelines recognize the following as costs directly related to state plan administration: EPSDT administrative services linked to outreach, scheduling, transportation, service coordination, and care arrangement; Medicaid eligibility determinations and redeterminations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services and utilization review; and Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system). Separate federal financial participation rates and claims payment and billing procedures apply.	*Medical assistance case management.* Case management is more narrowly defined and the scope of permissible case management services in a medical assistance context may be limited. *Case management billed as an administrative service.* Certain case management functions will not be recognized with respect to certain individuals, such as foster care children. The availability of federal Medicaid matching funds in cases where "third-party liability" exists, i.e., if another entity has primary responsibility for payment, appears to be reduced.

APPENDIX B
2007 FEDERAL POVERTY GUIDELINES

ANNUAL

Size of Family	PERCENT OF POVERTY							
	100%	133%	150%	185%	200%	250%	300%	350%
1	$10,210	$13,579	$15,315	$18,889	$20,420	$25,525	$30,630	$35,735
2	$13,690	$18,208	$20,535	$25,327	$27,380	$34,225	$41,070	$47,915
3	$17,170	$22,836	$25,755	$31,765	$34,340	$42,925	$51,510	$60,095
4	$20,650	$27,465	$30,975	$38,203	$41,300	$51,625	$61,950	$72,275
5	$24,130	$32,093	$36,195	$44,641	$48,260	$60,325	$72,390	$84,455
6	$27,610	$36,721	$41,415	$51,079	$55,220	$69,025	$82,830	$96,635
7	$31,090	$41,350	$46,635	$57,517	$62,180	$77,725	$93,270	$108,815
8	$34,570	$45,978	$51,855	$63,955	$69,140	$86,425	$103,710	$120,995

MONTHLY

Size of Family	PERCENT OF POVERTY							
	100%	135%	150%	185%	200%	250%	300%	350%
1	$851	$1,132	$1,276	$1,574	$1,702	$2,127	$2,553	$2,978
2	$1,141	$1,517	$1,711	$2,111	$2,282	$2,852	$3,423	$3,993
3	$1,431	$1,903	$2,146	$2,647	$2,862	$3,577	$4,293	$5,008
4	$1,721	$2,289	$2,581	$3,184	$3,442	$4,302	$5,163	$6,023
5	$2,011	$2,674	$3,016	$3,720	$4,022	$5,027	$6,033	$7,038
6	$2,301	$3,060	$3,451	$4,257	$4,602	$5,752	$6,903	$8,053
7	$2,591	$3,446	$3,886	$4,793	$5,182	$6,477	$7,773	$9,068
8	$2,881	$3,832	$4,321	$5,330	$5,762	$7,202	$8,643	$10,083

Effective, January, 2007
SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

APPENDIX C
TIMELINE OF OHP2 CHANGES

October 2002

- OHP2 Waiver approved by CMS

November 2002

- FHIAP program now included under OHP2 waiver for federal match (previously state-only funding)
- Opened up for increased enrollment

January 2003

- Implement voluntary copays on drugs ($2 generic/$3 brand) and ambulatory services ($3) for OHP fee-for-service clients
- Eliminate coverage for Lines 559-566 on the Prioritized List of Healthcare Services

February 2003

- Expand coverage for pregnant women and children < age 19 from 170% to 185% FPL
- Establish OHP Standard benefit package. (0-100% FPL; $6-$20 per person per month based on income)

  Changes include:
  - Elimination of coverage for vision exams and eyeglasses
  - Elimination of non-emergency medical transportation
  - Elimination of most medical equipment
  - Elimination of hearing Aids and related exams
  - Reduced dental benefits
  - Mandatory co-pays for following services (OHP Standard, FFS and MC)[112]:

Inpatient Hospital	$250 per admission
Outpatient Hospital	$20 for each outpatient surgery $5 for other outpatient service
Emergency Department	$50 but waived if admitted to hospital
Physician services	$5 per visits $5 for medical surgical procedures Most preventative services & immunizations Exempt from co-payments
Lab and X-ray	$3 per lab or x-ray
Ambulance	$50
Home healthcare	$5 per visit
PT/OT/ST	$5 per visit

[112] *Co-pays discontinued as a result of U.S. District Court Order, see June 2004.*

- Establish more stringent premium policy for OHP Standard clients
- (Individuals are disenrolled for at least 6 months if they cannot pay premiums)
- Can be denied services if they cannot pay co-pays
- Establish 6-month uninsurance requirement for new OHP Standard clients
- Begin roll-out of Senior Prescription Drug Assistance Program
- Eliminate coverage for survival priority levels 15-17 in the long term care system. Many of these individuals will also lose their OHP medical coverage.
- Eliminate Medically Needy program (see April change)
- Eliminate remaining safety net clinic funding

March 2003

- Further reduce OHP Standard benefit package by eliminating:
- Remainder of dental benefit
- Coverage of medical supplies
- Coverage of outpatient mental health services
- Coverage of outpatient chemical dependency services
- Coverage of prescription drugs (reinstated from mid-March through June 2003) *
- Move beginning date of eligibility to first of month following eligibility determination for OHP Standard population
- Reduce reimbursement rates to DRG hospitals (50 beds or more) by 12% for inpatient services and outpatient services. Eliminate outlier payments to DRG hospitals except for infants under age 1 served in Disproportionate Share Hospitals

April 2003

- Reduce payments to pharmacies from Average Wholesale Price minus 14% to minus 15% (pending CMS approval)
- Eliminate coverage for survival priority levels 12-14 in the long term care system. Many of these individuals will also lose their OHP medical coverage.
- Reinstate coverage for anti-rejection (transplant) and antiviral (HIV) drugs for former Medically Needy clients (through June 2003) **

** Prescription drug coverage is currently ongoing*
*** Coverage of these services is currently ongoing*

May 2003

- Enhanced exception process implemented to prescribe non-physician drug list (PDL) drugs in evaluated classes for fee-for-service clients
- Increased reimbursement rates to institutional pharmacies

June 2004

- As a result of Spry v U.S. Department of Human Services, Centers for Medicare and Medicaid Services and the Oregon Department of Human Services, a U.S. District Court has ordered the state to discontinue all co-pays for Oregon's Medicaid expansion population, OHP Standard, effective June 19, 2004.
- Require pharmacies to bill insurance carriers before billing Medicaid for clients who have prescription drug insurance coverage
- In order to meet budget requirement, the OHP Standard program will be capped at 25,000. June enrollment is at 56,000 people; if attrition alone does not project to an enrollment of 25,000 by July 2005, the income eligibility for OHP Standard may have to be reduced from 100% FPL

July 2004

- Due to a lack of state funds, OHP will stop enrolling new clients into the Oregon Health Plan (OHP) Standard benefit package (July 1, 2004)

August 2004

- (8/17/04) Federal officials authorized Oregon to begin levying an industry-supported tax on selected Oregon hospitals to help support a scaled-down Oregon Health Plan. Approval permits the state to continue offering the Health Plan's Standard benefit package to an estimated 24,000 low-income adults who otherwise would not qualify for Medicaid coverage. Earlier, the state received federal approval to levy a provider tax on 31 managed care insurance plans that serve OHP clients.
- (8/1/04) As directed by the 2003 Legislature under House Bill 2511, the OHP Standard benefit package will consist of the following core set of services:
    - physician services
    - ambulance
    - prescription drugs
    - laboratory and x-ray services
    - limited durable medical equipment and supplies
    - outpatient mental health
    - outpatient chemical dependency services
    - emergency dental service

- Although not part of the core set of services, the Standard benefit package will also include:
    - hospice
    - limited hospital benefit.
- Briefly, the limited hospital benefit will include:
    - evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the prioritized list);
    - hospital treatment for all emergency services;
    - urgent conditions for which prompt treatment will prevent life threatening health deterioration; a subset of number three that will require prior authorization
- The following optional services will not be included within the redefined Standard benefit package:
    - therapy services (physical therapy, speech therapy, occupational therapy)
    - acupuncture (except for the treatment of chemical dependency)
    - chiropractic services
    - home health services / private duty nursing
    - vision exams and materials*
    - hearing aids and exams for hearing aids*
    - non-ambulance medical transportation*

June 2006

- (6/1/06) Beginning June 1st, clients on the OHP Standard program who have been certified eligible based on income at or below 10% of the FPL will be exempt from paying premiums. The exempt clients will no longer be billed premiums for the remaining months of their certification period. Clients with incomes above 10% of the FPL will NOT be disqualified from coverage based on past-due premiums. They will need to pay all past-due premiums in full as a condition of being found eligible at recertification. If client recertifies at 10% or less of FPL, any existing premium arrears waived

New Premium Structure

>10 FPL up to 50% FPL	$9.00 per person
50% up to 65% FPL	$15.00 per person
65% up to 85% FPL	$18.00 per person
85% up to 100% FPL	$20.00 per person

July 2006

- (7/1/06) Proof of citizenship will be required for all Medicaid plans using federal dollars. Birth certificate or passports will be required to enroll or to recertify OHP members.

September 2006

- Elimination of routine vision examinations and glasses for non-pregnant adults enrolled in the OHP Plus benefit package.
    - Continues services to restore vision when the person was born without the organic lens or it was surgically removed.
    - Continues services for persons who have:
        - Keratoconus
        - Pseudoaphakia
        - Aphakia
        - Congenital aphakia
    - Adults will still receive their glasses if they've had their eye examinations, and the optician receives the prescriptions for glasses before February 1, 2007.
    - Children under 21 years of age still receive routine examinations and glasses.
- Limits over-the-counter (OTC) drugs prescribed primarily for conditions not covered by OHP for persons enrolled in the Plus and Standard benefit packages.
    - Still covers but requires prior authorization of:
        - Brand-name OTC drugs if the client is prescribed the drug for conditions covered by OHP.
        - Higher cost generic cough and cold medicines
    - Still covers without prior authorization:
        - Certain OTC drugs that are clinically critical and most often brand name drugs, such as insulin and drugs for nutritional support for persons who cannot eat or cannot eat enough to sustain themselves
        - Lower cost generic cough and cold medicines, such as generic forms of Benedryl and Robitussin
    - Eliminates coverage for herbal supplements
- Eliminates advanced dental restoration services and limits basic restoration procedures for adults enrolled in the Plus package.

- Places limits on basic restoration procedures. Limits generally are based on the number of procedures in a specific time period, while some are based on the effectiveness of a procedure for a specific age group. Limited procedures include:
    - Fillings for cavities
    - Crowns and root canals for anterior and bicuspid teeth
    - Endodontics
    - Periodontics
    - Reline and repair for clients with existing removable dentures.
- Continues coverage for:
    - Diagnoses
    - Prevention services
    - Fillings necessary to preserve a tooth
    - Urgent and emergency dental services

- Limits inpatient hospital coverage at DRG hospitals (those with 50 or more beds) to 18 days per person per year. This applies to persons age 21 and over who are enrolled in the OHP Plus and Standard benefit packages.
    - An entire hospital stay is covered if the client has available hospital days at the time of admission, even if the stay exceeds the available days.
    - This impacts fee-for-service OHP Plus and Standard adults. Adults enrolled in managed care plans are not affected by this reduction. Adults who are enrolled in both Medicare and Medicaid are not affected, because Medicare is the primary payer.
    - Children under 21 years of age are not limited to a specific number of days per person per year.

APPENDIX D
COMPREHENSIVE REFORM ISSUES

Maine

The Dirigo Health Plan (Latin for "to lead"), was enacted in June of 2003 with the intent of providing quality, affordable health coverage available to every Maine citizen by 2009 and initiate new and processes for cost containment and quality improvement. As noted above, the Dirigo Health Plan is a voluntary public program and arranges health coverage through a private health carrier to small businesses (50 or fewer employees), individuals, and the self-employed – enrollees benefit from lower and more stable rates provided by participation in a larger group. Sliding scale discounts are given to plan members to help pay premiums and cost-sharing up to 300% FPL. Employers pay 60% of employee only cost – discounts apply to employee's share. The Dirigo health plan offers comprehensive benefits and covers preventative services at 100%.[113]

Unlike other states, Maine has supported its Dirigo Health Initiative through assessments on insurers that are offset by the savings resulting from the Dirigo Reform Act including voluntary hospital cost reductions, an expanded Certificate of Need review program, reduced uncompensated care and other program cost savings. The state is also unique in that it is the only state whose health reform law stated that there is sufficient funding in the system to cover the uninsured if cost containment strategies successfully lowered the rate of healthcare cost growth and invested instead in coverage.

Maine's healthcare reform efforts, however, have not been without challenges. The Maine Association of Health Plans (of which Anthem BlueCross BlueShield of Maine is the largest member), the Maine State Chamber of Commerce, and the Maine Automobile Dealers brought a legal case against Dirigo Health in making three arguments: (1) that the Dirigo Health Reform Act was unconstitutional; (2) that the Savings Offset Payment was an unconstitutional delegation of the legislature's taxing powers; and (3) that both the methodology for determining the amount of savings to the healthcare system achieved by Dirigo Health Reform and the Superintendent of Insurance's ruling that Dirigo Health saved $43.7 million were invalid. In August 2006, Cumberland the appeal was denied.

The Dirigo Health Program was placed under review by a "Blue Ribbon Commission" in early 2006 to "propose alternatives to the savings offset payment for the Dirigo Health Program and subsidies under the program in a fair, equitable and broadly distributed manner, as well as review and make recommendations on methods proven effective in reducing and controlling healthcare costs and create savings in Maine's

[113] Rosenthal J. and Pernice, C. "Designing Maine's DirigoChoice Benefit Plan" The Commonwealth Fund (Dec. 2004). http://www.cmwf.org/publications/publications_show.htm?doc_id=253634

healthcare market, including how such methods may be incorporated in the DirigoChoice health insurance product."[114]

The commission, representing businesses, insurers, consumers, labor and the state government, reviewed the program and looked at similar efforts in other states. Final recommendations were made on January 1, 2007. The recommendations of the Commission were:

- A requirement that all employers provide a certain level of health benefits (employer mandate) along with a mandate for individuals with income over 400% FPL;
- An expansion of the program funded by increasing "sin taxes" on items that are deemed unhealthy such as cigarettes, bottled soft drinks and syrups, and beer and wine.
- Creation of a work group consisting of interested parties, including, but not limited to providers, consumers, employers, and insurers be convened to meet with the Dirigo Board and staff as soon as possible to determine the methodology and mechanism through which bad debt and charity care savings will be captured and redirected.
- Expansion of state oversight of health insurance through increasing transparency of insurance rates with comparative metrics, allowing allow sole proprietors to purchase coverage in the small group market; require insurers to cover dependents on parents' policy to age 30, create options to allow non-subsidized individuals and employees to purchase healthcare coverage using pre-tax dollars; require insurers to give premium discounts for worksite wellness programs and non-smokers; review Rule 850 to allow insurers to design plans in such as way as to increase incentives for use of high quality providers.
- The highest priority should be the uninsured and under-insured under 300% FPL; the needs of part time and seasonally employed adults should be addressed; Dirigo's definition of a part time workers should, consistent with the state's insurance law, allow employers to offer coverage to employees that work ten or more hours per week; and Adult individuals, sole proprietors, and employees of small businesses are eligible for DirigoChoice subsidy, however marketing should focus on sole proprietors and small businesses.
- The program should consider bidding pharmacy coverage separately from the health benefit and should explore purchasing prescription drugs coverage through the multi-state purchasing pool; DirigoChoice should have an option to self-insure, as long as the program maintains a "level playing field" with other small group plans in terms of benefit mandates and legislative oversight; the program should make increased use of focused chronic disease management,

[114] State of Maine Executive Order 14 FY06/07 "An Order Regarding Dirigo Health Reform" Office of the Governor.

with an understanding that savings will not accrue until after 2007; the program should examine strategies to maximize federal Medicaid matching funds, such as using Medicaid funds to pay for employer sponsored insurance, and finding better ways to inform members of potential Medicaid eligibility.

Massachusetts

In April 2006 Massachusetts enacted a multi-level strategy for healthcare system reform to provide universal health insurance coverage. The state was facing a rapid rise in the uninsured population,[115] expensive emergency department room care, poor emphasis on preventive and primary care, double-digit insurance premium rate hikes, businesses dropping or reducing health benefits, difficulty for individuals and small businesses to afford insurance and a $1.3 billion price-tag on the cost of its then active free care program. Moreover, Massachusetts's section 1115 Medicaid waiver of the Social Security Act was set to expire in 2008 and the Centers for Medicare & Medicaid Service (CMS) had begun to challenge state financing of its Medicaid waiver. Without restructuring the waiver, the state faced a loss of more than $385 million in federal funds.

- All of the state's residents will be required to carry a minimum level of health insurance by July 2007 and all employers operating in the state will face fines if they do not provide insurance to their employees. The individual mandate for health insurance will be enforced through the tax code by residents losing their state individual income tax deduction. Employers will be charged $295 per full-time employee annually if it is determined that they do not make a "fair and reasonable" contribution to their employees' health insurance (or ½ of average premium) and an additional surcharge if their employees access free care in 2008.
- The law establishes the Commonwealth Care Health Insurance Program (CCHIP) to provide subsidized health insurance coverage for uninsured adults with incomes below 300% of the Federal Poverty Level (FPL) and did not have employer-based insurance in the past six months. Those with incomes of 100-300% FPL will pay premiums on a sliding-scale basis and face no deductibles. The state's Medicaid program MassHealth also expanded children's eligibility from 200% to 300% FPL.
- The new law also establishes a quasi-public entity called the Commonwealth Health Insurance Connector Authority to reduce the health insurance administrative burden for small businesses (fifty or fewer workers), provide a pool for small businesses and individuals to afford coverage, allow individuals to buy insurance with pretax dollars, allow part-time and seasonal employers to combine employer contributions and enable individuals to keep their coverage when they change jobs. The board of the Connector is charged with determining,

[115] The uninsured population in Massachusetts was approximately 11.2% of the total population in 2004 compared to a national average of 15.9%.

given a family's financial circumstances, the minimum level of coverage required to meet the individual mandate and if coverage is affordable. The Connector also operates the Commonwealth Care program and includes an unsubsidized component which offers coverage to those with incomes above 300% FPL. The unsubsidized plans may have relatively high deductibles and limited provider networks, but they will be required to offer all state-mandated benefits.

It is estimated that the increase in economic well-being from improved health in Massachusetts will be about $1.5 billion.[116] Many issues remain however in the implementation of the new law such as defining "affordability", success of the Connector, employer response to reform and future revenues for expansions and subsidies. Additionally, it is also speculated that the reform does not have strong cost containment measures.[117] Nonetheless, Massachusetts's reform represents a systematic approach that engages government, employers and individuals to expand access to healthcare.

Vermont. In May 2006, Vermont also enacted healthcare reform to provide universal access to affordable health insurance. The focus for reform in the state also includes cost containment, improved quality, and promotion of health behavior and disease prevention. Like Massachusetts, Vermont also has a relatively low uninsured population in proportion of the total population of 9.8% compared with a national rate of 16% and the child uninsured population is an impressive 4.9%. The state's Dr. Dynasaur program is available to all children with household income under 300% FPL, to pregnant women under 200% FPL and parents and caretakers with household incomes under 185% FPL.

Currently, individuals requesting Dr. Dynasaur coverage with income between 185% and 225% FPL must pay a monthly premium of $15 per household. Those with income between 225% and 300% of FPL pay a $20 per month premium if the family has other insurance that includes hospital and physician coverage and $40 if it has no insurance besides Dr. Dynasaur.

- Vermont's healthcare reform in 2006 established the public insurance plan called Catamount Health, a comprehensive benefit plan modeled after a preferred provider organization plan with a $250 deductible and reimbursement rates that are 10% higher than Medicare rates. Cost sharing from the plan will not apply to chronic care management and preventative services. To qualify for the program a Vermont resident must be uninsured for at least 12 months with certain

[116] Holahan J and Blumberg L, "Massachusetts Healthcare Reform: A Look at the Issues," Health Affairs Web Exclusive 25:w432-w443 (September, 2006). This figure only estimates the value of healthy life years gained as a result of expanding insurance coverage to those who lack it, and it does not include other benefits associated with universal coverage that are much more difficult to quantify. The authors estimate $2,635 to be the discounted present value of lost health over time as a result of being uninsured and conversely the gain of being insured multiplied by approximately 550,000 uninsured people in the state for 2006.
[117] Ibid, Holahan and Blumberg 2006.

exemptions. Individuals who qualify may apply for the Catamount Health Premium Assistance Program at the following purchase rates:

- Under 200% FPL - $60 per month
- 200% to 225% FPL - $90 per month
- 225% to 250% FPL - $110 per month
- 275% to 300% FPL - $135 per month
- Over 300% FPL: Full cost (approximately $360 per month)

- The reform also determined that in order to contain costs, the state had to invests significant state resources into the *Blueprint for Health – the State's Chronic Care Plan* a public-private partnership to have systemic statewide system of care that improves the lives of individuals with, and a risk for, chronic conditions. The Blueprint model focuses on five change areas:
  - Patient Self-management.
  - Provider Practice Change.
  - Community Activation and Support.
  - Information Technology.
  - Health System Design.
- Vermont also established the OVHA Chronic Care Management Program (CCMP) to further its goals of cost containment. The Office of Vermont Health Access (OVHA), the state's Medicaid agency, is statutorily required to develop chronic care management program, consistent with the policies and standards established by the *Blueprint for Health*, through a contract with a private company for 25% of state public health insurance recipients. The OVHA is also mandated by the new law to determine how to restructure payments to healthcare professionals for chronic care to pay doctors to provide the right care at the right time. They will also provide incentive payments to healthcare professionals participating in the Medicaid care coordination program; and reimbursement increases in the future will be tied to performance measures established by the *Blueprint for Health*.

Funding for the programs within Vermont's Healthcare Reform is based on the principle that everyone contributes.

- Catamount Health Plan: Individuals contribute sliding scale premiums outlined above.
- Increases in Tobacco Product Taxes: a $0.60 per pack increase in cigarette tax beginning July 1, 2006 and an additional $0.20 per pack increase beginning July 1, 2008.
- Employers' Healthcare Premium Contribution: Employers will pay an assessment based on the number of "uncovered" employees, based on if they do not pay some part of a health insurance plan for their employees and for their employees that are ineligible to participate or refuse coverage.

- Vermont also entered into a new five year comprehensive Section 1115 federal Medicaid demonstration that increases and consolidates federal dollars as well as establishes the state OVHA as a public Managed Care Organization (MCO). Under the new waiver, the MCO can invest in health services that typically would not be covered by traditional Medicaid and provides flexibility to implement creative programs and reimbursement mechanisms to help curb healthcare costs.
- Other sources of funding include state general fund appropriations and caps premium assistance programs if sufficient funds are not available to sustain the programs.

Covering All Kids Issues

Illinois

When Illinois enacted universal health coverage legislation for children in October of 2005, several other states took notice and have since proposed similar legislation. The state had already expanded coverage to previously uninsured children in 2002 by increasing income thresholds into the state's Medicaid program "KidCare" program and sought to bring even more children into a new universal state program "All Kids".

- To be eligible for the new program a child must be 1) who is a resident of the State of Illinois; and 2) a child aged 18 or younger; and 3) if enrollee's family income is above 200% FPL, the child must be uninsured since January 1, 2006. Beginning in 2007, children will have to have been uninsured for at least 12 months. Exemptions for the third requirement include: newborns, children of families who lose employer-sponsored insurance, children who have lost eligibility for KidCare in the last 12 months. A child's immigration status does not affect his or her eligibility for the program.[118]
- The benefit package for All Kids includes immunizations, doctor visits, hospital stays, prescription drugs, vision care and some durable medical equipment. The program is also designed to exclude cost-sharing for regular check-ups or immunizations, regardless of income.
- Other than the 12 month uninsurance requirement to limit public insurance substitution for private insurance for certain services, Illinois also offers a FamilyCare/All Kids Rebate for enrolled families who have private or employer health insurance that covers doctor and inpatient hospital care. The rebate is up to $75 per person per month toward the cost of family premiums. This encourages families to stay with the same doctor and to use their previous health insurance card, although health benefits are limited to what private or employer insurance plan covers and enrollees pay any co-pays, coinsurance or deductibles.

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[118] Illinois Department of Healthcare and Family Services, "Answers to Your Questions about All Kids: Governor Blagojevich's All Kids Healthcare for All Kids" (2006) available online at *http://www.allkidscovered.com/assets/060706_akbooklet.pdf*.

Pennsylvania

The Governor of Pennsylvania signed House Bill 2699 on December 4 2006, which will expand eligibility for subsidized Pennsylvania's Children's Health Insurance Program (CHIP), increase subsidies for CHIP, and allow many who do not qualify for subsidized CHIP to purchase it at cost. CHIP will be available for those children who do not qualify for Medical Assistance if their family income is below 200% of the federal income poverty limit. Currently, that amount is $40,000 for a family of four. There is no resource (asset) test under CHIP. The following premium subsidies are available for children between 200% and 300% of the poverty level:

- 200% to 250% FPL - $36 per child per month
- 250% to 275% FPL - $50 per child per month
- 275% to 300% FPL - $57 per child per month
- Over 300% FPL – Full cost, approximately $143 per child per month

In order to discourage employers from dropping health insurance, no child in a family with income above 200% of the poverty level will qualify for CHIP unless they have been without health insurance for 6 months. This rule will not apply to children under the age of two (subject to CMS approval), or where the parent is eligible for unemployment compensation, or where the parent is not eligible for unemployment compensation but had health insurance and is no longer employed. The rule will also not apply if a child is transferring from one government subsidized healthcare program (i.e. Medical Assistance) to another.

In order for a family with income above 300% of the federal poverty level to qualify to purchase CHIP, the family must show either that: 1) purchasing individual or group coverage would exceed 10% of the family income, or 2) the total cost of coverage would exceed 150% of the CHIP premium, or 3) the family has been refused coverage due to a pre-existing condition.

The law gives the state the right to purchase coverage from an individual's employer rather than CHIP if the insurance meets minimum coverage requirements and the Insurance Department determines that it would be more cost effective. The new law will be effective 30 days following publication of a notice in the Pennsylvania Bulletin, or on January 1, 2007, whichever is later. The CHIP law sunsets on December 31, 2010.

Pennsylvania has also enacted cost-containment and regulation of the health insurance industry since 2005. For example, the state established the Pennsylvania Healthcare Cost Containment Council (PHC4) as an independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of healthcare and increasing access for all citizens regardless of ability to pay. The state established the Patient Safety Authority as an independent state agency to take steps that will reduce and eliminate medical errors by identifying problems and recommending solutions that promote safety in hospitals, ambulatory surgical facilities, birthing centers and other family planning clinics. More than 400 healthcare facilities subject to

medical malpractice law reporting requirements are submitting reports through PA-PSRS, a mandatory statewide Pennsylvania Patient Safety Reporting System.

Pennsylvania's Insurance Department has also been mandated by the legislature to regulate the not-for-profit health insurance entities such as Blue Cross/Blue Shield in the Community Health Reinvestment Agreement (CHRA) and Surplus Determination and Order. The CHRA commits the four Pennsylvania Blue Plans to make annual investment to provide affordable basic healthcare coverage to low income and uninsured Pennsylvanians through a state-sponsored program, currently the state's AdultBasic program that provides basic health insurance to uninsured adults earning less than 200% FPL. The Surplus Determination and Order established a model for evaluating the appropriateness of the financial surplus levels of the Blue plans. Three Blue plans were determined to have sufficient surpluses, which meant that premium rates for the plans were constrained to make them more affordable.