Oregon Health Fund Board

Eligibility and Enrollment Committee Meeting

Tuesday, January 8, 2008
General Services Building
1225 Ferry Street, SE
Salem, OR
Mt. Mazama Room, Basement
10 am – 1 pm

DRAFT AGENDA

Time (est)	Item	Lead	Action Items
10:00 am 10 min	**Call to Order, Approval of Dec 13 Meeting Minutes and Review of Revised Work Plan**	**Chair**	**X**
10:10 10 min	**Update on Oregon Health Fund Board and Committee Activities**	**Tina Edlund**	
10:20 30 min	**Defining Affordability in Health Care for Oregon**	**Tina Edlund**	
10:50 40 min	**Review of Affordability "Straw-Person" Draft Document**	**Tina Edlund**	
11:30 1 0 min	**Break**	**Chair**	
11:40 5 0 min	**Development of Committee Recommendations on Affordability**	**Chair and Vice Chair**	
12:30 10 min	**Next Meeting Agendas and Objectives**	**Chair**	
12:40 20 min	**Public Testimony**	**Chair**	
1 pm	**Adjourn**	**Chair**	

Next Meeting: January 23, 2008 2:00pm; Location: General Services Building 1225 Ferry St SE Salem, OR 97301
Mt. Mazama Room (Basement)

EXHIBIT MATERIALS:

A. Oregon Health Fund Board Newsletter
B. Eligibility and Enrollment Committee Revised Work Plan
C. Defining Affordability in Health Care for Oregon Document
D. Affordability "Straw Person" Document

OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

December 11, 2007
9:00 a.m.

State Archives Building – Large Conference Room
Salem, Oregon

MEMBERS PRESENT: **Ellen Lowe, Chair** (left at 11:40 a.m.)
Jim Russell, Vice Chair
Robert Bach
Jane Baumgarten
Dean Kortge
CJ McLeod
John Mullin
Bill Murray
Ellen Pinney
Noelle Lyda
Susan Rasmussen
Carole Romm
Ann Turner,MD (by phone)

MEMBERS EXCUSED: **Felisa Hagins**

STAFF PRESENT: **Tina Edlund, Deputy Administrator, OHPR**
Heidi Allen, Project Manager, OHREC
Nate Hierlmaier, Policy Analyst
Tami Breitenstein, Executive Assistant, OHFB
Paula Hird, Office Specialist

ISSUES HEARD:

- **Review of November 28 Meeting Minutes**
- **Update on Oregon Health Fund Board and Committee Activities**
- **Review of Oregon Health Fund Board Draft Design Principles and Assumptions**
- **Review of Affordability Recommendations and Consensus Development Matrices**
- **Presentation by Dr. Matt Carlson, Impact of Co-Pays on a Medicaid population**
- **Developing Consensus: Subsidy Structure Recommendations**
- **Next Meeting Objectives**
- **Public Testimony**

I. Call to order – there is a quorum

- Review of November 28 meeting minutes. Susan Rasmussen asked for a correction to show that she was present at that meeting

Tina Edlund **II. Update on Oregon Health Fund Board and Committee Activities**

Chair and Vice Chair **III. Design Principles and Assumptions**

- Draft has not yet been adopted by the Oregon Health Fund Board (OHFB)
- Indications are that it is very close to guidelines
- When asked if Board is operating on assumption of an OHP Plus and Standard or if it is a placeholder, Chair responded that OHP Standard will be SB 329 with a Medicaid match

Chair and Vice Chair **IV. Review of Affordability Recommendations and Consensus Development Matrices**

- Will need to meet Medicaid goals.
- Will be presented to Board on 12/12/07.

Discussion

- Affordability: What does it mean to each group?
- What parts of the population will be subsidized?
- Beginning and ending points of subsidies should be identified first with discussion of total cost to come later.
- What about the issues of crowd out? A suggestion was made to create a matrix that impacts that number.
- Employers need to continue to participate.
- The equity issue is enormous and goes beyond affordability of premiums. What will be the public perceptions?
- It is important that the Committee does not narrow its focus.

Dr. Matt Carlson and Bill Wright, Ph.D. **V. Presentation: Dr. Matt Carlson, Impact of Co-Pays on Medicaid Population**

- Bill Wright, Ph.D., Providence System Center for Outcomes Research and Education (CORE) introduced the presentation providing:
  - Summary of changes to OHP;
  - Survey followed 3,000 individuals for two years; and
  - OHP program redesign and cohort study milestones.
- Matt Carlson, Ph.D., Medical Sociologist, Portland State University:
  - Access to care;
  - Financial strain; and
  - Conclusions.

Tina Edlund will email presentation to Committee members and post it on the OHPB website.

Chair **VI. Developing Consensus: Subsidy Structure Recommendations**

Discussion

- Affordability and co-pays and the need to balance discouraging inappropriate use while encouraging proper use.
- Policies to change behavior of health care individual.
- Times that services are provided need to be extended beyond the usual 8:00 a.m. to 5:00 p.m. hours to make care accessible for workforce individuals.

- Health care incentives and wellness benefits.
- Design subsidy around income or premium?
- At what percentage of the Federal Poverty Level (FPL) should subsidies end?

Chair **VII. Next Meeting Agendas and Objectives**

- The Committee was asked to forward ideas and value statements to Tina Edlund by December 24 for compilation of a straw person to be presented at the January 8 meeting.

Vice Chair **VIII. Public Testimony**

- Joe Zaerr testified to difficulties regarding obtaining affordable insurance by a family member.
- Keary Knickerbocker offered information on a program his company has been developing that will cross reference??? Various agency informations on individuals to minimize duplication and complication.

Vice Chair **IX. Adjournment**

Vice Chair Russell adjourned the meeting at approximately 12:00 p.m.

EXHIBIT SUMMARY:

A. Health Fund Board December 2007 Newsletter
B. A Comprehensive Plan for Reform: Design Principles & Assumptions
C. Affordability Summary Matrix
D. Healthy Kids Plan: Medicaid Advisory Committee Recommendations

TENTATIVE WORKPLAN FOR ENROLLMENT AND ELIGIBILITY COMMITTEE

JANUARY 8th 10am to 1pm, General Services Building Mt. Mazama Room, 1225 Ferry Street SE, Salem

TOPIC: SUBSIDIES & AFFORDABILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of recommendations and minutes from last meeting.
- Articulate principles/values about how subsidies should work
- Discuss how a potential individual mandate, or requiring people to have health insurance, is related to the affordability of coverage
- **Action Item:** Develop consensus and recommend subsidy structure, cost-sharing and maximum out-of-pocket expenditures
- Public input

JANUARY 23rd 2-5pm, Mt. Mazama Room
TOPIC: ELIGIBILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of recommendations and minutes from last meeting
- Articulate principles/values underlying eligibility
- Review of MAC recommendations regarding eligibility
- **Action Items:** Review and finish Affordability Recommendations draft document and begin development of eligibility recommendations, including waiting periods, pre-existing conditions (what does this mean in a guaranteed issue world?)

February 12th 9am-12pm, Clackamas Community College Room 111, 29353 SW Town Center Loop, Wilsonville, OR

TOPIC: ELIGIBILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of minutes from last meeting
- Review of Health Equities recommendations concerning program eligibility
- Development of eligibility recommendations, continued with focus on residency and citizenship requirements
- Public input

February 27th 2-5pm Mt. Mazama Room

TOPIC: OUTREACH

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review of minutes from last meeting
- Review and approval of eligibility recommendations.
- Review of MAC recommendations regarding outreach
- Review of Health Equities Committee recommendations concerning outreach
- Review of staff documents/outreach "best practices"
- Development of recommendations for outreach
- Public input

March 11th 9am-12pm, Clackamas Community College Room 111

TOPIC: APPLICATION, ENROLLMENT PROCEDURES

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of outreach recommendations.
- Review of MAC recommendations regarding application, enrollment procedures
- Review of staff documents/experiences in other states
- Development of application, enrollment recommendations including a standardized application process, standards for disenrollment and changing enrollment
- Public input

April 8th 2-5pm, Clackamas Community College Room 111

TOPIC: PORTABILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of application, enrollment recommendations.
- Review of staff documents/experiences in other states
- Development of recommendations around portability
- Public input

April 23rd 2-5pm Mt. Mazama Room

TOPIC: CONSENSUS DOCUMENT

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of all Committee recommendations.
- Review of draft set of recommendations to forward to the Health Fund Board
- Public input

Building an Affordability Straw Person

Eligibility and Enrollment Committee of the Oregon Health Fund Board

January 8, 2008

What we've reviewed (and two new sources)

- Current spending on health care
- Oregon family budget analysis from Medicaid Advisory Committee
- OHP and CMS
- New: Take up rates and price sensitivity

Current Spending on Health Care

Urban Institute (Holahan, Hadley and Blumberg)

National data on health care

Findings

- Middle-income people spend an average of 8.5% of income on total health care costs
- Health insurance expenses are regressive, with the lowest income populations paying the largest amount as a percent of income
- Monthly out-of-pocket expenses (other than cost sharing) are about $25/month.

Current Spending on Health Care

Jonathan Gruber for the Massachusetts Connector

- National Consumer Expenditure Survey
- Analysis of enrollment in employer-sponsored insurance

Findings

- Families below 150% FPL ($30,975) spend all of their income on necessities
- Families between 150% and 300% FPL ($30,975 to $61,950) spend almost all income on necessities, but could afford modest premiums.
- Even below 100% poverty, 60% enroll in their employer-sponsored insurance when it is offered.

Current Spending on Health Care

Implications for E & E Committee

- No personal premium cost sharing below 150% FPL?
- Set up premium cost share as a percent of income beginning with nominal sharing at 150% FPL, increasing as income increases to eliminate regressiveness at very low and low incomes?

Family Budget Analysis

Medicaid Advisory Committee (MAC) analysis of a basic family budget in Oregon

Findings

- Family of 4 (2 parent, 2 child), no discretionary income until 250% of FPL ($51,625 annually) in Portland area, 200% of FPL in rural Oregon ($41,300 annually).
- Single parent with 1 child, no discretionary income until 300% of FPL ($41,070 annually) in Portland area, 250% of FPL in rural Oregon ($34,225 annually)

Family Budget Analysis

Implications for E & E Committee

- Nominal premium cost sharing below 250% FPL?
- Single parent families have fewer resources after spending for basic needs than an equal-size family with two adults. Consider individual, adult plus child, couple, and family premium rates?
- Geography matters. Families in the Portland area required more resources for basic needs than families in rural parts of the state. Consider differential rates based on geography?

Existing public programs

- CMS
  - Allows 5% of gross income maximum cost sharing in SCHIP
- Drs. Matthew Carlson and Bill Wright's 3-year Medicaid cohort study
  - Examined impacts of cost sharing on low-income (<100% FPL) OHP population after implementation of OHPII.

Findings

- Very low-income population highly sensitive to cost sharing. OHP Standard premium and co-pay structure had negative impacts on continuity of care and health status.

Existing public programs

Implications for E&E

- Structure total cost sharing (i.e., premium share, co-pays, deductibles, other out-of-pocket expenses) so that it doesn't exceed 5% of income?
- Structure co-pays so that desired utilization is incentivized: no co-pays for preventive and maintenance services, higher co-pays of emergency department utilization? No or nominal co-pays for generic Rx, higher co-pays for brand names?

New: Take-up rates and price sensitivity

- Leighton Ku and Teresa Coughlin for the Urban Institute (1997)
  - Looked at Washington, Hawaii and Tennessee

Findings

- Ku and Coughlin found that for low-income people (<200% FPL), when premium are 1% of income, about 57% participate, when premiums increase to 3% of income, 35% participate and at 5%, participation decreases to 18%.

Ku, Leighton; Coughlin, Teresa, “The Use of Sliding Scale Premiums in Subsidized Insurance Programs”, The Urban Institute, March 1997.

New: Take-up rates and price sensitivity

- Kenneth Thorpe for Vermont's Catamount Health Reform (2006)

Findings

- Found that almost all people at about 300% of FPL will purchase health insurance where premium is about 4% of income.

New: Take up rates and price sensitivity

Implications for E&E

- Set lower bound of affordability (at 300% FPL) at 4% of income.
- Premium cost share should be sufficiently below 5% of income to allow budget capacity for other cost sharing.

Federal Poverty Guidelines-Effective 1-24-2007

(Source: HHS)

	100 Percent		125 Percent		130 Percent		150 Percent		185 Percent		200 Percent	
Family Size	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
1	$10,210	$851	$12,763	$1,064	$13,273	$1,106	$15,315	$1,276	$18,889	$1,574	$20,420	$1,702
2	$13,690	$1,141	$17,113	$1,426	$17,797	$1,483	$20,535	$1,711	$25,327	$2,111	$27,380	$2,282
3	$17,170	$1,431	$21,463	$1,789	$22,321	$1,860	$25,755	$2,146	$31,765	$2,647	$34,340	$2,862
4	$20,650	$1,721	$25,813	$2,151	$26,845	$2,237	$30,975	$2,581	$38,203	$3,184	$41,300	$3,442
5	$24,130	$2,011	$30,163	$2,514	$31,369	$2,614	$36,195	$3,016	$44,641	$3,720	$48,260	$4,022
6	$27,610	$2,301	$34,513	$2,876	$35,893	$2,991	$41,415	$3,451	$51,079	$4,257	$55,220	$4,602
7	$31,090	$2,591	$38,863	$3,239	$40,417	$3,368	$46,635	$3,886	$57,517	$4,793	$62,180	$5,182
8	$34,570	$2,881	$43,213	$3,601	$44,941	$3,745	$51,855	$4,321	$63,955	$5,330	$69,140	$5,762
Each Addn'l Person Add	$3,480	$290	$4,350	$363	$4,524	$377	$5,220	$435	$6,438	$537	$6,960	$580

	Effective 3-20-2007						Effective 10-01-2007				Effective 1-24-2007	
	50% Regional Median Income						60% State Median Income					Approx. Hourly
Family Size	Annual	Monthly				Family Size	Annual	Monthly			Family Size	Income*
1	$23,750	$1,979				1	$19,327	$1,610			1	$4.91
2	$27,150	$2,263				2	$25,274	$2,106			2	$6.59
3	$30,550	$2,546				3	$31,220	$2,601			3	$8.26
4	$33,950	$2,829				4	$37,167	$3,097			4	$9.94
5	$36,650	$3,054				5	$43,114	$3,592			5	$11.61
6	$39,400	$3,283				6	$49,060	$4,088			6	$13.29
7	$42,100	$3,508				7	$50,175	$4,181			7	$14.96
8	$44,800	$3,733				8	$51,290	$4,274			8	$16.64
9						9	$52,405	$4,367				
10						10	$53,520	$4,460				
11						11	$54,635	$4,552				
12						12	$55,751	$4,645			*Based on 100% of Poverty.	
Each Addn'l Person Add	$2,700	$225				Each Addn'l Person Add	$1,412	$117			Calculation: Annual income divided by 2,078 hrs	

Program Guidelines Given for Selected Programs:

100%: Oregon Health Plan (Income Guidelines may vary for special population groups)

125%: Most Community Action Agency Programs

130%: Free School Meals

185%: Reduced Price School Meals, WIC, Food Stamps, USDA Commodities, Oregon Prescription Drug Program

200%: Clackamas County Food Basket Program

50% Regional Median Income: Low-Income Rental Housing Fund (LIRHF); Shelter Plus Care. NOTE: Metro Regional Income Higher than State Income

Source:Department of Housing & Urban Development (HUD)

60% State Median Income: All Energy Assistance Programs; LIEAP, OLGA, GAP, OEA, and Oregon Heat. NOTE: State Median Incomes are substantially lower than in the Metro Region.

Source: U.S. Department of Health & Human Services (HHS)

HUD 2007 Income Limits

Effective March 20, 2007

Household Size	30% (Extremely Low)	50% (Very Low)	80% (Low)
1	14,250	23,750	38,000
2	16,300	27,150	43,450
3	18,350	30,550	48,900
4	20,350	33,950	54,300
5	22,000	36,650	58,650
6	23,650	39,400	63,000
7	25,250	42,100	67,350
8	26,900	44,800	71,700

Median Income: $63,800 (family of four)

HOME Single Family Mortgage Limit $304,950 (6-18-07)

From "Defining Affordability in Massachusetts", April 2007,
Community Catalyst
Christine Barber
Michael Miller

Kenneth Thorpe's research for Catamount Health in Vermont
What is this analysis?
Economist Kenneth Thorpe recently devised a "take-up rate" formula for Vermont's health reform to assess how many uninsured would enroll. Thorpe uses a measure of price elasticity informed by economic theory, including the formula used by the Congressional Budget Office to estimate enrollment in public programs.[i] "Price elasticity" is the measure of how individuals respond to price changes for a particular good. Thorpe estimates price elasticity for health insurance at -0.5. This means for every 10 percent decline in the price of insurance, 5 percent of the uninsured will enroll.[ii] In addition to the price sensitivity of enrollment, Thorpe takes into account the share of the health premium as part of household income, and the amount of the public subsidy[iii].

Table 4: Thorpe's Take-up Formula[iv]

Percent FPL	Monthly Premium, *Most* Enroll	Premium as % income	Monthly Premium, *Nearly All* Enroll	Premium as % income
150% FPL	$27	2.2%	$15	1.2%
301% FPL	$175	6.8%	$83	3.4%
500% FPL	$288	6.9%	$138	3.4%

What are limitations of this analysis?
Because Thorpe's formula accounts for health insurance expenditures as *percentage of income*, this measure is most useful for people with low and moderate incomes. Going higher on the income scale, it becomes harder to argue people cannot *afford* insurance, even if they would not voluntarily buy it, if they have adequate discretionary funds available to purchase insurance.

Thorpe's calculations do not take into account the effect of an individual mandate. In the context of a mandate, a greater percentage of the uninsured will enroll in insurance.[v] However, this formula is a strong measure of what people would choose to purchase.

Thorpe's formula supplies premiums only, and does not account for other out-of pocket-costs. From the Holahan et al. analysis, we see that out-of-pocket costs create an additional expense of about $25/ per month. So, total health spending at the level at which "nearly all" people with income just above 300% FPL would voluntarily enroll in a health plan would be $108 per month, or about 4% of income.

What does this analysis tell us?
Like the Holahan et al. analysis, Thorpe's formula is useful in building a range of affordability. For people with income just above 300% FPL, using Thorpe's analysis gives us a "**lower bound" of affordability at about 4% of income**. Therefore, an

affordability scale emerges between 4% (at just above 300% FPL) and progressing to 8.5% of income (by 600% FPL).

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[i] Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals. Sherry Glied, Dahlia K. Remler, and Joshua Graff Zivin. The Milbank Quarterly. Vol 80, No. 4, 2002.

[ii] Overview of Catamount Health. Kenneth E. Thorpe. February 23, 2006. http://www.leg.state.vt.us/HealthCare/Overview_of_catamount_health_by_ken_thorpe_feb_2006.htm

[iii] The formula Thorpe uses is: *Newly insured= ((1- (premium as share of income) squared) x percent subsidy discount x .75.* Thorpe assumes that with a fully subsidized premium ((1-0) squared) x 100 x .75), only 75% of the uninsured would enroll. Therefore, enrolling "most" uninsured equals 65%, "nearly all" equals 70%. It should be noted that, to account for health plans without a subsidy, we altered Thorpe's formula to account for no subsidy.

[iv] At 150%, table includes subsidy levels for Commonwealth Care Plans in Massachusetts.

[v] Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets. Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission By Gorman Actuarial, LLC, December 26, 2006.

Memorandum

To: Eligibility and Enrollment Committee of the Oregon Health Fund Board

CC:

From: Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research, Committee Staff

Date: 1/7/2008

Re: Straw Person Proposal for Affordability Recommendations

Committee Members,
I'm attaching a straw person proposal for your review in preparation for our meeting this Tuesday. I have tried to capture the sense of the group from our meetings this Fall and from your written comments (also attached).

This is not meant to be a final document. Please review, comment and edit. We will go over this in detail on Tuesday and hopefully develop our final affordability recommendations for the Board.

Thanks,
Tina

Eligibility and Enrollment Committee
Affordability Recommendations to the Oregon Health Fund Board

STRAWPERSON PROPOSAL
January 8, 2008

Background

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs the Committee to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program.

In developing these recommendations, the Committee met 5 times, on October 24, November 13 and 28 , December 11 and January 8, 2008. The Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)		Number employed (not children, not military)
	Adults	Children under 19	
<150%	**208,000**	**46,000**	119,000
150% to below 200%	**67,000**	**29,000**	54,000
200% to below 250%	60,000	**10,000**	39,000
250% to below 300%	34,000	5,000	24,000
300% to below 350%	21,000	4,000	14,000
350% to below 400%	26,000	4,000	22,000
400% and above	83,000	16,000	70,000
Total	**499,000**	**114,000**	**342,000**

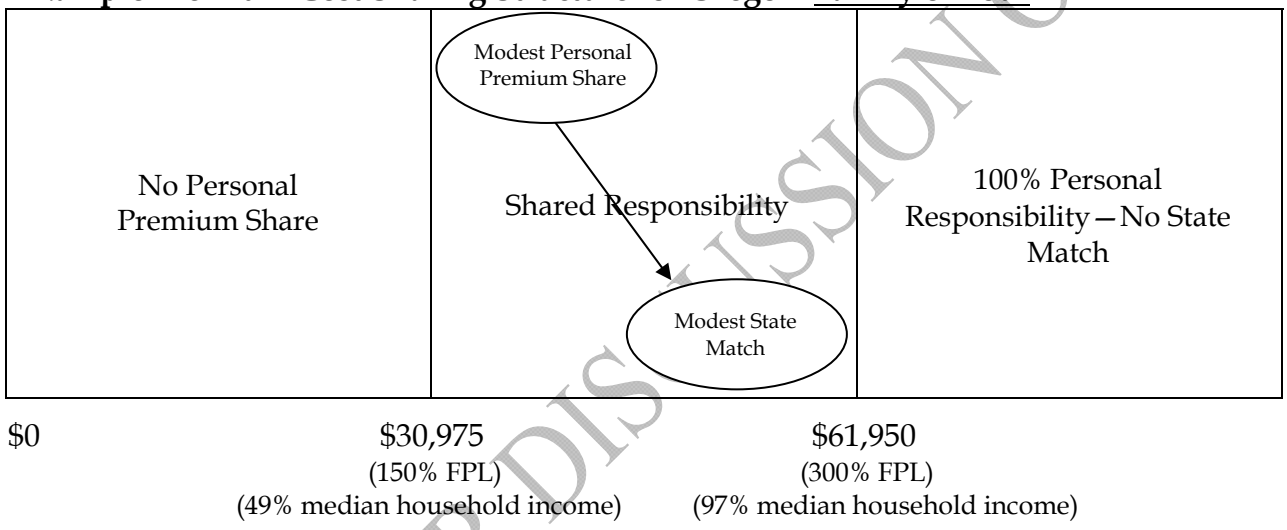
Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program
- Oregon Health Policy Commission's "Roadmap to Health Care Reform"
- Oregon Business Council's Policy Playbook's recommendations for Health Care
- Premium contribution and cost sharing structures in other states

- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance"*
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts"*
- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, *"Impact of Copays on a Medicaid Population"*

The following diagram is a depiction of the framework in which the committee was working:

Example Premium Cost Sharing Structure for Oregon Family of Four



The E & E Committee discussed and debated various approaches to defining affordability, struggling to balance maximizing individual affordability fairness and sustainability. The committee developed initial consensus around 4 options, two that described an income below which there would be no personal premium cost sharing and two that described the income above which premium cost would be 100% personal responsibility.

Proposed Cost Sharing Structures

A. The first question addressed by the committee was: At what income should a family reasonably be expected to share responsibility for premium cost?

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	150%	$15,315	33%
Couple	150%	$20,535	38%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

Option 2a: This option does not differentiate by family structure, and starts the personal premium cost share at a higher FPL than Option 1a for individuals and couples.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	200%	$20,420	44%
Couple	200%	$27,380	51%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

B. The second question addressed by the committee was: <u>At what income level should premium cost be 100% personal responsibility</u>?

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon Median HH Income
Individual	300%	$30,630	65%
Couple	300%	$41,070	77%
One adult, one child	350%	$47,915	90%
Family (4 person)	350%	$72,275	113%

Option 2b: This option continues to differentiate between families with and without children, but continues the state match to higher income levels.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon 2007 Median HH Income
Individual	350%	$35,735	76%
Couple	350%	$47,915	90%
One adult, one child	400%	$54,760	102%
Family (4 person)	400%	$82,600	129%

To develop a consensus recommendation each committee member was asked to evaluate the options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without controversy, including a concern that minimizing crowd-out should not be a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal

coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless there the proposed reform includes requirements for participation from employers.

There was also concern about the analyses by the economist Jonathan Gruber. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected by an automatic payroll deduction, is sometimes not optional, and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to support through policy.

An additional issue for committee members was the friction between designing a program purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

> *We have to convince conservatives that they have a stake in the uninsured, and that costs can be controlled*
>
> And
>
> *We have to convince liberals that limits must be set, and that we can't do everything medical science has invented for everyone.*

Strawperson Recommendations

Recommendation 1: **Require no personal premium match until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with a child).**

Partial state premium match to 300% FPL for individuals, couples and families.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state all contribute to paying health care costs. However, there was also recognition that below a certain income level, all of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for these families to obtain health insurance coverage, some kind of assistance is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is any individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses. The committee found:

- An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:
    - A family of four (2 adults, 2 children) does not have adequate budget resources for health insurance until their income reached 250% of the federal poverty level (FPL) or $51,625 annually for the Portland area, 200% of FPL or $41,300 annual income for rural Oregon.
    - A single parent with 1 child doesn't begin approaching an adequate budget for health insurance until 300% FPL ($41,070) in the Portland area, 250% FPL ($34,225) in rural Oregon.
- A study of affordability conducted by economist Jonathan Gruber, which focused on what households currently spend on health care showed that below 150% of the federal poverty level ($14,700 for an individual or $30,975 for a family of 4), budget's are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state match for premium costs.

The following summarizes the committee comments leading to this recommendation to the Board:

Affordability. The committee generally felt that the 150% was correct because all of the analyses reviewed indicated that below this level there is no discretionary income. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing scheme should reflect how little margin there is in these budgets and keep the cost sharing very small, especially between 150% and 200% FPL.

Equity. Equity was discussed in a couple general ways by the committee. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equal treatment for equally needy people. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Finally, some addressed the issue of treating families with children differently than families without: "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state costs for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I would favor shooting for the highest levels we can get from the feds… favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

Shared Responsibility. As one member stated, "Although (hopefully) small contributions from those at low income levels, they would still be participating early on. Members also felt that shared responsibility included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their health **care and help reduce costs, too."**

Recommendation 2: Design state premium match as a sliding scale to avoid the "notch effect" or series of cliffs that create perverse incentives for people to minimize income in order to keep benefits.

Premium cost sharing should be designed so that the state match decreases slowly as income increases. Studies of take-up and price sensitivity in voluntary programs show that very low-income populations are highly sensitive to price. A 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a

very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them. Scale in VERY small increments, particularly for those between 150-200%."

Recommendation 3: Within the subsidized portion of the program, structure total cost sharing (premium share, co-pays and deductibles and out-of-pocket) so that they do not exceed 5% of income.

"Affordability" must consider not only premiums but out of pocket costs for benefits provided by the plan and out of pocket costs for necessary health services that may not be covered by the plan. The Urban Institute's review of national healthcare spending indicated that health care costs are highly regressive, with the lowest income populations paying out the largest proportion of their incomes for health care.

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when benefits, out of pockets costs, rate of increase in personal income, and allowable rate of increase in annual 'premiums' (or strength of cost-containment measures for plans and providers) is unknown cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'."

Recommendation #4: Structure the personal premium cost share as a percent of income rather than a percent of premium and protect lower incomes more than higher incomes to mitigate regressive nature of health insurance costs. Premium share should be below 5% of income to allow for the impact of other individual cost sharing and should be a smaller percent of income at lower incomes.

For example:

Example Individual Premium Structure

FPL	Starting Point	Endpoint	Monthly Premium Share	Annual Premium Share	% of income
<150%	0	$ 15,315	$ -	$ -	0%
150% to below 200%	$ 15,316	$ 20,419	$ 18	$ 214	1.2%
200% to below 250%	$ 20,420	$ 25,524	$ 38	$ 459	2.0%
250% to below 300%	$ 25,525	$ 30,629	$ 94	$ 1,123	4.0%
300% to below 350%	$ 30,630	$ 35,734	$ 124	$ 1,493	4.5%
350% to below 400%	$ 35,735	$ 40,839	$ 160	$ 1,914	5.0%
400% and above	$ 40,840	na	$ 309	$ 3,708	9.1%

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that health care costs are highly regressive, with the lowest income populations paying the largest amount as a percent of income. This recommended

approach reverses that regressiveness by protecting low-income individuals and families.

Recommendation #5: Design premium structure with geographic adjustments to reflect higher cost of living in Portland area when compared to rural Oregon.

The Medicaid Advisory Committee's review of basic budgets in Oregon showed that the budget required for basic necessities is much higher in the Portland area than it is in rural Oregon.

Additional recommendations of the committee to other OHFB Committees:

1. **For the Benefits Committee**

- **Structure co-pays to incentivize desired utilization. Preventive services and health care services that support chronic care maintenance should not have any required co-pays.**

2. **For the Finance Committee**

- **Employer contribution requirement will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.**

Committee Membership:

Robert Bach, Lattice Semiconductor Corporation
Jane Baumgarten, Retired
Felisa Hagins, SEIU Local 49
Dean Kortge, Senior Insurance Specialist, Pacific Benefits Consultants
Ellen Lowe, Advocate and Public Policy Consultant
Noelle Lyda, Ed Clark Insurance, Inc.
C.J. McLeod, Senior Vice President and Chief Marketing Office, The ODS Companies
Bill Murray, CEO, Doctors of the Oregon Coast South (DOCS)
Ellen Pinney, Health Policy Advocate, Oregon Health Action Campaign
Susan Rasmussen, Manager, Special Programs, Kaiser Permanente NW
Carole Romm, Director, Community Partnerships and Strategic Development, Central City Concern
Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network
John Mullin, Oregon Law Center
Ann Turner, MD, Physician and Co-Medical Director, Virginia Garcia Memorial Health Center

Oregon Health Fund Board
Eligibility and Enrollment Committee

Member Comments on Affordability Options

Committee members were asked to comment on the following options for premium cost sharing in preparation for the January 9, 2008 meeting of the committee.

A. The first question addressed by the committee was: At what income should a family reasonably be expected to share responsibility for premium cost?

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	150%	$15,315	33%
Couple	150%	$20,535	38%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

Option 2a: This option does not differentiate by family structure, and starts the personal premium cost share at a higher FPL than Option 1a for individuals and couples.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	200%	$20,420	44%
Couple	200%	$27,380	51%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

B. The second question addressed by the committee was: At what income level should premium cost be 100% personal responsibility?

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon Median HH Income
Individual	300%	$30,630	65%
Couple	300%	$41,070	77%
One adult, one child	350%	$47,915	90%
Family (4 person)	350%	$72,275	113%

Option 2b: This option continues to differentiate between families with and without children, but continues the state match to higher income levels.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon 2007 Median HH Income
Individual	350%	$35,735	76%
Couple	350%	$47,915	90%
One adult, one child	400%	$54,760	102%
Family (4 person)	400%	$82,600	129%

Deidentified Member Comments:

1. **Affordability:**

Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important and least important based on evidence-based medicine. The benefits will have a co-pay patter that encourages primary prevention and that supports maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions. I would start the premium subsidy at 150% FPL and end them at 300%. The premium would begin with small increments, increasing at 25% FPL. Building upon the refundable earned income

tax credit, I would assign a number that reflects the average co-pays with a phase out component.

The real value of any health insurance package is dependent upon an environment with safe housing, adequate nutrition and physical education. It also needs primary care providers/clinics that are accessible when the insured are available.

Full subsidy for individual at <150% of poverty, 2 adults <150% poverty, 1 adult, l child < 200% poverty, family of 3 or greater < 200%

Partial subsidy for single individual at <300% of poverty, 2 adults < 300% FPL, 2 adults, 1 child or more < 400% poverty.

I feel that I have less of a sense of the "right %age for the higher income folks. In thinking about this, it seems to me that a couple of 2 adults have different earning capacities and expenses than l single parent and child.

Still, in terms of maximizing federal contributions, I would favor shooting for the highest levels we can get from the feds. So, if we could access full or partial subsidies at higher levels, I would favor doing this if the State budget can afford it. This goes to this issue of budget constraints.

So, in the first paragraph, I indicated what I think is affordable (best case scenario which is rarely the case for folks living in poverty), but favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this.

Again the idea of having premiums be the primary cost of the plan with minimal co-pays for basic services is important.

I am coming from the perspective of full cost of an adequate plan paid for by the State, at and below 200% of FPL. Cost sharing would begin above 200% of FPL in small income steps, as we have discussed, and then the state paid share would phase out completely at 400% of FPL. I should also note that from an Oregon Law Center perspective we are most interested in how low income Oregonians will be served by any changes recommended by our committee, and ultimately by the Oregon Health Fund Board.

As you know, the FPL is the same in the 48 contiguous states. The median income varies by state and then by region. Whatever we decide to propose as our guideline, I believe the OHFB will need to think about how it describes what is ultimately being presented. We had some discussion in our committee about looking at assistance that might be made available as "subsidies," a term that is likely to be used by opponents in

a negative way. As an illustration, the cut off point for premium assistance at 400% of FPL would be $82,600 for a family of 4, which is 129% of the median income in Clackamas County. Some Oregonians might struggle with this, and express concern that this would be a "subsidy" for more than half of Oregon families.

Anyway, as you know, the MI [*median income*] comparison to the FPL changes in proportion as household size changes. For example, a 1 person household at 30% of the median (considered extremely low income by HUD) is 145% of FPL. But for a household size of 4, 30% of MI is 99% of FPL. It's a bit hard to come up with rationale here. It should be noted however, that if we went with 200% of FPL as the point where we would begin charging some premium amount, an individual would fit in the "very low" income category, i.e., less than 50% of the median, and two or more person families would be in the "low" category, i.e., less than 80% of MI. So that position will be easier to articulate. The communication challenge, I believe, is at the other end where premium assistance tapers.

I like the idea of establishing the principle of no more than 5% household of income for health care. And I think that we should work totally with premiums, and not get into co-pays and deductibles. That will make it easier for consumers to budget for their healthcare. It will make the eligibility process relatively simple, making the program easier to administer. However, I believe education of providers and clients will be necessary. We want to ensure proper utilization.

Families USA has recently issued a December 2007 report that you probably both saw, and among the findings was the health care cost example of a typical family of 4, making $60,000, and having $2,990 left for healthcare, after paying for other essentials. Two comments: that's very close to 5% of total pre tax income; and this family is earning about 94% of the MI for Clackamas County.

In a the *2007-2008* <u>*Assets and Opportunities Scorecard*</u> by CFED (an organization that outgrew its acronym, but they kept the letters, similar to what AARP has done – this group looks at income, assets, and has a tag line of "expanding economic opportunity") Oregon gets a "C' ranking for asset building and preservation. Among the problems cited were the high costs of housing in Oregon. But they also list a concern about medical debt that can deplete assets, stating that in a nationwide comparison Oregon is: 34th in employer sponsored insurance; 44th in uninsured low income parents; and 33rd in uninsured low income children.

I think these two studies, the work of MAC, and lots of others could be the underpinning for our rationale for the 5% limit. I think that most people generally accept this kind of formulation in one other area – the well known concept that families should have to spend no more than 30% of their income on housing. And in my Community Action work, we promoted the idea that families should not have to spend

more than 11% of their income on utilities. Anyone who has worked with those in close proximity to the poverty level knows that those percentages are very often exceeded. So I am very comfortable with the 5% limit, as Families USA data show dramatic increases in the percentages of Oregonians who pay more than 10% of their income for health care expenses.

Providing a full subsidy for those up to 150% of the FPL would make health care affordable to that group of people, and, hopefully, we would be able to make it affordable for the State Budget.

It will depend on what the benefits are of the "basic plan" that would determine how fast the declining subsidy would be to reach up to 200% of the FPL

Getting to 5% - how do we do this?

I would like to see a simple system that is tied exclusively to premiums. This is more predicable and stable than keeping track of co-pays, deductibles, and other out-of-pocket costs. But I also recognize there is a big price tag and this proposal would mean other considerations as well.

Taking the example of the family of 4 at 400% of the poverty level, capping the premium at 5% of income would mean an annual contribution of $4,130, a considerable amount, at the high end. However, the benefit plan (depending on what is ultimately recommended by the OHFB) will likely cost much more than that a year. The Families USA report notes that the average job based family health plan now costs $12,106 a year. And if a family makes $82,601 they would pay the full cost, and that would be close to 15% of gross income for that family. There are, of course, federal and state medical deductions at 7.5% of adjusted gross income, but these benefits depend on itemizing, something that goes up steadily (according to Oregon Department of Revenue statistics) as adjusted gross income goes up.

The higher the full subsidy goes on the % of FPL dimension, the more affordable for the individual or family. This comment applies to this dimension on all four options

My response to the question of where should funding stop and start is that we should have:

Fully paid health insurance through a reinvigorated Oregon Health Plan (Medicaid) program up to somewhere in the 150% to 185% range of the Federal Poverty Level (FPL)

Subsidized premiums for health insurance using the insurance industry (group or non group) for individuals and families from 151/185% to some-where in the 200/250% range of the FPL

Above 200/250% of the federal poverty level, individuals get insurance through their employer or by purchasing an individual/family policy in the non group market place.

"Affordability" must consider not only premiums but out of pocket costs for benefits provided by the plan and out of pocket costs for necessary health services that may not be covered by the plan.

However 'affordability' is ultimately determined, there should not be huge cliffs in how it is implemented (ie: small increases in income, not large, should set the bars for small graduated increases in what an individual or family pays towards coverage).

The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute.

329 is nothing else if not ambivalent about what it intends for current market. But I believe it lands mostly on the side of change. If the 'essential' benefits package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed. I have attached to this document language in verbatim from 329 that I hope helps to illuminate this point. OHAC used this language in community meetings around the state.

Language from exercise presented to E&E committee:
Partial subsidy up to 300% of FPL.
$29,400: 126% of the median income for an individual.
$39,600, 77% of the median household income for a couple.
Up to 350% for a family of three:
$58,100, 100% of the median household income for a family of 3.

In general, I would say this: A model that looks only at subsidies for 'insurance premium' costs when benefits, out of pockets costs, rate of increase in personal income, and allowable rate of increase in annual 'premiums' (or strength of cost-containment measures for plans and providers) is unknown cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'.

What does this option imply about personal affordability?
Other questions to add: What does this option imply about family affordability?
I am not sure 'median income' comparison makes sense in the context of discussing 'affordability' at all. Median income will change. It may go up or down. It says absolutely nothing about the extent to which that median income results in affordability of health care or anything else. Health care costs will most likely go up, albeit, with 329 in place, one would hope at a slower and eventually even predicable and controlled rate.

Unless contributions are very low, this group [*full subsidy option 1*] will have trouble affording them. Scale in VERY small increments, particularly for those between 150-200%. Consider higher range for families.

Scaling subsidies in small steps will allow more affordability

2. Equity:

Our mission is to address the health care needs of the uninsured. I acknowledge that this does not create equity for the Oregonians who are underinsured or for employers who provide coverage for low-income workers. Access to accountable health plans for all Oregonians should be a second mission.

I would hope that what everyone and all employers would have the option to select this insurance product with a basic set of benefits (being worked on by Benefits committee) which would be something many if not most business would opt for. Then employers could choose to add benefits to this package as they chose.

Another way to look at this is to talk about the value of covering Oregonians. With an individual mandate, we have a level playing field. Most Oregonians will need assistance. It's similar, in my opinion, to saying that we want to encourage home ownership, and, in that instance, there are tax deductions that go to all income groups. So somehow we have to convey the value of the public benefit. Otherwise, people just rail away at how we are covering middle class folks (as played out, for example, in the SCHIP deliberations.)

To gain overall support for a change, it would seem we would have to recommend changes in tax policies. And there are already a number of existing health care tax expenditure statutes, including the Medical Deduction for the elderly, which allows those over the age of 62, who itemize their Oregon tax return to "deduct the full amount of their medical and dental expense from Oregon taxable income." (*State of Oregon 2007-09 Tax Expenditure Report* – this report also notes that 182,600 Oregonians took advantage of this deduction in tax year 2004.) Another difficult set of discussions in the area of tax policy is employer "pay or play," which we have discussed. It would seem that the "playing" part would need to come up to whatever is the final design of a basic

plan, and the "paying" part would have to be close to equal. But what about those with employers (like mine, for example) that have good coverage for individuals, couples, and families? To make for an equitable policy, should employees of generous firms be taxed on their benefits to ensure that they too are paying 5% of their income? That would help with the revenue needs, but this would be hugely controversial. I know the OHFB Finance Committee is working on a number of options, but there is crossover when our committee looks at affordability, equity, crowd out, budget constraints, and shared responsibility.

So getting to consumer affordability, creating a level playing field, and winning public support with what will undoubtedly be a hefty price tag, will be a significant challenge. Having said all of this, I still support capping consumer participation at 5% of gross income for premiums only.

I would welcome data about the ESI available to people at 50% median income. I wonder if full subsidy up to about that level would seem fair in relation to private insurance. I also think we should have equity within the subsidized insurance between individuals, couples, families - I'd suggest that full subsidy is up to the same percent of median income for whatever categories we finally select.

In our last meeting there was a comment about the importance of word choice for the political perception of equity. I'll continue to use "subsidy" in these comments, but I agree that we need another description.

Going higher than the first option increases the inequity with private insurance.

Similar to what I've asked above, I would want to know about the prevalence of ESI as related to median income levels, and employee cost sharing. I wonder how common ESI is at the 75% of median income level and how many Oregonians are at 75% and below. As above: "I also think we should have equity within the subsidized insurance between individuals, couples, families - I'd suggest that (end of) subsidy is (around) the same percent of median income for whatever categories we finally select." I'm simplistically thinking about the political perception of equity if we had full subsidy for the first quartile by median income and declining subsidy for the second quartile. Looking at actual data might refute this concept quickly.

First, I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process.

I believe that we as a committee need to be realistic about what the Oregon Health Fund Board and ultimately the Legislature and the voters of Oregon will support to bring

about a "new" Oregon Health Plan. I'm concerned that if we could not pass a tax on cigarettes to fund insurance for children, we need to get realistic about what the majority of the voters in Oregon will support. George Bernard Shaw's quote paraphrased, "The government that takes from Peter to pay Paul can always depend upon the support of Paul" may be appropriate. We are going to need Peter's support to bring about this change. It is for this reason that I'm taking a position that is more conservative from many of the other committee members.

I'll bookend my comments with a quote from Richard Lamm, the former Governor of Colorado, at the Kitzhaber Lecture in December of last year sponsored by the Foundation for Medical Excellence. During his presentation Governor Lamm said:

"We Have to Convince Conservatives That They Have a Stake In The Uninsured, and that Costs Can Be Controlled."

and

"We Have to Convince Liberals That Limits Must Be Set, and that We Can't Do Everything Medical Science Has Invented For Everyone."

We cannot really respond to this part without knowing the benefit structure-what the benefits would be of the new program?

Other questions to add: ***What does this option imply in the context of an 'individual mandate'?*** Where ever Oregon sets the bar on 'insurance affordability', until and unless we establish and maintain an employer mandate, the rest will be -- is required to be -- paid for by families or individuals…which brings me back to the italicized point immediately following the suggested premium subsidy thresholds. *(A model that looks only at subsidies for 'insurance premium' costs when benefits, out of pockets costs, rate of increase in personal income, and allowable rate of increase in annual 'premiums' (or strength of cost-containment measures for plans and providers) is unknown cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'.)*

In the context of equity for individuals being required to buy coverage one cannot disassociate 'equity' from 'sustainability'. If majority of the voters feel the program is inequitable (because it is not affordable, because the benefits are not what they need, because the plans are not accountable' (to cost-containment or access measures) there will be backlash that could kill all hopes for the future of health care for all.

This question (***What does this option imply about health coverage outside a new program?)*** in the context in which it is posed could be construed to imply that the market outside the 'new program" is intended to stay the same……beyond that even that we in Oregon benefit by having the market 'outside the new program" stay the same. I think it has become clear to the OHFB that, at least in the individual market,

things must change to create a workable insurance exchange. In the employer market---would we consider it 'bad' if an employer dropped existing coverage for employees and instead chose to contribute the same amount to an 'accountable health plan" of an employee's choosing. through an insurance exchange or outside of it? Or would we consider it 'bad' if an employer dropped existing coverage to pick up a new 'accountable health plan' product?

How many people in this group [*full subsidy option 1*] are working? Of those who are, what % are not taking up offered benefits? Of those, how many employers would participate in new product?

[*Partial subsidy option* 2] They = or exceed median income; these folks would not (or should not) be paying more than people with ESI

3. <u>Limiting crowd-out:</u>

I think for this to be workable as a sustainable plan, employers would need to be required to contribute an amount that would be enough to provide this basic benefit package to their employees. My vision is that there would be a basic benefits package that all Oregonians would have access to and then employers could provide add-ons at their discretion.

The data about ESI prevalence as related to percent of median income would be helpful here. By other policy choices, as we have discussed at E&E, we can keep employers in play; this subsidy level choice is not our best instrument for influencing employer participation. However, again I'm hopeful that somewhere around 50% of median, we are not creating great pressure on employers to drop insurance.

Moving the full subsidy higher increases the pressure on ESI and requires more counter-pressure by carrots and sticks to keep employers involved

Again, this cannot be answered until we know the benefit structure; assuming the "basic benefit" is less than traditional insurance plans, there would be some Crowd out up to the limits of the subsidy

Because of the known policy implication of 'crowd out' (ie: crowd out is when employers drop their own coverage), I would prefer the E&E committee explore our subsidy model with this concept in mind: ***"Maximizing continued employer contributions to employee/dependent health ccoverage". What does this option imply about potential loss of employer contribution?***

And I think the answer must really consider that employers are right now, outside the context of any proposal for universal coverage, dropping coverage for their employees or their employees' dependents. Or/and they are increasing employee required

contributions for both. Or /and they are reducing plan costs by shrinking benefits / increasing out of pocket costs for benefits. I believe I am safe in saying that the availability of SCHIP coverage has not hastened employer withdrawal from dependent coverage options….rather the cost of health care has been the almost exclusive explanation for that withdrawal.

I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee.

Perhaps the E&E committee (that has been tasked with developing a definition for 'affordability') needs to take a stand not only on the frequency of bars for an equitable affordability scale and the benefits and out of pocket costs that 'affordability' must consider but on the need for employer contributions to be part of any equitable, sustainable mix for affordability for Oregon's uninsured.

[*Partial subsidy option 1*] Maximizes contributions of employers; reasonable outlays for individuals. More affordable for state.

[*Partial subsidy option 2*] Would minimize crowd out less than #4, particularly if there is an employer mandate (pay or play). But would anyone take it up at low subsidy levels?

4. <u>Budget constraints/Sustainability:</u>

This is hard to know without having some cost estimates of this what subsidies would cost. In the MAC document, the requirement for larger employers to contribute 8% of their earnings seems reasonable looking at what our organization cost for health insurance is. In terms of making decisions about what we can afford to subsidize, it seems to me that we would need to know what the cost of the insurance plans would be at each of these levels. I do think that there is a greater need to be firm on the subsidy at the lower end of the scale than the upper.

Obviously the higher the income level for full subsidy, the greater the state financial burden. The total state expenditure is influenced by the benefit package (its cost) and federal agreement on participation. A leaner benefit package and federal agreement to participate up to 200% FPL would make full subsidy above 100% FPL more sustainable.

Moving the full subsidy higher makes this significantly less sustainable from a state perspective. Federal participation above 200% FPL seems unlikely, so subsidies will be all state funds.

I suspect that state participation gradually tapering off at 100% median will be quite a sustainability stretch, but I believe we should advance this as our recommendation.

There may have been some E&E votes for this, but I don't think we can walk into the Capitol talking about 400% FPL. I'm sticking with End Option 1 and won't extrapolate from those comments with the increased difficulties for End Option 2.

Providing subsidies up to 200% if the FPL will stretch the State Budget

Sustainability is not only about affordability for the state. It is about sustainability in the face of public support or opposition for the plans that all will be required to participate in and contribute to.

To repeat a sentence from the previous consideration: Perhaps the E&E committee (that has been tasked with developing a definition for 'affordability') needs to take a stand not only on the frequency of bars for an equitable affordability scale and the benefits and out of pocket costs 'affordability' must consider but on the need for employer contributions to be part of any equitable, sustainable mix for affordability for Oregon's uninsured.

[*Full subsidy option 2*] Would maximize employer contributions & reduce state expenditures. But still would be a hefty budget bite - and might be difficult to achieve, given Measure 50 defeat.

[*Partial subsidy option 1*] Better sustainability than #4; easier to get through the legislature, given median incomes and our experience with Measure 50

5. <u>Shared Responsibility:</u>
The individual would be responsible for purchasing the basic package; the basic package would be designed to incentivize their making good choices about using this insurance (prevention, care for chronic illness, etc.), the employer would be expected to "pay" or "play" for the basic plan, and the state would be charged with drawing down max of federal match, assuring that all participate, designing plan that will ultimately reduce costs or decrease rate of rise.

I think that beginning individual, couples and family participation in premium sharing above 50% median income is probably a reasonable balance for individual and employer sharing in the whole cost of Healthy Oregon; it may be just a little heavier on the state. I don't know if 50% median income means that one-fourth of Oregonians have household income below that level. Thinking about this politically, to have Oregon fully subsidize health care premiums for the lowest income quartile of the state is probably the maximum that could be supported by elected officials and ballot measure voters.

This option [*partial subsidy option 2*] is far too heavy on the state -- I don't think we can advance this option.

We need to do the math, once we have a defined benefit package and other information. With some adjustments, we may find that something around full subsidy for the first quartile by median income and declining subsidy for the second quartile is a reasonable sharing.

It is also important that we realize that having health insurance is only a small part of improving ones health. I'm supportive of an approach that changes behavior and improves people's health. We've talked about things like getting PE back in our schools. Other ideas include healthier choices for foods could be encouraged by taxing unhealthy foods and beverages (like pop, candies, and potato chips),taxing video games to pay for health care of children, smoking cessation programs (funded by sin taxes on tobacco), etc. Health care costs and improving the health of the citizens of Oregon (who are aging and will be consuming more health care) will be determined by personal choices as well as having access to health care.

I'm also supportive of price transparency, electronic medical records, medical homes, and evidence based care which I believe will also have positive outcomes on the health of Oregonians.

We will pick up full assistance of the poorest and provide some true assistance to the Working Poor.

SB 329, the Healthy Oregon Act
Accountable Health Plans

One goal of 329 is to "Ensure that all Oregonians have timely access to **and participate in** a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost."

Section 12 of the Act requires all Oregonians who do not have health coverage through their job or the Oregon Health Plan to "participate in the Oregon Health Fund program".

"The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals. The board shall establish subcommittees….to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

The design and implementation of a program to create a public partnership with **accountable health plans** to provide, through the use of an Oregon Health Card, health insurance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still

afford to pay for housing, food and other necessities.

The proposal must ensure that each accountable health plan:

1. Does not deny enrollment to qualified Oregonians….;

2. Provides coverage of the entire defined set of essential health services;

3. Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

4. Offers a simple and timely complaint process;

5. Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

6. Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

7. Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services

8. Ensures that all enrollees have a primary care medical home;

9. Includes in its network safety net providers and local community collaboratives;

10. Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

11. Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

12. Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

13. Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

14. Meets established standards for loss ratios, rating structures and profit or nonprofit status.

SB 329 Enrolled: Goals of the Healthy Oregon Act.

The intent of the Healthy Oregon Act is to develop a …. comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3**) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;**

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;
(8) Provide services for dignified end-of-life care;
(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor

SB 329 Enrolled: Principles of the Healthy Oregon Act
Health Fund program principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

[*Full Subsidy Option 2*] Although (hopefully) small contributions from those at low income levels, they would still be participating early on. Would take advantage of employer contributions. State would still have a big bite.

EMBARGOED
until
1 pm EST
Tuesday,
December 18, 2007

Too Great A Burden:

Oregon's Families At Risk

Families USA
December 2007

Too Great a Burden: Oregon's Families at Risk

Families USA Publication No. 07-112OR

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INTRODUCTION

Over the past eight years, relentless growth in health insurance premiums and out-of-pocket costs has made spending on health care an increasing burden. For many Oregonians, this means that health care is consuming an ever-growing share of their budgets, forcing them to make difficult sacrifices in other areas so they can make ends meet. And for many hard-working families, the burden of these health care costs has become too great to bear.

In Oregon alone, 852,000 people under the age of 65—more than one in four non-elderly Oregonians—are in families that will spend more than 10 percent of their pre-tax family income on health care costs in 2008. The vast majority (85.0 percent) of these people *have insurance*. In Oregon, 258,000 non-elderly people—more than four out of five of whom *have insurance*—are in families that will spend more than 25 percent of their pre-tax income on health care costs in 2008.

In addition, the number of Oregonians facing high health care costs has grown substantially over the last eight years. Between 2000 and 2008, the number of people in families that spend more that 10 percent of their pre-tax income on health care will have increased by 313,000. The number of people in families spending more than 25 percent of their family income on health care will have increased by 104,000. With a growing share of Oregon's families spending a substantial share of their income on health care, rising costs are putting thousands of families at risk.

KEY FINDINGS

Thousands of Oregonians Are Affected by High Health Care Costs

- More than one in four non-elderly Oregonians—852,000—is in a family that will spend more than 10 percent of its pre-tax income on health care costs in 2008 (Table 1).
- 258,000 Oregonians are in families that will spend more than 25 percent of their pre-tax income on health care costs in 2008 (Table 1).

Table 1

Oregonians in Families with High Health Care Costs, 2000 to 2008

Share of Pre-Tax Family Income Spent On Health Care	2000		2008		Increase
	Number	Percent of Pop.	Number	Percent of Pop.	
More than 10 Percent	538,000	17.9%	852,000	26.3%	313,000
More than 25 Percent	154,000	5.1%	258,000	8.0%	104,000

Note: Numbers may not add due to rounding.
Source: Estimates prepared by The Lewin Group for Families USA.

A Growing Burden: More Oregonians with High Health Care Costs, 2000 to 2008

- In 2000, 538,000 non-elderly Oregonians were in families that spent more than 10 percent of their pre-tax income on health care costs (Table 1).
- Between 2000 and 2008, the number of people in families spending more than 10 percent of their pre-tax income on health care costs will have increased by 313,000 (Table 1).
- In 2000, 154,000 Oregonians were in families that spent more than 25 percent of their pre-tax income on health care costs (Table 1).
- Between 2000 and 2008, the number of people in families spending more than 25 percent of their pre-tax income on health care costs will have increased by 104,000 (Table 1).

Thousands of Insured Oregonians Are Affected

- More than four out of five people (85.0 percent) in families spending more than 10 percent of their pre-tax income on health care costs *are insured* (Table 2).
- 724,000 non-elderly Oregonians *with insurance* are in families that will spend more than 10 percent of their pre-tax income on health care costs in 2008 (Table 3).
- More than four out of five people (80.2 percent) in families spending more than 25 percent of their pre-tax income on health care costs *are insured* (Table 2).
- 207,000 Oregonians *with insurance* are in families that will spend more than 25 percent of their pre-tax income on health care costs in 2008 (Table 3).

Table 2

Insurance Status of Oregonians in Families with High Health Care Costs, 2008

Share of Family Pre-Tax Income Spent on Health Care	People with High Health Care Costs		Percent Insured
	With Insurance	Total	
More than 10 Percent	724,000	852,000	85.0%
More than 25 Percent	207,000	258,000	80.2%

Source: Estimates prepared by The Lewin Group for Families USA.

Table 3

Insured Oregonians in Families with High Health Care Costs, 2000 to 2008

Share of Family Pre-Tax Income Spent on Health Care	2000	2008	Increase
More than 10 Percent	442,000	724,000	282,000
More than 25 Percent	118,000	207,000	89,000

Note: Numbers may not add due to rounding.
Source: Estimates prepared by The Lewin Group for Families USA.

FAMILY BUDGETS: HOW TIGHT ARE THEY?

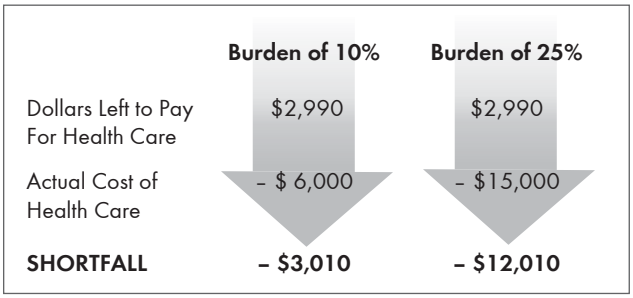
Health care costs that equal 10 percent or more of a family's pre-tax income represent a significant burden for working families and their already tight budgets. See, for example, this budget for a family of four with a gross annual income of $60,000.

A Typical Family Budget

Gross Annual Income	$ 60,000
Less Taxes (federal, state, and local taxes)	11,160
Disposable Income (gross income minus taxes)	$ 48,840
Annual Expenses	
Housing and Utilities	16,680
Transportation	10,940
Food, Beverages, and Personal Care Items	9,650
Pets, Sports, Entertainment, and Reading Materials	2,660
Education and Miscellaneous Expenses	2,530
Clothing and Footwear	2,310
Personal Insurance (non-health) and Pensions	1,080
Less Total Expenses	$ 45,850
Amount Left to Pay for Health Care (disposable income minus expenses)	**$ 2,990**

About this example: The Institute on Taxation and Economic Policy supplied the tax burden for this illustration. Expenditures were derived from the U.S. Bureau of Labor Statistics. A methodology is available upon request.

This family has only $2,990 left after paying for housing, food, and other necessities. The health care expenses they will need to cover with this $2,990 include: health insurance premiums, payments for physician and hospital services (including copayments and deductibles), prescription drugs, over-the-counter medications, and medical supplies.



But what if this family's health care expenses come to more than $2,990? What if these costs add up to $6,000—10 percent of their pre-tax income—as happens to so many American families? As this report shows, 852,000 Oregonians are in families that will spend more than 10 percent of their income on health care costs in 2008. In this particular example, the family would have to find another $3,010 to cover their health care costs—or go into debt.

DISCUSSION

To determine how many Oregonians face health care costs in excess of 10 and 25 percent of pre-tax family income in 2000 and 2008, Families USA asked The Lewin Group to analyze data from the U.S. Department of Health and Human Services and the U.S. Census Bureau. The results are troubling: 852,000 Oregonians—more than one out of four non-elderly state residents—are in families that will spend more than 10 percent of their pre-tax income on health care costs in 2008 (Table 1). More than four out of five (85.0 percent) of these people *have insurance* (Table 2). What's more, 258,000 people—more than four-fifths of whom *have insurance*—are in families that will spend more than 25 percent of their pre-tax income on health care costs in 2008 (Tables 1 and 2).

Why Is the Number of People with High Health Care Costs Increasing?

As our analysis demonstrates, millions of Americans are in families that face high health care costs, and this number has increased substantially over the last eight years. A number of factors have driven this phenomenon. First and foremost, health insurance premiums are increasing. As premiums rise, employers are forced to make tough decisions about the coverage they offer to their employees: some drop coverage, others increase the share of the premium that employees must pay, and more offer insurance that covers fewer services and/or requires high out-of-pocket costs. This, in turn, means that American families must shoulder a greater proportion of health care costs.

- **Premiums on the Rise**
  As health insurance premiums increase, so too does the burden these costs impose on American families. And, in the last few years, health insurance premiums have risen significantly. Between 2000 and 2007 alone, the average annual premium for job-based family health coverage rose from $6,351 to $12,106, an increase of more than 90 percent.[1] During the same period, the average worker's share of annual family premiums rose from $1,656 to $3,281, an increase of more than 98 percent.[2]

  Two primary factors, rising health care costs and insurance company practices, account for the lion's share of premium increases.

- **Rising Health Care Costs**
  Much of the increase in underlying health care costs is accounted for by rising spending on services such as prescription drugs and hospital care.[3] For example, annual spending on prescription drugs more than doubled from 2000 to 2008, rising from $120.8 billion to a projected $247.6 billion.[4] Likewise, spending on hospital services rose from $417.0 billion in 2000 to a projected $747.2 billion in 2008, an increase of nearly 80 percent.[5]

While rising spending on prescription drugs and hospital care account for a substantial portion of the increase in underlying health care costs, the growing use of new medical technologies also plays a significant role. Advances in the tools used to diagnose and treat medical conditions, including the development of new surgical procedures, biologic drugs, and medical devices, have all improved health care. These high-tech procedures, however, come at a price; some health care experts estimate that the use of new technology accounts for as much as half of the increase in health care spending.[6]

Together, rising spending on health care services and increased use of new technologies have driven up the cost of care provided in the U.S. Between 2000 and 2008, the amount we spend per person each year on health care is projected to grow by nearly two-thirds (64.4 percent), increasing from $4,034 to $6,631.[7] This, in turn, results in higher premiums.

- **An Insurance Market without Necessary Protections**

  While underlying health care costs are the largest cause of rising premiums, the growing advantage that insurance companies have over American families also plays a role in premium increases. A 2007 study found that there were more than 400 insurance company mergers in the last 12 years, resulting in near-monopoly power among insurance companies. In nearly two-thirds of major metropolitan areas, a single insurance company controls at least half of the market, and in 96 percent of metropolitan areas, a single insurer controls at least 30 percent of the market.[8]

  The near-monopoly power of insurance companies, coupled with little or no regulation of insurers, is a prescription for rising premiums. Currently, insurance companies are governed by a hodgepodge of state and federal rules. In many states, insurance companies have free reign over how much of each dollar they collect in premiums is spent on providing care and how much is retained as profit or spent on overhead, such as advertising and marketing. In addition, in some markets, insurers are free to charge people more—or deny coverage altogether—based on age, health status, and a range of other factors.[9] This increases premiums even more for the very people most likely to need comprehensive, affordable health coverage. Without appropriate consumer protections and rules to govern the influence and growth of large insurers, premiums are likely to continue their rapid ascent.

What Rising Premiums Mean for Employers

As premiums increase, it becomes more difficult for employers to offer their employees quality, affordable health coverage. Faced with the growing burden of health care costs, employers must make difficult decisions about the coverage they are able to provide to their employees. For some employers, particularly those that operate small businesses, the cost of health insurance has become too much to bear. Between 2000 and 2007, the total number of firms

offering health coverage declined by 9 percentage points (from 69 percent of firms to 60 percent), with small businesses being the most likely to drop coverage.[10]

While some employers have been forced to cut coverage across the board, others have dropped coverage for specific groups of people or placed limits on which employees are eligible. Some employers, for example, have found that it is no longer financially viable to offer coverage for workers' spouses and children (dependent coverage). Between 2001 and 2005, a loss of dependent coverage accounted for 11 percent of the decline in job-based coverage.[11] In addition, many employers do not offer coverage to part-time, temporary, or seasonal workers.[12] Others now require that employees work for the company for a period of time before becoming eligible for coverage. In 2007, three out of four employers (75 percent) imposed a waiting period for coverage, with the average waiting period being just over two months.[13]

The vast majority of employers who have continued offering coverage have been forced to shift some of the burden of rising health care costs onto their workers, usually by increasing the amount that workers are required to pay toward insurance premiums.[14] Others have resorted to "thinning" coverage—offering health insurance that covers fewer services and/or comes with higher deductibles, copayments, and co-insurance.[15] In addition, insurance coverage is evolving to require more cost-sharing for certain services, such as prescription drugs and hospital care. For example, more than 95 percent of people with job-based coverage are now required to pay hospital-specific cost-sharing, and more than 90 percent are in tiered drug plans that charge more for some drugs than for others.[16]

These trends are likely to continue in coming years, with nearly half (45 percent) of firms saying they are "very likely" or "somewhat likely" to raise employees' premium contributions, 42 percent saying they are very or somewhat likely to increase cost-sharing for doctor's visits, and 37 percent saying they are very or somewhat likely to raise deductibles in 2008.[17]

The thinning of coverage and the increasing number of plans that require higher deductibles and cost-sharing reflect a trend toward coverage that shifts financial risk onto families.[18] A range of "consumer-directed" plans have gained popularity among employers in recent years as a way to hold down costs. Although relatively few people have chosen to participate in these plans (only 5 percent of employees in 2007), 18 percent of companies with more than 1,000 employees and 10 percent of all firms now offer plans that pair high-deductible coverage with tax-sheltered health savings accounts (HSAs).[19]

New trends that shift financial risk onto families have been facilitated by changes in federal law and regulations that have been promoted by the current Administration. For example, in 2006, employers were given an additional impetus to move to higher deductible plans when Congress passed the Administration's proposal to increase the size of tax shelters for high-deductible plans linked to health savings accounts. These plans offer little or no benefit to low-income families, but they do provide a lucrative tax shelter for the wealthiest Americans.[20]

In addition, employers attempting to rein in costs are turning to programs that make workers directly responsible for their health care costs. In 2007, the Administration issued rules that amend federal insurance anti-discrimination protections.[21] These changes allow employers to charge workers more for their health insurance if they do not participate in certain health programs—or just because they have high blood pressure or other indicators of less-than-perfect health. Employers that have implemented these programs have gone so far as to dock the paychecks of workers who are unable to meet standards for cholesterol, blood pressure, and other similar measures.[22]

Consequences for American Families

More families than ever are facing burdensome health care costs, regardless of their insurance status. Rising premiums are only part of this equation. Now, millions of insured Americans live in families that face health care costs that exceed 10 percent of their pre-tax income. Insurance simply no longer offers the protection that America's families need.

As health care costs consume a growing share of family budgets, many families are forced to look for new ways to pay for care. With the majority of doctors' offices and hospitals now accepting payment by credit card, paying for health services via credit card is becoming increasingly common. In 2001 alone, for example, Visa reports that Americans charged $19.5 billion in health care services to Visa cards.[23] In addition, credit cards and loans marketed specifically for the purchase of medical care are becoming more common. Currently, there are at least nine separate lenders that offer medical credit cards and loans.[24] Cards such as the HELPcard and the CareCredit card allow people to get the health services they need, but these cards often come with terms and conditions that can trip up all but the most cautious consumer. While introductory offers may promise low interest rates, these rates often skyrocket when the introductory period ends or one late payment is made (see "Compounding the Problem: Medical Credit Card Debt" on page 9).

Given rising costs and an increased reliance on credit to pay for medical care, it comes as no surprise that a growing share of Americans reports having trouble with medical bills. More than one in four people *with insurance* report having trouble paying their medical bills or say that they are in the process of paying off medical debt.[25] The problem is even worse for people who are in health plans that have high premiums, that charge hefty cost-sharing, or that offer limited benefits.[26] Moreover, people in families that spend a higher percentage of their income on health care are more likely to suffer from problems with medical bills and medical debt. A 2003 study found that nearly half (46 percent) of insured families with high health care costs reported being contacted by a collection agency regarding medical bills in the last year, and more than one-third (35 percent) took drastic measures, such as re-mortgaging their home or running up credit card debt, to pay medical bills.[27]

When the burden of health care costs becomes too great, the consequences can be catastrophic. Faced with medical debt, families often have no choice but to consider drastic changes in lifestyle and, eventually, bankruptcy. One study found that, in the two years prior to filing for bankruptcy, more than 40 percent of families lost telephone service, approximately one-fifth went without food, and more than one-half went without needed medical or dental care because of the costs associated with that care.[28] When no options remain, bankruptcy is often the last resort for families. Since 2000, 5 million American families have filed for bankruptcy following a serious medical problem.[29] In all, approximately half of bankruptcies are due, at least in part, to medical expenses.[30]

CONCLUSION

As health care costs rise and a greater share of these costs is passed on to Oregonians, the state's hard-working families are put at risk. Tens of thousands of Oregonians are in families spending more than 10 percent—or even more than 25 percent—of their pre-tax income on health care costs, and this problem has grown substantially over the past eight years. With the economic stability of Oregon's families hanging in the balance, something must be done to bring costs under control.

WHAT CAN FAMILIES REASONABLY AFFORD?

This report looks at how many non-elderly people are in families that will spend more than 10 percent, and more than 25 percent, of their pre-tax income on health care costs in 2000 and 2008. The 10 percent threshold is commonly cited as the point at which health care costs become a significant financial burden for families.[31]

Our report does not suggest that 10 percent of income is an appropriate standard for affordability for all families. Spending 10 percent of income on health care costs is more than most low- and middle-income families can reasonably afford.[32] Middle-class families with health costs that exceed 10 percent of their income will find their finances strained and may have to go into debt to cover medical expenses. Paying high health care costs will be an even greater burden for low-income families.

In light of this, state health reform laws should use a sliding scale to determine how much families pay for health coverage. For example, in Massachusetts' recent health reform, "affordability" was defined as approximately 4 percent of income for people earning 300 percent of the federal poverty level (approximately $62,000 for a family of four) and as an increasing percentage for people with higher incomes.[33]

COMPOUNDING THE PROBLEM: MEDICAL CREDIT CARD DEBT

Families with high health care costs and tight budgets are turning to credit cards to finance their health care needs. This trend is driven in part by the rising number of providers—hospitals, pharmacists, and physicians—who not only accept credit cards, but who also offer medical-specific credit cards to their patients.

The following chart highlights the terms and conditions of three medical-specific credit cards:

Credit Card Company And Plan Name	Promotional Interest Rate	Interest Rate (APR)	Default Interest Rate (Delinquency APR)
Aetna's Healthy Living Visa, Preferred Accounts Plan	No Interest for 12 Billing Cycles	15.99%	29.99%
CareCredit, No Interest Promotional Plan	No Interest for 3, 12, or 18 Months	22.98%	28.99%
The HELP Card	Not Applicable	22.74%[a]	29.74%[b]

[a] The interest rate is the prime interest rate plus 14.99%. At the time this report was written, the prime interest rate was 7.75%. Total interest cannot be less than 22.99% and is not to exceed 29.99%.

[b] The interest rate is the prime interest rate plus 21.99%. At the time this report was written, the prime interest rate was 7.75%. Total interest is not to exceed 29.99%.

Credit card companies profit most when people are unable to pay off their balance in full. In 2005, credit card companies generated more than $25-$30 billion in revenue from basic customer transactions, in which the balance is paid in full each month. However, companies made more than twice that amount—$79 billion—from interest and late fee revenues.[34]

A POUND OF FLESH: AMERICANS FACING HIGH HEALTH CARE COSTS

With rising health care costs and thinning coverage, families are paying more out of pocket for their health care. Millions of people have had to make significant financial sacrifices to pay for their medical care. Too often, however, these sacrifices are not enough, and many families find themselves shouldering heavy medical debt. More than a third of non-elderly adults—34 percent—have had trouble paying their health care bills, are paying off accrued medical debt, or both.[35] High medical costs and medical debt can compromise a family's access to health care and undermine its economic security.

No Guarantee: Coverage without Adequate Protection

- More than three out of five adults who report having problems paying their medical bills had insurance at the time they incurred their debt.[36]
- 78 percent of those with private insurance and medical debt work full-time.[37]
- Two-thirds of privately insured adults with medical debt have household incomes between $20,000 and $75,000.[38]

Thinning Benefits: Individuals Bear the Burden

- Thinner benefit plans mean that people have to pay more to obtain basic health care services. Among Americans who have trouble paying their medical bills, 85 percent report that the bills included doctor bills, 62 percent report that the bills included lab fees, and 56 report that the bills included prescription drugs.[39]
- Plans with high deductibles are burdensome for American families. Half of adults enrolled in plans that have a yearly deductible of $500 or more struggle to pay medical costs.[40]
- Higher out-of-pocket costs are driven, in part, by the rising number of services that are excluded from coverage. Those with medical debt were less likely to have prescription drug coverage, dental coverage, vision benefits, or mental health coverage than were others with private coverage.[41] For example, among non-elderly insured adults without prescription drug coverage, 48 percent report having problems with medical bills or medical debt.[42]
- People who had reached the limit of what their insurance companies would pay for a specific service or illness were more than twice as likely to have problems paying their medical bills, have medical debt, or both as people who had not reached the coverage limit (65 percent versus 30 percent).[43]

Cost: A Barrier to Access

- People with medical debt are more likely to delay or forgo care. More than three times as many adults with medical debt or medical bill problems went without needed care because of costs compared to adults without medical debt or medical bill problems (63 percent versus 19 percent).[44] Insured adults who report having medical debt are four times more likely than insured adults without medical debt to postpone medical care due to cost.[45]
- Insured people with medical debt are more than twice as likely to go without a needed prescription as those without debt (24 percent versus 9 percent).[46]
- Health care providers are using more aggressive billing and debt collection practices, which have also made it difficult for people with medical debt to obtain care. Increasingly, providers are requiring payment for services at the time they are provided, deterring people who cannot afford the cost of care or forcing people to pay with credit cards.[47]

Families at Risk: Medical Costs Undermine Financial Security

- Of all adults who report having medical bill problems or medical debt, 39 percent used up all of their savings to pay medical bills.[48]
- More than a third (35 percent) of insured people with high health care costs had to take substantial financial risks—such as running up high levels of credit card debt or taking out a loan or a mortgage against their home—to pay medical bills.[49]
- When medical debt becomes too great to bear, the consequences can be catastrophic. Legal action, such as seizure of wages, assets, and property, may be taken against people with unpaid medical bills.[50]
- Bankruptcy is often the last resort for families with high medical costs. About half of all personal bankruptcy cases are due, at least in part, to medical costs.[51] Since 2000, approximately 5 million families have filed for bankruptcy after experiencing a serious medical problem.[52] And, among those whose illness led to bankruptcy, more than three in four had insurance at the onset of the illness.[53]

Medical Debt Affects People's Well-Being

- People with medical debt reported that their debt caused "significant stress, anxiety, and feelings of hopelessness." They also identified their medical debt as a source of "embarrassment and shame," despite the fact that they had no control over the medical event that caused their financial distress.[54]

ENDNOTES

[1] Families USA calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey* (Washington: Kaiser Family Foundation, 2000) and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (Washington: Kaiser Family Foundation, September 2007).

[2] Ibid.

[3] Kaiser Family Foundation, *Prescription Drug Trends* (Washington: Kaiser Family Foundation, May 2007); Paul Ginsberg, Bradley Strunk, Michelle Banker, and John Cookson, *Tracking Health Care Costs: Spending Growth Remains Stable at High Rate in 2005* (Washington: Center for Studying Health System Change, October 2006).

[4] Families USA calculations based on Centers for Medicare and Medicaid Services, "National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditures: Selected Calendar Years 1960-2005," available online at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, accessed on September 5, 2007; and Centers for Medicare and Medicaid Services, "National Health Expenditure Amounts, and Annual Percent Change by Type of Expenditure: Calendar Years 2001-2016," available online at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf, accessed on September 5, 2007.

[5] Ibid.

[6] Kaiser Family Foundation, *Snapshots: Health Care Costs—How Changes in Medical Technology Affect Health Care Costs* (Washington: Kaiser Family Foundation, March 2007). See also Carlos Angrisano, Diana Farrell, Bob Kocher, Martha Laboissiere, and Sara Parker, *Accounting for the Cost of Health Care in the United States* (Washington: McKinsey Global Institute, January 2007); and Dana Goldman and Elizabeth McGlynn, *U.S. Health Care Facts about Cost, Access, and Quality* (Santa Monica: RAND Corporation, 2005).

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[9] Cheryl Fish-Parcham, *Understanding How Health Insurance Premiums Are Regulated* (Washington: Families USA, September 2006).

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[12] Elaine Ditsler, Peter Fisher, and Colin Gordon, *On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary, and Contract Jobs* (New York: The Commonwealth Fund, December 2005).

[13] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, op. cit.

[14] According to Families USA calculations based on data from Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*, op. cit., and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, op. cit., between 2000 and 2007, the employee share of insurance premiums increased by more than 98 percent.

[15] James Robinson, "Reinvention of Health Insurance in the Consumer Era," *Journal of the American Medical Association* 291, no. 15 (April 21, 2004): 1,880-1,886; Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289-W5-302.

[16] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey,* op. cit.

[17] Ibid.

[18] James Robinson, op. cit.

[19] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*, op. cit.

[20] U.S. Government Accountability Office (GAO), *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans* (Washington: GAO, August 2006); and Edwin Park and Robert Greenstein, *GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals* (Washington: Center on Budget and Policy Priorities, September 2006).

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[22] Daniel Costello, "Workers Are Told to Shape Up or Pay Up; To Hold Down Medical Costs, Some Firms Are Penalizing Workers Who Are Overweight or Don't Meet Health Guidelines," *Los Angeles Times*, July 29, 2007.

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[26] Michelle Doty, Jennifer Edwards, and Alyssa Holmgren, *Seeing Red: Americans Driven into Debt by Medical Bills* (New York: The Commonwealth Fund, August 2005).

[27] Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, op. cit.

[28] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributers to Bankruptcy," *Health Affairs* Web Exclusive (February 2, 2005): W5-63-W5-73. See also Sarah R. Collins, Jennifer L. Kriss, Karen Davis, Michelle M. Doty, and Alyssa L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, op. cit.; and Sara R. Collins, Michelle M. Doty, Karen Davis, Cathy Schoen, Alyssa L. Holmgren, and Alice Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004).

[29] Elizabeth Warren, *Medical Bankruptcy: Middle Class Families at Risk*, Testimony before the House Judiciary Committee, July 17, 2007.

[30] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, op. cit.

[31] Cathy Schoen, Michelle Doty, Sara Collins, and Alyssa Holmgren, op. cit.; and Jessica Banthan and Didem Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," *Journal of the American Medical Association* 296, no. 22 (December 13, 2006): 2,712-2,719.

[32] Linda Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs* Web Exclusive (June 4, 2007): W463-W473.

[33] Ibid.

[34] Elizabeth Warren, T*estimony Before the Committee on Banking, Housing, and Urban Affairs of the United States Senate*, Hearing on Examining the Billing, Marketing, and Disclosure Practices of the Credit Card Industry, and Their Impact on Consumers, January 25, 2007.

[35] Sara Collins, Karen Davis, Michelle Doty, Jennifer Kriss, and Alyssa Holmgren, *Gaps in Health Insurance: An All American Problem* (New York: The Commonwealth Fund, 2006).

[36] Ibid. See also *USA Today*, Kaiser Family Foundation, and Harvard School of Public Health, *Health Care Costs Survey* (Washington: August 2005), available online at http:/www.kff.org/newsmedia/upload/7371.pdf, accessed on August 27, 2007.

[37] Catherine Hoffman, Diane Rowland, and Elizabeth Hamel, *Medical Debt and Access to Health Care* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2005).

[38] Ibid.

[39] *USA Today*, Kaiser Family Foundation, and Harvard School of Public Health, op. cit.

[40] Michelle Doty, Jennifer Edwards, and Alyssa Holmgren, op. cit.

[41] Catherine Hoffman, Diane Rowland, and Elizabeth Hamel, op. cit. See also Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, op. cit.

[42] Michelle Doty, Jennifer Edwards, and Alyssa Holmgren, op. cit.

[43] Ibid.

[44] Ibid.

[45] Catherine Hoffman, Diane Rowland, and Elizabeth Hamel, op. cit.

[46] Ibid.

[47] Cindy Zeldin and Mark Rukavina, *Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses* (New York: Demos and The Access Project, 2007). See also The Access Project, *The Consequences of Medical Debt: Evidence from Three Communities* (Boston: The Access Project, February 2003).

[48] Sara Collins, Karen Davis, Michelle Doty, Jennifer Kriss, and Alyssa Holmgren, op. cit.

[49] Cathy Schoen, Michelle Doty, Sara Collins, and Alyssa L. Holmgren, op. cit.

[50] Robert Seifert and Mark Rukavina, "Bankruptcy Is the Tip of the Medical-Debt Iceberg," *Health Affairs* Web Exclusive (February 28, 2006): W89-W92.

[51] David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, op. cit.

[52] Elizabeth Warren, "Medical Bankruptcy: Middle Class Families at Risk," op. cit.

[53] David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, op. cit.

[54] The Access Project, op. cit.

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OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

January 8, 2008
10:00 a.m.

General Services Building, Mt. Mazama Room
Salem, Oregon

MEMBERS PRESENT: Ellen Lowe, Chair
Jim Russell, Vice Chair
Felisa Hagins
Robert Bach
Jane Baumgarten
Dean Kortge (left at 11:30 am)
John Mullin
Ellen Pinney (arrived late)
Noelle Lyda
Susan Rasmussen (by phone)
Carole Romm
Ann Turner,MD
Eric Metcalf (awaiting Board confirmation – left at 12:15 pm)

MEMBERS EXCUSED: CJ McLeod and Bill Murray

STAFF PRESENT: Tina Edlund, Deputy Administrator, OHPR
Nate Hierlmaier, Policy Analyst
Paula Hird, Office Specialist, OHFB

OTHERS PRESENT: Darren Coffman, Health Services Commission Director
Sean Kolmer, Data and Research Manager

ISSUES HEARD:

- Call to Order/Review of December 11 Meeting Minutes/Review of Revised Work Plan
- Update on Oregon Health Fund Board and Committee Activities
- Defining Affordability in Health Care for Oregon
- Review of Affordability "Straw-Person" Draft Document
- Development of Committee Recommendations on Affordability
- Next Meeting Agendas and Objectives
- Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Chair

I. Call to Order, Approval of December 11 Meeting Minutes/Introduction of new members.

- There is a quorum.
- Chair Lowe introduced Eric Metcalf of the Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians, who is awaiting confirmation as a member of the Eligibility and Enrollment Committee (E & E) by the Health Fund Board on January 15.
- Ellen Pinney is testifying on LC 62 and will be arriving late.
- Tina Edlund reviewed the materials provided for the meeting.
- Review and Approval of minutes of December 11 meeting as amended.

Tina Edlund **II. Update on Oregon Health Fund Board and Committee Activities**

- Health Equities Committee (HEC) has met and will meet again January 10. The Committee is discussing recommendations for undocumented residents of the state. Final recommendations on this issue will be made at their meeting on January 10 and sent to the E & E Committee.
- The Exchange Workgroup will be looking for recommendations from E & E in their discussions on who is covered by the exchange and eligibility requirements.
- Discussion of the most appropriate and descriptive terminology for undocumented residents. It was noted that Tina Castanares of the Delivery Systems Committee uses the term unauthorized immigrants.

Tina Edlund **III. Defining Affordability in Health Care for Oregon (see exhibit materials for Power Point presentation)**

Format of presentation is from Community Catalyst, an advocacy organization, in Massachusetts that used the same approach in reviewing data. The following approaches were looked at and discussed.

- Current spending in the country.
  - Data from the Urban Institute was highlighted with clarification that the estimate of a family spending $25/per month out-of-pocket was for over-the-counter products and did not include premiums and co-pays.
- Jonathan Gruber, MIT Economist, in a report for the Massachusetts Connector, showed what is not affordable. Staff noted that he looked only at payroll deductions.
- In response to comments about changing the "subsidy" language, staff stated that Nate Hierlmaier, Policy Analyst, suggested discerning funding as contributions from three sources: 1) personal; 2) employer; and 3) state
- Oregon Family Budget Analysis (building from work by the Medicaid Advisory Committee (MAC)).
  - Discretionary income using the Federal Poverty Level (FPL).
  - Implications:
    - Additional cost burdens for single parent families, and
    - Premium rate groups for single parent families with one child, two children, etc.
    - "cliffs" in premium payments and politically
    - In California, for those over 300% FPL an Affordability Tax Credit was recommended.
- Existing Programs
  - CMS/SCHIP
  - Drs. Wright's and Carlson's Medicaid study after implementation of OHPII.
  - Implications
    - Cost sharing that doesn't exceed 5% of income and how to monitor these expenses.
    - No co-pays for preventive care and looking at benefit design plans in order to make recommendations.

- New: Take up rates and price sensitivity
  - L. Ku and T. Coughlin, Urban Institute, looked at participation changes as premium costs increased in three states.

- K. Thorpe, Vermont's Catamount Health Reform, looked at affordability and cost sharing.
- Implications for E & E include setting bounds of affordability.

Discussion

- FPL will be changing in the next couple of weeks.
- 36% of Oregonians are at 200% or less of the FPL
- Mayor Bloomberg, New York City, has asked for a review of the FPL, as it is not an accurate indicator.
- Use of median income data.
- Ways of framing recommendations to legislators.
- DMAP's statistics by county as a source of information.

Tina Edlund **IV. Review of Affordability "Strawperson" Draft Document (see exhibit materials)**

- Strawperson Recommendations 1-5 (page 5-9) reviewed.

Tina Edlund **IV. Development of Committee Recommendations on Affordability (see above exhibit materials)**

- Chair quoted Richard Lamb, Former Governor of Colorado : "We have to convince conservatives that they have a stake in the uninsured and that costs can be controlled and then we have to convince liberals that limits must be set and that we can't do everything medical science has invented for everyone."
- Chair voiced support for staff's suggestion for identifying contributors.
- Recommendations
  - What % of Oregonians will be receiving state premium contribution for those up to 300% of FPL?
  - Discussion of a tax credit for those above the 300% and a pre-tax option.
  - Data from California showed that the majority of those between 300-400% of FPL are sole proprietors whose income may vary throughout the year.
  - Suggestion to go to 400% FPL which is 129% of median income and credits for premiums that are over 5% of income.
  - Request for data on what is spent for housing at different income levels.
  - Between 250% to 400% get a tax credit for amount spent above 5%.
  - Subsidy language will be changed.
  - Recommendation 3 moves to 1, recommendation 1 moves to 3, recommendation 4 moves to 2, 5 should stay 5.
  - Add tax wording to #3.
  - Note there were reservations concerning only going to 300% FPL.
  - Advice to Benefits Committee would include evidenced-based support for procedures/tests performed.
  - Add language to "not include co-insurance."
  - Discussion on eliminating #4.
  - Problem with comparing Oregon's plan with California is that the cost-of-living in California is higher. Look at comparisons to other states?
  - Chair voiced recommendation to the Delivery Systems Committee that they look at *"making sure there is available accessible, affordable, culturally appropriate health services when the populations who need these services are most able to access."*

Followed by comments regarding the need to make services available at hours that fit into the working person's schedule.

Chair **VI. Next Meeting Agendas and Objectives**

- Members will submit comments within the next week to assist in rewording the recommendations.
- Continue with Committee recommendations on affordability.

Chair **VII. Public Testimony**

- Tootie Smith, Alliance Health Care Sharing Ministries, takes requests for help from those with needs beyond their regular medical costs. Organization is seeking exemption from tax code. Information emailed to Barney Speight, OHFB Executive Director.
- Betty Johnson, member of the Benefits Committee, member of Archimedes Movement, spoke on the need of controlling costs and simplicity of the administration.
- Written testimony was submitted by Lois Marie Zaerr asking "Does this discussion assume equal premiums among all insurance companies?"

Chair **VIII. Adjourn**

The meeting was adjourned at 1:00 p.m.

Next meeting is January 23, 2008.

EXHIBIT MATERIALS:

A. Oregon Health Fund Board Newsletter
B. Eligibility and Enrollment Committee Revised Work Plan
C. Defining Affordability in Health Care for Oregon Document
D. Affordability "Straw Person" Document

Eligibility and Enrollment Committee
Affordability Recommendations to the Oregon Health Fund Board

AFFORDABILITY PROPOSAL

January 23, 2008

Background

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program.

In developing these recommendations, the Committee met six times, on October 24, November 13 and 28, December 11, January 8 and 23, 2008. The Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

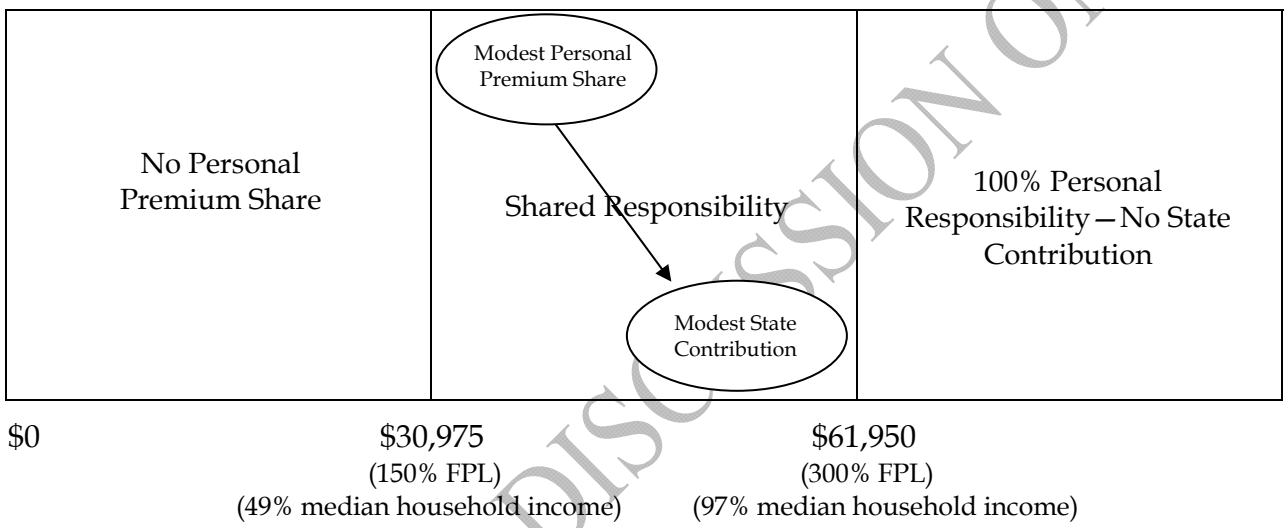
FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	**208,000**	**42%**	**46,000**	**40%**
150% to below 200%	**67,000**	**13%**	**29,000**	**25%**
200% to below 250%	60,000	12%	**10,000**	**9%**
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	**499,000**	100%	**114,000**	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program
- Oregon Health Policy Commission's "Roadmap to Health Care Reform"
- Oregon Business Council's Policy Playbook's recommendations for Health Care
- Premium contribution and cost sharing structures in other states

- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance*"[1]
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts*"[2]
- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, *"Impact of Copays on a Medicaid Population"*

The following chart is a depiction of the framework in which the committee was working:



The E & E Committee discussed and debated various approaches to defining affordability, struggling to balance maximizing individual affordability, fairness and sustainability. The committee developed initial consensus around 4 options, two that described an income below which there would be no personal premium cost sharing and two that described the income above which premium cost would be 100% personal responsibility.

[1] Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at http://econ-www.mit.edu/files/128.

[2] Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

Proposed Cost Sharing Structures

A. The first question addressed by the committee was: At what income should a family reasonably be expected to share responsibility for premium cost?

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	150%	$15,315	33%
Couple	150%	$20,535	38%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

Option 2a: This option does not differentiate by family structure, and starts the personal premium cost share at a higher FPL than Option 1a for individuals and couples.

Family Structure	Personal premium cost share begins at this FPL	Income	% of Oregon 2007 Median HH Income
Individual	200%	$20,420	44%
Couple	200%	$27,380	51%
One adult, one child	200%	$27,380	51%
Family (4 person)	200%	$41,300	65%

B. The second question addressed by the committee was: <u>At what income level should premium cost be 100% personal responsibility</u>?

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon Median HH Income
Individual	300%	$30,630	65%
Couple	300%	$41,070	77%
One adult, one child	350%	$47,915	90%
Family (4 person)	350%	$72,275	113%

Option 2b: This option continues to differentiate between families with and without children, but continues the state match to higher income levels.

Family Structure	Premiums are 100% personal responsibility with no state match at this FPL:	Income	% of Oregon 2007 Median HH Income
Individual	350%	$35,735	76%
Couple	350%	$47,915	90%
One adult, one child	400%	$54,760	102%
Family (4 person)	400%	$82,600	129%

To develop a consensus recommendation each committee member was asked to evaluate the options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without controversy, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design

envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

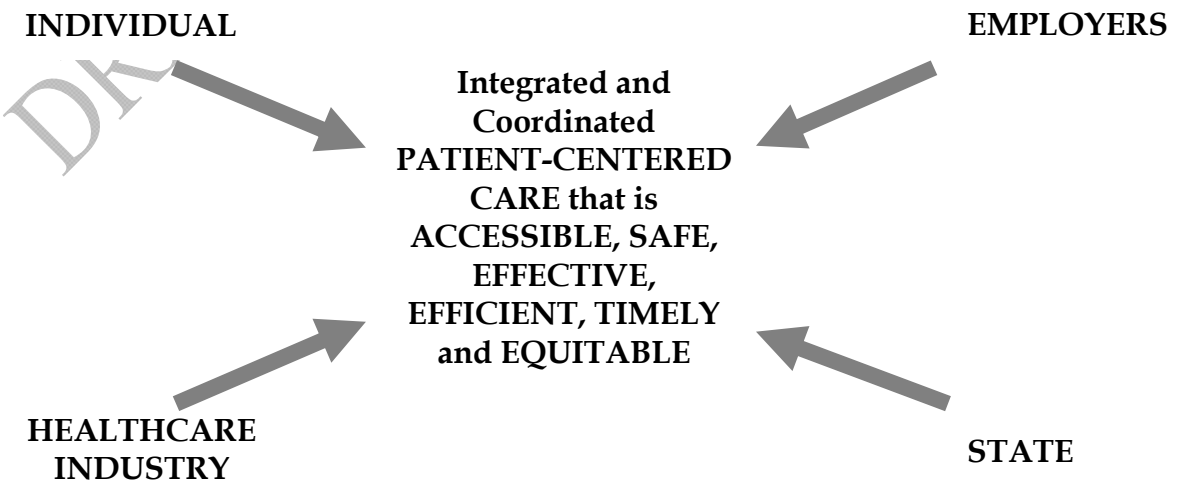
An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

> *We have to convince conservatives that they have a stake in the uninsured, and that costs can be controlled*
>
> And
>
> *We have to convince liberals that limits must be set, and that we can't do everything medical science has invented for everyone.*

The following summarizes the committee comments leading to these recommendations to the Board:

Shared Responsibility. The committee felt that shared responsibility was the intersection between individuals, employers, the healthcare industry and the state.

Shared Responsibility Model



First, individuals share responsibility in the affordability debate. As one member stated, "Although [there would be] (hopefully) small contributions from those at low income levels, they would still be participating early on." Members also felt that shared responsibility for the individual included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their healthcare and help reduce costs, too."

About employer responsibility, one member commented, "The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute."

Third, in discussing the responsibility of the health care industry, a member commented, "329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the 'essential' benefits package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important and least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests

dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning $50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is." Finally, the committee felt that a similar difference should be accounted for in cost of living in urban versus rural Oregon.

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state costs for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I … favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

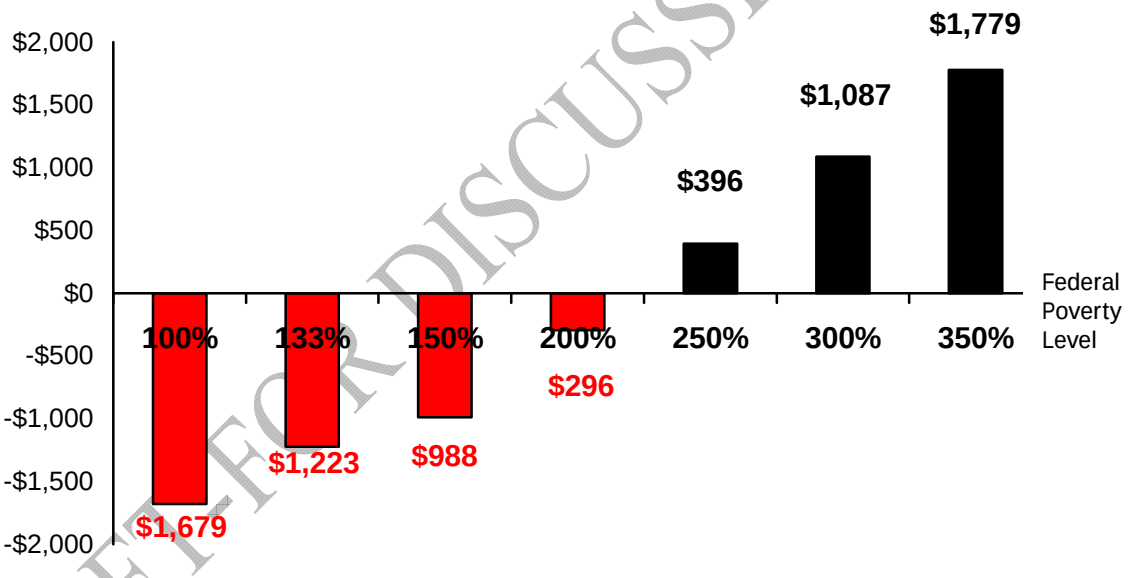
Affordability Recommendations

Recommendation 1: **Within the state contribution portion of the program, structure total member cost sharing (premium contribution, co-pays and deductibles and out-of-pocket) so that they do not exceed 5% of gross income.**

"Affordability" must consider not only premiums but out-of-pocket costs for benefits provided by the plan and out-of-pocket costs for necessary health services that may not be covered by the plan. The Urban Institute's review of national healthcare spending indicated that health care costs are highly regressive, with the lowest income populations paying out the largest proportion of their incomes for health care.

The Medicaid Advisory Committee's review of basic family budgets in Oregon also indicate that most, if not all, of a low-income family's income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



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

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when … out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual 'premiums' (or strength of cost-containment measures for plans and providers) is unknown cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'." Another member echoed the "administrative simplicity" sentiment by suggesting potentially simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation 2: **Structure the personal premium contribution as a percent of income rather than a percent of premium. The goal is to mitigate regressive nature of total health costs, particularly in lower income brackets.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that health care costs are highly regressive, with the lowest income populations paying the largest amount as a percent of income. This recommended approach mitigates that regressiveness by protecting low-income individuals and families. Additionally, the committee recommends, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing rather than co-insurance

Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

Recommendation 3: **Require no personal premium contribution until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children);**

Provide shared personal and state premium contribution to 300% FPL for individuals, couples and families; and,

Provide an advanceable state tax credit for households between 300% FPL to 400% FPL for amounts spent on health care premiums in excess of 5% of gross income. The tax credit should be designed to gradually diminish as income approaches 400% FPL.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is any individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

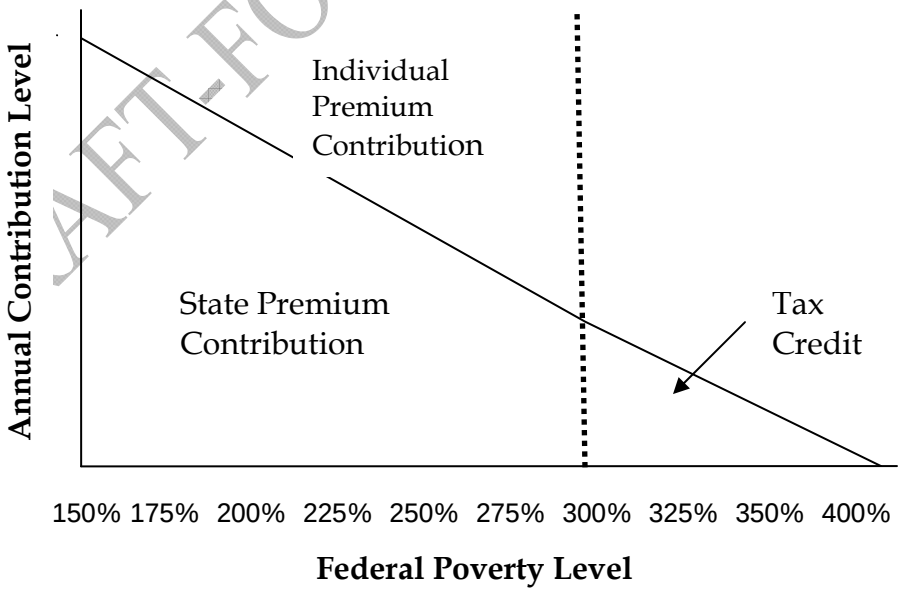
An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of the federal poverty level (FPL) or $51,625 annually for the Portland area, 200% of FPL or $41,300 annual income for rural Oregon.
- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL ($41,070) in the Portland area, 250% FPL ($34,225) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on what households currently spend on health care, showed that below 150% of the federal poverty level ($14,700 for an individual or $30,975 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy past 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and keep the cost sharing very small, especially between 150% and 200% FPL.

For example, below is an illustration on how this structure may look with the diagonal line indicating the slow ramp down of the state's contribution as household income increases:



The advanceable tax credit was supported by the committee members because it provided assistance to working families to gain health coverage and fulfill an individual mandate while reducing their state tax burden. The committee felt that the credit should be instantaneous as a result of the fact that committee members viewed the annual availability of such a program would be less preferable to Oregonians who need health coverage at different points during the year.

Recommendation 4: **Design state premium contribution as a sliding scale to avoid the "notch effect" or series of cliffs that create perverse incentives for people to minimize income in order to keep benefits.**

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them—Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #5: **Design premium structure with geographic adjustments to reflect higher cost of living in Portland area when compared to rural Oregon.**

The committee was in general consensus that the Medicaid Advisory Committee's review of basic budgets in Oregon showed that the budget required for basic necessities is much higher in the Portland area than it is in rural Oregon. However, one member noted that rising costs of transportation should also be considered if an adjustment is made.

Additional recommendations of the committee to other OHFB Committees:

1. **For the Benefits Committee**

- **Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should not have any required co-pays.**

2. For the Finance Committee

- **Employer contribution requirement will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.**

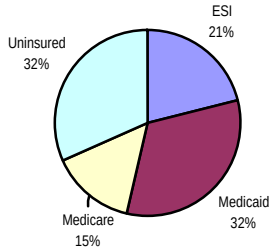
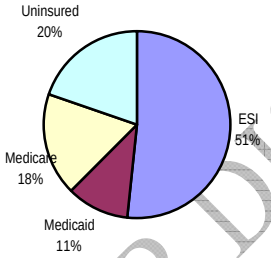
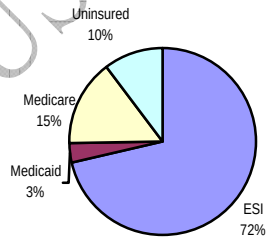
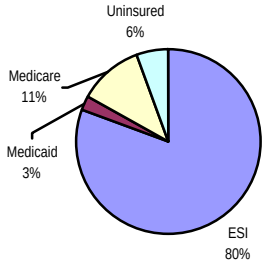
3. **For the Delivery Committee**

- **Ensure that Oregon provides affordable, accessible, health care that is culturally appropriate is available to people when they are able to receive it.**

Committee Membership:

Robert Bach, Lattice Semiconductor Corporation
Jane Baumgarten, Retired
Felisa Hagins, SEIU Local 49
Dean Kortge, Senior Insurance Specialist, Pacific Benefits Consultants
Ellen Lowe, Advocate and Public Policy Consultant
Noelle Lyda, Ed Clark Insurance, Inc.
C.J. McLeod, Senior Vice President and Chief Marketing Office, The ODS Companies
Bill Murray, CEO, Doctors of the Oregon Coast South (DOCS)
Ellen Pinney, Health Policy Advocate, Oregon Health Action Campaign
Susan Rasmussen, Manager, Special Programs, Kaiser Permanente NW
Carole Romm, Director, Community Partnerships and Strategic Development, Central City Concern
Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network
John Mullin, Oregon Law Center
Ann Turner, MD, Physician and Co-Medical Director, Virginia Garcia Memorial Health Center

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax credit)	400% and above (100% personal premium contribution)
806,000 Oregonians -550,000 insured (68%) -255,000 uninsured (32%) Insurance source for < 150% FPL: 	**1,032,000 Oregonians** -828,000 insured (80%) -204,000 uninsured (20%) Insurance source for 150% FPL to below 300% FPL: 	**513,000 Oregonians** -458,000 insured (89%) -55,000 (11%) Insurance source for 300% FPL to below 400% FPL: 	**1,311,000 Oregonians** -1,211000 insured (93%) -99,000 uninsured (7%) Insurance source for 400% FPL and above: 

Data from CPS 2-year average, Data collected in 2006 and 2007.

Eligibility and Enrollment Committee
Development of Eligibility Recommendations
January 23, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the eligibility requirements in a new Oregon Health Fund program.

What guidance do we have from SB 329?

1. In Section 3, (1), SB 329 states the following as one of its principles:

   > **Expanding access.** The state Medicaid program, Oregon SCHIP, and FHIAP must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

2. In Section 4, (1), the bill further states:

   > As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon SCHIP and FHIAP programs.

3. Section 4, (5), Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
4. Section 9 (2) (d) (B) (ii) states, "Requirements to ensure that enrollees demonstrate Oregon residency."
5. Section 12 (2) indicates that the Board cannot require residents to enroll in the Oregon Health Fund program who are already enrolled in:
   a) Commercial health insurance plans
   b) Self-insured programs
   c) Health plans funded by a Taft-Hartley Trust
   d) State or local government health insurance pools

SB 329 directs the Oregon Health Fund Board to develop the structures and policies necessary to ensure that all Oregonians have access to a defined set of essential health services within a reformed delivery system.

SB 329 does not direct the Oregon Health Fund Board to create a single payer system to replace employer and other sources of insurance. Rather the Board is to create the environment for health delivery reform through an approach integrating public and private delivery systems. The primary mechanisms for providing this leadership include:

1) Creating a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable insurance;
2) Designing insurance products based on the defined essential benefit package;

3) Ensuring a network of accountable health plans (AHPs) contracting with the state to administer the benefit package; and,
4) Creating a new public/private vehicle for organizing and furthering quality and transparency in the current system.

What assumptions have been indicated (as of January 2008) by the Oregon Health Fund Board and its Committees about comprehensive reform?

1) An individual mandate that requires all Oregon residents to have health insurance coverage;
2) Guaranteed issue and renewability with no pre-existing limitation;
3) State contributions at a sliding scale of income to make health coverage more affordable for individuals and families;
4) A mandate that employers provide health insurance coverage to their employees; and,
5) A new health insurance exchange that will include the Oregon Health Fund Program as well as providing a central forum for individuals and businesses to purchase health insurance coverage.

Possible Questions for Committee to Address:

Residency and Citizenship
What is an Oregon resident?

Will there be a residency waiting period? (i.e., requiring that someone is a legal resident for x months before they are eligible for the state subsidy?).

How will non-citizens be treated?

Period of eligibility
How long is the period of eligibility?

Interplay of OHFB and ESI
What about individuals who are eligible for ESI, but haven't taken it up?

How will we treat people who have ESI, but are eligible on the basis of income, for Medicaid?

How will w treat people who are in their waiting periods for ESI?

How will we treat people who have ESI and currently pay the employee share on their own? Do we provide a state contribution to this group? Or do we build a firewall between this group and state contribution?

Expansion of eligibility for public programs
Expansion of eligibility for public programs (OHP, e.g., adults to 200% FPL, children to 300%?) Expansion of Medicaid Buy-In program for the working disabled?

Recommendations around autoenrollment? Presumptive eligibility? Retroactive eligibility?

Accountability?
How do we ensure that these tax-supported services are provided only to those who are eligible?

Do we recommend that penalties be put in place in cases where people try to collect benefits for deceased persons, under fraudulant ID's, for non-residents?

Consumer Protections?
Possibly some recommendations about consumer protections -- Colorado is recommending the creation of an independent Consumer Advocacy organization that can specifically help residents with denials and support local communitiy efforts to get people enrolled. (This could be included here as well as with our enrollment recommendations?)

Health Care Costs and Financing

Rural workers have less employment-related health insurance for several reasons, including low wages and smaller employers

Rural residents make up a disproportionate number of the Nation's uninsured population. This disparity in health insurance among rural residents is related to the structure of rural employment, notably smaller employers and lower wages, according to Sharon L. Larson, Ph.D., of the Substance Abuse and Mental Health Services Administration, and Steven C. Hill, Ph.D., of the Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality. They found that workers living in the most rural areas are 10.4 percentage points less likely to be offered health insurance than urban workers. In rural counties not adjacent to urban areas, lower wages and smaller employers each accounted for about one-third of the total difference in employment-related health insurance.

The researchers analyzed data from the Medical Expenditure Panel Survey Household Component (1996-1998). They evaluated which characteristics contributed to lack of employment-related insurance among nonelderly adult workers in three types of nonmetropolitan areas—rural counties adjacent to urban areas; large rural nonadjacent counties (a town or city with over 10,000 population); and small rural, nonadjacent counties (no town with more than 10,000 people)—compared with metropolitan workers.

The median hourly wages of workers in rural counties were lower than those of urban workers ($10 in adjacent counties and $9 in large and small nonadjacent counties vs. $12 in urban counties). Workers from the most rural counties were less likely to work full-time and more likely to work part-time. Workers from nonadjacent counties were more likely to be self-employed (15 percent large; 16 percent small) and less likely to be members of a union (10 percent large and small) compared with urban and adjacent residents. Also rural workers were less likely to work in companies with 100 or more employees and more likely to work in companies with 10 or fewer employees.

See "Rural-urban differences in employment-related health insurance," by Drs. Larson and Hill, in the Winter 2005 *Journal of Rural Health* 21(1), pp. 21-30. Reprints (AHRQ Publication No. 05-R026)

OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

January 23, 2008
2:00 p.m.

General Services Building, Mt. Mazama Room
Salem, Oregon

MEMBERS PRESENT: Ellen Lowe, Chair
Jim Russell, Vice Chair
Robert Bach
CJ McLeod
Jane Baumgarten
John Mullin
Bill Murray
Ellen Pinney (by phone, joined at 2:33 p.m.)
Noelle Lyda
Susan Rasmussen
Carole Romm
Ann Turner,MD
Eric Metcalf

MEMBERS EXCUSED: Dean Kortge
Felisa Hagins

STAFF PRESENT: Tina Edlund, Deputy Administrator, OHPR
Nate Hierlmaier, Policy Analyst
Paula Hird, Office Specialist, OHFB

OTHERS PRESENT: Darren Coffman, Health Services Commission Director
Sean Kohlmer, Data and Research Manager
Heidi Allen, OHREC Project Manager

ISSUES HEARD:

- **Call to Order/Review of January 8 Meeting MinutesUpdate on Oregon Health Fund Board and Committee Activities**
- **Finalizing Affordability in Recommendations**
- **Development of Elgibility Issues**
- **Next Meeting Agendas and Objectives**
- **Public Testimony**

Chair Lowe **I. Call to Order, Approval of January 8 Meeting Minutes and Review of Revised Work Plan**

- There is a quorum.
- **Changes** to minutes of January 8 included showing that Bill Murray did not attend, but was excused and that the Public Testimony by Tootie Smith should reflect that the Alliance Health Care Sharing Ministries allows only Christians to participate.

Motion to approve the minutes as amended is seconded. **Motion passed unanimously.**

- Eric Metcalf was confirmed by the Board at its meeting on 01/15/08.
- Chair Lowe stated that Ellen Pinney was testifying before the Federal Laws Committee and that she had also testified.
- Tina Edlund reviewed the materials provided for the meeting.

- Chair Lowe shared an article relating statistics from the single reporting community health clinic: 95% of their patients were under 200% of the FPL, 36% were Hispanic/Latino, 4% African American, 2% Native American, and 2% Asian/Pacific Island and 47% seen were uninsured. Discussion on lack of data from these clinics, databases in other states and the effects of health reform on safety net clinics.

Tina Edlund

II. Update on Oregon Health Fund Board and Committee Activities

- The Health Fund Board (HFB) at their January 15 meeting heard testimony on community collaboratives, health safety net and existing models.
- The Delivery System Committee is considering different medical home models to recommend to the Board.
- The Finance Committee is looking at options.
- The Health Equities Committee is getting ready to make citizenship recommendations.

Chair Lowe and Vice Chair Jim Russell

III. Finalizing Affordability Recommendations (see exhibit C)

Staff presented highlights of updated Affordability Proposal.

- Page 2 – Chart depicting shared responsibility and 100% personal responsibility does not reflect the possible revenue from the employer mandate. This affects the 100% personal responsibility (right box) and, as 62-65% of these people are employed, they would be bringing employer money with them.
- Pages 3-4 Charts – It was noted that options 1a, 1b, and 2b did not cover all of the income levels being discussed.
- The Committee discussed opening the Affordability Proposal with:
  - The final recommendation followed by discussion and deleting the table not being recommended.
  - Making initial statements in a one page memo?
  - Staff related that the Board wants not only final recommend-dations but "the flavor" of decision-making.

- Page 8 – **Recommendation #1**.
  - Include from Recommendation #2, page 9, first paragraph, last sentence regarding the Medicaid Advisory Committee's (MAC) recommendation and emphasizing premiums over high deductibles.
  - Decision to leave out the term "highly regressive" in recommendations.
  - Discussion on tracking out-of-pocket payments, eliminating out-of-pocket and limiting to co-pay and premiums.
  - Small co-pays for discretionary services and small deductibles. Large deductibles will hinder low-income individuals/families.
  - Specifying set amounts of out-of-pocket expenses.
  - Changes discussed to **Recommendation #1** include:
    - Initial statement to reflect "total member health care costs" and delete the itemized costs.
    - Keep at 5% of income, with general policy terminology to reflect that the process should not be burdensome, but simplistic.
    - Use "state contribution" terminology.
- Page 9 – **Recommendation #3.** Discussion on contributions in relation to Federal Poverty Levels (FPL).
- **Recommendation #4**. Illustrates the gradual decrease in state contribution as income rises.
- **Population Affected by Affordability Proposal Charts** on pg. 14.

- Is there a choice to not use the program if you are in the group to be subsidized, can you take your subsidy amount and use it to buy a plan of your choosing outside the plan?
- Discussion on tax credits for those between 300%-400% and self-insured.
- **Recommendation #5**– Delete recommendation on geographic adjustments
- Recommendations will go forward to the Board and the Chairs of each of the committees.
- Member Eric Metcalf related problems that some Native American populations experienced as a result of the OHP Plus plan, SB 878 and the need to not create barriers to the access of Indian Federal programs, exemptions and waivers. Discussion by committee members about language to use. Eric Metcalf will be meeting with the Directors from the Indian Health Services for the Portland Area and from the NW Portland Area Indian Health Board as well as with the Tribal Representative on the Federal Laws Committee and compose a short statement to support protecting these federal programs.

Chair Lowe and Vice Chair Jim Russell

IV. Development of Eligibility Issues (See exhibit D)

- Due to time restraints the Committee was given homework to review the Development of Eligibility Recommendations.
  - Staff Highlighted the "Possible Questions for Committee to Address" on page 3 noting these are only suggestions to get started.
  - Next meeting will be the finalization of Eligibility Issue recommendations.

Chair

V. Next Meeting Agendas and Objectives

- It was noted that Kerry Barnett will be presenting at his class on Ethics.
- Meeting date change to February 13, 9:00 a.m. – 12:00 p.m.
- Continue with Committee recommendations on eligibility.

Chair

VI. Public Testimony

- **Tonya Stewart, MD, for the Palliative Care Physican's Roundtable,** presented testimony for the need to promote more discussion between doctors and patients and providing reimbursement to primary care providers to do this. Written testimony provided.

Chair

VII. Adjourn

The meeting was adjourned at 5:00 p.m.

Next meeting is February 13, 2008.

EXHIBIT MATERIALS:

A. Agenda for 01/23/08.
B. Minutes of January 8, 2008
C. Affordability Proposal
D. Development of Eligibility Recommendations
E. Health Care Costs and Financing: Rural Workers have less employment-related health insurance . .

Oregon Health Fund Board

Eligibility and Enrollment Committee

Affordability Recommendations to the Board

February 13, 2008

Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

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Committee Membership:

Ellen Lowe, Chair
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Jim Russell, Vice-Chair
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Jane Baumgarten
Retired
Coos Bay

Felisa Hagins
SEIU Local 49
Portland

Dean Kortge
Senior Insurance Specialist
Pacific Benefits Consultants
Eugene

Noelle Lyda
Ed Clark Insurance, Inc.
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Ellen Pinney
Health Policy Advocate
Oregon Health Action Campaign
Corbett/Salem

Susan Rasmussen
Manager, Special Programs
Kaiser Permanente NW
Portland

Carole Romm
Director
Community Partnerships and Strategic Development, Central City Concern
Portland

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program. In developing these recommendations, the Committee met six times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private coverage to public coverage. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee's task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

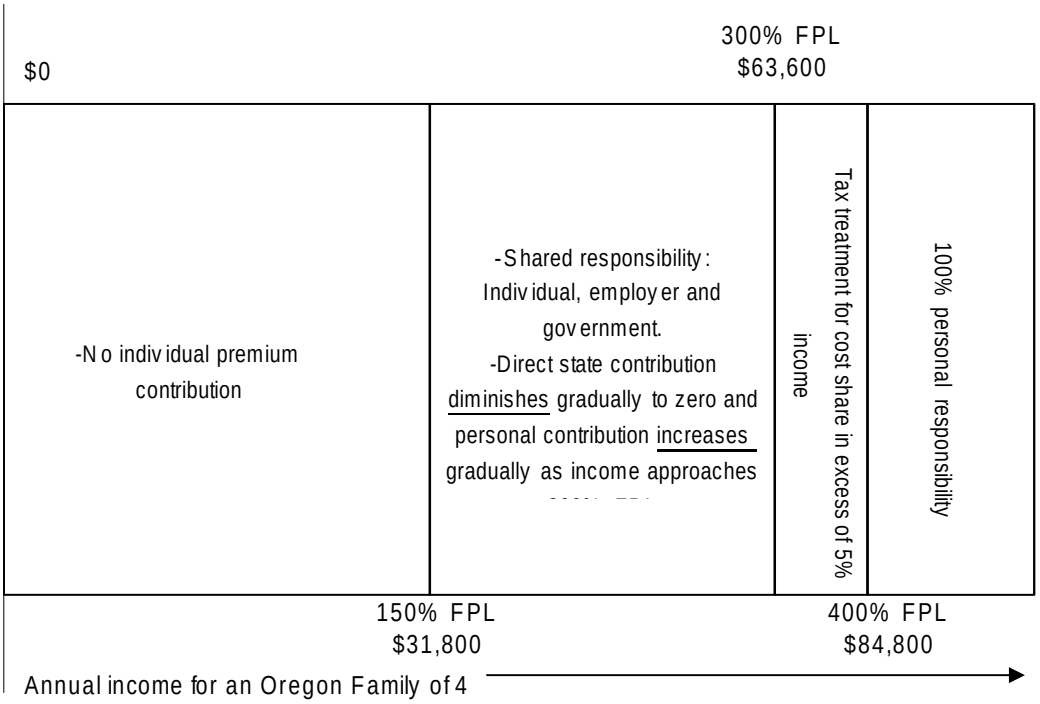
Annual Household Income for Oregon Family of Four ⟶

No Personal Cost Share For Premium Below x% FPL	Shared State, Individual, and Employer Responsibility Between x% and x% FPL	100% Personal Responsibility—No State Participation Above x% FPL

Reform Affordability Recommendations

- For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- Structure the personal cost share to emphasize premiums over other types of cost sharing.
  - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
  - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- Provide state tax relief (tax credits, tax deductions and/or pre-tax premium payments) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability framework as recommended by the Eligibility and Enrollment Committee:



Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should not have any required co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Finance Committee

- An employer contribution requirement will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.
- Explore the implementation dimensions necessary in a tax credit portion of the program.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it.

Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the six meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	**208,000**	**42%**	**46,000**	**40%**
150% to below 200%	**67,000**	**13%**	**29,000**	**25%**
200% to below 250%	60,000	12%	**10,000**	**9%**
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	**499,000**	100%	**114,000**	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care [www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance*"[1]
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of

[1] Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at http://econ-www.mit.edu/files/128.

Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts*"[2]

- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, "*Impact of Copays on a Medicaid Population.*" Which can be found at the following link: *www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf*

Proposed Cost Sharing Structure Options

A. The first question addressed by the committee was: *At what income should a family reasonably be expected to share responsibility for premium cost?*

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

B. The second question addressed by the committee was: *At what income level should premium cost be 100% personal responsibility?*

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

[2] Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit ($15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty ($26,000 annual income for one person), and a few felt that the state contribution should not phase out until 400% of federal poverty ($41,600 annual income for one person).

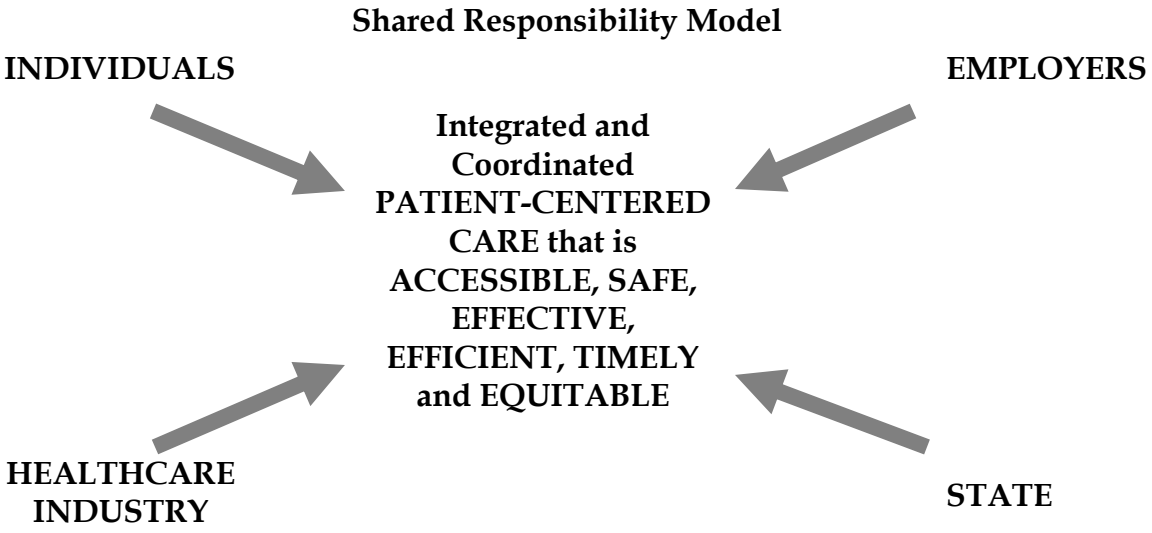
An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

We have to convince conservatives that they have a stake in the uninsured, and that costs can be controlled
And
We have to convince liberals that limits must be set, and that we can't do everything medical science has invented for everyone.

Summary of Committee Comments

The following summarizes the committee comments leading to these recommendations to the Board:

Shared Responsibility. The committee felt that shared responsibility was the intersection between individuals, employers, the healthcare industry and the state.



First, individuals share responsibility in the affordability debate. As one member stated, "Although [there would be] (hopefully) small contributions from those at low income levels, they would still be participating early on." Members also felt that shared responsibility for the individual included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their healthcare and help reduce costs, too."

About employer responsibility, one member commented, "The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute."

Third, in discussing the responsibility of the health care industry, a member commented, "329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the 'essential' benefits package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to

participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning $50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is." Finally, the committee felt that a similar difference should be accounted for in cost of living in urban versus rural Oregon.

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I … favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

Recommendations

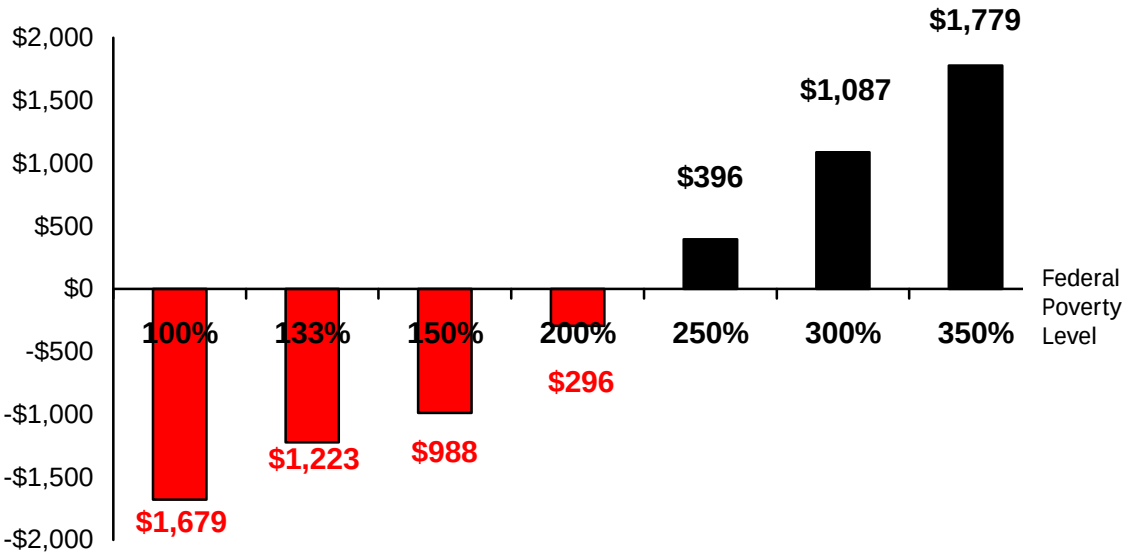
Recommendation #1: For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.

Proposal Overview

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute's review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee's recommendation to protect low and middle family incomes from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee's review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family's income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



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

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when … out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums…is unknown, cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'." Another

member echoed the "administrative simplicity" sentiment by suggesting potentially simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation #2: Structure the individual cost sharing to emphasize premiums over other types of cost sharing.

- **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
- **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. This recommended approach mitigates this factor by protecting low-income individuals and families. Additionally, the committee recommends, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of

the federal poverty level (FPL) or $53,000 annually for the Portland area, 200% of FPL or $42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL ($42,000) in the Portland area, 250% FPL ($35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level ($15,600 for an individual or $31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

Recommendation #3: Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them—Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #4: Provide state tax relief (tax credits, tax deductions and/or pre-tax premium payments) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The Committee noted that the state income tax code provides similar benefits for businesses and this would provide equity for individual households adhering to the individual mandate.

Additional Recommendations to OHFB Committees:

1. For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should not have any required co-pays.
- Co-pays are preferable to deductibles and co-insurance.

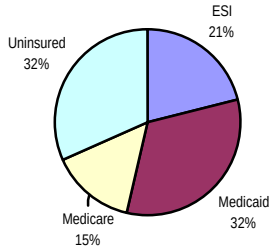
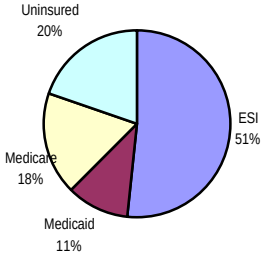
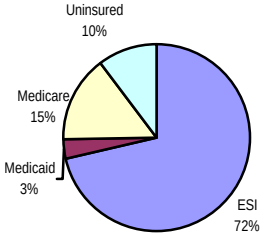
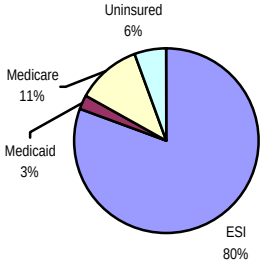
2. For the Finance Committee

- Employer contribution requirement will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.
- Explore the implementation dimensions necessary in a tax credit portion of the program.

3. For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it.

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
806,000 Oregonians	**1,032,000 Oregonians**	**513,000 Oregonians**	**1,311,000 Oregonians**
-550,000 insured (68%)	-828,000 insured (80%)	-458,000 insured (89%)	-1,211000 insured (93%)
-255,000 uninsured (32%)	-204,000 uninsured (20%)	-55,000 uninsured (11%)	-99,000 uninsured (7%)
Insurance source for < 150% FPL: 	Insurance source for 150% FPL to below 300% FPL: 	Insurance source for 300% FPL to below 400% FPL: 	Insurance source for 400% FPL and above: 

Data from CPS 2-year average, Data collected in 2006 and 2007.

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	$10,400	$15,600	$20,800	$26,000	$31,200	$36,400	$41,600
2	$14,000	$21,000	$28,000	$35,000	$42,000	$49,000	$56,000
3	$17,600	$26,400	$35,200	$44,000	$52,800	$61,600	$70,400
4	$21,200	$31,800	$42,400	$53,000	$63,600	$74,200	$84,800
5	$24,800	$37,200	$49,600	$62,000	$74,400	$86,800	$99,200
6	$28,400	$42,600	$56,800	$71,000	$85,200	$99,400	$113,600
Each add'tl person, add	$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Eligibility and Enrollment Committee
Overview of Eligibility Assumptions and Directions
February 13, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the eligibility requirements in a new Oregon Health Fund program.

What guidance do we have from SB 329?

1. In Section 3, (1), SB 329 states the following as one of its principles:

   Expanding access. The state Medicaid program, Oregon SCHIP, and FHIAP must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

2. In Section 4, (1), the bill further states:

   As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon SCHIP and FHIAP programs.

3. Section 4, (5), Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
4. Section 9 (2) (d) (B) (ii) states, "Requirements to ensure that enrollees demonstrate Oregon residency."
5. Section 12 (2) indicates that the Board cannot require residents to enroll in the Oregon Health Fund program who are already enrolled in:
   a) Commercial health insurance plans
   b) Self-insured programs
   c) Health plans funded by a Taft-Hartley Trust
   d) State or local government health insurance pools

SB 329 directs the Oregon Health Fund Board to develop the structures and policies necessary to ensure that all Oregonians have access to a defined set of essential health services within a reformed delivery system.

SB 329 does not direct the Oregon Health Fund Board to create a single payer system to replace employer and other sources of insurance. Rather the Board is to create the environment for health delivery reform through an approach integrating public and private delivery systems. The primary mechanisms for providing this leadership include:

1) Creating a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable insurance;
2) Designing insurance products based on the defined essential benefit package;
3) Ensuring a network of accountable health plans (AHPs) contracting with the state to administer the benefit package; and,
4) Creating a new public/private vehicle for organizing and furthering quality and transparency in the current system.

What assumptions have been indicated (as of January 2008) by the Oregon Health Fund Board and its Committees about comprehensive reform?

1) An individual mandate that requires all Oregon residents to have health insurance coverage;
2) Guaranteed issue and renewability with no pre-existing limitation;
3) State contributions at a sliding scale of income to make health coverage more affordable for individuals and families;
4) A mandate that employers provide health insurance coverage to their employees; and,
5) A new health insurance exchange that will include the Oregon Health Fund Program as well as providing a central forum for individuals and businesses to purchase health insurance coverage.

What are the citizenship requirements for the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP)?

U.S. citizenship and immigration policy for OHP and FHIAP is driven by federal regulation as both are a federal-state partnership through Medicaid and the State Children's Health Insurance Program (SCHIP). Prior to the Deficit Reduction Act of 2005 (DRA), an applicant for Medicaid and SCHIP had to declare, under penalty of perjury, legal immigrant status or U.S. citizenship to qualify for Medicaid and SCHIP benefits. No verification was required for citizenship, unless questionable. With passage of the DRA, U.S. citizenship and identity must now be verified using specific documents from a list of acceptable documentation developed by the federal government.

Legal immigration status is verified to determine if the individual meets the required immigrant status for Medicaid and SCHIP benefits. Documents issued by Homeland Security are verified through SAVE, an immigration status verification system. Once an individual has been in the country for five years with Legal Permanent Resident (LPR) status, or meets asylee or refugee status, they may receive Medicaid and SCHIP benefits if otherwise eligible, per federal regulations.

What are the new standards set forth in Executive Order 07-22 regarding Oregon drivers' licenses and identification cards?

In February 2008, the Oregon Transportation Commission adopted requirements set forth in executive order 07-22 that require driver's license and identification card applicants need a legitimate Social Security number, a U.S. passport or a foreign passport with U.S. immigration documentation.

What are the Oregon residency requirements for eligibility in OHP and FHIAP?

A statement of intent to reside in Oregon is sufficient for residency. OHP and FHIAP residency requirements are driven by federal regulations, directing that the State of

residency for a Medicaid or SCHIP applicant is the State where the individual is living with the intent to remain for an indefinite period of time, or the State they entered with a job commitment or seeking employment. The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.

Are there other state programs that treat residency differently?

Oregon's Board of Higher Education authorizes Oregon University System institutions to classify students as residents and nonresidents for the purposes of admission and instructional fee assessment. Nonresidents enrolled at these institutions (with the notable exception of state reciprocal agreements such as with Washington) pay the nonresident instructional fee.

The following factors, although not necessarily conclusive or exclusive, have probative value in support of a claim for Oregon resident classification:

1) Reside in Oregon for 12 consecutive months prior to the beginning of the term for which resident classification is sought and during that period be primarily engaged in activities other than those of a college student;
2) Reliance upon Oregon resources for financial support;
3) Domicile in Oregon of persons legally responsible for the student;
4) Acceptance of an offer of permanent employment in Oregon; and
5) Ownership by the person of his or her living quarters in Oregon.

Are there any potential legal problems in limiting subsidies based on length of residency?

In 1992, California enacted a statute limiting the maximum welfare benefits available to newly arrived residents. The scheme limits the amount payable to a family that has resided in the State for less than 12 months to the amount payable by the State of the family's prior residence. This law was challenged and overturned by the United States Supreme Court in 1999 with the case of Saenz v. Roe. In the ruling the court barred states from limiting welfare benefits on the basis on length of residency. In the majority opinion, Justice Stevens wrote,

> What is at issue in this case, then, is this third aspect of the right to travel, the right of the newly arrived citizen to the same privileges and immunities enjoyed by other citizens of the same State. That right is protected not only by the new arrival's status as a state citizen, but also by her status as a citizen of the United States. That additional source of protection is plainly identified in the opening words of the 14th Amendment: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States."

Excerpts of Oregon Law and Administrative Rule Pertaining to Eligibility and Residency

OREGON REVISED STATUTES, 2005 EDITION
Chapter 735 — OFFICE OF PRIVATE HEALTH PARTNERSHIPS
(Family Health Insurance Assistance Program)

ORS 735.720 Definitions for ORS 735.720 to 735.740:

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

OREGON ADMINISTRATIVE RULES, 2008 EDITION
Chapter 442— OFFICE OF PRIVATE HEALTH PARTNERSHIPS
(Family Health Insurance Assistance Program)

OAR 442-005-0010

Eligibility

In order for an applicant to qualify for a FHIAP subsidy, applicants must:

(1) Be a resident of Oregon or a full-time college student with a parent who is a resident of Oregon.

(2) Be a United States citizen or a qualified non-citizen who meets the alien status requirement.

(3) Not be eligible for or receiving Medicare benefits.

(4) Have investments and savings that are available of no more than $10,000 on the last day of the month prior to the month the application is signed. Investments and Savings are not available if owned by or a beneficial interest in them is held by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for the purposes of this subsection (4).

(5) Have income of less than 185% of the Federal Poverty Level in effect at the time of determination. Income determination is outlined in OAR 442-005-0070.

(6) Meet one of the statutory definitions of family in ORS 735.720(2) at the time of eligibility determination. To be included in the family size for FHIAP eligibility determination, the applicant's family members must meet the definition of dependent under OAR 442-005-0010(8):

(a) A dependent may be counted in two separate households for the purposes of determining eligibility for FHIAP and any other state assistance program;

(b) A dependent may be counted in two separate households for the purpose of determining eligibility for both families in FHIAP;

(c) A dependent may not be enrolled in FHIAP and OHP (or any other state medical assistance program) at the same time;

(d) A dependent may be enrolled in FHIAP and any other state assistance program (except medical) at the same time;

(e) If a dependent is counted in two separate households for the purpose of determining eligibility in two different assistance programs, enrollment will be determined by criteria established in procedure.

(7) Meet either a period of uninsurance requirement or exceptions listed in OAR 442-005-0060.

(8) Not be incarcerated for more than 30 days or be a ward of the State.

(9) Provide necessary materials in order to allow for eligibility determination. If information submitted is inconsistent, and applicant may be denied.

(10) If applying for subsidy in the group market, must be able to enroll in a group insurance plan that meets the benchmark standard established by the Office within twelve months of eligibility determination. If an applicant to the group market does not have access to a group plan, the group plan they have access to does not meet the benchmark standard, or they cannot enroll into their group plan within twelve months of eligibility determination, the applicant will be denied and placed on the reservation list for an individual subsidy using the same date they were placed on the group reservation list.

Definitions

(1) "Alien Status Requirement." A qualified non-citizen meets the alien status requirement for FHIAP if the individual is one of the following:

(a) A person who was admitted as a qualified non-citizen on or before August 22, 1996;

(b) A person who entered the U.S. on or after August 22, 1996 and it has been five years since he or she became a qualified non-citizen;

(c) A person who has obtained their qualified non-citizen status less than five years ago, but entered the U.S. prior to August 22, 1996. The non-citizen must show that he or she has been living in the U.S. continuously for five years from a date prior to August 22, 1996 to the date the non-citizen obtained their qualified status and did not leave during that five year period. If the non-citizen cannot establish the five-year continuous residence before he or she obtained their qualified status, the person is not considered to have entered the U.S. prior to August 22, 1996;

(d) Regardless when they were admitted, a person with one of the following designated statuses:

(A) A person who is admitted as a refugee under section 207 of the INA;

(B) A person who is granted asylum under section 208 of the INA;

(C) A person whose deportation is being withheld under section 243(h) of the INA;

(D) A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;

(E) A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988;

(F) A person who is a victim of a severe form of trafficking.

(e) Regardless of when they were admitted, a qualified non-citizen who is:

(A) A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or

(B) On active duty in the U.S. Armed Forces (other than active duty for training);

(C) The spouse or unmarried dependent child of the veteran or person on active duty described in (e)(A) and (B).

(f) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

(g) A member of an Indian tribe (as described in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(h) Any legal non-citizen who was approved for a FHIAP subsidy prior to November 1, 2004.

(22) "Qualified non-citizen" for the purposes of FHIAP. A person is a "qualified non-citizen" if he or she is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq);

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1523(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980;

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980);

(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the United States Immigration and Naturalization Service;

(i) American Indians born in Canada to whom the provision of section 289 of the INA (8 U.S.C. 1359) apply;

(j) Members of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(k) A veteran of the U.S. Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty requirements described in 38 U.S.C. ¶ 5303A(d);

(l) A member of the U.S. Armed Forces on active duty (other than active duty for training);

(m) The spouse or dependent child of a person described in either (k) or (l) above;

(n) A legal non-citizen approved for FHIAP subsidy prior to November 1, 2004.

(25) "Resident" means a citizen or qualified non-citizen who resides in Oregon or a full-time college student who is a citizen or qualified non-citizen with a parent who resides in Oregon.

Chapter 316 — Personal Income Tax

316.027 "Resident" defined. (1) For purposes of this chapter, unless the context requires otherwise:

(a) "Resident" or "resident of this state" means:

(A) An individual who is domiciled in this state unless the individual:

(i) Maintains no permanent place of abode in this state;

(ii) Does maintain a permanent place of abode elsewhere; and

(iii) Spends in the aggregate not more than 30 days in the taxable year in this state; or

(B) An individual who is not domiciled in this state but maintains a permanent place of abode in this state and spends in the aggregate more than 200 days of the taxable year in this state unless the individual proves that the individual is in the state only for a temporary or transitory purpose.

(b) "Resident" or "resident of this state" does not include:

(A) An individual who is a qualified individual under section 911(d)(1) of the Internal Revenue Code for the tax year;

(B) A spouse of a qualified individual under section 911(d)(1) of the Internal Revenue Code, if the spouse has a principal place of abode for the tax year that is not located in this state; or

(C) A resident alien under section 7701(b) of the Internal Revenue Code who would be considered a qualified individual under section 911(d)(1) of the Internal Revenue Code if the resident alien were a citizen of the United States.

(2) For purposes of subsection (1)(a)(B) of this section, a fraction of a calendar day shall be counted as a whole day. [1969 c.493 §8; 1987 c.158 §49; 1995 c.79 §165; 1999 c.1096 §1]

OREGON REVISED STATUTES, 2005 EDITION

Chapter 428 — Nonresident Persons With Mental Disabilities

OBLIGATIONS CONCERNING NONRESIDENT PERSONS WITH MENTAL DISABILITIES

428.205 Declaration of policy. It is declared to be the policy and intent of the Legislative Assembly that whenever a person physically present in the State of Oregon is in need of

institutionalization by reason of mental illness or mental deficiency, the person shall be eligible for care and treatment in an institution of the State of Oregon irrespective of the residence of the person, settlement or citizenship qualifications. [1975 c.155 §2]

428.210 Definitions for ORS 428.210 to 428.270. As used in ORS 428.210 to 428.270:

(3) "Nonresident" means any person who is not a resident of this state as defined in subsection (6) of this section.

(6) "Resident of this state" means a person who has lived in this state continuously for a period of one year and who has not acquired legal residence in any other state by living continuously therein for at least one year subsequent to the residence of the person in this state. However, a service man or woman on active duty in the Armed Forces of the United States who was domiciled in Oregon upon entry into active duty and who has acquired no other domicile shall be entitled to have his or her children considered a resident of this state so long as no other domicile is acquired by the service man or woman.

OREGON ADMINISTRATIVE RULES, 2008 EDITION

OREGON UNIVERSITY SYSTEM

580-010-0030 Determination of Residence

(1) For purposes of admission and instruction fee assessment, OUS institutions shall classify a student as Oregon resident or nonresident. In determining resident or nonresident classification, the primary issue is a person's intent in coming to Oregon. Intent is inferred from a person's conduct and history as they relate to the requirements of these residency rules. If a person is in Oregon primarily for the purpose of obtaining an education, that person will be considered a nonresident. It is possible for an individual to qualify as a resident of Oregon for purposes of voting or obtaining an Oregon driver's license and not meet the residency requirements established by these rules.

(2) An Oregon resident is a financially independent person who, prior to the term for which Oregon resident classification is requested, has both: (a) established and maintained a domicile in Oregon as provided under OAR 580-010-0029(1) 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

(3) A student may be considered primarily engaged in educational activities regardless of the number of hours for which the student is enrolled. However, a student who is enrolled for more than 8 hours in any semester or quarter during the 12-month period referred to in section (2) of this rule shall be presumed to be in Oregon for primarily educational purposes. Such period of enrollment shall not be counted toward the establishment of a bona fide domicile of 12 consecutive months in this state unless the student proves, in fact, establishment of a bona fide domicile in this state primarily for purposes other than educational.

(4) An Oregon resident is also a financially dependent person who is claimed as a dependent by another person who has both: (a) established and maintained an Oregon domicile as provided under OAR 580-010-0029(1) for 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

(5) A financially dependent person who is claimed as a dependent by another person who has not established and maintained an Oregon domicile shall be presumed to be a non-resident. This

presumption may be overcome by evidence of the student's long-standing presence in Oregon and demonstration of other factors under OAR 580-010-0031.

(6) The criteria for determining Oregon resident classification shall also be used to determine whether a person who has moved from Oregon has established a non-Oregon residence.

(7) If institution records show that the residence of a student or the person upon whom the student is dependent is outside of Oregon, the student shall continue to be classified as a nonresident until entitlement to resident classification is shown. The burden of showing that the residence classification should be changed is on the student requesting the change.

(8) Notwithstanding section (4) of this rule, a student who is financially dependent on a non-Oregon resident may nonetheless be considered an Oregon resident if the student resides in Oregon for at least 12 consecutive months with a parent or legal guardian who has both: (a) established and maintained an Oregon domicile under OAR 580-010-0029(1) for 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

580-010-0031 Residency Consideration Factors

(1) The following factors, although not necessarily conclusive or exclusive, have probative value in support of a claim for Oregon resident classification:

(a) Reside in Oregon for 12 consecutive months prior to the beginning of the term for which resident classification is sought and during that period be primarily engaged in activities other than those of a college student;

(b) Reliance upon Oregon resources for financial support;

(c) Domicile in Oregon of persons legally responsible for the student;

(d) Acceptance of an offer of permanent employment in Oregon; and

(e) Ownership by the person of his or her living quarters in Oregon.

(2) The following factors, standing alone, do not constitute sufficient evidence to effect classification as an Oregon resident:

(a) Voting or registration to vote;

(b) Employment in any position normally filled by a student;

(c) The lease of living quarters;

(d) Admission to a licensed practicing profession in Oregon;

(e) Automobile registration;

(f) Public records, for example, birth and marriage records, Oregon driver's license;

(g) Continuous presence in Oregon during periods when not enrolled in school;

(h) Ownership of property in Oregon or the payment of Oregon income or other Oregon taxes; or

(i) Domicile in Oregon of the student's spouse;.

(3) Reliance upon non-Oregon resources for financial support is an inference of residency in another state.

FACT SHEET ABOUT IMMIGRATION STATUS AND PERSONAL HEALTH CARE COVERAGE

submitted to the Equities Committee of the Oregon Health Fund Board
by Tina Castañares, MD 12/17/07

Disclaimer: *I'm not a trained expert in this field, so the "salient points" I've chosen to send you here should be checked with those who are such experts for accuracy before any policy recommendations might draw on them.*

- Unauthorized aliens (the federal term of art for people often referred to elsewhere as "undocumented workers," "illegal immigrants," and other such terms) have always been excluded from eligibility for federally-sponsored public health insurance (Medicaid, Medicare, and SHCIP). Exceptions are Alien-Waived Emergency Medicaid (called CAWEM in Oregon and some other states) and, in some states, certain uses of state-only Medicaid- or SCHIP-administered funds. Sometimes such latter exceptions have included prenatal care, HIV/AIDS care, hospice care, children's insurance, and other services. However, Oregon has not, in general, made such investments.

- H2A-program (agricultural guestworker) participants are not granted any exceptions to these exclusions. Interest in the H2A program is growing among Oregon farmers due to recent and projected labor shortages.

- No distinctions between naturalized and native-born citizens have ever been applied to date for eligibility for public health insurance. "Citizens are citizens."

- Lawful permanent residents (immigrants with "green cards"), prior to 1996, were eligible for public health insurance on the same basis as citizens.

- In 1996, the "Personal Responsibility Act" (Welfare Reform), spearheaded by the Clinton administration and enacted into law by Congress, for the first time distinguished lawful permanent residents from citizens by barring LPRs from eligibility from certain public programs, including public health insurance, until they had been lawfully present in the USA for no fewer than 5 years. States were given the option of making this bar longer or permanent. The 5-year bar was adopted and remains in effect in Oregon for Medicaid and SCHIP. The federal government applies it for Medicare.

- Thus, not only unauthorized aliens but also hundreds of thousands of lawfully present immigrants nationally, who would meet other eligibility criteria for Medicaid and SCHIP, are currently ineligible due to their not yet having reached 5 years of legal residency.

- Medicare eligibility is similar. Only after five years from legal entry may a lawful permanent resident who meets age and/or disability criteria be eligible for Medicare. If s/he has worked 40 qualifying quarters paying into the U.S. Social Security system, free Medicare benefits have parity with those of citizens. Certain family members are

allowed to contribute their own qualifying quarters to meet this criterion. If the criterion is not met, benefits are available for a privately paid monthly premium. In other words, such lawful permanent residents may "buy in" to Medicare after their 5-year bar.

- Efforts to restore intake and enrollment in Medicaid to pre-2004 processes are desirable because new requirements for proof of citizenship, nativity, or lawful immigration status have been demonstrated to deny eligibility to many US citizens, among others. However, success on this front alone will not address immigrants' great losses to eligibilty since 1996, nor the 20th-21st century US cultural denial of most public benefits to unauthorized aliens. (Public K-12 schooling is a notable exception, and there are others with less economic impact.) Certain other "first world" countries also deny benefits like we do, but many do not. Those who do not tend to cite cultural/ethical values (equity) and public health rationales for their investments.

- Emergency Medicaid (CAWEM) is, essentially, very restrictive hospitalization coverage for people who would be otherwise eligible for Medicaid were it not for their immigration status (unauthorized, or before passage of their 5-year ban). CAWEM can pay for life-saving or life-stabilizing treatment of serious medical conditions in a hospital setting. Obstetrical delivery is covered. All outpatient care and long-term care are excluded, with the exception of Emergency Department services meeting the serious/lifesaving sorts of criteria. Among specific services excluded are: outpatient medication coverage; cancer chemotherapy; hemodialysis; hospice or palliative care; rehabilitation services; durable medical equipment; sterilizations; prenatal care; scheduled (non-emergent) labs and imaging; primary care; non-emergent specialty consultation; home health care; and more.

- For unauthorized aliens and for lawful permanent residents (and those applicants "in process") who have not yet been legally present in the US for 5+ years, the availability of CAWEM for many hospital-based needed services means that their greatest gap in coverage is arguably for primary care.

  This observation is relevant to the Health Fund Board's committees' deliberations on benefit package, financing, eligibility and the delivery system. The Delivery System committee, in particular, is examining how it might support and enhance the primary care home concept. Efforts to create privately subsidized insurance plans for group or individual market s-- available to low-income workers who are not eligible for public insurance (for whatever reason) and who do not have commercial insurance provided by their employers – might well consider designing such plans to focus on services provided at or arranged by primary care homes. As for foreign-born Oregonians who could benefit from such plans, most now obtain outpatient services in the safety net system. Taking care to ensure adequate coverage/ compensation for safety net providers is obviously vital to the success of a new effort. I would add that ensuring coverage for services provided by trained Community Health Workers, who are likeliest to speak the relevant foreign languages and be effective in multicultural settings, is also vital. Such coverage does not, for the most part, exist today in public or commercial insurance plans.

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. The MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) to establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee," that is comprised, but not limited to the membership of the MAC. Additionally, the MAC is also required to present reports containing data and recommendations to the Committee as well as the Governor and Legislature on eligibility and enrollment.

The following is a series of eligibility recommendations and future considerations that the MAC has issued to the Eligibility and Enrollment Committee to consider in its deliberations on comprehensive health care reform.

Recommendations Concerning Eligibility

1. **All uninsured individuals and families should be able to participate.**
2. **Families should be kept intact programmatically.**
3. **Establish presumptive eligibility for all uninsured Oregonians.**
4. **There should be no requirement of a period of uninsurance to participate.**
5. **There should be no pre-existing condition limitations.**
6. **Open period of enrollment for changes of coverage or subsidies every 12 months.**
7. **Income limitations and/or asset testing should not apply in determining eligibility.**

Future Considerations

- *Determine the cost-benefit of covering all Oregonians regardless of citizenship in terms of uncompensated care, the cost-shift, public health, emergency preparedness, and the dignity and worth of every individual.*
- *For special populations, consider utilizing federal funds that allow retroactive eligibility to three months prior to the date of service (date stamp).*

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*

- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:

- Oregon Health Fund Program would not be "universal" in that low-income non-qualified Oregon residents excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:

- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:

- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:

- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,

- The “play or pay” amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

Eligibility and Enrollment Committee
Development of Eligibility Recommendations
February 13, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the eligibility requirements in a new Oregon Health Fund program.

Residency and Citizenship
What is an Oregon resident?

Will there be a residency waiting period? (i.e., requiring that someone is a legal resident for x months before they are eligible for the state subsidy?).

How will non-citizens be treated?

Period of eligibility
How long is the period of eligibility?

Interplay of OHFB and ESI
What about individuals who are eligible for ESI, but haven't taken it up?

How will we treat people who have ESI, but are eligible on the basis of income, for Medicaid?

How will we treat people who are in their waiting periods for ESI?

How will we treat people who have ESI and currently pay the employee share on their own? Do we provide a state contribution to this group? Or do we build a firewall between this group and state contribution?

Expansion of eligibility for public programs
Expansion of eligibility for public programs (OHP, e.g., adults to 200% FPL, children to 300%?) Expansion of Medicaid Buy-In program for the working disabled?

Recommendations around auto-enrollment? Presumptive eligibility? Retroactive eligibility?

Accountability?
How do we ensure that these tax-supported services are provided only to those who are eligible?

Do we recommend that penalties be put in place in cases where people try to collect benefits for deceased persons, under fraudulent ID's, for non-residents?

Consumer Protections?

Possibly some recommendations about consumer protections -- Colorado is recommending the creation of an independent Consumer Advocacy organization that can specifically help residents with denials and support local community efforts to get people enrolled. (This could be included here as well as with our enrollment recommendations?)

Recommendations & Guiding Principles
to Reform the Oregon Health System

As the Oregon Health Fund Board (OHFB) develops a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care, it is important to honor the unique health care obligations that the United States has to Tribes and Indian people. This document outlines principles and recommendations for Indian health program delivery that were established in previous health care reform activities and adopted by the consensus of all Tribes.[1]

Recommendations to Address the Core Principles[2,3,4]

The provision of health care to American Indians and Alaska Natives (AI/AN) is a legal and moral obligation of the federal government stemming from treaties with sovereign Indian Tribes and subsequent federal legislation and court decisions. This unique relationship requires that all federal health care funding for AI/AN people—in this case Medicare, Medicaid, and SCHIP programs—be directly available to Indian health programs. Any reform or changes in these programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

Trust Responsibility: Medicare, Medicaid, and SCHIP reform initiatives and regulations must be consistent with the federal government's obligation to Tribes and their programs. It is federal government and its agencies' responsibility to protect this trust; and as such can not shift the responsibility to the states. The legislation and regulations must contain specific protections for AI/AN consumers and specific directions that will assure Indian health programs are adequately compensated.

100% FMAP: As a federal responsibility, CMS must provide 100 percent FMAP for services covered in the State Medicaid Plan delivered to Medicaid beneficiaries by or through IHS or Tribal programs. The Indian health system is reimbursed for services at 100% Federal Medical Assistance Percentage (SSA Title IXX §1905(b)) for Medicare, Medicaid, and SCHIP-eligible related services provided by an Indian health provider. This provision makes services budget neutral for state Medicaid programs and must be factored when determining benefits packages and reimbursement methods.

Cost Sharing: Eliminate or waive American Indian/Alaska Native beneficiaries of all cost sharing. Legislation and regulation must extend the current SCHIP premium and cost sharing exemptions to

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[1] National Summit on Indian Health Care Reform, Washington D.C., Returning to a Natural State of Good Health," March 1993. Reaffirmed at National Roundtable on the Indian Health System and Medicaid Reform, October 1, 2005, Washington D.C. by NPAIHB, Urban Institute, and Kaiser Family Foundation.

[2] CMS List of 24 Issues raised during consultation with Tribes during 1999 and through other meetings and request, CMS Website, American Indian and Alaska Native Beneficiaries, Issues

[3] National Indian Health Board, Medicaid and Manage Care, 1998

[4] National Indian Health Board, Indian Health in Ten State Medicaid, Managed Care & SCHIP Programs, 2001

Medicaid and the co-payments for Medicare. Because of the 100% FMAP requirement States must adhere to exempting Indian beneficiaries in cost sharing requirements.

Benefits Design: Since Medicaid services are reimbursed at 100%FMAP, the OHBF should be make sure that any benefit packages for AI/AN Medicaid beneficiaries that are less in amount, duration, or scope than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This "most favored nation" rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.

Managed Care: If reform includes managed care, Indian programs and AI/AN people must have the following flexibility.

- Choice: AI/AN individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer.
- Default Assignment to Indian Health Program: Individual AI/AN must NOT be involuntarily assigned to non-Indian managed care plan when an Indian health program is available.
- Out of Plan Service: Require managed care plans or contractors to pay the Indian health providers when providing services to AI/AN people, who exercise their right to use Tribal/IHS programs.

Traditional Practices: Respect for cultural beliefs, blending of traditional practices with a modern medical model and emphases on public health and community outreach. CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.

Access to CMS Program Eligibility: Simplify and improve AI/AN outreach, enrollment and eligibility determination. Provide funding to Indian health programs for conducting outreach and linkage activities. Simplify the application process by reducing required documents, providing "real time" determination, and allowing self-declaration for residency and income. Allow Tribes the option to provide program enrollment and eligibility determination on-site.

Guiding Principles

1. Special Legal Obligations Involving American Indians

It is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to Indians and to provide existing health services with all resources necessary to affect that policy (P.L. 94-437 Indian Health Care Improvement Act).

2. Cultural Considerations in Indian Health Care

A community-based and culturally appropriate approach to health care is essential to accommodate the needs of Indian people and their cultures.

3. The Distinctive Needs of Indian People

The poor state of health across Indian Country is another factor that demands...focused attention and funding in order to break the cycle of illness and addiction that began with the destruction of a balanced Tribal lifestyle.

4. The Right to Comprehensive Health Care

It is comprehensive health care to which Indian Tribes are entitled under federal law.

5. Existing Indian Health Care Systems

Indian health care does not currently operate simply as an extension of the mainstream health system in America. To the contrary, federal support has built a system that is designed to serve Indian people. It is important…not to undo the existing system but instead build upon those programs that Tribes, the IHS and other Indian health providers have started.

6. American Indian Tribes as Sovereign Government

Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. It is unacceptable either legally or pragmatically to distribute funds or program authority to state governments (private insurance companies or HMOs) for distribution to Tribes and Indian people.

Tribes exercise powers of government. They form their own governing systems, determine who belongs to the Tribe, and elect their own leaders. Tribal Leaders, representatives of their nations, expect full, open communication with Federal leaders and expect to be consulted about changes that affect them.

Tribes have greater control over their health programs when they have access to, but not limited to, the following:

- *a) direct federal funding or allocation*
- *b) flexibility in setting eligibility and program design criteria*
- *c) equal access to any federal or state-administered grants or programs*
- *d) deemed certified given that the program meets Indian Health Service, Tribal or national certification standards*

In closing, there is a need to chart a delicate course between the goals of improving access and controlling costs while recognizing and supporting the special legal relationship with American Indian and Alaska Native Tribes.

Prepared 2/4/08 by the Northwest Portland Area Indian Health Board, 527 S.W. Hall Suite 300, Portland, OR 97201. Special thanks to the CMS Tribal Technical Advisory Group for assistance in preparing document. For questions, please contact Jim Roberts, Policy Analyst at (503) 228-4185 or by email at jroberts@npaihb.org.

NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klaliam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
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Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SENT VIA TELEFAX: (503) 378-5511

January 31, 2008

Barney Speight, Executive Director
Oregon Health Fund Board
General Services Building
1225 Ferry Street SE, 1st Floor
Salem, OR 97310

Dear Mr. Speight:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization[1] that represents the health care issues of the forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. We are writing on behalf of our nine Oregon Tribes with respect to the work that the Oregon Health Fund Board (OHFB) is currently undertaking.

As we are all aware, the Healthy Oregon Act (SB 329) created the Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. To accomplish this work, the OHFB has appointed committees to develop recommendations on various issues related to developing a comprehensive plan to reform Oregon's health care system. The OHFB and its committees are charged with a very difficult task to develop a comprehensive plan for health care while at the same time taking into consideration the needs of all Oregonians.

As the OHFB works to develop its recommendations there are some special circumstances for Tribal health programs that the committees should be aware of as they undertake their work. Most important is the unique relationship between the United States and Indian Tribes. This relationship forms the basis of a "federal trust relationship" and creates a federal obligation to provide health services to Indian people. Thus, any changes in the health care system must take into consideration this special relationship and the unique needs of Indian people who suffer the worst health disparities of any population in America. Any proposed changes in Oregon's health care system must carefully be evaluated for their impact on Tribal health programs. Changes in federal program eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing will have profound consequences for our people, our health care providers, and the economic well-being of our communities.

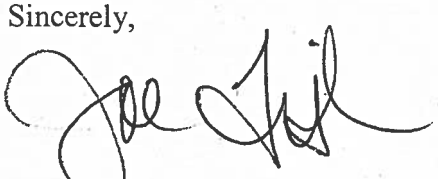
[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

To assist in your effort, we have prepared a set of guiding principles that should be taken into consideration by each OHFB committee. The guiding principles provide a framework that should be followed as the OHFB develops its recommendations for universal health care in Oregon. If followed, this framework will serve to protect the vital interests and needs that Indian people have in the health care system. Recommendations to address the core principles are also included in the areas of financing, managed care, access and benefits, and cultural considerations. Our hope is that by following the guiding principles we will not create any harm to the fragile health care system that provides care to Indian people.

Thank you for the opportunity to provide our advice and guidance to the Oregon Health Fund Board as it works to develop universal access to health care in Oregon. We support you in your work and offer our assistance for advice and guidance at any time. We also want to thank you for recognition and inclusion of Tribal health leaders on the various OHFB committees and look forward to the work ahead.

Again, thank you for your consideration!

Sincerely,



Joe Finkbonner,
Executive Director

cc: Susan King, Chair Benefits Committee
Kerry Barnett, Chair Finance Committee
Dick Stenson, Chair Delivery Systems Committee
Ellen Lowe, Chair Eligibility & Enrollment Committee
Frank Baumeister, Chair Federal Laws Committee
Ella Booth, Chair Health Equities Committee

Enclosure: Guiding Principles & Recommendations

OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

February 13, 2008
9:00 a.m.

Salem Public Library, Anderson Room A
Salem, Oregon

MEMBERS PRESENT:
Ellen Lowe, Chair
Jim Russell, Vice Chair
Felisa Hagins
Robert Bach
Jane Baumgarten
Dean Kortge
John Mullin
Bill Murray
Ellen Pinney
Noelle Lyda
Susan Rasmussen (by phone)
Carole Romm
Ann Turner,MD
Eric Metcalf (by phone)
CJ McLeod

STAFF PRESENT:
Tina Edlund, Deputy Administrator, OHPR
Nate Hierlmaier, Policy Analyst
Paula Hird, Office Specialist, OHFB

ISSUES HEARD:

- **Call to Order/Review of January 23 Meeting Minutes/Review of Revised Work Plan**
- **Update on Oregon Health Fund Board and Committee Activities**
- **Approval of Affordability Recommendations to the Oregon Health Fund Board (OHFB)**
- **Overview of Committee Direction from Health Oregon Act (SB 329) and ORS on Eligibility**
- **Development of Committee Recommendations on Affordability**
- **Next Meeting Agendas and Objectives**
- **Public Testimony**

Chair **I. Call to Order, Approval of December 11 Meeting Minutes/Introduction of new members.**

- There is a quorum.
- Review and Approval of January 23 meeting minutes.

Tina Edlund **II. Update on Oregon Health Fund Board and Committee Activities**

- Information on upcoming OHFB meeting on February 19 was provided.
- Recommendations from the E & E Committee and Health Equities Committee will be presented at the meeting.

Chair and Vice Chair **III. Approval of Affordability Recommendations to the Oregon Health Fund Board (OHFB) (See Exhibit Materials B)**

- Changes from last meeting were incorporated and presented.

- Information recently submitted by Committee member Eric Metcalf regarding concerns related to Indian Health programs was discussed. The Committee will review this material for further discussion at the next meeting.
- Changes to Executive Summary include:
  - **Page 3 -** Change "crowd-out" definition wording from "private coverage to public coverage" to "private funds to public funds."
  - Delete the word "document" from last sentence, first paragraph.
- **Page 5 –** Committee Recommendations
  - Benefits Committee – concern about terminology recommending no co-pays for some areas. Change to "low or no co-pays."
  - Finance Committee - remove the word "requirement" from first sentence and add participation to read "employer contribution and participation," as it has federal fund implications.
  - Employer contributions as a requirement and as a Federal Laws Committee (FLC) issue is discussed and will be sent to FLC as a recommendation.
  - Delivery Systems Committee – Add sentence reflecting "primary care model" as a way to improve outcomes and contain costs.
- **Page 4 –** Changes to wording surrounding tax recommendations.
- **Page 10 – "Equity" heading -** Delete last sentence that refers to "urban vs. rural Oregon" per agreement at last meeting.

Motion to adopt Affordability Recommendations to the Board as amended is **seconded**.

Discussion

- **Page 4 –** Review of household gross income and Federal Poverty Level (FPL) percentages.
- Discussion of number of Oregonians that would additionally be covered and the financial implications.
- It was noted that dissenting opinions expressed in the document.
- Chair Lowe will be presenting the document to the Board and related that she will use the *"frame of reference"* reflected by the members as well as the range of opinions expressed.

Call for the question. Motion passed unanimously.

Chair and Vice Chair

IV. Overview of Committee Direction from Health Oregon Act (SB 329) and ORS on Eligibility

Deferred to next meeting.

Carole Romm and Vice Chair

V. Review of Medicaid Advisory Committee (MAC) Eligibility Recommendations (See Exhibit Materials F)

Member Romm outlined recommendations to the Committee as directed by the Governor. Discussion of Medicaid terminology, including assumptive eligibility, timeline for eligibility recommendation and information for model input.

Heidi Allen

VI. Presentation of Health Equities Committee (HEC) Recommendations on Eligibility (See Exhibit Materials G)

Staff to the HEC provided background information and presented recommendations to the E & E Committee**.**

- Discussion on immigrant populations, undocumented workers, and audit performed by State revealing that most Medicaid enrollees are legally eligible for funds.
- Birth certificate requirement discussed.
- Terminology regarding immigrants and undocumented workers and employer perspectives.
- Concerns about accurate reporting of immigrants and/or undocumented workers and California's response allowing exemption if health services are offered on location.
- Agriculture businesses often hire companies, not individuals.
- Discussion on a separate pool for immigrant workers, obtaining data on workers with visas, and allocating funds based on percentage of a large pool rather than creating a separate pool.
- What are the implications for small agricultural businesses?
- What is the cost of ineligibility and where does that cost end up? Data may be obtained through CAWEM.
- Documentation requirements and cost shifting effects on Native American clinics.
- Heidi Allen related information about the future development of a blog by the Northwest Health Foundation to provide an avenue for public input concerning health care needs. It will be read by staff routinely.

Chair and Vice Chair **VII. Developing Consensus: Eligibility Recommendations (See Exhibit Materials H)**

- Staff reviewed possible questions and issues to initiate discussion on eligibility for next meeting, urging members to forward any additional questions to staff.

Chair **VIII. Next Meeting Agendas and Objectives**

- Discussion about the need for this information to be input into the model being developed.
- How will the high risk pool be part of the future?
- It was suggested that there is a need to overview current system.

Chair **IX. Public Testimony**

No public testimony was offered.

Chair **X. Adjourn**

The meeting was adjourned at 12:01 p.m.

Next meeting is February 26, 2008.

EXHIBIT MATERIALS:

A. January 23 Meeting Minutes
B. Eligibility and Enrollment Committee Affordability Recommendations
C. Overview of Committee Assumptions and Direction on Eligibility
D. Definitions of "Oregon Resident" in ORS and OAR
E. Fact Sheet RE Immigration Status and Public Health Care Coverage
F. Medicaid Advisory Committee Recommendations on Eligibility
G. Health Equities Committee Recommendations on Eligibility
H. Developing Consensus Document

TENTATIVE WORKPLAN FOR ENROLLMENT AND ELIGIBILITY COMMITTEE

February 26th 9am-12pm Oregon State Library Room 103

TOPIC: ELIGIBILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review of minutes from last meeting
- Articulate principles/values underlying eligibility
- Action Items: Begin development of eligibility recommendations, including waiting periods, pre-existing conditions (what does this mean in a guaranteed issue world?) and populations excluded
- Public input

March 11th 9am-12pm, Clackamas Community College Room 111

TOPIC: OUTREACH, APPLICATION, & ENROLLMENT PROCEDURES

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of eligibility recommendations.
- Review of MAC recommendations regarding outreach
- Review of Health Equities Committee recommendations concerning outreach
- Review of staff documents/outreach “best practices”
- Development of recommendations for outreach
- Review of MAC recommendations regarding application, enrollment procedures
- Review of staff documents/experiences in other states
- Development of application, enrollment recommendations including a standardized application process, standards for disenrollment and changing enrollment
- Public input

April 8th 2-5pm, Clackamas Community College Room 111

TOPIC: PORTABILITY

- Standing Agenda Items
    - Update on OHFB and other committees

    - Review a of minutes from last meeting
- Review and approval of application, enrollment recommendations.
- Review of staff documents/experiences in other states
- Development of recommendations around portability
- Public input

April 23rd 2-5pm Mt. Mazama Room

TOPIC: CONSENSUS DOCUMENT

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of all Committee recommendations.
- Review of draft set of recommendations to forward to the Health Fund Board
- Public input

Eligibility and Enrollment Committee
Overview of Eligibility Assumptions and Directions
February 13, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the eligibility requirements in a new Oregon Health Fund program.

What guidance do we have from SB 329?

1. In Section 3, (1), SB 329 states the following as one of its principles:

   Expanding access. The state Medicaid program, Oregon SCHIP, and FHIAP must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

2. In Section 4, (1), the bill further states:

   As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon SCHIP and FHIAP programs.

3. Section 4, (5), Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
4. Section 9 (2) (d) (B) (ii) states, "Requirements to ensure that enrollees demonstrate Oregon residency."
5. Section 12 (2) indicates that the Board cannot require residents to enroll in the Oregon Health Fund program who are already enrolled in:
   a) Commercial health insurance plans
   b) Self-insured programs
   c) Health plans funded by a Taft-Hartley Trust
   d) State or local government health insurance pools

SB 329 directs the Oregon Health Fund Board to develop the structures and policies necessary to ensure that all Oregonians have access to a defined set of essential health services within a reformed delivery system.

SB 329 does not direct the Oregon Health Fund Board to create a single payer system to replace employer and other sources of insurance. Rather the Board is to create the environment for health delivery reform through an approach integrating public and private delivery systems. The primary mechanisms for providing this leadership include:

1) Creating a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable insurance;
2) Designing insurance products based on the defined essential benefit package;
3) Ensuring a network of accountable health plans (AHPs) contracting with the state to administer the benefit package; and,
4) Creating a new public/private vehicle for organizing and furthering quality and transparency in the current system.

What assumptions have been indicated (as of January 2008) by the Oregon Health Fund Board and its Committees about comprehensive reform?

1) An individual mandate that requires all Oregon residents to have health insurance coverage;
2) Guaranteed issue and renewability with no pre-existing limitation;
3) State contributions at a sliding scale of income to make health coverage more affordable for individuals and families;
4) A mandate that employers provide health insurance coverage to their employees; and,
5) A new health insurance exchange that will include the Oregon Health Fund Program as well as providing a central forum for individuals and businesses to purchase health insurance coverage.

What are the citizenship requirements for the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP)?

U.S. citizenship and immigration policy for OHP and FHIAP is driven by federal regulation as both are a federal-state partnership through Medicaid and the State Children's Health Insurance Program (SCHIP). Prior to the Deficit Reduction Act of 2005 (DRA), an applicant for Medicaid and SCHIP had to declare, under penalty of perjury, legal immigrant status or U.S. citizenship to qualify for Medicaid and SCHIP benefits. No verification was required for citizenship, unless questionable. With passage of the DRA, U.S. citizenship and identity must now be verified using specific documents from a list of acceptable documentation developed by the federal government.

Legal immigration status is verified to determine if the individual meets the required immigrant status for Medicaid and SCHIP benefits. Documents issued by Homeland Security are verified through SAVE, an immigration status verification system. Once an individual has been in the country for five years with Legal Permanent Resident (LPR) status, or meets asylee or refugee status, they may receive Medicaid and SCHIP benefits if otherwise eligible, per federal regulations.

What are the new standards set forth in Executive Order 07-22 regarding Oregon drivers' licenses and identification cards?

In February 2008, the Oregon Transportation Commission adopted requirements set forth in executive order 07-22 that require driver's license and identification card applicants need a legitimate Social Security number, a U.S. passport or a foreign passport with U.S. immigration documentation.

What are the Oregon residency requirements for eligibility in OHP and FHIAP?

A statement of intent to reside in Oregon is sufficient for residency. OHP and FHIAP residency requirements are driven by federal regulations, directing that the State of

residency for a Medicaid or SCHIP applicant is the State where the individual is living with the intent to remain for an indefinite period of time, or the State they entered with a job commitment or seeking employment. The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.

Are there other state programs that treat residency differently?

Oregon's Board of Higher Education authorizes Oregon University System institutions to classify students as residents and nonresidents for the purposes of admission and instructional fee assessment. Nonresidents enrolled at these institutions (with the notable exception of state reciprocal agreements such as with Washington) pay the nonresident instructional fee.

The following factors, although not necessarily conclusive or exclusive, have probative value in support of a claim for Oregon resident classification:

1) Reside in Oregon for 12 consecutive months prior to the beginning of the term for which resident classification is sought and during that period be primarily engaged in activities other than those of a college student;
2) Reliance upon Oregon resources for financial support;
3) Domicile in Oregon of persons legally responsible for the student;
4) Acceptance of an offer of permanent employment in Oregon; and
5) Ownership by the person of his or her living quarters in Oregon.

Are there any potential legal problems in limiting subsidies based on length of residency?

In 1992, California enacted a statute limiting the maximum welfare benefits available to newly arrived residents. The scheme limits the amount payable to a family that has resided in the State for less than 12 months to the amount payable by the State of the family's prior residence. This law was challenged and overturned by the United States Supreme Court in 1999 with the case of Saenz v. Roe. In the ruling the court barred states from limiting welfare benefits on the basis on length of residency. In the majority opinion, Justice Stevens wrote,

> What is at issue in this case, then, is this third aspect of the right to travel, the right of the newly arrived citizen to the same privileges and immunities enjoyed by other citizens of the same State. That right is protected not only by the new arrival's status as a state citizen, but also by her status as a citizen of the United States. That additional source of protection is plainly identified in the opening words of the 14th Amendment: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States."

Excerpts of Oregon Law and Administrative Rule Pertaining to Eligibility and Residency

OREGON REVISED STATUTES, 2005 EDITION
Chapter 735 — OFFICE OF PRIVATE HEALTH PARTNERSHIPS
(Family Health Insurance Assistance Program)

ORS 735.720 Definitions for ORS 735.720 to 735.740:

(2) "Eligible individual" means an individual who:

(a) Is a resident of the State of Oregon;

(b) Is not eligible for Medicare;

(c) Either has been without health benefit plan coverage for a period of time established by the Office of Private Health Partnerships, or meets exception criteria established by the office;

(d) Except as otherwise provided by the office, has family income less than 200 percent of the federal poverty level;

(e) Has investments and savings less than the limit established by the office; and

(f) Meets other eligibility criteria established by the office.

(8) "Resident" means an individual who meets the residency requirements established by rule by the office.

OREGON ADMINISTRATIVE RULES, 2008 EDITION
Chapter 442— OFFICE OF PRIVATE HEALTH PARTNERSHIPS
(Family Health Insurance Assistance Program)

OAR 442-005-0010

Eligibility

In order for an applicant to qualify for a FHIAP subsidy, applicants must:

(1) Be a resident of Oregon or a full-time college student with a parent who is a resident of Oregon.

(2) Be a United States citizen or a qualified non-citizen who meets the alien status requirement.

(3) Not be eligible for or receiving Medicare benefits.

(4) Have investments and savings that are available of no more than $10,000 on the last day of the month prior to the month the application is signed. Investments and Savings are not available if owned by or a beneficial interest in them is held by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for the purposes of this subsection (4).

(5) Have income of less than 185% of the Federal Poverty Level in effect at the time of determination. Income determination is outlined in OAR 442-005-0070.

(6) Meet one of the statutory definitions of family in ORS 735.720(2) at the time of eligibility determination. To be included in the family size for FHIAP eligibility determination, the applicant's family members must meet the definition of dependent under OAR 442-005-0010(8):

(a) A dependent may be counted in two separate households for the purposes of determining eligibility for FHIAP and any other state assistance program;

(b) A dependent may be counted in two separate households for the purpose of determining eligibility for both families in FHIAP;

(c) A dependent may not be enrolled in FHIAP and OHP (or any other state medical assistance program) at the same time;

(d) A dependent may be enrolled in FHIAP and any other state assistance program (except medical) at the same time;

(e) If a dependent is counted in two separate households for the purpose of determining eligibility in two different assistance programs, enrollment will be determined by criteria established in procedure.

(7) Meet either a period of uninsurance requirement or exceptions listed in OAR 442-005-0060.

(8) Not be incarcerated for more than 30 days or be a ward of the State.

(9) Provide necessary materials in order to allow for eligibility determination. If information submitted is inconsistent, and applicant may be denied.

(10) If applying for subsidy in the group market, must be able to enroll in a group insurance plan that meets the benchmark standard established by the Office within twelve months of eligibility determination. If an applicant to the group market does not have access to a group plan, the group plan they have access to does not meet the benchmark standard, or they cannot enroll into their group plan within twelve months of eligibility determination, the applicant will be denied and placed on the reservation list for an individual subsidy using the same date they were placed on the group reservation list.

Definitions

(1) "Alien Status Requirement." A qualified non-citizen meets the alien status requirement for FHIAP if the individual is one of the following:

(a) A person who was admitted as a qualified non-citizen on or before August 22, 1996;

(b) A person who entered the U.S. on or after August 22, 1996 and it has been five years since he or she became a qualified non-citizen;

(c) A person who has obtained their qualified non-citizen status less than five years ago, but entered the U.S. prior to August 22, 1996. The non-citizen must show that he or she has been living in the U.S. continuously for five years from a date prior to August 22, 1996 to the date the non-citizen obtained their qualified status and did not leave during that five year period. If the non-citizen cannot establish the five-year continuous residence before he or she obtained their qualified status, the person is not considered to have entered the U.S. prior to August 22, 1996;

(d) Regardless when they were admitted, a person with one of the following designated statuses:

(A) A person who is admitted as a refugee under section 207 of the INA;

(B) A person who is granted asylum under section 208 of the INA;

(C) A person whose deportation is being withheld under section 243(h) of the INA;

(D) A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;

(E) A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988;

(F) A person who is a victim of a severe form of trafficking.

(e) Regardless of when they were admitted, a qualified non-citizen who is:

(A) A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or

(B) On active duty in the U.S. Armed Forces (other than active duty for training);

(C) The spouse or unmarried dependent child of the veteran or person on active duty described in (e)(A) and (B).

(f) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

(g) A member of an Indian tribe (as described in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(h) Any legal non-citizen who was approved for a FHIAP subsidy prior to November 1, 2004.

(22) "Qualified non-citizen" for the purposes of FHIAP. A person is a "qualified non-citizen" if he or she is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq);

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1523(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980;

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980);

(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the United States Immigration and Naturalization Service;

(i) American Indians born in Canada to whom the provision of section 289 of the INA (8 U.S.C. 1359) apply;

(j) Members of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(k) A veteran of the U.S. Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty requirements described in 38 U.S.C. ¶ 5303A(d);

(l) A member of the U.S. Armed Forces on active duty (other than active duty for training);

(m) The spouse or dependent child of a person described in either (k) or (l) above;

(n) A legal non-citizen approved for FHIAP subsidy prior to November 1, 2004.

(25) "Resident" means a citizen or qualified non-citizen who resides in Oregon or a full-time college student who is a citizen or qualified non-citizen with a parent who resides in Oregon.

Chapter 316 — Personal Income Tax

316.027 "Resident" defined. (1) For purposes of this chapter, unless the context requires otherwise:

(a) "Resident" or "resident of this state" means:

(A) An individual who is domiciled in this state unless the individual:

(i) Maintains no permanent place of abode in this state;

(ii) Does maintain a permanent place of abode elsewhere; and

(iii) Spends in the aggregate not more than 30 days in the taxable year in this state; or

(B) An individual who is not domiciled in this state but maintains a permanent place of abode in this state and spends in the aggregate more than 200 days of the taxable year in this state unless the individual proves that the individual is in the state only for a temporary or transitory purpose.

(b) "Resident" or "resident of this state" does not include:

(A) An individual who is a qualified individual under section 911(d)(1) of the Internal Revenue Code for the tax year;

(B) A spouse of a qualified individual under section 911(d)(1) of the Internal Revenue Code, if the spouse has a principal place of abode for the tax year that is not located in this state; or

(C) A resident alien under section 7701(b) of the Internal Revenue Code who would be considered a qualified individual under section 911(d)(1) of the Internal Revenue Code if the resident alien were a citizen of the United States.

(2) For purposes of subsection (1)(a)(B) of this section, a fraction of a calendar day shall be counted as a whole day. [1969 c.493 §8; 1987 c.158 §49; 1995 c.79 §165; 1999 c.1096 §1]

OREGON REVISED STATUTES, 2005 EDITION

Chapter 428 — Nonresident Persons With Mental Disabilities

OBLIGATIONS CONCERNING NONRESIDENT PERSONS WITH MENTAL DISABILITIES

428.205 Declaration of policy. It is declared to be the policy and intent of the Legislative Assembly that whenever a person physically present in the State of Oregon is in need of

institutionalization by reason of mental illness or mental deficiency, the person shall be eligible for care and treatment in an institution of the State of Oregon irrespective of the residence of the person, settlement or citizenship qualifications. [1975 c.155 §2]

428.210 Definitions for ORS 428.210 to 428.270. As used in ORS 428.210 to 428.270:

(3) "Nonresident" means any person who is not a resident of this state as defined in subsection (6) of this section.

(6) "Resident of this state" means a person who has lived in this state continuously for a period of one year and who has not acquired legal residence in any other state by living continuously therein for at least one year subsequent to the residence of the person in this state. However, a service man or woman on active duty in the Armed Forces of the United States who was domiciled in Oregon upon entry into active duty and who has acquired no other domicile shall be entitled to have his or her children considered a resident of this state so long as no other domicile is acquired by the service man or woman.

OREGON ADMINISTRATIVE RULES, 2008 EDITION

OREGON UNIVERSITY SYSTEM

580-010-0030 Determination of Residence

(1) For purposes of admission and instruction fee assessment, OUS institutions shall classify a student as Oregon resident or nonresident. In determining resident or nonresident classification, the primary issue is a person's intent in coming to Oregon. Intent is inferred from a person's conduct and history as they relate to the requirements of these residency rules. If a person is in Oregon primarily for the purpose of obtaining an education, that person will be considered a nonresident. It is possible for an individual to qualify as a resident of Oregon for purposes of voting or obtaining an Oregon driver's license and not meet the residency requirements established by these rules.

(2) An Oregon resident is a financially independent person who, prior to the term for which Oregon resident classification is requested, has both: (a) established and maintained a domicile in Oregon as provided under OAR 580-010-0029(1) 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

(3) A student may be considered primarily engaged in educational activities regardless of the number of hours for which the student is enrolled. However, a student who is enrolled for more than 8 hours in any semester or quarter during the 12-month period referred to in section (2) of this rule shall be presumed to be in Oregon for primarily educational purposes. Such period of enrollment shall not be counted toward the establishment of a bona fide domicile of 12 consecutive months in this state unless the student proves, in fact, establishment of a bona fide domicile in this state primarily for purposes other than educational.

(4) An Oregon resident is also a financially dependent person who is claimed as a dependent by another person who has both: (a) established and maintained an Oregon domicile as provided under OAR 580-010-0029(1) for 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

(5) A financially dependent person who is claimed as a dependent by another person who has not established and maintained an Oregon domicile shall be presumed to be a non-resident. This

presumption may be overcome by evidence of the student's long-standing presence in Oregon and demonstration of other factors under OAR 580-010-0031.

(6) The criteria for determining Oregon resident classification shall also be used to determine whether a person who has moved from Oregon has established a non-Oregon residence.

(7) If institution records show that the residence of a student or the person upon whom the student is dependent is outside of Oregon, the student shall continue to be classified as a nonresident until entitlement to resident classification is shown. The burden of showing that the residence classification should be changed is on the student requesting the change.

(8) Notwithstanding section (4) of this rule, a student who is financially dependent on a non-Oregon resident may nonetheless be considered an Oregon resident if the student resides in Oregon for at least 12 consecutive months with a parent or legal guardian who has both: (a) established and maintained an Oregon domicile under OAR 580-010-0029(1) for 12 consecutive months; and (b) during that period, has been primarily engaged in activities other than those of being a college student.

580-010-0031 Residency Consideration Factors

(1) The following factors, although not necessarily conclusive or exclusive, have probative value in support of a claim for Oregon resident classification:

(a) Reside in Oregon for 12 consecutive months prior to the beginning of the term for which resident classification is sought and during that period be primarily engaged in activities other than those of a college student;

(b) Reliance upon Oregon resources for financial support;

(c) Domicile in Oregon of persons legally responsible for the student;

(d) Acceptance of an offer of permanent employment in Oregon; and

(e) Ownership by the person of his or her living quarters in Oregon.

(2) The following factors, standing alone, do not constitute sufficient evidence to effect classification as an Oregon resident:

(a) Voting or registration to vote;

(b) Employment in any position normally filled by a student;

(c) The lease of living quarters;

(d) Admission to a licensed practicing profession in Oregon;

(e) Automobile registration;

(f) Public records, for example, birth and marriage records, Oregon driver's license;

(g) Continuous presence in Oregon during periods when not enrolled in school;

(h) Ownership of property in Oregon or the payment of Oregon income or other Oregon taxes; or

(i) Domicile in Oregon of the student's spouse;.

(3) Reliance upon non-Oregon resources for financial support is an inference of residency in another state.

FACT SHEET ABOUT IMMIGRATION STATUS AND PERSONAL HEALTH CARE COVERAGE

submitted to the Equities Committee of the Oregon Health Fund Board
by Tina Castañares, MD 12/17/07

Disclaimer: *I'm not a trained expert in this field, so the "salient points" I've chosen to send you here should be checked with those who are such experts for accuracy before any policy recommendations might draw on them.*

- Unauthorized aliens (the federal term of art for people often referred to elsewhere as "undocumented workers," "illegal immigrants," and other such terms) have always been excluded from eligibility for federally-sponsored public health insurance (Medicaid, Medicare, and SHCIP). Exceptions are Alien-Waived Emergency Medicaid (called CAWEM in Oregon and some other states) and, in some states, certain uses of state-only Medicaid- or SCHIP-administered funds. Sometimes such latter exceptions have included prenatal care, HIV/AIDS care, hospice care, children's insurance, and other services. However, Oregon has not, in general, made such investments.

- H2A-program (agricultural guestworker) participants are not granted any exceptions to these exclusions. Interest in the H2A program is growing among Oregon farmers due to recent and projected labor shortages.

- No distinctions between naturalized and native-born citizens have ever been applied to date for eligibility for public health insurance. "Citizens are citizens."

- Lawful permanent residents (immigrants with "green cards"), prior to 1996, were eligible for public health insurance on the same basis as citizens.

- In 1996, the "Personal Responsibility Act" (Welfare Reform), spearheaded by the Clinton administration and enacted into law by Congress, for the first time distinguished lawful permanent residents from citizens by barring LPRs from eligibility from certain public programs, including public health insurance, until they had been lawfully present in the USA for no fewer than 5 years. States were given the option of making this bar longer or permanent. The 5-year bar was adopted and remains in effect in Oregon for Medicaid and SCHIP. The federal government applies it for Medicare.

- Thus, not only unauthorized aliens but also hundreds of thousands of lawfully present immigrants nationally, who would meet other eligibility criteria for Medicaid and SCHIP, are currently ineligible due to their not yet having reached 5 years of legal residency.

- Medicare eligibility is similar. Only after five years from legal entry may a lawful permanent resident who meets age and/or disability criteria be eligible for Medicare. If s/he has worked 40 qualifying quarters paying into the U.S. Social Security system, free Medicare benefits have parity with those of citizens. Certain family members are

allowed to contribute their own qualifying quarters to meet this criterion. If the criterion is not met, benefits are available for a privately paid monthly premium. In other words, such lawful permanent residents may "buy in" to Medicare after their 5-year bar.

- Efforts to restore intake and enrollment in Medicaid to pre-2004 processes are desirable because new requirements for proof of citizenship, nativity, or lawful immigration status have been demonstrated to deny eligibility to many US citizens, among others. However, success on this front alone will not address immigrants' great losses to eligibilty since 1996, nor the 20th-21st century US cultural denial of most public benefits to unauthorized aliens. (Public K-12 schooling is a notable exception, and there are others with less economic impact.) Certain other "first world" countries also deny benefits like we do, but many do not. Those who do not tend to cite cultural/ethical values (equity) and public health rationales for their investments.

- Emergency Medicaid (CAWEM) is, essentially, very restrictive hospitalization coverage for people who would be otherwise eligible for Medicaid were it not for their immigration status (unauthorized, or before passage of their 5-year ban). CAWEM can pay for life-saving or life-stabilizing treatment of serious medical conditions in a hospital setting. Obstetrical delivery is covered. All outpatient care and long-term care are excluded, with the exception of Emergency Department services meeting the serious/lifesaving sorts of criteria. Among specific services excluded are: outpatient medication coverage; cancer chemotherapy; hemodialysis; hospice or palliative care; rehabilitation services; durable medical equipment; sterilizations; prenatal care; scheduled (non-emergent) labs and imaging; primary care; non-emergent specialty consultation; home health care; and more.

- For unauthorized aliens and for lawful permanent residents (and those applicants "in process") who have not yet been legally present in the US for 5+ years, the availability of CAWEM for many hospital-based needed services means that their greatest gap in coverage is arguably for primary care.

  This observation is relevant to the Health Fund Board's committees' deliberations on benefit package, financing, eligibility and the delivery system. The Delivery System committee, in particular, is examining how it might support and enhance the primary care home concept. Efforts to create privately subsidized insurance plans for group or individual market s-- available to low-income workers who are not eligible for public insurance (for whatever reason) and who do not have commercial insurance provided by their employers – might well consider designing such plans to focus on services provided at or arranged by primary care homes. As for foreign-born Oregonians who could benefit from such plans, most now obtain outpatient services in the safety net system. Taking care to ensure adequate coverage/ compensation for safety net providers is obviously vital to the success of a new effort. I would add that ensuring coverage for services provided by trained Community Health Workers, who are likeliest to speak the relevant foreign languages and be effective in multicultural settings, is also vital. Such coverage does not, for the most part, exist today in public or commercial insurance plans.

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. The MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) to establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee," that is comprised, but not limited to the membership of the MAC. Additionally, the MAC is also required to present reports containing data and recommendations to the Committee as well as the Governor and Legislature on eligibility and enrollment.

The following is a series of eligibility recommendations and future considerations that the MAC has issued to the Eligibility and Enrollment Committee to consider in its deliberations on comprehensive health care reform.

Recommendations Concerning Eligibility

1. **All uninsured individuals and families should be able to participate.**
2. **Families should be kept intact programmatically.**
3. **Establish presumptive eligibility for all uninsured Oregonians.**
4. **There should be no requirement of a period of uninsurance to participate.**
5. **There should be no pre-existing condition limitations.**
6. **Open period of enrollment for changes of coverage or subsidies every 12 months.**
7. **Income limitations and/or asset testing should not apply in determining eligibility.**

Future Considerations

- *Determine the cost-benefit of covering all Oregonians regardless of citizenship in terms of uncompensated care, the cost-shift, public health, emergency preparedness, and the dignity and worth of every individual.*
- *For special populations, consider utilizing federal funds that allow retroactive eligibility to three months prior to the date of service (date stamp).*

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*

- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:

- Oregon Health Fund Program would not be "universal" in that low-income non-qualified Oregon residents excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:

- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:

- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:

- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,

- The “play or pay” amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

Eligibility and Enrollment Committee
Development of Eligibility Recommendations
February 13, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the eligibility requirements in a new Oregon Health Fund program.

Residency and Citizenship
What is an Oregon resident?

Will there be a residency waiting period? (i.e., requiring that someone is a legal resident for x months before they are eligible for the state subsidy?).

How will non-citizens be treated?

Period of eligibility
How long is the period of eligibility?

Interplay of OHFB and ESI
What about individuals who are eligible for ESI, but haven't taken it up?

How will we treat people who have ESI, but are eligible on the basis of income, for Medicaid?

How will we treat people who are in their waiting periods for ESI?

How will we treat people who have ESI and currently pay the employee share on their own? Do we provide a state contribution to this group? Or do we build a firewall between this group and state contribution?

Expansion of eligibility for public programs
Expansion of eligibility for public programs (OHP, e.g., adults to 200% FPL, children to 300%?) Expansion of Medicaid Buy-In program for the working disabled?

Recommendations around auto-enrollment? Presumptive eligibility? Retroactive eligibility?

Accountability?
How do we ensure that these tax-supported services are provided only to those who are eligible?

Do we recommend that penalties be put in place in cases where people try to collect benefits for deceased persons, under fraudulent ID's, for non-residents?

Consumer Protections?

Possibly some recommendations about consumer protections -- Colorado is recommending the creation of an independent Consumer Advocacy organization that can specifically help residents with denials and support local community efforts to get people enrolled. (This could be included here as well as with our enrollment recommendations?)

Eligibility and Enrollment Committee
Eligibility Strawperson
February 26, 2008

1. **<u>Employer-sponsored insurance</u>: The Oregon Health Fund Board should adopt eligibility policies for the Oregon Health Fund Program that maximize health coverage and encourage the maintenance of employer contributions. There are three distinct policy options to consider for the implementation of this objective, they include:**
    a) **Firewall—an exclusion of those offered or have employer-sponsored insurance (ESI);**
    b) **Vouchers—allow employees to come into the pool with employer dollars; and,**
    c) **Premium assistance—combining employer contributions with state contributions.**

    <u>Rationale</u>
    - For the Oregon Health Fund Program to achieve fiscal sustainability it is important that employers continue to contribute to their employees' health insurance costs and therefore the Oregon Health Fund Board should safeguard against employees dropping employer contribution in favor of a state contribution.
    - The option c above has the least appeal because if premium assistance is offered to low income populations most of those eligible already have coverage; those individuals who turn down employer contributions do not value that contribution; and, if you subsidize employee contributions for a sizeable share of employees, employers will raise employee contributions.

    <u>Supporting Data</u>
    - Among those who are offered ESI below 300% of poverty, the vast majority take it. Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 6%.[1]
    - The federal government spent between US$ 31,000 and 83,000 per person who was newly insured by the introduction of a premium subsidy policy.[2] This is much higher than simulations of the costs per newly insured from most other policies that are contemplated for insurance expansion.

2. **<u>Oregon residency:</u> A statement of intent to reside in Oregon is sufficient for residency requirements to be eligible for the Oregon Health Fund Program.**

[1] *Jonathan Gruber and Ebonya Washington, Subsidies to employee health insurance premiums and the health insurance market, Journal of Health Economics Volume 24, Issue 2, , March 2005, Pages 253-276.*
[2] *Ibid.*

Rationale

- The Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP). In addition, it is the expectation that everyone enroll in health insurance as soon as possible after arriving in the state.

Supporting Data

- The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.
- The United States Supreme Court ruling on Saenz v. Roe, 1999 barred states from limiting welfare benefits on the basis on length of residency.

Non-qualified Oregon residents: Mechanisms should be developed to provide this population coverage and/or access to health care services. It is a goal under health reform to minimize/eliminate the cost shift. To the extent that population sectors are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.

Supporting Data

- The bipartisan Independent Task Force on Immigration and America's Future by the Pew Hispanic Center estimates that in 2002-04 period, there were between 100,000 and 150,000 undocumented immigrants living in Oregon. It is likely that Oregon's undocumented immigrant population has increased since 2002-04.[3]

3. **Period of enrollment: Oregonians eligible for Oregon Health Fund Program should be enrolled for 12 continuous months.**

Rationale

- 12 months of enrollment is consistent with group coverage and many of these individuals and families will be covered through subsidized group coverage.
- Increasing the enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
- Less frequent recertification will result in administrative savings.

Supporting Data

- 12 months of enrollment is consistent with group coverage and many of these individuals and families will be covered through subsidized group coverage.

[3] http://www.migrationpolicy.org/ITFIAF/publications.php

4. **Presumptive eligibility: An applicant who initially appears to meet income, asset, and other program eligibility criteria would be automatically eligible for the program, upon application and, Oregon Health Fund payment of an estimated premium, and would have 60 days to submit required verifications. If required verification were not submitted within this time period, eligibility for the program would be terminated, but services billed for during the presumptive eligibility period would be paid.**

   Rationale

   - Oregon Health Fund Board goal is to cover everyone, minimize cost-shift. Delayed verification is an option under federal law that allows state Medicaid programs to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

5. **Period of uninsurance: Individuals and families will be required to enroll in health insurance within 30 days? 60 days?**

   Rationale

   - Goal of universal coverage
   - Requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain kids and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

6. **Assets: There should be no asset limit for shared contribution portion of the Oregon Health Fund Program.**

   Rationale

   - Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.
   - The availability of assets should not interfere with expanding health coverage to the uninsured since those resources could be depleted within days in the event of a serious illness or injury.
   - Removing the need to determine family assets will result in simplification and administrative savings.

   Supporting Data

   - 47 of 51 Medicaid programs in the country, including Oregon's, do not currently have an asset limit. However, Oregon is one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs[4].

[4] *Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.*

- An actuarial review performed by Mercer for the Healthy Kids Plan showed that the impact of deductibles and coinsurance can be substantial ($10,000 or more) on a family with more than one child requiring hospital or other expensive care.

7. **Health Status: In the interest of community rating as a policy objective, that all Oregonians be eligible to enroll in the Oregon Health Fund Program regardless of health status.**

    - However, it has been noted that there is a potential risk of adverse selection into the program by individuals with substantial health services needs with other health insurance options. Such adverse selection could threaten the sustainability of the program. Therefore, as a technical note, the Committee suggests that state agencies take suitable precautions to a) monitor for adverse selection into the pool, and b) if needed, apply a remedy to preserve the viability of the pool.

8. **Federal Matching Funds: For all components of the Oregon Health Fund Program the state should maximize the use of matching federal dollars available to Oregon.**

    Rationale

    - The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose.
    - Program sustainability is enhanced through this funding mechanism.

    Supporting Data

    - The Committee assumes that the Oregon Health Fund will have Title 19 and Title 21 funding for Oregonians up to 200% FPL for childless adults and parents and up to 300% FPL for children.

Oregon Health Fund Board

Eligibility and Enrollment Committee

Affordability Recommendations to the Board

February 13, 2008

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

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Advocate and Public Policy Consultant
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Jim Russell, Vice-Chair
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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program. In developing these recommendations, the Committee met six times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee's task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

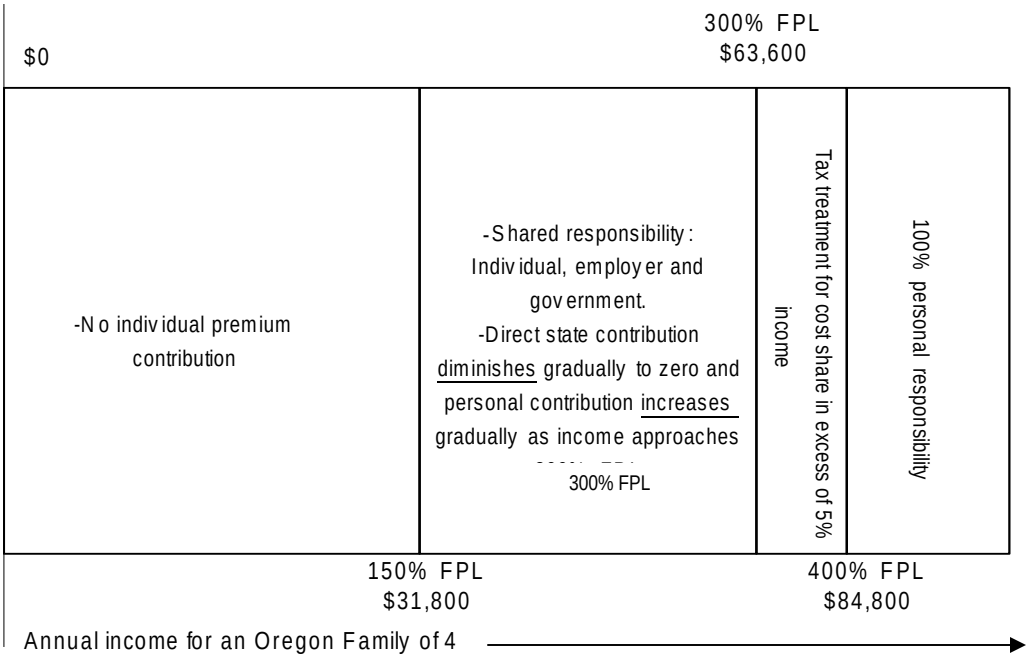
Increasing Annual Household Income →

No Personal Cost Share For Premium Below x% FPL?	Shared State, Individual, and Employer Responsibility Between x% and x% FPL?	100% Personal Responsibility—No State Participation Above x% FPL?

Affordability Recommendations

- For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- Structure the personal cost share to emphasize premiums over other types of cost sharing.
  - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
  - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability framework as recommended by the Eligibility and Enrollment Committee:



Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- Explore potential tax treatments for individuals between 300% and 400% FPL.
- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the six meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	**208,000**	**42%**	**46,000**	**40%**
150% to below 200%	**67,000**	**13%**	**29,000**	**25%**
200% to below 250%	60,000	12%	**10,000**	**9%**
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	**499,000**	100%	**114,000**	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance.*"[1]
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of

[1] Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at http://econ-www.mit.edu/files/128.

Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.*"[2]

- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, "*Impact of Copays on a Medicaid Population.*" *www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf*

Proposed Cost Sharing Structure Options

A. The first question addressed by the committee was: *At what income should a family reasonably be expected to share responsibility for premium cost?*

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

B. The second question addressed by the committee was: *At what income level should premium cost be 100% personal responsibility?*

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

[2] Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit ($15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty ($26,000 annual income for one person), while a few others felt that the state contribution should not phase out until 400% of federal poverty ($41,600 annual income for one person).

An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility

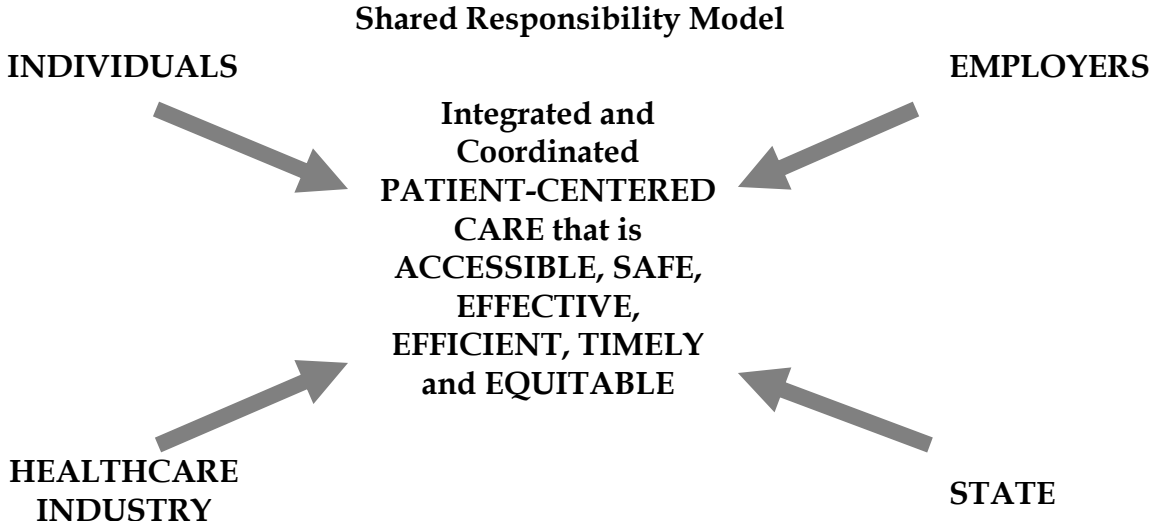
and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

> *We have to convince conservatives that they have a stake in the uninsured, and that costs can be controlled*
> And
> *We have to convince liberals that limits must be set, and that we can't do everything medical science has invented for everyone.*

Summary of Committee Comments

The following summarizes the committee comments leading to these recommendations to the Board:

Shared Responsibility. The committee felt that shared responsibility was the intersection between individuals, employers, the healthcare industry and the state.



First, individuals share responsibility in the affordability debate. As one member stated, "Although [there would be] (hopefully) small contributions from those at low income levels, they would still be participating early on." Members also felt that shared responsibility for the individual included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their healthcare and help reduce costs, too."

About employer responsibility, one member commented, "The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute."

Third, in discussing the responsibility of the health care industry, a member commented, "329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the 'essential' benefits

package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning $50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I … favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

Recommendations

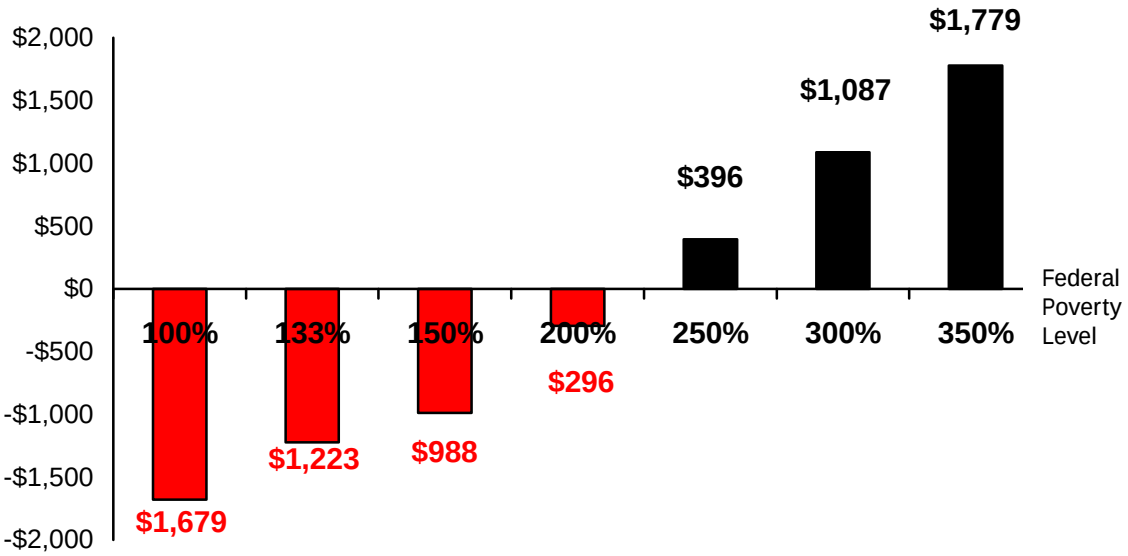
Recommendation #1: For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.

Proposal Overview

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute's review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee's recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee's review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family's income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



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

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when … out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums…is unknown, cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'." Another

member echoed the "administrative simplicity" sentiment by suggesting potentially simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation #2: Structure individual cost sharing to emphasize premiums over other types of cost sharing.

- **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
- **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee's approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of

the federal poverty level (FPL) or $53,000 annually for the Portland area, 200% of FPL or $42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL ($42,000) in the Portland area, 250% FPL ($35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level ($15,600 for an individual or $31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

Recommendation #3: Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them—Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #4: Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

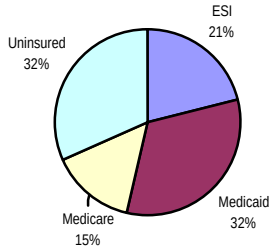
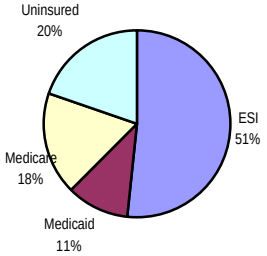
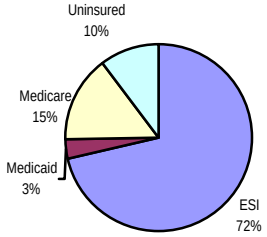
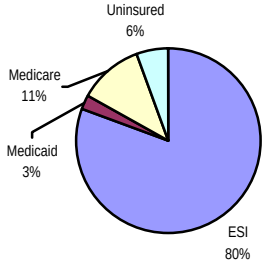
For the Finance Committee

- Explore potential tax treatments for individuals between 300% and 400% FPL.
- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
806,000 Oregonians	**1,032,000 Oregonians**	**513,000 Oregonians**	**1,311,000 Oregonians**
-550,000 insured (68%)	-828,000 insured (80%)	-458,000 insured (89%)	-1,211000 insured (93%)
-255,000 uninsured (32%)	-204,000 uninsured (20%)	-55,000 uninsured (11%)	-99,000 uninsured (7%)
Insurance source for < 150% FPL: 	Insurance source for 150% FPL to below 300% FPL: 	Insurance source for 300% FPL to below 400% FPL: 	Insurance source for 400% FPL and above: 

Data from CPS 2-year average, Data collected in 2006 and 2007.

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	$10,400	$15,600	$20,800	$26,000	$31,200	$36,400	$41,600
2	$14,000	$21,000	$28,000	$35,000	$42,000	$49,000	$56,000
3	$17,600	$26,400	$35,200	$44,000	$52,800	$61,600	$70,400
4	$21,200	$31,800	$42,400	$53,000	$63,600	$74,200	$84,800
5	$24,800	$37,200	$49,600	$62,000	$74,400	$86,800	$99,200
6	$28,400	$42,600	$56,800	$71,000	$85,200	$99,400	$113,600
Each add'tl person, add	$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Oregon
Theodore R. Kulongoski, Governor

Office for
Oregon Health Fund Board
General Services Building
1225 Ferry St. SE
1st Floor
Salem, OR 97301
(503) 373-1779
FAX (503) 378-5511

February 4, 2008

The Honorable Peter Courtney
Senate President
Oregon State Senate
State Capitol
Salem, Oregon 97301

The Honorable Jeff Merkley
Speaker of the House
Oregon House of Representatives
State Capitol
Salem, Oregon 97301

Dear President Courtney and Speaker Merkley:

The enclosed report, "Health Insurance Exchanges and Market Reform," was prepared pursuant to Senate Bill 329 (Chapter 697 Oregon Laws 2007) and is submitted to the Legislative Assembly on behalf of the Oregon Health Fund Board ("Board").

SB 329 directs the Board to present a plan for the design and implementation of a health insurance exchange. The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report describing the current work of the Board's Finance Committee and Exchange Work Group. Given the complexity of the issue and the time available since organizing the work of the Board, this report provides background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

I hope this report will be useful to the 2008 Legislative Assembly Special Session. An electronic version of the report will be available at the Board's website: www.healthfundboard.oregon.gov.

Sincerely,

Barney Speight
Director

HEALTH INSURANCE EXCHANGES AND MARKET REFORM

Introduction

This report to the 2008 Oregon State Legislative Assembly Special Session is prepared pursuant to Senate Bill 329 (Chapter 697, Oregon Laws 2007).

SB 329 directs the Oregon Health Fund Board ("Board") to present a plan for the design and implementation of a health insurance exchange ("exchange"). The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report, describing the *current* work of the Exchange Work Group and Finance Committee, rather than offering a set of recommendations from those groups.

As noted below, an exchange is one element, albeit an important one, of a comprehensive reform plan. Given the complexity of the issue and the time available since organizing the work of the Board, the objective of this report is to provide background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

Additionally, this report focuses primarily on a health insurance exchange in the context of reforms to the individual insurance market. Just as an exchange can have benefits for people seeking insurance in the individual market, it can also assist small employers and their employees. Once the Board develops the parameters for an exchange in the individual market, a second phase can more fully analyze the benefits and development issues of an exchange for the small group market.

Overview

An Important Element of Comprehensive Reform

With health insurance becoming increasingly inaccessible to millions of Americans, many states are exploring a wide range of options to bring their citizens into the health care system. Several jurisdictions are considering using a health insurance exchange to assist in reaching that goal.

Health insurance exchanges function as market organizers, facilitating the purchase of health insurance. Exchanges have the most obvious benefits for individuals without access to employer-sponsored coverage. In addition, they could also potentially serve segments of the business community that provide group health insurance to their employees.

Benefits of an Exchange

A health insurance exchange can offer a range of services with commensurate benefits. It can provide individuals with purchasing advantages similar to those of large groups. An exchange offers consumers an easy way to shop for and enroll in coverage. When combined with other

policy initiatives, it may also be used to extend tax advantages to individuals not enrolled in employer-sponsored plans. It offers access to continuous, portable coverage and provides a mechanism to aggregate premium contributions from multiple sources. An exchange simplifies administrative functions for users and can serve as a mechanism for administering public subsidies to low and moderate wage individuals and families. For small employer groups, an exchange can provide access to a larger range of plan options than are usually available to small groups. Lastly, an exchange can utilize value-based purchasing strategies that align with similar initiatives by state health care purchasing programs (e.g., Oregon Health Plan, Public Employees Benefits Board) and the private sector to improve the quality and efficiency of Oregon's delivery system.

Previous Attempts to Run Exchanges

Health insurance exchanges have existed in various forms over the years, including the Health Insurance Purchasing Cooperatives (HIPCs) of the early 1990s. Many HIPCs failed due to regulatory differences inside and outside of the cooperative. Where benefits, enrollment or other rules differed between the purchasing cooperative and the general market, HIPCs tended to attract higher cost, higher risk enrollees, creating a financially unsustainable situation.

Purchasing cooperatives often found it difficult to attract enough members to maximize efficiency and purchasing power. To increase membership, the cooperatives sometimes offered benefits that appealed especially to higher risk enrollees. Some HIPCs collapsed due to the financial losses associated with an "adverse selection spiral" in which expensive enrollees lead to higher premiums, causing lower risk enrollees to leave, further raising the proportion of high risk enrollees (and increasingly higher premiums).

The Massachusetts Connector

The most recent example of an operational health insurance exchange is the Commonwealth Health Insurance Connector Authority (the "Connector") in Massachusetts. The Connector was established as part of a comprehensive health reform initiative adopted by the Massachusetts legislature in 2006. The Connector is central to the Massachusetts market reforms and new public subsidy programs. The reforms include:

- An individual mandate;
- Merger of the individual and small group markets;
- Expansion of the state's Medicaid program; and
- Premium subsidies for low- and some moderate-income people.

The Connector administers public subsidies for health insurance premiums, and manages programs for both subsidized and non-subsidized purchasers.

The Connector administers two programs: Commonwealth Care and Commonwealth Choice. Uninsured individuals with incomes below 300% of the federal poverty level and no access to employer-sponsored coverage can access free or subsidized insurance through Commonwealth Care. For the first three years of the reform, only Medicaid-style plans run by groups that previously participated in the state's free care program may offer coverage to Commonwealth Care enrollees.

Commonwealth Choice offers access to non-subsidized commercial products for individuals with incomes above 300% FPL, as well as for small businesses. Commonwealth Choice plans are offered by insurance carriers participating in Massachusetts' commercial insurance market. Use of the Connector is voluntary, but it is the sole entry point to the health care system for individuals seeking public subsidies.

The Massachusetts reform includes an individual mandate. In order to comply with the mandate, all individuals must have health insurance that meets a minimum coverage benchmark. All plans offered through Connector meet the standard for "minimum creditable coverage".

The Connector offers a range of plan levels, with the most comprehensive, highest cost plans designated as "Gold" level. Silver plans are actuarially 80% of Gold plans, and Bronze plans are actuarially 60% of Gold. Bronze plans meet the minimum creditable coverage requirements. Within each level, all of the benefit plans are actuarially equivalent as well. Premium costs vary by plan level, with Gold plans costing the most. Bronze plans have the lowest premiums, but include higher cost-sharing for services. Young adults (up to age 26) may purchase either a Gold, Silver, or Bronze plan, or a "young adult" plan with reduced benefits, lower premiums and other differences in cost sharing, such as higher out-of-pocket limits and lower annual benefit limits.

The Oregon Market

While it is useful to understand the Massachusetts experience as Oregon considers options to increase access to affordable insurance for all Oregonians, the insurance markets in Oregon and Massachusetts differ. Due to these differences, Oregon should not simply import Massachusetts' design for a health insurance exchange. The Massachusetts experience in designing and implementing the Connector can be instructive, but not definitive for Oregon.

Oregon's Insurance Markets Differ from Those in Massachusetts

It is important to understand the similarities and differences between Massachusetts' individual and small group markets prior to reform and Oregon's current markets. First, the Massachusetts population is almost twice that of Oregon (in 2006, 6,437,193 versus 3,700,758). Massachusetts' pre-reform uninsurance rate was one of the lowest rates in the nation at 7% in 2006, compared to 16% in Oregon. Also, of the 500,000 individuals in Massachusetts that were uninsured prior to reform, 40% had incomes above 300% FPL, while in Oregon, only 25% have incomes at that level.[1] Thus, prior to its reforms, Massachusetts had both a lower uninsured rate, and of those who were uninsured, a larger percentage of the population had higher incomes. (See Appendix 2 for more on Oregon's uninsured by income.)

Before its reforms were implemented, Massachusetts' individual market was smaller and less robust than Oregon's. Prior to reform, Massachusetts had 42,500 enrollees (less than 1% of the state population) in its individual market, while Oregon's individual market has 218,000 participants (6% of the state population). Massachusetts' individual market was small and relatively expensive. This was a function of numerous regulations (including guaranteed issue

[1] In 2008, 100% of the federal poverty level is $17,600 for a family of three.

without an individual mandate) that caused premiums to be significantly more expensive than Oregon's, making it attractive to only those with significant health issues and discretionary income.

Compared to Massachusetts, Oregon has a relatively large individual market with high carrier participation. However, the market has an increasing rejection rate, and individuals who enter the individual insurance market do not bear much of the cost of covering enrollees in the high risk pool.

Prior to reform, Massachusetts had a 700,000-person small group market (11% of the state population), compared to Oregon's 283,000 people (8%). Massachusetts permitted "groups of one" to buy into the small group market while Oregon regulations defined the market as groups of 2 to 50 employees.

Looking at the relative combined size of the markets that might be included in an exchange, Oregon's market is larger than Massachusetts'. On a relative scale, a health insurance exchange could impact a larger percentage of Oregon's population than the Connector does in Massachusetts. (See Appendix 3 for more information on Oregon's individual and small group markets.)

Insurance Regulations

From a regulatory standpoint, Massachusetts differs from Oregon as well. Both before and after reform, Massachusetts had guaranteed issue and guaranteed renewability in both its individual and small group markets. "Guaranteed issue" means that any person who applies for health insurance must be issued coverage, without regard to the individual's health status. "Guaranteed renewability" requires that once an individual is covered, the insurer can not discontinue coverage due to the individual's health status or health care use. Oregon has guaranteed renewability in both markets but has guaranteed issue only in its small group market.

Both Massachusetts and Oregon have adjusted community rating in the individual market, with rating permitted by age. Community rating is a method of calculating health plan premiums that uses the average cost of actual or anticipated health services for all subscribers within a specific group. Adjusted community rating allows carriers to base a premium on an enrollee's geographic location, family composition, and age, but the medical claims history of an enrolled individual cannot be considered. A person at age 50 will pay more than a 25-year-old because of the higher average health care costs of the older group. A 25-year-old with high medical claims will pay the same as a healthy 25-year-old and less than a healthy 50-year-old.

Prior to its reform, Massachusetts had a 2:1 rate band in the individual market, meaning that the premium charged to an older individual could not be more than twice the premium for a younger individual. This, combined with guaranteed issue but no coverage mandate, led to high costs in the individual market. This combination also led some insurers to abandon the individual market, leaving fewer coverage choices for people seeking insurance there. As part of its reform, Massachusetts combined its individual and small group markets, with a 2:1 rate band for the new, combined market.

Unlike Massachusetts, Oregon does not have restricted age bands in the individual market; the premiums for each age range represent the actual average cost of health care of persons within the age band. In the small group market, however, starting in 2007, Oregon is phasing in rate bands of 3:1 based on geographic region, family composition, age and other factors. This means that the premium charged to the highest-cost group cannot be more than three times that charged for the lowest-cost group. As in the individual market, premiums paid by small groups are not based on the group's actual claims costs but on the average cost for groups with similar characteristics.

Massachusetts' design and implementation choices are worth considering, but given the differences in the market and regulatory environment in the two states, Oregon must approach these policy issues somewhat differently than Massachusetts. The characteristics of the Oregon market, along with information on key design and implementation factors of any exchange, must be considered in the development of an exchange in Oregon.

Role of an Exchange in Broader Reform

A health insurance exchange is a tool that works well in conjunction with other market reforms, but on its own it will not affect increased access for the uninsured. For an exchange to be effective, it should be accompanied by other key market reforms.[2] Several of these reforms form the backbone of the Oregon Health Fund Board's assumptions that underlie the group's work, including:

- Individuals must be required to have coverage (an "individual mandate"). Such a requirement ensures that healthy as well as sick people get insurance coverage. It also significantly alters the current individual market, which is voluntary. Compliance with an individual mandate would be enforced through incentives and penalties.
- Premium subsidies must make insurance premiums affordable for low and moderate income Oregonians. Subsidies paired with a mandate allow lower income individuals to acquire and retain coverage. In addition, the aggregate premium subsidies provided by the state for essential benefits must be sustainable.
- To assure that Oregonians can access insurance, the individual market must either implement guaranteed issue and renewability, or bolster the current high risk pool to allow it to absorb a large number of new enrollees. Without such changes, individuals with greater than average medical needs will not be able to comply with the mandate.

Underlying these market reforms is the assumption that consumers are offered a range of affordable plans with benefits that are attractive to them. An effective exchange will offer a choice of carriers and products, so that health plan offerings are affordable, consumer-valued and sustainable to the system's various payers.

---

[2] *A Consumer Guide to Creating a Health Insurance Connector*, Christine Barber and Michael Miller. Community Catalyst. July 2007.

In order to ensure affordability and that insurers participating in an exchange do not disproportionately enroll high cost individuals, any regulatory changes imposed must apply both inside and outside of the exchange. Mechanisms must be in place to protect insurers that do enroll high-risk members, such as risk adjustment formulas or reinsurance.

An effective health insurance exchange must offer meaningful choice of health plans within reasonable standardization of benefit offerings. The exchange must provide transparent information on cost, quality, and service for consumers. If implemented in conjunction with these reforms and guarantees, a health insurance exchange can be an important element of the state's comprehensive reform plan.

Exchange Work Group Efforts: Issue Identification and Exchange Options
Starting in November 2007, a Work Group of the Oregon Health Fund Board's Finance Committee has been discussing options for market reforms, goals for a potential health insurance exchange and key elements of such an exchange's structure, roles and functions.

The Work Group has identified a number of potential goals for an exchange:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.
- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Encourage Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency.

- **Encourage Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

While the work of the Exchange Work Group continues, the group has indicated that, of the 574,000 uninsured in Oregon, an exchange could assist an estimated 150,000 – 200,000 currently uninsured individuals who would enter the individual market as a result of an individual mandate and premium subsidies.[3] Toward this end, an exchange can enhance these consumers' ability to shop more effectively and efficiently for health coverage. An exchange could function at a number of levels in the individual insurance market.

Options for Exchange Functions

The following list outlines a range of exchange functions in three tiers: information, enrollment and administration; benchmarking and standard-setting; and rate negotiation and selective contracting. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

Tier 1: Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.
- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.

[3] Many of the currently uninsured will gain coverage through Medicaid or employer-sponsored coverage. An estimated 174,000 uninsured are below the federal poverty level and would be eligible for coverage through an expanded Medicaid program. For the uninsured at higher income levels, many would have access to coverage through their own or a family member's employer. Over 80% of employers offer insurance to at least some employees.

- Provide post-enrollment customer services, e.g., provide information, support, advocacy and referral for questions regarding benefit interpretation, claims payment and other issues.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

Tier 2: Benchmarking and Standards

- All of the functions listed in tier 1, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- Establish the role, functions and appropriate compensation for health insurance agents and brokers servicing the exchange and its customers.
- Innovate by contracting for complete packages of products and services from the carriers or allowing the exchange to contact separately for benefits or services that might better achieve benchmark performance.

[Note: All carriers that meet the benchmark standards could participate in the exchange.]

Tier 3: Rate Negotiation and Selective Contracting

- All of the functions listed in tiers 1 and 2, plus:
- Solicit bids or price proposals.
- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.

In addition, health care reforms will need to be enacted that address the following:

- Design mechanisms to protect insurers who enroll high-risk members both inside and outside of an exchange (for example, risk adjustment or reinsurance).
- Establish market regulations to avoid the exchange attracting a disproportionate number of high risk enrollees. The goal is to avoid an adverse risk spiral, in which enrollment of many high risk members increases plan costs, leading to a premiums increase, which chases away more low risk members, thereby again increasing costs and premiums until the program collapses.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.

The Exchange Work Group has identified the following issues as important to the development of a functional and sustainable exchange. The group is currently working on recommendations in these issue areas:

- Exchange Design
  - What should be its roles and functions?
  - Who may (or must) purchase through the exchange?
  - What entity should administer the exchange?
  - How will the costs of the exchange be funded?
  - What is the appropriate governance structure?
- Market Reform
  - Should medical screening be used to identify a high-risk pool for rating purposes?
  - How will the costs of high-risk enrollees be financed?
  - What mechanisms should be used to protect insurers from adverse risk selection?
  - How will rates and benefits be regulated?
  - How will the transition from the current market be managed to limit disruption to the existing market?
  - How can enrollment of different types of enrollees be phased in over time?
  - How will the individual mandate be enforced?

As the Exchange Work Group and the Finance Committee prepare recommendations for the Oregon Health Fund Board, they do so with the understanding that an exchange cannot be implemented in a vacuum. Without the appropriate complementary market reforms, no exchange will be viable over the long term.

List of Appendices

Appendix 1 Membership rosters of the Oregon Health Fund Board, Finance Committee and Exchange Work Group

Appendix 2 Uninsured Oregonians in 2006 by age and federal poverty level (2006)

Appendix 3 Individual and Small Group Market Shares, Oregon (2005)

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Oregon Health Fund Board

Bill Thorndike, Chair
President, Medford Fabrication

Jonathan Ater, Vice-Chair
Senior Partner, Ater Wynne LLP
Vice-Chair, Oregon Health Policy Commission

Eileen Brady
Co-Owner, New Seasons Market

Tom Chamberlain
President, Oregon AFL-CIO

Charles Hofmann, MD
Physician

Ray Miao
President, Oregon Chapter, AARP

Marcus Mundy
President, Urban League of Portland

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Finance Committee

Kerry Barnett, Chair
Executive Vice President
The Regence Group

John Worcester, Vice-Chair
Manager, Benefits and Compensation
Evraz Oregon Steel Mills

Andy Anderson
CFO & Senior Vice President
Cascade Corporation

Peter Bernardo, MD
Private Practice, General Surgery

Fred Bremner, DMD
Private Practice

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO, Lane Individual Practice Association, Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Jim Diegel
President and CEO
Cascade Healthcare

Steven Doty
President and Owner
Northwest Employee Benefits, Inc.

Laura Etherton
Advocate
Oregon State Public Interest Research Group

Cherry Harris
Labor Representative
International Union of Operating Engineers, Local 701

Denise Honzel
Healthcare Consultant
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission

David Hooff
Vice President, Finance
Northwest Health Foundation

John Lee
Consultant, Strategic Affairs
Providence Health Systems

Judy Muschamp
Tribal Health Director
Confederated Tribes of Siletz

Steve Sharp
Chairman of the Board
TriQuint Semiconductor, Inc.

Scott Sadler
Owner, The Arbor Cafe

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Exchange Work Group

Denise Honzel, Chair
Healthcare Consultant

Laura Etherton, Vice-Chair
Advocate
Oregon State Public Interest Research Group

Kerry Barnett
Executive Vice President
The Regence Group

Damian Brayko
Director, Small Group and Individual
Kaiser Permanente Northwest

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO
Lane Individual Practice Assn., Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Steve Doty
President and Owner
Northwest Employee Benefits, Inc.

Chris Ellertson
President
Health Net Health Plan of Oregon

Jack Friedman
CEO
Providence Health Plans

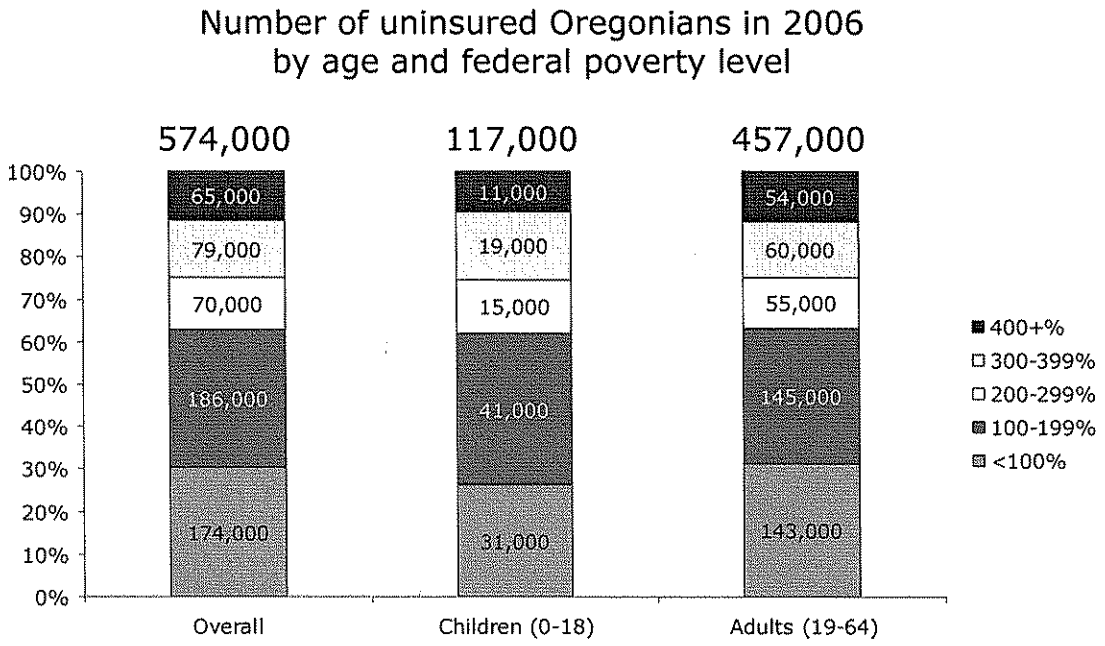
Jon Jurevic
Senior Vice President, Chief Financial Officer
ODS Companies

Ken Provencher
President and CEO
Pacific Source Health Plans

Nina Stratton
Owner
The Stratton Company

Kelsey Wood
Gordon Wood Insurance

Appendix 2



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

Appendix 3

Individual and Small Group Market Shares, Oregon (2005)

	A		B	C	D		E	
	Individual Market		Small Group (2 to 25)	Small Group (26 to 50)	Small Group (2 to 50)		Individual + Small Group (2 to 50)	
Health Net	4,642	2.3%	28,856	10,908	39,764	15.1%	44,406	9.5%
Kaiser	19,373	9.5%	26,722	5,533	32,255	12.2%	51,628	11.1%
LifeWise	42,238	20.8%	35,965	5,291	41,256	15.6%	83,494	17.9%
ODS Health	3,511	1.7%	3,082	2,663	5,745	2.2%	9,256	2.0%
PacificSource	11,232	5.5%	38,833	8,665	47,498	18.0%	58,730	12.6%
PacifiCare	1,596	0.8%	1,527	317	1,844	0.7%	3,440	0.7%
Providence	40	0.0%	23,022	20,767	43,789	16.6%	43,829	9.4%
Regence BCBS	71,642	35.3%	18,707	11,477	30,184	11.4%	101,826	21.8%
Subtotal	154,274	76.0%	176,714	65,621	242,335	91.8%	396,609	84.9%
Total, All Companies in Oregon	203,000	100.0%	193,000	71,000	264,000	100.0%	467,000	100.0%

Source: "Health Insurance in Oregon, January 2007". Department of Consumer & Business Services

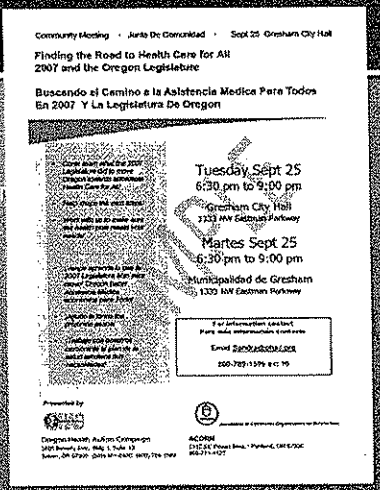
Oregon Health Action Campaign
"Affordable, comprehensive, quality health care for all."

Update and Public Input

The Road to Health Reform: A Community Meeting on the Healthy Oregon Act

Community Meeting Dates and Locations

August 16th, Portland
August 23rd, Medford
August 26th, Newport (2pm – 4p
September 25th, Gresham
September 6th, Salem
October 25th, Eugene
October 28th, Dallas
October 29th, Lincoln City
December 3rd, Salem


Community Meeting • Junta De Comunidad • Sept 25 Gresham City Hall

Finding the Road to Health Care for All
2007 and the Oregon Legislature

Buscando el Camino a la Asistencia Medica Para Todos
En 2007 Y La Legislatura De Oregon

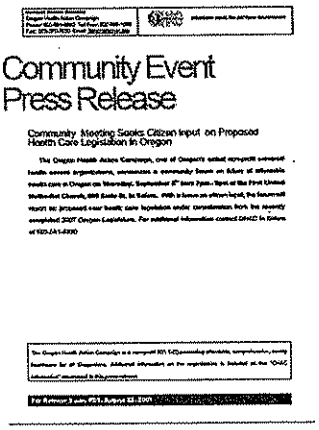
Tuesday Sept 25
6:30 pm to 9:00 pm
Gresham City Hall
1333 NW Eastman Parkway

Martes Sept 25
6:30 pm to 9:00 pm
Municipalidad de Gresham
1333 NW Eastman Parkway

Presented by

Community Meeting Logistics

- Night Time
- Food & beverages
- Seating logistics
- Advance Media Coverage
- Co-presentation with local organization



Community Event Press Release

Community Meeting Seeks Citizen Input on Proposed Health Care Legislation in Oregon

Community Meeting Process

- Popular Education model. Acknowledge, validate and utilize the personal life experience of participants in an interactive educational process.

Listen / Validate

- No censorship.

Meeting Agendas

Welcome and introductions: what do you want to take away from this meeting.

Visualization exercise: Designed to help participants visualize percentage concepts.

Blue slips: 2 out of 10 slips of paper in the audience. You represent the **uninsured.** 20% or 2 of 10 people at least uninsured at some point during year.

Green slips: 3 out of 10 slips: Represent Medicaid and Medicare enrollees.

Pink slips: People with **private insurance.** 5 out of 10 people in the room. Most of you, 80% get it on the job. 20% of you have it because you buy it. Of those of you who get your insurance on the job, half of you are in plans that are regulated by the state, half of you are in self-insured plans.

AGENDA

Finding the Road to Health Care for All in Oregon 2007 and the Oregon Legislature

Eugene Community Meeting
Thursday Oct 25
6:00 pm to 8:30 pm

Eugene Public Library
Lobby Room
100 W. 10th, Eugene

1. Welcome and Introductions
2. Visualizing Current Health Access in Oregon and your community
3. Premium $$$ and Healthy Kids: Understanding The Issue
4. At the end of the Premium $$$ road ?
5. What steps Making sure the plan works for you.
6. Adjournment

Presented by

Oregon Health Action Campaign
3800 Sunnyside Ave., Bldg 1, Suite 11 ~ Salem, OR 97305 ~ (503) 581-4050 (800) 795-1989

Health Care for ALL Oregon

Community Check-Ins

- How many of you are now in a health plan that you would consider 'accountable' as described in the Healthy Oregon Act?

- Who in your mind is required to participate in an accountable health plan after this plan is developed? Does this bill define the benefits that an accountable health plan must provide?

Grounding for Next Phase of Meeting

According to the Healthy Oregon Act, all Oregonians will be required to participate in an accountable health plan.

You and the public have some power here: in order to make the Healthy Oregon Act vision real, legislators will need to vote for it. They will need to hear from you that the plan will work. So our question today is: What would it take to make a health plan accountable to the health needs of you and your family?

OHAC will present this information to the Oregon Health Fund Board.

Your role is not done after this meeting.

Meeting Process, Result Comments and Recommendations

We invited elected officials from the community. A low camp. Some legislators who were invited said they knew very little about the bill. That we should invite Senators Bates and Westlund. Recommendation: proactive steps need to be taken by OHFB members and staff to inform all elected officials about the process and goals and provide them with an opportunity for input before the proposal is finalized.

Very few participants had any concept of the content of the Health Oregon Act. Recommendation: proactive steps need to be taken by OHFB members and staff to inform the public about the process and goals and provide them with an opportunity for input before the proposal is finalized.

When Healthy Oregon Act requirements for an "accountable health plan" were reviewed in the meeting, very few people (10% - 20% max) identified themselves as people who were in a plan the Healthy Oregon Act describes as "accountable."

Despite vast differences in experience, age and demographics of meeting participants, there was common articulated informed understanding of the extent to which the health system does and does not work well for all those within it and clarity about what it would take to make a health plan accountable.

SB 329, the Healthy Oregon Act
Accountable Health Plans

One goal of 329 is to **"Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost."**

Section 12 of the Act requires all Oregonians who do not have health coverage through their job or the Oregon Health Plan to "participate in the Oregon Health Fund program".

"The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals. The board shall establish subcommittees....to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insurance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities.

The proposal must ensure that each accountable health plan:

1. **Does not deny enrollment to qualified Oregonians....;**
2. **Provides coverage of the entire defined set of essential health services;**
3. **Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;**
4. **Offers a simple and timely complaint process;**
5. **Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;**
6. **Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;**
7. **Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services**
8. **Ensures that all enrollees have a primary care medical home;**

Compilation of essential Accountable Health Plan components

Summary of responses from 11 community meetings to these questions:

- What would make a health plan accountable to the needs of you, your family and your community?

- What are the essential ingredients of an insurance plan that you would be required to participate in and pay for?

Notes / Qualifications: *The accountable health plan (AHP) part of the meetings started with a review of the Healthy Oregon Act principles and goals and Healthy Oregon Act description of the components of an accountable health plan.*

Desired components of 'accountable health plans' raised at all community meetings:

a. Choice of providers.
b. Comprehensive: dental, vision, mental health, physical, prescriptions, therapies, hospice care, DME, etc.
c. All plans must offer same benefits. Uniform benefits.
d. Premiums and out of pocket costs for services are affordable for families of all income levels.
e. Prevention should be a priority.
f. All plans take all people who make the selection.
g. Include all pre-existing conditions. No pre-existing delays.
h. All plans are Non-profit.
i. There is an independent patient advocacy/ombudsman function.

Desired components of 'accountable health plans" raised at more than one community meeting.

a. Access to every type of licensed and certified practitioner (access to non-allopathic practitioners).
b. Safety net clinics as part of every plan's network.
c. Nurse advice line.
d. Plans have client advocates / navigators / coaches
e. Provide for out of state services in case of travel.
f. Promotes community based outreach/education.
g. Patient centered care
h. Plans make prompt payments to provider.
i. Efficient, effective and transparent billing procedures.
j. Services are fairly priced.
k. All plans pay providers the same amount for the same services.
l. I can keep the plan as long as I like. (I can take the plan with me.)
m. Protect confidentiality of provider – patient relationships. Protect medical records and their confidentiality.
n. Provides patients with access to their own medical records, copies of what's written.

COMPILATION OF ALL ACCOUNTABLE HEALTH PLAN RESULTS

Notes / Qualifications:

- *The categories (Provider / prevention / plan responsibility etc) were not mentioned in the meetings. Transcriber utilized them to organize responses.*
- *The accountable health plan (AHP) part of the meetings started with a review of the Healthy Oregon Act principles and goals and Healthy Oregon Act description of the components of an accountable health plan. Where those components were reiterated in the meetings, they are indicated in italics.*

** indicates this component was raised in all community meetings.
* indicates this component was raised in most community meetings.

Providers

a. Choice of providers. **
b. Access to every type of licensed and certified practitioner (non-allopathic practitioners) *
c. You can choose both your primary care provider and your specialist.
d. Providers decide what is best for patients – not administrators.
e. There should be thresholds for a timely response to need for a specialist appointment.
*f. Safety net clinics as part of every plan's network. **
g. Convenient access to urgent care clinics.
*h. Nurse advice line. **
i. Enrollees should be able to choose their hospital.
j. Respect for different religious practices.
k. Include community outreach workers / promotores
l. No conflict of interest.
m. Medical home model.

*** Plans have client advocates / navigators / coaches**

a. Plans have ability and knowledge with responsibility to connect folks to services offered by plan and community support services where they exist.
b. Provide opportunities for peer to peer support for certain kinds of conditions (mental health, cancer, diabetes, etc.
c. Plans make very effort to teach people about how to keep folks out of ER
d. Coach or personal assistance for folks who need help (patient advocacy –case management)
e. Use promotore model
f. Plans have outreach teams.

Benefits

a. Comprehensive: dental, vision, mental health, physical, prescriptions, therapies, hospice care, DME, etc. **
b. Plans held to services that are evidence based on randomized clinical trials (this was raised in Eugene amongst great discussion around the comment that that most trials are biased from the start).
c. All plans must offer same benefits. Uniform benefits. **

n. Non-profit. **
o. Premiums and out of pocket costs for services are affordable for families of all income levels. **
p. Services are fairly priced. *
q. Reimbursement that encourages more primary care providers, preventive care, education
r. All plans pay providers the same amount for the same services. *
s. Plans work together to create/support/nurture centers of excellence (as one way of improving quality and controlling unnecessary proliferation / duplication of services)
t. I can keep the plan as long as I like. (I can take the plan with me.) *
u. Knows due process
v. Protect confidentiality of provider – patient relationships. Protect medical records and their confidentiality. *
w. Plans respect religious differences.
x. Plans have advance directive process related to family planning/pregnancy termination
y. Plans have advance directive for end of life care
z. Plans have process for accepting contributions.
aa. Cannot terminate patients / enrollees.
bb. Lets enrollees know what their rights are and where to go with questions / concerns.
cc. Provides patients with access to their own medical records, copies of what's written. *
dd. Customer service is measured and recorded.
ee. Transparency- Provide enrollees/ potential enrollees with comparable information about benefits, costs, and quality.
ff. All plans should have an advice line.
gg. Plans should nurture and help teach patient responsibility.
hh. Reduce administrative overhead including control of CEO salaries.Should be a choice of a locally based plan (these understood to know about and utilize local resources).
ii. Understand and consider scope of practice: allow for appropriately trained people to do the services they can perform.
jj. All plans must ensure access locally!
kk. All plans have standards of care.
ll. Plans should have limitations on marketing & excess capacity

Institute for Health Policy Solutions
Options for treatment of low income workers eligible for employer coverage

Seven alternative policy constructs for treatment of low income workers eligible for employer coverage are enumerated below:

1. "Firewall": Deny eligibility for subsidies to anyone who is offered employer coverage.

2. "No Firewall": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

3. "Firewall with Premium Assistance": Require low-income workers who are eligible for employer coverage to accept that coverage as a condition of eligibility for public subsidies.
4. Employer "Buy-in"/"Vouchers": Allow low-income workers offered employer coverage to enroll in subsidized coverage where employer contribution follows
5. Benchmark Group Plan Option: make low income benchmark plan available through group health insurance plans.
6. No Firewall with a 2nd employer "pay-or-play" test for low wage workers
7. No Firewall with (Small) payroll fee from All Employers

Brief descriptions and observations follow on the next two pages.

Options for treatment of low income workers eligible for employer coverage:

If the state chooses to subsidize low-income people below some income level, should workers (and their dependents) below that income level who have access to employer coverage be eligible for public subsidies and, if so, on what basis? It is important to note that Massachusetts is the only state that has addressed this issue in the context of individual mandates, and that considerations are different in a state with relatively few low income workers and families.

Important inter-related **considerations** *include: "horizontal equity" (i.e., whether people of like incomes are treated equitably); individual affordability; reductions in # of uninsured covered if state instead extends "affordability waivers" to workers who cannot afford coverage; and, state cost implications (short-term, mostly in terms of "dual eligible" worker shifts to state subsidies, longer-term employers dropping coverage for workers). Note that these considerations are different in the context and scale of universal participation.*

There are several alternative policy frameworks:

1. "Firewall": Deny eligibility for subsidies to anyone who is offered employer coverage. *(Denying subsidies only to those who enrolled in employer coverage but not to like persons who declined such coverage seems untenable and unfair under an individual mandate, e.g. because it penalizes those who "did the right thing")*

- Attempts to conserve limited state funds by maintaining existing employer responsibility / contributions (but may not succeed if employers change plan eligibility or contribution rules, which could benefit both the employer and the worker where some of the savings are passed through via increased wages.)
- But would result in either

  a. Some low-income workers with employer coverage paying more out of pocket than they can afford, and/or than under public/pool coverage (*i.e. where their employer coverage has significant cost-sharing or their employer makes only a modest contribution toward the premium plus these workers "pay" via wage reductions),* or

  b. More uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

2. "No Firewall": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

   - Very good "horizontal equity"—gives people with the same incomes equitable access to publicly subsidized coverage.
   - But will be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions.

3. "Firewall with Premium Assistance": as a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make "premium assistance" payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

   - Very good "horizontal equity."
   - But more expensive than a firewall, and if broad-scale premium assistance "fills in" for shortfall of employer contributions relative to the premium for e.g. all under 300% FPL, creates strong incentives to lower employer contributions.
   - Very difficult to administer: Even obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult—

     To make this more feasible, the state might

     a.- require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal- *this could be easier for the state and for employers, but would not include employers who offer only self-insured plans*, or

     b.- require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays - *this might be a requirement except where an employer provides such information through its insurer or TPA*

   > More difficult yet if supplemental or "wrap-around" coverage is to be provided, since employer plans vary considerably. (Per below, group carriers instead might be asked to offer a benchmark plan option)

   > Also requires system to make "premium assistance" payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification)

4. Employer "Buy-in"/"Vouchers": Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if and only if their employer transfers to the pool or public system either, or (a) the amount the employer would contribute to the employer's own plan) or (b) a specified amount up to (a)

   Good "horizontal equity:"

   - Simpler to administer than "premium assistance." Would not require supplemental coverage. Does require system for billing cooperating employers.
   - Due to ERISA, employers cannot be directly compelled to cooperate. Therefore would leave worker hostage to employer willingness to cooperate with state and creates adverse selection cost exposure for state

5. Benchmark Group Plan option: alternative approach to 4 using insurance regulation to make low income benchmark plan available through group health plans. *Would work where employers offer at least one insured (as opposed to self-insured) plan.*

   Would require group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state "benchmark" plan for low income persons. *(If too costly at commercial*

premium/provider payment rates, this could be at premium costs comparable to state exchange coverage for same income groups.)

- Where carriers choose not to directly administer such a plan, they would have the option of coordinating with Exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)
- Low Worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the "parallel" product, less the employer and (subsidized) worker contributions.

6. No Firewall with a two-part employer "pay-or-play" test. In addition to being required to spend at least x% of payroll overall on health care for their workers—or pay the same percent of payroll to the state as a tax—employers would also be required to either:
   a. Spend at least a specified amount per hour worked by each employee individually—or, again, pay the equivalent amount to the state as a tax. *(This approach would assure that "offering" employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer's coverage.), or*
   b. Spend a specified average amount per hour, or % of wage, per worker on all workers earning less than a specified amount—e.g. less than $20,000 per year. *(Would assure that offering employers would either spend a "fair share" amount towards coverage of their low income workers, or would pay the state such an amount towards their coverage.)*
      - The workers included in such a "low-earner" definition would include all modest income part-time and temporary workers not eligible for employer coverage, and would allow the state to combine "fair share" contributions from their multiple workers towards stable coverage through the exchange,

7. No Firewall with (Small) payroll fee from All Employers : An alternative approach would be to allow all low-income workers and dependents access to publicly subsidized coverage without restriction (option 2, above), and require all employers to pay a relatively small payroll tax, whether or not they offer coverage to any of their workers.
   - Very good horizontal equity
   - Administratively easiest for state and for employers
   - Minimizes vulnerability to a successful ERISA challenge because it clearly does not regulate employer benefit plans or spending on such plans
   - Creates incentives for low income workers and their employers to shift from employer to state coverage; problem if payroll tax plus other rev. not adequate
   - Requires employers with generous plans and spending to spend somewhat more—substantial cross-subsidies from high to low wage firms/workers.

Incremental Universalism: The Policy Issues

Jonathan Gruber

MIT

Setting the Stage

- 3 key features of any move to universal coverage
  - Pooling
  - Affordability
  - Mandates
- One extreme: single payer
- Other extreme: tax credits

Massachusetts: Cleaving the Middle

- Privatized public insurance below 300% of poverty – Commonwealth Care
  - Choice of four MMCOs
  - Heavily subsidized
  - Very generous benefits package – no deductibles, low copays

Massachusetts Details, Continued

- Above 300% poverty
  - Merged small group and non-group markets into age-rated pool
  - Facilitate insurance purchase through Connector
  - Section 125 mandate

Massachusetts Details, Continued

- Individual mandate
  - – All eligible for commonwealth care
  - – Everyone above five times poverty
  - – Affordability schedule between 3-5 times poverty – exclude from mandate older persons & families
  - - Enforced through tax penalty

Issue #1: Integration with ESI

- Low income pool – how to treat those with ESI? Three alternatives
  1) Firewall – MA approach – but 30,000 are excluded from affordable coverage
  2) Premium assistance
     - sounds attractive, since many uninsured are offered ESI – leverage employer dollars
     - But it is actually incredibly expensive

Premium Assistance: Facts

Fact #1: Among those who are offered ESI below 300% of poverty, vast majority take it

- Below 100% of poverty: of all offered, only 25% uninsured
- 100-200% of poverty: 13% uninsured
- 200-300% of poverty: 6% uninsured

- Implication: if you offer premium assistance to low income populations, most of those eligible already have coverage!
- Great for horizontal equity – not for coverage

Premium Assistance: Facts

Fact #2: Among those offered ESI who are uninsured, price sensitivity is very low

- After all, these individuals were already offered a very large subsidy and declined!
- These are folks who don't want insurance

Fact #3: If you subsidize employee contributions for a sizeable share of employees, employers will raise those contributions!

Premium Assistance: Implications

- Simple example: 1000 persons below 300% of poverty offered insurance at $2000/year – 100 of them are uninsured
- Offer premium assistance of $1000/person
  - 750 of 900 already taking ESI take assistance
  - 25 of 100 not offered ESI take assistance
- Cost: 775,000
- Newly covered: 25 persons
- Costs/Newly covered: 31,000!
- Not unreasonable: my study of impact of Section 125 for Federal employees found cost per newly insured of $31,000 to $84,000

Another Alternative: Vouchers

- Allow employees to come to the pool with employer dollars
- In theory, same as premium assistance
- In practice, perhaps less expensive because employees who are covered are reticent to drop that coverage and move to the pool
- But still expensive per newly insured
- Hard choices on low income ESI eligible

Issue #2: Affordability and Benefits

- Central question in mandate context: what is “affordable”
- Three tools available to policy makers:
  - Subsidies
  - Minimum benefits
  - Mandate exemptions
- Massachusetts used all three

Affordability: Subsidies

- My analysis suggests fairly high levels are affordable (see report on my website)
  1) Even low income individuals devote sizeable share of budget to non-necessities
  2) Even low income individuals buy ESI if it is offered – even when expensive
- We ended up free below 150% of poverty, rising to typical cost of ESI at 300% of poverty
- Remember: health care is 16% of GDP! Someone has to pay…

Affordability: Minimum Benefits

- Evidence is clear: the ideal cost-effective insurance plan has three features:
  - High initial cost-sharing (deductible or coinsurance)
  - Income-related out of pocket cap
  - Up front coverage of chronic care maintenance (*maybe* prevention)
- All available evidence suggests that such a plan will minimize costs without sacrificing health – see my RAND HIE study for KFF
- MA: $2000 deductible, $5000 OOP max, doc visits & generic drugs with copay only

Affordability: OOP Costs

- Should OOP costs count towards affordability standards? No
- Uninsured individuals typically have little OOP costs – 0 is median for individuals
- So any new OOP costs are simply because they are using more care
- Can’t say insurance is unaffordable simply because individuals get more care!
- But need to have OOP limits that are reasonable relative to income – e.g. $2000 deductible plan not sensible for someone earning $10,000

Affordability: Exemptions

- Compromise on initial schedule
  - Comm Care premiums to 300% of poverty – 4.5% to 6.7% of income
  - Rises to 8.6% of income at 400-500% of poverty
  - Affordable for all above 500% of poverty
- Probably too conservative in long run as premiums rise
- Exempt 60,000 persons (15% of uninsured)
  - 30,000 below 300% offered ESI
  - 30,000 above 300%
- But nice feature: exemptions apply to older individuals and large families who will most value insurance – still mandating the young healthies

Issue #3: Role of the Connector

- Lot of attention to the Connector
- But this is really only important as an element of reform – not as the only reform
- Connector is just a portal through which individuals purchase insurance in reformed market
  - Anchor store in new insurance mall
  - Sets standards and offers choice, but nothing transformative

Connector Only?

- Is the Connector alone enough?
- Would help small businesses and individuals shop
- But unlikely to do much without subsidies and, especially, mandate
- In the end, it is about price & compulsion
- Voluntarism alone hasn’t been very successful in general across states

Issue #4: Governance

- Bill that passed in MA very vague
  - Subsidies to 300% of poverty, but levels not specified
  - Affordability exemption from mandate, but levels not specified
  - Minimum benefit level not specified
- Decisions left to 10 person connector board
  - Three appointees by Republic governor
  - Three by Democratic AG
  - Four administration ex-oficio
- Thus far, complete consensus

Issue #5: Cost Control

- States are moving ahead on coverage without fundamental cost control
- I’m here to say that is OK!
- We know how to move to universal coverage – we don’t know how to significantly control costs
- Don’t let comprehensive reform be the enemy of (politically acceptable) universal coverage

Final Message: I’m Here to Help!

- Modeling: 10 years of experience – critical role in MA and CA debates
- Economics: understanding and explaining the role of key policy levers
- Policy making: member of Connector board
- Let me know how I can help!

Eligibility and Enrollment Committee

Eligibility Strawperson

March 11, 2008

1. **Low-income employer-sponsored insurance:**

   a) **All low-income workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions placed on if they have access to employer-sponsored coverage. In order to mitigate for the loss of employer contributions if employees and dependents switch from employer contributions to state contributions—there should be a requirement that all employers contribute to a payroll tax dedicated to the Oregon Health Fund. Additionally, employers should also receive some sort of exemption from the payroll tax if they provide a minimum level of coverage to their employees and dependents.**

   Rationale

   The Oregon Health Fund Board should adopt eligibility policies for the Oregon Health Fund Program that maximizes health coverage and encourages the maintenance of employer contributions. However, denying subsidies only to those who enrolled in employer coverage but not to like persons who declined such coverage seems untenable and unfair under an individual mandate, e.g. because it penalizes those who "did the right thing". Doing so would run contrary to "horizontal equity" or treating people with similar incomes equitably.

   Supporting Data

   Calculations from the 2001 Current Population Survey (CPS) show that only 7% of those offered insurance are uninsured.[1] Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 7%.[2]

   b) **Alternative policy options for horizontal equity include:**

      i. **"Firewall": Deny eligibility for subsidies to anyone who is offered employer coverage.**

      Attempts to conserve limited state funds by maintaining existing employer responsibility /contributions (but may not succeed if employers change plan eligibility or contribution rules, which could benefit both the employer and the worker where some of the savings are passed through via increased wages.)

      But would result in either

[1] *J. Gruber and E. Washington, Subsidies to employee health insurance premiums and the health insurance market, Journal of Health Economics Volume 24, Issue 2, , March 2005, Pages 253-276.*

[2] *Ibid*

Some low-income workers with employer coverage paying more out of pocket than they can afford, and/or than under public/pool coverage (i.e. where their employer coverage has significant cost-sharing or their employer makes only a modest contribution toward the premium plus these workers "pay" via wage reductions), or

More uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

ii. "No Firewall": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

Very good "horizontal equity"—gives people with the same incomes equitable access to publicly subsidized coverage.

But will be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions.

iii. "Firewall with Premium Assistance": as a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make "premium assistance" payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

Very good "horizontal equity."

But more expensive than a firewall, and if broad-scale premium assistance "fills in" for shortfall of employer contributions relative to the premium for e.g. all under 300% FPL, creates strong incentives to lower employer contributions.

For example: 1000 persons below 300% of poverty are offered insurance at $2,000 per year. 100 of them are uninsured. If the state offers employer premium assistance of $1,000 per person—750 of 900 are already taking employer-sponsored coverage, 25 of 100 are not offered employer-sponsored coverage take the premium assistance. The total cost to the state is $775,000 for enrolling 25 people who were previously uninsured. This amounts to $31,000 per uninsured individual.

Very difficult to administer: Even obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult—

To make this more feasible, the state might

a. Require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal- this could be easier for the state and for employers, but would not include employers who offer only self-insured plans, or

b. Require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays - this

might be a requirement except where an employer provides such information through its insurer or Third Party Administrator.

> More difficult yet if supplemental or "wrap-around" coverage is to be provided, since employer plans vary considerably. (Per below, group carriers instead might be asked to offer a benchmark plan option)

> Also requires system to make "premium assistance" payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification)

iv. **<u>Employer "Buy-in"/"Vouchers"</u>: Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if and only if their employer transfers to the pool or public system either, or (a) the amount the employer would contribute to the employer's own plan) or (b) a specified amount up to (a)**

Good "horizontal equity"

Simpler to administer than "premium assistance." Would not require supplemental coverage. Does require system for billing cooperating employers.

Due to ERISA, employers cannot be directly compelled to cooperate. Therefore would leave worker hostage to employer willingness to cooperate with state and creates adverse selection cost exposure for state

v. **<u>Benchmark Group Plan option</u>: alternative approach to 4 using insurance regulation to make low income benchmark plan available through group health plans. *Would work where employers offer at least one insured (as opposed to self-insured) plan.***

Would require group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state "benchmark" plan for low income persons. *(If too costly at commercial premium/provider payment rates, this could be at premium costs comparable to state exchange coverage for same income groups.)*

Where carriers choose not to directly administer such a plan, they would have the option of coordinating with Exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)

Low-Income Worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the "parallel" product, less the employer and (subsidized) worker contributions.

vi. **No Firewall with a <u>two-part employer</u> "pay-or-play" <u>test</u>. In addition to being required to spend at least x% of payroll overall on health care for their workers—or pay the same percent of payroll to the state as a tax—employers would also be required to either:**

Spend at least a specified amount per hour worked by each employee individually—or, again, pay the equivalent amount to the state as a tax. (This approach would assure that "offering" employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer's coverage.), or

Spend a specified <u>average</u> amount per hour, or % of wage, per worker on all workers earning less than a specified amount—e.g. less than $20,000 per year. *(Would assure that offering employers would either spend a "fair share" amount towards coverage of their low income workers, or would pay the state such an amount towards their coverage.)*

The workers included in such a "low-earner" definition would include all modest income part-time and temporary workers not eligible for employer coverage, and would allow the state to combine "fair share" contributions from their multiple workers towards stable coverage through the exchange.

2. **<u>Oregon residency:</u> A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.**

   <u>Rationale</u>

   - The Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP).
   - The policy goal under an individual mandate is to get as many people covered as soon as possible. Residency definitions will define when the individual mandate clock begins. As one Committee member stated, the message in Oregon should be, "Welcome to Oregon, you have xx days to get health insurance coverage."

   <u>Supporting Data</u>

   - The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.
   - The United States Supreme Court ruling on Saenz v. Roe, 1999 barred states from limiting welfare benefits on the basis on length of residency.

3. **<u>Non-qualified Oregon residents:</u> All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide this population coverage and/or access to health care services. It is a goal under health reform to minimize/eliminate the cost shift. To the extent that population groups are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.**

Rationale:

Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance. The reason: the average health insurance premium for a family of four was roughly $12,000, nearly half of the average annual income of an immigrant worker. Because of these limitations and restrictions, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardize health and welfare, and create some cost-shifting.

The Committee struggled with the issue of whether individuals who don't meet federal qualifications to receive federal contributions for health coverage due to documentation status will be eligible to receive state contributions. There was general acknowledgement and strong support for ensuring that there is access to health care services for all Oregonians, especially if the state can invest resources into prenatal care through the SCHIP program as well as other preventive health care that will save costs in the long-term. Furthermore, the program should be structured so that individuals and families are not threatened or intimidated by notification of the Immigration and Naturalization Service.

Supporting Data

- Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care.[3] High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and admission to the hospital for potentially preventable complications of chronic and acute conditions. Insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by erecting barriers to timely access to effective care.[4],[5]
- The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between $65 million and $90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.[6]
- Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants

[3] *A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, Arch Intern Med. 2007;167(21):2354-2360.*

[4] *S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Gaps in Health Insurance: An All-American Problem (New York, The Commonwealth Fund, Apr. 2006)*

[5] *Schoen et al., Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, (New York, The Commonwealth Fund, Sept. 200*6)

[6] *Oregon Center for Public Policy, Undocumented Workers Are Taxpayers, Too, Apr. 2006*

arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence.

- The Pew Hispanic Center estimates Oregon's 2005 undocumented immigrant population at between 125,000 and 175,000.[7]

4. **Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.**

   Rationale

   - 12 months of enrollment is consistent with commercial coverage.
   - Longer enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
   - Less frequent recertification will result in administrative savings.

   Supporting Data

   - 12 months of enrollment is consistent with group coverage and many of these individuals and families will be covered through subsidized group coverage.

5. **Presumptive eligibility: An applicant who initially appears to meet income, asset, and other program eligibility criteria should be presumed eligible for state contributions through the program upon application. Additionally, individuals that can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.**

   Rationale

   - Oregon Health Fund Board goal is to cover everyone, minimize cost-shift.

     For the Medicaid program, delayed verification is an option under federal law that allows the program to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

6. **Period of uninsurance: The Committee recommends against any periods of uninsurance as requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.**

[7] *Pew Hispanic Center, "Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS," Fact Sheet dated April 26, 2006.*

Rationale

- Requiring that individuals have a period of time without health care coverage works in opposition to an individual mandate provision, which is one of the Oregon Health Fund Board assumptions.
- Requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

7. Assets: There should be no asset limit placed on eligibility for a direct state contribution.

Rationale

- Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.
- The availability of assets should not interfere with expanding health coverage to the uninsured since those resources could be depleted within days in the event of a serious illness or injury.
- Removing the need to determine family assets will result in simplification and administrative savings.

Supporting Data

- About 78 percent of uninsured adults with incomes below 200 percent of the federal poverty level have net assets (excluding home ownership) low enough to meet median Medicaid asset limit guidelines ($2,000). Of this group, fewer than 40 percent own a home.[8]
- 47 of 51 Medicaid programs in the country, including Oregon's, do not currently have an asset limit. However, Oregon is one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs. [9]

8. Guaranteed Issue: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status.

Rationale

If all individuals were required to purchase health insurance, policies could be put in place that spread the excess costs associated with high medical needs across the entire population. Because most individuals are healthy, each person's share of

[8] *D. M Cutler & A. M Garbe. (2003).* Frontiers in health policy research. Vol. 6. *NBER Frontiers in Health Policy Research Series. Cambridge, Mass: MIT.*

[9] *Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.*

these costs would be modest. Additionally, there would be no concerns that doing so would lead to declines in insurance coverage among the healthy or that average premiums would escalate as the insured population declined over time.

9. **Federal Matching Funds: For all components of the Oregon Health Fund Program the state should maximize the use of matching federal dollars available to Oregon.**

   Rationale

   - The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose.
   - Program sustainability is enhanced through this funding mechanism.
   - The Committee assumes that waiver provisions will allow Oregon to have access to Medicaid funding for Oregonians up to 200% FPL for childless adults and parents and SCHIP funding up to 300% FPL for children.
   - The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. One example would be assuring eligibility to segments of the population such as American Indians that would not require state funds because of federal agreements.

For the Federal Laws Committee

1. **Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.**
2. **Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.**

   Oregon would request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
3. **Reduce the five year ineligibility period for documented immigrants**

Eligibility and Enrollment Committee
Development of Enrollment Recommendations
March 11, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the enrollment requirements (outreach, application and retention) in a new Oregon Health Fund program.

Background: Before modifying program practices and procedures for existing state sponsored health insurance programs as well as developing new ones, it is important to consider why these practices exist. Many program requirements and administrative procedures were established to ensure program integrity—that is, to make sure that the programs serve only the Oregonians they were intended to serve. For instance, documentation of income requirements helps to assure that only individuals and families with incomes that qualify them for public health coverage receive it. The downside of using daunting administrative procedures (extensive documentation requirements, long detailed application forms, in-person interview requirements, frequent reporting, or reenrollment requirements) to ensure program integrity is that they can discourage even eligible families from participating in important programs.

A solution, however, lies in the definition of "program integrity." If a more comprehensive definition were used, one that includes how well a program serves its eligible population as well as how effectively it screens out the ineligible, Oregon could focus on balancing the impacts of exclusionary requirements against the imperative to serve targeted populations. Ultimately, decisions as to which administrative practices should be retained can be based on empirical research on the impact on program integrity of different policies and procedures, and agreement among stakeholders on what are acceptable tradeoffs between enrolling eligible and excluding ineligible children and families.

Unfortunately, there has been little research on the impact of different administrative procedures on program integrity. There is, however, much anecdotal evidence of the positive effect on program participation of administrative simplification and of a change in the relative values assigned to enrolling versus excluding children from public health insurance programs that accompanied the rollout of the State Children's Health Insurance Program (SCHIP) program beginning in 1998.

Specifically, when Medicaid was viewed as a welfare program tied to cash assistance, it included many administrative rules, practices, and procedures to discourage participation. With the advent of SCHIP and federal welfare reform, however, the reframing of the children's Medicaid program as a health insurance program, and a shift in policy focus to reducing the number of uninsured children, many of the administrative barriers to children's participation in Medicaid were reduced or eliminated.

At the same time, vestiges of the old restrictive Medicaid system remain, which means that the system that serves the poorest children still has more enrollment barriers than does SCHIP. For example, Oregon has also maintained an asset test (families need to document their assets on the application for benefits and are not eligible if their assets exceed a certain level) in their SCHIP program.

The good news, however, is that Oregon has greatly improved their enrollment procedures in recent years and is gradually adopting other procedures to simplify enrollment and retention processes. The Oregon Department of Human Services Division of Medical Assistance Programs (DMAP) has shortened the initial application for Medicaid and SCHIP to two pages, eliminated in-person interview requirements and separate applications for Medicaid and SCHIP. DMAP is also working with Oregon counties and school districts to have a "one stop shop" for federal program eligibility such as Medicaid/SCHIP, food stamps, and free/reduced school lunches.

Other states around the country have adopted innovative strategies to improve program integrity. For example, 13 states do not require families to provide verification of the income they report on their applications. This system greatly reduces the paperwork burden on families. These states now verify income and other information by matching identifying information provided by the family with existing state databases. Some states that have adopted self-declaration report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[1] Other studies have documented administrative cost savings from other administrative simplifications. Because effective simplification strategies increase enrollment in health insurance programs, however, they are not likely to reduce overall program costs. Nonetheless, reducing administrative costs can free up resources for delivery of health care services to enrollees.

Enrolling eligible children in public coverage programs is only the first step toward ensuring their access to health care; keeping children enrolled presents an ongoing challenge. Many studies have demonstrated that eligible children are at risk for losing coverage at any time, but that the probability of disenrollment is highest when children must renew their coverage. Both SCHIP and Medicaid have encountered the problem of "churning," in which children lose coverage but reenroll within a few months. Other children bounce between Medicaid, SCHIP, and private coverage. An unknown number may experience protracted periods of uninsurance after disenrollment. In response, states have adopted a variety of approaches for simplifying renewal policies and procedures.

For example, a growing number of states allow families to renew coverage for their children at longer intervals (such as every 12 months rather than every 6) or allow children to retain their public coverage for a full year even if their family income

[1] *Neuschler, E., and Curtis, R. Premium assistance: What works? Washington, DC: Institute for Health Policy Solutions, March 2003.*

changes.[2] Twenty-one states are using joint renewal forms for Medicaid and SCHIP, which are helpful to families who have children in different programs or whose changed circumstances have shifted their eligibility from one program to the other. Some states provide families with preprinted renewal forms and ask them to provide updates at renewal only on information that has changed. States are also experimenting with different methods for following up with families, such as phone calls, to remind them to reenroll their children. Florida uses a method called automatic or passive reenrollment in its SCHIP program. This procedure allows children to remain enrolled as long as families do not notify the program that their circumstances have changed, but continue to pay the program premiums. A study found that although other states experienced 30% to 50% drops in enrollment at renewal in the absence of premiums, Florida's disenrollment at renewal was only 5%.[3]

The launch of SCHIP in 1998 spurred intensive efforts to make the public aware of the new program and to actively encourage enrollment. SCHIP's objective of reducing the number of uninsured children in the United States dramatically influenced Medicaid's outreach and enrollment procedures. For the first time, a public health program emphasized the importance of program promotion and active efforts to enroll eligible children. States have since developed a range of marketing strategies to promote their public programs, including choosing appealing names and engaging the media, churches, and schools in enrollment campaigns.[4] Most states (73%) promoted their SCHIP and Medicaid programs jointly, which likely increased enrollment in both. Some states report that they enrolled several eligible but previously uninsured children in Medicaid for every child enrolled in SCHIP.

Yet budget constraints and an economic downturn have severely constrained Oregon's ability to continue with their public education and media campaigns. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures. Nonetheless, sustaining intensive outreach and public education efforts is necessary to reduce the high numbers of uninsured who are eligible for public coverage but not enrolled—especially since lack of knowledge about program availability and not valuing coverage remain important impediments to participation.

Targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. Outreach to immigrant families

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[2] *Cohen Ross, D., and Cox, L. Enrolling children and families in health coverage programs: The promise of doing more. Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2002.*

[3] *The Child Health Insurance Research Initiative. SCHIP disenrollment and state policies. Issue Brief No. 1. Rockville, MD: CHIRI, June 2002.*

[4] *0. Perry, M., Smith, V.K., and Smith, C.N. Marketing Medicaid and CHIP: A study of state advertising campaigns. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2000.*

should be in their own languages, should employ culturally appropriate messages to educate parents about the value of coverage and how to access the system, and should seek to allay inappropriate fears that program participation will jeopardize a family's stay in the United States. Similarly, adolescents need outreach programs that speak to their needs and concerns. Lastly, outreach to families made eligible for SCHIP or Medicaid as a result of the economic downturn may be particularly valuable if these families have not interacted with public assistance programs in the past. For all these groups, outreach from community-based organizations and institutions—and from other public benefit programs such as unemployment insurance—can be cost-effective.

Questions to Consider

Can DMAP coordinate with other public assistance programs noted above to auto-enroll children through the Oregon school system?

Should the state consider a self-declaration of income a legitimate basis for publicly sponsored health programs?

What renewal strategies should be included in health reform?

What outreach strategies should be included in health reform?

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Recommendation from the Health Equities Committee Concerning Outreach

A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon.

1. A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
    a. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
    b. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
    c. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund Board is the object and resources and interventions must be targeted towards this goal.

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. The MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) to establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee," that is comprised, but not limited to the membership of the MAC. Additionally, the MAC is also required to present reports containing data and recommendations to the Committee as well as the Governor and Legislature on eligibility and enrollment.

The following is a series of enrollment and outreach recommendations and future considerations that the MAC has issued to the Eligibility and Enrollment Committee to consider in its deliberations on comprehensive health care reform.

Recommendations Concerning Enrollment:

1. **Families should be kept intact programmatically.**

   Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

2. **Enrollment and recertification processes should be streamlined to increase the likelihood that eligible individuals will be covered and stay covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.**

   Both increased retention and streamlined enrollment and re-enrollment will result in administrative savings.

3. **Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.**

Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

4. **Allow applicants to use the previous year's tax return as a verification option.**
   Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

5. **Open period of enrollment for changes of coverage or subsidies every 12 months**
   12 months of enrollment is consistent with group coverage and many of these Oregonians should be covered similarly.

Other Considerations Concerning Enrollment

6. The Eligibility & Enrollment (E & E) committee should consider all options for enrollment including faxing, telephone applications, mail applications, and electronic applications.

7. E& E should also consider strategies to make application and product information available to populations outside of the low-income families, including people starting new businesses, early retirees, and others.

Recommendations Concerning Outreach

1. **There should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the Oregon Health Fund program.**
   Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts.

2. **Education and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
   - **Schools (public and private and school-based health services**
   - **Home school associations and support groups**
   - **Head Start**
   - **Child care**
   - **Safety-net clinics, including rural and migrant clinics**
   - **Physician and dental offices**
   - **Hospitals**
   - **Pharmacies**

- **Social service agencies**

Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

3. **Identify uninsured individuals and inform them about Oregon Health Fund program.**

   Existing data can be used effectively to target segments of the population.

4. **Increase outreach and retention for those individuals already eligible but not enrolled.**

   In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

5. **To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.**

   As noted earlier, the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

6. **All outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities.**

   As noted earlier, testimony at the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

7. **Families in the target population must be identified and engaged in dialogue before enrollment and retention can be maximized and work closely with communities for participation goals of Oregon Health Fund program can be realized.**

   Testimony at the MAC community meetings also gave insight into the need to create a process for outreach that utilized community insight rather than imposing perceived methods for outreach and enrollment.

8. **The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.**

   As noted above, the MAC's community meetings encouraged the unique understanding that distinct segments of Oregon's population have on their own communities that would offer innovative and effective public program.

9. **Work with employers and other agencies that do mailings to include information about Oregon Health Fund.**

   Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

Eligibility and Enrollment Committee

Eligibility Strawperson

March 11, 2008

1. **State premium contribution eligibility for people who have employer-sponsored insurance:**

   a) **All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored coverage. In order to mitigate for the loss of employer contributions if employees and dependents switch from employer contributions to state contributions, this option should be coupled with a requirement that all employers contribute to the Oregon Health Fund.**

   Rationale

   The Oregon Health Fund Board should adopt eligibility policies that maximize health coverage and at the same time encourage the continuation of employer contributions. Policies that provide access to state premium contributions for low-income individuals who are currently offered employer-sponsored coverage risk crowding out employer sponsored coverage.

   The committee considered multiple policy options to minimize the loss of employer sponsored coverage in these circumstances, and eliminated one from consideration: establishing a "firewall" that prevents anyone who is currently offered employer-sponsored insurance from coming into a health insurance exchange to obtain access to a state premium contribution. It seemed to committee members that denying the state contribution to those who enrolled in employer coverage but not to like persons who declined such coverage is untenable and unfair under an individual mandate, and it penalizes those who "did the right thing" by taking up coverage. Doing so runs contrary to "horizontal equity" or treating people with similar incomes equitably.

   Supporting Data

   Calculations from the 2001 Current Population Survey (CPS) show that only 7% of those offered insurance are uninsured.[1] Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 7%.[2]

[1] *J. Gruber and E. Washington, Subsidies to employee health insurance premiums and the health insurance market, Journal of Health Economics Volume 24, Issue 2, , March 2005, Pages 253-276.*

[2] *Ibid*

b) Alternative policy options for horizontal equity (in order of Committee preference) include:

i. <u>No Firewall with a two-part employer "pay-or-play" test</u>. In addition to being required to spend at least x% of payroll overall on health care for their workers—or pay the same percent of payroll to the state as a tax—employers would also be required to either:

- Require employers to spend at least a specified amount per hour worked by each employee individually—or pay the equivalent amount as a tax. (This approach would assure that "offering" employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer's coverage.), or
- Spend a specified average amount per hour, or % of wage, per worker on all workers earning less than a specified amount—e.g. less than $20,000 per year. (This approach would assure that offering employers would either spend a "fair share" amount towards coverage of their low income workers or pay the state such an amount toward their coverage.)

The workers included in such a "low-earner" definition would include all modest income part-time and temporary workers not eligible for employer coverage and would allow the state to combine "fair share" contributions from multiple workers towards stable coverage through an insurance exchange.

It is possible in such an approach that employers may take actions to contract with workers or create subsidiaries of workers to avoid state designation of employee responsibility.

ii. <u>Employer "Buy-in"/"Vouchers"</u>: Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if, and only if, their employer transfers to the pool or public system either, (a) the amount the employer would contribute to the employer's own plan or (b) a specified amount up to (a).

This approach would have good "horizontal equity" in that employees are not excluded from the state program, and it retains employer contributions. It also may be simpler to administer than "premium assistance."

Due to ERISA, employers cannot be directly compelled to cooperate. Therefore, this approach would leave the worker hostage to employer willingness to cooperate with the state, and it creates the potential for adverse selection cost exposure for the state. There may also be risk selection issues if an employer chooses to keep low-risk employees and allow higher-risk employees to go to the state program.

iii. <u>Benchmark Group Plan option</u>: Alternative approach to the employer buy-in or voucher approach using insurance regulation to make low income

benchmark plans available through group health plans. (*Would work where employers offer at least one insured (as opposed to self-insured) plan.)*

This approach requires group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state "benchmark" plan for low income persons.

Where carriers choose not to directly administer such a plan, they would have the option of coordinating with insurance exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)

Low-income worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the "parallel" product, less the employer and (subsidized) worker contributions.

iv. "<u>No Firewall</u>": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

This option provides very good "horizontal equity"in that it gives people with the same incomes equitable access to publicly subsidized coverage. Doing so may be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions. This approach is similar to the Committee recommendation but does not have a financing mechanism to recapture potentially lost employer contributions.

v. "<u>Firewall</u>": Deny eligibility for subsidies to anyone who is offered employer coverage.

This approach attempts to conserve limited state funds by maintaining existing employer responsibility /contributions

But would result in <u>either:</u>

- Some low-income workers with employer coverage paying more out of pocket than they can afford, or
- Increased number of uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

vi. "<u>Firewall with Premium Assistance</u>": As a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make "premium assistance" payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

This approach has very good "horizontal equity" but is more expensive than a firewall, and if broad-scale premium assistance "fills in" for shortfall of employer

contributions relative to the premium it creates strong incentives to lower employer contributions.

Maintaining employer contributions along with state contributions would be very difficult to administer as obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult.

To make this more feasible, the state might:

- Require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal. This could be easier for the state and for employers, but would not include employers who offer only self-insured plans, or
- Require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays. This might be a requirement except where an employer provides such information through its insurer or Third Party Administrator.

This alternative can be more difficult yet if supplemental or "wrap-around" coverage is to be provided, since employer plans vary considerably. It also requires the system to make "premium assistance" payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification).

2. **<u>Oregon residency:</u> A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.**

   <u>Rationale</u>

   The Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP).

   - The policy goal under an individual mandate is to get as many people covered as soon as possible. Residency definitions will define when the individual mandate clock begins. As one Committee member stated, the message in Oregon should be, "Welcome to Oregon, you have xx days to get health insurance coverage."

   <u>Supporting Data</u>

   - The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.
   - The United States Supreme Court ruling on Saenz v. Roe, 1999 barred states from limiting welfare benefits on the basis on length of residency.

3. **<u>Non-qualified Oregon residents:</u> All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide this population coverage and/or access to health care services. It is a goal under health reform to minimize/eliminate the cost shift. To the extent that certain groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.**

   <u>Rationale:</u>

   - Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance, primarily because the average health insurance premium for a family of four is roughly $12,000, nearly half of the average annual income of an immigrant worker. As a result, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardizing their health and welfare, and creating some cost-shifting.
   - If employers of such individuals are contributing to the cost of health care coverage in the state through a payroll tax or some contribution requirement—all of their workers should be eligible.
   - The committee struggled with the issue eligibility for state premium contribution for individuals who lack documentation of their legal status. However, there was general acknowledgement and support for ensuring that there is access to health care services for all Oregonians.

   <u>Supporting Data</u>

   - Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care.[3] High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and admission to the hospital for potentially preventable complications of chronic and acute conditions. Insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by creating barriers to timely access to effective care.[4],[5]
   - The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between $65 million and $90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.[6]

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[3] *A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, Arch Intern Med. 2007;167(21):2354-2360.*

[4] *S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Gaps in Health Insurance: An All-American Problem (New York, The Commonwealth Fund, Apr. 2006)*

[5] *Schoen et al., Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, (New York, The Commonwealth Fund, Sept. 200*6)

[6] *Oregon Center for Public Policy, Undocumented Workers Are Taxpayers, Too, Apr. 2006*

- Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence.
  - The Pew Hispanic Center estimates Oregon's 2005 undocumented immigrant population at between 125,000 and 175,000.[7]

4. **Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.**

   Rationale

   - Twelve months of enrollment is consistent with commercial coverage.
   - A longer enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
   - Less frequent recertification will result in administrative savings.

   Supporting Data

   Results from the baseline OHP cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.[8]

5. **Presumptive eligibility: An applicant who initially appears to meet income and other program eligibility criteria should be presumed eligible. Additionally, individuals that can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.**

   Rationale

   - Oregon Health Fund Board goal is to cover everyone, minimize cost-shift.
   - For the Medicaid program, delayed verification is an option under federal law that allows the program to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

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[7] *Pew Hispanic Center, "Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS," Fact Sheet dated April 26, 2006.*

[8] *Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" Annals of Family Medicine 4(5): 391-398*

6. **<u>Period of uninsurance</u>: The Committee recommends against any period of uninsurance as requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.**

   <u>Rationale</u>

   - Requiring that individuals have a period of time without health care coverage works in opposition to an individual mandate provision, which is one of the Oregon Health Fund Board assumptions.
   - Requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

7. **<u>Assets</u>: There should be no asset limit placed on eligibility for a direct state contribution.**

   <u>Rationale</u>

   - Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.
   - Removing the need to determine family assets will result in simplification and administrative savings.

   <u>Supporting Data</u>

   - About 78 percent of uninsured adults with incomes below 200 percent of the federal poverty level have net assets (excluding home ownership) low enough to meet median Medicaid asset limit guidelines ($2,000). Of this group, fewer than 40 percent own a home.[9]
   - 47 of 51 Medicaid programs in the country, including Oregon's, do not currently have an asset limit for its traditional Medicaid population (OHP Plus), although it does have a $5,000 asset limit for the expansion population (OHP Standard). Oregon is also one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs. [10]

8. **<u>Guaranteed Issue</u>: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status.**

   <u>Rationale</u>

   If all individuals are required to purchase health insurance, excess costs associated with high medical needs are spread across the entire population. Because most individuals are healthy, each person's share of these costs would be modest.

[9] *D. M Cutler & A. M Garbe. (2003).* Frontiers in health policy research. Vol. 6. *NBER Frontiers in Health Policy Research Series. Cambridge, Mass: MIT.*

[10] *Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.*

9. **<u>Federal Matching Funds</u>: For all components of the Oregon Health Fund Program, the state should maximize the use of matching federal dollars available to Oregon.**

   <u>Rationale</u>

   - The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. (What is the match?)
   - Program sustainability is enhanced through this funding mechanism.
   - The Committee assumes that waiver provisions will allow Oregon to have access to Medicaid funding for Oregonians up to 200% FPL for childless adults and parents and SCHIP funding up to 300% FPL for children.
   - The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. One example would be assuring eligibility to segments of the population such as American Indians that would not require state funds because of federal agreements.

10. **<u>Medicare</u>: Review mechanisms that would be appropriate to extend health care assistance to Medicare beneficiaries that will balance affordability for the individual and the state.**

    <u>Rationale</u>

    The There are three serious limitations of the Medicare benefit package that may require investment from the state:

    a. It does not cover some important health care products and services. For example, the program does not cover many preventive services (such as annual physical exams), routine eye and dental care.
    b. It has high cost sharing on some covered services such as outpatient care and none on others. These variations may lead to inefficient choices by beneficiaries and providers that could inappropriately affect patients' or providers' decisions about the setting for care.
    c. It has no limit on total cost sharing (catastrophic cap).

    <u>Supporting Data</u>

    The coinsurance liability for hospital outpatient services (20-55%) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20%). The high (50%) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services.[11]

[11] *G.M. Hackbarth. "Medicare Cost-Sharing and Supplemental Coverage" Statement before the Subcommittee on Health Committee on Ways and Means U.S. House of Representatives May 1, 2003.*

For the Federal Laws Committee

1. **Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.**
2. **Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.**

   Request the opportunity of returning to previous documentation methodology employed by the Department of Medical Assistance Programs for citizenship. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
3. **Eliminate the five year ineligibility period for immigrants that become legal permanent residents.**

Eligibility and Enrollment Committee
Development of Enrollment Recommendations
April 8, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the enrollment requirements (outreach, application and grievance and appeals processes) needed in a comprehensive plan for health reform.

Issues

Outreach

- There are high numbers of uninsured who are eligible for public coverage but are not enrolled—this may be due to lack of knowledge about program availability and not valuing coverage. In 2006, over 60 percent of Oregonians that are uninsured were under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs.
- Oregon state budget constraints and economic downturns have severely constrained Oregon's ability to engage in an outreach campaign to enroll eligible individuals into state sponsored health coverage. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures.[1]
- While media outreach can be effective, targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. For example, Washington State's new insurance laws mandate a "proactive, targeted outreach and education effort" to enroll children in health coverage, with a focus on populations with the highest rates of uninsurance.

Application

- A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, states relied on lengthy and complex Medicaid applications and required interviews at welfare offices. Recently, however, something of a revolution has taken place in Medicaid programs throughout the country. Complicated applications have been replaced with shorter forms; mail-in applications have made office interviews unnecessary, at least for pregnant women and children; and an increasing number of states have begun to rely on self-declarations and computerized data exchanges in lieu of applicant-supplied verification of eligibility.[2]

[1] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25*
[2] *Ibid, Lewit et al. 2003.*

- Administrative barriers such as submitting paycheck stubs for a defined period of time, as is done for the Oregon Health Plan, can be onerous on the applicant and have led states to innovate in changes to application requirements. For example, Lewit et al. note that 13 states do not require families to provide verification of the income they report on their applications. The authors contend that this system greatly reduces the paperwork burden on families—noting that these states now verify income and other information by matching identifying information provided by the family with existing state databases. [3] Other studies have also noted that states adopting self-declaration of income report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[4]
- The recertification process for enrollees is also an area where administrative barriers may actively disenroll or prevent continuation of health coverage. Studies have found that "churning"—when individuals fail to renew their coverage during the eligibility redetermination period required by the programs, but re-apply for coverage after the redetermination period is over—increases administrative costs and consumes limited staff time. Moreover, the most valuable benefit of continuous coverage is beneficiaries' improved health when services are not arbitrarily interrupted. Timely preventive and primary care visits can diminish costly hospitalizations and emergency room visits for uninsured residents.[5]

Grievance and Appeals

- The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.
- According to a National Health Law Program study, Medicaid beneficiaries often face significant challenges when resolving service disputes with a managed care organization.[6] Medicaid beneficiaries, who by definition have limited resources, may find it difficult to obtain medical records, understand notices, and even call the health plan for assistance. These difficulties are compounded for individuals who are illiterate or lack access to a telephone.

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[3] *Ibid, Lewit et al. 2003.*
[4] *Neuschler, E., and Curtis, R. Premium assistance: What works? Washington, DC: Institute for Health Policy Solutions, March 2003.*
[5] *D.C. Ross and I.T. Hill. (2003). "Enrolling Eligible Children and Keeping Them Enrolled," Future of Children 13(1):81-97*
[6] *J. Perkins, K. Olson, L. Rivera, and J. Skatrud. (1996). Making The Consumers'Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction. Chapel Hill, NC: National Health Law Program.*

Questions to Consider

Can DMAP coordinate with other public assistance programs noted above to auto-enroll children through the Oregon school system?

What outreach strategies should be included in health reform?

What application and renewal strategies should be included in health reform?

What grievance and appeals process strategies should be included in health reform?

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. The MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) to establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee," that is comprised, but not limited to the membership of the MAC. Additionally, the MAC is also required to present reports containing data and recommendations to the Committee as well as the Governor and Legislature on eligibility and enrollment.

The following is a series of enrollment and outreach recommendations and future considerations that the MAC has issued to the Eligibility and Enrollment Committee to consider in its deliberations on comprehensive health care reform.

Recommendations Concerning Enrollment:

1. **Families should be kept intact programmatically.**

   Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

2. **Enrollment and recertification processes should be streamlined to increase the likelihood that eligible individuals will be covered and stay covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.**

   Both increased retention and streamlined enrollment and re-enrollment will result in administrative savings.

3. **Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.**

Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

4. **Allow applicants to use the previous year's tax return as a verification option.**
   Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

5. **Open period of enrollment for changes of coverage or subsidies every 12 months**
   12 months of enrollment is consistent with group coverage and many of these Oregonians should be covered similarly.

Other Considerations Concerning Enrollment

6. The Eligibility & Enrollment (E & E) committee should consider all options for enrollment including faxing, telephone applications, mail applications, and electronic applications.

7. E& E should also consider strategies to make application and product information available to populations outside of the low-income families, including people starting new businesses, early retirees, and others.

Recommendations Concerning Outreach

1. **There should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the Oregon Health Fund program.**
   Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts.

2. **Education and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
   - **Schools (public and private and school-based health services**
   - **Home school associations and support groups**
   - **Head Start**
   - **Child care**
   - **Safety-net clinics, including rural and migrant clinics**
   - **Physician and dental offices**
   - **Hospitals**
   - **Pharmacies**

- **Social service agencies**

Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

3. **Identify uninsured individuals and inform them about Oregon Health Fund program.**

   Existing data can be used effectively to target segments of the population.

4. **Increase outreach and retention for those individuals already eligible but not enrolled.**

   In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

5. **To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.**

   As noted earlier, the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

6. **All outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities.**

   As noted earlier, testimony at the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

7. **Families in the target population must be identified and engaged in dialogue before enrollment and retention can be maximized and work closely with communities for participation goals of Oregon Health Fund program can be realized.**

   Testimony at the MAC community meetings also gave insight into the need to create a process for outreach that utilized community insight rather than imposing perceived methods for outreach and enrollment.

8. **The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.**

   As noted above, the MAC's community meetings encouraged the unique understanding that distinct segments of Oregon's population have on their own communities that would offer innovative and effective public program.

9. **Work with employers and other agencies that do mailings to include information about Oregon Health Fund.**

   Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Recommendation from the Health Equities Committee Concerning Outreach

A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon.

1. A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
    a. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
    b. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
    c. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund Board is the object and resources and interventions must be targeted towards this goal.

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Initial Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. The MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) to establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee (EEC)," that is comprised, but not limited to the membership of the MAC. Additionally, the MAC is also required to present reports containing data and recommendations to the EEC as well as the Governor and Legislature on eligibility and enrollment.

The following is a series of initial recommendations and future considerations that the MAC has issued to the Eligibility and Enrollment Committee on various statutory requirements laid out in the Healthy Oregon Act. Directives for the Medicaid Advisory Committee from the act are *italicized* and standing recommendations in **bold** as well as future considerations are listed thereafter.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: public subsidies of premiums or other costs under the program **(Section 9(2)(d)(A))**.

Standing Recommendations

1. **All uninsured individuals and families should be able to participate.**

   Rationale:

   - Universal coverage follows the legislative intent and public input through both the Healthy Oregon Act and the Healthy Kids Act that were passed by the 74th Legislative Assembly.

2. **Premiums should be based on the Federal Poverty Level income index with a sliding-scale.**

   Rationale:

   - Premium sharing should not exceed the limits of the family budget but should recognize the family's ability to contribute. Public meeting participants frequently suggested instituting "family premium" options for families with more than one child, resembling employer-sponsored insurance.
   - Comments at the MAC's Healthy Kids community meetings indicated a general preference for premium share over other forms of cost sharing because of predictability in family budgeting.

3. **Copayments should be modest in keeping with the income levels of families. For example, the copayment for physician office visits should be no more than $10 for those under 200% FPL.**

   Rationale:

   - A review performed by Office for Oregon Health Policy and Research staff showed that families in Oregon cannot be expected to have available resources to help pay for health insurance until income is above 200% FPL.[1]

4. **MAC recommends that cost-sharing take into consideration family monthly cost-of-living expenses by geographic regions when considering how much a family can afford to contribute to health care.**

   Rationale:

   - Research by the RAND Institute has shown that cost-sharing mechanisms reduce utilization of health care services but that consumers do not distinguish well between useful and trivial services.[2] The impact of cost-sharing, however, was found to have a larger effect on lower-income persons, particularly children. A panel of experts divided episodes of care into those in which medical care produces usually effective treatments and usually less effective treatments. It was determined that for those conditions in which medical care is highly effective, poor children in a cost-sharing plan were at a greater risk of not receiving treatment when such treatment would be effective.[3]

5. **Families should be kept intact programmatically.**

   Rationale:

   - Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

Future Considerations

- Consider family or couple based premiums in addition to individual premiums.
- Copayments should be designed to promote prevention, cost-effective management of chronic conditions, and appropriate utilization of healthcare resources.
- Investigate affordability by considering total cost sharing including premiums, co-payments, co-insurance, and deductibles.
- Consider allowing individuals/families to use previous year's tax return statements to determine subsidy levels.

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[1] *Heidi Allen, (March 2006) "Affordability Presentation for the Medicaid Advisory Committee."*

[2] *See Robert H. Brook, et al., (December 1983). "Does Free Care Improve Adults Health? Results from a Randomized Controlled Trial,"* New England Journal of Medicine, *309(23):1426-34 and Emmett B. Keeler, et al., (August 1987) "Effects of Cost Sharing on Physiological Health, Health Practices and Worry,* Health Services Research *22(3):297-306.*

[3] *Kathleen N. Lohr, et al., (September 1986) "Use of Medical Care in the RAND Health Insurance Experiment, Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial," Medical Care 24(9):Supplement S-S87.*

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: streamlined enrollment procedures, including, a standardized application process **(Section 9(2)(d)(B)(i))**.

Standing Recommendations

1. **Streamline enrollment and recertification processes to increase the likelihood that eligible children will be covered and stay covered. As part of this streamlining, there should be a "common application screening form" for Healthy Kids and it should be as short and straightforward as possible.**

   Rationale:

   - Both increased retention and streamlined enrollment and re-enrollment will result in administrative savings.

2. **There should be "one-stop shopping" for eligibility determination.**

   Rationale:

   - Comments at the MAC's community meeting revealed that administrative and logistical barriers allow enrollment in certain public programs and not others.

3. **Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.**

   Rationale:

   - Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

4. **Allow applicants to use the previous year's tax return as a verification option.**

   Rationale:

   - Feedback from public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

Future Considerations

- Consider all options for enrollment including faxing, telephone applications, mail applications, and electronic applications.
- Consider strategies to make application and product information available to populations outside of MAC's previous work including people starting new businesses, early retirees, and others

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: requirements to ensure that enrollees demonstrate Oregon residency **(Section 9(2)(d)(B)(ii)).**

Standing Recommendations

1. **There were no consensus recommendations on this directive.**

Future Considerations

- Determine the cost-benefit of covering all Oregonians regardless of citizenship in terms of uncompensated care, the cost-shift, public health, emergency preparedness, and the dignity and worth of every individual.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: streamlined enrollment procedures, including, a process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment **(Section 9(2)(d)(B)(iii)).**

Standing Recommendations

1. **Establish presumptive eligibility for all uninsured Oregonians.**

   Rationale:

   - Universal coverage for all Oregonians was an essential legislative intent of the Healthy Oregon Act and the Healthy Kids Act and therefore if an individual is not insured through their employer—that individual should be presumed eligible.

Future Considerations

- For special populations, consider utilizing federal funds that allow retroactive eligibility to three months prior to the date of service (date stamp).
- Explore the California One-E application for its public health coverage programs as a possible conduit to enrollment at the point of service.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: streamlined enrollment procedures, including, permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment **(Section 9(2)(d)(B)(iv)).**

Standing Recommendations

1. **There should be no requirement of a period of uninsurance to participate.**

   Rationale:

   - The MAC recognizes that most private insurance coverage in Oregon comes through employer-sponsored health plans. A sudden change in this practice will disrupt the effort to move this state toward coverage for all Oregonians and threaten the sustainability of current health insurance arrangements. However, public testimony to the MAC from organizations that advocate for and serve children report that requiring a lengthy period of uninsurance (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

2. **There should be no pre-existing condition limitations.**

   Rationale:

   - The assumption of an individual mandate for all Oregonians to have health insurance enhances the opportunity to have guaranteed issue in the Oregon Health Fund program and would also encourage the treatment of chronic conditions.
   - However, it has been noted that there is a potential risk of adverse selection into the program by people with substantial health services needs with other health insurance options. Such adverse selection could threaten the sustainability of the program. Therefore, as a technical note, the MAC suggests that state agencies take suitable precautions to a) monitor for adverse selection into the pool, and b) if needed, apply a remedy to preserve the viability of the pool.

3. **Open period of enrollment for changes of coverage or subsidies every 12 months.**

   Rationale:

   - 12 months of enrollment is consistent with group coverage and many of these Oregonians should be covered similarly.

4. **Income limitations and/or asset testing should not apply in determining eligibility.**

   Rationale:

   - Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.
   - The availability of assets to parents should not interfere with expanding health coverage to uninsured children since those resources could be depleted within days in the event of a serious illness or injury.
   - Removing the need to determine family assets will result in simplification and administrative savings.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: a grievance and appeals process for enrollees **(Section 9(2)(d)(C)).**

Standing Recommendations

1. **There should be an appeal process for eligibility decisions.**

   Rationale:

   - The MAC felt that consumer protections are important and therefore deserve a process to provide equal protection to all Oregonians in the comprehensive plan.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: standards for disenrollment and changing enrollment in accountable health plans **(Section 9(2)(d)(D)).**

Standing Recommendations

1. **Take a careful look at federal and state rules that influence standards of enrollment and disenrollment in accountable health plans.**

   Rationale:

   - Based on reforms elsewhere such as Massachusetts and prior experience with purchasing pools, policies must be aligned both inside and outside of the Oregon Health Fund program to make insurance more accessible to uninsured individuals and employees of small businesses.

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services **(Section 9(2)(d)(F)).**

Standing Recommendations

1. **There were no consensus recommendations on this directive.**

Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures **(Section 9(2)(d)(E)).**

Standing Recommendations

1. **That there should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the Oregon Health Fund program.**

   Rationale:

   - It is evident that to be successful, any entity would need to achieve a certain market share.

2. **Education and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
   - **Schools (public and private and school-based health services**
   - **Home school associations and support groups**
   - **Head Start**
   - **Child care**
   - **Safety-net clinics, including rural and migrant clinics**
   - **Physician and dental offices**
   - **Hospitals**
   - **Pharmacies**
   - **Social service agencies**

   Rationale:

   - Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

3. **Identify uninsured individuals and inform them about Oregon Health Fund program.**

   Rationale:

   - Existing data can be used effectively to target segments of the population.

4. **Increase outreach and retention for those individuals already eligible but not enrolled.**

   Rationale:

   - In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

5. **To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.**

   Rationale:

   - As noted earlier, the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

6. **All outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities.**

   Rationale:

   - As noted earlier, testimony at the MAC's community meetings revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

7. **Families in the target population must be identified and engaged in dialogue before enrollment and retention can be maximized and work closely with communities for participation goals of Oregon Health Fund program can be realized.**

   Rationale:

   - Testimony at the MAC community meetings also gave insight into the need to create a process for outreach that utilized community insight rather than imposing perceived methods for outreach and enrollment.

8. **The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.**

   Rationale:

   - As noted above, the MAC's community meetings encouraged the unique understanding that distinct segments of Oregon's population have on their own communities that would offer innovative and effective public program.

9. **Work with employers and other agencies that do mailings to include information about Oregon Health Fund.**

   Rationale:

   - Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

Eligibility and Enrollment Committee
Enrollment Recommendations Strawperson
April 8, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the enrollment requirements (outreach, application and grievance and appeals processes) needed in a comprehensive plan for health reform.

Outreach

1. **There should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the Oregon Health Fund program.**

   Oregon state budget constraints and economic downturns have severely constrained the state's ability to engage in an outreach campaign to enroll eligible individuals into state sponsored health coverage. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures.[1] Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts that have been effective and necessary to expand coverage to uninsured Oregonians.

2. **Education and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
   - **Schools (public and private and school-based health services**
   - **Home school associations and support groups**
   - **Head Start**
   - **Child care**
   - **Safety-net clinics, including rural and migrant clinics**
   - **Physician and dental offices**
   - **Hospitals**
   - **Pharmacies**
   - **Social service agencies**

   Public testimony to the Oregon Medicaid Advisory Committee (MAC) from advocacy organizations, programs that serve the uninsured, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

[1] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25*

3. **Identify uninsured individuals and inform them about Oregon Health Fund program.**

   While media outreach can be effective, targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. For example, Washington State's new insurance laws mandate a "proactive, targeted outreach and education effort" to enroll children in health coverage, with a focus on populations with the highest rates of uninsurance.

4. **Increase outreach and retention for those individuals already eligible but not enrolled.**

   There are high numbers of uninsured who are eligible for public coverage but are not enrolled—this may be due to lack of knowledge about program availability and not valuing coverage. In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

5. **To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.**

   The MAC's community meetings in developing the Healthy Kids Plan revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

6. **A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.**

   a. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
   b. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
   c. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

7. **The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.**

   As noted above, the MAC's community meetings encouraged the unique understanding that distinct segments of Oregon's population have on their own communities that would offer innovative and effective public program.

8. **Work with employers and other agencies that do mailings to include information about Oregon Health Fund.**

   Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

Application

1. **Application processes should be streamlined to increase the likelihood that eligible individuals will be covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.**

   A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, states relied on lengthy and complex Medicaid applications and required interviews at welfare offices. Recently, however, something of a revolution has taken place in Medicaid programs throughout the country. Complicated applications have been replaced with shorter forms; mail-in applications have made office interviews unnecessary, at least for pregnant women and children; and an increasing number of states have begun to rely on self-declarations and computerized data exchanges in lieu of applicant-supplied verification of eligibility.[2] The state of Oregon is currently creating a simplified version of its main application for state medical assistance programs. This effort should extend to new state programs created by the Oregon Health Fund Board.

2. **There should be modification to current state laws that preclude state agencies from verifying income and other information with existing state databases (i.e. income information from the Oregon Department of Revenue) for state programs to extend health coverage.**

   Administrative barriers such as submitting paycheck stubs for a defined period of time, as is done for the Oregon Health Plan, can be onerous on the applicant and have led states to innovate in changes to application requirements. For example, Lewit et al. note that 13 states do not require families to provide verification of the income they report on their applications. The authors contend that this system greatly reduces the paperwork burden on families—noting that these states now verify income and other information by matching identifying

[2] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25.*

information provided by the family with existing state databases.[3] Other studies have also noted that states adopting self-declaration of income report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[4]

3. **Allow applicants to use the previous year's tax return as a verification option.**

   Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

4. **Recertification of eligibility should not create new barriers to enrollment.**

   The recertification process for enrollees is an area where administrative barriers may actively disenroll or prevent continuation of health coverage. Studies have found that "churning"—when individuals fail to renew their coverage during the eligibility redetermination period required by the programs, but re-apply for coverage after the redetermination period is over—increases administrative costs and consumes limited staff time. Moreover, the most valuable benefit of continuous coverage is beneficiaries' improved health when services are not arbitrarily interrupted. Timely preventive and primary care visits can diminish costly hospitalizations and emergency room visits for uninsured residents.[5]

5. **Families should be kept intact programmatically.**

   Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

6. **Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.**

   Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

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[3] *Ibid, Lewit et al. 2003.*
[4] *Neuschler, E., and Curtis, R. Premium assistance: What works? Washington, DC: Institute for Health Policy Solutions, March 2003.*
[5] *D.C. Ross and I.T. Hill. (2003). "Enrolling Eligible Children and Keeping Them Enrolled," Future of Children 13(1):81-97*

Grievance and Appeals

1. **A grievance and appeal process should be established for any new state health programs to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.**

   According to a National Health Law Program study, Medicaid beneficiaries often face significant challenges when resolving service disputes with a managed care organization.[6] Medicaid beneficiaries, who by definition have limited resources, may find it difficult to obtain medical records, understand notices, and even call the health plan for assistance. These difficulties are compounded for individuals who are illiterate or lack access to a telephone.

[6] *J. Perkins, K. Olson, L. Rivera, and J. Skatrud. (1996). Making The Consumers'Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction. Chapel Hill, NC: National Health Law Program.*

Eligibility and Enrollment Committee
Eligibility Strawperson
April 13, 2008

Background

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs the Committee to operate under the Board's design principles and assumptions document.

This document describes the Committee's eligibility recommendations, which includes broad eligibility recommendations for the Health Fund Board program, but focuses on eligibility for state premium contributions within a health insurance exchange.

In developing these recommendations, the Committee met x times between February and April 2008. Committee members agreed that eligibility proposals would be evaluated on principles of fairness and equity for Oregon residents, employers and employees. A key focus of the Committee's discussion was about the difficult issue of equivalent treatment of families and individuals with similar incomes (horizontal equity), specifically in regard to offering state premium contribution to low-income workers who are offered employer-sponsored health insurance.

Recommendations

1. **<u>State premium contribution eligibility for people who have employer-sponsored insurance</u>:**
   a) **All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored insurance. In order to mitigate the potential loss of employer contributions if employees and dependents switch from employer contributions to state contributions--all employers in the state should contribute to the Oregon Health Fund.**
   b) **Further, the Committee supports a requirement that the employer contribution be coupled with a mechanism to credit employers who continue to provide a benchmark group plan. The specific mechanism should be included as part of the overall financing strategy developed by the Finance Committee of the Health Fund Board.**

The Committee's underlying principle in making this recommendation was that all employers in the state should contribute to the cost of health care for their employees and that it would be inequitable to allow the state to absorb the premium costs of low-income employees alone. The intent of the Committee with Recommendation 1a was to require broad-based employer contribution, but to avoid potential challenges from employers on the basis of the Employee Retirement Income Security Act of 1974 (ERISA). However, the Committee was also compelled by the principle of equity for employers as well as their workers and therefore supports the notion of crediting

employers for offering coverage to their workers, as is reflected in Recommendation 1b. The Eligibility and Enrollment Committee supports the work of the Finance Committee as it develops financing mechanisms that would integrate these two broad recommendations.

Rationale

The Oregon Health Fund Board should adopt eligibility policies that maximize health coverage and at the same time encourage the continuation of employer contributions. Policies providing access to state premium contributions for low-income individuals who are currently offered employer-sponsored insurance risk crowding out of that coverage. Because federal law such as ERISA constrains the ability of the state to require employers to provide health coverage—a broad-based requirement for all employers to contribute to a state health fund coupled with a credit mechanism would allow financial support for any potential loss of employer contributions.

The committee considered multiple policy options regarding allowing low-income individuals that have access to employer-sponsored insurance, and eliminated one from consideration: establishing a "firewall" that prevents anyone who is currently offered employer-sponsored insurance from coming into a health insurance exchange to obtain access to a state premium contribution. It seemed to committee members that denying the state contribution to those who enrolled in employer coverage but not to like persons who declined such coverage is untenable and unfair under an individual mandate, and it penalizes those who "did the right thing" by taking up coverage. Denying a state contribution to low-income workers runs contrary to "horizontal equity" or treating people with similar incomes equitably. Similarly, employers who provide adequate coverage to their employees should also be given consideration in the financing structure adopted by the Board.

Supporting Data

Calculations from the 2001 Current Population Survey (CPS) show that only 7% of those offered insurance are uninsured.[1] Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 7%.[2]

2. Oregon residency: A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.

Rationale

The Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP).

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[1] *J. Gruber and E. Washington, Subsidies to employee health insurance premiums and the health insurance market, Journal of Health Economics Volume 24, Issue 2, , March 2005, Pages 253-276.*

[2] *Ibid*

Residency definitions will define when the individual mandate clock begins. As one Committee member stated, the message in Oregon should be, "Welcome to Oregon, you have xx days to get health insurance coverage."

Supporting Data

- The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents.
- The United States Supreme Court ruling on Saenz v. Roe, 1999 barred states from limiting welfare benefits on the basis on length of residency.

3. **Non-qualified Oregon residents: All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide non-qualified Oregon residents with access to health care services as it is a goal under health reform to minimize/eliminate the cost shift. To the extent that specific groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.**

Rationale:

- Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance, primarily because the average health insurance premium for a family of four is roughly $12,000, nearly half of the average annual income of an immigrant worker. As a result, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardizing their health and welfare, and creating some cost-shifting.
- If employers of such individuals are contributing to the cost of health care coverage in the state through a payroll tax or some contribution requirement—all of their workers should be eligible.
- The committee struggled with the issue eligibility for state premium contribution for individuals who lack documentation of their legal status. However, there was general acknowledgement and support for ensuring that there is access to health care services for all Oregonians.

Supporting Data

- Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care.[3] High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and

[3] *A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, Arch Intern Med. 2007;167(21):2354-2360.*

admission to the hospital for potentially preventable complications of chronic and acute conditions. Insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by creating barriers to timely access to effective care.[4],[5]

- The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between $65 million and $90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.[6]
- Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence.
- The Pew Hispanic Center estimates Oregon's 2005 undocumented immigrant population at between 125,000 and 175,000.[7]

4. **Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.**

   Rationale

   - Twelve months of enrollment is consistent with commercial coverage.
   - A longer enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
   - Less frequent recertification will result in administrative savings.
   - A passive reenrollment process, where families do not complete a renewal form unless changes occur that affect eligibility, will further support continuous coverage and affordability goals.

   Supporting Data

   Results from the baseline OHP cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage

[4] *S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Gaps in Health Insurance: An All-American Problem (New York, The Commonwealth Fund, Apr. 2006)*

[5] *Schoen et al., Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, (New York, The Commonwealth Fund, Sept. 2006*)

[6] *Oregon Center for Public Policy, Undocumented Workers Are Taxpayers, Too, Apr. 2006*

[7] *Pew Hispanic Center, "Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS," Fact Sheet dated April 26, 2006.*

reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.[8]

5. **Presumptive eligibility for state contributions: An applicant who initially appears to meet income and other program eligibility criteria should be presumed eligible. Additionally, individuals who can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.**

   Rationale

   - Oregon Health Fund Board goal is to provide coverage and access to all Oregon residents.
   - For the Medicaid program, delayed verification is an option under federal law that allows the program to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

6. **Period of uninsurance: The Committee recommends against any period of uninsurance as a requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.**

   Rationale

   - Requiring that individuals have a period of time without health care coverage works in opposition to an individual mandate provision, which is one of the Oregon Health Fund Board assumptions.
   - Requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

7. **Assets: There should be no asset limit placed on eligibility for a direct state contribution.**

   Rationale

   - Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.
   - Collecting and verifying information about assets is complex for both applicants and eligibility workers. Eliminating the need to determine family assets supports a goal of administrative simplicity.
   - Some members of the Committee felt that establishing a high asset limit may ensure appropriate targeting of state premium contributions.

[8] *Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" Annals of Family Medicine 4(5): 391-398, 2006*

Supporting Data

- Asset tests may discourage low-income families from accumulating savings. Gruber and Yelowitz (1997) found that asset tests were associated with less savings and elimination of asset tests were associated with higher savings.
- About 78 percent of uninsured adults with incomes below 200 percent of the federal poverty level have net assets (excluding home ownership) low enough to meet median Medicaid asset limit guidelines ($2,000). Of this group, fewer than 40 percent own a home.[9]
- 47 of 51 Medicaid programs in the country, including Oregon's, do not have an asset limit for its traditional Medicaid population (OHP Plus), although it does have a $5,000 asset limit for the expansion population (OHP Standard). Oregon is also one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs. [10]

8. **Guaranteed Issue: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status.**

   Rationale

   - If all individuals are required to purchase health insurance, the ability of health insurers to deny coverage based on health status would undercut this requirement.
   - As most individuals are healthy, each person's share of these costs would be modest if excess costs associated with high medical needs are spread across the entire population through an individual mandate.

9. **Federal Matching Funds: For all components of the Oregon Health Fund Program, the state should maximize the use of matching federal dollars available to Oregon.**

   Rationale

   - In exchange for covering certain groups of individuals, 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 groups of individuals and provide additional services. This federal match allows states to maximize their capacity to meet the needs of their low-income population: Oregon's match rate is about 61% and approximately 72% for the State Children's Insurance Program (SCHIP).

[9] *D. M Cutler & A. M Garbe. "Frontiers in health policy research. Vol. 6." NBER Frontiers in Health Policy Research Series. Cambridge, Mass: MIT. 2003.*

[10] *Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.*

- The Committee assumes that waiver provisions will allow Oregon to have access to Medicaid funding for Oregonians up to 200% FPL for childless adults and parents and SCHIP funding up to 300% FPL for children.
- If the state were to cover all eligible low-income Oregonians under the Oregon Health Plan with limitations of 100% FPL for adults and 200% FPL for children, it would reduce the uninsured population by an estimated 250,000 people. This would require an investment of $390 million from the state that would be matched with $680 million from the federal government.
- The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. One example would be assuring eligibility to segments of the population such as American Indians that would not require state funds because of federal agreements.

10. **Medicare: Develop mechanisms to provide low-income Medicare beneficiaries with the same level of affordability protection advanced to all other Oregonians in the Oregon Health Fund Board program. Low-income seniors should be provided with access to adequate supplemental coverage and have access to state premium contributions.**

    One assumption about SB 329, and the work of our committee, is that we are looking first and foremost at the uninsured in Oregon. As part of a phased implementation, however, the Committee recommends that the Board provide affordability protection and appropriate supplemental coverage to low-income Medicare recipients.

    Rationale

    - Low-income Oregonians covered by Medicare may exceed the affordability standards established by the E&E Committee. There are three significant limitations in Medicare that expose low-income individuals to financial risk:
        1. Medicare does not cover some important health care products and services. For example, the program does not cover many preventive services (such as annual physical exams), routine eye and dental care.
        2. It has high cost sharing on some covered services such as outpatient care and none on others. These variations may lead to inefficient choices by beneficiaries and providers that could inappropriately affect patients' or providers' decisions about the setting for care.
        3. It has no limit on total cost sharing (catastrophic cap).
    - Oregon residents who are eligible for Medicare are a critical component of the state's health system. Health care reform should include this population in identifying potential cost savings, addressing fragmentation in delivery systems, ensuring access to primary care and preventive services, improving accountability for health outcomes, exploring incentives for appropriate use of medical services and reducing administrative differences and barriers between Medicare and Medicaid.

- Reducing financial barriers to early treatment of chronic conditions for Medicare beneficiaries, particularly those with cardiovascular disease or diabetes may have considerable social and economic value for the state of Oregon by improving health outcomes.

Supporting Data

- The Medicare Part B premium in 2008 has risen to $96.40 per month. For someone living solely on the maximum Social Security benefit, they will receive, on average, $1,079 per month in 2008.[11] In other words, this is a low income population without health care access. That example means that person would spend 8.9% of their income on the premium alone, with considerable additional out of pocket costs for Medigap or Medicare Advantage, co-pays, deductibles, etc.
- The coinsurance liability for hospital outpatient services (20-55%) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20%). The high (50%) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services. [12]

For the Federal Laws Committee

1. **Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.**
2. **Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.**

   Request the opportunity of returning to previous documentation methodology employed by the Department of Medical Assistance Programs for citizenship. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
3. **Eliminate the five year ineligibility period for immigrants that become legal permanent residents.**
4. **Eliminate the two-year waiting period for Medicare eligibility after a Social Security disability determination.**
5. **Investigate the methodology applied in determining the Medicare reimbursement levels in Oregon, which currently punishes the state for being efficient.**

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[11] *Social Security Administration – all workers with disabilities – amount varies according to family composition and other eligibility factors.*

[12] *G.M. Hackbarth. "Medicare Cost-Sharing and Supplemental Coverage" Statement before the Subcommittee on Health Committee on Ways and Means U.S. House of Representatives May 1, 2003.*

APPENDIX

Alternative policy options for horizontal equity (in order of Committee preference) include:

a) **No Firewall with a two-part employer "pay-or-play" test. Employers would be required to spend at least x% of payroll overall on health care for their workers—or pay the same percent of payroll to the state as a tax—employers would also be required to either:**

- Require employers to spend at least a specified amount per hour worked by each employee individually—or pay the equivalent amount as a tax. (This approach would assure that "offering" employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer's coverage.), or
- Spend a specified average amount per hour, or % of wage, per worker on all workers earning less than a specified amount—e.g. less than $20,000 per year. (This approach would assure that offering employers would either spend a "fair share" amount towards coverage of their low income workers or pay the state such an amount toward their coverage.)

The workers included in such a "low-earner" definition would include all modest income part-time and temporary workers not eligible for employer coverage and would allow the state to combine "fair share" contributions from multiple workers towards stable coverage through an insurance exchange.

It is possible in such an approach that employers may take actions to contract with workers or create subsidiaries of workers to avoid state designation of employee responsibility.

c) **Employer "Buy-in"/"Vouchers": Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if, and only if, their employer transfers to the pool or public system either, (a) the amount the employer would contribute to the employer's own plan or (b) a specified amount up to (a).**

This approach would have good "horizontal equity" in that employees are not excluded from the state program, and it retains employer contributions. It also may be simpler to administer than "premium assistance."

Due to ERISA, employers cannot be directly compelled to cooperate. Therefore, this approach would leave the worker hostage to employer willingness to cooperate with the state, and it creates the potential for adverse selection cost exposure for the state. There may also be risk selection issues if an employer chooses to keep low-risk employees and allow higher-risk employees to go to the state program.

d) **Benchmark Group Plan option: Alternative approach to the employer buy-in or voucher approach using insurance regulation to make low income**

benchmark plans available through group health plans. (*Would work where employers offer at least one insured (as opposed to self-insured) plan.)*

This approach requires group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state "benchmark" plan for low income persons.

Where carriers choose not to directly administer such a plan, they would have the option of coordinating with insurance exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)

Low-income worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the "parallel" product, less the employer and (subsidized) worker contributions.

e) "No Firewall": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

This option provides very good "horizontal equity"in that it gives people with the same incomes equitable access to publicly subsidized coverage. Doing so may be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions. This approach is similar to the Committee recommendation but does not have a financing mechanism to recapture potentially lost employer contributions.

The following options were discussed, but are not recommended:

f) "Firewall": Deny eligibility for subsidies to anyone who is offered employer coverage.

This approach attempts to conserve limited state funds by maintaining existing employer responsibility /contributions

But would result in either:

- Some low-income workers with employer coverage paying more out of pocket than they can afford, or
- Increased number of uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

g) "Firewall with Premium Assistance": As a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make "premium assistance" payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

This approach has very good "horizontal equity" but is more expensive than a firewall, and if broad-scale premium assistance "fills in" for shortfall of employer

contributions relative to the premium it creates strong incentives to lower employer contributions.

Maintaining employer contributions along with state contributions would be very difficult to administer as obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult.

To make this more feasible, the state might:

- Require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal. This could be easier for the state and for employers, but would not include employers who offer only self-insured plans, or
- Require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays. This might be a requirement except where an employer provides such information through its insurer or Third Party Administrator.

This alternative can be more difficult yet if supplemental or "wrap-around" coverage is to be provided, since employer plans vary considerably. It also requires the system to make "premium assistance" payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification).

Eligibility and Enrollment Committee
Enrollment Recommendations Strawperson
April 8, 2008

The Task: Propose recommendations to the Oregon Health Fund Board on the enrollment requirements (outreach, application and grievance and appeals processes) needed in a comprehensive plan for health reform.

Outreach

1. **There should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the Oregon Health Fund program.**

   Oregon state budget constraints and economic downturns have severely constrained the state's ability to engage in an outreach campaign to enroll eligible individuals into state sponsored health coverage. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures.[1] Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts that have been effective and necessary to expand coverage to uninsured Oregonians.

2. **Education and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
   - **Schools (public and private and school-based health services**
   - **Home school associations and support groups**
   - **Head Start**
   - **Child care**
   - **Safety-net clinics, including rural and migrant clinics**
   - **Physician and dental offices**
   - **Hospitals**
   - **Pharmacies**
   - **Social service agencies**
   - **Accountants**

   Public testimony to the Oregon Medicaid Advisory Committee (MAC) from advocacy organizations, programs that serve the uninsured, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

[1] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25*

3. **Identify uninsured individuals and inform them about Oregon Health Fund program.**

   While media outreach can be effective, targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. For example, Washington State's new insurance laws mandate a "proactive, targeted outreach and education effort" to enroll children in health coverage, with a focus on populations with the highest rates of uninsurance.

4. **Increase outreach and retention for those individuals already eligible but not enrolled.**

   There are high numbers of uninsured who are eligible for public coverage but are not enrolled—this may be due to lack of knowledge about program availability and not valuing coverage. In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

5. **To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.**

   The MAC's community meetings in developing the Healthy Kids Plan revealed possible duplication of effort among various social service agencies that could offer savings of time and money.

6. **A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.**

   a. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
   b. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
   c. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

7. **The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.**

   As noted above, the MAC's community meetings encouraged the unique understanding that distinct segments of Oregon's population have on their own communities that would offer innovative and effective public program.

8. **Work with employers and other agencies that do mailings to include information about Oregon Health Fund.**

   Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

Application

1. **Application processes should be streamlined to increase the likelihood that eligible individuals will be covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.**

   A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, states relied on lengthy and complex Medicaid applications and required interviews at welfare offices. Recently, however, something of a revolution has taken place in Medicaid programs throughout the country. Complicated applications have been replaced with shorter forms; mail-in applications have made office interviews unnecessary, at least for pregnant women and children; and an increasing number of states have begun to rely on self-declarations and computerized data exchanges in lieu of applicant-supplied verification of eligibility.[2] The state of Oregon is currently creating a simplified version of its main application for state medical assistance programs. This effort should extend to new state programs created by the Oregon Health Fund Board.

2. **There should be modification to current state laws that preclude state agencies from verifying income and other information with existing state databases (i.e. income information from the Oregon Department of Revenue) for state programs to extend health coverage.**

   Administrative barriers such as submitting paycheck stubs for a defined period of time, as is done for the Oregon Health Plan, can be onerous on the applicant and have led states to innovate in changes to application requirements. For example, Lewit et al. note that 13 states do not require families to provide verification of the income they report on their applications. The authors contend that this system greatly reduces the paperwork burden on families—noting that these states now verify income and other information by matching identifying

[2] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25.*

information provided by the family with existing state databases.[3] Other studies have also noted that states adopting self-declaration of income report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[4]

3. **Allow applicants to use the previous year's tax return as a verification option.**

   Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

4. **There should be passive reenrollment for the Oregon Health Fund Program as recertification of eligibility should not create new barriers to enrollment.**

   The recertification process for enrollees is an area where administrative barriers may actively disenroll or prevent continuation of health coverage. Studies have found that "churning"—when individuals fail to renew their coverage during the eligibility redetermination period required by the programs, but re-apply for coverage after the redetermination period is over—increases administrative costs and consumes limited staff time. Moreover, the most valuable benefit of continuous coverage is beneficiaries' improved health when services are not arbitrarily interrupted. Timely preventive and primary care visits can diminish costly hospitalizations and emergency room visits for uninsured residents.[5]

5. **Families should be kept intact programmatically.**

   Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

6. **Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.**

   Public testimony to the MAC from advocacy organizations and programs that serve children, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

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[3] *Ibid, Lewit et al. 2003.*
[4] *Neuschler, E., and Curtis, R. Premium assistance: What works? Washington, DC: Institute for Health Policy Solutions, March 2003.*
[5] *D.C. Ross and I.T. Hill. (2003). "Enrolling Eligible Children and Keeping Them Enrolled," Future of Children 13(1):81-97*

Grievance and Appeals

1. **A grievance and appeal process as well as an ombudsman should be established for any state health programs to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.**

   According to a National Health Law Program study, Medicaid beneficiaries often face significant challenges when resolving service disputes with a managed care organization.[6] Medicaid beneficiaries, who by definition have limited resources, may find it difficult to obtain medical records, understand notices, and even call the health plan for assistance. These difficulties are compounded for individuals who are illiterate or lack access to a telephone.

   While grievance and appeal processes have important formal standing, an independent ombudsman role is also recommended. This function, if done properly, can often resolve issues in lieu of a grievance or appeal. In addition, the ombudsman can steer a consumer to appeal and grievance processes if appropriate. As an example in a system with universal coverage, the Parliamentary and Health Service Ombudsman in the United Kingdom works to hold the National Health Service accountable and notes the following, in consumer friendly language: "we work to put things right where we can and share lessons learned to improve public services." Currently, Minnesota and Vermont are examples of health care ombudsmen in the United States. A healthcare ombudsman program developed in Oregon should have statutorily defined responsibilities to include investigation, negotiation, advocacy, and reporting functions.

[6] *J. Perkins, K. Olson, L. Rivera, and J. Skatrud. (1996). Making The Consumers'Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction. Chapel Hill, NC: National Health Law Program.*

The Essential Benefit Package

Draft Proposal

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The Essential Benefit Package
Executive Summary

The Essential Benefit Package (EBP) is designed to improve the overall health of the people of Oregon, reduce health care costs, provide a social safety net, reflect the values of Oregonians, and be affordable and sustainable for the individual and the state.

This EBP incentivizes the **rational redesign of the health care system**:

- Integrated health care homes become the basis for cost-effective, patient-centered care
- All parts of the body are treated equally
  - Mental health and dental services are covered just like other physical health conditions
- Coverage of services will be evidence-based
  - The Health Services Commission or other body should be adequately funded to provide ongoing evidence surveillance and enhanced guidance for the system

This EBP is **innovative**:

- Preventive services are emphasized
- Coverage focuses on care which reduces the overall cost and complications of disease
  - Value-based services are an integral part of the package, representing evidence-based services that reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
- Personal responsibility will be rewarded
  - Value-based services will include incentives and rewards for patients who actively participate in their own health care

The EBP is **affordable for individuals and the state**:

- Preventive care, value-based services, and diagnostic services are available to all with no or low cost barriers
- Other types of care are covered after the beneficiary meets a high deductible amount (adjusted for those close to or in poverty). This:
  - Protects individuals from profound financial losses from unforeseen catastrophic illness or injury
  - Reduces the cost of premiums
- After the deductible is met, personal financial responsibility for services increase for lower priority conditions as reflected in the Health Services Commission's Prioritized List of Health Services

The EBP would serve as the **"basement level" of health care coverage** below which no individual should fall. This:

- Allows for private market innovation to supplement the package
- Prohibits the availability of disease specific plans that do not serve the overall health of an individual

Introduction

When creating a set of essential services, several goals must be met. The Essential Benefit Package (EBP) as described here would:

1) Improve the overall health of the people of Oregon. This goal will be met through improved immunization rates to reduce vaccine transmissible disease, improved screening for diseases which are more cost-effective to treat at an early stage, reduced smoking rates, and improved population health markers such as fewer low-birthweight babies.
2) Incentivize a rational redesign of the health care system. The EBP would improve access to and utilization of services in an integrated health home. All body parts are treated equally; mental health and dental services are included with the same coverage as other physical health conditions.
3) Reward personal responsibility. Value-based services should be developed with rewards and incentives for individuals to actively participate in their own health care.
4) Reduce overall health care costs. This goal would be met through incentivizing patients to receive treatment for early disease in the less expensive outpatient setting rather than waiting until their disease process worsens and requires extensive hospitalization and surgeries. Mechanisms should be put in place to encourage patients to seek care in their health care home rather than the ER for common outpatient complaints. Certain diagnostic tests, procedures, medications, and treatments high cost, high utilization, and/or high variability in usage should be subject to robust, efficient and swift prior authorization processes. Additionally, the EBP would minimize uncompensated care and cost-shifting in the system.
5) Be innovative. The EBP includes value-based services, which are a selected group of evidence-based cost-effective outpatient health care treatments that have been shown to help prevent hospitalizations, ER visits, and expensive complications for particular health care conditions. The EBP would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.
6) Provide a social safety net. The EBP would protect individuals from devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury.
7) Be affordable for the individual and the state. The lowest acceptable "basement" package should be priced low enough to be affordable to all Oregonians above 400% of FPL and be fiscally responsible for the state to subsidize for/offer to Oregonians in or near poverty. It is anticipated that private insurers would be innovative in creating plans which offer a richer benefit package at higher premiums than the EBP.
8) Reflect the values of Oregonians. The EBP would provide services to special populations such as pregnant women and small children and provide dignified end-of-life care, which were values expressed by Oregonians in public meetings on health care reform.
9) Be evidence-based. The EBP would require that the Health Services Commission (HSC) be enhanced, meet more often, and be given greater financial resources to allow for a thorough and timely surveillance of the evidence and provide regular guidance to the system. It is further recommended that the Health Resources Commission become a standing body under the HSC to allow in-depth reviews of technologies and treatments.

It is also anticipated that the HSC will collaborate with other evidence-based bodies in the state, such as the Drug Effectiveness Review Program, the Evidence-Based Practice Center, and the Medical Evidence-Based Decisions (MED) Project.

The Essential Benefit Package responds to the goals above by having few financial barriers to preventive care, access to diagnostic visits and tests, and graduated personal contributions for health care based on priorities set by the Oregon Health Services Commission in the Prioritized List of Health Services. In addition, the plan incorporates both low barriers and incentives for certain "value-based services." These services include cost-effective outpatient treatments which have been shown to reduce hospitalization and ER visits for certain diseases, or which help encourage outpatient care for conditions which constitute a large proportion of current health care spending. Plan members are protected from profound financial loss by having a "cap" placed on out-of-pocket expenses.

The Essential Benefit Package is a "basement level" plan. No insurance plan should be allowed to offer a lower level of benefits. However, private purchasers and governmental programs such as Medicaid could offer a plan that provides more benefits and/or less cost sharing than the EBP. Companies could elect to buy up to a richer plan for employees and individuals could buy up to a richer plan through higher premiums. However, the low barriers to preventive services and value-based services must be maintained for a plan to qualify as meeting the minimum plan requirements. Additionally, such plans must provide the same services as the EBP with no greater cost sharing. It is anticipated the private market would create products which would help reduce premiums through competition and bulk purchasing as well as offer plans with additional, supplemental coverage. Purchase of these supplemental products would be at the discretion of the plan member, employer or other purchaser.

Basic Principles of the Essential Benefit Package

1) Services
    a. The Essential Benefit Package (ESB) is based on the Health Services Commission's Prioritized List of Health Services
        i. Coverage of conditions is not based solely on the part of the body affected, nor is the coverage of services based solely on the type of provider. Evidence and public values will drive coverage decisions.
            1. Dental and mental health conditions will be included as they appear on the Prioritized List
            2. Services such as physical and occupational therapy and complementary and alternative medicine services will be included as they appear on the Prioritized List, with guidelines as appropriate
        ii. Low priority conditions and services may not have any coverage
    b. Preventive services and "value-based services" should have low if any barriers to access
        i. Preventive services are included in Lines 1-7 of the 2008-09 Prioritized List
        ii. Value-based services will be a list of evidence-based services that reduce the overall cost of caring for common chronic diseases and incentivize the use of cost-effective outpatient care
            1. Value-based services are to be developed using evidence-based sources such as the Agency of Healthcare Research and Quality (AHRQ) Ambulatory Sensitive Conditions
            2. Value-based services are to be developed by the Health Services Commission and be a dynamic list reflecting changing evidence and the values of Oregonians
            3. Value-based services will include incentives and rewards for patients who actively participate in their own health care
    c. Diagnostic tests and visits will have some coverage, but may be subject to limitations and have varying cost sharing associated with them
        i. Basic point-of-service tests, such as lab tests or EKGs, and a limited number of diagnostic visits may be covered with limited or no cost sharing
        ii. Certain diagnostic tests, procedures, medications, and treatments with high costs, high utilization, and/or high variability in usage should be subject to limitations and cost sharing to promote the most appropriate use of resources. This should be accomplished using the following hierarchy of approaches:
            1. The used of evidence-based guidelines, where available, that are regularly reviewed and updated.
            2. A robust, efficient, and swift prior authorization process that reduces administrative barriers for patients and clinicians
            3. Cost sharing levels that will discourage the inappropriate use of diagnostic services, particularly those of high cost or which do not have an impact on the clinical management of the patient

   d. Ancillary services such as durable medical equipment and medical supplies should have cost sharing commensurate with the condition that they are being used to treat (i.e., Tiers I-IV on page 10). Such services should not be covered for non-covered conditions in the EBP.
   e. Enabling services such as translation services and care coordination should be incorporated into the administration component of the health care system so that their costs can be distributed across all enrollees as opposed to placing an undue burden on the relatively few who will need the services
   f. Comfort care services, including hospice and palliative care, should be included with little or no cost sharing for outpatient care
2) Financial considerations
   a. Personal financial responsibility should increase for services which are of lower priority on the Prioritized List
   b. Premiums, deductibles and out-of-pocket maximums should be scaled according to the individual's income level
   c. A limit on out-of-pocket (OOP) expenses should be included to prevent profound financial loss
   d. The deductible level and OOP maximum should be high enough to allow financial sustainability of the plan.
      i. The deductible and OOP maximums could be set numbers or could vary with total income
      ii. Deductible amounts and point-of-service cost sharing should be structured in such a way to drive health care utilization decisions
   e. The Essential Benefit Package should minimize uncompensated care and cost-shifting in the market.
3) Medications
   a. A drug formulary should be utilized
   b. The formulary should be supported by evidence-based sources such as the Drug Effectiveness Review Project (DERP)
   c. All medication prescriptions should be required to include ICD-9-CM diagnosis codes to allow efficient utilization of the formulary
   d. Cost sharing should be tiered to encourage the use of generic medications when available and therapeutically equivalent, and the most cost-effective brand name drugs when they are not
4) Integrated health home
   a. The Essential Benefit Package is based upon the concept that all patients will have access to an integrated health home
   b. Integrated health homes should include case management services, care coordination, and other mechanisms that provide for the most appropriate and efficient use of the delivery system
   c. A patient's integrated health home could be their primary care provider's office or a specialist office if it provides the required bundle of services and if the patient's medical situation is best served through a specialist's care (i.e. a patient with cancer may have his or her oncologist's office as their integrated health home)
   d. Ideally, mental health services would be available within the integrated health home

e. The criteria of becoming an integrated health home is anticipated to be developed by the Health Fund Board as informed by the recommendations of the Delivery Systems Committee

5) The EBP is a "basement level" package
   a. Government, private companies, and individuals can purchase or offer a more generous package. The private market can and should develop supplemental plans
   b. Allowable coverage should be based on coverage of at least all of the services provided under the Essential Benefit Package at no higher level of cost sharing
      i. No package should have any higher barriers to preventive and value-based services
      ii. Value-based services must be included as designed by the Health Services Commission and offered with the same or lower cost-sharing as the EBP
      iii. Basic diagnostic services must be offered as outlined in the EBP with no higher cost sharing
      iv. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ER services.
   c. Equivalence between a commercially available plan and the Essential Benefit Package must be based on actual coverage equivalence and not on the equivalence of actuarial value of the plans

Value-Based Services

Value-based services are to be a selected group of cost-effective health care treatments based primarily in the integrated health home which have been shown to prevent hospitalizations, ER visits, and other expensive treatments for particular health care conditions. By encouraging ambulatory use of these services, overall health care costs should be reduced and the population health improved. The Essential Benefit Package would incentivize these services through two mechanisms: 1) minimal cost barriers to receiving these services and 2) financial incentives for following treatment recommendations.

Conditions

Qualifying conditions and cost-effective outpatient treatments for these conditions should be determined by the Health Services Commission or other body designated by the Health Fund Board or Oregon Legislature. Candidates for possible value-based services should come from the list of AHRQ Ambulatory Sensitive Conditions and other evidence-based sources. Examples of value-based service conditions include diabetes, asthma, congestive heart failure, and low birthweight.

Once a list of conditions has been developed, then cost-effective outpatient treatments for these conditions would be determined. Next, evidenced-based guidelines would be created for the use of these treatments. Standards for compliance with these guidelines would be established according to condition and the incentive for meeting the acceptable compliance level would then be determined.

The lists of conditions and value-based services for these conditions would be continuously updated by the HSC or other oversight body based on changing evidence.

Value based services do NOT include all treatments for a condition. Conditions with possible value-based services, such as diabetes or asthma, are currently associated with a wide range of treatments on the Prioritized List of Health Services. These treatments range from inexpensive preventive care, such outpatient visits, to expensive services aimed at treating disease complications, such as ICU admissions and surgeries. A condition which is determined to have value-based services associated with it will remain on its designated Prioritized List line with all relevant **non**-value-based services. Only certain cost-effective outpatient treatments will be moved to the Value-Based Services List. For example, treatments for diabetes such as outpatient primary care visits, yearly diabetic eye exams, and care coordination could be placed on the Value-Based Services List while treatments such as ICU admissions for ketoacidosis or leg amputation surgery would remain on the diabetes line of the Prioritized List, which is currently in Tier I services.

Potential Value-Based Service Examples

The examples are provided for illustrative purposes only and may or may not ultimately be included in a list of value-based services.

1) Chronic disease
    - A patient with a chronic disease would have minimal cost sharing for outpatient provider visits, medications, and other cost-effective treatments for that condition. A patient who sees his or her doctor at recommended intervals, fills his or her prescriptions as prescribed, and actively participates in other aspects of his or her care would have a reduction in the cost sharing for the ER visits and hospitalizations for complications of his or her chronic condition.
2) Maternity care
    - Pregnant women would have no cost sharing for prenatal care. A patient who attends the recommended number of prenatal visits and otherwise completes the recommended portions of her prenatal care would have a no cost share towards the delivery of his or her child.
3) Smoking-related diseases
    - A patient with a chronic disease which is caused by or exacerbated by smoking would have a reduction in cost sharing for outpatient office visits and medications related to that condition if he or she quits smoking. Patients who continue to smoke would pay more for treatments and medications for the smoking-related condition.
4) Integrated health home incentives
    - A patient would have lower cost sharing for visits in the integrated health home compared to the specialty office or ER. In addition, a patient who is enrolled in an integrated health home would have points awarded that he or she could use to reduce the cost sharing for medication or other covered services.
5) Preventive care
    - Preventive services, such as immunizations, flu shots, pap smears, mammograms and screening colonoscopies, would have minimal cost sharing. Plan members who are up-to-date on current screening recommendations could have points awarded that he or she could use to reduce the cost sharing for medication or other covered services, or could use them for wellness activities (e.g., assistance in purchasing a gym membership).
6) Dental
    - Preventive dental exams and cleanings, and fillings for dental caries would have minimal cost sharing. Plan members who receive regular cleanings could have points awarded to use to reduce the cost sharing for restorative dental or other covered services.

Preventive and Family Care Services

Preventive and Family Care Services are a group of services located in Lines 1-7 of the 2008 Health Services Commission Prioritized List of Health Services. These services focus on primary prevention of disease through immunization and behavior change, and screening and early treatment of disease when primary prevention is not possible.

Preventive and Family Care Services include the following:

1) Maternity care
    - Examples: Prenatal visits, routine prenatal testing, high risk obstetrical care, vaginal and cesarean deliveries
2) Newborn care
    - Examples: Newborn preventive services and hospital nursery care
3) Preventive services for children
    - Examples: Well child checks, immunizations, screening for developmental and other problems
4) Preventive services for adults
    - Examples: Physical examinations, Pap smears, colonoscopies, immunization updates, prostate cancer screening, mammography
5) Abuse or dependence of psychoactive substances
    - Examples: Alcohol abuse or drug abuse treatment, both inpatient and outpatient
6) Tobacco dependence
    - Examples: Limited number of visits and medications for smoking cessation assistance
7) Reproductive services
    - Examples: Birth control prescriptions, tubal ligation, vasectomy, IUD devices and placement
    - Elective abortion is NOT included in this category

Preventive and Family Care Services could be subject to limitations through guidelines, prior authorization, or other means. For example, the number of obstetrical ultrasounds provided during an uncomplicated pregnancy could be limited by a guideline or the types of medications for smoking cessation assistance could be subject to a formulary.

The types of services included in this category should be regularly reviewed and updated by the Health Services Commission using evidence-based sources such as the US Preventive Services Taskforce on Preventive Services reports.

Organizational Considerations

• The Health Services Commission (HSC) should be given governance over the Essential Benefit Package (ESB) and its components (value-based services, guidelines, medication formulary, the Prioritized List of Health Services, etc.) as it has a nearly 20-year history of dealing with these types of issues.

- The HSC should adjust the Prioritized List, Plan Tiers, and other parts of the ESB based on changing evidence and public values
- The HSC should regularly review diagnostic tests and update guidelines, rules, or prior authorization requirements integrating the best available evidence
- The HSC should create and update the list of value-based services using available evidence

•To allow the HSC to accomplish these enhanced responsibilities, increased financial and organizational support will need to be provided

- Consideration should be given to having part- or full-time paid members
- It will need to meet more often, perhaps bi-weekly rather than bi-monthly
- It will need to be given adequate research and support staff

•To effectively lever state funds and scarce human resources, the HSC will need to collaborate with other evidence-based bodies in the state

- Drug Effectiveness Review Project (DERP) for formulary creation and maintenance
- AHRQ Evidence-Based Practice Center for assistance with evidence reviews
- Medical Evidence-Based Decisions (MED) Project for assistance with procedure and technology evaluation

•The Health Resources Commission (HRC) should become a standing committee under the HSC in order to provide reports for use in determining evidence-based benefits and value-based services

•An appeals process for the Essential Benefit Package should be created and administered by the HSC or other body

The Essential Benefit Package

Category of Care[1]	Cost-Sharing[2]			Deductible/OOP Max[3]
	Integrated Health Home	**Specialist, Procedures, Other**	**Inpatient, ER**	
Basic Preventive and Family Care Services (Lines 1-7)[4]	0%	5%	10%	•Deductible waived •$4,000-$20,000 OOP max applies (income-based)
Value-Based Services	0%	5%	Not applicable	
Basic Diagnostic Services (2 visits, basic office diagnostics)	0%	5%	No coverage	
Vision Exam (1 per year)	0%	5%	No coverage	
Comfort Care	0%	5%	20%	
Tier I (Lines 8-109)	20%	30%	40%	•$1,000-$7,500 deductible applies (income-based) •OOP max applies
Tier II (Lines 110-309)	40%	50%	60%	
Tier III (Lines 310-503)	60%	70%	80%	
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	Costs do not apply to deductible or OOP max
Excluded Conditions	No coverage	No coverage	No coverage	
Ambulance	$100 copayment, waived if paramedic or EMS standards determines meets transport criteria			
Medications	•$5 copay for generics, $15 copay for preferred brands, 50% co-insurance for other brands[5] •Evidence-based formulary will be used[6] •No coverage for medications for non-covered conditions			•Deductible waived •OOP max applies
Diagnostic Services	•In addition to 2 basic diagnostic visits and basic office diagnostics above •Co-insurance varies based on type of test (e.g., basic office tests 5%, MRIs 50%) •Limitations according to evidence-based guideline(s), location of service or other criteria •Certain high volume, high cost, or high risk laboratory studies, imaging, procedures and office diagnostics subject to prior authorization			Deductible and OOP max apply
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			Deductible and OOP max apply

Notes

[1]Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. Excluded conditions do not appear on the Prioritized List and include experimental treatments, infertility services, or cosmetic procedures.

[2]Co-insurance amounts are examples and can be adjusted until actuarial pricing is acceptable.

[3]Deductible amounts and out-of-pocket maximums should be varied based on income level. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

[4]Reproductive services could be moved to Line 5 and Tobacco Dependence and Drug/Alcohol Dependence removed from the Basic Preventive Services Category (i.e. consisting then of Lines 1-5).

[5]All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

[6]An evidence-based formulary should be utilized and based on sources such as Drug Effectiveness Review Project (DERP).

[7]Mental health and dental conditions are in the Tier which contains their relevant line number(s) on the Prioritized List or should be included as value-based services.

Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon healthcare marketplace.

To be a qualifying plan:

1) The plan must provide all services provided under the EBP at no higher level of cost sharing
    a. Preventive care and comfort care must have no or minimal co-insurance
    b. Value-based services must be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
    c. Basic diagnostic services must be offered as outlined in the EBP with no higher cost sharing
    d. Additional coverage must include at least those condition-treatment pairings included in the 2008-09 Prioritized List through line 503 with the same or lower cost sharing.
        i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ER services.
2) Additional conditions and services can be covered
3) A plan will not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package is required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than preventive, value-based services, basic diagnostic services, and comfort care) with a 20% cost-sharing, which is the lowest cost sharing amount permitted under the Essential Health Package "Tiers." Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in the following table. Note that these are simply example plans; numerous other variations would and could be expected.

Examples of Essential Benefit Package and Supplemental Plans

	Essential Benefit Package			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	$7,500			$2,500			$500		
Out-of-Pocket Maximum	$15,000			$10,000			$2,000		
Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income									
Co-insurance Level (No Deductible Required)									
	Integrated Health Home	Other OP Care	Inpatient, ER	Integrated Health Home	Other OP Care	Inpatient, ER	Integrated Health Home	Other OP Care	Inpatient, ER
Basic Preventive/Family Care Services (Lines 1-7)	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Value-Based Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Vision Exam (1)	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Co-Insurance Level (Deductible Applies)									
Tier I (lines 8-109)	20%	30%	40%	10%	15%	20%	5%	10%	15%
Tier II (lines 110-309)	40%	50%	60%	20%	30%	40%	10%	15%	20%
Tier III (lines 310-503)	60%	70%	80%	40%	50%	60%	20%	30%	40%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	80%	No coverage	No coverage	60%	70%	80%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Prescription Medication	Generic $5, Preferred Brand $15, Other Brand 50% co-insurance			Generic $5, preferred brand $10, other brand 30% co-insurance			Generic $5, preferred brand $10, other brand $25		
Ambulance	$100 copay, waived if criteria met			$75, waived if criteria met			$50, waived if criteria met		
Other Diagnostic Services	Varies			Varies			Varies		

The Essential Benefit Package
Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is at 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a dental cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ER via LifeFlight and spends several weeks in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a $1,000 deductible, then 40% of her bills until she reaches an out-of-pocket maximum of $4,000 (her deductible and out-of-pocket maximum were reduced due to her income level).

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. She would have a 10% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Jones' are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough, and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bronchitis. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a $5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting bronchitis in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and surgeries after meeting their $7,500 deductible. However, once the family meets the $15,000 out-of-pocket maximum for their plan, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year they are in the Oregon

Exchange. They are pleased that there are no pre-existing condition limitations in the Exchange. With this plan, Jenny's doctor visits are covered with a 5% co-insurance and her surgeries and hospitalizations are covered with a 15% co-insurance. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 30% co-insurance instead of the 50% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 90% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are $5 a prescription, but his preferred brand cholesterol medication is $15. Mary is able to get her screening colonoscopy with no cost sharing as it is in the basic preventive portion of their plan.

Bob starts to feel chest pain while watching the Bears game and goes to the ER where he is diagnosed with a heart attack and admitted to the hospital. Heart attack is a Tier I condition and requires a 20% co-insurance for ER and hospital inpatient care after Bob meets his $2,500 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his ER and hospital cost sharing to the outpatient level (10%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Migraine is in Tier III, carrying a 60% co-insurance for her ER visit after Mary's $2,500 deductible. She does not qualify for a reduction in cost sharing and must pay the full 60% unless that amount takes them above their $10,000 out-of-pocket maximum.

The next year, the Browns again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ER care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a home-maker. They have one daughter. The family is concerned about paying high cost sharing for

unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% co-insurance for this hospitalization, after meeting his $500 deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered with a 5% co-insurance under his diagnostic benefit. His broken ankle is in Tier III, making the casting and subsequent orthopedic surgeon office visit covered with a 30% co-insurance.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% co-insurance after she reaches her $500 deductible and purchases her generic medications with a $5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- ☐ a. essential to the public health of Oregonians?
- ☐ b. based upon a proven benefit model?
- ☐ c. reflective of the values of Oregonians?
- ☐ d. easy to adjust in response to new information on cost and effectiveness?
- ☐ e. affordable (to the individual, employer, and state) and economically sustainable?
- ☐ f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- ☐ a. Preventive care
- ☐ b. Chronic disease management
- ☐ c. Primary care medical homes
- ☐ d. Dignified end-of-life care
- ☐ e. Patient-centered care
- ☐ f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- ☐ a. wellness?
- ☐ b. patient engagement (including education towards self-management)?
- ☐ c. coordination and integration of care?
- ☐ d. population health?
- ☐ e. cost-effective care?
- ☐ f. cost-control/reductions in over-utilization?
- ☐ g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- ☐ a. Use of evidence-based medicine
- ☐ b. Efficacy of treatments
- ☐ c. Reduction of health disparities
- ☐ d. Personal responsibility
- ☐ e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- ☐ f. Incentives to encourage appropriate use of effective services
- ☐ g. Acute and tertiary care needs of the population

Appendix B: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of healthcare. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include:

1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
    - Examples include IMTALA, HIPAA, Medicaid and Medicare administrative rules, etc.
3) Workforce issues which must be addressed to allow creation of integrated health homes for all Oregonians
4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
    - Examples include educational interventions, non-emergent transportation, or personal health aides

Appendix C: Glossary

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

co-insurance A defined percentage of the total charges for a service that the patient is responsible for.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the price of services.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by CMS.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium, towards health care expenses covered by their insurance plan over the course of a year.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Modeling Results for "Straw Plan A": Payroll Fee with Credit Allowed

For Discussion Only

OHFB Finance Committee

April 16, 2008

Keep these things in mind…

CPS data used in modeling

- More accurate income data for estimating # eligible for OHP and premium contributions
- May not fully reflect current enrollment in public and private health insurance due to self reporting
- Net effect – likely overestimating the change in enrollment due to reform

Keep these things in mind…

ERISA constraints on payroll tax & credit design

- States can regulate insurance but not private employer-offered benefits
- Rules of thumb to reduce likelihood of ERISA challenge – state policies should not:
  - Require employers to offer health coverage
  - Dictate terms of an employer's health plan such as covered services, premium levels, contribution levels, etc.
  - Tax employer-sponsored health plans *per se*
  - Set standards to qualify for tax credit that are dependent on employer providing health insurance

Keep these things in mind…

Federal matching funds:

- Pricing includes assumptions regarding federal match rate
- No way to know right now what federal government will approve
  - Based on administrative policy priorities – usually not legislation or regulation
  - Can change when there is a new Administration
- Contingency planning could be part of recommendations

Policy Parameters and Assumptions (1 of 5)

- Individual mandate
  - Guaranteed issue
  - "Affordability waiver" at 5% income for people <400% FPL with access to ESI
    - “Access to ESI” → employer pays
      - 50% of premium for workers only (single coverage)
      - 25% of premium for workers AND dependents (family coverage)
  - Mandate effectiveness: 85% for employees and dependents; 70% for all other
- Payroll fee (5% on total SS payroll)
  - Offering (“play”) employers: receive credit up to 4.75% against tax
  - Non-offering (“pay”) employers: no credit, pay full 5%

Policy Parameters and Assumptions (2 of 5)

- Affordability tax credit 300%-400% FPL
  - Tax credit eligibility based on estimated premium of a $2,500 deductible plan
  - Limits family spending to 5% of gross family income
    - Calculated after the 30.3% assumed 125-plan savings
- PMPMs based on DMAP data and preliminary actuarial estimates
- Cost is for full implementation in 2010 dollars

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Policy Parameters and Assumptions (3 of 5)

- **Public (OHP)** includes
  - Adults: 0-99% FPL
  - Children: 0-199% FPL
- **Exchange** includes
  - No individual premium contribution
    - Childless adults, couples: 100-149% FPL
    - Parents: 100-199% FPL
  - Sliding-scale coverage (shared contribution between state and individual)
    - Childless adults: 150-299%
    - Families: 200-299% FPL
  - Affordability tax credit eligibles: 300-399% FPL
  - Employees from "pay" employers 400%+ FPL **(not receiving any state contribution)**
- **Non-group**
  - Anyone purchasing coverage directly from broker or insurance carrier
- **Group**
  - Anyone getting coverage through an employer

Policy Parameters and Assumptions (4 of 5)

- Basic Gruber model:
  - Assumes firms with 100+ workers are *very* unlikely to drop coverage
  - Does not allow employers to drop coverage for some workers and not for others
- Under Straw Plan A:
  - Employers with a number of workers <300% FPL would benefit from by changing their plan-eligibility rules to make those workers ineligible for their plan
    - Employers could save money
    - Workers could get wage increases and would be eligible for the Exchange
  - Most offering employers spend considerably more than 5% of SS payroll on health benefits.
    - Could reduce coverage and still meet the test
  - About 1/3 of all Oregonians with employer coverage are <300% FPL

Policy Parameters and Assumptions (5 of 5)

- **Thus, two different estimates are presented:**
  - Gruber's estimate
  - An additional (non-Gruber) estimate that illustrates the possible extent of additional state costs
    - This additional estimate is labeled *"if more shift" and is always shown in red italics*

Eligibility and Enrollment Affordability Recommendations

- No personal contribution toward premium
  - 0-149% FPL for individuals and couples
  - 0-199% for families
- Sliding-scale structure of shared personal and state premium contribution from 2-5% gross family income towards premiums
  - 150-299% FPL for individuals, couples
  - 200-299% families
- State affordability tax relief
  - Tax deductions, pre-tax premium payments, or tax credits
  - Households 300-399% FPL

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 1a: Coverage Status Before and After Reform*

Coverage Status (Thousands)	Before	(Gruber) After	(Gruber) Change	Percent Change
Public (OHP)	290	530	+240	+84%
New Exchange	0	370	+370	n/a
Non-group	160	100	-60	-39%
Group (Employer)	1,940	1,950	+10	+0.5%
Uninsured	680	120	-560	-83%
Total	3,060	3,060		

*Pop'n totals based on 2010 Census projections, less ~500,000 65+ and ~230,000 0-64 on Medicare or CHAMPUS. Coverage estimates based on 2006 CPS, not actual program enrollment where applicable. Totals may not add due to rounding.

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 1b: Coverage Status Before and After Reform*

Coverage Status (Thousands)	(Gruber) **After**	***(If more shift) After***	**Difference**	**Percent Difference**
Public (OHP)	530	*550*	+20	+4%
New Exchange	370	*530*	+160	+43%
Non-group	100	*100*	-	-
Group (Employer)	1,950	*1,770*	-180	-9%
Uninsured	120	*120*	-	-
Total	3,060	*3,060*	-	-

*Pop'n totals based on 2010 Census projections, less ~500,000 65+ and ~230,000 0-64 on Medicare or CHAMPUS. Coverage estimates based on 2006 CPS, not actual program enrollment where applicable. Totals may not add due to rounding.

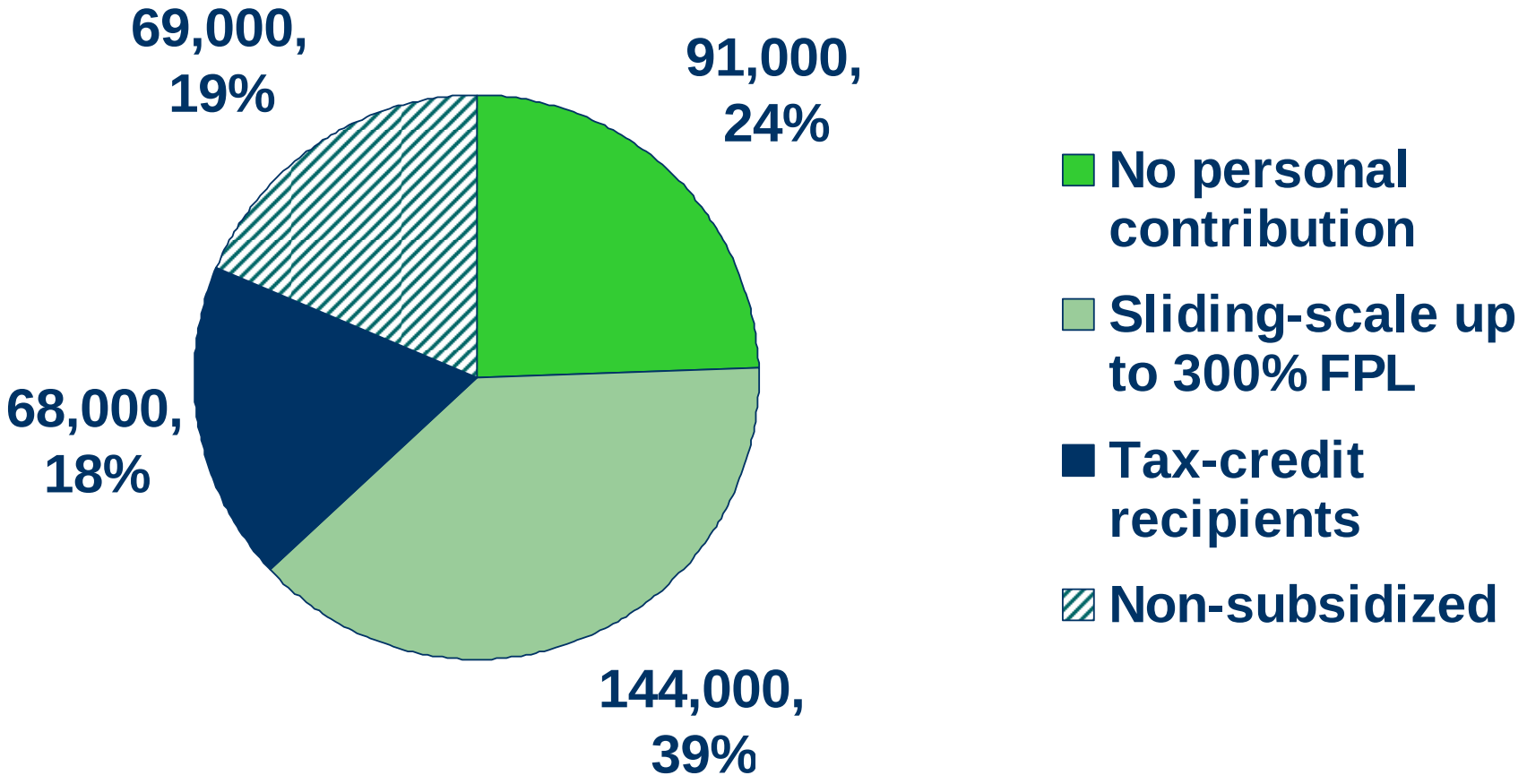
HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 2: Cost of Public (OHP) Coverage

Cost of OHP ($ Millions)	**Gruber Estimate**	***"If More Shift" Estimate***	***Difference***
Total Cost	$1,050	*$1,150*	*+$100*
Federal Match*	$670	*$730*	*+$60*
Net State Cost	**$380**	***$420***	***+$40***

*Assumes current Medicaid match rates at current waivers. Assumes SCHIP match rate from current OHP limit to 200% FPL for children.

Exchange Population (Gruber)



HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 3: Cost of Exchange Populations

Cost of Exchange ($ Millions)	Total	No Personal Contrib.	Sliding -Scale	Tax Credit	No Subsidy
Total Cost (Gruber) ***If more shift***	**$1,510** ***$2,170***	**$400** ***$580***	**$650** ***$940***	**$240** ***$340***	**$220** ***$310***
Individual Contributions	$480 *$690*	- -	$100 *$150*	$160 *$230*	$220 *$310*
Total Subsidy Needed	**$1,030** ***$1,480***	**$400** ***$580***	**$550** ***$790***	**$80** ***$110***	**-** **-**
Federal Matching Payments	$250 *$360*	$250 *$360*	- -	- -	- -
Net State Cost	**$780** ***$1,120***	**$150** ***$220***	**$550** ***$790***	**$80** ***$110***	**-** **-**

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 4: Payroll Tax Revenue

Payroll Tax Revenue ($ Millions)	**All Employers (0.25%)**	**"Pay" Employers (4.75%) (Gruber)**	***"Pay" Employers (4.75%) (if more shift)***
No Personal Contribution	$20	$140	*$140*
Sliding-scale	$30	$80	*$100*
Tax Credit	$20	$50	*$60*
No Subsidy	$90	$200	*$200*
Total = $630	**$160**	**$470**	***$500***

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 5: Employer Spending

Employer Spending ($ Millions)	Before	After	Change	Percent Change
For Group Coverage	$8,000	$7,940	-$60	-0.8%
Payroll Fees	-	$630	$630	-
Total	**$8,000**	**$8,570**	**+$570**	**+7%**

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 6: Summary of State and Federal Costs

($ Millions)	Total	Federal	State
Cost of Public Coverage *If more shift*	$1,050 *$1,150*	$670 *$730*	$380 *$420*
Cost of New Exchange Population	$1,030 *$1,480*	$250 *$360*	$780 *$1,120*
State Income Tax Revenue Loss	$70 *$70*	- -	$70 ***$70***
Total Costs	**$2,150** ***$2,700***	**$920** ***$1,090***	**$1,230** ***$1,610***

Note: State costs are highly dependent on additional federal funds that would require waivers.

HIGHLY PRELIMINARY ESTIMATES-
FOR DISCUSSION ONLY

Table 7: Summary of State Payroll Fee Revenue

($ Millions)	Total	Federal	State
Payroll Fee Revenue *If more shift*	$630 *$660*	n/a *n/a*	$630 *$660*
Summary of costs	$2,150 *$2,700*	$920 *$1,090*	$1,230 *$1,610*
Projected Additional Revenue Needed	**$1,520** ***$2,040***	**-** **-**	**$600** ***$950***

Decision Points for Adjustments to Modeling

- Federal match assumptions
- Affordability standard
- FPL bands for contributions
- Payroll fee level
- Per worker per hour requirement in addition to percent of payroll requirement
- Additional funding mechanisms necessary to meet reform goals

Oregon Health Fund Board
Benefits Committee
Members Appointed as of October 2, 2007

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
Public Health Administrator, Benton County
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Susan King, RN
Executive Director, Oregon Nurses Association
Portland

Jim Lussier
CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena
Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD
Staff Physician, Portland Veterans Affairs Medical Canter
Member, Health Services Commission
Portland

Nina Stratton
Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit
Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Oregon Health Fund Board
Delivery System Committee
Members Appointed as of October 2, 2007

Vanetta Abdellatif
Director of Integrated Clinical Services, Multnomah County Health Department
Member, Oregon Health Policy Commission & Safety Net Advisory Council
Portland

Mitch Anderson
Director, Benton County Mental Health Program
Corvallis

Tina Castanares, MD
Physician, La Clinica Del Carino Family Health Care Center
Hood River

David Ford
CEO, CareOregon, Inc.
Portland

Vickie Gates
Health Care Consultant
Member, Oregon Health Policy Commission
Lake Oswego

Maribeth Healey
Director, Oregonians for Health Security
Member, Archimedes Movement
Clackamas

Diane Lovell
Staff Representative, Association of Federal, State, County and Municipal Employees
Chair, Oregon Public Employees' Benefits Board
Canby

John Barton (Bart) McMullan, Jr., MD
President, Regence BlueCross BlueShield of Oregon
Portland

Dale Johnson, Jr.
Vice President, Corporate Human Resources, Blount International, Inc.
Portland

Ken Provencher
President and CEO, PacificSource Health Plans, Inc.
Member, Oregon Safety Net Advisory Council
Eugene

Steve Sharp
Chairman, TriQuint Semiconductor
Member, Oregon Health Policy Commission
Hillsboro

Lillian Shirley, RN
Director, Multnomah County Health Department
Portland

Richard Stenson
President and CEO, Tuality Healthcare
Member, Medicaid Advisory Committee
Hillsboro

Douglas Walta, MD
Physician, Gastroenterologist
Portland

Rick Wopat, MD
Vice President and Chief Quality Office, Samaritan Health Services
Member, Oregon Health Policy Commission & Medicaid Advisory Committee
Lebanon

Oregon Health Fund Board
Eligibility & Enrollment Committee
Members Appointed as of October 2, 2007

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Dean Kortge
Senior Insurance Specialist, Pacific Benefits Consultants
Eugene

Ellen Lowe
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Carlton James (CJ) McLeod
Senior Vice President and Chief Marketing Office, The ODS Companies
Portland

Bill Murray
CEO, Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney
Health Policy Advocate, Oregon Health Action Campaign
Corbett/Salem

Carole Romm
Director, Community Partnerships and Strategic Development, Central City Concern
Co-chair, Medicaid Advisory Committee
Portland

Jim Russell
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Mike Shirtcliff, DMD
Dentist and CEO, Advantage Dental Plan, Inc.
Member, Medicaid Advisory Committee
Redmond

Ann Turner, MD
Physician and Co-Medical Director, Virginia Garcia Memorial Health Center
Portland/Cornelius

Oregon Health Fund Board
Federal Laws Committee
Members Appointed as of October 2, 2007

Frank Baumeister, Jr., MD
Physician, Northwest Gastroenterology Clinic
Portland

Mike Bonetto
Vice President of Planning & Development, Clear Choice Health Plans
Bend

Chris Bouneff
Director Marketing and Development, DePaul Treatment Centers
Portland

Ellen Gradison
Attorney, Oregon Law Center
Corvallis

Michael Huntington, MD
Retired Physician, Radiation Oncology
Member, Archimedes Movement
Corvallis

Julia James
Consultant
Bend

Mallen Kear, RN (ret.)
Leader, Eastside Portland Archimedes Chapter
Portland

Sharon Morris
Health Care Administrator (ret.)
Grants Pass

Larry Mullins
President and CEO, Samaritan Health Services
Corvallis

Nicola Pinson
Director of Policy and Legal Counsel, Oregon Primary Care Association
Portland

Thomas Reardon, MD
Retired Physician
Gresham

Oregon Health Fund Board
Finance Committee
Members Appointed as of October 2, 2007

Richard (Andy) Anderson
Chief Financial Officer & Senior Vice President, Cascade Corporation
Portland

Kerry Barnett
Executive Vice President, The Regence Group
Chair, Oregon Health Policy Commission
Portland

Peter Bernardo, M.D.
Private Practice, General Surgery
Salem

Terry Coplin
CEO, Lane Individual Practice Association, Inc.
Eugene

Lynn-Marie Crider
Public Policy Director, Service Employees International Union (SEIU) Local 49
Portland

Jim Diegel
CEO and President, Cascade Healthcare
Bend

Steven Doty
President and Owner, Northwest Employee Benefits, Inc.
Portland

Cherry Harris
Labor Representative, International Union of Operating Engineers, Local 701
Gladstone/Oregon City

David Hooff
Vice President of Finance, Northwest Health Foundation
Portland

Denise Honzel
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission
Portland

Enrolled
Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER .....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon's health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon's financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon's health care crisis and comprehensive reform is required; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

SECTION 3. The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

SECTION 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. (1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. (1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.

SECTION 8. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. (1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians' access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients' compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees' Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee's physical worksite, regardless of the employee's state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. (1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. (1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. (1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

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Secretary of Senate

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President of Senate

Passed by House June 22, 2007

.....
Speaker of House

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

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Secretary of State

Summary of SB 329

<u>Section 1</u> – Names provisions of SB 329 the "Healthy Oregon Act"

<u>Section 2</u> – Definitions

<u>Section 3</u> - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	The health care safety net	…is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

Section 5 – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

Section 5 – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

Section 5 – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

Section 6 – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

Section 7 – Purchasing Rules

The Board is generally exempt from public contracting statutes.

Section 8 – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

Section 9 – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan
- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board
- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

- Standards for disenrollment and changing enrollment in AHPs
- Outreach plan regarding the program, eligibility requirements and enrollment procedure
- Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

Section 10 – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

Section 11 – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

Section 12 – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee
- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee
- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee
- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee
- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee
- Benefit Package(s)
- Cost Sharing

OHPR
- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

Health Disparities & Vulnerable Populations Committee
- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

The Office for Oregon Health Policy and Research (OHPR)

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

OHPR Programs

The *Oregon Health Policy Commission (HPC),* enacted in the 72nd Legislative session, is responsible for health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR.

The *Health Services Commission (HSC)* prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan.

The *Health Resources Commission (HRC),* established in 1991, conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with OHSU's Evidence-based Practice Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans.

The *Medicaid Advisory Committee (MAC)* advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan.

The *Oregon Health Research and Evaluation Collaborative (OHREC)* is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population.

The *Oregon Prescription Drug Program (OPDP)* is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP meets these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP unites Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines.

OREGON HEALTH FUND BOARD
ELIGIBILITY AND ENROLLMENT COMMITTEE
Draft By-Laws
Adopted by OHFB _____

ARTICLE I
The Committee and its Members

- The Eligibility and Enrollment Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

OREGON HEALTH FUND BOARD
ELIGIBILITY AND ENROLLMENT COMMITTEE
Approved by OHFB _____

Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board.

Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

Committee Membership

Name	Affiliation	City
Ellen Lowe, Chair	Advocate and Public Policy Consultant	Portland
Jim Russell, Vice-Chair	MidValley Behavioral Care	Salem
Robert Bach	Medicaid Advisory Committee (MAC)	Portland
Jane Baumgarten	Retired	Coos Bay
Dean Kortge	Pacific Benefits Consultants	Eugene
Felisa Hagins	SEIU Local 49	Portland
Noelle Lyda	Ed Clark Insurance Inc.	Salem
CJ McLeod	The ODS Companies	Portland
John Mullin	Oregon Law Center	Portland
Bill Murray	Doctors of Oregon Coast South	Coos Bay
Ellen Pinney	Oregon Health Action Campaign	Corbett/Salem
Susan Rasmussen	Kaiser Permanente	Portland
Carole Romm	Central City Concern, MAC	Portland
Ann Turner, MD	Virginia Garcia Health Center	Cornelius

Staff Resources

- Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research (OHPR) - Tina.D.Edlund@state.or.us; 503-373-1848 (Lead Staff)
- Heidi Allen, OHREC Director, Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1608
- Tina Huntley, Assistant, OHPR – Tina.Huntley@state.or.us; 503-373-1629

Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

OREGON HEALTH FUND BOARD
ELIGIBILITY AND ENROLLMENT COMMITTEE
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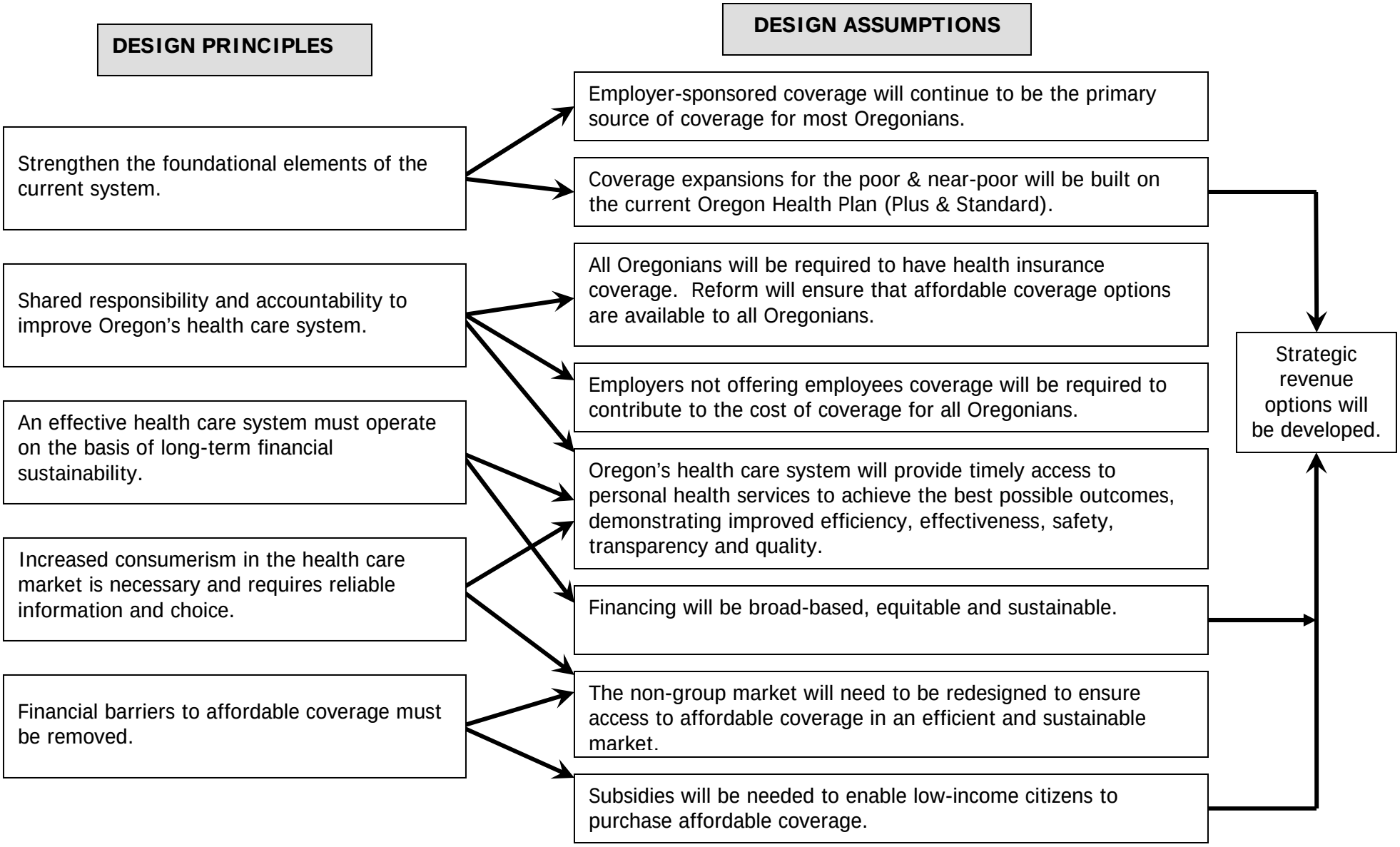
OREGON HEALTH FUND BOARD

A Comprehensive Plan for Reform: Design Principles and Assumptions



2007 Federal Poverty Levels

	Average Hourly Income*						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 4.91	$ 9.09	$ 9.82	$ 14.73	$ 17.18	$ 19.64
$ 13,690	2	$ 6.58	$ 12.18	$ 13.17	$ 19.75	$ 23.04	$ 26.33
$ 17,170	3	$ 8.26	$ 15.28	$ 16.51	$ 24.77	$ 28.89	$ 33.02
$ 20,650	4	$ 9.93	$ 18.37	$ 19.86	$ 29.79	$ 34.75	$ 39.72
$ 24,130	5	$ 11.60	$ 21.47	$ 23.20	$ 34.81	$ 40.60	$ 46.41
$ 27,610	6	$ 13.28	$ 24.56	$ 26.55	$ 39.83	$ 46.46	$ 53.10
$ 3,480	*each add'l person*	$ 1.67	$ 3.10	$ 3.35	$ 5.02	$ 5.86	$ 6.69

	Average Monthly Income**						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 851	$ 1,575	$ 1,702	$ 2,553	$ 2,978	$ 3,404
$ 13,690	2	$ 1,141	$ 2,111	$ 2,282	$ 3,423	$ 3,993	$ 4,564
$ 17,170	3	$ 1,431	$ 2,648	$ 2,862	$ 4,293	$ 5,008	$ 5,724
$ 20,650	4	$ 1,721	$ 3,184	$ 3,442	$ 5,163	$ 6,023	$ 6,884
$ 24,130	5	$ 2,011	$ 3,721	$ 4,022	$ 6,033	$ 7,038	$ 8,044
$ 27,610	6	$ 2,301	$ 4,257	$ 4,602	$ 6,903	$ 8,053	$ 9,204
$ 3,480	*each add'l person*	$ 290	$ 537	$ 580	$ 870	$ 1,015	$ 1,160

	Average Yearly Income***						
Yearly Income	Family Size	100%	185%	200%	300%	350%	400%
$ 10,210	1	$ 10,210	$ 18,889	$ 20,420	$ 30,630	$ 35,735	$ 40,840
$ 13,690	2	$ 13,690	$ 25,327	$ 27,380	$ 41,070	$ 47,915	$ 54,760
$ 17,170	3	$ 17,170	$ 31,765	$ 34,340	$ 51,510	$ 60,095	$ 68,680
$ 20,650	4	$ 20,650	$ 38,203	$ 41,300	$ 61,950	$ 72,275	$ 82,600
$ 24,130	5	$ 24,130	$ 44,641	$ 48,260	$ 72,390	$ 84,455	$ 96,520
$ 27,610	6	$ 27,610	$ 51,079	$ 55,220	$ 82,830	$ 96,635	$ 110,440
$ 3,480	*each add'l person*	$ 3,480	$ 6,438	$ 6,960	$ 10,440	$ 12,180	$ 13,920

* Computed using Monthly Family Income divided by 173.33 (average monthly work hours for a full time employee) and rounded using normal round

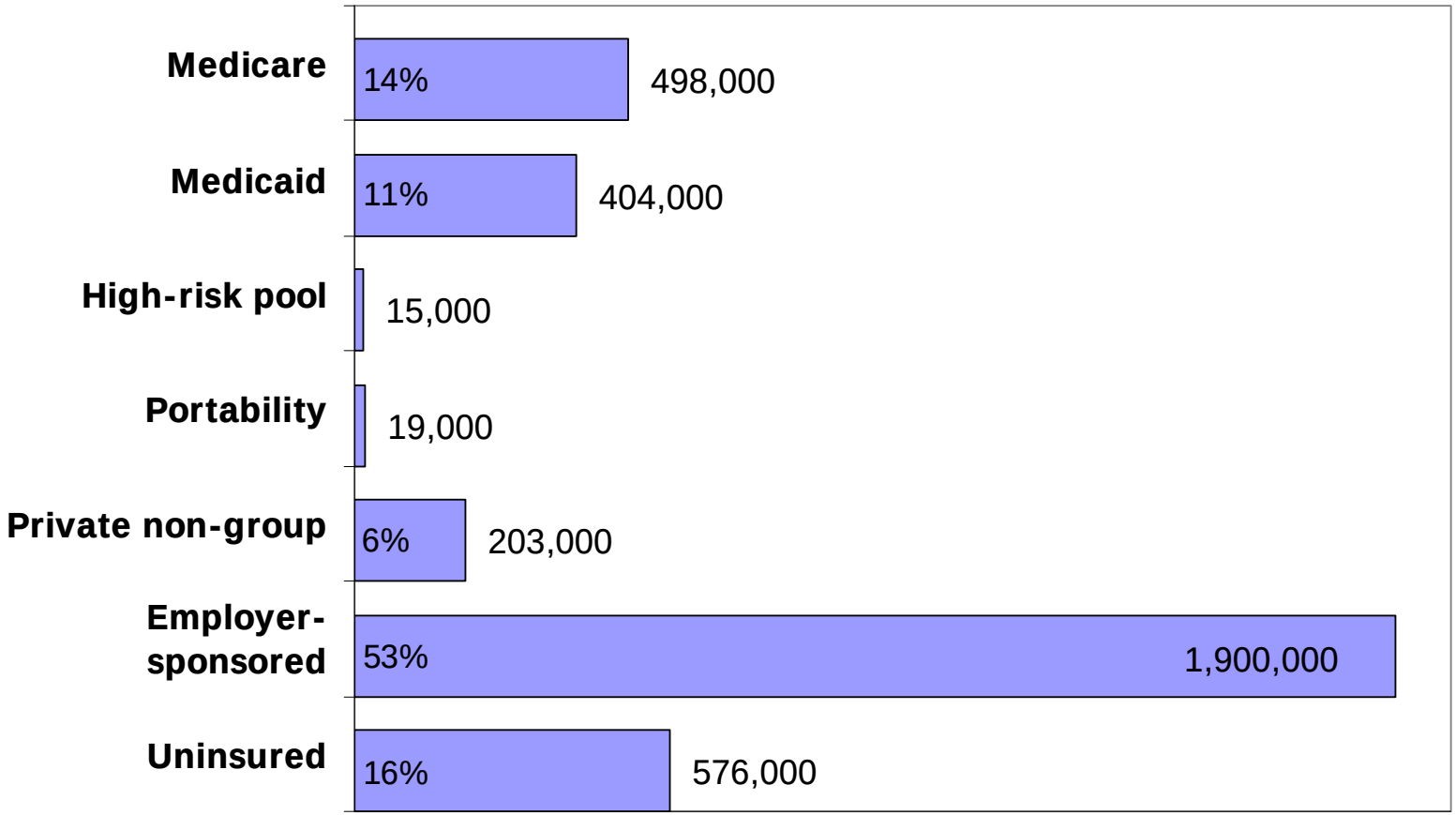
** Computed using HHS Yearly Income multiplied by FPL percent, divided by 12 (months) and then rounding the product up to the nearest dollar.

*** Computed using HHS Yearly Income multiplied by FPL percent and rounded using normal rounding conventions (0-49 down and 50-100 up)

Trends in Coverage
Oregon, 2006

The majority of Oregonians are covered by employer-sponsored insurance

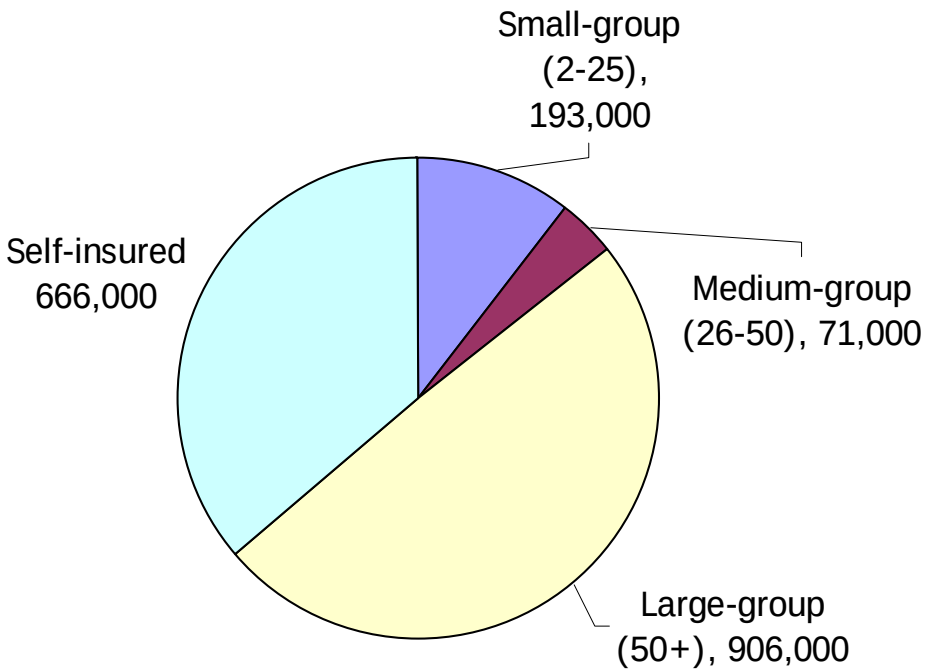
(Oregon population = 3.7 million)



Sources: Uninsured: 2006 Oregon Population Survey, Medicaid: DMAP August 2006 Eligibility Report, Medicare: CMS, 2005 State Report, High-Risk Pool, Portability and Private Non-Group: DCBS, "Health Insurance in Oregon", Jan. 2007, Employer-Sponsored: Kaiser Family Foundation, www.kff.org.

Roughly half of commercially insured are in large group coverage…

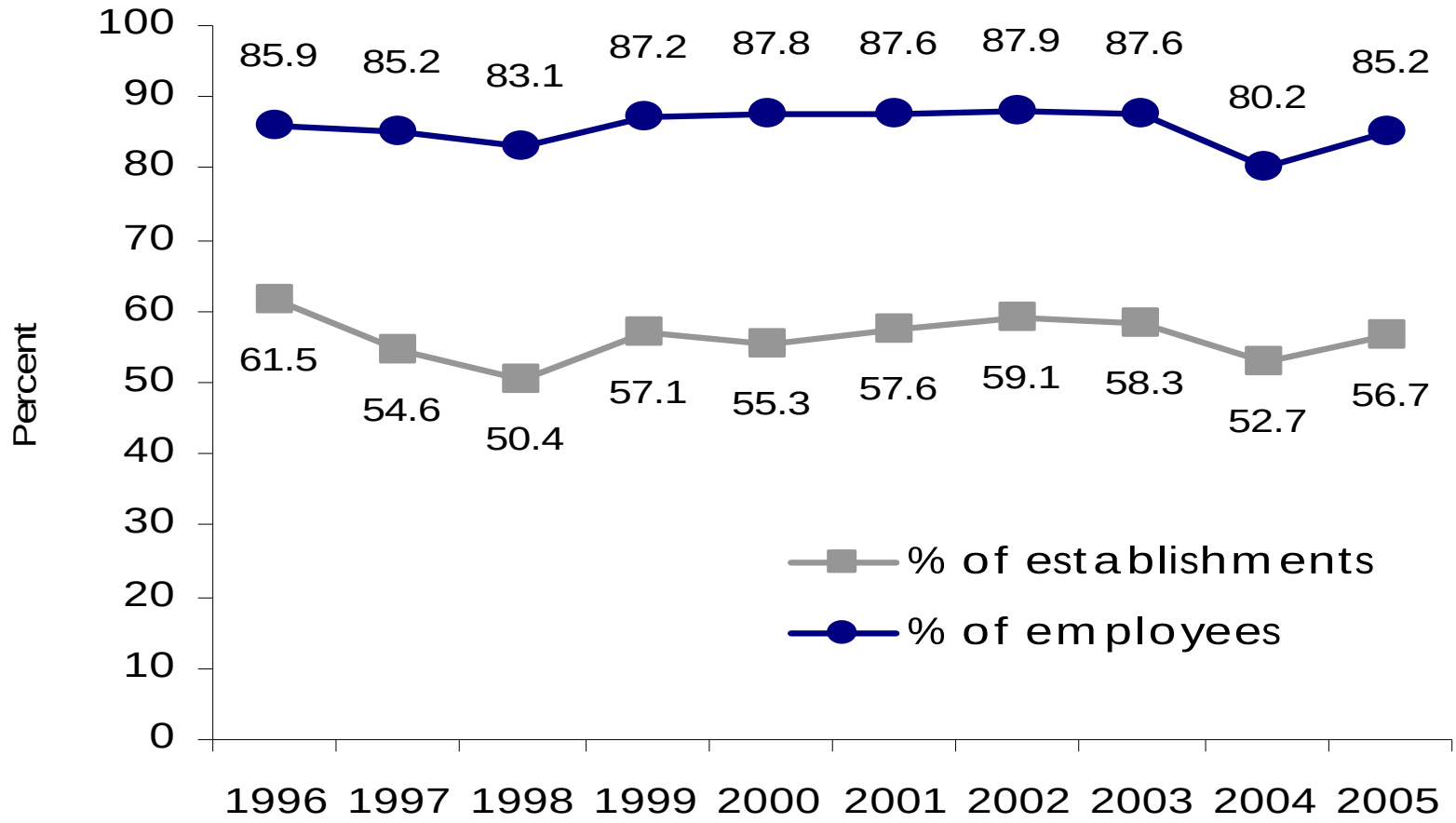
Distribution of commercial insurance in Oregon



Source: Department of Consumer and Business Services, January 2007

The percent of private businesses offering health insurance coverage has not changed significantly…

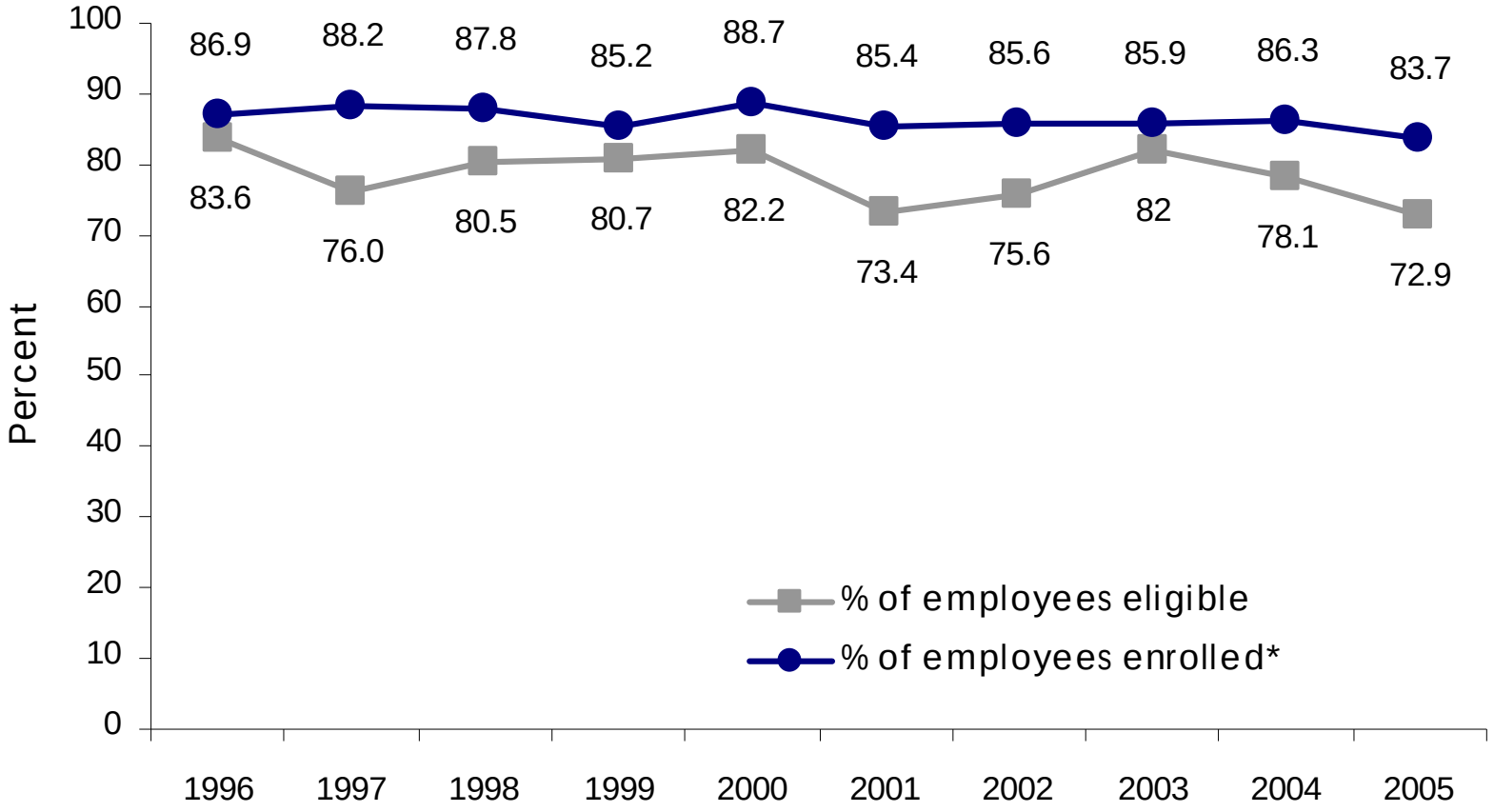
Percent of private establishments providing health insurance and percent of private employees working for businesses that offer insurance, Oregon



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

But the percentage of Oregon employees who are eligible has declined

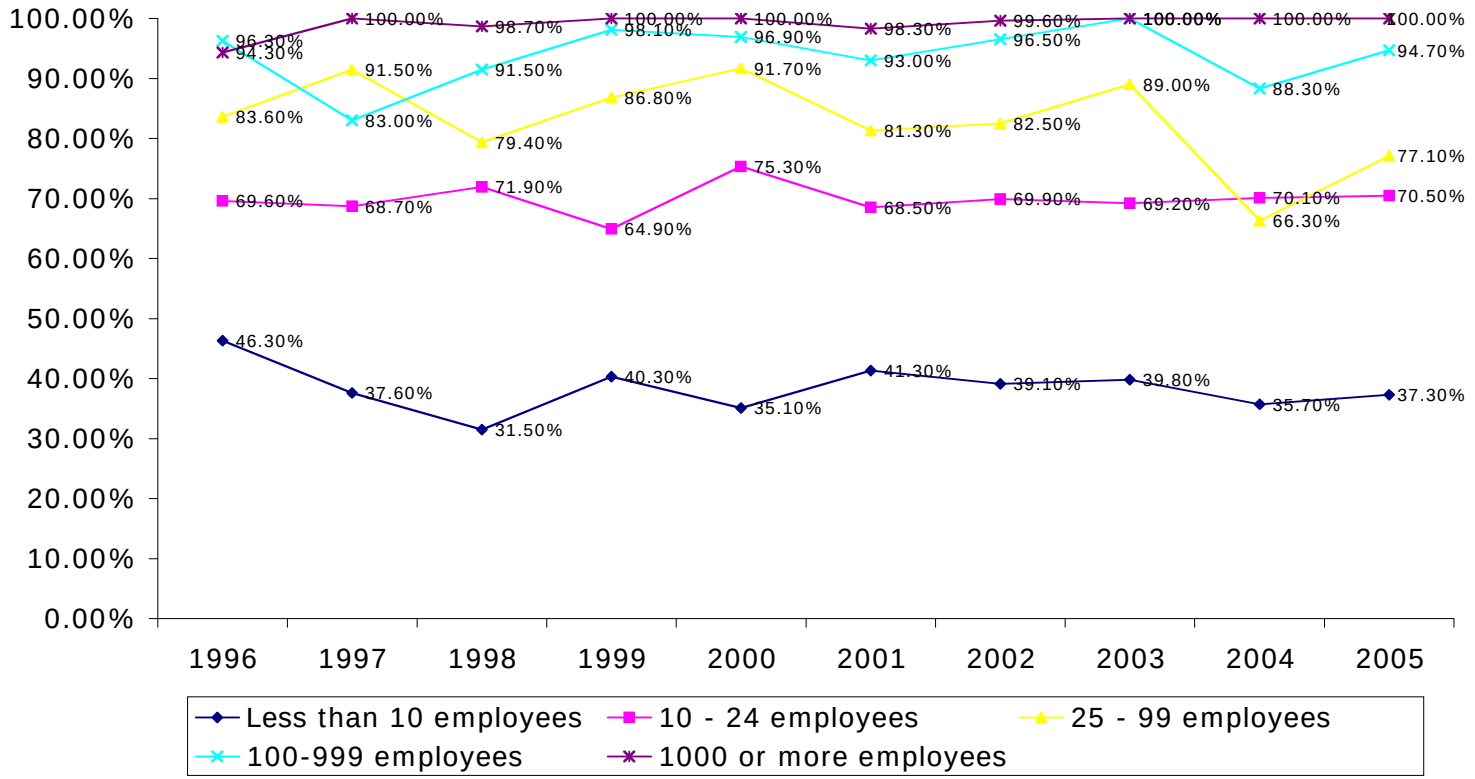
Percent of private employees eligible for employer-sponsored insurance and the percent of those eligible who are enrolled, Oregon



*As a percent of those eligible.

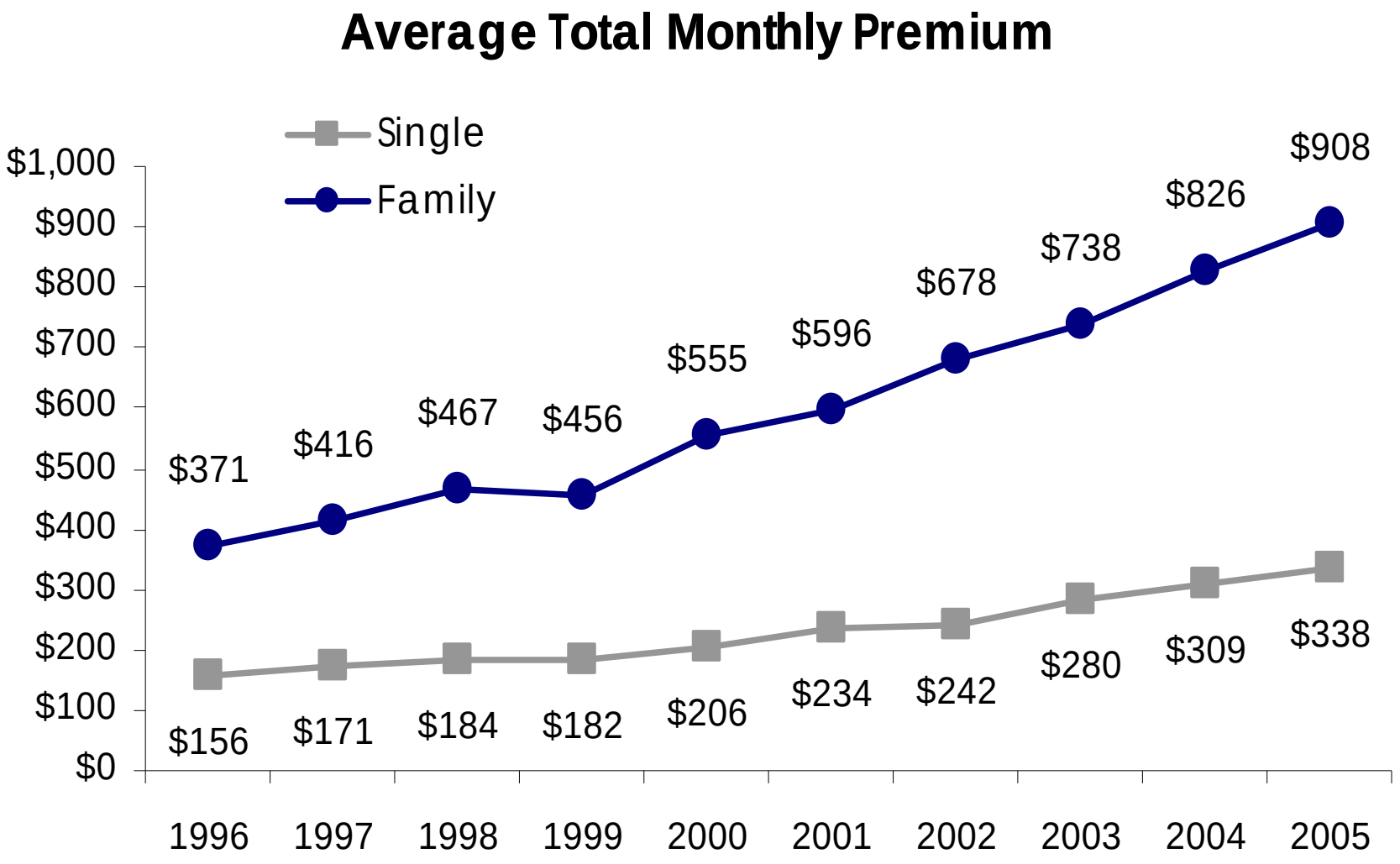
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Only private companies with <10 and 25-99 employees offering significantly less health insurance since 2000



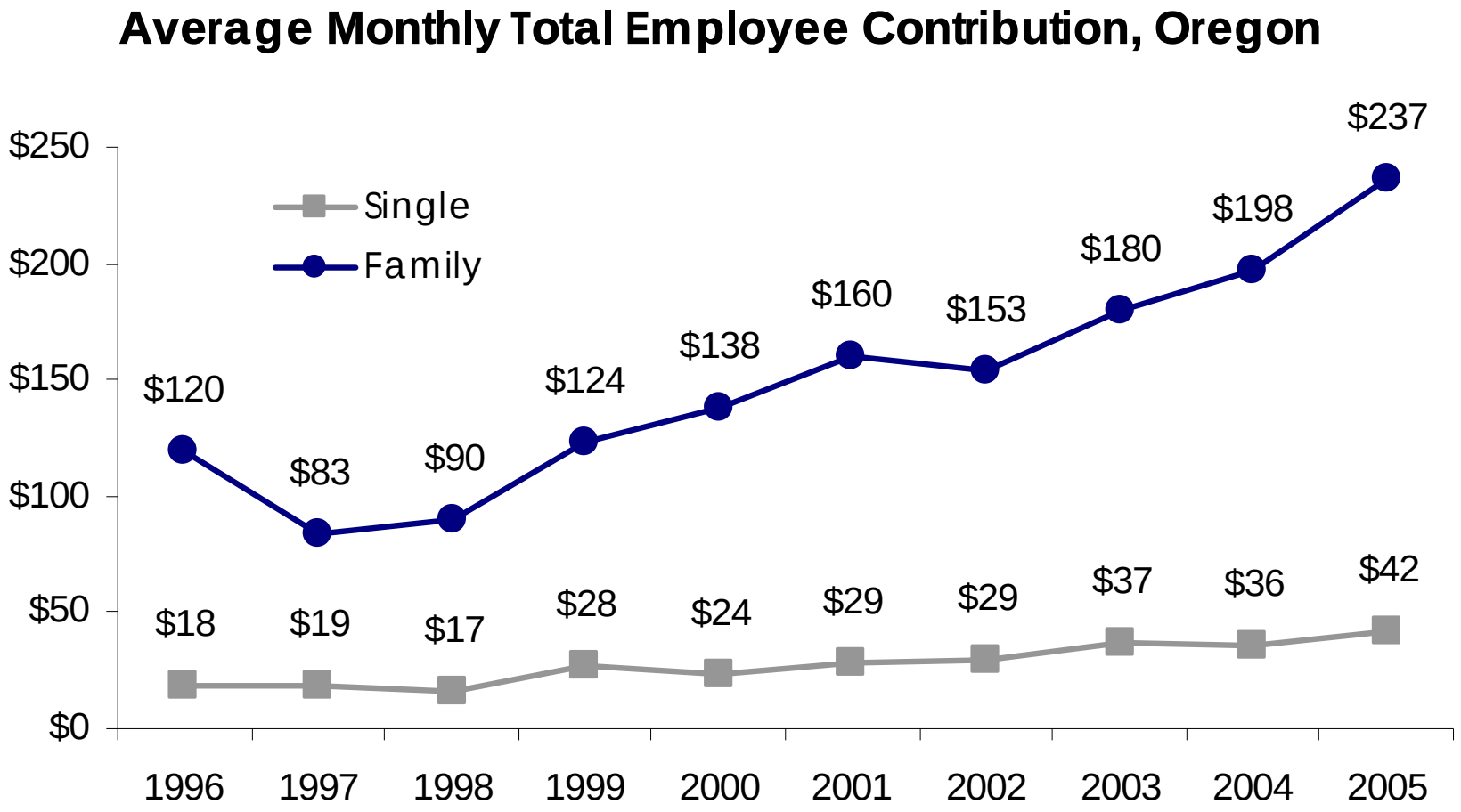
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Premium costs have steadily increased in Oregon.



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Employee contribution requirements have increased as premium costs grow…

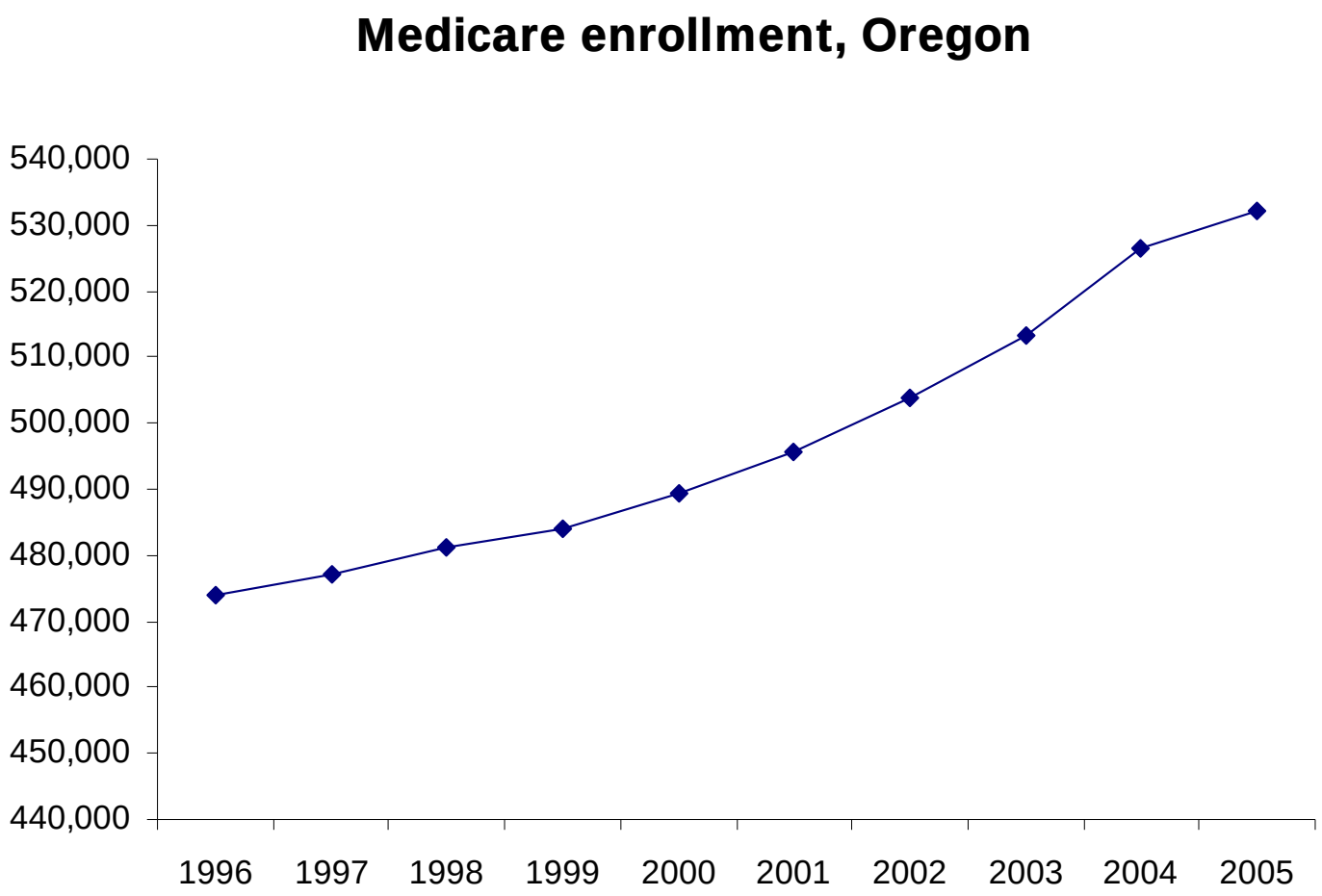


Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Medicare

- Federal insurance program for people age 65 and older and certain disabled people
- Centers for Medicare & Medicaid Services (CMS) operates
- Funded solely by the federal government

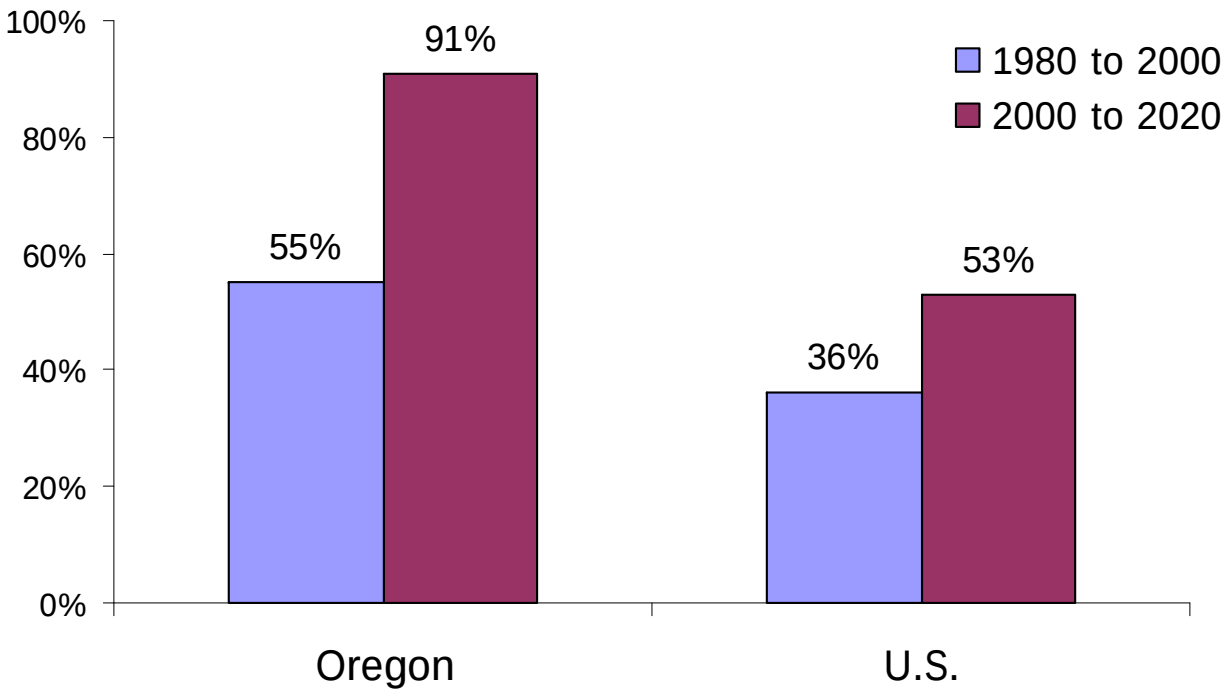
Medicare enrollment has grown as the population ages…



Source: Centers for Medicare & Medicaid Services, Medicare State Enrollment, 2005.

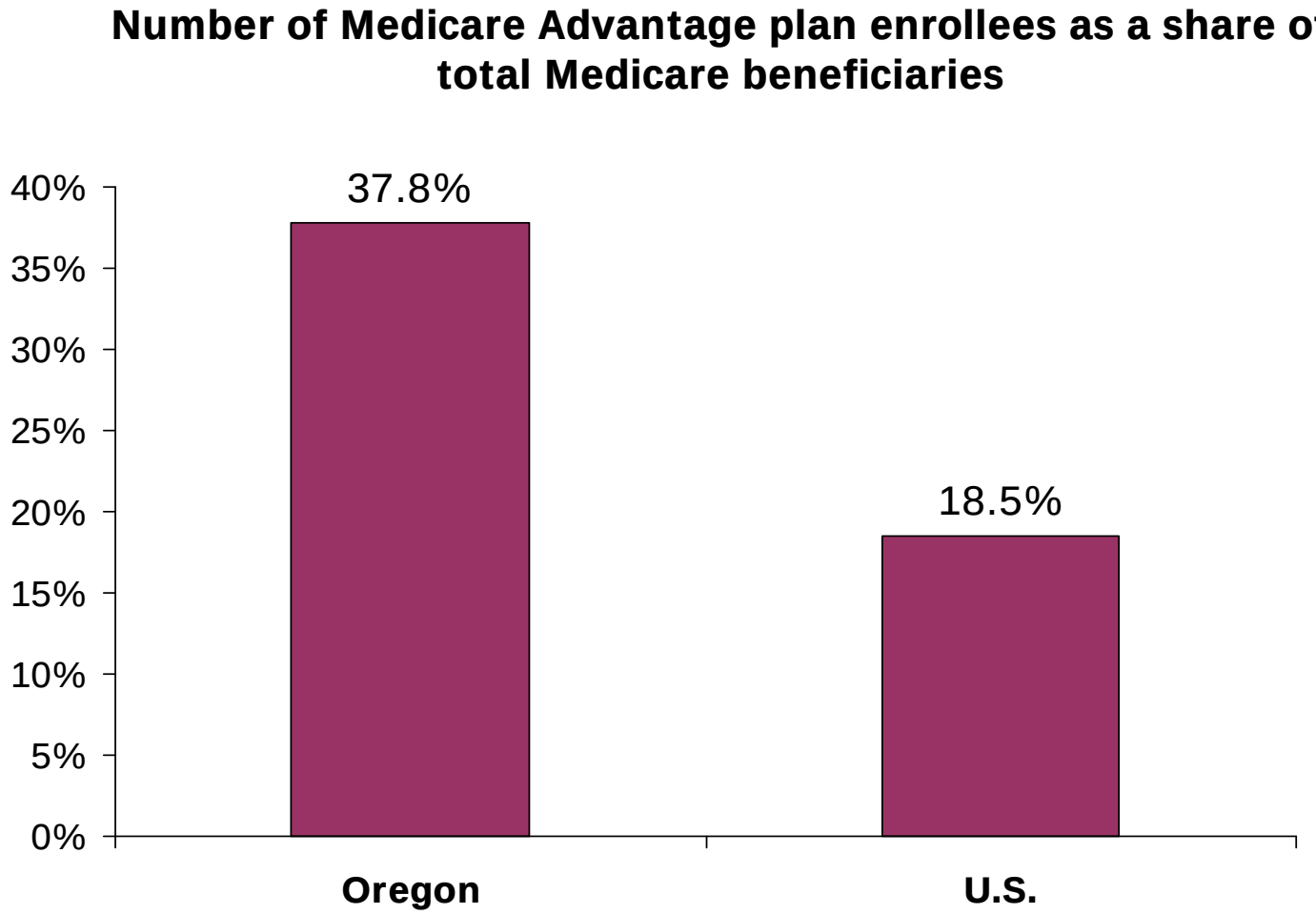
Oregon's 65+ population is increasing rapidly…

Projected percentage change in population 65+ years of age



Source: 2000 HRSA Report – Oregon Profile

Oregon leads country in Medicare Advantage enrollment *



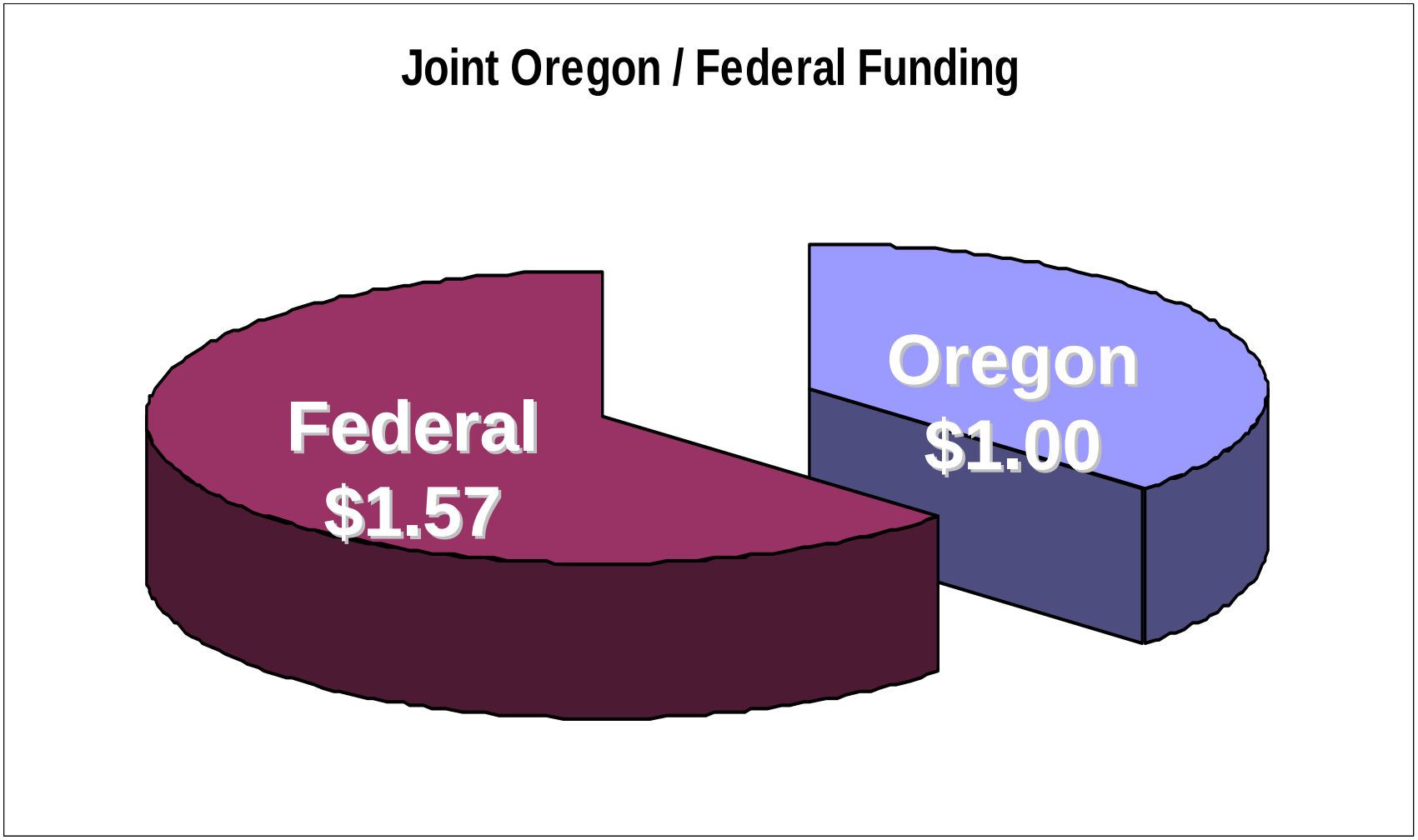
*Puerto Rico has MA penetration rate of 53.3%; OR has highest rate of states

Source: Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker

Medicaid (Oregon Health Plan)

- Pays for medical and long-term care services
  - low-income pregnant women
  - children
  - certain people on Medicare
  - disabled individuals and nursing home residents
- Shared program between the federal and state government

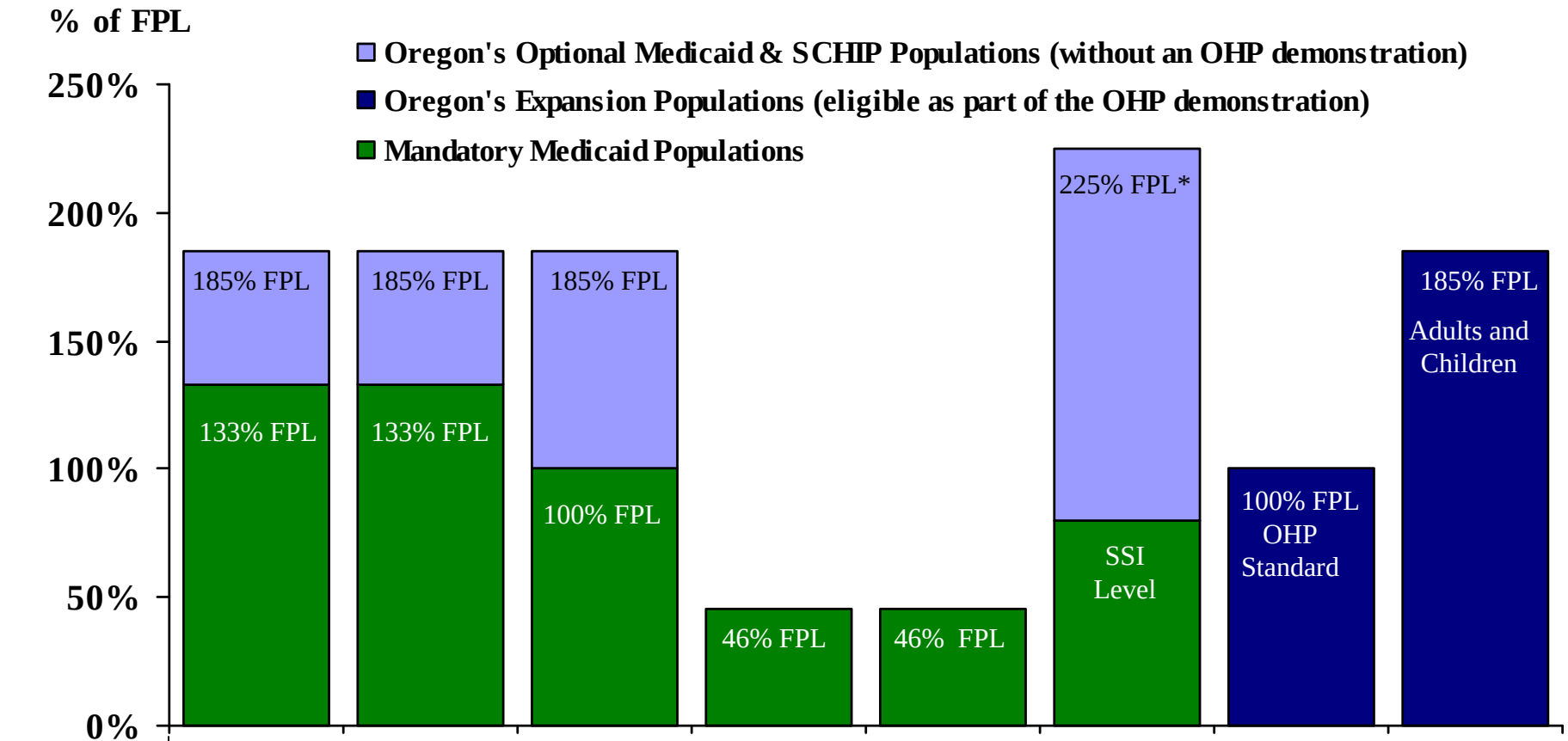
Medicaid is a State/Federal Partnership



Who is covered by the Oregon Health Plan?

- "OHP Plus" program (mandatory Medicaid populations)
  - Low-income elderly, blind & disabled
  - Families receiving Temporary Assistance for Needy Families (TANF)
  - Low-income foster children
  - Low-income children
  - Low-income pregnant women
- Expansion Populations
  - "OHP Standard" program
    - Low-income uninsured adults (OHP Standard)
  - Family Health Insurance Assistance Program (FHIAP)
    - Subsidies to help low-income adults and families purchase private insurance

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



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

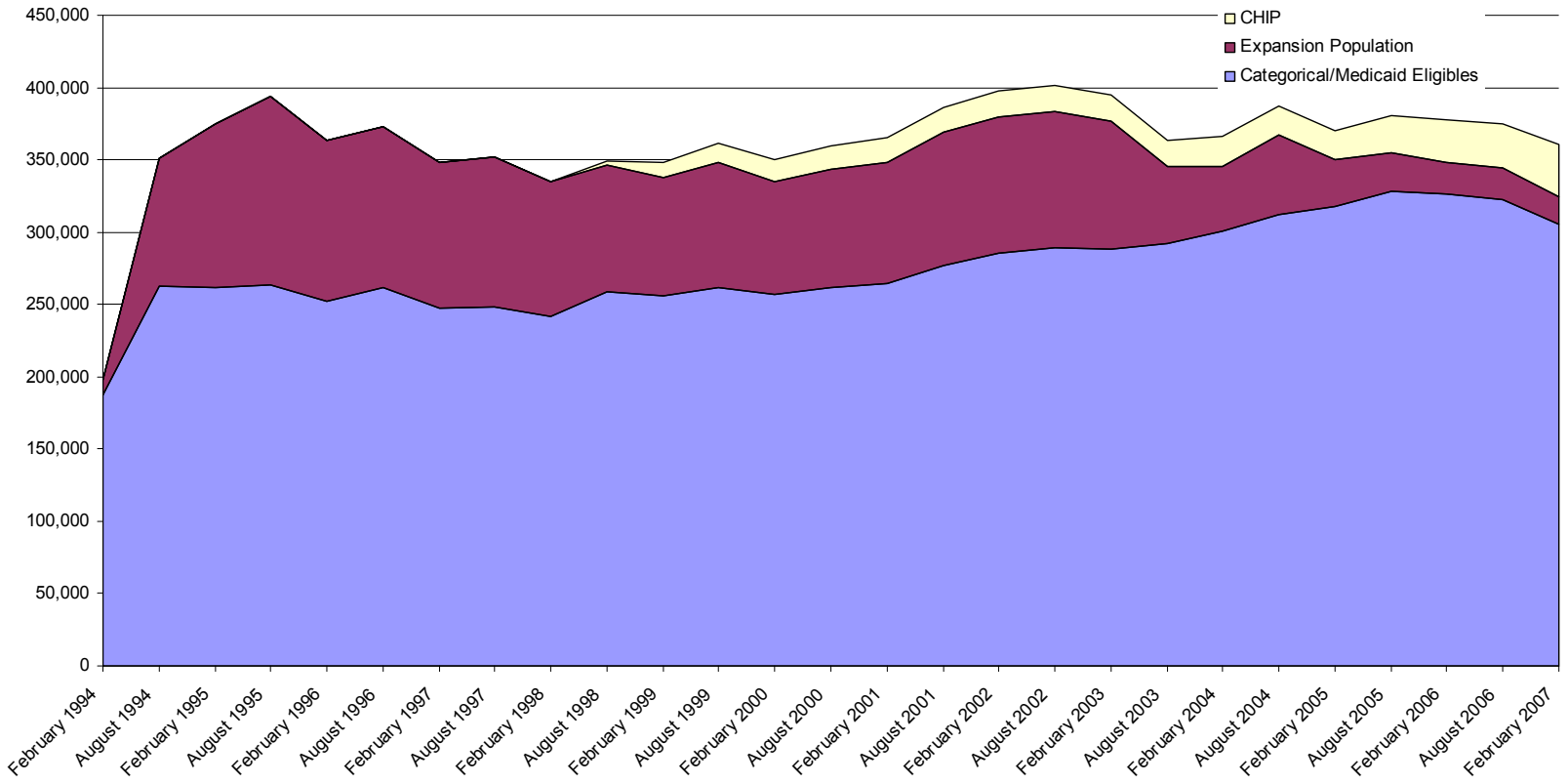
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level

**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% FPL must enroll 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.

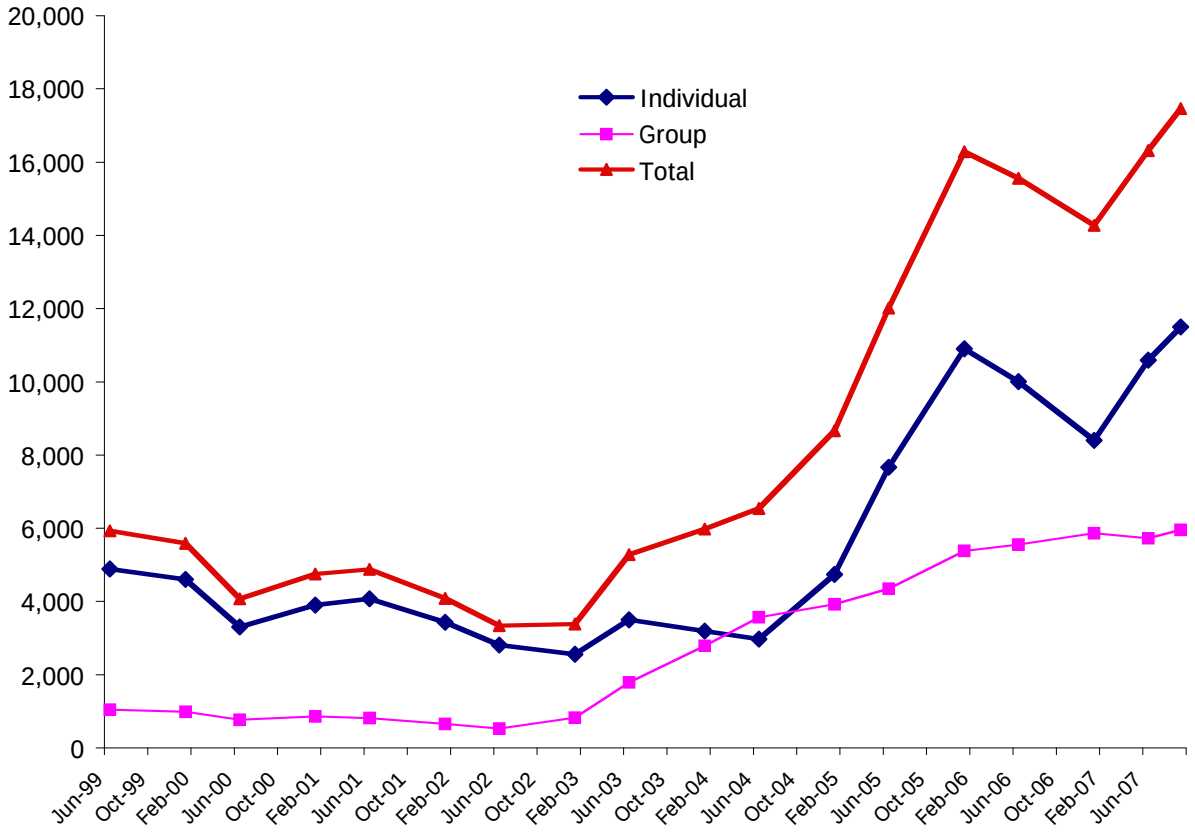
Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Total enrollment is fairly flat over time, but OHP expansion population is shrinking

Total Medicaid enrollment, Oregon, 1994 to 2007



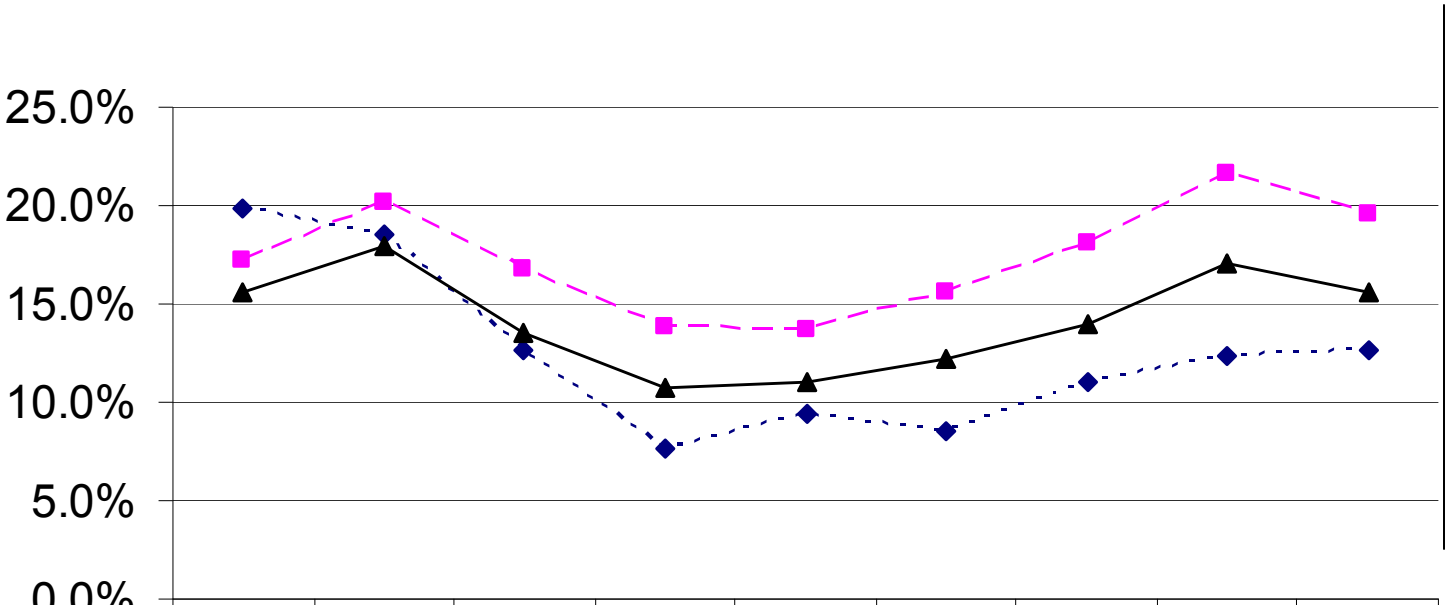
Family Health Insurance Program (FHIAP) enrollment continues to grow.



Who are the uninsured?

Almost one in five adults and one in six children are uninsured

Health Uninsurance Trends, Oregon

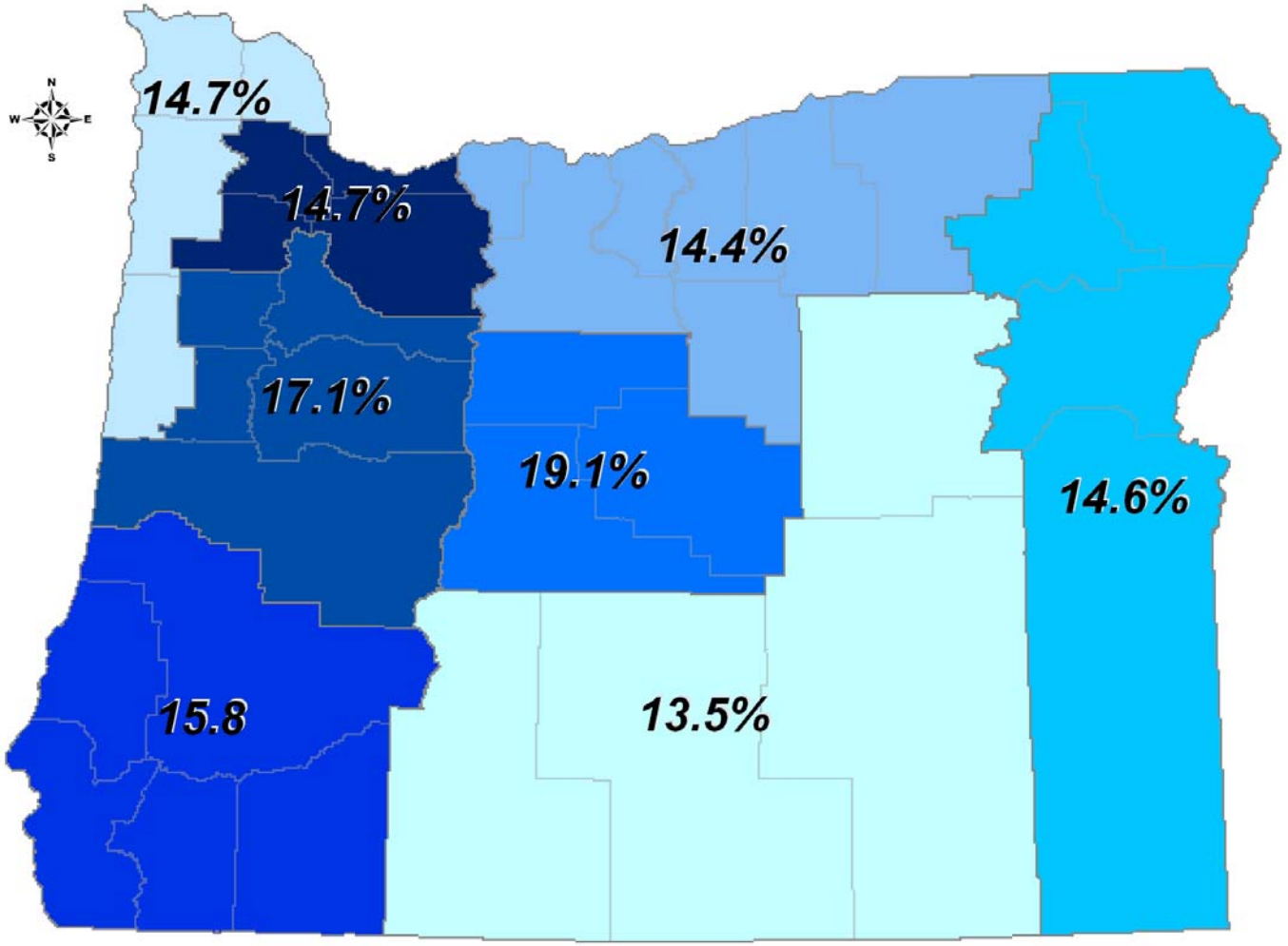


	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

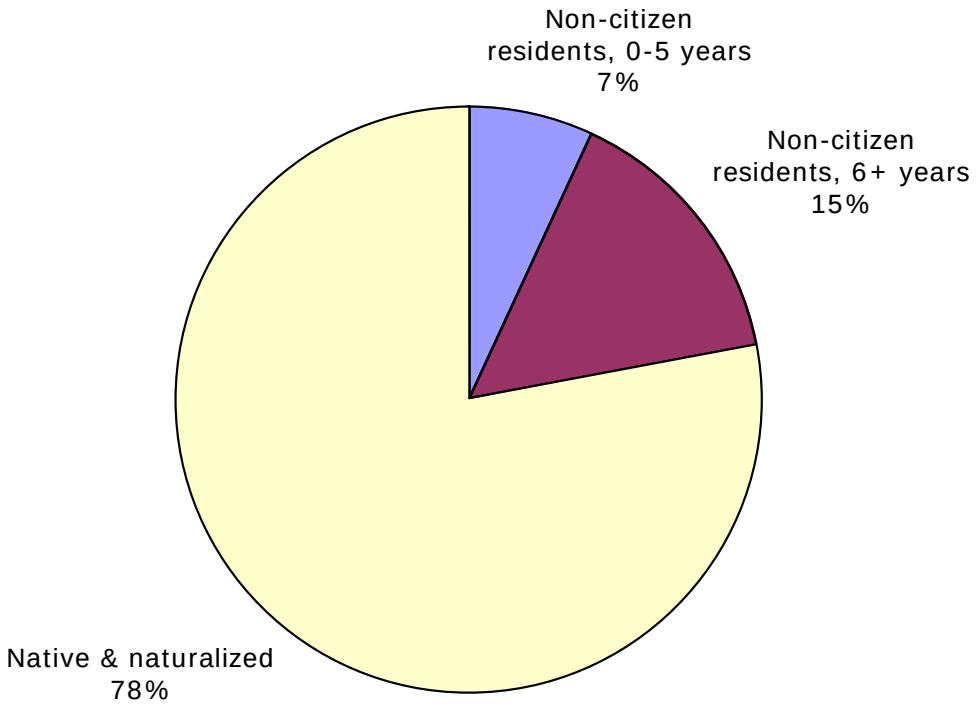
Source: Oregon Population Survey, 1990 to 2006.

Mid-Willamette Valley and Central Oregon have the highest rate of uninsured

Regional Percentages of the Uninsured, Oregon 2006

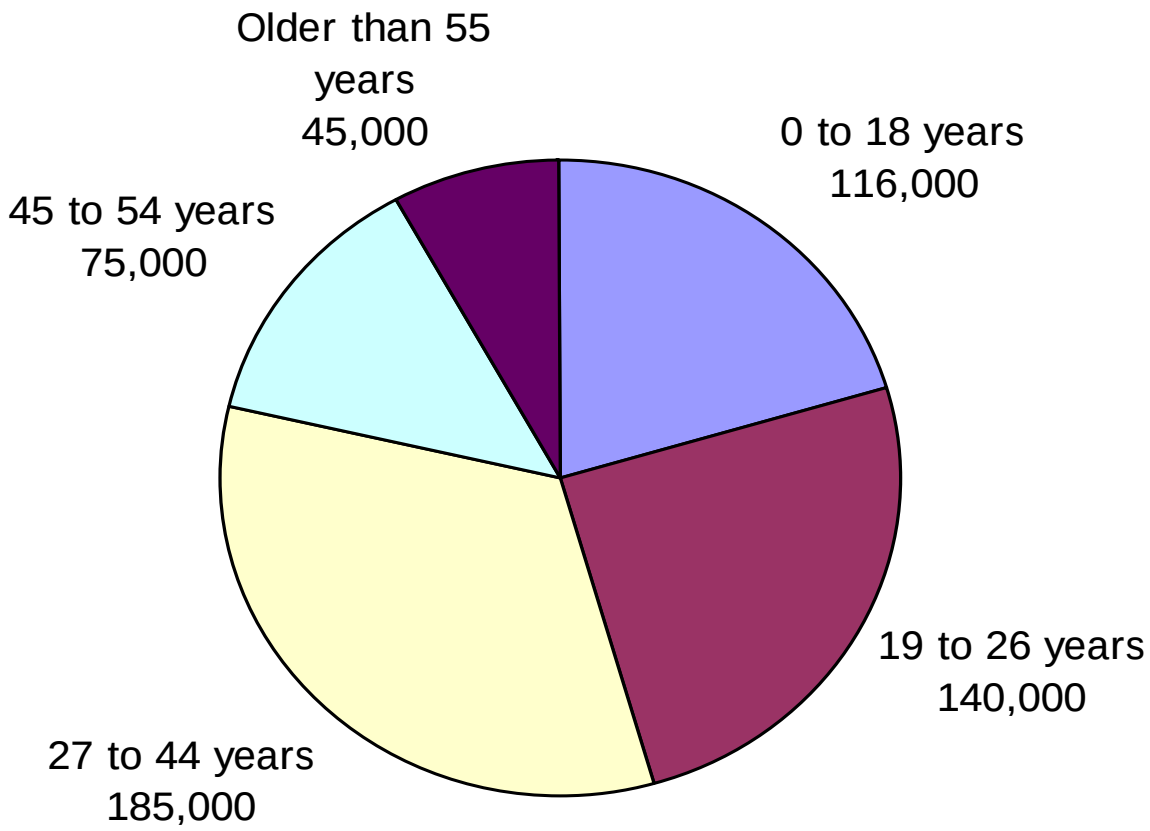


Native & naturalized citizens are over 70% of the uninsured...



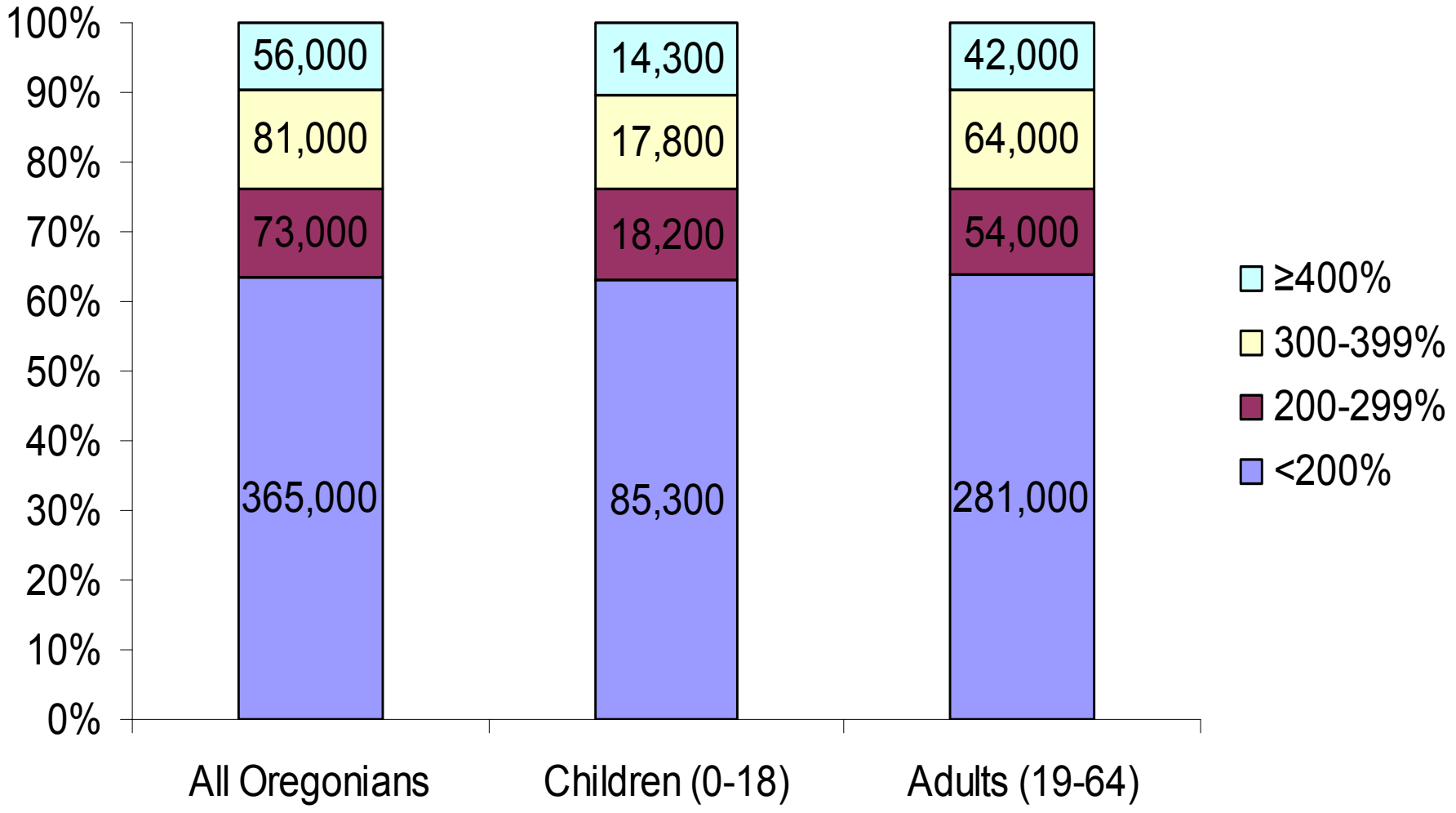
Source: Kaiser Family Foundation; The Uninsured: Key facts about Americans without health insurance, October 2007

Adults are more likely than children to be without insurance.



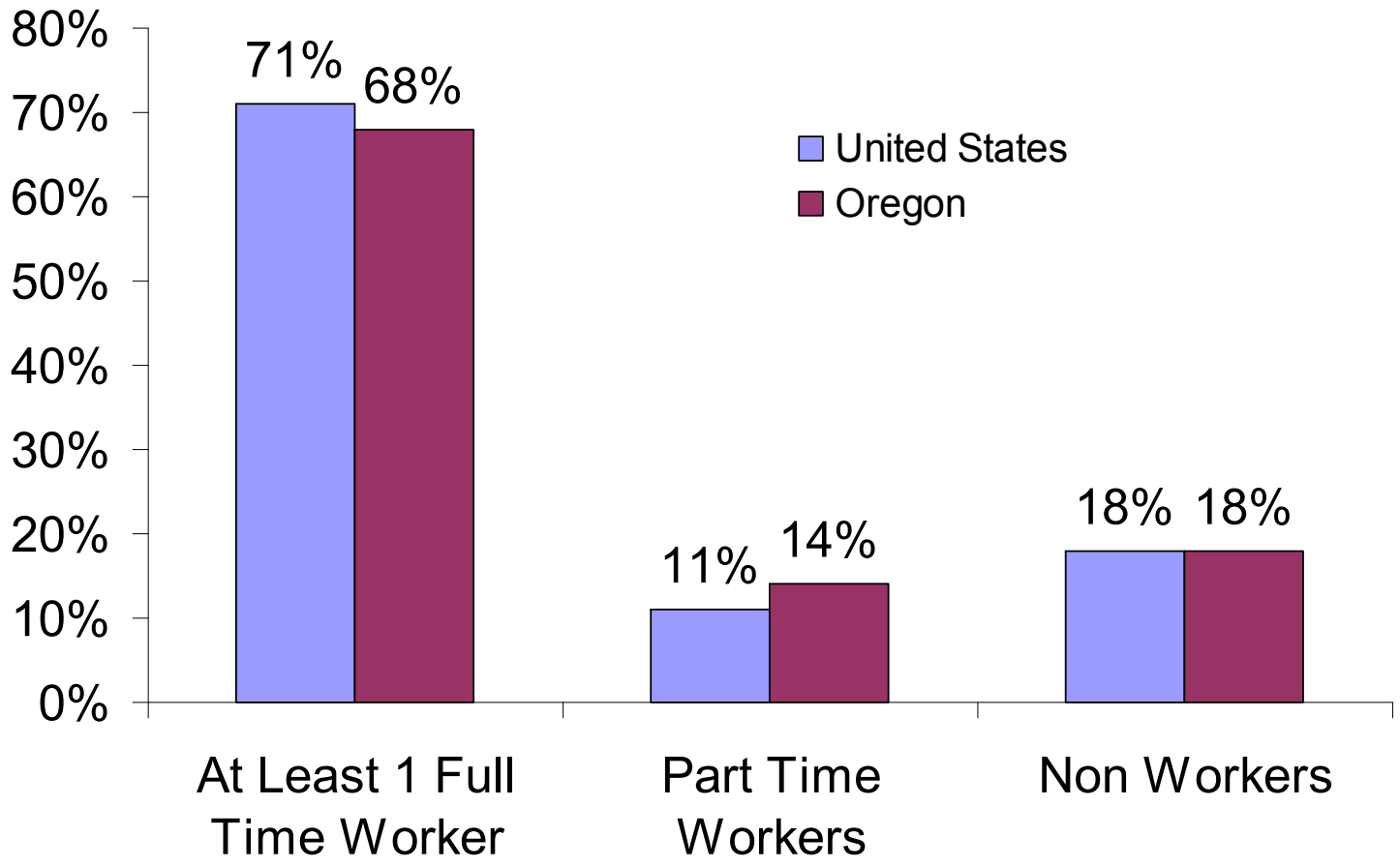
Source: 2006 Oregon Population Survey.

Over 60% of the uninsured are below 200% FPL



Source: 2006 Oregon Population Survey.

68% of uninsured in Oregon are from families with at least 1 full-time worker



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

Hispanics are most likely to be uninsured

Percent Uninsured by Race and Ethnicity:

- Asian – 9.7%
- White, non-Hispanic – 13.3%
- African-American – 14.1%
- American Indian – 27%
- Hispanic, any race – 32.5%

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

Consequences of being uninsured include:

- Reduced access to health care
  - Uninsured receive too little medical care and receive it too late
- Poorer medical outcomes
  - Uninsured are sicker and die sooner
- More expensive medical care
  - Often the only patient billed full charges from a hospital
    - Billed charges are 2.5x greater than actual payments[1]
  - 45.6% of all personal bankruptcies involve a medical reason or large medical debt[2]

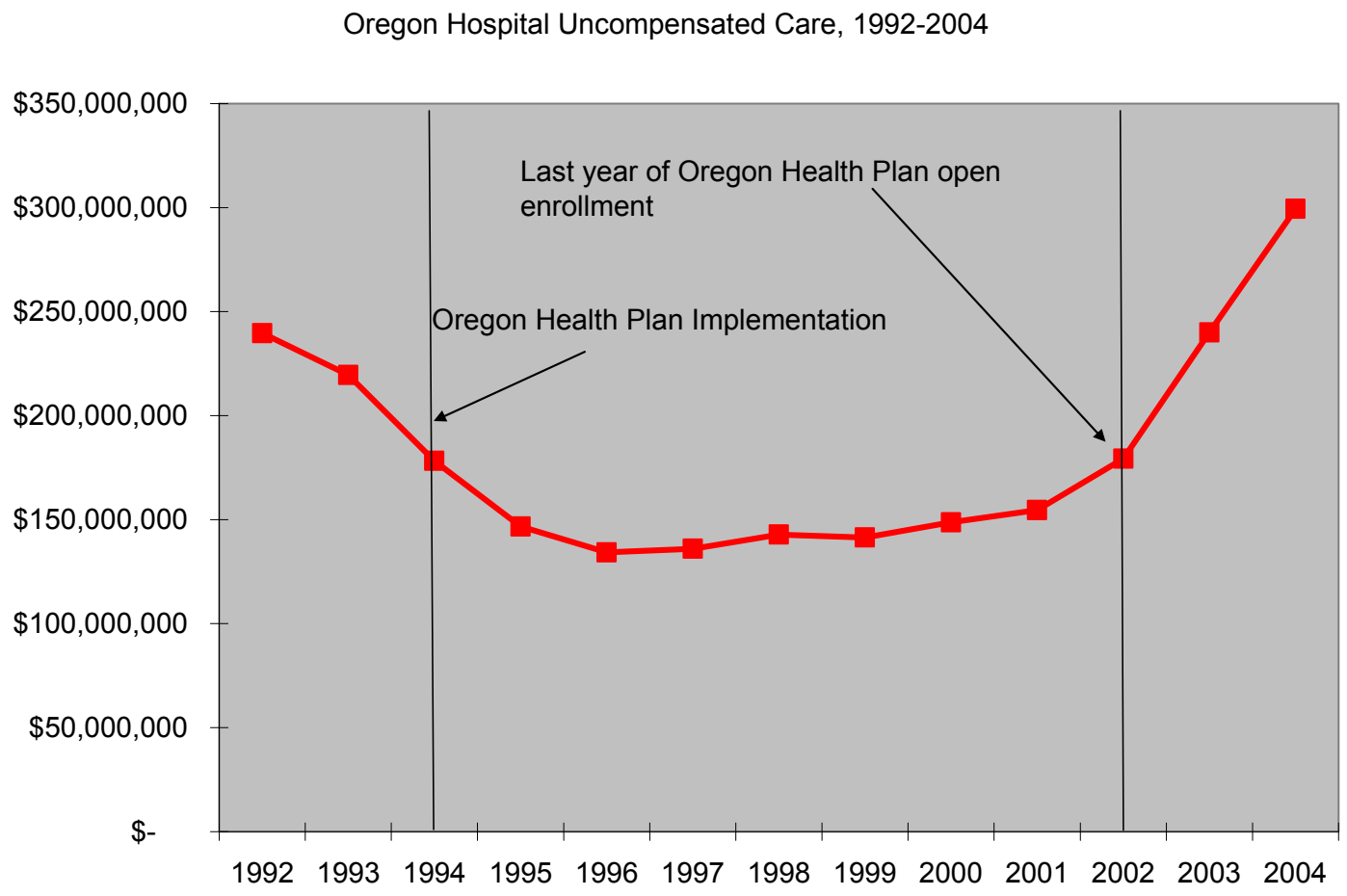
[1] Colmers JM. Public reporting and transparency. The Commonwealth Fund Commission on a High Performance Health System, January 2007.
[2] Norton's Bankruptcy

Lack of insurance results in avoidable hospitalizations

Uninsured are:

- 2.8X more likely to be hospitalized for diabetes
- 2.4x more likely to be hospitalized for hypertension
- 1.6x more likely to be hospitalized for pneumonia
- 1.6x more likely to be hospitalized for ulcers

In the absence of coverage, uncompensated care increases...



Sean Kolmer, MPH
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Sean.Kolmer@state.or.us
http://ohpr.oregon.gov

Existing Public Program Cost-sharing and Subsidy Levels

The Deficit Reduction Act of 2005 (DRA) provides state Medicaid agencies with new options as of March 31, 2006, to impose increased premiums and cost-sharing upon certain Medicaid recipients above 100 percent of the federal poverty level (FPL). It allows states to make the payment of premiums a condition of Medicaid eligibility and payment of cost-sharing a condition of receiving services. In addition, the DRA allows states to vary the premiums and cost-sharing charged based on income, eligibility category, and type of service. States must submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to implement cost-sharing options allowed under the DRA.

Table of Current Oregon Health Plan Deficit Reduction Act (DRA) – Allowable Premiums and Cost-sharing, by Risk Group

Categories	DRA *Unless otherwise noted, the allowable charges described below cannot in the aggregate exceed 5 percent of a family's income as applied on a monthly or quarterly basis.*
Mandatory children In Oregon, this category includes: • Children ages 0 to 5 at or below 133 percent of the federal poverty level (FPL)	• No premiums. • No cost-sharing for services. • No cost-sharing for preferred prescription drugs. • Cost-sharing for non-preferred drugs up to the nominal amount. Not subject to the 5 percent aggregate cap. • Cost-sharing for non-emergency use of the emergency department (ED) up to the nominal amount. Not subject to the 5 percent aggregate cap.
Optional children with incomes above 133 percent FPL In Oregon, this category includes: • Children ages 0 to 18 at or below 185 percent FPL	• Premiums allowed. • Cost-sharing for services – up to 20 percent of the cost of the item or service. • Cost-sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost-sharing for non-preferred drugs – up to 20 percent of the cost of the drug. • Cost-sharing for non-emergency use of the ED – no upper limit on charges.

Pregnant Women	• No premiums.
	• No cost-sharing for pregnancy-related services.
	• For non-pregnancy-related services:
	  o If income is less than 100 percent FPL – no apparent upper limit and 5 percent aggregate cap does not apply.
	  o If income is between 100-150 FPL – up to 10 percent of the cost of the item or service.
	  o If income is more than 150 percent FPL – up to 20 percent of the cost of the item or service.
	• No cost-sharing for preferred prescription drugs.
	• Cost-sharing for non-preferred drugs – up to the nominal amount.
	• Cost-sharing for non-emergency use of the ED– up to the nominal amount.

Existing Public Program Cost-sharing and Subsidy Levels

Categories	DRA *Unless otherwise noted, the allowable charges described below cannot in the aggregate exceed 5 percent of a family's income as applied on a monthly or quarterly basis.*
Adults with incomes less than 100 percent FPL	The DRA does not address premiums or cost-sharing for individuals with income below 100 percent FPL. HR 6111, *Tax Relief and Health Care Act of 2006*, Section 405, passed by Congress on December 9, 2006, clarified that for individuals at or below 100 percent FPL, provisions in Title XIX of the Social Security Act, Section 1916, apply. In Oregon, co-payments for OHP Plus (categorically eligible) on outpatient services is $3. There is also a co-payment of $3 for dental restorative services. The charges for medications are $2 for generic medications and $3 for brand-name drugs. There is a premium charge of $9 - $20 only on premiums for the OHP Standard program (non-categorically eligible).
Adults with incomes between 100-150 percent FPL In Oregon, this includes some people who are elderly or have disabilities	• No premiums. • Cost-sharing for services up to 10 percent of the cost of the item or service. • Cost-sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost-sharing for non-preferred drugs – up to the nominal amount. • Cost-sharing for non-emergency use of the ED up to two times the nominal amount. • Oregon's employer-sponsored insurance subsidy program, the Family Health Insurance Assistance Program (FHIAP), has a benefit cost-sharing based on a benchmark which decides which services are covered and also determine the enrollees' cost-sharing portion.
Adults with incomes more than 150 percent FPL In Oregon, this includes some people who are elderly or have disabilities	• Premiums allowed. • Cost-sharing for services up to 20 percent of the cost of the item or service. • Cost-sharing for preferred prescription drugs – states may waive payment or charge less than the nominal amount. • Cost-sharing for non-preferred drugs – up to 20 percent of the cost of the drug. • Cost-sharing for non-emergency use of the ED – no upper limit on charges. • Oregon's employer-sponsored insurance subsidy program, the Family Health Insurance Assistance Program (FHIAP), has a benefit cost-sharing based on a benchmark which decides which services are covered and also determine the enrollees' cost-sharing portion.

The Oregon Health Fund Board Eligibility and Enrollment Committee and the Healthy Oregon Act (SB 329-B)
Key Considerations and Implications for Proposals

Draft 11/5/2007

Healthy Oregon Act (SB 329-B) statutory purview of the E & E Committee	Key Considerations and Implications	Notes
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: ***public subsidies of premiums or other costs under the program*** **(Section 9(2)(d)(A))**.	• How do you prevent people who are struggling financially or with chronic conditions from paying a disproportionately high share of their income for health coverage? • What process would be necessary to determine the levels of subsidy starting with a "lower bound" of highly subsidized and an "upper bound" of no subsidy?	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including****, a standardized application process*** **(Section 9(2)(d)(B)(i))**.	• How do applications for public and private health coverage differ and how can they be improved?	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to**: *requirements to ensure that enrollees demonstrate Oregon residency*** **(Section 9(2)(d)(B)(ii)).**	• Could these requirements mirror ORS 428.210 (Nonresident Persons With Mental Disabilities) to encourage consistency? -Person who has lived in this state continuously for a period of one year	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including, a process to* ***enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment***	• What role does the provider community play in the facilitation of enrollment?	•

The Oregon Health Fund Board Eligibility and Enrollment Committee and the Healthy Oregon Act (SB 329-B)
Key Considerations and Implications for Proposals

Draft 11/5/2007

Healthy Oregon Act (SB 329-B) statutory purview of the E & E Committee	Key Considerations and Implications	Notes
(Section 9(2)(d)(B)(iii)).		
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including**, permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment*** **(Section 9(2)(d)(B)(iv)).**	• What state insurance coverage rules need to change or be reformed to ensure that what is deemed affordable is available? Such as……. --Guaranteed Issue, which means: every person can purchase health coverage, regardless of employment, health status or other criteria --Community Rating, which means: each coverage carrier must charge the same premium for each person covered by the same health plan, regardless of health status, age or other factors	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: ***a grievance and appeals process for enrollees*** **(Section 9(2)(d)(C)).**	• How would a new system utilize existing grievance and appeals processes in the public and private health coverage	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: ***standards for disenrollment and changing enrollment in accountable health plans*** **(Section 9(2)(d)(D)).**	• What is necessary to reduce administrative barriers to enrollment? and, • What tools should be provided to participants to more easily understand and compare health plan options?	•

The Oregon Health Fund Board Eligibility and Enrollment Committee and the Healthy Oregon Act (SB 329-B)
Key Considerations and Implications for Proposals

Draft 11/5/2007

Healthy Oregon Act (SB 329-B) statutory purview of the E & E Committee	Key Considerations and Implications	Notes
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: ***allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services*** **(Section 9(2)(d)(F)).**	• What potential rules for participating employers would bolster the size of the program to keep premiums affordable and benefits adequate?	•
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: ***an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures*** **(Section 9(2)(d)(E)).**	• What strategies are most efficient and effective in educating the public about this new program?	•

Medicaid Advisory Committee Recommendations on the Healthy Kids Plan and the Healthy Oregon Act (SB 329-B)

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *public subsidies of premiums or other costs under the program* **(Section 9(2)(d)(A))**.	Income-appropriate cost-sharing in Healthy Kids, and that premium sharing be the primary means of cost sharing as follows: • Maintain cost-sharing at zero (current level) in DMAP programs. • Adjust cost-sharing levels in FHIAP programs so that there is no premium contribution required for children below 200% of the Federal Poverty Level (FPL) guidelines and family premium contributions below 200% FPL are adjusted to mesh with Healthy Kids premium contributions above 200% FPL. • Set premium subsidies for families above 200% FPL so that total cost sharing does not exceed 5% of annual family income. • Discontinue premium subsidies at a family income level sufficient to pay full premium without jeopardizing the family's ability to cover basic costs of living. (The MAC estimated this level to be 350% FPL). • Adjust premium subsidies for the FHIAP portion of Healthy Kids to achieve parity with the DHS	• All uninsured individuals and families should be able to participate; • Premiums should be based on the Federal Poverty Level income index with a sliding-scale. • Copayments should be modest in keeping with the income levels of families. For example, the copayment for physician office visits should be no more than $10 for those under 200% FPL. • MAC recommends that cost-sharing take into consideration family monthly cost-of-living expenses by geographic regions when considering how much a family can afford to contribute to health care.	• Families should be kept intact programmatically • The E & E Committee should consider family or couple based premiums in addition to individual premiums • Copayments should be designed to promote prevention, cost-effective management of chronic conditions, and appropriate utilization of healthcare resources. • E & E should investigate affordability by considering total cost sharing including premiums, co-payments, co-insurance, and deductibles. • MAC recommends that E & E consider allowing individuals/families to use previous year's tax return statements to determine subsidy levels.

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
	portion of Healthy Kids and to reflect the characteristics of each type of coverage in terms of overall cost-sharing and benefits. • Co-payments should be modest in keeping with the income levels of Healthy Kids families. For example, the co-payment for physician office visits should be no more than $10. • Coinsurance and deductibles should not be part of Healthy Kids cost-sharing in the DHS portion due to imposition of severe financial burden on families with very sick children and/or with modest incomes. Coinsurance and deductibles will almost certainly remain in the FHIAP portion of Health Kids as reflections of the market.		
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including, a standardized application process* **(Section 9(2)(d)(B)(i))**.	• Streamline enrollment and recertification processes to increase the likelihood that eligible children will be covered and stay covered. As part of this streamlining, there should be a "common application screening form" for Healthy Kids and it should be as short and straightforward as possible. • There should be "one-stop	• See Healthy Kids Recommendations	• Consider all options for enrollment including faxing, telephone applications, mail applications, and electronic applications. • E & E should consider strategies to make application and product information available to populations outside of MAC's previous work including people starting new businesses, early

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	shopping" for eligibility determination. • Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services. • Allow applicants to use the previous year's tax return as a verification option.		retirees, and others
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *requirements to ensure that enrollees demonstrate Oregon residency* **(Section 9(2)(d)(B)(ii)).**	The MAC Healthy Kids Report did not address Oregon residency requirements.		E & E should determine the cost-benefit of covering all Oregonians regardless of citizenship in terms of uncompensated care, the cost-shift, public health, emergency preparedness, and the dignity and worth of every individual.
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including, a process to enable a provider to enroll an individual in the Oregon Health Fund program at*	Partner with organizations involved in health, social service, and educational programs for children, which may include: • Physician and dental offices • Safety-net clinics, including rural and migrant clinics • Hospitals • Pharmacies, and,		The MAC recommends that E & E establish presumptive eligibility for all Oregonians. For special populations, consider utilizing federal funds that allow retroactive eligibility to 3 months prior to the date of service (date stamp).

Medicaid Advisory Committee Recommendations on the Healthy Kids Plan and the Healthy Oregon Act (SB 329-B)

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
the time the individual presents for treatment to ensure coverage as of the date of the treatment **(Section 9(2)(d)(B)(iii)).**	• Social Service Agencies		MAC recommends that E & E explore CA's one-E application as a possible conduit to enrollment at the point of service.
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *streamlined enrollment procedures, including, permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment* **(Section 9(2)(d)(B)(iv)).**	• There should be no requirement of a period of uninsurance to become eligible for Healthy Kids. State agencies should, however, take suitable precautions to monitor "crowd-out" (as done in New York's Medicaid program) and add such a requirement if a significant shift from privately sponsored to publicly sponsored health coverage. • In the interest of community-rating as a policy objective, all children should be eligible to enroll in Healthy Kids regardless of health status. However, state agencies should monitor for adverse selection into the pool; and, if needed, apply a remedy to preserve the viability of the pool. • Children eligible for Healthy Kids should be enrolled for 12 continuous months. • There should be no asset limit for Healthy Kids. Attaining self-sufficiency depends on a family's ability to build financial reserves.	• There should be no requirement of a period of uninsurance to participate in the OHF. • No pre-existing condition limitations • Open period of enrollment for changes of coverage or subsidies every 12 months. • Income limitations and/or asset testing do not apply in determining eligibility.	

Medicaid Advisory Committee Recommendations on the Healthy Kids Plan and the Healthy Oregon Act (SB 329-B)

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
	The cost of health coverage can prevent that for families with modest resources. The availability of assets to parents should not interfere with expanding health coverage to uninsured children since those resources could be depleted within days in the event of a serious illness or injury. Removing the need to determine family assets will result in simplification and administrative savings.		
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *a grievance and appeals process for enrollees* **(Section 9(2)(d)(C)).**	The MAC Healthy Kids Report did not address Oregon an appeals process.	N/A	MAC recommends there is an appeal process for eligibility decisions.
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *standards for disenrollment and changing enrollment in accountable health plans* **(Section 9(2)(d)(D)).**	The MAC Healthy Kids Report did not address standards of disenrollment and changing enrollment in accountable health plans.	N/A	MAC recommends E & E take a careful look at federal and state rules that influence standards of enrollment and disenrollment in accountable health plans.

Medicaid Advisory Committee Recommendations on the Healthy Kids Plan and the Healthy Oregon Act (SB 329-B)

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services* **(Section 9(2)(d)(F)).**	The MAC Healthy Kids Report did not address employers offering health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.	N/A	
Develop proposals for the eligibility requirements and enrollment procedures of the Oregon Health Fund program, including, but not limited to: *an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures* **(Section 9(2)(d)(E)).**	That there should be an appropriately funded aggressive outreach effort to bring uninsured children into Healthy Kids. These efforts would aim to: • Partner with organizations involved in health, social service, and education programs for children, which may include o Schools (public and private and school-based health services o Home school associations and support groups o Head Start o Child care o Safety-net clinics, including rural and migrant clinics	That there should be an appropriately funded aggressive outreach effort to bring uninsured individuals into the OHF. These efforts would aim to: • Partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to: o Schools (public and private and school-based health services o Home school associations and support groups o Head Start o Child care o Safety-net clinics, including rural and	

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	o Physician and dental offices o Hospitals o Pharmacies o Social service agencies • Identify uninsured children and inform parents about Healthy Kids. • Increase outreach and retention for those children already eligible but not enrolled. • To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements. • All outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities. Similarly, different approaches may be more effective in rural and urban areas of the state. • Families in the target population must be identified and engaged in	migrant clinics o Physician and dental offices o Hospitals o Pharmacies o Social service agencies • Identify uninsured individuals and inform them about OHF. • Increase outreach and retention for those individuals already eligible but not enrolled. • To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements. • All outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities. • Families in the target population must be identified and engaged in dialogue before enrollment and retention can be maximized and the participation goals of OHF	

Medicaid Advisory Committee Recommendations on the Healthy Kids Plan and the Healthy Oregon Act (SB 329-B)

Healthy Oregon Act (SB 329-B) statutory purview of the MAC	MAC Healthy Kids Plan Recommendations	MAC Healthy Oregon Act Standing Recommendations	MAC Future Considerations for OHFB and Eligibility & Enrollment Committee
	dialogue before enrollment and retention can be maximized and the participation goals of Healthy Kids can be realized. • The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.	can be realized. • The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities. • Work closely with communities to develop local strategies for outreach. • Work with employers and other agencies that do mailings to include information about OHF.	

Defining Health Care Affordability in Oregon

Nate Hierlmaier, MPA
Heidi Allen, MSW
Tina Edlund, MS
Jeanene Smith, MD, MPH

Office for Oregon Health Policy & Research

Senate Bill 329: Principles relating to enrollment and eligibility

- Shared responsibility
- Equity
  - Horizontal
  - Vertical
- Affordability

Defining Affordability

- Affordability is defined as **the percentage of income a household can devote to health care while still having sufficient income to address other necessities**.
- One of the lessons from the Massachusetts health care reform experience is that an affordability scale should be a conservative measure.

Research on Affordability

- **Oregon Medicaid Advisory Committee:**
  - What do general household budgets look like in Oregon?
  - What resources are available after necessities to spend on health care based on state level cost data?
- **Massachusetts, Jonathan Gruber, MIT Health Economist**
  - What are the actual expenditures on necessities at different income levels based on national expenditure data?
  - How many people at different income levels enroll for insurance relative to health care costs?
- **Urban Institute (Blumberg et al.)**
  - What is the actual spending on health care (premiums and out-of-pocket) as a percentage of income for group and non-group markets?

Oregon Medicaid Advisory Committee Household Budgets

Data

- Economic Policy Institute (www.epi.org)
  - 2004 family budget calculator
    - Methodology available: *Family Budget Technical Documentation* (Allegretto & Fungard) www.epi.org.
  - Adjusted by inflation rate of 6.83% to reflect 2006 amounts
    - US Dept. of Labor Statistics Consumer Price Index Inflation Calculator at http://www.bls.gov/cpi
- The United States Department of Health & Human Services 2006 HHS Poverty Guidelines
  - Issued yearly and used for determining financial eligibility for means-tested federal programs

Oregon Household Budgets

2006
Portland-Vancouver
Rural Oregon

Office for Oregon Health Policy & Research

Calculations & Assumptions: Housing

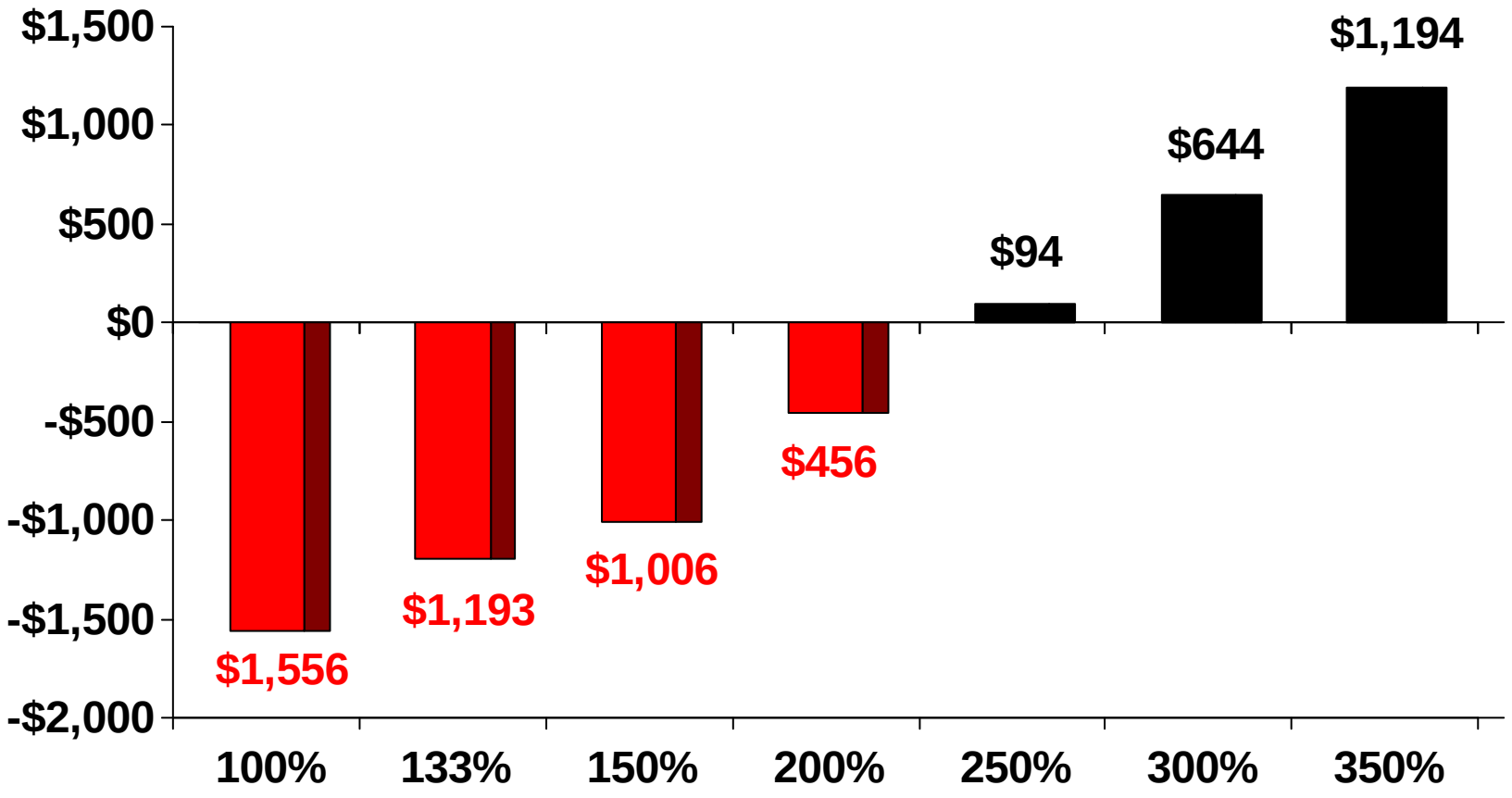
- Housing: based on the Department of Housing and Urban Development's fair market rents (FMR):
  - representing rent + utilities for "privately owned, decent, structurally safe, and sanitary rental housing of a modest (non-luxury) nature with suitable amenities".
- Assumptions:
  - Two bedroom apartments for families with 1 or 2 children.
  - Three bedroom apartments for families with 3 children.

For more information visit HUD: www.huduser.org/datasets/fmr.html

Calculations & Assumptions: Transportation

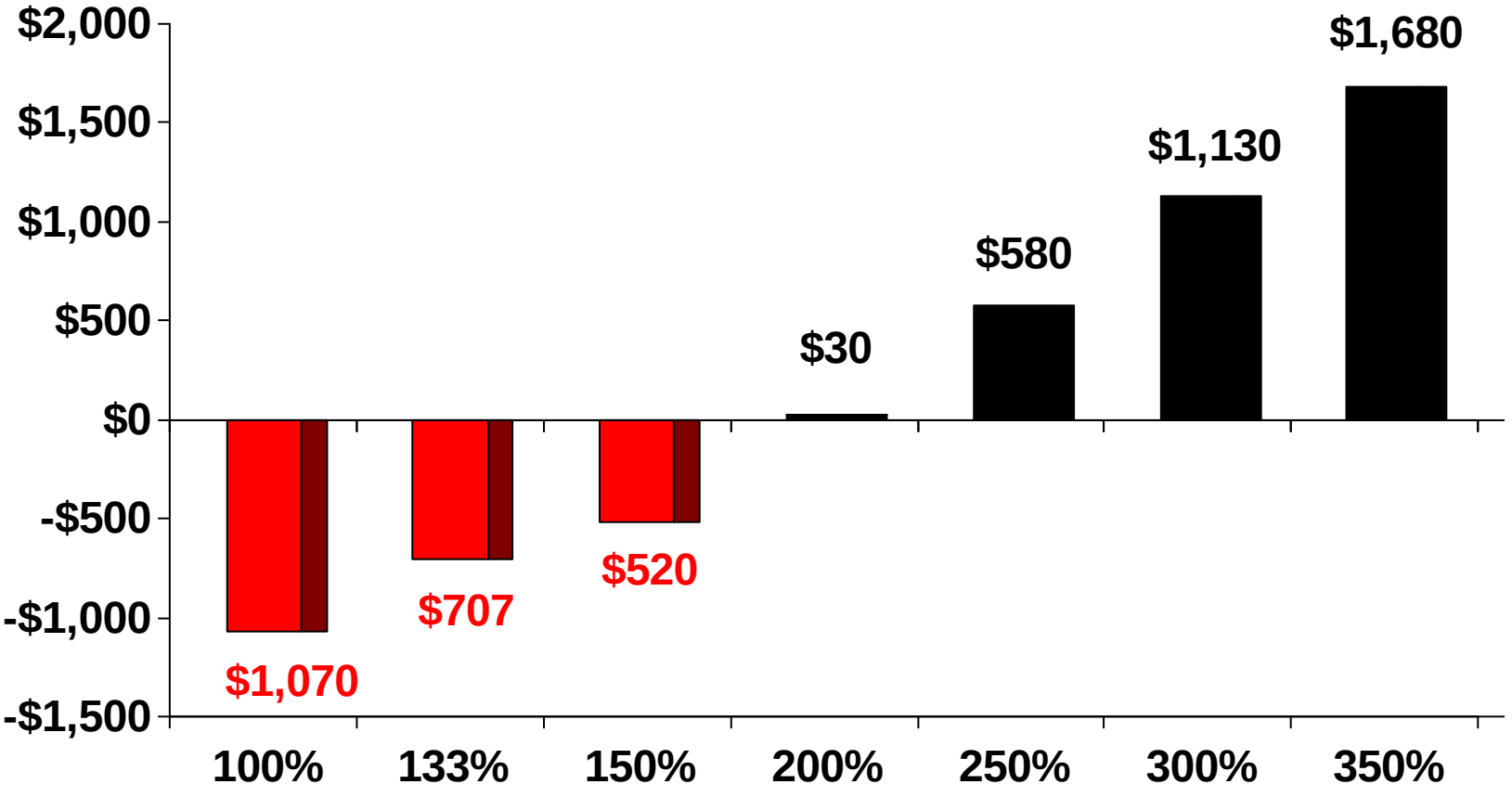
- Transportation costs per mile are from the IRS cost-per-mile rate, which includes the cost of gas, insurance, vehicle registration fees, maintenance, and depreciation.
  - Varies by urban or rural area, and number of parents in the family.
- Budget assumes only non-social trips (work, school, church, and errands for the 1st adult and only work trips for the 2nd adult).

Discretionary Monthly Income after 250% Federal Poverty Level (FPL)



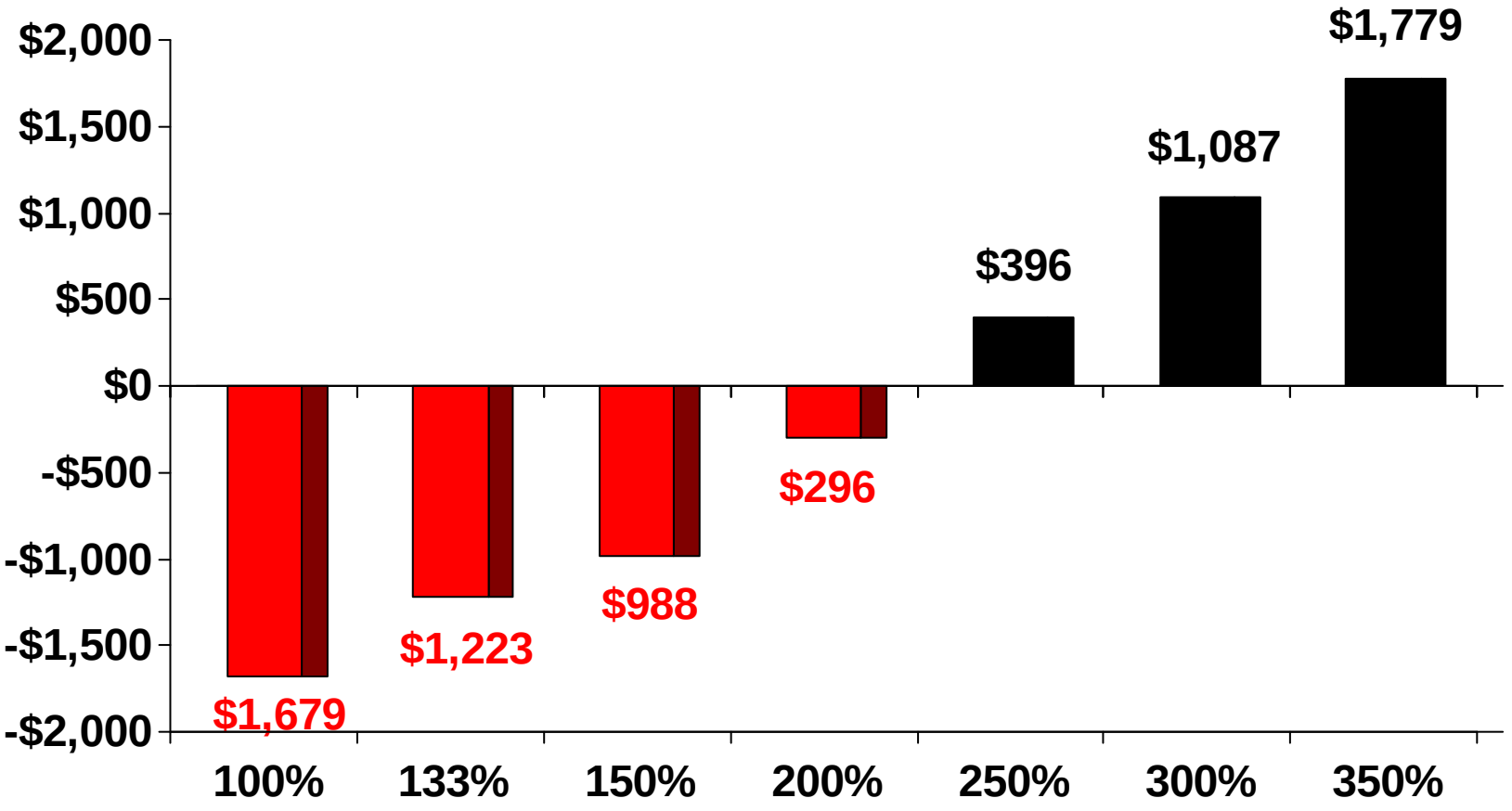
Portland-Vancouver (2006) 1 Parent + 1 Child

Discretionary Monthly Income after 200% Federal Poverty Level (FPL)



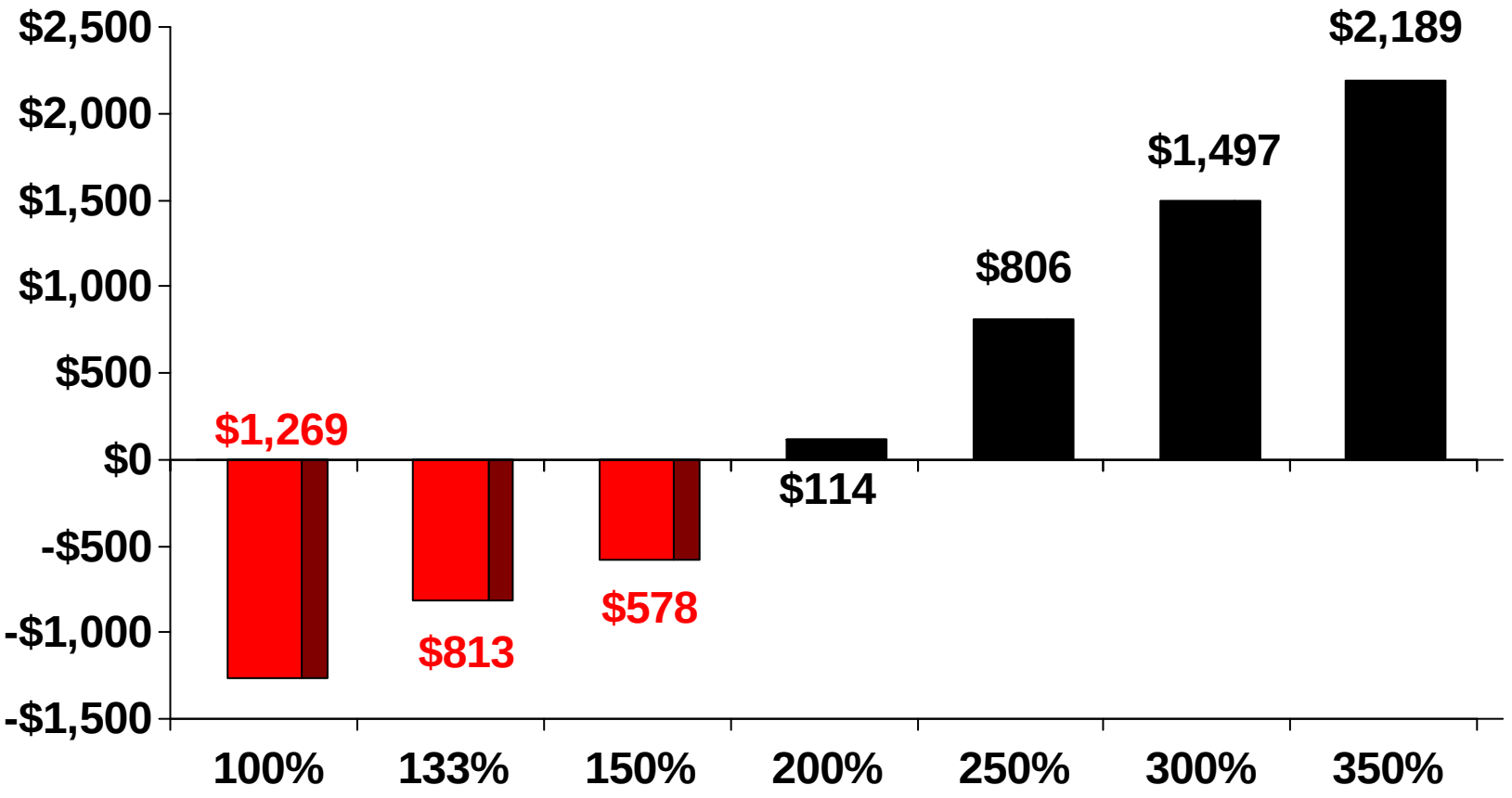
Rural Oregon (2006) 1 Parent + 1 Child

Discretionary Monthly Income after 250% of Poverty Level



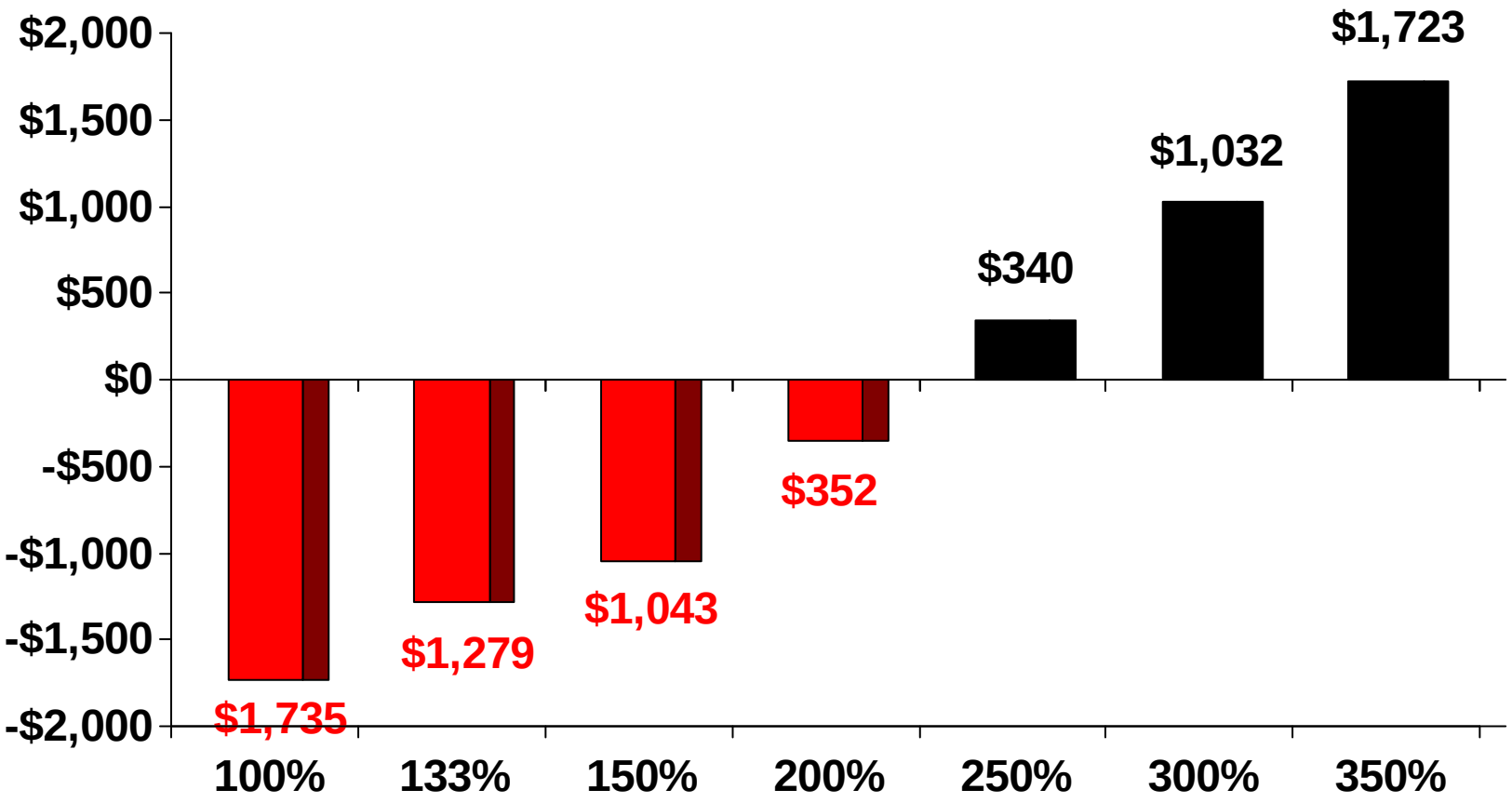
Portland Area (2006) 2 Parents + 1 Child

Discretionary Monthly Income after 200% of Poverty Level



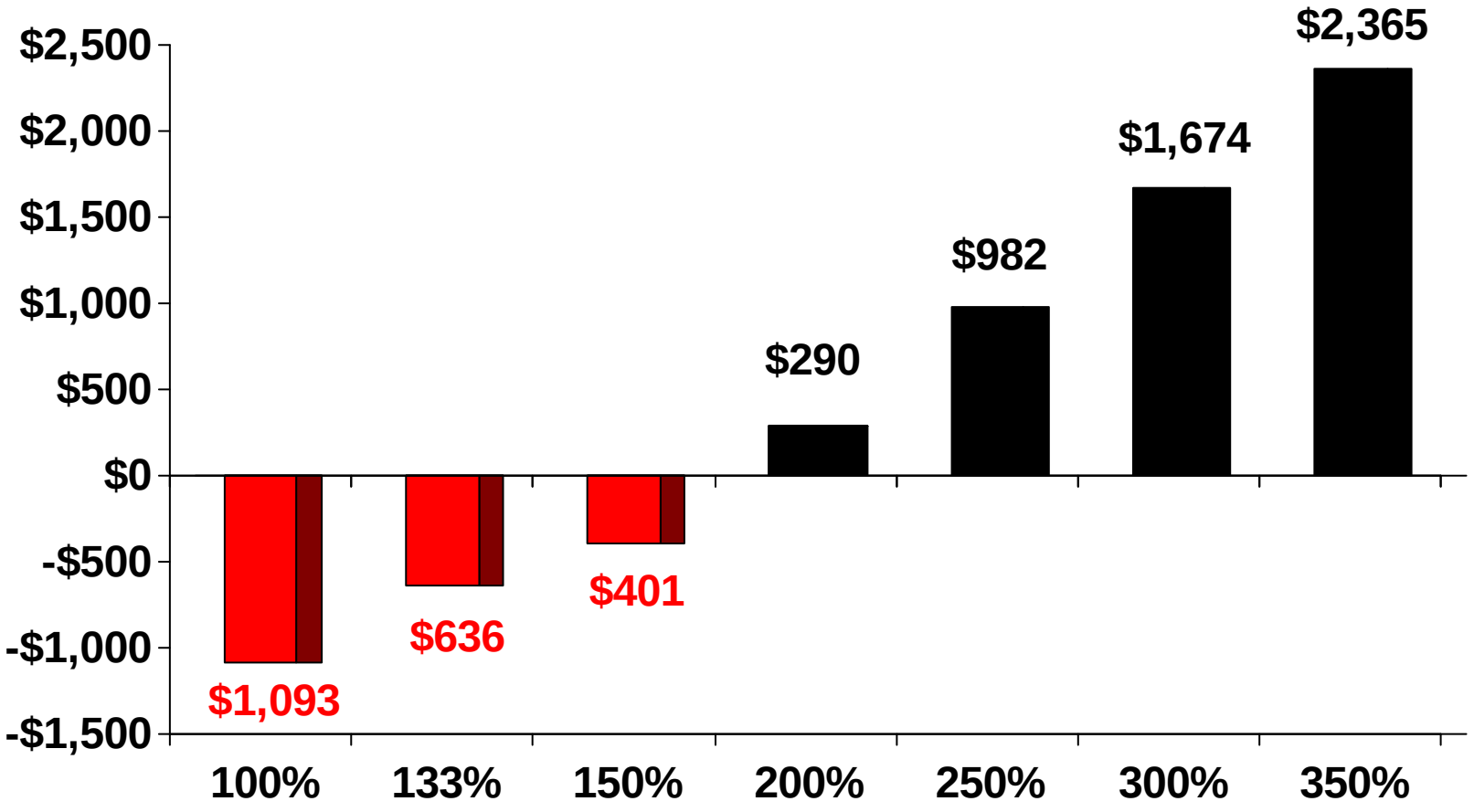
Rural Oregon (2006) 2 Parents + 1 Child

Discretionary Monthly Income after 250% FPL



Portland-Vancouver (2006) 1 Parent + 2 Children

Discretionary Monthly Income after 200% FPL *

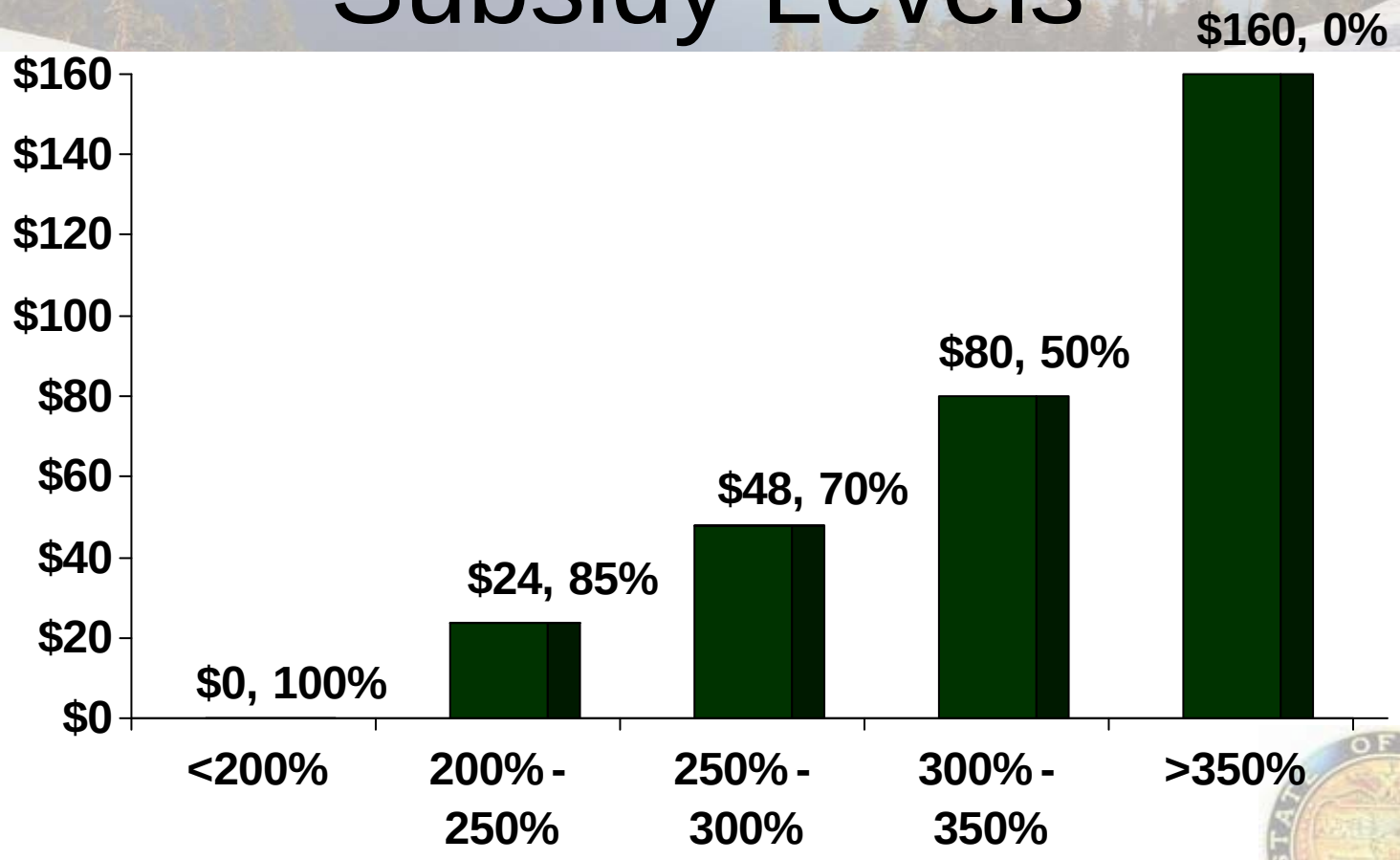


Rural Oregon (2006) 1 Parent + 2 Children

Conservative Decisions

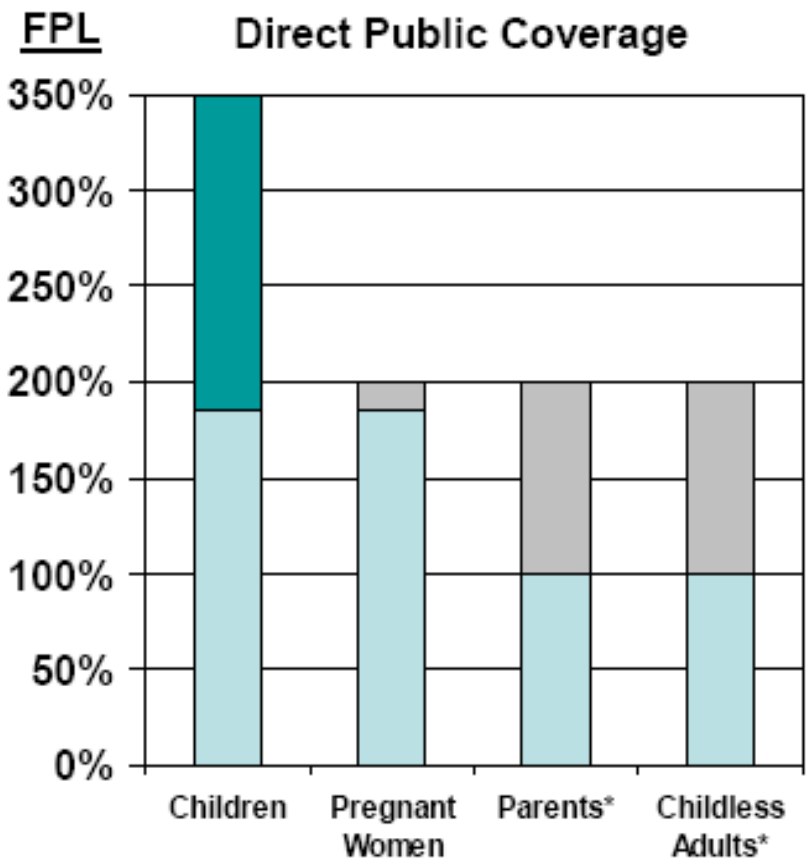
- Budgets do not include debt, or higher than normal interest rates that might affect families with less than perfect credit.
- Estimates are conservative (particularly regarding child care, housing, and food)
- Other factors, beyond health care, compete for discretionary income as income goes up. Assumed standard of housing stays the same.
- Budget does not include recommended savings or catastrophic expenses.

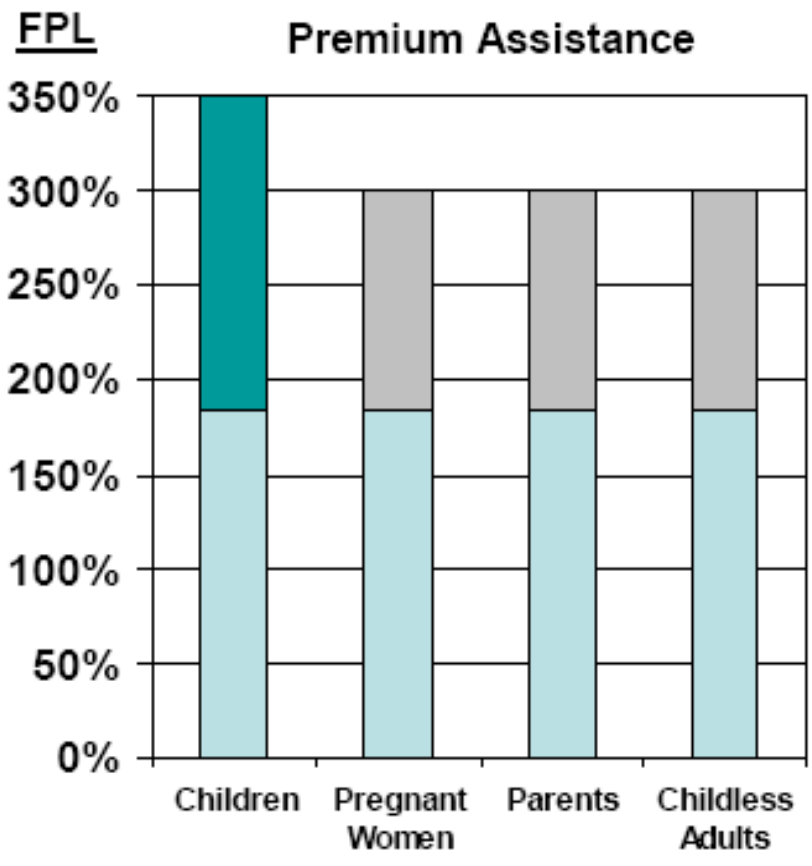
Healthy Kids Premium Subsidy Levels



Office for Oregon Health Policy & Research

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options





Proposed OHPC Expansion

Expansion Via Healthy Kids Program

Current Coverage Limit

*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Jonathan Gruber on Affordability and Enrollment

- Are the subsidy levels set by the Massachusetts Commonwealth Care Connector affordable?
- What income level do people decide to enroll in employer-sponsored insurance?

<u>Data</u>

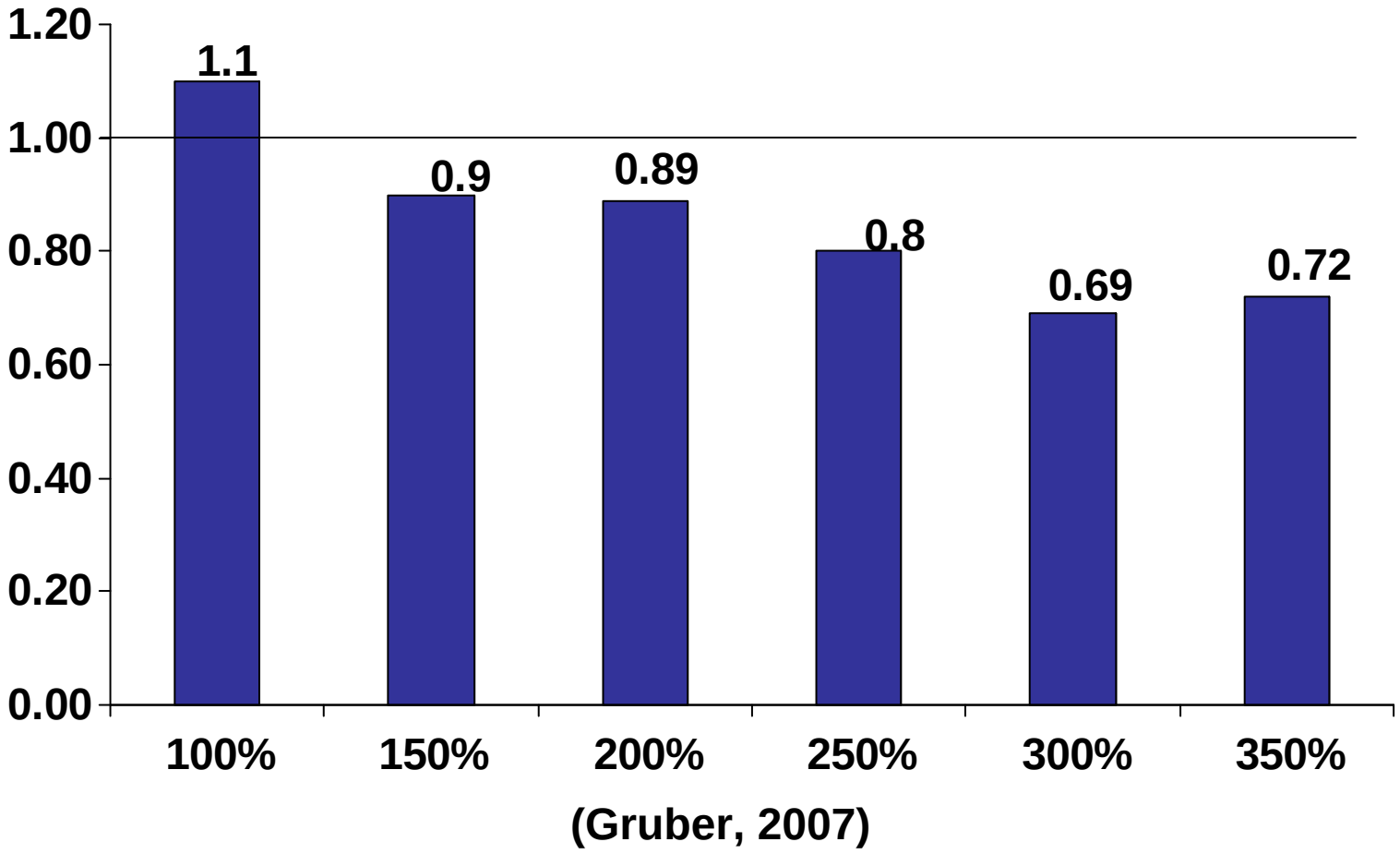
- Consumer Expenditure Survey (CEX), the nation's leading data source for consumption information.

Jonathan Gruber on Affordability and Enrollment

Results

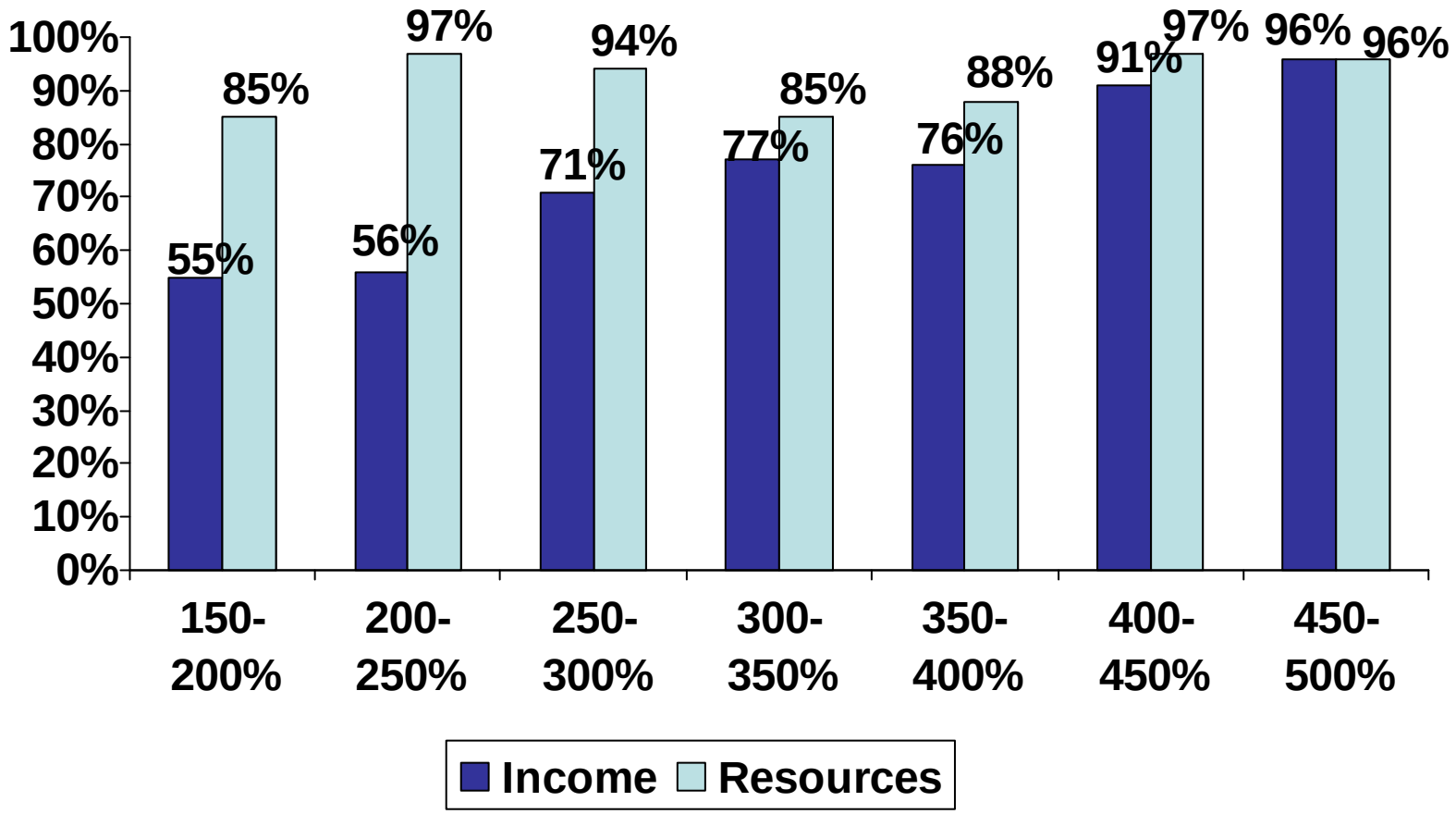
- Low income individuals have resources remaining after paying for necessities to pay for the Massachusetts subsidy program.
- Even the lowest income individuals enroll in employer insurance when it is offered, at costs ($60/month for singles and $250/month for families) that exceed, on average, what is paid by those below 200% of poverty.
- The majority of workers continue to enroll in employer-provided insurance even when it gets very expensive, not just overall but also in firms with a concentration of low income workers.

Necessities / Income,
Ratio of necessary dollars to income



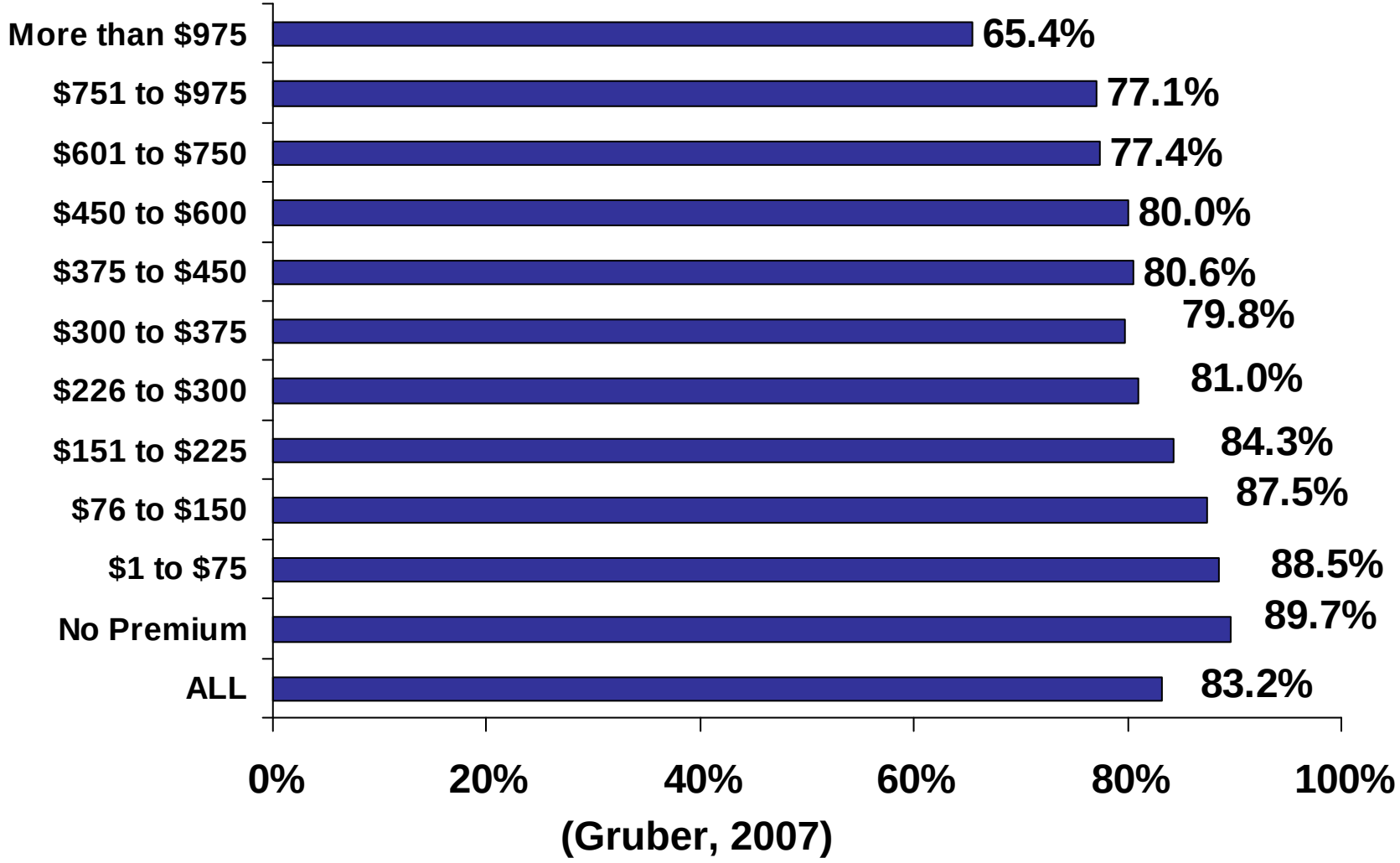
(Gruber, 2007)

Share of Group for Which Health Costs are "Affordable" for Premiums $350/Month



(Gruber, 2007)

Employer-provided insurance rates are responsive to price, yet over 60% of families enroll when the cost are more than $975 per month



(Gruber, 2007)

Blumberg, Holahan, Hadley & Nordahl (2007)

- What portion of income do low and moderate income families spend on health care?
- Does the proportion of income spent on health care costs differ for employer-based or non-group coverage?

<u>Data</u>

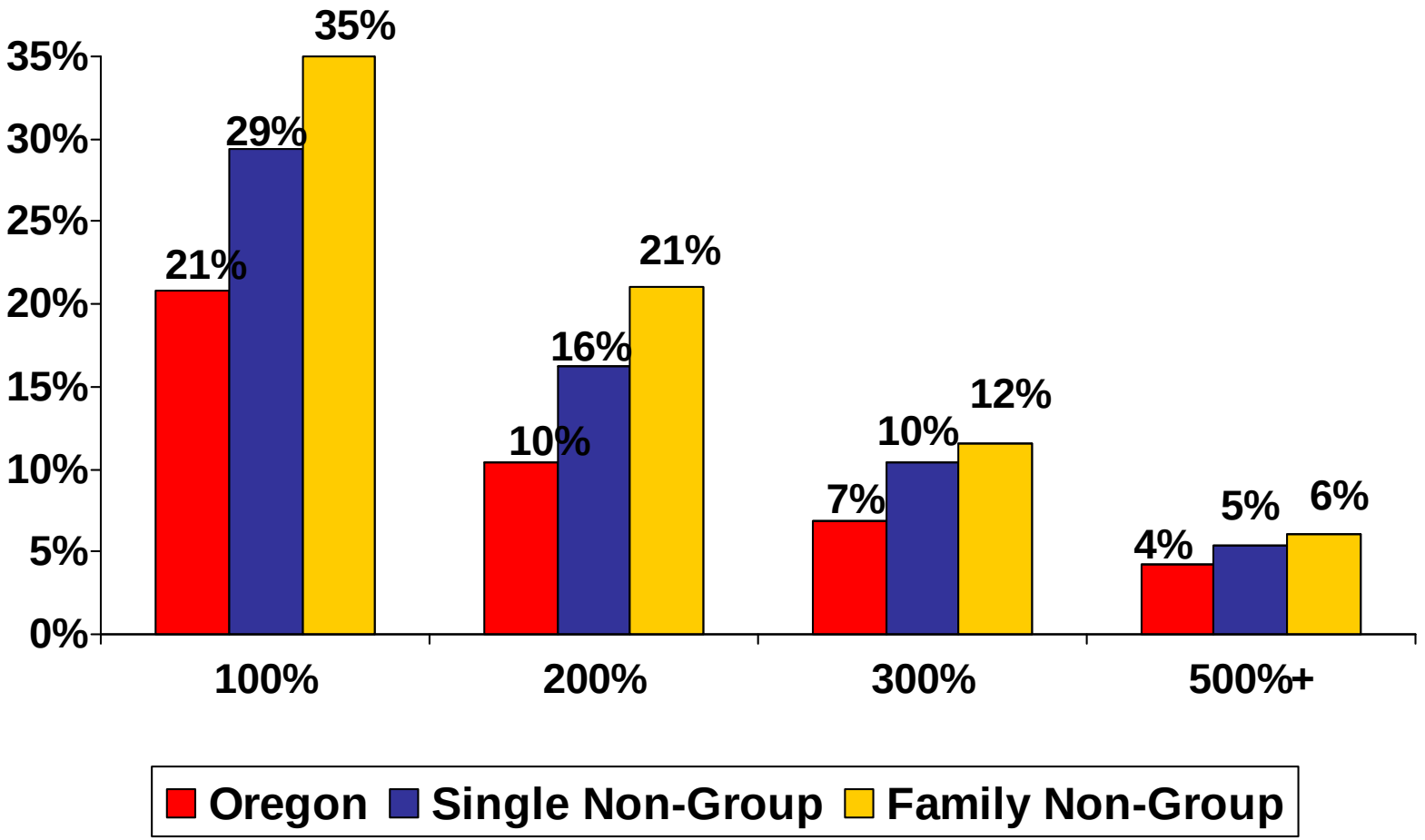
- Blumber et al. use national data on averages from the Medical Expenditure Panel Survey (MEPS, a survey of consumer health utilization and spending) for premiums and for out-of-pocket costs for families from 2001 to 2003

Blumberg, Holahan, Hadley & Nordahl (2007)

Results

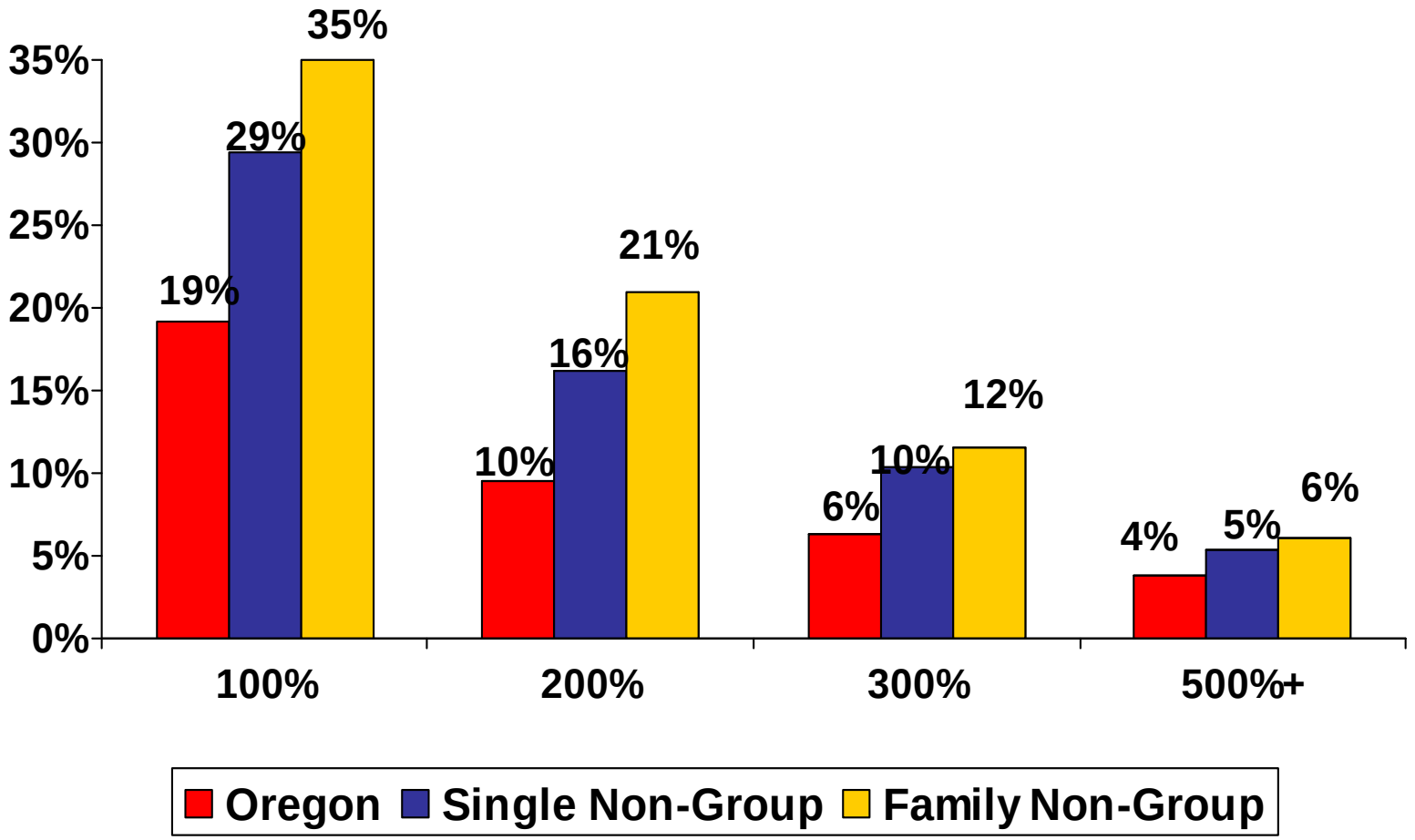
- Out-of-pocket costs and premiums can be very high as a percentage of income for those below 300% poverty, particularly for those with high medical needs.
- Spending patterns in alternative types of insurance (group, non-group) lead to different affordability standards.
- Individual and employer-sponsored insurance are very similar if adjusted for lost wages

Total Health Care Costs as a Percentage of Income



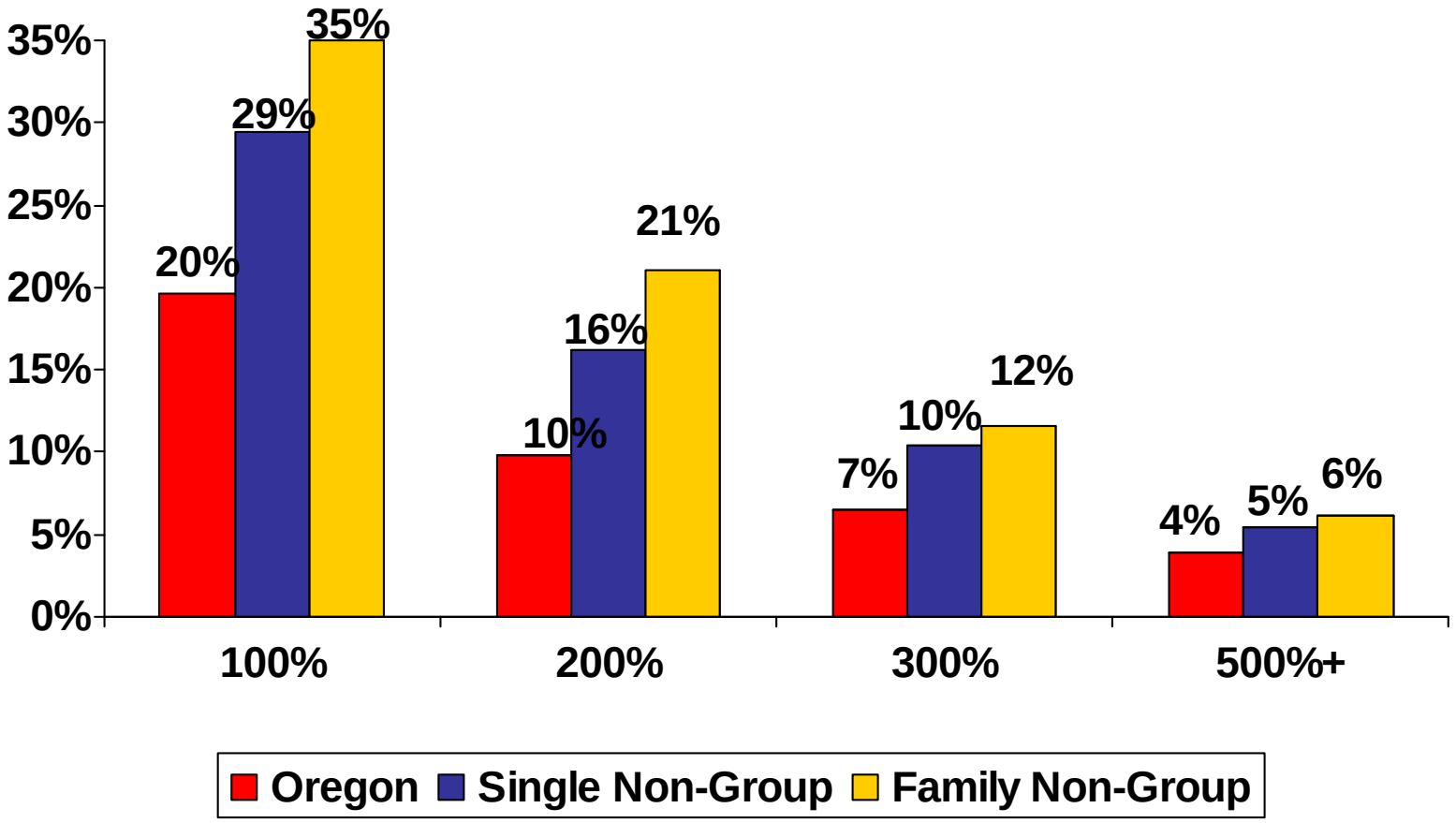
Oregon, 2006,1 Parent + 1 Child: **(EPI, 2007);**
Median Non-Group: **(Blumberg et al., 2007)**

Total Health Care Costs as a Percentage of Income



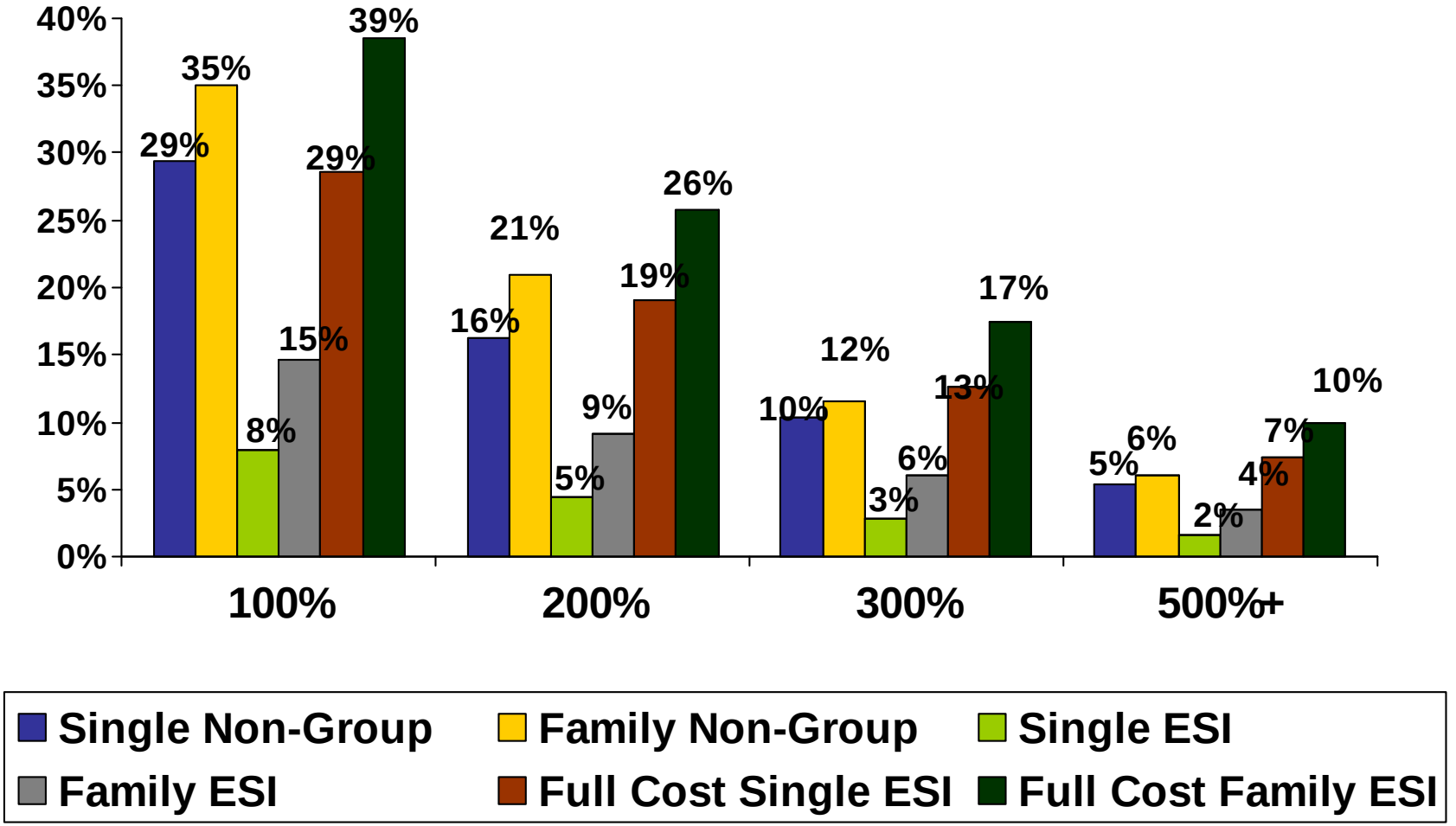
Oregon, 2006,1 Parent + 2 Children: **(EPI, 2007);**
Median Non-Group: **(Blumberg et al., 2007)**

Total Health Care Costs as a Percentage of Income



Oregon, 2006, 2 Parents + 2 Children: **(EPI, 2007);**
Non-Group: **(Blumberg et al., 2007)**

Total Health Care Costs as a Percentage of Income



Median Percentages of Income: **(Blumberg et al., 2007)**

Massachusetts Commonwealth Connector Premium Affordability Standards

Singles	Couples	Families w/Children
$0 - $15,315 (150%FPL) **$0**	$0 - $20,535 (150% FPL) **$0**	$0 - $25,755 (150% FPL) **$0**
$15,316 - $20,420 (200%) **$35**	$20,536 - $27,380 (200%) **$70**	$25,756 – $34,340 (200%) **$70**
$20,421 – $25,525 (250%) **$70**	$27,381 - $34,225 (250%) **$140**	$34,341 - $42,925 (250%) **$140**
$25,526 – $30,630 (300%) **$105**	$34,225 - $41,070 (300%) **$210**	$42,926 - $51,510 (300%) **$210**

Office for Oregon Health Policy & Research

Massachusetts Commonwealth Connector Program Premiums

Family income as a percent of the Federal Poverty Level (FPL)	Monthly enrollee premium for lowest cost plan per adult	Plan Type
0-100%	$0	1
100.1% -150%	$18	2
150.1% - 200%	$40	2
200.1% - 250%	$70	3 or 4
250.1% - 300%	$106	3 or 4

Massachusetts Commonwealth Care Health Plans

Plan Type	Description
1: Gold	Low co-payments. No deductible. Prescription drug coverage included.
2: Silver	Moderate co-payments. Some have no deductible. Prescription drug coverage. Each Carrier offers two “Silver” plans.
3: Bronze	Low premium. Most have deductibles and co-payments. Available with and without prescription drug coverage.
4: Young Adult	For 19-26 year-olds. Low premium. Most have deductibles, co-payments, and an annual limit on benefits. Available with and without prescription drug coverage.

Recommended Principles

- Keep it simple
  - Use a few broad income brackets
  - Broad mandate for upper income brackets to participate
  - Progressive sliding scale of premium contributions, stated as dollars/month, for lower income brackets
- Flexible enforcement
  - Accounting for individual circumstances
  - Robust appeals process
- Require participation in universal pool
- Benchmark ESI and non-group insurance in universal pool

OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

November 13, 2007 **Oregon State Library Room 103**
9:00 a.m. Tapes 1-2

MEMBERS PRESENT: **Robert Bach**
Jane Baumgarten
Dean Kortge
Ellen Lowe
CJ McLeod
John Mullin
Bill Murray
Ellen Pinney
Felisa Hagins
Noelle Lyda
Carole Romm
Jim Russell
Ann Turner,MD

MEMBERS EXCUSED:

STAFF PRESENT: **Tina Edlund**
Sean Kolmer
Nate Hierlmaier

ISSUES HEARD:

- **Call to Order, Update on Oregon Health Fund Board and Committee Activities**
- **Design Principles and Assumptions**
- **Review of Charter and Scope of Activities**
- **Implications of Affordability on Eligibility and Enrollment Recommendations**
- **Presentation of Trends in Coverage**
- **Presentation on Oregon Household Budgets and Healthcare Affordability**
- **MAC work on Healthy Kids & OHFB Recommendations & Considerations—deferred until December Meeting**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

I. Call to order – there is a quorum

Tina Edlund **II. Update on Oregon Health Fund Board –**

- **next meeting December 12, 2007**

III. Design Principles and Assumptions

Discussion

- Discussed idea that these are framework and starting point, changes will be made.
- Request for a listing of upcoming Health Fund Board meetings and dates on other committee meetings

IV. Charter

Discussion

- Health fund board approved Charter last meeting
- No comments

V. Implications of Affordability on Eligibility and Enrollment Recommendations

Discussion

- Members asked to direct any questions concerning legislation to Laurie Freeman, the legislative counsel who worked on 329
- Members asked to alert staff if they come across information in their research that needs committee response.
- Members advised to look at affordability as a total process, and to include out-of-pocket expenses, co pays, what insurance doesn't pay etc.
- Request for examples of application requirements for eligibility processes
- It was brought up that agenda-building should be looked at systematically. Start with affordability, but decide what to look at for next meetings.
- Question asked why, last month it was decided to look at affordability as a first item. Reason is that E&E's recommendations about subsidies and subsidy levels goes to the Benefits Committee, that requires these recommendations to move forward with their Charter. Benefits Committee is expecting E&E affordability and subsidy structure recommendations

Sean Kolmer **VI. Presentation: Trends in Coverage**

Nate Hierlmaier **VII. Presentation: Defining Health Care Affordability in Oregon**

VII. Next Meeting and Agenda--TBD

Submitted By: Reviewed By: Tina Edlund

EXHIBIT SUMMARY

A – Agenda
B – Oregon Health Policy Commission Roster
C – Oregon's Health Care Trends – by Bruce Goldberg, MD
D – Oregon Health Policy Commission – Overview of Commission Structure House Bill 3653
E – Enrolled Bill, House Bill 3653
F – Oregon Health Policy Commission Strategies and Measurable Objectives/Performance Indicators

TENTATIVE WORKPLAN FOR ENROLLMENT AND ELIGIBILITY COMMITTEE

NOVEMBER 28th, 2pm to 5pm, Mt. Mazama Room, 1225 Ferry Street SE, Salem

TOPIC: SUBSIDIES

- Brief Update on OHFB and other committees
- Review of Timeline and Tentative Workplan
- Review and summary of Affordability discussion at the November 13th meeting.
- Review of Medicaid Advisory Committee Affordability and Cost-Sharing Recommendations
- **Action Item:** Developing consensus: Where do we recommend that subsidies begin and end?
- Public input

DECEMBER 11th, 9 am to Noon, Archives Bldg, 2nd floor Conference Room, Salem

TOPIC: SUBSIDIES

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of recommendations and minutes from last meeting.
- Articulate principles/values about how subsidies should work
- Discuss how a potential individual mandate, or requiring people to have health insurance, is related to the affordability of coverage
- **Action Item:** Develop consensus and recommend subsidy structure, maximum out-of-pocket expenditures?
- Public input

JANUARY 8th

TOPIC: ELIGIBILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of recommendations and minutes from last meeting
- Review Affordability Recommendations draft document to forward to the Benefits Committee
- Articulate principles/values underlying eligibility
- Review of MAC recommendations regarding eligibility

- Action Items: Begin development of eligibility recommendations, including waiting periods, pre-existing conditions (what does this mean in a guaranteed issue world?)

JANUARY 23rd

TOPIC: ELIGIBILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review and summary of minutes from last meeting
- Review of Health Equities recommendations concerning program eligibility
- Development of eligibility recommendations, continued with focus on residency and citizenship requirements
- Public input

February 12th

TOPIC: OUTREACH

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review of minutes from last meeting
- Review and approval of eligibility recommendations.
- Review of MAC recommendations regarding outreach
- Review of Health Equities Committee recommendations concerning outreach
- Review of staff documents/outreach "best practices"
- Development of recommendations for outreach
- Public input

February 27th

TOPIC: APPLICATION, ENROLLMENT PROCEDURES

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of outreach recommendations.
- Review of MAC recommendations regarding application, enrollment procedures
- Review of staff documents/experiences in other states

- Development of application, enrollment recommendations including a standardized application process, standards for disenrollment and changing enrollment
- Public input

March 11th

TOPIC: PORTABILITY

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of application, enrollment recommendations.
- Review of staff documents/experiences in other states
- Development of recommendations around portability
- Public input

April 8th

TOPIC: CONSENSUS DOCUMENT

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of all Committee recommendations.
- Review of draft set of recommendations to forward to the Health Fund Board
- Public input

April 23th

TOPIC: CONSENSUS DOCUMENT

- Standing Agenda Items
    - Update on OHFB and other committees
    - Review a of minutes from last meeting
- Review and approval of all Committee recommendations.
- Review of draft set of recommendations to forward to the Health Fund Board
- Public input

Oregon Medicaid Advisory Committee and the Healthy Oregon Act

Cost-Sharing and Affordability Recommendations to the Eligibility and Enrollment Committee and the Oregon Health Fund Board

The Medicaid Advisory Committee (MAC) is a federally-mandated body that advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research and the Department of Human Services on the operation of Oregon's Medicaid program, including the Oregon Health Plan. In addition, the MAC develops policy recommendations at the request of the Governor and the Legislature.

In 2006 at the request of Governor Kulongoski, the Medicaid Advisory Committee created a set of policy recommendations for a State Children's Health Insurance Program (SCHIP)-expansion proposal called Healthy Kids. An explicit objective of this work was to determine program eligibility and strategies for enrollment into the Healthy Kids plan. While crafting these policy recommendations, the MAC received considerable testimony from policy experts, health service researchers, and healthcare advocates. The MAC held public meetings across the state to collect feedback from Oregonians on elements of the proposal. The process of developing policy for Healthy Kids made the Medicaid Advisory Committee uniquely positioned to provide recommendations concerning eligibility and enrollment as the state considers other health insurance expansion proposals. The full report to Governor Kulongoski can be viewed at: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

In 2007, the Oregon Legislature passed and the Governor signed the Healthy Oregon Act which mandated a process to develop a comprehensive health care reform for the state. Part of the statutory directive of this act was to have a central body called the Oregon Health Fund Board (OHFB) establish committees to collect data and make recommendations involved in the development of the comprehensive plan called the Oregon Health Fund Program. The act instructs the OHFB to establish an "Eligibility and Enrollment Committee (EEC)," that is comprised, but not limited to the membership of the MAC. The MAC is also required to present reports containing data and recommendations to the EEC as well as the Governor and Legislature on eligibility and enrollment.

On behalf of the Medicaid Advisory Committee, the following is the first of a series of initial recommendations and items for future consideration issued to the Eligibility and Enrollment Committee addressing eligibility and enrollment statutes in the Healthy Oregon Act of 2007. Recommendations are in **bold** with the rationales *italicized* below. Issues the MAC advises EEC to consider through further deliberations are included, but not in bold.

Recommendations Concerning Cost-Sharing and Affordability

1. **Premiums should be based on the Federal Poverty Level income index with a sliding-scale.**
    - *Premium sharing should not exceed the limits of the family budget but should recognize the family's ability to contribute.*
    - *Comments at the MAC's Healthy Kids community meetings indicated a general preference for premium share over other forms of cost sharing because of predictability in family budgeting.*

2. **Copayments should be modest in keeping with the income levels of families. For example, the copayment for physician office visits should be no more than $10 for those under 200% FPL.**

   Research by the RAND Institute has shown that cost-sharing mechanisms reduce utilization of health care services but that consumers do not distinguish well between useful and trivial services.[1] The impact of cost-sharing, however, was found to have a larger effect on lower-income persons, particularly children. A panel of experts divided episodes of care into those in which medical care produces usually effective treatments and usually less effective treatments. It was determined that for those conditions in which medical care is highly effective, poor children in a cost-sharing plan were at a greater risk of not receiving treatment when such treatment would be effective.[2]

3. **MAC recommends that cost-sharing take into consideration family monthly cost-of-living expenses by geographic regions when considering how much a family can afford to contribute to health care.**

   A review performed by Office for Oregon Health Policy and Research staff showed that families in Oregon cannot be expected to have available resources to help pay for health insurance until income is above 200% FPL.[3]

4. E & E should consider family or couple based premiums in addition to individual premiums.

   MAC Healthy Kids public meeting participants frequently suggested instituting "family premium" options for families with more than one child, resembling employer-sponsored insurance.

5. Copayments, if necessary, should be designed to promote prevention, cost-effective management of chronic conditions, and appropriate utilization of healthcare resources.

6. E & E should investigate affordability by considering total cost sharing including premiums, co-payments, co-insurance, and deductibles.

7. E & E should consider allowing individuals/families to use previous year's tax return statements to determine subsidy levels in order to accommodate seasonal variations in income.

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[1] *See Robert H. Brook, et al., (December 1983). "Does Free Care Improve Adults Health? Results from a Randomized Controlled Trial,"* New England Journal of Medicine, *309(23):1426-34 and Emmett B. Keeler, et al., (August 1987) "Effects of Cost Sharing on Physiological Health, Health Practices and Worry,* Health Services Research *22(3):297-306.*

[2] *Kathleen N. Lohr, et al., (September 1986) "Use of Medical Care in the RAND Health Insurance Experiment, Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial," Medical Care 24(9):Supplement S-S87.*

[3] *Heidi Allen, (March 2006) "Affordability Presentation for the Medicaid Advisory Committee."*

Affordability Discussion

- Policy Objectives:
  - Making coverage **affordable** to the eligible population
  - Emphasizing **shared responsibility**
  - Making coverage financially appealing to healthy as well as unhealthy residents below xxx% of FPL
  - Minimizing potential for "**crowd-out**". The contribution levels should not be so generous that employers (and employees) are encouraged to substitute publicly-financed care for privately-financed care.

Affordability Discussion

- Policy Objectives:
  - Ensuring cost-sharing is **equitable**: Is it fair to subsidize premium costs so much that enrollees will pay less in monthly premiums than they would if offered health insurance through an employer?
  - Ensure cost-sharing contributes to **sustainability** of the program. There is a relationship between the individual contribution and the ability to cover more Oregonians.

Affordability Discussion

- Policy Considerations:
  - **Treat children differently than adults?**
    - **Could use Medicaid Advisory Committee recommendations for Healthy Kids as the affordability standard for children.**
  - **Individual, couple and family (3+ individual) premium structure?**

Review of Research on Family Contributions to Health Care

Author	Methodology	Rationale
Medicaid Advisory Committee	●Development of Oregon specific "basic family budget" from state level cost to determine *income* available after paying for necessities	●The MAC discussion and input from public meetings supported basic family budget calculations
Gruber	●Analysis of national consumption data to measure the *resources* available to families at different income levels after paying for necessities ●If individuals are voluntarily enrolling in employer-provided insurance by income level and premium	●Using actual expenditure data is less prescriptive and involves fewer judgments ●If individuals are voluntarily enrolling in employer-provided insurance, then they can afford that coverage, so this provides a means of assessing "affordability"
California Budget Project	●Review of how much families currently spend on health care at different income levels and how other programs determine affordability levels	●How much families currently spend on health care can help policymakers understand how much families can afford to spend.
Urban Institute	●Review of Medical Expenditure Panel Survey, 2001 to 2003.	●How much families currently spend on premium can inform affordability discussions.

Exhibit 1: Urban Institute Premium Payments As a percentage of Income, by Income Level

Percent of Family Income		
Cost-to-Income Percentile	Single ESI	Family ESI
All (FPL)	2.0	3.6
100-199%	5.2	10.4
200-299%	3.2	6.5
300-499%	2.1	4.2
500% or more	1.1	2.2

Source: Analysis of 2001-2003 Medical Expenditure Panel Survey; Median Figures, Family ESI includes families, couples, and adult-plus-one family units

Exhibit 2: Urban Institute Premium Payments As a percentage of Income, By Income Level

Percent of Family Income		
Cost-to-Income Percentile	Single Nongroup	Family Nongroup
All (FPL)	11.5	9.6
100-199%	20.9	21.8
200-299%	12.1	13.8
300-499%	7.9	8.3
500% or more	4.6	4.6

Source: Analysis of 2001-2003 Medical Expenditure Panel Survey; Median Figures, Family ESI includes families, couples, and adult-plus-one family units

Exhibit 3: What is Premium Cost-Sharing for Employer-Sponsored Insurance in Oregon?

Employer-Provided Health Insurance Premiums: Single Coverage

	Total Premium	Avg. Employer Contribution	Avg. Employee Contribution	Employee Share
Oregon				
2004 (MEPS-IC)	$3,706	$3,279	$427	12%
2005 "	$4,015	$3,512	$503	13%
2006 (estimate)*	$4,304	$3,831	$473	11%
National				
2004 (Kaiser/HRET)	$3,695	$3,137	$558	15%
2005 (Kaiser/HRET)	$4,024	$3,413	$610	15%
2006 (Kaiser/HRET)	$4,242	$3,615	$627	15%

*Estimate based on average national increases in single premiums and employee share as reported in the Kaiser/HRET Employer Health Benefits Survey.

Exhibit 4: What is Premium Cost-Sharing for Employer-Sponsored Insurance in Oregon?

Employer-Provided Health Insurance Premiums: Family Coverage

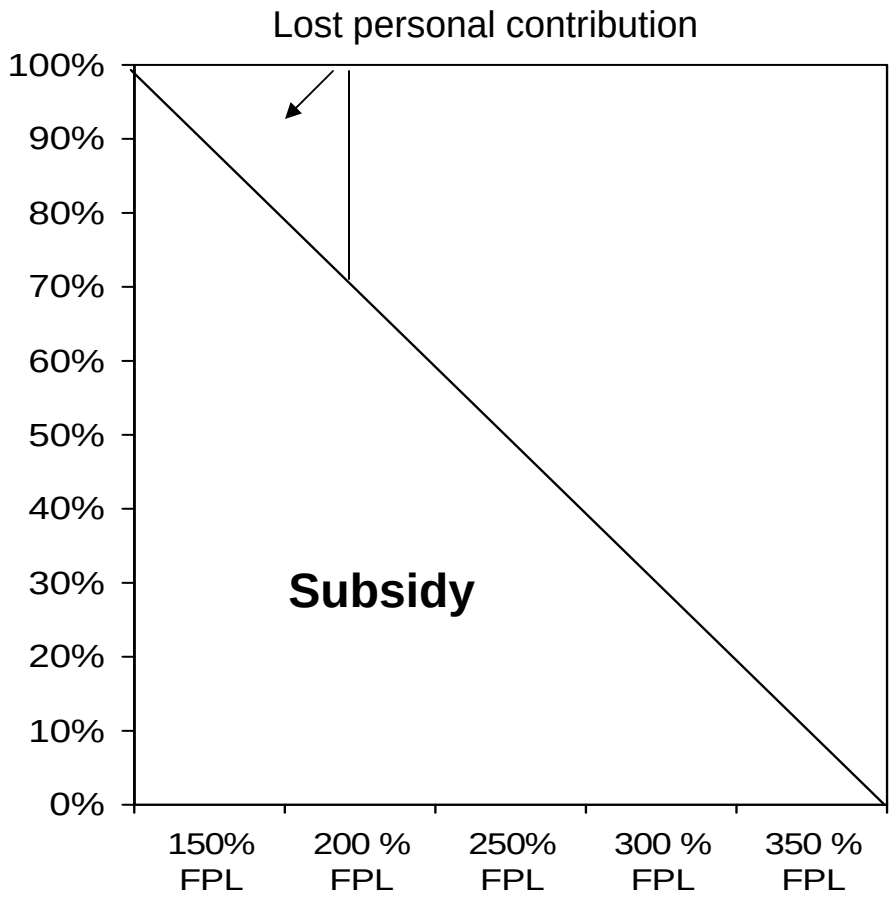
	Total Premium	Avg. Employer Contribution	Avg. Employee Contribution	Employee Share
Oregon				
2004 (MEPS-IC)	$9,906	$7,536	$2,370	24%
2005 "	$10,898	$8,060	$2,838	26%
2006 (estimate)*	$11,683	$8,529	$3,154	27%
National				
2004 (Kaiser/HRET)	$9,950	$7,289	$2,661	27%
2005 (Kaiser/HRET)	$10,880	$8,167	$2,713	25%
2006 (Kaiser/HRET)	$11,480	$8,508	$2,973	26%

*Estimate based on average national increases in family premiums and employee share as reported in the Kaiser/HRET Employer Health Benefits Survey.

Developing Consensus

If goal is to maintain financial sustainability within constrained resources….

- Moving the full subsidy up the income scale reduces state resources



Consensus Development

Where should personal contribution to premium share begin?

Subsidy Levels	Affordability	Equity	Crowd-out	Budget Constraints/ Sustainability	Shared Responsibility
Option 1 (150% FPL) Full subsidy up to: $15, 315 for individual, $20,535 for a couple and $25,755 for a family (3+)					
Option 2 (200% FPL) Full subsidy up to: $20,420 for an individual $27,380 for a couple and $34,340 for a family (3+)					
Option 3 (250% FPL) Full subsidy up to: $25,525 for an individual $34,225 for a couple and $42,925 for a family (3+)					

Consensus Development

Where should subsidies end?

Subsidy Levels	Affordability	Equity	Crowd-out	Budget Constraints/ Sustainability	Shared Responsibility
Option 1 (250% FPL) Some subsidy up to: $25,525 for an individual $34,225 for a couple and $42,925 for a family (3+)					
Option 2 (300% FPL) Some subsidy up to: $30,630 for an individual $41,070 for a couple and $51,510 for a family (3+)					
Option 3 (350% FPL) Some subsidy up to: $35,735 for an individual $47,915 for a couple and $60,095 for a family (3+)					

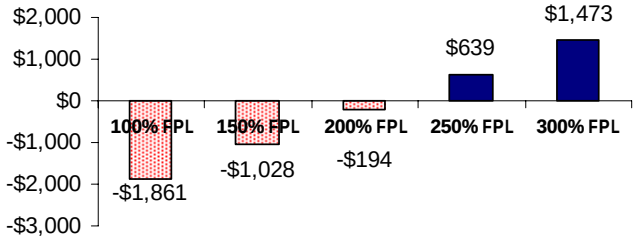
Health Care Reform Reference
Health Care Affordability in Oregon

Oregon's health values surveys have shown that Oregonians value personal responsibility. They also believe that families should share in the cost of health care on a sliding scale according to their ability to pay.[1]

To better understand what families in Oregon can afford to contribute for health care, the Office for Oregon Health Policy and Research reviewed information on regional household expenses developed by the Economic Policy Institute (EPI).[2] The following tables and charts exhibit the summary data from our review, with health care removed as a specific budget item. This brief outlines the data reviewed and how this information educated the health reform efforts of the Medicaid Advisory Committee (MAC) and the Oregon Health Policy Commission (OHPC).

Family Monthly Income Available to Contribute to Health Care in Oregon, 2006

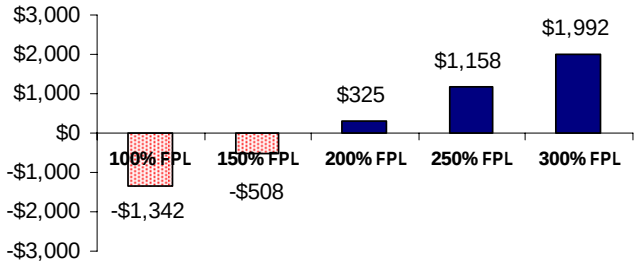
Budget Net of Basic Monthly Expenses
Portland Metro Area
(2 parent, 2 child household, 2006)



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

Budget Net of Basic Monthly Expenses
Rural Oregon
(2 parent, 2 child household, 2006)



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

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

[2] 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.

How Affordability Estimates Have Helped Frame Health Care Reform Discussions

In 2006, the Medicaid Advisory Committee (MAC) was charged with the task of developing recommendations for the Governor's office on the development of the Healthy Kids plan, a program to make health insurance available to all of Oregon's children. In April and May 2006, the MAC held six public hearings across the state. Attendees were presented with a brief overview of the Governor's Healthy Kids plan and MAC recommendations regarding asset limits, uninsurance requirements, and benefits. Participants were asked to contribute to a discussion around appropriate levels of state-subsidy and family cost-sharing.

The meetings were held in Medford, Bend, Newport, Corvallis, Portland and LaGrande. Representatives from the State of Oregon's Office for Oregon Health Policy and Research (OHPR), Oregon Health Research and Evaluation Collaborative (OHREC), Oregon's Office of Medical Assistance Programs (OMAP), and Governor Kulongoski's office attended these meetings with MAC members to facilitate small group discussions and to record public feedback.

To evaluate appropriate levels of cost-sharing, meeting participants were asked to comment on family budgets [based on the methodology described in detail below] to determine if estimated expenses were consistent with regional Oregonian experiences. All six meetings produced feedback from the public that the basic monthly expense estimates we presented were very conservative and the true cost of living was significantly higher. In five of the six community meetings, there was consensus that family premium contributions should not begin until families are earning 250% FPL or above, and that state subsidies should continue until families are at 300% or even 350% of FPL.

The Oregon Health Policy Commission (OHPC) also worked in 2006 to create a road map for providing everyone in Oregon access to an affordable, high value health care system. The OHPC used this information to recommend that full system reform require public subsidies up through 300% FPL, graduated based on income. Additionally, the OHPC used the estimates to create some affordability standards around the maximum proportion of family income that should be spent on health care at various income ranges. These ranges were used to inform the development and pricing of reform recommendations.[3]

Methodology for Oregon Basic Family Budget Estimates

Approximating how much money families living in Oregon can afford to contribute to health care (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, EPI used the following six major components to calculate a conservative estimate of average family expenses in Oregon:[4]

[3] The OHPC affordability standards ranged from 0% for the lowest income individuals and families through 15% at 250% FPL.

[4] The 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.

- 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: Budget includes clothing, personal care expenses, household supplies, reading materials, and school supplies (estimated at 27% of housing and food costs). [5]

To view the entire *Cost-Sharing Affordability* presentation with budget and discretionary income models for a variety of Oregon urban and rural family compositions, please visit the Office for Oregon Health Policy & Research website at: www.oregon.gov/DAS/OHPPR/index.shtml.

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

FOR DISCUSSION ONLY

Determining Oregon Affordability Scale: EXAMPLE ONLY

Individuals
OREGON MEDIAN FAMILY INCOME, 2006: $23,400

FPL	Starting Point	Endpoint	Monthly Premium Share	Annual Premium Share	% of income	% of premium (Assuming $309 average premium)
<150%	0	$ 15,315	0			0%
150% to 155%	$ 15,316	$ 15,826	$ 19	$ 234	1.5%	6%
155.01% to 160%	$ 15,827	$ 16,336	$ 20	$ 241	1.5%	7%
160.01% to 175%	$ 16,337	$ 17,868	$ 36	$ 428	2.5%	12%
175.01% to 200%	$ 17,869	$ 20,420	$ 56	$ 670	3.5%	18%
200.01% to 225%	$ 20,421	$ 22,973	$ 81	$ 976	4.5%	26%
225.01% to 250%	$ 22,974	$ 25,525	$ 111	$ 1,334	5.5%	36%
250.01% to 275%	$ 25,526	$ 28,078	$ 145	$ 1,742	6.5%	47%
275.01% to 300%	$ 28,079	$ 30,630	$ 183	$ 2,202	7.5%	59%
300.01% to 325%	$ 30,631	$ 33,183	$ 226	$ 2,712	8.5%	73%
325.01% to 350%	$ 33,184	$ 35,735	$ 273	$ 3,274	9.6%	88%
>350.01%	$ 35,736		$ 309	$ 3,708	10.4%	100%

Couples
OREGON MEDIAN FAMILY INCOME, 2006: $51,762

FPL	Starting Point	Endpoint	Monthly Premium Share	Annual Premium Share	% of income	% of premium (Assuming $618 average premium)
<150%	0	$ 20,535	0			0%
150% to 155%	$ 20,535	$ 21,220	$ 26	$ 313	1.5%	4%
155.01% to 160%	$ 21,221	$ 21,904	$ 27	$ 323	1.5%	4%
160.01% to 175%	$ 21,918	$ 23,958	$ 48	$ 573	2.5%	8%
175.01% to 200%	$ 23,959	$ 27,380	$ 75	$ 898	3.5%	12%
200.01% to 225%	$ 27,381	$ 30,803	$ 109	$ 1,309	4.5%	18%
225.01% to 250%	$ 30,804	$ 34,225	$ 149	$ 1,788	5.5%	24%
250.01% to 275%	$ 34,226	$ 37,648	$ 195	$ 2,336	6.5%	31%
275.01% to 300%	$ 37,649	$ 41,070	$ 246	$ 2,952	7.5%	40%
300.01% to 325%	$ 41,071	$ 44,493	$ 303	$ 3,636	8.5%	49%
325.01% to 350%	$ 44,494	$ 47,915	$ 370	$ 4,436	9.6%	60%
>350.01%	$ 47,916		$ 618	$ 7,416	15.5%	100%

Family of Three
OREGON MEDIAN FAMILY INCOME, 2006: $58,033

FPL	Starting Point	Endpoint	Monthly Premium Share	Annual Premium Share	% of income	% of premium (Assuming $618 average premium)
<150%	0	$ 25,755	0			0%
150% to 155%	$ 25,755	$ 26,614	$ 33	$ 393	1.5%	4%
155.01% to 160%	$ 26,615	$ 27,472	$ 34	$ 406	1.5%	4%
160.01% to 175%	$ 27,489	$ 30,048	$ 60	$ 719	2.5%	6%
175.01% to 200%	$ 30,049	$ 34,340	$ 94	$ 1,127	3.5%	10%
200.01% to 225%	$ 34,342	$ 38,633	$ 137	$ 1,642	4.5%	15%
225.01% to 250%	$ 38,634	$ 42,925	$ 187	$ 2,243	5.5%	20%
250.01% to 275%	$ 42,927	$ 47,218	$ 244	$ 2,930	6.5%	26%
275.01% to 300%	$ 47,219	$ 51,510	$ 309	$ 3,702	7.5%	33%
300.01% to 325%	$ 51,512	$ 55,803	$ 380	$ 4,561	8.5%	41%
325.01% to 350%	$ 55,804	$ 60,095	$ 464	$ 5,563	9.6%	50%
>350.01%	$ 60,097		$ 618	$ 7,416	12.3%	100%

OREGON HEALTH FUND BOARD – Eligibility & Enrollment Committee Meeting

November 28, 2007 **General Services Building Mt Mazama Room**
2:00pm

MEMBERS PRESENT: **Robert Bach**
Jane Baumgarten
Dean Kortge
Ellen Lowe
CJ McLeod
John Mullin
Ellen Pinney
Felisa Hagins
Noelle Lyda
Carole Romm
Jim Russell
Ann Turner,MD

MEMBERS EXCUSED: **Bill Murray**

STAFF PRESENT: **Heidi Allen**
Tina Edlund
Alyssa Holmgren
Sean Kolmer
Nate Hierlmaier

ISSUES HEARD:

- **Call to Order, Update on Oregon Health Fund Board and Committee Activities**
- **Review Timeline and Tentative Work Plan**
- **Review Affordability Research**
- **Review Medicaid Advisory Committee (MAC) Affordability and Cost-Sharing Recommendations**
- **Developing Consensus Recommendations**
  - **At what income are there 100% publicly funded subsidies**
  - **At what income are subsidies discontinued**

(Digitally Recorded)

I. Call to order – there is a quorum

II. Approval of Minutes from November 13th Meeting

Tina Edlund

III. Update on Oregon Health Fund Board –

- **Health Equities timeline of issuing recommendations to the Board and the Eligibility and Enrollment Committee on issues of eligibility and enrollment by January 15th**
- **Possibility of holding a joint meeting with the Eligibility and Enrollment Committee on issues regarding citizenship requirements**
- **Affirmation that the Health Equities Committee will discuss issues regarding people with disabilities; however, not the elderly population in general**
- **Discussion about the eligibility of the insured population such as those in public programs of Medicare and Medicaid**
- **Recommendation to attend the Board meeting on December 12th on Medical Home**

Chair

III. Review of Timeline and Tentative Work Plan

- **Change needed for February 12th meeting**

Tina Edlund

IV. Affordability Discussion

- **Policy considerations and objectives**
  - **Making coverage affordable**
  - **Emphasizing shared responsibility**
  - **Minimizing potential "crowd-out"**
  - **Ensuring cost-sharing is equitable**
  - **Designing a sustainable program**
  - **Should there be a child or family rate?**
- **Review of Research on Family Contributions to Health Care**
  - **Oregon Medicaid Advisory Committee**
  - **Jonathan Gruber**
  - **California Budget Project**
  - **Urban Institute**

Vice-Chair

V. Medicaid Advisory Committee Recommendations on Affordability and Cost-Sharing to the Eligibility and Enrollment Committee

- **Premiums should be based on the Federal Poverty Level income index with a sliding scale**
- **Copayments should be modest and keeping with the income levels of families. For example, the copayment for physician office visits should be no more than $10 for those under 200% of the federal poverty level.**
- **Cost-sharing take into consideration family monthly cost-of-living expenses by geographic regions when considering how much a family can afford to contribute to health care.**

<u>Future Considerations</u>

- **Consider family or couple based premiums in addition to individual premiums**
- **Copayments, if necessary, should be designed to promote prevention, cost-effective management of chronic conditions, and appropriate utilization of healthcare resources**

- **Investigate affordability by considering total cost-sharing including premiums, co-payments, co-insurance, and deductibles**
- **Consider allowing individuals/families to use previous year's tax return statements to determine subsidy levels in order to accommodate seasonal variations in income**

VI. Developing Consensus Recommendations: Where Should Personal Contribution to Premium Share Begin?

- **Increasing the full subsidy (no premium contribution) up the income scale reduces state resources available to cover more people**
- **Subsidies at the low end that start at a very low percent of income and raise incrementally up the income scale (i.e. starting 150% FPL) can limit expected contribution while retaining shared responsibility and budgetary considerations**
- ***"Whatever is done at the subsidy levels, there should be a gradual rather than steep drop in 5-10% increments higher up the income scale"***
- **Given the three options of 150% FPL, 200% FPL and 250% FPL, what would you recommend?**
  - **There was general consensus that personal contributions to premiums should be different for single rather than family units**
  - **Most felt that individuals and couples should begin contributions to their premiums around 150% FPL ($15,315 and $20,755 respectively)**
  - **Most also felt that full subsidies should be higher or around 200% FPL for families of three or more ($34,340)**

VII. Developing Consensus Recommendations: Where Should State Subsidies to Premium Share End?

- **Given the three options of 300% FPL, 350% FPL and 400% FPL, what would you recommend?**
  - **Most felt that the state should end subsidies to individuals around 350% FPL ($35,735) and families around 400% FPL ($61,950)**

Submitted By: Reviewed By: Tina Edlund

EXHIBIT SUMMARY

A – Agenda
B – Affordability Discussion Materials
C –Oregon Medicaid Advisory Committee (MAC) Recommendations to the Eligibility and Enrollment Committee
D –MAC Recommendations on the Healthy Kids Plan

Oregon Health Fund Board

December 2007 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  President, Oregon Chapter, AARP
- **Marcus Mundy**
  President, Urban League of Portland

Picking Up The Pace

By Barney Speight, Executive Director

During November the pace of activities of the Oregon Health Fund Board (OHFB) quickened. The Board's November 6 meeting focused on presentations and discussion of the regulatory framework of Oregon's health insurance market, the concept of health insurance exchanges, and the key drivers of cost increases in health care. In addition, with the recent kick-off meetings of the Federal Laws and Health Equities committees, all six committees of the Board are now organized and operational.

I've been asked about how the work of the committees will be coordinated in the months ahead. We will be using three approaches: 1) at committee members' request, committees will now receive summaries of the deliberations of other key committees; 2) the OHFB and OHPR staff meets weekly to discuss ongoing work and areas of policy development that potentially relate to multiple committees; and 3) Board officer(s) will meet jointly with the chairs of those committees that have critical interdependencies.

The OHFB website - http://healthfundboard.oregon.gov – is a useful tool to follow the work of the Board. Click on "Calendar" to review a list of all scheduled meetings of the Board and committees. At "Meeting Information," the rosters, meeting agendas and materials of the Board and committees are available for review and download. Use the "Contact Us" link to send an email to the Board.

Within the next few weeks, staff will have finalized a strategic communications plan for 2008. The Board is partnering with the Oregon Health Reform Collaborative (convened by the Northwest Health Foundation and the Oregon Health Policy Commission) to inform Oregonians about the ongoing work of the Board and to plan various outreach and communications activities when a draft reform plan is released for public comment. The Collaborative is "a group of more than 20 organizations committed to creating solutions to Oregon's health care crisis." We appreciate the ideas, commitment and resources the Collaborative will bring to OHFB.

During November, I was invited by several community and stakeholder groups to describe the OHFB and its charter under SB 329: the *Oregon Health Forum* (Eugene), a community health reform group in Corvallis; a meeting between State officials (including Governor Kulongoski) and the leaders of Oregon's tribal governments (Warm Springs); the *Expanded Access Coalition* (Salem); the *Oregon Community Mental Health Programs* (Portland); *Patient Advocates for Medicine* (Portland); the *OHP Contractors* (Salem); and the *Oregon Business Association* (Portland). While my schedule is increasingly complex, I will try to accept as many such invitations as possible.

The outstanding work being done under SB 329 is directly related to the professional staff supporting the Board and its committees. In future editions of the *OHFB Update*, I will share brief bios of the talented and dedicated crew that brings policy and organizational expertise to our efforts.

Reminder: There are 305 days between December 1, 2007 and October 1, 2008. Have a safe and wonderful holiday season.

Board Meeting Calendar:

December 12, 2007
1 to 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Ctr. Loop E
Wilsonville, OR

Thursday, Jan 15
11:30 am – 4 pm
Location: TBD

Committee Meeting Calendar:

Benefits

December 11, 2008
9:30 to 1:30 pm
Wilsonville Training Center
Room 218
29353 Town Center Loop E
Wilsonville, OR

January 15, 2008
(tentative)
9 am to Noon
Wilsonville Training Center
Room 218
29353 Town Center Loop E
Wilsonville, OR

Delivery Systems

December 12, 2007
1 to 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Center Loop E
Wilsonville, OR
(Combined with Health Fund Board meeting)

January 17, 2008
1 to 5 PM
Location: TBD

Continued on Page 2

Board, Committee & Workgroup Updates

Oregon Health Fund Board

The Oregon Health Fund board met on October 30 to discuss coverage trends in Oregon, how system performance in Oregon compares with other states, and other state reform efforts. Representatives of the OHPC and OBC presented their health reform recommendations. Additional committee appointments (final lists in draft charters) were distributed. The group discussed design principles, assumptions and committee timelines.

On November 6, the Board heard presentations on Oregon's health insurance market and health insurance exchanges, and received a demonstration of the Massachusetts Connector website. The group discussed major cost drivers in health care. The next meeting, to be held December 12, will be a joint meeting with the Delivery System Committee.

Benefits Committee

The Benefits Committee held an organizational meeting on October 17 and a second meeting on November 8. The Committee elected Susan King, RN as chair and Nina Stratton and Som Saha, MD as vice-chairs. The group heard presentations on the characteristics of the uninsured in Oregon and the use of the Prioritized List of Health Services under OHP. They began a discussion on the use of the Prioritized List to define a set of essential health services, which they will continue at their meeting on December 11.

Delivery System Committee

The Delivery System Committee held its first meeting on October 18. Dick Stenson, Tuality Health Care, was elected as chair and Maribeth Healey, Oregonians for Health Security, and Doug Walta, MD, physician, as vice-chairs.

The Committee next met on November 15 when to hear information on PEBB and Oregon Coalition of Health Care Purchasers' efforts to promote value-based health care purchasing. The Committee heard about how the work of the Governor's Health Information Infrastructure Advisory Committee will inform their recommendations. The Committee will next meet jointly with the Health Fund Board on December 12 to discuss primary care medical homes.

Delivery System Committee – Quality Institute Workgroup

The Health Care Quality Institute Workgroup will hold its first meeting on December 17.

Enrollment and Eligibility

The Eligibility and Enrollment Committee held its first meeting on October 24 and most of the meeting was devoted to organizational issues such as the charter, bylaws and timeline for the Committee. The second meeting (held on November 13) included presentations on "Trends in Health Insurance Coverage" and on "Defining Health Care Affordability". On November 28 the Committee met to review affordability research, hear recommendations from the Oregon Medicaid Advisory Committee on cost-sharing and affordability, and solidify a tentative work plan through April 2008. The Committee began a process to develop recommendations on where on the income scale personal contributions should continue as well as an end point for public subsidies.

Federal Laws Committee

The Federal Laws Committee held its first meeting on November 29. The meeting was primarily organizational. The committee elected Frank Baumeister, MD, a Portland physician, as chair and Ellen Gradison of the Oregon Law Center as vice-chair. The committee decided to solicit stakeholder comments and recommendations on federal requirements that may hinder Oregon's reform efforts. The next meeting will be held the week of January 21 and will include panel presentations and discussion with a focus on Medicaid requirements.

Committee Meeting Calendar (continued):

Quality Institute Workgroup (Delivery Systems)

December 17
1 – 5 pm
NW Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

January 3
1 – 5 pm
Location: TBD

January 10
1 – 5 pm
NW Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Enrollment & Eligibility

December 11
9 am to Noon
Secretary of State Archives
Large Conference Room
800 Summer St. NE
Salem, OR

January 8
10 AM to 1 pm
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

January 23
2:00 to 5 pm
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

Federal Laws

No meeting in December.
January meeting TBD

Continued on Page3

Board, Committee & Workgroup Updates (continued)

Finance Committee
The Finance Committee held its first meeting on October 18. Kerry Barnett of the Regence Group, was elected as chair and John Worcester, Evraz Oregon Steel Mills, as vice-chair. The Committee next met on November 19 to hear presentations on health insurance exchanges and the cost of covering the uninsured. The Committee also received information about the work of the consultants who will be conducting economic modeling for the Board.

> ***Finance Committee - Exchange Workgroup***
> The Exchange Workgroup met for the first time on November 29, electing Denise Honzel, a health care consultant, as chair and Laura Etherton, an advocate for the Oregon State Public Interest Research Group, as vice-chair. The group developed a "issue identification" list that it will use to shape the group's work over the next several months.

Health Equities Committee
The Health Equities Committee held its first meeting on November 27. This first meeting was organizational in nature. The committee elected Ella Booth, Ph.D., a health ethicist and Associate Dean at Oregon Health & Science University, as chair. The committee elected two vice-chairs, Tricia Tillman of Multnomah County Health Department's Health Equities program, and Joe Finkbonner, of the Northwest Portland Indian Health Board. The committee voted to meet twice a month in December and January. The December 20 meeting will include a discussion of eligibility and enrollment issues in preparation of making recommendations to the Eligibility and Enrollment Committee and the Board.

A Solicitation for Stakeholder Comments on Federal Laws

The Federal Laws Committee invites you to participate in its work! The Committee is charged with providing findings and recommendations on the impact of federal requirements on achieving Oregon's reform goals, particularly focusing on barriers to reducing the number of uninsured Oregonians. To do this, the Committee is requesting written comments from stakeholders on the following policy areas: Medicaid (including SCHIP and FHIAP), Medicare, ERISA, federal tax codes, EMTALA, HIPAA, and any other areas of federal policy that are relevant to Oregon's reform efforts. The Committee will also select stakeholders to participate in panel discussions during January – April Committee meetings.

Written comments should be sent no later than January 18 to Barney Speight at barney.speight@state.or.us. If you would like to be considered for participation on a panel, please contact Susan Otter at susan.otter@state.or.us or 503-373-0859 no later than December 21 for the Medicaid panel or by January 11th for panels on the other topics. For more information, please contact Susan Otter or see the OHFB website http://healthfundboard.oregon.gov soon for a link to the official solicitation letter.

Contact Information
Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538
Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Finance

December 19, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

January 9, 2008
1 – 5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Exchange Workgroup (Finance)

December 6, 2007
2 pm -5 pm
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

December 19, 2007
2 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Health Equities

December 20, 2007
8 – Noon
Location TBD

A Comprehensive Plan for Reform: Design Principles & Assumptions

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

VI. Reforms will build on the foundational elements of the current system.

BHS Draft, Dec 4

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & ↓ COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → ↑ QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

I. New revenue (tax) options will be required

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

H. - Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.
- A FHIAP-like program will serve Oregonians within defined income levels through premium subsidies.
- The Oregon Health Plan (Plus & Standard) will serve Oregonians below defined income levels.

Oregon Health Fund Board Eligibility and Enrollment Committee

Where should personal contribution to premium share begin? How do these policy dimensions influence your decision?

Option 1 Full subsidy up to: **(150% FPL)** $14,700, 63% median household income for an individual and $19,800, 38% median household income for a couple; **(200% FPL)** $33,200, 57% median household income for a family of three	
Affordability: What does this option imply about personal affordability?	
Equity: What does this option imply about health coverage *outside* a new program?	
Limiting Crowd-out: What does this option imply about the potential loss of employer contribution?	
Budget Constraints/ Sustainability: What does this option imply about the state budget?	
Shared Responsibility: What does this option imply about individual, employer and state responsibility?	

Oregon Health Fund Board Eligibility and Enrollment Committee

Option 2 Full subsidy up to: **(200% FPL)** $19,600, 84% median household income for an individual; $26,400, 51% median household income for a couple; and, $33,200, 57% median household income for a family of three	
Affordability: What does this option imply about personal affordability?	
Equity: What does this option imply about health coverage *outside* a new program?	
Limiting Crowd-out: What does this option imply about the potential loss of employer contribution?	
Budget Constraints/ Sustainability: What does this option imply about the state budget?	
Shared Responsibility: What does this option imply about individual, employer and state responsibility?	

Oregon Health Fund Board Eligibility and Enrollment Committee

Where should subsidies end? How do these policy dimensions influence your decision?

Option 1 Partial subsidy up to: **(300% FPL)** $29,400, 126% of the median household income for an individual and $39,600, 77% of the median household income for a couple; **(350% FPL)** $58,100, 100% of the median household income for a family of three	
Affordability: What does this option imply about personal affordability?	
Equity: What does this option imply about health coverage *outside* a new program?	
Limiting Crowd-out: What does this option imply about the potential loss of employer contribution?	
Budget Constraints/ Sustainability: What does this option imply about the state budget?	
Shared Responsibility: What does this option imply about individual, employer and state responsibility?	

Oregon Health Fund Board Eligibility and Enrollment Committee

Option 2 Partial subsidy up to: **(350% FPL)** $34,300, 147% of the median household income for an individual and $46,200 89% of the median household income for a couple; **(400% FPL)** $66,400, 114% of the median household income for a family of three	
Affordability: What does this option imply about personal affordability?	
Equity: What does this option imply about health coverage *outside* a new program?	
Limiting Crowd-out: What does this option imply about the potential loss of employer contribution?	
Budget Constraints/ Sustainability: What does this option imply about the state budget?	
Shared Responsibility: What does this option imply about individual, employer and state responsibility?	