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.

The Impact of Medicaid Cost Sharing on Low Income Adults

Results from an Ongoing Prospective Cohort Study

Matthew Carlson, Ph.D.
Portland State University
Center for Health and
Social Inequality Research

Bill J. Wright, Ph.D.
Providence Health System
Center for Outcomes
Research and Education

Carlson MJ, Wright B. (a) The impact of Medicaid program changes on low income adults: Results from a prospective cohort study. Invited presentation at the Oregon Health Fund Board, Eligibility and Enrollment Committee. Salem, OR. Dec, 2007.

Summary of Changes to OHP

Early 2003

- Premium changes - $6-$20 per month based on income.
- Expansion of co-pays - office visits, labs, ED, prescriptions, hospitalization; ranging from $5 to $250.
- Non-payment of premium results in 6 month “lock-out” from OHP.
- Eliminated coverage for dental, vision, outpatient mental health, substance abuse, durable medical equipment.

Summer 2004

- In response to a legal ruling, co-pays dropped for Standard members.
- Outpatient Mental health and chemical dependency benefits restored.

Summer 2006

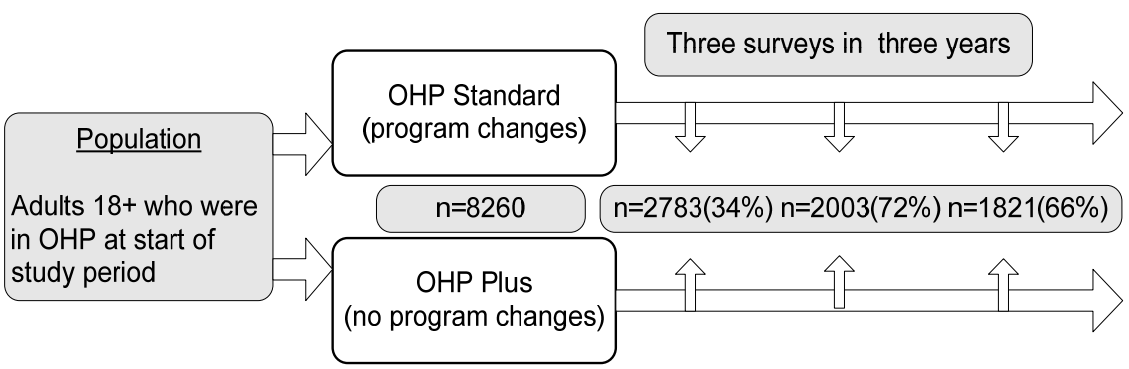
- In response to OHREC studies, premiums dropped for 0-25% FPL and “lock-out” rescinded.

Cost Sharing
OHP Plus and Standard

OHP Plus	OHP Standard
No Premiums Co-Pays • Voluntary only, may not be denied service for not paying • $3 Outpatient visit • $2/$3 generic/brand drugs	Premiums $6-$20 based on income Co-Pays • Non-Voluntary, service can be denied for not paying • $250 inpatient • $50 emergency dept. • $5 outpatient • $3 per lab/x-ray • $5 physical/speech /occupational therapy • $2/$15 generic/brand drugs. • In effect March 2003 – June 2004 only

Design of the OHP Cohort Study

Longitudinal cohort study designed to assess impacts of program redesign by following a group of people for three years after the initial changes.

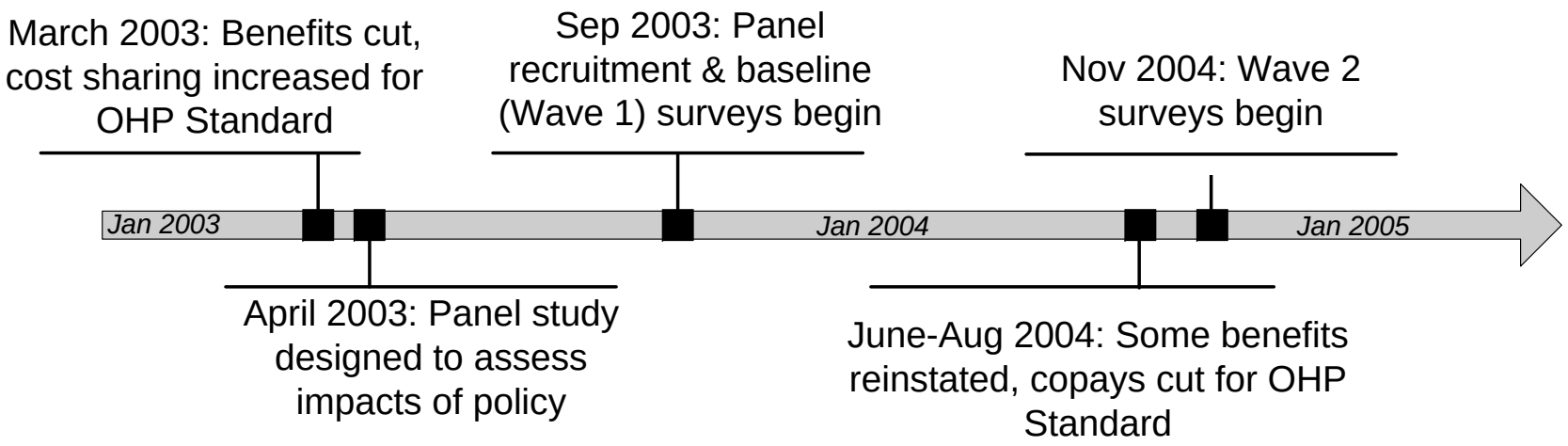


Outcomes Measured:
1. Enrollment/insurance status
2. Access
3. Utilization
4. Financial impacts
5. Health outcomes

Research Plan:
Assess each panel member's outcomes annually for three years.

Follow panel members, even if they leave OHP, to see what happens to them.

OHP Program Redesign and Cohort Study Milestones



Key Policy Question

What effect did changes in cost sharing have on OHP Standard beneficiaries?

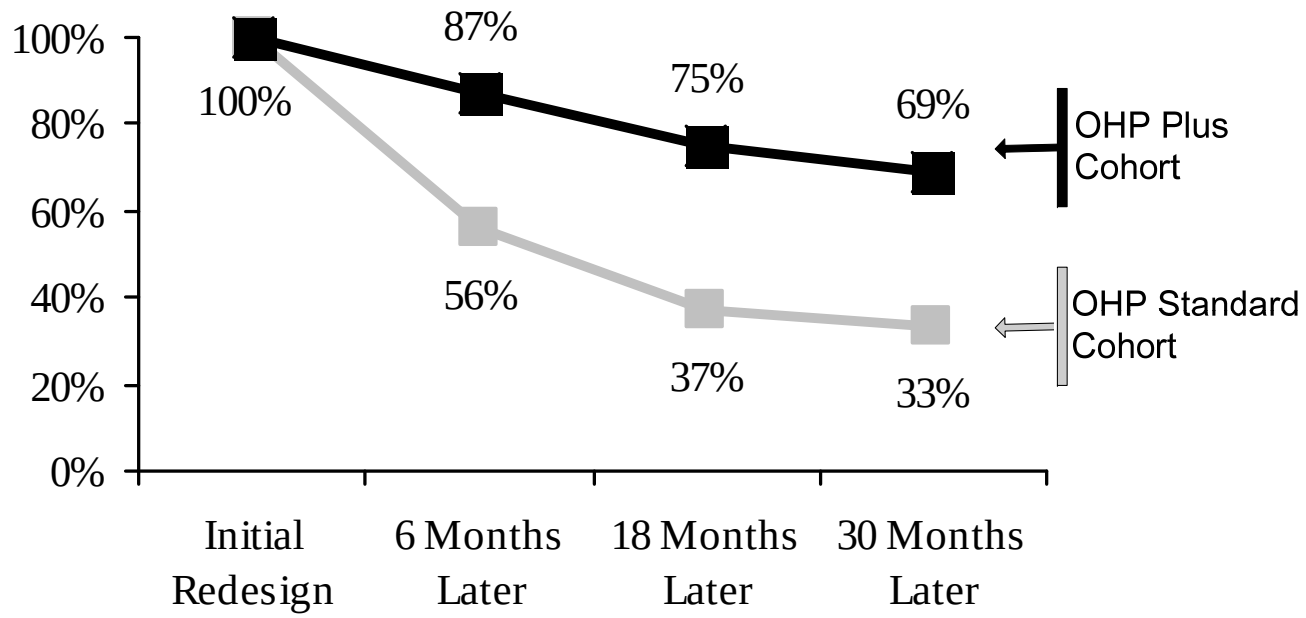
Key Outcome Measures:

- Coverage stability
- Access to care
- Utilization of care
- Financial strain due to medical costs

Coverage Stability

Two-thirds of the Standard cohort left OHP after the 2003 program redesign, mostly in the early months

Chart: Percent of Study Panel Still in OHP at Each Time Point

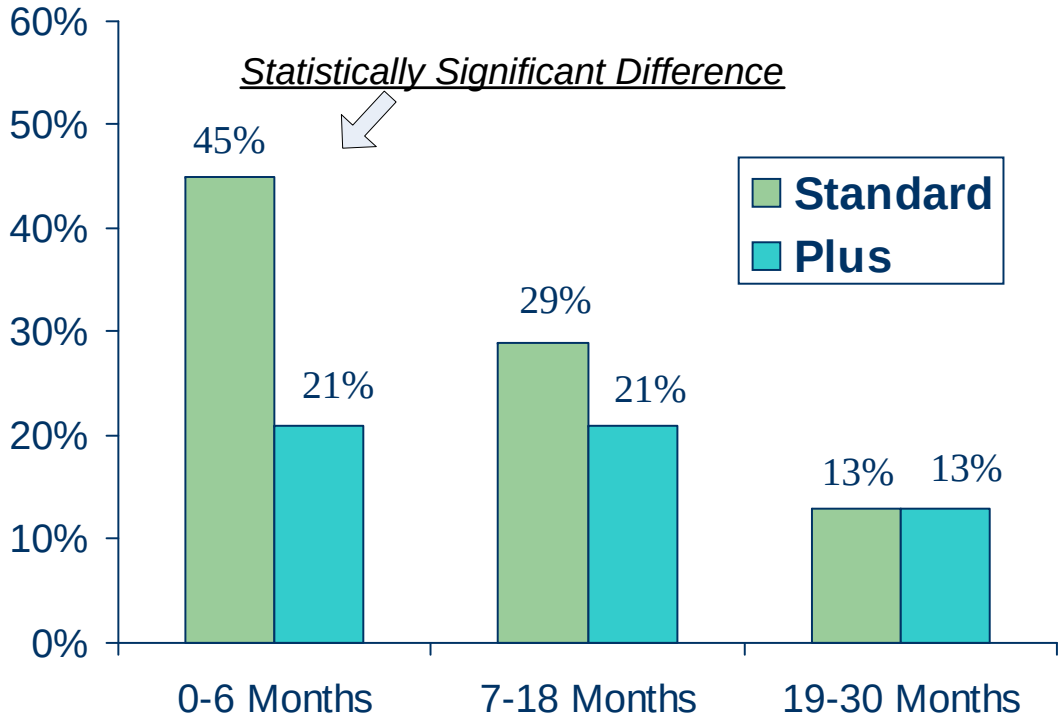


What This Means: Standard members initially left at an accelerated rate in response to the program redesign, then rates of leaving stabilized to look more like those of Plus.

Coverage Stability

In those early months after the redesign, cost was a key reason so many people left OHP Standard

Chart: Percent of Standard Cohort who Left OHP in the first 18 months after the redesign and reported cost as a reason



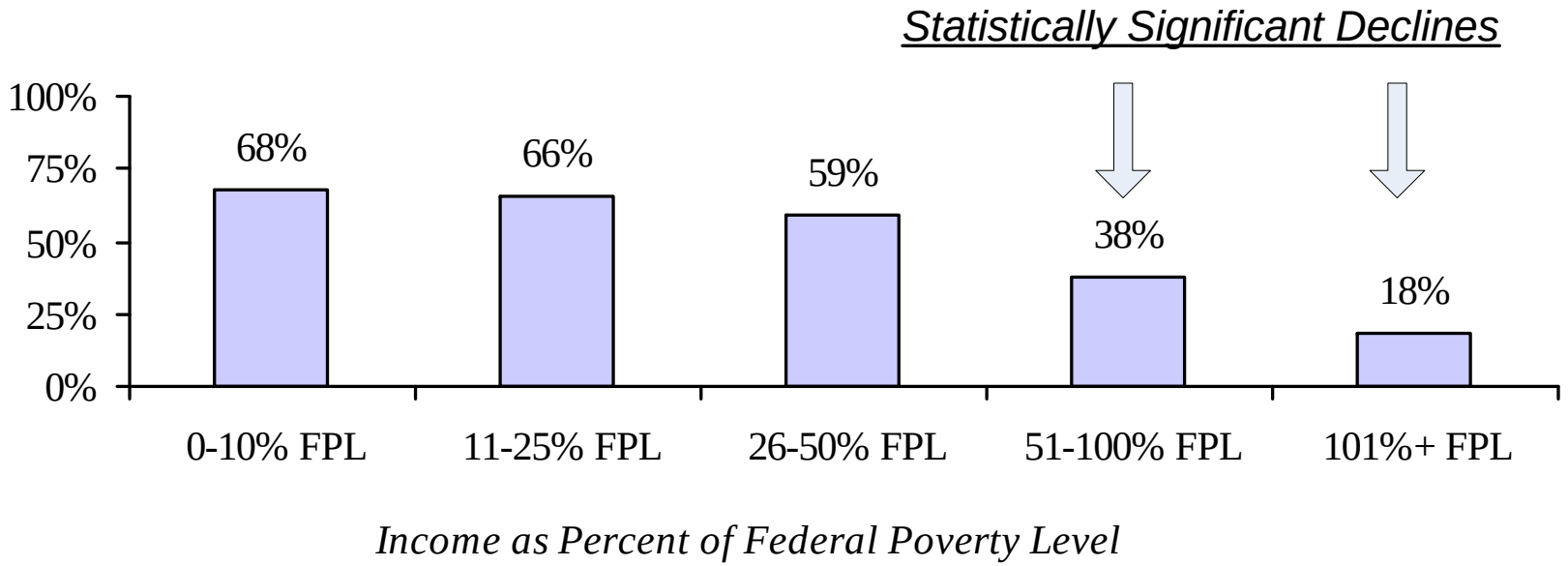
What This Means: Cost sharing is what drove Standard members to leave at a higher rate than those in Plus.

When Cost sharing went away, the two groups looked the same.

Coverage Stability

Increased cost sharing particularly affected the poorest OHP Standard members

Chart: Percent of Standard Cohort who Left OHP in the first 6 months after the redesign and reported cost as a reason

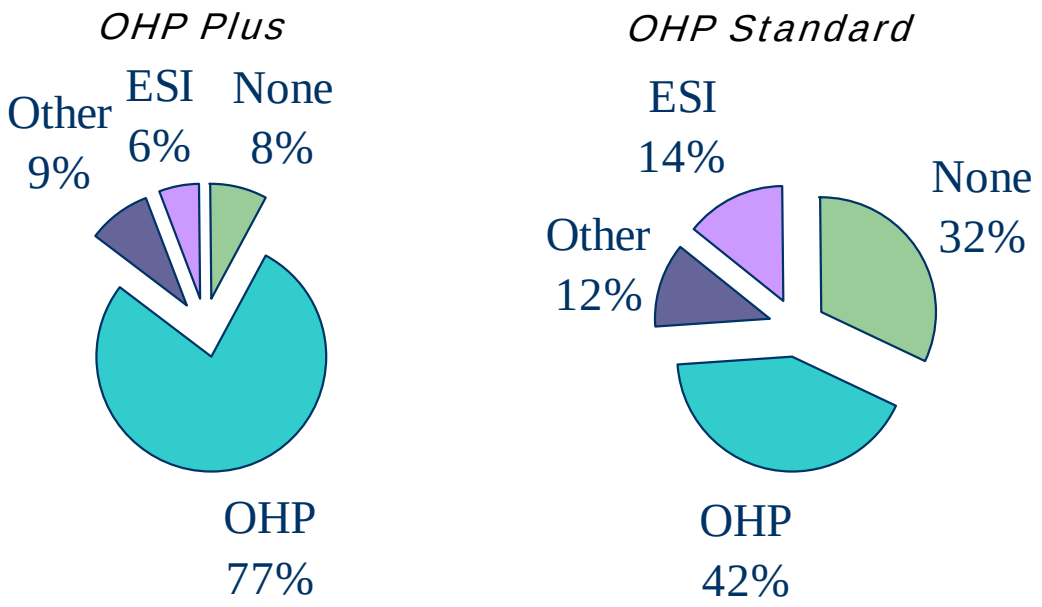


What This Means: Income may not "cushion" members against increased cost sharing until at least 50% FPL. Below that, even small increases drive disenrollment.

Coverage Stability

OHP Standard members were much more likely to still be uninsured at the end of the three year study

Chart: Insurance Outcomes at End of Study Period

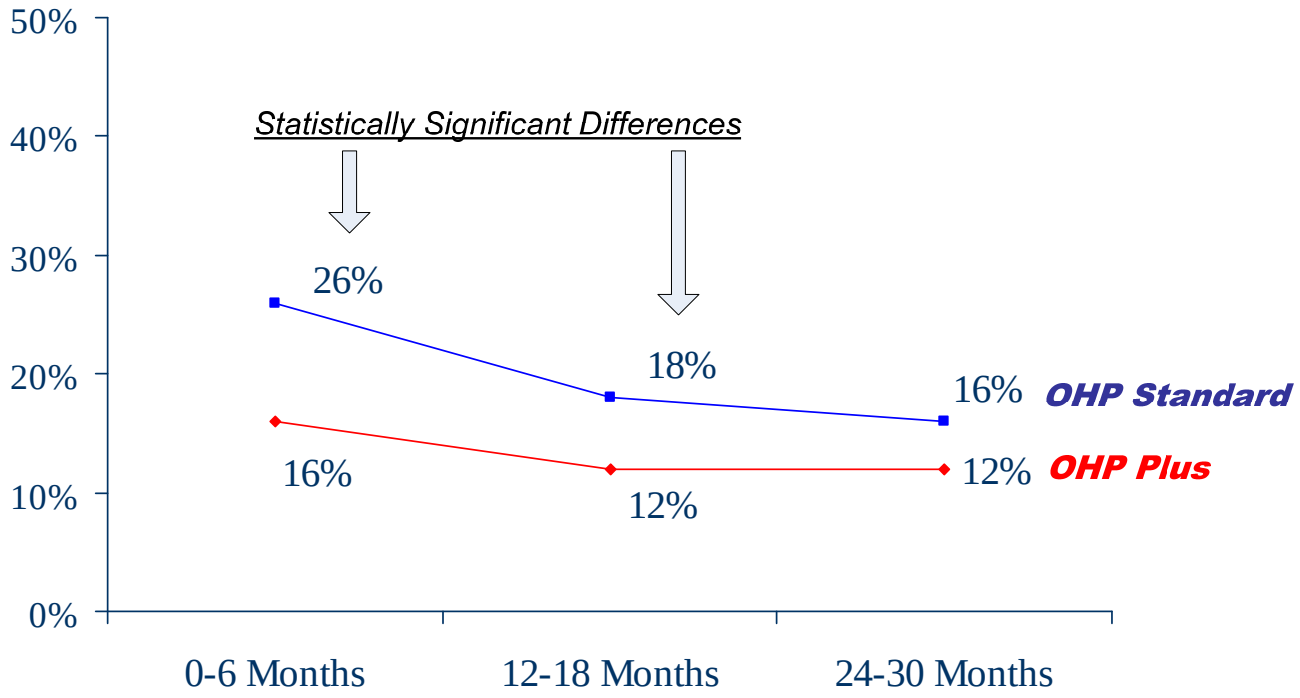


What This Means: Standard members were more likely to leave than Plus, and more of them ended up uninsured (32%) than found some other type of coverage (26%).

Access to Care

OHP Standard members reported more overall unmet medical need before co-pays were suspended

Chart: Percent of continuously insured reporting unmet medical care needs

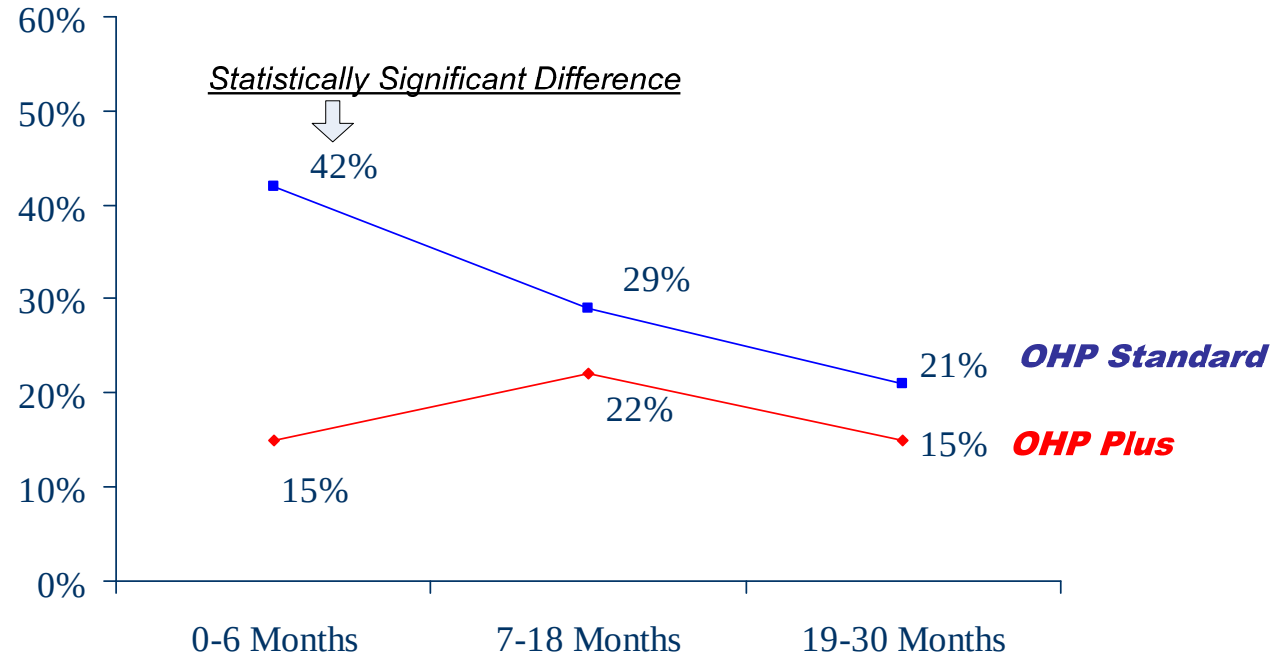


What This Means: While co-pays were in effect, access to care was worse among Standard members than Plus. When co-pays went away, so did the differences.

Access to Care

OHP Standard members more often identified cost as a reason for unmet need before co-pays were suspended

Chart: Percent of continuously insured reporting cost as a reason for not getting needed care

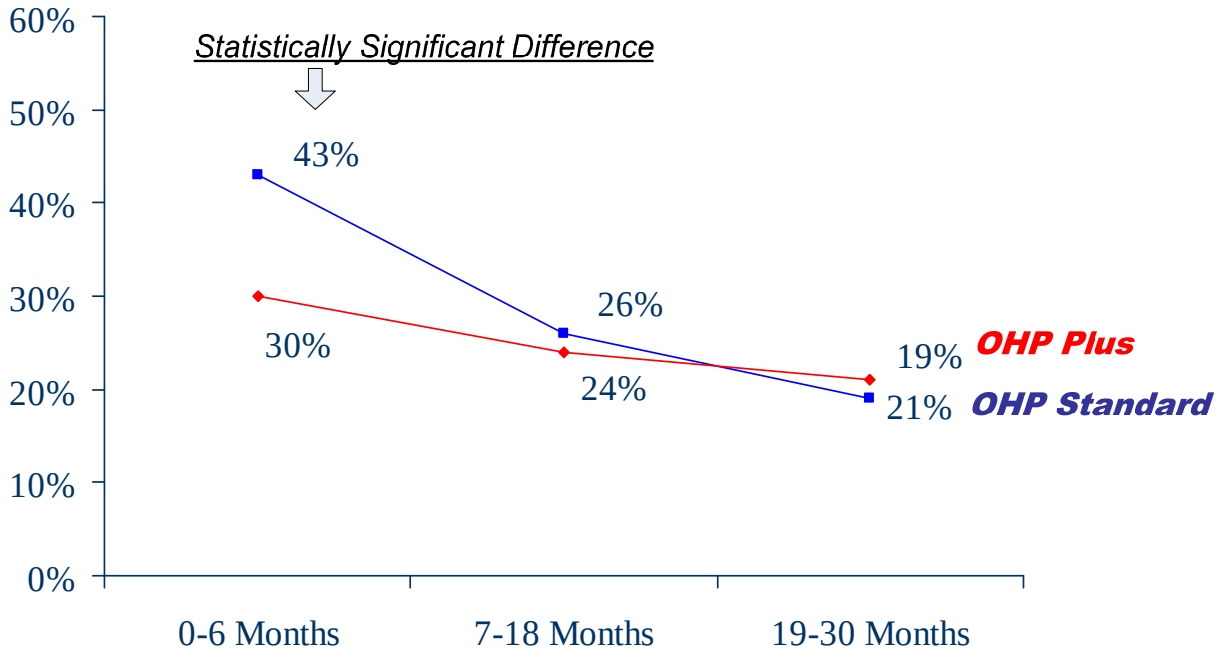


What This Means: While co-pays were in effect, cost was a much more common reason for unmet need among OHP Standard members than it was for Plus members. When co-pays went away, so did the differences.

Access to Care

OHP Standard members were more likely to go without prescription medications before co-pays were suspended

Chart: Percent of continuously insured reporting unmet medication need due to cost

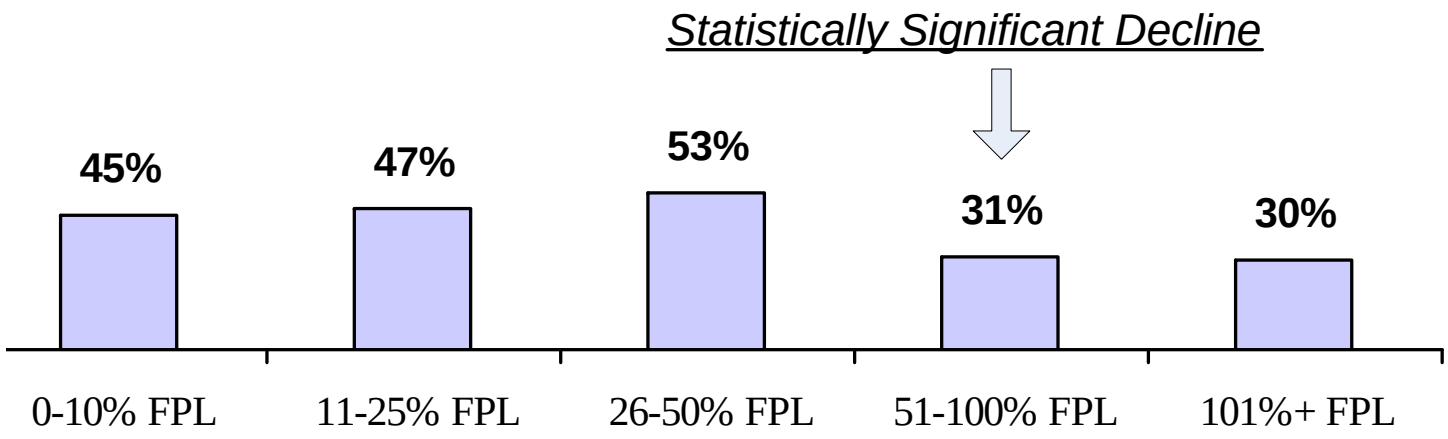


What This Means: While co-pays were in effect, Standard members were more likely than Plus members to go without medications due to cost. When co-pays went away, so did the differences.

Access to Care

Unmet Need was particularly common among the poorest OHP Standard Members

Chart: Percent of continuously insured Standard members reporting unmet need for health care during the study

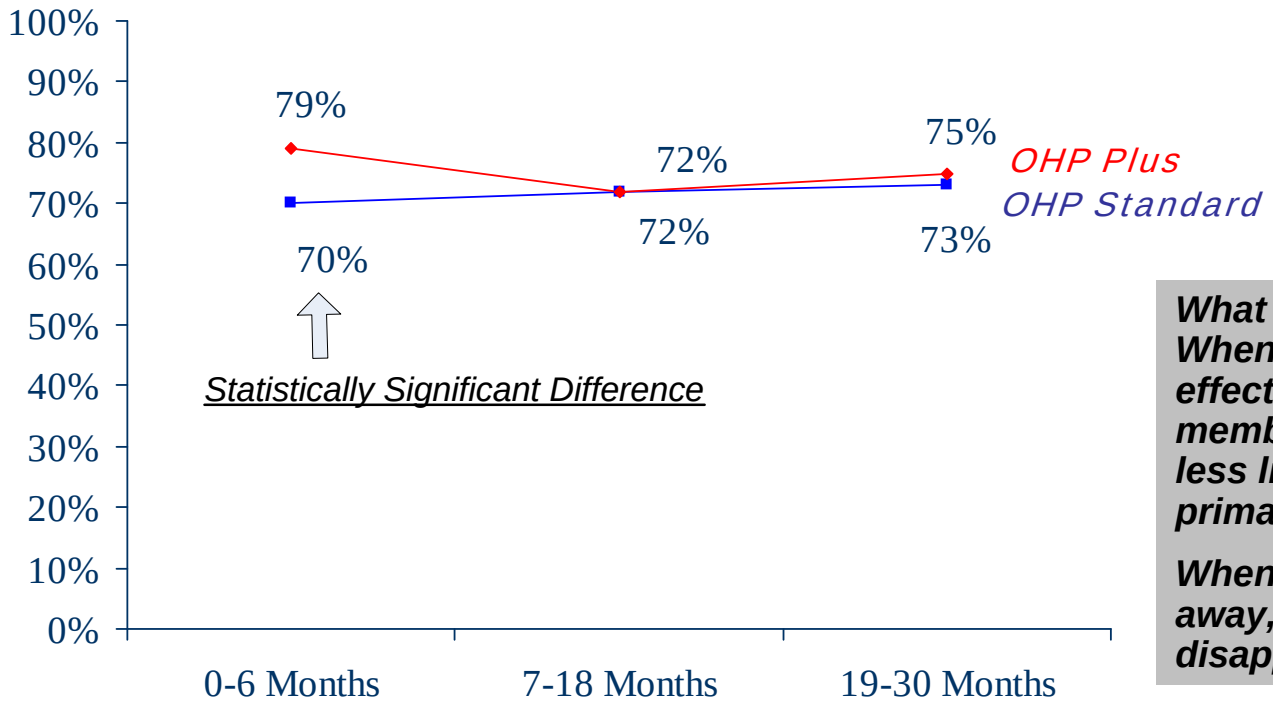


What This Means: Income may not "cushion" members against the access impacts of cost sharing until at least 50% FPL.

Utilization of Care

OHP Standard were slightly less likely to use primary care in first 6 months

Chart: Percent of continuously insured Standard members reporting more than one PC Visit



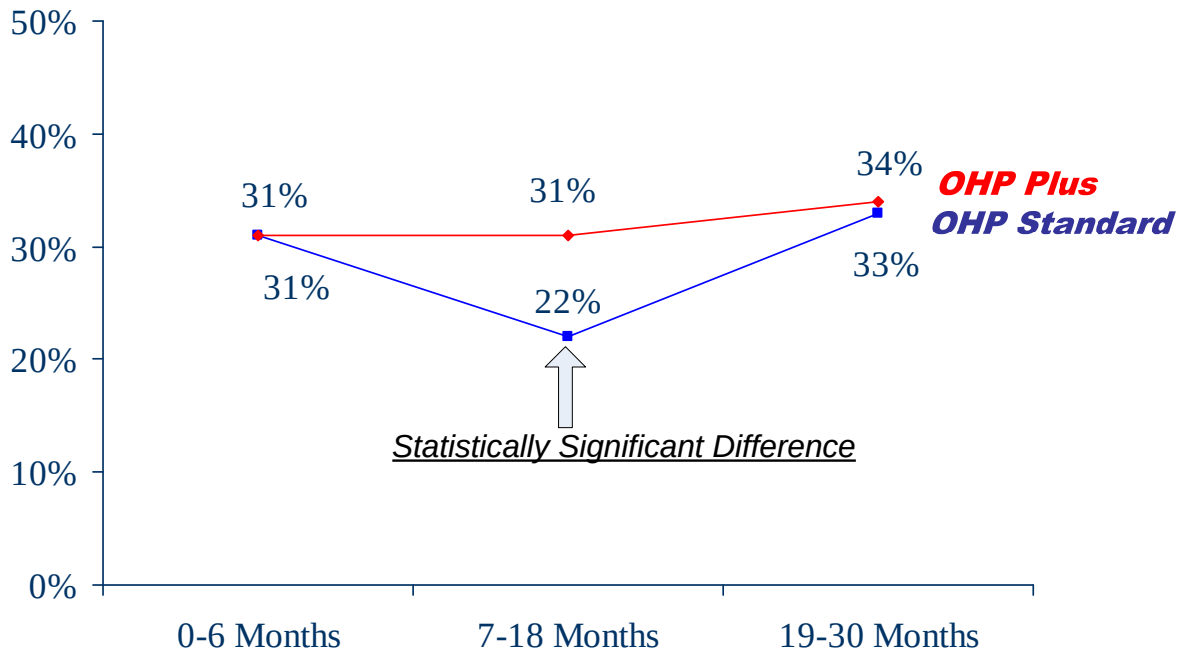
What This Means:
When co-pays were in effect Standard members were slightly less likely to use primary care.

When co-pays went away, the difference disappeared.

Utilization of Care

Evidence on the impact of co-pays on ED use was mixed.

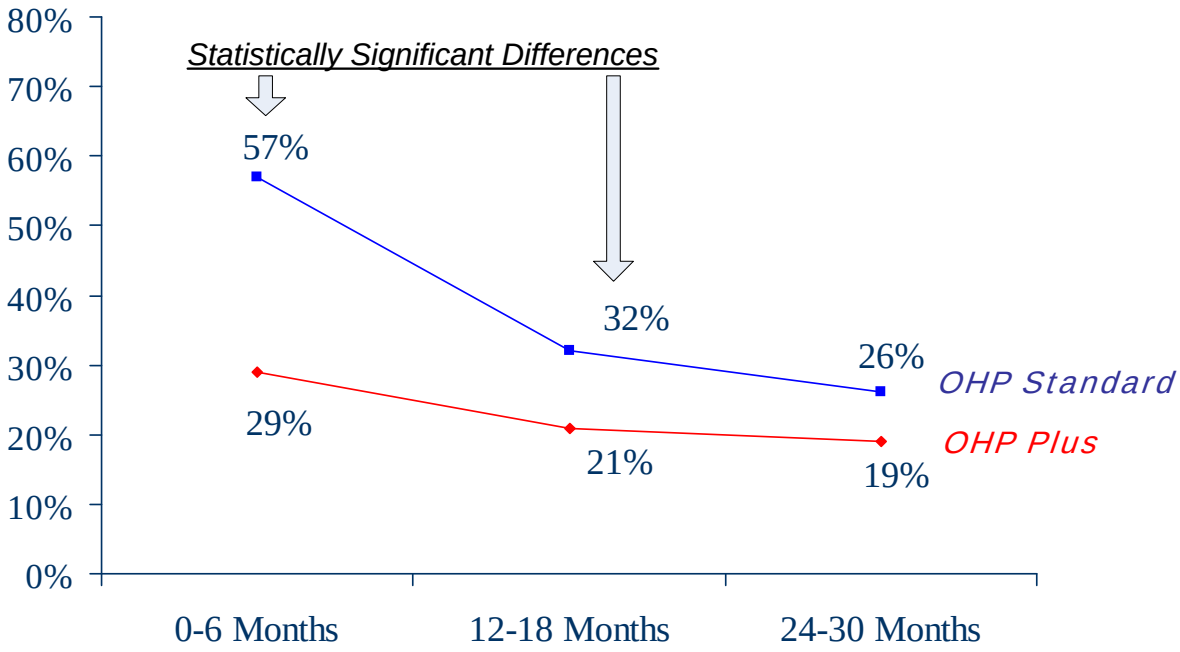
Chart: Percent of continuously insured Standard members reporting one or more ED visits



Financial Strain

OHP Standard members were more likely to report financial strain before co-pays were suspended

Chart: Percent of continuously insured Standard members reporting financial strain due to health costs during the study



What This Means: While co-pays were in effect, Standard members experienced greater financial strain due to medical costs than Plus members. When co-pays went away, so did the differences.

Conclusions

Reducing benefits and increasing co-pays dramatically impacted the health care of OHP Standard members

- The initial 2003 program redesign contributed to widespread loss of coverage among Standard members.
- The most economically vulnerable were the most likely to experience coverage disruption.
- Many who lost coverage did not find other insurance.
- Among those who stayed, cost sharing was associated with reduced access to care, less use of primary care, and greater strain on personal finances.
- These impacts were most evident in the early months after redesign and began to diminish after co-pays went away.
- The impacts of cost sharing began to decline as household incomes rose above 50% of FPL.

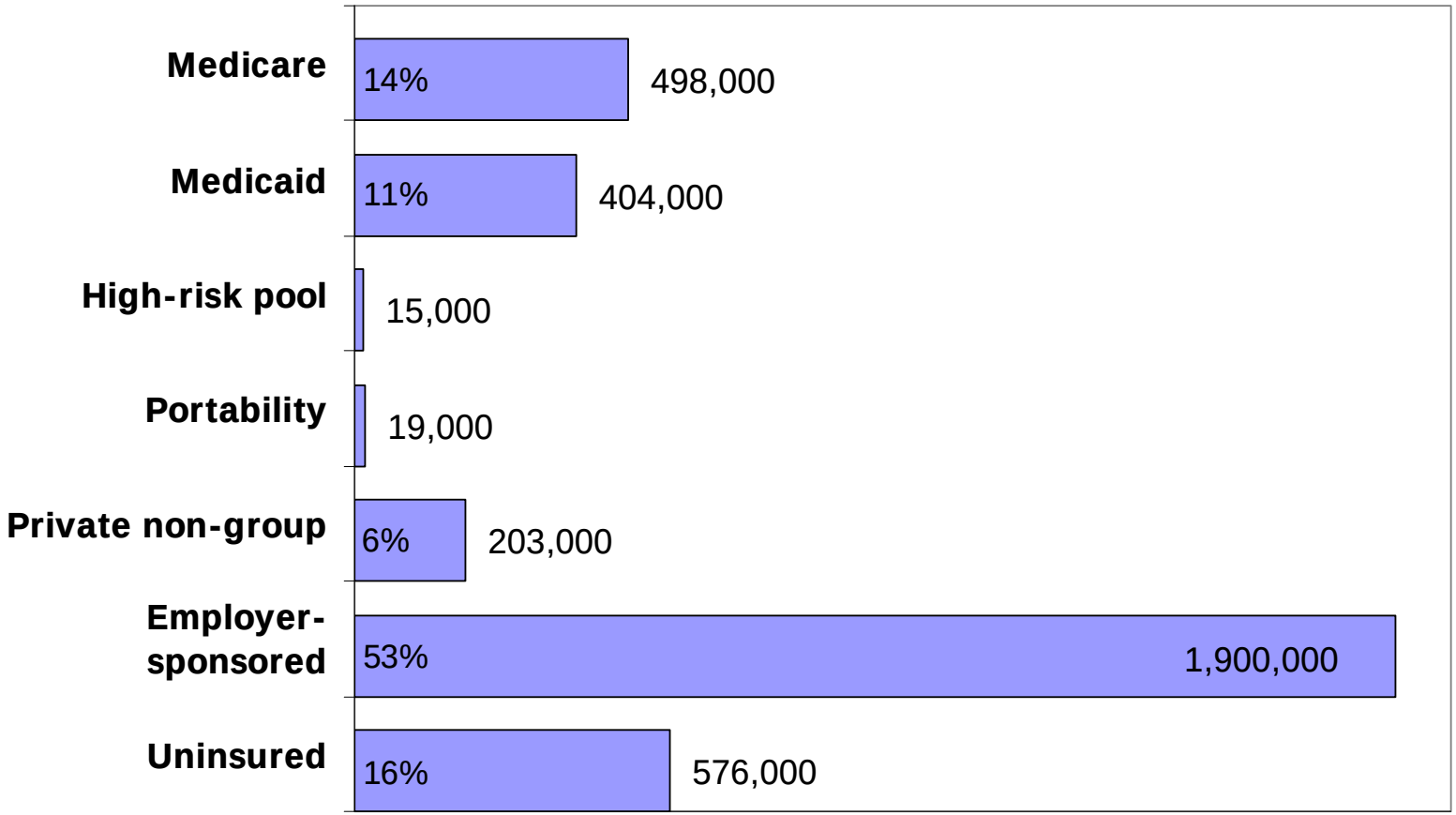
Acknowledgements

- The Robert Wood Johnson State Coverage Initiative, through the Office of Oregon Health Policy and Research, provided support for the planning and first wave of this study.
- The Commonwealth Fund and AHRQ (1 R03 HS016119-01) provided financial support for the second and third waves of the study.
- The Office of Medical Assistance Programs also provided support for this research.
- This study is being conducted through the *Oregon Health Research and Evaluation Collaborative*: Portland State University, Providence Health System, Oregon Health and Science University, Oregon State Office of Medical Assistance Programs, and the Office for Oregon Health Policy and Research.

Trends in Coverage
Oregon, 2006

The majority of Oregonians are covered by employer-sponsored insurance

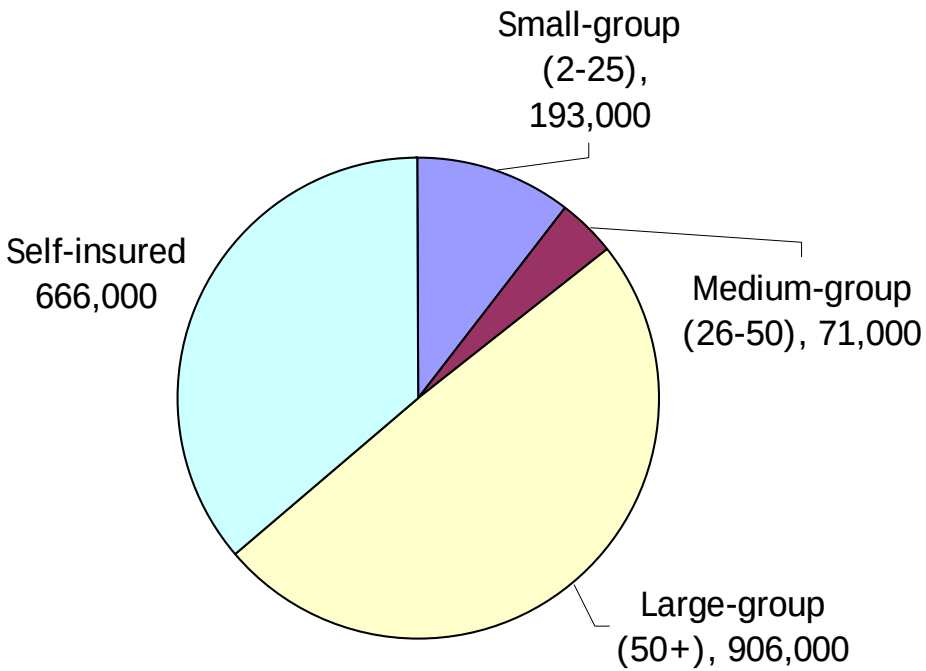
(Oregon population = 3.7 million)



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…

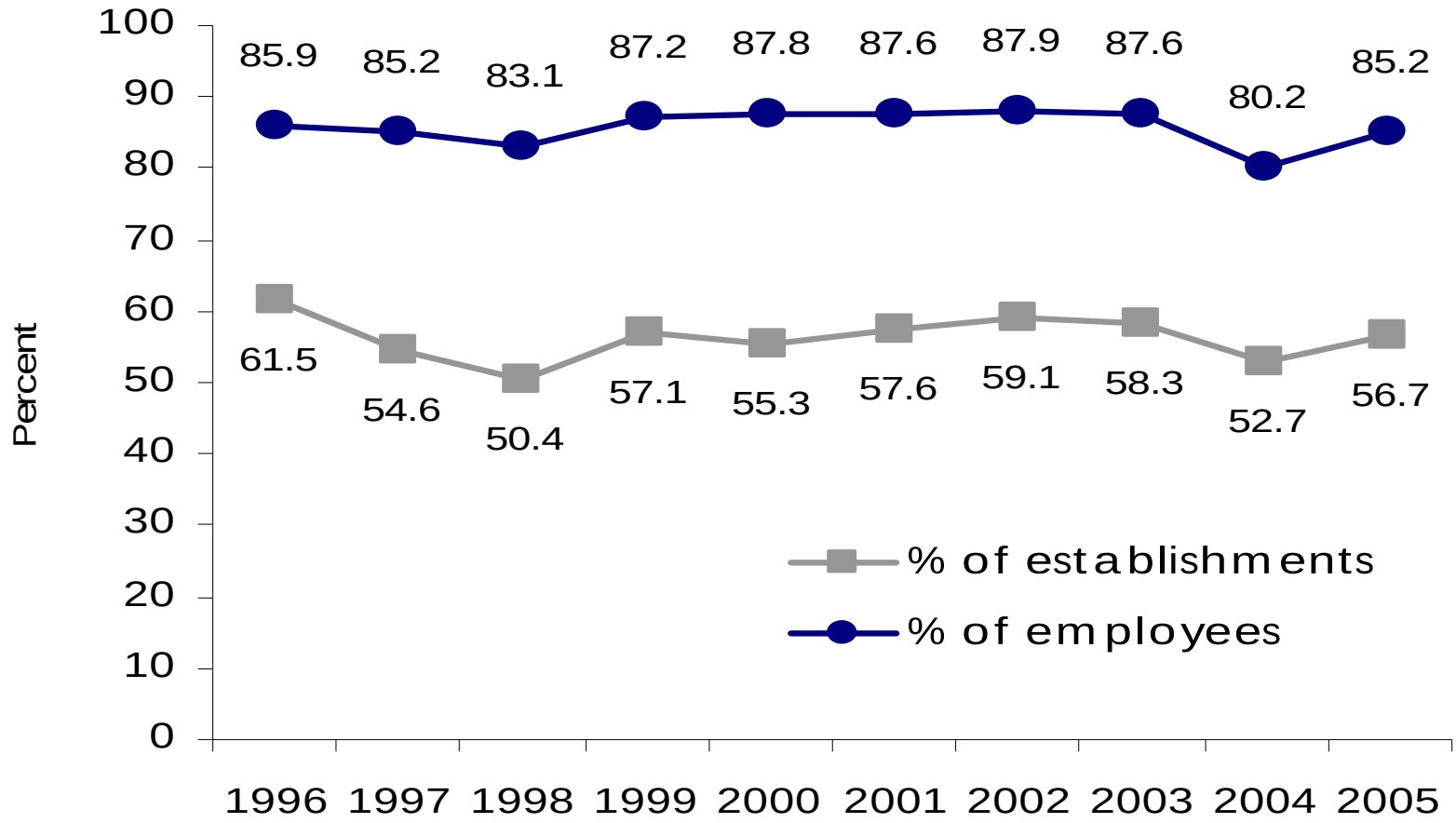
Distribution of commercial insurance in Oregon



Source: Department of Consumer and Business Services, January 2007

The percent of private businesses offering health insurance coverage has not changed significantly…

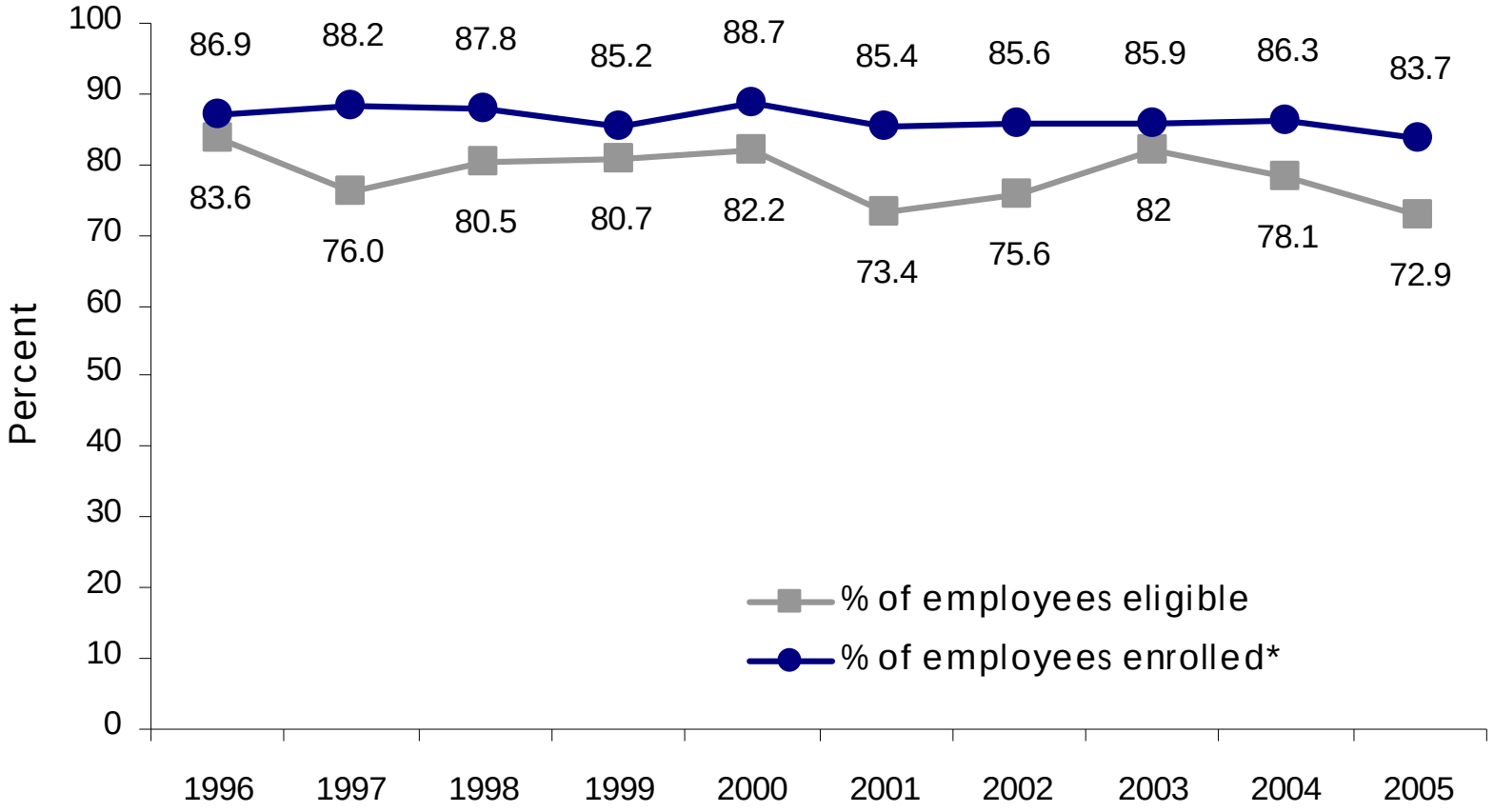
Percent of private establishments providing health insurance and percent of private employees working for businesses that offer insurance, Oregon



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

But the percentage of Oregon employees who are eligible has declined

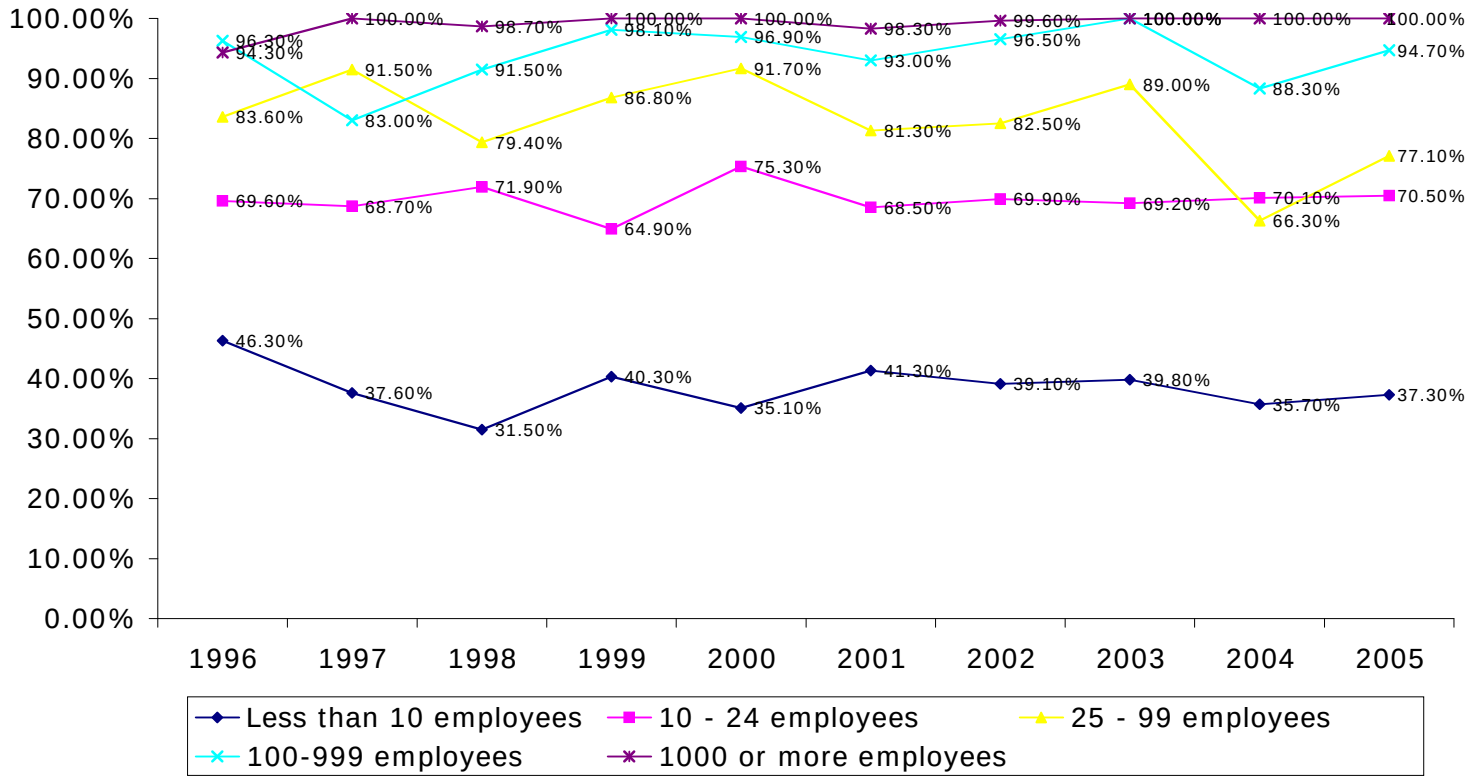
Percent of private employees eligible for employer-sponsored insurance and the percent of those eligible who are enrolled, Oregon



*As a percent of those eligible.

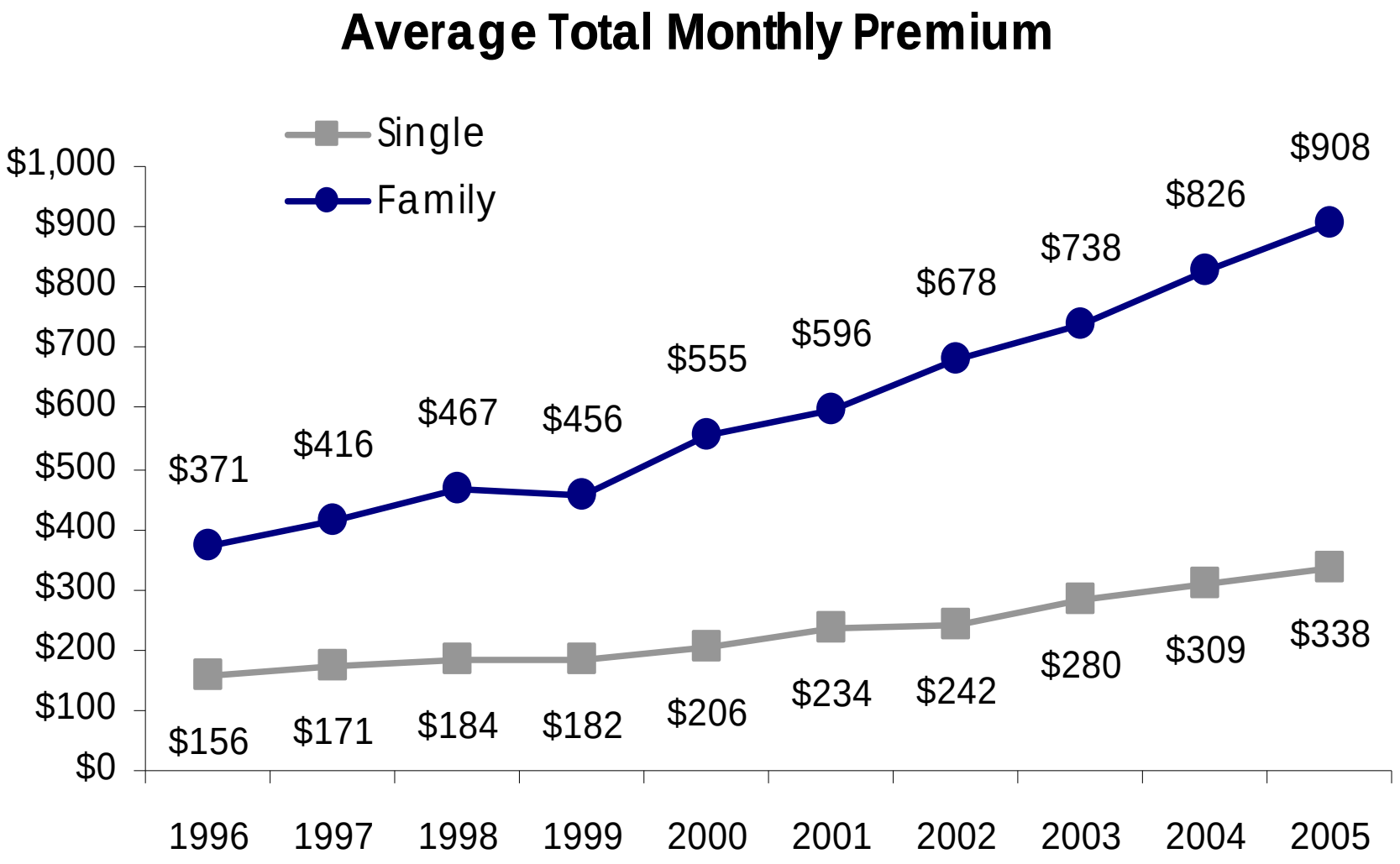
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Only private companies with <10 and 25-99 employees offering significantly less health insurance since 2000



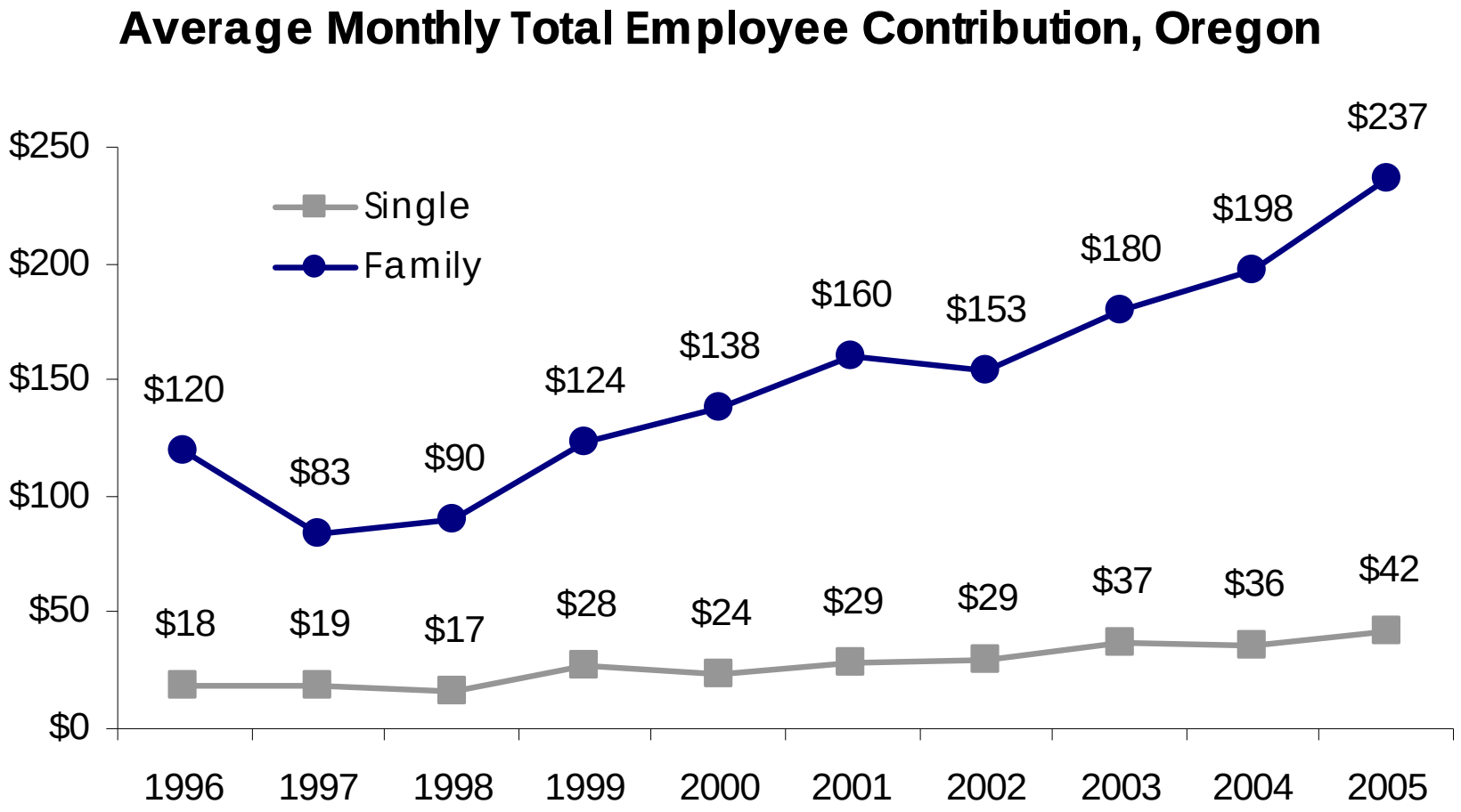
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Premium costs have steadily increased in Oregon.



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Employee contribution requirements have increased as premium costs grow…

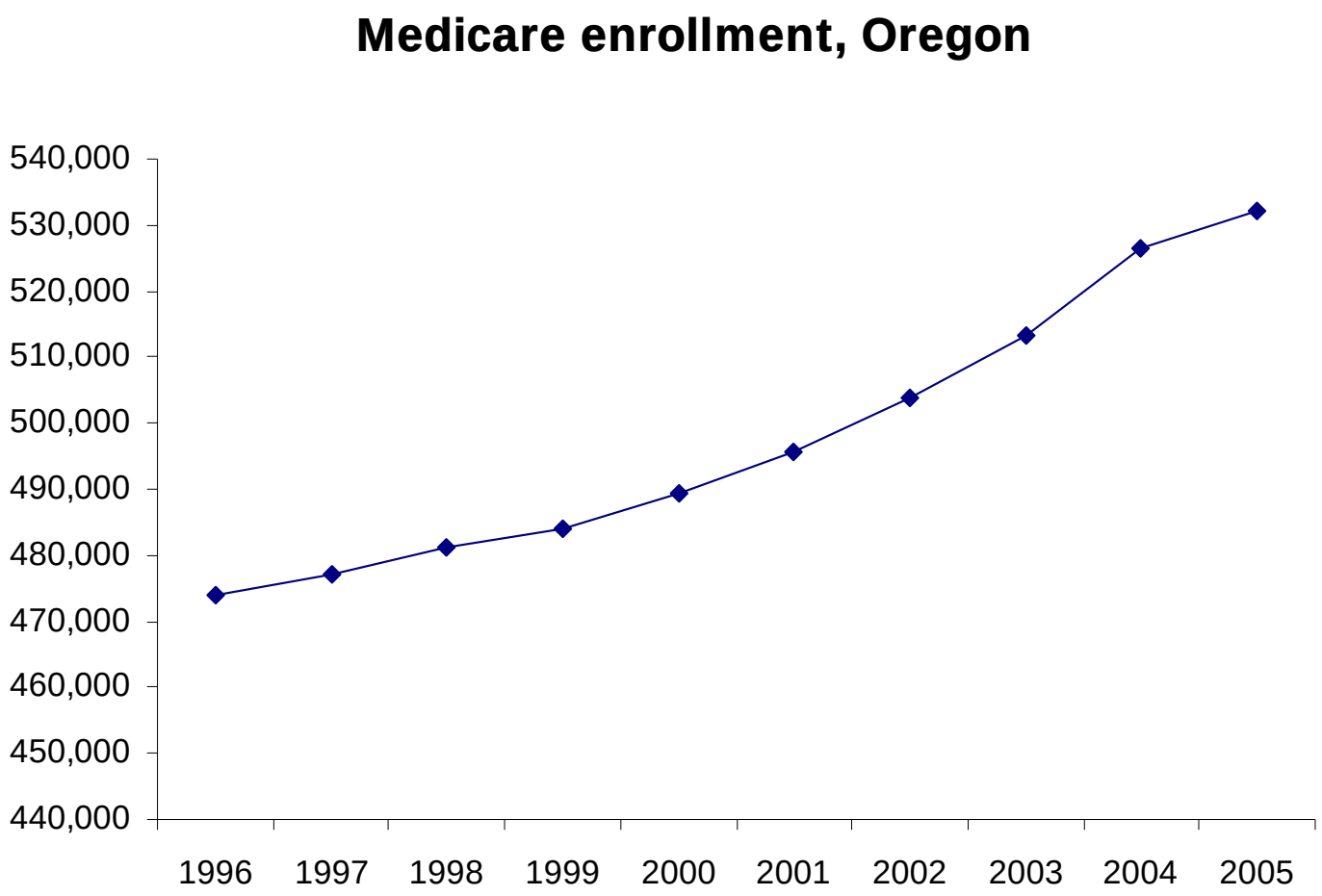


Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

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

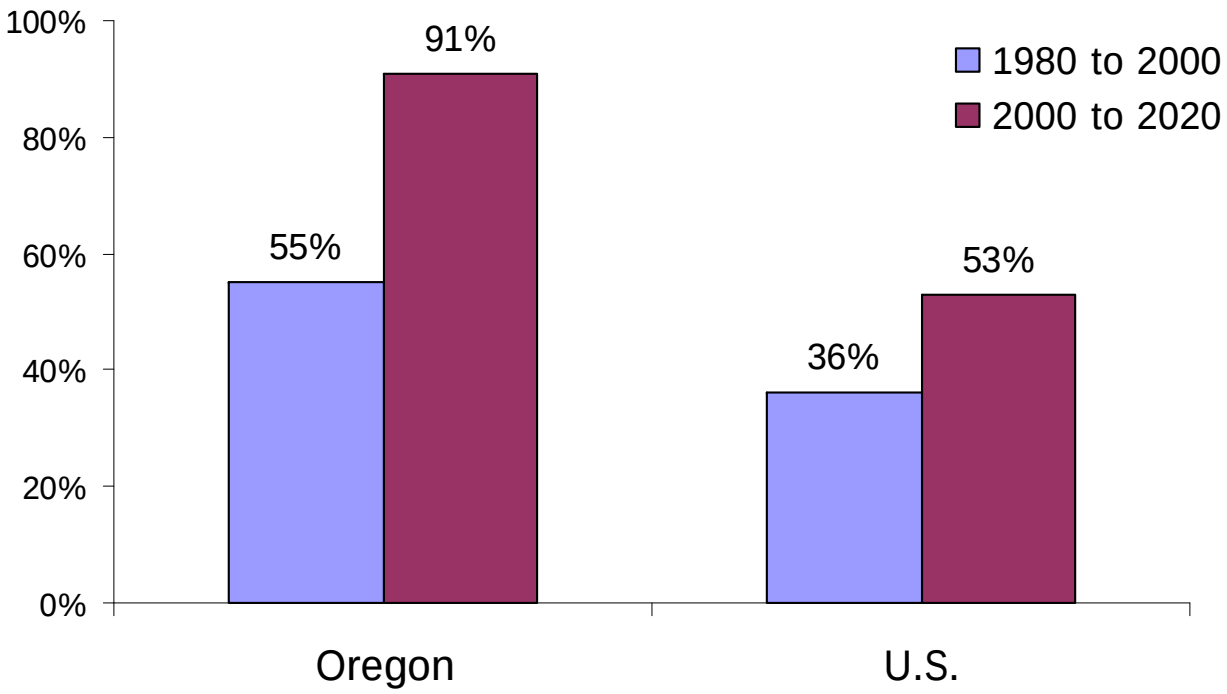
Medicare enrollment has grown as the population ages…



Source: Centers for Medicare & Medicaid Services, Medicare State Enrollment, 2005.

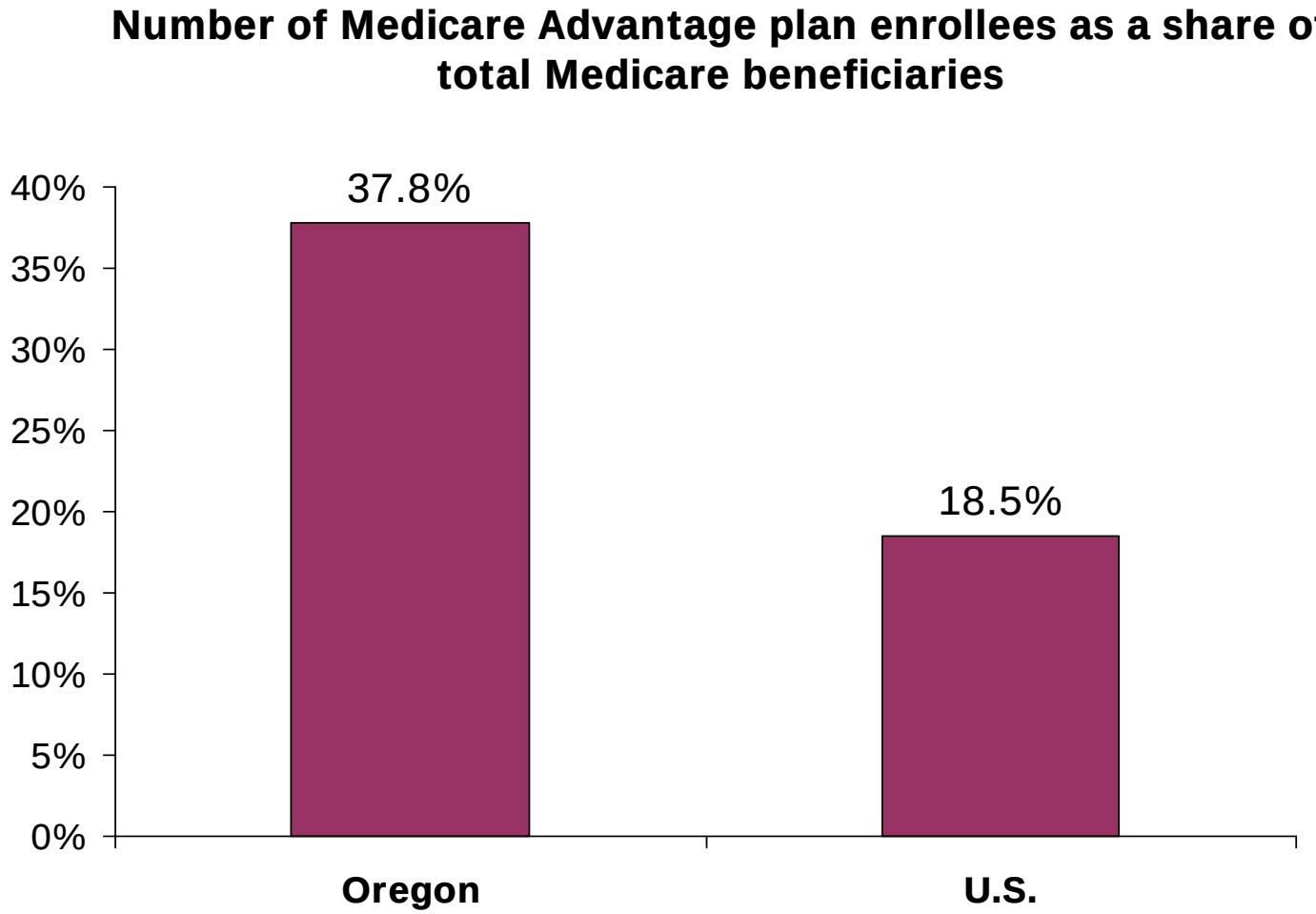
Oregon's 65+ population is increasing rapidly…

Projected percentage change in population 65+ years of age



Source: 2000 HRSA Report – Oregon Profile

Oregon leads country in Medicare Advantage enrollment *



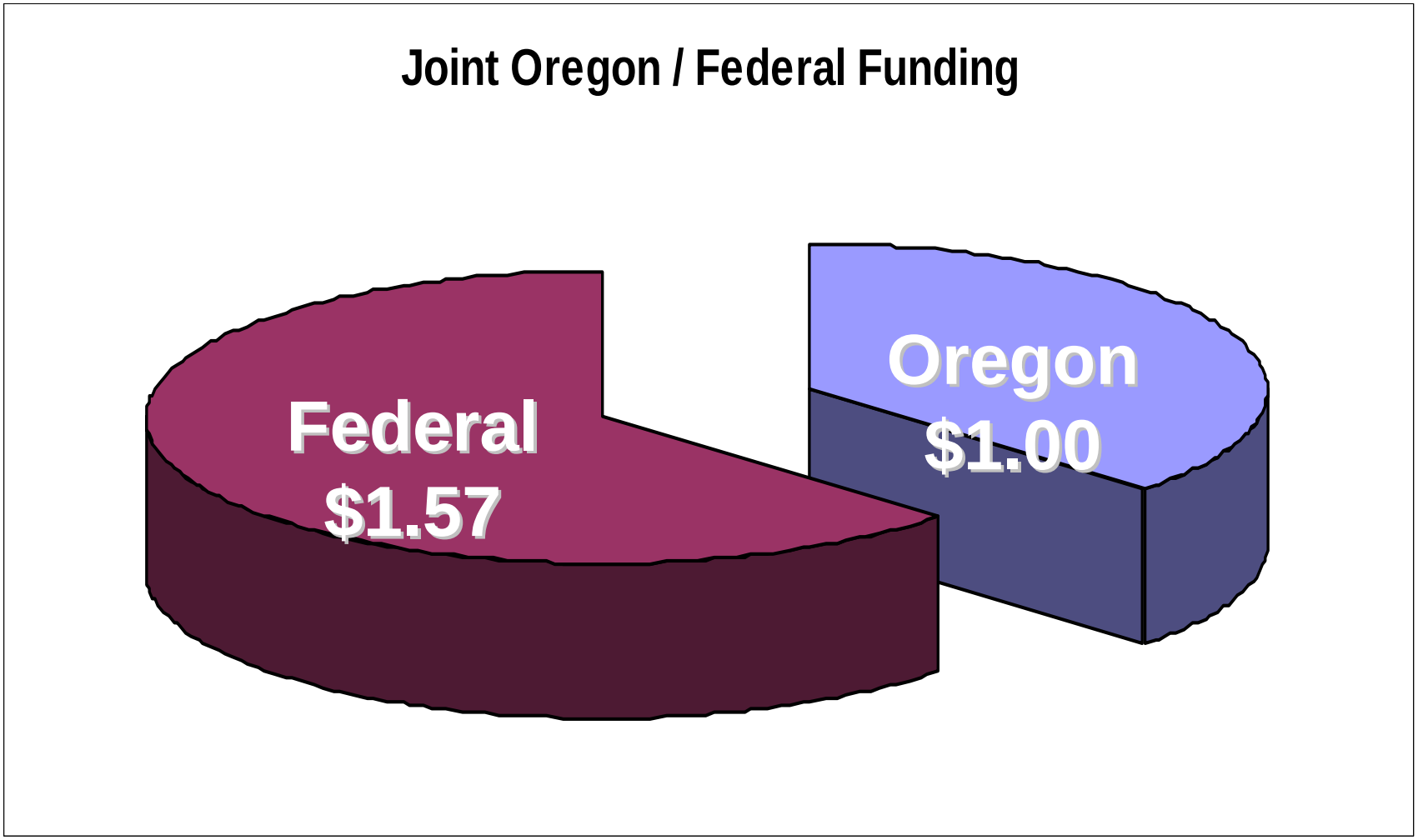
*Puerto Rico has MA penetration rate of 53.3%; OR has highest rate of states

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

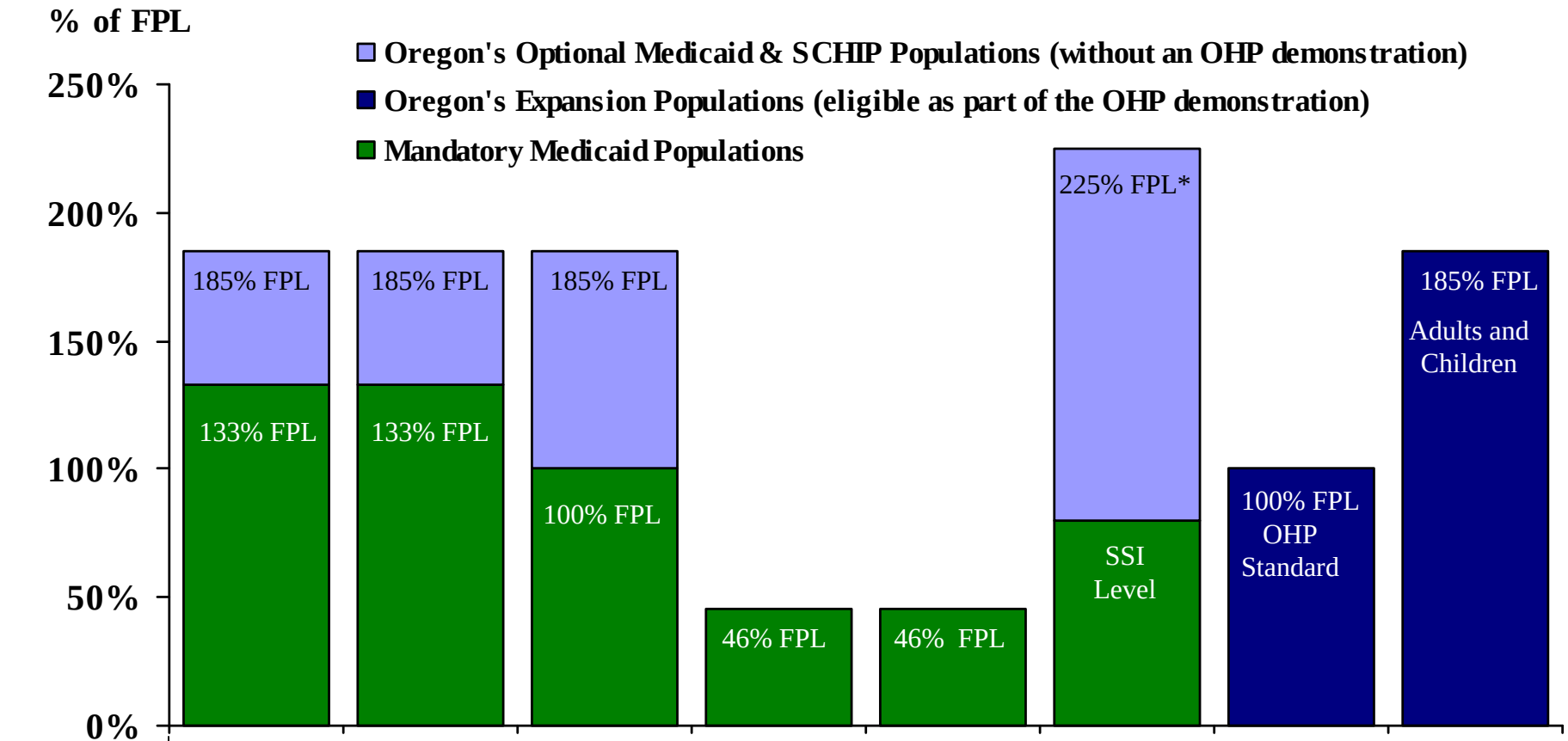
Medicaid is a State/Federal Partnership



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

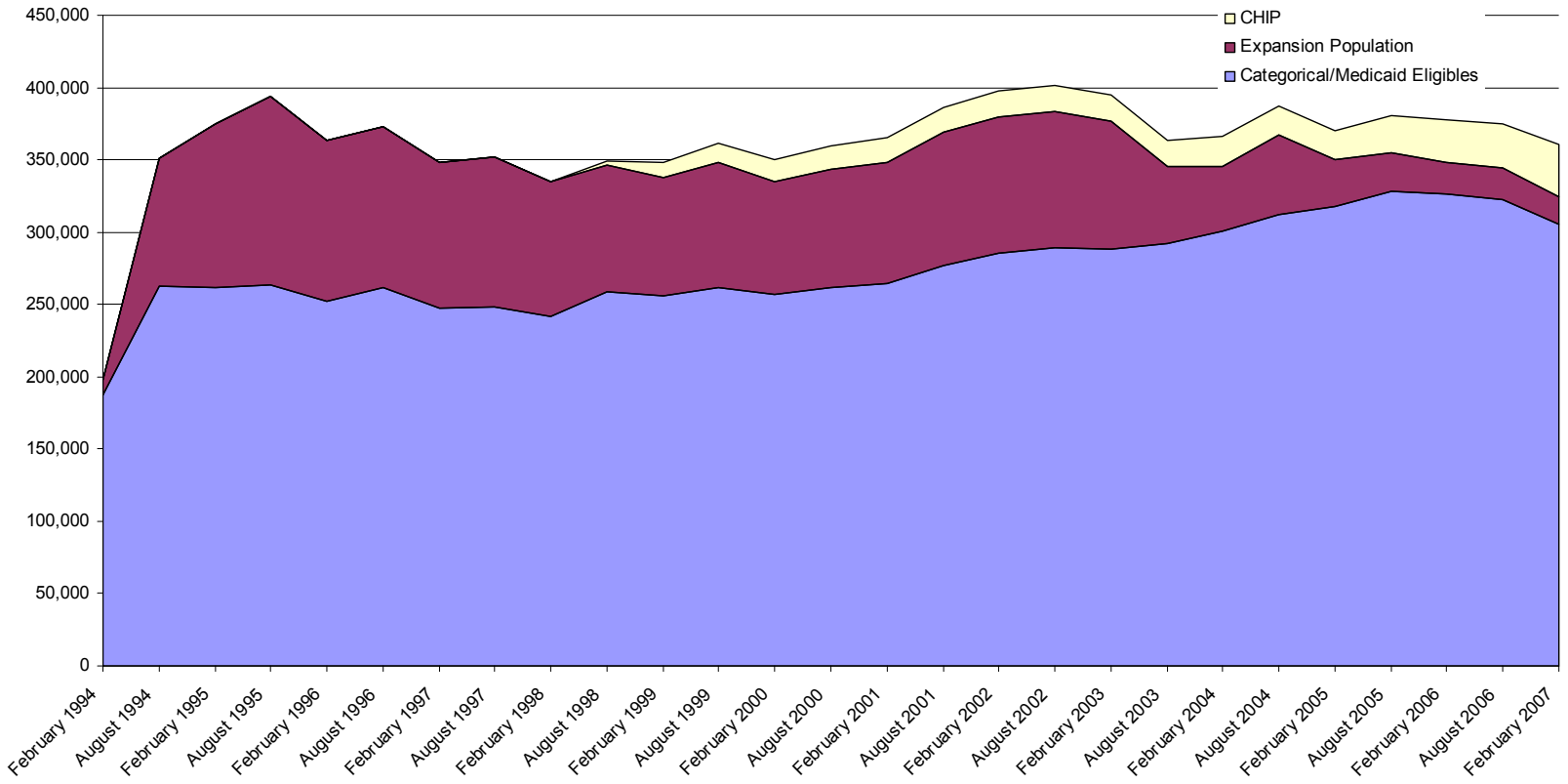
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level

**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.

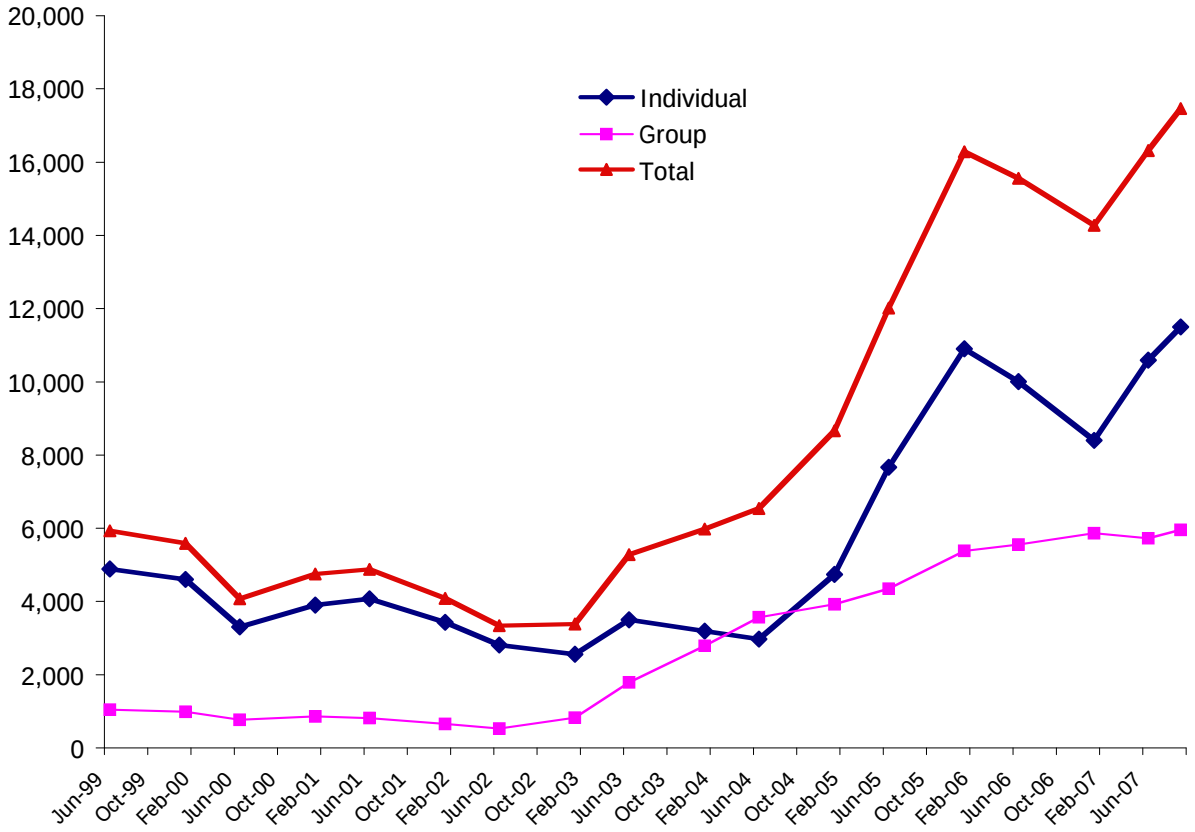
Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Total enrollment is fairly flat over time, but OHP expansion population is shrinking

Total Medicaid enrollment, Oregon, 1994 to 2007



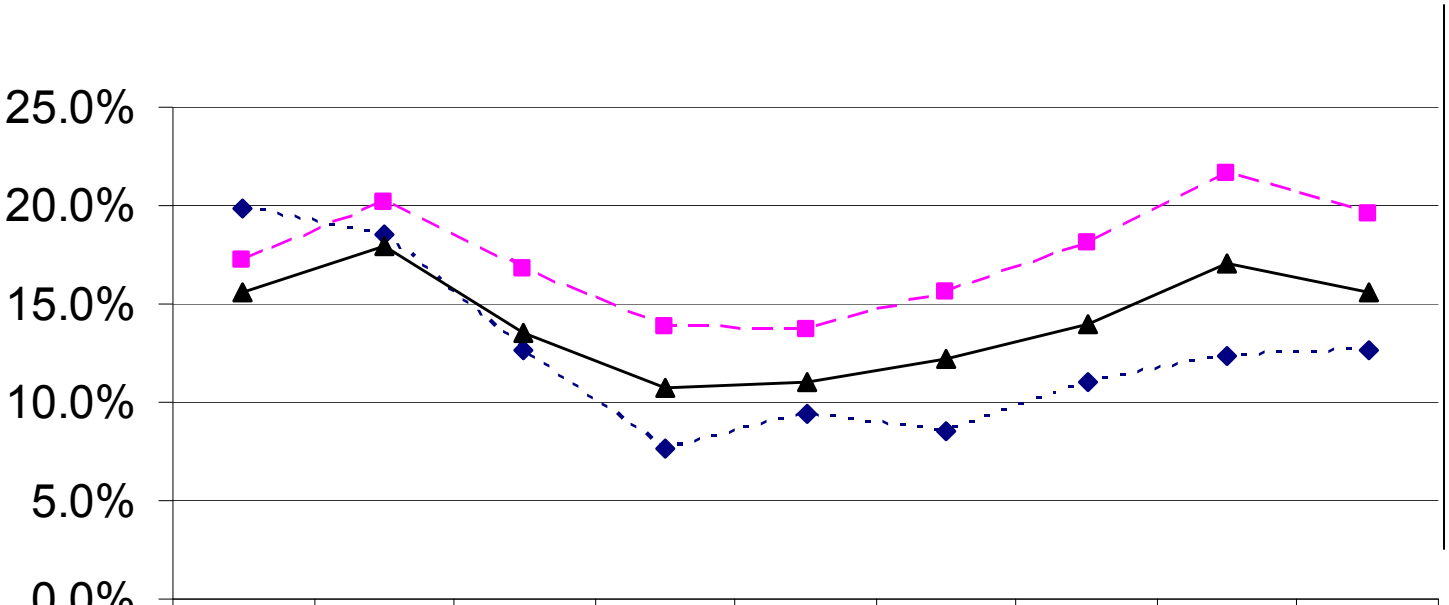
Family Health Insurance Program (FHIAP) enrollment continues to grow.



Who are the uninsured?

Almost one in five adults and one in six children are uninsured

Health Uninsurance Trends, Oregon

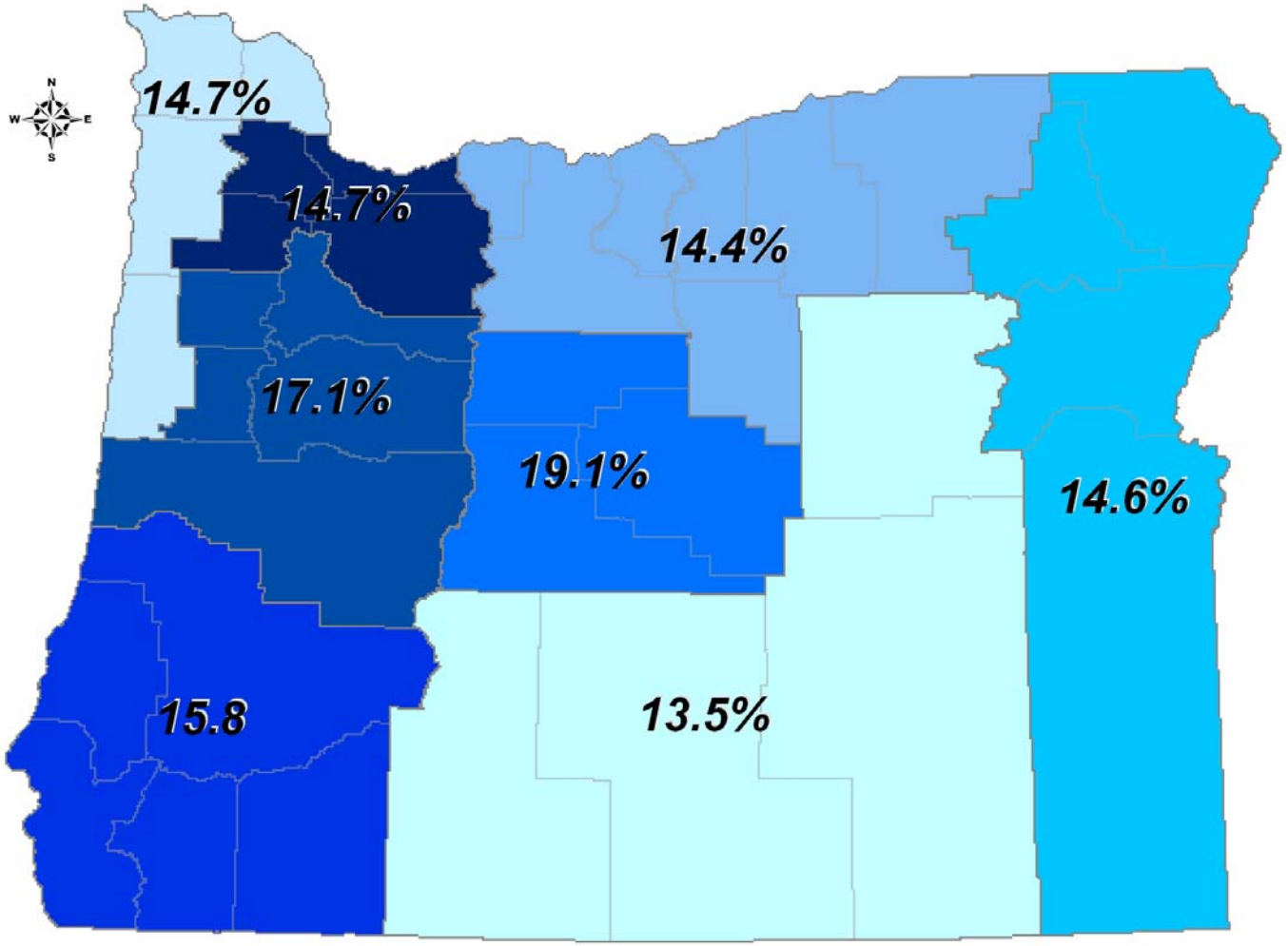


	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

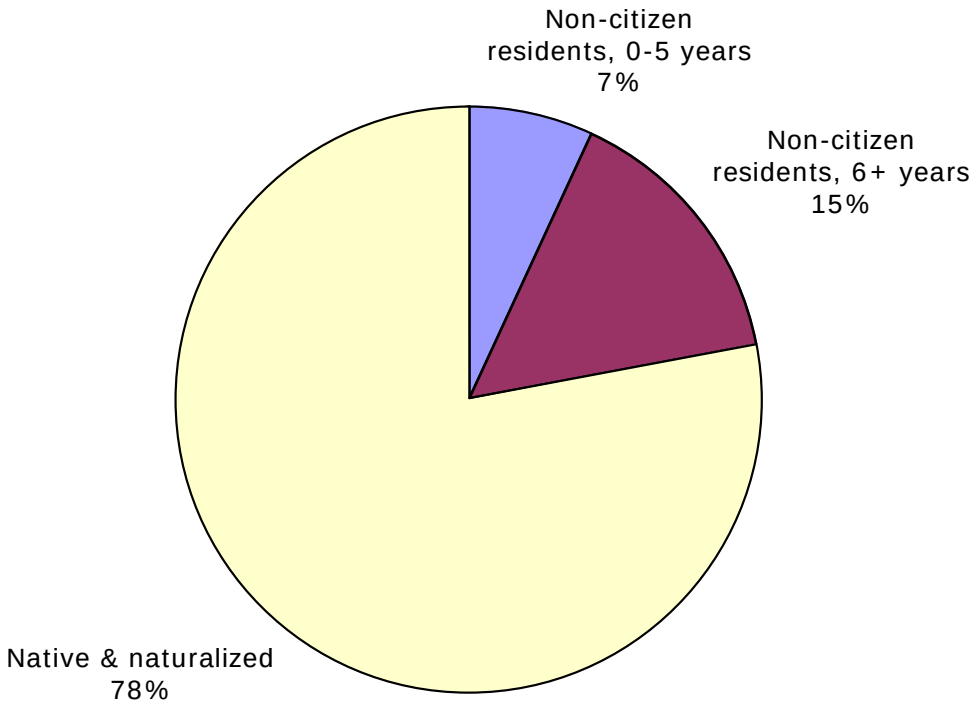
Source: Oregon Population Survey, 1990 to 2006.

Mid-Willamette Valley and Central Oregon have the highest rate of uninsured

Regional Percentages of the Uninsured, Oregon 2006

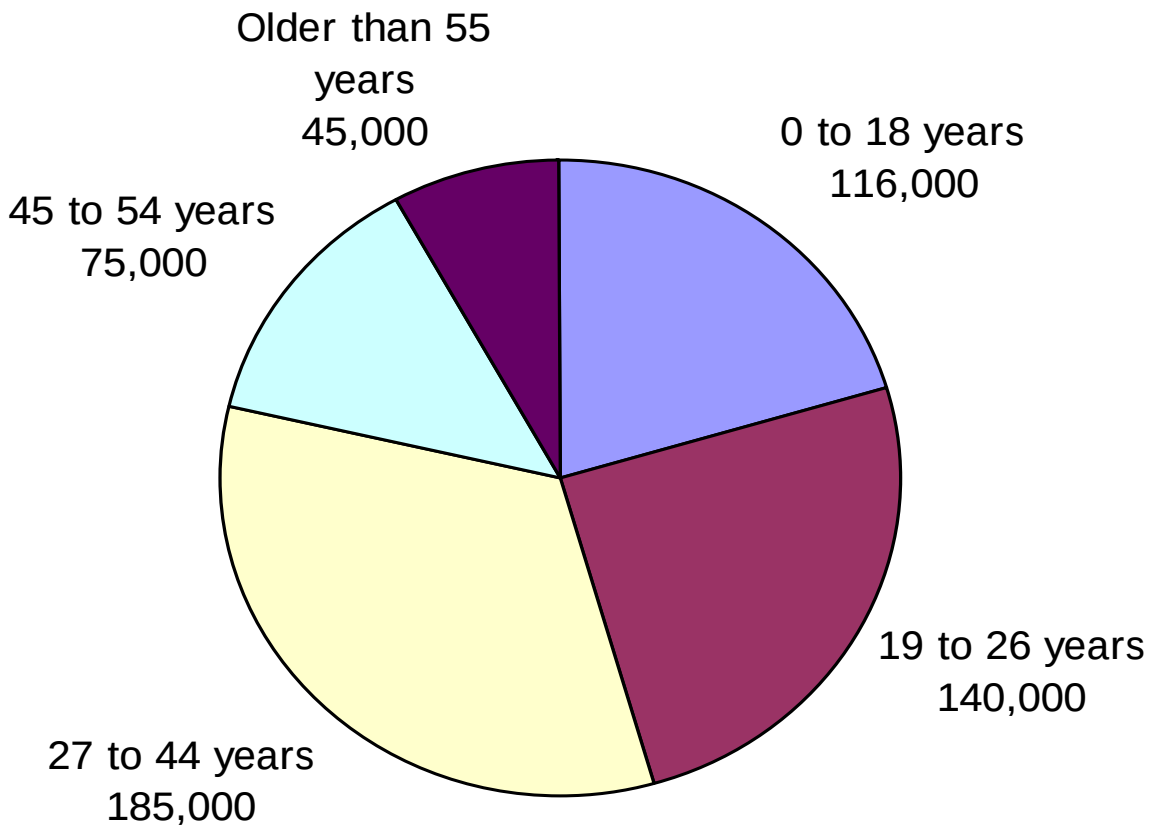


Native & naturalized citizens are over 70% of the uninsured...



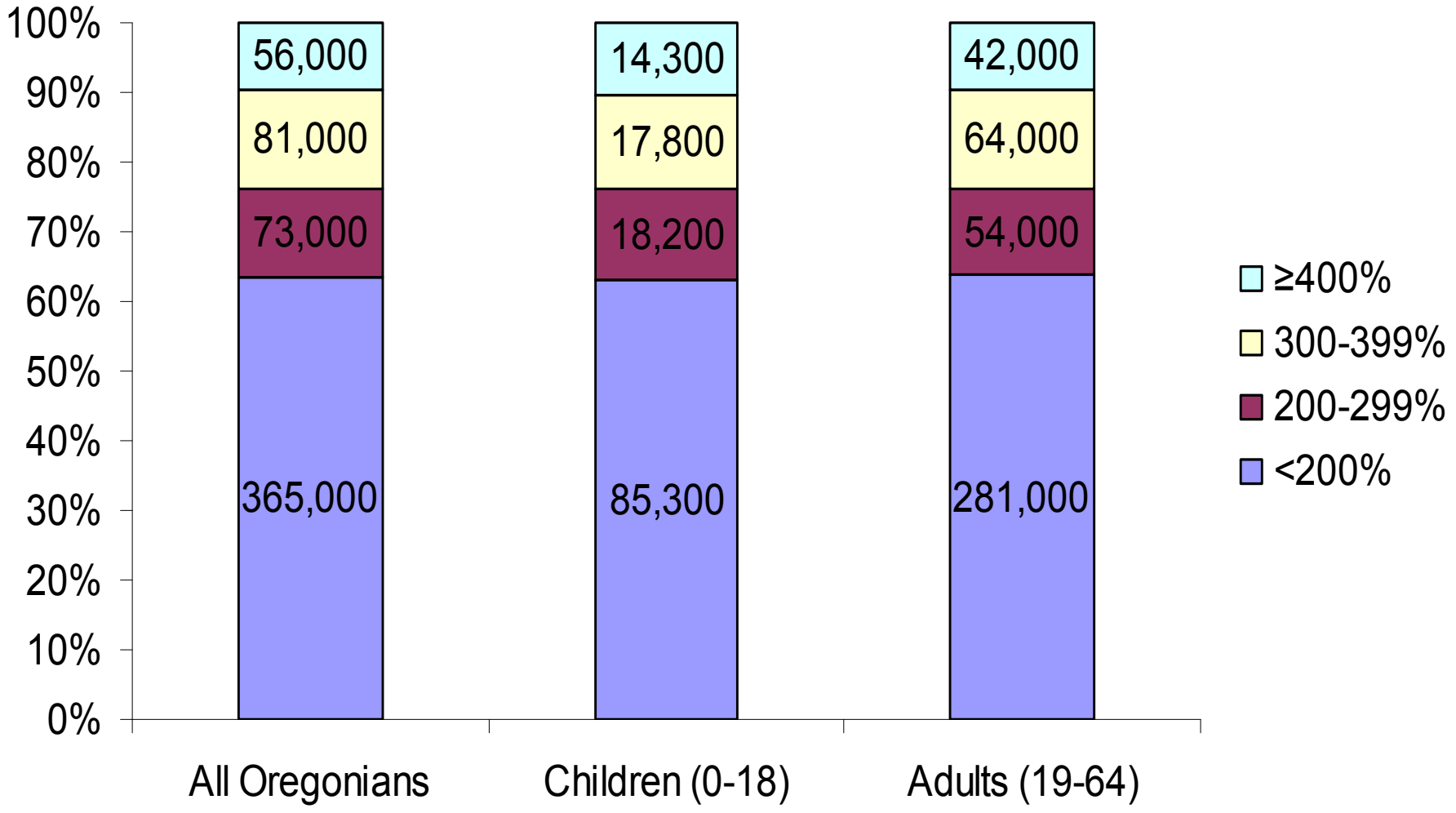
Source: Kaiser Family Foundation; The Uninsured: Key facts about Americans without health insurance, October 2007

Adults are more likely than children to be without insurance.



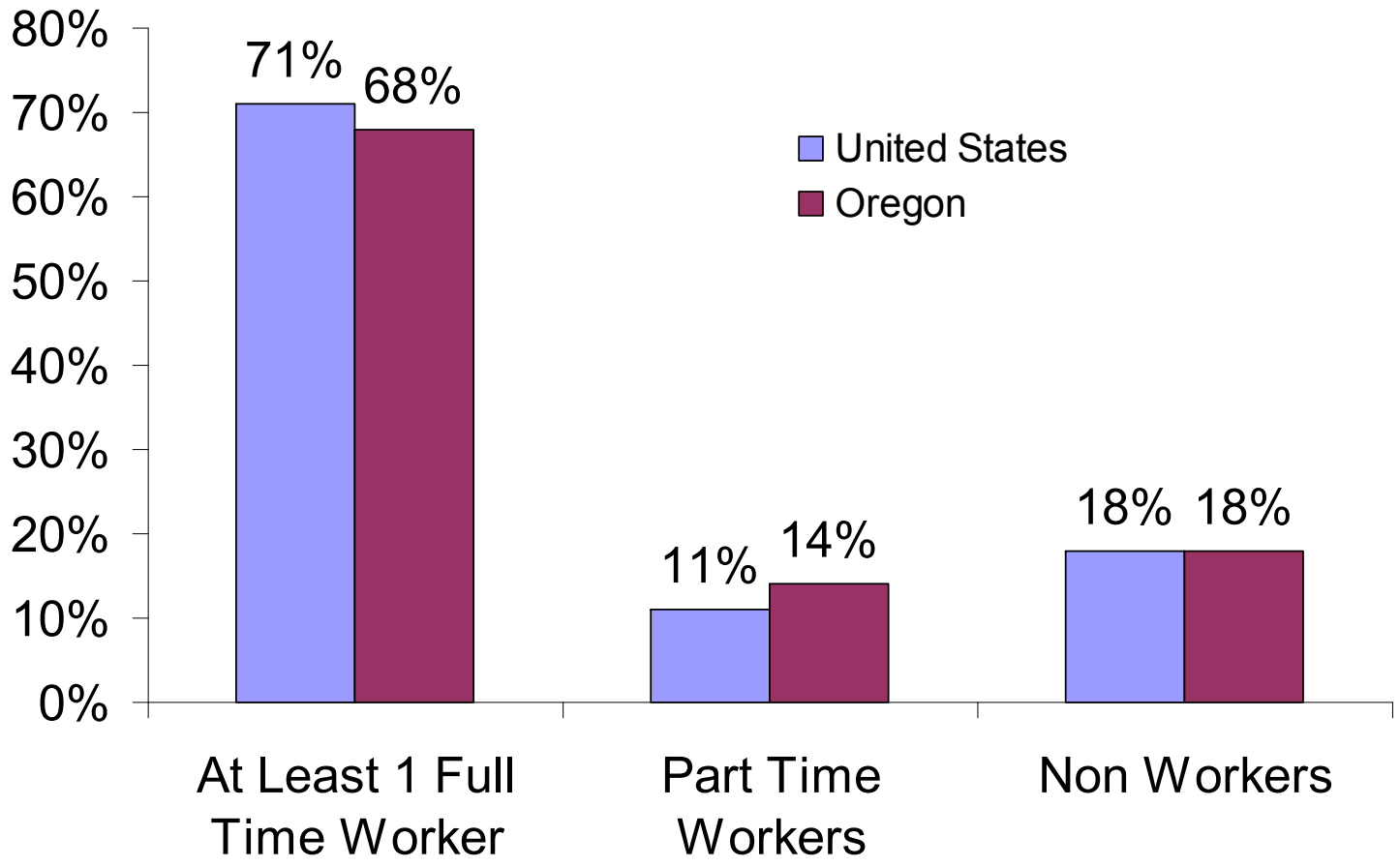
Source: 2006 Oregon Population Survey.

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]

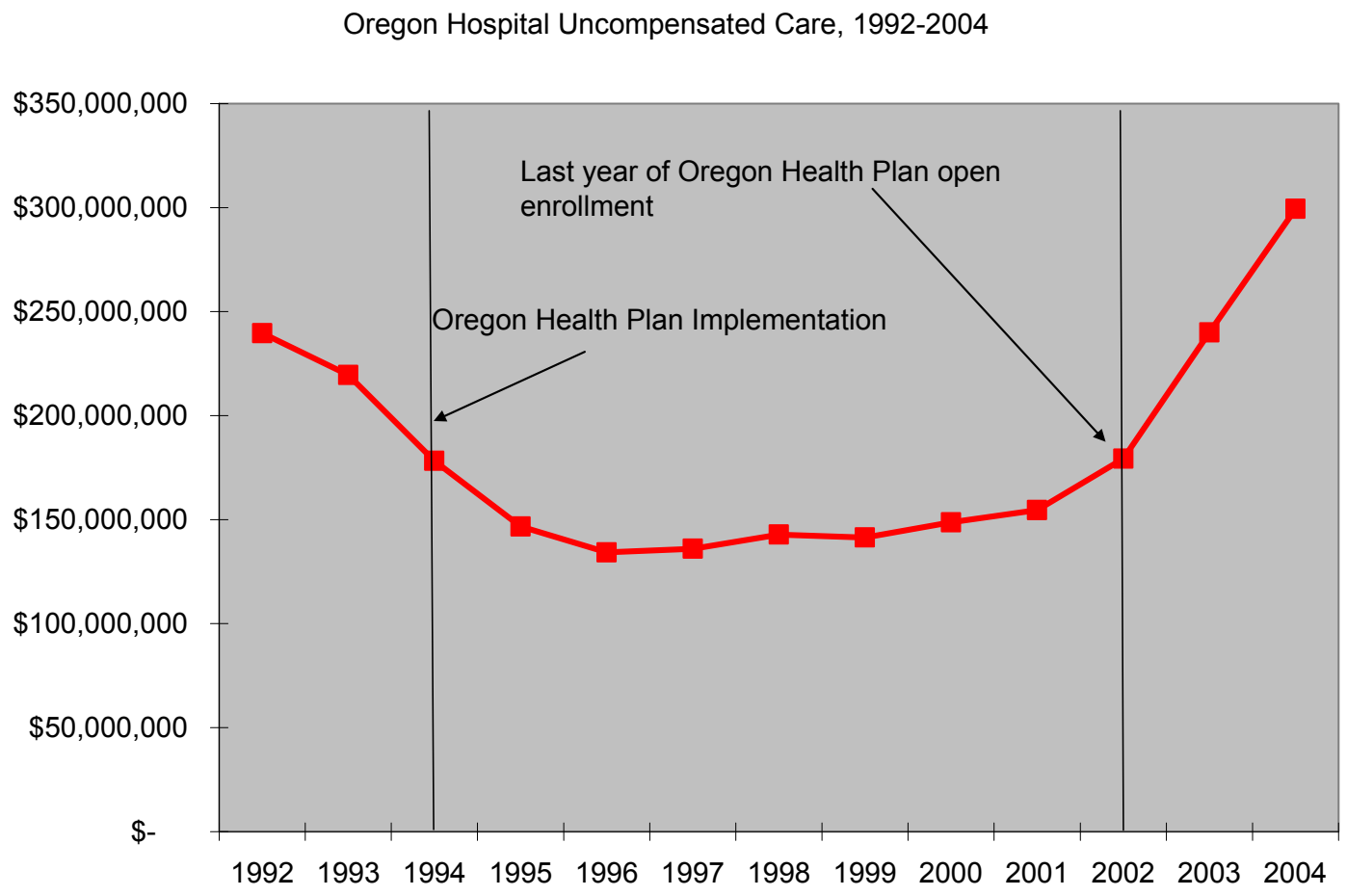
[1] Colmers JM. Public reporting and transparency. The Commonwealth Fund Commission on a High Performance Health System, January 2007.
[2] Norton's Bankruptcy

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...



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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

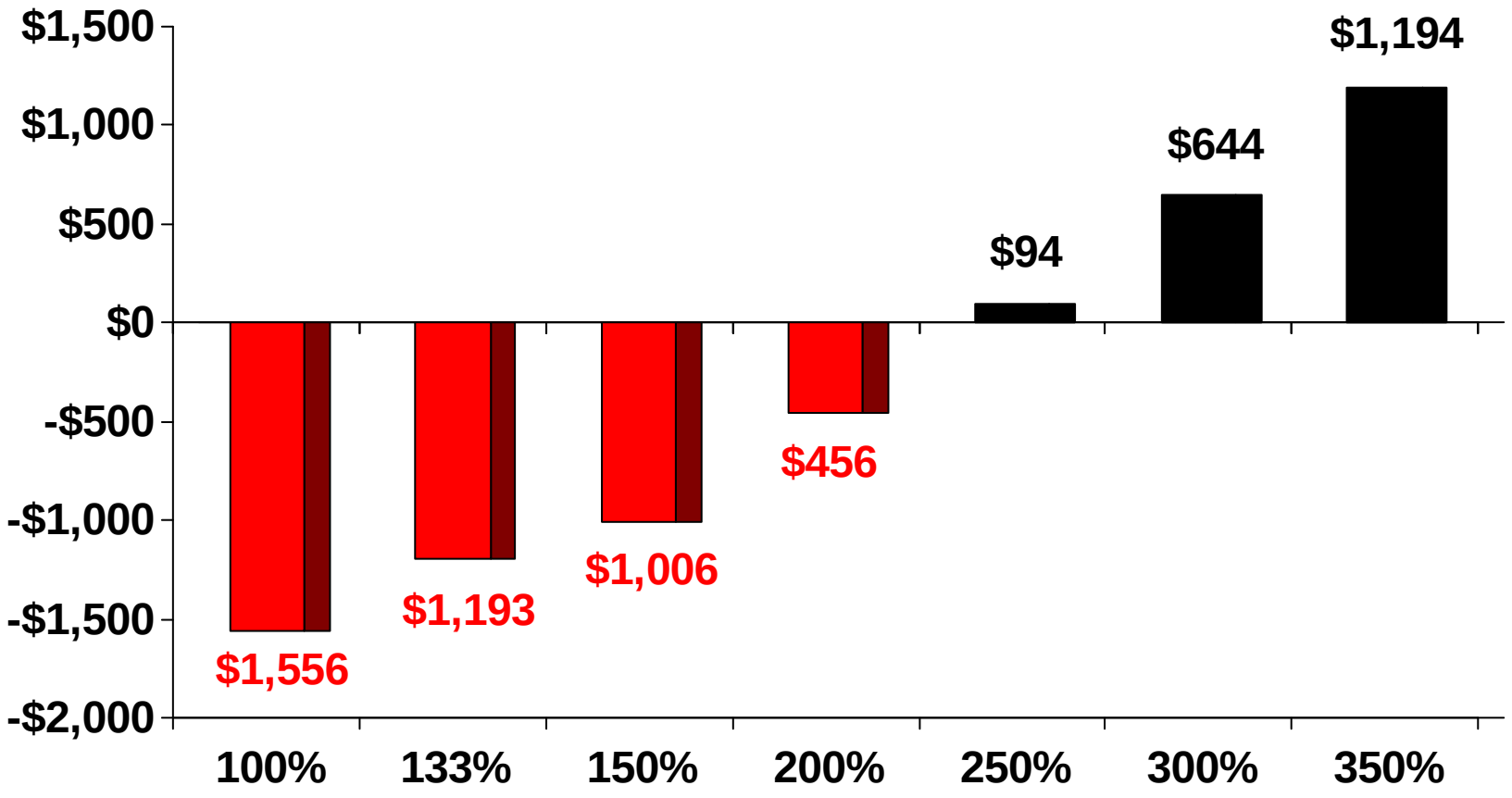
- Housing: based on the Department of Housing and Urban Development's fair market rents (FMR):
  - representing rent + utilities for "privately owned, decent, structurally safe, and sanitary rental housing of a modest (non-luxury) nature with suitable amenities".
- Assumptions:
  - Two bedroom apartments 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

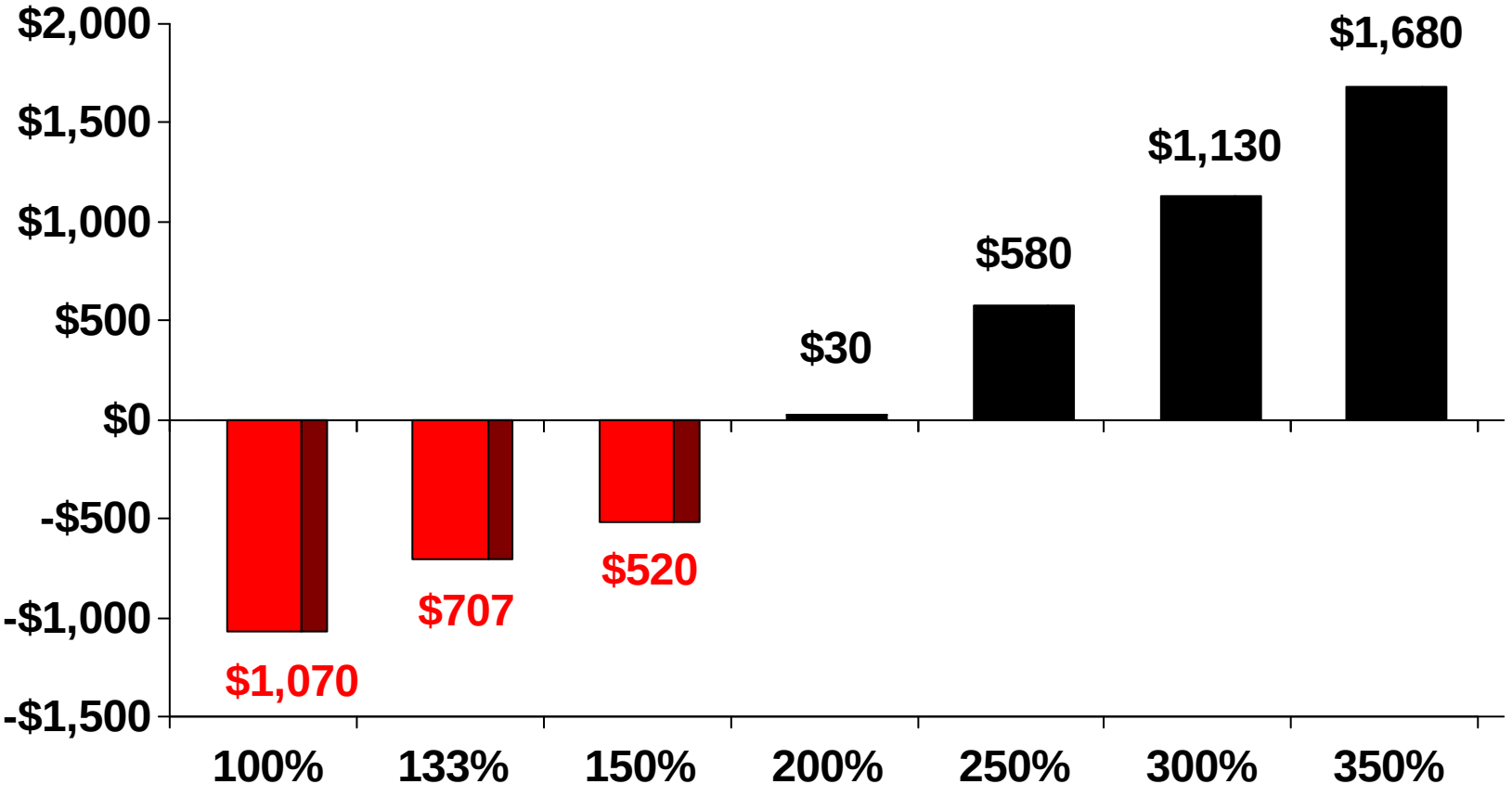
- Transportation costs per mile are from the IRS cost-per-mile rate, which includes the cost of gas, insurance, vehicle registration fees, maintenance, and depreciation.
  - Varies by urban or rural area, and number of parents in the family.
- Budget assumes only non-social trips (work, school, church, and errands for the 1st adult and only work trips for the 2nd adult).

Discretionary Monthly Income after 250% Federal Poverty Level (FPL)



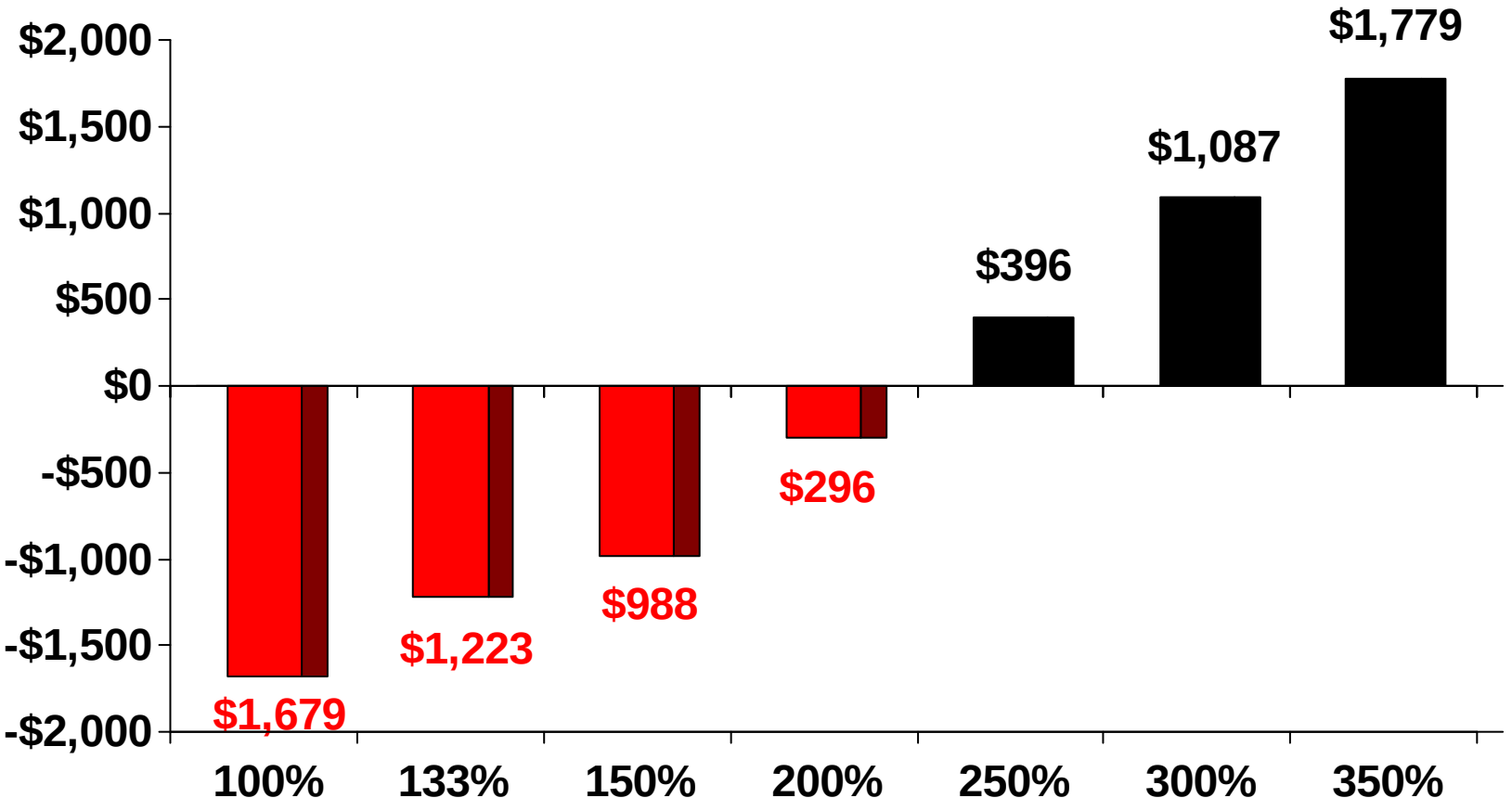
Portland-Vancouver (2006) 1 Parent + 1 Child

Discretionary Monthly Income after 200% Federal Poverty Level (FPL)



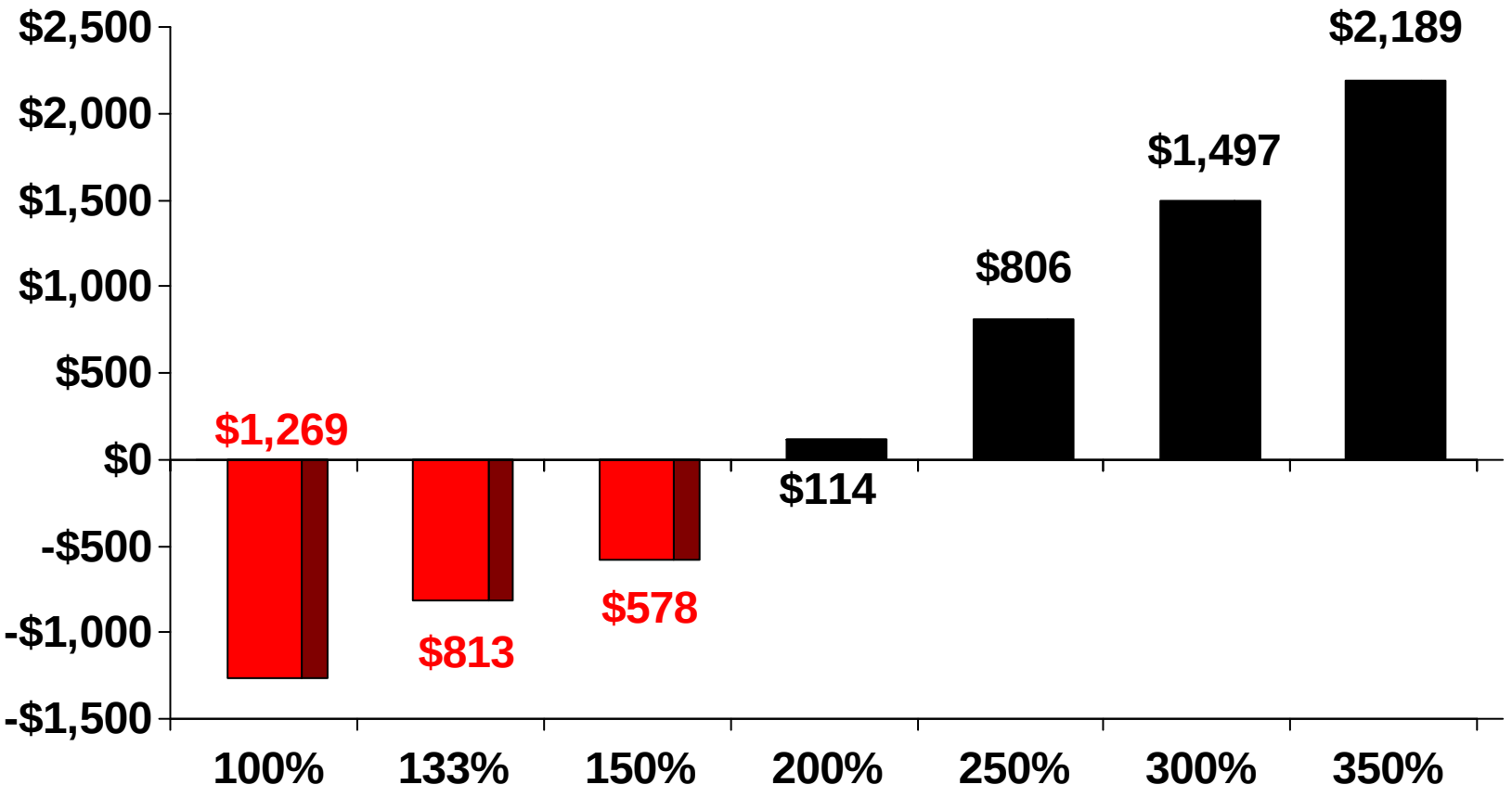
Rural Oregon (2006) 1 Parent + 1 Child

Discretionary Monthly Income after 250% of Poverty Level



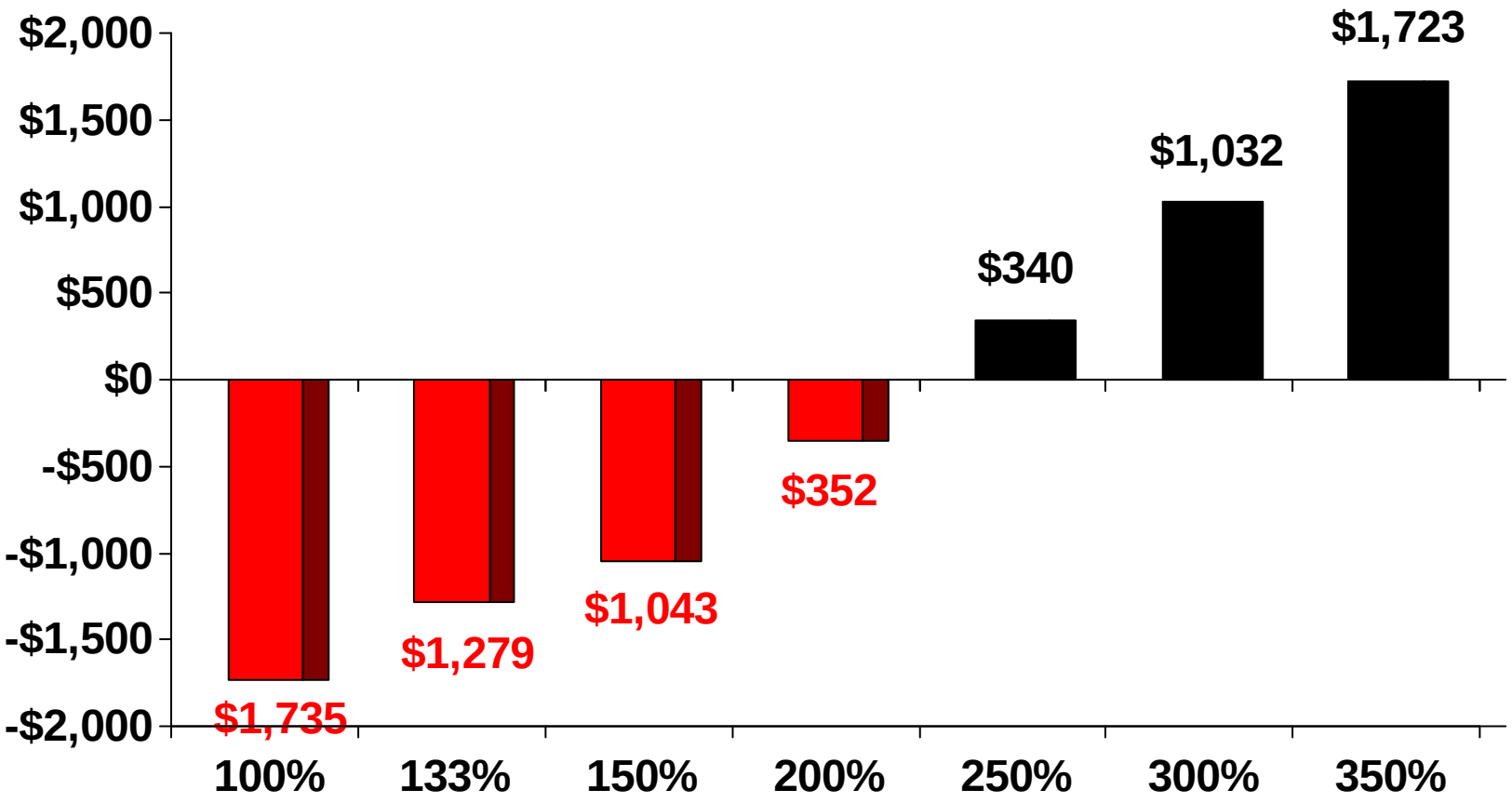
Portland Area (2006) 2 Parents + 1 Child

Discretionary Monthly Income after 200% of Poverty Level



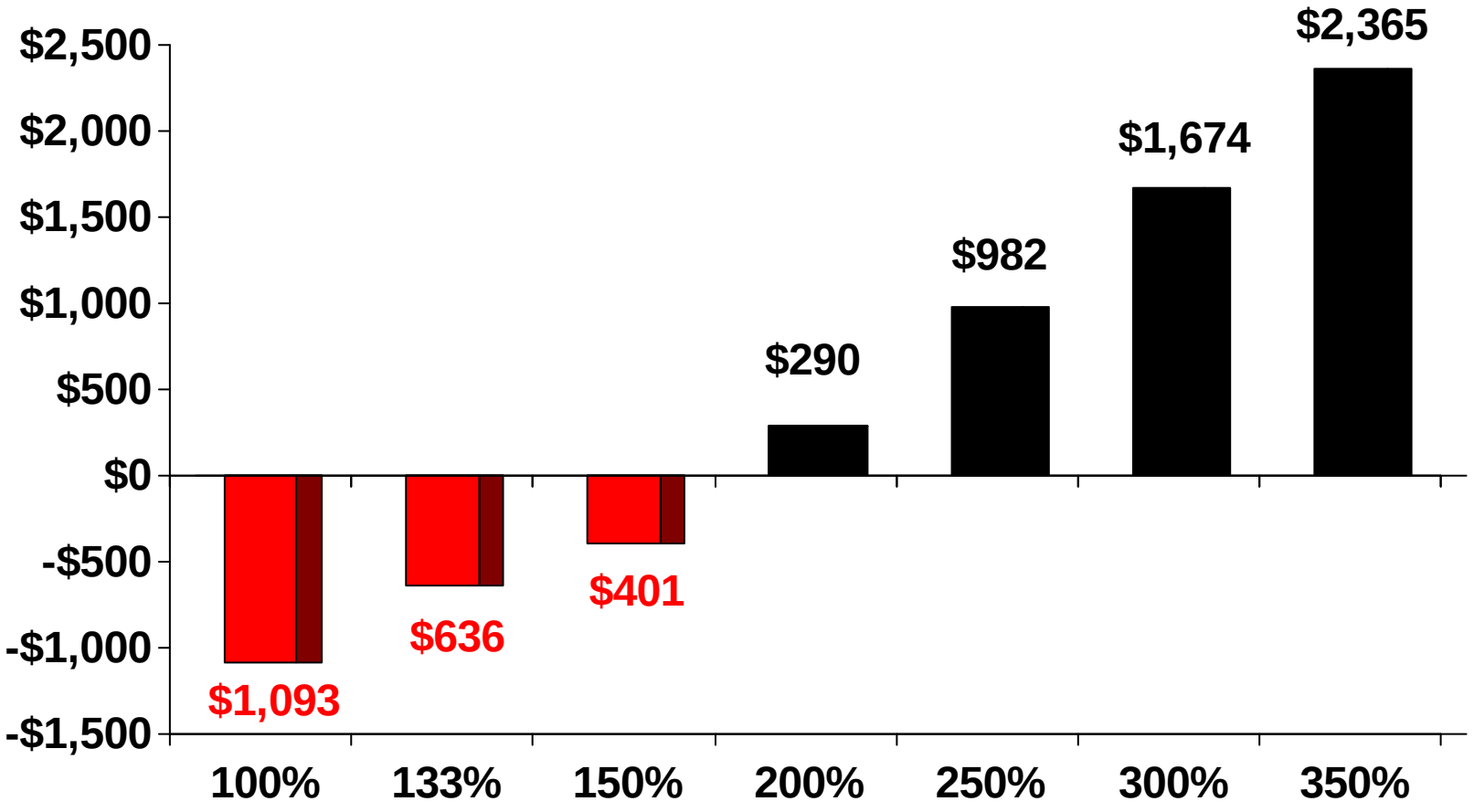
Rural Oregon (2006) 2 Parents + 1 Child

Discretionary Monthly Income after 250% FPL



Portland-Vancouver (2006) 1 Parent + 2 Children

Discretionary Monthly Income after 200% FPL *

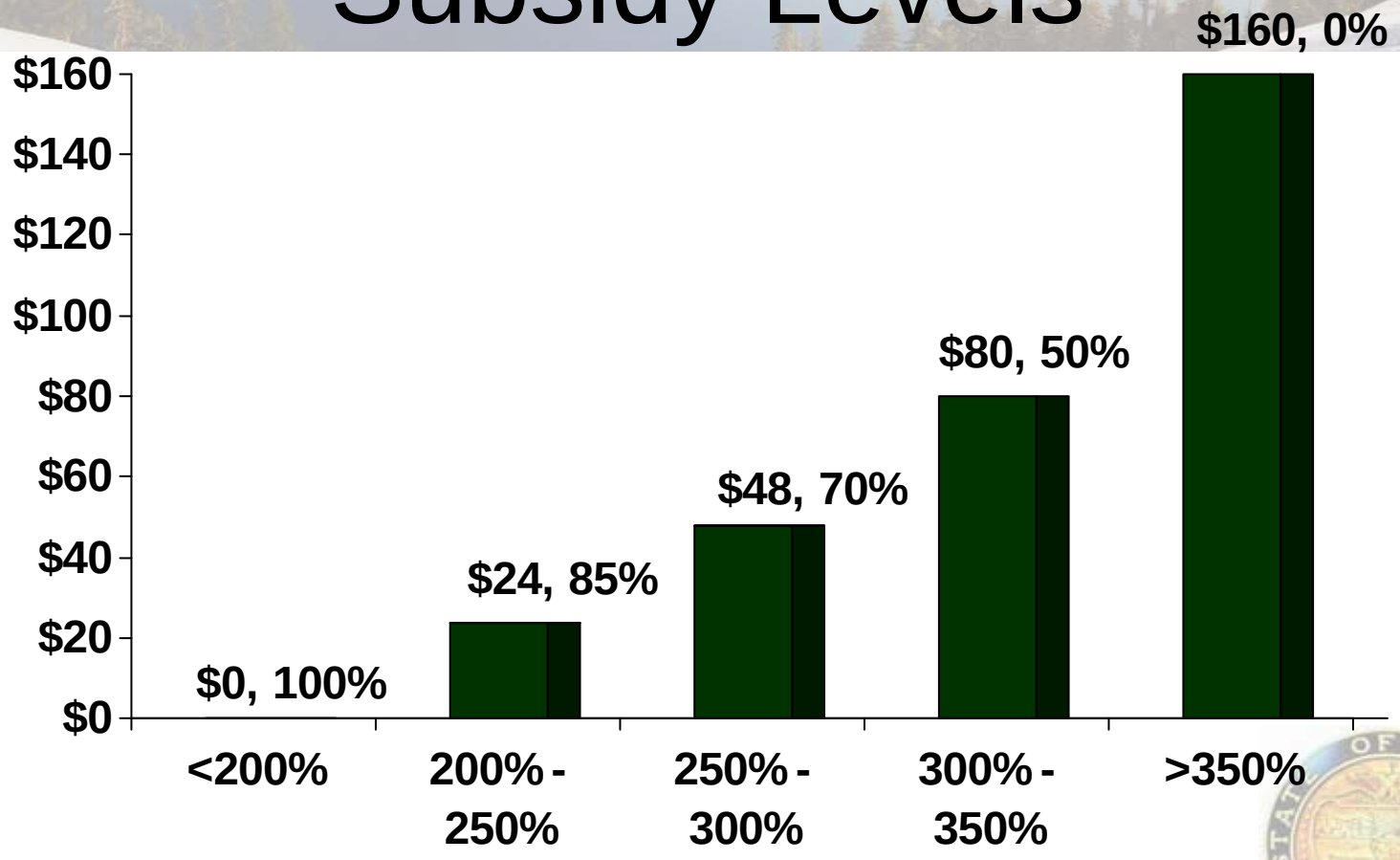


Rural Oregon (2006) 1 Parent + 2 Children

Conservative Decisions

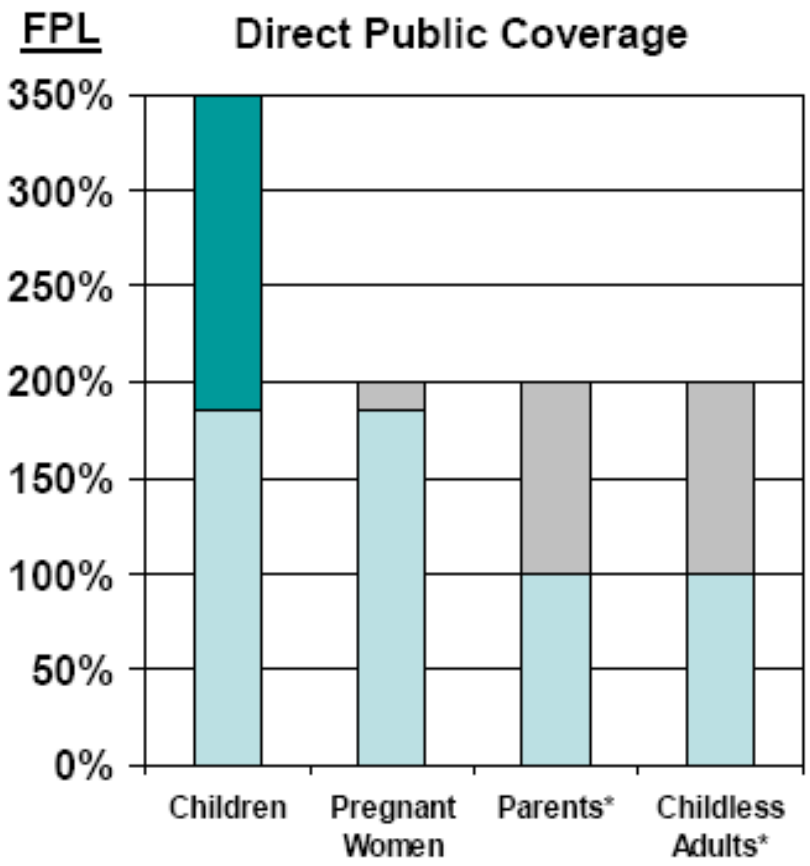
- Budgets do not include debt, or higher than normal interest rates that might affect families with less than perfect credit.
- Estimates are conservative (particularly regarding child care, housing, and food)
- Other factors, beyond health care, compete for discretionary income as income goes up. Assumed standard of housing stays the same.
- Budget does not include recommended savings or catastrophic expenses.

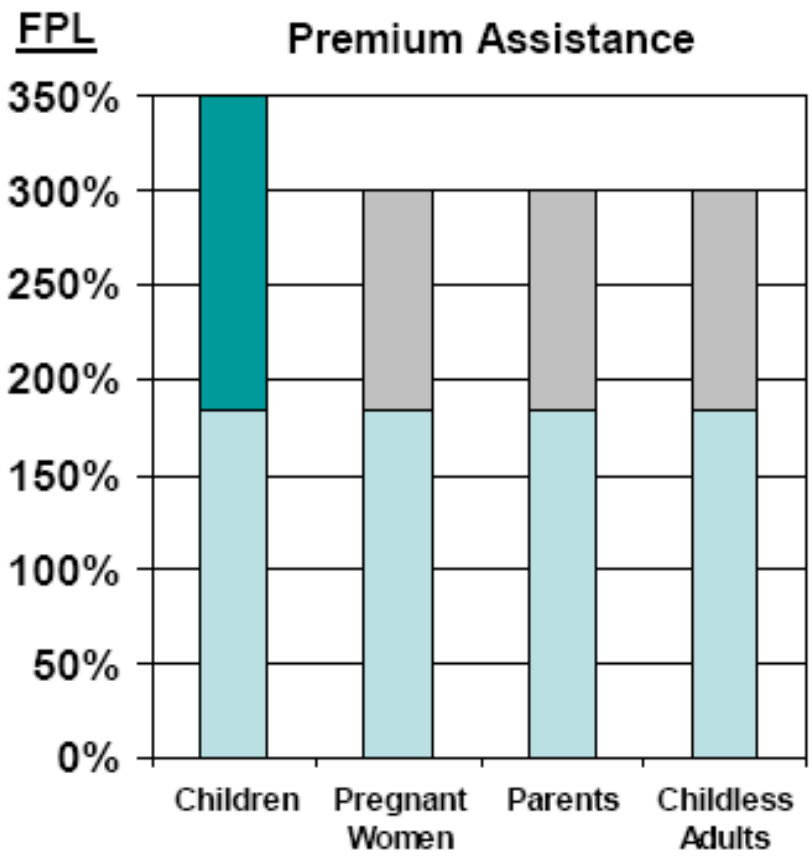
Healthy Kids Premium Subsidy Levels



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>

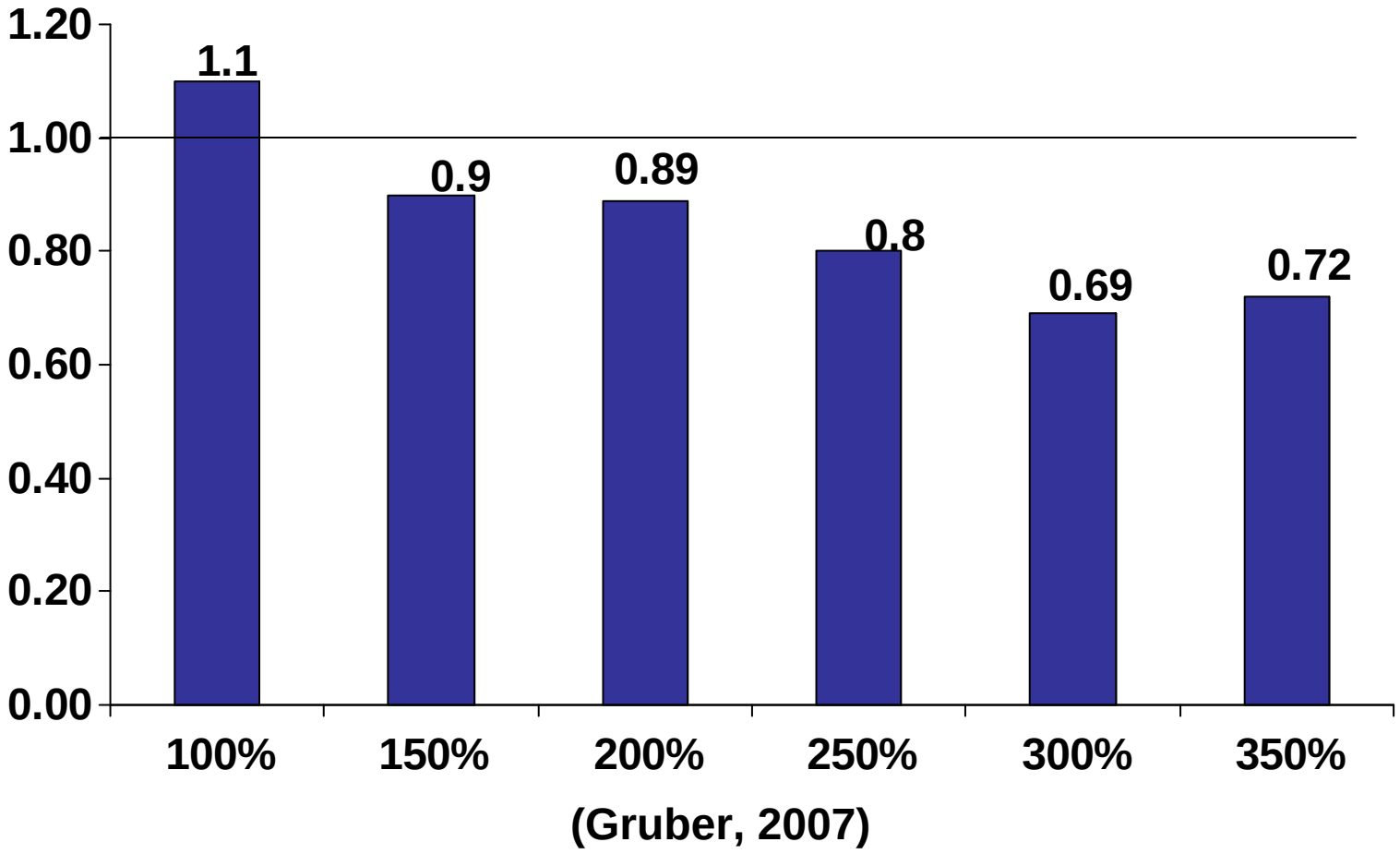
- Consumer Expenditure Survey (CEX), the nation's leading data source for consumption information.

Jonathan Gruber on Affordability and Enrollment

Results

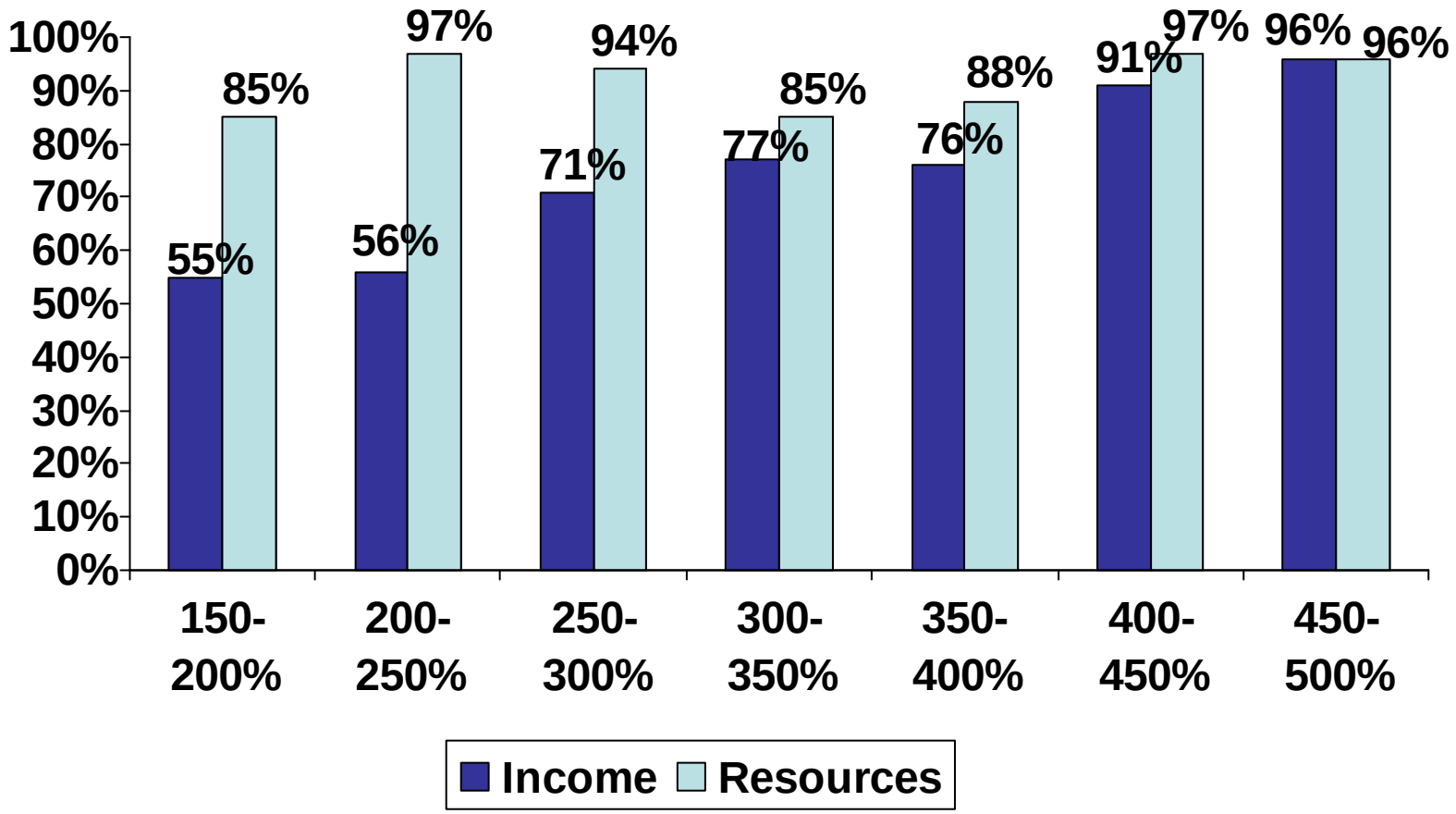
- Low income individuals have resources remaining after paying for necessities to pay for the Massachusetts subsidy program.
- Even the lowest income individuals enroll in employer insurance when it is offered, at costs ($60/month for singles and $250/month for families) that exceed, on average, what 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



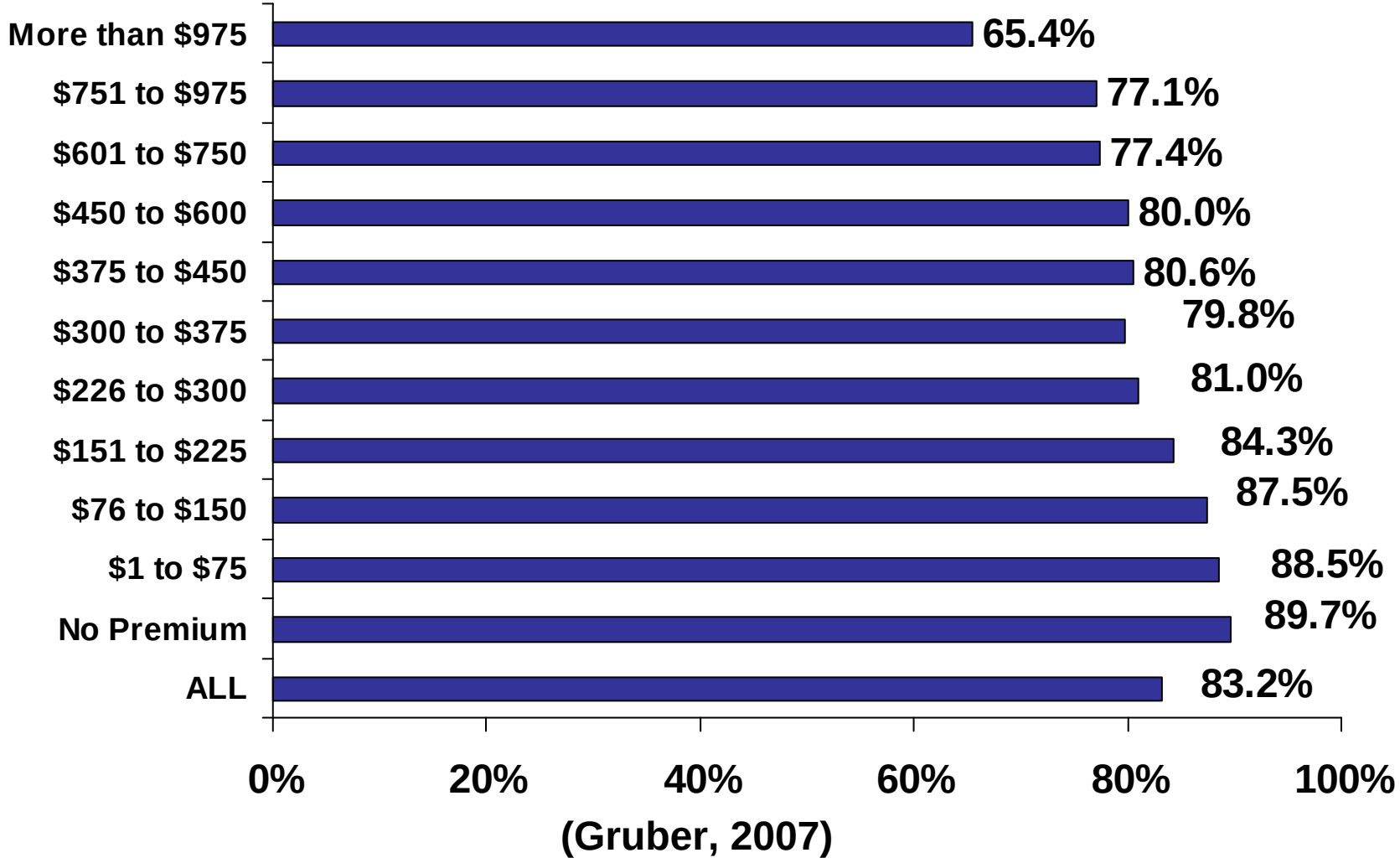
(Gruber, 2007)

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>

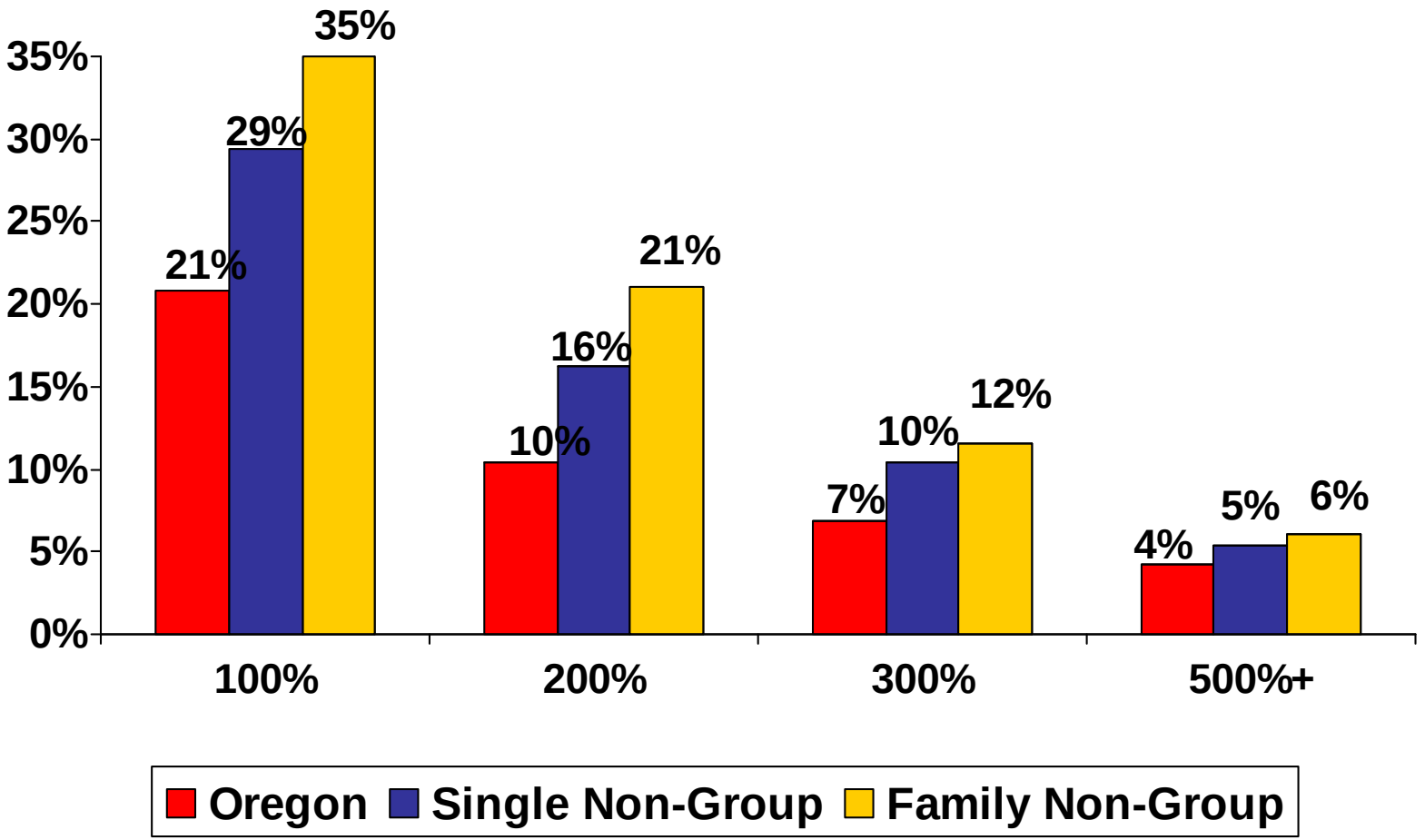
- Blumber et al. use national data on averages from the Medical Expenditure Panel Survey (MEPS, a survey of consumer health utilization and spending) for premiums and for out-of-pocket costs for families from 2001 to 2003

Blumberg, Holahan, Hadley & Nordahl (2007)

Results

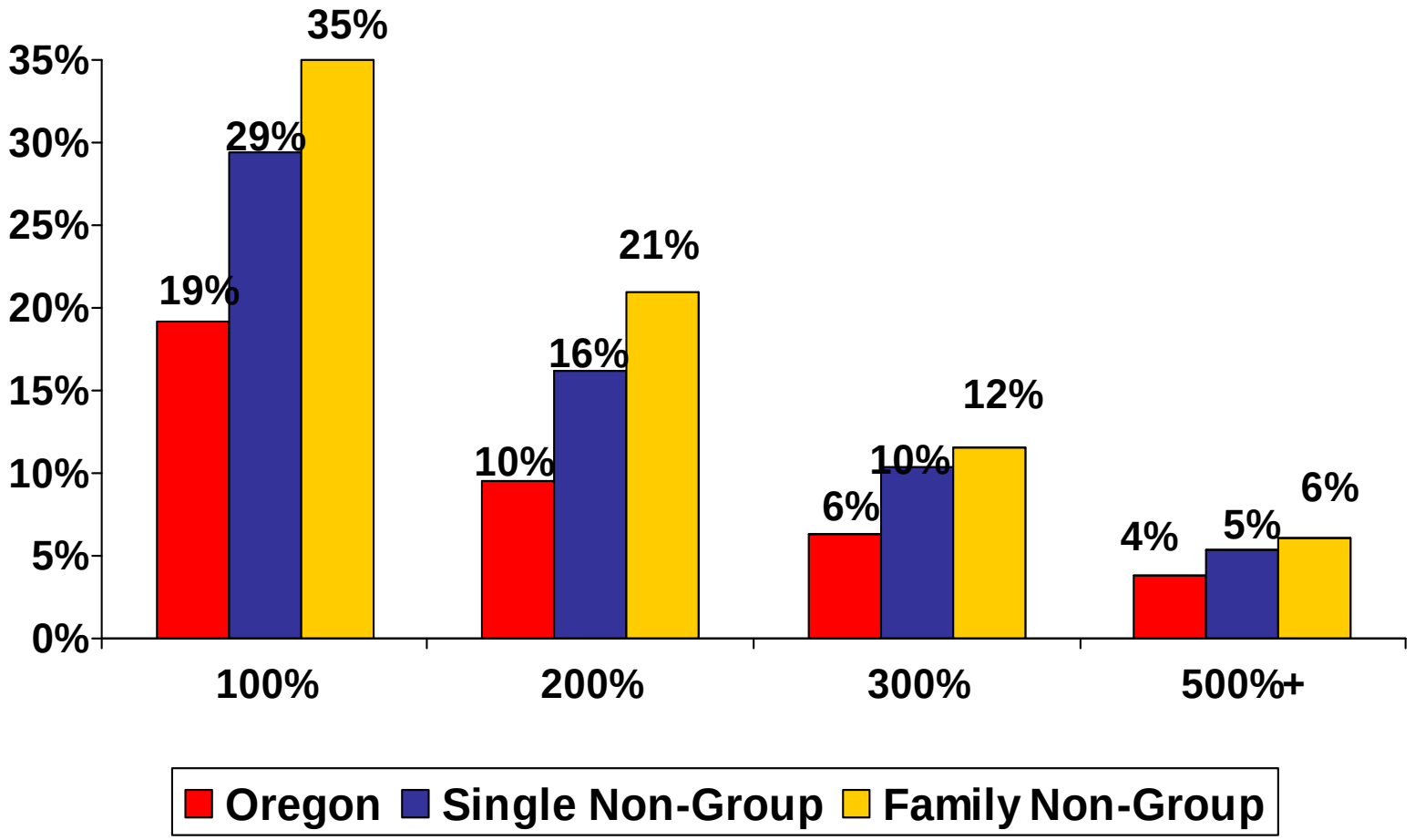
- Out-of-pocket costs and premiums can be very high as a percentage of income for those below 300% poverty, particularly for those with high medical needs.
- Spending patterns in alternative types of insurance (group, non-group) lead to different affordability standards.
- Individual and employer-sponsored insurance are very similar if adjusted for lost wages

Total Health Care Costs as a Percentage of Income



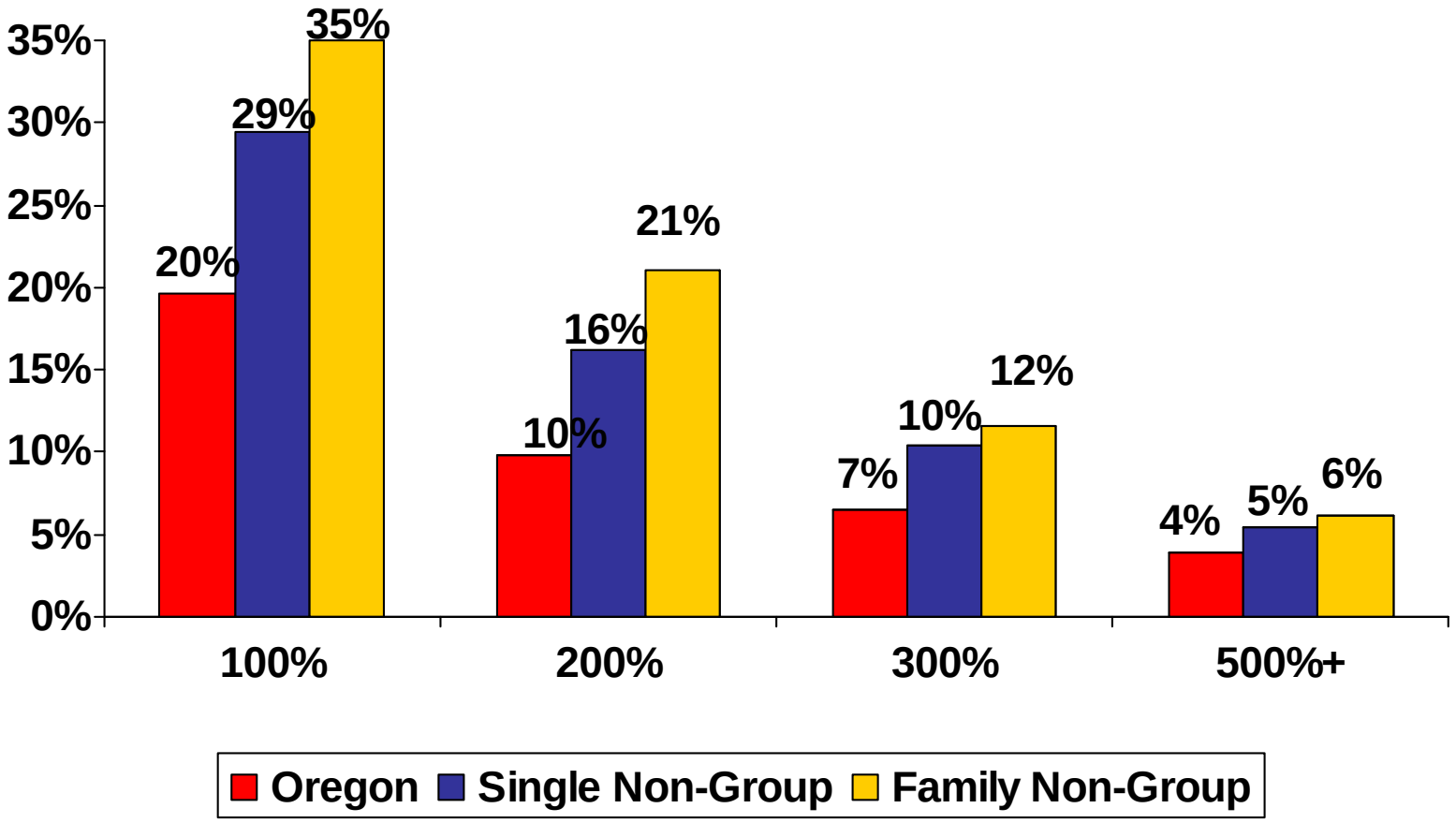
Oregon, 2006,1 Parent + 1 Child: **(EPI, 2007);**
Median Non-Group: **(Blumberg et al., 2007)**

Total Health Care Costs as a Percentage of Income



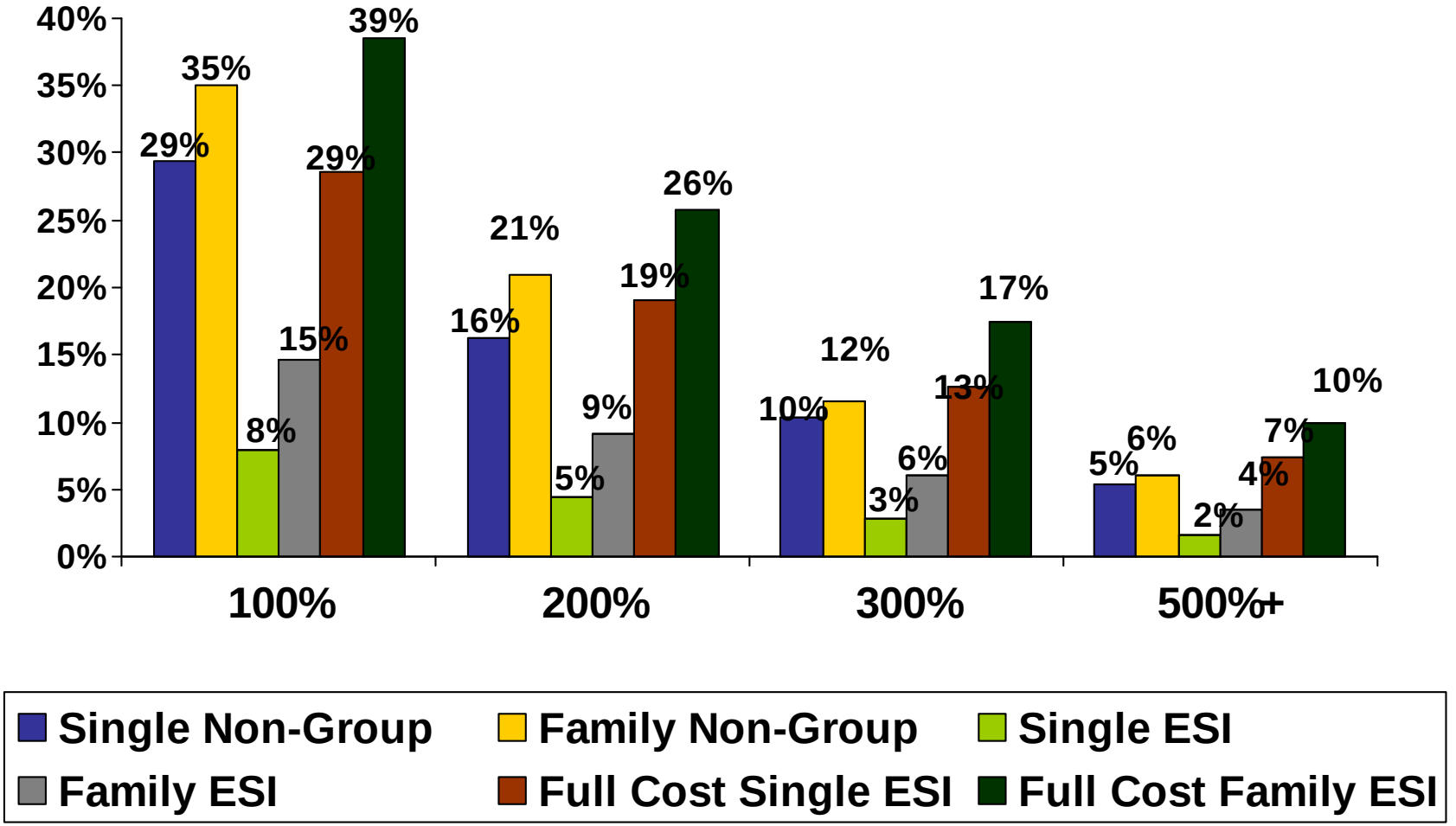
Oregon, 2006,1 Parent + 2 Children: **(EPI, 2007);**
Median Non-Group: **(Blumberg et al., 2007)**

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**

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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.

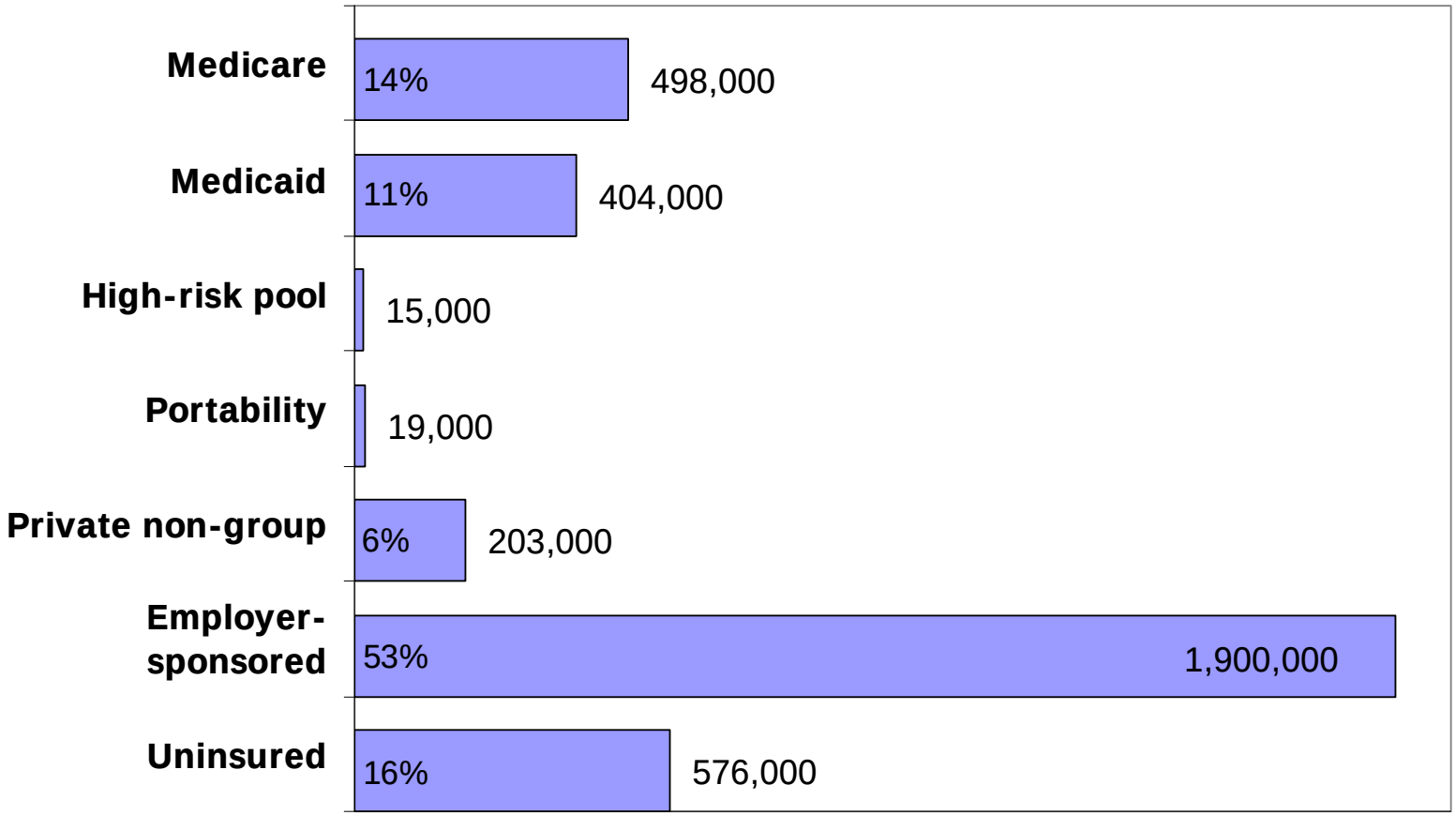
Recommended Principles

- 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

Trends in Coverage
Oregon, 2006

The majority of Oregonians are covered by employer-sponsored insurance

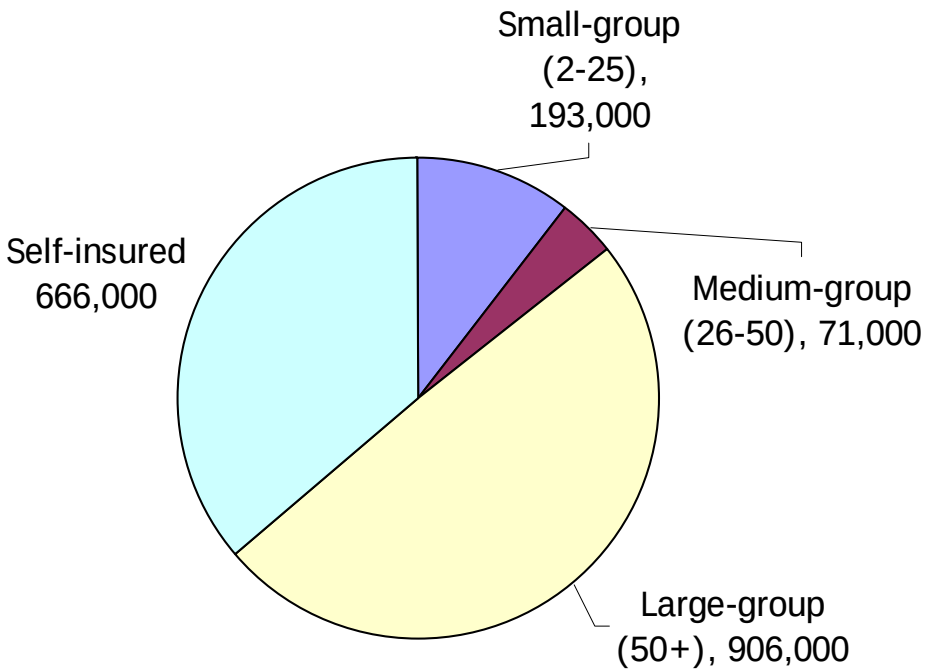
(Oregon population = 3.7 million)



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…

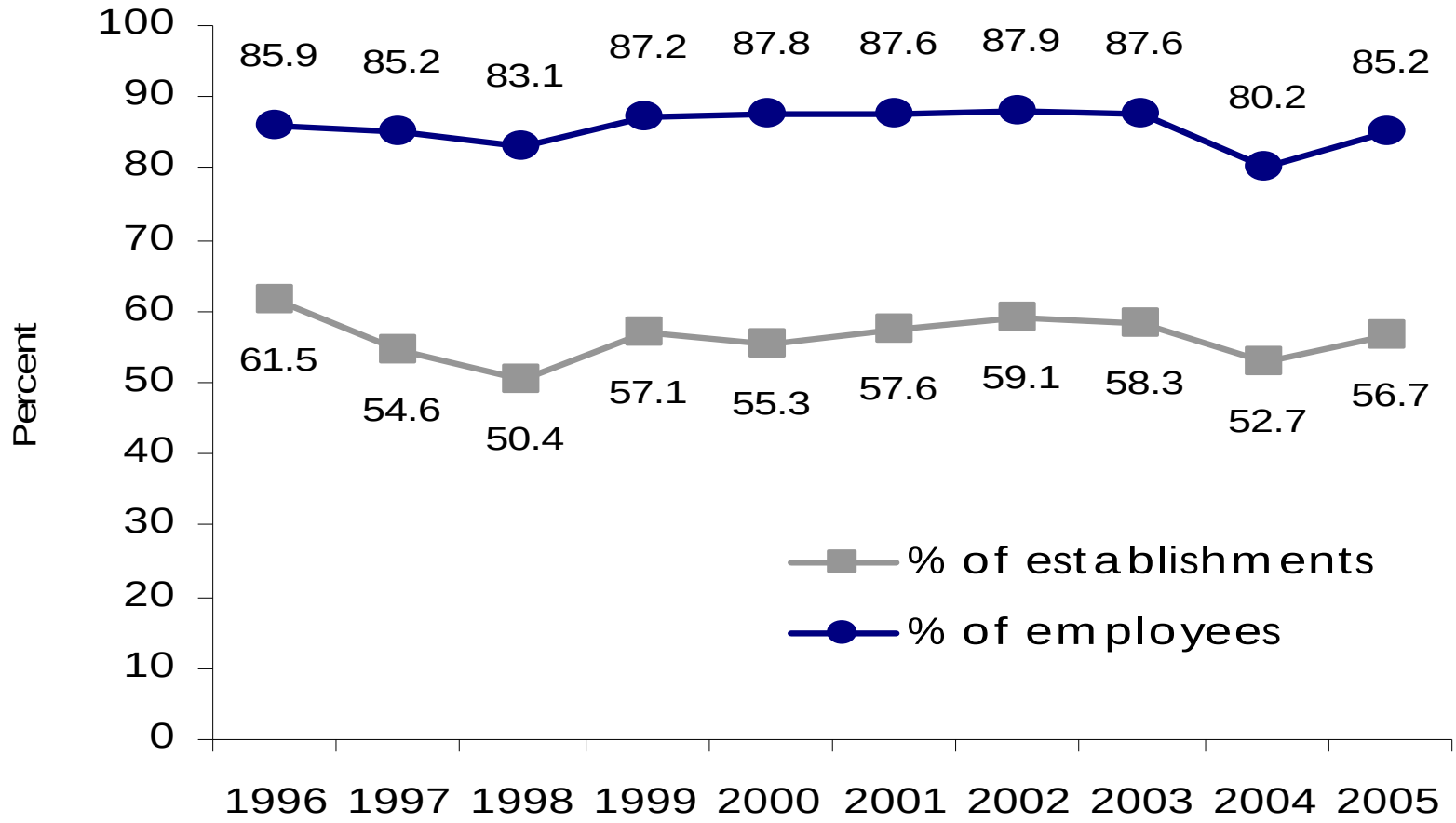
Distribution of commercial insurance in Oregon



Source: Department of Consumer and Business Services, January 2007

The percent of private businesses offering health insurance coverage has not changed significantly…

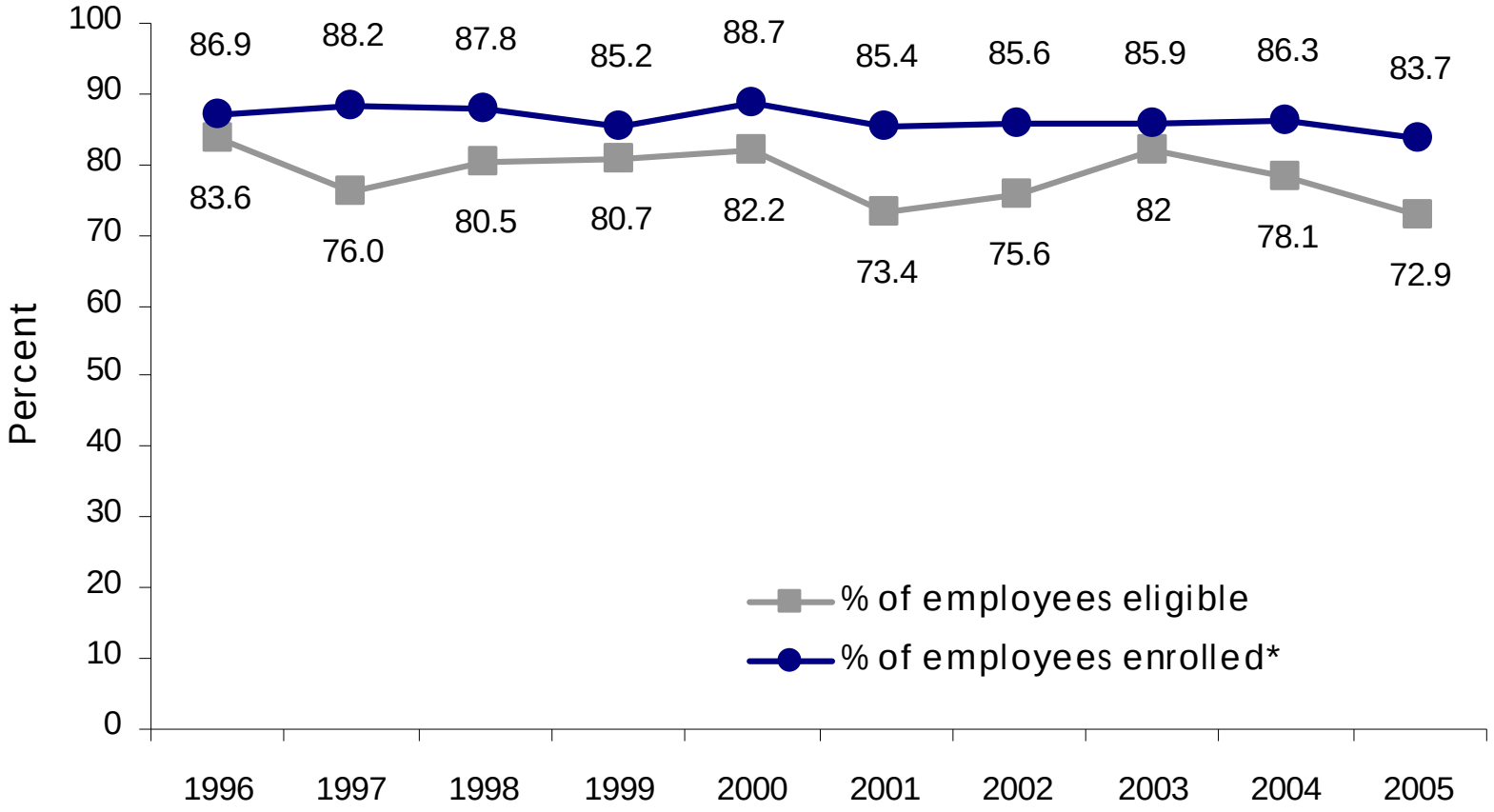
Percent of private establishments providing health insurance and percent of private employees working for businesses that offer insurance, Oregon



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

But the percentage of Oregon employees who are eligible has declined

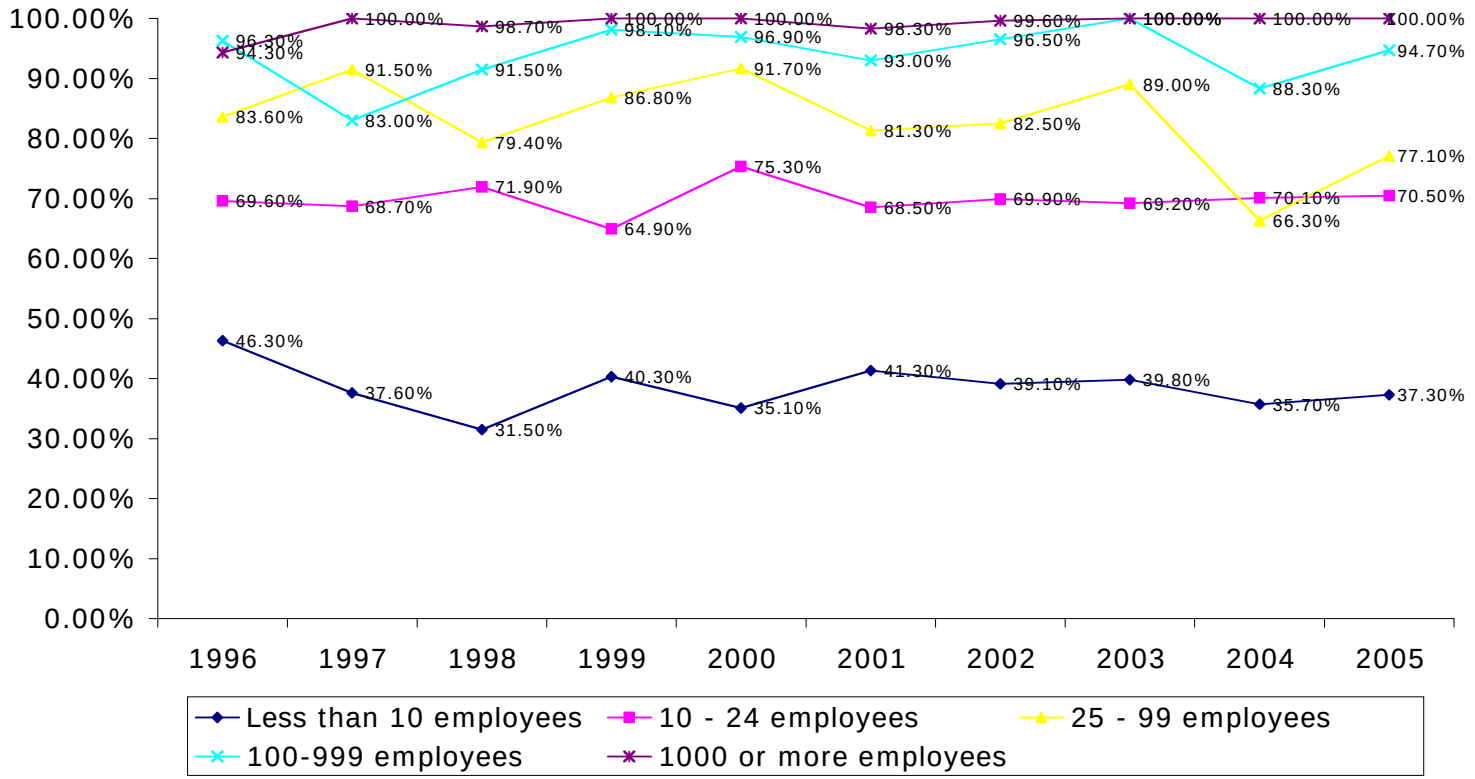
Percent of private employees eligible for employer-sponsored insurance and the percent of those eligible who are enrolled, Oregon



*As a percent of those eligible.

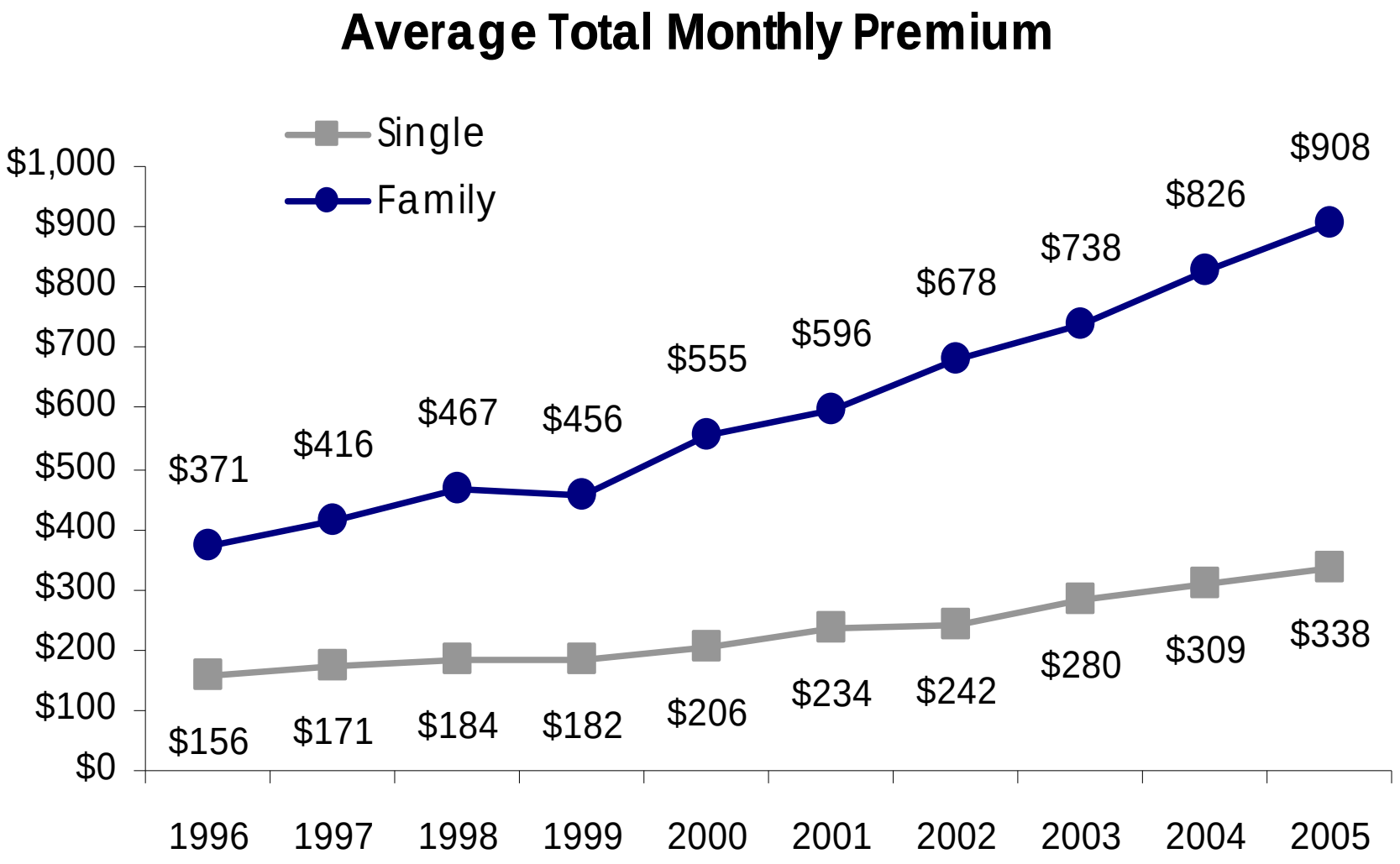
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Only private companies with <10 and 25-99 employees offering significantly less health insurance since 2000



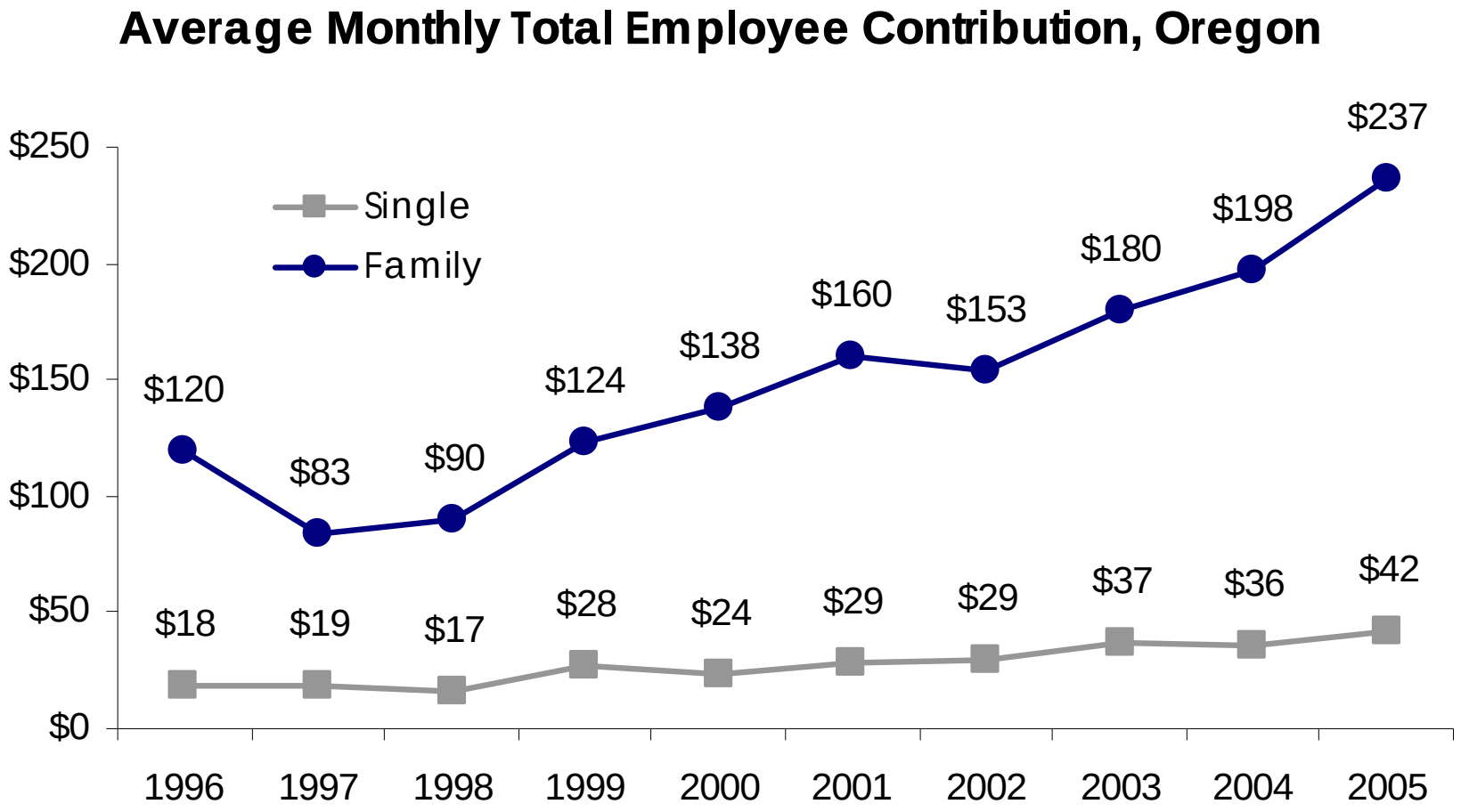
Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Premium costs have steadily increased in Oregon.



Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

Employee contribution requirements have increased as premium costs grow…

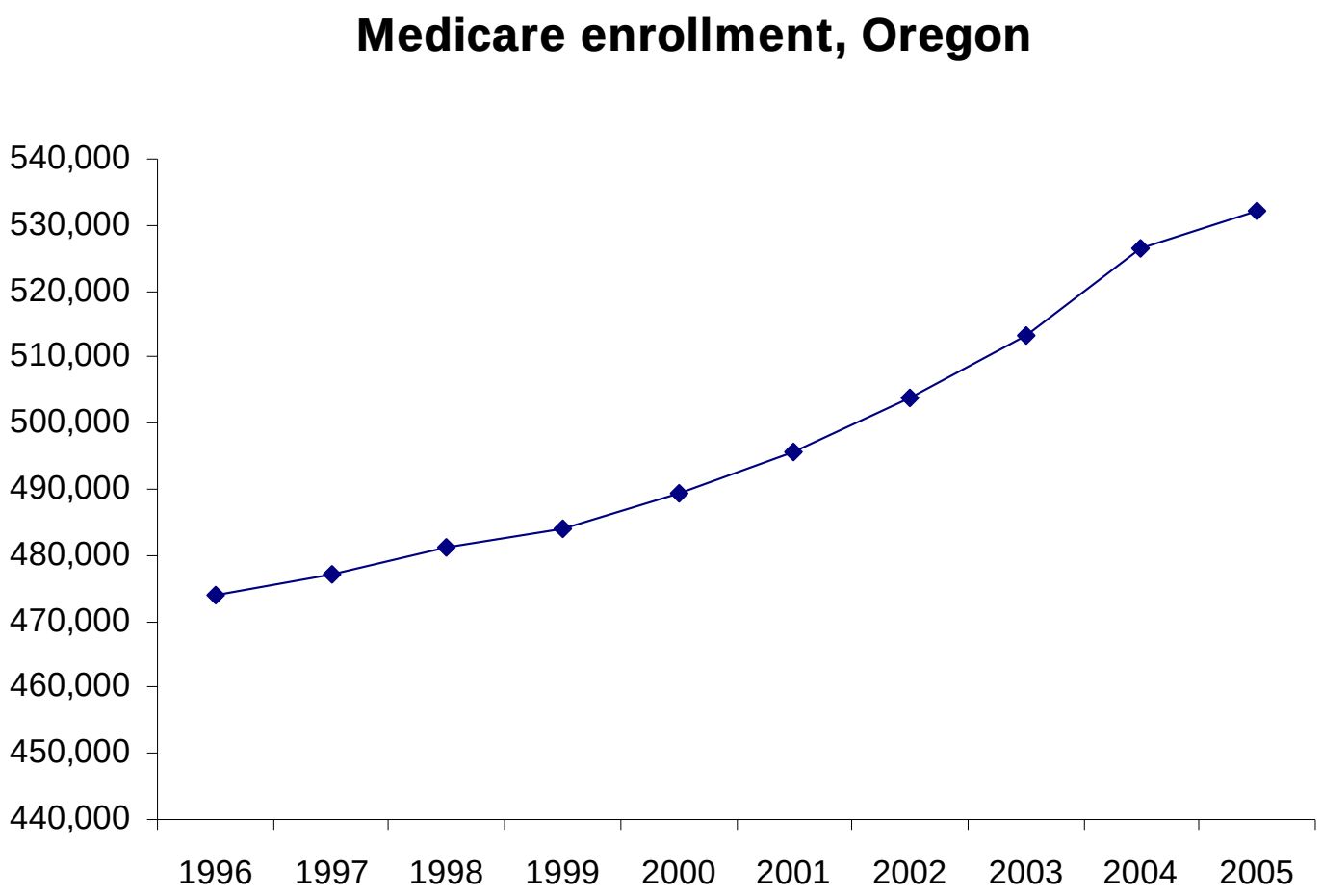


Source: Medical Expenditure Panel Survey, MEPSnet Insurance Component.

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

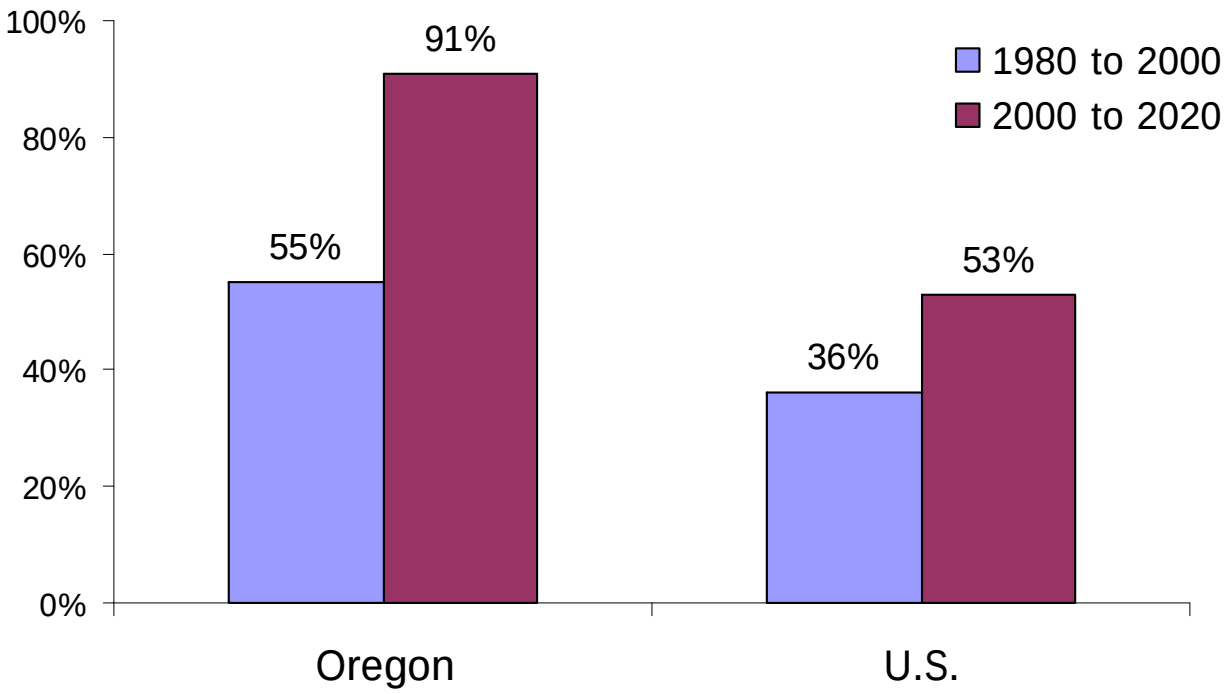
Medicare enrollment has grown as the population ages…



Source: Centers for Medicare & Medicaid Services, Medicare State Enrollment, 2005.

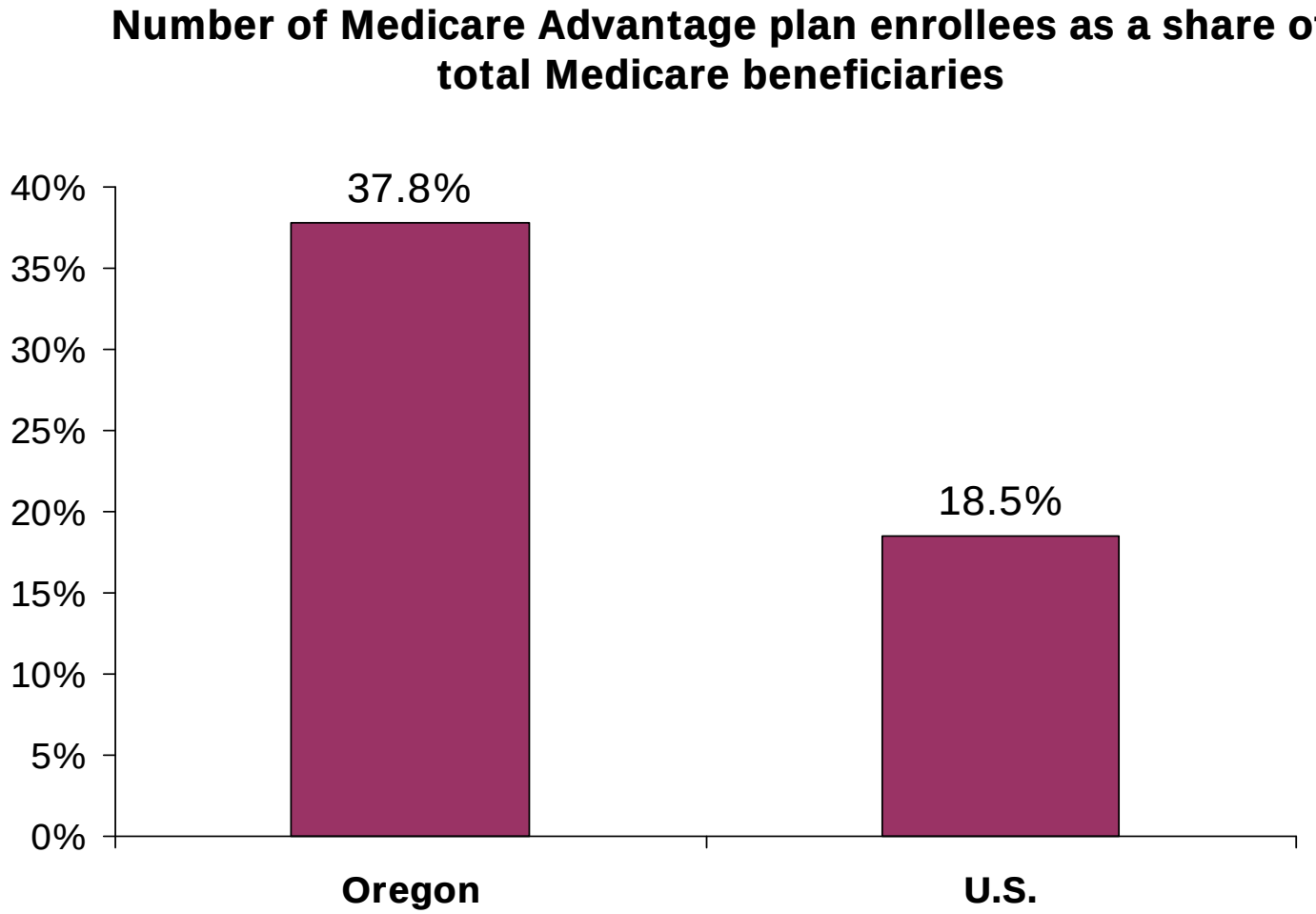
Oregon's 65+ population is increasing rapidly…

Projected percentage change in population 65+ years of age



Source: 2000 HRSA Report – Oregon Profile

Oregon leads country in Medicare Advantage enrollment *



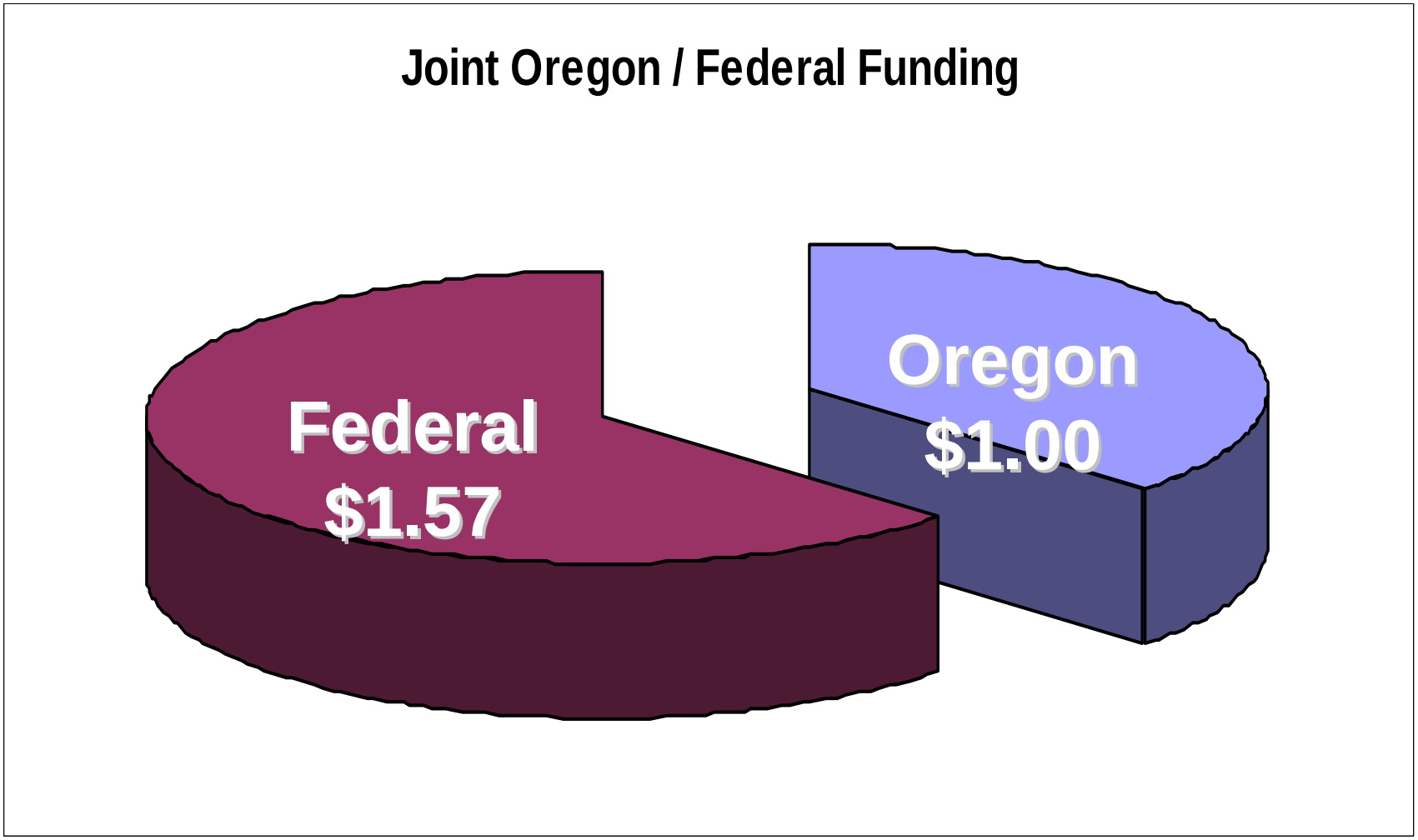
*Puerto Rico has MA penetration rate of 53.3%; OR has highest rate of states

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

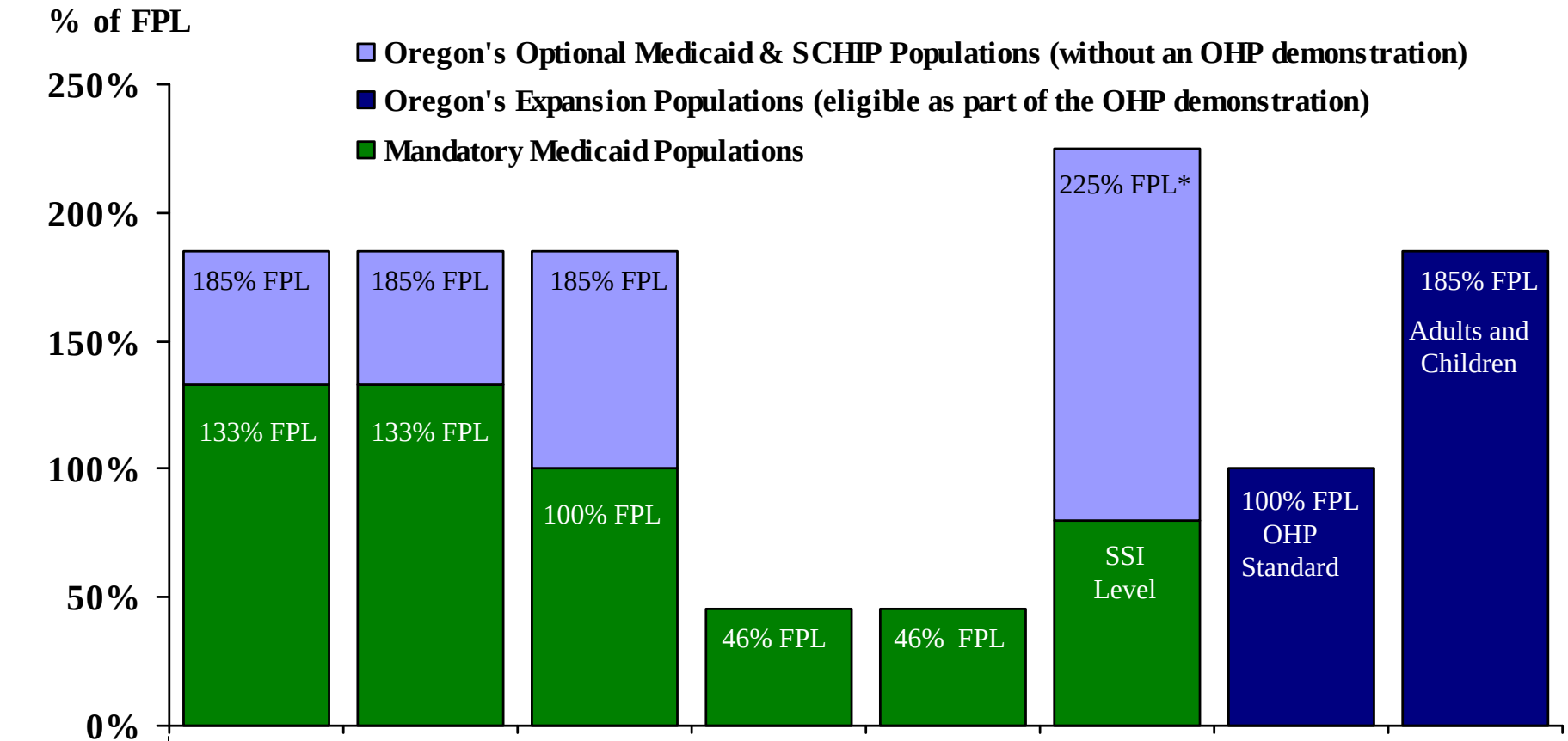
Medicaid is a State/Federal Partnership



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

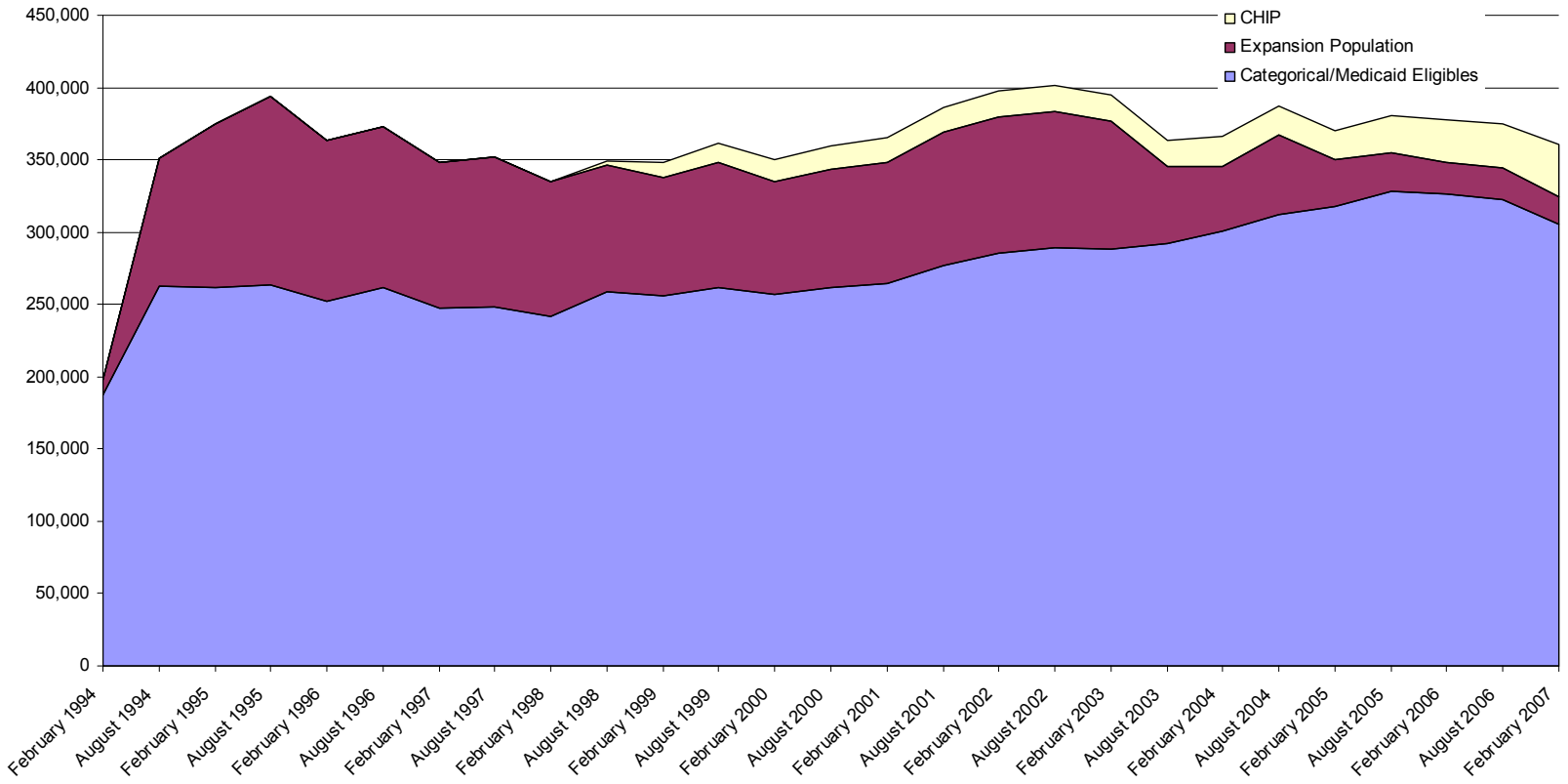
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level

**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.

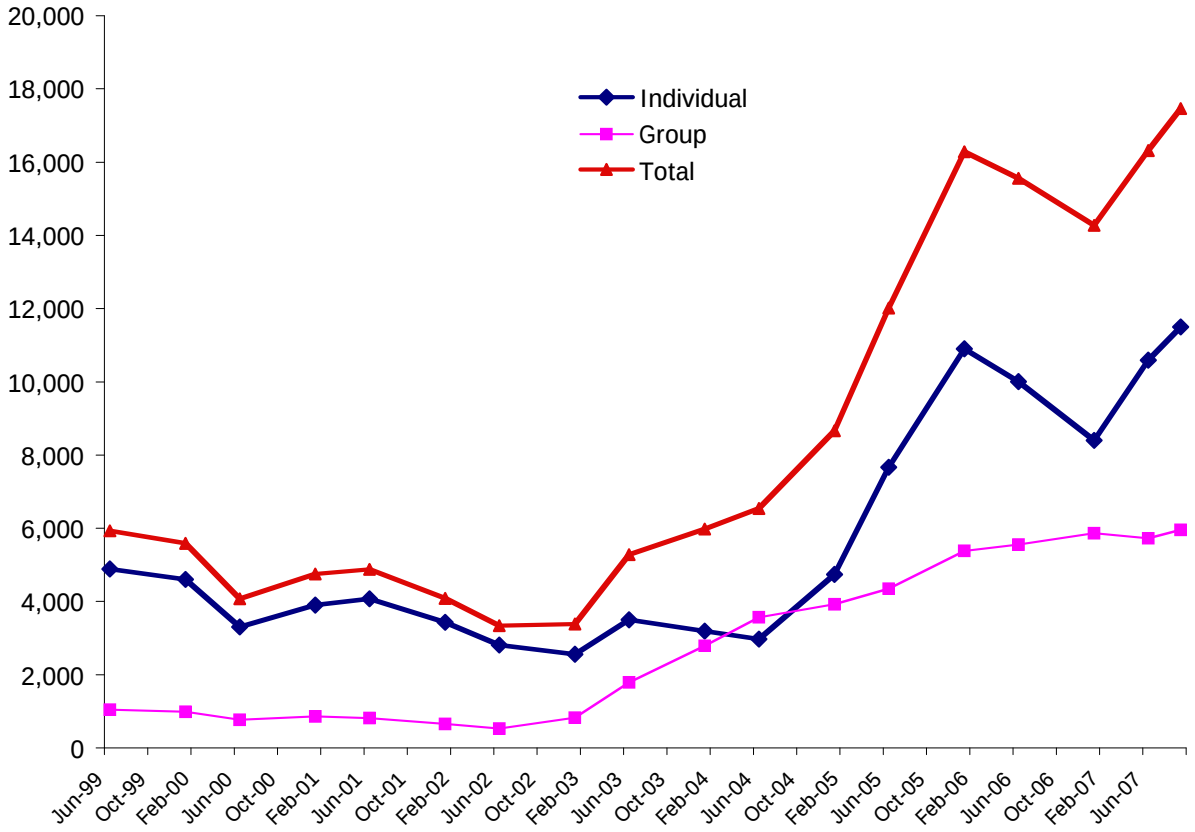
Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Total enrollment is fairly flat over time, but OHP expansion population is shrinking

Total Medicaid enrollment, Oregon, 1994 to 2007



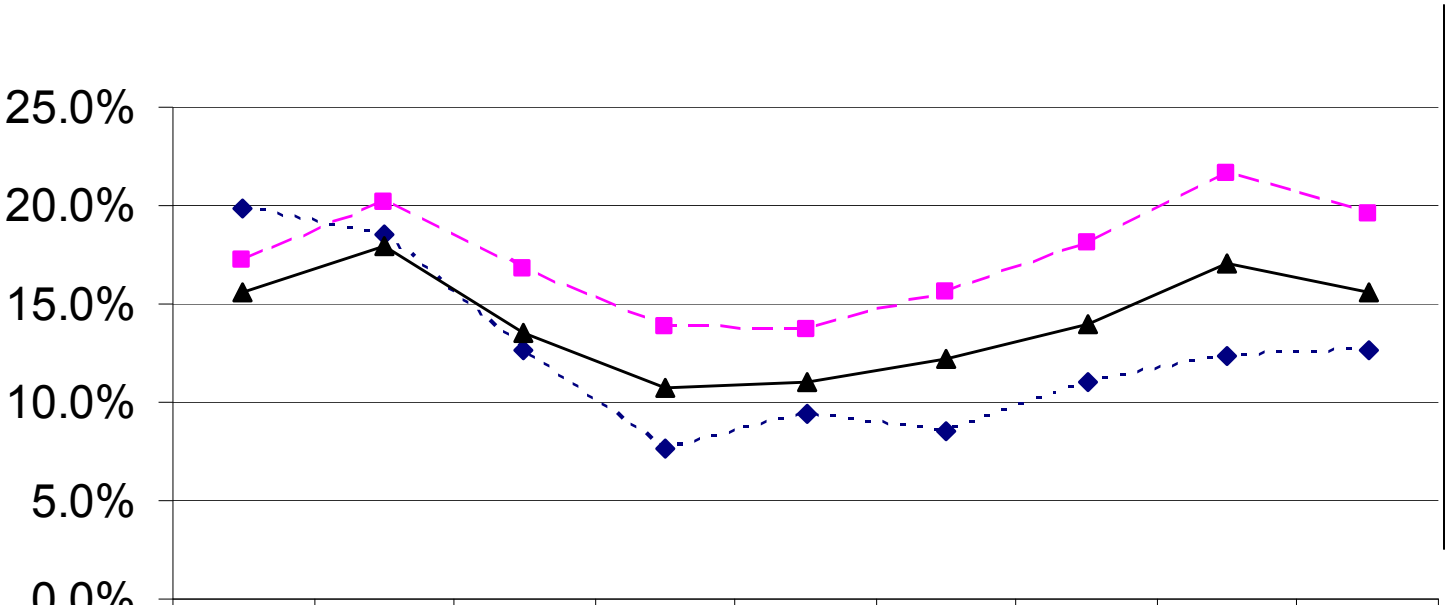
Family Health Insurance Program (FHIAP) enrollment continues to grow.



Who are the uninsured?

Almost one in five adults and one in six children are uninsured

Health Uninsurance Trends, Oregon

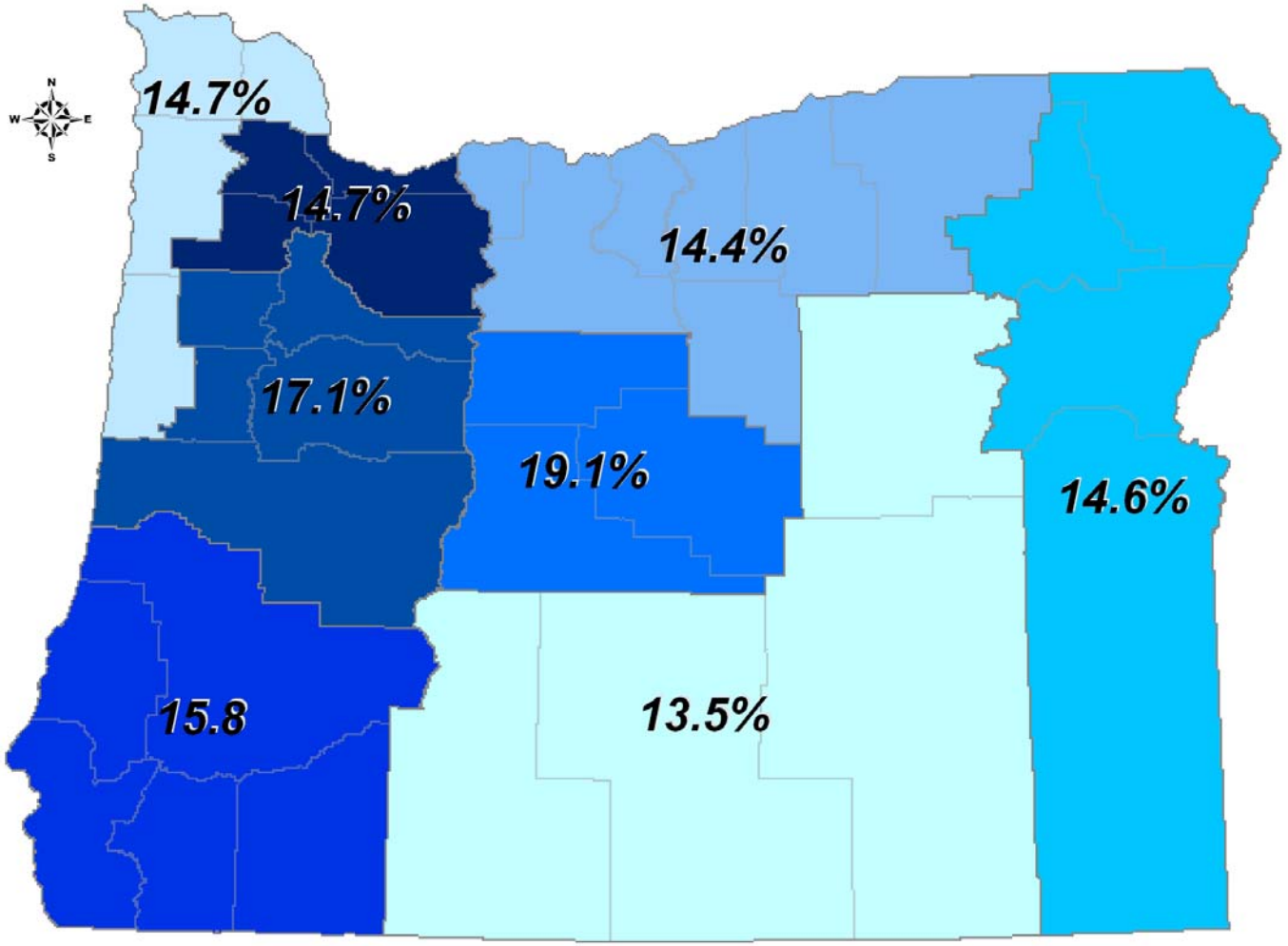


	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

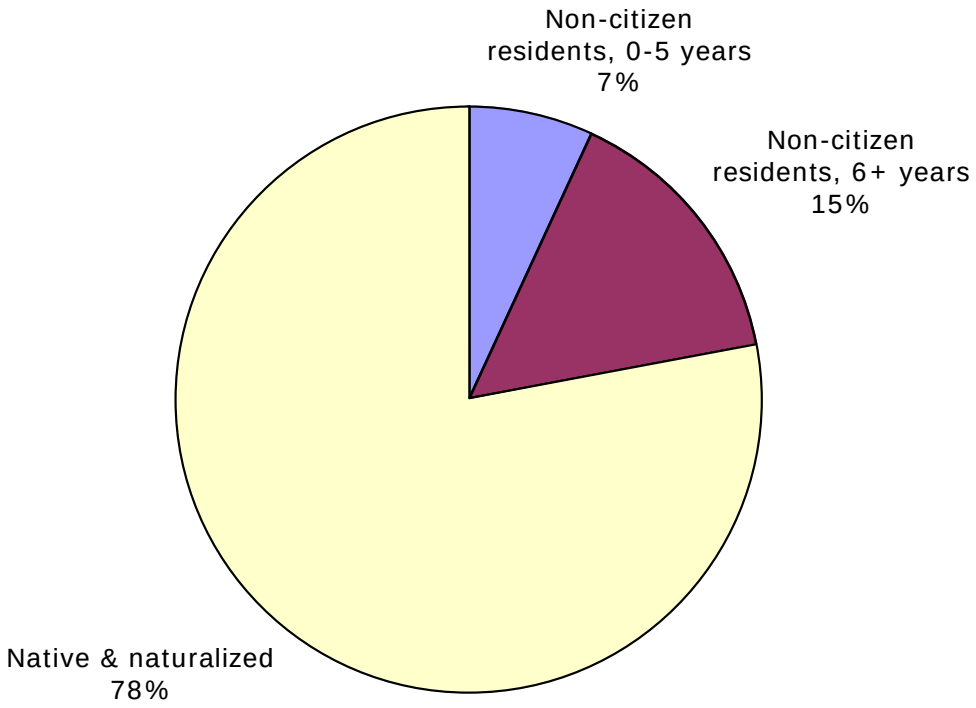
Source: Oregon Population Survey, 1990 to 2006.

Mid-Willamette Valley and Central Oregon have the highest rate of uninsured

Regional Percentages of the Uninsured, Oregon 2006

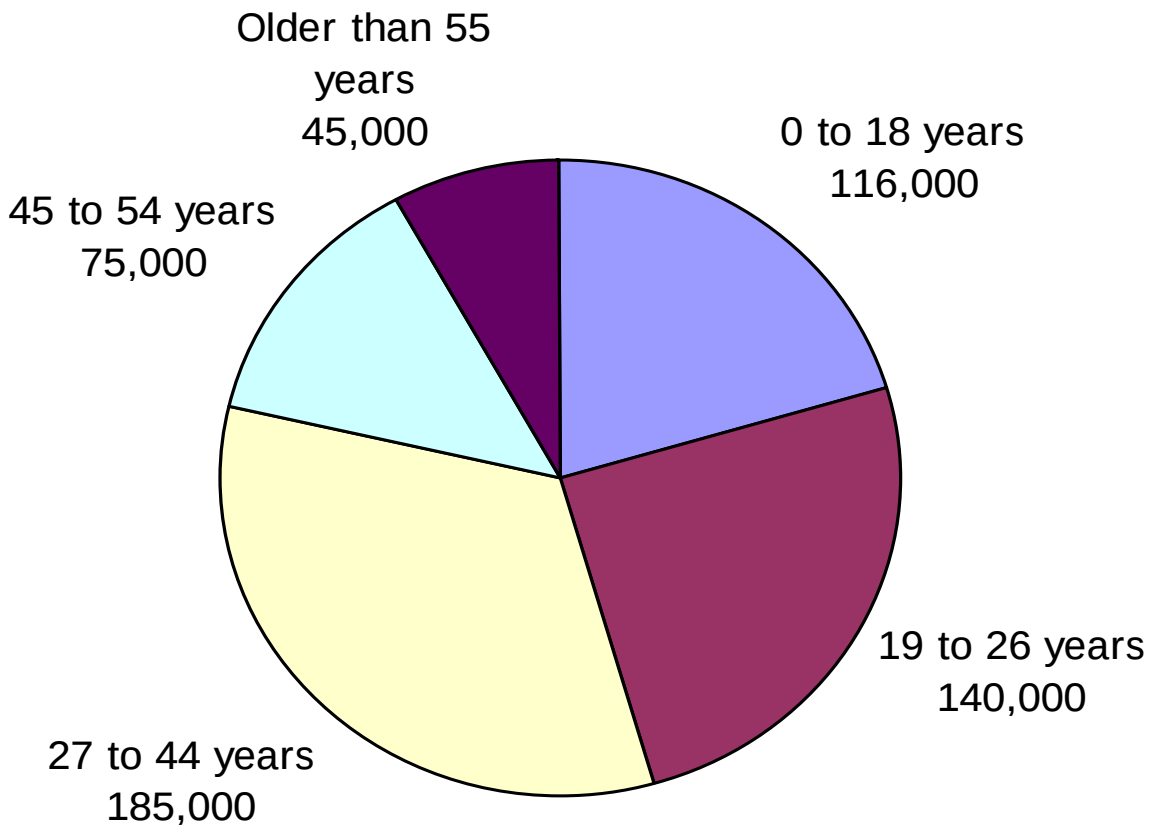


Native & naturalized citizens are over 70% of the uninsured...



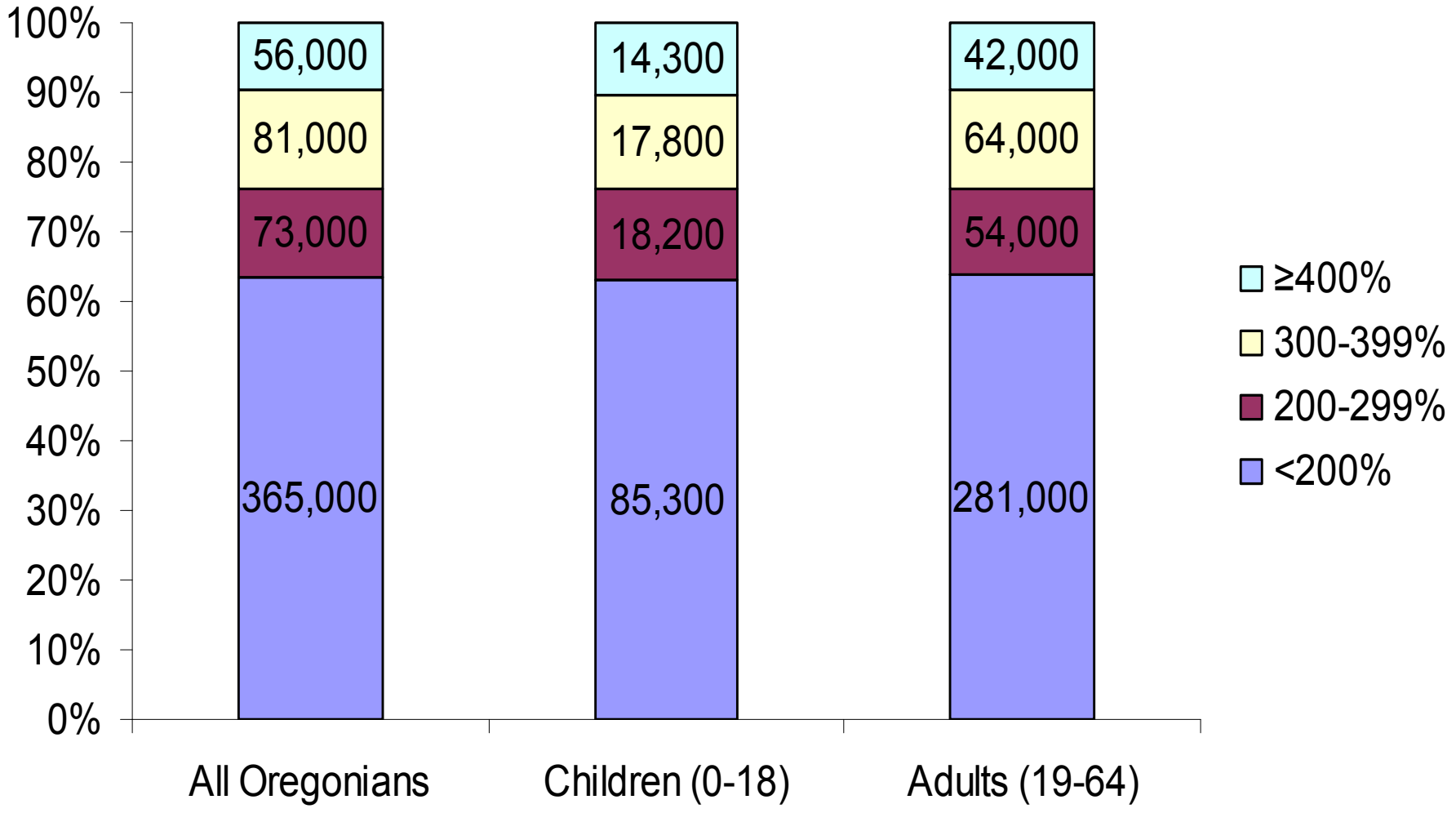
Source: Kaiser Family Foundation; The Uninsured: Key facts about Americans without health insurance, October 2007

Adults are more likely than children to be without insurance.



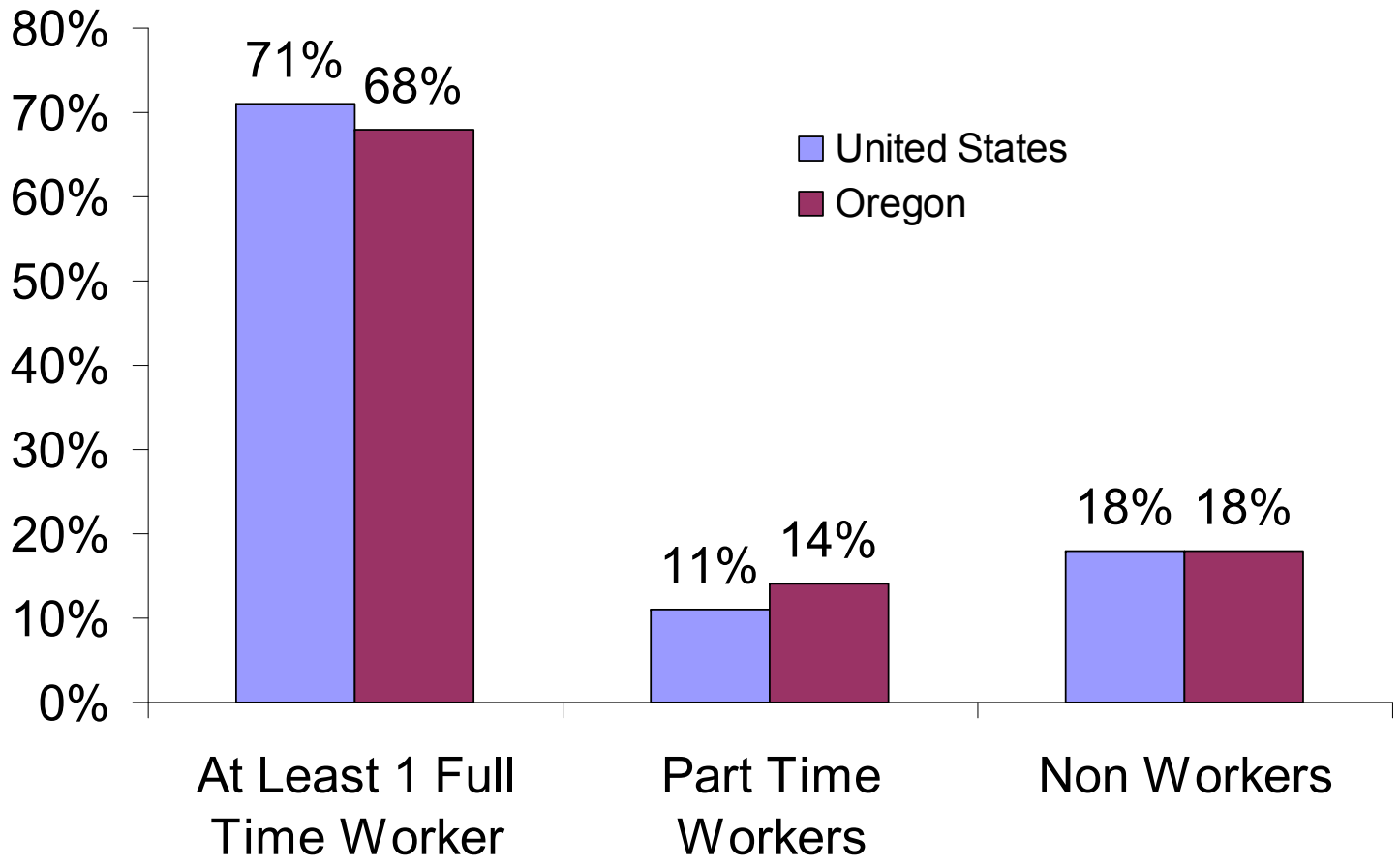
Source: 2006 Oregon Population Survey.

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]

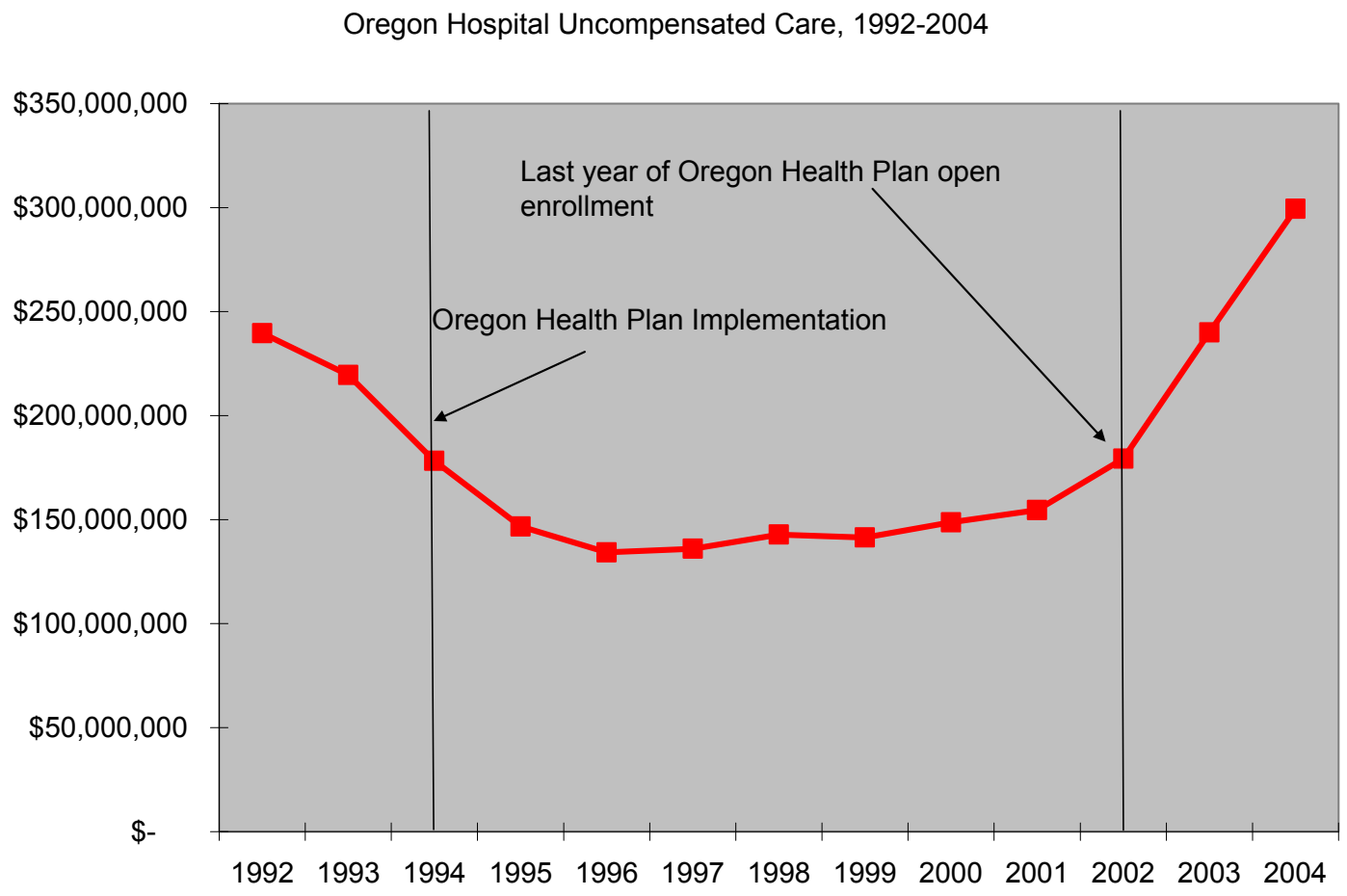
[1] Colmers JM. Public reporting and transparency. The Commonwealth Fund Commission on a High Performance Health System, January 2007.
[2] Norton's Bankruptcy

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...



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