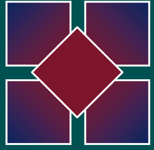
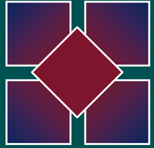


Oregon's Health Care Trends

Wednesday, January 21, 2004

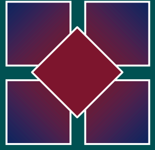
Bruce Goldberg, MD

Administrator, Office for Health Policy and Research



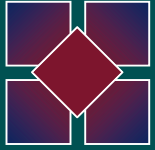
Overview

- Background of other state health commissions
- State of Oregon
  - Who’s Covered
  - Who’s Not
  - Other Issues
  - Future



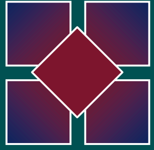
I. Other State Commissions

- Minnesota
- Rhode Island
- Maine
- Virginia
- Florida
- New Mexico



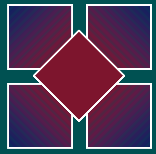
II. Trends

- 1) Who's Covered?
- 2) Who's Not?
- 3) Other Issues
- 4) Future



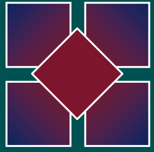
1) Who's Covered?

- Private Sector
  - Group (Employer-Sponsored Coverage)
    - Accounts for over 90% of private coverage
  - Individual
- Public Sector
  - Medicare
  - Medicaid



Oregon's Population by Source of Coverage (2002)

Source: Office for Health Policy & Research



U.S. Health Care Expenditures

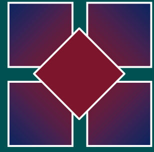
(in $ millions)

2000
1500
1000
500
0

1993 1997 2000 2001 2002

National Health Expenditures
Private
Public
State and Local

Source: U.S. Department of Health and Human Services, 2003



Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003

18
16
14
12
10
8
6
4
2
0

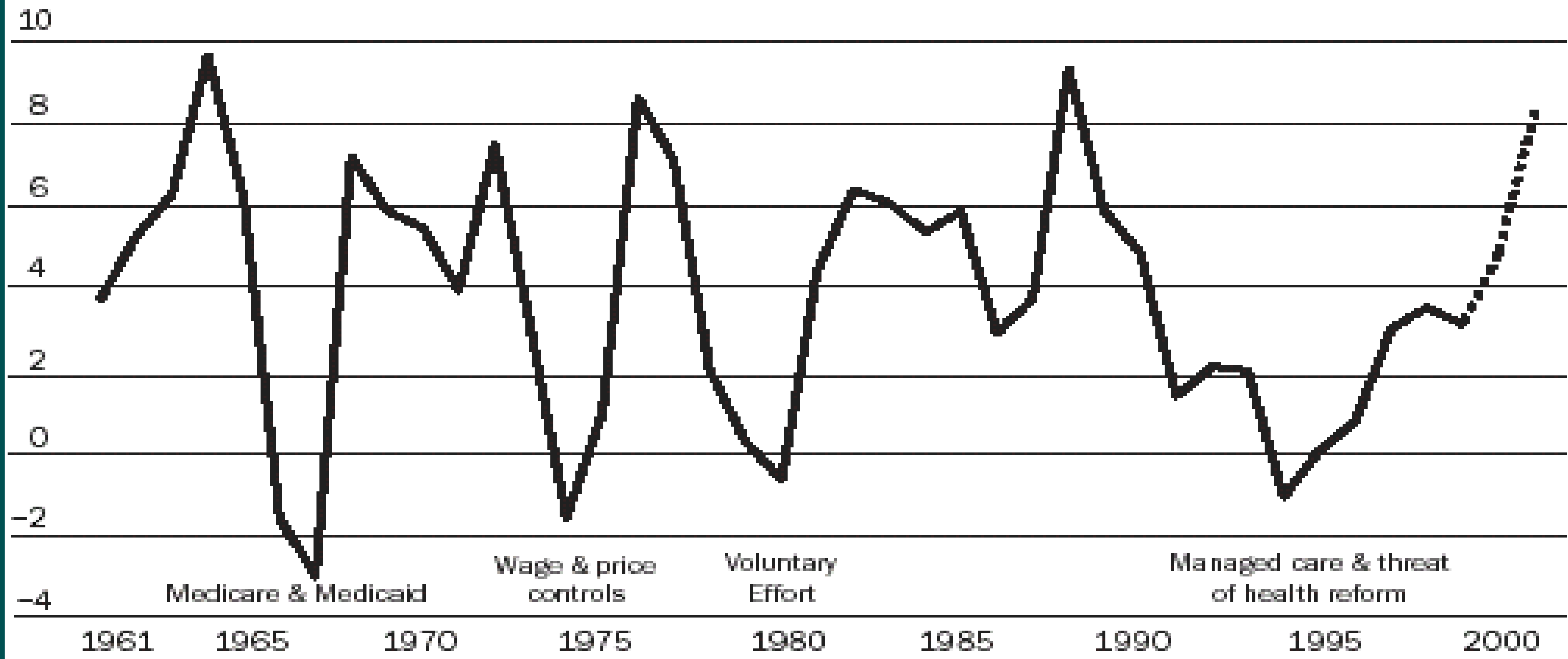
18.0
12.0
8.5
0.8
5.3
8.2
10.9
12.9
13.9

1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003

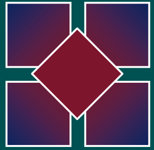
Health Insurance Premiums · Overall inflation · Workers earnings

Source: National data from 2003 Kaiser/HRET Survey Summary

EXHIBIT 1
Annual Change In Private Health Spending Per Capita (Adjusted For Inflation), 1961–2001



SOURCES: Henry J. Kaiser Family Foundation analysis. Private health expenditures per capita, 1960–1999, are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita, 2000–2001, is estimated based on average premium increases for employer-sponsored coverage from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
NOTES: Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961–2000 and July-to-July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than fifteen years ago. See J.C. Merrill and R.J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91–98.



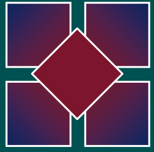
Health Plan Enrollments by Plan Type, 1988-2003

Year	Conventional	HMO	PPO	POS
2003	5%	24%	54%	17%
2001	7%	23%	48%	22%
2000	8%	29%	41%	22%
1999	9%	28%	38%	25%
1996	27%	31%	28%	14%
1993	46%	21%	26%	7%
1988	73%	16%	11%	

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

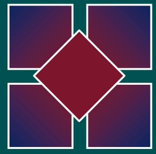
Conventional HMO PPO POS

Source: National data from 2003 Kaiser/HRET Survey



Average Annual Premiums for Covered Workers, For All Plans, 2001 and 2003

Source: National data from 2001 and 2003 Kaiser/HRET Surveys



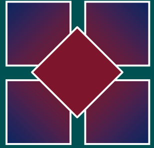
Average Monthly Worker Contribution for Single and Family Premiums, 1988-2003

Year	Single Coverage	Family Coverage
1988	$8	$52
1993	$34	$124
1996	$37	$122
2000	$28	$135
2001	$30	$149
2002	$39	$178
2003	$42	$201

Y-axis: $-, $50, $100, $150, $200, $250

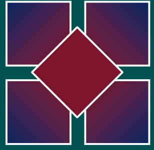
Legend: Single Coverage, Family Coverage

Source: National data from 2003 Kaiser/HRET Survey



Medicare

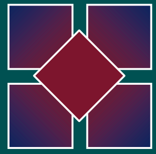
- Enrollment Trends
- Demographic Trends
- Payment Trends



TOTAL
Oregon Medicare Enrollment

1996	474,073
1997	477,022
1998	481,306
1999	483,898
2000	489,312
2001	495,704
2002	503,783

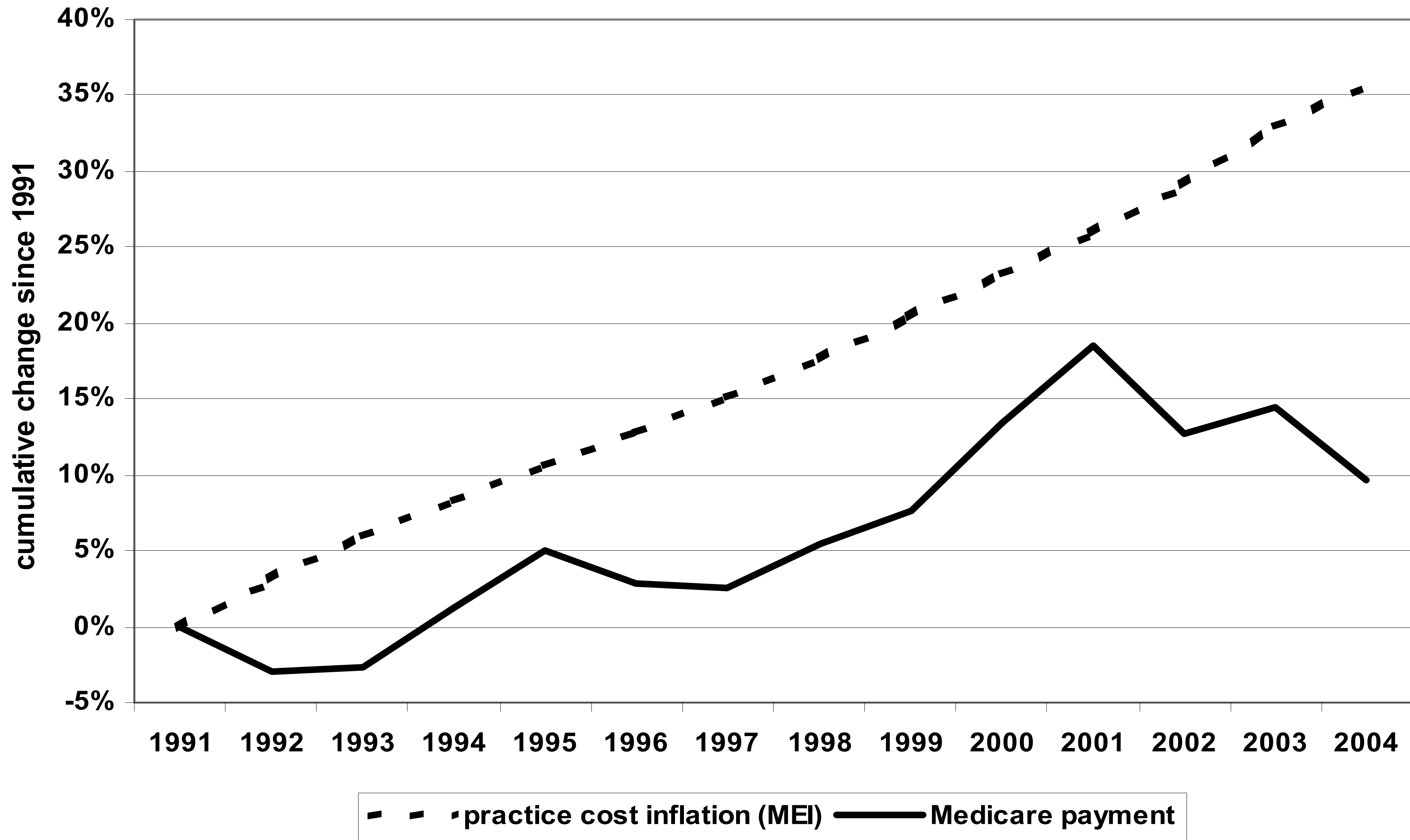
Source: Centers for Medicare and Medicaid Services, 2003



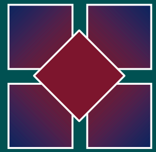
Projected Percentage Change in Population 65+ Years of Age

	1980-2000	2000-2020
Oregon	55%	91%
U.S.	36%	53%

Source: 2000 HRSA Report – Oregon Profile



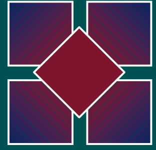
Sources: Practice cost inflation all years, Centers for Medicare and Medicaid Services (CMS); 1992-97 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS.



Medicare Payment Per Recipient

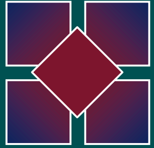
	Oregon	U.S.
1994	$3,285	$4,375
2000	$4,274	$5,423

Source: U.S. Department of Health and Human Services, 2003



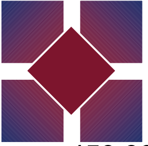
Medicaid – Oregon Health Plan

- Enrollment Trends
- Demographics
- Cost Trends



OHP / Medicaid

- Federal requirements
- States must:
  - cover specific populations/categories
  - cover specific conditions/services
  - receive federal approval to make any changes



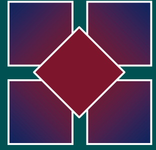
Total Medicaid Enrollees

of People

450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0

February 1994
August 1994
February 1995
August 1995
February 1996
August 1996
February 1997
August 1997
February 1998
August 1998
February 1999
August 1999
February 2000
August 2000
February 2001
August 2001
February 2002
August 2002
February 2003
August 2003

CHIP
Expansion Population
Categorical/Medicaid Eligibles

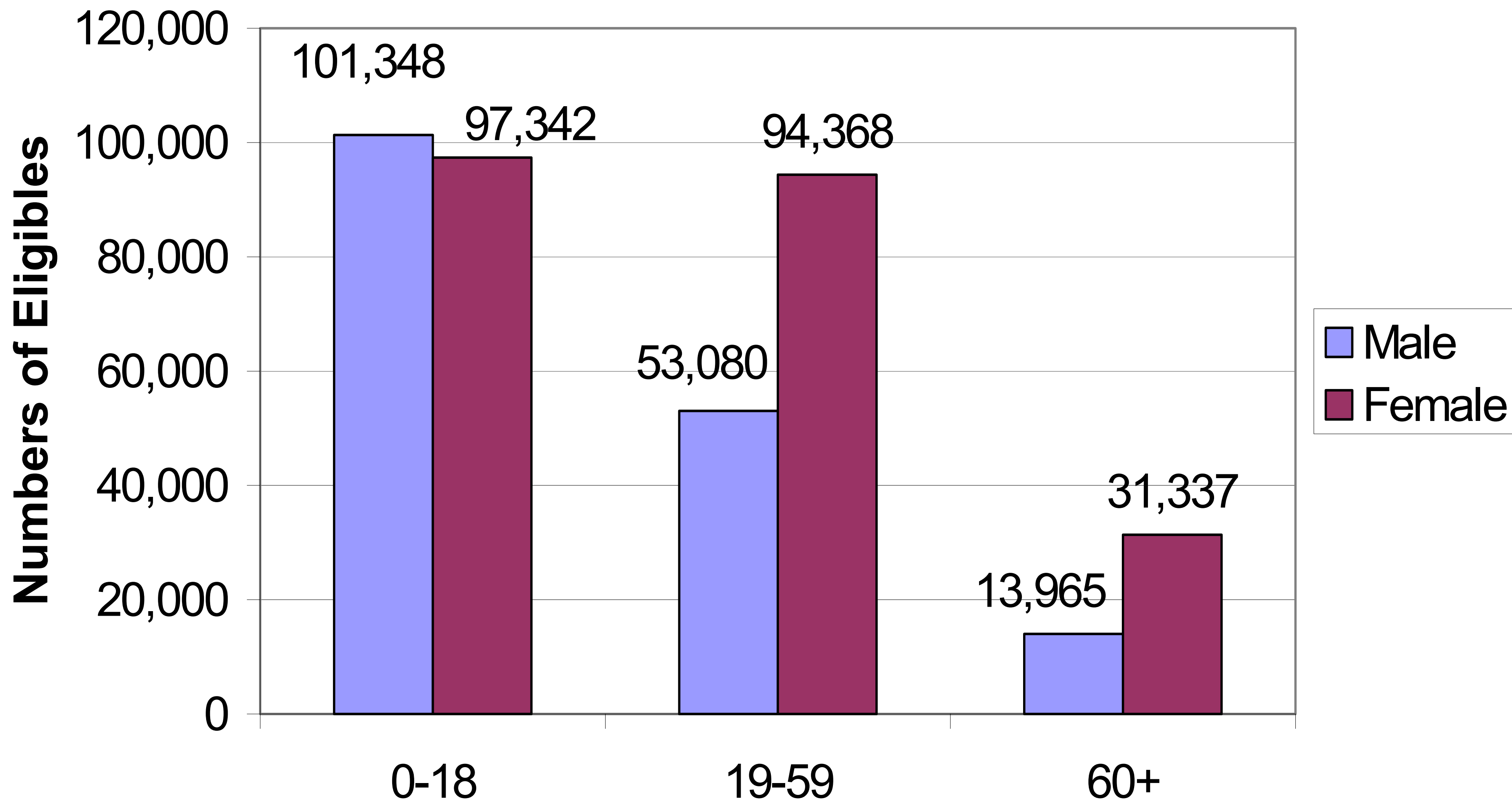


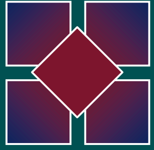
OHP Demographics

Percentage of Dually Eligible for Medicare

- 2003 = 12.9% (or 50,336)

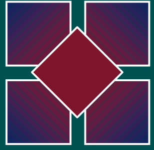
OHP Medicaid and CHIP Eligibles Report by Age Group and Gender on December 1, 2003 (N=391,440)





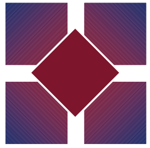
OHP / Medicaid

- 3 Fundamental Questions:
  - **Who** are we going to cover?
  - **What** are we going to cover?
  - **How much** are we going to pay?



Who are we going to cover?

- Expand coverage beyond "categoricals"
- Coverage to include individuals with incomes up to 100% Federal Poverty Level (FPL)
- Initial expansion covered additional 100,000 Oregonians



Oregon Health Plan
Covered Populations as of 1/21/04

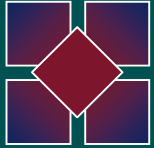
Federal Poverty Leve

225%
200%
175%
150%
125%
100%
75%
50%
25%
0%

75%
78%
52%
52%
185%
133%
185%
133%
185%
133%
185%
100%
100%

Old Age Asst
Aid Blnd/Aid Dsabld
Foster Children
Temp Ast Need Fam
CAWEM
Pregnant Women
Children (0-5)
Children (6-18)
Adults/Cpls/Families

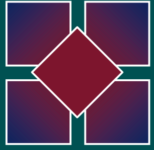
Mandatory



100% Federal Poverty Level

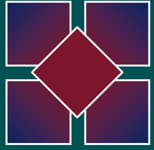
Size of Family Unit	Annual Earnings
1	$ 8,980
2	12,120
3	15,260
4	18,400
For each additional person, add	3,140

SOURCE: *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.



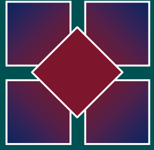
What are we going to cover?

- Expansion meant covering more people with a reduced benefit package
- Introduction of Prioritized List of Services
  - 548
  - **549**
  - 550
- “Above the line” and “Below the line”



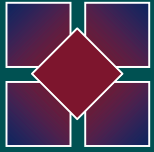
What are we going to cover?

- Original design – legislature would have ability to move the line based on available funding.
- Restrictions by federal government



How much are we going to pay?

- Coverage vs. Access
- Managed Care vs. Fee-For-Service

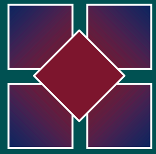


Reimbursement Comparisons

	Medicaid FFS	Medicaid Managed Care	Medicare FFS	Medicare Managed Care	Commerical Payers
Reimbursement	$26	$30-34	$36	$40-42	$52-58

Axis: $0, $20, $40, $60

Source: Lewin Group, 2002. Based on approximate conversion factors



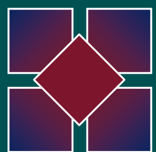
Medicaid Physician Payments as a Percentage of Medicare, 2000

120%
100%
80%
60%
40%
20%
0%

State	Percentage of Medicare	State Rank
Utah	62.1%	45*
California	65.2%	40
Washington	72.7%	35
Oregon	73.3%	33
Montana	90.6%	13
Idaho	97.2%	10
Nevada	103.2%	3

Source: The Lewin Group for the Medi-Cal Policy Institute, June 2001

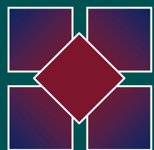
*State Rank



Medicaid Pay vs. Medical Practice Inflation

	1993	2003
Practice Cost Inflation	0%	30%
OHP physician rate increase	0%	9.3%

Source: Practice cost inflation all years, Centers for Medicare and Medicaid Services (CMS); Lewin Group, Analysis of Medicaid Reimbursement in Oregon, 2003



Medicaid Payment Per Recipient

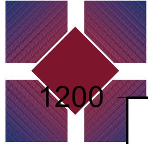
$5,000
$4,000
$3,000
$2,000
$1,000
$-

$2,283
$2,568
$2,915
$3,369
$3,135
$3,936

1990
1996
2000

Oregon
U.S.

Source: U.S. Department of Health and Human Services, 2003



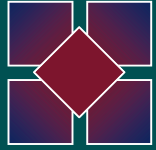
Medicaid and SCHIP Actual State-Fund Expenditures Per Biennium 93-95 to 01-03

In Millions

	93-95	95-97	97-99	99-01	01-03
Total	$497.1 mil	$694.4 mil	$762.8 mill	$880.3 mil	$1096.8 mil
MH / CD (4)	67.5	102.6	120.8	132.13	161.30
Dental	15.5	40.6	58.2	60.45	62.84
Drugs (3)	62.2	95.7	126.0	188.74	288.08
Non-Categorical (2)	76.2	139.5	121.1	147.44	172.52
Categorical (1)	275.7	316	336.7	351.59	412.09

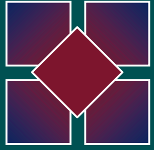
Y-axis: 0, 200, 400, 600, 800, 1000, 1200

Legend: Categorical (1), Non-Categorical (2), Drugs (3), Dental, MH / CD (4)



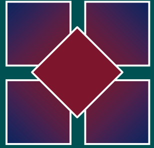
OHP Emerging Challenges

- Soaring health care costs
- Increasing demand for OHP coverage
- Decreasing private sector coverage
- Competing demands for resources
  - Education
  - Infrastructure
  - Economic Development
  - Criminal justice system



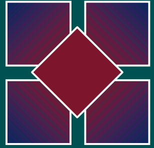
Recent Actions

- Benefit reduction
- Private market subsidies/premium assistance
- Cost Sharing/Shifting
  - Premium
  - Co-pay
  - Stagnant provider reimbursement



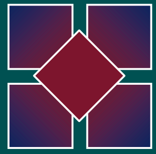
Results

- Federal government may not approve further benefit reductions
- Premium structure causing access problems
- Payment rates causing access problems
- Premium assistance inadequate to attract/maintain employer coverage



Results

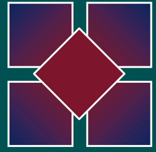
- Some health plans & providers are leaving the OHP, citing inadequate payments from the state
- Growing inequity among those who provide services to Medicaid population and those who do not



2) Who’s Not Covered?

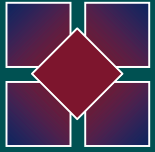
(The Uninsured)

- Trends
- Demographics
- Access



Insurance ≠ guarantee access to health care, but the consequences of being without health insurance are:

- 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
- More disparities in care: Uninsured receive poorer care.

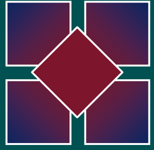


History of Oregon's Uninsured Rate

Percent Uninsured

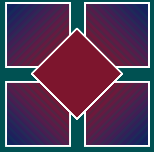
	All Oregonians	Adults 18-64	Children
1990	18	17	21
1992	17	20	15
1994	15	17	14
1996	11	14	8.5
1998	11	14	9.5
2000	12	15.5	8
2002	14	18	10

Source: Oregon Population Surveys, OHPR



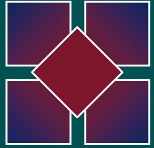
Uninsured Adults at Selected FPL

FPL	Uninsured Adults
<100%	113,653
101-200%	124,302
201-300%	87,018
301-400%	48,962
401-500%	25,042
501+%	38,621



Uninsured Children by Selected FPL

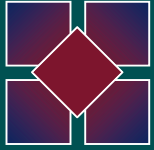
FPL	Uninsured Children
<100%	19,617
101-200%	29,170
201-300%	19,237
301-400%	6,929
401-500%	3,897
501+%	2,804



100% Federal Poverty Level

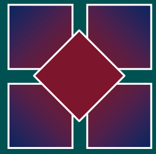
Size of Family Unit	Annual Earnings
1	$ 8,980
2	12,120
3	15,260
4	18,400
For each additional person, add	3,140

SOURCE: *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.



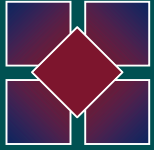
Uninsured Adults by Ethnicity

Ethnicity	Uninsured
White	16.6%
African-American	18.2%
Native American	23.1%
Asian or Pacific Islander	14.8%

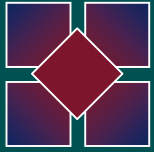


Uninsurance Percentages by Hispanicity – All Oregonians

	Uninsured
Hispanic	30.7%
Non-Hispanic	12.2%

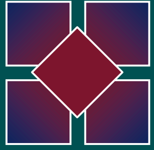


Uninsurance by Education Level



Uninsurance Percentages of Selected Counties

County	Uninsured
Deschutes	13.5%
Jackson	11.3%
Klamath	15.4%
Lane	14.1%
Marion	14.3%
Multnomah	14.9%
Umatilla	16.3%
Wasco	18.7%
Washington	12.8%



Health Care Safety Net

- FQHC's

  1998- 12 with 60 sites & 400,000 visits
  2002/2003 – 19 with >100 sites & 600,00 visits

- Rural Health Clinics

  1998 – 24 clinics

  2003 - 39 clinics

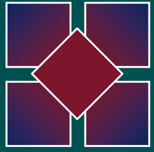
- School Based Health Centers

  1998 – 41 clinics/70,221 visits
  2001-2 – 43 clinics/86,939 visits

- Tribal Clinics

  1998 – 10 clinics/15,215 unduplicated members seen

  2002 – 10 clinics/14,630 unduplicated members seen

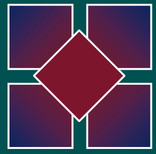


Unduplicated Safety Net Clinic Medicaid Population Totals

Year	Population Totals
1998	26,730
1999	28,439
2000	31,545
2001	41,850
2002	60,018
2003	61,301

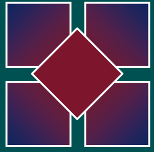
Population Totals

0
10,000
20,000
30,000
40,000
50,000
60,000
70,000



Safety Net Clinic Medicaid Encounter Totals

Year	Encounter Totals
1998	87,585
1999	99,716
2000	107,216
2001	152,055
2002	213,048
2003	206,383

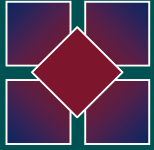


Oregon Hospital Charity Care

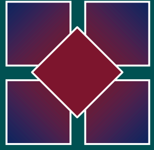
Charity Care (in millions $)

Year	Charity Care (in millions $)
1991	78
1992	82
1993	85.8
1994	77
1995	53.5
1996	50
1997	52.5
1998	52.7
1999	58.7
2000	60.7
2001	72.2

Data Source: Hospital Audited Financial

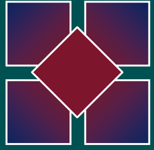


ADDITIONAL IMPORTANT ISSUES



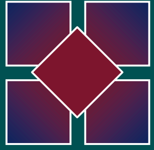
HEALTH CARE NON-SYSTEM

- Highly fragmented system/cottage industry
- Lacks even rudimentary information systems
- Unnecessary duplication
- Long wait times and delays
- Overuse of services
- Lacks “value” orientation



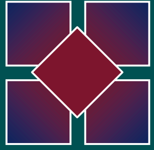
QUALITY

- Ensure that all Oregonians have the safest, highest-quality health care services possible.
- Opportunities for preventive care are frequently missed
- Improvement in the management of chronic diseases is possible



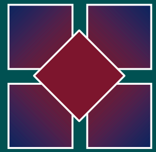
INFORMATION TECHNOLOGY

- Limitations in the availability of data constrain the ability to track and improve health care.
- Investment in information technology and information infrastructure can improve quality and efficiency of health care



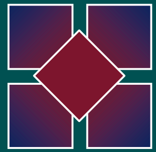
MENTAL HEALTH

- Integration of mental health, chemical dependency and physical health services
- Meeting the medical, social, employment, housing needs for the chronic mentally ill
- Science-based practice
- Instability of funding



DISPARITIES IN HEALTH CARE

- Racial and ethnic disparities consistently found across a wide range of disease areas and clinical services
- These disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
- Disparities in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)
- Disproportionate share of uninsured among racial and ethnic minorities and rural populations.

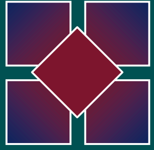


Physicians Per 10,000 Population

Physicians Per 10,000

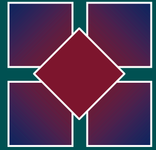
	Oregon	U.S.
1975	15.6	15.3
1985	19.7	20.7
1995	21.6	24.2
2001	23.7	25.2

Source: U.S. Department of Health and Human Services, 2003



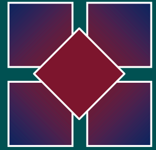
WORKFORCE

- Assuring adequate supply, distribution, and training of health care workforce
- Assure appropriate reimbursement to maintain access to a high quality workforce



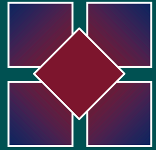
Population-based Health

- Assure the quality and availability of public health services
- Emphasize preventing illness and injury rather than treating a medical condition that has already occurred.
- Make evidence the foundation of decision making and the measure of success
- Improve the health of Oregonians



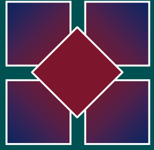
END OF LIFE CARE

- Increased health care expenses in last 6 months of life
- Adequacy of hospice services



LONG-TERM CARE

- Aging population and future demographics
- Increasing demand for long term care
- Oregon has been leader in home-based care and services



FUTURE

- Cost
- Access
- Quality
- Health Status
- Measurable Outcomes?
- Commission’s Mission/Vision?