

Childless Adult Coverage in Oregon

State Report

by
Tanya Alteras
Economic and Social Research Institute

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INTRODUCTION

Since 1994, Oregon has provided coverage to poor adults through its Medicaid program. Additionally, the state has a longstanding premium assistance program that helps low-income families and childless adults purchase private health insurance. In 2002, Oregon's Medicaid program went through a significant restructuring that had significant implications for coverage of childless adults.

This paper provides an overview of Oregon's efforts to cover low-income childless adults as of March 2004. It is based on interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults. It does not reflect the changes that have occurred to the OHP Standard program between March and June 2004 (see text box on page 3).

HISTORY AND BACKGROUND

Since the late 1980s, Oregon has been recognized as an innovator when it comes to delivering health care to low-income uninsured people. As part of its commitment to making publicly funded health coverage available to a broader spectrum of the population than those categorically eligible for Medicaid, the state took a bold step in 1994 and obtained a waiver to cover all individuals up to 100 percent of the Federal Poverty Line (FPL) through Medicaid.¹ In addition to providing coverage for individuals categorically eligible for Medicaid (children, pregnant women, parents, elderly and disabled), the Oregon Health Plan (OHP) made Medicaid coverage available to all poor adults, including those without dependent children. To pay for the expansion, the state redesigned the program from two angles. First, it established a set of benefits based on a prioritized list of more than 700 physical health, dental, chemical dependency and mental health condition-treatment pairs. The Oregon Health Services Commission (created concurrently with the Senate Bill 27 that initiated the OHP reforms) ranks this list of medical services from most to least important to the entire population, and the state determines how far down the list of prioritized services it will extend coverage. Second, it implemented a mandatory Medicaid managed care delivery system that created cost-efficiencies, allowing for coverage expansion. In the end, the state was able to cover more individuals through Medicaid under a more efficient delivery system, with the recognition that enrollees' benefit package would not be as comprehensive as it had been prior to the reform.

A few years later, the state undertook another innovative strategy to cover the uninsured by creating a fully state-funded premium assistance program that subsidized private employer-sponsored and individual coverage for lower-income people, known as the Family Health Insurance Assistance Program (FHIAP). One of the state's main goals in developing the program was to provide assistance to working people whose taxes go to support public programs, but who a) could not qualify for those programs; and b) cannot afford coverage on their own. FHIAP subsidizes between 70 percent and 95 percent of an enrollee's premium responsibility depending on income, but does not provide any contribution to an enrollee's cost-sharing responsibilities in the form of copayments, coinsurance, or deductibles. The program was designed to target a working uninsured population who could afford some of the costs of private coverage. Because a significant percentage of FHIAP enrollees did not have access to employer-based insurance, much of the premium subsidies ended up going toward individual

¹ The Federal Poverty Level (FPL) was \$15,260 for a family of three in 2003.

market policies. This put an enormous financial strain on what was a capped, non-entitlement program, leaving thousands of potential eligibles on a waiting list.

The OHP and FHIAP programs proved to be extremely popular among the uninsured. Before long the state realized that to continue providing expanded coverage it would have to explore ways to control costs in both programs. At the same time, Oregon wanted to further reduce the uninsured rate and expand the programs by increasing the income eligibility thresholds.

In 2000, while in the midst of an economic downfall, the state recognized that it could no longer afford to provide the entire Medicaid population with the full OHP benefit package. With Medicaid requiring a higher proportion of state spending than ever before, some in the state legislature argued in favor of dropping coverage for some optional groups altogether. After realizing the implications of that large an eligibility cut in federal matching revenues, the Governor called upon the HSC to examine ways in which the prioritized list could be altered to reduce spending and control rising costs. Before long, however, Oregon realized that a broad cut, either in population served or benefits, would be a band-aid measure, and that the economic realities it was facing demanded a more significant restructuring of the program.

Thus, in 2001, the state assembly offered House Bill 2519, which became the blueprint for an 1115 waiver amendment/HIFA waiver proposal that was submitted to CMS in 2002. Most of the changes called for in H.B. 2519 made it into the proposal, including creating separate coverage categories for different groups of beneficiaries; increasing premiums and copayments for some parents and other adults; using \$30 million in unspent federal SCHIP money to refinance the FHIAP program; placing limits on ancillary services and requiring preauthorization for certain services; and reviewing and evaluating the Prioritized List of Health Services.

These discussions at the state level were highly influenced by the federal Department of Health and Human Services' introduction of the HIFA waiver template, which encouraged states to expand coverage using existing resources and gave states increased flexibility to make changes in their Medicaid benefit packages. While debate took place over the provisions outlined in H.B. 2519, providers, hospitals, and advocates voiced concerns over what the new reform plan would mean for the OHP. Advocates and other stakeholders feared that adults would lose important protections under the reform. The vote to pass the bill was divided along party lines, with Democrats mainly opposed, and Republicans mainly supportive. While representatives on both sides of the aisle argued about the level of hospital reimbursements and the expansion of FHIAP, those opposed to the bill said that its method of reforming the OHP would result in increased pressure on the state's jails, hospitals, forensic care services, and its safety net as a whole. In the end, however, the bill passed, and it was up to a broad set of stakeholders to work on translating its language first into a waiver proposal, and finally into a reform package.

OVERVIEW OF RECENT CHANGES IN OHP

In May of 2002, following the passage of H.B. 2519, Oregon submitted a waiver amendment proposal to the Centers for Medicare and Medicaid Services (CMS), titled "Oregon Health Plan Two" (OHP2). OHP2 allowed the state to cut costs by reducing coverage and giving the state authority to cap enrollment for some people already covered under OHP. It also allowed the state to use SCHIP funds to expand Medicaid eligibility to some children and adults, depending on availability of state funding. Finally, the waiver enabled the state to refinance the FHIAP program by beginning to draw down federal Medicaid and SCHIP matching funds and to

implement a small expansion in the program from 170-185% of the FPL. Under OHP2, Oregon's Medicaid program was restructured into three categories of coverage:

- OHP Plus serves most previously eligible beneficiaries, including children, pregnant women, Supplemental Security Income recipients, parents receiving TANF, and adults receiving General Assistance as well as newly eligible children and pregnant women (170-185% of poverty). There are no premiums; some beneficiaries pay copayments. Benefits are the same as OHP benefits before the waiver amendment, but the state can make benefit reductions through a new "streamlined" CMS approval process. Individuals eligible for OHP Plus have the option of enrolling in FHIAP rather than OHP Plus.
- OHP Standard serves some previously eligible parents (0-100% of poverty, excluding those receiving TANF) and other adults (0-100% of poverty, excluding those receiving General Assistance). Under the waiver amendment, the state obtained authority to increase OHP Standard eligibility for parents and other adults to 185% of poverty, but the state has not implemented the expansion due to lack of state funding. The state can cap enrollment in OHP Standard based on available state funding. The waiver amendment enabled the state to provide a reduced benefit package to OHP Standard beneficiaries, and the state has significantly further reduced benefits since the waiver was approved. Beneficiaries pay premiums and copayments; they are disenrolled for failure to pay premiums and can be denied services if unable to pay copayments. Individuals eligible for OHP Standard, but who have access to employer-sponsored insurance must enroll in FHIAP rather than OHP Standard.
- FHIAP, a previously state-funded program, which subsidizes the purchase of employer-sponsored and individual insurance, was refinanced with SCHIP and Medicaid funding and eligibility was expanded from 170% of poverty to 185% of poverty. The state can limit enrollment based on available funding. Subsidized insurance must meet or exceed a specified benchmark, but subsidized coverage can have significantly more limited benefits and higher cost sharing than allowed under Medicaid.

Status of OHP Standard as of June 2004

In February, Oregon voters rejected a tax increase that would have been necessary for the appropriation of state general funds toward sustaining OHP Standard. In response, the state's Legislative Emergency Board in April accepted a plan from DHS to end the OHP Standard, essentially eliminating coverage for 50,000 adults.

Following this action, health care advocates and legislators worked together to submit a plan to CMS that would allow the state to use Medicaid managed care and/or hospital taxes to fund coverage for some portion of the OHP Standard population. CMS has approved the managed care tax, but as of June 8, 2004, approval of the hospital tax is pending.

Once approved, each tax dollar will be matched by \$1.50 in federal Medicaid funds. However, because this level of funding cannot sustain OHP Standard at its current enrollment level, the program will be closed to new enrollees as of July 1. The state estimates that enrollment must be reduced by more than 50 percent in order to make it sustainable under the new funding mechanism, and are setting a tentative enrollment cap of 24,000. State officials will continue to review the funding vs. enrollment projections, and may lower eligibility levels accordingly in order to maintain the program. There are also plans to further reduce OHP Standard benefits, including only providing a limited hospital benefit.

As a result of a recent court ruling, the state stopped charging OHP Standard copayments in mid-June. OHP Standard enrollees continue to be charged premiums.

Source: Oregon Association of Hospitals and Health Systems, 2004

OHP staff involved in the waiver negotiations said that, while it took longer to approve the waiver than they had originally hoped, the process was not difficult. The two major issues that required some discussion between the state and CMS were 1) whether or not there would be wrap-around services for individuals enrolled in employer-sponsored insurance through FHIAP who are eligible for OHP Standard; and 2) whether the state would be required to “screen and enroll” adults that applied for FHIAP but were eligible for OHP. The wrap-around issue was resolved by the state setting a benchmark for services that would have to be covered by an ESI or individual insurance plan in order to participate in FHIAP. However, this benchmark falls far below the required benefits and cost sharing limits for Medicaid. The state was allowed to require individuals eligible for OHP Standard but who have access to employer-sponsored insurance to enroll in FHIAP instead of OHP. The state assured CMS that individuals applying for FHIAP who did not have access to an employer sponsored insurance plan would be made aware that they had the choice to enroll in OHP Standard, and consequently CMS dropped the screen and enroll issue. The negotiations ended in the late summer of 2002, and the waiver was officially approved on October 15, 2002.

In the time between the waiver proposal’s submission and its approval in 2002, Oregon’s fiscal situation deteriorated significantly. As with other states, Oregon’s 8.1 percent unemployment rate (the highest in the country in 2003)² led to lower tax revenues and higher spending on public programs. Thus, as final federal approval came for the waiver, the state debated whether or not it could move forward with the expansion component of its waiver proposal. Oregon realized that even with eligibility held at 100 percent of FPL, the OHP Standard program would put a significant strain on the budget, and that the incremental increase to 185 percent of FPL was unimaginable. In addition, while the OHP Standard benefit package was already reduced in relation to the OHP Plus package, the budget deficit forced the state to make further reductions in the OHP Standard package in March 2003.

The state moved forward with the FHIAP refinancing and small expansion on November 1, 2002. It moved beneficiaries to the reduced OHP Standard coverage and implemented the small OHP Plus expansion for pregnant women and children on February 1, 2003. In March 2003, the state legislature implemented further reductions in OHP Standard benefits.

Until August 2003, when it finished the longest budget session in its history, the state operated the program through the use of continuing resolutions as it sought ways to fill a gap of \$175 to \$250 million for the OHP to maintain services for all those currently enrolled in the program. It was projected that the state needed approximately \$340 million total to cover the projected OHP Standard population for the remainder of 2003. The budget bill did ultimately pass with a proposed tax increase to help fill the deficit. However, voters rejected the bill through an initiative petition vote in February 2004. As such, the Department of Human Services has been directed to take action to meet disappropriation targets. Among the proposed actions are eliminating the OHP Standard and SCHIP programs altogether, as well as eliminating dental, vision, mental health and chemical dependency services, and therapeutic care, for adults in OHP Plus.³

Stakeholders’ Role in Waiver Development

Oregon’s dire budget situation was evident to all stakeholders, who recognized that program changes would have to be made in order to avoid making severe cuts to the Medicaid program.

² U.S Department of Labor

³ www.dhs.state.or.us/aboutdhs/budget.

In that context, while they were never in favor of the plans laid out in H.B. 2519, consumer advocates did accept an invitation from the Governor to work with the administration on designing the benefits and cost-sharing structure. Fears within the advocacy community that OHP Standard enrollees would bear the brunt of the state's cost containment efforts motivated them to participate in these discussions. However, in the end, it was the OHP Standard group that experienced all of the cutbacks. Between the premium levels and the disenrollment consequences of non-payment, advocates and providers felt that they lost a major battle. The fact that premiums would not be collected for a few months after the initial OHP2 implementation was a minor victory, however. In terms of benefits, stakeholders initially won the fight to retain dental benefits as part of the OHP Standard benefit package, but due to the budget deficit they were dropped in March 2003. Mental health and substance abuse treatment services were also part of the March 2003 benefit cuts, and stakeholders are working desperately to have both reinstated.

Among providers and hospitals, the major concern --- besides those of benefit cuts and cost-sharing changes --- involved reimbursement rates. The state acknowledged the importance of appropriate provider reimbursement in assuring that OHP enrollees have adequate access to care and told policymakers that it would be detrimental to the program to reduce reimbursement rates as a means of creating surpluses for the purpose of funding eligibility expansion. During the passage of H.B. 2519, managed care and fee-for-service reimbursements and hospital DRG rates were a major source of debate. According to some informants, prior to the OHP2 waiver, the managed care reimbursement rate for physicians was "barely adequate," and fee-for-service rates were "woefully inadequate," resulting in subsequent barriers to access due to non-participation among primary and specialty care providers. Despite the state's verbal commitment in 1994 to pay providers at rates that would cover the cost of Medicaid services, a study by the Lewin Group, commissioned by the Oregon Health and Hospital Association, found that providers were paid 78 percent of Medicare payment rates for services under a managed care model, and 72 percent of Medicare for those enrolled in fee-for service arrangements.

Similarly, the state's hospital association argued that reimbursement rates for facilities with over fifty beds have not kept pace with the exponentially growing costs of providing care. The Lewin study found that reimbursement payments for OHP managed care patients averaged only 74 percent of costs in 2001, because managed care plans used Medicaid inpatient fee-for-service rates for hospital payments. Outpatient fee-for-service payments have been capped at 59 percent of actual cost since 1992. One reason for this, the Lewin Group found, was that some portion of services that make up hospitals' actual costs were automatically excluded from reimbursement, due to the way the state's payment system was set up.

Informants reported that the original H.B. 2519 was "pitched" by Governor Kitzhaber as including higher payment rates, but in the end, H.B. 2519 resulted in rate cuts. Some said that the expansion was partially funded through a reduction in provider reimbursements, which was not the original intent of the administration. Further, in drafting the 2003-2005 biennium budget, the legislature is seriously debating a proposal to assess additional provider fees from hospitals. In March, 2003, hospitals sustained another twelve percent across the board cut in reimbursement rates, unrelated to the waiver, in an effort to close the budget gap, and saw the elimination of the Medicaid outlier program, which reimburses the state's hospitals for higher cost patients.

OVERVIEW OF CURRENT COVERAGE FOR CHILDLESS ADULTS

Under OHP2, the primary programs for childless adults are OHP Standard and FHIAP (Table 1).

Table 1: Health Coverage Options for Childless Adults

	Enrollment	Eligibility	Benefits	Cost Sharing
OHP Standard	33,972 (as of April 30, 2004)	Childless adults 0-100% FPL. (State has the authority to raise eligibility to 185% FPL, but has not had available funding)	Significantly limited benefit package with no coverage for non-emergency transportation, mental health, durable medical equipment, or dental.	Monthly premiums ranging from \$6-\$20 per person, based on income Copayments for all covered services, including \$250 per inpatient hospital admission.
FHIAP	4,112 (all adult enrollees as of June 28, 2004)	Individuals up to 185% FPL, with employer-sponsored or non-group coverage.	Private group or non-group benefit package. Private package must meet a benchmark, but that benchmark allows more limited benefits and higher cost sharing than Medicaid.	Enrollees pay the balance of the premium that is not subsidized by the state. Other cost sharing depends on private plan's requirements

OHP Standard

Any discussion of childless adults in the original OHP or OHP2 must be conducted within the context of the income distribution among the program's participants. Table 2 indicates the extremely high percentage of OHP eligibles who are very low-income:

Table 2: OHP Income Demographics

Income	Percent of OHP Standard Population
0 – 10 percent of FPL	40
Up to 25 percent of FPL	50
Up to 50 percent of FPL	75
Up to 75 percent of FPL	85

Eligibility. While the OHP2 waiver proposed expanding eligibility for adults up to 185 percent in OHP Standard, budget difficulties did not allow for the expansion to take place. Thus, eligibility remains at 100 percent of FPL. While there is still a commitment among some state legislators and other stakeholders to cover adults up to 185 percent of the FPL, most policymakers argue that there is simply not enough money to do so at this point. While the state at one point targeted July 1, 2003 as the date of an initial incremental expansion up to 110 percent of FPL, that expansion did not occur due to the lack of an FY 2003—2005 budget⁴. In addition to delaying the increase in income eligibility, the program was forced to implement reductions in benefits and increases in cost-sharing for the already-eligible adult population that are more significant than were originally intended in the OHP2 proposal. Further, under the OHP2 waiver, the state has the authority to cap enrollment in OHP Standard, based on availability of state funds. (See text box on page 3 for enrollment cap update).

⁴ The state operated under a continuing resolution until the legislative session ended in late August 2003.

Benefits. Oregon has a history of providing services to its Medicaid population based upon a prioritized list of services, each of which corresponds to specific conditions and treatments. The list ranks health services based on “the comparative benefit to the population to be served,” so as to make sure that priority services could reach the largest number of enrollees possible. It was created in anticipation of original 1994 waiver by several groups, including the Health Services Commission (HSC), the Insurance Pool Governing Board (IPGB), the Health Insurance Reform Advisory Committee (HIRAC), and the Waiver Application Steering Committee. Working together, they examined the universe of covered Medicaid services (both mandatory and optional) and arranged them in a list according to each service or treatment’s “ability to prevent death and alleviate symptoms” (Lewin report). In the end, the list contained 745 “condition-treatment pairings.” Benefits are controlled by a line, with all services above the line covered by the OHP, and all those below the line, not. The idea was to provide a way of containing costs in the program by limiting services, and the state’s understanding was that they would have the flexibility to move the line up or down as needed depending upon available funds.

When the waiver was approved in 1994, the state covered the first 606 items on the list, but the line moved up to item 578 just a year later. Reforms in 1998 led to the addition of several new condition-treatment pairs, but at the same time, the state moved the line to item 574. Subsequent years led to reductions in the number of items covered due to increasing budget constraints.

Beginning in 2000, the HSC was charged with redesigning the prioritized list in order to reduce the benefit package for the OHP Standard groups. The HSC’s goal was to reduce the cost of covering this population through a number of strategies, including restricting benefits. One theory was that the package of benefits could be restructured in a way that would make it parallel to those typically available in the private market. The state invited advocacy groups and other stakeholders to participate in the dialogue to determine what benefits were most important to the adult population (SCI report). The HSC noted that pharmaceutical and mental health and substance abuse coverage were considered vital for this group, along with other services such as inpatient and outpatient hospitalization, ER services, physician, lab and x-ray, and dental. Due to the high cost of some of these services, and the competing needs of cost-containment and expansion, the state initially chose to institute cost-sharing for this group at a level previously unknown in the OHP program rather than limit these benefits.

In addition to the initial benefit cuts and cost sharing requirements that were set by the waiver proposal, the state also requested authority to further change OHP Standard benefits without getting CMS approval, so long as the benefit package remained actuarially equivalent to mandatory Medicaid benefits. Since the waiver was implemented, the state legislature has made further reductions, including eliminating some of the benefits highlighted as most important during initial waiver development discussions. In March 2003, the state eliminated coverage for mental health and chemical dependency services, durable medical equipment, and dental care. One major impetus behind the cuts was the state’s decision to retain providers’ Medicaid reimbursement rates at their current levels. At the time, the state also eliminated prescription drug coverage for this population, but drug coverage was later restored after a huge backlash from advocates and managed care organizations.

At this time, OHP Standard provides a significantly limited benefit package that includes the following: inpatient and outpatient hospitalization, ER, physician services, lab and x-ray, ambulance services, prescription drugs, and physical, occupational, and speech language therapy.

Premiums. One of the biggest changes under the OHP2 waiver is the institution of significant premiums and cost-sharing for the OHP Standard population. Premiums were first implemented for some individuals in the original OHP in 1995, following a significant increase in enrollment during the program's first two years. Under OHP2, premiums increased and some adults who were not previously charged premiums became subject to them. Currently, premiums range from \$6-\$20 per person per month based on income. All OHP Standard enrollees⁵ are subject to premiums, including those with no incomes. (Table 2 outlines premiums based on the federal poverty guidelines for FY2003):

Additionally, under OHP2, the state implemented stricter premium payment policies. OHP Standard enrollees may now be disenrolled from coverage if a premium payment is not made by the premium due date. Individuals disenrolled due to failure to pay a premium are barred from reapplying for OHP coverage for a period of six months, conditional upon back-payment of premiums. As described earlier, enrollment data shows that approximately 40 percent of the OHP Standard population is under 10 percent of the federal poverty line, and approximately 60 percent are below 50 percent of the Federal poverty line. This population is unlikely to have the means to pay the monthly premium required to remain enrolled in OHP Standard.

Table 2: Premiums for OHP Standard

Household income as percent of FPL	Monthly Equivalent Income by Family Size			Premium Per Person/Month
	<u>1</u>	<u>2</u>	<u>3</u>	
0 up to 10%	<\$74	<\$100	<\$125	\$6
10 up to 50%	<\$369	<\$487	<\$626	\$9
50 up to 65%	<\$480	<\$647	<\$814	\$15
65 up to 85%	<\$627	<\$846	<\$1064	\$18
85 up to 100%	<\$738	<\$995	<\$1252	\$20

Oregon Health Plan Medicaid Demonstration presentation, December 6, 2002

Cost Sharing. As of February 1, 2003, most OHP Standard enrollees⁶ became responsible for copayments for hospital and surgical services, practitioner visits and home visits, laboratory services, and prescription drugs. Other services, such as alcohol, drug and mental health, dental, and durable mental equipment also required copayments before they were eliminated on March 1, 2003. Copayments are based on the service provided, and do not vary by enrollee income. They range from \$5 for outpatient hospital care to \$50 for an emergency room visit to \$250 for inpatient hospitalization.

Given the percentage of OHP Standard enrollees with incomes below 50 percent of the FPL, the copayment levels were considered by many stakeholders to be prohibitively expensive for this population. Advocates, in particular, argued in favor of restructuring the benefit package so that it would provide only those benefits that are considered most important to OHP Standard enrollees (substance abuse and mental health and pharmaceuticals) in order to significantly lower the cost-sharing burden. This would represent an explicit tradeoff between the scope of the benefit package and enrollee financial contributions. The reasoning seems to be that it would be better to provide a limited, but affordable, set of benefits than broader (yet still

⁵ American Indians and Alaska Natives are exempt from premiums and cost sharing.

⁶ American Indians and Alaska Natives who are members of a federally recognized Indian Tribe or Tribal Organization are exempt from copayments.

minimal), but less affordable coverage. This argument, however, did not get reflected in the final program design.

Additionally, under OHP2, providers obtained the new ability to refuse to provide service to OHP Standard enrollees who are unable to pay copayments. Under federal Medicaid law, providers are not allowed to deny services based on inability to pay. The waiver of this law could have important implications for OHP Standard enrollees ability to access necessary care, particularly those at the lowest incomes.

Delivery System. With the original OHP waiver came the implementation of a mandatory managed care delivery system for all enrollees in counties where managed care is available. The state contracts with health plans on the county level, and until recently, held contracts with fourteen plans to delivery managed care services across all counties. However, a number of plans have dropped out of the program, citing higher-than-expected costs and inability to assume greater risk. This drop in participating plans was also driven by the Legislative Emergency Board's decision during the transition period between the original OHP to the OHP2 to allow plans to not serve the entire OHP population. Although the plans' reimbursement rates are based on a risk assessment that pools Plus and Standard enrollees together, plans are now allowed to retain an OHP2 contract while only serving the Plus population. Thus, the number of remaining plans may be misleading, since a number of them do not serve OHP Standard enrollees.

While the provider pool seems to be experiencing some instability, not all movement among health plans stems directly from the OHP2 waiver. Negotiations between the state and Kaiser Permanente, which dropped out of the program in July 2003 citing losses of almost \$18 million, began prior to the development of the waiver. It made news, however, when it became the fifth commercial health plan to stop taking on new OHP enrollees. To the state's surprise, large commercial plans tended to drop out of the program more than smaller community-based plans following the OHP2 waiver implementation. One example is Providence Health Plan, which cut the number of OHP beneficiaries it covered by more than 80 percent.⁷

With this broadly sweeping managed care system in place, the state was eager to understand how it affected enrollees and their ability to get a medical home, their access to primary and preventive care, and their continuity of care. A study conducted in 2001 found that 11 percent of enrollees left their original plan for another within a year, while 38 percent of enrollees who selected a plan left that plan before the end of 12 months and did not return to the OHP.⁸ Some 42 percent of those who left their initial plan reported that they did so because their health plan left the market. Those who left their plans but stayed in OHP received care on a fee-for-service basis. Overall, only 34 percent of enrollees established eligibility, enrolled in a plan, and stayed in that plan for the entire year. The study concluded that short enrollment in managed care was a source of turbulence for enrollees, and could have a significant impact on an individual's ability to receive care, as well as a provider's ability to establish continuity of care. The report does not distinguish, however, among the different groups covered by OHP.

⁷ www.kaisernetwork.org, September 27, 2002

⁸ Bruce Bayley, et al., "Continuity and Turbulence in an Expanded Medicaid Managed Care Program: The Oregon Health Plan Experience," Funded by the Robert Wood Johnson Foundation, through its Center for Health Care Strategies, in conjunction with the Providence Health System's *Center for Outcomes Research and Education*

Enrollment Process. The OHP Standard enrollment process is the same as it was under the original OHP. Application information can be taken by phone or by mail. Individuals can also enroll at Federally Qualified Health Centers (FQHCs) or at Disproportionate Share Hospitals. Once declared eligible, enrollees have six months of continuous eligibility, contingent upon payment of premiums. Upon receiving their enrollment information, which includes comparative information on each health plan operating in their county, eligibles have 45 days to choose a plan. If they do not choose one by that time period, they are assigned to a plan. They have 30 days after enrolling to switch plans without cause. After that, switching can only be done with cause, and enrollees are locked-in to a plan for six months

FHIAP

FHIAP, which is overseen by the Insurance Pool Governing Board (IPGB), allows individuals and families up to 185 percent of FPL to enroll in private coverage and receive a subsidy to assist in paying the premium. The coverage can be either employer-based or a non-group market product. The percent of the premium subsidy an enrollee receives is based on income.

Until the approval of the OHP2 waiver, FHIAP's income eligibility only went up to 170 percent of FPL, and funding came solely from state appropriations (with tobacco settlement dollars making up a significant portion of those funds), with no federal matching funds. Because resources were so limited, enrollment was also limited. As a result, thousands of eligible applicants were placed on a waiting list every month to gain entry into the program. With the implementation of the OHP2 waiver, the state refinanced the program by beginning to draw down federal Medicaid and SCHIP match funds and raised income eligibility to 185 percent of the FPL. Subsidy levels have not changed.

There were a number of motivating factors behind the state's initial interest in implementing a premium assistance program, but foremost among them were the encouragement of: 1) consumer choice; 2) cost consciousness; and 3) and comparison shopping.⁹ Underlying the decision was the state's desire to provide support to the private insurance market.

The first step toward enrolling in FHIAP is establishing eligibility, via a call to the program's toll-free phone number. If determined eligible, the applicant is placed on a waiting list. As spaces become available, and/or budgetary resources allow for additional enrollment, FHIAP contacts potential eligibles, sends them application materials, which they have 60 days to fill out and return. According to one study, 65 percent of applications mailed to eligibles on the waiting list are not returned or are returned late.¹⁰

FHIAP provides subsidies for both employer-sponsored insurance as well as individual insurance coverage. Eligibles who have access to employer-sponsored insurance (ESI) coverage that is at least partially subsidized by the employer are required to sign up for that coverage in order to receive the FHIAP subsidy. However, if the eligible individual does not have access to ESI, the enrollee can choose a plan in the individual market and receive the state subsidy. OHP Standard applicants are screened for FHIAP eligibility and are required to enroll in the premium assistance program if they have access to ESI coverage.

⁹ Oregon Department of Administrative Services, OHPPR, "Evaluation of the FHIAP, 7/1/98-6/1/99," www.ohppr.state.or.us

¹⁰ Ibid.

The method of subsidy dispersal depends on whether the plan is individual or ESI. For those who are in ESI plans, the FHIAP subsidy is mailed to the enrollee close to the time that the payroll deduction is taken, to avoid cash flow problems. Administratively, the process works because employers do not have to set up a new system to accommodate the FHIAP enrollees. Perhaps an even more important issue, however, is the fact that the process protects employees' privacy. Those enrolled in individual insurance are sent a bill from the third party administrator (TPA) for the family's share of the premium, which is due within ten days of billing. The TPA combines the subsidy payment with the family's share and mails it all together to the health plan.

FHIAP Demographics. A study that looked at FHIAP enrollees over twelve months from 1998 to 1999 found that the program only served approximately 3 percent of Oregonians with incomes below 170 percent of FPL.¹¹ The low enrollment rate, which continued up to 2002, was due to the low level of public resources that the state appropriated for this program. It was originally funded at \$23.4 million, which the state projected would allow them to serve 15,000 to 17,000 uninsured from 1997- 1999. However, in 1998, enrollment had to be reduced due to increased competition for the tobacco settlement revenues and less than anticipated tax collections, both sources of funding for the program's appropriations. At that time, the state capped enrollment at 6,500 to 7,500. In 1999, as the participation rate went up to 5,500, the state had to close the program, with approximately 12,000 individuals on the waiting list. Average wait time was 3-4 weeks.

The FHIAP population, both prior to the OHP2 waiver and currently, is primarily in the lower range of the near-poor population. Almost 90 percent of FHIAP enrollees were below 150% FPL and 60% were below 125% of FPL, which made them eligible for the highest level of premium subsidy of 95 percent. Not only are the subsidies higher for these lower income individuals but they are more likely to not have access to ESI and therefore subscribe to individual insurance plans. Thus, with no employer contribution, the state is essentially buying individual insurance for thousands of uninsured.

Participation rates vary across the state, and are somewhat indicative of where FHIAP outreach efforts have been concentrated. Those efforts initially targeted regions that had both high uninsured rates and high population density. However, in the northeast and southeast, where the uninsured rates are high (14% and 12%, respectively), participation has been markedly low (4% and 3% of uninsured participating, respectively). Only 3.7% of potentially eligible children are enrolled in FHIAP.

Since its implementation, FHIAP enrollees have been disproportionately enrolling in the seven individual insurance plans that participate in the program, versus enrolling through an ESI plan. Approximately 80 percent of FHIAP enrollment at any given time is through the individual market, with the ESI group market representing less than 20 percent of enrollees. This 80 percent also reflects enrollment among FHIAP eligibles in the state's high risk pool, the Oregon Medical Insurance Pool (OMIP), which is an option for FHIAP-eligible individuals who are denied coverage for one of the seven FHIAP-certified individual plans. Some 22 percent of individual coverage enrollees are actually enrolled in OMIP, which is placing a huge strain on the program due to its premiums, which are higher than those for regular individual coverage and are being subsidized at a rate of 70-95 percent (63 percent receive 95 percent subsidization). As part of the recent waiver, the state will give priority to individuals on the FHIAP waiting list who have access to ESI coverage in order to ease the pressure on the

¹¹ Ibid.

program's fiscal stability, as well as to provide support to the ESI market, which was one of the program's original goals.

IMPACT OF THE OHP2 WAIVER ON CHILDLESS ADULTS

Coverage Losses

Enrollment by all categories of OHP eligibles grew steadily between 2001 and February 2003. These enrollment increases correspond with the downturn in the economy, and also provide the context in which the state realized that the size and scope of the original OHP would no longer be economically feasible to maintain. Since February 2003, when beneficiaries were moved to OHP Standard and subject to new and higher premiums and stricter premium payment policies, the state estimates OHP Standard enrollment has dropped by almost half or 50,000 individuals.¹²

While it is impossible to correlate the drop in enrollment directly to the different changes in the program, some state-based researchers and budget analysts are concerned that in addition to the impact of premiums on enrollment, changes in OHP Standard's benefits and cost sharing are having a significant effect on the enrollment rate, as well as the utilization rate of services among those who remain in the program. The confusion resulting from the need to switch from a managed care plan to a fee-for-service system following the decrease in number of health plans available to the OHP Standard population may have also added to the perceived access barriers, and may add to the decline in enrollment.

What remains to be seen is how the drop in enrollment will affect OHP Standard's sustainability. While it is still too early in the program's existence to fully understand the implications of these changes, there are some lessons learned from the original OHP that provide insight into what the OHP Standard changes will mean for the risk level of those who make up the enrollment pool. What is not known, however, is the extent to which costs are being shifted to other parts of the social service and safety net framework due to disenrollment in the program and what those cost shifts will mean for the state and its low-income population.

Many factors can influence enrollment trends, making it difficult to extract the independent impact of changes in benefits, premiums, and cost-sharing. However, given the significance of the changes overall for adults covered by OHP Standard, budget analysts at the Oregon Center for Public Policy argue that following "the adoption of increased fees and a two-tiered benefit structure in 2003, OHP enrollment declined precipitously."¹³ In past years, changes to the benefit package affected all OHP enrollees, so there are no natural experiments through which to examine the impact of a benefit change on one segment of the enrolled population as there is currently. In the case of premiums, however, Health Economics Research (HER) examined the experience the program had when it began imposing premiums on the non-categorical OHP adult population in 1995. The HER study, which combined some quantitative data analysis with focus group interviews, found that the introduction of premiums corresponded with a decline in enrollment, but it does not go so far as to establish a causal relationship between the two events. In fact, the drop in enrollment in the late 1990s may correlate with the nationwide decrease in Medicaid enrollment stemming from both welfare reform and positive economic

¹² Changes in Enrollment of OHP Standard Clients, Oregon Health Policy and Research, January 2004 Research Brief

¹³ Thompson, Jeff, "Recovery Lost: Oregon's Faltering Economy Brings More Bad News for Workers," Oregon Center for Public Policy, 9/1/03.

conditions. However, it is notable, as the researchers found, that the likelihood of recertifying for eligibility was 38 percent lower post-premium implementation than it was pre-premium implementation, and that the elderly, parents, and individuals who received at least one service within their six month enrollment period were the populations most likely to recertify. These findings, overlaid on the current program design, could imply adverse selection problems. This is particularly relevant considering that, through focus group interviews, HER found that enrollees with long-term or chronic health problems were more likely to consider premiums a bargain, while those without immediate health care needs were more likely to view them as excessive.

While data on the health status of the current OHP Standard population is not yet available, it would seem that for some of the lowest-income eligibles, the program has set up a number of barriers that outweigh the benefits, leading to a high drop-out rate.

Cost and Utilization

Soon after the implementation of the original OHP, the state found that the childless adult population had higher medical costs than were originally estimated. It was these higher costs, among other factors, that contributed to the budget deficit the program experienced in 1995, which ultimately led to the implementation of premiums.¹⁴

Although analysts are waiting until there is a full year of utilization and cost data on the OHP Standard population before it assesses the effect the OHP2 waiver has had, an early study by the Oregon Health and Science University's Center for Policy and Research in Emergency Medicine examined use of emergency room services among OHP enrollees, the uninsured, and those with commercial insurance. They found a decrease in emergency room use among OHP beneficiaries and an increase in use among the uninsured. On first glance, it would seem that a decrease in OHP beneficiaries being seen in emergency room is not a negative thing, and the researchers contend that more work has to be done before reaching any conclusions. Through this study, however, they did identify the most common problems that OHP Standard beneficiaries are having as a result of the OHP2 waiver, including:

- Confusion among consumers and providers about the cuts in benefits and changes in cost-sharing rules, resulting in doctors not knowing whether they are allowed to deliver services and consumers not knowing whether those services are available;
- Problems finding primary care providers who will accept OHP coverage; and
- Loss of behavioral health and substance abuse treatment coverage that results in inability to receive necessary treatment, regardless of having OHP coverage.

This last point may be an indicator of why enrollment has decreased since March 2003, when the most severe benefit cuts took place, given the high rate of utilization of these benefits among the childless adult population prior to the OHP2. Anecdotes from stakeholders confirm the study's findings that hospitals are seeing an enormous increase in the number of ER patients, particularly those with methadone and other drug addiction needs. Again anecdotally, these stakeholders estimate that approximately 25 percent of these patients would be eligible or were already enrolled in OHP Standard, but are coming to the emergency room because of the lack of mental health and substance abuse coverage.

¹⁴ Haber, Susan, et al., "Effects of Premiums on Eligibility for the Oregon Health Plan," Health Economics Research, Inc., 5/22/00

While the costs associated with the OHP2 specifically are not yet apparent, it is clear that the benefit cuts and enrollment decreases are having a significant and negative impact on the state's safety net institutions. Several informants believed that the OHP2 waiver could potentially decimate the existing safety net infrastructure for mental health, because of the flood of patients that would be entering and overloading the system due to the cuts. Some informants predicted that costs that would be shifted to other non-public health related pieces of the social service system when mental health and substance abuse were cut. In addition to the mental health infrastructure itself, they foresee ripple effects felt by the judicial system and the forensic medical system, as crime linked to drug usage increases.

Finally, as noted, low primary care provider availability is resulting in an increase in OHP Standard eligibles seeking care in hospital emergency rooms. This increase, combined with the inadequate hospital reimbursement (or uncompensated care reimbursement if the patient has dropped out of OHP Standard), is making hospitals extremely worried about how they will survive.

CONCLUSION AND LESSONS LEARNED

Given the uncertainty of the nation's and of Oregon's economic situations, it may be a long time before the state knows how its original concept for reforming the OHP will affect the health outcomes of low-income individuals. Until that day, however, the current situation --- in which the state is forced to constantly re-engineer a reform program in order to meet budget restrictions --- can serve as its own learning experience.

Beginning in the late 1980's when the discussions first began about the OHP, Oregon made a concerted effort to open up a dialogue among all the state's citizens on their values in regard to health care for the uninsured. Public discourse, facilitated through town hall meetings and other events, gave stakeholders at the state and county levels confidence that citizens would support the state's plans during the original OHP waiver as well as the OHP2 waiver. While some policies, like the prioritized list of benefits, and the shifting of adults into OHP Standard, were not popular, it seems that most are supportive of the state's governing philosophy: cover as many people as possible, even if it means sacrificing some benefits. Stakeholders remarked that despite the cost and efforts involved in assessing citizens' values, the payoff was invaluable.

A more controversial lesson, according to some stakeholders, is to not separate out childless adults from the general coverage population. Of course, Oregon did this in response to the budget crisis that it was facing in Medicaid (even before the general fiscal crisis). However, some informants believed that by doing so, it sent a message that the state does not think all low-income individuals deserve the same level of care. In addition, setting up different programs with different benefits and cost-sharing rules had a negative impact on providers, who, according to anecdotal reports, were having great difficulty keeping up with the changes being made to the program.

Oregon stakeholders recommended that states trying to cover childless adults should do so through Medicaid, because of the federal matching dollars. They remarked that covering these individuals up front, rather than paying for them in the safety net, was a wise investment.

Another item that many informants agreed upon was that the premiums and cost-sharing in OHP Standard were much too high and that they would essentially defeat the purpose of the program. One informant said that states should not finance a coverage expansion "on the backs of the poor." The cost-shifting that appears to be resulting from the high cost-sharing in

OHP2 may be even more painful than the original OHP. In addition to the cost-shifting that is taking place due to high cost-sharing, one informant noted that the state cut presumptive eligibility in order to cut costs, and that that too would just end up shifting costs to other areas of the safety net.

Oregon stakeholders were uniformly in favor of the federal government making the childless adult population a population categorically eligible through Medicaid and were also in favor of basing Medicaid eligibility on income rather than on population-based categories. Granted, the second recommendation might seem contradictory to what is taking place in the state. It does reflect, however, the frustration many stakeholders feel when it comes to having fewer resources than necessary to help a population that is growing in need. In other words, an ideal program would not distinguish among enrollees based on lifestyle, but in a budget crisis some sacrifices had to be made. In addition to the OHP Standard-specific recommendations, stakeholders discussed the need for the federal government to take on more of the cost responsibility for Medicare beneficiaries who were also eligible for full Medicaid benefits, including prescription drugs.

Informants discussed the need for federal support for community-based health plans, which for many rural counties are the only option for OHP enrollees. Ideas for how to provide this support include funding collaborations between hospitals and physicians in order to deliver care more efficiently to underserved communities.

Finally, stakeholders talked about the need for greater flexibility in terms of waiver budget neutrality, whereby the state could include cost-offsets in the safety net system in its calculations of total waiver costs. They also suggested that states be allowed to adjust Medicaid benefits without receiving CMS approval. Finally, they discussed the creation of federal programs that would give states the opportunity to cover non-impooverished medically needy individuals.

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