ASSESSING STATE STRATEGIES FOR HEALTH COVERAGE EXPANSION: CASE STUDIES OF OREGON, RHODE ISLAND, NEW JERSEY, AND GEORGIA

Sharon Silow-Carroll, Emily K. Waldman,
Jack A. Meyer, and Claudia Williams
Economic and Social Research Institute

and

Kimberley Fox and Joel C. Cantor
Center for State Health Policy at Rutgers University

FIELD REPORT

November 2002

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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ACKNOWLEDGMENTS

The authors gratefully acknowledge the support of The Commonwealth Fund. They would like to thank the people with whom they met in each of the states profiled in this report who were generous with their time and provided valuable information about the state coverage programs.

About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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Rutgers Center for State Health Policy (CSHP) informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation. CSHP provides impartial policy analysis, research, training, facilitation, and consultation on important state health policy issues. Established in 1999, the Center is the newest research unit within the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, New Brunswick, New Jersey.

ABOUT THE AUTHORS

Sharon Silow-Carroll, M.B.A., M.S.W., is a senior research manager at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects include: assessing state and local efforts to promote employment-based insurance; analyzing potential consequences of Internet-based tools for purchasing health insurance; reviewing community-based efforts to reduce financial and non-financial barriers to care; and developing a comprehensive strategy for expanding access to health care for at-risk populations. She is the author of an ESRI book analyzing the corporate/employer role in providing health care coverage to workers and families from economic, social, and cultural perspectives. She has also authored numerous reports and articles analyzing public- and private-sector initiatives aimed at enhancing access, containing costs, and improving quality of health care. Ms. Silow-Carroll received a master's degree in business administration from the Wharton School, University of Pennsylvania, and a master's degree in social work from the University of Pennsylvania School of Social Work.

Emily K. Waldman, M.H.S., is a senior policy analyst at ESRI. Most recently, Ms. Waldman has researched state and local initiatives to expand health coverage for the working uninsured. She also has evaluated public- and private-sector strategies to improve access to health insurance coverage and health care delivery for the District of Columbia Mayor's Health Care Systems Development Commission. Ms. Waldman also has conducted policy research and analysis on the issues confronting urban safety net institutions and academic medical centers, as well as studied the implications of managed care programs for people dually eligible for Medicare and Medicaid. Ms. Waldman received a master's degree in health sciences from the Johns Hopkins University School of Hygiene and Public Health.

Jack A. Meyer, Ph.D., is the founder and president of ESRI. Dr. Meyer has conducted policy analysis and directed research on health care access issues for several major foundations as well as federal and state government. He has led projects on community-wide reforms covering all regions of the U.S. Many of these projects have highlighted new strategies for overcoming barriers to health care access and innovative designs for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty. Dr. Meyer has also directed recent studies on building quality improvements into employer purchasing, Medicaid managed care for people with disabilities, the State Children's Health Insurance Program to extend coverage to lower-income children, and assessments of reform proposals to extend health coverage to

workers in small firms. Dr. Meyer received a Ph.D. in economics from Ohio State University.

Claudia Williams, M.S., is president of AZA Consulting. She has research and policy development expertise on issues ranging from health coverage reform to Medicaid and CHIP policy and community health assessment. Prior to founding AZA Consulting, Ms. Williams worked as a senior policy analyst in the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, where she co-led the development of the congressionally mandated CHIP evaluation, and as a senior manager at The Lewin Group.

Kimberley Fox, M.P.A., is a senior policy analyst at the Center for State Health Policy at Rutgers, where she currently directs projects related to pharmacy coverage, health insurance and access to care, and health care performance measurement. Prior to coming to CSHP, Ms. Fox was a senior research associate at Baruch College School of Public Affairs. She has extensive experience in health policy research and planning for at-risk populations, having worked as deputy director of planning at HIV CARE Services division of Medical and Health Research Association, deputy director of policy research at the Center on Addiction and Substance Abuse, and senior research analyst at the United Hospital Fund of New York City. Ms. Fox received her master's degree in public administration from the Maxwell School of Public Citizenship in 1986.

Joel C. Cantor, Sc.D., is the director of the Center for State Health Policy and professor of public policy at the Edward J. Bloustein School of Planning and Public Policy at Rutgers. Dr. Cantor's research focuses on issues of health care financing and delivery at the state and local levels. His recent work includes studies of the effect of health care market competition on access to care, the organization of the health care safety net for the uninsured, and the role of minority physicians in improving access to care of underserved populations. Dr. Cantor has published widely on health policy topics and serves on the editorial board of the policy journal *Inquiry*. Prior to joining the faculty at Rutgers, Dr. Cantor served as director of research at the United Hospital Fund of New York and director of evaluation research at the Robert Wood Johnson Foundation. He received his doctorate in health policy and management from the Johns Hopkins University School of Hygiene and Public Health in 1988, and was elected a fellow of the Academy for Health Services Research and Health Policy in 1996.

CONTACT INFORMATION FOR CASE STUDY STATES

Oregon

John Santa, M.D.
Administrator
Office for Oregon Health Plan Policy and Research
Telephone: 503/378-2422 ext. 401
E-mail: john.santa@state.or.us

Rhode Island

Tricia Leddy
Administrator
Center for Child and Family Health
Rhode Island Department of Human Services
Telephone: 401/462-2127
E-mail: tricial@gw.dhs.state.ri.us

New Jersey

Kimberley Fox
Senior Policy Analyst
Center for State Health Policy
Rutgers, The State University of New Jersey
Telephone: 732/932-3105 ext. 235
E-mail: kfox@cshp.rutgers.edu

Georgia

Sean Cucchi
Chief
Office of Planning and Fiscal Policy
Georgia Department of Community Health
Telephone: 404/656-0655
E-mail: scucchi@dch.state.ga.us

CASE STUDIES

OREGON

The objective in studying Oregon was to identify the factors that led to the successful implementation of the Oregon Health Plan, a program that uses Medicaid and CHIP funding to cover low-income Oregonians. Other state programs that have contributed to the reduction in the uninsured were examined as well, including the Family Health Insurance Assistance Program (a state-only program providing access to private insurance coverage), the Oregon Medical Insurance Pool (the state high-risk pool), and the Insurance Pool Governing Board (which helps small businesses and the self-employed gain access to coverage). This case study looks at some of the issues that Oregon faced as the state sought to provide a basic level of benefits to a large segment of their low-income population and how they chose to address those issues.

Summary

Oregon has long been a leader in state health reform, as evidenced by the development and implementation of a broad range of public- and private-sector coverage expansion initiatives over the last decade. Oregon's approach to broadening health coverage is built on the premise that it is better for a larger number of lower-income people to have good—though not necessarily the most comprehensive—health coverage than for a smaller number of people to have the best possible coverage. Trimming the benefit package and relying on managed care freed up resources to assist more of the population in need. Also, Oregon has several coverage initiatives that address different segments of the uninsured population, and those efforts include both public and private initiatives. Finally, with new opportunities for federal flexibility around the Medicaid benefit package for optional populations, Oregon's approach to its priority list of services and the development of its basic benefit package offers an interesting option that other states may wish to study and/or pursue (Table 1).

The cornerstone of Oregon's approach has been the Oregon Health Plan (OHP). This plan initially featured an extension of Medicaid to all state residents with incomes below the federal poverty level (FPL), with coverage extended to 133 percent of the FPL for children under the age of six and pregnant women. Pregnant women and their newborns between 133 and 170 percent of the FPL are now also covered. The next piece involved the 1998 implementation of a Medicaid look-alike State Children's Health Insurance Program (CHIP), which used the OHP infrastructure. CHIP was implemented to cover children from birth to six years old between 133 and 170 percent of the FPL and children from six to 19 years old between 100 and 170 percent of the FPL. The Family

Health Insurance Assistance Program (FHIAP) was implemented in 1998 with sliding-scale state-only subsidies to allow people with incomes up to 170 percent of the FPL to gain access to private insurance coverage outside OHP. These programs, along with a strong economy in the late 1990s, have contributed to a substantial reduction in the number of uninsured, from 16.4 percent in 1990 to 12.3 percent in 2000.[2]

Table 1. Oregon State Profile and Overview, 1999–2000

Oregon	Number
Total population	3,404,950
Nonelderly population (under 65)	3,004,320
Total population under 100% FPL	524,270
Total population under 200% FPL	1,096,000
Insurance status of nonelderly under 100% FPL	
Employer-sponsored coverage	93,294
Medicaid	187,214
Uninsured	169,623
Percent of all uninsured	36%
Insurance status of nonelderly under 200% FPL	
Employer-sponsored coverage	291,157
Medicaid	281,633
Uninsured	322,916
Percent of all uninsured	69%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

The underlying philosophy of the Oregon Health Plan is that all Oregonians should have access to a basic level of benefits and there should be equitable and appropriate utilization of services. To achieve this, the state took a comprehensive view and developed a multi-pronged approach to expanding access to different vulnerable populations. In addition to the Medicaid expansion that covered many poor and near-poor people, Oregon established a high-risk pool (Oregon Medical Insurance Pool) and provided small businesses with access to coverage (Insurance Pool Governing Board).[3] In order to fund the Medicaid expansion, Oregon received a federal 1115 waiver to extend coverage to the non-categorically eligible groups and enable the state to limit the benefit package and introduce managed care (Table 2).

[2] Oregon Office of Health Plan Policy and Research, *Oregon HRSA State Planning Grant Final Report to the Secretary,* October 2001. These numbers are from the Oregon Population Survey; to see how these numbers compare with the Current Population Survey, see Oregon Office of Health Plan Policy and Research, *Varying Rates of Uninsurance Among Oregonians: A Critical Comparison of Two Household Surveys,* October 2000.

[3] An employer mandate was also passed by the state legislature in 1989 but enabling legislation was not passed in time by the U.S. Congress so the state employer mandate never became law.

Table 2. Oregon Public Program Enrollment

Oregon	Number
Total enrolled in Medicaid/Oregon Health Plan (as of 12/01)	367,069
Total enrolled in CHIP (as of 12/01)	18,070
Total enrolled in Family Health Insurance Assistance Program (as of 3/02)	3,795
Total enrolled in Oregon Medical Insurance Pool (as of 10/01)	7,918

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers; www.cbs.state.or.us/external/omip for OMIP enrollment figures.

Several factors have contributed to the successful implementation of the Oregon Health Plan. First, publicity surrounding the death of a Medicaid-eligible boy who could not obtain an organ transplant because it was not a covered Medicaid service focused public attention on the provision of Medicaid services. Strong leadership in the state senate and later the governor's office helped garner support for a plan based on clearly defined goals and a clearly articulated philosophy. Stakeholder input contributed to the development of a prioritized list of services, a fundamental component of OHP. Growth of managed care capacity beyond the Portland–Salem metropolitan area helped in the implementation of OHP. Finally, FHIAP was successful because it allowed the whole family to be covered by one insurance plan, and it was structured as a public–private partnership supporting the employer-based system and did not carry a public program stigma.

Oregon encountered challenges in implementing OHP. The state has struggled with provider reimbursement, maintenance of its managed care capacity, and retention of support of the business community. FHIAP has a long waiting list for enrollment and has had difficulty attracting enrollees with access to employer-sponsored coverage.

Despite these challenges, Oregon is still committed to expanding coverage. Now, however, like many other states, they are facing a fiscal crisis. As of October 2001, Oregon's general fund revenues were down 9 percent compared with the September 2000 forecast, and personal and corporate income tax collections were down sharply compared with budgeted levels.[4] One of the largest components of the Oregon state budget is devoted to OHP, and the state believes that existing cost-containment mechanisms (managed care and benefit package limitations) are less effective than they were when OHP began. Compounding state budget issues are concerns about rapidly rising health care costs, particularly for prescription drugs. As a result, Oregon is being forced to find ways to contain, or even lower, costs within OHP.

As of winter 2001, state policymakers, at the urging of the governor, had chosen to reduce costs by coupling a coverage expansion with a reduction in benefits for certain

[4] National Conference of State Legislatures. *State Fiscal Outlook for FY 2002: October Update*. October 2001.

populations. The idea was that savings generated from the benefit reduction would allow Oregon to expand coverage to everyone under 185 percent of the FPL. In a sense, this was a step away from Oregon's commitment as embodied in OHP to cover people solely on the basis of income. Under the new plan, people with similar incomes but different family status would have different benefits. However, the state believed this was the most viable way of ensuring the long-term survival of OHP. At the end of May 2002, the state submitted waiver applications that, if approved and implemented, would expand coverage to an additional 65,000 people. Further details about the waivers are presented below.

The following case study presents the basic history of the Oregon Health Plan, outlines some of the successful components and obstacles in Oregon's strategy, and explains Oregon's approach to its latest coverage initiative.

History of Expansion Strategy

One of the first events that precipitated the development of OHP was publicity surrounding the death of a seven-year-old boy, Coby Howard. Coby Howard had acute lymphocytic leukemia and needed a bone marrow transplant. In response to rapidly increasing Medicaid costs, driven in part by the increasing number of organ transplants, the state legislature had decided to stop Medicaid coverage of such transplants. Coby Howard was unable to get a transplant and subsequently died. His death focused public attention on the pressing question of how best to allocate resources within a limited Medicaid budget.

John Kitzhaber, an emergency room physician and president of the Oregon senate, saw this as an opportunity to address the problem of lack of insurance coverage, particularly among low-income populations. He also saw this as a way to address problems created by a Medicaid benefit package that covered some less-effective treatments for minor conditions while denying potentially life-saving therapies. To explore options, Kitzhaber brought together stakeholders for discussion about how to address the dual problems of uninsurance and misallocation of health care resources. OHP and the concept of a prioritized list of health services resulted from those discussions.

The Oregon Health Plan

Several underlying principles have guided the development of OHP.[5] The first principle is that eligibility for public coverage should be based on financial need rather than on federally mandated eligibility categories such as family status. To that end, OHP covers all

[5] These have been outlined by Governor John Kitzhaber in various speeches. For example, see "Summit on the Oregon Health Plan," Eugene, Oregon, September 13, 2000 (www.governor.state.or.us/governor/speeches/s001013.html).

adults up to 100 percent of the FPL, regardless of family status. The second principle is that, because the public dollars that can be spent on health care are limited, these resources need to be rationally, equitably, and thoughtfully allocated. As a result, Oregon has developed a "priority list" of services and only covers services above a specified line, which can be moved up or down depending on available resources.[6] One important aspect of the prioritized list is the emphasis on primary and preventive care.

The third principle guiding the development of OHP is public accountability for the development of the prioritized list, determination of where to draw the line in coverage, and explicit reasons for both. Therefore, the Health Services Commission (HSC) develops the priority list and the state legislature "draws the line" that determines the benefit package.

Although legislation authorizing the development of OHP passed in 1989, the HSC did not develop the prioritized list and present it to the legislature until 1991. In August 1992, Oregon submitted a Section 1115 waiver to the federal government. The request was turned down by the Department of Health and Human Services on the basis of the Americans with Disabilities Act, because disability advocates did not believe the process or the list sufficiently took their concerns into consideration. The idea of Oregon's prioritized list also generated national controversy. Many interpreted the list as "rationing" care for low-income people. The Department of Health and Human Services approved the waiver in 1993 and OHP was implemented in 1994. When CHIP was passed by Congress in 1997, Oregon submitted a Title XXI state plan to place the newly eligible children into OHP. The Office of Medical Assistance Programs administers OHP for the state.

Family Health Insurance Assistance Program

The Family Health Insurance Assistance Program (FHIAP), a subsidy program that helps low- and moderate-income individuals purchase private individual or employer-based coverage, functions alongside OHP. It seeks to encourage participation in the private market and leverage employer dollars that are already being spent on health care. It also provides a mechanism for people leaving OHP to access coverage and maintain continuity of care, although this goal has been somewhat frustrated by the program's long waiting list. Therefore, although the program is run separately from OHP, it is a critical part of the state's overall strategy of covering the uninsured.

[6] Initially, the list was to have been used both for the Medicaid benefit package and to define a benefit package for the employer mandate.

FHIAP emerged from a 1996 ballot initiative that increased the state tobacco tax to raise money for tobacco cessation and OHP. Rather than use the money to shore up existing OHP coverage, the state decided to expand coverage through private market mechanisms. One of the primary barriers preventing low-income people from obtaining private coverage (either through their employer or through the individual market) was the high level of workers' contributions to monthly premiums. In 1996 and 1997, policymakers worked with stakeholders to develop FHIAP, a state-funded public–private partnership that would provide public subsidies toward the purchase of private health insurance.

FHIAP offers state subsidies to people with incomes below 170 percent of the FPL. The subsidies pay between 70 and 95 percent of the worker's share of the premium cost for employer-sponsored plans or non-group coverage purchased in the private market. If the employer offers coverage and pays some portion of the premium, the employee must enroll in his or her employer's plan to receive the FHIAP subsidy. Once the employee has been accepted into FHIAP, he or she must fill out an employer verification form that indicates the employer's contribution amount and the employee's share of the premium. The employer deducts the full amount of the employee's share of the premium through a payroll deduction, and the employee must send in the pay stub each month to show the deduction and be eligible to receive the premium subsidy. To ensure that the employee does not have cash-flow problems because of premium withholding, FHIAP sends the first subsidy payment out as soon as the employer verification form is received and before the first premium amount is withheld.

If the employer does not offer coverage or contribute to the premium, the employee may sign up for a private plan offered by one of the carriers participating in FHIAP, including the Oregon Medical Insurance Pool (OMIP), if the employee cannot obtain commercial insurance. Nonworking FHIAP-eligible individuals may also sign up for one of these plans or enroll in OMIP. Once enrolled, FHIAP pays the insurance carrier directly for the full cost of the premium and the enrollee pays FHIAP for his or her share of the premium. Most FHIAP participants (about 85 percent) are enrolled in individual insurance, including OMIP. Although the state believes that FHIAP has demonstrated it can work well for employer-sponsored coverage, it is important to note that employer coverage is only a small portion of FHIAP at present. Whether enrolled in employer-sponsored coverage or through the individual market, all dependent children must be covered by some form of health insurance before the adults in the family are eligible for the FHIAP subsidy.

Table 3. Oregon Current Major Access Programs (OHP, FHIAP)

Program aspect	Medicaid (OHP)	CHIP (OHP)	FHIAP
Waivers/legislation required	Section 1115 waiver	Title XXI state plan	Passed by state legislature July 1997
Time frame	March 1993 waiver approved February 1994 began enrollment	June 1998 CHIP plan approved	July 1998 began enrollment

Enrollment	Total enrolled: 367,069
	Enrolled in fully capitated health plans: 234,939
	(as of December 1, 2001)
		Total enrolled: 18,070
		Enrolled in fully capitated health plans: 12,715
		(as of December 1, 2001)
			• 3,795 enrolled
			  • 2,212 in individual coverage
			  • 985 in OMIP
			  • 598 in employer-sponsored
			• 12 approved for enrollment
			• 26,406 on reservation list
			(as of March 19, 2002)

Eligibility criteria	• Oregonians < 100% FPL • Children birth to 6 < 133% FPL • Pregnant women < 133% FPL • Pregnant women and their newborns between 133% and 170% FPL	• Children birth to 6 between 133% and 170% FPL • Children 6–19 between 100% and 170% FPL	• Oregon resident • U.S. citizen or legal noncitizen • No health insurance for past 6 months (unless coming from OHP) • Income < 170% FPL • Assets/savings < $10,000 • All eligible children must have coverage before adults get subsidy • Not Medicare-eligible
Benefits/subsidies	Comprehensive inpatient and outpatient benefits Sliding-scale premium for adult, nonpregnant "expansion" eligibles	Comprehensive inpatient and outpatient benefit package (same as Medicaid) No enrollee premiums	Sliding-scale subsidy of private insurance premium cost • Income < 126% FPL—95% • 126% to 150% FPL—90% • 151% to 170% FPL—70% Commercially available benefit packages
Financing	Federal share: 59.20% State share: 40.80% Member premiums as noted above	Federal share: 71.44% State share: 28.56%	State-only program

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers.

Other Access Programs

Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (OMIP), a high-risk pool, is part of OHP and was established by the state legislature in 1987.[7] The goal of OMIP is to provide insurance coverage for all Oregonians, including FHIAP enrollees, who are unable to obtain health coverage because of medical conditions. OMIP also provides health coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them. As of October 2001, there were 7,918 total OMIP enrollees; about 80 percent of them were enrolled in OMIP for medical reasons and the remaining 20 percent were enrolled for portability reasons. OMIP is subsidized through an assessment on insurers and reinsurers; the premium is capped at 125 percent of the premium for a comparable commercial plan for enrollees eligible for medical reasons, and at 100 percent for enrollees eligible for portability reasons. Regence Blue Cross Blue Shield of Oregon administers OMIP.

Insurance Pool Governing Board

The Insurance Pool Governing Board (IPGB), also created by the state legislature in 1987, is a small state agency that helps Oregonians obtain health coverage.[8] In 1989, the IPGB began certifying low-cost health insurance plans for small businesses and the self-employed. However, as small businesses began to find plans in the small employer health insurance market that fit their needs, the need for these IPGB-certified specialized plans decreased. As a result, the IPGB stopped certifying plans in 1999 and now concentrates on helping small businesses and the self-employed obtain coverage for themselves, their employees, and their employees' dependents. For example, the IPGB runs an agent referral program that links small businesses interested in purchasing health insurance with local brokers who can help them find affordable coverage that matches their insurance needs. IPGB also provides training for agents and community partners about the Oregon health insurance market and about health insurance legislation. In addition, IPGB conducts outreach and marketing regarding the importance of having health coverage.

Small-Market Reforms

The final component of OHP is a series of small-market reforms enacted by the state legislature in 1993 and 1995 and implemented for the most part by 1996. These laws include provisions for guaranteed-issue and renewability, preexisting condition clause restrictions, minimum benefit package requirements, modified community rating,

[7] For more information, see www.cbs.state.or.us/external/omip.
[8] For more information, see www.ipgb.state.or.us.

portability requirements, and the extension of small employer reforms to the individual market.[9]

Elements that Facilitated Development: Oregon Health Plan

Importance of Publicity in Spurring Action

The death of Coby Howard was instrumental in focusing attention on the provision of health care within the Medicaid program. More important to long-term change, however, was that the public discussion moved beyond a simple question of whether organ transplants should be covered by Medicaid to a drive for an overall improvement of the health care system in Oregon. This eventually led to the passage of OHP.

Program Champion

When serious reform debate began in 1987, John Kitzhaber was president of the state senate in a legislature where the Democrats controlled both chambers. His leadership and support of the program was instrumental in passing OHP. In 1994, Kitzhaber ran for governor just as the program was being implemented, and his role in developing OHP greatly contributed to the success of his campaign. As governor, he spent much time and energy working with the media to encourage support of OHP and was the most vocal champion of the program. He has served as governor since 1994 and is scheduled to leave office in January 2003. One of the reasons that policymakers are working so hard to strengthen OHP now is a fear that, when Governor Kitzhaber leaves office, there will be less support in the governor's office to ensure that the overall health reform program can survive the downturn in state revenues.

Clearly Defined Goal and Strong Local Support

From the beginning, OHP has had a clearly articulated philosophy: more people should have some level of basic coverage instead of a smaller number of people having a very generous benefit package. Therefore, the result of OHP has been to move some resources from those who have been determined by federal legislation to be "more entitled" to those who are "less entitled," but—in the eyes of the state—equally in need of assistance. Drawing the line initially at 100 percent of the FPL was somewhat arbitrary, and the state has planned to continue to expand coverage up the income scale, introducing sliding-scale premium contributions as appropriate.

The overt statement of purpose behind OHP has made it easier to gather support. While much of the rest of the country was critical of Oregon's attempt to "ration care"

[9] *The Oregon Health Plan and Oregon's Health Care Market,* a report to the 71st Legislative Assembly. Prepared by the Office for Oregon Health Plan Policy and Research, August 2000.

for the poor, the state's policymakers pulled together in defense of their strategy. In addition, many people were able to voice their concerns and many of those concerns were addressed as the plan was developed. Oregon has a relatively small population, making it possible for state policymakers to elicit opinions from their constituents.

The Prioritized List and Stakeholder Input

In the development of both the prioritized list and OHP, the inclusion of stakeholders was viewed by the state as a key ingredient in the successful implementation of the plan. To obtain stakeholder input, between January and March 1990, a group called Oregon Health Decisions conducted a series of community meetings on behalf of the HSC. A total of 47 meetings were held across the state, with a combined attendance of 1,048. Of those who attended, 9.4 percent were uninsured, 4.4 percent were Medicaid recipients, and 69.2 percent were health care workers. The process resulted in a list of 13 values (e.g., prevention, quality of life, effectiveness of treatment) that were forwarded to the HSC for consideration in prioritizing health services. The HSC used these values to construct and prioritize the 17 categories of care that, along with health outcomes information gathered from the literature and health care providers, determined the ordering of the May 1991 prioritized list of health services. As subsequent issues related to OHP have arisen, the infrastructure for community input created for OHP has served as a forum that can be used to discuss changes to the plan.

As other states explore the possibility of participating in the new Health Insurance Flexibility and Accountability demonstration initiative, they may look to Oregon's experience with the prioritized list as a model. Only certain aspects of Oregon's approach may be relevant to other states, however. Interviewees believed that Oregon's approach to covering the uninsured and the prioritized list reflect particular public values in Oregon. Other states could not take the list as developed by Oregon and implement it as is; the process of developing the list appears to be as important as the list itself.

Development of Managed Care

The implementation of OHP catalyzed managed care in Oregon as plans came together to serve the Medicaid population. Some managed care plans offered better coverage for certain services (e.g., adult dental health) under OHP than under traditional Medicaid plans. Managed care was phased in, first with the Aid to Families with Dependent Children (now Temporary Assistance for Needy Families) population and the noncategorically eligible population (e.g., those who qualified for OHP based solely on income). After the first year, the elderly, blind, and disabled populations and foster children were added. Again, the state worked with advocates, hoping to ensure that the transition to managed care for these special populations was smooth.

Elements that Facilitated Development: Family Health Insurance Assistance Program

As described earlier, FHIAP offers low-income individuals subsidies to help pay either a portion of a worker's share of the premium for employer-sponsored plans or coverage purchased in the private market or through OMIP.

Public–Private Partnership Supporting the Employer-Based System

Although FHIAP was developed later and covers far fewer people than OHP, FHIAP has become an important model for other states looking for ways to build up private, employer-based, or individual coverage. The public–private partnership aspect of FHIAP and the idea that it was supporting the employer-based system made FHIAP politically appealing. Another selling point was that the program does not require the employer to get involved in administering the subsidy. Employers deduct the full amount of the employee's share of the premium through a payroll deduction, as they would for any other employee, and the FHIAP-subsidized enrollee is reimbursed directly by the state for his/her share of the premium. Finally, having a third-party (nongovernmental) administrator was a big selling point in FHIAP's early stages, before the Insurance Pool Governing Board assumed administration of the program.

Family Covered Together

Another popular aspect of FHIAP is its subsidizing of family coverage through a single insurer. For adults to be eligible for the premium subsidy, all children in the household must also be covered (either through OHP or FHIAP). There is no wraparound coverage in FHIAP, so that the OHP benefit package is generally more generous than a FHIAP plan.[10] Yet, many parents want to enroll themselves and their children in FHIAP so that the entire family is covered by the same insurer. Currently, about one-third of FHIAP enrollees are children and about one-fifth are Medicaid-eligible. In addition to providing family coverage, FHIAP offers a choice of plans to those purchasing in the individual insurance market and can offer plans with different delivery systems and different incentives and disincentives for seeking various kinds of care. These aspects of FHIAP can result in better access to care than would be available through a Medicaid plan.

Not a "Public Program"

According to program administrators, FHIAP enrollees appreciate that they are not enrolled in an overtly public program and do not have a Medicaid card. Thus, no one knows that they are receiving a state subsidy. As noted above, many people enrolled in

[10] In fact, one reason that the FHIAP program is not eligible for a federal match is because the state does not want to add wraparound coverage to the program.

FHIAP are eligible for OHP. Their choice of a plan with less generous benefits and higher copayments shows the appeal of FHIAP and may reflect enrollees' desire to distance themselves from public programs. As changes are made to FHIAP, state policymakers recognize the need to maintain an identity for FHIAP distinct from that of Medicaid.

Obstacles and Issues: Oregon Health Plan

Provider Reimbursement Issues

Some principles were envisioned originally as part of OHP but not incorporated fully into the plan. For example, the state made an initial commitment to pay providers fairly and to avoid shifting costs to providers as a way of balancing the budget. For a variety of reasons, following through on this principle has become increasingly difficult as the plan has grown. The general feeling is now that physicians are not being paid fairly and that payments cannot be further reduced. Hospitals appear to be doing better than physicians, but still claim to be losing money on Medicaid patients. There are some physician reimbursement issues, but physicians generally tend to support OHP because it has increased access to care for many patients. OHP also means that, while there is less reimbursement for some patients, there are more patients with at least some degree of coverage.

Business Case

To gain support for OHP within the business community, the state presented the program in terms of an "investment" that would lead to financial benefits. The state argued that OHP would leverage federal funds to finance care for the poor and medically needy rather than just shift costs to private payers. However, businesses did not experience actual reductions in private insurance premiums. As a result, businesses may be wary of supporting new public coverage expansions, although a state purchaser coalition still supports the concept of OHP.

Managed Care Issues

Although OHP further encouraged the development of managed care in Oregon (particularly in expanding managed care outside the Portland/Salem area), at least initially, the delivery system relied too heavily on the willingness of managed care companies to expand outside metropolitan areas. Managed care plans did at first expand across the state, but they soon started to pull out of less-populated areas. Initially, managed care rates paid by the state for OHP members were set based on cost, and that policy helped ensure plan participation. However, over time, plans have begun to conclude that reimbursement rates are no longer sufficient because of the rising costs of providing care. This has contributed to the withdrawal of several plans from OHP. For example, Regence Blue Cross Blue Shield withdrew in May 2001, Kaiser has only limited enrollment, and Providence withdrew for a period, although they now are preparing to reenter OHP.

CareOregon has now absorbed many OHP patients who were enrolled in the other plans, particularly in the Portland/Salem area. CareOregon, a fully capitated managed care plan, began in 1994 as a collaborative partnership between the Multnomah County Health Department, Oregon Health Sciences University, the Clackamas County Health Department, and private nonprofit community and migrant health centers across Oregon. Initially, the Multnomah County Health Department administered the plan, but since 1997, CareOregon has operated as an independent nonprofit organization. Although state policymakers originally thought that the need for CareOregon would disappear as commercial plans developed Medicaid managed care capacity, CareOregon has grown as other plans have pulled out and has developed a collaborative relationship with the state. In addition to CareOregon, the state relies heavily on locally organized and locally controlled Independent Physician Associations (IPAs), and more and more physicians are forming IPAs to meet the increasing demand. In addition, commercial plans do still participate in OHP, although in a more limited way than they did initially.

Employer Mandate

When OHP was first conceived in the late 1980s, it included an employers' mandate to provide health coverage to their workers. At that time, the primary focus was on large- and medium-sized employer groups. However, by the time Oregon had received a federal waiver and set out to implement the plan, the focus had shifted to smaller employers who were concerned about the prospect of an employer mandate. There were also concerns that the mandate would violate the federal Employee Retirement Income Security Act (ERISA).[11] The composition of the state legislature had also changed. The house was now controlled by Republicans, the Democrats had only a narrow margin in the senate, and, perhaps most important, John Kitzhaber was no longer president of the senate. President Clinton's health plan was also on the horizon. The legislature decided to delay implementation of the employer mandate until 1996 and make it contingent on obtaining a waiver from the federal ERISA laws. When the state failed to obtain the exemption, the employer mandate was subject to a sunset provision.

Although the employer mandate was never implemented, there was still support for employers voluntarily providing access to coverage. Small businesses were resistant to the mandate, but appreciated the willingness of the state to help their employees afford coverage. Out of this, in part, came FHIAP.

[11] ERISA, enacted in 1974 to protect workers' pensions, gave employers the right to self-insure and be free of state insurance regulations.

Obstacles and Issues: Family Health Insurance Assistance Program

Waiting List

One of the critical distinctions between OHP and FHIAP is that, because FHIAP is entirely state-funded and there is limited money available, FHIAP is a "capped" program and can only provide subsidies for a limited number of people. (OHP is now an entitlement program that covers anyone who is eligible.) Because of the program's popularity, over 26,000 people were on the FHIAP waiting list as of March 2002. Although marketing of the program ended in 1998 because of the large demand, the state still receives between 1,000 and 1,500 applications per month.

In addition to being unable to meet demand and leaving people without coverage, the long waiting list means that FHIAP cannot be a vehicle to provide continuous coverage for people leaving OHP. When FHIAP was initially conceived, it was intended to provide a smooth transition for people who lose their OHP eligibility, allowing them to maintain continuous coverage. Although people generally must be uninsured for six months before they can apply for FHIAP, this waiting period is waived for those who have been enrolled in OHP. When OHP enrollees are about to lose eligibility, they receive a letter notifying them of their change in status and telling them about FHIAP. However, when they sign up for FHIAP, on average, there is about a 12-month waiting period before people who apply can enroll.

Market Split

FHIAP has been struggling to attract enrollees who have access to employer-sponsored coverage. One FHIAP requirement is that, if an applicant is offered employer coverage with the employer contributing some portion of the premium cost, the applicant must participate in that coverage to be eligible for the subsidy. Thus, subsidizing people who have access to employer-sponsored insurance is more cost-effective than covering those without such coverage. However, about 85 percent of FHIAP enrollees purchase coverage in the individual market and only about 15 percent have state-subsidized employer-sponsored coverage.

Family Health Insurance Program/Oregon Medical Insurance Pool Enrollees

Another issue facing FHIAP is that about one-quarter of FHIAP enrollees are enrolled in OMIP. These enrollees are high-risk individuals who are unable to obtain insurance in the private market and who use their FHIAP subsidy to participate in an OMIP plan. Because insurers subsidize the high-risk pool through an insurer assessment and pay based on a certain number of enrollees, their assessment increases as more individuals are enrolled in OMIP. As a result, insurers believe the state is shirking its responsibility to high-risk

FHIAP enrollees and forcing the private sector to absorb some of that cost of care, which insurers believe should be wholly covered by the state. This situation has created insurance industry opposition to further expansion of FHIAP.

Looking Ahead: A New Approach

The Oregon Health Plan—Current Initiative

Oregon is now in a bind. State policymakers have committed philosophically to covering people based on income and have developed a process to do so using the prioritized list, which they initially believed could be used as a tool to control costs. However, the federal government has been reluctant to allow the state to reduce the benefit package. As a result, Oregon believes that using a prioritized list has ceased to be a meaningful way to control costs in the current OHP. It also appears, in light of the state's current fiscal situation, that OHP is not sustainable in its current form. In response, the legislature passed House Bill 2519 in the 2001 legislative session. House Bill 2519 outlines several major changes to OHP that would expand coverage to more people but reduce the benefit package for certain groups to generate savings to fund that coverage expansion and to ensure the long-term survival of OHP. To implement these changes, in May 2002 the state submitted an amendment to their current Section 1115 waiver as well as a Health Insurance Flexibility and Accountability (HIFA) waiver application.

Because federal law has less flexibility regarding the federally mandated eligibility categories (pregnant women, children, elderly, blind, and disabled populations), the new waiver applications divide the current OHP population into several subgroups (Table 4). Categorically eligible populations will now be enrolled in OHP Plus and retain the same set of benefits that they currently have. All adults who qualified for OHP on the basis of income only will be switched into OHP Standard, which has a less generous benefit package. Oregon estimates that about 130,000 current OHP enrollees—nondisabled adults—will be switched from OHP to OHP Standard. In addition, the waivers expand coverage in OHP Standard to people with incomes between 100 percent and 185 percent of the FPL. The state is estimating that an additional 65,000 people will be newly eligible for coverage under the two waivers when they are fully implemented.

Oregon wants OHP Standard to be similar to private commercial plans. As expected, the discussions about which services should be in the benefit package have been lively. The benefit package outlined in the waivers introduces varied levels of copayments and coinsurance intended to encourage primary and preventive care and to discourage the inappropriate use of other services. In addition, there will be some reductions in covered services, such as nonemergency transport. The state is also trying to encourage more

effective treatments and is covering potentially expensive regular costs (for example, introducing lower copayments in OHP Standard for recurrent durable medical equipment costs such as oxygen or diabetic supplies than for one-time expenses such as crutches). Part of the state's philosophy is to focus OHP Standard on "access promotion" rather than "asset protection." Access promotion would structure the coverage to encourage the use of primary and preventive care services, rather than protect the enrollees' assets in the case of severe illness or a catastrophic event.

Policymakers in Oregon worked with stakeholders to determine where the line should be drawn for the OHP Standard benefit package. They estimated that the actuarial value of the OHP Standard package should be equivalent to about 78 percent of the actuarial value of OHP Plus. The waiver steering committee recommended where to draw the line, with final approval needed from the emergency board (a representative group from the legislature). Following this step, the state has submitted two federal waiver requests to allow them to implement the plan. Under these waivers, in addition to the changes to OHP, the state is hoping to obtain a federal match for FHIAP.

Table 4. Proposed Changes to OHP from May 2002 Waiver Applications

Current Eligibility Categories	Current Program/ Benefit Package	Proposed Eligibility Categories	Proposed Benefit Package
Oregonians < 100% FPL	OHP (Medicaid)	"Vulnerable populations"—mandatory federal categories (children, pregnant women, categorically eligible adults)	OHP Plus—entitlement
		"Adult population"—adults who qualify based on income only	OHP Standard—capped
Children birth to 6 < 133% FPL	OHP (Medicaid)	Same	OHP Plus—entitlement
Pregnant women < 170% FPL	OHP (Medicaid)	Same	OHP Plus—entitlement
Children birth to 6 between 133% and 170% FPL*	OHP (CHIP)	Same	OHP Plus—entitlement
Children 6–19 between 100% and 170% FPL	OHP (CHIP)	Same	OHP Plus—entitlement
Pregnant women & their newborns 170%–185% FPL	Not eligible	OHP Plus (1115 Waiver)	OHP Plus—entitlement
Children birth to 19 170%–185% FPL	Not eligible	OHP Plus (HIFA)	OHP Plus—entitlement
Oregonians < 170% FPL	FHIAP	"New eligibles"	OHP Standard—capped** *or* FHIAP (up to 170% FPL)***
Oregonians between 170% and 185% FPL	Not eligible		

* Newborns in this income group are funded through Medicaid.

** OHP standard enrollment will be expanded initially up to 110% of the FPL, then moved up by 15% income bands as budget allows, giving priority to parents of CHIP and poverty-level Medicaid children and current clients moving over the upper-income limit of the OHP standard.

*** FHIAP will expand by about 9,500 in the group insurance market and then will open individual insurance. At that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

Sources: Oregon HIFA application submitted May 31, 2002 and Oregon Section 1115 Waiver Amendment Application submitted May 31, 2002.

Consumer advocates were concerned that the coverage expansion initiative meant that there was less stakeholder and public involvement in the initiative than when OHP was first introduced. This may prove to be problematic if the waivers are approved and Oregon must rely on those same stakeholders to implement it. For example, one of the features of OHP Standard is a $250 deductible on inpatient hospital stays. However, many of these low-income OHP Standard enrollees will not be able to afford this deductible, and many hospitals have informally agreed to charity care policies that would waive the deductible anyway.[12] As a result, the hospitals view some of the recommended cost-sharing provisions as merely a way of shifting costs to them. If providers believe that unreasonable cost-sharing has been imposed, they may be less willing to see OHP Standard patients for nonemergent care. Adding a new population of enrollees may also shift the risk profile of OHP enrollees, affecting managed care reimbursement rates in a situation in which providers (safety net providers and others) already are concerned they are not compensated adequately.

In addition to concern on the part of providers that the copayments represent a shifting of costs to them, there is a concern among some policymakers that high copayments will discourage people from seeking necessary care. About 60 percent of adults now qualify for OHP based solely on income, and many of those adults have incomes below 50 percent of the poverty line. It may be unreasonable to expect any level of cost-sharing from these enrollees. Other policymakers, worried about some of the cuts in benefits, believe there should have been a broader benefit package with even higher copayments. Another issue that worries consumer advocates and managed care plans is managed care capacity, particularly in the Portland area. As discussed above, most health plans have withdrawn from the OHP market, although both commercial and safety net plans do still participate in OHP. As OHP prepares to expand, it is unclear whether the remaining plans can absorb the new enrollees, particularly because most of the burden will fall on CareOregon, which has just jumped from about 40,000 enrollees to close to 90,000 in the wake of Regence pulling out of the market. Portland/Salem is not currently a mandatory managed care area for OHP enrollees; there are about 30,000 "open card," or fee-for-service enrollees. These enrollees need to be absorbed into managed care before newly eligible persons are enrolled. If managed care plans are not able to enroll the newly eligible individuals, this group will not have access to primary care providers and be forced to seek care at emergency rooms or find providers willing to see them at Medicaid fee-for-service rates. Now, about 72 percent of OHP enrollees are in managed care (including fully capitated health plans and primary care case management); the goal is to reach 82 percent.

[12] For example, many hospitals write off all charges for people with incomes below 150 percent of the FPL, and only charge 50 percent for people with incomes between 150 percent and 200 percent of the FPL.

To accomplish this, the state plans to increase managed care enrollment through the following steps: identifying individuals who are not enrolled in managed care and should be enrolled; modifying the state's information system to allow members to remain in a plan when they move to a new area served by that plan; providing technical assistance and expansion assistance; holding regional meetings around the state with plans and caseworkers; and sending notices to all field staff about the benefits of managed care. Other strategies include continued work on administrative streamlining and adequate capitation rates for the plans and the introduction of copayments for the fee-for-service population, which the state expects will serve as an incentive for members to join managed care organizations.

Although many advocates are angry at the idea that benefits will be reduced for a subset of OHP population, the state still strongly believes in OHP's original philosophy of giving a greater number of people some basic level of benefits. The state argues that no one is advocating on behalf of the uninsured. The question, given the concerns about managed care capacity, is whether the state will actually be able to expand coverage to the newly eligible population or, instead, if benefits for the currently insured will be reduced with no concurrent coverage expansion.

Health plans are also concerned about how to handle the two benefit packages, OHP Standard and OHP Plus, and how to educate providers and enrollees about the two packages. The state will need to strike a balance between keeping things administratively simple and ensuring that enrollees are in the right plan. Equity issues also arise; under OHP, some groups have less generous coverage than others with higher incomes (e.g., a childless adult at 10 percent of the FPL has a less generous package than a pregnant woman at 125 percent of the FPL). Much change occurs in the OHP population as personal incomes fluctuate and people gain or lose eligibility for assistance or access to employer-sponsored coverage. Adding a new benefit package may make tracking these enrollees even more complicated. Finally, OHP Standard will now be a capped program; some who qualify for coverage may not be enrolled in the plan.

Primary Challenges and Lessons for Other States

In considering Oregon as a model for other states, it is important to remember that many of the hard choices the state must now make are direct results of choices that were made when the plan was established.

All states have only limited ways to finance coverage expansions without introducing new resources from outside the health care system (e.g., new taxes or tobacco settlement funds). States can trim the benefit package, raise cost-sharing, cut payments to

health plans and providers, search for efficiencies through better managed care, pull in more matching funds, or redirect existing subsidies such as disproportionate share hospital payments. In their most recent coverage initiative, Oregon decided to remain focused on trimming benefits, giving some attention to introducing more managed care and increasing copayments. Payment rates have been left mostly untouched out of concern for exacerbating the problem of plan withdrawals. Oregon initially had a rich benefit package under OHP (amendable as needed), but it is now limited in what it can do by federal law and is locked into a benefit package that it no longer believes is affordable.

The state believes that OHP never really rationed care: one-third of the services excluded from the benefit package are common exclusions in commercially available policies; one-third are commonly denied because insurance companies believe they are not medically necessary services; and the remaining third, the state maintains, are for services that are ineffective (for example, treating viral infections). While some are concerned that the discussions about the benefit package resemble discussions about commercial insurance rather than about the most appropriate public benefit package for low-income enrollees, the state believes it is not unreasonable to use the private group market as a model. Oregon also believes that, because a program like FHIAP relies on the private market to provide benefit packages, the state should be able to continue this arrangement, rather than be forced to amend the FHIAP benefit package to receive a federal match.

The state also has committed to a coverage expansion. However, by one account, OHP was 18,000 people over its limit three months into a two-year budget. Some argue that funding must be stabilized for the current program before further expansion. Others argue that it would make sense to evaluate what benefits could be reduced and what cost-sharing could be imposed without doing any harm, and then see how many additional people could be covered. Some believe that the state has decided instead that it wants to cover a certain number of additional people and then determine what benefits to cut to fund the expansion. Either way, it appears that as long as Oregon is interested in amending the generosity of benefits to generate additional revenue, and as long as the current federal guidelines apply, Oregon has little choice but to couple a coverage expansion with a benefits reduction for noncategorical populations. In the context of OHP, a coverage expansion that involves introducing capped enrollment for the noncategorical population is a significant change.

In addition to the decisions related to OHP, state budget characteristics also exacerbate Oregon's current fiscal situation. First, the state has no sales tax. Second, the legislature is bound by a law preventing the state from having more than a 2 percent

budget surplus; additional revenue must be returned to the taxpayers. As a result, even though until recently Oregon had a booming economy, the state has few reserves to sustain itself in an economic downturn. If Oregon does not want to change state law to generate additional revenue (and there is little or no discussion about doing so), few options exist to pay for programs such as OHP.

In conclusion, several things can be learned from Oregon's experience in attempting to extend coverage while limiting benefits. First, the process hinged on a public and transparent discussion of priorities. This took a great deal of time and investment and is ongoing. In the end, this public discussion might be unsustainable because of the effort involved and the political capital expended to implement the program "democratically." Second, federal structures have not historically been flexible in accommodating this sort of approach. Finally, the evidence-based benefits list may be of only limited value in reining in costs over time. Even with the list, Oregon is experiencing the same upward trends in costs experienced by other states. Oregon may now be reverting to a more categorical approach, in part because of what the state perceives has been a lack of federal flexibility toward further benefit reductions (although that may be less true under the new HIFA initiative), but also because it may be difficult to get additional cost savings through this approach and the state is concerned about increasing costs in OHP.

It appears there will be a budget crisis unless action is taken quickly. Governor John Kitzhaber appeared committed to having a five-year waiver in place that would implement the proposed changes to benefits and eligibility before he leaves office. However, the proposed changes cannot be implemented until the federal government approves the two waiver requests. It remains to be seen how the many issues raised above will be resolved to maintain one of the most concerted, sustained efforts by any state to provide their uninsured population with much-needed health care coverage.

RHODE ISLAND

The objective in studying Rhode Island was to determine the underlying forces that led to the development and successful multi-phase expansion of RIte Care, a joint Medicaid and CHIP program for low-income children, parents, and pregnant women. A specific goal was to examine the state's relatively new premium assistance program, RIte Share, to inform others about the impetus behind the program, its struggles, and how the state is addressing the difficulties of promoting private employer-based health coverage.