

The Oregon Health Plan

Stephen Hrinda
05.02.2007
MPHP439

Introduction.

When the Oregon Health Plan was first proposed in 1989, there were over 31 million Americans without health insurance coverage, which represented 15% of the population under 65 years of age. In the state of Oregon, which has a total population of 2.7 million, over 400,000 individuals were without health insurance coverage, many of whom were employed either full-time or part-time. Both Oregon and the nation as a whole suffered from a lack of health insurance coverage, particularly among low-income individuals, as well as denial of potentially life-saving medical treatments despite coverage of less effective therapies for less serious conditions. At the state level, the goal of health care reform was to reduce Medicaid expenditures using one of three potential methods, including 1) removing people from the program, which was generally perceived as the worst option; 2) lowering the rate of reimbursement to providers, which was undesirable because health care providers have been found to refuse Medicaid patients due to low reimbursement rates; or 3) reducing the benefits package. The Oregon Health Plan chose the third strategy, which was implemented by creating a prioritized list of diagnosis-treatment pairs in order to ensure that benefit reductions eliminate only the least effective and valuable treatments. Meanwhile, under the Oregon Health Plan, eligibility criteria and reimbursement rates to health care providers would remain constant, while the benefits package would be adjusted depending on changes in funding for the program. As such, the prioritized list serves as the Medicaid benefits package by indicating which services are covered and which are not. In addition, the list clearly defines which services are deemed medically necessary – if fiscal constraints were to require a reduction in benefits in the program, then the least effective and valuable treatments would be eliminated first.

The Oregon Health Plan.

In 1989, a revolutionary health care reform plan was introduced into the Oregon state legislature with the goal of providing universal health care coverage as well as a basic level of care to all individuals with incomes below the federal poverty level.¹ In July 1989, this plan became law under the Oregon Basic Health Services Act and represented the first state legislation to define an acceptable and adequate minimum standard of health care coverage for a large segment of the population.² The Oregon Basic

Health Services Act created the Oregon Health Plan (OHP), which stated that 1) all individuals (both families and childless adults) with incomes below 100% of the federal poverty level would be eligible for Medicaid coverage, 2) the Medicaid basic benefit package would be composed of a prioritized list of diagnosis-treatment pairs, 3) the state legislature would draw a line on the list below which any diagnosis-treatment pairs would not be subject to Medicaid coverage, 4) the legislature would not be permitted to decrease reimbursement rates for care provided to Medicaid recipients, 5) managed care plans would be used to provide Medicaid services, and 6) employers would be mandated to provide private insurance coverage to their employees with the prioritized list as the basic benefit package. Under the OHP, the primary goal of health care reform was to expand Medicaid coverage to more eligible people by controlling costs using a prioritized list of medical services. By offering a more limited Medicaid basic benefit package and covering fewer services than traditional Medicaid programs, a larger number of uninsured individuals could be enrolled in the Medicaid program of the OHP.³

The OHP included three pieces of legislation. First, the goal of Senate Bill 27 was to provide access to health care services for individuals with incomes below the federal poverty level while also controlling health care costs, and thereby Medicaid expenditures. The provisions of SB 27 include 1) to provide Medicaid coverage for all individuals with incomes below the federal poverty level, 2) to institute a Health Services Commission (HSC) responsible for prioritizing the list of medical services covered by Oregon Medicaid, 3) to prioritize these medical services based on the comparative benefits of diagnosis-treatment pair to the population of interest, 4) to include an estimate of the funding necessary to cover the costs of the medical services provided under the proposed program from an independent actuary, 5) to conduct public forums to obtain public opinion regarding the proposed program, 6) to actively solicit public involvement in the process in order to build consensus on the values and criteria to be used to direct prioritization of medical services and allocation of health care resources, 7) to allow the Joint Legislative Committee on Health Care recommend the proposed plan to the Legislative Assembly and the Governor, and 8) to make the Legislative Assembly responsible for developing a plan to fund the program

depending on the resources available within the overall state budget given that the legislature may not make any changes to the priority list without approval from the HSC.

The OHP was initiated with the establishment of the Oregon Health Services Commission (HSC) in 1989, consisting of 11 commissioners appointed by the Governor for 4-year terms. According to the OHP, this board of commissioners must include 5 physicians (including obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health, and one doctor of osteopathy), 1 social services worker, 1 public health nurse, and 4 consumers.⁴ Over the span of three years, these commissioners acquired public input into the development of the OHP and its prioritized list of medical services through community forums, in which the majority of attendees were health care providers or individuals with a college education. While only 5% of attendees at these forums were actually Medicaid recipients, Medicaid recipients were represented throughout this process by consumer advocate organizations. In addition to the HSC, the OHP also established the Oregon Medical Assistance Program (OMAP), which serves to eliminate or expand services covered in the order of the prioritized list created by the HSC based on the existing budget for the OHP. However, this is the only method by which the OMAP can make changes to the OHP in order to control costs, since under the OHP, it is not possible to decrease the number of persons eligible for Medicaid coverage or the reimbursement rates to health care providers.

As its primary objective, the HSC created the prioritized list of medical services that would define the basic benefit package for both Medicaid recipients as well as private insurance beneficiaries in the state of Oregon. First, the HSC established 17 categories of health problems (including acute conditions that can be fatal and for which treatment provides full recovery, acute conditions that are treatable and unlikely to be fatal, chronic conditions that are unlikely to be fatal, maternity and newborn services, and preventive care of proven efficacy). Then, all diagnoses and their respective treatments in both medical and surgical arenas (700 diagnosis-treatment pairs in total) were allotted to one of the 17 categories of health problems. Next, these diagnosis-treatment pairs were ranked according to 13 criteria (including life expectancy, quality of life, cost effectiveness of treatment, clinical effectiveness, net benefit, and whether it would benefit many people). Finally, based on the prioritized list and how much funding the

state legislature decided to allocate for the OHP, a line would be drawn on the prioritized list above which all services would be covered and below which no services would be covered.

This original prioritized list (which drew the line below item 587 under which care would not be covered) was rejected by the Bush administration in 1991 due to perceived undervaluation of the quality of life for people with disabilities; however, a subsequent version that ranked each diagnosis-treatment pair according to the probability of death or disability with and without treatment was approved by the Clinton administration in 1993. This new version of the list prioritized diagnosis-treatment pairs within categories with respect to outcomes data, quality of well-being, and fairness of rankings; eliminated the public survey results regarding the perceived impact of various health experiences on quality of life; edited the list from 709 to 699 diagnosis-treatment pairs; and increased the influence of HSC commissioner decisions on the order of the list. It should be noted that 85% of items on the 1993 version of the prioritized list were ranked in almost exactly the same position as the 1991 version.

In the final version of the prioritized list, treatments that prevent death and lead to full recovery were ranked as highest priority (including expensive therapies that are clinically effective), followed by maternity care, and then treatments that prevent death without full recovery. Conversely, treatments that result in minimal or no improvement were ranked as lowest priority. Some other notable diagnosis-treatment pairs include contraception at line 51, low birth weight at line 67, preventive services for children at line 143, medical therapy for HIV/AIDS at line 168, and preventive services for adults with proven effectiveness at line 181. Meanwhile, those diagnosis-treatment pairs ranked below line 578 could be managed appropriately by choosing an effective treatment higher than line 578 on the prioritized list, such as comfort care at line 260.

Because Medicaid services were to be provided through managed care plans under the OHP, the OMAP acquired a federal Section 1115 waiver under the Social Security Act from the federal Health Care Financing Administration (HCFA) on March 19, 1993 for a period of five years under the Oregon Reform Demonstration project. This waiver allowed Oregon to continue to receive federal Medicaid funding while circumventing federal regulations regarding state Medicaid programs, which govern eligibility and

services, protect liberty to choose a health care provider, and specify appropriate reimbursements for health care providers. As such, this waiver gave Oregon permission to 1) establish a basic benefits package of medical services for all individuals below the federal poverty level through a prioritized list of diagnosis-treatment pairs; 2) define eligibility for Medicaid only on the basis of gross family income rather than factors such as age, gender, and marital status; 3) restrict freedom of individuals to choose their own health care providers in order to control costs through capitated managed care plans; 4) permit reimbursement rates to health care providers working in Medicaid managed care plans to be greater than standard Medicaid reimbursement rates, thereby stimulating physician participation in the program; 5) preserve existing Medicaid programs for the elderly, blind, disabled, and individuals in mental health and chemical dependency programs; 6) provide medical services for Medicaid recipients in the Federally Qualified Community Health Center (FQHC) and Rural Health Clinic (RHC) programs through managed care plans with reimbursement rates greater than standard Medicaid reimbursement rates; and 7) eliminate services typically provided in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) children's program that were determined to be clinically ineffective.⁵ In other words, the Section 1115 waiver permits a state to require Medicaid recipients to enroll in capitated managed care plans, which could improve access to care and control costs in comparison to traditional Medicaid plans.

As a result of the Section 1115 waiver, the state of Oregon has contracted with 13 non-profit managed care plans. Overall, approximately 87% of OHP enrollees are enrolled in one of these capitated Medicaid managed care plans. The largest of these plans is HMO Oregon, which is owned by Blue Cross and Blue Shield of Oregon, with an enrollment representing approximately 34% of OHP managed care enrollees. At the national level, 33% of all Medicaid recipients were enrolled in managed care plans in 1996, representing a 33% increase from 1995. In Oregon, the successful enrollment of Medicaid recipients in managed care plans was facilitated by the strong historical presence of managed care plans in the state, including Kaiser Permanente, which has been present in the Oregon health care community since 1940 and began enrolling Medicaid recipients in 1976. Furthermore, the state of Oregon enrolled 90,000 Medicaid recipients in managed care plans in decade before the OHP was implemented.

However, despite the existence of Medicaid managed care plans, the OHP ensured that capitation payments to health care providers would be representative of the costs of medical services with a provision that precluded the state legislature from decreasing reimbursement rates to Medicaid providers. This provision was established for two reasons. First, it is more likely that physicians, hospitals, and managed care plans will support Medicaid funding if they are reimbursed sufficiently for care provided to Medicaid recipients. Second, adequate reimbursement rates create an incentive for physicians to provide care for Medicaid recipients, thereby increasing access to care for recipients. While the OHP mandated that capitation payments must cover the costs of medical services, most other state Medicaid programs have reimbursement rates less than the cost of care. Because the willingness of physicians to provide care for Medicaid recipients is directly related to the level of reimbursement, it is necessary to ensure that capitation payments accurately reflect the cost of care.

Despite these provisions, physicians still earn one-third less for medical services provided to Medicaid recipients in comparison to services provided to patients enrolled in private commercial insurance plans or Medicare. As a result, some physicians have restricted the number of Medicaid recipients for whom they provide care, especially in rural areas where Medicaid recipients constitute a larger proportion of the population. It must be noted that in 1995 the capitation rate for no disabled persons under 65 years of age was \$130 per member per month, which represented a 30% increase over fee-for-service Medicaid payments that physicians received prior to implementation of the OHP. Due to the increase in reimbursement rates, 88% of Medicaid enrollees reported satisfaction regarding their access to care in 1996, a significant improvement from 1994 prior to the OHP, at which time satisfaction rates with respect to access to care were only 70%.

A second piece of legislation in the OHP was Senate Bill 935, which had the goal of expanding health care coverage to uninsured individuals with income above the federal poverty level. The purpose of SB 935 was 1) to assess alternative methods for establishing a statewide insurance pool, 2) to aid small businesses with 25 or fewer employees in purchasing private commercial health insurance for their employees, 3) to determine the basic benefits package to be offered by the insurance pool founded in the

prioritized list of medical services created by the HSC, 4) to utilize the Medicaid benefits package as the basic level of care that must be provided in all insurance pool plans, 5) to create guidelines for incremental increases in the proportion of the previously uninsured population that would be covered under the insurance pool (including 50,000 individuals by October 1990, 100,000 individuals by 1991, and 150,000 individuals by 1992), 6) to provide tax credits for employers contributing to their employees' health insurance premiums as an incentive for voluntary employer participation, and 7) to establish a novel payroll tax on employers who do not provide health insurance benefits for their employees by January 1, 1994.

Finally, the third piece of legislation in the OHP was Senate Bill 534, which had the goal of supplying the funding necessary for the creation of a high risk insurance pool. SB 534 would achieve these ends by 1) providing coverage for high risk individuals who were uninsurable in the general market and 2) funding the pool using a combination of state subsidies, insurer assessments, and beneficiary or employer premiums with a maximum premium of 150% of the standard market premium. The basic benefit package for this plan would be identical to the prioritized list of medical services created by the HSC, which is the basic minimum coverage that all private health insurance plans are mandated to offer to their beneficiaries who are enrolled in the small business (SB 935) or high risk (SB 534) insurance pools.

However, as a result of pressure from small businesses, the employer mandate in the OHP (SB 935) never went into effect and was permanently repealed on January 1, 1996.⁶ Under the mandate, employers would have been required to play-or-pay in the OHP by either providing health insurance plans to their employees with the prioritized list as the basic benefits package or paying matching funds into the statewide insurance pool, which would then be used to subsidize alternative insurance options for uninsured employees and their families. The primary concern among small businesses was that once the OHP was implemented, some low-wage workers would be transferred from Medicaid into employer-sponsored or subsidized insurance, thereby increasing the financial burden on businesses to provide adequate benefits to their employees. In addition, the employer mandate was hindered by the federal

Employee Retirement Income Security Act (ERISA), which limits state power to regulate access to health care as well as fair sharing of cost burdens between employers and employees regarding benefits such as health insurance. Because the federal government was unable to amend ERISA prior to January 1, 1996 in order to allow the OHP to be implemented as planned, the employer mandate of the OHP was repealed. At the national level, the failed amendment of ERISA also curtailed the ability of states to make revisions to their health care systems in order to control costs, increase access, and improve quality.⁷ Due to the loss of the employer mandate, there are still 360,000 uninsured working individuals in Oregon. Furthermore, any increases in health care coverage must now be achieved solely through the expansion of the Medicaid population rather than through employer-sponsored private insurance.

Despite the rationing imposed by the prioritized list, there are methods by which physicians can provide care for their patients, even when this care may be in conflict with the prioritized list. First, because items on the list are listed as diagnosis-treatment pairs, a diagnosis is required before treatment can be denied. Therefore, for simple diagnoses that are listed below the rationing line, treatment may be provided at a simple diagnostic visit, and this care would be covered under the costs of the visit rather than as a separate health care event. In addition, complex diagnostic workups are also covered by the OHP, which gives physicians more leeway in treating their patients while remaining within the rules of the OHP. Second, physicians can game the system, in which they would assign a diagnosis that lies above the line for a given patient, even if that patient clearly presents with a diagnosis that falls below the line. In Oregon, the state Medicaid program mandates adherence to the prioritized list only for those physicians who treat the 13% of Medicaid recipients covered on a fee-for-service basis by the state rather than through a capitated Medicaid managed care plan. Therefore, for the 87% of Medicaid recipients in capitated managed care plans, the state has effectively shifted all financial risk from the state to the managed care plans, especially since no additional funds are available if treatments listed below line are provided for Medicaid recipients. However, medical directors of the capitated Medicaid managed care plans have authorized care for diagnosis-treatment pairs below the line on a case-by-case basis. Because

treatments below the line account for approximately 10% of all medical expenditures in the state, the state has subtracted 10% from capitation payments to managed care plans in order to control costs.

Performance of the Oregon Health Plan.

The OHP began operation on February 1, 1994 and expanded health insurance coverage under the Medicaid program by increasing enrollment by 100,000 individuals. By 1997, all state residents with annual incomes less than the federal poverty level (\$13,000 for a family of 3 individuals) were eligible for Medicaid enrollment. Conversely, prior to the OHP, only 57% of individuals with annual incomes less than the federal poverty level were eligible for enrollment. However, there were still 65,000 eligible state residents who were not enrolled in the OHP for multiple reasons, including choosing not to enroll, being discouraged by complicated enrollment procedures, and not being able to afford sliding scale premiums, which ranged from \$0 to \$28 per member per month depending on income level. Unlike private health insurance plans, these 65,000 eligible individuals could enroll in the OHP at any time and receive coverage for medical services on the same day as enrollment. From 1991 until 1995, federal data suggests that the OHP reduced the proportion of uninsured individuals of the 3.2 million state residents from 14% to 12%; state data suggests that the uninsured rate has dropped from 18% to 11% from 1992 until 1996. Meanwhile, the proportion of uninsured in the national population has increased from 14% to 15% from 1991 until 1995. Nationally, the uninsured population grew as a result of a decrease in employer-sponsored health insurance despite an increasing number of states expanding Medicaid coverage in order to provide health insurance to the uninsured. As employer-sponsored health insurance in the private sector decreases, states will be forced to increase coverage of the uninsured through public sector measures. Furthermore, while the number of Medicaid recipients increased by 39% and Medicaid expenditures increased 36% in Oregon from 1993 to 1996, national Medicaid expenditures increased 30% and coverage expanded only 11% over this same time period. As such, Oregon successfully expanded Medicaid coverage at a higher rate than the increase in total Medicaid expenditures, a significant accomplishment that has not been matched in other states.

Overall, the prioritized list of the OHP has actually expanded health care benefits more than it has reduced them since any decreases in medical services covered have been more than offset by the increases in enrollment. In addition, all enrollees are now covered for dental care and organ transplantation under the OHP, which was not the case in the traditional Oregon Medicaid plan prior to the OHP. Furthermore, the rationing line below which medical services may be denied was originally set very low on the prioritized list of diagnosis-treatment pairs and has remained low in relation to its starting point. Specifically, line movement, or upward movement of the line on the list so that fewer treatments are covered, has been limited by the federal Health Care Financing Administration (HCFA), which must approve any changes in coverage proposed by the state legislature. In 1996, the state legislature and the HCFA agreed to move the line from diagnosis-treatment pair item 606 to item 581. However, when the state legislature proposed moving the line from item 581 to item 574 in 1997, the HCFA only agreed to move the line to item 578. Because line movement often solicits protests from physicians, patients, and health plans it seems unlikely that the HCFA will approve further line movements proposed by the state legislature; therefore, the basic benefits package and number of covered medical services in the OHP should remain relatively static in the future.

Much of the initial success of the OHP from 1994 through 1998 could be attributed to a strong economy, including high state tax revenues and a low rate medical cost inflation. Nonetheless, it was clear that the OHP would face adversity in the future when these trends reversed. Specifically, if an increase in medical cost inflation coincided with an economic downturn and decreased availability of state funds through tax revenues, the only method of financing the OHP would be tax reform. Then, if no new state funds were available to extend coverage, the OHP would be forced to provide fewer services by moving the line upward on the prioritized list and reducing the benefits for existing enrollees in order to generate funds to bring more uninsured into the OHP.

In response to these concerns, the OHP was expanded in 2002 by the submission of a waiver through the Health Insurance Flexibility and Accountability (HIFA) initiative, which effectively modified the Oregon Reform Demonstration by creating OHP2. OHP2 represented an increase in the sheer size of

the OHP by 46,000 enrollees as the eligibility level for the Medicaid-expansion population of OHP was raised to 185% of the federal poverty level. This increase in the eligibility level was to be implemented over time based on available funding. Another goal of OHP2 was to gain federal matching funds for the Family Health Insurance Assistance Program (FHIAP), which is a premium subsidy program for private insurance that was previously financed solely by state funds. Because it was preferable to expand health insurance coverage through private insurance rather than Medicaid under the OHP, FHIAP represented a means of enrolling more individuals into the OHP without increasing the Medicaid burden. As the last hurdle in the approval process for OHP2, the Center for Medicare and Medicaid Services (CMS) granted a waiver for the implementation of OHP2 for 2003.

Under OHP2, the original OHP was segregated into two different insurance pools known as OHP Plus and OHP Standard. OHP Plus covered individuals who were categorically eligible for Medicaid, including pregnant women and children, Temporary Assistance for Needy Families (TANF), and disabled individuals. Like the OHP, the benefit package for OHP Plus was based on the prioritized list of medical services.⁸ Meanwhile, OHP Standard covered the expanded eligibility population, including single adults, couples, and parents not eligible for Medicaid under federal guidelines. Unfortunately, the benefit package for OHP Standard, while still based on the prioritized list, only provided coverage valued at approximately 78% of OHP Plus. While OHP Standard included vision and nonemergency transportation, it introduced several new cost-sharing measures that did not exist under the original OHP, including increased premiums and copayments. In addition, under OHP Standard, providers could refuse patients who could not afford the copayments.

Meanwhile, a federal waiver was requested in order to create an enrollment cap on OHP Standard that would allow the state to stop accepting new enrollees and establish a lower poverty level for eligibility depending on funding availability, thereby improving flexibility in controlling costs of the OHP. Finally, because the CMS had restricted utilization of line movement on the prioritized list as a cost control instrument, the basic benefits package of the OHP became stuck at a level of coverage that the state was unable to sustain due to fiscal constraints. Therefore, the only option remaining for the OHP

was to revise the basic benefits package to a level that was actuarially equivalent to the federally mandated Medicaid minimum. These revisions included cost-sharing measures in OHP Standard that were necessary due to the lack of state general funds for OHP Standard, which was financed entirely from provider taxes and beneficiary premiums.

After the implementation of OHP2, enrollment of the Medicaid expansion population in OHP Standard fell 53% from 104,000 in January 2003 to 49,000 in December 2003. Over the next 18 months, enrollment fell by another 50% until only 24,000 Medicaid recipients remained in OHP Standard. In short, the increased cost-sharing measures of OHP Standard deterred access for enrollees. In particular, OHP Standard enrollees who failed to pay their premiums for one month or longer were disenrolled and subjected to a 6-month lockout before they would be eligible again for coverage. Moreover, OHP Standard premiums increased; while the sliding scale premiums remained nearly the same for single individuals, they doubled for married individuals, ranging from \$6 to \$20 per month. In addition, premium exemptions under the OHP for individuals who were homeless, had zero income, or experienced crime, domestic violence, natural disasters, or a death in the family were eliminated under OHP Standard so that all enrollees would be required to pay some form of premium. Finally, copayments were instituted under OHP Standard, including \$5 for outpatient physician visits, \$50 for emergency department visits, and \$250 for inpatient hospital admissions. As a result of these changes, OHP Standard recipients had to pay increasing premiums for a decreasing benefit package, and in March 2003 coverage for dental care, medical supplies, outpatient mental health, outpatient chemical dependency services, and prescription drug coverage was eliminated. However, due to general dissatisfaction with OHP Standard, prescription drug coverage was reinstated 2 weeks later, while mental health and chemical dependency care was reinstated in August 2004. Overall, the uninsurance rate in Oregon climbed back up to 17% after being as low as 10% under the original OHP. In addition, 72% of individuals who lost coverage remained uninsured, thereby resulting in significant unmet needs in medical care. It is also necessary to note that continuous revisions to OHP Standard, including changes to the basic benefits package and cost-sharing

arrangements, created confusion for enrollees, providers, and administrators, which further contributed to access problems for enrollees.

External studies have found that changes to cost-sharing structures in public health insurance can affect participation in the system as well as access to and use of care. Within Medicaid programs studied, as premiums increased from 1% to 5% of annual income, participation rates among the uninsured decreased from 57% to 18%. Meanwhile, it was found that requiring copayments reduced both appropriate and inappropriate use of health care and medications, particularly for individuals with low income or chronic conditions. Decreases in participation rates arose for multiple reasons – some individuals voluntarily opt out of health insurance because they believe they are healthy enough while others simply cannot afford cost-sharing arrangements. Finally, uninsured individuals as well as individuals with low incomes have been found to demonstrate higher unmet health care needs and poorer health outcomes in comparison to insured individuals. Meanwhile, insured individuals have better access to care, are more likely to have a usual source of care, and have better overall health outcomes.

In a study specifically investigating the effects of cost containment strategies on OHP Standard enrollees, it was found that increased cost-sharing in the form of premiums and copayments was a primary driver for the exodus of OHP Standard enrollees. In fact, 50% of dropouts cited cost-sharing, particularly the inability to afford new premiums or copayments or owing back premiums, as the primary reason for disenrolling. The majority of those who left OHP as a direct result of cost-sharing became uninsured, had greater unmet need for care, were more likely not to buy prescription drugs because of cost, were less likely to have a usual source of care, were more likely to use emergency departments as a usual source of care, had fewer primary care visits and more hospital emergency department visits, accumulated more medical debt, were more likely to refuse care because of medical debt, and had worse health outcomes. It must also be noted that increased cost-sharing disproportionately affects the poorest individuals; as income decreases, the percentage of dropouts citing cost-sharing as the primary reason for leaving increases. In the end, the individuals with the lowest income were the most likely to lose coverage as a result of cost-sharing, especially due to elimination of the zero-income premium exemption.

When implementing cost-sharing arrangements in public insurance programs, it is necessary to consider the social costs of such measures as the shift in care patterns resulting from behavioral responses to cost-sharing could actually offset any direct savings resulting from increased cost-sharing. While increased cost-sharing could improve the financial stability of the OHP in the short-term, many individuals dropped out of OHP Standard because they were no longer able to afford coverage. Therefore, those who demonstrated the most dire need for medical care were unable to participate in Medicaid through the OHP. While several changes to OHP Standard have been proposed, including elimination of premiums for Medicaid recipients below 10% of the federal poverty level, and copayments for OHP Standard were eliminated due to a lawsuit, OHP Standard was closed to new enrollment on July 1, 2004 as there is only sufficient funding to support 24,000 enrollees.

Political and Economic Forces Impacting the Oregon Health Plan.

The architect of the OHP was Democrat John Kitzhaber, an emergency room physician prior to becoming President of the Oregon Senate, who observed firsthand the victims of Medicaid cuts in the form of patients presenting to the emergency department with serious illnesses that could have easily been treated at earlier stages. In 1989, the Democrats controlled both houses of state legislature as well as the governorship of Oregon, and Senate President John Kitzhaber and House Speaker Vera Katz were allied in the goal of health care reform. Combined with political support from a coalition of interest groups, including consumer activists (the Oregon Health Action Campaign), organized labor (the Oregon AFL/CIO), businesses (the Greater Portland Business Group on Health), and providers of health care (the Oregon Medical Association, the Oregon Hospital Association, and the Oregon Nurses Association), as well as a bipartisan coalition of support in the state legislature, the OHP was passed in 1989 in an ideal political climate within a fiscally conservative state that supported a generous benefits package without extensive rationing.

However, these favorable political conditions did not last long. In 1990, the Democrats lost control of the House and exited the 1992 elections with only a slim majority in the Senate. While the OHP benefited from the support of Governor Kitzhaber through 2002, his term as Governor was coming

to a close as he desired to move Oregon closer to universal coverage before leaving office. To achieve the goal of expanding coverage and reducing the uninsured population given fiscal constraints, Kitzhaber and the Democrats created new cost-sharing and premium policies to redirect revenues from existing enrollees to cover more people. This strategy represented the fiscal pragmatism and progressivism dominant in Oregon politics, specifically the application of conservative means to achieve liberal ends. Meanwhile, Republicans were supportive of this plan because they viewed the reduced OHP Standard benefit package combined with increased premiums, copayments, and direct consequences for failure to pay as reflecting private insurance plans emphasizing personal responsibility in contributing to medical care. However, the failure of this plan resulted from a discrepancy between the predicted behavior of low-income populations and the actual behavior of these individuals in reaction to increased cost-sharing measures. In reality, OHP Standard enrollees were significantly more price sensitive than expected, and the negative reaction to cost-sharing, especially as large numbers of individuals dropped out of OHP Standard, caused the plan to fail.

The need to implement the cost-sharing measures of OHP2 was borne from fundamental fiscal limitations in Oregon. For the basic benefit package of the OHP that was scheduled to be implemented on January 1, 1994, the state needed \$83.6 million in state funds, or else the prioritized list would have to be cut pending federal approval.⁵ In 1990, a property tax limitation initiative was passed that was expected to produce a \$1.2 billion state deficit by 1993. Then, Ballot Measure 5 was approved by voters in 1991, followed by Ballot Measure 47 in 1996, both of which reduced property taxes. Furthermore, because there is no general sales tax in Oregon, 70% of state revenues are derived from personal income taxes. Meanwhile, at the national level, it was possible that the federal budget-balancing act would reduce federal Medicaid funds, which finance 62% of OHP. In order to help finance the OHP, voters approved referenda raising state cigarette taxes, including a \$0.30 increase in the tobacco tax that would allow expansion of the OHP to 25,000 children and state subsidies to purchase private health insurance for 21,000 individuals. Because the prioritized list does not apply to these private health insurance plans, these plans may have high deductibles and limited benefits.

Despite these fiscal concerns, in 5 of the 6 fiscal biennia from 1989 to 2001, Oregon state revenues increased by 15% or more per biennia, and this increase exceeded 20% on two occasions. These consistent increases in state general revenue were essential to funding the initial implementation of the OHP. However, the state of Oregon has a budgetary provision, known as the surplus kicker, that mandates the state to refund tax funds whenever revenues exceed predicted costs by 2% or more, which prevents the state from building up reserves from budgetary surpluses in years of significant revenue growth. Furthermore, because there is a 2-year lag between budget forecasts and the kicker trigger, it could be possible for the state to be required to disburse a refund for a previous year in a year in which costs actually exceed revenues. The surplus kicker was triggered in 2001 when the economy took a downturn and the state was simultaneously required to refund \$254 million despite a budget deficit for that year.

Following 2001, Oregon's economy performed poorly, which contributed to the creation of OHP2, in which fundamental changes were made to the OHP to account for a lack of available financing from state general funds. From 2001 to 2003, Oregon had highest unemployment rate in the nation at 7.4%, and from 2002 to 2003, personal income tax revenues fell 19%. After moderate growth in health care costs in the mid-1990s due to the cost control measures imposed by the widespread growth of managed care, medical cost inflation began to increase. Because the prioritized list does not control costs for covered services, it was not possible for the OHP to offset medical inflation. After 2001, the economic recession, high unemployment, and growing uninsured population began to put increasing pressure on Medicaid as more people qualified for public insurance, thereby increasing enrollment in OHP Plus. Furthermore, as OHP Standard unraveled, the financing base for OHP2 fell out.

Meanwhile, at the federal level, the Federal Medical Assistance Program (FMAP), which provided matching funds to the OHP based on 3-year averages, fell out of sync with the current economic conditions in Oregon, and FMAP funding actually declined from 2001 to 2002 despite an increased need for federal funding. Finally, in 2003, the state legislature attempted to address the recent decline in state revenues with a \$542 million tax increase known as Measure 30. However, due to anti-tax forces, a state

ballot referendum is required to pass tax increases, and Measure 30 was turned down in February 2004 by a 59% vote. As a result of the failure of Measure 30, the state was automatically forced to cut \$542 million in state budget expenditures, including \$40 million from OHP Standard.

Furthermore, the political climate in Oregon had changed significantly since the early days of the OHP. Democratic Governor Ted Kulongoski opposed the passage of new tax initiatives, which left no state general revenue funding for the Medicaid expansion population in OHP Standard. In fact, health care reform was no longer a political priority like it was under the leadership of Governor Kitzhaber. In addition, an increasing conservative sentiment in the Republican Party created escalating partisan conflict and political tensions, and bipartisan support for the OHP, as well as general public support, eroded. In the end, OHP Standard was capped at 24,000 enrollees and closed to new enrollment due to a lack of available funding. OHP Standard now covers fewer services and fewer people in comparison to the Medicaid program prior to the OHP with limited hospital benefits and the elimination of physical, speech, and occupational therapy as well as home health care as OHP Standard funding is sustained by only a provider tax. Meanwhile, OHP Standard costs are increasing as there is a growing number of uninsured and increased emergency room use, which may result in Medicaid eligibility cuts in the future.

At present, the Oregon economy is recovering. With respect to the OHP, the state hopes to expand Medicaid insurance coverage to 117,000 uninsured children using funding from a new tobacco tax. More significantly, the HSC is currently working to revise the prioritized list in order to place a larger emphasis on chronic care and preventive services in an attempt to generate cost savings and expand OHP Standard to a larger population. However, the combination of medical inflation through ever-increasing health care costs and an increasing number of uninsured individuals due to declining trends in employer-sponsored private insurance means that the cost of expanding coverage will increase. Therefore, OHP will certainly require a more stable and sustainable source of funding in the future if Oregon hopes to continue to use the OHP as a means of achieving near-universal health care coverage among the general population.¹

Conclusion.

However, despite all of its troubles, the OHP can certainly stand as a lesson for states pursuing health care reform. It is a lesson of the competing demands of idealistic aspirations versus fiscal and political constraints. While it is necessary for states to enact coverage expansions in the uninsured population, it is equally important to sustain these expansions. As Medicaid expenditures take up a larger proportion of state budgets and medical inflation outpaces growth in state revenues, spending on public health insurance will necessarily reduce spending in other sectors of the economy, such as education. In addition, any economic recessions only increase pressure on Medicaid programs since during these times the eligible population expands while funding for these programs simultaneously declines. Also acting against state health care reform are balanced budget requirements and strong opposition from the medical industry to cost control efforts.¹ While the Oregon Health Plan was unsuccessful in its attempt to provide universal health care coverage to all residents of the state of Oregon, it represented a novel approach and a valiant effort to a common problem facing the entire nation.

For Further Reading – The Oregon Health Plan and Health Care Rationing.

Bodenheimer, T. (1997). The Oregon Health Plan – Lessons for the Nation (First of Two Parts). *The New England Journal of Medicine*. 337, 651-655.

Bodenheimer, T. (1997). The Oregon Health Plan – Lessons for the Nation (Second of Two Parts). *The New England Journal of Medicine*. 337, 720-723.

Brown, L.D. (1991). The National Politics of Oregon's Rationing Plan. *Health Affairs*. 10, 28-51.

Callahan, D. (1991). Ethics and Priority Setting in Oregon. *Health Affairs*. 10, 78-87.

Crittenden, R.A. (1995). Rolling Back Reform in the Pacific Northwest. *Health Affairs*. 14, 302-305.

Daniels, N. (1991). Is the Oregon Rationing Plan Fair? *Journal of American Medicine*. 265.

Dixon, J., and Welch, H.G. Priority Setting: Lessons from Oregon. *Lancet*. 337, 891-895.

Etzioni, A. (1991). Health Care Rationing: A Critical Evaluation. *Health Affairs*. 10, 88-95.

Floyd, E.J. (2003). Healthcare Reform through Rationing. *Journal of Healthcare Management*. 48, 233-241.

Fox, D.M. and Leichter, H.M. (1991). Rationing Care in Oregon: The New Accountability. *Health Affairs*. 10, 7-27.

Fox, D.M. and Leichter, H.M. (1993). The Ups and Downs of Oregon's Rationing Plan. *Health Affairs*. 12, 66-70.

Hadorn, D.C. (1991). The Oregon Priority-Setting Exercise: Quality of Life and Public Policy. *Hastings Center Report*.

Henderson, J.W. *Health Economics and Policy*. 3rd Edition, Thomson South-Western, 2005.

Oberlander, J. (2006). Health Reform Interrupted: The Unraveling of the Oregon Health Plan. *Health Affairs*. 25, w96-w105.

State of Oregon: Oregon Health Plan. (<http://www.oregon.gov/DHS/healthplan/>).

Wiener, J.M (1992). Oregon's Plan for Health Care Rationing. *Brookings Review*. 10.

Wright, B.J., Carlson, M.J., Edlund, T., DeVoe, J., Gallia, C., and Smith, J. (2005). The Impact of Increased Cost Sharing on Medicaid Enrollees. *Health Affairs*. 24, 1106-1116.

¹ Oberlander, J. (2006). Health Reform Interrupted: The Unraveling of the Oregon Health Plan. *Health Affairs*. 25, w96-w105.

² Fox, D.M. and Leichter, H.M. (1991). Rationing Care in Oregon: The New Accountability. *Health Affairs*. 10, 7-27.

³ Bodenheimer, T. (1997). The Oregon Health Plan – Lessons for the Nation (First of Two Parts). *The New England Journal of Medicine*. 337, 651-655.

⁴ Garland, M.J. (1991). Setting Health Care Priorities in Oregon. *Health Matrix: Journal of Law Medicine*. 1, 139-156.

⁵ Fox, D.M. and Leichter, H.M. (1993). The Ups and Downs of Oregon's Rationing Plan. *Health Affairs*. 12, 66-70.

⁶ Bodenheimer, T. (1997). The Oregon Health Plan – Lessons for the Nation (Second of Two Parts). *The New England Journal of Medicine*. 337, 720-723.

⁷ Crittenden, R.A. (1995). Rolling Back Reform in the Pacific Northwest. *Health Affairs*. 14, 302-305.

⁸ Wright, B.J., Carlson, M.J., Edlund, T., DeVoe, J., Gallia, C., and Smith, J. (2005). The Impact of Increased Cost Sharing on Medicaid Enrollees. *Health Affairs*. 24, 1106-1116.