Health Policy for Low-Income People in Oregon

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Occasional Paper Number 31

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Health Policy for Low-Income People in Oregon

Highlights of the Report

Over the last decade, Oregon's health care system has attracted positive attention—and occasional notoriety. Most of the focus is on a series of laws enacted in 1989, known collectively as the Oregon Health Plan (OHP), designed to ensure health insurance for all state residents. The most controversial part of the plan is an effort to rank medical diagnoses and treatments, deny Medicaid coverage for low-priority services, and use the savings to expand coverage to all persons living in poverty. Many observers criticized the plan's explicit "rationing" of care for the poor. Others claimed the plan undervalued the quality of life of people with disabilities. Federal officials spent more than three years negotiating the terms of the prioritization system before authorizing implementation.

Perhaps ironically, however, the prioritization system has so far had little effect on the health care received by Medicaid beneficiaries. The effort to ration has also generated surprisingly small financial savings (state officials suggest that Medicaid costs would be 2 percent higher without the list). One reason for the lack of savings is that federal officials will not let the state impose draconian cuts in the Medicaid benefit package. At the same time, state officials were never in favor of an overly restrictive benefit package. Indeed, the benefit package is actually more expansive than that provided prior to the implementation of the initiative. Finally, health care providers and managed care plans often circumvent the few restrictions that are imposed and deliver services that are not part of the official benefit package.

The national focus on prioritization and rationing has obscured the more important story about the Oregon health care system. Between 1990 and 1998, the state's uninsured residents declined from 18 percent in 1990 to just over 11 percent. This decline is especially impressive given the state's inability to implement legislation that would have required employers either to provide health insurance to all employees

(who worked more than 17.5 hours per week) or to pay into a state program that would provide insurance to this group.

There are three factors that best explain the low rate of uninsured residents in Oregon. First are the Medicaid expansions that provide coverage to all persons with income below the federal poverty level (FPL). Second are a series of efforts to reform the state's small-group insurance market. Third is the strength of the state's economy throughout much of the 1990s, which has led to new jobs and increased employer-sponsored health insurance coverage.

Over the last couple of years, however, the number of residents who are uninsured has begun to grow again. Between 1997 and 1998, the uninsured population increased from 340,000 to 363,000 (from 10.6 percent to 11.1 percent of the state's population). Policymakers suggest several explanations for the recent growth. Welfare reform is one factor. As the number of welfare beneficiaries has declined, so too has the number of Medicaid enrollees. At the same time, the state's economy has become unstable. There are several problems, most notably the recent Asian economic crisis (which has significantly reduced exports). This downward economic trend has reduced the number of persons with employer-sponsored health insurance. Finally, the recent increase in the state's minimum wage is another contributing factor: it pushed some families just above the poverty level and therefore off of the Medicaid rolls.

State officials are hopeful that two new programs, the Children's Health Insurance Program (CHIP) and the Family Health Insurance Assistance Program (FHIAP), will stop the growth in the number of uninsured. The state's CHIP provides coverage to children below the age of six in families between 133 percent and 170 percent of the FPL and to children ages 6 to 18 with income between 100 percent and 170 percent of the FPL. While Medicaid and the child health initiative are separate programs, in practice the distinction is minimal. Both programs are administered by the state's Medicaid agency; both have a single application, a single benefit package, and the same managed care network. As of November 1998, there were 8,700 enrollees in the new CHIP. State officials expect that number to double by mid-1999.

FHIAP, established in 1997 with funds generated from a state tobacco tax, subsidizes the cost of private health insurance for persons with income less than 170 percent of the FPL. FHIAP began enrolling clients in July 1998 and consumer interest seems strong. State regulators estimate that by mid-1999 there will be just over 7,000 beneficiaries and that another 7,000 will express interest in enrolling. The problem, however, is that the downturn in the state's economy minimizes the odds that the program will receive enough funding to cover more than 7,000 or so clients.

Several other important issues are on the state's health policy agenda. One is the state's Medicaid managed care initiative. Oregon is a leader in the national effort to require Medicaid beneficiaries to enroll in managed care: More than 80 percent of the state's Medicaid population is enrolled in managed care, including most elderly and disabled recipients. Moreover, Medicaid officials have long had a good relationship with the state's managed care industry, paying relatively high rates and treating

health plans as partners rather than adversaries. Indeed, a recent study compared Medicaid rates in 10 states to those in the commercial sector and found that Oregon's were the most generous. Nonetheless, several health plans have recently challenged the adequacy of the Medicaid rates, especially in rural counties. Some commercial plans have withdrawn from the Medicaid market, claiming it is no longer profitable. With no quick fix in sight, this trend troubles many state officials.

State officials are also trying to mediate a bitter dispute between doctors and hospitals over the division of the Medicaid capitation dollar. The allegation is that while hospitals prosper under Medicaid, physicians do not. There is evidence to support the charge. Nonetheless, state officials have tried to stay out of the debate, arguing that the allocation is the outcome of a private negotiation process between health plans and their providers. There is growing pressure, however, for legislative or executive intervention. More than 95 percent of Oregon's physicians participate in Medicaid (an extraordinarily high number), and state officials worry that the dispute could lead to many physicians opting not to treat Medicaid patients.

The Oregon health care system of long-term care is a national model. For more than 20 years, state lawmakers have enacted policies designed to encourage the elderly and disabled to receive home- and community-based services rather than entering a nursing home. Case managers ensure that this population is aware of the alternatives to institutionalization. In addition, an ongoing state effort works with the assisted living industry to place Medicaid enrollees in community-based facilities. In the 1980s, an aggressive effort was waged to recruit families willing to convert their home into an adult foster care setting. A strict certificate-of-need process controls nursing home construction.

These policy initiatives have worked. Oregon is the only state in the nation that spends more Medicaid dollars on home- and community-based services than on institutional care provided in nursing homes. The state is one of only two that have had a decline in the number of nursing home beds. Only in Oregon are more than 25 percent of assisted living facility residents Medicaid beneficiaries.

To be sure, there is little evidence to support state claims that the long-term care initiative is budget neutral. Clearly, some clients receive services they previously would have gone without. Moreover, there is occasional concern about inadequate coordination between the acute and long-term care systems: Most of the elderly and disabled receive acute care from a managed care organization and long-term care in the fee-for-service system. Nevertheless, these issues are not high on the legislative agenda. Instead, there is a bipartisan consensus that the state's long-term care system is in very good shape.

State Characteristics: Thumbnail Sketch of Oregon

Sociodemographic Profile

During the 1990s, Oregon's population grew at a rate twice the national average, increasing from 2.8 million in 1990 to 3.2 million in 1997 (table 1).[1] The pop-

Table 1 *State Characteristics*

	Oregon	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	3,187	260,202
Percent under 18 (1998)[b]	25.9%	27.4%
Percent 65+ (1998)[b]	13.8%	12.7%
Percent Hispanic (1994–95)[a]	5.3%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	1.7%	12.5%
Percent Non-Hispanic White (1994–95)[a]	88.4%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	4.5%	4.2%
Percent Noncitizen Immigrant (1994–95)[a]	6.5%	9.3%
Percent Nonmetropolitan (1997)[c]	29.7%	21.3%
Population Growth (1995–96)[d]	1.7%	0.9%
Economic		
Per Capita Income (1997)[c]	$24,393	$25,598
Percent Change in Per Capita Personal Income (1995–96)[e]	5.6%	4.6%
Percent Change in Personal Income (1995–96)[e]	7.4%	5.6%
Employment Rate (1997)[f,g]	64.6%	63.8%
Unemployment Rate (1997)[g]	5.8%	4.9%
Percent below Poverty (1995–96)[b]	11.5%	13.8%
Percent Children below Poverty (1994)[h]	18.1%	21.7%
Health		
Vaccination Coverage of Children Ages 19–35 Months (1996)[i,j]	70.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995)[k]	5.5%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)[l]	5.6	7.2
Premature Death Rate (Years Lost per 1,000) (1995)[m]	40.9	46.7
Violent Crimes per 100,000 (1996)[n]	463.1	634.1
AIDS Cases Reported per 100,000 (1996)[o]	14.5	25.2
Political		
Governor's Affiliation (1998)[p]	D	
Party Control of Senate (Upper) (1997)[q]	10D-20R	
Party Control of House (Lower) (1997)[q]	29D-31R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. AARP. *Reforming the Health Care System: State Profiles, 1998* (Washington, D.C., 1998).
c. AARP. *Reforming the Health Care System: State Profiles, 1997* (Washington, D.C., 1997).
d. U.S. Bureau of the Census. *Statistical Abstract of the United States: 1997* (117th edition). Washington, D.C., 1997. 1995 population as of April 1. 1996 population as of July 1.
e. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.
f. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages*. USDL 98-78. Washington, D.C., February 27, 1998.
g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
h. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
i. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46 (29). Hyattsville, Md., July 25, 1997.
j. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.
k. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45 (11, supp). Hyattsville, Md.: National Center for Health Statistics, 1997.
l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45 (12). Hyattsville, Md.: Public Health Service, 1997.
m. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.
n. U.S. Department of Justice, FBI. *Crime in the United States, 1996*. September 28, 1997.
o. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8 (2), 1996.
p. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998*. January 15, 1997.
q. National Conference of State Legislatures. D indicates Democrat and R indicates Republican.

ulation growth is concentrated in the 50-mile corridor between Portland (the largest city) and Salem (the state capital), where two-thirds of the state's population now lives. Despite the recent growth, the state's residents are less racially and ethnically diverse than those of most states. Only 6.4 percent of Oregonians are racial minorities (compared with 17.4 percent nationally)[2] and only 6.5 percent are first-generation immigrants (compared with 9.3 percent nationally).[3] In contrast, 88.4 percent of the state's residents are non-Hispanic whites (compared with 72.6 percent nationally).[4]

The state follows national trends in the age distribution of its population. The percentage of the state's population that is 65 or older is just over the national average (13.8 percent, compared with 12.7), while the percentage of children under 18 is just below (25.9 percent, compared with 27.4 percent).[5]

Political Profile

Oregon's governor is Democrat John Kitzhaber, a physician and a long-time supporter of health care reform. As a state legislator in the mid-1980s, Kitzhaber was the key sponsor of the OHP. By most accounts, however, Kitzhaber is now less focused on health policy than he was as a state legislator. At the top of his current agenda are education, environmental issues, and the state's economic infrastructure. Nonetheless, he remains knowledgeable about health care and interested in preserving the state's reform activities. He would oppose any effort to significantly restrict the state's health reform program.

The Republicans have controlled both houses of the state legislature since the 1995 legislative session. In 1999, 31 Republicans and 29 Democrats legislated in the Oregon House of Representatives and 20 Republicans and 10 Democrats legislated in the Oregon Senate. As a result of term limits, a large majority of the Oregon legislators are relative novices: Seventy percent of the state's legislators are in their first or second terms.

The Oregon legislature meets once every other year. Each session begins in January of the odd-numbered years and runs for approximately six months. The most recent legislative session began in January 1999 and concluded in July 1999. When the legislature is not in session, it appoints a Legislative Emergency Board, composed of a handful of key legislators, to meet as needed and to appropriate emergency funds when necessary.

Economic Profile

Before the 1980s, timber production and distribution were the state's dominant industries. As logging faltered in the 1970s, the state's economy declined. In an effort to end a crippling recession, state officials began an extensive effort to diversify the state's economy. The effort's most notable success was the creation of a thriving network of high-technology and computer companies. The Intel Corporation, the nation's largest manufacturer of computer chips, located its corporate headquarters in the state. Intel now has the largest payroll in the state and is the biggest con-

tributor to the state's tax revenue, paying nearly 40 percent of all corporate income taxes.

During most of the 1990s, Oregon's economy continued to diversify and prosper. The economic growth led to a 32 percent increase in average wages between 1990 and 1997 (10 percent adjusted for inflation).[6] While the average income in the state is still below the national average ($24,393 versus $25,598),[7] the gap is closing quickly. Moreover, the number of state residents living in poverty is less than the national average (11.5 percent versus 13.8).[8] The economic growth, and the budget surpluses it produced, prompted a taxpayer referendum, under which the state is required to return to the taxpayers any tax revenue that exceeds state predictions by more than 2 percent (the "2 percent kicker" law).

Over the last couple of years, however, the state's economy has become more unstable and state revenues have declined. There are six key problems. First, the state is a large exporter of goods to Asia (6.3 percent of the state's gross state product comes from these exports), and the recent economic crisis in Asia is reducing the continent's demand for goods.[9] Second, the state's rate of job growth is slowing: It was 3.4 percent in 1997, but dropped to 2.6 percent in 1998 (it is expected to decline to 1.3 percent in 1999).[10] Third, the state does not have a sales tax, making it unusually dependent on income tax revenues, a source whose growth is declining. Fourth, local taxpayers have voted twice in the 1990s to lower property taxes, reducing local tax revenues by more than $1 billion between 1997 and 1999. The state legislature in 1997 allocated nearly $800 million to replace the lost school tax revenue, but maintaining this level of support will be difficult. Fifth, because of the 2 percent kicker law, the state's financial reserves are not as large as they would otherwise be. Sixth, the Oregon Supreme Court recently ruled that the state needs to reimburse federal retirees for taxes paid on federal retirement benefits. The decision will require the state to provide tax refunds of more than $300 million.

The weakened state economy and drop in state revenues are accompanied by an unsettling rise in the number of persons without health insurance. Between 1997 and 1998, the number of uninsured residents increased from 340,000 to 363,000 (from 10.6 percent to 11.1 percent of the state's population).[11] This rise ends a seven-year period in which the number of uninsured residents declined rapidly. Policymakers suggest several hypotheses for the recent growth in the uninsured. Welfare reform may be one factor. While most former welfare beneficiaries remain eligible for Medicaid, many fail to enroll either because they are unaware of their ongoing eligibility or because they are deterred by the administrative burden of the enrollment process. The downturn in the state's economy is a likely cause as well, since the number of persons with employer-sponsored health insurance is declining. A recent increase in the state's minimum wage (the effect of which is to push some of the working poor off of Medicaid) is another possible explanation. It is too soon to tell, however, whether or not the rise in the number of uninsured will be a short-term phenomenon.

Even with the recent increase in the number of uninsured residents, the state is considered a national leader in the development of programs to reduce the uninsured population. The main reason for the state's reputation is a series of programs that form the OHP.

The Oregon Health Plan: An Overview

The origins of the Oregon Health Plan are well documented.[12] In 1987, the Oregon legislature faced a daunting budget shortfall caused, in part, by the state's rising Medicaid bill. One response to the financial crisis was a Medicaid cost-containment bill, enacted in July 1987, that included the elimination of Medicaid coverage for bone marrow transplants. Within just a few months, a seven-year old beneficiary, Coby Howard, went without a needed transplant and died. Howard's death received much publicity and there was a backlash against the Medicaid benefit cutback. There was also the beginning of an effort, led by then state senator John Kitzhaber, to reform the state's entire health care system.

The OHP, enacted in 1989, was the culmination of the reform activity. The legislation contained five key provisions. First, Medicaid eligibility was expanded to cover all persons with income below 100 percent of the FPL[13] (the previous criterion was roughly 57 percent of the FPL). Second, nearly all Medicaid beneficiaries were required to enroll in managed care. Third, employers were required either to provide health insurance to all workers (who worked for more than 17.5 hours a week) or to pay into a state program to provide insurance to this group (a "play-or-pay" employer mandate). Fourth, the Oregon Medical Insurance Pool (OMIP) was created and assigned the task of developing a subsidized insurance pool for persons excluded from or priced out of the regular insurance market because they suffered from a preexisting medical condition. Fifth, the Oregon Health Services Commission (OHSC) was created and assigned the task of prioritizing health services. The goal was to rank diagnoses and treatments in order of importance so that the legislature could decide which medical services both Medicaid and private employers needed to cover.

The OHP established a new social contract for health care in which everyone in the state received at least a minimum benefit package. According to the plan, all persons living in poverty would receive public insurance. Persons who worked would receive insurance from their employer. Those denied insurance because of their health status would receive insurance from a high-risk pool subsidized by the insurers themselves. The state planned to finance this insurance expansion with savings generated from the prioritization process (the "rationing" of care) and from the managed care initiative.

There were, however, two obstacles to the implementation of the new social contract. First, Medicaid law required the state to obtain federal permission before implementing the proposed changes to the state's Medicaid program. Second, the federal Employee Retirement Income Security Act prohibited the state from implementing an employer mandate.

The Medicaid Waiver

The first task was for the OHSC to develop a list of health diagnoses and treatments, ranked from the most important to the least important. The 11 commissioners (five doctors, four consumers, a nurse, and a social worker) held public hearings

around the state. The hearings helped to produce an initial list of 700 diagnoses and treatments ranked in order of importance. The OHSC then recommended that the first 587 be covered by Medicaid.

This process, and the list it produced, generated significant controversy around the country (though much less so within the state). Many observers decried the explicit "rationing" of the care provided to the poor. Others claimed that the choices did not properly value the quality of life of people with disabilities. Still others opposed the decision to exempt the needs of the elderly and disabled from the strictures of the list. Some also raised technical challenges to the process used to develop the rankings. The Bush administration, in the midst of a reelection campaign, rejected the state's request for a Medicaid waiver that would include the list of priorities, citing concerns about how it would affect people with disabilities.

Over the next two years, the national debate over the Oregon proposal continued. The OHSC revised the list in an effort to subdue federal objections. OHSC's efforts were aided immeasurably by Bill Clinton's election and his determination to encourage state experimentation and innovation. After much political maneuvering, the Clinton administration approved the waiver (which included a revised priority list) in March 1993.[14]

By this time, however, state officials acknowledged that neither the conversion to managed care nor the implementation of the list would produce enough savings to fund the eligibility expansion and that new revenues were needed. As a result, the state enacted legislation creating two new sources of Medicaid funding: a 10 cents per pack tobacco tax[15] and a 17 percent increase in the general revenues allocated to Medicaid. The 1993 state legislation also made two substantive changes to the health plan. First, the priority list would cover, beginning in February 1995, the elderly and disabled, many of whom would also be enrolled in managed care. Second, the priority list was amended to cover mental health services and chemical dependency services, changes to be phased in over time.[16] With the new funding, and with the substantive changes, the Medicaid expansion was implemented on February 1, 1994.

The Employee Retirement Income and Security Act Obstacle

Enacted in 1974, the Employee Retirement Income and Security Act (ERISA) prohibits states from requiring employers to provide health insurance to their employees.[17] ERISA was intended to ensure that workers are not unfairly denied expected pension benefits. The statute requires that employers disclose relevant information about company pension plans, adequately capitalize such plans, and avoid arbitrary and inequitable vesting requirements. At the same time, however, the statute prohibits states from regulating in areas that "relate to" employee benefit plans, except if the regulation constitutes the "traditional regulation of insurance." This provision limits state efforts to regulate the health insurance market.

The drafters of the OHP were well aware of the ERISA obstacle. The drafters assumed, however, that the tides of reform would persuade Congress to amend the law to permit the employer mandate. This assumption proved wrong. Neither Oregon, Washington state (which enacted its own employer mandate in 1993), nor the

dozen or so other candidates for ERISA waivers in the early 1990s ever received congressional approval.[18]

With the ERISA waiver application languishing during the 1991 legislative session, Oregon legislators deferred the employer mandate start date until 1995. Two years later, during the next legislative session, the legislature further delayed implementation (until 1997 for large companies and until 1998 for companies with fewer than 25 employees). The 1993 law also declared that the employer mandate would be repealed unless Congress granted an ERISA waiver by January 1996. Congress did not provide the requested ERISA waiver, and the provisions of the OHP that imposed the employer mandate were repealed on January 2, 1996.

The Oregon Medicaid Program: Enrollment and Cost Trends

The implementation of the Medicaid expansion in February 1994 was expected to increase the number of Medicaid beneficiaries from 260,000 to more than 400,000. While new enrollees during the first year of implementation were somewhat fewer than expected (around 125,000),[19] by the summer of 1995 there were approximately 395,000 Medicaid beneficiaries. Since that time, Medicaid enrollment has slowly but consistently declined. By August 1998, the number of Medicaid enrollees was down to approximately 330,000. (Even with the decline, however, the number of enrollees remained substantially larger than before the OHP began.)[20]

The recent Medicaid enrollment decline is due in part to legislation enacted in 1995 that made it more difficult to obtain benefits. The new $5,000 liquid asset test (where previously there had been none)[21] and the required submission of three months of income statements (the previous requirement was for one month of income information) toughened the application process. In addition, beneficiaries who were eligible because of the recently enacted expansions were suddenly required to pay premiums. The premiums, which range from $6 to $28 per month (the average premium is $11.82), are imposed on adult beneficiaries who are not pregnant. According to one state report, approximately 700 persons lose their insurance each month after failing to pay their premium.[22] The number would be significantly higher if it were not for the state's decision to grant premium waivers to around 5,000 persons each month.

Finally, welfare reform has also contributed to the enrollment slowdown.[23] As a result of the state's welfare-to-work waiver, first implemented in July 1995, the average number of Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) cases declined rapidly. The number of Medicaid beneficiaries receiving benefits through AFDC or TANF, as shown in table 2, fell from 128,000 in 1994 to 68,000 in 1997. Only three states had a larger decline in their welfare rolls.

Despite the recent enrollment downturn, however, the number of state residents now receiving Medicaid is significantly higher than in the pre-OHP era. For example, the number of adults and children receiving Medicaid but not receiving cash benefits increased from 110,000 in 1994 to 233,000 in 1997. Indeed, between 1994

Table 2 *Medicaid Enrollment and Expenditures by Eligibility Group, Oregon and United States, Fiscal Years 1994 and 1997*

	Oregon			United States		
	1994	1997	Average Annual Growth 1994–97 (%)	1994	1997	Average Annual Growth 1994–97 (%)
Enrollees (thousands)						
Elderly	28.0	31.3	3.8	3,477.2	3,575.8	0.9
Blind & Disabled	39.5	44.5	4.1	5,293.5	6,166.3	5.2
Adults	90.5	138.5	15.2	6,880.2	6,070.6	–4.1
Cash	41.6	20.6	–20.9	4,534.7	3,217.9	–10.8
Noncash	49.0	117.9	34.0	2,345.5	2,852.7	6.7
Children	148.3	162.4	3.1	16,435.1	16,212.2	–0.5
Cash	86.4	47.4	–18.2	9,833.7	7,546.8	–8.4
Noncash	62.0	115.1	22.9	6,601.4	8,665.4	9.5
Expenditures per Enrollee (dollars)						
Elderly	9,111.0	10,760.0	5.7	10,808.0	12,430.0	4.8
Blind & Disabled	9,612.0	12,815.0	10.1	8,760.0	9,793.0	3.8
Adults	2,282.0	2,330.0	0.7	2,251.0	2,655.0	5.7
Cash	2,361.0	2,177.0	–2.7	2,006.0	2,441.0	6.8
Noncash	2,216.0	2,356.0	2.1	2,724.0	2,897.0	2.1
Children	1,632.0	1,773.0	2.8	1,304.0	1,501.0	4.8
Cash	1,775.0	1,541.0	–4.6	1,153.0	1,348.0	5.4
Noncash	1,432.0	1,869.0	9.3	1,529.0	1,634.0	2.2
Expenditures (millions of dollars)						
Elderly	255.1	337.0	9.7	37,581.8	44,448.6	5.8
Blind & Disabled	379.6	570.2	14.5	46,370.8	60,387.1	9.2
Adults	206.6	322.6	16.0	15,485.0	16,117.3	1.3
Cash	98.2	44.9	–23.0	9,094.8	7,853.6	–4.8
Noncash	108.5	277.8	36.8	6,390.2	8,263.7	8.9
Children	242.1	288.0	6.0	21,424.9	24,329.2	4.3
Cash	153.3	73.0	–21.9	11,333.7	10,171.9	–3.5
Noncash	88.8	215.1	34.3	10,091.2	14,157.3	11.9

Source: The Urban Institute, 1999. Based on HCFA 2082 data.

and 1997 there was a 15.2 percent increase in the total number of adult Medicaid beneficiaries and a 3.1 percent increase in child beneficiaries, both figures that far exceed the national average. Even with the recent slowdown, Oregon is still far ahead of the national curve.

While enrollment of adults and children increased faster than the national average, the cost per enrollee increased more slowly than the national rate. Between 1994 and 1997, for example, the average cost per adult and child enrollee grew by 0.7 percent and 2.8 percent, respectively, compared with 5.7 percent and 4.8 percent nationally. However, because of a large increase in the number of enrollees in Oregon during this time, total Medicaid costs for adults and children grew by 16 percent and 6 percent, respectively, compared with national growth rates of 1.3 percent for adults and 4.3 percent for children.[24] In addition, the cost of caring for the blind and disabled rose by 14.5 percent and the cost for the elderly grew by 9.7 percent—both faster than the national rates.

Even with the increased costs, Oregon's fiscal stake in Medicaid is relatively low. In 1997, for example, Medicaid spending accounted for only 12.4 percent of total state spending. The national average that year was 20 percent.[25]

The Impact of Rationing: Rhetoric versus Reality

The OHP drafters assumed that savings generated by limiting the benefit package provided to Medicaid beneficiaries would finance much of the cost of increasing the total number of beneficiaries. The drafters also thought that if Medicaid costs rose unexpectedly, state policymakers would cut benefits, rather than reducing eligibility or provider reimbursement.

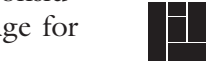
The Oregon strategy generated enormous controversy. The debate delayed by more than two years the state's effort to implement the Medicaid expansions. Oregon became famous (or infamous) for its explicit effort to ration care.

Remarkably, the rationing system has had little effect on the health care received by Medicaid beneficiaries. The effort to ration has also generated surprisingly small financial savings. Indeed, state officials suggest that the rationing initiative reduced total Medicaid expenditures by only 2 percent between 1993 and 1998.[26] Oregon's Medicaid expansions were financed, instead, by the state's 10 cents per pack tobacco tax, by significant increases in the general revenues allocated to Medicaid, and by some modest savings generated by the state's Medicaid managed care initiative.

One reason for the limited impact of the rationing initiative is that federal officials will not permit the state to impose draconian cuts in the Medicaid benefit package. Federal opposition to cuts began in the early 1990s during the initial debate over the Oregon plan. Even with lengthy negotiations and a supportive administration, the Medicaid waiver required the state to cover 606 out of 745 services on the priority list. More importantly, the waiver requires the state to seek federal permission before amending the list of covered services. As a result, state and federal officials have regularly clashed over state efforts to adjust the service package. For example, the state's Medicaid director recently complained that it took hours of lobbying before the state was permitted to exclude treatment for diaper rash.[27] The net result is that the current service package (as of May 1998) covers 574 out of 743 possible diagnoses and treatments.

Despite their best efforts to reduce covered services, state officials have never wanted an overly restrictive package:[28] The battles with federal officials are usually about services on the edge of medical necessity. Indeed, the benefit package today pays for far more treatments than Medicaid paid for before 1993, with especially generous coverage of mental health services, dental care, AIDS-related treatments, and organ transplants.[29] The state has even added physician-assisted suicide to the benefit package, despite federal refusal to contribute to the cost.

Many of the denied services are for treatments also denied by insurers (both public and private) in other states. For example, OHP will not pay for the treatment of conditions that get better on their own (such as sore throats) or for services considered primarily cosmetic (such as scar removals). The state also denies coverage for



certain experimental treatments: those with less than a 5 percent chance of extending life for more than five years.

Finally, health care providers and managed care plans often provide services that are not covered in the Medicaid benefit package. One explanation is that Medicaid covers all diagnostic services and certain uncovered conditions can be treated during the initial diagnostic visit. At the same time, providers can "game the system" by manipulating a patient's diagnosis. Health plans also can decide to cover services they deem medically necessary even if the service is not included on the state's list (though the capitation rates set by the state do not include the cost of such care). One health plan claims that 5 percent of its Medicaid claims are for noncovered services.[30]

For all of these reasons (federal oversight, state ambivalence, plan and provider discretion), prioritization has not had the expected impact. Nonetheless, the attempt to ration is hardly irrelevant. Health plans and providers do use the list as a reason to reject certain treatment requests. Moreover, and perhaps most importantly, the state ambivalence over the list and federal reluctance to allow the state flexibility may change. One high-ranking state official predicts that if the Oregon economy continues to decline, and Medicaid costs continue to rise, the state may decide to take a much more combative posture. The state's experiment with rationing is certainly not over.

The Medicaid Managed Care Initiative

Even before the enactment of the OHP, state Medicaid officials were encouraging (and sometimes requiring) beneficiaries to enroll in managed care. In 1985, for example, federal officials approved the state's request (under section 1915(b) of the social security act) to require beneficiaries in eight counties to enroll in managed care. Over the next five years, 31 percent of the state's Medicaid beneficiaries enrolled in managed care (about 68,000 persons), most of whom joined partially capitated plans (known as physician care organizations).[31]

The OHP expanded the managed care initiative in three important ways. First, managed care is mandatory for most beneficiaries around the state (not only those in the eight counties covered under the 1915(b) waiver). As a result, between 82 percent and 87 percent of the state's Medicaid beneficiaries are enrolled in managed care.[32] Second, beneficiaries are required to join fully capitated[33] health plans (unless there are not any such plans available in the client's county of residence). There are fully capitated plans in 33 of the state's 36 counties; the three without such plans are quite rural and have only a small Medicaid enrollment. Third, while mental health services and dental care services are carved out of the main managed care initiative, beneficiaries receive these services from separate mental health organizations and dental care organizations.

Medicaid Managed Care and the Elderly and Disabled

Oregon requires most elderly and disabled beneficiaries to enroll in managed care. As of November 1998, nearly two-thirds of the state's elderly Medicaid beneficiaries and 81 percent of the disabled beneficiaries were in managed care. These beneficiaries receive their Medicaid-covered acute care services through a managed care plan. In addition, certain services traditionally considered part of long-term care (home health, physical therapy, and prescription drugs) are also the responsibility of the managed care plan. Importantly, however, the other long-term care services (such as nursing home care, assisted living, adult foster care, and most in-home services) are carved out of the managed care initiative and remain in the fee-for-service system.

As in other states, there is occasional concern about inadequate coordination between the acute and the long-term care systems. Case managers in the long-term care system complain, for example, that they often are not informed about changes in prescription drug regimens that could impact home- and community-based services. State officials have taken three steps to improve coordination between the two systems. First, managed care plans are required to assign "exceptional need care coordinators" to work with the long-term care case managers in an effort to improve and coordinate care.[34] Second, the state prohibits the dual eligibles (those persons receiving benefits from both Medicaid and Medicare) from joining two separate managed care companies.[35] Third, the Senior and Disabled Services Division (SDSD) has established a task force to consider how to further improve the coordination of care between the acute and long-term care systems.

Finally, Oregon also has a Program for All-Inclusive Care (PACE) demonstration. Under this congressional initiative, nearly two dozen managed care plans around the nation receive capitated payments from both Medicaid and Medicare in exchange for providing a full slate of services (both acute and long-term care) to disabled dual eligibles who choose to enroll. In Oregon, the Providence Health Plan operates PACE sites at three locations in Portland. There are approximately 350 enrollees at the three sites. SDSD is now evaluating the state's PACE initiative to determine if it should be expanded.

The Medicaid Managed Care Delivery System

There are 13 fully capitated health plans in the state's Medicaid managed care delivery system: four are commercial HMOs that have added Medicaid as a new line of business and nine are provider-sponsored organizations that now enroll only Medicaid (and other publicly insured) beneficiaries. Table 3 lists the 13 plans and their enrollment as of February 1999.

As table 3 makes clear, the four commercial HMOs have enrolled about 56.6 percent of the state's Medicaid beneficiaries. The percentage enrolled in commercial HMOs, however, is slowly declining; back in 1995 their share was 66.5 percent. One reason for the shift is commercial disillusionment with Medicaid. Three commercial HMOs (PACC, PacificCare, and QualMed) have pulled out of the program and others (including Regence Blue Cross Blue Shield) are scaling back. The com-

Table 3 *Managed Care Enrollment, February 1999 (Total Enrollment—283,063)*

Name of Plan	Type	Enrollment as of 2/99	Enrollment (%)
Care Oregon	Provider	35,740	12.69
Cascade	Provider	6,594	2.33
Central Oregon	Provider	20,746	7.33
Douglas County	IPA	10,724	3.79
Evergreen	Provider	19,254	7.80
Inter-Community	Provider	12,764	4.51
Kaiser	HMO	22,751	8.04
Mid-Rogue	IPA	4,461	1.58
ODS	HMO	28,185	9.96
OR Health Management	Provider	10,511	3.71
Providence	HMO	41,803	14.76
Regence	HMO	67,550	23.86
Tuality	Provider	1,980	0.7

Source: Materials received from the Oregon Health Plan.

mercial plans complain that rates are too low and administrative demands are too high. In addition, many of these plans are not doing well in the commercial markets that comprise most of their business and are hoping to concentrate on their primary market by cutting back on their small, unprofitable Medicaid line. Finally, in the midst of this organizational turbulence, the Medicaid-only plans have become more experienced in managed care operations and are better able to compete effectively.

The organizational environment is less uncertain in the world of dental and mental health managed care. There are 13 dental care organizations and 12 mental health organizations that participate in the OHP, nearly all of whom are likely to remain in the market.

Marketing and Enrollment

The Oregon Medicaid program prohibits health plans from engaging in any direct marketing.[36] Instead, each health plan produces a state-approved four-page brochure that describes the plan and is distributed to Medicaid applicants. Each applicant is then required to select a managed care plan during the Medicaid enrollment process. Medicaid officials reject the applications of those persons who do not select a health plan. Roughly 5 percent of all applications are rejected for failure to select a managed care plan.[37] For this reason, unlike other states, Oregon does not need a system for assigning to a health plan those beneficiaries who do not voluntarily enroll.[38]

Health care providers are permitted to inform their patients about the health plans with which they have contracts. The providers are prohibited, however, from encouraging beneficiaries to enroll in a particular plan. By most accounts, Medicaid staff work hard to enforce the prohibition against provider marketing. The rule is especially important given that several of the plans in the Medicaid market were formed by providers anxious to retain their patient population. Nevertheless, even state officials concede that individual providers surely guide the choices of individual clients. The goal, however, is to keep such efforts to a minimum.

Clients with questions about their managed care options have several sources of information. First, the state Medicaid agency places eligibility workers at many hospitals and community health centers. Second, clients can visit a Medicaid eligibility office and speak to an eligibility worker. Third, clients can call a toll-free hotline staffed by inmates in the Oregon State Correctional Institute for answers to common questions and concerns. The inmates took over this task from the enrollment broker (HealthChoice) that the state used during the first year of the OHP.[39] The inmates also mail Medicaid applications to prospective applicants.

Paying Managed Care Plans: The Rate-Setting Process

Oregon Medicaid officials calculate health plan capitation rates[40] through a complex (though not unconventional) administrative process. The first step is for actuaries to estimate the actual cost of providing the managed care benefit package to 15 different categories of beneficiaries in five different geographic areas. The second task is to reduce those costs by about 10 percent to encourage managed care efficiencies. The third task (added in late 1998) is to adjust the rates paid to particular plans to account for the health risk status of individuals in three of the categories (those on general assistance, single adults and childless couples, and the blind and disabled who are not on Medicare).

By most accounts, the capitation rates were relatively high during the first few years of the OHP. For example, the average rate in 1996 for a nondisabled adult under the age of 65 was $130 per member per month; in Tennessee the average rate for a similar client was $100 per member per month, while in California the rate was $80.[41] Similarly, a recent study compared Medicaid capitation rates to those in the commercial sectors in 10 states: Oregon's Medicaid rates were the most generous according to this criterion.[42]

The technical explanation for the generous rates is that Oregon sets the capitation amount based on estimates of reasonable provider costs, while most other states set rates based on Medicaid fee-for-service rate schedules.[43] More fundamentally, however, state officials hoped to attract commercial HMO participation and set rates high in an effort to accomplish that task.[44] State officials also were determined to have a system of "managed cooperation" in which relationships between the health plans and government regulators were open and cordial.

Over the last couple of years, however, health plans have increasingly challenged the adequacy of the capitation rates, especially for enrollees in rural counties. These concerns encouraged several commercial HMOs to exit from the Medicaid market, a trend that began with three HMOs that each had relatively small market share (PACC, PacificCare, and QualMed). In January 1999, however, Regence Blue Cross Blue Shield, the HMO with the largest number of Medicaid beneficiaries in the state, abandoned its Medicaid contracts in several rural areas. (Regence, which lost $30 million in the Medicaid market in 1998, will continue its contracts in the larger, more urban counties). ODS, another HMO with a sizable Medicaid enrollment, also claims to be losing money in the Medicaid market and is threatening to abandon some of its Medicaid contracts.[45]

The rate controversy is unusual for a program that is proud of its partnership with health plans. State officials acknowledge that the geographic adjustment in the rate-setting process may cause rates in rural counties to be too low, and they intend to adjust the formula. Nonetheless, the likelihood of significant rate increases is rather slim. The first obstacle is the recent consultant report that suggests that Oregon Medicaid comes closer than other states to paying the rates offered in the commercial market.[46] The state's current fiscal downturn makes an increase even less likely.

One alternative to higher rates is to shift rural beneficiaries into a primary care case management system. Another approach would be to abandon administratively set rates altogether and to move to a system of competitive bidding, a change that would probably lead to lower, not higher, capitation rates.

It is hard to overstate the importance of the current rate controversy. State officials have to balance the effort to be a smart purchaser with the goal of encouraging commercial HMO participation. As part of this equation, state officials need to evaluate the impact on the system if other commercial HMOs exit the market. Will there be an adequate network of health plans? Are the rates high enough so that most of the Medicaid-only plans can survive? Should the state switch to a different rate-setting methodology?

Nearly every state in the nation is dealing with each of these issues. Nevertheless, Oregon officials have a particular strength to build upon: their reputation for dealing fairly and openly with the health plan industry. State Medicaid managers and health plan officials will need to maintain this positive relationship to most effectively resolve these problems.

Paying Health Care Providers: The Dispute between Doctors and Hospitals

The Oregon Medical Association (OMA) and the Oregon Association of Hospitals and Health Systems (OAHHS) are in the midst of a bitter dispute over the division of the OHP capitation dollar. The battle, which Medicaid officials characterize as a private dispute between health plans and their providers, was on the agenda of the 1999 legislative session.

The catalyst for the dispute is a 1997 report by health care consultant Joseph Henery[47] alleging that hospitals do far better under the OHP than do physicians. Henery sets forth three main arguments. First, physicians receive a higher percentage of the capitation dollar spent in the commercial managed care market than they do in the OHP. In the commercial managed care market, physicians receive 47.8 percent of the capitation dollar and hospitals receive 34.6 percent; in the OHP, physicians receive 35.9 percent of the capitation dollar and hospitals get 49.5 percent. Second, the disparity is caused in part by the payment methodology employed by most OHP plans: Physicians are capitated but hospitals are paid on a fee-for-service basis. This becomes important since hospitals have increased their outpatient visits and dramatically boosted their charges for those visits. Third, while overall OHP payments to hospitals have increased, payments to physicians have decreased.

Not surprisingly, the hospital association dismisses the Henery report as inaccurate and misleading.[48] Hospital representatives argue that OHP payment rates lag far

behind both Medicare and the commercial markets and that hospital operating margins are roughly the same as they were before the OHP. They claim that the hospital outpatient data cited by Henery are flawed. The high number of OHP maternity cases is one reason that OHP pays a greater percentage of the capitation dollar to hospitals. Finally, the hospital association sees the Henery report as a political manifesto, not serious health services research.

As this debate unfolds, state officials try to stay uninvolved. So far, the state has not made any effort to regulate the allocation of the capitation dollar between different provider groups. The allocation is instead considered the outcome of a private negotiation process between health plans and their provider networks.

There is growing pressure, however, for legislative or executive intervention. More than 95 percent of Oregon's physicians participate in Medicaid (an extraordinarily high number), and state officials worry that the dispute could lead to significant physician exit. Moreover, the legislature arguably contributed to the allocation disparity by requiring that rural hospitals receive cost-based reimbursement (thereby reducing the percentage of the capitation dollar available for other providers). Finally, the political visibility of the intramural dispute imposes additional pressure for some sort of state intervention.

The Quality of Care in Medicaid Managed Care

In Oregon, as in other states, it is hard to know the impact of managed care on the quality of care received by the Medicaid beneficiary. The health plans, and to a lesser extent the state, point to data that suggest improved care. According to OHP officials, the percentage of pregnant beneficiaries receiving adequate prenatal care is increasing, infant mortality is declining (slightly), and the number of young children receiving immunizations is on the rise. In addition, emergency room use is down by about 5 percent. Finally, client satisfaction seems relatively high: A state study reports that 88 percent of beneficiaries are satisfied with their care, compared with 70 percent satisfaction in 1994.[49]

Despite these positive findings, there is little data that accurately measures the quality of care (in Oregon or elsewhere) received by individual Medicaid beneficiaries. State officials indicate that health care providers often do a poor job of tracking encounters with patients. The results of the satisfaction surveys are generally ambiguous and do not report important information (such as the level of satisfaction among those who are ill). The variation of patient experience from provider to provider remains significant.

Perhaps the most persuasive evidence about the quality of care in the managed care initiative is that there is little controversy over the issue. Neither the consumer advocates nor the government regulators have alleged serious shortcomings in access or quality. There is instead an assumption shared by most of the key players that the quality of care is generally high. The lack of controversy is especially compelling given the national scrutiny that the program receives and the initial concern that the priority list would lead to inadequate care.

The Oregon Child Health Insurance Program

The Child Health Insurance Program (CHIP), enacted by Congress as part of the 1997 Balanced Budget Act, provides states with $20.3 billion over five years[50] to expand insurance programs for children under age 19.[51] Oregon's share of the CHIP revenue is $39 million annually. In order to receive its full allotment, however, the state needs to contribute $14.2 million in state general revenues. Under this division of payments, the federal government contributes 72 percent of the cost of the Oregon CHIP (substantially more than the 61.5 percent it contributes to the state's Medicaid bill).

Shortly before Congress enacted CHIP, in November 1996, the Oregon voters enacted their own child health insurance expansion initiative. The voters approved a referendum to increase the state's tobacco tax by 30 cents per pack and to use 90 percent of the tax revenue[52] to expand the OHP (the other 10 percent was for an anti-smoking education campaign and for other public health initiatives). The referendum, which passed with 56 percent of the vote, gives Oregon the third-highest tobacco tax in the nation (at 68 cents per pack).

In early 1997, the Oregon legislature decided to use some of the new tobacco tax revenue to fund expanded Medicaid eligibility for children. At that time, children six and under in families with income below 133 percent of the FPL were Medicaid-eligible, as were all other children in families with income below 100 percent of the FPL. The 1997 legislation increased the eligibility level to 170 percent for children 12 and under (the eligibility criteria for older children remained the same). The new rules were scheduled to take place in January 1998.

Following the enactment of CHIP, in late 1997, state policymakers reconsidered the Medicaid expansion. The state could maximize federal dollars by using CHIP dollars to finance the cost of the scheduled eligibility expansion. At the same time, however, state officials were not anxious to use their CHIP dollars to finance a Medicaid expansion. The state would have more discretion to set program policy under a new state-administered CHIP than it would under a straight Medicaid expansion.[53] Moreover, while Medicaid expansions were open-ended entitlements, the number of persons enrolled in a state-created CHIP could be capped.

After much debate, the state decided to create a separate state CHIP. The new program covers those children targeted by the proposed Medicaid expansion as well as older children left out of the earlier initiative. The program provides insurance coverage to children below age six in families with income between 133 percent and 170 percent of the FPL and to children ages 6 to 18 with income between 100 percent and 170 percent of the FPL.[54]

While Medicaid and CHIP are separate programs, in practice the distinction between the two is minimal. Both programs are administered by the state's Medicaid agency (the Oregon Medical Assistance Program). There is a single CHIP/Medicaid application form. Only clients that are not Medicaid-eligible are considered for CHIP.[55] CHIP enrollees receive six months of guaranteed eligibility (as do certain Medicaid beneficiaries).[56] Clients in both programs enroll in the same managed care

network and have a single benefit package. Managed care plans receive the same capitation rate for enrollees in the two programs.

In June 1998, federal officials approved the state's CHIP plan. The state began outreach and education immediately and enrolled the first beneficiaries in July 1998. According to most observers, there were fewer applications than expected during the summer of 1998, but the program grew quickly. By May 1999, there were more than 11,000 enrollees.[57] State officials expect that by late 1999 the program will reach its cap of 16,800 children. The program should therefore make a significant contribution toward reducing the number of uninsured children (now estimated to be between 60,000 and 70,000) in the state.

While Oregon's CHIP seems to be working fairly well, state officials are exploring other uses of the federal dollars. Many state policymakers are convinced that there needs to be more than a traditional insurance response to the problems of the uninsured. One possibility is to use CHIP dollars to cover the parents of eligible children.[58] A second strategy is to use CHIP dollars to fund the cost of care provided by safety net health care providers.[59] It is unclear, however, whether state officials will ever agree on an alternative strategy, or whether federal officials will permit such experimentation.[60]

Oregon's Efforts to Increase the Availability and Affordability of Private Insurance

Over the last decade, nearly every state has enacted a series of efforts to make private health insurance more available and more affordable. These initiatives focus on three problems in the health care system. First, employers in the small-business community often cannot afford to provide health insurance to their employees. Second, the employees in these companies generally earn too little to purchase their own health insurance policy. Third, persons with high-cost medical needs are often excluded from the individual insurance market even if they can afford a relatively high premium.

Oregon is a leader in the effort to reform the small-group and individual insurance markets. The state's reform initiatives can be divided into four broad categories. First are rules that govern the sale of insurance policies. Second is a state-created high-risk pool (which subsidizes the premiums for persons with high-cost health conditions). Third is a program that enables small businesses to join a state-created purchasing alliance. Fourth is a program that subsidizes the cost of private insurance for persons with income less than 170 percent of the federal poverty level.

The Oregon Small Employer Health Insurance Reforms

Over the last several years, the Oregon legislature has enacted a series of rules that govern health insurance policies sold to the small-business community. In 1989, for example, Oregon became the first state in the nation to permit insurers to offer no-frills (or "bare bones") insurance policies to small companies. The policy assump-

tion was that by waiving various coverage requirements, the cost of the policy would be lowered sufficiently to be more attractive. By 1995, 42 other states had followed the Oregon model and had authorized the sale of bare-bones policies.[61]

Oregon policymakers were also among the first to impose guaranteed issue and guaranteed renewal.[62] In 1991, the state legislature required all insurers in the small-group market (then defined as companies with 3 to 25 employees) to offer a bare-bones policy to all applicants. The 1991 law also required insurers to renew small-group coverage regardless of changes in health status. These requirements became effective in April 1993. Two years later, the state required insurers in the small-group market (this time defined as 2 to 25 employees) to guarantee issue of all insurance products. Finally, in 1997, the legislature modified the guaranteed issue and renewal requirements again, this time to comply with the recently enacted federal Health Insurance Portability and Accountability Act (HIPAA). The new rules extend guaranteed issue and guaranteed renewal to groups with up to 50 employees.

In each of the last five legislative sessions (1989–1997), Oregon policymakers have enacted additional insurance reform initiatives. One of the most important changes is a system of modified community rating in the small-group market. Under this system, enacted in 1993 and then amended in 1995, insurers are prohibited from considering health status when determining premiums for firms with 2 to 25 employees. While insurers can vary rates based on the age of the firm's employees, the most expensive small-group policy cannot be more than twice as costly as the least expensive.

Oregon has also enacted strict limits on insurers' ability to deny coverage for medical conditions that began prior to the insurance policy (limits on preexisting-condition exclusions). In the small-group market (2 to 50 employees), insurers cannot exclude preexisting conditions for more than six months, nor can they treat pregnancy as a preexisting condition. Insurers also must shorten the six-month exclusion if the insured had insurance coverage within the prior 62 days.

While Oregon's reforms in the small-group market are impressive, it is less aggressive in the individual insurance market. For years, reformers have unsuccessfully proposed guaranteed issue and modified community rating in the individual insurance market. Instead, state law simply requires that carriers use a state-approved standard health statement in the underwriting process. The limits of preexisting condition exclusions do apply, though in this market pregnancy is considered a preexisting condition.

The Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (OMIP) subsidizes the cost of insurance for high-risk individuals. There are no income or resource limits on eligibility. The only requirement is that individuals have been denied coverage for medical reasons by a private health insurer within six months of their OMIP application. There is, however, a six-month exclusion on coverage for preexisting conditions.

OMIP provides coverage to approximately 4,500 persons, most of whom are women over the age of 50. These beneficiaries pay no more than 125 percent[63] of the

cost of comparable coverage for healthy individuals. The balance of the cost is financed through a tax on insurers and reinsurers.[64] At the end of each year, the state calculates the difference between actual costs and premium income; the assessment is then levied to eliminate the gap.

OMIP enrollees have a choice of four types of plans: a traditional indemnity option, a preferred provider plan (which works like a point-of-service plan), an HMO option, and a limited benefit indemnity plan. The most popular option, selected by 50 percent of the enrollees, is the preferred provider plan. The HMO option is also popular, with roughly 36 percent of enrollees. The traditional indemnity option, which is by far the most expensive choice, has about 14 percent of enrollees. Less than 1 percent are enrolled in the limited benefit indemnity plan.

The state has hired Regence Blue Cross Blue Shield of Oregon to administer the OMIP program and, by most accounts, the program is well run. It is quite unlikely, however, that the number of OMIP enrollees will increase significantly. The reason for the informal enrollment cap is that Oregon's small-group insurance reforms require insurers to provide a modified community-rated insurance product to all persons who work for companies with 2 to 50 employees. OMIP caters to self-employed or unemployed individuals who are unable to receive Medicaid or some other insurance coverage.

The Oregon Insurance Pool Governing Board

The Oregon legislature created the Insurance Pool Governing Board (IPGB) in 1987 to encourage small businesses to provide health insurance to their employees. The main IPGB initiative is a purchasing pool that gives small companies (with 1 to 50 employees) the opportunity to buy health insurance at affordable rates. The pool is available to small employers who have not provided health insurance over the two years prior to the application. The employers must agree to pay at least $48 monthly toward the cost of the employee premium.

Two main strategies of the purchasing pool keep costs down. First, health insurance policies available through the IPGB are exempt from state benefit mandates. The policies must instead contain one of two benefit packages: a bare-bones policy or a more comprehensive policy (the "enhanced plan") that offers fewer benefits than the typical small-group policy). Second, the IPGB negotiates the cost of the policies with the participating health plans. As a result, while there is some variation in the cost of the different policies, the IPGB is able to guarantee below-market prices.[65]

Less than two years ago, the purchasing pool had 11,053 groups and 31,806 covered individuals (16,765 employees and 15,041 dependents). Since then, however, enrollment has steadily declined. As of June 1998, there were only 7,994 groups and 21,177 covered individuals (11,554 employees and 9,623 dependents). The main reason for the decline is the increased impact of the state's insurance reform initiatives. Insurance companies are now required to provide a modified community-rated insurance product to all persons who work for companies with 2 to 50 employees. The availability of this option has decreased interest in the IPGB pool; as

a result, state officials now expect the pool to be eliminated sometime in the next couple of years.

Even if the pool is discontinued, state officials expect the IPGB to expand its role in the provision of information and referrals to the small-business community.[66] The goal would be to create a source of education and outreach using a structure already in place.

The Family Health Insurance Assistance Program

In 1997, the Oregon legislature appropriated $23.7 million of tobacco tax revenue (for the 1997–1999 biennium) to create the Family Health Insurance Assistance Program (FHIAP), administered by IPGB. The goal of the program is to subsidize the cost of a standard benefit plan with a private health insurer for persons with income less than 170 percent of the FPL.[67] The amount of the subsidy varies based on the income of the beneficiary. The subsidy is 95 percent for persons below 125 percent of the FPL, 90 percent for persons between 125 percent and 150 percent of the FPL, and 70 percent for persons between 150 percent and 170 percent.

The IPGB ensures that applicants meet the income eligibility criteria and that they have not had insurance (other than Medicaid) during the previous six months. In addition, IPGB confirms that FHIAP does not subsidize any adults who have not enrolled their children either in Medicaid or FHIAP. Once clients pass this scrutiny, they receive a certificate of FHIAP eligibility. The beneficiary then purchases health insurance from any certified insurance company (unless their employers offer insurance through a certified carrier, in which case they must purchase from that carrier). Finally, enrollees receive the state subsidy (which averages $82 per month per enrollee).

FHIAP began enrolling clients in July 1998. So far, consumer interest in the program seems strong. As of November 1998, there were 1,153 persons receiving subsidies, 4,191 who had been certified eligible and were shopping for insurance, and 2,124 applicants under review. Program officials expect that by late 1999 there will be just over 7,000 total beneficiaries.

The key issue now facing program officials is the adequacy of state funding. The initial assumption was that there was enough funding to cover about 15,000 of the 67,000 Oregonians believed to be eligible. IPGB officials now suggest that to finance the cost of 15,000 enrollees the program will need between $50 million and $60 million for the 1999–2001 biennium. The officials acknowledge, however, that the likelihood of such an appropriation is minimal. Most observers believe the legislature will only allocate another $24 million for the next biennium. For that reason, the IPGB recently stopped sending out FHIAP applications. Persons who inquire are told that there is a waiting list for access to the program. For now, enrollment will be capped at around the 7,000 beneficiaries.

Given this bleak fiscal scenario, IPGB officials hope to generate federal dollars to expand the FHIAP initiative. The main strategy is to seek CHIP funding for children who enroll in FHIAP instead of CHIP (and perhaps even use CHIP dollars to finance part of the parents' care). Obstacles make this effort difficult. For example,

inconsistencies between CHIP and FHIAP need to be worked out (such as the FHIAP copayment rules). Also, federal officials are resistant to using CHIP dollars to subsidize care for adults. Nonetheless, without an infusion of federal money the program's future is not secure.

The Oregon Health Plan: The Impact on the Medical Safety Net

It is hard to decipher the impact the OHP has had on the state's medical safety net. The reduced number of uninsured should translate into increased revenue for safety net providers. According to the state hospital association, for example, charity care declined from nearly $94 million statewide in 1993–94 to just over $55 million in 1997–98, and outstanding medical debts declined from $98 million to $78 million during that same period.[68] This revenue is a windfall to an industry that has seen its negotiated discounts for the privately insured rise from less than $260 million in 1993–94 to more than $540 million in 1997–98.[69]

At the same time, however, the state's community health centers have not fared as well. The main problem is that the OHP eliminated the requirement that these facilities receive cost-based reimbursement from Medicaid.[70] As a result, community health centers must negotiate rates with the managed care organizations as part of the contracting process. According to one report, rates now are roughly 25 percent less than under the old fee-for-service system.[71] Moreover, certain services that were covered under the old fee-for-service rates (such as providing interpreters for non-English-speaking clients) are often not covered by managed care contracts.

In addition to having less revenue per Medicaid beneficiary, community health centers are coping with three problems. First, many clinics have fewer Medicaid patients. The decline is attributable to the decrease in the overall number of Medicaid beneficiaries and to the increase in competition for the remaining enrollees. Second, most clinics have had a slight increase in their uninsured population. The state's community health center association reports that as many as 75 percent of the patients in some clinics are uninsured. Third, the managed care industry requires the clinics to upgrade their information systems, to assume increased financial risk for the cost of patient care, and to simply cope with the changes associated with the managed care revolution. For these reasons, most community health centers operate at the financial edge. Three clinics closed in 1998 and others are at risk of following suit.

In an effort to minimize these and related problems, the Oregon Primary Care Association (which represents the state's community health centers), in a consortium with the Oregon Health Sciences University (the state's only academic medical center) and the Multnomah (Portland) county health department, formed a managed care organization called CareOregon. By all accounts, the organization is doing well. One indication of success is its membership growth. With just over 28,000 members, CareOregon ranks third in the state in the number of Medicaid enrollees. Over the last few years, plan membership has grown by approximately 10 percent annually,

which is especially impressive given the overall decline in Medicaid enrollment. CareOregon is also popular with its provider sponsors because it is considered "provider friendly" and pays the sponsors higher rates for primary care services than it pays to other network providers. Finally, CareOregon seems to be making a small surplus. The community centers are efficient, the inpatient care payments to the Oregon Health Sciences University are well below charges, and the plan is the chief beneficiary of the state-implemented risk adjustment.

Even with CareOregon, however, the safety net's future is uncertain. To protect it, state officials allocated $3.1 million (over two years), funds generated by the 1997 tobacco tax, to safety net providers. The money was distributed to 37 clinics in 17 counties, each of which demonstrated both fiscal need and an acceptable spending plan. The grants were used for a variety of purposes, the most common of which was for general operating costs (such as salaries, rent, and medical supplies). Other clinics purchased computers or adjusted their sliding-fee scale so that more uninsured individuals could remain patients. State officials, who are now evaluating the effectiveness of the safety net assistance program, are undecided whether the initiative will be renewed.

Long-Term Care in Oregon: An Emphasis on Home- and Community-Based Services

For more than 20 years, Oregon lawmakers have enacted policies that have successfully encouraged the elderly and disabled to receive home- and community-based services rather than enter a nursing home. Between 1981 and 1997, the number of Medicaid beneficiaries residing in nursing homes declined from 8,400 to 6,800, despite a substantial increase in the elderly population of Oregon. During that same period, the number who received home- and community-based services increased from 3,000 to 26,200. Oregon is the only state that spends more Medicaid dollars on home- and community-based services than on institutional care provided in nursing homes.[72]

The linchpin for the state's long-term care system is legislation enacted in 1981 mandating that long-term care services be delivered in the least-restrictive and least-institutional environment possible. The 1981 legislation designated the newly created Senior Services Department (now called the Senior and Disabled Services Division, or SDSD) as the state agency responsible for supervising and coordinating the various long-term care programs for the elderly. The legislation also delegated to the local Area Agencies on Aging (AAAs) the responsibility of developing a single point of entry for persons seeking long-term care so that they are informed of all available options.

Several factors are responsible for the enactment of the 1981 legislation. First, the senior advocacy community in the state is unusually influential and is strongly supportive of home- and community-based services. Second, state officials, struggling to cope with a severe recession and rapidly rising Medicaid costs, were persuaded that home- and community-based services are cost-efficient and a good

cost-containment strategy. Third, the legislation added to prior initiatives and was thus characterized as providing an incremental change. In 1975, for example, the state enacted the Oregon Project Independence, which provides state-funded in-home services to persons with incomes too high for Medicaid.[73] Similarly, between 1979 and 1981 four Oregon counties implemented a long-term care reallocation pilot project that became a model for the 1981 legislation. Fourth, there were energetic and charismatic public officials, such as Dick Ladd, who promoted long-term care reform. Ladd headed one of the county pilot projects and later became the first director of SDSD.

Standing on its own, however, the 1981 legislation could not have reconfigured the state's long-term care system. Six other initiatives were instrumental in its execution. First, in 1981, Oregon became the only state at the time to receive permission from the federal government to provide Medicaid funding for certain home- and community-based services that otherwise would not be covered. This Medicaid waiver program, designed for individuals who qualify for nursing home admission but who choose to remain at home, now serves nearly 21,000 persons.

Second, state officials used the nursing home certificate-of-need program to limit nursing home growth. As a result, the number of nursing home beds in Oregon decreased from 14,922 in 1980 to 14,502 in 1995, making it one of two states that had an actual decline in the number of nursing home beds during this period.[74] Third, Medicaid regulators kept nursing home reimbursement relatively low, thereby minimizing the incentive for new entrants. The average per diem rate in the state is $77 (compared with the national average of $84).[75]

Fourth, government officials worked diligently to expand the state's community-based services infrastructure. The focus was to develop adult foster care, assisted living, and other nonmedical residential settings, rather than traditional home care. Fifth, Oregon has the most liberal nurse delegation act in the nation. Under the law, nurses can train unlicensed staff to perform numerous medical tasks rather than having to do it themselves. For example, staff in assisted living facilities can take blood sugar levels (by sticking the client's finger to get a blood sample). As a result, unlicensed (but trained) staff can be responsible for more patients and more people can be accommodated by community-based residences. Sixth, and perhaps most importantly, SDSD and the AAAs developed a case management system that allowed clients to receive care in an unrestrictive environment.

Matching Clients to Services: The Case Management System

The key to the Oregon system is its case management system, which matches clients with needed services (preferably in home- and community-based settings). The system works as follows: A Medicaid beneficiary (or someone acting on the beneficiary's behalf) in need of long-term care services contacts the AAA[76] and speaks to a screener. The screener schedules an in-home visit by a case manager. During the

visit, the case manager assesses the extent of functional disability to determine if the beneficiary is truly in need of long-term care services.

The AAA then assigns a case manager to work with eligible clients to develop a care plan. The first task is to select among several systems of care: in-home care, adult foster care, residential care facilities, assisted living facilities, and nursing homes. The second task is to authorize the care and to select a provider, which sometimes includes negotiating a rate with community-based providers (though the state is trying to minimize this sort of negotiation). The third task is to monitor the client's case and to modify the care plan as needed.

In-Home Supportive Services

State policymakers rely heavily on in-home supportive services as an alternative to institutional care. As a result, the number of Medicaid beneficiaries who receive home care is much higher than the national average (60.3 per 1,000 beneficiaries, compared with the national average of 45 per 1,000).[77]

The main home care program relies on beneficiaries to hire and fire their own workers. The workers can be friends, relatives, or home care professionals. SDSD provides beneficiaries with administrative support (including the actual payment of wages). The client-employed provider program is especially helpful for relatively healthy elderly individuals (who need low-level homemaker-type services) and for younger individuals who have disabilities. The state also contracts with home care agencies to provide specialized care to the more disabled population.

There are two key issues in the state's home care program. First, it is increasingly difficult to hire home care workers because the wages are simply too low. Second, there is growing concern about the quality of care provided by many in-home workers. SDSD hopes to respond to both concerns with its Caregiver Quality Initiative; if enacted by the legislature, it would increase wages based on the amount of training a worker has and on the length of time the worker is employed.

Adult Foster Care

Oregon defines adult foster care as facilities with five or fewer residents and a live-in manager. During most of the 1980s, state officials vigorously promoted adult foster care as an alternative to nursing home care. State officials and AAA case managers worked hard to recruit families willing to convert their home into an adult foster care setting. In some cases, case managers negotiated deals under which facilities received higher reimbursement than was technically allowed under state law.

By the early 1990s, Oregon had hundreds of adult foster care facilities, 75 percent of which were family-owned and -occupied. These facilities became popular with both the private-sector market and the Medicaid population. More than 70 percent of the foster care residents were private, making Oregon the only state in which adult foster care was a mainstream long-term care option.

More recently, however, the adult foster care industry has entered a state of flux. The industry is no longer the featured attraction in the state's reallocation strategy.

The number of family-owned facilities is declining. The state's Long Term Care Ombudsman is challenging the quality of care provided in many of the facilities. SDSD audits confirm some problems with quality and the state legislature is demanding greater regulatory oversight.[78] The private-pay market is declining as adults who need and can afford care gravitate instead toward assisted living facilities. The supply of foster care now exceeds the demand, leading many facilities to hire placement recruiters. The industry is growing increasingly reliant on Medicaid dollars (though 60 percent of the residents are still private pay).

In this changing environment, SDSD is anxious to supervise more closely the rate negotiations between AAA case managers and foster care facilities. Under the old system, foster care rates varied by county (and even by case manager). More than 75 percent of all facilities negotiated a rate that was higher than the standard foster care rates. The new system, implemented in March 1998, raises the standard foster care reimbursement rates but makes it harder for case managers to negotiate exceptions to those rates. The impact of the new system is still to be determined.

Assisted Living Facilities

In 1989, Oregon policymakers set forth rules governing the state's assisted living industry. In some respects, the rules are quite specific. For example, every resident is entitled to a private apartment, at least 220 square feet large, with a private kitchen and a lockable door. In other ways, however, the rules are vague. There are no mandatory staff-to-resident ratios and few service requirements. Residents negotiate service packages that cover everything from making the bed to cleaning the bathroom.

In 1990, federal officials permitted the state to spend Medicaid dollars on services provided in assisted living facilities (though Medicaid will not pay for room and board). Assisted living soon became an important part of the state's reallocation strategy. Medicaid beneficiaries now occupy between 25 percent and 30 percent of the state's 4,900 assisted living beds.

According to industry representatives, the Medicaid rates are generally adequate, at least for clients who are significantly disabled. Indeed, until recently, the rates paid on behalf of the Medicaid clients were nearly comparable to private-pay rates.[79] By all accounts, however, the private-pay rates are rising more quickly than the Medicaid rates and the disparity between the two, while still small, is growing. This pattern is making it hard for Medicaid beneficiaries to find assisted living placements, a trend not likely to abate unless demand in the private market slows considerably.

The Nursing Home Industry

During Dick Ladd's tenure, many representatives from the nursing home industry felt that the industry was unfairly demonized. One industry representative recalled seeing a graph showing declining nursing home occupancy prominently displayed in Ladd's office. A high-ranking state official described the Ladd era as "the revolutionary period," because the state abandoned its previous bias for nursing home placement.

As part of this reallocation effort, Ladd (and his successor, Jim Wilson) tried to minimize nursing home reimbursement increases (and to direct funds to home- and community-based services). This effort led to ongoing, costly litigation; the industry sued under the Boren Act for higher reimbursement. According to industry representatives, state officials relied on the litigation to persuade the legislature not to get involved in nursing home reimbursement issues.

Amidst the political conflict, the nursing home industry itself has begun to change. Nursing home residents are now more impaired than in previous years. The relatively healthy elderly are diverted to home- and community-based alternatives. At the same time, the average length of stay is shortening. According to industry representatives, 80 percent of nursing home residents stay fewer than 90 days, 64 percent stay fewer than 30 days, and 41 percent stay fewer than 14 days. More than ever before, nursing homes are used as short-term, post-acute settings. Finally, nursing home owners are diversifying their holdings. Some are converting unused beds into alternate levels of care to accommodate patients with different levels of disability. Others are entering the assisted living market and developing campuslike settings in which residents "age in place."[80]

Over the last few years, the relationship between SDSD and the "new" nursing home industry has improved dramatically. One explanation is that the current head of SDSD, Roger Auerbach, is less confrontational than his predecessors. Auerbach acknowledges that the industry is an important part of the state's long-term care infrastructure. One of his first acts was to negotiate a settlement of the rate reimbursement litigation. He then included industry representatives in ongoing discussions about the future of the state's long-term care system.

The Rising Cost of Long-Term Care

The state's Medicaid waiver requires that the newly designed long-term care system be "budget neutral." While Oregon officials argue that the system costs less than its predecessor, little evidence supports this claim. State officials point to the reduced per capita costs of long-term care and to the cost-effectiveness of preventive services (for example, the hip fracture prevented by the delivery of in-home bathing services). Nonetheless, there clearly is some "woodwork" effect under which clients now receive services that they previously would have gone without. The extent of the woodwork effect is unknown (and state officials have little incentive to figure it out). However, federal officials have not focused on the budget neutrality issue during the waiver renewal negotiations.

Nonetheless, during the 1999 legislative session, SDSD managers need to explain why the agency requires a 20 percent increase in funding simply to maintain its current service budget for 1999–2001. This discussion will surely focus on the blind and disabled, the groups with the fastest-growing long-term care costs. SDSD officials also hope to persuade the legislature to fund several new long-term care initiatives (such as increased wages for in-home workers and expanded Medicaid eligibility for the working disabled).[81] While Oregon's emphasis on home- and community-based services may or may not be cost-effective, the overall cost of Oregon's long-term care system is clearly increasing.

Other Long-Term Care Initiatives

Oregon is planning and implementing a host of additional long-term care initiatives. First, the state has the nation's most aggressive estate recovery program, allowing it to claim assets (such as a home) that could not be counted when calculating eligibility. In 1997, the estate recovery division collected nearly 5 percent of its Medicaid nursing home expenditures from this effort, far more than any other state.[82] Second, Oregon is about to offer state employees the option of purchasing private long-term care insurance at the state's group rate. While the state will not subsidize the cost of this insurance, state officials are eager to test the popularity and the effectiveness of this approach. Third, Oregon has requested permission from the federal government to begin a "cash and counseling" demonstration; up to 300 beneficiaries will develop their own in-home service package and receive cash from the state in order to fund their care. Fourth, the state is implementing the so-called "Vision 2000" initiative, under which nursing homes that convert beds into alternative care settings can receive the higher nursing home reimbursement rate for five additional years.

Conclusion

Oregon leads the effort to guarantee low-income residents access to affordable health insurance; state efforts have contributed to a rapid decline in the number of uninsured residents. Oregon's long-term care system is a national model. No other state can claim that it spends more Medicaid dollars on home- and community-based services than on the institutional care provided in nursing homes. To the contrary, across the United States Medicaid spends more than 80 percent of its funds on the care provided in institutions.

Despite its achievements, Oregon still faces three important challenges for the future. First it must address the recent rise in uninsured residents. This trend is especially unsettling given the state's initiatives on behalf of low-income populations (CHIP and FHIAP). State officials are seeking to understand the causes of the trend (welfare reform, premiums charged to some OHP enrollees, downturn in the economy, etc.) and develop strategies to reverse it.

Second, state officials are also evaluating the impact of commercial HMO withdrawal from the Medicaid market. They are asking several questions, such as: How many plans will withdraw? Which counties will be left without plan coverage? Can the Medicaid-only health plans survive? Should the state adopt a primary care case management program in rural communities? In addition, state officials are trying to mediate the dispute between doctors and hospitals over the allocation of OHP capitation dollars. This is a private-sector issue with important public-sector consequences.

Finally, as the state's innovative long-term care system matures, new challenges arise. The costs of long-term care services are growing rapidly, especially for younger people with disabilities. Since the long-term care reforms were presented to the leg-

islature largely as a cost savings strategy, this is particularly problematic. The state remains firmly committed to further expanding home- and community-based services, but staffing shortages make this difficult. The state's regulatory structure has emphasized flexible service provision and consumer choice, but reports of poor-quality care in home- and community-based services raise questions about whether more oversight is needed.

Notes

1. State of Oregon, *Governor's Recommended Budget: 1999–2001* (1999), page ii-7.
2. AARP, *Reforming the Health Care System: State Profiles 1997* (Washington D.C., 1997).
3. Urban Institute, two-year concatenated March CPS files, 1995 and 1996. The Urban Institute TRIM2 microsimulation model edits these files. Excludes those in families with active military members.
4. Ibid.
5. AARP, *Reforming the Health Care System: State Profiles 1998* (Washington, D.C., 1998).
6. State of Oregon, *Governor's Recommended Budget: 1999–2001* (1999), page ii-1.
7. AARP, *Reforming the Health Care System: State Profiles 1998* (Washington, D.C., 1998).
8. Ibid.
9. State of Oregon, *Governor's Recommended Budget: 1999–2001* (1999), page ii-2.
10. Ibid., pages ii-3 and ii-4.
11. Data received from the Office for Oregon Health Plan Policy and Research.
12. Marsha Gold, "Markets and Public Programs: Insights from Oregon and Tennessee," *Journal of Health Politics, Policy and Law* (April 1997); Howard Leichter, "Rationing of Health Care in Oregon: Making the Implicit Explicit," in *Health Policy Reform in America: Innovation from the States, second edition*, edited by Howard M. Leichter (M.E. Sharpe, 1997); and Martin A. Strosberg, Joshua M. Weiner, and Robert Baker, editors, *Rationing America's Medical Care: The Oregon Plan and Beyond* (Washington, D.C.: The Brookings Institution, 1992).
13. The new law also expanded eligibility for pregnant women and children under age 6 to 133 percent of the FPL, as required by federal law.
14. Oregon's supporters in the White House did not include Vice President Al Gore. Gore was a fierce and prominent opponent.
15. This tax is scheduled to expire on December 31, 1999. State officials are, however, assuming that the legislature will renew the tax and that the tax will generate about $35 million over the next two years.
16. The phase-in was not completed until July 1997.
17. Employer mandates "relate to" employee benefit programs and are not considered part of the traditional state regulation of insurance.
18. The only state ever to receive an ERISA waiver is Hawaii. Hawaii is considered a special case because its employer mandate was enacted prior to ERISA.
19. Enrollment in the first three months of the initiative was higher than expected, leading to a variety of implementation problems. For example, when beneficiaries tried to call HealthChoice (the enrollment broker hired by the state), they generally had trouble accessing the toll-free telephone number. Clients complained of busy signals, long delays, and unanswered messages. Over the next several months, however, the number of new enrollees declined dramatically.
20. Office of Medical Assistance Enrollment and Disenrollment Reports, 1994–1998.
21. Liquid assets include cash, bank accounts, and securities but not a house or car.
22. State officials note that many of these persons subsequently pay their premiums and regain program eligibility (and perhaps later fail to pay and are again disenrolled).

23. An increase in the state's minimum wage may also be contributing to the reduced enrollment since 1995. The minimum wage increased from $4.75 per hour to $5.50 per hour as of January 1997. This increase raised the household income of the head of a two-person family who worked full-time from 91 percent of the FPL to 103 percent, from Medicaid-eligible to Medicaid-ineligible.

24. The Urban Institute, 1998. Based on HCFA 2082 and HCFA 64 data.

25. AARP, *Reforming the Health Care System: State Profiles 1998* (Washington, D.C., 1998).

26. Lawrence R. Jacobs, Theodore Marmor, and John Oberlander, "The Political Paradox of Rationing: The Case of the Oregon Health Plan" (The Innovations in American Government Program, Occasional Paper 5-98), p. 4.

27. Peter T. Kilborn, "Oregon Falters on a New Path to Health Care," *New York Times* (January 3, 1999), p. A-1.

28. A recent article argues that "state reformers used the rhetoric and process of prioritization and rationing to build a durable political coalition in favor of expanded access for the poor. Jacobs, Marmor, and Oberlander, p. 11.

29. Ibid., pages 4–5.

30. Ibid., p. 4.

31. Marsha Gold, "Markets and Public Programs: Insights from Oregon and Tennessee," *Journal of Health Politics, Policy and Law* (April 1997), p. 641.

32. In recent months, the percentage of beneficiaries enrolled in fully capitated health plans has declined. The main reason for the decline is the changed demographics of the Medicaid population. The percentage of aged and disabled beneficiaries is increasing (mainly because welfare reform is reducing the number of child beneficiaries) and only 65.4 percent of aged beneficiaries and 81 percent of disabled beneficiaries are enrolled in managed care.

33. Medicaid, like most health insurers, traditionally paid health care providers a separate fee for every medical service they provided. One goal of the managed care movement is to abandon this fee-for-service payment system, on the ground that it encourages providers to provide unnecessary care. There are three main alternatives. One approach is to require health plans to provide enrollees with a full range of primary and acute care services in exchange for a set per-member per-month fee. This is known as a fully capitated system. A second approach is to require the plans to provide primary care services in exchange for a set fee (with the clients receiving acute and specialty care under the old fee-for-service model). This is known as a partially capitated system. The final approach is to keep the basic fee-for-service model, but to pay primary care physicians an extra fee to manage the care of their patients.

34. The exceptional needs care coordinators also help special needs beneficiaries access acute care services.

35. Dual eligibles who are still in the Medicare fee-for-service system are required to join a Medicaid managed care plan. Medicaid also pays the Medicare deductibles and copayments. Dual eligibles who enrolled in a Medicare managed care plan that also participates in Medicaid must receive their Medicaid coverage through the plan as well. Dual eligibles who are enrolled in a Medicare managed care plan that does not participate in Medicaid are not required to join a different Medicaid managed care plan. The underlying theme is that each aged and disabled beneficiary should be in one (but not more than one) managed care plan.

36. State officials are considering an end to the ban on all direct marketing. The issue is whether new entrants to the market can compete without some marketing initiatives.

37. Irene Fraser, Elizabeth Chait, and Cindy Brach, "Promoting Choice: Lessons from Managed Medicaid," *Health Affairs* (October/November 1998), p. 172.

38. Oregon adopted this system in October 1996. Even before the new system was implemented, beneficiaries were expected to choose a plan during the application process; failure to select a plan was not, however, a ground for rejection. Under the previous system, more than 90 percent of applicants voluntarily selected a health plan. Marsha Gold, Karyen Chu, and Barbara Lyons, "Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon." A report sponsored by the Kaiser Family Foundation and the Commonwealth Fund. Washington, D.C.: Mathematica Policy Research, June 1995.

39. The state was not satisfied with the performance of the enrollment broker and did not renew its contract.

40. Health plans in Oregon provide a full range of medical services to enrollees in exchange for a fixed fee. This fee is known as the Medicaid capitation rate.

41. Thomas Bodenheimer, "The Oregon Health Plan: Lessons for the Nation (Part One)," *New England Journal of Medicine* (August 28, 1997).

42. Office for Oregon Health Plan Policy and Research. "Assessment of the Oregon Health Plan Medicaid Demonstration" (February 1999), page 55, citing a study by Milliman and Robertson.

43. Ibid.

44. Bodenheimer, "The Oregon Health Plan: Lessons for the Nation."

45. There are certainly many reasons why commercial health plans are exiting the Medicaid market. Regence Blue Cross, for example, had trouble negotiating an acceptable risk-sharing contract with several of its rural provider groups. Other health plans cite the uncertainty in the commercial market and the need to focus on core product lines. The fact remains, however, that health plans generally do not exit from profitable lines of business.

46. Milliman and Robertson, *Actuarial Review of the Reasonableness of OHP Managed-Care Capitation Rates* (December 9, 1998).

47. Joseph J. Henery, *Oregon Health Plan—The Financial Impact: A Comparative Study* (February 1997). The OMA commissioned the report.

48. Letter from Ken Rutledge, president of the Oregon Association of Hospitals and Health Systems (November 10, 1998).

49. Oregon Office of Medical Assistance Programs, *Progress Report—The Oregon Health Plan Medicaid Reform Demonstration: Part I—Overview of Key Accomplishments* (January 1997).

50. The program appropriates an additional $19.3 billion for the subsequent five years.

51. States can spend no more than 10 percent of the federal dollars on outreach, administration, or direct payments to providers.

52. During the 1997–1999 biennium, the new tobacco tax is expected to generate around $110 million.

53. Like other states, Oregon could choose whether to use the CHIP funds to liberalize its Medicaid eligibility criteria, or to finance a separate state-established program, or to do both.

54. The only group still covered by the Medicaid expansion is pregnant women in families with income below 170 percent of the FPL.

55. CHIP enrollees must also have not had health insurance (other than Medicaid) for the six months prior to their application, except if the child has an unusually serious medical condition or is a victim of domestic abuse.

56. Those Medicaid beneficiaries who receive coverage because of the Oregon Health Plan expansions receive six months of guaranteed eligibility; other Medicaid beneficiaries do not.

57. Data received from the Office for Oregon Health Plan Policy and Research.

58. The goal here is to use CHIP dollars to finance part of the cost of the state's Family Health Insurance Assistance Program (FHIAP), which subsidizes the cost of private insurance for families with income below 170 percent of the FPL.

59. Federal law prohibits states from using more than 10 percent of CHIP dollars for outreach and education, or to subsidize directly the cost of care provided to children. Several state officials are hopeful that Congress will either change that rule or authorize federal regulators to waive the rule where appropriate.

60. One obstacle to the effort to use CHIP dollars to finance part of the cost of FHIAP is that FHIAP has cost-sharing rules that are impermissible under CHIP.

61. Gail Jensen and Michael Morrisey, "Small Group Reform and Insurance Provision by Small Firms, 1989–1995" (Kaiser Family Foundation, fall 1997), p. 5.

62. Guaranteed issue laws require insurers to offer health care coverage to all applicants. As of 1997, 38 states have enacted laws that guarantee issue to persons in the small-group market. Guaranteed renewal laws require insurers to offer to renew the health care contracts of members so long as the member has complied with the basic rules of the policy. The laws are important because they prevent insurers from denying coverage to members who develop health care problems. As of 1997, 43 states have enacted laws that guarantee renewal to persons in the small-group market.

63. Before October 1996, premiums were not allowed to exceed 150 percent of the prevailing market rate.

64. The federal ERISA statute prevents the state from imposing the tax on companies that self-insure.

65. The price is also kept down because health plans are allowed to refuse to accept companies with high-risk employees. The only restriction on the underwriting is that health plans cannot selectively cover certain employees but not others; the plan must cover all employees (or all managers) or none at all.

66. The elimination of the IPGB purchasing pool would mark the second time an IPGB program was eliminated. In the early 1990s, IPGB administered a system of tax credits for those small businesses that chose to offer health insurance (after not having offered such insurance for at least two years). By most accounts, this initiative was neither effective nor equitable, and it was abandoned in July 1995.

67. The enabling legislation authorized subsidies for persons with income less than 200 percent of the FPL, but state regulators have capped enrollment at the 170 percent level.

68. OAHHS letter dated November 10, 1998.

69. Ibid.

70. Congress imposed the cost-based reimbursement requirement in 1989. The requirement led to increased revenue for most community health centers, including those in Oregon. When approving the Oregon Health Plan, however, federal officials also exempted the state from the cost-based reimbursement requirement. More recently, the Balanced Budget Act enacted by Congress in 1997 required the gradual phaseout of the cost-based reimbursement requirement in the rest of the country.

71. Tom Bodenheimer, "The Oregon Health Plan: Lessons for the Nation (Part Two)," *New England Journal of Medicine* (September 4, 1997).

72. Richard Ladd, Robert Kane, Rosalie Kane, and Wendy Neilsen, *State LTC Profiles Report* (University of Minnesota, November 1995).

73. This program now serves approximately 3,500 persons.

74. Similarly, in 1982, Oregon had 47.5 nursing home beds per 1,000 persons age 65 and over; by 1995 the number had declined to 33.8 (which is well below the national average). Lisa Maria B. Alecxih, Steven Lutzky, John Corea, and Barbara Coleman, "Estimated Cost Savings from the Use of Home and Community Based Alternatives to Nursing Facility Care in Three States" (The Public Policy Institute, AARP, November 1996), p. 7.

75. AARP, *Across the States, 1997: Profiles of Long-Term Care Systems* (Washington, D.C., 1997).

76. In some of the state's smaller communities, SDSD workers perform the case management functions.

77. AARP, *Across the States, 1997: Profiles of Long-Term Care Systems* (Washington, D.C., 1997). Interestingly, Oregon ranks last in the nation in home health expenditures per Medicare client.

78. Senior and Disabled Services Division, *Adult Foster Care: 1996 Audit Report Summary* (November 1996).

79. The rate paid on behalf of the Medicaid client includes the Medicaid reimbursement for medical services provided, and other government funding (mainly Social Security and Supplemental Security Income payments) to cover room and board.

80. The term "age in place" is generally used to describe a residential setting in which a consumer could move from one level of care (such as assisted living) to another (such as a nursing home) without leaving the campuslike setting.

81. In 1997, in an effort to lower costs, SDSD proposed a new long-term care reimbursement system. Under the proposed system, the state would set reimbursement levels based on client impairment; providers (from nursing homes to adult foster care facilities) would need to accept the client-based rate. The proposal was fiercely opposed by providers, advocates, and even government officials and is now off the agenda.

82. Charles P. Sabatino and Erica Wood, *Medicaid Estate Recovery: A Survey of State Programs and Practices* (Public Policy Institute, September 1996).

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