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Impact of Premium Changes in the Oregon Health Plan

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EXECUTIVE SUMMARY

In February 2003, Oregon implemented the Oregon Health Plan 2 (OHP2), comprised of three Medicaid benefit packages – Plus, Standard, and a premium subsidy program, the Family Health Insurance Assistance Program (FHIAP). The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves the Medicaid categorically eligible population. The OHP Standard benefit package, designed for Oregon's expansion population (adults, 19-64, up to 100 percent of the Federal Poverty Level) is characterized by a reduced benefit package, co-payments for most medical services, some increased premiums, premium collection rules resulting in disqualification for a single missed payment, elimination of waivers of premiums for special groups including zero-income beneficiaries, and a six-month lockout from OHP following disenrollment or disqualifications.

The results of these changes have been large decreases in enrollment and potential revenues from premiums. In brief:

- **Total enrollment fell from approximately 102,000 OHP Standard beneficiaries in 2002 to approximately 51,000 in late 2003.**
- **Approximately 16,000 OHP Standard beneficiaries (20% of enrollment) were disqualified in April under new administrative policies for premium payments**
- **Enrollment for zero-income OHP Standard beneficiaries fell from 42,000 in 2002 to approximately 17,500 in October, 2003, a 58% drop.**
- **Potential revenues for premiums fell from approximately $800,000 per month in 2002 to slightly more than $500,000 per month in late 2003.**
- **Although premiums increased across the board for all couples, potential revenues from premiums fell substantially less for couples than for single OHP Standard beneficiaries.**

These results suggest that low-income, single individuals have been most susceptible to the changes in OHP2.

INTRODUCTION

The Oregon Health Plan (OHP) Standard program, established in February, 2003, significantly changed the benefits and expenses associated with OHP for the approximately 100,000 beneficiaries in the 'expansion population' who would not be covered under a traditional Medicaid program. OHP Standard introduced co-payments for services, increased monthly premiums, and eliminated some benefits. One unintended consequence of those changes has been a dramatic decrease in enrollment, falling from an average of 102,000 beneficiaries a month in 2002 to slightly more than 50,000 in late 2003 – approximately a 50% drop in enrollment. In this report, we describe the effect of OHP Standard administrative changes on enrollment and highlight the effect on beneficiaries in different income brackets. We also describe the net effect of changes in enrollment and increases in premiums.

BACKGROUND

In February 2003, the Oregon Health Plan (OHP) made the most significant changes in its structure and design since its inception in 1994. The new plan, known as OHP2, was largely a response to the state's financial crisis and budget shortfall. The primary goal of the changes was to reduce the net expenditures associated with OHP while maintaining as much of the expanded coverage to individuals who would otherwise be uninsured.

Perhaps the most significant change was the creation of two distinct programs within OHP2, "OHP Plus" and "OHP Standard." Most of the approximately 300,000 beneficiaries who were categorically eligible for Medicaid were moved on to the OHP Plus plan. These beneficiaries have seen little substantial change in their benefit package. The 100,000 beneficiaries who were part of the OHP "expansion group" – those individuals who would be unlikely to find coverage through traditional Medicaid or private insurance – were moved on to the OHP Standard plan.

OHP Standard beneficiaries have seen a number of changes in their benefits, co-payments, and monthly premiums. These changes, and associated changes that occurred with OHP2, are outlined in detail in Appendix 1. In general, the OHP Standard plan represents an attempt to reduce total expenditures associated with OHP through a combination of increasing revenues (through increases in monthly premiums), reducing the potential for enrollment based on retrospective need for services (by requiring a 6 month period of un-insurance before re-enrollment), and reducing utilization by establishing mandatory co-payments for most services and elimination of some benefits. Initially this meant eliminating benefits for hearing, vision, and some dental services, as well as benefits for durable medical equipment (DME) and non-emergency transport. However, with increasing state budget deficits, cuts in benefits were expanded to include the elimination of the remainder of the dental benefit, as well as outpatient mental health services and outpatient services for chemical dependency. In addition, coverage of prescription drugs was eliminated at the beginning of March, but then reinstated in mid-March. The change in the premium structure that occurred with OHP Standard is shown in detail in Appendix 2. All cases that enrolled more than one individual (for example, married couples)

experienced an increase in monthly premiums. For instance, a married couple between 85% and 100% of the Federal Poverty Level (FPL, described in Appendix 3) would see their premiums increase from $23 to $40. Many cases with a single individual did not see changes in their premiums. However, individuals between 10% and 50% of FPL faced premium increases from $6 to $9. Moreover, prior to OHP2, a number of beneficiaries were able to waive their premium if, for example, they had no income at the time of enrollment. This premium waiver provision was eliminated with OHP Standard, effectively raising the premium on many of these individuals from $0 to $6. In total, approximately 40% of all individuals in OHP Standard would have seen an increase in their premiums beginning in February 2003.

Another important change that occurred with OHP Standard was a stricter administrative requirement of monthly premium payments. Previously, beneficiaries were allowed to pay their premiums in arrears for up to six months. If they did not pay, they were disenrolled but had the opportunity to re-enroll at any point by paying off their full premium debt. This stands in contrast to the current policy where OHP Standard beneficiaries who fail to pay a monthly premium bill are disqualified in the next month. Moreover, they may not re-enroll for another six months. Although this policy was part of the February 2003 changes, it was not enforced until April 2003, resulting in the single largest one-month decrease in OHP enrollment.

Together, these changes have resulted in a program that is more expensive for many beneficiaries and much less forgiving in missed payments. As a result, enrollment in the expansion population is down from around 102,000 in 2002 to 51,000 in October 2003 – a 50% drop in enrollment occurring in less than one year. In the following sections, we describe these changes and highlight the effect on specific groups of beneficiaries.

DATA

The findings in this report are based on monthly enrollment data for OHP Standard clients, spanning January 2002 through October 2003. These data provide information on whether an individual was enrolled for a given month. Demographic data are also available including information on the beneficiary's age, gender, race, income, and primary language. Additionally, these data include information on the number of children associated with the case (but not insured through OHP), monthly premium charged (but not necessarily collected), and a variable denoting whether the individual was "disqualified" in accordance with the OHP2 administrative regulations that disenrolled individuals who did not pay their premiums each month.

To be consistent with manner in which premium determination and payment policies were applied, the unit of observation for the study was an OHP Standard case. A case may contain an individual, a couple or a family. We used case level income data and guidelines from the Federal Registry to estimate the percent FPL for each case. FPL for 2002 and 2003 is listed in Appendix 3. In addition, we took four steps designed to eliminate observations that could not be reconciled with administrative policy. Specifically, to generate a cleaner dataset, we excluded the following cases:

- Cases that appeared to be “disqualified” at the time of their enrollment (37 cases eliminated).
- Cases with recorded premiums that were not used by the OHP system, or that were clearly an error in recording data. (105 cases eliminated).
- Cases with income > 300% FPL. (73 cases eliminated).
- Cases flagged as “disqualified” in accordance with changes in OHP2 policy but exhibiting continued enrollment. (209 cases)

An additional step was taken in the classification of clients. If any client registered “zero” premiums beginning sometime after May, 2003, and continuing until the last month of enrollment, it was assumed that this client had been “disqualified”, but the accounting system had not been updated to flag these patients with the “disqualification” field.

The original database contained 201,156 cases (226,934 individuals). After steps were taken to eliminate the cases described above, the database was left with 200,732 cases (226,458 individuals).

RESULTS

Changes in Enrollment

In this section, we describe the changes in enrollment among OHP Standard clients, and then describe changes among separate FPL brackets. We move on to discuss the underlying dynamics of these changes, including new enrollments, disenrollments, and individuals who are “disqualified” following the new administrative policies of OHP2. Finally, we describe the effect on revenues that occur with higher premiums but lower total enrollment.

Chart 1 displays total enrollment for the “expansion group”, or OHP Standard beneficiaries. Enrollment is relatively steady in 2002, with an average of 102,000 individual beneficiaries, begins to fall in February 2003, with the implementation of OHP2, and experiences a precipitous drop between April and May 2003. This sharp drop occurs with the official implementation of the disqualification policy, which in May disenrolled many OHP Standard beneficiaries who had failed to make a premium payment during the two months after initial OHP2 implementation. Enrollment appears to have stabilized by September and October 2003 at around 51,000 beneficiaries. This represents a 51% drop from the average enrollment of 102,000 in 2002.

OHP2 requires 6-month period of un-insurance before enrollment will be considered. This stipulation also applies to those who have disenrolled from OHP2 creating a six-month “lock-out” period for disenrollees. The number of individuals disqualified after April 2003, may be a reflection of confusion about the changes in the plan, rather than an indication of a specific choice not to re-enroll. Future analyses of data collected after October 2003 may provide some indication of the propensity of the large number of clients disenrolled in May 2003 to attempt to re-enroll six months later.

Chart 2 separates enrolled OHP Standard beneficiaries into one of seven FPL brackets, progressing from zero income beneficiaries to those registering incomes greater than 100 % FPL.[1] Among these seven FPL brackets, the bracket that includes the largest number of beneficiaries is the zero-income bracket. This group also displays the most substantial disenrollment occurring with OHP2, from an average of approximately 42,000 in 2002 to slightly more than 17,000 in October 2003, a 58% drop.

Chart 3 shows the change in case mix occurring with OHP2 by comparing October 2002 to October 2003. Proportionally, the largest drop occurred in beneficiaries with zero-income, who comprised approximately 41% of all 'expansion group' clients prior to OHP2 and approximately 34% of OHP Standard clients in October 2003. Currently, the program consists of proportionately more beneficiaries above 50% FPL, with these individuals comprising approximately 38% of all 'expansion group' clients prior to OHP2 and approximately 42% of OHP Standard clients in October 2003. Thus, the composition of the OHP expansion group has shifted to include a larger share of individuals with higher incomes. However, the zero-income group still represents the largest percentage (34%) of OHP Standard beneficiaries.

New enrollments, disenrollments, and disqualifications

Chart 4 displays the dynamics behind the changes in enrollment: new enrollments each month; disenrollments who are defined as individuals who drop off the program; and, disqualifications who are defined as the group of beneficiaries who are disqualified from the program after implementation of OHP2 due to failure to pay monthly premiums.

Most striking is the surge in disqualifications occurring in May: 13,071 individuals were disqualified in that month. From May through October 2003, 30,969 disqualifications took place, compared to 35,377 voluntary disenrollments during that same period, for a total of 66,346 individuals leaving the program.

Note that there were approximately 65,000 disenrollments in the same time frame in 2002. However, at that point in time, many of those disenrollments would be followed by a re-enrollment within a short period of time, while the 66,346 individuals leaving in May through October, 2003 were subject to a six month uninsurance period before becoming eligible for OHP coverage.

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[1]*Although OHP Standard's income eligibility extends only to individuals below 100% of FPL, approximately 3% of our observations registered incomes above this level. There are two likely explanations for this occurrence. First, FPL was calculated based on data for case income and our estimation of the number of the people in the family. Errors in our interpretation of children in the case or income associated with the case may have led to imperfect calculation of percent FPL. Second, the eligibility requirement of less than 100% FPL is typically based on a 3-month moving average of income. Some individuals may have registered incomes above 100% FPL for short periods of time, without technically losing their eligibility. These cases comprise about 3% of observations*

New enrollments remained fairly stable in 2002 but showed a very large drop in February and March 2003. By October 2003, new enrollments seemed to have climbed back to a more stable level. However, the approximately 6,000 new enrollments in October are only slightly more than half of the average monthly 10,000 new enrollments occurring in 2002.

Charts 5-10 display enrollment patterns for different FPL brackets. The patterns among these groups are fairly similar. The largest deviation seems to be among beneficiaries at the zero-income level. These individuals have a larger proportional rate of disqualification (approximately 7,000 in April, or 23% of enrollees in that month). In addition, the rate of new enrollment comes back to a much lower level for these individuals. While new enrollments tend to return to prior levels for other income groups, new enrollments at the zero-income level remain at less than half of the typical monthly enrollment in 2002.

Charts 11-14 display total enrollment for different case profiles: one-person cases without children; one-person cases with children; two-person cases without children; and two-person cases with children. The income distribution and enrollment patterns for these groups vary dramatically. In general, one-person cases with no children seem to be the poorest individuals, and two-person cases with children appear to be in the higher FPL brackets. The group showing the largest proportional drop in enrollment for any single group is the group of one-person cases with children and zero income. This group shows a 79% drop in enrollment, from an average of 4,300 enrollees in 2002 to slightly less than 900 in October 2003. Of note, enrollment for this group is in decline throughout 2002. However, even when comparing enrollment changes in January, 2003 to October, 2003, this group experiences a 71% drop in enrollment, which is still the largest proportional drop in enrollment for any of these groups. Details of the changes in enrollment, and proportional changes, are displayed in Tables 1 and 2.

Premium revenues

Revenues are calculated by taking a sum of premiums charged for each month. This figure represents the maximum collectable. In practice, collected revenues will be substantially lower, since premiums are collected at a rate lower than 100%. OMAP estimated a collection rate of between 70% and 80% in 2002, and projected a collection rate close to 95% in 2003.

Chart 15 displays changes in revenues occurring with implementation of OHP2. In 2002, potential monthly revenue from premiums averaged about $800,000, or $9.6M annually. The increase in premiums shows spike in potential revenues in February 2003, with a maximum of $900,000 collectable in that month. However, in the following months, the decline in enrollment leads to a net decrease in revenues, averaging slightly more than $500,000 a month by late 2003 (equivalent to $6 million annually), approximately 65% of potential revenues seen in 2002.

Chart 16 shows monthly revenue from each income group. Most of the revenue comes from the highest income group, the 85% to 100% FPL bracket. In 2002, slightly more than $200,000 per

month could be collected from this group. Following OHP2, these potential revenues are closer to $150,000 per month.

In 2002, individuals with no reported income made the next largest potential contribution to premium revenues, at slightly less than $200,000 per month. By 2003, however, these potential revenues are down to slightly more than $100,000 per month.

It is informative to consider the difference between cases with a single individual and cases with two individuals (e.g., a married couple). Two-person cases, unlike single individuals, received across-the-board increases in their premiums (see Appendix 2 for details). All else being equal, we would expect this change to result in increased disenrollment. However, both groups show disenrollment rates of approximately 50% between 2002 and October 2003. Enrollment of 76,000 single cases in 2002 fell to 38,000 individuals in October 2003. Enrollment of 11,000 couples (22,000 individuals) in 2002 fell to 5600 couples (11,200 individuals) in October 2003. The average one-person beneficiary is poorer than the average two-person case, and, since poorer groups were more likely to disenroll, the lack of greater disenrollment among couples may be a reflection of the different impact OHP2 had among different FPL groups. However, the fact that two-person beneficiaries did not fall off more rapidly suggests that two-person beneficiaries may place a higher value on health insurance. Alternatively, working as a couple may help to reduce their variability in income, or reduce the administrative navigation that might cause single individuals to fall off the program.

Since one-person and two-person beneficiaries fell off at about the same rate, but two-person beneficiaries experienced larger premium increases, premium revenues fell less dramatically for two-person beneficiaries. In total, potential premium revenues fell from an average of $650,000 in 2002 to approximately $371,000 in October 2003, a drop of 43% in potential revenues. Potential premium revenues from couples, on the other had, fell only 7%, from $168,000 in 2002 to $157,000 in October 2003.

Charts 17 and 18 show a striking difference between revenue collection for cases with a single individual (Chart 14) and cases with two individuals (Chart 15). Note that the revenue streams of couples are much more stable. In some cases revenue increased, as was observed among the 10% to 50% FPL. Thus, the decision to eliminate premium discounts among couples seems to have had a relatively less dramatic effect on enrollment decisions than other factors faced by OHP Standard beneficiaries.

PRELIMINARY CONCLUSIONS

The implementation of OHP2 resulted in a number of changes for beneficiaries in the OHP “expansion group”, who were moved to the newly created OHP Standard plan in February 2003. The new plan is characterized by a reduced benefit package, co-payments for most medical services, some increased premiums, premium collection rules resulting in disqualification for a single missed payment, elimination of waivers of premiums for special groups including zero-

income beneficiaries, and a six-month lockout from OHP2 following disenrollment or disqualification.

The impact has been a drop in enrollment of approximately 50%, with slightly more than 50,000 members enrolled in OHP Standard in late 2003. The group most significantly affected was beneficiaries with no reported income. Among these individuals, enrollment fell from an average of approximately 42,000 in 2002 to slightly more than 17,000 in October 2003, a 58% drop. Although premiums were raised for some beneficiaries in February 2003, this increase was substantially offset by a decrease in enrollment. Potential revenues from premiums have fallen from $800,000 per month in 2002 to slightly more than $500,000 per month in late 2003.

If one of the goals of the OHP2 is to maintain something close to the income case-mix that existed in 2002, the OHP Standard plan would have to make some changes to either accommodate beneficiaries below 10% FPL, or provide incentives for beneficiaries above 50% FPL to disenroll, or a combination of both.

A potential ongoing challenge for OHP policy-makers will be determining the administrative and premium policy for the large number of zero-income beneficiaries. As one of the largest groups of enrollees, a small, $6 premium provides the potential for substantial revenue collections. Yet the experience of OHP2 suggests that the inability to either waive this premium or make late payments has generated considerable difficulty for these beneficiaries.

In addition to the effects of changes in premiums and administrative policy, the reduction in benefits has probably also had a strong role in the changes in enrollment. If an enrollee relied on mental health services or chemical dependency coverage through OHP in the past, it is not clear if they would pay to renew if they could no longer get coverage for those benefits. Similarly, the impact of co-payments for services may have affected enrollment trends either through perceptions of (reduced) value of covered benefits and/or reducing the ability to pay premiums. Further research would be needed to distinguish these factors.

In the near future, OHP policy-makers are likely to consider a number of strategies that best suit the objectives of OHP2. More leniency in the payment of late premiums, the availability of premium waivers for zero-income clients, or elimination of the “lock-out” are likely to improve enrollment among the poorest individuals. Potential revenue loses in some aspects of such policy changes could be regained either through more continuous eligibility (and hence possibility of collection) or increased premiums for groups in higher income brackets, since these groups showed a proportionally smaller change in their enrollment following OHP2. Future research that incorporates utilization and expenditure data may help to identify the most appropriate strategies for controlling net expenditures while still providing coverage for a large number of Oregonians.

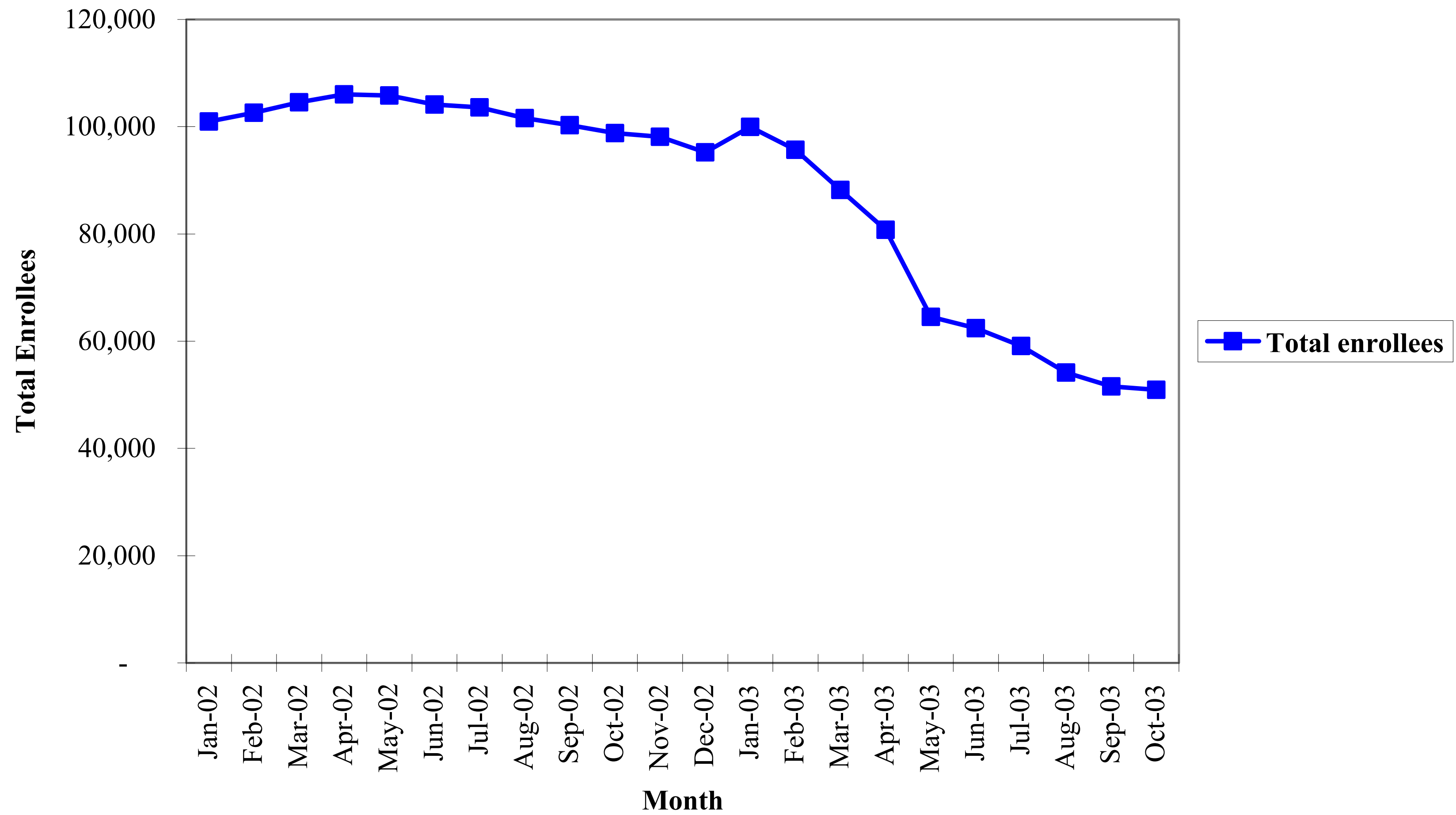


Chart 1.
OHP Standard Enrollees by Month
120,000
100,000
80,000
60,000
40,000
20,000
-
Total Enrollees
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
Total enrollees

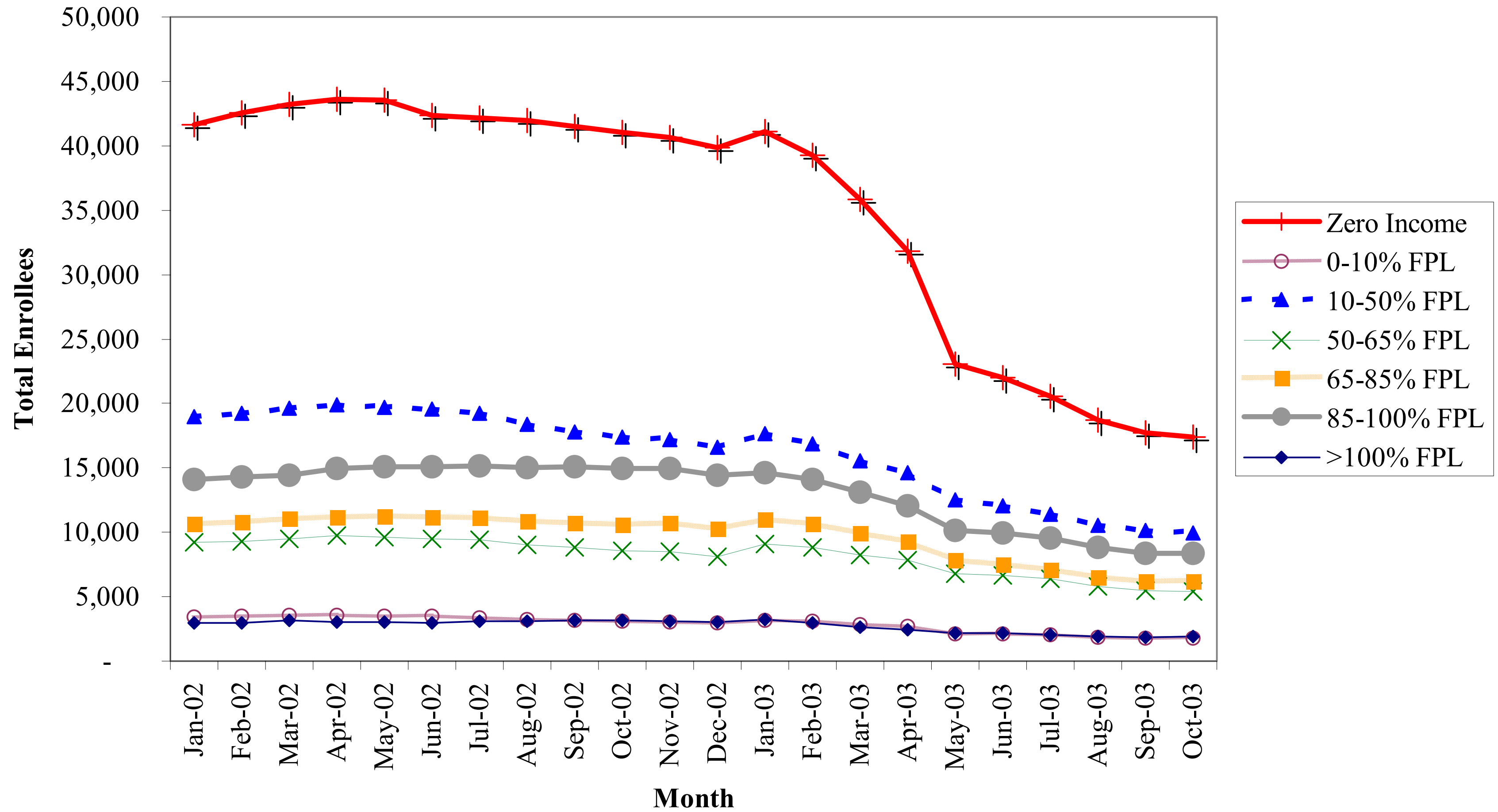
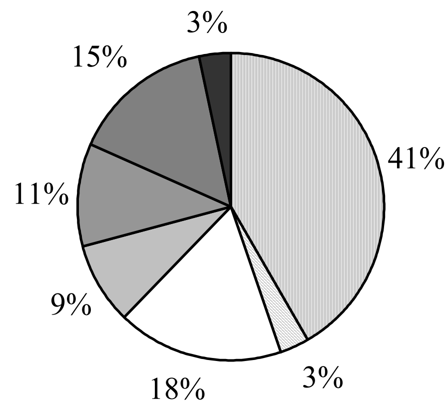


Chart 2.
OHP Standard Enrollees by FPL
Total Enrollees
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
Zero Income
0-10% FPL
10-50% FPL
50-65% FPL
65-85% FPL
85-100% FPL
>100% FPL

Chart 3.

Case Mix, October 2002

Case Mix, October 2003



Zero Income
0-10% FPL
10-50% FPL
50-65% FPL
65-85% FPL
85-100% FPL
>100% FPL

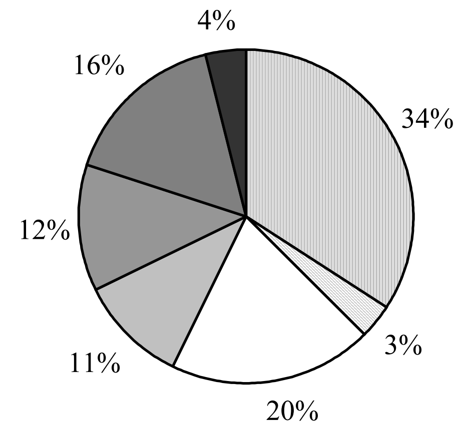
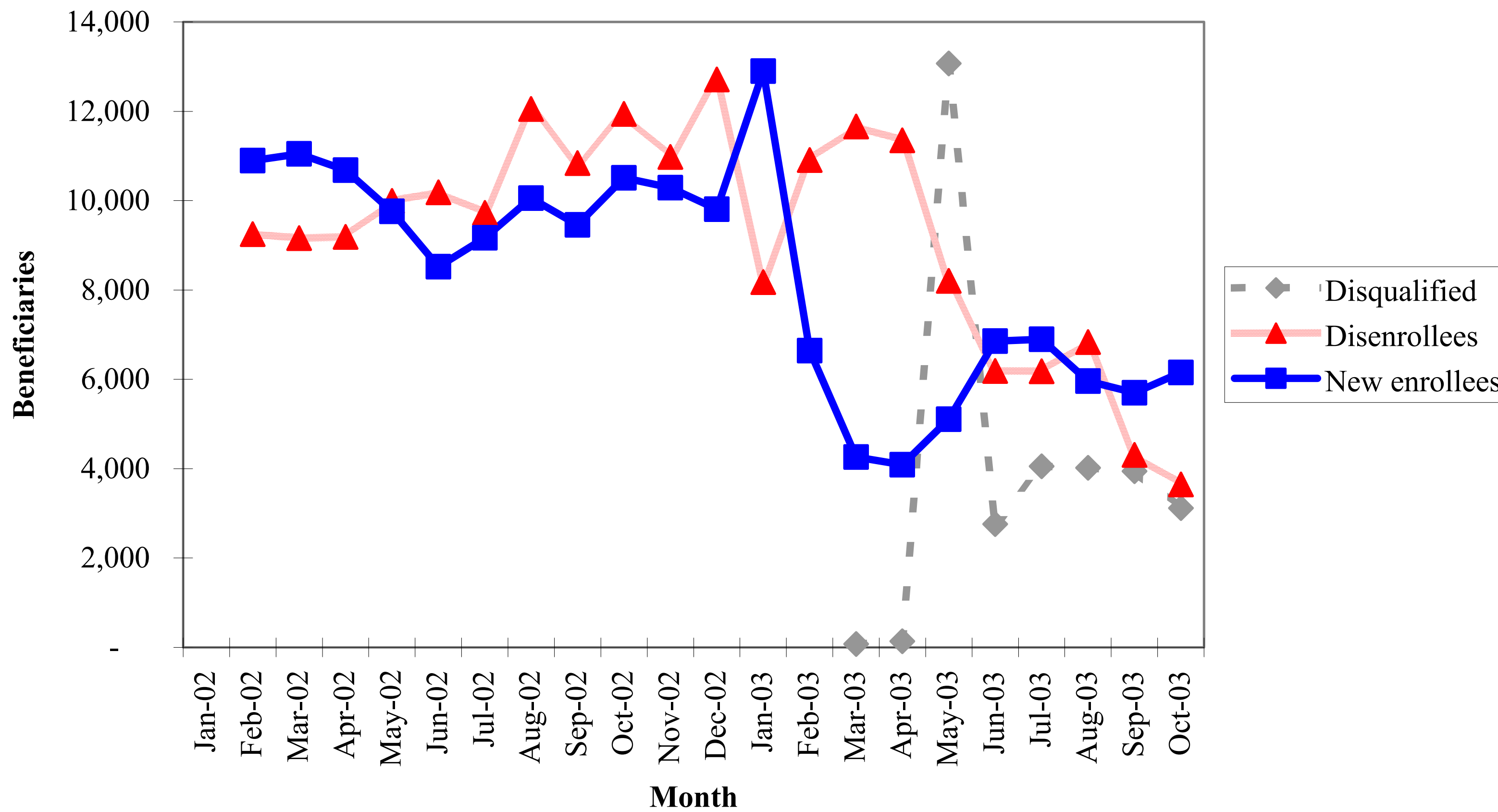


Chart 4.
New enrollments, disenrollments, and disqualifications: All OHP Standard



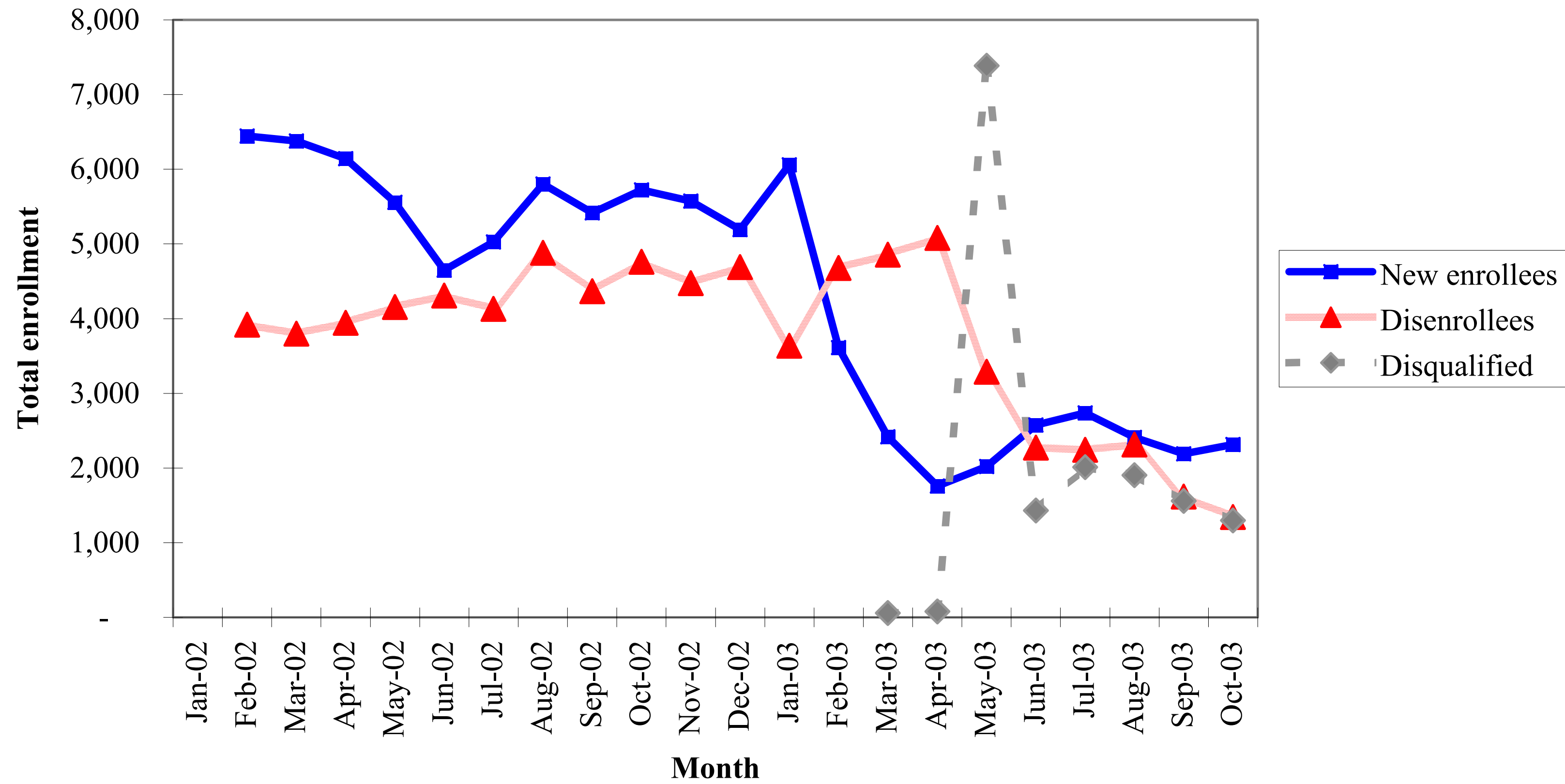


Chart 5.
Enrollment for Zero Income
Total enrollment
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
New enrollees
Disenrollees
Disqualified

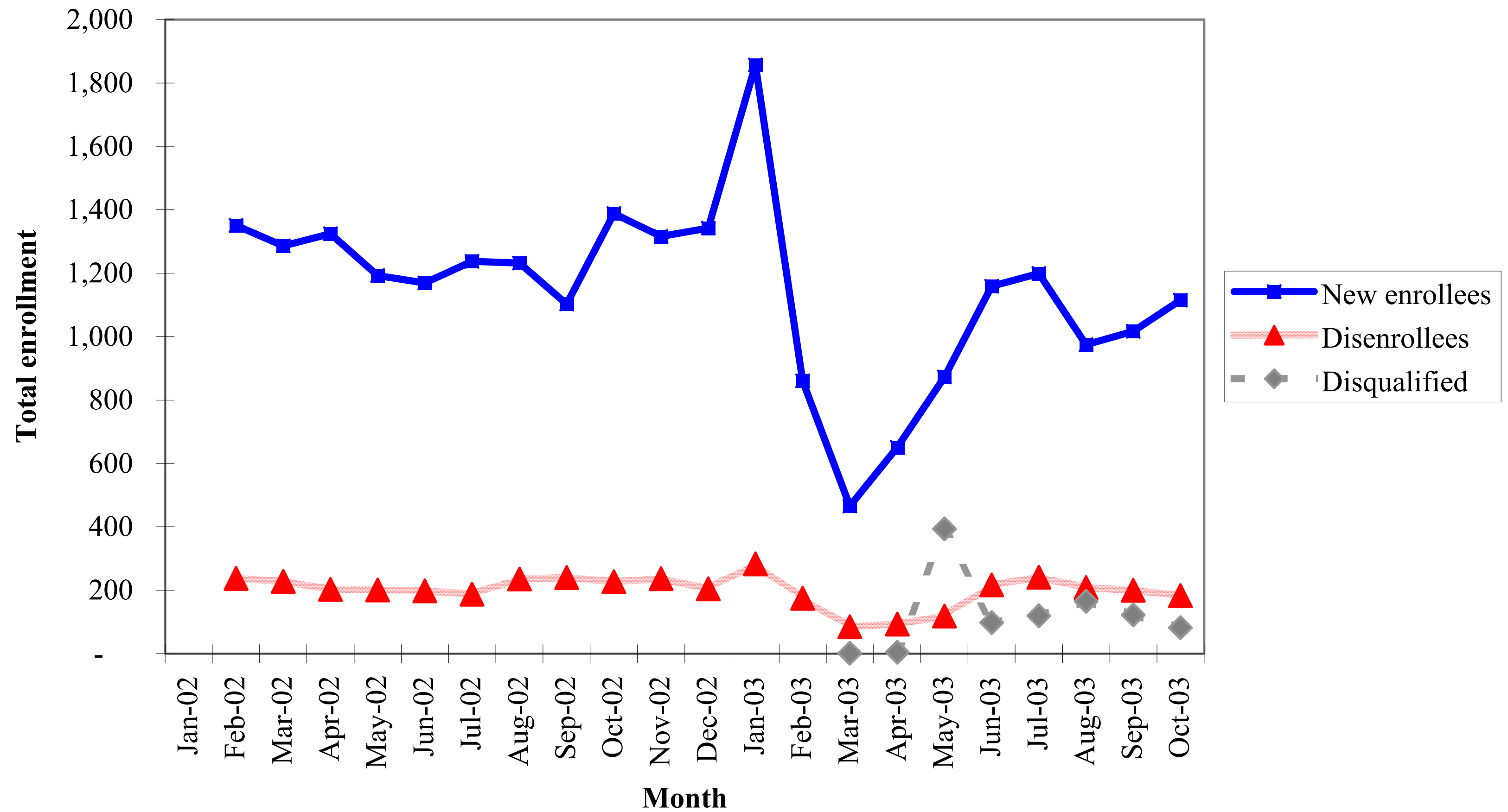


Chart 6.
Enrollment for >0 Income and <= 10% FPL
Total enrollment
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
New enrollees
Disenrollees
Disqualified

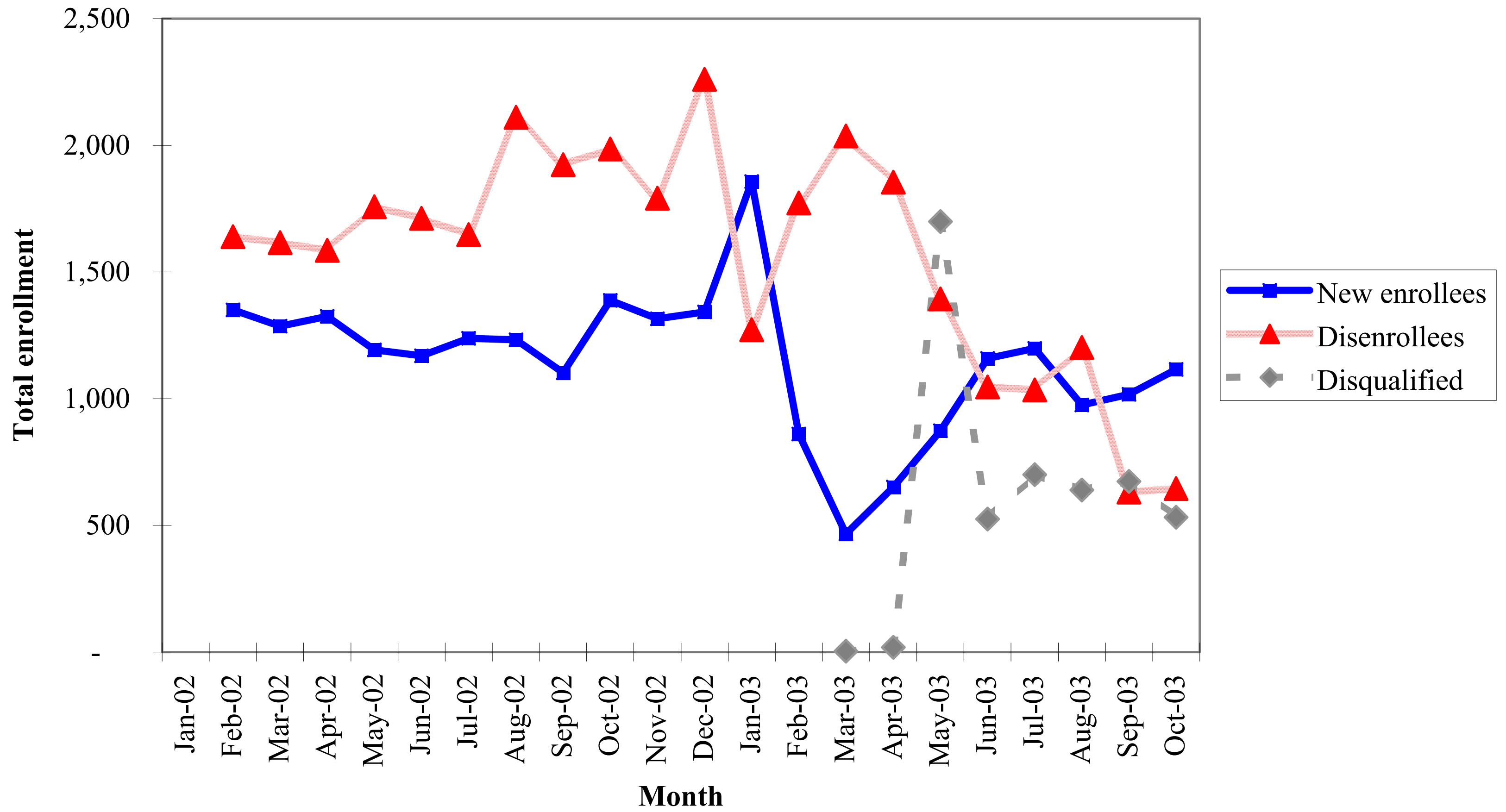


Chart 7.
Enrollment for 10% to 50% FPL
2,500
2,000
1,500
1,000
500
-
Total enrollment
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
New enrollees
Disenrollees
Disqualified

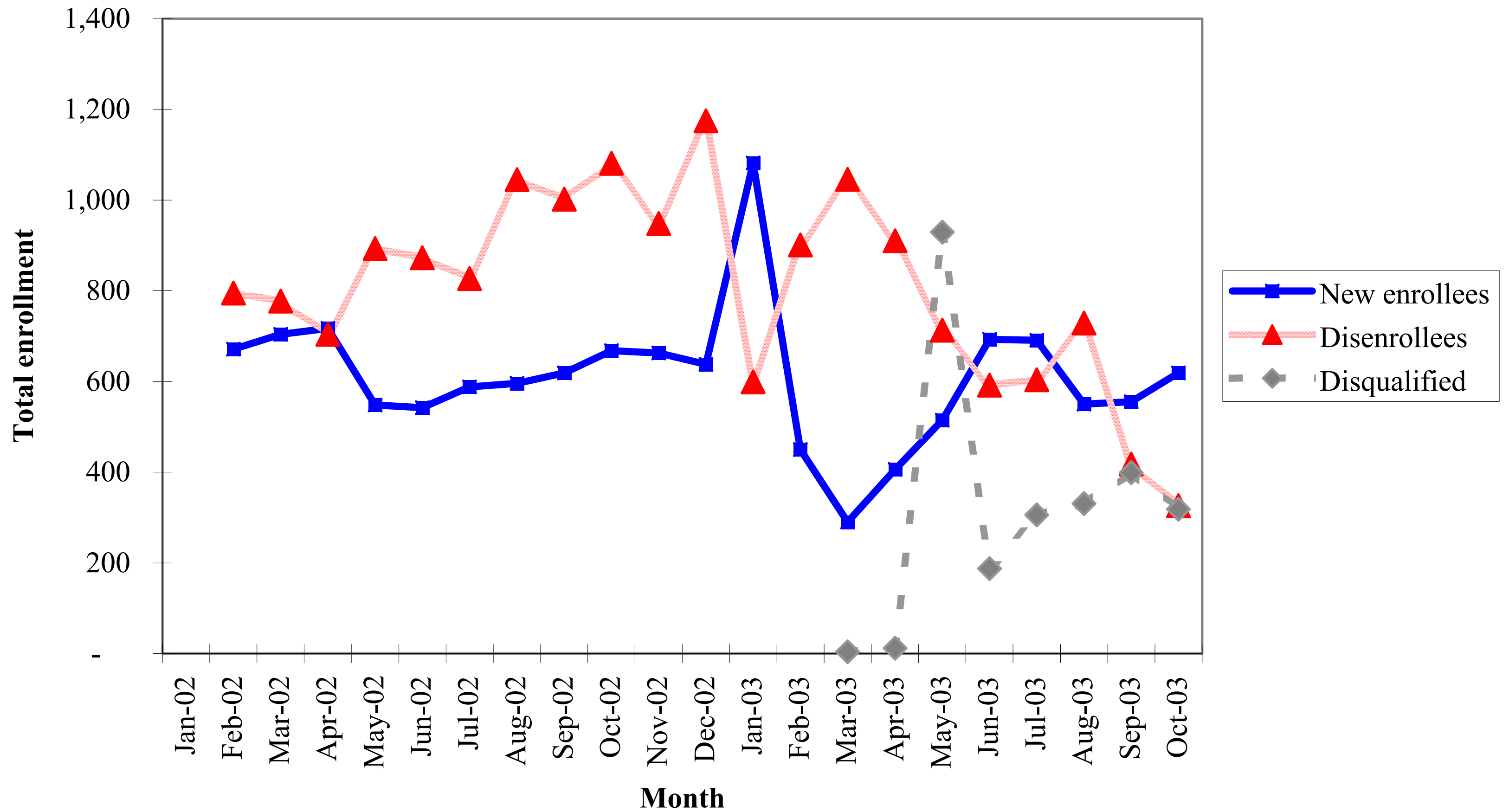
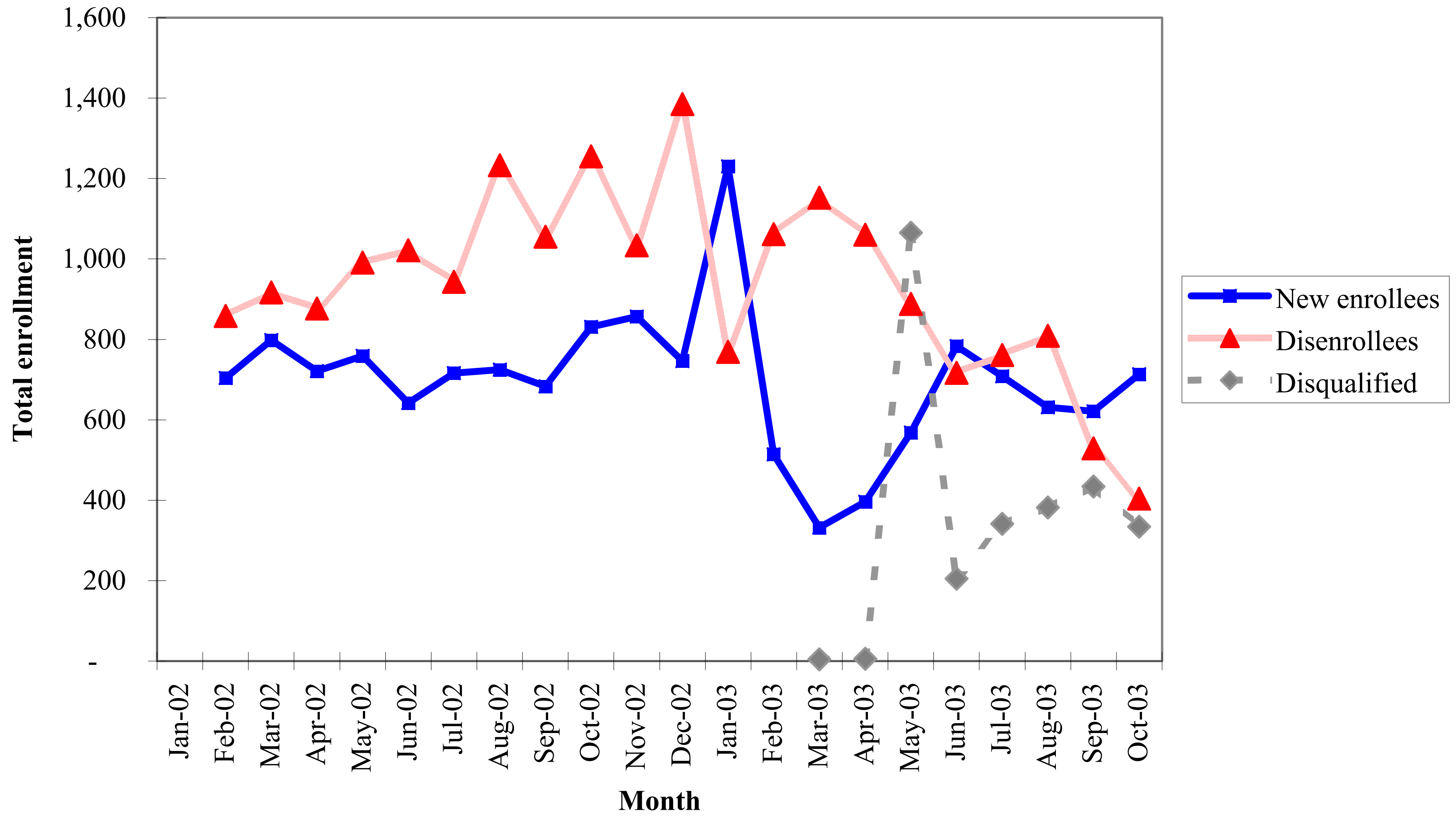


Chart 8.
Enrollment for 50% to 65% FPL
1,400
1,200
1,000
800
600
400
200
-
Total enrollment
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
New enrollees
Disenrollees
Disqualified

Chart 9.
Enrollment for 65% to 85% FPL



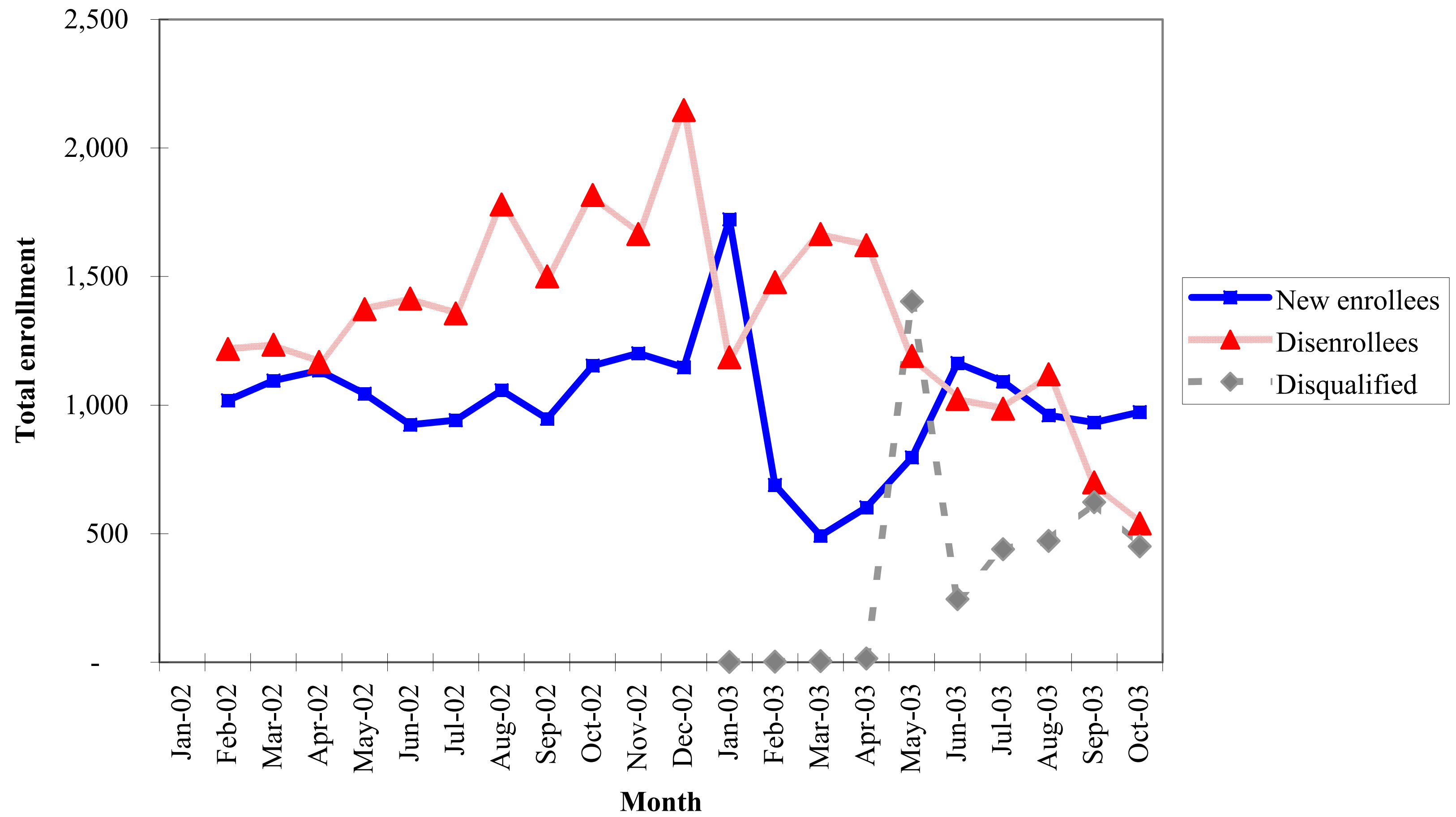


Chart 10.
Enrollment for 85% to 100% FPL
2,500
2,000
1,500
1,000
500
-
Total enrollment
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
New enrollees
Disenrollees
Disqualified

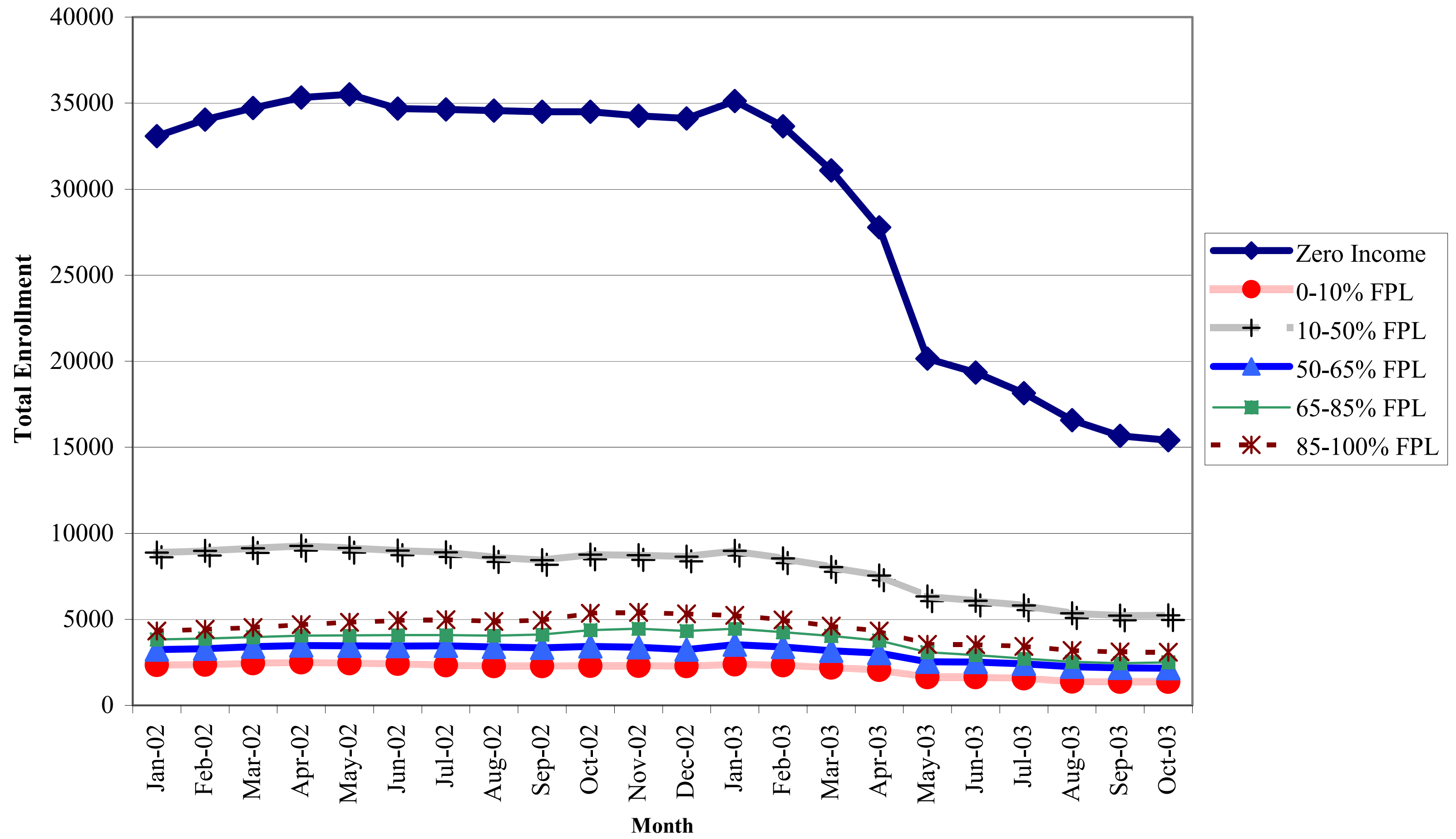


Chart 11.
Enrollment by FPL
single-person cases with no children
Total Enrollment
0
5000
10000
15000
20000
25000
30000
35000
40000
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
Zero Income
0-10% FPL
10-50% FPL
50-65% FPL
65-85% FPL
85-100% FPL

Chart 12.
Enrollment by FPL
single-person cases with children

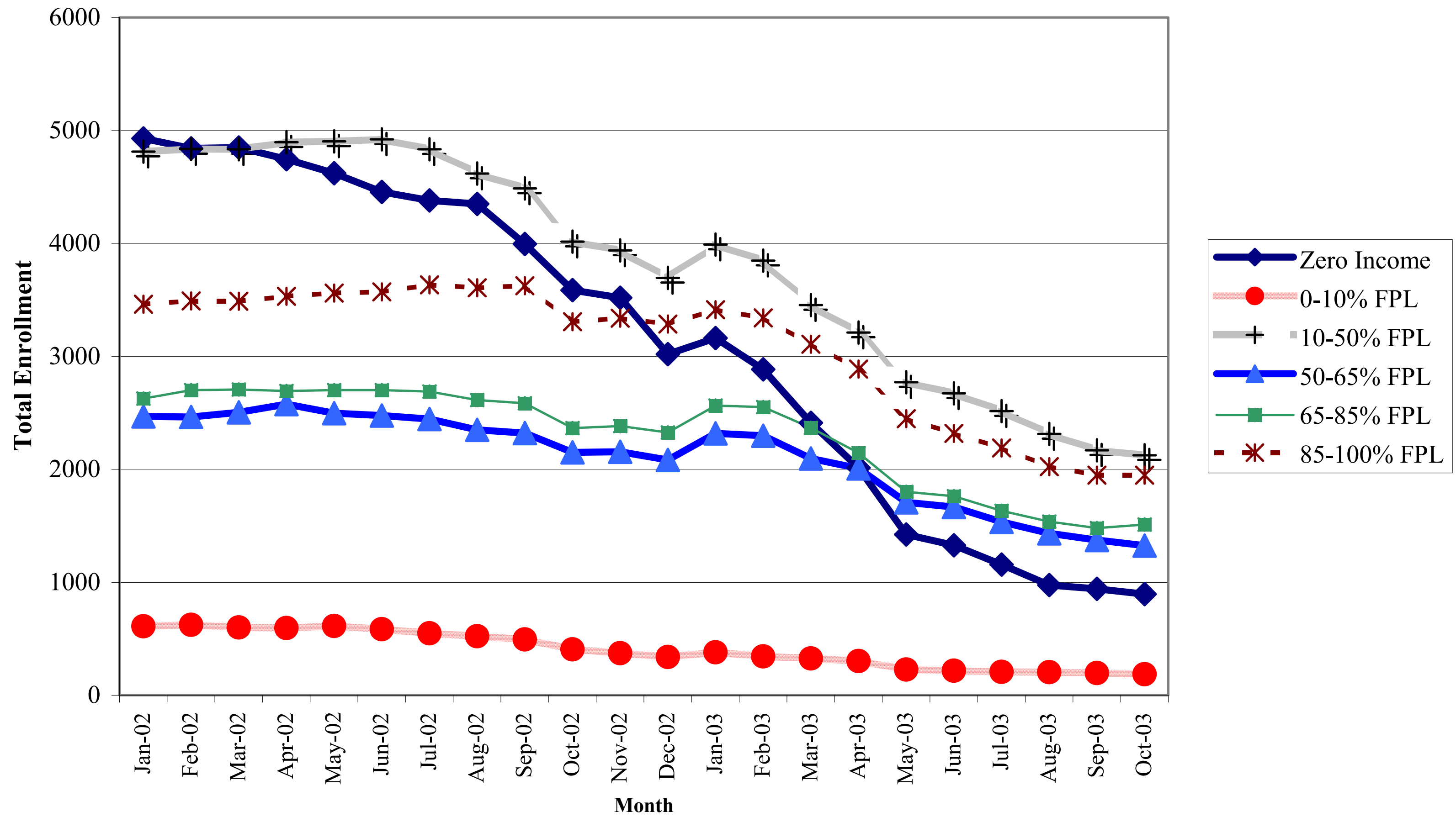
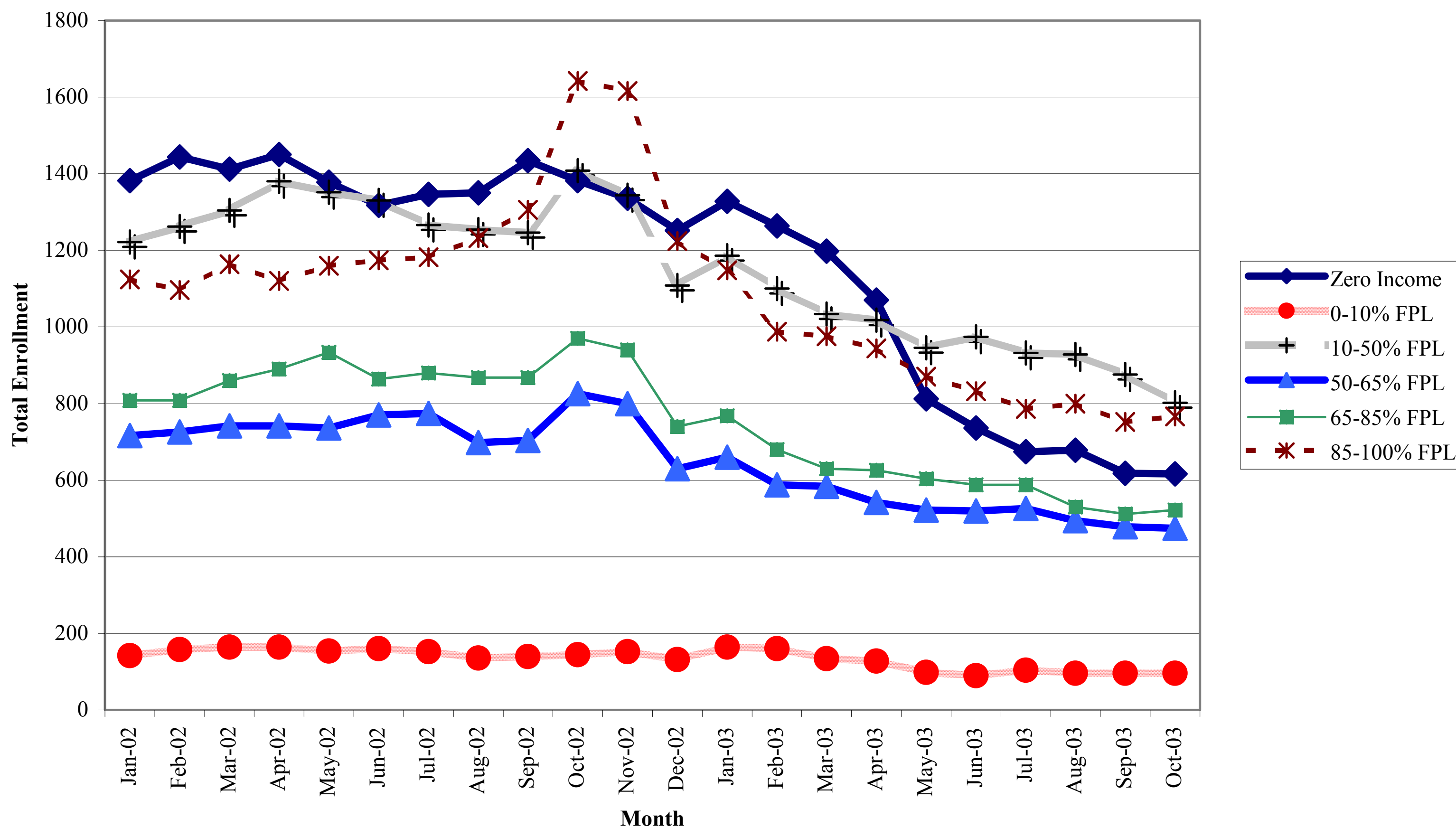


Chart 13.
Enrollment by FPL
two-person cases with no children



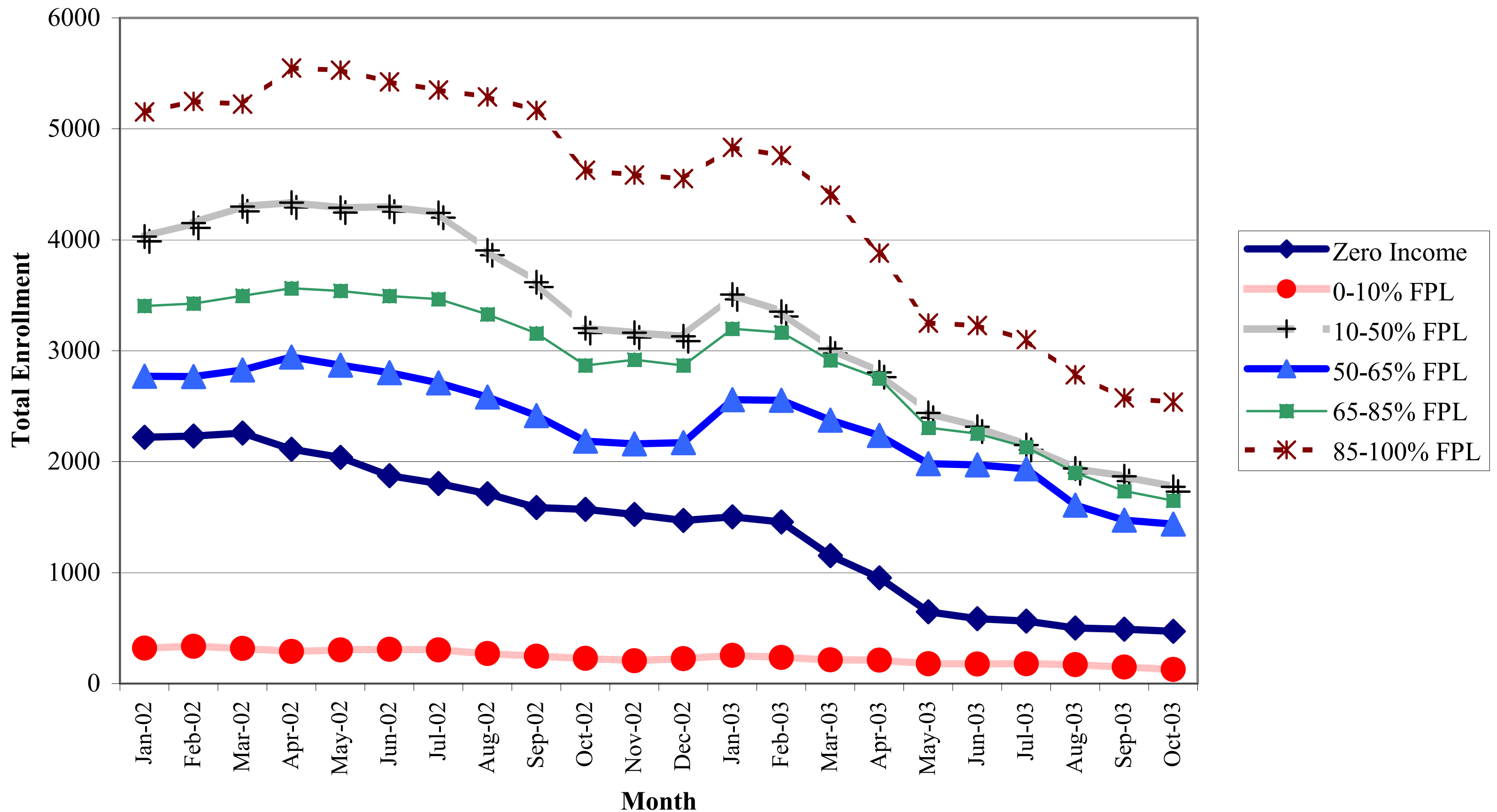


Chart 14.
Enrollment by FPL
two-person cases with children
Total Enrollment
6000
5000
4000
3000
2000
1000
0
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
Zero Income
0-10% FPL
10-50% FPL
50-65% FPL
65-85% FPL
85-100% FPL

Table 1.
Enrollment by FPL and Family type

Average enrollment in 2002

	1-Person cases with no children	1-Person cases with children	2-Person cases with no children	2-Person cases with children
Zero Income	34494	4274	1374	1867
0-10% FPL	2357	526	150	279
10-50% FPL	8874	4565	1290	3888
50-65% FPL	3382	2374	739	2601
65-85% FPL	4104	2591	869	3294
85-100% FPL	4883	3492	1253	5140

Enrollment in October 2003

	1-Person cases with no children	1-Person cases with children	2-Person cases with no children	2-Person cases with children
Zero Income	15411	896	616	472
0-10% FPL	1369	186	96	126
10-50% FPL	5236	2123	802	1774
50-65% FPL	2162	1324	474	1438
65-85% FPL	2490	1512	522	1648
85-100% FPL	3087	1948	766	2536

Table 2.
Proportional Change in Enrollment by FPL and Family type

Percentage drop in enrollment, from average enrollment in 2002 to enrollment in October, 2003

	1-Person cases with no children	1-Person cases with children	2-Person cases with no children	2-Person cases with children
Zero Income	55.3%	79.0%	55.2%	74.7%
0-10% FPL	41.9%	64.6%	35.9%	54.9%
10-50% FPL	41.0%	53.5%	37.8%	54.4%
50-65% FPL	36.1%	44.2%	35.8%	44.7%
65-85% FPL	39.3%	41.6%	39.9%	50.0%
85-100% FPL	36.8%	44.2%	38.9%	50.7%

Chart 15.
Potential Montly Revenues from Premiums Charged, All OHP Standard Clients

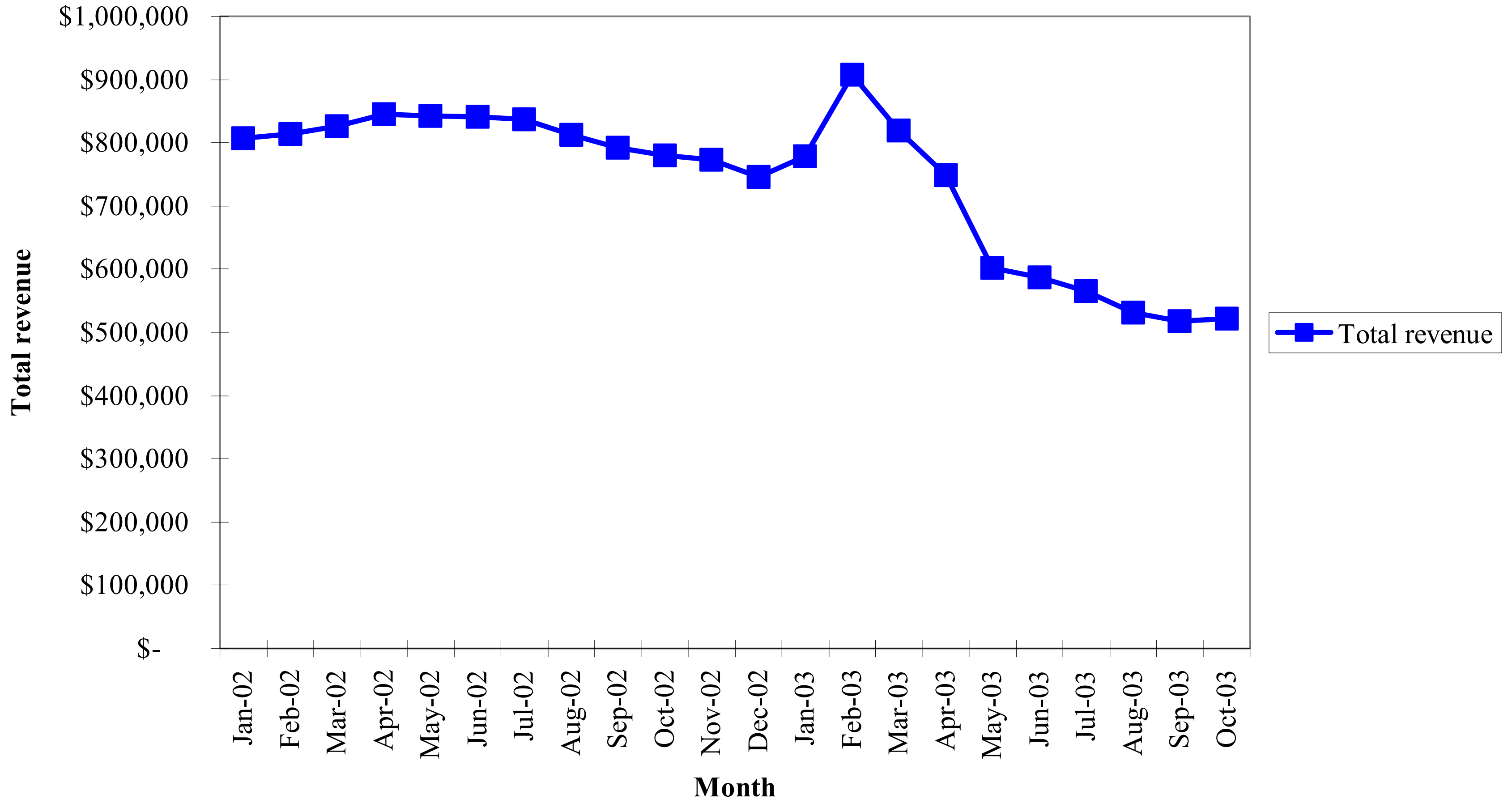
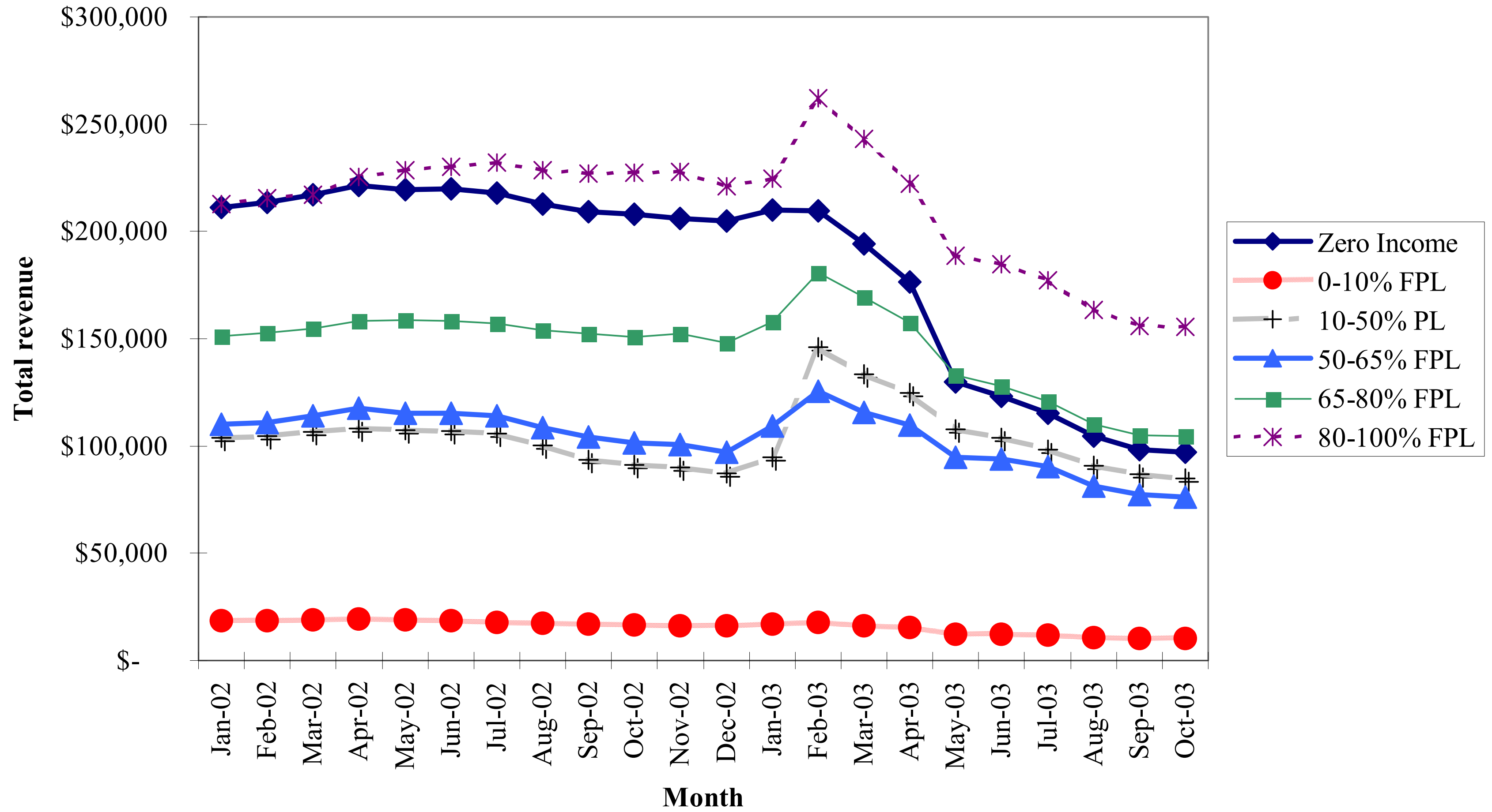


Chart 16.
Potential Montly Revenues from Premiums Charged, by FPL Group



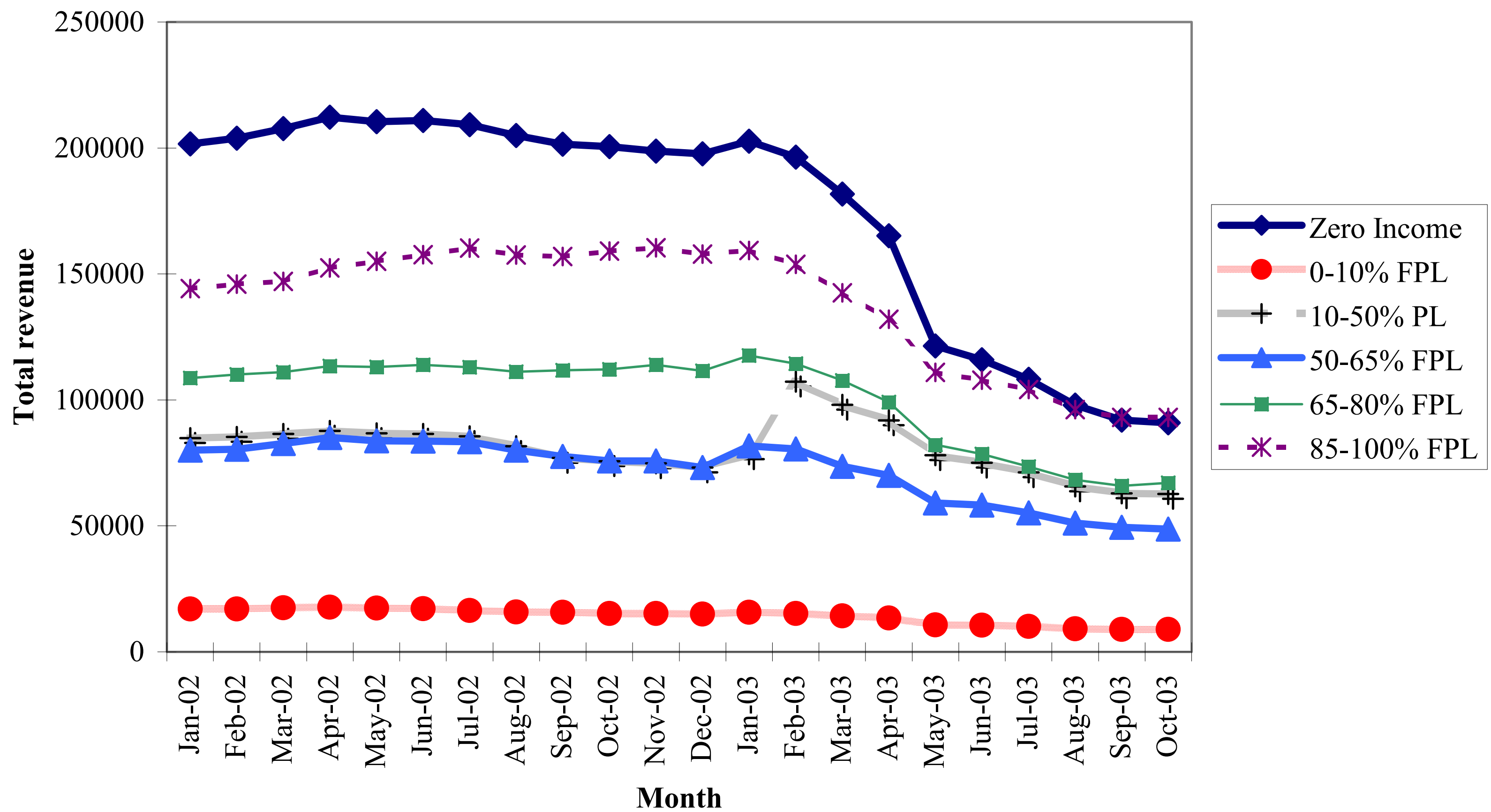
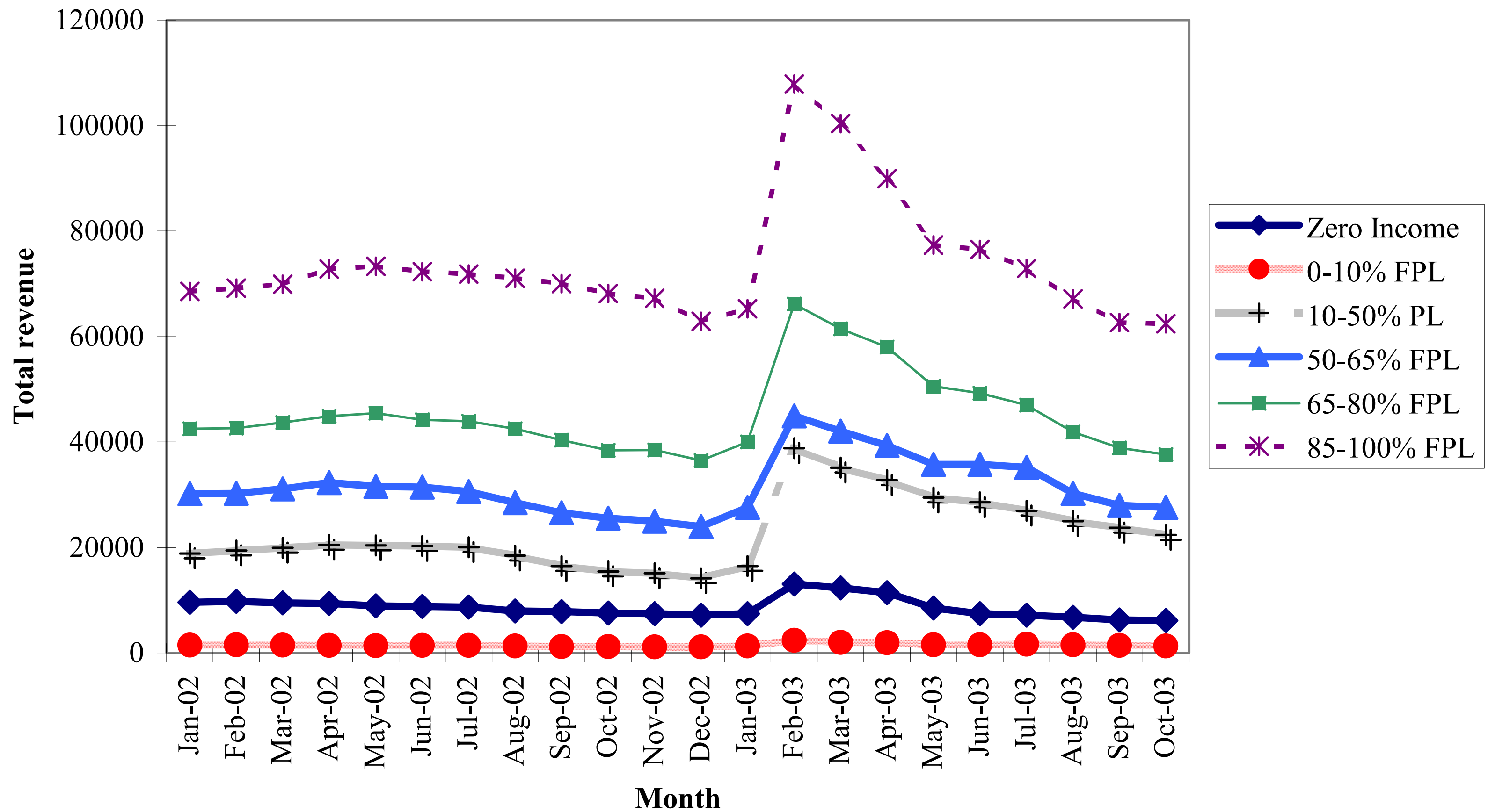


Chart 17.
Potential Montly Revenues from Premiums Charged, by FPL Group
Single Person Cases
250000
200000
150000
100000
50000
0
Total revenue
Jan-02
Feb-02
Mar-02
Apr-02
May-02
Jun-02
Jul-02
Aug-02
Sep-02
Oct-02
Nov-02
Dec-02
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Month
Zero Income
0-10% FPL
10-50% PL
50-65% FPL
65-80% FPL
85-100% FPL

Chart 18.
Potential Montly Revenues from Premiums Charged, by FPL Group
Two-Person Cases



Appendix 1: Changes occurring with OHP2

Oregon Health Plan Changes

January 2003

- Implement voluntary co-pays on drugs ($2 generic/$3 brand) and ambulatory services ($3) for OHP fee-for-service clients
- Eliminate coverage for Lines 559-566 on the Prioritized List of Health Care Services

February 2003

- **Expand coverage for pregnant women and children under age 19 from 170% FPL to 185% FPL**
- **Establish OHP Standard benefit package.** (0-100% FPL; $6-$20 per person per month based on income) Changes include:
  - Elimination of coverage for vision exams and eyeglasses
  - Elimination of non-emergency medical transportation
  - Elimination of most medical equipment
  - Elimination of hearing Aids and related exams
  - Reduced dental benefits
- Mandatory co-pays for following services:

(OHP Standard fee-for-service *and* managed care)

Inpatient Hospital	$250 per admission
Outpatient Hospital	$20 for each outpatient surgery $5 for other outpatient service
Emergency Room	$50 but waived if admitted to hospital
Physician services	$5 per visits $5 for medical surgical procedures Most preventative services & immunizations Exempt from co-payments
Lab and X-ray	$3 per lab or x-ray
Ambulance	$50
Home health care	$5 per visit
Physical therapy	$5 per visit
Occupational Therapy	$5 per visit
Speech Language Pathology Therapy	

- Establish more stringent premium policy for OHP Standard clients (Individuals are disenrolled for at least 6 months if they cannot pay premiums)
- Can be denied services if they cannot pay co-pays
- Establish 6-month un-insurance requirement for new OHP Standard clients

- Begin roll-out of Senior Prescription Drug Assistance Program

- Eliminate coverage for survival priority levels 15-17 in the long term care system. Many of these individuals will also lose their OHP medical coverage.

- Eliminate Medically Needy program (see April change)

- Eliminate remaining safety net clinic funding

March 2003

- Further reduce OHP Standard benefit package by eliminating:
- Remainder of dental benefit
- Coverage of medical supplies
- Coverage of outpatient mental health services
- Coverage of outpatient chemical dependency services
- Coverage of prescription drugs (reinstated from mid-March through June 2003)[*]

- Move beginning date of eligibility to first of month following eligibility determination for OHP Standard population

- Reduce reimbursement rates to DRG hospitals (50 beds or more) by 12% for inpatient services and outpatient services. Eliminate outlier payments to DRG hospitals except for infants under age 1 served in Disproportionate Share Hospitals

April 2003:

- Reduce payments to pharmacies from Average Wholesale Price minus 14% to minus 15% (pending CMS approval)

- Eliminate coverage for survival priority levels 12-14 in the long term care system. Many of these individuals will also lose their OHP medical coverage.

- Reinstate coverage for anti-rejection (transplant) and antiviral (HIV) drugs for former Medically Needy clients (through June 2003)[**]

May 2003:

- Enhanced exception process implemented to prescribe non-physician drug list (PDL) drugs in evaluated classes for fee-for-service clients

- Increased reimbursement rates to institutional pharmacies

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[*] *Prescription drug coverage is currently ongoing.*

[**] *Coverage of these services is currently ongoing.*

June 2003:

- Require pharmacies to bill insurance carriers before billing Medicaid for clients who have prescription drug insurance coverage

Appendix 2: Monthly Premiums for OHP Standard Clients

Premium Structure before OHP2

	Single	Couple
0% to 50% FPL	$ 6.00	$ 6.50
50% to 65% FPL	$ 15.00	$ 18.00
65% to 80% FPL	$ 18.00	$ 21.00
80% up to 100% FPL	$ 20.00	$ 23.00

Premium Structure with OHP2 (February 1, 2003)

	Per Person
0% to 10% FPL	$ 6.00
10% to 50% FPL	$ 9.00
50% to 65% FPL	$ 15.00
65% to 85% FPL	$ 18.00
85% to 100% FPL	$ 20.00

Prior to the implementation of OHP2, some individuals were eligible for a waiver that reduced their premium to $0 if they met the following exemption criteria:

- Victim of crime
- Death in the family
- Victim of Domestic Violence
- Homeless
- Zero-income at time of application or reapplication
- Victim of natural disaster

This waiver was removed in February, 2003.

Appendix 3: Federal Poverty Levels

Size of Family Unit	2002 HHS Poverty Guidelines	2003 HHS Poverty Guidelines
1	$ 8,860	$ 8,980
2	11,940	12,120
3	15,020	15,260
4	18,100	18,400
5	21,180	21,540
6	24,260	24,680
7	27,340	27,820
8	30,420	30,960
For each additional person, add	3,080	3,140

SOURCE: *Federal Register*, Vol. 67, No. 31, February 14, 2002, pp. 6931-6933, and *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.