Office for Oregon Health Policy and Research

HRSA State Planning Grant

Addendum to the Final Report to the Secretary

September 2005

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HRSA State Planning Grant

Addendum to the Final Report to the Secretary

Introduction:

The following information is an addendum to Oregon's Final Report to the Secretary filed with HRSA in October 2001, a supplemental report filed in March 2002, subsequent progress report provided in November 2002, and an update report in September 2004.

This report provides an update on activities related to Oregon's HRSA State Planning Grant from September 2004 through September 2005 completed by the Office for Oregon Health Policy and Research (OHPR). Additional data collection and analysis initiated prior to September 2004, that was either in the field and/or under analysis at the time of the September 2004 report.

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Policy and Analysis Unit

Prepared for:

Health Resource Services Administration

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Executive Summary

Even while facing serious fiscal challenges, Oregon remains committed to the goals outlined in its original HRSA State Planning Grant application. This report is an addendum to Oregon's Final Report to the Secretary filed with HRSA in October 2001, the supplemental report filed in March 2002, subsequent progress report provided in November 2002, and the supplemental report most recently submitted in September 2004.

This report provides an update on activities related to Oregon's HRSA State Planning Grant from September 2004 to September 2005 completed by the Office for Oregon Health Policy and Research (OHPR), as well as the additional data collection and analysis supported through the HRSA State Planning Grant prior to September 2004, which was in the field and/or under analysis at the time of the last report.

The specific aims for continuation funding relate to these three goals:

1. ***To increase health insurance through the expansion of both public and private financing.***
2. ***To increase the proportion of eligible people who apply and receive Medicaid coverage.***
3. ***To improve the capacity and capability of Oregon's delivery system, including the safety net clinics, to provide care to uninsured populations.***

The Oregon Health Plan (OHP) has served as an innovative example of Medicaid benefit delivery. Oregon's reform was extraordinarily successful, decreasing uninsurance in the state from 18 percent in 1994 to as low as 10 percent in 1998. However, with the state facing the worst state budget shortfalls since World War II, Oregon's Medicaid program was at risk of collapse. Initially designed through activities of Oregon's initial year of HRSA State Planning Grant funding, the approved Oregon Medicaid OHP2 waiver restructured the Oregon Health Plan. This allowed additional flexibility related to benefits, eligibility and coordination with employer-sponsored insurance.

Expanded coverage of pregnant women and children was implemented and the premium subsidy program, Family Health Insurance Assistance Program (FHIAP), continues to enroll low-income workers and their dependents, providing a public-private partnership that increases access to health insurance. However, due to continued declines in the state's economy and persisting high unemployment rates, Oregon reduced the number it had hoped to insure through the OHP2 Waiver and faced further budget cuts to its healthcare services. This has added to the number of uninsured Oregonians; 17% are now without health care coverage. Activities over the past several years have been focused on evaluating the impacts of these cuts and gaining consensus on what steps the state should take as it slowly emerges from this budget crisis, to increase access to health coverage for the growing number of uninsured Oregonians.

Oregon continues to pursue its initial goal of ***increasing health insurance through the expansion of both public and private financing***. Oregon's current governor is focusing on reexamining and planning the short-term and long-term goals of creating a sustainable state plan that will expand access to healthcare to all Oregonians. The Oregon Health Plan might have been that vehicle, but its current scope is more limited than it was at its inception. Recent changes make it clear that public programs are only a piece of the puzzle and that care options in Oregon need to be re-examined at the system level. The creation of the Oregon Health Policy Commission during the 2003 Legislative session pairs legislators with advocates and

stakeholders to develop a vision for Oregon to increase access to healthcare to all Oregonians. The Commission, formed in January 2004, is focused on strategic planning for the state's healthcare policy to set the "roadmap", guided by consideration of cost, quality, health status and access. The HRSA SPG activities have been closely aligned with the Commission's efforts, providing vital information to make informed policy decisions. Oregon completed a statewide Health Values Survey this past year with funding provided by the HRSA SPG. This survey along with public community forums, has provided the Oregon Health Policy Commission invaluable insight into Oregonians' attitudes and beliefs about access to healthcare in the state as well as what the public and private roles should be in providing that access.

One of Governor Kulongoski's key agendas for the state is The Children's Charter, which includes expanded insurance coverage for children as a component. For a myriad of reasons, publicly funded insurance programs have been unable to reach all eligible children or to ensure maintenance of coverage. According to the 2004 Oregon Population Survey, it is estimated that there are close to 68,000 children in Oregon who may be eligible for the Oregon Health Plan (Medicaid or SCHIP) but remain uninsured. Using HRSA SPG funding, OHPR conducted a statewide Children's Access to Health Care survey to better understand the barriers Oregon parents face in obtaining health insurance coverage for their children. These results are extremely valuable as the state begins to craft an insurance expansion aimed at covering every child in Oregon.

Oregon's 2003 legislative session directed the Insurance Pool Governing Board (IPGB), through House Bill 2537, to increase access to health insurance and health care by providing affordable health benefit plans for small employers with at least two but no more than 50 employees. An Alternative Group and Children's Group Plan were offered for enrollment starting in March 2005.

For Oregon's second goal, ***increasing the proportion of eligible people who apply for and receive Medicaid coverage,*** Oregon has experienced serious challenges. The state has successfully designed and implemented a waiver of traditional Medicaid rules in order to expand coverage to Oregonians up to 200% of FPL but because of the severe economic downturn in the state, Oregon had to close the state's expansion adult program, OHP Standard, to new enrollment and leave eligibility at 100% of FPL. The State was able to afford a coverage expansion to children and pregnant women with incomes up to 185% of FPL both in OHP Plus and in Oregon's premium assistance program, the Family Health Insurance Assistance Program (FHIAP). Currently children's enrollment due to SCHIP eligibility in OHP Plus is steadily increasing.

A group of community leaders, under this last year's HRSA State Planning grant efforts, has formed a collaboration around premium sponsorship for adults covered under OHP Standard, Oregon's 'expansion' population. The premium sponsorship group developed after implementation of OHP Standard, which requires enrollees to pay a premium based on their income or face disqualification from the program. If disqualified, they would not be eligible to re–enroll for six months. As a result of this policy change, an unexpectedly large number of OHP enrollees were being disenrolled for lack of premium payment. Research by OHPR on OHP Standard enrollees at the zero-income level showed that 58% were disenrolled for failure to pay premiums after implementation of the premium rules changes in March 2003. The premium sponsorship effort focuses on supporting those at the lowest income level, and since July 2003

there have been no disqualifications of enrollees between 0-10% FPL because of non-payment or premiums.

Sponsorship of OHP premiums is only one approach. The Oregon Health Policy Commission has built upon these community efforts through the current Delivery System Model Workgroup to explore other strategies that can leverage community dollars to increase access to health care coverage across multiple communities. Oregon wants to continue the effort to keep these players at the table, working toward community models that will maximize public and private dollars for expansion of access to coverage for the uninsured.

The state continues to work on its second goal to enroll those eligible for Medicaid coverage. Governor Kulongoski has initiated more focused efforts through the KidCare pilot of increased outreach to children in two Oregon counties with high rates of uninsured children. The results of this initiative and the findings of the Children's Access Survey will be examined to assess feasibility of expanding such efforts across the state.

As Oregon is economically forced to limit further expansions of its public Medicaid program, an important focus is the grant's third goal: ***to improve the capacity and capability of Oregon's delivery system, especially the safety net clinics to provide needed care to the uninsured populations.*** Initial efforts for this goal have been coordinated with the Governor's health policy staff and legislators to coordinate activities and craft data-driven state policy that will strengthen Oregon's overall healthcare delivery system, including the fragile safety net. Past work with the National Governor's Association and AHRQ led Oregon to compile detailed data at the county level on specified indicators of demand for healthcare services in both the physical and behavioral health arenas. Significant gaps remain in the data, primarily on the capacity and financial stability of providers who serve low-income, underinsured and uninsured patients. This past year's HRSA State Planning Grant continuation funds helped Oregon to fill essential gaps and start the process of developing indicators and benchmarks reflective of a well-functioning healthcare delivery system. Oregon will be able to gather meaningful and comprehensive data necessary to formulate solid recommendations to Oregon's policy makers.

By maintaining the infrastructure required for implementation of necessary waivers, ***the state is well positioned for expansion of coverage for children as the state's economy recovers.*** With legislative members of the Oregon Health Policy Commission positioned to champion the Commission's recommendations to the full legislature, Oregon is poised to work swiftly towards coverage expansion once the economy sustains signs of improvement. The background research and public-private partnerships developed in earlier HRSA-funded work serves as a platform for expansion, especially to children in Oregon. With collaboration among community stakeholders, community and political consensus can develop around approaches to improve access to healthcare, with children as a key focus.

The federal government has been generous in continuing to support the HRSA State Planning Grants and its value is long-lived. What would be helpful now to ***support State efforts*** is:

- Encouraging the adoption of data information systems that can communicate across a variety of health care delivery systems, within and across states,
- Partnering with states in evaluation efforts, using local researchers and state agencies knowledgeable about the specific policies and healthcare systems to facilitate the translation of research back to the policymakers,

- Provide additional health services research funding that would allow states to further advise other states and the nation on best practices and policies, identifying effective/ineffective approaches, especially those that have the potential for significant impacts on the vulnerable populations that the nation's public programs are designed to protect.

Clinical and "bench" research have received significant federal funding dollars, but health services research has been more limited, yet has broad sweeping impacts across populations. The HRSA SPG program has been a rare but valuable avenue to both provide resources for health services research and as a vehicle to share the research with other states, and should be continued. Sharing of best practices among state decisonmakers has important implications for both the publicly funded insured and the uninsured.

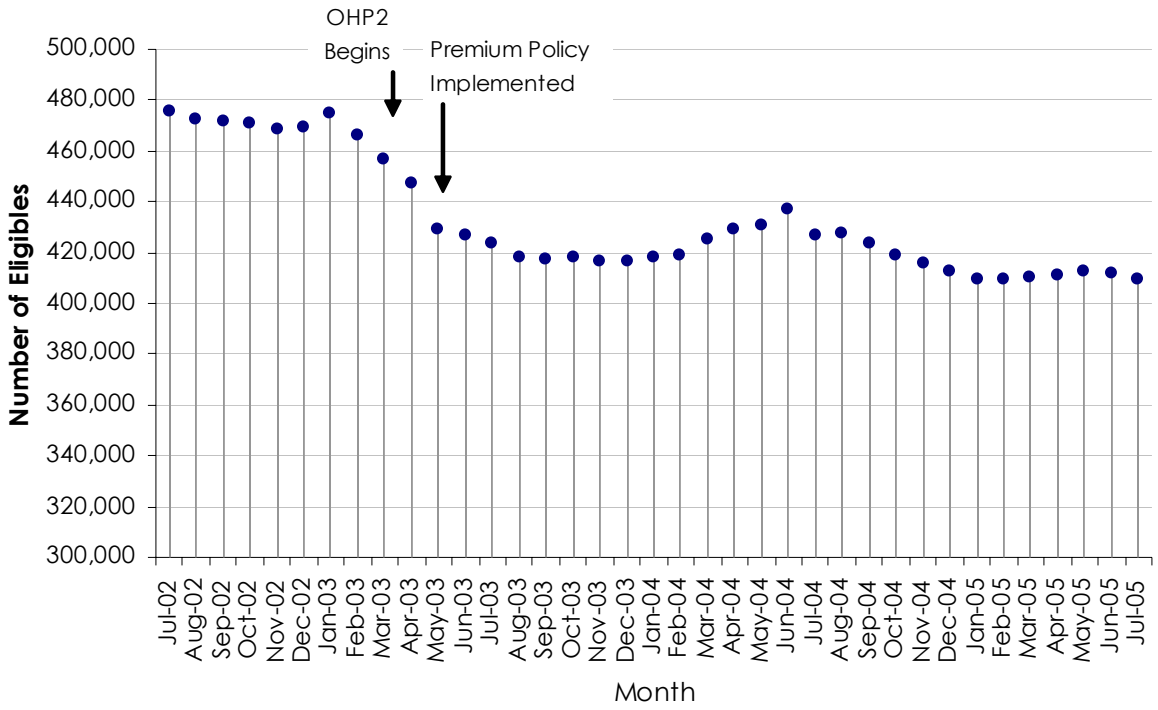
Addendum to Section 1: Uninsured Individuals and Families

Detailed answers to the questions were provided in our original full report in 2001. Provided below is a current overview of Oregon's Uninsured Individuals and Families with some specific updates to particular questions from this past year's HRSA SPG activities or through other Oregon-specific work.

During most of the 1990s, Oregon incrementally reduced the number of uninsured in the state. A booming economy, which increased employment, and implementation of the Oregon Health Plan, Oregon's 1115 Medicaid waiver, were key components to that success. Since OHP was launched, it has provided access to quality health care services for more than one million uninsured Oregonians and decreased uninsurance rates from 18 percent in 1994 to as low as 10 percent in 1998.[1]

While Oregon has been able to maintain expanded eligibility for pregnant women and children, and a premium subsidy program (FHIAP) up to185% of federal poverty, Oregon's expansion population, adults under 100% of federal poverty level, has dropped from 90,893 to 28,395 (as of June, 2005) since implementation of the OHP2 waiver in February 2003. Due to budget constraints, on July 1, 2004, new enrollment was closed for the Oregon Health Plan expansion population (OHP Standard) with a goal of decreasing enrollment to 25,000 by June 30, 2005.

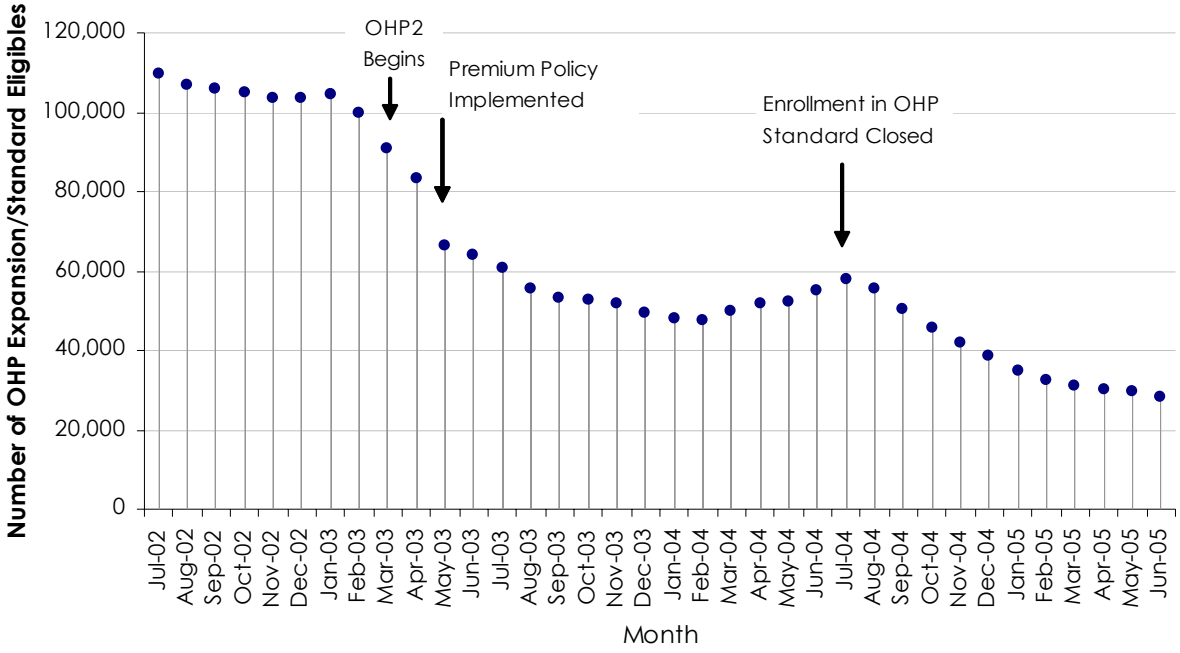
Chart 1-1: Enrollment in Oregon's Medicaid Program, 2002-2005



Source: Oregon Health Plan Medicaid and CHIP Reports, www.oregon.gov/dhs/healthplan/data_pubs/enrollment.

1 Office for Oregon Health Policy and Research Oregon's Uninsured: Summary of Findings from the 2002 Oregon Population Survey. http://www.ohppr.state.or.us/data/

Chart 1-2: Enrollment in Oregon's Medicaid Expansion Program, 2002 to 2005



Source: Oregon Health Plan Medicaid and CHIP Reports, www.oregon.gov/dhs/healthplan/data_pubs/enrollment.

Even while facing these fiscal challenges, Oregon remains committed to the goals outlined in its original HRSA State Planning Grant application. The specific aims for continuation funding are built around those three goals:

1. ***To increase health insurance through the expansion of both public and private financing.***
2. ***To increase the proportion of eligible people who apply and receive Medicaid coverage.***
3. ***To improve the capacity and capability of Oregon's healthcare delivery system, including safety net clinics, to provide care to uninsured populations.***

Specific Addendum to Q1.1: Current Level of Health Insurance Coverage in Oregon

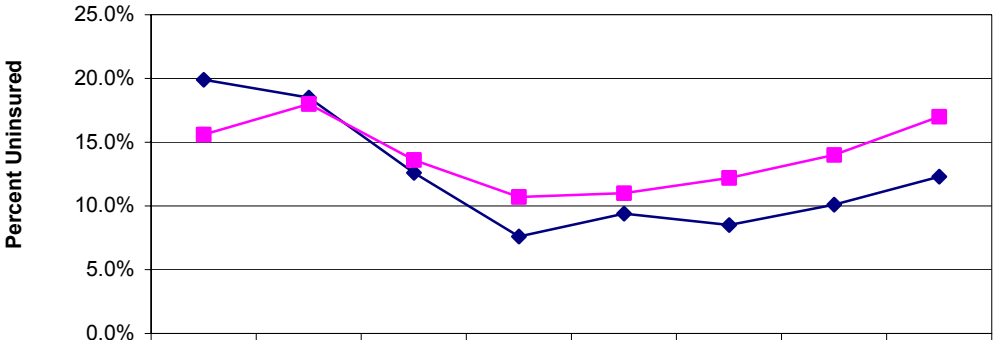
The most current numbers on insurance coverage in Oregon are from the 2004 Oregon Population Survey (OPS) [2] and the U.S. Census Bureau's Current Population Survey, Annual Social and Economic Supplement, 2005 (2004 data).

Using OPS data, it is estimated that 17% of Oregon's population is uninsured, and approximately 12.3% of Oregon's children (0-17) are lacking health care coverage. This translates to nearly 609,000 people without health insurance, including up to 105,000 children, and it represents an increase over the percentage and total number of uninsured when compared with 2002 figures. The uninsurance percentage still remains below the 18.1% figure reported in 1992, the highest percentage since the OPS began.

2 The Oregon Population Survey (OPS) is a biennial omnibus survey of Oregon households that has been fielded in the state since 1990. The survey's primary objective is to track numerous health, social and economic benchmarks, including measures of Oregonian's health insurance status. The 2004 OPS included 4,508 households.

Reasons for the increase in uninsurance percentages are varied; Oregon's seasonally adjusted unemployment rate in July 2005 was 6.6% (compared to the nation's 5.0% unemployment rate) and the increasing costs of health insurance for employers and the self-employed are likely significant contributors. [3]

Chart 1-3: Health Insurance Coverage Trends in Oregon's Population, 1990-2004



	1990	1992	1994	1996	1998	2000	2002	2004
Children (0 to 17)	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	10.1%	12.3%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%

Source: Oregon Population Survey, 1990 – 2004.

The U.S. Census Current Population Survey's (CPS) 2004 Annual Social and Economic Supplement estimates that 16.5% of Oregonian's lack health insurance; the 2003/2004 average is 16.8%.

Specific Addendum to Q1.2: Characteristics of the Uninsured. Sub-analysis of the 2004 CPS shows the following:

Income: Approximately 73% of the uninsured families in Oregon earn less than the 2004 median family income of $51,011, while 48.7% of the insured families earn less than the median family income.

Table 1-4: Characteristics of the Uninsured: Family Income

Family Income	CPS, 2004	
	Insured	Uninsured
Less than $9,999	7.5%	13.4%
$10,000 to $14,999	5.9%	10.3%
$15,000 to $24,999	9.1%	21.4%
$25,000 to $34,999	13.4%	15.4%
$35,000 to $54,999	18.6%	17.8%
$55,000 to $74,999	14.0%	5.7%
$75,000 to $99,999	13.0%	5.3%
$100,000 and above	18.5%	10.7%
Total	100.0%	100.0%

3 Oregon Labor Department, Oregon Labor Market Information System, http://www.qualityinfo.org/olmisj/OlmisZine, Sept. 2005.

An estimated 53.9% of the uninsured have family incomes totaling less than 200% of the federal poverty level.

Table 1-5: Characteristics of the Uninsured: Income-Poverty Ratio

Poverty Level	CPS, 2004	
	Insured	Uninsured
Below 100%	10.1%	19.8%
100% to below 200%	17.7%	34.1%
200% to below 250%	7.8%	11.0%
250% to below 300%	9.8%	6.7%
300% and above	54.5%	28.3%
Total	99.9%	99.9%

Age: The adult population makes up the majority of the uninsured in the state: 84.8% of the uninsured are between the ages of 18 and 64.

Table 1-6: Characteristics of the Uninsured: Age

Age	CPS, 2004	
	Insured	Uninsured
0 to 17	25.9%	14.6%
18 to 24	6.9%	23.0%
25 to 44	25.0%	42.0%
45 to 64	26.5%	19.8%
65 and over	15.8%	0.6%
Total	100.1%	100.0%

Many of the children under the age of 19 were eligible for public programs, but were not enrolled in either Medicaid or the SCHIP program. (The programs are administered separately in Oregon, but the separation is transparent to the client). At the time of the fielding of the 2004 OPS and CPS, approximately April 2004, there were 19,808 children enrolled in the SCHIP program; by June of 2005 that number had increased to 25,014. Oregon's HRSA State Planning Grant funded a Children's Access Survey to better understand the barriers to children's enrollment around the state, specifically at the community level (see Section 4 for more detailed information about the survey and this section, Q1.5 for the survey results). The goal of the survey research was to better assess the barriers to SCHIP and Medicaid enrollment as part of the Governor's commitment to providing access to health care for every child in the state.

Children and Income: Important to any program design for children's insurance is the income distribution of families with uninsured children. Table 1-7 shows Oregon children by family income to poverty ratio.

Table 1-7: Characteristics of the Uninsured: Children and Poverty

Family Poverty Level, Children 0 to 17	CPS, 2004	
	Insured	Uninsured
Below 100%	9.2%	19.7%
100% to below 200%	12.3%	33.8%
200% to below 250%	6.6%	11.5%
250% to below 300%	9.4%	6.4%
300% and above	62.5%	28.5%
Total	100.0%	99.9%

The 2004 Oregon Population Survey shows that there are an estimated 68,000 uninsured children (<19) in the state in families with incomes less than 200% FPL.

The 2004 Current Population Survey indicates that about 12,428 of the children under 200% FPL are non-citizens and therefore are not likely to be eligible for any federal programs.

Gender: The majority (53.3%) of the uninsured are men.

Table 1-8: Characteristics of the Uninsured: Gender

Gender		CPS, 2004	
		Insured	Uninsured
Male		49.0%	53.3%
Female		51.0%	46.7%
	Total	100.0%	100.0%

Family Composition: As with insured families, uninsured families are most likely to have a husband/wife composition, but a significantly greater proportion (25.5%) of uninsured families have a single female head of household.

Table 1-9: Characteristics of the Uninsured: Family Composition

Family Composition		CPS, 2004	
		Insured	Uninsured
Husband/wife family		65.7%	51.5%
Other female head		13.0%	25.5%
Other male head		21.3%	23.0%
	Total	100.0%	100.0%

Health Status: The Oregon Population Survey does not include a question regarding health status, and we have not had the opportunity to examine the 2004 CPS micro-data files to look at health status for the uninsured. However, we have 2003 CPS data as shown below. The data show that the uninsured are less likely (56.3%) than the insured (66.5%) to report being in excellent or very good health.

Table 1-10: Characteristics of the Uninsured: Health Status

Health Status		CPS, 2003	
		Insured	Uninsured
Excellent		35.5%	30.3%
Very Good		31.0%	26.0%
Good		23.1%	33.3%
Fair		6.3%	8.0%
Poor		4.0%	2.4%
	Total	99.9%	100.0%

Work Experience – Detailed: The data clearly show that employment does not assure health insurance coverage. Thirty-four percent of the uninsured report having worked year- round and full-time and another 16% report working year-round part-time.

Table 1-11: Characteristics of the Uninsured, Work Experience

Work Experience - Detailed	CPS, 2004	
	Insured	Uninsured
Worked full-time, year-round	32.2%	34.1%
Worked full-time, part-year	7.0%	16.0%
Worked part-time, year-round	5.3%	9.5%
Worked part-time, part-year	6.9%	10.2%
Did not work last year	27.4%	18.1%
Under 15 years old (not working age)	21.1%	12.1%
Total	99.9%	100.0%

Race: To better understand racial and ethnic disparities in the state, we are displaying both the race distribution of the uninsured and the level of health care coverage by race. CPS data is displayed here, as we do not have final OPS data yet because we are currently fielding a second, more robust sample of African-Americans for the OPS.

Table 1-12: Characteristics of the Uninsured, Race

Race	CPS, 2004	
	Insured	Uninsured
White alone	90.1%	83.1%
Black or African-American alone	1.8%	0.6%
American Indian or Alaska Native alone	1.0%	2.9%
Asian alone	4.1%	4.7%
Native Hawaiian & Other Pacific Islander alone	0.4%	3.0%
Two or more races	2.6%	5.6%
Total	100.0%	99.9%

Table 1-13: Health Insurance Coverage in Oregon by Ethnicity

Ethnicity	CPS, 2004		Total
	Insured	Uninsured	
Non-Hispanic	85.4%	14.6%	100.0%
Hispanic	63.7%	36.3%	100.0%

Table 1-14: Health Insurance Coverage in Oregon by Race

Race	CPS, 2004		Total
	Insured	Uninsured	
White alone	84.6%	15.4%	100%
Black or African-American alone	93.5%	6.5%	100%
American Indian or Alaska Native alone	63.8%	36.2%	100%
Asian alone	81.4%	18.6%	100%
Native Hawaiian & Other Pacific Islander alone	41.5%	58.5%	100%
Two or more races	70.1%	29.9%	100%

Ethnicity: The uninsured in Oregon, as in the rest of the U.S. are of Hispanic ethnicity; the Hispanic population in the state reports a much lower rate of health insurance coverage: 36.3% report that they do not have health insurance.

Table 1-15: Characteristics of the Uninsured, Ethnicity

Ethnicity		CPS, 2004	
		Insured	Uninsured
Non-Hispanic		93.5%	81.2%
Hispanic		6.5%	18.8%
	Total	100.0%	100.0%

Duration of Insurance Gaps: The 2004 OPS provides the best source of data on health insurance gaps in Oregon. Almost 9% of those who were insured at the time of the survey reported having experienced a gap in coverage at some time in the previous 12 months.

Table 1-16: Gaps in Health Insurance Coverage

Health insurance gaps in the last 12 months		OPS, 2004	
		Insured	Uninsured
Yes		8.7%	na
No		91.3%	na
	Total	100.0%	na

Both the uninsured and those reporting having experienced a gap were asked about the length of the gap. As the table shows, over 70% of the gaps were short lived (less than 6 months) for those who were covered at the time of the survey. Those reporting no current insurance had typically been uninsured for some time, with 78% reporting gaps of longer than 10 months in the previous year.

Table 1-17: Length of Gap in Health Insurance Coverage

Duration of Gap	OPS, 2004	
	Insured	Uninsured
Less than one month	0.7%	3.9%
1 to 3 months	38.2%	8.0%
4 to 6 months	33.8%	8.0%
7 to 9 months	13.1%	1.9%
10 to 12 months	14.2%	78.1%
Total	100.0%	99.9%

Geographic Location: The sample size for the OPS is not adequate for county-level estimates, but is made up of a stratified sample designed to yield geographic estimates. The state is divided into eight regions. The distribution of the uninsured generally follows the population distribution.

Table 1-18: Characteristics of the Uninsured: Geographic Distribution

Geographical Distribution	OPS, 2004	
	Insured	Uninsured
North Coast (Clatsop, Columbia, Lincoln & Tillamook)	4.2%	4.5%
Portland Metro (Clackamas, Multnomah, Washington, Yamhill)	45.1%	43.5%
Central Willamette Valley (Benton, Lane, Linn, Marion, Polk)	24.3%	26.6%
Southern (Coos, Curry, Douglas, Jackson, Josephine)	13.3%	10.1%
Gorge (Gilliam, Hood River, Morrow, Sherman, Umatilla, Wasco)	3.7%	4.0%
Central Oregon (Crook, Deschutes, Jefferson)	4.9%	5.4%
Southern Central (Grant, Harney, Klamath, Lake)	2.4%	2.6%
Eastern (Baker, Malheur, Union)	2.1%	3.3%
Total	100.0%	100.0%

Specific Addendum to Q1.3: Implications of Data on Health Insurance Coverage in Oregon

One of Oregon's key strategies to increase health insurance coverage in the state is to maximize enrollment of eligible children. These data show us that strategies focusing on children below 300% of federal poverty have the potential of covering 70% of the uninsured children in the state. Furthermore, strategies must be developed building on local community efforts to guarantee access will be important to the more than 12,000 non-citizen uninsured children.

Specific addendum to Q1.5: Why do uninsured individuals and families not participate in public programs for which they are eligible?

Children's health insurance status is significantly associated with the health insurance status of parents and other adults in the household. Oregon's recently completed Children's Access to Healthcare Survey (CAHS) for low-income families (For detailed description, see Section 4, and full report web link is in Appendix II) found that more than three-fourths of the parents (79.6%) who completed the survey about an uninsured child had no health insurance coverage themselves, compared with only 19.3% of parents with privately insured children. Nearly all of the uninsured children (90.6%) had at least one uninsured adult in the household. Almost half of the uninsured children (49.5%) had an adult in the household who recently lost OHP coverage compared to only 36.0% of children with private insurance. A slightly higher percentage of households with adults who recently lost OHP had uninsured children (10.9% vs. 8.0%).

The main reasons cited by parents for not wanting to enroll their children in OHP included: child already has other insurance (68.4%) the rules change too often (14.1%), it takes too much time to apply (10.1%), it is too difficult to see a provider when you have the OHP (12.5%) the application asks for too much private information (8.0%), and a belief that the OHP is currently closed to all new enrollees (5.9%).

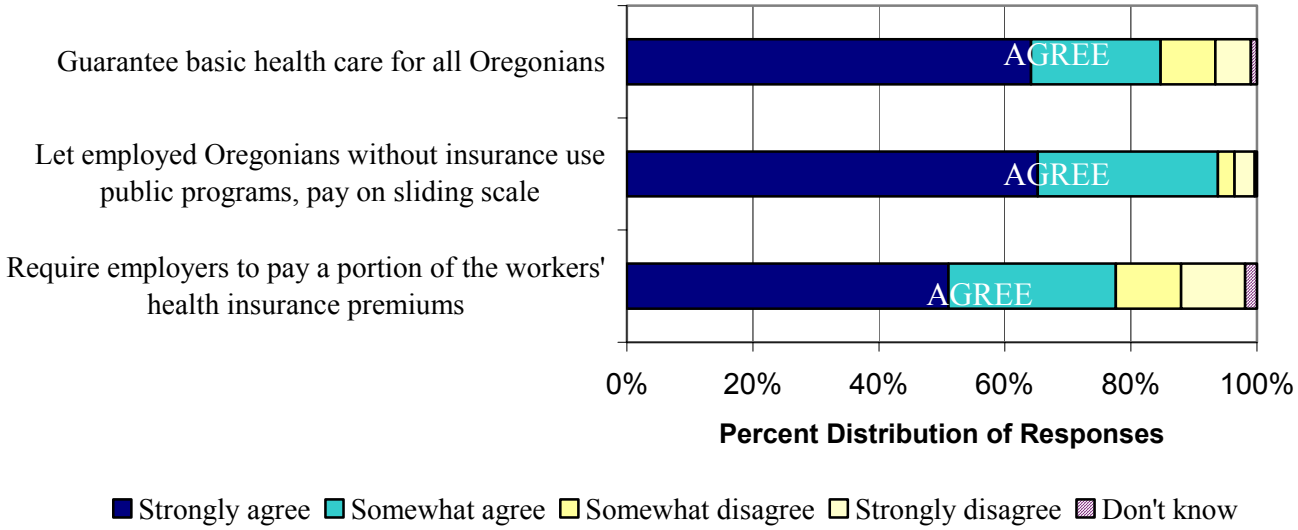
Among those parents familiar with the OHP application process, 69.1% found it very easy or somewhat easy, while 27.7% found it somewhat difficult or very difficult. For those parents who reported some difficulties with the OHP application process, the most commonly cited barriers included: it was difficult to gather all of the paperwork needed to enroll (43.7%), it takes too much time (23.4%), it is difficult to get through on the telephone (16.4%), and it was not possible to find transportation to the office (15.0%).

When asked to select three changes that would make the OHP application easier, many parents reported that it would be helpful if a child did not have to re-enroll in the OHP every six months (72.6%), if a child did not have to be without insurance coverage for six months before qualifying for OHP coverage (35.5%), if you could apply for the OHP online (34.1%), and if coverage started the same day that a child visits a health care provider's office (31.0%).

Specific addendum to Q1.8: Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Basic care for all continues to be a widely distributed, intensely held social goal. For respondents to the 2004 Health Values Survey, affordable health care for all continues to be seen as an extremely important focus for health policy efforts. When asked to rate on a 10-point scale the importance of several aspects of health care, 79% of respondents used a "10" to rate "affordable health care for you and your family." When asked to indicate whether they agree or disagree with the proposition that "All Oregonians should be guaranteed *basic and routine* health care services," a strong majority (64%) said they "agree strongly" and an additional 21% said they "agree somewhat." This overwhelming majority of 85% agreeing with the proposition is consistent with previous surveys where overall agreement levels were 92% (2000) and 87% (1996). It should be noted that a companion proposition, "All Oregonians should be guaranteed *any needed* care," drew considerably less agreement in all three surveys.

Chart 1-4: Oregonians' Opinions on Strategies for Helping the Uninsured Obtain Health Coverage.



Source: Office for Oregon Health Policy & Research Health Values Survey, 2004

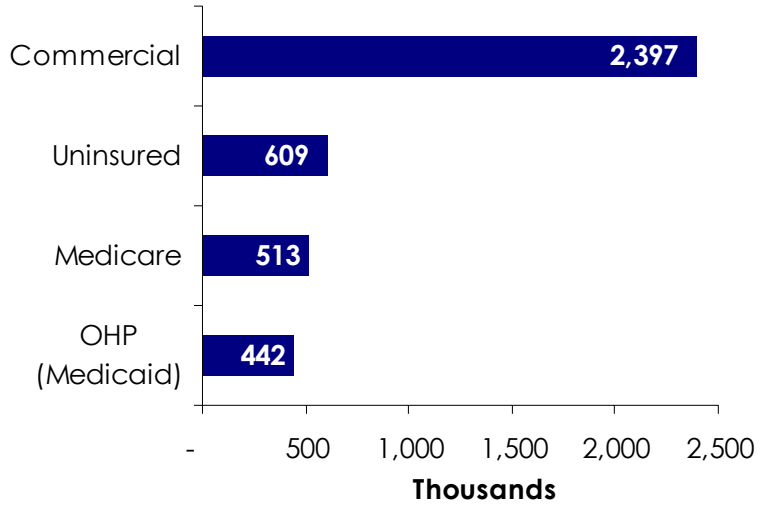
Having people stay uninsured, relying on emergency room care with cost shifting is not an acceptable policy. The respondents were asked to consider the following proposal. "Have these people (the uninsured) go without health insurance. They would probably use the emergency room for health care with the cost offset by those who can afford to pay for health care." In all three Health Values Surveys (1996, 2000, and 2004), respondents resoundingly rejected the proposal to formally endorse the status quo. When asked about strategies to provide coverage to employed Oregonians without health insurance, the vast majority of respondents agreed that employers should be required to pay a portion of the premium. The respondents also agreed that employed Oregonians without health insurance should be allowed to use public health care programs and pay on a sliding scale. Although a larger proportion of respondents agreed with this question than agreed with the previous question, this should not be interpreted to mean that Oregonians prefer one option over another.

Addendum to Section 2: Employer-Based Coverage

Detailed answers to the questions were provided in our original full report in 2001. Below is a current overview of Oregon's Employer-Based Coverage with some specific updates to particular questions from this past year's HRSA SPG activities or through other Oregon-specific work.

The private sector insures about 66% of the population in Oregon – an estimated 2.4 million people. Over half a million Oregonians receive health care through Medicare (14%) and 12% of the population is enrolled in Medicaid (442,000). The majority of the private sector coverage is through group health insurance accounts, with less than 10% of premiums written in the individual market.

Figure 2-1: Health Care Coverage in Oregon, 2004



Data Sources: Medicare - CMS, 2003; Medicaid – DSSURS/OMAP; Duals – OMAP; Uninsured, commercial – 2004 OPS

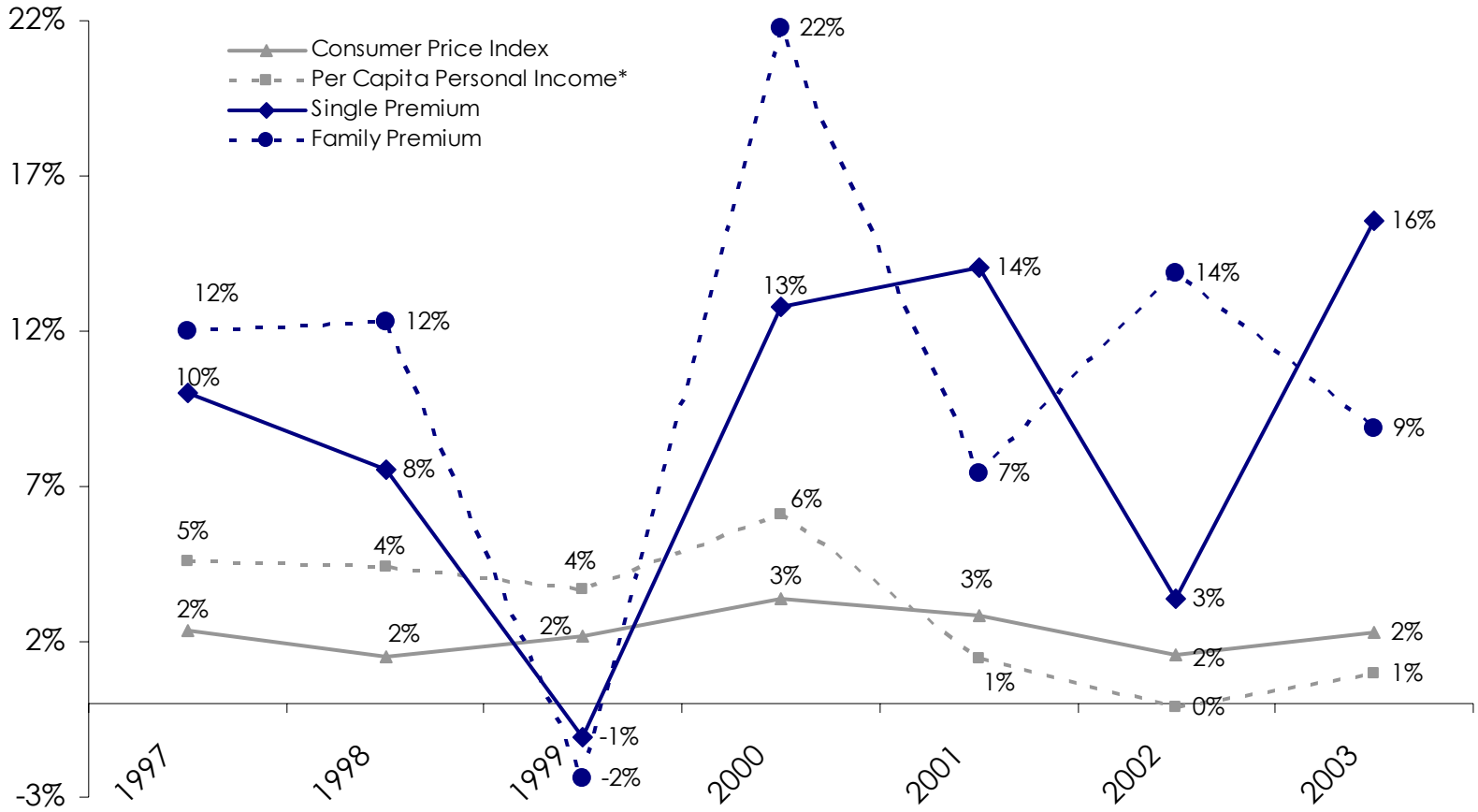
During most of the 1990s, Oregon incrementally reduced the number of uninsured in the state. A booming economy, which increased employment, and implementation of the Oregon Health Plan (OHP), Oregon's 1115 waiver program, were key components of that success. Since OHP was launched, it has provided access to quality health care services for more than one million otherwise uninsured Oregonians and helped to decrease uninsurance rates from 18 percent in 1994 to as low as 10.7 percent in 1996.[4] However, OHP's proposed employer mandate never materialized, and it remains primarily a public program.

While employer-sponsored insurance remains the primary vehicle for health insurance coverage, premiums are growing at approximately 12% a year, and there is evidence nationally that employers, especially smaller employers, are dropping health insurance as a covered benefit for their employees. A recent study by the Kaiser Family Foundation of employers nationwide revealed that the number of small employers (defined as 3 to 199 employees) offering health insurance had dropped from 68% in 2001 to 63% in 2004.

As is shown in Chart 2-2, the average annual increase in Oregon's health insurance premiums for most years between 1997 and 2003 far outpace the growth in per capita income or inflation.

4 Office for Oregon Health Policy and Research Oregon's Uninsured: Summary of Findings from the 2002 Oregon Population Survey. http://www.ohppr.state.or.us/data/

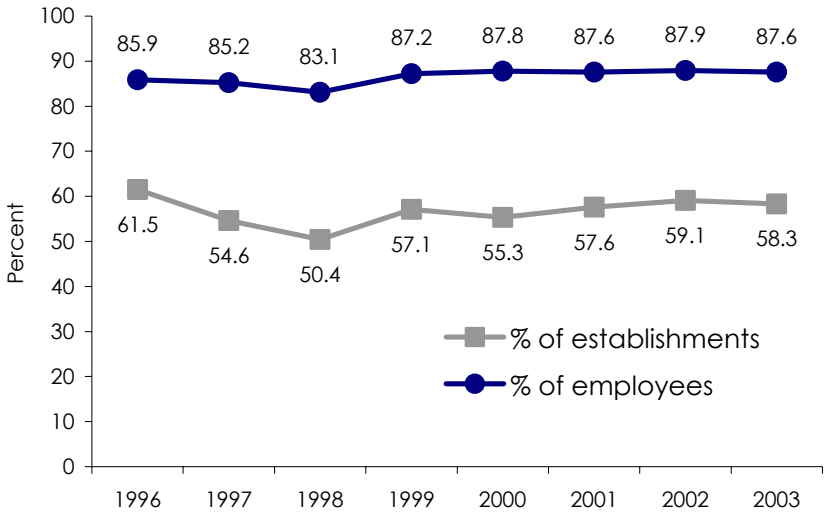
Chart 2-2: Increases in Oregon Health Insurance Premiums and Other Indices, 1997 to 2003



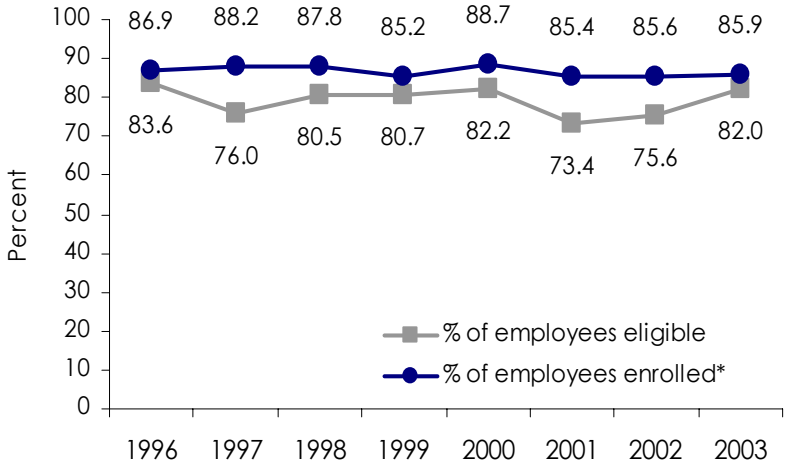
Charts 2-3 through 2-5 show trends in Oregon's employer-sponsored health insurance market from 1996 to 2003.

Chart 2-3: Oregon Health Insurance - Availability, Eligibility, and Enrollment, 1996 to 2003

- The percent of establishments that offer health insurance to their employees has not changed from 1996 to 2003.
- Additionally, the percent of employees who work at these establishments has also remained relatively constant.



- While employers continue to offer health insurance, there has been a decline in the percent of employees who are eligible for health insurance.
- Among employees who are eligible for health insurance, about 85% enroll which has remained constant.



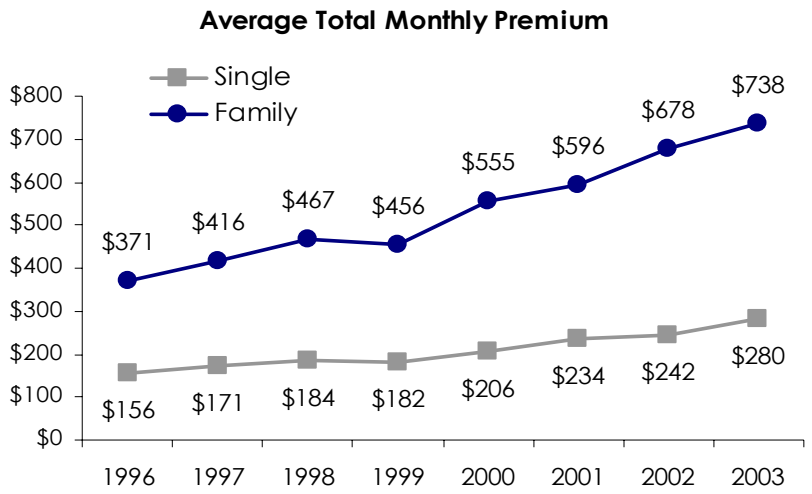
*Percent enrolled among those eligible

Source: Medical Expenditure Panel Survey, 1996-2002. (MEPS)

Additionally, while the percent of establishments offering health insurance for single coverage at no cost to the employee has remained relatively constant, the percent offering health insurance for family coverage at no cost to the employee has declined.

Chart 2-4: Oregon Average Total Monthly Premiums, 1996 - 2003

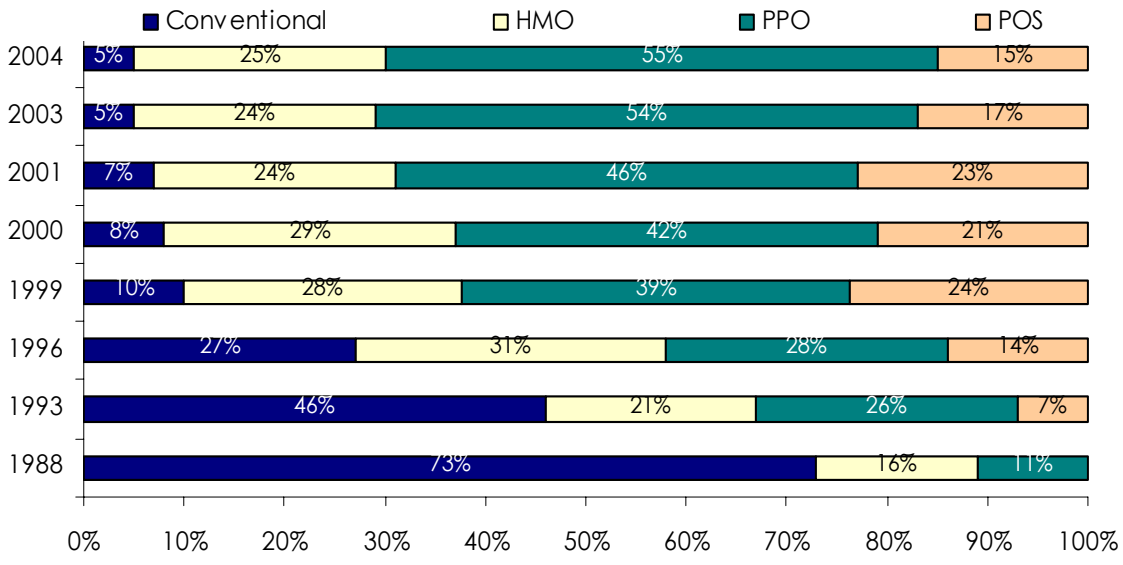
- Monthly premiums have increased for single and family plans, but to a greater extent for family plans.
- It appears that both employers and families are sharing the impact of these increasing premiums.



Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2003.

Another major market shift to take place in the U.S. over the last ten years is the shift away from conventional indemnity plans and toward preferred provider organizations:

Chart 2-5: Health Plan Enrollments by Plan Type, United States, 1998-2004



Source: National data from Kaiser/HRET Employer Health Benefits 2004 Chartpack at http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46206. Kaiser/HRET Survey of Employer-Sponsored Health Benefits (1999-2004), KPMG Survey of Employer-Sponsored Health Benefits (1993, 1996), The Health Insurance Association of America (HIAA): 1988.

As opposed to the U.S. numbers shown above, in Oregon, there has been a dramatic shift away from managed care. Managed care penetration in the state peaked in 1999, with slightly more than 50% of population enrolled in one of the state's 11 managed care plans.[5] Partially due to consumer backlash, managed care has been largely abandoned in Oregon; in 2003, only 22% of the population was enrolled in one of the five remaining commercial managed care plans.[6] The strongest remaining sector of managed care in the state is within the Medicaid delivery system, where 13 managed care plans deliver care to about 75% of the Medicaid population.

5 http://www.managedcaredigest.com/edigests/hm2000/hm2000c01s07g01.html. <December 2004>.

6 http://www.statehealthfacts.kff.org. <December 2004>.

Addendum to Section 3: Health Care Marketplace

Detailed answers to the questions were provided in our original full report in 2001. Provided below is a current overview of Oregon's Delivery Systems and Health Care Marketplace with some specific updates to particular questions from this past year's HRSA SPG activities or through other Oregon-specific work.

Oregon's Current Health Care Delivery System

Oregon has a long history of private sector managed care, beginning with the Kaiser Health Plan, established after World War II. The Medicaid Demonstration 1115 Waiver, implemented in February 1994, was designed to take advantage of managed care as a way to contain costs while preserving quality coordinated care. Originally, almost every health plan in the state participated in the Oregon Health Plan. Currently the majority of participating plans are non-commercial and community-based; many are essentially a cooperative agreement between the local physician-sponsored Independent Practice Associations (IPAs) and a local hospital. These community-based fully-capitated health plans (FCHPs) are locally created, owned and controlled.[7] As of July 2005, there were FCHPs in most of Oregon's 36 counties, and 76% of Oregon's Medicaid clients were enrolled in managed care with the remaining 24% in fee-for-service. This is a decline from the past; in January 1999 managed care penetration was greater, with 84% of Medicaid clients enrolled in FCHPs.

There are several reasons for the decline; there was some reduction after the implementation of the recent OHP2 waiver, which significantly restructured the OHP, and more after benefit reductions introduced by the Oregon Legislative E-Board[8] as a cost-containment strategy. As one cost-containment strategy, outpatient mental health and substance abuse treatment benefits were dropped from the OHP Standard benefit package in March 2003. Some FCHPs dropped enrollment for adults covered under OHP Standard, expressing doubt that they could manage the care for this population without access to the discontinued benefits. Reimbursement rates are also a major concern, especially during the recent economic downturn. Efforts are underway by the Medicaid agency to re-encourage participation as the managed care delivery system has generally increased access to care compared to fee-for-service access. However, with the August 2004 restoration of outpatient mental health and substance abuse coverage, every FCHP has once again agreed to enroll OHP Standard clients.

These changes have created additional pressure on Oregon's health care delivery system, especially in rural Oregon. Both commercially-insured and Medicaid patients suffer from an unequal distribution of providers between the urban and rural areas of the state. Accurate numbers on capacity of rural providers and the entire delivery system, including the safety net are lacking, and some of Oregon's activities this past year have focused on how to capture and understand the needs in underserved areas. A key part of Oregon's upcoming pilot planning project is to work with Oregon's Health Policy Commission's Delivery System Models Workgroup to examine alternative and/or expanded delivery system models for providing health care services to people enrolled in OHP, the underinsured and the uninsured. This past year's

7 Health Care Delivery systems in Oregon: A report to the Oregon Health Council, Access Subcommittee (2000). Oregon Health Council, Access Subcommittee, available at www.ohpr.state.or.us

8 Oregon has a citizen legislature that convenes every two years. During the interim, state budgetary decisions are made by the Emergency Board, which meets quarterly.

HRSA SPG activities, which are still under way, are to define capacity of the delivery system statewide and develop indicator benchmarks that will provide an analytical tool for the state to better understand provider capacity and to monitor outcomes at the community level. (For more details on the Healthcare Indicator Project, see Section 4, pg. 35)

Oregon's healthcare workforce capacity is difficult to capture, yet it is important to understand as the state seeks to salvage the safety net and maintain its managed care delivery system. While the Board of Medical Examiners and Nursing Board can provide the number of physicians and nurses licensed in Oregon, the data does not provide the number of hours per week each provider spends in direct patient care. In 2004, OHPR collaborated with the Oregon Medical Assistance Program (OMAP), the Oregon Medical Association (OMA), and the Oregon Medical Peer Review Organization (OMPRO) to field a new statewide provider survey. OHPR's subanalysis of primary care providers shows the following:

- Patient relationships are important, more than income despite physician's concerns with reimbursement.
- Physician retirement is outpacing replacement in Oregon
- Physician's response to increasing cost pressures and medical liability include increased referral of complex cases and decreasing hours
- Physicians are balancing the types of payers, and their decisions on Medicare impact decisions about Medicaid.

The results have added to the understanding of the current workforce issues, providing a statewide sample that can inform policymakers.

Table 3-1 – Members Enrolled in Reportable Health Plans in Oregon, by Insurer, as of Dec 31, 2004

Insurer Type	SEHI* Groups	Non-SEHI	Stop Loss Only	Medicare Advantage	Medicare HMO Cost	Medicaid	Portability	Individual	Total Lives Insured
Domestic HCSC	186941	964366	14774	116346	42965	14614	14945	98195	1453146
Foreign HCSC	0	3567	0	0	0	0	12	0	3579
Domestic HL	56711	111149	7434	0	0	0	1207	43572	220073
Foreign HL	9474	44549	112403	7797	0	13	47	30251	204534
Domestic Other	0	0	0	0	0	0	1895	8248	10143
Foreign Other	0	2200	91705	0	0	40	18	1773	95736
TOTALS	253126	1125831	226316	124143	42965	14667	18124	182039	1987211

Source: Oregon Department of Consumer and Business Services, Insurance Division

SEHI = Small Employer Health Insurance. HL = Health & Life Insurers, HCSC = Health Care Service Contractors.

Specific Addendum to 3.1: How adequate are existing insurance products for persons at different income levels or persons with pre-existing conditions?

Oregon has launched two new products to address some of the gaps in existing affordable coverage through its Insurance Pool Governing Board. The two plans, an alternative, basic plan for adults and a product directed toward dependent children for small business employers to offer to their employees, are further outlined in Section 4, page 29.

Specific Addendum to 3.4: What impact does your State have as a purchaser of health care?

The state's largest employer-based healthcare purchaser has reached a milestone in its effort to increase the value of care provided to approximately 116,000 state employees, dependents and other participants. Following an innovative, three-year planning and procurement process, the Public Employees' Benefit Board (PEBB) selected medical plans to begin in 2006 that have the best potential to achieve PEBB's 2007 Strategic Vision by producing significant improvements in healthcare quality, while also considering vendor responses to administrative and cost issues

PEBB's Strategic Vision: Oregon's Public Employees' Benefit Board believes the current healthcare system is in crisis. From the member to the provider to the insurer, the system is broken. At this time PEBB is not confident that the current marketplace can offer a tangible, statewide solution for the short or long term. The depth, breadth and complexity of this problem require long-term solutions. PEBB has developed the following vision statement to articulate its desired future. This vision statement says what the long-term solutions might look like. During the next five or more years, it will serve as a guide for the Board's strategic planning, its decision-making and its commitment of resources toward achieving that future.

PEBB envisions a new state of health for its members statewide over the next several years. Key components of the 2007 Strategic vision of the PEBB program will include:

- An innovative delivery system in communities statewide that provides evidence-based medicine to maximize health and utilize dollars wisely.
- A focus on improving quality and outcomes not just providing healthcare.
- The promotion of consumer education and informed choices.
- Appropriate market and consumer incentives that encourage the right care at the right time.
- System-wide transparency through explicit, available and understandable reports about costs, outcomes and other useful data.
- Benefits that are affordable to the state and employees.

Specific Addendum to 3.7: How did the planning process take Safety Net providers into account?

The healthcare indicator project work is also informing Oregon's *Safety Net Advisory Council (SNAC)*, a citizen committee brought together by Governor Kulongoski this past year. These efforts build on the background work Oregon conducted as one of four states receiving technical assistance last year to further understand the healthcare safety net through *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project,* sponsored by the National Governors Association (NGA) Center for Best Practices and coupled with comprehensive data tools from the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA). This technical assistance provided the impetus for the Governor to form

the *SNAC,* bringing key stakeholders, the Governor's health policy staff, and legislators, to coordinate activities and act as advisors to State policy, with a goal of strengthening the healthcare safety net throughout the state.

Oregon is continuing to develop data-driven healthcare policy options across the healthcare delivery system, especially looking at safety net policy options. Since the workgroup was formed, Oregon has integrated state and local data with the AHRQ data set and identified remaining information gaps. The Office of Oregon Health Policy and Research, through its work with the *SNAC* and proposed new activities guided by the Oregon Health Policy Commission for the upcoming year, will develop capacity and demand indicators at the community level.

Specific Addendum to 3.9: Did you consider the experience of other States with regard to:

- **Expansions of public coverage**

Oregon has continued to watch efforts of other states to expand public coverage, following closely Rhode Island, West Virginia, Maine and pending waivers from Iowa and South Carolina, but due to the state's barely recovering budget, Oregon has not yet been able to implement these options. Our OHP2 Waiver is up for renewal in the next 18 months, and with our Governor's recent Children's Charter and focus on children (See Section 4) we are beginning the waiver amendment process with a review of children's coverage expansion efforts of other states such as West Virginia and Florida.

- **Public/private partnerships**

While we continue with our public/private partnership, Oregon's Family Health Insurance Assistance Program, which provides premium assistance for group and individual coverage for low-income residents through our OHP2 Waiver, we struggle with participation. Oregon is predominately a small employer state, and they struggle with offering insurance to their employees. We have been closely watching the efforts regarding reinsurance in New York and the new pilot activities other HRSA SPG-funded states examining the best approach to reinsurance and other public-private options as Oregon looks to ways to lower the cost of insurance for employers.

Addendum to Section 4: Options and Progress in Expanding Coverage

Detailed answers to the questions were provided in our original full report in 2001 for our OHP2 Waiver expansion proposal that was designed under our first year of HRSA SPG funding. Provided below is a current overview of Oregon's more recent Options and Progress in Expanding Coverage with some specific updates to particular questions from this past year's HRSA SPG activities or through other Oregon-specific work.

The HRSA State Planning Grant activities have fueled Oregon's progress to expand access to health insurance across the state. Oregon had three goals when applying for the grant and they hold true today:

1. ***Increase health insurance through expansion of both public and private financing.***
2. ***Increase the proportion of eligible people who apply for and receive Medicaid coverage.***
3. ***Improve capacity and capability of Oregon's healthcare delivery systems, including the safety net clinics, to provide needed care to uninsured populations.***

Earlier Efforts to Reduce the Number of Uninsured Residents

This section outlines the states extensive efforts of the last 15 years to develop innovative ways to improve access to health insurance for Oregonians.

*The Oregon Health Plan***:** In 1987, Oregon initiated its health care reform efforts, collectively referred to as the Oregon Health Plan (OHP), in an attempt to reduce the number of uninsured Oregonians, strengthen its economy, and improve the health status of its citizens. At that time, 18% of Oregon's 2.85 million residents were uninsured, and the unemployment rate was 5.7%. In addition, the cost of health care was consuming an ever-growing portion of public and private sector budgets. The goal of the OHP was universal access to an adequate level of high quality health care at an affordable cost. The OHP has provided access to quality health care services for more than one million uninsured people and helped to decrease uninsurance in the state to as low as 10% in 1998, although it has since increased to 17% in 2004.

The major components of the original Oregon Health Plan were:

- Medicaid reform
- Insurance for small business
- High risk medical insurance pool
- Employer mandate

Medicaid Reform: The Oregon Health Plan (OHP) has been an innovative example of Medicaid reform, including a basic benefit package that expanded public coverage to the federal poverty level (FPL)[9] for families and adults, a managed care delivery system, and prioritized and integrated mental, physical and dental health care services. The OHP sought to lower costs by reducing cost shifting through expanding coverage, emphasizing managed care, preventive care, early intervention and primary care, and prioritizing the coverage of effective care over less effective treatments. Prior to March 2003, the OHP covered:

9 For 2004 Federal Poverty Guidelines, see Appendix B.

- Low-income adults beyond the mandatory groups up to 100% of the Federal Poverty Level (FPL)
- Children (Under 19 years of age) up to 170% of FPL through Medicaid or SCHIP
- Pregnant women up to 170% of FPL

Insurance for Small Business: As part of the Oregon Health Plan, the Insurance Pool Governing Board (IPGB) was created to encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds. [10] In 1997, Oregon's Legislature created the Family Health Insurance Assistance Program (FHIAP), which offers premium subsidies to assist Oregonians with incomes up to 185% FPL to purchase private coverage.

*High-Risk Medical Insurance Pool***:** The 1987 Legislature created the Oregon Medical Insurance Pool (OMIP) to provide affordable health insurance to individuals denied coverage in the individual insurance market due to pre-existing medical conditions. Over the last ten years, OMIP has provided coverage to almost 30,000 Oregonians otherwise unable to purchase coverage and has been a factor in FHIAP's success. Enrollment has risen to more than 7,000 individuals. OMIP is funded by the purchase of coverage by individuals, employers, and an assessment of insurers based on an insurer's total market share.

Employer Mandate: The employer mandate was never implemented, but would have required all employers to offer group health insurance or pay into a statewide insurance pool through a payroll tax. Implementation was dependent on Congressional exemption to the federal Employee Retirement Income Security Act (ERISA), which the state was unable to obtain.

*Subsequent Changes to OHP***:** As an early grantee in the State Planning Grant, Oregon began planning grant activities prior to the country's economic downturn. The original focus was on the first and second of Oregon's three HRSA State Planning Grant goals:

1. ***Increase health insurance through the expansion of both public and private financing.***
2. ***Increasing the proportion of eligible people who apply for and receive Medicaid coverage***

However, facing the worst state budget shortfalls since World War II[11], Oregon, like most other states, has looked at a Medicaid program at risk of collapse. With federal inflexibility to adjust the Prioritized List of Health Services further to control costs, Oregon turned to cost sharing and benefit reduction in an attempt to contain Medicaid costs. Background data collection and design work completed through Oregon's original HRSA State Planning grant, allowed the State to build on its 1115 waiver and use the flexibility provided by the HIFA initiative, to develop OHP2 in FY 2003.

The OHP2 Waivers separated the Medicaid program into two benefit packages—OHP Plus and OHP Standard. OHP2 waiver changes also resulted in including the State's premium subsidy program, the Family Health Insurance Assistance Program (FHIAP) under Medicaid so it could receive federal match for what had been previously funded with only state dollars.

10 IPGB designed a basic, no-frills benefit package that was offered by small group insurance companies at a set price for both small employers and self-employed, exempt from some insurance mandates, and if the employer had not offered group health insurance benefits for two years. At its peak, over 20,000 employers purchased these IPGB-certified plans, enrolling more than 60,000 employees and their dependents. Later insurance reforms enacted by the Oregon Legislature during the 1990's decreased the need for these specialized plans, and there was a migration to plans in the regular market.

11 Feder J, Levitt L. O'Brien E, Rowland D. Covering the Low-income Uninsured: The Case for Expanding Public Programs. Health Aff (Millwood). Jan-Feb 2001: 20(1):27-39

The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves low-income seniors, people with disabilities, families meeting the eligibility criteria for Temporary Aid to Needy Families (TANF) and children and pregnant women. The OHP Standard benefit package, designed for Oregon's expansion population (who are adults, 19 to 64 years of age up to 100 percent of the FPL), implemented in February 2003 was leaner in benefits and implemented significant co-pays. Premiums were increased for those enrolled in OHP Standard and administrative rules were tightened, including a six-month lockout for nonpayment of premiums. These changes were derived from objectives developed through extensive community input and advisory groups. The objectives were to:

- Generate revenue to provide flexibility in designing the OHP Standard benefit package that would otherwise have a very limited coverage level.
- Instill in clients the value of health care and ongoing coverage by structuring the program to include cost- sharing for accessing certain services and for maintaining eligibility.
- Make OHP Standard similar to commercial plans as a transitional step to private health insurance.

The original policy goal of OHP2 was to expand coverage to 185% FPL for children, pregnant women and adults through savings accrued by implementing the leaner OHP Standard benefit package, cost sharing and premiums. However, as the severity of Oregon's budget shortfall intensified, the reductions in coverage were implemented, but much of the expansion was not realized. In addition, the Oregon Legislature in March 2003 eliminated outpatient mental health and chemical dependency for the OHP Standard population. These benefits were reinstated in August 2004. Prescription drug coverage for OHP Standard was also eliminated but reinstated after two weeks following intense public pressure.

Chart 4-1: OHP 2 Waiver Changes, February 2003

	Waiver Provisions	Number Affected
Reductions Implemented	OHP Standard benefit package for Oregon's expansion population (adults, 19 to 64 up to 100% FPL). The changes were: ▪ Increased cost sharing and premiums ▪ Reduced benefit package ▪ Ability to cap enrollment ▪ No waivers of premiums for zero income ▪ Six-month lock out for non-payment of premiums	99,894 in OHP Standard as of end of month February 2003 As of September 2004, OHP Standard enrollment was 52,008
Expansions Implemented	Children (up to 19) and pregnant women increased from 170% FPL to 185% FPL Family Health Insurance Assistance Program (FHIAP) eligibility increased from 170% to 185%	An additional 2,557 children and 438 pregnant women as of September 2004 An additional 454 enrollees between 170% and 185% as of January 2005
Expansions Not Implemented	Parents, from 100% to 185% FPL Childless adults (19 to 64) from 100% to 185% FPL FHIAP to 200% FPL Children to 200% FPL	N/A

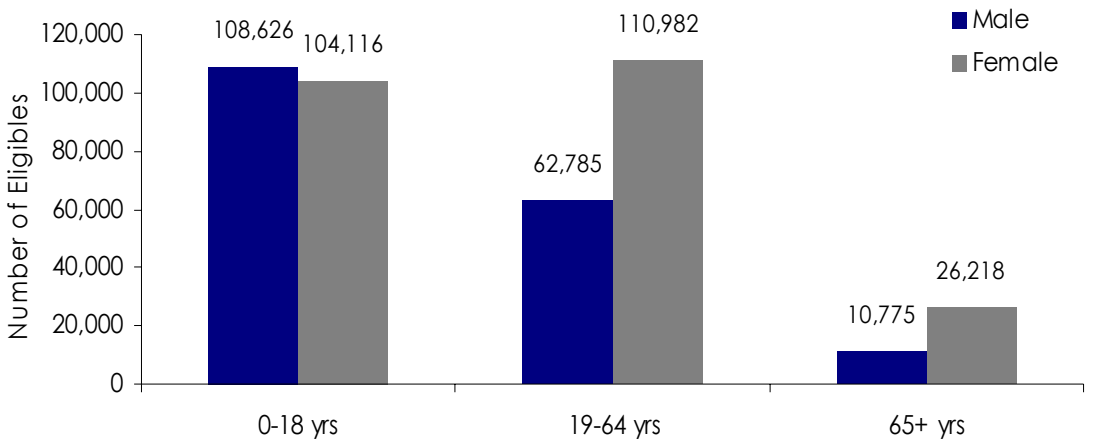
Changes to OHP in 2004:

Elimination of Co-payments for OHP Standard: In early 2003, the Oregon Law Center legally challenged the OHP Standard premium and co-payment policies authorized by the Centers for Medicare and Medicaid Services (CMS). The litigation (Spry v. Thompson) found that OHP Standard co-payments violated federal law; they were eliminated effective June 19, 2004, according to the court order. While the court decision did not affect OHP premium policies, OHP Standard co-payments are no longer a consideration as a cost sharing mechanism for future OHP Standard program changes.

OHP Standard status starting in Summer, 2004: The OHP Standard program:

- Operates entirely without General Fund resources, using provider taxes from the hospitals and managed care organizations, and premium payments from enrollees.
- Serves a reduced number of clients based on available provider tax revenue, premium payments, and federal matching funds.
- The program is currently closed to new enrollment.
- Has a redefined benefit package effective August 2004, which re-instated outpatient mental health and substance abuse treatments and very limited dental coverage.

Chart 4-2: OHP Medicaid and CHIP Enrollees, September 2004



Data Source: Oregon Medical Assistance Program (OMAP)

*Family Health Insurance Assistance Program (FHIAP)***:** A key tenet of the Oregon Health Plan was to build on public – private partnerships, reflected in Oregon's original HRSA SPG grant first goal. The state's health insurance premium subsidy program is an example of such a partnership. The Family Health Insurance Assistance Program (FHIAP) provides over 8,500 Oregonians with subsidies for their private health insurance premiums.

The program was created in 1997 with state-only dollars to address the needs of families who do not qualify for Medicaid or Medicare, but cannot afford private coverage. Following the design work done under Oregon's original HRSA SPG, FHIAP was incorporated into the OHP2 waiver in 2002. With the availability of federal matching dollars, the program allows more Oregonians to participate in the private health insurance market.

Benefits: Members enroll in their employer's group insurance plan if one is available; otherwise they enroll in an individual plan. The member is responsible for co-payments, co-insurance, and all deductibles. There is a basic benchmark benefit for subsidized employer-sponsored coverage that is comparable to coverage commonly found in the small employer or group health insurance market. This benchmark was developed as a tool to determine which health insurance plans offered by employers would be eligible for subsidy under the auspices of FHIAP.

Chart 4-3: FHIAP Enrollment by Subsidy Level, January 2005

Subsidy Level	% FPL	Individual	Group	Total
95%	*<=125%*	*3,036*	*1,891*	*4,927*
90%	*126% - 149%*	*1,023*	*1,056*	*2,079*
70%	*150% - 169%*	*408*	*648*	*1,056*
50%	*170% - 185%*	*136*	*318*	*454*
Total	*Na*	*4,603*	*3,913*	*8,516*

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

OHP Premium Sponsorship: As part of a community response to the dramatic decline in the OHP Standard caseload, an OHP premium sponsorship program, sponsored by various organizations around the state, has developed in Oregon. OHP Standard enrollees are required to pay a percentage of the premium share based on their income and to make timely premium payments or face disqualification from the program. If disqualified, they are not eligible to re–enroll for six months. In previous Oregon HRSA SPG activities, Washington's Basic Health Plan's model of financial sponsorship that developed in one portion of that state was examined. This past year's activities resulted in components of the Washington model implemented in Oregon in May 2004, keeping more than 2,000 OHP Standard enrollees from disqualification. (More details of the sponsorship effort are outlined later in this section, page 34)

Additional Notable Program Changes: Oregon's Medically Needy program was also eliminated due to budget cuts in February 2003, and efforts were soon initiated to reinstitute coverage. State dollars are now directed to a small subset of the formally Medically Needy program for organ transplant and HIV patients. Efforts to initiate a Medicaid Pharmacy Plus waiver program were not successful. However, as of March 1, 2005, the state started enrolling people in the Oregon Prescription Drug Program (OPDP). OPDP consolidates drug purchasing across state and local agencies and provides discounts to low-income (less than 185% FPL) adults between 55 and 64 years of age without drug coverage. The state partnered with the American Association of Retired Persons (AARP) in its marketing with an initial application mailing to 1,500 uninsured individuals who awaited the program's rollout. Enrollment at the end of August, 2005 was 3,123 uninsured individuals and 1,364 members from groups. Savings for the uninsured have been $169,085 for the first six months of operation or about $23 per prescription. 84% of the pharmacies in Oregon voluntarily joined the program, with participation in all areas of the state.

Several local governments are exploring their ability to participate with their next benefit renewal cycle.

Oregon's current efforts toward expanding coverage

Despite a sharp economic downturn, Oregon remains committed to its original HRSA State Planning Grant goals of increasing access to health insurance coverage for more Oregonians through efforts to:

1. Increase expansion of public and private programs
2. Increase enrollment of those already eligible, and
3. Improve capacity and demand in Oregon communities' delivery systems.

Efforts toward's Oregon's first HRSA SPG goal:

Oregon continues to pursue approaches to work towards its initial goal of ***increasing health insurance through the expansion of both public and private financing***. Governor Kulongoski's administration is focusing on reexamining and planning the short-term and long-term goals of creating a sustainable state plan that will expand access to healthcare to all Oregonians. The Oregon Health Plan could have been that vehicle, but currently its scope is more limited than it was at its inception. Recent changes make it clear that is only a piece of the puzzle and that care options in Oregon need to be re-examined at the highest level. To that end, the Oregon State Legislature created the Oregon Health Policy Commission in the 2003 Legislative session. This Commission, with members appointed by Governor Kulongoski, consists of key stakeholders and legislators, knowledgeable in health care. Starting in January 2004, the Commission has been examining the state's critical health policy issues, focusing on cost, quality, health status and access.

Past HRSA State Planning Grant projects included interviews of Oregon employers and health care purchasers in order to better understand trends in employer–sponsored health insurance; learn more about the possibilities of expanding FHIAP's subsidy program via the group insurance market, and identify employer partners who would be willing to advise the office on the design of an expanded employee subsidy program. Employer strategies and options were identified, and employers agreed to advise the state on expansion of FHIAP's employee subsidy program. Also, the state has increased marketing of the FHIAP program as part of an effort to increase enrollment under Oregon's current budget. There has been increased interest as the state has seen declines in eligibility for employer-sponsored insurance and OHP Standard enrollment.

Oregon's 2003 legislative session directed the Insurance Pool Governing Board (IPGB) through House Bill 2537 to increase access to health insurance and health care by providing affordable health benefit plans for small employers with at least two but no more than 50 employees. IPGB held focus groups and meetings across the state, to understand stakeholder issues and ideas. They met with insurance agents and carriers, employers, advocates, key policy makers, legislators, and legislative staff. The culmination of this effort was a recommendation to the IPGB board to offer two benefit designs: The Alternative Group Plan and the Children's Plan. The Alternative Group Plan may be offered only to an employee or his/her spouses; no children will be allowed to enroll. The plan design excludes some mandated benefits; as well as some standard services that most comprehensive small group plans usually cover. This plan will be guaranteed issue and employers may change carriers at renewal or if their current carrier no longer offers a certified

plan. The target premium for the Alternative Group Plan is 30 - 50 percent less than a typical benefit plan. However, this plan does not qualify for subsidy under the Family Health Insurance assistance Program (FHIAP).

The Children's Group Plan, however has lower deductibles and cost-sharing levels, as well as higher benefits, and qualifies for a FHIAP subsidy. This plan includes all required mandated services and is also guaranteed issue. This plan can be sold as a stand-alone product, or in conjunction with the Alternative Group Plan. This means that employers who can't afford to cover their employees have the opportunity to provide good, comprehensive coverage to the children of their employees. The Children's Group Plan was available for enrollment beginning in March 2005 and has 10 children currently enrolled.

Over the past four years, the HRSA SPG grant team has reviewed numerous national and local proposals for universal coverage. Oregon used supplemental funds to partner with two local organizations; the Metropolitan Alliance for Common Good (MACG) and the Foundation for Medical Excellence (TFME) to develop an approach to Health Dialogues focused on universal coverage options**.** [12] The MACG sponsored a meeting in 2004 on education, tax reform and health and attracted close to 5,000 attendees. MACG wanted to partner with OHPR because of our extensive experience in gathering public opinion on major health care issues through open public meetings. MACG had proposed employing Health Dialogues[13], with the intent of reaching beyond the Portland Metropolitan area to rural communities in order to broaden participation in discussion and decision–making processes. The steering committee, with participation from key healthcare stakeholders continues discussions about how best to fund a statewide Health Dialogues effort. The committee is currently applying for a grant to partner with similar efforts in Washington State to continue to achieve their goals. Those grant efforts will work closely with the Oregon Health Policy Commission.

By maintaining the infrastructure required for implementation of necessary waivers, the state is well positioned for expansion of coverage for children as the state's economy recovers. With legislative members of the Oregon Health Policy Commission positioned to champion the Commission's recommendations to the full legislature, Oregon is poised to work swiftly towards coverage expansion once the economy sustains signs of improvement. The background research and public-private partnerships developed in earlier HRSA-funded work serves as a platform for expansion, especially to children in Oregon. With collaboration among community stakeholders, community and political consensus can develop around approaches to improve access to healthcare, with children as a key focus.

Efforts towards Oregon's second HRSA SPG goal:

For Oregon's second goal, ***increasing the proportion of eligible people who apply for and receive Medicaid coverage,*** Oregon has experienced serious challenges. The state has successfully designed and implemented a waiver of traditional Medicaid rules in order to expand coverage to Oregonians up to Oregonians up to 200% of FPL, but because of the severe economic downturn in the state, Oregon had to close the adult program, OHP Standard to new enrollment and leave eligibility at 100% of FPL. The State was able to afford a coverage

12 The Metropolitan Alliance for Common Good (MACG), a collaborative group consisting of representatives from labor, faith–based, and other advocacy organizations a public, non–profit foundation created in November, 1984 to promote medical excellence through education and research

13 Health Dialogues will use the process of Viewpoint Learning, which conducted health dialogues all across Canada at the request of the Canadian Parliament.

expansion to children and pregnant women with incomes up to 185% of FPL both in OHP and in Oregon's premium assistance program, the Family Health Insurance Assistance Program (FHIAP). Currently SCHIP enrollment is steadily increasing.

Under current administrative rules, an individual is disqualified from the Oregon Health Plan and locked out for six months for failure to pay a premium for two consecutive months. Currently, there are no premium waivers allowed for zero-income clients, but legislation signed into effect by the Governor in August, 2005 eliminates premiums for all persons in OHP Standard who have incomes less than 10% FPL which will be implemented soon.

Impact of most recent policy reforms: OHPR worked with our state Medicaid agency, OMAP, to form the Oregon Health Research and Evaluation Collaborative (OHREC), an innovative partnership of the policy and academic health services research communities, to study the impact of waiver changes using funding from Oregon's Robert Wood Johnson Foundation State Coverage Initiatives (SCI) grant. Some of the key findings included:

Enrollment Impacts of OHP2 Waiver changes:

- OHP Standard enrollment fell 50% from approximately 102,000 clients in 2002 to approximately 51,000 in late 2003
- Low-income single adults have been most susceptible to the premium policy changes in OHP Standard, with the zero income group most affected (58% decline in enrollment)
- New enrollments among the zero income group dropped sharply and have not returned to pre-implementation levels
- Premium cost was the most common reported reason for loss of OHP Standard coverage
- Most (72%) who lost coverage remained uninsured at the time the study was undertaken

Unmet Need Impact of OHP2 Waiver changes:

Research found that clients who lost OHP Standard coverage had higher unmet health care needs:

- 60% reported unmet need for medical care; 80% for mental health care
- Clients with chronic illnesses were more likely to report unmet needs

Utilization Impacts of OHP2 Waiver changes**:**

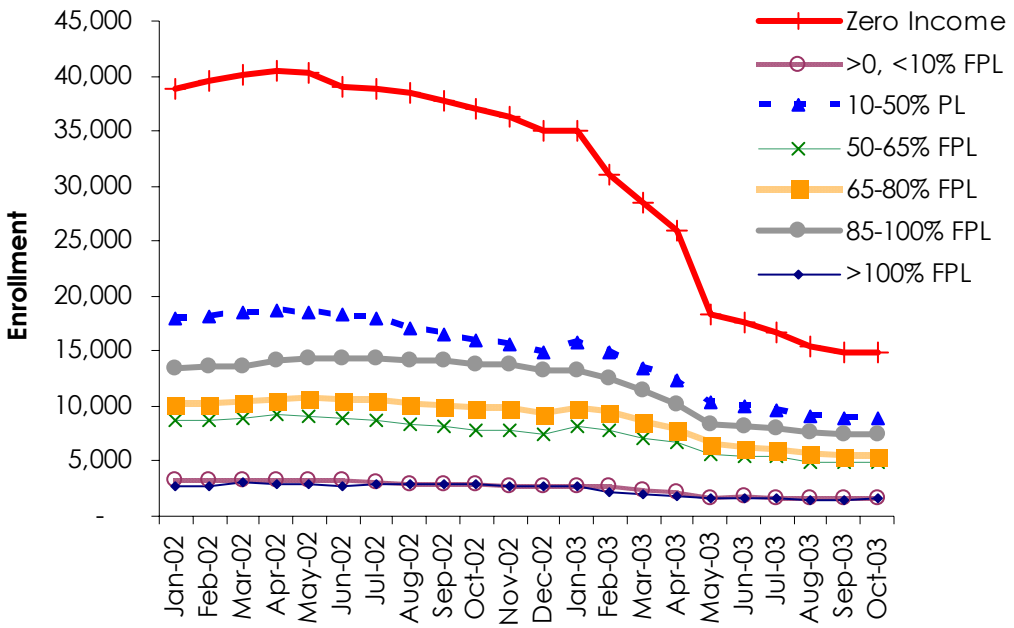
Research found that clients who lost OHP Standard coverage were:

- Nearly three times more likely to have no usual source of care
- More likely to skip filling a prescription due to cost (57% vs. 48%)[14]
- 4 to 5 times more likely to go to the emergency department for care

14 At the time the survey was undertaken, OHP Standard required co-payments for prescription drugs ranging from $2 to $15 per prescription.

The following chart shows the differential impact of OHP2 premium policy changes by income level:

Chart 4-5: Impact of Premiums and Administrative Lockout on OHP Enrollment



Source: McConnell KJ, Wallace N, "The Effect of Premiums and Administrative Lockout on OHP Enrollment", Presentation to Oregon Health Research and Evaluation Collaborative (OHREC), January 22, 2004. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/ohrec.html

As is shown in Chart 4-5, the lowest-income individuals (especially the zero-income group) have been most affected by the premium amount and administrative changes to OHP Standard. The changes (removal of the homeless and zero-income waiver criteria and implementation of the six-month disqualification) in premium policy were at least as important as the premium amount changes. The Kaiser Family Foundation Health Policy Forum invited testimony from OHPR about these premium impacts to provide information to legislative staff and advocates as MediCal redesign was being crafted. Results from OHREC research were also presented to the Connecticut Legislature as they considered cost sharing changes in their Medicaid program. Most recently, the Colorado SCHIP requested this data to inform their HIFA waiver design process.

New legislation alters premium payment policy for OHP2 Standard: The just completed 2005 Legislative session resulted in the passing of Senate Bill 782 which eliminates premiums for those OHP Standard enrollees with incomes less than 10% of the Federal Poverty Level and reinstates the previous premium repayment policy, allowing enrollees a full six months to pay past-due premiums, instead of the more restrictive one month OHP2 policy. The impact studies were critical to educating legislators and key stakeholders as to the need of adjusting the policies based on the evidence from the evaluation of the OHP2 changes.

Focus on Children: According to the 2004 Oregon Population Survey over 100,000 children are uninsured in Oregon and as many as 68,000 may be eligible for the Oregon Health Plan (Medicaid or SCHIP) using the existing eligibility guidelines. One of Governor Kulongoski's key agenda items for the state is the Children's Charter, which includes expanded health insurance coverage for children as one component. So far, efforts toward expanding access to coverage have resulted in a pilot in two counties of increased outreach activities, an increased asset limit ($10,000) for SCHIP eligibility, and development and implementation of the Children's Group Plan, which is designed and targeted to small business employers. The state is considering further options as it approaches its upcoming OHP2 Waiver renewal, with a focus on developing amendments that would increase options for low-income parents to obtain coverage for their children.

We know from our past years of study under the HRSA SPG efforts and our data on the uninsured that many of Oregon's children are eligible but not enrolled. The Children's Charter includes efforts to increase enrollment of those already eligible for Medicaid and SCHIP. Governor Kulongoski initiated more focused efforts this past year through KidCare, a pilot of increased outreach to children in two Oregon counties with high rates of uninsured children. Kid Care efforts reinforced the importance of community tailored efforts. A one-size fits all approach was not as effective as those designed with the unique elements of each community in mind. Local leaders played valuable roles in reaching target audiences while the state support facilitated collaborative efforts and educational opportunities. Future expansion efforts will be informed by outreach lessons learned in the Kid Care pilot project.

However, the state also wanted to know more about the barriers to obtaining coverage for children beyond the scope of the KidCare pilot. With our past year's supplemental grant, OHPR, in collaboration with an investigator at Oregon Health & Science University, designed and conducted a state wide Children's Access Survey, building on the Centers for Disease Control and Prevention's (CDC) National Survey of Children with Special Health Care Needs (2001) and the National Survey of Children's Health (2003). This statewide survey effort provided valuable, regional information essential to assessing children's barriers to access to healthcare in such a way that community-level interventions can be designed. The information developed from this survey, coupled with what can be learned from other states' efforts will be used by the Oregon Health Policy Commission to develop strategic policy options to address the large number of uninsured children in the state. Furthermore, this survey information will assist the Oregon Medical Assistance Program (OMAP), the Medicaid agency, to target outreach efforts toward children who are eligible for Medicaid or SCHIP, but not currently enrolled. The findings are outlined previously in Section 1, under specific addendum to Q1.5. The full report web link is available in Appendix II.

Our contacts through the HRSA SPG program, we have allowed us to follow closely other states' efforts to cover children. Oregon is especially interested in opportunities through the SCHIP program, since our current waiver already allows for expansion up to 200% FPL, but our past severe budget crisis precluded its implementation. For example, we have looked closely at West Virginia's incorporation of its SCHIP program for children and parents into its public employees' pool structure and will assess the feasibility of this approach to generate the cost savings that would allow for expansion. As part of our recently awarded Pilot Planning Grant activities, the SCHIP benefit options will include an examination of West Virginia's approach; as well as other states' SCHIP programs such as Florida and Rhode Island. Additionally, the new

dependent children product through FHIAP/IPGB will be compared to other private products offered on the market. Efforts will be directed to minimize crowd out and allow us to assess viability of an SCHIP redesign as we discuss our upcoming waiver renewal and potential waiver amendments.

Premium Sponsorship Activities: Oregon's HRSA SPG funding has been directed toward establishing the OHP Premium Sponsorship collaborative, a statewide pool of donated funds that is used to pay past-due premiums for clients who are in danger of disqualification from the OHP at the lowest premium level (0 >10% FPL; $6 premiums). The Premium Sponsorship Workgroup provided an avenue to begin discussions in Oregon around ways that individual communities could increase health insurance coverage, adding local funding to the mix of commercial and public financing. A group of community leaders, under last year's HRSA SPG grant efforts, had come together to form a collaboration around premium sponsorship for adults covered under OHP Standard, Oregon's 'expansion' population. OHP Standard requires enrollees to pay a percentage of the premium share based on their income, and to keep up on their premium payments or face disqualification from the program. If disqualified, they would not be eligible to re–enroll for six months. By March 2003, the second month of OHP Standard, OHP enrollees were being disenrolled for lack of premium payment. Building on Washington State's Basic Health Plan premium sponsorship model studied by Oregon in previous HRSA efforts, some community providers contributed towards the premium shares for their patients in order to ensure continuous coverage (sponsorship). Components of Washington's model were implemented in May 2004, keeping more than 2,000 OHP Standard enrollees from disqualification from the health plan. Since July 2003 there have been no disqualifications of enrollees between 0-10% FPL because of non-payment or premiums.

The Premium Sponsorship Workgroup has evolved over the last year, growing and shrinking as communities came to decisions of how they would approach fundraising and identification of potential sponsors. Discussions over the last year have included individuals from eleven of Oregon's thirty-seven counties. Together these participants have drafted a possible long-term sustainable model for premium sponsorship.

However, as the Premium Sponsorship Workgroup has been assessing different sponsorship models for the future, recent legislation has changed the focus somewhat. With the passage of SB 782 resulting in the elimination of premiums for the those enrollees with incomes less than 10% of Federal Poverty level, the role of the Premium Sponsorship effort is now less clear. The sponsors will need to evaluate whether they want to focus on other income level enrollees to assist premium payment, as their main targeted vulnerable population will not be required to pay premiums once the Centers for Medicaid and Medicare approve the change.

The premium sponsorship process has led to a group of communities forming local collaborative efforts, which provides an opportunity to look beyond premiums and perhaps to broaden the scope to identify health care issues where they can jointly intervene. We have continued to collaborate with these efforts over this past year with the initiation of the Delivery System Models workgroup of the Health Policy Commission. As the Commission is beginning a more focused look at the community models, great progress is being made in assessing how best the state can support such efforts. This has led to the efforts outlined in Oregon's upcoming pilot planning grant to provide technical assistance to those Oregon communities most ready to model delivery system reform. Similar to the proposed analysis of statewide options, economic

modeling at the community level with local stakeholder input is the next logical step toward having viable community models of 100% Access.

Efforts towards Oregon's Third HRSA SPG goal:

This past year's work for the grant's third goal: ***to improve the capacity and capability of Oregon's and healthcare delivery systems, including the safety net, to provide needed care to the uninsured populations*** was focused on developing a set of indicators measuring capacity, access, and outcomes of Oregon's delivery systems and to establish benchmarks that will allow the state to design and implement data-driven health delivery system policy. With these continuation funds, we are working to develop a combined dataset for the purposes of performance monitoring.

Oregon had started the important process of bringing often disparate, fragmented data together to inform policy in 2004 when Oregon participated in the National Governors' Association's (NGA) technical assistance collaboration with the Agency for Healthcare Research and Quality (AHRQ), *Enhancing the Safety Net Through Data-Driven Policy*. Oregon's Health Care Safety Net Policy Team, a group of key stakeholders, convened as part of the NGA/AHRQ effort in order to develop data-driven policy options. These policy options were specific to sustaining and strengthening the health care safety net providers and those they serve. One of these recommendations led Oregon to begin the work of developing performance indicators and benchmarks, which when completed, will allow us to monitor both the impact of policy changes and the health and stability of the health care delivery system in the state. This dataset will include information currently collected from multiple sources, such as the Oregon Primary Care Association (OPCA), Oregon Community Health Information Network (OCHIN), Oregon Hospital Discharge Data and surveys fielded by OHPR.

Healthcare Indicator Project: Starting in 2004, the Office for Oregon Health Policy and Research (OHPR), working with stakeholders on the Oregon Safety Net Policy Team, began the process of understanding capacity and demand in Oregon's health care delivery system by gathering and analyzing the following information:

- Demand for health care services - defining particular indicators, community characteristics, and measures of outcomes.
- Capacity of providers - focusing on services provided, hours of operation, organizational structure, and other information.

To continue with that work, OHPR, under this past year's HRSA SPG grant, is working collaboratively with the Office of Health Systems Planning and other key informants and stakeholders, to develop a set of indicators measuring primary health care capacity, access and outcomes. The overall goal underlying this grant's work is to provide greater granularity to data that would help to inform Oregon policymakers to incrementally expand health care coverage to all Oregonians.

To assist with the development of the indicators and to improve measurement of capacity and demand, OHPR will focus initially on strategies for defining urban primary care data analysis boundaries. These boundaries will provide a meaningful unit of analysis and are needed to complement the rural primary care service areas (PCSAs) developed by the Office of Rural Health (ORH). HRSA has already defined PCSAs nationwide by aggregating Zip Code Tabulation Areas (ZCTAs). However, the HRSA PCSAs may be too highly aggregated to meet

the State's needs for assessment of primary care access. For example, the HRSA PCSAs split Portland into just two service areas. This level of aggregation does not allow for sufficient community-level analysis of potential differences in access to primary care across the city.

Major Urban Areas

Bend
Corvallis (includes Albany)
Eugene (includes Springfield)
Medford
Portland/Tri-county metropolitan area
Salem
Source: Office of Rural Health (2003)

The first step for the indicator project work has been to bring together some technical experts in Oregon's delivery systems to discuss the potential strategies and reach consensus. The largest urban area, the three county area of the large metropolitan city of Portland is just being completed, and meetings with stakeholders are starting in the other smaller urban areas of the state. Once the PCSA's for the urban areas are defined, OHPR will be better positioned to determine both the supply of primary care health services and the demand for these services within each urban area, much as ORH has previously done for rural PCSAs. By using these access and capacity indicators, the State can then better assess the level of unmet need for primary care health services across the state. This will help to inform the work of the Oregon Safety Net Advisory Council and the Oregon Health Policy Commission.

Once the boundaries for analysis are decided, the next step for the technical workgroup will be to discuss definitions of primary care outcome measurements. This work will also be brought to other groups for input including the Safety Net Advisory Council and the Oregon Health Policy Commission. Examining outcomes will allow the State, informed by the expertise of the technical workgroup and collaboration with other key stakeholders, to develop primary care performance benchmarks. This work will place the State in a stronger position to design and implement data-driven healthcare policy that best utilizes scarce funding resources.

This healthcare delivery system benchmarking will also be valuable for the work another group of stakeholders who have been developing a community approach to identify strategies to cover the uninsured. Initial discussions started in the Premium Sponsorship Workgroup as the group felt that sponsorship of OHP premiums was only one approach towards increasing access to health coverage. Collaborating with that work, the Oregon Health Policy Commission developed a Delivery System Models Workgroup formed to continue the efforts to explore other strategies that can leverage community dollars to help those who have access to insurance remain covered. Oregon aims to continue the efforts to keep the community players at the table, working toward a community model that will maximize public and private dollars for expansion of access to the uninsured. Efforts are underway to identify and further develop collaborative community models and to specify the role the state can play in facilitating those efforts. The Healthcare Indicator Project work can provide a means of measuring the effectiveness of these efforts.

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Addendum to Section 5: Consensus Building Strategy

Detailed answers to the questions were provided in our original full report in 2001. Provided below is a current overview of Oregon' Consensus Building Strategy with some specific updates to particular questions from this past year's HRSA SPG activities or through other Oregon-specific work.

Oregon's continues to develop and build consensus among stakeholders for the specific goals, just as the original HRSA State Planning Grant led to consensus around the restructuring of the Oregon Health Plan. Oregon's State Planning Grant activities have always had a large public input component. As the HRSA SPG's lead agency, the Office for Oregon Health Policy and Research (OHPR) is ideally suited to facilitate this consensus building. OHPR is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analytical, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access. OHPR provides staff support to advisory bodies responsible for health care policy recommendations including the Oregon Health Policy Commission, Health Services Commission, Health Resources Commission and the Medicaid Advisory Committee.

OHPR's expertise in technical and policy support in advising the Legislature and the Governor's Office ensures that these activities can be used to build the necessary political will to achieve the overall program goal. This role has taken on greater visibility due to the creation of the Oregon Health Policy Commission during the last legislative session. The Commission has the responsibility to develop a strategic plan and monitor the implementation of state health policy now and for the upcoming years. Planned HRSA State Planning Grant activities are designed to work closely with the Oregon Health Policy Commission's focus, to develop a new state health policy reflective of a slow recovery from tough economic times. Broad stakeholder participation and public outreach are integral components to all of the proposed activities.

Oregon has a long and successful history of stakeholder and citizen involvement in health policy. The Prioritized List of Health Services of the Oregon Health Plan evolved from a series of public forums. During the first year of Oregon's HRSA State Planning Grant funding, OHPR and the Oregon Health Services Commission used community forums to inform its decisions about benefits for OHP Standard. Pubic input together with informing public and private-sector decision makers who bring knowledge, influence and authority to advance efforts have been vital so that all HRSA State Planning Grant projects have moved from data to proposals for statewide policy.

The Oregon Health Values Survey: In the past year, Oregon is sought statewide public input on a series of health policy options, on behalf of the newly created Oregon Health Policy Commission. Oregon policy makers realize the need for strong information to help shape the policy decisions they make. An Oregon Health Values Survey has been conducted twice, in 1996 and 2000, under the auspices of Oregon Health Decisions (OHD)[15], a non–profit citizen

15 Oregon Health Decisions (OHD) originally started in 1982 as an outreach effort by the Oregon Health Council. It evolved into an independent organization whose aim is to bring the general public into the process of shaping health policy. OHD has developed values information from the public for living will legislation, the development of practice guidelines, and the tasks of technology assessment and distribution. The organization played a pivotal role in organizing community meetings for the Oregon Health Services Commission in its work of creating a prioritized list of health services, a central feature of the Oregon Health Plan.

organization whose mission gives the public an opportunity to have a voice in health care policy. Past Health Values Surveys have gathered feedback from Oregonians on issues of access, consumer control, and quality of care.

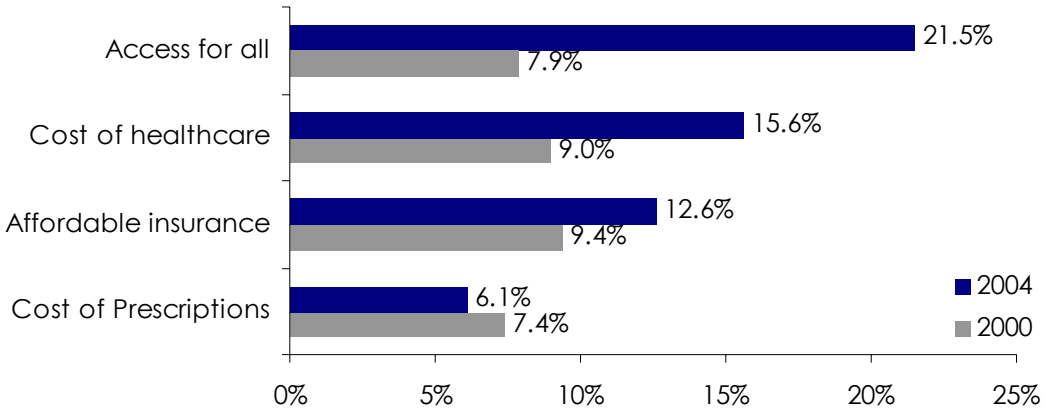
The HRSA SPG grant team partnered with OHD to focus on how to delineate which benefits Oregonians would support as the economy improves and additional funds might become available. Several legislative committees have been working to design a 'road map' to prioritize how populations will be returned to the OHP. What was missing was input from Oregonians, which has historically been an integral component of OHP decisions.

The 2004 Health Values Survey, a telephone survey conducted with 531 Oregonians yielded these key findings:

- Oregonians report that access for all and costs of health care and insurance were the top three health care problems that need to be solved in Oregon.
- An estimated 21.5% indicated that access for all was the most important issue, followed by concerns about the cost of health care and affordable insurance.
- The degree of consensus about these issues in 2004 is important to note; in 2000, cost of health care, affordable insurance, and cost of prescriptions were ranked as the top three concerns.

Chart 5-1 shows the key health issues as identified by Oregonians in both 2000 and 2004.

Chart 5-1: Most Important Health Care Issues, 2000 & 2004



Further findings of the Health Values Survey included:

- The majority of the public believes that all Oregonians should be guaranteed *basic* and *routine* health care services. Eighty-five percent agreed with this concept, but fewer agreed that *any* needed care should be guaranteed for all.
- Support for guaranteed access has declined slightly from 2004, but Oregonians increasingly support basing decisions regarding guaranteed services on cost and effectiveness of the treatment.

- When choosing between services to include in coverage for all Oregonians, the public cited preventive and primary care services as the overwhelming top priority.
- The public indicated that infants and small children should be prioritized first when allocating health care dollars for all Oregonians.
- Oregonians strongly support the policy that, when funds are limited for the Oregon Health Plan, policy-makers should reduce services but keep as many people as possible in the program.

Strategies supported by survey respondents to help the uninsured obtain coverage included the following:

- Use of public programs for those who are employed and unemployed and use of tax dollars to make health insurance affordable
- Discounted/sliding scale payment for public programs and purchased insurance
- Required employer contribution to their worker's premiums

Concurrent with the Health Values Survey, OHPR conducted additional public input community meetings for the Oregon Health Policy Commission (OHPC) during the summer and fall of 2004. The OHPC used the all of these results to shape short-range recommendations to the 2005 Oregon Legislature and will continue to incorporate the public input as they develop more long-range recommendations for the state's strategic health plan.

Additional Consensus-Building activities: The groundwork for achieving consensus around children expansion efforts have began through a series of efforts. OHPR has played an active role in Oregon's RWJF Covering Kids Grant activities, which have included piloting enhanced enrollment, outreach and retention strategies in four counties around the state. OHPR staff act as the liaison between state agencies and community stakeholders and facilitate the Covering Kids steering committee. OHPR has been involved in Oregon's Expanded Access Coalition, which brings together advocates, outreach workers and state program representatives throughout the state, to identify programs areas of concern as well as current challenges being faced in the field. This "front line" information has been valuable as Oregon considers both an expansion of coverage for children and now to address the need to maximize enrollment of those already eligible for coverage.

As discussed in earlier sections, efforts by the OHPC's delivery system workgroup to assess local communities' efforts statewide have involved healthcare leaders from communities across the state. This past year's projects focusing on healthcare indicators and the previous year's premium sponsorship efforts have all had broad citizen and local stakeholder involvement. State efforts to collaborate with local leaders have been and will be integral, as we proceed with our upcoming Pilot Planning Grant efforts to coordinated and assist development of options for individual communities. These activities are critical to foster viable strategies for expanding healthcare coverage to Oregonians for upcoming and subsequent legislative sessions.

Addendum to Section 6: Lessons Learned and Recommendations to States

Detailed answers for this section from our initial year of the HRSA SPG are in our full report of 2001. Current Lessons Learned and Recommendations to States from this past year's activities are detailed below.

Specific Addendum to Q6.1 How important was State-specific data to the decision-making process?

State-specific data has been and is extremely valuable to Oregon's decision-making process in all of its activities, allowing the State to use multiple data sources to create a coherent picture of Oregon's health care needs and construct viable options to key decision-makers. Findings from a recent survey of Oregon state legislators showed that they first and foremost want state specific data as they formulate policy. The data collected through HRSA State Planning Grant activities since 2000 have been vital to inform stakeholders and state decision makers, and continues to provide an opportunity to bring Oregon-specific data analysis to inform policymaking. The HRSA SPG-funded Oregon Health Values Survey and the Children's Access Survey are examples of state-specific data that will provide valuable input of Oregonians' values to the Oregon Health Policy Commission as it develops short and long term strategies for state health policy. Additionally, the federal MEPS and CPS data have become increasingly more valuable as they provide state-specific data with less lag time. Further efforts to decrease lag time between data collection and publication of results in these surveys would be extremely valuable to the state's processes. In addition, while recognizing federal budget constraints as well, increased sample size at the state level for both the MEPS and the CPS data would yield greater precision in our estimates using those data.

Specific Addendum to Q6.5: What additional data collection activities are needed and why?

Key data collection that would be valuable to the current policy planning process is better access to and measures of the cost of healthcare. This would include more quantitative studies of the cost shifting that occurs within the current healthcare system to cover the care the uninsured receive as well as the *cost of not covering* the care they *should* receive. Getting at the true cost of care has been challenging in our state, as well as other states and across the nation. Understanding these costs would be important for the rising cost of healthcare cripples any efforts to expand coverage. As costs rise, states such as Oregon have to make difficult decisions and choices to try and maintain any expanded coverage options.

We have analyzed the data needs and for more cost analyses, and are continuing to search for both local and national resources to assist the funding of an Oregon-focused analysis. State decisionmakers regularly request state-specific data, so the few national assessments have not been as useful to our policy planning process.

Specific Addendum to Q6.8: What are the key recommendations that your State can provide other States regarding the policy planning process?

As we were able to successfully obtain our OHP2 Waiver, which gives the state authority to increase coverage for the Medicaid expansion population to 200% of the FPL, in large part due to work completed under the initial HRSA SPG activities; we now appreciate the careful planning of an evaluation strategy as well. Using our RWJF State Coverage Initiatives grant

funding, we were able conduct the designed evaluations, with many significant studies completed about the impact of co-pays, premiums and other program changes. Data on the impact of co-pays and premiums on Medicaid populations was scarce when Oregon initially contemplated the OHP2 policy changes, and we hope our impact studies have been helpful to other States as they consider similar choices. We have focused on dissemination strategies that reach beyond Oregon and include collaboration with organizations that have a national presence, such as the Kaiser Family Foundation and The Commonwealth Fund, to ensure that other states have access to Oregon's findings.

Specific Addendum to Q6.9: How did your State's political and economic environment change during the course of your grant?

Like many other states, Oregon's economy has declined since late 2000. While things are starting to rebound nationally, Oregon has been slow to emerge from of its economic recession; it still has one of the higher unemployment rates in the nation. Oregon entered the just-completed biennial legislative session (2005) with another budget deficit, having used the majority of Oregon's reserves and a one-time "rainy day" fund to balance the budget in the past two bienniums. The 2004 Oregon Population Survey showed a significant rise in uninsurance, at 17%, which can be attributed to both a decline in public-sponsored insurance and private insurance.

Governor Kulongoski strives to achieve improved economic stability for Oregon, focusing on economic development and jobs. He is a champion for children, especially in education and healthcare. The legislature is slowly rebuilding the experience and knowledge base for complicated healthcare policy issues, after many years of term limits (recently overturned as unconstitutional in fall 2001). The Oregon Health Policy Commission (OHPC) plays a key role as it pairs legislators with advocates and stakeholders to develop the vision of where Oregon needs to go to increase access to healthcare to all Oregonians. The OHPC is beginning its strategic planning for the state's healthcare policy, setting the "roadmap" for Oregon's healthcare coverage efforts.

Specific Addendum to Q6.10: How did your project goals change during the grant period?

The budget crisis Oregon has been facing has required some tailoring of the actual activities, yet the state has remained focused on the original three goals initially outlined in 2000:

1. ***Increase health insurance through the expansion of both public and private funding.***
2. ***Increase the proportion of eligible people who apply for and receive Medicaid coverage.***
3. ***Improve the capacity and capability of Oregon's delivery system, including safety net clinics, to provide needed care to the uninsured populations***

Initially designed through activities of Oregon's initial year of HRSA State Planning Grant funding, Oregon's Medicaid OHP2 waiver was approved to restructure the Oregon Health Plan. This allowed additional flexibility related to benefits, eligibility and coordination with employer-sponsored insurance. However, due to severe declines in the state's economy and continued high unemployment rates, Oregon has reduced the number it had hoped to insure through the OHP2 Waiver and made further budget cuts to its healthcare services. The premium subsidy program, FHIAP, continues to enroll low-income workers and their dependents, providing a public-private

partnership that increases access to health insurance. Community partners have teamed together, with the assistance of HRSA State Planning Grant work, to provide premium sponsorship for OHP enrollees at the lowest income level (< 10% FPL), maintaining health insurance for this vulnerable population. During this last year, our focus has finally shifted from one of minimizing losses stemming from the budget crisis, to looking to future expansions.

The state continues to work on its second goal of enrolling those eligible for Medicaid coverage. Governor Kulongoski has initiated more focused efforts through KidCare, a pilot of increased outreach to children in two Oregon counties with high rates of uninsured children. The results of this initiative and the findings of the Children's Access Survey will measure the feasibility of expanding such efforts across the state.

We have broadened our third goal than originally stated in our initial year of HRSA SPG. The state also has expanded its efforts to better understand the healthcare delivery system. While there have been efforts to look closely at the safety net, this has been expanded to both the private and public delivery system. We have expanded previous efforts assessing the capacity and capability of Oregon's safety net clinics to the full delivery system. Both the HRSA SPG-funded Healthcare Indicator project and the OHPC's Delivery System workgroup are an example of this, with public and private stakeholders collaborating with the state to develop a better picture of what may be needed to provide coverage to Oregon's uninsured. Community partners continue to work with the state to understand information gaps, striving toward increased data collection through this coming year. There is collaboration on community-focused and statewide policies to strengthen the healthcare delivery system impacted by Oregon's recent economic crisis.

Specific Addendum to Q6.11: What will be the next steps of this effort once the grant comes to a close?

Oregon is fortunate to have been awarded a Pilot Planning grant from the HRSA State Planning Grant. This will enable the state to continue to pursue many health care expansion efforts. Efforts specifically outlined in the grant include:

- Provide economic and actuarial analysis to develop additional options for covering more uninsured adults and children in the Oregon Health Plan and in the Family Health Insurance Assistance Program (FHIAP).
- Provide a strategic plan for outreach and enrollment of those children already eligible but not enrolled in Medicaid, SCHIP, or FHIAP.
- Building on the past year's Healthcare Indicator Project and Premium sponsorship efforts by providing planning and technical assistance to communities to assist them in developing local models for providing access to health care coverage.
- Provide technical support to improve the collection of health insurance coverage information within the Oregon Population Survey regarding regional, racial, and ethnic community data.

These activities and analysis provide valuable information for Oregon's decisionmakers, including the Governor's office, the Legislature and the Oregon's Health Policy Commission as they continue to develop Oregon's short and long-term state health policy strategies. All of the activities will include consensus-building efforts, primarily through the Commission. Together with its legislative members, the Commission will work with the full Oregon State Legislature and Governor's office to achieve Oregon's goals for increasing access to health care for all Oregonians.

Addendum to Section 7: Recommendations to the Federal Government

Detailed answers for this section from our initial year of the HRSA SPG are in our full report of 2001. Recommendations to the Federal Government from this past year's activities are detailed below.

The federal government has been generous in continuing to support the HRSA State Planning Grants and its value is long-lived. The federal government assists with planning and research activities across the nation, but it the funds available through the HRSA SPG have been critical federal financial support, especially for small states such as Oregon.

What would be helpful now is continued flexibility and creativity in the use of federal funds, to either augment or replace limited state funds as states such as Oregon experience a slower recovery from the recent downturn in the economy. Our slow recovery has continued to drive our ability to tackle the growing numbers of uninsured. Continued support of state efforts to allocate resources across a broader population by offering different benefit plans, and showing federal flexibility in matching state and other funds would allow for coverage for people that would otherwise remain uninsured.

Specific Addendum to Q7.3: What additional support should the Federal Government provide in terms of surveys or other efforts to identify the uninsured in States?

- Encouraging the adoption of data information systems that can communicate across a variety of health care delivery systems, within and across states

Federal of data collection and analysis has been valuable. Efforts such as those through AHRQ, SHADAC, and the Census Bureau have provided vital information and technical assistance. Efforts such as these have great potential to help states more fully understand and use their state-specific information and information from other states. Acting as a clearinghouse for information, the federal government could convene states to collaborate on information system issues and consider partnering with states to fund collaborative efforts that better capture information about our nation's healthcare system. Encouraging the adoption of data information systems that can communicate across a variety of health care delivery systems, within and across states; to also provide funds to analyze and assess the capacity and capabilities of both public and private systems, while preserving patient confidentiality, would allow states to direct their limited healthcare funds to the most effective, data-driven policies and best practices.

Specific Addendum to Q7.4: What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

- Partnering with states in evaluation efforts, using local researchers and state agencies knowledgeable about the specific policies and healthcare systems to facilitate the translation of research back to the policymakers.
- Provide additional health services research funding that would allow states to further advise other states and the nation on best practices and policies, identifying effective/ineffective approaches, especially those that have the potential for significant impacts on the vulnerable populations that the nation's public programs are designed to protect.

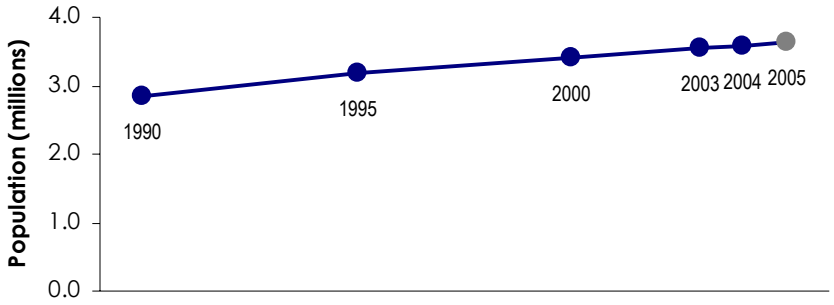
Oregon sees the need for additional longitudinal tracking studies to improve understanding of the impacts of health care policy decisions. Some of Oregon's early evaluation efforts have assessed the impact of changes to the Oregon Health Plan, rapidly informing policymakers so adjustments can be made in a timely manner, preventing unnecessary hardship to vulnerable populations. State budgets don't allow for detailed evaluations, with most activities directed toward program management. Individual states have attempted innovative ideas that others can learn from, both the positive and negative impacts, yet there is limited dollars to assess these attempts. Centers for Medicare and Medicaid Services (CMS) evaluations are valuable but are often delayed in completion, published long after a policy change and the research findings are not always translated back to state policymakers in a timely and easily understood manner.

Clinical and "bench" research have received significant federal funding dollars. Health services research funding has been more limited yet has broad sweeping impacts across populations. The HRSA SPG program has been a rare but valuable avenue to both provide resources for policy-relevant health services research and the ability to share that research with other states. The HRSA SPG program should be continued. Sharing of best practices amidst state decisonmakers has important implications for both the publicly funded insured and the uninsured.

Appendix I: Baseline Information – MEPS Analysis

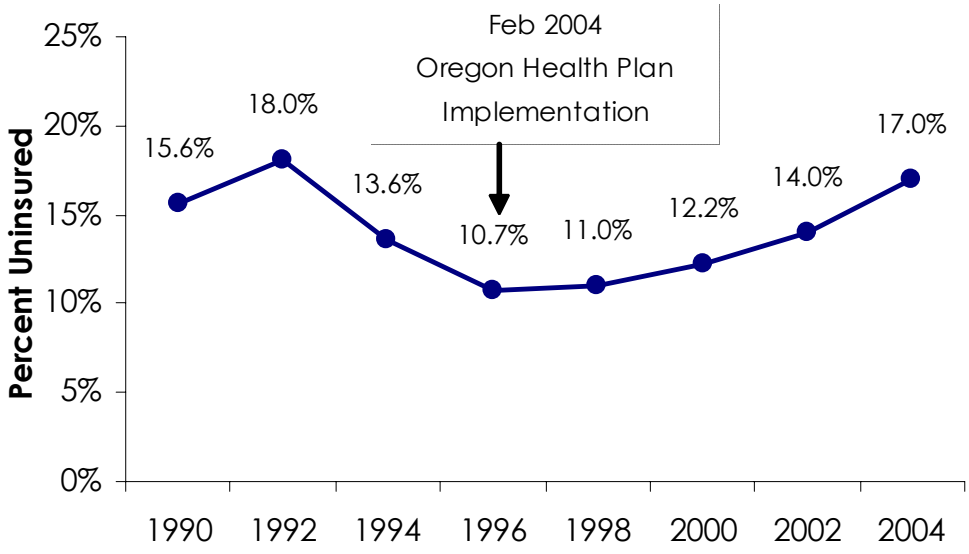
A. Oregon Population Trends

	Population*
1990	2,842,321
1995	3,182,690
2000	3,421,399
2003	3,541,500
2004	3,582,600
2005	3,625,100



**2005 population is projected*
Source: Portland State University Population Center,
http://www.upa.pdx.edu/CPRC/publications/annualorpopulation/cert.%20est.%202004.xls

B. Number and Percentage of Uninsured



Geographical Distribution of the Uninsured in Oregon, 2004	OPS, 2004	
	Insured	Uninsured
North Coast (Clatsop, Columbia, Lincoln & Tillamook)	4.2%	4.5%
Portland Metro (Clackamas, Multnomah, Washington, Yamhill)	45.1%	43.5%
Central Willamette Valley (Benton, Lane, Linn, Marion, Polk)	24.3%	26.6%
Southern (Coos, Curry, Douglas, Jackson, Josephine)	13.3%	10.1%
Gorge (Gilliam, Hood River, Morrow, Sherman, Umatilla, Wasco)	3.7%	4.0%
Central Oregon (Crook, Deschutes, Jefferson)	4.9%	5.4%
Southern Central (Grant, Harney, Klamath, Lake)	2.4%	2.6%
Eastern (Baker, Malheur, Union)	2.1%	3.3%
Total	100.0%	100.0%

Source: Oregon Population Survey, 2004.

C. Average Age of Population:

36.3 (Median Age, 2000 Census; U.S. Census Bureau)

D. Percent of Population Living in Poverty (<100% of the FPL):

Percent of Population by Income Level, 2004	
Income Level	**Percent**
At or below 100% of FPL	11.7%
101 to below 200%	20.4%
200 to below 300%	17.7%
300% and over	50.2%
Totals	100.0%

Source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2005.

E. Primary Industries:

According to Oregon's Bureau of Labor Statistics *(http://stats.bls.gov/)*:

Average Annual Non-Farm Employment, 2004		
	# Persons (thousands)	% Total
Natural Resources & Mining	9.6	0.6%
Construction	82.3	5.2%
Manufacturing	199.5	12.5%
Trade, Transportation and Utilities	320.2	20.1%
Information	33.0	2.1%
Financial Activities	96.6	6.1%
Professional and Business Services	176.8	11.1%
Education and Health Services	193.1	12.1%
Leisure and Hospitality	155.8	9.8%
Other Services	57.3	3.6%
Government	269.5	16.9%
Totals	1,593.7	100.1%

Source: Oregon Employment Department, <http://www.qualityinfo.org/olmisj/CES?areacode=01000000&action=summary&submit=Continue>

F. Number and Percent of Employers Offering Coverage:

Employers Offering Coverage, 2003		
	# Employers Offering Coverage	% Employers
1–9	54,486	39.8%
10–24	11,013	69.2%
25–99	8,235	89%
100–999	5,365	100%
1000+	9,886	100%
Totals	88,985	58.3%

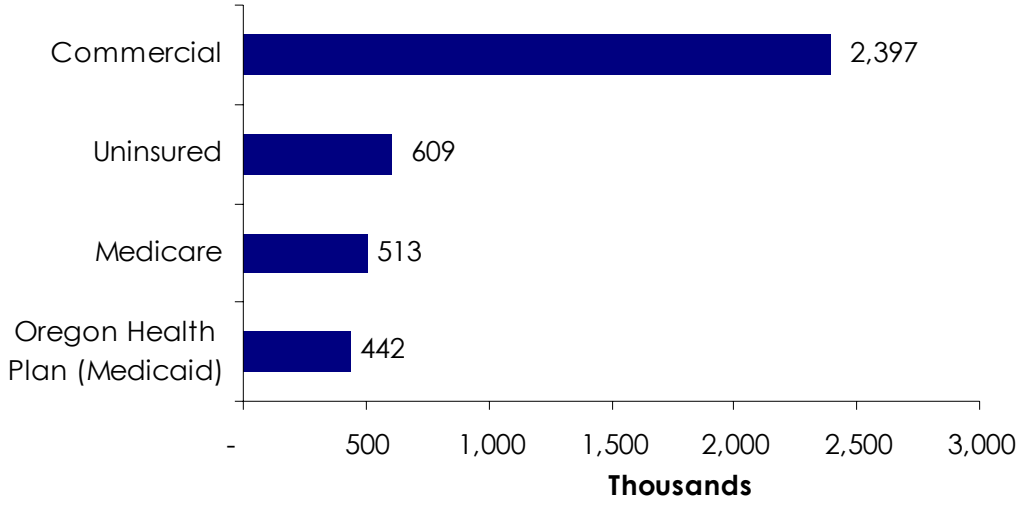
Source: 2003 Medical Expenditure Survey.

Number and Percent of Employees in Firms Offering Coverage, 2003			
Establishment Size	**No. of Employees**	**% Employees in Establishments Offering Coverage**	**% Employees Eligible for Coverage in Establishments Offering Coverage**
1 to 9	206,127	46.6%	83.6%
10 to 24	184,457	76.8%	80.6%
25 to 99	204,846	93.9%	78.6%
100 to 999	202,826	100.0%	77.0%
1000 and over	540,912	100.0%	85.1%
Total	1,339,168	87.6%	82.0%

G. Number and Percent of Self-insured Establishments:

Self-insured Establishments, 2003		
Number of Employees	**Total Establishments**	**% Establishments That Self-Insure at Least One Plan**
Fewer than 50 employees	69,583	11.6%
50 or more employees	19,402	55.8%
Totals	88,985	27.8%

H: Payer Mix:



Source: Oregon Population Survey, 2005.

I: Provider Competition:

Oregon moved forward with initiatives in the late 1990s consistent with a market approach. The Family Health Insurance Assistance (FHIAP) program was created using state-only funds to subsidize low-income Oregonians for individual and employer-based insurance. Oregon eliminated some small group initiatives in the late 1990s because of the success of the small group market, notably the certified small group plans offered by the Insurance Pool Governing Board (IPGB).

Market reform, however, by definition creates winners and losers. Profit margins narrowed for both health plans and providers, competition increased, and given the profits of the mid-1990s, expectations increased. The late 1990s were marked by painful market adjustments. Large physician groups failed, particularly those pursuing physician practice management strategies. Many specialty physicians not sufficiently oriented to managed care left the market. Large hospital systems with dominant market shares used their clout in contracting to minimize, if not eliminate risk, while insisting on rate increases double the medical Consumer Price Index CPI. Surviving physicians organized into Independent Practice Associations IPAs to increase their negotiating clout.

Medicare HMO rate increases failed to keep up with provider expectations. Health plans were tossed about within the turbulence of market reform and patient protection. Eventually health plans and providers returned to cost shifting and selection strategies to survive. Commercial HMOs began to withdraw from Medicaid markets, reduce Medicare enrollments and pass along provider increases to their commercial customers. Hospitals returned to cost shifting to meet their increased profit expectations. Physicians began to overtly select better paying and less sick populations in order to survive and compete. Some Oregon markets experienced greater than 50% turnover within their primary care infrastructure, leading to uncertainty and instability. This tumult demonstrated to policymakers that market reform would also be incremental and would require timely intervention and guidance in order to be sustained.

By the late 1990s, it was clear that new strategies would be required for Oregon to weather these earlier efforts. Communities reacted by organizing community-oriented, provider-dominated delivery systems to care for Medicaid patients. There has been a dramatic shift away from managed care in the state. Managed care penetration peaked in 1999, with slightly more than 50% of the population enrolled in one of the state's 11 managed care plans.[1] Partially due to consumer backlash, managed care has been largely abandoned in Oregon since that time; in 2004, only 19.5% of the population was enrolled in one of the five remaining commercial managed care plans.[2] The strongest remaining sector of managed care in the state is within the Medicaid delivery system, where 14 managed care plans deliver care to about 75% of the Medicaid population.

J. Insurance Market Reforms:

Following is a brief history of significant insurance market reforms in Oregon.

1989, Insurance Pool Governing Board (IPGB): This program, established by statue in 1987 was the first part of Oregon's health insurance reforms to become operational. The program's original intent was to increase the number of small employers who voluntarily provided health coverage for employees and their dependents.

1989, creation of a high risk insurance pool: The Oregon Medical Insurance Pool (OMIP) was designed to provide access to health insurance for people facing benefit limitations because of pre-existing conditions or for those refused insurance coverage by commercial carriers (and ineligible for Medicaid coverage).

Small business reform efforts included SB 1076 (which went into effect in 1993) and SB 152 (1994): SB 1076 was designed to level the playing field for small employers by mandating reforms in the underwriting, rating and marketing polices of health benefit insurers. SB 152 was designed to expand coverage to individuals and other groups. Major components of these two health insurance reforms include:

- *Eligibility:*

  SB 1076 was designed for small employers (3–25 eligible employees). SB 152 reforms were extended to 1) employers with from 2–25 employees; 2) any group with 2 or more members; 3) individuals leaving group coverage; 4) other individuals.

- *Guaranteed Issue:*

  As a condition of doing business in the state, insurance carriers under SB 1076 are required to make available to small employers an approved basic health plan. Benefits must be "substantially similar" to those provided to the Medicaid Demonstration portion of the Oregon Health Plan.

- *Guaranteed Renewability:*

  Under both pieces of legislation, carriers must continue to offer plan renewals to enrolled employers except where the number of eligible employees falls below a required participation level or in cases of non-payment, non-compliance, fraud or misrepresentation.

- *Underwriting Reforms:*

  Under SB 1076 no individual employee may be excluded from a small employer group plan because of existing or anticipated health status; the entire group is accepted or rejected in all health plans issued to small employers. Individual employees with pre-existing conditions cannot be excluded for more than 6 months and this restriction is waived for those employees with 6 months prior coverage in the small employer market. Pregnancy cannot be treated as a pre-existing condition.

- *Rating Rules:*

  Six geographic regions were established. By January 1 of each year, carriers are required to file geographic average rates (GAR), defined as the average rate for all health plans issued and marketed by a carrier within each geographic area. Premium rates cannot vary from the GAR by more than 33% unless they reflect additional benefits or differences in family size and composition. Premium variations within a plan must be based on family composition only; premium variations between plans must be based solely on differences in the benefits offered by each plan. In neither case can the health status of enrollees be part of the premium variations. Increases in rates are allowed once in a 12-month period as long as they do not exceed the GAR percentage change and are not more than a 15% increase.

- *Portability:*

  As of October 1, 1996 health insurance providers are required to provide individuals leaving their coverage after at least 6 months enrollment, a minimum of two standardized portability options—a low cost plan and a prevailing benefit plan. Portability plans are subject to the same requirements as other health benefit plans, i.e., guaranteed issue; ability to renew; no pre-existing condition exclusions; premium variations based only on geography, family composition, benefit design and/or age.

Individual market reforms include SB 152, which established a process for accepting or rejecting applicants for individual coverage based on a standardized health statement developed by the state. Accepted applicants cannot be excluded for pre-existing conditions over 6 months but pregnancy can be treated as a pre-existing condition. Premiums for individual coverage may vary only on the basis of geography, family composition, benefits and/or age and coverage is guaranteed renewable. Rejected applicants, who must be given written reasons for their rejection, can purchase coverage through OMIP.

[1] http://www.managedcaredigest.com/edigests/hm2000/hm2000c01g01.html. <December 2004>.
[2] http://www.statehealthfacts.kff.org. <September 2005>.

K. Eligibility for existing coverage programs (Medicaid/SCHIP/other):

The following tables outline the specific eligibility categories for both OHP Plus and OHP Standard:

OHP Plus Eligibility Categories

Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid Mandated or Optional?
Aid to the Blind/Aid to the Disabled (AB/AD)	Recipients of AB/AD, some also have concurrent Medicare eligibility	<78% FPL[f]	59,153	Mandatory
Old Age Assistance	Adults over 65 years of age, receiving old age assistance; majority have concurrent Medicare eligibility	<75% FPL	30,758	Mandatory
PLM-CH[c] 0-5	Children 0-5 years of age with family incomes under 133% FPL	<133% FPL	44,846	Mandatory
PLM-CH 6-18	Children 6-18 years of age with family incomes under 100% FPL	<100% FPL	41,268	Mandatory
SCHIP[d]	Children 0-18 years of age with family incomes under 185% FPL who do not meet one of the other eligibility classifications	133-185% FPL (age 0-5); 100-185% FPL (age 6-18)	23,167	Optional
Foster Children	Children covered by the State Office for Services to Children and Families	<52% FPL	16,380	Mandatory
PLM-A Pregnant Women	Pregnant women with family incomes under 133% FPL	<133% FPL	6,471	Mandatory
PLM-A Pregnant Women & their newborns	Pregnant women with family incomes greater than 133% FPL but under 185% FPL	133-185% FPL	3,197	Optional
TANF[e]	Recipients of TANF under current eligibility rules (including former recipients with extended Medicaid eligibility)	<52% FPL	129,966	Mandatory

(a) FPL = Federal Poverty Level
(b) As of September 2004
(c) PLM-CH=Poverty Level Medical Children
(d) SCHIP=State Children's Health Insurance Program
(e) TANF=Temporary Assistance to Needy Families
(f) Some eligibles with disabilities who receive services under Home and Community-Based Waivers may have incomes up to 300% of the SSI standard, or approximately 224% FPL.

OHP Standard Eligibility Categories

Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid mandated or Optional?
Adults/Couples	Single adults and couples age 19 or over, not Medicare eligible with income below 100% FPL who do not meet other eligibility classifications, and do not have an unborn child or a child under age 19 in the household	<100% FPL	37,697	Expansion/ Optional
Families	Adults ages 19 or over, not Medicare eligible with incomes below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household	<100% FPL	14,992	Expansion/ Optional

(a) FPL = Federal Poverty Level
(b) As of September 2004

Other OHP Eligibility Categories

Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid mandated or Optional?
CAWEM[c]	Coverage for emergency services only for individuals who meet criteria for one of the above eligibility categories except for U.S. citizenship or non-citizen status requirements	Varies	24,191	Mandated
Breast & Cervical Cancer	Coverage of treatment of breast and cervical cancers diagnosed through the federal Breast and Cervical Cancer Screening Program, who otherwise wouldn't quality for full medical assistance	Varies	174	Optional
Qualified/Specified Low-Income Medicare	For those qualified for Medicare, who have limited incomes but do not meet the income or resource standard for full medical assistance coverage. Some receive only assistance in paying premiums and deductibles for their Medicare A and B; some also receive OHP Plus benefits.	<100% FPL for most; subset get only premiums covered (100-135% FPL)	10,166	Mandated

(a) FPL = Federal Poverty Level
(b) As of September 2004
(c) CAWEM=Citizen-Alien Waived Emergency Medical

L. Use of Federal waivers:

The following waivers were approved initially in October, 2002, and further amended in July of 2004, in order to implement OHP2. The approval provides coverage of the current mandatory Medicaid, optional and expansion populations included in the original Oregon Health Plan as well as providing for an expansion of coverage of targeted low-income children, parents of children eligible for Medicaid and the State Children's Health Insurance Program (SCHIP), pregnant women and childless adults.

The approval was granted for a period of five years under the authority of section 1115 of the Social Security Act and is a part of the Health Insurance Flexibility and Accountability (HIFA) initiative.

Populations: The Title XIX Demonstration Populations 1 through 8 and 9 have the option of choosing OHP Plus or the Family Health Insurance Assistance Program (FHIAP):

Demonstration Population 1: Medicaid mandatory pregnant women included in the State plan with incomes from 0 to 133% of the FPL who are in direct State Coverage. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 2: Medicaid optional pregnant women included in the State plan with incomes from 133 to 170% of the FPL. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 3: Medicaid children 0 – 5 included in the State plan with incomes from 0 to 133% of the FPL. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 4: Medicaid children 6 – 18 included in the State plan with incomes from 0 to 100% of the FPL. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 5: Medicaid mandatory foster children. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 6: Medicaid mandatory TANF Section 1931 low-income families. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 7: Medicaid mandatory blind and disabled individuals with incomes at the SSI level of the FPL. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 8: Medicaid mandatory elderly individuals with incomes at the SSI level of the FPL. *These individuals are considered mandatory and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

OHP2 waivers of Medicaid and SCHIP state plan requirements contained in section 1902 and 2103 of the Act:

1 Section 1902(a)(10)(B); 42 CFR 440.230-250—*Amount, Duration and Scope of Services:*

To enable the state to redefine the Medicaid benefit package and to offer a different benefit package based on condition/treatment pairs than would otherwise be required under the state plan to mandatory Medicaid eligibles, to enable the State to limit the scope of services for optional and expansion populations.

2 Section 1902(a)(1); 42 CFR 431.50—*Statewideness:*

To enable the State to provide certain types of managed care plans only in certain geographical areas of the state.

3 Section 1902(a)(17); 42 CFR 435.100 and 435.602-435.823—*Eligibility Standards:*

To enable the state to waive the income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming rules, and to base eligibility on household family unit (rather than individual income).

4 Section 1902(a)(10)(A) and 1902(a)(34); 42 CFR 435.401 and 435.914—*Eligibility Procedures:*

To enable the state to apply streamlined eligibility rules for individuals. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income.

5 Section 1902(a)(23); 42 CFR 431.51—*Freedom of Choice:*

To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care plans (and other insurers), and by requiring beneficiaries to enroll in managed care plans without a choice of managed care plans.

6 Section 1902(a)(10) and 1902(a)(13)(C)—*Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs):*

To enable the state to offer FQHC and RHC services only to the extent provided through managed care providers.

7 Section 1902(a)(43)(A)—*Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):*

To waive the requirement that states must pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to the individual.

8 Section 1902(a)(13)(A)—*Disproportionate Share Hospital (DSH) Reimbursements:*

To allow the state to not pay DSH payments when hospital services are furnished through managed care entities.

9 Section 1902(a)(10)(C); 42 CFR 435.301, 435.811, 435.845, 435.850-52, and 440.220—*Medically Needy Eligibility:*

> *To enable the state discontinue the Medically Needy program under its state plan, except with respect to the aged, blind, and disabled populations.*

10 Section 1902(a)(30); 42 CFR 447.361—*Upper Payment Limit for Capitation Contracts:*

> *To enable the state to set capitation rates that would exceed the costs to Medicaid on a fee-for-service basis.*

11 Section 2103; 42 CFR 457.410(b)(1)—*Benefit Package Requirements*

> *To permit the State to offer a benefit package that does not meet the requirements of sections 2103 and 42 CFR 457.410(b)(1). This approval is granted to the extent necessary to allow families of certain SCHIP children to elect to receive coverage for their children through a private or employer-sponsored insurance plan, which may not offer an SCHIP benefit package and may not offer well-baby and well-child care services and immunizations as defined by the State. This does not waive the provision of required coverage of 42 CFR 457.410(b)(2) and (3) regarding age-appropriate immunizations and emergency services.*

12 Section 2103(c)

> *To permit the State to impose cost sharing in excess of statutory limits. This approval is granted to the extent necessary to allow families of certain SCHIP children to elect to receive coverage for their children through private or employer-sponsored insurance plan, which may require cost sharing in excess of the SCHIP limits.*

13 Section 1902(a)(4); 42 CFR 438.56(c)

> *To enable Prepaid Ambulatory Health Plans to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days.*

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, State expenditures under the OHP2 demonstration described below (which would not otherwise be included as matchable expenditures under section 1903) shall for the period of the project, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditures, except those waived in the award of October 15, 2002, and those specified as not applicable to these expenditure authorities in the award of October 15, 2002. In addition, all requirements in the Special Terms and Conditions apply to these expenditure authorities.

Demonstration Population 9: General Assistance expansion individuals with incomes up to and including 43% of the FPL. *These individuals are considered expansion and will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 10: Parents not otherwise eligible under Medicaid or this demonstration (expansion parents) ae 19 – 64, whose children are under age 19 with incomes

up to and including 100% of FPL. *These individuals are considered expansion and will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.*

Demonstration Population 11: Childless adults not otherwise eligible under Medicaid or this demonstration, age 19 – 64 with incomes up to and including 100% of the FPL. *These individuals are considered expansion and will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.*

Demonstration Population 12: Participants in the Family Health Insurance Assistance Program (FHIAP) with incomes up to 170% of the FPL as of September 30, 2002. *This would be the former state-funded FHIAP children, parents and childless adults who already had insurance as of September 30, 2002.*

Demonstration Population 13: Pregnant women who are not eligible for Medicaid or Medicare with incomes from 170 to 185% of the FPL. *These individuals are considered expansion and will be enrolled in OHP Plus; however if FHIAP is available, will be given the choice of FHIAP.*

Demonstration Population 14: Participants who would have been eligible for Medicaid but choose FHIAP instead with incomes from 0 to 185% of FPL.

1 Costs of coverage to individuals that would otherwise be excluded by virtue of enrollment in managed care delivery systems that do not meet all requirements of section 1903(m). Specifically, Oregon managed care plans will be required to meet all requirements of section 1903(m), except the following:

   1903(m)(1)(A) and (2)(A); 42 CFR 434.20 and 21, insofar as they restrict payment to a state that contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that:

   a. meet Federal health maintenance organization (HMO) requirements or State HMO requirements;

   b. allow Medicaid members to disenroll as set forth in section 1903(m)(2)(A)(vi). (The state will lock in enrollees for a period of six months or more in FCHPs, PCOs, and PCCM organizations).

2 Costs that might otherwise be disallowed under section 1903(f); 42 CFR 435.301 and 435.811, insofar as they restrict payment to a state for eligibles whose income is no more than 133 1/3 of the AFDC eligibility level.

3 Costs of Medicaid to individuals who have been guaranteed six months of Medicaid eligibility at the time they are enrolled in a capitated health plan, who were eligible for Medicaid when they were enrolled, and who ceased to be eligible during the 6 month period to OHP Standard demonstration participants and 12 months of guaranteed eligibility to FHIAP enrollees.

4 Costs of chemical dependency treatment services which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.

5 Costs for capitation payments provided to managed care organizations which restrict enrollees' right to disenroll in the initial 90 days of enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A).

6 Costs for services provided to OHP-eligible individuals between the ages of 22 and 65 who are institutionalized for mental diseases. This exception is limited to short-term (less than 30 days) inpatient mental health care for persons in the Eastern Oregon Psychiatric Center.

7 Costs for certain mandatory and optional Medicaid eligibles to elect to receive coverage through a private or employer-sponsored insurance plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct state coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct State coverage.

Medicaid Requirements not Applicable to the Costs Not Otherwise Matchable:

Cost Sharing, Section 1902(a)(14).

For the time period during which an eligible individual elects to receive coverage through a private or employer-sponsored insurance plan, these requirements do not apply, to the extent a private or employer plan would require cost sharing in excess of the limits outlined in statute.

Retroactive Coverage, Section 1902(a)(34).

For FHIAP participants, no retroactive payments will be made.

SCHIP Costs Not Otherwise Matchable

In addition, also under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2106(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under Title XXI), shall for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's Title XXI plan. All requirements of the Title XXI statute will be applicable to such expenditures, except those waived in the award letter of October 15, 2002, and those specified as not applicable to these expenditure authorities in the award letter of October 15, 2002. In addition, all requirements in the enclosed Special Terms and Conditions will apply to these expenditure authorities.

Demonstration Population 15: Uninsured children with incomes from 170 to 200 percent of the FPL (as defined in the Special Terms and Conditions) who meet the title XXI definition of a targeted low-income child and are enrolled in direct State coverage.

Demonstration Population 16: Uninsured children ages 0 – 5 with incomes from 133 to 200 percent of the FPL and uninsured children ages 6 – 18 with incomes from 100 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in FHIAP.

Demonstration Population 17: Uninsured parents of children who are eligible for Medicaid or SCHIP, who are themselves ineligible for Medicaid/Medicare with incomes from 0 to 200 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in FHIAP.

Demonstration Population 18: Uninsured childless adults who are not eligible for Medicaid/Medicare with incomes from 0 to 200 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in FHIAP.

SCHIP Requirements Not Applicable to the SCHIP Expenditure Authorities:

1. ***Cost Sharing- Section 2103(e)***

Rules governing cost sharing under section 2103(e) shall not apply to the demonstration populations to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored insurance plans for Demonstration Populations 16 through 18.

2. **Benefit Package Requirements-Section 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103 of 42 CFR 457.410(b)(1) for demonstration populations 16 through 18.

3. **General Requirements, Eligibility and Outreach- Section 2102**

Applicants for the demonstration will be screened for Medicaid and SCHIP eligibility. Applicants will be offered an informed choice of voluntary enrollment in the direct coverage program for which they may be eligible or in FHIAP if it is available. During the demonstration project, eligibility status of enrollees will be redetermined on a regular basis. Payment for the FHIAP enrollees will be based on the program for which they could have been eligible.

4. ***Restrictions of Coverage and Eligibility to Targeted Low-Income Children -Sections 2102 and 2110***

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

5. **Federal Matching Payment and Family Coverage Limits-Section 2105**

Federal matching payment is available in excess of the ten-percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable with respect to the demonstration populations. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

6. **Annual Reporting Requirements Section 2108**

Annual reporting requirements do not apply to the demonstration populations, with the exception of demonstration populations 15 and 16.

New expenditure authorities listed above are granted to demonstrate whether expanding eligibility for coverage of parents of Medicaid and SCHIP children, and the demonstration populations listed above, will improve the overall health of the community, and reduce overall rates of uninsurance. This result would promote the objectives of the Act.

The State will establish a process to ensure that demonstration expenditures do not exceed the state's available title XXI funding. To ensure the availability of the SCHIP allotment for the primary beneficiaries of title XXI, title XXI funding will be used to provide coverage in the following order:

- first to children eligible under the title XXI State plan,

- children eligible as demonstration population 15 and demonstration population 16,
- then for demonstration population 17,
- and, then for demonstration population 18.

Title XXI funding will first be used to cover those groups listed in the priority order above, then if title XXI funding has been depleted, the state will establish a process to ensure that demonstration expenditures will revert to title XIX.

Additional Information

Included as part of this award is the authority to implement the OHP2 program with a single managed care plan in urban areas. The State is required to continue its efforts to increase plan participation in the Oregon Health Plan 2. In addition, the state will permit beneficiaries to obtain services outside of the network consistent with treatment of enrollees in plans in rural areas.

Appendix II: Links to Research Findings and Methodologies

Additional Sources of Information for Oregon's HRSA State Planning Grant

1. **To view the HRSA pages of the Oregon Health Policy and Research website please visit:** http://egov.oregon.gov/DAS/OHPPR/RSCH/HRSA_information.shtml

This page contains links to the following documents referenced in this year's report

   a. **Premium sponsorship Project summary**
   b. **Children's Access Survey**
   c. **HIP Project summary**

2. **Additional research and studies done by the Office for Oregon Health Policy and Research are available at:** http://www.oregon.gov/DAS/OHPPR/RSCH/Doc_Rep_Present.shtml

3. **IPGB information on the internet:**
   a. **Children's Group Plan** http://egov.oregon.gov/IPGB/certified_plans.shtml
   b. **Alternative Group Plan Manual** http://www.oregon.gov/IPGB/docs/cover_with_insert.pdf

Appendix III Summary of Policy Options

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	Number of People served once implemented
Public-Private Premium Subsidy Program (Had state-funded Family Health Insurance Assistance Program (FHIAP) in place, so included into Medicaid via HIFA waiver to afford expansions)	Low-income employed uninsured ▪ FHIAP eligibility increased from 170% to 185% FPL ▪ FHIAP from 185% to 200% FPL	FY2003: 15,000 FY2004: 25,000 FY2005: 25,000	July 2001 – HB 2519, which directed the State to seek 1115 and HIFA waiver to restructure the Oregon Health Plan (OHP2), folding in the FHIAP Waivers Approved 10-2002	FHIAP Eligibility from 170% to 185% implemented October 2002, but eligibility up to 200% FPL not implemented due to state budget cuts	FY2004: An additional 454 enrollees between 170% and 185%, plus additional 3,000 under 170%, for a total estimate of approx. 4,000 (as of June 2005)
Medicaid Expansion for children and Pregnant Women	Children (up to 19) and pregnant women increased from 170% FPL to 185% FPL Children (up to 19) and pregnant women from 185% to 200%	FY2003: 1053 FY2004: 1580 FY2005: 1580	July 2001 – HB 2519, which Directed the State to seek 1115 and HIFA waiver to restructure the Oregon Health Plan (OHP2), folding in the FHIAP Waivers Approved 10-2002	Eligibility increases from 170% to 185 %FPL implemented in February 2003, but eligibility up to 200% FPL not implemented due to state budget cuts	FY2004: An additional 2,557 children and 438 pregnant women, for a total estimate of approx. 3,000(As of June 2005)

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	Number of People served once implemented
Medicaid Expansion for Adults	Parents, from 100% to 185% FPL and Childless adults (19 to 64) from 100% to 185% FPL	FY2003 5,717 FY2004 11,770 FY2005 11,927	July 2001 – HB 2519, which directed the State to seek 1115 and HIFA waiver to restructure the Oregon Health Plan (OHP2), folding in the Family Health Insurance Assistance Program (FHIAP) Waivers Approved 10-2002	Not implemented due to state budget cuts	N/A
Financial sponsorship by communities	Lowest income of those eligible for OHP Standard – expansion adults under Medicaid- to assist with premium payment	FY2004: 19,500 at 10%FPL premium level	Community-directed initiative with planning starting Fall 2002	Summer 2003	Estimated 5,000 people had premiums paid and remained enrolled in OHP Standard (as of June 2005)

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	Number of People served once implemented
Maximize enrollment of those eligible for Medicaid, but not enrolled – Children (Increase efforts in two counties for enrollment of those kids eligible	Children (up to age 19) for both Medicaid and SCHIP eligibility	FY 2005: 1500	June 2004	July – December 2004	(As of May 2005) Hood River county increase enrollment by 7% (avg. 200 over 4 months); Lincoln county by 5% (avg. 400 over 4 months)
Maximize enrollment of those eligible for Medicaid, but not enrolled – Children Lowered asset limit of SCHIP	Children (up to age 19) for both Medicaid and SCHIP eligibility	FY 2005: Up to 170% FPL =92 170-185% FPL = 13	Governor's Charter in June 2004	Fall 2004	Uncertain impact to date
Increase availability of affordable private plans for small employers – Insurance Pool Governing Board made two new products available: very basic adult plan and a dependent child plan	Low-income, employed uninsured families: adults and children	# business purchasing either plan FY 2005 :100 FY 2006 :400 # children enrolled FY 2005 :400 FY 2006 :800	HB 2537 passed in June 2003 - Directed Insurance Pool Governing Board to provide affordable health benefit plan for small employers (2-50 employees) by 2005	March 2005	Minimal enrollment to date as of September 2005