Oregon HRSA State Planning Grant

Final Report to Secretary: *Addendum*

Executive Summary

The following information is an addendum to Oregon's *Final Report to the Secretary* filed with HRSA in October 2001. This report provides an update on activities related to Oregon's State Planning Grant between November 2001 and February 2002, and describes work completed by the Office of Oregon Health Policy and Research, Health Services Commission, Waiver Application Steering Committee and several activities of the HRSA Grant Team. Additional data collection and analysis supported through the HRSA State Planning Grant will be described in a report to HRSA in Fall 2002.

Addendum to Section 1: Uninsured Individuals and Families

Oregon continues to integrate 2000 census information with the state's information. Providing estimates of small populations is an ongoing challenge. Even for the Oregon Population Survey, achieving adequate sample sizes for small populations can be a significant limiting issue. Since October 2001, the state completed the racial oversample to improve estimates for racial minorities in Oregon. While Oregon still does not have "final" data from the contractor, final uninsurance numbers are not expected to change from what was reported in October 2001.

Addendum to Section 2: Employer-based Coverage

2.3 *How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?*

Early in Oregon's HRSA planning grant the state considered using an employer survey to gather information about trends in employer sponsored insurance (ESI). The October 2001 Report relied on national employer surveys and on MEPS-IC data specific to Oregon, and the Grant Team discovered that these sources met the original planning needs. Now, as implementation of OHP2 draws near, the needs have changed. The Oregon site no longer plans to do an employer survey.

One option to expand health care access is to successfully expand the Family Health Insurance Assistance Program (FHIAP) via the group market. Currently, subsidized coverage of employer sponsored insurance (ESI) accounts for 16–20% of FHIAP enrollment. Oregon aims to increase that significantly. In place of an employer survey, Oregon designed a detailed and tailored approach to market FHIAP to the group market. Important steps included:

- Executive interviews with a sampling of brokers and benefits managers;
- Updated analysis of MEPS-IC data for Oregon (1999 data are now available), which did not alter the strategy of trying to increase subsidized ESI via FHIAP;

FHIAP staff continue to partner with the HRSA Grant Team to:

- ♦ Analyze who is currently on the FHIAP wait list;
- ♦ Develop a market plan;
- ♦ Develop an evaluation plan.

In August 2001 Oregon Health Policy and Research (OHPR) interviewed a sample of Oregon employers and health care purchasers in order to:

- ♦ Understand trends in employer-sponsored health insurance;
- ♦ Learn about possibilities of expanding FHIAP's subsidy program via the group insurance market;
- ♦ Identify employer partners who would be willing to advise OHPR on the design of an expanded employee subsidy program.

General Comments about Overall Costs:

Oregon is similar to the rest of the country—health care costs are rising sharply:

- ♦ According to Mercer/Foster Higgins, large employers (500+ employees) in Oregon and Southwest Washington faced a 9% increase in total health benefit costs in 2000.
- ♦ Rates increased faster in Oregon than in the nation (9% versus 6.6% in 2000).
- ♦ According to Milliman & Robertson, HMOs in Oregon raised group premiums an average of 17.1% for 2001.

Some Oregon employers cite higher rate increases than these. For example:

- ♦ The Oregon Coalition of Health Care Purchasers absorbed average increases of 22% for health care coverage in 2001.
- ♦ Firms represented by TOC Management Services faced 20% increases in premiums for 2000 and 2001; TOC expects the same in 2002. (TOC represents 500 companies, 100,000 workers. Two thirds of the firms represented by TOC are in wood products, one-third in manufacturing.)
- ♦ City County Insurance Services (CCIS), which represents 300 public sector employers (covering about 10,000 workers) reports an overall 12% increase from August 2000–July 2001 and a 25% increase from August 2001–July 2002.

Pharmacy cost is not the only reason for rising health care costs.

While rising pharmacy costs are an important driver of health care expenditures, employers understand that hospital and physician costs are also increasing quickly.

Employers don't see many options for controlling costs.

One employer painted a "gloomy picture" of health care costs and of the ability of purchasers to say "no" to hospitals, physicians and health plans. Another employer said, "all the easy stuff has been done." One broker described employers as saying "we've hit the wall."

General Comments about Contribution Rates/Cost-sharing:

Employers are looking to reward value by adjusting contribution rates.

While all health plans have raised their premiums, employers are finding that some plans offer much better rates than others do. As a result, some employers have changed their contribution policies to offer incentives to enroll in the low cost plans.

Employer contribution levels are decreasing.

While it is difficult to obtain reliable data about employer funding of health care coverage, contribution levels appear to be declining. Based on the 1998 Medical Expenditure Panel Survey, Oregon employers contributed an average of 90% of the cost of single coverage and 75% for family coverage in 1998. Small firms, those with fewer than 50 employees, contributed a smaller amount for family coverage than larger firms (66% versus 78%). Employers with low-income workers in small firms paid, on average, 50% of the premium for health insurance for family coverage.

Employee cost-sharing is rising.

According to employers interviewed, some have shielded employees from the full impact of the recent upsurge in the cost of health care. However, most employers and purchasers interviewed believe they have exhausted all the available avenues and are now forced to pass some of the increases to employees. Some examples:

- TOC and CCIS typical plans have $200–$300 deductibles. Both TOC and CCIS recently introduced $500 deductible plans to the employers they contract with. However, to date, not many employers have opted for these plans.
- CCIS recently increased the stop loss[*] of its most popular plan from $2,500 to $5,000.
- In 2001 the Port of Portland, which historically contributed 100% for family coverage, introduced across-the-board mandatory employee contributions of $40 per month. Multnomah County is also planning to introduce an employee contribution.

General Comments about Benefit Design:

Employers have not cut the array of benefits offered.

For those employers who choose to offer coverage, none appear to have substantively reduced benefits as a way of dealing with cost increases. As one possible exception, employers continue to tinker with pharmacy benefits. Those who have not yet established tiered co-pays for pharmacy are doing so. Two tiers were used, though employers are now experimenting with 4 and even 5 tiers.

Employers offer fewer choices of plans.

Public Employees' Benefit Board, PEBB, is an example of offering fewer plans, reducing the number of carriers from four to two this year. In another example of limiting choice, one company is considering establishing a "company doctor."

[*] In this context stop-loss is the point at which the plan pays 100%.

General Comments about Other Trends:

Take-up[†] rates are declining.

Take-up rates are hard to document, but interviewees said that as costs go up, participation goes down. Family participation rates are especially affected. One broker claims that "every time rates go up 20%, 2–3% of employees drop family coverage" but keep employee-only coverage. Insurers have mandatory participation requirements—usually 100% of eligible employees for firms with 25 or fewer employees and 75% of eligible employees for firms with 26+ employees. However, in the past, insurers have differed in how rigorously they enforced participation standards. As a result, employers have expressed concern that participation will decline to the point that an entire employee group could lose coverage. TOC, with 500 employers as members, "hasn't kicked any one out yet, but we have refused admittance" because an employer could not muster 75% participation.

Crowd-out remains an important issue.

Employers think about health care coverage in many ways: as a cost of doing business, as a benefit to employees, as a portion of a total compensation package, as a way to attract good workers, as an obligation created through the very act of having offered coverage. In other words, employers are entangled in the current system and universally say they would not drop coverage if their employees became eligible for publicly-sponsored health coverage. Employees, however, may pursue public coverage if benefit or premium structure is advantageous. Oregon is in a recession and employers are under extraordinary pressure. This is a critical trend to monitor.

The role of brokers and consultants continue to increase, as does the associated administrative cost to the health care system.

Brokers and consultants help employers navigate the tough choices. According to one health plan, 85% of small firms now use brokers. Brokers do not offer a free service, averaging about 5% of premium cost in the small group market. Since their rates are pegged to premiums, they rise as fast as premiums rise.

Addendum to Section 3: Health Care Marketplace

Oregon's health care system is clearly being stretched to respond to the changing economy. A variety of interesting events have occurred in the health care market place in Oregon during the last 12 months. These include:

- Oregon's unemployment rate is the highest in the country.
- Forty thousand (40,000) additional individuals, mostly adults, have enrolled in the Oregon Health Plan since the fall of 2001.
- The Oregon Medical Insurance Pool (OMIP), the state's high-risk pool is adding several hundred people a month—substantial increases compared to previous growth in OMIP.
- Medicare's announcement that physician's fees would be decreased consistent with established payment policy has led to large numbers of physicians threatening to withdraw from the participating program. The effects of this decrease will have a significant ripple across other payers. Medicaid has an even lower payment rate for physicians—decreases in

[†] The percentage of eligibles that elect to enroll in an offered health care plan.

Medicare have in the past led to physicians limiting their Medicaid population. If these changes affect payment rates in Medicare HMOs in Oregon, the state could see further decline in the market share of Medicare HMOs.

- Hospital performance has remained strong throughout the year. In fact, hospitals are one of the few Oregon industries increasing its workforce. Most small to medium-sized regions are finding that the hospital has become one of their largest employers.
- A prolonged nurses' strike at Oregon Health and Sciences University (OHSU) could result in increased labor costs across the industry in Oregon.
- Insurer/HMO profitability has improved as they have raised rates, eliminated less profitable groups, and reduced benefit packages. Rates for HMO coverage are now similar to PPO coverage for most IPA or network model HMOs. The insurance market has returned to an environment very similar to the 1980's—predominant indemnity models, minimal cost controls, and double-digit premium increases.
- The Oregon Coalition of Health Care Purchasers (OCHCP) has encouraged the entry of a new model—Patient Choice—based on the work of the Buyer's Health Care Action Group in Minnesota. This model offers non-overlapping health care systems that provide a PPO-type product in a setting where consumers are provided information about cost and quality of each system at the time of purchase.
- The effects of consolidation continue among insurers, hospitals and providers. Two hospitals are engaged in antitrust litigation in the Eugene/Springfield area. Questions have been raised regarding the effects on competition of physician consolidation that has occurred in various parts of the state.
- Oregon is planning to capitalize on the current administration's commitment to add 1,200 new Federally Qualified Health Centers (FQHC) throughout the United States within the next five years. Additionally, President Bush has called for a $114 million increase in safety net health center funding in FY2003.

Addendum to Section 4: Options for Expanding Coverage

Oregon continued its history of using public forums for discussion of OHP2 expansion strategies and development of the Waiver to be submitted to CMS. While this resulted in general agreement to recommend moving forward with submission of the waiver, discomfort about several issues remained—moving current OHP enrollees to OHP Standard, and the impact of increased cost-sharing on those with little or no income and ongoing health care needs.

During the summer of 2001 the Health Services Commission (HSC) sought input from OHP enrollees, expanding beyond the providers or other traditional stakeholders in OHP. A larger percentage of OHP enrollees attended community meetings than had attended past public forums sponsored by the HSC. The HSC repeatedly reflected on comments from the public meetings during their final decision-making process.

OHP2 will move an estimated 125,000 current OHP enrollees from OHP Plus to OHP Standard, which is more similar to commercial plans than the current OHP. While these OHP enrollees will retain most benefits, they will also incur increased cost-sharing. During the fall of 2001 the HSC and the Waiver Application Steering Committee (WASC) had the challenge of determining

which benefits would be included in OHP Standard. For the HSC, discussion expanded beyond the Prioritized List to address the impact of implementing OHP Standard. While the HSC used data from multiple sources, they found that data did not necessarily make their decisions less complex.

Just as the ranking of the original Prioritized List required a broad population view, so did the discussion of OHP Standard. Individual cases or situations were presented, challenging the group to keep the 'big picture' in view. The final rankings and cost-sharing recommendations passed by the HSC were not unanimous, and reflected their concerns, cautions and hopes for the future of OHP.

The WASC was formed in Fall 2001 and struggled with a large volume of information in a short period. Both the HSC and the WASC heard from advocates seeking to protect the current OHP, and very few advocated for either those who currently have no coverage and/or don't qualify for OHP. The Governor remained an advocate for that group, while many stakeholders and advocates aimed to maintain the status quo.

The WASC was troubled initially by the level of cost-sharing the HSC had recommended, and looked for other ways to curtail costs. By the final WASC meeting however, having heard testimony of advocates and OHP enrollees, the WASC understood the challenges faced by the HSC. The OHP Standard benefit package was approved by the majority of the WASC members, but again was not unanimous.

For the private side, in contrast, there was little conflict during development of the FHIAP benchmark. Upon completion of a survey of the health insurance market, the Insurance Pool Governing Board (IPGB) tried to get most of the plans offered to fit, to not disadvantage employees or employers. "Casting a broad net" was emphasized, yet still some plans currently being subsidized by FHIAP did not meet the benchmark. Two areas that were debated:

- *Drug benefit:* most private commercial plans offer it as a rider;
- *Dental benefits:* not required, since most employers buy separate policies for this coverage, if they offer it.

Debate overall was minimal, and the benchmark passed unanimously.

House Bill 2519

The public commitment to maintain the Oregon Health Plan (OHP) and the desire to extend coverage to more Oregonians resulted in the passage of House Bill 2519 by the 2001 Oregon Legislature. This legislation represents a bipartisan effort to restructure OHP in order to sustain the current program, expand coverage to higher income levels to stabilize insurance coverage and reach more uninsured Oregonians, and leverage private insurance, particularly employer-sponsored coverage. The restructured program in its entirety is referred to as OHP2. OHP2 has three components, two offered through public insurance (Medicaid and SCHIP) and one through private insurance:

- *OHP Plus*: OHP Plus will provide the current OHP benefit package to people eligible for Medicaid (without a waiver), General Assistance recipients, and pregnant women and children (both Medicaid and SCHIP) up to 185% of the FPL;

- *OHP Standard:* OHP Standard will provide a benefit package that is more similar to commercial insurance coverage and will be provided, up to a capped enrollment, to adults who are not otherwise eligible for Medicaid (including parents, singles and couples) with incomes up to 185% of the FPL;
- *Family Health Insurance Assistance Program (FHIAP):* FHIAP will provide premium subsidies for the purchase of private health insurance for uninsured Oregonians with incomes up to 185% of the FPL. Enrollment in FHIAP will be capped.

As stated, an important policy objective of HB 2519 was to encourage the transition to employer-sponsored insurance when it is available. OHP Standard is more like private insurance products than the current OHP, with cost-sharing including copayments and premiums. By gaining federal match for FHIAP, thousands of additional people will be able to receive health care coverage through their employer-sponsored insurance.

Savings from the reduced benefit program and additional federal financial participation (FFP) will finance the expansion for adults and children at higher income levels than are currently in place.

OHP Plus:

OHP Plus will be provided for all mandatory and certain optional populations. The groups that will receive OHP Plus include:

- The elderly and disabled at the current eligibility levels;
- The TANF population at the current eligibility levels;
- All Medicaid and SCHIP children in the program up to 185% of the FPL;
- Pregnant women up to 185% of the FPL;
- General Assistance recipients at the current eligibility levels.

There will be no premiums for OHP Plus enrollees. Following legislative direction for budget balancing during the 2001 Legislative Session, Oregon filed a State Plan Amendment to permit minimal co-payments on medications and outpatient services for those currently on OHP. The co-payments on medication will be $2 for generic drugs and $3 for brand-name drugs. There will also be a $5 co-payment for outpatient services. In compliance with 42 CFR 447.53(b), individuals through age 18, pregnant women, institutionalized individuals, emergency services, family planning services and supplies, and services provided by health plans will be exempt from co-payment requirements. Co-payments will be collected by providers, however OHP Plus enrollees cannot be refused services because of their inability to pay.

The Health Services Commission will continue to maintain its Prioritized List of Health Care Services, using it to establish the current OHP Plus benefit package of health care services. Any change in benefits in OHP Plus would be through a public process and would need approval by the Legislature or the Legislative Emergency Board. Oregon requests that as part of the terms and conditions of the waiver application, CMS and Oregon establish a streamlined process through which Oregon can move the coverage line further up or down the list.

OHP Standard:

The second benefit package, OHP Standard, will provide basic coverage more similar to private insurance. The initial benefit package, which includes premium sharing and copayments, has been designed to provide benefits at least actuarially equivalent to the federally mandated Medicaid benefit package.

The groups that may receive OHP Standard include those optional and expansion populations not included in OHP Plus that do not have qualified employer-sponsored insurance (ESI) available. These groups include:

- Parents and Adults/Couples below 100% of the FPL made eligible through the OHP waiver;
- Parents and Adults/Couples below 185% of the FPL made eligible through OHP2.

If federal match is approved, Oregon's subsidy program, the Family Health Insurance Assistance Program (FHIAP), will subsidize premiums for the purchase of qualified private health insurance for persons eligible for OHP2 if they desire private-sector coverage (subject to certain program limitations).

After completing a year of benefit analysis and obtaining public input, the Health Service Commission (HSC) published the *Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard* in October 2001. The report included recommendations for range of benefits and cost-sharing for OHP Standard. The Health Service Commission report was forwarded to the Waiver Application Steering Committee (WASC) as required by HB 2519.

Oregon is requesting the ability to adjust OHP Standard benefits to continue coverage when revenue constraints tighten. Specifically, Oregon is seeking permission to adjust the OHP Standard benefit level as long as this benefit level is at least actuarially equivalent to the federally mandated Medicaid benefit package. The federally mandated level is equivalent to approximately fifty-six percent (56%) of the value of the current OHP Plus benefits. The OHP Standard benefits described below are the initial benefits recommended for program implementation. In subsequent biennia, Oregon will set the OHP Standard benefits at a level that can be supported by available revenue, and OHP Standard benefits will always be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

Based on extensive discussions and recommendations from advocates and health plans, the WASC recommended the OHP Standard benefit package for the waiver application in December 2001. The prioritized ranking of the benefit packages, as determined by the HSC, was maintained. Working within the parameters established by the Governor and the legislative leadership, WASC recommended the final cost-sharing and premium requirements.

The OHP Standard benefit package covers basic services with cost-sharing. (See Table 4.1) Starting with a benefit package designed to provide benefits at least actuarially equivalent to the federally mandated Medicaid benefit package, the benefit package level recommended by the WASC is equivalent to approximately seventy-eight percent (78%) of the value of the OHP Plus benefit package, including a portion of the additional premiums.

Cost-sharing and benefit reductions in OHP Standard are overlaid on the Prioritized List of Healthcare Services. Services excluded from OHP Plus coverage because they are "below the line" will also be excluded from OHP Standard coverage. It is anticipated that any change in

benefits for OHP Standard would be through a public process and need approval by the Oregon Legislature or the Legislative Emergency Board. The HSC continues its work on further benefit strategies that would allow flexibility of the benefit package that can preserve the basic services, yet still be adjusted to available revenue as necessary.

Cost-sharing was added to OHP Standard in order to add optional services such as prescription drug coverage while achieving a benefit package that was comparable to the packages available in the private health insurance market. (See Table 4.2) Co-payments will be required of all OHP Standard enrollees. Providers will be responsible for collecting payments. However, unlike OHP Plus, providers may refuse to provide a service, except emergency services, if the co-payment is not paid. In keeping with the objectives to promote access to care at the appropriate time, co-payments will not be required for preventive services.

Premiums will be collected by the State for OHP Standard enrollees and those who fail to pay their premiums will be disenrolled after receiving adequate notice. (See Table 4.3) Those who want to come back into the program after having been disenrolled will be subject to a period of uninsurance of up to six months and any applicable waiting period.

Private-side Basic Benefit Benchmark Plan(s):

The Insurance Pool Governing Board (IPGB) is responsible for the Family Health Insurance Assistance Program (FHIAP), which provides premium subsidies for the purchase of private health insurance for qualified, uninsured Oregonians. As required by HB 2519, the IPGB, in consultation with the Health Insurance Reform Advisory Committee (HIRAC), developed a benchmark benefit plan, taking into account the most common employer-sponsored health benefit plans currently in the Oregon market. (See Table 4.3) In order to be subsidy-eligible, a plan must offer services in twenty (20) different benefit categories subject to overall cost-sharing limits. The IPGB did not create a new health benefit plan, merely a benchmark that potential subsidy-eligible plans will be measured against. The benchmark was also reviewed by the WASC in January 2002.

Table 4.1: OHP Standard Benefits, Cost-sharing and Premiums

Service	Cost Share %	Recommended Cost-Sharing Mechanism	
Inpatient Hospital	5.0%	$250 copay per admission	
Outpatient Hospital	4.5%	$20 copay/surgery $5 copay other outpatient services	
Emergency Room	12.0%	$50 copay waived if admitted	
Physician Services	4.3%	$5 copay office visits. $3–$10 copay medical & surgical procedures	
Lab & X-ray	5.7%	$3 copay for each lab and X-ray	
Ambulance	11.7%	$50 copay	
Prescription Drugs	15.2%	***0–100% FPL*** • $2 generic • $3 MH/cancer/ HIV brand drugs • $15 other brand	***101–185% FPL*** • $5 generic • $10 H/cancer/ HIV brand drugs • $25 other brand
Mental Health and Chemical Dependency	6.1%	$5 copay No copay on dosing/dispensing, or case management services	
Durable Medical Equipment	53.2%	***Recurrent:*** $2 copay per 30 days No coverage for one-time DME	
Dental	50.0%	***Dx & Preventive:*** zero/minimal copays ***Restorative:*** graduated copays $500 benefit limit	
Cumulative Cost	86.1%		
Behavioral Offset	6.0%		
Additional Premium Offset	2.1%	See below for revised premium structure.	
Net Cost	78.0%		

Table 4.2: Recommended OHP Standard Premium Structure for the 2001–03 Biennium

	Single	Couple	% Package
0–10% FPL	$6	$12	2.4%
11–50% FPL	$9	$18	3.6%
51–65% FPL	$15	$30	6%
66–85% FPL	$18	$36	7.2%
86–100% FPL	$20	$40	8%
101–125% FPL	$23[‡]	$46	9.2%
126–150% FPL	$35	$70	14%
151–170% FPL	$75	$150	30%
171–185% FPL	$125	$250	50%
Percentage savings to OHP Standard Benefit package: 2.1%			

[‡] *Premiums for people with incomes above 100% FPL will be based on percentage of the OHP Standard benefit package, not fixed at these dollar amounts.*

Table 4.3: FHIAP Benchmark for Group Health Insurance Plans

Pre-existing Condition Waiting Period	6 Months
Annual Deductible	$500 individual
Maximum Out-of-pocket *or* *Stop Loss*	$2,500 individual or $10,000 individual
Lifetime Maximum	$1,000,000
Prescription Drugs	25% enrollee cost-sharing
Prescription Drug Maximum Out-of-pocket	No out-of-pocket maximum
Doctor Visits	Covered Benefit*
Immunization	Covered Benefit*
Well Baby Care	Covered Benefit*
Well Child Care	Covered Benefit*
Women's Health Care Services	Covered Benefit*
Maternity	Covered Benefit*
Diagnostic X-Ray/Lab	Covered Benefit*
Hospital	Covered Benefit*
Outpatient Surgery	Covered Benefit*
Emergency Room	Covered Benefit*
Ambulance	Covered Benefit*
Transplant	Covered Benefit*
Mental Health/Chemical Dependency Outpatient	Covered Benefit*
Mental Health/Chemical Dependency Inpatient	Covered Benefit*
Skilled Nursing Care	Covered Benefit*
Durable Medical Equipment	Covered Benefit*
Rehabilitation Inpatient	Covered Benefit*
Rehabilitation Outpatient	Covered Benefit*
Hospice	Covered Benefit*
Home Health	Covered Benefit*

**Covered benefit means services are offered in a benefit category. Benchmark does not specify durational, internal, or cost-sharing limits beyond those imposed by the annual deductible, maximum out-of-pocket, stop loss, and lifetime maximums.*

Source: *Oregon Insurance Governing Board*

Addendum to Section 5: Consensus Building Strategies

Final summaries describing the public meetings and stakeholder meetings were published as Appendices to the *Oregon Health Services Commission Report: Prioritized List of Benefit Packages for OHP Standard* in October 2001. Overall more than forty stakeholder meetings and nine community meetings were held during late summer and early fall 2001. More than 600 Oregonians took part in the public discussion about OHP2 and the possible expansion strategies. More public comment was obtained during the Waiver Application Steering Committee (WASC) meetings.

Because health care safety net providers form a key component of Oregon's overall health care delivery system and because of the recent federal support to expand the safety net, the WASC invited safety net representatives to advise the committee and waiver process. In response, individuals representing the diversity of safety net providers from throughout Oregon formed the Waiver Application Safety Net Work Group. The HRSA Team coordinated and staffed the work group. The work group's goal was to help ensure that the needs, challenges, and strengths of Oregon's safety net were considered throughout the OHP2 waiver process.

After careful review of HB 2519, and while monitoring the deliberations of the Waiver Application Steering Committee, the Safety Net Work Group outlined four important issues and strategies to help ensure the success of the proposed waiver and the continued vitality of Oregon's safety net. These are:

- *Delivery system capacity*

  Keeping in mind that the federal government has doubled the amount of money it allocates to support safety net clinics, it is advantageous for Oregon policy makers to consider how to capitalize on this and other federal government opportunities. Policy makers need to consider how the safety net can help stabilize the delivery system and the role the safety net plays to help ensure access to health care for all Oregonians.

- *Funding*

  Maintaining the Prospective Payment System (PPS), further leveraging federal money, and exploring creative approaches to strengthen the relationship between the OHP carriers and safety net providers will help ensure that all Oregonians have access to quality care.

- *Benefits, cost-sharing, and eligibility*

  The Safety Net Work Group stressed the value of including mental health, dental and medical services in OHP in order for Oregon to maximize on recent federal policy and financial opportunities to expand the number of Federally Qualified Health Centers (FQHCs). If OHP2 does not include mental health, dental, and medical benefits in the OHP2 coverage package, it will be more difficult for Oregon communities to benefit from federal money devoted to strengthen and expand the safety net which serves 141,000 low-income Oregonians. Additionally, the Work Group recommended that Oregon prevent enrollment limits, or caps, for Oregonians who are categorically eligible for OHP and for individuals who are at or below the federal poverty level. The Work Group offered its expertise in the development of cost-sharing strategies for OHP enrollees.

♦ *Implementation*

The health care safety net has extensive expertise serving and supporting OHP members and the uninsured. The safety net is acknowledged for providing culturally and linguistically competent health care services, often to individuals who other providers struggle to serve. Because of the expertise of the safety net and its ability to provide quality services to underserved populations, safety net representatives requested that State policy makers and OHP2 program designers include safety net providers in all stages of the implementation process.

Addendum to Section 6: Lessons Learned and Recommendations to States

6.9 How did your State's political and economic environment change during the course of your grant?

Like many other states, Oregon's economy began to slow in late 2000 and continued slowing into early 2001. The events of September 11th accelerated the decline in the state's economy. Oregon currently ranks among the lowest states for several economic indicators and has the highest unemployment rate in the country. The decline in Oregon's economy has resulted in substantial layoffs and decline in income. Over 40,000 additional individuals are now covered by OHP. The Legislature approved a rebalance of the 2001–03 biennial budget to provide for this increased enrollment. Resources were found for the rebalance by using reserve funds within the Department of Human Services, reductions in programs within the Department and payment reductions to providers.

The political environment has also changed. Term limits and election/campaign reform continue to be important issues. Oregon's term limit law, passed by voter initiative, was determined to be unconstitutional in Fall 2001. Those legislators previously at the end of their terms can now run for reelection. Redistricting of legislative boundaries has also taken place, substantially changing several races for the legislature.

The Oregon Legislature completed its regular biennial session in July 2001. The state is facing a substantial budget deficit requiring special sessions of the Legislature. The solution to the deficit proposed by the Legislature in its first special session was vetoed by Governor Kitzhaber because of concerns that additional revenues proposed by the Legislature came from one time only sources (trust funds) rather than permanent revenue changes (tobacco tax, wine and beer tax). A second special session has just adjourned with a proposal similar to the first approved. The Governor has vetoed portions of this proposal also.

6.10 How did your project goals change during the grant period?

More than 12% of Oregonians remain uninsured, and Governor Kitzhaber is committed to reducing that number. In order to provide health care to all Oregonians the HRSA State Planning grant identified three specific goals:

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

3. Improve the capacity and capability of Oregon's safety net clinics to provide needed care to the uninsured populations, including Hispanics and other immigrants, as well as the homeless.

Oregon's major goals have remained the same—submit and receive approval for Medicaid waivers granting Oregon additional flexibility related to benefits, eligibility and coordination with employer sponsored insurance as well as sustain and strengthen the health care safety net. Various details related to Oregon's waiver work have changed however. For example, the process resulted in more emphasis on cost-sharing rather than eliminating benefits, in large part due to an effort to preserve a dental benefit, and based on the public input received during the last year.

6.11 What will be the next steps of this effort once the grant comes to a close?

Oregon is fortunate to have received a grant from the Robert Wood Johnson Foundation State Coverage Initiatives program that enables us to continue to pursue many of health care expansion efforts. Oregon passed legislation authorizing pursuit of a waiver consistent with our goals. We await direction from the Governor to submit the waiver currently drafted. We are currently continuing to pursue a variety of issues related to benefits, eligibility and coordination with employer-based insurance. We anticipate continuing to develop options related to the waiver and its implementation. We continue to learn more about the key issues related to our efforts and look forward to communicating what we have learned to other states and the federal government.

Addendum to Section 7: Recommendations to the Federal Government

Oregon recommends that the federal government should, at varying times, act as a facilitator, coordinator, as well as provide funds to support projects:

1. Facilitate communication among states who are considering similar waiver strategies. For example, segments of Utah's waiver are parallel to strategies that were discussed in Oregon and it would have been valuable to know of their efforts earlier. As it is, Oregon learned of Utah's efforts at a HRSA-sponsored grantee's meeting—sponsored by the federal government, but if Oregon had not been a HRSA grantee that information sharing would not have occurred.
2. Support further study of underinsurance. One of Oregon's challenges in designing OHP Standard was the struggle with defining adequacy of benefit packages. This area needs further exploration.
3. Continue support of state efforts to allocate resources across a broader population by offering different benefit plans, showing federal flexibility in matching state and other funds for people that would otherwise be uninsured.
4. Support research that clarifies the impact of premiums and cost-sharing on people with little or no income, and study the potential for various strategies to moderate that impact. Oregon is using HRSA State Planning grant resources to learn more about the Washington Basic Health Plan and the use of sponsor organizations who provide assistance to those who cannot afford their share of the premium, but can afford the co-pays. The Grant Team hopes to discern whether there are facets of this strategy that are replicable in Oregon.

5. Support research that would provide states evidence-based information regarding specific benefit issues, particularly prescription drug issues at the moment, but also other benefit approaches.
6. Continue support for efforts like SHADAC and the Arkansas Integrated Database that have great potential to help states more fully understand and use their state-specific information and information from other states.
7. Consider organizing states with high-risk pools to facilitate dialogue and information to the federal government regarding the interaction of individual tax credits and high risk pools.
8. Support research efforts exploring strategies to solicit public input regarding values and preferences pertaining to health care policy.
9. Continue to support and strengthen the health care safety net, which includes but is not limited to federally qualified health centers and rural health clinics.

References

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