



An historical overview

Department of Human Services
Health Services
Office of Medical Assistance Programs
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OHP Defined

The Oregon Health Plan (OHP) is a public and private partnership to ensure access to health care for all Oregonians. The major components are:

- ❖ Medicaid reform.
- ❖ Insurance for small businesses.
- ❖ High risk medical insurance pool.

In addition, OHP includes provisions for oversight, research, and analysis to achieve the best use of health care funding.

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Background

The Oregon Health Plan (OHP) formed in response to conditions that threatened the social and economic health of the nation: namely, the rising costs of medical care and the growing number of people unable to afford such care.

In the late 1980s, millions of Americans had no guaranteed medical benefits: They didn't qualify for public assistance (Medicaid), were not insured by an employer, and couldn't afford individual coverage. About 18 percent of all Oregonians, and more than 20 percent of our children, had no medical coverage. They were, in effect, excluded from our health care system.

Instead of seeking early preventive care, the uninsured sought emergency care as a last resort when their illnesses became severe. When emergency room doctors are not compensated, the care isn't really free. Instead, the cost of this expensive care is shifted to increase the cost of medical bills and insurance premiums. Those who can afford to pay for these increased costs, do.

States traditionally responded to these rising costs by reducing the number of people eligible for public assistance coverage and reducing Medicaid reimbursements to providers. In the private sector, employers reduced or dropped coverage for their workers. The result: ever-escalating costs as more people were priced out of coverage and into the "cost-shift."

As conditions worsened, Oregon's practice of fully insuring only Medicaid eligibles, while neglecting the rest of Oregon's uninsured poor, no longer made sense.

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OHP History

In 1987, the Oregon Legislature decided to no longer fund soft tissue transplants for Medicaid clients. This prompted a debate about what health services Oregon's Medicaid program should cover. That year, Governor Neil Goldschmidt appointed a workgroup of representative health care providers and consumers, businesses, labor, insurers, and lawmakers.

This group developed a political strategy to answer three main questions about Oregon's health plan: (1) who is covered, (2) what is covered, and (3) how is it financed and delivered.

OHP Goals

The workgroup agreed that:

- ❖ All citizens should have universal access to a basic level of care.
- ❖ Society is responsible for financing care for poor people.
- ❖ There must be a process to define a “basic” level of care.
- ❖ The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole.
- ❖ The health care delivery system must encourage use of services and procedures that are effective and appropriate, and discourage over-treatment.
- ❖ Health care is one important factor affecting health; funding for health care must be balanced with other programs that also affect health.
- ❖ Funding must be explicit and economically sustainable.
- ❖ There must be clear accountability for allocating resources and for the human consequences of funding decisions.

Blueprint Objectives

OHP is a blueprint for universal access to basic and affordable health coverage that offers:

Insurance Reforms

- ❖ A basic health care package for low-income persons.
- ❖ Health insurance for individuals who have been denied coverage for medical reasons.
- ❖ Two voluntary group insurance plans available to small employers — one offers low premiums, the other guarantees availability.
- ❖ Reforms to make insurance more available and affordable.
- ❖ Assessment of new technologies and their need in particular geographic regions.
- ❖ Assessment of service expansions and cost-containment.

Stewardship of Public Resources

The Oregon Health Plan also seeks to lower costs by:

- ❖ Reducing cost shifts.
- ❖ Emphasizing managed care, preventive care, early intervention, and primary care.
- ❖ Not covering ineffective care.

OHP provides a political dynamic for controlling costs by:

- ❖ Addressing the reality of fiscal limits.
- ❖ Recognizing medical care as one investment affecting health.
- ❖ Providing a political framework for balancing public spending to keep people healthy.
- ❖ Requiring decision-makers to be publicly accountable for funding decisions.

Implementation Timeline

To put the goals and objectives into practice, the Oregon Legislature passed a number of bills over successive sessions that created the framework for a private/public partnership that collectively became the Oregon Health Plan. Over time, OHP has expanded and contracted in response to society's economic fluctuations.

1987

Governor
Neil Goldschmidt

The Legislature establishes the Insurance Pool Governing Board (IPGB), to offer uninsured self-employed and small businesses (1-25 employees) the opportunity to purchase affordable small group health insurance from private companies (HB 2594).

The Legislature creates the Oregon Medical Insurance Pool (OMIP), to offer health benefits to people who can't buy individual health insurance because of a health condition. The bill establishes OMIP as a quasi-public agency with no state funding (SB 583).

1988

Senate President John Kitzhaber initiates the Oregon Medicaid Priority Setting Project, which laid the groundwork for the Prioritized List of Health Services.

1989

IPGB makes insurance available to uninsured small businesses and offers a tax credit.

The Legislature establishes the Employer Mandate, scheduled to begin January 1, 1994. It requires employers to provide medical insurance to those employees working 17.5 hours or more per week and their dependents. The alternative is to pay into a special state insurance fund that offers coverage to their employees (SB 935). It requires a Congressional exemption to the Employee Retirement Income Security Act (ERISA).

The Oregon Health Services Commission (HSC) is created to rank medical services from most to least important to the low-income populations. The Legislature defines the health care package benefits from this list.

The Legislature establishes the Oregon Medical Insurance Pool (OMIP) as a state agency with state funding (SB 534). OMIP offers health insurance to people who cannot buy coverage because of pre-existing medical problems.

A framework is developed for Phase I of the OHP Medicaid demonstration (SB 27).

1991

Governor
Barbara Roberts

Legislature develops a framework Phase II of the Medicaid demonstration (SB 44), which includes preparations to offer mental health and chemical dependency services (SB 1076).

Legislature establishes the Health Resources Commission (HRC) to develop a process for deciding the allocation of medical technologies in Oregon (SB 1077).

The Legislature mandates several insurance reforms, including a guaranteed-issue policy that all small-business insurance carriers in Oregon must offer. The Employer Mandate is postponed until July 1, 1995 (SB 1076).

The HSC recommends its first Prioritized List to the Governor and Legislature. It is funded through line 587/709 pending US Health Care Financing Administration (HCFA) approval.

Oregon sends the Medicaid waiver application to HCFA.

1992

HCFA denies the waiver application because of possible violations of the Americans with Disabilities Act.

HSC revises the prioritization methodology and reorders the list.

Oregon resubmits the waiver application to HCFA.

1993

Small business insurance policies go on sale.

Legislature directs HSC to review and adopt clinical practice guidelines (SB 757).

Employer Mandate is postponed until March 31, 1997 (HB 5530).

Funding package passes for Medicaid expansion, using General Funds, a 10-cents-a-pack cigarette tax increase, and matching federal funds. Legislature approves graduated funding levels on the Prioritized List over time (HB 5530). Beneficiaries to include seniors and people with disabilities. The initial Prioritized List approved by HCFA is funded through line 606/745. Benefits will include mental health and chemical dependency services.

HCFA approves expanded mental health coverage on a demonstration basis in 20 counties, representing about 25 percent of the OHP client base.

Legislature creates the Office of the Oregon Health Plan Administrator.

1994

Medicaid expanded to include Oregonians under 100 percent of Federal Poverty Level (FPL), providing a Basic health care benefit package via the Prioritized List.

1995

Governor
John Kitzhaber, M.D.

The Basic benefit package expands to include Medicaid seniors and people with disabilities, as well as children in foster/substitute care.

A gradual expansion of coverage for mental health services begins for Medicaid clients. OHP coverage expands to include chemical dependency services.

The Legislature approves premiums and a \$5,000 liquid asset limit for people newly eligible for Medicaid under OHP. It removes full-time college students from those eligible for OHP benefits.

Legislature introduces protections for managed care clients (SB 979).

Legislature introduces a major insurance reform package, including provisions to ensure that health insurance coverage comparable to that available to large groups is available to individuals or groups of two or more. It also addresses “portability,” to ensure that coverage for these small groups would continue if a covered person leaves the group (SB 152).

Legislature transfers the Oregon Health Council from the Department of Human Resources to the Office of the Oregon Health Plan Administrator (SB 1079). Covered services on the Prioritized List are funded through line 581/745, resulting in a reduction in coverage of 27 lines.

1996

Legislature repeals the Employer Mandate since Congress did not grant an exemption from the Employee Retirement Income Security Act (ERISA) by the deadline named by the Oregon Legislature.

1997

HB 3445 makes all OHP clients eligible for expanded mental health benefits that are provided through mental health organizations (MHOs).

Legislature creates a subsidy program, the Family Health Insurance Assistance Program (FHIAP), to help low-income working people pay for private health care coverage. The Insurance Pool Governing Board administers FHIAP (HB 2894).

Legislature renames the Office of Oregon Health Plan Administrator to the Office for Oregon Health Plan Policy Research (OHPPR) by HB 2894.

Covered services are reduced from line 581/745 to 578/745 instead of line 573/745 as requested of HCFA.

1998

Eligibility is restored to full-time college students who meet OHP income and asset criteria, are otherwise uninsured, and meet family economic standards for federal Pell grant eligibility.

The Basic benefit package expands to include pregnant women with income up to 170 percent FPL.

FHIAP begins accepting reservations, and sending out applications with the first enrollments in July.

Children's Health Insurance Program (CHIP) begins for uninsured children (through age 18). OHP eligibility rises to 170 percent FPL for these children.

1999

Legislature guarantees cost-based reimbursement for small hospitals (< 50 beds) that do not contract with managed care plans (SB 676).

Legislature approves reducing services to line 564 on the Prioritized List for coverage for 1999-2001 (however, HCFA never approved it).

Legislature releases IPGB from obligation to certify health insurance policies that are sold by health insurance carriers to uninsured small businesses (SB 414).

Legislature lowers liquid asset limit to \$2,000. Services to line 574/743 are funded.

2001

Legislature directs Oregon to seek new Medicaid waivers from the federal government to change the benefit package for some OHP recipients, and use the savings to pay for an expansion of OHP to people earning up to 185 percent FPL. The waiver will also allow federal money to be used to expand coverage to more people in FHIAP (HB 2519).

Legislature directs IPGB to develop a basic benchmark health benefit plan(s) for subsidized individual or employer-sponsored coverage (HB 2519).

Changed the name of OHPPR to Office for Oregon Health Policy and Research (OHPR) (HB 2101).

OHPR researches alternative methods of determining the capitation rate paid to the fully capitated health plans providing medical services to enrollees of OHP (HB 2519).

Legislature adopts Prioritized List funding through line 566/736.

Legislature creates the Practitioner Managed Prescription Drug Plan to create preferred drug list for OHP through evidence-based process for fee-for-service clients (SB 819).

2002

Breast and cervical cancer program begins.

Emergency Board approves OHP2 waivers with incremental expansion of Medicaid to 115 percent FPL (delayed indefinitely) and expansion of FHIAP.

DHS submits its second 5-year OHP project waiver request to Centers for Medicare and Medicaid Services (CMS, formerly HCFA).

The Pharmacy Management Program begins, limiting clients to a single pharmacy provider of their choice. Simultaneously, the Practitioner Managed Prescription Drug Program (PMPDP) begins, identifying the most cost-effective drugs, limiting client supplies, and reducing reimbursements.

The Disease Management Program begins, targeting clients with specific health conditions and providing case management.

CMS approves OHP waivers.

FHIAP begins expansion in November toward a goal of 25,000 enrollees.

2003

Governor
Theodore Kulongoski

Covered services on Prioritized List drop from line 566 to 558. Copayments are instituted for most adult fee-for-service clients using specified services. Exemptions are given to pregnant women, tribal clients, and long-term care clients receiving waived services.

The former Basic package is renamed OHP Plus; the covered services remain the same for categorically eligible clients. A new benefit package, OHP Standard, is created. The Standard package offers reduced benefits, higher copayments and requires premiums.

OMAP contracts with a new mail order vendor to provide discounted prescription drugs to OHP clients. OHP Plus clients are exempted from copayments for this service.

The Medically Needy (MN) and General Assistance programs are discontinued in February. A few MN clients are given back a prescription-only benefit for certain life-threatening conditions (SB 5548).

In February, OHP eligibility for pregnant women and children rises to 185 percent FPL.

Most OHP Standard applicants must have been uninsured for at least six months to be eligible for OHP Standard enrollment. Eligible, employed clients on the OHP Standard benefit package who have employer-sponsored health insurance available to them must apply for FHIAP coverage.

In February, OHP Standard benefit package discontinues coverage for routine visual, hearing services, durable medical equipment and non-emergent medical transportation.

OHP Standard benefit package premiums and copayment amounts increase. Penalties are put in place for failure to pay premiums.

Clients in long-term care at lesser-impaired Survivability Levels 15-17 lose eligibility.

In March, OHP Standard benefit package discontinues coverage for dental, outpatient mental health and chemical dependency services, as well as medical supplies.

Eligibility date for OHP Standard begins the month following approval.

Clients in long-term care at Survivability Levels 12-14 lose eligibility.

Legislature requires Fully Capitated Health Plan (FCHP) enrollment for all but a few exceptions (HB 3624). OMAP begins auto-enrolling clients in FCHPs by service area with a goal to increase enrollment to 70 percent and stay there for remainder of the biennium.

Legislature requests a 30-line move on the Prioritized List from 549 to 519. Process begins to obtain CMS waivers for this and several other actions in order to implement early in 2004.

Legislature revises OHP Standard benefit package to include physician, lab and X-ray, prescription drugs, outpatient mental health/chemical dependency and limited emergency dental services as a core benefit package, pending CMS approval. A limited hospital benefit will be added subject to CMS approval of provider taxes (HB 2511).

Legislature directs OMAP to expand CHIP coverage to 200 percent FPL (HB 2511) by early 2004.

Legislature establishes a prescription drug program, Medical Expansion to people with Disabilities and Seniors (MEDS), to begin in 2004 (HB 2511) and imposes several cost-saving measures to prescription drug services (pending CMS approval).

The Health Services Commission's revised Prioritized List of Health Services becomes effective in January with funding through line 549.

Legislature establishes Medicaid managed care plan and hospital provider taxes (HB 2747) to begin in 2004.

Legislature directs use of Physician Care Organization (PCO) program beginning July 2004 (HB 3624). A PCO is a partially capitated plan.

Legislature directs dissolution of the Oregon Health Council. It is replaced by the Oregon Health Policy Commission (HB 3653).

Legislature directs FHIAP to expand coverage up to 200 percent FPL in both HB 2511 and HB 2189.

Legislature directs IPGB to develop health insurance plans for small, uninsured businesses (HB 2537).

2004

Ballot Measure 30 fails. To help fund the state budget approved by the 2003 legislature, this tax measure asked for a three-year personal income tax surcharge, based on state income tax owed, an increase in the minimum corporate tax owed, and extension of the state's cigarette tax. Rejection of this measure necessitated the OHP benefit reductions and curtailed OHP Standard enrollment to occur later this year.

Physician Care Organization program implemented May 2004.

Court order directs OMAP to end copayments for clients on the OHP Standard benefit package effective June 19, 2004.

OHP Standard closed to new enrollment effective July 1, 2004.

The Health Services Commission's revised Prioritized List of Health Services becomes effective in August with funding through line 546.

Effective August 1, OHP Standard benefit package discontinues coverage of non-emergent hospital, acupuncture (except for treatment of chemical dependency), chiropractic and osteopathic manipulation, home health care, oral nutritional supplements, occupational therapy, physical therapy, speech therapy, and private duty nursing services.

Effective August 1, OHP Standard benefit package restores coverage of emergency dental services, diabetic supplies (including blood glucose monitors), respiratory equipment (CPAP, BiPAP, etc.), oxygen equipment (concentrators, humidifiers, etc.), ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies, outpatient chemical dependency services, and outpatient mental health services.

The Medicaid Managed Care Plan Tax becomes effective May 1, 2004. It applies to managed care premiums received by managed care organizations on or after May 1, 2004, and before January 1, 2008.

The Hospital Tax becomes effective July 1, 2004. It applies to net revenue received by DRG hospitals on or after July 1, 2004, and before January 1, 2008.

Governor Kulongoski's "Future of the OHP" workgroup makes recommendations on how to improve the sustainability of the Oregon Health Plan.

2005

Legislature directs DHS to adopt rules to adjust OHP services in order to align with the 2005-2007 Legislatively Adopted Budget (HB 3108), pending federal approval of any proposed benefit reductions resulting from this bill.

Legislature allows DHS to modify the OHP Plus benefit package for clients who are dually Medicare/Medicaid eligible so the major responsibility for prescription drugs will be Medicare's (SB 1088).

Legislature exempts OHP Standard clients from paying premiums if their family income is no more than 10 percent of the federal poverty level. For those still required to pay premiums, this bill allows a grace period for premium payments of up to six months, and it requires clients to pay overdue premiums before they can be eligible again. This bill eliminates the six-month disqualification period when someone fails to pay premiums (SB 782).

Legislature directs DHS to suspend, as opposed to terminate, medical assistance for a person with serious mental illness who becomes an inmate in a public institution (SB 913).

Legislature approves name change of IPGB to the Office of Private Health Partnerships (OPHP) (SB 303).

2006

The Health Services Commission's revised Prioritized List of Health Services becomes effective in January with funding through line 530 out of 710 lines. The HSC merged several lines during the 2005-07 biennial review, so that the new list has a funding level equivalent to the previous funding line drawn at line 546 (out of 730).

Starting January 1, OHP stops paying a prescription drug benefit for Medicare-covered drugs for dual-eligible clients as part of Medicare Modernization Act implementation. Certain categories of drugs not covered by Medicare are still covered.

Starting June 1, OHP no longer charges a premium to OHP Standard clients whose household income is 10% or less of the Federal Poverty Level (FPL). Also, clients on the OHP Standard benefit package whose income is above 10% FPL must now pay current and past-due premiums at the time of reapplication in order to remain eligible for continued OHP Standard coverage.

Starting June 1, client eligibility for the CHIP program is extended from 6 months to 12 months.

Oregon Health Plan Agencies

Governor



Oregon Health Plan Growth

Beginning February 1, 1994, the state embarked on a campaign to make Medicaid available to thousands of people who previously did not qualify, even though their income was below the poverty level.

The Oregon Health Plan (OHP) originally operated as a five-year Medicaid demonstration project, which required a waiver from traditional Medicaid rules. The waiver was granted in March 1993 by the former U.S. Health Care Financing Administration (HCFA).

The OHP's Medicaid expansion was unique in at least two ways:

- ❖ It made Medicaid available to most people living in poverty regardless of age, disability or family status.
- ❖ Its benefits were based on a priority list of health care conditions and treatments.

Medicaid Expansion

Basic Health Care Benefit Package

In 1994, OHP extended a Basic Health Care benefit package to approximately 100,000 newly eligible persons, in addition to about 250,000 Oregonians who previously qualified for Medicaid. It covered most people below the federal poverty level (FPL), as well as many seniors, persons with disabilities, and foster children. It also covered pregnant women and children under age six with income up to 133 percent of the FPL.

In 1994, OHP extended a Basic Health Care benefit package to approximately 100,000 newly eligible persons, in addition to about 250,000 Oregonians who previously qualified for Medicaid.

This “Basic” benefit package applied to nearly all members, with exceptions such as persons eligible for Medicare or those with exceptionally high medical expenses but with income over the poverty level (the Medically Needy Program). It was a way of offering Medicaid benefits to more Oregonians.

In January 1995, the state added some previously exempted groups and began integrating mental health and chemical dependency services into the OHP Basic Health Care Package. By July 1997, all OHP clients were made eligible for expanded mental health benefits.

Children’s Health Insurance Program

In 1997, Congress created the Children’s Health Insurance Program (CHIP) to increase funding to states for coverage of low-income children. OMAP administers Oregon’s CHIP. With this increased state and federal funding, the Basic benefit package was extended to pregnant women with income up to 170 percent FPL on March 1, 1998. CHIP extended OHP Medicaid benefits to uninsured children to age 19 up to 170 percent FPL beginning July 1, 1998.

OHP Plus and Standard Benefit Packages

To help control costs, and help reduce the number of low-income, uninsured Oregonians, the 2001 Oregon Legislature passed HB 2519. This bill directed Oregon to seek a new Medicaid waiver from the federal government to change the benefit package for some OHP recipients, and use the savings to pay for an expansion of OHP eligibility up to 185 percent FPL.

These changes introduced client copayments for most adults, and replaced the Basic benefit package with two newly defined packages—OHP Plus and OHP Standard.

The Basic benefit package was renamed OHP Plus. OHP Standard was a new benefit package whose clients would receive a reduced set of benefits, pay premiums for OHP coverage, and higher copayments.

The Centers for Medicare and Medicaid Services (CMS—formerly HCFA) granted Oregon another five-year waiver on October 15, 2002.

Medicaid Reform

The Oregon Health Plan changed Medicaid policy in four major ways:

- ❖ Eligibility—who can receive benefits
- ❖ Benefits—what is covered
- ❖ Service delivery—how clients receive their benefits
- ❖ Payment—how providers are reimbursed

Eligibility

OHP greatly simplifies the eligibility test and process for those not on public assistance. Eligibility is based primarily on income, which is averaged over a three-month period.

Applicants fill out a simple form—either in person or by mail. Most adults with liquid assets of \$2,000 or more are not eligible.

Generally, OHP eligibility is for six months at a time, compared to traditional Medicaid’s month-to-month eligibility. CHIP eligibility is for 12 months at a time.

OHP Plus (Medicaid)

Most Oregonians eligible for the Oregon Health Plan’s Medicaid coverage now receive the OHP Plus benefit package. Clients receiving the Plus Benefit Package include children under 19, pregnant women, blind, aged, people with disabilities, and other special need populations.

Individuals and families with income below federal poverty guidelines are eligible for OHP Medicaid coverage. Pregnant women and children under 19 in households with earnings up to 185 percent FPL are also eligible.

OHP Standard

Clients on the OHP Standard benefit package are people who would not be eligible for Medicaid benefits if it weren’t for OHP’s Medicaid expansion. OHP Standard clients must pay monthly premiums of \$9 to \$20 per person, depending on income. Beginning June 2006, those with income at or below 10% FPL do not pay premiums.

Beginning in 2003, Standard applicants must have been uninsured for at least six months before they can qualify for OHP coverage. If they are employed and eligible for FHIAP, they must first apply for that coverage.

Benefits—The Prioritized List

One of the defining differences of the OHP is how it determines the benefit packages covered for OHP clients. Instead of covering all medical services for a limited Medicaid population, the OHP covers both the traditional Medicaid population and the expanded OHP population using a limited list of medical services. This list is called the Prioritized List of Health Services.

Purpose

The Prioritized List emphasizes prevention and patient education. In general, services that help prevent illness are nearer to the beginning of the list (also referred to as “higher on the list”) than services that treat illness after it occurs. Treatment of advanced cancers,

**Federal Poverty Level (FPL)
effective February 2006**

No. in family	100%	133%	185%
1	816	1087	1511
2	1100	1463	2035
3	1383	1839	2559
4	1667	2217	3084
5	1950	2594	3608
6	2233	2970	4131
7	2517	3348	4656
8	2800	3724	5180
9	3084	4101	5705
10	3367	4478	6229
Add'l	284	377	525

for instance, has a lower priority on the list than regular checkups, in the belief that early detection or lifestyle changes may reduce the frequency of cancers that become untreatable.

List administration

The Health Services Commission (HSC), in hearings over more than 18 months involving more than 25,000 volunteer hours, originally devised a list of health services ranked by clinical effectiveness and value to society. Actuaries determined how much it would cost to provide the services on the list. Combined, these pieces of information indicate the value of the health service relative to the cost of providing the service.

The HSC reviews the Prioritized List at least every two years. The Legislature then decides how much of the list to include in the health care budget. The Legislature can fund services only in numerical order, and it cannot rearrange the order of the list. The state must have federal approval from CMS to move the funding line.

The OHPR Web site gives more detail about how the list was formulated. The current Prioritized List of Health Services is available at http://www.oregon.gov/DAS/OHPPR/HSC/current_prior.shtml.

Covered and Non-Covered Services

As of January 1, 2006, OHP covers services up through line 530 of the 710 condition/treatment pairs on the list.

Covered services include:

- ❖ Preventive services to promote health and reduce risk of illness.
- ❖ Comfort care or hospice treatment for terminal illnesses, regardless of where the conditions are on the list.

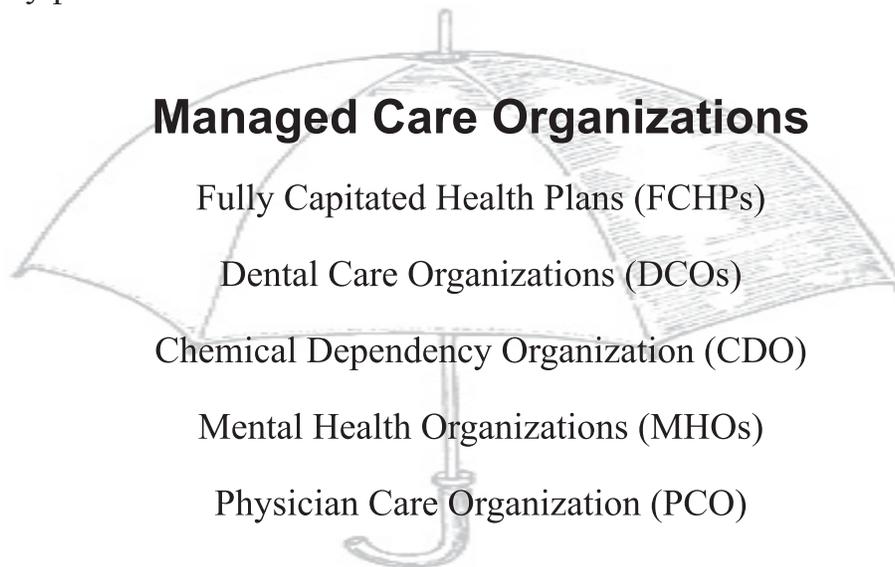
OHP benefits generally *do not* cover:

- ❖ Conditions that get better on their own (such as viral sore throat).
- ❖ Conditions for which home treatment works (such as food poisoning, sprains).
- ❖ Cosmetic procedures (such as scar removal).
- ❖ “Conditions for which treatment is generally ineffective,” such as aggressive treatment of some advanced cancers (see page 3, Blueprint Objectives).

Service delivery—managed care

Most OHP Medicaid clients receive their care through managed care organizations and a primary care practitioner who is a member of the plan. This service delivery system is in direct response to the original Blueprint Objective, “Emphasizing managed care, preventive care, early intervention, and primary care.” Other clients have a Primary Care Manager (PCM) or receive care on a fee-for-service (FFS) basis.

The OHP currently offers several types of organizations under the umbrella term, Managed Care Organizations (MCOs). Managed care organizations contract with DHS to provide physical, dental, mental health, and/or chemical dependency services for OHP clients. OMAP pays these plans a monthly fee for each enrolled person (*i.e.*, a capitation fee) for the services they provide.



Which plan (or plans) people belong to depends on the types of managed care available in their communities. When MCOs have the capacity to handle everyone who is eligible in a given area, clients generally must choose one of those plans. A few exceptions are made, however, and PCMs also play a role in areas where there are managed care organizations.

A provider may belong to more than one MCO and be enrolled as a PCM for Medicaid patients not enrolled in a plan. For plan distribution, see next page.

Fully Capitated Health Plans (FCHPs)

Like health maintenance organizations (HMOs), FCHPs receive a monthly fee to provide managed physical health services to clients. FCHPs manage each member’s care, from routine office visits to hospitalization or treatment by specialists. In Deschutes County, contracted FCHPs additionally provide chemical dependency services.

Wherever possible, OHP enrolls clients in FCHPs as the best means of controlling costs of health care. OMAP’s current goal is to enroll 80 percent of OHP clients in managed care.

Managed Care Organizations by County – May 2006

County	MHO	DCO	FCHP/PCO
Baker	1	2	1
Benton	1	4	1
Clackamas**	2	6	5
Clatsop	1	3	1
Columbia	1	4	1
Coos	1	3	2
Crook	1	3	1
Curry	1	1	0
Deschutes*	1	4	1
Douglas	1	3	4
Gilliam	1	1	0
Grant	1	2	1
Harney	1	2	1
Hood River	1	3	1
Jackson	1	5	4
Jefferson	1	3	1
Josephine	1	4	3
Klamath	1	3	3
Lake	1	2	1
Lane	1	5	1
Lincoln	1	3	0
Linn	1	4	3
Malheur	1	2	0
Marion**	1	4	3
Morrow	1	2	2
Multnomah**	2	6	4
Polk**	1	4	3
Sherman	1	2	1
Tillamook	1	3	0
Umatilla	1	3	2
Union	1	2	0
Wallowa	1	1	0
Wasco	1	4	1
Washington	3	6	4
Wheeler	1	2	1
Yamhill	1	4	3

* Deschutes County also has 1 CDO.

**Clackamas, Marion, Multnomah, and Polk Counties each have 1 PCO.

Dental Care Organizations (DCOs)

DCOs receive a monthly fee to provide managed dental care services to clients.

Chemical Dependency Organization (CDO)

One CDO receives a monthly fee to provide managed chemical dependency services to clients in Deschutes County.

Mental Health Organizations (MHOs)

The DHS Office of Mental Health and Addiction Services (OMHAS) contracts with three types of MHOs to deliver mental health services under the OHP's Medicaid program:

- ❖ **Fully Capitated Health Plans** that receive a monthly fee to provide managed mental health services.
- ❖ **County or regional governmental organizations** that operate or contract for community mental health services.
- ❖ **Private Mental Health Organizations** selected by OMHAS.

Physician Care Organization (PCO)

One PCO receives a monthly fee to provide managed physical health care services and chemical dependency services to clients. Unlike the FCHP, it is not capitated for inpatient hospital services. PCO members receive inpatient hospital care on a fee-for-service basis.

Primary Care Managers (PCMs)

In areas where there are not enough FCHPs to handle the client load, and for other reasons, OMAP contracts with physicians, physician assistants, nurse practitioners and naturopathic physicians to serve as primary care managers (PCMs). PCMs receive a monthly fee to manage each client's health care, and bill OMAP on a fee-for-service basis for care. Rural Health Clinics, Tribal Health Clinics, County Health Departments, and similar organizations may also serve as PCMs. At least one PCM serves every Oregon county.

Payment for services

Although payment is still on a fee-for-service basis in some instances, the OHP depends on managed care organizations to ensure more reasonable reimbursement rates to providers. This is an attempt to avoid shifting the cost of Medicaid onto other health care consumers as prescribed in the Blueprint Objectives.

The Prioritized List of Health Services determines which services the OHP may cover. Once a patient's condition has been diagnosed and a course of treatment proposed, providers must use the List to find out whether the condition and treatment fall between Line 1 and the currently funded line number.

Managed care organizations and fee-for-service providers can choose to provide services beyond the currently funded line and bill the client. As long as the member is informed in advance and has agreed to this arrangement, this is an option.

Insurance Reforms

As stated in the Blueprint Objectives, the OHP is also responsible for insurance reform. This charge resulted in expanding the health care coverage resources available to Oregonians, as listed below.

Oregon Medical Insurance Pool (OMIP)

The Oregon Medical Insurance Pool (OMIP) is a “high risk pool.” It addresses the Blueprint Objective, “Health insurance for individuals who have been denied coverage for medical reasons.” The following information comes from OMIP’s Web site <<http://www.omip.state.or.us>>.

A component of the OHP and part of Oregon’s Department of Consumer and Business Services, OMIP provides medical insurance coverage for all Oregonians who are unable to obtain medical insurance because of health conditions. OMIP also provides health insurance portability coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them. In addition, OMIP also offers coverage for individuals who have been affected by competition from foreign trade, and are eligible to receive a federal tax credit under Section 35 of the Internal Revenue Code.

OMIP is a “high risk pool” of insurance for individuals who have been denied coverage for medical reasons.

The 1987 Legislature established the program, and OMIP issued its first policy in July 1990. Since issuing its first policy, OMIP has insured more than 30,000 Oregonians who otherwise would have had no health care coverage. A citizen board of directors guides policy for the program. Regence BlueCross BlueShield of Oregon is OMIP’s administering insurer and handles eligibility, enrollment, member services, and claims processing.

OMIP has four Preferred Provider Organization (PPO) medical plans from which enrollees may choose. They differ primarily by the medical deductible amount, the maximum out of pocket expenses, and the coinsurance amounts.

As of 2003, OMIP has insured more than 30,000 Oregonians who otherwise would have had no health care coverage.

The premiums that OMIP enrollees pay actually cover only about 60 percent of the medical and drug claims costs in the program. The commercial insurance companies that conduct business in Oregon pay a special fee to OMIP to cover the remaining 40 percent.

For individuals who enroll because they meet the medical eligibility criteria, the premiums are higher than those charged by the commercial insurance carriers for similar individual health care coverage. For individuals who use OMIP as their portability

coverage option, the premiums are an approximate average of what the commercial carriers charge for their portability products in Oregon.

Individuals who enroll themselves or family members in an OMIP Plan must have the financial resources to pay the premiums. The program does not subsidize premiums or reduce them according to an individual's ability to pay.

Some lower-income people who are eligible for OMIP and who have not had health insurance coverage for at least six months may also be eligible for premium subsidy assistance from the Family Health Insurance Assistance Program (FHIAP). Otherwise, OMIP expects the enrollees to pay the full premiums each month to continue coverage.

Small employer health insurance (SEHI) reform

OHP created two voluntary group insurance plans available to small employers.

Small employers have found it particularly difficult to purchase health insurance. In order to address the Blueprint Objective requesting “two voluntary group insurance plans available to small employers,” the Legislature established the Small Employer Health Insurance (SEHI) Reform law of 1991.

To address the problems of small employers in obtaining group policies, SEHI reforms:

- ❖ Created the guaranteed issue Basic Health Benefit Plan. The Basic plan is accessible to all companies employing two to 50 people. Any insurance company in Oregon's small business market must offer this “basic” plan, and no employer in that category may be refused. The plan's benefits are “substantially similar” to the original OHP Basic Health Care Package, and include mental health and alcohol and chemical dependency benefits.
- ❖ Limited denial of benefits due to preexisting medical conditions and excluded pregnancy from the definition of preexisting conditions.
- ❖ Outlawed “selective cancellation” of policies, even for individuals who develop high-risk conditions.
- ❖ Controlled premium rates. Rates for new businesses must be within 33 percent of the midpoint in a geographic area; on renewals, the carrier must be within the approved annual trend (usually about 12 percent) plus 15 percent—*e.g.*, a small employer could receive up to a 27 percent increase annually, based on the group's claims experience. After October 1, 1996, the rate for both new and renewal policies is based solely on the group's composite age.

The [Department of Insurance and Finance](#) (now Department of Consumer and Business Services) approved the basic plan, and it went on sale March 1, 1993.

Office of Private Health Partnerships (OPHP)

The 1987 Oregon Legislature created the Insurance Pool Governing Board (IPGB) to help all Oregonians gain access to health care coverage. The 2005 Oregon Legislature renamed the Board the Office of Private Health Partnerships (OPHP).

In 1989, OPHP began certifying low-cost health insurance plans for uninsured small businesses and the self-employed. OPHP-certified plan enrollment peaked in 1996 at over 33,000 and eventually served over 60,000 Oregonians.

Thanks to increased insurance market reforms, the need for OPHP-certified plans decreased. The regular Small Employer Health Insurance (SEHI) market offered insurance plans that fit both the insurance needs and budgets of small businesses. Because of this, the 1999 Oregon Legislature removed the certified plan function of the OPHP. The OPHP then focused on providing resources to help small businesses and the self-employed obtain health insurance for themselves, their employees, and the employees' dependents (SB 414).

OPHP-certified plan enrollment peaked in 1996 at over 33,000 and eventually served over 60,000 Oregonians.

OPHP began working with insurance agents and carriers to develop a transition plan for the certified plan policyholders. The policyholders received information from the OPHP and their insurance carrier about their options in mid-1999, and moved to their new plan by either January 1, 2000, or July 1, 2000, depending on their carrier.

Since that time, insurance market pressures have made it increasingly difficult for small businesses to afford health insurance. Rising health care costs and double-digit premium rate increases have forced many employers to pass along these increases to employees or drop health care coverage altogether. HB 2537, passed in the 2003 Legislative Session, directed the OPHP to develop affordable plans for small, uninsured businesses and then contract with carriers to offer those plans across the state. These new OPHP-certified plans became available March 1, 2005.

Family Health Insurance Assistance Program (FHIAP)

FHIAP subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums.

OPHP administers the Family Health Insurance Assistance Program (FHIAP). FHIAP further satisfied the Blueprint Objective that asked for “reforms to make insurance more available and affordable.” It helps Oregon families afford the protection and benefits of a health insurance plan.

FHIAP subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums. This helps families and individuals obtain health insurance, maybe for the first time ever. Oregon voters in 1996 approved an additional 30-cent cigarette tax to increase OHP funding and pay for the new FHIAP program. FHIAP is currently a General Fund agency.

PERCENT OF FEDERAL POVERTY LEVEL (FPL)	AMOUNT OF FHIAP SUBSIDY
0 up to 125 percent FPL	95 percent
125 up to 150 percent	90 percent
150 up to 170 percent	70 percent
170 up to 185 percent	50 percent

In 2001, HB 2519 directed the State to seek waivers to receive federal matching funds for FHIAP. CMS approved the waivers on October 15, 2002, and FHIAP implemented the waivers beginning November 1, 2002. Since then, FHIAP new enrollments have qualified for either CHIP or Medicaid match rates. These savings will help fund expansion of FHIAP over the five-year demonstration period.

Employer Mandate

Full implementation of the Medicaid expansion and OMIP would still leave more than 400,000 people uninsured, most of them workers and their dependents. Part of the 1989 legislative package that created OHP was an “employer mandate” that would have required all employers to offer their “permanent” workers insurance via the “play or pay option,” beginning in July 1995:

- ❖ *Play:* Offer group health insurance.
- ❖ *Pay:* Pay into a statewide insurance pool through a payroll tax.

The mandate defined a permanent employee as one who is not seasonal or temporary and who works at least 17.5 hours per week. Small employers received tax credits for voluntary coverage before July 1995. Implementation of the mandate would have resulted in health care coverage for an estimated 165,000 additional Oregonians.

The employer mandate was **repealed** January 2, 1996, because Oregon did not receive federal exemptions.

The 1993 Legislature delayed implementation until March 31, 1997, for businesses employing 26 or more; and to January 1, 1998, for those with 25 or fewer employees. To implement, Oregon needed to receive Congressional exemption to the federal Employee Retirement Income Security Act (ERISA) by January 2, 1996. However, because it didn’t occur by the deadline, the employer mandate was repealed.

Office for Oregon Health Policy and Research

In 1993, the Legislature created the Office of the Oregon Health Plan Administrator. In 1995, the Legislature transferred the Office of Health Policy to the Office of the Health Plan Administrator to create one focal point for health policy and reform in the state.

In addition to coordination and oversight responsibilities for OHP, the Office for Oregon Health Policy and Research (renamed in 2001) provides support for the following bodies that prioritize health services, advise the Governor and Legislature on health care policy, conduct medical technology assessments, and advise both OHP and DHS regarding medical services to be provided under the OHP, and how the OHP is administered.

The OHP Web site has information on the three Commissions, the Medicaid Advisory Committee, legislative history, and other related topics. Its Web address is <<http://www.oregon.gov/DAS/OHPPR/index.shtml>>.

Health Services Commission (HSC)

The following information is adapted from the HSC Web site <<http://www.oregon.gov/DAS/OHPPR/HSC/index.shtml>>.

The HSC is responsible for creating and maintaining the Prioritized List of Health Services, ranking services from the most important to the least important, representing the comparative benefits of each service to the entire population to be served.

The HSC is responsible for creating and maintaining the Prioritized List of Health Services, ranking services from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The list is accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services.

The Commission is composed of eleven members. There are five physicians, including one Doctor of Osteopathy, four consumer representatives, a public health nurse, and a social worker. Commission members also chair subcommittees, task forces and workgroups that provide input. If appropriate, these groups may include representatives of specialty-specific providers, consumers, and advocacy groups within the area of interest.

The HSC performs a Biennial Review of the Prioritized List of Health Services, which is completed prior to each legislative session according to the Commission's established methodology. Based on the HSC report, the Legislature determines the funding line on the List, and advises the Governor accordingly.

The Commission also performs Interim Modifications to the Prioritized List that consist of:

- ❖ Technical Changes due to errors, omissions, and changes in ICD-9-CM, or CPT-4, HCPCS, or CDT-4 codes; and,
- ❖ Advancements in Medical Technology that necessitate changes to the List prior to the next biennial review.

Oregon Health Policy Commission

The 2003 Legislature abolished the Oregon Health Council and established the [Oregon Health Policy Commission](#) in its place, effective January 1, 2004. According to SB 3653, in addition to previous OHC duties, the new commission will serve as the policy-making body responsible for health policy and planning for the state. They are directed to:

The Commission serves as the policy-making body responsible for health policy and planning for the state.

- ❖ Develop a plan for and monitor the implementation of state health policy.
- ❖ Act as the policy-making body for a statewide data clearinghouse established within OHPR for the acquisition, compilation, correlation and dissemination of data from health care providers, other state and local agencies including the state Medicaid program, third-party payers and other appropriate sources.
- ❖ Review reports on such findings, trends and long-term implications.
- ❖ Provide a forum for discussion of health care issues facing the citizens of the state.
- ❖ Identify and analyze significant health care issues affecting the state and make policy recommendations to the Governor.
- ❖ Prepare and submit to the Governor and the Legislative Assembly resolutions relating to health policy and health care reform.
- ❖ Review state Medicaid Plan amendments, modifications in operational protocols, applications for waivers to CMS proposed by DHS, and administrative rules for the state's medical assistance programs and other health care programs.
- ❖ Act as primary advisory committee to OHPR, the Governor, and the Legislative Assembly.

Health Resources Commission (HRC)

The following information is taken from the HRC Web site <<http://www.oregon.gov/DAS/OHPPR/HRC/index.shtml>>.

The Commission's role is to encourage the rational and appropriate allocation and use of medical technology in Oregon.

The HRC is a component of the Oregon Health Plan to help it achieve its goal of ensuring all Oregonians access to high-quality, effective health care at an affordable cost, whether that care is purchased by the state or by the private sector.

The Commission's role is to encourage the rational and appropriate allocation and use of medical technology in Oregon. It does this by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians.

Through its activities, the Commission can contribute to reducing the cost and improving the effectiveness of health care, thereby increasing the ability of public and private sources to provide more Oregonians with financial access to that care.

Medicaid Advisory Committee (MAC)

The Committee advises on the operation and administration of the Oregon Health Plan, as well as the medical care to be provided under the OHP.

The following information is taken from the MAC Web site <<http://www.oregon.gov/DAS/OHPPR/MAC/MACwelcomepage.shtml>>.

The Medicaid Advisory Committee (MAC) is a federally-mandated body which advises the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, and the Department of Human Services on the operation of the OHP. The MAC develops policy recommendations at the request of the Governor and the Legislature.

The MAC is also mandated to advise on medical care, including mental health and alcohol and drug treatment and remedial care, to be provided under the OHP.

Acronyms

CAF	<u>C</u> hildren, <u>A</u> dults and <u>F</u> amilies is a cluster within DHS that provides specialized case management services to eligible families.
CDO	<u>C</u> hemical <u>D</u> ependency <u>O</u> rganization
CHIP	<u>C</u> hildren's <u>H</u> ealth <u>I</u> nsurance <u>P</u> rogram
CMS	<u>C</u> enters for <u>M</u> edicare and <u>M</u> edicaid <u>S</u> ervices, formerly called HCFA
COBRA	<u>C</u> onsolidated <u>O</u> mnibus <u>B</u> udget <u>R</u> econciliation <u>A</u> ct of 1985.
DCO	<u>D</u> ental <u>C</u> are <u>O</u> rganization
DHS	Oregon's <u>D</u> eartment of <u>H</u> uman <u>S</u> ervices
ERISA	<u>E</u> mployee <u>R</u> etirement <u>I</u> ncome <u>S</u> ecurity <u>A</u> ct is federal legislation.
FCHP	<u>F</u> ully <u>C</u> apitated <u>H</u> ealth <u>P</u> lan.
FFS	<u>F</u> ee- <u>f</u> or- <u>s</u> ervice is a billing method for services not covered by a capitated plan.
FHIAP	<u>F</u> amily <u>H</u> ealth <u>I</u> nsurance <u>A</u> ssistance <u>P</u> rogram
FPL	<u>F</u> ederal <u>P</u> overty <u>L</u> evel
HCFA	<u>H</u> ealth <u>C</u> are <u>F</u> inancing <u>A</u> dministration is the former name for CMS.
HIPAA	The <u>H</u> ealth <u>I</u> nsurance <u>P</u> ortability and <u>A</u> ccountability <u>A</u> ct is a comprehensive privacy protection law.
HMO	A <u>H</u> ealth <u>M</u> aintenance <u>O</u> rganization is a type of managed care plan. Generally, HMOs have a select list of providers, a limited choice of hospitals, and an emphasis on preventive care.
HPC	<u>H</u> ealth <u>P</u> olicy <u>C</u> ommission
HRC	<u>H</u> ealth <u>R</u> esources <u>C</u> ommission
HSC	<u>H</u> ealth <u>S</u> ervices <u>C</u> ommission
IPGB	<u>I</u> nsurance <u>P</u> ool <u>G</u> overning <u>B</u> oard (now OPHP).
LTC	<u>L</u> ong- <u>t</u> erm <u>c</u> are
MAC	<u>M</u> edicaid <u>A</u> dvisory <u>C</u> ommittee
MCO	<u>M</u> anaged <u>C</u> are <u>O</u> rganization
MHO	<u>M</u> ental <u>H</u> ealth <u>O</u> rganization
OHC	<u>O</u> regon <u>H</u> ealth <u>C</u> ouncil, former name for the Health Policy Commission.

OHP	<u>O</u> regon <u>H</u> ealth <u>P</u> lan
OHPR	Office for <u>O</u> regon <u>H</u> ealth <u>P</u> olicy and <u>R</u> esearch
OMAP	<u>O</u> ffice of <u>M</u> edical <u>A</u> ssistance <u>P</u> rograms
OMHAS	<u>O</u> ffice of <u>M</u> ental <u>H</u> ealth and <u>A</u> ddiction <u>S</u> ervices
OMIP	<u>O</u> regon <u>M</u> edical <u>I</u> nsurance <u>P</u> ool
OPHP	<u>O</u> ffice of <u>P</u> rivate <u>H</u> ealth <u>P</u> artnerships (formerly IPGB)
PCM	<u>P</u> rimary <u>C</u> are <u>M</u> anager
PCO	<u>P</u> hysician <u>C</u> are <u>O</u> rganization
SCHIP	<u>S</u> tate <u>C</u> hildren’s <u>H</u> ealth <u>I</u> nsurance <u>P</u> rogram, known in Oregon as CHIP
SPD	<u>S</u> eniors and <u>P</u> eople with <u>D</u> isabilities is a cluster within DHS that provides specialized case management services to those clients.
SSA	<u>S</u> ocial <u>S</u> ecurity <u>A</u> dministration
SSI	<u>S</u> upplemental <u>S</u> ecurity <u>I</u> ncome is for low-income people who are aged, blind or have disabilities as determined by SSA. Oregonians on SSI are automatically eligible for OHP Plus coverage (OHP with Limited Drug coverage for Medicare-Medicaid dual eligibles).

For more information

The Oregon Health Plan: An Historical Overview

http://www.oregon.gov/DHS/healthplan/data_pubs/main.shtml

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Salem, OR 97301-1077
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800-527-5772

Legislative bills & Oregon Revised Statutes (ORS)

<http://www.leg.state.or.us/billsset.htm>

Capitol Bill Room
(503) 528-8891

Oregon Administrative Rules (OARs) for Medical Assistance Programs

http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_tofc.html

Prioritized List of Health Services

<http://www.oregon.gov/DAS/OHPPR/HSC/index.shtml>

Oregon Health Plan Applications

OHP Application Center
800-359-9517 or TTY 800-621-5260.

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