# WAIVER WATCH ISSUE BRIEF #3: OREGON HEALTH PLAN 2

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# OREGON HEALTH PLAN 2

## Overview

On October 15th, 2002, after a long process that included many stops and starts, the state of Oregon received federal approval for a combined Health Insurance Flexibility and Accountability (HIFA) and Medicaid 1115 waiver—dubbed Oregon Health Plan 2 (OHP2). Ostensibly, HIFA waivers are meant to expand coverage for the uninsured, but some states have used them to reduce coverage for existing enrollees while offering at most nominal expansions.[i] While Oregon touts its new waiver as an expansion that will cover more than 65,000 additional people, its primary immediate effect will be to impose new costs on 127,000 current low income enrollees of the Oregon Health Plan while giving the state the flexibility to further increase costs and reduce benefits in the future.[ii] Specifically the OHP2 waiver gives the state permission to

- Impose substantial levels of cost sharing for certain currently eligible beneficiaries –childless adults and parents of SCHIP enrollees.
- Create a new, more stringent approach to premium collection that is likely to force some current enrollees to drop coverage
- Cap enrollment -- i.e. abrogate the entitlement to coverage -- for childless adults, a population not traditionally eligible for Medicaid, and also for parents with incomes as low as 52% of the federal poverty level (FPL).
- Further reduce benefits or raise premiums to meet expenditure targets--in other words, placing the entire risk of rising health care costs on low income uninsured people.

Enrollment expansion under OHP2 is likely to fall short of projections because the state makes a number of improbable assumptions, including that there will be no decline in enrollment as a result of higher cost sharing and new premium collection rules. It also assumes that group insurance enrollment in FHIAP, a publicly subsidized private insurance program, will increase by over 1900%—accounting for over half of the total expansion. Finally, reaching the expansion target is explicitly dependent on the availability of state funds and Oregon is in the midst of a budget crisis.[iii]

In addition, as a result of the OHP2 waiver:

- Hospitals, physicians and other health care providers are likely to incur new uncompensated care costs on as a result of higher cost-sharing requirements;
- Some low-income children are likely to receive less comprehensive coverage or lose coverage altogether as a side-effect of their parents losing coverage or enrolling in less comprehensive private insurance plans;
- There will be a shift in the patterns of care delivery to less clinically appropriate and cost effective settings as co-payments induce people to avoid seeking care appropriately.

**Eligibility for Oregon's Public Insurance Programs**

The Oregon waiver proposes an increase in eligibility for children and pregnant women from the current 170%FPL to 185% and no change for seniors. Coverage for other adults is nominally expanded from 100% to 185% FPL -- $16,391 for an individual—but there many caveats to this expansion.

Enrollment in the Oregon Health Plan is initially increased only to 110% FPL, extending eligibility to only an estimated 11,700 additional adults.[iv] (Although this expansion has already been delayed based on lack of funding[v] As discussed below (see p 9), eligibility for subsidies of employer sponsored insurance is extended to 185% FPL from the outset, but only a small percentage of the low income uninsured actually have access to employer based coverage. (Eligibility, benefits and cost sharing requirements for the new plan are summarized in Tables 1 and 2 below)

**Financing**

The federal share of financing relies largely on reprogramming unspent SCHIP funds (although Oregon has not extended coverage to children up to 200% FPL, the primary target for SCHIP). The state share of funding is supposed to come from increased cost sharing and reduction of benefits for certain current OHP enrollees, i.e. parents of SCHIP recipients and other low-income adults.

Cost sharing requirements include increases in co-payments for physician visits and prescription drugs, a $50 co-payment for ambulance service (which could induce people to delay calling an ambulance in an emergency) and a $250 per admission co-payment for hospitals.

There is no overall limit on out of pocket costs. Overall, the new benefit level is set at 78% of the current level for these recipients. The state has also obtained permission to reduce benefits still further, to 56% of the current level, if necessary to meet budget targets. (Note that in this case, "budget targets refers to undefined levels of state spending rather than to federal budget neutrality)

The tables below summarize eligibility for Oregon's current medical assistance programs and show how that will change under the new waiver. They also compare cost sharing requirements under the current OHP to be renamed OHP Plus and the new OHP Standard.

Table 1: Eligibility for Oregon Medical Assistance Programs

| **Population** | **Current Income Standard** | **Proposed Changes** |
|---|---|---|
| Children and Pregnant Women | 170% FPL | 185% FPL |
| Parents | 100% FPL | 110% initially, 185% FPL contingent on private sector enrollment and availability of state funds |
| Elderly and Disabled | 100% FPL | No Change |
| Adults w/o dependent children | 100% FPL | 110% initially, 185% FPL contingent on private sector enrollment and availability of state funds |

170% FPL for a family of three is $25,534
185 % FPL for a family of three is $27,787
100% FPL for an individual is $8,860, for a couple is $11,940 and for a family of three is $15,020
110% FPL for an individual is $9,746, for a couple is $13,134 and for a family of three is $16,522

**Table 2: Comparison of Benefits and Cost Sharing Under OHP Plus and OHP Standard***

| Benefit | OHP Plus Cost Sharing | OHP Standard |
|---|---|---|
| Physician services | $3 | $5 for office visits<br>$3-10 for in-office procedures |
| Urgent care | $3 | $3 |
| Ambulance | No co-pay | $50 |
| Emergency room | No co-pay | $50 (waived if admitted) |
| Lab and x-ray | No co-pay | $3 |
| Vision | No co-pay | Not covered |
| Prescription drugs | $2 for generic, $3 brand name | $2-5 generic**<br>$3-10 cancer and HIV brand<br>$15-$25 other brand |
| Out-of-pocket maximum | | $500 per year |
| In-patient | No co-pay | $250 per admission |
| out-patient hospital services | | $20 for out-patient surgery; $5 for other services |
| Specialty care | $3 | $3 |
| Mental health and substance abuse treatment | $3 | $5 copayment |

*OHP Plus covers children and pregnant women with incomes below 185% FPL (see previous page) and parents with income less than or equal to the cash assistance level of 52% FPL. OHP Standard is for parents with incomes above 52% FPL and non-parent adults

**Lower level of copayments applies to those with income below 100% FPL

Another way to look at the effect of cost sharing is to look at the out-of-pocket costs associated with a particular medical condition or episode of care. For example, the estimated cost for treatment of non-Hodgkins Lymphoma would be 25% of the gross monthly income of a person living at 150% of the poverty (about $1,100 per month)[vi]

**Premiums and Affordability**

Continuing current policy, premiums will be charged to even some of the lowest income OHP enrollees, those with incomes below 10% FPL. At the bottom of the income scale, proposed premiums actually exceed income. In the middle of the scale, 50-100% FPL (as low as $4430 for an individual), premiums are generally around 3% of income for individuals and 4-6% of income for couples. At these income levels, premiums of this magnitude are likely to significantly suppress enrollment. [vii] These relatively high premiums partially explain why over 100,000 low-income adults who are eligible for OHP are not enrolled.[viii]

Should Oregon actually extend eligibility at the upper end of the income scale, to above 150% FPL as it is permitted to do by the terms of the waiver, premiums as a percentage of income increase sharply, ranging from about 7-15% of income. This undoubtedly will reduce participation among people in this income group (see table below).

**Proposed premiums per person and as a percentage of income**

| Percent FPL | Monthly Premium Per Person | % Income Individual | % Income Couple |
|---|---|---|---|
| 100-125% | $23 | 2.5-3% | 4-5% |
| 125-150% | $35 | 3.2-3.8% | 4.7-5.6% |
| 150-170% | $75 | 6-6.7% | 8.9-10% |
| 170-185% | $125 | 9-10% | 14-15% |

**Role of Private Insurance—FHIAP**

A central component of the OHP2 waiver proposal is expansion of the Family Health Insurance Assistance Program (FHIAP). Currently FHIAP serves about 3500 people. Almost 85% of enrollees are in the medically underwritten non-group market. FHIAP is 100% state funded and there is a waiting list of 20,000 people. The income eligibility ceiling for FHIAP is 170% FPL, with a proposed increase to 185%. The asset limit is $10,000. To be eligible for FHIAP a person must have been uninsured for at least six months.

The OHP2 waiver provides federal matching funds for FHIAP and proposes to expand enrollment by up to 25,000, with the bulk of the enrollment in employer-sponsored insurance (ESI). After the initial target of 9,500 additional group enrollees is met, enrollment in non-group insurance will be opened with the limitation that spending on non-group subsidies not exceed spending for group insurance subsidies.

From a beneficiaries' point of view, there are some disadvantages to FHIAP relative to OHP. In particular, permissible cost-sharing in FHIAP substantially exceeds even the higher cost-sharing requirements of OHP Standard, including a $500 deductible and no limit on cost sharing for services up to a $2,500 per person out of pocket maximum (Although permissible cost-sharing in OHP Standard is generally lower than FHIAP, there is no out-of-pocket maximum). There is a separate cost-sharing arrangement for prescription drugs—up to 25% per prescription with no out-of-pocket maximum. For covered services, plans may include caps or limits on the duration and scope of benefits. In addition the OHP2 waiver gives Oregon permission to enroll children in FHIAP who would otherwise be eligible for OHP Plus benefits without providing the additional services and reduced cost-sharing in the OHP Plus package on a wrap-around basis. This provision means that some children will not be covered by the Medicaid requirement to provide children access to any Medicaid reimbursable service they require (Early Periodic Screening Diagnosis and Treatment or EPSDT requirement).

Notwithstanding these disadvantages, FHIAP gets favorable treatment relative to the OHP expansion:

- FHIAP eligibility is raised to 185% FPL, while for OHP enrollees, expansion to that income level is contingent on hitting the FHIAP enrollment target and the availability of state funds.
- FHIAP enrollees are allowed a higher asset limit $10,000 versus $2000 or $5000 for OHP Standard or Plus.
- Premiums as a percentage of income are much lower in FHIAP (although benefits are less comprehensive and cost sharing is higher). For example, an individual at 185% FPL pays only ½ what he/she would pay for OHP; at 100% FPL, the premium is less than 1/3 of what OHP charges (Assuming a $3,000 policy with the employer contributing a 50% share. If the employer contributes more, FHIAP cost relative to OHP is even lower).
- FHIAP eligibility is for 12 months, while OHP determinations are valid for only six months.
- The FHIAP application process is always open. If there is no opening, an applicant is placed on waiting list. For those eligible for OHP Standard, not only is the Medicaid entitlement eliminated, but there is not even right to apply. No waiting list is kept.
- If FHIAP enrollment is open, a person eligible for both FHIAP and OHP Standard must enroll in FHIAP (certain children and pregnant women are exempt from this requirement)

**Policy and Politics**

The OHP2 waiver followed a somewhat tortuous political path but in the end, despite the concerns raised by advocates and a dispute between Governor John Kitzhaber and the Republican-controlled legislature that almost derailed the process entirely, remarkably few changes emerged.[ix] Governor Kitzhaber presented the design of the OHP2 waiver as the only alternative to a dramatic scaling back of eligibility in the OHP and his vision carried the day.[x]

Throughout the process, advocates for low-income people raised significant concerns about the proposed waiver design, including the effect of new premium enforcement rules, the effect of allowing providers to deny services for failure to make co-payments, the new cost-sharing requirements, the enrollment caps, the use of tax dollars to subsidize discriminatory medically underwritten non-group plans and the potential loss of coverage for children—many of the issues raised in this paper.[xi] However, the parameters of the debate were largely set between the Governor and the legislature. The concerns of advocates were essentially brushed aside.

The waiver submitted to CMS tracks the legislation closely, but certain provisions of the legislation were adhered to more closely than others. For example, section 3(4) of the authorizing legislation states that subsidies should be based on an individual's ability to pay. However, as noted above, higher income FHIAP enrollees receive

deeper subsidies than do people with comparable or lesser incomes who are enrolled in OHP Standard.[xii] The legislation also calls for the differences in the Standard and Plus populations to be based on medical need, but in reality the differences are based on the state's desire to constrain spending and its ability to impose more limits on "non-categorically eligible" enrollees regardless of their medical needs.

## Discussion

**Fuzzy Math**
In his letter to HHS Secretary Tommy Thompson, Oregon governor John Kitzhaber claims that the OHP2 waiver will increase the number of Oregonians served by approximately 65,000. Detailed projections in the budget neutrality section of the waiver request show 69,000 people being covered. [xiii] Of the 69,000 people to be covered under OHP2:

- 3,400 are existing FHIAP enrollees for whom the state does not now receive federal match
- 22,000 are currently eligible but not enrolled// and so could, in theory be served even without the new waiver (These people are to be brought in through an enhanced outreach effort that is unlikely to materialize given the state of the Oregon budget)
- 25,000 are new FHIAP enrollees of which 19,500 are to be group enrollees and 5,500 non-group, with new enrollment in non-group contingent on an initial increase of over 9,000 in group coverage and full enrollment dependent on group enrollment surpassing 16,000.
- 16,400 are new OHP Standard (a target that would only be reached if the state extends enrollment to 185% FPL)
- 2,400 children and pregnant women between 170-185% FPL

However, a close analysis of these projections suggests that the OHP2 Waiver will actually extend coverage to far fewer people. The 3,400 current FHIAP enrollees are already covered and so are not properly counted as an expansion under the waiver. Similarly, no waiver is needed to conduct outreach to those currently eligible but unenrolled. In addition there is reason to be skeptical that there will be 22,000 new enrollees in this category. First, the state fiscal crisis calls into question whether new outreach efforts will actually be undertaken. Second, given new premium enforcement requirements, it is likely that some current enrollees will be forced off the program. Currently, people with an unpaid premium balance can request an amnesty at the time of their eligibility renewal and premiums can be waived for certain groups, e.g. the homeless. Under new rules exceptions will be eliminated and those not paying their premiums will be barred from re-entry into OHP for six months. This change is more likely to increase the number who are income eligible but uninsured than to reduce this number and will create significant new unmet medical need.

**FHIAP: If you build it, will they come?**
Although the entire OHP2 expansion is largely contingent on expanding group coverage enrollment in FHIAP, there is some reason to be skeptical of these enrollment targets as well. The target enrollment group—low-income uninsured adults that have access to employer sponsored insurance—comprise a very small portion of the low-income uninsured population. Of the roughly 190,000 low income uninsured adults, only 30-35 thousand are eligible for employer sponsored insurance, or about 17%.[xiv]

The performance of FHIAP to date gives further reason to doubt that enrollment targets will ever be met. Currently, FHIAP covers about 3,400 people, fewer than 500 of whom are enrolled in employer-sponsored coverage. The OHP2 waiver proposal initially opens enrollment only in the group market until enrollment there reaches 9,500. This would require an increase of roughly 1900% above the current level. Finally, the modest enrollment in other states that have undertaken premium assistance programs is a further reason to view FHIAP enrollment projections cautiously.

**Lack of Funds will Limit OHP Enrollment**
Most of the remaining enrollment expansion is anticipated in OHP Standard as a result of increasing eligibility to 185% FPL. This part of the expansion is contingent on the availability of state funds. However, state funds may be unavailable due to overestimates of the savings produced by cost sharing and more importantly because the state is in the midst of a severe budget crisis with significant declines in major revenue streams forcing budget retrenchment.[xv]

Assumptions of cost savings for the new OHP Standard population—the group receiving the new, reduced benefit package-- come from three sources—

- Reducing the scope of benefits accounts for 25% of projected savings,
- Increased cost sharing for 42%, and
- Behavioral changes resulting from higher cost sharing for 33%.[xvi]

Missing from the calculations is the likelihood that higher co-payments for physician services and prescription drugs, while reducing utilization for these services, will cause increases in hospital utilization.

Generally, studies looking at the effect of cost-sharing examine middle class insured populations and look at spending within the service category being studied. For example a recent RAND corporation study found that increasing cost sharing for prescription drugs in the commercially insured population did lower costs. The authors cautioned, however, that extreme care needed to be used in the context of designing services for low income people.[xvii] Several studies that have looked at the effect of increasing cost sharing or placing other access barriers in the way of physician and prescription drug utilization found that costs either failed to decline or actually increased[xviii]

Even if cost savings targets are met, or unanticipated savings result from declining enrollment, the state fiscal crisis is likely to place limits on the OHP Standard expansion. In fact, the state has already delayed implementation of the first OHP Standard expansion due to budget constraints.[xix]

In addition to falling short of its coverage goals, the OHP2 Waiver is likely to have other negative consequences, including:

- **Increased barriers to care**
  Several features of the OHP2 Waiver are likely to create new barriers to care for enrollees. First, increased cost sharing will reduce access.[xx] In addition, the state has received permission to allow providers to refuse to provide treatment or other services if the OHP Standard co-pay is not paid (except for emergency services). Medicaid law prohibits the denial of a service for failure to pay a co-payment. Waiving this provision will magnify the effect of higher cost sharing. Furthermore, denial of service to the OHP Standard population will spill over to the OHP Plus group because individuals won't understand their rights and neither will providers. Finally, faced with increased bad debt from OHP enrollees, some providers may elect to opt out of the program altogether, further undermining access to care.

- **Children will lose benefits and coverage**

The state has received permission to allow OHP Plus (Medicaid) eligible children to enroll in FHIAP. This issue is presented as one of parental choice. However, Oregon has also elected not to provide wrap-around coverage for the higher levels of cost sharing and benefits not covered in private plans. As a result children in FHIAP are likely to receive a lesser level of coverage even though they are eligible for more comprehensive care and will not be protected by the EPSDT requirement. Since, the state will collect much less information on utilization from those enrolled in private plans, it will be difficult to track the consequences of this provision. In addition, parents who are shifted to OHP Standard under the new rules and lose coverage because they cannot afford to pay the premium may fail to realize that their children are still eligible. As a result eligible children may become uninsured.

- **Benefits in OHP Standard, which are already low, could sink lower still**

Currently the OHP Standard benefit is set at 78% of the value of OHP Plus, but the state received permission to reduce benefits still further to meet state budget targets (not federal budget neutrality). In fact, effective in 2003, additional cuts are anticipated including further cuts in dental benefits and durable medical equipment for people on OHP Standard. Still more cuts may emerge as part of the SFY 04 budget.[xxi] The proposed floor on benefits is only 56% of the actuarial value of the current OHP benefit package—based on the minimum federal requirements for a Medicaid program which excluded prescription drugs—an option that every state has taken. It is particularly striking that the state has requested the ability to reduce benefits to meet unspecified state budget targets, rather than as a tool to maintain federal budget neutrality.

- **Increased free care and bad debt**

One underlying assumption of the waiver is that free care for hospitals will be reduced as a result of expansion. This is supposed to more than offset the burden of increased cost sharing which falls on providers as well as enrollees. But if new enrollment falls short of projections, or worse, if net coverage declines as a result of increased barriers and decreased enrollment efforts, the result will be an increase, rather than a decline in free care and bad debt.

According to waiver documents, losses to hospitals are projected at nearly $100 million based on the difference in PMPM spending multiplied by the number of enrollees who will be placed on the new benefit package (127,000 enrollees switched from OHP to OHP Standard).[xxii] To offset these losses, enrollment must increase by roughly 35,400. To the extent any of the very low income enrollees of OHP Standard lose coverage through stepped up enforcement of premium collections, (51,000 OHP Standard enrollees have no or nominal income) the amount enrollment must increase to offset the loss to hospitals through reduced benefits must correspondingly increase. Since, as discussed above, new enrollment projections for OHP2 are exceedingly optimistic, increased free care and bad debt are extremely likely. Another factor pointing to increased free care and bad debt expenditures is timing. Reductions in benefits happen immediately while the impact of increased enrollment is gradual, making losses for hospitals all but inevitable in the early years.

- **Delays in seeking treatment appropriately could reduce efficiency and effectiveness of care**

Higher cost sharing may cause people to delay seeking appropriate medical care increasing some costs and shifting utilization to a higher cost pattern with worse outcomes. Therefore, the benefits anticipated from offering primary care coverage may not accrue. This problem could become even worse if provider participation declines.

## Conclusion

The OHP2 waiver offers further indication that CMS is willing to permit purely nominal access expansions in the context of HIFA and that states will use lax requirements on access to craft waivers that are more about cutting spending than improving coverage. The original legislative authorization for the OHP2 waiver was characterized as an expansion, but in the context of the state budget deficit and concern about the cost of the OHP it appears instead to be primarily a vehicle for reducing OHP spending.

The only certain outcome of the waiver is the imposition of new costs on the current low-income enrollees of OHP, leading some to drop coverage and to an increase in unmet need among those who are able to retain coverage. These cuts will occur even if the coverage expansion, the ostensible rationale for CMS approving the cuts, never takes place or falls far short of projections. Even if the coverage expansions somehow do materialize as projected, they will be balanced out by the negative health impact on some of Oregon's most vulnerable residents.

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[i] See Waiver Watch #2, the Utah Primary Care Network available at www.communitycatalyst.org for a description of this type of waiver. For a general discussion of Medicaid waivers see Mann, Cindy, The New Medicaid and CHIP Waiver Initiatives, Kaiser Commission on Medicaid and the Uninsured, February 2002

[ii] Description of the OHP2 waiver is drawn from State of Oregon 1115 Waiver Amendment Application, May 31, 2002

[iii] www.hr.state.or.us/budget/e-board2002_11/omap3.pdf

[iv] Oregon 1115 Waiver Amendment Application, May 31, 2002, op cit, section 11 and author's estimate from Oregon Population Survey cited in Oregon HRSA State Planning Grant, Final Report to the Secretary, October 2001

[v] See www.hr.state.or.us/budget/e-board2002_11/omap3.pdf

[vi] Clincal Vignettes, Office of Oregon Health Policy and Research, June, 2002, www.ohppr.state.or.us/Waiver_Application/index_waiver.htm

[vii] Ku, Leighton and Coughlin, Teresa, Sliding Scale Premium Health Insurance Programs: Four States' Experiences, Inquiry, Winter 1999/2000

[viii] Stoll, Kathleen, The Health Care Safety Net: Millions of Low-Income People Left Uninsured, Families USA, July 2001 and Haber et al, Using Premiums to Finance Care for the Uninsured, Lessons from the Oregon Health Plan, Academy for Health Services Research annual meeting, 2000

[ix] Fogarty, Colin, Is Health Plan Expansion "Effectively" Dead?, Oregon Public Broadcasting, April 23, 2002

[x] Waiver Application Steering Committee Minutes, October 11, 2001

[xi] Testimony of Oregon Health Action Council 3/26/02 and 4/4/02 before the Joint Leadership Commission on Health Care Costs and Trends and Waiver Application Sterring Committee Minutes January 9, 2002.

[xii] House Bill 2519 as approved by the Governor, August 2, 2001

[xiii] Letter from John Kitzhaber to Tommy Thompson, May 31, 2002 and OHP2 waiver application budget neutrality section op cit

[xiv] ibid and Oregon HRSA State Planning Grant, op cit

[xv] State Fiscal Update, National Conference of State Legislatures, June 2002

[xvi] OHP2 Cost Shift Analysis, www.ohppr.state.or.us/Waiver_Application/index_waiver.htm, June 12, 2002

[xvii] RAND news release, October 8 2002, www.rand.org/hot/press.02/rxjama.html, and Joyce et al, Employer Drug Benefit Plans and Spending on Prescription Drugs, JAMA, October 9, 2002

[xviii] Newhouse et al, "Copayments and the Demand for Medical Care", Bell Journal of Economics, Spring 1978; Rassell, "Cost Sharing in Health Insurance—A Reexamination", NEJM, 4/27/95; Tamblyn et al "Adverse Events Associated with Prescription Drug Cost-Sharing Among the Poor and Elderly Persons", Journal of the American Medical Association, Jan 24/31, 01; Soumerai et al, "Payment Restrictions for Prescription Drugs Under Medicaid: Effects on Therapy, Cost and Equity, NEJM 27 August 87.

[xix] www.hr.state.or.us/budget/e-board2002_11/omap3.pdf, op cit

[xx] Newhouse et al, op cit

[xxi] www.hr.state.or.us/budget/e-board2002_11/omap3.pdf

[xxii] OHP2 Cost Shift Analysis, op cit