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THE OREGON HEALTH PLAN – FROM BOOM TO BUST

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In 1993 Oregon received permission from the U.S. Health Care Financing Administration to reform its state Medicaid program through the use of a prioritized list of services. The movement away from market based rationing in favor of rationing services based on shared community values remains a unique experiment in U.S. Medicaid reform. This article explores the politics and policy involved in the development and evolution of the Oregon Health Plan, as well as the challenges to sustaining reform in the face of a financial downturn.

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INTRODUCTION

When it was approved by the U.S. Health Care Financing Administration (HCFA) in March of 1993, the Oregon Health Plan (OHP) and its use of a prioritized list of services represented something entirely new in United States Medicaid reform. In fact, over a decade later Oregon remains the only state to have enacted large-scale systematic rationing of health care services. Throughout the 1990s, the OHP faced mixed predictions, with some suggesting it to be the future of Medicaid and others expressing concern that it was a “dangerous and morally dubious experiment” (Jacobs, et al. 1993). A decade later, none of these predictions have fully come to pass. The legacy of the OHP remains at best an example of a novel idea that was never fully implemented and at worst a shortsighted attempt to expand services without real consideration of Oregon’s financial realities. While the OHP itself may not represent a model for other states to follow, it does impart some valuable lessons for other states to keep in mind when planning their own reforms.

Oregon was one of the first states to receive a federal waiver under Section 1115 of the Social Security Act (SSA) (Bodenheimer 1997a). Section 1115 of the SSA was enacted in 1962 for the purpose of allowing states to establish innovative demonstration and pilot projects as approved by the Secretary of Health and Human Services (The Kaiser Commission 2001). These waivers were intended to encourage states to “demonstrate and evaluate a policy or approach [that] has not been demonstrated on a widespread basis” by allowing states to adopt policies that would otherwise only have been possible through legislative changes (Centers for Medicare & Medicaid Services 2005). These waivers afford states more flexibility than is found under Section 1915b waivers (which relate primarily to managed care) and permitted Oregon to make a major break from the standard Medicaid plan. After an initial rejection in 1992, Oregon received their waiver the following year, and the state set out to restructure Medicaid services in a number of ways, the most notable being rationing services available to enrollees (Oregon Department of Human Services 2006). The event that triggered this dramatic rethinking of Medicaid is generally held to be the death of a seven-year-old boy who was denied a bone marrow transplant under Oregon’s Medicaid program in 1987. In June of 1987, Oregon cut transplantation services from their Medicaid program in response to a budget crisis, and within only a few months, the young boy had died, ostensibly from being denied the life-saving transplant (Sparer 1999). This unfortunate event triggered a series of debates within the Oregon medical and policy communities about what represented a fair and appropriate set of benefits for the Medicaid population. John Kitzhaber, physician and then president of the Oregon Senate, took particular interest in this issue and, when he later became Governor of Oregon, the OHP became one of his platform policy issues (Bodenheimer 1997a).

Faced with increasing public debate regarding Medicaid services, in 1987 then-Governor Neil Goldschmidt appointed a workgroup of health care providers and consumers, business and labor representatives, insurers, and lawmakers to develop a strategy regarding who and what should be covered by Medicaid and how the program should be financed and delivered. The workgroup created a list of eight points that were intended to guide the development of any Medicaid reform in the state (Oregon Department of Human Services 2006, 2):

1. All citizens should have universal access to a basic level of care.
2. Society is responsible for financing care for poor people.
3. There must be a process to define a “basic” level of care.
4. 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.
5. The health care delivery system must encourage use of services and procedures that are health effective and appropriate, and discourage over-treatment.
6. Health care is one important factor affecting health; funding for health care must be balanced with other programs that affect health.
7. Funding must be explicit and economically sustainable.
8. There must be clear accountability for allocating resources and for the human consequences of funding decisions.

With these ideals in mind, Oregon engaged in a series of public debates and forums that involved practically “all stakeholders in Oregon” and was very much in line with determining the social consensus as required by point four of their guidelines (Mittler, et al. 1999, 15). Between 1987 and 1991 a series of legislation was enacted that helped create both the structure of the OHP and a number of complimentary insurance reform measures (Oregon Department of Human Services 2006). It was estimated that if all of the programs passed were implemented as planned, approximately 95 percent of the population would have insurance coverage, thus coming very close to meeting the goal of a basic level of care for all citizens (Julnes & Baker 1997).

THE PLAN TO INCREASE INSURANCE COVERAGE

Oregon’s plan for increasing coverage included a number of key elements in addition to Medicaid reform. The initial set of legislation passed between 1987 and 1991 also included the following provisions: (1) an employer mandate, (2) the Oregon Medical Insurance Pool, and (3) Small Employer Health Insurance. Additionally, the Family Health Insurance Assistance Program was established in 1997 (Oregon Department of Human Services, 6). The hope was that these four programs would achieve something as close to universal coverage as possible (Oberlander, 2007).

The employer mandate was initially enacted in 1990 with an effective start date of January 1, 1994. However, as with all employer mandates, a Congressional exemption from the Employee Retirement Income Security Act (ERISA) was needed to actually implement the mandate. The mandate followed a standard “pay or play” model and would have required all employers over a specified size to either provide insurance for employees who worked at least 17.5 hours/week or pay into a special state insurance fund that would offer coverage to their employees (Oregon Department of Human Services 2006). After pushing back the effective date a number of times in hopes of receiving an ERISA exemption, the mandate was finally repealed in 1996 after Congress failed to give an exemption before a self-imposed deadline. Since the mandate had been the primary strategy for achieving universal coverage, Oregon was now forced to concentrate its efforts on a public insurance model, thus putting an increasing amount of political pressure on Medicaid reform to succeed (Mittler, et al. 1999).

The Oregon Medical Insurance Pool (OMIP) is designed to provide insurance for those who would be otherwise unable to obtain coverage due to preexisting medical conditions or who

have exhausted their Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits. OMIP provides coverage for all eligible individuals, but does not help subsidize the cost of premiums based on income. However, commercial insurance companies in Oregon must pay a special fee to OMIP to help cover program costs (Oregon Medical Insurance Pool 2008). Since issuing its first policy in 1990, OMIP has provided insurance for over 35,000 individuals who would otherwise have gone uninsured (Oregon Medical Insurance Pool 2008). In contrast to OMIP, the Small Employer Health Insurance (SEHI) program and the Family Health Insurance Assistance Program (FHIAP) both work in the private insurance market to help ensure affordable policies. SEHI established a basic health benefit plan with controlled premiums for small businesses employing anywhere between two and 50 employees (Oregon Department of Human Services 2006). The FHIAP also works within the private insurance market, but instead it specifically targets low-income families and individuals. The program assists these consumers by providing them with sliding-scale subsidies based on income to help them purchase insurance. FHIAP has been receiving federal funds under a Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative waiver since 2002 and has generally been considered a very successful program (Oregon Department of Human Services 2006).

THE OREGON HEALTH PLAN

The Medicaid reform itself was based on the key principle of providing fewer services to more people, thus ensuring that as many people as possible receive at least a basic level of care (Oberlander 2007). The OHP expanded coverage to all legal residents under 100 percent of the federal poverty level (FPL), regardless of asset levels or if they fit into the specified categorically eligible populations. For those who did meet the traditional criteria for Medicaid, such as children and pregnant women, everyone under 133 percent FPL was now eligible for Medicaid benefits (Mittler, et al. 1999). This expansion was to be paid for both through appropriations from general revenue funds as well as a new ten-cent tobacco tax and matching federal funds (Oregon Department of Health Services 2006). At this point, the Oregon economy was still experiencing steady growth and was able to shift funds towards Medicaid with relative ease (Sparer 1999). Also key to the OHP were two cost containment mechanisms: the use of managed care and a prioritized list of services.

By moving as many people as possible into fully capitated managed care plans, Oregon hoped to see significant savings. Unlike fee-for-service plans where physicians receive payment from insurers based on the actual services provided to patients, capitated care plans function by providing physicians with a fixed amount per patient regardless of the actual services rendered. By encouraging physicians to spend fewer resources on each patient, capitated managed care plans can theoretically help control medical costs. Managed care organizations (“MCOs”) were already well established in Oregon by the time of the OHP, with groups such as Kaiser Permanente enrolling Medicaid populations into MCOs as early as 1976 (Bodenheimer 1997a). Given the familiarity with managed care and the fact that a number of organizations were already selling plans in Oregon at the time of the OHP transition, Oregon saw very positive results with 87 percent of enrollees in MCOs by 1997, compared to 33 percent prior to the OHP coming into effect (Jacobs, et al. 1993). Oregon also managed to improve access to MCOs across the state, with all but two counties being served by at least one fully capitated health plan by 1999 (Mittler, et al. 1999). Another factor that eased the transition to MCOs was Governor Kitzhaber’s

determination to ensure that the capitation rates were high enough to realistically cover the costs of care so that providers would not begin to turn away Medicaid patients (Bodenheimer 1997a). In 1995, the rate for nondisabled persons under 65 years of age was set to be 30 percent higher than the rates before the OHP (Bodenheimer 1997a).

THE PRIORITIZED LIST

The second and more novel means of cost containment was the establishment of a prioritized list of services. In 1988, Governor Kitzhaber initiated the Oregon Medicaid Priority Setting Project, under which the Health Services Commission sought to establish a list of ranked services that the OHP would or would not cover. The notion was that limiting the number of services provided would make more funds available to cover the expansion population. This was also an attempt to break away from the market-based rationing common in the U.S. in favor of rationing services based on what the community felt was important. Rather than looking at the list as rationing, OHP policy makers preferred to think of this as a means to improve resource allocation by prioritizing services in a “more sensible, systematic, and utilitarian manner” (Jacobs, et al. 1993, 5). Thanks to a great deal of community involvement and numerous public forums, Oregon was able to maintain overall support for the move to a prioritized list of services despite criticisms from policy experts that: (1) administrative waste should be eliminated before something as drastic as rationing was considered, (2) the rationing process was morally and methodologically flawed, and (3) it was unfair to have the Medicaid population bear the brunt of rationing (Jacobs, et al. 1993; Strosberg 1992). Indeed, in a state with less public involvement and more of an inclination to conduct policy behind closed doors, a project such as the prioritized list might readily have been rejected and deemed an attack on the poor.

This endeavor, which reduced “over 10,000 services to a prioritized list that initially ranked 709 condition and treatment pairs,” took over 18 months and more than 25,000 volunteer hours to complete (Oregon Department of Health Services 2006, 16; Jacobs, et al. 1993). Initially, the list was to be rooted in a strict cost/utility analysis based on health outcomes and the cost of treatment (Oregon Health Services Commission 2007). However, the results from this analysis were found “unacceptable because it conflicted substantially with the judgment of all Commission members, both physicians and non-physicians” (Oregon Health Services Commission 2007, 4). Oregon moved away from this essentially technocratic system because it failed to embody those community values that Oregonians wanted to see in their Medicaid system.

Instead Oregon opted to establish categories of care, with rankings internal to each category determined by “relative importance based on public input first, and effectiveness and cost secondarily” (Oregon Health Services Commission 2007, 5). The final step in this process was to conduct an additional review of the condition-treatment pairs, at times overriding the public ranking, to ensure that the list truly reflected the best judgment of clinicians. The list is reviewed and reapproved by HCFA every two years, with the State Legislature deciding how much of the list to include in the health care budget (Oregon Department of Health Services 2006). Services below the cut off point will not be reimbursed by the OHP, and the MCO capitation rate is based on this list of services. The initial list of services approved by HCFA in 1993 was set at 606 out of 745 condition and treatment pairs (Oregon Department of Health

Services 2006). However, the list has undergone a number of changes since the initial approval, with certain lines being added, removed, or combined. The aggregate effect of these changes has been to decrease the size and lower the cut-off point. The current list is set at 503 out of 680 condition and treatment pairs.

The list contains a broad range of conditions and treatments, with the first and most highly prioritized services being pregnancy/maternity care, followed by the birth of an infant/newborn care. The service at the very bottom of the most recent prioritized list is gastrointestinal conditions with no effective treatments or no treatment necessary (Oregon Health Services Commission 2007). Between these services is a broad range of condition and treatment pairs, and for many of these the decision of whether or not to offer coverage is much more contentious. For example, the current list will cover conditions such as selective mutism, but not hypotension, a potentially fatal condition.

More broadly, the basic benefit package that resulted from the list included services such as: (1) preventive services to promote health and reduce the risk of illness; (2) comfort care or hospice treatment for terminal illnesses, regardless of the ranking of the conditions on the priority list; (3) ancillary services such as prescription drugs, as long as they are appropriate for a covered condition treatment pair; and (4) most transplants (Mittler, et al. 1999). The list did not, and still does not, cover: (1) conditions that get better on their own; (2) conditions for which home treatment works; (3) cosmetic procedures; and (4) conditions for which treatment is ineffective, such as certain advanced cancers (Oregon Department of Health Services 2006). The overall philosophy of what services are and are not covered seems very much in line with the originally expressed desire to create a plan that would encourage health-effective and appropriate services while discouraging over-treatment.

The prioritized list also allowed for the increased accountability that the 1987 workgroup had sought. By forcing legislators to cut specific services, rather than simply cutting eligibility as many states do, Oregon policymakers hoped to ensure that the public would hold individual legislators responsible for their decisions. As Governor Kitzhaber noted, “let legislators make explicit decisions so that they can be held accountable for them” (Mittler, et al. 1999, 20). This strategy seemingly worked very well, since rather than face the scrutiny of voters for cutting potentially lifesaving treatments, policy makers agreed to a prioritized list which was a good deal more generous than Oregon Medicaid prior to the OHP.

In fact, the OHP now included a number of services, such as dental care and organ transplantation, which were previously denied (Bodenheimer 1997a). Rather than limiting services, the basic framework of the list instead served to increase the benefits available to Medicaid enrollees in Oregon. By casting the list as a means of limiting services and controlling costs, Governor Kitzhaber was able to obtain bipartisan support for the measure while simultaneously working to expand coverage through increased accountability (Jacobs, et al. 1993). In many ways, the prioritized list was as much a political move as a policy move in this regard. Greater accountability and transparency appears to be a successful political strategy to preserve benefits as long as the public remains disinclined to cut services for needy populations.

IMPLEMENTATION OF THE OHP

At the time of OHP implementation there was still a great deal of concern regarding how the program would function and how enrollees, particularly vulnerable populations, would fare under this new system of managed care and the prioritized list. To help ease the implementation process, Oregon decided to divide the OHP into two phases. During the first phase of implementation in 1994, Oregon enrolled all those who were eligible for OHP due to poverty, i.e. able-bodied low-income adults, pregnant women, and children. During the second phase, which took place the next year, vulnerable populations such as children in substitute care, and the aged, blind, and disabled were added to the OHP (Mittler, et al. 1999).

To further ensure the protection of vulnerable populations, phase two of the implementation also included a number of safeguards. While still using the prioritized list as the basis for the provision of services, OHP administrators assured the public that these vulnerable groups would be protected by a comorbidity rule. This rule allows for the coverage of services below the line if they impact services above the line. For example, if a child has "severe conduct disorder," which is not a covered condition, a physician can look for a comorbid condition that *is* covered in order to treat the child (Leichter 1999). A second rule was established that allowed enrollees to opt out of managed care if they require special coordination of care. The OHP also now added a contract requirement with their MCOs to hire and train at least one Exceptional Needs Care Coordinator to help the phase two population navigate and coordinate care. Finally, an ombudsman's office was established to work in conjunction with the Exceptional Needs Care Coordinator (Leichter 1999).

Although MCOs and providers sometimes authorized and paid out of their own pockets for services not on the prioritized list, OHP officials did not discuss this openly in order to avoid suggesting that the prioritized list might be an imperfect instrument. This too helped ease the transition to the OHP and avoided a number of negative public relations situations in cases where children or other vulnerable populations were denied a service. In fact, only fee-for-service arrangements, a minority of plans within in the OHP, are subject to scrutiny to ensure that no above the line services are provided (Ham 1998). While this is certainly not a major feature of the OHP, since any coverage of below the line treatment is up to the discretion of MCOs and providers, it helps empower providers to act on their own best judgment.

Overall, implementation was quite successful, although not without problems. Less than 10 percent of enrollees failed to choose a health plan as mandated and overall Medicaid enrollment increased from 260,000 in February of 1994 to 395,000 in the summer of 1995 (Sparer 1999). Initially, failure to choose a plan was not grounds for rejection; however, after a policy change in 1996, failure to choose a plan was now grounds for rejecting an application (Sparer 1999). While large enrollment numbers indicated success given the ultimate goal of reducing uninsurance, Oregon was unprepared for the amount of interest and the number of individuals who would be eligible under the expansion. During phase one of the OHP, Oregon had enlisted a contractor to manage their toll-free call center. The contract was based on an estimate of 4,000 to 5,000 incoming calls per month, much lower than the 5,000 calls per day that occurred during the first few months of the OHP.

EARLY BUDGET ISSUES

Not surprisingly, the unexpected volume of enrollment yielded costs higher than initially predicted. As long as Oregon's economy was growing at a rapid pace, it might have been feasible to finance the expansion largely through increasing funds from state general revenue, but in 1995 a financial slowdown forced Oregon to reconsider certain aspects of the OHP. Initially Oregon had hoped that the prioritized list and managed care would be sufficient to curb costs, but neither of these could entirely offset the increase that came from a large increase in enrollment. Rationing was also unable to control the costs of the services that were covered by the list, not to mention that the OHP was now substantially more generous than it was prior to the expansion, raising costs even higher. To further exacerbate the situation, the single adults in the expansion population were using noticeably more services than parents of similar age in the categorically eligible population. Studies indicated that this higher service use was driven largely "by their poorer physical and mental health status" (Haber 2000, 128). Not only, then, was OHP providing more services for more people, but also for a population that was significantly sicker and more inclined to need services. The tradeoff of using the list as a political tool to increase services was that the cost-containment aspects of OHP were thus substantially weaker than predicted. If Oregon had been realistically prepared for the limited savings that were produced by the list, it might have given more thought to other means of cost-containment or revenue.

OHP administrators estimated in 1997 that the move to managed care accounted for six percent of savings off the total costs of the program, while the list represented an even smaller share of savings at only two percent (Jacobs, et al. 1993). Even the first interim report on the OHP to HCFA noted that "the State has found that the priority list is a difficult way to manage a fiscal crisis," particularly on account of the fact that "HCFA must approve all line changes before they can be implemented by the State" (Rosenbach 1997, 15). Oregon attempted on a number of occasions to lower the cutoff point for services on the prioritized list, and was generally approved only for a smaller cut than requested, forcing the state to instead make adjustments to eligibility and payment levels to remain within budget. However, even if Oregon had been able to move the line further down the list, "the range just above the current funding level begins to include some serious but treatable conditions" (Oregon Health Services Commission 2007, 6). It is difficult to say if Oregon would have been able to truly use the list as a means of serious cost containment given the politically unpopular nature of eliminating coverage for conditions such as these.

When budget issues arose in 1995, the OHP opted, in addition to moving the list to 581/745, to reduce eligibility by establishing a \$5,000 asset limit, remove most college students, and require income to be calculated over a three-month period rather than one (Jacobs, et al. 1999; Oregon Department of Health Services 2006). At this point the legislature also reduced capitation rates and decided to begin to assess monthly premiums of between \$6 and \$28. Paired with a new tobacco tax of 30 cents in 1997, the OHP was, at least momentarily, on what seemed to be "secure financial footing" (Mittler, et al. 1999, 23).

Despite some early implementation problems and the 1995 changes to reflect the Oregon budget, the OHP was hailed as a success on most fronts. Uninsurance rates had dropped from 18 percent in 1991 to 11 percent by 1995 (Bodenheimer 1997a). Emergency room visits dropped 5

percent, and uncompensated care fell by more than 36 percent in the first two years (Rutledge 1997). Those who had feared that the prioritized list would hurt low-income individuals had generally been swayed by the generous benefit package and the absence of extensive rationing (Oberlander 2007).

THE OREGON HEALTH PLAN – 2

Despite, or perhaps because of, the success of OHP, Governor Kitzhaber decided to embark on a final effort to move Oregon closer to universal coverage before leaving office in 2003 (Oberlander 2007). In 2001, the Oregon legislature agreed to seek a new Section 1115 waiver and a HIFA waiver to reduce benefits in order to increase the expansion population to persons earning up to 185 percent FPL (Oregon Department of Health Services 2006). The OHP2, as approved by HCFA in 2002, consisted of reductions, refinances, and expansions. However, due to Oregon facing a significant budget crisis in 2002, with a deficit of more than \$900 million and the highest unemployment rate in the nation, many of the expansions never came into effect (Preusch 2002). While it does appear that Governor Kitzhaber genuinely desired to expand coverage, it is unclear if the Republican-led legislature saw OHP2 mainly as a means of further cost containment. Comments made by then Oregon House Speaker Mark Simmons in 2002 hint at this approach. Simmons cited Republican support for the waiver since “we now have assurance we’ll be able to cap enrollment and adjust the benefits - an ability to control costs that we haven’t had before” (Steves 2002).

Initially, the plan was to gradually increase eligibility to 185 percent FPL for the expansion population (i.e. single individuals) and those who were categorically eligible (i.e. women, children, and the disabled). This increase in eligibility would also have applied to the Family Health Insurance Assistance Program. In order to pay for these expansions, Oregon planned to divide the OHP population into two groups, one consisting of the expansion population and one consisting of the categorically eligible. This would then allow for services to be reduced, cost sharing and premiums to increase, and enrollment to be capped for the expansion population while leaving OHP generally intact for the categorically eligible (Mittler, et al. 1999). The funds saved by the reduction in services to the expansion population would then be used to increase income-based eligibility for both groups.

It is also worth mentioning that, while not part of the waiver, the Medically Needy Program was eliminated to help free up general revenue funds. This program had provided coverage for those not eligible for OHP but who had significant health expenditures due to afflictions such as HIV or Chron’s Disease. By eliminating this program, over 9,000 people lost coverage, some 60 percent of whom reportedly had to cut back on food expenses to pay for their medications (Mann 2004). This, paired with the fact that Oregon initially redirected its disproportionate share hospital funds into the OHP, indicated that Oregon was attempting to shift its focus to Medicaid coverage rather than secondary safety net programs (Bodenheimer 1997b).

The two eligibility groups established by OHP2 were OHP Standard for the expansion population, and OHP Plus for the categorically eligible. The eligibility for OHP Plus was increased to 185 percent FPL, while the eligibility for OHP Standard has remained at 100 percent FPL despite federal permission to increase it (Mann 2004). The prioritized list, now set at

566/736, continued to serve as a constraint on the services available to both groups. OHP Plus retained pre-OHP2 benefits, with the only changes being increased eligibility and a \$2 to \$3 co-pay for adults not enrolled in managed care. In contrast, OHP Standard saw dramatically reduced benefits with a substantially higher price tag. Enrollees in OHP Standard lost coverage for mental health and substance abuse services, durable medical equipment, and dental and vision services. These enrollees were also now subject to co-pays ranging from \$3 to \$250, and premiums ranging from \$6 to \$20 each month (Mittler, et al. 1999). While these premiums were technically lower than those imposed in 1995, they were now applied on an individual, rather than family basis and groups that previously had exemptions, such as the homeless or those with no incomes, had to pay premiums (Carlson, et al. 2006). Physicians could also deny services if the enrollee could not afford the co-pay, and if premiums were not paid, enrollees would be disenrolled and locked out from reenrolling for six months. To further complicate matters for members of OHP Standard, program enrollment was capped on July 1, 2004 (Mittler, et al. 1999). Consequently, if an individual had been disenrolled due to non-payment of premiums any time after February of 2004, they would have found themselves unable to reenroll in OHP Standard since program enrollment closed before their locking out period ended.

OHP2 saw a precipitous drop in enrollment after these changes came into effect. In the year following implementation, enrollment in OHP Standard dropped 53 percent, and in the next eighteen months it dropped another 50 percent (Mann 2004). A drop of over 50,000 people is remarkable for a reform that was billed in press releases by the Department of Health and Human Services as a request to expand coverage to another 60,000 people (U.S. Department of Health and Human Services, 2002). Nearly half of those who lost coverage indicated that the cause was program costs or ineligibility due to a missed premium (Carlson, et al. 2006). Those impacted the hardest were also those worst off economically. Enrollment among those with no income decreased 59 percent in the ten months after OHP2 went into effect, compared to a 44 percent decrease among those at 85-100 percent FPL (Mann 2004). Data from 2004 indicated that of those who lost coverage 72 percent remained uninsured, and even for those who remained in OHP Standard cost sharing served as a deterrent from using services when needed (Mann 2004). This was particularly troubling given that Oregon had weakened its other safety net programs for the uninsured.

Whatever hopes there had been to actually implement the expansion were lost when Ballot Measure 30, which would have mandated an income tax surcharge, an increase in the minimum corporate tax rate, and an extension of the tobacco tax, failed in February 2004 (Oregon Department of Health Services 2006). With the defeat of this measure, OHP2 lost all general revenue financing for the expansion population, leaving it entirely dependent on enrollee premiums, provider taxes, and federal matching funds (Oberlander 2007). Forcing a program that was originally intended to ration according to community values to now ration by price as well was detrimental not only to those on OHP2, but also to the program itself. By engaging in extensive cost-sharing, Oregon compromised its vision of providing a basic level of care determined by the community rather than financial ability to all its needy citizens.

Clearly, Oregon policymakers dramatically overestimated the ability of OHP Standard enrollees to pay for coverage. Not only did tens of thousands of previously insured people lose coverage, sending the uninsurance rate back up to 17 percent in 2005, but Oregon also failed to

see any increase in revenue from the higher premiums since so many people left the program (Science Letter 2005; Mann 2004). Ultimately, Oregon did generate some savings from OHP2 simply because so many people were forced out of the plan. In doing so, however, the state also managed to lose a significant portion of its matching federal funds. Given that the matching rate is set at 61 percent, Oregon actually only saved \$49 for every \$100 it managed to cut from OHP2 (Mann 2004). Since premiums and matching funds were two of the major funding mechanisms available for OHP Standard, the question of how to provide services for the remaining enrollees was hardly solved. Savings from cutting eligibility were also offset, at least to some extent, because emergency room visits by uninsured patients increased by 17 percent in the first three months following implementation. Visits for alcohol and substance abuse among the uninsured increased even more dramatically, rising by 136 percent and 200 percent respectively (Mann 2004). Reducing Medicaid coverage did not result in the clear-cut savings that policymakers had hoped for.

A little over a year after OHP2 went into effect, Oregon began to restore some services in an effort to correct what had been, by all accounts, a poorly executed attempt at reform. Limited dental, mental health, and substance abuse services were reinstated (although services such as physical therapy, non-emergency hospital, and home health care were removed in exchange), and copayments were removed after a court order in 2004. In 2005, the six-month lock out period was lifted and those at less than 10 percent FPL were exempted from premiums (Oregon Department of Health Services 2006). However, due to the capped enrollment, this did little to help those who had already been forced out of the program.

As of 2008, OHP Standard is enrolling once more, but since the program can still only afford to pay for a maximum enrollment of 24,000, Oregon has decided to randomly admit new individuals every month from the over 130,000 who qualify (Yardley 2008). When the cap has once again been met, it is likely that OHP2 will continue on as it has at least until December 31, 2010 when the renewal waiver expires (Centers for Medicare & Medicaid Services 2008). In Governor Kungoloski's proposed budget for 2009-2011, the OHP2 will be scaled back even further with as many as 13,000 seniors, disabled individuals and low-income families experiencing drops in services (Mann 2008). Interestingly, Kungoloski is also proposing expanding eligibility once again "to cover 80,000 additional children and 75,000 additional adults through a hospital provider tax, a cigarette tax and obtaining additional federal matching dollars" (Mann 2008). Given the current economic downturn in Oregon and the United States, it seems much more likely that the service cuts will be enacted than the proposed expansion in enrollment. Oregon policymakers should also be mindful to not repeat their earlier mistakes of cutting services to fund an expansion that will never come to pass.

LESSONS FROM THE FAILURE OF OHP2

What initially made OHP such a success in terms of coverage was minimal or no premiums, no asset tests, and a straightforward enrollment process with the same benefits for everyone regardless of categorical eligibility. Essentially, the simpler the process for enrollment the better, not only in regards to limiting administrative costs but also in ensuring that those who need services are able to obtain them in a timely manner. The use of MCOs for cost containment, paired with a desire to establish a methodologically sound rationing system, also helped make

the OHP viable in its early years. With the exception of the rationing model, which would require the time consuming process of obtaining a Section 1115 waiver, these practices lend themselves well to implementation in other states. Indeed, despite the eventual unraveling of the OHP2, there is no reason that states should not examine the positive elements of the OHP as a basis for their own Medicaid reforms.

OHP2 and its OHP Standard plan sacrificed the ease of the first OHP in an effort to save funds, and while admittedly the cost of OHP2 did decline compared to earlier years, the program was essentially gutted. The failure of OHP2 was partially due to the inadequacy of the prioritized list and the inherent structural issues mentioned earlier, but also partially due to HCFA's unwillingness to grant Oregon cuts to the list as requested. Oregon was denied its requested cut in 1997, 1999, and 2003 leaving the state with little recourse but to return to more traditional ways of containing costs in 2004 (Oregon Department of Health Services 2006).

However, even if Oregon had been granted the ability to cut services at will, and this had been a politically feasible option, the list would not have been able to generate enough savings to make up for a lack of funding. Oregon had focused almost entirely on cost-containment rather than finding a sustainable revenue source, setting itself up for failure in the event of a decrease in general revenues. Rationing and cost-containment in general cannot take the place of a reliable stream of funding. The majority of funding for the OHP2 continues to come from general revenues, and given that Oregon has no sales tax, these funds will inevitably decrease when unemployment increases and income taxes decrease (Oberlander 2007). Since Medicaid enrollment increases as unemployment increases, using general revenue funds alone to finance programs like the OHP2 is fundamentally untenable.

The political nature of the list had, in a sense, limited Oregon from pursuing other means of funding and cost-containment. Admitting that the list would actually increase services rather than cutting them would likely have killed the legislation before enactment. The price that Kitzhaber paid for expanding services was to some extent setting the OHP2 up for failure if Oregon ever faced financial difficulties. Given the cyclical nature of economies, it was hardly a surprise when this eventually came to pass. Indeed, most of the research on the OHP prior to the OHP2 identified funding as a potentially critical and perhaps neglected issue.

Once OHP policymakers finally did realize the need to shore up the funding stream through the implementation of higher premiums, it was executed in such a poor manner that premium revenue instead declined due to the drop in enrollment. It appears as though Oregon failed to acknowledge that moving back to market-based rationing would inevitably hurt those who cannot afford to pay, and while reducing enrollment may be an effective means of cutting costs, it is not always cost efficient. Perhaps even more detrimental to the continued sustainability of OHP Standard is the failure of Oregon to account for the fact that raising premiums will serve to push out individuals with less need for care, raising the average cost for the individuals who do remain on OHP Standard. Surveys of those who lost coverage support this principle, with those who dropped coverage more likely to be male, white, and not have a chronic health condition compared to those who remained in OHP Standard (Carlson, et al. 2006).

States must realize that while cost-sharing can play an important role in funding a Medicaid program, too much of the burden cannot be placed on enrollees or the plan will collapse. Program enrollees are low-income by definition, and to assume that they can meet a substantial share of their health expenses is counter-intuitive at best. If states want to establish an ongoing and efficient Medicaid program, they must be willing and able to fund that program, even if the financial climate sours. The most important lesson for other states to take from Oregon is not that a prioritized list can serve as a cost-containment device (although not a particularly effective one as implemented within the current social and political climate of the U.S.) but instead that Oregon had a functioning Medicaid program and it was essentially decimated by overzealous cost-sharing mechanisms due to a lack of continued funding from the state.

States undertaking serious Medicaid reform must ensure, before embarking on such a project, that any reforms will remain financially viable in a fiscal downturn. If Oregon had managed to stick to community values-based rationing and establish a sound funding mechanism in its 1995 reforms rather than beginning down the path towards market-based rationing, the state might have avoided a great deal of grief for low-income Oregonians who lost their insurance coverage with the advent of OHP2.

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