

*Effective Coverage Expansions for Uninsured Kids and Their Working Parents:  
Links to Job-Based Coverage*

May 18, 2001

Conference Transcript: "Oregon Plan"

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**Oregon's Plan for Coverage and Continuity of Provider Care for Uninsured Families**

**Speakers:**

- John Santa, MD, Administrator, Oregon Health Plan.
- Kevin Earls, Vice President, Finance and Health Policy, Oregon Association of Hospitals and Health Systems
- Robert DiPrete, Associate Administrator, Office for Oregon Health Plan Policy and Research

(Additional information about the speakers appears at the end of this section.)

Speaker Introductions: Rick Curtis, President, Institute for Health Policy Solutions

**Transcript:**

MR. CURTIS: We are starting with a panel of gurus from Oregon for a simple reason. If there is a state with a long, proud tradition of thinking outside of the box on health coverage issues, I think—as everyone in the room knows—it is Oregon. They are unusually forward thinking, and I'm not going to steal their thunder by indicating in what ways they're forward thinking now. I'll leave it to them. But they have asked me to very quickly introduce the panel.

**John Santa** is now the Administrator of the Oregon Health Plan. As you know, he's had predecessors who were very talented. John is extraordinarily talented himself. He happens to be an M.D., which is always helpful to these kinds of jobs. He has a background, among other things, as senior executive with a private health plan, so he knows employment-based coverage from that side. He's a very sophisticated thinker, as well, about integrated provider systems and how the financing system can encourage the right kind of delivery of care.

Most people here in the room know **Bob DiPrete**, I believe. Bob is the director of the Oregon Health Council and also Associate Administrator of the Oregon Health Plan. Bob is one of the most thoughtful people on health policy in the country. I've had the privilege of knowing and working with him for many years.

**Kevin Earls** is now Senior Vice President of the Oregon Association of Hospital and Health Systems. I've also had the privilege of knowing Kevin for quite a while. Previously, he wore a hat with Associated Oregon Industries, an employer organization, as the head health person. There he was involved in putting up a program like the one Phil Vogel runs in Connecticut for small employers. In fact, Bob and John's predecessor were looking at trying to coordinate with that program, and they will probably be alluding to their frustrating experience in trying to deal with HCFA in getting approved what needed to be approved in order to make that work.

With that, here's Oregon.

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DR. SANTA: Good morning. The three of us will try and move across a lot of information quickly. Governor Kitzhaber sends his regrets and his appreciation to you all on behalf of the National Governors' Association. There is no issue that's more important to him than the one we're going to be talking about this morning.

Well, as you can see, or you'll be able to see when we get up, we don't bring you any tight jeans, cowboy boots or big belt buckles this morning. I suppose we're going to do our best imitation of the "Three Amigos" and tell you what's going on in Oregon. There are some additional materials that we'll be referring to as we make our comments that we put on the back table, some information that's recent about enrollment issues and about where we're headed with prescription drug issues that we thought might be of interest.

I'm going to start by trying to emphasize three issues that the governor would always emphasize that have been important to Oregon and to our success. The first is the importance of having a plan and a partnership that supports that plan.

**THE OREGON HEALTH PLAN**

- ▲ **CREATING A PARTNERSHIP**
  - ▲ **PUBLIC STRATEGIES--OMIP, IPGB, SMALL GROUP REFORM, MEDICAID DEMONSTRATION**
  - ▲ **PRIVATE STRATEGIES—EXPANSION DESPITE EMPLOYER MANDATE REPEAL, REDUCTION IN COST SHIFT, AWARENESS OF UNINSURANCE, MARKET STABILIZATION, MANAGED CARE**

We've had a lot of success creating partnerships, creating partnerships through both public and private initiatives. On the public side, we did a number of things in the late '80s and early '90s. The Oregon Medical Insurance Pool is our high-risk pool. IPGB, the Insurance Pool Governing Board, created a basic benefit plan for small groups. A number of small group reforms were done in the state, but the biggest reform, of course, was our Medicaid demonstration project. It brought a variety of things to both the public and private markets and stabilized them through the decade.

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Our private strategies were equally important and while most folks, both in and out of the state, initially point out that we were unable to carry off an employer mandate, that doesn't mean that we haven't had some very significant successes. We believe we have had a very significant expansion of private coverage in the state due to a number of reasons: a significant reduction in the cost shift; a significant awareness of the importance of uninsurance by employers in the state; stabilization of the market that occurred because of our public strategies.

Important among those was the increased reimbursement that the Oregon Health Plan and the Medicaid demonstration brought to the provider system. And finally, we had a very productive decade in managed care that kept our costs low.

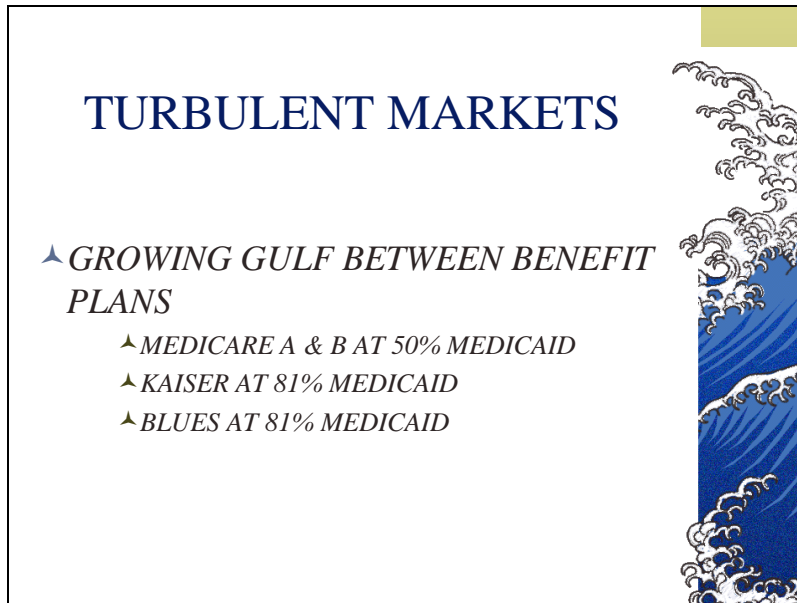
A second principle that was important to our success was the inclusion of poverty as a criteria for Medicaid coverage, moving away from categorical indicators as the major drivers of eligibility. Moving to poverty really changed the dynamics of public coverage for our state, and I'm sure many of you know this from the experiences you've had in your own state.

This has brought some very significant challenges for us. We have very significant turnover in terms of enrollment. We're going to be sharing a little bit of the dynamics of that with you. Some of the data that I've brought comes from a disenrollment survey done by one of our provider systems, the Provident system, which basically demonstrates that poverty is just a very dynamic phenomenon, particularly around 100 percent of the federal poverty level. There are large numbers of individuals moving on and off the plan. They are mainly moving on and off because their incomes are changing, and that makes it a very different beast to deal with, particularly in terms of risk. Our managed care plans that work in the Oregon Health Plan have learned a lot about the dynamics of that risk selection.

The third issue that's been a major driver for us, though not surprising, I think, to this audience, is the importance of benefits. That's the wheel that the governor has really been interested in being able to turn. We've referred to them as priorities. Many of you all know of our interest in this area because of our prioritized list.

While this brought us some initial flexibility, as again I'm sure most of you know, we've ended up the last half of the decade at a stalemate between the state and federal governments regarding benefits and flexibility around those issues. This has resulted actually in Oregon having both a very unique package—one that really does not bridge well to the private side, to the private benefit packages—and a very rich package. As a number of issues have changed in the late '90s, the richness of that package has become a major issue and, as you'll see, really is again at the middle of our discussions about how to change.

MR. EARLS: As John mentioned, we've got a benefit package that has been perceived as uniquely rich in the Medicaid program in Oregon, and it's always been perceived as richer than the benefit plans seen in the private sector. Now, as premiums are increasing in the employer market, that disparity is becoming even more apparent. We have some actuarial comparisons up here to demonstrate the kind of gulf between the Medicaid benefit package and some benchmarks.

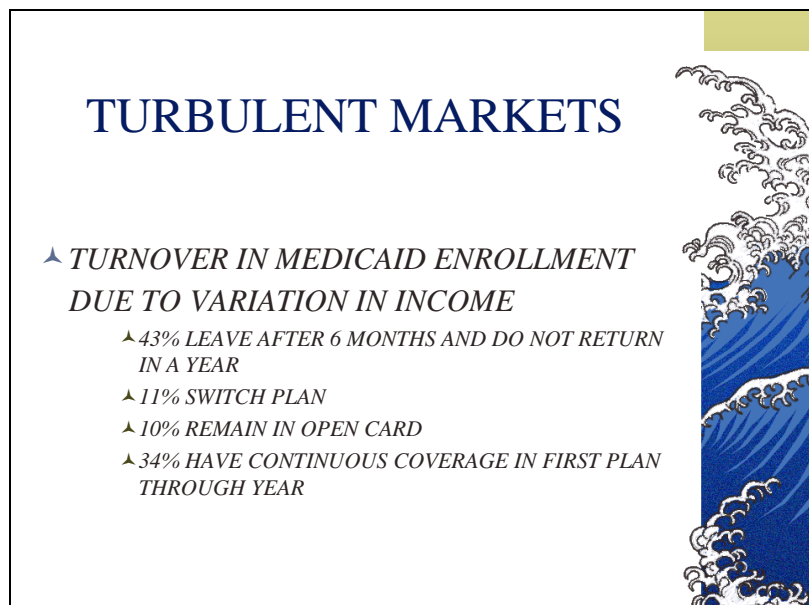


**TURBULENT MARKETS**

▲ *GROWING GULF BETWEEN BENEFIT PLANS*

- ▲ *MEDICARE A & B AT 50% MEDICAID*
- ▲ *KAISER AT 81% MEDICAID*
- ▲ *BLUES AT 81% MEDICAID*

Medicare Part A and B is roughly 50 percent of the Medicaid benefit package actuarial equivalent. Kaiser's standard plan is at 81 percent, and the Blue Cross/Blue Shield plan is at 81 percent. (The Blue Cross plan is the public employee benefit plan.) A fourth point would be benefits mandated by the traditional Medicaid benefit package, which are in the low 60 percent range on an actuarial comparative basis, compared to the current Oregon health plan benefit package.



**TURBULENT MARKETS**

▲ *TURNOVER IN MEDICAID ENROLLMENT DUE TO VARIATION IN INCOME*

- ▲ *43% LEAVE AFTER 6 MONTHS AND DO NOT RETURN IN A YEAR*
- ▲ *11% SWITCH PLAN*
- ▲ *10% REMAIN IN OPEN CARD*
- ▲ *34% HAVE CONTINUOUS COVERAGE IN FIRST PLAN THROUGH YEAR*

Another factor creating turbulence in Oregon's Medicaid program is turnover in Medicaid enrollment, and John alluded to that. The driving factor there seems to be due to variations in income, fluctuations in income of the recipients. Forty-three (43) percent of the

enrollees leave after six months and don't return during the course of the year. Eleven (11) percent of the enrollees switch plans to another health benefit plan but stay within the program. Ten percent remain in the program, but move to an open-card fee-for-service arrangement. And only 34 percent of the total enrollees will have continuous coverage in the Oregon Medicaid program during the course of the full year. So, lots of churning is occurring and only a third of the enrollment is actually staying for the course of a full year. So you can see the risk implications that John was alluding to for the health plans that are participating.

Another significant factor in Oregon that's creating turbulence in the marketplace is the rising cost of prescription drugs, both in commercial plans, but particularly acute in the Medicaid program. Our budget in Oregon is a biennial budget—a two-year budget—and the current governor's recommended budget is anticipating a 61-percent increase in prescription drug costs in the Oregon Health Plan. It will represent 32 percent of the total Medicaid budget. To put that in perspective, prescription drugs are now the single largest component of Oregon Health Plan costs. Drugs passed the component for physician expenses in the '99-'01 budget. They're going to pass the cost for hospitals in the '01-'03 budget. So, very unsustainable growth in costs.

This biennium's increase in prescription drugs is not unique. We've had 61 percent in this biennium coming up, 52 percent in the previous biennium. So, clearly, the increasing cost of prescription drugs is unsustainable.

Current law in Oregon doesn't permit the use of a formulary, and we're going to talk and maybe have a handout for you about some legislation that's going to be offered this session to allow the Medicaid program to move to a limited reference based drug formulary.



**TURBULENT MARKETS**

- ▲ *RISING COSTS PARTICULARLY IN PRESCRIPTION DRUGS*
  - ▲ *60% INCREASE IN RX COSTS*
  - ▲ *RX 32% OF MEDICAID BUDGET*
  - ▲ *RX NOW LARGEST COMPONENT OF MEDICAID BUDGET*
  - ▲ *MINIMAL CONTROL, MEDIOCRE QUALITY*

Then, as a case study, we've got a number of local communities that have a lot of turbulence occurring within them in the delivery systems. We took a snapshot for you of Medford, Oregon, the southern part of the state, about 25 miles north of the Oregon-California border. It's the fifth largest city in the state, about 100,000 plus people in the community.

Sixty (60) percent of the primary care practices have been dissolved or reorganized in that community. The largest and oldest group practice, the Medford Clinic, with about 50 or 60 primary care physicians, has been dissolved. The largest physician-hospital organization was also dissolved. All the commercial HMOs that were working in that market (and had been present for some time) have all withdrawn. Only one Medicaid HMO remains.



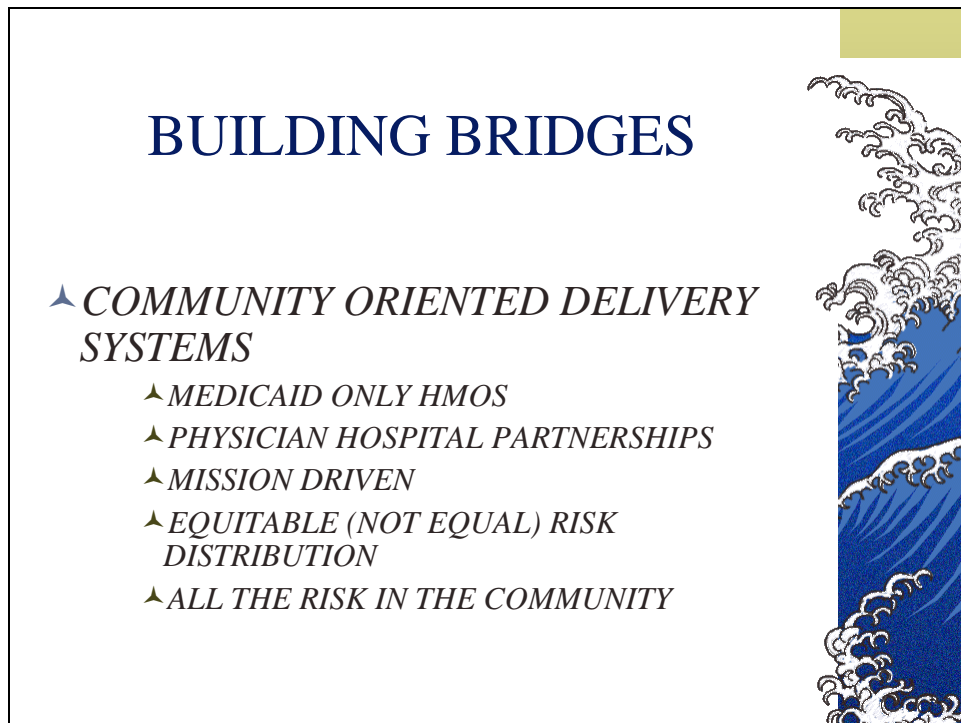
**TURBULENT MARKETS**

- ▲ *TUMULTUOUS DELIVERY SYSTEMS—MEDFORD, OREGON*
  - ▲ *60% OF PRIMARY CARE PRACTICES DISSOLVED, REORGANIZED*
  - ▲ *LARGEST, OLDEST GROUP PRACTICE BANKRUPT*
  - ▲ *LARGEST PHYSICIAN HOSPITAL ORGANIZATION DISSOLVED*
  - ▲ *ALL COMMERCIAL HMOs WITHDRAWN*
  - ▲ *ONLY ONE MEDICAID HMO REMAINS*

The root causes of the turbulence that we're seeing in these communities are traceable to a couple of things. There's fundamental failure of the integrated systems and a kind of disconnect between the partners in the systems. And there are arguments over the level and allocation of reimbursements that are flowing through from the capitated payments. The Medford experience is just typical of the fracturing of the managed care delivery systems in key communities throughout Oregon.

MR. DiPRETE: With the larger commercial insurers pulling out of the Oregon Health Plan, the last couple of years have seen the development of new bridges between the Oregon Health Plan and Oregon communities, particularly outside the Portland metropolitan area. We have the emergence of smaller health plans that are Medicaid only HMOs. These tend to be characterized by physician-hospital partnerships. They tend to be mission driven in the sense that they have agreed to as a provider community taken as a whole to manage the health care and

the risk present in the community. They have achieved equitable, though not always exactly equal risk distributions, so that none of the providers feel as though they're losing at the expense of other providers consistently, but there are adjustments made. Also, they take on all the risk in the community and control it locally. With the departure of larger insurers that are headquartered elsewhere, the governance of these health plans has been controlled locally.




**BUILDING BRIDGES**

- ▲ *COMMUNITY ORIENTED DELIVERY SYSTEMS*
  - ▲ *MEDICAID ONLY HMOS*
  - ▲ *PHYSICIAN HOSPITAL PARTNERSHIPS*
  - ▲ *MISSION DRIVEN*
  - ▲ *EQUITABLE (NOT EQUAL) RISK DISTRIBUTION*
  - ▲ *ALL THE RISK IN THE COMMUNITY*

As an effort to build a bridge between the Oregon Health Plan and private insurance, the Oregon legislature passed in 1997 (just before the passage of CHIP legislation at the federal level) the Family Health Insurance Assistance Program [FHIAP]. This program subsidizes group and individual health insurance. There is a requirement that applicants be uninsured for six months in order to be eligible. This is a barrier against crowd-out or substitution.

The objective was to make private coverage affordable with subsidies, and the subsidies decline as income goes up. This is an important point, because in Oregon before the implementation of the FHIAP program, as in many other states, there is, in effect, a cliff when you reach the end of Medicaid eligibility. Instead of that, what we're trying to build, I guess, is a ramp, so that there is a gradual decline in support from the government for health insurance and an increase in self-reliance, if you will.

We also offer a choice in the individual market of qualified commercial plans and, in the small group market, or the group market, it is the coverage that is offered by the employer that is subsidized. The program is currently 80 percent individual, 20 percent group. We need to increase the group coverage, obviously. We also have a requirement that the children must be insured first before the parents can qualify for a subsidy for private health insurance.



**BUILDING BRIDGES**

- ▲ *FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM-FHIAP*
- ▲ *GROUP AND INDIVIDUAL SUBSIDIES*
- ▲ *6 MONTH UNINSURANCE REQUIRED*
- ▲ *AFFORDABLE WITH SUBSIDY*
- ▲ *CHOICE OF QUALIFIED COMMERCIAL PLANS (INDIVIDUAL)*
- ▲ *80% INDIVIDUAL, 20% GROUP*
- ▲ *CHILDREN FIRST*
- ▲ *5,000 COVERED, 15,000 WAITING LIST*
- ▲ *STATE ONLY FUNDS, NO FEDERAL MATCH*

The program has 5,000 people covered. I believe there are now 19,000 or 20,000 on a reservation or waiting list. We've reached the limit of what state funding can do, and this just points up the importance of getting federal match for this program. Currently, it's state-only funds, and we intend to try to try to change that.

We attempted to build another sort of partnership with Associated Oregon Industries using its purchasing cooperative, the Health Choice program, as a basis for a CHIP state plan amendment that would allow us to use CHIP dollars to subsidize employer sponsored insurance. This had the advantages of the purchasing cooperative as a platform. The administrative functions were already in place. It was targeting the small group market. It has standardized benefits and cost sharing, which is important when you're trying to bring benefits and cost sharing to meet requirements that have been developed by the federal government. It emphasizes, of course, family coverage—the children being covered with the parents, rather than targeting just children or just specific kinds of adults. And we hoped to qualify this coverage for federal subsidy funding.

One of our objectives was to encourage employers not currently offering coverage to offer it, because it would be affordable now for their employees. We tried for 18 months to reach agreement with the federal government on this program and were unable to do so, primarily because of federal requirements having to do with cost sharing, and the requirement that people who are eligible for Medicaid must go to Medicaid for federally matched health insurance. This points out the fact that we need more flexible approaches on both eligibility and benefits to increase our employer-sponsored insurance subsidy program in Oregon.

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DR. SANTA: Over the last 18 months, we've tried to channel our energy towards a number of strategies that we're hoping will bring us more flexibility and more ability to reenergize the public-private partnership in Oregon. We've taken a number of steps in that direction. The first has been to look at defining populations within our Medicaid population and we've started by looking at two populations, a vulnerable population and an adult population.

The vulnerable population is defined as all those individuals categorically eligible for Medicaid, all children, and all pregnant women. The adult population is defined, in our parlance, as our "new eligibles"—these are all adults who have come into the plan based on income. This is our expansion population. There's about 85,000 new adults or new-eligible adults in our population and about 280,000 categorically eligible children or pregnant women.

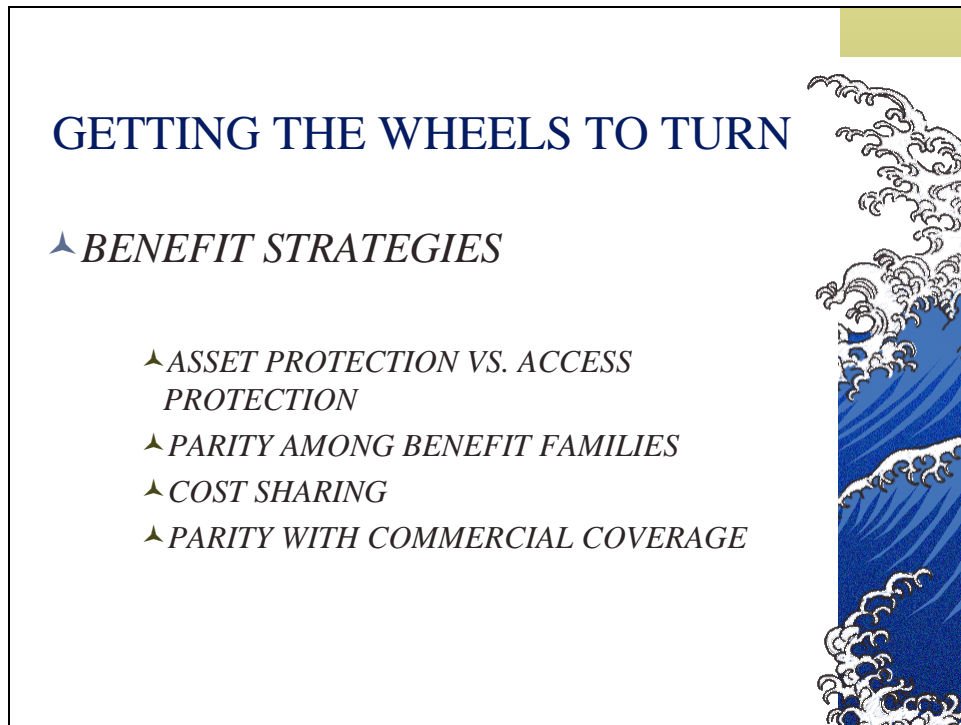
The second thing we've done has been to look at two different benefit plans. The first we would call the "Plus Plan." Essentially, we would have the benefits that the current plan has for the Plus Plan, and this benefit plan would be provided to the vulnerable population.

The second benefit plan, which we've called the Standard Plan, would have benefits more like a commercial plan. A benefit design that would end up somewhere between the mandated Medicaid benefit plan and the current benefit plan that we have. In the back of the room, you'll find legislation, House bill 2519, that at least is the start of describing where we're going from a legislative point of view. That's passed our House and is on the way to the Senate.

Well, looking at two different benefit plans has resulted in the emergence of a variety of benefit strategies that we are in the process of discussing at the Health Services Commission. The Health Services Commission is the body—citizen and public body—that has driven the benefit process for us in Oregon. There are some interesting strategies that are starting to emerge there.

I think it's likely that this standard plan will be driven more by a desire to protect access than to protect assets. What this will likely mean is that cost sharing will be minimal on the front end of the delivery system and cost sharing will tend to occur more around hospital and more complicated care. So, a bit of the reverse of the usual benefit approach in terms of a traditional insurance approach, protecting access rather than protecting assets.

We're having a lot of discussion about what kind of parity there should be between benefit families: physical health, mental health, dental, vision, transportation, a variety of benefit families. Of course, one key discussion is around physical health and mental health. I suspect in our state there will be parity in public coverage for mental health. The key will be how will we bridge to private coverage where we don't have parity? We have a mandated mental health approach on our private side that is not at parity.



A number of different cost-sharing strategies are being evaluated. Again, the key differentiator, I suspect, will emphasize cost sharing strategies that will be focused on less effective procedures and will protect front end access for individuals having that standard benefit plan.

Finally I think this benefit design will look a lot more like commercial coverage than our current Medicaid coverage does and will at least reduce the current gulf in coverage between those two types of benefit plans.

There are going to be some administrative opportunities and challenges. Our intention is to take the resources saved from the creation of this standard benefit plan and use that for expansion. We estimate that we can expand the Oregon Health Plan to approximately 50,000 individuals currently uninsured with the savings that will result from this change, and that that will be budget neutral.

We're pursuing this, and House bill 2519 is pegged at being budget neutral because of the shift in those savings. At this point, it appears the best way to do that will be for individuals to enter through a public program and for groups to enter through a private program, so that percentage that Bob referred to earlier in terms of FHIAP will actually probably shift the other way, 80 percent group and 20 percent individual.

We're intrigued by the opportunities that we believe some of the associations, including the AOI Association, may bring us in terms of a more organized approach to small group coverage, and we're hopeful that the federal government will work with us on this approach so

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that we'll be able to get additional match for those state-only funds for FHIAP and from some other sources, and that we'll be able to leverage the dollars in employer coverage to make our approach to the uninsured more efficient.

That latter we think will be particularly challenging. We do think there are opportunities among low-wage workers and large employers who have reasonable benefit plans and reasonable contributions, and we need to be able to figure out how to find them more efficiently and take advantage of that.

We also think that the current difficulties in the small group market, particularly around age rating and participation rates, will give us some opportunities in terms of these subsidy programs, where we think subsidizing some individuals in small group will allow them to meet participation rates that they currently have trouble meeting, and we think that some of the difficulties caused by age rating can be addressed with our subsidy approach.

Finally, again, we believe that working through associations may help us reduce some of the concern around risk issues and reduce some of the administrative challenges that we may have. A key issue, though, in this approach will be to give families choices among the benefit plans available, and that's going to be a particularly important strategy for us to pursue.

MR. DiPRETE: What we're trying to move away from is the situation we have now, where program rules often dictate that the children will be covered outside the family, as with the CHIP program, or that one of the other family members—a pregnant woman or young child, for example—will go to Medicaid while the rest of the family is in another coverage plan.

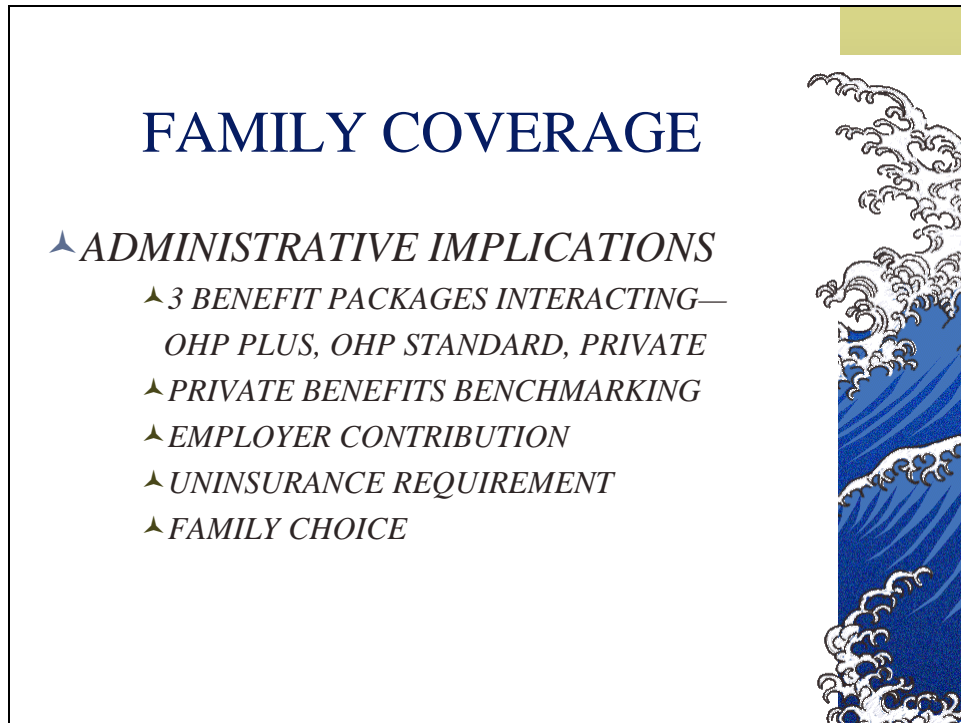
It's our objective to give families the option to have the entire family covered together if that's what they prefer, but to explain to them all of the coverage options that might be available. What we envision is that we will use FHIAP for private coverage, benchmarked group coverage, and that means that we will qualify the coverage to be subsidized and make sure that it does meet a standard.

In addition, we'll have individual coverage expanded through Medicaid and CHIP, and here we'll have a new Oregon Health Plan Standard Benefit package in addition to the current Oregon Health Plan package, which will become the OHP Plus benefit package.

The individual coverage will all be administered by the same folks, at least as we envision it now, who administer our Medicaid program. But, again, the benefit packages will vary, depending on whether the enrollee is an adult or a child and, if an adult, whether they're aged, blind, disabled, or a pregnant woman and so qualified for OHP Plus benefit package.

Now, there are a number of administrative implications for all of this. We are going to have three benefit packages in play and interacting, and we'll have to make sure that we coordinate these and that people understand the implications of each of these benefit packages. We're going to be benchmarking private benefits to qualify them for the subsidy to be financed with state dollars and federal match.

We'll also have a minimum employer contribution, and we intend to base this on the characteristics of the marketplace in Oregon related to the target population we're trying to expand coverage to.



**FAMILY COVERAGE**

- ▲ *ADMINISTRATIVE IMPLICATIONS*
  - ▲ *3 BENEFIT PACKAGES INTERACTING—  
OHP PLUS, OHP STANDARD, PRIVATE*
  - ▲ *PRIVATE BENEFITS BENCHMARKING*
  - ▲ *EMPLOYER CONTRIBUTION*
  - ▲ *UNINSURANCE REQUIREMENT*
  - ▲ *FAMILY CHOICE*

We intend to continue our requirement that applicants be uninsured for six months, again as a barrier against crowd-out or substitution. And we want to maximize family choice. I guess the easiest way to explain this is that we don't want to be in the position of telling a family, "It's Medicaid or nothing" for one or more family members. And we also don't want Medicaid to, in effect, split the family because of program requirements so that some family members are covered under this program and others must be covered under Medicaid.

And our goal is, in fact, informed family choice among coverage options that are qualified under the Oregon Health Plan.

Now, as you all know, I'm sure, there are barriers in both Title XIX and XXI, both Medicaid and CHIP programs, that make it difficult to do this. The cost-sharing requirements that came along with the CHIP program were set quite low. Cost-sharing limits are set at the Medicaid level for children up to 150 percent of federal poverty level, with a cap of five percent of annual family income for those above 150 percent.

We think that those levels are too low, especially when the entire family is going to be covered. Five percent of the family's annual income is too low a limit on cost sharing. We also, as I mentioned, don't want to be in the position of saying that, if you qualify for Medicaid, that's where you have to go for your coverage. We don't want the families to be split if the families

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prefer to be covered together. And we want reporting requirements to match the situation when we're dealing with private coverage rather than a Medicaid program.

Now, the policy issues are also numerous. We're going to be asking again for flexibility on benefits with a new benefit package that more closely resembles private coverage. And, we will be asking for flexibility on cost sharing so that we don't have a cliff where the subsidies all of a sudden come to an end, but instead the family's share of cost gradually rises as income rises.

**FAMILY COVERAGE**

▲ *POLICY ISSUES*

- ▲ *FLEXIBILITY ON BENEFITS*
- ▲ *FLEXIBILITY ON COST SHARING*
- ▲ *FAMILY CHOICE AMONG QUALIFIED PROGRAMS*
- ▲ *FLEXIBILITY ON EMPLOYER CONTRIBUTION*
- ▲ *CROWD OUT*

We want family choice among qualified programs. We want flexibility on the employer contribution so that it can be set at a level that matches the segment of the marketplace in Oregon where most of the target population works. And we need to devise barriers against crowd-out, some of which we built into the FHIAP program even before CHIP came along and the federal government made clear its concern about substitution. It's our objective to maintain or even increase overall employer contributions to financing health coverage, and if we have crowd-out or substitution, it will undermine our ability to achieve an overall gain in the percent and number who are insured.

However, if we can get the flexibility we need on these policy areas and administrative requirements, we think we have a good chance to rebuild the public-private partnership that was the basis of the Oregon Health Plan and to stabilize and expand the Oregon Health Plan.

MR. EARLS: In addition to the policy flexibility that Bob has described, he's also mentioned that we need to focus on rebuilding the public-private partnership that has been the cornerstone of the development of the Oregon Health Plan if we're going to be successful in growing the health plan to reach a significant chunk of the remaining uninsured.

To do that, we're going to have to focus on stabilizing a couple of the key elements that we've talked about this morning. We've got to nurture the employer-sponsored coverage that has been a significant portion of the expansion of the broader Oregon Health Plan. We need to create a cost effective public expansion, and we need to restore adequate incentives for provider participation where we've seen some slippage.



**Rebuilding the Public Private Partnership**

- ▲ *STABILIZING THE KEY ELEMENTS:*
  - ▲ *EMPLOYER SPONSORED COVERAGE*
  - ▲ *COST-EFFECTIVE PUBLIC EXPANSION*
  - ▲ *INCENTIVES FOR PROVIDER PARTICIPATION*

In the employer sponsored insurance market, we've seen expansion that's greatly exceeded, I think, most expectations, even in the absence of the employer mandate that was part of the original enabling legislation.

The voluntary nature of employer-sponsored coverage, of course, makes it volatile. Oregon is a uniquely small business state, and that, I think, contributes to the potential volatility of employer-sponsored coverage. And, of course, employers there are threatened by rising premiums, as they are elsewhere in the country, and we're also beginning to see in Oregon the return of uncapitated care and cost shifting which had abated with the initial launch of the Oregon Health Plan.

Bob mentioned that we need to foster public programs that allow families to be covered together if they so choose. Public programs must minimize the administrative burden on

employers. Again, I think it's acutely important in Oregon because of our unique status as a small business state, and the pain threshold for administrative burden in the small employer community is pretty low.

**Rebuilding the Public Private  
Partnership:  
Stabilizing the Key Elements:**

- ▲ *EMPLOYER SPONSORED INSURANCE*
  - ▲ *EXPANSION HAS EXCEEDED EXPECTATIONS*
  - ▲ *VOLUNTARY NATURE MAKES IT VOLATILE*
  - ▲ *PUBLIC PROGRAMS MUST ALLOW FAMILIES TO BE COVERED TOGETHER*
  - ▲ *PUBLIC PROGRAMS MUST MINIMIZE ADMINISTRATIVE BURDEN ON EMPLOYERS*
  - ▲ *COVERAGE SHOULD MINIMIZE DIFFERENCES BETWEEN COWORKERS*



Finally, a key component: coverage needs to minimize the differences between coworkers. People working side by side ideally won't be able to distinguish the fact that one is receiving their employer-sponsored coverage with some assistance through Medicaid.

In stabilizing the component of cost-effective public expansion, coverage for the new eligibles, the non-aged, non-disabled adults, must look, function and cost like private coverage in three key ways:


- Benefits must be similar in scope. That rich benefit package that we talked about at the outset needs to be narrowed for this population so that it looks more similar to commercial insurance.
- Cost sharing principles must be present on the public side akin to what we see in the commercial market, at least in design.
- And, again, employer-sponsored coverage when offered and the family prefers [it] must be available.

Stabilizing the incentives for provider participation. We need to pump some air back in the tires in this area. We need to be able to foster these community-based partnerships which John has described. We need to ensure or restore adequate payment to ensure adequate provider participation—closer to the kinds of reimbursement that we see on the private pay side. That

was a kind of founding element of the Oregon Health Plan—that reimbursement to providers would be more equitable and more on par with the kind of reimbursements that they see in the private market.

**Rebuilding the Public Private  
Partnership:  
Stabilizing the Key Elements**

- ▲ *INCENTIVES FOR PROVIDER PARTICIPATION:*
  - ▲ *COMMUNITY BASED PARTNERSHIPS*
  - ▲ *ADEQUATE PAYMENT*
  - ▲ *MINIMIZE ADMINISTRATIVE BURDEN ON PROVIDERS*



And we need to minimize the administrative burden on providers. Again, it's got to be fairly smooth and fairly easy for them to administer. So, to be successful, we need to minimize the differences between public and private coverage for all involved. It will allow us to reach significant number of Oregon's remaining uninsured—I think we've targeted about 50,000—while minimizing the sources of friction that have hindered the program's success in more recent times.

And, with that, the three amigos are available for questions.

AUDIENCE PARTICIPANT: That 60-percent increase in drug costs that you referred to earlier—I hope that was per biennium and not per year?

DR. SANTA: Yes, that's for a biennium. In Oregon, one thing we have not done a very good job of thinking out of the box on is around prescriptions. Actually, the pharmaceutical companies succeeded, I think, 15 years or so ago in putting into statute a prohibition on formularies in Medicaid. So we really have virtually no control over cost of prescription drugs.

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AUDIENCE PARTICIPANT: Can you tell me the population of Oregon and your percent uninsured?

DR. SANTA: Our population is about 3.4, 3.5 million. By our surveys, we're at ten percent uninsured.

AUDIENCE PARTICIPANT: I have a question about the cost-sharing increases that you want to impose. The goal is to try to bring it somewhat closer to parity with employer-based coverage, as I understand it. If you're getting coverage through the employers, you have things like payroll deductions. In many cases, you have tax-advantaged plans like flexible spending that make it fairly easy and often a little bit less onerous, cost-wise, to buy into employer-based insurance. But you don't have this as easily if you're going on the individual side, which is where many people will continue to be coming to the plan. If you increase your premiums, but you don't have the convenience of payroll deductions and those other things that happen in the workplace, how is it going to end up that participation is not going to plummet?

DR. SANTA: Well, actually we've been pretty successful so far at a premium contribution approach for those new eligible adults. They're contributing premiums in the one to two percent range. And, actually, one of the concerns was that we were having disenrollment because of that premium contribution structure, and it turns out in a survey [we did that] only about three percent of individuals disenrolling attributed that to premiums. It's working relatively smoothly in that very low-income population at relatively small contributions. That's, I think, going to be an important issue, though, in terms of the sliding scale. It may become more of an issue for people between 100 and 200 percent of the federal poverty level, and we share your concerns.

Any other questions? Well, we'll be around and available, and if you have any questions on some of the additional information, stop us. Thanks.

## About the Speakers

**John Santa, M.D.**, is currently the Administrator of the Office for Oregon Health Plan Policy and Research. Dr. Santa is a general internist with experience in a diverse array of clinical, administrative, community and research activities. He attended Stanford University, Tufts Medical School and is now pursuing a Masters in Public Health at Oregon Health Sciences University. He practiced medicine for thirteen years in solo, group and employed settings. He has worked in administrative positions for hospitals, insurers, medical groups, and now the State of Oregon. His activities have often involved implementation of health policy initiatives.

**Kevin Earls** is the Vice President of Finance and Health Policy for the Oregon Association of Hospitals and Health Systems in Lake Oswego, Oregon. Prior to joining the OAHHS team, Kevin spent 12 years with Associated Oregon Industries (AOI), Oregon's largest business organization, where he served as the AOI Health Care lobbyist, and Vice President of their member-services company. While at AOI, Kevin was also responsible for starting AOI HealthChoice, a company that pools the purchasing of group health insurance for the business-members of AOI. Kevin is a native Oregonian and attended University of Oregon, Willamette University's Atkinson School of Administration, and is a graduate of Southern Oregon University.

**Robert S. DiPrete** is the Director of the Oregon Health Council, which is the health care policy advisory board to the Governor and the Legislature. Bob has worked in health care finance and delivery since 1976 as a manager and consultant on projects addressing Medicaid, Medicare, and private insurance. His responsibilities have included provider network development, membership management, rate-setting and risk management, research, evaluation, and health policy analysis. For the past ten years, Bob has worked on the Oregon Health Plan. Prior to his current position with the Health Council, he participated in the design of Oregon's Medicaid waiver program and was project director for the state's first grant under the Robert Wood Johnson Foundation "State Initiatives" program.