

State of Oregon

1115 Waiver Amendment Application

May 31, 2002

Table of Contents

1. Statement of Purpose	1
2. Environment	3
3. Benefits	12
4. Eligibility	20
5. Eligibility Rules/Enrollment Process	23
6. Service Delivery/Access	27
7. Implementation Plan and Timeline	30
8. Monitoring	33
9. Evaluation	36
10. Waivers and Expenditure Authority Requested	39
11. Budget Neutrality	43
Appendices	51

Section 1: Statement of Purpose

Since 1994 Oregon has had a Section 1115 waiver that allows the State to provide Medicaid coverage to individuals with incomes up to 100 percent of the federal poverty level (FPL) and to provide benefits to Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries based on the explicit prioritization of health services. Oregon considers the Oregon Health Plan (OHP) to be a successful program. However, it is now apparent that OHP cannot continue as currently designed for a number of reasons:

- The current benefit package cannot support all program enrollees if the program is to be expanded to more low-income Oregonians. Oregon needs more flexibility to adjust benefits to meet resource limitations;
- Employer-sponsored coverage was an integral part of the original OHP design but could not be implemented as a consequence of the Employee Retirement Income Security Act (ERISA) — the design called for an employer mandate. Many Oregonians prefer private insurance coverage even if the benefit package is less comprehensive and cost-sharing is greater than coverage provided by Medicaid;
- The income level for eligibility is too low, and individuals cycle on and off the program. This “churning” puts a strain on the delivery system and makes it more difficult to achieve the benefits of population-based preventive interventions.

These and other concerns led to the passage of House Bill 2519 (See Appendix 1.1), which represents a bipartisan effort to restructure OHP in order to sustain the current program, expand coverage to higher income levels to stabilize insurance coverage and reach more uninsured Oregonians, and leverage private insurance, particularly employer-sponsored coverage. The restructured program in its entirety is referred to as OHP2.

OHP2 has three components, two offered through public insurance (Medicaid and SCHIP) and one through private insurance:

- *OHP Plus*. OHP Plus will provide the current OHP benefit package to people eligible for Medicaid (without a waiver), General Assistance recipients, and pregnant women and children (both Medicaid and SCHIP) up to 185 percent FPL.
- *OHP Standard*. OHP Standard will provide a benefit package that is more similar to commercial insurance coverage and will be provided, up to a capped enrollment, to adults who are not otherwise eligible for Medicaid (including parents, singles and couples) with incomes up to 185 percent FPL. OHP Standard enrollment will be expanded initially up to 110 percent of FPL, then moved up by 15 percent income bands as budget allows, giving priority to parents of SCHIP and PLM children and current clients moving over the upper income limit of OHP Standard.

- *Family Health Insurance Assistance Program (FHIAP)*. FHIAP will provide premium subsidies for the purchase of private health insurance for uninsured Oregonians with incomes up to 185 percent FPL. Enrollment in FHIAP will be capped. FHIAP will expand by about 9,500 in group insurance initially then will open enrollment in individual insurance. After that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

In order to implement OHP2, Oregon is submitting this waiver amendment application to modify its current Section 1115 waiver as well as submitting a Health Insurance Flexibility and Accountability (HIFA) waiver. Together, these waiver application requests seek:

- Expansion of coverage for children and pregnant women with incomes from 170 percent up to 185 percent FPL;
- Expansion of coverage (under a capped enrollment) for all adults not eligible for Medicare with income up to 185 percent FPL;
- Approval and Federal financial participation (FFP) for the OHP Standard benefits package with the associated cost-sharing;
- Approval and FFP for the FHIAP program (both individual and group) including coverage of individuals currently enrolled in the program as well as additional individuals who may become eligible under a capped enrollment expansion up to 185 percent FPL;
- The provision of funding for the expansion population under Title XXI until the State's allotment is exhausted, at which time funding will switch to Title XIX;
- The same end date for the Section 1115 and the HIFA waivers.

Oregon is aware of the Administration's proposal to offer federal refundable tax credits to help low-income Americans purchase health insurance. If this proposal becomes law, the FHIAP component of the OHP2 waiver could manage federal refundable tax credits within a state program that subsidizes both individual and employer-sponsored insurance (ESI). The necessary infrastructure is already in place - FHIAP has successfully administered subsidies for individual and group insurance since 1998. As a barrier to "crowd-out," FHIAP already requires that applicants are uninsured for a minimum of six months before being determined eligible. Federal refundable tax credits managed through FHIAP could make private health insurance affordable to a greater portion of the target population: the uninsured above income limits for Medicaid.

Section 2: Environment

Oregon has explicitly acknowledged the limiting effect of fiscal realities of the State's ability to provide publicly-funded health care benefits. It is the only state in the nation to set explicit health care priorities based on clinical effectiveness, and it has used this priority setting mechanism to allocate sufficient public resources to expand Medicaid coverage up to 100 percent of the federal poverty level (FPL).

This acknowledgement of fiscal limits, setting of priorities, and coverage expansion is embodied in the State's current Section 1115 waiver. The State now wishes to submit a waiver to provide a further expansion of eligibility and to utilize both private insurance and a basic benefits package to make such an expansion fiscally feasible. This proposed waiver builds upon years of public policy examination and discussion, and is the direct result of bipartisan efforts in the Oregon Legislature.

This section discusses the historical context of the existing Section 1115 waiver and the development of OHP2 and this waiver amendment application.

A. History of the Oregon Health Plan

Beginning in 1987, a group of Oregonians that included health care providers and consumers, business, labor, insurers and lawmakers, agreed on a common objective: keep Oregonians healthy. They posed three basic questions: who is covered, what is covered, and how is it financed and delivered. They then developed the following public policy objectives:

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

As a result of this work, over the period from 1989 through 1993, the Oregon Legislature passed a series of laws known collectively as the Oregon Health Plan (OHP). The key legislation from that period includes the following:

- *Senate Bill 27 (1989) extended Medicaid coverage to Oregonians with income below the federal poverty level (FPL) through a package of benefits based on the explicit prioritization of health services and on available resources. This expansion required an 1115 waiver of federal law from the (then) Health Care Financing Administration (HCFA) which was granted in March 1993, with implementation starting February 1, 1994. SB27 required that Medicaid deliver services through managed care plans where possible and created the Oregon Health Services Commission to rank medical services from most to least important to the entire population to be covered. The Legislature defines the level of benefits from this list;*
- *Senate Bill 935 (1989) required employers to cover employees working 17.5 hours or more per week and their dependents, or pay into a special State insurance fund to finance coverage for those employees. This “play-or-pay” provision was known as the employer mandate. SB 935 also called for small employers who had not previously offered health insurance to employees to receive tax credits if they volunteered to do so before July 1995. The employer mandate needed a Congressional exemption from the federal Employee Retirement Income Security Act (ERISA). Because the exemption was not granted by the deadline specified by the Legislature, the employer mandate was repealed;*
- *Senate Bill 534 (1989) created the Oregon Medical Insurance Pool (OMIP), which offers health insurance to people who cannot buy individual coverage because of pre-existing medical conditions;*
- *House Bill 5530 (1993) allowed the State to implement the Oregon Health Plan by:*
 - a. Allocating resources for the Medicaid expansion,
 - b. Funding the Oregon Health Plan for 1993-95 to cover 606 of 745 services on the Prioritized List of Physical Health Services,
 - c. Authorizing the integration of seniors and persons with disabilities into coverage based on the prioritized list benefit package,
 - d. Approving the gradual integration of coverage for mental health and chemical dependency services,
 - e. Creating the position of Oregon Health Plan Administrator (now the Office for Oregon Health Policy and Research);
- *House Bill 2894 (1997) created the Family Health Insurance Assistance Program (FHIAP), a State-funded subsidy program to help low-income people afford private group or individual health care coverage. FHIAP provides a premium subsidy that individuals and families can use to access their employer-sponsored insurance (ESI), including portability, state continuation, and COBRA. When ESI is unavailable, FHIAP offers premium assistance to purchase individual policies, including OMIP coverage. FHIAP is administered by the Insurance Pool Governing Board (IPGB). The IPGB was established to increase the number of employers who voluntarily provide health insurance for employees and their dependents. FHIAP was implemented in 1998 and currently has approximately 4,000 enrollees and 22,000 people on its reservation lists.*

B. OHP Revisited

Spring 2000 Public Outreach

In his January 2000 “State of the State” speech, Governor John Kitzhaber challenged citizens to renew their commitment to achieve affordable coverage for all Oregonians. He called for public discussion of these issues, resulting in a public outreach effort, “Making Health Policy 2000,” in the spring of 2000.

More than 1,000 Oregonians from diverse backgrounds participated in 16 community meetings. This was coupled with focus groups and a telephone survey of more than 700 Oregonians as a means of obtaining ideas from the public about how best to shape the health care system to better serve all Oregonians. Four main findings resulted from this public outreach:

- Cost and affordability are important issues, thus new strategies are needed in order to sustain progress toward covering more Oregonians;
- Extending access to all Oregonians gained increased support compared with previous community meetings in 1996;
- All Oregonians should have access to a basic package of health care benefits, consistent with a clear recognition of the limits of financial resources available for health care;
- The delivery system should be more efficient, streamlined and flexible to address the needs of the public.

Basic Benefits Task Force

In the summer of 2000, a Task Force on Basic Benefit Plans was created within the Oregon Health Council. The Task Force held public discussions on the complex issues involved in defining a basic benefit plan. The Task Force considered two types of models for benefit design:

- 1) *Access promotion* - a system that encourages early diagnosis through routine health care in order to increase the potential for better outcomes of treatment and reduced costs;
- 2) *Asset protection* - a system that provides the individual protection from losing their assets due to a severe illness or “catastrophic” event.

The Task Force concluded that a basic benefit plan for uninsured adults between 100 and 200 percent FPL should stress access promotion. By focusing on access promotion there would be enhanced coverage of preventive and early intervention health care, even if coverage of high-cost cases were limited. This plan is consistent with the public health goal of encouraging preventive care and early diagnosis to improve health outcomes for the entire population.

The Health Services Commission (HSC)

The HSC was originally established in 1989 to develop and maintain the Prioritized List of Health Services that is the keystone of the Oregon Health Plan. The HSC consists of five physicians, one social worker, one public health nurse, and four at-large members.

In December 2000, Governor John Kitzhaber directed the members of the Health Services Commission to begin work on defining a standard benefit package that could be used to expand

access to health care to non-categorical Oregonians with household incomes up to 200 percent FPL. (The enacted version of the legislation lowered this goal to 185 percent FPL.) The current OHP benefit package would continue, remaining available to the categorical and medically vulnerable populations. The standard package would be at least actuarially equivalent to the benefit package federally mandated under Medicaid. The Governor directed that “OHP Standard” should be consistent with the level of typical commercial plans at around 78 percent of the actuarial value of OHP’s current benefit package.

C. The Conditions that Resulted in HB 2519

As the design and policy objectives of the Oregon Health Plan were revisited, certain conditions were observed that renewed the State’s commitment to achieve affordable health care coverage for all Oregonians. Among the conditions recognized were:

- The Oregon Health Plan expanded income eligibility for Oregon’s Medicaid program to cover persons under the FPL except for those eligible for Medicare. As a result, approximately 100,000 low-income Oregonians gained health coverage. However, Oregon has noted a significant “churning” effect as people go on and off coverage as their monthly incomes fluctuate around 100 percent FPL. As a result, many face the prospect of moving from comprehensive health coverage to no health coverage at all. This occurs because many of those who lose eligibility for OHP as a result of an increase in income work at jobs that do not offer health insurance, offer insurance but require someone to be with the company a set amount of time, or offer insurance but do not provide a sufficient employer contribution. In addition, these individuals typically cannot afford individual coverage. Thus a slight increase in income around 100 percent FPL can lead to uninsurance.
- Oregon’s rate of uninsurance decreased from 18 percent when OHP started in 1994 to as low as 10 percent in 1998. However, in 2000 the uninsured rate rose to 12.3 percent based on Census 2000 weighting factors and Oregon Population Survey data analysis.
- Despite Oregon’s well-established record for health care cost efficiency, costs for the Oregon Health Plan have increased significantly over the last eight years, as have health care costs in general. The cost of drugs is the fastest growing component of the OHP budget.
- The Oregon Health Plan was based on a commitment to the concept of a basic benefit package built around the prioritization of medical services. This process has served Oregon well and provided an open and accountable way to make the difficult choices necessitated by the reality of fiscal limits.
- The Oregon Health Plan was designed to control costs by adjusting the Prioritized List of Health Services. The current OHP benefit package is far more comprehensive than the federal Medicaid statutory minimum. The last effort to adjust the benefit level based on the Prioritized List of Health Services was not approved under the previous administration.
- Medicaid law mandates a minimum benefit level. The current Oregon Health Plan goes beyond the required benefits and provides a package that is more comprehensive than the mandated benefits for Medicaid eligibles, including the OHP “new eligibles” up to 100

percent FPL. Flexibility concerning the benefit package is key to preserving OHP with today's rising health care costs.

- Private sector health insurance contributed significantly to the decrease in the rate of uninsurance in Oregon during the 1990s. The private insurance market should be supported.
- The Family Health Insurance Assistance Program (FHIAP) is an innovative and successful model program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 170 percent FPL. FHIAP provides a choice of private plans, with a sliding scale subsidy for premiums. Approximately 18 percent of current adult FHIAP enrollees are eligible for OHP but choose FHIAP despite the required cost sharing.
- The FHIAP program is State-funded, making it limited in scale. The current budget restricts enrollment to about 4,000 participants, but there is a reservation list of about 22,000 with the addition of 1,000 to 1,500 each month. As part of OHP2, Oregon intends to leverage State dollars with Federal financial participation (FFP) to expand coverage through FHIAP within the confines of the Federal test of budget neutrality.

D. HB 2519

The public commitment to maintain the Oregon Health Plan (OHP) and the desire to extend coverage to more Oregonians resulted in the passage of House Bill 2519 by the 2001 Oregon Legislature (See Appendix 1.1). The legislation outlines the policy framework and the process to expand the number of people eligible for OHP using savings from creating a basic benefit package (OHP Standard). The legislation passed by a 45-5-10 vote in the House of Representatives and a 27-2-1 vote in the Senate, demonstrating a strong bipartisan commitment to increase access to affordable health care coverage for low-income uninsured Oregonians.

A key policy objective of HB 2519 is to design OHP2 (the combined packages of OHP Plus, OHP Standard and FHIAP) to encourage the transition to ESI, rather than remaining on Medicaid-style coverage. OHP Standard is more like private insurance products than the current OHP, with cost-sharing and premiums. OHP2 will also expand FHIAP, with an explicit emphasis on ESI coverage. By accessing FFP in FHIAP, thousands of additional people will be able to receive health care coverage through their employer(s).

The State of Oregon health policy specified in the bill is that the State will:

- 1) "...in partnership with the private sector, move toward providing affordable access to basic health care services" for low-income, uninsured children and families;
- 2) Provide subsidies to low-income Oregonians to expand coverage, with responsibility for coverage shared among all parties in the public and private sector;
- 3) Clearly define the roles and responsibilities of all stakeholders;
- 4) Base subsidies on an individual's ability to pay; and
- 5) Encourage the use of evidence-based health care services, including education, intervention and prevention, and procedures that are effective in producing good health.

Findings by the Legislature discussed in HB 2519 include that:

- 1) The Oregon Health Plan has provided access to health care services to over one million Oregonians;
- 2) OHP has improved health outcomes by expanding access to services;
- 3) Inadequate reimbursement rates create cost-shifting and barriers to health care for OHP enrollees;
- 4) The current trend of increasing health care costs creates concerns including the sustainability of the OHP, as well as for individuals, public and private insurers, and health care providers; and
- 5) Employer-sponsored health coverage provides the majority of coverage for Oregonians and “must be supported by public policies that remove barriers to obtaining private health insurance coverage.”

Key provisions of HB 2519 include:

- Increased access for uninsured individuals:

“... subject to funds available, the State of Oregon shall increase access to basic health care services provided through Medicaid, the Children’s Health Insurance Program or private insurance for uninsured Oregonians with an income up to 185 percent of the federal poverty guidelines.”
- Waiver approach for private insurance coverage:

“...the Department of Human Services shall apply to the Centers for Medicare and Medicaid Services for waivers to obtain federal matching dollars for public subsidies for low-income, working Oregonians for the purpose of making private health insurance more accessible and affordable.”

“The waiver application shall provide for the establishment of a basic benchmark health benefit plan or plans, or approved equivalent, for subsidized employer-sponsored coverage in the small employer health insurance market.”
- Levels of coverage for Medicaid:

Medicaid benefits will include a basic benefit package called “OHP Standard” and a benefit package “for persons with greater medical needs” called “OHP Plus.”
- Subsidies for Health Insurance Coverage:

“Subject to funds available, the waiver program ...shall provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals based on incomes up to 185 percent of the federal poverty level.”

E. Public Process

Governor John Kitzhaber and agencies of the Executive Branch, including the Department of Human Services, various advisory groups, and the public worked together to develop the waiver

application. The following is an overview of efforts that involved the public in the development of OHP2.

The Health Services Commission (HSC)

HB 2519 requires that OHP Standard be at least actuarially equivalent to the federally mandated Medicaid benefits. HB 2519 also directs the HSC to rank in priority order additional packages of benefits that could be added to the standardized benefit package as available resources permit. In addition, HB 2519 states “the commission shall recommend whether Oregonians receiving subsidies for OHP Standard be required to pay premiums and copayments based on the individual’s ability to pay and how to structure the copayments and premiums in a manner that encourages the use of preventive services.”

The HSC debated how best to structure the standard benefit package called for by HB 2519 (OHP Standard). The HSC initially considered defining the benefit package using the Prioritized List of Health Services currently in use under the existing Medicaid Demonstration waiver. However, in order to reach the projected 22 percent reductions in benefits necessary to reach budget neutrality, significant cuts in the Prioritized List of Health Services would have been necessary. It was estimated that the coverage level would have to be reduced from line 566 to line 350 or above. This would mean eliminating effective treatment for some non life-threatening diseases (e.g. glaucoma, closed fractures), as well as some conditions that are life-threatening. The current Prioritized List of Health Services will remain, however, as the basis for determining coverage for specific conditions and treatments for both OHP Plus and OHP Standard.

The HSC then looked at the insurance model as a basis for defining the OHP Standard benefit package. Mirroring the vast majority of commercial insurers, the Commission identified the incorporation of cost-sharing as a method of providing more flexibility in designing benefit plans. Thus the Health Services Commission made cost-sharing an integral part of the prioritized listing of benefit packages.

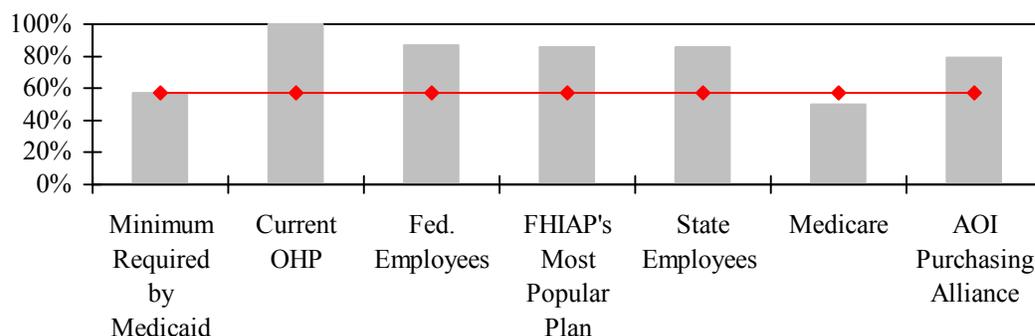
The HSC also worked with the Dental Care Organizations (DCOs) to determine if any savings could be obtained from some restrictions in benefit service levels and the addition of cost-sharing. The DCOs public input into the HSC process provided a means of continuing coverage for a core package of dental benefits with cost sharing.

The HSC modeled actuarial comparisons of plans and analyzed benefit costs. The database used as an approximation of the expansion population was claims and encounter data for the current OHP “new eligibles.”

Starting with the federal Medicaid mandated benefits as outlined by the Social Security Act and the current OHP benefit package, the HSC compared the actuarial equivalence of various plans including Medicare, Oregon’s Public Employees Benefit Board, small employer plans offered by the Association of Oregon Industries (AOI), and the most commonly selected plan in FHIAP. Medicare was significantly less comprehensive in benefits, while the value of the other plans was about 20-25 percent less than OHP (See Exhibit 2.1). This level of benefits, 78-80 percent of OHP’s actuarial value, is in the range the Governor had first suggested to the HSC as a value for OHP Standard to meet budget neutrality targets. The similarity of OHP Standard to Oregon’s current private health care insurance market is important since part of the expansion is to be

provided through the FHIAP program and its prevailing employer-sponsored insurance basic benefit benchmark plan(s).

Exhibit 2.1: Actuarial comparison of various plans to current OHP (OHP Plus) modeled by the HSC:



The HSC also reviewed models of various cost-sharing options, including co-insurance, copayments, out-of-pocket maximums, and deductibles. The HSC compared different plans' actuarial values with the current OHP, which has very little cost-sharing (currently only premiums for "new eligible adults"). A multitude of scenarios were used to see how the different cost-sharing elements affected the overall actuarial value. In addition, the HSC debated exclusions and limitations of specific services, comparing OHP to commercial products. The cost-sharing literature was also reviewed to assess the impact of cost-sharing on enrollees.

Based on its deliberations the HSC prepared a report that included a "Prioritized List of Benefit Packages" and recommendations for cost-sharing.

Summer 2001 Public Outreach

To assist the HSC in making decisions required by HB 2519, community meetings were designed to encourage current and potential OHP enrollees to participate by eliciting citizen input on changes to the benefit structure and cost-sharing options. During July and August 2001, nine community meetings involving more than 300 participants were conducted throughout Oregon. To gather further opinion and comment about the changes being planned to OHP, over 40 stakeholder meetings involving another 300 participants were also conducted in association with the public meetings.

Insurance Pool Governing Board

The Insurance Pool Governing Board (IPGB) is responsible for the Family Health Insurance Assistance Program (FHIAP), which provides premium subsidies for the purchase of private health insurance for qualified, uninsured Oregonians. As required by HB 2519, the IPGB, in consultation with the Health Insurance Reform Advisory Committee (HIRAC), developed a group benchmark benefit plan, taking into account the most common employer-sponsored health benefit plans currently in the market. As described in Section 3, in order to be subsidy-eligible, a plan must offer services in 20 different benefit categories subject to overall cost-sharing limits.

The IPGB did not create a new health benefit plan, merely a benchmark that potential subsidy-eligible plans will be measured against. The IPGB then recommended the group benchmark benefit plan to the Waiver Application Steering Committee and the Leadership Commission.

Waiver Application Steering Committee (WASC)

As required by HB 2519, the Department of Human Services (DHS) established the Waiver Application Steering Committee (WASC) to 1) recommend a benefit package for the OHP Standard population, and 2) assist and advise DHS in the preparation of the waiver application. The WASC included legislators and representatives of a broad range of interest groups.

The Health Service Commission report was forwarded to the WASC. Based on extensive discussions and recommendations from advocates and health plans, the WASC recommended the OHP Standard benefit package and the cost-sharing requirements within the parameters established by the Governor and the legislative leadership. The WASC also discussed other issues related to the waiver application (e.g. eligibility, waiver strategy, premium levels, and the choice between public and private programs) and advised DHS on these issues. In addition, the WASC reviewed the recommendation regarding the benefits benchmark for FHIAP.

Joint Leadership Commission on Health Care Costs and Trends

The Leadership Commission consists of eight legislators. The role of the Leadership Commission on Health Care Costs and Trends with regard to the expansion of the Oregon Health Plan is primarily one of oversight. The commission received reports from the Health Services Commission on the costs of the basic benefit package of health care services under OHP and from the Insurance Pool Governing Board on the basic benchmark health benefit plan related to employer-sponsored benefit plans. In addition, the Leadership Commission received a draft of the waiver application before it was forwarded to the Emergency Board for review.

Legislative Emergency Board

The Legislative Emergency Board authorizes changes in funding while the legislature is not in session. It is a joint House/Senate committee of 17 members. The draft application was first submitted to the Legislative Emergency Board as directed by HB 2519 on January 7, 2002. The waivers were approved for submission to the Centers for Medicare and Medicaid Services on May 1, 2002.

Section 3: Benefits

A. Overview

Oregon Health Plan 2 (OHP2) will serve as a bridge from traditional Medicaid/SCHIP benefits to private coverage benefits. OHP2 will maintain the current Oregon Medicaid/SCHIP benefit package for certain populations, add a second reduced benefit package – OHP Standard - for other populations, and subsidize private insurance for people eligible for OHP2 and who have qualified employer-sponsored insurance (ESI) available to them or, if ESI is not available, individual coverage. Savings from the reduced benefit program and additional federal financial participation (FFP) will be allocated to finance the results of outreach and an eligibility expansion for adults and children at higher income levels than are currently in place.

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

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

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

The second benefit package, OHP Standard, will provide basic coverage more similar to private insurance coverage. The initial benefit package, which includes premium sharing and copayments, has been designed to provide benefits at least actuarially equivalent to the federally mandated Medicaid benefit package. The benefit level recommended by the WASC is equivalent to approximately 78 percent of the value of the OHP Plus benefit package (including a portion of the additional premiums). The groups that may receive OHP Standard include those optional and expansion populations not included in OHP Plus that do not have qualified employer-sponsored insurance (ESI) available. These groups include:

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

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

B. OHP Benefits and Cost-Sharing

In the current waiver demonstration (OHP), there is only one Medicaid benefit package and all enrollees receive services according to the Prioritized List of Health Care Services. Currently, covered services include those described by lines 1 through line 566 on this list of 736 lines. Copayments are not currently imposed, but a schedule of copayments on medications and outpatient services has been proposed to CMS as part of a State plan amendment. This schedule will apply to OHP Plus enrollees. See the description of OHP Plus below for a discussion of the copayments.

In addition, certain enrollees, including OHP “new eligibles” (those covered by virtue of the existing Oregon waiver who are not otherwise Medicaid eligible) are required under the current program to pay the following premiums:

Percentage of FPL	Single Adult	Couple
0% up to 50% FPL	\$6.00	\$6.50
50% up to 65% FPL	\$15.00	\$18.00
65% up to 80% FPL	\$18.00	\$21.00
80% up to 100% FPL	\$20.00	\$23.00

The State collects the premiums. Enrollees who do not pay the premium continue to be covered but owe any unpaid premiums. The next time they apply for OHP, they may not be eligible until they have paid past-due premiums. However, Oregon has a process that allows enrollees to request a waiver of past-due premiums when they reapply for OHP. This process will not apply in OHP2 since failure to pay the premium will result in disenrollment effective the following month after receiving adequate notice.

C. OHP Plus

Benefits for OHP Plus

Under OHP2 the Health Services Commission will continue to maintain its Prioritized List of Health Care Services, using it to establish the OHP Plus benefit package of health care services. Coverage is currently provided through line 566 on this list. It is anticipated that any change in benefits in OHP Plus would be through a public process and would need to be approved by the Legislature or the Legislative Emergency Board. Oregon requests that as part of the terms and conditions, CMS and Oregon establish a streamlined process through which Oregon can move the coverage line further up or down the list.

Cost-Sharing for OHP Plus

As noted above, the State has filed a State plan amendment to permit minimal copayments on medications and outpatient services. The copayments on medications will be \$2 for generic drugs and \$3 for brand-name drugs. There will also be a \$3 copayment for outpatient services. In compliance with 42 CFR 447.53(b), individuals through age 18, pregnant women, institutionalized individuals, emergency services, family planning services and supplies, and services provided by health plans will be exempt from copayment requirements. Copayments will be collected by providers. OHP Plus enrollees who indicate to the provider that they cannot

pay the copayment at the time the service is provided cannot be refused services because of their inability to pay. However, enrollees are liable for the copayment and are expected to pay the copayment when they are able to do so.

There will be no premiums for OHP Plus enrollees.

D. OHP Standard

Benefits for OHP Standard

The OHP Standard benefit package has been designed to more closely mesh with private insurance products. The OHP Standard package covers basic services, with cost sharing. Cost sharing and benefit reductions in OHP Standard are overlaid on the Prioritized List of Healthcare Services. Services excluded from OHP Plus coverage because they are “below the line” will also be excluded from OHP Standard coverage.

As initially funded, the following benefits will be included in OHP Standard:

- Inpatient hospital
- Outpatient hospital
- Emergency room
- Physician services
- Lab and X-ray
- Ambulance
- Prescription drugs
- Mental health and chemical dependency
- Durable medical equipment (needed on an ongoing, not one-time, basis)
- Dental

The following benefits will not be included in OHP Standard:

- Vision
- Non-emergency transportation

OHP Standard benefits appear in an order that reflects the value placed on the services as indicated through the community forums, stakeholder meetings, and the Health Services Commission’s judgment as to the priority in a benefit package designed to promote access to care. It is anticipated that any change in benefits for OHP Standard would be through a public process and would need to be approved by the Legislature or the Legislative Emergency Board. The HSC will do additional work on further benefit approaches to allow ongoing flexibility of the benefit package so it can be adjusted to available revenue as necessary.

Cost-Sharing for OHP Standard

The first six benefits (through Ambulance – see list above) of the OHP Standard package are Medicaid mandatory services. These six services, with no cost-sharing, account for 56 percent of the actuarial value of the current OHP package (the OHP Plus package under OHP2). In order to add optional services such as prescription drugs and achieve a benefit package that was comparable to the packages available in the private health insurance market, cost-sharing was

added to the mandated services as well as the optional services included in the package. Cost-sharing for OHP Standard will include copayments and premiums.

Anticipated copayments in the initial benefit package (at 78 percent of the value of OHP Plus) will be as follows:

Service	Copayment		
Inpatient Hospital	\$250 copayment per admission		
Outpatient Hospital	<ul style="list-style-type: none"> • \$20 copayment/surgery • \$5 copayment for other outpatient services 		
Emergency Room	\$50 copayment, waived if admitted		
Physician Services	<ul style="list-style-type: none"> • \$5 copayment for office visits • \$3 to \$10 copayment for medical & surgical procedures 		
Lab and X-ray	\$3 copayment for each lab and X-ray		
Ambulance	\$50 copayment		
Prescription Drugs	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>0% up to 100% FPL</u> <ul style="list-style-type: none"> • \$2 generic • \$3 MH/cancer • \$15 other brand </td> <td style="width: 50%; vertical-align: top;"> <u>100% up to 185% FPL</u> <ul style="list-style-type: none"> • \$5 generic • \$10 MH/cancer/ /HIV brand drugs • \$25 other brand </td> </tr> </table>	<u>0% up to 100% FPL</u> <ul style="list-style-type: none"> • \$2 generic • \$3 MH/cancer • \$15 other brand 	<u>100% up to 185% FPL</u> <ul style="list-style-type: none"> • \$5 generic • \$10 MH/cancer/ /HIV brand drugs • \$25 other brand
<u>0% up to 100% FPL</u> <ul style="list-style-type: none"> • \$2 generic • \$3 MH/cancer • \$15 other brand 	<u>100% up to 185% FPL</u> <ul style="list-style-type: none"> • \$5 generic • \$10 MH/cancer/ /HIV brand drugs • \$25 other brand 		
Mental Health and Chemical Dependency	<ul style="list-style-type: none"> • \$5 copayment • No copayment on dosing/dispensing or case management services 		
Durable Medical Equipment	<ul style="list-style-type: none"> • <u>Recurrent</u>: \$2 copayment per 30 days • No coverage for one-time DME 		
Dental	<ul style="list-style-type: none"> • <u>Preventive and Dx</u>: zero/minimum copayments (See Appendix 3.1) • <u>Restorative</u>: graduated copayments (See Appendix 3.1) • \$500 benefit limit 		

In keeping with the objectives of OHP and OHP2 to provide access to care at the appropriate time, copayments will not be required for the following preventive services:

- Pap smears
- Mammograms
- Women's annual health exams
- Fecal occult blood tests/Diagnostic sigmoidoscopy (over age 50)
- Total blood cholesterol screenings (men age 35-64, women age 45-64)
- Preventive dental exams
- Rubella serology or vaccinations (women of childbearing age)
- Tetanus diphtheria (Td) boosters
- Age-appropriate Influenza immunizations
- Age-appropriate Pneumococcal vaccinations

Except as noted above, copayments will be required of all OHP Standard enrollees. Providers will be responsible for collecting copayments. However, unlike in OHP Plus, providers may refuse to provide a service (other than emergency services) if the copayment is not paid.

The anticipated premium structure for OHP Standard will be as follows:

Percent FPL	Per Person	Premium Share
0% up to 10% FPL	\$6.00	2.4%
10% up to 50% FPL	\$9.00	3.6%
50% up to 65% FPL	\$15.00	6%
65% up to 85% FPL	\$18.00	7.2%
85% up to 100% FPL	\$20.00	8%
100% up to 125% FPL	\$23.00 ¹	9.2%
125% up to 150% FPL	\$35.00	14%
150% up to 170% FPL	\$75.00	30%
170% up to 185% FPL	\$125.00	50%

As is currently done for OHP, the State will collect premiums. Unlike in OHP, persons in OHP Standard who fail to pay their premiums will be disenrolled after receiving adequate notice. People who want to come back into the program after having been disenrolled will be subject to a period of uninsurance of up to six months and any applicable waiting period (See Section 5.A).

E. FHIAP

FHIAP Benchmark

The Insurance Pool Governing Board (IPGB), in consultation with the Health Insurance Reform Advisory Committee (HIRAC), is statutorily charged with establishing a group benchmark for subsidized ESI coverage to be used as a tool for evaluating private-sector health insurance. In effect, the benchmark identifies a minimum level of benefits qualifying for FHIAP subsidy – it does not define a benefit plan to be offered to enrollees.

Based on an evaluation of the benefits and cost-sharing provisions common in Oregon's small group health insurance market, the IPGB established a group benchmark that includes:

- A six-month pre-existing condition waiting period;
- 20 benefit categories;
- The following maximum cost-sharing levels:
 - \$500 annual individual deductible,
 - \$2,500 maximum out-of-pocket per individual or \$10,000 stop-loss, and
 - \$1,000,000 lifetime maximum benefit.

In addition, since prescription drug benefits are generally purchased separately from medical coverage as an optional benefit, the IPGB established a prescription drug cost-sharing level of 25 percent with no out-of-pocket maximum.

¹ Premiums for people with income above 100 percent FPL will be based on percentage of the OHP Standard benefit package, not fixed at these dollar amounts.

FHIAP group coverage will include persons who have qualified employer-sponsored insurance (ESI) available, including portability, State continuation, and COBRA. An ESI plan will qualify if it meets or exceeds the FHIAP group benchmark. The IPGB and their actuaries are developing a tool to evaluate benefit plans against the group benchmark. This evaluation tool will be used when a submitted group plan fails on initial examination to meet or exceed the benchmarks. With the tool, IPGB can determine if the overall relative value of the submitted plan meets or exceeds the value of the benchmark. ESI is considered available if it is offered by the employer to the employee, and the employer contributes appropriately to the cost of coverage.

Insurance subsidies will also be available for individual health insurance policies in specific circumstances and will be subject to a cost-effectiveness test as outlined in Section 8, subsection B. Individuals and families accepted into FHIAP individual coverage may only purchase health insurance from FHIAP-certified carriers. There are currently seven certified carriers for FHIAP individual coverage.

The IPGB has adopted a benchmark for the individual market; it is identical to the group benchmark. Note that like other states, Oregon mandates that certain services be covered in private health insurance policies. A description of the current Oregon mandates is included in Appendix 3.2.

Oregon is requesting the ability to adjust the FHIAP benefit benchmark as necessary to continue to subsidize benefit coverage commonly found in Oregon's small employer health insurance market, as directed to in House Bill 2519. Specifically, Oregon is seeking permission to adjust the FHIAP benefit benchmark as long as this benchmark is at least actuarially equivalent to the federally mandated Medicaid benefit package. The FHIAP benefit benchmark described below is the initial benchmark recommended for program implementation. The IPGB may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP benefit benchmark will always be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

A complete list of the benefits and cost-sharing levels for the FHIAP benchmark for group health insurance plans are presented on the following page:

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

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

FHIAP Subsidy

The current FHIAP subsidy levels are based on a family's average monthly gross income and are a percentage of premium cost after any applicable employer contribution. The anticipated FHIAP subsidy levels under OHP2 are as follows:

- 0% up to 125% FPL: 95% subsidy
- 125% up to 150% FPL: 90% subsidy
- 150% up to 170% FPL: 70% subsidy
- 170% up to 185% FPL: 50% subsidy

People enrolled in an employer's plan will be reimbursed for the premium withheld from their paychecks (minus the enrollee's share of the premium), provided the enrollee submits verification that the premium is being withheld. Copies of paycheck stubs will serve as verification. After a written warning, failure to provide verification will result in termination from the program.

Enrollees in the individual market will be billed by FHIAP each month for their portion of the premium. The State will then combine the enrollee's portion with the subsidy and pay the carrier. As with OHP Standard enrollees, FHIAP enrollees who fail to pay their premium will be disenrolled. Also as with OHP Standard, people who want to re-enroll in the program after being disenrolled for failure to pay premiums will be subject to a period of uninsurance up to six months and any applicable waiting period.

Section 4: Eligibility

Oregon Health Plan 2 (OHP2) will be comprised of the eligibility groups that existed prior to the State's current Section 1115 waiver, the groups added by OHP (OHP "new eligibles"), and a new group of expansion eligibles. These groups are displayed and discussed below.

Current Eligibles

This group, referred to as "current eligibles" by the State, was eligible for Medicaid before the OHP waiver or were added as a result of the enactment of SCHIP. The group is composed of the following categories of eligibility and will be covered under the OHP Plus benefit package:

Eligibility Category	Income Criteria
Blind/Disabled	SSI level
Old Age Assistance	SSI level
PLM (Poverty Level Medical)-CH (Children) 0-1	< 133% FPL
PLM-CH 1-5	< 133% FPL
PLM-CH 6-12	< 100% FPL
PLM-CH 13-18	< 100% FPL
TANF	< 52% FPL
PLM-A Pregnant Women	< 133% FPL
PLM-A Pregnant Women and their newborns	>133% up to 170% FPL
Foster Children	< 52% FPL
SCHIP Children	>TXIX and < 170% FPL

The above eligibility categories are referred to by CMS as "mandatory populations" with the exception of the PLM-A Pregnant Women 133 percent up to 170 percent FPL and their newborns, and the SCHIP population. Both groups are referred to by CMS as "optional populations."

New Eligibles (OHP)

This group is referred to as "new eligibles" by the State because they were made eligible in 1994 through Oregon's existing Section 1115 waiver. The group is composed of the categories of eligibility contained in the table below and, other than General Assistance, will receive the OHP Standard benefit package or Family Health Insurance Assistance Program (FHIAP). People in the General Assistance category will receive benefits under OHP Plus. Generally, eligibles with employer-sponsored insurance (ESI) available will receive coverage under the FHIAP group insurance subsidy program (See Section 5.D).

Eligibility Category	Income Criteria
General Assistance	< 43% FPL
Parents	< 100% FPL
Adults/Couples	< 100% FPL

The parent's category is referred to by CMS as an "optional population" while the Adults/Couples and General Assistance categories are referred to by CMS as "expansion eligibles" because these groups could not be made eligible for Medicaid without a waiver. As a general rule, CMS recognizes optional populations as exempt from budget neutrality requirements.

Expansion Population (OHP2)

This group, referred to as the "expansion population" by the State, will be made eligible through the OHP2 waiver. The group is composed of the following categories of eligibility:

Eligibility Category	Income Criteria
PLM – A Pregnant Women and their newborns	170% up to 185% FPL
SCHIP Children	170% up to 185% FPL
Parents	100% up to 185% FPL
Adults/Couples	100% up to 185% FPL
FHIAP Parents/Families (Existing and Expansion)	0% up to 185% FPL
FHIAP Adults/Couples (Existing and Expansion)	0% up to 185% FPL

In this "expansion population" category of eligibility, PLM-A Pregnant Women and their newborns, SCHIP children, Parents, FHIAP Existing Families, and FHIAP Expansion Families categories are referred to by CMS as "optional populations." Single Adults/Couples, FHIAP Existing Single Adult/Couples, and FHIAP Expansion Single Adults/Couples categories are referred to by CMS as "expansion populations" because the groups could not be made eligible for Medicaid without a waiver.

Pregnant women and SCHIP children will be covered by the OHP Plus benefit package unless they choose to enroll in qualified private coverage through FHIAP. The families (parents) and single adults and couples will receive benefits under the OHP Standard benefit package unless they have qualified ESI coverage available. In specific circumstances, insurance subsidies may

also be available for individual health insurance policies. If qualified ESI coverage is available, benefits will generally be obtained through the FHIAP group insurance subsidy program.

There are currently families and adults/couples receiving FHIAP group or individual insurance subsidies. OHP2 requests federal financial participation (FFP) for persons currently enrolled in FHIAP group or individual coverage that meets the FHIAP benchmarks. OHP2 will also expand FHIAP eligibility from 170 percent FPL up to 185 percent FPL. Additionally, the FHIAP asset resource limit will be set higher than the resource limit for either Medicaid or SCHIP (See following section for a discussion of eligibility rules and enrollment process). Oregon also requests FFP for individuals enrolled in the FHIAP element of the program with these higher resource limits.

Section 5: Eligibility Rules and Enrollment Process

A. Eligibility Requirements

Income eligibility for all components of OHP2 will be determined using the existing process for OHP and Family Health Insurance Assistance Program. However, for some eligibility groups, the time period used to calculate income will change. Currently, OHP uses a combination of actual income for the two prior calendar months and projected income for the current month. OHP2 will use the historical (actual) income for either the previous three calendar months or 13 weeks prior to the date of application.

Current asset limits for OHP, SCHIP, and FHIAP will continue to apply under OHP2. The asset limit for both OHP Plus and OHP Standard will be \$2,000 (the current limit for Medicaid adults), with no asset limit for Medicaid children. The asset limit for SCHIP children will continue to be \$5,000. The asset limit for FHIAP (both individual and group) will be \$10,000. Note that the asset test will be tied to the program and not the funding source. For example, although FHIAP will be funded in part by SCHIP and Title XIX dollars, the asset test will be \$10,000, not \$5,000.

Existing residency and citizenship requirements for OHP will continue to apply under OHP2. In order to guard against substitution of private health insurance coverage, applicants for OHP Standard, SCHIP, and FHIAP (both individual and group) will be required to have been uninsured for at least six months prior to enrollment. This period of uninsurance will not apply to individuals who become eligible for OHP Plus through an existing Medicaid category of eligibility. Also, OHP is not and will not be considered insurance for FHIAP, and under OHP2, FHIAP coverage will not be considered insurance for OHP Standard or SCHIP. Meeting the six months uninsured requirement for any OHP2 program (including FHIAP) will satisfy the requirement for all OHP2 programs.

B. Enrollment Limitations

There will be no limit on enrollment (i.e. a cap on the total number of enrollees) for the eligibility categories that are covered by OHP Plus. However, as described in Section 11, Oregon proposes a limit on enrollment when needed for budget management, for OHP Standard and for FHIAP applicants. Once enrollment limits are met, new enrollment will be suspended.

In the case of OHP Standard, the State will not accept any applications and will not maintain a waiting list once the enrollment limit is reached. However, in the case of FHIAP, there will be reservation lists. There will be separate reservation lists for FHIAP individual and group insurance subsidies. Persons who request a FHIAP application when a limit on enrollment is in effect will be placed on the appropriate reservation list until slots open up. When a slot opens up they will be sent an application, and their eligibility will be determined based on the completed application. The enrollment process is described in more detail later in this section. New FHIAP enrollment will emphasize those people with group coverage available. The reservation list has proven to be an invaluable tool in managing FHIAP enrollment into employer sponsored insurance (ESI) coverage.

Availability of FHIAP individual coverage subsidy will be more limited than for other OHP2 components. House Bill 2519 directs the Insurance Pool Governing Board (IPGB) to move towards a 50/50 division of funds between the group and individual market segments of the program. To accomplish this, IPGB will adjust enrollment in either portion of the program, depending on the mix of enrollees and budget projections. In addition, individual market subsidies will be subject to a cost-effectiveness test as described in Section 8, subsection B.

Eligibility for OHP Plus and OHP Standard is for six months; eligibility for FHIAP is for a twelve-month period.

C. Enrollment

There will be a separate application and enrollment process for OHP Plus and Standard, and for FHIAP (individual and group). Applicants can submit an OHP application, a FHIAP application, or both.

People who apply for FHIAP will be informed about OHP Plus and Standard. All FHIAP applicants currently receive a letter that includes income guidelines and the phone number for OHP. Under OHP2, FHIAP applicants will receive a letter with information about OHP Plus and OHP Standard.

The application form for OHP Standard and OHP Plus includes a question about the availability of ESI. Applicants who indicate that they have ESI available and are otherwise eligible for OHP Standard will be referred to FHIAP. As described under "Choice Among Components" below, people who are eligible for both OHP Plus and FHIAP will have a choice between these two programs.

OHP Enrollment

The enrollment process for OHP Plus and Standard will be the same as under OHP. It is designed to allow clients access to several options for obtaining and completing an application. The main access point is a toll-free phone number through which an application can be requested to be mailed to the client's address of choice. This system was developed to help diminish the "welfare stigma" often associated with Medicaid when it is linked to other public assistance programs. OHP applications are, however, still accessible through local DHS Community Human Services offices. Clients may also obtain applications through outreach sites such as hospitals, county health departments, federally qualified health centers, rural health clinics, migrant health clinics, family planning clinics, alcohol and drug detox centers, urban Indian and tribal health clinics, and alcohol and drug youth residential treatment centers.

After the client has completed the application, it is mailed to a Children, Adult, and Family Services (CAFS) central processing unit for eligibility determination. In some cases the eligibility may be established at the local DHS branch office. When a client is given an application, a date stamp is placed on the application. The State has 45 days from the date of request to process the application. All new eligibles and expansion eligibles will obtain benefits for a six-month period, subject to applicable payment of premiums. At the end of their eligibility period, OHP Plus and Standard will automatically receive information about reapplying for enrollment.

OHP Standard enrollment will be expanded initially up to 110 percent of FPL, then moved up by 15 percent income bands as budget allows, giving priority to parents of SCHIP and PLM children and current clients moving over the upper income limit of OHP Standard.

FHIAP Enrollment

The current FHIAP enrollment process will continue under OHP2. Low-income, uninsured Oregonians interested in receiving premium assistance for private sector health insurance plans will contact FHIAP and be placed on one of the program's two reservation lists (one for individuals and families with ESI available and one for those without ESI coverage).

FHIAP will be expanded by up to 25,000 additional clients, maintaining the goal of having available funds equally distributed between providing group coverage and individual coverage. FHIAP will expand by about 9,500 in group insurance initially then will open individual insurance. After that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

When there is room available in the program, FHIAP will mail an application packet to the people on the reservation lists. Applicants with access to ESI coverage will be required to provide specific information about the ESI plan in order to determine if the plan is subsidy-eligible. Upon receipt of the application, FHIAP will determine an applicant's eligibility according to the program's statutes and rules. The application will be approved, pending, or denied.

If the application is pending, the applicant will be sent written notice of the reason and what information is needed to complete the eligibility determination. The applicant will have an additional 30 days to provide the requested information. If the information is not provided within that timeframe, eligibility is denied, and the applicant is given written notice of the reason for the denial and their appeal rights. If eligibility is denied, the applicant is given written notice of the reason for the denial and their appeal rights. The appeal rights include IPGB staff review, a contested case hearing by the State's hearings officer panel, and the right to take their case to the Court of Appeals.

If approved for a subsidy and the ESI plan meets the program's group benefit benchmark, the applicant has 90 days to enroll in the ESI plan. If an applicant is approved for an ESI subsidy, but the ESI plan fails to meet the group benefit benchmark, other coverage options will be explored. If the applicant is OHP Plus eligible, they may enroll in that coverage. If the applicant is OHP Standard eligible but space is unavailable in OHP Standard or FHIAP individual coverage, the applicant can be placed on the FHIAP Individual Market Reservation List using the original Group Market Reservation List date.

Once enrolled in an ESI plan, members will be reimbursed for the premium withheld from their paychecks (minus the member's share of the premium) provided the member submits verification that premium is being withheld. After a written warning, failure to provide verification will result in termination from the program.

If approved for an individual coverage subsidy, the applicant is sent a FHIAP Certificate of Eligibility that they send to an insurance carrier with their insurance application. Insurance carriers will accept this Certificate of Eligibility in lieu of the initial premium payment normally required at application. Applicants then have 90 days to enroll in a FHIAP-certified individual market health benefit plan.

Every month, FHIAP will bill members with individual policies for their portion of the premium. FHIAP will combine the member's payment with the subsidy and will pay the insurance carrier. Members who fail to pay their premium share (after being sent a final notice) will be terminated from the program.

D. Choice Among Components

Applicants who are eligible for or enrolled in OHP Plus will be permitted to choose qualified FHIAP coverage if enrollment is open. Applicants who are enrolled in FHIAP but eligible for OHP Plus will be permitted to leave FHIAP and enroll in OHP Plus instead. Other applicants who have FHIAP-qualified ESI coverage available will not be permitted to enroll in OHP Standard if FHIAP group enrollment is open.

E. Outreach

Current outreach efforts conducted by the State under OHP will continue under OHP2. Education and training will be given a high priority both during the implementation of OHP2 and on an ongoing basis. Education and training will be directed toward all affected groups – clients, providers, managed care plans, staff, and the general public.

In addition, outreach efforts currently conducted for FHIAP will continue. IPGB has partnered with public and private sector groups and organizations in a grassroots, community-based effort to reach the uninsured. Partners include insurance agents, State agencies, schools, and safety net clinics. IPGB distributes various informational materials, including posters, brochures, and guides. It also conducts special mailings to targeted groups, makes presentations on the program, and receives radio and television exposure.

Section 6. Service Delivery/Access

OHP2 will rely on the existing OHP service delivery system and Family Health Insurance Assistance Program (FHIAP) will continue to rely on the private health coverage delivery system. The State is committed to building additional capacity as required.

The current OHP delivery system consists of:

- Managed care options including fully-capitated health plans, mental health organizations, dental care organizations and primary care case managers;
- Fee-for-service providers;
- Safety net providers.

A. Current Service Delivery System

Managed Care Options

The managed care options consist of Fully Capitated Health Plans, Mental Health Organizations, Dental Care Organizations, and Primary Care Case Managers. A map showing coverage by each of these entities is attached as Appendix 6.1.

Fully Capitated Health Plans (FCHPs)

As of November 1, 2001, 63 percent of OHP participants were enrolled in Fully Capitated Health Plans (FCHPS). Currently the State contracts with 14 FCHPs. Two are commercial plans and 12 are community-based plans. The State's requirements for participation in OHP, including enrollment rules, benefits, financial requirements, provider panel requirements, and performance expectations are included in the State's contracts with the FCHPs.

Mental Health Organizations (MHOs)

Mental health services are provided by stand-alone organizations that specialize in such services. OHP pays a capitated rate. The State currently contracts with 10 MHOs.

Dental Care Organizations (DCOs)

Dental services are contracted on a stand-alone basis through DCOs, which are paid a capitated rate. The State currently contracts with seven DCOs. The requirements for a DCO mirror much of the FCHP requirements.

Primary Care Case Managers (PCCMs)

If no health plan providers are available within a specified number of miles, an OHP enrollee may choose a Primary Care Case Manager (PCCM) from a list provided by the State. A PCCM provides covered primary care and makes referrals for specialty and inpatient care as medically necessary. The patient's PCCM is noted on the OHP coverage card. As of November 2001, OHP had 13,498 people (3 percent of OHP enrollees) enrolled with PCCMs.

Fee-for-service Providers

Fee-for-service providers include medical, dental, mental health, and chemical dependency providers and continue to play an important role in OHP. Services provided include certain carve-out services (e.g., non-emergency medical transportation) and the full range of services in geographic areas where no managed care providers are available. As of November 2001, 128,000 people (38 percent of OHP enrollees) received services from fee-for-service providers.

Safety Net Providers

Oregon's safety net clinics are an essential part of Oregon's Medicaid delivery system. These organizations provide preventive and primary care for Oregon's most vulnerable populations. Oregon has 133 safety net clinics located throughout the State (29 of 36 Oregon counties include at least one safety net facility). There are 29 Rural Health Clinics, 30 Federally Qualified Health Centers, 10 Indian Tribal Clinics, 46 School Based Health Centers and 18 others. Together these facilities serve 55,000 Oregon Health Plan enrollees per year (about 15 percent of all enrollees). In addition, they provide services to 86,000 uninsured Oregonians every year. Services include urgent care, primary care (acute and chronic disease treatment), preventive care, and enabling services (such as translation/interpretation, case management, transportation and outreach). In addition some safety net clinics provide mental health, dental and vision services.

B. Family Health Insurance Assistance Program

Currently FHIAP has approximately 4,000 enrollees and 22,000 people on its waiting lists. Over 80 percent of current enrollment is in individual coverage through seven certified insurers. Under legislative direction, FHIAP will expand enrollment in the group market to equalize funding between group and individual coverage. Both FHIAP individual enrollees and FHIAP group enrollees use the private health insurance delivery system, which includes the providers and hospitals contracting with Oregon's insurance carriers.

C. Capacity/Access Assurances

The State of Oregon will modify existing contracts with providers and health plans within the existing service delivery system to reflect changes in benefit packages and to accommodate the OHP Plus and Standard expansion populations. The current system will be strengthened and improved as necessary.

Key strategies include:

1. Increasing enrollment in managed care – The Joint Ways and Means Committee of the 2001 Legislative Assembly supported the Oregon Department of Human Services goal to increase the percentage of OHP clients enrolled in managed care to 82 percent by 2003 (currently FCHP participation is at 63 percent). This effort has begun. DHS is considering the following measures:

- Offering technical assistance;
- Simplifying administrative requirements;
- Assessing the adequacy of capitation rates;
- Ensuring that OHP clients can remain in FCHPs even if they move from location to location within the State;

- Holding regional best practice forums;
 - Promoting the importance of managed care enrollment to DHS field staff.
2. Increasing the number and strength of community-based health care plans;
 3. Increasing public-private partnerships;
 4. Increasing involvement and capacity of safety nets;
 5. Continuing to use (and possibly expand) Primary Care Case Management (PCCM).

Section 7: Implementation Plan and Timeline

OHP2 will begin implementation on October 1, 2002. OHP Plus and OHP Standard benefits will be managed through the Office of Medical Assistance Programs (OMAP) within the Department of Human Services (DHS), which administers the current Oregon Section 1115 waiver. FHIAP will be managed by the Insurance Pool Governing Board (IPGB) under an interagency agreement with DHS who will act as the single state agency. Implementation activities have already begun.

Implementation Approach

Implementation of OHP2 currently involves a number of entities within the state. These include the Governor's Office, the Office of Oregon Health Policy and Research, Insurance Pool Governing Board (IPGB), the Health Services Commission, the Department of Consumer and Business Services, and the Department of Human Services.

Within DHS, four key staff will lead implementation of OHP2. An OHP2 Project Manager has been appointed within the Department of Human Services, and three new limited duration positions have been created. These positions are:

- Delivery Systems Developer – to focus on the maintenance and expansion of the provider network, especially managed care. This position will coordinate issues of access, capacity, and the development and implementation of alternative plans if the managed care system is not sufficient for the expanded client population;
- Operations System Developer – to focus on the State administrative structure necessary to implement and manage OHP2;
- Information and Data Coordinator – to focus on information systems, data systems, and payment systems for OHP2. This position will coordinate information systems changes, work with the State agencies, the managed care plans, providers, contractors and clients, to assure that information, data and payment issues are addressed and necessary changes made to the systems, including testing of the systems by the implementation date.

Because OHP2 implementation requires the participation of numerous functional areas within and outside DHS, the State has formed six OHP2 implementation teams.

- Eligibility and Enrollment Team
- Delivery Team
- Payment Systems Team (including Information Systems and Reporting)
- Waiver Submission/Reporting Systems Team
- Education Team
- Finance Team

A seventh team consisting of team leaders and co-team leaders will address the administrative structure and provide overall coordination. Team membership includes key staff from all of the agencies involved in OHP2.

Beginning with the administrative structure, the teams are charged with the following tasks:

Administrative Structure

- Review the current OHP administrative structure, including components in all State agencies;
- Identify, plan and implement changes needed in State agencies to administer the increased complexity of OHP2. Consider multiple programs (OHP Plus, OHP Standard, FHIAP), multiple benefit packages, and client cost-sharing, and other complexities;
- Develop and implement an interagency agreement which clearly defines the roles and responsibilities of both DHS and IPGB.
- Using the DHS rulemaking process, identify, plan, propose and implement Oregon Administrative Rules (OARs) necessary for the administration of OHP2.

Enrollment

- Review current eligibility/enrollment systems and processes;
- Develop policies on administration of enrollment caps;
- Identify changes needed to accommodate the increased complexity of income tracking, a more complex premium structure, multiple programs, multiple benefits packages, client cost-sharing and other new requirements in the waiver;
- Through the rulemaking process, identify, plan, propose and implement OARs necessary for the administration of eligibility determination, enrollment and disenrollment, data collection and data sharing for OHP2;
- Every possible effort will be made to follow the implementation plan and achieve full implementation on October 1, 2002. However, during the early summer of 2002 an assessment will be made to determine if full enrollment of all eligibility groups on October 1 is on track and achievable. Any problems identified during that assessment would be dealt with through implementation plan adjustments or the designation of additional resources to deal with specific issues.

Delivery Systems/Provider Network

- Review current delivery system/provider network, including the safety net system;
- Work with managed care plans and other providers, including the safety net system, to identify changes needed to accommodate the increased complexity and increased caseload of OHP2;
- Project and plan for health care needs and access-to-care issues under OHP2.
- Plan for alternatives – Partially Capitated Organizations (PCOs), Primary Care Case Manager systems (PCCMs), etc. if existing systems cannot accommodate the caseload of OHP2 or if access-to-care issues require other alternatives;
- DHS and IPGB will assess their respective delivery systems and current capacity, and will determine if alternative systems are needed. If needed, alternative models will be implemented;
- Technical assistance will be provided to Federally Qualified Health Centers (FQHCs) and other safety net clinics to support their efforts to accommodate the caseload of OHP2 and maintain access to care.

Payment Systems/Information

- Review current payment systems, information systems and data systems;
- Identify, plan for, and implement changes needed to accommodate the increased complexity of OHP2 (increased use of income information, multiple programs, client cost-sharing, and other issues);
- A more detailed plan from the IS program is forthcoming;
- Identify, plan for, and implement changes needed in both State and provider systems to share necessary information (DHS, FHIAP, managed care plans, providers, etc.). Consider HIPAA and other constraints;
- Review current reporting requirements and reporting capabilities. Identify new reporting needs for OHP2 – Federal, State, Legislative and internal;
- Build flexibility into MMIS and other systems for future reporting needs;
- Identify, plan for, and perform other necessary IS programming changes.

Education and Training

- Client Education (OHP Plus, OHP Standard, FHIAP, benefits packages, new eligibility regulations, enrollment/disenrollment, new cost-sharing requirements, etc.);
- Provider Education (benefit packages of programs, cost-sharing, payment systems, information systems, etc.);
- Managed Care Plan Education (all of above plus new capitation rate setting, access issues, etc.);
- Staff Education (DHS staff, FHIAP staff, other agencies involved in OHP2);
- General Public Education (Health education, outreach, media, etc.). Considerable public education has already occurred in Oregon due to publicity about the legislative bill and work of the Waiver Application Steering Committee. Needs for public education will be assessed and a plan developed by the team, utilizing extensive public input through an open meeting process throughout the State.

Fiscal Issues

- Negotiate budget neutrality terms;
- Complete and update forecasts;
- Capitation rate setting – utilize independent actuary, work with managed care plans, set capitation rates and enter into new contracts with managed care plans;
- Build in flexibility and monitoring capacity to expand/contract the program based on funding available.

Section 8: Monitoring

OHP has in place an established and effective quality improvement system for monitoring access to and quality of care. This monitoring system will remain in place for OHP Plus and OHP Standard. For Family Health Insurance Assistance Program (FHIAP), the monitoring approach must be different since insurers are not under contract to the State and will not provide the standard CMS reports.

A. Monitoring OHP Plus and OHP Standard

The existing components of the OHP quality improvement system that will remain in place include many of the standard measures of quality and access to care as well as special quality improvement (QI) initiatives. The core measures include:

- Quality improvement (QI) evaluations of health plans focused on their QI programs (includes on-site review; plan-submitted documentation of their QI programs etc.; annual to bi-annual reviews);
- External Quality Review Organization (EQRO) that uses chart reviews and encounter/claims data to determine if the quality of care meets clinical practice guidelines. (At the present time, the EQRO that is contracted with OMAP is Permedion);
- Plan-reported complaints (Quarterly submission of complaint reports);
- Disenrollment quarterly reports (State collected “reasons for disenrollment” from health plans);
- State’s Client Advocate Services Unit quarterly report (Reasons for calls by plan);
- Enrollment/Eligibility tracking reports (Monthly enrollment numbers; “Churning” in plans);
- Health plans’ annual Physician Capacity report;
- Financial statements submitted quarterly by plans (monitor financial solvency);
- MCO submitted annual performance measures (i.e., selected HEDIS measures);
- HEDIS and modified HEDIS measures addressing utilization, access to care, and quality of care from encounter/claims data;
- Ad Hoc studies of access to and quality of health care (irregular);
- Survey of client satisfaction with access to and quality of care given health status of clients (CAHPS-Consumer Assessment of Health Plans Survey);
- Regular contact with and technical assistance to QI coordinators of health plans such as on-site attendance at plan QI committee meetings etc.;
- Monitoring of data quality, accuracy and completeness (i.e. encounter data monitoring).

In addition to these core features of the OHP quality improvement and monitoring plan, two special initiatives are also in place:

- Statewide QI Projects: Project PREVENTION! is required of all health plans. For example, projects that have been adopted are Immunization ALERT Registry, Tobacco Cessation and Early Childhood Cavities Prevention);
- Monitoring access to and quality of care through community partnerships such as Oregon MothersCare (access to prenatal care) and through coordination of mental health and primary care.

B. Monitoring FHIAP

Since private insurance plans do not contract with the State, the State cannot require the plans to meet Medicaid requirements or produce encounter data or other reports. Of necessity, then, the monitoring approach must be different. The State will rely on the enrollment and disenrollment information (period of time the coverage was purchased, reason for termination such as loss of employment or dissatisfaction with coverage) contained in the FHIAP data system and client satisfaction surveys (e.g., CAHPS). The FHIAP application and data system will also allow the State to monitor the demographics of those participating in the program, the cost of coverage purchased, and the percentage of income required for premium contributions.

In addition, Oregon will monitor costs for enrollees in FHIAP to ensure that costs are not higher than costs would be for coverage in the direct coverage program. The State will also monitor changes in employer contribution levels and make modifications in FHIAP if necessary.

FHIAP currently collects, and reports weekly, the following information regarding costs to the FHIAP program (on a per life basis):

- **Premium Costs (member share and State subsidy):** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Subsidy Costs:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Enrollee Premium Contributions:** By type of coverage (individual or group) and subsidy level, with a weighted overall average for each type of coverage.
- **Employer Contributions:** By subsidy level, with a weighted overall average.
- **Overall Premium Cost:** For individual and group, with a weighted overall average.
- **Overall Subsidy Cost:** For individual and group, with a weighted overall average.

In order to measure costs, the State will compare the overall weighted average subsidy cost (which is reported on a per member per month basis) to the per member per month cost of the OHP Standard benefit package. This would be done on a quarterly basis.

The State will develop reports that show the employer contribution by subsidy level, both in terms of total dollars and percentage of premium. In addition, FHIAP will report historical levels of employer contributions, as total dollars and percentage of premium, on a monthly or quarterly basis. These reports could be used by the State to determine if the employer contribution levels were declining, and if so, what steps could be taken to stop or reverse the decline. Options include requiring (or raising) a minimum dollar contribution or minimum premium percentage contribution from the employer towards individual or family coverage before an employer plan could be subsidized by FHIAP.

While these historical reports reflect the experience of FHIAP, comparing the FHIAP levels to the experience of the regular health insurance market may help the State determine if the premium assistance program is having a negative effect on employer contributions. This could be accomplished by working with major domestic carriers to collect information on employer contribution levels. This would need to be done on a voluntary basis, since the State currently doesn't collect this information and may not have statutory authority to require it.

Section 9: Evaluation

The State of Oregon understands that CMS may select an independent contractor to evaluate OHP2. The State will not undertake these evaluation activities itself, but suggests them only for consideration by CMS and its independent contractor(s). The purpose of this section is to suggest a framework for structuring an evaluation undertaken by an independent contractor to assess the effectiveness of the OHP2's conceptual basis, design, ongoing operations, impact and outcomes, in light of relevant policy and budget objectives.

A. Hypotheses, Evaluation and Monitoring Objectives and Expected Outcomes

The research questions/hypotheses, expected impact/outcomes, and specific objectives of research are presented below:

Coverage: To what extent is OHP2 effective in providing expanded health insurance coverage to Oregon's low-income population? What are the characteristics of those who choose Family Health Insurance Assistance Program (FHIAP) versus OHP Standard or OHP Plus?

It is expected that:

- OHP2 enrollment will increase by 40,000 or more by the end of the second year and that disenrollment will follow the same pattern and rate currently observed in OHP;
- By the end of the third year, "churning" of people on and off coverage will have decreased;
- By the end of the second year, uninsurance will decrease by 1 percent. Uninsurance will decrease in all regions of the State;
- Individuals enrolled in FHIAP will have higher incomes than those in OHP Standard or OHP Plus;
- A percentage of individuals who choose to enroll in FHIAP will be otherwise Medicaid eligible but choose the private insurance coverage.

Coverage could be evaluated through qualitative and quantitative measurement of:

- The extent to which the new eligibles, expansion population, and FHIAP enrollees enroll and disenroll in OHP2 programs;
- The rate of uninsurance in Oregon and by region, race/ethnicity, age, income, education, gender, etc;
- The pattern of enrollment in OHP Plus, OHP Standard, and FHIAP by region, race/ethnicity, age, income, education, gender, etc.

Access: To what extent does OHP2 result in improved access to health care for OHP Plus, OHP Standard, and FHIAP enrollees?

It is expected that:

- Rates and types of utilization under OHP2 will remain similar to those under OHP for preventive and physician office-based services;
- Enrollees' perception of accessibility will improve from baseline both as a consequence of the reduction in churning and expanded income thresholds for those newly added to the program;
- Access to health care under OHP2 will improve for all enrollees, with particular attention to disparities among racial and ethnic populations when compared to baseline measure. This includes no negative impact on access due to cost-sharing.

Access could be evaluated through qualitative and quantitative measurement of:

- Utilization by service categories in OHP2 for OHP Plus and OHP Standard;
- Beneficiary perception of accessibility to health care in OHP Plus, OHP Standard, and FHIAP;
- Extent to which OHP2 addresses issues related to access specific to underserved populations, including ethnic and racial populations;
- Effect of cost-sharing and reduced benefits on qualified beneficiaries' ability/desire to participate over time, stratified by race/ethnicity, age, income, education, gender, region, etc.

Quality: What is the impact and outcome of OHP2 on health status and quality of care for OHP Plus, OHP Standard, and FHIAP enrollees?

It is expected that:

- OHP2 beneficiary perceptions of quality will be maintained or improved;
- Self-reported health status measures will improve from baseline for newly enrolled OHP Standard and FHIAP beneficiaries. Self-reported health status for continuing OHP clients will remain stable;
- Health status and outcomes for OHP2-covered populations, including all racial and ethnic populations will not be negatively impacted.

Quality could be evaluated through qualitative and quantitative measurement of:

- Beneficiary perception of quality of care for OHP Plus, OHP Standard, and FHIAP enrollment;
- Beneficiary self-reported health status for OHP Plus, OHP Standard, and FHIAP;
- Clinical assessment of health outcomes for OHP Plus and OHP Standard enrollees;
- Extent and direction of OHP2's effect on recognized health disparities between the general population and racial/ethnic populations (e.g., low birthweight, tobacco use, HIV, longevity, etc.).

Feasibility: What is the financial and administrative impact of OHP2 on the State, health plans and providers?

It is expected that:

- Health plans that participate in OHP2 will maintain their financial stability over the life of OHP2;
- OHP2 will have a positive economic effect as related to charity care and the safety net system;
- The overall OHP2 administrative cost burden to the State of Oregon will be maintained within budget limits.

Qualitative and quantitative measurements could include:

- Measure of the financial stability of health plans that participate in OHP2;
- Effect of OHP2 implementation on charity care and the safety net system;
- Measurement of crowd-out.

B. Potential Data Sources*

- Oregon Population Survey (OPS)
- Complaints reports
- Disenrollment reports
- Chart reviews
- External quality reviews
- Encounter/claims data
- Client surveys
- Provider surveys
- Health plan financial statements
- Annual hospital reports
- Eligibility tracking system
- FHIAP data system analysis
- Vital statistics

* Some data sources may not be available for FHIAP

C. Methodologies

Various methodologies and designs – both qualitative and quantitative – could be used to test the research hypotheses and track the process of the OHP2 demonstration using the data sources described above, including the following:

- Pre/post comparison of OHP vs. OHP2, focusing on changes over time for OHP Plus, OHP Standard, and FHIAP enrollees.
- Pre/post comparison of OHP and OHP2 using baseline data at the time of initial OHP enrollment compared to follow-up measures.

Section 10. Waivers and Expenditure Authority Requested

In order to implement OHP2 as described in this application, the State of Oregon will need to maintain its existing Section 1115 waivers and expenditure authority and obtain additional waivers and expenditure authority. The proposed new waivers and expenditure authority are needed for the following key purposes:

- To allow the proposed enrollment limit for OHP Standard and Family Health Insurance Assistance Program (FHIAP);
- To allow the State to implement the cost-sharing proposed for OHP Standard and FHIAP enrollees;
- To allow the State to implement private insurance subsidies with Federal financial participation (FFP) under FHIAP.

A. Existing Waivers and Expenditure Authority

The State of Oregon currently has the following waivers and expenditure authority for its Oregon Health Plan demonstration under the authority of Section 1115(a)(1) and (a)(2) of the Social Security Act, some of which need to be modified as identified below. The State wishes to maintain and in some cases expand these waivers and expenditure authority.

Amount, Duration and Scope of Services – Section 1902(a)(10)(B); 42 CFR 440.230-250

To enable the State to redefine the Medicaid benefit package based on condition/treatment pairs, OHP Standard benefits packages and FHIAP benefits packages, and to permit coverage of benefits for the demonstration population that are not covered for the non-demonstration population.

Uniformity – Section 1902(a)(1); 42 CFR 431.50

To enable the State to provide certain types of health care coverage (managed care and employer-sponsored) only in certain geographical areas of the State.

Medically Needy Eligibility – Section 1902(a)(10)(C); 42 CFR 435.301, 435.811, 435.845, & 440.220

To enable the State to operate a Medically Needy program with different eligibility rules, including raising the income eligibility level to 185 percent of the Federal poverty level for demonstration eligibles, and to waive the requirement that a Medically Needy program be available to pregnant women and children if it is available to other populations.

Eligibility Standards – Section 1902(a)(17); 42 CFR 435.100 et seq. & 435.602-435.823

To enable the State to waive the income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming rules, and to base eligibility on household family unit (rather than individual income).

Eligibility Procedures – Section 1902(a)(10)(A) & 1902(a)(34); 42 CFR 435.401 & 435.914

To enable the State to apply streamlined eligibility rules for demonstration eligibles that are not receiving or deemed to be receiving cash assistance. The three-month retroactive coverage does not apply, and income eligibility is based only on gross income.

Freedom of Choice – Section 1902(a)(23); 42 CFR 431.51

To enable the State to restrict freedom-of-choice of provider.

Upper Payment Limit for Capitation Contracts – Section 1902(a)(30); 42 CFR 447.361

To enable the State to set capitation rates that would exceed the costs to Medicaid on a fee-for-service basis.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Section 1902(a)(43)(A)

To waive the requirement that states must pay for any service required to treat a condition identified during an EPSDT screening; some may not be offered, due to the redefined Medicaid benefit package.

Disproportionate Share Hospital (DSH) Reimbursements – Section 1902(a)(13)(A)

To allow the State to not provide DSH payments when health plans are responsible for reimbursing hospitals.

Managed care lock-in requirements – Section 1903(m)(1)(A) & (2)(A); 42 CFR 434.20 & 21

To allow the State to lock in enrollees for periods of six months or more in FCHPs, MHOs, DCOs, PCOs, FHIAP, and PCCM organizations.

Limits on FFP for people over certain income level – Section 1903(f); 42 CFR 435.301 & 435.811

Expenditures that might otherwise be disallowed under section 1903(f); 42 CFR 435.301 and 435.811, insofar as they restrict payment to the State for eligibles whose income is no more than 133 percent of the AFDC eligibility level.

Limits on FFP for certain managed care enrollees

Expenditures to provide Medicaid to individuals who have been guaranteed six months of Medicaid eligibility at the time they are enrolled in a capitated health plan, who were eligible for Medicaid when they were enrolled, and who ceased to be eligible during the six-month period.

Limits on FFP for adults institutionalized for mental diseases

Expenditures for services provided to OHP-eligible individuals between the ages of 22 and 65 residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. Enrollees who were residing in an IMD as of the date of the award letter, but who were admitted prior to the date of this letter, will not be eligible for Title XIX reimbursement for that stay. Enrollees who are admitted on or after the date of the award letter will be eligible for Title XIX reimbursement, subject to the 30/60 limits.

Limits on FFP for erroneous payments – Section 1903(u)

Expenditures, which might otherwise be disallowed under section 1903(u), which establishes rules and procedures for disallowing Federal financial participation in erroneous Medicaid payments due to eligibility and recipient liability errors, detected through a Medicaid eligibility quality control program.

Referral requirements for chemical dependency services

Chemical dependency treatment services which would have been disallowed under section 1905(a)(13) of the Act in the absence of a recommendation of a physician or other licensed practitioner.

B. Additional Waivers and Expenditure Authority Requested*Hearing rights – Section 1902(a)(3); 42 CFR 431 Subpart E*

These provisions say that beneficiaries are entitled to a hearing before the state Medicaid agency for any denial of services. State of Oregon patient protection statutes provide hearing rights for people who are denied services by their private sector health plans, but these provisions are not identical to those in these federal Medicaid requirements and do not apply to self-insured plans. Therefore, a waiver of the Medicaid provisions is needed.

Opportunity to apply – Sections 1902(a)(3) & 1902(a)(8); 42 CFR 435.906 & 435.911

These provisions require that persons wishing to apply for Medicaid be given an opportunity to do so, that their applications be considered in a timely manner, and that they have a right to hearing if their claim is not acted on with reasonable promptness. Due to the limited availability of State funds, OHP Standard and FHIAP will have an enrollment limit that will apply to all applicants. When a limit on enrollment is in place, persons will not be allowed to submit an application for enrollment until there are openings available in the program. Therefore, Oregon requests a waiver of the above requirements for the OHP Standard and FHIAP components of OHP2.

Cost-Sharing

The State of Oregon requests that expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply be considered expenditures under the State's Title XIX plan. The cost-sharing requirements for OHP Standard and FHIAP are described in Section 3. We have requested approval for a benefit package and benchmarks actuarially equivalent to the cost of mandated Medicaid services. The State assumes that it can increase benefits under OHP Standard and FHIAP above the approved level at its option, subject only to the constraints of budget neutrality.

Private Insurance Subsidies

OHP2 proposes Medicaid and/or SCHIP FFP for the FHIAP, which provides subsidies for the purchase of private individual and group health insurance plans, including portability, State continuation, and COBRA. Since private health insurance plans are not under contract to the

State, the State cannot require the plans to meet Medicaid requirements or produce encounter data or other reports. Thus, Oregon requests that expenditures to provide subsidies for the purchase of private health insurance plans that do not meet all Medicaid requirements otherwise applicable to Medicaid health plans be regarded as expenditures under the State's Title XIX plan.

In addition to the above specific requests for waivers and expenditure authority, the State of Oregon requests that the Secretary grant any other waiver or expenditure authority under Section 1115 of the SSA that the Secretary or CMS determines is necessary for implementation of OHP2.

Section 11. Budget Neutrality

Oregon understands that the State must demonstrate budget neutrality for this waiver request. Budget neutrality means the State may not receive more federal dollars under the waiver than it would have received without it. The State is seeking both a Section 1115 waiver and a HIFA waiver. This Section discusses the budget neutrality tests of both waivers.

The Section 1115 budget neutrality test performed for this waiver request will build upon the methodology that was adopted for the Oregon Health Plan extension that was recently granted. The budget neutrality test for the HIFA waiver request will follow the guidelines issued by CMS and consists of a test against the Title XXI allotment.

When submitting both a Section 1115 and a HIFA waiver application, States are required to include an initial showing that the waiver is expected to be budget neutral. This showing itself is not the test of budget neutrality, but rather the State's best estimate of cost and caseload at the time it submits its waiver. The test for budget neutrality will be applied according to the terms and conditions for the waiver that have been agreed to by the State and CMS, and will be measured periodically throughout the course of the waiver and will finally be measured at the conclusion of the waiver.

This Section is organized into two major parts:

- ❑ The first part presents Oregon's proposal for managing budget neutrality and the components of the actual tests of budget neutrality. This part begins with a discussion of managing budget neutrality, and then follows with a discussion of the components of the budget neutrality tests for each of the two types of waivers.
- ❑ The second part presents Oregon's cost and caseload estimates, the key assumptions that underlie those estimates and the specific waiver timeframes. Additional details of the cost and caseload estimates are reflected in a series of exhibits and two appendices.

A. Budget Neutrality Terms And Conditions

This part describes how the State intends to ensure that the waiver is budget neutral, and the specific components of the test of budget neutrality for each of the two types of waivers.

Managing Budget Neutrality

While the design of the waiver must satisfy the requirements for federal budget neutrality in order to be approved by CMS, the design of the waiver must also satisfy the requirements for state budget neutrality in order to be implemented by Oregon. To satisfy both of these requirements, the waiver has been designed with two primary management tools: an adjustable enrollment cap and an adjustable benefit level.

The adjustable enrollment cap will be used to limit the size of the waiver populations, and will be established based on funding availability and/or budget neutrality capacity. Initially, the cap on

enrollment for the expansion group² added by this waiver request will allow over 3,400 current FHIAP enrollees and 25,000 FHIAP expansion enrollees to join the program. The initial FPL percentage for the OHP Standard expansion adults will be set at 110 percent with a periodic evaluation. Over the life of the waiver, it is anticipated that the cap for the OHP Standard expansion population will be raised such that over 16,400 eligibles will participate in the program. All told, more than 46,000 Oregonians will receive health care coverage through the requested waivers.

The enrollment cap may apply to various subsets of the groups who will receive the OHP Standard or the FHIAP benefit packages. The waiver design contemplates that the enrollment cap will permit the State to limit the number of individuals enrolled in the program either through:

- ❑ Discontinuing eligibility determinations (with or without establishing a reservation list), or
- ❑ Establishing a lower level of FPL as the basis of eligibility.

If an enrollment cap is imposed, as a safeguard, Oregon will continue to evaluate OHP Standard applicants for eligibility under traditional Medicaid eligibility categories before eligibility is denied. This will ensure that eligibility standards remain at least as high as they are today for the non-waiver populations.

In addition to the overall enrollment cap, the State may manage intake into the program based upon program options. For example, the State may limit enrollment in either or both of the FHIAP programs (group or individual markets), or conversely, the State may limit the number of eligibles covered by the OHP Standard benefit package.

The SCHIP program and enrollees funded under either the Title XXI state plan or the HIFA waiver will be limited by the amount of SCHIP funds available in Oregon's allotment. The first priority for the funding will be eligible children, with expansion FHIAP and OHP Standard expansion populations having a lower priority. If sufficient funds are not available to fund the expansion FHIAP or OHP Standard expansion populations, these groups will be shifted to Title XIX funding, to the extent funds and budget neutrality capacity exist.

In addition to an enrollment cap, the waiver has been designed to allow the State the option to manage budget neutrality by altering the benefit packages offered to OHP Standard and FHIAP program eligibles. Oregon also requests that as part of the terms and conditions, CMS and Oregon establish a streamlined process through which Oregon can move the coverage line further up or down the Oregon Prioritized List of Health Care Services.

As discussed in previous sections, the mandatory Medicaid benefits have been determined to be approximately 56 percent of the current OHP coverage. Under the proposed waiver, the current OHP benefits level will be designated as OHP Plus. A second benefit package – OHP Standard – will be available to the parents and adults/couples brought into the program by the original OHP

²Expansion Group consists of the following categories on Exhibit 1: OHP Standard Expansion, the two current FHIAP Groups and the two FHIAP Expansion Groups.

waiver or this waiver request, and who receive services through the Oregon Medical Assistance Program. The OHP Standard package has initially been established at 78 percent of the value of the OHP Plus package (including a portion of premiums collected). In addition to these packages, the FHIAP program will offer health coverage through private insurance options. These private insurance options provide approximately 80 percent of the value of benefits provided by the OHP Plus coverage.

In order to manage state and federal budget neutrality, the State may adjust the benefits, copays and premiums of the packages offered to Oregon Health Plan Standard and FHIAP enrollees. At a minimum, the value of the benefits offered will always be at least equal to the value of the Medicaid mandatory services.

In order to provide for administrative efficiency and management flexibility, the waiver has been designed so that the State may invoke any of the budget neutrality management strategies, with appropriate notice to CMS.

Components of the Budget Neutrality Test

The components of the budget neutrality test differ for the Section 1115 waiver and the HIFA waiver.

Section 1115 Waiver

CMS defines the major components to the Section 1115 waiver test of budget neutrality. In addition to these components, Oregon has one additional component, the use of prior waiver savings. The State's proposal for each of these five components is presented below.

Type of Budget Neutrality Agreement

Oregon requests that the current Section 1115 waiver methodology be used for the purpose of evaluating budget neutrality.

This methodology uses a set of specified annual per capita costs multiplied by the actual or allowed enrollment for each year of the five-year demonstration. The result of this calculation is an aggregate allowable expenditure level. Actual enrollment is used each year for the "current eligible" (or pre-waiver eligibility) categories, and a ratio (that has been set at .4686) is applied to the Phase I "current eligible" population groups (TANF, Poverty Level Medical - Adults and Poverty Level Medical - Children) to determine the "allowable" waiver populations. The ratio is not used to limit actual enrollment in the waiver populations, but rather to determine the "allowable" population for determination of the aggregate allowable expenditure level.

The addition of the expansion population will not change the functioning of the "Limits on Federal Expenditures" that applies to the current waiver. However, the new populations of pregnant women and newborns (from 170 percent up to 185 percent of

FPL) will be added to the current eligible population just as CMS has handled previous expansions of these populations in the past.

Base Year

Oregon proposes to use the CY 2002 “Oregon Estimate of Per Capita Cost” for the various eligibility groups that are being used for the current waiver for determination of the base year expenditures. This base year “Oregon Estimate of Per Capita Cost” was agreed to by the State and CMS for the recent waiver extension.

Trending Factors

The annual trend factor of 8 percent that was agreed to by the State and CMS for the current waiver will be used to trend the base year per capita rates. The allowable per capita rates with the 8 percent trend appear in Appendix 11.1.

Beneficiaries and Services Included

The budget neutrality test will be limited to the Oregon acute care and behavioral health programs. Medicaid services and populations (e.g., QMB/SLMB, long-term care) currently covered outside the demonstration will be excluded from budget neutrality calculations.

Historical Savings

Oregon is requesting to use the historical waiver savings (currently estimated at \$860 million total funds) if it is necessary for the test of budget neutrality. This figure reflects the savings estimates identified by Oregon and CMS through the eight-year life of the Oregon Health Plan waiver.

Administrative costs will continue to be reimbursed based on the current federal matching rates of 50 percent, 75 percent and/or 90 percent of the administrative expense and would not be subject to budget neutrality.

HIFA Waiver

Under the HIFA waiver, CMS has indicated that budget neutrality will be measured on the basis of the SCHIP allotment. The waivers submitted are designed for Oregon to avail itself of its entire Title XXI allotment by funding the expansion FHIAP and OHP Standard populations to the extent the SCHIP allotment is available. Once the allotment is in jeopardy of being oversubscribed, the funding for some or all of these expansion populations will transfer to Title XIX. The expenditures from the SCHIP allotment will be offset by the federal share of the premiums collected from this group. No redistribution funds have been anticipated in the design of the waiver but will be applied if they are available.

B. Cost and Caseload Estimates

This section describes the cost and caseload estimates for these waiver submittals, as well as additional background information and key assumptions that underlie these estimates.

Waiver Time Frame

The proposed waivers will begin October 1, 2002, subject to CMS approval, and terminate September 30, 2007. FHIAP expansion will begin on October 1, 2002, and OHP Standard expansion and benefits will begin on December 1, 2002. State-funded FHIAP individuals that are currently enrolled in that program and eligible under the expansion will be converted on October 1, 2002. The FHIAP program will begin enrollment on October 1, 2002, with the expectation that the initial enrollment cap will be achieved by August 2003. The OHP Standard expansion members will begin enrollment in December 2002, with the first eligibility plateau reached in August 2003 at over 11,700. The cost and caseload estimates are based on these begin and end dates.

Caseload Estimates

This part provides estimates of the number of people who will be enrolled in OHP2.

Exhibit 11.1 presents the five-year forecast (based on Federal Fiscal Year) of the enrolled population. The chart is divided into four sections: OHP Title XIX, OHP Title XXI, Outreach Eligibles, and Expansion Eligibles. All populations are reported as the average number of persons covered for the entire period.

The two categories of "OHP" reflect the estimates of enrollment for the categories that are currently in the program, either through the state plan(s) or through the existing Section 1115 waiver. The Title XIX category is the Medicaid population while the Title XXI is the SCHIP population. These estimates, as all caseload estimates in the forecast, were prepared by the Forecast, Finance and Policy Unit of the Oregon Medical Assistance Program. The forecasts for the existing eligibility categories were to a large extent influenced in the near term by the rise in the unemployment rate and the overall state population trends.

The "Outreach Eligibles" category reflects the estimated increase in enrollment caused by any Oregon outreach efforts and increased public awareness of the program. These forecasts depict the largely one time increase of the additional population that would be added to the current base population (in the current eligibility categories) in order for all the affected sub-populations to achieve a health care coverage level of 83 percent for adults and 95 percent for children. The enrollment into these categories is not based on any changes in eligibility, rather an effort by the State to ensure health care coverage (whether public, private or employer related) to all sub-populations at the above levels. It is anticipated that over 22,000 additional individuals will be receiving health care coverage by June 2003 as a result of outreach/public awareness.

The exclusion of a population from the "outreach eligibles" category indicates that that sub-population is currently at or above these health insurance coverage levels.

The “Expansion Eligibles” category reflects the increased enrollment that will accompany approval of the waiver request. By the end of the five-year demonstration it is anticipated that over 46,000 additional individuals will be receiving health care coverage under the program.

Within this expansion population, the enrollment for SCHIP children and pregnant women and their newborns with incomes from 170 percent up to 185 percent of FPL have been estimated based on the assumed overall targeted level of coverage of 83 percent of the population for adults and 95 percent of the population for children. The population for the current FHIAP coverage is based on the actual enrollment. The population estimates for the balance of the expansion population (OHP Standard expansion and FHIAP group and individual) have been derived based upon anticipated impacts on federal and state budget neutrality, SCHIP allotment availability, and, in the case of the FHIAP program, the anticipated number of lives that the program can manage.

The budget neutrality analysis assumes the current FHIAP caseload, as well as the pregnant women and their newborns (the PLM A and the PLM C), will be funded from Title XIX funds. The SCHIP children will be funded from the Title XXI funds. The expansion in the FHIAP caseload as well as the OHP Standard expansion population (which is composed of both Parents and Adults/Couples) will initially be funded from Title XXI funding, and then after the prior year allotments are spent down, will shift some or all of their funding to Title XIX.

As described above under “*Type of Budget Neutrality Agreement*” there is a limit on the “allowable population” for the purpose of calculating the budget neutrality limit. Appendix 11.2 provides additional information on determining allowable caseloads by FFY.

Cost Estimates

Section 1115 Waiver

This section provides the forecast of expenditures for the Title XIX program and presents the State’s demonstration of budget neutrality for the requested Section 1115 waiver.

Exhibit 11.2 presents the waiver’s total Title XIX spending for five fiscal years compared to the Section 1115 waiver budget neutrality limit.

- ❑ *Total Allowable Expenditures.* This line presents the estimated³ expenditure limit imposed under the current Section 1115 waiver extended for five years for the purpose of this waiver request. Total allowable spending over the five-year period is estimated to be \$12.942 billion. The per capita expenditure amounts and the allowable enrollment levels used to calculate the limit are included in Appendix 11.1 and 11.2.
- ❑ *Total Title XIX Expenditures.* This line presents the estimated Title XIX expenditures over the five year period. Separate lines are presented that show program expenditures,

³ This is an estimate since the number of actual eligibles to be used in the calculation at the end of the demonstration may vary from this estimate.

DSH/GME, and ProShare payments. Total program expenditures are estimated to be \$12.732 billion, with DSH/GME and ProShare at just over \$207 million. Total Title XIX spending under this waiver over the five years is \$12.939 billion. This results in a small amount of room (\$2.8 million) that estimated expenditures are below allowable expenditures.

- *Historical Savings.* As noted earlier in this section, Oregon is requesting credit for historical waiver savings. The current estimate of the savings to date is \$860 million total funds.
- *Beneath (Above) the Allowable Limit.* The Exhibit indicates that over the life of the waiver the program would be beneath the budget neutrality limit before consideration of the historical savings. With the historical savings, the program shows a positive budget neutrality balance of \$863 million.

Exhibit 11.3 presents the Title XIX program expenditures by eligibility group by fiscal year. Of particular interest is the absence of Title XIX funding for the FHIAP expansion categories except for the last year in the program and the delayed Title XIX funding of the OHP Standard expansion population. Title XIX funding is not used for the OHP Standard populations until part way through FFY 2003. At that time the funding begins to shift from the HIFA/Title XXI waiver to the Section 1115 waiver. In FFY 2003, it is anticipated that 23 percent of the funding for this group will be shifted from Title XXI to Title XIX, and by FFY 2004 through the end of the waiver, the population will be entirely funded through Title XIX.

The Title XIX expenditures depicted on Exhibit 11.3 were determined based on the caseloads from Exhibit 11.1 and per capita expenditure amounts estimated by the State for the life of the waiver.

HIFA Waiver

Exhibit 11.4 presents the funds flow for the HIFA waiver, and as such, represents the budget neutrality measurement for the Title XXI funding. All funding on this Exhibit is presented in terms of the federal share.

- *State's Allotment.* This line presents the State's estimate of its SCHIP allotment over the five-year period. Each year the allotment is assumed to be \$37,000,000, which approximates the FFY 2002 allotment of \$37,597,000.
- *Funds Carried Over.* This line presents the amount of allotment carried over from previous years. The State is anticipating carrying over the full \$50,134,100 from its FY 2001 allotment as well as the full allotment of \$37,597,000 from its FY 2002 allotment.
- *Redistributed Funds.* The State does not anticipate any redistributed funds will be made available during the life of the requested HIFA waiver (but will use them to fund base program and/or expansion eligibles if they are made available).
- *Current Year Expenditures.* The estimated amount of expenditures is depicted. Further detail is contained in Exhibit 11.5.

- *Ending Balance.* The estimated ending balance of the SCHIP allotments at the end of the five-year waiver period is \$.3 million. Thus, the requested HIFA waiver is budget neutral.

Exhibit 11.5 displays additional detail on the expenditures under the HIFA waiver. The top half of the Exhibit depicts the program expenditures and premium collections on a total funds basis. The bottom half of the Exhibit presents the same information on a federal funds basis.

As Exhibit 11.3 illustrated the increasing Title XIX funding for the OHP Standard expansion population group beginning part way through FFY 2003, Exhibit 11.5 shows the decreased Title XXI funding for the same group. Part way through FFY 2003 the funding for the OHP Standard expansion population will shift away from Title XXI funding, unless additional funds (such as redistributions) are available. In FFY 2007, the funding for the FHIAP population will shift away from Title XXI funding, unless additional funds are available.

The Title XXI expenditures depicted on Exhibit 11.5 were determined based on the caseloads from Exhibit 11.2 and the per capita expenditure amounts estimated by the State for the life of the waiver. Premium amounts were estimated based on the initial premium schedules proposed in this waiver submittal.

**APPENDIX 1.1
HB 2519**

71st OREGON LEGISLATIVE ASSEMBLY--2001 Regular Session

Enrolled

House Bill 2519

Sponsored by Representative KRUSE; Representatives LEE,
MORRISETTE, NELSON (at the request of Interim House Health and
Human Services Committee)

CHAPTER

AN ACT

Relating to the Oregon Health Plan; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Preamble. It is the primary goal of sections 1 to 11 of this 2001 Act to increase access by Oregon's low-income, uninsured children and families to affordable health care coverage.

SECTION 2. Findings. The Legislative Assembly finds that:

(1) The Oregon Health Plan has provided access to health care services to over one million Oregonians who would otherwise not have been able to afford health care services.

(2) The Oregon Health Plan has improved health outcomes by expanding access to timely preventive services and primary health care services.

(3) In spite of the Oregon Health Plan's important achievements, thousands of Oregonians still do not have health insurance coverage, often seeking health care services through the emergency department late in the course of their illness when costs are higher and outcomes are less favorable.

(4) The costs incurred by the health care delivery system by providing health care services through emergency departments are shifted to patients with health insurance coverage, driving up the costs of health care services and health insurance for all Oregonians.

(5) The lack of flexibility in current federal Medicaid policy forces the state into 'one-size-fits-all' benefit packages and 'all-or-nothing' coverage decisions, preventing the state from using federal resources to develop a system of subsidies for public and private insurance coverage based on the relative medical need and financial vulnerability of those being served.

(6) The lack of adequate reimbursement rates creates unwanted cost-shifting and barriers to health care providers at all levels in providing health care services to enrollees of the Oregon Health Plan.

(7) The current trends in increases in health care costs create concern for:

(a) The future sustainability of the Oregon Health Plan and the private insurance market;

(b) The State of Oregon in administering benefit plans for its employees;

(c) Individuals unable to pay for all or part of the costs of their health care;

(d) Employers providing health care coverage for their workers and their dependents;

(e) Health care providers providing services; and

(f) Insurers and other organizations providing health care coverage.

(8) Complex factors affect the balance between public and private health care programs and need to be better understood in order to establish policies that result in necessary access to health care. These factors include, but are not limited to:

(a) Whether the current structure of Medicare, Medicaid and the private insurance market is cost-sustainable;

(b) The reasons behind general health care cost trends;

(c) Appropriate reimbursement methods that reduce cost-shifting and optimize access to providers and plan choices;

(d) Whether public programs for low-income Oregonians that ensure adequate coverage are cost-effective and provide a realistic transition to private coverage; and

(e) Whether private coverage that is affordable offers sufficient benefit choices and is based on a market-based system.

(9) Employer-sponsored health coverage:

(a) Provides coverage for a majority of all Oregonians; and

(b) Must be supported by public policies that remove barriers to obtaining private health insurance coverage.

SECTION 3. Policy. It is the policy of the State of Oregon that:

(1) The state, in partnership with the private sector, move toward providing affordable access to basic health care services for Oregon's low-income, uninsured children and families;

(2) Subject to funds available, the state provide subsidies to low-income Oregonians, using federal and state resources, to make health care services affordable to Oregon's low-income, uninsured children and families and that those subsidies should encourage the shared responsibility of employers and individuals in a public-private partnership;

(3) The respective roles and responsibilities of government, employers, providers, individuals and the health care delivery system be clearly defined;

(4) All public subsidies be clearly defined and based on an individual's ability to pay, not exceeding the cost of purchasing a basic package of health care services, except for those individuals with the greatest medical needs; and

(5) The health care delivery system encourage the use of

evidence-based health care services, including appropriate education, early intervention and prevention, and procedures that are effective and appropriate in producing good health.

SECTION 4. Increased Access for Uninsured Individuals. In order to carry out the policy established in section 3 of this 2001 Act, subject to funds available, the State of Oregon shall increase access to basic health care services provided through Medicaid, the Children's Health Insurance Program or private insurance for uninsured Oregonians with an income of up to 185 percent of the federal poverty guidelines.

SECTION 5. Waiver for Private Insurance Coverage. (1) (a) In order to make progress toward the goal set forth in section 1 of this 2001 Act, the Department of Human Services shall apply to the Centers for Medicare and Medicaid Services for waivers to obtain federal matching dollars for public subsidies for low-income, working Oregonians for the purpose of making private health insurance more accessible and affordable.

(b) Prior to the submission of the waiver application, the department shall comply with ORS 291.375 (1) and (2).

(2) The waiver application shall provide for the establishment of a basic benchmark health benefit plan or plans, or approved equivalent, for subsidized employer-sponsored coverage that is comparable to coverage common in the small employer health insurance market. Consideration shall be given to the appropriate inclusion of preventive services for children and innovative means of ensuring access to such coverage. Options in the development of the benchmark health benefit plan may include, but are not limited to, provision of supplemental coverage for preventive services.

(3) The Insurance Pool Governing Board, in consultation with the Health Insurance Reform Advisory Committee, shall identify and recommend to the Waiver Application Steering Committee created under section 13 of this 2001 Act and the Leadership Commission on Health Care Costs and Trends created under section 14 of this 2001 Act a basic benchmark health benefit plan or plans that qualify for a subsidy under the waiver program, taking into account employer-sponsored health benefit plans currently in the market.

(4) The waiver application shall be based on a consideration of various models to maximize subsidies for employer-sponsored coverage with special attention given to creative means of increasing dependent coverage under the employer-sponsored health benefit plans.

(5) The waiver application shall ensure that:

(a) Coverage under the proposed program does not reduce employer-sponsored coverage presently available; and

(b) The risk distribution of the current population covered by the state's Medicaid program is not adversely affected.

(6) The waiver application shall strive to minimize administrative complexities for enrollees, employers, providers, health insurance plans and public agencies that participate in the proposed program.

(7) Prior to its submission for legislative review under subsection (1) of this section, the department shall submit the

waiver application to the Leadership Commission on Health Care Costs and Trends for review.

SECTION 5a. Family Health Insurance Assistance Program. Upon receipt of the waiver, the Insurance Pool Governing Board shall focus on expanding group coverage provided by the Family Health Insurance Assistance Program, with the goal of having available funds equally distributed between providing group coverage and individual coverage.

SECTION 6. Levels of Coverage for Medicaid. In the Medicaid portion of the Oregon Health Plan, the state shall provide levels of benefit packages of health care services as described in sections 7 and 8 of this 2001 Act. One level shall provide a basic benefit package of health care services and be called 'OHP Standard.' The second level shall provide a benefit package of health care services for persons with greater medical needs and be called 'OHP Plus.'

SECTION 7. Basic Benefit Package. (1) The Health Services Commission, in consultation with the legislative committees with oversight of health care issues, shall develop a basic benefit package of health care services for the Medicaid portion of the Oregon Health Plan, the cost of which shall be actuarially equivalent to the minimum level of care mandated by the current federal Medicaid law.

(2) (a) In addition to the basic benefit package of health care services developed under subsection (1) of this section, the commission shall develop and rank in priority order additional benefit packages of health care services that may be provided to the extent the Legislative Assembly has provided funds for additional benefit packages.

(b) When developing the benefit packages of health care services to be provided, the commission shall consider that those benefit packages of health care services may be provided through managed care organizations with contracts to provide services to enrollees of the Oregon Health Plan as well as commercial carriers.

(3) The commission shall obtain from an independent actuary the costs of providing the benefit packages of health care services identified in subsections (1) and (2) of this section.

(4) The commission shall recommend whether Oregonians receiving subsidies for OHP Standard be required to pay premiums and copayments based on the individual's ability to pay and how to structure the copayments and premiums in a manner that encourages the use of preventive services.

(5) The commission shall submit its report on benefit packages for health care services by July 1 of the year preceding each regular session of the Legislative Assembly to the Governor, the Speaker of the House of Representatives and the President of the Senate.

SECTION 8. Prioritized List. The Health Services Commission shall continue to develop and report to the Legislative Assembly the prioritized list of health care services required in ORS 414.720. The list shall be used to establish the OHP Plus benefit package of health care services to be provided to Oregonians who are categorically eligible for medical

assistance as defined by rule by the Department of Human Services and persons receiving general assistance as defined in ORS 411.010.

SECTION 9. Written Report of Costs. (1) For the biennium beginning July 1, 2001, and no later than November 1, 2001, the Health Services Commission shall prepare and give to the interim legislative committee with oversight of health care issues, the chairpersons of the Emergency Board and the Waiver Application Steering Committee created under section 13 of this 2001 Act a written report of the costs developed by the actuary under section 7 of this 2001 Act of a basic benefit package of health care services and the additional benefit packages of health care services in priority order.

(2) The Waiver Application Steering Committee shall recommend the level of benefits to be included in the waiver application for the OHP Standard benefit package.

SECTION 10. Funding by Legislative Assembly. (1) The Legislative Assembly shall determine the health care services provided under the Medicaid portion of Oregon Health Plan by funding:

(a) OHP Standard, which shall be the combination of the basic benefit package of health care services developed in section 7 (1) of this 2001 Act and any additional benefit packages, added in priority order, from the packages developed under section 7 (2) of this 2001 Act.

(b) OHP Plus, which shall be the benefit package developed in section 8 of this 2001 Act.

(2) The cost of the benefit package of health care services provided under OHP Standard may not exceed the cost of the benefit package of health care services provided under OHP Plus.

SECTION 11. Subsidies for Health Insurance Coverage. (1) Subject to funds available, the waiver program described by section 5 of this 2001 Act shall provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals based on incomes up to 185 percent of the federal poverty level. The objective is to create a transition from dependence on public programs to privately financed health insurance.

(2) Public subsidies shall apply only to the cost of the basic benchmark health benefit plan or the approved equivalent established in section 5 of this 2001 Act.

(3) Cost-sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.

(4) Cost-sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan approved as provided under subsection (2) of this section.

(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources.

SECTION 12. Rates. (1) The Department of Human Services shall recommend to the Seventy-second Legislative Assembly an

alternative method of determining the capitation rate paid to fully capitated health plans, mental health organizations, dental organizations and other managed care entities providing services to enrollees of the Oregon Health Plan.

(2) Rates recommended under subsection (3) of this section shall:

(a) Be sufficient to provide appropriate access to services covered by the Oregon Health Plan; and

(b) Ensure that the current health care delivery system of fully capitated health plans, mental health organizations and dental care organizations used to deliver health care services to enrollees of the Oregon Health Plan is maintained and enhanced as needed to provide appropriate access to covered health care services for all enrollees of the Oregon Health Plan.

(3) The recommendation regarding the capitation rate shall:

(a) Provide for the rate to be constructed in a manner that allows providers, patients and policymakers to easily understand how the rate is developed and the components that are used to develop the rate;

(b) Use nationally recognized comparators for constructing the rate including but not limited to:

(A) The Medicare Resource Based Relative Value conversion factor for physician services;

(B) The Medicare hospital reimbursement principles; and

(C) Medical inflation rates used by the Centers for Medicare and Medicaid Services;

(c) Seek to equitably reimburse the different providers at rates necessary to provide appropriate access to services covered by the Oregon Health Plan; and

(d) Consider reasonable estimates of health care service utilization based on an actuarially appropriate model for projecting such utilization.

SECTION 13. Waiver Application Steering Committee. (1) The Department of Human Services shall establish a Waiver Application Steering Committee to assist and advise the department in the preparation of the application for federal waivers from the Centers for Medicare and Medicaid Services necessary to carry out sections 1 to 11 of this 2001 Act. The committee shall ensure that the concerns and views of Oregonians interested in the Oregon Health Plan are fully considered in the preparation of the waiver application.

(2) The committee shall consist of, but not be limited to, the following:

(a) Two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the Emergency Board;

(b) Two members of the Senate appointed by the President of the Senate, one of whom shall be a member of the Emergency Board;

(c) A representative of a statewide association representing hospitals and health systems;

(d) A representative of a statewide association representing physicians licensed under ORS chapter 677 to practice medicine in this state;

(e) A representative of community-based health plans with

contracts to provide health care services under the Oregon Health Plan;

(f) A representative of dental care organizations with contracts to provide health care services under the Oregon Health Plan;

(g) A representative of commercial carriers;

(h) A representative of safety net clinics;

(i) Advocates for health care consumers and persons without health insurance;

(j) Advocates for persons with mental illness;

(k) One representative each of small and large businesses;

(L) A representative of insurance agents; and

(m) A representative of organized labor.

(3) (a) When preparing the waiver application, the Department of Human Services and the Waiver Application Steering Committee shall carefully consider the connection between the coverage provided through the state Medicaid program and coverage provided through private insurance.

(b) The waiver application shall set forth the circumstances under which persons covered under the waivers may use coverage provided through the state Medicaid program and when they may use coverage provided by private insurance. These circumstances shall ensure that the viability of the community-based health plans currently with contracts to provide health care services under the Oregon Health Plan will be maintained.

(c) The department and the committee shall consider the following factors when setting forth the circumstances described in paragraph (b) of this subsection:

(A) Personal choice;

(B) The ability of a family to obtain employer-sponsored group coverage;

(C) The cost to a family to obtain employer-sponsored group coverage;

(D) The cost to the department to obtain or supplement employer-sponsored group coverage for a person and the person's family; and

(E) The medical needs of the person and the person's family.

SECTION 14. Leadership Commission on Health Care Costs and Trends. (1) In order to provide a sound basis for future consideration of strategies to improve access to an adequate level of high quality health care at an affordable cost for all Oregonians, the Leadership Commission on Health Care Costs and Trends is created, consisting of eight members. The commission shall consist of:

(a) The President of the Senate or a member of the Senate designated by the President;

(b) The Speaker of the House of Representatives or a member of the House of Representatives designated by the Speaker;

(c) Two members of the Senate appointed by the President of the Senate, one of whom shall be a member of the Emergency Board;

(d) Two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the Emergency Board; and

(e) One member each appointed by the minority leadership of the Senate and the House of Representatives.

(2) The commission shall develop an Oregon Health Care Cost Index. The index shall categorize health care cost components and health care trends to inform future policymakers about potential implications of trends in health care programs provided by public and private programs.

(3) The commission shall review the health care cost trends that are reducing the affordability and availability of private coverage and thereby increasing dependence on publicly funded health care services.

(4) The commission shall monitor developments of possible federal health benefit tax credit programs and determine ways to maximize opportunities to expand health insurance coverage through a state income tax credit.

(5) The commission may contract with a private entity to develop the index.

(6) The commission shall recommend to the Seventy-second Legislative Assembly methods to:

(a) Update and distribute the index annually; and

(b) Report to policymakers and the public on potential implications for health care coverage available in Oregon.

(7) Except as provided in this section, the commission is subject to the provisions of ORS 171.605 to 171.635 and has the authority contained in ORS 171.505 and 171.510.

(8) The President of the Senate and the Speaker of the House of Representatives shall develop a work plan for the commission. The work plan shall be filed with the Legislative Administrator.

(9) The Legislative Administrator, in cooperation with the President of the Senate and the Speaker of the House of Representatives, shall provide staff necessary to the performance of the functions of the commission.

(10) Members of the Legislative Assembly who serve on the commission shall be entitled to an allowance as authorized by ORS 171.072. Claims for expenses incurred in performing functions of the commission shall be paid out of funds appropriated for that purpose.

(11) Subject to approval of the Emergency Board, the commission may accept contributions of funds and assistance from the United States Government or its agencies, or from any other source, public or private, and agree to conditions thereon not inconsistent with the purposes of the commission. All such funds are to aid in financing the functions of the commission and shall be deposited in the General Fund of the State Treasury to the credit of separate accounts for the commission and shall be disbursed for the purpose for which contributed in the same manner as funds appropriated for the commission.

(12) Official action taken by the commission shall require the approval of the majority of the members of the commission. All legislation recommended by official action of the commission must indicate that it is introduced at the request of the commission. Such legislation shall be prepared in time for presession filing pursuant to ORS 171.130.

SECTION 15. Benefit Packages for 2001-2003 Biennium. For

the 2001-2003 biennium, the benefit package of health care services provided to individuals currently receiving services under the Oregon Health Plan shall be the benefit package funded by the Seventy-first Legislative Assembly until sections 6 and 11 of this 2001 Act become operative.

SECTION 16. Operative Date. (1) Sections 6, 10 and 11 of this 2001 Act become operative the day after the date of receipt by the Department of Human Services of the necessary waivers from the Centers for Medicare and Medicaid Services.

(2) The Director of Human Services shall notify the President of the Senate, the Speaker of the House of Representatives and the Legislative Counsel upon receipt of the waivers or denial of the waiver request.

SECTION 17. Effective Date. This 2001 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2001 Act takes effect on its passage.

Passed by House May 14, 2001

Repassed by House July 6, 2001

.....
Chief Clerk of House

.....
Speaker of House

Passed by Senate July 5, 2001

.....
President of Senate

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2001

.....
Secretary of State

**APPENDIX 3.1
DENTAL COPAYMENTS**

The following plan applies to OHP Standard adult clients, only.

Prioritized List Line 301

Diagnosis: Preventive Dental Services

Treatment: Cleaning and Fluoride

Services:

Exams	no co-pay
Cleaning	no co-pay
Oral health instruction	no co-pay
Periodontic scaling & root planing	no co-pay
Therapeutic injection	no co-pay

Prioritized List Line 358

Diagnosis: Dental Conditions (i.e. Infections, broken appliances)

Treatment: Urgent and Emergent Dental Services

Services:

Exams	no co-pay
Office visit after regular hours	no co-pay
Palliative treatment	no co-pay
Re-cement inlay	no co-pay
Re-cement crown	no co-pay
Sedative filling	no co-pay
Direct pulpcap	no co-pay
Indirect pulpcap	no co-pay
Pulpotomy	no co-pay
Gross pulpal debridement	no co-pay
Tooth re-implantation	no co-pay
Adjust complete upper denture	no co-pay
Adjust complete lower denture	no co-pay
Adjust partial upper denture	no co-pay
Adjust partial lower denture	no co-pay
Repair broken complete denture	no co-pay
Re-cement fixed partial denture	no co-pay
Intraoral incision and drain abscess	no co-pay

Extraoral incision and drain abscess	no co-pay
Single tooth extraction	\$10.00 co-pay w/max OOP of \$40
Each additional tooth	\$10.00 co-pay – see limit above
Root removal	\$10.00 co-pay
Surgical removal erupted tooth	\$10.00 co-pay
Soft tissue impaction	\$25.00 co-pay
Partially bony impaction	\$25.00 co-pay
Complete bony impaction	\$25.00 co-pay
Complete bony, unusual complications	\$25.00 co-pay
Surgical root removal	\$25.00 co-pay
Oral fistula closed	\$25.00 co-pay

Prioritized List Line 507

Diagnosis: Dental Conditions (i.e. Dental caries, fractured tooth)

Treatment: Basic Restorative

Services:

One surface amalgam	\$15.00 co-pay
Two surface amalgam	\$15.00 co-pay
Three surface amalgam	\$15.00 co-pay
Four surface amalgam	\$15.00 co-pay
One surface resin, anterior	\$15.00 co-pay
Two surface resin, anterior	\$15.00 co-pay
Three surface resin, anterior	\$15.00 co-pay
Four surface resin, anterior	\$15.00 co-pay

new One surface resin, posterior \$15.00 co-pay

new Two surface resin, posterior \$15.00 co-pay

new Three surface resin, posterior \$15.00 co-pay

new Four surface resin, posterior \$15.00 co-pay

(these services are below the funded line but OHP Dental Services Guide covers if paid at the amalgam rate)

Resin crown	\$15.00 co-pay
Pin retention	\$15.00 co-pay
Post removal	\$15.00 co-pay
Crown repair	\$15.00 co-pay

Anterior root canal \$50.00 co-pay

Bi-cuspid root canal \$70.00 co-pay

Removal cyst up to 1.25 cm	\$10.00 co-pay
Removal cyst over 1.25 cm	\$10.00 co-pay
Destruction of lesion	\$10.00 co-pay
Treatment post surgical complications	\$10.00 co-pay

Prioritized List Line 508

Diagnosis: Dental Conditions (i.e. Severe tooth decay)

Treatment: Stabilization of Periodontal Health, Complex Restorative, and Removable Prosthodontics

Services:

Periodontic scaling and root planing	no co-pay
Prefabricated post core	\$10.00 co-pay
Each additional tooth	\$10.00 co-pay
Complete upper denture	\$100.00 co-pay per arch
Complete lower denture	\$100.00 co-pay per arch
Immediate upper denture	\$25.00 co-pay per arch
Immediate lower denture	\$25.00 co-pay per arch
new Resin upper partial denture	\$25.00 co-pay per arch
new Resin lower partial denture	\$25.00 co-pay per arch
Repair broken complete denture base	\$10.00 co-pay
Repair complete denture	\$10.00 co-pay
Repair denture base	\$10.00 co-pay
Repair cast frame partial	\$10.00 co-pay
Repair or replace broken clasp	\$10.00 co-pay
Replace broken teeth-per tooth	\$10.00 co-pay
Add tooth to partial denture	\$10.00 co-pay
Add clasp to partial denture	\$10.00 co-pay
Rebase upper denture	\$50.00 co-pay
Rebase lower denture	\$50.00 co-pay
Rebase upper partial denture	\$50.00 co-pay
Rebase lower partial denture	\$50.00 co-pay
Reline chairside upper complete denture	\$10.00 co-pay
Reline chairside lower complete denture	\$10.00 co-pay
Reline chairside upper partial denture	\$10.00 co-pay

Reline chairside lower partial denture	\$10.00 co-pay
Reline lab upper complete denture	\$25.00 co-pay
Reline lab lower complete denture	\$25.00 co-pay
Reline lab upper partial denture	\$25.00 co-pay
Reline lab lower partial denture	\$25.00 co-pay
Tissue conditioning, upper	\$10.00 co-pay
Tissue conditioning, lower	\$10.00 co-pay
Re-cement bridge	\$10.00 co-pay
Prefab post/core in addition to bridge retainer	\$10.00 co-pay
Bridge repair	\$10.00 co-pay
Alveoloplasty, not with extractions	\$50.00 co-pay
Removal of exostosis, per site	\$15.00 co-pay

Prioritized List Line 530

Diagnosis: Dental Conditions (i.e. Tooth loss)
 Treatment: Space Maintenance and periodontal maintenance

Services:

Gingival curettage per quadrant	\$25.00 co-pay
Periodontal maintenance	\$25.00 co-pay
Unscheduled dressing change	\$15.00 co-pay

Covered Services Not Listed in the Prioritized List

X-rays	no co-pay
Tests and Laboratory Examinations	no co-pay
Tobacco cessation	no co-pay
Full mouth debridement	no co-pay
Professional consultation	no co-pay
Office visit for observation during office hours	no co-pay
Biopsy hard oral tissue	\$10.00 co-pay
Biopsy soft oral tissue	\$10.00 co-pay
Excision of malignant tumor up to 1.25 cm	\$10.00 co-pay
Excision of malignant tumor over 1.25 cm	\$10.00 co-pay
Vestibuloplasty (D7340)	\$50.00 co-pay

Vestibuloplasty (D7350)	\$50.00 co-pay
Partial ostectomy	\$50.00 co-pay
Radical resection of mandible with bone graft	\$50.00 co-pay
Anesthesia, regional block	\$20.00 co-pay
Trigeminal division block anesthesia	\$20.00 co-pay
Oral pre-medication	\$20.00 co-pay
Other drugs and/or medicaments	\$20.00 co-pay
Analgesia (nitrous oxide)	\$20.00 co-pay
D9220 general anesthesia, 30 minutes	\$100.00 per encounter
D9221 general anesthesia, each additional 15 minutes – see above	
D9241 IV sedation, 30 minutes	\$100.00 per encounter
D9242 IV sedation, each additional 15 minutes – see above	

APPENDIX 3.2
HEALTH INSURANCE AND PROVIDER MANDATES AS OF JULY 1, 2001

	Mandate	Description	Statute	Date adopt.	Subject to repeal (Yes/No) & date	Federal mandate	Insurance type			Policy type		
							Commercial insurer	HMO/HCSC	Self-ins	Small group	Large group	Individual
	Diseases and conditions											
1	Alcoholism - Individual (mandatory offering)	Coverage for alcoholism treatment, at the request of the insured.	ORS 743.412	1977 & 1981	No, pre-1985	No	Yes	Yes	No	No	No	Yes
2	Chemical dependency/mental conditions	Group health insurance coverage for treatment of chemical dependency, including alcoholism, and for mental or nervous conditions.	ORS 743.556	9/87; rev. 10/99	No	*No	Yes	Yes	No	Yes	Yes	No
3	Pregnancy/childbirth reimbursement	All health benefit plans must provide payment or reimbursement for expenses with pregnancy care.	ORS 743.693	Oct-99	Yes, 10/2006	No	Yes	Yes	No	Yes	Yes	Yes
4	Particular drug coverage	No insurance policy providing coverage for a prescription drug to a resident of this state shall exclude coverage	ORS 743.697	Oct-97	No	No	Yes	Yes	No	Yes	Yes	Yes
5	Diabetes	Requires group health benefit plans to cover costs of supplies, equipment and diabetes self-management programs associated with treatment of various types of diabetes.	SB 286 (2001)	2001	Yes, 1/2008	No	Yes	Yes	No	Yes	Yes	No
6	Diabetes self-management education	Every group health insurance policy shall provide coverage for diabetes self management education programs.	ORS 743.704	1986	**Repealed 1/92	No	Yes	Yes	No	Yes	Yes	Yes
7	Maxillofacial prosthesis	All group health insurance policies providing hospital, medical, or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.	ORS 743.706	1981	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes
8	Diethylstilbestrol prescribed for mother	Prohibits denial or cancellation of health insurance because of diethylstilbestrol use by mother of insured prior to insured's birth.	ORS 743.710	1979	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes

	Mandate	Description	Statute	Date adopt.	Subject to repeal (Yes/No) & date	Federal mandate	Insurance type			Policy type		
							Commercial insurer	HMO/HCSC	Self-ins	Small group	Large group	Individual
9	Tourette syndrome	Reimbursement for treatment of Tourette Syndrome, a neurological disorder that affects children between the ages of 2 & 6.	ORS 743.717	1985	**Repealed 9/91	No	Yes	No	No	Yes	Yes	No
10	Mammography screening & schedule	Every health insurance policy that covers hospital, medical, or surgical expenses shall provide coverage of mammograms.	ORS 743.727	11/93, rev. 97 & 99	Yes, 10/2006	No	Yes	Yes	No	Yes	Yes	Yes
11	Pelvic/pap smear exam and schedule	All policies providing health insurance shall include coverage for pelvic examinations and pap smear examinations.	ORS 743.728	1/94, rev. 99	Yes, 10/2006	No	Yes	Yes	No	Yes	Yes	Yes
12	Enteral formula prescription reimbursement	All policies providing health insurance shall include coverage for a nonprescription elemental enteral formula for home use if the formula is medically necessary.	ORS 743.729	Jul-93	**Repealed 7/99	No	Yes	Yes	No	Yes	Yes	Yes
13	Inborn errors of metabolism reimbursement	All individual & group health insurance policies providing coverage shall include coverage for treatment of inborn errors.	ORS 743.726	Jul-97	Yes, 7/2003	No	Yes	Yes	No	Yes	Yes	Yes
14	Federal Women's Health & Cancer Rights Act (breast reconstruction)	All group health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998.	ORS 743.737(15), 743.754(9), & 743.766(9)	Oct-99	Yes, 10/2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	Newborns' & Mothers' Health Protection Act (minimum maternity stay)	The department shall enforce insurer compliance with the federal Newborns' and Mothers' Health Protection act.	ORS 743.823	Jun-97	Yes, 10/2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	Emergency eye care	Any insurer that offers a health benefit plan that provides eye care services shall allow any enrollee to receive emergency eye services.	ORS 743.842	Oct-99	Yes, 11/2006	No	Yes	Yes	No	Yes	Yes	Yes

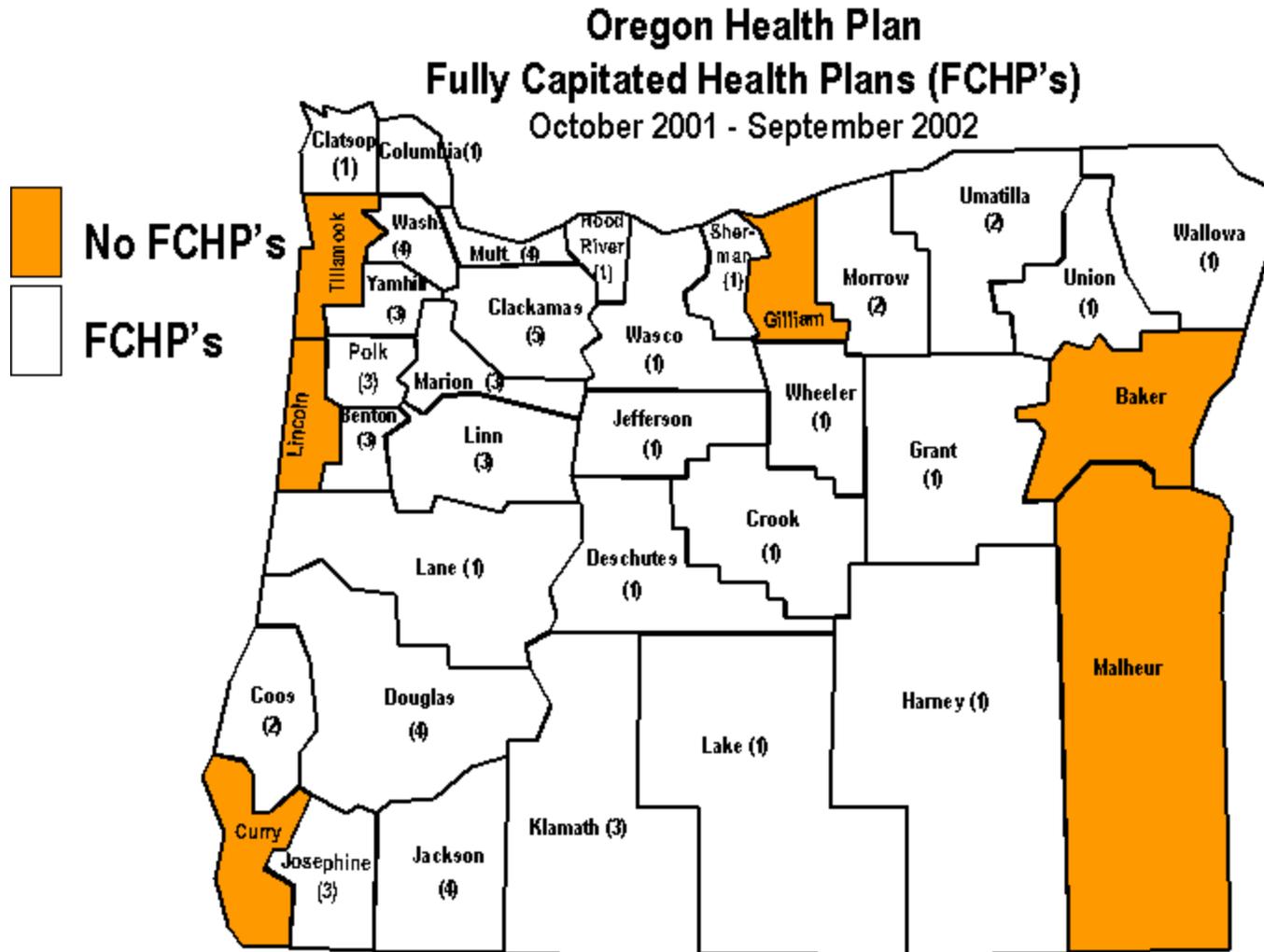
	Mandate	Description	Statute	Date adopt.	Subject to repeal (Yes/No) & date	Federal mandate	Insurance type			Policy type		
							Commercial insurer	HMO/HCSC	Self-ins	Small group	Large group	Individual
17	HIV, AIDS, and ARC	No inquiry in an application for health or life insurance coverage shall be directed toward determining the applicant's sexual orientation.	ORS 746.240 & OAR 836-050-0240 to 836-050-0250	1988	No	No	Yes	Yes	No	Yes	Yes	Yes
Provider reimbursements												
18	Choice of drug outlets and pharmacies	An insured may limit the drug outlets or pharmacists.	ORS 731.485	1993	No	No	Yes	Yes	No	Yes	Yes	Yes
19	State hospital reimbursement	No policy shall exclude from payment or reimbursement losses for service rendered at a State of Oregon or any approved mental health program.	ORS 743.701	Sep-71	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes
20	Optometrists	Reimbursement for services of optometrist.	ORS 743.703 & 750.065	Sep-67	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes
21	Psychologists	Reimbursement for services provided by psychologist.	ORS 743.709	Sep-75	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes
22	Nurse practitioners	Reimbursement for services of certified nurse practitioner, including prescribing or dispensing drugs.	ORS 743.712	Jul-79	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes
23	Denturists	Notwithstanding any policy provisions of dental insurance, the insured under such policy shall be entitled to reimbursement for such service.	ORS 743.713	12/78 (rev. 93)	No, pre-1985	No	Yes	No	No	Yes	Yes	Yes
24	Clinical social workers	The insured under the policy shall be entitled to have payment or reimbursement made to the uninsured.	ORS 743.714	7/81 (rev. 89)	No, pre-1985	No	Yes	No	No	Yes	Yes	Yes
25	Ambulance care & transport coverage	Any insurance policy shall provide that payments will be made to the provider.	ORS 743.718	Sep-87	No	No	Yes	Yes	No	Yes	Yes	Yes
26	Dental surgeons	Reimbursement for certain surgical services performed by dentist.	ORS 743.719	Sep-71	No, pre-1985	No	Yes	Yes	No	Yes	Yes	Yes

	Mandate	Description	Statute	Date adopt.	Subject to repeal (Yes/No) & date	Federal mandate	Insurance type			Policy type		
							Commercial insurer	HMO/HCSC	Self-ins	Small group	Large group	Individual
27	Acupuncturists	Whenever a policy provides for payment for acupuncture services performed by a physician, the policy also shall pay for acupuncture service performed by an acupuncturist.	ORS 743.722	Sep-87	**Repealed 10/98	No	Yes	Yes	No	Yes	Yes	Yes
28	Physicians Assistants	Reimbursement for claim submitted by physician assistant.	ORS 743.725	Oct-97	Yes, 10/2003	No	Yes	Yes	No	Yes	Yes	Yes
29	Women's primary health care provider	Every health insurance policy shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider.	ORS 743.845	9/95 (rev.10/99)	Yes, 10/2006	No	Yes	Yes	No	Yes	Yes	Yes
30	Emergency services coverage	All insurers offering a health benefit plan shall provide coverage without prior authorization.	ORS 743.699	Oct-97	Yes, 10/2003	No	Yes	Yes	No	Yes	Yes	Yes

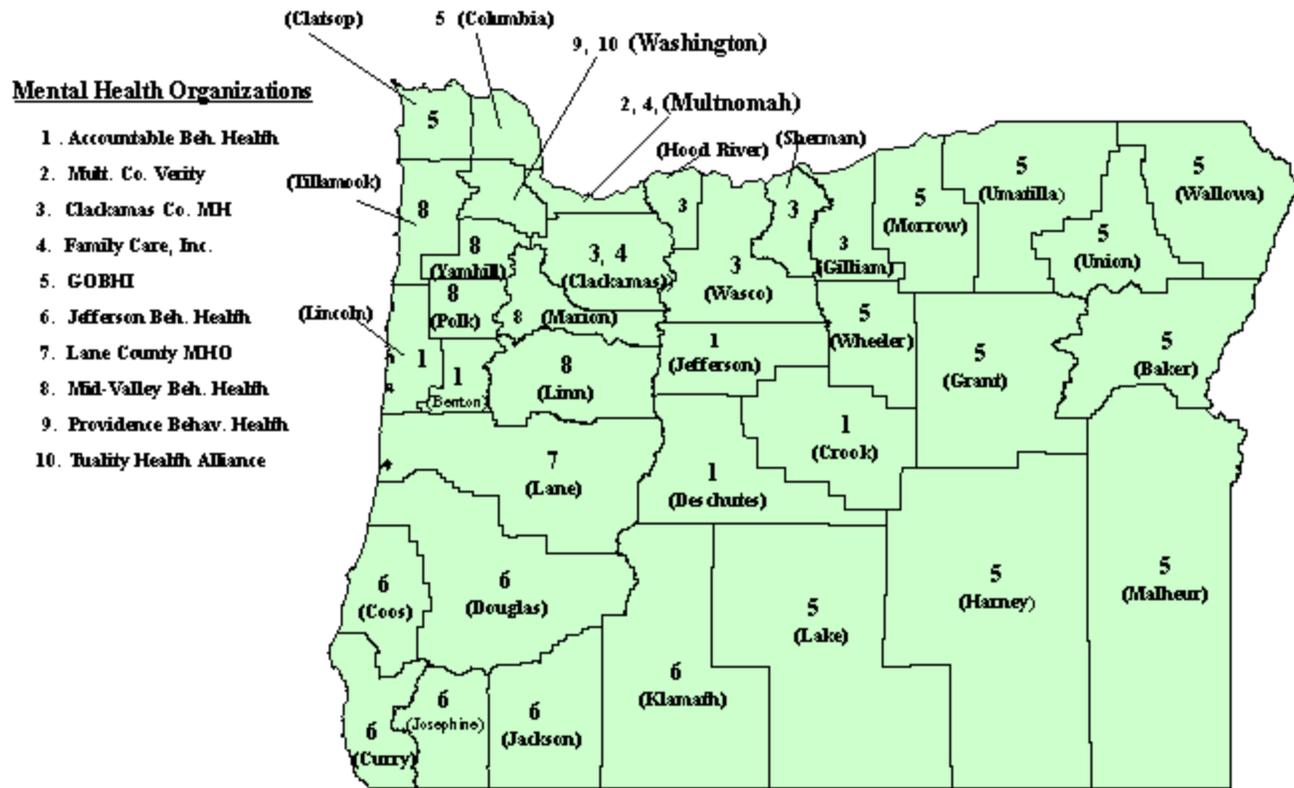
* Applies only to mental health benefits for groups of 51 or more employees

** Inoperative because of ORS 743.700 (sunset law)

**APPENDIX 6.1
MANAGED CARE COVERAGE MAPS**



OHP Mental Health Managed Care Coverage (October 1, 2001)



Oregonmapgreen
4:12 21.00

Oregon Health Plan Dental Care Organizations (DCO's)

October 2001 - September 2002

