Evaluation of the Oregon Medicaid Reform Demonstration

Second Interim Report

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Executive Summary

The Oregon Health Plan (OHP) is Oregon's innovative Section 1115 Medicaid waiver program. OHP has garnered national attention for its use of a prioritized list of health care services to define the program's benefit package. In addition, OHP expanded eligibility to cover uninsured residents below the Federal Poverty Level (FPL), regardless of whether they meet traditional categorical Medicaid eligibility requirements. Funding for this expansion has come, in part, by moving nearly all OHP eligibles into capitated managed care plans.

This report presents selected analyses conducted as part of our HCFA-funded evaluation of OHP. While the report focuses largely on OHP's Phase 1 population (traditional ADC plus expansion eligibles), future reports also will examine the Phase 2 population: SSI disabled and dual Medicare eligibles.

Update on the Oregon Health Plan

Higher than expected costs have meant that OHP has had to seek new ways to finance care. While one rationale for the priority list was as a tool for budgetary control, it has not yet served this end as well as some in the State had hoped. Restricting the list has been cumbersome because of approval requirements at the State and Federal levels. The most recent (1997) revision to the priority list both added two new treatment-condition pairs to the existing list of 741 and changed their ranking. This resulted in a funding line of 574

(as opposed to 578 on the 1995 list), and HCFA refused to approve the new list until May 1998.

Like other states, Oregon has turned to tobacco tax revenues to support its expanded Medicaid program. A new 30-cent tax was passed overwhelmingly to support OHP, and will be used for the following:

- Expand the PLM program to cover pregnant women up to 170 percent of FPL;
- Re-extend coverage to uninsured Pell Grant college students who had lost coverage as the result of an earlier OHP budget shortfall; and
- Create the Family Health Insurance Assistance Program (FHIAP) to subsidize private insurance premiums for low-income adults and children.

The newest source of revenue for OHP will come from the State Children's Insurance Program (CHIP). Oregon's share is $39.1 million annually. The State's plan (which was approved by HCFA in June 1998) will provide coverage for children up to age 18 who live in households with incomes from 100 to 170 percent of FPL.

Using Premiums to Finance OHP for the Expansion Population

OHP's expansion population is required to pay monthly premiums based on a sliding scale, determined by income and family size. Waivers are available for those unable to pay, and have been granted to about 3 percent of households (usually because the family reported zero income). The majority of expansion households appear willing and able to make the

premium payments, with 66 percent of billed premiums collected from two-thirds of all households.

Expansion eligibles who fail to pay their monthly premium bills are carried in arrears for the entire six-month eligibility period, rather than being terminated immediately. Upon re-application, however, eligibles will be denied coverage if premium payments are not up to date. A relatively small number of such individuals are terminated for non-payment: about 1,000 individuals living in 700 households out of the 79,000 households billed each month.

It is not clear how many expansion eligibles fail to re-apply, either because they can not continue to make the premium payments or because they are in arrears (and know they will be denied anyway). Anecdotal evidence suggests that some, particularly single adults and childless couples, do not re-apply because the illness that precipitated their initial application to OHP has been resolved.

Paying Providers in a Capitated Medicaid Managed Care Program: Lessons from OHP

State administrators originally designed OHP's rate setting system to ensure that capitation rates would adequately cover the expected costs of treating various eligibility groups. In particular, the system was designed to discourage adverse selection by paying out higher reimbursement rates for OHP beneficiaries who belong to more expensive eligibility groups. OHP has faced several challenges in setting capitation rates, however. First, the

State has had to refine its rate categories to more accurately reflect costs incurred by different groups. Initially, expansion eligibles were combined for rate purposes with traditional Medicaid eligibles. These eligibility groups proved to be very heterogenous with respect to utilization, however, and eventually OHP divided this single rate group into five separate groups.

The availability of accurate data for setting rates has also been an obstacle. The New Adults/Couples expansion population was assumed to resemble a commercially insured population and the actuaries used Blue Cross/Blue Shield of Oregon claims to help set their capitation rates. However, this group proved to be far more expensive, as they often first became eligible during a hospitalization. The data used to calculate rates for traditional Medicaid and New Families eligibles have also become increasingly inaccurate. Actuaries at OMAP initially used pre-OHP Medicaid fee-for-service claims to set rates for these eligibility groups. Yet, as an increasing number of eligibles become enrolled in managed care, what fee-for-service claims remain become increasingly non-representative.

To develop a more accurate base for determining capitation rates, OMAP has made a concerted effort to employ encounter data submitted by the participating health plans as the basis for future capitation rate determinations. Undermining these efforts have been concerns about the quality of the encounter data being submitted to OMAP. Specifically, earlier analyses of the data indicated that reporting on encounters varied significantly in terms of accuracy and completeness. More recent data submissions, however, show a dramatic increase in reporting. As a result, OHP actuaries began using encounter data to risk adjust capitation rates for certain eligibility groups as of June 1, 1998.

Managed Care Contracting in OHP: Market Consolidation and Delivery System Impacts

OHP has succeeded in creating a statewide managed care delivery system, with contracting plans in all but two of Oregon's 36 counties. Local, physician-sponsored plans have emerged as increasingly important, particularly in rural areas. These plans reflect an effort by providers to retain local control over service delivery decisions and to resist the intrusion of centrally-organized, statewide managed care plans. The growing importance of these locally sponsored plans, along with the departure of several commercial plans has increased OHP's reliance on "non-mainstream" plans that either were initially formed to contract with OHP or enroll only Medicaid eligibles.

However, several of these OHP-only plans are either considering or have already branched into the Medicare and commercial markets. Balanced Budget Act provisions that permit contracting with provider-sponsored networks should further encourage expansion of OHP into these new markets.

Over time, the number of plans contracting with OHP has fallen, as has the number of plans per county. The number of counties with only one plan (and thus offer no choice of plan to OHP eligibles) increased from 6 in 1994 to 15 in 1997. Most of these are rural, sparsely-populated counties, where it is unlikely that more than one plan is viable. Although nearly all of the physicians in the community contract with the sole OHP plan, the lack of choice among different health plans could adversely impact rural and small town beneficiaries' access to care.

Impact of the Priority List on OHP Eligibles

Outside Oregon, the use of a priority list to define the OHP benefit package has been highly controversial. Within the State, however, there has been relatively little criticism, as the list is believed to have helped OHP finance its insurance expansion. Nevertheless, to date, there has been no objective information available on how often OHP eligibles may be denied treatment because the service is "below the line" and what impact this has, if any. We conducted a survey of OHP Phase 1 eligibles in 1996, asking them whether they had ever "been told that OHP would not pay for a test, service, or treatment that [they] thought [they] needed." A surprisingly high number (32%) reported "yes." In many instances, these services were not covered, because the respondent had failed to follow managed care rules and procedures (e.g., prior approval for emergency room visits). The most common reason for denial, however, was that the service fell "below the line." About 12 percent of all OHP eligibles reported that they had needed a below–the-line service that OHP would not cover.

One-half of all eligibles with uncovered services succeeded in getting the service anyway. In the case of below-the-line services, like circumcision of newborns and chiropractic services, individuals paid out-of-pocket. Other types of uncovered services, like ER visits, were more likely to remain unpaid and undoubtedly became bad debts for their providers. In a small number of cases (8%), OHP ended up paying for the service, presumably through a successful appeals process.

Among those eligibles who failed to get the service anyway, the majority (60%) reported that their health had worsened as a result. Such reports were significantly higher

in cases where the service had not been covered because it was below-the-line, such as nicotine patches, hernia repair, and treatment of back pain. While the below-the-line services in question tended to be relatively minor, policymakers should note that the majority of survey respondents who were denied a service indicated that their health had deteriorated. Continued monitoring of access to care seems warranted, especially as the priority list continues to be revised.

The Role of Federally Qualified Health Centers in OHP

Many of Oregon's traditional safety net providers, particularly the Federally Qualified Health Centers (FQHCs), have suffered financially under OHP. Changes in reimbursement and competition with other OHP providers have particularly impacted the FQHCs and the populations they serve. Prior to OHP, FQHCs were eligible for cost-based reimbursement of Medicaid services. Under OHP, their payments are now negotiated directly with the managed care plans, who are not willing to pay these high, cost-based rates. Unlike other state 1115 waiver programs, Oregon chose not to supplement managed care payments with additional funds to make up the shortfall to FQHCs. Through its contracts with managed care plans, OHP has substantially broadened the network of providers available to Medicaid eligibles, and particularly to the expansion population that previously was uninsured. Once they were covered by OHP, some FQHC clients have switched to more mainstream providers.

In order to assist FQHCs and other safety-net providers, the State legislature has authorized a special, one-time financial assistance package of $3.1 million. Applicants must have local matching funds and use the assistance to continue providing services, while working to develop a stable financial base.

1 Update on the Oregon Health Plan

This chapter provides an update on key aspects of the Oregon Health Plan (OHP) that have changed since our previous interim report. In particular, it reflects information learned during our October 1997 site visit as well as from updated OHP eligibility and enrollment files. For the most part, this site visit focused on the Phase 1 population, i.e., traditional ADC eligibles plus the expansion population. As a result, many of the issues discussed in this chapter (as well as subsequent chapters in this report) deal primarily with Phase 1 eligibles. A second site visit (conducted in February 1998) focused on the Phase 2 population (SSI disabled and dual Medicare eligibles).

This program update concentrates on the following issues:

- **Financing OHP.** Budget shortfalls, as well as a desire to further expand coverage, has meant that OHP has had to seek new ways to finance care. These include increased tobacco taxes, adoption of a premium requirement for the expansion population, and the recent State Children's Health Insurance Program (CHIP).
- **Changes in eligibility and enrollment.** Over the past two years, OHP has made a number of changes to its eligibility requirements. In particular, the expansion population must pay monthly premiums (unless exempted) and must choose a managed care plan before services will be covered.
- **Revisions to the priority list.** Every two years, the priority list is revised to reflect changes in technology, in coding practice, and the like. In addition, the line demarcating covered and uncovered services may be re-drawn at this time. The most recent revision to the list, however, was not approved by HCFA until May 1998, delaying its implementation.

- **Changes in market structure.** There has been a recent growth in local, physician-sponsored managed care plans, especially outside the Portland area. While these plans were developed just to serve OHP clients, some of them are considering entering the Medicare and commercial markets, a move now made easier as a result of the Balanced Budget Act.
- **Private insurance subsidy.** The State wants to help the uninsured buy into employer-sponsored or individual health insurance. This will enable the State to extend coverage without expanding its Medicaid population.
- **Special help for safety-net providers.** Safety-net providers in Oregon, especially the FQHCs and RHCs, have been hard hit under OHP. The State legislature has authorized a special one-time assistance package for these providers.

In the sections that follow, we expand the discussion for each of these issues. Some of the issues are analyzed in greater detail in subsequent chapters.

1.1 Financing the Oregon Health Plan

Since its implementation, the Oregon Health Plan has enjoyed tremendous political and provider support. Oregonians appear to take considerable pride in the large number of formerly uninsured (about 100,000 adults and children) who now enjoy health care coverage under OHP. At the same time, the State must find ways of financing this coverage, especially when there are competing demands for State funds (in particular, by public education).

OHP has found that its health care outlays are higher than anticipated for several reasons. First, new eligibles under the New Adults/Couples program (part of the expansion population) have proven to be far more expensive than expected. Their health care utilization is reported to more closely resemble that of the General Assistance population (as

compared with the New Families component of the expansion population). Data collected as part of a 1996 household survey of the Phase 1 population confirm this (see Table 1-1). Eligibles in the New Adults/Couples program were significantly less likely to have had insurance immediately prior to joining OHP, and if uninsured, had gone without insurance for a longer period of time, compared with those adults eligible through the New Families program. New Adults/Couples also were significantly less likely to have had a usual source of care prior to joining OHP, and were in significantly worse health status (as indicated by their lower SF-12 scores).

Second, OHP's budget calculations originally had failed to capture the costs associated with retroactive eligibility. Individuals meeting the OHP eligibility criteria are covered retroactively to the time of application. Many expansion individuals (especially those in the New Adults/Couples program) become eligible during a hospital admission when the hospital submits an application to OHP on their behalf. These cases obviously end up being far more expensive, as the individual is sicker to start with and the hospitalization is reimbursed on a fee-for-service basis.

Third, OHP has found that a larger proportion of Phase 2 eligibles are being exempted from managed care than anticipated (about 20%), presumably because of their special health care needs. These eligibles (who then remain in fee-for-service) are reported to be higher cost. Whether this is, in fact, the case is an empirical question. Analysis of our Phase 1 survey population found no difference in health status between those enrolled in

Table 1-1

Prior Insurance Coverage, Usual Source of Care, and Current Health Status in the OHP Expansion Population

	New Families	New Adults/Couples
Prior health insurance in 30 days prior to joining OHP:		
Percent yes	24.3%	12.0%*
For those who weren't insured, amount of time without insurance:[a]	--	--*
Less than one year	25.6%	17.3%
1-5 years	40.3	30.5
More than 5 years	16.9	28.6
Never had insurance	17.3	23.7
Usual source of care prior to joining OHP?		
Percent yes	67.3%	55.5%*
Health Status (SF-12) Scores		
Physical health	48.8	43.1*
Mental health	49.3	45.6*

[a] Columns sum to 100 percent.

* Significantly different from New Families at the .05 level.

SOURCE: HER-RTI of OHP eligibles, 1996.

managed care and those remaining in fee-for service. SF-12 physical health scores averaged 45.7 for OHP managed care enrollees and 45.9 for those in fee-for-service. Similarly, mental health scores were 46.8 and 45.5 for managed care and fee-for-service eligibles, respectively.

Despite higher than expected outlays, the State wanted to continue expanding coverage to some of its uninsured residents. To do so, the Governor proposed a new 30 cent tobacco tax (in addition to an already existing 10 cent tax) explicitly intended "to support and expand OHP." The new tax was passed overwhelmingly, with 90 percent of the revenues earmarked for OHP and 10 percent for smoking prevention and education. The Governor had proposed that 50 percent of the tobacco funds be used to maintain the current OHP program and 50 percent for program expansion. The State legislature changed this split to 75-25, so that less funds were available for expansion.

The tobacco revenues will be used to expand the PLM program to cover pregnant women up to 170 percent of the Federal Poverty Level (FPL). In addition, eligibility will be re-extended to uninsured Pell Grant college students who are uninsured (who had lost coverage due to an earlier OHP budget shortfall).[1]

The current OHP budget for the 1997-99 biennium is $700 million, of which over one-quarter comes from the tobacco tax. This is a much larger share of the budget than originally intended. Some general fund revenues that would have supported OHP were withdrawn to support public education, and tobacco funds were used to fill the deficit. In

[1] Tobacco revenues also will be used to finance private insurance subsidies for uninsured individuals below 170 percent of FPL. This subsidy is described in Section 1.5 below.

addition, about $13 million in premium payments (collected from the expansion population) will be used to support OHP.

What would have happened, in the absence of this tobacco tax? While one rationale for the priority list was as a tool for budgetary control, it has not yet served this end as well as some in the State had hoped. Restricting the list has been cumbersome because of approval requirements at the State and Federal levels. (This is described in more detail in Section 1.3 below.)

An important new source of revenue for Oregon is the Children's Health Insurance Program (CHIP), enacted as part of the Balanced Budget Act of 1997 and which authorizes funding for uninsured children under Title XXI of the Social Security Act. Title XXI entitles states to annual federal allotments that must be used to purchase health insurance for targeted low-income children who are ineligible for other forms of public assistance (including Medicaid). Oregon's annual share is $39.1 million.

CHIP will be administered by OMAP and is expected to enroll approximately 20,000 children up to 18 years of age, beginning in July 1998. To apply, children must be ineligible for Medicaid and live in families with incomes from 100 to 170 percent of FPL.[2]

[2] Children from birth to age 6 whose family incomes are less than 133 percent of FPL are already eligible for OHP under Title XIX Medicaid rules. Thus, for these children, the income eligibility requirement for SCHIP is between 134 and 170 percent of FPL.

Title XXI requires that the health benefits package developed by states for CHIP must be modeled after one of the three federally-approved benchmark plans.[3] In Oregon, the benchmark plan for health benefits is the state employee health plan. However, the State has decided to provide a richer benefit package than that required by Title XXI and will offer the same benefits as those provided to OHP eligibles, including the use of the priority list and emphasis on managed care.

1.2 Changes in Eligibility and Enrollment

In the years following the implementation of OHP, the Office of Medical Assistance Programs (OMAP) made a series of program modifications related to eligibility and enrollment requirements, including the initiation of monthly premiums for expansion group eligibles in the second year of the program. This change was intended to ease financial pressure on the program.

In a similar vein, a second series of changes to the eligibility and enrollment requirements were initiated in the third quarter of 1996 to close the estimated $18 - 25 million gap in general funds for OMAP's 1995 - 1997 budget. In an attempt to increase beneficiary enrollment in managed care from 82 to 87 percent, OMAP received HCFA's approval to implement the following changes related to membership in prepaid health plans on October 1, 1996:

[3] The three benchmark plans specified by the CHIP legislation are: the Blue Cross/Blue Shield standard option package for federal employees, the health plan offered to State employees, or the HMO plan with the greatest commercial enrollment in the State.

1. All individuals in the expansion population applying for OHP, except for Native Americans and individuals with other types of insurance, are required to choose a prepaid health plan at the time of application. If they do not, their application will not be approved.[4] Prior to this change, applications could be approved regardless of whether or not applicants selected a health plan.
2. All current OHP members, except for Native Americans and individuals with other types of insurance, are auto-enrolled in prepaid health plans if they did not provide OMAP with their health plan choice.

Three months later, OMAP instituted program modifications designed to decrease the time period between initial eligibility approval and enrollment in a prepaid health plan, in order to minimize OHP's fee-for-service exposure. Beginning on January 1, 1997, enrollment of OHP eligibles into prepaid health plans, which was formerly done on a monthly basis, was now done each week. In the past, enrollment in a prepaid health plan had not begun until the first of the month following the start of eligibility. Consequently, many newly-eligible beneficiaries would be seen by a physician under fee-for-service in the weeks prior to being enrolled in their plan, at which time they would be restricted to the plan's panel of physicians. Along with the implications for continuity of care, this delay in plan enrollment was also costly because the State was financially responsible for covering services provided while OHP beneficiaries were under fee-for-service.

[4] This rule applies to first-time applicants only. If they do not choose a health plan, their application is held until that information is received, or the application time period expires. However, for a re-application, the health plan choice does not need to be included as long as this choice has been indicated on the prior application.

1.3 Revisions to the Priority List

Every two years, the Health Services Commission revises the priority list. New condition-treatment pairs may be added, and the relative ranking of existing pairs on the list may be altered. These changes may come about as the result of new technology, publication of new evidence regarding cost-effectiveness, or simply inadvertent omissions from the earlier list. In between these biannual revisions, the Commission also makes what they term "technical corrections" to the list. These corrections may be necessary because of changes in ICD-9 or CPT-4 codes, or simply because of typos in the original list.

The revised list is sent to the actuaries for pricing, and their report is then forwarded to the State legislature for a funding decision. Based on the available budget, the legislature decides where to draw the line, i.e., how many services on the list can be covered. Thus, the 1995 priority list included 745 condition-treatment pairs, of which 606 were covered. Condition-treatment pairs numbered 607 through 745 were "below-the-line" and hence not covered. In January 1996, the line was raised to 581 and then to 578 a year later when the State was faced with a budget shortfall.

The Health Services Commission also can control expenditures under the priority list by issuing guidelines on how the priority list is to be implemented. Faced with overwhelming demand for dental services, for example, the Commission developed guidelines for dental services. These guidelines, which went into effect in January 1997, effectively limit OHP's dental benefit but without actually changing the priority list. Partial

dental plates remain covered, for example, but only for those with at least four teeth missing and who can not chew.

Most recently, the Commission developed its new priority list for 1997. This new list, which represents a significant re-prioritization of the 1995 list, contains 743 condition-treatment pairs. Included on the new list are two new condition-treatment pairs: autologous bone marrow transplant (ABMT) for breast cancer, and smoking cessation counseling. Along with approval of this new list, the State sought permission from HCFA to move the cut-off line down from line 578 to line 574. Although technically a line change, in reality the State was not proposing to move the cut-off line since line 574 on the new list is the actuarial equivalent of line 578 on the 1995 list.

If approved, the new list would cover previous below-the-line services such as cochlear implants, treatment of club foot, non-migraine headaches, treatment for lethal granulotomosis, and fecal incontinence. For those services that were moved below the line, the Commission argued that they were self-limiting conditions that do not require medical treatment (e.g., infectious mononucleosis), were cosmetic in nature (e.g., repair of deviated septum), or could have been provided in a less costly manner (e.g., partials in lieu of bridges).

HCFA had several reservations about the updated priority list, and authorization for the new list was thus delayed for several months while HCFA and the State worked towards an agreement. In particular, HCFA had concerns relating to the noncoverage of fixed bridges for anterior tooth replacements, asserting that the alternative treatment covered on the new list had the potential to impair speech significantly and create pain and discomfort.

HCFA also expressed concern about other conditions not covered on the new list, including peritoneal adhesions, unspecified anomolies of the ear, and facial defects.

Ultimately, HCFA approved the new priority list after the State satisfactorily addressed their concerns about the noncovered services mentioned above. In addition, HCFA stipulated that the Health Services Commission consider the ramifications of not covering fixed bridges on OHP beneficiaries' "comfort, aesthetics, and function." After gaining clearance from HCFA, OMAP implemented the new priority list on May 1, 1998.

1.4 Changes in Market Structure

OHP has established a statewide network of managed care plans even in isolated areas of the State with small population bases. Since 1995, all but two of Oregon's 36 counties have been served by at least one fully capitated health plan. Although managed care had been well-established for many years in the western population centers of the State, OHP provided the first introduction to managed care in much of the rest of Oregon, particularly the sparsely populated counties east of the Cascade Mountains.

Local, physician-sponsored plans have emerged as increasingly important in OHP, particularly in rural areas. These plans reflect an effort by providers to retain local control over service delivery decisions and to resist the intrusion of centrally-organized, statewide managed care plans. The growing importance of these locally sponsored plans, along with the departure of several commercial plans, has increased the reliance of OHP on "non-mainstream" plans that either were initially formed to contract with OHP or enroll only

Medicaid beneficiaries. However, several plans that were developed just to serve OHP clients are either considering or have already branched into the Medicare and commercial markets. Balanced Budget Act provisions that permit contracting with provider sponsored networks should encourage expansion of OHP plans into these new markets.

Over time, the number of plans that contract with OHP has fallen, as has the number of plans per county. The number of counties with only one contractor, where beneficiaries do not have a choice of plan, increased from 6 in 1994 to 15 in 1997. Most of these are rural areas with small populations, where it is unlikely that more than one plan is feasible. Although nearly all of the physicians in the community contract with the sole OHP plan, the lack of choice among different health plans can adversely impact rural and small town beneficiaries' access to care. If beneficiaries are dissatisfied with their plan's decision to deny care, for instance, they cannot "vote with their feet" and enroll in another plan that might offer the service.

There has also been a reduction in the number of choices available to beneficiaries in areas where there are multiple plans offered. It appears that OHP's open-door policy of contracting with any plan that meets its requirements had resulted in an unsustainable number of plans in some areas.

1.5 Private Insurance Subsidy

With the demise of its employer mandate, the State has sought alternative means of assisting employed individuals in buying health insurance. The State has allocated $23.4 million of the tobacco tax funds for the creation of a new State program entitled the Family Health Insurance Assistance Program (FHIAP). This program will subsidize private insurance premiums for low-income adults and children. Because there are sufficient funds to subsidize only 20,000 individuals, a waiting list will be maintained and subsidies will be available on a "first come, first served" basis. For individuals with employer-sponsored health insurance, the subsidy will be used to pay the employee's share. For those whose employers do not offer insurance, the subsidy will be used to buy individual policies.

Eligibility for the program is based largely on financial considerations and legal residency requirements. Families must have no more than $10,000 in liquid assets and their income must not exceed 170 percent of FPL. Participants must be legal residents, but are not required to be U.S. citizens. Two additional eligibility requirements deserve special attention. First, FHIAP will contain a "look-back" provision that requires family members to have been continuously uninsured for six months before becoming eligible for the voucher program[5]. This requirement is designed to discourage Oregon families from dropping private insurance in favor of the subsidy.

[5] Oregon is considering an exemption to the "look-back" requirement for children under six years of age in recognition of the importance of health coverage for immunizations and screening during these years.

Second, to ensure that Oregon children will benefit from this program, FHIAP eligibility rules will require that adult family members cannot take part in the subsidy program unless their children have health coverage. Thus, parents can use the subsidy to purchase private insurance for their children (either through their employer or by purchasing an individual policy) without purchasing coverage for themselves, but they may not use vouchers to purchase insurance for themselves unless they either purchase private coverage for their children or enroll them in the State Children's Health Insurance Program (CHIP).

FHIAP will be managed by Oregon's Insurer Pool Governing Board, which will provide vouchers to qualified families beginning in July 1998. The subsidy will pay from 70 to 90 percent of the cost of the employee's premium contribution, depending on a family's income relative to the FPL. Oregon's Insurer Pool Governing Board plans to hire a third-party administrator (TPA) to process applications, determine eligibility, track enrollment, distribute subsidies, and administer contracts with participating health plans.

FHIAP will not require commercial plans receiving vouchers to offer a standardized set of benefits. Thus, health benefits and out-of-pocket costs for FHIAP beneficiaries will vary depending on the health plans offered by their employers.[6] However, to help control out-of-pocket costs for FHIAP beneficiaries, the program will limit such contributions to 5 percent of family income. Families who incur costs that exceed this percentage can submit documentation of receipts to the TPA and will be reimbursed accordingly.

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[6] Oregon has plans to eventually develop a CHIP-funded component for children and their parents within FHIAP, in which participating health plans would be required to adhere to the benefits benchmark (i.e., the state-employee health plan) and cost-sharing limits mandated by Title XXI.

1.6 Special Assistance for Safety-Net Providers

Many of Oregon's traditional safety net providers, particularly the FQHCs and RHCs, have suffered financially under OHP. While there may be many reasons to explain their losses, two appear to be particularly important. First, Medicare and Medicaid historically have reimbursed these community centers based on their costs, but managed care plans have balked at paying such high rates for their services. Many other states have supplemented managed care payments with additional funds to alleviate the resulting shortfall for FQHCs and RHCs. Oregon, however, chose not to do this. Second, some FQHC and RHC clients switched to more mainstream providers, once they were covered by OHP.

To assist these safety-net providers, the State legislature authorized a special, one-time financial assistance package of $3.1 million. The money is available to public health departments, migrant community health centers, FQHCs, RHCs, and hospital clinics. Applicants must have local matching funds and use the assistance to continue providing services while developing a stable financial base.

2 Using Premiums to Finance OHP for the Expansion Population

Oregon launched its ambitious Oregon Health Plan (OHP) in February 1994. This plan expanded Medicaid coverage to the previously uninsured with incomes below the Federal Poverty Level, began a transition of all Medicaid eligibles into managed care, and used a prioritized list of health services to define the benefit package. The expansion population included both families (New Families) and single adults and childless couples (New Adults/Couples) who would not otherwise meet the categorical criteria under the traditional Medicaid program. This new coverage proved immediately popular, and by mid-1995, 123,268 individuals not previously eligible had been enrolled in OHP. Higher than expected costs associated with serving this population, along with other factors, resulted in a State budget shortfall by the second year of the program.

To offset the budget deficit, the 1995 Oregon legislature directed the Office of Medical Assistance Programs (OMAP) to require premiums from the OHP expansion population.[1] OMAP anticipated that these premiums would contribute approximately $14 million in revenue to the State's biennial Medicaid budget of $681 million for 1995-1997. Although HCFA approved this new requirement (subject to certain exemptions, as described below), it has remained somewhat controversial in public policy circles. Even a nominal payment may prove difficult for individuals and families living below the Federal Poverty

[1] Negotiations between OMAP and representatives from Oregon's Native American population resulted in the decision to exempt Native Americans from the premium requirement.

Level (FPL), and could discourage some uninsured from applying for OHP coverage. In this chapter, we describe the premium requirement and its implementation and seek to evaluate its impacts on Oregon's expansion population.

2.1 Implementation of Premium Requirement

Premium charges are based on both family size and family income measured as a percentage of FPL. For a single person, premiums range from $6.00 per month for those with incomes below 50 percent of FPL to $20.00 per month for those within 86 to 100 percent of FPL. For a family of four or more, the monthly payment ranges from $7.50 (below 50 percent of FPL) to $28.00 (86 to 100 percent of FPL). Table 2-1 presents the range of premium charges based on family size and income level.

Table 2-1

Premium Charges for OHP's Expansion Population

Income as Percent of FPL	Family Size 1	2	3	4+
Less than 49%	$6.00	$6.50	$7.00	$7.50
50-65%	15.00	18.00	20.00	22.00
66-85%	18.00	21.00	24.00	26.00
86-100%	20.00	23.00	26.00	28.00

The premium requirement went into effect on December 1, 1995. During the first month, all households were billed at the lowest premium rate ($6.00-$7.50 per month) depending on their family size, but regardless of their level of family income. Then in January 1996, as expansion enrollees re-applied with proof of their most recent income (a process known as re-certification), households began to be charged premium rates appropriate to family size, as well as family income[2]. Data provided by OMAP indicates that the average premium per household is approximately $11.00 per month.

Because the expansion eligibles are re-certified only once every six months and premium charges are calculated only at initial enrollment or re-enrollment, the implementation of the premium requirement was actually phased in over a period of several months. OMAP chose to phase-in the sliding fee scale over a six-month period to ensure that it was using accurate data on household incomes. Premium bills are mailed out each month to the household, along with an explanation of which family members are subject to the premium requirement.

Beneficiaries and their advocates have criticized the lag time between notification of eligibility for OHP and the schedule for mailing premiums. For example, individuals completing an application at the beginning of the month (September 1st), might not be notified until 45 days later (October 15th). Eligibility is retroactive to the date of application; thus, new members will be charged a premium for the month of September, even though they did not know they were eligible to receive services until the middle of October. Because

[2] Income is based on a three-month average, which has been the method used for eligibility determination since the income eligibility rule was modified in October 1995.

most people will not attempt to use OHP until they receive notice of eligibility, advocates feel that beneficiaries are unfairly charged for coverage they did not know they had.

An important characteristic of the premium requirement, and one that departs from most commercial billing and collection policies, is that the State maintains continuous eligibility for enrollees during their six-month enrollment period even if they are not current in their premium payments. This means that an individual who has failed to make premium payments during the entire six-month enrollment period will not experience any lapse in OHP coverage. However, to be re-certified for another six-month period of enrollment, beneficiaries must either be current in their premium payments or receive a premium waiver from OMAP.

2.2 Premium Requirement and Re-enrollment in OHP

In March 1996, HCFA approved Oregon's plan for disqualifying individuals at the time of re-certification if they were in arrears for premium payments and for allowing waivers of the premium requirement in certain situations. To better understand the effects of the premium requirement on OHP re-certification, it is helpful to review the time line for enrollment and application for re-enrollment for expansion eligibles. After meeting all eligibility criteria, expansion eligibles are enrolled for a six-month period. During this period, they receive premium bills each month that they are enrolled. To renew OHP coverage for another six-months, beneficiaries' applications (a process called re-

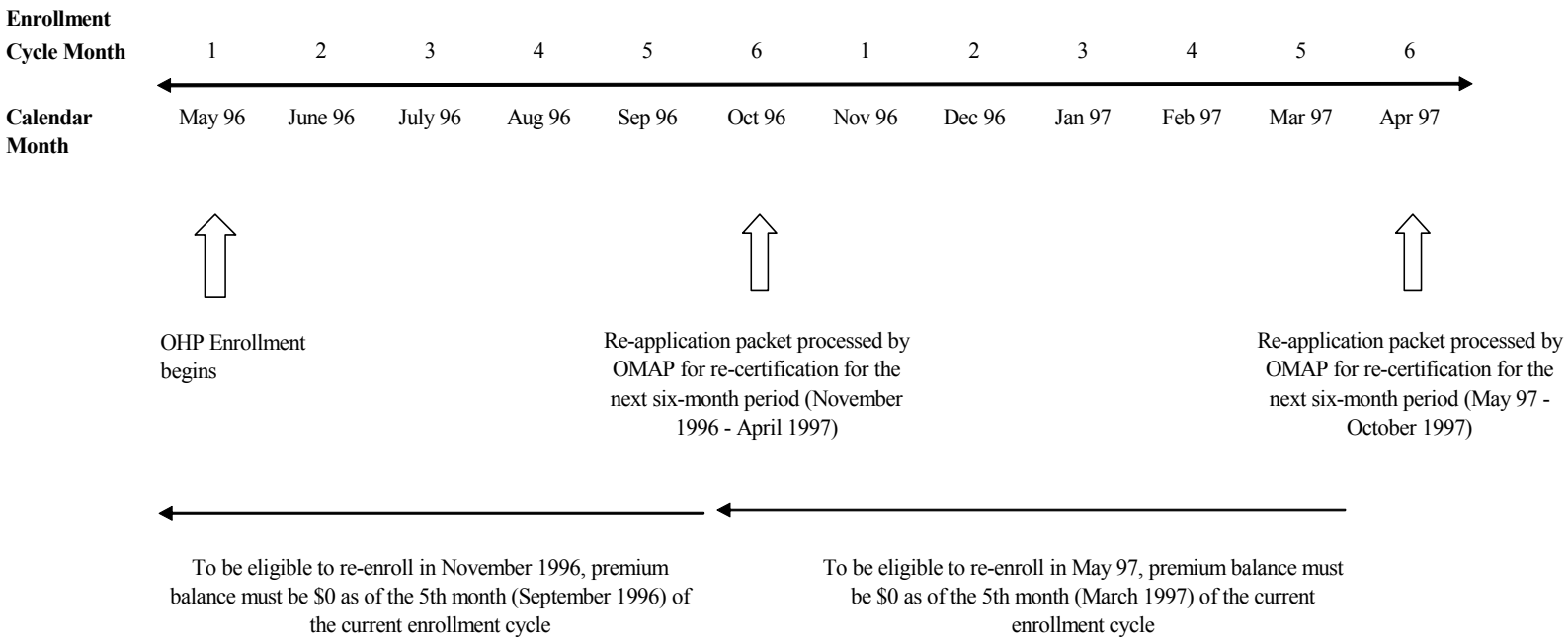
certification) are processed during the last month (month six) of their current enrollment period.

Beginning May 1, 1996, OMAP instituted the rule that an individual's application for re-enrollment could be denied if the person had outstanding premium payments at the fifth month of the current six-month certification and had not received a premium waiver from OMAP. Because of the time necessary to process premium payments during the last month (6th) of certification, a person is considered "current" in their premium payments if they are not carrying an unpaid balance at the end of the fifth month in the enrollment cycle.

Figure 2-1 illustrates an example of the time line for OHP enrollment by expansion eligibles, application for re-enrollment, and period of time for which the "zero premium balance" requirement is in effect for eligibles whose enrollment began on May 1, 1996. In this example, beneficiaries' applications for re-enrollment are processed during the last month of their current enrollment cycle (October 1996). As part of the eligibility requirements, their files are reviewed to verify that they have a zero premium balance as of the fifth month of the current enrollment cycle (September 1996). If beneficiaries meet the eligibility criteria, they are enrolled for another six month period beginning on November 1996. If beneficiaries do not voluntarily withdraw from OHP, the re-certification process, including the zero premium balance requirement, is repeated in April 1997. OMAP also stipulates that individuals who have been denied re-certification because premiums were not paid (or waived) must wait three years before they are eligible to re-enroll in OHP. (Of course, they can re-enroll before then by simply paying the arrears.)

Figure 2-1

Time Line for OHP Enrollment by Expansion Eligibles, Application for Re-enrollment, and Period of Time for Which the "Zero Premium Balance" Requirement is in Effect for Eligibles Whose Enrollment Begins on May 1, 1996



2.3 Premium Waivers

An important factor in HCFA's decision to approve Oregon's premium requirement was the state's provision to grant premium waivers for certain types of hardship cases. The waiver permits coverage to continue for persons who are unable to pay their premium. OMAP agreed to grant waivers of missed premium payments for the following conditions: persons with zero income, victims of domestic violence, victims of a crime causing loss of money or income, victims of a natural disaster, death of a household member, and loss of housing/homelessness.

Requests to waive the premium requirement are handled during the re-certification process and are retrospective. That is, waivers apply to past due premiums only, and have no bearing on future premium bills that beneficiaries will receive in subsequent enrollment cycles. Beneficiaries must re-apply for a waiver after each six-month period of eligibility, even if the condition for which they received the waiver has not changed. Although premiums are billed at the end of each month of eligibility, waivers are granted retroactively for the entire previous six-month certification period.

The retroactive nature of this process has caused confusion for some beneficiaries. Beneficiaries with no income at the time of enrollment, for example, may not understand why they continue to receive premium bills each month. They may not realize that if they are still considered to have no income at the time of re-certification (six months later), they will not be penalized for any outstanding premium balance. Conversely, beneficiaries who were considered to have no income at the time of initial eligibility determination will <u>not</u>

qualify for a premium waiver during their next re-certification if, during that re-certification process, they are deemed to have income. In some cases, the retroactive nature of the premium waiver works to the financial advantage of beneficiaries. For example, beneficiaries who have income at the initial eligibility determination, but report no income during the following re-certification process, will receive a waiver for any unpaid premiums billed during the previous six-month certification period, even if they had income during the first half of that period.

OMAP admits that both beneficiaries and case workers have experienced problems understanding the circumstances in which the zero-income waivers should be applied. Perhaps better outreach and training in this area, as well as additional instructions for the types of documents needed to support waiver requests, would help both OHP members and OMAP caseworkers understand the waiver criteria correctly.

A "Request to Waive Past Premium Payments" form is included in all re-application packets that are mailed to beneficiaries six to eight weeks before their current six-month certification period ends. Beneficiaries are asked to complete the form and mail it to OMAP along with other application materials. The instructions explain the conditions necessary to receive a waiver for **past due** premiums and also direct the beneficiaries to supply written documentation to support their request. A waiver is granted only if the beneficiary requests one, *unless income is determined to be zero during the re-enrollment process.* In these cases, waivers are automatically granted, regardless of whether or not a waiver request form was submitted.

The waiver request form lists each of the conditions that could result in a waiver of past premium bills, *except* for the "no income" provision, an omission that has been criticized by some health care advocates. OMAP, however, states that they have ready access to the necessary information, since income determination is made at the time of re-enrollment. OMAP prefers to rely on their automated system to grant waivers for persons with no income, regardless of whether or not they completed the form.

Table 2-2 presents the total number of waivers granted, and the reason for the waiver, from June 1996 (the first month after the waiver process was initiated) to June 1997 (the most recent month that data are available). During this time period, OMAP granted an average of 2,454 waivers per month. Waivers granted for "zero income" account for the vast majority (85 percent). Loss of housing/homelessness accounts for another 11 percent, with the remaining reasons (crime victim, victim of domestic violence, and death in the family) making up less than four percent of waivers during this time period. Data provided by the State indicate that OMAP denies relatively few requests for waivers, only about 10 denials each month. Applications for waivers are most commonly denied because either they do not contain adequate documentation to support the reason for the waiver, or the request does not fall within waiver criteria.

In some instances, beneficiaries make premium payments after the deadline has passed for automated update by the computer systems. When such payment is confirmed by the billing office, the case worker codes "case discrepancy" to prevent the case from being terminated for nonpayment. There have been 8,773 such instances during the period

Table 2-2

Number and Type of Premium Waivers, June 1996 - June 1997

Reason for Waiver	Number Waived	Percent
Zero Income	27,156	85.1%
Homeless	3,624	11.4
Domestic Violence	448	1.4
Crime Victim	261	0.8
Natural Disaster	258	0.8
Death in Family	150	0.5
TOTAL	**31,897**	**100.0%**
Monthly Average	2,454	

covered

by Table 2-2. OMAP staff believe that some case workers may use this code for clients without income to ensure that they are not terminated, rather than relying on OMAP's computer system to assign the zero-income waiver automatically. Thus, the actual number of zero-income waivers granted during this time period could be somewhat greater than the number presented in the table.

2.4 Billing and Collection

In December 1995, the State awarded a contract for billing and processing premium payments to a third-party administrator (TPA), the William C. Earhardt Company. Under

the contract, the TPA received a flat-fee of $14,000 (to cover start-up costs), plus $1.26 per household per month. Although the State originally had estimated that 84,000 households would be subject to the premium requirement, data provided by OMAP indicate that slightly fewer households fell under the premium requirement (about 79,000). We estimate that during the 19 months of premium billings covered by the State's 1995-1997 biennial budget period, the TPA received $1.9 million for its services.[3] The Federal Government contributed 50 percent of this amount through Federal matching funds.

The TPA is responsible for billing all households subject to the premium requirement and then processing incoming payments. At the end of each month, the State sends the TPA an electronic file of the households and calculated premium amounts that should be billed at the beginning of the next month. The TPA mails premium bills to each household and processes incoming payments. After each month's billing cycle, the TPA provides the State with an electronic file that contains information about which households are current in premium payments and which ones are in arrears. However, the TPA has no role in determining eligibility for premiums or premium waivers.

The premium bills contain instructions that all payments be made by check. Some community advocates have voiced dissatisfaction with this policy, noting that many low-income people do not maintain checking accounts. The advocates feel that this requirement imposes an unnecessary hardship for households who cannot simply write a personal check, but instead must go to a bank or other vendor to obtain a cashier's check or money order.

[3] The State's 95-97 biennial budget extended from July 1995 through June 1997. However, the new premium requirement was not implemented until December 1995; thus, there were only 19 months during this budget period during which premiums could be billed.

These households may experience increased financial costs associated with getting transportation to such institutions and then paying the service charges associated with purchasing money orders/cashier's checks or maintaining personal checking accounts.

The TPA reports that the majority of beneficiaries do, in fact, pay with a personal check or money order. Only about 20 to 30 of the 35,000 or so payments they receive each month are in cash. When this occurs, the TPA does not return the cash payment, but instead accepts it just like they would a check. So, although there is some inherent risk in sending cash payments through the mail, doing so does not appear to penalize the beneficiary in terms of OHP eligibility.

Oregon is collecting the majority of premium payments from beneficiaries. Table 2-3 presents the dollar amounts of premiums billed and the percentages that are collected, waived, adjusted, or outstanding for the period December 1995 through June 1997. OMAP and its TPA bill an average of $814,198 in premiums each month. As of June 1997, OMAP had received 66 percent of premiums billed during this period. Because OMAP does not require beneficiaries to keep their premium payments current from month-to-month within a six-month certification period, the percentage of paid premium receipts will rise during the six months as the re-certification deadline approaches. After accounting for waived or adjusted[4] premiums, the percent of premiums that remain outstanding averaged 28 percent.

[4] Adjustments occur when OMAP determines that the case worker may have entered incorrect information that resulted in mis-calculations of premium amounts. OMAP only performs adjustments if it will benefit the enrollee. Refunds are given when enrollees should never have been billed. Otherwise, the balance is credited to current and future billings.

Table 2-3

Total Premium Amounts Billed and Collected, and Percentages Billed, Collected, Waived, Adjusted, and Outstanding, by Month

Month	Amount of Premiums Billed	Amount of Premiums Collected	Percentage Collected	Percentage Waived	Percentage Adjusted	Percentage Outstanding
Dec 95	$494,286	$214,652	43.4%	--	--	56.6%
Jan 96	$566,907	$281,517	49.7	--	--	50.3
Feb 96	$655,105	$353,147	53.9	--	--	46.1
Mar 96	$737,107	$434,785	59.0	--	--	41.0
Apr 96	$821,052	$520,755	63.4	3.7	0.1	32.8
May 96	$897,211	$582,089	64.9	3.6	0.4	31.1
Jun 96	$942,858	$589,400	62.5	4.7	1.0	31.8
Jul 96	$926,506	$652,901	70.5	5.4	1.1	23.1
Aug 96	$901,938	$600,574	66.6	5.5	0.8	27.1
Sep 96	$847,379	$593,788	70.1	7.2	0.8	21.9
Oct 96	$836,743	$656,386	78.5	12.4	3.8	5.3
Nov 96	$848,339	$527,270	62.2	6.8	1.1	30.0
Dec 96	$822,775	$493,552	60.0	8.4	0.9	30.7
Jan 97	$868,148	$654,416	75.4	7.4	0.9	16.3
Feb 97	$856,994	$613,311	71.6	9.4	0.0	19.0
Mar 97	$842,222	$667,340	79.2	10.4	0.0	10.4
Apr 97	$862,498	$626,607	72.7	1.9	0.7	24.7
May 97	$858,827	$616,652	71.8	2.2	0.8	25.2
Jun 97	$882,863	$595,473	67.5	6.5	0.6	25.4
Total	**$15,469,758**	**$10,274,615**	--	--	--	--
Average per month	**$814,198**	**$540,769**	**66.4%**	**5.3%**	**0.7%**	**27.5%**

NOTE: Data from December 1995 - November 1996 reflects payments received, waived, and adjusted as of January 31, 1997; data from December 1996 to June 1997 reflects payments received, waived, and adjusted as of October 26, 1997.

One of the primary reasons for initiating the premium requirement was to generate additional funding to support the Oregon Health Plan. As noted earlier, State officials expected premium payments to generate revenues of approximately $14 million to counter budget shortfalls in Oregon's 1995 -1997 Medicaid budget. As can be seen in Table 2-3, OMAP and its TPA were able to collect only $10.3 million over the 19-month budget period. There are several reasons for the shortfall in premium collections: (1) premiums were billed only for 19 months, rather than the full 24 month budget period; (2) bills were artificially low during the first few months, as all beneficiaries were billed the minimum premium amount; and (3) the State's estimate had been based on a 90 percent collection rate, considerably higher than the 66 percent rate actually realized. Had the premium requirement been imposed for the entire two-year budget period, on the other hand, we estimate that $13 million in premiums would have been collected.

The $10.3 million in collected premiums is a gross figure. After netting out the payments to the TPA, net income from the premium amounted to $8.4 million.[5] However, 50 percent of the premium was reimbursed by Federal Medicaid matching funds, so the net contribution to the state budget was actually $9.35 million. Although the state was able to recover 50 percent of its administrative expense to collect premiums, the premium revenue itself is not counted as a deduction from state expenditures for the purpose of computing the Federal match for benefits expenses.

[5] The premium amounts and TPA payments are in separate OMAP accounts, and apparently never formally reconciled in their determination of net revenue to the State. Given the relatively high costs associated with collecting these premium payments (especially for those households making the minimum contribution), we believe that this reconciliation is necessary in order to gain an accurate picture of premium-generated revenues for budget purposes.

Based on experience to date, OMAP has lowered its estimate of premium-generated revenue for the next State budget period (1997-1999). Assuming a 72 percent collection rate, they expect to collect $13 million (gross of TPA payments). This estimate also takes into account the somewhat smaller expansion population from that enrolled in 1995. From an all-time high of 133,804 in August 1995, the number of expansion enrollees appears to have stabilized at around 100,000.

2.5 Terminations for Non-Payment of Premium

Each month, OMAP discontinues coverage for individuals who have applied for re-certification but have not paid their premiums (and have not received a waiver). Some household cases are closed completely because all family members in the household are subject to premiums, but in others, only some eligible members are terminated. For example, children under six, or a pregnant woman in a household may not be required to pay premiums (because they are eligible under traditional Medicaid rules), but other adult members, who are eligible under the expansion rules, would be required to pay. If the family was in premium arrears at the time of re-certification, only the OHP enrollees from the expansion population would be disenrolled.

Table 2-4 presents the number of households losing eligibility due to premium arrears, from May 1996 through June 1997. Nearly 700 households a month are either completely terminated, or have individuals who are disqualified, because they owe premium

Table 2-4

Households Affected by Termination Due to Premium Arrears

Type of Action	May 1996 - June 1997 (14 months)
Households closed	4,578
Individuals disqualified from mixed eligibility households	5,103
Total households affected	9,681
Average per month	692

bills at the time they attempt to recertify in OHP. OMAP estimates that these households contain approximately 1,000 individuals who are disenrolled from OHP each month.

Unfortunately, no data are available on the distribution of terminations between New Families and New Adults/Couples. We suspect that they may occur disproportionately among New Adults/Couples for several reasons. First, New Adults/Couples are more likely to become eligible during a spell of illness. When the time comes for them to re-certify, they may be less willing to pay their premium arrears if they are no longer ill. Second, New Family households may be more reluctant to risk losing eligibility for their children. Our survey of expansion eligibles found that, compared with childless adults, New Family

respondents were significantly more likely to report that the lack of health insurance (prior to joining OHP) caused them "some" or "a lot of" worry.

Data on the numbers of families receiving and paying premium bills indicates that OHP has been able to collect payments from the majority of billed households. Table 2-5 presents the numbers of households billed, the percentages paid, and estimates for the percentages of families who either received premium waivers or were disqualified for non-payment.[6] During December 1995 through June 1997, OMAP's TPA mailed premium bills to roughly 79,000 households each month and received payments from an average of 64 percent of these families. Another 3 percent of billed households were granted premium waivers and less than one percent of billed households were disqualified each month for premium arrears.

Although very few households are being terminated because they owe past premiums and do not qualify for a waiver, we do not know how many OHP members fail to re-apply for the program because of the premium requirement. As can be seen in the far-right column of Table 2-5, about one-third, or 25,000, households have outstanding premium bills that are neither paid nor waived in any given month.[7] This proportion has remained fairly constant over time. It is not possible to determine what proportion of these households are just behind in premium payments within their six-month certification period and will pay their balance

[6] Family-level data linking dates of OHP renewal with premium status and waiver approvals at the time of renewal are not available. Therefore, Table 2-5 presents the percentage distribution of all households billed, not just those up for renewal in any given month. We are currently discussing the development of linked files with OMAP.

[7] The last three columns in Table 2-5 are "estimates" because the month the waiver is granted is not included in the months that the premiums were incurred. The only way to match waivers to incurred premiums is to estimate the waivers granted in each month as the monthly mean over the entire period.

Table 2-5

Number of Households Receiving Premium Bills, Number and Percentage Paid, and Estimated Percentages Waived and Disqualified

Month	Number of Households Billed	Number of Households Paid	Percent of Households Paid	Estimated Percent of Households Granted Waivers*	Estimated Percent of Households Disqualified due to Premium Arrears**	Estimated Percent of Households with Unpaid Premiums
Dec 95	79,893	59,260	74.2%	- -	- -	25.8%
Jan 96	84,088	56,302	67.0	- -	- -	33.0
Feb 96	83,489	55,475	66.4	- -	- -	33.6
Mar 96	81,102	53,235	65.6	- -	- -	34.4
Apr 96	81,587	52,538	64.4	- -	- -	35.6
May 96	83,863	52,115	62.1	2.9	0.8	34.1
Jun 96	83,077	53,055	63.9	3.0	0.8	32.4
Jul 96	81,335	52,372	64.4	3.0	0.9	31.7
Aug 96	79,152	50,813	64.2	3.1	0.9	31.8
Sep 96	75,176	48,792	64.9	3.3	0.9	30.9
Oct 96	74,877	46,508	62.1	3.3	0.9	33.7
Nov 96	75,653	44,345	58.6	3.2	0.9	37.2
Dec 96	73,270	40,914	55.8	3.3	0.9	39.9
Jan 97	77,554	49,095	63.3	3.2	0.9	32.6
Feb 97	76,091	49,857	65.5	3.2	0.9	30.3
Mar 97	75,275	49,089	65.2	3.3	0.9	30.6
Apr 97	77,363	48,364	62.5	3.2	0.9	33.4
May 97	77,302	47,370	61.3	3.2	0.9	34.7
Jun 97	79,573	46,315	58.2	3.1	0.9	37.8
Average	**78,933**	**50,306**	**63.7%**	**3.2%**	**0.9%**	**32.2%**

*Households receiving waivers are based on the month the waiver was granted rather than the month the premium was billed. Therefore, for this percentage, the numerator is based on the average number of waivers granted each month for the period of June 1996 - June 1997 (2,454) and the denominator is based on the month the premium was billed.

**Households, or individuals within households, disqualified for premium arrears are based on the month the disenrollment occurred rather than the month the premium was billed. Therefore, for this percentage, the numerator is based on the average number of households disqualified (692) and the denominator is based on the month the premium was billed.

in time for re-certification, what proportion of households with premium arrears will not attempt to be re-certified because of the financial strains imposed by the premium requirement, and what proportion will fail to re-apply for other reasons.

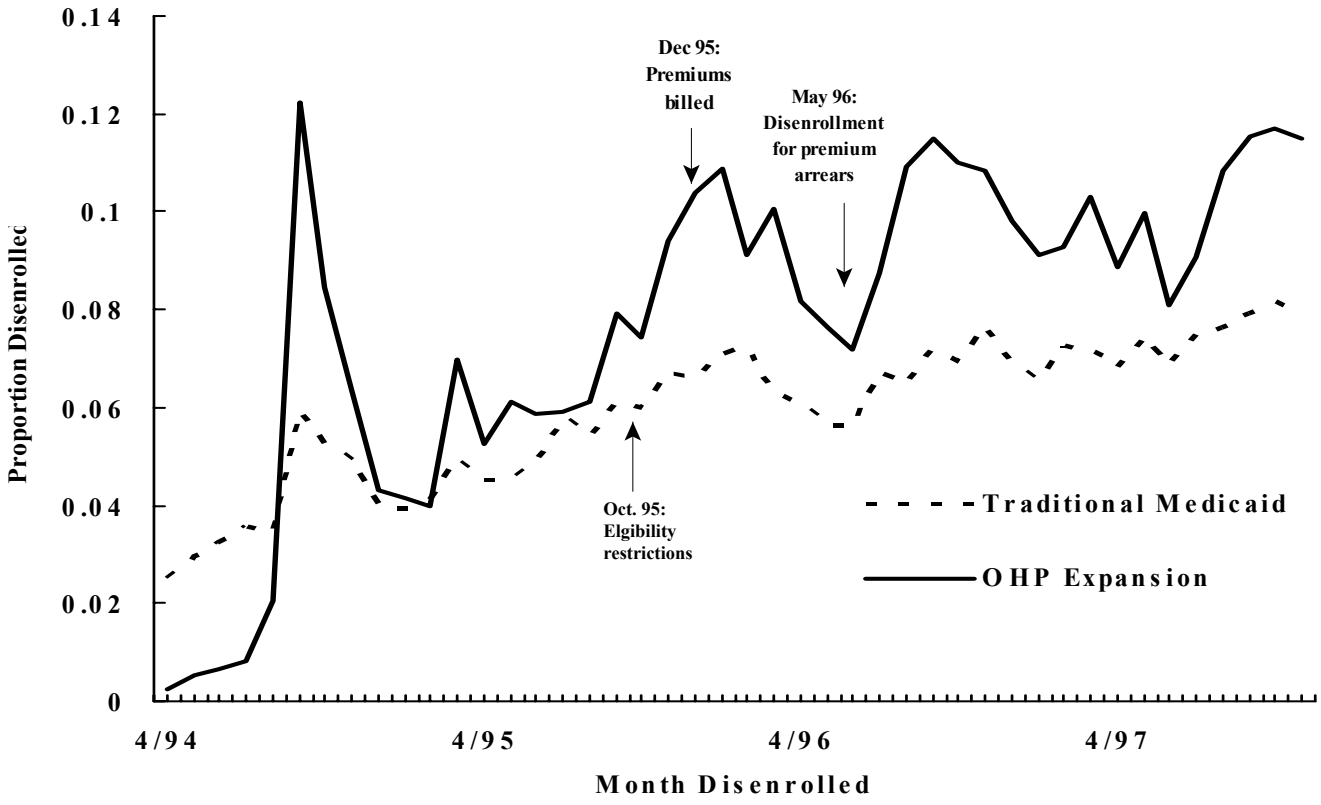
In an attempt to explore this question further, we plotted the rate of disenrollment from health plans and PCCMs due to loss of eligibility for each month from April 1994 through November 1997, separately for traditional (e.g., ADC) vs. expansion eligibility categories (Figure 2-2). We hypothesize that, in the absence of a premium effect on re-certification, the trends for the traditional and expansion groups should be similar. If they diverge noticeably at key points following the implementation of the premium requirement, it would suggest that there had been an effect on re-certification, as traditional eligibles are not subject to the premium requirement. Thus, the trend for traditional eligibles represents a baseline expectation for the expansion population in the absence of a premium effect.

The first general observation from Figure 2-2 is that, following the initial 7 months when expansion eligibles were flooding into the program, the disenrollment rate has almost always been higher for expansion eligibles than for traditional eligibles. This is somewhat surprising, since the traditional 1-month certification period was extended to 6 months for the expansion population in order to assure HMOs a more stable risk pool. Thus, the expansion population has a higher underlying disenrollment baseline than the traditional population.

Following this initial period, the rates are similar from about December 1994 through October 1995, when the disenrollment rate for the expansion population begins to increase

Figure 2-2

Rate of Health Plan Disenrollment Due to Loss of OHP Eligibility, by Type of Eligibility Category



substantially faster than the rate for the traditional population. This divergence peaks in January 1996 and returns to baseline in June 1996. This reflects the first major eligibility restrictions imposed by OHP in October 1995: the shift to 3-month average income, the asset criterion, and the exclusion of full-time students. When the first premium bills were mailed in December 1995, the increasing trend continued for one more month before it began to decline. OMAP did not deny re-certification to anyone for unpaid premiums until May 1996, just before the unexpectedly high disenrollment rate for expansion eligibles falls back to baseline. Shortly after the denials of re-certification began, in July 1996, the rates diverged again, following almost exactly the same pattern through January 1997. Thus, we see in Figure 2-2 two periods of very similar rapid increases in the disenrollment rate for expansion eligibles relative to the rate for traditional eligibles; the first apparently associated with the changes in eligibility criteria and the second apparently associated with the start of denials of re-certification for failure to pay premiums.

Although a clear causal relationship cannot be established with this method, this finding suggests that a substantial number of members may have left OHP at re-certification because of the premium requirement. One disconcerting aspect of Figure 2-2, however, is a third repetition of the pattern of divergence beginning in June 1997. There are no changes in OHP eligibility policy that would have caused a similar pattern to develop at this time. Thus, although it appears that OHP eligibility policy resulted in the first two disenrollment rate increases, it is possible that, instead, there is some unobserved phenomenon that causes the rates to diverge in this pattern every 9 or 10 months.

Alternatively, this cyclical peak in disenrollment may reflect the uneven distribution in initial enrollment of the expansion population during the first few months of the program and who then continue to come up for re-certification at about the same time every six months. If substantial numbers of these eligibles are not re-enrolled (for reasons unknown) at each subsequent re-certification period, this phenomenon could appear as a series of "spikes" in the disenrollment rate for expansion eligibles. However, as the distribution of the month of enrollment for expansion eligibles flattens over time, the pattern of apparent cyclical increases in disenrollment should also diminish.

It should be noted that, during the first year or so of premium implementation, some premiums were being paid by third-parties. Anecdotal evidence suggests that employers, churches, and even providers were making premium payments on behalf of expansion eligibles in order to keep them from being dropped from OHP. Most notably, CareOregon (the managed care plan consisting of many of the State's safety-net providers) paid overdue premiums on behalf of 3,368 enrollees from April 1996 through February 1997. Despite this, less than one-half of these CareOregon enrollees (1,399) re-applied.

2.6 Conclusions

OMAP has implemented the premium requirement in a way that appears flexible and takes into account the difficulty some eligibles will have in paying the premium. Waivers are available and appear to be granted with some frequency, especially for "zero-income".

Expansion eligibles are carried in arrears for the remainder of their six-month eligibility period, rather than being terminated immediately for non-payment of the monthly premium bill.

The majority of expansion households appear willing and able to make the premium payments, with 66 percent of billed premiums collected from two-thirds of all households. After deducting the payments to the TPA who collects these premiums and adding the Federal matching funds for that payment, about $9.35 million was generated in revenue for OHP. Although considerably less than what the State had anticipated collecting, these net premiums represented over 1.0 percent of OHP's total biennial budget for 1995-1997.

A relatively small number of expansion eligibles were denied re-certification for failing to make the premium payments, about 1,000 individuals living in 700 households out of the 79,000 households billed each month. In any one month, however, there are an additional 25,000 households who are not current in their premium payments and have not received a waiver. We do not know how many of these will pay their arrears before their six-month eligibility period expires, and how many will simply fail to re-apply. The latter includes those households who will not re-apply because they know they will be denied for non-payment of premiums, those who simply can not afford to continue premium payments, and those who will fail to re-apply for other reasons (e.g., because their incomes now exceed OHP's eligibility criteria, they have gained insurance through a new employer, etc.). Comparison of disenrollment rates between traditional and expansion eligibles suggests that the premium requirement may be associated with a failure to re-apply.

Many in the expansion population first become eligible during a spell of illness, and it is believed that some number fail to re-apply because their illness has resolved and they know that they can always apply for coverage in the future.[8] It is possible that the premium requirement acts as a deterrent in these cases (e.g., why pay for coverage now when I am no longer sick). Although the data are not available to confirm this, we suspect that this is more likely to be the case among the New Adults/Couples. Families with children are apt to be more concerned about retaining insurance coverage. More research is needed as to the reasons why expansion eligibles fail to re-apply. If some are going without coverage for financial reasons, the long-run costs to OHP may be high. Without primary and preventive care, these uninsured individuals may be quite costly when they eventually get sick again and re-apply for coverage.

[8] The managed care plans complain that this has resulted in "adverse selection", leaving the residual expansion eligibles sicker and more costly to treat.

3 Paying Providers in a Capitated Medicaid Managed Care Program: Lessons from the Oregon Health Plan

3.1 Introduction

Oregon Health Plan (OHP) beneficiaries are required to enroll in a capitated managed care plan in all areas of the State where contracting plans are available.[1] In areas without a plan or where capacity is inadequate to serve the entire OHP population, beneficiaries are enrolled in primary care case management (PCCM). As of December 1997, OHP contracted with fully capitated health plans (FCHPs) to provide physical health services in all but two of Oregon's 36 counties. FCHPs cover a full range of acute care services.[2]

Managed care plans receive a monthly[3] capitation payment for each enrollee[4] that varies by rate category and geographic area. The State's actuarial consultant, Coopers and Lybrand, sets the capitation rates and all plans are paid the same rate. Oregon contracts with any plan willing to accept the payment amounts and that meets contracting standards in areas such as access, financial solvency, and quality assurance activities. This chapter describes

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[1] Certain beneficiaries are exempt from managed care enrollment, including Medicare dual eligibles who are enrolled in a Medicare HMO that does not contract with OHP and Native Americans. Individuals for whom managed care enrollment would create access barriers or would disrupt continuity of care either are enrolled with a primary care case manager (PCCM) or remain in traditional fee-for-service.

[2] Separate managed care plans cover dental and behavioral health services.

[3] Initially, new members were only enrolled in a managed care plan on the first day of the month. In January 1997, OHP began weekly enrollment of beneficiaries. Plans receive pro-rated capitation payments for members that are not enrolled for a full month.

[4] Separate capitation payments are made for each member of a family enrolled in a plan.

rate setting for physical health plans during the first four years of OHP. The chapter begins with a description of OHP's capitation rate categories and the methods used to establish these rates. We then look at trends in capitation payments over time, as well as variation by region of the State. The possibility that plans will enroll populations with differing risk characteristics poses serious challenges for setting equitable reimbursement rates under capitated programs. While varying capitation rates by eligibility group mitigates potential selection problems, differential selection within rate categories may still occur. The chapter concludes with a description of evidence of risk selection in OHP, as well as future plans for risk adjusting capitation payments.

3.2 Rate Setting Methodology

3.2.1 Rate Categories

Ideally, rate categories should capture groups of beneficiaries that are relatively homogeneous with respect to expected cost. If there is non-random variation within groups, plans may be able to identify lower-cost beneficiaries and selectively enroll them. While defining rate categories more finely can reduce opportunities for risk selection, there are limits to the number of categories that are feasible. First, a greater number of categories increase the complexity of administering a program. Second, cost estimates may not be stable if there are an insufficient number of beneficiaries in a given category. Thus, there is a trade-off between minimizing potential for selection bias and administrative feasibility.

Over time, OHP has increasingly disaggregated its rate categories. Initially, four categories were established for the Phase 1 population and five for the Phase 2 population. These categories are shown in Exhibit 3-1. The bulk of the Phase 1 population was covered by the OHP Basic category, which included all Phase 1 beneficiaries with incomes below the Federal Poverty Level (FPL) except the General Assistance (GA) population. Along with several categories of traditional Medicaid eligibles, OHP Basic included the two expansion population groups. The eligibility groups that comprised the Basic rate category were:

- Aid to Families with Dependent Children (called ADC) beneficiaries;
- pregnant women (called poverty level medical, or PLM, adults) in families with incomes under 100 percent of FPL;
- PLM children born after September 30, 1983 in families with incomes under 100 percent of FPL;
- OHP single adults and childless couples with incomes under 100 percent of FPL; and
- OHP families with incomes under 100 percent of FPL.

Separate rate categories were established for:

- PLM pregnant women with family incomes up to 133 percent of FPL;
- PLM children under the age of 6 with family incomes up to 133 percent of FPL; and
- General Assistance beneficiaries, which includes low-income adults who are unable to work due to a medical disability and not otherwise eligible for Medicaid.

Exhibit 3-1

OHP Rate Categories

Effective 2/94 through 9/97	Effective 10/97
Phase 1	**Phase 1**
OHP Basic	ADC PLM Pregnant Women < 100% FPL PLM Children < 100% FPL OHP Families OHP Adults/Couples
PLM Pregnant Women 100-133% FPL	PLM Pregnant Women 100-133% FPL
PLM Children 100-133% FPL	PLM Children 100-133% FPL
General Assistance	General Assistance
Phase 2	**Phase 2**
Aged with Medicare	Aged with Medicare Part A&B/Part A only Aged with Medicare Part B only[1]
Aged without Medicare	Aged without Medicare
Blind and Disabled with Medicare	Blind and Disabled with Medicare
Blind and Disabled without Medicare	Blind and Disabled without Medicare
Children in Foster Care	Children in Foster Care

[1] A separate category for aged beneficiaries with Medicare Part B went into effect in March 1997.

PLM pregnant women and children above poverty were expected to have higher monthly costs than the corresponding PLM beneficiaries below poverty. Although total expected costs per eligibility spell are similar for PLM pregnant women above and below poverty, they do not have the same expected monthly costs because of differences in eligibility rules for these two groups. PLM pregnant women below poverty have longer guaranteed eligibility than those above poverty, so their maternity costs (the main expense for this population) are spread over a longer time period. As a result, PLM pregnant women below poverty should have a lower monthly capitation payment. PLM children below poverty have an older age distribution than those above poverty due to differences in age limits for eligibility. PLM children below poverty are, therefore, expected to be lower cost on average. General Assistance beneficiaries, who qualify for OHP by virtue of their disability, are expected to have higher expenses than other eligibles below poverty.

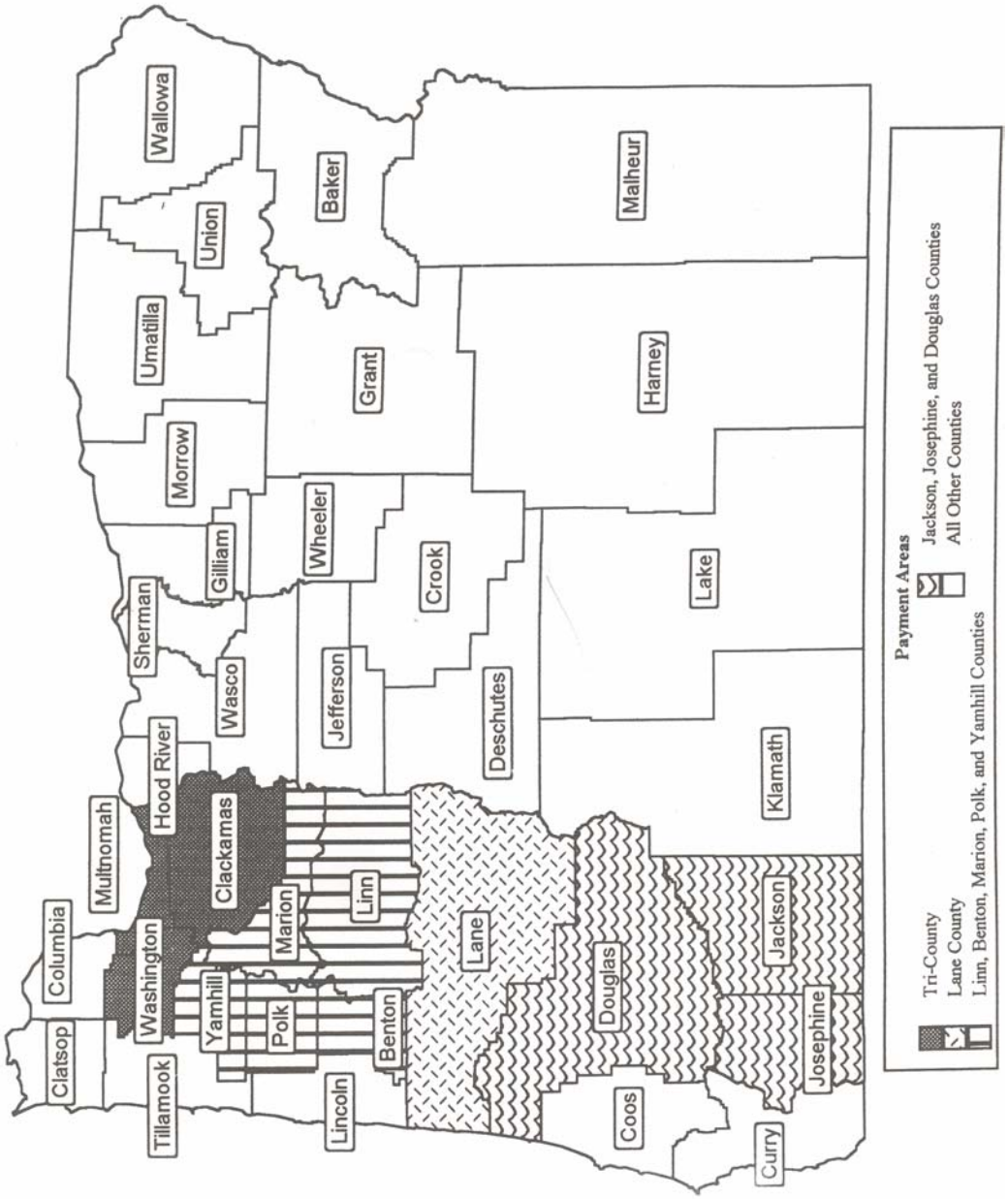
Phase 2 eligibles were divided into five groups, defined by basis of eligibility and Medicare coverage. These included aged beneficiaries, with and without Medicare; blind and disabled beneficiaries, with and without Medicare; and children in foster care.

In 1997, OHP increased the number of rate categories from 9 to 14. As shown in Exhibit 3-1, changes applied to the OHP basic and aged with Medicare categories. The most significant change was that separate rate categories were established for the five groups within the OHP basic category. Although the beneficiary groups within this category had different utilization patterns and expected costs, according to OHP administrators, this split was not driven by concerns over selection bias. Rather, the State had found it difficult to accurately estimate the relative size of each group. Because the OHP basic rate was a

weighted average of the costs for the five subgroups, calculating the capitation payment was dependent on accurately measuring the size of each group. After separate rate categories were established, the relative size of the subgroups was no longer required for the rate calculation. The Phase 2 rate categories were largely unchanged, although the aged with Medicare category was divided into those with Part B coverage only and those with both Part A and B or Part A only. Beneficiaries with Part B coverage only are significantly more costly because Medicaid is the primary payer for hospital charges. Although aged beneficiaries with Part B only are a small share of all OHP eligibles, they comprise about one-fifth of the aged with Medicare population.

OHP also sets different rates for five geographic areas of the State (Figure 3-1). The definition of these areas, which is based on groupings of counties, has not changed over the course of the program. The areas vary along an urban/rural dimension and are intended to reflect input price differences for medical services across the State. However, they do not account for regional variation in service delivery patterns. The most expensive area is the tri-county metropolitan Portland region. The least expensive category (Other) includes counties in the sparsely-populated area of Oregon east of the Cascade Mountains, as well as several rural counties in northwestern and southwestern Oregon.

Figure 3-1
OHP Geographic Payment Areas



3.2.2 Data Used to Set Rates

OHP's actuary estimates the cost of delivering services to the program's beneficiaries in two-year cycles. To date, cost estimates have been developed for the periods February 1994 through September 1995; October 1995 through September 1997; and October 1997 through September 1999. In each cycle, separate estimates are prepared for each eligibility group. Finding utilization data on which to base rates poses a substantial challenge as managed care programs mature and enrollment in prepaid plans becomes increasingly prevalent. In addition, there are usually no sources of data on prior utilization by expansion populations. Although some programs, including OHP, require managed care plans to report encounter data on services delivered, the quality of these data is often problematic. As a result, OHP rates have been based on fee-for-service claims data. Two main sources of fee-for-service data have been used: Oregon Medicaid fee-for-service claims data and Blue Cross/Blue Shield of Oregon (BCBSO) claims data for a commercially insured population.

Rates for the pre-OHP Medicaid populations have been based primarily on each group's fee-for-service Medicaid experience. ADC data were used for the OHP family expansion group, which was expected to have utilization patterns similar to this traditional categorical population. The other expansion group, OHP adults and couples, was initially assumed to resemble a commercially insured population. During the first two rate setting cycles, their rates were based mainly on BCBSO data. The commercial BCBSO data were adjusted to reflect differing demographic characteristics of the OHP adults and couples

population[5] and the higher utilization of certain services in a newly insured population. Experience showed the comparison to a commercially-insured population to be a poor one. OHP adults and couples often became eligible during a spell of illness and were far more costly than originally anticipated. In this respect, the GA population was determined to be a better benchmark. In the third rate-setting cycle, rates for this population were based on GA fee-for-service data.

Pre-OHP fee-for-service Medicaid data, which were the most current data available, were used for the first two rate setting cycles. Even in the early years of OHP, there were limits on the accuracy of this data for the ADC population. Prior to OHP, Oregon operated a mandatory managed care for ADC beneficiaries in nearly half of the State's counties (including Portland, the most heavily-populated area). Under this program, managed care plans did not submit claims or encounter data for capitated services to the State. However, most plans were not capitated for a full range of services, so that excluded services were reflected in claims data. Thus, available claims data included most inpatient hospital care and prescription drugs because they generally were not capitated. Physician services, on the other hand, were not reported in the pre-OHP claims data for a large portion of the ADC population. If utilization patterns varied across the State, furthermore, then the pre-OHP claims experience will not accurately reflect Statewide average utilization rates.

The problem of estimating payment rates in a managed care program in the absence of encounter data has become more acute as OHP ages and pre-OHP claims data grow

[5] These differences included an over-representation of men, under-representation of pregnant women and children, but an overall younger age profile.

further out-of-date. Although some claims are submitted under OHP, fee-for-service data have become increasingly non-representative given widespread enrollment in fully capitated plans.[6] Fee-for-service claims are only submitted for services delivered to beneficiaries not enrolled in managed care. Thus, claims are reported either for services received early in an eligibility spell before enrollment goes into effect, or for services provided to beneficiaries who do not enroll in managed care at all. In both cases, fee-for-service utilization is likely to be higher than average. Utilization may be disproportionately high immediately after eligibility begins, while sicker beneficiaries may choose not to enroll in a managed care plan. Indeed, the agency that administers OHP, the Office of Medical Assistance Programs (OMAP), contends that the most severe adverse selection in OHP occurs in the fee-for-service portion of the program.

In 1996, we surveyed traditional adult Medicaid eligibles covered under the Aid to Dependent Children (ADC) program and adults in the expansion population, New Families and New Adults/Couples. The survey included questions to construct SF-12 health status scores. The survey results for adults in the AFDC and OHP expansion populations showed no difference in self-reported health status (based on their SF-12 scores) between beneficiaries enrolled in managed care and those in fee-for-service.

OHP's actuary determined that, for the most part, post-OHP fee-for-service data could not be used for rate setting. Instead, the third-round of rate setting again used Medicaid claims data from the two years preceding OHP implementation for all categories

[6] As of December 1997, approximately 89 percent of Phase 1 beneficiaries were enrolled in a fully-capitated managed care plan. The enrollment rate was somewhat lower among the Phase 2 population, only 80 percent.

except GA and OHP adults and couples. For these groups, the actuary used Medicaid claims data from the first two years of OHP despite the recognized problems with post-OHP fee-for-service data. Rates for both of these groups were based on GA utilization data. The GA population was not eligible for full benefits prior to OHP so that cost estimates derived from pre-OHP data were felt to be inaccurate.[7] OHP fee-for-service data were also used to adjust rate calculations for some populations based on relative utilization rates between eligibility groups. For example, utilization rates for OHP New Adults and Couples were determined to be only one-fifth as high as GA rates. OHP claims data also showed OHP New Families to have fee-for-service utilization rates about 11 percent lower than ADC beneficiaries. Based on this information estimated costs for OHP families, which had been based on ADC utilization, were reduced.

To date, encounter data have not been used for rate setting because of concerns about their completeness and quality. However, OHP's actuary feels that they can no longer develop accurate cost estimates by trending forward increasingly out-of-date pre-OHP fee-for-service data. OMAP has announced its intention to use encounter data for rate setting beginning with the 1999 biennial calculation. OMAP plans to use encounter data covering a two-year period from July 1995 to June 1997. Plans were given a deadline of January 31, 1998 to submit complete encounter data for this time period. OMAP reported a heavy volume of encounter submissions from the plans in response to this deadline, but as of early

[7] Most importantly, GA beneficiaries were not covered for inpatient services prior to OHP.

July 1998, a final determination about the adequacy of the data for rate setting had not yet been made.

3.2.3 Setting Capitation Rates

Using the data sources described above, the actuary calculates the cost of providing the full OHP benefit package by eligibility group. Adjustments are made for changes in eligibility rules and, for expansion groups, demographic differences from the populations used to estimate utilization rates. One of the objectives of OHP was to eliminate cost-shifting from the Medicaid program to private payors by ensuring that rates were set high enough to cover the cost of services provided. Service costs are estimated from claims charges using a combination of: (1) hospital cost-to-charge ratios; (2) information on discounts negotiated by managed care plans; and (3) the Resource Based Relative Value Scale (RBRVS) ranking of relative resource intensity for professional services. Costs are then trended forward to the contract period to account for changes in input prices.

Fee-for-service costs are further adjusted to reflect anticipated managed care savings. During the first biannual rate setting cycle, fairly modest savings were assumed. Initially, a 20 percent reduction in inpatient costs was allowed for most eligibility groups. Rates also reflected 15 percent savings on prescription drugs for the aged, blind and disabled populations with Medicare and 5 percent savings for those without Medicare. Substantially greater savings from managed care efficiencies were built into rates beginning in October 1995. Inpatient savings were increased to 30 percent for most eligibility groups. An

additional 10 percent saving for maternity care was also built in. However, adjustments were made for an offsetting 10 percent increase in physician services for most populations, as well as an increase in prescription drug use for all except the aged, blind, and disabled.

Managed care plans are not responsible for the hospitalization costs of beneficiaries who become eligible during an inpatient stay. This is particularly significant for the GA and OHP adults and couples categories, because OMAP believes that a high proportion of these beneficiaries generally become eligible during a spell of illness. Capitation rates for these groups are reduced to account for fee-for-service use prior to enrollment in managed care. These reductions are particularly steep for the GA population, where it is assumed that less than half of the total costs will occur during enrollment in managed care. Roughly two-thirds of the service costs for OHP adults and couples are assumed to fall during the capitated period.

In the initial stages of the rate setting process, the actuary estimates the cost of providing the complete OHP benefit package. In order to calculate the cost of the actual set of benefits covered, costs are allocated by line item on the priority list. The percent of total costs associated with each line item is calculated. Based on the funding line for a given time period, the capitation rate is set at a percentage of total costs.

Capitation rates include an allowance for administrative costs. Until October 1997, administrative costs were set at 6 percent of the capitation payment. This rate was assumed to cover administrative costs for a mature managed care plan and was not intended to compensate for start-up costs. However, it appears that even established commercial plans in OHP incurred administrative costs that exceeded this amount. During the first three years

of operation, the eight commercial plans that participated in OHP reported administrative expenses that were nearly 10 percent of total revenues on their OHP line of business (see Appendix A). The average across all participating plans was approximately 9 percent. In response to complaints from plans, the administrative cost allowance was increased to 8 percent beginning October 1997.

3.2.4 Alternatives to Rate Setting

Oregon has a history of using actuarial rate setting in Medicaid managed care dating back to the 1915(b) program that preceded OHP.[8] However, other States have used alternative approaches for setting capitation rates, including rate negotiation and competitive bidding. Since the inception of OHP, Oregon legislators have repeatedly introduced bills requiring OMAP to contract with plans through a competitive bidding process, contending that this would save money over administered prices.

To date, OMAP has resisted competitive bidding proposals. OMAP views such market-driven approaches as incompatible with the public-private partnership that they consider to be a foundation of OHP. This is seen as anathema to the spirit of openness they have sought. Furthermore, while poor quality encounter data have made rate setting difficult, accurate utilization data are also needed to evaluate alternative bids. OHP plans have also not embraced competitive bidding proposals. In response to past budget shortfalls,

[8] Coopers and Lybrand had also set rates under Oregon's earlier 1915(b) program and, thus, had long experience with Medicaid managed care in Oregon.

plans have preferred rate reductions over proposals to institute competitive bidding. Nonetheless, as persistent budget problems have made rate setting a more rancorous process, the OMAP administration has expressed greater openness to competitive bidding.[9]

These issues aside, it is not clear whether competitive bidding would save money. OMAP has estimated that competitive bidding would realize a 2 percent savings.[10] Particularly in rural areas, it is not evident that there is a basis for competition. In these areas there is often a single hospital and a limited number of providers who are all associated with a single IPA that contracts with managed care plans. Public officials may be reluctant to exercise the threat to cancel plan contracts and dislocate patient-provider relationships, particularly in a visible program that serves vulnerable populations. Finally, in a public program, it may be difficult to accommodate the possibility that competitively bid rates will exceed the program's fixed budget.

3.3 Capitation Rate Trends

In general, new capitation rates have gone into effect at the beginning of each fiscal year. However, mid-year rate changes have been adopted at several points to accommodate movements in the cut-off line for coverage of services on the priority list, as well as changes in the scope of services that are the responsibility of managed care plans. While actuarial cost estimates are the basis for rate setting, OMAP notes that rate adjustments over the

[9] Oregon Health Forum, November 1997.

[10] Ibid.

course of the program have also responded to budgetary pressures and perceptions of payment levels that are acceptable to contracting plans.

Table 3-1 shows statewide average FCHP capitation rates in effect at the inception of OHP and at the start of each fiscal year through October 1997. These rates include both basic and optional services under OHP contracts, as well as the administrative cost allowance.[11] Rate changes, in part, reflect differences in covered services between years, due to both line movements and other changes in OHP's scope of services. As described previously, the OHP Basic category was broken into five groups beginning in 1997; blind and disabled beneficiaries with Medicare Part B only were also separated from other blind and disabled dual eligibles.

While capitation rates for some categories have been fairly stable over the course of the program, others have shown a good deal of volatility. The most dramatic movements have been in payments for the GA population. Calculating GA rates has proved particularly difficult because pre-OHP utilization was not available for inpatient services, which were first covered for this population under OHP. Uncoupling the five eligibility groups that comprised the OHP Basic category also produced marked changes for some groups.

[11] The definition of optional services has varied over the course of the program. Currently, optional services include abortion and maternity case management. Vision care and family planning originally were optional services, but became mandatory in October 1995. They are the optional services included in the rate calculations shown in Tables 3-1 and 3-2. Additional optional services at various times included dental, inpatient mental health, and psychotropic prescription drugs. These exclusions are described in the footnotes to Tables 3-1 and 3-2.

Table 3-1

Statewide Average FCHP Monthly Capitation Rate by Eligibility Group, 1994-1997

Eligibility Group	2/94 Line=565	10/94 Line=565	10/95 Line=606	10/96 Line=581	10/97 Line=574	
Phase I						
ADC					$135.56	
PLM Pregnant Women <100% FPL					570.43	
PLM Children <100% FPL	$110.44	$116.27	$106.62	$106.79	103.12	$128.09*
OHP Families					105.42	
OHP Adults and Couples					117.90	
PLM Pregnant Women 100-133% FPL	610.02	639.76	559.69	609.61	684.59	
PLM Children 100-133% FPL	167.61	175.30	118.95	131.15	145.90	
General Assistance	295.48	308.78	241.77	261.88	478.64	
Phase II						
Blind and Disabled with Medicare	N/A	N/A	179.23	184.46	215.72	
Blind and Disabled without Medicare	N/A	N/A	454.24	489.73	478.16	
Aged with Medicare	N/A	N/A	149.20	159.14	171.27	
Aged without Medicare	N/A	N/A	423.95	454.43	445.51	
Children in Foster Care	N/A	N/A	112.67	118.39	131.61	

NOTE: Capitation rate includes FCHP basic and optional services, as well as administrative costs. Inpatient mental health and mental health/chemical dependency prescription drugs are excluded from the optional services for February 1994. These categories were not included in subsequent rates. Dental services are excluded from the optional services for 1994 and 1995; beginning in October 1996, dental was no longer an optional service for FCHPs. Beginning in March 1997, the Aged with Medicare category excludes beneficiaries with Part B only. The October 1997 rate for this group was $198.08.

* This amount represents the average of the five separate capitation rates, weighted by the number of OHP beneficiaries in each eligibility category.

SOURCE: Office of Medical Assistance Programs.

Table 3-2 shows percent changes in capitation rates, by eligibility category, during the first four years of OHP. Between February and October 1994, rates increased approximately 5 percent to reflect inflation. The rate reductions in October 1995 reflect the assumption of greater managed care savings in the second rate setting cycle. According to OMAP, the adjustment for managed care efficiencies was made in order to deflect competitive bidding proposals advanced in response to budget overruns. Because the new assumptions incorporate a large reduction in inpatient utilization, the most dramatic impact on rates is seen in categories where inpatient services are a large share of total utilization. Rates remained relatively flat between 1995 and 1996, following a reduction in benefits through upward movement of the priority line and the assumption of lower medical inflation. The relative weights of the five eligibility groups in the OHP basic category also changed, leaving this rate virtually unchanged during this time period. The net effect of these changes was to leave rates for Phase 1 eligibles somewhat lower in October 1996 than they were at the start of the program.

In October 1997, however, rates rose sharply due to concerns over the financial condition of plans. Analysis of financial data reported by the plans to OHP shows an overall loss of more than $14 million dollars during the program's first three years in operation and a deterioration of financial performance between 1995 and 1996 (see Appendix A). In response, OMAP estimates that rates increased an average of 10 percent across all eligibility groups. GA rates, in particular, rose dramatically, by more than 80 percent. Disaggregation of the OHP basic category also produced some marked changes, highlighting the lack of

Table 3-2

Percent Change in Statewide Average FCHP Monthly Capitation Rate by Eligibility Group, 1994-1997

Eligibility Group	2/94 to 10/94	10/94 to 10/95	10/95 to 10/96	10/96 to 10/97	
Phase I					
ADC				26.9%	
PLM Pregnant Women <100% FPL				434.2	
PLM Children <100% FPL	5.3%	-8.3%	0.2%	-3.4	19.9%*
OHP Families				-1.3	
OHP Adults and Couples				10.4	
PLM Pregnant Women 100-133% FPL	4.9	-12.5	8.9	12.3	
PLM Children 100-133% FPL	4.6	-32.1	10.3	11.2	
General Assistance	4.5	-21.7	8.3	82.8	
Phase II					
Blind and Disabled with Medicare	N/A	N/A	2.9	16.9	
Blind and Disabled without Medicare	N/A	N/A	7.8	-2.4	
Aged with Medicare	N/A	N/A	6.7	7.6	
Aged without Medicare	N/A	N/A	7.2	-2.0	
Children in Foster Care	N/A	N/A	5.1	11.2	

NOTE: Capitation rate includes FCHP basic and optional services, as well as administrative costs. Inpatient mental health and mental health/chemical dependency prescription drugs are excluded from the optional services for February 1994. These categories were not included in subsequent rates. Dental services are excluded from the optional services for 1994 and 1995; beginning in October 1996, dental was no longer an optional service for FCHPs. Beginning in March 1997, the Aged with Medicare category excludes beneficiaries with Part B only. The October 1997 rate for this group was $198.08.

*This amount represents the average percent increase for the five eligibility groups, weighted by the number of OHP beneficiaries in each eligibility category.

SOURCE: HER analysis of data provided by the Office of Medical Assistance Programs.

homogeneity in this rate category. Rates for PLM pregnant women under poverty more than quadrupled, while those for PLM children and OHP families fell slightly. A comparison of survey findings for adult beneficiaries in the ADC, OHP family, and OHP adults and couples categories showed significant differences between these eligibility groups in self-reported health status (Table 3-3). While all three groups have physical health scores that fall below the 50th percentile for the population as a whole (53.6), the ADC and OHP adults and couples scores fall below the 25th percentile (46.5).[12] This provides further evidence that the OHP basic category encompassed a diverse group of beneficiaries. Thus, the decision to set separate payment rates for the groups within this category appears to have been well-founded.

Table 3-3

Average SF-12 Health Status Scores by Eligible Group

	Physical Health*	Mental Health*
ADC	45.6	44.3
OHP Adults/Couples	43.1	45.6
OHP Families	48.8	49.3

* Eligibility groups are significantly different at p=.0001.

NOTE: A higher score indicates better health status.

SOURCE: HER-RTI survey of OHP Phase 1 eligibles, 1996.

[12] SF-12 norms for the general population appear in Ware JE, M Kosinski and SD Keller: *SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales.* The Health Institute, New England Medical Center, Boston, MA, December 1995.

As described previously, OMAP varies rates by geographic area of the State (Figure 3-1). Table 3-4 shows geographic rate differences for the largest Phase 1 and Phase 2 eligibility groups—ADC and the blind and disabled without Medicare. These eligibility groups show similar geographic rate differentials. Over time, the difference between areas has diminished. In February 1994, there was nearly a 10 percent difference between the ADC rates in the highest cost area (Tri-County) and the lowest cost rural area (Other). By 1997, this difference had narrowed to approximately 6 percent. The geographic differentials adjust only for input price differences, not variation in service delivery patterns. If rural areas have less costly practice patterns because access to specialists and high technology procedures is limited, this policy would overpay plans in rural areas relative to urban. Indeed, analysis of plan financial performance shows that predominantly rural plans have fared well under OHP, while the larger, predominantly urban plans are experiencing financial difficulties (Appendix A).

3.4 Risk Adjustment

Risk selection is a persistent concern in capitated managed care programs. Plans that enroll a sicker than average population within a rate category are at a financial disadvantage if payment rates are not adjusted to reflect these differences. In addition, failure to risk adjust creates incentives for plans to enroll the healthiest beneficiaries. Opportunities for risk selection are somewhat limited in programs like OHP, where managed care plans cannot market directly to beneficiaries and the benefit package is fixed by the State. Nonetheless,

Table 3-4

FCHP Monthly Capitation Rate as a Percent of Statewide Average, 1994-1997

	2/94	10/95	10/97
ADC			
Statewide Rate	$111.85	$106.62	$135.56
Tri-County	105%	106%	103%
Linn/Benton/Marion/Polk/Yamhill	97	97	98
Lane	98	100	101
Jackson/Josephine/Douglas	98	99	98
Other	96	94	97
AB/AD without Medicare			
Statewide Rate	N/A	$454.24	$478.16
Tri-County	N/A	105%	103%
Linn/Benton/Marion/Polk/Yamhill	N/A	97	98
Lane	N/A	100	102
Jackson/Josephine/Douglas	N/A	99	98
Other	N/A	95	97

NOTE: Capitation rate includes FCHP basic and optional services, as well as administrative costs. Inpatient mental health and mental health/chemical dependency prescription drugs are excluded from the optional services for February 1994. These categories were not included in subsequent rates. Dental services are excluded from the optional services for 1994 and 1995; beginning in October 1996, dental was no longer an optional service for FCHPs.

SOURCE: HER analysis of data provided by the Office of Medical Assistance Programs.

selection may occur "naturally" by virtue of the providers associated with a plan. Plans may also selectively encourage high cost beneficiaries to disenroll.

3.4.1 Evidence of Risk Selection

While claims of risk selection are largely anecdotal, there is some evidence that high cost cases are not equally distributed across plans. For example, according to OMAP, beneficiaries with HIV/AIDS are disproportionately enrolled in CareOregon, a plan associated with federally-qualified health centers and other traditional indigent care providers. OMAP has also found that maternity and transplant cases are concentrated in certain plans. CareOregon contends that its greater concentration of non-English speaking members also constitutes adverse selection because the greater demand for translation service increases service delivery costs; however, OMAP considers this a cost factor, but not a risk factor *per se.*

To explore the issue of adverse selection among plans, we used questions from the 1996 survey of Phase I OHP beneficiaries to construct SF-12 health status scores. A cross-plan comparison of the survey findings for four plans[13] are displayed in Table 3-5. Overall, there appeared to be no evidence of risk selection. No significant differences were found between SF-12 scores in these plans when adult ADC and OHP expansion eligibles were compared as a group.[14] When these eligibility groups were examined separately, there were

[13] These plans were CareOregon, Regence HMO Oregon, Kaiser, and ODS Health Plan.

[14] At the time of the survey in 1996, OHP paid a single rate for the OHP basic category.

Table 3-5

Average SF-12 Health Status Scores for Selected Health Plans

	ADC Adults, OHP Adults/Couples, and OHP Families Combined		ADC		OHP Adults/Couples	
Plan	Physical Health	Mental Health	Physical Health*	Mental Health	Physical Health	Mental Health
CareOregon	47.7	45.9	50.1	41.6	46.3	42.9
Kaiser Permanente	47.1	48.2	44.9	43.9	46.5	47.3
ODS Health Plan	43.3	46.3	41.7	47.3	41.0	46.6
Regence HMO Oregon	45.3	46.1	45.8	45.1	42.3	44.4

* Plans are significantly different at p=.10.

NOTE: A higher score indicates better health status.

SOURCE: HER-RTI survey of OHP Phase 1 eligibles, 1996.

mildly significant differences in physical health scores across plans for the ADC population (p=.10), but no significant differences for OHP adults and couples.[15] While this analysis did not find strong evidence of risk selection, comparable data were not available for populations, such as the aged, blind, and disabled, where it might be a greater concern.

3.4.2 Approaches to Risk Adjustment

During the first four years of OHP, OMAP did not directly adjust capitation payments for risk differences across plans. However, two policies did address concerns about adverse selection. First, the State offered stop-loss insurance to participating plans. In addition, a maternity and newborn withhold was established to adjust for differences across plans in the percentage of enrollees requiring maternity services. Twenty-five percent of the capitation payment amounts attributed to maternity and newborn services were placed in the withhold pool. The withhold was then distributed to plans based on their relative shares of newborns enrolled at birth. This approach has been widely criticized because it does not accurately measure a plan's provision of maternity services because newborns are not always enrolled in the mother's plan. For example, if the infant dies or the family moves to a new service area, the plan in which the mother received maternity services would not receive credit. Beginning in June 1998 OMAP has included an adjustment for the prevalence of maternity and newborn services based on experience reflected in encounter data for the preceding year.

[15] The sample size for OHP families was not large enough to examine this group separately.

In addition, OMAP has recently adopted more general risk adjusters. Risk adjustment was implemented for GA, OHP adults and couples, and blind and disabled beneficiaries without Medicare on June 1, 1998. The risk adjustments are based on the Disability Payment System (DPS) developed by the Medicaid Working Group.[16] The DPS was developed using data for disabled Medicaid beneficiaries in five States and was considered better suited to the Medicaid population than other risk adjustment methods. The DPS assigns relative cost weights to beneficiaries based on the presence of selected diagnoses that are predictive of future utilization. Thus, as with OMAP's plans for rate setting, implementation of the DPS is dependent on having accurate encounter data. The Medicaid Working Group is extending the DPS to cover the non-disabled Medicaid population. If that work is completed in time, OMAP plans to apply comprehensive risk adjustment to all eligibility categories beginning October 1, 1998.

In addition, OMAP may implement selected condition-specific adjustments, for example HIV/AIDS. However, some plans have objected to focusing on a limited set of individual conditions. They contend that the list over-emphasizes the financial risk associated with some conditions, while ignoring other conditions that also may be more costly to treat.

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[16] Kronick, Richard, Tony Dreyfus, Lora Lee, and Zhiyuan Zhou, "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System," *Health Care Financing Review*, 12(3):7-33, Spring 1996.

3.5 Conclusion

When OHP was introduced, providers were generally satisfied with the capitation rates because they were based on the cost of providing services and, therefore, were more generous then historical fee-for-service rates. It is difficult to directly compare rates for Medicaid beneficiaries with those from commercially insured populations because utilization patterns differ substantially.[17] However, for those plans with both OHP and commercial business, the average profit margin on the OHP line of business was more than 5 percent lower than their overall corporate profit margin (see Appendix A). From this, one can infer that OHP capitation rates are set relatively lower than commercial rates.

Over time, OMAP has been forced repeatedly to reduce capitation payments in response to budget shortfalls and provider discontent with payment levels has grown. Although the priority list was intended to be the primary budget mechanism in OHP, OMAP has also achieved savings through changes in the assumptions underlying the rate setting process. Partly as a result of this, two and a half years into OHP, rates were largely unchanged from the program's inception. In response to evidence of severe financial problems among contracting plans, OMAP increased rates in the fourth year of the program. However, in light of HCFA's refusal to approve the most recent priority line movement, it appears that OMAP may have reached the limit of its ability to manage the OHP budget using the priority list. OMAP has turned to supplemental tobacco tax revenues and new

[17] A comparison of Medicaid and commercial populations enrolled in the same HMO found that Medicaid enrollees were 23 percent more expensive. See Welch WP and M Wade: "The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs". *Health Affairs*, 14:212-223, 1995.

revenues from the Children's Health Insurance Program (CHIP) to stave off budget crises. Nonetheless, it is possible that they will again have to look to rate reductions for savings. Although plans have responded positively to the most recent rate increases, it is likely that capitation rates will be an ongoing area of tension.

As they mature, managed care programs face a challenge to collect utilization data that can be used for rate setting. With increasing enrollment in managed care, fee-for-service claims data dwindle and become increasingly non-representative. Many Medicaid managed care programs have been frustrated in their attempts to enforce encounter data reporting requirements. Although encounter data collection in OHP has been problematic, OMAP appears committed to using encounter data for rate setting and risk adjustment. The expectation that payment rates are dependent on encounters should provide significant incentives for plans to submit complete data. At this time, however, it is uncertain whether the plans' responses to these incentives are adequate to use encounter data as the basis for setting payment rates.

4 Managed Care Contracting in the Oregon Health Plan: Market Consolidation and Delivery System Impacts

4.1 Introduction

Oregon Health Plan (OHP) beneficiaries are required to enroll in a capitated managed care plan in all areas of the State where contracting plans are available.[1] In areas without a capitated managed care plan or where capacity is inadequate to serve the entire OHP population, beneficiaries are enrolled in primary care case management (PCCM). As of December 1997, OHP contracted with fully capitated health plans (FCHPs) to provide physical health services in all but two of Oregon's counties.[2]

This chapter describes the impact of OHP on the health care market in Oregon. We begin by describing the physical health plans that have contracted with OHP over the life of the program and the consolidation of the OHP market over time. As a result of this consolidation, OHP contracts with fewer plans and, in most counties, offers beneficiaries a choice of fewer plans than it did at the beginning of the program. At the same time OHP has succeeded in introducing managed care to areas of the State it had not penetrated before. We

[1] Certain beneficiaries are exempt from managed care enrollment, including Medicare dual eligibles who are enrolled in a Medicare HMO that does not contract with OHP and Native Americans. Individuals for whom managed care enrollment would create access barriers or would disrupt continuity of care either are enrolled with a primary care case manager (PCCM) or remain in traditional fee-for-service.

[2] Separate managed care plans cover dental and behavioral health services.

then describe the impact of OHP on physicians in Oregon. OHP has served to galvanize the physician community, particularly in rural areas of the State. Finally, we describe spillover effects from OHP on the commercial and Medicare markets.

4.2 Participation of Managed Care Plans in OHP

4.2.1 Contracting Process

Oregon has a long history of managed care service delivery, beginning with the entry of Kaiser Permanente Health Plans in the 1940s. The State is considered to have one of the most mature managed care markets in the country and has among the highest managed care penetration rates. More than 40 percent of the privately insured population in the Portland area is enrolled in a managed care plan and more than 50 percent of Medicare beneficiaries are in a plan with a Medicare risk contract, the highest rate in the country.[3] Oregon had considerable experience with Medicaid managed care under a 1915(b) waiver dating back to 1985 that covered the Aid to Families with Dependent Children (AFDC) population in 17 of the State's 36 counties. Nonetheless, at the time OHP began operation, managed care activity was largely confined to the western areas of the State and HMOs operated in only 8 counties.[4]

One of the goals of OHP was to deliver a statewide managed care delivery system and, where possible, to contract only with plans capitated for the full range of physical health

[3] Marsden, Jill, "Community Snapshots Project: Portland, Oregon/Vancouver, Washington, Site Visit Report," Center for Studying Health Systems Change, Washington D.C., undated.

[4] The Office for Oregon Health Plan Policy and Research, "Effects of the Oregon Health Plan," Salem, OR, undated.

services.[5] In Oregon, the Department of Insurance licenses health maintenance organizations (HMOs) as Health Care Service Contractors (HCSCs). The Office of Medical Assistance Programs (OMAP), the State agency that administers OHP, chose not to make licensure a requirement for contracting plans. This was done to encourage the participation of managed care plans in all areas of the State, particularly those without commercial managed care activity. This policy also allowed unlicensed managed care plans that had participated under the 1915(b) waiver to continue serving the Medicaid population. Instead, OHP plans must meet state contracting standards in areas such as financial solvency, access, and internal quality assurance activities.

Two additional contracting policies facilitate broad plan participation. First, OMAP contracts with managed care plans on a county-by-county basis. This strategy encouraged the formation of local plans to participate in OHP. Second, OMAP has an "open door" policy of contracting with any plan that meets its requirements and does not limit the number of plans per county. However, as described below, new contractors have been given an opportunity to enter the program only once since its inception because OMAP feels that current contractors provide adequate capacity.

OMAP solicits plans interested in participating in OHP through a request for application (RFA) process. OMAP does not have an official policy on how frequently it issues RFAs. In general, they expect an RFA for physical health services to be issued approximately every two years. Two RFAs were issued during the first four years of the

[5] Many of the plans that contracted under the 1915(b) program were partially capitated.

program. Interim RFAs were also issued in cases where the sole contractor left a county and their enrollees were not assumed by another plan. In the future, OMAP anticipates issuing a Statewide RFA for contracts that would go into effect at the start of the October 1999 fiscal year.

An RFA was issued in November 1991 after the State's Section 1115 waiver was submitted to the Health Care Financing Administration (HCFA). This RFA was left open until the waiver was approved in March 1993. The initial RFA resulted in the award of contracts to 16 fully capitated health plans (FCHPs) and 4 partially capitated health plans (known as physician care organizations, or PCOs). These contracts covered 28 of Oregon's 36 counties.

OMAP issued a second RFA in April 1995. This RFA requested applications for the expansion of existing FCHPs into areas without a managed care plan or with a PCO; the conversion of existing PCOs to FCHPs; and the entry of new FCHPs into areas without managed care or with a PCO. Applications were received from five existing FCHPs , two PCOs requesting conversion to FCHP-status, and two new FCHPs. The applications from all nine plans were approved in October 1995.[6] At this time OMAP also discontinued contracting with PCOs and the contracts of the two PCOs that elected not to covert to FCHP status were terminated. As a result of these new contracts, only two counties remain without a managed care plan (Gilliam and Tillamook).[7] OMAP considers it unlikely that there will

[6] The request from one plan to expand into Tillamook County was denied; however, its expansion into two other counties was approved.

[7] Although a contract was awarded for Gilliam County, the plan withdrew from the area after three months.

ever be a managed care plan in either of these counties, which are very sparsely populated and have few providers.

4.2.2 Characteristics of Contracting Plans

OMAP has contracted with 22 plans over the life of the program. Table 4-1 summarizes the key features of these plans, including their dates of OHP participation, their OHP contractual arrangement, pre-OHP Medicaid managed care experience, enrollment of commercial and Medicare beneficiaries, and their organizational form.

Of the initial group of twenty contracting plans, eight were existing plans that served the commercial market. Six of these plans had previous Medicaid experience under the 1915(b) waiver program and six enrolled Medicare beneficiaries on a risk or cost basis. Of the remaining twelve plans, which served the OHP population only, six had been 1915(b) contractors. Of the remaining six, five were FCHPs that were formed for the sole purpose of contracting with OHP and one was a PCO. As of July 1994, 87 percent of the OHP population enrolled in managed care was in a plan with prior managed care experience, either Medicaid, commercial, or Medicare. Nearly 75 percent were in a plan with pre-OHP Medicaid managed care experience. Indeed, the depth of managed care capacity in Oregon is widely credited for the successful expansion of managed care under OHP.

Table 4-1

Characteristics of Prepaid Health Plans Participating in the Oregon Health Plan Since its Inception, as of December 1997

	OHP Start Date	OHP Termination Date	OHP Contractual Arrangement	Prior 1915(b) Waiver Provider	Commercial Enrollees	Medicare Risk/Cost Contractor	Type of Plan
CareOregon	**2/1/94**		**FCHP**	**N**	**N**	**---**	**Clinic**
Cascade Comprehensive Care[1]	2/1/94		PCO-FCHP-PCO-FCHP Conversion	N	N	---	Clinic
Central Oregon Independent Health Services	**10/1/95**		**FCHP**	**N**	**N**	**---**	**IPA**
Columbia Managed Care	2/1/94	1/31/95	FCHP	N	N	---	Clinic
Coordinated Healthcare Network	**2/1/94**	**3/31/96**	**FCHP**	**N**	**N**	**---**	**Clinic**
Evergreen Medical Systems	2/1/94		FCHP	Y	N	---	Clinic
FamilyCare	**2/1/94**		**FCHP**	**Y**	**N**	**---**	**Clinic**
Good Health Plan	2/1/94		FCHP	Y	Y	R	Open panel, HSC
InterCommunity Health Network	**3/1/94**		**FCHP**	**N**	**N**	**---**	**Clinic**
Kaiser Permanente	2/1/94		FCHP	Y	Y	R	Closed panel, HSC
Medford Clinic[2]	**2/1/94**	**9/30/1996**	**PCO**	**Y**	**N**	**---**	**Clinic**
Mid-Rogue IPA	11/1/95		FCHP	N	N	---	IPA
ODS Health Plan	**3/1/94**		**FCHP**	**N**	**Y**	**---**	**Open panel, HSC**
Oregon Health Management Services[3]	2/1/94		PCO-FCHP Conversion	Y	N	---	Clinic
PACC Health Plan	**2/1/94**	**9/30/1996**	**FCHP**	**Y**	**Y**	**C**	**Open panel, HSC**
PacifiCare of Oregon	2/1/94	9/30/96	FCHP	Y	Y	R	Open panel, HSC
PrimeCare	**2/1/94**	**6/30/95**	**PCO**	**Y**	**N**	**---**	**Clinic**
QualMed	3/1/94	8/1/1996	FCHP	N	Y	---	Open panel, HSC
Regence HMO Oregon[4]	**2/1/94**		**FCHP**	**Y**	**Y**	**R/C**	**Open panel, HSC**
SelectCare	2/1/94		FCHP	Y	Y	R	Open panel, HSC
SureCare[5]	**3/1/94**		**FCHP**	**N**	**Y (6)**	**---**	**IPA, HSC**
Tuality Healthcare	2/1/94		FCHP	Y	N	---	Clinic

[1] Formerly known as Klamath Comprehensive Care.
[2] Medford Clinic was taken over by Oregon Health Management Services in October 1996.
[3] Formerly known as Grants Pass Management Services.
[4] Formerly known as HMO Oregon.
[5] Formerly known as RHEI Health Plan.
[6] RHEI began as an OHP only plan, but subsequently entered into commercial contracts as well.

Since its inception, OHP has contracted with seven plans that were initially organized to participate in the program. In addition to five that were among the original contractors, two new plans entered OHP in 1995. Four of the start-up plans were "clinic-based" models, in which one or more clinics or group practices accept risk as a managed care organization. Three of these served a single market area. The fourth, CareOregon, is a joint venture of the Multnomah County Health Department, the Oregon Health Sciences University (OHSU), and federally-qualified health centers (FQHCs) around the State. The plan was developed to ensure continuity of care to the indigent population traditionally served by these providers and to preserve their Medicaid revenue stream. As of July 1997, CareOregon enrolled 9 percent of the OHP population in capitated managed care and was the third largest plan. CareOregon initially served 11 counties and has since expanded to 14. However, the vast majority of its enrollees reside in the Portland metropolitan area (Multnomah, Clackamas, and Washington Counties).

The remaining three start-up plans are sponsored by local IPAs. SureCare (formerly Roseburg Health Enterprises, Inc.) has been the sole OHP contractor in most of Douglas County, a rural area in southwestern Oregon, since the beginning of the program.[8] Rather than contract with the large statewide plans, the local physicians chose to organize their own OHP plan to keep Medicaid revenues at home and "eliminate the middleman."[9] Although it originally enrolled only OHP members, SureCare subsequently expanded into the

[8] HMO Oregon serves OHP members in a small area of Douglas County near Coos Bay.

[9] However, the IPA contracts with other managed care plans (including Regence HMO Oregon, SelectCare, PacifiCare, ODS Health Plan, and QualMed) for commercial accounts.

commercial market in November 1995. The plan also extended its OHP contract to cover Lincoln County beginning in October 1997.[10]

Following on the success of SureCare, Central Oregon Independent Health Services (COIHS) and Mid-Rogue Valley IPA (MidRIPA) entered OHP in 1995. Like SureCare, COIHS serves a rural area of Oregon. COIHS began operation in three counties and later expanded to cover the remaining four counties represented by the Central Oregon IPA. Subsequently, COIHS was approached by the IPA in the adjacent Columbia Gorge region and now also contracts for Hood River, Sherman, and Wasco Counties. COIHS is the sole OHP contractor in the counties it serves. MidRIPA serves Josephine and Jackson Counties. Unlike the other IPA-sponsored plans, MidRIPA competes with other plans and only accounts for 16 percent of its market.

During the first four years that OHP was in operation, seven plans left the program. Among these were two of the local, clinic-based start-up plans. Two PCOs terminated their contracts because they did not convert to FCHP status when OMAP elected to discontinue contracting with PCOs. However, the physician groups that sponsored these four plans have continued participating in OHP as subcontractors to other plans. The remaining departures were for-profit, commercial plans—PACC Health Plan, PacifiCare of Oregon, and QualMed. Both PACC and PacifiCare had participated in the 1915(b) program. With their departures, the remaining OHP plans with substantial commercial business are all non-profits. These three commercial plans had each sustained losses during their tenure in the program and, with the exception of PacifiCare, had failed to gain a sizable market share.

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[10] SureCare subsequently withdrew from Lincoln County in April 1998 after sustaining heavy losses.

The net effect of plan entries and exits has been an increase in the reliance of OHP on "non-mainstream" plans. Ten of the fifteen contractors as of December 1997 either were initially formed to contract with OHP or enroll only Medicaid beneficiaries. The market share of start-up plans grew from 15 percent in July 1994 to 25 percent in July 1997. The proportion of beneficiaries in plans that only serve the Medicaid population also increased slightly over this time period, from 29 percent to 32 percent. Some State officials have expressed concern over the growing importance of start-up plans, which may be less stable than established plans. In addition, they believe that having commercial enrollees in a plan helps assure quality of care for Medicaid beneficiaries.

4.2.3 Changes in Contracting Plans over Time

There was considerable flux in OHP contractors during the first four years of the program, both in the number of plans contracting with OHP and in the counties served by each plan. Nearly one-third of the 22 plans that have contracted with OMAP since the inception of the program have withdrawn. However, the participating plans have been stable since October 1996.

Even more dramatic has been the turnover in the counties served by each plan (Table 4-2). Of the fifteen plans that remain in the program, six had not changed their market area as of December 1997. With the exception of Kaiser, each of these plans serves a single

Table 4-2

Changes in OHP Market Areas

	Change in Number of Counties Served Since Entering OHP	Number of Counties Served in December 1997
Plans with Stable Market Area		
Cascade Comprehensive Care[1]	0	1
Evergreen Medical Systems	0	2
InterCommunity Health Network	0	2
Kaiser Permanente	0	9
Mid-Rogue Valley IPA	0	2
SelectCare	0	1
Tuality Health Care	0	1
Expanding Plans		
CareOregon	+3	14
Central Oregon Independent Health Services	+7	10
FamilyCare	+3	11
Good Health Plan	+1	6
Oregon Health Management Services[2]	+1	2
SureCare[3]	+1	2
Consolidating Plans		
ODS Health Plan	-4	11
Regence HMO Oregon[4]	-10	16
Terminated Plans		
Columbia Managed Care	-1	0
Coordinated Healthcare Network	-3	0
Medford Clinic	-1	0
PACC Health Plan	-4	0
PacifiCare of Oregon	-7	0
PrimeCare	-1	0
QualMed	-11	0

[1] Formerly known as Cascade Comprehensive Care.

[2] Formerly known as Grants Pass Management Services.

[3] Formerly known as RHEI Health Plan.

[4] Formerly known as HMO Oregon.

market area. Kaiser contracts with OHP for all market areas where it enrolls commercial beneficiaries. Six plans expanded their market areas. COIHS had the most dramatic growth, increasing from three to ten counties. Three plans contracted their service areas. ODS Health Plan and Regence HMO Oregon (HMOO), the two largest OHP plans, have both significantly consolidated their market areas. ODS has dropped from 15 to 11 counties. By far the most marked changes, however, have been in the counties served by HMOO. HMOO entered OHP serving 26 counties and, at one point, contracted for 30 of Oregon's 36 counties. As of December 1997, HMOO had left nearly half of the counties it served, remaining in 16.

Eight of the counties from which HMOO departed are now served by local IPA-sponsored plans (seven by COIHS and one by SureCare). As a result, locally sponsored plans have emerged as increasingly important in OHP. These departures reflect dissatisfaction of the physicians in these rural communities with HMOO's centralized administration, which they perceive as being oriented to the urban areas of the State with mature managed care markets. According to OMAP staff, HMOO initially "bought a statewide network" by promising high rates, but then cut reimbursement in response to substantial losses. These reductions further disenchanted physicians in rural areas with HMOO. While HMOO was initially poised to provide a nearly comprehensive statewide network, its service area is now confined to the large population centers in western Oregon, along with five rural counties in the northeastern area of the State.

Including plans that no longer contract with OHP, there were 50 instances between the program's inception and December 1997 where a plan left a county it served. In some instances, the primary care physicians for a terminating plan were also affiliated with an ongoing contractor, in which case enrollees were assumed by the plan that continued in OHP. In other cases, as in the eight rural counties that left HMOO to affiliate with an IPA-sponsored plan, the provider panel simply transferred their contract to a new plan. In other instances, for example, when two of the commercial plans left OHP, enrollees were given an opportunity to choose a new plan. In one case, enrollees of a departing commercial plan were assigned to an existing plan that did not have an overlapping physician panel. OMAP considered this to be a failure and will not use this procedure in the future. In cases where no overlapping physician panel exists in the new health plan, OHP clients must find new care providers, which may cause disruptions in care, especially if clients use a number of different services. Although OMAP has been able to assure PCP continuity in many cases, plan changes may nonetheless have an impact on beneficiaries if, for instance, plans have different policies regarding specialist referral or enforcement of the priority list.

OMAP officials anticipate that the OHP market will remain dynamic. They question the stability of some of the remaining plans, particularly those without commercial business. They also expect rural areas to remain in flux as IPAs continue to "shop" the plans to find the best deal. One of the challenges to OMAP has been to make transitions following plan departures as transparent as possible for beneficiaries. To facilitate transition planning, OMAP has increased the notice that plans must give before terminating their contract from 30 to 90 days. In addition, OMAP has announced that it will only allow provider panels to

change plans in October at the start of a new contract year. According to OMAP, these policies are designed "to orchestrate the speed of change" and achieve stability in the delivery system, while remaining responsive to local conditions.

4.2.4 Market Consolidation

During the course of OHP, there has been a reduction in contracting plans, both program-wide and within counties. The total number of contracting plans has fallen from 20 to 15. While the number of counties without an OHP managed care plan has dropped from eight to two, as shown in Table 4-3, the number of plans operating per county has also fallen. In 1994, ten counties had more than four plans. By July 1997, only five counties had more than four plans. The number of counties with only one contractor, where beneficiaries do not have a choice of plan, has increased from 6 in 1994 to 15 in 1997.[11] Among these fifteen counties, four had no managed care contractors in 1994. While OMAP would theoretically like to offer a choice of plans in all areas of the State, in practice, its staff believe this is not feasible. Much of Oregon is sparsely populated and it is unlikely that more than one plan is viable. Of the 15 counties with one plan, six have fewer than 2,000 OHP eligibles and all but three have fewer than 5,000. Furthermore, in many of these areas, having an additional contractor might not improve access because nearly all of the physicians in the community contract with the sole OHP plan. On the other hand, the choice of another

[11] Including Douglas County, where SureCare is the sole contractor in most areas, there were 7 counties with only one plan in 1994 and 16 in 1997.

Table 4-3

Distribution of the Number of Plans Operating in Each County

Number of Plans Operating in County	Number of Counties			
	July 1994	July 1995	July 1996	July 1997
None	8	8	2	2
One	6	7	11	15
Two[1]	6	7	9	6
Three to Four	6	4	5	8
Five to Nine	7	7	8	5
Ten or More	3	3	1	0

[1] Douglas County is classified as having two plans. However, SureCare is the sole contractor in most of Douglas County.

plan could offer greater access to the extent that the alternative plan offered more generous policies regarding specialist referrals or less rigorous enforcement of the priority list.

Although a relatively large number of counties did not have any plans in 1994, these were sparsely populated counties. As shown in Table 4-4, only 3.6 percent of initial OHP eligibles lived in an area where managed care was not available. By 1997, less than 1 percent of eligibles lived in a county without any contracting plans. However, for those eligibles living in areas where managed care is available, the extent of choice has diminished. Other than six counties that originally had no plans, only two counties have seen an increase in the number of contractors. In total, the number of plans fell in 15 counties between 1994 and 1997. The most substantial reduction was in the Portland area from 12 to 7. In 1997, 14 percent of eligibles lived in a county with only one plan as compared to 5 percent in 1994 (Table 4-4). On the other hand, in 1994, 68 percent of eligibles had a choice of 5 or more plans, whereas only 43 percent of eligibles had this range of choices in 1997. Figure 4-1 shows the number of plans operating in each county in 1997. In general, counties where beneficiaries have substantial choice among plans are clustered in the western area of the State. In 1997, counties east of the Cascade Mountains (the geographic dividing line in Oregon) were served almost exclusively by a single plan per county.

The decreasing number of plans generally has not concerned OMAP. OMAP staff feel that, as a result of their open door contracting strategy, there was an unsustainable number of plans in some areas and that consolidation was inevitable. They note that most of the departing plans have had small enrollments. Managing the large number of

Table 4-4

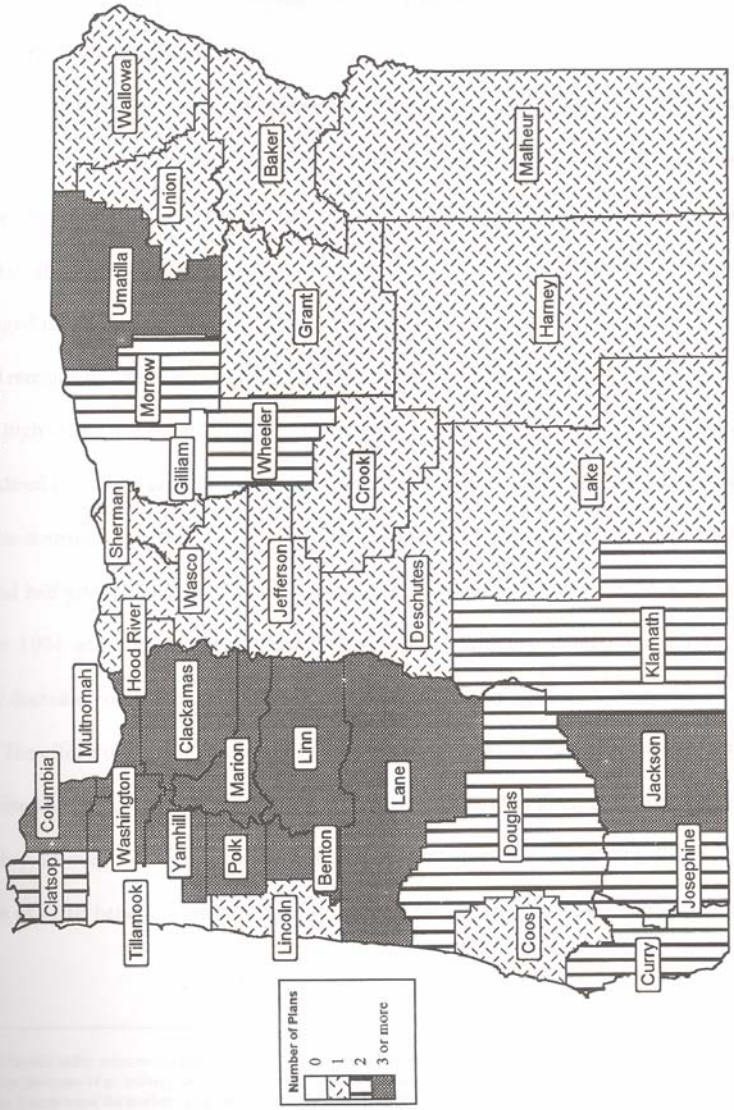
Distribution of OHP Eligibles by Number of Plans Operating in Each County 1994 and 1997

Number of Plans Operating in County	Percent of Eligibles July 1994	Percent of Eligibles July 1997
None	3.6%	0.8%
One	5.2	14.1
Two[1]	10.6	12.8
Three to Four	12.1	29.3
Five to Nine	35.4	43.0
Ten or More	33.0	0.0

NOTE: Columns sum to 100 percent.

[1] Douglas County is classified as having two plans. However, SureCare is the sole contractor in most of Douglas County.

Figure 4-1
Number of Plans by County: July 1997



Note: Douglas County is classified as having 2 plans. However, SureCare is the sole contractor in most of Douglas County.

contractors was also administratively burdensome. Indeed, OMAP staff consider even the remaining number difficult to manage.

Despite the large number of contractors, OHP enrollment is concentrated in a small number of plans. Table 4-5 shows OHP market share, by plan, from 1994 to 1997. In 1994, the five largest plans—CareOregon, Kaiser, ODS, HMOO, and SelectCare—enrolled 69 percent of all OHP members in managed care. The market share of the top five plans was unchanged in 1997, although Good Health Plan replaced SelectCare among the top five. HMOO remains the predominant plan. However, it has lost market share over time, falling from a high of 43 percent in 1996 to 33 percent in 1997. In contrast ODS, which also consolidated its market area, increased its market share from 7 percent to 12 percent. One of the most striking changes is the emergence of COIHS, which entered OHP in October 1995 and had grown to the sixth largest plan by 1997. Although the number of plans fell between 1994 and 1997, the Herfindahl Index, which measures market concentration, actually decreased over this time period due to HMOO's declining market share.[12]

The effects of market consolidation are even more striking when plan market share is examined by market area. Table 4-6 shows the market shares of plans in the counties in which they operate. Four plans dominate the market areas they serve, enrolling 80 percent or more of OHP beneficiaries enrolled in managed care (Cascade Comprehensive Care,

[12] The Herfindahl Index summarizes the distribution of market shares among plans. The Index was developed to measure the competitiveness of an industry by calculating the extent of market concentration. The higher the Herfindahl Index, the more concentrated the market. The OHP Herfindahl Index fell from 1,788 in 1994 to 1,501 in 1997. The Herfindahl Index is defined as the sum of the squares of plan market shares.

Table 4-5

Statewide Managed Care Enrollment and Market Share: By Plan 1994 to 1997

	JULY 1994		JULY 1995		JULY 1996		JULY 1997	
	Number of Enrollees	Managed Care Market Share	Number of Enrollees	Managed Care Market Share	Number of Enrollees	Managed Care Market Share	Number of Enrollees	Managed Care Market Share
Total Enrollees in Managed Care Plans	**188,957**	**100.0%**	**295,687**	**100.0%**	**300,184**	**100.0%**	**288,150**	**100.0%**
CareOregon	16,951	9.0	25,288	8.6	24,635	8.2	26,326	9.1
Cascade Comprehensive Care[1]	4,503	2.4	5,818	2.0	5,432	1.8	5,756	2.0
Central Oregon Independent Health Services	0	0.0	0	0.0	1,887	0.6	19,191	6.7
Columbia Managed Care	264	0.1	0	0.0	0	0.0	0	0.0
Coordinated HealthCare Network	713	0.4	1,729	0.6	0	0.0	0	0.0
Evergreen Medical Systems	1,781	0.9	1,681	0.6	1,692	0.6	1,363	0.5
FamilyCare	7,278	3.9	9,224	3.1	10,790	3.6	12,854	4.5
Good Health Plan	5,648	3.0	16,651	5.6	19,920	6.6	23,718	8.2
InterCommunity Health Network	1,555	0.8	5,845	2.0	7,167	2.4	10,629	3.7
Kaiser Permanente	17,765	9.4	17,960	6.1	19,476	6.5	19,871	6.9
Medford Clinic	3,584	1.9	5,412	1.8	5,138	1.7	0	0.0
Mid-Rogue IPA	0	0.0	0	0.0	4,059	1.4	4,443	1.5
ODS Health Plan	13,062	6.9	25,610	8.7	25,760	8.6	34,186	11.9
Oregon Health Management Services[2]	3,744	2.0	4,042	1.4	3,969	1.3	9,640	3.3
PACC Health Plan	4,156	2.2	6,574	2.2	3,310	1.1	0	0.0
PacifiCare of Oregon	7,633	4.0	13,350	4.5	10,035	3.3	0	0.0
PrimeCare	4,585	2.4	0	0.0	0	0.0	0	0.0
QualMed	2,498	1.3	1,942	0.7	1,629	0.5	0	0.0
Regence HMO Oregon[3]	71,771	38.0	123,809	41.9	127,809	42.6	95,603	33.2
SelectCare	11,301	6.0	15,683	5.3	12,801	4.3	11,570	4.0
SureCare[4]	8,989	4.8	12,892	4.4	12,439	4.1	11,044	3.8
Tuality Health Care	1,176	0.6	2,177	0.7	2,236	0.7	1,956	0.7

[1] Formerly known as Klamath Comprehensive Care.

[2] Formerly known as Grants Pass Management Services.

[3] Formerly known as HMO Oregon.

[4] Formerly known as RHEI Health Plan.

Table 4-6

Plan Market Share in Counties of Operation

	July 1994	July 1995	July 1996	July 1997
	Percent	Percent	Percent	Percent
CareOregon	12.5	12.0	10.2	11.5
Cascade Comprehensive Care[1]	87.2	79.3	76.8	79.6
Central Oregon Independent Health Services	N/A	N/A	88.1	99.9
Columbia Managed Care	0.6	N/A	N/A	N/A
Coordinated Health Network	1.1	1.6	N/A	N/A
Evergreen Medical Systems	3.2	1.8	1.9	1.6
FamilyCare	7.8	6.1	7.0	8.7
Good Health Plan	7.7	13.8	14.3	18.5
InterCommunity Health Network	14.6	40.1	50.3	82.8
Kaiser Permanente	16.6	10.7	11.5	12.8
Medford Clinic	30.4	30.4	26.6	N/A
Mid-Rogue IPA	N/A	N/A	13.2	15.5
ODS Health Plan	10.7	13.6	13.5	19.4
Oregon Health Management Services[2]	51.1	36.8	12.9	33.6
PACC Health Plan	4.6	4.6	3.0	N/A
PacifiCare of Oregon	7.7	8.4	8.0	N/A
PrimeCare	38.9	N/A	N/A	N/A
QualMed	1.8	1.8	1.4	N/A
Regence HMO Oregon[3]	39.4	43.3	45.0	44.5
SelectCare	50.1	48.7	39.6	38.1
SureCare[4]	92.1	93.0	92.9	93.3
Tuality Health Care	9.5	11.0	11.2	10.5

[1] Formerly known as Klamath Comprehensive Care.
[2] Formerly known as Grants Pass Management Services.
[3] Formerly known as HMO Oregon.
[4] Formerly known as RHEI Health Plan.

COIHS, InterCommunity Health Network, and SureCare). With the exception of Cascade Comprehensive Care, all are OHP start-up plans. Both ODS and HMOO increased their market share in the counties in which they remained after consolidating. In its counties of operation, HMOO accounts for nearly half of the OHP population in managed care.

4.3 Role of Physicians in OHP

OHP has had a major effect on the organization of physicians in Oregon. This is most clearly evidenced by the development of IPAs. Prior to OHP, IPAs were mainly confined to the population centers in the western part of the State. According to the Oregon Medical Association (OMA), by 1997, physicians in virtually every county in the State were represented by at least one IPA. The OMA identifies 16 IPAs that have formed since 1993, all in direct response to the advent of OHP.[13] As OHP introduced managed care into areas of the State where it had not been seen before, physicians perceived a need to organize themselves both for contracting purposes and to counteract the power of managed care organizations. These physician groups, particularly in rural areas where they usually represent the entire physician community, have a growing sense of their importance in the managed care system and have increasingly been willing to exercise their bargaining power.

A spectrum of models of physician participation has emerged under OHP. At one end, are physician-sponsored plans such as SureCare, COIHS, and MidRIPA. At the other end are physician groups that contract with plans. The Mid-Valley IPA, which represents

[13] Personal communication with Joy Conklin, Oregon Medical Association.

nearly all physicians in the Salem area outside of the Kaiser system, contracts with several OHP plans, including HMOO, ODS, and CareOregon. In the middle of the spectrum are IPAs that contract with outside plans (for example, those in Lane and Coos Counties), but maintain control of functions such as utilization review. These IPAs view the managed care plans with which they contract as third-party administrators and have sought a direct relationship with OMAP, for example, in submitting their own encounter data and attending contractors' meetings. The State, however, has resisted the development of these direct relationships, viewing them as administratively burdensome. It remains to be seen whether these IPAs will build on the experience gained while exercising this quasi-control and make the transition to sponsoring their own plans.

The path taken by local physician groups is a product of individual personalities, local market conditions, and geography. The formation of SureCare, the earliest physician-sponsored plan, has been described as a function of the entrepreneurial atmosphere in the community, as well as strong leadership by several members of the medical community and a business entrepreneur. The COIHS administrator also cited the importance of Central Oregon's entrepreneurial environment. Because of their geographic isolation, many of Oregon's rural counties have largely self-contained delivery systems, which has also fostered the formation of locally-controlled plans. Absent a schism within the physician community, the IPA offers the only contracting alternative for physician services and, as such, has considerable leverage relative to managed care plans.

Ironically, the absence of prior managed care experience appears to facilitate the formation of locally controlled plans. Commercial managed care plans were introduced in Douglas County at roughly the same time as OHP. On the other hand, managed care has still not penetrated the market in Central Oregon because of its sparse population and the absence of large employers. Therefore, neither the Douglas County or Central Oregon IPA had a strong existing relationship with outside managed care plans. In contrast, the Salem IPA has a long-standing involvement in commercial managed care. Their relationship with precursors of HMOO dates back to the 1970s. With 45,000 commercial lives insured by HMOO, the Salem IPA sees a high political cost to breaking with the plan. Likewise, unlike the rural markets, HMOO has much at stake if it alienates physicians in the Salem area. While HMOO sharply reduced its rates in rural areas in response to large losses in 1996, the Mid-Valley IPA's payment rates have remained unchanged.[14] According to one physician in the Columbia Gorge IPA, which currently contracts with COIHS, HMOO de facto withdrew from the market there when it raised the withhold to 30 percent. Subsequently, the Columbia Gorge IPA discontinued its contract with HMOO and affiliated with COIHS. The transfer of Lincoln County from HMOO to SureCare was also driven partly by rate cuts.

While Mid-Valley IPA administrators note that they have "taken heat" from other IPAs for not striking out on their own, they are not interested in becoming a direct OHP contractor and maintain that it would not be cost-effective for them to take on functions such

[14] On the commercial side, the Mid-Valley IPA was able to negotiate a reduction in HMOO's proposal to increase their 15 percent withhold from 30 percent to 20 percent (Oregon Health Forum, October 1997)

as claims processing. Nonetheless, they have proposed assuming responsibility for referral authorizations, which are currently handled centrally by the plans with which they contract.

The increasing importance of locally-sponsored rural plans like SureCare and COIHS represents a revolt against the large statewide plans. Providers in these plans express a desire to retain funds in the local community and to reduce administrative costs by "eliminating the middleman" so more resources can be directed to patient care. These plans also reflect a belief that utilization management functions are best handled locally and that physicians will have greater incentives to manage care efficiently if they own the plan. In contrast to the large statewide plans, SureCare and COIHS have given local providers responsibility for referral authorizations when they have expanded into new markets. Although having a well-developed managed care market contributed to the successful transition to statewide managed care under OHP, transferring administrative and reimbursement mechanisms from mature markets to areas of the State without managed care experience has not always worked well. Providers in rural areas needed to be educated about how to function in a managed care system and the large plans were not prepared to take on this role. The administrators of SureCare and COIHS see provider education in managed care techniques as an important part of their function.

Despite its successes, SureCare has experienced growing pains. Administration of SureCare was split from the Douglas County IPA in 1997, partly in response to some providers' perceptions that the IPA was indistinguishable from SureCare and was not adequately representing their interests. SureCare also is planning major changes in its

reimbursement structure. In the past, primary care physicians were subcapitated for office visits and received a small case management fee. Because of concerns that this system did not provide incentives for delivery of quality care, SureCare will move to discounted fee-for-service payments in 1998 with a larger case management fee that is adjusted for performance on a variety of quality and utilization indicators.

While OMAP does not expect to see new IPA-sponsored plans emerge, they do think that the OHP delivery system in rural areas will remain in flux with providers either switching between the large plans in search of more favorable arrangements or allying with the existing IPA-sponsored plans. Because of this, as described previously, OMAP has instituted new policies that would allow provider panels to switch plans only at the beginning of the contract year. SureCare and COIHS have already expanded beyond their initial markets. While both plans say that they have not actively sought expansion into new areas, they are willing to do so when approached by local provider organizations. Although most rural areas of Oregon are too sparsely populated to support a locally-sponsored plan, combining rural markets under a single network may be a viable strategy for spreading risk. Both plans indicate that they have been approached by additional IPAs seeking to contract with them.

4.4 Impact of OHP on the Health Care Market

OMAP is a major purchaser of health insurance in Oregon. According to OMAP, approximately 10 percent of the population is enrolled in OHP. There are currently six plans

in OHP that enroll both Medicaid and commercial populations. The importance of OHP to these plans varies considerably. Table 4-7 shows OHP enrollees as a percent of total membership in these plans as of June 30, 1997. With the exception of SureCare, which began as an OHP plan, OHP constitutes a minor share of the enrollment in these plans. Over 60 percent of SureCare's membership are OHP beneficiaries. At the other end of the spectrum, only 6 percent of the enrollees in Kaiser are eligible for OHP. While not a majority, OHP enrollees comprise a substantial share of the member base in ODS (25 percent) and HMOO (20 percent).[15] On average, OHP accounts for 16 percent of the enrollees in OHP managed care plans with commercial business. Including plans that do not enroll OHP members, OHP beneficiaries constitute about 8 percent of enrollees in all commercial plans in Oregon.

The extent to which OHP has had an impact on the health care market beyond Medicaid varies across the State. While the market in the Portland metropolitan area and other population centers in the western portion of Oregon has been extremely dynamic since the introduction of OHP, this is seen as largely driven by the highly competitive commercial and Medicare markets. In rural areas however, the spillover effects of OHP have been substantial.

Most significantly, OHP first introduced managed care to much of rural Oregon. OMAP staff have described OHP as "putting a face on managed care" and making it less

[15] Blue Cross Blue Shield of Oregon offers a second managed care product in addition to Regence HMO Oregon. When enrollment in this plan is included, OHP accounts for only 9 percent of enrollment in managed care plans sponsored by Blue Cross Blue Shield.

Table 4-7

Enrollment in OHP Managed Care Plans with Commercial Members, June 30, 1997

Plan Name	OHP Enrollees	Total Enrollees	OHP as Percent of Total
Good Health Plan	25,377	183,187	13.9
Kaiser Permanente	20,160	331,489	6.1
ODS Health Plan	36,176	139,574	25.9
Regence HMO Oregon[1]	90,576	460,560	19.7
SelectCare	11,991	103,788	11.6
SureCare[2]	11,114	17,948	61.9
ALL OHP PLANS	**195,394**	**1,236,546**	**15.8**
ALL MANAGED CARE PLANS IN OREGON	**195,394**	**2,359,869**	**8.3**

[1] Formerly known as HMO Oregon.
[2] Formerly known as RHEI Health Plan.

SOURCE: Oregon Department of Insurance.

threatening to providers in these areas. Furthermore, they say that OHP provides "training wheels" for plans and the lessons learned by providers under OHP will benefit commercial plans that enter these areas. OHP is also viewed as instrumental in engaging rural physicians with the business side of medical care for the first time. This has promoted a desire among physician organizations to manage their own risk and the insurance function. As described previously, in some cases this has already led IPAs in some areas to split with the large statewide plans. However, State officials are skeptical that the physician groups understand what it means to fully assume risk. One official expressed concern that there could be a backlash against managed care in the rural areas if local plans fail.

OHP has also funded the start-up of new provider-sponsored plans. OMAP staff attribute this to their "open door" contracting policy, as well as issuance of county-by-county contracts. They contrast Oregon's experience with Washington State, which uses competitive bidding to contract with providers for its Medicaid managed care program. Unlike Oregon, IPA-sponsored plans have not emerged in Washington. OHP provides start-up plans, particularly those that are the sole contractor in their service area, with an assured population base and cash flow. In contrast to the highly competitive commercial market, start-up costs for OHP plans are relatively low. Having gained experience in Medicaid, several OHP-only plans are now expanding their markets. In a reversal of the usual scenario in which existing commercial and Medicare plans enter the Medicaid market, plans that initially served only OHP enrollees have spawned commercial and Medicare products.

To date, only SureCare has made the transition beyond OHP business, first enrolling commercial clients in 1995. According to plan administrators, including OHP, SureCare covers roughly one-fifth of the non-Medicare insured population in Douglas County. Diversification into commercial business is part of a long-term strategy to assure the plan's survival. Plan administrators note that, because it is a demonstration project, the future of OHP is not assured. Furthermore, they believe that the OHP population in Douglas County does not provide an adequate base for risk-spreading. For this reason, SureCare has also expanded into additional counties on both the commercial and OHP sides. A second OHP-only plan, FamilyCare, received a Health Care Services Contractor (HCSC) license and began marketing a commercial product in Southern Oregon in early 1998. The IPA in northeastern Union County, which was formed to contract with OHP, has allied with the local hospital to sponsor a managed care plan for hospital employees. If successful, this is seen as a precursor to a locally-sponsored commercial product that could challenge outside HMOs.[16]

The potential for establishing commercial plans in much of rural Oregon is likely to be limited by the small population and absence of large employers. However, Medicare provides an alternative market for rural plans. In June 1997, only 19 percent of rural Medicare beneficiaries were enrolled in a managed care plan, as opposed to more than 51 percent in the population centers of Portland, Salem, and Eugene.[17] Although it sees limited

[16] The Office for Oregon Health Plan Policy and Research, op cit.

[17] Oregon Health Forum, September 1997.

commercial opportunities in Central Oregon, COIHS has applied for HCSC status in order to enter the Medicare market. If it is not granted a HCSC license, COIHS intends to apply for entry into the Medicare market as a provider sponsored network (PSN). Cascade Comprehensive Care has also expressed interest in entering the Medicare market.[18] Balanced Budget Act provisions that permit contracting with PSNs should encourage expansion of OHP plans into Medicare.

4.5 Lessons Learned

OHP has been able to maintain a statewide network of managed care plans, even in isolated areas of the State with small population bases. OHP administrators attribute their success to the strong foundation of managed care in Oregon, as well as contracting policies that encouraged the formation of locally-sponsored plans. Bringing managed care to nearly every county in Oregon is one of OHP's notable achievements. County-by-county contracting has brought forth local managed care models that may fit Oregon's diverse communities better than "one size fits all" statewide plans.

However, these successes have not been without costs. The large number of plans increased the administrative complexity of OHP and may have made it more difficult to monitor and enforce policies such as encounter data collection. In addition, several markets ended up with an unsustainable number of plans, leading to a sizable number of plan departures in the early years of the program. The growing importance of locally-sponsored

[18] Oregon Health Forum, November 1997.

plans has also made OHP more reliant on start-up and Medicaid-only plans. Compared to established commercial entities, the long-run stability of these managed care plans is uncertain. There are persistent concerns that provider-sponsored plans are not fully prepared to act as insurers and manage risk. Contracting with plans that only serve the Medicaid population also fosters the impression that beneficiaries are receiving second-class medical care.

It is notable that, even in a State with a mature managed care market, OHP has had significant effects on the health care market in Oregon. Impacts in the population centers in the western portion of the State, where managed care was well-established, have been less dramatic than in rural areas.

In rural Oregon, OHP was instrumental in establishing the first toehold of managed care. In response, physicians organizations have emerged to coordinate managed care contracting and to consolidate the power of the local medical community. Locally-sponsored plans are expanding, as providers resist the encroachment of statewide plans in their communities. OHP plans are now diversifying into the commercial and Medicare markets. However, plans that originate in a Medicaid program may find themselves stigmatized as "second class" plans for the indigent population, making it difficult to expand into the privately-insured and Medicare markets. On the other hand, IPA-sponsored plans in rural areas that include all of the local providers may find themselves less encumbered by their Medicaid origins.

Managed care contracting in OHP has been a dynamic process marked by the emergence of new entities, departures of others, and shifting provider alliances. It is not clear whether the OHP market is approaching equilibrium or whether it will remain in flux. Although a number of plans anticipate diversification from OHP into the commercial and Medicare markets, most of these products are in the planning stages and their prospects for long-run success are unknown. In this chapter, we have described Oregon's experience through the end of the fourth year of OHP. However, the story of OHP impacts on Oregon's health care market will continue to evolve.

5 Impact of the Priority List on OHP Eligibles

5.1 Statement of the Problem

Over the last five years, a growing number of states, including Oregon, have received Section 1115 waivers from the Health Care Financing Administration (HCFA) to expand Medicaid eligibility. As in Oregon, most of these states have financed this expansion through savings generated by increased enrollment in managed care and revenues generated by earmarked cigarette tax revenues. Only Oregon, however, has taken the innovative step of using a priority list of health services to help underwrite its eligibility expansion. This priority list consists of paired conditions and treatments that are ranked hierarchically from most to least medically necessary. (The development of this list has been described in detail by others; see, for example, Bodenheimer, 1997.) Covered services are those above a cut-off line that is established based on the budgetary resources available to fund the Medicaid program in a given period. Services "below the line" are uncovered, except in cases where there is a comorbid condition that would qualify the service for coverage.[1]

The priority list was explicitly designed to give the State the ability to control Medicaid expenditures by rationing the types of services that are covered. This approach was deemed preferable to previous cost control efforts that focused on cutting provider payments or restricting eligibility for selected populations. In cases of a budget shortfall,

[1] This exceptions process was developed to help ensure against inappropriate denials of service. Tonsillectomy and adenoidectomy procedures, for example, are "below the line". However, should the enlarged tonsils and adenoids obstruct the upper airway leading to sleep apnea (a comorbid condition), then this surgery would be covered.

the line could be moved upwards, thereby restricting the number of funded services. The hierarchical nature of the priority list would ensure that the least medically necessary services would be dropped first.

Outside Oregon, the use of this list has been highly controversial and delayed the approval of the waiver for two years. Within the State, however, there has been relatively little criticism for two reasons. First, the implementation of the Oregon Health Plan (or OHP, as the State has named its expanded Medicaid program) has extended insurance coverage to approximately 100,000 previously uninsured residents. Second, the list of covered services actually expands the benefit package for adults from what had been provided under the State's traditional Medicaid program to include dental care, preventive care, and organ transplants.

Nevertheless, there are some "below the line" services that may pose hardship for OHP clients when they are not covered. Media attention in Oregon has focused on two in particular, treatment of club foot in children and repair of symptomatic hernias in adults, but there are many other uncovered services. In 1996, the line was set at 578 out of a total of 744 treatment-condition pairs; this means that there were a total of 166 (744-578) "below the line" services. To date, however, there has only been anecdotal evidence regarding the frequency and nature of such uncovered services. There is no information on how often OHP clients are denied treatment because the service is "below the line", what kinds of services these represent, or the resulting health impact, if any. This paper seeks to answer these questions for the first time.

5.2 Data and Methods

Because services that fall "below-the-line" by definition are not covered by OHP, there is no administrative "paper trail" by which to identify the extent to which OHP eligibles do not receive such services.[2] For this reason, we designed a survey to determine the frequency with which this occurs.

Sample Selection

Three categories of OHP eligibles were identified for inclusion in the survey: traditional Medicaid eligibles under the Aid to Dependent Children (ADC) program; and two groups in the expansion population, New Families and New Adults/Couples. Individuals' experience under OHP may vary depending on whether they are enrolled in managed care or have an "open card" (OHP's term for fee-for-service). For this reason, we also stratified each eligibility category along this dimension as well. A total of seven strata were created for sampling purposes:

1. ADC – in fee-for-service prior to the start of OHP (January 1994) but then enrolled in a managed care plan;
2. ADC – in fee-for-service prior to OHP but then remaining in fee-for-service;
3. ADC – in managed care prior to OHP and remaining in a managed care plan;
4. New Adult/Couple – enrolled in a managed care plan;
5. New Adult/Couple – in fee-for-service;

[2] If below-the-line services are provided, managed care plans are still required to submit encounter reports for them. However, OHP's encounter data have been found to be woefully incomplete thus far. Of course, there still would be no record of below-the-line services that were not provided anyway.

6. New Family – enrolled in a managed care plan; and
7. New Family – in fee-for-service.

Because only a small percent of OHP eligibles remain in fee-for-service (about 10% in Phase 1), these strata were over-sampled.

The strata were defined using the OHP eligibility and enrollment files. The sampling frame was defined as all OHP eligibles aged 19 to 64 years of age as of April 15, 1996.

Data Collection

The survey was designed as a short mailed questionnaire. In addition to questions on any services that were denied by OHP, questions were included on satisfaction with care and health status. For the expansion population, questions were also included on usual source of care and the availability of health insurance prior to joining OHP.

Data collection took place between May and October 1996. The questionnaire was mailed to 2,669 OHP eligibles, with telephone follow-up of non-respondents. Completed surveys (including both returned questionnaires and telephone interviews) were obtained for a total of 1,438 respondents for a response rate of 54 percent. Almost all of the non-responses were due to an inability to locate the individual, usually because he/she had moved. Less than 100 of the non-responses were attributable to the individual refusing or being incapable of completing the survey. Respondents were somewhat more likely to be female, white, and middle-aged, compared with those not completing the survey.

Table 5-1 shows the final unweighted sample sizes for each of the seven strata. In all analyses, observations are then weighted to adjust for oversampling and non-response bias. Table 5-1 also displays the relative frequency of each stratum, after weighting back to their population prevalence.

Defining Uncovered Services

All respondents were asked the following question:

> "Since joining the Oregon Health Plan, have you been told that the Oregon Health Plan would not pay for a test, service or treatment that you thought you needed?"

Respondents answering "yes" were then asked the following two open-ended questions:

> "What test, service, or treatment was it?" and
> "Why wouldn't they pay for it?"

Verbatim responses to both questions were reported on the survey. One of the methodological difficulties associated with such open-ended questions is how to reliably categorize the responses, and for this reason, these questions are rarely used in large surveys such as this one. Because of the large number of below-the-line services, however, it was not possible to develop a limited set of possible responses to the question on uncovered services.

Table 5-1

Sample Sizes

	Actual N	Weighted Frequency
Traditional Medicaid Population (ADC)	**600**	**20.6%**
Pre-OHP *OHP*		
FFS - MC	251	7.0
FFS - FFS	172	1.2
MC - MC	177	12.4
Expansion Population	**838**	**79.4**
New Family		
Pre-OHP *OHP*		
Unenrolled - FFS	160	3.1
Unenrolled - MC	212	41.4
New Adult/Couple		
Pre-OHP *OHP*		
Unenrolled - FFS	133	3.9
Unenrolled - MC	333	30.9
TOTAL	**1,438**	**100.0%**

NOTE: FFS = fee for service, MC = managed care.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

WEIGHTED FREQUENCY: Represents population prevalence within each group.

Using responses to both questions in tandem, we categorized each individual reporting an uncovered service along two dimensions: (1) the reason for the denial; and (2) the type of service.

Five categories were developed for the reason a service was not covered by OHP:

1. **Below-the-line.** The service could be clearly identified from the respondent's description as being uncovered by the priority list during the time in question (1994-1996). We were very conservative in our assignment of services to this category, including only those services described in sufficient detail that their below-the-line status could be validated and those services in which the respondent specifically mentioned the priority list as the reason that OHP would not pay.
2. **Managed care.** The service was not paid because the respondent did not adhere to the rules of the managed care plan. For example, they lacked a referral from their PCP (e.g., for an ER or specialist visit), sought care from an out-of-plan provider, or had exceeded the utilization limits (e.g., one eye exam per year).
3. **Other uncovered service.** This category included two types of services. First, some services clearly were above-the-line, but not covered for some other reason. In many instances, the reason for denial was unclear. Second, some services simply were not described in sufficient detail to determine whether they were above- or below-the-line.
4. **Not eligible.** Some respondents found that OHP would not pay for the service because they had lost their eligibility for the program.
5. **Unspecified.** The respondent reported that a service was not covered, but either could not remember the specific service or was sufficiently vague that the service could not classified in any of the preceding categories.

Services were also classified based by type of medical test or treatment. Table 5-2 lists the specific categories. Below-the-line services that were mentioned sufficiently frequently to be analyzed separately are shown in italics (as subsets of a larger category of service).

Statistical Tests

Chi-square tests were used to determine the statistical significance of all categorical variables, and t-tests for continuous variables. Logistic regression was used to estimate the odds that OHP would not pay for a service that client thought they needed; for those with uncovered services, the odds that they would receive it anyway; and for those who did not succeed in getting it anyway, the odds that their health had worsened as a result. Because of the complex sample design, it is inappropriate to use statistical procedures that assume simple random sampling. Weighting and standard error adjustments have been made using SUDAAN software.

5.3 Results

Who Doesn't Receive a Service and Why?

About one-third of all respondents (31.8%) reported that they had needed a service that OHP would not pay for (see Table 5-3). Traditional Medicaid eligibles were significantly more likely to report an uncovered service, compared with the expansion eligibles (43% vs. 29%). Within the expansion population, there were no differences in rates of uncovered services between newly eligible families and newly eligible adults/couples (data not shown). OHP eligibles enrolled in managed care plans also were somewhat more likely to report an uncovered service, compared with those remaining in fee-for-service (32% vs. 29%).

Table 5-3

Who Doesn't Receive a Service and Why?

	Expansion Population	Traditional Medicaid	Managed Care	Fee-for-Service	All Eligibles
Any services OHP wouldn't pay for but you thought you needed?					
Percent yes	29.0%	42.6%*	32.1%	28.8%	31.8%
Percent yes (excluding those with lapse in eligibility)	28.9	41.1*	31.3	25.4#	31.3
Reason for Denial[a]					
Below-the-line service	37.7	35.4	37.6	30.6	37.1
Managed care	28.0	29.3	28.8	23.0	28.4
Other uncovered service	28.4	22.6	26.5	31.4	26.8
Lapse in eligibility	0.7	6.0	1.6	9.5	2.1
Unspecified	5.1	6.8	5.6	5.4	5.6

[a] Columns sum to 100 percent.

* Significantly different from the expansion population at the .05 level.

Significantly different from the managed care population at the .05 level.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

Why wouldn't OHP pay for these services? The most important reason was that the service was below-the-line (37% of denials, or 12% of all eligibles). The bulk of the remaining cases were uncovered either because of managed care plan rules and procedures (28%) or because of some other reason (27%). As noted in section 5.2 above, some services included in the last category probably were below-the-line, suggesting that the 37 percent figure may be an under-estimate of all denials attributable to the priority list. In addition, the number of reported denials may be underestimated, since the questionnaire collected information on only one incident of denial per respondent. It is possible that some respondents experienced numerous denials.

A small number of respondents, almost all of them traditional Medicaid eligibles with open cards, reported that OHP would not pay for a needed service because of a lapse in program eligibility. Because our focus is on uncovered services *while the individual was enrolled in OHP*, these responses were re-coded as "no uncovered service" in all subsequent analyses. This change served to widen the differential between managed care and fee-for-service, with OHP eligibles in managed care plans now significantly more likely to report uncovered services (31%) than those in fee-for-service (25%).

Among those who did report an uncovered service, OHP eligibles in fee-for-service were as likely as those actually enrolled in managed care to cite a "managed care" type of reason as to why OHP would not pay for the service. This seemed counter-intuitive, given their open cards, but review of their verbatim responses identified two distinct explanations. First, all of the fee-for-service eligibles were enrolled in capitated dental care organizations

(DCOs), and some had sought services from out-of-plan dentists. Second, a number of fee-for-service eligibles had gone to emergency rooms for care, and were later told that OHP would not pay for the visit, because the medical problem was not life-threatening and could have been treated in a physician's office.

What Types of Services Does OHP Not Pay For?

What types of services were not paid for by OHP? Table 5-4 displays a frequency distribution of uncovered services across the service categories we created. Dental care was by far the most common uncovered service, accounting for almost 17 percent of all services reported as denied by OHP. Other frequently cited types of service included: prescription drugs (7.5%), tests (9.7%), treatment of back problems (8.8%), surgery (9.7%), and ER visits (8.2%).

Table 5-4 also shows similar frequency distributions based on the reason for denial. Individual below-the-line services most frequently mentioned were chiropractic services (16%), circumcision of newborns (7.3%), TMJ splints (4.4%), hernia repairs (5.8%), and allergy testing (3.6%). Removal of moles and warts (included under dermatology) also were frequently cited.

ER visits were by far the single most common reason for a managed care-related denial, accounting for over one-quarter of all such services. Dental care also was frequently mentioned here (14% of managed care denials), generally because the OHP eligible visited an out-of-plan dentist.

Table 5-4

What Types of Services Does OHP Not Pay For?[a]

	Reason for Denial			
	Below-the-Line	Managed Care	Other Uncovered Service	All[b]
Prescription drugs/medications	9.2%	4.0%	7.1%	7.5%
Tests	3.8	9.1	19.4	9.7
Lab Tests	0.2	0.4	14.0	3.9
X-rays	0.0	8.7	5.4	4.4
Allergy tests	3.6	0.0	0.0	1.4
Screening/prevention	6.6	4.9	5.7	5.6
Nicotine patches	5.8	0.0	0.0	2.2
Eye exams	2.3	4.3	1.1	2.4
Eye glasses/contacts	4.1	2.5	6.4	4.0
Dental care	9.7	14.2	32.5	16.7
TMJ splints	4.4	0.0	0.0	1.7
Dermatology	9.2	4.3	0.1	4.8
Back/neck treatment	22.8	0.6	0.0	8.8
Chiropractic care	16.0	0.0	0.0	6.1
Physical therapy/rehabilitation	6.2	3.9	6.4	5.3
Surgery	19.2	2.6	5.9	9.7
Circumcision	7.3	0.0	0.0	2.8
Hernia repair	5.8	0.0	0.0	2.2
Emergency room visit	0.0	27.5	0.7	8.2
Mental health services	0.2	8.2	3.8	3.6
GYN services	2.1	2.4	4.2	2.6
Podiatry	2.3	2.1	0.7	2.0
Other/unspecified	4.9	9.2	6.2	9.2

[a] Columns sum to 100 percent.

[b] Includes those reasons for denial that could not be categorized.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

The third group of uncovered services probably represents a mix of both below-the-line and managed care denials, as well as some potential access problems. Dental care accounts for one-third of this group. While we can not determine exactly why these services were not covered, we do know that the combination of limited dental capacity in Oregon, along with tremendous pent-up demand among the formerly uninsured, has led to serious access problems for many OHP clients.[3] Many respondents in this category reported that crowns and bridges were not covered. Under the priority list, whether or not crowns and bridges are covered depends on which teeth are involved (posterior crowns and bridges are below the line). The verbatim responses to the question did not contain this level of specificity. We suspect that they included a mix of above and below the line services.

Finally, tests, especially lab tests, also accounted for a disproportionate share (19%) of this third group of uncovered services. Since diagnostic tests are almost always above-the-line, this is puzzling. The type of lab tests reported as denied included pregnancy tests, HIV tests, and tests for cancer (unspecified), but with most simply described as "blood work". One possibility is that individuals used non-OHP participating laboratories and/or sought a lab test directly without a referral from their primary care provider.

[3] Since this survey was conducted, OHP has taken a number of steps to both increase supply and limit demand. Beginning in October 1996, the State "uncoupled" dental coverage from the prepaid health plans, and began to provide dental coverage exclusively through capitated Dental Care Organizations (DCOs). By giving dental providers direct control of the capitated payments, the State hoped to stimulate the entry of new providers to OHP. In January 1997, the State placed limits on the dental benefit itself, implicitly moving some services below-the-line.

Who Ends Up Getting the Service Anyway and Who Pays?

Respondents reporting an uncovered service were asked if they "got the service anyway". Surprisingly, fully one-half replied that they had ended up receiving the service after all (Table 5-5). Traditional Medicaid eligibles were significantly more like to receive an uncovered service than were those in the expansion population (60% vs. 47%). There were no differences between those with open cards and those enrolled in managed care plans. Who paid for these uncovered services? In over one-half of the cases, the client paid him/herself. In another third of the cases, the bill had not yet been paid. OHP ended up paying in a small number of cases (8%), apparently the result of either a formal appeals process or the successful attempt on the part of the PCPs to get the managed care plan to cover the service. Traditional Medicaid eligibles were significantly more successful in getting OHP to pay for their uncovered services than were those in the expansion group.

Lab tests, ER visits, newborn circumcision, and chiropractic services were the uncovered services that clients were most likely to get anyway. Table 5-6 displays these four services and who paid for them. Circumcision and chiropractic care (both below the line services) were overwhelmingly paid for by the clients. Lab tests and ER visits were largely unpaid, and presumably will become bad debts for their respective institutions.

The reason for denial would appear to have little relationship with whether or not the client received the service (Table 5-7). Although clients with managed care denials were somewhat more likely to get the service, this difference was not statistically significant. There is a strong relationship, however, with who paid for the service. The vast majority

Table 5-5

Who Ends Up Getting the Service Anyway and How?

	Expansion Population	Traditional Medicaid	Managed Care	Fee-for-Service	All Eligibles
Did you get the service anyway?					
Percent yes	46.6%	59.8%*	49.9%	52.0%	49.9%
If received the service, who paid?[a]					
Self	54.6	52.7	54.4	42.2	54.0
Other insurance	2.4	1.7	1.0	16.8	2.2
Hasn't been paid for	32.1	28.3	31.4	31.8	27.1
OHP	4.7	14.6*	8.2	5.6	7.9
Other	6.2	2.6	5.2	3.6	3.3

[a] Columns sum to 100 percent.

* Significantly different from the expansion population at the .05 level.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

Table 5-6

Who Pays for the Most Frequently Received Uncovered Services?[a]

	Self	Not Paid	OHP	Other Insurance
Chiropractic care	92.7%	7.3%	0.0%	0.0%
Circumcision	90.8	6.0	3.2	0.0
Lab tests	27.6	61.5	5.0	5.9
ER visits	10.8	85.9	3.3	0.0

[a] Rows sum to 100 percent.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

Table 5-7

Getting the Service Anyway: Relationship to Reason for Denial

	Reason for Denial		
	Below-the-Line Service	Managed Care	Other Uncovered Service
Percent receiving the service anyway	49.7%	58.8%	42.1%
If received anyway, who paid?[a] *			
Self	84.4	29.3	46.5
Not paid	7.4	55.2	29.2
OHP	2.3	12.6	11.8
Other	5.9	2.9	12.5

[a] Columns sum to 100 percent.

* Significantly different by reason for denial at the .05 level.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

(84%) of below-the-line services received anyway were paid out-of-pocket. By contrast, clients who received services that had been managed care denials were much less likely to pay for the services themselves; over one-half of these services remained unpaid.

Impact of Uncovered Services on Health Status and Satisfaction

While one-half of respondents ended up getting the service anyway, the other half were not successful. About 60 percent of these clients replied that their health "had gotten worse" as a result (Table 5-8). The difference between traditional Medicaid eligibles and the expansion group was not statistically significant at conventional levels (p=.08), presumably because of their relatively small sample sizes. OHP eligibles who did not receive a service because it was below the line were significantly more likely to report that their health had gotten worse, compared with those who had not received a service because of a managed care or some other reason. Presumably this reflect the difference in service mix across these categories of reason for denial. Virtually all individuals who had not received hernia repairs or nicotine patches (both below the line services), for example, reported that their health had gotten worse as result.

Table 5-8

Impact on Health Status of Not Receiving the Service

	Expansion Population	Traditional Medicaid	Managed Care	Fee-for-Service	All Eligibles
Did not receive uncovered service and health got worse?					
Percent yes	58.7%	72.3%	61.3%	62.4%	61.5%
	Reason for Denial				
	Below-the-line	Managed Care	Other Uncovered Service		
Did not receive uncovered service and health got worse? *					
Percent yes	77.6	66.2	41.3		

* Significantly different by reason for denial at the .05 level.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

In addition to the specific questions on uncovered services, all respondents were asked a series of other questions on health status and satisfaction with OHP. Health status questions included the twelve questions needed to construct the Physical and Mental Health components of the SF-12, and respondents' perception of their health status at the time of interview compared with a year ago. Satisfaction questions included respondent's satisfaction with the quality of care since joining OHP, and whether or not they would recommend OHP to a friend. We compared responses to all of these questions as a function of: whether or not they had needed a service that OHP would not pay for; whether or not they received the service anyway; and for those not receiving the service, whether or not their health had gotten worse as a result (Table 5-9).

Table 5-9

Satisfaction and Health Status for Eligibles With and Without Uncovered Services

	Uncovered Service?		Got Uncovered Service Anyway?		Didn't Get and Health Worse?	
Health Status	Yes	No	Yes	No	Yes	No
SF-12 Scores						
Physical Health Scale	41.7	47.5*	42.6	40.4	38.1	43.9*
Mental Health Scale	43.7	48.1*	45.6	41.6*	39.8	44.1
Health Compared to a Year Ago [a]	—	— *	—	—	—	— *
Much better	10.5%	18.9%	9.5%	11.9%	8.7%	17.5%
Somewhat better	19.4	17.0	20.5	18.5	14.5	24.7
About the same	38.6	48.6	41.6	35.8	31.1	41.2
Somewhat worse	21.7	11.4	19.3	22.8	29.9	12.0
Much worse	9.9	4.2	9.1	11.0	15.9	4.6
Satisfaction						
Since Joining OHP, satisfaction with quality of care has: [a]	—	— *	—	— *	—	—
Increased	43.4%	53.4%	36.7%	50.6%	52.5%	51.2%
Stayed the Same	36.9	38.9	40.9	31.9	31.1	35.1
Decreased	19.8	7.7	22.4	17.4	16.5	13.7
Would You Recommend OHP to a Friend? [a]	—	— *	—	—	—	—
Definitely yes	60.1%	74.9%	59.8%	61.7%	61.5%	66.7%
Probably yes	32.8	22.3	33.4	30.7	31.7	26.5
Probably no	3.3	2.3	2.0	4.6	3.0	6.5
Definitely no	3.8	0.5	4.8	3.0	3.9	0.3

[a] Columns sum to 100 percent.

* Significantly different from those OHP eligibles reporting "yes".

SOURCE: HER-RTI survey of OHP eligibles, 1996.

OHP eligibles reporting "yes" to the uncovered service question were in significantly poorer health than those responding "no", based on both the physical and mental health scales of the SF-12. (Lower scores indicate poorer health status.) Does this mean that OHP's denial of coverage led to this relatively poorer health? We can not determine any such causality for three reasons. First, the SF-12 questions capture health status based on self-reports for the four weeks prior to the interview. The uncovered service question, on the other hand, refers to any time since joining OHP, and thus could have occurred as long as two years prior to the interview. Second, OHP eligibles responding "no" to the uncovered service question include both those who did receive a needed service and those who may never have sought services (presumably because they were healthy and did not need medical care). Third, in a small number of cases, OHP eligibles reporting "yes" were actually referring to a service needed by a child or spouse.

Despite these caveats, it is noteworthy that eligibles reporting that OHP would not cover a needed service also were significantly more likely to rate their health as worse *compared to a year ago*. About 30 percent of those responding "yes" said their health was "somewhat worse" or "much worse" than a year ago, compared with only 15 percent of those without an uncovered service.

Not surprisingly, OHP eligibles with an uncovered service expressed considerably less satisfaction with the Oregon Health Plan. They were significantly more likely to report that their satisfaction with the overall quality of their medical care had decreased since joining OHP, and significantly more likely to state that they would not recommend OHP to a friend.

OHP eligibles who succeeded in getting the uncovered service anyway had significantly higher scores on the Mental Health Scale of the SF-12, compared with those who did not. (See the middle two columns of Table 5-9.) Although we can only speculate, it is possible that these relatively healthier individuals were better able to "work the system" to get what they felt they needed. There were no differences in physical health scores, or in self-reported health compared with a year ago. Interestingly, despite their success, OHP eligibles who got the service anyway were significantly less satisfied with the quality of their care since joining OHP. There were no differences, however, in the willingness to recommend OHP between those who did or did not succeed in getting the needed service.

Among those OHP eligibles not succeeding in getting the service anyway, those reporting that their health got worse as a result were, in fact, significantly less healthy than those who reported no adverse health impacts. These individuals had significantly lower scores on the physical health scale of the SF-12, and were significantly more likely to rate their health as worse compared to a year ago. The caveats raised earlier with regard to causality still apply here. There were no differences between the two groups in mental health scores or satisfaction with OHP.

Multivariate Analysis

Three logistic regressions were estimated: (1) the odds that the OHP eligible would report an uncovered service; (2) given an uncovered service, the odds that the eligible would get it anyway; and (3) given that the eligible did not succeed in getting an uncovered service, the odds that his/her health would be worse as a result. The same independent variables were included in all three equations. Means for all independent variables and the sample sizes included in each logistic regression are shown in Table 5-10.[4]

Two dummy variables were included to capture the reasons for OHP eligibility: (1) whether the respondent was part of the expansion population; and (2) whether the respondent was eligible as part of the New Adult/New Couple program. An additional dummy was included for those enrolled in managed care. Demographic characteristics included dummy variables for whether the respondent was male, white, or in one of the following age categories: 26-34 years of age, 35-44 years, 45-54 years, or 55 to 64 years of age. (Respondent aged 19 to 25 constituted the omitted category.) Two dummy variables captured geographic location: whether the respondent resided in a rural area or in an urban areas other than Portland. (Those living in Portland were the omitted group.) Finally, the two SF-12 scales were included to capture health status. As these scales are both specified as continuous variables, the odds ratios associated with them are interpreted somewhat differently from those associated with categorical (dummy) variables. Their odds ratios can be interpreted as the change in the odds of an uncovered service accompanying a one unit

[4] The sample used in the regression analysis is somewhat smaller than that reported earlier due to missing values. About 11 percent of respondents failed to answer one or more of the questions needed to construct the SF-12 scales.

change in the independent variable—in this case, an increase of one point in the SF-12 score (Hosmer and Lemeshow, 1989).

Table 5-10

Means for Logistic Regressions

	Odds of Uncovered Service (n=1,281)	Given an Uncovered Service, Odds of Getting It Anyway (n=435)	Given Did Not Get Anyway, Odds That Health Got Worse (n=203)
Expansion Population	0.79	0.74	0.79
Eligible as New Adult/New Couple	0.45	0.44	0.51
Enrolled in managed care plan	0.92	0.93	0.93
Male	0.42	0.36	0.35
White	0.85	0.93	0.97
Age: 26-34	0.30	0.33	0.27
35-44	0.28	0.26	0.32
45-54	0.14	0.17	0.18
55-64	0.08	0.08	0.07
Resident of rural area	0.38	0.41	0.40
Resident of urban area (excl. Portland)	0.27	0.29	0.25
SF-12 - Physical Health	45.68	41.66	40.56
Mental Health	46.65	43.77	41.76

SOURCE: HER-RTI survey of OHP eligibles, 1996.

Table 5-11 presents the odds ratios from the three logistic regressions. The reasons for eligibility, expansion vs. traditional Medicaid and New Adult/New Couple vs. family (including both New Families and the traditional ADC families), had no impact on the odds of having an uncovered service. Holding all other factors constant, however, OHP eligibles enrolled in managed care plans were 46 percent more likely to report an uncovered service than were those remaining in fee-for-service. This finding proved remarkably robust, remaining highly significant even when the definition of uncovered services was changed to exclude those services not covered by OHP for "managed care" reasons (logistic

regressions not shown). Presumably, managed care plans are better able to understand and operationalize the priority list. These organizations have traditionally devoted considerable resources to developing and implementing utilization review and care authorization procedures. This experience undoubtedly provides them with a strong foundation for allocating care through the priority list, compared with physicians in private practice.

Age and gender had no effect on the odds of having an uncovered service, but race

Table 5-11

Odds Ratios From Logistic Regressions

	Odds of Uncovered Service	Given an Uncovered Service, Odds of Getting It Anyway	Given Did Not Get Anyway, Odds That Health Got Worse
Expansion Population	0.71	0.73	0.82
Eligible as New Adult/New Couple	0.79	0.48	0.83
Enrolled in managed care plan	1.46*	0.97	0.84
Male	0.89	1.24	0.85
White	2.41*	0.48	3.93
Age: 26-34	1.41	0.91	1.88
35-44	0.97	0.44	1.86
45-54	1.47	0.80	1.50
55-64	1.54	1.74	1.21
Resident of rural area	1.40	1.01	1.85
Resident of urban area (excl. Portland)	1.36	1.64	3.01*
SF-12 - Physical Health	0.97*	1.01	0.97
Mental Health	0.97*	1.03*	0.97*

* Significant at the .05 level.

SOURCE: HER-RTI survey of OHP eligibles, 1996.

was highly significant. White eligibles were more than twice as likely to report that OHP would not pay for a service that they needed. Although admittedly *ex post*, the explanation would appear to lie in differential managed care enrollment patterns by race. (There were

no differences by race in the proportion remaining in fee-for-service.) Non-white OHP eligibles were more likely to enroll in CareOregon, the managed care plan formed by the traditional safety net providers in Oregon (e.g., Oregon Health Sciences University, the Multnomah County Health Department, and the FQHCs). Anecdotal evidence suggests that CareOregon was far less likely to deny needed services to its clients, even going so far as to cover below-the-line services and to pay OHP premiums for those who could not afford them.[5]

Geographic residence had no effect on the odds of an uncovered service. Residents of rural and smaller urban areas were as likely to report an uncovered service as were those living in Portland.

Finally, health status had a highly significant impact on the odds that OHP eligibles would report uncovered services. Persons with higher (lower) SF-12 physical health and mental health scores were significantly less (more) likely to state that OHP had refused to cover a service that they needed. The odds ratios associated with each of the SF-12 variables imply that every one-point change in score will alter the odds of an uncovered service by about 3 percent. The SF-12 scale ranges from 0 to 100, however, so a one-point change is relatively small. A more relevant comparison would be to evaluate the impact of a 5- or 10-point difference in SF-12 scores. Thus, an increase of 10 points will lower the probability of an uncovered service by about 26 percent.

[5] CareOregon stopped paying premiums around February 1997, when the fiscal realities of this practice sank in. Interviews with FQHC administrators in September 1997 also revealed that the plan was much more likely to deny below-the-line services than it had been in prior years.

For those individuals with an uncovered service, the only significant predictor of whether they would get the service anyway is the SF-12 mental health scale. OHP eligibles who scored higher on this scale (indicating better mental health) were significantly more likely to get the service anyway. A one point increase in the SF-12 mental health score is associated with a 3 percent increase in the odds of receiving an uncovered service.

The SF-12 mental health scale also was a significant predictor of whether individuals would report that their health got worse as a result of not getting the service. OHP eligibles with lower scores (indicating worse mental health status) were significantly more likely to state that their health had worsened.[6] Residents of small urban areas were three times as likely to report worsened health, compared with those living in Portland. Why this should be the case is unclear, although residents of these areas were somewhat more likely to report below-the-line services. Recall from Table 5-8 above that OHP eligibles who did not succeed in getting their below-the-line services covered anyway were significantly more likely to report that their health had worsened as a result, compared with those whose services remained uncovered for some other reason.

[6] The SF-12 physical health scale was not significant at conventional levels (p=.11), even though its odds ratio appears identical to that associated with the mental health scale. This apparent likeness is an artifact of rounding.

5.4 Conclusions and Policy Implications

A surprisingly high number—almost one-third—of OHP eligibles reported that OHP would not pay for a service they felt that they needed. In many instances, these services were not covered because of a failure to follow the proper procedures of the managed care plan (e.g., going to the ER without prior approval). The most common reason for denial, however, was that the service fell "below-the-line". About 12 percent of all OHP eligibles in the Phase 1 population reported that they had needed a below-the-line service that OHP would not cover. This is an under-estimate, as some uncovered services were not described in sufficient detail to be definitively categorized as above or below the line. If we assume that one-half of this "other uncovered" service category represented below-the-line services, the number could be as high as 16 percent.

Persons enrolled in managed care plans were significantly more likely to report uncovered services than were those remaining in fee-for-service, a finding that persisted even when we restricted the definition of uncovered services to include only those below-the-line. Assuming no differences in the type of care sought by managed care vs. fee-for-service eligibles, the managed care plans probably were better able to understand the priority list and identify those treatment-condition pairs that were below-the-line. This implies that fee-for-service physicians were more likely to provide below-the-line services to their patients, either because they did not know that they would not be reimbursed by OHP or because they chose to provide the care anyway on a *pro bono* basis.

The rate of uncovered services also was significantly higher among those OHP eligibles in relatively poorer physical and mental health. Most likely, this reflects the fact

that persons needing any service (whether they received it or not) are apt to be in poorer health. The survey question simply asked whether OHP had ever denied payment for a service the respondents felt that they needed. Persons responding "no" include both those who succeeded in receiving OHP-covered services, as well as those who did not need services (because of their good health) and hence did not seek care.

Surprisingly, one-half of all eligibles with uncovered services succeeded in getting them anyway. In the case of below-the-line services, like circumcision of newborns and chiropractic services, individuals paid out-of-pocket. Other types of uncovered services, such as ER visits, were more likely to remain unpaid and undoubtedly became bad debts for their providers. In a small number of cases (8%), OHP ended up paying for the service, presumably through a successful appeal process. OHP eligibles who succeeded in getting their uncovered services after all were in significantly better mental health, compared with those who failed to do so. One possibility is that these healthier individuals were better able to "work the system" to get the desired services.

Among those OHP eligibles who failed to get the service anyway, the majority (60%) reported that their health had worsened as a result. Adjusting for reason for eligibility and demographic characteristics, these individuals were, in fact, in poorer mental health than those who did not report that their health had deteriorated as a result of not getting the needed service. Since we do not have SF-12 scores for a time period *prior to* needing the uncovered service, we can not determine causality. However, in a separate question, these eligibles also were significantly more likely to report that their health was "somewhat worse" or "much worse" compared with a year ago.

Reports that their health had worsened as a result were significantly higher in cases where the service had not been covered because it was below-the-line. Should State policymakers be concerned that the priority list might be having an adverse effect on health? Probably not—with the exception of hernia repair, the below-the-line services in question tended to be relatively minor, e.g., nicotine patches, sprains, and the like. Nevertheless, it is clear that many OHP eligibles *believe* that failure to receive a given service has had deleterious health effects. Consider these verbatim responses to the survey, for example:

> "I was refused treatment for a back injury from work. My employer had no insurance and I went to OHP to receive physical therapy. They said it wasn't important enough and I'm still in a great deal of pain four months later."
>
> "[OHP wouldn't pay for] a hernia operation. They said it wasn't life-threatening but it does hamper my work ability."
>
> "They diagnosed my foot as a sprain, so I wasn't allowed to see a specialist. I had to pay if I wanted further treatment. My foot still hurts to this day."
>
> "[OHP wouldn't pay for] chiropractic services. I have a very bad back and neck caused by a car wreck."
>
> "[OHP wouldn't pay for] surgery for my jaw. I could barely open my mouth, lots of pain. Not high enough on the list of treatment, but it was something I desperately needed."
>
> "I want to receive the patch to quit smoking so I won't have another heart attack. They said it wasn't covered."
>
> "They said no help for back pain and I suffered. [They] said they won't help with anything that will go away on its own."

Since our survey was conducted in 1996, the priority list has undergone some revisions in its condition-treatment pairs and in where the line was set. Smoking cessation programs, including nicotine patches, are now a covered service. A number of dental services, on the other hand, have moved below-the-line. New surveys, planned for early

1998, will provide more recent data on the frequency of uncovered services. These will enable us to determine whether the impact of the priority list on OHP eligibles has increased or decreased over the past two years. Of particular interest will be whether the list has had a differential impact on OHP's disabled and dual Medicare eligibles (a population not included in the current survey).

6 The Role of Federally Qualified Health Centers in the Oregon Health Plan

6.1 Introduction

The Oregon Health Plan (OHP) is Oregon's revolutionary Section 1115 waiver program that uses service-rationing through a prioritized list of health services and managed care to expand Medicaid eligibility to uninsured residents below the federal poverty level. OHP was implemented in February 1994. This chapter looks at the role of federally qualified health centers (FQHCs) in OHP. We focus on FQHCs because of their central role as safety net providers in Oregon. OHP and similar policy initiatives in other States have raised important questions about the future of safety net providers in the current health care market.[1]

One of the goals of OHP is to provide access to "mainstream" care for Oregon's Medicaid recipients. Historically, many private providers have been unwilling to accept Medicaid patients because of the program's low payment rates. As a result, FQHCs and other safety net providers are a primary source of care for Medicaid beneficiaries and other indigent populations. To address this access problem and eliminate cost shifting to private payors, the Oregon legislature has mandated that OHP payment rates be set high enough to cover the costs of services provided.

[1] Belzer MB: "Will Congress Shred the Safety Net?" *Postgraduate Medicine* :98:15-19, 1995..

While FQHCs are eligible to participate in OHP, their role and treatment under the program do not differ from those of other providers. This has had an impact of FQHCs in several areas. First, there has been a fundamental shift in their reimbursement. Prior to OHP, FQHCs were eligible for cost-based reimbursement. Oregon has not established special payment provisions for FQHCs and their reimbursement depend on the terms of contracts negotiated with managed care plans. Second, through its contracts with managed care plans, OHP has substantially broadened the network of providers available to Medicaid beneficiaries. The impact is particularly marked for the previously uninsured expansion population. As a result, FQHCs have had to compete with private sector providers for their traditional population base. FQHCs have also have to adapt their administrative operations to compete in the new managed care environment. Third, certain eligibility changes implemented under OHP may have a disproportionate impact on the population served by FQHCs. This chapter describes the impact that these policy changes have had on the role and survival of FQHCs in the Oregon health system.

6.2 What is an FQHC?

Safety net providers consist of a broad variety of not-for-profit health care entities, including FQHCs, that care for underserved populations and have an open-door policy regardless of a patient's ability to pay.[2] The mission of FQHCs is to provide comprehensive outpatient care to the uninsured and underserved through the provision of core services in

[2] Ibid.

their target communities.[3] Exhibit 6-1 lists the services that FQHCs are required to provide, either on-site or through contractual arrangements.

Exhibit 6-1

Mandated Core Clinical Services for FQHCs

Primary health services (by physicians and/or mid-level practitioners)
Primary care for all life cycles
Basic laboratory
Emergency care
X-Ray
Pharmacy
Preventive health
Preventive dental
Transportation
Case management
Hospital specialty care

The Public Health Service (PHS) Act specifies four categories of clinics that are automatically eligible for FQHC status and that receive Federal grants from the PHS: Migrant Health Centers; Community Health Centers; Homeless Health Centers; and programs operated by tribal organizations. Since OBRA 1989, Federal law has mandated that FQHCs receive cost-based reimbursement under Medicare and Medicaid. Currently,

[3] "Comparison of Rural Health Clinic and Federally Qualified Health Center Programs," Office of Rural Health Policy, U.S. Department of Health and Human Services.

there are 17 community/migrant health centers located in Oregon that qualify as FQHCs under the PHS Act.[4]

6.3 Context

This chapter draws on case study data collected during site visits to four FQHCs in Western Oregon--West Salem Clinic, Salud Medical Center, La Clínica del Cariño, and Multnomah County Primary Care Centers. Although similar in their mandated management structure and mission, the four FQHCs were selected because of differences in their local markets, their varying experiences with managed care prior to OHP, and their responses to OHP. We briefly describe each of the sites below in terms of their target population, services, staffing, and hours. Characteristics of the FQHCs are summarized in Table 6-1. We then describe the role of each FQHC in managed care under the Oregon Health Plan.

6.3.1 FQHC Characteristics

West Salem Clinic is located on the western side of the Willamette River, across from Salem, Oregon's capital. The West Salem Clinic serves the homeless, those with mental illness, and migrant workers. They provide a full range of primary care services, as mandated by the federal government for FQHC status. They also offer mental health services. The clinic is staffed by four family practitioners, a half-time internist, two

[4] Personal communication with J. Hamilton, Program and Marketing Director, Oregon Primary Care Association, January 29, 1998. One FQHC, which had struggled financially prior to OHP, closed since the program began operation. Sources at the State and the Oregon Primary Care Association attribute the closure to poor management, not the implementation of OHP.

Table 6-1

Characteristics of Case Study FQHCs

	Service Area	Payor Mix	Total Encounters	Managed Care Model	Contracting Agent
West Salem Clinic	Marion County	40% OHP 35% uninsured 25% other	Not available	IPA	IPA
Salud	Marion, East Polk Counties	43% OHP 51% uninsured 6% other	19,000	IPA	IPA
La Clínica del Cariño	Hood River County	40% OHP 40% uninsured 20% other	21,600	IPA	IPA/PHO
Multnomah Primary Care Program	Multnomah County	25% OHP 71% uninsured 4% other	93,000	Network	FQHC

physician assistants, and one nurse practitioner. Mid-level providers, with physician back-up, provide 24-hour after-hours care seven days a week. Clinic hours have expanded since the institution of OHP to include two evenings per week.

Salud Medical Center is located along the I-95 corridor in Woodburn, a rural town just north of Salem. The clinic serves a primarily Hispanic, migrant population. The clinic offers a full range of primary care services, as well as on-site dental care and a dispensary. There are approximately 19,000 patient visits per year. The clinic is staffed by two family medicine physicians, two physician assistants, one nurse practitioner, three nurse midwives, and eight nurses and certified nursing assistants. Mid-level providers and physicians rotate to cover 24-hour call. The clinic is open five days per week, including two evenings.

La Clínica del Cariño Family Health Center is located in Hood River, a small town along the Columbia Gorge in Central Oregon, whose main industries are the tourist trade and orchard farming. Sixty percent of its caseload is Hispanic, reflecting the migrant client population in the community. La Clínica del Cariño provides approximately 1,200 primary care visits and 130 "off-site" visits (primarily in the orchards) per month. There are also 500 dental visits per month. The clinic is staffed by 4.7 full-time equivalent family medicine physicians, a part-time physician assistant, and 50 other full-time equivalent employees. Twenty-four hour call is shared by the physicians. The clinic is open five days a week from 7 a.m. to 7 p.m.

Multnomah County Health Department Primary Care Clinics comprise the multiple sites of the FQHC administrated by the Multnomah County Health Department. The Health Department itself is located in downtown Portland. Nine primary care clinic

sites are located throughout the Portland area. These sites provide a full range of primary care services for 26,000 clients with 93,000 visits per year. Several medical specialties (such as optometry, dermatology, podiatry, endocrinology, pediatric pulmonology, ear, nose, and throat, rheumatology, and obstetrics/gynecology), as well as an HIV clinic, are available through the primary care system. Clinic hours vary among sites and several clinics have added after hours clinics.

6.3.2 The Role of FQHCs in Managed Care Plans

FQHCs have differing levels of experience with managed care. West Salem Clinic and Salud Medical Center participated as primary care case manager (PCCM) providers under Oregon's 1915(b) waiver that preceded OHP. However, both FQHCs continued to primarily see clients on a fee-for-service basis. La Clínica del Cariño had minimal managed care experience prior to OHP. The Multnomah County Health Department, in contrast, had substantial experience and held a capitated Medicaid contract under the 1915(b) waiver.

The Multnomah County Health Department is unique among FQHCs in its sponsorship of an OHP managed care plan.[5] Multnomah County has a long tradition of providing primary care and, at the outset of OHP, the state was concerned that it would not have adequate primary care capacity in the Portland metropolitan area if Multnomah County Health Department providers did not participate. The Health Department Board of Directors

[5] CareOregon was initially created as an enterprise fund of the Multnomah County Health Department. It has since separated and become a private, non-profit entity. This change was motivated by marketing and insurance regulation concerns. Cutting public sector ties also freed CareOregon of some of the bureaucracy that limits the health plan in terms of flexibility and speed of adaptation.

believed that continuing to provide primary care furthered their mission of ensuring universal access to care and increased their leverage and credibility. With encouragement from the State, the Health Department, in collaboration with Oregon Health Sciences University (OHSU) and the Oregon Primary Care Association (OPCA), capitalized on its managed care experience to create a network model[6] plan: CareOregon. CareOregon's commitment to primary care is reflected in the plan's administration within the Multnomah County Health Department (rather than at OHSU). Furthermore, its capitation and risk arrangements channel more of the overall payment to primary care providers relative to other plans. CareOregon initially served 11 counties and has since expanded to 14. CareOregon has the third largest OHP enrollment in the state, with most of its members living in the Portland area.

Despite establishing its own plan and building in favorable payment rates for primary care, the Multnomah County Health Department has faced financial pressures since the implementation of OHP. Medicaid income has decreased by 30 percent,[7] while revenues from sliding scale fees and federal grants have stayed stable or decreased. Two community health centers in Multnomah County would have closed without the infusion of additional funds from the county to support primary care. Overall, the county general fund stream increased 61 percent during the first four years OHP was in operation. Hence, the

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[6] A network model is an organized health care system that contracts with two or more independent group practices to provide health services. Nationally, 16 percent of plans are network models. (Group Health Association of America, *1994 National Directory of HMOs*, Washington, D.C., 1994)

[7] For Multnomah County, Medicaid income dropped 30 percent from $11,344,069 to $7,899,500 (Letter to Tom Bodenheimer, MD from Patsy Kohlberg, MD, MPH, Medical Director, Multnomah County Health Department, July 23, 1997).

CareOregon administrator poses the question: "Are we merely shifting the burden to other parts of the state or county budgets?"

West Salem Clinic and Salud are affiliated with two OHP plans through their physicians' membership in the local IPA. Separate from the IPA, the clinics also contract with CareOregon. As members of the Oregon Primary Care Association, they share similar missions with CareOregon and feel that the IPA does not completely represent their interests. They have, thus, contracted outside of the IPA with CareOregon, which pays higher primary care rates than other plans.

La Clínica del Cariño operates in a very different local environment. The clinic is associated with the sole OHP managed care plan in its area through the individual membership of its physicians in the local IPA. The IPA, in turn, contracts with the plan. In contrast to the Salem area FQHCs, staff at La Clínica del Cariño contend that there is considerable pressure in the local medical community against "IPA busting" and they might not be able to sustain tenable professional relationships in their area if they contracted outside the IPA with CareOregon. Furthermore, it would be difficult for CareOregon to establish contracts with hospitals and specialists given its rate structure, which benefits primary care providers.

The recognition of the role of FQHCs as essential community providers may have greatest influence on their long term support and survival in the managed care environment. This is perhaps best exemplified in Hood River, where, as one administrator put it, "we are still trying to learn that "who we are"; that is, in a small health care community, each part is integral to the success of the whole. Although a representative of the IPA conceded that

competition for clients has the potential to create friction between La Clínica del Cariño and other providers in the IPA, people have begun to look at the entire area as a community. Within that community, La Clínica del Cariño provides a culturally sensitive milieu for the provision of care to the Hispanic population; which benefits everyone. For example, due to La Clínica del Cariño's community outreach, very few women show up at the hospital for deliveries without prenatal care. The local hospital's administrator reiterated the value of La Clínica del Cariño to the community, noting that, should the clinic fail, there would be an increase in emergency room use at the hospital and a decrease in outreach for patient care. In the end, it may be this sense of interconnection that will enable FQHCs to survive in the increasingly profit-oriented environment of managed care.

6.4 FQHC Reimbursement under OHP

When the FQHC benefit was enacted by OBRA 1989, payment for services was calculated as an all-inclusive rate based on facility costs. Oregon's 1115 waiver eliminated facility-specific cost-based reimbursement, thus "leveling the playing field." The State believed that cost-based reimbursement was inflationary and allowed cost-shifting of Medicaid dollars to uninsured clients. Other States offset the loss of cost-based reimbursement under managed care by supplementing the payments that FQHCs receive. For example, Washington provides an additional per member per month (PMPM) wrap around payment.

Under OHP, FQHCs' reimbursement is set by the terms of their contracts with managed care plans. In general, managed care plans do not contract with FQHCs directly.

Rather, the providers affiliated with an FQHC will contract with managed care plans, often through their membership in a local IPA, and then subassign their fees to the clinic. Thus, the relationship between FQHC providers and managed care plans does not differ from that of other physicians in the community and there is no recognition of their status as safety net providers.

The loss of cost-based reimbursement has affected the FQHCs in two ways. Most obviously, they are receiving less money. FQHCs contend that their payments, whether discounted fee-for-service or capitation rates, do not cover the costs of a visit. For example, La Clínica del Cariño states that their average cost per visit is $100, but they are reimbursed an average of $56 per visit. The second, more subtle way in which loss of cost-based reimbursement impacts the FQHCs is that they are no longer able to cover the costs of the service enhancements they had adopted following the implementation of the PHS Act. The PHS Act provided FQHCs with grants that they used to build new facilities, recruit physicians, and increase enabling services (such as translation, social, outreach services). These added costs are not covered by the payments they receive from managed care plans.[8]

On a second level, OHP's approach to capitation rate setting may also have a financial impact on FQHCs. Under OHP, managed care plans receive monthly capitation payments that are set separately by eligibility category. Payment rates vary slightly by geographic area of the State, to reflect input price differences in urban and rural locales. There is currently no risk adjustment beyond that implicit in the eligibility categories

[8] Personal communication with T. Castañares, Director, La Clinical del Cariño, September 1997.

themselves. Thus, all plans in a geographic area receive identical payments for beneficiaries in the same eligibility group.

The FQHCs contend that they are subject to adverse selection, caring for the sickest, highest-cost patients in the population. They argue that their payments should be risk-adjusted to compensate for their higher costs. The FQHCs have advocated for the State to adjust payment rates for sites that serve special populations. Although the State has not supported site-specific adjustments, OMAP is planning to risk adjust capitation payments for selected eligibility groups beginning in April 1998. In addition, OMAP is considering adjusting rates for the incidence of specific conditions, such as HIV/AIDS, as well as extending risk adjustment to all eligibility groups.

6.5 Ability of FQHCs to Compete in a Managed Care Environment

OHP expanded Medicaid eligibility to all legal State residents below the Federal Poverty Level (FPL), without regard to categorical eligibility criteria. The expansion had tremendous impact on the number of people enrolled in the program.[9] For FQHCs, the enrollment explosion has great potential to increase the number of insured among their clients. At the same time, OHP has made a wide range of new providers available to a population that formerly relied substantially on safety net providers for the delivery of health care services. As a result, FQHCs now must compete with private sector providers for their traditional patient population. Given a choice of providers, former clients may choose to go elsewhere for care and FQHCs may find themselves with fewer patients. Thus, despite the

[9] For the past year, for example, the expansion population has averaged 100,000.

extension of insurance to large numbers of previously uninsured people, FQHCs may not share in the new revenues from the OHP eligibility expansion and they may find that their remaining clients are disproportionately uninsured.

FQHCs may have difficulties competing with private providers, both because of perceptions that they provide second-tier medicine and because they are lacking in physical amenities. For example, the West Salem Clinic is situated in an older building located amidst crumbling sidewalks and closed-up storefront shops. During our site visit, several people, who had been transported to the clinic by van as part of a PHS Homeless grant, joined a solitary patient in the dilapidated waiting room. Clinic staff believes that insured clients are reluctant to share a crowded waiting room with the homeless population, many of whom exhibit symptoms of mental illness and poor hygiene. Similarly, since its original building suffered earthquake damage four years ago, Salud Medical Center has been located in a warehouse located between two strip malls. Inside the clinic, makeshift examination rooms made of plywood are closed off with curtains.

Nonetheless, FQHCs may provide important services that are not available from private providers. Anecdotally, at least one FQHC reported that their clients initially chose to go elsewhere but are being drawn back to the FQHC by the agency's cultural competency and enabling services. We analyzed enrollment and encounter data in Multnomah County to assess whether pre-OHP users of the FQHC, who remained eligible after OHP was implemented, enrolled in CareOregon. Multnomah County was chosen, because FQHCs in this county contract exclusively with CareOregon. Users were defined as those eligibles with at least one visit to an FQHC in the year prior to OHP implementation. Only 50 percent

of pre-OHP FQHC users enrolled in CareOregon; the other 50 percent were enrolled in other plans with other providers. Although pre-OHP FQHC users enrolled disproportionately in CareOregon, the FQHCs were not able to retain a large percentage of their clients in a competitive marketplace.

In addition to their physical infrastructure, FQHCs may find their ability to compete effectively in a managed care environment undermined by their outdated administrative infrastructure. In a competitive marketplace, FQHCs face increased costs associated with developing the infrastructure necessary for managed care such as a management information system (MIS), as well as utilization and quality management systems. In addition, they must compete for more highly skilled, higher priced administrators and staff with managed care expertise.

When asked, in retrospect, how they would have responded differently to OHP, each of the FQHCs visited said they would devote more time, money, and personnel to developing their MIS. All four FQHCs identified not only the need for better data and an enhanced MIS, but also for resources and technical knowledge to learn to use such a system. As the State is planning to use encounter data for rate setting and risk adjustment, the FQHCs consider upgrading their MIS an even higher priority.

"Top to bottom" training at all staffing levels in managed care techniques was identified as a need at all the FQHCs except Multnomah County, which had prior experience with managed care. At the time of our site visit, management at West Salem had changed in the preceding three months, primarily because the previous administrator lacked managed care experience. La Clínica del Cariño has undergone two administrative changes since

OHP. According to a local hospital administrator, La Clínica del Cariño had suffered "poor management" and a "lack of understanding of the rudiments of business" in the past. Approximately one year ago, the hospital stepped in to perform interim management through a twelve-month contractual relationship.

6.6 Impact of OHP Eligibility Policies on FQHCs

Populations traditionally served by FQHCs may be less likely to take advantage of the expansion of insurance coverage under OHP as a result of social and cultural barriers. Despite the expansion of eligibility under OHP, none of the FQHCs visited reported a measurable change in their mix of insured and uninsured clients. Evidence from the 1996 Current Population Survey substantiates concerns that barriers to enrollment may exist, e.g., improvement in insured rates have not been consistent statewide, nor within groups that are frequently served by FQHCs. In Oregon, only eight percent of children are uninsured (Table 6-2).[10] In comparison, prior to OHP, 20 percent of children were uninsured. Hispanic and other minority children, however, are more likely to be uninsured (14 and 9 percent respectively).[11] Among those with incomes below 100 percent of FPL, and thus eligible for OHP, 21 percent of adults and 10 percent of children remain uninsured. FQHCs report that the proportion of their client populations that is uninsured has essentially not changed since

[10] In contrast, nationwide, 14 percent of children are uninsured.

[11] These figures, however, are better than the national statistics, which report that 27 percent of Hispanic and 15 percent of other minority children are uninsured.

the implementation of OHP and it remains higher than the statewide rate. As shown in Table 6-1, these rates range from 35 percent (West Salem)[12] to a high of 71 percent (Multnomah).[13]

The FQHCs cite the mobility of their clients, language, and cultural barriers as explanations for the high number that continue to lack insurance. Mobility is a particularly difficult problem because many of the populations served by FQHCs commonly lack a stable place of residence. West Salem Clinic has many clients who are homeless or mentally ill; Multnomah's population is the urban poor; La Clínica del Cariño and Salud focus on migrant workers. Material mailed by the clinics or OHP, including eligibility cards, may not reach their clients. When mail is returned to OHP because of an incorrect address, the client is automatically disenrolled, although the client is likely to show up again for care.

[12] Personal communication with L. Martin, Director, West Salem Clinic, Septempber 1997.

[13] Letter to Tom Bodenheimer, MD from Patsy Kohlberg, MD, MPH, Medical Director, Multnomah County Health Department, July 23, 1997.

Table 6-2

Uninsured Population in Oregon, by Age and Poverty Status

	Adults	Children	Total
Total Population	2,381,182	800,600	3,181,782
Uninsured	279,170	61,281	340,451
Percent Uninsured	11.7%	7.6%	10.7%
< 100% FPL	254,542	120,908	375,450
Uninsured <100% FPL	52,622	11,903	64,525
% < 100% FPL Uninsured	20.7%	9.8%	17.2%

SOURCE: Current Population Survey, 1996.

Approximately 20 percent of FQHC clients do not have phones, so communicating with providers and OHP is difficult.

Bilingual staff is often needed for interpretation during the enrollment process. At La Clínica del Cariño, 60 percent of the population cite Spanish as their preferred language. Although each of the FQHCs has an "outstation worker" hired by the State to distribute OHP applications and assist clients in completing them, many clients do not understand deadlines and fail to finish the application process.

Several modifications to eligibility rules since the implementation of OHP may disproportionately affect FQHC clients. First, income is measured as the average of the most recent three months' income instead of the previous month's income alone. The three-month average is designed to minimize the possibility that people who qualify on the basis of a single month of unusually low income could remain eligible after their income has exceeded eligibility limits. Three-month income averaging, however, has compounded eligibility problems for seasonal workers. During the five-month harvest season, the increase in income disqualifies workers from OHP, although they would be eligible during the remainder of the year. For seasonal workers, therefore, "timing is everything." To remain eligible, clients must submit the application when the average of current month and the previous two months of income would qualify them for the program.

Effective December 1, 1995, OHP began charging premiums to expansion eligibles (single adults, childless couples, and new families).[14] Expansion eligibles, who are

[14] For a single person, premiums ranged from $6.00 per month (for those below 50 percent of the FPL) to $20.00 per month (for those between 86 and 100 percent of FPL). For a family of four, the monthly payment ranged from $7.50 to $28.00.

recertified for OHP coverage every six months, retain their eligibility for the current certification period, but are denied recertification if in arrears for the premium payments.[15] Concerned that the premiums would discourage re-enrollment, CareOregon (the health plan owned and operated by Multnomah County Health Department) paid overdue premiums from April 1996 through February, 1997 for 3,368 of its members, yet fewer than half (1,399) re-enrolled.[16] This suggests that the premiums are not the primary reason clients served by FQHCs do not re-enroll in OHP. La Clínica del Cariño and West Salem Clinic believe, however, that the premium charged to the expansion population has discouraged enrollment even if it has not affected re-enrollment.

6.7 Conclusion

The implementation of OHP dramatically expanded insurance coverage for many of the populations traditionally served by FQHCs. Nonethelesss, far from providing a windfall for these safety net providers, their financial condition actually may have eroded under OHP.[17] FQHCs have found it difficult to retain their patient base in the face of competition from private sector providers. Furthermore, they were forced to adapt "overnight" to the loss of cost-based reimbursement--a stark contrast to the recently passed Balanced Budget Act of 1997, which phases out cost-based reimbursement over six years. A more gradual phase-

[15] In the first re-enrollment period, less than one percent of total households billed were disqualified due to past due payments. Office of Medical Assistance Programs, Oregon Health Plan Medicaid Demonstration Report - First Quarter, 1995-6.

[16] Oregon Health Forum, February 1997.

[17] Future analyses of data reported by FQHCs to the Health Resources and Services Administration, DHHS, and to OMAP will examine changes in the financial condition of FQHCs since the implementation of OHP.

out would have allowed time for FQHCs to reduce their costs by paying off building costs, cutting staff, and making other adjustments.

In general, OHP has not provided special treatment for FQHCs. Indeed, it may be that the mission of FQHCs is "out of step with the goals of OHP."[18] The state of Oregon has an explicit policy objective of providing Medicaid coverage in the *private* arena for a carefully *defined* set of eligibles and benefit package, while meeting reasonable costs *across* facilities. In this framework there is no clearly delineated role for providers, such as FQHCs, that have a goal of providing *comprehensive* health care to the uninsured and underserved regardless of ability to pay. Success will be predicated, not on controlling, but on adapting to the new health care environment and market forces.

The question remains, however, whether a program like OHP should make special provisions to ensure the participation and survival of FQHCs and other traditional safety net providers. Although increasing access to private sector providers is an important goal of programs like OHP, safety net providers remain a critical link in the health care system. Safety net providers, which deliver culturally sensitive services and are well-connected to the social service system, may be better suited to serve the needs of some populations. Furthermore, there inevitably remains a "notch" population without insurance that relies on FQHCs and other safety net providers to meet their health care needs.

Despite its initial stance against affording special treatment to FQHCs, Oregon has recently adopted policies designed to partially offset some of the negative impacts of OHP. First, OHP is planning to implement risk adjustment. Second, in 1997, the Oregon

[18] Bob DiPrete, Health Plan Administrator's Office.

legislature set aside $3.1 million for grants to safety net providers. Although the criteria for disbursing the funds are still under development, a match from the community will be required. However, there is widespread agreement, in both State government and among the FQHCs, that these funds are not nearly adequate to meet the needs of safety net providers. For now, FQHCs continue their struggle to adapt and to continue their mission as advocates for Oregon's uninsured and underserved.

Appendix A

A The Financial Experience of OHP Managed Care Plans, 1994-1996

A.1 Introduction

To evaluate the financial performance of managed care plans in the Oregon Health Plan (OHP), we conducted an analysis of the plans' annual audited financial statements and the special quarterly financial reports that OHP-participating plans are required to submit to the Office of Medical Assistance Programs (OMAP). This section reviews and analyzes the financial performance of health and dental plans participating in OHP, as represented in the information available to date from these financial reports. After discussing the methods and data issues, we present the results for the physical health and dental plans separately. Primary emphasis is given to examining the financial experience of the physical health plans.

A.2 Data and Methods

OMAP maintains two separate financial reporting requirements. It requires OHP contractors to provide audited financial statements within six months after the end of each calendar year. In addition, OMAP requires contractors to provide quarterly financial statements, as well as utilization reports, within 60 days after the end of each quarter. Specific formats and detailed definitions are indicated for such reporting.[1] OMAP staff

[1] See "Solvency Plan and Financial Reporting," OMAP, October 1, 1995.

carefully review the reported data, flag inconsistencies, and work with the plans to resolve discrepancies.

This analysis is largely based on the quarterly financial reports (in electronic format) for the first twelve quarters of OHP activity, beginning with the first quarter of 1994 and continuing through the fourth quarter of 1996.[2] Although all plans are represented in this data, the quality and completeness of reporting varies considerably. We have also reviewed the plans' audited financial statements for 1994, 1995, and 1996.

The audited financial statements, in principle, should be the more dependable source of plan financial information. Unfortunately, however, the audited statements are generally less useful for evaluating OHP financial experience. OMAP does not require that the audited income statement report revenue and expense on an OHP-specific basis. In 1996, ten of the 19 OHP-participating physical health plans provided services only to OHP members. For these plans, accounting for less than a quarter of premiums paid to health plans in that year, the audited income statements fairly depict OHP experience.[3] For the other 9 plans, most of which have large commercial groups, the audited statements report revenue and expense only on a consolidated, corporate basis. Therefore, it is not possible to distinguish OHP-specific experience.

In their quarterly reports, plans are required to report experience on an OHP-specific basis. Although no guidance is provided on allocating overhead costs across product lines,

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[2] Although OMAP had also provided us with provisional results for the first and second quarters of 1997, they asked that we not report those findings pending completion of OMAP's desk audit.

[3] In general, the information reported from their audited statements tracks reasonably well with the annual aggregation of quarterly-reported data. Nevertheless, OMAP and GAAP reporting requirements are somewhat different.

these quarterly reports, if prepared correctly and consistently, should fairly depict the OHP-specific revenues, expenses, and profitability of each plan. As we shall see, however, the reports are not always prepared correctly and consistently.

For most plans, the quarterly financial reports indicate extraordinary volatility in financial results from quarter to quarter. The variances are too large to be attributable to differential operating results, and we can only surmise that they arise due to reporting difficulties or accounting idiosyncrasies. For this reason, we shall focus on each plan's cumulative financial experience under OHP, aggregating experience over one or more of the calendar years for which we have information. To the extent that revenues and expenses are simply misreported by quarter, such aggregation should substantially mitigate comparability problems.

A.3 Financial Performance of Prepaid Health Plans

In Table A-1, we report the cumulative financial results, 1994 through 1996, for all 22 health plans that had participated in OHP during its first three years. These results include seven plans that have withdrawn from the program (Columbia Managed Care, Coordinated Healthcare, Medford Clinic, PACC Health Plan, PacifiCare, Prime Care, and QualMed). As

Table A-1

Cumulative Financial Results on OHP Line of Business, January 1, 1994 Through December 31, 1996, by Plan

					In Percent		
	Total Revenue	Administrative Expense	Medical Expense	Net Income	Administrative Ratio	Medical Loss Ratio	Profit Margin
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Prepaid Health Plan							
CareOregon	**$103,980,030**	**$10,977,875**	**$91,695,515**	**$1,306,640**	**10.56%**	**88.19%**	**1.26%**
Cascade Comprehensive Care	12,902,654	1,623,055	11,409,490	-129,891	12.58	88.43	-1.01
Central Oregon IHS	**12,029,551**	**1,287,886**	**9,066,900**	**1,674,765**	**10.71**	**75.37**	**13.92**
Columbia Managed Care	392,447	135,418	292,442	-35,413	34.51	74.52	-9.02
Coordinated Healthcare Network	**3,625,669**	**633,590**	**3,375,409**	**-383,330**	**17.48**	**93.10**	**-10.57**
Evergreen Medical Systems	8,767,113	548,924	7,779,757	438,432	6.26	88.74	5.00
FamilyCare	**37,077,854**	**4,102,618**	**32,821,770**	**153,466**	**11.06**	**88.52**	**0.41**
Good Health Plan	78,702,773	9,647,806	69,516,479	-461,512	12.26	88.33	-0.59
InterCommunity Health Network	**28,093,453**	**1,778,158**	**26,235,537**	**79,758**	**6.33**	**93.39**	**0.28**
Kaiser Permanente	76,235,988	3,562,574	74,807,193	-2,133,779	4.67	98.13	-2.80
Medford Clinic	**7,947,365**	**1,238,059**	**5,739,635**	**969,671**	**15.58**	**72.22**	**12.20**
Mid-Rogue IPA	8,700,537	654,852	7,409,129	636,556	7.53	85.16	7.32
ODS Health Plan	**112,025,668**	**5,895,752**	**106,080,731**	**49,185**	**5.26**	**94.69**	**0.04**
Oregon Health Management Services	15,231,662	1,624,750	12,322,153	1,284,759	10.67	80.90	8.43
PACC Health Plan	**24,606,845**	**2,717,984**	**23,266,635**	**-1,377,774**	**11.05**	**94.55**	**-5.60**
PacifiCare of Oregon	48,688,719	4,735,123	46,064,861	-2,111,265	9.73	94.61	-4.34
PrimeCare	**3,750,583**	**479,513**	**3,112,727**	**158,343**	**12.79**	**82.99**	**4.22**
QualMed	8,675,962	1,556,346	8,651,590	-1,531,974	17.94	99.72	-17.66
Regence HMO Oregon	**501,976,349**	**39,137,309**	**479,722,878**	**-16,883,838**	**7.80**	**95.57**	**-3.36**
SelectCare	62,760,817	3,748,152	58,906,776	105,889	5.97	93.86	0.17
Sure Care	**47,929,690**	**7,594,530**	**37,162,671**	**3,172,489**	**15.85**	**77.54**	**6.62**
Tuality Healthcare	9,355,880	730,046	7,759,642	866,192	7.80	82.94	9.26
TOTAL/AVERAGE	**$1,213,457,609**	**$104,410,320**	**$1,123,199,920**	**-$14,152,631**	**8.60%**	**92.56%**	**-1.17%**

Table A-1 (continued)

Cumulative Financial Results on OHP Line of Business, January 1, 1994 Through December 31, 1996, by Plan

					In Percent		
	Total Revenue	Administrative Expense	Medical Expense	Net Income	Administrative Ratio	Medical Loss Ratio	Profit Margin
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Dental Care Organization							
Capitol Dental Care	**$32,761,134**	**$3,121,838**	**$25,504,033**	**$4,135,263**	**9.53%**	**77.85%**	**12.62%**
Cascade Dental	2,096,620	326,766	1,599,073	170,781	15.59	76.27	8.15
Frontier Dental	**132,881**	**9,020**	**118,800**	**5,061**	**6.79**	**89.40**	**3.81**
Hayden Family Dentisty	23,098	2,754	18,588	1,756	11.92	80.47	7.60
Jefferson Dental	**276,120**	**91,733**	**200,984**	**-16,597**	**33.22**	**72.79**	**-6.01**
Managed Dental	11,044,167	880,939	10,017,616	145,612	7.98	90.71	1.32
MultiCare Dental	**10,250,928**	**815,617**	**9,643,436**	**-208,125**	**7.96**	**94.07**	**-2.03**
ODS Dental	35,596,708	4,850,669	30,110,415	635,624	13.63	84.59	1.79
Roseburg Dental	**4,980,094**	**949,610**	**3,792,298**	**238,186**	**19.07**	**76.15**	**4.78**
South Coast Dental	1,324,555	236,982	1,020,308	67,265	17.89	77.03	5.08
Willamette Dental	**$7,093,820**	**1,808,739**	**4,859,132**	**425,949**	**25.50**	**68.50**	**6.00**
TOTAL/AVERAGE	**$105,580,125**	**$13,094,667**	**$86,884,683**	**$5,600,775**	**12.40%**	**82.29%**	**5.30%**

NOTES: Administrative Ratio = col. (2)/col. (1); Medical Loss Ratio = col. (3)/col. (1); Profit Margin = col. (4)/col. (1).

SOURCE: Prepaid Health Plan Quarterly Financial Solvency Reports, Twelve Quarters (1/1/94-12/31/96), original analysis by Health Economics Research, Inc.

seen from Table A-1, aggregate OHP premiums paid to prepaid health plans over the 1994-1996 interval amounted to $1,213 million. Regence HMO Oregon (HMOO), with $502 million in premium, is the largest, accounting for 41.4 percent of premiums paid. The next largest health plans are ODS and CareOregon, accounting, respectively, for 9.2 and 8.6 percent of total premiums. Only three other health plans—Kaiser, Good Health Plan, and SelectCare—received as much as five percent of the premiums. In the aggregate, these six plans received almost four-fifths of total premiums paid to health plans.

Some 13 of the 22 plans reported a net gain on OHP business, and nine plans reported a loss. Aggregate net income ranges from a $16.9 million loss for HMOO to a $3.2 million gain for SureCare. Moreover, the percent net income (or profit margin) ranges from –17.7 percent for QualMed (no longer participating) to +13.9 percent for Central Oregon Independent Health Services (a comparatively new plan). In the aggregate, the plans report that they lost 14.2 million dollars on OHP business during the program's first three years, for an aggregate average profit margin of –1.2 percent. In addition to HMOO, four other health plans—Kaiser, PACC Health Plan, PacifiCare and QualMed—lost more than a million dollars each. All except HMOO and Kaiser have now withdrawn from the program.

The reported medical loss ratios (medical expenses as a percent of premiums) vary markedly, ranging from 72.2 percent for Medford Clinic to 99.7 percent for QualMed. The average aggregate medical loss ratio, based on plan reported spending, is 92.6 percent.

The reported administrative ratios (administrative expense as a percent of premium) vary even more dramatically, ranging from 4.7 percent for Kaiser to 17.9 percent for QualMed.[4] The average aggregate administrative ratio is 8.6 percent.[5]

Although the audited financial statements are inadequate or incomplete in other respects, they are nevertheless helpful in understanding and interpreting the quarterly-reported information. In particular, in some instances, they suggest that the reported costs are understated, inconsistent or incomplete:

- InterCommunity Health Network states in all three years that: "Members provide certain services to the Network without charge. These services include occupancy expenses and salaries and benefits for certain employees who perform services on behalf of the Network."
- The 1994 audit report for Cascade Comprehensive Care states that "incurred but not reported" (IBNR) claims are not reflected in the financial statements.
- The auditors for Oregon Health Management Systems (OHMS) note that their 1994 statements were prepared on a cash basis, which would mean that IBNR claims are not included.
- CareOregon's 1994 audit report notes that "the County also funded certain expenses." Moreover, the 1994 income statement reports a loss of $360,000 whereas the quarterly reports indicate a $151,000 gain.
- Tuality Healthcare's 1996 audit report indicates a $494,000 loss on a company-wide basis, whereas Tuality had reported a modest gain on a corporate basis to OMAP.
- SelectCare's 1994 audit report indicates that the plan's OHP liability is understated by approximately $400,000. However, they do not adjust the income statement.

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[4] In its comparatively brief existence, Columbia Managed Care reported an administrative ratio of 34.5 percent.

[5] When medical loss ratios plus administrative ratios exceed 100 percent, this means that the plans are losing money. As noted earlier, OHP plans combined incurred an average loss of 1.2 percent.

Moreover, we have other indications that reporting is conspicuously incomplete. Until the third quarter of 1995, Medford Clinic included no physician service expense in its quarterly reports. We are also concerned that administrative costs are consistently understated in the quarterly reports of some plans:

- SelectCare reports negative administrative expenses in the first quarter of 1995. At the time, the Oregon Department of Insurance had deemed SelectCare "impaired" for its commercial business. The plan was informed that they could not continue their OHP contract if they showed a loss on this line of business. It appears that SelectCare under-reported its administrative costs to avoid showing a deficit.
- PacifiCare's administrative expense drops from $551,000 in the fourth quarter of 1994 to $50,000 in the first quarter of 1995. Several components of administrative expense are reported as "0" for the first three quarters of 1995.
- ODS Health Plan improbably reports that its administrative ratio declines from 8.3 percent in 1994 to 2.3 percent in 1995, and then rebounds to 6.9 percent in 1996.

On balance, nevertheless, we believe that plan reporting problems have diminished over time and that near-term financial results were reported more reliably to OMAP. With the notable exception of Tuality Healthcare and SelectCare, the 1996 financial statements indicate fewer apparent problems with the consistency or completeness of reporting. In order to facilitate comparison of the plans' earlier and later financial experience with OHP, Table A-2 reports three basic financial performance indices—(1) profit margin, (2) medical loss ratio and (3) administrative ratio—on a calendar year basis for 1994, 1995 and 1996. For convenient reference, Table A-2 also reports OHP revenue by year.

Table A-2

Trends in Financial Performance Indices, By Plan, 1994-1996

	Profit Margin			Medical Loss Ratio			Administrative Ratio			OHP Revenue		
	1994	1995	1996	1994	1995	1996	1994	1995	1996	1994	1995	1996
Prepaid Health Plan												
CareOregon	**0.75%**	**1.22%**	**1.51%**	**88.03%**	**87.86%**	**88.53%**	**11.21%**	**10.92%**	**9.96%**	**$19,989,492**	**$38,693,449**	**$45,297,089**
Cascade Comprehensive	9.44	9.71	-11.32	77.55	77.74	98.87	13.01	12.55	12.45	2,161,911	4,195,815	6,544,928
Central Oregon IPS		**-15.24**	**14.65**		**92.43**	**74.85**		**17.24**	**10.50**		**359,630**	**11,669,921**
Columbia Managed Care	-9.02			74.52			34.51			392,447		
Coordinated Healthcare Network	**-26.76**	**-6.31**		**92.97**	**93.13**		**33.80**	**13.18**		**755,333**	**2,870,336**	
Evergreen Medical Systems	2.40	6.23	6.11	90.50	88.13	87.79	7.10	5.65	6.11	2,710,438	2,931,690	3,124,985
FamilyCare	**0.28**	**2.47**	**-1.28**	**89.98**	**88.14**	**88.09**	**9.74**	**9.39**	**13.19**	**8,069,721**	**13,415,002**	**15,593,131**
Good Health Plan	-9.73	1.49	0.14	98.34	85.67	87.83	11.40	12.84	12.03	9,873,831	29,826,724	39,002,218
InterCommunity Health Network	**-7.56**	**1.85**	**0.29**	**93.56**	**93.59**	**93.24**	**14.00**	**4.56**	**6.47**	**2,043,399**	**10,156,987**	**15,893,067**
Kaiser Permanente	-2.62	-1.94	-3.71	96.28	97.93	99.65	6.33	4.01	4.05	21,227,393	26,080,155	28,928,440
Medford Clinic	**70.21**	**-8.51**	**3.81**	**13.56**	**92.16**	**82.29**	**16.23**	**16.36**	**13.90**	**1,710,660**	**3,806,763**	**2,429,942**
Mid-Rogue IPA		8.98	7.06		80.00	85.94		11.02	6.99		1,149,335	7,551,202
ODS Health Plan	**5.16**	**-1.34**	**-0.22**	**86.58**	**99.04**	**93.31**	**8.27**	**2.30**	**6.91**	**14,735,879**	**44,356,926**	**52,932,863**
Oregon Health Management Services	24.63	6.91	4.87	50.31	78.76	90.20	25.05	14.33	4.93	2,293,561	4,385,726	8,552,375
PACC Health Plan	**-8.71**	**-4.99**	**-3.71**	**97.25**	**94.59**	**91.64**	**11.46**	**10.40**	**12.07**	**5,989,440**	**12,890,845**	**5,726,560**
PacifiCare of Oregon	-3.90	-5.43	-3.05	93.75	97.87	90.52	10.15	7.56	12.53	9,665,500	22,858,280	16,164,939
PrimeCare	**2.88**	**6.39**		**83.91**	**81.51**		**13.21**	**12.10**		**2,313,185**	**1,437,398**	
QualMed	-30.27	-10.47	-17.86	111.04	92.41	102.52	19.23	18.06	15.35	2,587,998	4,583,899	1,504,065
Regence HMO Oregon	**-4.19**	**-0.11**	**-5.97**	**94.13**	**92.75**	**98.71**	**10.06**	**7.36**	**7.26**	**89,671,027**	**196,101,985**	**216,203,337**
SelectCare	0.98	0.00	-0.05	90.06	95.85	93.57	8.97	4.15	6.48	11,998,253	26,513,549	24,249,015
Sure Care	**5.83**	**4.49**	**9.03**	**79.99**	**77.22**	**76.67**	**14.09**	**18.29**	**14.31**	**9,387,152**	**19,029,121**	**19,513,417**
Tuality Healthcare	12.31	3.65	12.92	79.26	87.84	80.10	8.43	8.51	6.98	1,511,354	3,595,323	4,249,203
AVERAGE/TOTAL	**-1.58%**	**-0.16%**	**-1.90%**	**91.20%**	**92.11%**	**93.53%**	**10.38%**	**8.04%**	**8.37%**	**$219,087,974**	**$469,238,938**	**$525,130,697**

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Sure Care	**5.83**	**4.49**	**9.03**	**79.99**	**77.22**	**76.67**	**14.09**	**18.29**	**14.31**	**9,387,152**	**19,029,121**	**19,513,417**
Tuality Healthcare	12.31	3.65	12.92	79.26	87.84	80.10	8.43	8.51	6.98	1,511,354	3,595,323	4,249,203
AVERAGE/TOTAL	**-1.58%**	**-0.16%**	**-1.90%**	**91.20%**	**92.11%**	**93.53%**	**10.38%**	**8.04%**	**8.37%**	**$219,087,974**	**$469,238,938**	**$525,130,697**

Table A-2 indicates that the health plans nearly broke even in 1995, with the plans reporting an aggregate average loss of only 0.2 percent. This was a considerable improvement on an apparent, but probably under-reported, loss of 1.6 percent in 1994. For 1996, however, the plans indicate that their financial experience with OHP has deteriorated, with the aggregate average loss widening to 1.9 percent. Moreover, if we exclude the reports from Tuality and SelectCare, the average loss is 2.1 percent.

The reported administrative ratio declines markedly from 10.4 percent in 1994 to 8.0 percent in 1995, and then rebounds modestly to 8.4 percent in 1996. The medical loss ratio, however, trends upwards throughout the three-year observational interval, rising from 91.2 percent in 1994 to 92.1 percent in 1995, and then to 93.5 percent in 1996. Thus, the 1995-1996 increase in the medical loss ratio largely accounts for the near-term deterioration in profit margin.

For the eight plans with substantial commercial business, Table A-3 compares their OHP-specific experience in 1996 to their experience on a larger corporate basis (also as reported to OMAP). Since the corporate numbers also reflect OHP experience, the real differences between the financial experience of a plan's OHP and non-OHP line of business are even larger than those indicated in this table.

In 1996, the eight plans included in Table A-3 reported an average corporate profit margin of 1.1 percent. By comparison, these same plans reported an average loss of 4.3 percent on their OHP business. This average, however, is substantially skewed by

Table A-3

Comparison of OHP-Specific and Corporate Financial Performance Indices, 1996

	Profit Margin		Medical Loss Ratio		Administration Ratio	
	OHP	Corporate	OHP	Corporate	OHP	Corporate
Prepaid Health Plan						
Good Health Plan	0.14	0.27	87.83	89.25	12.03	10.47
Kaiser Permanente	**-3.71**	**0.93**	**99.65**	**95.01**	**4.05**	**4.06**
ODS Health Plan	-0.22	3.52	93.31	87.51	6.91	8.97
PACC Health Care	**-3.71**	**6.51**	**91.64**	**76.33**	**12.07**	**17.16**
PacifiCare of Oregon	-3.05	-1.21	90.52	88.54	12.53	12.67
QualMed	**-17.86**	**1.81**	**102.52**	**85.10**	**15.35**	**13.09**
Regence HMO Oregon	-5.97%	-3.46%	98.71%	91.45%	7.26%	12.01%
SelectCare	**-0.05**	**0.16**	**93.57**	**87.02**	**6.48**	**12.82**
AVERAGE	**-4.30**	**1.07**	**94.72**	**87.53**	**9.59**	**11.41**

SOURCE: Prepaid Health Plan Quarterly Financial Solvency Reports, Four Quarters (1/1/96-12/21/96), original analysis by Health Economics Research, Inc.

QualMed's disastrous loss of 17.9 percent. If we exclude QualMed, the simple average OHP-specific margin in 1996 is –2.4 percent. Even so, this leaves a very substantial, 3.4 percentage point negative variance in average margin. Only two plans, Good Health Plan and SelectCare, report similar margin results on both an OHP-specific and corporate basis. OHP's largest plan, HMOO, reports that it lost 3.5 percent on a corporate basis, compared to a 6.0 percent loss on its OHP business.

The differences in profitability substantially reflect differences in the medical loss ratio by line of business. As we see in Table A-3, the average OHP-specific loss ratio is seven percentage points higher than the corporate average loss ratio. Moreover, if we remove QualMed from the comparison, we still have a six percentage point variance.

The plans report that their OHP administrative ratios average about two percentage points less than their corporate administrative ratios. Although four plans report that their OHP administrative ratios are similar or even more than their corporate ratios, the other four plans report that the OHP ratios are considerably less. In our opinion, this pattern is suspicious and constitutes additional evidence that some plans have under-reported their OHP administrative costs. In meeting with the plans, we were consistently told that OHP members are more costly to administer than commercial members.[6] If the corporate and OHP administrative ratios were in fact similar, the average difference in profit margin would have been more than five percentage points.

As we see it, a plan's corporate experience provides a useful benchmark for evaluating whether OHP offers a similarly attractive business opportunity. Our results clearly indicate that, to date, the plans' OHP activity has not been similarly profitable. This undeniably prompts reasonable concern about the prospects for plans continuing to participate in the program. Indeed, three of the eight plans included in Table A-3—PACC, PacifiCare and QualMed—have already withdrawn from OHP.

A.4 Financial Performance of Dental Plans

The financial experience of OHP's dental plans is also depicted in Tables A-1 and A-2. By comparison with the health plans, it appears that the dental plans have done quite well under OHP. Accumulating experience over the first three years, their average aggregate

[6] On the other hand, the plans incur no direct marketing expense, which can be a significant contributor to the administrative costs of some health plans.

profit margin is +5.3 percent. Moreover, as we see in Table A-2, overall profitability improved markedly in the last year of our data, with the average margin rising from 2.3 percent in 1994 and 2.8 percent in 1995 to an extraordinary 8.2 percent in 1996. In 1996, only Jefferson Dental (a small, new plan) lost money on its OHP dental business. Three plans, including the two largest (Capitol Dental Care and ODS Dental), earned a profit of more than ten percent.

Consistent with the margin results, we find that the dental plans' medical loss ratios average about ten percentage points less than the loss ratios for OHP health plans. Aggregating over all three years, the dental plans report an average medical loss ratio of 82.3 percent. The recent trend in the loss ratio, however, is even more striking. Their medical loss ratio falls rather precipitously from 85.7 percent in 1994 and 89.3 percent in 1995 to 75.8 percent in 1996. However, this decline is almost wholly due to a single plan's (ODS Dental) halving of its medical loss ratio from 1994 to 1996.

The dental plan administrative ratios also exhibit a rather peculiar pattern. The three-year average administrative ratio is 12.4 percent. However, the ratio declines from 12.0 percent in 1994 to 7.9 percent in 1995, and then increases sharply to 16.0 percent in 1996. This pattern is also difficult to explain. Perhaps the plans were simply allocating more costs to OHP in 1996 in order to avoid reporting an even larger profit margin. We also note that the administrative ratios vary considerably across dental plans.

As seen from Table A-1, aggregate OHP premiums paid to dental plans over the 1994-1996 interval amounted to $106 million, or less than a tenth of the amount paid to health plans. The two largest plans are Capitol Dental Care, accounting for 31.0 percent of

dental premiums paid, and ODS Dental, accounting for 33.7 percent of dental premiums. Two plans, Managed Dental and MultiCare Dental, received approximately ten percent of premiums paid; and two others, Willamette Dental and Roseburg Dental, received between five percent and ten percent.

A.5 Discussion of Financial Results

Although some of the financial performance data may be of questionable reliability, the general thrust of the results is that the health plans, on average, are incurring a modest loss on their OHP lines of business, while the dental care organizations are earning surprising gains. Five of the seven plans that terminated their OHP contracts had incurred a financial loss.

Plan	OHP Termination Date	Profit Margin
Columbia Managed Care	1/31/95	-9.0%
Coordinated Healthcare Network	3/31/96	-10.6
Medford Clinic	9/30/96	12.2
PACC Health Plan	9/30/96	-5.6
PacifiCare of Oregon	9/30/96	-4.3
PrimeCare	6/30/95	4.2
QualMed	8/1/96	-17.7

Perhaps of greater concern, however, is the recent financial experience of HMOO and Kaiser, two of OHP's largest plans. Together, these two plans account for nearly 40 percent of OHP's enrollment. In 1996, HMOO lost almost six percent and Kaiser lost nearly

four percent. Moreover, in both instances, the two plans' financial experience deteriorated sharply in 1996 due to rapidly rising medical loss ratios. In October 1997, OMAP responded to the evident financial difficulties of OHP-participating plans by increasing its health plan rates an average of 10 percent.

While most of the larger, predominantly urban plans are experiencing financial difficulties, the predominantly rural plans, by contrast, are doing extraordinarily well. The three substantially rural plans—Central Oregon Independent Health Services, Mid-Rogue IPA, and SureCare—each earned seven percent or more in 1996. We suspect that this disparity between urban and rural plans in financial results is largely attributable to rate setting. In particular, OMAP does not take account of regional practice differences in its actuarial development. Thus, the rates implicitly assume that the average practice intensity in rural Oregon is the same as that in Portland, despite evident differences in the availability of specialty provider resources.

The comparative financial success of the dental care organizations in 1996 is a conundrum that requires further investigation. If the pre-existing, "pent up" needs for dental care have been met, as we suspect, dental rates should perhaps be adjusted downwards to reflect the lesser costs of maintenance-level care. However, other explanations for the dental plans' recent good fortune may also be possible.