May 2004
Volume 2, Issue 1

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Background Brief on…

Oregon Health Plan

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Background

From 1989 to 1999, the Oregon Legislature passed a series of laws collectively known as the Oregon Health Plan **(OHP)**. OHP expanded access to health care using a combination of public and private insurance plans and a prioritized list of health care services. Currently, more than 450,000 Oregonians have access to health care under the OHP.

The Department of Human Services **(DHS)**, Office of Medical Assistance Programs **(OMAP)** administers the public insurance components of OHP, including Medicaid and the State Children's Health Insurance Program **(SCHIP)**. SCHIP is a separate federal/state funded program to provide health care services to certain low-income children.

The Family Health Insurance Assistance Program **(FHIAP)**, created by the 1997 Legislature, provides subsidies for the purchase of private health insurance by low-income workers. As part of OHP, FHIAP is currently funded solely with state dollars—about $20 million in tobacco settlement funds—and the number of people served is capped at around 4,000. FHIAP currently provides services to people with incomes up to 170 percent of the federal poverty level **(FPL**). Subsidies range from 70 percent up to 95 percent of the premium costs depending on family size and income.

House Bill 2519 (2001) modified the program to provide coverage to more uninsured Oregonians, have more flexibility in the program's benefits, secure more federal dollars, and help control the program's rising medical costs. The program, which began in 2003, is commonly called OHP2 and has three components: OHP Plus and OHP Standard, which are offered through Medicaid. The third component—premium subsidies through FHIAP—is offered through private insurance. Through federal waivers[1], OHP2 was intended to increase the number of people covered, control

[1] OHP2 uses funds that are allocated under federal Medicaid law, so the state must apply for and obtain a special "waiver" of the law from the federal government.

costs by capping the programs' enrollees, and give the state greater flexibility in the programs' benefit packages, which will also help control costs.[2]

Over several special sessions of the legislature and through emergency board actions, and primarily due to revenue shortfalls, some components of HB 2519 were never enacted and benefits for the OHP Standard population were modified or cut altogether. Other requirements for OHP Standard, such as disenrollment for not paying required premiums, also resulted in a considerable number of people being dropped from the program.

During the 2003 Legislative Session, HB 2511 directed DHS to seek federal approval to again modify the OHP. However, this plan was based on a budget contingent on voters approving Ballot Measure 30 for a temporary tax increase. HB 5077 (2003) also prescribed targeted reductions to DHS and other state programs if Measure 30 failed, which ultimately occurred in February 2004.

At the April 2004 meeting of the Emergency Board, Members approved a DHS rebalance and disappropriation plan that preserves all of the services and the entire population for the OHP Plus benefit package, which includes approximately 300,000 Oregonians (see below). The decision was also made to discontinue General Funds for the OHP Standard program, which ultimately will mean dropping approximately 47,000 OHP Standard enrollees as of August 1, 2004. However, discussions are currently underway between the state and health care providers to examine the use of hospital and managed care organization provider taxes to restore services to at least a portion of the OHP Standard population.
(During the 2003 Legislative Session, HB 2747 was passed that imposes a provider tax on managed care organizations, hospitals and Programs of All-Inclusive Care for the Elderly (PACE) for the purpose of generating revenue to help fund the OHP. For more information, see the publication, *Health Care Provider Taxes* at: http://www.leg.state.or.us/comm/lfo/2004_3_Provider_Taxes.pdf)

[2] The OHP is subject to the state budget and availability of funds. Benefit levels, eligibility and other provisions may change from what is outlined in this Background Brief.

OHP Plus

Eligibility

People eligible for OHP Plus include low-income elderly and people with disabilities, people receiving Temporary Assistance for Needy Families **(TANF)**, children eligible for Medicaid and SCHIP up to 185 percent FPL[3], pregnant women up to 185 percent FPL, low-income foster children, and severely disabled people on General Assistance (below 52 percent FPL). Pregnant women and children covered by SCHIP may also enroll in private coverage under FHIAP. Medicaid-eligible enrollees cannot have assets over $2,000, and SCHIP children cannot have assets over $5,000 (with some items excluded for both groups).

OHP Plus coverage

OHP Plus coverage is similar to current OHP coverage prior to the OHP2 waiver and includes:

- Prescriptions[+]
- Physician services[+]
- Check-ups (medical and dental)[+]
- Diagnostic services for all conditions
- Family planning services
- Maternity, prenatal and newborn care
- Hospital services
- Comfort care and hospice
- Dental services
- Alcohol and drug treatment
- Mental health services

Services not covered include:

- Conditions that get better on their own
- Conditions that have no useful treatment
- Treatments that are not generally effective
- Cosmetic surgery

[3] For example, at the 2004 Federal Poverty Level a family of three cannot have an annual income of over $15,670.

[+] OHP Plus recipients with fee-for-service coverage are required to pay $2 for generic drugs and $3 for brand name drugs. There is also a $3 co-payment for outpatient services. Some individuals and services are exempt.

- Gender changes
- Most services to aid in fertility
- Weight loss programs

OHP Standard

Eligibility
Eligibility for OHP Standard includes parents and adults/couples who are not eligible for OHP Plus. Generally, low-income adults with access to employer-sponsored insurance will receive coverage in FHIAP. Enrollees cannot have over $2,000 in assets (with some items excluded such as the person's house or car).

OHP Standard coverage

OHP Standard covers basic services such as:

- Inpatient/outpatient hospitalization
- Emergency room
- Physician services
- Lab/X-ray
- Ambulance
- Prescription drugs

These services include cost-sharing such as co-payments and premiums. Co-payments range from $2 for generic prescription drugs to $250 per admission for inpatient hospitalization. Co-payments are not required for preventive services such as pap smears, mammograms, vaccinations and other similar services. Monthly premiums are based on the person's income, and range from $6 (for those 0 – 10 percent of FPL) up to $23 per month for those with incomes at 100 – 125 percent of FPL. People who fail to pay premiums are disenrolled and subject to a six-month period of being uninsured before becoming eligible for re-enrollment.

Services not covered in OHP Standard include:

- Non-emergency transportation
- Routine vision services
- Services related to hearing aids
- Dental services
- Medical equipment and supplies
- Outpatient mental health and chemical dependency services

Family Health Insurance Assistance Program (FHIAP)

Eligibility
Families with average monthly gross income up to 185 percent FPL may be eligible for FHIAP. Subsidies range from 50 percent up to 95 percent of the premium costs after any employer contribution, based on family size and income. Enrollees who do not pay their share of the premium will be disenrolled and must undergo a six-month period of uninsurance before being allowed to re-enroll. Eligibility is for 12 months. The asset level for FHIAP is $10,000. Qualified individuals must also have been uninsured for at least six months (except for those leaving the Medicaid program).

FHIAP coverage
There are minimal benchmarks for group and individual plans to qualify for the FHIAP program. Plans must include at least the following:

- Coverage in 19 defined benefit categories (group) or 15 benefit categories (individual)
- $1,000/year individual deductible
- $4,000 maximum out-of-pocket per person or $10,000 stop-loss
- $1,000,000 lifetime maximum benefit

Prescription drugs can have cost-sharing up to 50 percent with no out-of-pocket maximum. Plans can have up to a six-month pre-existing condition waiting period.

FHIAP members who have health insurance available to them through an employer are required to enroll in that coverage if the employer pays any part of the premium. All other members can purchase a policy in the individual health insurance market from one of seven FHIAP-certified insurance companies.

The Insurance Pool Governing Board

The Insurance Pool Governing Board (**IPGB**) is the state agency responsible for FHIAP. It also conducts educational seminars to stakeholders across the state on the benefits of providing and/or using health insurance, and acts as a clearinghouse or central source for health insurance information. IPGB is also developing health benefit plans for small, uninsured

businesses as directed by House Bill 2537 (2003 legislative session.)

Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (**OMIP**), also known as the "high risk pool," was established by the 1987 Legislature to provide access to medical insurance for Oregonians who have been denied individual market medical coverage because of a pre-existing medical condition. OMIP also provides health benefit portability coverage to Oregonians who have exhausted COBRA benefits (federal law that may allow terminated employees to purchase group health coverage) and have no other portability options available to them. OMIP has no enrollment cap and no waiting list. To date OMIP has insured over 35,000 Oregonians. The program is funded by member's premiums and an assessment paid by health insurance companies. OMIP is within the Department of Consumer and Business Services.

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