Background Brief on …

Oregon Health Plan

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The Oregon Health Plan **(OHP)** expands 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 program has three components, two of which (OHP Plus and OHP Standard) are offered through Medicaid and the Children's Health Insurance Program. The third component is offered through the Office of Private Health Partnerships as premium subsidies through the Family Health Insurance Assistance Program **(FHIAP)**.

FHIAP provides subsidies for the purchase of private health insurance by low-income, uninsured families. FHIAP provides assistance to people with incomes up to a certain percentage of the federal poverty level **(FPL**) and subsidizes commercial premiums based on family size and income.

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

OHP Plus

Eligibility - As of June 2006, there are approximately 358,000 children and adults in the OHP Plus population. 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 CHIP up to 185 percent FPL[1], pregnant women up to 185 percent FPL, and low-income foster children. Pregnant women and children may opt to enroll in private coverage under FHIAP instead of Medicaid and CHIP. Generally, many Medicaid-eligible enrollees cannot have assets over $2,000, and CHIP children cannot have assets over $10,000 (with some items excluded for both groups).

Coverage - Benefits and services that people on OHP Plus receive include:

- Prescriptions[2,3]
- Physician services[2]

- Check-ups (medical and dental) [2]
- Diagnostic services for all conditions
- Family planning services
- Maternity, prenatal and newborn care
- Hospital services [3]
- Comfort care and hospice
- Dental services [3]
- Alcohol and drug treatment
- Mental health services
- Vision services[3]

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

OHP Standard

Eligibility - As of June 2006, there are approximately 21,000 people in OHP Standard. Eligibility for the program includes parents and adults/couples who are not eligible for OHP Plus. Enrollees must be age 19 and older, not be eligible for Medicare and family income must be under 100 percent FPL. Enrollees cannot have over $2,000 in assets (with some items excluded such as the person's house or car).

Coverage - OHP Standard covers basic services, such as:

- Emergent and urgent hospital care [4]
- Physician services
- Lab/X-ray
- Prescription drugs [4]
- Outpatient mental health and chemical dependency treatment
- Emergency transportation
- Emergency dental
- Some durable medical equipment and supplies (diabetic supplies, respiratory, oxygen)

Services *not* covered include:

- Non-emergency transportation
- Routine vision services
- Services related to hearing aids
- Dental services (besides emergency)
- Most medical equipment and supplies
- Acupuncture (except for treatment of chemical dependency)
- Chiropractic and osteopathic manipulation
- Home health care
- Nutritional supplements
- Occupational, Physical and Speech Therapy
- Private duty nursing

Some OHP Standard clients pay premiums for their coverage. Monthly premiums are based on the person's income, and range from $9 (for those 10-50 percent of FPL) up to $20 per month for those with incomes at 85-100 percent of FPL. Persons with incomes below 10 percent of FPL do not pay premiums. People who owe past premium payments at their semi-annual eligibility determination are disenrolled. These individuals are not eligible to re-enroll until they pay their past premiums and the program is open to new enrollment.

The OHP Service Delivery System

People in the OHP receive health care services through managed care organizations. There are three managed care delivery systems: fully capitated health plans **(FCHPs)**, primary care management **(PCM)**, and physician care organizations **(PCOs)**.

Approximately 74 percent of people in the OHP are enrolled in FCHP/PCOs.[5] These programs are similar to health maintenance organizations **(HMOs)** in that FCHPs receive a set amount of money per enrollee in return for providing the services for which the person is eligible, including inpatient hospital care. There are currently 14 FCHPs in the state that serve OHP clients. PCOs provide the same range of services as FCHPs, except for inpatient hospital services. There is one PCO.

Approximately three percent of OHP enrollees receive their care through a PCM. This care includes preventive, primary care and specialty services managed by a physician, nurse practitioner or other provider.

Due to federal law, state policies or because a managed care organization may not provide services in some parts of the state, approximately 23 percent of OHP clients receive health care on a fee-for-service **(FFS)** basis. These clients receive their health care from a provider who bills the state directly for services.

Enrollees who are eligible for dental and mental health services through the OHP receive care through stand-alone dental care organizations and mental health organizations. These services operate similarly to FCHPs in that dental and mental health plans receive a set amount of money per enrollee to provide health care benefits for which the person is eligible.

Family Health Insurance Assistance Program

Eligibility - Families with average monthly gross income up to 185 percent FPL may be eligible for FHIAP. Subsidies range from 50-95 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. 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, those previously enrolled in FHIAP or those enrolled in Tri Care military insurance.

Coverage - There are minimum benchmarks that group and individual plans must meet 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 (or less) individual deductible
- $4,000 maximum out-of-pocket per person or $10,000 stop-loss
- $1,000,000 (or higher) lifetime maximum benefit

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

Subsidy - FHIAP subsidizes both employer-sponsored (group) and individual health plans. The backbone of FHIAP is the private-sector health insurance market. To leverage state and federal funds (on average, the program receives approximately 65 percent federal match on expended state dollars), as well as private-sector dollars and encourage participation in the employer-based market, 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 (these plans must also meet the benchmark). This allows the state to leverage the employer dollars. However, members who do not have group insurance available can purchase a policy in the individual health insurance market from one of eight FHIAP-certified insurance companies.

Enrollment - As of August 2006, FHIAP has approximately 14,700 lives enrolled in the program, with 38 percent of these members enrolled in employer coverage. While group is less costly to the state, the most vulnerable population are those Oregonians with no access to employer-sponsored insurance. Many of those enrolled in individual health insurance plans work for small businesses where group coverage is not offered or, if it is offered, provides no dependent benefits, they can't afford their share of the premium, or they don't work enough hours to qualify for coverage. Additionally, 27 percent of the FHIAP population is enrolled in the Oregon Medical Insurance Pool high-risk plans (see below). These enrollees are predominantly female, over the age of 50 and have chronic health conditions.

Office of Private Health Partnerships

The Office of Private Health Partnerships **(OPHP)**, formerly the Insurance Pool Governing Board, is the state agency responsible for FHIAP. OPHP conducts educational seminars for 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. OPHP also developed lower-cost, adult-only, limited benefit health plan for small, uninsured businesses. A Children's Group Plan with benefits rich enough to qualify for a FHIAP subsidy was also developed, though enrollment in both plans is low.

Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (**OMIP**), also known as the "high-risk pool," provides access to medical insurance for Oregonians who have been denied private health insurance coverage because of a pre-existing medical condition.

OMIP also provides health benefit portability coverage to Oregonians with no Consolidated Omnibus Budget Reconciliation Act **(COBRA)** coverage, State Continuation, or Portability available to them; those who have already exhausted their COBRA benefits and have no commercial portability options available to them; or who don't live in their portability carrier's service area. COBRA is a federal law that allows terminated employees to purchase group health coverage through their employer.

OMIP also provides coverage to people eligible for the Federal Health Coverage Tax Credit.

OMIP has no enrollment cap and no waiting list. OMIP has over 15,500 enrollees, and to date has insured over 45,000 Oregonians. The program is funded by members' premiums and an assessment paid by health insurance companies licensed and doing business in Oregon. OMIP is within the Department of Consumer and Business Services.

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For more detailed information on the OHP, including historical and legislative information, see *Oregon Health Plan: An Historical Overview* at:
http://www.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf

End Notes:

1. For example, at the 2006 Federal Poverty Level, a family of three generally cannot have an annual income of over $16,600.

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

3. Due to OHP budget cuts from the 2005 session, DHS will eliminate routine eye exams and glasses, limit over-the-counter drugs, limit basic dental restorations and eliminate advanced dental restorations, and limit inpatient hospital coverage at some hospitals to 18 days per year.

4. Due to OHP budget cuts from the 2005 session, DHS will limit over-the-counter drugs, and limit inpatient hospital coverage at some hospitals to 18 days per year.

5. The percentages used in this fact sheet of enrollees in various program are taken from the June 2006 OHP data reports. Note that these reports are a "snapshot" in time and so, due to the time it takes to process individual enrollment and disenrollments, do not reflect the exact and most current number of people in each program.