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Legislative Committee Services  
State Capitol Building  
Salem, Oregon 97301  
(503) 986-1813

Background Brief on ...

# Oregon Health Plan

The Oregon Health Plan (**OHP**) expands access to health care through a combination of public and private insurance plans and a prioritized list of health care services. Currently, more than 500,000 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 (**CHIP**). 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' Division of Medical Assistance Programs administers the public insurance components of the OHP, including Medicaid and the CHIP. CHIP is a separate federally and state-funded program to provide health care services to certain low-income children.

## **OHP Plus**

*Eligibility* - As of January 2010, there were 448,789 children and adults in the OHP Plus population. People eligible for the OHP Plus include low-income elderly and people with disabilities, people eligible for Temporary Assistance for Needy Families (**TANF**), children eligible for Medicaid and CHIP up to 200 percent FPL, 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 adult enrollees may not have assets (with some items excluded such as a person's house and car) over \$2,000 or \$2,500, depending on the individual program. There is no asset limit for pregnant women and most children.

*Coverage* - Benefits and services that people on the OHP Plus receive include (with some co-pays and limitations):

- 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; and
- Vision services\*.

\*OHP Plus dental and vision benefits were reduced for non-pregnant adults (21 years and older), effective January 1, 2010.

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; and
- Weight loss programs.

## **OHP Standard**

*Eligibility* - As of January 2010, there are 25,188 people in the OHP Standard. Eligibility for the program includes parents and adults/couples who are not eligible for the 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).

Last biennium, both hospitals and Medicaid managed care organizations paid taxes to cover

an average of 24,000 clients on OHP Standard. During the current biennium, only hospitals pay taxes to support the program but at a higher tax rate than last biennium. The revenue generated is enough to cover approximately 60,000 by the end of the 2009-2011 biennium. Because OHP Standard enrollment is limited by the tax revenue, the department uses a reservation list to add new people to the program. In October 2009, the department opened the reservation list to gather more names. By May 2010, the list contained the names of approximately 111,000 individuals. The department randomly selects names and mails applications to individuals on a monthly basis to achieve caseload targets.

*Coverage* - The OHP Standard covers basic services (with some limitations), such as:

- Emergent and urgent hospital care;
- Physician services;
- Lab/X-ray;
- Prescription drugs;
- Outpatient mental health and chemical dependency treatment;
- Emergency transportation;
- Emergency dental; and
- 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; and
- 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 whose incomes are at 10 to 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 80 percent of people in the OHP are enrolled in FCHP/PCOs. 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 one 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 19 percent of OHP clients receive health care on a fee-for-service 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 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 are 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;
- \$750/year (or less) individual deductible;
- \$4,750 maximum out-of-pocket per person (includes deductible) or \$20,000 stop-loss; and
- \$1,000,000 (or higher) lifetime maximum benefit.

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

*Subsidy* - FHIAP subsidizes both employer-sponsored (group plans) 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 to 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 benchmarks above). 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 March 2008, FHIAP had approximately 16,200 Oregonians enrolled in the program, with 32 percent of these enrolled in employer coverage. While group coverage is less costly to the state, the most vulnerable individuals 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, 29 percent of the FHIAP population is enrolled in the Oregon Medical Insurance Pool high-risk plan (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. The 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.

### **Oregon Medical Insurance Pool**

The Oregon Medical Insurance Pool (OMIP) is the "high-risk health insurance pool" for the state. OMIP was established by the Oregon Legislative Assembly to cover adults and children who are unable to obtain medical insurance because of health conditions.

The 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.

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

The OMIP has no enrollment cap and no waiting list. As of December 2009, OMIP has approximately 14,481 enrollees. The program is funded by members' premiums and an assessment paid by health insurance companies licensed and doing business in Oregon. The OMIP is located within the Department of Consumer and Business Services (DCBS).

### **Additional Resources**

For more detailed information on the OHP, including historical and legislative information, see [Oregon Health Plan: An Historical Overview](#)

### **Staff and Agency Contacts**

Judy Mohr Peterson, Lynn Read, and/or  
Jean Phillips  
Department of Human Services  
[Division of Medical Assistance Programs](#)  
503-945-5772

Tom Jovick  
[Oregon Medical Insurance Pool](#)  
Administrator, Office of Private Health  
Partnerships  
503-378-5165

Jeanene Smith, MD  
[Office for Oregon Health Policy and  
Research](#)  
503-373-1625

Sandy Thiele-Cirka  
[Legislative Committee Services](#)  
503-986-1485