Oregon Health Fund Board

Eligibility and Enrollment Committee
Recommendations to the Oregon Health Fund Board

June 2008

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Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

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Committee Membership

Ellen Lowe, Chair
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Jim Russell, Vice-Chair
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Jane Baumgarten
Retired
Coos Bay

Felisa Hagins
SEIU Local 49
Portland

Dean Kortge
Senior Insurance Specialist
Pacific Benefits Consultants
Eugene

Noelle Lyda
Ed Clark Insurance, Inc.
Salem

C.J. McLeod
Senior Vice President and Chief Marketing Office
The ODS Companies
Portland

Eric Metcalf
Director of Health Services
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians
Coos Bay

Bill Murray
CEO
Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney
Health Policy Advocate
Oregon Health Action Campaign
Corbett/Salem

Susan Rasmussen
Manager, Special Programs
Kaiser Permanente NW
Portland

Carole Romm, RN
Director
Community Partnerships and Strategic Development, Central City Concern
Portland

John Mullin
Oregon Law Center
Portland

Ann Turner, MD
Physician and Co-Medical Director
Virginia Garcia Memorial Health Center
Portland/Cornelius

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Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. In developing these recommendations, the Committee met 12 times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, February 13th and 26th, March 11, April 8th and 23rd and May 13th 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, fairness to individuals in similar financial circumstances (horizontal equity), and program sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

- *Shared Responsibility*. The Committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of, and the access to, quality health care.
  - A critical aspect of this responsibility was the determination that all Oregon residents (regardless of federal requirements) should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide non-qualified Oregon resident with access to health care services as it is a goal under health reform to minimize/eliminate the cost shift. To the extent that specific groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.
  - Recognizing that a disproportionate amount of the uninsured are at lower income levels signifies that the cost of coverage is beyond the grasp of many Oregonians in this financial situation. Therefore, state contributions are necessary to help achieve coverage at the following levels:
    - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children).
    - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
    - Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these

households in maintaining coverage when they lose their direct state contribution.

- *Equity.* The Committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.
  - All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored insurance.
- *Crowd Out.* Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The Committee operated with the assumption that effective policies will be required to keep employer contributions in the system.
  - In order to mitigate the potential loss of employer contributions if employees and dependents switch from employer -sponsored insurance to state contributions—all employers in the state should contribute to the Oregon Health Fund. Further, the Committee supports a requirement that the employer contribution be coupled with a mechanism to credit employers who continue to provide an essential benefits plan. The specific mechanism should be included as part of the overall financing strategy developed by the Finance Committee of the Health Fund Board.
- *Sustainability.* The Committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The Committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and would be a vital feature of health care reform in Oregon.
- *Maximizing Coverage.* The Committee identified a need for program outreach and social marketing efforts about health care reform. They also recognized numerous administrative barriers to enrollment that must also be alleviated, and that a grievance, mediation and appeal process as well as an independent ombudsman should be established.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee's task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

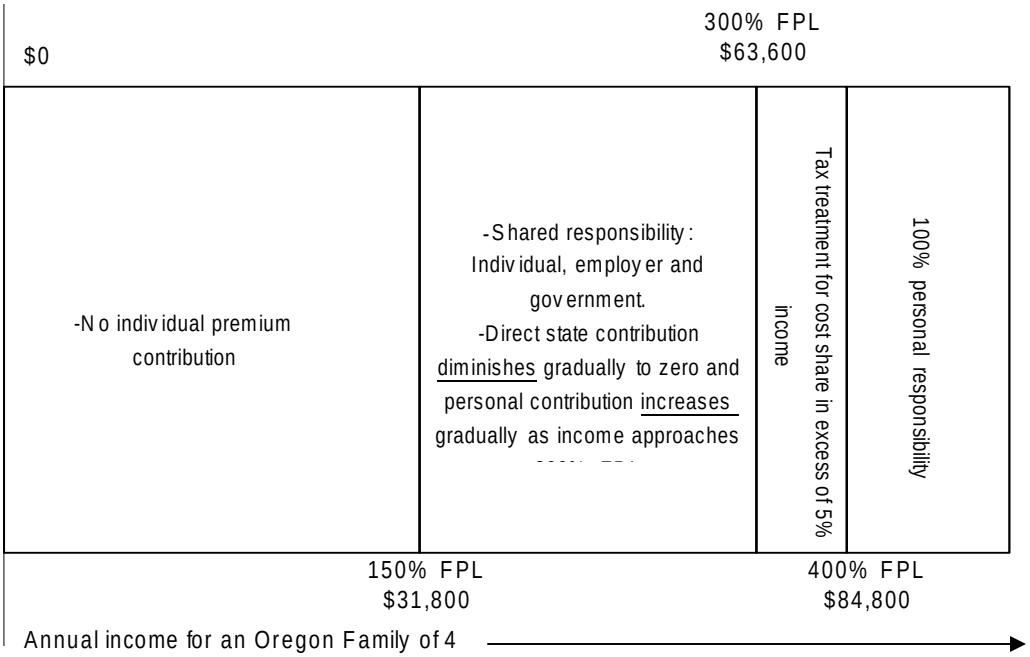
Increasing Annual Household Income →

No Personal Cost Share For Premium Below x% FPL?	Shared State, Individual, and Employer Responsibility Between x% and x% FPL?	100% Personal Responsibility—No State Participation Above x% FPL?

Recommendations

- For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- Structure the personal cost share to emphasize premiums over other types of cost sharing.
  - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
  - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability guidlines as recommended by the Eligibility and Enrollment Committee:



- State premium contribution eligibility for people who have employer-sponsored insurance:
  - All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored insurance. In order to mitigate the potential loss of employer contributions if employees and dependents switch from employer -sponsored insurance to state contributions--ALL employers in the state should contribute to the Oregon Health Fund.
  - Further, the Committee supports a requirement that the employer contribution be coupled with a mechanism to credit employers who continue to provide an essential benefits plan. The specific mechanism should be included as part of the overall financing strategy developed by the Finance Committee of the Health Fund Board.
- Oregon residency: A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.
- Non-qualified Oregon residents: All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide non-qualified Oregon resident with access to health care services as it is a goal under health reform to minimize/eliminate the cost shift. To the extent that specific groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.

- Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.
- Presumptive eligibility for state contributions: An applicant who initially appears to meet income and other program eligibility criteria should be presumed eligible. Additionally, individuals who can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.
- Period of uninsurance: The Committee recommends against any period of uninsurance as a requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.
- Assets: There should be no asset limit placed on eligibility for a direct state contribution.
- Guaranteed Issue: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status. There must be a comprehensive plan to transition the state's high risk pool system, the Oregon Medical Insurance Pool, into a guaranteed issue insurance market.
- Federal Matching Funds: For all components of the Oregon Health Fund Program, the state should maximize the use of matching federal dollars available to Oregon.
- Medicare: Develop mechanisms to provide low-income (<300% FPL) Medicare beneficiaries with the same level of affordability protection advanced to all other Oregonians in the Health Fund Board program. To the extent that Medicare products do not meet the essential benefit plan low-income seniors should have access to state premium contributions for comparable coverage.
- Outreach:
    - There should be an appropriately funded social marketing campaign on state requirements to have health coverage as well as aggressive outreach effort to bring individuals and families into the Oregon Health Fund program for affordability assistance.
    - Social marketing and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to: Schools (public and private and school-based health services, home school associations and support groups, Head Start, child care, safety-net clinics (including rural and migrant clinics), Tribal Health Centers, physician and dental offices, hospitals, pharmacies, social service agencies, accountants, health insurance brokers, 211 Info.

- Identify uninsured individuals and inform them about Oregon Health Fund program.
- Increase outreach and retention for those individuals already eligible but not enrolled.
- To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.
- A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.
- Literacy levels, disability status and linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities (e.g., explanation of benefits).
- Work with employers and other agencies to include information about Oregon Health Fund in their regular communications with employees and stakeholders.

❖ Application

- Application processes should be streamlined to increase the likelihood that eligible individuals will be covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.
- With appropriate privacy safeguards and protections, there should be modification to current state laws that may preclude state agencies from verifying income and other information with existing state databases (i.e. income information from the Oregon Department of Revenue) for state programs to extend health coverage.
- Allow applicants to use the previous year's tax return as a verification option.
- There should be passive reenrollment for the Oregon Health Fund Program as recertification of eligibility for state premium contribution should not create new barriers to enrollment.
- Establish administrative mechanisms needed to prevent participation of non-residents or individuals that move out of the state.

- Optimize the ability of families to be enrolled within the same plan.
- Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.

❖ Grievance and Appeals

- A grievance, mediation and appeal process as well as an independent ombudsman should be established for any health plans operating in the state to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.

❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

❖ Explore potential tax treatments for individuals between 300% and 400% FPL.

❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

❖ Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.

- Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.
- Request the opportunity of returning to previous documentation methodology employed by the Department of Medical Assistance Programs for citizenship. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
- Eliminate the five year ineligibility period for immigrants that become legal permanent residents.
- Eliminate the two-year waiting period for Medicare eligibility after a Social Security disability determination.
- Investigate the methodology applied in determining the Medicare reimbursement levels in Oregon, which currently punishes the state for being efficient.

Eligibility and Enrollment Committee Recommendations to the Oregon Health Fund Board

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the twelve meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	**208,000**	**42%**	**46,000**	**40%**
150% to below 200%	**67,000**	**13%**	**29,000**	**25%**
200% to below 250%	60,000	12%	**10,000**	**9%**
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	**499,000**	100%	**114,000**	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- State of Oregon Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance.*"[1]

[1] Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at http://econ-www.mit.edu/files/128.

- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.*"[2]
- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, "*Impact of Copays on a Medicaid Population.*" *www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf*
- MAC Eligibility and Enrollment Recommendations.
- State of Oregon Revised Statutes and federal law regarding eligibility and enrollment in state programs.
- Analysis Jonathan Gruber and invited testimony by Rick Curtis from the Institute for Healthcare Improvement on horizontal equity.

Proposed Cost Sharing Structure Options

A. The first question addressed by the committee was: *At what income should a family reasonably be expected to share responsibility for premium cost?*

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

B. The second question addressed by the committee was: *At what income level should premium cost be 100% personal responsibility?*

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated

[2] Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit ($15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable

upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty ($26,000 annual income for one person), while a few others felt that the state contribution should not phase out until 400% of federal poverty ($41,600 annual income for one person).

An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

We have to convince conservatives that they have a stake in the uninsured, and that costs can be controlled

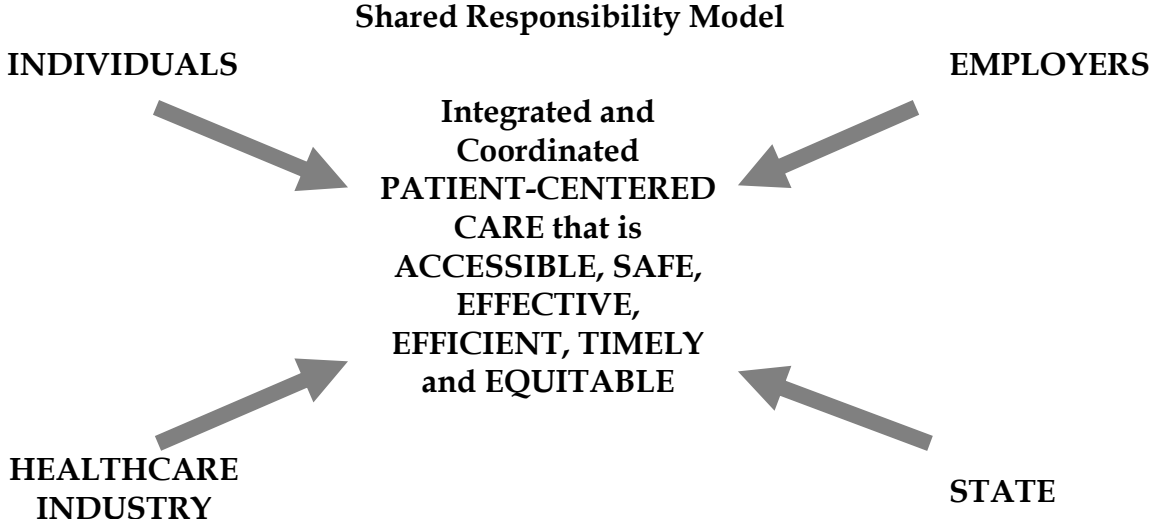
And

We have to convince liberals that limits must be set, and that we can't do everything medical science has invented for everyone.

Summary of Committee Comments

The following summarizes the committee comments leading to these recommendations to the Board:

Shared Responsibility. The committee felt that shared responsibility was the intersection between individuals, employers, the healthcare industry and the state.



First, individuals share responsibility in the affordability debate. As one member stated, "Although [there would be] (hopefully) small contributions from those at low income levels, they would still be participating early on." Members also felt that shared responsibility for the individual included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their healthcare and help reduce costs, too."

About employer responsibility, one member commented, "The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute."

Third, in discussing the responsibility of the health care industry, a member commented, "329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the 'essential' benefits package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning $50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers

participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I … favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

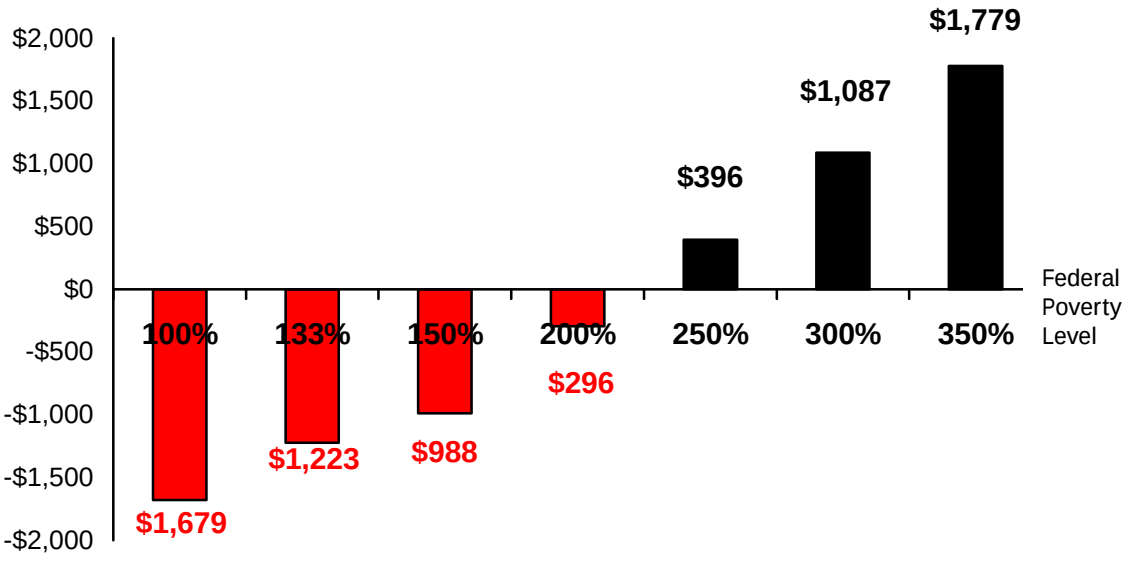
Recommendations

1. **For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.**

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute's review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee's recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee's review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family's income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



Source: Economic Policy Institute "Basic family budget calculator" Accessed online <12.05.06> http://www.epi.org/content.cfm/datazone_fambud_budget

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when … out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums…is unknown, cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'." Another member echoed the "administrative simplicity" sentiment by suggesting potentially

simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

2. **Structure individual cost sharing to emphasize premiums over other types of cost sharing.**
   a) **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
   b) **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee's approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of the federal poverty level (FPL) or $53,000 annually for the Portland area, 200% of FPL or $42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL ($42,000) in the Portland area, 250% FPL ($35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level ($15,600 for an individual or $31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

3. **Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.**

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them—Scale in VERY small increments, particularly for those between 150-200%."

4. **Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.**

The Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

5. **State premium contribution eligibility for people who have employer-sponsored insurance:**
   a) **All low-income (<300% FPL) workers and dependents should have access to receive state contributions through the Oregon Health Fund Program without restrictions based on access to employer-sponsored insurance. In order to mitigate the potential loss of employer contributions if employees and dependents switch from employer -sponsored insurance to state contributions--ALL employers in the state should contribute to the Oregon Health Fund.**
   b) **Further, the Committee supports a requirement that the employer contribution be coupled with a mechanism to credit employers who continue to provide an essential benefits plan. The specific mechanism should be included as part of the overall financing strategy developed by the Finance Committee of the Health Fund Board.**

The Committee's underlying principle in making this recommendation was that all employers in the state should contribute to the cost of health care for their employees and that it would be inequitable to allow the state to absorb the premium costs of low-income employees alone. The intent of the Committee with Recommendation 1a was to require broad-based employer contribution, but to avoid potential challenges from employers on the basis of the Employee Retirement Income Security Act of 1974 (ERISA). However, the Committee was also compelled by the principle of equity for employers as well as their workers and therefore supports the notion of crediting employers for offering coverage to their workers, as is reflected in Recommendation 1b. The Eligibility and Enrollment Committee supports the work of the Finance Committee as it develops financing mechanisms that would integrate these two broad recommendations.

The Oregon Health Fund Board should adopt eligibility policies that maximize health coverage and at the same time encourage the continuation of employer contributions. Policies providing access to state premium contributions for low-income individuals who are currently offered employer-sponsored insurance risk crowding out of that coverage. Because federal law such as ERISA constrains the ability of the state to require employers to provide health coverage—a broad-based requirement for all employers to contribute to a state health fund coupled with a credit mechanism would allow financial support for any potential loss of employer contributions.

The committee considered multiple policy options regarding allowing low-income individuals that have access to employer-sponsored insurance, and eliminated one from consideration: establishing a "firewall" that prevents anyone who is currently offered employer-sponsored insurance from coming into a health insurance exchange to obtain access to a state premium contribution. It seemed to committee members that denying the state contribution to those who enrolled in employer coverage but not to like persons who declined such coverage is untenable and unfair under an individual mandate, and it penalizes those who "did the right thing" by taking up coverage.

Denying a state contribution to low-income workers runs contrary to "horizontal equity" or treating people with similar incomes equitably. Similarly, employers who provide adequate coverage to their employees should also be given consideration in the financing structure adopted by the Board.

Calculations from the 2001 Current Population Survey (CPS) show that only 7% of those offered insurance are uninsured.[3] Below 100% of poverty of all offered, only 25% of those offered are uninsured. This number decreases as incomes rise. For example, between 100-200% of poverty only 13% of those offered are uninsured and between 200-300% the number drops to 7%.[4]

6. **Oregon residency: A statement of intent to reside in Oregon and proof of an Oregon mailing address is sufficient for Oregon Health Fund Program eligibility.**

The Committee believes that the Oregon Health Fund Program should be consistent with other state health care programs such as the Oregon Health Plan (OHP) and the Family Health Insurance Assistance Program (FHIAP). Residency definitions will also define when the individual mandate clock begins. As one Committee member stated, the message in Oregon should be, "Welcome to Oregon, you have xx days to get health insurance coverage."

The Department of Human Services (DHS) is prohibited from denying Medicaid or SCHIP eligibility because an individual has not resided in Oregon for a specified period. An applicant may move into Oregon on the same day they apply for Medicaid or SCHIP benefits, and if they intend to reside for a period of time, they are to be considered Oregon residents. The United States Supreme Court ruling on Saenz v. Roe, 1999 barred states from limiting welfare benefits on the basis on length of residency.

7. **Non-qualified Oregon residents: All Oregon residents should be eligible for the Oregon Health Fund Program. Mechanisms should be developed to provide non-qualified Oregon resident with access to health care services as it is a goal under health reform to minimize/eliminate the cost shift. To the extent that specific groups of people are left out of the Health Fund Program, and to the extent that this population seeks health care, a cost shift will remain.**

Documented and undocumented immigrants are almost always unable to access employer-based or private health insurance, primarily because the average health insurance premium for a family of four is roughly $12,000, nearly half of the average annual income of an immigrant worker. As a result, documented and undocumented immigrants are more likely to go without needed medical services and preventive health care, jeopardizing their health and welfare, and creating some cost-shifting.

The Committee views that if employers of such individuals are contributing to the cost of health care coverage in the state through a payroll tax or some contribution

[3] J. Gruber and E. Washington, Subsidies to employee health insurance premiums and the health insurance market, Journal of Health Economics Volume 24, Issue 2, , March 2005, Pages 253-276.
[4] Ibid

requirement— all of their workers should be eligible. The committee, however, struggled with the issue eligibility for state premium contribution for individuals who lack documentation of their legal status. However, there was general acknowledgement and support for ensuring that there is access to health care services for all Oregonians.

Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care.[5] High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and admission to the hospital for potentially preventable complications of chronic and acute conditions. Moreover, insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by creating barriers to timely access to effective care.[6],[7]

The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between $65 million and $90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.[8] Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence. The Pew Hispanic Center estimates Oregon's 2005 undocumented immigrant population at between 125,000 and 175,000.[9]

8. Period of enrollment: Oregonians eligible for state contributions through the Oregon Health Fund Program should be eligible for 12 continuous months without redetermination.

The following points summarize Committee agreement on periods of enrollment:

- Twelve months of enrollment is consistent with commercial coverage.
- A longer enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
- Less frequent recertification will result in administrative savings.

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[5] A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos, Arch Intern Med. 2007;167(21):2354-2360.

[6] *S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Gaps in Health Insurance: An All-American Problem (New York, The Commonwealth Fund, Apr. 2006)*

[7] Schoen et al., Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, (New York, The Commonwealth Fund, Sept. 2006)

[8] Oregon Center for Public Policy, Undocumented Workers Are Taxpayers, Too, Apr. 2006

[9] *Pew Hispanic Center, "Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS," Fact Sheet dated April 26, 2006.*

- A passive reenrollment process, where families do not complete a renewal form unless changes occur that affect eligibility, will further support continuous coverage and affordability goals.
- Results from the baseline OHP cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly higher medical debt than those with stable coverage.[10]

9. Presumptive eligibility for state contributions: An applicant who initially appears to meet income and other program eligibility criteria should be presumed eligible. Additionally, individuals who can provide verification documents that they have been enrolled in a Medicaid program outside the state within the past 12 months will be presumed eligible to enroll in the Oregon Health Plan until an annual redetermination.

The Committee viewed that a principle goal Oregon Health Fund Board is to provide coverage and access to all Oregon residents and therefore supported reducing administrative barriers to state programs. For the Medicaid program, delayed verification is an option under federal law that allows the program to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications.

10. Period of uninsurance: The Committee recommends against any period of uninsurance as a requirement of eligibility for the Oregon Health Fund Board Program or for the state contribution toward premium.

Requiring that individuals have a period of time without health care coverage works in opposition to an individual mandate provision, which is one of the Oregon Health Fund Board assumptions. Additionally, requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain individuals and thus runs contrary to the fundamental purpose of the Healthy Oregon Act.

11. Assets: There should be no asset limit placed on eligibility for a direct state contribution.

Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources. Collecting and verifying information about assets is complex for both applicants and eligibility workers. Eliminating the need to determine family assets supports a goal of

[10] Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" Annals of Family Medicine 4(5): 391-398, 2006

administrative simplicity. Some members of the Committee felt that establishing a high asset limit may ensure appropriate targeting of state premium contributions.

Asset tests may discourage low-income families from accumulating savings. Research has demonstrated that asset tests were associated with less savings and elimination of asset tests were associated with higher savings.[11] About 78 percent of uninsured adults with incomes below 200 percent of the federal poverty level have net assets (excluding home ownership) low enough to meet median Medicaid asset limit guidelines ($2,000). Of this group, fewer than 40 percent own a home.[12] 47 of 51 Medicaid programs in the country, including Oregon's, do not have an asset limit for its traditional Medicaid population (OHP Plus), although it does have a $5,000 asset limit for the expansion population (OHP Standard). Oregon is also one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs. [13]

12. Guaranteed Issue: All Oregonians should be eligible to enroll in the Oregon Health Fund Program regardless of health status. There must be a comprehensive plan to transition the state's high risk pool system, the Oregon Medical Insurance Pool, into a guaranteed issue insurance market.

If all individuals are required to purchase health insurance, the ability of health insurers to deny coverage based on health status would undercut this requirement. As most individuals are healthy, each person's share of these costs would be modest if excess costs associated with high medical needs are spread across the entire population through an individual mandate. The Committee recognizes that there will be a direct impact on the insurance market by allowing individuals enrolled in the high risk pool into the general market that needs to be mitigated.

13. Federal Matching Funds: For all components of the Oregon Health Fund Program, the state should maximize the use of matching federal dollars available to Oregon.

In exchange for covering certain groups of individuals, the federal government matches the state's Medicaid spending at an established rate called the Federal Medical Assistance Percentage (FMAP). Each state also receives federal matching payments to cover additional groups of individuals and provide additional services. This federal match allows states to maximize their capacity to meet the needs of their low-income population: Oregon's match rate is about 61% and approximately 72% for the State Children's Insurance Program (SCHIP). The Committee assumes that waiver provisions will allow Oregon to have access to Medicaid funding for Oregonians up to 200% FPL for childless adults and parents and SCHIP funding up to 300% FPL for children.

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[11] J. Gruber and A. Yelowitz, "Public Health Insurance and Private Savings," Journal of Political Economy, 107(6):1249-1274. December 1999.

[12] D. M Cutler & A. M Garbe. "Frontiers in health policy research. Vol. 6." NBER Frontiers in Health Policy Research Series. Cambridge, Mass: MIT. 2003.

[13] Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

If the state were to cover all eligible low-income Oregonians under the Oregon Health Plan with limitations of 100% FPL for adults and 200% FPL for children, it would reduce the uninsured population by an estimated 250,000 people. This would require an investment of $390 million from the state that would be matched with $680 million from the federal government. The ability of the state to serve Oregonians is greatly extended by availing itself of federal dollars dedicated to the same purpose. One example would be assuring eligibility to segments of the population such as American Indians that would not require state funds because of federal agreements.

14. Medicare: Develop mechanisms to provide low-income (<300% FPL) Medicare beneficiaries with the same level of affordability protection advanced to all other Oregonians in the Health Fund Board program. To the extent that Medicare products do not meet the essential benefit plan low-income seniors should have access to state premium contributions for comparable coverage.

Low-income Oregonians covered by Medicare may exceed the affordability standards established by the Committee. There are three significant limitations in Medicare that expose low-income individuals to financial risk:

- Medicare does not cover some important health care products and services. For example, the program does not cover many preventive services (such as annual physical exams), routine eye and dental care.
- It has high cost sharing on some covered services such as outpatient care and none on others. These variations may lead to inefficient choices by beneficiaries and providers that could inappropriately affect patients' or providers' decisions about the setting for care.
- It has no limit on total cost sharing (catastrophic cap).
- The Part B premium in 2008 has risen to $96.40 per month. For someone living solely on the Social Security benefit, they will receive, on average, $1,079 per month in 2008.[14] In other words, this is a low income population without adequate health care access. That example means that person would spend 8.9% of their income on the premium alone, with considerable additional out of pocket costs for Medigap or Medicare Advantage, co-pays, deductibles, etc.
- The coinsurance liability for hospital outpatient services (20-55%) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20%). The high (50%) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services.[15]

[14] Social Security Administration – all workers with disabilities – amount varies according to family composition and other eligibility factors.
[15] G.M. Hackbarth. "Medicare Cost-Sharing and Supplemental Coverage" Statement before the Subcommittee on Health Committee on Ways and Means U.S. House of Representatives May 1, 2003.

Oregon residents who are eligible for Medicare are a critical component of the state's health system. Health care reform should include this population in identifying potential cost savings, addressing fragmentation in delivery systems, ensuring access to primary care and preventive services, improving accountability for health outcomes, exploring incentives for appropriate use of medical services and reducing administrative differences and barriers between Medicare and Medicaid. Furthermore, reducing financial barriers to early treatment of chronic conditions for Medicare beneficiaries, particularly those with cardiovascular disease or diabetes may have considerable social and economic value for the state of Oregon by improving health outcomes.

Although there was general consensus that affordability protections should be provided by the state to low-income Medicare beneficiaries on the basis of equity—many of the Committee members felt that a primary goal of SB 329 is to design a health reform plan that has a primary focus on the uninsured and a secondary focus on those who currently have health coverage.

15. Outreach

a) **There should be an appropriately funded social marketing campaign on state requirements to have health coverage as well as aggressive outreach effort to bring individuals and families into the Oregon Health Fund program for affordability assistance.**

A social marketing campaign applies marketing principles to influence behavior to improve health or benefit society. Social marketing is particularly useful in reducing barriers that limit behavior change such as promoting the benefits of health coverage and affordability support given by the state.[16]

Oregon state budget constraints and economic downturns have severely constrained the state's ability to engage in an outreach campaign to enroll eligible individuals into state sponsored health coverage. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures.[17] Evidence from other publicly-subsidized programs such as the Family Health Insurance Assistance Program (FHIAP) and the Oregon Health Plan demonstrate the importance of supporting marketing and other outreach efforts that have been effective and necessary to expand coverage to uninsured Oregonians.

b) **Social marketing and outreach efforts should aim to partner with organizations involved in health, social service, and education programs for individuals, which may include but not limited to:**
    - **Schools (public and private and school-based health services**

[16] *"The Basics of Social Marketing, How to Use Marketing to Change Behavior," Turning Point National Program Office, University of Washington School of Public Health and Community Medicine: www.turningpointprogram.org*
[17] *E. M. Lewit, C. Bennett and R.E. Behrman, (2003)" Health Insurance for Children: Analysis and Recommendations," Future of Children 13(1):1-25*

- **Home school associations and support groups**
- **Head Start**
- **Child care**
- **Safety-net clinics, including rural and migrant clinics**
- **Tribal Health Centers**
- **Physician and dental offices**
- **Hospitals**
- **Pharmacies**
- **Social service agencies**
- **Accountants**
- **Health Insurance Brokers**
- **211 Info**

Public testimony to the Oregon Medicaid Advisory Committee (MAC) from advocacy organizations, programs that serve the uninsured, as well as public testimony, support a broad-based, community-specific, collaborative approach to identifying and enrolling individuals that would be eligible for the program.

c) Identify uninsured individuals and inform them about Oregon Health Fund program.

While media outreach can be effective, targeting outreach and public education campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. For example, Washington State's new insurance laws mandate a "proactive, targeted outreach and education effort" to enroll children in health coverage, with a focus on populations with the highest rates of uninsurance.

d) Increase outreach and retention for those individuals already eligible but not enrolled.

There are high numbers of uninsured who are eligible for public coverage but are not enrolled—this may be due to lack of knowledge about program availability and not valuing coverage. In 2006, over 60 percent of Oregonians that are uninsured are currently under 200 percent of poverty and most of this population is eligible for Oregon public health coverage programs, but are not enrolled.

e) To the extent possible, there should be a coordinated screening effort to link with health and social services programs with similar eligibility requirements.

The Medicaid Advisory Committee's (MAC) community meetings that were part of developing the Healthy Kids Plan revealed possible duplication of effort among various social service agencies that could offer savings of time and money. Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's community meetings offered numerous stories of

bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

f) **A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.**

    i. These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.
    ii. The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.
    iii. The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.

g) **Literacy levels, disability status and linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities (e.g., explanation of benefits).**

This is especially true in communicating the advantage of being enrolled in health coverage to communities that may have a limited understanding of health insurance and what the scope of benefits mean.

h) **Work with employers and other agencies to include information about Oregon Health Fund in their regular communications with employees and stakeholders.**

Employers offer a key facilitation role in gaining health insurance coverage and therefore need to be considered as part of the eligibility and enrollment activities.

16. <u>Application</u>

a) **Application processes should be streamlined to increase the likelihood that eligible individuals will be covered. As part of this streamlining, there should be a "common application screening form" for the Oregon Health Fund Program and it should be as short and straightforward as possible.**

A simple, family-friendly application process is at the core of an effective enrollment strategy. For years, Oregon has relied on a lengthy and complex Medicaid application. Recently, however, the complicated application has been replaced with a shorter form. Making provisions for additional avenues such as on line applications will further simplify the process. This effort should extend to new state programs created by the Oregon Health Fund Board.

b) With appropriate privacy safeguards and protections, there should be modification to current state laws that may preclude state agencies from verifying income and other information with existing state databases (i.e. income information from the Oregon Department of Revenue) for state programs to extend health coverage.

Administrative barriers such as submitting paycheck stubs for a defined period of time, as is done for the Oregon Health Plan, can be onerous on the applicant and have led states to innovate in changes to application requirements. For example, Lewit et al. note that 13 states do not require families to provide verification of the income they report on their applications. The authors contend that this system greatly reduces the paperwork burden on families—noting that these states now verify income and other information by matching identifying information provided by the family with existing state databases. [18] Other studies have also noted that states adopting self-declaration of income report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[19]

c) Allow applicants to use the previous year's tax return as a verification option.

Feedback from Healthy Kids public meetings indicated that income verification requirements (then at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers.

d) There should be passive reenrollment for the Oregon Health Fund Program as recertification of eligibility for state premium contribution should not create new barriers to enrollment.

The recertification process for enrollees is an area where administrative barriers may actively disenroll or prevent continuation of health coverage. Studies have found that "churning"—when individuals fail to renew their coverage during the eligibility redetermination period required by the programs, but re-apply for coverage after the redetermination period is over—increases administrative costs and consumes limited staff time. Moreover, the most valuable benefit of continuous coverage is beneficiaries' improved health when services are not

[18] *Ibid, Lewit et al. 2003.*
[19] *Neuschler, E., and Curtis, R. Premium assistance: What works? Washington, DC: Institute for Health Policy Solutions, March 2003.*

arbitrarily interrupted. Timely preventive and primary care visits can diminish costly hospitalizations and emergency room visits for uninsured residents.[20]

e) Establish administrative mechanisms needed to prevent participation of non-residents or individuals that move out of the state.

Steps should be taken similar to other public programs such as the Oregon Health Plan that do not allow non-state residents to remain enrolled if that individual moves from Oregon to another state.

f) Optimize the ability of families to be enrolled within the same plan.

Feedback from the Healthy Kids public meetings indicated that various health plans and programs can often lead to confusion and bewilderment of families if certain members of the family are enrolled in different plans that have different rules, benefits and providers.

g) Applications should be made widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.

Public testimony to the MAC from advocacy organizations, as well as public testimony, supports a broad-based, community-specific, collaborative approach to identifying and enrolling Oregonians.

17. Grievance and Appeals: A grievance, mediation and appeal process as well as an independent ombudsman should be established for any health plans operating in the state to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of contracting health plan decisions concerning appealable actions.

According to a National Health Law Program study, low-income individuals and families often face significant challenges when resolving service disputes with a managed care organization.[21] People with limited resources, may find it difficult to obtain medical records, understand notices, and even call their health plan for assistance. These difficulties are compounded for individuals who are illiterate or lack access to a telephone and have to go to separate state agencies for resolving complaints in Medicaid and the commercial market. An effective grievance and appeals process becomes even more important within a program that requires every resident to have health care coverage. The Committee would like these processes and administrative functions streamlined in order to avoid confusion and duplication of efforts, while allowing for an independent medical review of appeals.

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[20] *D.C. Ross and I.T. Hill. (2003). "Enrolling Eligible Children and Keeping Them Enrolled," Future of Children 13(1):81-97*

[21] *J. Perkins, K. Olson, L. Rivera, and J. Skatrud. (1996). Making The Consumers'Voice Heard in Medicaid Managed Care: Increasing Participation, Protection, and Satisfaction. Chapel Hill, NC: National Health Law Program.*

While grievance and appeal processes have important formal standing, an independent ombudsman role is also recommended. This function, if done properly, can often resolve issues in lieu of a grievance or appeal. In addition, the ombudsman can steer a consumer to appeal and grievance processes if appropriate. As an example in a system with universal coverage, the Parliamentary and Health Service Ombudsman in the United Kingdom works to hold the National Health Service accountable and notes the following, in consumer friendly language: "we work to put things right where we can and share lessons learned to improve public services." Currently, Minnesota and Vermont are examples of health care ombudsmen in the United States. A healthcare ombudsman program developed in Oregon should have statutorily defined responsibilities to include investigation, negotiation, advocacy, and reporting functions.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- Explore potential tax treatments for individuals between 300% and 400% FPL.
- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

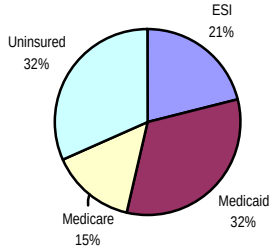
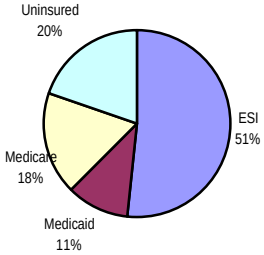
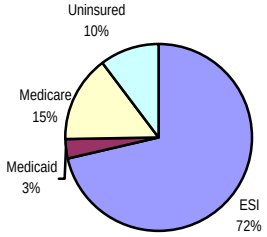
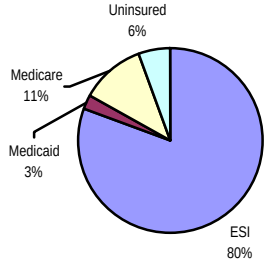
For the Federal Laws Committee

- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)
- Investigate the opportunity of presumptive eligibility for Medicaid if individuals can provide verification of Medicaid enrollment from another state within the past 12 months.

- Explore the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2005.
- Request the opportunity of returning to previous documentation methodology employed by the Department of Medical Assistance Programs for citizenship. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.
- Eliminate the five year ineligibility period for immigrants that become legal permanent residents.
- Eliminate the two-year waiting period for Medicare eligibility after a Social Security disability determination.
- Investigate the methodology applied in determining the Medicare reimbursement levels in Oregon, which currently punishes the state for being efficient.

Appendix A

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
806,000 Oregonians	**1,032,000 Oregonians**	**513,000 Oregonians**	**1,311,000 Oregonians**
-550,000 insured (68%)	-828,000 insured (80%)	-458,000 insured (89%)	-1,211000 insured (93%)
-255,000 uninsured (32%)	-204,000 uninsured (20%)	-55,000 uninsured (11%)	-99,000 uninsured (7%)
Insurance source for < 150% FPL: 	Insurance source for 150% FPL to below 300% FPL: 	Insurance source for 300% FPL to below 400% FPL: 	Insurance source for 400% FPL and above: 

Data from CPS 2-year average, Data collected in 2006 and 2007.

Appendix B

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	$10,400	$15,600	$20,800	$26,000	$31,200	$36,400	$41,600
2	$14,000	$21,000	$28,000	$35,000	$42,000	$49,000	$56,000
3	$17,600	$26,400	$35,200	$44,000	$52,800	$61,600	$70,400
4	$21,200	$31,800	$42,400	$53,000	$63,600	$74,200	$84,800
5	$24,800	$37,200	$49,600	$62,000	$74,400	$86,800	$99,200
6	$28,400	$42,600	$56,800	$71,000	$85,200	$99,400	$113,600
Each add'tl person, add	$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Appendix C

Alternative policy options for horizontal equity in recommendation #1, on employer-sponsored insurance (in order of Committee preference) include:

a) **<u>No Firewall with a two-part employer "pay-or-play" test</u>. Employers would be required to spend at least x% of payroll overall on health care for their workers—or pay the same percent of payroll to the state as a tax—employers would also be required to either:**

- Require employers to spend at least a specified amount per hour worked by each employee individually—or pay the equivalent amount as a tax. (This approach would assure that "offering" employers would have to pay something toward coverage for any of their low-income workers who enrolled in publicly subsidized coverage rather than in the employer's coverage), or
- Spend a specified average amount per hour, or % of wage, per worker on all workers earning less than a specified amount—e.g. less than $20,000 per year. (This approach would assure that offering employers would either spend a "fair share" amount towards coverage of their low income workers or pay the state such an amount toward their coverage.)

The workers included in such a "low-earner" definition would include all modest income part-time and temporary workers not eligible for employer coverage and would allow the state to combine "fair share" contributions from multiple workers towards stable coverage through an insurance exchange.

It is possible in such an approach that employers may take actions to contract with workers or create subsidiaries of workers to avoid state designation of employee responsibility.

b) **<u>Employer "Buy-in"/"Vouchers"</u>: Allow low-income workers and dependents who are offered employer coverage to enroll in publicly subsidized coverage if, and only if, their employer transfers to the pool or public system either, (a) the amount the employer would contribute to the employer's own plan or (b) a specified amount up to (a).**

This approach would have good "horizontal equity" in that employees are not excluded from the state program, and it retains employer contributions. It also may be simpler to administer than "premium assistance."

Due to ERISA, employers cannot be directly compelled to cooperate. Therefore, this approach would leave the worker hostage to employer willingness to cooperate with the state, and it creates the potential for adverse selection cost exposure for the state. There may also be risk selection issues if an employer

chooses to keep low-risk employees and allow higher-risk employees to go to the state program.

c) <u>Benchmark Group Plan option</u>: Alternative approach to the employer buy-in or voucher approach using insurance regulation to make low income benchmark plans available through group health plans. (*Would work where employers offer at least one insured [as opposed to self-insured] plan.)*

This approach requires group insurers to offer (under all employer group contracts) an alternative product to be available to subsidy-eligible low income workers in those groups. The benefits would meet a state "benchmark" plan for low income persons.

Where carriers choose not to directly administer such a plan, they would have the option of coordinating with insurance exchange plans (i.e. collect and convey employer contribution and worker enrollment data.)

Low-income worker contributions for this product could be limited to the amount they would be charged for the publicly subsidized coverage. The state would pay the insurer the difference between the (negotiated) premium for the "parallel" product, less the employer and (subsidized) worker contributions.

d) "<u>No Firewall</u>": Make publicly subsidized coverage available without any conditions relating to availability of employer coverage.

This option provides very good "horizontal equity" in that it gives people with the same incomes equitable access to publicly subsidized coverage. Doing so may be very expensive for the state, because for every worker and dependent currently covered by employer coverage who switches to state-subsidized coverage, it substitutes public funds for current employer contributions. This approach is similar to the Committee recommendation but does not have a financing mechanism to recapture potentially lost employer contributions.

e) "<u>Firewall</u>": Deny eligibility for subsidies to anyone who is offered employer coverage.

This approach attempts to conserve limited state funds by maintaining existing employer responsibility /contributions

But would result in <u>either:</u>

- Some low-income workers with employer coverage paying more out of pocket than they can afford, or
- Increased number of uninsured low income persons if the state waives the individual mandate for workers who face high costs for their employer coverage.

The following options were discussed, but are not recommended:

f) "Firewall with Premium Assistance": As a condition of eligibility for public subsidies (premium assistance), require low-income workers who are eligible for employer coverage to accept that coverage. Make "premium assistance" payments to such workers so that they do not have to pay more out of pocket than they would have for publicly subsidized coverage.

This approach has very good "horizontal equity" but is more expensive than a firewall, and if broad-scale premium assistance "fills in" for shortfall of employer contributions relative to the premium it creates strong incentives to lower employer contributions.

Maintaining employer contributions along with state contributions would be very difficult to administer as obtaining and keeping current information on worker and (all) employer contribution amounts would be extremely difficult.

To make this more feasible, the state might:

- Require all group health insurers to collect employer/worker contribution amounts at initial issue and renewal. This could be easier for the state and for employers, but would not include employers who offer only self-insured plans, or
- Require employer submission of such information as a condition of state tax benefits/deductions/exemptions for employer health insurance outlays. This might be a requirement except where an employer provides such information through its insurer or Third Party Administrator.

This alternative can be more difficult yet if supplemental or "wrap-around" coverage is to be provided, since employer plans vary considerably. It also requires the system to make "premium assistance" payments directly to participating workers, and to verify use for coverage. (Group health plans might be asked to provide such verification)