

OHA/Health Programs – Program Area Totals

	2007-09 Actual	2009-11 Legislatively Approved	2011-13 Governor's Recommended	2011-13 Legislatively Adopted
General Fund	924,283,536	726,423,629	927,628,388	914,450,359
Other Funds	1,230,243,760	1,213,880,749	1,092,772,597	1,664,199,641
Federal Funds	2,688,870,686	4,248,325,814	3,289,615,065	4,237,803,490
Other Funds (NL)	446,265,208	2,862,669,952	3,254,911,521	3,254,911,521
Total Funds	\$5,289,663,190	\$9,051,300,144	\$8,564,927,571	\$10,071,365,011
Positions	288	370	341	543
FTE	268.31	340.75	329.33	527.82

Summary Description

Health Programs consists of Medical Assistance Programs, Public Employee Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), and Private Health Partnerships, as well as program support and administration. It is the largest of the Oregon Health Authority program area budgets, and the 2011-13 legislatively adopted budget includes over \$914 million of General Fund.

The *Medical Assistance Programs* include the Oregon Health Plan (OHP), Non-Oregon Health Plan (Non-OHP), and the Children's Health Insurance Program (CHIP). Almost all the General Fund in Health Programs is contained in these three programs.

OHP is expected to provide medical care to over 600,000 low income Oregonians in 2011-13. Services include physician, pharmaceutical, hospital, vision, dental, and other acute care services. The Health Plan includes the state's Medicaid waiver programs (OHP Plus and OHP Standard), the Children's Health Insurance Program and the Family Health Insurance Assistance Program (FHIAP).

The Non-OHP budget includes payments on behalf of Qualified Medicare Beneficiaries for certain forms of Medicare cost sharing such as co-payments or coinsurance. This budget also contains a General Fund "clawback" payment to the federal government that is required under the Medicare Modernization Act (MMA). In addition, this part of the budget includes funding for the state's Breast and Cervical Cancer program and the Citizen Alien Waived Emergency Medical program.

The 2009-11 budget included the implementation of two service expansions: the Health Care for All Oregon Children initiative (Healthy Kids), and doubling the size of the OHP Standard program. These expansions were funded with a newly established health care premium assessment of 1% and a re-structured Medicaid hospital provider tax, respectively, included in HB 2116. Both of these programs continue in 2011-13.

The *Public Employees Benefit Board* contracts for and administers medical and dental insurance programs for state employees and their dependents, representing about 128,000 Oregonians.

The *Oregon Educators Benefit Board* contracts for and administers medical and dental insurance programs for various school, education service, and community college districts throughout the state.

The *Private Health Partnerships* includes FHIAP which provides health insurance premium subsidies to previously uninsured, low-income families and individuals. It also includes Healthy KidsConnect which is the private market insurance component of the state's Healthy Kids program. It provides choices for families that earn too much to qualify for OHP, but cannot afford to pay the full cost of private health insurance premiums. This unit also includes the Oregon Medical Insurance Pool (OMIP) and Federal Medical Insurance Pool (FMIP), which offer guaranteed issue health insurance coverage for individuals who are unable to obtain medical insurance because of health conditions, regardless of income level.

The *Program Support and Administration* budget provides funding for staff who provide policy direction and administrative support for all programs as well as persons who manage the Health Plan's automated claims payment system.

Revenue Sources and Relationships

Other Funds revenue includes a significant amount of Tobacco Tax (approximately \$334 million), Medicaid provider taxes (about \$947 million), pharmaceutical manufacturer drug rebates, client contributions, third party recoveries, numerous licensing and other fees, and other governmental or quasi-governmental entity (such as the Oregon Department of Education and Oregon Health and Science University) funds eligible for federal match.

In order to avoid large program reductions during the 2011-13 biennium, significantly higher hospital provider taxes were negotiated during the legislative session. These increased provider taxes are expected to generate up to \$460 million in additional Other Fund revenue and almost \$1.2 billion in additional resources when the federal matching revenue is included.

PEBB and OEPP collect premiums for all insured individuals, and then purchase insurance with those revenues. The expenditures are shown as Nonlimited Other Funds in the budget. These programs combined account for over \$2.8 billion in Other Funds Nonlimited, or 28% of the total funds budget for Health Programs. PEBB and OEPP fund their operational costs through an administrative charge (assessment) added to the employees' health insurance premiums. OMIP is funded with premiums collected from insured individuals and insurer assessments, while FMIP is funded with a combination of premiums collected from insured individuals and federal revenues.

Federal Funds revenue sources are mainly two: Medicaid, which accounts for more than 90% of the division's Federal Funds, and CHIP revenue. Medicaid requires a state match and the match rate is recalculated each year by the federal government. The composite match rate used in the 2011-13 budget for Medicaid is approximately 37% state funds and 63% Medicaid funds for most services. This match rate is significantly reduced from last biennium, when the state received the enhanced match rate included in the federal American Recovery and Reinvestment Act (ARRA), at about 30% state funds and 70% federal funds. (Medicaid staffing expenditures, such as those in program support and administration are generally funded with half state funds and half Federal Funds.) CHIP funds also require state matching funds. The match rate for CHIP is about 26% state funds to 74% Federal Funds. Medicaid Federal Funds are, in theory, available as long as a state has matching funds. CHIP Federal Funds are a block grant and each state's allocation is limited by Congress.

Budget Environment

In March 2010, Congress passed federal health care reform legislation, the Affordable Health Care Act, which is intended to reduce health care spending over the next decade. It will expand health care coverage to an estimated 500,000 additional Oregonians by 2014 through a combination of subsidized private insurance and expanded Medicaid coverage. Federal subsidies to states will cover 100% of the additional cost of those who are newly eligible through 2016. It also allocates money to improve quality and halts certain insurance practices. In addition, the law creates exchanges or marketplaces for health insurance in 2014. The Oregon Health Insurance Exchange was established in SB 99, passed during the 2011 legislative session.

HB 2009, from the 2009 legislative session, began Oregon's version of health care reform. It created the Oregon Health Authority and the Oregon Health Policy Board. The Board is charged with coordinating the state's existing patchwork system of purchasing and regulating health care, community services, and workforce training. The Board has been involved in making recommendations on the health care workforce, medical liability, population health, integrated primary care, health purchasing, administrative simplification, and technology.

Oregon, like all other states, has taken an incremental approach to controlling cost growth in Medicaid programs in recent years. Historically, three main levers have been used to control the OHP budget: limit client eligibility, reduce client benefits, and cut provider reimbursement. All three of these tools are problematic. With the 2011-13 budget, the new federal health care reform law requires states to maintain eligibility levels that were in place as of March 23, 2010. Therefore, this tool is no longer available to the state. Also, reducing clients does not address recognized structural flaws in the current health care system. Reducing client benefits is only of limited value under current Medicaid rules since the majority of health care reimbursement is for hospital care or physician services, both of which are mandatory Medicaid services. Oregon can reduce or eliminate optional Medicaid services, such as prescription drugs, dental, therapies, rehabilitation, optometry, preventative and diagnostic services. However, many of these services prevent more expensive alternatives such as

hospitalization. Finally, cutting provider reimbursement will eventually limit access to medical services to low-income Oregonians.

The other option for reducing costs in the system is to structurally change the health care delivery system in Oregon, consistent with the goals of the federal health care reform and HB 2009. This is a health care system that funds services to improve population health, and prioritizes prevention services while removing resources from the back end of the system, primarily hospital care. In addition, administrative costs in the system must be substantially reduced. The challenge for the 2011-13 budget is that reform measures may not produce enough savings in this short timeline.

Finally, the OHP budget is greatly influenced by economic conditions. As a general rule, when the economy is not doing well, more people are without medical coverage and seek Medicaid services. Caseloads are expected to remain high throughout the 2011-13 budget period. Approximately 600,000 Oregonians are forecasted to need some type of OHP coverage during 2011-13, an increase of 14% over 2009-11.

Legislatively Adopted Budget

The 2011-13 legislatively adopted budget for Health Programs is \$10.1 billion total funds (\$914.5 million General Fund). This budget is \$1 billion, or 11%, higher than the 2009-11 legislatively approved budget and \$1.5 billion or 18% higher than the Governor's budget. General Fund in the adopted budget is \$188 million, or 26%, higher than the 2009-11 approved budget.

Although the General Fund increases \$188 million over the 2009-11 biennium, that does not begin to cover the back-fill of more than \$600 million in one-time revenues that were used in the 2009-11 budget – mostly the enhanced FMAP that was provided to states as part of the ARRA stimulus package.

The adopted budget includes standard reductions to continue allotment reduction savings from the 2009-11 biennium, the elimination of inflation, and a reduction in personal services compensation. The budget is also reduced by \$0.8 million General Fund as a result of the 6.5% reduction to services and supplies, and the 3.5% supplemental ending balance hold back reduces the budget by \$33.1 million General Fund for Health Programs.

The Governor's budget proposed reductions to provider reimbursement rates of 19% from the 2009-11 level. The adopted budget mitigates that reduction, primarily through an increase in hospital provider tax. This negotiated hospital tax increase provides about \$260 million in additional revenues to bring the average provider rate reimbursement reduction down to 11.2%. Up to an additional \$200 million in resources will be available to the hospitals. When the federal matching funds are included, this represents a total funds increase of almost \$1.2 billion.

As in the Governor's budget, the adopted budget assumes that cost savings of \$239 million in the second year of the biennium will result from health care transformation, including changes implemented in HB 3650, passed in the 2011 legislative session. HB 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery System in which Coordinated Care Organizations (CCOs) are used to improve health, increase the quality of care, and reduce costs. CCOs will be managed within fixed global budgets, and will be accountable for integrating physical, mental, and oral health care. CCOs are expected to operate under contracted performance standards to ensure that care is being improved while costs are reduced.

The budget also includes a number of benefit changes that result in savings. This includes expanded prior authorizations, a change in pharmacy reimbursement, and selective co-pays, among others. It also includes eliminating 13 conditions from the priority list for the Oregon Health Plan. Finally, the budget assumes several administrative efficiencies, including additional third party collections and the submission of medical claims electronically.

Health Programs – (Special Payments Only)

	2007-09 Actual	2009-11 Legislatively Approved	2011-13 Governor's Recommended	2011-13 Legislatively Adopted
General Fund	902,665,556	697,243,798	899,629,484	878,236,706
Other Funds	1,209,889,241	1,152,847,897	1,057,218,418	1,609,216,777
Federal Funds	2,660,433,030	4,142,352,324	3,240,103,020	4,170,024,067
Other Funds (NL)	446,265,208	2,862,669,952	3,254,911,521	3,254,911,521
Total Funds	\$5,219,263,035	\$8,855,113,971	\$8,451,862,443	\$9,912,389,071

Program Description

Medical Assistance Programs

For budgetary purposes, Medical Assistance Programs special payments are divided into three sections: Oregon Health Plan (OHP) payments, Non-Oregon Health Plan (Non-OHP) payments, and the Children's Health Insurance Program or CHIP.

The *Oregon Health Plan* legislatively adopted budget for the 2011-13 biennium is about \$645 million General Fund – about 73% of the \$878 million of General Fund special payments made by Health Programs. The OHP is governed by a Medicaid state plan which includes waivers to various Medicaid administrative rules. In addition, Oregon statutes also dictate what the state's Medicaid plan will include. The plan, proposed amendments to the plan, and waivers to Medicaid rules all require review and approval by the Centers for Medicare and Medicaid Services (CMS), the federal agency which administers Medicaid. This means that policy changes to the plan, particularly those that would have a significant program or budgetary impact, must pass muster with CMS. This approval process usually takes time. Moreover, reaching consensus about program changes prior to submitting a plan amendment or waiver is difficult because such changes often involve numerous interested parties (e.g., advocates for clients, managed care organizations, hospitals, physicians, pharmacists, pharmaceutical companies, and commercial insurers).

The Medicaid state plan details eligibility for the program, what services or benefits are offered, and how, in general terms, providers will be reimbursed. These three elements – eligibility, benefits, and reimbursement – are the main levers that have been used to control the OHP budget.

Eligibility for OHP

The following is a list of those who are eligible for the Oregon Health Plan. Medicaid is considered an entitlement, under federal law. That is, anyone who meets the eligibility criteria established in a Medicaid state plan must be provided services, without regard to the state's financial ability to pay for those services. In the past if a state wanted to reduce eligibility, it had to receive approval from CMS to do so. The new federal health care reform law requires states to maintain eligibility levels that were in place as of March 23, 2010.

1. Persons receiving cash assistance under the Temporary Assistance to Needy Families (TANF) program.
2. Families transitioning from TANF into employment, who are eligible for 12 months after cash assistance ends.
3. Children in foster care or for whom adoption assistance payments are made.
4. Persons in the Poverty Level Medical (PLM) program, which includes children from birth to age 5 in households with incomes up to 133% of the federal poverty level (FPL), children 6 to 18 in households with incomes up to 100% of FPL, and pregnant women and their newborns in households with incomes up to 185% of FPL. Persons who are age 65 or over who are eligible for Supplemental Security income (SSI). The SSI grant is currently \$674/month for a household of one, which represents about 74% of FPL. In addition, seniors (and persons with disabilities) who are eligible for Medicaid long-term care are also eligible for the health plan. The income standard for Medicaid long-term care is 300% of the SSI grant, or about 233% of FPL. To qualify for long-term care, however, a person must also have impairments that limit their activities of daily living.
5. Blind and disabled persons, who are eligible for SSI or, like seniors, are eligible for Medicaid long-term.
6. Blind and disabled persons who are presumed eligible for SSI.
7. Adults with incomes under 100% of FPL who are not eligible for Medicare may be eligible for the OHP Standard program. Due to cuts in the state's General Fund, OHP Standard closed to new enrollment in 2004. Since that time the program has relied primarily on provider taxes as its state revenue source, allowing a biennial average enrollment of about 24,000 clients. However, the Medicaid hospital provider

tax was restructured during the 2009 legislative session and approved as part of HB 2116, providing funding for another 35,000 adults to enroll in OHP Standard. Medicaid managed care plans will continue to be assessed through a health insurance premium tax – also part of HB 2116. This latter assessment will be used to support the newly established Health Care for All Oregon Children program.

OHP Benefits

All those eligible for OHP, except for those eligible for OHP Standard, receive a benefit package known as “OHP Plus.” Today, OHP Plus includes hospital, physician, prescription drug, durable medical equipment, dental, non-institutional mental health and drug and alcohol services, and transportation to medical providers with limited or no co-payments. Vision services (except those deemed medically necessary) for non-pregnant adults were eliminated from the budget during the 2009 legislative session.

Currently, the OHP Standard benefit package is less comprehensive, and excludes transportation, vision, and a portion of the dental services. The hospital benefit covers only emergency services and hospital admission through the emergency department for conditions for which prompt treatment would prevent life-threatening health deterioration. In addition, Standard requires premium payments for eligible persons with household incomes between 10% and 100% of the federal poverty level. If the premium is not paid, the client will lose coverage.

However, the 2011-13 legislatively adopted budget increases the OHP Standard hospital benefit to be the same level as the OHP Plus hospital benefit, effective January 1, 2012. By increasing the OHP Standard hospital benefit, the state will provide additional coverage for inpatient and outpatient services and will not be limited to urgent and emergent diagnoses.

Underlying all the benefits for both OHP Plus and Standard is the OHP “prioritized list of services.” Services are available based on a prioritized list of health conditions and specific treatments. Theoretically, the amount of funding available determines the services that are covered. The Health Services Commission, administered by OHA, determines the content and establishes the priority of listed services. In practice, however, excluding treatments from the bottom of the list has been difficult to do. Historically, the Health Care Financing Administration (the predecessor to CMS) allowed only modest rationing of services using this method. Likewise, CMS has been extremely reluctant to limit treatment by excluding treatments based on the prioritized list.

OHP Provider Reimbursement

OHP Medicaid payments are made to managed care organizations and, on a fee-for-service basis, to doctors, hospitals, pharmacies, dentists, and other contractors to provide medical services. About 80% of those eligible are served through managed care organizations (other than those providing dental services), which receive capitation payments from OHA and who assume the risk of providing necessary medical services for their members. The remaining 20% are served on a fee-for-service basis. Dental care organizations (managed care organizations providing dental services) serve nearly 95% of those OHP clients eligible for dental coverage.

The *Non-Oregon Health Plan* budget includes several types of expenditures: a General Fund payment to the federal government required under the Medicare Modernization Act for clients eligible for both Medicare and Medicaid known as the “clawback” payment (\$165.6 million General Fund and total funds), and expenditures for the Citizen Alien Waived Emergency Medical (CAWEM) program (\$57.5 million total funds), and women eligible for the Breast and Cervical Cancer Prevention and Treatment Program (\$27.4 million total funds). This budget also includes assistance for low-income Medicare clients which covers Medicare deductibles, coinsurance, and copayments (\$20.1 million total funds), and limited prescription drug coverage for select former clients of the Medically Needy Program. The entire Non-OHP legislatively adopted budget for 2011-13 is \$299.1 million total funds (\$204.9 million General Fund).

The *Children’s Health Insurance Program* is a federal (Title XXI of the Social Security Act) program designed to improve the health of children by increasing their access to health care services. Oregon’s CHIP program was implemented in July 1998. Oregon’s policy makers took advantage of the more favorable federal CHIP match rate (currently about 74% for CHIP versus 63% for Medicaid) to expand OHP services to more children than would have been covered if the funds were coming from Medicaid alone. To qualify for CHIP, children must be ineligible for OHP-Medicaid benefits and have been uninsured, except for Medicaid, for six months prior to

application. In addition, the children must be living in households with incomes between 100% (or, in some instances, 133%) and 200% FPL. Those eligible for CHIP receive the OHP Plus benefit package. The 2011-13 adopted budget for CHIP is \$373.2 million total funds (\$18 million General Fund).

Public Employees Benefit Board

PEBB contracts for and administers medical and dental insurance programs for state employees and their dependents, representing about 128,000 Oregonians. The Board also selects and administers life and disability insurance coverage for eligible state employees. A major part of the Board's responsibility is developing benefit packages to meet the needs of state government and its employees, and preparing benefits information and answering inquiries from employees and their dependents about coverage. PEBB began to move toward self-insurance in 2006. By 2010, 85% of participants were enrolled in self-insured medical and visions plans, and 75% were enrolled in self-insured dental plans. The 2011-13 adopted budget for PEBB is \$1.41 billion Other Funds Nonlimited.

Oregon Educators Benefit Board

OEBB was created in 2007. The Board designs, contracts, and administers benefit plans for about 145,000 educational entity employees and early retirees, and their eligible dependents, in 231 school districts, education service districts, community colleges, and charter schools throughout Oregon. The law prohibits those districts, with certain exceptions, from offering benefit plans other than those offered by the Board on or after October 1, 2008. The 2011-13 legislatively adopted budget for OEBB is \$1.44 billion Other Funds Nonlimited.

Private Health Partnerships

The *Family Health Insurance Assistance Program* was created in 1997 as an expansion of OHP and is regulated by federal Medicaid waivers and administrative rules. It provides direct premium subsidies to low-income individuals up through 200% of FPL who may earn too much to qualify for Medicaid, but not enough to afford private health insurance. Depending on family income, subsidies range from 50% to 95% of the premium cost for adults, and 100% for children up to age 19. The 2011-13 legislatively adopted budget for FHIAP is about \$51.8 million total funds (\$8.9 million General Fund). As of August 2011, about 7,790 members were enrolled in the program, while more than 36,800 people remained on the reservation list. This budget assumes that FHIAP will be closed to new adult applications starting the 2011-13 biennium and enter a period of natural attrition, during which 8,100 covered lives will be reduced to 6,400 by the end of the biennium.

To qualify for a FHIAP subsidy, members must have been uninsured for two months. Members can serve this period of uninsurance while waiting on the reservation list. There are a few exceptions to the uninsurance period including, but not limited to enrollment in OHP or loss of insurance due to change in employment. In addition to a portion of the monthly premium, members are responsible for any co-payments, co-insurance, and deductibles of the plan they select. Enrollment is on a first-come, first-served basis.

Healthy KidsConnect (HKC) is the private sector component of the **Healthy Kids Program**, which was created by the 2009 Legislative Assembly as part of the Health Care for All Oregon Children initiative, established in HB 2116. While the bulk of the expenditures for Healthy Kids are included in the Medical Assistance Programs' budget, Private Health Partnerships' budget includes funding for premium subsidies for the private health insurance coverage offered in HKC. Healthy KidsConnect contracts directly with commercial health insurance carriers for benefit plans that are comparable to the OHP Plus benefits.

Private Health Partnerships provides premium subsidies to families with household incomes above 200% and through 300% FPL. Families may use these subsidies (85 or 90 percent of monthly premiums) to purchase health insurance through Healthy KidsConnect contracted carriers or insurance through their employer, as long as the employer plan meets federal benefit standards. Families over 300% of the federal poverty level can still enroll their children in HKC, but are not eligible for subsidies. The legislatively adopted budget for Healthy KidsConnect in 2011-13 is \$84.9 million total funds. This budget assumes an end of biennium enrollment in Healthy KidsConnect of 14,860 and a monthly average of 10,050. Current enrollment in HKC is 5,279 children as of August 2011.

Health insurer's premium tax is used to help fund both FHIAP and HKC. The tax is forecast to generate \$28.3 million Other Funds revenue for these programs during the 2011-13 biennium.

The *Oregon Medical Insurance Pool (OMIP)* and *Federal Medical Insurance Pool (FMIP)* are the high-risk health insurance pools for the State of Oregon. The high-risk pools serve Oregonians who cannot get private health insurance because of pre-existing medical conditions, regardless of income level. OMIP also serves as Oregon's portability option for residents who are eligible for portability coverage, but have no access to a commercial portability plan. The 2011-13 legislatively adopted budget for OMIP is \$411.7 million Other Funds Nonlimited, while the budget for FMIP is \$41.3 million Other Funds and \$41.3 million Federal Funds.

Revenue Sources and Relationships

The federal government will fund approximately 63% of OHP Medicaid costs during the 2011-13 biennium. Most of the state's 37% match comes from the General Fund, tobacco taxes, a hospital Medicaid provider tax, and a health care premium tax to support children's health care that was established in 2009. The remaining state match for the OHP Plus benefits comes from a variety of Other Funds revenue sources including OHP premiums; federally required drug manufacturer rebates; and recoupments from insurance companies, providers, and clients. Additional revenue comes from state agency and county transfers designed to maximize the receipt of federal matching funds, and from miscellaneous receipts.

A large hospital provider tax increase was negotiated during the 2011 legislative session. The rate is expected to increase from the 2.32% rate at the end of the 2009-11 biennium to a rate up to 5.25%. Part of this increase is subject to federal approval, and the final rate could be somewhat less. These increased provider taxes are expected to generate up to \$460 million in additional Other Fund revenue and almost \$1.2 billion in additional resources when the federal matching revenue is included.

The adopted budget uses \$30 million of the Tobacco Master Settlement Agreement (TMSA) in lieu of General Fund, for the Oregon Health Plan.

PEBB and OEBB collect premiums for all insured individuals, and then purchase insurance with those revenues. The expenditures are shown as Nonlimited Other Funds in the budget. OMIP is funded with premiums collected from insured individuals and insurer assessments. Enrollee monthly premiums fund about 55% of OMIP expenditures, while assessments on health insurers fund approximately 45%. FMIP is funded by a combination of member premiums and funds from the federal government.

Budget Environment

Many factors affect the budget of Health Programs, including population growth and aging; policies of other OHA and DHS divisions and state agencies; federal welfare and Medicaid laws; changing medical technologies and their costs; medical inflation; and the status of the economy. The changes resulting from the federal health care reform, as well as HB 2009, Oregon's health care reform, have been discussed above. The hope is that in the longer run these reforms will reduce costs in the system. However, in the short run, significant reductions to programs have been needed to balance the 2011-13 state budget.

Caseload Changes – The OHP budget is based on caseload forecasts and cost estimates that are projected for the coming two years. Because of the size of the OHP budget, even the slightest variance from the original forecast can result in a significant budget shortfall – or windfall. The caseload forecasts for the OHP used to generate the 2011-13 legislatively adopted budget were developed in the spring of 2011. These forecasts used actual data through September 2010– two years and nine months prior to the end of the 2011-13 biennium. Clearly, this forecast is inherently risky – especially given current economic conditions or if policies are modified without reasonable certainty of the financial consequences. Unlike commercial insurers, the OHP does not have established reserves that can be used if caseload forecasts (or for that matter, costs) are understated and more funding is required – except for the state's General Fund.

Medical Inflation and Utilization Trends – Under federal Medicaid law and state statutes, OHA is responsible for paying rates that are sufficient to assure access to health care services for Medicaid recipients. In other words, Medicaid must adequately reimburse providers of medical care to compete with other health care purchasers in the market place so Medicaid clients may receive services. Because costs for medical services have risen dramatically over the last decade or so, states purchasing Medicaid services have had to spend greater proportions of their budgets on medical services. Causes for these cost increases are complex and include greater use of medical services by an aging population, the use of new high-cost medical technology such as pharmaceuticals or diagnostic tools, medical labor shortages, and a growing uninsured population.

When uninsured persons use medical care, but cannot pay for it, providers may be forced to increase their charges to clients who can pay, thereby driving up commercial and public health care costs. Further, some analysts believe that unique billing systems and extensive paperwork requirements may be responsible for as much as 25-30% of all health care costs. Solutions to health care cost problems have been proposed, but have not been easy to implement in either the private health care market or in public programs such as Medicaid or Medicare. It remains to be seen whether the recent federal health care reforms will significantly reduce these cost trends.

Federal Policy and Funding Changes – Medicaid is a state-federal partnership of unequal partners. The federal share of administrative costs ranges from a low match rate of 50% for most administrative functions to 90% for certain programs. Most program costs are matched at a rate of approximately 37% state to 63% federal funds. The federal government sets the rules and guidelines for the program and must approve any waivers and changes to waivers that are authorized for the state.

Changing congressional priorities and federal funding levels greatly impact funding for Medical Assistance programs. The Medicare Modernization Act (MMA), passed by Congress in December 2003, for example, greatly influenced the health plan budget. The MMA provided a new Medicare benefit, Part D prescription drug coverage. Oregon's 52,000 "dual-eligibles" (clients eligible for both Medicare and Medicaid) had been receiving their prescription drugs through Medicaid. The Medicare Part D benefit meant that these clients would no longer receive a Medicaid drug benefit. This lowered the costs of the Medicaid program considerably. At the same time, Congress required states to make a payment to the Medicare program to support part of the federal government's Part D costs. This payment became known as the "clawback." This General Fund payment is included in the agency's Non-OHP payments' budget that is discussed above. The clawback is based on a formula that conceptually represents a percentage of the savings states would have realized from the elimination of Medicaid drug costs for dual-eligible clients. The percentage used in calculating the clawback is reduced over time, allowing states to realize more savings from the implementation of the MMA Part D benefit.

More recently, in December 2006, Congress passed the Tax Relief and Health Care Act which temporarily lowered the ceiling for Medicaid provider taxes from 6% to 5.5%. This will go back to 6% in October 2011 unless altered by Congress. Discussions in recent months regarding the federal deficit have led to increasing concerns among states that the federal government may significantly reduce their contribution to the Medicaid program.

Benefit Issues – As noted earlier, OHP Plus services are based on a prioritized list of medical conditions, treatments, and procedures. The extent to which the conditions on the list are covered depends on the amount of funding available. In theory, as well as legislative intent, the OHP budget would be balanced and funding decisions made based on the list of prioritized services and available funds. In practice, however, the federal government has allowed very little flexibility in removing services from coverage. Because of this, the agency and the Legislature have looked to alternative methods of budgetary control, such as eliminating specific services or eligibility groups, finding greater efficiencies in delivering care, changing the effective dates of eligibility, and attempting to control medical costs through managed care.

Legislatively Adopted Budget

The 2011-13 legislatively adopted budget of \$9.9 billion total fund (\$878 million General Fund) is almost \$1.1 billion, or 11.9% higher than the 2009-11 legislatively approved budget. Adopted budget General Fund is \$181 million, or 26%, more than the 2009-11 budget level.

The 2009-11 budget used over \$600 million of one-time revenues that were not available in the 2011-13 period. An increase in hospital provider tax replaced a portion of that one-time revenue. While the Governor's budget proposed reductions to provider reimbursement rates of 19% from the 2009-11 levels, the increase in hospital provider tax brought this down to an average of 11.2% reduction. Additional provider tax resources will be available to hospitals to bring their rate reduction down even further. Hospital provider taxes will also be used to increase the intergovernmental transfer to Oregon Health and Sciences University by \$12 million, and to fund an enhanced hospital benefit package for the OHP Standard program beginning January 1, 2012 (\$13.9 million).

In spite of this large increase in hospital provider tax, the adopted budget assumes \$239 million General Fund savings in the second year of the biennium as a result of health care transformation. The passage of HB 3650, as

well as other policy bills, will provide the health care system with tools to help bring down costs to providers. However, there are on-going concerns that the system cannot transform as quickly as assumed in the budget.

Insurer's premium assessments continue to fund the Healthy Kids program. In addition, \$10 million of insurer's tax is used to prevent reimbursement reductions to primary care providers, in order to maintain access to health care for children. Likewise, \$13.3 million is used in order to avoid cuts to children's health services. Outreach efforts for Healthy Kids is reduced by \$2.5 million in order to reprioritize those dollars for direct service, as described above.

A number of benefit changes is expected to generate \$7.8 million General Fund savings. This includes a streamlined prior authorization process, a new reimbursement methodology to pharmacies, and a reduction in the use of non-preferred drugs. The budget does include funding for mental health drugs without the use of an enforceable preferred drug list. The agency also expects to realize \$8.9 million in savings through various administrative efficiencies, including continuous improvement initiatives, additional savings from third party liability efforts, and savings from drug rebate changes as a result of national health care reform. Both the benefit changes and administrative efficiencies include small investments in staff in the Program Support and Administration unit. In addition, the Governor's budget proposed eliminating 39 lines from the OHP priority list for a savings of \$29.1 million General Fund. The legislative budget adds back \$22.2 million General Fund to restore 26 of the 39 lines.

The adopted budget includes \$12.5 million General Fund to eliminate rate reductions for all Type A and B hospitals. Additional General Fund resources were added to the budget to mitigate rate reductions for rural ambulances (\$300,000) and durable medical equipment (\$600,000).

The legislatively adopted budget funds SB 433 which expands medical assistance eligibility for low-income and uninsured women diagnosed with breast or cervical cancer (\$3.7 million total funds), and SB 608 to continue to provide medical liability insurance premium subsidies to physicians and nurse practitioners in underserved rural communities (\$6.1 million total funds).

Finally, the 2011-13 budget includes \$41.3 million Other Funds and \$41.3 million Federal Funds expenditure limitation for the new Federal Medical Insurance pool (FMIP).

Health Programs – Program Support and Administration

	2007-09 Actual	2009-11 Legislatively Approved	2011-13 Governor's Recommended	2011-13 Legislatively Adopted
General Fund	21,617,980	29,179,831	27,998,904	36,213,653
Other Funds	20,344,519	61,032,852	35,554,179	54,982,864
Federal Funds	28,437,656	105,973,490	49,512,045	67,779,423
Total Funds	\$70,400,155	\$196,186,173	\$113,065,128	\$158,975,940
Positions	288	370	341	543
FTE	268.31	340.75	329.33	527.82

Program Description

This budget unit includes funding for the staff that administer Health Programs. This includes the Medical Assistance Programs, PEBB, OEBC, Healthy Kids, and Private Health Partnerships. Of the \$159 million total funds legislatively adopted budget for 2011-13, about 47% is used for personal services (salary, and other payroll expenses such as medical insurance, Public Employee Retirement System contributions, or Social Security taxes). Almost half the budget is for services and supplies. This includes professional services, such as actuarial, pharmacy benefit management, or disease management services. The other services and supplies' budget is used for office expenses, telecommunication, publications, IT equipment, Attorney General costs, and training. The budget also includes a \$4.4 million total funds payment to the State Commission on Children and Families for its Healthy Start program. The Commission transfers General Fund to Medical Assistance Programs where it is matched with federal administrative Medicaid funds and subsequently returned to the Commission in this special payment.

Program Support and Administration now includes the Information, Education and Outreach (IEO) programs that were formally a part of the Office of Private Health Partnerships. These programs establish and maintain relationships with private and public sector partners, train insurance producers, industry professionals, civic groups and employers, and educate consumers and stakeholders on the healthcare delivery system and state program options.

Revenue Sources and Relationships

The Program Support and Administration budget for Health Programs is funded with General Fund, allocations of Other Fund revenue discussed earlier, such as prescription drug rebates from pharmaceutical manufacturers or Medicaid provider taxes, health insurance premium assessments, as well as federal Medicaid revenue. PEBB and OEBC operational costs are funded through an administrative charge (assessment) added to the employees' health insurance premiums. By law, the assessment cannot exceed 2% of monthly premiums. For 2011, PEBB has reduced the assessment from 0.6% to 0.4%, and the OEBC assessment remains at 0.95% of monthly premiums.

Legislatively Adopted Budget

The 2011-13 legislatively adopted budget of \$159 million total funds (\$36.2 million General Fund) is 19% less than the 2009-11 legislatively approved budget. Adopted budget General Fund, however, is \$7 million, or 24%, higher than the 2009-11 budget of \$29.2 million.

The increase in General Fund is a result of two program transfers into this budget. The OHP-only eligibility unit is transferred from the Department of Human Services to OHA and will be combined with outreach functions. This includes \$9.1 million General Fund, \$22.9 million total funds, and 196 positions. In addition, the Care Assist prescription drug program moves from Public Health and is combined with other prescription drug activities in this unit. This transfer includes \$3.5 million General Fund, \$23.5 million total funds, and nine positions.

Other budget adjustments include the following:

- A reduction of \$3.1 million General Fund and \$7.4 million total funds as a result of continuing the 2009-11 allotment reductions.
- The statewide 6.5% reduction to services and supplies reduces this budget by \$0.8 million General Fund.
- A total of nine vacant positions are eliminated, for a total funds savings of \$0.8 million.