

*Investing in Texas: Financing Health Coverage Expansion  
Conference Proceedings*

**The Oregon Experience**

**Kenneth Apfel:** I would now like to introduce another student from the policy research class, Kate Brodsky. She is the perfect person to introduce our next speaker from Oregon—Kate worked in the governor’s office in Oregon and also spent time working for the Oregon legislature, and I think she brings the same passion for the issue of the uninsured as our next speaker does. Next month, Kate starts to work here in Texas here on prison health care issues, which is something I am sure none of us want to experience personally.

**Kate Brodsky:** I am very pleased to be able to introduce Mark Gibson. Mark currently serves as a policy advisor to Oregon’s governor, John Kitzhaber, on health care and human services issues. As executive assistant to then senate president John Kitzhaber, Mark was intimately involved in the creation of the Oregon Health Plan. He has since been involved at both state and federal levels with the plan’s implementation. He has also studied the plan’s progress and made recommendations for adjusting its approach.

Mark has worked as a consultant to state governments on health policy issues. He is a widely recognized expert in health care and health care access, lecturing both nationally and internationally. Mark also serves as chair of the Reforming State Group, a project to reform health care policies and health care decision making in the U.S. I believe Mark can provide us with incredibly valuable insight on developing and implementing strategies for health coverage expansion, particularly in times of economic stress.

Mark is excited to be here in Austin, and I am sure enjoying Austin’s music scene tonight will be a nice change from spending his evenings at the special session that just ended in Oregon. We are also very excited that he could be here. Please join me in welcoming Mark Gibson.

**Mark Gibson:** Thanks Kate. It is certainly a pleasure to be here. Here we are talking about health care reform yet again. You know, I have been at this for almost 15 years now and laboring in this particular venue has given me a real sense of appreciation for what Winston Churchill must have meant when he said “history is just one goddamned thing after another.” Even though it seems like we are just singing different verses of the same old song, I believe that real and substantial health care reform is growing more and more imperative everyday. In fact, if the current trends continue, it may well be one of the biggest domestic issues in the next presidential campaign. I believe this for three main reasons.

First is because our system is enormously inefficient. No other system embraces plurality like we do, and of course in our case plurality is just a euphemism for a wasteful lack of

standardization under the guise of personal choice in which mere mortals, even those of us who actually work in this field, have very little idea of how to determine which of the many options offered to us will be in the best interest of our own families. This results in a system that is staggering under the enormous burden of marketing, billing, and claims costs, none of which provide a single iota of care, nor do they improve quality, nor do they promote better outcomes.

Second, our system is too costly. The cost of purchasing care or coverage is a major barrier to millions of Americans. Moreover, no other nation spends nearly the percentage of its GDP on health care that we do. We spend more for pharmaceuticals than any other nation, effectively subsidizing pharmaceutical research for the rest of the world. We have enormous variations in practice that bear no positive link to better outcomes, but spend copious amounts of money, and we routinely adopt new technology without any evidence-based review of whether or not the new stuff is better than the old stuff.

Finally, our system is inequitable. Perhaps, we could tolerate some of the shortcomings that I mentioned previously, if we were confident that our system was fair and built on a sound policy framework, but alas, here we are at a deficit as well. To bring this point home, I would like to share with you a model piece of legislation that my boss, Governor Kitzhaber, drafted. It is designed to reflect the policy that our current health care system embraces. Let us call this the Healthcare Equity and Empowerment Act of 2002.

Preamble: There shall be no explicit policy objective adopted to guide the allocation of public health care resources.

Section 1: Categories shall be established to differentiate between the deserving poor and the undeserving poor.

(A) The deserving poor shall include women who are pregnant, families with dependent children, and those who are blind and disabled. Citizens in these categories shall be provided with publicly funded health care.

(B) The undeserving poor shall include poor women who are not pregnant and poor men. These citizens shall be denied health care.

Section 2: All those who are over 65 shall be entitled to publicly financed health care regardless of their income.

(A) Employed citizens under the age of 65, regardless of whether they can afford health care for themselves and their families, shall be required to pay a portion of their taxes to purchase health care for wealthy citizens over the age of 65.

Section 3: Tax Benefits and Penalties

(A) All citizens who can afford a private insurance policy shall be allowed to deduct the premium cost of that policy from their taxable income.

(B) All citizens including those who cannot afford health insurance shall be required to subsidize the health care of those who can afford such insurance through disproportionate taxation.

#### Section 4: Criteria for Assistance and Benefits

(A) The criteria of financial need and ability to pay shall not be used to determine eligibility for a public subsidy.

(B) The relative effectiveness of various medical interventions in producing health shall not be considered in determining which services will be paid for by public funds.

Now, I doubt that anyone in this room or anyone in the Texas Legislature would openly support the policy embraced by this Healthcare Equity and Empowerment Act of 2002. Yet these policies are reflected in our current system and if they are not addressed explicitly we will be prevented from truly reforming our health care system. These are exactly the issues that we tried to address in Oregon when we created the Oregon Health Plan. While I am not here to proselytize for what we have done in Oregon (our efforts have met with some success, but we are far from perfect), I would like to offer our policy in contrast to the one I just articulated. To do this I will explain the policy framework we have adopted in Oregon and briefly discuss the programs that have resulted from that policy.

Our experience tells us that the first step in creating a rational health policy is to place health care in its proper context. Clearly, health care is only one of a continuum of the human services available in our society and that are funded by public dollars for certain residents. The beginning of our health care policy in Oregon establishes a rationale for investments in human services including education and social supports. It says that we invest in human services for one primary reason, and that is to assist our residents in becoming as self-sufficient as their abilities will allow. In other words, health care does not stand alone. It is part of a continuum of services that exists in order to help our residents become self-sufficient.

If the overarching goal of human services is to support self-sufficiency, what then is the specific policy objective of health care services? The Oregon policy says that health care is provided for the purpose of improving health and, more specifically, that it is to focus on population-wide improvements in health.

In other words, health care is not the end we seek. It has no intrinsic value. It only has value if it improves health. After all, improved health is what supports self-sufficiency. Health care is a means, health improvement is the objective, and the focus is on the health of the entire population and not on the health of an individual at the expense of the entire population. Our policy recognizes that in the pursuit of population-wide health gain some health care services are more effective than others and that our system must have a mechanism to help us determine which among the many health care services available are most effective in helping us reach our objective.

Our policy also recognizes that there are many other social supports that have an effect on health. Overspending on health care at the expense of some other social supports could actually have an adverse effect on the health of the population we are serving. I will never forget walking by a food drive collection bin on my way to a legislative committee hearing, during a very emotional debate over whether we should fund major organ transplants in our Medicaid program. We were debating whether or not we should provide organ transplants in Medicaid and, at the same time, there was significant evidence that many Oregonians were malnourished. Clearly, housing and education are also good examples of other social supports that must be maintained as part of a logical health policy.

Our policy also recognizes that it is better to cover everyone for a carefully selected set of health care services than to create a richer benefit package for some at the expense of coverage for similarly situated individuals. We all believe that it is better to treat hypertension in a community than stroke or myocardial infarction in the hospital and the long-term care facility; that it is better to provide prenatal care than to wait and treat a low birth-weight infant in neonatal ICU. Our policy pushes this notion one step further. It says that population-based health outcomes are better served by giving fewer (yet high priority) services to everyone rather than by blindly adding high-tech services to the benefit package of persons who have coverage already, yet not providing basic coverage for many others.

So, in Oregon, we moved away from the standard “all or nothing” Medicaid approach of categorical eligibility determination. Instead, we adopted a policy that anyone with an income below the federal poverty level would be eligible for Medicaid, and we also adopted an employer mandate (since repealed, but that is another very long story), requiring coverage to be provided for all employees who worked at least 17.5 hours per week.

Expanding coverage to this extent brought us face-to-face with the limited ability of both government and employers to finance such coverage. So, our policy then required us to reduce services when funds were insufficient to purchase everything provided by the health care system. We in effect decided to explicitly ration health care services as opposed to reducing eligibility standards, thereby rationing people out of the system. To make sure that our rationing system supported population-based health gain, we prioritized the health care services available based on their respective ability to improve and maintain health.

One of the things that we have learned along the way was that when you are constructing a publicly financed benefit package, you must very carefully separate the work of determining the clinical effectiveness of health care services and in determining how much of those services will be provided. One process is clinically oriented, while the other is strictly a resource allocation issue.

In our approach, the evaluation of the effectiveness of health care services was conducted by a commission consisting of five physicians, two consumers, a licensed social worker, and a public health nurse. This group was charged with prioritizing health care services

but not determining how much of the priority list should be funded. Obviously, a commission focused solely on health services would want to include as many of those services as possible as benefits. The number of services to be funded was left strictly to the legislature because clearly the legislature is where the balance must be struck between health care and all of the other valuable services the state provides. So the commission created a prioritized list of services and the legislature constructed the Medicaid benefit package by funding down the list of services until it determined that the next available state dollar was better spent elsewhere. A commission biased toward health care did not make resource allocation decisions and the legislature was spared the dilemma of trying to determine if infertility services were more important to population health than an appendectomy.

In the legislation that became known as the Oregon Health Plan, we set our population eligibility at 100 percent of the federal poverty level regardless of category. In addition to that, all health services were prioritized and the reimbursement for providing those services was determined by an actuary, not the state budget process, in order to avoid rationing by underpayment of providers. Now, many of you have watched the phenomenon that take place as provider reimbursement rates sink—access just vaporizes because providers reach the limit of loss that they can absorb with every additional patient. On the private sector side, we enacted the employer mandate and a high-risk pool for people that have been underwritten out of the commercial insurance market.

I want to talk just a little bit about the prioritization by the Health Services Commission because it is always a point of interest in terms of how we came up with a list that set priorities over all of those services that are available in the health care system. First, all similar conditions were grouped together (e.g., fractures of the long bones) and services that would treat those conditions were linked to them (e.g., immobilization and surgical reduction). Then these condition/treatment pairs were ranked according to three criteria: first priority was given based on the ability of a condition/treatment pair to prevent death; second, if condition/treatment pairs were equal in their ability to prevent death they were then rank ordered from the least to the most expensive; and finally, the list was altered to reflect the values that Oregonians expressed as desirable in their health care system. Thus there was both an objective and a subjective element to the priority setting.

This yielded a list topped by acute fatal conditions where treatment would restore the patient to his or her previous state of health. Examples would be appendectomy for appendicitis, or hospitalization and antibiotic treatment for bacterial pneumonia.

Maternity care was second because Oregonians placed high value on good birth outcomes. Acute fatal conditions where a person's life would be saved but they would not return to their former state of health were next. Severe stroke or head injury or other disabling trauma are examples of such conditions.

Preventive care for children came next followed by treatment for chronic fatal conditions. Chronic fatal conditions included diabetes and asthma as you might expect, but also treatable cancers, and in one of the more important developments to emerge from the priority setting process, serious mental illnesses were also included. If you think about it,

schizophrenia is a chronic fatal condition that if left untreated has a significant mortality incidence. The same can be said for bipolar disorder and some other severe mental illnesses. The commission recognized that the mind could not be separated from the body and from this point forward in the priority-setting, mental health services were fully integrated into the list.

These categories of care were followed by reproductive services, comfort care, which includes palliative care for terminally ill patients, dental care, and so on until at the low priority end of the list are treatments that have very little demonstrable health benefit.

As I mentioned before, the legislature funded down the list to the point where it felt additional state dollars would be better used elsewhere. The Oregon Legislature has funded 566 of the 700-plus condition/treatment lines on the list. All patients receive the primary and diagnostic care required to establish a diagnosis, and when a condition treatment pair is funded, it includes all ancillary services required to complete the care needed including prescription drugs, physical therapy, etc. The last three funded lines are contact dermatitis, symptomatic urticaria, and dysfunction of the tear ducts. The first three lines that are not funded are chronic anal fissure, dental conditions such as broken appliances that require complex prosthetics, and some impulse disorders.

The last feature of the OHP that I'll discuss is an insurance subsidy program called the Family Health Insurance Assistance Program (FHIAP). FHIAP subsidizes personal insurance either through employment-based coverage or coverage in the individual insurance market. It is not an entitlement; it is budget-capped. It works in this priority order: if you have children in your family, you can get a subsidy to cover your children, and if you cover your children, you can also cover the adults and we'll help subsidize your insurance. If you have employer-sponsored coverage offered, you have to take the employer-sponsored coverage. If you do not have employer-sponsored coverage then you can go to the individual market for your coverage.

We have about 6,000 people currently covered and 20,000 people on the waiting list. About 90 percent of those covered are in the individual insurance market. The subsidy varies based on family income as follows: between 100 and 125 percent of the priority level, we cover 95 percent of the patient's premium costs. If the employer picks up part of it, we only subsidize the patient's portion of the cost. From 125 to 150 percent, we subsidize 90 percent of the patient's cost; and from 150 to 170 percent, we subsidize 70 percent of the cost.

Because of the repeal of the employer mandate in our original legislation, we have incrementally expanded from our 100 percent of the poverty level cut-off point that we originally adopted in 1989.

All of this activity has yielded a coverage patchwork that looks like this:

- Medicaid covers all persons regardless of category up to 100 percent of FPL.
- Medicaid and CHIP cover pregnant women and all children up to 170 percent of FPL.

- The FHIAP subsidizes private insurance premiums up to 170 percent of FPL but is capped subject to funds available.
- The high risk pool subsidizes premiums for persons underwritten out of the commercial market regardless of income.

Our current efforts to expand the Oregon Health Plan are focused on the gap between 100 and 200 percent of the poverty level. That is primarily where all of our remaining uninsured are. At 200 percent of the poverty level, 95 percent of the folks have health insurance. We think of that 5 percent uninsured level as more or less an organic rate of uninsured that will be very difficult to close simply because there are residents for whom an insurance style coverage is virtually unusable.

Expanding the Oregon Health Plan at this moment is both difficult and necessary. It is difficult because the Medicaid system exists within the health care system. It does not drive the health care system, and so the cost increases occurring in the health care system overall right now are played out in our Medicaid system as well and that creates enormous pressure within the state budget. This pressure is further exacerbated by changes in state law enacted through the initiative petition process that have shifted 80 percent of the responsibility for funding K through 12 education onto the state general fund without any additional revenue, and have sent the state on a prison building boom that further erodes our ability to fund health services. Further complicating our effort is the fact that we have the highest unemployment rate (8.1 percent) in the nation and a revenue system that depends almost exclusively on the income tax. Of course when employment dips, the income tax follows.

However, we have some underutilized opportunities as well, such as the fact we have underutilized our CHIP funds by about \$19 million per year. So we are missing out on some valuable matching funds.

In spite of these challenges, we felt there had to be a way for us to make a little more progress and with the Bush administration coming into Washington, it appeared some additional flexibility might be available, so we are preparing another waiver request that reorganizes the OHP. The plan expands Medicaid eligibility and expands the insurance subsidy program, and we do this through increasing federal matching funds and reducing benefits to certain members of our Medicaid population. The benefit reduction was consistent with our policy, which says that it is better to cover more people for less than it is to maintain a rich benefit package for fewer people. By all accounts, even using the prioritized list, the Medicaid benefit package was the best coverage in the state of Oregon, bar none, even in the commercial sector.

Medicaid will expand for women and children to 185 percent of the federal poverty level. These expansions are an entitlement. In addition, eligibility for persons who would not have been categorically eligible prior to the Oregon Health Plan being enacted will expand up to 185 percent of FPL, but this expansion is budget-capped. Finally, the proposal will allow us to receive federal matching funds for our insurance subsidy

program, which is currently funded with state-only dollars. This structure allows us to do the whole expansion within the current cost of our Medicaid program.

The benefit reduction was accomplished by creating two benefit packages within the OHP. One is the current comprehensive benefit package provided through the priority list, and it will cover pregnant women, children, and persons with disabilities. The second benefit package has fewer services and it will be provided to adults without disabilities. Our attempt here was to find a surrogate for medical vulnerability, and to a large extent, poor adults that do not qualify for disabled coverage fit that bill.

The reduced benefit package is about 78 percent of the actuarial cost of the current Medicaid benefit. We eliminated vision coverage although diseases of the eye are still cared for. We eliminated non-emergency transportation, and through a carefully structured cost-sharing process, cut down on the cost of our dental package by almost 50 percent. Additional cost-sharing requirements are imposed for professional services, hospital inpatient care, and pharmaceuticals. As a result, we lowered the cost of coverage for the non-disabled adult population by about 22 percent. The savings from the benefit reduction are then used to help fund the eligibility expansions.

The increased cost-sharing was at times controversial because, for example, as the hospital association pointed out, a \$250 copayment for hospitalization is not going to be affordable for some of these patients. The counter to that argument was that many of these patients would be admitted anyway and their copayment would be 100 percent, so on balance this allows the hospital to have a payer associated with this person, and even though in some cases they will not be able to collect that copayment, 95 percent of the cost of the care is covered for the hospital. The most difficult cost-sharing to structure was for pharmaceuticals, due largely to the fact that some of the people in this group have significant mental illness but still do not qualify as disabled, and they have very low incomes. To deal with this, patients with incomes below 100 percent of the poverty level had very low copayments of between \$2 and \$3.

When all of the eligibility changes are made from the benefit reduction and the infusion of additional federal dollars we estimate that we can expand access to about 55,000 additional Oregonians who are currently uninsured with an income below 185 percent of the poverty level. This creates coverage for another 1.5 percent of our population.

In closing, during conversations at dinner last night, I came to understand that you are grappling with many of the same issues that we are struggling with in Oregon, and as you struggle with those challenges, I would really encourage you do two things. First is to take the time to set a clear policy that will guide the programmatic steps you take. If you have that clear and defensible policy, then I think you have a far better chance of developing the support required to make some real progress. We have been lucky in Oregon in the past to have strong support from hospitals, physicians, consumer organizations, organized labor, and others, but as funds become scarcer and as costs in the system increase, even those coalitions that have served us well in the past are becoming strained. Having a clear policy framework to point to is something that has been very beneficial in holding that together.

Finally, remember that health care reform should not just be limited to adding pharmaceutical benefits for patients who already have Medicare coverage or to increasing protections to folks who already have managed care coverage, but rather it has to be about providing a floor of preventive and primary care for some of the 40 million uninsured that live in our country. It is clear we can do better, and it is clear we must because reform is imperative. Do we have time for questions?

**Kate Brodsky:** Mark, could you speak a little bit to the issue of coalition-building that Oregon needed in order to implement this plan?

**Mark Gibson:** You know the building of coalitions is a pretty ticklish process but one of the pieces that was important in the original health plan, and as I mentioned, as resources shrink it gets more and more difficult to hold this together, but I think it is always worth a try to go this way. In the original process, everybody with a legitimate health care interest came to the table and together we articulated the policy we wanted to pursue. Then, as we articulated the program changes for reforming the system, people were able to argue their own self-interest within the context of the agreed policy. So, having the general discussion first was critically important so that we understood the framework we were working in, and then as the specific pieces were put in place, folks could say, well, that is not going to be good enough for us in the hospital industry because of X, Y, and Z, but their responsibility was also to bring back a solution that fit within the policy framework. So, if you can create a structured conversation that is guided by policy and then has folks offering solutions to their particular problems in their particular interests within the context of that policy, it helps in the long run. It helps sustain the results in the long run as well.

**Jim Walton:** I am a practicing internist, and I would like to ask a question. As you reformed your program in Oregon, how would you weigh the buy-in from the physician community to participating in the Oregon Health Plan and actually taking care of the patients and being a part of that network of providers.

**Mark Gibson:** The physicians were incredibly constructive. They are still the plan's strongest supporters, I think, among the various interest groups that act in health care in Oregon. There is a lot of detail but I left that out. Essentially, what we did was we committed to do this in a managed care system wherever possible within the state. Physicians have taken these patients on capitation, and they have provided a medical home for these patients. They see them like their own patients. Access improved remarkably as a result of those arrangements and especially in places like pediatrics and for Medicare for older adults, we have had some really striking improvements in terms of both access and results, in terms of better birth outcomes and so on. So, the physicians have been great. They have been very supportive, and there is some real pressure there right now. Oregon is a traditionally low-reimbursing state. Its AAPCC is among the lowest in the nation on the Medicare side, and, as you all know, Medicare and Medicaid are two separate programs, but they are connected through the providers that see the patients, and so there are stresses and strains and it's hard for them, but they are still staying with us.

**Jim Walton:** What do you measure at the state level to actually demonstrate that the physicians are participating? What are your sensitive indicators, what we would call dummy lights on our car, that tell you that they are actually playing with you, and your provider network is stable, improving, increasing, or decreasing?

**Mark Gibson:** In the evaluation requirements placed on us by CMS, we have to essentially shadow bill everything that takes place under the managed care system, so we have that, and then we audit the feedback from the provider community, so we track those processes and services through our monitoring program.

**Jim Walton:** What are you tracking? What would you recommend us to track to be able to demonstrate the stability of your provider network? Actually seeing the patients in the preventive medical home as opposed to just paying the bills in the emergency room, or those who used to be uninsured are now insured by the state, and you are just paying the bills now?

**Mark Gibson:** Basically, we have a lower incidence of emergency room use in our Medicaid clientele than in the commercially insured, so that is one thing that we look at, and we believe that we have been successful in getting there. In addition to that, we are articulating policies to make sure that we are supporting hospitals when it is appropriate for them to send the patient back to their medical homes as opposed to deal with them in the emergency departments. So, there are number of ways in which we are doing that. Hospital charity care has dropped significantly since this has been instituted.

**Ruth Bryant:** Would you expand on what you said about the long-term cost benefits of prenatal care as opposed to crisis births and the statistics on infant mortality in the nation as a whole?

**Mark Gibson:** That was one of the things we looked at in the process of deciding where we can spend our money. There was a value judgment made by Oregonians in a series of both surveys and public forums throughout the state, a value judgment made that maternity care was absolutely critical. A good healthy start is one of the best things we can do for any child born in Oregon, but we think that there is good outcome data to support that getting care to mothers prior to birth is going to improve their outcomes. We are now in the top 10 in terms of good birth outcomes, in terms of low incidents of low birth-weight and neonatal hospitalizations required.

**Mario Salinas:** I am with the comptroller's office. I was wondering if you could speak about the clinically validated benefit and if you use something besides just outcomes, maybe protocols of some kind to validate a benefit?

**Mark Gibson:** That is a great question. The Health Services Commission thought about moving into the articulation of practice guidelines. They steered away from that ultimately because they felt that was something that needed to come from the medical community as opposed to being imposed upon the medical community. The way that was done in Oregon was, as we did the priority list, we convened subcommittees of the specialties for the various condition/treatment pairings, and so we consulted Oregon

physicians and asked what the research shows, what does your practice experience show, and how should these pieces be ranked, and their work went back to the Health Services Commission for its final integration. So, we used a snapshot of the best practices we could find in the state at the time and that is the way we continue to do that.

**Mario Salinas:** So, if we could get a little bit more detail on your current proposal and how you are achieving budget neutrality—are you going up to 185 percent?

**Mark Gibson:** Right.

**Mario Salinas:** And in order to do that, you are adopting a more limited benefit package and increasing copayments on the entire population that you are covering. So, some people in your system are losing coverage.

**Mark Gibson:** Right.

**Mario Salinas:** In order to achieve neutrality. I guess my question is more about the politics of how that plays out in Oregon. How people who are advocates for current recipients think about that kind of proposal.

**Mark Gibson:** Right. That is a great question too. Just to be a real clear about this, pregnant women, children, and people with disabilities all still have the comprehensive benefit package established by the priority list with only nominal copayments and optional copayments. That population is still covered under the first level. It is the new eligibles, the folks who would not otherwise be eligible for Medicaid; it is that group of people who are primarily single adults and childless couples. Those are the folks who have the truncated benefit package, and it is the savings from that that then finances the additional expansion, both for children and pregnant women, and for an additional group of the new eligibles.

And the next piece is by having that additional flexibility, we were able to change the structure of our insurance subsidy program enough to go back and argue that we need a HIFA waiver to bring those folks in and use the rest of our SCHIP allotment which we are leaving on the table for New York to spend every year. So that combination of factors gets us about 55,000 people over a two-year period, and somewhere in the neighborhood of \$120 million new federal dollars, which is a shot in the arm for us in Oregon. We have about 3.5 million people in the state, about the size of some of your counties, I understand.

**Kenneth Apfel:** I would like to thank our two panelists for giving us some real food for thought. We are going to hear from Leah Kegler next to talk about the potential applicabilities and options for Texas in this general area. Thank you very much.