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Health Policy Brief

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The Oregon Health Insurance Experiment. A 2008 lottery extending Medicaid to selected residents allowed for a randomized study on the impact of Medicaid coverage.

WHAT'S THE ISSUE?

One of the principal strategies contained in the Affordable Care Act (ACA) to achieve near-universal health insurance coverage is expansion of eligibility for the Medicaid program. There has been much debate about whether expansion of the Medicaid program should be used to extend health care benefits to the low-income uninsured.

This brief summarizes findings of the Oregon Health Insurance Experiment, a randomized controlled study made possible by a unique lottery process used in 2008 to expand Medicaid coverage in the state. The study addresses many of the issues being considered by policy makers, including take-up rates and characteristics of enrollees; use of health services; health outcomes and measures of well-being; enrollee finances and medical debt; as well as indirect societal effects on labor markets, private insurance coverage, and participation in other public programs.

WHAT'S THE BACKGROUND?

Medicaid, established under Title XIX of the Social Security Act (SSA), is the jointly financed federal and state program that provides comprehensive health insurance coverage to many of the poorest Americans. States must meet certain minimum federal requirements in terms of the populations that must be covered, minimum benefits, and service delivery but otherwise have flexibility to tailor their programs within federal parameters. Under section 1115 of the SSA, the secretary of health and human services (HHS) has broad authority to grant demonstration waivers that allow states to implement their Medicaid programs in ways that deviate from federal requirements, so long as the programs are determined by the agency to promote Medicaid objectives.

Prior to implementation of the ACA, in the absence of a waiver, eligibility for Medicaid was limited to individuals with limited income and assets who fell within specified categories such as children, pregnant women, parents of eligible children, and individuals with disabilities. States could not receive federal Medicaid matching funds for individuals who did not fall within one of the specified categories. Those excluded from eligibility consisted primarily of low-income nondisabled childless adults.

The Oregon Health Plan

In the late 1980s, with approximately 18 percent of Oregonians uninsured, a group of citizen activists engaged the state in a discussion of the ethics of the existing Medicaid system that granted comprehensive health benefits

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to certain groups of poor people but excluded others altogether. This process resulted in the development of the Oregon Health Plan (OHP), an experimental approach to implementing Medicaid whereby all citizens or legal residents with incomes under the poverty level would be eligible for Medicaid coverage. Because the OHP's design contained a number of variations from federal Medicaid requirements, a section 1115 waiver from HHS was necessary.

Oregon submitted a waiver application to HHS in 1991. The waiver was ultimately approved by the Clinton administration in February 1994. The Oregon Medicaid waiver has been revised and renewed a number of times since then and currently has approval until June 30, 2017.

The OHP contains two components intended to produce the savings in the program necessary to finance the expanded enrollment. First, covered benefits are based on a prioritized list of health services, along with their treatments, ranked according to their clinical effectiveness, cost-effectiveness, and value to society. Then, based on the resources available in the state budget and the estimated costs of the benefits, the state draws a line. Those services and treatments above the line are included in the benefit package, while those below the line are not. Preventive and chronic disease management services are generally near the top of the list, while those that fall below the line include conditions that get better on their own (for example, sore throat), conditions that respond to home treatment (for example, sprains), cosmetic procedures, and conditions for which aggressive treatment is generally ineffective (for example, advanced cancer).

The second source of projected savings under the OHP is the use of full-risk capitated plans to deliver benefits to enrollees. Generally, enrollees must enroll in a managed care plan that serves their community. If there are none, or if the plans have insufficient capacity, enrollees are assigned to primary care case managers who are paid a monthly fee by the state to manage their clients' care. The OHP also uses separate prepaid plans that specialize in providing dental, chemical dependency, mental health, and transportation services.

In 2003 a serious downturn in Oregon's economy caused the state to significantly restructure the OHP. Instead of changing eligibility criteria to reduce enrollment in the expansion population, the state chose to reduce benefit costs for this population.

HHS approved a new waiver allowing for the creation of the OHP2. Two distinct benefit packages—still based on the prioritized list—were offered to the individuals participating in the demonstration. The original benefit package, renamed the OHP Plus, was provided to those categorically eligible for Medicaid. A new benefit package, the OHP Standard, was created for the expansion population: Oregon citizens and legal residents ages 19–64 with incomes below the poverty level who were uninsured for at least six months.

The OHP Standard imposed premiums, required higher copayments, and had more limited benefits (for example, dental, vision, mental health, and chemical dependency services were scaled back or eliminated) than the first OHP. The expansion population also saw stricter premium collection rules requiring automatic disenrollment of individuals for late or missed premium payments and locking them out of the OHP for six months.

State officials misjudged the impact of these OHP Standard provisions. They underestimated the price sensitivity of OHP enrollees as well as the effects of complex coverage and cost-sharing rules and strict administrative rules related to premium payments. Instead of expanding the number of enrollees, enrollment in the OHP Standard plummeted by more than half, from 102,000 in 2002 to 51,000 in late 2003. Researchers Bill J. Wright and colleagues, of Providence Health and Services' Center for Outcomes Research and Education in Portland, Oregon, found that those who left the OHP were disproportionately very poor and likely to remain uninsured, experience unmet health care needs, accumulate sizable medical debt, and experience financial strain.

In 2004 voters in Oregon rejected a tax measure intended to help fund the OHP. As a result, new enrollment in the OHP Standard was closed as of July 1, 2004. Many of the problematic policies were subsequently changed for the 24,000 remaining enrollees, including elimination of copayments, exemption from premiums for those with incomes up to 110 percent of the poverty level, a six-month grace period for payment of premiums, and elimination of the six-month lock-out from coverage for failure to pay premiums. The OHP experience provided valuable insights for policy makers considering strategies to expand coverage of low-income populations.

WHAT'S THE EXPERIMENT?

The Oregon Health Plan Enrollment Lottery

After a multiyear freeze on new enrollment, Oregon officials determined in early 2008 that they had sufficient resources to reopen enrollment in the OHP Standard. Yet they also expected demand to be greater than the number of slots permitted by the new funding. So, for a limited time in early 2008, Oregon opened an additional 10,000 slots in the OHP Standard and established a reservation list for those interested in enrollment. More than 85,000 people put their names on the list. Between March and October 2008, about 35,000 individuals were randomly selected from the list in a lottery and permitted to apply for coverage for all members of their households. Of those selected, only about 60 percent submitted an application, and only about one-third of those applying actually met eligibility requirements and were allowed to enroll. Oregon used the lottery system, periodically opening new slots, as its strategy to expand Medicaid up until the implementation of the ACA in 2014.

The Oregon Health Insurance Experiment

The Oregon lottery provided a unique opportunity for research on the effects of Medicaid coverage on health care use, health outcomes, financial hardship, and other outcomes, as it provided an essentially randomized study population. A group of academic researchers and key individuals associated with the OHP organized themselves as the Oregon Health Study Group to take advantage of this opportunity. A study population was established from the reservation list, including approximately 30,000 individuals who were selected and roughly 45,000 who were not.

Administrative data, including hospital discharge and emergency department records, credit reports, mortality records, and records on participation in other public programs, were analyzed for this entire group. Data on a subset of the study population were collected from mail and telephone surveys, as well as more detailed in-person interviews and physical health screenings. Study results from the Oregon Health Insurance Experiment have been published in a number of peer-reviewed publications including *Health Affairs*, the *New England Journal of Medicine*, *Science*, and *American Economic Review: Papers and Proceedings*.

Analysis of those who joined the reservation list showed them to be older and sicker than the target OHP population and more likely to be motivated to obtain insurance. Based on survey responses, the researchers attributed the low enrollment rate to the fact that many whose names were selected from the lottery did not meet eligibility requirements and also to barriers posed by paperwork and documentation requirements.

The Experiment's Early Findings

Examination of the effects of Medicaid coverage on the use of health services revealed greater use of all types of health care services by the population enrolled as a result of the lottery compared to those remaining uninsured. Specifically, the researchers found that the likelihood of using outpatient care rose by 35 percent, the likelihood of being hospitalized rose by 30 percent, and the likelihood of using a prescription drug rose 15 percent.

In the first year of coverage after the lottery, Medicaid increased the use of preventive care, including cholesterol monitoring, by 50 percent, and more than doubled the likelihood that women older than age forty had mammograms within the past year compared to the control group, those who remained uninsured. In the eighteen months after the lottery, emergency department visits increased by about 40 percent on average for the newly enrolled group as compared to the control group.

The experiment also allowed researchers to examine the impact of coverage on people's health. A survey and health screenings conducted about two years following the lottery revealed mixed results on the impact of OHP enrollment on health status. While enrollment increased the probability that people reported themselves to be in good to excellent health (compared with fair or poor health) by 24 percent, certain objective measures of physical health did not show significant signs of improvement.

Specifically, there was no statistically significant effect on measures of blood pressure, cholesterol, or blood sugar or on the diagnosis of, or medication for, blood pressure issues or high cholesterol. Medicaid enrollment also did not reduce the predicted risk of a cardiovascular event within ten years and did not significantly change the probability that a person was a smoker or obese. It did, however, raise rates of diabetes detection and manage-

40%

Emergency department visits increased by about 40 percent.

ment, and it reduced observed rates of depression by 30 percent.

Researchers also found that being enrolled in Medicaid clearly had positive effects on participants' financial well-being. Enrollment nearly eliminated out-of-pocket catastrophic medical expenditures and reduced the probability of having to borrow money or skip paying other bills because of medical expenses by more than 50 percent and decreased the probability of having an unpaid medical bill sent to a collection agency by 23 percent. Analysis of the indirect effects of Medicaid expansion on the labor market showed no statistically significant effect on employment or mean annual earnings.

"Researchers also found that being enrolled in Medicaid clearly had positive effects on participants' financial well-being."

After The Affordable Care Act

As part of its strategy to obtain near-universal coverage, the ACA makes fundamental changes to the Medicaid program. Beginning in 2014, eligibility for Medicaid has been expanded to include all citizens and legal US residents younger than age sixty-five with family incomes up to 133 percent of the federal poverty level. Because the law allows 5 percent of income to be disregarded for purposes of determining eligibility, the effective income threshold is 138 percent of poverty. In 2015 this amounts to $16,105 for an individual and $32,913 for a family of four (higher in Alaska and Hawaii).

The ACA requires that all states expand their Medicaid programs or face withholding of their existing Medicaid funding. However, in 2012 the US Supreme Court ruled that the federal government could not withhold matching funds for states' existing Medicaid programs if they choose to forgo expansion, essentially making Medicaid expansion optional for states. As of June 2015, thirty states and the District of Columbia had expanded their Medicaid programs, two others were considering expansion, and nineteen states had opted out.

Under the ACA, the federal government pays most of the costs for those made eligible because of the new rules: 100 percent for the years 2014–16. After 2016 the federal matching rate is phased down year by year until it reaches 90 percent in 2020 and beyond. The ACA also requires that minimum Medicaid benefits for the expansion population include the ten essential health benefits required of coverage offered through the new health insurance exchanges. Section 1115 waiver authority is changed in the ACA only to the extent that it requires greater transparency in the waiver process and creates some new waiver authorities.

Oregon expanded Medicaid eligibility in conformance with the ACA, effective January 1, 2014. Since the OHP Standard did not meet ACA essential benefit requirements, all Medicaid enrollment in Oregon is now in the OHP Plus. The state continues to use the prioritized list of health services and managed care.

WHAT'S THE DEBATE?

A great deal of controversy exists about reducing the number of uninsured people in the United States through Medicaid expansion. Advocates for Medicaid point to evidence showing that Medicaid has been an essential part of the nation's safety net, providing access to comprehensive health care for the nation's most vulnerable.

Critics of Medicaid, on the other hand, believe Medicaid has put a tremendous strain on state budgets and increased dependency on government programs. They argue for state-based solutions that place more emphasis on subsidizing enrollment in private insurance for the low-income uninsured. The findings from the Oregon Health Insurance Experiment are cited by both sides as evidence in support of their positions.

Advocates for Medicaid expansion emphasize the importance of the Oregon study findings related to reduced rates of depression as well as reductions in the financial burdens of health care. In an editorial in the *New England Journal of Medicine*, Richard Kronick and Andrew Bindman point to Oregon's success in providing the two primary purposes of health insurance: financial protection and improving access to care. They also argue that the lack of improvement in health status may be as a result of limitations of the study, such as the small study sample and short follow-up period. Jonathan Cohn cautioned in the *New Republic* that the Oregon study did not disprove that Medicaid produced physical health benefits, only that it could not pinpoint results with enough precision.

Conservative commentators argue that the study's failure to show improvements in health outcomes proves that Medicaid does not work. They also make the point that Medicaid is supposed to reduce costs by improving access to primary care settings and reducing

emergency department care, and that this was not the early experience in Oregon.

Advocates remind critics that, unlike Medicaid, private insurance is typically not assessed on whether it improves clinical health outcomes.

WHAT'S NEXT?

As ACA implementation continues, the findings of the Oregon Health Insurance Experiment can be useful to other states to help in estimating the impacts of Medicaid expansion on their budgets, designing programs to avoid some of the pitfalls experienced in Oregon such as enrollment strategies and benefit design, working with providers to meet increased demands for services, and developing broader strategies to improve the health status of enrollees.

The Obama administration continues to work with states to address some of their concerns with Medicaid expansion. They have granted some section 1115 waivers for such things as allowing Medicaid funds to be used to subsidize the purchase of private insurance and charging premiums and allowing cost sharing not otherwise permitted under the law.

Medicaid expansion is caught up in the long-standing partisan debates that are beginning to heat up for the 2016 election. Changes in political leadership in Washington or in the states could have significant implications for Medicaid expansion and for health coverage in general. ■

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