Health Affairs Blog

Oregon's High-Risk, High-Reward Gamble On Medicaid Expansion

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Health policy in Oregon is like football in the Southeastern Conference: not only a contact sport but also a source of intense civic pride. In the early 1990s, under the leadership of its physician Governor John Kitzhaber, Oregon created a "first in the nation" state-run managed care plan for Medicaid, the Oregon Health Plan, expanding its covered population by nearly 50 percent. He funded the expansion in part by a controversial priority system for redesigning the benefit package, and instituted population-based payments to health insurers.

The Oregon Health Plan succeeded in mainstreaming Medicaid patients into private plans, eliminating the Medicaid stigma, and markedly broadening physician acceptance of Medicaid patients into their practices. Within a decade, however, economic pressures caught up to the OHP, and a recession forced the state to reduce eligibility for the program by almost 50 percent. When Kitzhaber returned to office in 2010, co-incident with the implementation of the Affordable Care Act (ACA), he made the reconstitution of the Oregon Health Plan the centerpiece of his third term as Governor.

Establishing Coordinated Care Organizations

In 2012, Kitzhaber made a bold contract with the federal government through a Section 1115 Medicaid waiver: Oregon would reduce the rate of growth of per capita spending by two full

percentage points, to 3.4 percent per year, in exchange for $1.9 billion in federal funds. The waiver enabled both a significant expansion of the program and full risk capitated contracting for the entire covered population through contracting entities known as Co-ordinated Care Organizations (CCOs).

When the coverage expansion unfolded in the fall of 2013, Oregon's new risk contracting framework enabled the state to expand its Medicaid population by nearly two-thirds, adding more than 400,000 citizens to coverage. Today, over one million Oregonians participate in the Oregon Health Plan, roughly 25 percent of the state's citizens. By comparison, California expanded its Medicaid population by a little more than one-third.

News of the expansion of OHP was overshadowed by the crash of Oregon's ill-starred state exchange, Cover Oregon, which collapsed in a heap of lawsuits and political recriminations in 2014, forcing Oregon to rely on the federal exchange. The exchange population eventually reached 147,000 additional citizens. The combined effect of Exchange enrollment and the expanded Oregon Health Plan brought Oregon's uninsured population down to around 7 percent, below the national average.

Kitzhaber's original vision for the CCOs was for them to function as community-governed purchasing co-operatives on behalf of the Oregon Health Plan, with seven CCOs covering the state's vast geography. As the intense local politics surrounding CCO implementation unfolded, Kitzhaber's seven CCOs expanded to 16, with two metro areas—Portland and Medford—both having two "competing" CCOs covering their geographies.

In important respects, CCOs differed from the Accountable Care Organizations (ACOs) created by the Affordable Care Act. They had more power; they actually purchased health coverage from health plans and care systems on behalf of real, not statistically attributed, patients. They were also fully prospective in funding, not shadow systems looking backward at historical performance.

While some of these CCOs were run by previously existing health plans such as CareOregon, PacificSource, and FamilyCare, others were run by Independent Practice Associations (IPAs) owned and governed by local physician groups. Others were special purpose community organizations created specifically to represent local care systems, county governments, and consumer advocates.

Portlandia

Portland, Oregon is one of the most mature managed care markets in the nation, with almost two-thirds of its Medicare population in Medicare Advantage plans, and more than 25 years of experience with managing non-Medicare risk in the commercial market. Many Portland physicians will actually not accept regular Medicare, urging their patients to choose a MA Plan to reduce both cost and hassle.

Kitzhaber wanted a single CCO—HealthShare—to cover metropolitan Portland. However, political pragmatism resulted in two CCOs, and an incredibly confusing matrix of contracting relationships. A Medicaid/Medicare Managed Care Organization (MCO), FamilyCare, whose root system emerged from the Osteopathic medical community, pulled out of HealthShare at the last minute, forming a competing CCO with a narrower network of providers. This created complications for enrollees, who had to be assigned to the right CCO based on their primary provider of choice, or else randomly assigned when they signed up for OHP coverage.

All the state's CCOs were pragmatic to the extent that they shifted risk to care providers, calibrating their contracting methodology to the capacity of the local health system to manage

risk. But all of them limited resource growth to the 3.4 percent per capita rate of increase built into Oregon's 1115 waiver, and crossed care system silos to incorporate behavioral health and dental care into the package.

HealthShare became the state's largest CCO, enrolling almost one-quarter of Oregon Health Plan members. Rather than an ACO, it mirrored the Health Alliance structure envisioned by the abortive Clinton reforms — a commissioning body that transmitted population health risk to health plans (but also care systems). HealthShare's founders included CareOregon, the largest Medicare/Medicare Advantage health plan in the state, as well as the rest of the major non-profit health plans in metropolitan Portland and all the major Portland care systems, who otherwise vigorously compete against one another in the commercial and Medicare Advantage markets. (To further confuse the picture, Care Oregon, with roughly 250,000 members, operates two other CCOs in the rest of the state.)

Successes And Controversies

The CCOs were a stunning success. In three short years, they accumulated over $900 million in surpluses. At least four distinct factors were responsible: the advance funding provided by the 1115 waiver (much of whose $1.9 billion in payments were front-end loaded into the first two program years), a deliberate set-aside of CCO revenues as reserves, a very generous capitation rate from the state's Medicaid agency (the Oregon Health Authority), and aggressive care management activities from the CCO's capitated networks.

Oregon Health Plan's expansion far exceeded expectations, bringing into the Medicaid pool a lot of healthier (and employed) younger people who used far less care than expected. According to Bruce Goldberg, former Director of the Oregon Health Authority, CCOs also cut emergency room visits and costs, raised primary care visits, and achieved a 50 percent increase in medical home enrollment, suggesting that they may have improved the health status of their members. Whether they achieve Kitzhaber's loftier goal of reallocating care system dollars away from acute care by ameliorating some of the social determinants of ill health is subject to debate.

The CCOs' success generated political controversy, both about the investment of CCO surpluses and about the surprise sale in 2015 of one CCO founder — a physician controlled IPA based in Eugene that founded the Trillium CCO — to Centene, a publicly traded Medicaid managed care company, for around $100 million. Both Kitzhaber (who resigned in early 2015 in the midst of a media tornado regarding alleged but yet unproven conflicts of interest) and the Oregon General Assembly health leader Mitch Greenlick have criticized the CCOs for failing to invest sufficiently in community health and for being insufficiently transparent about their governance and payment policies.

At the very time that CCOs were racking up large unexpected surpluses, Oregon's individual health insurance market melted down into a pile of goo. Underwriting losses were widespread in 2015, including Kaiser Permanente, Portland's largest health insurer, and the Providence Health Plan, as well as Regence Blue Cross, the region's largest health insurer. For most, the losses carried over into the first half of 2016.

Some observers feel the State's certifying 16 plans for the Exchange might have set health plans up for failure. Washington State certified only six plans for a state with a 75 percent larger population. Other observers suggested that just as the CCOs might have benefited by enrolling a less-sick population than the current Medicaid enrollees, private insurers may have been damaged by enrolling a disproportionately sick and therefore costly segment of privately insured or exchange lives. In other words, selection effects might have broken in different directions in the public sector and private markets.

Many people I interviewed attribute the individual market meltdown to an aggressive effort by a local insurgent insurer, Moda, to grow its marketshare with deep premium discounts unmatched by cost controls or rate concessions from providers. Moda's share grab was successful; they got well more than half of the first wave of exchange members, and a lot of off-exchange individuals to boot. This was followed directly by hundreds of millions in underwriting losses. Moda's expectations to recover some of its losses from the federal risk-corridor reimbursement scheme created by the ACA to cushion against adverse selection were dashed in early 2016. As of this writing, Moda continues to struggle financially, despite being recapitalized mid-2016 with a $165 million asset sale.

A tidal wave of underwriting losses swamped Oregon's two CO-OP health plans (Oregon's Health CO-OP and Health Republic) forcing them to shut down. They also forced LifeWise, Premera Blue Cross's Oregon subsidiary, to exit Oregon's insurance market. Several other start-ups, like the physician-founded health insurance plan Zoom+, also withdrew from the exchange.

Obstacles On The Horizon

Even though it met its cost growth objectives for the waiver, the costs for the ambitious coverage expansion to Oregon taxpayers are mounting rapidly. For the two-year budget 2017-2018, Oregon faces a $700 million deficit due to Medicaid, created by two changes in federal matching formulae: the resetting of the federal match for the 400,000 newly eligible from 100 percent to 95 percent, and a downward readjustment of the match for the rest of its Medicaid population based on improvements in Oregon's per capita income. There is also a large unfunded liability for pension costs for Oregon's public employees, bringing the state's looming deficit to around $1.3 billion.

In the November 2016 election, which was otherwise a Democratic sweep in the state, Oregon voters rejected Measure 97, which would have levied a 2.5 percent gross receipts tax on all businesses with more than $25 million in sales. This tax would have raised $6 billion over two years, creating a comfortable fiscal cushion to sustain committed public spending. Governor Kate Brown has apparently taken rolling back the Medicaid coverage expansion off the table in budget talks, focusing instead on raising revenues and cutting OHP expenses. It remains to be seen how enduring this commitment will be.

According to Mitch Greenlick, closing the revenue gap may require increases in the state's Medicaid provider tax and possible tightening of the state's community benefit requirements for non-profit hospitals. On the cost side, it would not be surprising to see reductions in the Oregon Health Plan's capitation payments to CCOs. How robust the care management capabilities of CCOs, or the leverage from potential investments in social determinants to reduce health spending, may be sorely tested by a capitation rate reduction. Those unexpected CCO surpluses mentioned earlier will probably end up being re-purposed, either targeted at social determinants, or else reclaimed for deficit reduction.

None of these calculations take into account the potential impact of a repeal of Obamacare by the newly unified Republican government in Washington. Congress might also reduce the federal match for the 400,000 newly covered Oregonians as part of a block grant transformation of Medicaid. The fate of the renewal of the 1115 Medicaid waiver currently under negotiation is also uncertain. The state was looking for $1.25 billion for the next five years of Oregon Health Plan operations (2017-2022). That decision awaits the incoming Trump administration and will undoubtedly become entangled in the politics of "repeal and replace."

Another fiscal risk is the effect of a possible recession on state revenues. Because the state lacks a sales tax (a radioactive political issue), has no rainy day fund like neighboring California, and already has one of the highest personal income tax rates in the nation, it lacks the fiscal

flexibility to cope with a downturn in the economy.

Oregon is not unaccustomed to rain, and sustaining the remarkable coverage expansion made possible for the Affordable Care Act may take no less than heroic political leadership.

HEALTH POLICY LAB

ASSOCIATED TOPICS: COSTS AND SPENDING, MEDICAID AND CHIP, MEDICARE, PAYMENT POLICY

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