

## **Chapter 2**

# **Context of the Oregon Proposal**

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## Context of the Oregon Proposal

## INTRODUCTION

Oregon's Medicaid proposal is the State's unique response to the changing health care system. This chapter will explore the context of the Oregon proposal by reviewing the State's demographic composition and health status indicators, the dilemmas of the Medicaid program, and the problem of an increasing uninsured population.

*Population and Income*

In 1990 the State of Oregon had approximately 2.8 million residents (278). Most lived in the metropolitan areas in the western part of the State; more than 68 percent resided in the Portland and Salem county areas.

During the 1970s, the State underwent a major population increase, growing by 26 percent, but in the past decade growth has slowed dramatically (figure 2-1). The populations of Portland and Salem, however, continued to increase, by 23 and 33 percent, respectively, from 1980 to 1990.

Approximately 91 percent of the Oregon residents are white, much higher than the national rate of 76 percent (277). While Oregon has fewer minorities overall than the national average, it has a slightly

larger proportion of Native and Asian Americans (figure 2-2).

The median age of Oregonians is 34.5 years, higher than the U.S. average of 32.6. Oregon's proportion of young residents is about the same as in the country as a whole (25 percent under age 18), but the State has a higher proportion of elderly residents (14 vs. 12 percent age 65 and over in Oregon and the United States, respectively) (278).

In 1989, Oregon's median household income was higher than the national average (\$30,003 vs. \$28,910) (280), while per capita personal income in both current and constant dollars was slightly less than the national average (\$13,422 vs. \$14,948 in current dollars) (283). Oregon's average annual growth of personal income between 1988 and 1989 was slightly higher than the national average (4.7 vs. 2.9 percent), but it was lower throughout most of the 1980s.

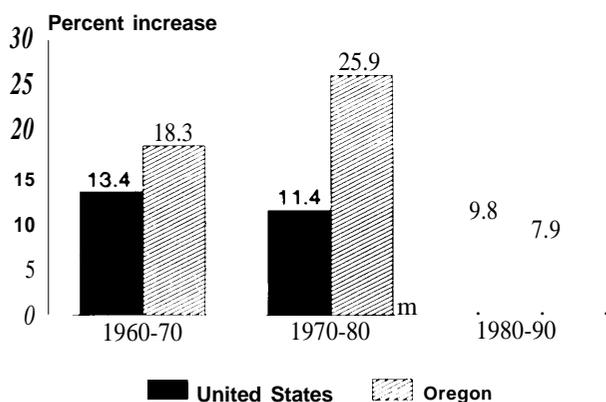
Over the 3 year period 1988-90, Oregon averaged 10.3 percent of persons in poverty, substantially lower than the U.S. average (13.5 percent in 1990) (282),

*Health Status and Resources*

By most measures of infant health, Oregon babies are slightly better off than babies nationwide. Compared with U.S. figures, Oregon has lower rates of low-birth-weight infants, inadequate prenatal care, and infant mortality (16 1). The number of teenage pregnancies in Oregon is also relatively low (11.4 per 1,000 live births to women under age 20, ranking 25th in the Nation), although it has been increasing recently, reversing the trend of the early 1980s (161).

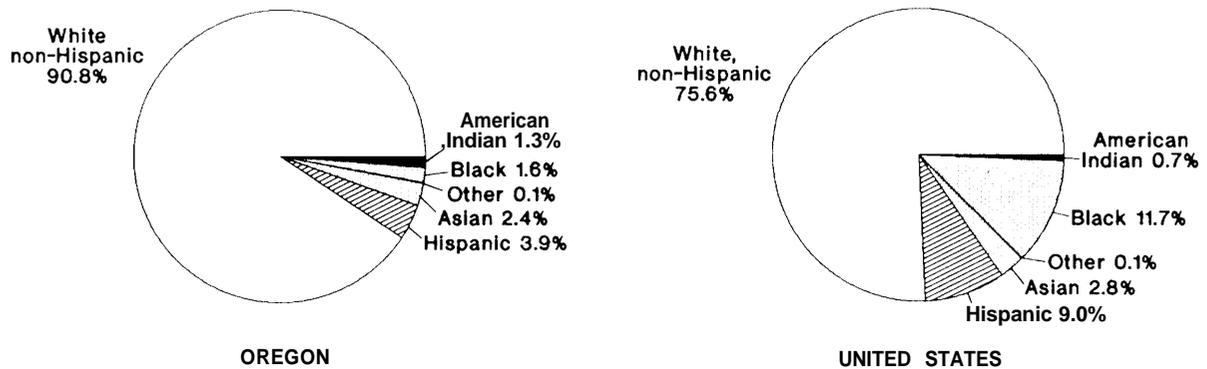
Overall mortality rates (adjusted for differences in age distribution) are also slightly lower in Oregon than the national average. (Unadjusted mortality rates are higher, since the population of Oregon has fewer young adults (18 to 24 years old) and more adults over age 65 than the national average) (278). Oregon, however, has a higher (unadjusted) mortality rate for cerebrovascular disease, cancers, several vascular disorders, and suicides. Some of Oregon's statistical advantage in health status indicators may be due to its low proportion of racial minorities.

Figure 2-1—Resident Population, Percent Increase 1960-90



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States: 1991 (111th Edition)* (Washington, DC: U.S. Government Printing Office, 1991).

Figure 2-2—Percent Distribution of Population by Race/Ethnicity, Oregon vs. United States, 1990



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, "Census Bureau Completes Distribution of 1990 Redistricting Tabulations to States," press release, Washington, DC, Mar. 11, 1991.

Membership in a racial or ethnic minority in the United States is associated with poorer overall infant health measures and higher mortality rates associated with AIDS/HIV (acquired immunodeficiency syndrome/human immunodeficiency virus), cancer, diabetes, liver cirrhosis, and cardiovascular disease (151,152).

Oregon has fewer hospitals and physicians per capita than the national average. In 1990, the State had 268 hospital beds per 100,000 residents, with an occupancy rate of approximately 64 percent (6,209). By comparison, the United States averaged 353 hospital beds per 100,000 persons and had an average occupancy rate of 69.6 percent (6,209). Oregon had 220 physicians per 100,000 individuals (approximately one practicing physician per 455 Oregonians), compared with the national average of 240 physicians per 100,000 residents. About 80 percent of Oregon's hospital beds, and about 80 percent of its practicing physicians, are located in metropolitan areas (188).

## MEDICAID IN THE UNITED STATES AND OREGON

The Medicaid program was instituted to fill the gaps of private health insurance by protecting vulnerable populations otherwise unable to afford coverage. The program is jointly funded by Federal and State governments; however, each State administers its own program within Federal guidelines.

### *Eligibility*

Medicaid originally covered certain "categorically eligible" low-income groups: women and children receiving Aid to Families with Dependent Children (AFDC) and poor aged, blind, and disabled persons receiving Supplemental Security Income (SSI). Reforms in eligibility standards for Medicaid since 1984 have broadened the population qualifying for coverage (table 2-1). Federal rules now require States to extend Medicaid eligibility to pregnant women and children under age 6 with incomes up to 133 percent of the Federal poverty level. Children born after September 30, 1983 who are over 6 years old are eligible if their family incomes are up to 100 percent of the Federal poverty level. Thus, by 2002, all poor children under age 19 with incomes up to the Federal poverty level will be covered. States must also extend coverage to families in AFDC-Unemployed Parent (AFDC-UP) programs, which provide welfare for two-parent families with one unemployed parent. States have the option of expanding coverage to pregnant women and infants up to age one with incomes up to 185 percent of the Federal poverty level.

The current Medicaid program in Oregon covers the mandatory populations: aged, blind, and disabled individuals receiving SSI, AFDC families, pregnant women and children under 6 years old with incomes less than 133 percent of the Federal poverty level, and families with unemployed parents receiving AFDC. It also covers the optional 'medically needy' population of children under 18 and

Table 2-I-Summary of Recent Federal Medicaid Mandates

Year	Legislation and description
1984	<p><i>Deficit Reduction Act (Public Law 98-369)</i></p> <ul style="list-style-type: none"> <li>• Expanded coverage to include all pregnant women qualifying for Aid to Families with Dependent Children (AFDC) and all children 5 and under with family income up to AFDC levels.</li> </ul>
1986	<p><i>Omnibus Budget Reconciliation Act (Public Law 99-272)</i></p> <ul style="list-style-type: none"> <li>• Eliminated categorical restrictions for pregnant women.</li> <li>• Allowed States to cover pregnant women and children up to age 5 with incomes up to 100 percent of the Federal poverty level.</li> <li>• Instituted “presumptive eligibility:” temporary coverage for prenatal care.</li> </ul>
1987	<p><i>Omnibus Budget Reconciliation Act (Public Law 100-203)</i></p> <ul style="list-style-type: none"> <li>• Allowed States to extend coverage to pregnant women and infants with incomes up to 185 percent of the Federal poverty level.</li> <li>• Allowed States to cover children under 5 up to the poverty level, with phase-in coverage for children under 8 in poverty.</li> <li>• Instituted nursing home reform requiring States to: <ol style="list-style-type: none"> <li>1. Determine level of care for each patient,</li> <li>2. Improve nursing aide training,</li> <li>3. Institute pre-admission screening for mentally ill and mentally retarded patients, and</li> <li>4. Comply with Federal standards.</li> </ol> </li> </ul>
1988	<p><i>Medicare Catastrophic Coverage Act (Public Law 100-360)</i></p> <ul style="list-style-type: none"> <li>• Required States to pay Medicare premiums, deductibles, and repayments for qualified Medicare beneficiaries whose income is up to 100 percent of the Federal poverty level and whose resources are up to two times the Supplemental Security Income level.</li> <li>• Instituted “spousal impoverishment” plan to protect the savings of noninstitutionalized spouses.</li> <li>• Mandated Medicaid coverage of pregnant women and infants up to age 1 with incomes below 100 percent of poverty by July 1990.</li> </ul> <p><i>Family Support Act (Public Law 100-485)</i></p> <ul style="list-style-type: none"> <li>• Required States to continue covering families losing AFDC benefits as a result of increased income for 12 months.</li> <li>• Made AFDC-UP, coverage for two-parent families with one unemployed parent, mandatory.</li> </ul>
1989	<p><i>Omnibus Budget Reconciliation Act (Public Law 101-239)</i></p> <ul style="list-style-type: none"> <li>• Required States to extend Medicaid to all pregnant women and children born after September 30, 1983 up to age 6 with incomes up to 133 percent of the Federal poverty level, superseding the Medicare Catastrophic Coverage Act.</li> <li>• Set requirements for Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), Medicaid’s preventive care program for children under age 21.</li> </ul>
1990	<p><i>Omnibus Budget Reconciliation Act (Public Law 101-508)</i></p> <ul style="list-style-type: none"> <li>• Required States to gradually extend coverage to all children born after September 30, 1983 until they reach age 19 in families with incomes below poverty.</li> <li>• Required States to pay Medicare premiums for qualified Medicare beneficiaries with income levels between 100 and 110 percent of poverty by January 1993; the income level rises to 120 percent of poverty in January 1995.</li> <li>• Allowed States to institute limited coverage for home care of elderly persons who would otherwise be institutionalized and also fund home and community-based services for mentally retarded persons.</li> </ul>

SOURCE: Office of Technology Assessment, 1992,

pregnant women who “spend down” into poverty due to high medical bills. The State does not cover the optional category of pregnant women and infants with incomes between 133 and 185 percent of the Federal poverty level.

The population concentration of Oregon is reflected in the Medicaid population. Of the more than 150,000 projected Medicaid enrollees for FY 1993, fewer than one-third live in rural, nonmetropolitan counties (182).

### *Benefits*

Under Federal rules, all States must provide a standard benefit package to the categorically needy (those receiving AFDC and SSI benefits) that includes: physician services, x-ray and laboratory services, inpatient and outpatient hospital services, family planning, home health care and skilled nursing facilities for adults, rural health clinic services, nurse-midwife services, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) serv-

Table 2-2—Mandatory and Optional Services Covered by the Oregon Medicaid Program, 1991

**Mandatory Services**

- Inpatient hospital services
- Outpatient hospital services
- Physician services
  - Early and Periodic Screening, Diagnosis, and Treatment services for children under age 21
- Family planning services and supplies
- Laboratory and x-ray procedures
- Skilled nursing facility and home health care services for adults (i.e., 21 years and older)
- Rural health clinic services
- Services of certified nurse-midwives and pediatric and family nurse practitioners
- Service of federally qualified health centers receiving funds under sections 329, 330, or 340 of the Public Health Service Act

**Optional Services Covered by Oregon**

- Case management
- Additional home health services
- Services of other licensed practitioners, including psychologists, chiropractors, optometrists, podiatrists, and naturopaths
- Clinic services
- Other diagnostic, preventive, and rehabilitative services
- Prescription drugs
- Intermediate care facility services for mentally retarded persons
- Eyeglasses, prosthetic devices, and orthopedic shoes
- Private duty nursing
- Inpatient psychiatric care for those under age 21 and care in institutions for mental diseases for adults aged 65 or older
- Physical, occupational, and speech, hearing, and language disorder therapies
- Other medical or remedial care recognized under State law, including personal care in the home, transportation and emergency services, home and skilled nursing facility care for those under age 21, and respiratory care services
- Home or community-based services under a waiver
- Respiratory care services for ventilator-dependent individuals
- Services for persons aged 65 or older in a mental institution
- Transplant services (Oregon limits transplants to cornea and kidney for adults; for those under 21, Oregon covers a professionally determined range of nonexperimental transplant services)
- Additional services for pregnant women: needs assessment, case management, nutritional counseling, and home services

**Optional Services Not Covered by Oregon**

- Dental care for adults
- Hospice services
- Preventive screening services for adults
- Christian Science nurses
- Organ transplants for adults (other than cornea and kidney)

a To the extent they are authorized to practice under State law or regulation.

SOURCES: U.S. Department of Health and Human Services, Health Care Financing Administration, Division of Intergovernmental Affairs, *Medicaid Services State by State*, HCFA Pub. No. 02155-90 (Washington, DC: U.S. Government Printing Office, October 1990); Oregon Department of Human Resources, Office of Medical Assistance Program, Salem, OR, "Medicaid and the State of Oregon Medical Assistance Programs," (OMAP3061), January 1991.

ices for children. States that cover the medically needy<sup>1</sup> must also provide a benefit package for this group that at minimum includes prenatal care and delivery for pregnant women and ambulatory care for children. States may supplement the standard packages with an array of optional services.

In 1990, Oregon provided all mandatory services and an additional 27 optional services (out of a possible 31). Of the 27, 22 were provided for both categorically and medically needy recipients. Oregon did not cover screening services, nursing facilities for individuals over 65 in mental hospitals, Christian Science nursing, or hospice care (table

2-2). The State currently covers prescription drugs only for SSI medically needy adults (177).

### *Program Costs and Spending*

Nationally, approximately 45 percent of Medicaid funding comes from the States, with the remainder provided by the Federal Government. By law, individual States contribute from 17 to 50 percent of their programs' expenditures for services, depending on the State's per capita personal incomes. In fiscal year (FY) 1991, 17 States contributed the maximum match of 50 percent, and 14 States contributed less than 30 percent (287). Oregon's anticipated 1992-93

<sup>1</sup>The medically needy are individuals who are eligible for medical, but not financial, assistance (287).

State contribution will be 37.6 percent, or \$278 million, a slight increase from its 1991 total of 36.5 percent (8,165).

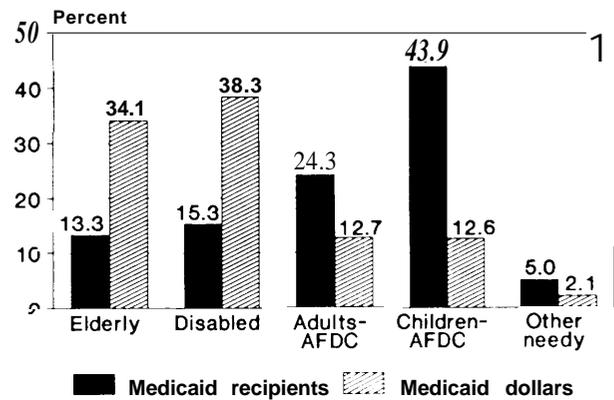
Medicaid program costs, following national health spending trends, have increased dramatically over the last 20 years in all States. Increases have been a result of both program expansions and health care cost inflation. Since FY 1987, total Medicaid expenditures have risen a minimum of 10 percent annually (291). Total Medicaid spending in the Nation, excluding administrative costs, was more than \$68 billion in FY 1990, a growth of almost 20 percent from FY 1989 (291). State Medicaid funding grew 13 percent from 1988 to 1989 and 18 percent from 1989 to 1990. In Oregon, State Medicaid spending increased almost 19 percent from 1989 to 1990 (290).

One of the consequences of these increases is that States have had difficulty predicting the programs' costs accurately (147). In FY 1990, 26 States, including Oregon, overspent their allotted Medicaid budgets by \$662 million (97). In FY 1990, total Medicaid expenditures in Oregon increased to nearly \$541 million, of which approximately \$200 million was State-funded (290).

In 1991, Medicaid expenditures accounted for almost 14 percent of the States' budgets nationwide. Compared with this average, Oregon spent a relatively low proportion of its budget on Medicaid—slightly over 9 percent (147). This spending covered services for approximately 227,000 State Medicaid beneficiaries. Oregon's average program cost per Medicaid beneficiary was \$2,283, lower than the national average of \$2,568 (290).

Despite federally mandated eligibility expansions that have increased coverage for pregnant women and children, a large portion of program spending continues to be consumed by other beneficiaries. The difference in spending for different groups of beneficiaries is largely explained by Medicaid's major role in funding long-term care. Over 45 percent of nursing home care in 1990 was funded by Medicaid. Persons aged 65 and over constituted 13 percent of the program's population but consumed over 34 percent of Medicaid dollars. From 1980 to 1990, long-term care spending increased by 10 percent, or \$8.2 billion (207). In 1990, Oregon's

**Figure 2-3 Medicaid Recipients' Share of Medicaid Spending, by Recipient Group, 1990**



NOTE: Percentages may not equal exactly 100 due to rounding error.  
 DATA SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, HCFA 2082 data from the *Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services, Section D (2), Eligibles for Medical Care by Age, Race/Ethnicity, and Sex*, Baltimore, MD: Health Care Financing Administration, Dec. 24, 1990.

proportion of Medicaid expenditures spent on long-term care was slightly higher than the national average (40.9 vs. 38.6 percent) (290). Children in the United States, for example, received less than 13 percent of total (Federal/State) Medicaid dollars in 1990, while they made up almost 44 percent of the Medicaid population (figure 2-3).

### State Responses

States have resorted to a variety of measures to offset program expenditure increases resulting from Federal mandates, health care cost inflation, and other sources. Some have reduced optional benefits and optional enrollee categories. For example, Oregon eliminated all dental services for adults in 1991 due to budget constraints. Another common cost reduction strategy has been to freeze or lower reimbursement to providers. Upon 1981 changes in the Federal Medicaid rules (Public Law 97-35), for example, most States replaced their cost-based retrospective hospital payment systems with some form of prospective reimbursement.<sup>2</sup> Broader use of alternative delivery systems (e.g., those using some form of managed care) also has become a common strategy to constrain spending. By 1991, 47 States used a prospective payment system for Medicaid hospital services, and 23 States had implemented

<sup>2</sup>In nearly half of these States, a method based on diagnosis-related groups (DRGs) is used (103). Oregon, as well as 20 other States, reimburses based on these diagnosis-specific, prospective rates (207).

some form of prepaid managed care, covering nearly 900,000 beneficiaries (207,217).

A decade of payment controls has led to low Medicaid reimbursement for many services. In Oregon, for example, hospitals received only 59 percent as much for services rendered to Medicaid patients as they received under Medicare in 1990 (the second lowest rate in the country after Illinois (207). The so-called Boren Amendment provision of the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, Public Law 97-35), however, requires that hospitals and nursing homes be paid "reasonable and adequate rates." As of April 1991, providers in 21 States had sued for inadequate reimbursement.

The Oregon Association of Hospitals brought suit against the State of Oregon in 1991. The two parties reached an out-of-court settlement in which the State agreed to pay approximately \$64 million over a 2-year period to compensate for underpayment of inpatient services provided to Medicaid patients (156,157). About \$24 million (36.6 percent) of the settlement will come from State funds, in accordance with the State's matching rate for Medicaid program funding.

States have also commonly imposed limits on covered benefits as a means of controlling costs. These limits may be in the form of either copayments for services, caps on the number of physician visits or days of hospitalization, or the need for prior authorization for certain services. Twenty-two States, including Oregon, require prior authorization for procedures such as organ transplants and hemodialysis (203). Several States have at one point limited office visits, home visits and emergency room visits for nonemergencies. As of 1985, 35 States (not including Oregon) had used some form of cost sharing (primarily copayments for prescription drugs).<sup>3</sup>

In addition to these widely used strategies for program cost control, some States have cut back optional services and eligibility categories to reduce budget deficits. A survey of 32 States found that 6 States made both expansions and reductions in their Medicaid programs for FY 1992. Eight States reduced services and/or eligibility, 11 States expanded services and/or eligibility, and 7 States made no changes (8). Illinois, for example, eliminated its Aid to Medically Indigent Program, which was

completely funded by the State. Maine lowered its medically needy income limit from 133 to 100 percent of the Federal poverty level and also reduced the income limit for AFDC recipients (8,66). In Oregon, the State cut coverage for nonpregnant, AFDC-related adults under their medically needy program and reduced coverage for medically needy-SS1 adults by restricting coverage to prescription drugs only.

Several States have recently proposed even more dramatic changes in their Medicaid systems. The State of Maryland, for example, will soon require all Medicaid recipients to have a personal primary physician. This program is an effort to extend access to preventive measures and limit the use of emergency facilities for routine care (82).

To complement their attempts at cost control, States have also tried to increase their Federal Medicaid resources. Some States, for example, have augmented their Medicaid funds through the collection of "voluntary contributions" and provider taxes. By applying such funds to the State share, States have been able to secure more Federal matching funds. In some States, providers that contributed regained some or all of their contributions in the form of increased Medicaid reimbursement (225, 226). The Federal and State governments reached an agreement in November 1991 that eliminates Federal matching funds for most provider donations and provider-specific taxes (225,226).

Governors have also asked for some lenience in complying with the Federal mandates. In February 1991, the National Governors' Association (NGA) asked for a 2-year delay in implementing the changes from OBRA 1990 to give States sufficient time "to assess the depth of the recession and the opportunity to develop long-term solutions for the restructuring of the Medicaid program" (101). NGA also resolved that the Health Care Financing Administration (HCFA) must publish final regulations before States should be required to implement changes.

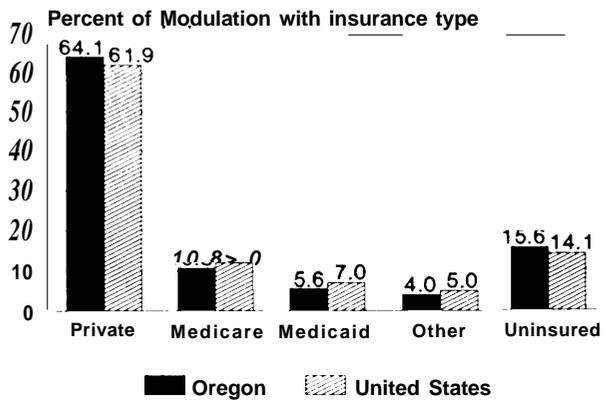
## THE UNINSURED

### *The Problem*

For all of its rising costs, Medicaid has not solved the problem of ensuring that Americans have financial access to health care. According to current

<sup>3</sup> Some small cost savings have been realized, but there is no evidence regarding cost sharing's effects on utilization (103).

**Figure 2-4-Health Insurance Status,  
Oregon vs. United States, 1990**



SOURCE: S. Raetzman (cd.), *Reforming the Health Care System: State Profiles 1990* (Washington, DC: American Association for Retired Persons, 1991).

estimates, the uninsured population in the United States in 1990 increased to 34.7 million, up from the 1989 estimate of 33.4 million (279,281). While there has also been an increase in the proportion of the population receiving Medicaid (from 8.6 percent or 21 million people in 1989 to 9.7 percent or 24 million in 1990), many poor people still lack insurance coverage.

Nonetheless, 59 percent of the Americans that lack insurance coverage are employed or dependents of employed persons (279). Many of the uninsured workers are either self-employed or work for small companies with fewer than 25 employees (60). Other uninsured individuals lack coverage because of preexisting conditions and their inability to either qualify or pay for private coverage. About 14 percent of all children aged 17 years old and under lack any form of health insurance coverage (279).

The rising number of uninsured persons has become a prominent issue in the national health care debate. Existing proposals for providing and funding their care include such ideas as expanding public programs, tax break options, universal access to health insurance or services, and an employer-mandated “pay-or-play” system (26,49,61,65). Increased coverage, however, will probably increase costs further. Some observers have suggested that eventually the United States must ration services to reduce health care spending (1), although not all share this view (126,214).

Oregon has reason to reflect the national mood of concern. In 1988, the most recent year for which equivalent data are available, Oregon’s rate of uninsured persons was higher than the national average (15.6 vs. 14.1 percent) (figure 2-4). Oregonians are more likely to be covered by private insurance, but they are slightly less likely to be covered by Medicare or Medicaid than are U.S. residents in general (209).

Oregon estimates that at present approximately 400,000 to 450,000, or 16 percent, of its residents lack any health insurance coverage (177). Approximately two-thirds of these uninsured persons are employed (or dependents of employed persons) and one-third have incomes that fall below the Federal poverty level. A 1986 study of uninsured individuals in Oregon determined that the typical uninsured Oregonian was a female, single parent, poorly educated, and employed in retail or service for a small, non-union company (199).

Concern for the uninsured population stems from some evidence that lack of insurance decreases health care access (71). For example, Hadley et al. determined that an individual’s condition on hospital admission, use of resources during hospitalization, and likelihood of death all varied according to health insurance status (71). In this study, uninsured people were more likely to be admitted for conditions with a relatively high expected risk of death and less likely to have discretionary procedures performed. Researchers have also shown that uninsured individuals have shorter average lengths of hospital stay and fewer physician visits per year (89,228).

A recent study has also associated newborns’ insurance coverage with resource allocation in hospitals. Newborns without insurance received fewer services than Medicaid-covered newborns, who in turn received less care than privately insured newborns (22).

The tendency of those without insurance to delay treatment and to not receive preventive care may lead to poorer health outcomes in this population (50). Loss of Medicaid benefits has been shown to adversely affect both the access to care and the health status of poor adults with diabetes and hypertension (132). Although the evidence support-

ing the link between poorer health and uninsuredness is strong, it is not definitive.<sup>4</sup>

### **Barriers to State Solutions**

A few States have implemented ambitious programs to address the problems of their uninsured populations. Hawaii, for example, requires all employers to provide health insurance to their employees. Employees who work at least part time qualify and share the costs of their coverage (128). Hawaii has also developed a program for citizens who have fallen through the gap of the employer-based coverage and the Medicaid program. The State Health Insurance Program is subsidized by both the State government and private insurance companies. It provides care to approximately 30,000 individuals who are mostly dependents of low-income workers and seasonal workers (128).

In 1988, Massachusetts passed a universal health bill which included an employer mandate that would have required employers to provide insurance or pay into a fund for their workers. However, implementation of the law has been delayed and is in jeopardy of being repealed (20). Since 1990, about one-fifth of the States, including California, New Jersey, and Oregon, have begun to offer or have considered enacting tax credit programs to small employers providing coverage. In addition, almost 40 percent of the States have enacted high-risk pools for individuals who cannot obtain health insurance due to chronic illness or other “preexisting” conditions (139).

Solutions for reducing the uninsured population such as these depend primarily on State financing. Increasingly, however, States have cited limited funds, their duty to maintain balanced budgets,<sup>5</sup> and overall fiscal distress as impediments to expanding such programs. Several factors have influenced the States’ overall financial outlook. According to NGA and the National Association of State Budget Officers (NASBO), the Federal Government has decreased its aid to cities and States, which has placed a higher burden on the States to help local governments (147). NGA and NASBO also claim that many States used increased revenue from the mid-1980s to implement new programs; however,

once revenue growth slowed in the late 1980s and 1990s, many States began to use reserves to fund ongoing programs.

In an effort to end FY 1991 with balanced budgets, 29 States cut almost \$7.5 billion from their budgets. Oregon cut a total of \$40.6 million (147). The total year-end balance for FY 1991, the amount of resources States have available at the end of the fiscal year, was at the lowest level since 1983 (147). The national total year-end balance as a percent of expenditures was 1.5 percent. Only 15 States, mostly concentrated in the mid- and far west, had balances of 5 percent or more, while 19 States had balances of less than 1 percent (147). Oregon was one of the 15 States with relatively large balances.

The national economy has been in a recession: unemployment rates have risen, personal income growth has slowed, and State balances are at an all-time low (147). According to NGA and NASBO, the recession has hit the Eastern States the hardest, while the Western States have been somewhat less affected (147). According to NGA and NASBO, Oregon leads the West in spending growth,<sup>6</sup> and personal income growth in that region continues to be the highest in the Nation. Nonetheless, NGA and NASBO conclude that decreases in the State ending balances “[place] all the States at an increased risk (for budget shortfalls) should the economic recovery be stalled for long” (147).

Oregon’s funding problems may deepen as a result of a statewide referendum passed in November 1990. Ballot Measure 5 phases in a rollback of local property taxes over 5 years, and it requires the State to replace billions of dollars lost by local counties for school funds from the State’s general fund. The referendum is expected to result in a tax loss of \$540 million in the 1991-93 budget cycle, \$1.7 billion in the 1993-95 biennium, and \$2.9 billion in the 1995-97 budget cycle (185). The Governor’s office expects the State to have \$3.1 billion for all expenditures other than schools in the 1991-93 budget cycle, \$2.6 billion in 1993-95, and \$1.9 billion in 1995-97 (269).

Because of Measure 5, Oregon’s tax burden will fall considerably. In FY 1989, Oregon ranked 22d in per capita tax collections (\$1,806 in Oregon vs.

<sup>4</sup> An ongoing OTA study is examining the relationship between insurance coverage and access to care.

<sup>5</sup> Forty-nine States are required by their State constitutions to balance their budgets (147).

<sup>6</sup> Spending growth is defined here as an increase in the amount spent by States’ general funds.

\$1,888 in the United States). Under full implementation of Measure 5, Oregon's ranking will most likely fall to the bottom fifth of the Nation (185).

By law, the State of Oregon must balance its budget; therefore, the State must either cut the budget or increase taxes to compensate for the new obligation to replace local revenue losses. Since 84 percent of the State's general fund is already supported by personal income taxes, the passage of Measure 5 has encouraged discussion about restructuring Oregon's tax system, including instituting a sales tax (122).

### ***Oregon's Efforts To Expand Health Care Access***

**In 1987**, the Oregon State legislature voted to end Medicaid coverage for organ transplants, an optional service. These funds were intended to be used instead to cover another optional service—prenatal care for approximately 1,200 pregnant women and basic care for 1,800 children under the poverty level medical program (225).<sup>7</sup> Oregon's decision became highly publicized when two children were denied transplants. One infant's family moved out of the State to receive the transplant. The family of the other child, a 7-year-old boy with leukemia, attempted to raise the funds, but the child died before his family's efforts to raise \$100,000 for the operation succeeded. (At the time of his death the boy was not medically eligible for the procedure (79,84,225 ).)

Following the transplant debate, Oregon Health Decisions (OHD), a nonprofit organization, held a series of 19 community discussions on priorities for health care.<sup>8</sup> A "Citizen's Parliament" summarized the results of the community deliberations and issued 15 principles that were then used to form lists of health services, ranked in order of importance, for 4 distinct age groups (i.e., infants, children, adults, and elderly). Another group, composed primarily of medical and legal experts, compiled the four lists into one prioritized list that was intended to inform "the State legislature, insurance companies, and others concerned with health care resource alloca-

tion' (186). A report including the list and accompanying actuarial estimates was submitted to the Oregon State legislature. This report and another report from the Governor's Commission on Health Care were the roots of the Oregon effort to reform health care.

Oregon's recent effort to extend health insurance coverage to its citizens is a compilation of several pieces of State legislation targeted at various groups of uninsured Oregonians. Several of the principles developed by the OHD's Citizen's Health Care Parliament are incorporated into this package of health care legislation.

The Health Partnership Act (Senate Bill (SB) 935) provides tax credits to small businesses that have not previously provided health insurance coverage to their employees. By 1995, all employers must either provide coverage to their employees or pay into a pool that would provide coverage. If 150,000 people gain insurance between 1989 and 1993, then employer coverage will remain voluntary. The State has committed to making health insurance more affordable to small employers through the Health Insurance Reform Act (SB 1076). Oregon also hopes to provide statewide health care cost data to providers through the Health Resources Commission Act (SB 1077).

Persons who do not qualify for Medicaid and cannot obtain insurance because of preexisting health conditions are covered under the State Health Risk Pool Act (SB 534), which mandates that coverage be available to these individuals at a premium rate no higher than 150 percent of the rate for other individuals.

Finally, the Oregon Medicaid Demonstration Act (SB 27) expands coverage to all individuals with incomes below the Federal poverty level by: 1) funding a prioritized list of medical services, 2) instituting managed care programs in all service areas, and 3) ensuring adequate payment to providers (177). This proposal, which requires Federal approval to qualify for Federal Medicaid matching funds, is the subject of the remainder of this report.

<sup>7</sup> See glossary for definition of poverty level medical.

<sup>8</sup> OHD had earlier conducted 300 community meetings throughout the State to discuss health care access, cost control measures, allocation of public funds, disease prevention and patient autonomy and dignity (43).