Issue Brief:

Covering Kids in Oregon

May 2005

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The Office for Oregon Health Policy & Research

ISSUE BRIEF: COVERING KIDS IN OREGON

INTRODUCTION

In November 2003, Governor Ted Kulongoski announced the Children's Charter, asking Oregonians to ensure that:

- Every child in Oregon is safe, healthy and has adequate food and shelter
- Every younger child in Oregon is ready to enter school
- And every older child in Oregon graduates from high school and is ready to join the work force or go on to college[i]

The Governor's 'call to action' included a goal to expand access to basic health care, including increasing the number of children with health insurance. The Governor raised the asset limit for children covered by the State Children's Health Insurance Program, under the Oregon Health Plan (OHP), from $5,000 to $10,000; announced the development of a children's health insurance product to be available in March 2005; and announced that the Department of Human Services would pilot expanded outreach strategies for children.

Oregon provides low-income, uninsured children with health care coverage through the Oregon Health Plan (OHP), which includes a myriad of programs[1], with the majority of children enrolled in Poverty Level Medicaid and the State Children's Health Insurance Program (SCHIP). OHP provides coverage for children up to 19 years old and under 185% of the federal poverty level (FPL). Currently, there are 212,410[ii] children enrolled in OHP receiving coverage under the OHP Plus benefit package.

The Family Health Insurance Assistance Program (FHIAP) also provides coverage for many children in Oregon. FHIAP helps low-income Oregonians afford private health insurance. This program subsidizes health insurance premiums for private individual or group coverage. FHIAP subsidizes a portion of the insurance premium (50-95% premium subsidy, depending upon income level, up to 185% FPL). Participants must re-enroll every 12 months and cannot exceed $10,000 in liquid assets. Currently, there are 3,343 children under the age of 19 enrolled in this program[iii].

PRIMARY SOURCES OF HEALTH INSURANCE COVERAGE FOR LOW-INCOME CHILDREN IN OREGON

Poverty Level Medicaid:

- *Children 0-5 yrs, up to 133% FPL*
- *Children 6-18 yrs, up to 100% FPL*

State Children's Health Insurance Program (SCHIP):

- *Children 0-18 yrs, 133-185% FPL*
- *Children 6-18 yrs, 100-133% FPL*
- *Limit of $10,000 in liquid assets*

The Family Health Insurance Assistance Program (FHIAP)

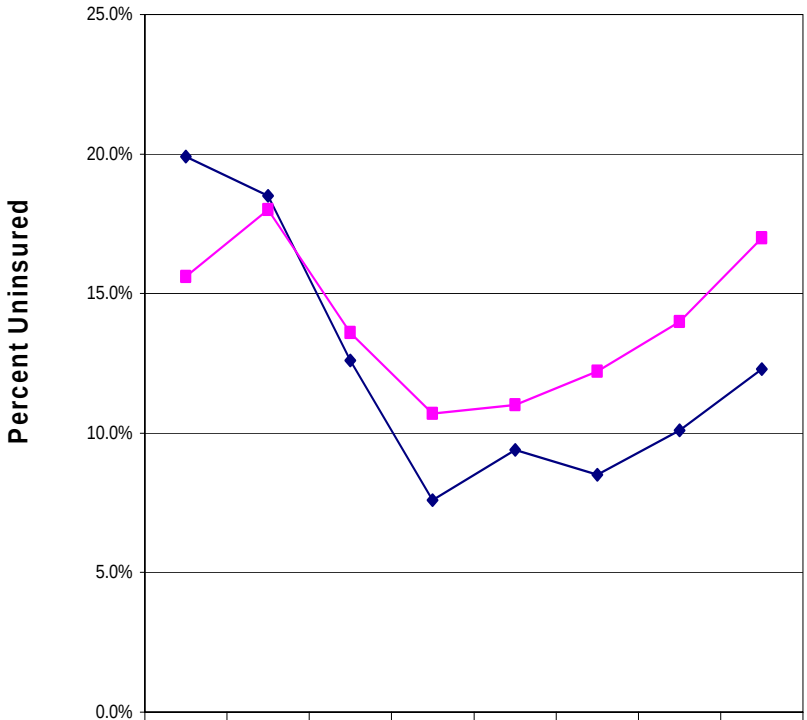
- *50-95% subsidy of health insurance premiums*
- *Children 0-18 yrs, up to 185% FPL*
- *Limit of $10,000 in liquid assets*

[1] The Oregon Medical Assistance Program enrolls children in several different categories, depending on a child's age, family income level and other qualifying criteria. Medical Assistance programs covering children include: Poverty Level Medicaid, Transitional Aid to Needy Families (TANF), Aid to the Blind/Aid to the Disabled, Foster Care/Substitute Care and the State Children's Health Insurance Program.

For myriad reasons, publicly funded insurance programs have been unable to reach all eligible children or to ensure maintenance of coverage. It is estimated that as many as 66,653[iv] children in Oregon who are eligible for public coverage remain uninsured. This brief will explore the importance of health insurance, barriers to getting children covered, and discuss possible strategies to reach all eligible children in Oregon.

Percent Without Health Insurance in Oregon, 1990 to 2004

(Source: Oregon Population Survey)



	1990	1992	1994	1996	1998	2000	2002	2004
Children (0 to 17)	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	10.1%	12.3%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%

Year

BACKGROUND

Why is health insurance so important? Research has clearly shown the link between access to health insurance and access to health care. Children lacking health insurance coverage are less likely to receive preventive health services such as immunization, dental and vision care[v]. There is a substantial amount of empirical evidence supporting the important role of insurance in children's health status. Recent studies indicate that:

LACK OF COVERAGE LEADS TO UNMET HEALTH CARE NEEDS[vi]

- Uninsured children are less likely to receive preventive care, and are half as likely to have seen a doctor in the past year.
- Uninsured children are over five times more likely to report having an unmet need for medical care.

LACK OF COVERAGE IMPACTS THE USE OF EMERGENCY ROOM VISITS AND HOSPITAL ADMISSIONS[vii]

- Lack of timely and effective ambulatory care can result in a greater number of hospitalizations, especially for certain conditions and among vulnerable groups.
- Preventive care linked to continuity of care with a provider can lead to decreased hospitalizations for a Medicaid population of children and adults.

LACK OF APPROPRIATE HEALTH CARE PUTS KIDS AT RISK AT SCHOOL

- Children with insurance experience a 25% improvement in health and a 68% improvement in "paying attention in class" and "keeping up with school activities"[viii].
- Recent research suggests that school children with health insurance miss school due to illness less than uninsured children and have better school attendance[ix].

LACK OF COVERAGE IMPACTS THE OVERALL COST OF HEALTHCARE[x]

- The uninsured are 30-50% more likely to be hospitalized for an avoidable condition.
- The average cost of an avoidable hospital stay in 2002 was estimated to be about $3,300.

RECRUITMENT BARRIERS

Children and families may encounter barriers when attempting to access publicly funded insurance programs such as Medicaid and the State Children's Health Insurance Program (SCHIP). In Oregon, SCHIP is seamlessly integrated with the Medicaid program (OHP), making it difficult for the public to distinguish between the two programs. Therefore, when Oregonians hear that OHP is reducing enrollment, or reducing benefits, it may be difficult for parents to discern that their children are not affected by these changes. The fact that children's eligibility is NOT tied to parent's eligibility for public programs should be made very clear and enrollment should be made as simple as possible.

WHY INSURANCE MATTERS

Having insurance improves children's access to routine well-child care. *Well-child care and having a regular medical provider are very important for children's health. This continuity allows better monitoring of children's development: potential problems are detected earlier, when they are more responsive to treatment. On average, uninsured children:*

- *Are less likely to get routine well-child care;*
- *Have worse access to health care; and*
- *Use medical and dental services less frequently than do insured children.*

Source: Institute of Medicine, Health Insurance is a Family Matter, brief. Pg 5., September 2002. Available at: http://www.iom.edu/Object.File/Master/4/161/0.pdf

To meet a statewide policy goal of covering all eligible low-income children, Oregon should take steps to frame the program in such a way that families will strive to get and keep their children enrolled. Factors that may affect enrollment include:

PROCEDURAL ISSUES

- Although the OHP application is written at a sixth-grade reading level, the application may still pose literacy and comprehension challenges.
- The requirement to provide proof of income for three months (FHIAP) or 4 months (OHP) can be an obstacle for many families. For example, a parent who is paid weekly would have to provide as many as 16 pay stubs in order to meet this requirement. If there is more than one worker or source of income, this documentation requirement can be prohibitively burdensome.
- Disenrolling children because of a slight increase in their parent's income may provide inappropriate incentives. This could mean a working parent may refuse a raise just so he or she can keep health insurance coverage for their children.

ACCESS TO PROVIDERS

- Enrollees with coverage still have difficulty finding providers who will accept the OHP medical card.
- The number of providers is limited in frontier (less than six people per square mile) and rural areas of Oregon.
- Some providers across Oregon are limiting the number of OHP and SCHIP patients they enroll/serve[xi].

STIGMA OF PUBLIC ASSISTANCE

- Some Oregonians distrust government, avoiding public programs like OHP/SCHIP and FHIAP.
- Some perceive governmental assistance as an indicator of weakness. They don't want a "hand-out."

RACIAL AND CULTURAL ISSUES

- Language and cultural differences can be barriers to enrolling in publicly funded insurance programs. African-American, Native American and Hispanic children are less likely to be insured than white, non-Hispanic children both locally and nationally.

REACHING MORE CHILDREN

Research shows that the most effective strategy to insure more children is to insure their parents[xii]; and that there is a direct connection between a parent's uninsurance and their children being uninsured[xiii]. However, expanding coverage to more low-income adults may not be feasible. Oregon's persistent budget deficit has forced difficult decisions about *reducing* enrollment and eligibility levels for adults. Some low-income adults may have lost OHP coverage but have children who are still eligible for enrollment. It is therefore critical to develop strategies to keep parents informed regarding eligibility and benefits for their children and to reduce administrative barriers to enrollment and retention.

Furthermore, states' decisions to undertake (or discontinue) strategies are guided by the research literature yet appear mostly to be budget-driven decisions (i.e., increase enrollment during periods when budgets are adequate and eliminate those strategies when budgets are tighter). It is clear that strategies are used and sometimes discarded without strong evidence to predict or prove their effectiveness. The following approaches have been tried and have shown some positive results in other states.

CREATE SEPARATE IDENTITY FOR CHILDREN'S HEALTH INSURANCE

Many states have named, or 'branded' their SCHIP programs. *Dr. Dynasaur*[xiv] is a program created in Vermont that targets uninsured children up to age 18 and pregnant women. Georgia has created *PeachCare for Kids*[xv] that covers uninsured children 18 years and younger and ensures that each child has a primary care physician who coordinates his or her care. In Iowa, the state has named their SCHIP program *Hawk-I*[xvi], Healthy and Well Kids in Iowa. Branding the SCHIP program provides a strategic backdrop for all outreach efforts that occur and averts some confusion when cuts or changes occur in the adult Medicaid program. Strategies would need to be developed to give Oregonians an image associated with the program brand and message.

DECREASE PERIOD OF UNINSURANCE

In Oregon, children and adults must be uninsured for six months before being eligible for SCHIP and FHIAP. Nineteen states do not require a period of uninsurance prior to SCHIP enrollment[xvii]. Several states waive the period of uninsurance for SCHIP under specific circumstances.

- South Dakota waives the waiting period when private insurance coverage exceeds 5% of the SCHIP family's gross income.
- New Jersey waives its six-month uninsurance requirement if a family drops private pay insurance but is under 200% FPL.

STREAMLINING THE APPLICATION PROCESSES

States have the discretion to eliminate the requirement of:

- An assets test. Oregon is one of only six states that still require an asset test to enroll a child in Medicaid or SCHIP[xviii]. Forty-four states have dropped this requirement.
- Documents to verify income, residency and child's age. Oregon has only waived documents to verify the child's age, still requiring income and residency documentation. Other states' experiences have shown that when families are allowed to self-verify income without necessary documentation, more families enroll and the program integrity is not sacrificed[xix]. This does not mean income is not verified – these states use several methods, including electronically verifying income using a combination of state and federal databases. This process also saves substantial dollars in administrative costs. A recent study estimates that a simplified enrollment process could save almost half of the costs typically associated with enrollment verification [xx].

States also have the discretion to align OHP enrollment and renewal periods with other state programs that low-income families are eligible for, such as Food Stamps, TANF, and childcare assistance programs. This would allow families to move through and between these various programs with much less confusion, thus reducing the risk of disenrollment.

There is an obvious trade-off between the conflicting goals of administrative ease to reduce enrollment barriers and assurance of program integrity. Additional research may illuminate which administrative barriers are most detrimental to enrollment of eligible individuals, and which, if any, are crucial to program integrity.

MAXIMIZE AVAILABLE TECHNOLOGY

- Oregon should assure that all required forms and instructions for completion and submission are readily available electronically, via the Internet, and easily accessible to the public.

KEEPING KIDS COVERED

Research has shown that it is more cost-effective to keep eligible participants continuously enrolled in health insurance programs than to administratively re-enroll them over and over again[xxi]. This is particularly true when the process of re-enrollment result in gaps in coverage, which is often the case. For children especially, gaps in coverage can result in a costly overuse of emergency department services and delays in the preventive health care services that are necessary to high-quality and cost-effective care[xxii]. There are several administrative strategies that could be considered to encourage continuous coverage.

RENEWAL PERIOD

Once a client is deemed eligible and qualifies for coverage they will be required to re-enroll and submit a new application to retain coverage. States determine the renewal period, or length of time between re-enrollment, for Medicaid and SCHIP. This period varies between every six or twelve months. The re-enrollment process every six-months in Oregon may be one barrier parents face in keeping children enrolled in Medicaid and/or SCHIP.

PASSIVE RE-ENROLLMENT

States not only determine the length of time for re-enrollment but also the process. In Oregon, at the time of re-enrollment, the client must complete the same application and verification process as they did in their original determination while in some states, a person's eligibility information is assumed to remain the same unless they share information that shows changes have occurred. At the time of re-enrollment, if the family does not report changes, the child's coverage is continued at the current level. Several states use this strategy to reduce the burden of re-enrollment and administrative costs.

CONTINUOUS ELIGIBILITY

Continuous eligibility means that once a client is deemed eligible, they retain coverage for a defined period of time regardless of whether their conditions change during that period. For example, if income increases above eligibility limits during that period, under continuous eligibility, they would remain covered until the period runs out. This strategy has been implemented and discontinued in several states, even though there is little data to show the impact on families or administrative savings.

Twenty-five states, not including Oregon, guarantee 12 months of coverage for children in either SCHIP or Medicaid, even if there are changes in family circumstances[xxiii].

ANNUAL RENEWAL

Forty states and the District of Columbia allow children's coverage for Medicaid and SCHIP to be renewed annually instead of every six months.

POLICY IMPLICATIONS

Oregon's current fiscal constraints make it difficult to implement any strategy, especially if the state's general fund dollars are to be tapped. However, political will does exist to provide health care coverage for children, especially since many of the strategies discussed have been shown to save administrative dollars. Increasing coverage to parents, shown to be the most effective method, is unlikely to be approved this session. Short of that, removing as many barriers as possible and simplifying the application/renewal process are the most feasible. In between, there is a range of cost and effectiveness to the strategies used in other states.

In order to accomplish long-term change in enrollment and retention of children in Medicaid and SCHIP, Oregon's agencies should work collaboratively on outreach, eligibility and coverage for children to develop (and agree to use) a simple, consistent message for outreach and a plan to improve the current process. The state's agencies have done the best they can do given the resources they have, but doing more of the same will not change the level of enrollment and retention. An infusion of new ideas partnered with existing efforts will maximize Oregon's potential to reach children who have been missed by current outreach efforts.

In conclusion, using methods described in this brief, Oregon can decrease the number of children who are uninsured but eligible for existing programs. The Governor has expressed support for several strategies, including outreach expansion, development of a kids-only health insurance product and raising the asset limit so that more children will be covered. The next step requires collaboration among those agencies charged with serving Oregon's children in order to capitalize on lessons learned in Oregon and elsewhere. Oregon has the discretion, as all states do, to utilize a combination of common-sense approaches and previously tested strategies to increase the number of children in Oregon with health care coverage. Piloting some of these ideas will move the state from what "might" work to what reduces barriers cost effectively in Oregon.

RECOMMENDATIONS

- *Create an identity for health care coverage for kids, including development of a coherent outreach message that will encourage enrollment of children and support parents to maintain coverage once enrolled.*
- *Target outreach to hard-to-reach communities, following the work of other states to partner with school districts, reduced-fee lunch programs, faith-based organizations and community health providers.*
- *Reduce or eliminate the required period of uninsurance for kids.*
- *Reduce or eliminate administrative barriers in order to increase enrollment of eligible children.*
- *Implement strategies found to be effective in improving the retention of enrolled children, including continuous eligibility and passive re-enrollment*

[i] Outline of Governor Kulongoski's *Children's Charter* is available at: http://governor.oregon.gov/Gov/children.shtml

[ii] The data was drawn from the DSSURS Elig 6 year table on May 3, 2005 by Dept. of Human Services/ OMAP/Analysis and Evaluation Unit

[iii] Reflects enrollment as of April 25, 2005 http://egov.oregon.gov/IPGB/docs/snapshot/4_25_05.pdf

[iv] Reflects calculations as of January 26, 2005 from the Oregon Population Survey using the number of uninsured children under 200% FPL as proxy for eligible children that remain uninsured.

[v] Kaiser Commission on Medicaid and the Uninsured. (2002, May). *Children's health-Why insurance matters.* Retrieved on Jan. 20, 2005 from http:// www.kff.org

[vi] Kaiser Commission on Medicaid and the Uninsured. (2002, May). Supra Note v.

[vii] Kozak, L.J. et al (2001). Trends in Avoidable Hospitalizations: 1980-1998. *Health Affairs* 20 (2), 225-232.

[viii] California for Health Kids Fact Sheet pulled down from http://www.100percentcampaign.org/assets/pdf/fs-healthy-families-041214b.pdf on March 14, 2005

[ix] Lykens, K & Jargowsky, P "Medicaid Matters: Children's Health and the Medicaid Eligibility Expansions, 1986-1991," Working Paper 00-01, University of Texas at Dallas, February 2000 cited from Broaddus, M. & Ku, L. (2000, December) *Nearly 95 Percent of Low-Income uninsured Children are Eligible for Medicaid or SCHIP; Measures Need to Increase Enrollment Among Eligible But Uninsured Children.* Washington, DC: The Center of Budget and Policy Priorities.

[x] Hadley, J (2003, May). *Economic consequences of Being Uninsured: Uncompensated Care, Inefficient Medical Care Spending, and Foregone Earnings.* Presentation to the Senate Subcommittee on Labor and HHS Appropriations, Salem, OR.

[xi] *2004 Oregon Physician Workforce Survey* presented to Oregon Health Research and Evaluation Collaborative, January 2005 http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/2004PhysSurvey_011805.pdf

[xii] Dubay, L. & Kenney, G. (20001, October) *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[xiii] Davidoff, A, Dubay, L, Kenney, G., & Yemane, A. (2003). The effect of parents' insurance coverage on access to care for low-income children. *Inquiry*, 40(3), 54-68.

[xiv] Information pulled down from http://www.dpath.state.vt.us/Programs_Pages/Healthcare/drdynasaur.htm on 2/25/05

[xv] Information pulled down from http://www.peachcare.org/dehome.asp on 2/25/05

[xvi] Information pulled down from http://www.hawk-i.org/ on 2/25/05

[xvii] Ross, D.C.& Cox, L. (2004). Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families. From the Kaiser Commission on Medicaid and the Uninsured, an initiative of the Henry J. Kaiser Family Foundation, obtained at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=47039 on 10/2004.

[xviii] Ross & Cox, Supra note xvii.

[xix] Studies included as cited in - 100% Campaign (2004, October). *Modernizing enrollment through paperless income verification: A smart approach to covering more uninsured children eligible for Medi-Cal and Healthy Families.* Retrieved on Jan. 20, 2005 from http://www.100percentcampaign.org.

Cox, L. (2001). *Allowing families to self-report income: A promising strategy for simplifying enrollment in children's health coverage programs.* Austin, TX: Center on Budget and Policy Priorities.

Ross, D.C. & Cox, L. (2003). *Preserving recent progress on health coverage for children and families: New tensions emerge.* Washington DC: The Kaiser Commission on Medicaid and the Uninsured.

[xx] Fairbrother, G., Dutton, M.J., Bachrach, D., Newall, L., Boozang, P., and Cooper, R. (2004). Costs of enrolling children in Medicaid and SCHIP. *Health Affairs*, 23(1), 237-243.

[xxi] Ku, L. & Ross, D.C. (2002). *Staying covered: The importance of retaining health insurance for low-income families.* A report sponsored by the Center on Budget and Policy Priorities. New York: The Commonwealth Fund.

[xxii] Ku & Ross (2002), Supra note xxi.

[xxiii] Ross & Cox (2004). Supra note xvii See Table 7.