Office for Oregon Health
Policy and Research

TRENDS IN OREGON'S HEALTH CARE MARKET AND THE OREGON HEALTH PLAN

A Report to the 73rd Legislative Assembly

January 2005

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Prepared by:
Department of Administrative Services
Office for Oregon Health Policy and Research
http://www.oregon.gov/DAS/OHPR

Bruce Goldberg, MD
Administrator

Jeanene Smith, MD
Deputy Administrator

Tina Edlund
Research and Data Manager

Janne Boone
Research Analyst

Laura Brennan
Health Policy Analyst

Katya Medvedeva
Research Assistant

Jessica Miller
Research Assistant

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Executive Summary

Over the past decade the health care market in Oregon has seen significant economic, structural and policy changes that have affected the way hospitals, health plans, physicians and purchasers do business and how consumers access health care services. In Oregon and the rest of the country, health care costs have increased at a rate higher than those in the rest of the market. Health care expenditures currently account for more than 20% of the Oregon state budget in programs such as the Oregon Health Plan (OHP), Seniors and People with Disabilities (SPD), Public Employees Benefit Board (PEBB), the State Children's Health Insurance Program (SCHIP), and public health.

Understanding this critical component of the state budget requires that we also have a picture of the health care market, its major components and the key drivers of health care costs. Previous Legislative Reports issued by the Office for Oregon Health Policy and Research (OHPR) focused largely on the Oregon Health Plan and its related elements. This report to the 73rd Legislative Assembly presents a broader representation of the health care marketplace in Oregon.

Chapter 1 focuses on *Oregon population trends and demographics* as well as *how much we spend on health care*.

- One driver of changing health care needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, and health care utilization and costs in the years to come.
- Between 2003 and 2010, the fastest growing segments of the population in Oregon are those 60 to 64 years of age (53% projected growth) and those 65 to 69 years of age (39% projected growth). As these individuals age, their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program. As a result, Medicare spending will begin to rise.
- Approximately 70% of health care dollars are spent on hospital care, physician services, and prescription drugs.
- Cost drivers for the rise in health care costs include medical technology including new prescription drugs, an aging population, changes in health care market power, workforce shortages, health insurance, capital and construction spending, government policy, medical errors, and the medical-legal environment.

Chapter 2 focuses on *the Oregon Health Plan* looking at trends and program changes in 2003 and 2004.

- Government is a major provider of health insurance, both as an employer and through Medicare and Medicaid. Medicaid is the second largest component (after education) in most state budgets; in Oregon it accounted for an estimated 13% of the state total funds budget in the 2003/2005 biennium.
- For every $1 that Oregon invests in Medicaid, the federal government matches with approximately $1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state. These dollars trigger successive rounds of earning and purchases as they continue to circulate through the economy.
- For Oregon, the downturn in the state's economy starting in the late 1990s led to high unemployment and increased demand for publicly financed health care. In order to avert a collapse of the Medicaid program in Oregon, the state turned to a variety of cost containment measures.
- Facing the same kind of challenges it had in 1987, the highest unemployment rate in the nation and an unprecedented budget deficit, Oregon turned to cost sharing and benefit reduction in the Oregon Health Plan in 2003.
    - There were a total of 423,502 total OHP Medicaid and CHIP enrollees in September 2004. Of total eligible, 50% were children 18 years and under, 41% were adults 19-64 years of age, and 9% were adults 65 years and older.
    - Low-income single individuals (especially the zero income group) have been most affected by the premiums and administrative changes to OHP Standard.
    - Administrative changes (removal of the waiver criteria and implementation of the six-month disqualification) in premium policy were at least as important as the premium increases.
    - OHP changes had impacts on access to health care for vulnerable populations, with most who lost coverage remaining uninsured and facing higher unmet needs for medical care, urgent care, mental health care and prescription medications. This is especially true for those with chronic illness. This could result in increased costs for these populations due to health complications from not maintaining care for these illnesses.
    - Those who lost coverage were nearly three times more likely to report no usual source of care and four to five times more likely to report the emergency department as their usual source of care. This was primarily noted in the lowest income group, especially those with chronic disease. This has impacts on the state's health care facilities, especially hospital emergency departments.

- Oregon spends slightly less, as a proportion of overall expenditures, on long-term care when compared to the U.S. Acute care services account for 61% of the Medicaid budget and provides services to over 400,000 people, while long-term care accounts for approximately 3% of the budget and provides services to an average case load of approximately 39,000 people.

Chapter 3 focuses on *who's covered* looking at trends in Medicare and private sources of coverage.

- Medicare is a federal health insurance program covering over 513,000 Oregonians[1] who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.
- The population over 65 years of age is projected to increase more rapidly in the next twenty years than it did in the prior twenty years. This projected growth is larger in Oregon than in the U.S., and this population is expected to almost double (91%) by 2020 in Oregon. These trends have serious implications for the Medicare program.
- Employer-sponsored insurance remains the primary source for health insurance for most Oregonians, covering an estimated 66% of the population in 2004.[2] However, with premiums growing at approximately 12% a year, there is evidence nationally that employers, especially smaller employers, are dropping health insurance as a benefit for their employees.
- The average annual increase in Oregon's health insurance premiums for most years between 1997 and 2002 far outpace the growth in per capita income or inflation.
- While employers continue to offer health insurance, there has been a decline in the percent of employees who are eligible for health insurance.
- Among employees who are eligible for health insurance, about 85% enroll. This proportion has remained constant. In general, an employee might decline enrollment if they receive insurance through a family member, or if they cannot afford or choose not to pay cost-sharing obligations.
- The percent of employers offering health insurance for single coverage at no cost to the employee has remained relatively constant.
- In Oregon, there has been a dramatic shift away from managed care. Managed care penetration in the state peaked in 1999, with slightly more than 50% of population enrolled in one of the state's 11 managed care plans.[3] The strongest remaining sector of managed care in the state is within the Medicaid delivery

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[1] *http://www.cms.hhs.gov/researchers/*

[2] *Office for Oregon Health Policy and Research, 2004 Oregon Population Survey.*

[3] *http://www.managedcaredigest.com/edigests/hm2000/hm2000c01s07g01.html*. *<December 2004>.*

system, where 13 managed care plans deliver care to about 75% of the Medicaid population.

- Health Savings Accounts (HSAs) are emerging as a new insurance product that works with qualifying high-deductible health coverage to help people finance medical expenses. This impacts both individuals and states.

Chapter 4 focuses on *who's not covered,* examining the impacts, trends and characteristics of the uninsured in Oregon.

- Health care coverage does not guarantee access to quality care or any care at all, but it has long been accepted that there are negative consequences to being uninsured, not just for the individual lacking in coverage, but also for the community.
- Oregon's recent high rates of unemployment, increasingly expensive health insurance premiums and declining enrollment in the Oregon Health Plan are all contributors to Oregon's growing uninsured population, which went from 14% in 2002 to 17% in 2004.
- Seventeen percent of Oregonians report that they currently have no health insurance coverage; this translates into an estimated 609,000 individuals, or 1 in 6 Oregonians.
- The ability to obtain and keep health insurance coverage is not distributed equally across the population. Since most health insurance in the U.S. is employer-based, many of the same characteristics that impact employment status and income also impact health insurance status.
- Young adults tend to have less coverage than any other age group. More than one-third of young adults between the ages of 18 and 24 in Oregon are without health insurance.
- Individuals with higher household income and more education have substantially higher rates of health insurance.
- Oregonians < 100% FPL are six times as likely to be uninsured than those with incomes over 500% FPL.
- Although children are uninsured at lower rates, this income disparity remains evident.
- Health insurance coverage increases as the level of education increases: adults with no high school degree are over four times more likely to be uninsured than adults with advanced degrees.
- Almost all individuals 65 and older are almost all covered by Medicare. Only those without ten years of covered work credits or those who choose not to enroll remain without Medicare after 65.

Chapter 5 focuses on *access* presenting information about the health care delivery system in Oregon, including the health care safety net, hospitals and the health care workforce.

- There are many factors that determine access to care. Constraints in access to health care services are compounded for those without health insurance coverage.
- Access to care for the uninsured and underinsured is provided in large part by the health care safety net. The health care safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Oregon's health care safety net includes Federally Qualified Health Centers (FQHC), Rural Health Centers, Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC) Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments, as well as some private health care providers.
- The provision of uncompensated care serves as an indicator of both the need for care among people who are unable to pay, and the willingness and capacity of health care providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect increasing numbers of uninsured individuals and families in the community.

Chapter 6 focuses on *racial and ethnic health disparities* in Oregon examining the changing make-up of Oregon's population and the need for increased data collection efforts.

- In 1990, racial and ethnic minorities made up 9.2% of Oregon's population; in 2003, an estimated 17.8% of the population is African-American, Native American, Asian/Pacific Islander and/or Hispanic.
- The Institute of Medicine has outlined four broad policy challenges: public and provider awareness of racial and ethnic disparities, expanding health insurance coverage, improving capacity and number of providers in underserved communities, and increasing the current knowledge base on causes and interventions to reduce disparities.
- Disparities in access and coverage have serious negative health consequences: Hispanics in the U.S. are almost twice as likely to die from diabetes as non-Hispanic whites and the infant death rate among African-Americans in the U.S. remains more than double that of whites.
- The racial and ethnic make-up of the provider community does not reflect that of the population. Only 10% of the provider community consists of racial minorities and only 2% are Hispanic.
- Data is not routinely collected on access, health status or utilization for Oregon's racial and ethnic minorities. Standardized data collection is critically important

to inform policy and to understand and eliminate racial and ethnic disparities in Oregon.

Chapter 7 focuses on *health status* by looking at the prevalence of chronic disease, high-risk conditions and modifiable risk behaviors.

- Providing health care impacts health status, but health status also influences demand for and the cost of health care. It is important, therefore, to examine health care both in the context of health status and as an important determinant of health outcomes.
- Chronic disease in Oregon represent areas of opportunity for the state where improved quality and access to primary health care can improve health status and reduce costs associated with these conditions.
    - In Oregon, these major chronic diseases accounted for over 20,000 deaths, almost 66,000 hospitalizations, and nearly $1 billion in hospitalization charges during 2000.
    - Over a third of adults in Oregon report having a chronic disease.
    - Those with chronic diseases have higher death rates, incur higher costs, experience higher rates of depression, and are more frequently limited from performing their usual activities.
- High-risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many of the chronic diseases described above.
    - Screening for these conditions can help to detect chronic disease early in its development. Decreasing prevalence of these conditions is important in reducing the chronic disease burden in the population.
- Modifiable risk behaviors are influenced by many inter-related factors including genetic predisposition, environmental exposure, and social circumstances such as socio-economic status, medical care, and behavioral patterns. Some of these factors can be changed, while others.
    - Three key health behaviors – tobacco use, physical activity, and diet – can impact the development of chronic diseases and/or risk conditions.

Chapter 8 focuses on *Oregon's health values trends,* presenting information from the 2004 Health Values Survey and previous years' results.

- Oregon has a long history of involving the public in the policy process, especially in the health care arena. A statewide health values survey has been conducted periodically since 1996 to assess Oregonian's basic values around health care policy issues.
    - Oregonians report that access for all, cost of health care, and the cost of health insurance were the top three health care problems that need to be solved in Oregon.

- The vast majority of the public believes that all Oregonians should be guaranteed *basic* and *routine* health care services.
- When choosing between services to include in coverage for all Oregonians, the public cited preventive and primary care services as the overwhelming top priority. Reasons for this prioritization included cost efficiency and improvement of individual and social well being.
- The public indicated that infants and small children should be prioritized first when allocating health care dollars for all Oregonians.
- The public supports policies that help the uninsured obtain health coverage.

Forward

Over the past decade the health care market in Oregon has experienced significant economic, structural and policy changes that have affected the way hospitals, health plans, physicians and purchasers do business and how consumers access health care services. In Oregon and the rest of the country, health care costs have increased at a rate higher than those in the rest of the market. Health care expenditures currently account for over 21% of the Oregon state budget in programs such as the Oregon Health Plan (OHP), Seniors and People with Disabilities, Public Employees Benefit Board (PEBB), the Children's Health Insurance Program (SCHIP), and public health.

Understanding this critical component of the state budget requires that we also have a picture of the health care market, its major components and the key drivers of health care costs. Previous Legislative Reports issued by the Office for Health Policy and Research (OHPR) focused largely on the Oregon Health Plan and its related elements. This report to the 73rd Legislative Assembly presents a broader representation of the health care marketplace in Oregon. To that end, the report is organized as follows:

Chapter 1 focuses on *Oregon population trends and demographics* as well as *how much we spend on health care*.

Chapter 2 focuses on *the Oregon Health Plan* looking at trends and program changes in 2003 and 2004.

Chapter 3 focuses on *health insurance,* looking at trends in Medicare and private sources of coverage.

Chapter 4 focuses on *who's not covered* examining the impacts, trends and characteristics of the uninsured in Oregon.

Chapter 5 focuses on *access* presenting information about the health care safety net in Oregon.

Chapter 6 focuses on *racial and ethnic health disparities* in Oregon by looking at what is known about disparities in health care, the changing make-up of Oregon's population, and the need for increased data collection efforts.

Chapter 7 focuses on *health status* by looking at the prevalence of chronic disease, high-risk conditions and modifiable risk behaviors.

Chapter 8 focuses on *Oregon's health values,* presenting information from the 2004 Health Values Survey.

About the Office for Oregon Health Policy and Research

The Office for Oregon Health Policy and Research (OHPR) provides analysis, technical, and policy support to the Governor and the Legislature on issues relating to health care costs, utilization, quality, and access and serves as the policy making body for the Oregon Health Plan. OHPR also provides staff support to statutorily-established advisory bodies, including the Oregon Health Policy Commission, the Health Resources Commission, the Health Services Commission, the Advisory Committee on Physician Credentialing and the Medicaid Advisory Committee. In addition, the Office coordinates the work of the Oregon Health Research and Evaluation Collaborative. For more information about OHPR, visit http://www.oregon.gov/DAS/OHPPR or contact the office at (503) 378-2422.

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CHAPTER 1
BACKGROUND

In this chapter:

- Oregon Population Trends and Demographics
- Health Care Spending
- Drivers of Health Care Costs

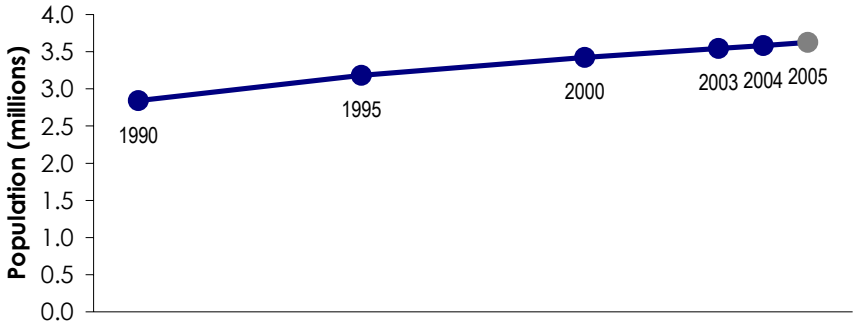
Oregon Population Trends and Demographics

One driver of changing health care needs and costs is a growing and shifting population. Oregon's population is changing rapidly, not only in total size but also in its age distribution, racial and ethnic makeup, and on economic factors. These changes have implications for health, health coverage, health care utilization and costs in the years to come. Following are a set of charts and tables that describe the changes in detail.

Population Trends in Oregon, 1990 to 2005

	Population*
1990	2,842,321
1995	3,182,690
2000	3,421,399
2003	3,541,500
2004	3,582,600
2005	3,625,100

*2005 is projected



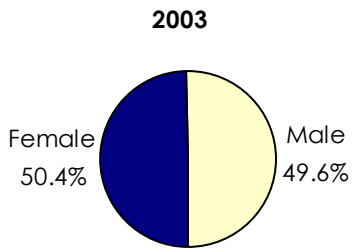
- Oregon's population has grown on average 1.8% per year since 1995 – from almost 2.9 million in 1995 to over 3.5 million in 2003 – and is projected to grow at 1.1% per year in 2004 and 2005.
- The natural increase, or the number of births in excess of number of deaths, is relatively stable at over 15,000 per year. Migration into Oregon far exceeds migration out of the state, more so in 1999 and 2000 when net migration was over 26,000 per year, but has started to trend upward in 2003 and 2004.

Data Sources (Population): Oregon Office of Economic Analysis - 2003 Oregon Population Report, Table 1 (1990, 1995, 2000, 2003); Certified Estimates for Oregon, Its Counties and Cities, July 1, 2004 (2004); Population Forecasts, Table C.1. (2005).

Data Sources (Population Component Change): Oregon Center for Health Statistics (1999-2003), Oregon Office of Economic Analysis (2004 projection).

Gender in Oregon, 2003 and 2010 projection

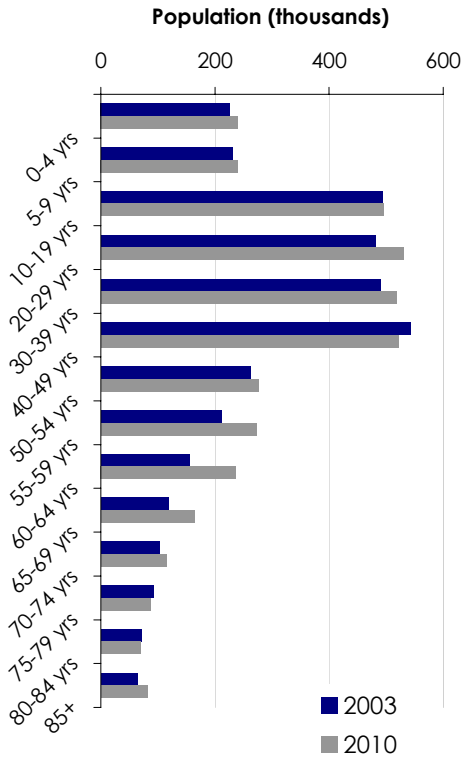
	2003	2010	% Change
Male	1,760,922	1,924,902	9.3%
Female	1,780,578	1,925,998	8.2%



- The ratio of males to females in Oregon is projected to remain stable at about 50:50, and both groups are projected to grow over 8% by 2010.

Data Sources: Oregon Office of Economic Analysis, Population Forecasts by Age and Sex, Table C.2.

Age Distribution in Oregon, 2003 and 2010 projection

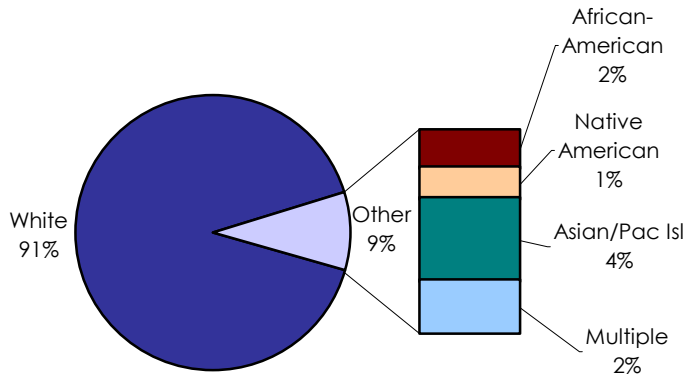


	2003	2010	% Change
0-4 yrs	226,684	240,806	6.2%
5-9 yrs	230,477	240,309	4.3%
10-19 yrs	494,261	495,803	0.3%
20-29 yrs	481,092	530,676	10.3%
30-39 yrs	490,478	517,878	5.6%
40-49 yrs	542,072	521,375	-3.8%
50-54 yrs	261,794	275,913	5.4%
55-59 yrs	211,493	273,115	29.1%
60-64 yrs	154,644	236,650	53.0%
65-69 yrs	118,056	164,464	39.3%
70-74 yrs	102,955	115,171	11.9%
75-79 yrs	92,455	87,639	-5.2%
80-84 yrs	71,278	69,417	-2.6%
85+	63,761	81,682	28.1%

- Consistent with national trends, Oregon's population is aging. The fastest growing age groups are 55-59, 60-64, and 65-69 years, projected to grow in size by 29%, 53%, and 39%, respectively, by 2010.

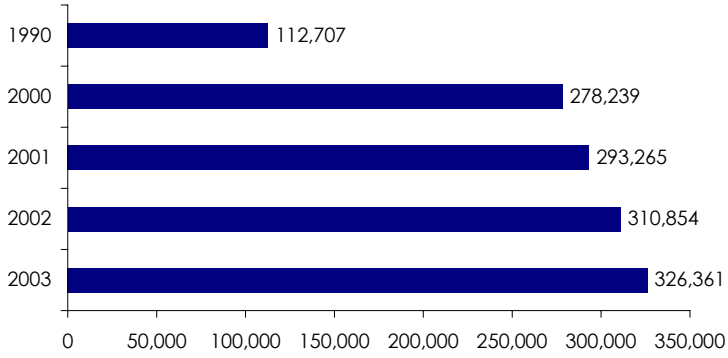
Data Sources: Oregon Office of Economic Analysis, Population Forecasts, Components of Change, Table C.2.

Race* and Ethnicity, 2003



	2003	2010	% Change
White	3,233,336	3,253,348	0.6%
African- American	63,665	70,758	11.1%
Native American	49,090	53,439	8.9%
Asian/Pac Isl	131,277	147,170	12.1%
Multiple	82,228	--	--
Hispanic	326,361	--	--

Oregon's Growing Hispanic Population



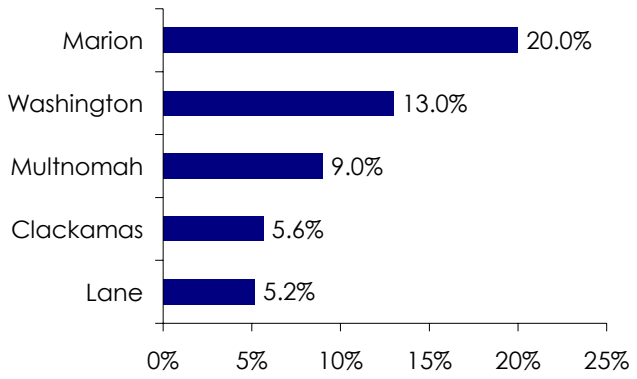
- Oregon's population includes 82% non-Hispanic whites and 18% racial or ethnic minorities.
- Oregon is becoming more diverse, and its minority population is growing, especially among younger ages.
- The number of Native Americans is projected to grow by 9% by 2010, and the number of African-Americans is projected to grow by 11%.
- In some rural counties, an aging white, non-Hispanic population is shrinking and the minority population is growing, especially Hispanic populations.
- The Hispanic population currently makes up 9.2% of Oregon's population and is forecast to continue growing.

*Race categories are independent of Hispanic ethnicity.

Data Sources: Population Division, U.S. Census (2003), Oregon Office of Economic Analysis (2010 projections)

Ethnicity in Specified Oregon Counties, 2003

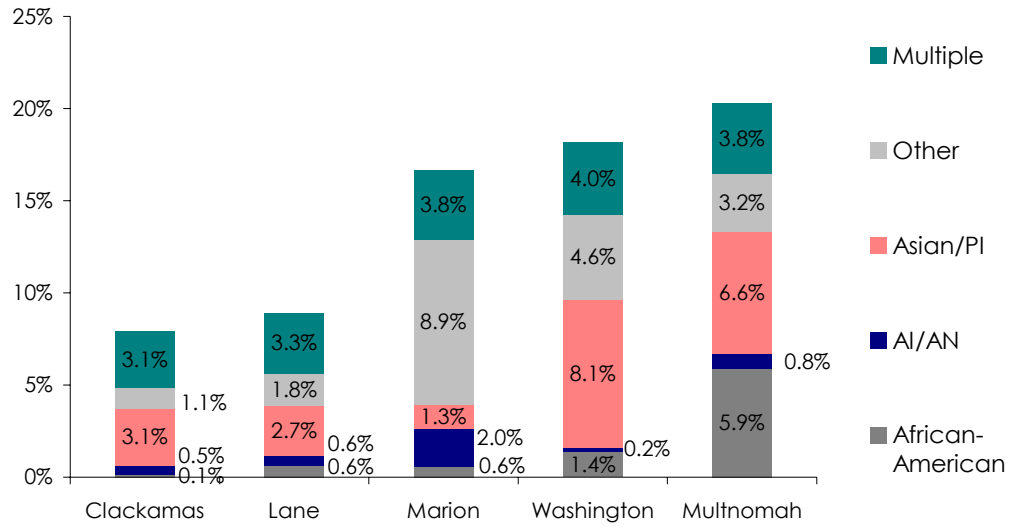
- While the statewide population is largely non-Hispanic white, there are large Hispanic populations in some counties*, including Marion and Washington Counties.
- The Hispanic population is not dispersed; it tends to be concentrated in small cities in rural counties, e.g., Hood River, Morrow and Malheur.



*Counties displayed were limited to those with sufficient sample size.

Data Source: American Community Survey, 2003

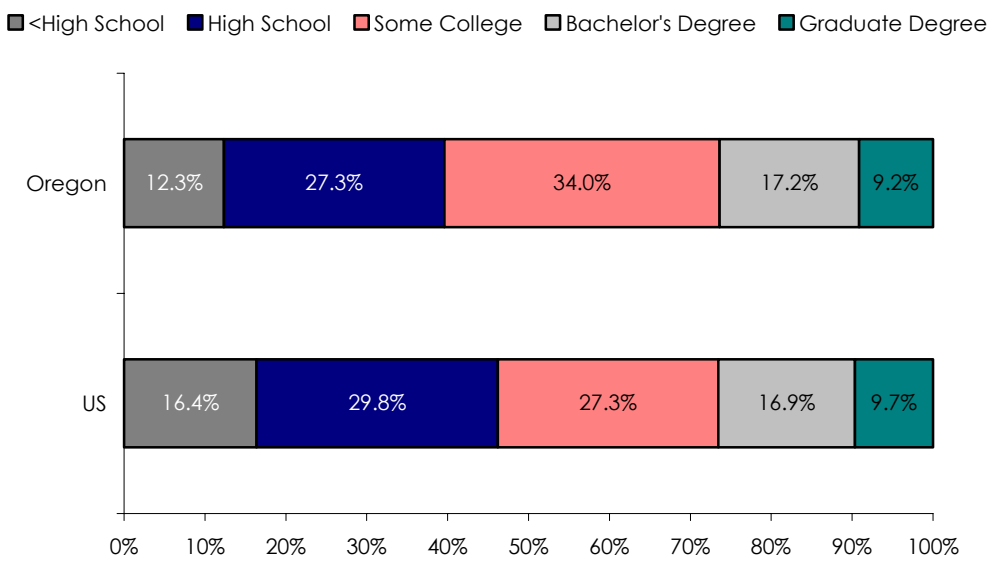
Race Categories in Specified Oregon Counties, 2003



- Similarly, racial groups are larger in certain counties.
- Multnomah County has the most racially diverse population, with 20% minorities.

Data Source: American Community Survey 2003

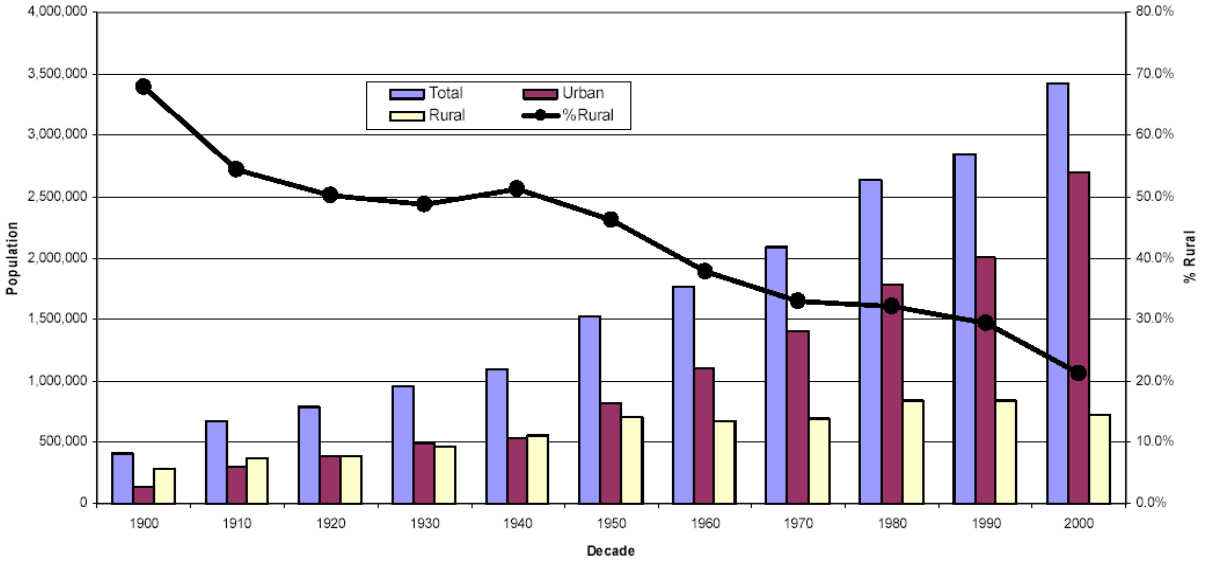
Educational Achievement in Oregon and the U.S., 2003



- In 2003, 27% of Oregonians had a high school diploma or equivalent, 17% had a Bachelor's degree, and 9% had a graduate degree. Over 60% had attended at least some college.

Data Source: American Community Survey 2003

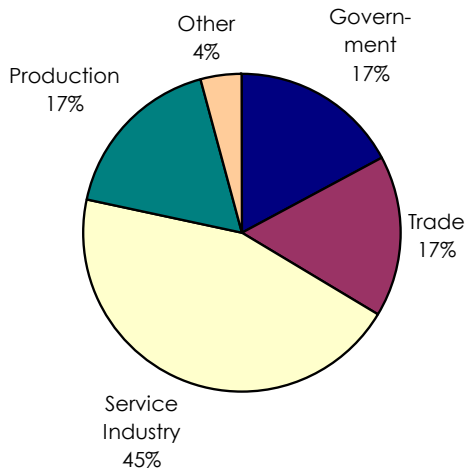
Total, Urban, and Rural Populations for Oregon, 1900 to 2000



- Urban/rural populations from 1900 to 2000 reflect the decline in Oregon as a natural resource state economy.

Data Source: Population Research Center, Portland State University

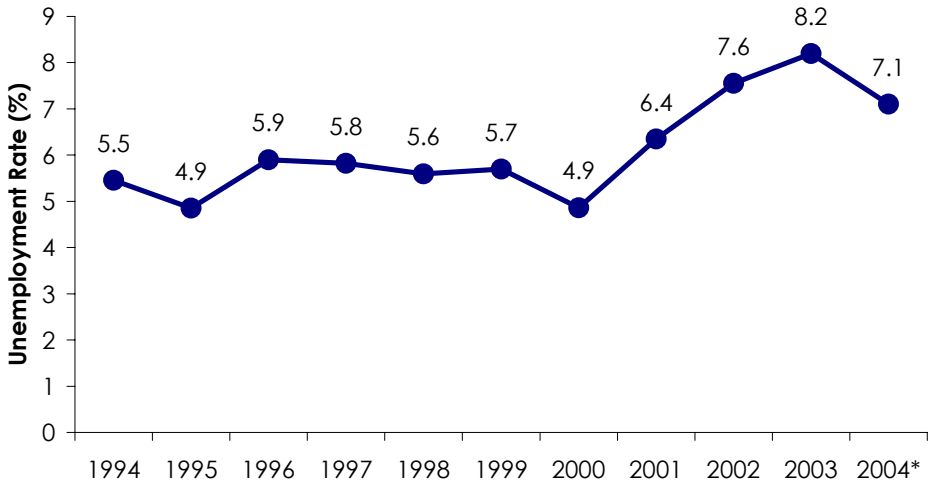
Employment Sectors in Oregon, 2003



- In 2003, the service industry was the largest employment sector, providing 45% of employment in Oregon.
- Trade, production, and government each provided 17% of employment, and 4% were employed by other employment sectors.

Data Source: Oregon Economic and Community Development Department

Unemployment in Oregon, 1994-2004



*Unemployment for Jan-Sep 2004.

- After rapidly increasing from 2000 through 2003, unemployment is projected to decrease by 1.1 percentage points in 2004.

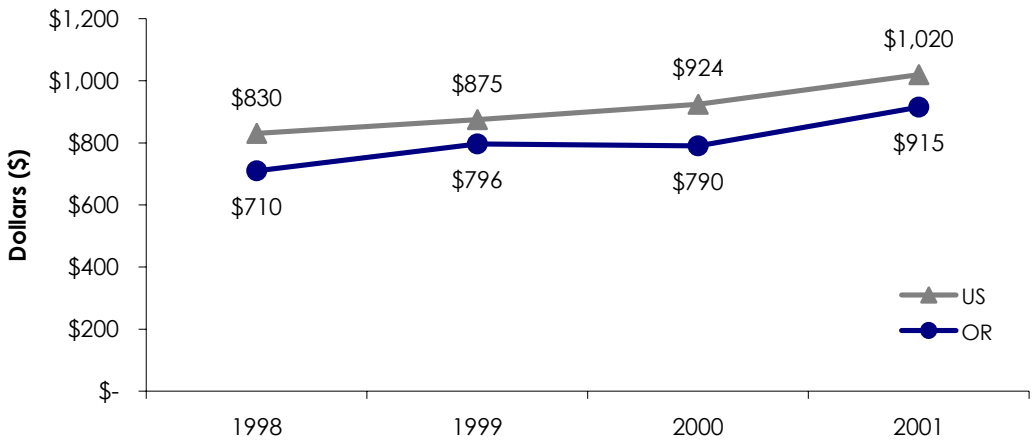
Data Source: U.S. Department of Labor, Bureau of Labor Statistics, seasonally adjusted

Health Care Spending

Health care costs are the single largest component of the U.S. economy, accounting for 15.3% of the U.S. Gross Domestic Product in 2003.[4] This report looks at health care costs in two distinct ways: the first examines health care spending as part of the state budget, the second examines overall personal health care spending in the state, which includes spending for all public and privately funded health care services as well as out-of-pocket spending for services such as hospitals, physician services, nursing services and prescription drugs**.**

Healthcare Expenditures in the State Budget. Combined state spending for health care, including Medicaid, public employees' health benefits, corrections health, university health services, and public health account for more than 20% of the state budget.[5] On a per capita basis, state budget expenditures have increased 29% from 1998 to 2001 compared to 23% nationally.

State Health Care Spending per Capita in Oregon and the U.S., 1998 to 2001



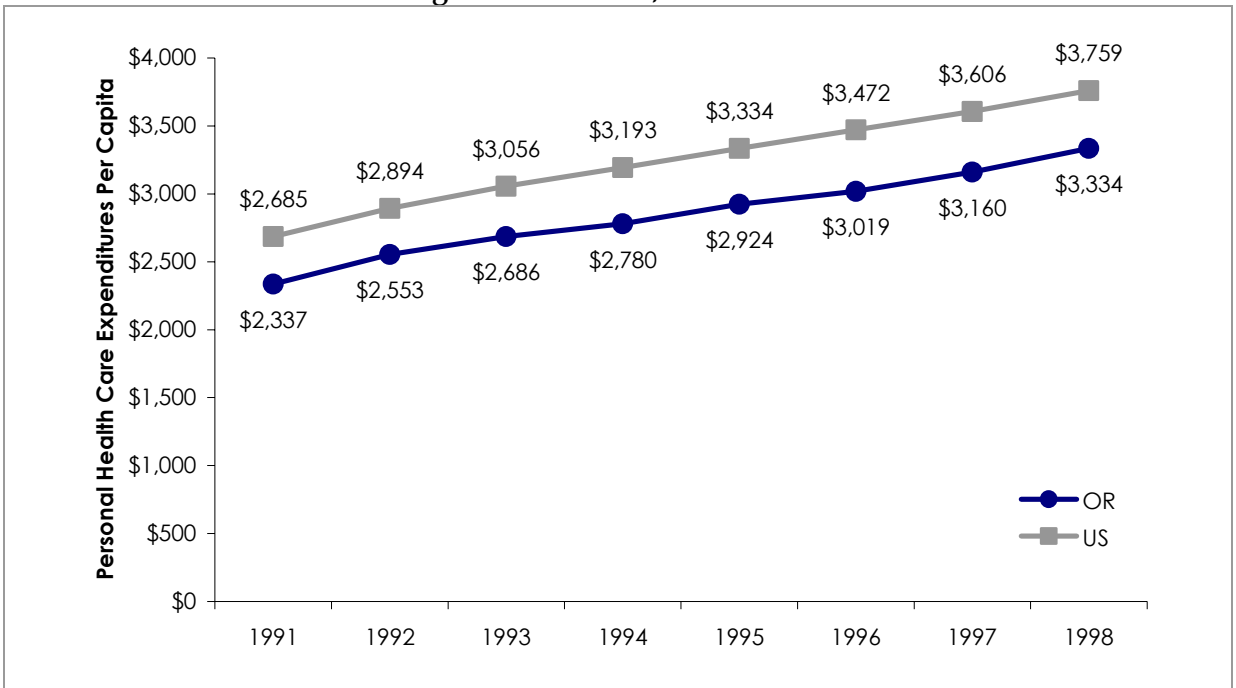
Source: Milbank Memorial Fund Report, 2000-2001 State Health Care Expenditure Report. Includes combined state spending for Medicaid, public employees' health benefits, corrections health, university health services, and public health services.

[4] *Smith C, Cowan C, Sensenig A, Catlin A, "Health Spending Growth Slows in 2003, Health Affairs, Vol 24, Issue 1, 185-194 .*

[5] *State of Oregon, Department of Administrative Services, Budget and Management, Presentation: "2005/07 Governor's Recommended Budget, Ways & Means, Human Services Overview." 1/25/05.*

Personal Health Care Spending. The Centers for Medicare and Medicaid Services (CMS) provide estimates of total personal health care spending for the U.S. and at the state level. The most recent state estimates, completed in 2002 with 1998 data, totaled $10.9 billion in Oregon in 1998 and $1.016 trillion in the United States. On a per capita basis, personal health care spending in Oregon increased from $2,337 in 1991 to $3,334 in 1998. The following chart exhibits the change in per capita health care spending from 1991 to 1998:

Trends in Personal Health Care Expenditures Per Capita, Oregon and the U.S., 1991 to 1998

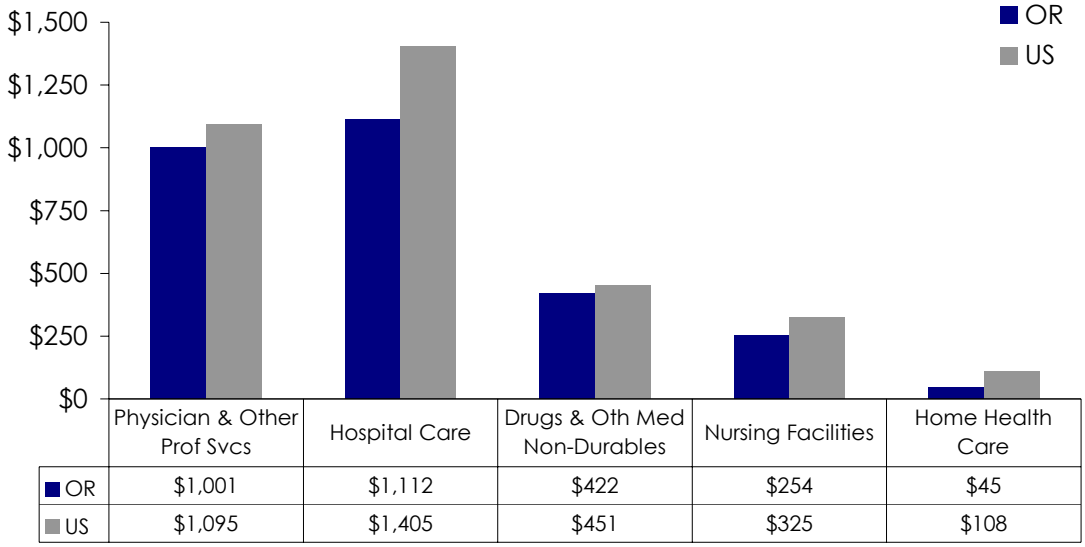


Source: Centers for Medicare and Medicaid Services, Office of the Actuary, 2002.

Oregon experienced an average annual increase in personal health care spending of 5.2% from 1991 to 1998 compared to a 4.9% average annual increase in the U.S.

The components of Oregonians' personal health care spending in 1998 were as follows:

Components of Health Care Spending Per Capita, Oregon and U.S., 1998

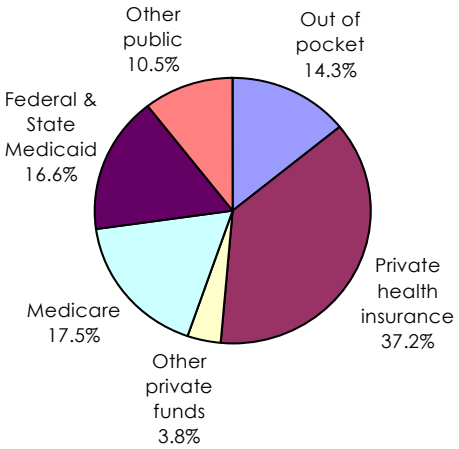


	Physician & Other Prof Svcs	Hospital Care	Drugs & Oth Med Non-Durables	Nursing Facilities	Home Health Care
OR	$1,001	$1,112	$422	$254	$45
US	$1,095	$1,405	$451	$325	$108

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2002.

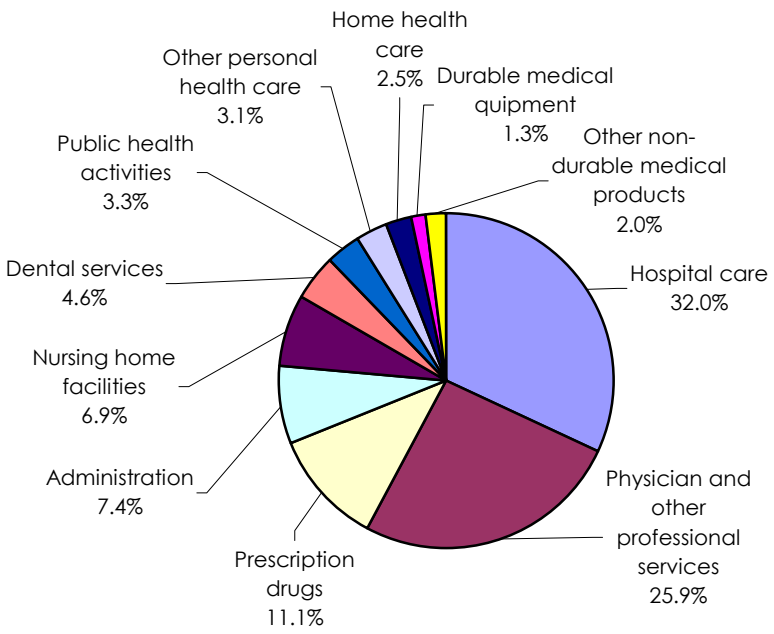
Sources of Funds. Data for national health care expenditures are available from as recently as 2003. Those data show that private health insurance continues to account for the largest share of health care expenditures: 37.2% of total expenditures in 2003. Public funds pay for 34% of total health care expenditures in the U.S., 16.6% from state and federal Medicaid dollars and 17.5% from Medicare.

Expenditures for Health Services in the U.S. by Source of Funds, 2003



Source: Smith C, Cowan C, Sensenig A, Catlin A, "Health Spending Growth Slows in 2003", Health Affairs, January/February 2005, p.188.

Components of Health Care Spending in the U.S., 2003



Source: Smith C, Cowan C, Sensenig A, Catlin A, "Health Spending Growth Slows in 2003", *Health Affairs*, January/February 2005, p.186.

Hospital services continue to account for one-third of total health care spending, but spending growth slowed from 8.5% in 2002 to 6.5% in 2003. Physician services grew by 8.5% in 2003, up from 8.2% in 2002.

Prescription drugs are the fastest growing sector of health care spending, increasing 14.9% in 2002 and 10.7% in 2003. The slowing of growth in prescription drug spending is attributed to a reduction in utilization, a shift to generic drugs, expansion of tiered co-payment plans and increased purchasing from non-U.S. pharmacies. [6]

[6] *Smith C, op.cit., p.189.*

Drivers of Health Care Costs

Health care cost trends are influenced by not only the allocation of health dollars into various products and services, but also growth (or decline) in each cost category. From the information above, it is clear that health care accounts for a large and growing proportion of overall spending. Further, almost three-quarters of health care dollars are spent on hospital care, physician services, and prescription drugs as noted above. But what is driving the rise in costs in these areas over time? Research has shown that if health care costs rise at a significantly faster rate than incomes, more people will become uninsured. [7] Outlined below are the main drivers of costs in health care services.

Medical Technology

- New medical technology, and its enthusiastic acceptance into mainstream medical practice, is felt to be the most important long-term driver of health care costs.[8] This includes such things as new prescription drugs, innovations in diagnostic imaging, treatments, and non-invasive surgical techniques, which accounted for an estimated 12% to 39% of national health care spending growth in the 1990's. This growth is expected to continue at similar levels well into the 2000's.[9]
- Price inflation and increased utilization both contribute to increased spending on medical technological advances such as new prescription drugs. Direct-to-consumer (DTC) advertising is also a key area of growth, outpacing growth in research and development. Direct costs incurred by DTC advertising as well as the resulting increase in utilization impact the total cost of prescription drugs.[10]
- Although many advances are extremely valuable, others have only slight benefits for patients and some are ultimately found to be harmful—the result of rapid diffusion without rigorous research on medical effectiveness of comparable treatments.[11]
    - It is important to assess proximity to the so-called "flat of the curve", or that point at which increased expense of medical technology yields little or no improvement in patient outcomes.
- New technologies can be initially very expensive but highly efficacious and cost-efficient in the long run.

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[7] Kronick, R and Gilmer, T "Explaining the Decline in Health Insurance Coverage, 1979-1995," Health Affairs, Vol 18, No. 2 (March/April 1999)..
[8] Strunk, BC and Ginsburg, PB "Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004" Issue Brief No. 91, Center for Health System Change, December 2004.
[9] Primary Source Project Hope, 2001 based on CMS data; Secondary source: BCBS Medical Cost Reference Guide revised October 2004.
[10] Secondary source: BCBS Medical Cost Reference Guide revised October 2004.
[11] Ginsburg, P Controlling Health Care Costs New England Journal of Medicine, 351; 16 (Oct. 14, 2004).

- For example, diagnostic imaging is a rapidly growing technology and was the most expensive technology in 2001. However, it was ranked as the most important innovation among physicians, and allows for early detection of potentially detrimental and expensive conditions.[12]

Aging Population

- While health care costs are rising for both young and older age groups,[13] older adults incur more health care costs. Health care costs begin to rise in those 40 years of age an older, accelerating by age 60.
- In Oregon, the number of adults 65 to 69 years of age is expected to grow 36% by 2010[14], which has important implications for Medicare costs.
- Likewise, the number of adults aged 55 to 64 is expected to grow by 37%,[15] impacting health care demand among the workforce and health care costs for private insurers.

Changes in Healthcare Market Power

- The health care market place has changed. During the mid-1990s, managed care was the dominant market power. The managed care plans, as the employer's agent, coerced efficiencies among providers and constrained consumer choice.
- Providers responded by reducing excess capacity and consolidating which tended to turn the balance of power back toward providers. There was resistance to selective contracting and risk sharing by the health plans. Coupled with the resistance by consumers to limit their preferences in obtaining services or in selecting providers, managed care declined in Oregon and across the nation.
- Providers now focus primarily on two strategies to bolster their financial position—pressing health plans for better payment rates and contract terms and investing in select services and technology that are particularly well compensated, especially cardiac, cancer and orthopedic services. Many medical groups are opening ambulatory surgery and diagnostic centers and adding capacity to deliver radiology, laboratory and imaging services in their practices. The intense competition for niche specialty services may be an indication that public and private payers are inadvertently overpaying for some services while underpaying for others.[16]

[12] *Secondary source: BCBS Medical Cost Reference Guide revised October 2004*
[13] *Primary Source Strunk and Ginsburg, 2002; Secondary source: BCBS Medical Cost Reference Guide revised October 2004*
[14] *See Demographics trends section*
[15] *See Demographics trends section*
[16] *Ginsburg, PB & Nichols, LM; "The Health Care Cost-Coverage Conundrum – The Care We Want vs. The Care We Can Afford" Center for Studying Health System Change – Annual Essay 2002-03, obtained at www.hschange.com on January 18, 2005.*

Workforce Shortages

- Hospital price increases are due in part to strong growth in wage rates for hospital workers, which have been driven up by a persistent worker shortage, particularly for nurses.
- The use of agency/traveling nurses to fill vacant staff openings contribute to increasing hospital costs as well; U.S. hospitals spent $71 million on agency/traveling nurses in 2001.
- There are also shortages in technicians and therapists, dental hygienists and assistants, and some medical specialties.
- Rural areas are most negatively impacted by workforce shortages.
- Almost 20% of Oregon's primary care physicians are planning to retire within the next five years.[17]

Health Insurance

- Private health insurance premium increases were attributable to the rising costs of benefits and prescription drugs, and a shift in enrollment to higher-cost benefit plans. A continued upward swing in the underwriting cycle also contributed to premium increases as insurers sought to recover prior years' losses and build up profitability.[18]
- Employers have tried to offset these increases by increased cost-sharing, which includes a higher incidence of deductibles and larger dollar amounts, as well as increased employee contribution to premiums and co-payments.
- New insurance products, including Consumer-Directed Health Plans (CHDPs), Health Savings Accounts (HSAs), and Health Reimbursement Accounts (HRAs) also shift more of the costs back to the employees. [See Chapter 3 for more detailed information about these products]
- Prior authorization, along with disease and case management tools are being reinstated in attempts to control costs by controlling the utilization of services.

Capital and Construction Spending

- Capital spending includes cost for the replacement of equipment and facilities, expansion of capacity, and adoption and updating of medical and information technology equipment.
- A projected 40% expansion in capacity over the next decade will help to meet the needs of the aging population.
- Construction expansion slowed in 1980's and 1990's, but the nation saw large increases in 2002.

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[17] Office for Oregon Health Policy and Research, Presentation, "2004 Oregon Physician Workforce Survey." Available at http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/ohrecnotes011805.pdf

[18] Strunk, BC, Ginsburg PB, Gabel JR. Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000. Data Bulletin No 21 – Revised. Center for Studying Health System Change. September 2001.

Government Policy

- Medicare plays a role in costs. While there have been declines in the Medicare payment rate, in 2002 this was offset by increasing visits, procedures, and tests, which resulted in an increase of 5.7 percent in Medicare spending. In 2003, Medicare volume and growth slowed, and there was a slightly higher Medicare payment to providers.[19]
- Medicare costs have been influenced by federal policies such as the legislative changes enacted as part of the Balance Budget Refinement Act (BBA), which softened reductions in disproportionate share payments, reduced the amount of cuts to graduate medical education funding and temporarily boosted reimbursement to sole community provider hospitals.
- The Centers for Medicare and Medicaid Services (CMS) estimates that the new Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) will provide drug coverage to approximately 130,000 Medicare eligible Oregonians who currently have no drug coverage through retiree benefits, through privately purchased prescription drug coverage or through Medicaid.
- The MMA has an impact on the state through the Phase-Down State Contribution ("claw back") where states are required to share in the cost of drug coverage for those dually eligible for both Medicaid and Medicare.
- To control growth in Medicaid spending and enrollment in 2003, thirty-four states tightened eligibility and restricted benefits for these programs. Medicaid payment rates were cut or frozen in 50 states, which have slowed the growth in Medicaid spending. The impact of all of this, as seen in Oregon with cuts to the Oregon Health Plan, can result in increased uncompensated care, which is the care given by providers and hospitals to the uninsured. These costs are then passed on, which can increase costs for other payers.
- Federal regulation such as the Health Insurance Portability and Accountability Act (HIPAA), while designed to protect patient information, carries with it a cost to health care providers to update systems that ensure the privacy of health care information.

Medical Errors

- Medical errors account for an estimated $17 billion to $29 billion in total annual costs nationally, including lost income, lost production, increased health care costs and increased disability. Health care costs are estimated to be one-half of that total.[20]
- The Oregon Patient Safety Commission was directed in 2003 by the Legislature and the Governor to address patient safety issues in the State and is currently

[19] *Smith C, Cowan C, Sensenig A, Catlin A, "Health Spending Growth Slows in 2003, Health Affairs, Vol 24, Issue 1, 185-194.*
[20] *Institute of Medicine, "To Err is Human: Building a Safer Health System", 1999, pp. 1-2.*

developing a voluntary reporting system and processes on sharing of best practices for preventing medical errors.

Medical-Legal Environment

- The practice of defensive medicine adds to health care costs.[21]
- Medical malpractice premiums are rising. Money spent on premium increases raises overall health care costs.[22]
- The Center for Studying Health System Change looked at medical liability issues in their twelve nationally representative sites, finding limitations on access and patient choices. These included doctors in some locations no longer delivering babies in order to lower their premiums, and instead referring patients to safety net facilities. Their report notes this may not only drive up health care costs but could also contribute to overcrowding at these facilities.[23]

[21] *Kessler D, McClellan M, "Do Doctors Practice Defensive Medicine?" Quarterly Journal of Economics, 111(2):353-90.1996.*

[22] *Ibid.*

[23] *http://www.hschange.org.*

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CHAPTER 2
HEALTH INSURANCE COVERAGE: THE OREGON HEALTH PLAN

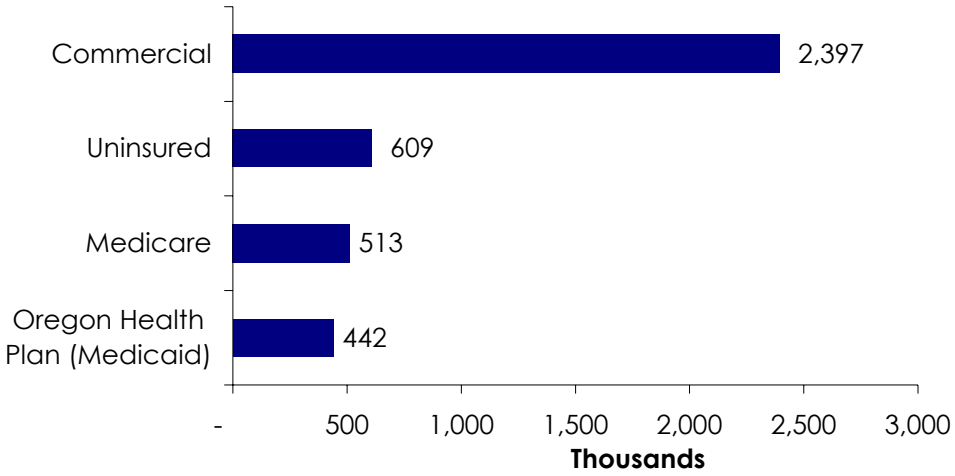
In this chapter:

- Overview: Medicaid
- Medicaid Expenditures
- Medicaid Reimbursement
- Impact of OHP2 Policy Changes
- Public-Private Partnership: Family Health Insurance Assistance Program (FHIAP)
- Long-Term Care

Overview: Medicaid

Employers are still the primary source for health insurance in the U.S.; 60% of all Americans were covered by health insurance provided through an employer in 2003.[24] However, government is a major provider of health insurance, both as an employer and through Medicare and Medicaid. Medicaid is the second largest component of most state budgets; in Oregon it accounted for an estimated 13% of the state budget in 2004.

Health Care Coverage in Oregon, 2004



- By far the most common source of health care coverage is employer-sponsored insurance.
- An estimated 609,000 Oregonians are uninsured.
- Approximately 900,000 Oregonians have Medicare, Medicaid, or both.

Data Sources: Medicare - CMS, 2003; Medicaid – DSSURS/OMAP; Duals – OMAP; Uninsured, commercial – 2004 OPS

[24] *DeNavas-Walt D, Proctor B, Mills R, U.S. Census Bureau, Current Population Reports, P60-226, Income, Poverty, and Health Insurance Coverage in the United States: 2003, U.S. Government Printing Office, Washington, DC, 2004.*

Medicaid provides health and long-term care services to low-income populations through a financing structure shared by the federal and state government. Nationally, Medicaid is a source of health insurance for 38 million low-income children and parents, and a critical source of acute and long-term care coverage for 12 million elderly and disabled individuals, including more than 6 million low-income Medicare beneficiaries.[25] In addition, the State Children's Health Insurance Program (SCHIP), adopted in 1997, provides capped federal funds to states expanding coverage to children who are not eligible under Medicaid.

Under both Medicaid and SCHIP, each state decides how to structure eligibility, benefits, service delivery and payment rates within guidelines established by federal law. In exchange for covering certain groups of individuals (referred to as "mandatory groups") and offering a minimum set of services (referred to as "mandatory benefits"), the federal government matches the state's Medicaid spending at an established rate called the Federal Medical Assistance Percentage (FMAP). Each state also receives federal matching payments to cover additional ("optional") groups of individuals and provide additional ("optional") services. This federal match allows states to maximize their capacity to meet the needs of their low-income population, and for Oregon the match rate is 61.12%. There is a slightly higher match rate for the SCHIP program, where every state dollar is matched at 72.78%.

Economic Impact of Medicaid. With federal matching dollars, for every $1 that Oregon invests in Medicaid, the federal government matches it with approximately $1.57. This injection of federal dollars has a positive impact on state business activity, available jobs, and aggregate state income. Medicaid payments to hospitals, nursing homes, and other health-related businesses pay for goods and services and support jobs in the state. These dollars trigger successive rounds of earning and purchases as they continue to circulate through the economy. For example, health care employees spend their salaries on cars, appliances and other non-health related goods and services. This ripple effect is called an economic "multiplier effect." The estimated economic multiplier effect in Oregon is that every $1 million in state Medicaid expenses accounts for $3.12 million in business activity, 34 jobs, and $1.33 million in wages.[26]

However, state budget crises, a growing and aging population, inflation, increased utilization of health services and increased use of new technology have all contributed to increased fiscal pressure within Medicaid programs nationally. For Oregon, the downturn in the State's economy starting in the late 1990s led to high unemployment and increased demand for publicly financed health care.

The Oregon Health Plan. This is not the first time the state has faced economic challenges in its Medicaid program. In 1987, Oregon initiated its health care reform efforts, collectively referred to as the Oregon Health Plan (OHP), in an attempt to reduce the number of uninsured Oregonians, strengthen its economy, and improve the health status of its citizens. At that time, 18% of Oregon's 2.85 million population were

[25] *Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance" January 2004.*
[26] *Klein R, Stoll K, Bruce A, Medicaid: Good Medicine for State Economies, 2004 Update, Washington: Families U.S.A, May 2004.*

uninsured, and the unemployment rate was 5.7%. In addition, the cost of health care was consuming an ever-growing portion of public and private sector budgets. The goal of the OHP was universal access to an adequate level of high quality health care at an affordable cost.

The major components of the original Oregon Health Plan were:

- Medicaid reform
- Insurance for small business
- High risk medical insurance pool

Medicaid Reform. The Oregon Health Plan (OHP) has been an innovative example of Medicaid reform, with a basic benefit package that expanded public coverage to the federal poverty level (FPL)[27] for families and adults, built upon a managed care delivery system, with prioritization and integration of mental, physical and dental health care services. The OHP sought to lower costs by reducing cost shifts with expanding coverage, emphasizing managed care, preventive care, early intervention and primary care, and not covering ineffective care. Prior to March 2003, the OHP covered:

- Low-income adults beyond the mandatory groups up to 100% of the Federal Poverty Level (FPL)
- Children (Under 19 years of age) up to 170% of FPL either through Medicaid or SCHIP funding
- Pregnant women up to 170% of FPL

Insurance for Small Business. As part of the Oregon Health Plan, the Insurance Pool Governing Pool (IPGB) was created to encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds. [28] In 1997, Oregon's Legislative Assembly created the Family Health Insurance Assistance Program (FHIAP), which offers premium subsidies to assist Oregonians initially up to 170% FPL (later increased up to 185% FPL – see next section) to gain access to coverage.

High-Risk Medical Insurance Pool. The 1987 Legislature created the Oregon Medical Insurance Pool (OMIP) to provide affordable health insurance to individuals denied individual coverage due to pre-existing medical conditions. (See later section for more details)

Oregon's health care reform was in many ways extraordinarily successful; in the fifteen years since it was launched, the OHP has provided access to quality health care services for more than one million uninsured people and helped to decrease uninsurance in the state to as low as 10 percent in 1998, although it has since increased to 17% in 2004.

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[27] *For 2004 Federal Poverty Guidelines, see Appendix B.*

[28] *IPGB designed a basic, no-frills benefit package that was offered by small group insurance companies at a set price for both small employers and self-employed, exempt from some insurance mandates, and if the employer had not offered group health insurance benefits for two years. At its peak, over 20,000 employers purchased these IPGB-certified plans, enrolling more than 60,000 employees and their dependents. Later insurance reforms enacted by the Oregon Legislature during the 1990's decreased the need for these specialized plans, and there was a migration to plans in the regular market.*

Changes to OHP in 2003. Facing the same kind of challenges it had in 1987, the highest unemployment rate in the nation and an unprecedented budget deficit, Oregon turned to cost sharing and benefit reduction in the Oregon Health Plan in 2003. Building on its 1115 waiver and using the flexibility provided by the Health Insurance Flexibility Act (HIFA) initiative, Oregon developed changes to the program in a waiver referred to as OHP2. These efforts separated the Medicaid program into two benefit packages—OHP Plus and OHP Standard. OHP2 waiver changes also resulted in including the State's premium subsidy program, the Family Health Insurance Assistance Program (FHIAP) under Medicaid so it could receive federal match for what had been previously funded with only state dollars.

The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves low-income seniors, people with disabilities, families meeting the eligibility criteria for Temporary Aid to Needy Families (TANF) and children and pregnant women. The OHP Standard benefit package, designed for Oregon's expansion population (who are adults, 19 to 64 years of age up to 100 percent of the FPL), implemented in February 2003 is leaner in benefits and implements significant co-pays. Premiums were increased for those enrolled in OHP Standard and administrative rules were tightened, including a six-month lockout for nonpayment of premiums. *[See Timeline of OHP2 Changes, Appendix A].* These changes were derived from objectives developed through extensive community input and advisory groups. The objectives were to:

- Generate revenue to provide flexibility in designing the OHP Standard benefit package that would otherwise have a very limited coverage level.
- Instill in clients the value of health care and ongoing coverage by structuring the program to include costs for accessing certain services (co-payments) and for maintaining eligibility (premiums).
- Make OHP Standard similar to commercial plans as a transitional step to private health insurance.

The original policy goal of OHP2 was to expand coverage to 185% FPL for children, pregnant women and adults through savings accrued by implementing the leaner OHP Standard benefit package, cost sharing and premiums. However, as the severity of Oregon's budget shortfall intensified, the reductions in coverage were implemented, but much of the expansion was not realized.

OHP 2 Waiver Changes, February 2003

	Waiver Provisions	Number Affected
Reductions Implemented	OHP Standard benefit package for Oregon's expansion population (adults, 19 to 64 up to 100% FPL). Changes: • Increased cost sharing and premiums • Reduced benefit package • Ability to cap enrollment • No waivers of premiums for zero income • Six-month lock out for non-payment of premiums	99,894 in OHP Standard as of end of month February 2003 As of September 2004, OHP Standard enrollment was 52,008
Expansions Implemented	Children (up to 19) and pregnant women increased from 170% FPL to 185% FPL Family Health Insurance Assistance Program (FHIAP) eligibility increased from 170% to 185%	An additional 2,557 children and 438 pregnant women as of September 2004 An additional 454 enrollees between 170% and 185% as of January 2005
Expansions Not Implemented	Parents, from 100% to 185% FPL Childless adults (19 to 64) from 100% to 185% FPL FHIAP to 200% FPL Children to 200% FPL	NA

In addition, the Oregon Legislature in March 2003 eliminated the optional Medicaid benefits of outpatient mental health and chemical dependency for the OHP Standard population. These benefits were reinstated in August 2004. Prescription drug coverage for OHP Standard was also eliminated but reinstated after two weeks following intense public pressure.

Changes to OHP in 2004

Elimination of Co-payments For OHP Standard. In early 2003, the Oregon Law Center legally challenged the OHP Standard premium and co-payment policies authorized by the Centers for Medicare and Medicaid Services (CMS). The litigation (Spry v. Thompson) found that OHP Standard co-payments violated federal law and, therefore, were eliminated effective June 19, 2004, according to the court order. While the court decision did not affect OHP premium policies, OHP Standard co-payments are no longer a consideration as a cost sharing mechanism for future OHP Standard program changes.

OHP Standard Status as of Summer, 2004. The OHP Standard program:

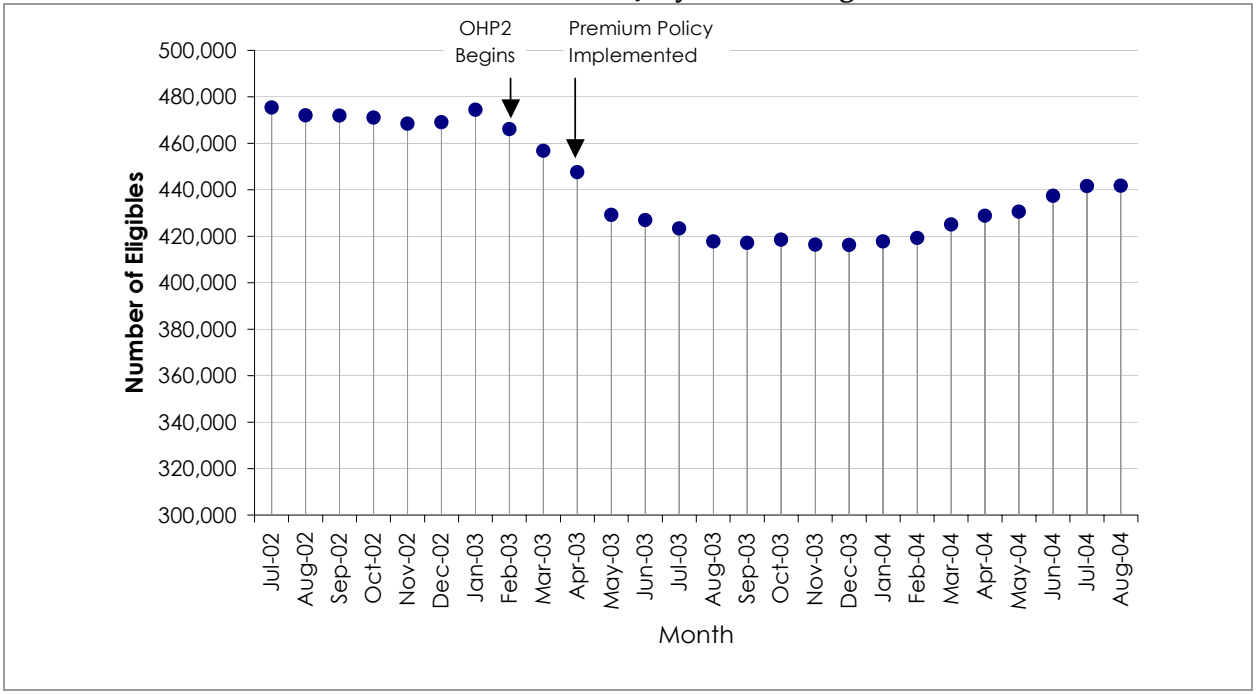
- Operates entirely without General Fund resources, using provider taxes from the hospitals and managed care organizations.
- Serves a reduced number of clients based on provider tax revenue, premium revenue and federal matching funds.

- The program is currently closed to new enrollment.
- Has a redefined benefit package effective August 2004 (as provided in HB 2511 from the 2003 legislative session). *For summary of OHP Standard benefit package, see below.*

Service	OHP Standard Benefits (As of August 2004)
Premiums	• $6-$20 according to income level
Hospital Benefit (Inpatient and Outpatient)	"Limited" benefit at approx. 85% of full hospital benefit • Includes: evaluation, lab, x-ray and other diagnostic tests to determine diagnosis (line zero on the prioritized list) • Hospital treatment for all emergency services • Urgent conditions for which prompt treatment will prevent life threatening health deterioration (a selected set will require prior authorization • No copays
Emergency Room	No copay
Physician Services	No office visit copay
Lab Services	No copay
Imaging Studies (X-ray)	No copay
Ambulance	No copay
Preventive Care	No copay
Prescription Drugs	No copay
Mental Health & Chemical Dependency	Outpatient services coverage resumes
Durable Medical Equipment and Supplies	Some medical equipment and supplies, limited to: • Diabetic supplies (including blood glucose monitors) • Respiratory & oxygen equipment, ventilators • Suction pumps • Tracheostomy, urology and ostomy supplies
Dental Services	Emergency dental services only
Hospice	Covered

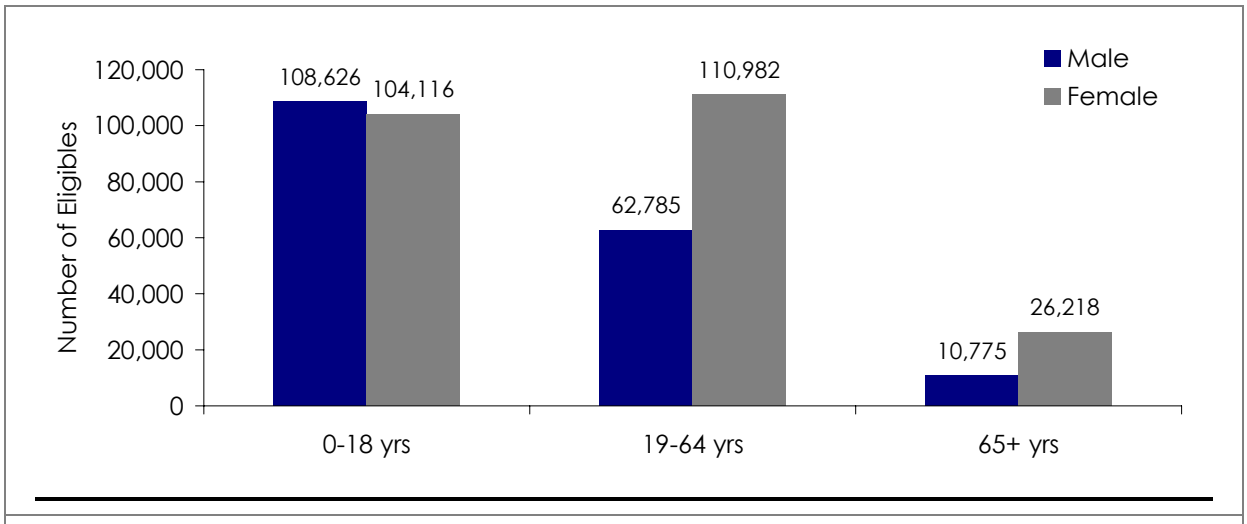
The following chart shows OHP enrollment trends during the period of OHP2 implementation:

OHP Enrollment Trends, July 2002 to August 2004



The following chart shows the distribution of OHP enrollees as of September 2004. For specific eligibility categories see the following pages.

OHP Medicaid and CHIP Enrollees, September 2004



- There were a total of 423,502 total OHP Medicaid and CHIP enrollees in September 2004.
- Of total eligibles, 50% were children 18 years and under, 41% were adults 19-64 years of age, and 9% were adults 65 years and older.

Data Source: Oregon Medical Assistance Program (OMAP)

Who is eligible for OHP coverage?

The following tables outline the specific eligibility categories for both OHP Plus and OHP Standard:

OHP Plus Eligibility Categories

Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid Mandated or Optional?
Aid to the Blind/Aid to the Disabled (AB/AD)	Recipients of AB/AD, some also have concurrent Medicare eligibility	<78% FPL[f]	59,153	Mandatory
Old Age Assistance	Adults over 65 years of age, receiving old age assistance; majority have concurrent Medicare eligibility	<75% FPL	30,758	Mandatory
PLM-CH[c] 0-5	Children 0-5 years of age with family incomes under 133% FPL	<133% FPL	44,846	Mandatory
PLM-CH 6-18	Children 6-18 years of age with family incomes under 100% FPL	<100% FPL	41,268	Mandatory
SCHIP[d]	Children 0-18 years of age with family incomes under 185% FPL who do not meet one of the other eligibility classifications	133-185% FPL (age 0-5); 100-185% FPL (age 6-18)	23,167	Optional
Foster Children	Children covered by the State Office for Services to Children and Families	<52% FPL	16,380	Mandatory
PLM-A Pregnant Women	Pregnant women with family incomes under 133% FPL	<133% FPL	6,471	Mandatory
PLM-A Pregnant Women & their newborns	Pregnant women with family incomes greater than 133% FPL but under 185% FPL	133-185% FPL	3,197	Optional
TANF[e]	Recipients of TANF under current eligibility rules (including former recipients with extended Medicaid eligibility)	<52% FPL	129,966	Mandatory

(a) FPL = Federal Poverty Level
(b) As of September 2004
(c) PLM-CH=Poverty Level Medical Children
(d) SCHIP=State Children's Health Insurance Program
(e) TANF=Temporary Assistance to Needy Families
(f) Some eligibles with disabilities who receive services under Home and Community-Based Waivers may have incomes up to 300% of the SSI standard, or approximately 224% FPL.

OHP Standard Eligibility Categories

Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid mandated or Optional?
Adults/Couples	Single adults and couples age 19 or over, not Medicare eligible with income below 100% FPL who do not meet other eligibility classifications, and do not have an unborn child or a child under age 19 in the household	<100% FPL	37,697	Expansion/ Optional
Families	Adults ages 19 or over, not Medicare eligible with incomes below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household	<100% FPL	14,992	Expansion/ Optional

(a) FPL = Federal Poverty Level
(b) As of September 2004

Other OHP Eligibility Categories

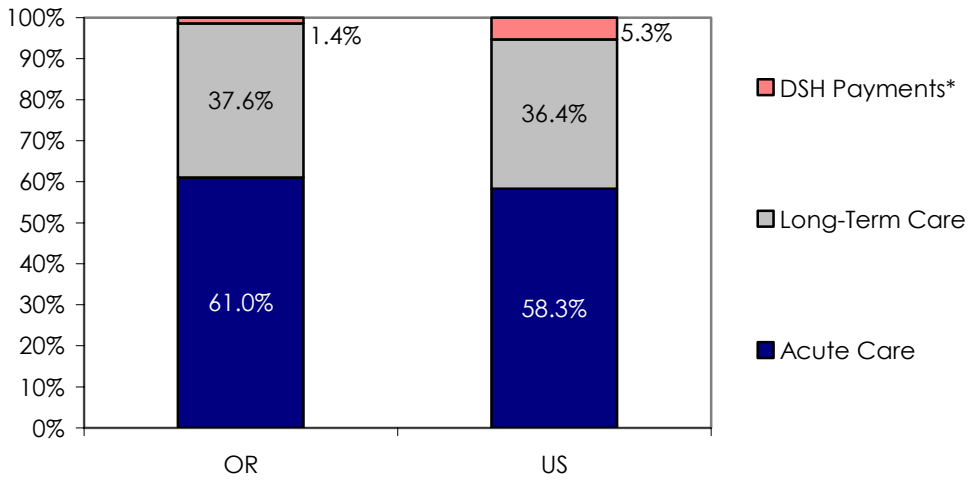
Eligibility Category	Description of Group	Income Level by Criteria by FPL[a]	# of enrollees[b]	Medicaid mandated or Optional?
CAWEM[c]	Coverage for emergency services only for individuals who meet criteria for one of the above eligibility categories except for U.S. citizenship or non-citizen status requirements	Varies	24,191	Mandated
Breast & Cervical Cancer	Coverage of treatment of breast and cervical cancers diagnosed through the federal Breast and Cervical Cancer Screening Program, who otherwise wouldn't quality for full medical assistance	Varies	174	Optional
Qualified/Specified Low-Income Medicare	For those qualified for Medicare, who have limited incomes but do not meet the income or resource standard for full medical assistance coverage. Some receive only assistance in paying premiums and deductibles for their Medicare A and B; some also receive OHP Plus benefits.	<100% FPL for most; subset get only premiums covered (100-135% FPL)	10,166	Mandated

(a) FPL = Federal Poverty Level
(b) As of September 2004
(c) CAWEM=Citizen-Alien Waived Emergency Medical

Medicaid Expenditures

Oregon spends slightly less as a proportion of overall expenditures on long-term care when compared to the U.S. Acute care services account for 61% of the Medicaid budget providing services to over 400,000 people, while long-term care accounts for approximately 38% of the budget and provides services to approximately 39,000 people.[29]

Distribution of Medicaid Expenditures in Oregon and U.S., 2003



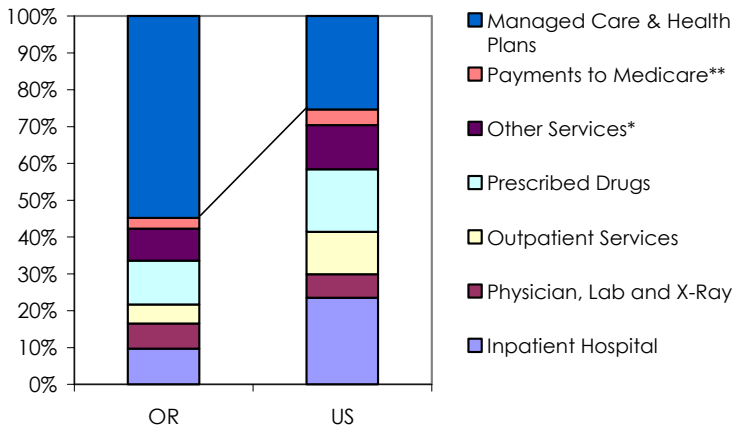
*A Disproportionate Share Hospital (DSH) provides care to a high number of patients who cannot afford to pay and/or do not have insurance. DSH hospitals receive a percentage add-on to their operating payment rates. Oregon has four DSH hospitals. Eligibility for DSH payments is determined based on the ratio of patient days for low-income consumers (Medicaid and uninsured) to total days for all patients.

Source: Kaiser Commission on Medicaid and the Uninsured, "2003 State and National Medicaid Spending Data (CMS 64)" Table 1a, Percent Distribution of Medicaid Expenditures by Type of Service, FFY 2003.

The chart on the following page shows the distribution of acute care expenditures for Oregon's Medicaid program compared to the U.S. As the chart on the following page shows, a much larger proportion of Oregon's acute care services are delivered through managed care systems. This complicates our ability to directly compare the costs for prescription drugs, inpatient services, and other components of Medicaid spending with national expenditures, because many of the component services are delivered by managed care organizations and are therefore wrapped into the managed care expenditure category.

[29] *Oregon Department of Human Services, Seniors and People with Disabilities.*

Distribution of Medicaid Expenditures on Acute Care Services, Oregon & U.S., 2003



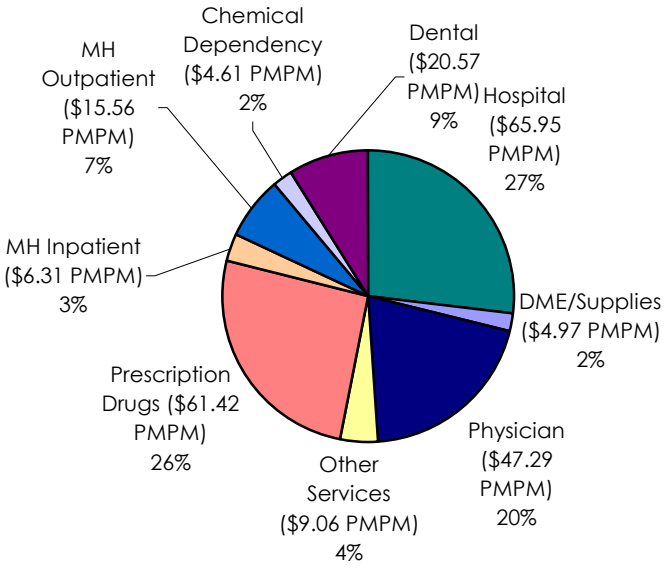
Source: Kaiser Commission on Medicaid and the Uninsured, "2003 State and National Medicaid Spending Data (CMS 64)" Table 2a: Percent Distribution of Expenditures on Acute Care Services, FFY 2003.

*"Other Services" includes dental, other practitioners, dentures, eyeglasses, etc.

**Payments to Medicare are primarily premiums paid by Medicaid for Medicare enrollees.

Because of the high penetration of Medicaid managed care, Oregon-specific data is not directly comparable to other states; the following chart shows components of all spending (FFS and Managed Care) for the Oregon Health Plan in 2002/2003).

Distribution of OHP Expenditures (FFS and Managed Care), 2002/2003



Source: Office for Oregon Health Policy and Research, Health Services Commission, "SFY 2006/2007 Benchmark Rate Study: Oregon Health Plan", November 2004.

Medicaid Reimbursement[30]

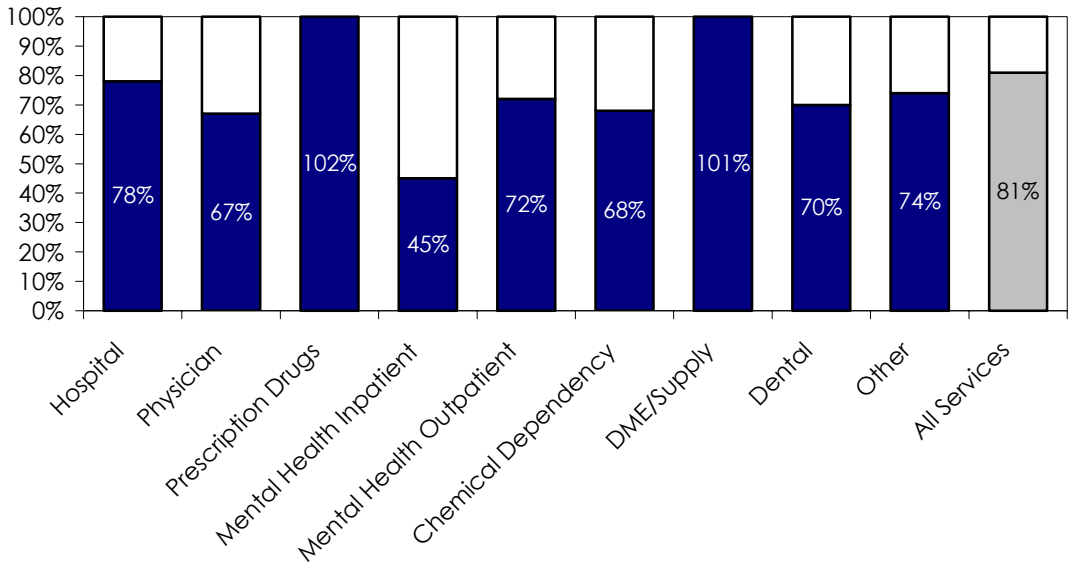
When the Oregon Health Plan (OHP) was initially implemented, one of the cornerstones of the plan was to increase access to benefits by bringing payments to providers more in line with their costs of providing care. Satisfaction with the OHP ran high with providers and plans during its early years, but declining state revenues have lead to a consensus among those providing OHP benefits that payments have not kept up with increasing health care costs. House Bill (HB) 3624, passed during the 2003 legislative session, was seen as an attempt to explicitly quantify how much payments are differing from costs, by setting benchmark rates for the major categories of health care services to which reimbursements can be compared. In addition, these benchmark rates can be used to measure the relative equity of payments among the providers of these services.

HB 3624 directed the Health Services Commission (HSC) to work with an actuary to establish these benchmark rates. The initial goal of the Commission was to use a common measuring tool across all categories of service, such as a percentage of Medicare reimbursement. This was not possible, however, since not all categories had a common payer and actual cost data was not available for many. Therefore, one of five different methodologies was used to develop a unit cost benchmark, depending on the best information on cost available for each service category.

The following chart provides a comparison of fee-for-service (FFS) reimbursements during the historical data period to the FFS unit cost benchmarks established during this process. The figure can be used to determine how best to achieve equity among providers when future funding decisions affecting the Oregon Health Plan are made. The last column of the chart indicates that all service categories could be reimbursed equally at 81% of cost if current resources were redistributed.

[30] *This section of the 2005 Legislative Report is taken verbatim from the Oregon Health Services Commission and the Office for Oregon Health Policy and Research's "SFY 2006-2007 Benchmark Rate Study: Oregon Health Plan, November 2004. Readers interested in more detail can see the full report at http://www.oregon.gov/DAS/OHPPR/HSC/docs/11-04Summary.pdf.*

Comparison of 2002 Medicaid FFS Reimbursements to 2002 FFS Unit Cost Benchmarks



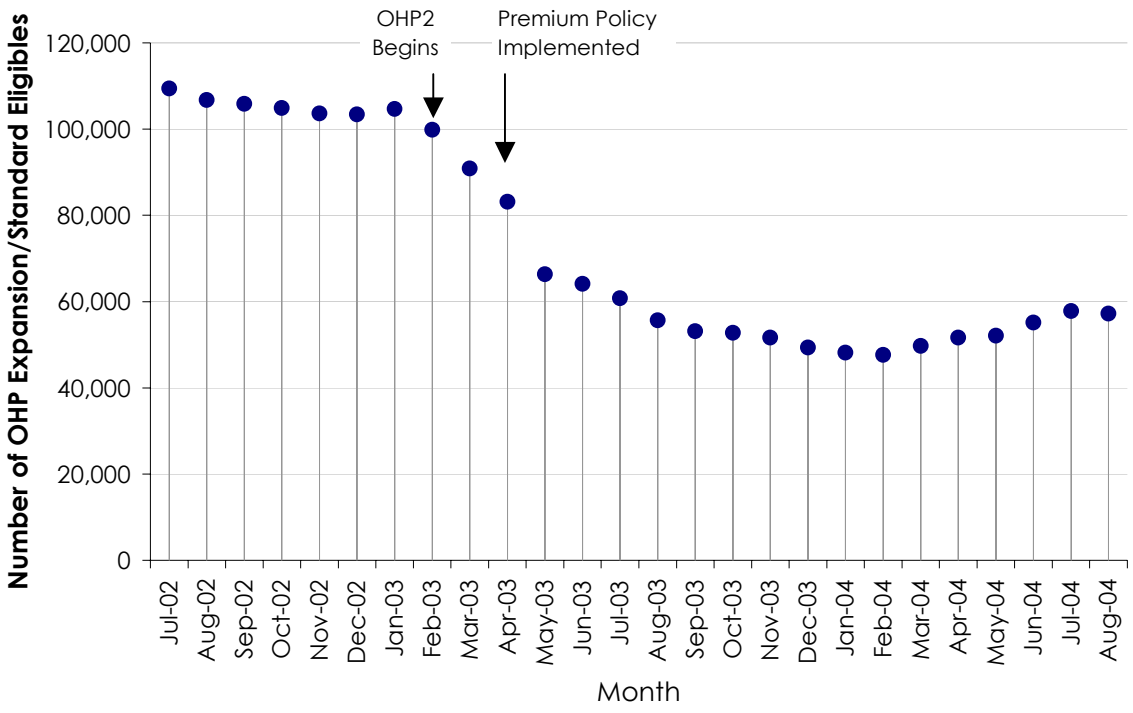
Source: Office for Oregon Health Policy and Research, Health Services Commission, "SFY 2006/2007 Benchmark Rate Study: Oregon Health Plan, November 2004.

It should be noted that a true unit cost benchmark could not be calculated for prescription drugs due to the proprietary nature of the necessary data. It is assumed that the state is already paying at or above cost for prescription drugs based upon a review of profit margins and with no information to the contrary.

Impact of OHP2 Policy Changes

As presented earlier in this chapter, OHP enrollment declined by about 12% from the month preceding the implementation of OHP2 in February 2003 to December 2003. This decline was especially pronounced for the OHP expansion population, later called the OHP Standard population, for which enrollment fell 53% in the same time period.

OHP Expansion/Standard* Enrollment, July 2002-August 2004



*OHP Expansion prior to February 2003; OHP Standard from February 2004 forward

The Oregon Health Research and Evaluation Collaborative (OHREC), a unique and innovative partnership of the policy and academic health services research communities in the state, has focused its efforts toward understanding the impact of the OHP2 Waiver changes in early 2003 to the Oregon Health Plan (OHP). The Office for Oregon Health Policy and Research (OHPR), working with the Office of Medical Assistance Programs (OMAP) brought together a team of health services researchers to study these changes through several initial studies, using funding from Oregon's Robert Wood Johnson Foundation State Coverage Initiatives grant. Through these studies, the following impacts have been identified:

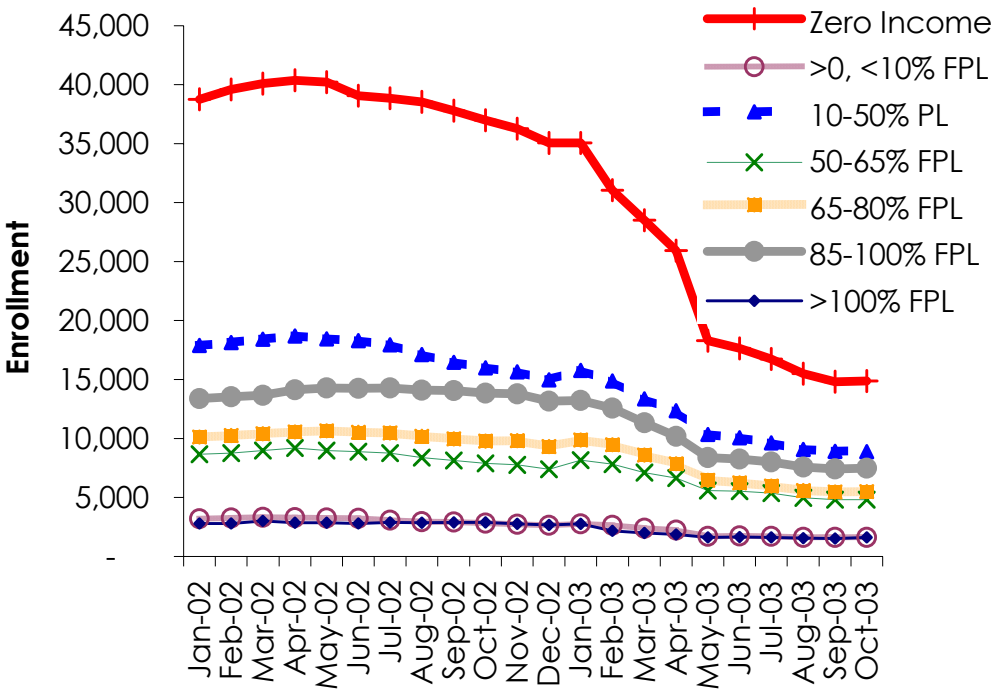
Enrollment Impacts

- OHP Standard enrollment fell 50% from approximately 102,000 clients in 2002 to approximately 51,000 in late 2003

- Low-income single adults have been most susceptible to the premium policy changes in OHP Standard, with the zero income group most affected (58% decline in enrollment)
- New enrollments among the zero income group dropped sharply and have not returned to pre-implementation levels
- Premium cost was the most common reported reason for loss of OHP Standard coverage
- Most (72%) clients who lost coverage remained uninsured at the time the study was undertaken
- 48% reported they would reapply if premiums were decreased by $3 a month

While the OHP Standard caseload declined for all income groups, the implementation of the co-payment and premium policy changes did not exclusively influence enrollment trends. Significant OHP Standard benefit package reductions (elimination of outpatient behavioral health and chemical dependency coverage and temporary loss of prescription drug coverage) also influenced client enrollment. The chart on the following page shows changes to enrollment for OHP Standard clients at various income levels.

Impact of Premiums and Administrative Lockout on OHP Enrollment



Source: McConnell KJ, Wallace N, "The Effect of Premiums and Administrative Lockout on OHP Enrollment", Presentation to Oregon Health Research and Evaluation Collaborative (OHREC), January 22, 2004. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/ohrec.shtml

Unmet Need

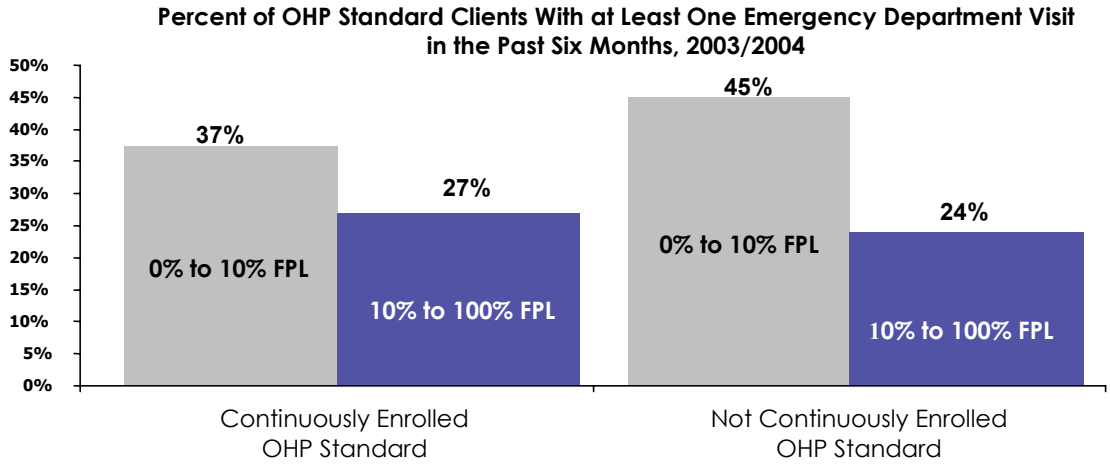
Research found that clients who lost OHP Standard coverage:

- Had higher unmet needs for health care
  - 60% reported unmet need for medical care
  - 80% reported unmet mental health care need
- Clients with chronic illnesses were more likely to report unmet needs
- Clients indicated the primary reason for unmet health care needs was concern about cost.

Utilization Impacts

Research found that clients who lost OHP Standard coverage were:

- Nearly 3 times more likely to have no usual source of care
- More likely to skip filling a prescription due to cost than those remaining on OHP (57% vs. 48%)[31]
- 4 to 5 times more likely to go to the emergency department for care
  - Emergency department visits were even higher for the lowest income groups (especially those with chronic conditions)



Source: Carlson M., Wright B., "Impact of Program Changes on Health Care for the OHP Standard Population", Presentation to Oregon Health Research and Evaluation Collaborative (OHREC), March 17, 2004. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/ohrec.shtml.

[31] *At the time the survey was undertaken, OHP Standard required co-payments for prescription drugs ranging from $2 to $15 per prescription.*

The research findings suggest that:

- Low-income single individuals (especially the zero income group) have been most affected by the premium amount and administrative changes to OHP Standard.
- The changes (removal of the homeless and zero income waiver criteria and implementation of the six-month disqualification) in premium policy were at least as important as the premium amount changes.
- In spite of losing coverage, most individuals reported that paying premiums was worth the value of having health care coverage.
- The changes had impacts on access to health care for vulnerable populations, with most who lost coverage remaining uninsured and facing higher unmet needs for medical care, urgent care, mental health care and prescription medications. This is especially true for those with chronic illness. This could result in increased costs for these populations due to health complications from not maintaining care for these illnesses.
- Those who lost coverage were nearly 3 times more likely to have no usual source of care and 4-5 times more likely to report the emergency department as their usual source of care. This was primarily noted in the lowest income group, especially those with chronic disease. This has impacts on the state's health care facilities, especially hospital emergency departments.

Premium Sponsorship

As a result of the dramatic decline to the OHP Standard caseload, a significant community response has been the development of premium sponsorship by various organizations around the state. These organizations are providing funds to pay premiums for clients who would otherwise be disqualified from the program. Because the community organizations' funds are not sufficient to pay all premiums, the large sponsoring organizations have recently requested that the lowest income clients be given priority.

In evaluating policy options, the impact of premium sponsorship is difficult to analyze and predict. This activity provides increased OHP Standard revenue and prevents cost-shifts to other parts of the health care system but may undermine some of the other premium objectives. When the new premium policies were implemented in early 2003, premium sponsorships came primarily from three community organizations and one county government. Since the months approaching the closure of OHP Standard to new enrollment on July 1st, 2004, a significant increase has occurred in sponsorship activity that has expanded to ten county-based entities, each focused on sponsoring clients for their part of the state, as well as two entities focused on statewide efforts. In July, sponsoring organizations paid for all past due premiums for clients under 10% of the federal poverty level at risk of being disqualified. At this point in time, the future of premium sponsorship programs is uncertain as federal laws set restrictions on

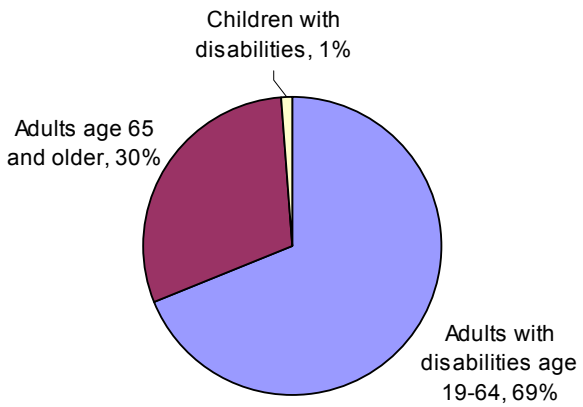
donations and create legal obstacles especially for larger sponsoring organizations. However, a workgroup of advocates and stakeholders has been working closely with OMAP to develop sustainable processes for the premium sponsorship program.

Elimination of the Medically Needy Program

In addition to changes made through the OHP2 waiver process, additional program reductions were made because of the budget shortfall. On January 31, 2003, Oregon's Medically Needy (MN) program, which provided limited benefits to 8,750 people, was eliminated. The Medically Needy program is a federally-matched optional program in which states may chose to provide Medicaid coverage and/or Medicare premium assistance to certain groups that are not otherwise eligible for Medicaid but have significant health care needs. In a Medically Needy program, individuals may qualify for Medicaid even though they are above the Medicaid income limit through a mechanism called "spending-down." Each state has its own predetermined level of spending-down. In Oregon, where eligibility for the Medically Needy program was determined on a monthly basis, an individual subtracted his or her qualifying medical expenses for a given month from countable income for that same month. If the difference was at or below the Medically Needy Income Limit (MNIL) of $413, the individual then qualified for program benefits for that month.

Oregon's Medically Needy coverage was limited to prescription drugs, some medical transportation and limited mental health and chemical dependency coverage. Prescription drug coverage accounted for 88% of program expenditures with mental health accounting for 9%, medical transportation 2% and chemical dependency services 1%.[32]

Medically Needy Program, Enrollment Make-Up, 2003



Source: Zerzan J, Research Brief, "The Medically Needy Program Survey," Oregon Health Research and Evaluation Collaborative, October 2003.

[32] *Zerzan J, Research Brief, "The Medically Needy Program Survey," Oregon Health Research and Evaluation Collaborative, October 2003.*

An OHREC-sponsored telephone survey of 439 former Medically Needy (MN) enrollees conducted in August 2003, six months after the program closed, revealed the following:

- Medically Needy Enrollees had an average of 3-4 chronic conditions, taking on average 5-6 prescriptions daily.
- Two-thirds of people rate their current health as poor or fair and compared to last year, 44% rate their health as worse and 39% about the same.
- Loss of the Medically Needy program has resulted in patients changing their use of medications and a financial impact in their daily lives.
    - 60.6% skipped doses or have taken less of a medication
    - 63.8% have gone without filling a prescription
    - 49.0% reported there are prescriptions they are supposed to be taking and are not
    - 59.9% cut back on their food budget
    - 48.5% skipped paying other bills or paid bills late in order to pay for prescriptions
    - 20.5% have added credit card debt in order to pay for prescriptions
- Drug company assistance programs are not a sustainable way for this population to obtain all of their prescriptions
    - 45% currently use these programs with most getting only some of their medications
    - 68% get assistance in filling out applications for these programs
    - Over half report using these programs is very or somewhat hard to do and are not confident they will be able to continue to use these programs

Public-Private Partnership: Family Health Insurance Assistance Program (FHIAP)

Overview. Another key tenet of the Oregon Health Plan was to build on public – private partnerships. The state's health insurance premium subsidy program is an example of such a partnership. The Family Health Insurance Assistance Program (FHIAP) provides families with subsidies to help them pay for their private health insurance premiums. The program helps families purchase health insurance for over 8,500 Oregonians.

The program was created in 1997 to address the needs of families who do not qualify for Medicaid or Medicare, but can't afford private coverage. As part of the OHP2 waiver, Oregon received permission from CMS to match state dollars with federal dollars to fund FHIAP in fall of 2002, allowing the program to serve more people and expand in the employer-sponsored health insurance market.

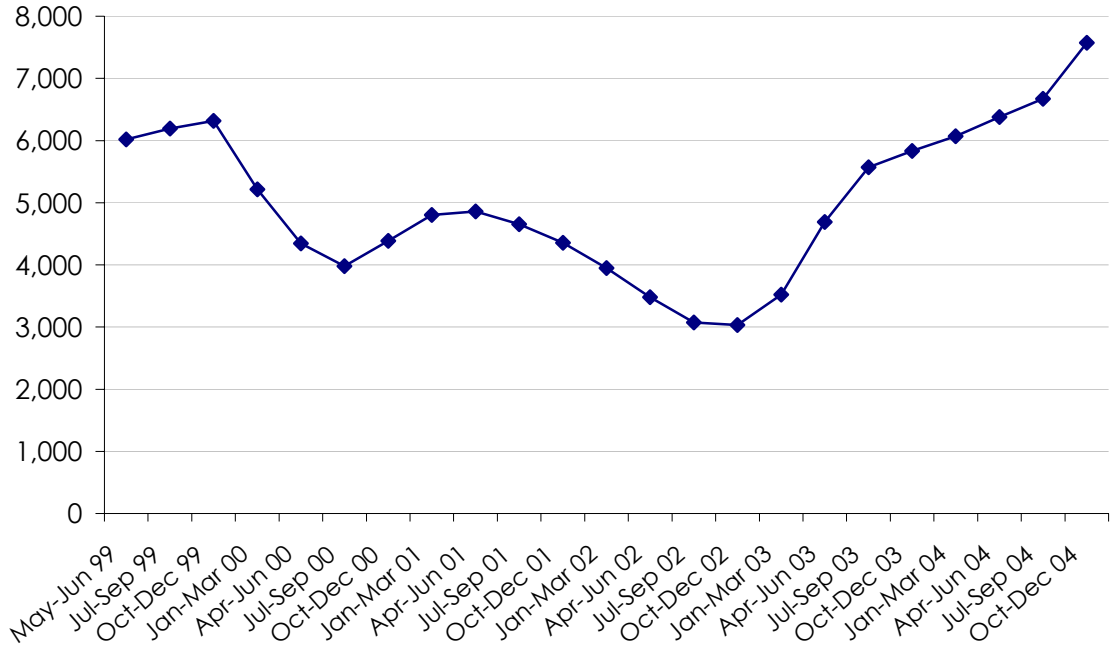
Program eligibility. Eligibility for FHIAP is as follows:

- Oregonians who earn less than 185% of Federal Poverty Level
- Uninsured for at least six months (except for people leaving OHP/Medicaid or SCHIP)
- Other criteria, including citizenship and assets tests ($10,000 liquid asset limit)
- Enrollment is managed using two first-come, first-served reservation lists - one for people with employer-sponsored insurance available, the other for those who can only purchase an individual market plan.

Benefits. Members enroll in their employer's group insurance plan if the employer pays part of the premium; otherwise they enroll in an individual plan. Members are responsible for the co-payments, co-insurance, and deductibles of their private insurance plans.

Enrollment. FHIAP's quarterly enrollment trends from May 1999 to December 2004 are shown below:

FHIAP Quarterly Enrollment, May 1999 – December 2004



FHIAP Enrollment by Subsidy Level, January 2005

Subsidy Level	% FPL	Individual	Group	Total
95%	<=125%	3,036	1,891	4,927
90%	126% - 149%	1,023	1,056	2,079
70%	150% - 169%	408	648	1,056
50%	170% - 185%	136	318	454
Total	Na	4,603	3,913	8,516

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

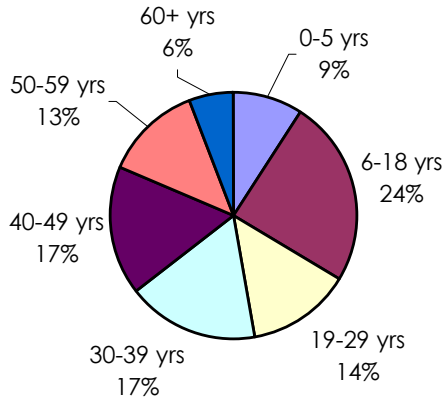
FHIAP Enrollment by Region

Region	Lives	% of FHIAP Enrollment	% of Population	% of Uninsured
Metropolitan Portland	2,715	32%	44%	31%
Willamette Valley	2,366	28%	25%	27%
Southern/South Coast	1,742	20%	13%	18%
Central	460	5%	4%	6%
NW/North Coast	379	4%	4%	5%
Mid-Columbia	349	4%	4%	5%
Southeast	239	3%	3%	4%
Northeast	231	3%	2%	4%
Other	35	0%	0%	0%
Total	**8516**	**100%**	**100%**	**100%**

- FHIAP enrollment is concentrated in the population centers in Oregon – Metropolitan Portland, Willamette Valley, and the Southern and South Coast contribute 80% of FHIAP enrollees, 82% of the state population, and 76% of the state's uninsured.
- While it appears that Metropolitan Portland may be under-represented, and the Southern/South Coast over-represented in FHIAP relative to the population distribution, FHIAP enrollment matches closely with the distribution of uninsured throughout the state.

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

FHIAP Enrollment by Age Group, January 2005

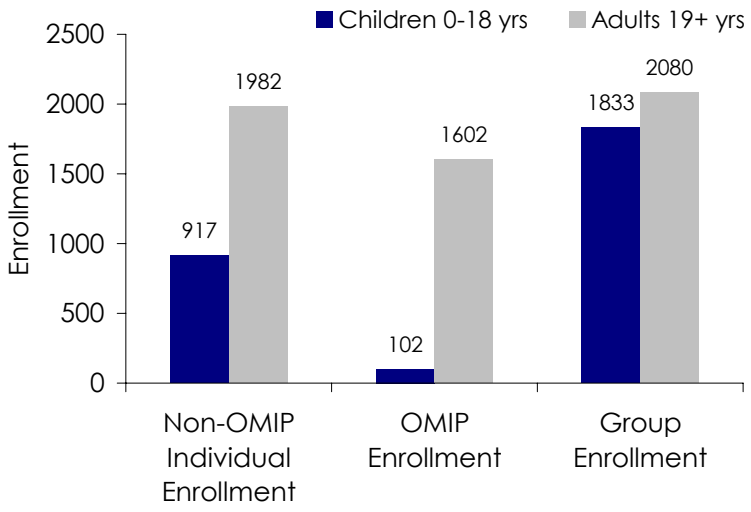


- FHIAP enrollees are composed of 34% children 0-18 years, 61% adults 19-59 years, and 6% older adults 60 years and older
- Compared to the total population in Oregon, older adults are less represented (17% statewide) and children are more represented (27% statewide) in FHIAP.

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

FHIAP Enrollment in Individual and Group Plans, January 2005

	Children 0-18 yrs	Adults 19+ yrs
Non-OMIP Individual Enrollment	917	1982
OMIP Enrollment	102	1602
Total Individual Enrollment	1019	3584
Group Enrollment	1833	2080

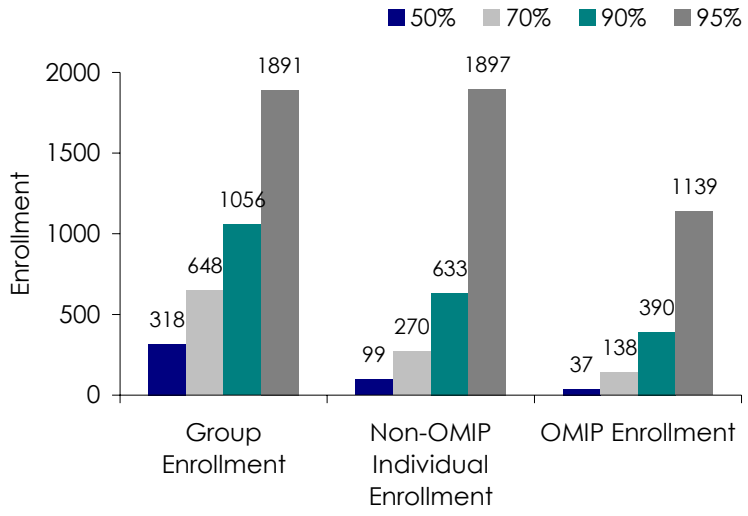


- 54% of FHIAP enrollees are enrolled in individual plans, and 46% are enrolled in group plans.
- The majority of children in FHIAP are enrolled in group plans (64%).
- Over half of adults in FHIAP are enrolled in individual plans (63%).

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

FHIAP Enrollment by Subsidy Level, January 2005

	Subsidy Levels			
	50%	70%	90%	95%
Children 0-18 yrs	206	414	704	1528
Adults 19+ yrs	248	642	1375	3399
Total	454	1056	2079	4927



- For over half of children (54%) and adults (60%) enrolled in FHIAP, 95% of their premium is subsidized by the FHIAP program.
- For one-quarter of children (25%) and almost the same proportion of adults (24%), 90% of their premium is subsidized.
- The remaining 22% of children and 16% of adults in FHIAP are enrolled at the 50% or 70% subsidy levels.

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

Average FHIAP Subsidy, January 2005

Average Subsidy for Group Market

	Subsidy Levels				Weighted
	50%	70%	90%	95%	Average
Member Contribution	$56.90	$39.11	$12.63	$6.07	$17.44
FHIAP Subsidy Per Month	$56.54	$90.96	$113.57	$114.81	$105.79
Total Employee Premium Share	$113.07	$129.95	$126.19	$120.86	$123.17
Employer Contribution	$109.49	$95.86	$97.70	$91.20	$95.21

Average Premium and Subsidy for Individual Market

	Subsidy Levels				Weighted
	50%	70%	90%	95%	Average
FHIAP Subsidy Per Month	$97.28	$167.90	$234.15	$251.95	$235.98
Member Contribution	$97.28	$71.96	$26.02	$13.26	$23.78

- Those on group plans contribute on average $17 to their premiums per month
- Those on individual plans contribute on average $24 to their premiums

Source: FHIAP Snapshot of Program Activity, 01/24/2005; www.ipgb.state.or.us/fhiap/index.html

FHIAP Benchmark Plan

In 2001, House Bill 2519 directed the Insurance Pool Governing Board (IPGB) to establish a basic benchmark benefit plan for a subsidized employer-sponsored coverage that is comparable to coverage commonly found in the small employer or group health insurance market. This benchmark would be used as a tool to determine which health insurance plans offered by employers would be eligible for subsidy with federal matching funds under the auspices of FHIAP. The benchmark was developed out of a survey of Oregon-based insurance companies that determined what benefits were being offered in the HMO and indemnity markets.

The value of benefit plans must meet or exceed the following benchmark:

FHIAP Benchmark for Group Health Insurance

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Pre-existing Condition Waiting Period	6 Month
Medical Cost Sharing	
Annual Deductible	$1,000 individual
Coinsurance Level	30%
Stop Loss Level	$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual
Required Services: Prescription Medication Cost Sharing[1]	
Member Coinsurance Level	$15 or 50% whichever is greater
Out-of-pocket Maximum	No out-of-pocket maximum
Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Department	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

Data Source: www.ipgb.state.or.us/fhiap/pdf/group_benchmark.pdf

FHIAP Carriers, January 2005

Health Net	**ODS Health Plans:**
PPO $500 deductible, 80/50	Individual Option $1,000 deductible
PPO $500 deductible, 80/60	Individual Preferred Option $1,000 deductible/20% option
PPO $1,000 deductible, 80/60	Individual Preferred Option Plus $1,000 deductible/20% option
Well Beginnings $500 deductible	
Well Beginnings $1,000 deductible	
Well Youth $500 deductible	
Well Youth $1,000 deductible	**Oregon Medical Insurance Pool (OMIP)**
Well Adult $1,000 deductible	
Value Plan $1,000 deductible	**PacifiCare**
HMO 25	Individual Plan II+ with prescription coverage
Kaiser Permanente	**PacificSource**
Kaiser Platinum Rx	Elect Plus - $500 deductible
Kaiser Gold Rx, $500 deductible	Elect Plus - $1,000 deductible
	Elect FlexPerks - $1,000 deductible
Life Wise Health Plan of Oregon*	
Plus: $500, $1000 deductible only	**Regence BlueCross BlueShield of Oregon**
Preferred: $500, $1,000 deductible only	Blue Selections Basic, $1,000 deductible
Choice: $500, $1,000 deductible only	Blue Selections Plus, $500 or $1,000 deductible
*Must also purchase buy-up option for prescriptions.	Blue Selections Premier, $500 or $1,000 deductible

Data Source: http://ipgb.state.or.us/jhiap/carrier.html

Long-Term Care

Medicaid is the largest single payer for long-term care services in the U.S., and long-term care expenditures account for approximately 38% of Oregon's Medicaid budget. Every state is required to pay for nursing facility care and home health services for eligible people over 21 years of age who are "nursing home eligible." States also have the option of covering other services such as personal care, intermediate care facilities for individuals with developmental disabilities (ICF/MR), and home and community-based services (HCBS).

Who's Eligible. Medicaid provides long-term care services only to the poor or those who have become poor after paying out-of-pocket for their long-term care costs. To be eligible for nursing home and community-based care services, seniors and people with disabilities must be both financially eligible for Medicaid and have impairments that limit their ability to perform common every day tasks. These tasks are called activities of daily living and include the following categories: mobility, eating, elimination, cognition, bathing/personal hygiene, dressing and grooming. Need for long term care services is determined in Oregon by a comprehensive assessment through the Client Assessment and Planning System (CA/PS) based on the degree to which the person seeking services needs assistance with activities of daily living. Once the assessment is completed, individuals are assigned a priority score on a seventeen-level scale. Eligibility at specific priority levels is determined by the available budget.

Priority levels are as follows:

Level 1 Client needs full assistance in all major activities of daily living. They need another person to provide hands-on care throughout the entire day.

Level 2 Client requires full assistance in mobility, eating and cognition. The major difference with clients in level 1 is these individuals do not need help with elimination.

Level 3 Client needs full assistance in at least one of the following activities of daily living; mobility, cognition or eating.

Level 4 Client needs full assistance in elimination.

Level 5 Client is only slightly less impaired then individuals assessed at the higher levels. At this level the client needs substantial assistance with mobility and eating and requires assistance with elimination.

Level 6 Client requires substantial assistance with mobility and eating.

Level 7 Client needs substantial assistance with mobility and assistance with elimination.

Level 8 Client needs assistance with mobility and eating and elimination.

Level 9 Client needs assistance with eating and elimination.

Level 10 Client needs substantial assistance with mobility.

Level 11 Client needs assistance with elimination and minimal assistance with ambulation.

Level 12 Client needs assistance with eating and minimal assistance with ambulation.

Level 13 Client needs assistance with elimination.

Level 14 The individual needs assistance with eating.

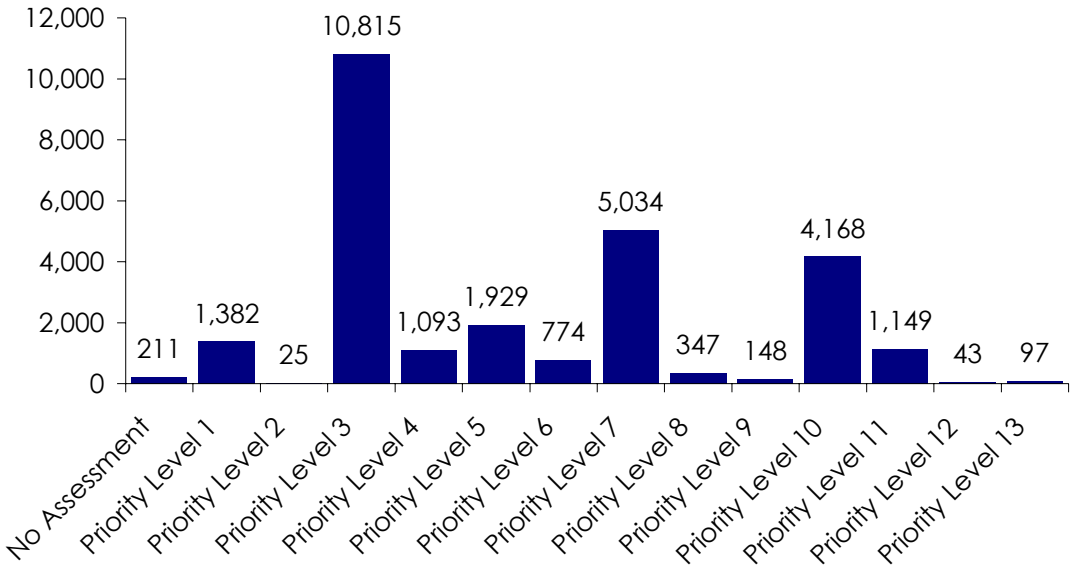
Level 15 The individual needs minimal assistance with ambulation.

Level 16 The individual needs full assistance with bathing or dressing.

Level 17 The individual needs assistance with bathing or dressing.

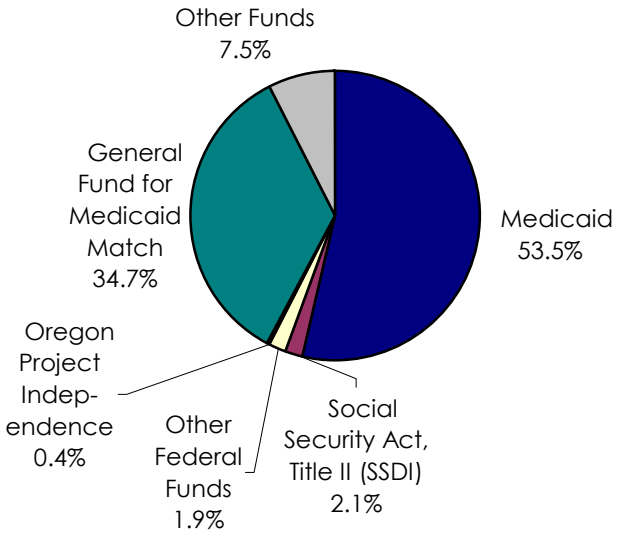
The state currently funds priority levels 1 through 13. The following chart shows the distribution of clients with physical disabilities (27,215) by service level.

Distribution of Seniors and People with Physical Disabilities, July 2003



Source: State of Oregon, Department of Human Services, Seniors and People with Disabilities, County Chartbook, November 2004. *Does not include clients with developmental disabilities.

Sources of Funds. As in the rest of the country, Medicaid is the major funder of long-term care in Oregon. For the 2003-2005 biennium, the specific sources for long-term care services were:

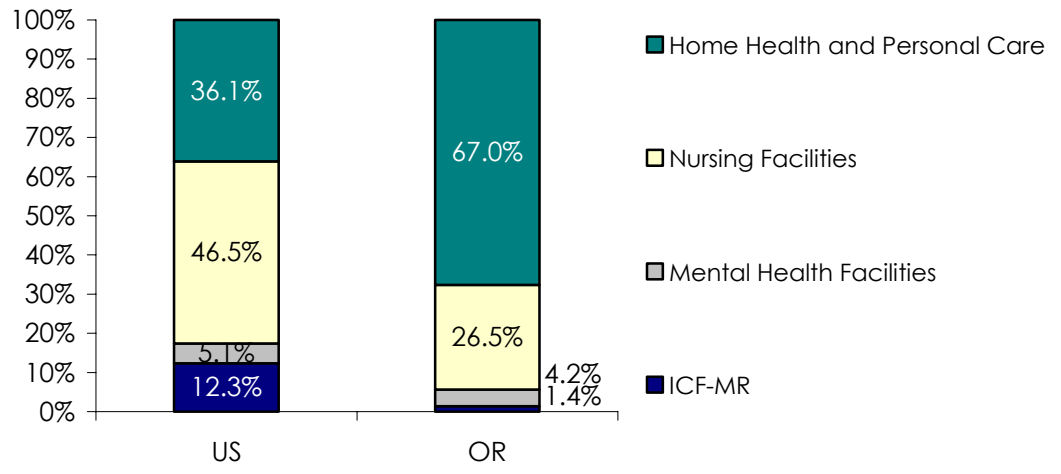


Oregon Background and Trends. Prior to 1981, Medicaid financing for long-term care was limited to home health, personal care services and to institutional settings (hospitals, nursing facilities and some intermediate care facilities). Because of this narrowly focused financing stream, low-income senior or disabled citizen's only option for long-term care was often institutionalization. Two major legislative changes in 1981 allowed Oregon to move away from institutionalization and toward a home and community-based long-term care system. First was Section 1915c of the Social Security Act, the Medicaid Home and Community-Based Services (HCBS) Waiver program. Section 1915c allows certain low-income and disabled persons to live in their own homes and communities. Oregon was the first state in the country to be granted a waiver of some Medicaid rules under the HCBS program. Oregon currently has HCBS waivers for Intermediate Care Facilities/Mental Retardation (ICF/MR), aged and disabled, and disabled. Second, the Oregon legislature also enacted state policy that guides the state to serve seniors and persons with disabilities in the least restrictive way possible (ORS 410.010).

In keeping with this 1981 legislative guidance, the Department of Human Services built a system of long-term care for seniors and people with disabilities based on a philosophy that emphasizes home and community-based services.

The following charts clearly reflect Oregon's emphasis on home and community-based services:

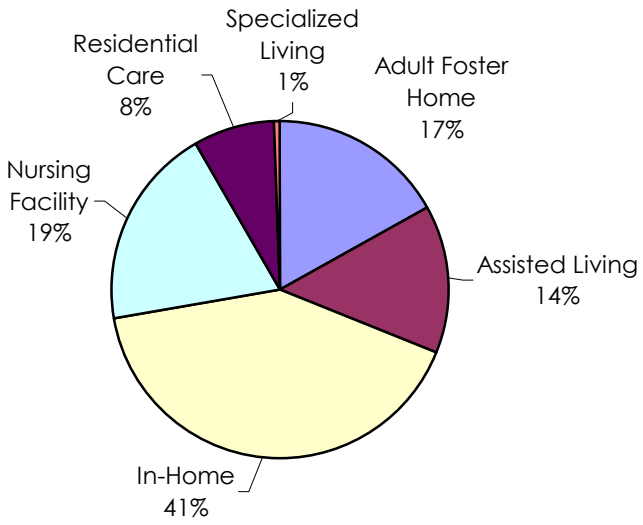
Expenditures on Long-Term Care Services, Oregon and U.S., 2003



*ICF-MR=Intermediate Care Facility – Mental Retardation

Source: O'Brien E, Elias R, "Medicaid and Long-Term Care", Kaiser Commission on Medicaid and the Uninsured, *Table 3: Expenditures on Long-Term Care Services, FFY 2003*, January 2005

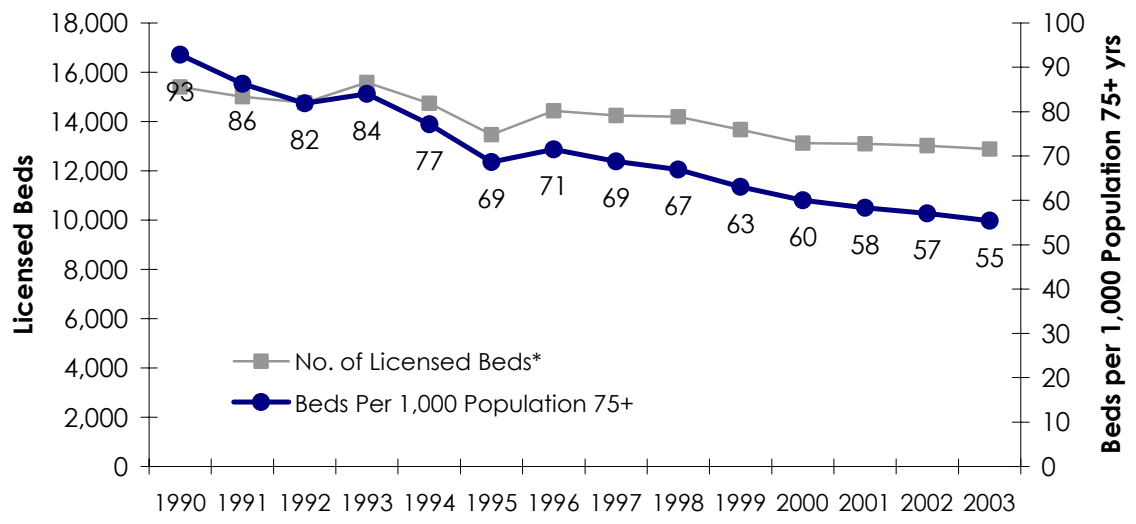
Distribution of Long-Term Care Clients by Site of Service, Oregon, 2004



Source: Source: State of Oregon, Department of Human Services, Seniors and People with Disabilities, County Chartbook, November 2004.

The de-emphasis on nursing facilities is reflected in the steady decline in nursing facility beds in Oregon over the last 20 years.

Oregon Nursing Facility Bed Capacity, 1990 to 2003



- The number of licensed nursing facility beds in Oregon has declined over time, even more so relative to the size of the population over 75 years of age.

Data Source: OHPR Annual Nursing Facility Survey, 1990-2003

Finally, nursing homes have become extensions of hospital units with average lengths of stay in terms of days instead of months or even years.

Lengths of Stay in Oregon Nursing Facilities, 2003

Lengths of Stay	Number	% of total
Less than 1week	4,551	17%
7 to 14 days	6,449	24%
2 weeks to 30 days	7,097	26%
1 to 3 months	4,484	16%
3 to 6 months	1,403	5%
6 to 12 months	1,087	4%
1 to 2 years	854	3%
2 to 4 years	805	3%
4+ years	507	2%
Total	27,237	100%

- Nursing facility lengths of stay are relatively short in Oregon.
- In 2003, 41% of nursing facility admissions lasted less than two weeks.
- 67% stayed less than one month, and 83% stayed less than 3 months.

Data Source: OHPR Annual Nursing Facility Survey, 2003

CHAPTER 3
HEALTH INSURANCE COVERAGE: MEDICARE & PRIVATE COVERAGE

In this chapter:

Medicare

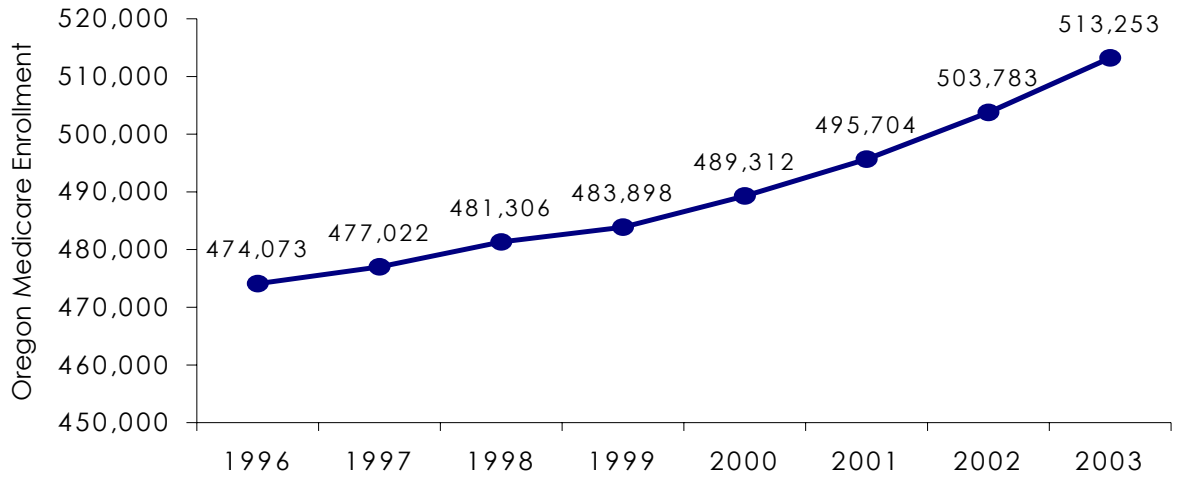
Medicare is a federal health insurance program covering over 513,000 Oregonians[33] who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.

Medicare is currently made up of three component parts, with a fourth to be implemented in January 2006.

- Part A includes hospitalization, limited skilled nursing, limited home health, hospice care, and blood. Part A does not include long-term care, and the individual is responsible for any co-payments or deductibles.
- Part B is medical insurance and includes physician services and outpatient visits, lab and x-ray, ambulance and some preventive care. Part B includes an out-of-pocket coinsurance and a premium for Part B coverage.
- Part C, formerly known as "Medicare + Choice," is now known as "Medicare Advantage". If an individual is entitled to Medicare Part A and enrolled in Part B, he or she is eligible to switch to a Medicare Advantage plan, if a plan is available.
- Part D, the new prescription drug benefit, will be implemented in January 2006.

[33] *http://www.cms.gov*

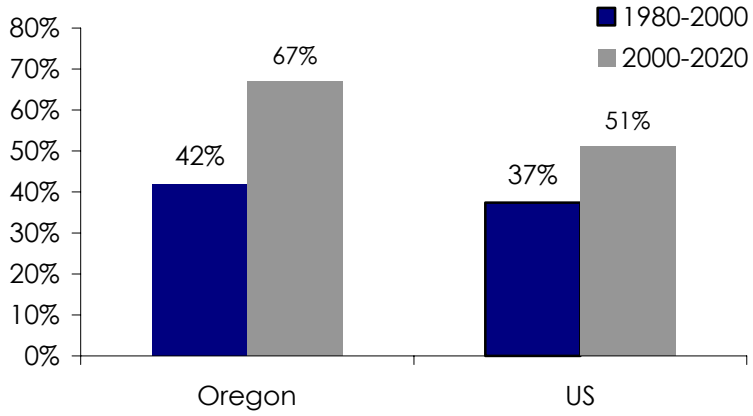
Medicare Enrollment Trends, Oregon, 1996 - 2003



- Total Oregon Medicare enrollment has steadily increased 8% since 1996
- In 2003, 87% of the Oregon Medicare population was 65 years of age or older

Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2003.

Projected Percentage Change in 65+Population in Oregon

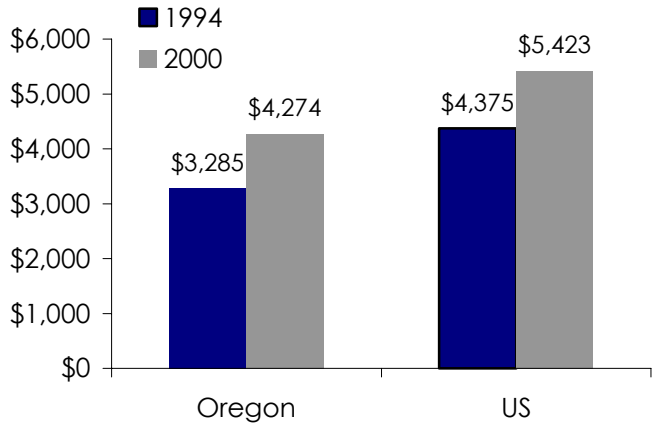


- The population over 65 years of age is projected to increase more rapidly in the next twenty years as it did in the prior twenty years.
- This projected growth is larger in Oregon than in the U.S. – this population is expected to increase 67% by 2020 in Oregon.
- These trends have serious implications for the Medicare program.

Source: United States Department of Commerce, U.S. Census Bureau, Population Division; Census Data for Public Health Research, CDC WONDER On-line Database, March 2003. <02.02.05>

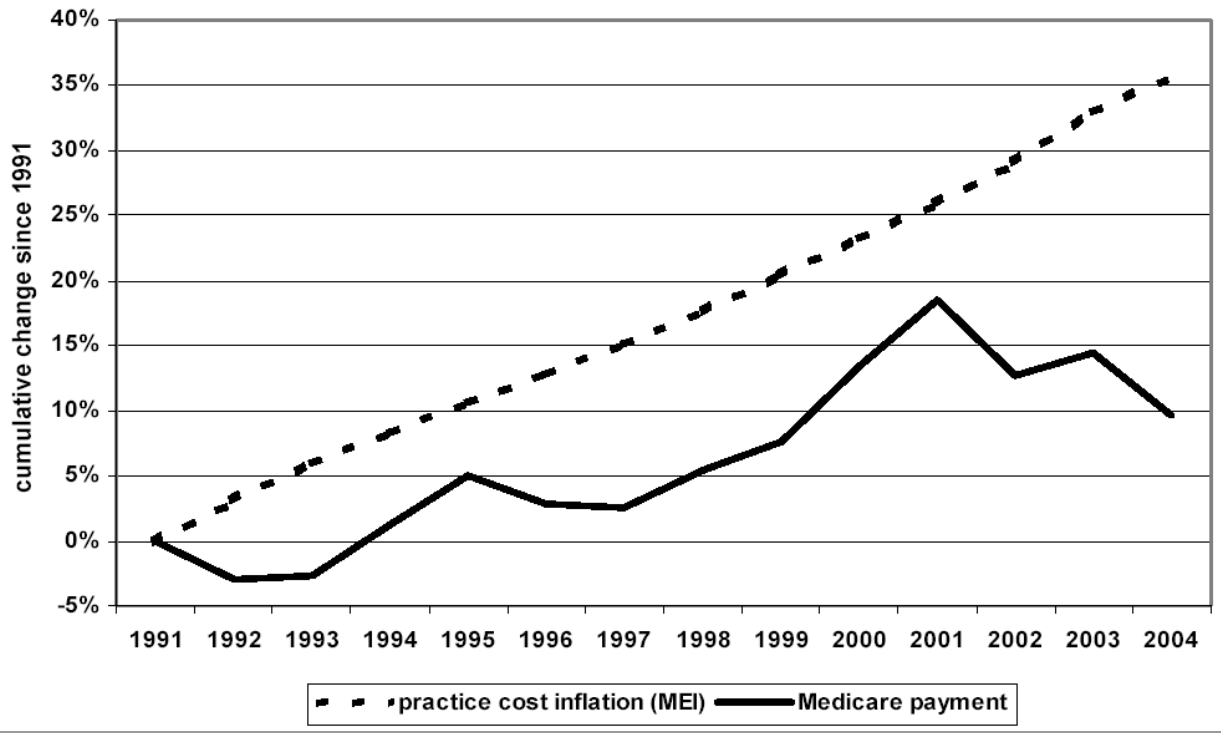
Medicare Payment per Recipient, Oregon and U.S., 1994 and 2000

- Medicare payments are lower in Oregon that they are in the U.S. as a whole. This is a combination of lower rates and lower utilization in Oregon.
- Medicare payment has increased more in Oregon (30%) than it has nationally (24%).



Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2004.

Payment Trends: Medicare Payments vs. Cost Inflation, U.S., 1991-2004



- However, Medicare payment growth has not kept pace with practice cost inflation, making care of Medicare patients less affordable for providers.

Sources: Practice cost inflation all years, Center for Medicare and Medicaid Services (CMS); 1992-1997 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS

Medicare: Emerging Issues

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created a Medicare prescription drug benefit (Medicare Part D) that begins in 2006. Financing for the prescription drug benefit includes payments to the Federal government from state Medicaid programs. States will be required to provide funding for the MMA based on their level of Medicaid prescription drug spending in fiscal year 2003 for the portion of the Medicaid population known as "dual eligibles." As of November 2004, there were 51,166 dual eligibles in Oregon.

Dual eligibles are eligible for both the Medicare and Medicaid programs, either because they have a disability or are aged and have incomes that would qualify them for Medicaid. Medicare does not currently have a prescription drug program, but every state Medicaid program provides prescription drug coverage as an optional benefit. Under current program benefits, low-income aged or disabled individuals eligible for Medicare may find that it's beneficial to join Oregon's Medicaid program to receive prescription drug benefits as well as other Medicaid benefits.

Under the new Medicare prescription drug program, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. This is referred to as the "claw back." Essentially, states are being required to continue paying for a prescription drug benefit for dual eligibles. The impact of this provision is that states like Oregon, which has what is considered a generous drug benefit, will pay more per "dual eligible" than states having a less generous Medicaid drug benefit.

Additional areas of concern for states include:

- Under the MMA, states cannot be reimbursed for the same prescription drugs to dual eligibles that are provided under the Medicare drug program. The private sponsors of the plans will determine specifics of the new Medicare coverage, so it is difficult for state Medicaid programs to plan for or develop costs for coverage of dual eligibles at this time.
- Under current law, Medicaid programs are required to purchase drugs at the "best price" available. If Medicare drug prices, which are set independently, are lower, this may cause a conflict for Medicaid with the requirement for "best prices".
- There may be an unknown "outreach effect". Participation in the dual eligible program has been low in the past, but individuals applying for the new drug program will be automatically enrolled in Medicaid if they qualify. This could increase state Medicaid spending as the new enrollees utilize services.
- The time frame for transitioning dual eligibles from Medicaid to Medicare is ambitious. Information about the private plans participating in the Medicare

benefit is not scheduled to be available until the fall of 2005. This leaves little time to transition these individuals from their Medicaid benefit to the January 2006 start up of the Medicare benefit.

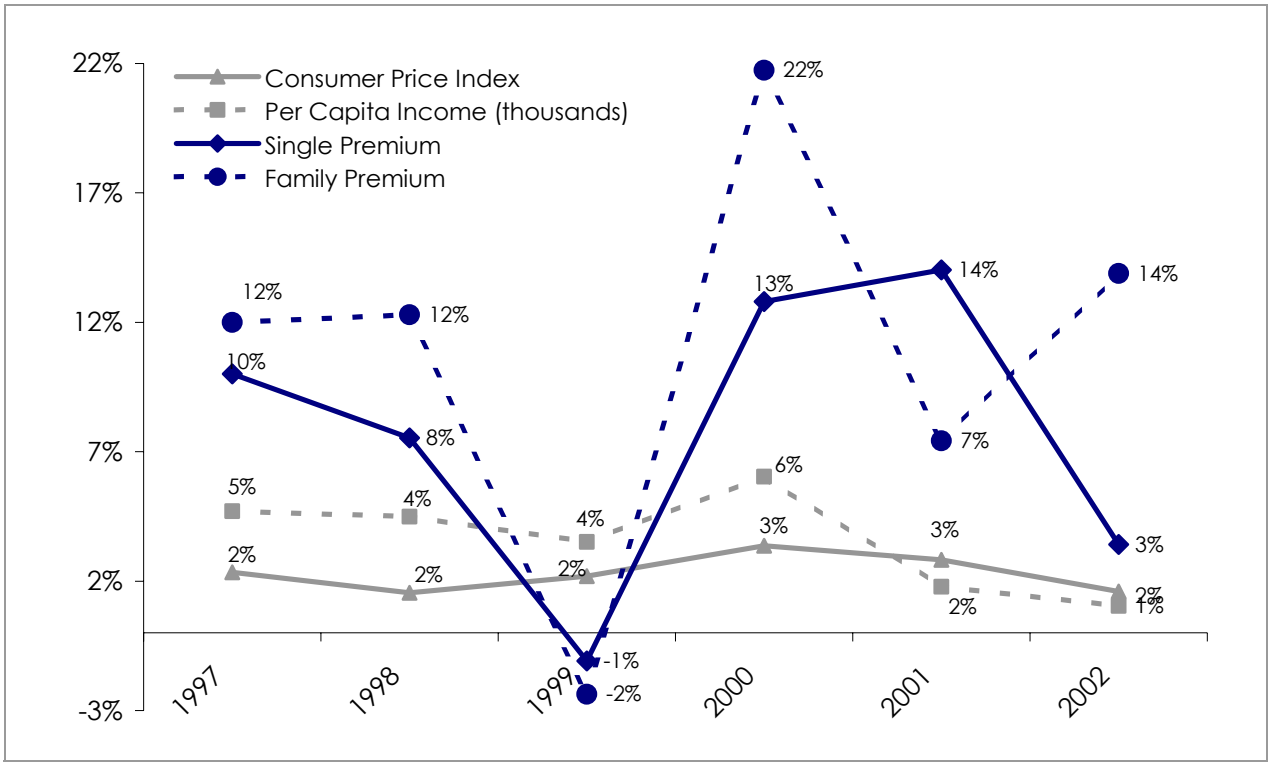
- The prescription drug coverage dual eligibles currently receive under Oregon's Medicaid program is full and comprehensive. These individuals may find it difficult to obtain some of their medications under the Medicare drug plans because of co-pays and because some of their medications may not be covered under Medicare Part D. With detailed information about the Medicare drug plans not due until the fall of 2005, little time is left for states to assess the budget implications of offering any supplemental prescription drug coverage to this group.
- Medicare Part D enrollment is voluntary, but any individual who does not have other drug coverage meeting specific criteria for 63 continuous days or longer and fails to enroll in Part D during open enrollment will pay a penalty. The late-enrollment penalty is intended to promote participation in the Part D program, but it may disproportionately impact certain populations (e.g., individuals with cognitive impairments or those with poor literacy).

Private Health Insurance

Employer-sponsored insurance remains the primary avenue to health insurance for most Oregonians, covering an estimated 66% of the population in 2004.[34] However, with premiums growing at approximately 12% a year, there is evidence nationally that employers, especially smaller employers are dropping health insurance as a covered benefit for their employees. A recent study by the Kaiser Family Foundation of employers nationwide revealed that the number of small employers (3 to 199 employees) offering health insurance had dropped from 68% in 2001 to 63% in 2004.

As is shown in the chart below, the average annual increase in Oregon's health insurance premiums for most years between 1997 and 2002 far outpace the growth in per capita income or inflation.

Increases in Oregon Health Insurance Premiums Compared to Other Indices, 1997 to 2002

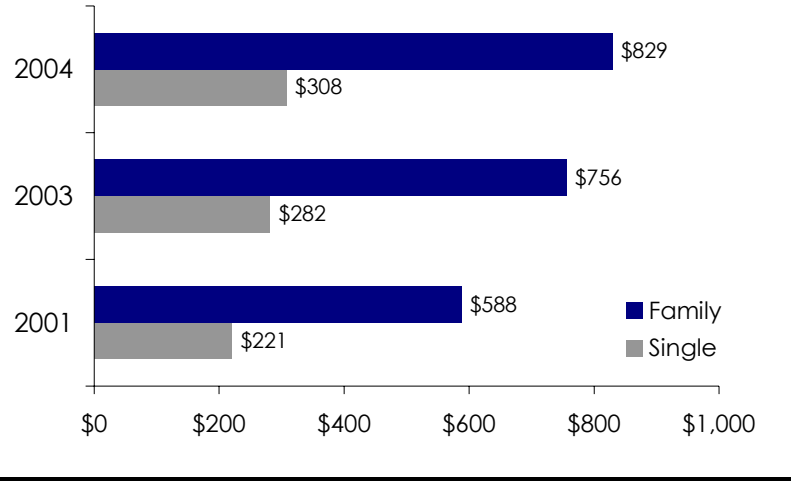


Sources: Medical Expenditure Panel Survey (MEPS), Bureau of Labor Statistics

[34] *Office for Oregon Health Policy and Research, 2004 Oregon Population Survey.*

The average monthly premium for covered workers in the U.S. now exceeds $800 for family coverage and $300 for single coverage:

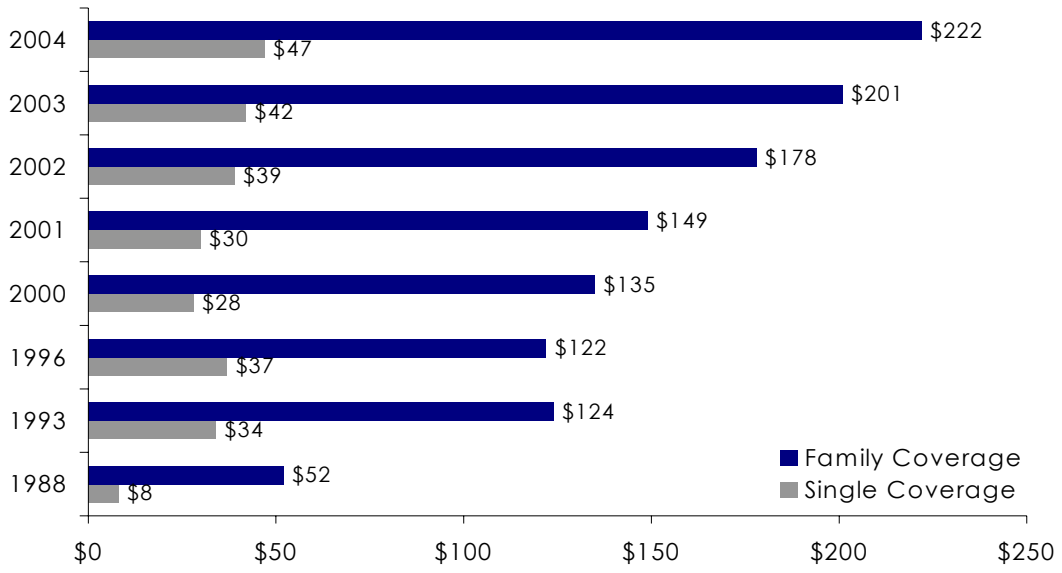
U.S.: Average Monthly Premiums for Covered Workers, All Plans, 2001, 2003, & 2004



- Nationally, premiums continue to increase for both single and family coverage.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2001, 2003, 2004

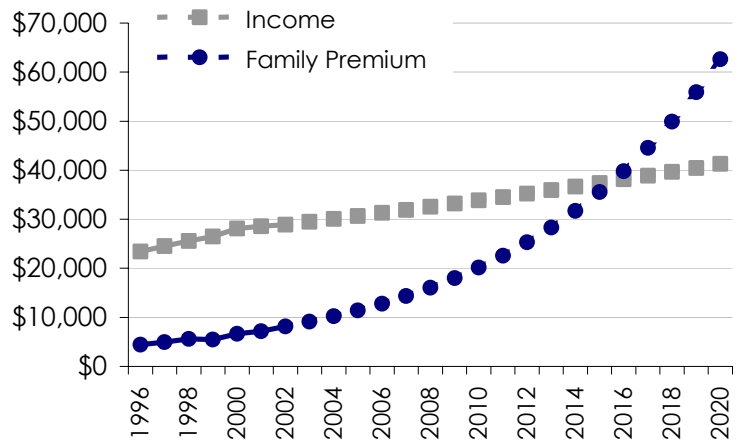
U.S.: Average Monthly Worker Contribution for Single & Family Premiums, 1988-2004



- Similarly, employee contributions for premiums have also increased, most dramatically for family premiums.

Source: National data from Kaiser/HRET Employer Health Benefits 2004 Chartpack at http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46206. Kaiser/HRET Survey of Employer-Sponsored Health Benefits (2000-2004), KPMG Survey of Employer-Sponsored Health Benefits (1993, 1996), The Health Insurance Association of America (HIAA): 1988.

Average Health Insurance Premiums and per Capita Annual Income, U.S.



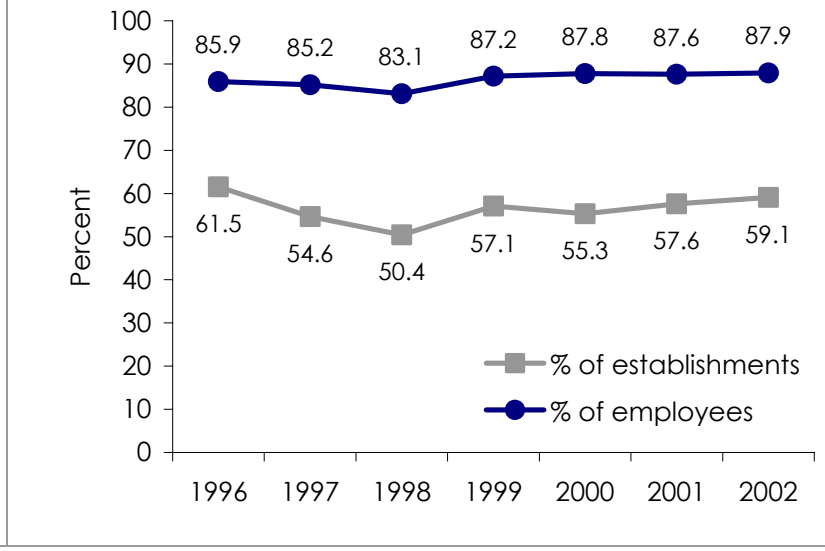
- The current trends in health insurance premium costs are not sustainable; at current rates, premium costs will exceed per capita annual income by 2016.

Note: Values are projected from 2003 forward

Source: 1996-2002 Medical Expenditure Panel Survey (MEPS). 2003-2020 projected.

Oregon Establishments Offering Health Insurance, 1996 to 2002

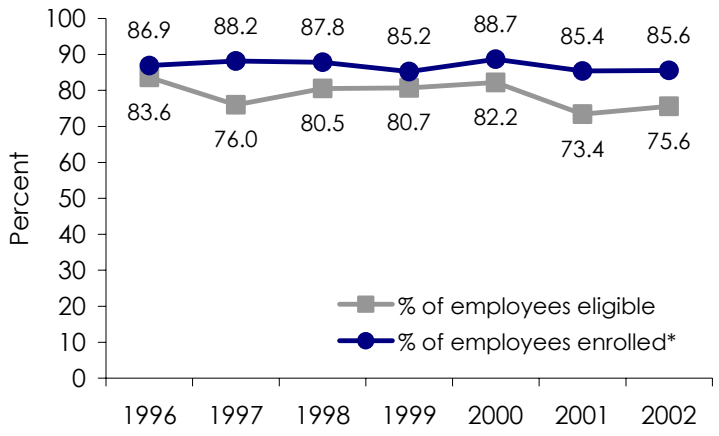
- The percent of establishments that offer health insurance to their employees has not changed from 1996 to 2002.
- Additionally, the percent of employees who work at these establishments has also remained relatively constant.



Source: Medical Expenditure Panel Survey (MEPS)

Oregon Eligibility and Enrollment in Health Insurance, 1996 - 2002

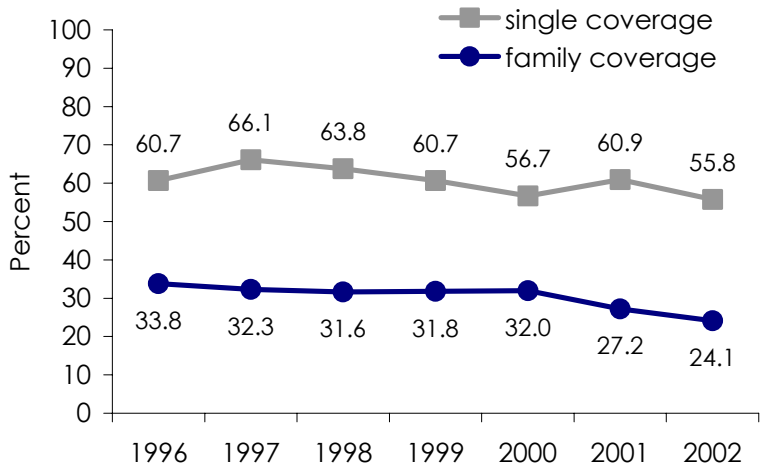
- While employers continue to offer health insurance, there has been a decline in the percent of employees who are eligible for health insurance.
- Among employees who are eligible for health insurance, about 85% enroll. This proportion has remained constant. In general, an employee might decline enrollment if they receive insurance through a family member, or if they cannot afford or choose not to pay cost-sharing obligations.



*Percent enrolled among those eligible

Source: Medical Expenditure Panel Survey (MEPS)

Oregon Establishments Offering Coverage Requiring no Employee Contribution, 1996 - 2002

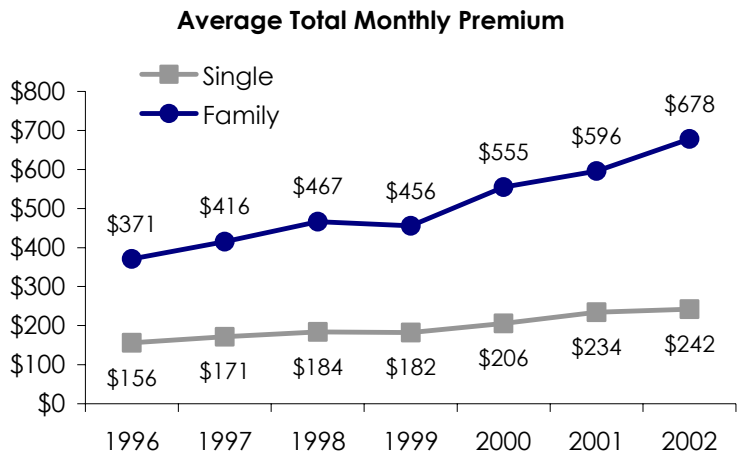


- The percent of establishments that offer health insurance for single coverage at no cost to the employee has remained relatively constant.
- The percent offering health insurance for family coverage at no cost to the employee has declined.

Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2002.

Oregon Premiums, 1996 - 2002

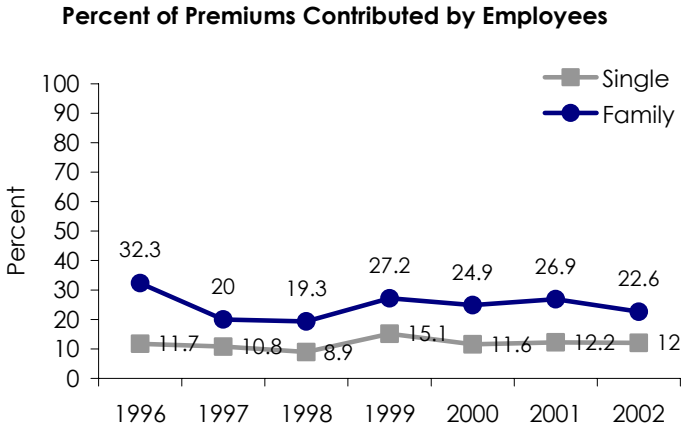
- Monthly premiums have increased for single and family plans, but to a greater extent for family plans.



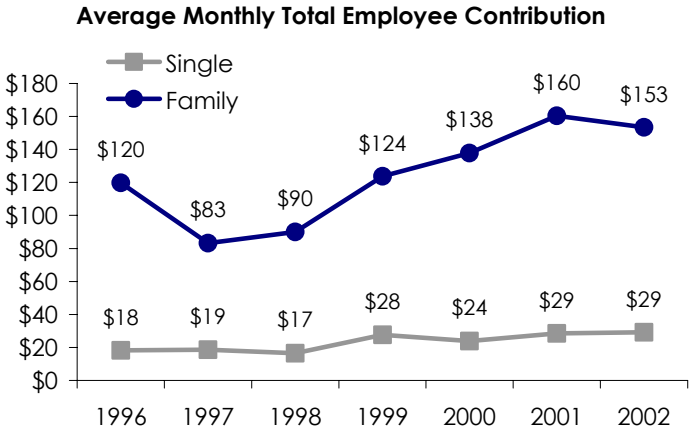
Source: Medical Expenditure Panel Survey (MEPS), 1996 to 2002.

Oregon Employee Contribution, 1996 - 2002

- Despite increasing premiums, employee contribution as a percent of total premiums has remained steady for single coverage and declined for family coverage.



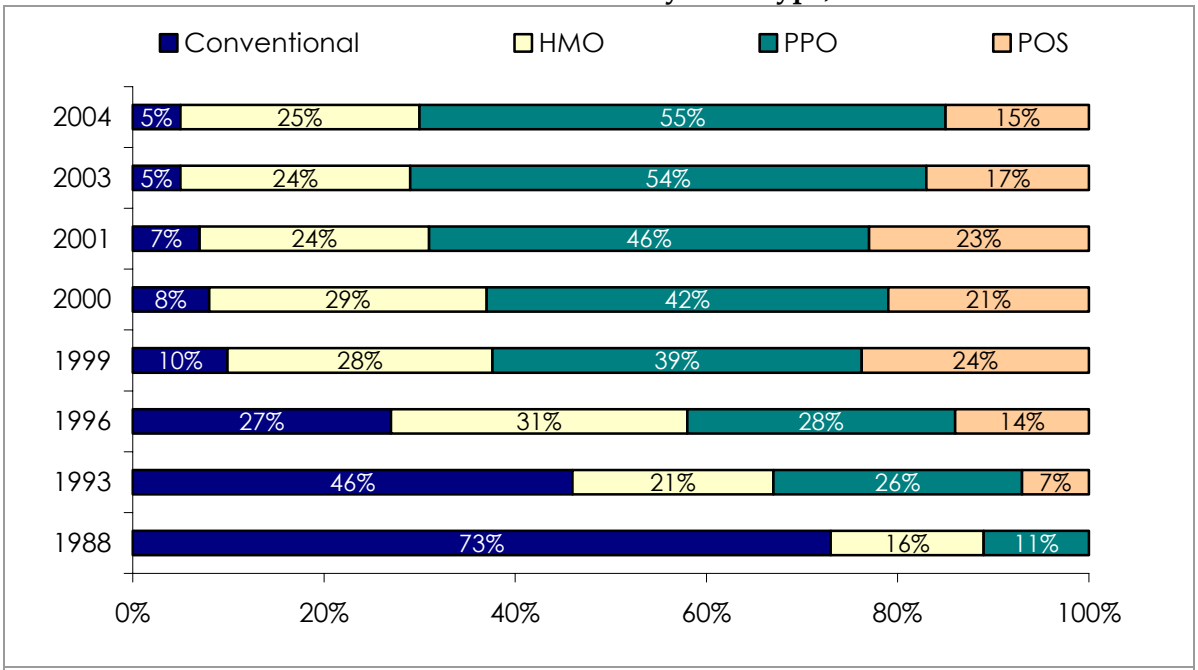
- Similarly, monthly employee contribution has also increased to a greater extent for family than single coverage
- It appears that both employers and families are sharing the impact of these increasing premiums



Source: Medical Expenditure Panel Survey (MEPS)

The other major market shift to take place in the U.S. over the last ten years is the shift away from conventional indemnity plans and toward preferred provider organizations:

U.S.: Health Plan Enrollments by Plan Type, 1998-2004



- There was a shift from traditional indemnity plans to Preferred Provider Organizations (PPO) and Point of Service (POS) during the 1990's; this shift has slowed substantially but continues from 1999 through 2004.

Source: National data from Kaiser/HRET Employer Health Benefits 2004 Chartpack at http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46206. Kaiser/HRET Survey of Employer-Sponsored Health Benefits (1999-2004), KPMG Survey of Employer-Sponsored Health Benefits (1993, 1996), The Health Insurance Association of America (HIAA): 1988.

As opposed to the U.S. numbers shown above, in Oregon, there has been a dramatic shift away from managed care. Managed care penetration in the state peaked in 1999, with slightly more than 50% of population enrolled in one of the state's 11 managed care plans.[35] Partially due to consumer backlash, managed care has been largely abandoned in the Oregon; in 2003, only 22% of the population was enrolled in one of the five remaining commercial managed care plans.[36] The strongest remaining sector of managed care in the state is within the Medicaid delivery system, where 13 managed care plans deliver care to about 75% of the Medicaid population.

[35] *http://www.managedcaredigest.com/edigests/hm2000/hm2000c01s07g01.html.* <*December 2004*>.
[36] *http://www.statehealthfacts.kff.org.* <*December 2004*>.

Private Health Insurance: Health Savings Accounts

Health Savings Accounts. In 2003, the U.S. Congress enacted legislation to allow people to establish health savings accounts (HSAs) to work with qualifying high-deductible health coverage to help people finance medical expenses. Beginning January 1, 2004, individuals or employers were allowed to make contributions to these accounts.

HSAs, or consumer-driven health plans, are tax-free accounts that can be set up by individuals or employers; they are personal accounts that are owned by individuals, even when employers establish and contribute to them. Interest earned is not taxed, and funds that are not used may carry over to the following year. HSAs are required to be established with a high-deductible health plan (HDHPs). A health plan qualifies as an HDHP if it has an annual deductible of at least $1,000 ($2,000 for families) and annual out-of pocket expenses – deductibles, co-payments, and coinsurance – that do not exceed $5,000 ($10,000).

There are key differences among health savings accounts (HSAs) and previous tax-preferred accounts such as medical savings accounts (MSAs), flexible savings accounts (FSAs) and health reimbursement arrangements (HRAs) with regard to eligibility rules, the tax benefit, and the type of health coverage that can be used to coordinate with the account.

Although similar to medical savings accounts, HSAs are not as restrictive, have broader eligibility rules, provide a bigger tax break, and allow for an annual deductible that is lower than that for MSA-qualified policies. States' decisions about whether to promote HSAs and the required high-deductible health insurance may affect the type and price of coverage that is available in their health care markets. For example, encouraging people to buy high-deductible coverage further shifts the cost of health care from employers and health plans to individuals. With more of their dollars at stake, consumers may make more cost-efficient choices regarding their health care services. On the other hand, cost shifting might also result in people not getting or delaying necessary care – which could ultimately increase health care costs for employers and health insurers if people develop more serious conditions as a result of postponing services, and could perhaps increase costs for states if people turn to state-funded programs.

Comparison of Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs)[37]

	HSAs	MSAs	FSAs	HRAs
Health plan type	High-deductible only	High-deductible only	High-deductible and comprehensive	High-deductible and comprehensive
Carry over from year to year?	Yes	Yes	No	Yes
Portable?	Yes	Yes	No	No (up to employer)
Type of coverage?	Individual and job-based health coverage	Small business or self-employed health coverage only	Job-based only	Job-based only
Who contributes?	Individuals, employees, and employers	Employee, self-employed, or small business employer (50 or less empl.) – both employee and employer cannot contribute in a tax year	Employee	Employer
How is it taxed?	"Above the line" deduction (employer contribution not taxed as income)	"Above the line" deduction (employer contribution not taxed as income)	Not taxed as income	Not taxed as income

Kaiser Family Foundation's recent 2004 Health Survey found:

- A description of so-called "consumer-driven" plans (catastrophic coverage paired with a health savings account) was viewed unfavorably by people with employer-sponsored coverage.
- Those who are more favorable towards catastrophic plans tend to be younger, higher-income, and people who currently purchase their own insurance.

Considerations for state policymakers are:

- HSAs could have an impact in segmenting risk in the private market: when choosing between low-cost, high-deductible coverage and more costly comprehensive coverage, individuals, if healthy tend to choose the lower cost

[37] *Kofman, M "Health Savings Accounts: Issues and Implementation Decisions for States" Issue Brief Vol V, No 3 State Coverage Initiatives, Academy Health September 2004*

alternative. This can leave fewer healthy people covered by traditional insurance, contributing to a rise in premiums for that type of coverage.

- HSAs could have an impact on tax revenues on both a state and federal level. HSAs are projected to cost the federal government approximately $7 billion in lost revenue over 10 years due to the tax breaks for individuals. If states link their taxes to income determinations based on federal tax calculations, they will lose revenue as well.
- HSAs do not remedy the fact that a minority of people, typically the elderly and individuals with chronic conditions, account for the vast majority of health care costs. These individuals may have difficulty maintaining HSAs because of their significant health care expenses.

CHAPTER 4
WHO'S NOT COVERED: THE UNINSURED

In this chapter:

- The Impact of Being Uninsured
- Health Insurance Trends in Oregon
- Characteristics of the Uninsured

The Impact of Being Uninsured[38]

Health care coverage does not guarantee access to quality care or any care at all, but it has long been accepted that there are negative consequences to being uninsured, not just for the individual lacking in coverage, but also for the community. Some of the major impacts documented have been:

Impacts on Early Diagnosis

- Adults without coverage are less likely to receive preventive care; they are more than 30% less likely to have had a check-up in the past year.
- Adults more often go without recommended screenings for hypertension, cancer, diabetes and other chronic conditions, delaying diagnosis until the disease is more advanced.
- Uninsured pregnant women have a 30% higher likelihood of an adverse outcome of their pregnancy, leading to increased use of neonatal intensive care units.
- Uninsured children are 70% less likely to obtain needed care for ear infections, sore throats and asthma, and 30% less likely to receive medical attention when they are injured.
- Uninsured children with appendicitis wait twice as long before receiving care, and stay in the hospital twice as long due to increased complications.

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[38] *This discussion is derived from the following sources:*
The Uninsured and Their Access to Health Care - Kaiser commission on Medicaid and the Uninsured Key Facts Sheet, January 2003, obtained at www.kff.org on 5/2003.

Fihn, S.D., land J.B. Wicher (1988). Withdrawing routine outpatient medical services. Journal of General Internal Medicine 3 (July/August): 356-62.

Hadley, J (2002) Sicker and Poorer: The Consequences of Being Uninsured – A Review of the Literature. From the Cost of Not Covering the Uninsured Project, an initiative of the Henry J. Kaiser Family Foundation, obtained at www.kff.org on 5/2003.

Hadley, J (2003) Economic consequences of Being Uninsured: Uncompensated Care, Inefficient Medical Care Spending, and Foregone Earnings. Presentation on May 14, 2003 to the Senate Subcommittee on Labor and HHS Appropriations.
Kozak, L.J. et al (2001). Trends in Avoidable Hospitalizations: 1980-1998. Health Affairs 20 (2), p. 225-232.

Impacts on Ability to Manage Chronic Disease and Its Complications

- Adults who have no coverage for a year or more miss timely eye, foot and blood pressure exams that help prevent blindness, amputation, and cardiovascular disease.
- Reduced access to health care: uninsured receive too little medical care and receive it too late.

Impacts on the Use of the Emergency Department (ED) and Hospital Admissions

- It is estimated that 10% to 50% of all ED admissions could be treated in primary care offices.
- Uninsured adults are 30% to 50% more likely to have avoidable hospitalizations (e.g., treatment for diabetes or pneumonia).
- Communities with poor access to care had higher rates of hospitalizations for certain chronic conditions.
- In one study, 41% of adults who lost coverage had uncontrolled high blood pressure (compared to 8% of adults with continuous coverage).

Impacts on the Cost of Healthcare

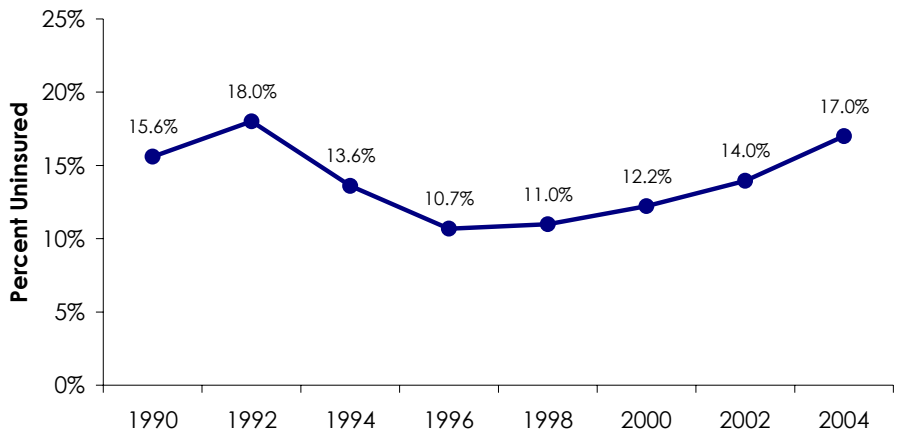
- In 2002, the average cost of an avoidable hospitalization was estimated to be $3,300.
- ED visits for complication of untreated chronic illness can cost 20 to 50 times more than one primary care visit.
- Providing primary care in the ED costs three times as much as in a primary care office.

Health Insurance Trends in Oregon

Oregon collects data on health insurance trends through the Oregon Population Survey (OPS), a statewide telephone survey of Oregon households conducted every other year since 1990. The survey's primary objective is to track numerous health, social and economic "benchmarks", including measures of Oregonians' health insurance status. The 2004 survey included 4,508 households with data from 11,565 individuals.

As evident from the previous chapters, insurance rates are influenced by many factors, including the economy and employment rates, Medicaid and Medicare policy, and the costs of health insurance for employers and employees. Oregon's recent high rates of unemployment, increasingly expensive health insurance premiums and the shrinking Oregon Health Plan are all contributors to Oregon's growing uninsured population, which went from 14% in 2002 to 17% in 2004.

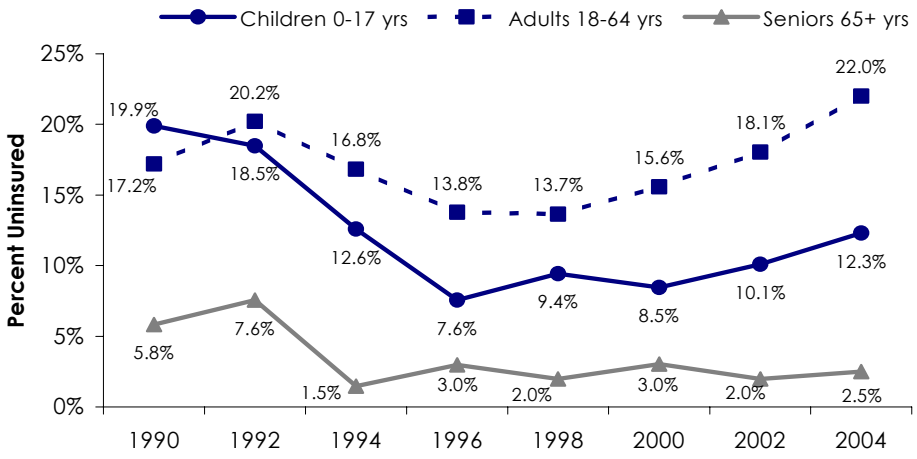
Trends in Oregon's Uninsured Rate, 1990 to 2004



- The economic downturn near the end of the 1990's, rising health care costs, and reductions in Oregon Health Plan due to budget constraints in 2003 correspond with an increasing number of uninsured in Oregon, from 10.7% in 1996 to 17.0% in 2004.
- One in six of all Oregonians are currently uninsured.

Data Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2004

Oregon Health Insurance Trends among Children, Adults, and Seniors



- With the exception of the elderly, who generally qualify for health care coverage through Medicare, all age groups are increasingly uninsured.
- Adults are above the previous historical recorded high at 22% uninsured, while children remain well below the 1990 rate of 19.9%.
- The number of uninsured children has continued to increase in recent years, despite increased children's coverage within the Oregon Health Plan.

Data Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2004

Insurance in the Last 12 Months. Capturing an accurate estimate of Americans lacking health insurance and understanding the dynamic nature of this population is vital to designing effective policy. The Office for Health Policy and Research estimates the percentage of uninsured from the Oregon Population Survey's (OPS) point-in-time estimates, providing only a snapshot of the uninsured, which ignores the ongoing stream of people who flow quickly into and out of the uninsured "pool."

The OPS also asks those who state that they are currently insured if they've been uninsured at any time in the previous 12 months. Another 8.8 percent of the respondents reported a gap in their coverage at some time in the previous year. More than half of those had been uninsured for the entire year; the average gap in insurance was almost 9 months.

This finding is mirrored in a recent study examining the stability of Americans' health insurance status over a continuous, four-year period from 1996 to 1999. The authors found that relatively few Americans were continuously uninsured for the four years, but a sizable number of uninsured lacked a stable source of coverage.[39]

Key findings from the national study included:

- The repeatedly uninsured represent the largest group with 33% having at least two uninsured and two covered spells;
- Only 12% were uninsured for the entire four years; and
- 19% experienced a single gap in coverage, while 6% had temporary coverage and were otherwise uninsured.

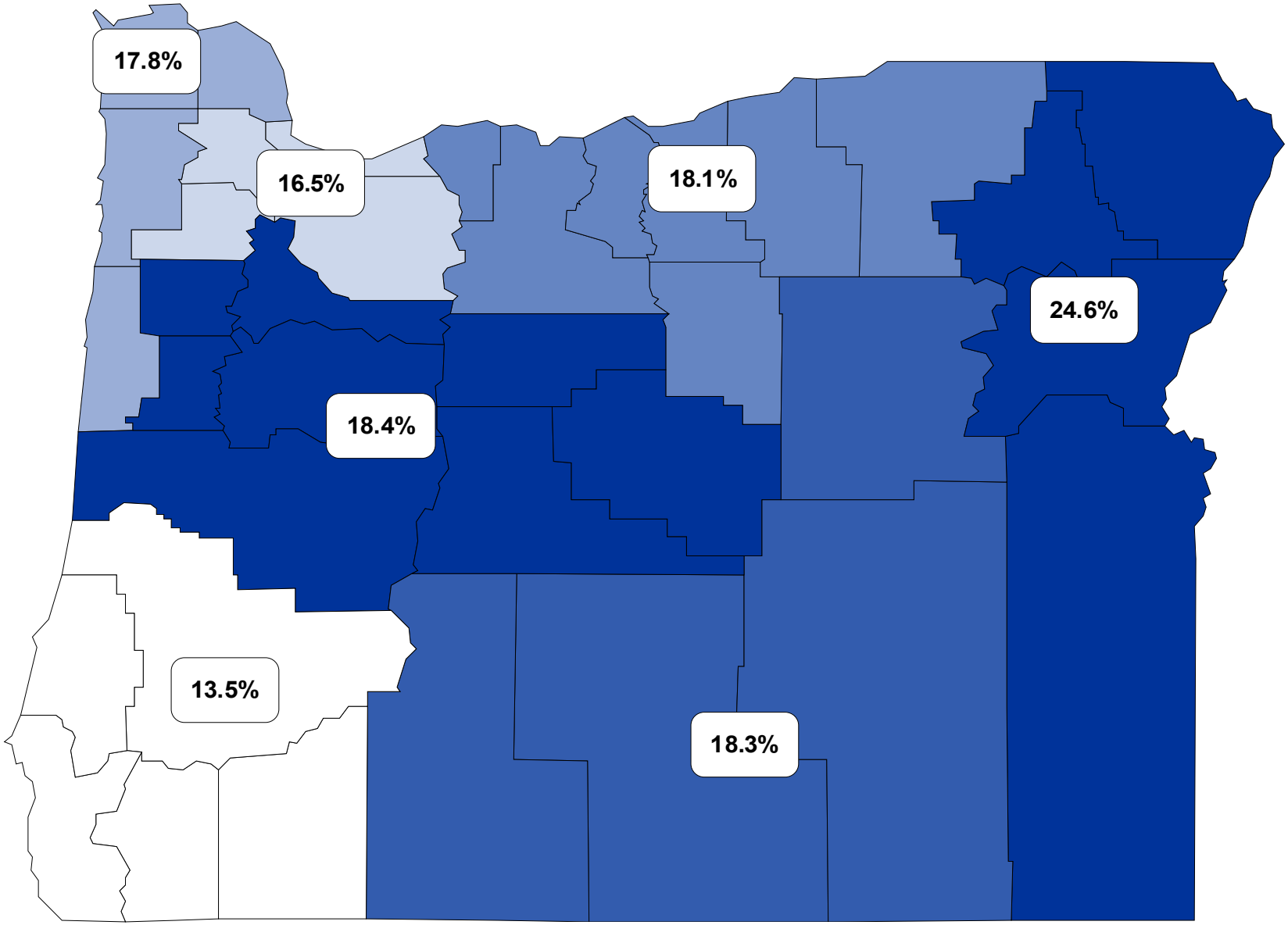
These findings have important policy implications; the "uninsured" essentially refers to gaps in coverage that people experience repeatedly over time rather than isolated incidents.

Regional Differences. The map on the following page displays regional differences in the uninsured rates across the state. The southeastern part of the state shows the lowest rates of uninsurance in the state (13.5%) for reasons that are not well understood. The region has a much higher proportion of the population over 65 years old than the rest of the state and a much higher proportion of its population participates in the Oregon Health Plan; these high rates of publicly financed health insurance in the region may be partially explanatory.

Almost twenty-five percent of the population in the far eastern region of the state, Baker, Malheur, Union and Wallowa counties, reported being without health insurance at the time of the 2004 OPS (August 2004).

[39] *Pamela Farley Short and Deborah R. Graefe. Battery-Powered Health Insurance? Stability In Coverage of the Uninsured. Health Affairs,November/December 2003; 22(6): 244-255*

Regional Percentages of the Uninsured in Oregon, 2004

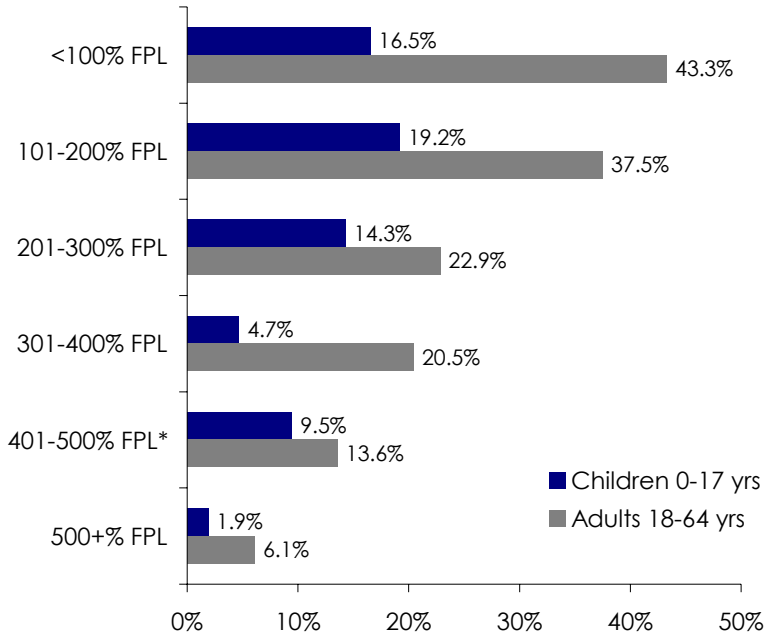


Characteristics of the Uninsured

The ability to obtain and keep health insurance coverage is not distributed equally across the population. Since most health insurance in the U.S. is employer-based, many of the same characteristics that impact employment status and income also impact health insurance status. Young adults tend to have less coverage than any other age group. Education, income and age are all correlated with health insurance as well. Finally, health care disparities persist for racial and ethnic groups and those are reflected in health insurance coverage as well.

Percent Uninsured at Selected FPL*, Oregon, 2004

- Individuals with higher household income have substantially higher rates of health insurance.
- Oregonians < 100% FPL are over six times as likely to be uninsured than those with incomes over 500% FPL.
- Although uninsured at lower rates, this income disparity is still evident among children.

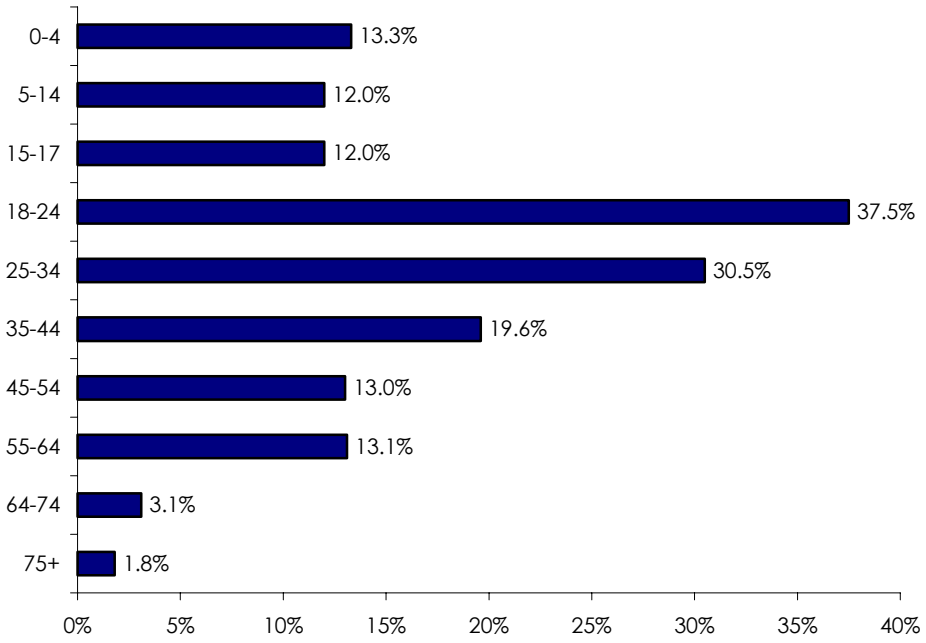


*FPL=Federal Poverty Level, which is based on household size and income. Income is presented as a percent of FPL; for example, <100% of FPL means that the household income is below the federal poverty level, 200% FPL means that the household income is twice the federal poverty level. Percent of FPL is approximated based on broad income categories.

Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2004.

Percent Uninsured by Age, Oregon, 2004

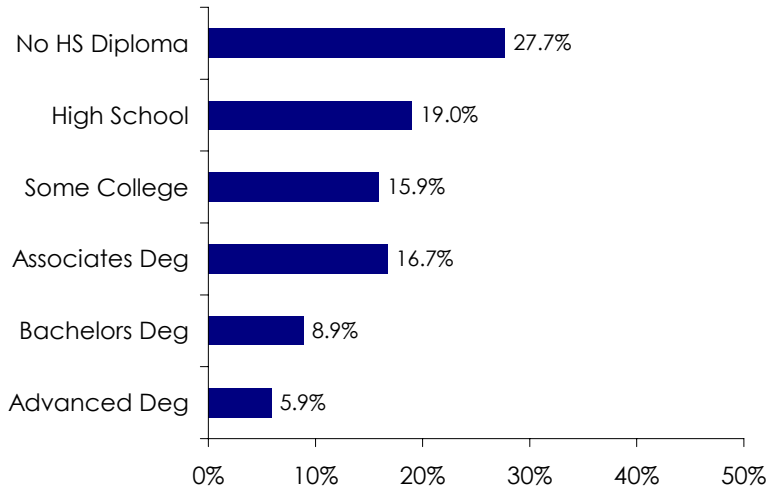
- Young adults are most at risk for being without health insurance; more than one-third of young adults between 18 and 24 in Oregon are without health insurance.
- Individuals 65 and older are almost all covered by Medicare.
- Only those without enough work credits or those who choose not to enroll remain without Medicare after 65.



Source: Oregon Population Survey, 2004

Percent Uninsured by Level of Education, Oregon, 2004

- Health insurance coverage increases as the level of education increases: adults with no high school degree are over four times more likely to be uninsured than adults with advanced degrees.



Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2004. Data restricted to adults 25 years old and older.

Racial and Ethnic Disparities. Oregon's racial and ethnic minority populations are disproportionately without health insurance. However, because of the relatively small size of diverse racial groups, simple random sampling of the population does not yield an adequate number of respondents to produce reliable estimates of health insurance coverage. Therefore, to enhance reliability in both 2002 and 2004, special augment samples were randomly selected for the Oregon Population Survey (OPS). At the time of this report the 2004 ethnic and racial group data were not available, but we saw in 2002, when 14% of the overall population was uninsured, 31% of Oregon's Hispanic population did not have health insurance coverage. A full analysis of 2004 racial and ethnic group data on insurance coverage will follow. For a broad discussion of racial and ethnic health disparities, see Chapter 6.

What Else Do We Know About Oregon's Uninsured? A full reporting of Oregon's Uninsured will be available in March 2005, but some early analysis from the 2004 OPS show the following:

- 54% male and 46% female
- 75% have been in Oregon more than 5 years
    - 5% moved to Oregon from California in the last 5 years
    - 5% moved to Oregon from Latin America or Mexico
    - 3% moved to Oregon from Washington
    - In-migrants from Florida, Idaho, Utah and Arizona account for another 6.2%
- 60% (of those 16 and over) report that they are employed
    - 30% of those who are employed have work in food preparation, office support or construction.
- 16% report that they have a lasting mental, developmental, physical or learning disability
    - 43% of those reporting a disability report that they have a physical disability
    - 29% report a mental disability
    - 24% report a learning disability

CHAPTER 5
ACCESS TO HEALTHCARE

In this chapter:

- The Health Care Safety Net
- Hospitals

Insurance status does not guarantee access to needed medical care. There are many other factors that determine access to care, such as:

- Availability of providers within a particular area. This issue is particularly important in rural areas, where population is sparse, and providers have found it much more difficult to maintain their practices.
- Availability of providers who will accept health coverage, particularly Medicare and Medicaid, which reimburse providers at lower levels than commercial payers.
- Accessibility of health care services for patients who with special needs, such as translation services, alternative formats for written material, or physical accommodations.

Access to health care services is compounded for those without health insurance coverage. There are essentially two health care systems in the U.S.; one, the mainstream system supported by commercial health insurance and two, the safety net system, which is made up of a wide range of providers.

The Health Care Safety Net

Access to care for the uninsured and underinsured is provided in large part by the health care safety net. In 2004, Oregon's Health Care Safety Net Policy Team defined the health care safety net as follows:

- The health care safety net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Health care safety net patients often experience barriers to accessing services from other health care providers due to cultural, linguistic, geographic and financial issues. Safety net patients tend to be uninsured, underserved, Medicaid/Medicare enrollees, and other vulnerable/special populations.
- Health care safety net providers deliver services to persons experiencing barriers to accessing the services they need. These providers include a broad range of local non-profit organizations, government agencies, and individual providers.
- Core health care safety net providers are especially adept at serving people regardless of their ability to pay. They have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need, and serve a

substantial share of Medicaid/Medicare enrollees, people who have no health insurance, as well as other vulnerable/special populations.

Oregon's health care safety net includes Federally Qualified Health Centers (FQHC), Tribal Health Centers, County Health Departments, Migrant Health Centers, School-Based Health Clinics (SBHC) Veteran's Administration Clinics, Volunteer and Free Clinics and hospital emergency departments as well as some private providers. For those with federal or state designations, some definitions are useful to understanding the array of safety net providers in the state:

Federally Qualified Health Centers (FQHC's). Federally Qualified Health Centers (FQHC's) are eligible for federal grants and enhanced Medicare and Medicaid reimbursement. There are 23 FQHCs with over 100 sites in Oregon. In order to be designated as a Federally Qualified Health Center the following requirements must be met. A Health Center must:

- Serve a federally designated health professional shortage area, medically underserved area or medically underserved population
- Provide services to patients regardless of insurance status
- Use a sliding fee scale for uninsured patients based on income status
- Operate as a nonprofit corporation governed by a board of directors of which a majority are users of the Health Center

There are three types of Federally Qualified Health Centers: Section 330 Health Centers, Federally Qualified Health Center-Look Alikes, and Tribal Health Programs

Section 330 Health Centers. There are four types of Section 330 Health Centers:

- Community and Migrant Health Centers
- Health Care for the Homeless Programs
- Public Housing Primary Care Programs
- School-Based Health Centers

Community and Migrant Health Centers. Community and Migrant Health Centers provide comprehensive primary health care for adults, children and families. These Health Centers are public or private corporations governed by consumer-majority boards of directors that represent the communities they serve. Health Centers receive reimbursement for services from patients according to their ability to pay. Health centers also receive third party reimbursement from private insurance, Medicare and Medicaid. Federally funded Community and Migrant Health Centers receive operating grants under Section 330 of the Public Health Service Act. Migrant health centers in Oregon include La Clinica del Carino in The Dalles and La Clinica del Valle in Medford, Salud and Virginia Garcia Memorial Center (in multiple locations).

Health Care for the Homeless Programs. Health Care for the Homeless programs provide outreach and case management services, primary medical and

dental care, 24-hour emergency services, mental health and substance abuse counseling and treatment to homeless individuals. They also provide referrals to other services, such as emergency food, clothing and shelter programs, placement services for long term employment and housing.

Unlike the Health Center model, homeless people are not charged directly for services. Health Care for the Homeless programs in Oregon include The Old Town Clinic, the Portland Alternative Health Center, and Outside In.

School-Based Health Centers. Forty-seven percent of Oregon's School-Based Health Centers are either FQHCs or affiliated with an FQHC. School-Based Health Centers (SBHC) are located in a school or on school grounds and operate year-round for at least 30 hours per week. SBHCs are designed to ease access to health care by reducing the barriers that have historically prevented adolescents from seeking the health services they need including inconvenience, cost, transportation, concerns surrounding confidentiality, and apprehension about discussing personal health problems. The practitioners provide a full range of services for all students, regardless of whether or not they have health insurance coverage. There are 43 school-based health centers in 14 counties in Oregon. During service years 2002-2004, the centers served 34,904 clients in 148,312 visits. Service years 2002-2004 experienced a temporary loss of funding and later reinstatement resulting in incomplete data sets as school-based health centers closed and re-opened.

Federally Qualified Health Center- Look-Alikes. The Federally Qualified Health Center provision is also available to organizations that meet all of the federally funded Community Health Center program expectations, but do not receive federal operating grants under the Section 330 Public Health Service Act. Such organizations are formally designated Federally Qualified Health Center Look-alikes by the U.S. Department of Health and Human Services. There is one FQHC Look-Alike in Oregon, Oregon Health & Science University's (OHSU) Richmond Clinic in Portland.

Tribal Health Centers. Tribal health programs seek to provide a framework that encourages tribal, inter-tribal and interagency collaboration, coordination and communication to assure that comprehensive, high-quality health care is available and accessible to the Oregon Native American population. There are two Indian Health Service clinics that also have FQHC status in Oregon, the Grande Ronde Health Center and the Siletz Community Clinic. There are a total of ten Tribal Health Centers in Oregon, serving over 15,000 unduplicated members in a year.

In addition to the Federally Qualified Health Centers, there are other key safety net providers in the state, including rural health clinics, non-FQHC Tribal Clinics and hospitals.

Rural Health Clinics (RHCs). Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act in 1977. The purpose of RHCs is to increase primary care services for Medicaid and Medicare patients in rural communities. RHCs ownership/governance structure can operate as public, private, or non-profit. The main requirements to obtain RHC status include that the clinic is NOT located in an "Urbanized Area" as designated by the U.S. Census Bureau. RHCs are located in Health Professional Shortage Area (HPSA), or Medically Underserved Area (MUA), generally determined by information from the State Health Department.

RHC status qualifies the clinic for enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. There are currently 55 RHCs in the state.

Health Professional Shortage Areas. An inequitable distribution of providers in urban and rural areas impedes the ability of all health care systems, both safety net and non-safety net, to deliver adequate care in rural areas. Accurate numbers on capacity of rural providers and the entire health care safety net are lacking, but a 1998 study of primary care capacity conducted by the Office for Rural Health in 102 rural areas found that 35% of these areas had less than 25% of their primary care needs met. In contrast, only about 14% of the rural areas had more primary care capacity than needed.

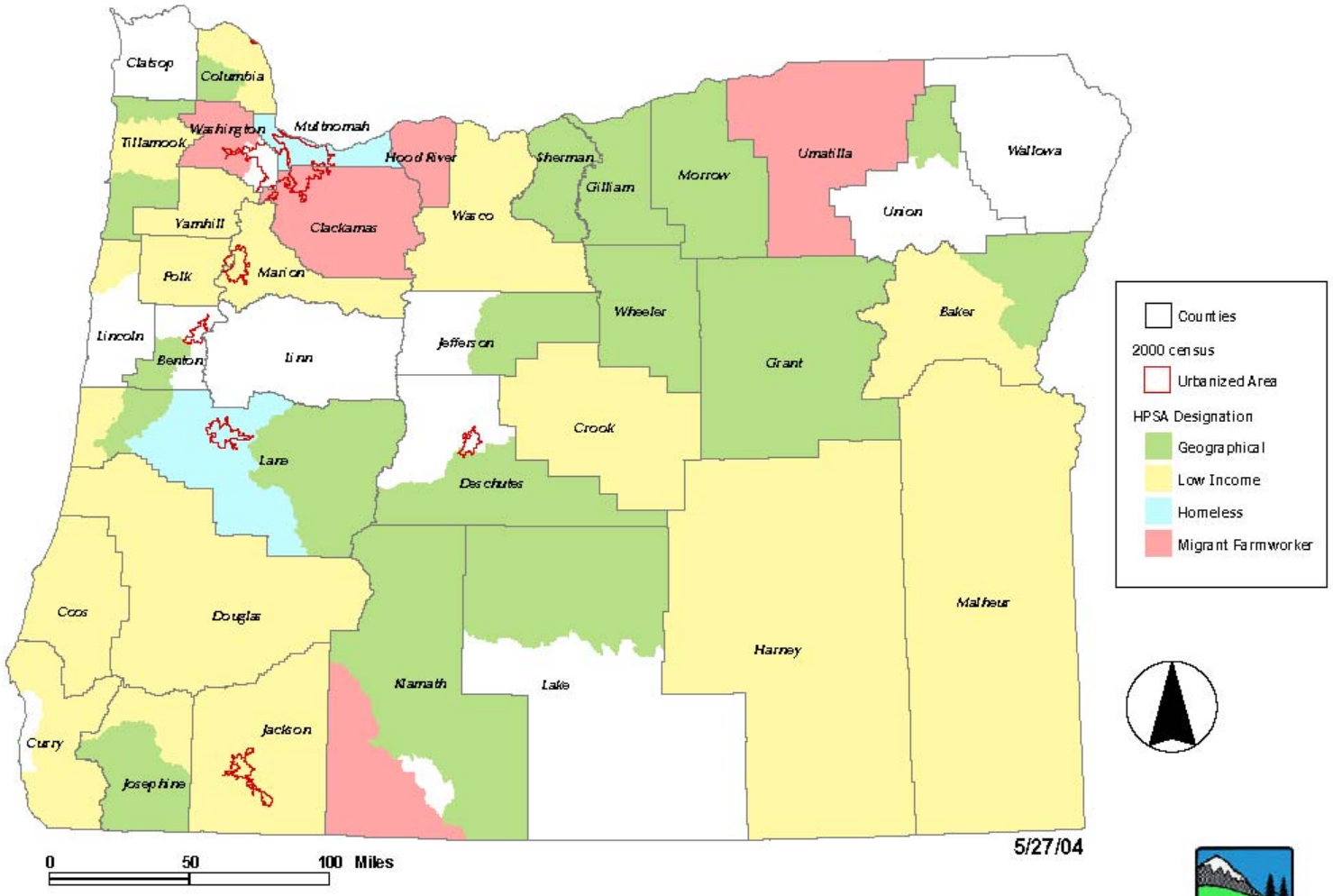
The federal Health Resources and Services Administration (HRSA) develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a Health Professional Shortage Area (HPSA) or a Medically Underserved Area or Population (MUA/MUP). HPSAs may have shortages of primary medical care, dental or mental health providers and may be urban or rural areas, population groups or medical or other public facilities.

HPSA Map. The white areas on the HPSA map on the following indicate areas that do not currently have a HPSA designation. This does not necessarily mean that they do not meet the criteria, as areas must ask to be considered for designation. There are three major types of HPSA designations:

- Geographic HPSAs (a shortage for the total population)
- Population HPSAs (an underserved population in geographic area such as the Low-Income or Migrant Farmworkers)
- Facility designations (Community Health Clinics, Rural Health Clinics, federal and state correctional facilities)

The map on the following page shows currently designated Primary Care Health Professional Shortage Areas (HPSAs) in Oregon.

Oregon Primary Care HPSAs



OREGON OFFICE OF RURAL HEALTH

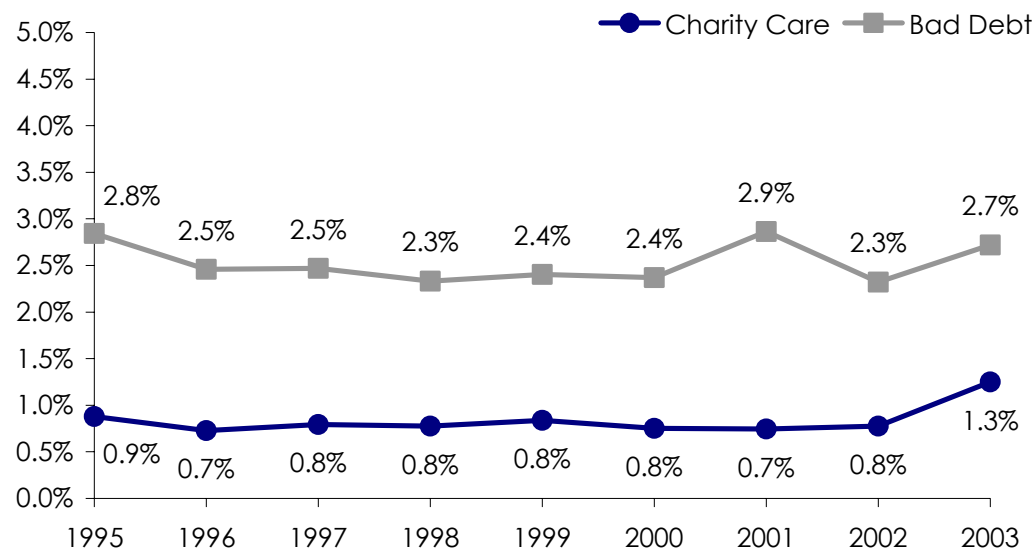
Hospitals

To the extent that hospitals provide uncompensated care, provide care to a disproportionate share of Medicaid patients, or provide primary care services in the Emergency Department (ED), they play a role in the health care safety net.

The provision of uncompensated care serves as an indicator of the need for care, both among people who are unable to pay, and the willingness and/or capacity of health care providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect uninsurance trends in the community.

The following chart shows the trends in hospital uncompensated care in Oregon from 1995 to 2003:

Median Uncompensated Care as Percent of Gross Patient Revenue, Oregon Acute Care Hospitals, 1995 to 2002



Source: Office for Oregon Health Policy and Research, 2004.

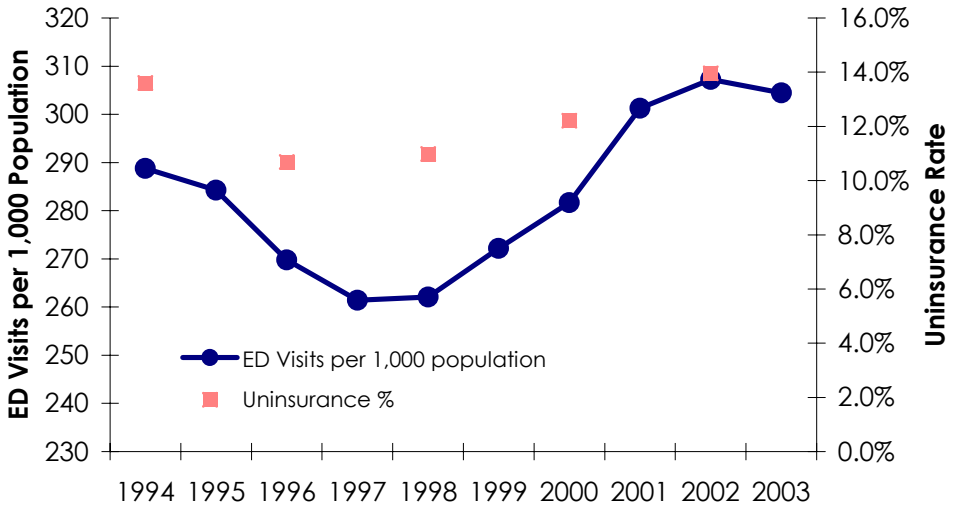
Finally, emergency department (ED) utilization can serve as an early warning system of capacity problems in a local community's primary care system. To the extent that practices are closed to new patients or individuals cannot afford physician visits, people will turn to the ED as their primary care provider. A recent study of individuals who lost their Oregon Health Plan coverage reported that 10% (vs. 2% of those maintaining coverage) used the ED as their usual source of care.[40]

[40] *Carlson M, Wright B, Gallia C, Presentation, "The Impact of Program Changes on Healthcare for the OHP Standard Population", http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC2004Presentations.pdf.* <*January 2005*>

The following table and chart shows ED visits increasing as the number of uninsured increase in Oregon:

Emergency Department Visits and the Uninsured, Oregon, 1994 - 2003

Year	ED Visits	Oregon Population	ED Visits per 1,000 population
1994	901,059	3,119,940	289
1995	904,791	3,182,690	284
1996	875,456	3,245,100	270
1997	863,190	3,302,140	261
1998	877,994	3,350,080	262
1999	923,721	3,393,410	272
2000	963,673	3,421,399	282
2001	1,045,969	3,471,700	301
2002	1,076,855	3,504,700	307
2003	1,078,267	3,541,500	304



Source: Databank (ED Visits); Oregon Office of Economic Analysis, 2003 Oregon Population Report, Table 1 (Oregon Population); 1994 to 2004 Oregon Population Survey (Uninsurance)

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CHAPTER 6
RACIAL AND ETHNIC HEALTH DISPARITIES

In this chapter:

- Racial and Ethnic Minorities in Oregon
- Racial and Ethnic Health Disparities

Racial and Ethnic Minorities in Oregon

Demographic data indicates that there are a growing number of racial and ethnic minorities in the United States and in Oregon. Furthermore, the number of racial and ethnic minorities in Oregon is expected to continue to grow over the next decade. According to population data for Oregon, racial and ethnic minorities (i.e., African Americans, Native Americans, Asians/Pacific Islanders, and Hispanics) made up about 9.2% of the population in 1990.[41] By 2000, these groups represented 16.5% of the population[42], increasing further by 2003 to 17.8%.[43] These demographic changes magnify the importance of examining the health of racial and ethnic minorities and addressing existing and preventing future disparities.[44] See Chapter One of this report for more detailed data on racial and ethnic minorities in Oregon.

Racial and Ethnic Health Disparities

Disparities in "health care" and in "health" are often referred to as if they are one and the same. For example, a health care disparity refers to differences in coverage, access, or quality of care that are not due to health needs. A health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one population group in relation to another. The two concepts are related in complex ways, most clearly in that disparities in access to health care can contribute to health disparities. For example, differences in access to care, use of services, quality, and provider-patient communication have all been shown to contribute to health disparities.[45] And yet the goal of health services is to maintain and improve a population's health. [46] However, other factors such as family medical history, personal behavior, educational attainment, income, and other socio-economic factors also are determinants of a population's health.

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[41] *U.S. Bureau of the Census, 1990 Census of Population and Housing*
[42] *U.S. Bureau of the Census, 2000 Census of Population and Housing*
[43] *U.S. Bureau of the Census, 2003 American Community Survey*
[44] *Satcher, D. (2001). Our Commitment to Eliminate Racial and Ethnic Health Disparities. Yale Journal of Health Policy, Law, and Ethics.*
[45] *Bierman AS, Lurie N, Scott Collins K, & Eisenberg, JM, "Addressing the Racial and Ethnic Barriers to Effective Health Care: The Need for Better Data." Health Affairs, (May/June 2002).*
[46] *Health Care and the 2004 Elections. Kaiser Family Foundation. www.kff.org*

Racial and ethnic disparities in health care – whether in insurance coverage, access, or quality of care – are factors producing differences in health status in the United States. The importance of race and ethnicity in determining what care is provided is described in the Institute of Medicine (IOM) 2000 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. After a comprehensive literature review, the IOM concluded that racial and ethnic minority Americans "tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."[47] Furthermore, the IOM states that "although myriad sources contribute to these disparities some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care."

The IOM report recommended the use of a comprehensive multi-level strategy to address potential causes of racial and ethnic disparities in care that arise from interactions at the patient, provider, and health care system levels. These recommendations point to four broad areas of policy challenges:[48]

- Raising public and provider awareness of racial and ethnic disparities in care;
- Expanding health insurance coverage;
- Improving the capacity and number of providers in underserved communities;
- And increasing the knowledge base on causes and interventions to reduce disparities.

Eliminating health disparities is politically sensitive and challenging, in part because their causes are part of a controversial history of race relations in the United States. However, assuring greater equity and accountability of the health care system is important to a growing constituency base, including policy makers, health plan purchasers, payers, providers of care, and patients. To the extent that inequities in the health care system result in lost productivity or use of services at a later stage of illness, there are health and social costs beyond the individual or specific racial and ethnic group.

Healthy People 2010. "Healthy People 2010" is a comprehensive health promotion and disease prevention agenda for the United States. Healthy People 2010 is designed to serve as a roadmap for improving the health of all people during the first decade of the 21st century. According to Healthy People 2010, individual health is closely linked to community health: the health of the community and environment in which individuals live, work, and play. Likewise, community health is profoundly affected by the collective beliefs, attitudes, and behaviors of everyone who lives in the community. Healthy People 2010 has two overarching goals:

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[47] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*

[48] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*

- Increase quality and years of healthy life
- Eliminate health disparities

Healthy People 2010's focus on health disparities is attributed to a variety of reasons. Current information about the biologic and genetic characteristics of African Americans, Alaska Natives, Native Americans, Asians, Hispanics, Native Hawaiians, and Pacific Islanders does not explain the health disparities experienced by these groups compared with the white, non-Hispanic population in the United States.

Even though the United States' infant mortality rate is low, the infant death rate among African-Americans is still more than double that of whites. Heart disease death rates are more than 40 percent higher for African-Americans than for whites. The death rate for all cancers is 30 percent higher for African-Americans than for whites; for prostate cancer, it is more than double that for whites. African-American women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for white women.[49]

Native Americans and Alaska Natives have an infant death rate almost double that for whites. The rate of diabetes for this population group is more than twice that for whites. Native Americans and Alaska Natives also have disproportionately high death rates from unintentional injuries and suicide.[50]

Asians and Pacific Islanders, on average, have indicators of being one of the healthiest population groups in the United States. However, there is great diversity within this population group, and health disparities for some specific segments are quite marked. For example, Vietnamese American women experience cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis also are higher in Asian and Pacific Islanders than in whites.[51]

Hispanics living in the United States are almost twice as likely to die from diabetes as are non-Hispanic whites. Hispanics also have higher rates of high blood pressure and obesity than non-Hispanic whites.[52]

Health and health care disparities, such as those identified above, have devastating consequences such as poverty, disability, and premature death. They often lead to avoidable specialty and hospital care that helps to drive the rapid health care cost increases, disrupting the effectiveness of the health system for all Oregonians.[53] Unfortunately, a complete picture of the health of racial and ethnic minorities in Oregon is not available. Limited data on health behaviors, disease burden, and mortality among racial and ethnic minorities are collected but are not routinely available and often have limited reliability. Oregon-specific data, however, is needed to obtain an accurate idea

[49] *Healthy People 2010. U.S. Department of Health and Human Services. http://www.healthypeople.gov*
[50] *Healthy People 2010. U.S. Department of Health and Human Services. http://www.healthypeople.gov*
[51] *Healthy People 2010. U.S. Department of Health and Human Services. http://www.healthypeople.gov*
[52] *Healthy People 2010. U.S. Department of Health and Human Services. http://www.healthypeople.gov*
[53] *Healthy People 2010. U.S. Department of Health and Human Services. http://www.healthypeople.gov*

of health status and disparities. Multnomah County did release a report in August 2004 that illustrates that health disparities in urban Oregon are similar to those that exist nationally.[54]

Racial and Ethnic Health Insurance Coverage. Race and ethnicity clearly matter in the United States health system, as do many other factors, particularly insurance coverage. Racial and ethnic minority Americans make up about a third of the U.S. population, but disproportionately comprise 52% of the uninsured – 23 million of the 45 million uninsured in 2003.[55] When compared with the insured, the uninsured are less likely to have a regular doctor or to get timely and routine care, are more likely to be hospitalized for preventable conditions, and are more apt to die from needless complications.[56]

Differences in health insurance coverage across racial and ethnic groups are partially explained by differences in types of employment and eligibility for public programs. Although employer sponsored insurance is the major source of coverage for whites as well as racial and ethnic minority groups, Medicaid is an important safety net for 26% of non-elderly African Americans, 22% of Hispanics, as compared to 10% of whites nationally.[57] Oregon shows similar patterns, with 19% of non-elderly Hispanics and 21% of those of other racial and ethnic minorities, as compared to 13% of white enrolled in Medicaid.[58]

Racial and Ethnic Healthcare Workforce. Despite efforts to increase the number of racial and ethnic minority health professionals, few practice or are educated in Oregon. After an exhaustive literature review, the IOM recommended that expanding the racial and ethnic diversity of the health professions workforce and developing provider training programs and tools in cross-cultural education in order to strengthen patient-provider communication and relationships.[59] These recommendations are based on evidence that racial and ethnic minority providers are more likely than whites to practice in communities of color and medically underserved areas. Furthermore, research indicates that when patient and providers are of the same race there is greater satisfaction and adherence to treatment.[60]

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[54] *Racial and Ethnic Health Disparities in Multnomah County: 1990-2002. http://www.co.multnomah.or.us*
[55] *Health Care and the 2004 Elections. Kaiser Family Foundation. www.kff.org*
[56] *American College of Physicians and the American Society of Internal Medicine (ACP-ASIM) (2000). No Health Insurance? It's Enough to Make You Sick.*
[57] *March 2004 Current Population Survey, accessed through Kaiser Family Foundation http://www.statehealthfacts.org.*
[58] *Urban Institute and Kaiser Commission on Medicaid and the Uninsured. Estimates based on pooled March 2003 and 2004 Current Population Surveys. Total U.S. numbers are based on March 2004 estimates, http://www.statehealthfacts.org.*
[59] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*
[60] *Institute of Medicine, March 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* Care.

These concerns are mirrored in a recent survey of Oregon physicians, which shows that only 10% of physicians are racial minorities, and just 2% are Hispanic (see table below). A higher percentage of physicians can communicate in other languages – 17% in Spanish, less than 1% in Russian and Vietnamese, and 10% in some other language.

Physician Race (2004) vs Oregon Population Race, (2003)

	Percent of Physician Workforce, 2004*	Percent of Population, 2003**
White	90.4%	91%
African-American	0.5%	2%
Asian/Hawaiian/Pacific Islander	5.7%	4%
Native American/Alaska Native	0.1%	1%
Other Race	1.9%	NA
Multiple Races	1.4%	2%

Source: *Oregon Medical Association, Oregon Medical Assistance Program, Oregon Physician Workforce Survey, 2004, **Portland State University Population Research Center, 2003.

Racial and ethnic diversity is substantially higher among Oregon medical school graduates from the 2002/2003 academic year, with 26% of racial or ethnic minority Americans. However, the majority (73%) of Oregon's racial and ethnic minority medical school graduates were Asian, 13.6% Hispanic, and 13.6% Native American. None of these graduates were African American.[61]

Racial and Ethnic Data. Baseline and follow-up data across racial and ethnic minorities in Oregon is essential for policy, monitoring, and evaluation purposes. Information about racial and ethnic minorities and the potential causes of health disparities assists in making decisions about how to create supportive policies and allocate resources to eliminate disparities. Accessing accurate information requires regularly collecting and analyzing data on health care use and health status across racial and ethnic groups. As identified in the Racial and Ethnic Health Care Task Force, enhanced data collection utilizing culturally appropriate methods is greatly needed.[62]

The lack of data on racial and ethnic minority groups in Oregon creates problems. Data from national and state surveys, health insurers, and different health settings is needed to better understand the problems and interventions. In part, little is known about the health status and utilization of health services for racial and ethnic minorities in Oregon because data simply was not collected, methods to collect such data were outdated and/or inaccurate, or administrative procedures were not reliable.[63] Exacerbating these

[61] *Association of American Medical Colleges, Applicant-Matriculant File, 2003; accessed through Kaiser Family Foundation http://www.statehealthfacts.org*
[62] *Governor's Racial and Ethnic Health Task Force Final Report. (November 2000). http://www.dhs.state.or.us/publichealth.*
[63] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*

data collection and analysis challenges are the relatively few numbers of racial and ethnic minorities in Oregon.

Standardized data collection is critically important to understand and eliminate racial and ethnic disparities in health care. Data on patient and provider race and ethnicity would allow:

- Policy makers to create more effective policies and regulations
- Researchers to better sort out factors that are associated with health care disparities
- Health plans to better monitor performance
- Ensure accountability to enrolled members and payers
- Improve patient choice
- Allow for evaluation of intervention programs
- Help identify discriminatory practices[64]

Unfortunately, Oregon-specific data on racial and ethnic differences in care are generally unavailable, and a number of concerns present challenges to data collection and monitoring, including the need to protect patient privacy, the costs of data collection, and resistance from health care providers, institutions, plans and patients.[65] The challenges to data collection, however, need to be addressed, for the costs of failing to assess racial and ethnic disparities in care likely outweigh burdens caused by data collection and analysis.

To more comprehensively explore satisfaction levels of racial and ethnic minorities, Oregon became the first state to over-sample racial and ethnic populations and to include racial and ethnic breakouts in its CAHPS (Consumer Assessment of Health Plans Study) survey of Oregon Health Plan (OHP) enrollees. This over-sample included 4,671 Oregonians who identified themselves as African Americans, Hispanic, or Native American.

The results of the survey show that Oregon's various racial and ethnic communities are distributed somewhat unevenly among OHP health plans, with the differences often (but not always) reflecting geographic differences in the general population. For example, CareOregon and Kaiser have more than 20% of their total OHP enrollment in the categories other than white, while Doctors of the South Coast, Douglas County, and Mid-Rogue Community health plans have only about 5% of total enrollment in those categories (African Americans, Hispanic, Native American, Asian, and Other).

In terms of satisfaction with the health care and delivery system, there were few significant differences among the racial and ethnic groups. However, whites were more likely to be dissatisfied with their health plan, and Hispanics more likely to be very

[64] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*
[65] *Lillie-Blanton, M., Rushing, O.E., Ruiz, S. (Update June 2003). Key Facts: Race, Ethnicity and Medical Care, Kaiser Family Foundation www.kff.org.*

satisfied, than were other groups. Also, African Americans and Hispanics were more likely to be very satisfied with their personal doctor than were other groups. Finally, whites are significantly more likely to find office staff courteous and helpful, and Hispanics significantly less likely, than other groups.

Other Strategies. Other strategies to improve the health of racial and ethnic minorities as well as the delivery of health care exist and are needed in Oregon. For example, the Governor's Affirmative Action Office in conjunction with the State of Oregon Employment Department identify prospective employees and recruitment strategies needed to create a culturally /linguistically diverse and competent work force.

Furthermore, the Department of Human Services, Office of Multicultural Health provides training to health care workers regarding services to racial and ethnic groups and works with the Diversity Development Coordinating Council, which addresses access to health services, language issues, diversity in planning and decision-making, and workforce diversity and training. Similarly the Governor's Office of Affirmative Action identified prospective contractors to assess organizational cultural competence and design agency-specific training activities regarding diversity.

Conclusion. A growing number of racial and ethnic minorities reside in Oregon. This demographic trend is anticipated to continue. Information about racial and ethnic minorities and the potential causes of health disparities is essential to assist in making decisions about how to create supportive policies and allocate resources to eliminate disparities. Oregon-specific data pertaining to racial and ethnic minorities is needed for policy, monitoring, evaluation, and program design purposes. Such necessary information, however, is not collected or analyzed routinely or reliably in Oregon.

A comprehensive, multi-level strategy that provides quality and needed services to racial and ethnic minorities will assist in the elimination of racial and ethnic health disparities in the state. Stakeholders, including policy makers, health care providers, payers, health plan purchasers, patients, and others need to work together to eliminate health disparities experienced by racial and ethnic minorities. If stakeholders are to succeed in providing quality and timely access to needed health care services, however, reliable and routinely collected data on racial and ethnic minorities in Oregon are essential.

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CHAPTER 7
HEALTH STATUS

In this chapter:

- Chronic Disease
- Risk Conditions
- Modifiable Risk Factors

Chronic Disease

The preceding chapters focused on *health care* – costs of health care, health care coverage, and access to health care. Implicit in our discussion of health care is the assumption that *health care* impacts *health status*, but health status also influences demand for and the cost of health care. It is important, therefore, to examine health care both in the context of health status and as an important determinant of health outcomes.

The following charts focus on the prevalence of specific chronic diseases in Oregon. These represent areas of opportunity for the state, whereas improved quality and access to primary health care can improve health status and reduce costs associated with these conditions.

Deaths and Hospitalizations Due to Selected Conditions, Oregon, 2000

Disease	Total Deaths	% of all Deaths	Total Hospitalizations	Hospitalization Charges
Cardiovascular Disease	10,547	35.7%	44,843	$ 699,109,784
Cancer	6,989	23.7%	12,218	$ 210,559,415
Chronic Lung Diseases	1,696	5.7%	5,823	$ 44,846,159
Diabetes	847	2.9%	3,090	$ 30,242,846
Total	20,079	68.0%	65,974	$ 984,758,204

- Chronic disease contributes not just higher mortality, but also increased health care utilization and costs.
- In Oregon, these major chronic diseases accounted for over 20,000 deaths, almost 66,000 hospitalizations, and nearly $1 billion in hospitalization charges during 2000.

Source: Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003

Primary Sources: Oregon resident death certificates, Oregon Hospital Discharge Database

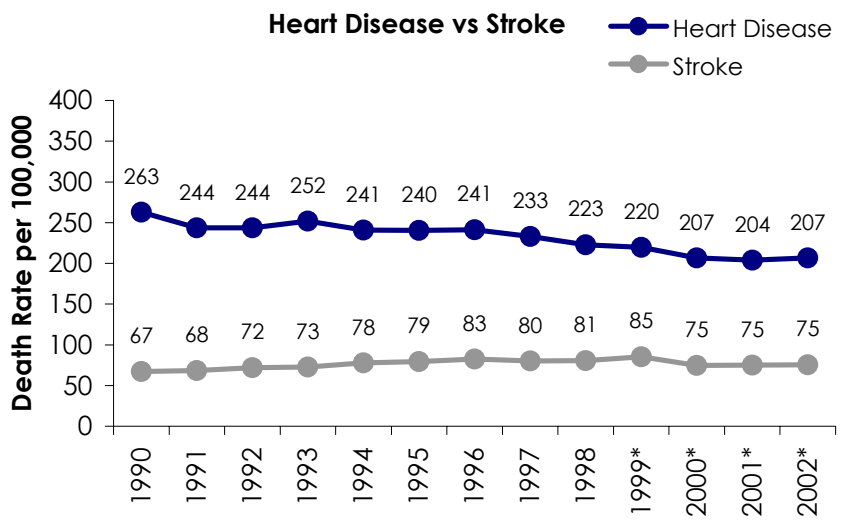
Prevalence of Selected Chronic Diseases, Oregon, 2000-2001

Prevalence	% of Oregon Adults
Arthritis	35%
Asthma	9%
Heart Attack	4%
Coronary Heart Disease	5%
Stroke	2%
Diabetes	6%

- Over a third of adults in Oregon report a chronic disease.
- Those with chronic diseases have higher death rates, incur higher costs, experience higher rates of depression, and are more frequently limited from performing their usual activities.

Source: Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003
Primary Source: BRFSS County Augment

Heart Disease and Stroke in Oregon, 1990 - 2002

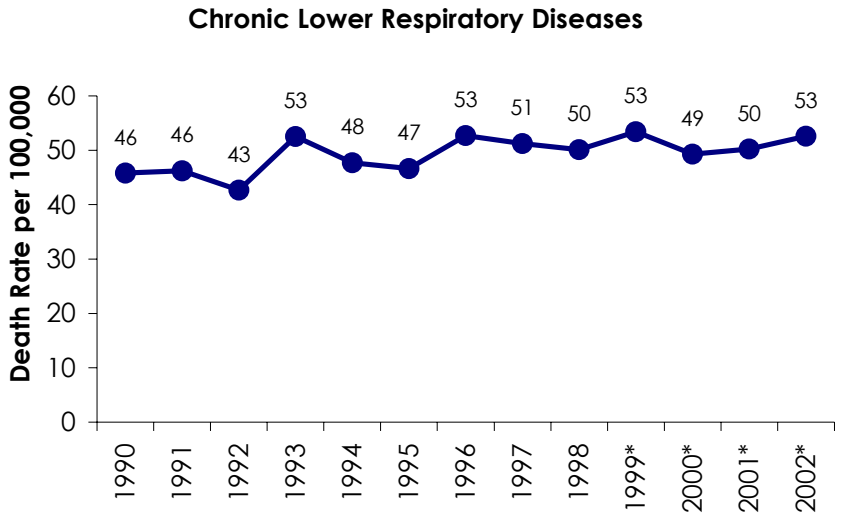


- Heart disease and stroke account for over 91% of cardiovascular disease deaths in Oregon.
- While heart disease death rates have declined since 1990, stroke death rates have increased in Oregon.
- In 2003, Oregon had the 3rd highest stroke death rate in the nation.

*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2002, Table 6-3 From Volume 2

Chronic Lower Respiratory Disease (CLRD) in Oregon, 1990 - 2002

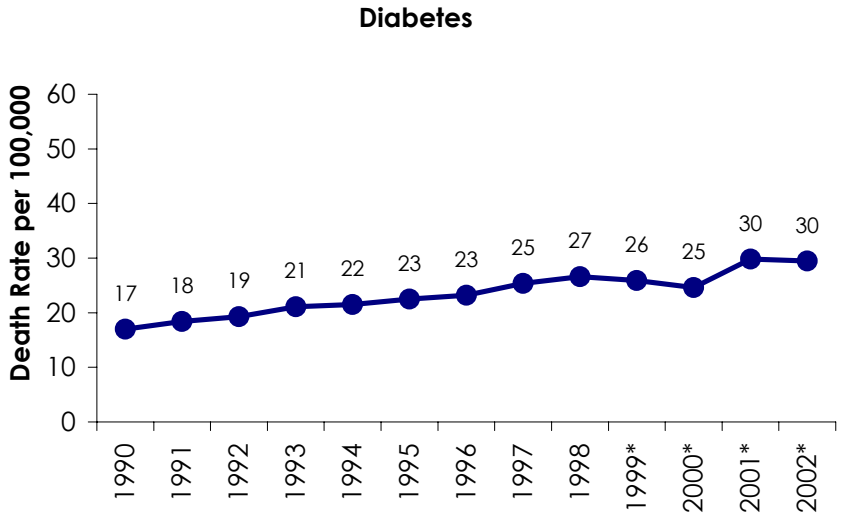


- CLRD includes chronic bronchitis, emphysema, asthma, and chronic airway obstruction.
- Hospital charges for CLRD in 2000 were over $44 million.
- Almost 90% of CLRD can be attributed to cigarette smoking.

*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2002, Table 6-3 From Volume 2 (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (Hospital Charges and the Role of Cigarette Smoking)

Diabetes in Oregon, 1990 - 2002



- In Oregon, the diabetes death rate has nearly doubled since 1990.
- Risk of diabetes increases with age, and is higher among those who are obese and/or not physically active.

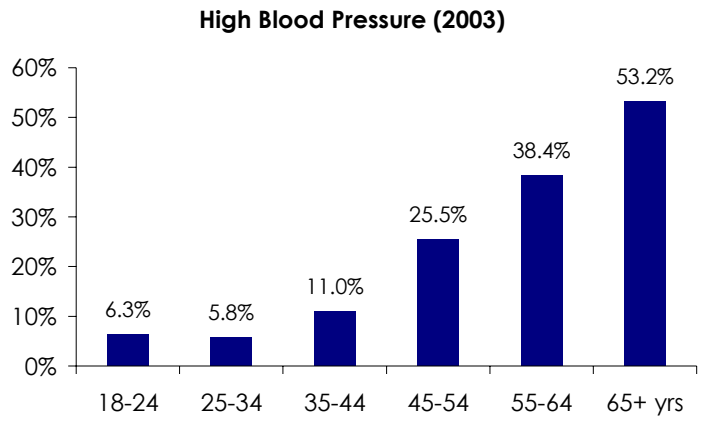
*From 1990-1998, deaths were classified according to the 9th revision of the International Classification of Diseases (ICD-9); starting in 1999, deaths were classified according ICD-10.

Sources: Oregon Vital Statistics Report 2002, Table 6-3 From Volume 2 (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (hospital charges, risk factors)

Risk Conditions[66]

Risk conditions such as high blood pressure, high cholesterol, and obesity are strongly related to many of the chronic diseases described above. Screening for these conditions can help to detect chronic disease early in its development, and decreasing prevalence of these conditions is important to reducing chronic disease burden in the population.

High Blood Pressure in Oregon

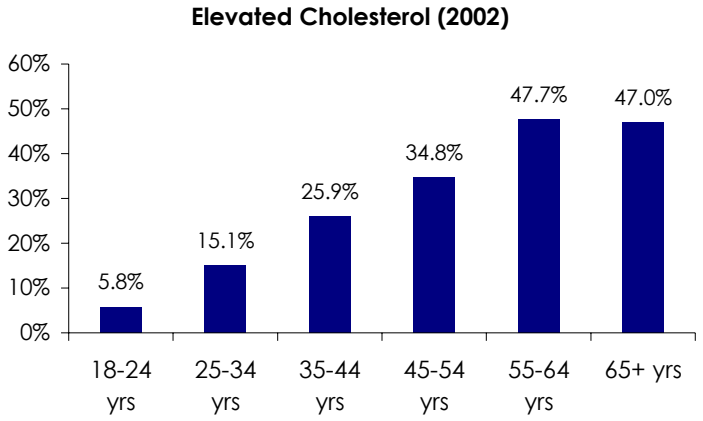


- Over 23% of adults in Oregon have been diagnosed with high blood pressure.
- Those with chronic disease are more likely to report high blood pressure.
- Physical activity is important for reducing the risk of high blood pressure as well as controlling high blood pressure.

Source: BRFSS 2003, http://www.dhs.state.or.us/publichealth/chs/brfs/03/hyper/chhipres.cfm <01.25.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

Elevated Cholesterol in Oregon, 2003

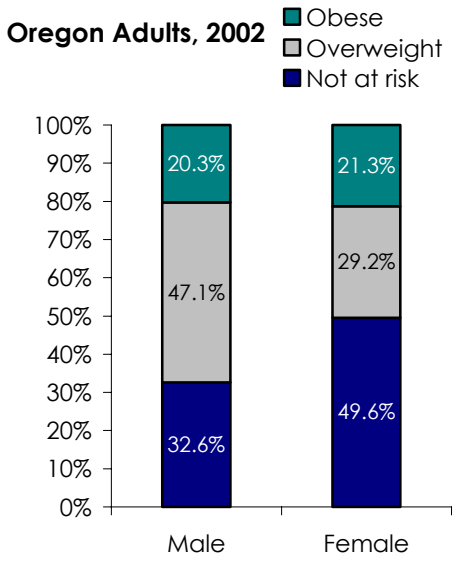
- Elevated cholesterol is an important risk factor for heart disease.
- 34% of adults in Oregon have been diagnosed with high cholesterol; older adults are at higher risk.
- Over 50% those with cardiovascular disease and diabetes report high cholesterol.
- Physical activity, diet, and tobacco are key behaviors that impact cholesterol level.

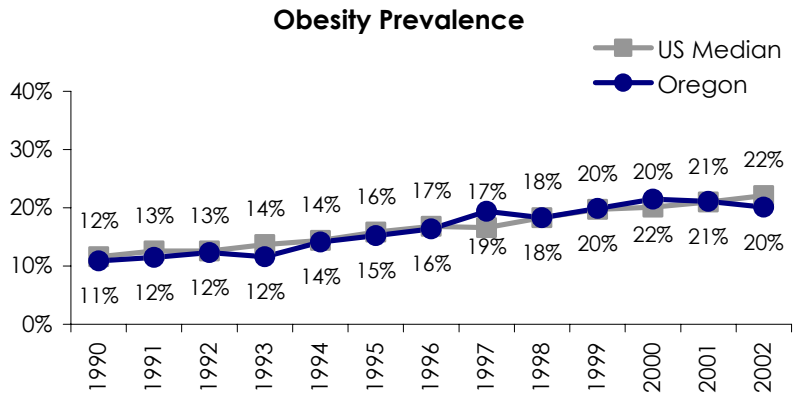


Source: BRFSS 2003, http://www.dhs.state.or.us/publichealth/chs/brfs/03/cholest/chhidiag.cfm <01.28.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

[66] *This section is based in large part on Oregon Department of Human Services' "Keeping Oregonians Healthy" report, June 2003.*

Obesity in Oregon, 1990 - 2002





- In 2002, 20.8% of adults in Oregon were obese, and 59.0% were either overweight or obese. Overweight and obesity are more prevalent among men than women.
- Obesity prevalence in adults and children combined has almost doubled since 1990 both nationally and in Oregon. Overweight is also a growing problem among children and particularly among adolescents.
- Overweight and obesity are usually a result of poor diet and physical inactivity.
- Obesity is linked to a wide range of diseases including cardiovascular disease, some cancers, and especially diabetes.

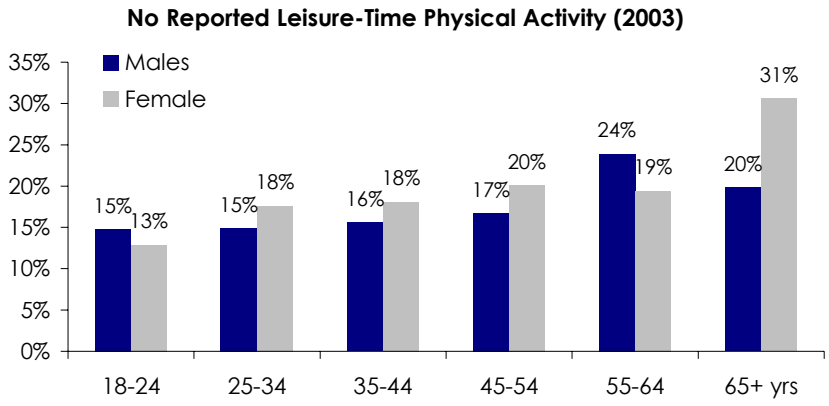
Source: BRFSS 2002, http:// www.dhs.state.or.us/publichealth/chs/brfs/02/dem/rfbmi2cat.cfm <01.05.05> (2002 data); Centers for Disease Control and Prevention, BRFSS, http://apps/nccd/cdc.gov/brfss/trends/TrendData.asp (prevalence trends); Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003 (risk factors and consequences)

Modifiable Risk Factors[67]

The chronic diseases and risk conditions described above are influenced by many inter-related factors including genetic predisposition, environmental exposure, social circumstances such as socioeconomic status, medical care, and behavioral patterns. Some of these factors can be changed, while others cannot. Three key health behaviors – tobacco use, physical activity, and diet – can impact the development of chronic and/or risk conditions and are discussed in this section. Further, behavior, while modifiable, is influenced by one's community conditions; for example, sidewalks, transit facilities, recreation facilities and greenways located closer to people's homes make it easier to incorporate exercise into a daily routine.

[67] *This section is based in large part on Oregon Department of Human Services' "Keeping Oregonians Healthy" report, June 2003.*

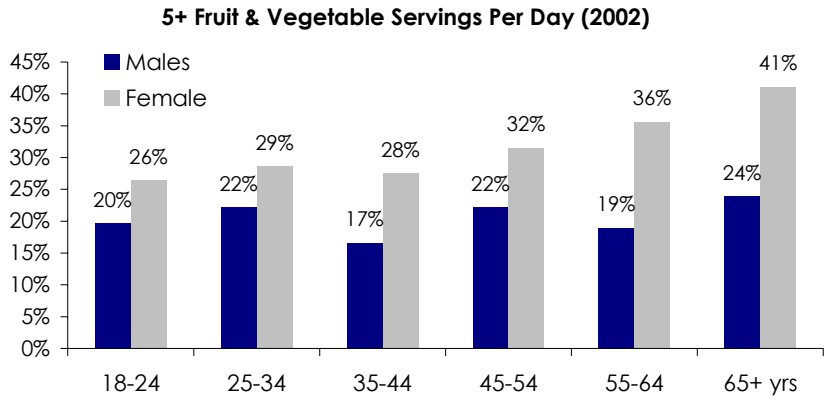
Physical Activity in Oregon, 2003



- 18.9% of Oregon adults do not report any leisure-time physical activity.
- Lack of physical activity is more common with increasing age and for females.
- Sedentary lifestyles increase the risk for obesity and many chronic diseases.
- Physical activity is strongly related to one's community surroundings.

Source: BRFSS 2003, http://www.dhs.state.or.us/publichealth/chs/brfs/03/hyper/brfsqu03.cfm <01.25.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

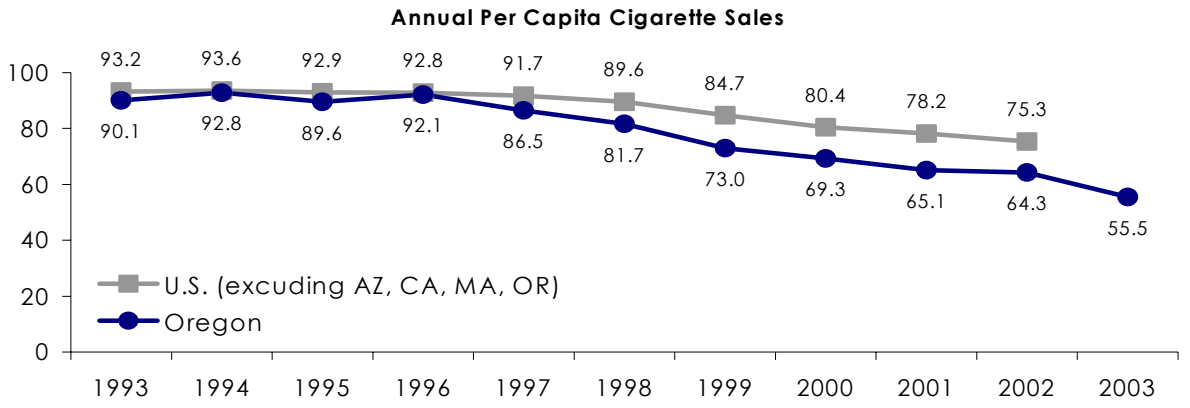
Healthy Diets in Oregon, 2002

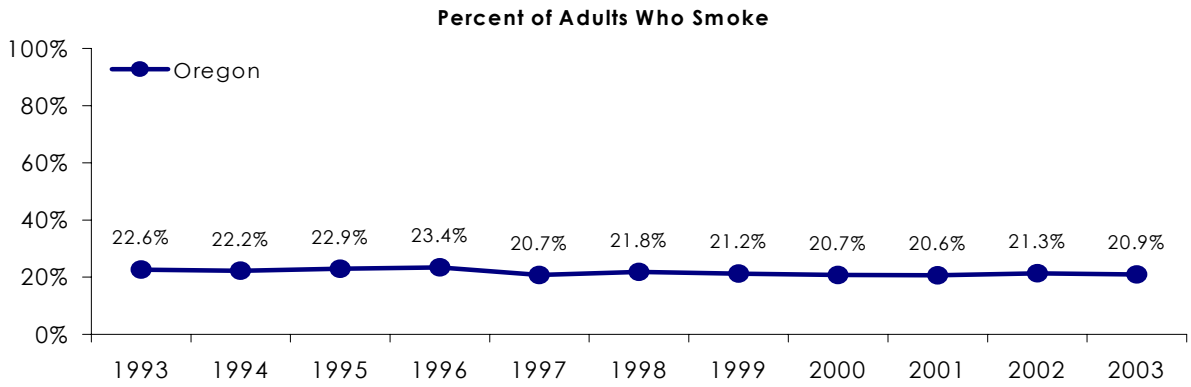


- While a healthy diet is composed of a wide variety of foods, fruit and vegetable consumption is a good marker for diet quality.
- Only 26.4% of Oregon adults report eating five or more servings of fruits and vegetables per day.
- Women are more likely than men to meet this recommendation, especially in older age groups.
- Only about a quarter of young Oregonians meet the recommendation.

Source: BRFSS 2002, http://www.dhs.state.or.us/publichealth/chs/brfs/02/nutrition/frtindx.cfm <01.25.05> (graph); Keeping Oregonians Healthy, Oregon Department of Human Services (risk factors)

Tobacco Use in Oregon, 1993 - 2003





- While cigarette sales have declined, smoking trends have remained relatively flat. In 2001, over 500,000 Oregon adults reported using tobacco.
- Younger adults and those with lower education attainment and household income are more likely to report tobacco use.
- Tobacco elevates the risk of developing cardiovascular disease, some cancers, respiratory diseases, and others. There were 7,016 tobacco-related deaths in 2002.

Source: Keeping Oregonians Healthy, Oregon Department of Human Services, June 2003;
Primary Data Sources: Oregon Department of Revenue, Research Triangle Institute, BRFSS

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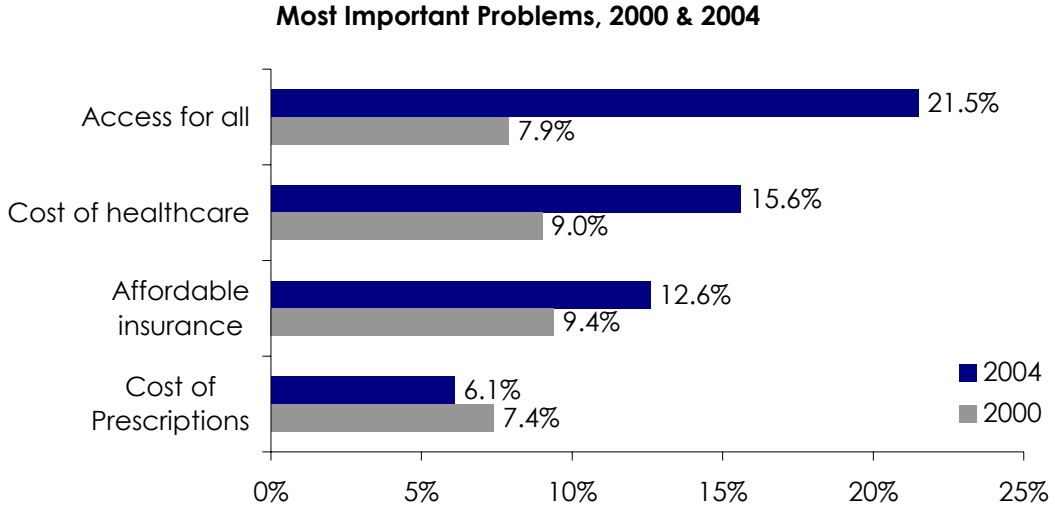
CHAPTER 8
OREGON'S HEALTH VALUES

In this chapter:

- The 2004 Oregon Health Values Survey

The 2004 Oregon Health Values Survey

The immense amount of data and information associated with health services and health status generally serve a common purpose – to describe the people, resources, and tradeoffs involved in health and health care. This information is gathered and presented in the hope of informing policy makers in the state, but the Oregon public is a key stakeholder as well. Oregon has a long history of involving the public in the policy process, especially in the health care arena. Beginning in 1982, the Oregon Health Council established Oregon Health Decisions (OHD), which became an independent citizen organization dedicated to bringing the public into the process of shaping health policy. As part of that effort, OHD has conducted a statewide health values survey periodically since 1996 to assess Oregonian's basic values around health care policy issues. The 2004 Health Values Survey, a telephone survey conducted with 531 Oregonians yielded these key findings:[68]



Source: Health Values Survey 2000 & 2004

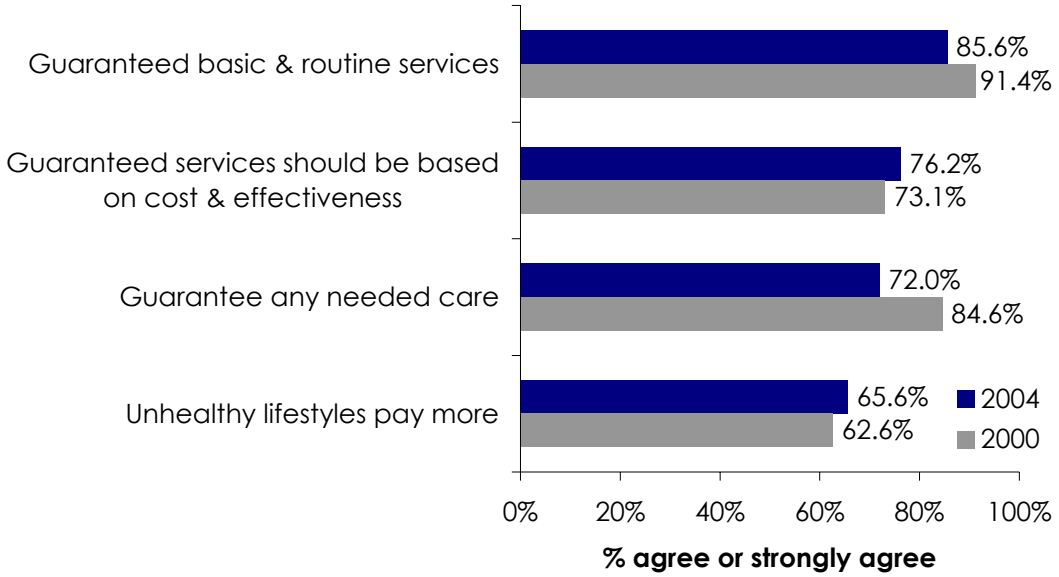
Note: Problems are ranked in descending order of 2004 frequency

[68] *Adapted from Oregon Health Decisions' Health Values Survey 2004 report, November 2004.*

Oregonians report that access for all and costs of health care and insurance were the top three health care problems that need to be solved in Oregon. An estimated 21.5% indicated that access for all was the most important issue, followed by concerns about the cost of health care and affordable insurance. The degree of consensus about these issues in 2004 is important to note; in 2000, cost of health care, affordable insurance, and cost of prescriptions were ranked as the top three concerns, but less than 10% cited any given reason.

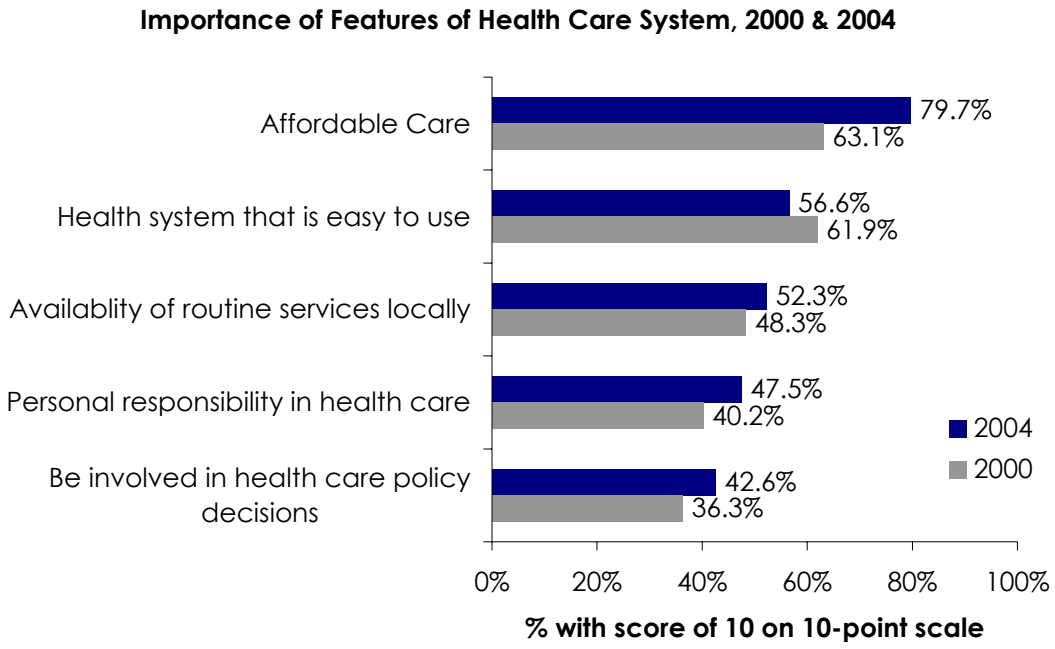
The vast majority of the public believes that all Oregonians should be guaranteed *basic* and *routine* health care services. Eighty-five percent agreed with this concept, but fewer agreed that *any* needed care should be guaranteed for all. Support for guarantees access has declined slightly from 2004, but Oregonians increasingly support basing decisions regarding guaranteed services on cost and effectiveness of the treatment.

Opinions about Guaranteeing Access, 2000 & 2004



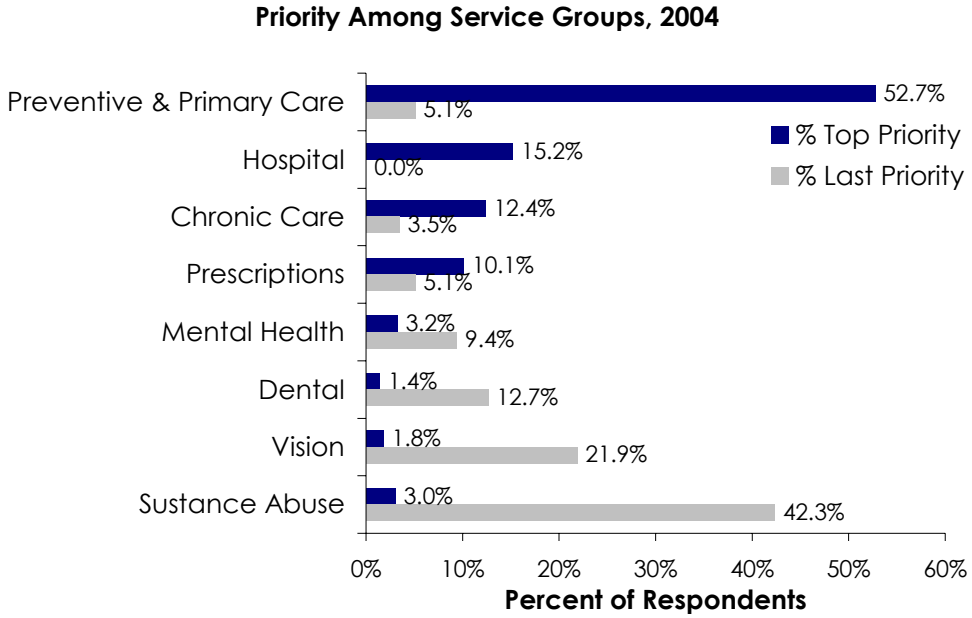
Source: Health Values Survey 2004

Affordability of care, ease of use, and availability of routine services locally were all ranked high as important features of the health care system. Affordable care, local access, and personal responsibility in health care were ranked higher in 2004 than they were in 2000.



Source: Office for Oregon Health Policy and Research, Health Values Survey 2004

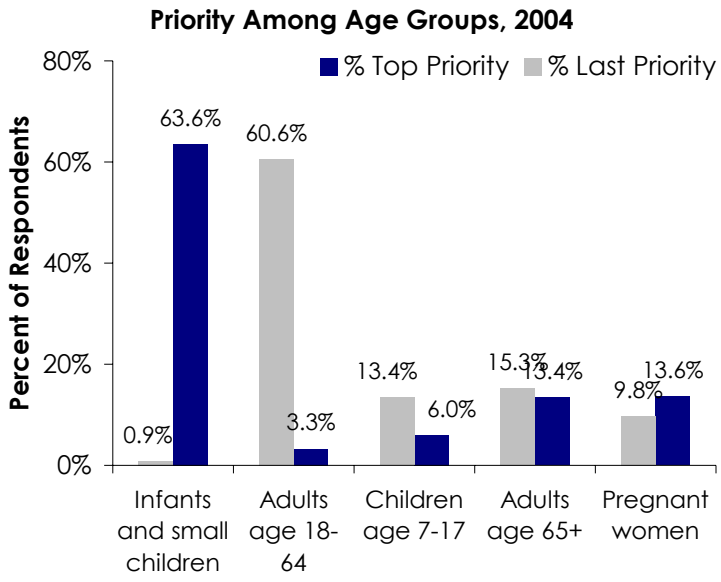
When choosing between services to include in coverage for all Oregonians, the public cited preventive and primary care services as the overwhelming top priority. Reasons for this prioritization included cost efficiency and improvement of individual and social well-being. Substance abuse treatment was most often ranked as the last priority.



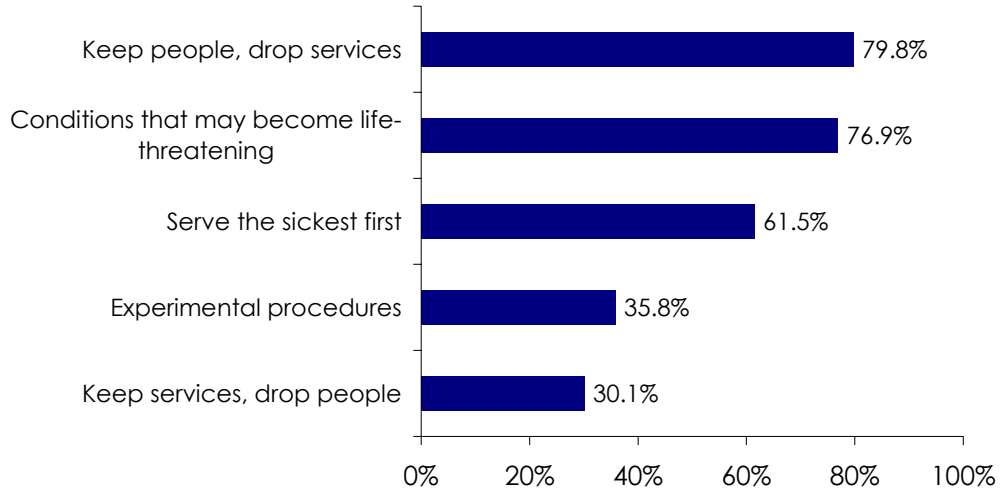
Source: Office for Oregon Health Policy and Research, Health Values Survey 2004

The public indicated that infants and small children should be prioritized first when allocating health care dollars for all Oregonians.

Oregonians strongly support the policy that, when funds are limited for the Oregon Health Plan, policy-makers should reduce services but keep as many people as possible in the program. Additionally, payment for treatments for conditions that may become life-threatening was supported, even if some treatments for less serious conditions may not be paid for.



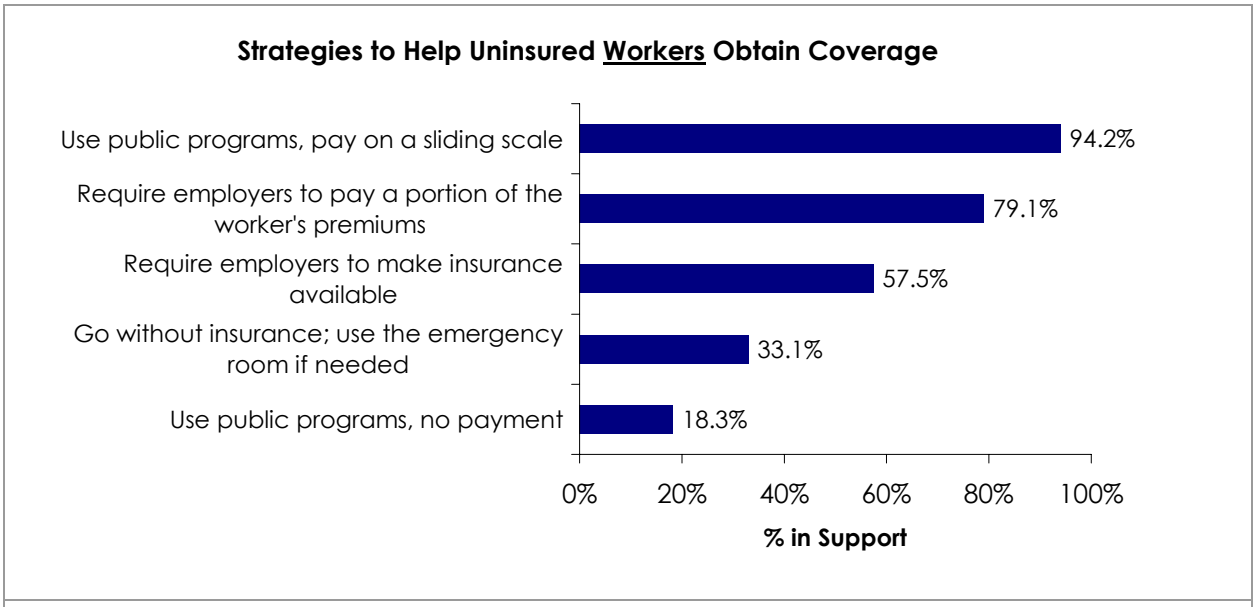
Source: Health Values Survey 2004



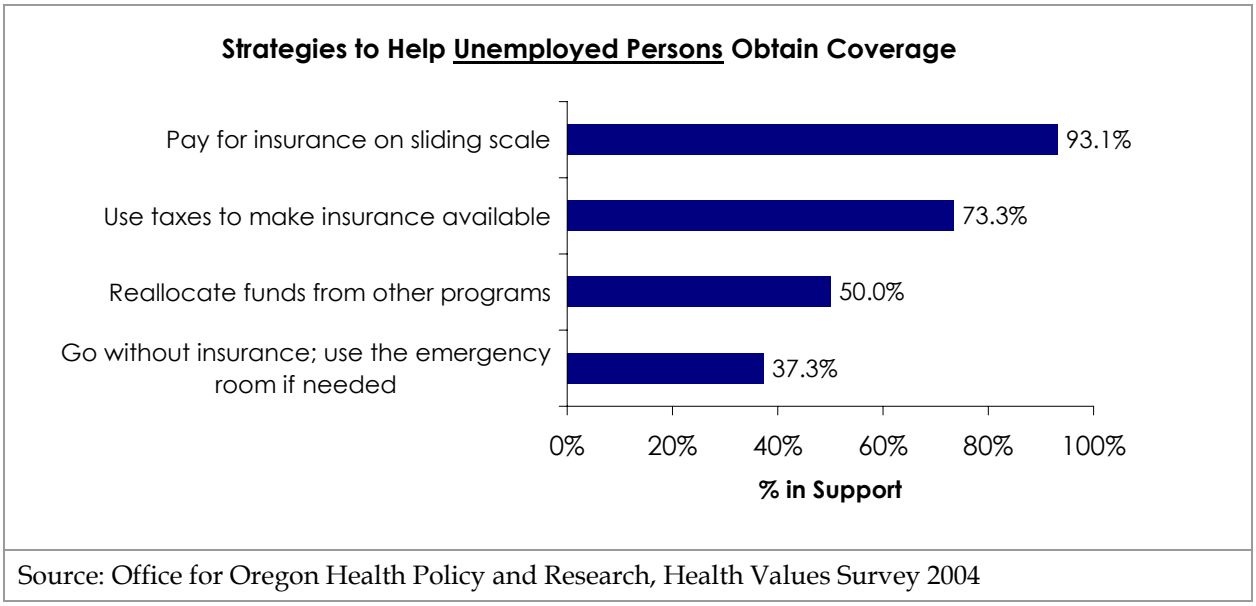
Source: Office for Oregon Health Policy and Research, Health Values Survey 2004

The public supports policies that help the uninsured obtain health coverage – most did not agree that having the uninsured remain without coverage, relying on emergency department care only, was a sound policy. Strategies for helping the uninsured obtain coverage included the following:

- Use of public programs for those who are employed and unemployed and use of tax dollars to make health insurance affordable
- Discounted/sliding scale payment for public programs and purchased insurance
- Required employer contribution to their worker's premiums



Source: Office for Oregon Health Policy and Research, Health Values Survey 2004



Source: Office for Oregon Health Policy and Research, Health Values Survey 2004

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APPENDIX A
TIMELINE OF OHP2 CHANGES

August 2004

(8/17/04) Federal officials authorized Oregon to begin levying an industry-supported tax on selected Oregon hospitals to help support a scaled-down Oregon Health Plan. Approval permits the state to continue offering the Health Plan's Standard benefit package to an estimated 24,000 low-income adults who otherwise would not qualify for Medicaid coverage. Earlier, the state received federal approval to levy a provider tax on 31 managed care insurance plans that serve OHP clients.

(8/1/04) As directed by the 2003 Legislature under House Bill 2511, the OHP Standard benefit package will consist of the following core set of services:

- physician services
- ambulance
- prescription drugs
- laboratory and x-ray services
- limited durable medical equipment and supplies
- outpatient mental health
- outpatient chemical dependency services
- emergency dental service

Although not part of the core set of services, the Standard benefit package will also include:

- hospice
- limited hospital benefit.

  Briefly, the limited hospital benefit will include:
  (1) evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the prioritized list);
  (2) hospital treatment for all emergency services;
  (3) urgent conditions for which prompt treatment will prevent life threatening health deterioration; a subset of number three that will require prior authorization

The following optional services will not be included within the redefined Standard benefit package:

- therapy services (physical therapy, speech therapy, occupational therapy)
- acupuncture (except for the treatment of chemical dependency)
- chiropractic services
- home health services / private duty nursing
- vision exams and materials*

- hearing aids and exams for hearing aids*
  non-ambulance medical transportation*

July 2004

- Due to a lack of state funds, OHP will stop enrolling **new** clients into the Oregon Health Plan (OHP) Standard benefit package (July 1, 2004)

June 2004

- As a result of Spry v U.S. Department of Human Services, Centers for Medicare and Medicaid Services and the Oregon Department of Human Services, a U.S. District Court has ordered the state to discontinue all co-pays for Oregon's Medicaid expansion population, OHP Standard, effective June 19, 2004.
- Require pharmacies to bill insurance carriers before billing Medicaid for clients who have prescription drug insurance coverage
- In order to meet budget requirement, the OHP Standard program will be capped at 25,000. June enrollment is at 56,000 people; if attrition alone does not project to an enrollment of 25,000 by July 2005, the income eligibility for OHP Standard may have to be reduced from 100% FPL

May 2003

- Enhanced exception process implemented to prescribe non-physician drug list (PDL) drugs in evaluated classes for fee-for-service clients
- Increased reimbursement rates to institutional pharmacies

April 2003

- Reduce payments to pharmacies from Average Wholesale Price minus 14% to minus 15% (pending CMS approval)
- Eliminate coverage for survival priority levels 12-14 in the long term care system. Many of these individuals will also lose their OHP medical coverage.
- Reinstate coverage for anti-rejection (transplant) and antiviral (HIV) drugs for former Medically Needy clients (through June 2003)**

March 2003

- Further reduce OHP Standard benefit package by eliminating:
- Remainder of dental benefit
- Coverage of medical supplies
- Coverage of outpatient mental health services
- Coverage of outpatient chemical dependency services

*** Coverage of these services is currently ongoing*

- Coverage of prescription drugs (reinstated from mid-March through June 2003)*
- Move beginning date of eligibility to first of month following eligibility determination for OHP Standard population
- Reduce reimbursement rates to DRG hospitals (50 beds or more) by 12% for inpatient services and outpatient services. Eliminate outlier payments to DRG hospitals except for infants under age 1 served in Disproportionate Share Hospitals

February 2003

- Expand coverage for pregnant women and children under age 19 from 170% FPL to 185% FPL
- Establish OHP Standard benefit package. (0-100% FPL; $6-$20 per person per month based on income)
  Changes include:
  - Elimination of coverage for vision exams and eyeglasses
  - Elimination of non-emergency medical transportation
  - Elimination of most medical equipment
  - Elimination of hearing Aids and related exams
  - Reduced dental benefits
  - Mandatory co-pays for following services (OHP Standard, FFS and MC)*69*:

Inpatient Hospital	$250 per admission
Outpatient Hospital	$20 for each outpatient surgery
	$5 for other outpatient service
Emergency Department	$50 but waived if admitted to hospital
Physician services	$5 per visits
	$5 for medical surgical procedures
	Most preventative services & immunizations
	Exempt from co-payments
Lab and X-ray	$3 per lab or x-ray
Ambulance	$50
Home health care	$5 per visit
PT/OT/ST	$5 per visit

- Establish more stringent premium policy for OHP Standard clients

  (Individuals are disenrolled for at least 6 months if they cannot pay premiums)
- Can be denied services if they cannot pay co-pays
- Establish 6-month uninsurance requirement for new OHP Standard clients
- Begin roll-out of Senior Prescription Drug Assistance Program

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** Prescription drug coverage is currently ongoing*
69 Co-pays discontinued as a result of U.S. District Court Order, see June 2004.

- Eliminate coverage for survival priority levels 15-17 in the long term care system. Many of these individuals will also lose their OHP medical coverage.
- Eliminate Medically Needy program (see April change)
- Eliminate remaining safety net clinic funding

January 2003

- Implement voluntary co-pays on drugs ($2 generic/$3 brand) and ambulatory services ($3) for OHP fee-for-service clients
- Eliminate coverage for Lines 559-566 on the Prioritized List of Health Care Services

November 2002

FHIAP program now included under OHP2 waiver for federal match (previously state-only funding)

- Opened up for increased enrollment

October 2002

OHP2 Waiver approved by CMS

APPENDIX B
FEDERAL POVERTY GUIDELINES BY PERCENT OF POVERTY AND FAMILY SIZE

ANNUAL

Size of Family	PERCENT OF POVERTY							
	100%	133%	150%	185%	200%	250%	300%	350%
1	$9,310	$12,382	$13,965	$17,224	$18,620	$23,275	$27,930	$32,585
2	$12,490	$16,612	$18,735	$23,107	$24,980	$31,225	$37,470	$43,715
3	$15,670	$20,841	$23,505	$28,990	$31,340	$39,175	$47,010	$54,845
4	$18,850	$25,071	$28,275	$34,873	$37,700	$47,125	$56,550	$65,975
5	$22,030	$29,300	$33,045	$40,756	$44,060	$55,075	$66,090	$77,105
6	$25,210	$33,529	$37,815	$46,639	$50,420	$63,025	$75,630	$88,235
7	$28,390	$37,759	$42,585	$52,522	$56,780	$70,975	$85,170	$99,365
8	$31,570	$41,988	$47,355	$58,405	$63,140	$78,925	$94,710	$110,495

MONTHLY

Size of Family	PERCENT OF POVERTY							
	100%	135%	150%	185%	200%	250%	300%	350%
1	$775.83	$1,031.86	$1,163.75	$1,435.29	$1,551.67	$1,939.58	$2,327.50	$2,715.42
2	$1,040.83	$1,384.31	$1,561.25	$1,925.54	$2,081.67	$2,602.08	$3,122.50	$3,642.92
3	$1,305.83	$1,736.76	$1,958.75	$2,415.79	$2,611.67	$3,264.58	$3,917.50	$4,570.42
4	$1,570.83	$2,089.21	$2,356.25	$2,906.04	$3,141.67	$3,927.08	$4,712.50	$5,497.92
5	$1,835.83	$2,441.66	$2,753.75	$3,396.29	$3,671.67	$4,589.58	$5,507.50	$6,425.42
6	$2,100.83	$2,794.11	$3,151.25	$3,886.54	$4,201.67	$5,252.08	$6,302.50	$7,352.92
7	$2,365.83	$3,146.56	$3,548.75	$4,376.79	$4,731.67	$5,914.58	$7,097.50	$8,280.42
8	$2,630.83	$3,499.01	$3,946.25	$4,867.04	$5,261.67	$6,577.08	$7,892.50	$9,207.92

Effective, April 2004