Office for Oregon Health Policy and Research

Healthy Kids Plan:

Medicaid Advisory Committee Recommendations

A Report to Governor Ted Kulongoski

May 2006

May 17, 2006

The Honorable Ted Kulongoski
Governor of Oregon

Dear Governor:

As you requested, the Medicaid Advisory Committee (MAC) has reviewed key issues in the design of the Healthy Kids program. The MAC's recommendations on these issues form the body of this report. Also included are a) a brief description of the context in which the MAC review took place, b) a summary of the statewide meeting process through which the MAC sought and received public input, and c) appendices containing supporting materials.

In addition to its recommendations, there are several points the MAC would like to make about the proposed Healthy Kids program. First, we applaud your commitment to expanding health coverage and access for all Oregonians, and the MAC looks forward to working with you to develop programs for uninsured adults, particularly uninsured parents and adults with chronic conditions. Untreated illnesses such as hypertension, diabetes, and depression cause suffering and disability for many of the state's low-income uninsured adults, and parents are more likely to apply for health insurance for their children if health insurance is also available to them.

Second, it is critical that Healthy Kids will mean all Oregon children are eligible for comprehensive, affordable health insurance. The MAC fully supports your intention to ensure that factors such as income, health status, and citizenship status will no longer interfere with an Oregon child's ability to access needed health care. Every child is owed a healthy start in life regardless of decisions made by that child's parents, and every child living in our state is a member of the Oregon community.

Third, we fully support your commitment to develop outreach programs to identify, enroll, and retain in the Healthy Kids program the estimated 60,000 children who are already eligible for Medicaid or CHIP coverage but remain uninsured. It would be a tragic mistake to focus on uninsured children at higher income levels without also finding a way to cover those already eligible who live at or near poverty level.

Fourth, Healthy Kids will set an important precedent by virtue of its availability to uninsured children of all income levels, including those in families above the income

limit for subsidies who decide to pay full premium. In effect, this means that the purpose of an application for Healthy Kids is to determine how much help a family needs in affording health coverage for its uninsured children. This is particularly important given that the fastest growing segment of the uninsured population is the middle class. With Healthy Kids, no uninsured child will be ineligible, just as no child will be "second rate." The MAC looks forward to working with the Governor's Office and the Legislature in expanding this inclusive and means-tested approach to cover all uninsured Oregonians.

Finally, we want to reiterate our support for your position that school-based clinics, safety net clinics, and other providers of care to vulnerable children should be fully included in the Healthy Kids provider networks.

The process of developing our recommendations on Healthy Kids has been both challenging and gratifying. We are pleased to submit this report, but realize that our work on Healthy Kids is not done. As the various state agencies move into the implementation planning phase, the MAC will assist in any way it can to assure that Healthy Kids fulfills its great promise.

There are several issues (in addition to expanding coverage for adults) that the MAC intends to address in the future. These issues include a) the design elements of the next Oregon Health Plan federal demonstration and the application for needed federal waivers, b) sustainable funding for public health insurance programs, and c) long-term care. In addition, the MAC may want to revisit the issues of children with special needs and children using mental health services. We look forward to collaborating with your office on those efforts, as well.

Please let us know if there is any part of these recommendations in need of clarification, or if there is any other assistance we can provide your office.

Sincerely,

Tina Kotek
Co-Chair
Medicaid Advisory Committee

Carole Romm
Co-Chair
Medicaid Advisory Committee

Medicaid Advisory Committee Report

Submitted to Governor Kulongoski

May 17, 2006

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Medicaid Advisory Committee's Recommendations for the Healthy Kids Plan – *Executive Summary*

The following is a summary of the MAC recommendations on Healthy Kids. The full recommendations are found later in this report, with rationale and supporting data for each recommendation.

1. Period of enrollment: children eligible for Healthy Kids should be enrolled for 12 continuous months.

2. Period of uninsurance: there should be no eligibility requirement of any particular period of uninsurance.

3. Assets: there should be no asset limit for Healthy Kids.

4. Health Status: in the interest of community rating as a policy objective, all children should be eligible to enroll in Healthy Kids regardless of health status.

5. Outreach: there should be an appropriately funded aggressive outreach effort to bring uninsured children into Healthy Kids.

6. Federal Matching Funds: for all components of Healthy Kids, the state should maximize the use of matching federal dollars available to Oregon.

7. Multiple Approaches: Healthy Kids should be composed of three coordinated elements: Oregon Health Plan (OHP) Medicaid and Children's Health Insurance Program (CHIP), Family Health Insurance Assistance Program (FHIAP), and a new state sponsored insurance plan for insurance for children. This new state insurance plan might be operated under risk contract by health plans, or might be operated by the state as a separate pool.

8. Cost Sharing: Healthy Kids should include income-appropriate cost sharing, and further premium sharing should be the primary means of cost sharing.

9. Delivery Systems: the Oregon Department of Human Services (DHS) should make specific preparations to assure that the OHP system will be able to deliver needed care to newly eligible children covered through Healthy Kids.

10. Coordination for Health Policy Objectives: state agencies should design Healthy Kids as part of a larger health policy agenda consistent with universal coverage and access to care.

11. Employer-Sponsored Insurance: the Department of Human Services, the Insurance Division, and the Office of Private Health Partnerships should closely monitor the employer-sponsored health insurance market for signs of a shift of funding responsibility from employers to government programs. DHS and FHIAP should take steps to encourage employer contributions to health insurance.

Problem, Background, and Approach

The Problem – Uninsured Kids

Governor Kulongoski noted in a February 24, 2006 press release that:

- More than 117,000 children were without health insurance as of the summer of 2004.
- Uninsured children lack access to doctors, medicine, eyeglasses, asthma inhalers, and other health care services people with insurance take for granted.
- Nearly half of these uninsured children may already be eligible for coverage under Oregon's Medicaid or CHIP programs but are not enrolled.
- Thousands more are from working families who earn too much to qualify for Medicaid or CHIP but not enough to pay for private insurance

Key Components of Healthy Kids

In the same press release, the Governor proposed to address the problem of uninsured children three ways:

1. Continue expanding school-based health centers.
2. Improve and expand access to the state's Medicaid and CHIP programs.
3. Expand health coverage for kids by giving parents with higher incomes (too high to qualify for federal programs) the opportunity to buy affordable, state-subsidized group coverage for their children.

Governor Kulongoski identified the following key components:

- All uninsured Oregon children up to age 19 are eligible for coverage.
- Every child insured through Healthy Kids will have the same insurance card.
- Streamline the Healthy Kids and simplify the enrollment process by using existing programs and partnerships with schools, health care providers, and non-government organizations.
- All kids in families with incomes up to 200% of federal poverty level (for a family of four, about $40,000) will be eligible for comprehensive coverage through the existing Oregon Health Plan and Family Health Insurance Assistance Program (FHIAP) models.
- Families with incomes above 200% of federal poverty level will be eligible to buy affordable comprehensive group coverage for their children, including mental health and dental benefits; a sliding scale based on family income will determine the size of premium and co-pays.
- School-based health centers will expand into five new counties; and at least five more centers will open in the 19 counties that already offer school-based health care.

The MAC Process

Following the charge from the Governor, the MAC met over the last several months to discuss the Governor's vision for Healthy Kids and to work on its recommendations. MAC members heard presentations from health service researchers on the recently conducted Oregon Children's Access Survey and reviewed state data on the number of uninsured in Oregon. They looked at approaches to broader health coverage for children that other states had adopted and background requirements for expansion under the federal State Children's Health Insurance Program (SCHIP).

The MAC heard testimony from consumer advocates, health plans and insurers, school-based and safety net clinics, and state insurance division representatives, and asked questions of the Office of Medical Assistance Program (OMAP) and the Family Health Insurance Assistance Program (FHIAP) representatives. Through a federal state planning grant, the Office for Oregon Health Policy and Research (OHPR) contracted with an actuarial consultant to work with MAC members to look at potential benefit design options for some aspects of Healthy Kids. OHPR, OMAP and FHIAP staff also assisted MAC members in designing and implementing an approach to obtain statewide public input through a series of community meetings (see below). All of these informational resources were reviewed and discussed as the MAC developed their final recommendations.

The MAC Community Meetings

In April and May of 2006, the MAC held six public meetings to gain input about values relating to Healthy Kids. These meetings were held in Medford, Bend, Newport, Corvallis, Portland, and La Grande. Oregon Health Action Campaign contracted to handle logistics and get the word out to those who might want to participate by sharing their ideas about health insurance for children.

In particular, the MAC sought information about:

- how much can reasonably be expected as cost sharing from families at various income levels.
- what kinds of outreach and public education are likely to be most effective in identifying uninsured children and motivating their parents to get and keep them enrolled in health coverage.

Participants were also asked to identify other issues the state should take into account in designing programs to cover uninsured children, and were given a questionnaire to return.

Each meeting included MAC members and staff, as well as staff from the four key state agencies involved (Office for Health Policy and Research, Office of Medical Assistance Programs, Family Health Insurance Assistance Program and Department of Human Services). In addition, a graduate student intern in public policy attended all meetings and helped to develop the record of proceedings included in this report.

Attendance at these meetings was modest, but the discussions were uniformly robust and productive. It quickly became clear that many of the advocates for low-income families might

themselves be eligible for Healthy Kids if their children were uninsured. The Chief Fiscal Officer for one safety net clinic noted that the cost of health insurance for employees' families has become unsupportable even for those who are in the business of providing health care to children. In general, participants confirmed the MAC's assumptions that affordability of health insurance is a real and growing problem for working class and middle class families, and that it is important to require premium sharing indexed to family income. Participants also generally agreed that premium sharing should be the main portion of cost sharing, though modest copays were also deemed acceptable. Deductibles and coinsurance were generally viewed less favorably due to the potential of severe liability for families with sick children and modest incomes.

Regarding outreach and public education, participants made it clear that schools and day care centers are important sites, along with clinics (including school-based clinics) where care is provided to children. Several other promising outreach sites were also suggested, as well as methods for getting information across effectively.

The community meetings began with introductions of state staff and MAC members, and a slide presentation about the MAC and its role in Healthy Kids, with a general description of what Healthy Kids is intended to do and how it might operate. The participants broke into small discussion groups of five to ten people, facilitated by MAC or state program staff. After an hour of discussion, the small groups reported back in plenary session and a moderator asked clarifying questions and noted points of agreement and disagreement. Two hours was allocated for each of these meetings, but they typically ran 15 to 30 minutes longer.

In addition to these six community meetings, a seventh meeting of representatives from Oregon's racial and ethnic communities was held to develop more effective approaches for finding and enrolling these uninsured children. Participants at all seven meetings were invited to visit the OHPR web site to follow developments in the design of Healthy Kids.

See Appendix C for a summary of the proceedings at each of these meetings.

Recommendations for Healthy Kids

The following recommendations were developed by the Medicaid Advisory Committee (MAC) under a set of guiding principles:

1. All uninsured Oregon children should be eligible under Healthy Kids for comprehensive, affordable health coverage.
2. Effective outreach is needed to find all uninsured children and simplified eligibility and enrollment is needed to cover them.
3. In order for health insurance to be affordable, families need the ability to accommodate health costs into their monthly budgets in a predictable way.
4. The financial risk for health care costs should be spread as broadly as possible so that the costs of care for the sick are shared by the well.
5. Since coverage without access is ineffective in improving health, Healthy Kids should be designed so as to assure that enrollment into coverage means access to needed care.
6. The state should assure that Healthy Kids provides access to culturally competent providers.

Healthy Kids is envisioned as a single program with a single card and a “no wrong door” approach to outreach, eligibility determination, and enrollment. However, it is also anticipated that Healthy Kids will offer options within this integrated approach, depending on family income and other insurance available.

The recommendations are interrelated but are presented for the sake of clarity in two sections: (1) Eligibility and Enrollment, and (2) Benefit Structure.

All recommendations have the same policy objectives: a) get all Oregon children covered; b) assure them access to needed health care; and c) make this coverage and access affordable to the state and to the families in the Healthy Kids.

Recommendations are in bold.

Section I: Eligibility and Enrollment

1. **<u>Period of enrollment</u>: The MAC recommends that children eligible for Healthy Kids be enrolled for 12 continuous months.**

   <u>Rationale</u>
   - 12 months of enrollment is consistent with group coverage and many of these children will be covered through subsidized group coverage.
   - Increasing the enrollment period will reduce gaps in coverage and so will increase the effectiveness of health maintenance, preventive care and management of chronic conditions.
   - Less frequent recertification will result in administrative savings.

   <u>Supporting Data</u>
   - 12 months of enrollment is consistent with group coverage and many of these children will be covered through subsidized group coverage.

2. **<u>Period of uninsurance</u>: The MAC recommends that there be no requirement of a period of uninsurance to become eligible for Healthy Kids.**

   <u>Rationale</u>

   - Requiring a lengthy period (e.g., 6 months) without health insurance creates a significant risk of reduced health status for certain kids and thus runs contrary to the fundamental purpose of the Healthy Kids.

   - The MAC recommends close monitoring for "crowd-out" (as is done in New York) in order to avoid expending limited resources on children who were already insured rather than on the target population of uninsured children. If a significant shift from private to public financing of insurance for children occurs, then a short period of uninsurance can be added to the eligibility criteria.

   - In the event that monitoring for "crowd-out" leads to a required period of uninsurance prior to enrollment in Healthy Kids, children with disabilities or chronic diseases should be exempt from the requirement. Similarly, children in families whose employers left the state or went out of business should be exempt.

3. **<u>Assets</u>: The MAC recommends that there be no asset limit for Healthy Kids.**

Rationale

- Attaining self-sufficiency depends on a family's ability to build financial reserves. The cost of health coverage can prevent that for families with modest resources.

- The availability of assets to parents should not interfere with expanding health coverage to uninsured children since those resources could be depleted within days in the event of a serious illness or injury.

- Removing the need to determine family assets will result in simplification and administrative savings.

Supporting Data

- 47 of 51 Medicaid programs in the country, including Oregon's, do not currently have an asset limit for children. However, Oregon is one of three states that currently have an asset limit for SCHIP-funded Medicaid expansion programs for children[1].

- An actuarial review performed by Mercer showed that the impact of deductibles and coinsurance can be substantial ($10,000 or more) on a family with more than one child requiring hospital or other expensive care (see appendices).

4. Health Status: The MAC recommends, in the interest of community rating as a policy objective, that all children be eligible to enroll in Healthy Kids regardless of health status.

However, it has been noted that there is a potential risk of adverse selection into the program by children with substantial health services needs with other health insurance options. Such adverse selection could threaten the sustainability of the program. Therefore, as a technical note, the MAC suggests that state agencies take suitable precautions to a) monitor for adverse selection into the pool, and b) if needed, apply a remedy to preserve the viability of the pool.

5. Outreach: The MAC recommends that there be an appropriately funded aggressive outreach effort to bring uninsured children into Healthy Kids. These efforts would aim to:

[1] *Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.*

- **Partner with organizations involved in health, social service, and education programs for children, which may include:**
  - **Schools (public and private) and school-based health services**
  - **Home school associations and support groups**
  - **Head Start**
  - **Child care**
  - **Safety net clinics, including rural and migrant clinics**
  - **Physician and dental offices**
  - **Hospitals**
  - **Pharmacies**
  - **Social service agencies**

- **Identify uninsured children and inform their parents about Healthy Kids.**

- **Increase outreach and retention for those children already eligible but not enrolled.**

- **Streamline enrollment and recertification processes to increase the likelihood that eligible children will be covered and stay covered. As part of this streamlining, there should be a "common application screening form" for Healthy Kids and it should be as short and straightforward as possible.**

- **To the extent possible, there should be a coordinated screening effort to link children with health and social services programs with similar eligibility requirements.**

- **The MAC further recommends that all outreach, eligibility, and enrollment efforts recognize the cultural diversity of Oregonians. Since no single approach will be equally effective with all Oregon communities, the MAC recommends that state agencies develop approaches appropriate to Oregon's various racial and ethnic communities. Similarly, different approaches may be more effective in rural and urban areas of the state.**

Rationale

- Families in the target population must be identified and engaged in dialogue before enrollment and retention can be maximized and the participation goals of Healthy Kids can be realized**.**

- Both increased retention and streamlined enrollment and re-enrollment will result in administrative savings.

- There should be "one-stop shopping" for eligibility determination.

- Feedback from public meetings indicated that income verification requirements (currently at four months) posed a significant a barrier to families with unstable or variable income such as self-employed and seasonal workers. Recommendations included allowing applicants to use the previous year's tax return as a verification option.

- Applications should be more widely and readily available at locations frequented by families of all income levels and where families in certain target populations tend to seek services.

- The linguistic and cultural diversity of Oregon's communities should be reflected in all outreach, eligibility, and enrollment materials and activities.

Supporting Data

- As of the summer of 2004, there were an estimated 117,000 uninsured children in Oregon, of whom approximately 60,000 were within the income guidelines for Medicaid or CHIP but were not enrolled in those programs.

- The Robert Wood Johnson Foundation Covering Kids pilot programs in Oregon are developing effective ways to reach the parents of uninsured children.

6. Federal Matching Funds: the MAC recommends that for all components of Healthy Kids the state should maximize the use of matching federal dollars available to Oregon.

Rationale

- The ability of the state to serve Oregon children is greatly extended by availing itself of federal dollars dedicated to the same purpose.

- Program sustainability is enhanced through this funding mechanism.

Supporting Data

- The MAC assumes that Healthy Kids will have Title 21 (or Title 19) funding for children up to 300% FPL. OHP Plus meets federal standards for CHIP coverage.

- For example, the 2005-07 FHIAP budget is $87,087,565 broken out by the following fund types:

General Funds:	$24,536,511.
Federal Funds:	$60,905,129.
Other Funds (misc):	$1,645,925.

  {Federal Funds are $48,767,418 Title XXI (CHIP) and $12,137,711 Title XIX (Medicaid)}.

Section II: Benefit Structure

As noted before, Healthy Kids is envisioned as a single program with a single card and a "no wrong door" approach to outreach, eligibility determination, and enrollment. However, it is also anticipated that Healthy Kids will offer options within this integrated approach, depending on family income and other insurance available.

7. **Multiple Approaches: the MAC recommends that Healthy Kids be composed of three coordinated elements: OHP Medicaid and CHIP, FHIAP, and a new state sponsored insurance plan for insurance for children. This new state insurance plan might be operated under risk contract by health plans or insurance carriers, or might be operated by the state as a separate pool.**

   - **The MAC recommends that the comprehensive package of services of OHP Plus be the standard used for Healthy Kids.**

   - **For families below 200% of the federal poverty level (FPL), the MAC recommends that children be enrolled in Oregon Health Plan Medicaid and CHIP coverage, either in OHP Plus or in subsidized employer-sponsored coverage through FHIAP**.

   - **For families with incomes above 200% FPL, the MAC recommends that DHS adopt the comprehensive benefit package of services of OHP Plus for children in the state plan but with appropriate cost sharing as recommended below.**

   - **Families with qualified employer-sponsored insurance may choose to have that coverage subsidized by FHIAP as their Healthy Kids coverage, or may choose either OHP Plus or the state plan.**

   Rationale

   The Governor has indicated his intent that Healthy Kids offer comprehensive health services to Oregon's children and that the benefits in the state plan portion

of Healthy Kids should be similar to OHP Plus but with some cost sharing, scaled to income, expected of eligible families.

Supporting Data

- OHP Plus has proven to be an effective benefit package for children, meeting their health service needs in physical health, mental health, and dental health in an integrated manner.

- The MAC assumes that Healthy Kids will have Title 21 (or Title 19) funding for children up to 300% FPL. OHP Plus meets federal standards for CHIP coverage.

8. **Cost Sharing: The MAC recommends income-appropriate cost sharing in Healthy Kids, and further recommends that premium sharing be the primary means of cost sharing as follows:**

   - **Maintain cost-sharing at zero (current level) in OMAP programs.**

   - **Adjust cost sharing in FHIAP programs so that there is no premium contribution required for children below 200% FPL and family premium contributions below 200% FPL are adjusted to mesh with Healthy Kids premium contributions above 200% FPL.**

   - **Set premium subsidies for families above 200% FPL so that total cost sharing does not exceed 5% of annual family income.**

   - **Discontinue premium subsidies at a family income level sufficient to pay full premium without jeopardizing the family's ability to cover basic costs of living. (The MAC estimates this level to be 350% FPL.)**

   - **Adjust premium subsidies for the FHIAP portion of Healthy Kids to achieve parity with the DHS portion of Healthy Kids and to reflect the characteristics of each type of coverage in terms of overall cost sharing and benefits.**

   - **Co-payments should be modest in keeping with the income levels of Healthy Kids families. For example, the co-payment for physician office visits should be no more than $10.**

   - **Coinsurance and deductibles should not be a part of Healthy Kids cost sharing in the DHS portion due to the imposition of severe financial burden on families with very sick children and/or with modest incomes. Coinsurance**

and deductibles will almost certainly remain in the FHIAP portion of Healthy Kids as reflections of the market.

Rationale

- MAC discussion and input from public meetings has placed a high importance on assuring that cost sharing is set at an appropriate level.

- Comments at Healthy Kids community meetings indicated a general preference for premium share over other forms of cost sharing because of predictability in family budgeting.

- Premium sharing should not exceed the limits of the family budget but should recognize the family's ability to contribute. Public meeting participants frequently suggested instituting "family premium" options for families with more than one child, resembling employer-sponsored insurance.

- Co-payments should be set low enough to assure that they will not be a barrier to needed health care.

- In addition, MAC has concerns about the effects of deductibles, co-pays, and co-insurance in the Healthy Kids program and recommends that they not be utilized in benefit plans designed for Healthy Kids. These cost-sharing mechanisms impose the greatest financial burdens on families whose children have serious health care needs. This impact is magnified in families with two or more children in need of hospital care in a given year.

- The financial impact of coinsurance is highly volatile and unpredictable.

- The bearing of risk by families with limited incomes may jeopardize access to needed care.

Supporting Data

- Research by the Rand Institute has shown that these cost-sharing mechanisms reduce utilization of health care services but that consumers do not distinguish well between useful and trivial services[2]. The impact of cost-sharing, however, was found to have a larger effect on lower-income persons, particularly children. A panel of experts divided episodes of care into those in which medical care produces usually effective treatments and usually less effective

[2] *See Robert H. Brook et al., "Does Free Care Improve Adults Health? Results from a Randomized Controlled Trial,"* New England Journal of Medicine, *309(23), December 1983:1426-1434 and Emmett B. Keeler, et al., "Effects of Cost Sharing on Physiological Health, Health Practices, and Worry,* Health Services Research, *22(3) August 1987: 297-306.*

treatments. It was determined that for those conditions in which medical care is highly effective, poor children in a cost-sharing plan were at a greater risk of not receiving treatment when such treatment would be effective[3].

- A review performed by OHPR staff showed that families cannot be expected to have available resources to help pay for health insurance until income is above 200% FPL (see appendices).

- 23 out of 30 states that currently require SCHIP premiums and enrollment fees for children (as of December 2004) have some form of "family premium per month" or family maximum for families with more than one child enrolled in the program[4].

- Actuarial data reviewed by the MAC demonstrates the concentration of financial burden in families with sick and very sick children.

9. <u>Delivery Systems</u>: The MAC recommends that DHS make specific preparations to assure that the OHP system will be able to deliver needed care to newly eligible children covered through Healthy Kids.

- **Assure that health plans that contract with OMAP develop sufficient capacity to provide services to the additional children they will be enrolling.**

- **Make full use of safety net clinics and school-based clinics.**

- **Recruit additional primary care case managers to coordinate the care of children who cannot be enrolled in managed care plans.**

- **Maximize the use of managed care throughout the state.**

<u>Rationale</u>

Healthy Kids will add a large number of children to state health coverage through the FHIAP and OHP Plus programs and the state Healthy Kids pool. This number may be greater than 100,000 if 90% of eligible children are enrolled. The MAC recognizes that coverage without access is an empty gesture, and that access depends on sufficient available capacity of appropriate providers in all service

[3] *See Kathleen N Lohr, et al., "Use of Medical Care in the RAND Health Insurance Experiment, Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial,"* Medical Care, *24(9), Supplement, September 1986, S-S87.*

[4] *See "SCHIP Enrollment in 50 States: December 2004 Data Update", Kaiser Commission on Medicaid and the Uninsured, 2005.*

areas, including culturally competent providers serving racial and ethnic communities.

The delivery systems for Healthy Kids will include:

- The OHP Plus delivery system consisting of managed care plans where available, primary care physician case managers where available, and "open card" fee-for-service where necessary.

- The delivery systems of the various health plans and insurance carriers with products qualifying for FHIAP participation.

- Those health plans and insurance carriers contracting to provide coverage through the state plan.

10. <u>Coordination for Health Policy Objectives</u>: the MAC recommends that state agencies design Healthy Kids as part of a larger health policy agenda consistent with universal coverage and access to care.

- **Cost monitoring and cost containment should be a core function of Healthy Kids program management to strengthen sustainability.**

- **Plans should seek to maximize the availability of both private and public health coverage to eligible families.**

- **DHS should design future requests for revised federal waivers to be consistent with the policy objectives of Healthy Kids within the context of the Oregon Health Plan.**

- **DHS should design Healthy Kids to complement other programs created to expand coverage to all currently uninsured Oregonians.**

<u>Rationale</u>

Failure to coordinate administrative features among multiple social service programs easily creates unintended barriers for those in need of assistance from these programs. Participants at the MAC's public meetings offered numerous stories of bewilderment and frustration. These experiences result in the failure of well-intended programs to achieve their goals.

Supporting Data

- 47 of 51 Medicaid programs in the country, including Oregon's, do not currently have an asset limit for children. However, Oregon is one of three states that currently have asset limit tests for SCHIP-funded Medicaid expansion programs for children[5].

- All children in New Mexico's CHIP program, a Medicaid expansion, can receive presumptive and guaranteed eligibility, thereby enhancing early and continued access to care for all children under 235% FPL[6].

- In states such as Georgia, the use of passive redetermination as a way to reduce rates of annual disenrollment has led to a 0% rate of disenrollment due to failure to provide information or income verification documentation—in comparison with Kansas which has a 25% disenrollment rate and requires both information and documentation for reenrollment, and 19% disenrollment rate for Michigan which also requires income verification documentation[7].

- In Kansas, a separate CHIP program has created a state clearinghouse staffed by both private and state eligibility workers. The clearinghouse processes joint applications for Medicaid and CHIP and eliminates the need for applications to be referred to an outside agency for final determination. The single location for staff and application processing enhances timely and accurate determination and enrollment of Medicaid and CHIP applicants. In addition, the CHIP and Medicaid programs share an eligibility information system that allows the programs to track referrals and enrollment between the two programs[8].

11. <u>Employer-Sponsored Insurance</u>: the MAC recommends that DHS, the Insurance Division, and the Office of Private Health Partnerships closely monitor the employer-sponsored health insurance market for signs of a shift of

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[5] *Ibid.*

[4] *Ibid.*

[3] *Source: Sarah Schulte et al., "Progress and Innovations in Implementing CHIP: A Report of Four State Site Visits,"* National Academy for State Health Policy, *June 2000.*

[4] *Ibid.*

[5] *Ibid.*

[6] *Ibid.*

funding responsibility from employers to government programs, and should take steps to encourage employer contributions to health insurance.

Rationale

The MAC recognizes that most private insurance coverage in Oregon comes through employer-sponsored health plans. A sudden change in this practice will disrupt the effort to move this state toward coverage for all Oregonians and threaten the sustainability of current health insurance arrangements. In particular, a rapid shift could overwhelm the budget for Healthy Kids. It could also lead to an increase in the number of adult Oregonians without health insurance. The MAC believes that DHS and FHIAP should monitor the employer-based insurance market as Healthy Kids comes on line so that needed health policy decisions can be made in a timely fashion.

Supporting Data

- "Other states have monitored the percentage of enrollees who dropped employer-sponsored insurance to enroll in SCHIP, which may provide a better estimate of actual crowd out: Missouri estimated that the rate of crowd out is between 1.6 percent and 3.2 percent of the population of its SCHIP expansion members; New York found 4.87 percent crowd out based on application questions about health insurance status; and North Carolina reported 8.3 percent crowd out rate of enrollees based on data from a survey of sample SCHIP enrollees. In 2000, the Mississippi legislature passed a bill that eliminated the state's six-month waiting period all together."[9]

- In a recent study, the Urban Institute found that there are a variety of ways in which different states are approaching the crowd-out issue including waiting periods, monitoring crowd-out (New York), verifying insurance status against databases of private coverage (Alabama, Michigan, Mississippi, Missouri and Wisconsin), implementing cost-sharing in the forms of premiums or co-payments (Alabama, New York and Washington), subsidizing employer-based coverage such as Oregon's FHIAP program and finally, imposing obligations on employers or insurers (repealed in California and yet to be implemented in Massachusetts). [10]

[7] *Source: Sarah Schulte et al., "Progress and Innovations in Implementing CHIP: A Report of Four State Site Visits,"* National Academy for State Health Policy, *June 2000.*

[10] *Amy Westpfahl Lutzky and Ian Hill. "Has the Jury Reached a Verdict? States Early Experiences with Crowd Out Under SCHIP."* The Urban Institute, *June, 2001.*

- "Studies in California, Colorado and Texas have found that a small portion of program applicants have been denied eligibility because they possessed private insurance at the time of application (or within the state's waiting period) . . . based on information gathered from 18 study states, it is apparent that pressures to increase enrollment have begun to outweigh concerns about crowd out at state and local levels."[11]

- Similarly, in states such as Georgia, Kansas, Michigan and New Mexico, it was found that waiting periods to prevent crowd-out of private insurance affect 1-2 percent of applicants[12].

- All four of these states have a waiting period where enrollees must be uncovered by health insurance for some minimum period of time before enrolling in CHIP. Waiting periods range from 3 to 12 months and can include any insurance coverage (Kansas), creditable coverage (Kansas and New Mexico), or employer-based plans (Michigan and Georgia). Each state also allows exceptions in certain cases such as involuntary loss of coverage (all states), change in work status including reduction in hours or leave without pay (Georgia and Michigan), coverage which does not provide geographic access (Kansas and Michigan), and catastrophic illness (New Mexico)[13].

[11] *Source: Sarah Schulte et al., "Progress and Innovations in Implementing CHIP: A Report of Four State Site Visits,"* National Academy for State Health Policy, *June 2000.*

[12] *Ibid.*

[13] *Ibid.*

Appendices

Theodore R. Kulongoski
Governor

February 8, 2006

Tina Kotek, Chair
Executive Director
Children's First of Oregon
PO Box 14914
Portland, OR 97293

Dear Ms. Kotek:

Thank you for your commitment to the state and to Oregon's Medicaid-eligible individuals through your service on the Medicaid Advisory Committee. Your role as an advisory committee to me, to the Department of Human Services, and to the Legislature will become increasingly important in the coming months as Oregon prepares to renew its Oregon Health Plan (OHP) demonstration project.

As we begin to prepare for the OHP renewal and for the 2007 legislative session, I am asking you to play a pivotal role in my health care agenda by helping me develop my Healthy Kids Plan – a program that will optimize existing and new resources to provide health care coverage for all children in the state.

Today more than 117,000 of Oregon's uninsured are children under the age of 19, and the number is growing. Between 2002 and 2004, the number of Oregon kids under 19 without health insurance increased from 10% in 2002 to approximately 13% in 2004. Because they are uninsured, those children are more likely to use the emergency room for regular care, less likely to visit a primary care provider or dentist, and more likely to suffer worsened health outcomes, including preventable disability and death. In addition to the health consequences of being uninsured, poor physical and mental health negatively affect the ability of children to learn and succeed in school. Consequently, an investment in the health of our children is an investment in Oregon's future.

I know you share my vision for Oregon as a place in which every citizen has access to basic and necessary health care. To continue moving Oregon toward that vision, I am committed to making health care more affordable for all Oregonians and improving access to health care for the more than 600,000 Oregonians without health

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insurance is critical piece of that work. To that end, I have asked the Health Policy Commission over the next year to develop recommendations for incrementally moving toward a sustainable health care system that provides everyone with access to affordable health care. I have also asked the Health Services Commission to reorder services under the Oregon Health Plan Prioritized List to reflect a higher emphasis on preventive services and the management of certain life threatening chronic diseases, allowing us to focus our limited OHP dollars more effectively for our OHP Standard Plan clients. Your work directly relates to both of those efforts and you will be offered an opportunity to engage in them. To meet legislative timelines, however, I ask that you prioritize your work on the Healthy Kids Plan which will be part of both the 2007 legislative session and the OHP demonstration renewal.

On February 24, I will deliver my State of the State address and provide more detail about my vision for the Healthy Kids Plan. I look forward to working with you to meet the healthcare needs of Oregon children and thank you in advance for your time and dedication to this very important work.

Sincerely,

Theodore R Kulongoski

THEODORE R. KULONGOSKI
Governor

TRK:EKS/glv

Copy: Bob DiPrete – Director, Medicaid Advisory Committee
Gretchen Morley, Director, Health Policy Commission
Kerry Barnett, Chair, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Eric W. Walsh, M.D., Chair, Health Services Commission
Jeanene Smith, Acting Director, Office of Health Policy and Research
The Honorable Karen Minnis, Oregon State Representative
The Honorable Peter Courtney, Oregon State Senator

Office of the Governor February 24, 2006

Governor Kulongoski's Healthy Kids Plan

The Problem:

More than 117,000 Oregon children live without health insurance. They lack access to doctors, medicine, eyeglasses, asthma inhalers, and the other health care services people with insurance take for granted. Nearly half these children may be eligible for coverage under one of Oregon's existing public programs, but they are not enrolled. Thousands more are from working families who earn too much to qualify for those programs, but not enough to pay for private insurance.

When children lack health care, everyone suffers. Kids without access to heath care don't do as well in school. Their treatable illnesses and injuries go untreated making them more likely to end up in emergency rooms, where they receive extremely expensive care. They become sick more often and miss more school days, requiring their parents have to stay home and care for them – which also translates to lower productivity for employers.

The Solution:

Enact Governor Kulongoski's Healthy Kids Plan. Provide every child in Oregon access to the health care he or she needs to grow into a happy, productive adult.

Meet children's health care needs in three ways.

- Continue expanding school-based health centers.
- Improve and expand access to the state's Medicaid and SCHIP programs.
- Expand health care coverage for kids by giving parents with higher incomes (too high to qualify for federal programs) the opportunity to buy affordable, state-subsidized group coverage for their children.

Key components.

- All uninsured Oregon children up to age 19 are eligible for coverage.
- Every child insured through the Plan will have the same insurance card.
- Streamline the Plan and simplify the enrollment process by using existing programs and partnerships with schools, health care providers and NGOs.
- All kids in families with incomes up to 200 percent of the federal poverty level (for a family of four - $37,700.00) will be eligible for comprehensive coverage through the existing Oregon Health Plan and Family Health Insurance Assistance Program (FHIAP) benefit models.
- Families with incomes above 200 percent of the federal poverty level will be eligible to buy affordable comprehensive group coverage for their children, including mental health and dental benefits; a sliding scale based on family income will determine the size of premiums and co-pays.

- School-based health centers will expand into five new counties; and at least five more centers will open in the 19 counties that already offer school-based health care.

The Process.

Governor Kulongoski has asked the Medicaid Advisory Committee (MAC) to work with state agencies and community partners to design some of the key elements of the Healthy Kids Plan. In the next three months, MAC will focus on recommendations around the delivery system serving kids in Oregon, enrollment and retention in the Plan, and the benefit options for expanding coverage for children in families with incomes above 200 percent of the federal poverty level, including the appropriate levels of state-subsidy and family cost-sharing. In creating benefit options for working, middle class families, MAC will explore the possibility of parents purchasing group coverage through OHP Managed Care, PEBB and FHIAP. In April 2006, MAC will host public hearings statewide on their recommendations to the Governor.

Cost.

The Governor's proposal funds the Healthy Kids Plan with federal, state and other fund revenue sources, maximizing federal revenue available to the state. The Healthy Kids Plan will cost up to $292 million more than what the state currently spends on kids' health coverage every biennium (approximately $110 million state dollars and $182 million federal match). Depending on the benefit design MAC recommends (the amount family contribution verses the amount of state subsidy), the cost of the Healthy Kids Plan should go down.

Previous efforts to expand health care access to kids.

- In 2003, Governor Kulongoski preserved funding for School-Based Health Centers and in 2005 the Governor expanded state funding for SBHC, growing the number of counties with SBHCs from 14 to 19. Oregon will finish the current biennium with at least 47 certified SBHCs.
- In 2004 Governor Kulongoski changed the asset limit for Oregon's State Children's Health Insurance Program (SCHIP) from $5000 to $10,000. He also directed the Department of Human Services to sponsor two pilot projects for enhanced outreach to children who are eligible for, but not enrolled, in the Oregon Health Plan and SCHIP. Lessons learned from that outreach effort will be applied to the Healthy Kids Plan enrollment and retention policies.
- To improve access to private health insurance coverage for more children in 2004 Governor Kulongoski developed a Children's Group Insurance Plan in conjunction with the Insurance Pool Governing Board. The Children's Group Plan offers an opportunity for employers to, at a minimum, provide coverage to the children of their employees. The plan became available in early 2005. Only a small number of small employers have enrolled in the plan, highlighting the need for more affordable group coverage options for kids, as will be part of the Healthy Kids Plan.

Appendix B: Cost Sharing Analysis

Oregon Health Policy and Research
Oregon's Healthy Kids Plan Benefit Structure Analysis

Overview of Pricing Project

Data Sources

Development of Managed Care Organization (MCO) Monthly Per Capita Cost for Federal Fiscal Years 2006/2007 --
Managed Care Annualized Utilization Rates per 1,000 Members
Development of Fee-for-Service Monthly Per Capita Cost for Federal Fiscal Years 2006/2007 --
Summary of Fee-for-Service Annualized Utilization Rates per 1,000 Members

MCO Monthly Per Capita Cost for Federal Fiscal Years 2006/2007

Fee-for-Service Monthly Per Capita Cost for Federal Fiscal Years 2006/2007

Populations Used

- PLM, TANF, and CHIP Children < 1
- PLM, TANF, and CHIP Children 1 - 5
- PLM, TANF, and CHIP Children 6 - 18

Assumed Number of Uninsured Kids

Children < 1	4,100
Children 1 - 5	31,000
Children 6 - 18	82,600
Total	117,700

Assumed Premium Subsidies

% FPL	% Subsidy
200%-250%	85%
250%-300%	70%
300%-350%	50%
350%-400%	0%

Plan Designs Priced

HMO with $5 office visit and $50 copay for inpatient day

HMO with $10 office visit and $100 copay for inpatient day

PPO with $500 deductible, 20% coinsurance, $4k out of pocket maximum

Administrative Cost Load Assumption

$20 pmpm (slightly higher than the average for current OHP children programs of $18.50)

Analysis Steps

1. Determine expected **total premium** for each plan design
2. Apply assumed **premium subsidies** based on sliding scale
3. Analyze population to determine **cost-sharing burden** for varying health status levels
4. Show **total cost (subsidized premium plus cost-sharing)** for various combinations of plan, health status, and income
5. Show **total cost as a % of annual income** for various combinations of plan, health status, and income

Chart 1: Annual Out of Pocket Costs for a Child Vary by Benefit Design, Income Level, and Health

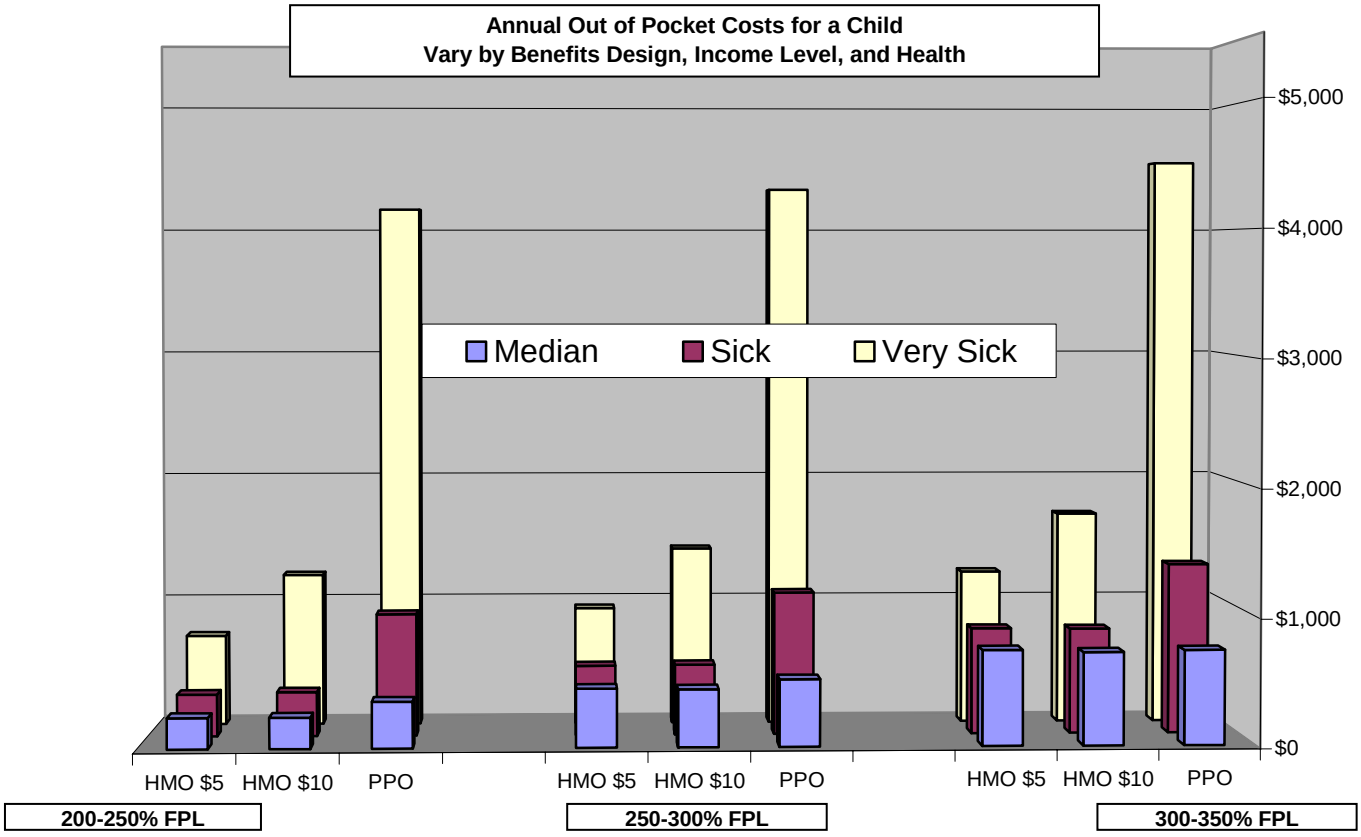
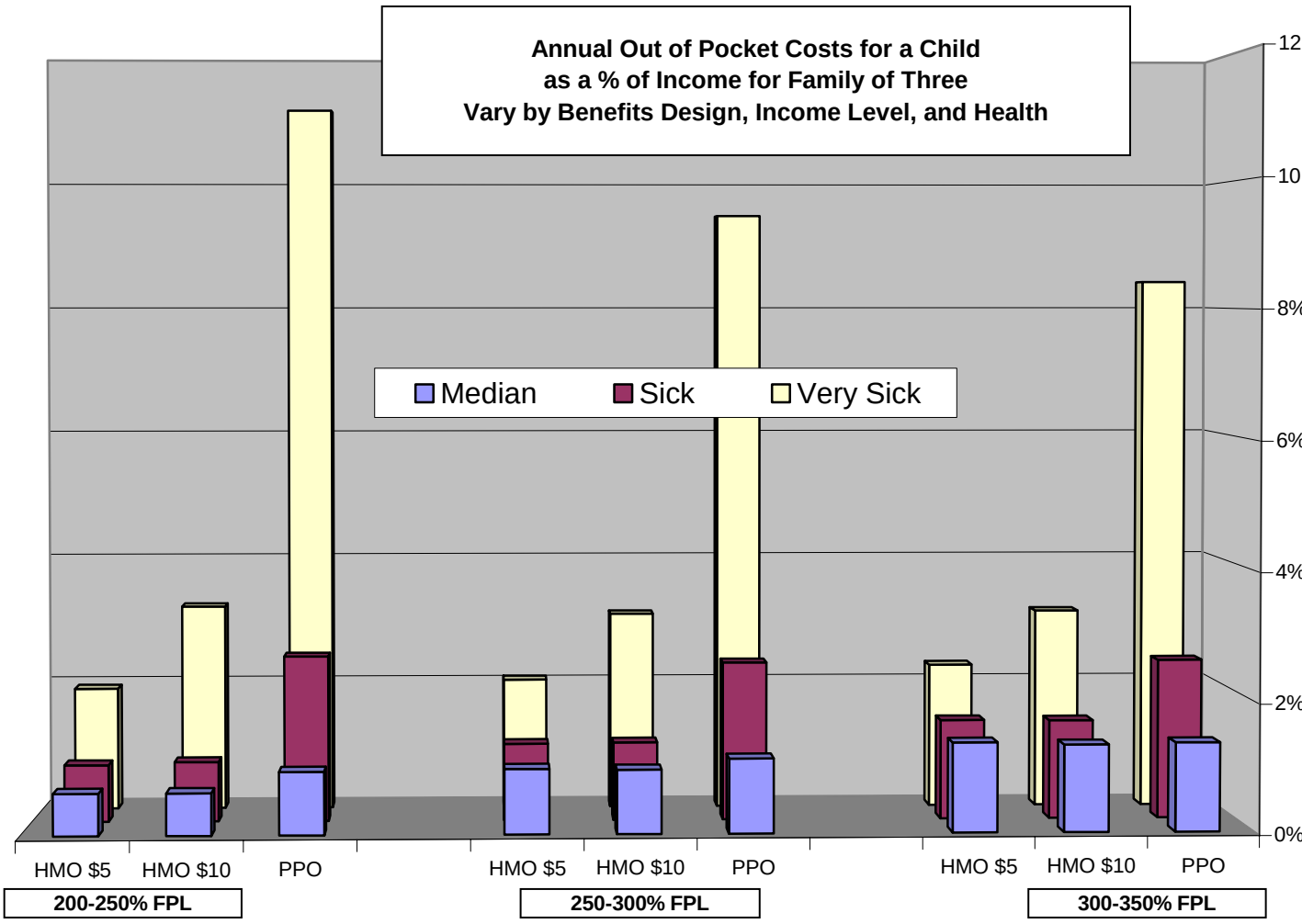


Chart 2: **Annual Out of Pocket Costs for a Child as a % of Income for Family of Three Vary by Benefits Design, Income Level, and Health**



Notes on Method and Assumptions

1 Annual costs include premium (after subsidy), deductible, coinsurance, copayments for covered services.

2 Median reflects a person with approximately $200 in annual costs (5 of 10 are this level or above)

3 Sick reflects a person with approximately $2,000 in annual costs (1 of 10 are this level or above)

4 Very sick reflects a person with approximately $100,000 in annual costs (1 of 2,000 is this level or above)

5 Federal Poverty level for 2006 used for this analysis:

Family Size	48 States and DC
1	$ 9,800
2	13,200
3	16,600
4	20,000
5	23,400
6	26,800
7	30,200
8	33,600

6 Premium Subsidies assumed as follows:

% FPL	% Subsidy
200%-250%	85%
250%-300%	70%
300%-350%	50%
350%-400%	0%

Appendix C: Summary Proceedings from Community Meetings

Medford Healthy Kids Public Meeting Feedback

Small/Large Group Discussion

<u>On "fairness and responsibility"</u>

Set a line for cost sharing in 200-300% FPL range. Ease in cost-sharing above that line.

Pay attention to dynamic of multiple premium sharing, and co-insurance in large families especially if chronic illness or spread of infection multiplies impact.

Use sliding scale above line but use same monthly cost during whole period of eligibility.

Single scale above line but use same monthly cost during whole period of eligibility.

Single card idea—"No flag of poor kids."

Design cost share to maintain stability of out-of- pocket costs.

"All is all" –all kids, with immigration status irrelevant.

<u>Involve Business</u>

Employers can be enrollers

Mandate enrollment by employers, not necessarily employer sponsor

Focus on small business with tax incentives subsidies, play or pay.

Remember single payer option

<u>Getting kids in program</u>

Schools are key place

Recruit volunteer aids and sites to help enrollment i.e. supermarkets, laundromats, WIC, electronic enrollment, convenient distribution of forms, re-enrollment

Use tax return info to locate families

Staff vigorous outreach for both new and renewal

Hospital obstetrics units, emergency departments

Advertise

Go where they are—natural communities such as faith centers

Remember both parents and kids need access

Further thoughts

Simplify the application process and forms!!!

Open eligibility across programs and promote automatic transfer of applications to appropriate programs such as food assistance.

Promote improved distribution of services and providers to maintain access.

Maximize willing providers

Don't forget about transportation as an element of access

Increase coverage of pregnant women to 200% FPL

No "insurance waiting period."

Examine correlations between preventative care and catastrophic coverage in content of low income.

Support continuous enrollment.

Use 30 day financial history to establish eligibility rather than three to six month.

Healthy Kids Public Meeting Questionnaire

1. What did you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

Tying school enrollment to access to insurance.

Access to signing up for coverage at pharmacies, particularly at grocery stores.

Kids living in homes @ 250% FPL should not pay any cost.

Low income budgets cannot handle many unexpected expenses even $3can be too much. Do you want me to send my budget to you again, you guys?

Single entry—if eligible for Head Start or free/reduced lunch then you should be eligible.

System simplification among programs—i.e. one application for free and reduced lunch and Medicaid/OHP –CHIP school lunch.

This needs to be for all kids!

We need to think about how we can access Oregon Health Plan benefits to children in a streamlined fashion; hence, connect or marry the OHP application with the free/reduced lunch application.

2. What didn't you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

Ensure mental health coverage has parity with physical health care

Opportunity for direct debit (electronic) for making premium payments

All Oregon kids need medical insurance including non-citizens

Transportation is becoming a HUGE barrier to care! Costs are going up and ability is going down to get to care when needed—(not all counties have Tri-Met after all!!)

Cover even more than I realized. I would be happy to help sell the final product and/or talk with legislators etc.
In fairness and responsibility recognize the health care system in total rewards and incentivizes (financially) high cost services vs. PREVENTION. Realign financial incentives for health care providers toward prevention.

Insurance status is impacting the health of those who are above 200% FPL.

I didn't hear that it may be helpful to hire more OHP outreach workers; moreover, where would funding come from?

3. Is there any other information about children and health care that you think we should know about?

Integrate providers so they serve both OHP/Healthy Kids and private insurance in all areas including mental health.

Emphasize the importance of sustaining care for example, a child in mental health treatment that is covered for a time and brief transition period currently has no coverage for ongoing treatment and medication to sustain health in long term.

OHP is a great insurance program, don't change the comprehensive services—nutrition, dental, medical and mental health. Keep drug formulary and areas of services that are non-covered.

Most kids are the healthiest part of the family—preventive care helps as long as families are all involved. Be sure to FIHAP as many parents as possible if needs be.

Prevention care, prevention education, and healthy lifestyles/choices.

Community Health Centers are natural and vital parts of the system—they know how to outreach and increase enrollment. They are a natural partner of this proposed system and provide high quality care at lower costs.

The state can improve enrollment and coverage for all children by eliminating the period of uninsurance requirement. Provide one year continuous program enrollment with streamlined renewal and remove or increase asset limits for kids.

I personally advocate for universal health insurance.

All children need coverage, need access to health care.

Bend Healthy Kids Public Meeting Feedback

Small/Large Group Discussion

On "fairness and responsibility"

During the discussion at Bend on "fairness and responsibility" there was great concern about the rising cost of both transportation and school expenses are eating into the discretionary income of many working families in the area. In a semi-rural area such as Bend, the rising cost of fuel may price out many families from the ability to kick in an extra amount for health insurance. Miscellaneous school expenses similarly seem to be a growing cost to these families and may prove to be a barrier to the ability to pay for even a state subsidized health insurance program for their kids.

Most of the parents at the meeting were willing to contribute part of their income to pay premiums for a Healthy Kids Plan, yet were very realistic about the need for some kind of "sliding scale" approach considering the nature of a tourist economy in central Oregon. There was, however, a support for the MAC projection of the ability for a family at 200% FPL to pay around $50 per child for health insurance premiums per month. There was also a sense that these families would pay a little more for co-payments if it would reduce the monthly cost.

Many of the parents who attended the meeting presently have kids or have had kids enrolled in the OHP and wanted to voice a concern about the denial of access to health care providers in their area. They were hesitant to support an expansion of insurance if there was nothing done to improve their ability to utilize these services. Apparently there was a belief that only one primary care physician in the area who would readily take OHP patients.

Involving Business

During the discussion on involving business in the process of covering children there was general support for all of the options offered by MAC at the meeting. The main concern that many parents had at the meeting was that despite an option of purchasing health insurance through an employer, this option was well beyond the price range of what many of the parents could afford. This was seen as a problem that many small businesses cannot afford what the insurance market currently has to offer.

Getting kids into the program

In the discussion on getting kids into the program, there was a general consensus that reaching kids through schools, health centers and community groups such as religious organizations, Head Start, and parks and recreation programs would be much more beneficial than a media campaign. These groups should be targeted and given access to forms online that they can distribute to families.

Overall, the main concern that these parents had about this subject was that the process become simpler for many of the parents who have low literacy levels. They viewed the current eligibility and recertification process for the OHP to be cumbersome and often times a reason for many families to have their children fall off the program. More specifically, there was a sense that

having families fill out a full application every six months as a hindrance to coverage and that something along the lines of the food assistance program re-application would suffice.

Further thoughts

One of the parents who came to the meeting wanted to emphasize her support for the great coverage she had through the OHP program for her kids. She wanted to voice a concern however coverage should be extended to the parents so that their increased health can help provide resources to cover their kids. She also wanted to state that considering child support as income is detrimental to coverage because child support often goes unpaid.

Another parent wanted to expand the role of safety net clinics and wanted to voice her support for the work they are doing in immigrant communities. She wanted to voice the willingness of many in these communities to contribute to a program for their children.

Healthy Kids Public Meeting Questionnaire

4. What did you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

There should be a sliding scale for this program. Parents are willing to pay something even if it is a $3 co-payment for the lower income population. Not having to re-enroll every six months—just updating changes.

Helping with employer side and tax incentives and a sliding scale for co-payments.

5. What didn't you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

Parents need coverage too!

Provider payment—if providers receive more for services, access will be a barrier.

It is important to learn from the challenges and frustrations of families on OHP to improve next system (i.e. lack of medical/dental providers).

6. Is there any other information about children and health care that you think we should know about?

Parents need the option to change providers especially if they feel they are receiving dispirit treatment.

If you would like the perspective of Head Start Staff—those individuals who work with low income families, please let me know and I can help facilitate that.

Newport Healthy Kids Public Meeting Feedback

Defining "affordability," "fairness" and "responsibility"

The estimation for average family expenses was very low for this area. There was a sense that in determining a workable program there has to be common ground between fairness and responsibility. For people to spend hard-earned and few extra dollars per month would necessitate a benefit package that parents could see as benefiting their families. In the same vein, there needs to be some sort of requirement on parents to enroll their kids so that they are held responsible for their children just as those driving motor vehicles are held responsible for auto insurance.

This idea of a requirement on parents led to a discussion about the need to craft a program that is sustainable for both the taxpayers of Oregon and for a family's affordability. Those in attendance determined that families at 200% FPL were generally not at an income level that could have much disposable income and that an appropriate share of premium would be around $15-$30 rather than $40-$50. There was also a sense that a family in the Newport area of Oregon at 250% of the FLP may be able to afford ½ of $130 premium and that at there should be a sliding scale up to 350% FPL as the full premium.

Getting kids into the program

Several people brought up the point that school programs already require that children are insured to participate in school activities and that some sort of program can be linked to school enrollment and extra curricular activities. Many of those in attendance also wanted to emphasize that the process for enrollment that exists for the OHP program is very difficult for many parents to complete. They envisioned a new eligibility process for this new program as user friendly in the same way as the federal free and reduced lunch program, and suggested that two months of income verification would be better than six months.

The group also felt that outreach efforts should target the entire income spectrum in different communities from media activities, increased provider-state agency outreach, organizational dissemination, hospital and pharmacy enrollment, and tax eligibility through IRS and Oregon Department of Revenue. Another idea was that the state program for both enrollment and re-enrollment should work more proactively with community agencies so that busy parents aren't overwhelmed with the paperwork when many agencies can provide assistance. The final idea was that the Oregon Department of Revenue could incorporate a form for enrollment on the income tax form and parents could forgo their dependent child credit or other forms of family credit to pay for insurance premium on an annual basis.

Further thoughts

Many in the meeting felt that access was just as important issue as insurance coverage and that the reimbursement rate for providers should not determine if parents can take their kids to the local clinic. There was also a concern for children who have parents who are either absent or not involved in their kids' lives. In order to address this it was determined that there should be an avenue for social service providers to enroll these children.

Healthy Kids Public Meeting Questionnaire

7. What did you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

Willingness of Governor and Legislature to make movements on this issue!

It is very important to have insurance for children.

8. What didn't you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

State and Federal budget guarantees.

9. Is there any other information about children and health care that you think we should know about?

The true costs of Americans not having health coverage (i.e. bankruptcy, strain of emergency rooms, etc.)

Healthy kids should be about all kids including those new to the country and those who do not already have citizenship. The five year waiting period to be eligible for state assistance in health care is a great burden for hard working families who are new to this

Portland Healthy Kids Public Meeting Feedback

Fairness and Affordability

It was determined by the group at the Portland meeting that it is important to build cost sharing for low/middle income folks around premiums rather than focusing on co-payments, co-insurance, and deductibles. The discussion centered on the idea of cost-sharing and the need for a stable and predictable amount so that families can work this insurance plan into their daily/monthly/yearly budget. There was a general concern that families are now in a position that when a child is very sick—that they will not be able to afford the medical costs, but also that families should be held responsible for a reasonable share of the cost of care but not put in financial jeopardy. This was illustrated in the idea that cost sharing is necessary because it can reduce over-use of the system; however, there should be a "cap" on out-of-pocket payments. Along the same lines—there was a concern that parents should not be penalized for using "preventative care" and that copayments should not drive kids into emergency rooms for non-emergency care, thus driving up the costs for everyone.

The group found that an average family of four living around 200% of FPL is living at a level in which they are not yet able to afford health care premiums when considering the costs of living in the Portland Metro Area. If there is some sort of payment required by this group of families—this payment should be minimal because many families living in this situation are living paycheck to paycheck. This program should not force families to choose between necessities such as food and shelter on the one hand, and the opportunity to get health insurance for their children on the other.

In determining when and how a payment plan should look to an average family of four paying premiums to the Healthy Kids program, the Portland group found that the family share of premiums should incrementally increase as disposable income rises. The family share of premium should start at 250% FPL and end somewhere in the range of 350-400% FPL. If $130 is the total monthly premium per child, then the family of four living at around 300% FPL should be able to afford ½, or $65 per child. Likewise, at 350-400% FPL a family of four should be able to afford the full estimated $130 premium per child. As the family size increases, there was a perception that there should be a family rate instead of a per-child rate. This would mean that a family with six children would pay the same amount as a family at the same income level with 3 children.

Getting Kids into the Program

The group in Portland overall wanted both a comprehensive outreach to get kids enrolled in the Healthy Kids program and a very simple process to enroll so as to not dissuade parents because of the complex paper work required. There was a general consensus that the natural place to enroll kids was through the schools, medical centers, pharmacies, faith communities, libraries, grocery stores and other public meeting places. Perhaps these places could hold a "Healthy Kids Sign-up Nights" where DHS staff could set up a booth and talk to parents and enroll kids on the spot. It was thought that presumptive eligibility and/or auto-enrollment through school registration would be a logical place to get kids into the program. All kids should mean all kids just as public education means all kids are eligible.

In order to simplify the process it was determined that the eligibility application form for families should be no more than one or two pages and that income verification for premium purposes should be in the form of a signed affidavit randomly audited. There was also a need for an electronic version online, a help-line, and translated forms in multiple languages in the mass mailings of the forms. Along these lines, it was thought that a kiosk at medical centers, community locations or pharmacies could serve as a place to update information or make payments. The form of payment could also possibly be through payroll deduction through their employer or through electronic debit as taxes are taken out.

It was felt that everyone should pay something, even at a nominal level.

Corvallis Healthy Kids Public Meeting Feedback

Fairness, Responsibility and Affordability

The discussion regarding the basic family budget in Corvallis determined that the average monthly budget for a family of four is around $3,600 just to "break even" or to cover basic expenses (about 225% FPL). At 250% FPL a premium share of around $50 per child was found to be an affordable figure for the area and that state subsidy should decrease as the income level rises. It was felt that at 300% FPL a family could afford the entire $130 premium. There was also a sense that many felt that a mixture of premiums and co-payments is appropriate but that the co-payments should indexed to income so that those with less disposable income are not penalized for using services.

Getting Kids into the Program

Schools, child care programs, and hospitals were all named as the best place to enroll children, and it was felt that applications should also be distributed in public places such as libraries and various other community service outlets. There was a perceived need for an aggressive advertising campaign, but it was felt that such an effort should not take money away from the administration of the program. It was also determined that working with employers, employment training programs, and unions are all important areas to get applications into parent's hands. In order to make the process more "user friendly" there should be a form online with a Q&A section and that the form for re-enrollment should be very basic. Finally, there was an idea of working with the Oregon Department of Revenue to notify parents that they appear to qualify and possibly a passive enrollment process that automatically enrolls families unless they "opt-out" on their state tax returns.

Further Thoughts

Making sure that kids are covered by health insurance should not always depend on the parents' initiative and that in many circumstances parents are not responsive if they are not mandated to do so. The state should work with various social service agencies in and out of state government to do outreach so that all kids are covered—including those with irresponsible parents.

Healthy Kids Public Meeting Questionnaire

10. What did you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

People at 200-250 FPL are still concerned about catastrophic financial events. Paying for health insurance for healthy kids often is valued less than saving for an adverse event.

All children deserve health care—your children are in unless you opt out.

Do not expand this program at the expense of the OHP.

11. What didn't you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids Plan?

Employers need to support health care access to ensure a healthy work force.

Universal rights for all.

12. Is there any other information about children and health care that you think we should know about?

Children's coverage should be mandatory, all uninsured children sill be signed up and then parents have an opportunity to opt out.

Funding should come from a state-wide entertainment tax—corporate tax deductions reduced.

In dental care—if parents come in for treatment, it is more likely that the kids will be brought regularly.

13. Oregon and its governor are looking for ways to encourage business to keep offering insurance for employees and employees' children. Please share your thoughts.

Pool all government employer funds paid for health insurance with funds for Medicaid into a single payer system so that government (state and local) get the same insurance as those on Medicaid. That way, Oregon governments would model what it expects private employers to do. Then require private employers to provide health insurance or buy into the government/Medicaid pool and add their employees to that group insurance. Finally, withhold corporate kicker refunds from employers who do not provide health benefits—and use them to pay Medicaid match for their employee's care.

La Grande Healthy Kids Public Meeting Feedback

Small/Large Group Discussion

<u>On "fairness and responsibility"</u>

- In discussing family contributions to a Healthy Kids premium there was a general sense that many working families in this area may have a lower median income than other more urban parts of the state. Nonetheless, several people found it reasonable to have a sliding scale for the premium starting at 150% FPL (very minimal, maybe $10-20 per child), 225% FPL as ½ of the $130 per child figure and 300% FPL as the end point for subsidy

- Another group of individuals thought that living expenses were such that even if the income level was different in Eastern Oregon—many families still had a tough time paying bills. Their estimation of beginning contribution was around 250% FPL, 325% FPL for ½ of the premium, and 500% FPL as the end of contribution respectively.

- Similarly, some in the group found that a family of four living in the La Grande area of Oregon at around 200% FPL should be able to save about 10% of their disposable income—the reality is that families at this level are living paycheck to paycheck. Furthermore, until basic needs are met—they won't be looking at saving or improving social circumstance.

- There was however a concern that many parents see health insurance as something that is optional and that they don't view covering their kids as important as buying a new truck or some other luxury item.

- .Some thought that having cost-sharing in some form would encourage responsibility in accessing care—stopping frivolous visits.

<u>Getting kids into the program</u>

- There was a general sense at the meeting that there is a need to bring the application process to where people go in their everyday lives in Eastern Oregon and the rest of the state. This included:

    - Reaching parents through schools—despite the fact that they didn't think that teachers should take on the entire responsibility; they felt that parent-teacher conferences or school registration were natural places they should go to register for the Healthy Kids initiative. Many schools already offer a very limited "school event insurance" policy to families with uninsured children; it should be straightforward to offer Healthy Kids, as well.

    - Advertising and providing forms at local medical centers, libraries, post-offices, restaurants, utility companies, employers, child-care facilities and grocery stores.

At the last locale, grocery stores, it was thought that the state should work with these businesses to print the application – or at least a brief screening questionnaire - on brown grocery bags.

- Many at the meeting also articulated the need to simplify the process and to utilize technology to make the process more efficient. These ideas included:

    - Providing a phone line for assistance;
    - Asking prospective budgeting rather than requiring pay-stubs, or using W2 forms for income verification;
    - Including a question on the State of Oregon income tax form if they have insurance for their kids with a follow-up from DHS.
    - Collapsing all eligibility forms into a single page;
    - Allowing the first two medical services free (no copay);
    - Creating a central processing center so that everyone sends the forms to one location;
    - Ensure that hospitals and other medical centers are reporting uninsured children to DHS with information so that the parents can be contacted.

Further thoughts

- Some people like FHIAP better than the OHP because they feel that they are treated better than those on public assistance.

- Start the Healthy Kids Plan at birth and make one program/process that gets the child enrolled and then assesses periodically what the family can contribute according to their income level.

- Rethink what eligibility means: with Healthy Kids, all uninsured children are eligible for coverage, but what needs to be determined is whether and how much premium subsidy they qualify for

- If there is outreach for this program through the schools, make sure that it includes private and home schooling kids.

- Expand school “health based” centers that can enroll kids at the schools.

Portland Multicultural Stakeholders Healthy Kids Public Meeting Feedback
May 3rd, 2006

Attendees: Michelle Mack (CAF-DHS), Jeanny Phillips (DHS-OMAP), Craig Kuhn (FHIAP), Mae Chao (IRCO/AFC), Charenndi Van-Si (Multnomah co. Health Department), Bruce Bliatout (Multnomah co. Health Department), Sik Yin Chan (Portland Impact), Erinn Kelley Siel (Governor's Office), Richard Aceuedo (Director's Office, DHS), Alberto Moreno (DHS-Migrant Health), Jenny Lee Berry (DHS, Multicultural Health), Everette L. Rice (DHS, Office of Multicultural Health), Daniel Ward (La Clinica Del Carmo Family Health Care Center), Lorena Sprager (La Clinica del Carmo Family Health Care Center), Tina Edlund (OHPR), Heidi Allen (OHPR), Jeanene Smith (OHPR), Bob DiPrete (Medicaid Advisory Committee), Carmen Urbina (Medicaid Advisory Committee), Nate Hierlmaier (PSU).

General Messages:

- It is essential that we engage Multicultural Stakeholders beyond today's meeting: integrating feedback into long-term planning, using Multicultural "experts" to participate in the outreach strategy design and efforts, and "closing the loop", keeping communities informed about progress.
- Healthy Kids should be for ALL KIDS, not just those with citizenship.

Outreach Strategies: Materials Development

- Healthy Kids materials need to be available in oral as well as written format. A significant proportion of minority populations come from oral traditions, do not have a written language, and do not read English.
- Materials and information need to be explicit and clear about the risks in applying for the program when targeting non-citizens.
- Cultural messages need to be considered along with linguistic considerations when developing materials related to Healthy Kids.
- Clarity: Use simple but key messages with clarity about the risks to non-legal or immigrant citizens in applying for a governmental "program"

Outreach Strategies: Systemic Suggestions

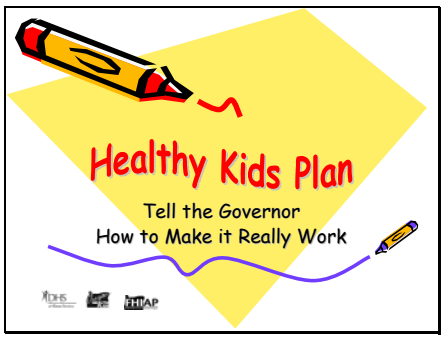
- In order to utilize expertise in designing outreach, outreach workers should be bicultural, bilingual, and either have an immigration experience personally or in the family.
- Identify respected and trusted community leaders to help facilitate outreach.
- State-employed outreach workers need the flexibility to attend cultural events that do not fit into the traditional M-F work-day paradigm.
- Communities of color are relationship-based; it might be more cost-effective and efficient to outsource outreach to established and trusted agencies serving communities of color. This should be done in a way that does not introduce competition into the agencies serving communities of color, but encourages multi-agency collaboration.
- Use incentives for plan referrals when it appears that the community does not understand the value of the service offered (example given: gift certificate to a grocery store in exchange for getting a mammogram was successful in recruiting large numbers of women in an ethnic minority community when other outreach attempts had failed).

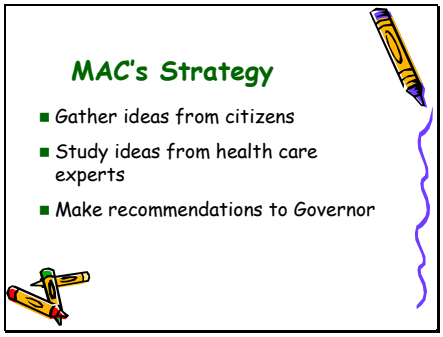
- Income verification should be flexible for seasonal workers (tax-returns versus demonstrating previous four months insurance).
- Enrollment process needs to be simplified.
- Outreach efforts need to be sustained over time with adequate funding, and on-going attention to outreaching communities of color.
- State needs to diversify its own work-force to increase effectiveness in addressing multicultural concerns
- Recognize that families of color might be supporting/sponsoring (financially or otherwise) extended family members when deciding on cost-sharing. Also families might be concerned about risking their relatives' citizenship application process if they accept government aid.

Outreach Strategies: Targeting Communities of Color

- Advertise in multicultural newspapers
- Use Office of Multicultural Health as resource
- Faith Leaders
- Nail salons, hair salons, laundromats, cable television programs that target people of color, community events, Small Business Associations and insurance agents, Park & Recreation catalogues, community centers, civic organizations.
- Need to build relationships with leaders connected to various communities
- Target urban American Indians (rural AI's are more likely to be already insured). Work closely with NARA.
- Have face-to-face meetings with outreach & enrollment workers

Appendix D – PowerPoint Presentation from Public Hearings





The problem

- 117,000 Oregon children have no health insurance
- About half qualify for programs, but are not enrolled
- All Oregon children should have access to:
  - Doctors
  - Hospital care
  - Medicine
  - Eyeglasses
  - Basic health care services

Governor's proposal "Healthy Kids"

The Governor's Vision

- Cover all uninsured Oregon children up to age 19
- Comprehensive health care.
- Build on existing programs
- Simpler enrollment
- No "second class" kids

What You Should Know…

- Kids already covered through Medicaid, CHIP, and FHIAP -- keep their coverage.
- Uninsured kids -- new opportunities for coverage.

The MAC's Ideas so far…

- Renew coverage once a year
- All kids without insurance qualify
- Financial help available to families with modest income and resources
- Find uninsured kids, get them enrolled, and keep them enrolled

Here is What We Need From You!!

Questions for small workgroups

What is Fair and Affordable?

- How far up the family income ladder should government help pay for kids' insurance? (making insurance premiums affordable)
- How much can a family afford to contribute to their children's health care?

How Can We…

- Find kids who are uninsured?
- Help families get kids enrolled?
- Keep kids enrolled in a health plan?

How do we encourage…

- More businesses to offer health care benefits for their employees and employee's children?

Where Will Your Ideas Go From Here?

- To the MAC for recommendations, then…
- To the Governor

OHPR's Contact Information

- **Phone: 503-378-2422**
- **Address: Public Service Building, 5th Floor**

  255 Capitol St. NE

  Salem, OR 97310

For More Information:

- The Governor's Website
  - http://governor.state.or.us/
- FHIAP's Website
  - http://www.oregon.gov/OPHP/FHIAP/index.shtml
- OMAP's Website
  - http://www.oregon.gov/DHS/healthplan/index.shtml
- MAC's Website
  - http://oregon.gov/DAS/OHPPR/MAC/MACwelcomepage.shtml

Appendix E- Affordability presentation

Affordability Presentation for the Medicaid Advisory Committee

March 22, 2006

Heidi Allen, MSW
Office for Oregon Health Policy and Research

OHPR

The Quest

- To get an idea of how much money families can afford to contribute to health care (through premiums, co-pays, and deductibles) depending on:
  - How many wage-earners in the home
  - How many children in the home
  - Monthly Income (measured by Federal Poverty Level Guidelines)
  - Monthly expenses
  - Geographic Area (rural vs. urban)

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Data Sources

- Economic Policy Institute (www.epi.org)
  - 2004 family budget calculator
    - Methodology available: *Family Budget Technical Documentation* (Allegretto & Fungard) www.epi.org.
- The United States Department of Health & Human Services 2004 HHS Poverty Guidelines
  - Issued yearly and used for determining financial eligibility for means-tested federal programs

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Calculations & Assumptions: Housing

- Housing: based on the Department of Housing and Urban Development's fair market rents (FMR):
  - representing rent + utilities for "privately owned, decent, structurally safe, and sanitary rental housing of a modest (non-luxury) nature with suitable amenities".
- Assumptions:
  - Two bedroom apartments for families with 1 or 2 children.
  - Three bedroom apartments for families with 3 children.

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Calculations & Assumptions: Food

- Food Costs: based on the Department of Agriculture's "Official USDA Food Plans: Cost of Food at Home at Four Levels" report.
- Budget uses the "low-cost" plan, the second lowest plan calculated.
- Assumes a very basic diet, and that almost all food will be prepared in the home.

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Calculations & Assumptions: Transportation

- Transportation costs per mile are from the IRS cost-per-mile rate, which includes the cost of gas, insurance, vehicle registration fees, maintenance, and depreciation.
  - Varies by urban or rural area, and number of parents in the family.
- Budget assumes only non-social trips (work, school, church, and errands for the 1st adult and only work trips for the 2nd adult).

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Calculations & Assumptions: Child Care

- For the most part, costs are based on child care centers and varies by urban vs. rural locations.
- Budget assumes a 4 year-old in one-child families, one 4 year-old and one school-age child in two-child families, and a 4 year-old and two school-aged children in three child families.

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Calculations & Assumptions: Taxes

- Taxes include federal personal income tax, federal Social Security and Medicare payroll taxes, state income taxes, and well as local income or wage taxes.
- Budgets assume:
  - All families are renters
  - All adults work and all income is from work
  - Adults take advantage of all tax credits

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Calculations & Assumptions: Other Expenses

- Clothing
- Personal Care expenses
- Household supplies
- Reading materials
- School supplies
- Estimated as 27% of housing and food costs
  - Based on data from the Consumer Expenditure Survey (http://www.bls.gov/cex)

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The Budgets

2004
Portland-Vancouver
Rural Oregon

Family Budget: Portland-Vancouver 1 Parent/ 1 Child*

	2004 $ amount
Monthly housing	$ 717
Monthly food	$ 265
Monthly child care	$ 557
Monthly transportation	$ 275
Monthly taxes	$ 407
Monthly other necessities (e.g., clothing)	$ 265
Monthly total mandatory expenses	$ 2,486
Annual total	$ 29,832

* Economic Policy Institute (2004)

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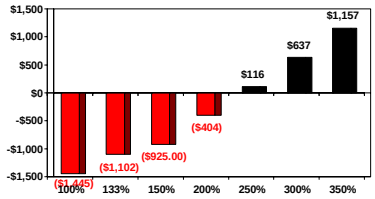
Discretionary Monthly Income after 250% Federal Poverty Level (FPL)*



* Portland-Vancouver (2004) 1 Parent + 1 Child

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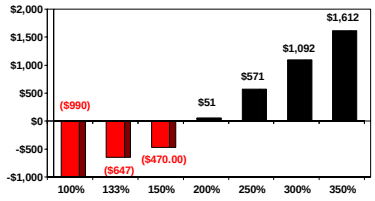
Family Budget: Rural Oregon 1 Parent/ 1 Child

	2004 $ amount
Monthly housing	$ 589
Monthly food	$ 265
Monthly child care	$ 418
Monthly transportation	$ 313
Monthly taxes	$ 215
Monthly other necessities (e.g., clothing)	$ 231
Monthly total mandatory expenses	$ 2,031
Annual total	$ 24,372

Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 200% FPL*



Rural Oregon (2004) 1 Parent + 1 Child

OHPR

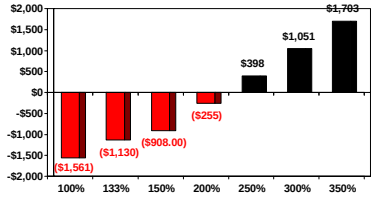
Family Budget: Portland-Vancouver 2 parents/1 child*

	2004 $ amount
Monthly housing	$ 717
Monthly food	$ 448
Monthly child care	$ 557
Monthly transportation	$ 375
Monthly taxes	$ 455
Monthly other necessities	$ 315
Monthly total mandatory expenses	$ 2,867
Annual total	$ 34,404

Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 250% of Poverty Level *



* Portland Area (2004) 2 Parents + 1 Child

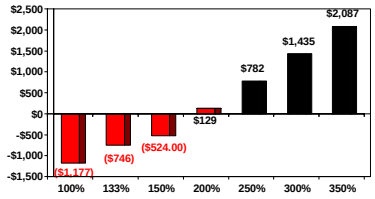
OHPR

Family Budget: Rural Oregon 2 Parents/1 Child

Rural Oregon-2 Parents + One Child	
	2004 $ amount
Monthly housing	$ 589
Monthly food	$ 448
Monthly child care	$ 418
Monthly transportation	$ 420
Monthly taxes	$ 328
Monthly other necessities	$ 280
Monthly total mandatory expenses	$ 2,483
Annual total	$ 29,796

Economic Policy Institute (2004) OHPR

Discretionary Monthly Income after 200% of Poverty Level *



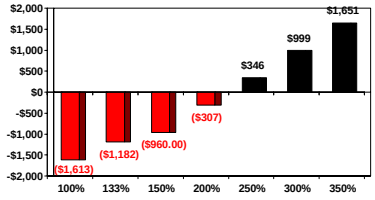
* Rural Oregon (2004) 2 Parents + 1 Child OHPR

Family Budget: Portland-Vancouver 1 Parent/ 2 Children*

	2004 $ amount
Monthly housing	$ 717
Monthly food	$ 405
Monthly child care	$ 855
Monthly transportation	$ 275
Monthly taxes	$ 364
Monthly other necessities (e.g., clothing)	$ 303
Monthly total mandatory expenses	$ 2,919
Annual total	$ 35,028

Economic Policy Institute (2004) OHPR

Discretionary Monthly Income after 250% FPL *



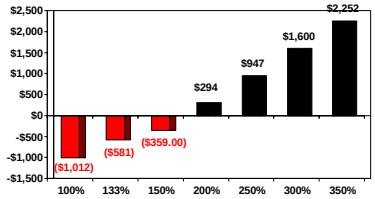
*Portland-Vancouver (2004) 1 Parent + 2 Children OHPR

Family Budget: Rural Oregon 1 Parent/ 2 Children

	2004 $ amount
Monthly housing	$ 589
Monthly food	$ 405
Monthly child care	$ 657
Monthly transportation	$ 313
Monthly taxes	$ 86
Monthly other necessities (e.g., clothing)	$ 268
Monthly total mandatory expenses	$ 2,318
Annual total	$ 27,816

Economic Policy Institute (2004) OHPR

Discretionary Monthly Income after 200% FPL *



Rural Oregon 1 Parent + 2 Children OHPR

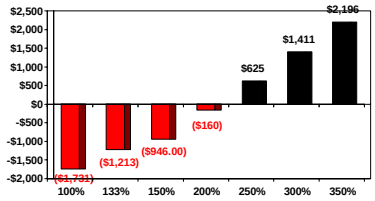
Family Budget: Portland-Vancouver 2 Parents/ 2 Children *

	2004 $ amount
Monthly housing	$ 717
Monthly food	$ 587
Monthly child care	$ 855
Monthly transportation	$ 375
Monthly taxes	$ 416
Monthly other necessities (e.g., clothing)	$ 352
Monthly total mandatory expenses	$ 3,302
Annual total	$ 39,624

Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 250% FPL *



*Portland-Vancouver (2004) 2 Parents + 2 Children

OHPR

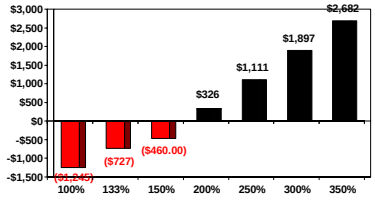
Family Budget: Rural Oregon 2 Parents/ 2 Children *

	2004 $ amount
Monthly housing	$ 589
Monthly food	$ 587
Monthly child care	$ 657
Monthly transportation	$ 420
Monthly taxes	$ 245
Monthly other necessities (e.g., clothing)	$ 318
Monthly total mandatory expenses	$ 2,816
Annual total	$ 33,792

* Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 200% FPL *



*Rural Oregon (2004) 2 Parents + 2 Children

OHPR

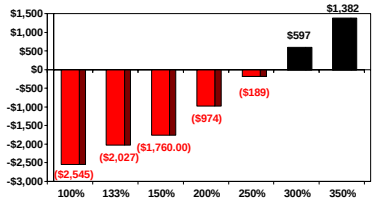
Family Budget: Portland-Vancouver 1 Parent/ 3 Children*

	2004 $ amount
Monthly housing	$ 1,044
Monthly food	$ 562
Monthly child care	$ 1,154
Monthly transportation	$ 275
Monthly taxes	$ 647
Monthly other necessities (e.g., clothing)	$ 434
Monthly total mandatory expenses	$ 4,116
Annual total	$ 49,392

* Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 300% FPL



*Portland-Vancouver (2004) 1 Parent + 3 Children

OHPR

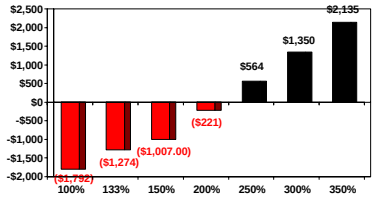
Family Budget: Rural Oregon 1 Parent/ 3 Children

	2004 $ amount
Monthly housing	$ 827
Monthly food	$ 562
Monthly child care	$ 896
Monthly transportation	$ 313
Monthly taxes	$ 390
Monthly other necessities (e.g., clothing)	$ 375
Monthly total mandatory expenses	$ 3,363
Annual total	$ 40,356

Economic Policy Institute (2004)

OHPR

Discretionary Monthly Income after 250% of FPL



Rural Oregon (2004) 1 Parent + 3 Children

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Discussion Points

- These budgets do not include debt, or higher than normal interest rates that might affect families with less than perfect credit.
- Estimates are conservative (particularly regarding child care, housing, and food)
- Other factors, beyond health care, compete for discretionary income.
- Budget does not include recommended savings or catastrophic expenses.

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Appendix F- Uninsured Children in Oregon presentation

Children's Health Insurance Coverage In Oregon

The Numbers

Tina Edlund
Research and Data Manager
Office for Oregon Health Policy and Research (OHPR)
January 2006

1

Why is health insurance so important?

- Lack of coverage leads to unmet health care needs
  - Uninsured children are half as likely to receive preventive care, and half as likely to have seen a doctor in the past year.
  - Uninsured children are over 5 times more likely to report having an unmet need for medical care.

Source: Kaiser Commission on Medicaid and the Uninsured, "Children's Health—Why Insurance Matters," May 2002.

Why is health insurance so important?

- Lack of coverage impacts the use of emergency room visits and hospital admissions.
  - Lack of timely and effective ambulatory care can result in a greater number of hospitalizations, especially for certain conditions and among vulnerable populations.
  - Preventive care linked to continuity of care with a provider can lead to decreased hospitalizations for a Medicaid population of children and adults.

Source: Kozak, L.J., et al, "Trends in Avoidable Hospitalization: 1980-1998." *Health Affairs*, 20 (2), 225-232.

Why is health insurance so important?

- Lack of appropriate health care puts kids at risk at school.
  - Children in poor health miss school more often.
  - Children who are not treated for health conditions such as asthma perform poorly in school.

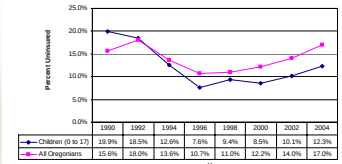
Source: Kaiser Commission on Medicaid and the Uninsured, "Sicker & Poorer: The Consequences of Being Uninsured," 2002.

How Health Insurance Status is Measured
Oregon Population Survey, 2004

- Statewide random digit dial telephone survey of Oregon households
- Conducted every other year since 1990, last conducted in 2004.
- Primary objective is to track numerous health, social and economic "benchmarks", including measures of Oregonian's health insurance status.
- 2004 survey included 4,508 households, representing 11,595 individuals.
- Special study for African-American population conducted in June/July, 2005.

Trends

Percent Without Health Insurance in Oregon, 1990 to 2004*
(Source: Oregon Population Survey)



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

When the 18th year is added, 2004 percentage of children without insurance is 13%, representing over 117,000 children.

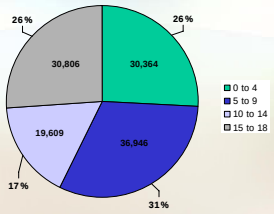
Distribution of Uninsured Children by Race & Ethnicity

Race/Ethnicity	% of total population*	% of total uninsured children	Number of uninsured children
White/Caucasian	87.4%	78.1%	91,918
Black/African-American*	1.7%	1.8%	2,153
American Indian/Alaska Native	1.0%	2.1%	2,438
Asian/Pacific Islander	3.7%	1.2%	1,382
Hispanic, any race	9.6%	36.0%	42,335

*2004 American Community Survey, All Ages, not restricted to 19 and under.

Will not add to 117,000 because categories are not mutually exclusive.

Distribution of Uninsured Children by Age



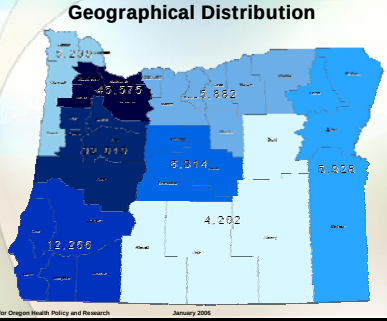
Poverty Status of Uninsured Children

Poverty Level	% of total uninsured children	Number of uninsured children
Less than 100% fpl	18.7%	21,898
100% to 200% fpl	34.3%	40,082
201% to 300% fpl	23.6%	27,640
301% to 400% fpl	4.2%	4,865
401% to 500% fpl	7.3%	8,520
More than 500%	3.3%	3,827
Unknown income	9.3%	10,891

- 53% are below 200% of federal poverty level
- 77% are below 300% of federal poverty level

2005 Federal Poverty Guidelines
$19,350 for a family of four

Geographical Distribution



Gaps in Children's Coverage

Another 10.7% of the children who were insured at the time of the survey experienced a gap in coverage at some time in the previous 12 months...

Length of Gap in Previous 12 months	% of children with gap in previous 12 months	Number of children (under 19)
1 month or less	20.6%	17,370
2 months	17.7%	14,850
3 months	21.2%	17,820
4 months	6.9%	5,772
5 months	5.8%	4,849
6 months	17.5%	14,692
More than 6 months	10.4%	8,772
Total	**100%**	**84,125**

To Summarize

- **Children without health insurance are less likely to get routine well-child care, have worse access to health care and use medical and dental services less frequently than insured children.**
- **In Oregon, 117,000 children under the age of 19 are currently without health insurance.**
- **About 58% may qualify for public coverage.**
- **Another 84,000 experience some gap in their coverage during the year.**

COVERING KIDS:

Children's Access to Health Care

Results from a Statewide Oregon Survey

Jen DeVoe, MD, DPhil
Department of Family Medicine
Oregon Health and Science University
January 2006

1

RESEARCH TEAM

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Lisa Krois, MPH Co-Investigator
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Office for Oregon Health Policy and Research

2

STUDY OBJECTIVES

- To hear directly from low income Oregon parents about the barriers to accessing health insurance coverage for their children.
- To explore potential links between health insurance status and access to healthcare services for Oregon's children.

3

STUDY METHODS

- Survey of a random sample drawn from all families with children (age 1-19) enrolled in the food stamp program as of January 31, 2005.
- Total sample size is 2,681.

4

STUDY METHODS

- Sample is representative based on key demographic variables: age, gender, race/ethnicity.
- We would expect that virtually all of these children qualify for the State Children's Health Insurance Program (SCHIP), but found that 10.9% are uninsured.

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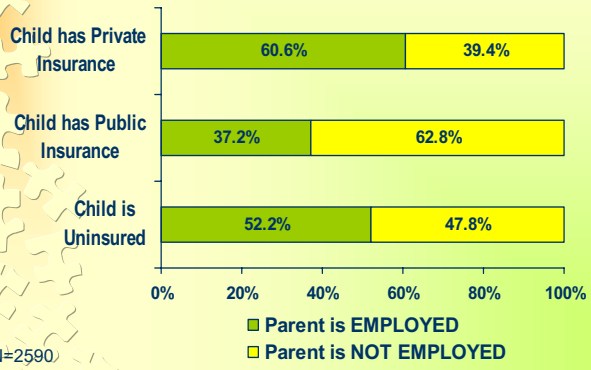
Health Insurance Status

Among Oregon children in the food stamp population, higher rates of uninsurance were associated with being:

- Hispanic
- Older than 14 years of age
- Living in a household earning between 133%-185% of the Federal Poverty Level
- Having an uninsured parent

6

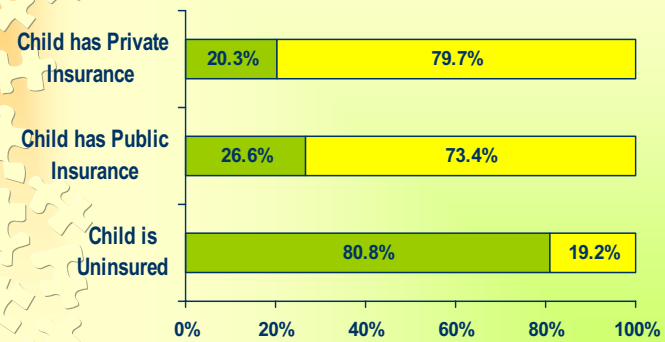
Over Half of the Uninsured Children Had Employed Parents



N=2590
p<0.0001

7

A High Percentage of Uninsured Children Had Uninsured Parents



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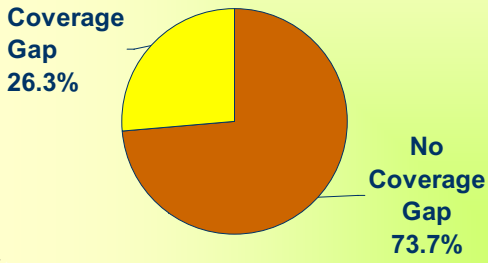
8

Insurance Coverage Gaps

"At any time in the last 12 months, was your child without health insurance?"



N=2510

9

Why Did Your Child Go Without Health Insurance Coverage?

- 20.7% - My child is not eligible for the Oregon Health Plan because of my income.
- 20.3% - The person whose health insurance covered my child was no longer eligible for coverage (due to reasons like job change or part-time work).
- 16.5% - We could not afford to pay the premiums for insurance provided at work.

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"Other" Reported Reasons for Children's Coverage Gaps

- Problems with the OHP application process.
- Missing the OHP re-certification window.
- Confusion about OHP premiums and children's eligibility if parents no longer eligible.

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Why Was Your Child Uninsured?

"Because I owe money to OHP for back premiums when they dropped adults from the health plans…"

"We own our own business and could not afford insurance premiums…had to wait 6 months to apply for OHP…"

"My employer does not offer insurance, and I don't make enough to get it on my own, and OHP denied us…"

"Their dad was supposed to get them covered through his work, but the costs was too much, and it didn't happen…"

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Impacts: Access to Care

In the past 12 months…

- 1 in 3 uninsured children did not visit a primary care provider.
- 4 out of 5 uninsured children did *not* get necessary dental care.

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Impacts: Access to Care

Compared to Insured Children, the Uninsured Children in this study were…

- 6 times more likely to have no usual source of care.
- 3 times more likely to go to the Emergency Department for regular care.

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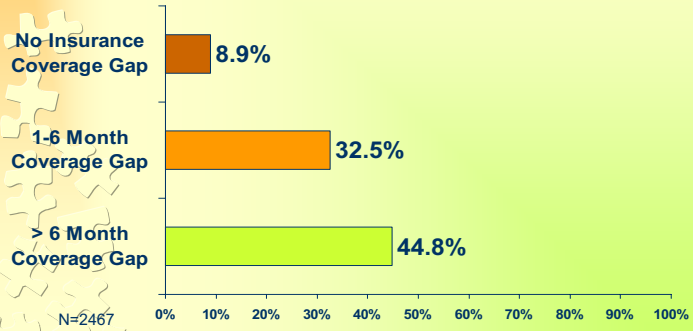
Children With Insurance Gaps Had the Highest Rates of Unmet Medical Need

"In the Past 12 Months, My Child Needed Medical Care but Did Not Receive It."

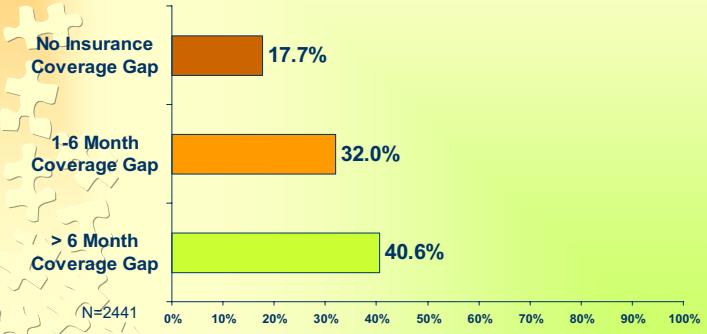


N=2467
p<0.0001

15

Children With Insurance Gaps Had the Highest Rates of Unmet Prescription Medication Need

"In the Past 12 Months, My Child Did Not Receive Prescription Medications Due to Cost."



N=2441
p<0.0001

16

When Parents Were Asked to Identify Three Changes that Would Make it Easier to Stay Enrolled…

- ✓72.6% said it would be easier if you did not have to re-enroll your child in the OHP every 6 months.
- ✓35.5% said it would be easier if your child did not have to go without health coverage for 6 months.
- ✓34.1% said they would like to be able to apply on-line.

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In Conclusion

- Despite eligibility for public or private coverage, Oregon's low-income families have children who are uninsured or experience gaps in their healthcare coverage.
- Cost and administrative hurdles are the major reasons for families not carrying insurance coverage for their children.

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In Conclusion

- Lack of health insurance is associated with significantly higher rates of unmet healthcare needs for many of Oregon's children.
- Many of these children have parents who are employed; however, no employer-sponsored coverage is offered, premiums are too expensive, or dependent coverage is not available.

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In Conclusion

- Children are more likely to remain uninsured if their parents are also uninsured.
- Gaps in coverage lead to the same problems as not having any coverage at all.

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Policy Implications

- Targeted efforts to maximize enrollment and retention of eligible children:
  - Eliminating or reducing the required period of uninsurance.
  - Simplifying the Oregon Health Plan renewal process.
  - Extending the OHP re-enrollment period from 6 to 12 months.
  - Streamlining the OHP application process.
- Explore ways to lower the cost of coverage for families who have access to employer-sponsored insurance.
- Explore ways to contain the rising cost of healthcare.

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ACKNOWLEDGEMENTS

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A special thanks to Janne Boone, Jessica Miller and James Oliver (OHPR); Rebecca Ramsey and Pooya Naderi (PSU); additionally, our appreciation for the efforts of Ron Taylor and Jeff Tharpe (CAF).

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Healthy Kids Public Meeting Questionnaire

During tonight's public meeting we talked about the goals of the Governor's Healthy Kids plan and how the plan is being developed. We also heard your opinions about how to make sure families pay a fare share of the cost of health care for their kids, and how to reach and enroll uninsured kids in the new program. Please complete the following questions with tonight's meeting in mind.

Return completed questionnaires to one of the facilitators or mail it to the address listed on the back.

1. What ***did*** you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids plan?

2. What ***didn't*** you hear tonight that you think is especially important to keep in mind while developing the Healthy Kids plan?

3. Is there any other information about children and health care that you think we should know about?

Basic Family Budget

The expenses listed in the ***Estimated Mandatory Expenses*** chart (right) are based on a family which includes two parents and two children living in Portland, Oregon, and uses numbers from the Economic Policy Institute (increased by 5% from 2004 for inflation).

Spend 5 minutes looking at the chart as a group. Do the amounts seem reasonable to you? Do you think the general budget should be increased or decreased?

2005 Estimated Mandatory Expenses	
Housing	$ 753
Food	$ 616
Child care	$ 898
Transportation	$ 394
Taxes	$ 437
Other necessities (e.g., clothing)	$ 370
Monthly total	**$ 3,467**
Annual total	**$ 41,605**

Activity #1 Evaluating Discretionary Income

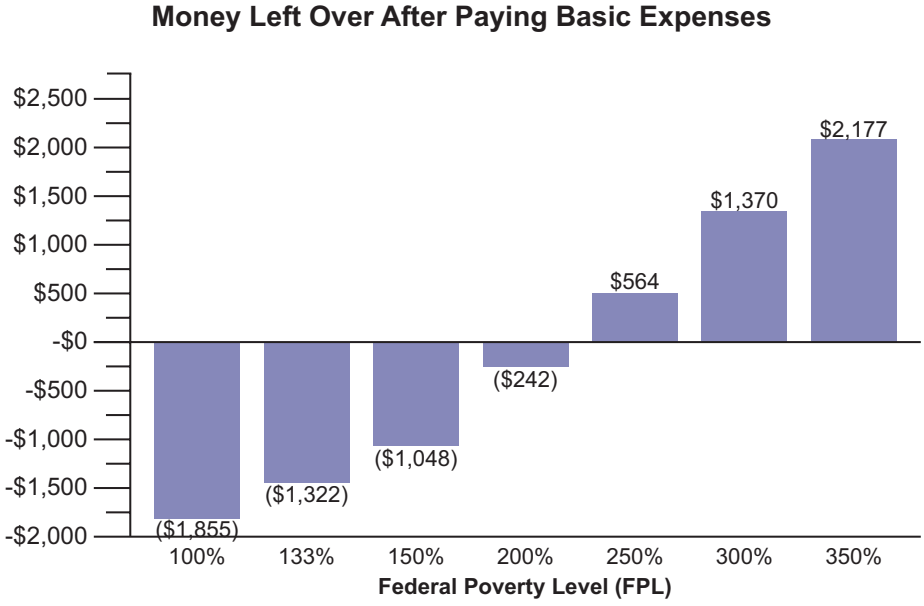
What part of a family's monthly income do you think is reasonable to go towards:

_____ Savings, and

_____ Improving social circumstances. For example, moving to a larger apartment, or paying for recreational activities for the kids (i.e., sports)

Look at the **Money Left Over After Paying Basic Expenses** chart. The chart shows how much money a family has "left over" every month after they have paid for their basic expenses. The "left over" money is based on the family income.

As you can see, in order for a family to pay for the basic, they would have to have an income of over 200% of the FPL.



Activity #2

In thinking about how much a family can afford to pay toward the monthly premium cost for its children in the new Healthy Kids program, we are figuring that a family at 200% FPL would pay something less than half the premium cost for insuring its children. So, if the total premium cost is $130 per child, a family at 200% FPL might pay a premium share in the neighborhood of $40 or $50 per month for each child's insurance.

Keeping that in mind, we would like you to help us get an idea of where on the income scale a family could pay a premium share of half, which would be $65 per month for each child's insurance.

We would also like you to help us get an idea of where on the income scale a family could reasonably be expected to pay the full premium cost of $130 per month for each child's insurance.

This will help the MAC in making its recommendations about what is a fair premium share contribution to expect from families at different income levels.

(a) What can a family at 200% FPL pay in monthly premiums?

(b) When should a family be able to pay half of the monthly premiums per child?

(c) When should a family be able to pay the full monthly premium without help from the state?

Activity #3

(a) Do you think it is better for families to pay more in monthly premium shares (which stay the same no matter how many health services are used) or in cost sharing (which is paid when services are used and goes up the more services are used)?

(b) Here is another way to think about it: When everybody pays a little bit higher monthly premium, they share the "financial burden" of any sick kids in the group equally; When everybody pays lower monthly premiums with cost-sharing for use of medical services, only families who have a sick child end up paying more. Does this change your thinking about (a) at all?

Family Contributions Glossary

Premium share: this is the part paid by the family toward the monthly cost of a child's health insurance. For example, if the monthly premium is $130 and the family contribution is 50%, then the family would pay $65 per month for each child's health insurance. Premium share stays the same monthly amount per child no matter how many services a child uses.

Co-payment: this is the amount a family pays toward the cost of care when a child uses a service (sees a doctor, has a prescription filled, has an x-ray, receives care at a hospital). For example, co-payments might be $10 for each doctor visit, $5 for each prescription, $50 for each visit to the emergency room, and so on.

Coinsurance: this is the percentage of the cost of a service. The family would pay this percentage for certain kinds of services. For example, a family might be required to pay 20% of the total cost of a hospital stay, up to a pre-specified limit. Coinsurance means the family pays more when a child uses more expensive services.

Deductible: this is the amount a family must pay before the child's health insurance starts to pay. For example, with a $100 deductible for each child, a family would have to pay the first $100 worth of services received by a child before that child's insurance started paying for services.

Out-of-pocket limit: this is the most a family would have to pay in a year before the child's health insurance started paying 100% of the cost of covered services used by the child. For example, if the out-of-pocket limit is $1,500 per year, that means that once a family has paid $1,500 in co-payments and coinsurances, then the insurance pays for all covered services a child uses from that point on for the rest of the year. The family would not be required to pay any more co-payments or coinsurances, however, the family would still responsible for the monthly premium shares.

How these all fit together

In Medicaid and CHIP programs, families sometimes have co-payments or premium shares, but these are small.

In many employer-sponsored insurance plans, the family pays a sizeable monthly premium share and also pays co-payments and coinsurance costs for some services. Typically, employer-sponsored insurance also has a deductible amount the family has to pay before the insurance will pay anything. To protect families from catastrophic debt, there is typically a limit on the total amount the family has to pay for co-payments and coinsurance for each family member and for the family as a whole.

Business and Kids' Insurance

The Medicaid Advisory Committee and the Governor want to encourage businesses, particularly small businesses, to offer health insurance coverage for their employees and their employee's children.

Other states are also looking at ways to provide incentives for businesses to do this. We have borrowed from these ideas to create a list of options for you to weigh in on. Please add your suggestions to the list and then rank your top five (with 1 being your first choice).

Rank	*Option*
_____	Create a small employer health insurance group purchasing pool which allows small businesses and the self-employed to buy insurance while minimizing administrative costs and increasing purchasing power in the private market.
_____	Tax credits to small businesses offering health insurance.
_____	Premium assistance to small businesses offering insurance through a state-managed health insurance pool.
_____	State legislation requiring all businesses to offer either employee and family health insurance, or contribute to an 'uninsurance pool' from which the state would provide health insurance coverage.
_____	State legislation that assesses businesses not offering family health insurance.
_____	State legislation requiring larger businesses to dedicate a certain percentage (generally 8%) of earnings to employee family insurance plans.
_____	Allow employer-sponsored Health Savings Accounts (HSAs) to be eligible for state subsidies.
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____

Ideas for getting kids into the program

The Medicaid Advisory Committee and the Governor want to make it easy for families to enroll their children in Healthy Kids. We are concerned with finding the best way of getting information about Healthy Kids to families, and then making it easy for them to apply.

What are your ideas of how we can find eligible kids to enroll in the plan?

What are the top three ways you would like us to get you an application for your child/children?

1. _____
2. _____
3. _____

Please share your ideas of how we could make the application process simple and easy for your family