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City Club of Portland (Portland, Or.)

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Information Report on
Medical Indigency in Oregon

To the Board of Governors,
City Club of Portland:

I. INTRODUCTION

Medical indigency is a term used to describe the situation faced by persons without sufficient finances or insurance to pay for needed medical care. The problem of medical indigency is of growing concern nationwide, as increases in health care costs continue to outstrip inflation, costly treatment regimes continue to be developed, and health care providers face mounting pressure to hold down costs by limiting "charity care". While even families and individuals with very good insurance coverage can become indigent when faced with extraordinary costs, those least prepared to face even moderate health care costs are those without insurance coverage.

Among persons likely to fall into this category are those who are unemployed and financially unable to purchase insurance, and indigent persons not eligible for Medicaid or welfare medical assistance. Some Oregonians have medical conditions which make them uninsurable at any price. Others gamble on their continued good health. However, the largest segment of the uninsured are full-time or part-time workers whose employers do not provide coverage, and dependents of these workers. In Oregon, it is estimated that about 400,000 people have no medical insurance from any source. About 65% of these uninsured are employed adults.

This report focuses primarily on the lack of insurance among the employed and efforts in Oregon to address this problem.

II. THE UNINSURED POPULATION IN OREGON

A. Estimates of the Uninsured in Oregon

Three recent surveys have estimated that at least 400,000 Oregonians under the age of 65, or about 17% of the non-elderly population of the state, have no medical insurance from any source. In fall 1986, the Committee for Counting the Medically Indigent (CCMI) of the State Health Planning and Development Agency reported that 16% of non-elderly households statewide are without insurance. Regional figures ranged from a low of about 13% in the Portland metro area to higher figures of 19% in the mid-Willamette Valley and southern Oregon. Eastern Oregon reported 16% uninsured.

A similar survey of the Portland and Salem areas sponsored by Kaiser Permanente Center for Health Research (Kaiser) estimated 17% with no coverage among households headed by someone under 65 years old. Both of these studies undercount the medically indigent because they do not include households without telephones (or without homes), and because they count as insured all family members of an insured head-of-household, even though some programs do not cover all family members.

A recent analysis of the U.S. Population Survey results also estimated over 17% of Oregon's non-elderly population to be without coverage. This estimate for Oregon is quite similar to the Population Survey estimate for the U.S. as a whole.

B. The Uninsured are the Working Poor

The majority of uninsured heads of households in Oregon are employed either full time (47%) or part-time (18%). The available Oregon studies did not address dependents. However, national figures show 86% of all uninsured are either workers or dependents of workers.

About two-thirds of the employed uninsured work for smaller companies (under 25 employees), including a large number in retail or service businesses. The reasons they do not have insurance vary. In most cases (about 60%), medical coverage is simply not offered by the employer. When medical insurance is available through an employer, some employees do not qualify (e.g., part-time workers) or report that the cost share required of the employee is unaffordable.

Each of the recent studies points to household income as a critical difference between the insured and uninsured. In the Portland area, most of the uninsured have very low household incomes: 51% have family incomes under \$10,000; 75% have incomes under \$15,000. In contrast, only 25% of the insured have family incomes under \$15,000. The uninsured group includes more young adults than does the insured population. About half of all uninsured households include children.

C. Health Care for the Uninsured

The Kaiser and CCMI studies addressed health status and utilization of health care services. In both studies, adults in households without insurance reported somewhat poorer overall health, with more chronic conditions requiring medical care. Outpatient care received by adults was less frequent among the uninsured. However, those uninsured who reported receiving care reported more visits than

their insured counterparts. This pattern was primarily a result of the high proportion among the uninsured of young women receiving maternity-related services.

The Kaiser survey found no significant difference in the percentages of the insured and uninsured who had been hospitalized in the previous 2 years (approximately 13% of uninsured heads of households compared to 14% of the insured; 26% of uninsured wives compared to 24% of insured wives). Sixty-four percent of the hospitalizations of uninsured wives were for childbirth, compared to 39% of those of the insured wives.

For children, differences in services between the uninsured and the insured appeared to be small. About 64% of uninsured children and 70% of insured children were reported to have seen a physician in the past six months. About 11% of the uninsured and 10% of insured children (excluding newborns) had been hospitalized within the past 2 years.

D. Who Pays for Care Received by the Uninsured?

A significant part of the care received by the uninsured is paid for by the recipients. On average, uninsured households spend a greater amount in dollars and a greater percentage of disposable income on medical care than do insured households. The Kaiser survey found that 13.3% of the uninsured reported paying over \$1,000 in physicians fees during the previous year, compared to 7% of the insured.

Most care for serious illnesses and injuries, and for childbirth, is provided to the uninsured by hospitals. Available reports indicate the amount of such care is large and steadily increasing. The Oregon Hospital Association in a December 1986 position paper estimated that 16% to 17% of services billed by Oregon hospitals are not paid for. A Pacific Health Policy Research study based on a sample of Portland-area hospital admissions with substantial unpaid charges found that about 60% of the amount of unpaid care resulted from treatment given to patients without insurance. (The remaining 40% of this shortfall was due to Medicare and Medicaid payments which did not cover the full amount billed.)

III. EFFORTS IN OREGON TO ADDRESS MEDICAL INDIGENCY

An early Oregon effort to provide basic health care within an innovative and cost-effective program was Multnomah County's Project Health operated from 1975 to 1983. Project Health pooled federal, state and county funds, enabling enrollees to choose from several existing health care providers (Kaiser, OHSU, Providence and others).

In 1981, the Governor's Conference on the Medically Poor studied the issue and recommended the expansion of the Oregon Medicaid program. In 1982, a State Health Plan (SHP) was proposed by the Multnomah County Blue Ribbon Committee on the Medically Needy. The SHP proposed a major restructuring of the current health care purchase and delivery system to provide services to all Oregonians, including inpatient and outpatient care, prescription drugs, laboratory services, and basic dental and mental health services. SHP proposed no new funding, suggesting that government, employer and consumer health care monies already used for health care would cover the program's costs if pooled in such a way that administration of funds would be more efficient.

More recently, a number of health care bills were introduced during the 1987 session of the Oregon Legislature, including SB 547, a comprehensive basic health plan similar to SHP. Possible negative impact on small business was the major concern of opponents of this measure, which was not enacted. A payroll tax measure (HB 2357) applicable to firms not offering health insurance to employees was defeated largely for the same reason. HB 2352, providing for a subsidized insurance pool to be made available for lower income families and individuals at reduced rates, was rejected primarily because of lack of a viable funding source.

SB 583, establishing a risk pool for uninsurables such as AIDS victims, was adopted. However, this bill's provision for operating funds was dropped in order to secure passage, leaving the measure with only a minimal budget (\$150,000) for start-up. A board has been established to implement the program and its recommendation regarding a permanent funding mechanism is forthcoming.

HB 2594, also enacted, is an innovative but as yet untested voluntary program aimed at employers. This measure provides a temporary tax credit to employers with 25 or fewer employees who have not provided health coverage to employees in the past and now elect to do so. During the first two years, the tax credit is equal to one-half of the premium paid by the employer, up to \$25 per month per eligible covered employee. Implementation of this program has been slow. An Insurance Pool Governing Board, which will certify private carriers to offer basic insurance plans under this program, has yet to be appointed.

In February 1988, Governor Goldschmidt established a 16 member Commission on Health Care for the Uninsured. This Commission is charged with recommending ways to provide reasonable access to health care for all Oregonians. The Commission report to the Governor is due September 1, 1988, and is to outline problems in gaining access to health care and strategies for addressing those problems.

IV. NEW PROGRAMS IN OTHER STATES

Many other states have studied the problems of medical indigency and, at this writing, a few have enacted legislation. Two state programs receiving considerable attention nationally are those recently passed in Washington and Massachusetts.

A. Washington State Health Care Plan

In 1987, the State of Washington enacted a pilot program to provide coverage to the uninsured. The legislation was the result of five years of study and contains the following provisions:

Basic Health Plan: This law creates a program through which 30,000 low income Washingtonians can purchase health insurance. These individuals will be reached through five demonstration sites around the state. They will pay premiums, ranging from \$10 to \$50 per month per family, depending on their income. The state will determine eligibility (family income may not exceed 200% of the federal poverty level) and will select managed care systems for participation. Once deemed eligible, enrollees may choose between several carriers for coverage. The cost will be subsidized through general revenue. An effort to place a 2% payroll tax on employers not offering coverage was defeated, but is expected to be renewed in 1988.

Medicaid Expansion: Income levels for Medicaid eligibility were increased and the state will provide coverage for all pregnant women below the poverty level.

Prenatal Grant: The state doubled the funding of a county-based program for delivering prenatal care to pregnant women with incomes up to 185% of the poverty level.

Medicaid Buy-In: Those people losing Medicaid eligibility due to increased incomes may continue Medicaid benefits for one year by making an as yet undetermined contribution to the cost of coverage.

Risk Pool: Washington also adopted a risk pool for those people with means who cannot get private insurance due to health conditions. The structure of this program is fairly conventional, but a sliding scale premium is still under consideration.

Uncompensated Care Grant: The state will provide direct grants to "disproportionate share" providers. This is aimed at funding care for those "structurally uninsured" who fall between the cracks of the other programs.

B. Massachusetts Health Care Program

In April of this year, the Massachusetts Legislature adopted by far the most comprehensive state bill yet addressing coverage for the uninsured. Among other things, the bill does the following:

Payroll Tax: This gives employers of six or more a very strong incentive to provide health insurance for employees and their dependents. By 1992, those businesses failing to do so will be assessed a surcharge of 12% of the first \$14,000 of the wages of each employee who works at least 20 hours per week, or approximately \$1,680 per worker. Employers providing health insurance for the first time will receive tax credits offsetting their expense. Self-employed persons and companies with fewer than 6 employees are exempt from the payroll surcharge. Firms in business less than three years will pay a lower surcharge.

Universal Health Care Plan: Unemployed people and workers not covered through their jobs may buy health insurance from a new state pool, paying on a sliding scale according to income. Premiums are to be less than the cost of private insurance. A new Department of Medical Security is to administer the plan.

Uncompensated Care Pool: Existing Massachusetts law provided for an uncompensated care pool to pay for the free care and uncollected bad debt at Massachusetts hospitals. The pool was financed by a 13.4% surcharge on all hospital bills. Under the new measure, this pool will be capped at current levels. Demand on the fund is expected to drop as the universal health care provisions are phased in.

Costs: The Massachusetts Senate Ways and Means Committee estimates the bill will cost the state \$660 million through 1992.

V. FEDERAL PROPOSALS

Two major national health bills were proposed in Congress during 1987. S 1265 was introduced by Senator Edward Kennedy of Massachusetts and S 1139 was introduced by

Senator John Chafee of Rhode Island. Kennedy's bill would require employers to provide minimum health care benefits for all workers who work over 17 hours per week. Employees would pay 20% of the cost, employers 80%. Small employers (those with fewer than 25 employees) could join regional risk pools. This measure would cover about 66% of those currently uninsured.

Chafee's bill would expand Medicaid eligibility, allowing persons with income between 100% and 200% of the federal poverty standard to buy Medicaid coverage. It would also allow people who are uninsurable or those who have exhausted their private insurance benefits, as well as small employers, to buy Medicaid coverage. This proposal would cover an estimated 62% of the uninsured.

Neither of these bills was passed in the 1987 Congress. Major concerns about these proposals include how the federal and state governments are going to finance expansions of Medicaid eligibility and whether employer required health insurance will result in job dislocation or business failure.

VI. SUMMARY

Medical indigency is receiving a great deal of attention nationwide, particularly since it impacts all aspects of the health care system. Hospitals attribute at least half of their uncompensated care problem to uninsured patients. Employers who provide insurance are becoming less tolerant of increases in health care costs which result from the need for providers to recover their costs for uncompensated care. The public is demanding to know why insurance is unavailable or unaffordable for so many people. Public officials and health advocates are concerned that health care is not accessible to the low income population.

Nationally, legislation has focused on mandatory employer coverage for employees working over 17 hours per week and expansion of Medicaid eligibility. However, it is at the state level where programs have been enacted and the most progress is being made. We have noted two states -- Massachusetts and Washington -- which have enacted complex legislation to deal with the lack of insurance.

In Oregon, we are on the brink of dealing with the medically indigent and the uninsured. The implementation of HB 2594 (the tax credit for employers who begin to provide health insurance) is anticipated with optimism, but at the same time, many have doubts whether a voluntary employer program will garner enough participants to be effective. The Governor's Commission on Health Care will produce recommendations in September 1988. The recommendations of a commission of this stature may present the basis and the

opportunity for Oregon to design a comprehensive approach to the extension of medical insurance, and to build the support needed for its passage.

This issue will have an impact on City Club members and many opportunities for involvement will arise as Oregon continues to grapple with solutions to the problems of medical indigency.

Respectfully submitted,

Eric Busch
Barbara Ann Dow
Sonnie Russill
Philip Spiers
Margaret M. Mahoney, Chair

Approved by the Research Board on May 26, 1988 for submittal to the Board of Governors. Approved by the Board of Governors on June 27, 1988 for publication. NOTE: BECAUSE THIS REPORT CARRIES NO CONCLUSIONS OR RECOMMENDATIONS, NO OFFICIAL ACTION IS REQUIRED OF THE MEMBERSHIP.

APPENDIX APrimary Reference Materials

- Center for Health Research, Kaiser Permanente, "Health Insurance: Access and Choice -- A Survey of Community Households," June 1986.
- Citizens Advisory Committee, "Recommendations to the Interim Joint Health Care Committee," October 14, 1986.
- Committee for Counting the Medically Indigent, "Description of Findings," 1986 Health Insurance Coverage Survey, State Health Planning and Development Agency.
- "Health Care for the Uninsured Program Update," a newsletter published by the Alpha Center under a grant from the Robert Woods Johnson Foundation.
- League of Women Voters, "Health Care for the Medically Indigent," April 1984.
- Oregon Association of Hospitals, "Medical Indigency and Uncompensated Care," Executive Summary and Report, December 1986.
- Pacific Health Policy Research, Inc., "Uncompensated Hospital Care in the Portland, Oregon Metropolitan Area," January 1987.
- "Project SHP," Executive Summary of a Proposal for a State Health Plan for Oregon.
- State of Washington, Senate Bill 5357, "Washington State Health Care Access Act of 1987."

David Cook to Chair Ballot Measure Study

David Cook, Deputy Director of the Public Employees Retirement System (PERS), will chair the "repeat felony offender" ballot measure study. *Cook* has served on two previous ballot measure studies and was a member of the Club's Education Standing Committee from 1983-85.

This committee will study the ballot measure sponsored by Congressman Denny Smith which would require certain repeat felony offenders to serve full sentences without parole, probation or other reduction.

New Member Welcome!

MacGregor Hall, Marketing Representative, Crabbe-Huson.

Thomas Palmer, Associate Attorney, Tonkon, Torp, Galen, Marmaduke & Booth.

Erick Petersen, Capital Campaign Coordinator, OMSI.

Scott South, CPA/Supervisor, Coopers & Lybrand.

Dale Victor, Partner, Anderson-Victor-Cunningham.

John Angell, Director, Justice Services, Multnomah County.

James Chapel, Senior Vice President, R.A. Kevane & Associates.

Faye Hall, District Sales Manager, OIL-DRI Corporation.

Richard Mastbrook, Executive Director, Loaves & Fishes Centers, Inc.

Karen Nettler, Branch Manager, Adult & Family Services.

Madelyn Robertson, Cash Management Officer, U.S. Bank.

Robert Wise, Director of Planning, Portland, State University.

NEWSPAPER SECOND CLASS POSTAGE PAID AT PORTLAND, OREGON
