THE AVAILABILITY OF MEDICAL CARE TO INDIGENT CHILDREN IN LANE COUNTY

by

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Lane County provides medical care to indigent children through a network of state and local programs. State-funded programs include Medicaid, the Children Health Insurance Program (CHIP), which provide managed care health insurance at no cost, the Family Health Insurance Assistance Programs (FHIAP), which subsidizes insurance premiums, and the Oregon Medical Insurance Pool (OMIP), which provides coverage for individuals with chronic health conditions. Local programs include clinics that provide low or no cost services. To determine how well this network meets the medical needs of indigent children, I interviewed professionals, did literature searches, and observed at local clinics. From my research, I conclude that the community is not adequately meeting the medical needs of illegal immigrants and children in families with incomes between 170 percent and 200 percent of the federal poverty level (FPL). The State can address these problems by broadening the eligibility of CHIP and increasing support for local programs.

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CHAPTER I

INTRODUCTION

Health care is of vital importance to the well-being of every individual. Although having health insurance does not necessarily indicate good health, those that have access to medical care are much more likely to be in better health. According to the Oregon Population Surveys 1990 – 1998, eight percent of children[1] in Oregon remain uninsured (Office for Oregon Health, Application 2). This number is a great improvement over the early ninety's, when twenty percent of children were without insurance. However, the progress made over the last ten years has not been uniform across racial, ethnic, socioeconomic, or geographic boundaries (Office for Oregon Health, Information 7). Unfortunately, people of Hispanic descent and other racial and ethnic minorities, those who live in rural areas, and families with moderate incomes exhibit higher than average rates of being without insurance (Office for Oregon Health, Information 7).

For this reason, Oregon implemented programs at both the state and local level to assist low-income[2], uninsured families in obtaining medical and dental services, which would otherwise be inaccessible due to financial difficulties. The network of state programs offering health care to indigent children includes Medicaid, Children Health Insurance Plan (CHIP), Family Health Insurance Assistance Plan (FHIAP), and the Oregon Medical Insurance Pool (OMIP). These plans, with the exception of OMIP, offer medical care either through managed care or subsidized premiums for individual health plans. Unlike the other programs listed above, OMIP is available only to individuals who

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[1] Children are considered to be under the age of 19.

[2] Low-income refers to a family income of less than 200 percent of the federal poverty level.

have been denied insurance based on current or past medical conditions, and does not subsidize premiums or copayments. Local programs, in addition to state-funded health insurance, are a fundamental source of health care for uninsured children and are more easily tailored to the community's needs. In Lane County, these include free clinics, such as the Healthy Tomorrows Well Child Program (HTWCP) and school-based clinics, and providers that charge based on a sliding scale, such as Lane Public Health Services (LPHS) and the White Bird Clinic.

To characterize the services provided by the clinics I listed above, I visited each for a few hours and interviewed one of their staff members. During these interviews, I asked questions about where the clinic receives its funding, how it is staffed, what services they provide and who accesses them, what additional resources the clinic requires, and how the state and community could best guarantee universal health coverage to children. My goal was to understand what local services are available to low-income children without insurance. I also determined what programs are available through the state and federal government by attending a public discussion about the Oregon Health Plan (OHP) at Sacred Heart hosted by the Oregon Health Council (OHC), interviewing the Director of the OHC, Bob DiPrete, and a representative of the Office of Medical Assistance Programs (OMAP), Joan Kapowich, and through extensive literature searches. By combining this knowledge, I pinpointed populations of children in Lane County who are under-served, which include illegal immigrants and children with family incomes between 170 percent and 200 percent of the Federal Poverty Level (FPL). Here, I propose a method to reduce the number of uninsured and present potential ways to fund additional programs.

Although state and local programs have greatly reduced the number of uninsured children in Lane County, six percent of residents remain without reliable medical care, indicating we have yet to fully address the medical needs of children. Children must be immunized at the appropriate times, have a primary care provider who keeps accurate records, receive regular well child exams, have access to sick child care, and be able to obtain referrals, prescriptions, medical equipment, and emergency care. To meet these needs for every child, Lane County must expand health care coverage by implementing school-based health centers in the elementary and middle schools, broadening the eligibility standards of state programs, abolishing waiting lists for state-funded health insurance, and supporting local efforts. These actions require additional funding for the Oregon Health Plan and local programs, which could potentially come from the state's general fund, additional taxes, or earmarked funds[3].

[3] A special source of money, such as from a tobacco settlement, which the state earmarks to fund a particular program.

CHAPTER II

STATE PROGRAMS

Providing health care to an indigent population in any area is a combined effort between the Federal Government, the State Government, and the local community. In this chapter, I outline the network of programs in Lane County that are offered through the State of Oregon. This discussion includes programs that are found nationwide, such as CHIP and Medicaid, but are uniquely structured from state-to-state. Furthermore, for each program, I present a detailed description of the eligibility requirements, services covered, and the method of delivery.

State programs are an integral part of insuring indigent children in Lane County. Medicaid, the largest of these, provides low-cost or free medical and dental services for certain families with limited financial resources under Title XIX of the Social Security Act, and was enacted as law in 1965 (OMAP, Overview 1). Medicaid programs are jointly-funded by Federal and State governments, and therefore, must uphold basic standards set forth by the Federal Government (King 1-1). These standards, for example, include providing Medicaid to children under the age of six with family incomes lower than 133 percent of the federal poverty level (FPL). Children born after September 30, 1983, up to the age of 19, with incomes under 100 percent of the FPL must also be insured (Administration, Head Start 68). The FPL is determined by the number of individuals of a family and varies year to year. For example, the current FPL for a family of four is $1,421 per month (See Table 1).

Medicaid programs vary widely from state to state, because each has the choice of whether or not to insure those who do not meet the minimum standards set by the Federal Government. Furthermore, state governments are also responsible for determining the type, amount, duration, and scope of services, as well as the rate of payment (Administration, Head Start 73). Each state administers its own program, and for the State of Oregon, the responsible agency is the Office of Medical Assistance Programs (OMAP).

The component of Medicaid that is in charge of providing health care to children is referred to as the Early and Periodic, Diagnostic, and Treatment Services (EPSDT). EPSDT became a part of Medicaid in 1969, and is now a mandatory plan that provides screening services, immunizations, dental, vision, and hearing services to anyone eligible for Medicaid under the age of 21 (Administration, Head Start 73). In Oregon, this group consists of children under the age of 6 with an income of less than 133 percent of the FPL, children ages 6 to 18 with an income of less than 100 percent of the FPL, and children under the age of one, whose mothers are enrolled in Medicaid, with a family income of up to 170 percent of the FPL (Kitzhaber 51; See Table 2). In order to be eligible, the families of these children must not have more than 5,000 dollars in liquid assets, such as cash, stocks, and checking accounts, be an Oregon resident, U.S. citizen, or a qualified resident alien[4] (Kitzhaber 12).

Despite the efforts of Medicaid, there were still 70,000 uninsured children in Oregon in 1998 (Kitzhaber 3). In order to address this issue, Oregon Governor John Kitzhaber submitted an application for a State children health plan to the Federal

Government in February of 1998 under Title XXI of the Social Security Act. This title, created by the Balanced Budget Act of 1997, provides additional funding to insure children with low family incomes. The Federal Government agreed to help fund a children health plan for Oregon, granting over thirty-four million dollars to cover administration and program costs through the year 2000 (Kitzhaber 42). Oregon used these funds, along with nearly thirteen million of its own dollars, to initiate a state-run program called the Children Health Insurance Plan (CHIP), which was implemented in July of 1998. Children ineligible for Medicaid can now be insured through CHIP if their family income is between 133 percent and 170 percent of the FPL (Kitzhaber 51).

CHIP is often referred to as a Medicaid-like program because its services are offered through the same providers, the benefits are the same, and the application processes are identical. The reason for creating a separate program was to obtain a higher matching rate of federal to state dollars. Currently, the federal government matches 72 percent of state dollars for CHIP, but only 60 percent for Medicaid (DiPrete, Speech, 5/2/00).

In Oregon, 88 percent of CHIP and Medicaid services are offered through managed care (Office for Oregon Health, Information 2). In contrast to fee-for-service plans, managed care is characterized by capitation. In other words, the organization charges a fixed monthly rate per person, regardless of the number of services accessed, as long as they are covered under the plan.

Managed care organizations (MCO) can take many different forms. For example, Health Maintenance Organizations (HMO), arguably the most well-known of MCOs,

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[4] Legal alien residents are eligible for federal assistance programs only if they entered the country after August 22, 1996. FHIAP is a state-only programs, and therefore all legal alien residents are qualified if

generally conform to the staff, group, or network model. In the staff model, the HMO owns the clinical facilities and the physicians are paid a salary (Capuzzi and Modrell, Cost Containment 18). In this model, physicians do not undertake any financial risk, because they receive a fee for every service provided (Birenbaum 16). The group-model HMO, however, "contracts with one large (professionally autonomous) multi-specialty medical group practice for physician services. The HMO pays the medical group a monthly amount per member to provide services" (Freeborn and Pope 21). The network model is essentially an expansion of the group model, with the major difference being that the HMO contracts with numerous physicians groups (Birenbaum 16). Therefore, in both the network and group model, the care providers assume financial risk in the arrangement, because they are paid according to the number of people that are enrolled to obtain services from their facility, and not by the number of individuals treated (Birenbaum 16). Another type of MCO, which is also rapidly increasing in number, is the Independent Practice Association (IPA). IPAs are comprised of individual physicians, who "contract to care for covered individuals, usually on a heavily discounted fee-for-service basis" (Birenbaum 16).

The advantage of managed care is the degree to which it reduces costs. According to a RAND study, the cost per individual in a managed health care plan is 28 percent lower than in fee-for-service insurance plans (Capuzzi and Modrell, Cost Containment 19). However, managed care often directly or indirectly rewards, or at the least, strongly encourages providers to minimize costs, and thus there are financial incentives to under-treat.

Primary care physicians, specialists, and hospitals that provide health

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otherwise eligible (DiPrete, E-mail, 5/9/00).

> care services in managed care settings are reimbursed in different ways. Capitation continues to be the primary method of reimbursement to primary care physicians (45 percent of total reimbursements), and fee-for-service continues to be the primary method of reimbursement to specialists (52 percent of total reimbursements). "Per Diem" is most frequently used to reimburse both inpatient and ambulatory hospital services, with almost 48 percent of HMOs using this method. HMOs sometimes pay salaries to their contracted physicians, but this accounts for about 6 percent of the total reimbursements to primary care physicians and only 3 percent of the total paid to specialist. (Health Insurance Association of America 54-55).

However, according to OMAP, the State "monitors for the care delivered and has seen few cases of care withheld or under-utilization of care we could link to the payment (capitation of care). If anything, the care reported was often less than the care provided as documented in the medical record" (Joan Kapowich, E-mail, 5/19/00).

According to Joan Kapowich of OMAP, most of the services offered under the Oregon Health Plan are paid either on a fee-for-service basis, or through partial capitation, with a certain amount withheld based on performance (E-mail, 5/19/00). In the latter, the providers receive the withheld payment once they attain a certain benchmark (Kapowich, E-mail, 5/19/00). For example, they are only given 90 percent of their fee unless they immunize a certain percentage of children. This type of incentive, in addition to rules and standards set by OMAP, help ensure that individuals who are insured through the Oregon Health Plan receive quality care.

Individuals enrolled in CHIP or Medicaid access general medical services through Fully Capitated Health Plans (FCHP). Currently, there are two FCHPs in Lane County that contract with the State: Providence Health Plan (PHP) and Lane IPA (LIPA). As of March 1, 2000, there were 25,520 people enrolled in a FCHP in Lane County, 13,653 in LIPA and 11,867 in Providence (OMAP, OHP Enrollment 1). FCHPs are very similar to

health maintenance organizations (HMOs), as they function to manage each enrollee's care, from annual physicals to hospitalization (OMAP, OHP History 15).

As of 1984, the state can only contract with organizations to provide Title XIX services that maintain quality assurance methods and protocols (Kitzhaber 28). These criteria, among others, are outlined in OMAP's OHP Administration and General Rules. These rules are, in essence, to "ensure that OMAP members are treated with the same dignity and respect as non-OMAP members or other patients who receive services from Contractor and its subcontractors" and provide them with the same quality of care (OMAP, FCHP Contract 6). Based on OMAP surveys, in 1996, 84 percent of OHP members were satisfied with their health care, which was up from 77 percent in 1994 (OMAP, OHP Programs Report 3).

Individuals enrolled under Providence Health Plans, for example, are covered under a plan called the Oregon Option, which is reserved for those covered by the Oregon Health Plan. Once a member of this plan, the individual must choose a primary care provider, who is then responsible for the majority of the person's care (Providence 1). This provider is the first person to see the patient for all non-emergency medical problems, and refers the patient to specialists or a hospital, as necessary. If a patient does have an emergency, they can go directly to the hospital without first contacting their primary provider, but must call them as soon as possible (Providence 1). If the patient is unsure whether or not they are having a medical emergency, they can contact the on-call physician or provider seven days a week, 24 hours a day (Providence 1).

Oregon contracts with managed care organizations to provide care for Medicaid recipients, and therefore the state is responsible for determining which services are

covered by the Oregon Health Plan, not the MCO. The theory behind Medicaid is to expand the number of people who can obtain health care by restricting what types of care are covered by the government. However, there is a basic package that each state must offer to every person eligible for Medicaid, with additional services required for children. The EPSDT benefit package must include screening services, in the form of a comprehensive, unclothed physical examination, health and developmental history, a physical, and mental health education (Administration, Head Start 59). Each state must also cover immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP), laboratory tests, and health education (Administration, Head Start 59). Further, dental services, hearing and vision services, including hearing aids and eyeglasses, must also be offered. In order to assure access to these services, all EPSDT packages are required to provide assistance with transportation and the scheduling of appointments (Administration, Head Start 59).

The OHP rations medical services through a prioritized list. This list consists of 743 medical conditions paired with the method of treatment, and is ranked in consideration of the cost to benefit ratio (OHP Overview 14). Of these 743, the government currently covers the first 574. Therefore, providers of Title XIX services are required to set up a system that covers these treatments, at minimum (Kapowich, E-mail, 5/19/00). The formation of this list was prompted by the case of seven year old Cody Howard, who was afflicted by acute leukemia (Klein, Day, and Redmayne 110). His only hope of survival, albeit a slim one, was for a bone marrow transplant. The State of Oregon refused to take on the expense of the surgery, and the young boy died before his

parents could raise enough funds from alternative sources (Klein, Day, and Redmayne 110).

In order to create a defined benefit package for those insured by Medicaid, the legislature passed the Basic Health Services Act in 1989, marking the formation of a fundamental component of the OHP. The governor appointed, eleven-member Health Services Commission was responsible for ranking the conditions and treatments in consideration of their cost, the duration of benefit, physicians' opinions of the probability that treatment will relieve symptoms or prevent death, and the community's input (OMAP, Policy 3). Over 50 physician panels were consulted and 1,001 Oregon residents were polled throughout this process (OMAP, Policy 3).

Oregon also addresses the need to insure indigent children through the Family Health Insurance Assistance Program (FHIAP). Created by the 1997 Oregon Legislature, FHIAP is funded with money from state tobacco taxes and federal funds (Kitzhaber 7). For the 1999-01 biennium, the FHIAP budget is slightly under 22,000,000 dollars (Office for Oregon Health, Information 5). FHIAP functions by subsidizing insurance obtained through the workplace or the individual market for families with incomes less than 170% of the FPL. Those with employers that significantly contribute to health insurance costs are required to enroll through their workplace in order to receive subsidies (Insurance Pool, FHIAP Handbook 9). In addition, FHIAP subsidies cannot be used for the parents alone. They must be used to cover either the children only or the family as a whole (Insurance Pool, FHIAP Handbook 9). Children in families who are eligible for FHIAP are often also eligible for Medicaid or CHIP. In these cases, the parents are given the choice of which insurance they prefer for their children (Kitzhaber 7-8).

In addition to income criteria, to receive FHIAP subsidies families must be Oregon residents, hold less than 10,000 dollars in investments and savings, and be uninsured for at least six months prior to their application (Insurance Pool, FHIAP Handbook 2-3). If a family meets all of the above requirements, they are eligible to receive a percentage of their share of the health insurance premium, i.e. not any part of which is paid by the employer. The government will either pay 95 percent, 90 percent, or 70 percent of their monthly premium payment, depending on the family size and monthly income (See Table 3). For example, if a family of four has a monthly income of $1,392-$1,752, the State will pay 95 percent of their payment. If their insurance premium is 200 dollars, of which their employer pays 100 dollars, the family's premium payment is five dollars a month.

Health care financed by FHIAP is accessed through either the employer's health insurance plan or a company approved by FHIAP (Insurance Pool, FHIAP Handbook 9). Those with employers that contribute to health insurance costs are required to enroll through their workplace in order to receive subsidies. Although, if the FHIAP member misses their employer's open enrollment period, or is not employed where health insurance is offered or contributed towards, they may select a private health insurance plan (Insurance Pool, FHIAP Handbook 10). In Lane County, the approved plans are ODS Health Plans, PacifiCare, QualMed, or Regence BlueCross BlueShield of Oregon.

Although all health plans are different, we can look at the plans offered through ODS Health Plans to understand the differences between the managed care plans offered through Medicaid and CHIP and those available through FHIAP. The two plans approved by FHIAP through ODS are the Individual Option and the Individual Preferred

Option. Under the Individual Option, the family has a choice of a plan year deductible per member of either 1,000 or 5,000 dollars (ODS 4). Once the cost of medical treatments exceeds this amount for one member of the family, the cost for further services are generally 20 percent of the billed amount. However, the family is not required to pay over 2,000 dollars for the out-of-pocket portion of their fees (ODS 4). It is not necessary for members of this option to receive care from any particular provider, and therefore can see any licensed medical professional.

In the Preferred Option plan, the family has a choice of a 1,000, 2,500, or 5,000 dollar deductible per member per year. This plan also covers any out-of-pocket costs above 2,000 dollars (ODS 4). Similar to the Individual Option, members are not required to see certain providers. However, in this plan, the patient is given a price break for going to participating physicians. After the deductible, services from a non-preferred provider only cost 40 percent of the charged amount, while only 20 percent for a preferred provider (ODS 4).

Rates for coverage including both spouses and their children for the Individual and Individual Preferred options range based on the age of the primary applicant and the deductible chosen. For example, if the primary applicant is between the ages of 35 to 39, a 1,000 dollar deductible totals $276.31 per month, and the 5,000 deductible plan costs $186.73 per month. For the same family under the preferred option with a 1,000 deductible, the plan comes to $217.82 per month, with a 2,500 dollar deductible, $177.94, and with a 5,000 dollar deductible, $148.01. Although the majority of these premiums are paid for through FHIAP, the out-of-pocket costs are not. The minimum deductible

for either of these plans is 1,000 dollars per family member, which comes directly from their own finances.

In addition to facilitating children with low-income families to access health insurance, the Oregon Health Plan also works to cover individuals that have been denied coverage for health reasons through the Oregon Medical Insurance Pool (OMIP). An OMIP-eligible person is an Oregon resident who has been either rejected for individual health insurance, had their insurance involuntarily canceled, or an insurance agent would not apply for health insurance on their behalf based on health concerns within the last six months (Insurance Pool, OMIP Handbook 1). An individual can also be insured through OMIP if they have exhausted their COBRA[5] benefits and are not accepted for a portability[6] plan, or alternatively they are insured through a portability plan but are no longer in the portability service area (Insurance Pool, OMIP Handbook 1). Under these circumstances, the individual must apply for OMIP within 63 days of losing their previous insurance (Insurance Pool, OMIP Handbook 1). Although this component of the OHP is not targeted at indigent children, it is a necessary source of medical care for children with chronic health conditions.

Created by the 1987 Oregon Legislature, OMIP has covered nearly 17,000 Oregonians since its inception (Insurance Pool, OMIP Annual Report 1). As of November 1999, nearly 6,000 residents were insured under OMIP. For the 1999-01

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[5] COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985. As of July 1, 1997, this federal law requires that group health plans which cover 20 or more employees to allow each individual to continue their coverage, including their dependents, for 18 months after a "qualifying event." Qualifying events can be a reduction in work hours, termination of employment, death, or divorce (Insurance Pool, OMIP Handbook 17).

[6] Portability coverage refers to individual health insurance offered to a person who is leaving an employer-based, group plan (Insurance Pool, OMIP Handbook 19).

biennium, the OMIP's budget is $42,028,345, and is funded through assessments on insurers in Oregon (Oregon Health, Information 7). OMIP-based insurance is available through four different plans. The premiums for each of these plans are calculated according to the age of the oldest person being covered. Among these plans, the monthly premium for an individual can be as low as 72 dollars, or as high as 424 (Insurance Pool, OMIP Handbook 12). The cost for family coverage ranges from 219 up to 943 (Insurance Pool, OMIP Handbook 12).

Plan I, also referred to as the Traditional Indemnity Plan, is characterized by the ability to see any physician, and the individual pays a set percentage of their health care costs. For example, they are responsible for 20 percent of fees incurred for doctor visits, hospital services, prescription drugs, and outpatient surgery (Individual Pool, OMIP Handbook 12). This plan also includes an annual deductible of 300 dollars, although the overall out-of-pocket costs per person do not exceed 1,300 dollars. At this point, OMIP covers all health care charges, up to a lifetime maximum of 1,000,000 dollars. Notably, none of OMIP's plans offer coverage beyond 1,000,000 dollars (Insurance Pool, OMIP Handbook 12).

The Preferred Provider Plan, or Plan II, offers a greater amount of coverage when the individual goes to a preferred provider for medical care. The premiums are lower for this plan, and the percent a member has to pay for services are the same as in Plan I as long as they are obtained through a preferred provider (Insurance Pool, OMIP Handbook 12). If the patient sees providers outside of the "physician network," their out-of-pocket costs double. The annual deductible is also 300 dollars, however, the maximum out-of-

pocket costs are 2,200 for services outside of the preferred providers, and 1,300 within the network (Insurance Pool, OMIP Handbook 12).

In the Managed Care Plan, Plan III, the member does not have the option to go to any physician present in the area. Instead, they are required to select a primary care physician who is a part of the OMIP network. This person is responsible for overseeing all of the individual's medical care (Insurance Pool, OMIP Benefits 2-3). The 300 dollar deductible for this plan counts towards prescriptions only, and many of the services also include a copayment as well as a flat percentage of the fees. For example, a member must pay a 200 dollar copayment for hospital services, in addition to 20 percent of the total charges. However, doctor visits are entirely paid for after a 15 dollar copay (Insurance Pool, OMIP Handbook 12).

The final plan offered by OMIP is the Low Cost Traditional Plan, or Plan IV. The premiums for this plan are significantly reduced, although so are the benefits. It is similar to Plan I in that members may see any physician they choose, and there is not a price break for using preferred providers. Unlike the other plans, services such as women's health care, immunizations, and mental health treatments are not covered. Also, the individual must pay 30 percent of the cost of the covered services, and the annual deductible is 1,000 dollars for medical expenses and 1,000 for prescription drugs. Overall, members are not charged more than 4,000 dollars in out-of-pocket costs.

CHAPTER III

LOCAL PROGRAMS

In Chapter III, I discuss four clinics in the Eugene area that provide medical care to indigent children. As a part of my research on local programs, I visited each of these clinics and spoke with one of the directors. Here, I have combined the information from my interviews and literature sources to characterize each program's funding, staff makeup, eligibility requirements, and available services. I also describe which populations of children obtain their services and any problems the clinic is experiencing in terms of funding or accessing other resources.

Local programs are a fundamental part of the network offering health care to indigent children. In Lane County, they consist of the Healthy Tomorrows Well Child Program (HTWCP), school-based clinics, Lane Public Health Services (LPHS), and the White Bird Clinic. These programs are a vital source of medical care for children in a multitude of situations. For example, this population of children includes those ineligible for state programs because they have not been uninsured for six months, and also those who have families with incomes that are too high to obtain state assistance, but are still too low to afford health insurance. Furthermore, they also provide health care for illegal immigrants, which is often not accessible through state funds, regardless of their economic situation.

Healthy Tomorrows Well Child Program (HTWCP), located in the Peace Health building on West Broadway in Eugene, offers free medical services to indigent children. The clinic is small in size, consisting of a small front office, a single exam room, which

also holds the nurse's desk, and a storage area filled with medications and pamphlets. All signs at the clinic are in both English and Spanish, because 80 to 90 percent of their patients are Hispanic (Writer, Personal Interview, 2/7/00). The receptionist is fluent in both Spanish and English and often translates for the Nurse Practitioner, although she also speaks Spanish relatively well.

HTWCP is funded by numerous sources, as is true for most clinics of its kind in the Lane County area. It receives $50,000 per year from a federal grant, called Healthy Tomorrows, $20,000 per year from the Robert Wood Johnson outreach grant, and $3,600 per year from the Children's Miracle Network (CMN) (Writer, Personal Interview, 2/7/00). CMN also funds $250 per month in medications. To cut down on costs, the clinic's Nurse Practitioner, Charlotte Writer, mixes and labels as many of her own medications as possible. Labeling alone usually costs eight dollars, and therefore by doing it herself, she can redirect these funds for items such as medical supplies (Writer, Personal Interview, 2/7/00). The clinic also saves money by accepting prescription drugs donations from pharmaceutical companies. Furthermore, Oregon Medical Labs donates all of the required laboratory work, and is located, conveniently, just a few floors beneath the clinic.

To be eligible for the services provided at HTWCP, the child must be ineligible for Medicaid and also have a family income of less than 200 percent of the FPL (TheLane 3). HTWCP provides vision and hearing screenings, dental referrals, immunizations, and well and sick child care (TheLane 3). Families can also obtain assistance with applying for state programs, such as Medicaid, and receive information on other programs such as WIC and Head Start (Writer, Personal Interview, 2/7/00).

During the afternoon I observed at HTWCP, Writer saw three patients, and all spoke Spanish as their first language. The first child she saw was three years old and had an ear infection, which Writer treated with amoxicillin that she mixed, labeled, and gave to the child's mother all right there in the clinic. The second patient was just under three years old, and was afflicted with persistent diaper rash. She gave the mother small samples of athlete foot medicine to put on the area and directed her to also apply Lotramine AF, which she needed to buy at the store. Although this treatment, as Writer explained, is not traditional for rashes, she believes it is still effective and much more cost efficient than the commonly prescribed hydrocortizone cream. The last patient Writer examined was a seven-year old boy, also with a rash. She performed a throat culture to rule out strep throat and instructed the family to come back in a few days if the rash did not disappear. In addition, Writer gave the patient a developmental exam, including a vision test, from which she concluded that the child needed glasses, and directed the parent to inquire at his school for help with purchasing them.

Lane County also offers health care to low income children through school-based clinics. These clinics serve mostly high school aged children. In this area, only one elementary school contains a health clinic, and one has yet to be started in a middle school (Fries, Personal Interview, 4/14/00). Nearly all of the high schools boast some type of a clinic, although this method of providing care is a relatively new trend. South Eugene High School, where I observed for an afternoon, has been operating for ten years. This clinic is funded through a patchwork of different sources, including state grants, Peace Health, insurance corporations, with the majority of their funding provided by the Eugene 4J School District (Fries, Personal Interview, 4/14/00).

All students at South Eugene can visit the clinic, although only those with large health insurance deductibles or no insurance are given exams or prescriptions (Fries, Personal Interview, 4/14/00). The clinic also sees younger children from time to time, who are not students, but they live nearby the school. However, this service is not well advertised, and thus is not taken advantage of very often (Fries, Personal Interview, 4/14/00).

Susan Fries, the nurse practitioner of the clinic, estimates that 30 to 40 students visit the clinic per day, with three to four of them requiring an exam (Personal Interview, 4/14/00). All services are free, and range from handing out food and over-the-counter medications, to gynecological and physical exams. For students who need prescription drugs, Fries writes their prescriptions on special forms that the patient can fill at Bi-Mart without being charged. The bill, instead, goes to the school and is paid for by the clinic. Fries is also capable of giving students referrals for specialists from an extensive list of physicians, and even surgeons, in the area willing to donate their services. If students need to stay in the hospital, they can remain at Peace Health for a short stay at no cost, as long as the physician caring for the patient donates their services.

Lane Public Health Services (LPHS), which serve as an additional source of low-cost medical care for indigent children, is responsible for public health issues. Their facilities are located at 135 E 6th Street, where they offer a wide range of services, from assistance with tobacco cessation to family planning. The building holds six exam rooms, multiple reception areas, and offices for the clinical and administration staff. The entire clinic employs 61 people, two of whom are Nurse Practitioners, although neither works full-time (Gillette, Personal Interview, 5/17/00). LPHS also has a half-time

physician, who serves as their health officer and a number of nurses. The program at LPHS that sees the highest number of children is the walk-in immunization clinic, and is only open on Wednesday mornings, from 8:00 am to 11:30 am (TheLane 1).

LPHS is jointly-funded by dollars from the Oregon Health Division and the Lane County General Fund (Gillette, Personal Interview, 5/17/00). Over the years, their funding continues to be reduced, despite increasing personnel costs. For example, last year LPHS was allocated 42,000 dollars for their immunization clinic, and this amount was cut in half for the current year (Gillette, Personal Interview, 5/17/00). Karen Gillette, the programs manager of the immunization clinic, indicated that this dramatic budget cut will significantly reduce the number of staff hours the clinic can afford.

Although LPHS receives funds from the State, it does not check whether or not potential clients are citizens (Gillette, Personal Interview, 5/17/00). Therefore, they are an important source for immunizations for children that are in the country illegally. Further, even though LPHS charges eight dollars per vaccination, they do not turn anyone away. Those who are incapable of paying at the time for the services are provided are given a receipt that reminds them to send a payment into the clinic whenever possible (Gillette, Personal Interview, 5/17/00). LPHS does not treat these receipts as bills, and therefore low-income families commonly utilize their services. However, the clinic is consistently in need of more funds, and reminds its patients to contribute when possible with a sign saying, "Due to budget restrictions in this clinic, any monies that you can pay today will help keep this clinic open."

Fortunately, LPHS contracts with delegate organizations that provide immunizations at other locations and times. These include clinics in Oakridge, Cottage

Grove, Florence, and school-based health centers throughout the county (Gillette, Personal Interview, 5/17/00)). They are open 1:00 p.m. to 2:30 p.m. on the first and third Wednesday of the month, 1:00 p.m. to 2:45 p.m. on the first and the third Tuesday, and 9:30 am to 11:30 am, 1:00 p.m. to 3:00 p.m. on the second and fourth Tuesday, respectively (LPHS, Lane 1). As delegate organizations, they receive their vaccinations from the Center for Disease Control, and thus can offer immunizations at low or no cost.

In addition to offering walk-in clinics, LPHS also actively reminds parents when their children are due for immunizations. Once a month, they print a report of the children under the age of two who have been to LPHS and, according to their records, are not caught up on their immunizations (Gillette, Personal Interview, 5/17/00). The families of children who are identified through this process are then sent a postcard reminding them to bring their children in for the necessary shots (Gillette, Personal Interview, 5/17/00). LPHS also coordinates with the public schools and certified daycare centers in an annual screen for children who are not fully immunized, and then sends letters out to the respective parents.

The White Bird clinic, located at 1400 Mill Street in Eugene, is a large facility with services, such as an in-house pharmacy, which cannot be found at other clinics that serve indigent children in this area. The half-time physician, Dr. Mike, who is also the medical director, spoke with me for about an hour and explained how the facility works and what services they provide. White Bird is staffed by part-time Physician Assistants and Nurse Practitioners, who combined, work at the clinic for 40 hours. In addition, usually one or two volunteer physicians work during the morning to provide primary care, and volunteer optometrists and optometry technicians also come in to provide visual

services. In all, 60 physicians, 40 optometrists, and 15 optometry technicians donate their time to the clinic (Weinstein, Personal Interview, 5/19/00).

White Bird's annual budget totals 360,000 dollars, and is funded by a combination of the State and Federal governments and local grants. Fortunately, within the last five years, local grants have matched the increasing cost to run White Bird. However, many of those local grants have been exhausted, and the clinic is currently facing anywhere from a 60,000 to 80,000 dollar loss in revenue (Weinstein, Personal Interview, 5/19/00). Inevitably, this cut will mean a drastic decrease in the number of services they can provide unless additional funding becomes available.

During the morning, the clinic serves as a medical center for low-income/homeless people. Their care is generally offered free of charge, and is funded by multiple grants. Each grant specifies who is eligible for the funds, and therefore the clinic can only treat those who meet the specific requirements (Weinstein, Personal Interview, 5/19/00). For example, the clinic currently has a Robert Wood Johnson Grant that is reserved for Hispanic people. White Bird is also responsible for 300 people on the Oregon Health Plan, and thus receives a capitated payment for each person from the government (Weinstein, Personal Interview, 5/19/00). In the afternoon, the clinic functions somewhat like a typical clinic, although its fees are greatly reduced in comparison to other providers. Furthermore, they charge on a sliding-base scale, which is calculated according to the federal poverty level (Weinstein, Personal Interview, 5/19/00).

CHAPTER IV

OUTREACH EFFORTS

A necessary part of ensuring that children receive medical care is linking indigent families with the available resources. Therefore, I have dedicated this chapter to discussing the methods used by our community to identify children at risk of not having the ability to access health care and how they are subsequently enrolled into appropriate programs. The first half of Chapter IV addresses outreach for newborns, and the second half deals with older children.

The presence alone of programs like CHIP, FHIAP, and Medicaid is not enough to successfully enable low-income children to access health care. The state must also work to identify families unlikely to have access to health care and educate these people about the available services. Oregon strives to identify newborns of such families through the Healthy Start program. There are fourteen Healthy Start sites in the State of Oregon, one of which is located in Lane County. Services through Lane County Healthy Start were available beginning February 8, 1995.

Oregon Healthy Start was established under the Oregon House Bill 2008, which passed in 1993 (Katzev et al.1). It receives its funding through the Oregon Commission on Children and Families, which allocates certain federal and state general funds meant to support local programs for children. From 1997 to 1999, Healthy Start was given $8,317,425 of these funds (Katzev et al. 4). Its purpose is to screen families for "characteristics that potentially place them at risk for poor child and family outcomes" (Katzev et al. 1). Families that are found to have few or no risk characteristics are

offered short-term services, such as a welcome-home visit, parenting newsletters, and information about the resources available in their community. However, families with a number of risk characteristics can access a number of services, including developmental screens for their children, parent education and support, and assistance with obtaining community resources, such as health care (Katzev et al. 1).

In the 1998 to 1999 year, 1,595 mothers gave birth to their first child in Lane County (Katez et al. Table 1). Of these newborns, Healthy Start screened 1,293 children, a total of eighty-one percent (Katez et al. Table 1). Healthy Start also screened an additional 270 children that were not firstborns. In the same year, 746 of the families received basic services as described above and 582 accessed intensive services (Katez et al. Table 4).

The Oregon Healthy Start program has proved to be a major success and an important source of preventive care for children. In the Oregon's Healthy Start Effort 1998 – 1999 Status Report, the Oregon State University Family Policy Program found that 98 percent of higher risk families obtaining services through Healthy Start have a primary health care provider (iv). Furthermore, 92 percent of these children are seen for regular well-child exam (Katez et al. iv). Even more impressive, 97 percent of two-year-olds enrolled in the program were adequately immunized, in comparison to 75 percent of all Oregon two-year-olds (Katez et al. iv).

Healthy Start is a phenomenal program, which greatly increases the probability that indigent children will have access to medical care. Furthermore, this program targets children at the earliest stages in their lives, which is an important aspect in preventing avoidable diseases and developmental disabilities.

The State must also address the reality that many older children remain uninsured. Adult and Family Services branch offices, which are found throughout the State, including Lane County, offer assistance with Medicaid and CHIP applications and serve as sources of information for available programs (Kitzhaber 4). Prospective Medicaid/CHIP recipients may also access information through the OHP Medicaid Application Center, which has a widely published telephone number (Kitzhaber 5). This center can both mail applications upon request and answer questions related to completing the necessary forms. The State also maintains a Maternal and Child Health hotline, called SAFENET, which works to inform indigent families of the health care services provided by their communities (Kitzhaber 5). SAFENET is available from 8:00 am to 8:45 p.m., Monday through Friday, and offers services in both English and Spanish. In April of 1995, a Teen InfoLine was introduced to better serve this population, and also provides information and referrals for services such as immunizations and well-child care, WIC nutrition programs, and the Oregon Health Plan (Oregon Health, Maternal 25-27). In addition, the state publishes a brochure describing available services and eligibility requirements, which is distributed to libraries and other community centers (Kitzhaber 4).

Schools can also assist children with obtaining state-funded insurance. However, at the South Eugene High School clinic, the Nurse Practitioner expressed concern that they lacked the necessary information to fill out OHP applications. Although the clinic has brochures about Medicaid, Susan Fries explained that in the future she would like to have a parent trained in assisting students with applying for the Oregon Health Plan to

work in the clinic a few days of the week. It would seem that all schools should have this service, because most children go to school at some time in their lives.

CHAPTER V

FUTURE NEEDS AND APPROPRIATE FUNDING

In the previous chapters, I explained what state and local programs are available to indigent children and the current outreach efforts. Here, I present my opinion of the problems with the OHP and local clinics as well as potential solutions. I also suggest how the state might obtain additional funding to increase the number of children who have access to medical care.

Two major problems remain in the Oregon Health Plan: eight percent of children in Oregon are uninsured, and programs offered through the state to insure families are either at fully capacity and have waiting lists or are nearing one. The first concern speaks to the gaps present in the network of coverage for indigent children. This network of state or local programs must be in some manner expanded to eliminate discrepancies. According to the Oregon Health Council (OHC) "the best way for Oregonians to gain access to the health system is to be covered by health benefit plans," and thus they hold that "the goal of the state should be to ensure that Oregonians have full access to quality health care by ensuring universal coverage" (Oregon Health, Recommendations 2).

It would be possible to expand state programs by increasing the number of eligible individuals, but it would also be difficult to determine the exact requirements that would offer universal coverage for children, while still excluding those with families that can afford private insurance. The OHC claims, "there will always be some individuals that fall through the cracks" (Oregon Health, Recommendations 2). However, instead of letting these people go without proper medical care, the state should support local clinics

that offer free or sliding scale health care to assure that even those without health plans can obtain medical services. To address both the goal of universal coverage and the need for a safety net to serve the uninsured, the state must expand the number of children eligible for CHIP and provide more support for local programs, especially school-based health centers, which offer primary care services to uninsured children.

State Programs

Within the last few years, Oregon made essential improvements in its health care system with the implementation of programs such as CHIP and FHIAP. However, the Oregon Health Council's goal of universal coverage is still yet to be attained. Lane County alone holds 6,800 uninsured children, and as many as 68,109 exist in the whole of Oregon (DiPrete, E-mail, 5/9/00). In 1998, the State estimated that of children with family incomes between 150 and 200 percent of the FPL, 11.5 percent from the birth to the age of five, 18.7 percent from the ages of six to eleven, and 20.2 percent from twelve to eighteen were uninsured (Office of Health, Information 4). It is obvious from these statistics that this group is greatly under-served. Their incomes are high enough to virtually exclude them from state programs, and likely too low to be able to absorb the cost of insurance premiums.

For the same age groups in families with incomes over 200 percent of the FPL, these numbers drastically drop to 3.9, 3.5, and 5.1 percent uninsured, respectively (Office of Health, Information 4). The discrepancy between the number of uninsured children between these two groups indicates a transition between the need for state-funded health insurance and the financial ability to pay for health care. Therefore, it seems only logical to extend the eligibility parameters of CHIP to incomes up to 200 percent of the FPL.

Ineligibility for state programs is not the only cause of being uninsured in Oregon. Unfortunately, being eligible for plans such as CHIP and FHIAP does not give you the right to immediate health insurance coverage. For example, FHIAP has a current waiting list over thirty thousand families long (DiPrete, Speech, 5/2/00). The CHIP program is still open at this time, with current enrollment at 16,500 children and 300 available spots. However, it is expected to be full by early next year (DiPrete, Speech, 5/2/00). As these relatively new programs begin to reach their maximum capacity, those in need will be left uninsured. Medicaid coverage, in contrast, is guaranteed to all who qualify. Even so, it is not enough to cover only the most needy children in Oregon with Medicaid, and leave those with only slightly more resources without even the most basic medical services. The State must find a way to abolish waiting lists and ensure that indigent children who are eligible for state programs are able to enroll in them.

Local Programs

Community-based programs are an integral part of Oregon's health care network and need stable funding in order to remain in existence. They often serve as the only source of health care for indigent children. This reality is especially true for illegal immigrants, who often have no other options, because the State does not offer programs for this population.

School-based health centers are particularly important because they essentially eliminate the problem of access. Unfortunately, in the Eugene-Springfield area, there is not even a single school-based health center in a middle school, and there is only one to be found in the elementary schools. Nearly all of the high schools have some form of a clinic, although Susan Fries, the Nurse Practitioner at South Eugene H.S., emphasized the

difficulty their clinic has experienced in obtaining adequate funds. Unfortunately, they spend much of their time trying to piece together a multitude of grants to keep their program running. This reality seems a terrible waste of a precious resource. It may be unreasonable to attempt to implement health centers in every school, but it does seem logical to place these clinics in locations of high need as well as rural areas, especially in elementary and middle schools, whose students are at the age when they need immunizations and developmental screens.

School-based health centers are not the only local clinics in need of additional revenue. Lane Public Health Services is also a vital source of health care for indigent children and is in dire need of more funding. For example, they are incapable of keeping their immunization clinic open longer than one morning a week due to financial limitations. It is likely that many low-income families who access services at LPHS have difficulty with transportation and are employed at jobs where they are not allowed to leave during the middle of the day. Therefore, one morning a week is too limited of a schedule for many of these families.

To alleviate this problem, the State should elevate funds for LPHS and bring it back up to past revenue levels. Furthermore, LPHS, and all other clinics that serve indigent children, should receive a slight increase in their funding from the State government each year to compensate for rising health care costs. The consequences of not doing so are apparent in the case of the White Bird Clinic, which now must contend with a budget cut of 60,000 to 80,000 dollars. Lane County already has too many children without adequate medical care. We cannot afford to place more children in this category, which would be inevitable if we lose existing local programs.

Potential Funding Sources for State and Local Programs

In the United States, Oregon ranks 35 in Medicaid spending per resident and 47 in expenditures per Medicaid eligible (Office for Oregon Health, Information 4). Evidently, Oregon has not made funding health care a priority, which is unfortunate considering the number of uninsured children who remain in this state. More funds must be allocated to support state program for both expansion and to guarantee health care to those eligible for existing programs.

Oregon Health Plan expenditures consistently rise each year. Even so, the amount allocated from the state's general fund drastically dropped between the 1995-1997 biennium and the 1997-1999 biennium as a result of new revenue from tobacco tax dollars (Office for Oregon Health, Health Policy 9; See Graph 1). With the OHP's apparent need for additional funds, a larger percent of the general fund should be redirected towards supporting state programs. Furthermore, with the success of the tobacco tax, the Oregon legislature should explore future taxes on commodities such as alcohol, that have been scientifically proven to be detrimental to one's health. In 1995, the Oregon Health Council estimated that in a two-year time period, a tax of a penny per container of beer would raise 13 million dollars (OHC, Recommendations 27). Although this tax would not completely eliminated the financial need of state programs, a combination of taxes and redirected funds have the potential to adequately finance universal coverage.

In the past, Oregon has considered cost-sharing as a method to raise funds for state health plans (OHC, Recommendations 24). Cost-sharing can take on many forms, including copayments and coinsurance. Copayments are synonymous with deductibles,

or in other words, the patient incurs a fixed amount of the health care expenses each time services are accessed before the health plan becomes responsible for the cost (Office of Technology 2). Coinsurance, on the other hand, is a percentage of the covered expenses for which the patient is responsible. Often, these out-of-pocket costs are limited to a certain number of dollars per year per individual. Cost-sharing is not currently a part of Medicaid or CHIP, although insurance subsidized by FHIAP or obtained through OMIP usually include both copayments and coinsurance.

The concept behind cost-sharing is that it significantly reduces the number of unnecessary services obtained, and thus cuts down on the overall cost of health care. However, in a paper published by the U.S. Congress's Office of Technology Assessment, which outlined the findings of the Rand Health Insurance Experiment (HIE), the authors emphasized the potential harm of cost-sharing. For example, the results of the HIE demonstrated that plans with copayments/coinsurance reduced the number of pediatric prevention services accessed by children, especially immunizations for children younger than seven (8). Furthermore, this trend was amplified in families with lower incomes, indicating that their children sought medical care even less frequently (8).

Overall, the Rand Experiment found that cost-sharing does not promote families to obtain cost-effective, appropriate care, but instead deters individuals from seeking treatment altogether. Therefore, this method of funding the OHP is not acceptable, and should not be considered in the future without either strong new evidence which contradicts the HIE findings, or new program designs which prevent under-treatment. In addition, the state should examine whether or not children in health plans financed by FHIAP and OMIP are being properly treated. If they are not, the state must provide

alternative coverage to these families that would allow them to be able to obtain appropriate medical services.

Obtaining additional funds is not the only method of financing state and local programs in Oregon. There is still much left to be done in the way of increasing efficiency and cutting down on waste. For example, eliminating redundancy in the system is an essential part of reducing health care costs. Duplication of exams, immunizations, record keeping, and other services unnecessarily waste precious resources that could be allocated for caring for other children. Therefore, it is vital that health care providers are required to use standardized systems. For example, Oregon currently maintains a computer record for immunizations given to children. This program, which is referred to as Oregon Immunization Alert, allows parents, doctors or nurses, schools, child care providers, and county health departments to easily access any child's immunization history (Oregon Heath Division 1). This record serves to insure primary care providers are aware of which shots a child needs and to prevent them from giving duplicate shots. Therefore, it both works to guard children against preventable diseases and reduces health care costs. However, this system has yet to be implemented even at major clinics, such as LPHS. Although these programs may take a large initial investment, they are vital to ensuring quality and efficient health care. The Immunization Alert system cannot properly function unless all clinics participate, and thus it is essential for the State to encourage its implementation with financial or other incentives. These types of programs should be formed whenever possible, including for standardized billing and all data gathering.

CHAPTER VI

CONCLUSION

Oregon has failed to provide universal health coverage to its children. 6,500 children in Lane County alone remain uninsured. However, our current system has significantly reduced the number of uninsured children, from 21 percent in 1990, to 8 percent in 1999 (Office for Oregon Health, Application 2). Current efforts must be expanded to provide medical services to all children. Although local programs are an important part of our health care network, they are not an adequate or appropriate substitute for health insurance. Therefore, for the health of our children, Oregon needs to guarantee state-funded insurance for children with families incapable of financing health insurance. Furthermore, the state should also increase support for local clinics that serve as a medical safety net for children without insurance.

Insurance is necessary for children to have access to medical services. Uninsured Americans are 3.8 times less likely to obtain medical or surgical care in comparison with their insured counterparts, 4.7 less likely to get prescription drugs, and 3.3 times less likely to purchase needed eyeglasses (Office for Oregon Health, Information 14). Furthermore, the uninsured have a higher probability of being hospitalized for conditions such as diabetes, pneumonia, and asthma, and also die more often in hospitals (Office for Oregon Health, Information 14). Unfortunately, uninsured children are also 1.7 times less likely to receive treatment for a sore throat, tonsillitis, or asthma and 1.9 times for an acute earache (Office for Oregon Health, Information 14). It is obvious from these statistics that the only viable way to guarantee that Oregon's indigent children are

receiving the same quality and degree of health care as those with greater financial resources is to provide them with health insurance. Therefore, CHIP's eligibility standards should be broadened to include children of families with incomes of less than 200 percent of the FPL. Undoubtedly, this expansion will not guarantee universal coverage, and thus the state should also form a petition process for those that are financially incapable of purchasing health insurance, but who do not meet state requirements for CHIP-funded insurance.

Children are one of the most vulnerable groups in our society. Because of their age, they are rarely capable of funding their own health insurance, and thus must rely on either their parents or the state. Proper medical care is essential during childhood, because this is the time of our lives when we require immunizations, as well as good health, to develop normally and avoid preventable diseases. Therefore, the Oregon Health Plan should focus on providing universal coverage for children. This goal would be best achieved by extending both local and state-based programs. Hopefully, the people of Oregon in the twenty-first century will prove to be a community that holds health care as a priority and understands the importance of funding the Oregon Health Plan.

APPENDIX A

TABLE 1. Federal Poverty Level[1]

Effective 4/1/1999 – 3/31/2000

Family Size	100%	133%	170%	200%
1	$ 696	$ 926	$1,183	$1,392
2	$ 938	$1,248	$1,595	$1,876
3	$1,179	$1,568	$2,004	$2,358
4	$1,421	$1,890	$2,416	$2,842
5	$1,663	$2,212	$2,827	$3,326
6	$1,904	$2,534	$3,237	$3,808
7	$2,146	$2,854	$3,648	$4,292
8	$2,388	$3,176	$4,060	$4,776

[1] Office for Oregon Health Plan Policy and Research.

APPENDIX B

TABLE 2. Coverage of the Oregon Health Plan and CHIP[2]

	Under Age 1 Non-Medicaid Mom	Under Age 1 Medicaid Mom	Age 1 – 5	Age 6 – 18
<100% FPL				
With Insurance	OHP	OHP	OHP	OHP
Without Insurance	OHP	OHP	OHP	OHP
100% FPL< 133% FPL				
With Insurance	OHP	OHP	OHP	Not Eligible
Without Insurance	OHP	OHP	OHP	OHP
133% FPL< 170% FPL				
With Insurance	Not Eligible	OHP	Not Eligible	Not Eligible
Without Insurance	CHIP	OHP	CHIP	CHIP

[2] The Administration for Children and Families & The Health Care Financing Administration.

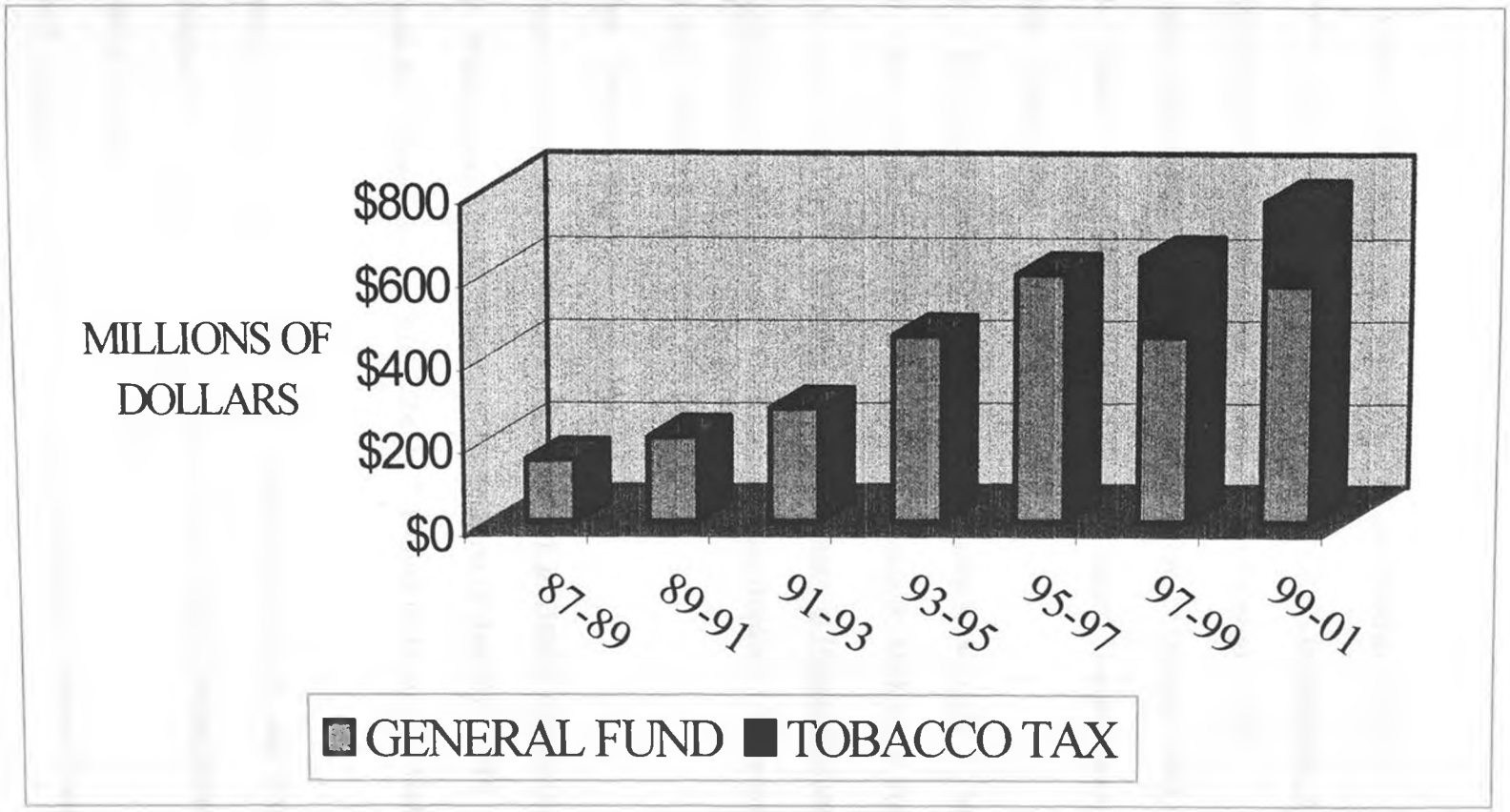
TABLE 3. Eligibility for the Family Health Insurance Assistance Plan[3]

Family Size			
1	$696-$870	$871-$1,044	$1,045-$1,183
2	$938-$1,172	$1,173-$1,406	$1.407-$1,594
3	$1,179-$1,474	$1,475-$1,769	$1,770-$2,005
4	$1,421-$1,776	$1,777-$2,131	$2,132-$2,415
5	$1,663-$2,078	$2079-$2494	$2,857-$3237
6	$1,904-$2,380	$2,381-$2,856	$2,857-$3,237
7	$2,146-$2,682	$2,683-$3,219	$3,220-$3,648
8	$2,388-$2,984	$2,985-$3581	$3,582-$4,059
For Additional Family Members Add:	$242-$302	$303-$363	$364-$411
FHIAP Will Pay:	95%	90%	70%

[3] Insurance Pool Governing Board.

APPENDIX C

GRAPH 1. Expenditures of the OHP[4]



[4] Office for Oregon Health Plan Policy and Research.

Works Cited

Birenbaum, Arnold. Managed Care. Westport: Praeger Publishers, 1997.

Capuzzi, Cecelia, PhD, RN and Linda Modrell, MBA. Cost Containment: The Effectiveness of Select Stategies. Salem: State of Oregon, 1995.

---. Cost Control and Managed Health Care. Salem: State of Oregon, 1995.

DiPrete, Bob. "Health Policy 2000." Oregon Health Council. Sacred Heart Hospital, Eugene. 2 May 2000.

DiPrete, Bob. "Re: Questions on OHP." E-mail to Jessica R. McKay. 17 May 2000.

DiPrete, Bob. "Re: Questions on OHP." E-mail to Jessica R. McKay. 9 May 2000.

Freeborn, D.K., and Pope, C. R. Promise and Performance in Managed Care: The Prepaid Group Practice Model. Baltimore: Johns Hopkins University Press, 1994.

Fries, Susan, N.P. Personal Interview. 14 April 2000.

Gillette, Karen. Personal Interview. 17 May 2000.

Health Insurance Association of America. Source Book of Health Insurance Data 1997 – 1998. Washington: Health Insurance Association of America, 1998.

Kapowich, Joan M. "Questions on OHP – Reply." E-mail to Jessica R. McKay. 19 May 2000.

Katzev, Aphra R., Ph.D., Clara C. Pratt, Ph.D., Deana Grobe, Ph.D., and William McGuigan, M.S. Oregon's Healthy Start Effort 1998-99 Status Report. Corvallis: Oregon State University, 2000.

King, Martha P. Insuring More Kids: Options for Lawmakers. Denver: National Conference of State Legislatures, 1998.

---. Medicaid Survival Kit. Washington, D.C.: National Conference of State Legislatures, 1996.

Kitzhaber, John A. Application for State Child Health Plan Under Title XXI of the Social Security Act-State Children's Health Insurance Program. Salem: State of Oregon, 1998.

Klein, Rudolf, Patricia Day, and Sharon Redmayne. Managing Scarcity. Buckingham: Open University Press, 1996.

Lane County Public Health Services. Clinic Schedules. Eugene: Lane County Public Health Services, 2000.

Medicaid Advisory Committee. 4 November 1998. 3 November 1999 <http://www.omap.hr.state.or.us/library/mac/mac110498.html>.

ODS Health Plans. ODS Individual Options. Portland: Oregon Dental Service and ODS Health Plans, Inc., 2000.

Providence Health Plans. Members' Rights and Responsibilities. 16 May 2000 <http://www.providence.org/healthplans/PHP/memrights.htm>.

State of Oregon. Insurance Pool Governing Board. OMIP Annual Report 98 – 99. 10 May 2000 <http://www.cbs.state.or.us/external/omip/docs/Annual>.

---. Insurance Pool Governing Board. Benefits and Eligibility. 10 May 2000 <http://www.cbs.state.or.us/external/omip/docs/omipbens.htm>/.

---. Insurance Pool Governing Board. FHIAP Member Handbook. Salem: State of Oregon, 1999.

---. Insurance Pool Governing Board. OMIP Member Handbook. Salem: State of Oregon, 1999.

---. Office of Medical Assistance Programs. History of the OHP. 8 November 1999 <http://www.ohppr.state.or.us/About.history.htm>.

---. Office of Medical Assistance Programs. OHP Enrollment Reports, March 2000. 10 April 2000 <http://www.omap.hr.state.or.us/managedcareplans/ed/0300/fchp0300.pdf>

---. Office of Medical Assistance Programs. Oregon Health Plan Progress Report. 1 May 1997. 2 November 1999 <http://www.omap.hr.state.or.us/library/fpl.97.JPG>.

---. Office of Medical Assistance Programs. Overview of the OHP. 8 November 1999 <http://www.omap.hr.state.or.us/library/overview98.pdf>.

---. Office for Oregon Health Plan Policy and Research. Information about the Oregon Health Plan and Oregon's Health Care Market. Salem: State of Oregon, 2000.

---. Oregon Commission on Children and Families. Building the Foundation for Results: Report to the Legislature and the Governor, 1997 – 1999. Salem: State of Oregon, 2000.

---. Oregon Health Council. Maternal and Child Health Title V Block Grant FY 98 Application. Salem: State of Oregon, 1998.

---. Oregon Health Council. Recommendations for a Fair and Affordable Health System. Salem: State of Oregon, 1995.

---. Oregon Health Division. Oregon Immunization Alert. Salem: State of Oregon, 2000.

TheLane. 2 November 1999 <http://www.thelane.net/medhelp.html>.

Timm, Ian. Oregon Primary Care Association Page. 3 November 1999 <http://www.orpca.org/budget.html>.

United States. The Administration for Children and Families and the Health Care Financing Administration. Head Start, Medicaid, and CHIP. Washington: GPO, 1999.

---. Health Care Financing Administration. Overview of the Medicaid Program. 22 August 1997. 6 November 1999 <http://www.hcfa.gov/medicaid/mover.htm>.

U.S. Congress, Office of Technology Assessment. Benefit Design in Health Care Reform: Background Paper – Patient Cost Sharing. Washington: GPO, 1993.

Weinstein, Michael, M.D. Personal Interview. 19 May 2000.

Writer, Charolette. Personal Interview. 7 February 2000.