

# **Securing Children Health Insurance Program Funding for Oregon's Safety Net**

## *A Briefing Paper*

There is no simple solution to the challenge of providing health care to all of Oregon's children, nor is there an easy way to preserve and strengthen Oregon's "safety net" health clinics. Because of the role the safety net plays in providing health care to uninsured children throughout Oregon, this paper considers financial compensation to the safety net for health care services provided to children who are income-eligible for Medicaid or SCHIP but whose families cannot or do not complete an application process.

### **Uninsured Children in Oregon**

Although Oregon has made tremendous strides in reducing the number of children without health insurance, an estimated eight percent or approximately 70,000 children in Oregon remain uninsured.<sup>1</sup> Included in that number are about 36,000 children with family incomes between 100 and 200 percent of poverty.<sup>2</sup> Many of these uninsured children appear eligible for publicly funded programs such as SCHIP.<sup>3</sup> However, for a myriad of reasons, their parents or guardians cannot or will not enroll them in SCHIP, Family Health Insurance Assistance Program (FHIAP), or Medicaid. At least in the short run, some policy experts and advocates believe that even with comprehensive publicly funded insurance programs, there will remain a segment of Oregon's children who will be difficult to reach and enroll, and may in fact never enroll. In order to get their health care needs met these children and their families rely on safety net providers comprised of a broad range of local non-profit and governmental organizations.

### **Oregon's Safety Net**

Oregon's safety net includes community health centers, school-based health centers (SBHC), county health departments, Federally Qualified Health Centers (FQHC), rural health clinics (RHC), and migrant health clinics (MHC). These clinics vary in terms of size, numbers and types of professionals employed, client characteristics, service area population density and demographics, diversity and stability of revenue sources, and sophistication in business management practices.<sup>4</sup> They also vary in their ability to collect and use data. Oregon's safety net is not an integrated system. Oregon Community Health Information Network (OCHIN), a statewide network, was organized in September 2000 to assist in the development of a fully integrated, comprehensive health care safety net and an essential information system.

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<sup>1</sup> Portland State University Center for Population Research & Census (1998) Oregon Population Survey.

<sup>2</sup> Moderate-income, Uninsured Oregonians. (May 2000) Office for Oregon Health Plan Policy and Research.

<sup>3</sup> Broaddus, M. & Ku, L. (December 6, 2000) "Nearly 95 percent of low-income uninsured children now are eligible for Medicaid or SCHIP." Center on Budget and Policy Priorities.

<sup>4</sup> Gilmore, D. (July 2000). "Technical Assistance Guide for Understanding the Potential of Adverse Selection within Safety Net Systems in Medicaid Managed Care Programs" Center for Health Care Strategies.

Safety net providers throughout Oregon offer health services to low-income people, including those without insurance. The safety net delivers care to its patients without regard to ability to pay, although most patients do pay a sliding fee or receive care covered by Medicaid, Medicare and private insurance.<sup>5</sup> Services provided by the safety net include, but are not limited to:

- Urgent care;
- Primary care (acute and chronic disease treatment);
- Preventive care;
- Enabling services (translation/interpretation, case management, transportation and outreach);
- Services based on identified need (mental health, dental, and vision); and
- Well-child care<sup>6</sup>

The safety net helps keep children immunized, healthy, and in school. Despite providing needed health care services, safety nets are not always compensated for the cost of providing such care. Because they provide services with little to no charge to their needy patients, safety net clinics are frequently financially unstable.<sup>7</sup> Although the safety net system is fragmented and often financially unstable, it plays a critical role in providing primary and preventive health care to those who do not access care through mainstream hospitals and health systems.

### **Barriers to Access and Utilization**

The Institute of Medicine (IOM) determined that even within the context of insurance reform, some people continue to rely on safety net providers for their health care services. Furthermore, because many of the safety net providers have expertise in meeting the particular needs of low-income uninsured and other vulnerable populations, they are often the “provider-of-choice,” not simply the provider of last resort.<sup>8</sup>

Children and families often encounter barriers when attempting to access publicly funded insurance programs such as SCHIP.<sup>9</sup> Some of those barriers to access and utilization of SCHIP include:

- **Regulatory and Procedural** — Some parents find the six-month re-application process burdensome or overwhelming. In other cases, parents don’t reapply because they experienced a slight increase in income and assume that it put them over program eligibility limits.<sup>10</sup>
- **Provider Access** — Children in public insurance programs such as SCHIP sometimes lack access to health services despite coverage. Even if a child is enrolled in a publicly funded

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<sup>5</sup> Gilmore.

<sup>6</sup> Oregon School-based Health Centers 2000 Report

<sup>7</sup> Norton, S.A., & Lipson, D.J. September 1998. Public Policy, Market Forces, and the Viability of Safety Net Providers

<sup>8</sup> America’s health care safety net: Intact but endangered (1999). Institute of Medicine

<sup>9</sup> Robert Wood Johnson Foundation Covering Kids Initiative Grant. Summary of System Barriers to OHP Enrollment/Re-enrollment June 2000

<sup>10</sup> Milliman & Robertson, February 1999, Safety Net Study.

program, providers in a community may limit the number of low-income patients they serve. In frontier (less than six people per square mile) and rural communities, the number of providers and Oregon Health Plan/SCHIP eligibility workers are limited.<sup>11</sup> State contracted health plans across Oregon are reducing the number of OHP and SCHIP patients they are willing to enroll and OHP has relied on health plans to assure access to health care.<sup>12</sup>

- **Stigma of “Welfare”** — Some parents have a distrust of government and avoid all public programs including SCHIP. Others find SCHIP to be stigmatizing. Still other parents avoid enrolling their children in insurance programs because of their own psychosocial issues, e.g., illiteracy, alcohol and drug issues, mental illness.<sup>13</sup>
- **People of Color and Immigrants** — Legal immigrants and their families who arrived after August of 1996 are not eligible for SCHIP or other federally funded health coverage due to federal law.<sup>14</sup> Additionally, language and cultural differences are identified as barriers to enrolling in publicly funded insurance programs. African American, Native American and Hispanic children are less likely to be insured than white, non-Hispanic children both locally and nationally. In Oregon, seven percent of white non-Hispanic children between 100% and 200% FPL are uninsured as compared to an estimated 14 percent of Hispanic children and nine percent of other children of color.<sup>15</sup>

These and other barriers dissuade parents of eligible children from accessing SCHIP or Medicaid. If more children are to be enrolled, the federal government and state need to take additional steps to implement simpler, more-effective enrollment procedures.<sup>16</sup> If the opportunity that SCHIP has created is to be realized more fully, low-income families — especially working families — will need both to be more aware of their children's eligibility for health insurance programs and to be able to enroll their children more easily.<sup>17</sup>

## School-Based Health Centers

It is important to mention the integral role that school-based health centers (SBHC) play within Oregon's safety net system. SBHCs focus on the provision of preventive and developmentally appropriate health services that are easy for young people to access. There are forty-six SBHC

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<sup>11</sup> Milliman & Robertson.

<sup>12</sup> Health Care Delivery Systems in Oregon: A report to the Oregon Health Council by Its Access Subcommittee (August 2000) and Managed Care Plans by County update on December 20, 2000 OMAP retrieved 1/01.

<sup>13</sup> Oregon Health Council Access Subcommittee.

<sup>14</sup> Feld, P. PhD, Power, B. (November 2000) “Immigrants access to health care after welfare reform: Findings from focus groups in four cities.” Kaiser Commission on Medicaid and the uninsured.

<sup>15</sup> Office for Oregon Health Plan Policy and Research. (May 2000) Moderate Income Report.

<sup>16</sup> Uninsured in American: A chartbook. May 2000. Second Edition. The Kaiser Commission on Medicaid and the Uninsured.

<sup>17</sup> Broaddus, M. & Ku, L. (December 6, 2000)

throughout Oregon serving children in grades K-12.<sup>18</sup> One third of the children served have no health insurance.<sup>19</sup> These clinics provide primary physical and mental health services.<sup>20</sup>

In 1998-99, there were over 18,000 users of SBHC.<sup>21</sup> SBHC clients made 70,221 visits for an average of nearly 4.0 visits per user.<sup>22</sup> The majority of visits to SBHC are for general medical services related to acute and chronic conditions such as headaches, abdominal pain, coughs, colds, sprains, strains and issues related to adolescence.<sup>23</sup> Staff coordinate a student's care with a student's primary care provider whenever possible, however SBHCs are often the primary source of medical care for these children.<sup>24, 25</sup>

## **Funding for Safety Nets & School-Based Clinics**

Oregon's population is rapidly increasing. Between 1990 and 1999, the state grew by 16.7%; the nation as whole grew by 9.6%.<sup>26</sup> As the total number of Oregonians increased so has the number of uninsured Oregonians (even though the *percentage* of uninsured Oregonians has not). It is a mounting challenge for both the public and private health sectors to serve persons who are uninsured while simultaneously remaining fiscally stable. In order for the safety net to provide vital health care services, they must generate money from diverse sources.<sup>27</sup>

A patchwork of financial support assists the safety net in providing care to those without health insurance.<sup>28</sup> When funding from one or more of these sources is unstable or shrinking, the viability of the safety net is threatened.<sup>29</sup> Grants, donations, patient self-pay, local, state, and federal government support, as well as private insurance are the primary funding sources for safety net clinics.<sup>30</sup> At least one of Oregon's school based health centers has helped sustain itself through bake sales.<sup>31</sup> The Institute of Medicine (IOM) describes the unparalleled pressure that results from the growing number of uninsured persons as well as from cutbacks in government support to the safety net. "Absent new policies, the increasing demand for care for indigent populations, the diminishing resources to support

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<sup>18</sup> Oregon Health Division, School-Based Health Center 2000 Report

<sup>19</sup> Oregon Health Division

<sup>20</sup> Oregon Health Division

<sup>21</sup> Oregon Health Division

<sup>22</sup> Oregon Health Division

<sup>23</sup> Oregon Health Division

<sup>24</sup> Oregon Health Division

<sup>25</sup> Oregon Health Division

<sup>26</sup> US Census Bureau. [www.census.gov](http://www.census.gov)

<sup>27</sup> Analysis of Oregon Health Care Safety Net Services, February 1999

<sup>28</sup> American's Health Care Safety Net: Intact but Endangered. Committee on the changing market, managed care and the future viability of safety net providers, Institute of Medicine, March 2000.

<sup>29</sup> IOM

<sup>30</sup> IOM

<sup>31</sup> IOM

such care and the mounting access barriers faced by uninsured people will endanger the fragile patchwork of providers and institutions that serve this nation's most vulnerable groups."<sup>32</sup>

The ability of the safety net to meet the demands of uninsured patients is strained by increased managed care enrollment and declines in Medicaid reimbursement. Due to the recent transition to managed care for Oregon's Medicaid recipients, many persons who historically received services from safety net clinics are now required to access services through their OHP/SCHIP health plan. Although these contracted health plans may subcontract with safety net providers, financial compensation for providing health services is lower than payments previously received directly from the state.<sup>33</sup> Since compensation for delivery of primary care services in a managed care setting is sometimes inadequate to cover actual costs there is less flexibility for the safety net to serve the uninsured than it had prior to managed care. Accordingly, safety net providers are more dependent on grant dollars and donations to subsidize care for the uninsured, which vary considerably from clinic to clinic and from year to year. Additionally, these dollars are often allotted for specific programs or populations, and not for infrastructure and administrative development.

Some action has been taken at federal, state and local levels to improve funding for safety net providers. In December 2000, the United States Congress approved the Safety Net Preservation Act (S. 1277/H.R. 2341) and a \$150 million increase for FY 2001 for federally qualified health centers and rural health clinics across the country.<sup>34</sup> This is the largest increase in the history of the Health Center program. Oregon will receive an approximate three million dollar increase to be allocated to the hundreds of safety net providers.

In 1997, the Oregon Legislature directed the Office for Oregon Health Plan, Policy & Research (OHPPR) to conduct a study of the services and status of Oregon's health care safety net and report findings to the 1999 Oregon Legislative Assembly. Furthermore, they allocated \$3.1 million as interim funding to clinics at financial risk. Then, in the 1999 session, Oregon's Legislature allocated \$1 million to safety nets.

A local initiative to assist safety nets become more financially secure and independent is led by Multnomah County Health Department's Communities in Charge project, funded by the Robert Wood Johnson Foundation. The project explores delivery and financing of health care to the community's low-income uninsured populations. Multnomah County has partnered with Clackamas and Washington Counties to develop and implement a new system for delivering and financing culturally competent, high quality, affordable and compassionate health care for low-income uninsured populations.

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<sup>32</sup> American's Health Care Safety Net: Intact but endangered. (March 2000) Committee on the changing market, managed care and the future viability of safety net providers, Institute of Medicine,

<sup>33</sup> Oregon Medical Assistance Program

<sup>34</sup> National Association of Community Health Centers. [http://www.nachc.com/Federal\\_Affairs/Frame/snpa.htm](http://www.nachc.com/Federal_Affairs/Frame/snpa.htm). Retrieved 12/30/00

These and other efforts contribute to the sustainability of Oregon's safety nets. However, safety net clinics, including school based health centers, struggle to stay financially stable while providing care to the uninsured.

## **SCHIP**

Congress enacted the Balanced Budget Act of 1997, creating the Children Health Insurance Program (SCHIP), under Title XXI of the Social Security Act. SCHIP enabled states to insure children from working families with incomes too high to qualify for Medicaid and too low to afford the premiums required by other public or private insurance programs.

In 1998, Oregon implemented its SCHIP program, a plan that covers children up to 19 years old with income levels up to 170% FPL. Presently, SCHIP covers over 16,000 children statewide.<sup>35</sup> Oregon chose to implement SCHIP as a Medicaid look-alike program, rather than an expansion of Medicaid. There is a single application and eligibility determination process. All applicants are screened for eligibility through the OHP application then assigned to OHP or SCHIP depending upon their qualifying level of income. Every six months participants need to re-apply. SCHIP services are received through the same delivery system as OHP and the benefit packages are nearly identical. The comprehensive benefits package includes case management, preventive health care, interpreter, and non-emergency transportation services at no additional costs, deductibles, co-pays or premiums for enrollees.

## **SCHIP Funding**

With the Balanced Budget Act of 1997, nearly \$40 million was allotted to Oregon for SCHIP implementation. SCHIP provides federal funding to states to provide health coverage to children who live in families with incomes above a state's Medicaid level but under 200 percent of the FPL. As with Medicaid, the federal government matches state spending. To encourage states to take advantage of SCHIP to cover uninsured children, the federal government matches state spending with an "enhanced match." That is, the federal government pays a greater share of the costs for SCHIP-funded expansions than it pays for a state's existing Medicaid program.

Oregon's Committee on Health Care Safety Net Support, state officials, policy makers, and safety net advocates are examining the utilization of SCHIP funds to reimburse safety net clinics for the care provided to SCHIP eligible children. The goal is to provide uninsured low-income children with needed safety net services until they are enrolled in an insurance program. The Community Partnerships Subcommittee of the Oregon Health Council has drafted a SCHIP waiver application seeking federal permission to implement this approach. Oregon officials hope that this waiver request to HCFA will make the point that they have followed the statutory requirements, and still have uninsured, non-Medicaid eligible children, thus demonstrating the need to move beyond the insurance model while still encouraging and facilitating application for Medicaid and SCHIP.

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<sup>35</sup> OMAP web site November 2000

## Conclusion

Although the trends toward increased health coverage and access for children in Oregon are encouraging, work remains to be done. There are children in Oregon still without health insurance and, presumably, without dependable access to the mainstream health care system. These children disproportionately share characteristics such as low-income status, racial and ethnic minority status and/or rural life style that present barriers to getting insurance or health care.<sup>36</sup> Some of these children and families do not access publicly funded insurance programs and enter the health care system on an as needed basis.

Oregon's safety net is an important component of the health care system, although little data is available to demonstrate the extent or specifics of their role. With the help of local, state and federal efforts safety net clinics are making plans to develop more effective infrastructure and potentially become more fiscally stable and independent.

From a policy perspective, the safety net is important not only to those who lack access to care, but also to Oregon at large. While not all Oregonians are direct users of safety net services, the benefits of the safety net affect a range of groups and interests, including both the public and private sector. Most uninsured persons are employed (or dependents of the employed) and constitute a workforce whose health and well-being is vital to Oregon's economic vitality. Furthermore, safety net providers, supported by federal, state and local resources, keep children immunized, learning, and growing. It is essential to provide preventive and primary care where children are most likely to get health care and to ensure the stability and viability of those providers.

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<sup>36</sup> Oregon's SCHIP FFY 1998 ANNUAL REPORT TO HCFA, [www.hcfa.gov](http://www.hcfa.gov)