

CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION

HEALTH INSURANCE AND ACCESS TO HEALTH CARE IN OREGON

ALTHOUGH nationwide a growing number of workers are uninsured, the proportion of working Oregonians (defined as persons 18-64 years old) with health insurance has increased since 1993.¹ Much of that improvement is due to implementation of the Oregon Health Plan (OHP).² We used data from the Behavioral Risk Factor Surveillance Survey (BRFS) to assess the extent of health care coverage in Oregon and its impact on medical care choices. The BRFS is an ongoing survey of adults in randomly chosen households with telephones.

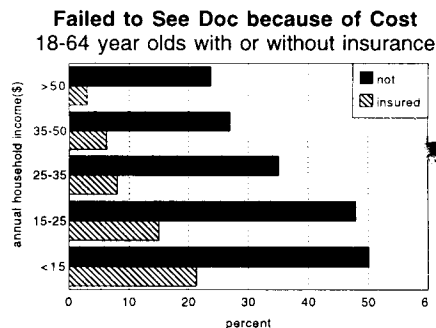
Although 99 percent of Oregonians 65 years or older are covered by health insurance (including Medicare), coverage is lower for working-age adults—only 80% of Oregonians 18 to 35 years old, for example. Not surprisingly, having insurance is an important determinant of health care access. BRFS respondents were asked: "Do you have any kind of health care coverage?" and "Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?" Regardless of income, Oregonians without health insurance coverage were 2 to 3 times more likely than those with coverage to report that they did not seek medical care when needed because of cost considerations.

Annual Income	Percent	Est. number
<\$15K	49	45,000
\$15-35K	44	65,000
>\$35K	12	4,500

Furthermore, in 40 to 50 percent of the households with annual income under \$35,000, adults of working-age who lacked health insurance coverage failed to seek needed health care at least once during the year which preceded the interview.³ This translates

³ Because 10 to 20 percent of households with health insurance and annual income below \$35,000 report a lack of access, it is clear that other important economic barriers to medical care exist.

into 110,000 Oregonians who did not seek health care because they could not afford it.



Clearly, although access to medical services is essential for personal health, for many people access is closely linked to the availability of health insurance. Moreover, the viability of many current health care delivery systems depends upon widespread health care coverage.

THE OREGON HEALTH PLAN

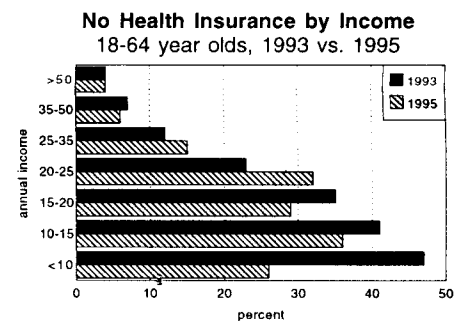
Before 1994, problems associated with lack of health insurance were most pronounced among households with incomes below the federally defined poverty level. Although Medicaid programs provided care for some, many below the poverty level did not qualify for such aid (e.g., women beyond their pregnancy years, males with an income >56% of the poverty level). Such households went without medical care or placed an undue financial burden on providers if they sought it. That is, whenever potential clients are unable to afford doctor visits, independent service providers suffer a loss of revenue. The revenues of Health Maintenance Organizations (HMOs) tend to be reduced also because a high proportion of young adults—those most likely to be "revenue-positive" members—fail to enroll. And hospitals who treat uninsured patients in their emergency facilities without reimbursement must absorb increased costs of operation or pass such costs on to other payers. The OHP was designed, in part, to solve this

problem.

Implemented in February, 1994, the OHP expanded Medicaid eligibility so that all households below the poverty level were eligible for a basic health care package. Coverage for some diagnoses was limited, based on a rank-ordered list. The change was intended to provide essential health services to more poor families without significantly reducing health care quality or increasing health care costs.

IS IT WORKING?

Households with annual income below \$10,000 are more likely to have health insurance after implementation of the OHP. In fact, the percentage of these poorest Oregonians who lack health insurance dropped dramatically: from 47 percent in 1993 to 26 percent in 1995. Coverage is higher for households with annual incomes between \$10-\$20,000 as well. Still, about one-third of all households with incomes below \$25,000 were without health care coverage in 1995—a rate five to six times higher than that of households with income of \$35-\$50,000.



To determine further how successful the OHP strategy has been, we classified BRFS respondents into four groups based on household size and annual income. Group I consisted of those households most likely to fall below the poverty level and thus be eligible for OHP medical care. Group II represented households characterized by marginal poverty—an unknown proportion of whose members are OHP-eligible. The other two groups included

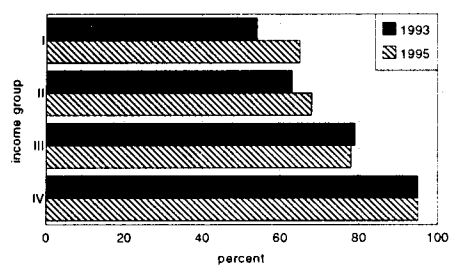
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Health Care Coverage
 18-64 year-olds, 1993 vs. 1995



respondents with sufficient income to disqualify them from the OHP: members of Group III had incomes below \$35,000 and those in Group IV had incomes of \$35,000 or more. Table 1 shows the number of people interviewed in each group. Respondents from 1993—the last full year prior to implementation of the Oregon Health Plan—were classified within the same categories and responses to two key questions were compared for the period prior to implementation of the OHP and the first full year of operation.

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs (health maintenance organizations), or government plans such as Medicare?

The first full year after implementation of the OHP, 65 percent of respondents classified in Group I—those most likely to qualify for medical care under OHP—reported some type of health care coverage. This represents improvement over the 54 percent registered in 1993. Group II displayed less evidence of improvement. Those with income above the poverty level essentially showed no evidence of change.

Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?

In 1993, thirty-eight percent of those classified in Group I failed to seek care because of cost; whereas, only 31 percent of comparable respondents did so in 1995. That is, in 1995 fewer members of Group I—those most likely to be served by the OHP—reported that they had been unable to afford a visit to the doctor. While consistent with improved access to medical care, these data are not conclusive because of the limited size of sample.

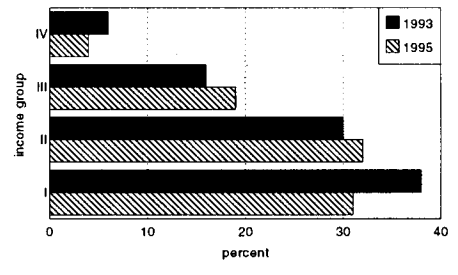
Comparison of 1993 and 1995 data for Groups II and III suggest that households that were somewhat better off financially may have been less able to afford doctor visits in 1995. Taken together, these observations provide evidence that during a period when other households with annual income below \$35,000 found it more difficult to afford medical services, the OHP made it easier for the poorest Oregonians to gain access to care.

SUMMARY

Following implementation of the OHP, an increasing proportion of low-income households are covered by health insurance; members of these households report improved access to medical care. BRFSS data confirm that having health insurance coverage remains key to assuring access to medical services. Improvements in health care coverage have been less dramatic for those with modest incomes just above the poverty level.

While money may not buy love or happiness—even in the era of the Oregon Health Plan—it can buy health

Unable to Afford Doctor Visit
 18-64 year olds, 1993 vs. 1995



insurance, access to medical care, and the attendant benefits to personal health that such access brings.

REFERENCES

1. Fronstin, P. The decline in health insurance and labor market trends. *Statistical Bulletin*. 1996;77(3):28-36.
2. Oregon Health Trends, Series 43, Nov. 1995. There were 877 survey respondents from 1993 and 1,019 from 1995 used in this analysis.

Cancer Case Reporting Deadline

The reporting deadline for 1996 cancer cases is nigh. This is the first year of the legislatively mandated Oregon Central Cancer Registry (OSCaR). All Oregon medical practitioners should have received *Cancer Reporting Standards, Vol. II, Reporting Procedures for Practitioners*, a 4-page document that outlines reporting requirements and procedures. Provider-reportable cases are those that were first diagnosed and/or treated in a practitioner's office on or after January 1, 1996. This reporting would only include those cases in which the patients have *not* been admitted to a reporting facility (hospital or ambulatory surgical center) for diagnosis or treatment of this cancer within 180 days of diagnosis. If you have questions or need another copy of the reporting guidelines, contact OSCaR (503/731-4858).