## Worth: What Are We Willing to Pay?

The value or worth of something is what we are willing to pay to obtain it. The price of something is what we actually pay to obtain it. When the value of something is much greater than what we pay to obtain it, we get a good deal (economists call this consumer surplus).

About two years ago, my mother had persistent swelling in her feet and legs that was painful and making it hard for her to walk. She saw her doctor and tried a bunch of things, but nothing helped for over two months. She was distressed, and I would guess that she was willing to spend upwards of $2000 to be rid of the swelling. Then, a nurse told her to buy pressure hose. My mother bought two pairs for about $32, and was rid of the swelling in a week. She was mighty pleased, this was a really good deal. Economists would say that she received lots of consumer surplus.

Reduced mortality gives us extra length of life. The value of reduced mortality is what we are willing to pay for the extra length of life. All of us make decisions—such as the type of work we do, whether our car has airbags and other safety devices, whether we have a smoke detector or not, etc.—that affect our length of life and our wealth. We can analyze these decisions to estimate how much we would be willing to pay for reductions in mortality. There is a large economics literature that does precisely this. The foremost researcher in this field is probably Kip Viscusi of Harvard University.

When we say that the reduced mortality from heart disease was worth over $13 billion annually to Oregonians,we are estimating that Oregonians would be willing to pay over $13 billion in foregone wages, better safety devices etc., to obtain the extra length of life due to reduced mortality from heart disease. It does not mean that we spent $13 billion on reducing mortality from heart disease.

When we say that the value of potential future improvements in health and longevity is enormous, we mean that if, for example, we had the option of reducing mortality from heart disease by another 5 percent by spending more, we would indeed be willing to spend a lot more.

That the value of reduced mortality from heart disease alone has been of a magnitude comparable to all health spending in Oregon shows that we have been getting a good deal on the money that we spend on healthcare. This is not to say that the deal can't or shouldn't be better for consumers. Indeed, it can and should be better. We are trying to say that in all this criticism of the healthcare system, we should not forget that—on balance—the extra length of life and better health we get for our spending are extremely valuable to consumers.

*Rajiv Sharma*

*(As a society we value interventions for life threatening conditions even when the costs are astronomical. Dr. Tina Castañares addresses society's need for more sophisticated analyses, more guiding values and criteria to make intervention decisions in* Oregon's Future *Healthcare Panel Discussion (Spring 2004). She shares a story of her 97-year old father and how society dedicates huge proportions of our healthcare spending to people in their last few weeks or days of life. —Ed.)*

# The Hidden Costs of the Uninsured

by Robert A. Lowe, MD, MPH, Matthew Carlson, PhD
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In early 2003 the Oregon Health Plan (OHP) underwent major cutbacks. In order to understand the impact of these cuts and to inform policymakers, two state agencies, the Office for Oregon Health Policy and Research and the Office for Medical Assistance Programs, convened a group of researchers from Portland State University, the Providence Center for Outcomes Research and Education, Oregon Health and Science University, and elsewhere. In convening this group, the state agencies demonstrated a real commitment to understanding the true impact of the cutbacks. This essay summarizes the findings to date.

### What were the OHP cutbacks?

A one-year-old child, covered by the Oregon Health Plan, accidentally swallowed his mother's diabetes medication. Although he was at risk for a life-threatening drop in his blood sugar, his mother delayed getting care for him because she feared that she would have to pay out of pocket. In fact, recent OHP cutbacks did not affect children. However, the mother's confusion—and the danger it created for her child—exemplifies the confusion that affects so many OHP beneficiaries, and many of the rest of us.

To understand the OHP cutbacks, we need to go back to 1994. Before then, Oregon's only medical coverage for the poor was the traditional, federal Medicaid program. Although Medicaid covered about 300,000 Oregonians, it still excluded many who were in need. Traditional Medicaid only covers people who fall into specific "categories" of eligibility: Temporary Assistance to Needy Families (for instance, a mother with one child is eligible if her total income is less than $499/month) Disabled, Old Age Assistance, etc. Traditional Medicaid does not cover many individuals whose incomes fall below the Federal Poverty Level. An "able-bodied" single adult is not covered, no matter how poor. As a result of this selective coverage, 30% percent of Americans below the Federal Poverty Level are uninsured.

When the Oregon Health Plan was implemented in 1994, it expanded medical coverage to an additional 100,000 Oregonians. Everyone with incomes under the Federal Poverty Level ($1,306/month for a family of three) became eligible. Children and pregnant women with incomes up to 1.33 times the Federal Poverty Level were covered, with coverage expanded to 1.7 times the Federal Poverty Level by 1998. Beyond expanding the number of insured Oregonians, the OHP focused on the values of universal and

**"It is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured." Single payer is not the only path to accomplishing universal coverage.**

preventative healthcare. Through a series of community forums held through the state, Oregonians agreed on the principle of universal, but prioritized, health services. Second, the plan emphasized preventive services and primary care, based on knowledge that early prevention and treatment can reduce future suffering and costs. Over the past decade, the OHP has provided care to over 1 million Oregonians.

In 2001, Governor John Kitzhaber, MD and the Oregon Legislature wanted to expand the OHP to cover all Oregonians up to 185% of the Federal Poverty Level beginning in February 2003. To pay for the expansion, adult OHP beneficiaries who were not eligible for the traditional Medicaid program would be covered by a reduced benefit package called "OHP Standard." They would be charged co-payments for medical services - $3 for prescriptions and lab tests, $5 for physician visits, $50 for emergency department visits, and $250 for hospitalizations. They would pay monthly premiums of $6 to $20 per person. Although there had been some premiums before, under the new system payment of premiums would be enforced strictly; a beneficiary who did not pay a premium on time would be dropped from the OHP and would not be eligible for coverage for six months. Although the cutbacks represented a substantial reduction in coverage for OHP Standard beneficiaries, the trade-off was to sustain the financial viability of the program in order to expand coverage. Oregonians eligible for traditional Medicaid, pregnant women and children would be enrolled in "OHP Plus," with no change to their benefits.

Then, the recession hit. The Oregon legislature faced severe budget shortfalls in early 2003. Cuts to OHP Standard were implemented. The first cuts took the form of increased premiums and co-payments, while expanding the plans coverage to the slightly-less-poor. Next to go was the scope of services—eliminating all outpatient coverage for mental health, chemical dependency, and alcoholism. The legislature also eliminated Oregon's Medically Needy Program. This program covered 8,750 people at the time of its demise. It had provided limited benefits (mainly prescription drugs) to Oregonians whose medical expenses were so high, and incomes so low, that they had income of less than $413/month remaining after paying medical bills.

Now, further cutbacks are occurring. Lack of tax revenues will require that OHP Standard enrollment be capped at 25,000 people by June 2005. With current enrollment around 51,000, the number of enrollees will have to decline significantly. As of July 1, 2004, no new enrollees are allowed in OHP Standard and if attrition does not drive down enrollment enough, more Oregonians will be dropped from the plan next year. (At the same time, a court decision has forced the state to eliminate OHP Standard co-payments. However, premiums will remain.)

### What happened to OHP members?

The new monthly premiums, co-payments, and reductions in benefits had a substantial effect on enrollment. While there were about 102,000 OHP Standard members in 2002, a year later the number had fallen to 51,000. The poorest were the hardest hit: the number of enrolled members with zero income fell from 42,000 to 17,500.

### Is the loss of coverage hurting people?

Research to date is limited. However, given the risks of delaying any policy discussions until the "definitive" research is completed, let us consider what we already know.

In December 2003, a survey was conducted of nearly 3,000 Oregonians who had been enrolled in OHP as of February 2003. Of those who had been on OHP Standard in February, 45% lost coverage; 72% of those who lost coverage remained uninsured. The most common reason cited by Oregon citizens for losing coverage was that they could not afford the premiums. In addition, 6% reported dropping out of OHP Standard because mental health and chemical dependency benefits had been cut.

Sixty-five percent of these newly uninsured Oregonians reported that, in the last six months, they had been unable to get health care that they needed. Fifty-seven percent reported being unable to obtain prescription medications because of cost, as did 72% of those with chronic illnesses such as diabetes, asthma, hypertension, emphysema, and heart failure. When asked where they usually turned for medical care, 24% had no usual source of care.

> An OHP beneficiary with a history of high blood pressure could not obtain his medications. He came to the emergency department with his blood pressure markedly elevated, causing severe heart failure. He required hospitalization in the Medical Intensive Care Unit.

Another clue to patients' access to care is how much they rely on emergency departments (EDs) for care. The survey of Oregonians who lost OHP coverage found that 9% relied on EDs as their usual source of care. Other evidence points to the increased use of EDs as a "safety net" for patients with no place else to go. Oregon Health and Science University saw a 17% increase in ED visits by uninsured patients in the first three months after the cutbacks.

### What has happened to the Medically Needy?

For the 8,750 Oregonians who lost this benefit, survey data suggest that 60% cut back on food, 49% skipped other bills or paid them late, 47% borrowed money from family or friends, and 20% added credit card debt to pay for their medicine. Forty-nine percent reported not taking prescriptions because of cost. Compared to a year earlier, 44% rated their health as worse while only 17% rated their health as better.

### What happened to those with mental illness?

A man who had been on methadone maintenance for his narcotic dependence began using heroin after the OHP ceased covering his chemical dependency treatment. He came to the hospital with multiple skin abscesses.

OHP Standard eliminated coverage for outpatient mental health treatment. Chemical dependency treatment, including methadone maintenance, was eliminated, as was alcoholism treatment. A study from Lane County found that 29% of OHP members with severe persistent mental illness lost their mental health benefit, along with 48% of OHP members with drug dependency. Oregon Health and Science University saw substantial increases in ED visits by uninsured patients with mental health problems: a doubling in alcohol-related visits and a tripling in drug-related visits.

### But don't these people have other places to get help?

Can Health Department clinics, private doctors, and volunteer "free clinics" serve as an adequate safety net? To quote from a recent report, in which key staff at safety net clinics were interviewed:

- "Informants noted that it is not uncommon to experience a 6-month wait for a specialist appointment."

A woman came to the emergency department after she had been to two other providers seeking care for her depression. Both providers had told her that they could not help her find treatment because she was on OHP. A hospital social worker spent over an hour with her but could not find a source for outpatient counseling.

- "[Clinics] report not having the capacity to absorb the increased demand for mental health services brought on by the loss of OHP coverage for the large number of individuals with significant mental health problems who visit their clinics."
- "Numerous examples were provided by key informants of patients coming into clinics with substantial fears about their ability to fill needed prescriptions on an on-going basis."
- "This policy change, which has been calculated to 'save' money for the Oregon Health Plan (i.e., the state) by making sure every service has a co-payment, has shifted a major element of the administrative burden for OHP to health care providers. This is going to be a major disincentive for private practitioners to continue to accept charity care, including Medicaid patients."

### Can we afford to fix this?

This is a very tough question, in the face of Oregon's current financial struggles. Should we channel funds to the OHP and reduce spending on schools or law enforcement? Should we raise taxes? Most states are facing similar dilemmas; if there were an easy solution, other states would have already found it.

Let's look at what we know, and don't know, about the costs. We don't really know how much we are "saving" with these cutbacks. First, OHP's reduced enrollment has led to an estimated $1 to $2 million fall in premium revenues to the state treasury. Second, Medicaid is a federal-state matching program. For every $100 in coverage reductions, Oregon spends $40 less in state funds but loses $60 in federal Medicaid matching funds. Third, money "saved" by withholding medical care may force money to be spent elsewhere. A patient who can no longer receive outpatient treatment for depression may attempt suicide, resulting in hospitalization for treatment of an overdose or self-inflicted injury, followed by inpatient psychiatric care. All of the inpatient care is paid for by the OHP.

**And don't let anyone tell you that we can't solve this problem.**

Do the lost premium revenues, the lost federal matching payments, and the added costs for treatment of advanced illness offset the savings from the OHP cutbacks? It would probably cost more to restore the OHP, but no one knows the real fiscal trade-off.

### Why should I care?

Perhaps it would help to know more about the people who are uninsured. There are 500,000 Oregonians without insurance—one out of every seven under age 65. In 2002 Oregon ranked twelfth highest of the states in the proportion of uninsured adults, and that situation may be worse now because of the OHP cutbacks. Among working adults in Oregon, 18% were uninsured. In fact, eight out of every ten uninsured Americans are in working families. Some among us feel that the working poor and their children deserve basic access to medical care.

One of our child's best friends has a father who is self-employed and a mother who works part-time as a registered nurse – not enough hours to qualify for insurance. They have purchased health insurance for their child but they can't afford to buy it for themselves. The mother has gallstones. She knows the risks but can only hope that she doesn't develop complications before their child is old enough that she can go back to work full-time and qualify for benefits.

Some among us will remain unconvinced that we have any moral imperative to help our neighbors get health care. We refer these readers to a report by the Institute of Medicine, "A Shared Destiny: Community Effects of Uninsurance." This panel of national medical experts reports, "It is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured." The added volume of uninsured patients seeking care in county health

departments takes resources that would otherwise be used to fight epidemics or prepare for bioterrorism attacks. The influx of patients using emergency departments as a safety net has contributed to the national crisis in emergency department overcrowding, such that patients with heart attacks or major trauma may experience life-threatening delays in care. The greater burden of disease and disability in a community interferes with our quality of life.

**In fact, recent OHP cutbacks did not affect children.**

Ultimately, those of us with insurance pay the costs of treating uninsured patients. People with chronic illnesses such as hypertension, asthma, and diabetes who don't have their needs met in primary care end up receiving more expensive treatment in emergency departments or are hospitalized because their problems have escalated to emergencies. As providers pass along the costs for increased charity care by raising their fees, and as insurance companies pass along these increased fees by raising premiums, we all pay.

### Are you saying we should raise taxes?

How readers feel about the trade-off between raising taxes, allowing the OHP cutbacks to stand, or cutting other services depends on feelings about "societal responsibility" versus "personal responsibility." To some extent, these decisions are based on core personal values. Intelligent people who agree on the facts may disagree on the best way to implement change.

What at first glance may seem like a social responsibility we do not want to be burdened with may actually be in our own best interests, i.e. a personal responsibility.

You may not want your tax dollars to pay for an addict's methadone but chances are you do want to protect yourself and your children from getting stuck by the drug works of addicts who go back on heroin. You may not want to pay for a homeless alcoholic's tuberculosis treatments but you probably don't want to get TB when he coughs on you in a crowded elevator. You may not want to pay for people on welfare to get primary care doctors but when your father has a heart attack, you may not want his care to be delayed in an emergency department that is overcrowded by uninsured people—seeking access to care in the only safety net that remains for them.

We know that the OHP has substantially improved access to medical care for poor Oregonians and that the cutbacks are hurting those people. But when we talk about using tax dollars to pay for the OHP, we have to consider the direct benefit to all of us, not just those on the OHP.

### What should I do?

Start by talking. Talk with your friends and neighbors. You will be surprised how many lack adequate insurance and are forced to take risks with their health. If you discover that friends are in medical need, suggest that they call their local OHP office, county health department, or a social worker at their local hospital, to see if they might be eligible for OHP and what other help is available. They should call safety net clinics. Encourage them to persist. It is common to spend one or two days on the telephone before finding a provider who can see an uninsured patient.

Think local. Contribute money to local safety net clinics; if you have more time than money, call local clinics and ask how you can help. Consider supporting local taxes that help the uninsured. Even small measures can make a difference.

At the state level, let legislators know you are worried about your neighbors. Until the recession ends, Oregon faces some tough choices but we need to keep access to medical care high on the list of priorities. You can find more details about the research summarized here at the Office for Oregon Health Policy Research web site (http://www.ohppr.state.or.us/index.html); click on the link for the Oregon Health Research & Evaluation Collaborative.

At the national level, learn about potential solutions. Because the issues are complex, it is easy for politicians and special interest groups to hide a self-serving proposal under the banner of "promoting access to medical care," so evaluate all proposals critically. Look at web sites from Cover the Uninsured Week (http://covertheuninsuredweek.org/) and the Kaiser Family Foundation (http://www.kff.org/uninsured/index.cfm).

Don't let anyone tell you that we can't solve this problem. A country with our resources can certainly do what every other developed country in the world has done—provide access to health care for all of its citizens. In the 1990s, Oregon led the nation in developing the Oregon Health Plan. We can do it again.

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