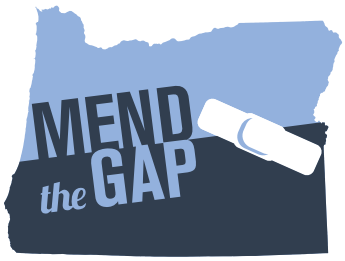
MEND the GAP

WHY FULL COVERAGE MAKES SENSE FOR OREGON

NOVEMBER 2015

OHEA
Oregon Health Equity Alliance



ACKNOWLEDGEMENTS

Many people from Oregon and beyond have contributed their knowledge, experience and effort to this report. We would like to acknowledge them as co-creators of this document, which we hope will lead to a strong and vibrant state where every Oregonian has access to and can afford the health services they need.

Research Team

- Marina Barcelo, NARAL Pro-Choice Oregon
- Janet Bauer, Oregon Center for Public Policy
- Amy Casso, Western States Center
- Jay Donahue, DataCenter
- Kristina Narayan, Asian Pacific American Network of Oregon (APANO)
- Linda Roman, Oregon Latino Health Coalition
- Hannah Rosenau, Oregon Foundation for Reproductive Health
- Joseph Santos-Lyons, Asian Pacific American Network of Oregon (APANO)

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Design: by Angus Maguire, SEIU Local 49.
Photos: Jules Garza, Wayne Bund Photography and Western States Center

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EXECUTIVE SUMMARY

Oregon's strength lies in our people. It lies in our rural communities, in our suburban families, in our urban small businesses and in each of us. How well Oregon rises to the challenges of the next generation will depend on the health and resilience of all our residents.

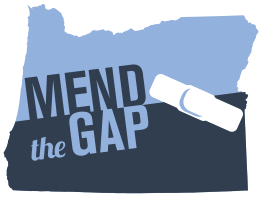
Oregon is an innovator and a national leader, implementing bipartisan solutions that are improving health. In this report, we work within the Oregon tradition of promoting opportunity. We envision pragmatic yet impactful policies that have the potential to strengthen the health of thousands of Oregonians who remain uninsured and underinsured. This Mend-the-Gap report examines the remaining health coverage gaps that, despite the recent progress, prevent Oregonians from accessing the care they need.

While coverage gaps have declined through recent federal and state health reform efforts, there are still over 383,000 Oregonians — roughly one in 10 — who are uninsured. Still others with health insurance have trouble getting care and at a price they can afford. These gaps disproportionately impact rural Oregonians, communities of color, immigrant children and adults, women, LGBTQ people, people with chronic conditions and low-wage working families.

Our state leaders have policy options to mend these gaps and ensure all Oregonians in every county have access to care. This report outlines a number of these policy options.

POLICY RECOMMENDATIONS:

1. *Adopt a Basic Health Program for Oregon.*
2. *Restore Medicaid coverage to COFA Oregonians.*
3. *Extend comprehensive health insurance to Oregon's undocumented children.*
4. *Open health insurance structures to Oregon's undocumented adults.*
5. *Enable Oregonians in the "family glitch" to access affordable coverage.*
6. *Strengthen benefits and lower costs for reproductive health services.*
7. *Remove administrative barriers that deny service to transgender people.*
8. *Adopt a multi-pronged plan for improving rural health care access.*
9. *Lower costs for those with chronic conditions, including older working-age Oregonians.*
10. *Strengthen standards for dental and vision coverage in the commercial market.*



INTRODUCTION

Every person in Oregon matters. Every family in Oregon matters. And every Oregonian — regardless of the color of their skin, their place of origin, their gender, their sexual identity or their financial resources — deserves a chance to be healthy.

While our state has made strides in extending health insurance to more Oregonians, significant disparities persist. Thousands of Oregonians struggle without health insurance due to structural exclusions and because the cost of coverage is too expensive for working families. For others with health insurance, essential services are out of reach due to cost, inadequate coverage, discrimination, limited provider capacity and other barriers to access.

Access to health care is the cornerstone of the well-being of Oregon families. With regular access to care that affordable, high-quality health insurance makes possible, preventable conditions can be avoided, diseases detected early and appropriate treatments delivered. With regular access, costly conditions are less likely to occur. On the other hand, lack of regular access to quality care can mean needless suffering, a lifetime of poor health outcomes and increased mortality.[1]

The barriers that prevent Oregonians from regularly accessing quality care come at a price for all of us. The uninsured and underinsured are more likely to end up in emergency rooms and hospitalized for preventable illnesses, adding costs to the health care system and state budget. In time, the impacts ripple out to the economy when illness means children attain lower educational levels, and workers are less productive and have lower spending power.[2]

LACK OF HEALTH INSURANCE COVERAGE PERSISTS

Despite recent gains due to the Affordable Care Act, thousands of Oregonians still lack health insurance. In 2014, about 383,000 Oregonians – nearly 10 percent – had no coverage.[3] Some are uninsured because coverage remains too expensive even with federal premium subsidies. Others are uninsured because federal law continues to exclude them due to their citizenship status and other factors.

LOW-INCOME OREGONIANS ARE TWICE AS LIKELY TO BE UNINSURED.

OREGON'S UNINSURED ARE DISPROPORTIONATELY PEOPLE OF COLOR, LGBT AND LOW-WAGE WORKERS

Even as growing racial and ethnic diversity strengthens our state, many Oregonians of color, LGBT people and low-wage workers face barriers to health insurance.

In 2014, 18 percent of Oregonians of color lacked health insurance – a far higher rate than experienced by non-Hispanic whites who lacked coverage at a rate of about 8 percent.[4]

Inequities in health insurance are particularly acute for some communities of color. In 2014, 22 percent of American Indian/Alaska Native people living in Oregon were uninsured. Twenty-one percent of Latinos and 18 percent of Native Hawaiians/Pacific Islanders remained uninsured that year.[5]

The lack of health insurance is also more common among Oregon's LGBT community. Researchers found that lesbian, gay and bisexual adults in Oregon were less likely to have health insurance, with 77 percent of them being insured as compared to 82 percent of heterosexual adults.[6] No comparable figures are available for transgender Oregonians; however, national research finds that transgender Americans are less likely than Americans generally to have health coverage.[7]

Finally, lack of health insurance is a serious problem for Oregon's low-wage workers. In 2014, low-income Oregonians not eligible for Medicaid – those with income between 138 and 200 percent of the federal poverty line – were more than twice as likely as Oregonians with higher incomes to be uninsured.[8] In 2014, 200 percent of the federal poverty line was less than $31,860 in yearly income for a family of two. (The federal poverty line varies by family size).

WHEN HARD WORK DOESN'T MAKE A DIFFERENCE

"I work hard at PDX airport making sure that passengers who need assistance get to their planes on time, making minimum wage with no benefits. I'm a single mother of four kids. Many of my coworkers qualify for OHP but I am excluded. Not having insurance means when I get sick, I do nothing."

Kasil Kapriel, Marshallese worker

Kasil simply takes a Tylenol when sick. When things are really bad, she forfeits a shift and, living on the edge, wonders if she'll still have a job to return to.

MANY IMMIGRANT OREGONIANS ARE STILL LEFT OUT

Immigrants contribute to Oregon's economy, performing some of the most arduous and dangerous jobs. Undocumented immigrants and legal permanent residents contribute to national, state and local public structures through the various taxes they pay. For instance, undocumented immigrants alone in Oregon pay an estimated $154 million to $309 million in state and local taxes each year, and their share, as employees, of Medicare and Social Security taxes.[9] Yet, many immigrants are excluded from the health insurance opportunities that protect other Oregonians.

Legal permanent residents: Legal permanent residents are barred by federal law from the Oregon Health Plan – Oregon's Medicaid program – for the first five years of residency. Unfortunately, there are no other affordable coverage options available for legal permanent residents who would otherwise qualify for Medicaid and do not have affordable job-based coverage. Although they are permitted to purchase insurance through the marketplace, they may not be able to afford the coverage because the premium subsidies are likely insufficient, being designed for folks with above-Medicaid-level incomes. Between 3,500 and 6,500 Oregonians experience this predicament and are nearly certain to go uninsured.[10]

COFA immigrants: Individuals from a group of Pacific island nations are permitted to live and work in the United States under "compacts of free association" (COFA), but are permanently barred from Medicaid. While COFA residents used to have access to Medicaid, Congress stripped that protection in 1996 when it overhauled welfare. COFA nations include the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau. There are an estimated 3,000 COFA immigrants in Oregon.[11] Since many work for low wages, many would likely qualify for Medicaid except for their immigration status. Instead, they go uninsured. While some states provide state-funded coverage to COFA residents, Oregon has yet to do so.[12]

COMPACTS OF FREE ASSOCIATION (COFA)

Oregon has a sizable COFA population, having the third largest in the continental United States.[13] *Marshallese students comprise the second largest group of English language learners in the Salem-Keizer school district.*[14]

Since the 1940s, the United States has located military bases on the islands that now comprise the COFA nations and has used the islands for nuclear weapons testing. People of COFA nations are permitted to reside the United States in exchange for continued U.S. military occupation.

COFA populations endure a range of health issues related to the United States military activities in their homeland. COFA Pacific Islanders experience exceptionally high rates of cancer. Researchers have found liver cancer among Marshallese men to be thirty times more prevalent than among the U.S. population generally, breast cancer five times higher and lung cancer three times more prevalent.[15] *COFA populations suffer from high rates of stroke, heart disease, blood disorders and genetic conditions — illnesses that are associated with high doses of radiation.*[16]

OREGON'S CHILDREN EXCLUDED FROM BASIC CARE

Karla is a first generation higher education student at Mt. Hood Community College. When she was in elementary and middle school Karla, was categorically ineligible for Oregon Healthy Kids. As a child with asthma, Karla was sick often and needed long term primary care. The only affordable options were free clinics, school events and low-cost doctors. Occasionally, she would find a free clinic that would offer care for only 10 minutes once a year. Oregon has a responsibility to ensure that all children have a chance to be healthy and ready for school.

Undocumented children: Undocumented children in Oregon have a difficult time getting the care they need. They seldom have job-based coverage through a parent and are barred by federal law from Oregon's Medicaid program. Undocumented children cannot purchase coverage with or without tax credits through Oregon's health insurance marketplace. While Oregon's safety net clinics fill some of the void in primary care, they reach only a portion of undocumented children in Oregon and are not a substitute for comprehensive health insurance in addressing disease and promoting health.

About 17,600 undocumented children under the age of 19 live in Oregon.[17] Oregon would reap economic and social benefits by including these children in a medical assistance program equal to other children. Insured children are healthier and less likely to end up using emergency care compared to children without insurance. Childhood health is linked to higher earnings and greater wealth in adulthood.[18] Six states provide health coverage to every child in their state.[19]

Immigrants with DACA status: Starting in 2012, young people under age 32 who arrived in the United States as children can apply for a temporary status called Deferred Action for Childhood Arrivals (DACA). At the same time, federal authorities also barred the young people from Medicaid and the Children's Health Insurance Program. There are nearly 16,000 Oregon residents approved for DACA.[20] For many of these individuals intent on getting ahead, their lack of health coverage makes the path to a successful life more difficult.

Undocumented adults: Oregon's estimated 142,000 undocumented adults often work in jobs that lack affordable health insurance.[21] Like undocumented children, they are barred from the Oregon Health Plan and cannot receive federal subsidies for marketplace plans. Extending access to affordable, quality health insurance to undocumented immigrants would close a coverage gap in the state, improving their health status, reducing their medical debt, supporting their productivity at work and moving Oregon closer to its health reform goals.

FAMILY COVERAGE TOO EXPENSIVE, LEAVING SOME UNINSURED

Family members of workers offered health insurance by an employer may find themselves unable to afford health insurance, having fallen victim of the so-called "family glitch."

The Affordable Care Act bars people from receiving federal subsidies for marketplace coverage if their employer offers an affordable and adequate health insurance plan. Affordability is determined by comparing the cost to the employee of the employee's coverage with household income.

An affordability problem can arise when an employer offers family insurance, which many do, and contributes little or nothing toward the coverage. To accept the coverage, the family must pay much or all of the cost of the family coverage. Because federal rules determine whether an offer of family coverage is affordable to a family based on the cost of the employee-only coverage, modest income families who can afford the employee-only coverage but not the family coverage are not able to turn to the marketplace to purchase insurance with federal subsidies.[22] This "family glitch" may be due to a drafting error in the federal health reform law.

Health insurance for modest-income households caught in the family glitch can mean economic hardship for them. Some may simply go uninsured, being unable to afford the cost of either the employer-offered family coverage or unsubsidized non-group coverage. Over a million people nationally, possibly many more, are estimated to be affected. Researchers are assessing the extent of the problem in Oregon and in other states.[23]

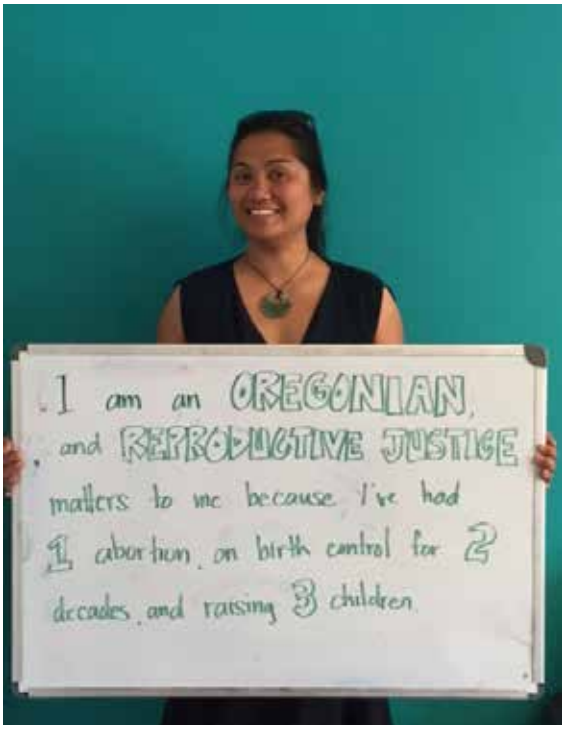
EVEN WITH HEALTH INSURANCE, OREGONIANS EXPERIENCE BARRIERS TO CARE

FOR EVERY DOLLAR A STATE SPENDS ON FAMILY PLANNING SERVICES, ***$7 IS SAVED*** *IN MEDICAID-RELATED COSTS*

Having health insurance coverage is necessary, but not sufficient. Many Oregonians with health insurance cannot access the health services they need due to cost, inadequate coverage, insufficient number of providers and discrimination. Indeed, women, LGBT people, rural households and those with chronic conditions particularly face barriers to accessing health services.

REPRODUCTIVE HEALTH CARE IS NOT ALWAYS COMPREHENSIVE OR AFFORDABLE

While the Affordable Care Act has improved coverage of reproductive health services, barriers remain in coverage and access. Access to a full range of reproductive health services enables women to more fully participate in the economic, cultural and social life of their communities.



The state benefits, as well. For every dollar the state spends on family planning services, $7 are saved in Medicaid costs.[24] Since almost half of all pregnancies in Oregon are unintended, more should be done to ensure that women are able to get contraceptive and pregnancy-related care.[25]

Preventive services such as breastfeeding support, birth control and prenatal care now must be provided without cost sharing. However, private plans typically require deductibles and coinsurance or co-payments for other important but expensive services such childbirth and newborn care.[26] The consequences of inadequate pregnancy-related care are serious and disproportionately impact Oregon's communities of color.[27]

Women face even greater obstacles to accessing abortion services. Abortion is an unexpected, time-sensitive and expensive health care need. It is also common, safe and a part of the full range of reproductive health care options, with nearly one in three American women accessing abortion by the age of 45.[28]

Private insurance plans in Oregon are not required to cover abortion care. When they do, costs to the consumer can be considerable. Abortion services are typically subject to a deductible, which in Oregon ranges from $1,000 to $6,600 for an in-network provider.[29] The average out-of-pocket cost of abortion services nationally is nearly $500 and can range up to $3,500 or more depending on the procedure.[30] Some plans in Oregon do not cover abortion care, leaving women to pay the full cost.[31]

Getting to a clinic to obtain an abortion can be problematic. Twenty-eight of Oregon's 36 counties have no abortion clinic, which means that about a third of Oregon women must travel to receive care.[32] Women accessing such care outside of their county can face additional barriers such as hours of travel, time off of work and the cost of transportation and lodging.

Ensuring that all Oregon women have adequate access to the full range of reproductive services will help women stay as healthy as possible, bear healthy children, care for their families and fully participate in economic life.

22 PERCENT *OF TRANSGENDER OREGONIANS REPORT BEING REFUSED MEDICAL CARE.*

TRANSGENDER COMMUNITIES EXPERIENCE PARTICULAR OBSTACLES TO CARE

LGBT people face systemic barriers rooted in homophobia and transphobia, which impacts the ability of LGBT people to get the care they need. Transgender people face some of the greatest barriers to care. A recent study found that 22 percent of transgender Oregonians reported being refused medical care.[33]

Transgender men – people who were assigned female at birth and identify as male – experience the same barriers to reproductive care as women do, described above.

In addition, transgender people often must navigate administrative obstacles. When a transgender person does not conform to the expected gender associated with a needed health care service, care is sometimes denied. Health insurance enrollment forms require individuals to mark either "male" or "female." These categories can result in refusal of care for transgender people when the needed care appears incompatible with the person's gender. This is problematic since a person transitioning from male to female may still need a prostate exam, for example, and a person transitioning from female to male may still need a gynecological exam.

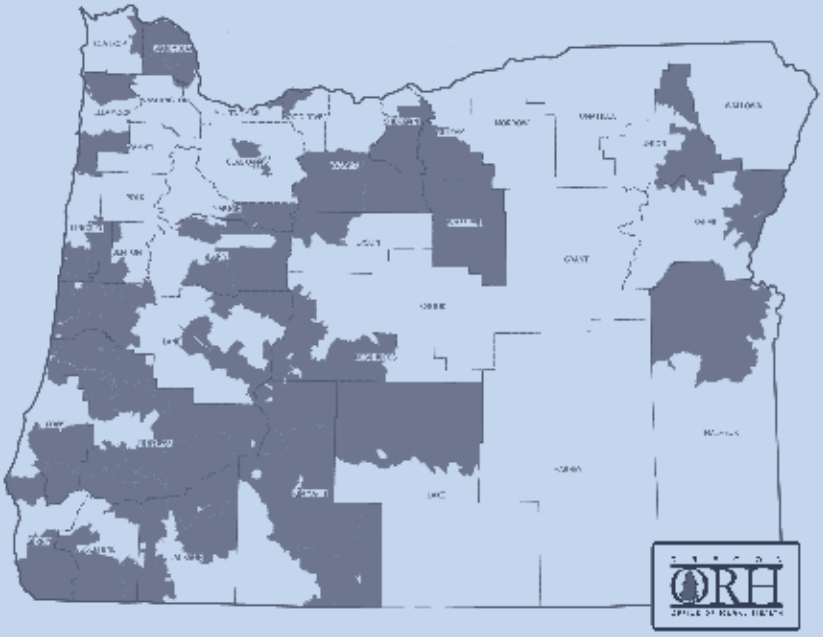
Fortunately, the national association that establishes billing standards developed a simple solution – a billing code to designate when an apparent gender/procedure mismatch is legitimate.[34] The federal Department of Health and Human Services recently endorsed its use, yet this fact may not be widely known.[35]

BARRIERS TO REPRODUCTIVE CARE

"I was denied reproductive health care because I was $4 short. I went to get birth control. I went to go get it. I was under 18 at this point. They said it was $79. I only had $75 dollars. They made me come back for another appointment two weeks later when I had the $4. It was ridiculous. They were very rude about it. I was young and I did not want to get pregnant."

Anonymous

UNMET HEALTH CARE NEED IN RURAL OREGON



Data for 2015. Unmet health care need areas based on criteria of the Oregon Office of Rural Health.[38]

RURAL OREGONIANS HAVE UNIQUE DIFFICULTIES OBTAINING CARE

While Oregonians living in rural areas are about as likely to have health insurance as Oregonians in urban areas, many rural residents have a harder time accessing care.

Large swaths of rural Oregon suffer from poor access to health services, according to the Oregon Office of Rural Health.[36] Residents in these areas often have trouble finding a primary care provider within a reasonable distance to their home. A specialist or hospital may be hours away. And the health providers who do serve their community may be booked and unable to take new patients. Oregonians in these areas of high unmet health care need suffer from comparatively high rates of preventable hospitalizations, mortality and low birth weight.[37]

Improving access to health care providers in Oregon's rural communities would help residents stay healthy and avoid serious illness.

PEOPLE WITH CHRONIC CONDITIONS CAN FACE UNAFFORDABLE OUT-OF-POCKET COSTS

People with chronic conditions can have trouble paying for the care they need even with comprehensive health insurance coverage. Older Oregonians not yet eligible for Medicare are more likely than younger individuals to have chronic health conditions and face this challenge.

Take, for example, 57-year old Mary with diabetes who earns $33,000 per year. Mary is eligible for premium tax credits but makes too much to receive federal cost-sharing subsidies to help with out-of-pocket expenses. Management of diabetes is costly, involving medication, medical equipment, regular office visits and laboratory tests. Assuming those costs are no higher than the plan's deductible, the premiums plus the out-of-pocket costs could be about $6,000 annually, likely a hardship for Mary. And out-of-pocket costs for diabetes care can easily be higher.

Individuals in this circumstance can face the difficult choice of managing a chronic condition or meeting other basic needs, such as housing and food. For modest income individuals, high out-of-pocket expenses can put their physical and financial health at risk.

DENTAL AND VISION COVERAGE IS LIMITED; ACCESS PROBLEMATIC

Routine dental and vision care is important in preventing disease and diagnosing it early. Regular care helps Oregonians of all ages successfully participate in school, work and community life.[39] Unfortunately, many Oregonians lack vision and dental coverage even if they have other medical coverage because commercial health plans in Oregon are not required to cover those services for adults. Fortunately, the benefit package for those on the Oregon Health Plan covers both routine vision and dental care for children and adults.

With or without appropriate coverage, Oregonians can face challenges when trying to obtain dental and vision care when there are not enough service providers in their area. These problems of inadequate provider networks can disproportionately affect people of color, low-income people and those in rural areas.

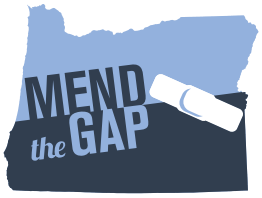
ALL OREGONIANS, ALL SERVICES: FULL COVERAGE MAKES SENSE

Oregon's economic future depends on the health of everyone. Affordable, comprehensive health care coverage makes sense for families and for the state of Oregon. When families have affordable, comprehensive health coverage, they are able to devote more of their resources to meeting other important needs. Having to spend less on health care helps families to get ahead.

Healthier people also tend to be more productive and better able to contribute to the economy. They miss fewer days of work, are less likely to become disabled and participate longer in the workforce.[40] Health is also linked to educational achievement. Affordable, comprehensive coverage for all Oregon children would help ensure that every child succeeds in school, improving their success as adults.

Ultimately, providing affordable, comprehensive coverage reflects our state's values: That every person and every family in Oregon matters.

The following pages offer policy recommendations to help Oregon realize its economic potential and achieve its health reform goals.



POLICY RECOMMENDATIONS TO MOVE OREGON FORWARD

1. ADOPT A BASIC HEALTH PROGRAM FOR OREGON

A Basic Health Program could reach many Oregonians who currently go uninsured. Basic Health would offer more affordable coverage than marketplace plans to low-income Oregonians who make too much to qualify for the Oregon Health Plan. Basic Health could increase coverage and reduce disparities among low-income Oregonians, a group at particular risk of going uninsured and more likely to include people of color.

A Basic Health Program could offer affordable coverage for legal permanent residents and COFA individuals who have low incomes and would otherwise be covered by the Oregon Health Plan but are barred by federal law.

Basic Health could help people get the care they need by reducing high out-of-pocket costs that deter some from seeing a doctor. By lowering or eliminating co-payments, coinsurance and deductibles, individuals needing reproductive services and chronic disease management care would be more likely to get it. Boosting access to health services for cash-strapped households would be a boon for improving birth outcomes, reducing costly preventable illnesses and addressing health disparities due to race, ethnicity and age. Basic Health could also fill gaps in vision and dental coverage for the eligible group.

2. RESTORE MEDICAID COVERAGE TO COFA OREGONIANS

Oregon should correct an injustice and restore Medicaid coverage to COFA Oregonians. It should do so with state funds as other states have done. Should Oregon implement a Basic Health Program, the group could potentially be moved to that program, saving the state the funds.

3. EXTEND COMPREHENSIVE HEALTH INSURANCE TO OREGON'S UNDOCUMENTED CHILDREN

Oregon benefits when all children have the chance to grow up healthy, succeed in school and thrive. To achieve this goal, Oregon should extend the Oregon Health Plan to cover undocumented children. Covering undocumented children would benefit all of Oregon by improving educational achievement and nurturing the young talent needed to drive the state's future economy.

4. OPEN HEALTH INSURANCE STRUCTURES TO OREGON'S UNDOCUMENTED ADULTS

Immigrant Oregonians work hard and contribute to our state's economy. Assuring undocumented adult workers are able to stay healthy with comprehensive coverage would benefit them and our state. A state-funded Oregon Health Plan-like program and premium subsidies for commercial coverage would address this coverage gap.

5. ENABLE OREGONIANS IN THE "FAMILY GLITCH" TO ACCESS AFFORDABLE COVERAGE

It is in our state's interest for Oregonians in the "family glitch" to have an affordable, comprehensive package of health services. A state-funded Oregon Health Plan-like program and premium subsidies for commercial coverage would address this coverage gap.

6. STRENGTHEN BENEFITS AND LOWER COSTS FOR REPRODUCTIVE HEALTH SERVICES

Standards for reproductive health services in Oregon are not strong enough to assure that women are as healthy as possible, can choose if and when to have children, and have healthy pregnancies and births. Requiring all plans to cover the full range of reproductive services and lowering their out-of-pocket costs would go a long way to improving access to those vital services. Doing so holds promise for boosting women's economic opportunities, improving birth weights and infant survival — outcomes that at the same time would advance health equity in our state.

7. REMOVE ADMINISTRATIVE BARRIERS THAT DENY SERVICE TO TRANSGENDER PEOPLE

Oregon should promptly require that health insurers and providers adopt a new nationally-recognized protocol (a new billing code) that accommodates the needs of transgender people. Using the new billing code would help ensure that transgender people are not denied care because of administrative problems.

8. ADOPT A MULTI-PRONGED PLAN FOR IMPROVING RURAL HEALTH CARE ACCESS

Oregon should develop and implement a plan that builds on innovative ways to bring needed services to underserved regions, to bring residents to existing resources and builds upon current progress in rural health care access. The plan should strengthen requirements for provider networks in both public and commercial health insurance and evaluate the effectiveness of current public rural health investments.

9. LOWER COSTS FOR THOSE WITH CHRONIC CONDITIONS, INCLUDING OLDER WORKING-AGE OREGONIANS

Oregon could help people with chronic conditions better afford care by subsidizing treatment for people with high expenses compared to their income. In addition, Oregon could promote health insurance plan designs that lower out-of-pocket costs for particular services for this group. These steps would move Oregon closer to the goals of health reform — keeping people healthy and helping them avoid costly conditions.

10. STRENGTHEN STANDARDS FOR DENTAL AND VISION COVERAGE IN THE COMMERCIAL MARKET

Including adult dental and vision coverage in Oregon's "essential health benefit" benchmark plan would help reduce affordability barriers to the coverage in the commercial market that Oregonians now can experience. Alternatively or in combination, Oregon could subsidize such coverage.

KEY TERMS

Coinsurance – an individual's share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. For example, if the health insurance plan's allowed amount for an office visit is $100 and your coinsurance payment is 20 percent, you would pay $20 in coinsurance. The health insurance plan pays the rest of the allowed amount.

Compact of Free Association (COFA) – An international treaty currently in place between the U.S. and three sovereign nations, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

Co-payment – a flat amount the insured person pays for a covered service.

Deductible – the amount an individual must pay out-of-pocket each year for covered health care services before a health insurance plan begins to pay.

Deferred Action for Childhood Arrivals (DACA) – an American immigration policy instituted in June 2012 that allows certain undocumented immigrants under the age of 32 who entered the country before their 16th birthday and before June 2007 to receive a renewable two-year work permit and exemption from deportation. It does not confer legal citizenship status or provide a path to citizenship.

Health insurance premium – the amount that must be paid by an individual or employer for an individual's health insurance. Premiums paid by an individual are usually paid monthly.

LGBT – Lesbian, Gay, Bisexual and Transgender.

Medical assistance program – a jointly-funded federal-state program that pays for health care services provided to low-income individuals.

Oregon Health Plan (OHP) – the Medicaid medical, dental, reproductive and mental health care program for adults under 138 percent and children under 300 percent and of the federal poverty level.

People of Color – A term in the United States context defining persons who share a common experience of being presently and historically impacted by racial inequities and racism.

Premium subsidy – financial assistance to help low- and middle-income people purchase and use health insurance. There are two kinds of federal subsidies available for individual health insurance plans in the marketplace. The Advance Premium Tax Credit lowers an individual's monthly insurance premium. Cost Sharing Reduction reduces the out-of-pocket costs an individual pays during the policy period, including deductible, coinsurance and copayments.

Undocumented Immigrant – A foreign-born person who presently lacks or has lost documentation required for federally-recognized citizenship in the United States.

ENDNOTES

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3. Data from the American Community Survey. Using different methods, another estimate of Oregon's uninsured conducted by Oregon Health and Sciences University found 223,000 Oregonians, or 5.7 percent, were uninsured in 2014. *Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon*: *County Results/Statewide Update*, Oregon Health and Sciences University, February 2015, https://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/upload/Health-Insurance-Coverage-in-Oregon-County-Results.pdf.

4. Oregonians of color includes all Oregonians who reported being of one race only, including those reporting being Hispanic white, except those reporting being non-Hispanic white. Oregon Center for Public Policy (OCPP) analysis of American Community Survey data.

5. In 2014, 9 percent of both Black/African American and Asian Oregonians lacked health insurance. OCPP analysis of American Community Survey data.

6. *State Health Profile*, Oregon Public Health Division, Oregon Health Authority, September 2012, https://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf.

7. Kates, Jen; Usha Ranji; Adara Beamesderfer; Alina Salganicoff and Lindsey Dawson. *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, Kaiser Family Foundation, July 2015, http://files.kff.org/attachment/issue-brief-health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s.

8. In 2014, 15.2 percent of Oregonians with income between 138 percent and 200 percent of the federal poverty line (FPL) were uninsured. That year, 6.4 percent of Oregonians above 200 percent FPL were uninsured. OCPP analysis of American Community Survey data.

9. *Undocumented Workers Are Taxpayers, Too*. Oregon Center for Public Policy, January 2012, http://www.ocpp.org/media/uploads/pdf/2012/01/iss20120125UndocumentedTaxpayers_fnl.pdf.

10. A recent study estimated that 6,500 legally-residing Oregonians with incomes below 138 percent of the federal poverty level cannot access Oregon's Medicaid program because of federal restrictions. Many of these individuals are legal permanent residents barred from Medicaid for five years. Others are COFA residents who are barred from the program indefinitely. This report is not able to precisely estimate how many legal permanent residents are barred from Medicaid but the number is between 3,500 (6,500 less all the estimated COFA population assuming all the COFAs are Medicaid-eligible) and 6,500 (assuming none of the COFA individuals are Medicaid-eligible). *Oregon Basic Health Program Study*, Wakely Consulting Group and the Urban Institute, October 29, 2014, p. 17, http://www.ocpp.org/media/uploads/pdf/2014/11/Oregon_BHP_Report20141029.pdf.

11. OCPP analysis of data from the Government Accountability Office, http://www.ocpp.org/media/uploads/pdf/2015/10/20150930MemoEstimateCOFAOregon_fnl.pdf.

12. With some limitations, Hawaii, Massachusetts, Minnesota and the District of Columbia offer health coverage to legally-residing adults who are ineligible for federally-supported programs. *Medical Assistance Programs for Immigrants in Various States*, September 2015, http://www.ocpp.org/media/uploads/pdf/2015/10/NILC_med-services-for-imms-in-states-2015-09.pdf.

13. OCPP analysis of data from the Government Accountability Office.

14. *A Community of Contrasts: Asian Americans, Native Hawaiians and Pacific Islanders in the West*, Asian Americans Advancing Justice, 2015, p. 53, http://www.advancingequality.org/sites/aajc/files/AAAJ_Western_Dem_2015.pdf?_ga=1.135352180.496307322.1445625027.

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16. Palafox, Neal A., Testimony before Senate Energy and Natural Resources Committee, July 19, 2005, http://www.gpo.gov/fdsys/pkg/CHRG-109shrg24536/html/CHRG-109shrg24536.htm.

17. *Health Care for all Children*, Oregon Latino Health Coalition and Oregon Center for Public Policy, October 21, 2014, http://www.ocpp.org/media/uploads/documents/2014/rpt102114HealthCareforAllChildrenReport_fnl.pdf.

18. Baker, James A. III. *The Economic Impact of Uninsured Children on America*, Institute of Public Policy, Rice University, June 2009, http://bakerinstitute.org/media/files/Research/6db8160c/HPF-pub-HoShortUninsuredChildren-060309.pdf.

19. States that provide comprehensive health coverage to undocumented children are Washington, California, Illinois, New York, Massachusetts and the District of Columbia. *California to Foot Bill for Health Care of Undocumented Children*, BloombergPolitics, June 25, 2015.

20. *Data Set: Form I-821D Deferred Action for Childhood Arrivals*, Department of Homeland Security, http://www.uscis.gov/tools/reports-studies/immigration-forms-data/data-set-form-i-821d-deferred-action-childhood-arrivals.

21. Oregon has an estimated 160,000 undocumented immigrants including 17,600 children below age 19. Figure for adults is calculated by subtracting estimated undocumented children from total undocumented Oregonians. *Health Care for All Children*, Oregon Latino Health Coalition and Oregon Center for Public Policy, October 21, 2014, http://www.ocpp.org/media/uploads/documents/2014/rpt102114HealthCareforAllChildrenReport_fnl.pdf

22. Children with income up to 300 percent of the federal poverty level can typically access the Oregon Health Plan. Therefore, spouses with modest incomes are more likely to be affected by the family glitch.

23. No estimate of the scale of the family glitch problem in Oregon was available by publication date, however, authors have learned of research underway aimed at estimating impacts at the state level. Burkhauser, Richard V., Sean Lyons and Kosali I. Simon, *The Importance of the Meaning and Measurement of "Affordable" in the Affordable Care Act*, National Bureau of Economic Research, August 2011, http://www.nber.org/papers/w17279.pdf.

24. Frost, Jennifer J., Adam Sonfield, Mia R. Zolna, Lawrence B. FIner. "Return on Investment: A fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program." *The Milbank Quarterly*, Vol 92, No. 4, 2014 (pp 667-720), http://www.guttmacher.org/pubs/journals/MQ-Frost_1468-0009.12080.pdf.

25. *State Facts About Unintended Pregnancy: Oregon*, Guttmacher Institute, 2014, https://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/OR.pdf.

26. *Guide to 2015 Health Insurance Coverage for Oregonians: Women's Health*, Oregon Department of Consumer and Business Services, http://www.oregon.gov/DCBS/insurance/news/Pages/2014/oct032014.aspx.

27. In 2009, the low birth rate for Blacks was 11 percent and for Whites was 6 percent. The State of Black Oregon, Urban League of Oregon, 2015, http://ulpdx.org/wp-content/uploads/2015/05/State-Of-Black-Oregon-2015.pdf. The infant mortality rate for 2011-13 for non-Hispanic Blacks was 8.29 per thousand live births and for non-Hispanic Whites, 4.72 per thousand live births. *Infant Mortality Statistics From the 2013 Period Linked Birth/Infant Death Data Set*, National Vital Statistics Report, Centers for Disease Control and Prevention, August 6, 2015. http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf.

28. *Fact Sheet: Induced Abortion in the United States*, Guttmacher Institute, July 2014, https://www.guttmacher.org/pubs/fb_induced_abortion.html.

29. Moda silver-level single coverage plans include a deductible of $1,150 for an in-network provider; $4,250 deductible for a bronze-level plan and $6,600 deductible for a catastrophic plan. Deductibles for out-of-network providers are higher and can reach $13,000; https://www.modahealth.com/pdfs/members/2015/ind_health_plan_brochure_or_2015.pdf.

30. Average cost of abortion nationally is $485 and is based on expenses for people with out-of-pocket costs above zero (those who paid nothing are excluded in the calculation) and includes people with either public or private coverage. Jones, Rachel K. et al. *At What Cost? Payment for Abortion Care by U.S. Women*. Women's Health Issues, Volume 23, Issue 3, e173 – e178, http://www.guttmacher.org/pubs/journals/j.whi.2013.03.001.pdf.

31. Providence plans do not cover abortion services. https://healthplans.providence.org/individuals-families/2015/health-plan-details/list-of-exclusions/#rs.

32. Jones, Rachel K. and Jenna Jerman, *Abortion incidence and service availability in the United States*, 2011, Perspectives on Sexual and Reproductive Health, 2014, 46(1):3–14, http://www.guttmacher.org/pubs/journals/psrh.46e0414.pdf.

33. *Findings of the National Transgender Discrimination Survey, Oregon Results*, National Center for Transgender Equality and the National Gay and Lesbian Task Force, http://www.endtransdiscrimination.org/PDFs/ntds_state_or.pdf.

34. The federal Medicare agency adopted the National Uniform Billing Committee's newly-created code (45 -- Ambiguous Gender Category) to indicate when a gender/procedure mismatch is not an error. *Medicare Claims Processing Manual*, Chapter 32, Revised February 20, 2015, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf.

35. The Department of Health and Human Services released proposed rules that would make illegal the practice of categorically excluding all gender transition-related health care from coverage. The rule will apply to all health insurance plans sold on the state and federal exchanges, as well plans sold by a companies with federal contracts or receiving federal funds. http://www.hhs.gov/ocr/civilrights/understanding/section1557/nprmsummary.html.

36. *2015 Areas of Unmet Health Care Need In Rural Oregon Report*, Oregon Office Of Rural Health, http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2015-Unmet-Need-Report.pdf.

37. Ibid.

38. The Oregon Office of Rural Health identifies areas of unmet health care need based on five factors, which include percentage of primary care visits met, preventable hospitalizations, travel time to nearest hospital, comparative mortality and low birth weigh rate.

39. *Action for Dental Health: Bringing Disease Prevention into Communities*, American Dental Association, December 2013, http://www.ada.org/~/media/ADA/Public%20Programs/Files/bringing-disease-prevention-to-communities_adh.ashx.

40. The percentage of people self-reporting "very good" or "excellent" health were nearly five times as likely to be employed as someone reporting "poor" health and nearly twice as likely to be employed as someone reporting "fair" health. Driscoll, Anne K., and Amy B. Bernstein. *Health and Access to Care Among Employed and Unemployed Adults: United States, 2009–2010*, http://www.cdc.gov/nchs/data/databriefs/db83.pdf.

SUPPORTING ORGANIZATIONS

Over the last year, the Oregon Health Equity Alliance (OHEA), a coalition of organizations representing communities of color, low-income communities, LGBTQ communities, immigrants and women, has worked together to develop recommendations to ensure health care coverage for those still being left behind by the Affordable Care Act and state level health expansion reforms. These organizations recognize that our communities would be stronger with full coverage, and we are also stronger when we come together under a unified platform.

APANO

Oregon Action

Breastfeeding Coalition of Oregon

OCPP Oregon Center for Public Policy
Because facts matter.

CareOregon

OPCA Oregon Primary Care Association

CIO

Oregon Foundation for Reproductive Health

Data Center
Research for Justice

Oregon Latino Health Coalition

International Center for Traditional Childbearing

Planned Parenthood
Act. No matter what.
Planned Parenthood Advocates of Oregon

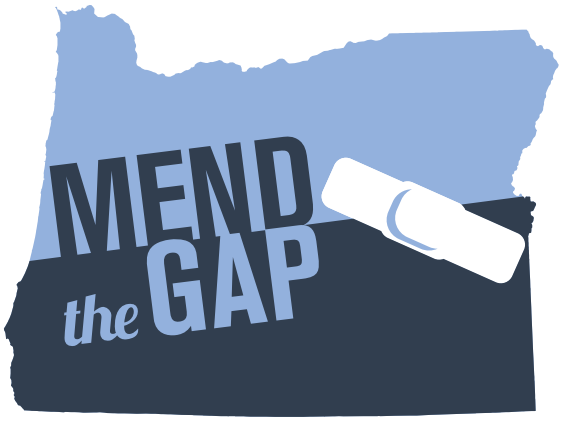
Health Care for ALL Oregon

SEIU
Stronger Together

the Main Street alliance

NARAL Pro-Choice Oregon

Western States Center



OHEA
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FOR MORE INFORMATION CONTACT:
Linda Roman, *Policy Director*
240 N Broadway Ste. 115 | Portland, OR 97227
503-523-7230 | linda@orlhc.org