A Study of Washington State Basic Health Program

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PARTNERSHIP BACKGROUND

Washington State Basic Health and Oregon Health Policy and Research

The Washington State Health Care Authority (HCA) surveyed Basic Health (BH) members in the summer of 2001 to assess member satisfaction with the program and with contracted health plans, on plan performance, and program administration.

The Basic Health survey project was done in partnership between the Health Care Authority's Health Policy and Research Development (HPRD) and the Washington State University (WSU) Social and Economic Sciences Research Center (SESRC) of Pullman, Washington. The survey tool to gather the desired information and feedback was developed and fielded by SESRC in May and June 2001, based on parameters developed by HCA and WSU. The survey would further serve as a baseline from which to gather additional information at a later time and to build and improve upon. The intent for this iteration was to:

- provide information about members' experiences and preferences regarding potential program changes;
- provide feedback for improvements to the Basic Health Program;
- assess members' preferences and interests for future initiatives;
- make improvements for further surveys;
- develop follow up plans and strategies.

At about the time that the survey was completed, the state of Oregon was seeking information on programs like the Basic Health, since Oregon is in the process of expanding the Oregon Health Plan. The experiences of Washington Basic Health seemed appropriate to assess as Oregon policy makers considered options similar to the Washington experience.

Representatives from Oregon Health Policy and Research met with HCA representatives to discuss the information that would be of most value to Oregon. It was decided that, in addition to specific survey information, the HCA would provide more in-depth information regarding the Basic Health Financial Sponsor program. A partnership between the HCA and Oregon Health Policy and Research was formed. The partnership hopes to utilize and continue sharing information and data between the two states that can be of mutual benefit to policy makers and the populations served by the respective state programs.

This initial report provides program experience information, feedback on perceptions of BH members regarding things like quality, access and affordability, as well as a discussion of the financial sponsor program, initial survey findings and other policy implications.

This partnership intends to build upon this first effort and to continue exchanging valuable information and experience, including best practices in policy, program

administration and operations. Additionally, other Washington contacts and linkages have been recommended and established with the state of Oregon regarding various Basic Health and financial sponsor issues. These contacts provide invaluable first hand experience and viewpoints that can benefit policy making, stakeholder management, program administration and customer service.

The first collaborative partnership work provides specific information for the state of Oregon in the following areas:

1) An Overview of Basic Health
   a) Brief history and structure of Basic Health
   b) Enrollment growth
   c) Benefit structure
   d) Cost sharing philosophy, rationale, methodology

2) Financial Sponsoring Organizations—Background
   a) Requirements for sponsorship
   b) Interests, goals and extended role of the financial sponsor
   c) Cost share requirements for provider sponsors
   d) Demographic composition of financial sponsor enrollees

3) Analysis and findings from the Washington Basic Health Plan survey of enrollees conducted in May and June 2001

4) Other Policy Implications

Washington State looks forward to expanding this collaborative partnership and in continuing to build on this initial work. Basic Health staff is pleased to be able to provide our program's valuable lessons learned and an assessment of feedback and perceptions from the customers we serve. We hope that this helps to make the Oregon experience even more successful. By combining and leveraging our joint efforts we hope to be able to better serve the residents of both states with hallmark best practices, policy excellence and world class research. We look forward to learning from the Oregon experience, in having regular dialogues and in leveraging resources for our mutual benefit.

EXECUTIVE SUMMARY

The State of Washington has a strong history of progressive health care policy. It has been a leader in comprehensive health care reform. The Health Care Access of Act of 1987 established the Washington State Basic Health program, the first insurance program of its kind in the nation. BH is a state-sponsored program that offers subsidized managed care coverage to low-income Washington residents who are not eligible for Medicare, or institutionalized at time of enrollment. Enrollees pay a sliding-scale premium based on their family size, income, age, and the health plan selected. The minimum premium is $10 per adult per month. Children under age 19 who are eligible for Medicaid may join BH Plus (a free program), which essentially enrolls the children in Medicaid through coordination with the Medical Assistance Administration of Department of Social and Health Services. Limited coverage is available for current enrollees who do not meet income guidelines and who pay the full cost of their coverage. This "full-premium" coverage is not available to new enrollees or to all current enrollees, however.

This report summarizes BH history, enrollment, benefits structure, and cost sharing. As specifically requested, the report includes detailed information on the financial sponsor program, and recent findings from a survey of BH enrollees conducted by Washington State University in 2001. It also discusses policy options and issues. Highlights include:

- Provider sponsors are required to pay a minimum of $15 per enrollee per month for persons below 100% of the FPL, and $20 per enrollee per month for persons whose family income is between 100% and 125% of the FPL.
- Financial sponsorship represents 16 percent of total BH enrollment.
- 87 percent of respondents of all FPL groups are high school graduates (Table 11).
- When compared with general BH subsidized population, financial sponsor enrollees are more likely to be: young adults (19 to 39 years old); Native Americans, or Hispanic origin; Spanish speaking; an education level of less than high school graduate (Table 12).
- Regardless of their income level or financial sponsorship, the majority of respondents considered the co-payment for doctor office visits, prescription drugs, and premiums affordable (Table 15, Table 16).
- Over two-third of all respondents would prefer to increase co-payments for services rather than increase monthly premiums if costs have to be increased (Table 15).
- Financial sponsor enrollees were more likely to prefer increased monthly premiums for services instead of increased co-payments (Table 16).
- The factor of "low costs" was considered as the most important health plan choice concern for all respondents, followed in order by "high quality of care," and "wide range of benefits" (Figure 13, Figure 15).
- Community-based organizations are an effective way to assist and serve hard to reach and underserved populations with health care.

BASIC HEALTH OVERVIEW

Brief History and Structure of Basic Health

The current Basic Health program has undergone considerable evolution since its early inception in 1986. The road to its implementation was paved with many debates, with numerous commissions and studies on how to best achieve access to health care while controlling expenditures. The Washington Health Care Project Commission of 1986, known as the McPhaden Commission, included legislators from both houses and parties as well as key leaders from provider, business, and constituent groups. The Commission with its technical advisory groups conducted a statewide survey to determine the number of eligible persons and their characteristics, generated actuarial estimates of various program designs, and considered the governance and administration of the program. The debate and work on benefit design and funding sources continued and Basic Health legislation finally passed in 1987, part of a "patchwork" of programs introduced as a package by House Democrats. The programs used federal funds but, where necessary, covered costs with state funds. The patchwork included:

- ***Creation of the Basic Health Program***
- Expansion of Medicaid eligibility and of a state funded prenatal care program
- Adoption of the 1987 Omnibus Budget Reconciliation Act for maternity coverage under Medicaid
- Restoration of adult dental coverage under Medicaid
- Creation of a High Risk Pool for the uninsurable
- Grants to selected hospitals with high rates of uncompensated care

In 1987, ESSB 4777 created Basic Health (BH) as a demonstration program with funding source from state funds. Reasons to create a state program without the Medicaid match were: 1) to cover a portion of the target population that would not be eligible for federal funds; and 2) a strong preference to avoid the stigma of Medicaid welfare coverage. The key features of BH as enacted were:

- A five-year demonstration project with a defined enrollment ceiling of 30,000 in five congressional districts
- Separate from Medicaid, funded with state general revenues
- Voluntary insurance program for Washington residents under age 65 with income below 200% of federal poverty level
- Required financial participation by enrollees (sliding scale premium and co-payments)
- Administered by separate entity with single agency
- Program design not determined by statute, and exempt from insurance regulation
- Care provided by managed care system under contract to the state
- Emphasis on prevention benefits

While BH began as a pilot demonstration program, the Legislature created the Health Care Authority (HCA) and the Public Employees Benefits Board (PEBB) in 1988. In 1993, the Legislature made BH a permanent statewide program and it was merged with the HCA. The

Legislature passed the Health Services Act,[1] established the Health Services Account (HSA) to support it, and directed the HCA and Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) to create a system to coordinate eligibility and benefit coverage for BH and Medicaid enrollees. The Basic Health Plus (BH Plus) program was then established for children as well as the Maternity Benefits program for eligible pregnant women. BH provides coordinated coverage for women and children who may cycle in and out of Medicaid eligibility as a result of family changes or income fluctuations. With the coordination, the whole family is covered, under two different programs, involving two separate state agencies, but under the same health plan. To the member, it's all Basic Health.

In 1995, the Legislature repealed much of the Health Services Act of 1993, but reaffirmed Basic Health provisions, along with those on guaranteed issue, portability, limitations of waiting periods for pre-existing conditions, and elimination of individual underwriting. In the mean time, Healthy Options[2] was offered in all counties statewide. The BH financial sponsor program experienced rapid growth. Provider sponsors were required to contribute a minimum of $30 in 1997, later reduced to $15/$20 in 1998 per sponsored member per month. The HCA also implemented 1997 legislation authorizing BH to limit eligibility for person in institutions. While health plans incurred underwriting losses, the HCA and MAA conducted joint procurement for BH, Healthy Options, and PEBB.

The BH was funded for statewide expansions. By October 1996, the enrollment growth reached its funded capacity. During 1997-99 biennium, the Legislature provided BH more funding to reach the enrollment goal of 137,200 subsidized enrollees. However, some plans discontinued participation, which resulted in reduced number of plan choices and unstable service areas. The HCA began to work regularly with MAA, health plans, provider groups, and representatives of labor, hospitals, and medical groups, to re-evaluate its purchasing approach. In 2000, in order to stabilize the subsidized program that is the priority for HCA and to prevent adverse impacts on rates, health plans that bid to provide subsidized BH coverage were no longer required to bid for non-subsidized BH (or full-premium) coverage. Most health plans did not bid to continue to offer non-subsidized BH because of rising costs. By the end of year 2001, no plan would allow new enrollment into non-subsidized BH coverage.

The 2002 Legislature appropriated I-773[3] funds for enrollment of a specific Medical Assistance population whose program is ending October 1, 2002, as well as expansion of up to 20,000 additional enrollees beginning January 2003. The initiative required, however, that this funding could only supplement, not supplant, funding for a base enrollment of 125,000 subsidized BH enrollees. Therefore, the funding cannot be accessed if BH fails to maintain enrollment of at least 125,000 from non-I-773 funds.

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[1] The 1993 Health Services Act is a comprehensive restructuring of the individual insurance market. It includes provisions on portability and guaranteed issue, limitations on waiting periods for pre-existing conditions, elimination of individual underwriting, insurance market pooling and community rating, a minimum benefits package, and an employer/individual insurance mandate.

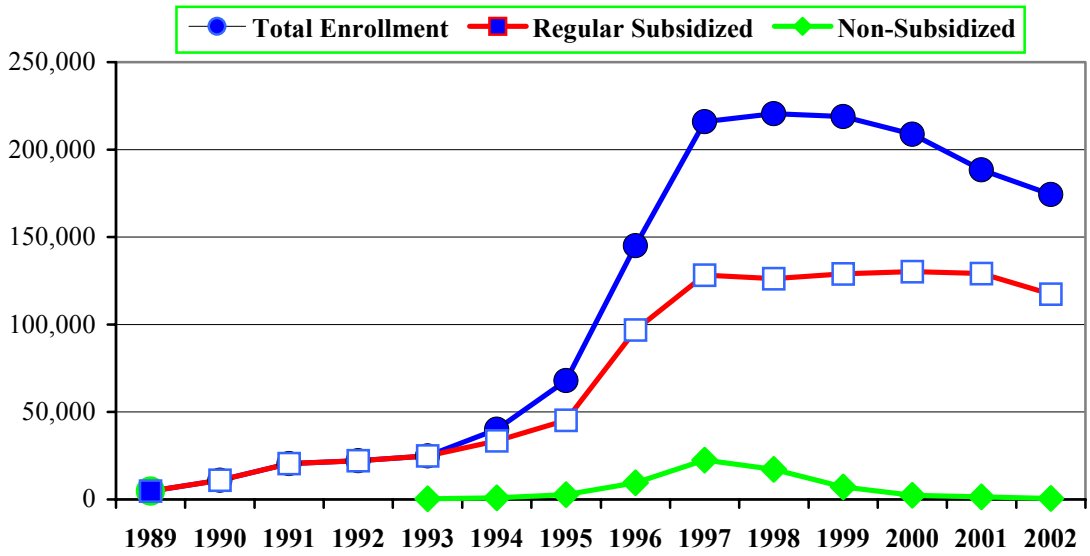
[2] Healthy Options is DSHS MAA's managed care health program for Medicaid eligible clients.

[3] Initiative 773 was approved in 2001, which provides increased tobacco tax revenues to fund additional BH enrollment slots beginning in 2002.

Enrollment Growth

BH began as a pilot project, open to 4,000 residents in King and Spokane counties in 1988. Gradually, BH expanded its services to other counties, added capacity for more enrollment as the time passed. **Figure 1** shows the trend of BH total enrollment growth and regular subsidized on average from 1989 to June 2002. The number of enrollees doubled in 1994 when BH became a permanent and statewide program. The BH non-subsidized program started in December 1993 with 283 enrollees, reached its peak enrollment in 1997 and then decreased over the next few years, to the current 476 enrollees in June 2002. There were about 2,500 enrollees covered under transition coverage[4] starting in January 2000 and ending in December 2000. Subsidized enrollment increased to its peak, approximately 133,360, by February 2001. BH then reached enrollment capacity due to funding limitations in April 2001, which resulted in enrollment delays of 120-150 days.

Figure 1. Basic Health Enrollment History



Note: Total Enrollment includes all regular/individual subsidized and non-subsidized enrol children, S-Medical pregnant women, and home care workers.

As required in Initiative 773 language, in order to utilize this revenue, BH needs to reduce enrollment further during the first half of 2002 to achieve and maintain an average enrollment level of 125,000 for the 2002-2003 fiscal year.

Benefit Structure

Basic Health was established as a voluntary and separate insurance program from the state Medicaid program, and given authority to independently design and administer the

[4] When several health plans ended their contracts for non-subsidized coverage for contract year 2000, Basic Health created "transition" coverage for enrollees who lost eligibility for premium subsidy, to continue coverage with the enrollee's current plan through December 2000.

program. The original target population was non-elderly uninsured Washington residents with incomes of no more than 200% of the Federal Poverty Level (FPL) ($22,500 for a family of four in 1987). Coverage was basic but comprehensive, including coverage for preventive care, hospital, physician services, emergency room, and ambulance services, with maternity coverage through Medicaid if eligible. The initial BH benefit package did not cover prescription drugs, mental health, vision, or dental care, and included a 12-month waiting period for coverage of services for pre-existing conditions. In 1994, the coverage of prescription drugs benefit was added. In 1995, the Legislature required health plans in the individual market to offer "model plans" based on the BH schedule of benefits—"Basic Health look-alikes." The BH schedule of benefits was expanded to include limited mental health, chemical dependency, and organ transplants. The Legislature also funded reductions in BH premiums, and reduced premiums for home care agencies and personal care workers. **Table 1** shows the schedule of benefits and co-payments for 2002 BH subsidized enrollees.

Table 1. 2002 Basic Health Subsidized Benefits Summary

Benefit	Covered	Co-payment	Comments
Physician Office/Clinic visits	Yes	$10/visit	No co-payment for maternity care or routine physical exams
Hospital	Yes	$100/admit; maximum of $500/PMPY	No co-payment for maternity care or readmission for the same condition within 90 days
Outpatient facility			
Non-emergency	Yes	$25/visit	No co-payment for maternity care or readmission for the same condition within 90 days
Emergency	Yes	$50/visit	Co-payment waived if an inpatient admission results
Ambulance (Air/Ground)	Yes	$50/transport	No co-payment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services
Lab & x-ray	Yes	$0	No co-payment
Preventive care	Yes	$0	No co-payment
Maternity care	Yes	$0	No co-payment; services through DSHS MAA for those who are eligible for Medicaid; services through BH for those who apply for but ineligible for Medicaid; not covered beyond first 30 days after diagnosis otherwise
Well baby care	Yes	$0	No co-payment

Table 1. ***Continued…***

Benefit	Covered	Co-payment	Comments
Organ transplants	Yes	$10/visit; $100/admit	12-month waiting period for pre-existing condition, except for children continuously covered from birth or placed for adoption within 60 days of birth and continuously covered from the date of placement. Costs for donor search not covered
Mental Health	Yes	$10/visit; $100/admit	Inpatient limited to 10 days/year; outpatient limited to 12 visits/year
Chemical Dependency	Yes	$10/visit; $100/admit	Limited to maximum $5,000/24 months; $10,000/lifetime
Durable medical equipment	No	Not applicable	Except as part of inpatient care or when it is expected that coverage will result in a lower total cost to the health plan if the member were to stay enrolled for a subsequent 4 years
Vision/hearing	No	Not applicable	Except services incidental to a routine physical examination; refraction and hardware not covered
Dental care	No	Not applicable	Except for repair of accidental injury
Chiropractic/Physical therapy	Yes	$10/visit	Limited to 6 visits per year for post-operative treatment within one year of the surgery
Pharmacy	Yes	Tier 1: $3 Tier 2: $7 Tier 3: 50%	Up to a 30-day supply per prescription

Cost Sharing Philosophy, Rationale and Methodology

BH enrollees are required to participate in managed health care systems under contract to the state, and to share in the cost of the program through sliding-scale premiums based on income and family size and through co-payment for services. To qualify for the subsidized program, enrollees must have an income that is less than or equal to 200 percent of FPL. The HCA reserves the right to limit enrollment in the subsidized program based upon available funding. Monthly rates are paid for each enrolled family member and a maximum of three children based on a structure that is tiered according to age.

Bidding medical plans submit base rates for an adult age 40 to 54 years old. The rates for enrollees in other age tiers reflect multiples of these base rates as listed below:

Age Factors

Age 40-54:	base rate
One Child:	base rate multiplied by 0.39
Two Children:	one child rate multiplied by 2.00
Three or More Children:	one child rate multiplied by 3.00
Age 19-39:	base rate multiplied by 0.78
Age 55-64:	base rate multiplied by 1.71
Age 65 or more:	base rate multiplied by 2.16

For subsidized enrollees, premiums charged to enrollees are equal to the subsidized bid rates of the contracted health plans minus the state contribution, which varies by income. Subsidized enrollees in lower income groups receive a greater subsidy than similarly aged enrollees in higher income groups. The health plans are paid the same monthly rates for subsidized enrollees regardless of their income or whether the enrollee is from an employer group or receives financial sponsorship.

Historically, the HCA establishes one or more health plans that are available to enrollees at the lowest, or "benchmark" price during the procurement process. A goal of HCA is that the "benchmark" plan, combined with any less expensive plans, will be available to 90 percent of subsidized enrollees statewide. To select the "benchmark" plan, the HCA places successful bidders in order according to bid rates. The HCA then assesses the lowest cost plans based on the percentage of current enrollees who reside in geographic areas serviced by those plans and select the "benchmark" plan based upon availability to current enrollees.

The HCA may designate additional benchmark-priced plan(s) to be available to enrollees at a premium equivalent to the enrollee premium for the "benchmark" plan in any geographic area where neither the "benchmark" plan nor a lower cost plan are available or access guidelines are not met.

Enrollees who select plans with bid rates that are higher than the "benchmark" plan will pay more than those who select the "benchmark" plan. Enrollees will pay the selected plan

premium minus the state contribution based on the "benchmark" bid rates. The following **Table 2** shows an example of cost sharing between a subsidized enrollee who is less than 40 years old with a family size of three and the 2002 HCA benchmark plan rate by FPL.

Table 2. 2002 Subsidized Enrollee Share of Benchmark Plan
(Based on Adult Age<40 with Family Size of Three)

Income Bands (FPL)	Monthly Income at top of Income Band	Premium share monthly	Premium as a percent of income
Less than 65%	$792.45	$10.00	1.26%
65% - <100%	$1,219.16	$14.00	1.15%
100% - <125%	$1,523.95	$17.50	1.15%
125% - <140%	$1,706.83	$21.61	1.27%
140% - <155%	$1,889.70	$33.13	1.75%
155% - <170%	$2,072.58	$43.22	2.09%
170% - <185%	$2,255.45	$54.74	2.43%
185% - 200%	$2,438.45	$66.27	2.72%

The BH program provides health care coverage for individual and group enrollment. Group enrollment includes employers, home care agencies, and financial sponsors. These groups of individuals have all or part of their premiums paid by the financial sponsor or employer group. To be eligible for BH as an employer group, a business must be licensed in Washington State, provides BH with a Unified Business Identifier (UBI), and employs one or more persons in addition to the business owner. Employers must also demonstrate that they will be enrolling at least 75 percent of their eligible employees within a classification of employees, and may not offer other health insurance to the same classification of employees. Examples of classifications include full time employees, part time employees, or a distinct bargaining unit.

Financial sponsors agree to pay BH monthly premiums for a specified group of sponsored members. State agencies and health care plans that contract with BH may not be a financial sponsor. Government funded institutions may not serve as financial sponsors for their residents. Financial sponsors are required to submit a letter of intent to the HCA, go through a review and contracting process, and receive approval from the HCA Administrator. The following section provides more details on financial sponsor program.

FINANCIAL SPONSORING ORGANIZATIONS

The financial sponsor program started in 1995. The enrollment is comprised of health care providers or facilities (provider sponsor), Native American Tribes or nations, local (non-state) governments, church groups, benefactors, and other non-profit organizations (non-provider sponsor) as approved by the HCA Administrator. Prior to the summer of 1997, most financial sponsors were providers. There was a substantial shift in the composition of the financial sponsors due to the requirement that provider sponsors pay the surcharge in the budget proviso. Most provider sponsors either discontinued participation or limited participation to the persons they were currently serving. Other organizations with non-provider decision-making boards became sponsors. These organizations often work closely with providers and receive contributions from the clinics.

Requirements for Sponsorship

The Financial Sponsor Program is an option that allows certain individuals, organizations, or agencies to help an individual or family apply for BH and pay all or a portion of the premium the individual would pay for BH coverage. The requirements for financial sponsors, found in WAC 182-25-070, are included in **Appendix A**.

To serve as a financial sponsor, an organization must be approved by the HCA administrator and sign a financial sponsor agreement with the agency. State agencies or health plans contracting with the HCA cannot serve as financial sponsors.

Organizations that serve as financial sponsors, who are paid to provide BH services (provider sponsors), are required to pay a minimum contribution, based on current appropriations legislation. For the current biennium, the fee per enrollee per month is $15.00 for those with income below 100 percent of FPL, $20 for those from 100 to 125 percent FPL. Exceptions are made for charitable, fraternal or government organizations (other than state agencies) that are able to demonstrate organizational and financial autonomy and experience no direct financial gain from the enrollee's coverage.

In addition to paying the premiums for their sponsored enrollees, financial sponsors are expected to assist enrollees in their interaction with Basic Health and distribute communications to them.

Interests and Goals of the Financial Sponsor

One of the original concepts of the BH framework was that it was allowed to be flexible with the ability to experiment and be a "laboratory" for potential future endeavors. Financial sponsorship was one of the areas in which the program was able to experiment. While there are various views as to the purpose of financial sponsorship, certain goals have existed throughout the history of the sponsor program. The goals included:

- Providing health care to hard to serve populations;
- Involving populations with little experience with health insurance and managed care concepts;
- Addressing ethnic and racial health care disparities; and
- Developing integrated health care for low income underserved populations.

Focus on these goals has varied during the history of the sponsor program. Those who question the program generally have at least one of the following concerns:

- Basic Health was created to provide insurance coverage for working persons with low income who are to share in the cost of purchasing their coverage. Financial sponsors pay for the person's premium, which arguably contradicts this goal.
- Sponsoring organizations may have a financial interest in providing health care to the persons they sponsor.
- Sponsorship should be transitional coverage. Sponsored enrollees should be transitioned to pay the full cost of their premium.

The first financial sponsor proposals were submitted in early 1995 by the Jamestown S'Klallam Tribe and the Yakima Valley Farmworker's Clinic. These two projects were granted provisionary status by the HCA, and were authorized to perform as pilot projects for a year, after which time there would be an assessment to determine continuation of the concept. Both proposals contained a requirement to provide for health education for all members in the sponsored groups which included the value and appropriate use of health insurance, use of preventive care, and compliance with income and other eligibility requirements.

Financial sponsors assist applicants to meet BH requirements, such as the application form; providing income and residency documentation. They also communicate with BH staff regarding these documents with the member's authorization. This resource and partnership leveraging was a good fit for BH, and an effective way to increase underserved and ethnic enrollment. Members who previously did not have a medical home now have one. Referrals, specialty care or tertiary care that might not have been possible before, or may have been inconsistently accessed for those needing care, is now available. The program improved coordination and delivery of health care for those members.

Cost Share Requirements of Provider Sponsors

In 1997, legislative concerns about the participation of the provider sponsors resulted in a budget proviso that caused a major change for the financial sponsor program. The proviso initially required provider sponsors to pay a $30 surcharge per sponsored individual per month. The amount of the surcharge was reduced with pressure on the legislature by sponsoring organizations and other health access advocates. The surcharge was changed to $15 PMPM for members with incomes below 100% FPL and $20 PMPM for members with incomes between 100% and 200% FPL in 1998.

The HCA developed rules to define which sponsors were subject to the proviso. Three types of groups were determined to be exempt from the proviso requirement:

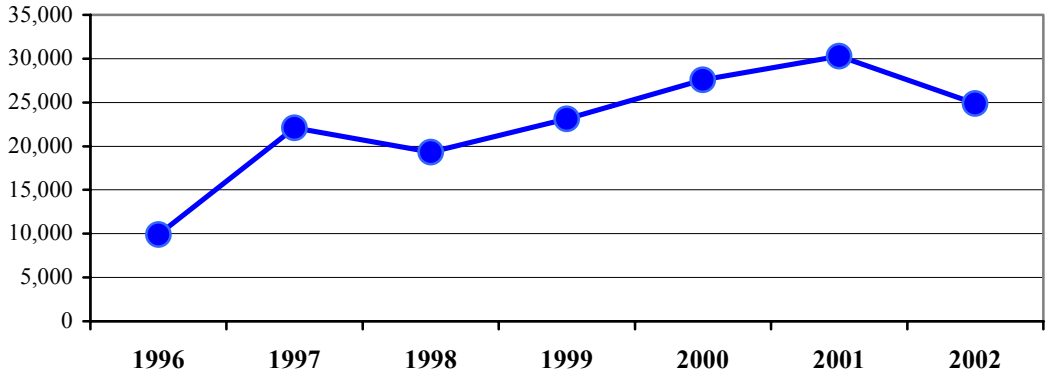
1. Organizations with funding that does not come from entities providing health care;
2. Organizations that receive contributions from providers but whose decision making body is not comprised of providers; and
3. Governmental entities, other than state agencies, whose primary purpose is not the provision of health care, such as the tribes and local governments.

In addition, the sponsor rules require that enrollees have the right to select their health plan and provider and sponsors cannot base their decision to sponsor on the enrollee's choice of health plan. Premiums charged for enrollees receiving financial sponsorship are determined in the same manner as premiums charged for other enrollees.

Demographic Composition of Financial Sponsored Enrollees

Financial sponsorship currently represents 16 percent of total BH enrollment. **Figure 2** shows the financial sponsorship total enrollment trend on average from 1996 to June 2002. The total enrollment number started with 9,901 in 1996, increased to 22,107 in 1997, declined a couple of thousands in 1998, and gradually increased to 30,297 in 2001.

Figure 2. Basic Health Financial Sponsorship Enrollment Trend



Most financial sponsored enrollees are adults under age 40 (See **Table 3**).
The total sponsor enrollment in June 2002 was 27,490 with the majority (94 percent) enrolled through Community Health Plan of Washington (CHPW), the BH contracted health plan that was selected as the benchmark plan for 2002. The two largest financial sponsors by far are El Centro de la Raza and Mount Adams Health Foundation.

Table 3. BH Financial Sponsorship Enrollment Detail, June 2002

Financial Sponsor		Regular Subsidized		Total	
		Number	Percent	Number	Percent
Provider Sponsor					
Child Rated	0-22	9	1.7%	86	14.3%
Adult Rated	0-39	244	46.8%	246	41.0%
	40-54	195	37.4%	195	32.5%
	55-64	72	13.8%	72	12.0%
	65+	1	0.2%	1	0.2%
	Subtotal	521	100%	600	100%
Non-Provider Sponsor					
Child Rated	0-22	1,185	5.0%	4,242	15.8%
Adult Rated	0-39	14,223	59.8%	14,278	53.1%
	40-54	6,084	25.6%	6,087	22.6%
	55-64	1,956	8.2%	1,956	7.3%
	65+	327	1.4%	327	1.2%
	Subtotal	23,775	100%	26,890	100%
All Financial Sponsor Total		24,296		27,490	

Note:
"Child Rated" reflects dependents age 0-22 including students and disabled dependents.
"Adult Rated" reflects all subscribers and spouses regardless of age and disabled dependents over age 22.

WASHINGTON STATE BASIC HEALTH SURVEY 2001

The following describes Washington State Basic Health survey conducted in 2001, including its objectives, methodology, sampling design, response rate, and survey findings by federal poverty level and by group type.

Background and Objectives

The purpose of the survey was to provide information about member experiences and feedback for improvement to BH program, and to assess preferences and interest in future initiatives. The survey was managed by the Washington State Health Care Authority and conducted by the Social and Economic Sciences Research Center (SESRC) at Washington State University.

Method

The survey was conducted in May and June 2001 using the Computer-Assisted Telephone Interviewing (CATI)[5] system. It involved 2,235 complete interviews with individuals currently enrolled in one of the nine insurance plans available through the BH program. The sample consisted of 9,805 cases. Each case received a minimum of 5 call attempts. The average interview length for the survey was 19 minutes.

Description of Population

The population for the study consisted of current enrollees in the BH subsidized enrollees. There were approximately 78,376 households (non-duplicated) enrolled in BH. Households in which more than one person was enrolled in BH were only counted as one household in the population. Each family selected a specific health plan for their coverage from among nine health plans contracting with BH. A break down of the population of households can be found in **Table 4**.

Table 4: BH Survey Selection Account Summary

Carrier	Financial Sponsor	Employer Group	Regular / Individual	Total
Aetna US Healthcare of Washington	25	27	2,144	2,196
Community Health Plan of Washington	12,551	174	24,998	37,723
Columbia United Providers	20	15	2,743	2,778
Group Health Cooperative	87	77	11,193	11,357
Kaiser Health Plan	82	18	2,047	2,147
Northwest Washington Medical Bureau	25	63	2,861	2,949
Premera Blue Cross	512	77	8,980	9,569
Molina Healthcare	-	12	1,299	1,311

[5] The CATI system displays survey questions on a computer monitor from which the interviewer can read the question to the respondent and then enter the response directly into the CATI database for storage on the server computer.

Regence BlueShield	368	111	7,867	8,346
Total Households	13,670	574	64,132	78,376

Description of Sample

Basic Health stratified a random sample from the population to participate in the study. The sample was then sent to SESRC. A break down of the sample sent to SESRC can be seen in **Table 5**.

Table 5: BH Survey Actual Selection

Carrier	Financial Sponsor	Employer Group	Regular / Individual	Total
Aetna US Healthcare of Washington	25	26	1,949	2,000
Community Health Plan of Washington	603	173	1,224	2,000
Columbia United Providers	20	15	1,965	2,000
Group Health Cooperative	87	77	1,836	2,000
Kaiser Health Plan	82	18	1,900	2,000
Northwest Washington Medical Bureau	25	63	1,912	2,000
Premera Blue Cross	512	77	1,411	2,000
Molina Healthcare	-	12	1,299	1,311
Regence BlueShield	368	111	1,521	2,000
Total Households	1,722	572	15,017	17,311

Given the disposition of the pretest sample, it was determined that all 17,311 cases were not needed to reach the goal of 1,800 completes. It was decided that only half of the Regular sample would be released. All of the Financial Sponsored and Employer households were included. A break down of the sample released is presented in **Table 6**.

Table 6: BH Survey Actual Fielded

Carrier	Financial Sponsor	Employer Group	Regular / Individual	Total
Aetna US Healthcare of Washington	25	26	975	1,026
Community Health Plan of Washington	603	173	612	1,388
Columbia United Providers	20	15	983	1,018
Group Health Cooperative	87	77	918	1,082
Kaiser Health Plan	82	18	950	1,050
Northwest Washington Medical Bureau	25	63	956	1,044
Premera Blue Cross	512	77	706	1,295
Molina Healthcare	-	12	650	662
Regence BlueShield	368	111	760	1,240
Total Households	1,722	572	7,511	9,805

Weights

The sample for this survey included a simple random sample of people enrolled in nine health care plans. To derive estimates of population totals, the survey data must be weighted for each of these samples.

Table 7: Completes by Health Plan

Carrier	Financial Sponsor	Employer Group	Regular / Individual	Total
Aetna US Healthcare of Washington	4	9	313	326
Community Health Plan of Washington	40	54	134	228
Columbia United Providers	6	3	273	282
Group Health Cooperative	20	15	198	233
Kaiser Health Plan	10	7	250	267
Northwest Washington Medical Bureau	-	8	235	243
Premera Blue Cross	63	14	143	220
Molina Healthcare	-	7	208	215
Regence BlueShield	48	21	152	221
Total Completes	191	138	1,906	2,235

The weights are based on the population enrolled in a plan (see **Table 4**) divided by total number of interviews completed (see **Table 7**) for that plan and group type. **Table 8** lists the weights for all nine health plans for each group type.

Table 8: Weights

Carrier	Financial Sponsor	Employer Group	Regular / Individual	Total
Aetna US Healthcare of Washington	6.25	3.00	6.85	6.74
Community Health Plan of Washington	313.78	3.22	186.55	165.45
Columbia United Providers	3.33	5.00	10.05	9.85
Group Health Cooperative	4.35	5.13	56.53	48.74
Kaiser Health Plan	8.20	2.57	8.19	8.04
Northwest Washington Medical Bureau	-	7.88	12.17	12.14
Premera Blue Cross	8.13	5.50	62.80	43.50
Molina Healthcare	-	1.71	6.25	6.10
Regence BlueShield	7.67	5.29	51.76	37.76

Sampling Errors

Sampling error is a measure of the degree to which a randomly selected sample of respondents represents the population from which it is drawn. Sampling error also is the basis upon which tests of statistical significance are calculated. One formula for calculating the sample error for a proportion at the 95% confidence level is presented below, and this can be used to calculate the sample error for survey results in this report.

$$SE = 2\sqrt{\frac{pq}{(n-1)}\left(\frac{N-n}{N}\right)}$$

Where: SE= sample error
p = proportion of "yes" responses for a specific question
q = proportion of "no" responses for a specific question
n = sample size = number of completed interviews for a specific questions
N = population size for the survey

For this survey, completed interviews were obtained from 2,235 of the 78,376 estimated Basic Health recipients in Washington State yielding a margin of error of about ±2.1 % at the 95 percent confidence level. Sampling errors for individual health plans are estimated in **Table 9**.

Table 9: Sampling Weights

Carrier	Sampling Errors
Aetna US Healthcare of Washington	5.1%
Community Health Plan of Washington	6.6%
Columbia United Providers	5.6%
Group Health Cooperative	6.5%
Kaiser Health Plan	5.7%
Northwest Washington Medical Bureau	6.2%
Premera Blue Cross	6.7%
Molina Healthcare	6.2%
Regence BlueShield	6.7%

Response Rates

Three kinds of response rates for the fielded sample are calculated from the number of completed interviews obtained and are presented in **Table 10**. The **Cooperation rate** is the ratio of the number of completed and partially completed interviews to the number of completed, partially completed, and refusal cases. The formula for calculating the cooperation rate is:

$$\frac{(CM)}{[(CM+PC)+RF]}$$

where CM = number of completed interviews
PC= number of partially completed interviews
RF = number of refusals

Therefore, for the total fielded sample, the total **cooperation rate** was 75% (2235/2972).

The **Response rate 1** is the ratio of the number of completed interviews to the total number of potential respondents who were contacted but who were unable to be interviewed. The formula is:

$$\frac{(CM)}{[(CM+PC)+RF+UI]}$$

where CM = number of completed interviews
PC= number of partially completed interviews
RF = number of refusals
UI = number unable to interview

For the total fielded sample, the total **response rate 1** was 73% (2235/3078).

The most conservative rate is **Response rate 2** which is the ratio of the number of completed interviews to the total number of potential respondents who were contacted but unable to be interviewed and who were not contacted because they never answered the telephone during the survey period. The formula is:

$$\frac{(CM)}{[(CM+PC)+RF+UI+UR]}$$

where CM = number of completed interviews
PC= number of partially completed interviews
RF = number of refusals
UI, UR = number unable to interview, unable to reach

For the total fielded sample, the total **response rate 2** was 27% (2235/8253).

This lower-than-desired response rate 2 largely reflects difficulties making initial contacts with eligible persons (see the number of unable to reach), rather than outright refusals to participate, a common problem in random-digit-dialed surveys.

Table 10: Disposition & Response Rate				
Disposition	Financial Sponsor	Employer Group	Regular / Individual	Total
Completed Interview	191	138	1,906	2,235
Partial Complete	9	0	46	55
Refusal	55	46	581	682
Unable to Interview	20	4	82	106
Unable to Reach	971	283	3,921	5,175
Non-working	427	85	839	1,351
Electronic Device	32	5	50	87
Ineligible	15	10	51	76
Other	2	1	35	38
Total	1,722	572	7,511	9,805
Cooperation Rate	75%	75%	75%	75%
Response Rate 1	69%	73%	73%	73%
Response Rate 2	15%	29%	29%	27%

Interview Design

The original survey was developed by BH staff members. SESRC staff members then worked with BH to develop a final questionnaire for the pretest. After the pretest, the survey was modified to address problems that occurred during the interviews. After the questionnaire was finalized SESRC began calling on the project.

The survey consisted of a variety of 79 questions concerning current services received, services the respondent would like to see covered by BH, quality of service and some general demographic information about the respondent. The survey was conducted in English, with provision for Spanish translation. The questionnaire is included in **Appendix B**.

Results

The following show the survey findings of socioeconomic profile, utilization and health status profile, affordability and cost sharing, access, choice factors, and other information by federal poverty level and financial sponsor group.

Socioeconomic Profile

Federal Poverty Level

To have a clearer picture of Basic Health enrollees for this survey, **Table 11** shows their socioeconomic characteristics by federal poverty level (FPL). Females are almost two thirds of total respondents across three FPL groups. Over 40 percent of respondents of three FPL groups are between 19 and 39 years old. For those with income less than 65% of FPL, the majority of

respondents are Whites; 2 percent Blacks; 3 percent Native Americans; 5 percent Asian or Pacific Islanders; and 9 percent Hispanic or Latin Americans.

At least 87 percent of respondents of all FPL groups are high school graduates. Family type and size have statistically significant differences among three FPL groups. Respondents with income less than 65% FPL were more likely to be single, living alone or with partners, than the other respondents with income over 65% FPL.

The majority of respondents, regardless of their income level, enrolled in BH as an individual. About 14 percent of respondents with income under 65% of FPL, 12 percent in the income band between 65 and 100% FPL, and 4 percent with income over 100% FPL are financial sponsor enrollees. There is a statistically significant difference on employed versus unemployed status by income levels. About 66 percent of respondents with income under 185% FPL were employed and 34 percent unemployed, compared with 48 percent of those with income less than 65% FPL who were employed and 52 percent unemployed. It appears that respondents who earned less monthly income were more likely employed on a seasonal or temporary basis.

Regardless of their income, the majority of respondents speak English, have lived in Washington State for as least 21 years, and have been enrolled in BH on average for three years and ten months.

Financial Sponsor Group

Table 12 provides the socioeconomic characteristics of financial sponsor group enrollees as well as a comparison with individual enrollees and employed group enrollees. There are significantly more respondents in financial sponsor groups with income less then 65% FPL than in employer group or individual coverage. As the data indicated the significant difference among the three types of enrollees, the financial sponsor enrollees are more likely to be younger (19 to 39 years old), Native Americans, or Hispanic origin, Spanish speaking with an educational level of less than high school graduate.

The majority of financial sponsor respondents were single living with less than 3 other persons. Half of financial sponsor respondents worked—41 percent had full time jobs, 33 percent worked part time, and 25 percent worked on a seasonal or temporary basis. Almost half of financial sponsor respondents were unemployed, compared with 10 percent unemployed from employer groups.

In general, financial sponsor respondents have lived in Washington State for 20 years and have enrolled in Basic Health on average for three and half years. In order to compare the demographic information of BH survey sample with the current BH population, **Appendix C** shows the demographic background of BH current members by group type.

Table 11

Socioeconomic Profile of BH Survey Respondents by Federal Poverty Level, 2001

Characteristic	Federal Poverty Level			Total
	Less than 65%	65-100%	100-185%	
Gender				
Female	65.1%	62.9%	65.5%	64.8%
Male	34.9	37.1	34.5	35.2
Age				
19~39	44.5%	40.1%	43.1%	42.9%
40~54	35.8	42.8	36.9	37.7
55~64	18.9	17.2	20.1	19.1
65+	0.8	0.0	0.0	0.3
Race/Ethnicity				
White	74.7%	78.7%	86.3%	80.8%
Black/African American	2.4	1.6	1.5	1.8
Indian/Native American	2.7	2.1	1.6	2.0
Asian/Pacific Islander	4.8	2.3	1.9	2.9
Hispanic/Latin American	8.8	7.0	3.6	6.1
Other	6.7	8.2	5.2	6.3
Educational Attainment				
Less than high school	10.5%	12.6%	7.3%	9.5%
High school	26.5	27.4	32.8	29.6
More than high school	63.0	60.0	59.9	61.0
Family Type				
Single	77.0%	58.6%*	51.5%*	61.6%
Married	23.0	41.4*	48.5*	38.4
Family Size				
1~2 persons	72.4%	52.3%*	52.6%*	59.3%
3~4	20.3	33.5	31.8	28.2
5 or more	7.3	14.3*	15.6*	12.5
Group Type				
Regular/Individual	83.9%	83.9%	86.1%	84.8%
Financial Sponsored	13.7	12.2	3.7	8.8
Employer Sponsored	2.4	3.9	10.2	6.3
Employment Status				
Working	48.2%	59.6%	66.0%*	58.6%
Full time	45.4	48.9	60.5	53.9
Part time	41.4	38.1	30.5	35.1
Seasonal/temporary basis	13.2	13.1	9.0	11.0
Unemployed	51.8	40.4	34.0*	41.4
Language Speaking				
English	95.1%	96.2%	98.5%	96.9%
Spanish	4.9	3.9	1.5	3.1
WA Residence				
Number of years living in WA (Median)	21.0	23.5	24.0	23.0
Length of Coverage				
1~3 years	54.2%	43.4%	45.3%	47.9%
4~6 years	37.2	43.9	44.5	41.9
7~9 years	6.6	9.3	8.2	7.9
10 years and above	2.0	3.4	2.0	2.3

Note:

** Asterisks denote statistical difference from the "Less than 65% FPL" group at the .05 level or better.*

Table 12

Socioeconomic Profile of BH Survey Respondents by Group Type, 2001

Characteristic	Group Type			Total
	Financial Sponsor	Employer Group	Regular / Individual	
Federal Poverty Level				
Less than 65%	52.9%	13.2%*	33.7%*	34.1%
65-100%	28.3	12.5*	20.1	20.4
100-185%	18.9	74.3*	46.2*	45.5
Gender				
Female	57.1%	52.9%	66.5%*	64.8%
Male	42.9	47.1	33.5*	35.2
Age				
19~39	56.0%	43.4%*	41.5%*	42.9%
40~54	28.8	40.4*	38.4*	37.7
55~64	14.1	16.2	19.8	19.1
65+	1.1	0.0	0.2	0.3
Race/Ethnicity				
White	40.3%	88.5%*	84.5%*	80.8%
Black/African American	0.5	2.3	1.9	1.8
Indian/Native American	10.2	1.5*	1.2*	2.0
Asian/Pacific Islander	6.5	1.5*	2.7	2.9
Hispanic/Latin American	33.9	1.5*	3.5*	6.1
Other	8.6	4.6	6.2	6.3
Educational Attainment				
Less than high school	32.3%	5.9%*	7.4%*	9.5%
High school	24.3	30.4	30.0	29.6
More than high school	43.4	63.7*	62.6*	61.0
Family Type				
Single	67.5%	55.9%	61.5%	61.6%
Married	32.5	44.1	38.6	38.4
Family Size				
1~2 persons	62.3%	60.3%	58.9%	59.3%
3~4	26.7	33.1	28.0	28.2
5 or more	11.0	6.6	13.1	12.5
Employment Status				
Working	52.4%	89.7%*	57.0%	58.6%
Full time	41.4	66.4*	53.6*	53.9
Part time	33.3	23.0*	36.7	35.1
Seasonal/temporary basis	25.3	10.7*	9.7*	11.0
Unemployed	47.6	10.3*	43.0	41.4
Language Speaking				
English	80.6%	99.3%*	98.4%*	96.9%
Spanish	19.4	0.7*	1.6*	3.1
WA Residence				
Number of years living in WA (Median)	20.0	25.0	23.0	23.0
Length of Coverage				
1~3 years	47.7%	38.2%*	48.7%	47.9%
4~6 years	51.8	61.0*	39.4*	41.9
7~9 years	0.5	0.7	9.2*	7.9
10 years and above	0.0	0.0	2.7	2.3

Note:

** Asterisks denote statistical difference from the "Financial Sponsor" group at the .05 level or better.*

Utilization and Health Status Profile

Federal Poverty Level

This survey asked the respondents' their health status and their utilization experience with preventive care and prescription drugs. As **Table 13** indicates, there is little difference in preventive services used or prescriptions filled among these three groups by income level.

The survey respondents were asked to rank their health as being "Excellent, "Very Good," "Good," "Fair," or "Poor." Although almost half of the respondents with income less than 65% FPL claimed that they were having an ongoing medical condition during the survey period, about 80 percent of them reported their health status in general was good, very good to excellent.

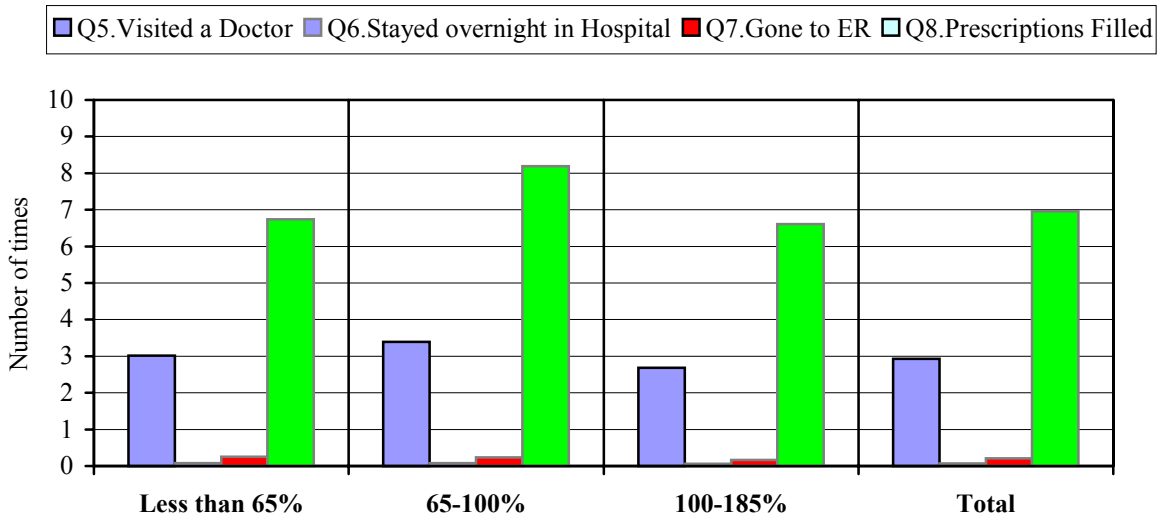
Table 13

Utilization and Health Status by Federal Poverty Level, 2001

		Federal Poverty Level			Total
	Respondent Experience	**Less than 65%**	**65-100%**	**100-185%**	
	Using Preventive Services				
Q22A	Immunizations	31.1%	36.4%	34.3%	33.6%
Q22B	Routine/Physical exams	74.6	78.6	75.9	76.0
Q22C	Mammograms (females only)	50.6	51.2	52.6	51.7
Q22D	Pap tests (females only)	79.2	79.6	82.8	81.0
Q22E	Prostate screening (males only)	28.2	27.4	24.7	26.6
Q22F	Other	32.3	36.4	35.5	34.6
	Prescriptions Filled				
Q12	Not filled	25.4%	26.2%	26.7%	26.2%
Q13	More than 1 prescription filled	46.8	50.0	46.2	47.2
Q27	Having an Ongoing Medical Condition				
		49.0%	48.3%	45.5%	47.3%
Q72	Self-reported Health Status				
	Excellent/Very good	47.0%	49.3%	54.1%	50.7%
	Good	32.0	32.0	31.4	31.7
	Fair	15.1	14.2	12.0	13.5
	Poor	6.0	4.6	2.5	4.1

Figure 3 shows a more detailed comparison of utilization. Regardless of federal poverty level, respondents on average visited doctors three times, stayed overnight in hospital or had gone to an emergency room less than one time, and have filled prescriptions 7 times during the last 6 months.

Figure 3. Utilization Information during the Last Six Months by FPL, 2001



Overall, there is no any statistically significant difference of utilization or health status among these three groups by income levels.

Financial Sponsor Group

Financial sponsor respondents were less likely to use preventive services for mammograms and pap tests, even though these services were available without a co-pay, but were more likely to fill more than one prescription, compared with Employer Group or individual enrollees (**Table 14**). Financial sponsor enrollees also were less likely to report that they had very good to excellent health but more likely to consider their health status as fair.

This is consistent with their utilization experience presented in **Figure 4**. Financial sponsor respondents on average were more likely to visit doctors (4 versus 2 times) and fill more prescriptions (7 versus 4) than employer sponsored respondents.

Table 14

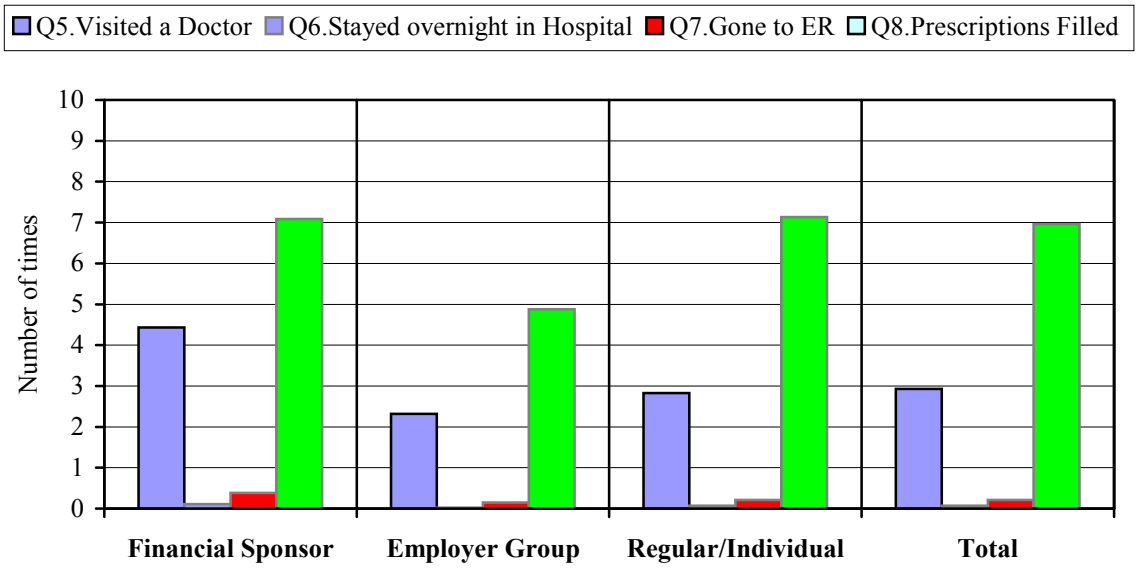
Utilization and Health Status by Group Type, 2001

	Respondent Experience	Group Type			Total
		Financial Sponsor	Employer Group	Regular / Individual	
	Using Preventive Services				
Q22A	Immunizations	27.6%	20.7%	35.2%	33.6%
Q22B	Routine/Physical exams	73.2	66.2	77.0	76.0
Q22C	Mammograms (females only)	35.7	44.6	53.5*	51.7
Q22D	Pap tests (females only)	65.8	77.0*	82.5*	81.0
Q22E	Prostate screening (males only)	23.4	25.8	27.1	26.6
Q22F	Other	31.4	29.1	35.3	34.6
	Prescriptions Filled				
Q12	Not filled	20.3%	28.8%	26.5%	26.2%
Q13	More than 1 prescription filled	55.3	41.8	46.8	47.2
Q27	Having an Ongoing Medical Condition				
		42.9%	40.0%	48.3%	47.3%
Q72	Self-reported Health Status				
	Excellent/Very good	35.5%	64.7%*	51.2%*	50.7%
	Good	30.2	27.2	32.2	31.7
	Fair	27.5	8.1*	12.4*	13.5
	Poor	6.9	0.0*	4.1	4.1

Note:

** Asterisks denote statistical difference from the "Financial Sponsor" group at the .05 level or better.*

Figure 4. Utilization Information during the Last Six Months by Group Type, 2001



Affordability and Cost Sharing

Federal Poverty Level

Table 15 presents respondents' opinions regarding affordability and cost sharing by federal poverty level. Almost every respondent (97 percent), regardless of their income level, indicated that they could afford the co-payment for doctor office visits, which is $10 per office visit. The majority of respondents ranging from 75 percent to 85 percent by their income level considered the co-payment for their prescription affordable, which was $1 to $5 for tier 1 and 2 and 50% for tier 3 in 2001.

Most providers collected the co-payment at the time of the visit. For those who did not pay the co-payment, providers billed them later. About 25 percent of those with incomes below 65% of the FPL did not have to pay the co-payment, compared with 28 percent of those with income 65~100% FPL and 13 percent of those with income 100~185% FPL.

Table 15

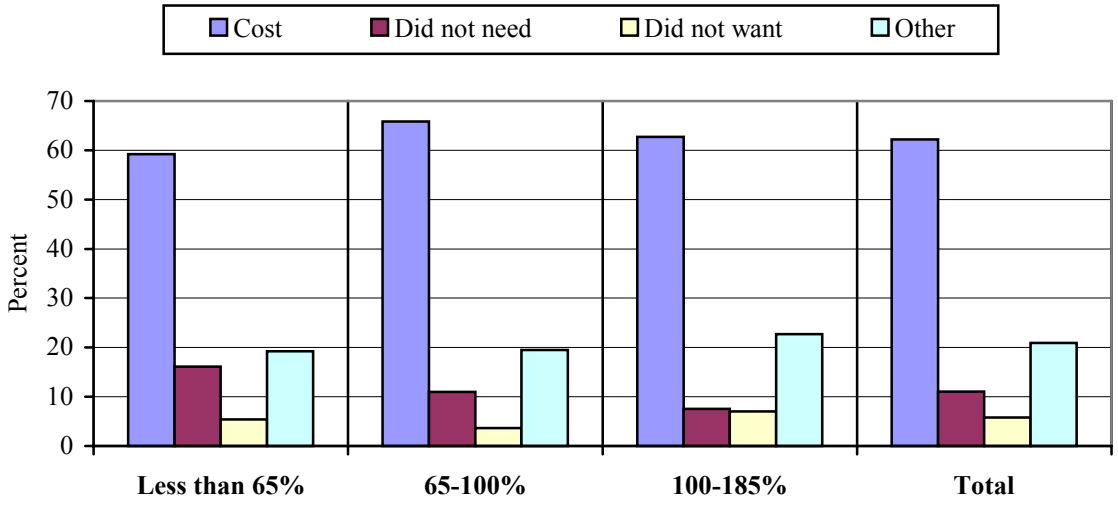
Affordability / Cost Sharing by Federal Poverty Level, 2001

	Respondents Experience	Federal Poverty Level			Total
		Less than 65%	65-100%	100-185%	
	Co-payment Affordable				
Q9A	Prescription	84.7%	76.9%	81.6%	81.7%
Q14	Office visits	96.5	96.1	97.5	96.9
Q23	Provider Collect Co-payment				
	Yes	88.6%	91.4%	94.6%	91.9%
	No	11.4	8.6	5.4	8.1
Q24	└→ Because…				
	They bill you	74.6%	72.2%	87.0%	77.9%
	No co-payment required	25.4	27.8	13.0	22.1
Q37	Cost Sharing Preference				
	Increased co-payment	67.2%	67.5%	71.9%	69.5%
	Increased monthly premiums	32.8	32.5	28.1	30.5
	Willing to pay a higher premium for:				
Q38	Dental care	81.6%	82.7%	83.7%	82.8%
Q40	Vision care	54.1	56.9	58.5	56.7
Q42	Physical therapy	32.5	30.9	29.6	30.9
Q44	Chiropractic care	29.4	31.4	29.2	29.7

Over 65 percent of all respondents would prefer to increase co-payments for services rather than increase monthly premiums if costs have to be increased. Those with incomes below 65% of the FPL were as likely to be willing to pay a higher premium each month for dental care, vision care, physical therapy, and chiropractic care as those with incomes over 100% FPL. In other words, the results do not vary by respondents' income level.

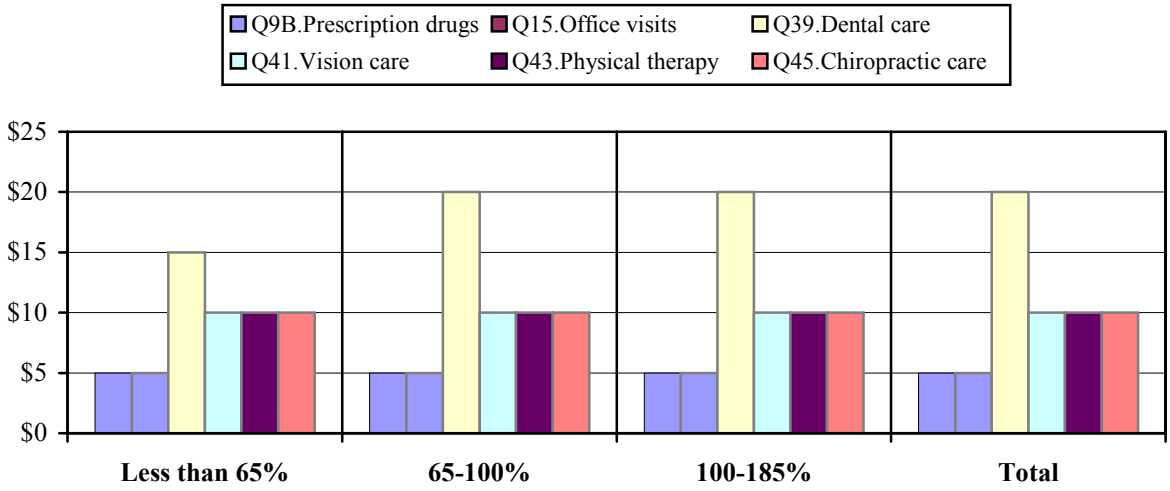
About 1 in 4 did not fill needed prescriptions (see **Table 13**). When asked why respondents chose not to fill the prescription, their main likely reason was cost (**Figure 5**).

Figure 5. Why Respondents Chose not to Fill the Prescription by FPL, 2001 (Q12B)



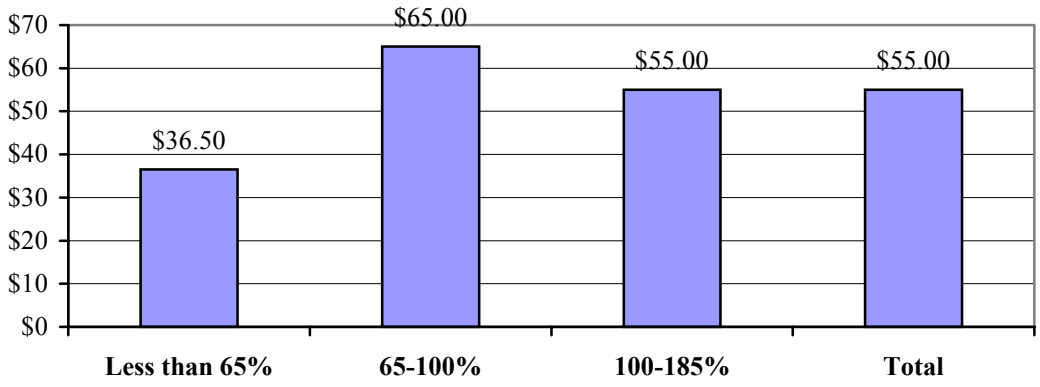
For those who said that the co-payment of prescription or office visits were unaffordable, the preferred affordable amount was $5 for each service. For respondents of the three income groups that indicated they would be willing to pay a higher premium each month to have specific services, the median affordable amount was $15 to $20 for dental care, $10 for vision care, $10 for physical therapy, and $10 for chiropractic care (**Figure 6**).

Figure 6. Affordable Amount of Share by Service Category and FPL, 2001



When respondents were asked "How much would your part of the premium be if you accepted coverage from your employer," the median employee share of those with incomes below 65% of the FPL was $36.50, compared with $65 for those with income below 100% FPL and $55 from those with income between 100 and 185% FPL (**Figure 7**).

Figure 7. Amount of Premium Respondents Would Share with Coverage from the Employer by FPL, 2001 (Q70)



Financial Sponsor Group

As shown in **Table 16**, more than 3 in 4 financial sponsor respondents said that the co-payment for prescription coverage was affordable. Almost everyone said that they could afford $10 co-pay for doctor office visits (97 percent). Compared to employer sponsored or individual enrollees, providers' offices were less likely to collect financial sponsor enrollees' co-payment partly because it was not required (33% versus 14% and 19%, respectively). Moreover, financial sponsor enrollees were more likely to prefer increased monthly premiums for services instead of increased co-payments, which is a statistically significant difference from the other two groups. It is possible that because financial sponsor groups pay premiums for sponsored members, thus they would not care much about co-payments.

There is little difference in respondents' willingness to pay a higher premium for services that BH does not cover among these three groups, except that there were more employer sponsored respondents willing to pay a higher premium for dental care. In general, for financial sponsor respondents, 3 in 4 were willing to pay a higher premium for dental care, 1 in 2 for vision care, 1 in 3 for physical therapy, and 1 in 4 for chiropractic care.

Figure 8 shows the list of reasons why respondents chose not to fill the required medication by group type. Almost two-third of respondents across three group types said the main reason was cost.

Table 16

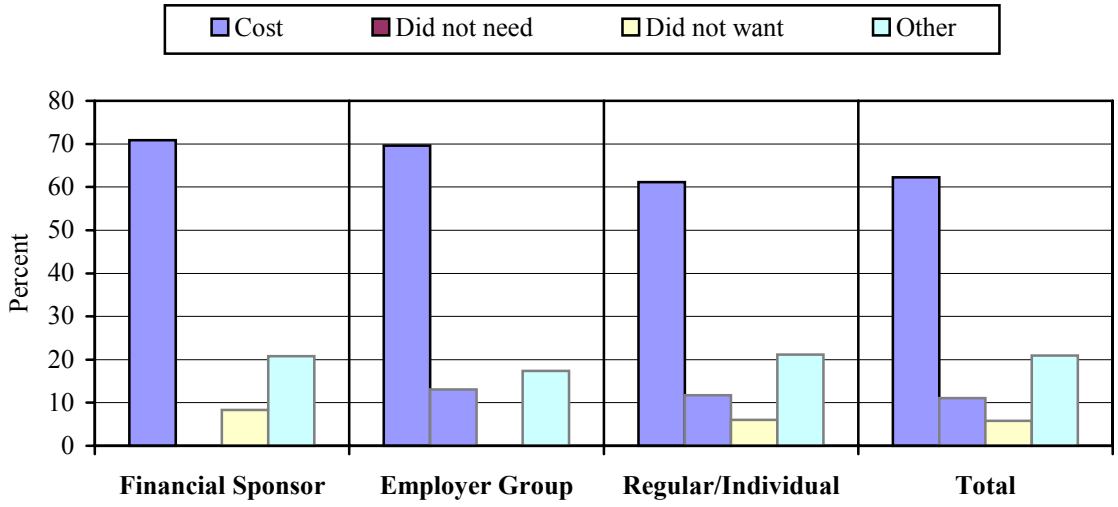
Affordability / Cost Sharing by Group Type, 2001

	Respondents Experience	Group Type			Total
		Financial Sponsor	Employer Group	Regular / Individual	
	Co-payment Affordable				
Q9A	Prescription	76.5%	82.9%	82.1%	81.7%
Q14	Office visits	97.2	97.7	96.8	96.9
Q23	Provider Collect Co-payment				
	Yes	79.1%	93.6%	93.1%	91.9%
	No	20.9	6.5*	6.9*	8.1
Q24	└→Because…				
	They bill you	66.7%	85.7%	80.6%	77.9%
	No co-payment required	33.3	14.3	19.4	22.1
Q37	Cost Sharing Preference				
	Increased co-payment	48.8%	68.8%*	71.5%*	69.5%
	Increased monthly premiums	51.2	31.2*	28.5*	30.5
	Willing to pay a higher premium for:				
Q38	Dental care	75.0%	88.7%*	83.1%	82.8%
Q40	Vision care	55.0	58.8	56.7	56.7
Q42	Physical therapy	32.3	34.9	30.4	30.9
Q44	Chiropractic care	28.4	27.1	30.0	29.7

Note:

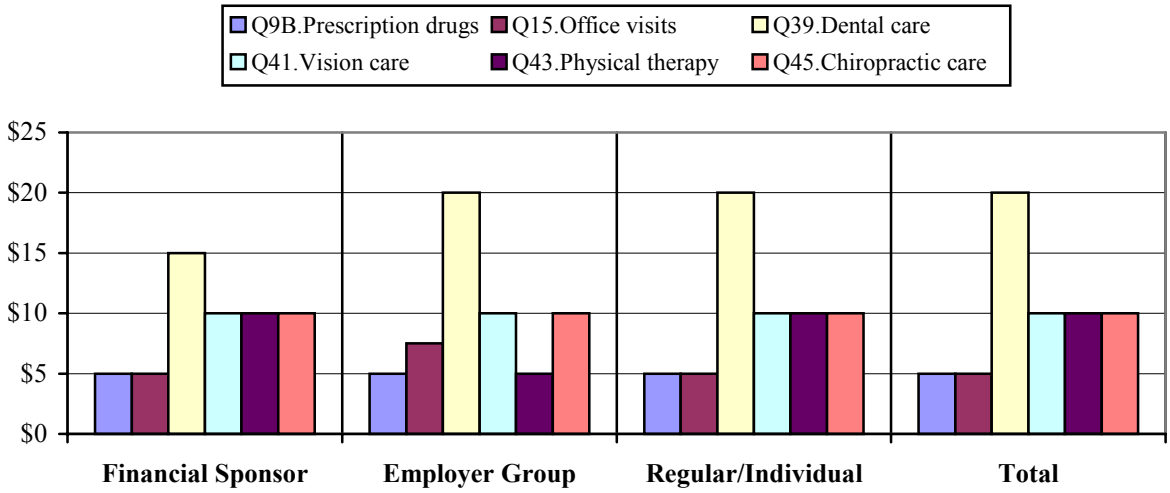
** Asterisks denote statistical difference from the "Financial Sponsor" group at the .05 level or better.*

Figure 8. Why Respondents Chose not to Fill the Prescription by Group Type, 2001 (Q12B)



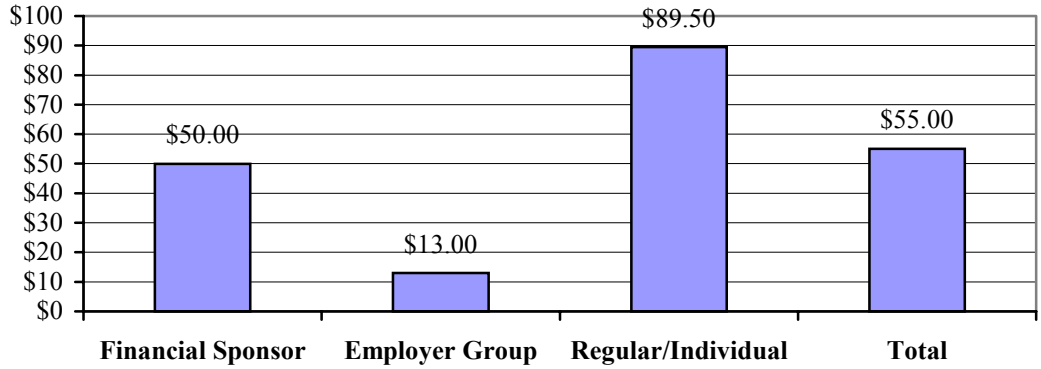
As illustrated in **Figure 9**, financial sponsor respondents said that the median affordable co-payment amount would be $5 for prescription drug, $5 for office visits, $15 for dental care, $10 for vision care, $10 for physical therapy, and $10 for chiropractic care. The cost sharing by service does not vary much between these three groups.

Figure 9. Affordable Amount of Share by Service Category and Group Type, 2001



The median employee share of premium of all respondents was $55. It is revealing that financial sponsor enrollees would be willing to pay a higher median amount of the premium ($50) than employer sponsored enrollees ($13) if they accepted health care coverage from their employers (**Figure 10**).

Figure 10. Amount of Premium Respondents Would Share with Coverage from the Employer by Group Type, 2001 (Q70)



Access

Federal Poverty Level

As indicated in **Table 17**, when asked if they have been denied services because of a pre-existing condition, less than 5 percent of respondents across three income levels had such an experience. Half of them stated there was a service they needed for their health, but BH didn't cover the service. When further examined to identify the service in an open-ended format, most of respondents specified dental care, eye exams, and physical therapy. Less than 1 in 5 had difficulty finding a primary care provider who would accept new patients. The majority of respondents chose their own primary care providers, compared with 25 percent who were assigned.

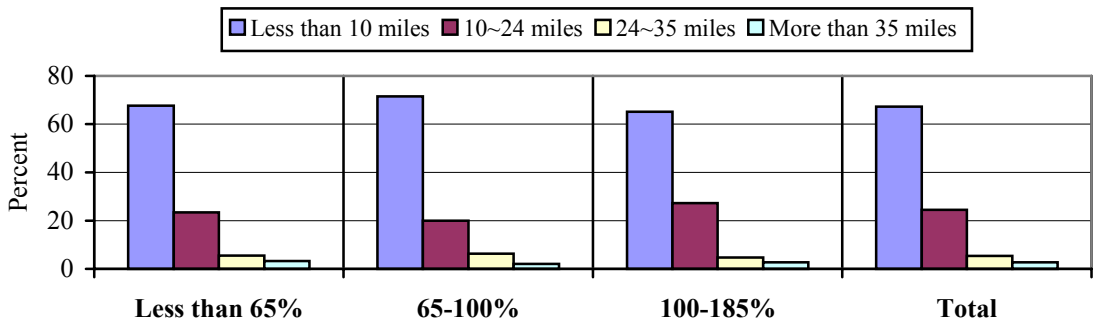
Table 17

Access by Federal Poverty Level, 2001

	Respondents Experience	Federal Poverty Level			Total
		Less than 65%	65-100%	100-185%	
Q19	Being Denied Services due to a pre-existing condition	4.1%	4.3%	2.9%	3.6%
Q25	Services Needed but not Covered	50.1%	50.0%	51.3%	50.6%
Q35	Difficulty Finding Primary Care Providers	18.1%	18.9%	18.4%	18.4%
Q34	How Primary Care Providers Obtained				
	Chose	75.1%	78.5%	79.2%	77.7%
	Assigned	24.9	21.5	20.8	22.3

Almost 70 percent of respondents with an income below 65% FPL stated that they traveled less than 10 miles one-way to get medical services from their primary care providers. Less than 9 percent of them traveled more than 24 miles one-way to see their doctors. The same pattern appears to respondents with income above 65% and 100% FPL (**Figure 11**).

Figure 11. One-way Distance to Primary Care Provider by FPL, 2001 (Q18)



Financial Sponsor Group

Table 18 shows respondents' access experience by group type. About 4 percent of financial sponsor respondents have been denied services because of a pre-existing condition; fewer than half of them needed a service that BH didn't cover—most related to dental and vision care; and 18 percent had difficulty finding a primary care provider who would accept new patients. In regard to primary care providers, 64 percent of financial sponsor respondents chose their own providers, in contrast to 81 percent of individual respondents.

Table 18

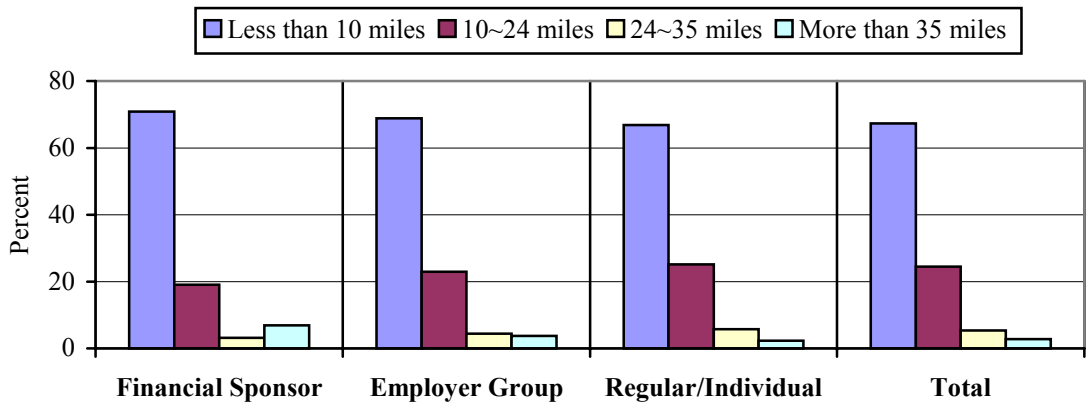
Access by Group Type, 2001

	Respondents Experience	Group Type			Total
		Financial Sponsor	Employer Group	Regular / Individual	
Q19	Being Denied Services due to a pre-existing condition	4.2%	2.9%	3.6%	3.6%
Q25	Services Needed but not Covered	47.2%	47.3%	51.2%	50.6%
Q35	Difficulty Finding Primary Care Providers	18.3%	16.0%	18.6%	18.4%
Q34	How Primary Care Providers Obtained				
	Chose	63.8%	55.3%	80.8%*	77.7%
	Assigned	36.2	44.7	19.2*	22.3

Note:
** Asterisks denote statistical difference from the "Financial Sponsor" group at the .05 level or better.*

As illustrated in **Figure 12**, the majority of financial sponsor respondents traveled less than 25 miles one-way to see their primary care providers (90 percent), which was similar to those who were employer sponsored or regular members.

Figure 12. One-way Distance to Primary Care Provider by Group Type, 2001 (Q18)

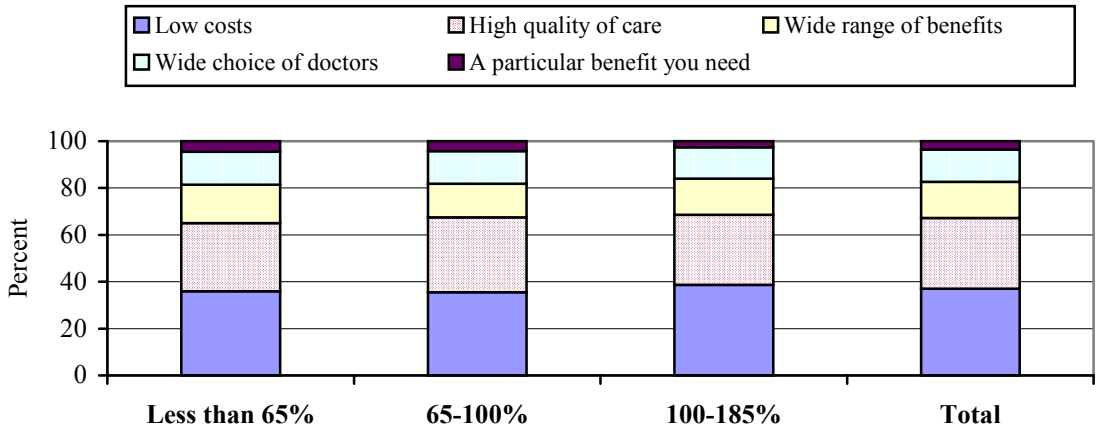


Choice Factors

Federal Poverty Level

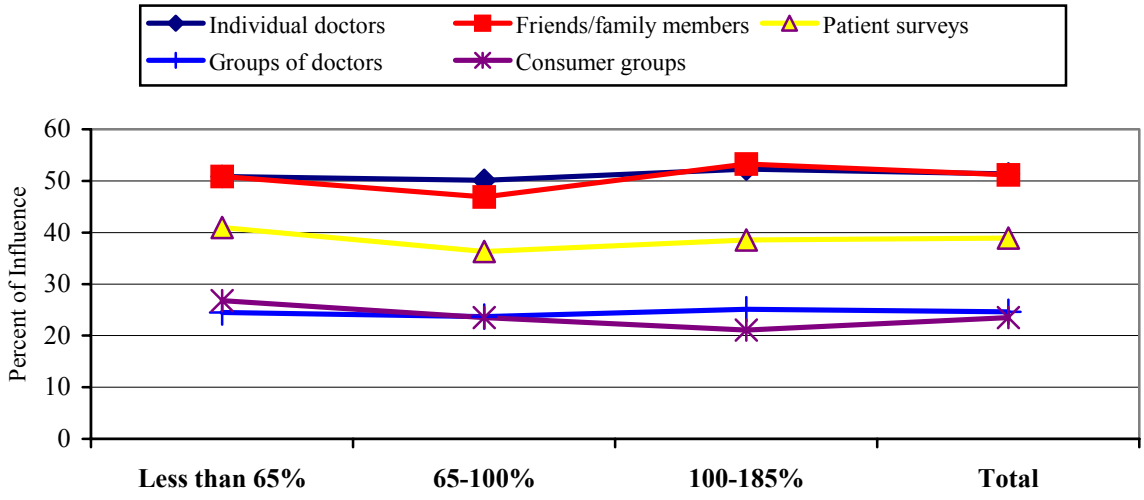
We asked respondents to identify their most important health care concern. As shown in **Figure 13**, regardless of income level, "low costs" was considered as the most important factor, followed in order by "high quality of care," "wide range of benefits," "wide choice of doctors," and "a particular benefit you need."

Figure 13. The Most Important Concerns to Respondents by FPL, 2001 (Q30)



Respondents were given a number of items and asked to rank them on a four-point scale (from "a lot of influence" to "no influence") related to their choice of health plans. **Figure 14** shows the top five factors. Regardless of their income level, respondents assigned "a lot of influence" to their individual doctors and to family or friends, followed by patient surveys. The recommendations or ratings of plans by employer, government agencies, or the mass media have less influence on their choice.

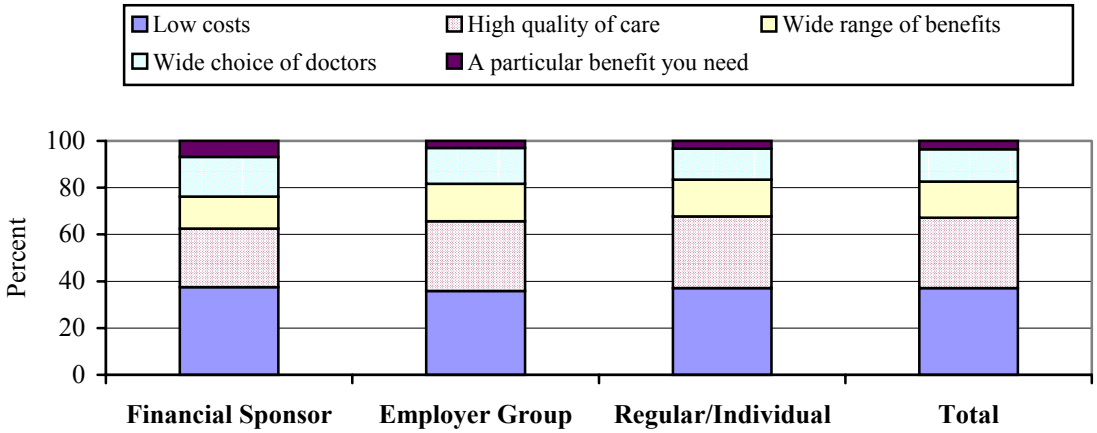
Figure 14. Top Five Choice Factors of Health Plans by FPL, 2001 (Q33)



Financial Sponsor Group

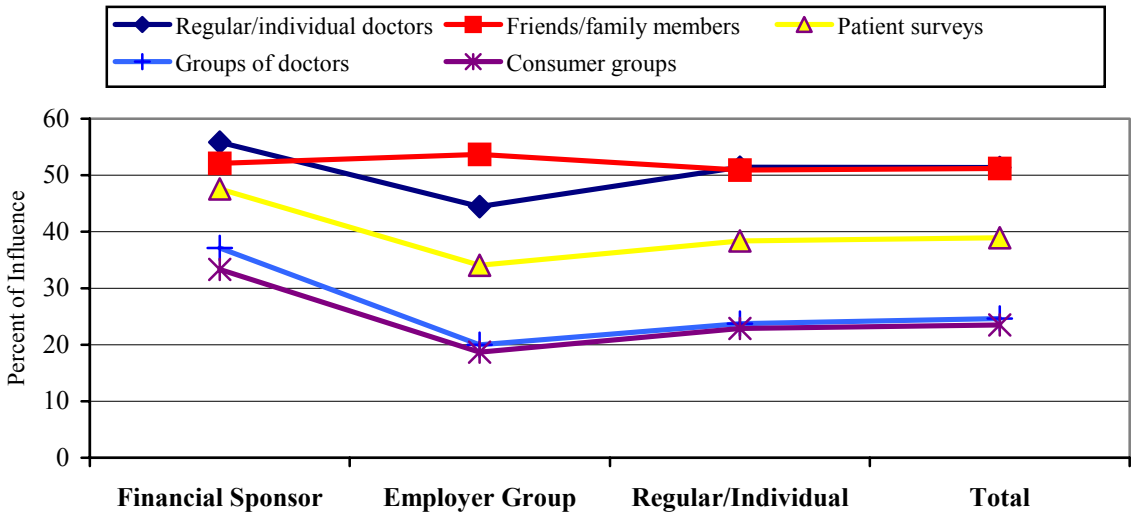
As shown in **Figure 15**, the most important concern of health care for financial sponsor respondents was "low costs," followed by "high quality of care," which shared the same concerns with the other two groups. While employer group and individual respondents considered "wide range of benefits" as the third most important factor, financial sponsor respondents selected "wide choice of doctors."

Figure 15. The Most Important Concerns to Respondents by Group Type, 2001 (Q30)



For financial sponsor respondents, their individual doctors' recommendations or rating of plans have a lot of influence on their choice of health plans, followed by recommendations from friends or family members, and then patient surveys. The other two groups shared the same pattern (**Figure 16**).

Figure 16. Top Five Choice Factors of Health Plans by Group Type, 2001 (Q33)



Other Information

Federal Poverty Level

In order to understand BH customer services, we asked respondents questions regarding their former health insurance coverage and how they used automated transactions. **Table 19** presents such background information. Respondents with income less than 65% FPL were less likely to have health insurance before BH than those with income over 100% FPL (39% versus 52%). For those who were employed, respondents with income less than 65% FPL were less likely to have health insurance covered by employers than those with income level over 100% FPL (19% versus 34%). It may relate to the employed status—working part-time or full-time—and health benefits offered by employers.

Table 19

Health Insurance Coverage and Automated Transactions by Federal Poverty Level, 2001

		Federal Poverty Level			Total
	Respondents Experience	**Less than 65%**	**65-100%**	**100-185%**	
Q60	Had Health Insurance before BH				
	Yes	39.0%	42.0%	52.3%*	45.7%
	No	61.0	58.0	47.7*	54.3
Q69	Employer Offer Health Insurance				
	Yes	18.9%	26.8%	34.2%*	28.4%
	No	81.1	73.2	65.8*	71.6
	Automated Transactions				
Q57	Using Internet	54.3%	47.9%	55.8%	53.7%
Q58	At home	78.5	82.9	83.8	81.8
	At a library	4.5	3.8	2.0	3.2
	At school	4.3	3.8	1.1	2.7
	Other	12.8	9.5	13.1	12.3
Q59A	Monthly transfers of premiums	21.0%	24.0%	20.9%	21.6%
Q59B	Change account online	36.5%	36.2%	37.9%	37.1%
Q59C	Change account by a self-service phone line	49.5%	47.1%	49.9%	49.2%
Q59D	Payment by credit or debit card	43.1%	41.7%	41.9%	42.2%

Note:

** Asterisks denote statistical difference from the "Less than 65% FPL" group at the .05 level or better.*

Over half of the respondents with income less than 65% FPL used the Internet. Among them, 79 percent used it at home, implying they had a computer. Those with income over 65% or 100% FPL had the similar situation. Overall those using automated features vary little by income level—1 in 5 would if offered use automatic monthly transfers of premiums from their bank account to BH; 1 in 3 make changes to their account online; 1 in 2 change their account by a self-service phone line; and almost 1 in 2 make a payment by credit or debit card.

Financial Sponsor Group

As indicated in **Table 20**, 75 percent of financial sponsor respondents did not have health care insurance before they enrolled with BH, compared with 52 percent of employer sponsored or regular respondents. As expected, employer sponsored respondents were more likely to have health insurance coverage than financial sponsored and regular respondents (81% versus 23%).

About 31 percent of financial sponsor respondents used the Internet, compared with 61 percent of employer sponsored and 55 percent of regular respondents. Although the majority of financial sponsor respondents used the Internet at home, only 23% of them would make changes to their account online, if offered.

Table 20

Health Insurance Coverage and Automated Transactions by Group Type, 2001

	Respondents Experience	Group Type			Total
		Financial Sponsor	Employer Group	Regular / Individual	
Q60	Had Health Insurance before BH				
	Yes	24.9%	47.8%*	47.7%*	45.7%
	No	75.1	52.2*	52.3*	54.3
Q69	Employer Offer Health Insurance				
	Yes	23.3%	81.2%*	22.8%	28.4%
	No	76.8	18.8*	77.3	71.6
	Automated Transactions				
Q57	Using Internet	31.4%	61.0%*	55.4%*	53.7%
Q58	At home	71.7	63.9	83.9	81.8
	At a library	8.3	6.0	2.7*	3.2
	At school	10.0	1.2*	2.4*	2.7
	Other	10.0	28.9*	11.1	12.3
Q59A	Monthly transfers of premiums	15.6%	12.9%	22.8%	21.6%
Q59B	Change account online	22.8%	40.3%*	38.3%*	37.1%
Q59C	Change account by a self-service phone line	42.2%	49.6%	49.9%	49.2%
Q59D	Payment by credit or debit card	33.7%	38.8%	43.4%*	42.2%

Note:

** Asterisks denote statistical difference from the "Financial Sponsor" group at the .05 level or better.*

DISCUSSION AND POLICY IMPLICATIONS

Affordability

Our survey findings suggest that BH enrollees at every income level are willing to pay moderate premiums and co-payments. However, the data also shows that providers are least likely to require co-payments from their lowest-income patients, and financial sponsors pay all or part of the premium for a number of the lowest-income enrollees.

Over the years, as premiums or co-payments have increased, BH has experienced some fluctuations in enrollment that correspond with those changes. The majority of enrollment has been, and continues to be, enrollees whose income is no more than 125 percent of federal poverty level (receiving a higher subsidy). In addition to those who voluntarily disenroll with no explanation or are disenrolled for nonpayment, a small percentage of enrollees, when leaving Basic Health coverage, have stated that the reason is that the premiums are unaffordable (See **Appendix D**). This calls into question whether the program is truly affordable, especially for those who must pay more than the minimum premium.

Based on this information, more research would be required to determine with any certainty at what level cost sharing becomes a barrier to coverage or access to services. **Appendix E** provides BH enrollees' cost sharing information.

Population

Overall, BH enrollment demographics by county are consistent with the general Washington State population by county according to the state population survey. Financial sponsor enrollment, however, includes a much higher minority population than the general state population.

A majority of all BH enrollees have incomes of no more than 125 percent of federal poverty level. Enrollment drops off sharply at the higher income levels, when the subsidy is reduced.

Employer group enrollment has not reached the level envisioned by the Legislature. There are various reasons for this, including an employer's need to provide similar coverage to all eligible employees and retain administrative simplicity. BH program requirements excluding specific employees by virtue of age and income create additional requirements that not all employers are willing to accept. In addition to these constraints, employers are reluctant to pay the additional employer fee of $25 for full time and $15 for part time employees. Creating a true employer product in lieu of an individual coverage "look a like" could conceivably enhance and create interest in employer based state assisted coverage.

During the 2002 Legislative Session, legislation was passed that required BH to offer coverage to a population whose Medical Assistance coverage is ending October 2002. Funding for this new population of Washington residents depends on revenues from increased tobacco

tax. This funding source cannot be accessed unless BH maintains an average enrollment base of 125,000 over and above this new population.

This population of approximately 27,000, mostly children, will change BH's overall population. Having a significantly younger and healthier population reduces the risk to the contracted health plans and may result in lower managed care rates for BH. This new population may reduce the per member per month costs to the State, which could be used to leverage a higher level of enrollment.

Access Issues

As a result of health plan mergers, other business decisions and the return of the individual market, enrollee choice for a low cost plan has been reduced to one option in most counties for 2002.

Problems in physician contracting reflect a general shortage of health care providers in the state. Factors contributing to this shortage include reduced compensation for providers and increased cost of operation and liability, in particular the cost and availability of malpractice insurance. The Office of the Insurance Commissioner has published an article titled "Voluntary Program Created For Medical Malpractice Insurance Crisis" which discusses the cause and effect in more detail. For additional information, please go to the following website http://www.insurance.wa.gov/. Reductions in Medicare compensation result in reductions in other compensation that are based on a percentage of Medicare compensation which may further exacerbate provider contracting issues.

In spite of these difficulties, subsidized BH coverage is still available statewide for contract year 2002. Procurement for 2003 is currently being conducted but results will not be known for several weeks.

Health Care Outcomes

It is not known why BH members in general and particularly sponsored members did not report a higher level of preventive service utilization. Additionally, further research and study is necessary to assess the health status of individuals in BH, especially in determining whether those members in the sponsor program are a higher or lower risk to insure. On a cursory review, it would appear that since the sponsored population tends to be younger, they would be a healthier population.

Financial Sponsor Program

While a formal overall assessment of the sponsor program has not occurred, there are indicators that the concept has made inroads in certain access dimensions. The sponsor program has been instrumental in significantly boosting ethnic enrollment by effectively

reaching ethnic and racial minorities. The cooperative efforts between BH and sponsors have resulted in defined divisions of labor and wise use of resources between the program and sponsor organization. BH would not have been able to provide the unique level of support and tailored assistance to special populations that sponsor organizations are equipped to provide.

In addition to paying the premiums, financial sponsors are expected to assist enrollees in their interaction with BH and distribute communications to them.

Community Based Support

In the past, sponsor organizations as well as other community-based organizations have assisted BH in program promotion and enrollment assistance. Their efforts have resulted in helping BH achieve enrollment targets. Sponsor organizations and the community-based partners identified in the **Appendix F & G** are expected to assist with the proposed I-773 expansion. Most of these organizations will have special promotion and outreach efforts through the Washington Coalition of Medicaid Outreach structure described earlier. This assures a centralized and coordinated statewide effort and allows for various strategies aimed at reaching all populations.

Involvement of community based organizations can be a valuable resource to any program and the positive outcome is well worth developing community partnerships.

Summary

Basic Health enrollees appear to be willing to pay premiums and copayments. Experience shows that, as premiums increase, programs may be at risk of retaining a sicker population, as those requiring care retain coverage. This creates a delicate balance, especially for a state-funded non-entitlement program, attempting to keep the program affordable for enrollees while remaining within budget and paying a reasonable rate to contracted health plans. More research is required to determine the level of cost sharing that would be affordable at various income levels. An excellent document resource for this would be the "Targeting the Uninsured in Washington State" created by the State Planning Grant Consulting Team. This group has produced numerous documents related to Washington's uninsured. Information can be accessed at the following web site: http://www.ofm.wa.gov/accesshealth/products.htm.

The Basic Health program continues to look ahead for opportunities to maximize coverage at reasonable enrollee costs, improve health outcomes and remain within budget allocation.

APPENDICES

A. WAC 182-25-070
The Requirements for Financial sponsors

(1) A third party may, with the approval of the administrator, become a financial sponsor to BH enrollees. Financial sponsors may not be a state agency or a managed health care system.
(2) BH may require a minimum financial contribution from financial sponsors who are paid to deliver BH services. Sponsors who meet the following criteria will be exempt from the minimum contribution:
  (a) Organizations that are not paid to perform any function related to the delivery of BH services, and do not receive contributions from other organizations paid to deliver BH services;
  (b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BH services, who receive contributions from other individuals or organizations who may be paid to deliver BH services, if the organization can demonstrate all of the following:
    (i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BH services);
    (ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);
    (iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and
    (iv) There is no direct financial gain to the sponsoring entity.
  (c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BH services, if the organization can demonstrate all of the following:
    (i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;
    (ii) There is organizational and financial autonomy (the organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BH services);
    (iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BH services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and
    (iv) There is no direct financial gain to the sponsoring entity.
(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all BH eligibility requirements as outlined in WAC 182-25-030.[6]
(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. It is the financial sponsor's responsibility to collect the enrollee's portion

[6] WAC 182-25-030 relates to the eligibility of BH enrollees. To be eligible for enrollment in BH, an individual must be a Washington state resident who is not eligible for free Medicare coverage or eligible to buy Medicare coverage, or institutionalized at the time of enrollment.

of the premium, if any, and remit the entire payment to BH and to notify BH of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BH of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, it is the responsibility of the financial sponsor to notify sponsored enrollees and BH if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BH toll-free information number.

(8) BH may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

B. QUESTIONNAIRE

SELECT

May I please speak to (respondent's name)

BEGIN
Hello, this is (your name) from Washington State University and I'm calling on behalf of Basic Health. Basic Health has asked WSU to conduct this survey to provide feedback for health plan improvements and to help Basic Health members like you make informed health care choices when enrolling in the program.

CONFD
This interview is voluntary and has been approved by Basic Health and Washington State University. My supervisor may monitor this interview to check my work. However, all of the information you provide will be kept confidential and will not impact your eligibility in Basic Health. No names will be associated with any of the answers. If I come to any question you prefer not to answer, just let me know and I'll skip over it. I wanted to let you know the survey will take about 10 minutes.

Q1
Are you enrolled in Basic Health?

1. Yes
2. No→Go to Q5
D. Don't know → Q5
R. Refuse→ Go to Q5

Q2
What health plan are you enrolled in?

1. Aetna US Healthcare of Washington
2. Community Health Plan of Washington
3. Columbia United Providers
4. Group Health Cooperative
5. Kaiser Health Plan
6. Northwest Washington Medical Bureau
7. Premera Blue Cross
8. Molina Healthcare
9. Regence BlueShield
D. Don't know
R. Refuse

Q3M, Q3Y
How long have you been enrolled in Basic Health?
____Months
____Years
D. Don't know -→ go to Q4
R. Refuse → go to Q4

[If Q3Y =0 and Q3M=0 go to Q4]
Q3
How sure are you that this is the exact length of time you have been enrolled in Basic Health? Would you say you are…

1. VERY SURE
2. SOMEWHAT SURE
3. BETWEEN SURE AND UNSURE
4. SOMEWHAT UNSURE
5. VERY UNSURE
D. Don't know
R. Refuse

Q4
Are you enrolled as a…

1. INDIVDUAL MEMBER
2. MEMBER OF FINANCIAL SPONSOR GROUP
3. OR MEMBER OF EMPLOYER SPONSOR GROUP INCLUDING HOME CARE AGENCY
4. Other (foster parent)
D. Don't know
R. Refuse

Q5
During the last 6 months, how many times have you personally visited a doctor (seen your primary care providers)?

Numeric response (0-999)
D. Don't know
R. Refuse

Q6
During the last 6 months, how many times have you had an overnight stay in the hospital?

Numeric response (0-999)
D. Don't know
R. Refuse

Q7
During the last 6 months, how many times have you gone to a hospital emergency room for medical treatment?

Numeric response (0-999)
D. Don't know
R. Refuse

Q8
During the last 6 months, how many prescriptions have you had filled?

Numeric response (0-999)
D. Don't know →Go to Q14
R. Refuse →Go to Q14

[If Q8=0 go to Q14 Else continue]
Q9
For most of the prescriptions you had filled, how much did you have to pay?

1. $1.00
2. $3.00
3. Other amount (please specify)
D. Don't know
R. Refuse

Q9A
In your opinion are the co-payments you pay for your prescription affordable?

1. Yes →Go to Q10
2. No
D. Don't know
R. Refuse

Q9B
What would be an affordable amount?

Numeric response (1-999)
D. Don't know
R. Refuse

Q10
Were there any prescriptions you purchased that were not covered by your health plan?

1. Yes
2. No

D. Don't know
R. Refuse

Q12
Have you been prescribed medication from your doctor that you did not have filled?

1. Yes
2. No→ Go to Q13
D. Don't know → Go to Q13
R. Refuse → Go to Q13

Q12B
Why did you choose not to fill the prescription?

1. Cost
2. Felt I didn't need it
3. Didn't want to take it
4. Other
D. Don't know
R. Refuse

Q13
Do you generally have more than one prescription filled at a time?

1. Yes
2. No
D. Don't know
R. Refuse

Q14
In you opinion are the co-payments you pay for office visits affordable?

1. Yes→ Go to Q71
2. No
D. Don't know
R. Refuse→Go to Q71

Q15
What would be an affordable amount?

Open-ended response (1-999)
D. Don't know
R. Refuse

Q71
(IF NECESSARY, ASK: "For survey purposes I need to ask, are you male or female?")

1. Male
2. Female
R. Refuse

Q18
How far do you travel one-way to get medical services from your primary care provider? Would you say…

1. LESS THAN 10 MILES
2. BETWEEN 10 MILES AND 24 MILES
3. BETWEEN 24 MILES AND 35 MILES
4. MORE THAN 35 MILES
D. Don't know
R. Refuse

Q19
Have you been denied services because of a pre-existing condition?

1. Yes
2. No
D. Don't know
R. Refuse

Q22A Please tell me which of the following preventive services covered by Basic Health you use. Do you use immunizations?

1. Yes
2. No
D. Don't know
R. Refuse

Q22B (Please tell me which of the following preventive services covered by Basic Health you use.) Do you use Routine exams or physical exams?

1. Yes
2. No
D. Don't know
R. Refuse

[If R is male go to Q22E else continue]
Q22C Do you use Mammograms?

1. Yes
2. No
D. Don't know
R. Refuse

Q22D Do you use Pap tests?

1. Yes
2. No
D. Don't know
R. Refuse

[If R is female go to Q22F else continue]
Q22E Prostate screening

1. Yes
2. No
D. Don't know
R. Refuse

Q22F Other preventative services (please specify) {IWR: If R asks what other services, say " Are there any other preventative services you use that I haven't already mentioned?"}

1. Yes
2. No
D. Don't know
R. Refuse

[If ALL Q22A-Q22F=no then ask Q21 else go to Q23]
Q21
Why don't you use these preventative services?

1. Don't know about them
2. Don't have the money for them
3. Too far away
4. Don't have time during office hours
5. Some other reason (please specify)
D. Don't know
R. Refuse

Q23
Does your provider's office collect your co-payment at the time of the visit?

1. Yes →Go to Q25
2. No
D. Don't know → Go to Q25
R. Refuse →Go to Q25

Q24
If they don't collect it at that time is it because…

1. THEY BILL YOU
2. OR THE PROVIDER DOESN'T REQUIRE THE CO-PAYMENT
D. Don't know
R. Refuse

Q25
Is there a service you need for your health that Basic Health doesn't cover?

1. Yes
2. No→ Go to Q27
D. Don't know→ Go to Q27
R. Refuse → Go to Q27

Q26
What is that service?

Open-ended response
D. Don't know
R. Refuse

Q27
Do you have an ongoing medical condition?

1. Yes
2. No → Go to Q30
D. Don't know→ Go to Q30
R. Refuse → Go to Q30

Q28
What is that condition? {IWR: Please enter all answers given in the text box provided}

Open-ended response
D. Don't know
R. Refuse

Q30
Please tell me which of the following concerns is MOST important to you?
Is it….

1. LOW COSTS
2. WIDE RANGE OF BENEFITS
3. A PARTICULAR BENEFIT YOU NEED
4. HIGH QUALITY OF CARE
5. WIDE CHOICE OF DOCTORS
D. Don't know
R. Refuse

Q31
Based on what you've heard, read or experienced yourself, do you think there are big differences, small differences, or no difference in the quality of care among health plans that are available to you?

1. Big difference
2. Small difference
3. No difference
D. Don't know
R. Refuse

Q32
Here are some aspects of health care plans that are important to people. Please tell me how important this aspect is to YOU.

Q32A. (The first/next one is) Variety of health care programs the plan offers. (Such as those that help people lose weight or stop smoking.) Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32B. (The first/next one is) Having doctors who explain things well and who listen well. Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32C. (The first/next one is) Having a low number of doctors with malpractice suites. Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32D. (The first/next one is) A large range of health benefits available beyond medical coverage. (Such as prescription drugs, eye care, and dental care.) Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32E. (The first/next one is) Making it easy to see a specialist. (Such as orthopedists, allergists and doctors who treat heart problems) Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32F. (The first/next one is) Having few complaints filed by members against the health plan. Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32G. (The first/next one is) Plan that will help you find the care you need. (Such as the best place to get a particular surgery done) Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32H (The first/next one is) Low health plan costs. Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

Q32I (The first/next one is) Plans with safety initiatives or efforts to reduce medical errors. Would you say this is VERY IMPORTANT, SOMEWHAT IMPORTANT, SOMEWHAT UNIMPORTANT, VERY UNIMPORTANT.

(1=VERY IMPORTANT, 2=SOMEWHAT IMPORTANT,3= SOMEWHAT UNIMPORTANT, 4=VERY UNIMPORTANT, D=Don't know, R=refuse)

Q33
If you had to CHOOSE a new health plan, tell me how much influence each of the following is likely to have on your choice.

Q33A. Recommendations or ratings of plans by Patients who are surveyed about the quality of care. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33B. Recommendations or ratings of plans by Your regular doctor or other individual doctors. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33C. Recommendations or ratings of plans by Groups of doctors like state medical societies. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33D. Recommendations or ratings of plans by Newspapers or magazines. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33E. Recommendations or ratings of plans by Consumer groups. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33F. Recommendations or ratings of plans by Friends or family members. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33G. Recommendations or ratings of plans by Your employer or someone at work who deals with health benefits. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

Q33H. Recommendations or ratings of plans by Government agencies. (Would this have a lot of influence on your choice of health plans, some influence, only a little influence, or no influence?)

(1=A lot of influence, 2=Some influence, 3=Only a little influence, 4=No influence, D=don't know, R=refuse)

Q34
Did you choose a primary care provider or was one assigned?

1. Chose primary care provider
2. Assigned primary care provider
D. Don't know
R. Refuse

Q35
Did you have difficulty finding a primary care provider who would accept new patients?

1. Yes
2. No
D. Don't know
R. Refuse

Q36
We'd like to know how quickly you received your health plan ID card. In your best estimate, would you say that you received your most recent ID card……

1. WITHIN 2 WEEKS FROM THE DATE OF COVERAGE
2. OR MORE THAN 2 WEEKS FROM THE DATE OF COVERAGE
D. DON'T KNOW
R. Refuse

Q37
If prices had to increase, would you prefer increased co-payments for services or increased monthly premiums?

1. Increase co-payment
2. Increase premiums
D. Don't know
R. Refuse

Q38
Would you be willing to pay a higher premium EACH MONTH to have dental care?

1. Yes
2. No → Go to Q40
D. Don't know →Go to Q40
R. Refuse → Go to Q40

Q39
How much more are you willing to pay each month?
{IWR PROBE: " Please round to the nearest dollar amount.}

Numeric response (1-999)
D. Don't know
R. Refuse

Q40
Would you be willing to pay a higher premium EACH MONTH to have vision care?

1. Yes
2. No → Go to Q42
D. Don't know →Go to Q42
R. Refuse →Go to Q42

Q41
How much more are you willing to pay each month?
{IWR PROBE: " Please round to the nearest dollar amount.}

Numeric response (1-999)
D. Don't know
R. Refuse

Q42
Would you be willing to pay a higher premium EACH MONTH to have physical therapy?

1. Yes
2. No →Go to Q44

D. Don't know →Go to Q44
R. Refuse →Go to Q44

Q43
How much more are you willing to pay each month?
{IWR PROBE: " Please round to the nearest dollar amount.}

Numeric response (1-999)
D. Don't know
R. Refuse

Q44
Would you be willing to pay a higher premium EACH MONTH to have chiropractic care?

1. Yes
2. No→ Go to Q46
D. Don't know →Go to Q46
R. Refuse →Go to Q46

Q45
How much more are you willing to pay each month?
{IWR PROBE: " Please round to the nearest dollar amount.}

Numeric response (1-999)
D. Don't know
R. Refuse

Q46
Have you called Basic Health in the last 6 months?

1. Yes
2. No
D. Don't know
R. Refuse

Q47
Have you ever called Basic Health when receiving a notification only to be told you need to contact someone else?

1. Yes
2. No -→ go to Q49
D. Don't know --→ go to Q49
R. Refuse -→ go to Q49

Q48
Whom were you referred to?

1. DSHS
2. Your health plan
3. Other (Specify)
D. Don't know
R. Refuse

Q49
When you call Basic Health, do you generally get help with one call?

1. Yes -→ go to Q50
2. No
D. Don't know -→ go to Q50
R. Refuse → go to Q50

Q49A
Please tell me why you generally don't get help with one call.

Open-ended
D. Don't know
R. Refuse

Q50
If you needed to call Basic Health, would you be most likely to call….

1. BEFORE 8 AM
2. BETWEEN 8AM AND NOON
3. BETWEEN NOON AND 5PM
4. AFTER 5PM
D. Don't know
R. Refuse

Q51
Have you used your member handbook in the last six months?

1. Yes
2. No
D. Don't know
R. Refuse

Q52
For did you use your handbook for?

Open-ended response

D. Don't know
R. Refuse

Q53
Did you receive something from Basic Health that you didn't understand and had to call them to understand it better?

1. Yes
2. No -→ go to Q56
D. Don't know → go to Q56
R. Refuse → go to Q56

Q54
What was it that Basic Health sent you that you didn't understand?

1. A letter/notice
2. A premium statement
3. A suspension letter
4. A personal eligibility statement
5. Don't know or remember
6. Other (please specify)
R. Refuse

Q55
When you called, were you able to reach them?

1. Yes
2. No
D. Don't know
R. Refuse

Q56
When do you send updated income information to Basic Health?

Open-ended
D. Don't know
R. Refuse

Q57
Do you use the Internet?

1. Yes
2. No→Go to Q59A
D. Don't know →Go to Q59A
R. Refuse →Go to Q59A

Q58
Where (do you use the Internet)?

1. At home
2. At a local library
3. or at school
4. Other (please specify)
D. Don't know
R. Refuse

Would you use any of the following features? The first (next) one is…
(1=yes, 2=no, D-don't know, R=refuse)

Q59A. Automatic monthly transfers of premiums from your bank account to Basic Health?

Q59B. The ability to make changes to your account online?

Q59C. The ability to make changes to your account by a self-service phone line?

Q59D. The ability to make a payment by credit or debit card?

Q60
Did you have health care insurance just before you enrolled with Basic Health?

1. Yes
2. No
D. Don't know
R. Refuse

Q67
Are you currently employed?

1. Yes
2. No→Go to Q71
D. Don't know→Go to Q71
R. Refuse →Go to Q71

Q68
Are you EMPLOYED…

1. PART-TIME
2. FULL-TIME
3. ON A SECOND BASIS
4. OR ON A TEMPORARY BASIS
D. Don't know
R. Refuse

Q69
Does your employer offer YOU health insurance coverage?

1. Yes
2. No→Go to Q71
D. Don't know →Q71
R. Refuse →Go to Q71

Q70
How much would your part of the premium be if you accepted coverage from your employer?

Numeric response (0-999)
D. Don't know
R. Refuse

Q72
Would you say your health in general is…

1. EXCELLENT
2. VERY GOOD
3. GOOD
4. FAIR
5. POOR
D. Don't know → go to Q73
R. Refuse → go to Q73

Q72A
How sure are you that your health really is <Fill in answer from Q72>? Would you say you are….

1. VERY SURE
2. SOMEWHAT SURE
3. BETWEEN SURE AND UNSURE
4. SOMEWHAT UNSURE
5. OR VERY UNSURE
D. Don't know
R. Refuse

Q73
Please tell me the racial or ethnic background that best describes you. {IWR: Use "Other category for those this multiple backgrounds} {IWR: Read categories if R gives you a race or ethnicity that does not fit the list}

1. Black or African-American → go to Q77
2. White (Caucasian) →go to Q77

3. Eskimo → go to Q77
4. Aleut → go to Q77
5. Indian or Native American → got oQ77
6. Asian or Pacific Islander -→ go to Q74
7. Hispanic, Latin American -→ go to Q75
8. Other or mixed ethnic background (specify) → go to Q77

D. Don't know → go to Q77
R. Refuse → go to Q77

Q74
How would you describe you Asian background?

1. Asian Indian → go to Q77
2. Cambodian → go to Q77
3. Chinese→ go to Q77
4. Filipino → go to Q77
5. Guamanian → go to Q77
6. Hawaiian → go to Q77
7. Japanese → go to Q77
8. Korean → go to Q77
9. Laotian → go to Q77
10. Samoan → go to Q77
11. Vietnamese → go to Q77
12. Other (specify) → go to Q77

D. Don't know → go to Q77
R. Refuse → go to Q77

Q75
How would you describe your Hispanic background?

1. Mexican, Mexican American, Chicano
2. Puerto Rican
3. Cuban
4. Other Hispanic or Latin American

D. Don't know
R. Refuse

Q77
What is the LAST grade that you COMPLETED in school?

1. None, or grade 1-8
2. High school incomplete (grades 9-11)
3. High school graduate (grade 12 or GED)
4. Business, technical or vocational school AFTER high school
5. Some college, no 4 year degree
6. College graduate (B.S., B.A., or other four year degree)

7. Post graduate training or professional schooling after college (e.g., toward a master's degree or Ph.D., law or medicine)
D. Don't know
R. Refuse

Q79
How many years have you lived in Washington State?
{IWR: If R has lived in the state for less then a year code as 0}

Numeric response
D. Don't know -→ go to N1
R. Refuse → go to N1

[Go to N1 if Q79>0]
Q79M
How many months have you lived in Washington State?
Numeric response
D. Don't know
R. Refuse

N1
That completes our survey. We appreciate your time and cooperation. I want to thank you for helping us out. Do you have any additional comments or questions about this survey?

Open-ended response

C. Demographics of BH Enrollment by Group Type, June 2002

Characteristic	Group Type			Total
	Financial Sponsor	Employer Group	Regular / Individual	
Federal Poverty Level				
Less than 65%	44.5%	13.4%	31.0%	33.1%
65-100%	25.1	19.1	20.7	21.4
100-185%	30.3	67.5	48.4	45.5
Gender				
Female	55.5%	52.5%	57.3%	57.1%
Male	44.5	47.5	42.7	42.9
Age				
0~18	15.7%	32.0%	39.9%	35.9%
19~39	52.8	36.6	26.9	31.1
40~54	22.9	24.5	22.9	23.0
55~64	7.4	6.9	9.8	9.4
65+	1.2	0.0	0.6	0.7
Race/Ethnicity				
White	35.0%	87.4%	83.0%	81.0%
Black/African American	1.0	2.6	2.5	2.1
Indian/Native American	11.0	2.0	1.0	1.9
Asian/Pacific Islander	7.0	2.0	2.5	3.5
Hispanic/Latin American	37.0	2.0	4.0	5.0
Other	9.0	4.0	7.0	6.5

D. Basic Health Member Disenrollment by Reason

		Member Disenrollment by Reasons																			
		Disenrolled for non-payment		Voluntarily disenrolled to private insurance		Disenrolled for various reasons such as Divorce		Medicare eligible		Disenrolled due to non compliance		Out of state		Voluntarily disenrolled		Disenrolled, non subsidized coverage no longer available		Disenrolled to Medicaid		Disenrolled – cannot afford the premium		Disenrolled due to death	
Month Disenrolled from*		Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month	Count	% of Month
2000	July	1,511	1.2%	849	0.6%	524	0.4%	172	0.1%	21	0.0%	203	0.2%	167	0.1%	4	0.0%	91	0.1%	60	0.0%	7	0.0%
	August	1,720	1.3%	1,015	0.8%	544	0.4%	173	0.1%	36	0.0%	223	0.2%	165	0.1%	7	0.0%	88	0.1%	62	0.0%	10	0.0%
	September	1,445	1.1%	979	0.7%	509	0.4%	186	0.1%	34	0.0%	203	0.2%	161	0.1%	4	0.0%	85	0.1%	64	0.0%	9	0.0%
	October	1,590	1.2%	997	0.8%	591	0.5%	175	0.1%	37	0.0%	186	0.1%	140	0.1%	11	0.0%	103	0.1%	89	0.1%	10	0.0%
	November	1,692	1.3%	780	0.6%	552	0.4%	184	0.1%	64	0.0%	117	0.1%	152	0.1%	19	0.0%	119	0.1%	54	0.0%	5	0.0%
	December	1,600	1.2%	1,025	0.8%	556	0.4%	192	0.1%	105	0.1%	181	0.1%	232	0.2%	314	0.2%	104	0.1%	124	0.1%	10	0.0%
2001	January	1,261	1.0%	905	0.7%	403	0.3%	196	0.1%	99	0.1%	130	0.1%	194	0.1%	205	0.2%	105	0.1%	72	0.1%	11	0.0%
	February	1,772	1.3%	905	0.7%	466	0.3%	200	0.1%	89	0.1%	146	0.1%	192	0.1%	173	0.1%	145	0.1%	83	0.1%	12	0.0%
	March	1,722	1.3%	773	0.6%	472	0.4%	180	0.1%	327	0.2%	238	0.2%	245	0.2%	157	0.1%	121	0.1%	94	0.1%	10	0.0%
	April	1,333	1.0%	679	0.5%	439	0.3%	217	0.2%	606	0.5%	196	0.1%	183	0.1%	189	0.1%	123	0.1%	93	0.1%	13	0.0%
	May	1,118	0.9%	712	0.6%	331	0.3%	206	0.2%	491	0.4%	184	0.1%	166	0.1%	232	0.2%	81	0.1%	78	0.1%	14	0.0%
	June	1,381	1.1%	725	0.6%	328	0.3%	404	0.3%	490	0.4%	233	0.2%	220	0.2%	183	0.1%	90	0.1%	89	0.1%	16	0.0%
Grand Total		18,140	1.2%	10,344	0.7%	5,725	0.4%	2,483	0.2%	2,394	0.2%	2,240	0.1%	2,217	0.1%	1,499	0.1%	1,255	0.1%	962	0.1%	128	0.0%

	Date	Monthly Total Regular Subsidized Enrollment	**Monthly Disenrollment Total**	
			Members	% of Month
2000	July	130,736	3,609	2.8%
	August	130,229	4,043	3.1%
	September	130,820	3,679	2.8%
	October	130,938	3,929	3.0%
	November	131,260	3,738	2.8%
	December	131,580	4,443	3.4%
2001	January	131,009	3,581	2.7%
	February	133,360	4,183	3.1%
	March	132,592	4,339	3.3%
	April	130,996	4,071	3.1%
	May	128,704	3,613	2.8%
	June	129,513	4,159	3.2%
Grand Total		1,571,737	47,387	3.0%

* Example:
3,609 or 2.8% of members enrolled in July 2000 disenroll from entire program for two consecutive months, August and September 2000.

E. Basic Health Cost Sharing Information

Enrollee Health Care Costs

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	
Office Visit	$8	$8	$8	$8	$8	$10	$10	$10	$10	$10	
Hospital	$50	$50	$50	$50	$50	$100	$100	$100	$100	$100	per admission
Outpatient	$0	$0	$0	$0	$0	$25	$25	$25	$25	$25	
Emergency Room	$25	$25	$25	$25	$25	$50	$50	$50	$50	$50	member's MHCS
" "	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	non-participating facility
Lab & X-ray	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Ambulance	$25	$25	$25	$25	$25	$50	$50	$50	$50	$50	
Preventive	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Maternity	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Pharmacy	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$1/$5/50%	$3/$7/50%	

Enrollee Premium Share and Minimum Premiums

Income Bands	1997	1998	1999	2000	2001	2002
Up to 65% FPL	$10.00	$10.00	$10.00	$10.00	$10.00	$10.00
65% - 99%	$10.00	$12.00	$12.00	$13.00	$14.00	$14.00
100% - 124%	$10.00	$15.00	$15.00	$16.25	$17.50	$17.50
125% - 139%	15%	24%	24%	15%	15%	15%
140% - 154%	23%	33%	33%	23%	23%	23%
155% - 169%	30%	40%	40%	30%	30%	30%
170% - 184%	38%	49%	49%	38%	38%	38%
185% - 200%	46%	59%	59%	46%	46%	46%

Federal Poverty Levels (adjusted July of each year)

Based on Family Size of 3

	1996	1997	1998	1999	2000	2001	2002
Monthly 100% Level	$1,081.67	$1,110.83	$1,137.50	$1,156.67	$1,179.17	$ 1,219.17	$ 1,251.67
Increase from Prior Year		2.7%	2.4%	1.7%	1.9%	3.4%	2.7%

F. Washington State Basic Health Sponsor Directory

May, 2002

Sponsor Organization	General Service Area Coverage	Executive Contact	Operations Contact	Members As of: May 2002	Required Member Contribution
Franciscan Health System *(Provider Sponsor)*	Tacoma Existing enrollees only	Mr. Mike Fitzgerald (253) 627-4100 1149 Market Street Tacoma, WA 98401	Ms. Angela Marlow (253) 428-8430 angelamarlow@chiwest.com 1149 Market Street Tacoma, WA 98401	23	No
St. John's Peace Health *(Provider Sponsor)*	Up to 125% FPL Longview Cowlitz, Lewis counties	Ms. Medrice Coluccio (360) 414-7304 PO Box 3002 Longview, WA 98632	Ms. Donna McCool (360) 414-2301 DMcCool@peacehealth.org PO Box 3002 Longview, WA 98632	347	No
University of Washington Physicians *(Provider Sponsor)*	Seattle area Existing enrollees only	Mr. Marc Provence (206) 543-6420 mprov@uwp.washington.edu 1910 Fairview Avenue E. Suite 304 Seattle, WA 98102	Mr. Tom Crews (206) 543-6420 Tcrews@uwp.washinton.edu 1910 Fairview Avenue E. Suite 304 Seattle, WA 98102	287	No
El Centro de la Raza	Below 125% FPL Arlington, parts of King County, Pierce County, Thurston, Vancouver	Ms. Estela Ortega (206) 329-2974 eortega@cartero.elcentrodelaraza.com 2524 16th Ave S Seattle WA 98144	Ms. Christy Andres (360) 671-3225, ext. 254 ahyeah97@hotmail.com Sea-Mar Community Health Centers 4455 Cordata Parkway Bellingham, WA 98226	7,710	No
Housing Hope	Below 150% FPL Snohomish County	Mr. Ed Peterson (425) 347-6556 edpeterson@housinghope.org 5830 Evergreen Way Everett, WA 98203	Mr. Steven Gadd (425) 347-6556 stevengadd@housinghope.org 5830 Evergreen Way Everett, WA 98203	1,271	Anything above benchmark and one year in advance
Jamestown S'Klallam Tribe	200% FPL and below living in Clallam/ East Jefferson Counties with at least 1/8th blood quantum	The Honorable W. Ron Allen (360) 681-4621 1033 Old Blyn Hwy Sequim, WA 98382	Ms. Cindy Bennett-Lowe (360) 582-2891 vlowe@jamestowntribe. org 1033 Old Blyn Hwy Sequim, WA 98382	51	No
Leah Layne Foundation	Up to 200% FPL **Grant County** (Moses Lake, Warden, Royal City, Mattawa, Desert Aire, Beverly Schwana) **Franklin County** (Connell Basin City) **Adams County** (Lind, Hatton areas)	Mr. Samuel Garza (509) 346-1140 Head of the insurance sponsorship committee Insurance Sponsorship Committee, Leah Layne Foundation (no email address)	Mr. Carlos Martinez (509) 488-5256, ext. 209 carlos@cbha.org (While Leo Gaeta is on military duty) 66 South First Ave Othello, WA 99344	1,630	Foundation pays 80% of premium up to $20.00 per person Collected twice per year

Sponsor Organization	General Service Area Coverage	Executive Contact	Operations Contact	Members As of: May 2002	Required Member Contribution
Lummi Nation Lummi Indian Business Council of the Lummi Indian Nation	NW Washington Bellingham area	Mr. Dan Kamkoff Dank@lummi-nation.bia.edu (360) 384-0464 2592 Kwina Road Bellingham Road, WA 98226	(same as Executive Contact)	None	No
Mt. Adams Health Foundation	Up to 200% FPL Tri Cities, Walla Walla, Yakima area, Toppenish, Grandview areas	Mr. Gerald (Jerry) Besel (509) 575-6406 gjbeselcpa@aol.com PO Box 10443 Yakima, WA 98909	Ms. Christy Lopez (509) 865-5898 ChristyL@YVFWC.org Yakima Valley Farmworker's Clinic PO Box 190 518 West First Avenue Toppenish, WA 98948	15,843	Minimum of $2.00
Port Gamble S'Klallam Tribe	Eligible for Port Gamble S'Klallam Contract Health Service Funding, has no other type of health insurance and is not eligible for Medicaid, Port Gamble area	The Honorable Ronald Charles (360) 297-2646 ext. 342 31912 Little Boston Road N.E. Kingston, WA 98346	Ms. Kerstin Powell (360) 297-9601 kerstin@pgst.nsn.us 32014 Little Boston Road N.E. Kingston, WA 98346	172	No
Quinault Indian Nation	Tribal members living in Grays Harbor and Jefferson Counties No other health insurance and certified by Quinault Nation Enrollment office as possessing minimum decendency from the Aberdeen, Queets, Taholah area	Ms. Fawn Tadios-Hahn (360) 276-4405 PO Box 219 Taholah, WA 98587	Ms. Jacquie Capoeman (360) 276-8215, ext. 437 jcapoeman@quinault.org PO Box 219 Taholah, WA 98587	293	No
Total Members				**27,627**	

G. Washington State Basic Health Community Based Organizations

Look at the County you live in. If the clinic you are currently getting your care through is listed, call them and they will help you fill out the application. If your clinic is not listed, or you don't know which clinic you receive care through, call one of the organizations listed **in your county**. Those organizations with an * by them may be able to help you pay for your coverage---YOU MUST LIVE in that COUNTY to qualify.

COUNTY	ORGANIZATION	CONTACT NAME(S)	ADDRESS	CITY	PHONE NUMBER (S)	LANGUAGES OTHER THAN ENGLISH
Adams	*Columbia Basic Health Association Othello Family Clinic	Eligibility Dept.	140 E. Main	Othello	509-488-5256	Spanish
Adams	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Asotin	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Benton/Franklin	Community Health Center/La Clinica	Erica, Margaret	515 W. Court	Pasco	509-547-2204	Spanish
Benton	Community Health Center/La Clinica	Inez	5219 W. Clearwater	Kennewick	509-783-4454	Spanish
Chelan/Douglas	Columbia Valley Comm. Health	Alejandra, Vera	600 Oronda Suite 1	Wenatchee	509-664-3528, or 509-662-6000	Spanish
Chelan	Community Choice	Jesus	Central Hospital 1300 Fuller Street	Wenatchee	1-888-452-0731	Spanish
Chelan	Community Choice	Maria	Wenatchee Valley Med. Ctr 820 N. Chelan Ave.	Wenatchee	1-888-452-0731	Spanish
Chelan	Community Choice	Jennifer	Lake Chelan Hospital 503 E. Highland Ave	Chelan	1-888-452-0731	Spanish
Clallam	Clallam Bay Medical Clinic	Lana	Forks Comm. Hosp. 530 Bogachiel Way	Forks	360-374-6271	English Only
Clark	*Sea-Mar Clinic	Maria	1412 NE 88th	Vancouver	360-574-4074 360-566-4414	Spanish
Clark	Southwest Washington Health District	Health Access Program	2000 Ft. Vancouver Way	Vancouver	360-397-8118	Russian/Spanish
Columbia	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Cowlitz/Wahkiakum	St. John's Peace Health	Donna	1615 Delaware	Longiview	360-414-2301	English only
Cowlitz	Family Health Center	Sara	1057 12th Avenue	Longview	360-636-3892	Spanish, Russian
Douglas	Community Choice	Janet	Okan-Douglas Dist. Hospital 507 Hospital Way	Brewster	1-888-452-0731	Spanish
Ferry	Health for All	Mona	295 N. Main	Colville	1-888-311-7394	English only
Ferry	Kettle River Comm. Health Ctr.	Ask for BH assistance	518 E. Clay	Chewelah	509-935-8424	English only
Garfield	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Grant	Mattawa Community Clinic	Sandra	PO Box 1581	Mattawa	509-932-5373	Spanish
Grant	Moses Lake Community Health Center	Rosita, Carmen	605 Coolidge Drive	Moses Lake	509-765-0674 1-800-371-8638	Spanish

COUNTY	ORGANIZATION	CONTACT NAME(S)	ADDRESS	CITY	PHONE NUMBER (S)	LANGUAGES OTHER THAN ENGLISH
Grant	*Columbia Basin Health Association Wahluke Family Ctr.	Eligibility Dept.	601 Government Way	Mattawa	509-488-3535	Spanish
Grant	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Grant	Community Choice	Maria	Wenatchee Valley Med. Ctr. 820 N. Chelan Ave	Wenatchee	1-888-452-0731	Spanish
Grays Harbor	Peninsula Community Health Services-Aberdeen	Trudy	2700 Simpson Avenue, Suite 101	Aberdeen	360-538-1293	Spanish anguage Lines
Grays Harbor	Peninsula Community Health Services-Copalis Beach	Trudy	31010 State Route 109	Copalis Beach	360-538-1293	Spanish Language lines
Grays Harbor	CHOICE Regional Health Net.	Ask for BH assistance	PO Box 3466	Olympia	1-800-981-2123	Spanish
Island	Whidbey General Hospital	Cynthia ext. 7656 Kathy ext. 7601	101 N. Main	Coupeville	360-678-7656 360-678-7656	English Only
King	Community Health Access Prog.	Ask for a CHAP asst.	300 Elliott Ave.	Seattle	1-800-756-5437	Spanish
King	Alder Square Public Health	Suzette	1404 S. Central, #111	Kent	425-205-1936	Spanish, Toisanese, Cantonese
King	*Auburn Public Health (CHCKC)	Juana, Oksana, Llesenia	126 S. Auburn Ave., Suite 300	Auburn	253-735-0166	Spanish, Russian, Ukrainian
King	Auburn Public Health	Ask for BH Assistance	20 Auburn Ave.	Auburn	253-833-8373	Spanish
King	*Bothell Community Ctr. (CHCKC)	Shannon, Terri, Diana	10414 Beardslee Blvd.	Bothell	425-486-0658	Spanish
King	Columbia Health Center	Rosa, Ly	4400 37th Ave. S	Seattle	206-296-4650	Spanish
King	Comm. Health Ctr. Of King Cty.	Anna, Sylvia, Shannon	410 2nd Ave. S	Kent	253-372-3629 253-372-3840 206-372-3848	Russian Korean Spanish
King	Downtown Public Health	Ask for BH Assistance	2124 4th Ave.	Seattle	206-296-4755	English Only
King	Eastgate Public Health	Jaime	14350 SE Eastgate Way	Bellevue	206-205-8994	Spanish
King	*Eastside Comm. Health Center (CHCKC)	Otto, Job, Grisela	16315 NE 87th	Redmond	425-882-1697	Spanish
King	Evergreen Hospital	Lillia	12040 NE 28th St.	Kirkland	425-899-3250	Spanish
King	Public Health South King County Latino Outreach	Anel, Jair, Sharon	33431 13th Pl. S	Federal Way	206-296-9871	Spanish
King	*Federal Way Comm. Health Ctr. (CHCKC)	Juana, Monica, Lana, Chris	33431 13th Pl. S.	Federal Way	253-874-7634	Spanish, Russian, Ukrainian, Korean
King	*Kent Comm. Health Ctr. (CHCKC)	Griselle, Ang, Patricia, Elena	403 E. Meeker St., #200	Seattle	253-852-2866	Spanish, Russian, Cantonese, Ukrainian
King	Kent Teen Clinic	Suzette	613 W. Gowe	Kent	425-296-7450	Spanish, Toisanese, Cantonese

COUNTY	ORGANIZATION	CONTACT NAME(S)	ADDRESS	CITY	PHONE NUMBER (S)	LANGUAGES OTHER THAN ENGLISH
King	International Community Health Services	Ask for BH Assistance	720 8th Ave. S Suite 100	Seattle	206-461-3235	Chinese, Korean, Japanese, Tagalog Cantonese, Mandarin, Toisinese, Vietnamese
King	North Public Health	Pat	10501 Meridian Ave. N	Seattle	206-296-4990	English Only
King	Northshore Public Health	Ask for BH Assistance	10808 NE 145th	Bothell	206-296-9800	Spanish
King	*Renton Comm. Health Ctr. (CHCKC)	Julie, Francisco	138 S. Third Pl.	Renton	425-226-5536	Spanish
King	Renton Public Health	Jeanne	3001 NE 4th St.	Renton	206-205-1674	English Only
King	White Center Public Health	Theresa	10821 8th Ave. SW	Seattle	206-205-7242	Spanish, Vienamese, Cambodian
King	Roxbury Family Health Care	Patricia	9635 17th Ave. SW	Seattle	206-763-5057	Spanish
King	Puget Sound Neighborhood Health Centers-45th Street Clinic	Jose , Katherine Duque	1629 N. 45th Street	Seattle	206-633-7636	Spanish
King	Puget Sound Neighborhood Health Centers-Greenwood Medical Clinic	Sam, Frehewet	415 N. 85th Street	Seattle	206-782-8660 Ext: 107 for Amharic	Chinese Mandarin, Thai, Laotian, Amharic, Tigrigna
King	Puget Sound Neighborhood Health Centers-High Point Medical Clinic	Martha, Matthew	6554 32nd Avenue	Seattle	206-461-3955	Spanish, Vietnamese
King	Puget Sound Neighborhood Health Centers-Rainier Park Medical Clinic	Trinh , Zemen	4400 37th Avenue S.	Seattle	206-461-3708 ext: 135 or 136	ArabicVietnamese, Amharic, Tigrigna,
King	Puget Sound Neighborhood Health Centers-Rainer Beach Medical Clinic	, Aline , Matthew	8444 Rainer Avenue S.	Seattle	206-722-8444 ext: 131	French, Swahili,
King	*Sea Mar Clinic	Freida, Rosa, Maria, Raquel, Jose	8720 14th Ave. Se	Seattle	206-762-3730 206-764-0488	Spanish
King	Country Doctor Community Clinic	Janine	500 19th Avenue	Seattle	206-299-1627	English only
King	FMC	Carolyn	2101 E. Yesler Way	Seattle	206-299-1947	Spanish
Kitsap	Peninsula Community Health Services-Bremerton	Patient Resource Department	616 Sixth Street	Bremerton	360-475-3721	Interpreters, Language Lines
Kitsap	Peninsula Community Health Services-Port Orchard	Patient Resource Department	1950 Pottery, Lower Level	Port Orchard	360-475-3721	Language Lines
Kitsap	Peninsula Community Health Services-Pousbo	Patient Resource Department	19045 Hwy. 305, Suite 180	Poulsbo	360-475-3721	English, Interpreters, Language lines
Lewis	CHOICE Regional Health Net.	Ask for BH assistance	PO Box 3466	Olympia	1-800-981-2123	Spanish
Lincoln	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only

COUNTY	ORGANIZATION	CONTACT NAME(S)	ADDRESS	CITY	PHONE NUMBER (S)	LANGUAGES OTHER THAN ENGLISH
Mason	CHOICE Regional Health Net.	Ask for BH assistance	PO Box 3466	Olympia	1-800-981-2123	Spanish
Okanogan	Family Health Center-Brewster	Grace	525 J Street	Brewster	509-422-5700	Spanish
Okanogan	Family Health Center-Okanogan	Grace	716 First Avenue South	Okanogan	509-422-5700	Spanish
Okanogan	Family Health Center-Tonasket	Grace	106 S. Whitcomb	Tonasket	509-422-5700	Spanish
Okanogan	Community Choice	Janet	Okan-Douglas Dist. Hospital 507 Hospital Way	Brewster	1-888-452-0731	Spanish
Okanogan	Community Choice	Julie	North Valley Hospital 102 Western	Tonasket	1-888-452-0731	Spanish
Pacific	Family Health Center-Cowlitz	Arlene		North Beach	360-665-3000	Spanish
Pacific	CHOICE Regional Health Net.	Ask for BH assistance	PO Box 3466	Olympia	1-800-981-2123	Spanish
Pend Oreille	Health for All	Mona	295 N. Main	Colville	1-888-311-7394	English only
Pend Oreille	NE Washington Health Programs	Carrie	509 E. Main	Chewelah	509-935-6001	Spanish
Pend Oreille	Selkirk Comm. Health Ctr.	Ask for BH Assistance	208 Cedar Creek Terrace	Ione	509-732-4252	English only
Pierce	*Sea Mar Clinic	Marilinda	1112 S. Cushman Ave	Tacoma	253-593-2144	Spanish
Pierce	Comm. Health Care Downtown	Ilona, Diana, Alla	1102 S. “I” St.	Tacoma	253-597-3813	Spanish, Russian, Ukraine
Pierce	Comm. Health Care Eastside	Karen, Rosa, Sami	1720 East 44th St.	Tacoma	253-471-4553	Spanish, Vietnamese, Cambodian
Pierce	Comm. Health Care Lakewood	Young, Diana	9112 Lakewood Dr. SW R203	Tacoma	253-589-7030	Korean, Spanish
Pierce	Comm. Health Care McKinley	Alla, Rafael	3418 East McKinley	Tacoma	253-404-0737	Russian, Ukraine, Spanish
Pierce	Comm. Health Care Parkland	Chung, Rafael	11225 Pacific Ave.	Parkland	253-536-2020	Korean, Spanish
Pierce	Comm. Health Care Sumner	Tara, David	1110 Fryar Rd.	Sumner	253-863-0406	Spanish
Pierce	Comm. Health Care Tillicum	Toni	14916 Washington Ave. SW	Lakewood	253-589-7027	Spanish
Skagit	*Sea Mar Clinic	Raquel	1400 Laventure	Mt. Vernon	360-428-4075	Spanish
Snohomish	*Sea Mar Clinic	Adriana	9710 State Ave	Marysville	360-653-1742	Spanish
Snohomish	Comm. Health Ctr. Of Snohomish County (CHCSC)	Diana	1410 Broadway	Everett	425-258-1830	Spanish
Snohomish	Comm. Health Ctr. Of Snohomish County (CHCSC)	Thelma	8609 Evergreen Way	Everett	425-347-7797	Spanish
Snohomish	Comm. Health Ctr. Of Snohomish County (CHCSC)	Nancy	4111 194th St. SW	Lynnwood	425-775-2589	English only
Spokane	Health For All	Ask for BH Assistance	421 W. Riverside, Suite 353	Spokane	509-444-3066	English only
Spokane	Comm. Health Assoc. of Spokane	Beth	238 W. Sprague	Spokane	509-835-1205	English only
Spokane	Comm. Health Assoc. of Spokane	Lisa	4001 N. Cook	Spokane	509-487-1604	Spanish
Spokane	Comm. Health Assoc. of Spokane	Christine	9227 E. Maine	Spokane	509-444-8200	English only
Spokane	Comm. Health Assoc. of Spokane	Sue	3919 N. Maple	Spokane	509-444-7801	English only
Stevens	Health for All	Mona	295 N. Main	Colville	1-888-311-7394	English only
Stevens	NE Washington Health Programs	Carrie	509 E. Main	Chewelah	509-935-6001	English only

COUNTY	ORGANIZATION	CONTACT NAME(S)	ADDRESS	CITY	PHONE NUMBER (S)	LANGUAGES OTHER THAN ENGLISH
Stevens	Chewelah Comm. Health Ctr.	Ask for BH Assistance	518 E. Clay	Chewelah	509-935-8424	English only
Stevens	Loon Lake Comm. Health Ctr.	Ask for BH Assistance	3994 Colville Rd	Loon Lake	509-233-8412	English only
Stevens	Northport Comm. Health Ctr.	Ask for BH Assistance	411 Summit	Northport	509-732-4252	English only
Stevens	Springdale Comm. Health Ctr.	Ask for BH Assistance	105 N. 2nd	Springdale	509-258-4234	English only
Thurston	CHOICE Regional Health Net.	Ask for BH assistance	PO Box 3466	Olympia	800-981-2123	Spanish
Thurston	*Sea Mar Clinic	Liz	130 Marvin Rd. SE	Olympia	360-491-1399	Spanish
Walla Walla	*Yakima Valley Farm Workers Clinic	Ask for BH Assistance	1120 W. Roe	Walla Walla	1-800-957-9696 509-525-6650	Spanish
Whatcom	*Sea Mar Clinic	Kristi	4455 Cordata Pkwy.	Bellingham	360-671-0000	Spanish
Whatcom	*Sea Mar Clinic	Norma	6884 Hannegan Rd.	Everson	360-354-7667	Spanish
Whatcom	Interfaith Community Health Center	Jeanne	809 E. Chestnut St.	Bellingham	360-676-6177 ext. 107	English only
Whitman	Health For All	Ask for BH Assistance	421 W. Riverside Suite 353	Spokane	1-866-444-3066	English only
Yakima	Yakima Neighborhood Health Services-Yakima	Annette	12 S. Eighth Street	Yakima	509-454-4143	Spanish
Yakima	Yakima Neighborhood Health Services-Sunnyside	Annette	614 E. Edison	Sunnyside	509-454-4143	English, Spanish
*Yakima	Yakima Valley Farm Workers Clinic	Ask for BH Assistance	518 W. 1st Ave.	Toppenish	1-800-957-9696	Spanish
All Counties	Statewide Health Insurance Benefits Advisors (SHIBA)	Ask for BH Assistance for transition population	Statewide	Statewide	1-800-397-4422	Interpretive services available