WASHINGTON STATE PLANNING GRANT
ON
ACCESS TO HEALTH INSURANCE

REPORT to the SECRETARY

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Making Health Care Work for Everyone

Washington State
HRSA State Planning Grant on Access to Health Insurance
Report to the Secretary: 2003 Continuation Grant

EXECUTIVE SUMMARY

Washington's State Planning Grant Program

Washington received its first State Planning Grant (SPG) in March 2001.[1] Two continuation grants (in 2002 and 2003) have created an enduring spotlight in the Governor's Office on the uninsured.

Consistent with federal program goals of profiling the uninsured and supporting efforts to develop health insurance coverage options, Washington's SPG has focused on four areas:

- *"launching pad" research* (e.g., identify gaps, overlaps and barriers to coverage based on detailed profiles and affordability analyses; stimulate discussion by articulating a set of potential policy options for enhancing coverage);
- *technical data improvements* (e.g., address "Medicaid undercount" issues in the state population survey; integrate coverage and access data sources; minimize incorrect use of survey data);
- *neutral, expert resource and "voice"* on Washington's uninsured (e.g., act as clearinghouse to answer questions on the uninsured and who's doing what to address various issues; raise level of understanding and influence thinking in Governor's policy and budget offices); and,
- *policy and evaluation assistance* on coverage- and access-related activities (e.g., impacts of public program cost-sharing changes; Governor's rural access package; community development of low-income coverage strategies; safety net and public program dependencies; impacts of proposed policy changes on employer coverage offerings).

A history of Washington's SPG program is given in Figure ES-1.

In the remainder of this executive summary we: (1) review Washington's economic and political environment, (2) provide an update on covering Washington's uninsured, and (3) preview the content of our Report to the Secretary.

An Environment for Change?

Washington's SPG program has existed during challenging times. Simultaneous with receipt of the initial grant in 2001, Washington's economy and state budget were hit hard by recession. In fact, within days of receipt of the grant we got an inkling of things to come – an inquiry from legislative staff wondering if we'd lost our marbles talking about coverage expansion when the state couldn't afford to cover people already on its programs![2]

Three-plus years later the economy is looking up. For example, the state's latest forecast indicates a small increase in revenue available to the 2004 Legislature as it decides the 2005-07 biennial budget. However, least we get too optimistic the 05-07 general fund budget deficit is still pegged at around $1.1 Billion dollars[3]. In addition, the state's Health Services Account (HSA), which funds many of

[1] The State Planning Grant program is funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration, Bureau of Professions.
[2] It is interesting that the assumption made was that coverage expansion would automatically mean public program expansion.
[3] As of July 2004, the Governor's Office of Financial Management was estimating revenue of $24.75 billion and expenditures of $25.85 billion for the 2005-07 biennium. These numbers are constantly being reworked and are solely intended to give an "order of magnitude" sense of status.

Washington's health coverage and access programs, is also projected to be in the red – the current estimate is a deficit of over $80 million for 05-07.

On the employment side, things are improving as well, but somewhat slowly. After recession high unemployment rates above seven percent, Washington's 2004 rate (August) is just over six percent. Again, least we get too optimistic it's probably not safe to assume that as jobs return coverage will necessarily return with them. Consider the potential implications of the following combination of factors: (1) a continuous decline in employer-based coverage in Washington for the last 10 years, (2) the changing face of employment as full-time jobs give way to contract, multiple-employer, part-time, and often lower-paying jobs[4] that frequently don't include health insurance, and (3) the continuing pressure of health care inflation that makes it increasingly difficult for employees to take-up the coverage offered by their employers.

On the political front, the previous environment for the SPG has been relatively free of major upheavals; where changes have occurred they often have been overshadowed by the dire condition of the economy and state budget. However, in the future we will be working in a changed political context. In January 2005 Washington will have a new Governor. Both major party candidates highlight health care in their campaigns, although with different areas of emphasis and different perspectives on what is needed to address the growing number of uninsured Washingtonians. In addition to a new Governor, there potentially will be new faces, philosophies, and leadership in the Legislature as all members of the House and one-half the Senate are up for election in November 2004.

Needless to say, the challenges and opportunities to meet the Washington SPG program goals of "making health care work for everyone" and "covering the uninsured" continue.

Coverage Update: A Leader Falters[5]

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working (Basic Health) and for children and their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention). Coverage steadily increased.

More recently, Washington has lost ground. The state's overall uninsured rate rose from 7.7% in 2000 to 8.4% in 2002. Coverage via an employer has steadily eroded for the under-65 population, dropping from 70.9% in 1993 to 66.5% in 2002. Coverage for children has taken a turn for the worse. Although 2002 data show an impressively low uninsured rate for children (0-18) of 4.5%, public program changes since 2002 have altered the picture. Estimates of the number of children who have lost coverage vary but are in the thousands and we presume (although don't know for sure) that many of these children are now uninsured. Responses to the 2004 state population survey

[4] Notwithstanding that definitions of "living wage" can be argued, one recent source finds that "Of all job openings [in Washington], 26 percent pay less than the $10.07 an hour living wage for a single adult. Seventy-seven percent pay less than the $20.97 an hour living wage for a single adult with two children." *Searching for Work That Pays: 2004 Northwest Job Gap Study*, Northwest Federation of Community Organizations and Paul Somers, 2004 .

[5] Figures cited in this section are primarily from the 2000 and 2002 Washington State Population Surveys.

are currently being cleaned and coded; data will be available in late Fall to better assess the current status of coverage.[6]

Given the environment described earlier, state policy vis-à-vis coverage has focused most recently on (1) maintaining existing public programs for the most vulnerable, (2) providing a supportive environment for employers to offer coverage and individuals to purchase it, and (3) assisting the clinic-based safety net system with funds and regulatory support. Notwithstanding these efforts, people unfortunately have still lost coverage, most notably in public programs – immigrant children were moved from Medicaid to Basic Health and did not re-enroll as hoped, Basic Health coverage slots were decreased and funded by dollars intended (via a citizen's initiative) for expansion, Medicaid administrative changes resulted in much larger than anticipated exits of children, major changes to Basic Health cost-sharing (including deductibles and co-insurance) were implemented (evaluation of impacts is underway).

However, there also have been a few recent "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, resolving an individual market collapse, forestalling a small group market "affordability" crisis, and Governor Gary Locke's decision to delay until July 2005 premiums for some Medicaid children (those below 200% federal poverty); although children in SCHIP (201% - 250%) saw an increase in premium sharing effective July 2004.

All in all, the mixture of Washington's progressive social policy, conservative fiscal policy (e.g., 1993 passage of spending cap), and recent economic downturn has produced a current "health system for low-income individuals [that] seems to be in a fairly fragile state".[7]

The irony of working on a grant to achieve broader coverage, simultaneous with watching the uninsured rate increase, does not escape us. It has been an on-going challenge.

Lessons from SPG's Three Years

While we have learned many "factual" things (which are the focus of our report) over the last few years of the SPG, we want to embrace this opportunity to make the following "value-based" observations.

- Our most important lesson as we researched, discussed, and debated covering the uninsured and did so during a prolonged period of state recession and increasing health care costs is this: ***If we fail to reserve during the good times the financial resources to maintain and enhance public funding and programs during the bad times we have failed our residents most miserably.*** It is during times of economic downturn that government assistance is most needed, not only for those traditionally defined as most vulnerable but also for those who find themselves in temporary, but nonetheless devastating need.

[6] The state population survey captures insurance status at a point in time. There are various accepted, but different, ways of measuring how many people are uninsured – point in time, for an entire year, during any time period within a year (or over several years). The array of numbers can be mind-boggling and it often appears that much time is spent searching for the number that supports a position. Perhaps the most useful point of view is this: All estimates are wrong, some are useful, most tell a consistent and compelling story about the level (or lack thereof) of access to coverage.

[7] Holahan, John and Mary Beth Pohl. 2002. "*Recent Changes in Health Policy for Low-Income People in Washington*." Washington, D.C.: The Urban Institute. The quote used is as true today as it was when Holahan & Pohl wrote it.

- Second, we suggest a restatement of the end-game – the end-game is not about insurance, it is about a healthy, productive (in all respects, not just economically) population. In this latter view, everyone benefits -- communities, governments, businesses, individuals -- and the discussion centers on where to draw the line between ***what in health care is a social good for which we take societal responsibility (such as we do in basic education) and what in health care is a "commodity" to which some people may have access and others may not.***

- Finally, even if there is no universally acceptable one-size fits all solution[8], there certainly are some "truisms" that repeat themselves time and again. One of the most persistent is that low-income people need substantial subsidies in order to afford coverage that offers any reasonable measure of health and financial security. Aligned with this, due in large part to the subsidy issue, is that public programs are very effective in meeting the coverage needs of the low income. Washington has already made consistent *policy* decisions regarding who needs help: adults to 200% and children to 250% of federal poverty. ***Surely, if it is the right policy decision then it should also be the right budget decision – to search out all who are eligible, subsidize their coverage, and reduce the number of uninsured in Washington by over two-thirds.***

Report Preview

The remainder of this Report to the Secretary is organized as requested. In Sections 1 –3 we discuss data collection and analysis activities related to profiling uninsured individuals and families, employer-based coverage, and Washington's health care market place. During this last grant cycle we spent considerable time updating our information on the uninsured based on 2002 State Population Survey data. There were few surprises from what the 2000 data showed – Washington's uninsured are members of working families, and are poor, young, and often without dependent children. There continue to be disparities in coverage, with the highest rates occurring among Hispanics and American Indians/Alaskan Natives. Middle-income families are feeling the pinch and make up a significant segment of the uninsured population. As noted earlier, we are somewhat skeptical that the low rate of uninsurance for children reflects current reality given changes to public programs that occurred post the 2002 survey. We are looking forward to seeing what the 2004 survey results will show.[9]

[8] There are multiple ways to slice and dice the uninsured population, a necessary exercise when focused on incremental, targeted strategies. A recent list includes "employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near-elderly, young adults, children, and immigrants". Dorn, S. *Towards Incremental Progress: Key Facts About Groups of Uninsured*. Economic and Social Research Institute, September 2004.

[9] Given the consistency over time of the story (if not the numbers) about who the uninsured are and their circumstances, it's fair and logical to question the usefulness of continually updating this information. We would argue its importance for two reasons: (1) what gets measured, gets changed. (2) "It is the health policy analogue of permanent military preparedness" – when policy makers are ready to act, policy analysts must be ready with up-to-date information to support breakthrough thinking. Reinhardt, U. *Is There Hope for the Uninsured?,* Health Affairs Web Exclusive, August 27, 2003.

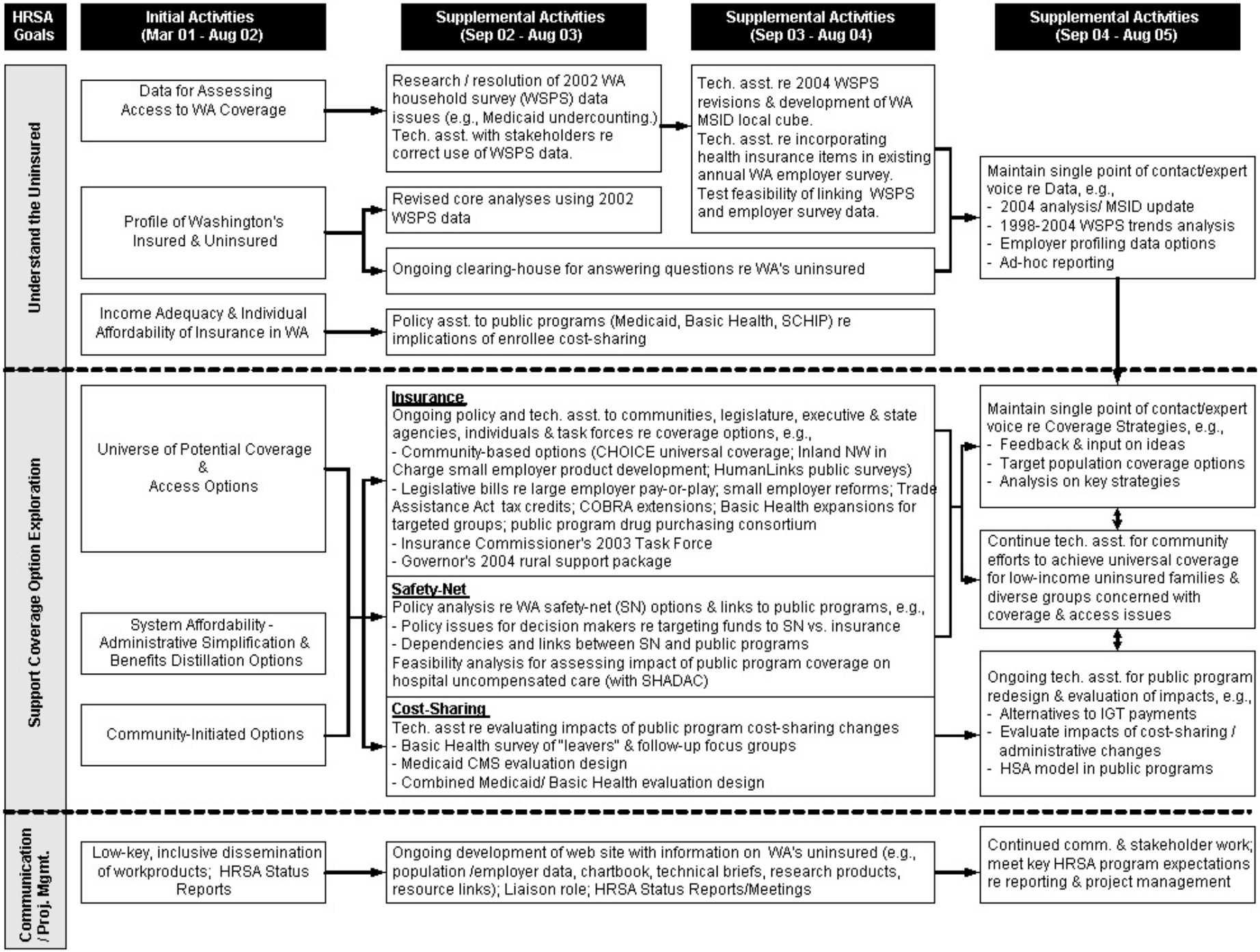
In Section 4 we describe a select set of coverage and access activities conducted largely in 2003-04 and for which State Planning Grant (SPG) support has been important. Much of our work has been of a support nature and is somewhat difficult to capture succinctly – answering a myriad of ad-hoc questions, participating in policy and design discussions organized by a variety of groups, creating a "presence" in the executive branch to ensure that Washington's uninsured aren't lost in the shuffle of budget deficits. We do our best to show the essence of our support role but the exactness is somewhat elusive. First, we describe coverage options that have risen to the top of the *state policy* agenda (see side box). Next, we provide examples of *other activities* in Washington related to coverage and access. Finally, we highlight select examples of SPG supported work (community-based efforts; work to assess the impacts of cost-sharing changes in public programs; activities to enhance or better understand rural and safety net access; on-going administrative simplification efforts).

State Policy Agenda Most Aligned with "Covering the Uninsured"

- Cover all children
- Small employer assistance
- Employer coverage responsibilities
- Stabilize the private market
- Redesign public programs

The last section of our report is a review of our communication strategy, noting important messages about covering the uninsured. During this last grant cycle we focused significant effort on redesigning our website (our main communication tool) to make it more user friendly and, importantly, to integrate it into existing state sites as a means to ensure "life after the grant".

Figure ES-1: A HISTORY OF WASHINGTON'S STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE



SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Although rates of uninsurance have varied over time, the typical profile of Washington's uninsured individuals and families remains fairly constant. They are members of working families, they are poor, young, many do not have dependent children; they are less healthy than the insured; and, regional and racial disparities are apparent. Not surprising, this picture generally mirrors the story conveyed by national surveys for most states and the nation, including reports by the United States Census Bureau[1] in August 2004. The new twist (from what we see in our historical data) is that middle-income families make up a fast growing segment of the uninsured population.

Like other states, Washington is losing ground. Although the 1990's witnessed broad success from our public coverage strategy with rates of uninsurance declining steadily for all age groups (Figure 1-1), that is now changing. With the widespread economic downturn that took hold in 2001, public program changes and steady erosion of employer-sponsored insurance have reversed the trends and uninsurance rates have begun to creep up. While the number of people with health insurance has increased more than the number without (Table 1-1), the net result since 2000 has been an increase in the proportion of the population uninsured. The uninsured rate for the total population increased from 7.7% in 2000 to 8.4% in 2002 (i.e., from about 453,000 to just over 506,000 individuals). Most people are covered by a health insurance plan related to employment, however, coverage via an employer has slowly but surely decreased for the under age 65 group, dropping from 70.9% in 1993 to 66.5% in 2002 (Figure 1-2.) Coverage for children has also taken a turn for the worse. Although 2002 data show an impressively low uninsured rate for children (0-18) of 4.5%, public program changes since 2002 have altered the picture. Estimates of the number of children who have lost coverage vary but are in the thousands and we presume (although don't know for sure) that many of these children are now uninsured. Responses from the 2004 Washington State Population Survey (WSPS) are currently being coded; data will be available in late Fall to better assess the current status of coverage.

In the following sections we describe a set of profiling activities conducted largely in 2003-2004 and for which SPG support has been essential. Our initial analysis of the uninsured provided a demographic snapshot as of 2000[2] and set a baseline for understanding who has insurance in Washington and who doesn't. More recently we focused our efforts on replicating and refining that analysis with 2002 data to build an ongoing profile of the uninsured. We have included a selection of charts and graphs[3] to help describe the characteristics of Washington's uninsured. As with much of our recent work our profiling activities have been of a supportive nature, answering questions about the uninsured and the availability and appropriate use of data sources (local data in particular), and participating in (and often instigating) efforts to improve the collection and use of local data. We have tried to capture this "clearinghouse" role for data on Washington's uninsured; it has been a challenge.

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[1] DeNavas et al. 2004. Income, Poverty, and Health Insurance Coverage in the United States: 2003. US Census Bureau. The Census reports confirm that Washington is one of six states in the west (Alaska, Oregon, Washington, Montana, Idaho and Nevada) continuing to experience an increase in uninsurance rates.

[2] Analysis of individuals and families was primarily based on information collected biennially by Washington's State Population Survey. Results from the 2004 survey will allow comprehensive analysis over an 8-year span. Detailed information and data on all surveys are available at: http://www.ofm.wa.gov/sps/index.htm

[3] This report includes information specifically requested by HRSA. Further highlights and a more extensive array of charts, graphs and data on the uninsured are available via pull down menus on the grant project web site, http://www.ofm.wa.gov/accesshealth/accesshealth.htm

A. Profile of Washington's Uninsured Population:
Over 99% of Washington's uninsured population is under age 65. The group age 65 and older is predominantly covered by Medicare. Many live in institutions and are not included in the WSPS survey, and responses from those who are surveyed describe characteristics of this population that appear inconsistent with our administrative data. Consequently, while we continue to look for ways to improve data for the age 65 and older population, the under age 65 group has been the focus of our analysis.

Age:
Uninsurance rates vary considerably by age. Rates for children under age 19 declined from a high of 11.4% in 1993 to 4.5% in 2002, just over 73,000 children in 2002 (Figure 1-1). Rates for adults age 19-64 also declined from a high of 14.0% in 1993 to 10.0% in 2000 but then increased since 2000 to 11.5% in 2002 (Figure 1-1). Public program changes since 2002 have likely altered the picture for children and exacerbated the picture for adults – we expect 2004 WSPS data to show increased rates of uninsurance for all age groups. For example, estimates of numbers of Medicaid children who have lost coverage since summer 2002 vary; however most estimates put the number around 45,000. While some of these children have since returned to Medicaid, and a few have enrolled in Basic Health, we believe that many of them remain uninsured. The 2004 WSPS interviews were conducted in April 2004 and will likely capture the essence of changes in public program coverage.

To gain a more comprehensive picture of the uninsured we looked within these broad age groups to identify sub-groups who are disproportionately uninsured.

Since 1998, young adults aged 19 to 34 have made up the largest proportion of the uninsured, close to 45% of those uninsured under age 65 in 2000 and in 2002 (Figure 1-3.) (About 224,000 individuals). The rate of uninsurance also has steadily increased for this group. **By 2002, young adults were more than three times as likely to be uninsured as were children** (Figure 1-4) in spite of wide access to employer coverage described in section 2. Consistent with the recent release of Census data by DeNavas et al, children's gains in coverage to 2002 were more than matched by these young adults' coverage losses. Adults aged 35-54 make up the next largest segment of the uninsured. The combined group of adults age 19-54 who typically comprise the bulk of the work force now make up close to 80% of the uninsured under age 65.

National studies [4] also indicate that young adults (age 19 to 29) are one of the largest and fastest-growing segments of the population without health insurance. In Washington, although this group comprises only 16% of the under age 65 population, it makes up 36% of the uninsured. At age 19, these young adults often lose coverage under their parents' policies or are no longer eligible for Medicaid/SCHIP programs. Those that remain covered under their parents' policies while they attend college are often uninsured for a period of time immediately following graduation.

About **15% of the uninsured under age 65 are children** (Figure 1-3, 2002). Up until 2002 the distribution of uninsured children remained stable among infants, preteen school age children, and teenagers. With the decline in numbers of uninsured children in 2002, that distribution changed. The greatest reduction in uninsurance rates was felt among infants (dropping from 4.5% in 2000 to 3.3% in 2002) and teenagers in particular (dropping from 6.3% in 2000 to 4.8% in 2002). As a result, the group of children age 6-12, which changed little in sheer numbers, became a larger

[4] For example, Sara Collins et al. 2004. Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help. *The Commonwealth Fund.* Can be retrieved at www.cmwf.org

portion of uninsured children, increasing from almost 38% to 44% (Figure 1-5). **Over 75% of uninsured children are school age,** about 57,000 in 2002 (Table 1-1.) Furthermore, although uninsurance rates for all children's age groups have declined progressively since 1998, **the likelihood of being uninsured increases as children reach school age** (Figure 1-6). This is consistent with cut-off points for public programs that focus on coverage for infants. In 2002, the uninsurance rate for infants under age 6 was 3.3%, while rates for school age children moved closer to 5%.

Family Income:

Family income remains a persistent underlying factor in the uninsurance rate and for the source of insurance for those who are insured. About 58% of the uninsured are members of families with incomes up to 200% of federal poverty[5] (Figure 1-7) although this group represents less than 30% of Washington's under age 65 population. Families with incomes over 400% of federal poverty represent 44% of the population under age 65 but less than 15% of the uninsured. This disparity has remained fairly consistent in spite of the potential availability of public programs for adults with family incomes up to 200% of federal poverty and for children in families with incomes up to 250% of federal poverty. In both 2000 and 2002 more than 75% of the uninsured were in families earning less than 300% of federal poverty ($54,300 for a family of four in 2002).

The likelihood of being uninsured has increased at almost all income levels, an indication of the impact of Washington's economic downturn in recent years, the corresponding increase in unemployment, and changes made in the funding of health care to help address a fiscal gap of $2.7 billion in a budget of $23 billion. While the likelihood of being uninsured clearly declines with income, **upper income families (over 400% of federal poverty) and lower-middle income families (between 200% and 300% of federal poverty) are the fastest growing segments of the population without health insurance** (Figure 1-8). Lower-middle income families are the most likely to be feeling stressed given a 30% increase in their rate of uninsurance, 5 times the rate of increase in the poorest families (up to 200% of federal poverty) who are traditionally supported by public programs. Although changes in public programs have resulted in a loss of coverage for some families, public programs have clearly dampened the effect of the economic downturn on the lowest income families. But, many lower-middle income families are virtually one "pink slip" away from being uninsured.

The priority Washington has placed on ensuring that children have access to health insurance is clearly evident in the variation in source of coverage by income. Close to 70% of children in low income families, up to 200% of federal poverty, have consistently been covered through public programs (Figure 1-9). For children in higher income families public programs play a minor role and employer based insurance covers about 80% of these children. With Medicaid, SCHIP and Basic Health programs available as potential coverage options for children in families up to 250% of federal poverty, it is somewhat surprising that in 2002 and even in 2000, children in low income families were actually more likely to be uninsured than all children. In 2002, low income children had an uninsurance rate of 6.2% (about 40,000 individuals) compared with higher income children whose rate of uninsurance was 3.4% (about 33,000 individuals) (Figure 1-9 and Figure 1-10).

[5] Federal poverty guidelines are a federal measure of poverty issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). In 2002, the poverty level was defined as an income of $8,860 for the 1st member of a family plus $3,080 for each additional family member (i.e., for a family of four, the federal poverty level was $18,100.) A description of federal poverty measures is available at: http://aspe.hhs.gov/poverty/01poverty.htm. Specific federal poverty guidelines from 1982 to 2004 are available at: http://aspe.hhs.gov/poverty/figures-fed-reg.shtml.

Figure 1-10 shows that **if all children potentially eligible for public programs were enrolled, about 68% of uninsured children would be insured** (over 49,000 individuals). This is important because many studies[6] show that lack of insurance coverage negatively affects access to care among low income children. Uninsured but Medicaid eligible children are twice as likely as those enrolled in Medicaid to have an unmet medical need and to have not seen a doctor. To close the gap in access to health care for children, **ensuring that public programs cover all potentially eligible children would leave only 1.5% of all children uninsured**.

Furthermore, if there were no funding or enrollment limitations on public programs, we estimate that about 243,000 more adults would be potentially eligible for coverage; over 60% of whom could join the Basic Health program. Adding children to the mix, **about 58% of the uninsured under age 65 could potentially be covered under current public programs** (292,000 individuals).

Gender:

Among children (under age 19) and adults, the likelihood of being uninsured is greater for males than females, however, of all groups male adults are the most likely to be uninsured. A little over 13% of male adults are uninsured whereas just over 9% of female adults are uninsured (Figure 1-11). This discrepancy is further evident in the gender distribution of the under age 65 uninsured population. Public programs have been so effective in reaching women and children in particular that **male adults now make up 50% of the under age 65 uninsured population** (just over 250,000 individuals). However, likely as a result of public program changes, the number of uninsured female adults actually increased at a faster rate than males, almost 20% for females compared with just over 18% for males.

Health Status:

Individuals who report that they are in excellent or very good health are about half as likely to be uninsured as individuals who are less healthy (Figure 1-13). This supports the growing body of literature suggesting that although insurance doesn't guarantee access to health care it remains an important vehicle. When health status is aligned with source of insurance it appears that healthier pools of individuals tend to be covered by employer-based and individual markets products (Figure 1-14) and less healthy pools are either covered by public programs or are uninsured.

Family Composition:

Given public programs emphasis on covering children and their parents, it's not surprising to find that young adults age 19 to 34 without dependent children[7] make up a large portion of the uninsured (approximately 25% of all uninsured; approximately 30% of uninsured adults). The public program targeted to low income adults, Basic Health, has been unavailable to many of them as a result of limits on enrollment driven by public program funding challenges. Approximately **half the uninsured under age 65 are adults without dependent children** (around 250,000 individuals) (Figure 1-15).

At most levels of family income, adults without dependent children make up the largest portion of the uninsured, but this is particularly evident in families with incomes over 300% of poverty (Figure 1-16). In the highest income families, (those over 400% of federal poverty) close to two-thirds of the uninsured are adults without dependent children.

[6] Dubay, L. et al. 2001. Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children. *Urban Institute*.

[7] Legal guardians of children, including grandparents, are recognized as parents for analyses of the relationship between children, their parents and their uninsurance status.

From our initial SPG research we found that a **key factor in predicting the insurance status of children is the insurance status of their parents**; only 2% of children with an insured parent were uninsured. In 2000 and in 2002, **over 60% of uninsured children in Washington had uninsured parents**. As discussions continue to focus on options for covering children, understanding patterns of uninsurance in families with children is clearly a critical issue. While we have not been able to examine these patterns in our recent work, we plan to conduct more targeted analysis of families with children once 2004 WSPS data are available.

In these families we are also interested in further understanding the relationship between family coverage and use of health services. National studies [8] find that parents' use of health services strongly influences their children's use of health services**.** Parents who are insured are more familiar with systems, and especially when covered by the same insurance as their children, they are more effective advocates for their family's care. When parents are uninsured they are more likely than insured parents to delay or forgo getting care for themselves and their children. Although changes in public program eligibility over the past 15 years have generally enhanced access to coverage, they have created a situation in many low-income families where not all members are eligible and where coverage differs for different age groups. While ensuring coverage for children continues to be an accepted public priority, **neglecting to insure their parents may have the unintended effect of reducing the impact of insurance for children**.

Employment Status:

In 2000, close to 75% of the uninsured (341,000 individuals) were members of families in which at least one adult was working (Figure 1-17). In 2002, that pattern continues, in spite of Washington's economic challenge and steady ranking for unemployment among the top three states. **Close to 70% of the uninsured under age 65 (348,000 individuals) are found in families with one or more workers** (Figure 1-18).

In a nation in which health insurance is typically financed by employers (see Section 2), the importance of having workers in a family is striking – to gain access to coverage and to support the financial ability to afford coverage. In 2000, before we felt the impact of the recession, the uninsurance rate among families with no workers was close to five times the rate in families with two or more workers. Although that gap closed in 2002, the uninsurance rate in families with no workers remained at least double the rate in families with one worker and more than three times the rate in families with two or more workers (Figure 1-19). This is consistent with studies that connect rising unemployment rates with related loss of health insurance. For example, Lambrew[9] determined that the rate of uninsurance among unemployed adults is nearly three times the rate in the general population.

Race/Ethnicity:

As is shown in national studies, Washington's uninsured population has historically been predominantly White. Results from each WSPS since the inception of the survey, show that around

[8] Sample studies that confirm this picture on a national level include: Davidoff, A. et al. 2001. Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions. *Urban Institute*. Assessing the New Federalism, Series B, No. B-39, November 2001; Hanson, Karla. 2001. Patterns of Insurance Coverage Within Families with Children. *Health Affairs*, 20(1):240-246; Dubay, L. et al. 2001. Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children. *Urban Institute;* Kaiser Commission on Medicaid and the Uninsured. 2002. Enrolling Uninsured Low-Income Children in Medicaid and SCHIP. Fact Sheet #2177-03.

[9] Lambrew, Jeanne. 2001. How the Slowing U.S. Economy Threatens Employer-Based Health Insurance, *The Commonwealth Fund.*

73% of the uninsured are White, (close to 372,000 individuals in the 2002 survey) (Figure 1-20). Hispanics account for about 14% of the uninsured and other groups, Black, American Indian/Alaskan Native and Asian/Native Hawaiian are between 3 and 5% each.

The likelihood of being uninsured is highest for Hispanics and American Indian/Alaskan Natives and these groups have historically remained disproportionately uninsured (Figure 1-21). While the percent of Whites that are uninsured has remained steady at around 8-9%, rates among the other groups have fluctuated in recent years. This variation reflects standard issues in the collection of race and ethnicity data that affect the reliability and comparability of the data over time: how people report and how the data are coded[10]. But it is important to not get sidetracked by these data issues. Regardless of the data noise, the fundamental message is the consistent insurance disparity for Hispanics and American Indian/Alaskan Natives.

Immigration Status:

Although non-citizens are nearly twice as likely to be uninsured as citizens, in sheer numbers citizens have historically made up the bulk of the uninsured. As might be expected, some survey respondents are reluctant to divulge their immigration status. In 2002, they represented less than half a percent of the uninsured and therefore do not impact the message. In 2002, citizens made up over 94% of the uninsured (approximately 472,000 individuals, Figure 1-22) while they comprised about 96% of the total population under age 65. Non-citizens made up almost 6% of the uninsured (28,000 individuals) and almost 4% of the total population under age 65.

Education:

National studies have shown that the presence of a college degree is positively related to income and is associated with employment in certain sectors and types of jobs that are more likely than others to include a health insurance benefit[11]. The rate of uninsurance for adults without a high school degree is about 4.5 times as high as the rate with a college degree and nearly three times as high as the rate with some college education (Figure 1-24). Our initial SPG research indicated that this discrepancy is likely not as striking as it seems. When income and other factors were controlled for, rates of insurance improved less dramatically with increasing education, and the adjusted rate for individuals without a high school degree was only twice as high as the rate with a college degree. These differences are likely related to economic opportunities more available with higher education levels.

Of interest in Washington as a potentially insurable group is the sub group of students who attend university or college and are uninsured. Depending on the data source we estimate between 33,000 and 47,000 uninsured students at 4-year universities and community and technical colleges[12]. Anecdotal comments suggested that students who were uninsured had access to an on-site clinic for needed services, were typically healthy and simply could not afford health insurance.

---

[10] In asking survey respondents to identify their race, WSPS, like the Current Population Survey (CPS), offers respondents the option of choosing one or more races, which are then recoded to identify a primary race. Hispanic origin is reported separately, reflecting an ethnic heritage rather than a racial group. An individual can therefore be both White and Hispanic, Asian and Hispanic, Native American and Hispanic. In our analysis of race/ethnicity the Hispanic category includes all individuals that identified their ethnicity as Hispanic, regardless of their chosen race.

[11] Gabel, Jon. 1999. Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny. *Health Affairs* 18(6):62–74.

[12] From projected 2002 student figures we estimated that there might be about 14,000 4-year college students and 33,000 community and technical college students uninsured at some time in 2002. Based on self-reported student status available in WSPS 2002 we estimated that just over 10,000 4-year college students and just over 22,000 community and technical college students were uninsured.

Geographic Location / Region:
WSPS divides Washington state into eight geographic regions. Regions (underlined) and counties within each are as follows:

Mostly Urban: • Clark: Clark • Other Puget Metro: Kitsap, Pierce, Snohomish, Thurston • King: King
Mixture of Urban and Rural: • Spokane: Spokane
Mostly Rural: • West Balance: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum • Yakima-Tri-Cities: Benton, Walla Walla, Yakima • North Puget Sound: Island, San Juan, Skagit, Whatcom • East Balance: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Whitman.

In general, as in 2000, rates of uninsurance are lower in the more urban regions of the state; the lowest uninsured rates occuring in Clark County (7.1%), King County (7.4%) and the Other Puget Metro region of Thurston, Pierce, Kitsap and Snohomish Counties (8.7%) (Figure 1-25). The "West Balance" region, which represents most rural Western Washington counties, has the highest uninsured rate at 14.3% in 2002. Uninsurance rates are also relatively high in Eastern Washington, especially in the most rural counties (excluding the more metropolitan areas of the Spokane and the Yakima-Tri Cities regions). These discrepancies are largely due to economic and demographic factors that result in typically higher rates of uninsurance in rural than urban areas. However, from 2000 to 2002 many parts of the Puget Sound area saw dramatic increases in the rates of uninsurance; the West Balance region with a 49% increase and the Other Puget Metro region with a 33% increase.

The dominance of employment as a source of coverage continued in all regions (Figure 1-26), with the higher rates of employer coverage in the more urban regions of Clark (75%), King (72%), and Other Puget Metro (69%).

As expected, public coverage continued to play a more prominent role in the more rural regions where seasonal and temporary employment are often concentrated. Public programs covered just over 30% of the under age 65 population in the East Balance region, and just under 29% in the North Puget Sound and Spokane regions. Rates of uninsurance in 2002 were dampened in some regions by large increases in public coverage; the North Puget Sound (51%) and King County (33%) regions in particular; and by increases in employer-based coverage in the Tri-Cities region (23%).

Reasons for Uninsurance:
The reasons people typically give for not having health insurance (in national as well as in our state household survey) are:

- **Insurance is unaffordable**. Overwhelmingly this is the reason given for not having health insurance. Research conducted during the initial phase of our grant showed that in Washington, many families cannot afford to buy private coverage unless their incomes are above 250% of federal poverty (see http://www.ofm.wa.gov/accesshealth/research/33affordability.pdf).

- **Employer doesn't offer**. In some cases the employer offers coverage but the person is ineligible (e.g., may be part-time, seasonal, hasn't worked for the company long enough).
- **Unemployed or in-between jobs**.
- Another family member has **insurance** but it **doesn't cover the whole family**.
- **Can't get insurance or were refused**, usually because of poor health or age. For example, applicants in Washington's individual market must pass a health screen. Many of those who do not pass and are referred to the state's high-risk pool do not follow-through because they consider it to be too costly (even for those with some subsidy assistance).
- **Don't think it's needed** because they are healthy. Young adults are most likely to give this reason although overall it is rarely cited as the main reason for not having insurance

Other contributors to peoples' uninsured status include:

- **Ineligibility for public programs** such as Medicaid (primarily focused on children) or the state-only, subsidized Basic Health program for working adults under 200% of federal poverty (enrollment slots limited).
- **Other perceived or real barriers** such as knowledge about insurance options and how to access them; newly implemented administrative and cost-sharing changes that make continuous enrollment in public programs more difficult; an historically strong safety net that could be substituted for insurance (described in Section 4); and for some immigrant groups, the whole concept of insurance is simply foreign and senseless.

B. Technical Assistance:

While the SPG has had the effect of shining a spotlight on the WSPS as the most comprehensive source of data on Washington's uninsured individuals and families, this has been a somewhat mixed blessing. The data support sub-state analyses that provide valuable insights to health care issues at a local level with a degree of credibility and depth that cannot be matched by national surveys[13]. The increased interest in WSPS has motivated improvements in the data collection and coding processes, including: adjusting for Medicaid undercounting (described below); adding a question to verify lack of insurance coverage; honing the capture of Medicare recipient information; and, recoding variables that describe labor force participation and employment characteristics. It has also established the SPG as a "clearinghouse" for questions and data on Washington's uninsured population. Examples of the types of questions presented to SPG staff in support of understanding data on the uninsured are included in Appendix 1.

At the same time, we continue to struggle with the timeliness of available data and the need to make the right information available to interested stakeholders, in a usable way, quickly. Existing data by their very nature tell yesterday's story. In the context of a changing (and declining) health system we can run the risk of missing the nuances important for today's discussions or worse, being irrelevant to the discussion. In an effort to speed up access to more broadly available information, we participated in the Multi-State Integrated Database (MSID) championed by Arkansas. Thus far our efforts have been successful in defining the set of WSPS variables most pertinent to analyses of the uninsured (Figure 1-27) and these data are being loaded into a local cube for Washington. With

[13] Details on the value of local data to Washington were discussed with SHADAC in answer to a series of questions including: What type of local nuances did your state-level household survey identify? What questions from policy makers or the public were you able to answer using your state data that you would otherwise have been unable to answer? What did any state or local policy makers do with this information that they could not have done with data from the CPS, NSAF, NHIS or BRFSS?

the success of the SPG Continuation Grant application we hope to complete the development of the local cube, add 2004 WSPS data, and establish a sustainable "home" for the project into the future.

And finally, we struggle with the focus of media, advocates, policymakers, and others on the question, "Which number of uninsured is right?" as results of national and local surveys provide confusingly different percentages of Washington's uninsured. When the story, if not the numbers, is consistent across all surveys it is disappointing to see such energy directed towards getting to "the right number" and explaining why the numbers are different. Perhaps the dilemma is best explained this way: All estimates are wrong, some are useful, most tell the same story.

Medicaid Undercounting.
When findings from our preliminary 2002 WSPS analysis were seriously questioned by legislative staff, we collaborated with the WSPS statisticians to understand why rates of children's coverage by public programs looked lower than expected from historical administrative data. The interpretation was that we must have seriously overstated the rate of uninsurance in the state by undercounting the numbers of individuals enrolled in Medicaid and Medicare. A considerable body of national literature describes underreporting as a problem for other surveys including the Current Population Survey, Survey of Income and Program Participation, Medical Expenditure Panel Survey and the Community Tracking Survey, the undercount ranging from 7 to 50%[14]. The undercount in the 2000 WSPS was estimated to be around 25% and appeared to have been growing over time.

WSPS statisticians developed a methodology to adjust for the undercount; we assisted in testing the results and we called upon SHADAC staff to help keep us honest. A brief description of the adjustment methodology is included in the side box. SHADAC's peer review is included in Appendix 2. For children, the impact of the correction was huge. Their rate of uninsurance dropped from 8.5% in the preliminary (questionable) analysis to 4.5% after controlling for the Medicaid undercount, a rate that passed the straight face test, given its alignment with administrative data.

Medicaid Undercount Correction Methodology

Step 1: Imputations were made to correct responses where insurance information was missing but the individual had a high probability of being on Medicaid based on their responses to other WSPS questions (e.g., participation in TANF, Supplemental Security Income and children whose parents were on Medicaid.)

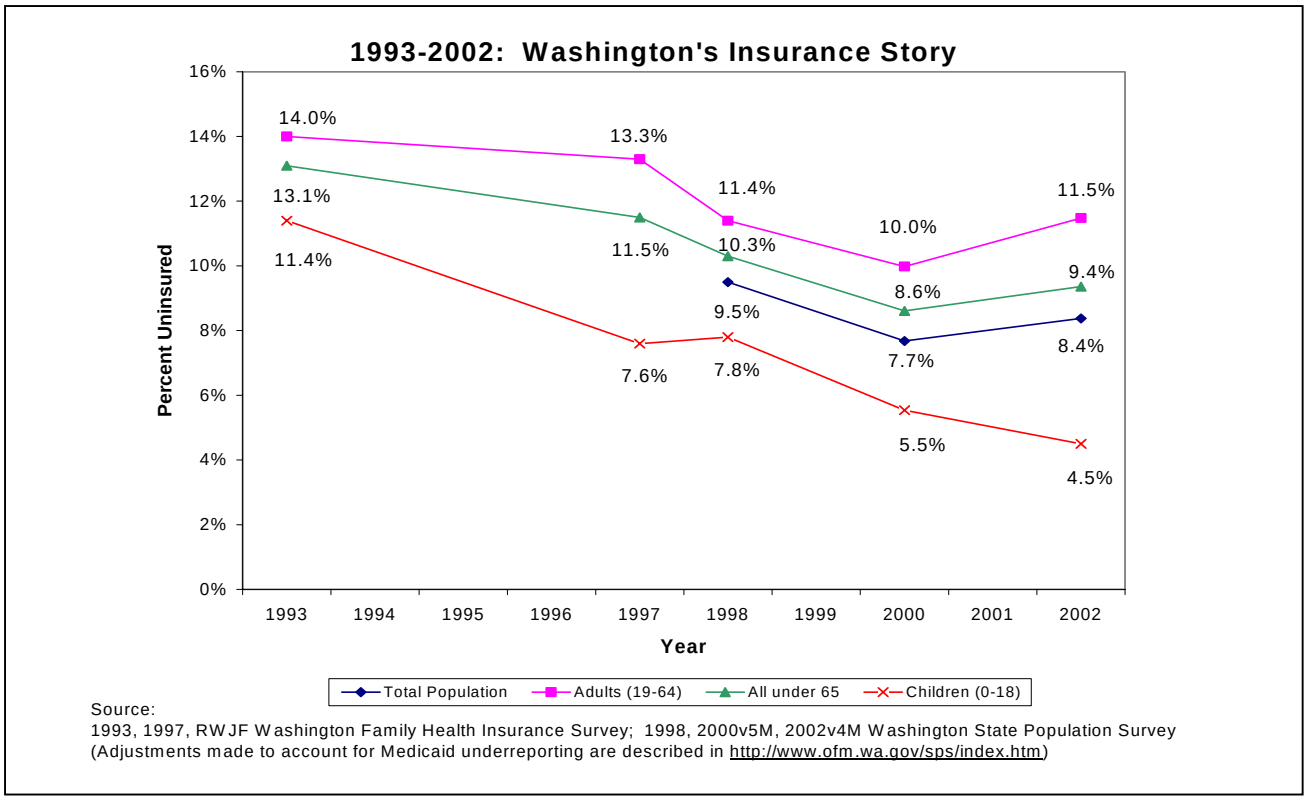
Step 2: Post-stratification weighting was changed to incorporate Medicaid administrative counts in addition to Washington's Census and population forecasts, so that adjusted weights better reflected characteristics of Washington's total population.

A technical description of the methodology is available at http://www.ofm.wa.gov/research/briefs/brief020.pdf.

Note: In general, figures cited are point estimates and do not reflect confidence interval ranges. Caution is encouraged in interpreting percentages that, in particular, are small and/or close together.

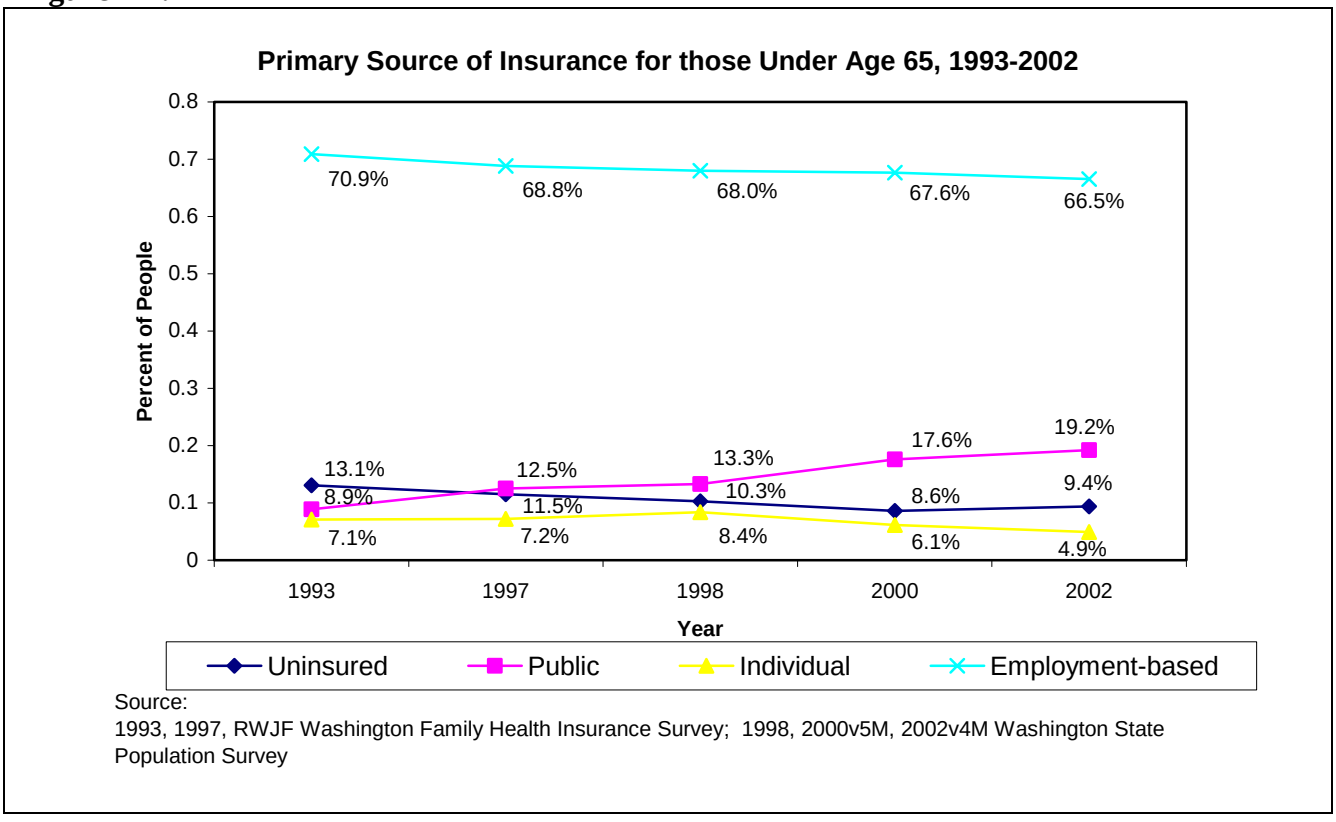
[14] Many researchers have noted that general population surveys of health insurance coverage appear to undercount the number of individuals enrolled in Medicaid programs. Swartz, K. and J. Purcell (1989). "Letter: Counting uninsured Americans." *Health Affairs* 8(4): 193-197.

Figure 1-1.



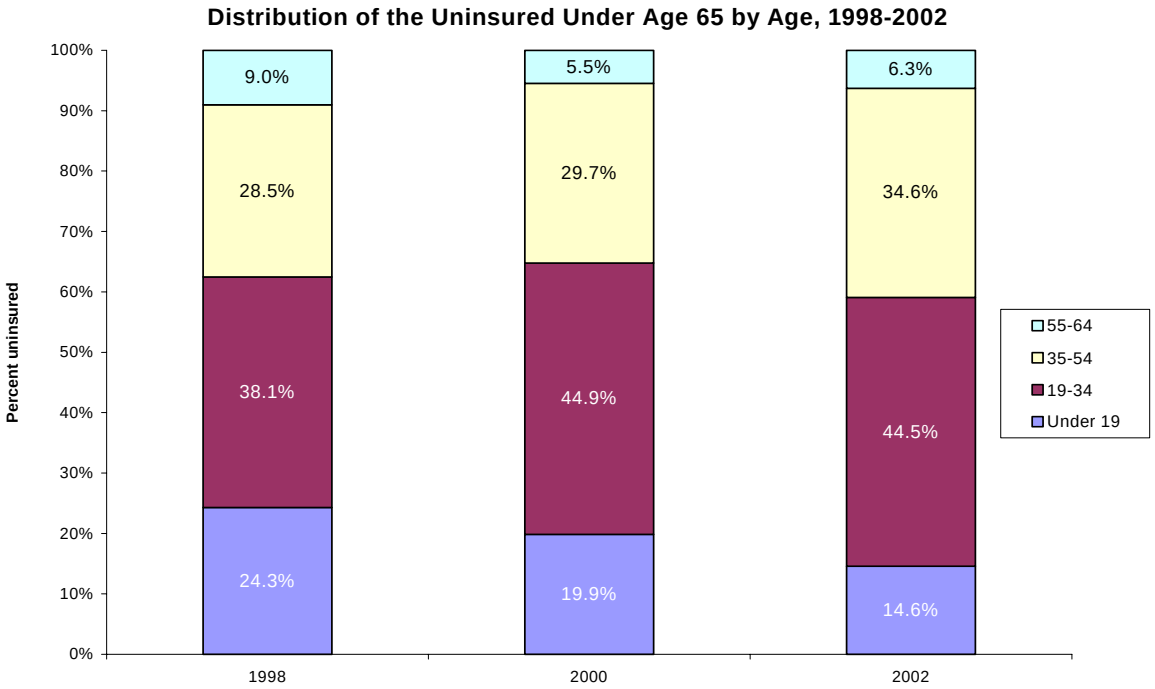
Source:
1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000v5M, 2002v4M Washington State Population Survey
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-2.



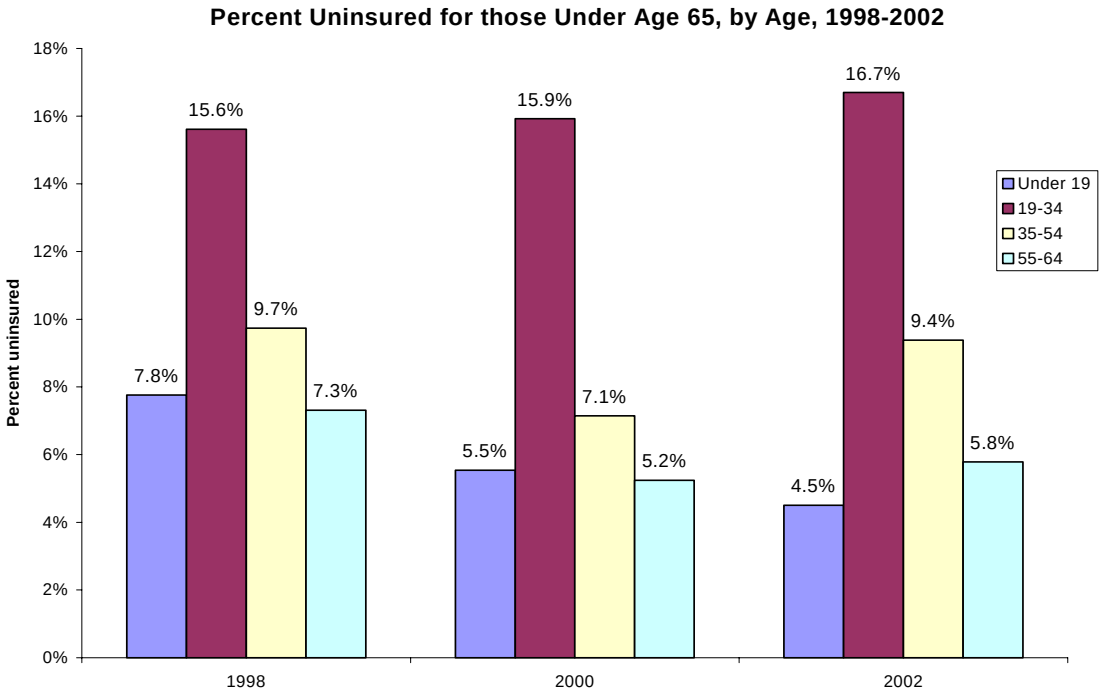
Source:
1993, 1997, RWJF Washington Family Health Insurance Survey; 1998, 2000v5M, 2002v4M Washington State Population Survey

Figure 1-3.



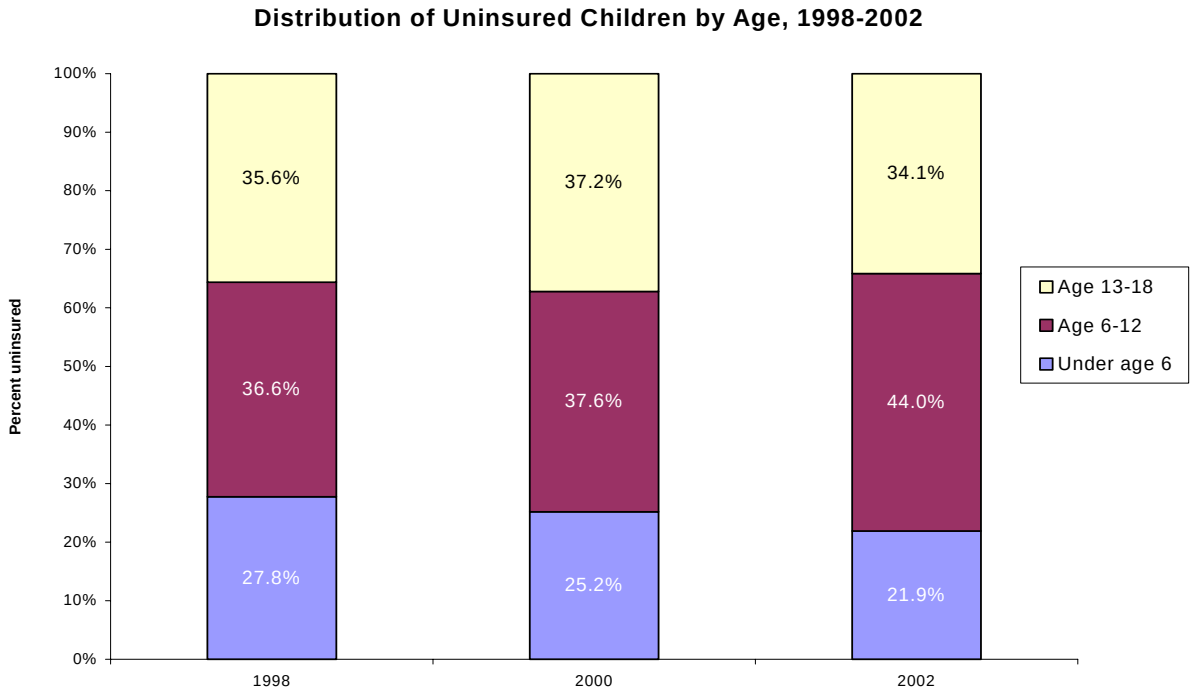
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-4.



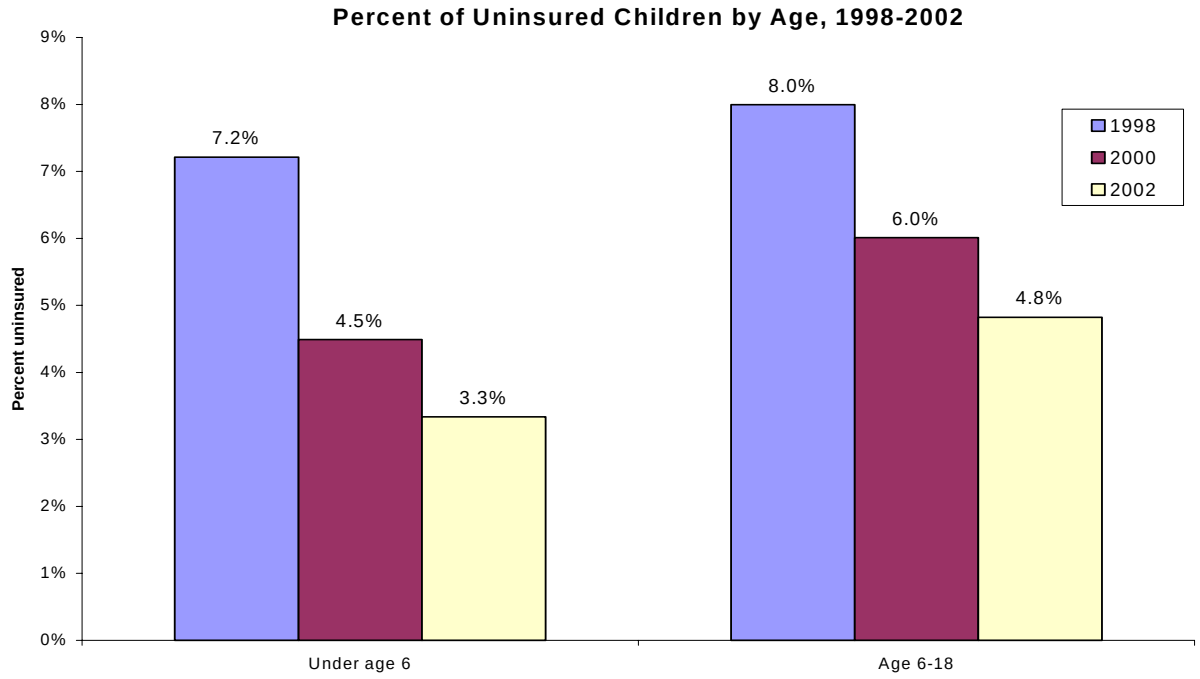
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-5.



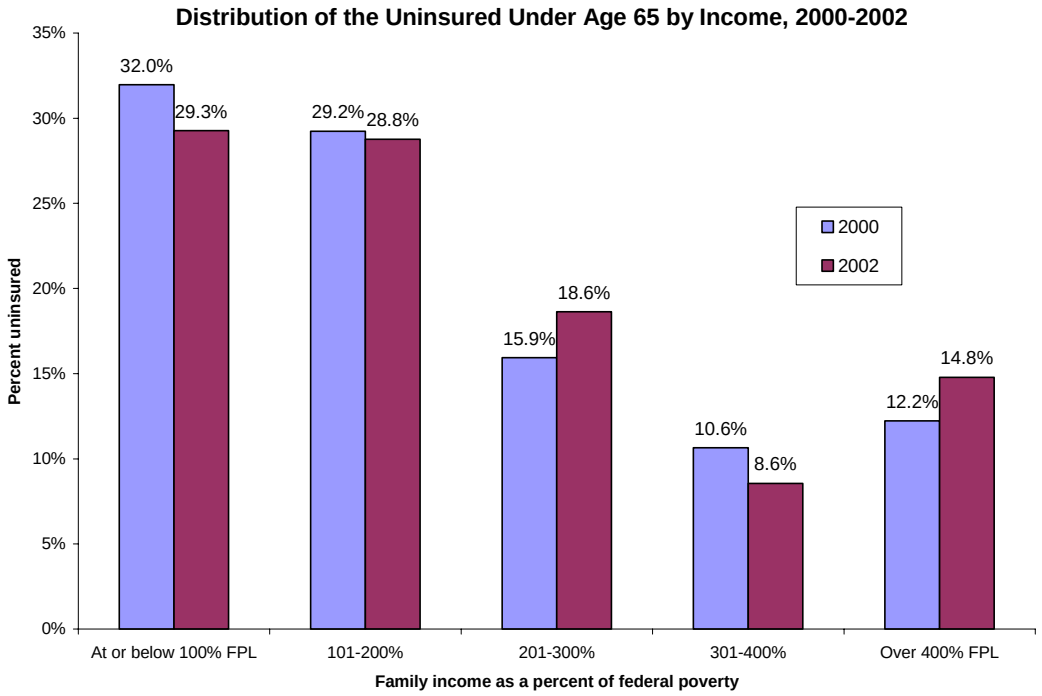
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-6.



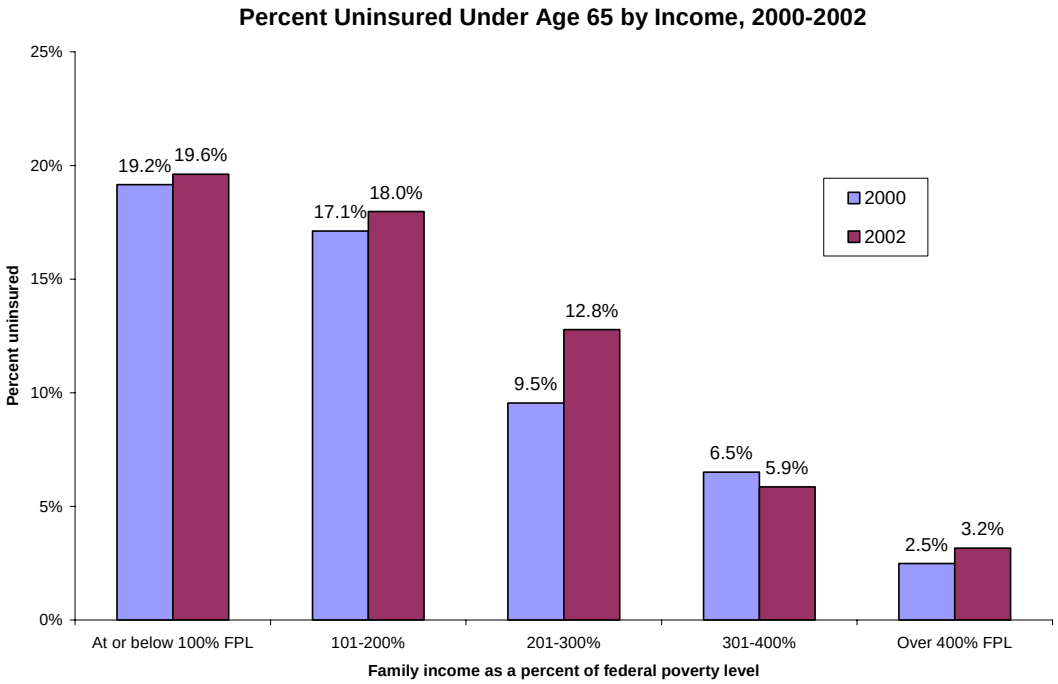
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-7.



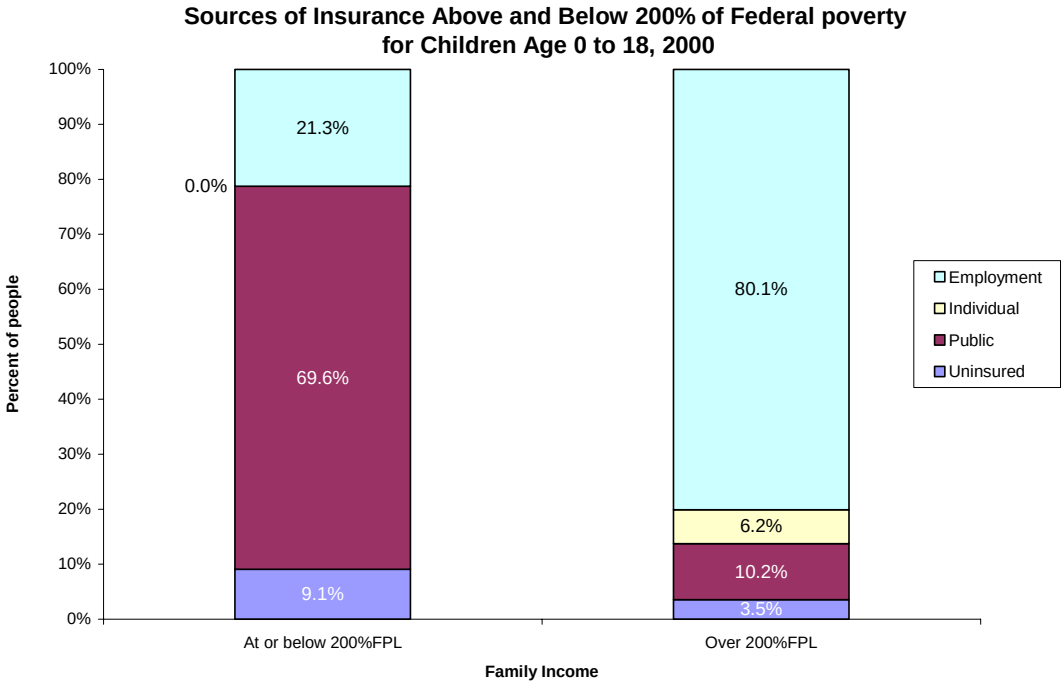
Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-8.

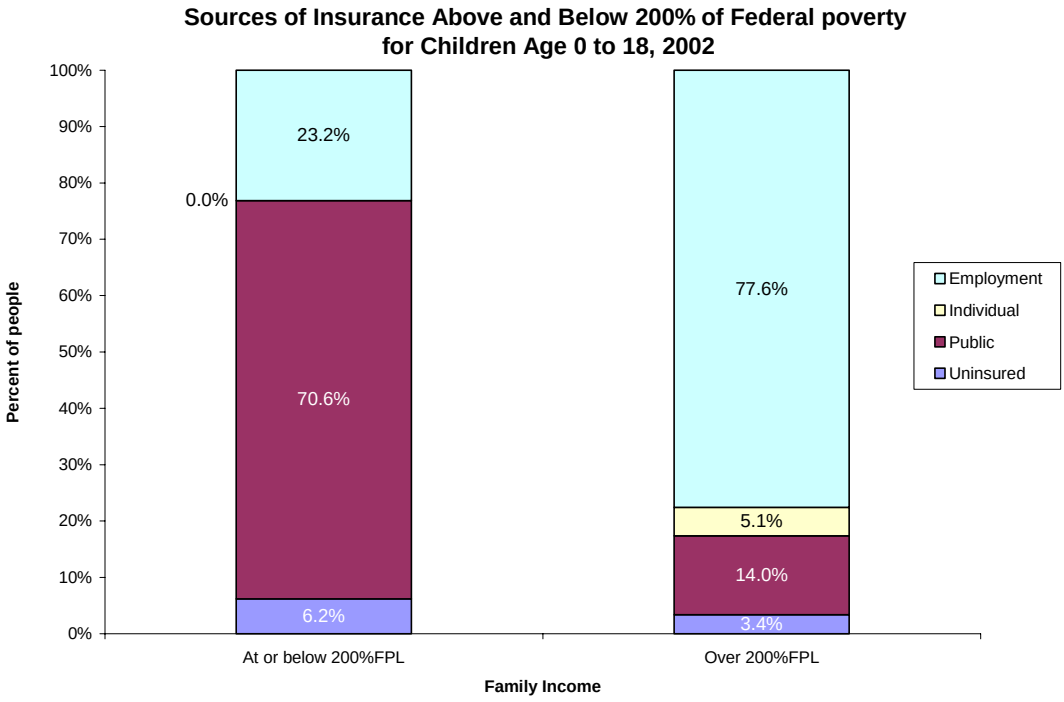


Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-9.



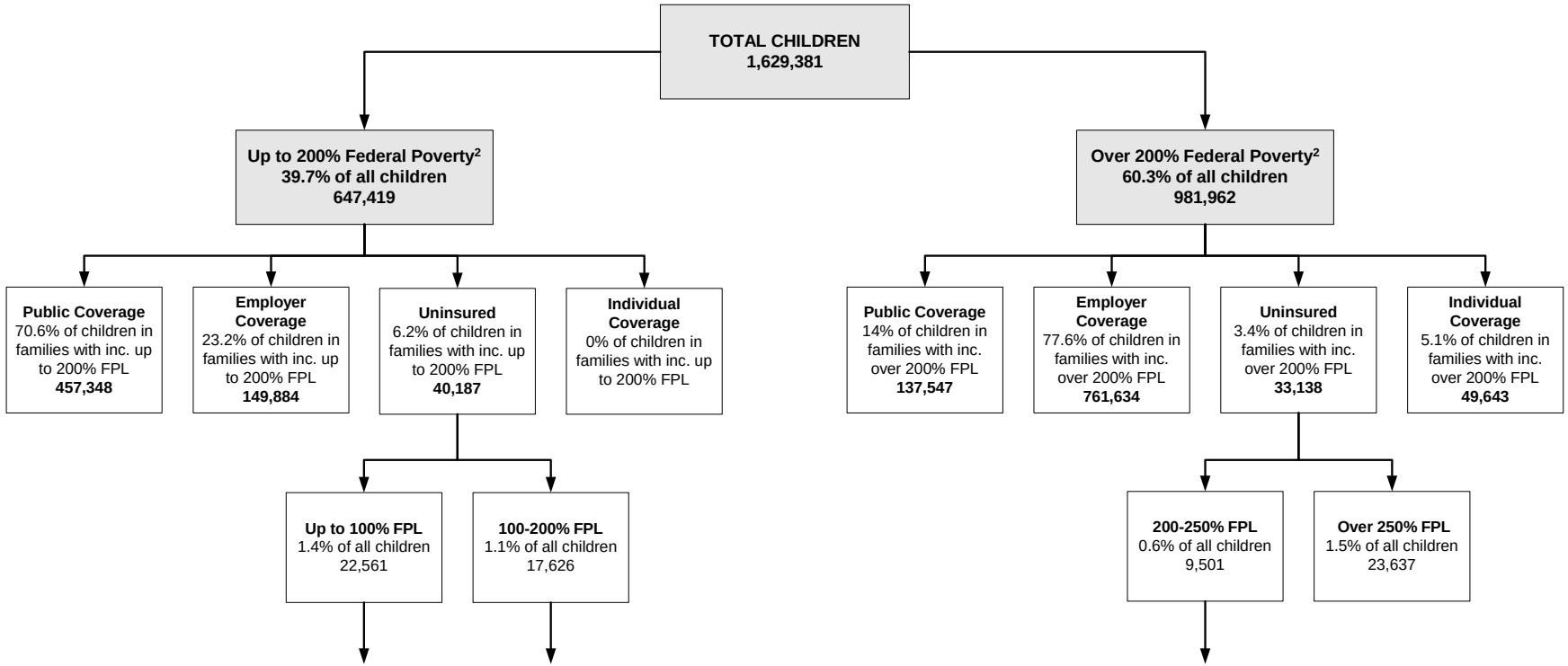
Source: Washington State Population Survey 2000v5M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)



Source: Washington State Population Survey 2002v4M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-10.

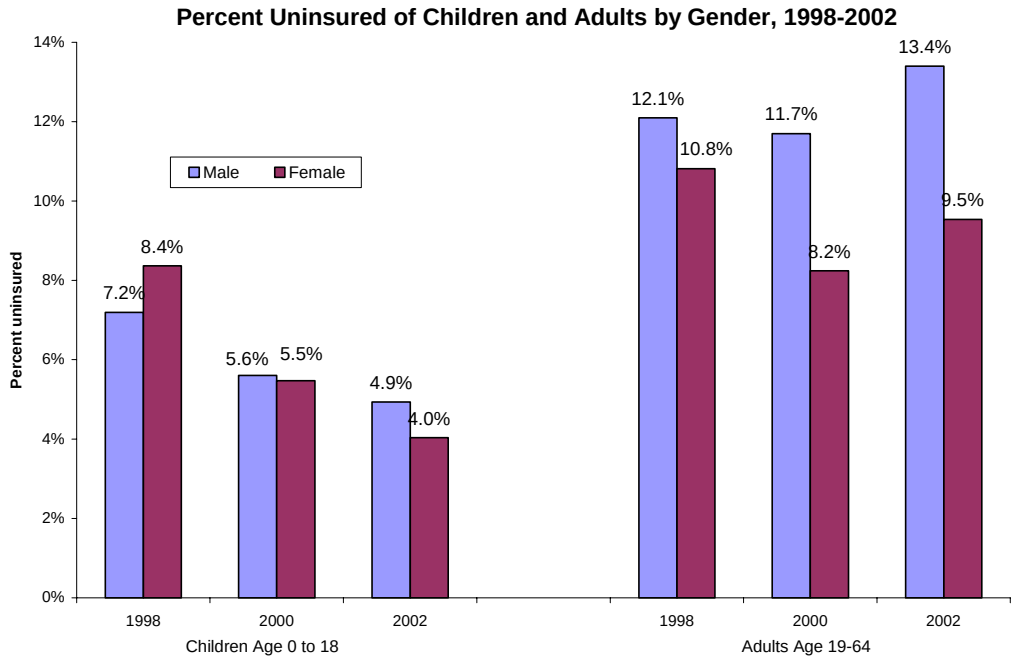
WASHINGTON STATE PLANNING GRANT ON ACCESS TO HEALTH INSURANCE
2002 Children Age 0-18 Years [1]



67.8% of all uninsured children are potentially eligible for public coverage through the current Medicaid, SCHIP, and Basic Health programs.

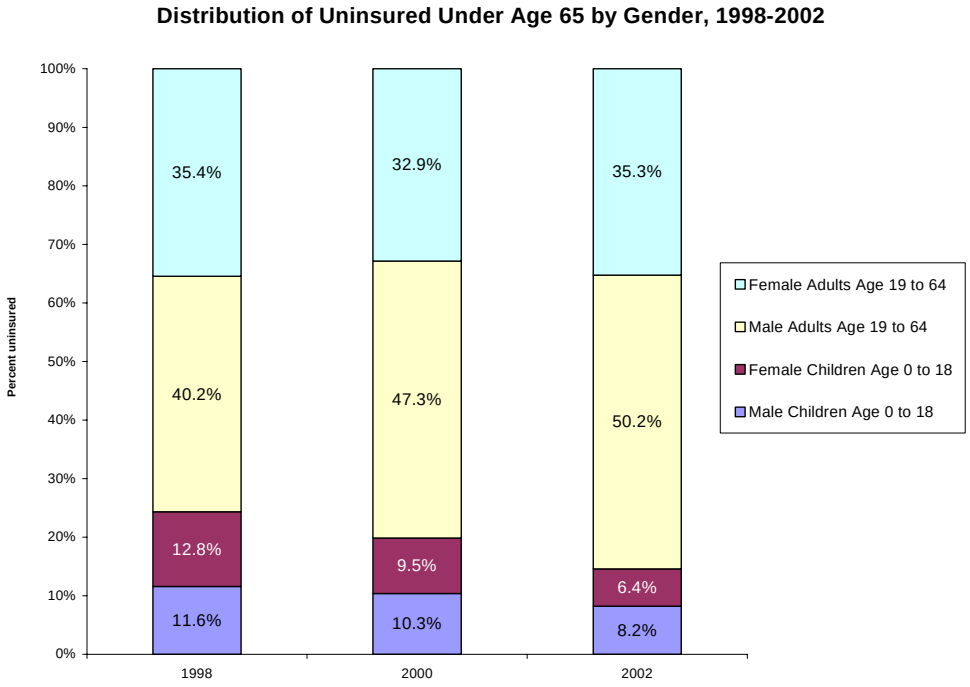
[1] Source: 2002v4M Washington State Population Survey
[2] Poverty level for a family of four in 2002 was defined as $18,100.
For more information see the Department of Health and Human Services website http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

Figure 1-11



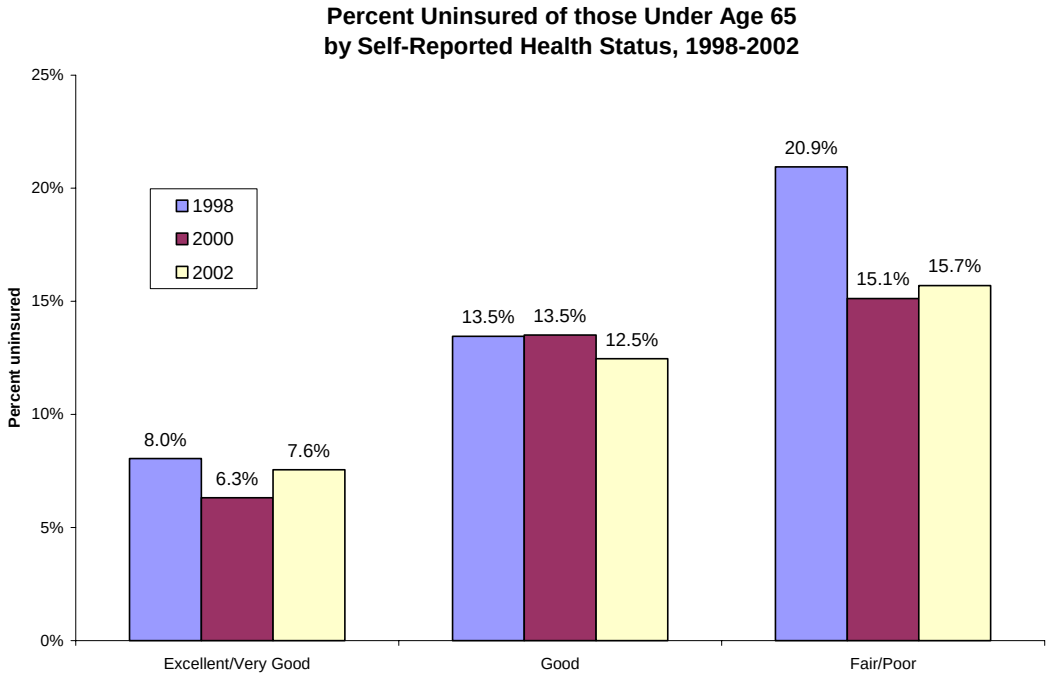
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-12



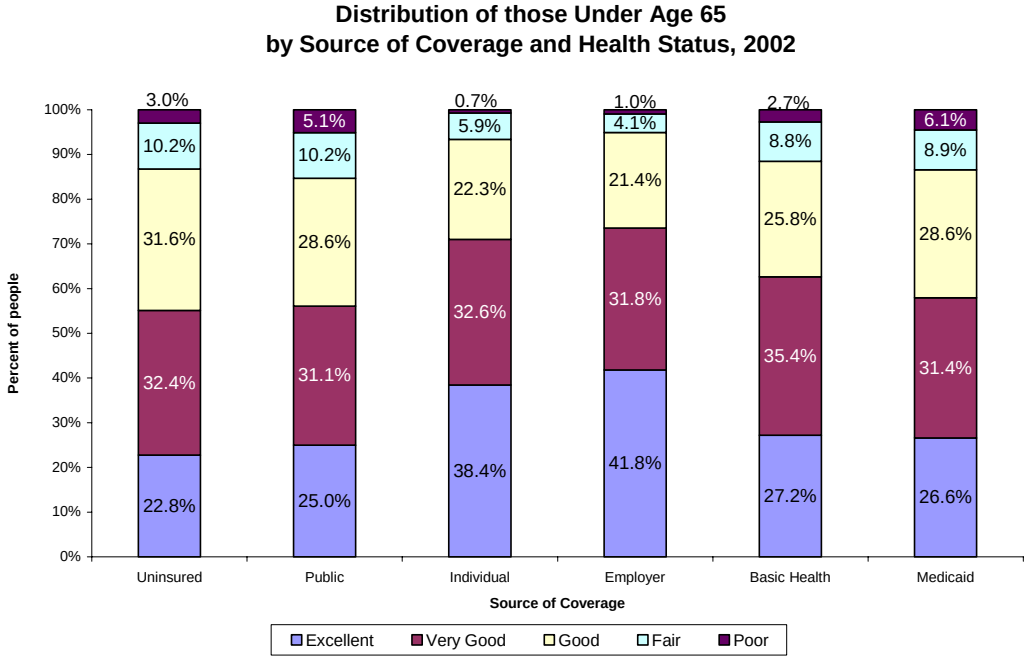
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-13



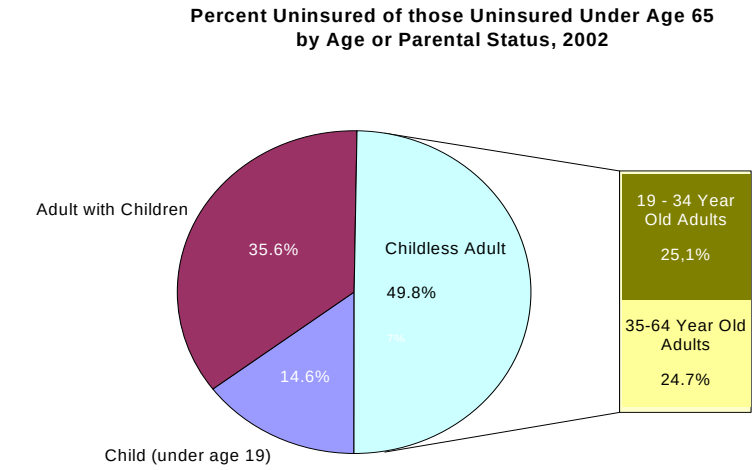
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-14



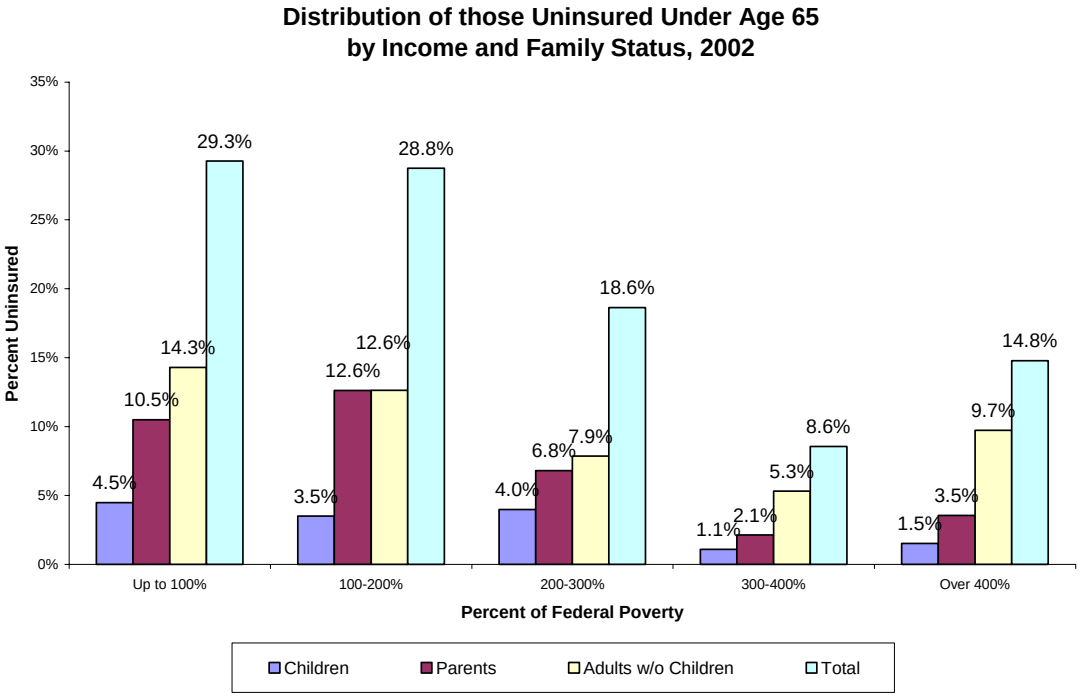
Basic Health and Medicaid are shown separately and also included as subsets of Public coverage.
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-15



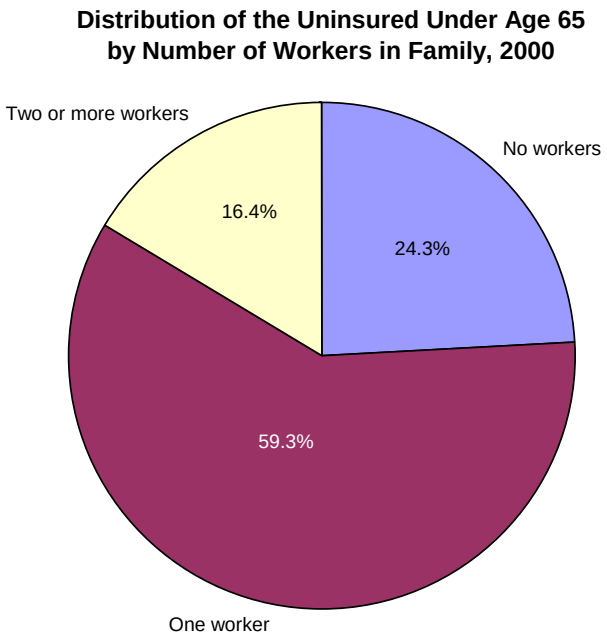
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-16



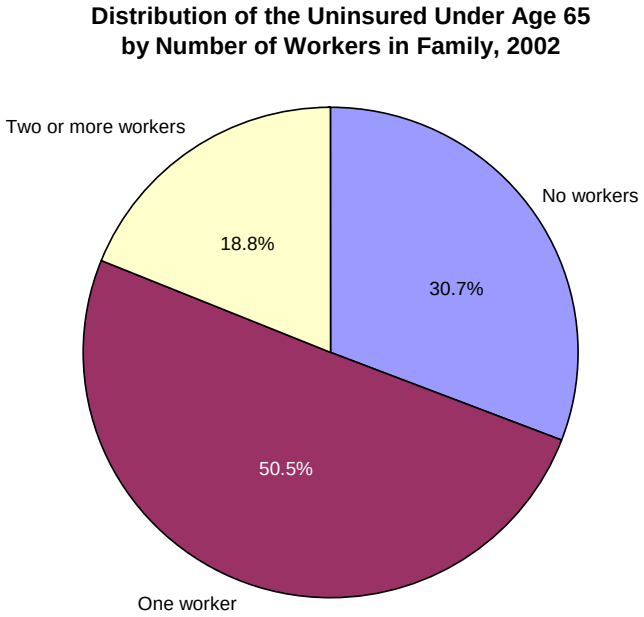
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-17



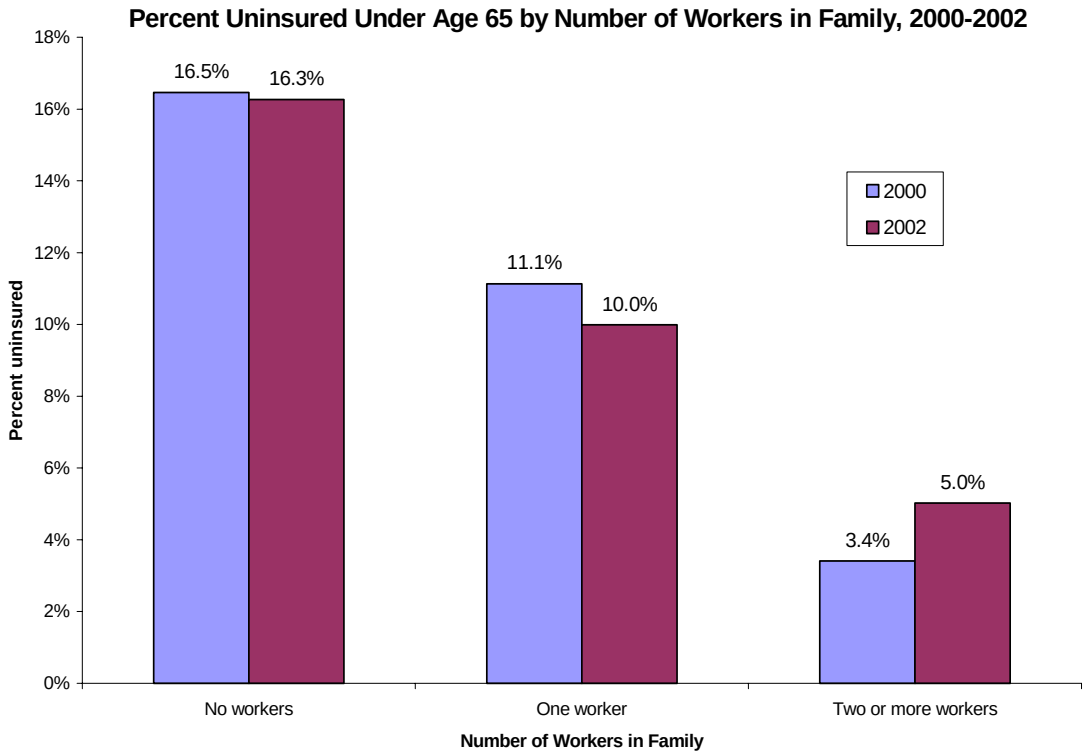
Source: Washington State Population Survey 2000v5M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-18



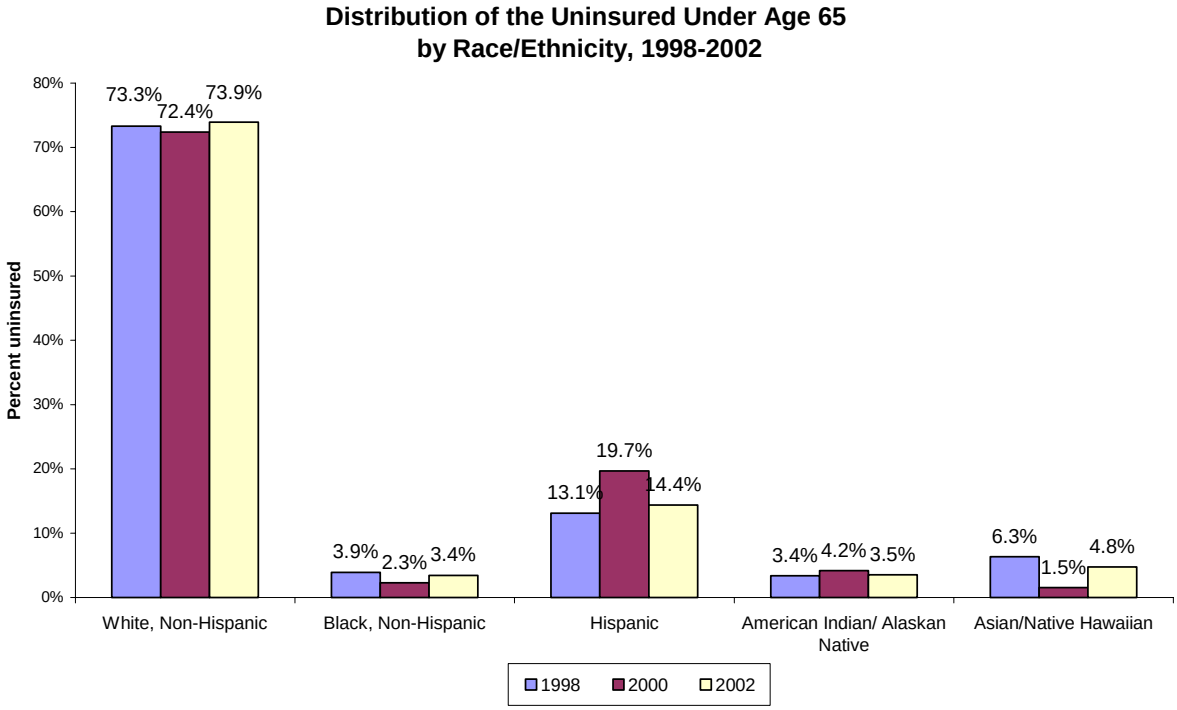
Source: Washington State Population Survey 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-19



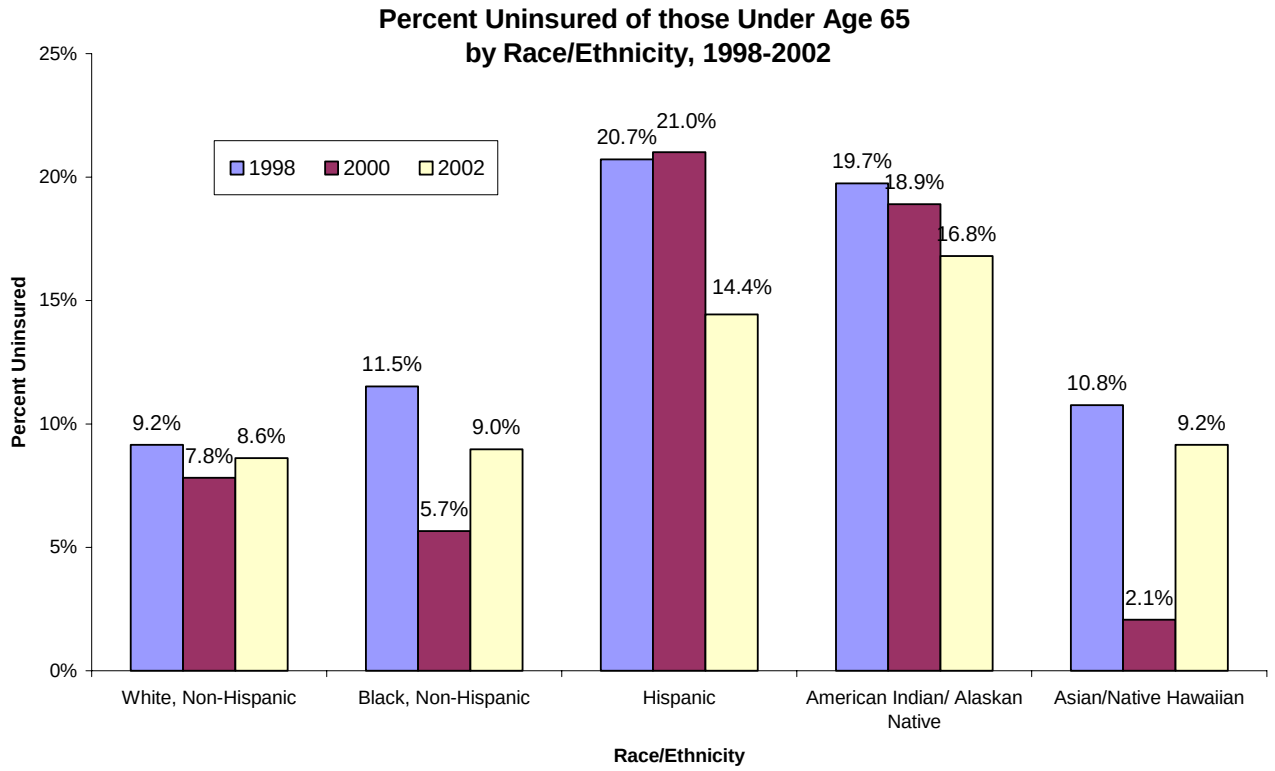
Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-20



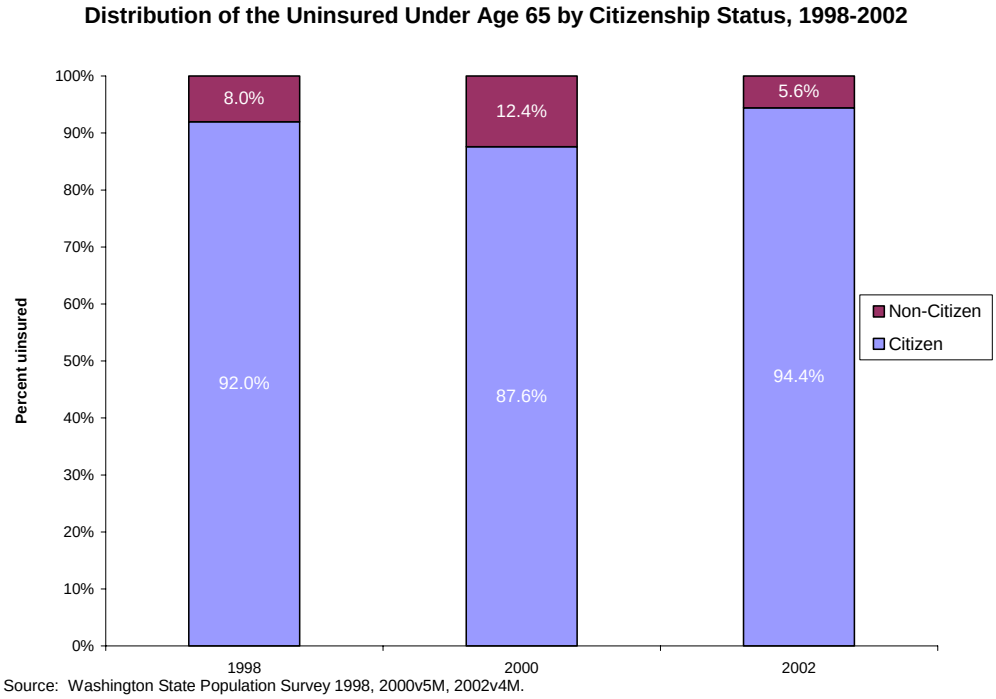
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-21



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

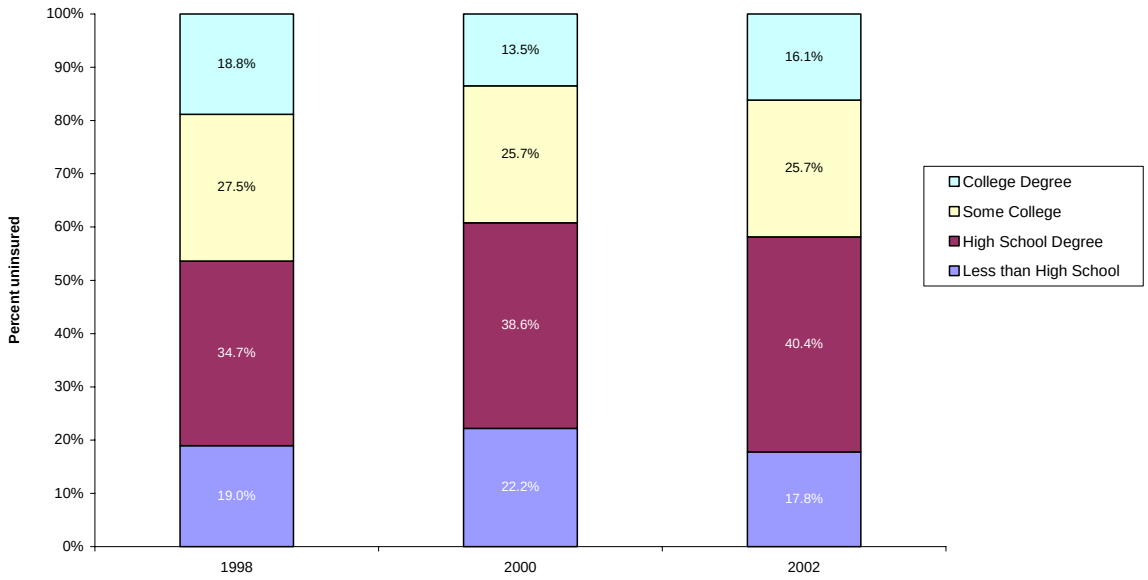
Figure 1-22



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-23

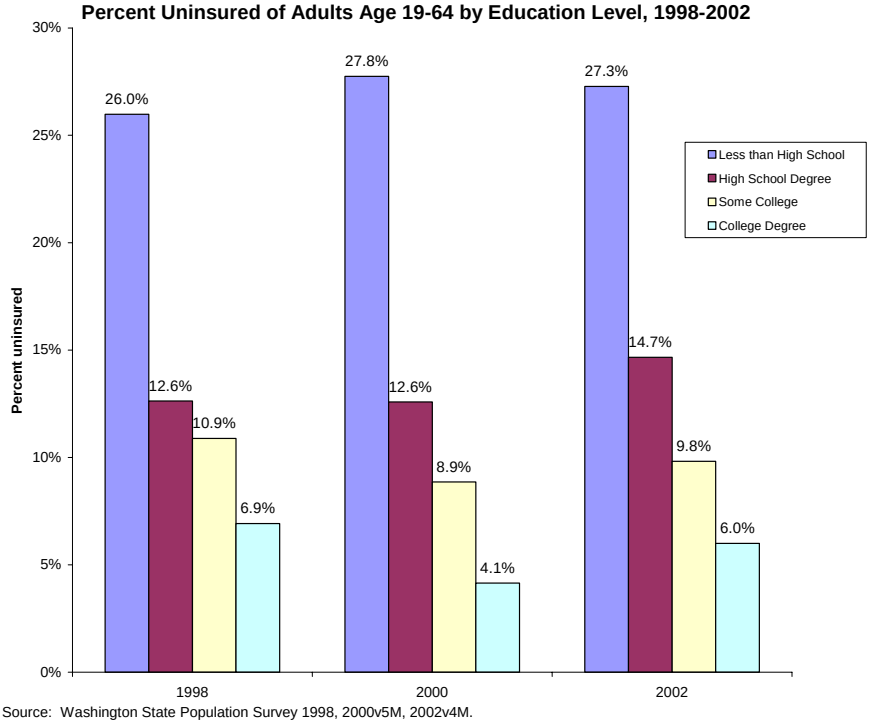
Distribution of Adults Age 19-64 Uninsured by Education Level, 1998-2002



Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

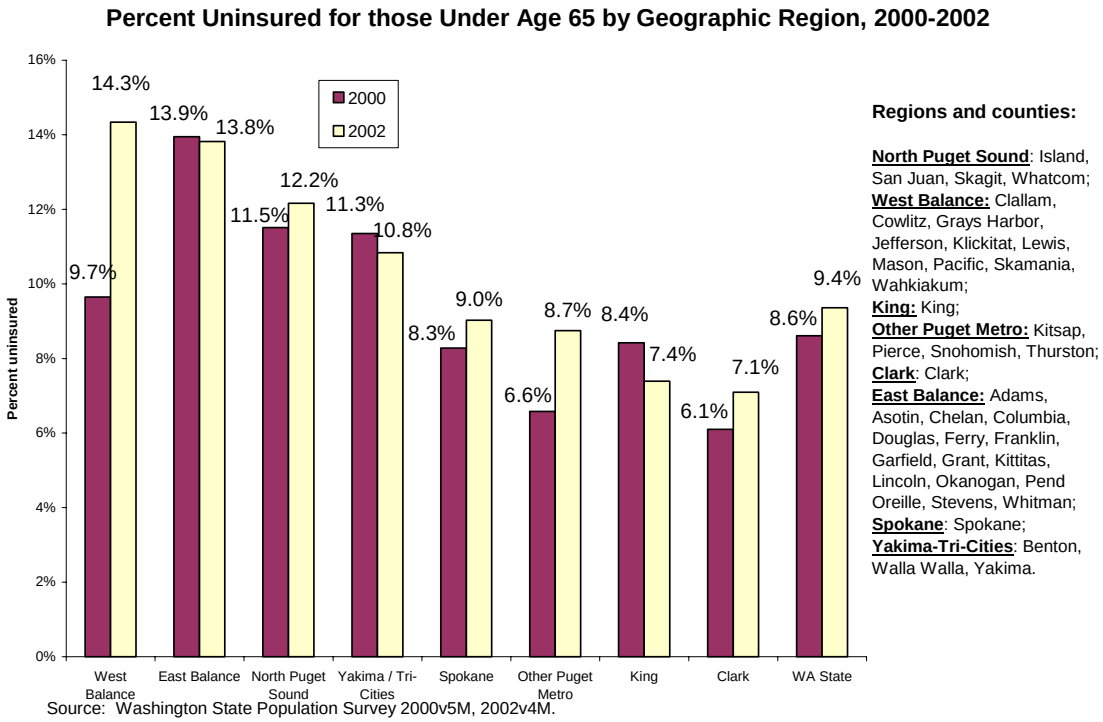
Figure 1-24

Percent Uninsured of Adults Age 19-64 by Education Level, 1998-2002



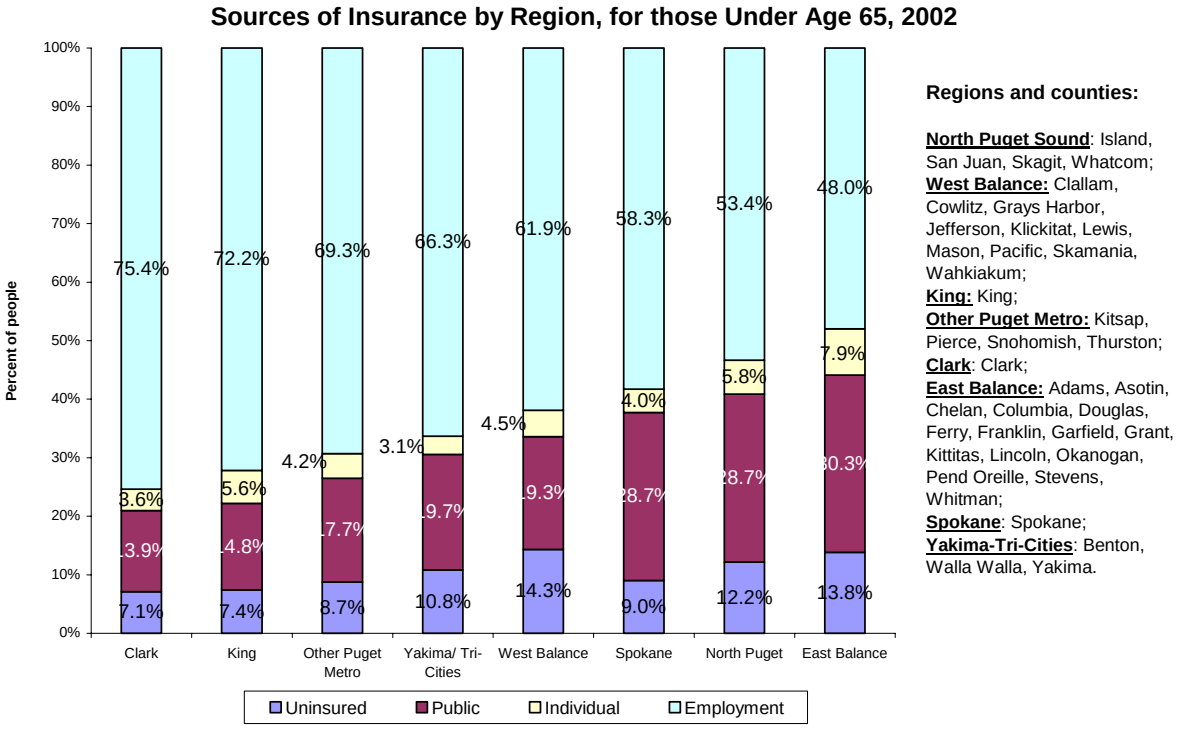
Source: Washington State Population Survey 1998, 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-25



Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

Figure 1-26



Source: Washington State Population Survey 2002v4M
(Adjustments made to account for Medicaid underreporting are described in http://www.ofm.wa.gov/sps/index.htm)

Figure 1-27

Multi-State Integrated Database Variables

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
YEAR	Survey year	DI	System assigned
ID	Household	DI	System assigned
PNUM	Person number in house	DI	System assigned
REGION	Region	GE	REGN
FNLWGT	Non-Ins Analyses Weight - USE FOR ALL VARIABLES **NOT** IN HI DOMAIN	DI	Constructed
MAAWGT	Insurance Analyses Weight - USE FOR ALL VARIABLES IN HI DOMAIN	HI	Constructed
Q2P6	Sex	DI	Q2R6
AGE	Age	DI	Q2R7M, Q2R7D, Q2R7Y, Q2R8
AGECAT	Age Categories	DI	Constructed
Q2P16	Are you of Hispanic origin?	DI	Q2R16
Q2P13M1	Race	DI	AR213
RACE	Race incl Hispanic	DI	Constructed - Cross tab Q2P16 and Q2P13M1
Q2P14	Marital Status	DI	Q2R14
PARENTS	Number Parents	DI	Constructed
SINGSEX	Single Family Head Sex	DI	Constructed
WORKERS	Workers in Family	WS	Constructed
PARINS	Parents Insurance Status	HI	Constructed
Q215P	Served in Armed Forces	DI	Q215R
Q2P15	In Armed Forces Now	DI	Q2R15
Q215B1	Armed Forces Conflict	DI	Q215A
Q2P17	Education Level	DI	Q2R17
EDUCATN	Education Level Gps	DI	
EDUCATN	1 = Less than High School		Constructed - Q2P17<3
EDUCATN	2 = High School		Constructed - Q2P17=3, 4, 5
EDUCATN	3 = Some College		Constructed - Q2P17=6, 7
EDUCATN	4 = College Degree		Constructed - Q2P17=8, 9, 10, 11
Q2P18	Born US Citizen	DI	Q2R18
Q2P20	Year Came to US	DI	Q2R20
Q2P20CAT	Decade Came to US	DI	Constructed - Q2P20 = 1917-2002
CITIZEN	US Citizen	DI	Q2R21
PLACE1YR	Place Lived Last Year	GE	Q223A

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
Q3P2	Own or Rent Home	DI	Q3R2
Q3P2A	Home Financing	DI	Q2R2A
Q3P2B	Govt Rental Subsidy	DI	Q3R2B
Q3P5	Monthly Rent	DI	Q3R5
Q3P5CAT	Monthly Rent Gps	DI	Constructed
Q4P42	Chronic Condition	HS	Q4R42
Q4P4A	Physical Condition	HS	Q4R4A
Q4P4B	Learning Disability	HS	Q4R4B
Q4P4C	Grooming Disability	HS	Q4R4C
Q4P4D	Leaving House Disability	HS	Q4R4D
Q4P4E	Difficulty Working	HS	Q4R4E
Q4P4F	Difficulty Seeking Work	HS	Q4R4F
Q4P4G	Difficulty Workg for Pay	HS	Q4R4G
Q4P3	Employed Last Week	WS	Q4R3
Q4P6	Unemployment Reason	WS	Q4R6
Q4P8	Main Job Wkly Hrs Wrkd	WS	Q4R16
Q4P8CAT	Main Job Wkly Hrs Gps	WS	Constructed
Q4P9	Employer	WS	Q4R9
Q4P10	Employment Industry	WS	Q4R10 Coded with NAICS
Q4P12	Occupation	WS	Q4R12 coded with SOCS
MAJIND02	2002 Industry Recodes	WS	Constructed
HOURWEEK	All Jobs Wkly Hrs Wkd	WS	Constructed
WGHR1ST	Main Job Hrly Wage	IN	Q4R14-constructed
EARNINGS	Main Job Hrly Wage Gps	IN	Constructed
Q4P23	Temporary Work	WS	Q4R23
Q4P24	Reason for Temp Work	WS	Q4R24
Q4P26	Union Membership	WS	Q4R26
Q4P29	Job Laidoff Full Time	WS	Q4R29
Q4P31	Student Status	DI	Q4R31
Q4P30	Educational Institution	DI	Q4R30
Q4P33	Weeks Looking for Work	WS	Q4P32 = 1 and Q4P6A < 1/ Q4R33
Q4P33CAT	Time Looking for Work	WS	Constructed
Q4P34	Reason Not Look for Wk	WS	Q4R34
LFS	Labor Force Status	WS	Constructed
Q6SS1	2001 SSI Payments	IN	Q6SS1
Q6DI1	Investment Income	IN	Q6DI1
Q6FS1	Food Stamps	IN	Q6FS1
Q6GA1	Govt Cash Assistance	IN	Q6GA1
Q6CS1	Child Support	IN	Q6CS1

NAME (8 char max)	BRIEF DESCRIPTION (24 characters max)	DOMAIN*	WSPS Questionnaire Reference(s)
Q6UI1	Pension UI Workers Comp	IN	Q6UI1
FAMINC01	2001 Family Income	IN	Constructed - family sum from Q6P1A, Q6P4A and PNWAGE
FAMINCAT	2001 Family Income Gps	IN	Constructed
POVLEV	Family Income FPL	IN	Constructed
POVCAT	Family Income FPL Gps	IN	Constructed
PRIMECOV	Health Insurance Source	HI	Constructed
SRCECOV	Health Insurance Payor	HI	Constructed
INS_BHP	Basic Health Ins		Q7R3I
INS_MAA	Medicaid Ins		Q7R3D
INS_MDCR	Medicare Ins		Q7R3C
INS_EMP	Employer-based Ins		Q7R3A
INS_MIL	Military ins		Q7R3G
INS_OWN	Self-paid ins		Q7R3E
INS_OTH	Others paid ins		Q7R3K
INS_OUT	Outside employer pd ins		Q7R3J
CUR_INS	Insurance Status	HI	Constructed
Q7P7	Coverage Before BH	HI	Q7R7
Q7P6	Reason for no HI	HI	Q7R6
Q7P5	Employer Offers HI	HI	Q7R5
Q7P11	Health Status	HS	Q7R11
Q8P9	English language	DI	Q8R9
Q8P10	Non-English language	DI	Q8R10
Q4P16	Employer Size	WS	Q4R16
Q4P16CAT	Employer Groups	WS	Constructed

* Demographics & Identifiers (DI), Health Status & Utilization (HS), Health Insurance & Related Data (HI), Work Status & Employment-related Data (WS), Income (IN), Geography (GE)

Table 1-1										
Washingtonians With or Without Health Insurance Coverage by Selected Characteristics: 2000 and 2002										
			2002					**2000**		
CHARACTERISTIC	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**
Total Population		8.4%	506,261	5,536,998	6,043,259		7.7%	452,806	5,441,316	5,894,122
Population Up to 64 Years										
AGE										
Up to 64 years	100.0%	9.4%	502,690	4,867,478	5,370,168	100.0%	8.6%	450,694	4,783,118	5,233,812
19 to 34 years	44.5%	16.7%	223,713	1,115,985	1,339,698	44.9%	15.9%	202,550	1,069,055	1,271,605
35 to 54 years	34.6%	9.4%	174,106	1,681,694	1,855,800	29.7%	7.1%	133,982	1,741,976	1,875,958
55 to 64 years	6.3%	5.8%	31,546	513,743	545,289	5.5%	5.2%	24,682	446,435	471,117
19 to 64 years	85.4%	11.5%	429,365	3,311,422	3,740,787	80.1%	10.0%	361,214	3,257,466	3,618,680
Under 19 years	14.6%	4.5%	73,325	1,556,056	1,629,381	19.9%	5.5%	89,480	1,525,652	1,615,132
CHILDREN (Age 0-18 years)										
Under 19 years		4.5%	73,325	1,556,056	1,629,381		5.5%	89,480	1,525,652	1,615,132
Under 6 years	21.9%	3.3%	16,060	465,614	481,674	25.2%	4.5%	22,530	479,263	501,793
6 to 12 years	44.0%	5.1%	32,230	596,479	628,709	37.6%	5.8%	33,668	550,686	584,354
13 to 18 years	34.1%	4.8%	25,035	493,963	518,998	37.2%	6.3%	33,282	495,703	528,985
6 to 18 years	78.1%	5.0%	57,265	1,090,442	1,147,707	74.8%	6.0%	66,950	1,046,389	1,113,339
Under 13 years	65.9%	4.3%	48,290	1,062,093	1,110,383	62.8%	5.2%	56,198	1,029,949	1,086,147
FAMILY INCOME (Up to 64 years)										
Up to 100% FPL	29.3%	19.6%	147,164	603,220	750,384	32.0%	19.2%	144,052	607,589	751,641
100-200% of FPL	28.8%	18.0%	144,540	659,466	804,006	29.2%	17.1%	131,732	637,838	769,570
200-300% of FPL	18.6%	12.8%	93,654	639,240	732,894	15.9%	9.5%	71,852	680,800	752,652
300-400% of FPL	8.6%	5.9%	43,009	691,052	734,061	10.6%	6.5%	47,994	689,859	737,853
Over 400% FPL	14.8%	3.2%	74,323	2,274,500	2,348,823	12.2%	2.5%	55,064	2,167,032	2,222,096
FAMILY INCOME (Children under 19 years)										
Up to 200% of FPL	54.8%	6.2%	40,187	607,232	647,419	59.3%	9.1%	53,087	531,347	584,434
Over 200% of FPL	45.2%	3.4%	33,138	948,824	981,962	40.7%	3.5%	36,393	994,305	1,030,698
200-250% of FPL	13.0%	7.8%	9,501	113,069	122,570	10.4%	6.9%	9,343	127,028	136,371

			2002					2000		
CHARACTERISTIC	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**
Over 250% of FPL	32.2%	2.8%	23,637	835,755	859,392	30.2%	3.0%	27,050	867,277	894,327
RACE/ETHNICITY										
White Non-Hispanic	73.9%	8.6%	371,594	3,940,254	4,311,848	72.4%	7.3%	326,225	4,112,261	4,438,486
Black Non-Hispanic	3.4%	9.0%	17,157	173,927	191,084	2.3%	10.5%	10,281	88,062	98,343
Hispanic	14.4%	14.4%	72,329	428,570	500,899	19.7%	20.7%	88,628	339,578	428,206
American Indian/ Alaskan Native	3.5%	16.8%	17,732	87,815	105,547	4.2%	20.3%	18,717	73,362	92,079
Asian/ Native Hawaiian	4.8%	9.2%	23,878	236,912	260,790	1.5%	3.9%	6,843	169,855	176,698
CITIZENSHIP										
Citizen	94.0%	9.1%	472,401	4,702,594	5,174,995	87.5%	7.9%	394,500	4,613,862	5,008,362
Non-Citizen	5.6%	15.4%	27,927	153,864	181,791	12.4%	26.2%	55,742	157,017	212,759
Unknown	0.4%		2,362	11,020	13,382	0.1%	0.0%	-	7,441	7,441
GENDER										
Male	58.4%	10.8%	293,554	2,427,252	2,720,806	57.6%	9.8%	259,789	2,394,828	2,654,617
Female	41.6%	7.9%	209,136	2,440,226	2,649,362	42.4%	7.4%	190,905	2,388,290	2,579,195
Children (age 0-18)										
Male	56.5%	4.9%	41,396	797,029	838,425	52.1%	5.6%	46,642	785,732	832,374
Female	43.5%	4.0%	31,929	759,027	790,956	47.9%	5.5%	42,838	739,920	782,758
HEALTH STATUS										
Excellent/Very Good	55.1%	7.6%	277,201	3,393,152	3,670,353	51.1%	6.3%	230,306	3,417,266	3,647,572
Good	31.6%	12.5%	159,003	1,117,289	1,276,292	36.2%	13.5%	163,187	1,044,733	1,207,920
Fair/Poor	13.2%	15.7%	66,486	357,037	423,523	12.7%	15.1%	57,201	321,119	378,320
REGION										
North Puget	7.6%	12.2%	38,323	276,736	315,059	7.9%	11.5%	35,620	273,866	309,486
West Balance	10.2%	14.3%	51,165	305,649	356,814	7.5%	9.7%	33,751	315,946	349,697
King	23.4%	7.4%	117,576	1,472,850	1,590,426	29.2%	8.4%	131,411	1,428,965	1,560,376
Other Puget Metro	28.3%	8.7%	142,419	1,485,791	1,628,210	22.9%	6.6%	103,118	1,464,702	1,567,820
Clark	4.6%	7.1%	23,348	305,681	329,029	4.2%	6.1%	19,110	294,034	313,144
East Balance	11.0%	13.8%	55,101	343,598	398,699	12.2%	13.9%	55,144	340,216	395,360
Spokane	6.7%	9.0%	33,517	337,845	371,362	6.7%	8.3%	30,249	335,060	365,309

			2002					2000		
CHARACTERISTIC	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**	**Distribution of Uninsured**	**Percent Uninsured**	**Uninsured**	**Insured**	**TOTAL**
Yakima-Tri-Cities	8.2%	10.8%	41,241	339,328	380,569	9.4%	11.3%	42,291	330,329	372,620
EMPLOYMENT STATUS										
No Workers in Family	30.7%	16.3%	154,341	794,390	948,731	24.3%	16.5%	109,505	555,677	665,182
1 Worker in Family	50.5%	10.0%	253,901	2,288,615	2,542,516	59.3%	11.1%	267,246	2,134,119	2,401,365
2 or More Workers	18.8%	5.0%	94,448	1,784,473	1,878,921	16.4%	3.4%	73,943	2,093,322	2,167,265
FAMILY COMPOSITION										
Children	14.6%		73,325			19.9%		89,480		
Adults with Children	35.6%		178,959			38.0%		171,394		
Childless Adults	49.8%		250,406			42.1%		189,820		
EDUCATION (Age 19-64 Years)										
Less than High School	17.8%	27.3%	76,397	203,706	280,103	22.2%	27.8%	80,202	208,813	289,015
High School	40.4%	14.7%	173,381	1,009,195	1,182,576	38.6%	12.6%	139,429	968,556	1,107,985
Some College	25.7%	9.8%	110,252	1,012,748	1,123,000	25.7%	8.9%	92,980	956,856	1,049,836
College Degree	16.1%	6.0%	69,335	1,085,773	1,155,108	13.5%	4.1%	48,603	1,123,241	1,171,844

Source: Washington State Population Survey 2000v5M, 2002v4M.
(Adjustments made to account for Medicaid underreporting as described in http://www.ofm.wa.gov/sps/index.htm.)

SECTION 2. EMPLOYER-BASED COVERAGE

Employer-based coverage remains the primary source of health insurance coverage in Washington for workers and their dependents. Options for its expansion continue to be of particular interest to a broad set of Washington stakeholders. Although the employer-based coverage system has been steadily eroding in Washington, dropping from 70.9% in 1993 to 66.5% in 2002, the typical profile of employers who offer insurance and workers and their dependents who are covered has changed little. There is a solid body of literature on the patterns of health insurance coverage among workers. Large firms and firms that employ higher-wage workers offer insurance more often than small firms and firms that employ lower-wage workers. Consequently, uninsured workers are found disproportionately in firms smaller than 25 employees; in the agriculture, construction, retail and trade industries; and in the private sector rather than the public sector. And they are more likely to work part-time or in seasonal activities, be low-wage workers; and those who live in low-income households[1]. As with the patterns of uninsurance described for individuals and families, Washington parallels the national picture.

The complication for Washington has been its high unemployment rate in recent years, which consistently tracks higher than the national average due mainly to a relatively high concentration of resource-based industries[2]. Although down from an average of 7.5% in 2003 (6.0% nationally) to 6.2% in August 2004[3] (5.4% nationally) the recovery trend has not been as fast as anticipated. Manufacturing, construction, leisure and hospitality sectors have been hit hard. Although workers are now becoming employed, debts built up during extended periods of unemployment make health insurance premiums a commonly unaffordable expense. Furthermore, as job growth occurs many workers are returning to lower paying jobs (those less likely to offer health insurance) in hospitality, finance, retail and segments of health care and business services[4]. Manufacturing, in which 68,000 jobs have been lost since January 2001, and for which more jobs are relatively high-paying (and tend to come with health insurance benefits), has yet to recover.

Significant work occurred in Washington in the mid 1990s to understand the characteristics and motivations of employers who offer and do not offer coverage. Analyses conducted during our first SPG built upon these previous descriptive efforts, with a particular emphasis on understanding more about small employers. With access to comprehensive albeit proprietary data sources, our consultants developed a broad profile of Washington's employers and their workers, to help understand the characteristics and circumstances surrounding the likelihood that a worker is employed in a business offering health coverage[5]. More recently we focused efforts on identifying local data sources for replicating and refining this work, to establish a template for future data gathering and analysis efforts and enhance our historical picture of employer-based coverage. We have tried to capture the challenges since they have caused us to profile Washington's employers and workers using a variety of data sources, none of which tells a complete story in and of itself.

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[1] Greenman, E., et al. 2001. Workers Without Health Insurance. *Urban Institute and W.K.Kellogg Foundation.* Available at www.wkkf.org/pubs/healthcommunityvoices/pub712.pdf

[2] See Washington trends available at: www.ofm.wa.gov/trends/htm/fig105.htm.

[3] See September 14 news release available at: http://fortress.wa.gov/esd/portal/info/newsroom/releases/nr091404.htm

[4] Holt S., and Blanca Torres articles in Seattle Times. Jobless Find New Work, Not Old Standard of Living, July 14, 2004. State Jobless Rate Inches Higher, September 15, 2004.

[5] Research reports are available at: http://www.ofm.wa.gov/accesshealth/accesshealth.htm

A. Data Sources:

Continuing the theme that local data bring a level of credibility and depth not available from national surveys, we began our more recent analysis of employers and employees using data gathered in WSPS 2002. However not all data constructs important for analysis of employers, or workers and their dependents, are directly measured in or able to be derived from WSPS alone. In some cases responses are skipped by too many respondents (e.g., employer type); not consistently provided (e.g., employer size, self-employed status); inadequately coded (e.g., labor force status of non-respondents) or the information is not known by employees (e.g., details about employer behavior; employee wage-mix) and therefore not collected.

Our original SPG consultants resolved these problems by synthetically matching each worker in the 2000 WSPS to an employer in the 1997 RWJF Employer Health Insurance Survey (EHIS)[6], and thereby attaching all the characteristics of a single employer to each worker (e.g., industry, size of firm, employee wage-mix, part-time/full-time mix, seasonality etc). In addition they imputed premiums that would have to be paid for workers in firms that do not offer coverage based on understanding characteristics of firms that do offer coverage. Details of this approach are outlined at: http://www.ofm.wa.gov/accesshealth/research/31appenab.pdf. To repeat this process we looked for a source of current, local, employer data to replace EHIS data that were no longer accessible and were perceived to reflect employer status prior to Washington's economic recession.

A short, fill-in-the-blanks survey of employers is conducted semi-annually by the Employment Security Department (ESD) to capture critical labor market information on job vacancies. In late 2002 we collaborated with ESD to pilot expansion of the survey to collect employer benefits information. Although not comparable with the sophistication (or cost) of the WSPS, it sampled almost 11,000 employers and gathered a set of health insurance coverage details. Unfortunately we found puzzling discrepancies from official labor market data in our follow-up analysis. These were isolated to an uncorrectable weighting issue and we were unable to generalize the 2002 survey results to all employers.

However, we were encouraged at the potential for replicating our consultants' initial SPG research using ESD data. We suggested changes to the October 2003 job vacancy survey to expand data collected on employers' offer of health insurance, although the number of changes was restricted to avoid compromising employer response rates on job vacancies, the survey's primary data gathering purpose[7] (See Figure 2-1 for a sample of the Employee Benefits section). The weighting methodology was corrected and we then attempted to match ESD employer data with WSPS 2002. This time insurmountable problems occurred as a result of incomplete WSPS responses that allowed us to match less than 50% of workers to an employer. We hope that this issue will be resolved by improvements to the WSPS 2004 survey so we can continue this effort in our future SPG activities.

B. Profile of Washington's Employers and Employees

[6] RAND designed and the Robert Wood Johnson Foundation funded the Employer Health Insurance Survey (EHIS) in 1993 and 1997. It sampled private employers included in Dun's Market Identifiers and collected data from local, state and federal government agencies to represent public employers. These data are proprietary and not available for public use, however they were accessible to our SPG because RAND participated in our consultant consortium. For ongoing analysis the survey is not being repeated.

[7] The 2003 Washington Benefits Survey was distributed to a sample of 20,484 employers with a 44% response rate. It earned ESD the 2004 Labor Market Information Communications Publication Award from the National Association of State Workforce Agencies.

Uninsureds' Worker Status

Because of the high interest in 2003-2004 by state policy makers in employment-related coverage options, Figure 2-2 became a "favorite" at policy discussions. How many of the uninsured might a "pay or play" scheme impact? What if it affected only full time employees? How many small firms are not offering coverage? Unfortunately, we had to construct Figure 2-2 based on initial SPG research rather than our most recent data sources, for all the reasons discussed earlier. Although "old" data, the fact that it was Washington-specific and consistent with national information, gave it the needed "face validity" to inform policy discussions.

In addition, we were reminded that information "packaging" is important. When presented in new ways and shaped to the interest of the moment, existing data can be a valuable foundation for policy discussions. We learned that it is not always essential to have *new* data; what is important is the relevance and usefulness of the information.

Finally, construction of Figure 2-2 clearly pointed out gaps in information. These include characteristics of self-employed workers and their dependents (approximately 35% of the uninsured in 2000); and characteristics of firms in which workers do not take-up insurance even when they are eligible (17% of the uninsured in 2000).

Concurrent with data gathering efforts we have completed further, although limited, analysis of employer-based coverage based on a variety of sources that include the 2003 ESD survey, our original SPG research, WSPS 2002 and MEPS 2001. These data sources do not cover exactly the same subset of Washington firms or workers; the 2003 ESD survey includes firms with 4 or more employees; our original SPG research includes all firms and workers and in some cases, their dependents; WSPS does not include firms; and MEPS 2001 does not include self-employed workers or any workers' dependents. As a result, our analysis is rather a patchwork of information with some data gaps.

Distribution of Washington Business

In 2002, approximately 60% of Washington's workers[8] were employed in firms with 50 or more employees (Figure 2-3), although these firms made up less than 4% of the number of firms in the state (Figure 2-4). Over 80% of firms were small, with fewer than 10 employees, and these firms employed only 15% of Washington's workers. This distribution remains virtually unchanged in 2003.

The distribution also is reflected in the MEPS 2001 data in Table 2-1. We found reworking and comparing different data sets in this way to be useful and important. Although our data sources don't cover exactly the same subset of firms and time frame, the comparison of analyses from each source allowed us to triangulate on the story in Washington and build a greater level of comfort and face validity in our findings.

Common Benefits

National studies show that employers who do not offer health insurance tend not to offer other benefits, such as paid sick leave and paid vacation[9]. From the 2003 ESD survey we find that for the

[8] Self-employed workers are counted as individual firms with no employees.

[9] For example, Sara Collins et al. 2004. Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace. *The Commonwealth Fund.* Can be retrieved at www.cmwf.org

most part, firms that offer health insurance also offer paid vacation and paid sick leave, benefits often taken for granted. Firms that did not offer paid vacation also did not offer health insurance.

For full-time employees, paid vacation is the most commonly offered benefit and health insurance is the second most common. Eighty-two percent of Washington firms offer paid vacation and 76% offer health insurance to their full-time employees (Figure 2-4). The story is quite different for part-time employees for whom only 36% offer paid vacation and 26% offer health insurance. This disparity is consistent across all regions, industries, and firm sizes.

Firm Size

Size of firm makes a difference in the offer of health insurance (Figure 2-5). **Large firms are much more likely to offer coverage to their workers than small firms**. Almost all (97%) of firms with more than 100 employees offer coverage to their full-time employees and more than half (53%) offer coverage to their part-time employees. However, only 72% of smaller firms with between 4 and 19 employees offer coverage to their full-time employees and fewer than a quarter of them (23%) offer coverage to their part-time employees.

Although it offers the most current picture of Washington business, the ESD survey does not tell the full story of the smallest firms or the self-employed. For that story we revert to findings from MEPS 2001 (Table 2-1) and our initial SPG research, which show that **between 49% and 54% of workers in firms with fewer than 10 workers are offered coverage.** This pattern holds even when adjustments are made for factors related to firm size, such as unionization, seasonality and presence of low-wage or part-time workers.

However, regardless of firm size, **when workers are offered health insurance and they are eligible, they typically do enroll** (Table 2-1). Excluding the self-employed who made up approximately 35% of the uninsured in 2000, the MEPS 2001 survey indicates that approximately 86% of Washington workers are employed by firms that offer health insurance; 77% of these workers are eligible for coverage; and 85% of those offered and eligible are enrolled. In particular, over two-thirds (about 69%) of workers in small firms that are offered coverage are actually eligible and most of those eligible (89%) are enrolled. Workers in small firms who are eligible for coverage are much more likely to enroll than workers in the largest firms (82%).

Industry

Industries differ in their likelihood of offering health insurance. Local, state, and federal government agencies, and firms engaged in finance and insurance are most likely to offer insurance while firms engaged in the agriculture, forestry, or fishing industries are the least likely (Figure 2-6).

Industries less commonly offering health insurance to full-time workers also tend to pay lower average wages (Figure 2-7). Annual average wage for Washington firms was $38,249 in 2003. Industries with below average wages and low rates of health insurance coverage include retail trade, accommodation and food services, and agriculture, forestry and fishing. Although average wages in health care were low, over 90% of health care firms offered health insurance to their full-time workers.

Although there is variation in the availability of health insurance across industry, workers in large firms have higher sponsorship and eligibility, but not necessarily take-up rates, regardless of industry. As noted, firm size drives the opportunity for coverage more often than industry.

Wages

From our original SPG research we determined that characteristics of a firm's workers are also related to the likelihood that insurance is offered. Although much emphasis is placed on firm size, regardless of firm size, the average wage paid by a firm is an important indicator of offer of coverage. **Workers in firms with a large share of low-wage workers (and low average wage) are less likely to be offered health insurance than workers in firms with higher-wage workers (and higher average wage)** (Figure 2-8).

Dependents

Not surprising, the ESD survey confirms that dependent coverage is not offered as frequently as coverage for workers but the general characteristics of firms that offer coverage to workers apply to dependents as well. In Washington, the availability of health insurance is highest for dependents of: full-time workers; workers in large firms; workers engaged in public administration, finance and insurance, and mining and utilities; and firms located in urban Seattle-King County rather than in the more rural regions of Eastern Washington.

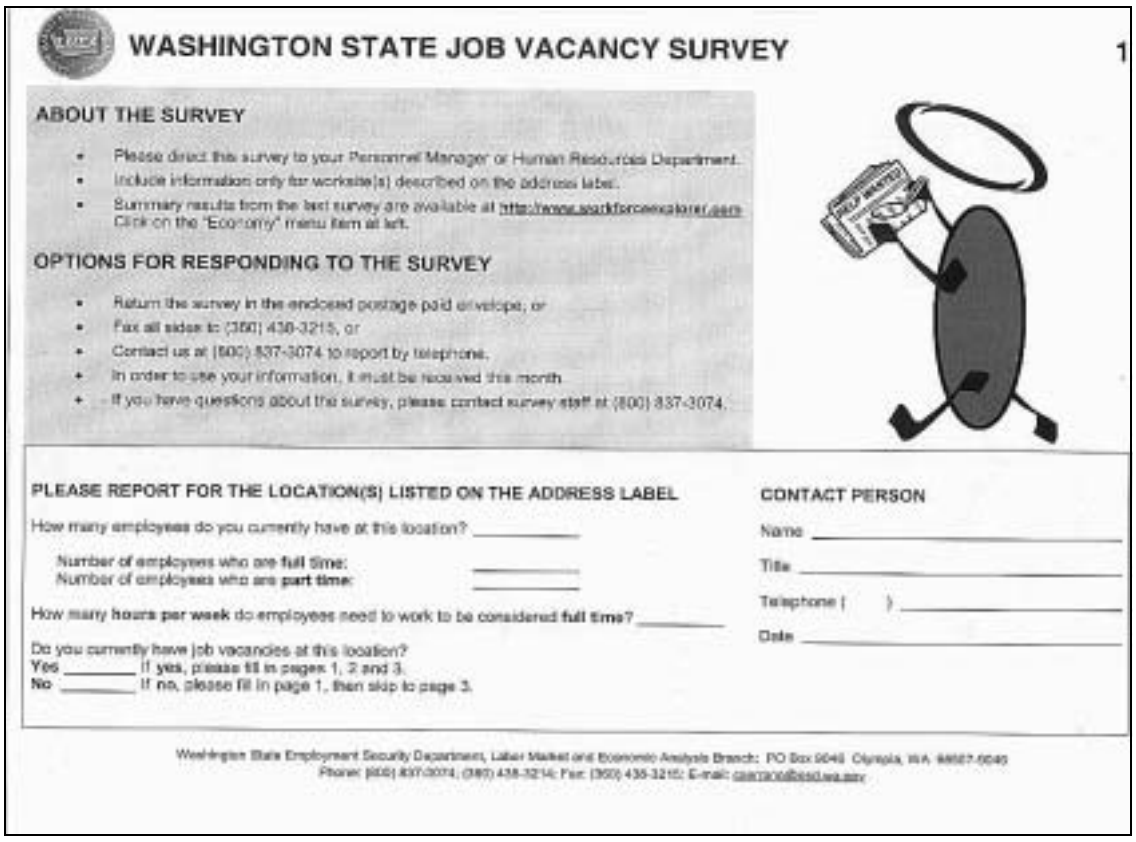
Reasons for Not Offering Coverage

Overwhelmingly, expense is the reason given by firms for not offering health insurance to at least some of their employees (73% of firms not offering health insurance) – not surprising given that national studies show that health insurance premiums have climbed rapidly in recent years, and are continuing to climb at double-digit rates[10]. For some of the largest employers in Washington, health insurance coverage is becoming a large financial drain. Starbucks for example, pays more in health insurance for its employees than it does in raw coffee[11]. In the ESD survey, expense was more often an issue for the smallest firms (4 to 19 employees) than the largest (100 or more employees). A surprising 11% of firms say they don't know why they don't offer a health insurance benefit, although estimates are based on responses given typically by staff in human resource departments who really may not know. A further 8% of firms don't offer coverage because their competitors don't.

[10] John Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New forms of Cost-Sharing," *Health* Affairs 22 (September/October 2003): 117-26. Employer Health Benefits 2004 Summary of Findings, Kaiser Family Foundation and Health Research and Educational Trust.

[11] Remarks made by CEO of Starbucks at NGA meeting in Seattle, July 19, 2004. General Motors made the same comment with respect to the cost of health insurance compared with raw steel.

Figure 2-1. Selected Pages from ESD Employment Benefits Survey



WASHINGTON STATE JOB VACANCY SURVEY

1

ABOUT THE SURVEY

- Please direct this survey to your Personnel Manager or Human Resources Department.
- Include information only for worksite(s) described on the address label.
- Summary results from the last survey are available at http://www.workforceexplorer.com. Click on the "Economy" menu item at left.

OPTIONS FOR RESPONDING TO THE SURVEY

- Return the survey in the enclosed postage paid envelope, or
- Fax all sides to (360) 438-3215, or
- Contact us at (800) 837-3074 to report by telephone.
- In order to use your information, it must be received this month.
- If you have questions about the survey, please contact survey staff at (800) 837-3074.

PLEASE REPORT FOR THE LOCATION(S) LISTED ON THE ADDRESS LABEL

How many employees do you currently have at this location? _____

Number of employees who are **full time**: _____
Number of employees who are **part time**: _____

How many **hours per week** do employees need to work to be considered **full time**? _____

Do you currently have job vacancies at this location?
Yes _____ If yes, please fill in pages 1, 2 and 3.
No _____ If no, please fill in page 1, then skip to page 3.

CONTACT PERSON

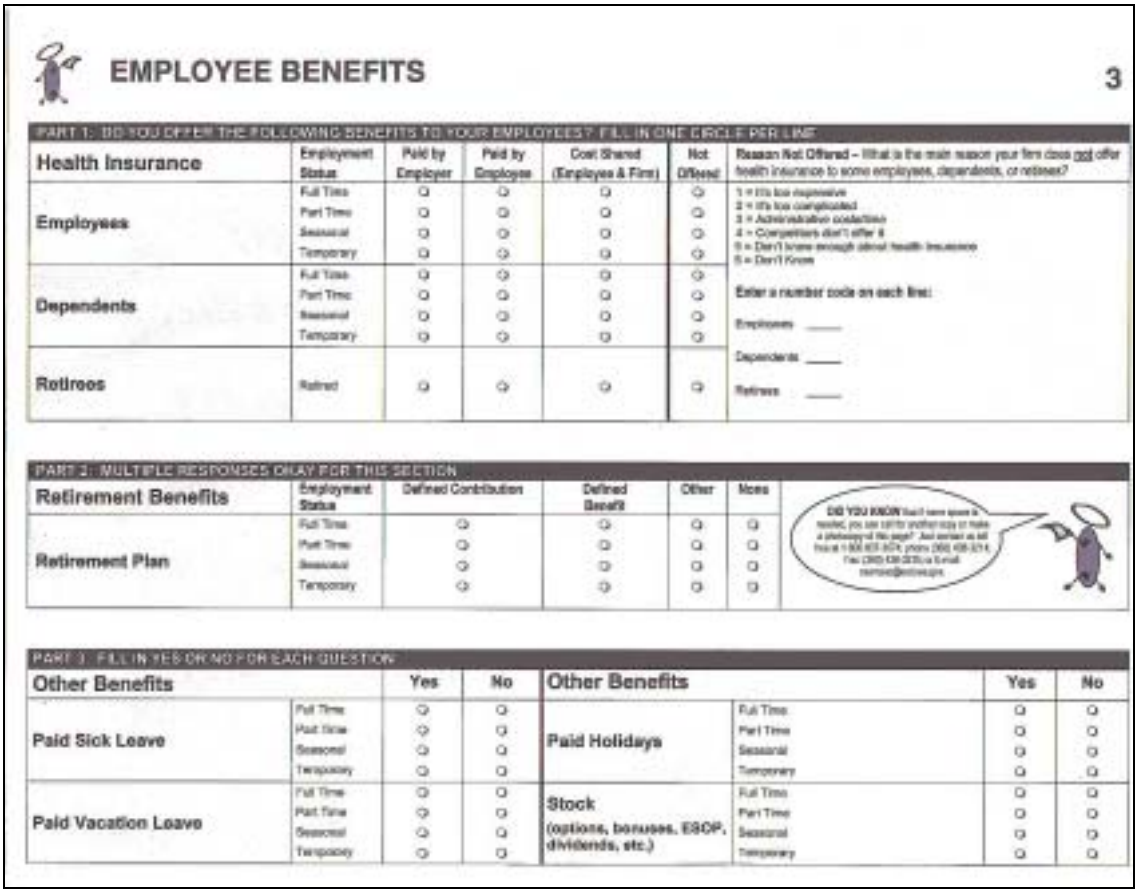
Name _____

Title _____

Telephone ( ) _____

Date _____

Washington State Employment Security Department, Labor Market and Economic Analysis Branch; PO Box 9046, Olympia, WA 98507-9046
Phone: (800) 837-3074, (360) 438-3214; Fax: (360) 438-3215; E-mail: [illegible]



EMPLOYEE BENEFITS

3

PART 1: DO YOU OFFER THE FOLLOWING BENEFITS TO YOUR EMPLOYEES? FILL IN ONE CIRCLE PER LINE

Health Insurance	Employment Status	Paid by Employer	Paid by Employee	Cost Shared (Employee & Firm)	Not Offered
Employees	Full Time	○	○	○	○
	Part Time	○	○	○	○
	Seasonal	○	○	○	○
	Temporary	○	○	○	○
Dependents	Full Time	○	○	○	○
	Part Time	○	○	○	○
	Seasonal	○	○	○	○
	Temporary	○	○	○	○
Retirees	Retired	○	○	○	○

Reason Not Offered – What is the main reason your firm does not offer health insurance to some employees, dependents, or retirees?

1 = It's too expensive
2 = It's too complicated
3 = Administrative costs/fees
4 = Competitors don't offer it
5 = Don't know enough about health insurance
6 = Don't Know

Enter a number code on each line:

Employees ____
Dependents ____
Retirees ____

PART 2: MULTIPLE RESPONSES OKAY FOR THIS SECTION

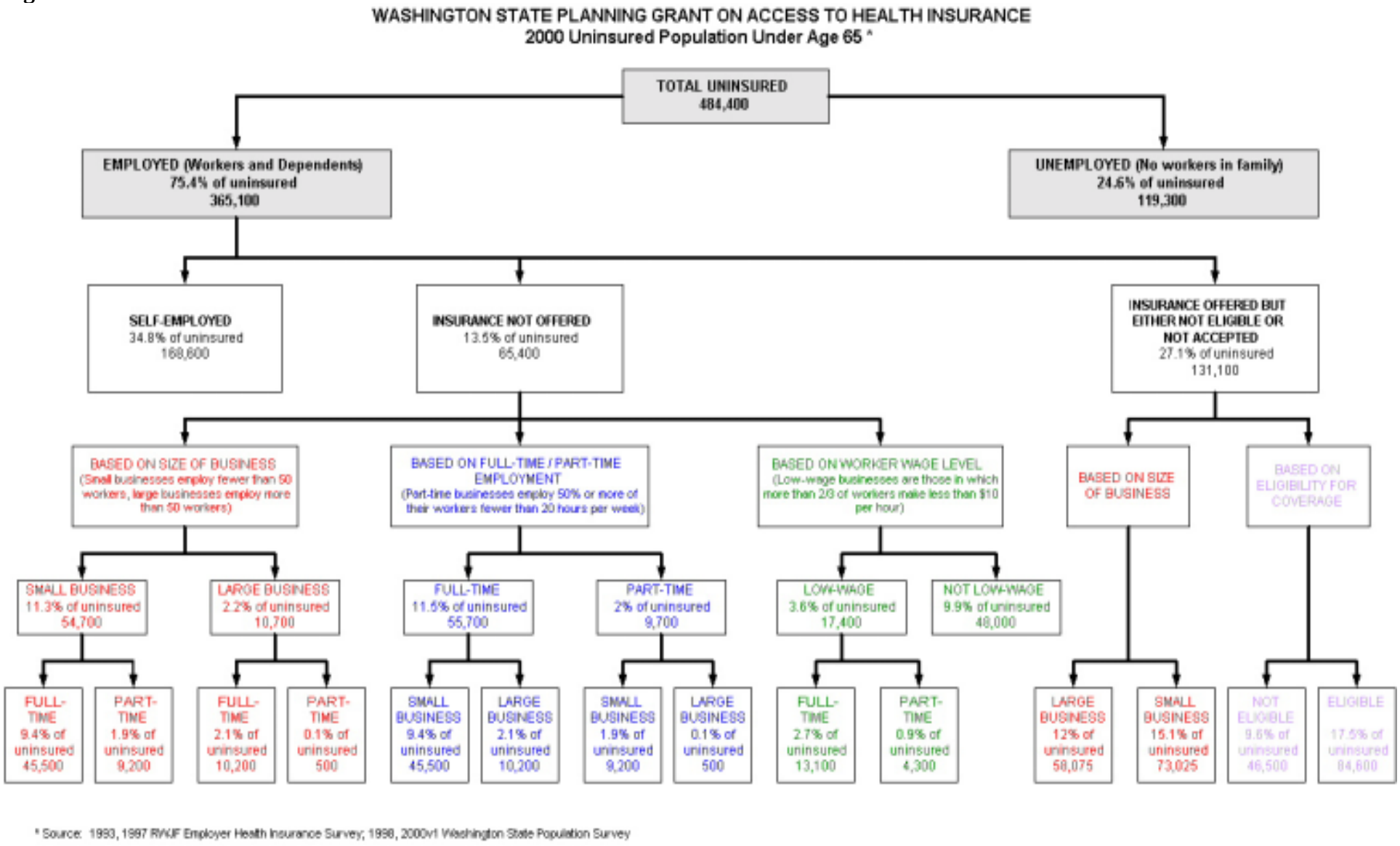
Retirement Benefits	Employment Status	Defined Contribution	Defined Benefit	Other	None
Retirement Plan	Full Time	○	○	○	○
	Part Time	○	○	○	○
	Seasonal	○	○	○	○
	Temporary	○	○	○	○

DID YOU KNOW [illegible]

PART 3: FILL IN YES OR NO FOR EACH QUESTION

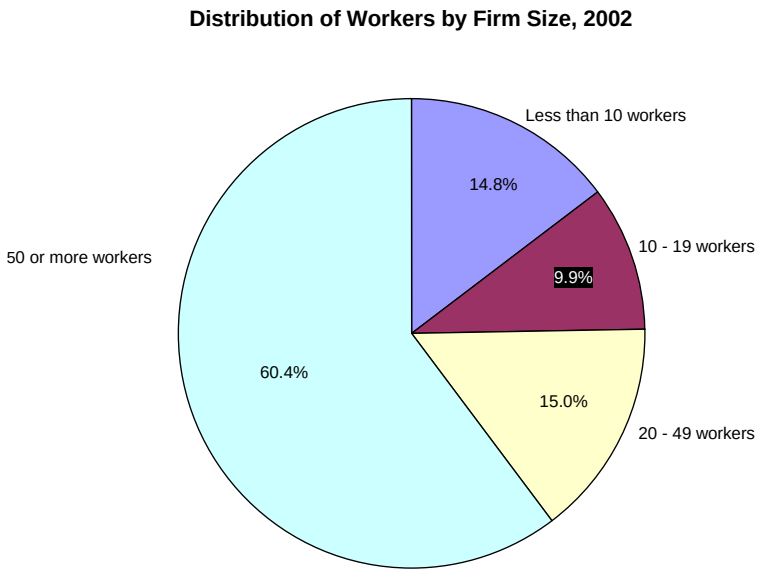
Other Benefits		Yes	No	Other Benefits		Yes	No
Paid Sick Leave	Full Time	○	○	Paid Holidays	Full Time	○	○
	Part Time	○	○		Part Time	○	○
	Seasonal	○	○		Seasonal	○	○
	Temporary	○	○		Temporary	○	○
Paid Vacation Leave	Full Time	○	○	Stock (options, bonuses, ESOP, dividends, etc.)	Full Time	○	○
	Part Time	○	○		Part Time	○	○
	Seasonal	○	○		Seasonal	○	○
	Temporary	○	○		Temporary	○	○

Figure 2-2



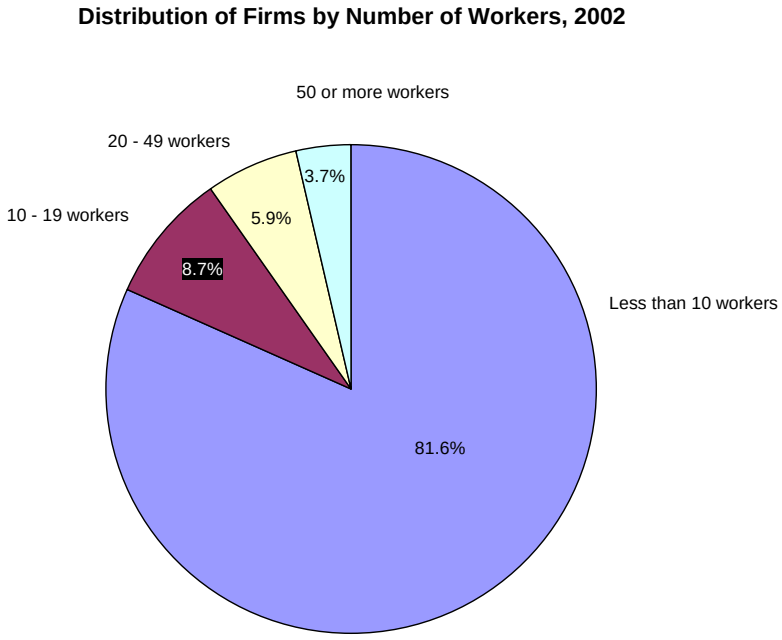
* Source: 1993, 1997 RWJF Employer Health Insurance Survey; 1998, 2000v1 Washington State Population Survey

Figure 2-3



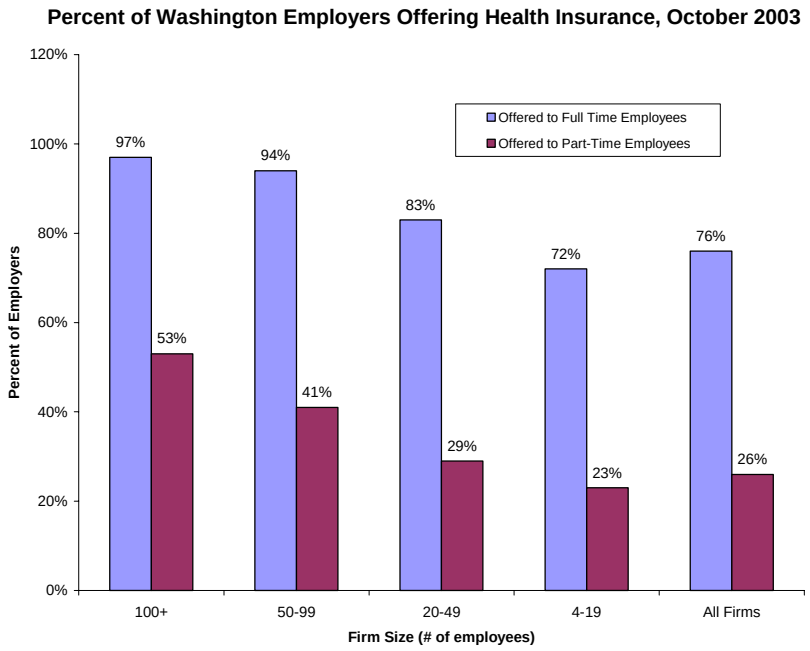
Source: Labor Market and Economic Analysis, ESD, 2002 1st Quarter

Figure 2-4



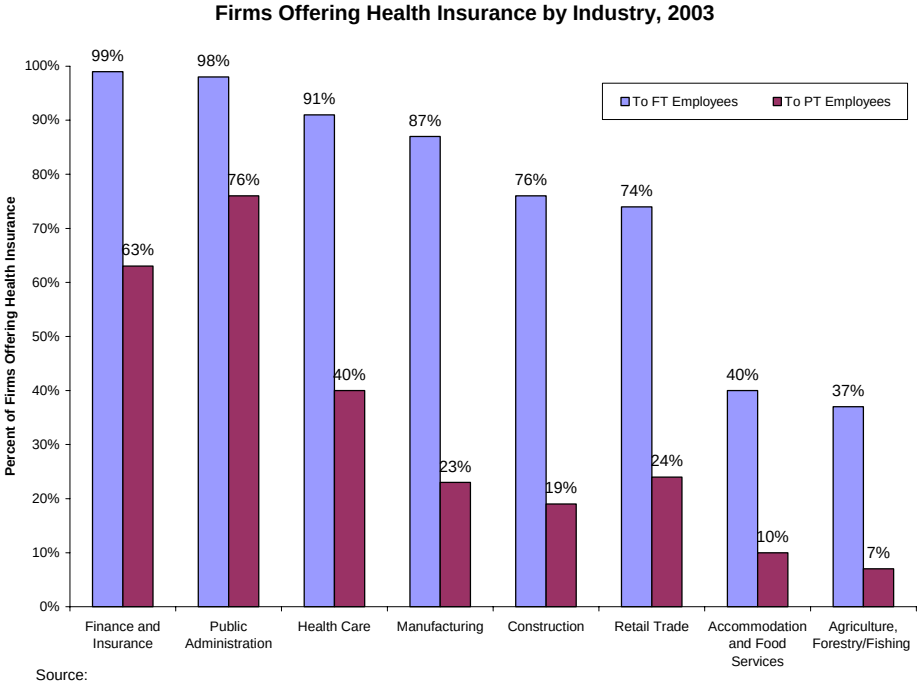
Source: Labor Market and Economic Analysis, ESD, 2002 1st Quarter

Figure 2-5



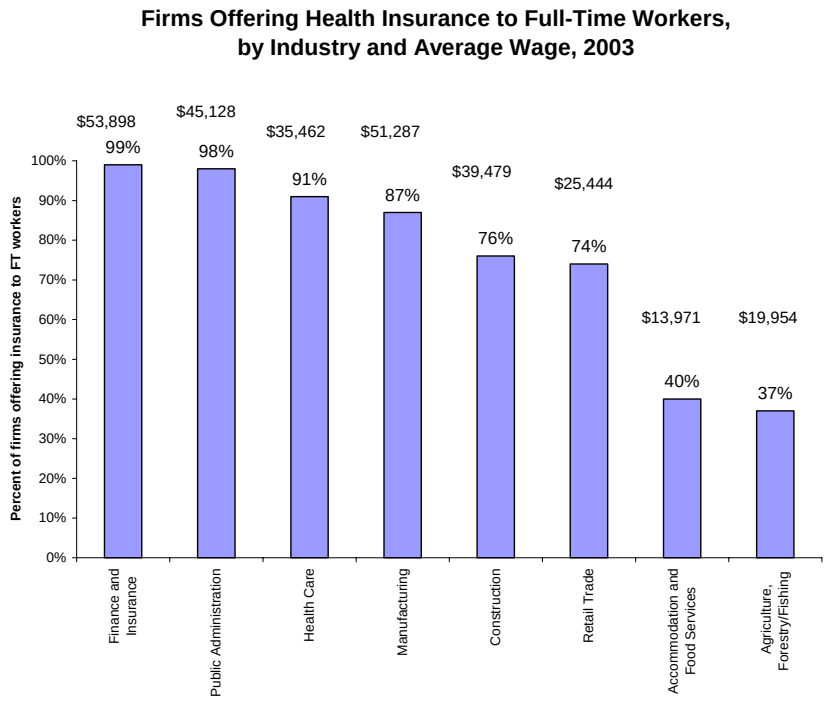
Source:
October 2003 Washington Employee Benefits Survey, available at www.workforceexplorer.com
(Firms under size 4, and employee dependents not included)

Figure 2-6



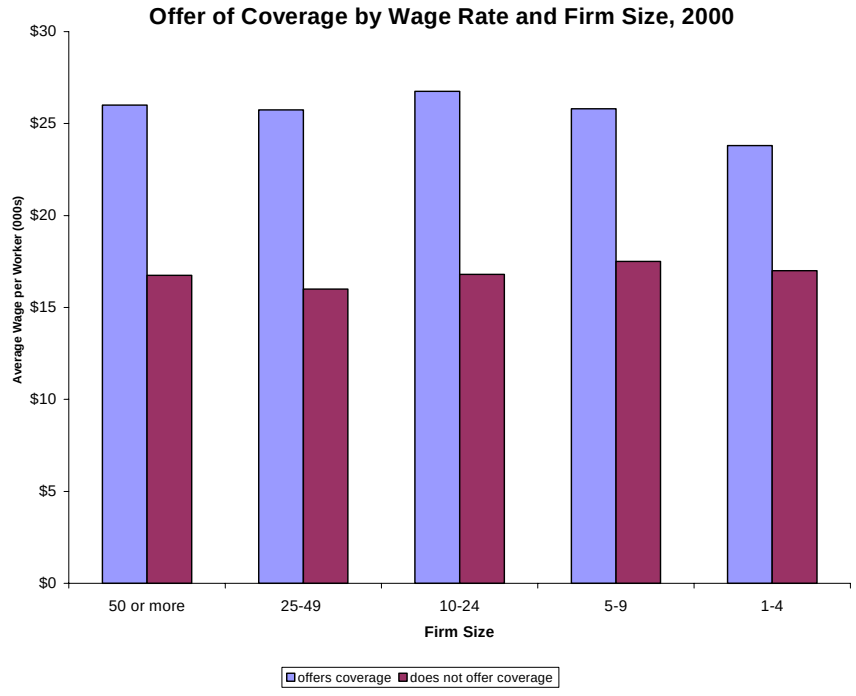
Source:
October 2003 Washington Employee Benefits Survey, available at www.workforceexplorer.com
(Firms under size 4 not included)

Figure 2-7



Source:
October 2003 Washington Employee Benefits Survey, available at www.workforceexplorer.com
(Firms under size 4 not included)

Figure 2-8



Source: 1993, 1997, RWJF Washington Family Health Insurance Survey

Table 2-1.

MEPS, 2001 (Multi-establishment firms included as 1 firm)

Firm Size	# of firms	% of firms	% that offer insurance	# employees	% employees	% in firms that offer ins.	% eligible in firms that offer ins.	% eligible & enrolled in firms that offer ins.
Total	140,902	100%	52.8%	2,219,465	100%	86.1%	77.1%	85.3%
1-9 employees	87,894	62.4%	35.6%	366,792	16.5%	49.3%	68.7%	88.9%
10-24 employees	17,323	12.3%	61.7%	203,079	9.1%	67.0%	82.2%	88.3%
25 -99 employees	11,712	8.3%	80.4%	321,355	14.5%	84.4%	77.4%	93.8%
100-999 employees	7,489	5.3%	91.1%	363,839	16.4%	99.3%	76.1%	84.6%
1,000+ employees	16,483	11.7%	98.7%	964,400	43.5%	99.7%	78.3%	82.2%

	Small Employers (Size 1-49)	**Large Employers (100-999)**	**Very Large Employers (1000+)**	**Imputed Big employers (100+)**	MEPS Variable
Number of **firms**	111,444	7,489	16,483	23,972	IIA1
Percent of number of firms	79.1%	5.3%	11.7%	17.0%	IIA1A
Percent of firms that offer HI	41.7%	91.1%	98.7%	96.3%	IIA2
Number of employees	708,343	363,839	964,400	1,328,239	IIB1
Percent of number of **employees**	31.9%	16.4%	43.5%	59.8%	IIB1A
Percent of employees in firms that offer HI	59.4%	99.3%	99.7%	99.6%	IIB2
Percent of employees eligible for HI in firms that offer HI	75.6%	76.1%	78.3%	77.7%	IIB2A
Percent of employees eligible for HI that are enrolled in HI at firms that offer HI	90.7%	84.6%	82.2%	82.8%	IIB2A1
Number of **full-time** employees	490,804	282,500	740,380	1,022,880	IIB3
Percent of number of full-time employees	29.6%	17.0%	44.6%	61.7%	IIB3A
Percent of full-time employees at firms that offer HI	70.6%	99.3%	100.0%	99.8%	IIB3B
Percent of full-time employees eligible for HI at firms that offer HI	88.0%	89.3%	86.3%	87.1%	IIB3B1
Percent of full-time employees eligible for HI that are enrolled in HI at firms that offer HI	91.4%	87.1%	86.2%	86.5%	IIB3B1A
Number of **part-time** employees	217,539	81,339	224,020	305,359	IIB4
Percent of number of part-time employees	38.8%	14.5%	39.9%	33.1%	IIB4A
Percent of part-time employees at firms that offer HI	34.2%	99.4%	98.9%	99.0%	IIB4B
Percent of part-time employees eligible for HI at firms that offer HI	17.8%	30.1%	51.6%	45.9%	IIB4B1
Percent of part-time employees eligible for HI that are enrolled in HI at firms that offer HI	75.2%	58.1%	60.3%	59.9%	IIB4B1A

A. Washington's Current Market:

Not surprising, employer-based coverage is the primary source of health insurance for Washington's under age 65 population. Within that market, Washington law distinguishes between small employers (groups of 2-50) and large employers (groups larger than 50). Individuals not provided coverage through an employer have an opportunity to purchase health insurance through the individual market, in which 8% with the highest health risk are screened into a high- risk pool. Three major carriers provide coverage for over 80% of the market (Figure 3-1).

Rates of public and private insurance vary substantially by income. The likelihood of having employer-based (private) coverage is well over twice as high for those with family incomes above 200% of federal poverty (roughly $36,200 for a family of four in 2002) compared to those with lower incomes (Figure 3-2.) Targeted expansion in public programs (Medicaid and Basic Health) addresses the coverage gap for close to half the low income population, even though nearly 20% of this group remains uninsured (approximately 292,000 individuals).

In spite of historical efforts to cover the uninsured and stabilize the insurance market described in the next section, Washington's system remains stressed. Current interest is focused on the small group market where insurance products are becoming increasingly costly, prompting small employers (redefined during the 2004 Legislative session to groups of 2-50 employees) to shift costs to their employees or drop coverage altogether. As noted in Section 2, data that allow in-depth evaluation of local trends in this market (and in the large group market) are incomplete.

B. Washington's Market History:

A 2002 assessment of health policy for low-income people in Washington noted that Washington has been a leader in health reform beginning with a major legislative package passed in 1993.[1] That package included employer and individual mandates, expansion of Medicaid coverage for low-income children, extended home and community based coverage for the elderly and disabled, major reforms of the individual and small-group insurance markets, and expanded enrollment of the state's Basic Health (BH) program (a subsidized, state-only funded insurance program for low-income working families with incomes up to 200% of federal poverty).

While many of the health reform components were repealed by the Legislature in subsequent years, major public program expansions continued and were very successful. By 2002, nearly 96% of the state's children were insured. These expansion efforts built upon the Medicaid and BH programs, targeting (1) uninterrupted coverage for low-income children ages 0-18, (2) affordable public / private pooling for low-income working adults, and (3) family unity by coordinating coverage for children and adults across programs. The most notable successes include:

- Medicaid completed a series of innovations promoting uninterrupted coverage for low-income children ages 0-18 by expanding eligibility for Children's Medicaid to 200% federal poverty and by implementing SCHIP coverage for children between 200 and 250% FPL.
- In addition, Medicaid initiated a small premium assistance program, partnering with employers to fund private coverage for Medicaid-eligible adults.

[1] Holahan, John and Mary Beth Pohl. "Recent Changes in Health Policy for Low-Income People in Washington." Assessing the New Federalism, State Update No. 24, February 2002. Washington D.C.: The Urban Institute.

- BH expanded as a state subsidized pool emphasizing affordable coverage for low-income working adults, that incorporates enrollee premium contributions based on a sliding scale and point-of-service co-payments. It has become a nationally recognized "ready laboratory" for assessing the impacts of health policy options on low-income families.
- BH and Medicaid developed seamless coordination of coverage to support family unity for low-income families, enrolling children in Medicaid (BH Plus) and their parents in BH.
- BH implemented an employer-sponsored insurance program, offering individual coverage to employers as a group.

Between Medicaid and BH, approximately 958,900 residents, (16% of all state residents), including 538,000 (33%) children were covered in July 2001. At the same time that employer-based coverage rates were declining, Washington's overall insured rates were increasing due in no small part to public programs – at least up until 2002.

Figures 3-3 to 3-5 depict highlights of public program expansion efforts in Washington, and provide an overview of programs for children and adults by income eligibility. Figure 3-4 depicts public programs for children by income eligibility cutoffs. An array of programs is available for children with family incomes up to 250% of federal poverty, from ages 0 through 18. Public insurance options for working age adults are also available up to 200% of federal poverty, however most programs target only the lowest income adults with a disability or children (Figure 3-5).

Washington's more recent history, beginning with the 2001-03 biennium, vis-à-vis public programs is a little different. The nexus of our progressive social policy and our conservative fiscal policy (coupled with the economic downturn) have produced a "health system for low-income individuals [that] seems to be in a fairly fragile state". People are losing coverage and rates of uninsurance are increasing – immigrant children that were moved from Medicaid to Basic Health did not re-enroll as hoped, Basic Health coverage slots were decreased (and remaining slots were funded by dollars intended for expansion), administrative changes in Medicaid resulted in much larger than anticipated exits of children, radical changes to the cost-sharing design of Basic Health (including deductibles, out-of-pocket maximums, and co-insurance) were implemented (although to-date it looks as though exit rates have not risen substantially). However, there are a few "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, and Governor Locke's decision to delay until July 2005 premiums for some Medicaid children (below 200% federal poverty); although children in SCHIP (201% - 250%) saw an increase in premium sharing starting July 2004.

In addition to its struggles with sustaining public program coverage, Washington also has a recent history with problem-ridden individual and small group insurance markets. For example, the individual market literally collapsed in 1998-99 – you could not buy individual coverage in Washington – and did not re-open until 2000-01 following Legislative action that in part allowed health underwriting to return. More recently, the small group market has been the focus of attention. Although it did not collapse in the same way as the individual market, the warning signals were clear. Lively debates on how to solve the market's "premium affordability" problems resulted in Legislative action in 2004. However, the business community felt the bill fell short of success and gathered signatures on an "initiative to the people" to allow plans with less coverage of services, fewer categories of providers, and changes in regulatory oversight of rates. Too few signatures were collected for the initiative to be included on the November 2004 ballot.

The outcome described above regarding the small group market illustrates a current difficulty in Washington re coming to consensus on how to maintain / extend insurance coverage. There are strong philosophical differences that make it difficult to find common ground on solutions – these differences are evidenced by proposed initiatives to the people that range from less government (the small group initiative described above) to more government (create a new government agency that would develop a health care plan for all state residents). In addition, there are few formal avenues currently in place other than Legislative and initiative processes where public policy on covering the uninsured can be debated.[2]

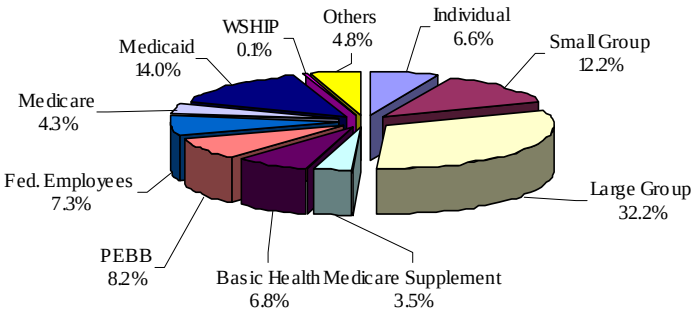
Thus, despite early progress expanding insurance in the state, Washington has gone from a leader in health reform to a state struggling to maintain its existing coverage programs. Dramatic increases in health care costs have come face to face with falling revenues and serious budget problems. And it's not over – latest figures show that we are creeping over a potential $1 billion dollar general fund deficit for 2005-2007, and an increasing gap between revenue and expenditures in the Health Services Account (source of funding for many of Washington's public coverage programs).

[2] In 2003, the independently-elected Insurance Commissioner initiated and chaired a task force on covering the uninsured. Although the group was unable to come to consensus on strategies, the Commissioner took lessons from their discussions and crafted proposed (albeit unsuccessful) 2004 legislation involving reinsurance and a premium assistance program for employees of small employers. Currently, the Governor's Office and executive branch agencies are engaged in a "priorities of government" exercise that will be used to set policy and budget priorities for Governor Locke's final budget proposal. This is a well-publicized process open to public input through usual channels—but in the end, it's an executive branch exercise not a public policy debate forum.

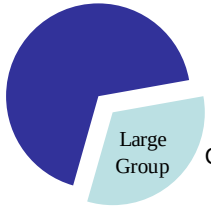
FIGURE 3-1. **WASHINGTON STATE PLANNING GRANT ON ACCESS ON HEALTH INSURANCE**
WASHINGTON'S INSURANCE MARKET, 2002

Private Insurance Carriers' Market Composition (2002)

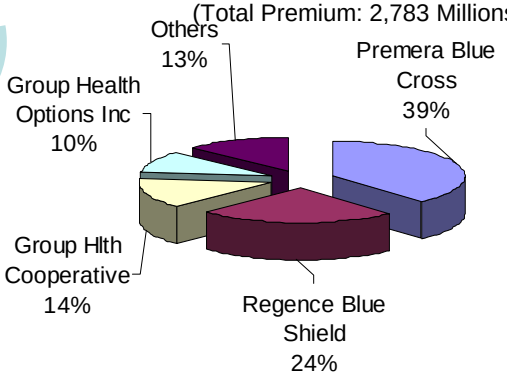
2002 Total Enrollment: 2,755,491
(51% of Total Insured in Washington State)



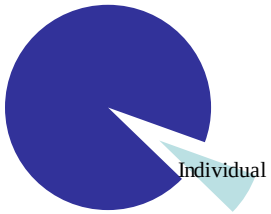
Private Health Care Insurance Market Segment Large Group (2002)



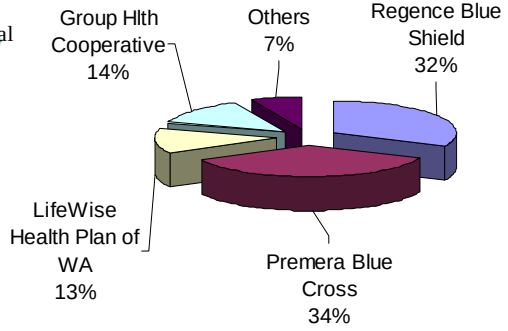
2002 Total Enrollment: 1,193,743
(Total Premium: 2,783 Millions)



Private Health Care Insurance Market Segment: Individual (2002)

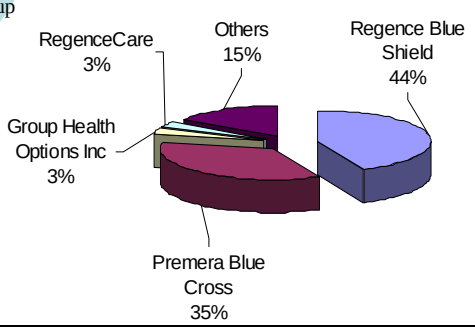


2002 Total Enrollment: 192,887
(Premium: $330 Millions)



Private Health Care Insurance Market Segment Small Group (2002)

2002 Total Enrollment: 361,429
(Total Premium: 810 Millions)



Source: OIC 2003 Task Force - 2002 Financial statements filed with Washington OIC and NAIC; Washington State Population Survey 2000v4.

Figure 3-2.

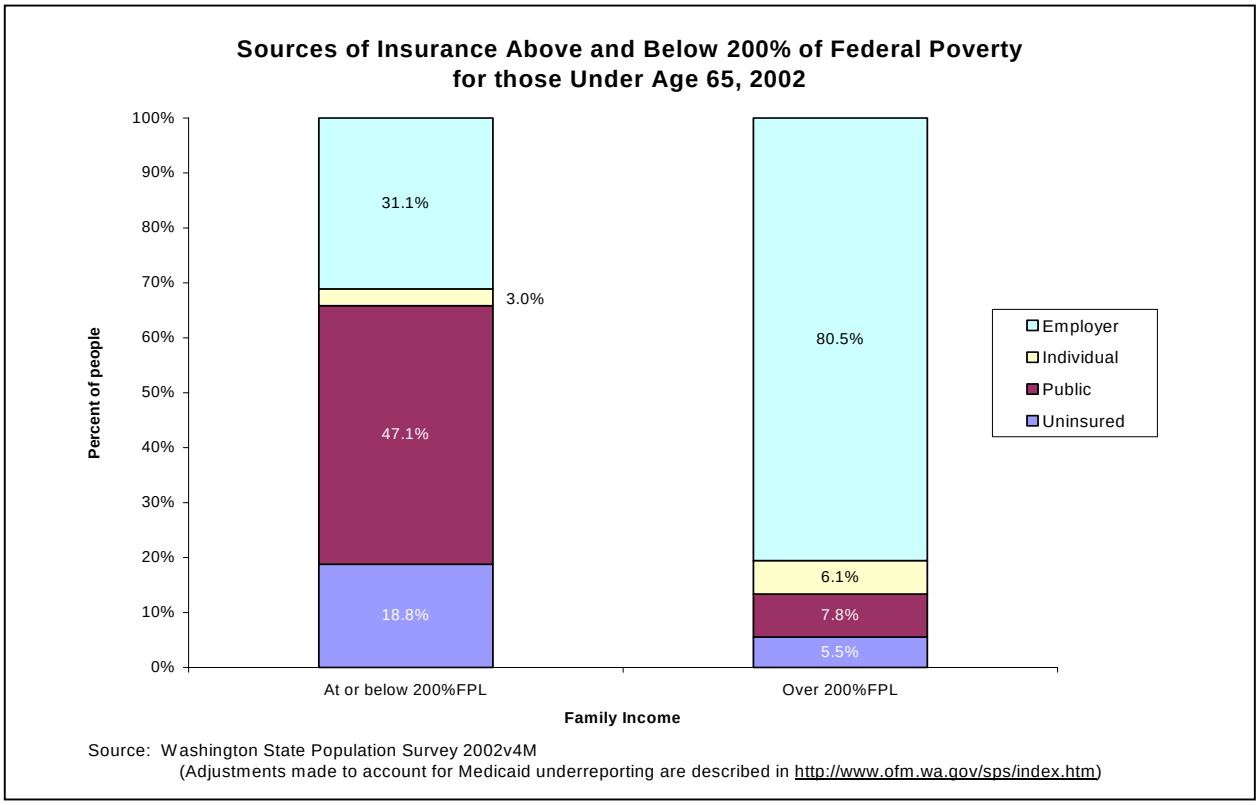
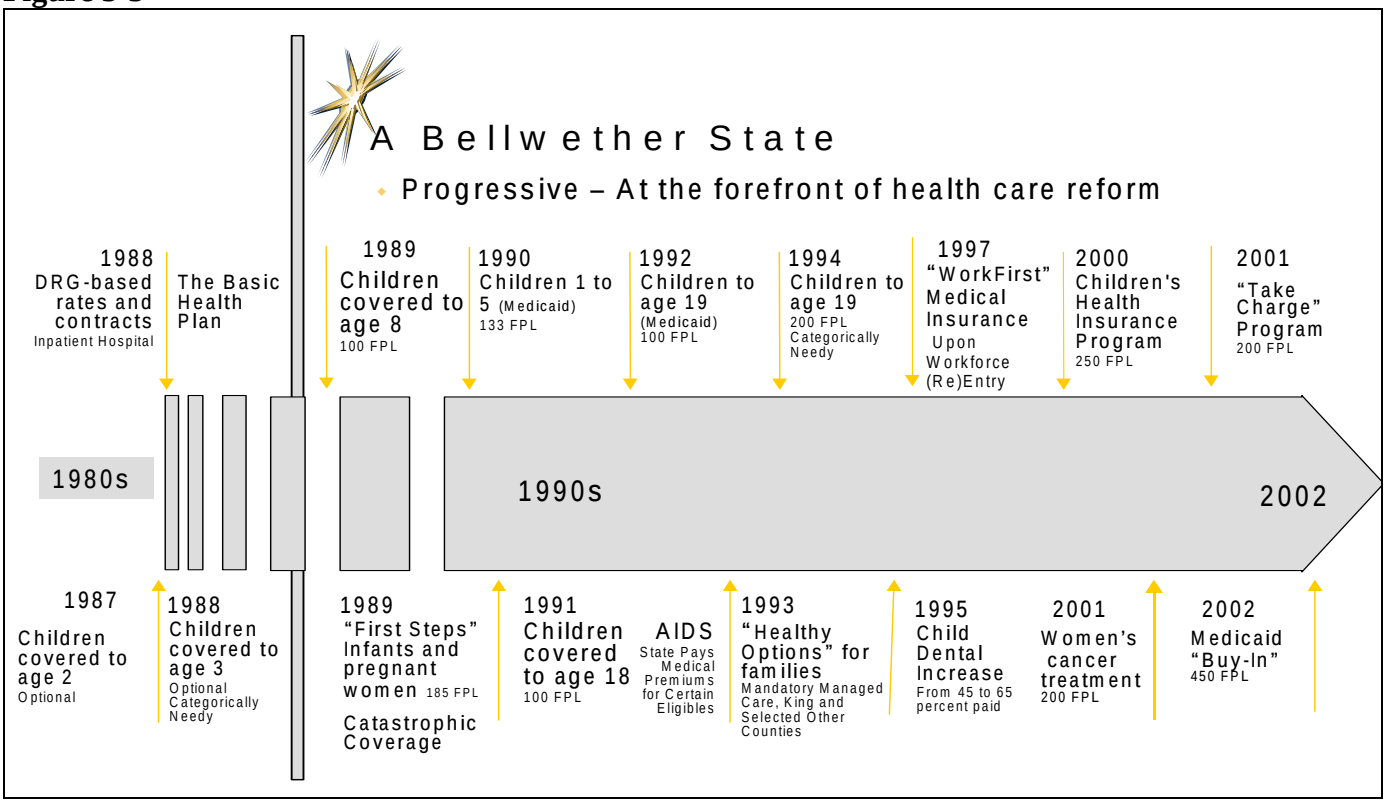


Figure 3-3



"Bellwether" chart provided by State of Washington, Department of Social and Health Services.

Figure 3-4

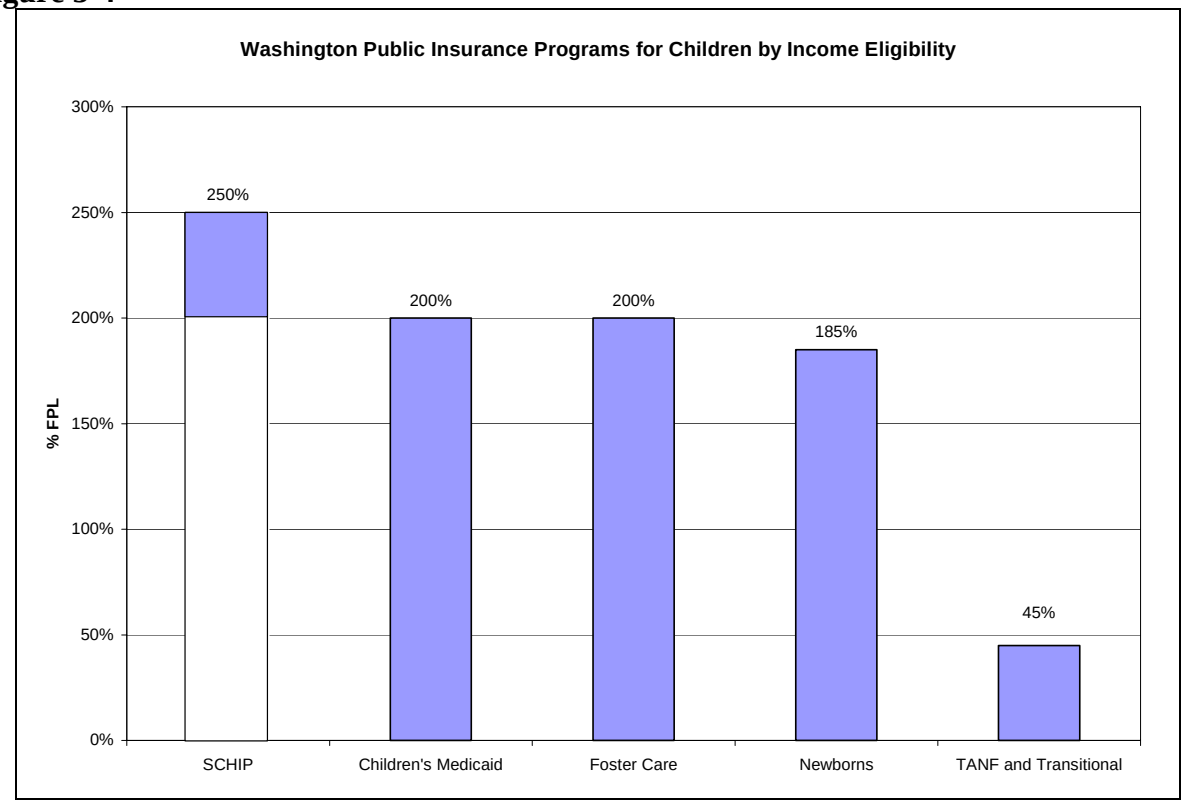
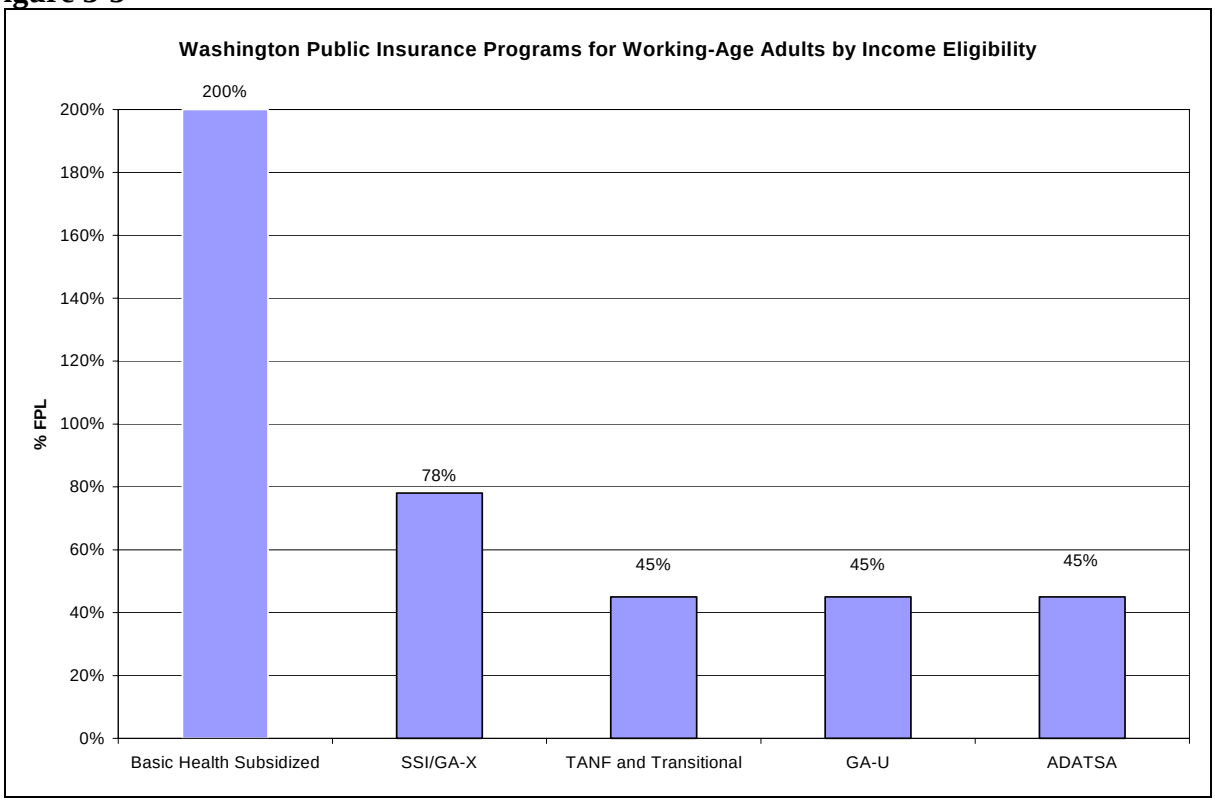


Figure 3-5



SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working (Basic Health) and for children & their families (Medicaid coverage for children up to 200% federal poverty before SCHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention).

More recently, particularly in light of the state's prolonged recession and resulting budget deficits, public policy vis-à-vis coverage has focused on:

- maintaining public programs for the most vulnerable,
- providing a supportive environment for employers to offer coverage and individuals to purchase it, and
- assisting the clinic-based safety net system with funds and regulatory support.

Notwithstanding these efforts, people unfortunately have still lost coverage, most notably in public programs – immigrant children were moved from Medicaid to Basic Health and did not re-enroll as hoped, Basic Health coverage slots were decreased and funded by dollars intended (via a citizen's initiative) for expansion, Medicaid administrative changes resulted in much larger than anticipated exits of children, major changes to Basic Health cost-sharing (including deductibles and co-insurance) were implemented (evaluation of impacts is underway).

However, there also have been a few recent "incremental" bright spots including coverage for the working disabled, opening Basic Health to people eligible for Trade Act coverage, resolving an individual market collapse, forestalling a small group market "affordability" crisis, and Governor Gary Locke's decision to delay until July 2005 premiums for some Medicaid children (those below 200% federal poverty); although children in SCHIP (201% - 250%) saw an increase in premium sharing effective July 2004.

All in all, the mixture of Washington's progressive social policy, conservative fiscal policy (e.g., 1993 passage of spending cap), and recent economic downturn has produced a current "health system for low-income individuals [that] seems to be in a fairly fragile state".[1]

The irony of working on a grant to achieve broader coverage, simultaneous with watching the uninsured rate increase, does not escape us. It has been an on-going challenge.

In the following sections we describe a select set of coverage and access activities conducted largely in 2003-04 and for which State Planning Grant (SPG) support has been invaluable. Before doing so, it's important to note that much of our work has been of a support nature and is somewhat difficult to capture succinctly – answering a myriad of ad-hoc questions, participating in policy and design discussions organized by a variety of groups, creating a "presence" in the executive branch to ensure that Washington's uninsured aren't lost in the shuffle of budget deficits. We do our best to show the essence of our support role but the exactness is somewhat elusive. (Note: Most Figures referenced in this section are included at the end of the section.)

[1] Holahan, John and Mary Beth Pohl. 2002. "*Recent Changes in Health Policy for Low-Income People in Washington*." Washington, D.C.: The Urban Institute. The quote used is as true today as it was when Holahan & Pohl wrote it.

A. The Range of Coverage Efforts

Over the last couple of years, coverage options that have risen to the top of the *state* policy discussion list include covering all children, revising the small group market to assist small employers in providing coverage, "stimulating" employers to provide coverage, stabilizing the private market, and redesigning public insurance programs. In Figure 4-1 we elaborate on state policy efforts in these areas.

In addition to this state policy focus, there have been a variety of *other activities* in Washington related to coverage and access. In Figure 4-2 we try to capture as many of these as possible and link them to the initial SPG research on potential policy options. In the following sections we briefly elaborate on a few of these.

Finally, in Appendix 1 we provide examples of the types of data and policy questions responded to by SPG staff in support of coverage discussions and programs.

B. Community-Based Efforts

We are highlighting the following three community-based efforts because (1) they demonstrate different aspects of the SPG program strategy to support others' efforts to enhance coverage, (2) the initiators represent different types of "communities" (providers, occupation-based, public health) with which we have collaborated, or (3) the efforts represent a diversity of access and coverage thinking, as well as incremental and transformative approaches.

Community Health Works[2] is an example of a community activity with which we have had a long-standing relationship. The SPG program chose to become closely involved in this activity because of its "transforming health coverage and access" orientation. The majority of coverage options in-play these days are incremental – Community Health Works was an opportunity to collaborate with a dedicated group of local providers, public health officials, policy shapers, consumers, brokers and others to design a program that would provide 100% access for all low-income (below 250%) residents of a five county region in Washington state.

The goal of this project is to pilot a community-based coverage, delivery and administration model sometime around 2008. Although still a work-in-progress, one of most "transformative" pieces under discussion is the development of a "Community Health Management District" (CHMD). Because the governance of the CHMD would be local, it would reflect local values in terms of access-to-care guarantees (what care should everyone in the community have access to), in terms of making service delivery better (collaborative and subsidized information technology; shared provider and resident responsibility for ensuring a medical home for everyone), and in terms of managing and leveraging funds to pay for the "community-responsibility" piece of health care access (lower individual costs for care via community-shared reinsurance for higher costs). Although it has evolved significantly since then, one of the "birth places" for this idea was a SPG-sponsored technical assistance meeting conducted in May 2002 on Community-

[2] *Community Health Works* (previously the 100% Access Project) is funded by the U.S. Department of Health and Human Services, Health Resources & Services Administration (HRSA), Bureau of Professions' Community Access Program (CAP). More information is available from Kristen West or Dan Rubin at CHOICE Regional Health Network, 2409 Pacific Avenue SE, Olympia, WA 98501, 360-493-4550.

Based Purchasing and Coverage.[3] Emphasizing that the CHMD model is a work-in-progress, a recent vision of the model is given in Figure 4-3.

Most recently, health coverage and access projects from around the state have come together as *Communities Connect.* Their commonality is based on six principles (see side box) that are also the guiding principles of the Community Health Works project and serve to demonstrate the growing, community-driven, wave of change moving across Washington

"We believe we can deliver better health care for more people at less cost by formalizing community collaboratives throughout Washington State who will be "in action" on six interdependent principles: 1) Stabilize the safety net of hospitals and practitioners who provide care to the low-income and uninsured; 2) Create flexible and attractive ways for employers to financially contribute towards coverage for low-wage workers; 3) Enroll people with limited incomes in a medical home, starting with children; 4) Deliver evidence-based and patient-focused care through health teams; 5) Reduce costs and redirect savings to cover more people; 6) Purchase services of greater value to the community through Community Health Management Districts (CHMDs)."

Community-Based Health Care, Issue Paper Draft #3, Communities Connect, available from Choice Regional Health Network, Community Health Works program.

Washington Artists Health Insurance Project[4] (WAHIP) is an example of an activity in which we have just recently become involved. In fact, the project itself is quite recent and held its first "kick-off" meeting with representatives of the arts community in September 2004. Among the goals of this project are (1) develop new strategies to improve artists' access to health insurance in Washington state and (2) serve as a national "process and implementation" model for other state and community efforts to enhance coverage options that benefit artists.

Washington's SPG program is particularly interested in this effort for several reasons. First, we see an opportunity for this group to serve as a proxy for a changing work force. The rise of contract, temporary, contingent, multiple-employer workers fits the long-standing fluid

[3] State Coverage Initiatives (SCI) staff assisted in organizing this invitation-only meeting attended by community-based coverage champions and facilitated by several national experts. SCI is a program of The Robert Wood Johnson Foundation.

[4] *WAHIP* is part of Leveraging Investments in Creativity (LINC), a 10-year national effort to strengthen artists' ability to work in their professions and to connect with their communities. Funding for LINC is provided by the Ford Foundation, Allen Foundation for the Arts, Nathan Cummings Foundation, John S. and James L. Knight Foundation, and the Rockefeller Foundation. More information about WAHIP is available from Claudia Bach, 7702 14th Avenue NW, Seattle, WA 98117, 206-789-2418, Claudia@advisarts.com.

employment pattern of many artists and those who work in arts-related occupations (e.g., set designers). If we "use artists to see beyond artists" and focus on coverage options that meet the "work styles" of this group perhaps we have a head-start on forging viable coverage approaches to meet the needs of a changing future workforce. Second, we see this as an opportunity to bring new thinkers to the table. Those of us who have worked in health policy for years can have a tendency (although we certainly fight it) to believe we've "been there done that" and perhaps get myopic in our thinking. Here is a new force in Washington, the arts community, that is willing and enthusiastic to bring its resources and creative talent to this issue. Finally, we believe the resources of the SPG and the needs of the WAHIP are aligned (see side box) – we have an on-going strategy of supporting, through research and policy analysis, *any* group that is willing to tackle *any* aspect of "covering the uninsured". This certainly is the case with the artists' initiative.

> "With regard to health and retirement insurance and similar benefits, we need (a) much better and more up-to-date information about who has insurance and who does not; (b) information about the various and most advantageous ways in which artists currently get insurance and also promising ways in which they may be able to obtain it in the future; and (c) information about advocacy efforts for heatlh and retirement insurance inside and outside the cultural sector. Specific information about groups with which artists may become allied would also be useful."
>
> Jackson, M.R. et al. *Investing in Creativity: A Study of the Support Structure for U.S. Artists*. Washington D.C.: The Urban Institute Press, pgs 79-80.

We currently are exploring with WAHIP leadership the different ways in which we can collaborate. On a range of less-to-more involvement these include: participating as one of a consortium of experts that guides the project, exploring State Population Survey data to see if information about artists can be reasonably isolated (and if so, conducting basic analyses to identify gaps in knowledge), providing technical assistance in designing a survey of Washington artists and arts-related workers regarding their insurance status and needs, contributing resources for analysis of survey results, jointly sponsoring a meeting of national experts to explore coverage options, providing policy assistance in evaluating the viability of options, collaborating on locating resources and partners to implement a demonstration.

Although our involvement has been minimal to-date (attendance at a few meetings and phone conversations), we chose to highlight this activity because it demonstrates the on-going interest in Washington of finding coverage options, that there are new groups willing to struggle with old issues, and that the support provided by the SPG program continues to be of value.

Kids Get Care[5] is our last example of a community-based effort. We have chosen to highlight it for several reasons. One, it's an example of another aspect of our SPG strategy on achieving coverage -- that is, we literally have had no visible roll in supporting this effort; rather, we have

[5] *Kids Get Care* is an initiative of the King County Health Action Plan and received initial funding from the HRSA Community Access Program. For more information contact Susan Johnson, Director, King County Health Action Plan, 206-296-4669, susan.johnson@metrokc.gov.

quietly advocated for its "principles" through policy and budget discussions in the Governor's Office, discussions with legislative staff, and through our involvement in other community-based efforts at coverage. Second, it turns conventional thinking about coverage and access 180 degrees – rather than viewing coverage as providing access to care, it uses access to care as an entrée for showing people the value of insurance (access has "face validity" for almost anyone while insurance does not) and moving them into coverage. Third, it practices what is so commonly preached today – evidence-based, preventive medicine with a positive return on investment. By ensuring "that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home"[6] the program is building on evidence that 2-year olds who have up-to-date Well Child Checks are 48% less likely to have avoidable hospitalizations.[7] And finally, we are highlighting it because there is growing interest in Washington in covering all children and the *Kids Get Care* approach could be an integral step in that strategy (see side box).

Integrating the Kids Get Care Approach Into an Effective Cover-All-Kids Strategy

- Couple Kids Get Care program (i.e., medical home using best practices in preventive care) with undoing administrative barriers to public programs recently put in place.
- Engage and financially support community partners in building "medical home" capacity.
- Engage state and community partners in doing outreach to reach all kids currently eligible for state programs.
- Expand state programs to 300% federal poverty to capture most of the rest of the kids. (Washington SCHIP currently goes to 250% federal poverty; combined with Medicaid and Basic Health, approximately *68% of currently uninsured children are eligible* for coverage.)
- When the kids are covered, cover their parents. Overwhelmingly, research indicates that (1) parents' use of services strongly influences their children's use of services, (2) uninsured parents are more likely (than insured) to delay or forgo getting care for their insured children, (3) uninsured parents are less likely (than insured parents) to be effective in working with the system that covers their child. Thus, neglecting the insurance status of parents may have the unintended effect of reducing the impact of insurance coverage for children. If we want to get maximum value from the coverage we deem a priority (i.e., coverage for children), we need also to consider covering the parents of these children.
- Finally, consider auto-enrollment in public coverage for kids who lose coverage because their parents lose job(s), while the parent searches for employment (a kind of "unemployment" health assistance program).

C. Impacts of Premium & Cost-Sharing Changes on Low-Income Individuals & Families

Assisting public programs in designing and conducting evaluations of the impacts of premium and cost-sharing changes on low-income individuals and families has been a major focus of the SPG during the last year. There is good news and bad news regarding our progress.

[6] *Kids Get Care* program materials available at www.metrokc.gov/health/kgc.

[7] Hakim, R. and Bye, B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, *Pediatrics*, 108: 90-97, July 2001.

The good news is that the need for such an evaluation specific to the Medicaid program was forestalled by Governor Gary Locke's June 2004 decision to delay, at least until July 2005, implementation of premium sharing in Medicaid.[8] It's hard to predict if the need will re-arise come July 05 – a number of factors come into play including state revenue levels, health inflation and cost increases, and the outcome of the November 2004 election (a new Governor and potentially many new legislators).

The (sort of) bad news is that the evaluation work with the Basic Health (BH) program has not reached the point where results are available for this report, although analysis currently is underway and results will be available shortly.[9] Thus, the focus of our comments in this progress report is mainly on background, process, methodology and lessons.

Background: In the 2003 legislative session, during the throes of one of the longest recessions and deepest budget deficits in recent Washington history, policy and budget decisions were made to implement premiums for (optional) children's Medicaid coverage (effective February 2004) and to reduce the actuarial value of the state's BH program[10] by 18% (effective January 2004). The state was in the process of obtaining (and ultimately received) a waiver for premiums in Medicaid; BH is a state-only program so federal waiver issues do not apply.

Initially, Medicaid was to charge premiums for children at and above 100% federal poverty. Over time, who would be charged and how much was the subject of strong debate. The final outcome, or so we thought, occurred with the 2004 budget authorizing a $10 per-month premium for categorically needy-optional children in households with incomes between 151% and 200% of federal poverty, to be implemented July 2004 (mandatory children in this income range would not be subject to premiums).

Somewhat simultaneous, the BH program redesigned itself to meet the Legislature's mandate of an 18% reduction[11] and in January 2004 implemented a much changed benefit design. In addition to increases in premium-sharing and co-payments, with which BH enrollees were familiar, enrollees would also face deductibles, co-insurance, and out-of-pocket maximums, all new aspects of the BH design. There was significant concern about the impact of these changes on enrollees and the ability of the program to continue to serve its target population of low-income residents (at and below 200% federal poverty).

Process: In mid-2003 a small policy and research group began meeting to discuss options for a joint Medicaid-BH evaluation of the impacts of premium & cost-sharing changes. Of particular concern was the impact on families that cut across both programs. Because of timing issues and differences in accountabilities (e.g., Medicaid to CMS[12]) the programs elected a dual path: *coordinated* work on routine monitoring of the impacts of the changes on the programs (e.g.,

[8] Premiums for optional children at 151% - 200% federal poverty were delayed – this is a group that never before has had premium contributions. The increase in SCHIP premium sharing went ahead as scheduled in July 04.
[9] SPG staff will participate in a panel discussion on preliminary results at the 11th Annual Washington State Joint Conference on Health, October 2004.
[10] Basic Health is a state-only funded program for low-income working. It contracts with private health plans and provides subsidized coverage, using an income-based sliding scale, to people at and below 200% of federal poverty, not eligible for Medicare, and not institutionalized at the time of enrollment. (There are a few nuances to these eligibility rules, such as for homecare workers, but the above cover the main criteria.)
[11] The Legislature's specific directive was to reduce by 18% the actuarial value of the Basic Health design.
[12] CMS = Centers for Medicare and Medicaid Studies, the federal agency within the Department of Health and Human Services that oversees the joint federal-state Medicaid program.

make-up of the risk pools) and enrollees (e.g., surveys of program participants) and *joint* assessment of the impacts on the external delivery system (e.g., impacts on hospital emergency departments and community clinic operations).

Because BH changes were implemented in January 2004, the program was somewhat ahead of Medicaid in its need to monitor and assess the impacts of the changes. So while the programs worked on the joint assessment piece (impacts on the broader delivery system) and on developing an evaluation design for Medicaid that would meet CMS guidelines, BH moved forward on assessing its program changes. The evaluation design for Medicaid was submitted to CMS in April 2004, assuming a July 2004 implementation of premium-sharing. However, the Governor's decision to delay implementation of children's premiums until at least July 2005 has lessened the "of-the-moment" nature of moving forward on the evaluation (from the perspective of both CMS and the state).

Therefore, the rest of this section focuses on the efforts of BH to assess the impacts of its program changes on low-income working and highlights those elements where the SPG has been most involved.

Methodology: Summaries of the changes to BH are given in Figures 4-4 (cost-sharing) and 4-5 (premium-sharing). The evaluation that is underway includes monitoring changes in enrollment levels (via administrative data), changes in characteristics of enrollees and the aggregate pool (via claims data from health plans), and impacts on enrollees and their families (via surveys).

The SPG program has primarily been involved in assisting BH and its contractor to design the enrollee survey and analyze its results. The survey was fielded in May-June 2004. Its primary purpose was to understand why people who left the program (Leavers) and those who stayed in the program (Stayers) made the decisions they did, and the role that the premium and cost-sharing changes had in those decisions. In addition to understanding the drivers of their decisions we were also interested in what happened to the Leavers (e.g., do they have coverage) and in better understanding the "tipping points" for the Stayers (e.g., what types of future program changes would be hardest on them and perhaps cause them to reconsider the decision to stay in the program). A summary of the survey content is given in Figure 4-6.

Findings/Lessons: Although it's premature to discuss the results in detail, there are a couple of things worth noting at this point.

Regarding findings:

- Preliminarily it seems there is something in the survey results for everyone – no matter what your pre-conceived position on the impacts of the premium and cost-sharing changes you can find something in the data to support it. This is often the case with first-level analyses (e.g., simple frequencies) of complex topics.
- Taken together, the combined findings of the enrollment, claims, and survey data indicate:
    - There are no changes in program exit rates or risk pool make-up that can be directly linked to the premium and cost-sharing changes.
    - A sizeable portion of people who left the program are uninsured.
    - For those who stayed, the program still is highly valued however there is some indication that the target population is being stressed by the changes (based on answers to questions about delays in getting care, amount of out-of-pocket spending, and skipping other household expenses to pay for insurance and care).

Regarding Lessons:

- Designing questions to adequately capture the "tipping point" of the Stayers (i.e., what additional changes might cause them to leave BH) was challenging. Based on preliminary survey results we didn't achieve our goal as well as we had hoped. We tried a series of trade-off questions balancing premium increases, increases in out-of-pocket costs, and reductions in benefits. Hopefully, a thorough analysis of the results and some follow-up focus groups will improve future efforts in this area.
- Timing of the evaluation is an issue and may play out differently in the separate components of the evaluation. For example, given the design of the claims analysis it is likely to reflect impacts of premium changes rather than other cost-sharing changes. The survey, having been fielded in May-June, may have a better chance at capturing some of the impacts of both types of changes – at initial decision time for both Leavers and Stayers and later on for the Stayers as they get more experience with the consequences of deductibles and co-insurance.
- Connecting events that occur in the same time and space can be useful for supporting a point of view but simply be wrong. For example, there is already a tendency by some to link decreases in BH enrollment to the premium and cost-sharing changes when in fact the decreases occurred because of pre-determined caps on enrollment (i.e., the 2003 Legislature directed BH to get enrollment down to 103,000 by December 2003 and then to maintain an average enrollment in 2004 of 100,000).

D. Rural and Safety Net Access, and Uncompensated Care

Our initial grant research included a review of the safety net in Washington, as well as assessment of options for expanding access via the safety net.[13] That work paired with the gradual erosion of our public insurance programs over the last two biennia evolved into a series of incremental efforts to 'stem the tide' and maintain access where possible, and a parallel review of the capacity of the safety net to respond to losses of public insurance coverage.

The availability of new research and monitoring tools assisted our initial efforts to assess the health viability of our safety net. The new set of Safety Net Monitoring Tools from the federal Agency for Healthcare Research and Quality (AHRQ) paired with the Community Tracking Study[14] results for Washington and other states, helped us to objectively confirm that Washington has had a relatively strong safety net compared to many states, at least while economic times were good and uninsurance rates were declining.

More recently as hospitals and community health centers began predicting dramatic increases in uninsured patients, our assessment activities evolved into a more focused review of uncompensated care provided by community hospitals and community health centers, and the intricate link with public insurance and financing programs. The resulting briefing paper is discussed below and, along with a HRSA presentation on this topic, is available on our web site at http://www.ofm.wa.gov/accesshealth/accesshealth.htm.

[13] Washington State Planning Grant, *Targeting the Uninsured in Washington State: Chapter 7 – The Role of the Safety Net; Policy Options Overview and Conclusions, and Research Paper: Direct Provider Subsidies for Safety Net or Charity Care Services.* April 2002. Available on our website at http://www.ofm.wa.gov/accesshealth/accesshealth.htm

[14] Agency for Healthcare Research and Quality(AHRQ) *Safety Net Profile Tool*. September 2003. Felland, Lesser, Staiti, Katz,and Lichiello. *The Resilience of the Health Care Safety Net*, 1996-2001. Health Services Research 38:1, February 2003.

Public Financing and Uncompensated Care Provided by Washington State Community Hospitals and Community Health Centers. This briefing paper includes a look at ten years of charity care and bad debt experience at the 95 community hospitals licensed in Washington State, using financial data submitted to the state Department of Health. The experience of "safety net clinics" or community health centers is represented by the array of clinics that had grants from the federal Bureau of Primary Health Care (BPHC), in 2001. BPHC awarded grants to 21 organizations in Washington, with 205 clinic sites throughout the state.

Inspired by recent work of Jack Hadley and John Holahan,[15] we completed a parallel assessment of financing for uncompensated care in Washington – identifying a range of financing mechanisms that help support uncompensated care, including the critical role public insurance plays, especially for the community health centers and for most of our hospitals. The community health centers in Washington are slightly more dependent on the fate of public insurance programs than centers nationwide because they have organized as a health insurance plan and have become one of the key Medicaid and Basic Health program service providers (Table 4-1).

Table 4-1: Insurance Status of Community Health Center Patients

BPHC Community Health Centers	Washington State[16]	Nationwide[17]
Patients uninsured	34%	39%
Patients insured by Medicaid/SCHIP	40%	36%
Other Public insurance (e.g., Basic Health, Medicare)	15%	9%
Private Insurance	11%	15%

We summarized the key financing mechanisms that help support uncompensated care, and 2001 funding levels, to help policy makers see the complex and disconnected funding streams (available in Table 4-2). Although many of the funding streams are federal, several options are under direct control of state policy makers, and the briefing paper includes recommendations for state policy makers' consideration, including:

- Revisions to our state charity care law;
- Full review of tax expenditures and subsidy payments with application of performance and accountability expectations (e.g., Washington state has allowed a property tax exemption for hospitals since 1886, longer than we have been a state, however there is no explicit performance agreement with the state in exchange for this 'expenditure');
- Renewed state policy dialogue on our commitment to ensuring uninsured have access to care, and the policy and budget tradeoffs of investing in insurance programs vs. subsidies for uncompensated care.

[15] Jack Hadley and John Holahan, *How Much Medical Care Do The Uninsured Use, and Who Pays For It*? February 2003. Health Affairs. Institute of Medicine. Hadley and Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* May 2004. The Kaiser Commission on Medicaid and the Uninsured.

[16] Bureau of Primary Health Care: State Summary for Washington for 2001. Users by Socioeconomic Characteristics.

[17] Sara Rosenbaum, Peter Shin, Julie Darnell. *Economic Stress and the Safety Net: A Health Center Update*. June 2004. Kaiser Commission on Medicaid and the Uninsured.

With respect to this last recommendation, the Brief reminds policy makers that

- Insurance investments are more effective at increasing access to care among low-income populations;
- Investments in insurance may be more effective at reducing emergency room use than an equal investment in subsidy payments to Community Health Centers;
- Enrollment in public insurance coverage can significantly reduce hospital uncompensated care and free up financing currently directed at subsidizing uncompensated care.

Table 4-2.

Financing Mechanisms and Examples in Washington State

Financing Mechanism and Origin of $	*Washington State Examples for 2001 (Aggregate statewide budget figures, sources not available to all facilities)*
Medicare (Federal) **and Medicaid** (Federal and State) • Disproportionate Share Hospital Payments (DSH) – payment adjustment for large numbers of Medicare and Medicaid patients. • Upper Payment Limit (UPL) programs - supplemental payments for some hospitals and nursing homes • Indirect Medical Education (IME) adjustment for teaching costs related to graduate medical education (GME) • Cost-Based Reimbursements for qualified hospitals and clinics	**Medicaid Examples:**[18] • DSH: $42.2 million in payments to hospitals • UPL: $9.2 million in flat payments to Hospital-based nursing homes (known as ProShare payments; not directly linked to uninsured) • IME/GME: $8.3 million to two hospitals with graduate teaching programs • Medicaid Cost-Based Reimbursement payment adjustments of $5.6 million for Critical Access Hospitals and approximately $65 million for Federally Qualified Health Centers
State and Local Payments • Indigent care programs • Trauma Care Payments • Uncompensated care pools	**Example of State Funded Indigent Program:**[19] • Medical Assistance Medically Indigent Program: $33.6 million payments to 33 hospitals in 2001 *Program eliminated by 2003 Legislature, partially replaced with hospital DSH grants for rural and urban hospitals* • Trauma Care Payments (DOH program linked to trauma care for the uninsured.) • Medicaid Hospital Trauma Payments: Payments of $24 million to hospitals for trauma care exclusively for Medicaid patients.
Tax Appropriations (State and Local) Tax income appropriated directly or through exemptions	**Examples of Washington Tax Exemptions:** [20] • Hospital property tax exemptions: $32 million in 2001 (state $7.33 million; local $24.69 million) • Hospital laundry services – sales tax exemption $139,000 in 2001 • Hospital business and occupations tax exemptions on revenues from public programs (Medicare, Medicaid, Basic Health) – estimated at $20 million **Examples of Washington direct tax appropriations:** $50 million in tax revenues in 2001 (41local public hospital taxing districts) [21]
Direct Grants for Care (Federal, State and Local) Federal examples: Bureau of Primary Health Care; National Health Service Corps; Maternal and Child Health Bureau; Indian Health Service; Department of Veterans Affairs; HIV/AIDS;	*Direct Grants for Care – State example* • **State** grants for medical and dental services through Community Health Services grants to clinics of $6 million in 2001 to 29 clinics with 120 sites. [22] *(Grants were increased $2.5 million, 25%, in FY04)*

[18] Washington State Medical Assistance Administration Hospital Analysis for Calendar Year 2001
[19] Washington State Medical Assistance Administration Medically Indigent Program Payments to Hospitals for 2001
[20] Washington State Department of Revenue, Summary of Tax Exemptions for Washington Non-Profit Hospitals cy2001. (Representing approximately 69 non-profit hospitals)
[21] Washington State Department of Health hospital financial reports, and Association of Washington Public Hospital Districts
[22] Washington State Health Care Authority, Community Health Services grant program.

Minnesota Study Replication

In 2003-2004 we also explored the opportunity to replicate a recent University of Minnesota SHADAC study on hospital uncompensated care.[23] SHADAC's study demonstrated that enrollment in public insurance coverage in Minnesota significantly reduced hospital uncompensated care. This finding seemed particularly relevant to policy and budget discussions in Washington, and the recent budget and coverage cuts in our public coverage programs, as described in the executive summary. Responding to state policy makers' interests in locally grounded research and state specific data, we explored the opportunity to replicate the SHADAC study for Washington's public insurance programs.

We provided SHADAC with historical enrollment by county for Medicaid and Basic Health programs, and statewide hospital data, so that they could assess the feasibility of replicating the Minnesota study for Washington. Unfortunately, they found our historical data inadequate to demonstrate a precise relationship, and we were unable to pursue study replication.[24] We have nonetheless successfully incorporated key findings of SHADAC's research into discussions about budget and policy tradeoffs.

Other Rural and Safety Net Access Activities

As mentioned earlier, the grant also supported a series of incremental efforts to 'stem the tide' and maintain access where possible. In addition to efforts briefly described in earlier sections, grant staff researched and developed recommendations for the Governor's rural health 2004 budget package, aimed at supporting rural health infrastructure. The Governor's proposal included expansion of the loan and scholarship program for health professions, expansion of support to assist volunteer retired providers, expansions to assist rural hospitals with a telehealth network, and expanded support for the school nurse corps to ensure sick children in mostly rural school districts had access to minimal health care. While not all proposals were funded by the final Legislative budget, most were, along with expanded state support for community health centers (25% increase), a new family planning outreach pilot in a rural, heavily Hispanic, community, and the 'buy-down' of the proposed premium amounts for children enrolled in Medicaid

In addition to incremental budget investments in rural access, grant staff supported discussion of key policy changes focused on rural access that were presented to, and passed by, the 2004 Legislature, including bills to:

- Expand liability protections for providers volunteering at community health care settings;
- Assist retired providers with malpractice insurance;
- Assist Critical Access Hospitals with the regulatory burden associated with certificate of need and 'swing beds'.

E. On-Going Administrative Simplification Efforts

During the initial grant we included research on system affordability and an assessment of administrative simplification efforts of primary interest to the private sector, in an effort to cooperatively reduce the administrative costs of health care.[25] The hypothesis is that

[23] Lynn Blewett, Gestur Davidson, Margaret E. Brown, and Roland Maude-Griffin. University of Minnesota, State Health Access Data Assistance Center. *Hospital Provision of Uncompensated Care and Public Program Enrollment*. Medical Care Research and Review, December 2003.

[24] A copy of their assessment is available in the Appendix and on our web site at http://www.ofm.wa.gov/accesshealth/accesshealth.htm

[25] State Planning Grant, *Administrative Simplification: An Overview of Selected Administrative Simplification Initiatives and Potential State Actions for Support.* April 2002. Available on our web site.

simplification of the system will (1) reduce inefficiencies and redundancies, and thus contribute to slowing overall cost growth trends and (2) reduce the "hassle factor" for plans and providers, increasing the likelihood that they will continue to 'play' in Washington's market.

The initial research recommendations from a consortium of private sector insurance carriers, hospitals, and providers, known as the Healthcare Forum, caught the interest of legislative policy makers and the executive branch. Subsequently, the activities of the Healthcare Forum have expanded to include a partnership with three state agency insurance programs (state employees, Medicaid, and injured workers).

The broad consortium has now developed twenty-two policy changes concentrated in three main areas: claims payments processes, referral processes, and credentialing processes.[26] These changes will move the industry toward standardization in key business practices and save time and money across the system, as well as decrease the hassle between providers and health plans. There is an estimated 226 hours of weekly savings in staff hours (156.5 for health plans, 44 for hospitals, and 25.5 for providers) from these policy changes alone. Examples of the changes include agreements from all participants (business competitors) to use standardized forms for submitting supporting claims documentation, corrected claims, standard referral actions, and requests for prospective review. This project now has a life of its own outside the SPG and continues to hold the interest of legislative policy makers, as demonstrated by two legislative hearings in September and anticipated legislative discussions in December.

An additional administrative simplification effort continued our work, albeit in a slightly different direction. With the assistance of SPG staff, the Governor sponsored a broad private-public task force to focus on hospital administrative burdens. The task force of eight executive branch agencies,[27] the Washington State Hospital Association, and member hospitals focused on identifying opportunities to streamline the regulatory burdens associated with on-site hospital inspections, and the potential overlap of responsibilities of these multiple agencies. The task force identified recommendations in three main areas – patient care related inspections, fiscal and tax inspections, and facility or physical plant inspections.

Legislation capturing key recommendations was introduced and passed in the 2004 Legislative session[28], and coordination efforts expanded beyond the state agencies to include local government inspections (e.g., coordination with the state fire marshal and local building or fire agencies), and where possible, coordination with the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). Progress continues to be made with pilot sites, and a formal progress report to the Legislature is due in December 2004.

[26] A complete list of the 22 policy changes can be found on the Healthcare Forum's web site at www.wahealthcareforum.org.
[27] The range of agencies with regulatory authority include: the State Auditor's Office, the Department of Revenue, the Department of Social and Health Services, the Department of Health, the State Board of Pharmacy, the Department of Ecology, the Office of the State Fire Marshal, and the Department of Labor and Industries.
[28] Senate Bill 6485, Improving the Regulatory Environment for Hospitals

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
Cover All Kids		**(HB 3184) Study and recommendations on health insurance coverage for children.** Declares *intent* to provide access to health insurance for all children in Washington by 2008 by building upon and strengthening employer-sponsored coverage and publicly supported children's health insurance programs. Requires a *study* and recommendations on possible approaches; due to the Governor and Legislature by December 1, 2004.
Small Employer Assistance	✓	**(ESHB 2460) Health insurance for small employers and their employees.** Changes definition of small employer from 1-50 to 2-50 employees; authorizes limited benefit plans for all small employers; authorizes initial small group rates based on claims costs and rate increases based on benefit design and provider network (up to 4% variation from carrier's entire small group pool); under specific circumstances, ex-employees of employers with < 20 employees can apply for individual coverage without taking the health screen questionnaire required by the individual market; continuity of coverage requirement extended to groups of up to 200 with provisions for when policy can be cancelled. **(HB 3104) Health insurance for employers and their employees.** A provision of this bill (that did not end up in ESHB 2460) was elimination of Washington's "every category of provider" requirement (currently, for all plans subject to state regulation enrollees have the option of seeking treatment from any type of provider as long as the condition is covered by the plan, the treatment is appropriate to the condition, and the provider is acting within scope of practice). This issue was important enough to small business representatives that they proposed an initiative to the people, one provision of which would allow plans with fewer categories of providers; the initiative did not get enough signatures to appear on the November 04 ballot. **(HB 2785) Access to health insurance coverage.** See description under Large Employer Incentives **(HB 2798) Stabilizing the health insurance market and providing coverage for the uninsured.** See description under Private Market Access & Affordability.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(SB 6422) Small employers and Basic Health. Would have pooled Basic Health's small employer group enrollees with subsidized enrollees for purposes of rating (independent of whether the employer group enrollees are subsidized or not).
		(HB 2015) Health insurance for small employers and their employees. A unique component of this bill (not appearing in any passed bill) was the requirement that state agencies offering Medicaid and Basic Health collaborate with community and regional health care access efforts to design coverage pilot programs aimed at small employers.
		(HB 2087) Definition of small employer. Would have specifically included self-employed and sole proprietors (often businesses of one) in the definition of small employer in order to assist them in finding affordable health coverage. (In contrast to the bill that passed that excluded groups-of-one from the definition.)
		(SSB 5521) Health insurance for employers and employees. This earlier cousin to the bill that passed (ESHB 2460) included some widely debated provisions that didn't appear in the final bill; these included partial exemption from Washington's "every category of provider" law for bare bones/value plans; a cap on community rating based on age of employee of 500 percent; and use of the health screen for sole proprietors and the self-employed.
Employer Coverage Options & Responsibilities		**(HB 2785) Increasing access to health insurance coverage.** (Washington's version of "Pay or Play") Would impose a fee on large employers (> 50 full time equivalent employees) to be used to purchase health insurance for employees; would authorize Basic Health funds to be used to subsidize employee premium shares for small-employer sponsored health insurance; would allow small employers to enroll as a group in Basic Health and have their costs subsidized.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(SHB 3047) Health care services. Would require applicants for state purchased health care benefits (e.g., Medicaid and Basic Health) to identify their employer (originally included applicants for uncompensated hospital care as well).
		(SB 5944) Employers & Basic health. Would require 50/50 premium split between Basic Health enrollees & their employers (employer amount divided among employers for enrollees with more than one employer). Other unique aspects of the bill (not found elsewhere) included increasing the premium tax from 2% to 3% (one of the revenue streams that supports Basic Health) and setting the minimum Basic Health enrollment level at 70,000 (is currently set at 100,000).
		(HB 1830) Public program coverage of employed individuals. Basic Health and Medicaid (Medicaid subsequently deleted) could seek reimbursement from public and private employers if their employees were enrolled in public programs.
		(SB 5704) Employer participation in Basic Health. Would have removed authority of Basic Health to accept applications from employer groups; instead, it would require any employer of a Basic Health enrollee to contribute to the enrollee's premium.
Private Market Access & Affordability	✓	**(SHB 2985) Individual health insurance for retired and disabled public employees.** If unable to offer access to group coverage, political subdivisions must assist their retirees and disabled employees in applying for individual health insurance.
	✓	**(ESSB 6112) Multiple employer welfare arrangements**. Creates consumer protection standards to better ensure financial status and operational competence of MEWA-based health insurance coverage – issue is to ensure that employees who *think* they have reliable coverage through a MEWA, in fact, actually *do have* reliable coverage.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(HB 2798) Stabilizing the health insurance market and providing coverage for the uninsured. Would create (1) a Health Insurance Market Stabilization Pool to provide reinsurance for enrollees with over $25,000 in annual health services expenses; (2) a small employer-sponsored health insurance premium assistance program for employees whose current employer has not offered health insurance within the last six months; and, (3) a premium assistance program for individuals receiving health services through the Washington State Health Insurance Pool (i.e., high risk pool). (Bill was outgrowth of Washington Insurance Commissioner's – Commissioner Mike Kreidler -- task force on reconstructing the health care market.)
		(HB 2018) High risk pool eligibility. Would open the state's high risk pool to HIPAA-eligibles and people eligible for the Trade Act's federal tax credit *without* first requiring them to take the state's individual market health screen questionnaire (and be rejected for individual coverage and thus referred to the high risk pool). (See ESHB 2797 under Public Program Redesign & Accessibility)
Public Program Redesign & Accessibility	✓	**(ESHB 2797) Health insurance for people eligible for the Federal Health Coverage Tax Credit.** Basic Health now available as a qualified plan for the federal Health Coverage Tax Credit Program (under federal Trade Act of 2002).
	✓	**(SB 6057) Basic health funding.** Amends an initiative passed by the people so that money raised through increased cigarette & tobacco taxes and intended for expansion of Basic Health slots can be used to fund existing enrollees (below the 125,000 base called for in the initiative).
	✓	**(HB 2285) Cost-sharing in public programs.** Authorizes premium and other cost-sharing (e.g., co-payments, deductibles, coinsurance) for enrollees of Medicaid and other state medical assistance programs. (Basic Health already has this authority.)

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
	✓	**(EHB 1777) Homecare worker coverage**. Via collective bargaining between the state and individual home care workers hired by the state (but not considered state employees), the state pays the majority of the premium for workers eligible for Basic Health coverage. A provision for the state to contribute $400 per month per homecare worker for health care benefits through a Taft-Hartley trust was not passed.
	✓	**2003 Biennial and 2004 Supplemental Budgets** • Medically indigent program changed from open-ended entitlement program to 2 capped grant programs (one for rural hospitals, another for all other hospitals). • 2003 budget set premiums for (optional) children's medical coverage in Medicaid and SCHIP, effective Feb 04. 2004 supplemental revised the premium amounts and moved start date -- children's premiums set at $10 if 151% - 200% federal poverty & $15 if 201% - 250% federal poverty, effective July 04. Governor's administrative action delayed implementation until at least July 05 for children 151%-200%. • Use of SCHIP money to cover about 65% of cost of pre-natal coverage for low-income, immigrant women not eligible for Medicaid. • Increase income verification requirements in Medicaid & Basic Health. • In medical assistance, reduce scope of adult dental coverage & expenditures on adult durable medical (DME) equipment; require co-payments for adult DME & optical services. • Limit Basic Health enrollment to 103,000 by Dec 03; after Dec 03 maintain average enrollment at 100,000. • Implement by Jan 04 Basic Health premium, benefit & cost-sharing changes to reduce state costs of covered services by 18%. • Increase cost-sharing in the AIDS prescription drug assistance program (from 2-4% to 5-10% of family income). • Study costs/benefits of K-12 bargaining units purchasing coverage through public employees' benefits program.
		(SB 5944) Employers & Basic health. See description under Employer Coverage Options & Responsibilities.
		(SB 5704) Employer participation in Basic Health. See description under Employer Coverage Options & Responsibilities.

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		(HB 1375) Basic Health eligibility. Would eliminate Basic Health eligibility for full-time students who are on temporary visas to study in US.
		(SHB 2019) Basic Health eligibility. Would allow applicants to be rejected from non-subsidized Basic Health, and referred to the state's high risk pool, based on their health screen questionnaire results (the same questionnaire required by applicants to the individual market).
		(ESSB 5807) Basic Health eligibility. Most notable eligibility changes include (1) restricting Basic Health to citizens and people legally admitted for permanent residence (currently any state resident is eligible); (2) removing provision that allows expansion of subsidized Basic Health from 200% to 250% of federal poverty if funds are available; and, (3) making people ineligible if they qualify for Medicaid. In addition, the Legislature would get directly involved in setting minimum premiums.
		(SB 5998) Community-based demonstrations. Would require state agencies to actively recruit local organizations to operate pilot projects to test different Basic Health eligibility, benefit design, and cost-sharing arrangements (with the expectation that a greater number of people could be covered).
Health System Reform (Coverage Aspects)		**(HCR 4403) Health Care Access Options Working Group**. A working group of stakeholders would be created to make recommendations on improving Washington's health care insurance system to make private coverage more affordable and accessible. (Although this bill did not pass, the Insurance Commissioner created a separate task force to address similar issues. One result was HB 2798 described under Private Market Access & Affordability.)

Figure 4-1: State Policy Activities Most Directly Aligned with the Federal State Planning Grant Program Goal Of "Covering The Uninsured"

COVERAGE STRATEGY	✓ = Passed	2003-04 PROPOSED AND/ OR PASSED LEGISLATION MOST DIRECTLY RELATED TO ACCESS TO HEALTH INSURANCE COVERAGE
		SB 5313: Washington Health Care Recovery. Proposed a number of changes that would have affected access to coverage including requirements for (1) a specific deductible in Basic Health, (2) state agency participation with local organizations to develop alternative Basic Health offerings, and (3) prohibiting additional mandated benefits in the private market pending a study of current mandates.

Notes:

Table contents focus on proposed and/or passed legislation that is most directly related to health insurance coverage. Other strategies indirectly related to coverage, such as shoring up the safety net, access in rural areas, administrative simplification & coordinated state purchasing, additions/deletions of certain benefits (e.g., prescription drugs), and medical malpractice are not included.

In addition, the intent is to capture the provisions in the bills that are most directly related to insurance coverage – bills may contain other provisions.

Finally, for some issues many similar bills are initially introduced (small employer / small group market is a good example). In the case of bills that did not pass, not all coverage-related provisions are noted; highlighted are those provisions that generally did not make it into final bills and that spurred debate.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
I. Financial incentives to individuals and families to purchase health insurance (Subsidies include vouchers, tax credits, and direct payments)	**Subsidies to assist low income in buying individual coverage**	Basic Health and Medicaid 2004 program changes (see section VI below)
	Subsidies to assist high-risk people in buying individual coverage (state high risk pool)	2003 and 2004 Legislative discussions explored options for modifying the high risk pool and becoming federally qualified.
	Subsidies or reforms for transitional coverage (e.g. COBRA)	• Awareness campaign to alert eligibles re federal income tax credit through Trade Adjustment Act (TAA); state labor department request to expand tax credit • 2004 statutory approval for Basic Health to become a "qualified plan" under the TAA Health Coverage Tax Credit program. Enrollment growing.
	Subsidies of employee contributions to employer-sponsored insurance (premium assistance programs)	Medicaid program small but still functioning; CMS discussions on expansion.
II. Financial incentives to employers to purchase health insurance for their employees	• Direct subsidies or tax credits to employers • Play or pay mandate on employers	• 3- and 4-part contribution options for small employers being explored by community groups • 2003 and 2004 legislative discussions re various "pay or play" requirements for employers
III. Health insurance purchasing pools	• Employer-based purchasing pools • Individual or individual/small market purchasing pools • Other community-based purchasing pools • Mobile worker purchaser pools • Consolidated state funded pools	• Safe Table (educational) forums on employer coverage options and pooling opportunities • "Local purchasing utility" idea being explored by community group as means of pooling financing (inspired by SPG-SCI community-based coverage & purchasing pool technical assistance meeting) • 2003 statutory approval for low-income seniors to participate in consolidated drug purchasing program for state agencies.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
		• 2004 statutory authorization for collective bargaining agreement for independent home care workers, including health coverage. Taft-Hartley trust option being pursued by union/ Home Care Quality Authority. • Private Fortune 500 companies (including WA-based Starbucks) spearheading collaborative to cover retirees, part time employees & other special populations • Washington Artists Health Insurance Project to improve access to coverage for people in the arts and arts-related occupations
IV. Insurance market regulations	• Relief from benefit mandates • Individual and small-group market regulations • High-risk pool expansion • **Universal catastrophic coverage**	• 2004 Legislative reforms for small employer groups – redefined group size as 2-50, community rating range increased, some benefit mandate relief. Continuing interest in 2005 ballot initiative to further refine benefit mandates and rate adjustments. • Subsidies not changed but health screening questionnaire revised in June 2003 to screen additional people out of individual market and into high risk pool (about 20% of those referred to pool enroll; some get coverage elsewhere; many forgo any coverage) • 2003 statutory limit placed on number of subsidized "HIV Insurance Program" people that can be enrolled in high risk pool. • 2003 legislative discussion re Washington high risk pool becoming "qualified" under TAA – concern by small business & carriers about any action that would expand high risk pool access – legislation didn't move. See section I above re Basic Health TAA qualified status. • Interest in universal catastrophic coverage (coupled with individual mandate) by Insurance Commissioner, included in "Let's Get Washington Covered" task force discussions.

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
V. Direct subsidies for safety net or charity care services (for those whom insurance may never seem like a viable option)	• **Expand state's Community Health Services grant program** • **Create discount health cards for individuals** • **Expand federal health professional shortage areas (HPSAs)** • **Expedite Rural Health Center designation** • Increase payment to providers via health plan contracts • Tax credit for not-for-profit hospitals • Tax credit for physicians, physician assistants, and nurse practitioners • Uncompensated care pools	• Expansion of direct grant program to migrant and community health clinics included in Governor's 2003-05 budget (eliminated in final budget negotiations); funded in 2004 supplemental • Priority of community coverage initiative is to stabilize safety net by expanding number of community health centers & rural clinics • Use of discount cards for low-income uninsured being used by community group in central WA • Modest expansion of designated HPSA areas • Governor's 2004 rural budget package with investments in rural infrastructure, increase in health professional loan program and state paid med-mal insurance for retired providers to expand access in rural communities • 2004 legislation offering medical malpractice protection for providers serving in clinics as volunteers • Modifications in DSH payments to "compensate" for elimination of Medically Indigent program in Medicaid
VI. Public Insurance Program Expansions	• Although options re public insurance programs are part of our SPG work, our initial background research did not include a review of detailed options. Washington has been a leader in the three areas most commonly discussed, i.e., (1) attain full enrollment of all currently eligible individuals into existing public programs, (2) expand eligibility for children by raising the income eligibility level, and (3) extend coverage for adults – first focusing	• BH cost-sharing changes for 2004 including introduction of deductibles, increased co-pays and premium share, and reduction of enrollment slots to 100,000 from 130,000 • Elimination of state funded Medically Indigent program in Medicaid • Medicaid children premium sharing for 2004 (2003 statutory approval for cost-sharing in Medicaid, 2004 waiver accepted by CMS; Governor Locke delayed implementation until July 2005) • Expansion of SCHIP coverage for pregnant women • Local initiative to develop consumer-driven, incentive-based

Figure 4-2: Examples of Activities Related to Potential Policy Options for Enhancing Access to Health Insurance

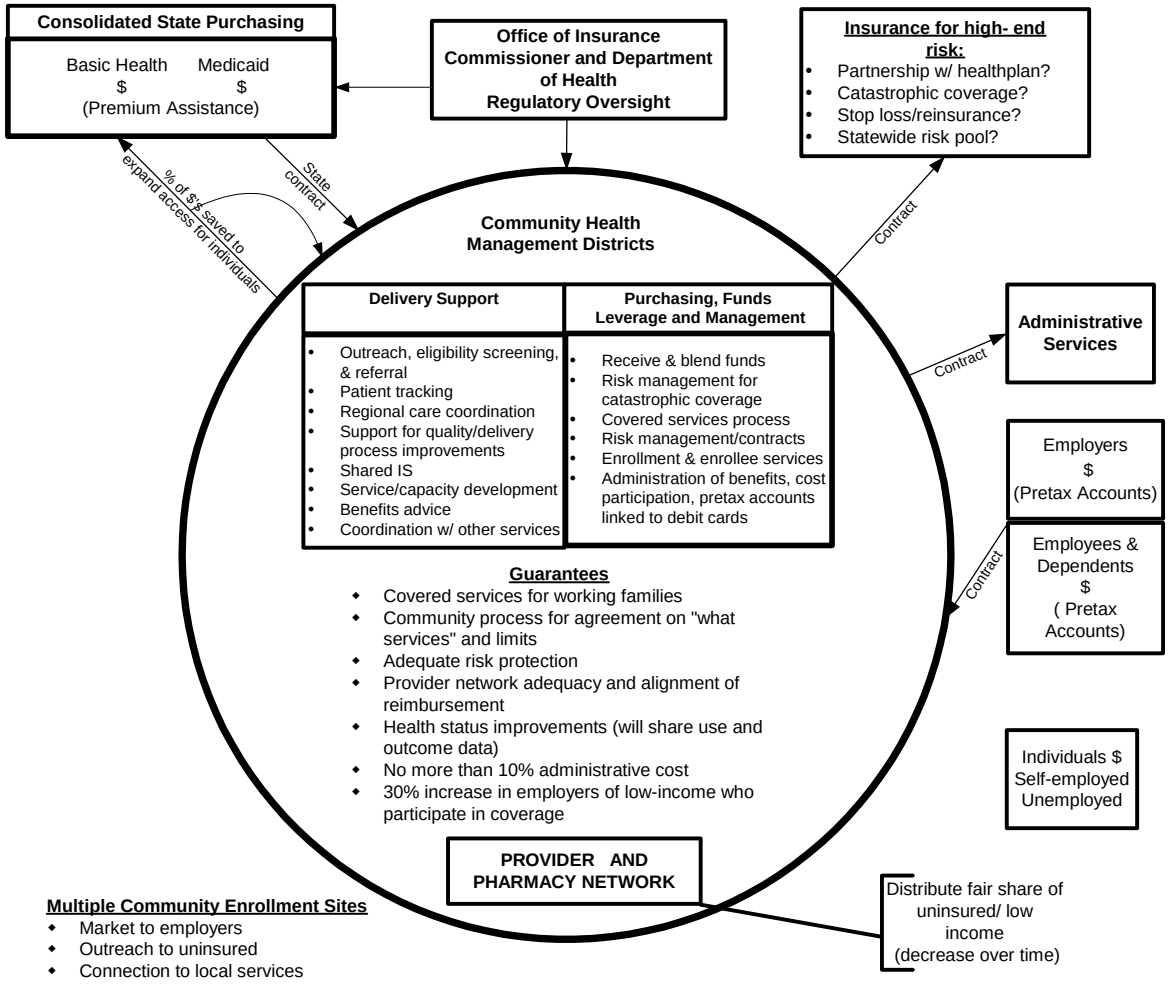
Major Grouping[i]	Specific Options Addressed in Initial SPG Research	Examples of Related Activities Affecting Coverage in WA State 2003 – 2004
	on parents of eligible children and then on adults without children.	coverage option (health reimbursement account + proven preventive care) to potentially pilot in a public program (Health Plan for Life) • Statutory request to find cost savings in local government procurement of health insurance for home care worker agencies
VII. Other (including Administrative Simplification)		• 2003 statutory requirement for uniform administrative, purchasing & quality policies across state programs • Public / private partnership among state agencies, hospitals, and private consortium of insurance carriers to reduce administrative burdens and increase efficiency. • Foundation sponsored community roundtables, dialogues and surveys to identify values of Washington residents vis-à-vis access & coverage to care • Community initiatives to use access to medical homes and preventive care as entrée to access to insurance coverage • ONEHEALTHPORT developed secure digital portal for efficient processing of medical records – collaboration of private insurance carriers and health care providers. Current efforts targeting the development of a secure medical records sharing platform.

[i] See *"Potential Policy Options for Enhancing Access to Health Insurance Coverage in Washington State"*, available at: http://www.ofm.wa.gov/accesshealth/accesshealth.htm

Bolding indicates options identified in initial research as "most promising" based on these criteria: (1) effectiveness in insuring high risk people, (2) effectiveness in insuring low-income people, (3) effectiveness in improving access to health services for the uninsured, (4) benefit per dollar of new state spending, (5) cost to the state, and (6) implementation feasibility.

Figure 4-3:

Community Health Management District: Schematic with Illustrative Guarantees



Source:

Community-Based Health Care, Issue Paper Draft #3, Communities Connect, available from CHOICE Regional Health Network, Community Health Works program.

Figure 4-4: Major Cost-Sharing Changes in Basic Health Benefit Design, 2003 to 2004

Cost-Sharing	2003	2004
Deductible and co-insurance	None	$150 per person per year; 80/20 co-insurance
Out-of-pocket maximum	None	$1500 per person per year
Office Visit Co-pay	$10	$15
Share of prescription drug costs	3 Tiers: T1: $3 on specific drugs such as prenatal vitamins & insulin T2: $7 on generics in health plan's formulary (except if in Tier 1) T3: 50% co-insurance on all other drugs (e.g., brand name) in plan's formulary	2 Tiers: T1: $10 co-pay on generics in health plan's formulary; T2: 50% co-insurance on all other drugs (e.g., brand name) in plan's formulary

Figure 4-5: Basic Health Enrollee Premium Share, 2003 and 2004, By Income Band, For a 40-54 Year Old in the Benchmark Plan

Income Band (% of federal poverty)	2003	2004
< 65 %	$10.00	$17.00
65% - < 100%	$14.00	$22.50
100% - < 125%	$17.50	$30.00
125% - <140%	$30.15	$39.47
140% - < 155%	$46.23	$51.57
155% - < 170%	$60.30	$65.72
170% - < 185%	$76.38	$82.29
185% - 200%	$92.46	$100.91

70+ percent of enrollees are in families with incomes below 125% of poverty

Benchmark Plan: Typically the lowest priced plan in an area.
'03 Benchmark Plan rate = $201.36
'04 Benchmark Plan rate = $184.05

Basic Health is age-rated with older adults paying more per month than younger. There are four adult age groups: 0-39, 40-54, 55-64, and 65+. The 40-54 year old group, used in this table, typically accounts for around 35-40 percent of adult enrollment.

One perspective on the magnitude of these changes for a low-income person is this: Between 2003 and 2004, a 40-54 year old in the benchmark plan with income at 100% federal poverty had a 70 percent increase in the amount of his/her income that had to be set aside for premium. (In 2003, 2.3% of income went to premium; in 2004, 3.9% went to premium.)

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS APPEARING ONLY ON LEAVER VERSION

Cost-Sharing and Coverage

No.	Question Summary	Response Format	Comment
2a-2m	Reasons for not currently being in BH 2a Got coverage thru another source 2b Couldn't afford BH 2c If need care, can get it free or at low cost from local providers 2d Need services not covered by BH 2e Decided don't need coverage now because don't get sick 2f More important to spend what have on insurance or care for other family members 2g More important to spend what have on other household expenses or bills 2h Desired health plan or providers are not longer available in BH 2i Income increased so no longer eligible 2j Found a health plan that's a better value 2k Didn't get monthly premium in on time 2l Requirements & paperwork are too much of a hassle 2m Some other reason not mentioned	Yes, No, Don't Know, Refused To each of the 13 items	
2n	"Other" reasons for not being in BH	Open-ended	Asked if "yes" to 2m
2o	Most important reason for leaving BH	Pick one of 2a-2n	Asked if "yes" to > 1 of 2a-2n "Most important" inferred if "yes" to only one of 2a-2n
3a	Aware of cost-sharing changes to BH	Yes, No, Not sure, Refused	
3b	Amount of influence cost-sharing changes (collectively) had on decision to leave BH	A lot, A little, Nothing, Don't know, Refused	Asked if 3a = yes, don't know, or refused

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
3c1-3c5	Level of influence of each cost-sharing change (separately) on leaving BH 3c1 Change in monthly premium 3c2 Increase in office visit co-pay from $10 to $15 3c3 Increase in share of prescription drug costs 3c4 Introduction of annual $150 deductible 3c5 Introduction of $1500 out-of-pocket maximum per year	Rate each of the five changes on scale of 1 (no effect) to 5 (major effect), Don't know, Refused	Analyze individually & collectively Asked if 3b = A lot, A little, Don't know
3d	Most important influence on leaving BH	Pick one of 3c1-3c5	Asked if highest score given to > 1 of 3c1-3c5 Most important inferred if highest score to only one of 3c1-3c5
4a	Have health coverage now (for self only)	Yes, No, Don't know, Refused	
4b	How get that coverage (from where)	Open-ended: Following used for coding & if person unsure are read as prompts: Your employer, Your spouse's or partner's employer, Through COBRA, Through your parents or another family member, Military coverage (e.g., Champus or TriCare), A plan you purchase directly & pay for on own, Medicaid or Healthy Options, Through school, Medicare, Indian Health Services	Asked if 4a = yes
4c	Current coverage compared to BH	Better than, Worse than, About the same as, Don't know, Refused	Asked if 4a = yes
4d	Reason why coverage is (better, worse, same as) BH	Open-ended	Asked if 4c = better, worse, or same as

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS APPEARING ONLY ON STAYER VERSION

Cost-Sharing and Coverage

No.	Question Summary	Response Format	Comment
2	Aware of cost-sharing changes to BH	Yes, No, Not sure, Refused	
3a-3m	Importance of reasons for staying in BH 3a Too much hassle to look for other coverage 3b BH is still best value 3c Would have to pay more per month if not in BH 3d Someone helps pay BH monthly premium 3e No other insurance choices are affordable 3f Can have same health plan as children 3g Can keep BH even if change jobs 3h Can get preventive care like shots & routine exams without paying anything at doctor's office 3i Like that BH is sponsored by state government 3j No other insurance choices cover services that are needed 3k Afraid couldn't get back in BH if leave 3l In middle of treatment for an illness or injury & can't risk interruption in care 3m Some other reason, for staying, not mentioned	Rate each of 3a through 3l on scale of 1 (not at all important) to 5 (very important), Don't know, Refused 3m: Yes, No, Don't know, Refused	
3n	"Other" reason for staying in BH	Rate on scale of 1 (not at all important) to 5 (very important), Don't know, Refused	Asked if 3m= yes
3o	Most important reason for staying in BH	Pick one of 3a-3n	Asked if highest score given to > 1 of 3a-3n Most important inferred if highest score given to only one of 3a-3n
4a	If trade-off needed, which would be harder – pay higher monthly premium or pay more out-of-pocket when get care	Higher monthly premium, More out-of-pocket, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
4b	If trade-off needed, which would be harder – pay higher monthly premium or have some benefits reduced	Higher monthly premium, Reduce benefits, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions
4c	If trade-off needed, which would be harder – have some benefits reduced or pay more out-of-pocket when get care	Reduce benefits, More out-of-pocket, Don't know, Refused	Analyze 4a-4c collectively as set of 3 trade-off questions
4d(a)	Have to leave BH if premium increased by $10 / month	Yes, Maybe, No, Don't know, Refused	Asked if "increase premium" selected 2X in 4a-4c
4d(b)	Have to leave BH if premium increased by $5 / month	Yes, Maybe, No, Don't know, Refused	Asked if "increase premium" selected 2X in 4a-4c AND 4d(a) = yes, maybe, don't know, refused
4e(a)	Have to leave BH if deductible increased by $50 / year (making it $200 / year)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(b)	Have to leave BH if deductible increased by $25 / year (making it $175 / year)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c AND 4e(a) = yes, maybe, don't know, refused
4e(c)	Have to leave BH if Rx co-pay increased by $5 (making it $15)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(d)	Have to leave BH if Rx co-pay increased by $2 (making it $12)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c AND 4e(c) = yes, maybe, don't know, refused

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
4e(e)	Have to leave BH if office visit co-pay increased by $5 (making it $20)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4e(f)	Have to leave if new $15 office visit co-pay for preventive & maternity care added (compared to no co-pay now)	Yes, Maybe, No, Don't know, Refused	Asked if "increase OOP" selected 2X in 4a-4c
4f	Which 1 or 2 benefits, if eliminated, would make you leave BH	Open-ended	Asked if "reduce benefits" selected 2X in 4a-4c

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

ITEMS COMMON TO BOTH LEAVER AND STAYER VERSIONS

Access to Care (for self)

No.	Question Summary	Response Format	Comment
5a	Any time you did not get / delayed getting needed care or Rx since January	Yes, No, Don't know, Refused	
5b	Happen > 1 time	Yes, No, Don't know, Refused	Asked if 5a = yes
5c	(Last time it happened) Main reason for not getting or delaying care / Rx	Open-ended. Following used for coding & if person unsure are read as prompts: Did not have money to pay for it, Could not get appointment as soon as wanted, Could not get care or prescription because already owed money to the doctor, clinic, hospital or pharmacy, Provider would not accept insurance plan, Did not think problem serious enough to pay amount asked, Did not know where to go for help, Takes too long to travel to where help is available, Could not get there when they're open, Did not have childcare, Did not have transportation, Health plan would not pay for needed treatment, Could not find specialist, *Employer* would not give time off from work, *Personally* too hard to find free time because of work & other commitments, Could not afford to take time off from work, Other: _____, Don't know, Refused	Asked if 5a = yes

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
Utilization of Services (for self)			
6	Number of emergency room visits since January	Open-ended. Following used for coding & if person unsure are read as prompts: None, 1, 2-3, 4-5, More than 5, Don't know, Refused	
7	Number of office, clinic, other provider visits since January (include preventive care & care when sick; exclude emergency room visits & overnight hospital stays)	Open-ended. Following used for coding & if person unsure are read as prompts: None, 1, 2-3, 4-5, More than 5, Don't know, Refused	
Financial Impacts (for family)			
8a	Amount of out-of-pocket spending for medical care and Rx since January (self & family) (exclude monthly premiums & dental expenditures)	Less than $100, More than $100, Don't know, Refused	
8b	If more than $100 out of pocket, how much spent	Less than $500, $500 but less than $1000, $1000 but less than $1500, $1500 or more, Don't know, Refused	Asked if 8a = More than $100
9	Since January, had to skip or cut back on paying other bills or household expenses to pay for health insurance, medical care or Rx for self or family	Yes, No, Don't know, Refused	
Health Status & Chronic Conditions (for self)			
10a	Rate own health	Excellent, very good, good, fair, poor, Don't know, Refused	
10b	Rate current health compared to one year ago	Much better now, Somewhat better now, About the same, Somewhat worse now, Much worse now	

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
11a-11k	Have any of these chronic conditions 11a Asthma 11b Diabetes or sugar diabetes 11c High blood pressure or hypertension 11d Depression, anxiety, or other mental health condition 11e Heart problems 11f Physical disability 11g Lung disease 11h High cholesterol 11i Cancer 11j Serious headaches or backaches 11k Other _____	Yes, No, Don't know, Refused To each of the 10 listed conditions plus "other" option	
Household Make-up & Coverage Impacts			
12a	Number of children (< age 19) living in household	Open-ended	
12b	Any children in state coverage programs	Yes, No, Don't know, Refused	Asked if 12a > 0
12c	Continue coverage of child(ren) if new or additional premiums of $5-$10 per month per child	Open-ended. Coded to following: Yes, because no other choice Yes, for some but not all children Yes, any other reason or no reason given No Don't Know, Refused	Asked if 12b = yes
12d	Drop own coverage if new or higher premiums of $5-$10 per child	Yes, No, Don't know, Refused	Asked if 12c = yes, don't know, refused
Demographics (self)			
13	Current employment situation	Work in own business, Work for someone else in full-time job, Work for someone else in one or more part-time jobs, Other _____, Don't know, Refused	

Figure 4-6: Basic Health 2004 Survey: Summary of Survey Items for People Who Left (Leavers) and People Who Stayed (Stayers) Following Implementation of Cost-Sharing Changes

No.	Question Summary	Response Format	Comment
14	Full-time student	Yes, No, Don't know, Refused	
15	Race/Ethnicity	Open-ended. Following used for coding & if person unsure are read as prompts: Black or African-American, White (Caucasian), Eskimo or Aleut or Alaska Native, American Indian or Native American, Asian American or Pacific Islander Hispanic or Latin American (e.g., Mexican, Puerto Rican, Cuban, Latino), Other or mixed background: _____, Don't know, Refused	

Notes:
Exact wording of questions and response options is paraphrased in above table.

Additional demographics from administrative/enrollment records include: Basic Health income band, primary language spoken, geographic location (county / zip), gender, date of birth, enrollment history.

Unless otherwise noted "cost-sharing" refers to both premium sharing and other types of cost-sharing such as deductibles, co-payments, coinsurance, and out-of-pocket maximums.

SECTION 5. CONSENSUS BUILDING STRATEGIES:

Our communication strategy reflects a long-standing belief that has underpinned the SPG program – consensus building on coverage strategies in Washington will occur over the long run through political processes fed by the grant but not pushed by the grant. Our communication plan is built around the **theme** of "sustaining awareness" of the individual and societal problems associated with less-than-full coverage of our population. Overall, our **strategy** is best described as low-key, personal, and under-the-radar. An **underlying philosophy** has been to stay relevant to the environment and discussions as they change and occur within varied audiences.

Our strategy has several **objectives**: (1) to function as a clearinghouse of information and visible point of contact within the executive policy office, (2) to encourage and support (but rarely endorse) any group, organization, or individual that is willing to think creatively about addressing coverage and access issues, and 3) to "create" demand for our research work as an objective foundation for discussions and planning, and to respond to existing needs for information. We purposefully elected to exclude "selling a specific set of coverage options" as an objective.

Avenues we use to communicate include (1) a SPG-specific website containing all of our research results, (2) "fast facts" two-page briefs, (3) presentations to small groups (some of which we contact; others of which contact us), (4) assistance to groups and individuals in tailoring our information to their needs, and (5) personal participation in state and community groups with related interests.

Examples of our primary **audiences** are policy makers, advisors, and researchers; and, state and community program developers, leaders, and activists. However, we have adopted an operating principle of "wherever two or more are gathered" we will come.

Core Messages:
"Making Health Care Work for Everyone" has been our **unifying theme** since the inception of the grant. It is used on most of our general information as a tag line. We chose it because it allows us to convey several key messages, for example: (1) Washington's health care system needs to work for everyone who has a stake in it – financers, deliverers, receivers, (2) the goal to get everyone covered is a means to an end, the end being a healthier and more financially secure population, and (3) there will always be some subset of the population (e.g., homeless, undocumented immigrants) that will not be covered and we still need to ensure their access to care.

Beyond that unifying theme, we try to tailor our messages depending on the audience, what we're trying to communicate, and the nature of the interaction we want to have. In general, however, we weave-in **core messages** about (1) who Washington's uninsured are (e.g., most are members of working families – they build our homes, feed us, take care of our young children and aging parents), and (2) the personal and societal consequences of being uninsured (e.g., the uninsured live sicker and die earlier; better health improves individual earnings and in turn our local and state economies; many of us are one job or one birthday away from losing coverage).

Examples of audience specific messages include:

a. **Coverage Options**: Pragmatic and resilient strategies to achieving broad coverage will cost money, will require melding of divergent values, and will need to build on currently accepted and trusted systems.
b. **Insurance Coverage**: Access to Coverage ≠ Access to Care. (Nonetheless: Although health insurance is not the only key to accessing care and improving health, it is among the most easily changed.)
c. **Individual Affordability**: Although not the only barrier to coverage, affordability is the most prominent and persistent for low-income families (e.g., for many families, affordability for private coverage starts at about 250% of federal poverty).
d. **Quality and Administrative Simplification**: Some of our best opportunities for redirecting system dollars to pay for covering the uninsured will, in the long run, come from addressing poor quality and inefficient administration (e.g., 25-30% of every direct health care dollar goes to poor quality and waste).
e. **System Sustainability**: Today's fiscal challenges underscore the need to develop a system (especially for public programs) that can weather future economic downturns better than we are doing so today.
f. **Federal / State Roles**: Some issues are national issues for which the federal government must step up and take responsibility so that state dollars can be redirected (e.g., Medicare prescription drug program).
g. **Local Innovation**: Not all solutions need be, nor should be, top-down. Much creative work regarding coverage and delivery is occurring in local communities that should be supported in their efforts. It is equally important, however, that local solutions be assessed in terms of broader community-to-community and population-to-population impacts.
h. **Data Ins and Outs**: The state population survey is a tremendous source of information, <u>when used correctly</u>.

Also, based on recent "profile" information we have begun incorporating the following message: While Washington's uninsured rate is on the rise, it is important not to lose sight of the good we have done and the strategies that have worked for us in the past.

Examples of communication materials:

Our major **communication materials** have been (1) research and policy reports, (2) fact sheets – briefing papers, and (3) general use of our project website as the primary distribution system for all written materials. This year we undertook a major revision of the project web site to ensure the research and information prepared under the grant is incorporated into other health research sponsored by the state and more effectively linked to existing information in a 'clearinghouse' fashion. The web redesign also incorporated our goal of ensuring the information will "live on" after the funded lifecycle of the grant itself.

Effective Channels:

Our most effective **"on-going" channels** have been (1) electronic (including our website http://www.ofm.wa.gov/accesshealth/accesshealth.htm and E-Mail Alert system), (2) personal interactions (including one-on-one and small group meetings, and participation in and support of others' work groups, advisory and steering committees, and task forces), and (3) actively encouraging use of our research work (either "as is" or repackaged to fit needs). We have purposefully shied away from *broad* media coverage, however we have provided information to the media when revised messages were important.

Greatest challenges or barriers in communicating:
Greatest **challenges** included: (1) the sad state of the economy and thus people's ability to "hear" a message about expanding coverage and (2) resistance to "policy lessons" from our/others' research/practical findings when those findings do not support the pragmatic decisions that need to be made or the popular idea of the moment. (Findings regarding coverage affordability for low-income families and findings regarding the ineffectiveness of small employer pools – as currently designed - to significantly reduce costs are examples.)

To work within these challenges we (1) adopted an approach that did not include "pushing" for buy-in on specific options (although our research work did involve developing options), (2) acknowledged that consensus building on strategies viable in Washington would occur over the long run through processes fed by the work of the grant but not unique to the grant (e.g., the Legislative process) and (3) elected to "key into" what people are willing to focus on as common-ground starting points (e.g., employees of small business, children, the state becoming a better partner (especially in areas of administrative simplification), coverage and access in rural areas, sustaining public program gains).

APPENDICES

1. Sample Policy and Technical Requests
2. SHADAC Peer Review of Washington Methodology for Adjusting Medicaid Undercount
3. SHADAC Review of Washington Safety-Net Data for Replicating Minnesota Study

Appendix 1: Sample Policy and Technical Requests

Request	Specific Interest Supported (where known)
Explanation for difference in results based on Census Bureau's Current Population Survey (CPS) (and other national survey data) and Washington State's Population Survey (WSPS).	Widespread media, academic, policy makers, advocates, independently elected officials interested in understanding which numbers tell "truth"
Explanation for results that don't resemble HRSA and OFM results but use the same WSPS data	Various individuals interested in replicating /doing their own research with OFM data Common explanations for differences: • Different versions of WSPS used (e.g., 2002 WSPS v4 includes correction for Medicaid undercounting, previous versions do not) • Analyses cover different populations e.g., total vs. age 0-65a • Incorrectly attributing coverage source when multiple sources are identified – hierarchy of selection necessary • Handling of missing data • Unadjusted weights used • Observation counts not weights used • Confusing definitions – e.g., firms vs. establishments; employees (exclude self-employed); workers (include self-employed); dependents included or not? • Not using historical oversample • Nuances in collected vs imputed vs personally derived data (e.g., POVCAT provides predefined aggregation based on income levels which are not exactly at public program cutoffs) • Variations in software rounding
Review analysis completed by public and private "researchers" from technical perspective: • Are WSPS being used correctly? • How should they be used? • Which variables are most reliable? • Which variables should not be used?	Various individuals interested in replicating /doing their own research with OFM data
Who has access to affordable coverage? Who does not? Who would if enrollment limits on public programs were lifted?	Budget discussions

Request	Specific Interest Supported (where known)
Profiles of the uninsured targeted by Legislative districts (data not available by district / proxy for county level data currently the most representative	Basis for Legislators (and staff) understanding of their constituents and for their "home" presentations
Uninsured population aged 50-64	Basis for estimating the population that might be interested in the State's prescription drug discount card – people with insurance are assumed to have "some" prescription drug coverage.
County-level estimates of the uninsured (WSPS data reliable at the regional level – no county estimates actually available.) • Specific counties • Groups of counties (not aligned with the regions sampled in WSPS)	Basis for community-level options for serving the uninsured. Reasonable proxy can be determined from regional uninsured estimates and county population estimates.
Non-US citizens who are resident aliens	Constituent interested in understanding stories about non-citizens receiving benefits through public programs
Numbers of uninsured by income: • up to 200%FPL • 100-200%FPL	Populations for which existing public programs may be viable alternatives (e.g., Basic health for population up to 200% FPL)
Spells of uninsurance for Washington's uninsured population --- profiles of population with "short vs. long" spells	• OIC Task Force options • Cost impacts from churning
Coverage individuals / families had before becoming uninsured	General interest
"Real" access to providers for those who are uninsured	General interest
Numbers of uninsured who are eligible for Medicaid (and Basic Health) • statewide and by region	OIC background information as Legislation for 2005 considered
Counts of families that are uninsured or in which someone is uninsured	General interest
Regional or county variations in the American Indian and Alaskan Native populations insurance status – by age; poverty level and insurance source	Community and tribal planning to respond to local issues with access to coverage and care

Request	Specific Interest Supported (where known)
Patterns of uninsurance among different family sizes and composition (e.g. • children only • adults with children (single or dual parent) • adults with no children	Understanding populations for which existing public programs may be viable alternatives
Population over age 65 that is uninsured or underinsured - data sources are limited because residents of institutional housing (e.g., nursing homes, adult family homes, boarding homes) are not surveyed	Basis for understanding potential elderly population that might be served by free community clinic
Counts of university and community college students potentially eligible for health insurance if it were a requirement of enrollment	Development of a catastrophic coverage product being considered by carriers to serve this population
Distribution of self-employed workers and their dependents who are uninsured, by income (data at this level are not available) • Uninsured males age 20-30 of particular interest	Further understanding of the sub-group of self-insured young males who are the largest group of clients receiving workers' compensation for job-based injuries
Health care spending for: • Washington's total population • Washington's uninsured population	OIC Task Force
Numbers of women age 40-64 who are underinsured? And below 250% FPL?	DOH opportunity to use Breast and Cervical Health Program grant monies to serve the underinsured
Distribution of uninsured individuals by family status and income level breakdown based on public program administrative rules • Children (0-18) • Parents (19-64) • Childless adults (19-64)	Advocacy group work at community level to understand opportunities to support low income children and their parents
Distribution of uninsured families by family status and income level breakdown based on public program administrative rules • Families with children • Families with no children	Advocacy group work at community level to understand opportunities to support low income children and their parents
Best approach for conducting analysis of employer-based coverage • Update RAND consultant's analysis of WA employer-based coverage?	Ongoing and increasing interest from Legislative staff, policy makers, public programs, advocates, in options for making employer coverage "more affordable"

Request	Specific Interest Supported (where known)
Profile Washington employers and their offering of health insurance to: • Individuals • Families • Retirees	Ongoing and increasing interest from Legislative staff, policy makers, public programs, advocates, in options for making employer coverage "more affordable"
Best questions to ask in community-based survey of values re covering the uninsured	HumanLinks (local community foundation)
Approaches and strategies for covering all children • Estimated numbers of children potentially covered under different strategies	Ongoing Legislative interest in creative strategies for covering all children
Questions useful in understanding impacts on enrollees of cost-sharing / benefit changes in public programs	Other states work on understanding implications of cost-sharing for low-income populations

Appendix 2. SHADAC Peer Review of Washington Methodology for Adjusting Medicaid Undercount

June 26, 2003

TO: Thea N. Mounts
State of Washington
Office of Financial Management

Jenny Hamilton
Governor's Executive Policy Office

FR: Michael Davern, Ph.D.
Kathleen Call, Ph.D.

RE: Undercount Methodology Review

We enjoyed reviewing your paper, and have spent a lot of time thinking about the Medicaid undercount, or the fact that *estimates* of the number of individuals on Medicaid derived from general population surveys are always less than the number of individuals that administrative records indicate are enrolled. In fact, we are currently working on a proposal to RWJF's Health Care Financing and Organization program to request funding to study this issue in more depth. Our comments fall into two broad categories: the implications of the undercount (what is and is not known), and administrative data issues.

Implications of the undercount:
Although many researchers, including, Lewis, Ellwood and Czajka (1998) have noted that general population surveys of health insurance coverage appear to undercount the number of individuals enrolled in Medicaid programs (Swartz and Purcell 1989; Holahan, Winterbottom et al. 1995; Bennefield 1996; Dubay and Kenney 1996; Blumberg and Cynamon 1999; Congressional Budget Office 2003), we know less about the implications of the Medicaid undercount for other estimates derived from these surveys (other public or private coverage, or those lacking insurance altogether).

The assumption made by some analysts is that the undercount leads to an overestimate in the number of uninsured derived from general population surveys. For example, consistent with your imputations methodology, the Urban Institute uses a simulation model (TRIM2) to adjust the CPS data for those respondents who do not report Medicaid enrollment but from all other responses

would likely be covered by Medicaid (Giannarelli 1992; Lewis, Ellwood et al. 1998). That is, "eligible" respondents are reassigned from

uninsured to Medicaid in order to match the count of recipients indicated in the Medicaid administrative files. As you know, the adjustment lowered the CPS rate of uninsurance from 17.4 for 15.5 percent.

The assumption underlying this recoding of "eligible" to "enrolled" based on other program enrollment (e.g., Temporary Aid to Needy Families, food stamps) are less firm since welfare reforms severed the link between cash and other assistance programs and Medicaid. Although, it could be argued that those "eligible and uninsured" would be enrolled in the event of medical need, right?

Although the Medicaid undercount *implies* that Medicaid recipients do not report Medicaid coverage in surveys asking about health insurance coverage, the question remains whether they report coverage through a source other than Medicaid or they report no coverage at all. We conducted a study in Minnesota (Call, Davidson et al. 2001) to directly test the assumption that the undercount of Medicaid recipients leads to an overestimate of the number of people without health insurance. In this study we analyzed responses to health insurance questions from a *known* sample of public program enrollees to determine the accuracy of their reports of insurance coverage. The results indicated that, for the most part, Medicaid enrollees know whether or not they have insurance; they also know that they have public, rather than private, coverage; they are less sure, however, which public program they are enrolled in. When the results of the survey of public program enrollees were applied to the estimates from the state household survey (conducted in conjunction with the enrollee survey) we found that the Medicaid undercount introduced only a negligible (non-significant) bias to the estimate of the uninsured in Minnesota.

The study results call into question the reliability of the assumption that estimates of the uninsured from general population surveys are biased as a result of the Medicaid undercount as well as calling into question the wisdom of adjusting estimates of the uninsured to match administrative counts of Medicaid enrollment. HOWEVER, it is unclear how well the Minnesota findings generalize to other states; therefore, we are seeking funding to replicate this study in three states with different public program configurations, and who use different survey instruments in the state surveys.

Administrative data issues:
Methodologies that adjust survey estimates to match administrative counts of public program enrollment necessarily make assumptions about the extent to which administrative data are the gold standard by which to judge the results of survey data. Clearly, neither is error free, and uncovering the source of the discrepancy between survey estimates and administrative counts of Medicaid participation is a study in and of itself.

Your documentation does not fully describe how the administrative counts were derived, so we want to draw your attention to a couple of issues to increase your confidence in making appropriate comparisons between your state population survey (SPS) counts and administrative data counts:

- If the institutionalized population (e.g., half-way houses, nursing homes, many out-of-home placement facilities for children – excluding juvenile detention facilities) is screened out of your SPS, they must also be removed from the administrative data count.

- How Medicare/Medicaid "dual eligibles" are counted in administrative counts and survey estimates must be attended to. Do they count one or twice in enrollment files? Are they captured in your SPS? Can respondents indicate they have more than one source of coverage? If yes, the question remains whether they "identify" more with Medicare and not mention Medicaid (assuming they don't confuse the names altogether) and therefore contribute to the undercount?
- Are residents of Washington with private coverage also allowed to enroll in Medicaid? Minnesota allow residents to be enrolled in the Medicaid program *and* to retain certain kinds of private insurance as well—generally only if the private coverage provides very low levels of insurance coverage and then it will be billed for Medicaid services as a third-party with liability (e.g., disabled children enrolled in TEFRA programs where Medicaid coverage supplements private coverage for these very costly children). For any number of reasons, these Medicaid/Third-party-liability (TPL) recipients are likely to report private rather than Medicaid coverage, and therefore also contribute to the undercount in the SPS.
- Duplication of records in administrative data is always a concern -- particularly of people that move between programs and show up, and therefore are counted, more than once. In a study we are currently conducting with the Minnesota Department of Human Services, within the one-month population of 521,000 program enrollee records, there were multiple instances for 3,000 enrollees, which resulted in 65,000 duplicate records.
- Emergency Medicaid or "spend Downs" for emergency medical services can be a source of under-reporting. In some states this type of coverage is available to people over the income eligibility threshold going through costly medical procedures, and to non-citizens who may (or may not) be otherwise eligible for Medicaid. For example is a study conducted by California:

  > "More than 400,000 non-citizens who were Medi-Cal beneficiaries under the OBRA Aliens aid code received a limited scope of Medi-Cal benefits: coverage for pregnancy or emergency medical services only. Those who were covered for prenatal care and delivery would be likely to remember having received Medi-Cal because they usually had coverage over for at least a few months, but those who had coverage only for emergency medical services or just for the delivery of a baby (i.e., women who did receive any prenatal care covered by Medi-Cal) may not recall it because their coverage may have been all but "invisible" to them, paying only a stay in the hospital or some equivalent" (Brown et.al. 1997).

Another adjustment issue: do you make an adjustment for interrupted phone service in your post-stratification weights? If so, what was the impact of this adjustment on your Medicaid and uninsurance estimates? We know that households without telephones are more likely to be publicly insured or uninsured than privately insured (Hall et al. 1999).
I wonder if this is worth exploring. The adjustment for interrupted phone service had a negligible impact on coverage estimates in the MN survey, but did have in impact in West Virginia.

Again, thank you for the opportunity to review your paper. If you would like to set up a time to discuss your paper and related issues, let us know. You can reach us at:

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Kathleen Call, 612-624-3922
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Appendix 3: SHADAC Review of Washington Safety-Net Data for Replicating Minnesota Study

WA Uncompensated Care Study—Feasibility Assessment

Gestur Davidson, January 14, 2004

1. The county-specific Medicaid enrollment data are required in one form or another—either as a separate, independent control variate or to combine with the WA-BH data—in order to assess the impact of the Washington State Basic Health/total public program coverage on the levels of uncompensated care. Since WA currently can locate Medicaid enrollment data only back to January 1997, we need to assess whether it's worthwhile to conduct such a study with the analytic time-frame restricted to that period forward. By worthwhile I mean: What is the likelihood you could detect a policy important impact of Washington State Basic Health coverage on the levels of uncompensated care? This is essentially a question of statistical power: is there enough *variation* in enrollment over this period to likely provide us with a chance to see an impact on total uncompensated care per capita across the counties?

2. Since WA-BH began sometime in 1993, we need to assess whether enrollment in that program from 1997 onward provides us with that likely amount of variation. The first point to note is that over the period from 1997-2003, statewide the enrollment in WA-BH ***declined*** by 25%. This means that we would be in the somewhat uncomfortable position of having to sell to policy-types and politicians a study on the impact of WA-BH coverage based on uncompensated care going up as enrollment declined, rather than the reverse for the MN study.

3. But even assuming away that "political salability" hurdle, there is not very much variation over time among the counties in their WA-BH enrollment. [Note that variation *across* counties does not impact our estimates because of the fixed-effects estimator that we would be required to employ, as we did in MN. Such an estimator bases the impact of WA-BH solely on the change *over time* within counties.] Recall that in our MN study we had data on the enrollment of MnCare starting from its inception in the latter months of 1992 through the period of very rapid growth ending in 1996, when the growth in enrollment more or less slowed way down. The restricted period of time for the proposed WA study would begin *after* the substantial growth into WA-BH had stopped (indeed 1998 enrollment was almost exactly equal to 1997 statewide). That is, over this restricted period of time we see some variation among the counties in the direction and quantitative amounts of their WA-BH enrollment change, but it is not large. Specifically, 29 of the 39 counties had percentage rates of growth over the entire seven year period of between –40% and + 40%; and 20 of the 39 counties had percentage rates of growth over the entire seven year period between the more limited range of –25% and + 25%.

4. The preponderance of low levels of variability in WA-BH enrollment over time of course is especially critical since there are relatively few counties in WA to use in defining our unit of analysis. Again, in MN we had 81 counties with at least one hospital and five years of data on them, resulting in 405 county-year observations. Here we would have 273.

5. In the MN study we did not aggregate public program enrollment since there was very little change in Medicaid enrollments over that time period but, as noted, very rapid growth over time in MnCare. Adding them together would likely have produced a small non-significant finding. Indeed, the coefficient for the impact of Medicaid enrollment by itself was very small (i.e. 7% of the size of the MnCare one) and had a p-value of 0.68! [Note that the coefficient of the combined public program enrollment could be thought of as a weighted one, and of course MnCare was quite small relative to Medicaid.] And I think that is what you might expect with little total variation, including the number of counties, the number of years and of course the magnitude of the changes over time in them. There is no theoretical reason for not considering combining all public program enrollment in a study for WA. But if you do so, you get even less variation over time among the counties: 26 of the 39 counties had growth in combined WA-BH and Medicaid enrollment over the entire seven year period of between –20% and + 20%. Clearly that is not going to help.

6. Finally, as we did in the MN study, we would use weighted LS regression so that the larger counties had more weight, since we want an estimate that generalizes to the entire state. In the WA data, we see a tendency for there to be less change in the larger counties. Specifically, the weighted variance of the overall percentage change in WA-BH enrollment is only 54% of the unweighted variance.

7. I've looked at the financial data on the hospitals from the URL that was supplied and I only have a single question: I see Charity Care listed, but no mention of Bad Debt. I see something called Other Deductions but it often looks pretty small. I would need to know if Bad Debt is lumped in with the Charity Care numbers, which if so is fine.

CONCLUSIONS

Overall, considering everything, I believe that without the early Medicaid data—and hence the need to restrict the modeling to the 1997-2003 period—there would be a pretty large chance that we would *not* find anything meaningful for an effect size for the impact of Washington State Basic Health enrollment on uncompensated care. It appears that the other data are available, conditional on the Bad Debt being included in the Charity Care numbers. Thus the replication of the MN analysis *could be* done and with the resources we estimated early on. But I would have a hard time recommending that it *should be* undertaken with so low a probability of realizing any meaningful end result.

Finally, I haven't done a rigorous power analysis since I did not have the county population data on which to form the per capita dependent and independent variables. Despite not having this more refined power analytic information upon which to base an opinion, given the nature of the numbers that I have examined, I feel comfortable basing an opinion on them.